

Shared Services Partnership Committee Part A (2)

Thursday 16 July 2026, 10:00 - 11:40

Microsoft Teams



Part A (2) - Items for Information - NWSSP Annual Reports 2025-26

Agenda

1. Items for Information - NWSSP Annual Reports 2025-26

Information

 NWSSP Annual Reports 2025-26 (for SSPC information) SSPC CP July 2026.pdf (3 pages)

1.1. NWSSP Audit Committee Annual Report 2025-26

Information

 NWSSP Audit Committee Annual Report 2025-26.pdf (14 pages)

1.2. Local Counter Fraud Services Annual Report 2025-26

Information

 Local Counter Fraud Services Annual Report 2025-26.pdf (12 pages)

1.3. NWSSP Concerns and Complaints Annual Report 2025-26

Information

 NWSSP Concerns and Complaints Annual Report 2025-26.pdf (12 pages)

1.4. NWSSP Declarations of Interest and Gifts, Hospitality & Sponsorship Annual Report 2025-26

Information

 Annual Report on Conflict of Interests, Gifts, Hospitality and Sponsorship 2025-26.pdf (16 pages)

1.5. Health and Safety Annual Report 2025-26

Information

 Health and Safety Annual Report 2025-26.pdf (33 pages)

1.6. Welsh Language Annual Report 2025-26

Information

 Welsh Language Annual Report 2025-26.pdf (31 pages)

1.7. Duty of Quality Annual Report 2025-26

Information

 Duty of Quality Annual Report 2025-26.pdf (37 pages)

1.8. Medical Examiners Service Annual Report 2025-26

Information

 Medical Examiner Services Annual Report 2025-26.pdf (27 pages)

1.9. Surgical Materials Testing Laboratory (SMTL) Annual Report 2025-26

Information

-  [Surgical Materials Testing Laboratory Annual Briefing 2025-26 SSPC CP July 2026.pdf \(7 pages\)](#)
-  [Appendix 1 - 2025 UKAS Inspection Report for SMTL.pdf \(18 pages\)](#)
-  [Appendix 2 - 2025 UKAS Schedule of Accreditation for SMTL.pdf \(8 pages\)](#)

 GIG CYMRU NHS WALES		Partneriaeth Cydwasaethau Shared Services Partnership		Date of Meeting: 16 July 2026	
<i>The report is <u>not exempt</u></i>					
Teitl yr Adroddiad/Title of Report:					
Suite of NWSSP Annual Reports 2025-26					
Arwwinydd/ Lead:		Various Individuals Across NWSSP			
Awdur/ Author:		Roxann Davies, Corporate Services Manager			
Swyddog Adrodd/ Reporting Officer:		Alison Ramsey, Director of Finance & Corporate Services			
Pwrpas yr Adroddiad/Purpose of the Report:					
To present to the Committee, for information, a suite of NWSSP Annual Reports for 2025-26 which have been prepared in accordance with existing established governance arrangements.					
Llywodraethu/Governance:					
Amcanion/ Objectives:		The paper supports the Committee's role in maintaining oversight of the wider governance and assurance framework across NWSSP by presenting annual reports that have already been subject to their relevant internal governance routes.			
Tystiolaeth/ Supporting evidence:		The annual reports appended to the Part A2 public bundle, together with confirmation that they have progressed through the appropriate established governance mechanisms prior to submission to the Committee.			
Ymgynghoriad/Consultation:					
The reports have already been approved through the established agreed governance mechanisms, with all reports having had oversight from the NWSSP Senior Leadership Group through the May and June cycles. A number of the reports were also presented to the Extraordinary NWSSP Audit Committee meeting on 15 June 2026. This paper does not seek further approval or endorsement from the Committee, it is for information only.					
Adduned y Pwyllgor/Committee Resolution (insert ✓):					
DERBYN/ APPROVE		ARNODI/ ENDORSE		TRAFOD/ DISCUSS	
Argymhelliad/ Recommendation:		The Committee is asked to receive, for information only, the NWSSP Annual Reports for 2025-26 appended to the Part A2 public bundle, entitled "Part A2 - Public - Annual Reports for Information", for information only. A small number of additional annual reports remain subject to finalisation through their established governance routes and will be presented to			

	the Committee for information at its next meeting on 15 September 2026.
Crynodeb Dadansoddiad Effaith/Summary Impact Analysis:	
Cydraddoldeb ac amrywiaeth/Equality and diversity:	There are no direct equality and diversity implications arising from this information-only paper. Any relevant considerations are addressed within the governance arrangements for the individual reports, where applicable.
Cyfreithiol/Legal:	There are no new legal implications arising from this covering paper. Any statutory or regulatory requirements relevant to the individual annual reports have been considered through their established governance routes.
Iechyd Poblogaeth/Population Health:	There are no direct population health implications arising from this information-only paper.
Ansawdd, Diogelwch a Profiad y Claf/Quality, Safety & Patient Experience:	There are no direct quality, safety or patient experience implications arising from this covering paper. Where relevant, these matters are addressed within the individual annual reports and their associated governance arrangements.
Ariannol/Financial:	There are no direct financial implications arising from this information-only paper.
Risg a Aswiriant/Risk and Assurance:	The presentation of these reports provides assurance that NWSSP continues to maintain annual reporting arrangements across key areas of responsibility. The reports appended have been subject to their relevant governance mechanisms prior to being shared with the Committee. The remaining reports will be presented to the Committee once their respective governance routes have concluded.
Dyletswydd Ansawdd/Duty of Quality:	There are no specific Duty of Quality implications arising from this covering paper. The submission of annual reports through established governance routes supports transparency, accountability and organisational learning.
Gweithlu/Workforce:	There are no direct workforce implications arising from this information-only paper.
Deddf Rhyddid Gwybodaeth/Freedom of Information Act:	Open. The information is disclosable under the Freedom of Information Act 2000.

SUITE OF NWSSP ANNUAL REPORTS 2025-26

1. INTRODUCTION

This paper presents, for information only, a suite of NWSSP Annual Reports for 2025-26 appended to the Part A2 public bundle. No decision is required from the Committee in relation to the individual reports at this stage.

Each report has been prepared by the relevant lead area and progressed through the appropriate established governance mechanism prior to inclusion within the bundle. The cover paper is intended to provide Committee visibility and does not seek approval, endorsement or further scrutiny of the reports.

In summary, the Part A2 public bundle comprises completed NWSSP Annual Reports for 2025-26 which have concluded their respective governance routes and are therefore presented to the Committee for information only.

A small number of further annual reports remain subject to final governance review and will be submitted for information at the next Committee meeting on 15 September 2026, these being the Information Governance, Welsh Infected Blood Support Scheme and the Legal & Risk and Welsh Risk Pool Annual Reports.

The Part A2 public bundle comprises the following reports:

1. NWSSP Audit Committee Annual Report 2025-26;
2. Local Counter Fraud Services Annual Report 2025-26;
3. NWSSP Concerns and Complaints Annual Report 2025-26;
4. NWSSP Declarations of Interest and Gifts, Hospitality & Sponsorship Annual Report 2025-26;
5. Health and Safety Annual Report 2025-26;
6. Welsh Language Annual Report 2025-26;
7. Duty of Quality Annual Report 2025-26;
8. Medical Examiners Service Annual Report 2025-26; and
9. Surgical Materials Testing Laboratory Annual Report 2025-26.

2. RECOMMENDATION

The Committee receives the suite of annual reports, for information only.



GIG
CYMRU
NHS
WALES

Partneriaeth
Cydwasaethau
Shared Services
Partnership



GIG
CYMRU
NHS
WALES

Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

Velindre University NHS Trust Audit Committee for NHS Wales Shared Services Partnership

Annual Report 2025-2026

1. FOREWORD

I am pleased to present the Annual Report of the Velindre University NHS Trust Audit Committee for NHS Wales Shared Services Partnership (the Committee). It outlines the coverage and results of the Committee's work for the year ending 31 March 2026.

I have acted as the Chair of the Audit Committee since 1 February 2024 and have been ably supported by Independent Member, Vicky Morris, throughout the year. I would like to take this opportunity to put on record my sincere thanks to Vicky for her significant contributions made during the year. I wish to record my thanks also to John Union (Independent Member (Finance)) who observed the February meeting of the Audit Committee. He will be joining the Committee as an additional Independent Member.

I would also like to express my thanks to all the NWSSP Officers supporting the Committee who have supported and contributed to the work carried out on its behalf and for their commitment in meeting important targets and deadlines. I also wish to record my appreciation for the support and contribution given by Internal Audit at NWSSP, Local Counter Fraud Services and by Audit Wales.

During 2025-26 NWSSP has continued to grow both in terms of size and complexity. The total revenue expenditure for the year was £1,146m, compared to less than £50m when NWSSP was first established in 2011. The wide range of services provided by NWSSP significantly changes its risk profile and requires the Committee to work with its auditors in particular, in ensuring that appropriate assurances are in place.

Most meetings continue to be held virtually and have worked well, albeit that we have reintroduced one face-to-face meeting annually. A characteristic of the Committee's work and its related meetings has been the willingness of all parties to raise issues, acknowledge shortcomings and put forward positive suggestions to help bring about meaningful improvements to services, systems, and day-to-day working practices. This approach is to be welcomed and is very much appreciated by the Committee.

I am keen to foster and promote a culture of continual improvement and, as a Committee, we continued to conduct a brief effectiveness review session at the end of each meeting and introduced topical service presentations to the agenda in order to strengthen and engage in a meaningful way with this process. We also conduct an annual survey which seeks the opinion of Committee members and those who attend the meetings as to the effectiveness of the Committee and its proceedings.

Looking forward, the Committee intends to continue to pursue a full programme of work covering a wide range of topics and subject areas as part of its long-term aim to help further strengthen the governance arrangements of NWSSP, in order to achieve better value for money and high quality, sustainable outcomes for NHS Wales.



Mr Gareth Jones
Chair of the Velindre University NHS Trust Audit
Committee for NWSSP

2. INTRODUCTION

The Committee's business cycle runs from the closure of the Annual Accounts in one financial year to the next. This reflects its key role in the development and monitoring of the Governance and Assurance framework for NWSSP, which culminates in the production of the Annual Governance Statement.

This report sets out the role and functions of the Audit Committee and summarises the key areas of business undertaken during the year. In addition, the report sets out some of the key issues, which the Committee will be focussing on over the next few years.

3. ROLE, MEMBERSHIP, ATTENDEES AND COMMITTEE ATTENDANCES

3.1 Role

The primary role of the Velindre University NHS Trust Audit Committee for Shared Services Partnership (the Audit Committee) is to review and report upon the adequacy and effective operation of NWSSP's overall governance and internal control system. This includes risk management, operational and compliance controls, together with the related assurances that underpin the delivery of NWSSP's objectives as set out in the Audit Committee Terms of Reference, which were reapproved in July 2024 to ensure these key functions were embedded within the SSPC Standing Orders and governance arrangements. The membership of the Audit Committee comprises Trust Board members. Therefore, the Audit Committee provides assurances to the SSPC and also to the Trust as host.

The organisation's system of internal control has been designed to identify the potential risks that could prevent NWSSP achieving its aims and objectives. It evaluates the likelihood of the risks being realised, considers the impact should they occur and seeks to manage them efficiently, effectively, and economically. Where appropriate, the Committee will advise the SSPC and Velindre University NHS Trust as host, where appropriate and the Accountable Officers of NWSSP and the Trust on where and how the Assurance Framework may be strengthened and developed further.

The Committee operates in accordance with Terms of Reference which are included within the Standing Orders for the SSPC and Velindre University NHS Trust.

3.2 Governance Framework

NWSSP is a non-statutory hosted organisation. It operates within an established governance and accountability framework set out by Welsh Ministers. This framework, as set out below, is designed to ensure that NWSSP operates in true partnership, owned and operated by the NHS in Wales operating under a hosting arrangement with Velindre University NHS Trust.

Decisions on NWSSP services are made on an all-Wales basis by the Shared Services Partnership Committee (SSPC). The SSPC was established in accordance with the Velindre National Health Service Trust Shared Services Committee (Wales) Regulations 2012 and the functions of managing and providing shared services (professional, technical, and administrative services) to the NHS in Wales is included within the Velindre National Health Service Trust (Establishment) (Amendment) Order 2012. The Regulations were subsequently amended in 2021 to include Special Health Authorities (SHAs) via the Velindre National Health Service Trust Shared Services Committee (Wales) (Amendment) Regulations 2021.

Model Standing Orders are issued by Welsh Ministers to Local Health Boards and Welsh NHS Trusts using powers of direction provided in section 12(3) of the National Health Services (Wales) Act 2006.

Velindre University NHS Trust (the Trust) must agree Standing Orders for the regulation of the Shared Services Partnership Committee's (the SSPC) proceedings and business. These SSPC Standing Orders form an Annex to the Trust's own Standing Orders and have effect as if incorporated within them.

They are designed to translate the statutory requirements set out in the Velindre University NHS Trust Shared Services (Wales) Regulations 2012 (2012/1261 (W.156)), amended 2021 and the Trust's Standing Order 3 into day-to-day operating practice. These together with the adoption of a scheme of decisions reserved to the SSPC; a scheme of delegation to NHS Wales Shared Services Partnership officers and others; and in conjunction with Velindre University NHS Trust Standing Financial Instructions (SFIs), they provide the regulatory framework for the business conduct of the SSPC.

Health Boards, NHS Trusts and, latterly the two Special Health Authorities have collaborated over the operational arrangements for the provision of shared services and have an agreed Memorandum of Co-operation to ensure that the arrangements operate effectively through collective decision making in accordance with the policy and strategy set out above, determined by the SSPC.

A Hosting Agreement dated June 2012 between the Partners provides for the terms on which Velindre University NHS Trust will host NWSSP and an Interface Agreement between the Chief Executive of the Trust (as the Accountable Officer for the organisation) and the Managing Director of NWSSP (as the Accountable Officer for NWSSP) dated June 2012 defines the respective roles of the two Accountable Officers.

These documents together form the basis upon which the SSPC governance and accountability framework has developed. Together with the adoption of the Trust's Standards of Behaviour Framework, this is designed to ensure the achievement of the standards of good governance set for the NHS in Wales.

Welsh Government Independent Review of NHS Wales Shared Services Partnership Accountability & Governance Arrangements

In April 2025, Welsh Government commissioned an independent review of NWSSP accountability and governance arrangements, recognising the increasing scale, complexity and maturity of the organisation since the current framework was established. This followed commitments set out in A Healthier Wales (2018) to review hosted and national functions to consolidate national activity and provide greater clarity of governance and accountability.

The Independent Review, published in December 2025, concluded that the overall governance framework for NWSSP is fundamentally sound, while making recommendations to strengthen clarity of accountabilities, assurance to NHS Boards, and the effectiveness of key governance arrangements. This included particular emphasis on the operation of the Shared Services Partnership Committee (SSPC) and the relationship between NWSSP and Velindre University NHS Trust, as the statutory host organisation.

Throughout the review and implementation of its recommendations, which is ongoing, NWSSP has continued to operate within the requirements of the existing governance framework, maintaining effective accountability and assurance arrangements. The Review and its ongoing implementation provide an opportunity for governance arrangements to be actively strengthened, with continued oversight through established governance structures into 2026–27.

3.2 Membership

The Audit Committee for NWSSP is a sub-committee of Velindre University NHS Trust and operates alongside the Trust's own Audit Committee. Membership during the year has been two Independent Members who serve on both Audit Committees, with one being the Chair which satisfied the quorum requirements.

The Terms of Reference of the Committee provide for there to be three members who are Independent Members of the Trust. However, for 2025-26 there were two dedicated Independent Members, both of whom attended every meeting of the Committee ensuring that each meeting was quorate.

During the year, the Trust appointed a dedicated Independent Member for Finance who observed the February 2026 meeting of the Audit Committee and subsequently joined the Committee as a member.

3.3 Attendees

The Committee's work is informed by reports provided by Audit Wales, Internal Audit, Local Counter Fraud Services and NWSSP officers. Although they are not members of the Committee, auditors, and other key personnel from both Velindre University NHS Trust, as host, and NWSSP are invited to attend each meeting of the Audit Committee. Invitations to attend the Committee meeting are also extended where appropriate to staff where reports relating to their specific area of responsibility are discussed.

3.4 Attendance at Audit Committee 2025-26

During the year, the Committee met on four occasions. All meetings were quorate and were well attended as shown in **Figure 2** overleaf:

Figure 2: Meetings and Member Attendance 2025-26

In Attendance	13/05/20 25	8/07/202 5	07/11/20 25	10/02/20 26	Total
Members					
Gareth Jones, Chair & Independent Member	✓	✓	✓	✓	4/4
Vicky Morris, Independent Member	✓	✓	✓	✓	4/4
Audit Wales					
Audit Team Representative	✓	✓	✓	✓	4/4
NWSSP Audit and Assurance Services					
Director of Audit & Assurance	✓	✓	✓	✓	4/4
Head of Internal Audit	✓	✓	✓	✓	4/4
NWSSP Counter Fraud Services					
Local Counter Fraud Specialist	✓	✓	✓	✓	4/4
NWSSP					
Professor Tracy Myhill OBE, Chair of SSPC	x	✓	✓	x	2/4
Neil Frow OBE, Managing Director	✓	✓	✓	✓	4/4
Alison Ramsey, Director of Finance & Corporate Services	✓	✓	✓	✓	4/4
Linsay Payne, Deputy Director of Finance & Corporate Services	✓	✓	✓	✓	4/4
James Quance, Assistant Director of Corporate Services	✓	✓	✓	✓	4/4
Carly Wilce, Corporate Services Manager	✓	✓	✓	✓	4/4
Velindre University NHS Trust					
Matthew Bunce, Executive Director of Finance Services	✓	x	x	✓	2/4
David Donegan, Chief Executive, Part year to November 2025	✓	x	-	-	1/2
Carl James, Deputy Chief Executive and Interim Chief Executive Officer from November 2025	-	✓	✓	x	2/4
Non Gwilym, Interim Director of Corporate Governance	✓	✓	x	x	2/4

3.5 AUDIT COMMITTEE BUSINESS

The Audit Committee provides an essential element of the organisation's overall assurance framework. It has operated within its Terms of Reference in accordance with the guidance contained within the NHS Wales Audit Committee Handbook.

The Audit Committee agenda broadly follows a standard format, comprising of four key sections; External Audit, Internal Audit, Counter Fraud Services and 'Internal Control and Risk Management'. These are discussed further below.

3.5.1 EXTERNAL AUDIT (AUDIT WALES)

Audit Wales provides an Audit Position Statement at each meeting, summarising progress against its planned audit work. The following additional reports were presented during the year:

- Audit Wales Nationally Hosted NHS IT Systems Assurance Report
- Audit Wales Management Letter
- Audit Assurance Arrangements

Audit Wales have stated that the findings of their work enable them to place reliance on the services provided by NWSSP.

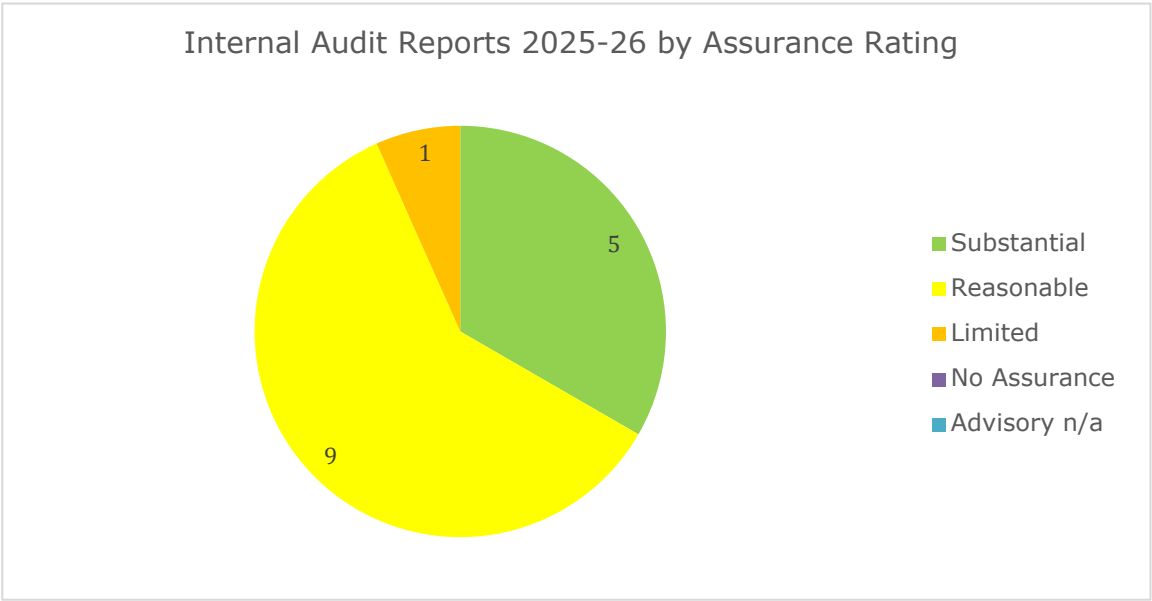
3.5.2 INTERNAL AUDIT

Internal Audit have continued to support the organisation in the development and improvement of its governance framework by providing proactive advice and support on new developments and ensuring that the existing systems and processes of control are reviewed, weaknesses identified, and suggestions for improvement made.

15 Internal Audit reports were generated during 2025-26 and they achieved assurances as follows:

- Five reports achieved Substantial Assurance;
- Nine reports achieved a Reasonable Assurance;
- One achieved Limited Assurance;
- None were Advisory/Non-Opinion; and
- None were rated as No Assurance.

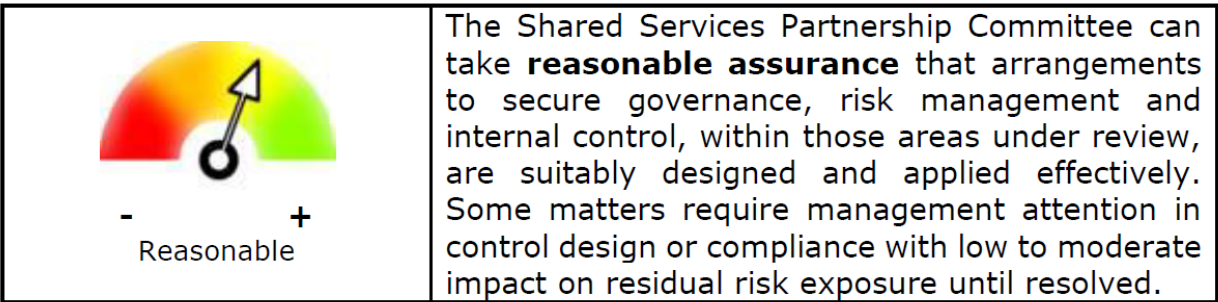
Figure 3: Internal Audit Reports 2025-26 by Assurance Rating



During 2025-26, the reports to Committee on Internal Audit’s programme of work included:

- Internal Audit Position Statement at each meeting;
- Head of Internal Audit Opinion and Annual Report;
- Quality Assurance and Improvement Programme Report;
- Internal Audit Operational Plan; and
- Internal Audit Reports, as detailed in Appendix A.

Figure 4: Head of Internal Audit Opinion: Reasonable Assurance



3.5.3 LOCAL COUNTER FRAUD SERVICES

The work of the Local Counter Fraud Services is undertaken to minimise the risk of and incidence of fraud (and/or corruption) within NWSSP to an absolute minimum. Regular reports were received by the Committee to monitor progress against the agreed Counter Fraud Plan, including the following:

- Counter Fraud Work Plan 2025/26
- Counter Fraud Progress Update at each meeting; and
- Counter Fraud Annual Report 2025/26.

NWSSP's dedicated local Counter Fraud specialist operates a regular annual programme of raising fraud awareness, for which a number of days are allocated and included as part of a Counter Fraud Work Plan which is approved annually by the Audit Committee. In addition, staff newsletters are produced periodically and are published on NWSSP's intranet; all successful prosecution cases are publicised to obtain the maximum deterrent effect.

3.5.4 INTERNAL CONTROL AND RISK MANAGEMENT

In addition to the audit reports dealt with by the Committee during the reporting period, a wide range of internally generated governance reports/papers were produced for consideration by the Audit Committee including:

Annual Governance Statement: During 2025-26, the NWSSP produced its Annual Governance Statement which explains the processes and procedures in place to enable NWSSP to carry out its functions effectively. The Statement brings together all disclosures relating to governance, risk, and control for the organisation.

Tracking of Audit Recommendations: The Committee has continued focus on the timely implementation of audit recommendations. The overall position with this is very positive but occasionally requests are made to extend the date of an agreed action due to a change in circumstance. All such requests have to be approved by the Committee.

Following the introduction of the Global Internal Audit Standards (GIAS) from April 2025, Internal Audit reporting terminology has been updated. Audit recommendations are now referred to as key findings, and progress against management responses is monitored through the Agreed Management Actions Tracker, replacing the previous Tracking of Audit Recommendations report.

Audit Committee Effectiveness Survey: The Audit Committee completes an annual committee effectiveness survey evaluating the performance and effectiveness of:

- the Audit Committee members and Chair;
- the quality of the reports presented to Committee; and
- the effectiveness of the Committee secretariat.

The survey questionnaire comprises self-assessment questions intended to assist the Audit Committee in assessing their effectiveness with a view to identifying potential areas for development, going forward.

The annual committee effectiveness survey was discussed at the Audit Committee meeting in April 2026, having been deferred pending the outcome of the Welsh Government Review. The Review sought evidence regarding its operation and made no recommendations regarding the effectiveness of the Committee. Consequently, it was agreed to undertake the survey in May 2026

and report back the findings, including any agreed development actions, to the Audit Committee meeting in July 2026.

In addition, Audit Committee Members were invited to participate in the Autumn Committee Development Day held in October 2025, which provided a dedicated forum for members to reflect on and inform the strategic direction of NWSSP. The session included a review and refresh of the NWSSP Strategy Map, consideration of the MAG report and broader organisational priorities, and discussion on how NWSSP can further support health organisations in delivering their plans. Updates were also provided on key transformation programmes, including Transforming Access to Medicines (TrAMS) and the Electronic Staff Record (ESR), alongside collective reflections from members to support continuous improvement in the effectiveness and impact of the Committee.

Private Meeting with Auditors

In line with recognised good practice, an annual private meeting was held in January 2026 between Audit Committee members, Internal Audit, External Audit, and the Local Counter Fraud Specialist. This provided an opportunity for any matters of concern to be raised without the involvement of NWSSP corporate directors. No issues of concern arose from the meeting. All auditors are also aware that they can directly approach the Chair at any time with any matters that concerns them.

5. REPORTING AND COMMUNICATION OF THE COMMITTEE'S WORK

The Committee reports a summary of the key issues discussed at each of its meetings to the Senior Leadership Group, Shared Services Partnership Committee and to Velindre University NHS Trust Board by way of an Assurance Report. In addition, this Annual Report seeks to bring together details of the work carried out during the reporting period, to review and test NWSSP's Governance and Assurance Framework. The outcome of this work has helped to demonstrate the effectiveness of NWSSP's governance arrangements and underpins the assurance the Committee was able to provide.

6. CONCLUSION AND FORWARD LOOK

The work of the Audit Committee in 2025-26 has been varied and wide-ranging. The Committee has sought to play its part in helping to develop and maintain a more effective assurance framework in a constantly changing and developing organisation, and improvements have been evidenced by the findings of internal and external audit.

Looking forward to 2026-27 the Audit Committee will continue to explore the financial, management, governance and quality issues that are an essential component of the success of NWSSP.

Specifically, the Audit Committee will:

- Continue to examine the governance and internal controls of NWSSP;

- Monitor closely risks faced by NWSSP;
- Work closely with external and internal auditors, on issues arising from both the current and future agenda for NWSSP;
- Ensure that the SSPC and Velindre's Trust Board is kept aware of its work including both positive and adverse developments; and
- Request and review a number of deep dives into specific areas to ensure that it provides adequate assurance to both the Audit Committee and the SSPC.

APPENDIX A
List of Internal Audits Undertaken and Assurance Ratings

Internal Audit Assignment	Assurance Rating 2025-26	Date Presented To Audit Committee
Primary Care Service - Ophthalmic	Substantial	7 November 2025
Targeted Estates Funding	Substantial	10 February 2026
Payroll Services	Substantial	28 April 2026
NWSSP Recruitment and Retention	Substantial	15 June 2026
Budget Setting	Substantial	15 June 2026
Accounts Payable	Reasonable	7 November 2025
Risk Management	Reasonable	7 November 2025
Radiopharmacy (1)	Reasonable	7 November 2025
TrAMS Digital	Reasonable	10 February 2026
Single Lead Employer	Reasonable	28 April 2026
Digital Strategy	Reasonable	28 April 2026
Procurement (Single Tender Actions and Declaration of Interests)	Reasonable	15 June 2026
Health Courier Services	Reasonable	15 June 2026
Radiopharmacy (2)	Reasonable	15 June 2026
Cyber Security Governance Arrangements	Limited	15 June 2026
<i>Substantial Assurance Rating</i>	5	
<i>Reasonable Assurance Rating</i>	9	
<i>Limited Assurance Rating</i>	1	
<i>No Assurance Rating</i>	0	
<i>Assurance Not Applicable</i>	0	
Total	15	

APPENDIX B**Internally Generated Assurance Reports/Papers**

Report/Paper	Every Meeting	Annually	As Appropriate
Tracking of Audit Recommendations	✓		
Governance Matters	✓		
Corporate Risk Register	✓		
Audit Committee Forward Plan	✓		
Annual Governance Statement		✓	
Audit Committee Effectiveness Review and Results		✓	
Audit Committee Annual Report		✓	
Audit Committee Terms of Reference		✓	
Assurance Mapping		✓	
Information Governance Annual Report		✓	
NWSSP Integrated Medium Term Plan (IMTP)		✓	
NWSSP Annual Review		✓	
Welsh Language Annual Report		✓	
Review of Stores Write-Offs		✓	
Review of the Shared Services Partnership Committee's Standing Orders (SSPC SOs)			✓



**NHS WALES
Shared Services Partnership
(NWSSP)**

**Counter Fraud Annual Report
01/04/2025 – 31/03/2026**

**Mark Weston
Local Counter Fraud Manager
NHS Wales Shared Services Partnership
30 June 2026**

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1. Introduction

NHS bodies in Wales must implement anti-fraud, bribery and corruption measures in accordance with Welsh Government Directions on Counter Fraud Measures and the service agreement under section 83 of the Government of Wales Act 2006, and in compliance with Government Functional Standard – GovS 013: Counter Fraud. This report provides details of the work carried out by the NHS Wales Shared Services Partnership (NWSSP) Local Counter Fraud Manager for NWSSP for the financial year 1 April 2025 to 31 March 2026.

The report’s format has been adopted, in consultation with the Director of Finance and Corporate Services, to update the Velindre University NHS Trust Audit Committee for NWSSP (the Audit Committee) about counter fraud activity including fraud awareness, risks, proactive work, referrals, investigations, recoveries and other operational issues.

The Counter Fraud Annual Plan 2025/2026 was completed jointly by the NWSSP LCFS Manager and approved by the Director of Finance and Corporate Services and Audit Committee on **13 May 2025**.

NWSSP continues to employ a Local Counter Fraud Manager to provide Local Counter Fraud Services for NWSSP. As at 31 March 2026, all 211 days of counter fraud work had been completed against the agreed 210 days in the Counter Fraud Annual Work Plan for the 2025/26 financial year.

The breakdown of these days, including costs and on-costs, is as follows:

TYPE	Days Planned	Days Actual	+/-	Costs
Proactive	140	115	-25	£38,749.55
Reactive	70	96	+26	£32,347.45
Total	210	211	+1	£71,097

2. Progress

Infrastructure/Annual Plan outcomes

The Counter Fraud Plan’s objectives for 2025/2026 were fully aligned to the NHS Counter Fraud Authority (NHS CFA) requirements, as stipulated in Government Functional Standard 13 (GovS 013). The plan set out the proposed delivery throughout the year and has been updated to outline the outcomes delivered against each objective set by NWSSP’s Local Counter Fraud Manager during the reporting period from 1 April 2025 to 31 March 2026, as reported in the Functional Standards Return authorised by the Audit Chair and Director of Finance and Corporate Services.

It is pleasing to state that all but one of the functional standards have been rated as Green and can be summarised as follows.

Ref	Objective / Functional Standard	Rating
1	Accountable individual	GREEN
1b	Counter Fraud Champion, Audit Chair and Board Level Reporting	GREEN
2	Counter fraud bribery and corruption strategy	GREEN
3	Fraud bribery and corruption risk assessment	AMBER
4	Policy and Response Plan	GREEN
5	Annual action plan	GREEN
6	Outcome-based metrics	GREEN
7	Reporting routes for staff, contractors and members of the public	GREEN
8	Report identified loss	GREEN
9	Access to trained investigators	GREEN
10	Undertake detection activity	GREEN
11	Access to and completion of training	GREEN
12	Policies and registers for gifts and hospitality and COI.	GREEN

At the end of 2025/2026, NWSSP arranged with SBUHB to provide 12 days of specialist additional resource to assist with risk assessments, effective from 1 April 2026.

In addition to the Annual Plan objectives, which are aligned to the Government Functional Standards, a summary is also provided of the traditional core actions, as follows:

- Fraud Awareness to develop an Anti-Fraud Culture.
- Prevention and Detection of Fraud.
- Investigation.
- Sanctions and Financial Recoveries.

Fraud Awareness

The development of an anti-fraud culture and improved fraud awareness within each organisation is an essential part of combatting economic crime in NHS Wales. The NWSSP LCFS Manager provides fraud awareness in a number of ways. A summary table of activity is provided below, followed by further details on each method used.

Summary of Activity

Fraud Awareness interactions 2025/2026	Total Staff 2025/2026	Total Staff 2024/2025 For comparison
New Starter Fraud Awareness (x 9)	166	149
Fraud Awareness Session (x11)	242	186
e-Learning	309	1,098
Newsletters, emails, SharePoint Blogs & other media (using Sways and LinkedIn) (x15)	5,618	124
Social Media Posts - “X” (Formerly Twitter) impressions (NWSSP no longer uses “X”)		693
Total	6,335	2,250

Fraud Awareness Presentations

From 1 April 2025 to 31 March 2026, a total of **11** fraud awareness sessions were delivered to **242** NWSSP staff. Groups and divisions included Primary Care Services, Specialist Estates, Surgical Materials Testing Laboratory (SMTL), Accounts Payable, People and Organisational Development. Fraud awareness sessions were also provided to Finance and Corporate Services and Heads of Procurement Services on the new Failure to Prevent Fraud offence introduced by the Economic Crime and Corporate Transparency Act 2023 (ECCT).

Since November 2023, NWSSP’s new employees have been invited to attend fraud awareness sessions, which are now conducted monthly via MS Teams. **166** new staff attended **9** sessions in 2025/2026.

Staff during each session were very engaging, with feedback forms that were issued following most sessions providing very supportive and positive feedback.

Fraud awareness is also now signposted in the NWSSP induction toolkit presented to new staff at the “Welcome Session” which is delivered virtually.

All Wales E-Learning Fraud Awareness Module

The NWSSP LCFS Manager collaborated with NHS CFS Wales and NWSSP Learning and Development to produce a new Fraud Awareness e-Learning module, which was launched in April 2023 and made available to all NHS Wales staff. A manual version has also been produced for staff with restricted access to computers. The module is also now available in Welsh.

Although NWSSP has not made the fraud e-learning module mandatory, with the support of the Director of Finance and Corporate Services, selected divisional staff are currently required to complete the module. This produced excellent progress, with **1,098** staff completing the module in 2024/2025 and a further **309** in 2025/2026. A push to increase participation further will take place in the forthcoming financial year, using improved data to encourage areas of lower participation.

Newsletters

Several bilingual media articles relating to cases and risks were posted on the SharePoint/Intranet page to promote fraud awareness.

Bilingual newsletters and LinkedIn posts were also issued to coincide with International Fraud Awareness Week during November 2025. The newsletters reached 868 people, and LinkedIn posts, which included short videos highlighting common fraud themes against NHS Wales, reached 3,872 people through a combination of impressions and video views.

The combined engagement throughout the year using various methods from presentations to Sharepoint and media platforms such as LinkedIn to promote fraud awareness was accessed by over 6,300 people as presented in the table above.

Counter Fraud Videos

The NWSSP LCFS Manager previously collaborated with the NWSSP Communications Team to produce five videos to improve fraud awareness. Each video was also translated into Welsh. The videos continue to be promoted and are available on the NWSSP intranet/internet sites via a YouTube link and have been disseminated to staff by email and social media. The videos were also made available to all health bodies in NHS Wales to help raise fraud awareness.

Counter Fraud App

The NWSSP LCFS Manager previously collaborated with the NWSSP Communications Team to produce a Counter Fraud Mobile App. Despite this innovative approach, uptake has remained low; however, the NWSSP LCFS Manager continues to promote it in all fraud awareness presentations and communications.

Failure to Prevent Fraud - The Economic Crime and Corporate Transparency Act 2023

The new criminal offence of Failure to Prevent Fraud under the Economic Crime and Corporate Transparency Act 2023 (the Act) became effective from 1st September 2025. The genesis of the Act is fraud in the commercial sector, but it does also cover large public sector organisations.

The LCFM and Assistant Director of Corporate Services attended Counter Fraud Authority training on the Act in July 2025. The LCFM has liaised with the Director of Finance and Corporate Services and Assistant Director of Corporate Services to review whether NWSSP has reasonable procedures in place to prevent fraud, as

required by the Act. This was also considered by the Senior Leadership Group, which supported further work on risk assessments.

The LCFM delivered awareness sessions explaining the details and requirements of the Act to the NWSSP Senior Leadership Group, the Procurement Senior Leadership Group and all Accounts Payable staff. Details of the new offence are also included in all fraud awareness sessions.

The Act centres on an organisation benefiting from fraud perpetrated by an employee or agent. Case history in NHS Wales does not appear to include any cases that would have come under the Act had it been in place at the time. Compared with other sectors, the NHS has well-developed counter fraud arrangements. The annual review and submission of the Counter Fraud Authority Functional Standards Return, together with reporting to Audit Committees, ensures that arrangements to prevent and detect fraud are in place and operating effectively.

The only area in the most recent NWSSP Return which was 'amber' rated was risk assessment which had been planned to be addressed during 2025-26 and the Act has provided further focus to this area.

The LCFM continues to work with the Assistant Director of Corporate Services to develop and enhance the recording of fraud risks and fraud risk assessments at NWSSP.

The implications of the Act are also being discussed at an all-Wales level in the Counter Fraud Steering Group and the Counter Fraud Liaison Group in order to ensure a consistent approach.

Fraud Prevention and Detection Activity

Fraud prevention is another key component in minimising the risk of fraud. Work is undertaken both reactively and proactively.

Once a fraud risk or system weakness is identified it is important to mitigate those risks by improving processes and systems to help prevent fraud from occurring in the first place.

The NWSSP LCFS Manager receives Fraud Prevention Notices (FPNs) and Intelligence Bulletins (IBURNs) from the NHS Counter Fraud Authority (NHS CFA). These alerts are often collated from specific fraud risks identified by NHS CFA, other health bodies in England and Wales, and NHS Scotland.

Where fraud cannot be prevented, it is also important to consider ways to detect fraud at the earliest opportunity to minimise the risk of further loss. NHS CFS Wales and LCFS colleagues in NHS Wales collaborate to ensure that systems and processes are robust and that staff awareness, system checks, controls and data analytics are used to detect and report fraud without delay.

The NWSSP LCFS Manager also conducts proactive work to prevent and detect fraud. All work is logged on the Clue Case Management System in accordance with NHS CFA procedures, which are followed within NHS Wales by all LCFS colleagues and NHS CFS Wales. A summary of actions taken is set out below.

Summary 2025/2026

Advice on Fraud Related Matters	<i>Number of contacts (emails / calls) where the LCFS has given advice on fraud related queries</i>	101
No of Fraud Prevention Activities	<i>Actions undertaken to directly change procedures identified as being at risk to fraud, or actions to implement a structured prevention process e.g. fraud proofing, LPEs, Risk reviews</i>	16

Fraud Prevention Notices (FPN'S) and Intelligence Bulletins / Alerts (IBURN's)

The NHS CFA issues Fraud Prevention Notices and Fraud Bulletins from risks identified throughout the wider NHS Counter Fraud Community. All information received is reviewed, risk assessed and actioned according to the nature of issue identified.

Where appropriate FPN's and IBURN's are also actioned by NWSSP's LCFS Manager centrally and outcomes disseminated to all Lead LCFS in NHS Wales to avoid duplication which previously existed in verifying similar alerts.

All FPN's and IBURN's are recorded and actioned on the CLUE 2 database in accordance with NHS CFA requirements. In 2025/2026 the following Notices and Alerts were received and actioned.

- An FPN issued by NHS CFA was disseminated to relevant staff on 2 April 2025 for awareness in relation to the management of risks associated with agency staff timesheet fraud.
- FPN's were also issued and dealt with in relation to Corporate Impersonation Fraud, Business Email Compromise and Asset Management.
- An IBURN Intelligence Alert was issued by the NHS CFA Intelligence Unit regarding concerns about an individual using a false identity while seeking employment, often via a nursing agency. Checks were made with recruitment on an all-Wales basis, with no concerns identified.
- A Fraud Alert was issued by an NHS Wales health board following concerns regarding a potential scam involving fake emails arranging refunds and purporting to be from the Home Office UK Visas and Immigration (UKVI) and Immigration Skills Charge (ISC). The information was disseminated to Recruitment and Finance teams for awareness, and checks confirmed that no emails had been received by NWSSP.
- Several Fraud Prevention Notices and alerts were issued to relevant staff on payment diversion fraud/mandate fraud. A fraud risk assessment was undertaken on the processes relating to the management of creditor bank amendments and the risks associated with mandate fraud. Although a comprehensive range of preventative and detective controls is in place and

operating effectively, it will be difficult to reduce the risk score further due to the inherent nature of mandate fraud and the prevalence of evolving external threats. Ongoing monitoring therefore focuses on maintaining the effectiveness of controls, staff awareness and timely escalation of emerging risks in this area, rather than further reducing the current risk score. The LCFM liaises frequently with the Accounts Payable Supplier Maintenance Team, which manages bank amendments, particularly when potential risks arise.

A review of the bank mandate processes within Primary Care Services was also undertaken by the LCFM. Recommendations were made to align the processes with the Accounts Payable Supplier Maintenance Team to provide more robust controls to prevent mandate fraud. The recommendations were accepted and changes to the processes were implemented.

A further local risk was also identified in relation to the management of maternity leave within the Single Lead Employer (SLE). Additional controls were advised, and a review will be carried out towards the end of the year to measure the effectiveness of those controls.

The LCFM liaises regularly with Internal Audit and also continues to liaise with the Cyber Security Team on Phishing and Spam email concerns.

The LCFM meets regularly with The CFS Wales Team and Lead LCFS Colleagues at the Counter Fraud Liaison Group.

The NWSSP LCFM also assists and advises other NHS staff, LCFS colleagues and NHS CFS Wales with queries on fraud-related matters. Data is now requested by NHS CFS Wales on the volume of queries and advice received in relation to fraud matters; as such, a record is logged and maintained on queries and assistance provided.

During 2025/2026, the NWSSP LCFM received 101 queries on a wide range of topics, including several mandate fraud checks, NFI checks, recovery of salary overpayments and various system queries. The LCFM has also liaised with NHS CFS Wales and advised Workforce on the All-Wales Social Media Policy and the All-Wales Disciplinary Policy regarding sections relating to fraud. The LCFM has also liaised with NHS CFS Wales and Welsh Government on the inclusion of NHS Wales organisations in the Digital Economy Act, which will assist with sharing information to prevent and detect fraud and may assist in the recovery of salary overpayments.

LCFM has also provided feedback on the proposed new Welsh Government Directions on Counter Fraud.

National Fraud Initiative

Payroll data has been uploaded; analysis has commenced and is ongoing. Some anomalies have been detected and are being examined further with relevant staff at other health bodies. Matches are considered on a risk basis. The majority of payroll-to-payroll matches relate to NWSSP Single Lead Employer doctors who may have changed employers, worked additional shifts or undertaken bank shifts at other health boards. This is permissible and common, with all such cases closed with no issues so far. A significant volume was checked during Q4 and many were closed with no further action, with responses awaited on others.

The summary can be seen as follows;

Report 68.1 Payroll to Payroll phone number

Only one match was identified, which was closed as no risk following confirmation that a recording error had occurred.

Report 78 Payroll to Pensions

All 26 matches were closed with no issues, as the majority related to staff who had retired and returned.

Payroll to Payroll Report

Out of 364 matches:

- 312 matches have now been closed with no issues found;
- 41 have been opened and are awaiting a response and/or further checks or investigation;
- 11 not yet opened.

A total of 339 out of 391 matches have been closed.

The LCFM also attended a webinar on 24 March 2026 on the NFI feature “App Check”, which is a real-time, secure web-based tool designed to help public sector organisations prevent fraud at the application stage. It has mainly been used by local government to validate applicants, such as for housing and employment. Access will be arranged by Audit Wales and the Cabinet Office during Q1 2026/2027. NWSSP LCFS and LCFS colleagues, together with CFS Wales, are due to meet further with Audit Wales and the Cabinet Office to discuss this in more detail and consider the use of App Check in NHS Wales.

Referrals/Enquiries/Investigations

Summary 1 April 2025 – 31 March 2026

The table below shows a summary of the number of cases investigated, together with values of Fraud Prevented, Fraud Recovered and Sanctions in 2025/2026.

	Caseload	2025/26 Total
A	Cases b/f at 1 April 2025	1
B	Add: New cases opened	14
D	Less: Cases closed or transferred	11
E	Cases open at 31 March 2026	3
	Fraud Prevented	£0
	Fraud Recovered	£1,200
	Total Prevented / Recovered	£1,200
	Number of sanctions	1

The financial recovery of £1,200 related to an investigation where IT equipment was not returned on termination of employment. Following intervention by the LCFM, the equipment was recovered to safeguard NWSSP assets.

Other cases investigated and closed during 2025/2026 resulted in no further action. Some cases related to matters that were more appropriate for recovery by Payroll and the NWSSP Finance Team, including working while on sick leave.

3. Conclusion

NWSSP Counter Fraud provision has demonstrated compliance with the requirements of the Welsh Government Directions to NHS Bodies on Counter Fraud Measures and the Government Functional Standard – GovS 013: Counter Fraud, with an overall Green rating as shown in the Counter Fraud Functional Standards Summary and Return (Appendix 1). This demonstrates the continued efforts of the NWSSP LCFS Manager in working innovatively to achieve a balance of both reactive and proactive work to meet the NHS Counter Fraud Authority's Standards and the Government Functional Standards on Counter Fraud.

The NWSSP LCFS Manager can demonstrate a continued trajectory of improvement across the service, with continued success shown across key measures. Key areas of work for next year include developing work associated with

Prevent and Deter, building on fraud risk analysis, identifying specific fraud-risk-based proactive exercises and recording outcomes on Clue3 against Government Functional Standard 013 – Counter Fraud and NHS requirements. The LCFM will continue to maintain focus on Inform and Involve, continuing to raise awareness of fraud, bribery and corruption and further embedding an anti-fraud culture within NWSSP.

NWSSP Counter Fraud provision has demonstrated compliance with the requirements of the Welsh Government Directions to NHS Bodies on Counter Fraud Measures.

Mark Weston
Local Counter Fraud Manager
NHS Wales Shared Service Partnership
30 June 2026

 GIG CYMRU NHS WALES	Partneriaeth Cydwasaethau Shared Services Partnership	Date of Meeting: 17 July 2026
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The report is not Exempt

Teitl yr Adroddiad/Title of Report

Concerns and Complaints Annual Report 2025-26

ARWEINYDD: LEAD:	James Quance Corporate Services, NWSSP
AWDUR: AUTHOR:	Carly Wilce Corporate Services Manager
SWYDDOG ADRODD: REPORTING OFFICER:	Alison Ramsey Director of Finance & Corporate Services
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**Pwrpas yr Adroddiad:
Purpose of the Report:**

The purpose of this report is to provide the Shared Services Partnership Committee with an update on concerns received by NWSSP during the financial year 1 April 2025 to 31 March 2026.

Llywodraethu/Governance

Amcanion: Objectives:	Excellence – to develop an organisation that delivers process excellence through a focus on continuous service improvement.
Tystiolaeth: Supporting evidence:	-

Ymgynghoriad/Consultation:

The Concerns and Complaints Management Protocol, together with its associated literature, was last reviewed and approved by the Senior Leadership Group in January 2024, in accordance with its established triennial review cycle. Following implementation of the Listening to People process, the Protocol is currently subject to formal review by Legal and Risk Services to ensure it remains compliant, fit for purpose, and fully aligned with the revised Framework.

Ongoing oversight is maintained through the routine reporting of concerns and complaints to each formal meeting of the Senior Leadership Group,

providing a clear governance route for scrutiny, assurance, and the identification of learning and improvement actions.

Adduned y Pwyllgor/Committee Resolution (insert ✓):

DERBYN/ APPROVE		ARNODI/ ENDORSE		TRAFOD/ DISCUSS		NODI/ NOTE	✓
Argymhelliad/ Recommendation		The Committee is asked to receive the Report for information only.					

**Crynodeb Dadansoddiad Effaith:
Summary Impact Analysis:**

Cydraddoldeb ac amrywiaeth: Equality and diversity:	No direct impact.
Cyfreithiol: Legal:	Regulation 51 of the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 ("the Regulations") provides that each responsible body in NHS Wales must prepare an annual report on complaints. This report provides assurance to the Committee that NWSSP is dealing with, and learning from, concerns in accordance with the Regulations.
Iechyd Poblogaeth: Population Health:	No impact.
Ansawdd, Diogelwch a Profiad y Claf: Quality, Safety & Patient Experience:	The provisions of the Protocol ensure that NWSSP's services are delivered in a satisfactory manner and support Health Bodies in delivering excellent services, contributing to improvements in quality, safety and patient experience.
Ariannol: Financial:	Not applicable.
Risg a Aswariant: Risk and Assurance:	This report provides assurance to the Committee that NWSSP has robust governance processes in place.
Dyletswydd Ansawdd / Duty of Quality:	The provision of high-quality, safe and reliable care is dependent on good governance, leadership and accountability, which feature as overarching principles within the quality themes outlined in the Duty of Quality.
Gweithlu:	No impact.

Workforce:	
Deddf Rhyddid Gwybodaeth/ Freedom of Information	Open. The information is disclosable under the Freedom of Information Act 2000.

1. BACKGROUND

The NWSSP Concerns and Complaints Management Protocol sets out the arrangements by which NHS Wales Shared Services Partnership (NWSSP) manages concerns and complaints in order to meet the requirements of the Code of Practice on Openness in the NHS (1995), the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011, Welsh Government's Putting Things Right Guidance on Dealing with Concerns about the NHS (Version 3, November 2013), the Public Services Ombudsman for Wales Act 2019, the Health and Social Care (Quality and Engagement) (Wales) Act 2020, particularly Part 2 – Duty of Quality and Part 3 – Duty of Candour, and the Velindre University NHS Trust Handling Concerns Policy and Concerns Toolkit.

The Protocol raises awareness among members of the public about how NWSSP deals with all types of complaints, as published on the NWSSP website:

[Concerns & Complaints Management Protocol](#)

2. GOVERNANCE AND ASSURANCE ARRANGEMENTS

Regulation 51 of the "National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 ("the Regulations")" states that each responsible body in NHS Wales must prepare an Annual Report on complaints. The report must contain, as a minimum:

- Number of concerns received (including, in the case of Welsh NHS bodies, concerns reported under Part 7 of the Regulations related to cross border services);
- Number of concerns deemed well founded; and
- Number of concerns referred to the Public Services Ombudsman for Wales.

This report provides assurance to the SLG and then to the Shared Services Partnership Committee (SSPC) that NWSSP is dealing with and learning lessons from concerns brought to the attention of the organisation, in accordance with the specified Regulations.

3. SUMMARY OF CONCERNS AND EARLY RESOLUTION COMPLAINTS RECEIVED

During the 2025/26 financial year, **35** concerns were received, of which:

- **27** concerns were responded to within 30 working days (77%);
- **Seven** concerns were responded to outside of the 30-working-day target (23%); and
- **One** concern was ongoing at the time of writing.

Formal Concerns

During 2025/26, 35 formal concerns were received and recorded by Corporate Services, consistent with the same reporting period in the 2024/25 financial year.

As detailed above, 77% of complaints received were responded to within the 30-working-day target. Where this timeframe was not achieved, holding responses were issued to ensure complainants remained fully informed of progress.

Delays were primarily associated with more complex cases, particularly those relating to Primary Care and the Medical Examiner Service. In some circumstances, delays in providing substantive responses were attributed to the need for third-party involvement.

Early Resolution Concerns

During the reporting period, **two** early resolution concerns were addressed locally within 48 hours, avoiding the need for formal escalation, compared with 20 in the 2024/25 period. This is a positive indicator of strengthened local resolution, demonstrating that more issues are being addressed promptly and effectively at source, reducing the need for escalation through the early resolution process.

In addition, as previously reported to the SLG, there has been an overall decrease in payroll concerns compared with previous years, which had contributed to the total number of early resolution concerns received corporately. During the year, Corporate Services has worked closely with nominated concerns liaison contacts within services that have historically reported higher numbers of concerns. This has had a positive impact on the resolution process and has mitigated the need for further escalation through the Protocol, due to timely service engagement and effective local triaging.

Public Services Ombudsman Referrals

There were **zero** complaints relating to NWSSP referred to the Public Services Ombudsman for Wales during the year.

Requests for Independent Review / Appeal

During 2025–26, **one** request was submitted to the Managing Director for an independent review of a complaint outcome (appeals process), representing a reduction from four requests recorded in 2024–25.

The original investigation related to eligibility criteria for the second payment under the Targeted Incentive Scheme, administered by NWSSP on behalf of Welsh Government (WG). The complaint was initially not upheld, as WG is responsible for authorising payments made under the Scheme in accordance with the relevant criteria, and it was outside NWSSP’s remit to override its decision. However, following the independent review, NWSSP worked in partnership with WG to resolve the matter, and WG subsequently agreed to release the payment. Three recommendations made by NWSSP following the independent review were also implemented in partnership with WG and HEIW.

This outcome demonstrates the effectiveness of NWSSP’s internal governance arrangements and provides assurance that the appeals process is operating as intended, offering a fair and transparent mechanism for review and, where appropriate, the correction of decisions.

Figure 1 – Total Complaints Received by Directorate from 1 April 2025 to 31 March 2026

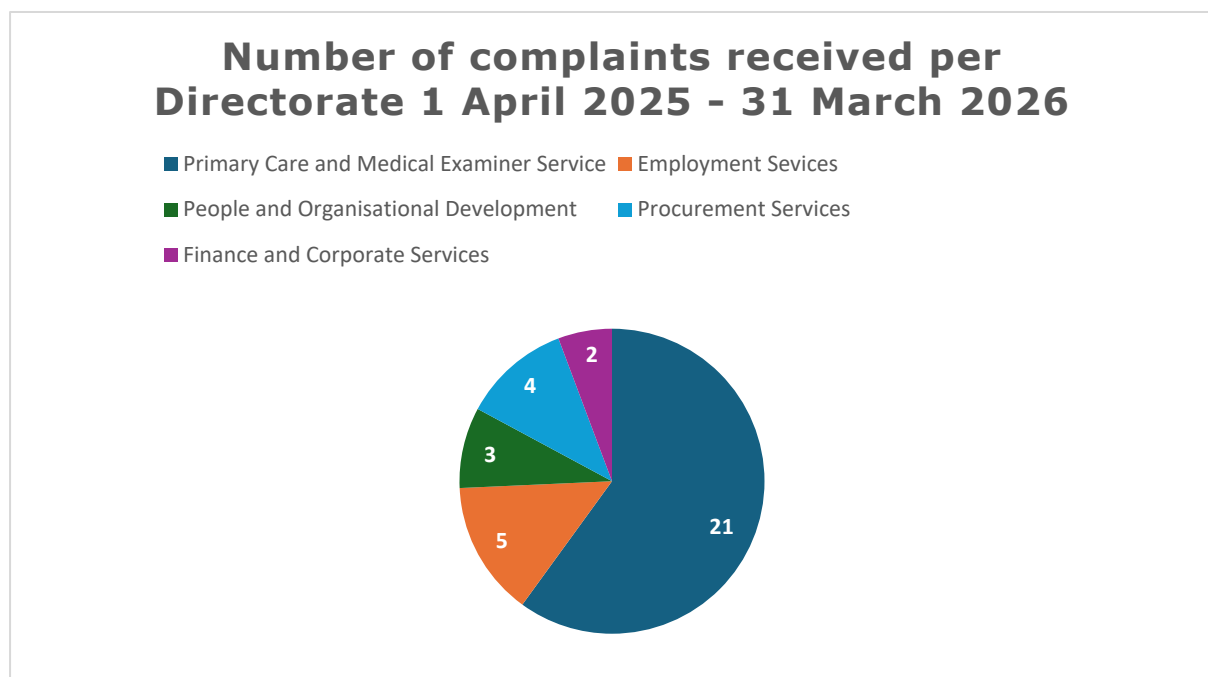
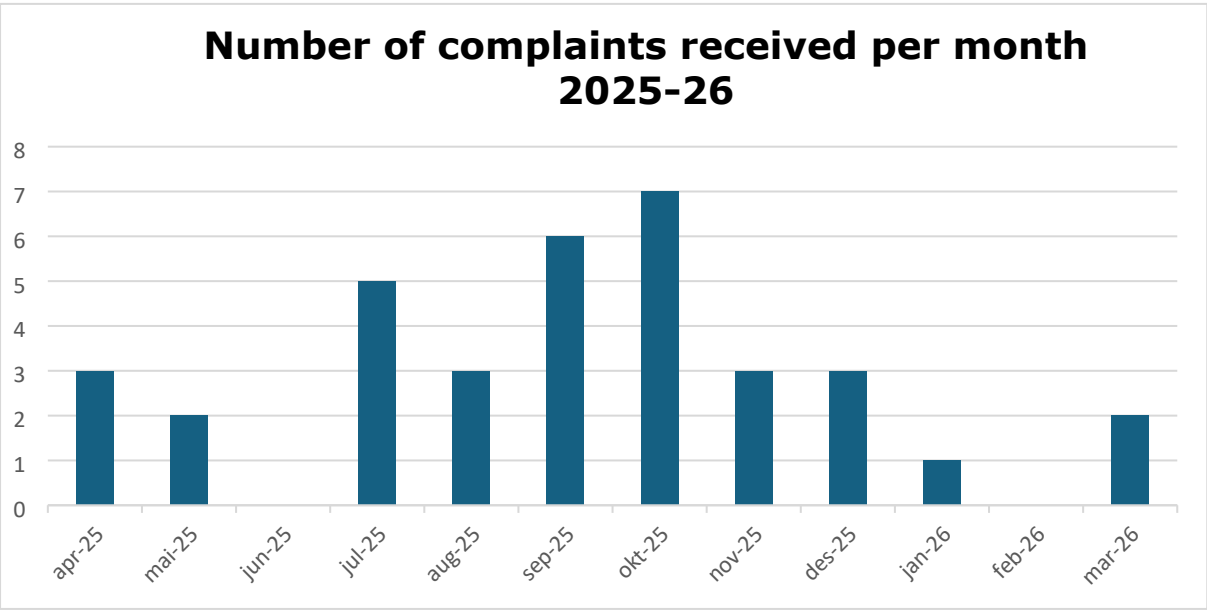


Figure 2 – Total concerns received per month from 1 April 2025 to 31 March 2026



4. TIMELINESS OF RESPONSE

The Protocol stipulates that all concerns will be acknowledged within two working days of receipt of the initial contact, and that a full response to the points raised, where applicable, will be issued within 30 working days, excluding weekends and bank holidays.

During the period 1 April 2025 to 31 March 2026, all concerns received were acknowledged within the two-working-day target, and 77% of concerns received a full response within the 30-working-day target.

Seven responses were issued outside of the target, with responses provided between 31 and 43 working days. These cases took longer to issue a full response due to complexity, the need for further information and/or third-party involvement. However, in all instances, holding communications were issued to complainants advising that NWSSP was still investigating the matters raised and that a substantive response would be provided as soon as the investigation had concluded.

5. NATURE OF COMPLAINTS OUTCOME AND LESSONS LEARNED

A brief summary of the nature of the concerns received is set out below:

Employment Services

- **Five** complaints were received for Employment Services, of which:
 - **One** related to issues with pay, which negatively impacted a Universal Credit claim and caused financial hardship. The root cause was a system issue, with NWSSP dependent on a third-party supplier, IBM, to resolve it.
 - **One** related to a request for compensation for a shift lost due to an administrative error by the Payroll Department, which resulted in the termination of the employee's bank employment record.
 - **One** related to a maternity pay error. The request for averaging payments should have been identified and actioned by the Payroll Team; however, the Cardiff and Vale University Health Board (CAVUHB) Maternity Application Form did not include a section for requesting average Occupational Maternity Pay.
 - **One** related to a complaint regarding advice received concerning NHS pension contributions for the 2024/25 tax year.
 - **One** was in relation to a Direct Earnings Attachment Order.

Of the **five** outlined above, **two** were upheld, **one** was not upheld and **two** were upheld in part.

People and Organisational Development

- **Three** concerns were received by the People and Organisational Development Directorate, all of which related to the Single Lead Employer. These included:
 - **One** related to the rejection of claims for exam payments under the Universal Incentive Scheme for the August 2023 trainee cohort. This matter remains open and is currently being finalised.
 - **One** related to poor service and communication concerning shared parental leave and maternity leave applications. The delays identified were due to capacity within the team.
 - **One** concern related to eligibility criteria for the second payment under the Targeted Incentive Scheme administered by NWSSP on behalf of Welsh Government (WG), which was initially not upheld. However, following a request for an independent review, NWSSP worked in partnership with WG to resolve the matter, and WG subsequently agreed to release the payment. Three recommendations made by NWSSP following the independent review were also implemented in partnership with WG and HEIW.

Of the **three** complaints, **one** was upheld, **one** was not upheld, and **one** remained under investigation at the time of writing.

Procurement Services

- **Four** concerns were received for Procurement Services, of which:

- **Three** concerns related to Health Courier Services, primarily concerning alleged inappropriate conduct and driving behaviour by operatives; and
- **One** concern was received regarding missing laundered items. The procedure for laundered items was not followed, and the complainant was referred to the Health Board to pursue a claim through the appropriate channels for the missing items.

In relation to conduct and behaviour matters, these concerns are subject to thorough investigation, including early engagement with the individuals involved to review the issues raised and reinforce expected standards of conduct. Where concerns are upheld, they are referred to People and Organisational Development for management, in line with internal policies and procedures.

Outcomes relating to conduct issues cannot be disclosed to complainants. However, staff are reminded of their professional obligations and expected standards of conduct when representing NHS Wales, to help prevent recurrence of such incidents.

The concern relating to missing laundered items was **not upheld**.

Primary Care and Medical Examiner Services

A total of **21 complaints** were received relating to Primary Care and Medical Examiner Services during the reporting period.

Medical Examiner Service:

Of these, **11 complaints** related to the Medical Examiner Service. The majority concerned delays in the registration of deaths, communication issues, and concerns regarding the Medical Examiner scrutiny process. It should be noted that some aspects of these complaints related to factors outside the direct control of NWSSP.

The complaints received covered the following themes:

- **Communication and family liaison (4)** – including concerns regarding communication with next of kin, incorrect next of kin information being recorded, delays in providing updates, and communication relating to coroner referrals.
- **Delays in processes and documentation (3)** – including delays in issuing Medical Certificates of Cause of Death (MCCDs), delays affecting funeral arrangements, and delays in notifications from GP practices.
- **Medical Examiner scrutiny process (2)** – including concerns regarding the scrutiny process and a request for a formal review of the Medical Examiner process.

- **Professional conduct and service delivery (2)** – including allegations of rude or unprofessional behaviour and concerns regarding the handling and escalation of a serious safeguarding allegation.

Primary Care Services

- Medical Records: **Four** concerns were received, of which three related to the cross-border transfer of records, specifically between Wales and England, and one related to delays in the recipient receiving hard copies of medical records.
- GP Registration: **Two** complaints were received, relating to the incorrect removal of individuals from GP practices and the non-receipt of GP registration confirmation.
- Prescription Pricing: **Three** concerns were received, all relating to missing payments for prescriptions.
- Payments: **One** concern was received and related to a refund of contact lenses.

Of the **21** complaints received for Primary Care Services, **seven** were upheld and **14** were not upheld.

To support service improvement, several lessons have been identified and recorded. This has resulted in changes to existing processes, including earlier engagement with bereaved families at the outset of the process, rather than at its conclusion.

As an additional control measure, the Medical Director will continue to review all formal responses relating to the Medical Examiner Service to provide assurance over the quality and consistency of communications.

Finance and Corporate Services

- **Two** concerns were received for Finance and Corporate Services.
 - Corporate Services: **One** complaint was received, relating to clarification of participation in a meeting of the Shared Services Partnership Committee.
 - Finance: **One** complaint was received in relation to a dispute regarding an outstanding balance owed on a lease car.

Both concerns outlined above were **not upheld**.

Thematic Review

A review of the concerns identified a number of recurring themes, which have informed targeted service improvements and strengthened governance arrangements, as outlined below.

A thematic review of concerns and complaints received during the reporting period identified a small number of consistent, overarching themes.

Complaints were primarily driven by communication issues, timeliness and delays, and the consistent application of processes, with a proportion of concerns relating to matters outside the remit of NWSSP and therefore requiring signposting to other organisations.

During the year, concerns received for the Medical Examiner Service and Primary Care functions remained consistent with the previous year and primarily related to delays in the issuing of Medical Certificates of Cause of Death, the cross-border transfer of medical records, and the processing of payments or prescriptions.

The SLG receives regular reports on concerns and complaints at each meeting, enabling appropriate scrutiny, oversight, identification of lessons learned, and timely management action. This structured approach provides assurance that emerging themes are identified, addressed, and used to inform service improvements and strengthen operational performance.

Communication and Family Engagement

A consistent theme was the need to enhance communication with bereaved families. Improvements have been implemented to ensure earlier engagement with next of kin at the outset of the process, providing greater clarity and transparency. Additionally, opportunities have been identified to improve communication during transition points (e.g. referral to the Coroner), to reduce uncertainty and ensure families are kept appropriately informed throughout the process.

Inter-Service Coordination and Handover Arrangements

Several cases highlighted the importance of clear roles and responsibilities between the Medical Examiner Service and clinical teams, particularly during handover stages. Strengthening coordination, reinforcing accountability during transitions, and improving visibility of case status (including referrals) were identified as key areas for improvement to support timely and effective progression of cases.

Process Improvement and Operational Practice

Lessons learned have informed enhancements to operational processes, including the introduction of more direct communication routes (e.g. telephone contact with pharmacists where clarification is required) to reduce avoidable delays. Improvements have also been made to internal procedures, such as strengthening protocols for the secure dispatch of medical records and updating administrative forms where gaps have been identified.

Governance, Escalation and Compliance

The need for robust escalation processes and adherence to legislative requirements was identified, particularly in relation to addressing concerns regarding clinical practice and professional standards relating to the Medical

Examiner Service. In response, a formal escalation mechanism has been established within the service to ensure timely referral of issues to the appropriate Health Board Medical Director, supporting improved oversight and accountability.

Professional Conduct and Organisational Values

Feedback reinforced the importance of maintaining professional, respectful and compassionate interactions at all times, particularly given the sensitive nature of the Medical Examiner Service. Reinforcement of NWSSP's core values has been embedded within ongoing service improvement activity to support consistent standards of behaviour.

Partnership Working and System Alignment

A number of concerns highlighted the reliance on effective partnership working across NHS organisations. Continued engagement with clinical sites and stakeholders was identified as essential to ensure consistent application of processes and shared understanding of roles and responsibilities across the wider system.

6. LOOKING AHEAD

NWSSP's existing concerns management arrangements are based on the Putting Things Right arrangements, as outlined in Section 2. The Protocol will be updated to align with the Listening to People Framework, which came into effect on 1 April 2026. The revised Framework represents a significant shift in the management of concerns and complaints across NHS Wales, replacing previous arrangements with a more person-centred and responsive approach.

The Protocol was last reviewed in 2024 and is formally due for review in 2027. However, following the introduction of the Listening to People Framework, effective from 1 April 2026, which supersedes the Putting Things Right process, the Protocol is being reviewed and will be updated in advance of the scheduled review date. This will ensure it fully reflects the revised arrangements and requirements applicable to NWSSP.

Key changes include the mandatory offer of a listening discussion at an early stage of the process. However, as NWSSP delivers professional, technical and administrative services to NHS Wales, and does not provide direct patient care, the operational impact of these changes is expected to be limited.

The Protocol and its effectiveness are subject to regular oversight through established governance arrangements, including routine reporting to the Senior Leadership Group (SLG). This includes a monthly report to SLG,

alongside this Annual Report, providing analysis of trends, themes and lessons learned in relation to concerns and complaints management, and ensuring the Protocol remains fit for purpose.

In line with the updated Putting Things Right Guidance and the Health and Social Care (Quality and Engagement) (Wales) Act 2020, including the Duty of Quality and Duty of Candour, greater emphasis has been placed on the terminology associated with concerns handling. As a result, the term “concern” has been formally incorporated into the definitions section of the Protocol. For the purposes of the Protocol, a concern is defined as an incident or expression of dissatisfaction that does not require a formal response.

7. RECOMMENDATION

The Committee is asked to receive the report **for information** only.

 GIG CYMRU NHS WALES		Partneriaeth Cydwasaethau Shared Services Partnership		Meeting Date 16 July 2026		
The report is not Exempt						
Teitl yr Adroddiad/Title of Report						
NWSSP Annual Report on Conflict of Interests Declarations and Gifts, Hospitality & Sponsorship for 2025-26						
ARWEINYDD: Lead:		Alison Ramsey Director of Finance & Corporate Services				
AWDUR: Author:		Carly Wilce Corporate Services Manager				
SWYDDOG ADRODD: Reporting Officer:		James Quance Assistant Director of Corporate Services				
MANYLION CYSWLLT: Contact Details:		James Quance Assistant Director of Corporate Services James.Quance@wales.nhs.uk				
Pwrpas yr Adroddiad: Purpose of the Report:						
The purpose of this report is to provide the SSPC with a record of Directors Interests and a summary of the completion rates for each service for Conflicts of Interest, as at 30 June 2026. This report will be considered at the NWSSP Audit Committee at its meeting on 7 July and will subsequently be published on the NWSSP website, as part of the Audit Committee papers. This paper also includes a summary of the Gifts, Hospitality and Sponsorship declared within the reporting period, 1 April 2025 to 31 March 2026.						
Llywodraethu/Governance						
Amcanion: Objectives:		Excellence – to develop an organisation that delivers a process excellence through a focus on continuous service improvement.				
Tystiolaeth: Supporting evidence:		-				
Ymgynghoriad/Consultation:						
This report has been considered by the Senior Leadership Group at its meeting on 25 June 2026.						
Adduned y Pwyllgor/Committee Resolution (insert ✓):						
DERBYN/ APPROVE		ARNODI/ ENDORSE		TRAFOD/ DISCUSS	NODI/ NOTE	✓

Argymhelliad/ Recommendation	The Committee is asked to receive the Report for information only.
Crynodeb Dadansoddiad Effaith: Summary Impact Analysis:	
Cydraddoldeb ac amrywiaeth: Equality and diversity:	No direct impact
Cyfreithiol: Legal:	Not applicable
Iechyd Poblogaeth: Population Health:	No direct impact
Ansawdd, Diogelwch a Profiad y Claf: Quality, Safety & Patient Experience:	This report provides assurance to the Committee that NWSSP has robust governance processes in place.
Ariannol: Financial:	Not applicable
Risg a Aswiriant: Risk and Assurance:	This report provides assurance to the Committee that NWSSP has robust governance processes in place.
Safonnau Iechyd a Gofal: Dyletswydd Ansawdd / Duty of Quality:	Access to the new Heath and Care Quality Standards can be obtained from the following link: Duty of Quality (sharepoint.com) . These Standards drive the approach that we take to making decisions in our work.
Gweithlu: Workforce:	No impact
Deddf Rhyddid Gwybodaeth/ Freedom of Information	Open. The information is disclosable under the Freedom of Information Act 2000.

NWSSP Annual Report on Conflict of Interests Declarations and Gifts, Hospitality & Sponsorship for 2025-26

1. BACKGROUND

The [Velindre University NHS Trust Standards of Behaviour Framework](#) outlines arrangements within the organisation to ensure that staff comply with requirements, including recording and declaring potential conflicts of interest. It is imperative that any private interests do not conflict with NHS duties.

The Nolan Principles on Public Life were established in 1994 and have been extended to define public office as applying to all those involved in the delivery of public services. The seven principles are as follows:

1. **Selflessness** - *You should take decisions solely in terms of the public interest. You must not act in order to gain financial or other material benefit for family or friends;*
2. **Integrity** - *You should not place yourself under any financial or other obligation to any individual or organisation that might reasonably be thought to influence you in the performance of your duties;*
3. **Objectivity** - *You must make decisions solely on merit when carrying out public business (including the awarding of contracts);*
4. **Accountability** - *You are accountable for your decisions and actions to the public. Consider issues on their merits, taking account of the views of others and ensure the organisation uses resources prudently and in accordance with the law;*
5. **Openness** - *You should be as open as possible about all decisions and actions, giving reasons for your decisions and restricting information only when the wider public interest demands;*
6. **Honesty** - *You have a duty to act honestly. Declare private interests relating to public duties and take steps to resolve any conflicts arising in a way that protects the public interest*
7. **Leadership** - *Holders of public office should promote and support the foregoing principles by leadership and example.*

It is the responsibility of all individuals to ensure that they are familiar with the requirements of the Nolan Principles. Every public body should develop Codes of Conduct for staff and Independent Members which reflect these principles and its shared values. The guidance in terms of disclosing potential conflicts of interest is to err on the side of caution and disclose more rather than less. What is important is whether a relationship could be perceived as a conflict of interest, whether or not it actually is. Guidance has been revised to require staff to highlight any family or close personal relationships in their declarations, in accordance with our [Managing Personal Relationships at Work Protocol](#).

2. DECLARING CONFLICTS OF INTEREST

All employees, regardless of band, are required to declare any conflicts of interest or submit a nil return. This approach aligns with best practice and supports improved compliance, as part of the implementation of lifetime declarations for all staff across NWSSP.

Members of the Senior Leadership Group will continue to confirm their annual declaration, the details of which will be published on the NWSSP website (Appendix A – List of Declarations for SLG Members). Once a declaration has been submitted, staff are only required to update their submission should their circumstances change.

Declarations of interest for NWSSP Audit Committee and Shared Services Partnership Committee members are recorded within a central register held and maintained by NWSSP Corporate Governance Team and supporting appropriate oversight, transparency and accountability. NWSSP publishes its declarations for its Senior Leadership Group (SLG) members and Chair, and NWSSP is reliant upon NHS Wales organisational publication of declarations relating to Committee Members and Independent Members, through their own publication route.

In addition, declarations of interest are requested as a standing item at each SLG and Committee meeting, providing members with a regular opportunity to declare any actual, potential or perceived interests in relation to the business under consideration. This provides a further assurance mechanism by ensuring that interests are considered at the point of decision-making and that any necessary mitigating actions can be identified and managed appropriately.

Declarations are to be completed via the ESR Self-Service Portal. For staff without access to the system, a hard copy form may be used; however, this must be authorised by the relevant Director of Service before submission to Corporate Services for recording. This is an exception to the rule, as all staff with access to a computer are expected to complete declarations via ESR to ensure consistency and maintain a single, central register. This requirement includes Laundry Services.

Guidance on completing a declaration via ESR is available via a dedicated staff intranet page for [Conflicts of Interest](#). Managers requiring further support may contact the Corporate Governance Team for assistance. New starters are also required to complete a declaration via ESR as part of the onboarding and induction process, as included within the Welcome Toolkit and associated declaration of compliance.

It is the responsibility of all individuals to ensure that they are familiar with the requirements of the Standards of Behaviour Framework and that they duly complete a declaration of any potential or perceived conflicts of interest. Where potential or perceived conflicts require mitigating action, an action plan must be developed. It is also important to note that further declarations are required in procurement processes and that individuals are excluded from the exercise where a conflict of interest is deemed to exist.

The table below records the current position regarding completion across the organisation, as at 18 June 2026. Figures are based on ESR and paper records.

Procurement includes drivers and stores staff, and not solely staff involved in procurement exercises.

Directorate	Headcount	Percentage Completion	Outstanding Declarations
Audit & Assurance Services	58	98%	1*
Finance & Corporate Services			
o Corporate Services	25	100%	0
o Finance Services	28	100%	0
o Accounts Payable	159	94%	10
o Counter Fraud	7	100%	0
o E-Business Central Team Services	20	95%	1*
Legal & Risk and Welsh Risk Pool Services	198	90%	19
People and Organisational Development			
o Digital Workforce	27	92%	2
o Medical Workforce Team	23	95%	1*
o People and OD	48	100%	0
Employment Services			
o Employment Services	337	99%	1
Planning, Performance & Informatics	77	96%	3
Primary Care and Medical Examiner Services			
o Medical Examiner Service	98	88%	12
o Primary Care Services	307	99%	2
Procurement, Supply Chain and Laundry Services			
o Laundry Services	205	64%	73
o Procurement Services, including supply chain and Health Courier Services	845	93%	57
Specialist Estates Services	54	98%	1
Surgical Materials Testing Laboratory	45	98%	1
Pharmacy Technical Services	59	93%	4
Total	2,620	93%	185

**A small number of outstanding declarations relate to staff who are currently absent from work. These will be followed up through local management arrangements when individuals return.*

Directors are responsible for developing local action plans for the management of potential conflicts. A summary of declarations received for each directorate will be shared with the relevant Directors to support follow-up on outstanding declarations, following presentation of this paper to the Committee, together with template action plans for completion and return.

Of the 57 outstanding declarations within Procurement, Supply Chain and Laundry Services, the majority relate to Band 2 and 3 staff, primarily drivers, where the perceived risk of conflicts of interest is considered lower. This reflects the nature of these roles, which are operational in focus and do not ordinarily involve budgetary decision-making, contract award, supplier selection or direct influence over

procurement decisions. The outstanding declarations are therefore assessed as presenting a lower overall risk to the organisation, while still remaining subject to the same declaration requirements and follow-up arrangements as all other staff groups. The Corporate Governance Team will, however, continue to monitor compliance and identify opportunities for improvement.

In comparison with the previous year, overall compliance within the Service has improved significantly, reflecting the transition from paper-based forms to electronic submission via ESR. This represents a substantial improvement in the overall completion position and provides assurance that the revised process is strengthening visibility, consistency and central oversight of declarations across the Service. This approach has recently been implemented within Laundry Services by management, and a similar improvement in ESR compliance is anticipated during the forthcoming cycle.

Notwithstanding the current level of compliance within Laundry Services, hard copy declarations submitted in previous years remain on record in the form of existing lifetime declarations. These confirm that no declarations have been identified which present a risk to NWSSP, and that no mitigating action has previously been required.

3. GIFTS, HOSPITALITY & SPONSORSHIP

All employees of NWSSP should consider the implications very carefully before accepting any personal gifts or offers of hospitality during, or outside of, office hours. They should avoid placing themselves in a position where acceptance of such gifts or hospitality might be perceived to influence their decision in respect of purchasing goods or services, awarding contracts, or making appointments. Anyone found to be in breach of this procedure could face disciplinary action.

If staff receive any offer over the value of £25 (or several small gifts, which value over £100, received from the same or closely related source in a 12-month period), whether accepted or declined, these are required to be recorded in the Gifts and Hospitality Register, held by the Corporate Services Manager. A summary of declarations received is presented to the Audit Committee at each meeting.

Summary of declarations received during 2025-26

The following declarations were received during 2025/26 and have been reported to previous meetings of the NWSSP Audit Committee:

Department	Type of sponsorship	Source of hospitality	Description	Value	Accepted or declined
Legal and Risk Services (LaRS)	Hospitality	Andrew Post KC (previously of Hailsham Chambers but now retired).	Lunch for four members of LaRS staff.	£80	Declined: by the Managing Director. Given the nature of LaRs' business and the relationship with the former KC, it was determined that a potential conflict of interest could arise and the request was therefore declined.
Specialist Estates Services (SES)	Hospitality	The Institute of Healthcare Engineering and Estate Management (IHEEM).	Attendance for nine members of staff at the Joint IHEEM / NWSSP SES Wales Regional Conference 2025 at the International Convention Centre Wales in Newport. The lead speaker was Judith Paget, Chief Executive Officer of NHS Wales. IHEEM stands for the Institute of Healthcare Engineering & Estate Management. IHEEM is a registered charity (257133) and arranges similar events across the UK and Ireland.	Total: £2,285	Accepted: The Institute of Healthcare Engineering and Estate Management (IHEEM) and NWSSP SES jointly hosted a conference in Cardiff, to which delegates were invited to hear speakers, including Judith Paget, covering a range of engineering and estate management issues. This is a repeat of annual events jointly staged in previous years. In essence, IHEEM pays the costs of the event through private company sponsorships and delegate admission fees. In return, NWSSP provides

					administration, technical support and speakers on subjects relating to the NHS in Wales. In summary, the nature of benefits for those attending comprises: a) Admission to the event over 2 days (including refreshments and food) b) Overnight hotel and breakfast c) Admission to the Gala awards dinner (at which I will be assisting in presenting awards) Up to nine employees attended the event.
Finance & Corporate Services (FCS)	Hospitality	Fiscal Tec, Reading.	The service was allocated four tickets to attend the annual EMPOWER Conference in Reading on 25 and 26 September, involving an overnight stay. Fiscal Tec is NWSSP's service provider for Duplicate Payment and Statement Reconciliation software. Historically, the service has only been offered two tickets but, in recognition of the input made by NHS Wales in developing its Statement Reconciliation software, the service was allocated four	£1,560.00	Accepted: This was a repeat of annual events jointly staged in previous years. Four of the six tickets offered were approved.

			tickets. The two-day event was facilitated by Fiscal Tec and included several guest speakers, including from the NHS. It provided an opportunity for the team to meet software leads and network. Travel was funded by NWSSP.		
Specialist Estates Services	Hospitality	Joint IHEEM Healthcare Estates Conference Manchester. IHEEM stands for the Institute of Healthcare Engineering & Estate Management.	The Director of Specialist Estates was invited to attend the event as a speaker and panellist to represent NHS Wales at the conference. They were also invited, as a guest of the IHEEM President, to attend the Gala Awards Dinner. IHEEM is a registered charity (257133) and arranges similar events across the UK and Ireland. Travel has been funded by NWSSP.	£390.00 approximately	Accepted: This is a repeat of annual events arranged in previous years. IHEEM is a registered charity (257133) and arranges similar events across the UK and Ireland.
Finance & Corporate Services	Hospitality	Joint IHEEM Healthcare Estates Conference Manchester. IHEEM stands for the Institute of Healthcare Engineering & Estate Management.	Joint IHEEM Healthcare Estates Conference Manchester. The Head of Estates was invited to attend the event as a delegate. There were no costs to the NHS, and the individual did not attend the Gala Dinner. Travel has been funded by NWSSP.	£0	Accepted: This is a repeat of annual events arranged in previous years.

Finance & Corporate Services	Hospitality	Oracle Enterprise Performance Management (EPM) – Shaping the Future of Decision Making – accelerating reporting cycles and unlocking AI-powered insights; Oracle Office London. Oracle and Version 1 (managed service provider).	Presentation by the supplier on the latest system developments and case studies from other customers, sharing learning from system change and implementation. Lunch and refreshments were provided by the supplier. Travel by train funded by NWSSP.	£20 approximately	Accepted: lower than the specified threshold.
Welsh Risk Pool	Sponsorship	RLDatix: 1 Church Rd, London TW9 2QE.	Funding from RLDatix to NWSSP to facilitate members of the Welsh Risk Pool Safety & Learning Pool to attend the event, which is a national event. The funding is effectively free places (at a full cost of £429 per person). Eight places have been provided as NHS Wales is presenting at the event. The organiser has also negotiated half price accommodation for those attending (which represents a £50	£3,353.00	Accepted: Sponsorship accepted to support NWSSP representation and participation at a national event where NHS Wales was presenting, providing clear organisational benefit, with funding considered proportionate, non-influential, and appropriately declared in line with policy.

			saving per person) – which applies to all attendees who book early.		
Finance & Corporate Services	Hospitality	Vector Consumer.	Offer of lunch or dinner.	Unknown	Declined by the Finance Business Partner.
Finance & Corporate Services	Gift	Mrs Bucket Cleaning Company.	Small gift box of Gower Cottage Brownies received via post.	£20	Accepted: lower than the specified threshold.
Legal and Risk Services	Hospitality	Lisa Jones The Medical and Legal Experts Practice (TMLEP).	Lunch at Leonardo Hotel Cardiff.	Unknown	Declined: The Director of Finance acknowledged that such arrangements are common practice within the private sector; however, in light of the potential public perception associated with a high-end restaurant setting hosted by a client, it was determined that a more formal and appropriate venue should be used.
Finance & Corporate Services	Gift	Welsh Infected Blood Support Scheme (WIBSS) beneficiary.	6 bottles of wine, box of chocolates and bunch of flowers.	£80 to 100	Accepted in part: The beneficiary was informed of the policy, which states that managers are not permitted to accept gifts following an offer of money. Despite this, the individual had left the gifts at Companies House. In accordance with security procedures, the items needed to be collected; the flowers and chocolates were therefore shared with the WIBSS team, and the six bottles of wine will

					be donated for inclusion in a charity raffle.
Legal and Risk Services	Gift	Simon Hilton – Counsel at Kings Chambers.	Bottle of prosecco.	£20 approximately	Declined: The gift was cancelled by the sender after being informed by the recipient that they were unable to accept it in line with policy.
Legal and Risk Services	Hospitality	St Johns Chambers	Lunch to discuss customer service/barristers' availability.	£45 approximately	Declined: After considering the potential wider public perception, the member of staff was advised that business-related matters should be discussed in a more formal setting.
Primary Care Services	Gift	Nasreen Ali of Welchem Ltd (Pharmacy chain).	Lindt luxury chocolates.	£20 approximately	Declined: The chocolates were donated to the Macmillan Coffee Morning taking place at Matrix House in Swansea.

All accepted declarations detailed above were reported to the NWSSP Audit Committee during the period, as a matter of course.

4. RECOMMENDATION

The Committee is asked to receive the report **for information** only.

Appendix A – List of Declarations for SLG and Chair, 2025-2026, as at May 2026

Name	Job Title	Disclosure
Neil Frow, OBE	Managing Director of NWSSP	- Observer Life Science Hub Board - Attend Board Meetings, Non-Paid. - Spouse employed by Cwm Taf Morgannwg University Health Board.
Simon Cookson	Director of Audit and Assurance Services	Owner and Director of S Cookson Consulting Ltd (formed in 2013). Company has been dormant since 2014.
Stuart Douglas	Director of Specialist Estates Services	- Inactive Director of Chadwick Holdings Limited – receipt of dividend income only. - Shareholder in Chadwick Enterprises Limited – receipt of dividend income only. - Shareholder in Newminster House Bristol Limited – receipt of dividend income only. - Mace are tenants at the Newminster House offices. They have been on successive Building for Wales frameworks over the years (including the current one). I was not active in the bid review process. - The Division has occasionally used Mace, but I have not been directly involved in their selection. This will remain under constant review. - Shareholder in The Exchange Bridgwater Limited – I may receive dividends in future. - Director of Douglas Management Consultants Limited (not trading). - Family members working within NHS Wales, as follows (no professional interaction with them as part of his work): - Son is a Specialist Registrar (Anaesthetics & Critical Care) working with Cardiff & Vale University Health Board at University Hospital of Wales and Aneurin Bevan University Health Board at the Grange (on a training rotation). - Daughter is a Staff Nurse (Paediatrics) working at Princess of Wales Hospital for Cwm Taf Morgannwg University Health Board. - Daughter in Law is registered as a Bank Midwife at UHW for Cardiff and Vale University Health Board.
Martin Edwards	Medical Director	Specialist Application Associate with the General Medical Council (GMC).

(from April 2026)		• Consultant Paediatrician at Cardiff and Vale University Health Board. • Treasurer of a local Scout Group in Cardiff. • Trustee of the Advanced Life Support Group (ALSG).
Gareth Hardacre	Director of People & Organisational Development and Employment Services	• Spouse is Director of Nursing and Midwifery at Cwm Taf Morgannwg University Health Board. • Son is an Admin Employee in Cardiff and Vale University Health Board. • Chair of HPMA Cymru - and National Committee Member of HPMA (a Charity for NHS HR Professionals). • Sister is a full-time officer with the Public and Commercial Services (PCS) union. • Niece is employed by a Welsh Government Sponsored Body, the Commission for Tertiary Education and Research (MEDR).
Mark Harris	Director of Legal & Risk Services and Welsh Risk Pool	• Spouse is a GP partner in a medical centre in the Aneurin Bevan area.
Dr Gavin Hughes	Director of Surgical Materials Testing Laboratory	• American Patent Number 20060140911. <i>Bacteriophage for the treatment of bacterial biofilms</i>. 29th June 2006; ◦ Professor Richard Sharp, Dr Gavin Hughes, Dr James Taggart Walker (Health Protection Agency, Porton Down, Salisbury, Wiltshire, SP4 0JG) ◦ Professor Anthony Hart (Department of Medical Microbiology and Genitourinary Medicine, Royal Liverpool University Hospital, Liverpool). • Worldwide International Patent Number PCT/GB2004/000073. <i>Bacteriophage for the treatment of bacterial biofilms</i>. 27th July 2004; ◦ Professor Richard Sharp, Dr Gavin Hughes, Dr James Taggart Walker (Health Protection Agency, Porton Down, Salisbury, Wiltshire, SP4 0JG) ◦ Professor Anthony Hart (Department of Medical Microbiology and Genitourinary Medicine, Royal Liverpool University Hospital, Liverpool). • Honorary Senior Lecturer with Cardiff University School of Medicine.
Jonathan Irvine	Director of Procurement, Supply Chain, Logistics, Transport and Laundry Services	No interests to declare.

Laura-Jayne Keating (From March 2026)	Director of Pharmacy Technical Services	No interests to declare.
Rebecca Nelson	Director of Planning Performance and Informatics	• Council Member for CIPFA 2025-2027 – unremunerated. • Independent Member of the Audit Committee for the Representative Body of the Church in Wales – unremunerated. • Spouse of the Member of Parliament for Torfaen, UK Government Paymaster General and Cabinet Office Minister for European Relations.
Nicola Phillips	Director of Primary Care Services	• Mother is an Independent Board Member for Swansea Bay University Health Board.
Alison Ramsey	Director of Finance & Corporate Services	• Governor on the University of South Wales Board and Chair of the Audit Committee of the University of South Wales until 31 March 2026 when the term came to an end.
Tracy Myhill OBE (Ended 30/06/2026)	NWSSP Chair	• Non-Executive Director - Ministry of Defence People Committee. • Appeals Board Member - Ministry of Defence LGBT Financial Recognition Scheme • Associate Alumni Global - executive recruitment NHS. • Director and owner of Tracy Myhill Associates Ltd. Management Consultancy providing Organisational Development Support and Mentoring to public, private and third sector including the NHS. • Spouse is Director in Tracy Myhill Associates Ltd. Management Consultancy providing Organisational Development Support and Mentoring to public, private and third sector including the NHS. • Through Tracy Myhill Associates Limited: ○ Provide consultancy support on Development of Health Education to University of South Wales. ○ On the HEIW framework for mentoring, coaching and speaking/presentations to aspiring senior leaders. ○ OD consultant with Association of Ambulance Chief Executives providing mentoring, coaching and Organisational Development support to Ambulance services across the UK and Ireland. ○ Provision of Organisational Development and mentoring and coaching support to NHS organisations in Wales, England and Scotland. ○ On Academi Wales Framework for coaching.

**NWSSP Health and Safety Annual Report
2025-2026**

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PURPOSE OF THE REPORT

Annual quality management review to ensure continuing suitability, adequacy and effectiveness of the Health and Safety Management System and alignment with the strategic direction of NWSSP.

Version:	1.0
Status:	Draft
Owner:	Alison Ramsey, Director of Finance and Corporate Services
Author:	Paula Jones, Health and Safety Manager
Approver:	Senior Leadership Group

Date:	May 2026
Next Review Date:	July 2027

EXECUTIVE SUMMARY

This report presents an overview of NHS Wales Shared Services Partnership (NWSSP)'s health and safety management arrangements and performance for the period 1 April 2025 to 31 March 2026. It demonstrates NWSSP's continued commitment to protecting the health, safety and welfare of its staff, service users, visitors and contractors, and to preventing work-related injury and ill health across all services.

Health and safety leadership is provided by the Director of Finance and Corporate Services, supported by the Health and Safety Manager, with clear governance, assurance and oversight arrangements operating through the NWSSP All Wales Health and Safety Group, Senior Leadership Group (SLG), Shared Services Partnership Committee and Velindre University NHS Trust as the host organisation. Health and safety remains fully embedded within organisational governance and business planning processes.

During 2025–26, 84 health and safety incidents were reported, representing an increase from the previous year. However, long-term trend analysis (2017–2026) continues to show an overall downward trajectory in incident reporting, providing reasonable assurance that risk controls have matured over time. Recent increases highlight specific operational risks requiring continued management focus.

The principal incident trends remain:

Trend Category	2019-20	2020-21	2021 - 22	2022–23	2023 - 24	2024 -25	2025-26	Trend
Contact or /Struck by an Object	11	11	26	30	18	16	29	
Violence and Aggression	14	10	10	15	20	11	17	
Manual Handling	14	12	23	16	16	17	19	
Slips, Trips and Falls	14	10	10	15	6	16	14	

Targeted improvement activity continues to be aligned to these risks through the Health and Safety Strategic Improvement Plan 2025–26 and supporting objectives.

There were 10 RIDDOR-reportable incidents, primarily related to manual handling, and no enforcement action from the Health and Safety Executive or Environmental Health. One new personal injury claim was received during the year.

NWSSP operates a mature and integrated Health and Safety Management System aligned to the HSE HSG65 Plan–Do–Check–Act framework. During the year, 12 HSG65 assessments were completed across corporate, support and operational sites:

- 58% achieved Substantial Assurance
- 42% achieved Reasonable Assurance (primarily laundry services)

No sites were rated Limited or No Assurance. Action plans are in place for all Reasonable Assurance sites, providing a strong platform for continued improvement during 2026–27.

Fire safety performance remained strong. 22 fire-related incidents were reported, the majority being unwanted fire signals linked to ageing alarm infrastructure. Only one incident involved minor smoke exposure, which was promptly and effectively managed. External assurance was provided through a Mid and West Wales Fire and Rescue Service familiarisation visit, which confirmed satisfactory compliance.

Looking Ahead:

The Health and Safety Strategic Improvement Plan will continue into 2026–27, with a focus on:

- Targeted risk reduction in higher-incident services;
- Strengthening manual handling and equipment safety controls;
- Sustaining reductions in slips, trips and falls;
- Continued focus on violence and aggression prevention and support;
- Further embedding of health and safety leadership and culture.

Overall, this report provides reasonable to substantial assurance that NWSSP's health and safety arrangements remain effective, proportionate, and continuously improving.

INTRODUCTION

This report sets out NHS Wales Shared Services Partnership's (NWSSP) arrangements and performance in managing health and safety for the financial year 1 April 2025 to 31 March 2026. It highlights key developments, achievements and areas of focus during the reporting period, while also outlining priorities and objectives for the year(s) ahead.

The primary purposes of this annual report are to promote effective health and safety management across NWSSP and to provide assurance and transparency on progress made to continually improve health and safety performance. The report reflects NWSSP's ongoing commitment to the prevention of work-related injury and ill health, and to maintaining safe, healthy and supportive working environments.

Our Aim for Health and Safety

*To provide and maintain a safe and healthy environment for all that
use our services and create a positive culture*

A health and safety strategic improvement plan is in place which provides NWSSP with a framework for health and safety governance and assurance. In addition, a set of objectives provides an additional framework to deliver health and safety within NWSSP.

NWSSP places the highest priority on the health, safety and welfare of its staff, service users, visitors and contractors. Achieving a positive health and safety culture is recognised as a shared responsibility, requiring active engagement and collaboration between management and staff at all levels of NWSSP.

Strategic leadership and accountability for health and safety are provided by the Director of Finance and Corporate Services, supported by the NWSSP Health and Safety Manager and the team. Overseeing continuous improvement through performance monitoring, review of systems and processes, and structured governance arrangements, including regular discussions at the NWSSP All Wales Health and Safety Group.

Overall, this report demonstrates NWSSP's structured and proactive approach to health and safety management during 2025–26 and provides a sound foundation for continued improvement in the years ahead.

NWSSP HEALTH AND SAFETY OBJECTIVES

1. *Aim to reduce work related slips, trips and falls in the workplace, aspiring to a 10% reduction over two years.*
2. *Aim to reduce work related Contact with or Struck by an Object in the workplace, aspiring to a 10% reduction over two years.*
3. *Aim to reduce work related manual handling incidents in the workplace, aspiring to a 10% reduction over two years.*
4. *Develop and enhance the health and safety and risk management knowledge and skills of managers and supervisors throughout NWSSP.*
5. *Continually improve the health and safety culture within NWSSP.*
6. *Regularly monitor and evaluate the health and safety performance and provide appropriate assurance to the Senior Leadership Group, Shared Services Partnership Committee and Velindre University NHS Trust as the statutory organisation hosting NWSSP.*
7. *Promote NO EXCUSE FOR ABUSE – REPORT IT – DON'T ACCEPT IT.*

HEALTH AND SAFETY INCIDENT TRENDS 2025-26

During 2025-26, the Health and Safety Incident Trends remain as:

Trend Category	2019-20	2020-21	2021 - 22	2022-23	2023 - 24	2024 -25	2025-26	Trend
Contact or /Struck by an Object	11	11	26	30	18	16	29	
Violence and Aggression	14	10	10	15	20	11	17	
Manual Handling	14	12	23	16	16	17	19	
Slips, Trips and Falls	14	10	10	15	6	16	14	



A decrease can be seen in the number of incidents reported in the following categories:

Slips, Trips and Falls.

- NWSSP **continues to achieve its aim** to reduce work related slips, trips and falls in the workplace, aspiring to the 10% reduction over two years. This demonstrates sustained improvement and effective risk control. This objective is marked as green, due to the aspiration of reducing the number of incidents by at least 10% over two years has been achieved. Whilst this is a positive position, there will continue to be a focus on this objective to ensure the success is maintained and the objective achieves a continually reducing trend.



An increase can be seen in the number of incidents reported in the following categories:

- Manual Handling.**
 - Despite the slight increase in the number of incidents reported for 2025-26, NWSSP **continues to achieve its aim** to reduce work related manual handling incidents in the workplace, aspiring to 10% reduction over two years. Although incidents increased in 2025-26, NWSSP is still on track with its long-term goal of reducing manual handling incidents by 10% over two years. This objective is marked as yellow on the assurance rating, as whilst there has been a numerical increase in year, the trend continues to be reasonable. This provides assurance of improvement.

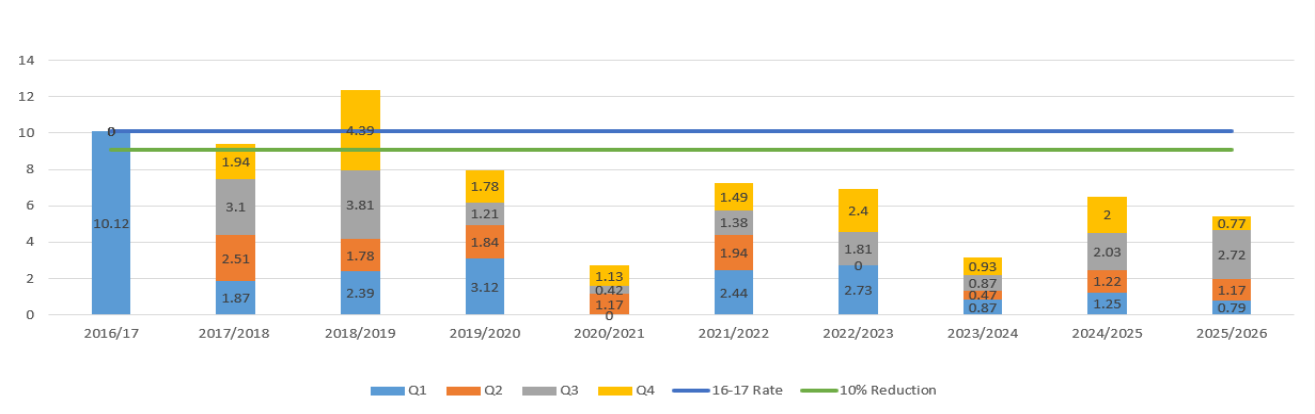
- **Contact with or Struck by an Object.**
 - NWSSP **has not achieved its aim** to reduce work related contact with an object/struck by and object per 100 employees. This objective is marked as red on the assurance rating, as reduction in the volume of incidents has not been achieved and there has been a marked increase in the number of events. The increase reflects continued exposure within higher-risk operational services rather than a weakening of existing controls.

- **Violence and Aggression.**
 - Incidents have risen, however, NWSSP actively encourages reporting, reinforces its **NO EXCUSE FOR ABUSE** message, and contributes to the Anti-Violence Collaborative Wales. This objective is marked as amber on the assurance rating, as there has been an increase in incident reporting which is linked staff awareness but there needs to be a further focus to reduce the trend.

OBJECTIVE 1

Aim to reduce work related slips, trips and falls in the workplace, aspiring to a 10% reduction over two years.

Figure 1 – Incident rate per 1,000 employees by Quarter 2025-26



A decrease can be seen in the number of incidents reported in the category of slips, trips and falls. NWSSP **continues to achieve its aim** to reduce work related slips, trips and falls in the workplace, aspiring to the 10% reduction over two years. This can provide assurance of improvement.

Figure 2 – slips, trips and falls in the workplace incidents by Service Group and Site 2025-26

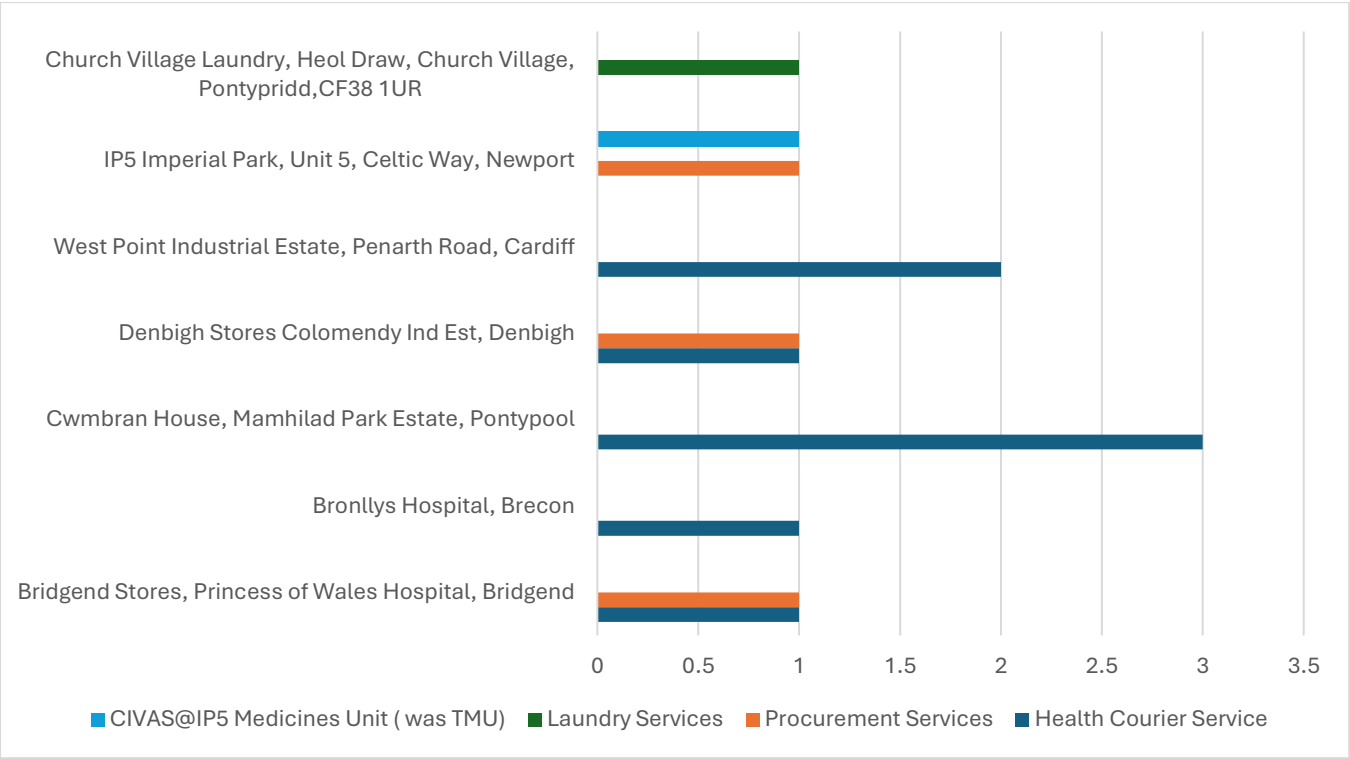
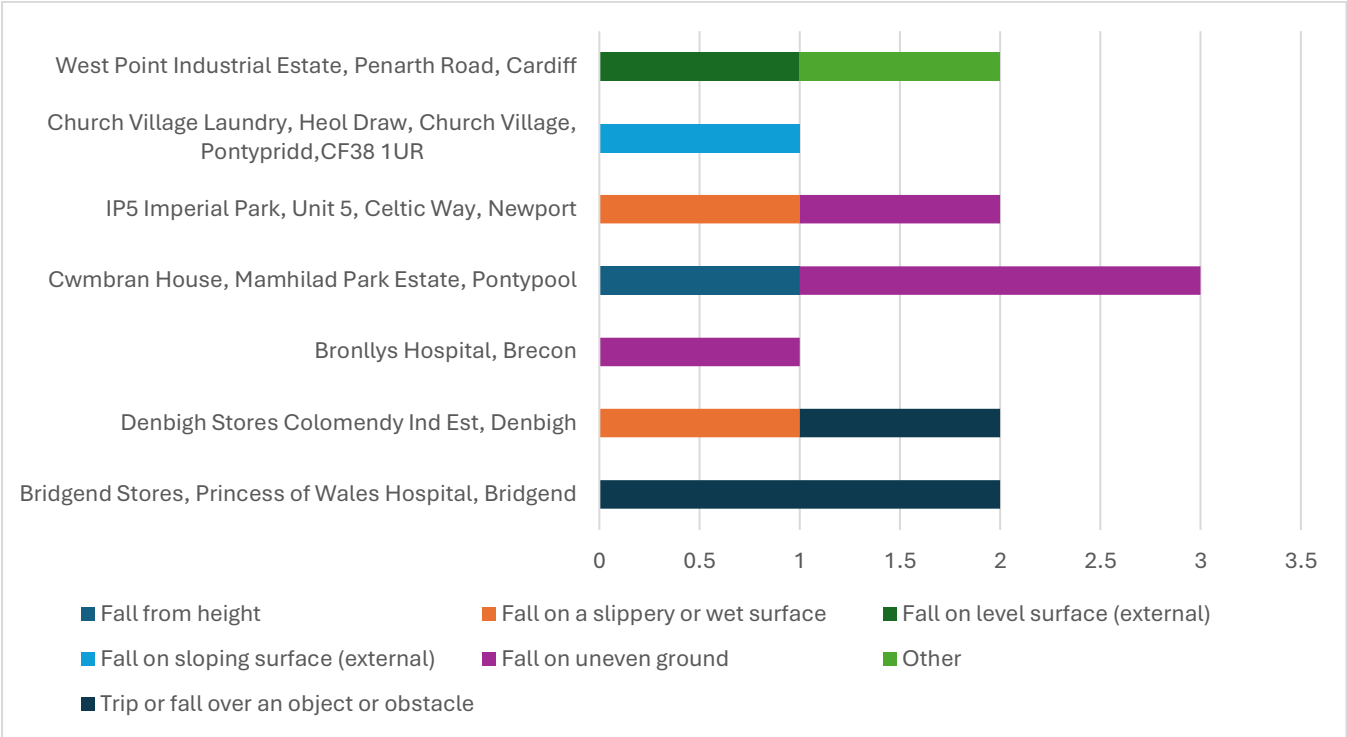


Figure 3 – slips, trips and falls in the workplace incidents by Site and Sub-category 2025-26



Overall, trips and falls over objects or obstacles represent the highest number of reported incidents, with a total of 13 cases, making this the most significant contributor to slip, trip and fall incidents. This suggests ongoing issues with housekeeping, storage, and temporary hazards within the workplace environment.

Falls on slippery or wet surfaces are the next most prominent category, accounting for 2 incidents, indicating continued risk from spillages, wet floors, or inadequate cleaning controls. Falls on uneven ground also feature repeatedly (4 incidents), pointing to external environment risks such as poor maintenance of walkways, yards, or car parks.

Strategic Improvement Plan and Achievements for slips, trips and falls during 2025-2026

During the reporting period, the Health and Safety Team delivered a comprehensive programme of preventative and improvement activity aimed at reducing slips, trips, and falls across internal and external environments, with a particular emphasis on winter resilience and housekeeping standards.

Key actions included strengthening workplace and external area inspection regimes, issuing seasonal safety guidance on icy conditions, and enhancing preventative maintenance arrangements for car parks and pedestrian routes. Targeted physical improvements were completed at multiple sites, addressing pedestrian walkways, electric vehicle charging areas, loading and unloading zones, vegetation management, lighting, and identified tripping hazards such as worn floor coverings.

Tree safety and external grounds risks were proactively managed through formal Visual Tree Assessments and the completion of required remedial actions. In response to national HSE communications, loading bay controls were reviewed across warehouse locations, with further risk controls implemented locally where necessary.

The team reinforced expectations around good housekeeping through updated promotional materials, staff reminders, and site engagement during HSG65 visits. Messaging was strengthened around winter maintenance, spill reporting, spill response training, and adherence to emergency procedures. Incident management performance was monitored to ensure timely reporting and investigation, with continued emphasis on the use of correct templates and compliance with agreed KPIs.

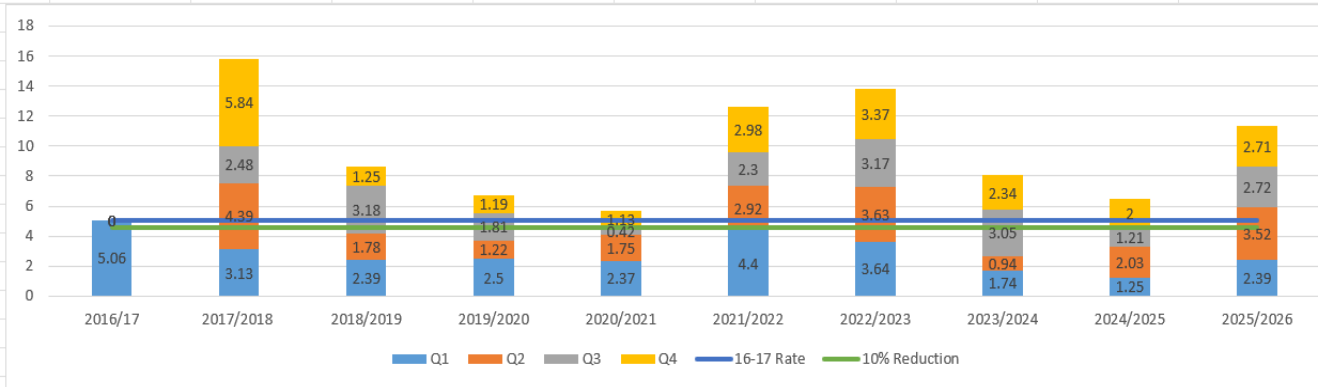
Intentions for 2026-2027

Looking ahead to 2026–2027, the Health and Safety Team will continue to deliver the strategic improvement plan, prioritising sustained improvements in housekeeping, obstruction management, and storage practices. Ongoing focus will be placed on floor condition management and external area risks, particularly uneven and sloping surfaces, supported by robust inspection and maintenance regimes.

OBJECTIVE 2

Aim to reduce work related Contact with or Struck by an Object in the workplace, aspiring to a 10% reduction over two years.

Figure 4 – Incident rate per 1,000 employees by Quarter 2025-2026



An increase can be seen in the number of contact with or struck by an object. NWSSP **has not achieved its aim** to reduce work related contact with an object/struck by and object per 100 employees. The increase reflects continued exposure within higher-risk operational services rather than a weakening of existing controls.

Figure 5 – contact with or struck by an object incidents by Service Group and Site 2025-2026

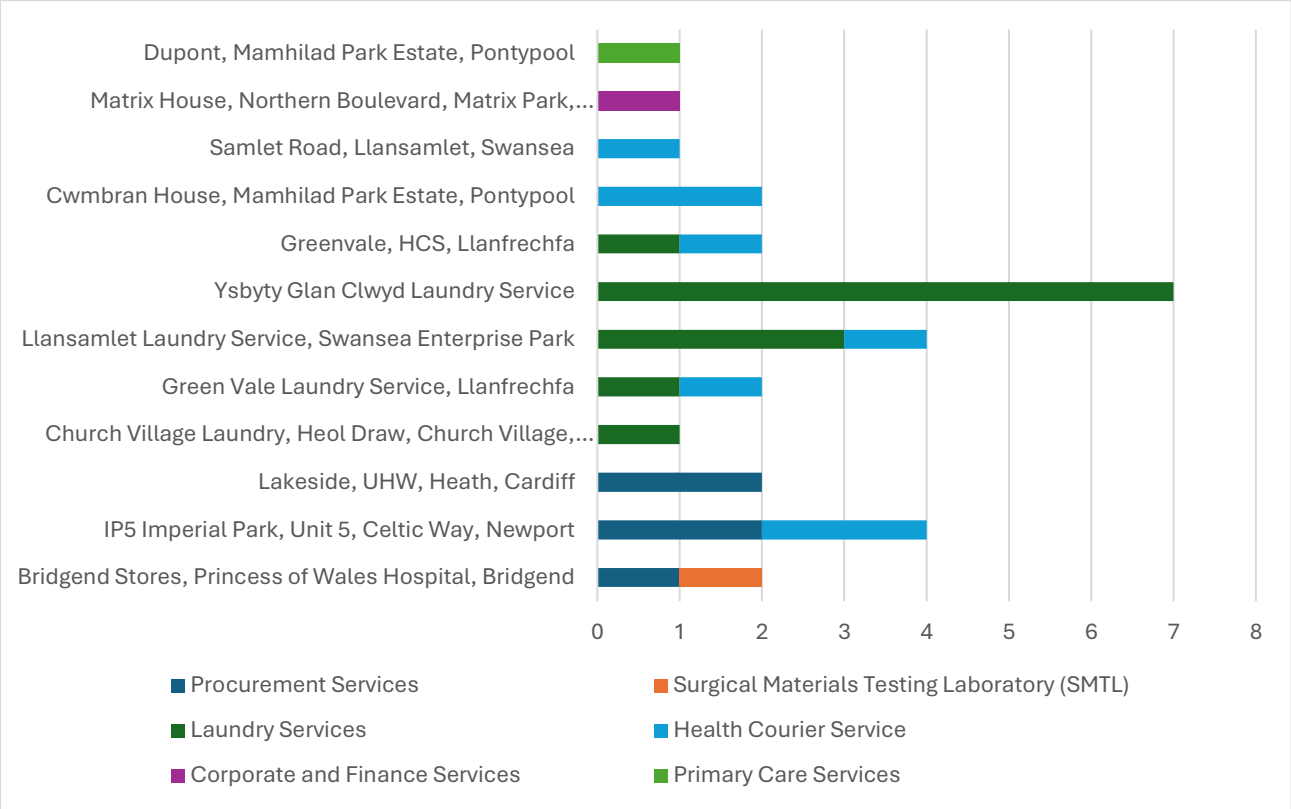
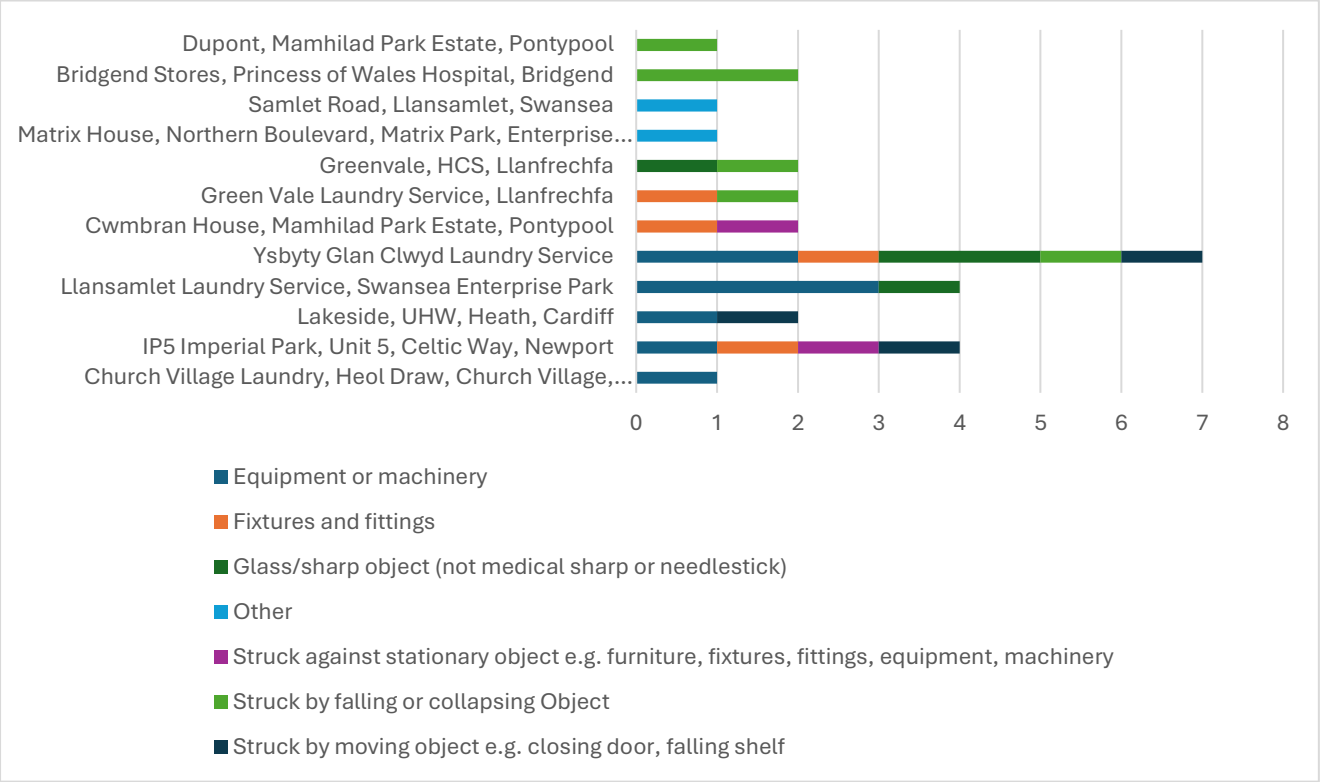


Figure 6 – contact with or struck by an object incidents by Site and Sub-category 2025-26



A total of 29 incidents of contact/struck by object were recorded during the reporting period. Incidents occurred across a wide range of sites, with the highest concentrations seen in the laundry services. Incidents primarily involved equipment, fixtures/fittings, and falling or moving objects, indicating routine operational risks rather than abnormal or one-off failures.

Strategic Improvement Plan and Achievements for Contact with or Struck by an Object *in the workplace during 2025-26*

Key actions included reinforcing the defective roll-cage process, reiterating staff training on the safe use of roll cages, and undertaking targeted audits to ensure consistent application of controls. Health and safety governance was strengthened through HSG65 site visits, enhanced inspection activity, and improved assurance around PPE compliance. Performance monitoring remained a priority, with continued oversight of investigation timeliness and incident reporting through Datix Cymru, alongside regular audits to ensure investigation templates were completed appropriately.

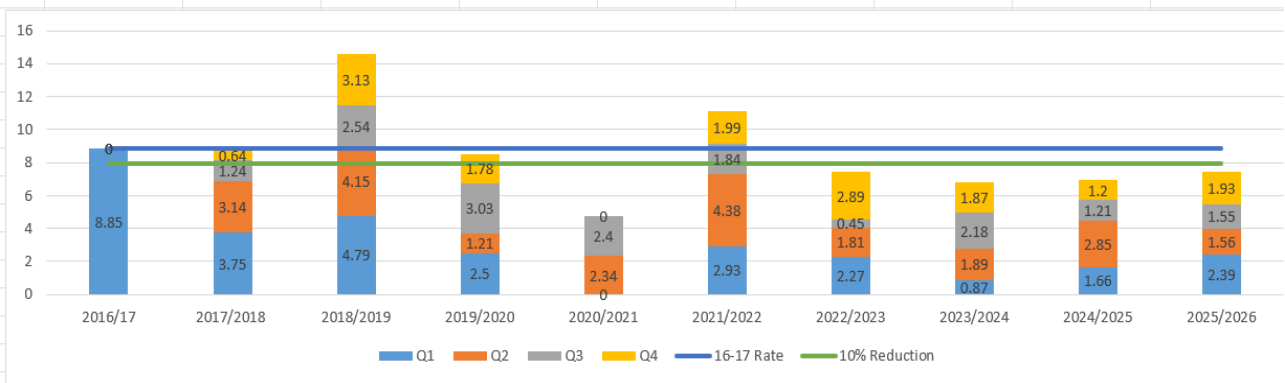
Intentions for 2026-2027

Looking ahead to 2026–2027, the Health and Safety Team will continue to deliver the strategic improvement plan, with a particular emphasis on higher-incidence services. Planned actions include enhanced monitoring of housekeeping and inspection regimes, review and strengthening of safe systems of work for moving equipment, trolleys, and doors, and more robust risk assessments within laundry services. Incident trend analysis will be used to inform targeted safety briefings and toolbox talks, supported by proactive sharing of learning across sites to address common underlying causes and further reduce incident risk.

OBJECTIVE 3

Aim to reduce work related manual handling incidents in the workplace, aspiring to a 10% reduction over two years.

Figure 7 – Incident rate per 1,000 employees by Quarter 2025-2026



An increase can be seen in the number of incidents reported in the category of manual handling.

Despite the slight increase in the number of incidents reported for 2025/2026, NWSSP **continues to achieve its aim** to reduce work related manual handling incidents in the workplace, aspiring to 10% reduction over two years. This can provide assurance of improvement. Although incidents increased in 2025-26, NWSSP is still on track with its long-term goal of reducing manual handling incidents by 10% over two years.

Figure 8 – Manual handling incidents by Service Group and Site 2025-2026

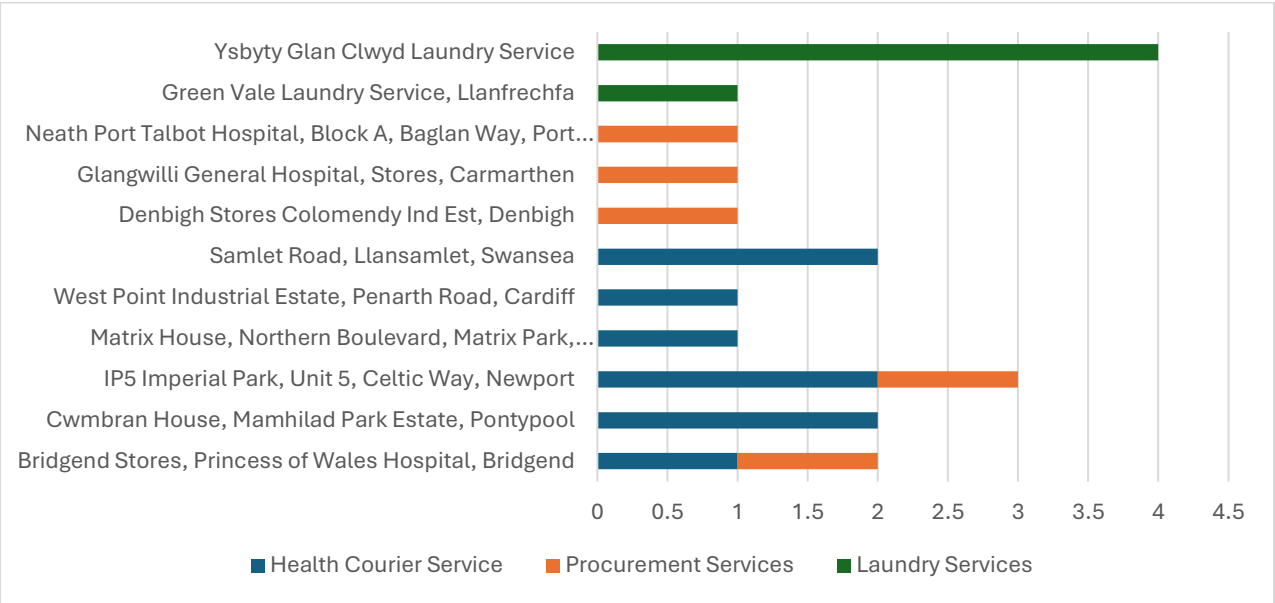
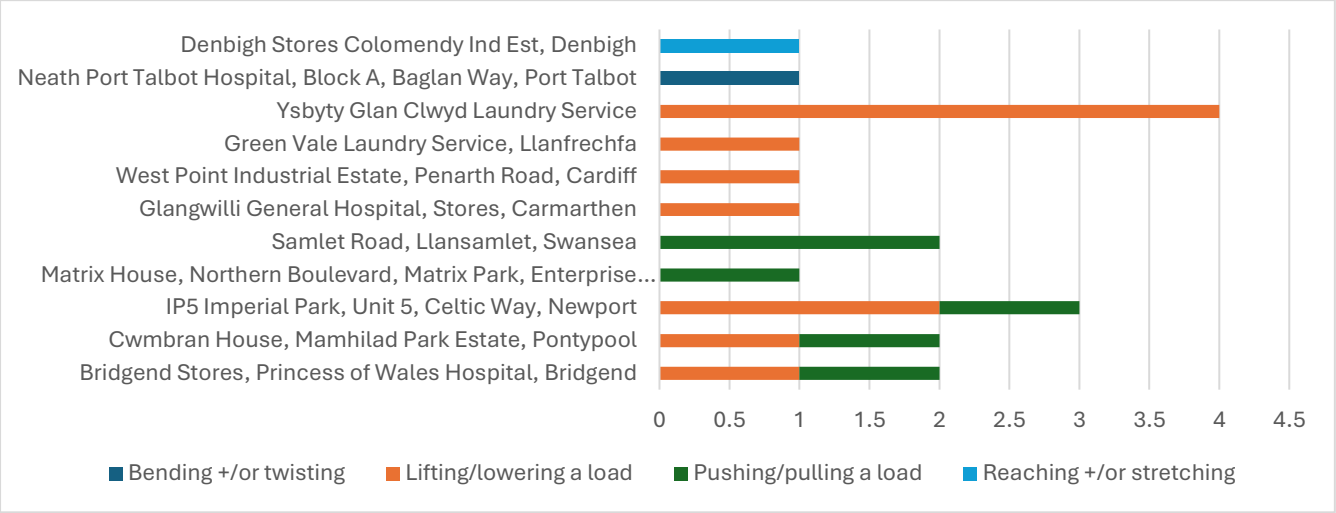


Figure 9 – Manual Handling incidents by Site and Sub-category 2025-2026



A total of 19 manual handling incidents were reported. Incidents are distributed across NWSSP sites. The analysis indicates that manual handling risks remain an All-Wales operational issue, rather than being confined to a single site.

Ysbyty Glan Clwyd Laundry Service shows the highest site-specific incidents, driven primarily by reaching/stretching activities. Samlet Road and Imperial Park report multiple incidents, indicating potential hotspots for targeted intervention.

Strategic Improvement Plan and Achievements for Manual Handling incidents during 2025-2026

During 2025–2026, the Health and Safety Team delivered a targeted programme of work to reduce manual handling risks and improve compliance, investigation quality, and staff awareness.

Key achievements included strengthened monitoring of safer handling training compliance, enhanced audit activity, and improved oversight of incident reporting and investigation performance against agreed KPIs. Training content was actively reviewed to ensure it reflected real causal factors arising from incidents, and staff were continually encouraged to report incidents promptly through Datix Cymru.

Additional progress was made through the completion of a musculoskeletal staff survey focused on display screen equipment (DSE) risks and by upskilling Health and Safety Support Officers through RoSPA Manual Handling Training in preparation for more specialist risk assessments.

Intentions for 2026-2027

Looking ahead to 2026–2027, the focus will shift toward deeper analysis of manual handling incident trends, particularly those involving lifting, lowering, pushing, and pulling. The Health and Safety Team will explore opportunities to enhance training provision through more practical, in-house approaches and improved application of ergonomic principles. Planned priorities will include reviewing the roll cage risk assessment and associated safe systems of work, with the overarching aim of reducing manual handling incidents across NWSSP.

OBJECTIVE 4 AND 5

Develop and enhance the health and safety and risk management knowledge and skills of managers and supervisors throughout NWSSP.

Continually improve the health and safety culture within NWSSP.

Strategic Improvement Plan and Achievements during 2025-2026

During 2025–2026, NWSSP made significant progress in strengthening health and safety capability, culture, and governance across the organisation. The Health and Safety Team focused on developing the knowledge and skills of managers and supervisors, embedding ownership of health and safety responsibilities, and delivering sustained improvements through the Strategic Improvement Plan.

Visible and accessible health and safety support was provided across NWSSP, including tailored advice to managers, regular site visits, functional assessments, and ongoing review of incident investigations. Strong collaborative working was established with People & OD, Legal Services and Occupational Health, ensuring that managers received timely and consistent guidance. Investment in workforce capacity was achieved through the recruitment of an ad hoc bank member.

A key priority was improving incident reporting, investigation, and learning. Staff were supported through Datix Cymru trend analysis, investigation training, and practical tools such as reissued Datix submission cards for staff without routine computer access. Communication and engagement were strengthened through regular newsletters, briefings, monthly 7-minute briefings, revised posters, and quarterly Senior Leadership Group reports to maintain organisational visibility and accountability.

Training and education remained central to culture change. Delivery and support were provided for IOSH Working Safely and Managing Safely courses, DSE Assessor training, Safer Manual Handling training, and local site health and safety induction resources. These initiatives were designed to empower staff and managers to work safely and confidently within their roles. Additional support included familiarisation visits for new Health and Safety staff, ensuring continuity and consistency of service.

Intentions for 2026-2027

The health and safety strategic plan have contributed to a more coordinated, informed, and proactive health and safety culture across NWSSP. Building on these achievements, the Health and Safety Team will continue to deliver the Strategic Improvement Plan during 2026–2027, with a focus on sustained improvement, leadership engagement, and embedding good practice across all services.

OBJECTIVE 6

Regularly monitor and evaluate the health and safety performance and provide appropriate assurance to the Senior Leadership Group, Shared Services Partnership Committee and Velindre University NHS Trust as the statutory organisation hosting NWSSP.

Strategic Improvement Plan and Achievements during 2025-2026

During 2025–2026, the Health and Safety Team continued to strengthen and assure a robust Health and Safety Management System in line with the HSG65 Plan–Do–Check–Act framework. Regular monitoring and evaluation of performance enabled the provision of assurance to the Senior Leadership Group, the Shared Services Partnership Committee, and Velindre University NHS Trust as the statutory hosting organisation for NWSSP.

Key achievements during the year included targeted enhancements to the Health and Safety Management System, delivery of HSG65 compliance visits with supporting action plans, and the completion of ad hoc safety walks to provide frontline assurance. Compliance with mandatory training, including safer manual handling, fire marshal provision, and Display Screen Equipment assessor competence, continued to be monitored and supported. The team also reviewed NHS Staff Survey musculoskeletal feedback to inform ongoing preventative activity. Incident management remained a priority, with consistent monitoring of key performance indicators relating to timely reporting and investigation. Monthly incident reviews, trend analysis, and proportional investigation processes continued, supported by revised investigation templates to improve narrative quality and learning outcomes. Improved accessibility to reporting, including refreshed Datix Cymru posters and QR-enabled reporting cards, helped promote a good reporting culture across all sites.

Regular communication and governance arrangements were maintained through quarterly All Wales Health and Safety meetings, updated terms of reference, attendance at Velindre NHS Trust Health and Safety meetings, and the issuing of quarterly performance reports to SLG. Ongoing briefings and regular updates to the Health and Safety SharePoint pages ensured staff and managers had access to current guidance and learning. Training in Datix Cymru trend analysis supported service groups to take a more proactive approach to investigating incidents. *Continued with the robust systems in place for investigating incidents at a proportional level with a feedback mechanism to review and share the relevant findings by ensuring lessons learnt are communicated.*

Intentions for 2026-2027

Looking ahead to 2026–2027, the Health and Safety Team will continue to deliver against the strategic improvement plan, with a focus on continuous improvement, performance assurance, learning from incidents, and the exploration of suitable digital solutions to further enhance health and safety performance management across NWSSP.

OBJECTIVE 7

Promote **NO EXCUSE FOR ABUSE – REPORT IT – DON’T ACCEPT IT.**

Figure 10 – Violence and Aggression incidents by Service group and category 2025-2026

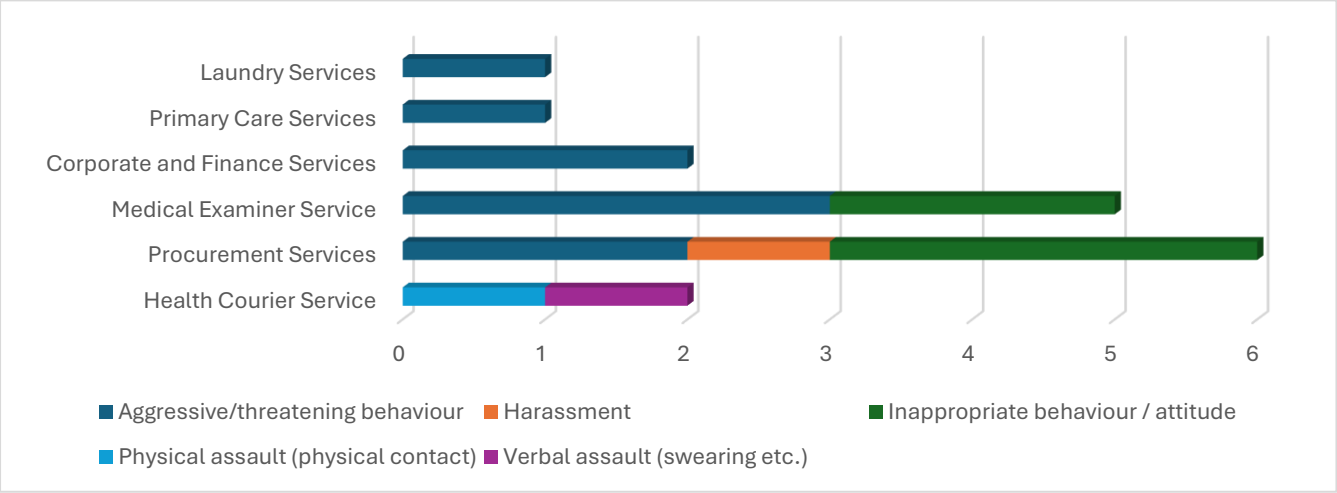
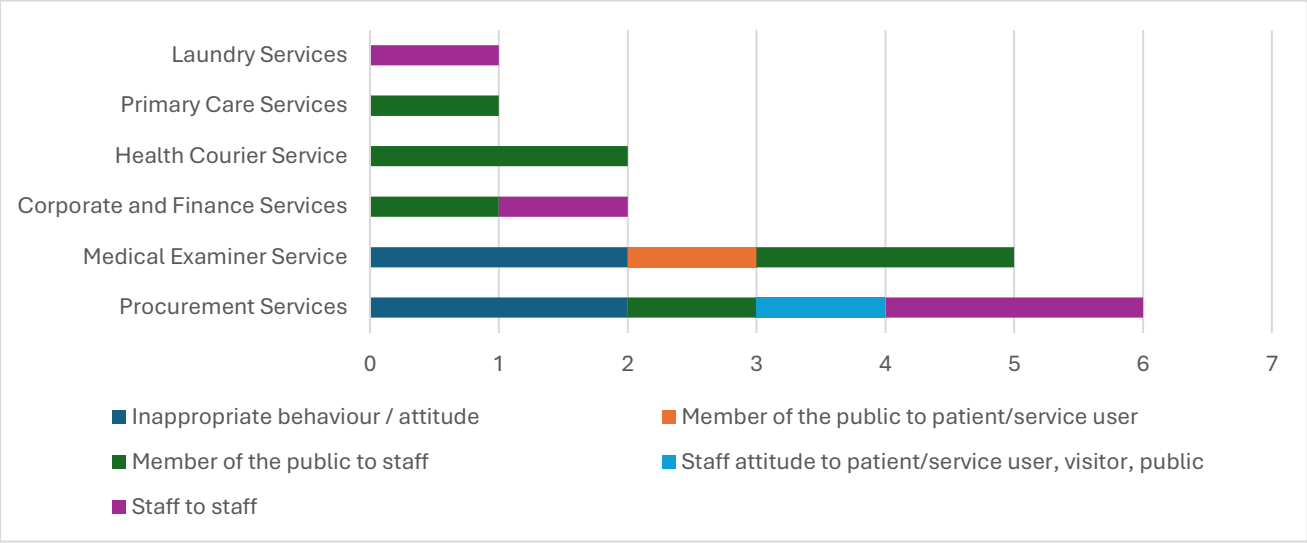


Figure 11 – Violence and Aggression incidents by Service group and Sub-category 2025-2026



By service group, Procurement Services and Medical Examiner Services account for the highest number of reported incidents, with a combined total that represents a significant proportion of all recorded incidents. Within these groups, incidents largely relate to poor attitude or behaviour between staff and towards service users or the public, indicating potential pressure points which could be linked to workload, service demand, or role complexity.

The analysis reinforces the health and safety objectives and the requirement for continued emphasis on violence and aggression prevention, clear behavioural expectations, staff training, and robust reporting and support mechanisms.

Strategic Improvement Plan and Achievements during 2025-2026

During 2025–2026, the Health and Safety function has made substantive progress in strengthening the organisation’s approach to the prevention, reporting, and management of violence and aggression against staff.

A key achievement has been the evolution of organisational messaging from Zero Tolerance to “No Excuse for Abuse – Report It – Don’t Accept It”, reinforcing clear expectations, staff confidence, and organisational commitment. This message has been consistently promoted across the workforce and supported through updated communications materials, including a revised violence and aggression poster.

Significant collaboration has taken place at a national level through active contribution to the Anti-Violence Collaborative Wales, including engagement in the development of a Violence Prevention and Reduction Standard. Operationally, staff have been supported through the provision of nationally endorsed guidance, including the Full Guide for NHS Staff and specific guidance for victims of violence and aggression in the workplace. Access to appropriate reporting mechanisms has also been strengthened, including the introduction of Anti-Social Behaviour referral pathways within Cardiff and Vale UHB and ongoing quarterly sharing of violence and aggression incident data with the Anti-Violence Collaborative for forward sharing with Welsh Government.

The investigation and post-incident response processes have been enhanced through improved information sharing and closer alignment with the Anti-Violence Collaborative lead. A strong emphasis has been placed on staff wellbeing, with listening meetings offered following incidents to ensure appropriate support. The promotion and adoption of the Speaking Up Safely anonymous reporting platform has further supported a culture of openness, with the Health and Safety Manager acting as a designated conversation recipient for health and safety concerns.

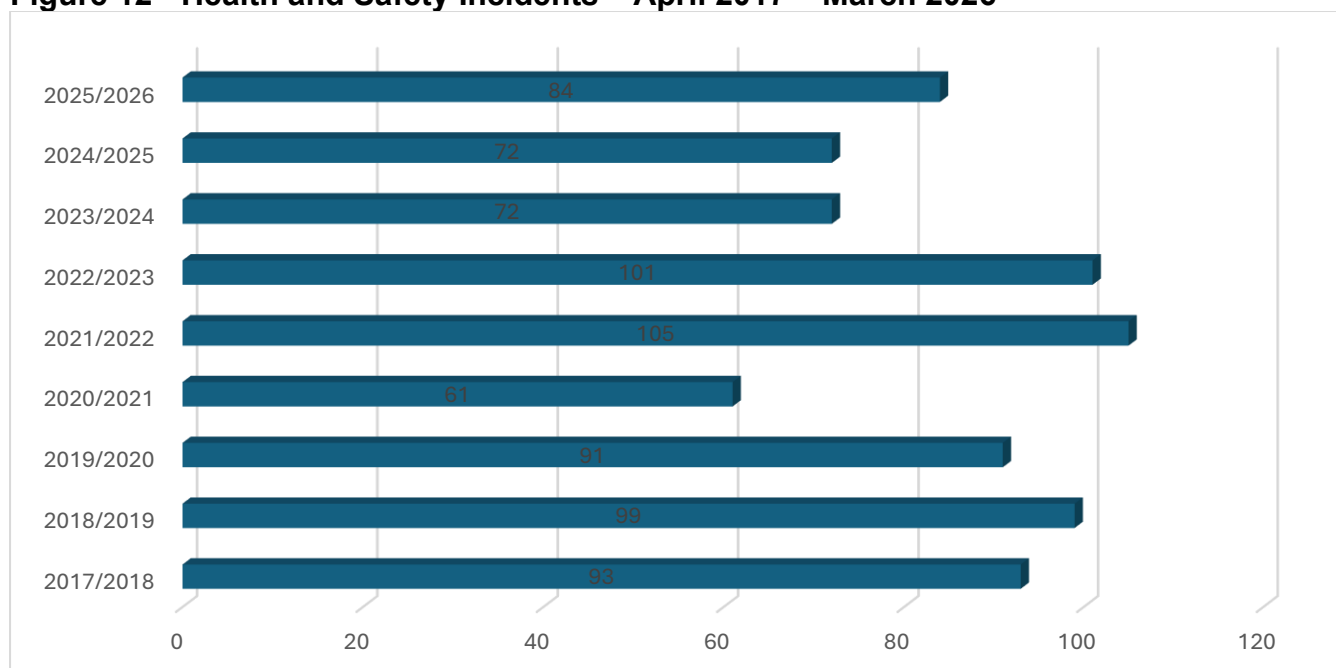
Intentions for 2026-2027

Looking ahead to 2026–2027, the Health and Safety Team will continue to deliver against the Strategic Improvement Plan, maintaining momentum in violence and aggression prevention and response. Planned priorities include the exploration and development of a series of de-escalation training sessions.

HEALTH AND SAFETY INCIDENT REPORTING 2025-2026

Information on Health and Safety incidents within NWSSP.

Figure 12 - Health and Safety Incidents – April 2017 – March 2026



There were 84 health and safety incidents reported in 2025-2026. This is an increase on the previous year which was 72 incidents.

Figure 13 – Category of health and safety incidents by Quarter during 2025-2026

Month	Accidents	V&A	ill health	Total by Month
April 2025 – QR1	5	2	1	8
May 2025 – QR1	4	0	0	4
June 2025 – QR1	6	2	0	8
Total QR1	15	4	1	20
July 2025 – QR2	6	0	0	6
August 2025 – QR2	4	1	0	5
September 2025 – QR2	6	0	0	6
Total QR2	16	1	0	17
October 2025 – QR3	6	4	0	10
November 2025 – QR3	6	1	0	7
December 2025 – QR3	7	2	0	9
Total QR3	19	7	0	26
January 2026 – QR4	3	2	0	5
February 2026 – QR4	6	1	0	7
March 2026 – QR4	7	2	0	9
Total QR4	16	5	0	21
Total Incidents for 2025-2026	66	17	1	84

Figure 14 - Health and Safety Incidents by Sub Type by Quarter during 2025-2026

accidents - Sub Type	Manual Handling	Slips Trips and Falls	Contact with an Object	Struck by an object	Contact with or exposure to hazardous substance	Contact with needles or medical sharps	ill Health	Contact or exposure to electricity (electric shock)	Entrapment / Drawn in	Burns or scalds	Road Traffic Collision	Violence and aggression	Total
April	1	1	2	1	0	0	1	0	0	0	0	2	8
May	4	0	0	0	0	0	0	0	0	0	0	0	4
June	1	1	1	2	0	0	0	0	0	1	0	2	8
July	2	1	0	3	0	0	0	0	0	0	0	0	6
August	1	1	2	0	0	0	0	0	0	0	0	1	5
September	1	1	3	1	0	0	0	0	0	0	0	0	6
October	2	2	1	1	0	0	0	0	0	0	0	4	10
November	2	1	1	1	0	0	0	0	0	0	1	1	7
December	0	4	2	1	0	0	0	0	0	0	0	2	9
January	2	1	0	1	0	0	0	0	0	0	0	2	6
February	2	1	0	0	0	1	0	0	0	0	2	1	7
March	1	0	6	0	0	0	0	0	0	0	0	2	9
Total	19	13	18	11	0	1	1	0	0	1	3	17	84

During 2025-2026 the health and safety trends remain as:

- Manual handling;
- Slips, trips and falls;
- Contact with an object/struck by an object;
- Violence and Aggression.

The analysis supports the continued health and safety objectives, alongside ongoing monitoring to ensure sustained improvement in health and safety performance.

Figure 15 - Health and Safety Incidents by Service Group 2025-2026

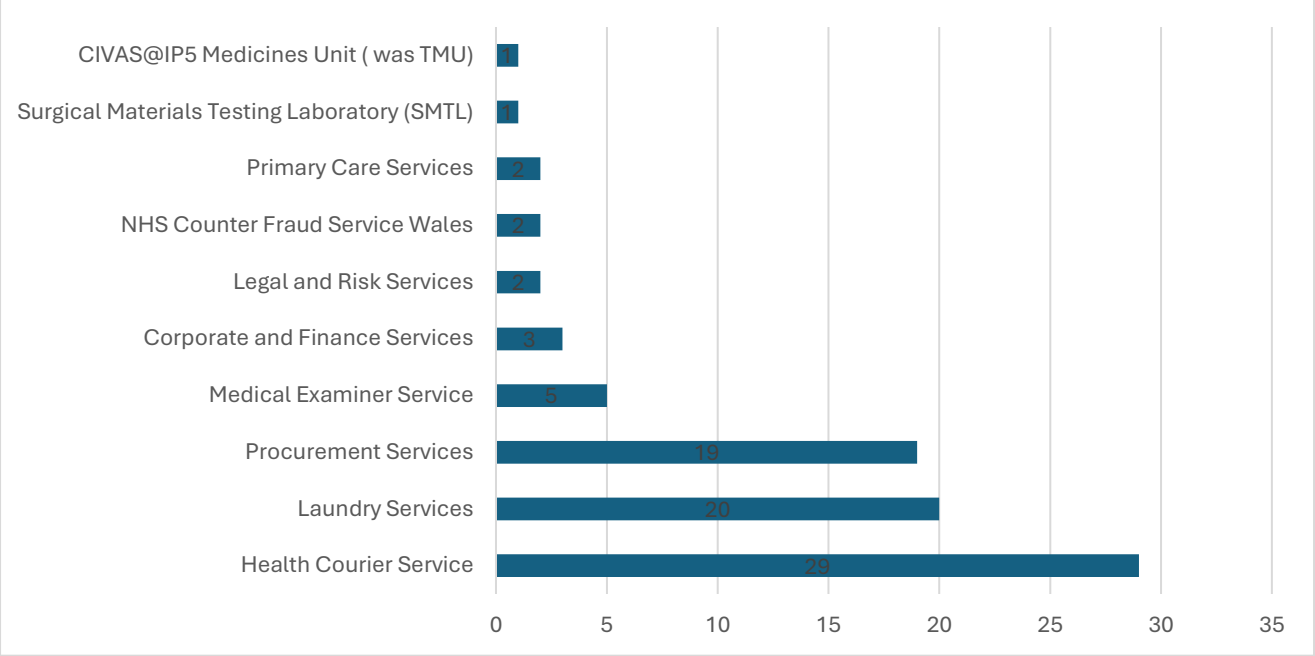


Figure 16 - Health and Safety Incidents by Service Group from 2017 to 31st March 2026

	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25	25/26
Procurement Services	42	34	34	25	25	41	16	20	19
Health Courier Services	19	20	22	18	37	32	36	25	29
Employment Services	16	16	16	6	4	1	3	2	0
Laundry Services					23	19	10	14	20
Primary Care Services	10	9	6	6	5	1	2	4	2
Finance and Corporate	4	13	4	4	3	0	1	3	3
Medical Examiners Services	0	0	0	0	2	3	3	1	5
People and OD	0	3	1	1	0	0	0	0	0
Legal and Risk Services	0	1	0	0	1	1	0	0	2
SMTL	0	1	1	0	1	1	0	1	1
Specialist Estates Services	0	1	2	0	0	1	0	0	0
Audit and Assurance	1	1	1	0	0	0	0	0	0
NHS Counter Fraud	1	0	1	0	0	0	1	0	2
CIVAS@IP5	0	0	0	1	1	0	0	1	1
Digital Work Solutions	0	0	0	0	2	0	0	0	0
WEDS	0	0	1	0	0	0	0	0	0
Student Awards	0	0	1	0	0	0	0	0	0
Single Lead Employer	0	0	0	0	0	0	0	1	0
Total	93	99	90	61	104	100	72	72	84

The highest reporting service group for 2025-2026 was Health Courier Services.

Procurement Services remains the single largest contributor, despite a significant reduction from earlier years. Incidents have reduced from over 40 per year pre-2021 to fewer than 20 most recently, indicating sustained improvement.

Health Courier Services consistently records elevated incident levels. This reflects the inherently higher operational risk associated with transport and logistics activities.

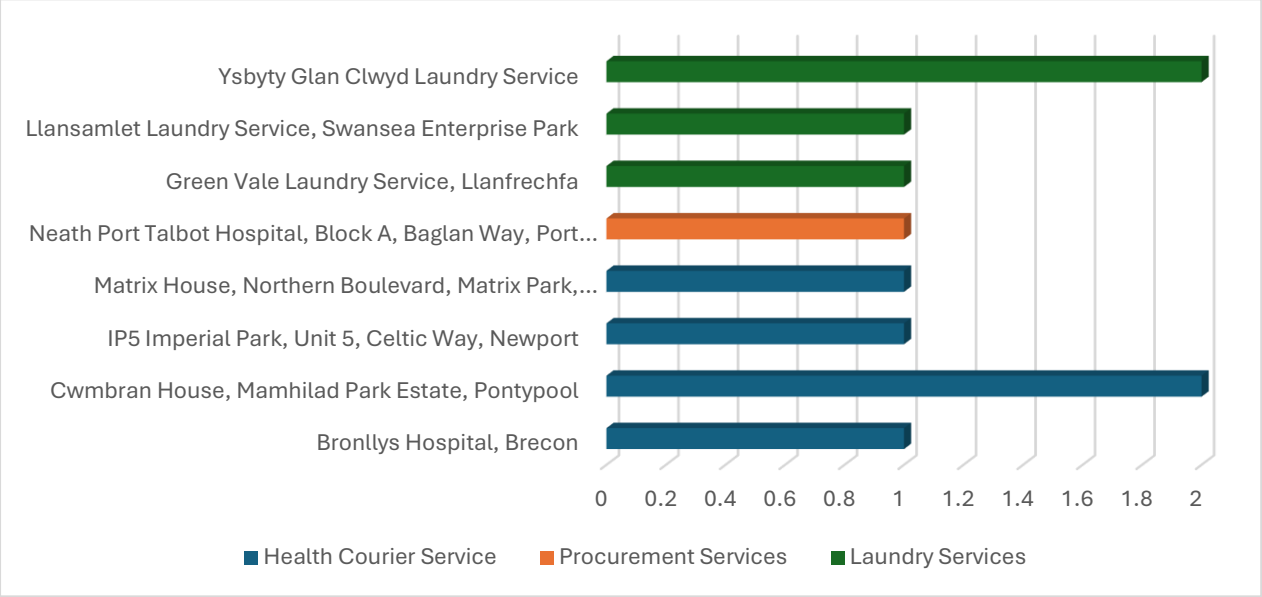
Laundry Services consistently records elevated incident levels. Again, this reflects the inherently higher operational risk associated with laundry operations.

The remaining service areas consistently report low or negligible incident numbers, broadly aligned with their operational risk exposure.

Health and safety incident reporting across NWSSP over the nine-year period 2017-18 to 2025-26 shows a long-term downward trend. Overall, the data provides reasonable assurance that arrangements are effective and suggests that risk controls have matured over time, though recent increases indicate areas requiring continued management attention of which the Health and Safety Team will continue to deliver against the Strategic Improvement Plan.

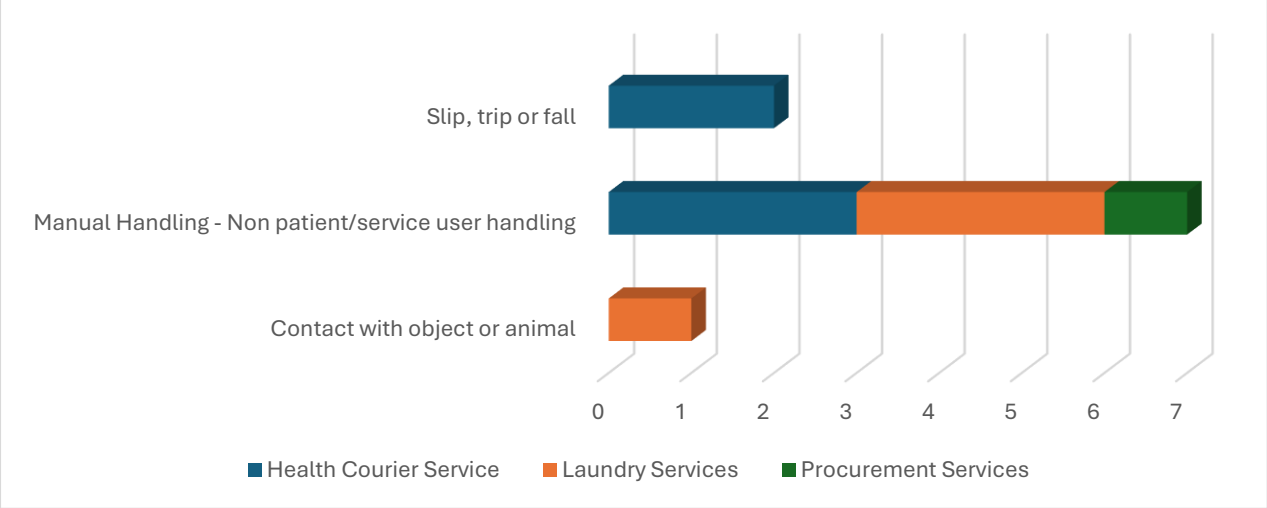
REPORTING OF INJURIES, DISEASES AND DANGEROUS OCCURRENCES
REGULATIONS (RIDDOR)

Figure 17 - RIDDOR incidents by Service Group and Site 2025-26



A total of 10 incidents were reported under RIDDOR to the Health and Safety Executive (HSE) in 2025-2026. In the previous year there were 8 incidents reported, indicating a modest upward trend in reportable incidents.

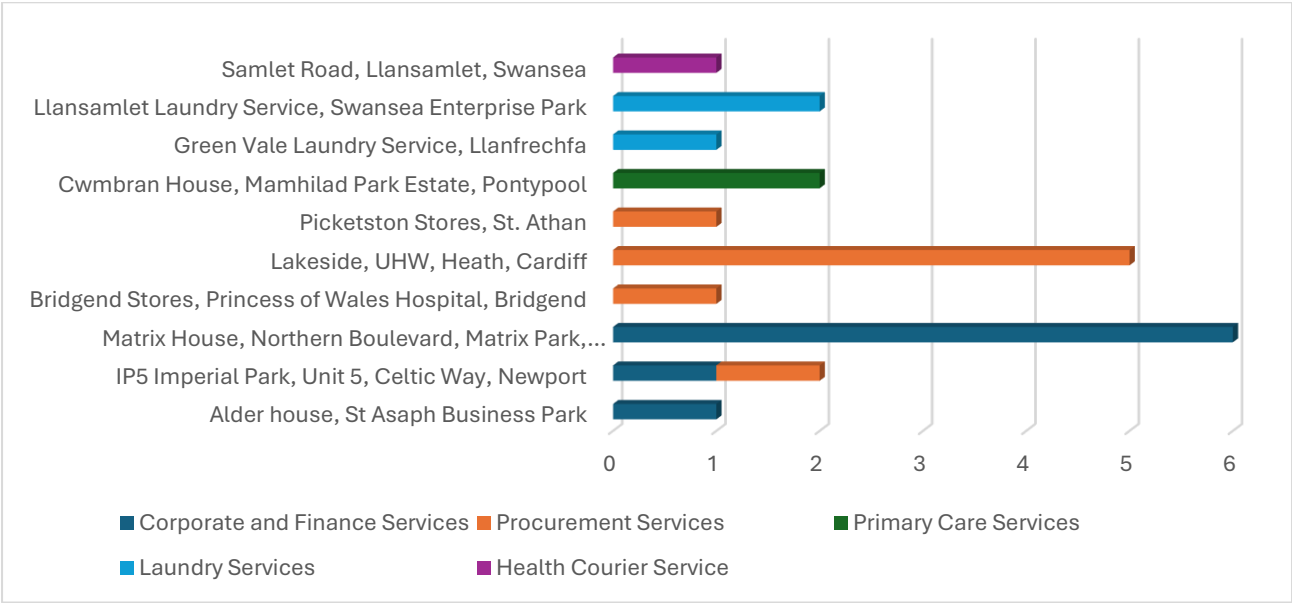
Figure 18 - RIDDOR incidents by Service Group and Site 2025-2026



Analysis of RIDDOR data shows that manual handling injuries is the most frequently reported category. Health Courier Services emerged as the service group with the highest number of RIDDOR reports. Targeted interventions may be required within this operational area. Overall, the data indicates the need for continued focus on manual handling risk management, particularly within Health Courier Services, alongside ongoing monitoring, training, and preventative measures to reduce the likelihood and impact of future RIDDOR-reportable incidents.

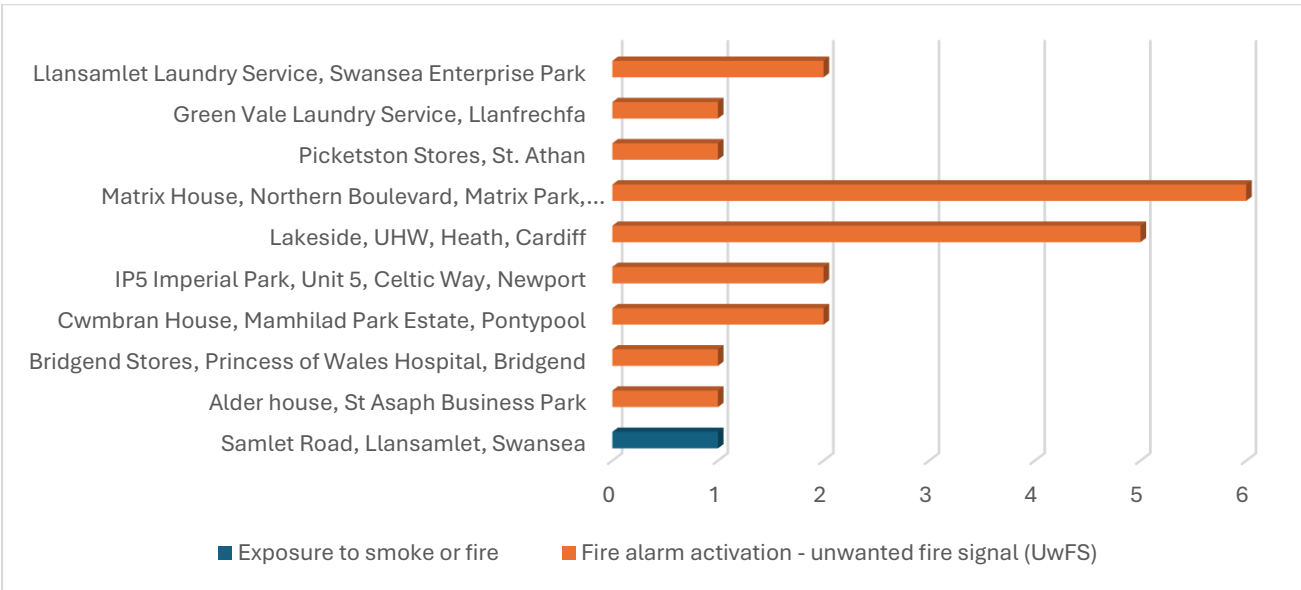
FIRE MANAGEMENT

Figure 19 – fire related incidents by service group and site 2025-2026



A total of 22 incidents were reported.

Figure 20 – fire related incidents by site and sub-category 2025-2026



During the 2025–2026 reporting period, 22 fire-related incidents were recorded across the NWSSP estate. Fire safety performance remained strong. 22 fire-related incidents were reported, the majority being unwanted fire signals linked to ageing alarm infrastructure. Only one incident involved minor smoke exposure, which was promptly and effectively managed. External assurance was provided through a Mid and West Wales Fire and Rescue Service familiarisation visit, which confirmed satisfactory compliance.

Looking forward, NWSSP has committed to a proactive improvement programme for 2026–2027, including systematic surveying of fire detection and alarm systems across the estate. This work will assess system age, condition, type, and reliability, enabling a prioritised approach to upgrading or replacing infrastructure and improving ongoing resilience.

A Fire Risk Assessment (FRA) Schedule for 2025–2026 was issued by the Fire Safety Advisor, ensuring statutory risk assessments were planned and coordinated across relevant sites.

External assurance was also provided during the year. On 4 July 2025, Mid and West Wales Fire and Rescue Service conducted a fire service familiarisation visit at Matrix House. The visit was successful, with the service confirming satisfaction with overall estates compliance and the quality of fire risk management information available. Only minor observations were identified, requiring limited follow-up action which has been addressed.

HEALTH AND SAFETY MANAGEMENT SYSTEM FRAMEWORK (HSG65)

NWSSP operates a comprehensive Health and Safety Management System (HSMS) aligned to the Health and Safety Executive's HSG65 framework, which requires organisations to undertake regular health and safety inspections and maintain effective management controls.

The HSMS is underpinned by an HSE-approved assessment tool and structured around the Plan, Do, Check, Act (PDCA) model. An annual programme of site audits is maintained by the Health and Safety Team to provide systematic assurance that health and safety risks are being effectively managed across the organisation.

The implementation of an integrated HSMS ensures consistency, reliability and robustness in how health and safety is managed throughout NWSSP. By building on existing policies, procedures and governance structures, the system supports safe and reliable operations and promotes a more rigorous and standardised approach to risk management.

The HSG65 Assessment Tool provides assurance to the organisation that health and safety arrangements are operating effectively. It enables the identification of strengths and areas for improvement, with any weaknesses escalated to management alongside clear professional advice on corrective actions. For each assessment, a jointly agreed action plan is developed by the site manager and Health and Safety Manager, with defined timescales and progress monitored on a quarterly basis.

The objectives of the HSG65 audit process are to:

- Confirm compliance with the requirements of the audit standard;
- Confirm effective implementation of the health and safety management system; and
- Confirm the system's capability to achieve organisational health and safety policy objectives.

A key principle of the framework is that HSG65 is embedded into day-to-day operations, rather than being a one-off compliance exercise. Sites are therefore required to undertake regular self-assessments throughout the year, supporting continuous improvement and ensuring that health and safety considerations remain integral to operational decision-making.

For the 2025–2026 cycle, the HSG65 assessment questions and audit templates were reviewed and refreshed to ensure continued relevance, consistency and alignment with best practice. This refreshed approach reinforces the expectation that the HSG65 process is an “always-on” management system, supporting proactive risk control, assurance, and sustained improvement across NWSSP. Overall, the HSG65 framework provides NWSSP with a mature, evidence-based and continuously improving system for managing health and safety risks, delivering assurance to senior leaders and supporting the organisation's wider Duty of Quality and governance obligations.

HSG65 ASSESSMENTS UNDERTAKEN DURING 2025-2026

Sites	Date Visit Undertaken	Assurance Rating
Charnwood Court	10.06.2025	Substantial Assurance
Glangwili Hub	13.06.2025	Reasonable Assurance
Matrix House	20.06.2025	Substantial Assurance
IP5 Procurement	16.07.2025	Substantial Assurance
Dupont	31.07.2025	Substantial Assurance
Greenvale Laundry	14.08.2025	Reasonable Assurance
Swansea Laundry	05.11.2025	Reasonable Assurance
IP5 Facilities	18.11.2025	Substantial Assurance
Church Village	03.12.2025	Reasonable Assurance
Companies House (Finance and Corporate)	17.02.2026	Substantial Assurance
HCS Bridgend Stores	04.03.2026	Substantial Assurance
North Wales Laundry	17.03.2026	Reasonable Assurance

Figure 21 – Key to the Assurance Ratings

Substantial Assurance	SLG can take substantial assurance that arrangements are in place regarding the management of health and safety on site and internal control are in place. Few matters require attention.
Reasonable Assurance	SLG can take reasonable assurance that arrangements are in place regarding the management of health and safety on site and internal control are in place. Some matters require management attention.
Limited Assurance	SLG can take limited assurance that arrangements are in place regarding the management of health and safety on site and internal control are in place. More significant matters require management attention.
No Assurance	SLG has no assurance that arrangements are in place regarding the management of health and safety on site and that internal control are in place. Action is required to address the whole process.

During the 2025–2026 period, a total of 12 HSG65 health and safety management system assessments were completed across a range of operational, corporate, and support service sites.

Overall, the outcomes demonstrate a strong level of health and safety management maturity across the organisation:

- 7 sites (58%) achieved Substantial Assurance, indicating that effective systems and controls are in place, with only minor improvements required.
- 5 sites (42%) which were laundry services achieved Reasonable Assurance, confirming that fundamental arrangements are being established, though further enhancement is required to strengthen consistency and assurance. The initial due diligence exercise with subsequent actions undertaken by NWSSP Health and Safety Manager has ultimately achieved the reasonable assurance rating for the laundries.

No sites were assessed as Limited or No Assurance, indicating no critical failures in health and safety management were identified during this period.

The results provide a strong platform for targeted improvement activity, particularly at sites achieving Reasonable Assurance, to support continuous improvement and progression towards consistently high standards of health and safety performance.

PERSONAL INJURY CLAIMS

During the period 1st April 2025 to 31st March 2026 there was one new claim received.

HEALTH AND SAFETY EXECUTIVE (HSE) ENFORCEMENT ACTION

During the year there have been no prosecutions, enforcement actions or intervention costs by either the Health and Safety Executive (HSE) or Environmental Health.

DUTY OF QUALITY

The Duty of Quality, which came into force on 1 April 2023, places a statutory obligation on NHS bodies to ensure that due regard is given to quality in the delivery of both clinical and non-clinical services. The overarching aim is to continuously improve the quality of health services and health outcomes for the people of Wales. NWSSP delivers a wide range of services through a divisional structure and has taken a proactive and structured approach to embedding the Duty of Quality across the organisation.

Quality is considered through the six STEEEP domains: Safe, Timely, Effective, Efficient, Equitable and Patient-centred, alongside the core organisational enablers of quality by design, planning, assurance, improvement and control. These frameworks underpin how NWSSP assures itself that quality is systematically embedded and consistently applied across all service areas.

The Health and Safety function plays a key role in supporting the Duty of Quality, with robust governance arrangements in place to ensure a safe environment for staff, patients, visitors and contractors. Assurance is supported by strong promotion and communication mechanisms, including NWSSP All Wales Health and Safety meetings, health and safety meeting, monthly 7-minute briefings, quarterly newsletters and dedicated health and safety SharePoint pages.

A comprehensive programme of internal and external audit and monitoring is in place, aligned to a formal Health and Safety Management System utilising an HSE-approved tool based on the Plan–Do–Check–Act model. An annual schedule of site audits provides systematic assurance and supports continuous improvement.

NWSSP holds several corporate certifications that reinforce the Duty of Quality, including the Corporate Health Standard and ISO 14001 Environmental Management Standard. In addition, many NWSSP services hold independently verified certifications that directly support quality, safety and regulatory compliance, including ISO 9001 (Quality Management), ISO 27001 (Information Security), ISO 45001 (Health and Safety) within Procurement Services, ISO 17025 (Testing and Calibration of Laboratories) and ISO 11014 (Material Safety Data Sheets).

External regulatory assurance during the year included audits and inspections relating to STS Food Safety, Carriage of Dangerous Goods, compliance with Public Sector Internal Audit Standards (PSIAS), and continued regulation by the Medicines and Healthcare products Regulatory Agency (MHRA) for both Good Distribution Practice and Good Manufacturing Practice. NWSSP also achieved accreditation as a Mental Health First Aid Trainer Organisation, further strengthening its approach to staff wellbeing and safety culture.

Performance and safety are continuously monitored against defined objectives and targets, informed by trend analysis and supported by targeted improvement plans. NWSSP promotes a strong learning culture, encouraging the reporting of incidents and near-misses via Datix Cymru, with an emphasis on capturing lessons learned and preventing recurrence.

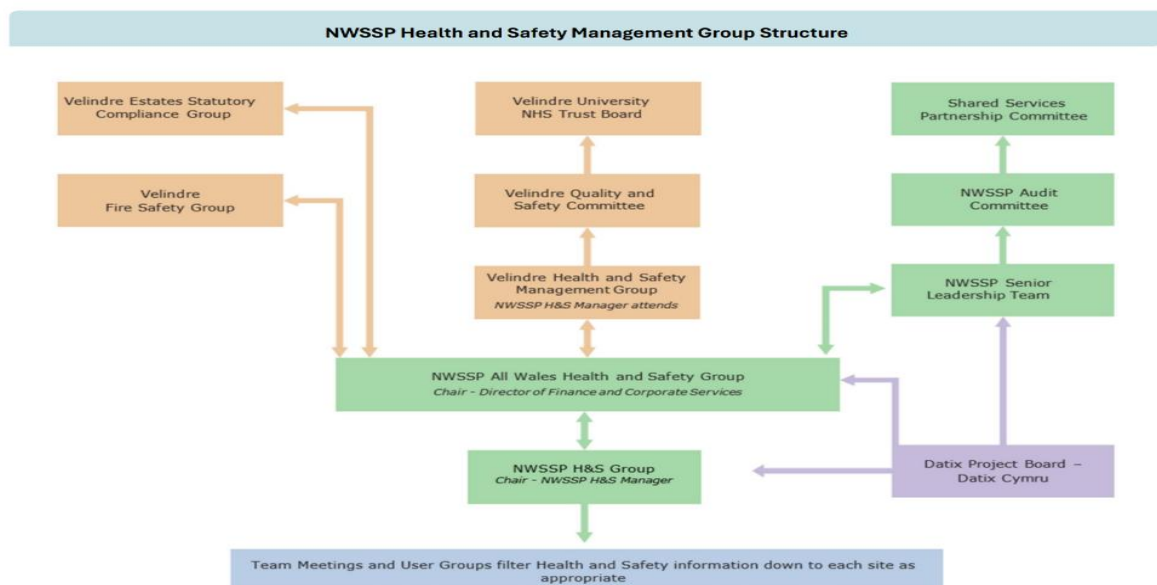
Key achievements in embedding the Duty of Quality during 2025–2026 included increased awareness through targeted engagement with the Shared Services Partnership, Senior Leadership Group and staff, the establishment of a Quality Champions Network to share best practice, enhanced quality-driven reporting, and strengthened use of performance data, quality controls and external reviews as sources of assurance and continuous improvement.

Overall, NWSSP continues to demonstrate a mature, structured and evidence-based approach to fulfilling its Duty of Quality, ensuring quality is embedded across governance, service delivery, assurance and continuous improvement activities.

NWSSP has established a robust and well-governed approach to health and safety consultation, communication and control, underpinned by clear leadership, structured oversight, and effective staff engagement mechanisms.

Health and safety are effectively embedded within NWSSPs governance arrangements. Quarterly health and safety performance reports are presented to the Senior Leadership Group (SLG), where they are actively scrutinised and discussed. The SLG ensures that health and safety risks, issues and improvement actions are fully integrated into the Integrated Medium-Term Plan (IMTP) and aligned with wider business planning and assurance processes.

NWSSP has a strong commitment to health and safety governance, communication and staff consultation & engagement via the NWSSP Health and Safety Management process.



The NWSSP All Wales Health and Safety Group provides a formal forum for consultation with employees and Trade Union representatives. The group has appropriate management representation to support effective decision-making and implementation of actions, with meetings held on a quarterly basis. The consolidation of regional meetings into a single All Wales forum has strengthened consistency, coordination and oversight.

These mechanisms promote a proactive safety culture, ensuring staff are informed, consulted, and engaged on relevant health and safety matters.

CONCLUSION

This annual report demonstrates that NHS Wales Shared Services Partnership (NWSSP) continues to operate a structured, robust and proactive approach to health and safety management across the organisation during the 2025–2026. Strong leadership, clear governance arrangements and an established Health and Safety Management System have ensured that health and safety remains embedded within operational delivery, decision-making and organisational culture.

Overall performance provides reasonable to substantial assurance that arrangements for managing health and safety risks are effective. Long-term incident trend data continues to show improvement, indicating increasing maturity of risk controls and learning systems over time. While there has been a short-term increase in reported incidents during 2025–2026, this reflects both the inherent risks within certain operational services and an open reporting culture, particularly in relation to violence and aggression and manual handling incidents.

Progress has been achieved against several key objectives, including the continued reduction in slips, trips and falls, improvements in health and safety capability across management and supervisory levels, strengthened governance and assurance processes, and the further embedding of the HSG65 Plan–Do–Check–Act framework. The completion of 12 HSG65 assessments, with no sites assessed as Limited or No Assurance, provides further confidence in the organisation's health and safety arrangements.

The report also highlights areas requiring ongoing focus, particularly in relation to contact with or struck by an object incidents, manual handling risks within higher-risk service areas, and the continued prevention and management of violence and aggression. Targeted improvement actions are already in place through the Health and Safety Strategic Improvement Plan, informed by trend analysis, audit findings and learning from incidents.

Fire safety arrangements throughout the NWSSP estate remain effective, with no serious harm events reported, prompt remedial action where required, and external assurance provided by Fire and Rescue Service engagement. Regulatory compliance has been maintained, with no enforcement action taken by the Health and Safety Executive, further supporting the overall assurance position.

Looking ahead to 2026–2027, NWSSP is well positioned to build on the progress made. The continued delivery of the Strategic Improvement Plan, sustained leadership engagement, targeted risk reduction activity, and further embedding of a safety culture will continue to be key priorities. Through these actions, NWSSP will continue to strengthen assurance, protect its workforce, and support the safe delivery of essential services across Wales.

Welsh Language Annual Performance Report

2025 - 2026

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Introduction

This Welsh Language Annual Performance Report highlights our key achievements in 2025/26 in delivering services through the medium of Welsh, alongside our performance against the Welsh Language Standards (No. 7) 2018, the Welsh Language (Wales) Measure 2011, and our wider statutory duties including the Duty of Quality.

Throughout the year, we have maintained careful oversight of our compliance with the Welsh language standards, reviewed our processes and protocols to drive ongoing improvements, and pursued innovative approaches to support other NHS organisations with translation services, enabling them to meet compliance requirements and provide Welsh language services for patients and the public.

Our work continues to be guided by the Welsh Language Standards (No. 7) 2018 and the priorities outlined in the *More Than Just Words* Strategy 2022–2027, as well as the long-term vision of *Cymraeg 2050*, which seeks to increase the use of Welsh across all aspects of public life. These frameworks, together with the Well-being of Future Generations (Wales) Act 2015, ensure that our Welsh language services are planned sustainably, with consideration for the needs of both current and future service users.

The delivery of Welsh language services is embedded within our integrated medium-term plan, ensuring that the requirements of services and service users are met in the short, medium, and longer term, while upholding our commitment to high-quality, accessible services through the medium of Welsh.

Service Delivery Standards (Standards 1 – 64)

We continuously monitor compliance with the Welsh Language Standards through a structured, cyclical process. Each year, every division and service area completes a self-assessment, with the following year dedicated to addressing any issues identified.

Directors, deputy directors, heads of service, and managers use the compliance notice and code of practice to guide their evaluations, providing evidence to demonstrate adherence to the standards.

The self-assessment also sparks local improvement plans, highlighting areas for additional support and creating opportunities to share best practice across the organisation.

The results of the 2025/26 self-assessment for service delivery standards are as follows:

Set of Standards	Level of compliance 2023/24	Level of compliance 2024/25	Level of Compliance 2025/26
Correspondence (1,4,5,6,7)	Medium level of compliance	Medium level of compliance	Medium to high level of compliance
Telephone services main number/contact centres (8,9,10,11,12,13,14,15,16)	Medium level of compliance	Medium level of compliance	Medium level of compliance
Telephone services direct numbers (16,17,18, 19)	Low to medium level of compliance	Medium level of compliance	Medium level of compliance
Telephone automated systems (20)	High level of compliance	High level of compliance	High level of compliance
Meetings (21,22, 22A, 22CH)	High level of compliance	High level of compliance	High level of compliance
Public Meetings (26,27,28,29)	Not applicable	Not applicable	Not applicable
Displaying written material at public meetings (30)	Not applicable	Not applicable	Not applicable
Public Event (31,32,33,34)	Medium to high level of compliance	Medium to high level of compliance.	Medium to high
Forms to be completed by individuals (36)	High level of compliance	High level of compliance	High level of compliance
Documents available to individuals (37)	High level of compliance	High level of compliance	High level of compliance
Documents and Forms (38)	High level of compliance	High level of compliance	High level of compliance
Websites (39,40,,41,42,43)	High level of compliance	Medium level of compliance	High level of compliance
Apps (used on electronic devices) (44)	High level of compliance	High level of compliance.	High level of compliance

Social media (45,46)	Medium to high level of compliance	Medium level of compliance	High level of compliance
Signage in publicly accessible areas (47,48,49)	Medium to high level of compliance	Medium to high level of compliance	Medium to high level of compliance
Reception services (50, 52, 53)	Medium level of compliance	Medium level of compliance	High level of compliance
Applications and documents for grants (54,55,56)	High level of compliance	High level of compliance	High level of compliance
Invitations to Tender (57,58,59)	Low to medium level of compliance	Low to medium level of compliance	Medium level of compliance
Promote Welsh language services (60-61)	High level of compliance	High level of compliance	High level of compliance
Corporate Identity (62)	High level of compliance	High level of compliance	High level of compliance
Public Address Systems (64)	Not applicable	Not applicable	Not applicable

Over the past three years, we have continued to strengthen compliance with the Welsh Language Standards across our services. Several areas have demonstrated notable improvement:

- **Correspondence** has progressed from a medium level of compliance in 2023/24 and 2024/25 to a medium-to-high level in 2025/26, reflecting targeted efforts to ensure written communication meets Welsh language expectations. This has been achieved by better sign-posting to our SOPs on our intranet.
- **Reception services** have moved from medium compliance in previous years to a high level in 2025/26, demonstrating enhanced front-line delivery of Welsh language support.

We have strengthened our reception services by ensuring that all job descriptions and advertisements clearly specify the requirement for Welsh language skills at Level 3 (Foundation Level B1/B2 CEFR). Over the past year, we successfully recruited to vacant posts by promoting opportunities widely, including on NHS Jobs, our own website, social media, and external platforms such as Lleol.net and Swyddi 360. These measures have enhanced our front-line capacity to deliver Welsh language services and contributed to achieving a high level of compliance in reception services.

- **Procurement and Invitations to Tender (Standards 57, 58 and 59):**
In 2025/26, we delivered a dynamic and innovative initiative to develop and pilot an assessment tool to determine whether Invitation to Tender specifications should include Welsh language requirements.

This work ensured that the needs of Welsh-speaking patients and public health service users across Wales were fully considered and that tender documentation clearly identified where translation and bilingual provision were

required. In doing so, it directly supported improved access, equity, and service effectiveness in line with the Duty of Quality.

The work contributed to compliance with Welsh Language Standards 57, 58 and 59 by strengthening processes for considering and embedding Welsh language requirements at the procurement stage. It also aligned with the *More Than Just Words Strategic Framework*, particularly its emphasis on integrating Welsh language provision into health and social care services as an essential component of safe, person-centred care.

A key enhancement through this work was the clearer articulation of expectations placed on third-party contractors delivering patient care services, including those providing digital systems, platforms, and interfaces used by staff and the public.

This ensured that Welsh language requirements were explicitly considered not only in direct service delivery, but also in the design, functionality, and usability of systems where patient-facing or staff-facing interaction occurs, thereby strengthening accountability for linguistic accessibility across the full-service pathway.

A key strength of the initiative was the collaborative approach, with consultation sessions undertaken with Heads of Procurement within NWSSP and Welsh Language Leads across all NHS organisations in Wales. This ensured a consistent, system-wide approach to Welsh language considerations in procurement practice.

Furthermore, the project supported the principles of the Duty of Quality by embedding a structured, evidence-based method to improve decision-making, accessibility, and equity of service delivery. It also aligns with the Foundational Economy priorities in Wales by strengthening local public service delivery systems, improving responsiveness to population needs, and ensuring that procurement activity contributes to social value, inclusion, and long-term public benefit.

By combining evidence-driven analysis with practical testing, the project set a new benchmark for accessibility, inclusivity, and linguistic responsiveness in public health procurement across Wales.

We expect to see level of compliance move from low to medium during 2026/27 and 2027/28 and moving to high level of compliance for 2028/29.

- **Social media platforms** have risen from medium compliance in 2024/25 to a high level of compliance in 2025/26, reflecting more consistent use of Welsh in digital engagement.
- **Websites** have returned to a high level of compliance after a temporary dip in 2024/25, following updates to digital content and accessibility and a full audit of our website.

Other areas, including telephone automated systems, forms, documents, apps, and corporate identity, have maintained consistently high levels of compliance, reinforcing our ongoing commitment to delivering high-quality Welsh language services.

Some areas, such as public meetings and public address systems, remain not applicable, while core contact centres and direct telephone lines continue to maintain medium levels of compliance, highlighting opportunities for further focus in the coming years.

We are currently undertaking a programme of work to review all job descriptions, which will support the implementation of an assessment tool to determine whether posts require Welsh Essential or Welsh Desirable skills. As this work progresses, and as posts become vacant or new roles are created, we expect to strengthen compliance, moving from medium/high to consistently high levels.

In addition, we have successfully recruited Welsh speakers to our administrative bank and have begun incorporating references to the CEFR framework within updated job descriptions to further standardise language requirements.

Overall, these results reflect steady progress and demonstrate the effectiveness of our cyclical self-assessment and improvement process, which continues to drive higher standards and more accessible Welsh language services across the organisation.

Policy Making Standards (Standards 69 – 77)

Policy Making Standards (Standards 69–77)

The Welsh language is consistently considered as part of all local NWSSP policy development and review processes.

Following the seminar hosted by the Welsh Language Commissioner in November 2023, and a subsequent workshop in April 2025, we undertook a review of our existing approach. This led to the development of a more robust Welsh Language Impact Assessment tool, enabling us to assess whether proposed Organisational Protocols or Policy Changes will have a positive, neutral, or negative impact on the Welsh language.

Authors, divisions, and services are encouraged to identify and implement solutions that maintain or enhance positive impacts wherever possible.

We have continued to strengthen this approach throughout the year to ensure that Welsh language considerations are fully embedded in all policy decisions. During 2025/26, we completed 15 Welsh Language Impact Assessments, demonstrating ongoing commitment to consistent and meaningful application of the framework.

Set of Standards	Level of compliance 2023/24	Level of compliance 2024/25	Level of compliance 2025/26
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Standards 69 to 77	Low level of compliance	Medium level of compliance	High level of compliance.
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As highlighted in NWSSP's 2024/25 Performance Report, the Concerns & Complaints Policy was reviewed and updated to provide all staff with clear guidance and operating procedures for handling complaints or concerns received in Welsh. Complaints specifically relating to Welsh language services are led by the Head of Welsh Language Services and Compliance, who oversees the investigation, ensures conclusions are reached, and drives actionable recommendations.

The policy is fully accessible to the public and service users via the NWSSP website, with both Welsh and English versions available.

Compared to the expectations outlined in the Welsh Language Commissioner's 2025/26 Line of Enquiry, NWSSP's arrangements demonstrate strong alignment: bilingual guidance is visible online, internal processes are fully integrated to manage Welsh complaints, informal concerns can be captured, and senior oversight is clearly assigned.

Any perceived gaps in the Commissioner's report—such as visibility of a Welsh-specific complaints section or markers—are already addressed in practice, with NWSSP providing clear, accessible information and robust internal procedures.

Operational Standards (Standards 79 – 114)

Operational Standards were reviewed through our self-assessment process, with the outcomes summarised as follows:

Set of Standards	Level of compliance 2023/24	Level of compliance 2024/25	Level of compliance 2025/26
Welsh Language Policy – Using Welsh internally (79)	Medium level of compliance	Medium level of compliance	Medium to high level of compliance
Contract of Employment (80)	High level of compliance	High level of compliance	High level of compliance
Documents relating to employment of employees (81)	High level of compliance	High level of compliance	High level of compliance
Policies relating to employment & workplace (82)	High level of compliance	High level of compliance	High level of compliance
Complaints made by staff & disciplinary matters (83 – 88)	High level of compliance	High level of compliance	High level of compliance
Computer software for spelling and grammar & interfaces (89)	Medium to high level of compliance	Medium to high level of compliance	Medium to high level of compliance
Intranet pages (90 – 95)	High level of compliance	High level of compliance	

Assessing Welsh language skills of employees (96)	Medium to high level of compliance	Medium to high level of compliance	High level of compliance
Training for staff in key areas (97 & 98)	Medium to high level of compliance	Medium level of compliance	Medium to high level of compliance
Opportunities to learn Welsh (99 – 103)	High level of compliance	High level of compliance	High level of compliance
Email signatures, wording and Welsh language logo (104)	High level of compliance	High level of compliance	High level of compliance
Welsh badges and branding for staff (105)	High level of compliance	High level of compliance	High level of compliance
Assessing skills, advertising, recruiting & onboarding (106 – 109)	Medium level of compliance.	Medium level of compliance	Medium to high level of compliance
Signage & notices (113)	High level of compliance	High level of compliance	High level of compliance
Recorded announcements (114)	Not applicable	Not applicable	Not applicable.

All intranet pages detailed in our compliance notice are available in Welsh. When a new page is produced and published it is done so in Welsh at the same time as the English version of the page. Any reviews and updates are undertaken in both languages at the same time.

NWSSP's compliance for recording Welsh language skills is currently at 96% a 1% increase since 2023/24. We recognise that we need to find a solution to enable trainees on the SLE programme to be able to access ESR from smart laptops and devices to be able to update their skills on ESR. We will be looking into this further during 2025/26.

We have developed several training modules in Welsh. All statutory and mandatory training on ESR is available in Welsh, these also include dealing with the public and health & safety. The quality of courses is scrutinised and tested to ensure that they are fully operational prior to publication or launch. We encourage open dialogue for constructive feedback to make continuous improvement. Our E-Ateb team supports all NHS Wales staff with queries relating to their employment and training on our Electronic Staff Record (ESR) System, and the support on this helpline is available in Welsh.

In 2024/25, 284 members of staff received induction training, and within that training there is specific information about the Welsh language and their obligations as employees to comply with our Welsh language standards. They are also informed and signposted to where they can find support to deliver our services through the medium of Welsh.

We offer several opportunities to introduce our staff to the Welsh language and culture as specified in Standards 99 to 103. To support this piece of work, a business case was made in the IMTP planning process to be able to recruit a Welsh Language Facilitation Officer which has been successful. This means we will be advertising the role during the first half of 2025/26 with a view to have the vacant post filled by September 2025.

During 2025/26 we will review current training for managers across the organisation and will embed Welsh language awareness into relevant managers’ training, rather than create separate modules of training as a stand-alone. The reasoning behind this is that the Welsh language should be embedded into everything that we do, and not something we need to do as an add on.

Staff Learning Welsh 2025/26

We actively promote and provide Welsh language courses to staff in line with Standards 99, 100, and 101. In 2025/26, 62 staff participated, a decrease from 73 in 2024/25, primarily due to individuals choosing not to continue their learning or leaving the organisation.

A further 16 members of staff at Intermediate Level

CEFR Learning Level	Number of staff registered on courses
Entry Level 1 (A1)	16
Entry Level 2 (A1)	12
Foundation Level 1 (A2)	13
Foundation Level 2 (A2)	0
Intermediate Level 1 (B1)	5
Intermediate Level 2 (B1)	4
Advanced Level 1, 2 and 3 (B2)	9
Proficiency (C1/C2)	3
Total	62

During Q4 of 2025/26, 16 staff members at Level 3 (Intermediate B1) participated in one-to-one Welsh language sessions over a 10-week period to build confidence. We have invited these participants to share their experiences through case studies and vlogs, aiming to encourage wider uptake of this development opportunity in 2026/27.

Record Keeping Standards (115 – 117)

Record Keeping Standards - Complaints and Concerns - Standard 115:

No official complaints or concerns were received via the Welsh Language Commissioner’s Office during 2025/26.

However, we received two queries to support the Commissioner to establish the current position on two specific matters:

Delivering Consent in Welsh: Bank and Agency Workforce Guidance

The Welsh Language Commissioner raised a query following information received from a Health Board which suggested that certain guidance relating to consent for bank and agency workers may have been of national origin.

To clarify the position and ensure accuracy across the system, this prompted a piece of investigative work to establish the provenance of the “Local Induction Checklist for Bank and Agency Workers” and the extent to which it was being referenced or relied upon within wider All Wales practice.

Through engagement with colleagues within the All-Wales Consent Group and wider workforce and organisational development contacts, including discussions facilitated via NHS Wales Shared Services Partnership (NWSSP), it was confirmed that the document in question is not a nationally issued resource. Instead, it is a locally developed tool created within a single Health Board as part of a previous workforce optimisation initiative and had subsequently been referenced more widely in error.

This clarification was shared and discussed with relevant stakeholders, and further dialogue with the Welsh Language Commissioner’s office and All Wales Consent colleagues provided an opportunity to reset the position collaboratively and ensure a shared understanding of the status of the document.

The discussion also highlighted the importance of maintaining clear governance over guidance materials used across NHS Wales, particularly where they relate to consent processes and Welsh language delivery.

As a result of this work, the All-Wales Consent Group has been progressing the development of clearer, system-wide guidance to support consistent practice in relation to consent through the medium of Welsh, particularly for bank and agency workers. The intention is for this guidance to be issued through People and Organisational Development divisions across all Health Boards and Trusts, ensuring it is embedded within induction and onboarding processes.

The guidance will reinforce the importance of offering and recording consent appropriately through the medium of Welsh and will include clear signposting to relevant learning resources via platforms such as Learning@Wales and ESR.

This will ensure that bank and agency staff have straightforward access to training and support materials as part of their core induction requirements.

Overall, this work will help to clarify a misunderstanding at system level, strengthen collaboration between national stakeholders, and support the development of more consistent and accessible guidance for temporary workforce groups across NHS Wales.

Clarification regarding requests for interviews through the medium of Welsh

The second query was received from the Welsh Language Commissioner in support of an investigation into a complaint regarding a Health Board’s failure to offer a candidate an interview in Welsh, despite this preference being clearly stated at the application stage.

The recruiting manager indicated that the request was not visible following shortlisting; however, this was not accurate.

We were able to confirm that the language preference remained visible within the system by providing supporting screenshots, while ensuring that no personal identifiable information relating to the candidate was disclosed.

Allegation of advertising a Welsh Essential Role in English only

A concern was raised directly with the Head of Welsh Language Services and Compliance late in Q4 regarding the advertising of the Welsh Language Facilitation Officer post. The individual alleged that the post had been advertised only in English and closed within 24 hours with a single applicant.

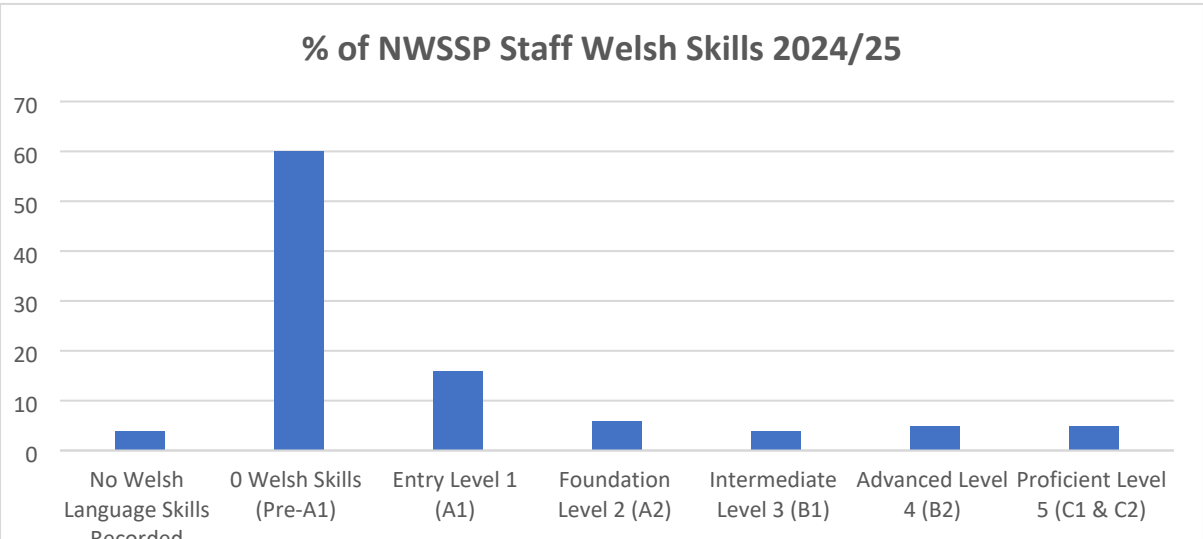
Following a thorough investigation, the allegation was unfounded.

The post was advertised bilingually across multiple platforms, including the NWSSP homepage, NHS Jobs, Health Jobs, Lleol.net, and Swyddi360, for the full period of 1–31 March 2026. A total of 44 applications were received, including 26 applicants with no Welsh language skills.

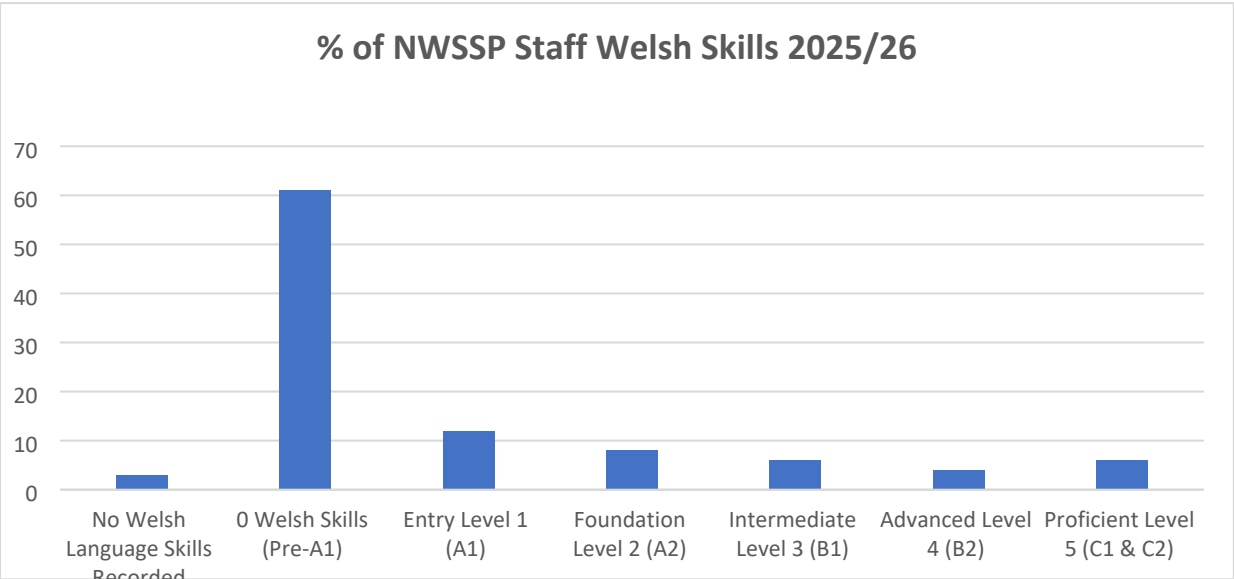
The concern arose from a LinkedIn notification issued in English by the platform’s algorithm, and a single “apply” click did not reflect the number of completed applications submitted via the website. The Commissioner’s Office was notified, and the matter was closed with no further action required.

Welsh Language Skills Recording (Standard 116)

All staff are required to record their Welsh language skills within the Electronic Staff Record (ESR). In 2024/25, the proportion of staff who had recorded their skills—across speaking and understanding, and reading and writing in Welsh—was as follows:



During 2025/26 we saw a slight flux in Welsh language skills:



A comparison of 2024/25 and 2025/26 shows a broadly stable profile in Welsh language skills across NWSSP, with some positive movement in capability levels.

The proportion of staff with no Welsh skills (Pre-A1) remains the largest group and has stayed broadly consistent at around 60%. The percentage of staff with no skills recorded has reduced slightly, indicating improved compliance with ESR recording requirements.

At the same time, there has been a shift towards higher proficiency levels. Entry level (A1) has decreased modestly, while Foundation (A2) and Intermediate (B1) levels have both increased, suggesting progression among learners. Proficient (C1/C2) levels have also risen slightly, indicating a strengthening of advanced Welsh language capability within the organisation. Advanced (B2) remains broadly stable.

Overall, the data demonstrates steady improvement in Welsh language capability, with measurable progression beyond entry level and a modest increase in higher-level proficiency. This reflects both improved recording compliance and targeted recruitment, where Welsh language skills are specified as desirable or essential. To strengthen oversight, a Power BI reporting tool has been implemented to enable monthly monitoring of Welsh language skills across the organisation.

Building on this, a robust workplan is in place for 2026/27 to increase Welsh language capability in key operational areas, supported by the appointment of a Welsh Language Facilitation Officer.

Record Keeping Standards - Advertising vacancies – Standard 117:

Total number of vacancies advertised as:	
Welsh language skills are essential	6
Welsh language skills are desirable	435
Welsh language skills need to be learnt when appointed to the post	0
Welsh language skills are not necessary	0

NHS Wales Shared Services Partnership's Senior Leadership Group agreed in 2020/21 that the baseline requirement for advertising vacancies is that Welsh language skills are specified as "desirable". NWSSP is an inclusive organisation that values and actively promotes Welsh language capability within its workforce.

A clear protocol is in place for advertising vacancies in Welsh, supported by a fully bilingual recruitment process. All job descriptions and person specifications are translated and uploaded via the TRAC recruitment system, which integrates directly with the NHS Jobs portal, ensuring consistent bilingual publication for all vacancies.

To strengthen oversight, a Vacancy Control Panel has been established, comprising the Director of People and OD, Director of Finance & Corporate Services, and Director of Planning and Performance. The Panel ensures Welsh language requirements are appropriately considered for each post, supporting service continuity and alignment with operational need.

During 2024/25, work commenced to develop a structured assessment tool to support recruiting managers in determining whether posts should be advertised as Welsh Essential or Welsh Desirable, including the level of language competency required. The tool also prompts consideration of service user demographics and existing workforce capability data held on ESR. This work has been delivered alongside job description review activity agreed with Welsh Government and was subject to testing and pilot during 2025/26, ahead of full implementation in 2026/27.

As part of early testing, the assessment tool has been applied to roles including reception staff, call handling teams (main telephone and helpline services), and communications functions. This has helped validate the approach and ensure relevance in frontline service areas.

Further development is underway to support a broader NWSSP Welsh Language Strategy, which will focus on increasing organisational capacity to deliver services through the medium of Welsh. The strategy development has been temporarily paused to allow completion of foundational work, including the development of a robust Internal Use of Welsh Language Policy, which will underpin the strategic framework.

Despite delays linked to capacity and resourcing, testing of skills assessment tools has continued throughout 2025/26 to ensure compliance, consistency, and auditability.

The full rollout is planned for 2026/27, supported by a comprehensive communications and training programme for recruiting managers and business partners, and aligned to the Vacancy Control Panel governance structure. This area of work was also outlined in our IMTP for 2025/26.

Integrated Medium-Term Plan for NWSSP 2025/26

Engagement with Single Lead Employer on Welsh Language Requirements

The Single Lead Employer (SLE) model in Wales primarily applies to postgraduate medical and dental training, including foundation doctors, specialty trainees, General Practice trainees, and dental foundation and specialty trainees. It exists to support rotational training by providing continuity of employment across multiple placements and Health Boards. In this arrangement, employment is managed centrally by NHS Wales Shared Services Partnership, while training design, delivery, and quality assurance are overseen by Health Education and Improvement Wales.

This separation ensures that trainees remain on a single employment contract while progressing through structured, nationally recognised training programmes aligned to UK professional standards set by the relevant Royal Colleges and regulated by bodies such as the General Medical Council and General Dental Council.

Within this system, Health Boards are responsible for delivering the day-to-day clinical environment in which training takes place. They provide clinical supervision, manage rotas and service delivery, and ensure access to appropriate learning opportunities to meet curriculum requirements. They also hold operational responsibility for ensuring compliance with statutory and mandatory training requirements, including those recorded through systems such as the Electronic Staff Record, and are expected to actively monitor, facilitate, and enforce completion of required modules to support patient safety and service readiness. In addition, Health Boards organise local teaching, support workplace-based assessments, and provide first-line management of concerns relating to workload, supervision, wellbeing, or workplace culture.

NWSSP, as the Single Lead Employer, underpins the system by providing the employment framework for trainees, including contracts of employment, HR policy application, payroll, and access to ESR. While operational responsibility for ensuring completion of mandatory training sits primarily with Health Boards, NWSSP retains responsibility where non-compliance escalates into formal employment or contractual matters.

HEIW, meanwhile, does not directly monitor ESR compliance but retains oversight of training progression and quality, with concerns arising from persistent non-compliance addressed through educational supervision or formal assessment processes where appropriate.

Together, these arrangements ensure that responsibility for mandatory training compliance is primarily exercised at service level, supported by employment governance through NWSSP and educational oversight through HEIW, enabling a coordinated approach to safe training delivery across Wales.

In relation to Welsh language development, NWSSP has been working to improve uptake of the Welsh Language Awareness Training Module in line with the *More*

Than Just Words strategy and the duty of quality under the Health and Social Care (Quality and Engagement) (Wales) Act 2020.

This has included targeted email communications, simplified access via Microsoft Forms, and signposting through ESR, although completion and response rates remain very low.

Further engagement activity is being developed, including outreach to Welsh-speaking trainees as peer advocates, the creation of a forum of Welsh language champions, and the development of supporting case studies and vlogs. Trainees are also being directed towards Welsh language learning opportunities and resources such as the *Gofalu Trwy'r Gymraeg* app to strengthen awareness and engagement.

However, to achieve sustained improvement, further strategic, cross-organisational discussions across NHS Wales will be required to strengthen engagement with the Welsh Language Awareness Training Module on ESR and to ensure consistent and accurate recording of trainees' Welsh language skills on the system.

Medicines Homecare Service

The NHS Wales Shared Services Partnership (NWSSP) Medicines Homecare Service continued to operate in alignment with Welsh Government policy requirements during 2025/26, with specific advice provided by the Head of Welsh Language Services and Compliance to ensure appropriate integration of Welsh language considerations within service delivery.

This included strengthening compliance with the principles of the *More Than Just Words* framework and supporting the organisation's responsibilities under the Health and Social Care (Quality and Engagement) (Wales) Act 2020, including the duty of quality. Key considerations included ensuring that patients can access medicines homecare services in their preferred language, that bilingual communication is embedded across patient-facing correspondence and information materials, and that Welsh language standards are reflected in provider arrangements and contractual expectations where applicable.

The service has incorporated this guidance into operational practice, and ongoing advisory support will continue to be provided to ensure sustained compliance, continuous improvement, and equitable access to services for Welsh-speaking patients.

Procurement Planning Processes - Standards 57, 58, 59

This work delivers a comprehensive assessment tool designed to support procurement and contracting teams across NHS Wales in determining when Welsh language requirements must be embedded into service contracts, invitations to tender, and associated procurement documentation. It has been developed through extensive engagement with 14 NHS organisations across Wales, alongside national and local procurement teams and Welsh language leads.

The intention is to address long-standing inconsistency in how Welsh language obligations are interpreted and applied within procurement processes, and to provide a clear, structured approach that strengthens decision-making and compliance.

The tool responds directly to the statutory context of Welsh language requirements in Wales, where public bodies are expected to comply with Welsh Language Standards set under the Welsh Language (Wales) Measure 2011. In practice, contact managers and procurement teams have often struggled with inconsistent interpretation of when Welsh language service delivery is required, with a tendency to rely on generic references to standards rather than embedding clear, contract-specific requirements. This has resulted in variability in approach, unclear expectations for suppliers, and missed opportunities to ensure meaningful Welsh language provision in commissioned services.

The purpose of the tool is to introduce a standardised and defensible framework that allows procurement professionals and Welsh language leads to establish, at the earliest stage of procurement, whether services, systems, or goods will be delivered to patients, the public, or staff through the medium of Welsh. It ensures that where required, Welsh language specifications are explicitly included within the invitation to tender rather than being deferred to general compliance statements that bidders may not fully understand or be able to interpret consistently.

It also supports better design of procurement documentation by identifying when bilingual ITT documents are required in line with statutory obligations, including compliance with Standard 57. In addition, it enables Welsh language capability to be appropriately considered within evaluation frameworks, ensuring that delivery in Welsh is not treated as an afterthought but as a structured element of contract assessment and award.

The development of the tool has been based on extensive collaboration and iterative refinement. Engagement was undertaken with 14 NHS organisations across Wales, involving procurement managers, contracting leads, and Welsh language specialists.

The resulting tool operates as a structured decision-making framework that guides users through key considerations about service delivery, including whether services involve direct interaction with patients or the public, whether digital or face-to-face communication is involved, and the extent of potential Welsh language need. It also considers linguistic risk, including the likelihood and impact of Welsh language usage within a service, as well as the potential for exclusion if Welsh language provision is not adequately considered. From this, it determines the appropriate contractual response, whether that is no specific requirement, inclusion of Welsh language conditions, development of a bespoke specification, or mandatory bilingual publication of procurement documents.

The tool is designed to be embedded directly into procurement workflows. It can be used at the pre-ITT stage to inform commissioning decisions, during ITT development to shape specifications and contractual requirements, and during

evaluation to support structured assessment of Welsh language capability. It also provides an audit trail for decision-making, supporting governance, consistency, and assurance across organisations.

A key outcome of the tool is its contribution to a clear compliance improvement trajectory across NHS Wales. In the short term, over a period of two years, it is intended to support a shift from low to medium compliance by standardising how Welsh language requirements are assessed and applied. In the medium term, over two to four years, it is expected to support progression to high compliance, with Welsh language considerations becoming embedded as a routine part of procurement design rather than a reactive or interpretive exercise.

The broader value of the work lies in improving consistency across organisations, strengthening supplier understanding of Welsh language expectations, and reducing ambiguity in procurement processes. It enhances governance and audit readiness, improves alignment with statutory requirements, and ultimately supports better service outcomes for Welsh-speaking patients, the public, and NHS staff.

Overall, this work represents a significant shift in how Welsh language considerations are integrated into procurement practice within NHS Wales. It replaces fragmented interpretation with a structured, transparent, and consistent approach that strengthens compliance while also improving the quality and clarity of procurement activity across the system.

Direct engagement with Welsh speaking communities:

Targeted engagement with Welsh-speaking communities was delivered throughout 2025/26 as part of a coordinated programme of outreach activity designed to strengthen visibility, understanding, and confidence in the role of NHS Wales Shared Services Partnership within the NHS Wales structure with Welsh-speaking populations.

This included attendance at major cultural events such as the Urdd Eisteddfod and the National Eisteddfod, alongside structured engagement with Cardiff University and Bangor University, as well as targeted sessions with secondary schools and colleges across Wales.

Attendance at the Urdd Eisteddfod and National Eisteddfod provided a highly effective platform for direct engagement with Welsh-speaking audiences in environments where the language is actively used and celebrated. These events enabled meaningful conversations about the importance of Welsh language provision within NHS Wales, while also raising awareness of NWSSP as an employer and its role in supporting service delivery across the health system. The informal, high-footfall nature of these events allowed for accessible, two-way dialogue and helped reinforce the organisation's commitment to operating bilingually.



Engagement at Cardiff University and Bangor University provided an opportunity to connect with students at a critical stage of career decision-making. These sessions highlighted the importance of Welsh language capability within NHS Wales systems, not only in frontline service delivery but across procurement, commissioning, communications, and corporate functions. They also helped broaden awareness of career pathways within NWSSP and reinforced the message that Welsh language skills are a valued and practical asset in public service roles.

Work with secondary schools and colleges extended this engagement further by introducing younger learners to the relevance of Welsh language in public sector careers at an earlier stage. This helped reinforce the idea that Welsh is a working language with clear professional application, supporting longer-term language confidence and encouraging consideration of future roles within Welsh public services.

Across all settings, a key benefit has been the ability to ground Welsh language policy in real-world context, linking it directly to service delivery, patient experience, and public accountability. This approach has strengthened understanding, improved organisational visibility within Welsh-speaking communities, and supported broader workforce and recruitment objectives by positioning NWSSP as an organisation where Welsh language capability is both valued and actively embedded.

Audit and Review NWSSP Websites/Social Media

The audit and review of NHS Wales Shared Services Partnership (NWSSP) website and social media content was undertaken during Q1–Q2 2025/26 and led by the Head of Welsh Language Services and Compliance.

This work formed part of a wider programme to strengthen Welsh language assurance across digital communications and ensure that organisational output

aligns consistently with Welsh Language Standards and internal compliance expectations.

The review involved a detailed examination of web pages, social media channels, and associated digital content across all relevant NWSSP service areas. Each item of content was assessed against Welsh language compliance requirements, with particular attention given to bilingual presentation, accuracy of translation, consistency of terminology, and the accessibility of Welsh language content in comparison to English. Consideration was also given to how frequently pages were updated, whether Welsh content was being maintained in parallel with English versions, and whether social media output demonstrated consistent bilingual practice in line with organisational expectations.

Overall compliance was found to be high at 96%, which reflects a strong baseline of Welsh language integration across NWSSP digital platforms. However, the audit identified a small number of non-compliant or partially compliant pages where Welsh language content was either missing, outdated, inconsistently applied, or not fully aligned with required standards. These issues were not widespread but were significant enough to warrant structured follow-up to ensure that compliance expectations were fully met and sustained over time.

Where gaps were identified, relevant divisions were formally contacted and provided with clear feedback outlining the specific issues and required corrective actions. Action plans were agreed with each area to ensure that remedial work was completed in a timely and consistent manner. This process also included clarification of responsibilities for content ownership, particularly in relation to ensuring that Welsh language versions of pages and posts are created and maintained concurrently with English-language updates rather than retrospectively.

The review also highlighted the importance of clearer governance arrangements for ongoing digital content assurance. As a result, and following the appointment of the new Head of Communications and Engagement, responsibility for routine website content auditing and oversight will be formally integrated into the Communications team's remit. This includes embedding Welsh language considerations within standard communications workflows and ensuring that compliance monitoring is not treated as a standalone exercise but as part of business-as-usual activity.

Ongoing oversight is now supported through the communications group, which brings together representatives from each division. This group provides a structured mechanism for reviewing digital content practices, sharing expectations, and ensuring consistency in how Welsh language requirements are applied across NWSSP communications channels. It also strengthens accountability by ensuring that divisions retain visibility of their responsibilities in relation to bilingual content production and maintenance.

Overall, this work has not only provided a clear compliance snapshot of NWSSP's digital estate but has also contributed to strengthening governance, embedding

clearer accountability, and improving the long-term sustainability of Welsh language standards within organisational communications practice.

Research and re-procure a Translation Memory System

Following a 2023/24 feasibility study, a structured pilot was undertaken to assess the most suitable translation memory systems, focusing on functionality, scalability, security, and interoperability. The outcome informed a clear specification, leading to the implementation of a centrally hosted system administered by NWSSP.

The platform is now shared by NHS Wales Shared Services Partnership, Velindre University NHS Trust, Public Health Wales, Welsh Ambulance Service Trust, and Digital Health Care Wales, with Powys Teaching Health Board, Cardiff and Vale Health Board, and Swansea Bay University Health Board successfully onboarded. Hywel Dda trialled the system but did not proceed, while Health Education and Improvement Wales received support from NHS Wales Shared Services Partnership to optimise their separate but equivalent system.

Sharing a single system reduces duplication of translation work by enabling reuse of validated content through a central translation memory. This improves turnaround times, ensures consistency of terminology, and enhances overall quality across organisations. Notably, organisations that have been part of the system for two years or more are now seeing a reduction in their reliance on external translation services, as previously translated content is readily available for reuse.

This reduction directly translates into cost savings. By avoiding repeat translation of identical or similar content, organisations lower their spend on external suppliers. In addition, a single, once-for-Wales procurement approach removes the need for multiple organisations to run separate procurement exercises, reducing administrative overheads and leveraging collective buying power to secure better value. Over time, this delivers significant system-wide savings while ensuring consistent access to a high-quality solution.

Robust governance underpins the system, with clear protocols for managing personally identifiable, sensitive, and commercially sensitive information. These include role-based access controls, audit trails, secure storage, and defined review and approval workflows to maintain compliance and data integrity.

Comprehensive training is provided for all end users to ensure effective use of the system, supporting consistent standards and maximising efficiency.

Overall, the shared approach delivers cost efficiency, strengthens collaboration, reduces duplication, and supports high-quality, consistent multilingual communication across the NHS Wales organisations using the system.

“Y Sgwrs / The Conversation” Roadshow

The People and OD team has been engaging directly with colleagues across all areas of the organisation to gather insights on employee experience and

organisational culture. This has included exploring perceptions of what it is like to work here, identifying key strengths, and highlighting opportunities for improvement.

As part of this programme, the Head of Welsh Language Services and Compliance has joined visits to several sites, with a specific focus on the Welsh language. This has included assessing accessibility, understanding of organisational responsibilities, and perspectives on developing a genuinely bilingual workplace. Feedback has been largely positive, alongside constructive insights to support further progress.

The findings from this engagement will directly inform the People and OD Strategy for 2026–2030. This will include a dedicated Welsh language section, aligned with and underpinned by the Welsh Language Policy developed through extensive consultation over the past year, ensuring a coherent and forward-looking approach to embedding bilingualism across the organisation. We visited all our sites to discuss staff priorities.



Welsh Language Media Training

We commissioned and delivered training for staff in strategic and senior-facing roles within NHS Wales Shared Services Partnership (NWSSP) as part of a broader programme to strengthen organisational capability in responding confidently and appropriately to media engagement through the medium of Welsh.

The focus of this work was to ensure that NWSSP can respond effectively to Welsh language media queries received via key outlets such as BBC Cymru Wales, BBC Radio Cymru, S4C, and other Welsh-medium press and digital platforms.

The training was designed specifically for roles where media engagement is either frequent or likely, particularly where organisational reputation, service delivery, and public accountability may be communicated externally. A key driver for the programme was the recognition that while Welsh language compliance in written communications was well established, confidence and fluency in real-time or reactive Welsh language media situations varied across senior teams. This created a potential risk in terms of responsiveness, consistency of messaging, and the ability to engage naturally and credibly with Welsh-speaking audiences.

The sessions focused on building practical capability rather than linguistic theory, with emphasis placed on handling interview scenarios, responding to unexpected questions, and maintaining clarity and control when communicating under pressure in Welsh. Consideration was also given to how messages are prepared in advance, how key organisational narratives can be translated and delivered effectively in Welsh, and how staff can work with communications teams to ensure accuracy and consistency in bilingual messaging.

A further important element of the training was confidence-building. For some participants, Welsh was a working language but not one they regularly used in high-profile or external-facing contexts. The training therefore supported staff in developing fluency for professional media situations, helping to reduce hesitation and improve the natural flow of communication. This was particularly important in ensuring that Welsh language engagement is not treated as an exception or a secondary channel, but as a normal and confident part of organisational communications practice.

The programme also reinforced internal processes for managing Welsh language media enquiries, ensuring that there are clear escalation routes, defined roles, and appropriate support available when responding to Welsh-medium outlets. This includes strengthening coordination between communications functions and operational leads to ensure that responses are timely, accurate, and fully aligned with organisational position.

Overall, the training has contributed to a stronger organisational capability within NWSSP to engage meaningfully with Welsh language media, improving both responsiveness and confidence at senior levels. It supports a more consistent and credible public presence across Welsh-medium platforms and reinforces the organisation's commitment to operating bilingually in high-profile and externally visible contexts.



Translation Services through Service Level Agreements:

During the 2025/2026 financial year, NWSSP's Translation Unit continued to play a critical role in supporting NHS Wales organisations to meet their statutory Welsh Language obligations and deliver safe, inclusive and accessible services for patients, service users and staff. This has been achieved while maintaining a strong focus on efficiency and value for money.

The Unit sustained and further strengthened its core translation and proofreading services, ensuring consistent quality, terminology and tone across NHS Wales communications. Timely delivery of Welsh and English translations across clinical, corporate, digital and public-facing materials has enabled organisations to communicate effectively with Welsh-speaking communities and uphold the Welsh Language Standards.

A key area of focus during the year was quality assurance and linguistic consistency. Robust review and proofreading processes were applied to sensitive and high-risk content, including patient information, clinical pathways, consent documentation, job descriptions and policy materials. This work directly supports patient safety, informed decision-making and regulatory compliance.

The Translation Unit also made significant progress in supporting digital transformation across NHS Wales. Close collaboration with digital and communications teams ensured that new and updated systems, platforms and online content were bilingual by design. This proactive approach has reduced the need for retrospective translation and embedded Welsh language considerations earlier in project lifecycles.

Collaborative working relationships with Health Boards, Trusts and national programmes were further strengthened. The Unit provided responsive advice and guidance on Welsh language requirements and best practice, helping to build organisational confidence and capability in delivering effective bilingual communication.

Operational resilience remained a key strength. The team successfully managed peaks in demand, short-notice requests and priority work, while maintaining service levels. Recruitment of an experienced translator and steps to secure additional bank translator capacity have strengthened the Unit's ability to respond to anticipated future demand.

The Unit also continued to drive efficiency through shared services, reducing duplication and making effective use of translation technology, while maintaining the essential contribution of human linguistic expertise.

Partnership Working

In collaboration with the Head of Welsh Language Services and Compliance, NWSSP's translation managers played a leading role in supporting Health Boards to adopt a centrally procured translation system. This work aligns with the Welsh Government's *More Than Just Words* strategic framework.

Extensive engagement, including regular meetings, demonstrations and mentoring sessions, enabled Powys Teaching Health Board, Swansea Bay University Health

Board and Cardiff and Vale University Health Board to be successfully onboarded ahead of schedule. These organisations are now contributing to and benefiting from a shared translation system.

This pan-Wales approach is expected to deliver significant benefits, including improved consistency and accuracy of technical translations, reduced duplication of effort, and long-term cost savings. It also supports the sharing of best practice across NHS Wales, underpinned by strong partnership working and leadership from NWSSP.

Powys Teaching Health Board

The Health Board's translation memory was successfully uploaded to the shared system. Since adopting the system in November 2025, the translator has reported clear benefits in terms of efficiency, with measurable time and cost savings.

Swansea Bay University Health Board

Following issues with its previous translation memory software, Swansea Bay was onboarded to the NWSSP system within 24 hours of requesting support. This ensured business continuity, and the system is now embedded in daily use.

Hywel Dda Teaching Health Board

Accounts were created and engagement sessions were delivered to demonstrate the benefits of the shared system. While discussions were constructive, the Health Board had not committed to joining the system by the end of 2025/2026.

Cardiff and Vale University Health Board

Cardiff and Vale joined the system in January 2026. NWSSP provided tailored training and successfully integrated their translation memory. Discussions will continue into 2026/2027 regarding a formal service level agreement to provide additional translation support.

Health Education and Improvement Wales

Engagement took place during the year, including system access for a trial period. However, no formal commitment to adoption has yet been made.

Public Health Wales

Public Health Wales continues to make extensive use of the translation system through a comprehensive service level agreement. NWSSP works closely with their Welsh language team, delivering large-scale and highly technical translations, often exceeding 15,000 words per project. During peak periods, output reached over 100,000 words per week, requiring a high level of linguistic expertise and quality assurance.

Digital Health and Care Wales

Digital Health and Care Wales continue to utilise the system fully, supported through an established service level agreement.

Velindre

Velindre makes full use of the system and benefits from a comprehensive service level agreement. NWSSP also provides additional support during periods of reduced internal capacity, alongside training opportunities.

WAST

WAST continues to use the system extensively. A major project commenced in March 2026 to translate the NHS 111 symptom checker into Welsh. This work will improve access to appropriate healthcare services by enabling Welsh speakers to navigate care pathways more effectively, supporting better outcomes and more efficient use of NHS resources.

The project has required significant input from multiple members of the Translation Unit and has included additional value through review and refinement of the English source text in collaboration with clinical teams. This has enhanced overall quality and usability.

The work has delivered substantial cost avoidance for WAST, estimated at £20,000–£30,000 for an initial three-month period, with projected savings increasing to £50,000–£60,000 as the project continues.

Training Offered by NWSSP's Translation Unit During 2025/2026

NWSSP continued to invest in the development of translation capability across NHS Wales. Translation managers delivered tailored one-to-one training sessions and supported staff in achieving professional accreditation, including successful attainment of full membership of the Association of Welsh Translators and Interpreters.

In partnership with the Association, NWSSP also delivered workshops for its own staff, service users and wider NHS Wales translators. As a result, NWSSP continues to play a leading role in coordinating and delivering professional development and mentoring opportunities across the NHS Wales translation community.

Consistency of Terminology

Maintaining consistency and accuracy of terminology remained a priority. Translation managers and staff provided ongoing guidance to system users on quality assurance expectations and best practice.

During the year, new medical terminology was developed in consultation with clinical and linguistic experts, including the Association, experienced translators, Welsh Government and Canolfan Bedwyr. This ensures that the shared system remains current and reduces the need for independent research, supporting both quality and efficiency.

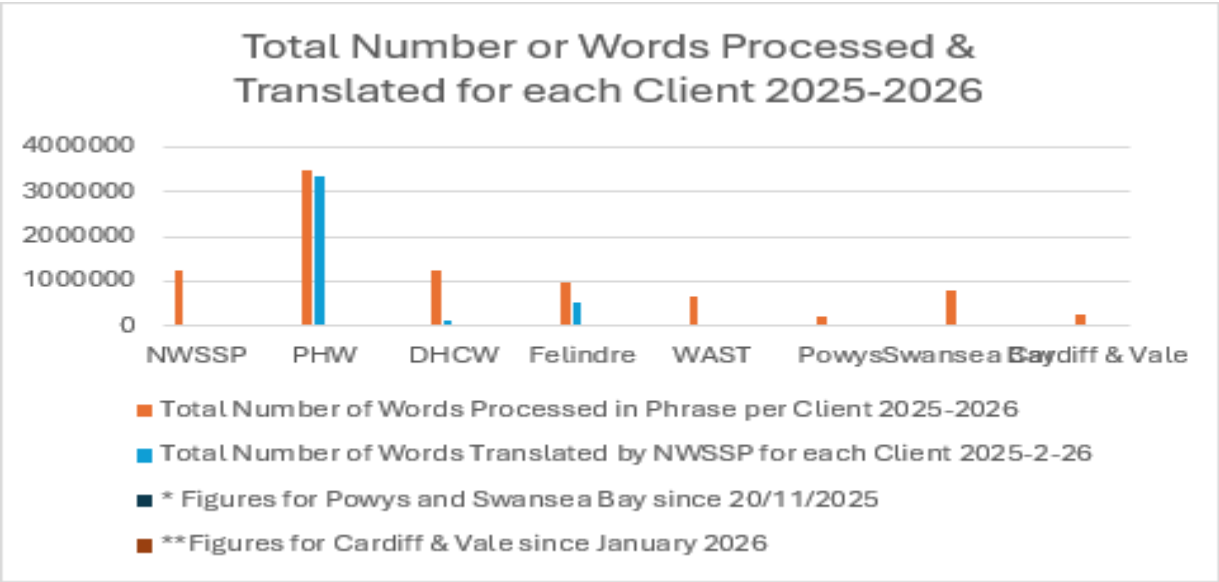
NWSSP Translation Service Efficiency

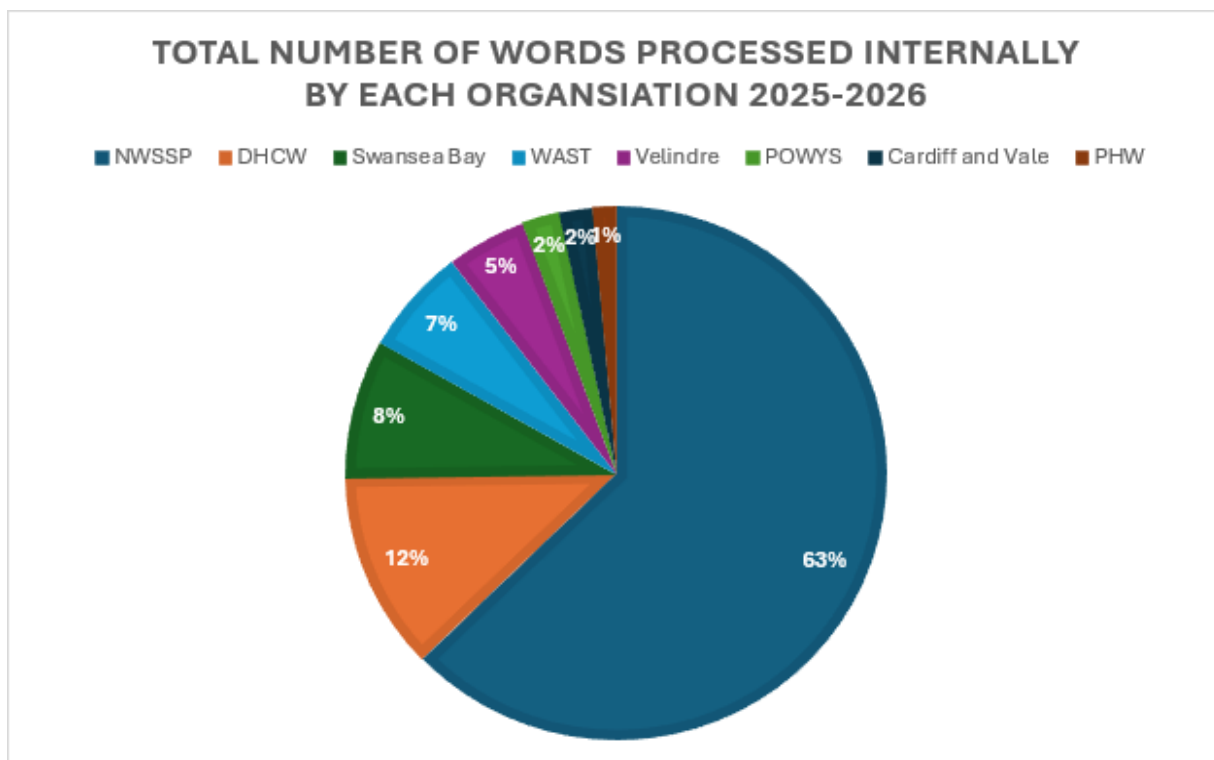
The Translation Unit maintained a high level of service performance, with over 98% of requests delivered on or ahead of agreed deadlines. A significant proportion of work was completed ahead of schedule, often on the same day. Where delays occurred, these were typically due to issues with source material requiring clarification. This reflects an additional benefit of the service, as translators frequently identify and resolve issues in English texts, improving clarity, safety and usability.

To further enhance efficiency, the Unit developed and shared guidance for service users on best practice when commissioning translation work.

Overall, during the 2025/2026 financial year, the NWSSP Translation Unit consolidated its role as a trusted, specialist service within NHS Wales. It continues to deliver high-quality bilingual content, support statutory compliance, enhance patient safety and experience, and contribute to system-wide efficiency.

Demand for the service continues to grow, reflecting its value and importance across NHS Wales.





Additional Activity During 2025/26

Translation of Job Descriptions for Health Boards

A further area of work arose during the year following engagement with the Welsh Language Commissioner's office and Welsh Government officials as part of their routine compliance discussions with NHS organisations regarding Welsh Language Standards and the "More Than Just Words" strategic framework. During these discussions, it was highlighted that several Health Boards were experiencing significant challenges in translating all job descriptions into Welsh and ensuring that both job descriptions and associated vacancy advertisements were consistently published bilingually.

In response to this, both the Commissioner's officers and Welsh Government officials approached NHS Wales Shared Services Partnership (NWSSP) to explore whether there was potential for a coordinated, system-wide approach to supporting this requirement.

This included consideration of whether NWSSP could provide centralised support for translation activity, particularly using existing translation memory systems and the development of standardised or generic job description templates to reduce duplication of effort across Health Boards.

At present, three out of seven Health Boards are utilising NWSSP's translation memory system, which presents an opportunity to expand this model further in 2026/27.

However, initial scoping identified that further preparatory work is required before any full implementation can be progressed. This includes determining whether job descriptions already translated elsewhere across the system can be consolidated and uploaded into a shared translation memory and exploring the feasibility of Health Boards collaborating more formally to reduce duplication and improve consistency.

There is also potential for NWSSP to support the development of a suite of generic job descriptions for translation, which could then be adapted locally. This would need to be aligned with the wider Job Description review programme being undertaken across NHS Wales at the request of Welsh Government, to ensure consistency and avoid duplication of effort.

Due to the timing of the request and competing capacity demands during the reporting period, this work has been paused pending further scoping and will be revisited in 2026/27.

111 Symptom Checker Project

The editorial process for the review of the 111 Symptom Checkers has involved a structured and collaborative approach, drawing on the expertise of clinical leads, developers, and specialist language professionals. Initial discussions took place in Q3 of 2025/26 to define scope, standards, and governance, with the work formally commencing in February 2026. From the outset, the focus has been on ensuring that all English-language content is clinically accurate, accessible to users, and aligned with digital and service requirements.

Clinical leads and developers have worked closely to review and validate the underlying medical content, ensuring that symptom pathways, triage logic, and user-facing language are both safe and effective. This has been complemented by a rigorous editorial process, including detailed research, translation where required, and careful proof-reading. Emphasis has been placed on consistency of terminology, tone, and structure across the symptom checkers, ensuring a coherent user experience and reducing the risk of misinterpretation.

Translation and editing have been undertaken in-house by expert linguists with strong backgrounds in clinical and medical terminology. This has enabled a high level of precision and contextual understanding, supporting compliance with duty of quality standards. Consistency checking across multiple pathways and iterations has been a key component, alongside iterative editing cycles to refine clarity, readability, and alignment with clinical intent.

As the programme of work progressed, it became clear that the scale and complexity of the work were greater than initially anticipated. As a result, the editorial, translation, and quality assurance activities will continue into 2026/27. Maintaining this work in-house has not only safeguarded quality but has also delivered significant

efficiencies, allowing for closer collaboration, faster iteration, and better integration with clinical and technical teams ahead of launch.



Conclusion

In 2025/26, NWSSP has demonstrated sustained progress in embedding the Welsh language across all aspects of its functions, reinforcing its role as a system leader within NHS Wales in delivering accessible, high-quality bilingual services. Performance against the Welsh Language Standards has remained strong, with clear upward trends in several key service delivery areas, including correspondence, reception services, digital platforms, and social media. These improvements reflect the effectiveness of the organisation's cyclical self-assessment approach, targeted interventions, and strengthened governance arrangements.

Significant advancements have also been made in policy making and operational standards, with Welsh language considerations now fully integrated into decision-making processes through the enhanced impact assessment framework and consistent application across the organisation. The achievement of high compliance in Policy Making Standards marks a notable milestone and demonstrates the maturity of NWSSP's approach to embedding bilingualism as a core organisational principle rather than a compliance exercise.

Throughout the year, NWSSP has continued to innovate and lead collaborative, system-wide initiatives. The development of the procurement assessment tool, expansion of the shared translation memory system, and targeted engagement with Welsh-speaking communities all represent significant contributions toward improving consistency, accessibility, and quality of Welsh language provision across NHS

Wales. These initiatives not only strengthen compliance but also deliver tangible benefits in terms of efficiency, cost savings, and service user experience.

The organisation has also maintained a strong focus on workforce development, increasing Welsh language capability through recruitment, training, and structured learning opportunities. While the overall skills profile remains stable, there is clear evidence of progression at intermediate and advanced levels, supported by improved recording, targeted programmes, and the planned introduction of a Welsh Language Facilitation Officer.

Looking ahead, there remain areas for continued focus, particularly in strengthening Welsh language provision within telephone services, further increasing workforce capability, and fully embedding new tools and frameworks such as the procurement assessment model and job description skills assessment tool. These priorities are supported by a clear and structured workplan for 2026/27 and beyond, aligned to organisational strategy and national policy frameworks.

Overall, this report evidences a positive trajectory of continuous improvement, underpinned by strong leadership, effective collaboration, and a clear commitment to delivering equitable, person-centred services through the medium of Welsh. NWSSP is well positioned to build on this progress, further strengthening its contribution to the ambitions of *More Than Just Words* and *Cymraeg 2050*, and ensuring that Welsh language services remain integral to safe, high-quality healthcare across Wales.

Priorities outlined in our IMTP for 2026/27

Deliver our Internal Use of Welsh Language Policy in line with our People and OD Strategy 2026/2030.

Welsh Language Service Improvement Programme – auditing our telephone services and working with the Customer Excellence programme to evaluate our Welsh language services by sending out surveys to our service users. Collate data and publish a report to be included in our Welsh language performance report for 2026/27.

Outreach activities with schools and colleges in the vicinity of our offices and locations across Wales.

Support all divisions across NWSSP Business in ensuring service delivery continues to be equitable and accessible through the medium of Welsh.



NHS WALES SHARED SERVICES PARTNERSHIP

Duty of Quality Annual Report

2025 - 2026

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Introduction from Chair and Managing Director of NWSSP

We are pleased to present the third NHS Wales Shared Services Partnership’s Duty of Quality Report, prepared in line with the Health and Social Care (Quality and Engagement) (Wales) Act 2020.

Although NWSSP does not directly provide frontline clinical care, the services we deliver nationally have an indirect impact on patient safety and the effective running of NHS Wales. From Laundry, Pharmacy Technical Services, Workforce support to Procurement & Supply Chain and Primary Care Administration services, our role is to enable high-quality, safe and sustainable healthcare across Wales.

For NWSSP, quality means more than compliance. It means ensuring that our systems, advice and services consistently support better patient outcomes, strong governance and value for public money. Over the past year, we have continued to strengthen our quality and assurance arrangements, embed learning and improvement across our directorates, and maintain a clear focus on safety and regulatory standards. As a national shared service operating within a partnership model, we recognise the importance of collaboration, transparency and accountability. We work closely with Health Boards, Trusts, Special Health Authorities and Welsh Government to ensure that our services support improvement across the wider NHS in Wales. This report outlines the progress we have made, the challenges we continue to address, and provides a deeper insight into the work we do and how we continue to embed quality every day. We would like to thank colleagues across NWSSP for their continued professionalism and commitment to delivering high-quality services for the people of Wales.



Neil Frow,
Managing Director



Tracy Myhill,
Chair

Medical Director’s Introduction

This year we have set ourselves the challenge of considering what a high-quality Shared Service organisation looks like in the context of each division.

Armed with this vision we have reconsidered:

- » Do our KPIs and other reporting metrics tell the story of quality?
- » Does our ‘always-on’ reporting demonstrate the quality story in an accessible manner?
- » How do we demonstrate that we have quality at the core of our planning and decision-making processes?
- » How do we link this into an overarching quality management system?
- » How do we capture, report and share quality improvement across divisions?
- » How do we draw together our organisation-wide quality management system?
- » How do we work together with other non-clinical organisations to share learning?

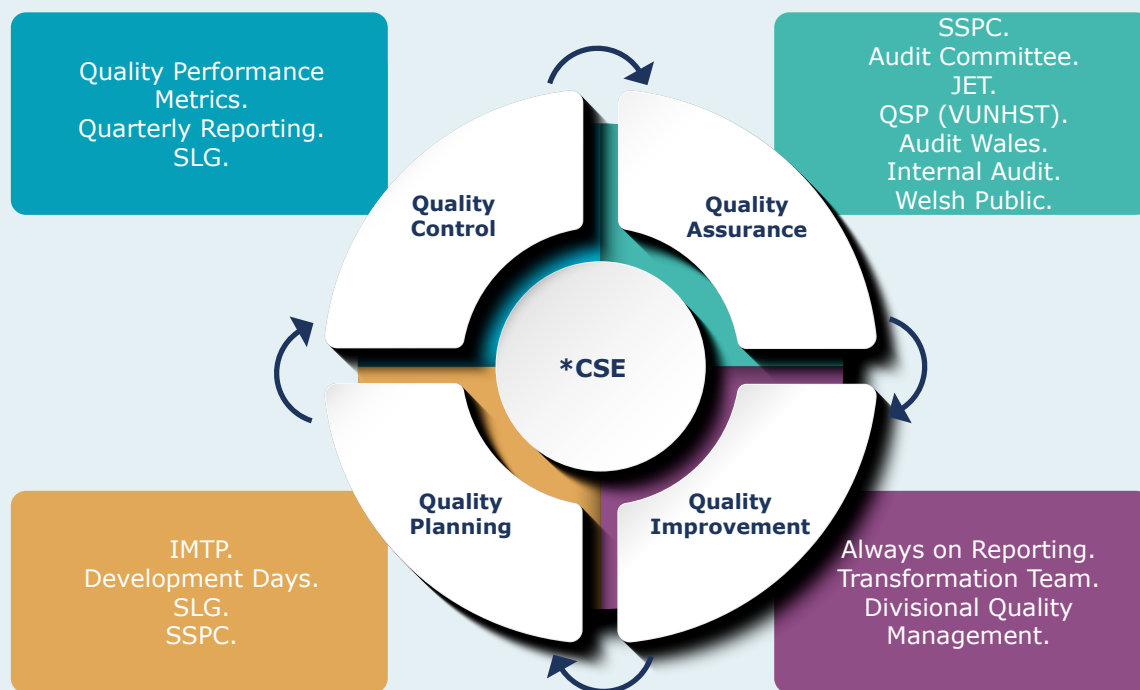
We agreed, as a Senior Leadership Group, that we would ensure that the 12 Health and Care Quality Standards would be more visible in the quarterly divisional holding to account meetings. This ensures that quality is demonstrably considered alongside performance and finance in our regular reporting rhythms which encompass quality control and quality assurance.

Our always on Vlogs and Blogs continue to be used, and feedback from the Quality, Safety and Performance meetings where they are linked into our assurance reports are positive.

Quality Impact Assessments are now embedded into our strategic papers for reporting and considering proposals.

We continue to meet as a cross divisional quality team to share good practice and highlight areas of mutual learning. An example of this is the use of Quality Impact Assessment Logs which were introduced last year.

We have drafted an overarching Quality Management System which will continue to develop and evolve over the next year. It demonstrates our commitment to quality with examples of our many external accreditations which provide quality assurance, and we will touch on this later in this report.



***CSE** = *Customer Service Excellence*

Diagram: NWSSP Overarching QMS

The progress we have made has assured me, as I step down from my role as Medical Director for NWSSP, that quality has always been at the heart of this organisation and that the Duty of Quality and its associated reporting systems have shone a light on this. It has been a useful vehicle for demonstrating standards across divisions and externally.

I hope you will be able to appreciate this as you review our third annual report.



Dr. Ruth Alcolado,
Medical Director

Key Achievements 2025-26

Our second annual duty of quality report was submitted in July 2025 and was received positively by partner organisations in Wales through approval by the Shared Services Partnership Committee. We have also, following this, engaged with other non-clinical organisations within the NHS to further develop our approach and look at how best to support evidencing compliance. We remain cognisant of the fact that we are measured in terms of compliance in exactly the same way as our clinically focussed colleagues.



Quality Planning and Decision Making

The IMTP and the Duty continue to be integrated into our working practices. There are ongoing challenges in terms of service improvement and financial constraints, however, we have ensured that, by using the duty of quality and the quality wheel to guide decision making, the quality of the services we provide has been maintained and driven forward to ensure service improvement.

This is evidenced using the domains and enablers in the quarterly review process which measures the progress of each division against their IMTP objectives. We have explained this in more detail later in this report.

Quality Management Systems

In 2021, Welsh Government published a Quality and Safety Framework: Learning and Improving. This, taken together with the Duty of Quality, states that “organisations at every level should function as a quality management system to ensure that care meets the six domains of quality”. Recent work done by Improvement Cymru has reinforced this through the Safe Care Partnership, to support the adoption of Quality Management Systems within NHS organisations in Wales. Within NWSSP it would be challenging to operate a single QMS given the wide range of services which we provide. However, we have proposed the development of an overarching QMS which will be underpinned by the current systems in place.

This will have our Customer Service Excellence framework at the centre, with the four components of the Quality Management System, Quality Assurance, Quality Improvement, Quality Planning and Quality Control building around this. ***This is demonstrated in the diagram above.***

Each of our divisions have their own Quality Management System (QMS) tailored to the very different needs of each division, ranging from a more clinically based QMS which needs to meet the requirements of the Medicines and Healthcare Products Regulatory Agency (MHRA) for our Pharmacy Services and UKAS for our Surgical Materials Testing Laboratory to the largely non-clinical Procurement and Workforce Divisions.

The diversity of the divisions within NWSSP requires a flexibility of implementation to ensure that service provision is maintained and enhanced across NHS Wales. Sharing of best practice across divisions is a key element of our ongoing quality improvement strategy. This is done through senior leadership meetings, at local divisional meetings and through the Duty of Quality Implementation team meetings. More locally this will be embedded through both face to face and online learning.

We have also begun working on an overarching Quality Management System for NWSSP, which is designed to support the existing Quality Management Systems within areas such as Pharmacy Technical Services and the Surgical Materials Testing Laboratory, both of which are heavily externally regulated and have existing robust Quality Management Systems.

This overarching Quality Management System is in accordance with the Welsh Government focus on the Quality Management process and we are working closely with partner organisations at a national level to ensure our ongoing compliance.

Quality Driven Reporting

We continue to use 'always on' reporting through our quarterly reporting programme, which is being developed to include quality as an equal part with finance and performance. As an organisation we acknowledge that we need to ensure that quality is used as an objective measure of our services and we are using the Health and Care Quality Standards Self-assessment to enable our divisions to demonstrate where they meet the standards and where they are able to identify where additional work is needed.

The use of Equality Impact Assessment and Quality Impact Assessment documentation further underpins the integration of quality into the work of NWSSP.

These demonstrate, when attached to papers for proposals and services developments, that the Duty and quality management are incorporated throughout the organisation and forms part of our 'always on' reporting approach.



Quality Driven reporting into Health Boards and Trusts

NWSSP has a unique position within the NHS in Wales. We are hosted by Velindre University NHS Trust (VUNHST) and report through their Quality, Safety and Performance Committee to the Welsh Government for the annual Duty of Quality Report. Our divisional structure enables the provision of a variety of services across the whole of NHS Wales. Examples include:

- » Development of a water and energy recovery system for Laundry Services supported by external accreditation.
- » Legal and Risk Services have maintained the Law Society service excellence accreditation, which enables them to provide assurance across the NHS in Wales that the advice and support they give is of a high standard.
- » Decarbonisation – as NWSSP is responsible for Specialist Estates Services and procurement within the NHS in Wales, it has a major influence on areas such as transport, travel and buildings. This is outlined in more detail in the [2024-2026 Decarbonisation Action Plan](#).



How do we approve the Annual Duty of Quality Report

NWSSP was established in 2011 to deliver centralised functions on behalf of Health Boards and Trusts in Wales. In 2012, the then Welsh Government established Velindre University NHS Trust (VUNHST) as the host for NWSSP.

NWSSP is part of the Shared Services Partnership Committee (SSPC) which is attended by Senior Executives from all Trusts and Health Boards and sets policy and strategy and the management of shared services across NHS Wales. The Duty of Quality Annual Report is submitted to SSPC following ratification by the internal Formal Senior Leadership Group within NWSSP. This ensures that this report is approved by senior leadership across the NHS in Wales.

As part of the reporting process this report is submitted annually, usually in July, to the Quality, Safety and Performance Committee for VUNHST, to assure our host body that NWSSP is meeting its statutory obligations. The report is then submitted to Welsh Government as a chapter attached to the VUNHST annual quality report.

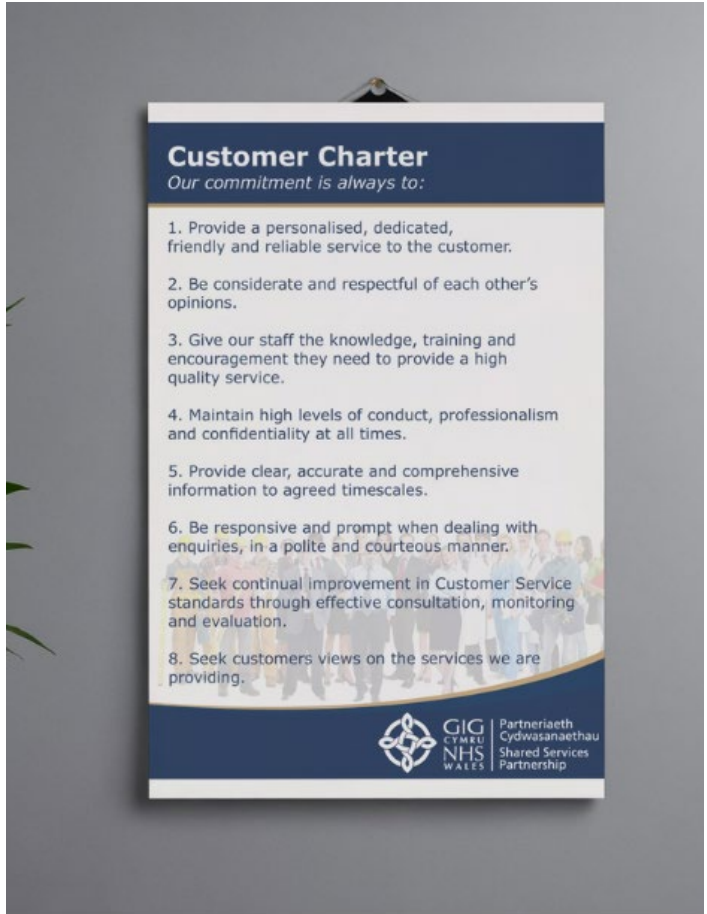
This provides both NWSSP and VUNHST with an established assurance and governance process with evidence that NWSSP is meeting its quality obligations under legislation and aligns with the QMS as described in the Medical Director's introduction above.

NWSSP Customer Charter

We felt that it was important to highlight the relaunch of our Customer Charter in 2025. The charter confirms and reinforces the commitment of NWSSP to providing quality services to all of our customers and colleagues.



The charter can be found here!





Quality Control and using data for quality improvement

As mentioned above, we continue to undertake divisional quarterly reviews. These continue to rely on and use the data we collect to provide assurance to our senior leadership team and thence to the Shared Services Partnership Committee. During these reviews, divisions are held to account for Key Performance Indicators (KPIs) which are based on the safe, timely, effective, efficient, equitable and person-centred quality domains. KPIs are regularly reviewed with quality measures in mind. With the further addition of Quality as a measure of assurance, the reviews will be enhanced.

We continue to develop performance dashboards to enable real time data driven decision making.

The examples below show how some of our Divisions are using data to impact both performance and quality to improve the services we provide.

Central Team eBusiness Service (CTeS)

The NHS Wales Shared Services Partnership (NWSSP) is responsible and accountable for ensuring the NHS Wales Procurement, Supply Chain, and financial systems meet both current and future demands of NHS organisations across Wales. These systems are mission critical - they enable all Health Boards, Trusts, NWSSP, and Special Health Authorities to order, pay for, and report on essential goods and services that directly support patient care. They also underpin statutory financial reporting obligations to the Welsh Government.

Systems were hosted on legacy infrastructure located within the Cardiff and Vale UHB Data Centres. The hardware supporting the platform was rapidly approaching the end of its warranty lifespan, while performance and storage capacity were nearing their limits.

This created a significant risk of system failure and degraded service quality, putting our ability to meet agreed Service Level Agreements (SLAs) under pressure.



- » **Quantitative feedback** showed that system backups and batch processing were exceeding agreed Recovery point targets. Infrastructure usage reports confirmed that both computer and storage utilisation had reached 90%+ capacity, with no ability to scale further. Hardware support costs were rising year on year, while vendor support availability was declining.
- » **Qualitative feedback** further highlighted growing operational concerns. NHS Wales finance teams reported sluggish system performance during peak periods (e.g. month-end close and year-end reporting). Procurement teams experienced intermittent issues with interface stability and data refreshes, affecting ordering and supply visibility. Stakeholders expressed concerns about system reliability and resilience, particularly given increasing reliance on digital services and analytics.

The system was deemed mission critical, maintaining its resilience and future-readiness became a priority. A joint NHS Wales project was initiated well ahead of critical deadlines, enabling structured analysis, stakeholder engagement, and evidence-based decision making. The CTeS team assessed options including like-for-like hardware refresh, private cloud hosting, and a full cloud migration, ultimately choosing Oracle Cloud Infrastructure (OCI) to align with NHS Wales Cloud First strategy and deliver scalable, secure, and modern hosting. Using the available data evidenced the need to protect NHS Wales operational resilience, compliance, and digital ambitions and it was proactively delivered through evidence-based planning and robust governance.

The work was fully aligned with the Duty of Quality:

Safe: Addressing hardware failure risk and improving DR capability.

Timely: Reducing downtime risk and improving incident response.

Effective: Enabling consistent, high-performing service for all users.

Efficient: Lowering long-term costs by avoiding on-premises investment.

Equitable: Ensuring all 16k users have stable, secure access.

Person-centred: Indirectly supporting clinical services by safeguarding supply chain and financial operations.

Using leadership skills and data to practice, the CTeS team were able to work with colleagues to move the NHS Wales Financial Management Solution (FMS) from on-premises data centres to Oracle Cloud Infrastructure (OCI). This transformation not only modernised national financial services but also set a standard for leadership in digital change, resilience planning, and structured testing.

Medical Examiner Service (MES)



The Medical Examiner Service has developed a set of national dashboards which bring together information from every case and present it in a clear and meaningful way. These dashboards show key details such as the number of cases reviewed, the place of death, the care provider involved, the number of referrals made to His Majesty’s Coroner, and the time taken between a person’s death and the Medical Certificate of Cause of Death (MCCD) being sent to the Registrar.

By looking at this information across different parts of the system, the care provider, the MES and Welsh Government can see how well each sector is performing, compare patterns across Wales, and identify any areas where delays or pressure points are emerging. This allows the service and its partners to make timely improvements and ensure the process works smoothly for families, clinicians and registrars.

Using data in this way supports the Duty of Quality, turning information into meaningful action that improves the service.

It also reflects the national focus on delivering care that is **timely**, by reducing delays at every stage of the process; **efficient**, by ensuring information moves smoothly between teams and avoiding unnecessary steps; **effective**, by using accurate data to support better decisions and drive learning across services; and **equitable**, by providing the same high standard of review and support for every family across Wales. This approach also demonstrates strong leadership, as the Medical Examiner Service uses clear, transparent data to guide improvement, monitor performance, and support good governance. Finally, it strengthens a whole system approach, helping hospitals, community teams, coroners, registrars and Health Boards work together so the process is consistent, joined up and centred around the needs of families. Over the most recent winter period, this approach has helped the MES monitor pressures, maintained performance, and clearly demonstrated progress to partners across Wales.



Procurement Services

Our Procurement team works across NHS Wales to deliver cost effective and efficient services to the NHS and the people of Wales.

Under the newly established Provider Selection Regime, which was introduced in February 2025, NWSSP Procurement Services successfully delivered a wide-scale national procurement to deliver 164,000 first outpatient appointments across 18 specialities and patient pathways. A common national specification for outpatient services for Wales was developed which allowed delivery at prices below the usual national tariff. This involved extensive engagement with framework contractors and clinicians across multiple specialities and necessitated the use of data to identify needs and benefits.

Appointments were provided in key specialities and were scheduled during evenings and weekends to avoid disruption to routine health board activity and to maximise use of existing NHS Wales infrastructure, including estates and equipment.

This initiative helped to reduce referral bottlenecks, reduced the risk of harm, and accelerated treatment, leading to improved health outcomes for patients across Wales. Next steps will include 'see and treat' appointments for some patients, meaning that they are seen and treated on the first appointment, preventing the need for further appointments and ensuring that the patients are not delayed or placed on waiting lists unnecessarily.



Primary Care Services

Audit Wales engaged with NWSSP and its Primary Care Services Division to undertake a pilot data-matching exercise to look at duplicate patient registrations and where deceased individuals were not removed from active patient lists.



The reasons for the exercise were to identify any errors in the system and to look at how NHS Wales could improve its processes in relation to GP lists.

A report was then published ([accessible here Checking the patients: Results from a pilot data matching exercise on GP patient lists](#)).

Funding for GP services is, in part, dependent on patient numbers and it is therefore important and financially responsible to ensure that payment is made based on accurate patient lists. Findings revealed a small number of errors, and a small number of deceased patients who had not been removed from the lists. Audit Wales acknowledged that NWSSP had already begun to review its approach in terms of checking lists. NWSSP was complimented by the Auditor General for Wales for taking forward learning in relation to data-matching and data analysis.



Using Artificial Intelligence in Radiology in Wales – Specialist Estates Services (SES)

Artificial intelligence (AI) is transforming numerous fields and Radiology is no exception. Radiology, a branch of medicine that uses imaging technology to diagnose and treat diseases, has always been at the forefront of technological advancement. However, the integration of AI marks a new era, where machine learning algorithms and advanced data processing capabilities are poised to take Radiology to unprecedented levels of precision and efficiency. AI algorithms, particularly those based on deep learning, have shown remarkable competence in analysing medical images. These systems can detect abnormalities such as tumours, fractures, bleeds, and lesions with a high degree of accuracy. For instance, AI solutions can assist Radiologists by highlighting areas of concern on scans, facilitating earlier detection of cancers and other conditions. AI systems can gather and analyse vast amounts of data from diverse sources, enabling them to recognise patterns that might be missed by the human eye. This capability significantly enhances diagnostic accuracy. Studies have demonstrated that AI can match the performance of Radiologists in identifying certain conditions, helping to lead to more timely diagnoses.

NWSSP Specialist Estates Services had the idea to create a Welsh AI group, and the 'AI in Radiology Implementation Group' was established to provide a collective understanding for the assessment and impact of AI on NHS Wales organisations. It was important to create a 'Once for Wales' solution, with multi-organisation collaboration.

One of the roles of the SES imaging team is to give expert advice and guidance to all health boards and to facilitate their imaging needs. The team has already created a joined-up approach by implementing a successful national diagnostic programme. As a team, they can enable projects to be rolled out more efficiently, leveraging buying power by using positive relationships that have already been forged with suppliers, utilising national frameworks, and influencing what can be achieved in the longer term in a more controlled way. This SES project really champions the values of NWSSP in delivering value for money across NHS Wales, creating efficiencies and potential cost savings; innovation through investigating new advances in technology; and excellence through partnership, working with groups such as Public Health Wales, Imaging Executive, NIAW, Life Sciences Hub Wales, and Welsh Government. This contributes towards every aspect of the patient journey through Radiology. At the very start, it can be used to speed up scan times. The team has recently successfully secured Welsh Government funding for purchasing AI software upgrades on scanners across Wales. This can help shorten scan times by up to 73%, directly improving patient care and experience, as well as increasing clinical productivity.



This aims to increase throughput by 20% once the AI solutions are fully commissioned, significantly increasing capacity. Using existing mobile MRI units, patient numbers can be increased by around eight per day, which over the course of a year could mean 2,800 more patients could be scanned. It also means that Radiographers have more time per patient, which is invaluable for improving patient care, which is particularly important for claustrophobic, additional needs or paediatric patients and makes the whole imaging journey more comfortable. There is also a saving of energy consumption per patient, accumulating to significant overall energy savings per year. The AI group has successfully evaluated different bone age AI solutions using Welsh data. If there are concerns over a child's growth, then a bone age study is performed, which helps evaluate how fast or slowly a child's skeleton is maturing and indicates their level of biological and structural maturity better than the chronological age. Specialised paediatric Radiologists report an X-Ray of the hand & wrist. But with the decline in the number of these specialists, inevitably there have been reporting delays. They often take 15-20 minutes each to report, and there can be inconsistencies and subjectivity with the reporting. The team has evaluated bone age AI solutions that can aid the bone age diagnosis. So far, the results have been extremely successful, 100% accurate agreeing with the original Radiologist report, and all taking 10 seconds to return a report.

This project aligns wholly with the aims of the Duty. It is evidence-based and designed to support and enhance the patient journey whilst showing savings on time and cost in the long run. It is safe, timely, efficient, equitable, effective and person centred and demonstrates how the Duty works in practice and partnership, across Health Boards and professional boundaries to benefit patients.



Digital and Workforce Productivity

The team has undertaken two key pieces of work this year which demonstrate not only data to practice but also the way in which this can be used to support staff in the workplace.

The team has implemented an Agency Digital Onboarding Platform. The Digital Learning Team has been collaborating with Health Boards to enhance recruitment processes for agency workers through the all-Wales Temporary Staffing Group. They have developed a digital platform to streamline the onboarding of agency workers, moving away from the current manual process, which relies on forms and emails. Built within Learning at Wales, the platform captures 'declarations' from both the Agency Worker and Agencies regarding ID checks, digital ID photos, and competencies. Additionally, 70% of the learning materials required by agency workers is stored in the system, allowing them to address any training gaps immediately. The platform also has appropriate restrictions in place to ensure organizations and agencies can only view their own workers' information. Reporting capabilities are included to support both agencies and organisations in monitoring compliance, conducting audits, and assessing counter-fraud measures as needed.

A pilot with PTHB and two agencies began in June 2025, and following a positive evaluation, NWSSP has engaged with two more Health Boards to initiate implementation. This maps clearly to Workforce, Learning, Improvement and Research and Culture with the domains of Safe, Effective, Timely and Efficient.

The second piece of work is the development of an International Recruitment Pastoral Application.



As detailed within a Welsh Health Circular Standardised Information Provision for Internationally Educated Nurses (IENs) (WHC/2024/021), NWSSP led the project and collaborated with an external provider to develop a Pastoral application. This app aims to support international recruits during their initial employment, ensuring their well-being, smooth transition, and retention. Initially crafted for nurse recruitment in 2025, NWSSP (Digital Workforce) received the green light to adapt it for broader healthcare professional international recruitment. We've included key information for medics, such as GMC requirements, and have further enhanced it to support international dental recruitment.

The app serves as a comprehensive resource for individuals relocating to the UK through our international recruitment programs. Each health board has developed a tab to showcase information about their local area, featuring practical guidance on registering with a GP or dentist, local shops and amenities, religious buildings, and other useful details. Additionally, the app contains several testimonials from NHS Wales recruits, offering valuable insights and encouragement to new recruits.

This shows leadership in partnership with benefits for Workforce, Information, Learning, Improvement and Research, and uses all the enablers to achieve this.

Primary Care Services

Primary Care Services use data to support data driven decision making.

The Primary Care Services dashboards provide a vital information resource for key stakeholders, including Welsh Government, HEIW, Optometry Wales and others. These dashboards enable evidence based, informed decisions relating to service delivery, workforce planning, digital transformation and quality improvement across primary care. By ensuring that accurate, standardised and meaningful data is readily accessible, the dashboards actively support the Duty of Quality by enhancing transparency, strengthening governance, and enabling targeted actions that improve patient experience, safety and outcomes.





External Quality Reviews, accreditations and awards

Customer Service Excellence Accreditation (CSE)



As part of the ongoing drive for excellence within NWSSP, we again sought Customer Service Accreditation for the whole organisation. We are very pleased to have earned this accreditation for the second year and are very proud of all the colleagues who have made this possible.

We continue to ensure the ongoing interdependency between CSE and the Duty of Quality, and you can see examples of this in the attached vlogs linked to the Quality Wheel below.

The feedback from CSE assessors will continue to be used to improve our processes and we will continue to use our 'always on' reporting systems to inform this. The CSE report also demonstrates the linkage and collaboration between the various divisions in NWSSP.



Audit Wales Finance Assurance

Audit Wales undertakes assurance processes with each NHS body as part of their statutory functions. Following this stringent external audit of NWSSP accounts, it was concluded that there were no issues identified concerning the services provided by NWSSP. Audit Wales were able to provide positive assurances to NHS external audit teams on the activities of NWSSP for accounts opinion purposes, with no recommendations arising from their work for the year. This aligns with the **Safe, Timely, Effective, and Efficient** domains of the Duty of Quality wheel.

Achievement	Division	Quality Domains	Quality Enablers
CSE	Organisation wide	» Equitable » Person Centred	» Leadership » Culture » Information
ISO/IEC 17025:2017 UKAS audit showed exceptional levels of compliance	Surgical and Materials Testing Laboratory	» Safe » Timely » Effective » Efficient	» Information » Whole System » Learning, Improvement and Research
ISO 9001	Across divisions	» Safe » Timely » Efficient » Effective » Equitable » Person centred	» Information » Leadership » Culture
Law Society Lexcel Accreditation	Legal and Risk Services	» Timely » Effective » Efficient » Equitable » Person centred	» Leadership » Workforce » Culture » Information » Learning, improvement and research » Whole system Approach
ISO2000-1 standard and BACS certification, covering information technology, service management and system requirements	Central Team E-Business Services	» Timely » Effective » Efficient » Equitable » Person-centred	» Leadership » Workforce » Culture » Information » Whole system approach
ISO 9001 ISO 45001 STS Food Safety	Procurement Services	» Efficient » Effective	» Safe » Culture » Workforce » Whole System approach

ISO standard 9001 relates to quality management systems and is held by multiple areas across NWSSP, this links in with the work we are currently undertaking around a whole systems approach to an organisational QMS.

Legal and Risk

Our Legal and Risk team, which provides a service across NHS Wales, was again assessed for Lexcel over a 3-day period. This is a yearly assessment which supplements the 5-day assessment which is held every 3 years. The assessor interviews staff members from all levels, selects a randomised group of legal cases for review and assesses the policies and procedures in place, ensuring a full and objective assessment process.



Whilst these are formal external assessments, these and other divisions within NWSSP also undertake other forms of internal quality assurance. This includes the work undertaken by the People and Organisational Development team who, quantitatively and qualitatively, measure responses to surveys and evaluations including the People and OD survey, the NHS Wales Staff survey, experiential and impact evaluations of courses, action point response times and the quality of external speakers. These assessments provide feedback for the organisation, course and survey participants and staff, allowing for improved service delivery.





Staff Voices

The 12 health and care standards which comprise the 6 measures of quality and the 6 key enablers laid out in the Duty of Quality are shown in the inner ring and outer ring respectively on the wheel below.

The 6 measures/domains of quality are:

Safe: These focuses on avoiding preventable harm, getting processes and care right, and learning from incidents and concerns to prevent repetition.

Timely: This is described as providing high quality care in the right timeframe.

Effective: This reflects utilisation of evidence-based practice including prevention as well as treatment.

Efficient: A values-based approach to improve outcomes for people.

Equitable: Providing equality of opportunity and human rights.

Person-centred: Meeting people's needs.

The 6 enablers are:

Workforce: Ensuring that the workforce is skilled and available to provide care and support to those providing care.

Leadership: Clear vision with governance and accountability embedded in the organisation.

Culture: Quality systems and safety in a supportive way enabling sharing new ideas and learning from mistakes.

Information: Using data and knowledge to inform service quality and development.

Learning and Improvement: quality improvement to deliver quality services and outcomes.

Whole System Approach: Improving quality across the health care system to improve population outcomes.

These can be further explored by clicking on the following link: <https://www.gov.wales/sites/default/files/consultations/2022-10/the-duty-of-quality-statutory-guidance-2023-and-quality-standards-2023.pdf>



Explore the wheel below (by clicking on each section) to hear staff in NWSSP explaining how quality is key to their work on behalf of NHS Wales and what it means to them, or to see links explaining how quality is demonstrated in NWSSP.



Leadership

The importance of the Armed Forces covenant cannot be overemphasised. It is a cultural engagement which shows a two-way commitment to engagement and support which is invaluable to both veterans and NWSSP. It prioritises inclusivity and mentorship. It demonstrates and values leadership and problem solving.

Workforce

We have used the Customer Service Excellence Award presentation for this as it demonstrates a workforce wide commitment to the quality of services we provide in NWSSP.

Information

Information governance relates to the safe handling of identifiable and commercially sensitive information. It means ensuring that we protect identifiable information and only use it for the reason why it was collected.

This is a legal obligation, and the team ensures that the Duty of Quality is considered when handling data.

Culture, Efficient, Equitable

We have grouped these domains and enabler together to demonstrate across a series of video snips, the work that the Wales General Ophthalmic Scheme (WGOS) is doing across Wales to improve eye care for our population. It aligns with the Welsh Government's report "A Healthier Wales" which was published in 2018 and aims to make sure that health services work better together. The WGOS team, led by clinical leads and supported by NWSSP Primary Care Services, has redesigned eye care to focus on the patient. It aims to standardise services, no matter where in Wales the patient lives and accesses health care and change the culture of ophthalmic service delivery to ensure that all parts of the system, optometrists, GP and hospital-based services work together with seamless pathways so that patients are seen by the right person at the right time.

Learning, Improvement and Research

NWSSP was the first organisation in NHS Wales to achieve the Customer Service Excellence Award, a prestigious government standard. This segment looks at the impact which holding and working towards this award has across the organisation and how the continuous improvement cycle leads to learning and improvement.

Whole Systems Approach

The Counter Fraud Specialist (CFS) in NWSSP works across multiple systems including Health Bodies in Wales, Welsh Government, Audit Wales, the Crown Prosecution Service and the NHS Counter Fraud Authority to ensure that economic crime in the NHS is dealt with appropriately. The CFS provides specialist training to staff at all levels to ensure that money in the NHS is used for the purpose for which it is meant – the care of patients.

Safe

Our Health and Safety team has used a variety of methods to support, inform and educate staff across NWSSP including attendance at meetings, newsletters and coffee mornings. This ensures that all staff have an opportunity to learn and understand the importance of Health and Safety across the wide variety of workplaces in NWSSP, including laundry units, laboratories and office settings.

Effective

The NWSSP finance team operate in accordance with professional standards. The team has a responsibility to comply with the International Financial Reporting Standards which set a quality expectation on finance professionals with the focus on global comparability and transparency. The team is compliant with the UK Financial Reporting Council Framework which ensures that their work is effective and accurate. 44% of the team have a professional accountancy qualification.

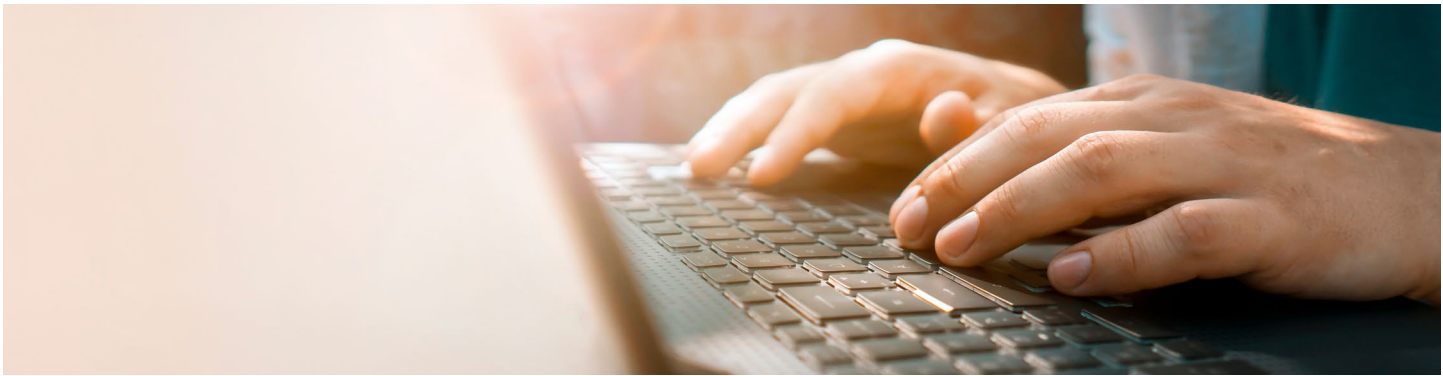
Timely

The finance team within NWSSP supports both internal and external customers by providing financial information. The stakeholders include the Shared Services Partnership Committee, the Welsh Risk Pool Committee, Welsh Government and other Health Boards and Trusts. The financial information must be provided in a timely manner to enable accurate and efficient decision making to maximise value for money. Budget holders have dashboards to enable access to their financial information and the four seasons of the financial year are explained as well as how this impacts on financial management.

Person centred

The NWSSP Armed Forces community is continuing to develop and is strongly person centred, focussing on the value that the armed forces community and their families can bring to the organisation and the wider community. NWSSP works with partner organisations such as Career Transition Partnership and Forces Families Jobs to provide and promote flexible support and employment opportunities.





Medical Directors Summary - *Our Next Steps*

Dr Martin Edwards has summarised the progress of NWSSP and identified the way forward in continuing to embed Quality into the diverse divisions within NWSSP.

As I step into the role of Medical Director for NWSSP on 1 April, I am joining an organisation that has already demonstrated a strong and mature commitment to the Duty of Quality. The work undertaken over the past three years has created a firm foundation: clear governance arrangements, increasingly data driven reporting, strengthened divisional quality systems, and a growing culture of collaboration and learning across our diverse services.

My role now is to build on this progress and help shape the next phase of our organisational approach to quality. NWSSP occupies a unique space in NHS Wales - one where the quality of our services may not always be visible to the public, yet has a profound impact on the safety, timeliness and effectiveness of care across the entire system. Ensuring that our contribution is recognised, understood and continuously improved will be a central focus of my tenure.

In reviewing this Duty of Quality report, it is evident that our divisions are increasingly embedding quality principles into planning, performance, assurance and everyday decision making. Our externally accredited services provide strong assurance; our use of real time data and dashboards is accelerating;

and the growing maturity of our internal quality networks is helping to spread learning at pace. These strengths position us well to meet the evolving expectations of NHS Wales, regulators and our partner organisations.

At the same time, it is important that we continue to challenge ourselves. The scale, diversity and complexity of NWSSP demand a coherent quality narrative - one that not only reflects the excellent work taking place locally but also demonstrates how our collective effort and systems thinking enhance the health and wellbeing of the population we serve. As the new Medical Director, I see real opportunity in developing this narrative further, ensuring that quality is consistently central to our strategy, our transformation programmes and our future operating model.



Martin Edwards,
Medical Director

Our Next Steps

Over the coming year, our priorities will be to deepen and strengthen NWSSP’s quality approach through the following actions:

1. Finalise and implement the overarching Quality Management System (QMS)

We will complete and embed our organisational QMS, ensuring it is meaningful, proportionate and aligned with existing divisional systems. This will allow us to present a coherent “once for NWSSP” framework while respecting the specialist requirements of our more regulated services.

2. Strengthen strategic quality planning

Quality considerations must shape our strategic choices - not simply follow them. I will work with colleagues to ensure that Quality Impact Assessments are used not only as assurance tools but as mechanisms to support strategic decision making, prioritisation, and early risk identification.

3. Enhance our quality driven performance and reporting

Building on our existing quarterly review arrangements and ‘always on’ reporting, we will further strengthen how quality is evidenced alongside finance and performance. Our aim is to ensure that every division can clearly articulate its quality story, supported by robust, real time data and transparent metrics.

4. Broaden shared learning and collaboration

As a non clinical organisation operating across the NHS, NWSSP is uniquely positioned to drive system wide improvement. Over the next year, I will prioritise strengthening our cross divisional quality network, enhancing external collaborations, and developing more structured mechanisms for sharing learning across NHS Wales.

5. Develop our quality narrative

To fulfil our statutory responsibilities - and to ensure our contribution is fully recognised - we need to articulate clearly how our work supports safe, effective and equitable care. I will lead the development of a strengthened NWSSP quality narrative, ensuring that our data, accreditations and success stories are consistently and confidently presented.

6. Continue to support a culture of quality and curiosity

A strong culture is the backbone of high quality services. I will work closely with colleagues to ensure that staff feel supported, able to innovate, and confident in raising concerns or learning from experience. Quality improvement capability, strong leadership behaviours and open communication will remain key enablers.



Conclusion

I am proud to join an organisation with such a clear commitment to quality. The progress made to date reflects the dedication of colleagues across all divisions, and I look forward to working with you to build on this momentum. By strengthening our systems, clarifying our narrative and embedding a strategic approach to quality, we will continue to demonstrate the essential contribution NWSSP makes to safe, sustainable and high quality healthcare across Wales.



Appendix A - IMTP Duty of Quality 2026 - 2029



Workforce

Accounts Payable	We will continue to ensure that all staff receive clear and effective "purchase to pay" training. This will include creating robust training frameworks and regularly reviewing and updating induction programs.
All Wales Laundry Service	We plan to support the development of future laundry engineers by offering student work placements through local colleges.
Audit and Assurance	We plan to complete a review of our divisional structure and make necessary changes to optimise resources. This will help improve service delivery through better staff utilisation and a stronger talent pipeline.
Pharmacy Services	We plan to develop a workforce plan to strengthen recruitment, retention, and succession planning.
Procurement and Health Courier Services (HCS)	We plan to conduct a training needs analysis to identify HEIW-funded and commissioned courses for Wales Pharmacy Technical Service. This will ensure staff have access to accredited education and training.
Specialist Estates Services	We plan to build workforce capability and capacity to meet changing organisational needs through improved recruitment, retention, succession planning, and training.
Surgical Materials Testing Laboratory	We plan to ensure continuity by creating a costed recruitment and induction plan to manage senior retirements.



Culture	
Accounts Payable	We will improve staff benefits across NHS Wales by launching a dedicated staff benefits portal.
Digital Workforce Solutions	We continue to lead the delivery of the All-Wales International Recruitment Programme to support workforce sustainability across NHS Wales.
People & OD	We will embed the inclusive culture action plan to create a workplace that is safe, anti-racist, inclusive, and compassionate.
Single Lead Employer	We will support attendance management for Resident Doctors, Dentists, and trainees by providing reasonable adjustments. This will ensure trainees who need specific support can focus on training and delivering patient care.
Single Lead Employer	We will embed speaking up safely within NWSSP to promote openness, effective monitoring, and organisational wellbeing.



Information	
All Wales Laundry Service	We will future-proof laundry operations by introducing automated production dashboards, replacing manual processes, and ensuring a resilient, high-quality service.
Central Team eBusiness Services	We will support the TRAMS project by implementing a new computer based manufacturing system based on Oracle applications, enabling better insights and informed decision making.
Digital Workforce Solutions	We will use Health Roster to support Nurse Workforce Planning across NHS Wales, ensuring workforce plans include temporary staffing and demand forecasting.
Medical Examiner Services	We will improve data quality and accessibility by developing an MES reporting tool with ICD11 coding. This will allow real-time analysis of morality patterns to support public health planning and decision-making.
Pharmacy Services	We will continue to manage the supply chain across Wales, quantifying volumes and building resilience to address medicines shortages. This will require robust data consolidation and analysis.
Primary Care Services	We will continue to support the Primary Care Strategic Workforce Plan by delivering the Primary Care Workforce Intelligence system and supporting services. Shared data sets will help inform workforce planning across Wales.



Learning, Improvement and Research

Accounts Payable	We will explore options to replace OCR software with AI automation, which will deliver a more efficient Accounts Payable service.
All Wales Laundry Service	We will explore options to benchmark Laundry Services against commercial and NHS providers to further improve service delivery and key performance indicators.
Employment Services	We will evaluate workforce sustainability options to create a clear approach for locum management across primary and community care, aligned with national workforce goals. This will improve workforce planning and help maintain service continuity while responding to changing demands.
Legal and Risk & Welsh Risk Pool	We will work with other nations to share knowledge and good practice about the management of clinical negligence claims.
Primary Care Services	We will introduce and embed research and development within Primary Care Services to ensure we remain at the forefront of delivering evidence-based care to patients in Wales, while offering learning opportunities to other regions in the UK.
Surgical Materials Testing Laboratory	We will complete literature searching and synthesis training within the Research & Development team to strengthen evidence-based practices.
Surgical Materials Testing Laboratory	We will review new post-market surveillance rules from the Medicines and Healthcare products Regulatory Agency (MHRA) and changes to UK Medical Devices Regulations (MDR) to ensure colleagues are supported with interpretation and compliance.



Whole System Approach	
Central Team eBusiness Services	We will expand the use of robotics to support health organisations Financial Management System (FMS) processes, including service desk support and the design of new finance and procurement processes using the Microsoft Power Platform.
Digital Workforce Solutions	We will lead the development of the People Portal Transformation Programme - a flexible, agile workforce system designed to meet NHS Wales’ evolving needs, with seamless integration to other NHS Wales e-systems.
Employment Services	We will actively contribute to the Director’s Workforce Workplan by providing subject matter expertise, promoting business efficiency, and improving the customer’s journey to ensure safe and effective change.
Legal and Risk & Welsh Risk Pool	We will provide guidance and support to NHS organisations with the introduction of revised national guidance for Putting Things Right (PTR), to be renamed Listening to People (LTP)
Pharmacy Services	We will deliver the seasonal vaccination programme through a national model for vaccine delivery.
Pharmacy Services	We will develop three transforming Access to Medicines (TRAMS) Hubs across Wales, increasing NHs Wales’ capacity to prepare essential medicines and enabling the use of advanced technology and automation to improve patient safety and free up nurses time for patient care.
Primary Care	We will deliver a consistent, efficient, and equitable national process for providing Gluten-Free Subsidy Cards to eligible patients across Wales, ensuring a centralised and reliable service.



Leadership

Audit and Assurance	We will develop a strategy to establish a commercial arm for Audit & Assurance services to provide support to organisations outside NHS Wales.
Digital Workforce Solutions	We will lead the development of the People Portal Transformation Programme, moving from procurement to planning and mobilisation. This will provide a structured, coordinated, and standardised approach throughout the migration process.
Digital Workforce solutions	We will lead the delivery of the NHS Wales International Recruitment Programme, reducing gaps in the clinical workforce and providing a viable and cost effective method for filling hard to fill vacancies through targeted international recruitment.
Legal and Risk & Welsh Risk Pool	We will introduce Digital Decision Making and Consent across NHS Wales, giving clients access to a platform that digitises the consent process.
Pharmacy Services	We will transform Access to Medicines (TRAMS) by developing an operational model for the Radiopharmacy unit. This will build capacity and contingency to ensure patients receive timely, high-quality services.
Procurement and Health Courier Services (HCS)	We will continue work on the Scan4Safety as part of the Wales modernisation programme (a five-year initiative)
Single Lead Employer	We will expand services and specialities under the Single Lead Employer model, giving trainees a streamlined employment relationship so they can focus on training and patient care.
Specialist Estates Services	We will deliver enhanced services to Welsh Government and NHs organisations to support decarbonisation.



Timely	
All Wales Laundry Services	We will implement strategic linen stock holdings to create resilience across the service and ensure sufficient stock to maintain supply if production at a site is disrupted
All Wales Laundry Services	We will examine distribution options for the remaining four laundries based on geographical boundaries to maximise capacity at each site and better meet customer demand.
All Wales Laundry Service	We will develop customer self-service functionality for managing rented stock orders, reducing delays and empowering users.
Central Team eBusiness Services	We will utilise available resources to extend robotics support to health organisations Financial Management System (FMS) processes, including service desk support and the design of new finance and procurement processes using the Microsoft Power Platform. This will free up time for organisations to focus on value-added activities.
Pharmacy Services	We will conduct an All-Wales assessment and management of unlicensed medicines, which will release staff time back to local services.
Pharmacy Services	We will deliver the Transformation Access to Medicines Hubs across Wales to provide sufficient capacity and contingency, ensuring a timely supply of high-quality aseptic products. This will help meet patient treatment demands and reduce waiting times.



Safe	
Central Team eBusiness Services	We will coordinate the annual Financial Management System (FMS) Disaster Recovery (DR) test to ensure readiness in the event of a disaster, providing continuity of service.
Legal and Risk & Welsh Risk Pool	We will advance the design, implementation and evaluation of Safety & Learning programmes, focusing on maternity and neonatal services to mitigate litigation risk by addressing underlying clinical safety issues.
Pharmacy Services	We will maintain the required regulatory and professional licences and registrations (including those from the Medicines and Healthcare Products Regulatory Agency, Home Office licensing, and the General Pharmaceutical Council). This will assure service users that our pharmacy services meet a high standard of quality, evidenced through external review.
Pharmacy Services	We will transform Access to Medicines (TRAMS) by developing an operational model for the Radiopharmacy unit, ensuring patients receive high-quality, timely services.
Pharmacy Services	We will review progress on the strategic implementation of gas testing training and recruitment plans for 2025/26. This will enable pharmacy services across Wales to support gas systems testing and deliver medical gases to patients at their point of need within all Health Boards and Trusts.
Procurement and Health courier Services (HCS)	We will continue implementing Scan4Safety as part of the Wales modernisation programme (a five-year initiative), which will help prevent patient harm.
Surgical Materials Testing Laboratory	We will explore the ability to measure background levels of hydrogen peroxide within decontamination areas, enabling more accurate measurement using gas detector tubes.



Effective	
Audit and Assurance	We will review our audit approach to ensure it remains in line with NHS Wales Requirements and the Global IIA Standards in readiness for External Quality Assessment. This will ensure Audit and Assurance provides a high-quality and effective service.
Legal and Risk &Welsh Risk Pool	We will provide guidance and support to NHS organisations with the introduction of revised national guidance for Putting Things Right (PTR). This will support the fair, effective, and efficient management of cases.
Pharmacy Services	We will implement biosimilars with maximum efficiency for NHS Wales, delivering timely savings and ensuring high-quality, cost-effective care.
Pharmacy Services	We will pilot and roll out an electronic Pharmaceutical Quality System to enhance compliance and streamline processes.
Primary Care Services	We will deliver solutions to drive automation and support embedding the Wales Ophthalmic contract to ensure the timely and effective submission and payment of claims.
Surgical Materials Testing Laboratory	We will review the structure of the Surgical Materials Testing Laboratory to ensure effective service delivery and strengthen resilience through a staffing review.



Efficient	
All Wales Laundry Services	We will work closely with our Health Courier Service colleagues to plan the most efficient and carbon-friendly routes for all laundry deliveries across Wales.
All Wales Laundry Services	We will centralise Laundry Services administrative functions to ensure work is distributed efficiently, improving capacity and meeting customer demand.
Audit and Assurance	We will further develop our digital approach to audit delivery and innovation, ensuring a high-quality, cost-effective service.
Central Team eBusiness Services	We will extend robotics support to Financial Management Systems (FMS) processes and leverage the Microsoft Power Platform for automation, reducing manual effort and boosting productivity.
Medical Examiners Service	We will continue digital development to replace paper-based Medical Certificate of Cause of Death (MCCD) processes, promoting direct referrals via a QR code portal and implementing an improved notification system.
Primary Care Services	We will review solutions to support the digital paper medical record in Wales and reduce physical storage requirements across the NWSSP estate.
Primary Care Services	We will deliver a consistent, efficient, and equitable national process for providing Gluten-Free Subsidy Cards to eligible patients across Wales, creating a simplified and more convenient process.
Procurement and Health Courier Services (HCS)	We will investigate opportunities for AI services to support current transactional activity, reducing errors and creating a more efficient service.



Equitable	
Digital Workforce Solutions	We will lead the development of the People Portal Transformation Programme, moving from procurement to planning and mobilisation. This will provide structure, coordination, and a standardised approach throughout the migration process, resulting in consistent work data across NHS Wales organisations.
People & OD	We will strengthen our Employee Relations (ER) processes and foster a culture of fairness and accountability by establishing a substantive Investigating Officer role. This role will provide specialist, impartial, and high-quality investigations into complex ER cases, ensuring consistent application of policies and procedures, timely progression and closure of cases, reduced risk or procedural error or employee harm, and greater confidence among staff in the fairness of internal investigations.
Pharmacy Services	We will develop a standardised product portfolio for 2026/27, allowing medicines to be manufactured at scale to move medicines closer to patients, improve equity of access, and drive positive service outcomes and patient experiences.
Procurement and Health Courier Services (HCS)	We will support the Foundational Economy workplan by promoting local supplier engagement and fair economic growth.
Procurement and Health Courier Services (HCS)	We will meet the required planning and delivery phases for Pharmacy Logistics, including Year 2 of the Influenza Programme (and other vaccine campaigns), Radio Pharmacy, Home Care Medicines, TrAMS, and other Pharmacy Modernisation Programme. This will ensure a single logistics model that is consistent across all health boards in Wales.
Single Lead Employer	We will support the management of attendance for Resident Doctors, Dentists, and trainees through reasonable adjustments, ensuring those with additional needs receive the support required to focus on their training.



Person Centred

Accounts Payable	We will launch the staff benefits portal across NHS Wales, ensuring improved access to benefits for all staff.
All Wales Laundry Service	We will develop a self-service order management solution for All Wales Laundry Services, empowering customers to manage their own rented stock orders.
All Wales Laundry Service	We will support the development of future laundry service engineers by securing student work experience placements through local colleges.
Digital Workforce Solutions	We will drive the People Portal Transformation Programme from procurement to planning and mobilisation, enhancing user experience and self-service culture.
Pharmacy Services	We will deliver Access to Medicines (TRAMS) hub development across Wales to enable more capacity and contingency, ensuring high-quality, timely service to patients.
Single Lead Employer	We will embed the Speaking up Safely (SUS) arrangements within NWSSP and ensure concerns are managed in accordance with the agreed policy. We will also ensure effective monitoring arrangements to track actions and outcomes under the Speaking up Safely framework.

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Duty of Quality Annual Report 2025-2026

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ALL WALES MEDICAL EXAMINER SERVICE ANNUAL REPORT 2025– 26

NWSSP - Medical Examiners Service

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1. Executive Summary

The All Wales Medical Examiner Service Annual Report 2025–26 reflects a year of consolidation, refinement, and operational strengthening following the full statutory implementation of the service in September 2024. Building on the foundations established in 2024–25, the service has focused on enhancing efficiency, optimising processes, and deepening engagement with key stakeholders across Wales. The year was shaped by a period of significant winter pressure in 2024–25, during which the service demonstrated resilience, adaptability, and a strong commitment to maintaining high-quality scrutiny.

Following a challenging 2024–2025 winter period, the service has entered 2025–2026 with a renewed emphasis on strengthening service efficiency, deepening stakeholder engagement, and refining operational processes. Over the past year, we have successfully implemented significant changes both internally and in the way we interact with stakeholders regarding case notifications. These developments have supported smoother workflows, clearer communication pathways, and improved consistency across the service.

Building on this progress, our priorities for 2025–2026 included a continued focus on process development and refinement, alongside a structured review of operational practice to ensure resilience and sustainability. Service efficiency remained central, with ongoing efforts to streamline caseload management, enhance data visibility, and improve turnaround times while maintaining a supportive and collaborative service culture.

Quality has remained consistently high throughout, evidenced by strong MCCD completion standards and continued monitoring of return rates. Importantly, the continued development of the All-Wales Business Intelligence tool marks a key advancement in our ability to assist stakeholders view the death certification pathway from death to sending the MCCD to the register office. This provided improved oversight of Health Board responsibilities and supports more timely escalation, reporting, and service planning for all involved.

Key Achievements:

During 2025–26, the service continued to make measurable improvements in efficiency through refinements to internal workflows, clearer prioritisation of time-critical cases, and strengthened escalation arrangements. These changes supported timely and consistent scrutiny throughout the year and helped reduce unnecessary delays. Engagement with stakeholders was also strengthened, with clearer and more consistent case-notification processes across Health Boards, primary care, hospices, and external partners. This improved reliability, supported better planning, and reduced avoidable disruption to case flow.

Revised and standardised processes were fully embedded across the end-to-end scrutiny pathway, leading to greater consistency in decision-making and more efficient progression of cases from notification through to certification. Early operational planning and improved capacity modelling had a clear impact during the 2025–26 winter period, which was significantly less pressured than the previous year. In particular, December 2025 and January 2026 saw a 4–6 day reduction in the time between death and MCCD submission to the register office across several Health Boards in comparison to 2024 – 2025, demonstrating improved performance across the wider death certification system.

High standards of MCCD quality were maintained throughout the year, supported by routine monitoring of return rates, targeted feedback to certifying clinicians, and the continued delivery of structured learning and support. At the same time, significant progress was made in developing the All Wales Business Intelligence tool, providing clearer visibility of the full death certification pathway and enabling Health Boards to better understand performance, identify delays, and meet their statutory responsibilities. Operational resilience was further strengthened through improved rota planning and capacity arrangements, ensuring staffing levels were better aligned with regional needs and seasonal variation, and supporting service stability during periods of increased demand.

Challenges Managed:

The significant winter pressures experienced during 2024–25 prompted the service to undertake a thorough review of its operational arrangements, including how capacity was planned, how demand was managed, and how work flowed through the death certification system. This review led to changes in rota planning, earlier engagement with stakeholders, and clearer escalation processes. As a result, the 2025–26 winter period was noticeably more stable, with fewer delays, improved flow of cases, and better overall timeliness across the death certification pathway. While some variation remained in how stakeholders notified cases, particularly across different care settings, this was managed through ongoing communication, clearer guidance, and reinforcement of national processes. Workforce pressures and regional recruitment challenges also continued during the year; however, these were mitigated through flexible deployment of staff, cross-cover between teams, and a strengthened focus on training and professional development, helping to maintain service continuity and quality throughout periods of increased demand.

Forward Planning:

During 2025–26, the service refined its short-, medium-, and long-term priorities to support continued improvement and sustainability. These priorities focused on improving efficiency, embedding consistent ways of working across Wales, strengthening collaboration with partners, and ensuring the workforce is skilled, confident, and well supported. Alongside this, further development of business intelligence dashboards, digital reporting, and thematic learning tools was prioritised to improve day-to-day oversight of activity and performance, and to support shared learning and continuous improvement across the service.

Engagement with stakeholders remained a key area of focus, with ongoing work to embed consistent case-notification processes, improve communication pathways, and strengthen feedback routes with clinicians, bereaved families, and Health Boards. These actions are designed to support clearer expectations, reduce variation, and improve the overall flow of cases through the system. Delivery of the Integrated Medium-Term Plan for 2025–26 provided clear, measurable objectives for process improvement, leadership development, and long-term service sustainability, ensuring progress could be monitored and reviewed throughout the year.

Looking ahead to 2026–27, the service has identified workforce development as a central priority. There will be a strong focus on developing staff skills, knowledge, and professional capability, recognising that a well-trained and supported workforce is essential to driving further improvements in efficiency, effectiveness, and resilience. This will include strengthened training pathways, clearer competency development, and enhanced professional support, helping to ensure the Medical Examiner Service is well prepared to meet future demand and continue to deliver high-quality scrutiny across Wales.

Commitment to Quality:

Throughout 2025–26, the service continued to deliver a high standard of work, with a strong focus on ensuring death certification was legally accurate, supporting learning that contributes to patient safety, and providing compassionate, clear support to bereaved families at a difficult time. Arrangements to monitor and improve quality were fully embedded in everyday practice, supported by a growing programme of internal audits and the ongoing development of a service-wide Quality Manual, which helps staff work consistently and confidently. During the year, reporting arrangements to the National Medical Examiner were reviewed and refined, making it clearer when and how issues should be escalated and improving oversight of emerging themes across Wales. The Health Care Quality Standards were built into performance reporting, allowing the service and NWSSP to assess performance more consistently and to better link Medical Examiner scrutiny with national expectations for quality and safety. A detailed review of the mortality feedback process improved how learning from Medical Examiner scrutiny is shared with clinical teams and patient safety groups, helping to ensure concerns are acted on and lessons are not missed. The use of LOOP was expanded as a central source of information for staff, giving easier access to guidance, training materials, standard operating procedures, and service updates, and helping teams stay informed and work in a consistent way. In addition, the approach to monitoring coroner Prevention of Future Death reports was strengthened, with clearer identification of Medical Examiner involvement to support follow-up actions, track recurring themes, and share learning across the service. All of these improvements are supported by the continued use of the All Wales Business Intelligence tool, which provides clear oversight of the full death certification process and helps Health Boards understand performance, identify delays, and take action where needed.

As the All Wales Medical Examiner Service moves into the next phase of its development, it does so with a strengthened operational foundation, enhanced data capability, and a clear commitment to service excellence. The collective achievements of 2025–26—delivered through collaboration, resilience, and a shared dedication to quality—have positioned the service to operate more efficiently, more effectively, and with greater consistency across Wales. With continued focus on workforce development, process refinement, and digitally enabled improvement, the service is well-placed to support safer, more transparent death certification and to contribute meaningfully to the wider aims of patient safety and organisational learning across the Welsh health and care system.

2. Introduction

This report provides an overview of the work undertaken during 2025–2026 and offers assurance that the All Wales Medical Examiner Service continued to deliver safe, effective, and timely independent scrutiny of deaths following the statutory implementation of the Death Certification Reforms (DCR) in September 2024.

Building on the transition year of 2024–25, the service focused on consolidating statutory requirements, refining processes, and strengthening operational resilience in response to challenges experienced during the previous winter period. Significant emphasis was placed on improving service efficiency, enhancing stakeholder engagement, and embedding consistent, standardised scrutiny across all care settings in Wales.

Throughout 2025–26, the Medical Examiner Service maintained high standards of independent scrutiny and coroner referral practice, while continuing to support bereaved families with compassion and clarity. The service also worked collaboratively with care providers and system partners to identify learning opportunities, contribute to patient safety improvement, and support the wider quality agenda across the Welsh healthcare system

3. Background

Following the Coroners and Justice Act 2009, new statutory arrangements came into force in Wales in September 2024, establishing a legal requirement for all non-coronial deaths to be independently scrutinised by Medical Examiners.

The reforms—implemented through the Medical Examiner (Wales) Regulations 2024, the Medical Certificate of Cause of Death Regulations 2024, and the National Medical Examiner (Additional Functions) Regulations 2024—underpin a national system designed to:

- Improve the accuracy and completeness of causes of death recorded on MCCDs, supporting population health intelligence and planning.
- Enhance patient safety by identifying and escalating clinical governance concerns.
- Provide bereaved families with transparency and the opportunity to raise questions or concerns.
- Ensure appropriate and timely referrals to the Coroner service.

The All Wales Medical Examiner Service was established as a single national service to deliver consistent, independent scrutiny of deaths across all care settings. During 2025–26, the service operated as an embedded statutory model, focusing not only on number of cases but on the efficiency, quality, and resilience of the end-to-end death certification pathway.

4. Implementation and Structure

Following statutory commencement in September 2024, 2025–26 was a year focused on consolidating and strengthening the All Wales Medical Examiner Service. Building on the progress made during the implementation year, the service reviewed and refined how it operated, drawing on learning from periods of high demand to improve resilience and consistency. Full statutory coverage was maintained across all regions and care settings in Wales, with national scrutiny standards applied consistently. Engagement with General Practitioners, primary care teams, hospices, and community services continued to improve, supporting clearer case-notification processes and more timely scrutiny. The service maintained a skilled workforce in line with the National Medical Examiner's model, supported by flexible working arrangements and cross-cover to manage fluctuations in demand. The benefits of the All-Wales service model were further demonstrated through the ability to move work between regions when required, particularly during seasonal pressures. Targeted operational review and forward planning ahead of winter demand contributed to improved performance and reduced pressure across the system during the 2025–26 winter period.

5. Systems and Processes

The Medical Examiner Service continues to use the Medical Examiner Module within DATIX as its core case management system. During 2025–26, systems and processes were further refined to improve efficiency, visibility, and consistency.

Key developments during the year included:

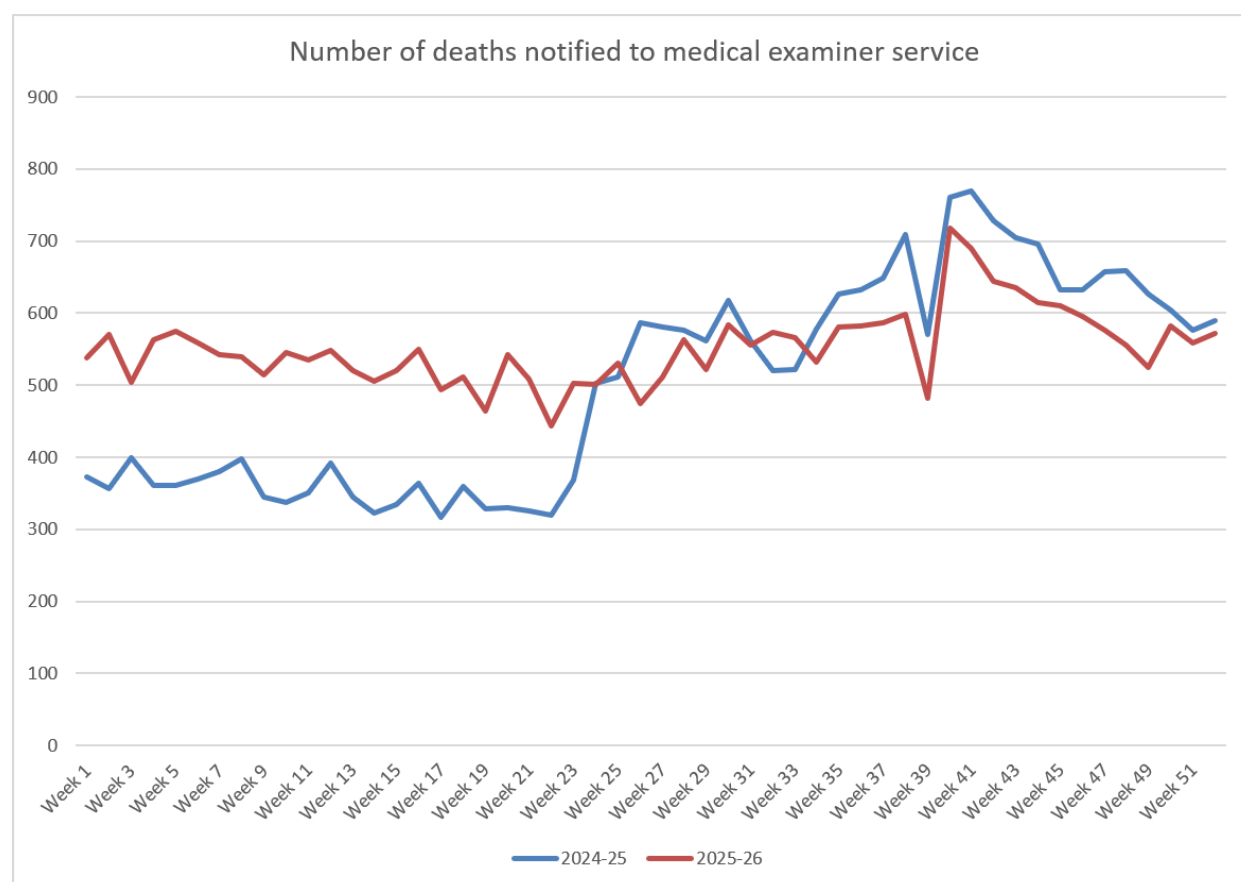
- Continued collaboration with NWSSP Informatics and the Once for Wales DATIX team to enhance reporting capability, including the progression of an All-Wales Business Intelligence tool providing month-by-month performance data and end-to-end oversight of the death certification pathway.
- Review, refinement, and embedding of Standard Operating Procedures and performance frameworks, informed by operational learning following statutory implementation and winter pressures.
- Scheduled six- and twelve-month post-implementation SOP reviews to ensure processes remain proportionate, efficient, and aligned with statutory requirements.
- Maintenance of equitable scrutiny across all care settings and regions, ensuring national consistency in Medical Examiner decision-making and death certification standards.
- Continued reporting of concerns identified during the three-stage scrutiny process via DATIX, using the Health Care Quality Standards (HCQS) framework developed in conjunction with the All Wales Mortality Group. This has enabled more consistent comparison of mortality-related concerns and supported Health Board learning and governance processes.

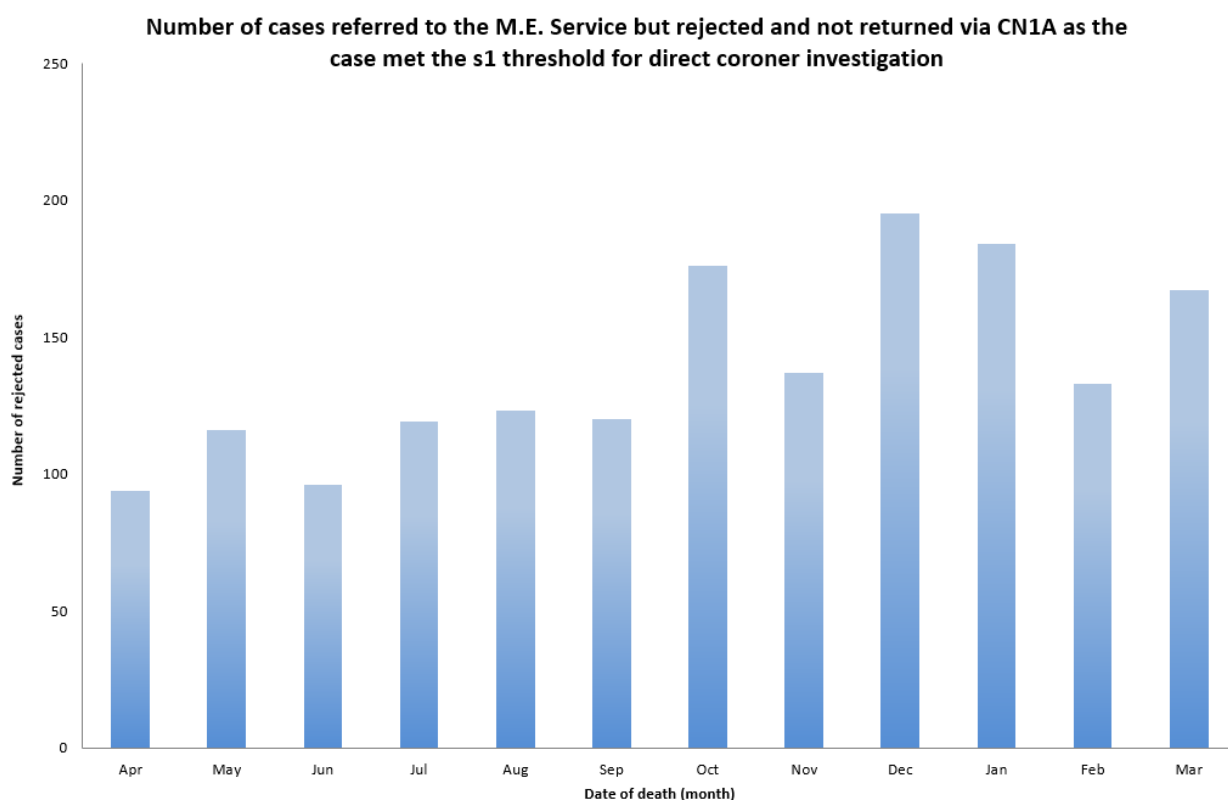
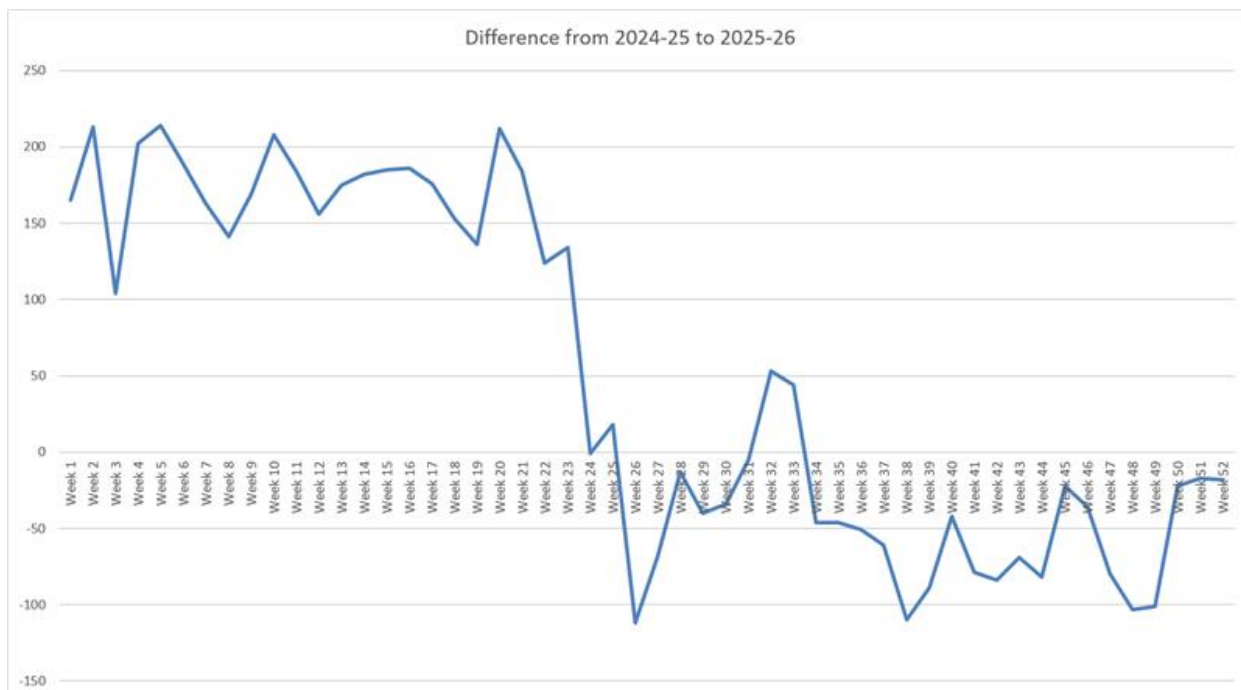
Together, these system and process developments have strengthened the service's ability to deliver timely, high-quality scrutiny while supporting improved data quality, transparency, and organisational learning

6. Activity

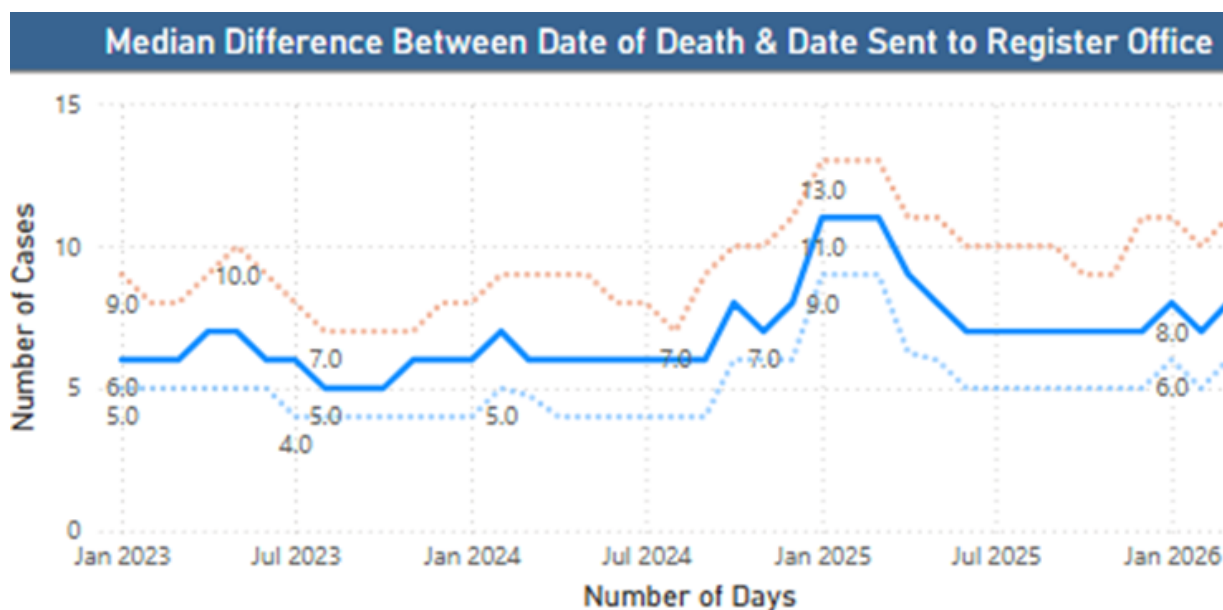
From April 2025 to March 2026, there were 30,051 deaths notified to the medical examiner service, of these 28,341 deaths that were notified to the Medical Examiner Service underwent scrutiny in line with national guidance and the expectations set out by the National Medical Examiner for the independent review of non-coronial deaths. Of these, 914 (3.2%) required further ME scrutiny due to new or additional information being presented by the bereaved or the clinical team after initial scrutiny was completed.

The remaining 1,710 cases did not progress to full Medical Examiner scrutiny. These cases were identified early by Medical Examiner Officers during initial record review or discussion with the attending practitioner as requiring immediate referral to the Coroner. In these instances, the deaths had been notified to the Medical Examiner Service in error, where a direct coroner referral should have been made by the clinical team. While formal scrutiny by a Medical Examiner was not undertaken, these cases still required Medical Examiner Service input. Medical Examiner Officers provided advice and guidance to attending practitioners, and where there was a time-critical element, facilitated coroner notification to avoid delay. This approach is consistent with National Medical Examiner guidance, ensuring timely escalation while maintaining appropriate use of Medical Examiner scrutiny.

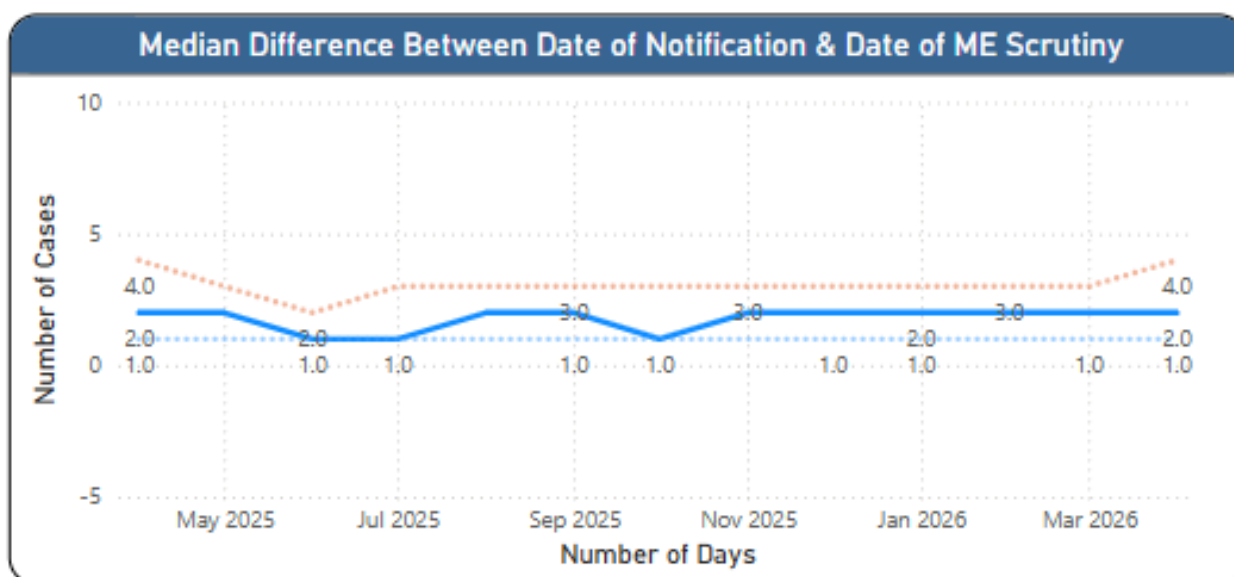




The service continued to perform well against timeliness expectations. The mean and median time from death to the signed MCCD being sent to the register office were 7.31 days and 7.00 days respectively, while the mean and median time from notification to the Medical Examiner Service to MCCD submission were 4.46 days and 4.00 days. These figures reflect improved system performance and effective management of the end-to-end death certification process.



In terms of scrutiny timeliness, 80% of cases were reviewed within 72 hours, with an average (mean) review time of 1.22 days and a median of 2.00 days, meeting the National Medical Examiner's standard for timely case assessment



During 2025–26, Medical Examiners directly completed 35 Medical Certificates of Cause of Death (MCCDs) out of 28,341 deaths that underwent Medical Examiner scrutiny. This represents a very small proportion of overall activity and is entirely consistent with National Medical Examiner guidance, which makes clear that Medical Examiner completion of an MCCD is intended to be an exceptional pathway, rather than routine practice.

National guidance sets clear expectations that the attending practitioner remains responsible for completing the MCCD wherever possible, with the Medical Examiner's role focused on independent scrutiny, assurance, and oversight of the certification process. Medical Examiner completion of an MCCD is reserved for specific, limited circumstances, such as where no appropriate attending practitioner is available, where there is a clear and agreed cause of death but no clinician able to certify, or where exceptional system pressures risk causing significant delay for bereaved families. The low number of MCCDs completed directly by Medical Examiners during the year demonstrates that this principle has been consistently applied across Wales.

Each instance in which a Medical Examiner completed an MCCD was subject to clear governance, defined criteria, and appropriate oversight, ensuring that the pathway was used only when it was necessary and appropriate. Decisions were taken in line with national guidance, supported by Medical Examiner Officer review and documentation, and with consideration of the legal, clinical, and bereavement implications in each case. This approach ensures that the Medical Examiner Service supports timely certification without undermining the role and responsibility of the attending practitioner.

Maintaining this exceptional approach is an important safeguard within the death certification system. It prevents over-reliance on Medical Examiners for certification, supports professional accountability among certifying clinicians, and reduces the risk of role blurring or "mission creep" beyond the Medical Examiner's statutory remit. It also aligns with the National Medical Examiner's expectations that services demonstrate restraint, consistency, and strong control in the use of this pathway.

The fact that over 99.8% of scrutinised cases progressed with MCCD completion by the attending practitioner, following Medical Examiner scrutiny and advice where required, provides assurance that the service is functioning as intended. It reflects a mature, well-governed Medical Examiner Service that prioritises independent scrutiny, supports clinicians to certify accurately, and uses Medical Examiner certification only where it adds clear value and prevents avoidable delay for families.

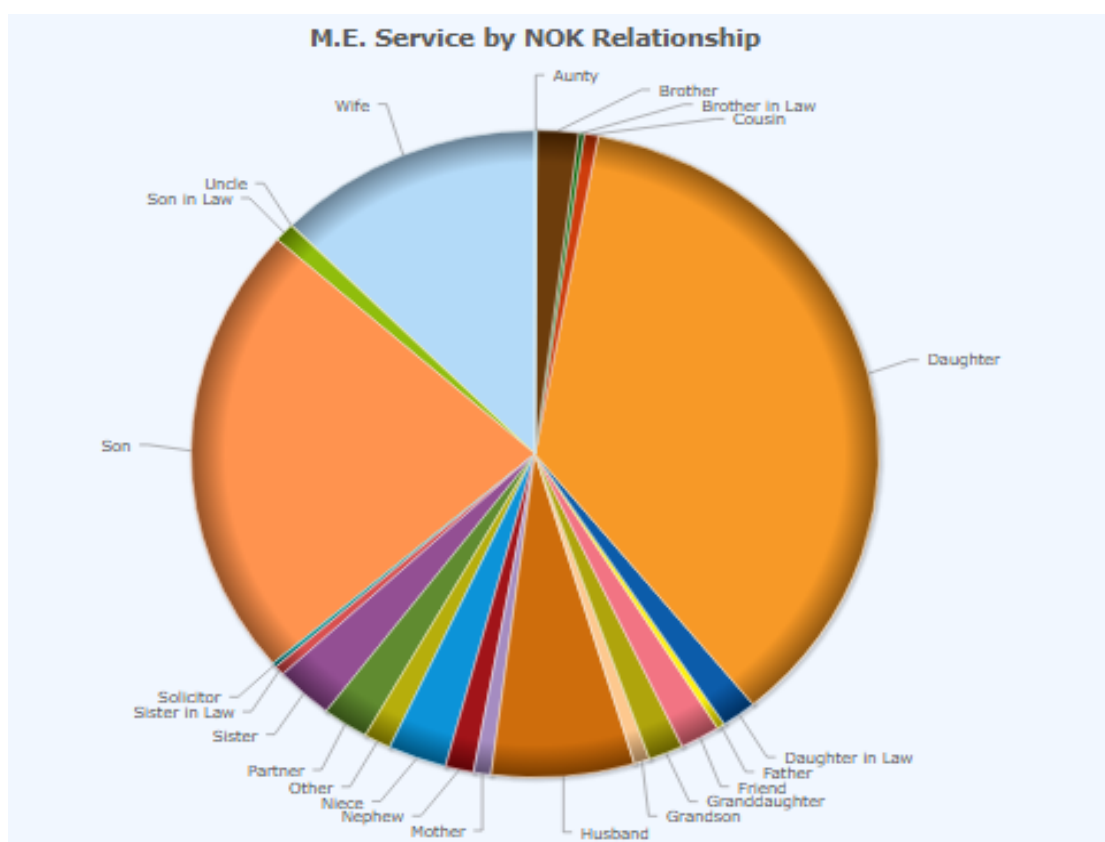
In line with National Medical Examiner guidance for England and Wales, the Medical Examiner Service ensured that a discussion took place with a representative of the deceased in 100% of cases that underwent Medical Examiner scrutiny during 2025–26. This reflects the core requirement of the guidance that bereaved families, or those acting on their behalf, are given the opportunity to ask questions, raise concerns, and understand the cause of death before certification is completed.

While the guidance places emphasis on engagement with the bereaved family, it also recognises that there are circumstances where it is appropriate and necessary to speak with an alternative advocate or representative acting in the best interests of the deceased. During 2025–26, 96.64% of discussions were held directly with family members, demonstrating strong adherence to the principle of family-centred scrutiny. In the remaining 3.36% of cases, contact was made with an appropriate representative rather than a family member. This included 1.87% with friends, 0.22% with solicitors, and 1.27% with other representatives, such as social workers or appointed advocates.

These arrangements were made in line with guidance where family members were unavailable, where legal or safeguarding considerations applied, or where another

individual was better placed to represent the deceased's interests. In all such cases, the Medical Examiner Service ensured that the representative was appropriately identified, that the discussion covered the same key elements required for family conversations, and that any concerns raised were considered and acted upon in the same way as those raised directly by family members.

Achieving 100% representative engagement demonstrates that the service consistently met the National Medical Examiner's expectations for meaningful independent scrutiny, transparency, and support for the bereaved. It also provides assurance that no case progressed to certification without an opportunity for questions or concerns to be raised. This approach reflects a well-governed service that applies national guidance proportionately, while remaining sensitive to individual circumstances and safeguarding requirements.



7. Thematic Insights and Impact

Throughout 2025–26, the Medical Examiner Service continued to play a critical role in identifying, monitoring, and responding to emerging risks and themes across the health and care system in Wales. Analysis of case activity, intelligence from scrutiny, and external signals such as Prevention of Future Death reports, media coverage, and coroner feedback highlights several recurring themes that have shaped service priorities and reinforced the value of independent scrutiny.

A consistent theme during the year was concerns about standards of care in institutional settings, particularly care homes and hospital wards. Multiple cases raised issues relating to neglect, hydration, hygiene, unexplained injuries, infection prevention, and safeguarding. In some instances, these concerns were identified through family accounts rather than clinical records, reinforcing the importance of robust next-of-kin engagement as part of Medical Examiner scrutiny. The service responded by maintaining a low threshold for vigilance, ensuring patterns were flagged early, and supporting appropriate escalation to coroners, Health Boards, safeguarding teams, and professional regulators where required.

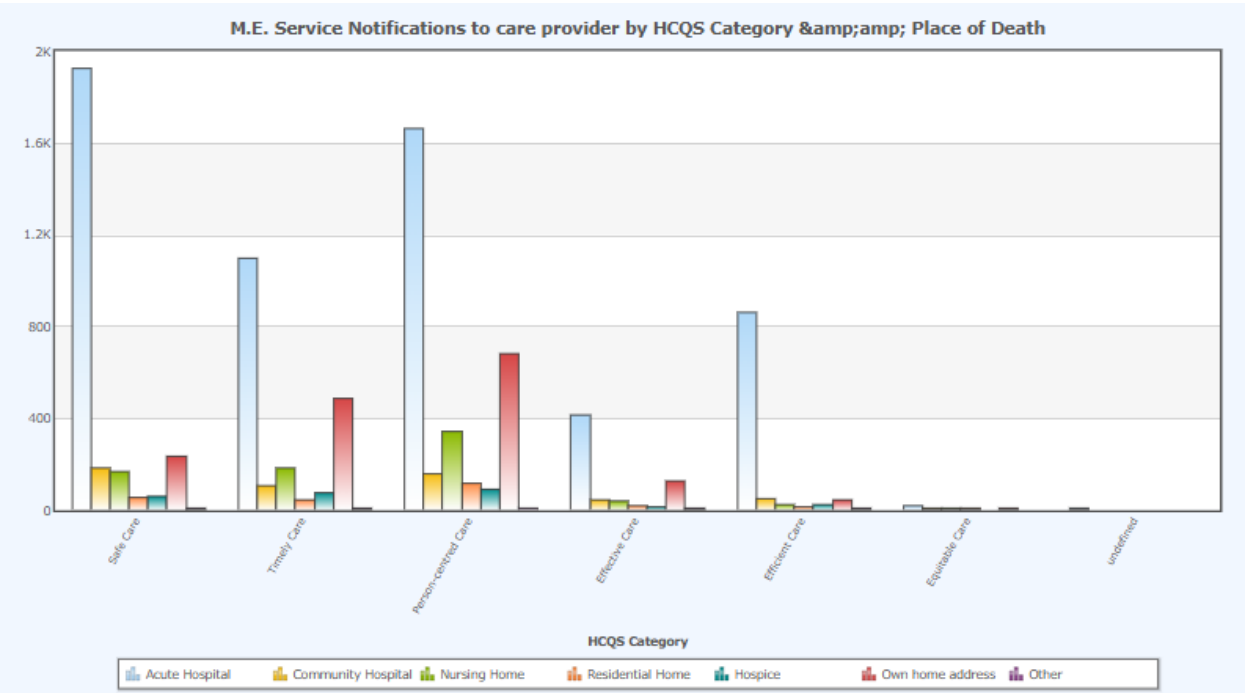
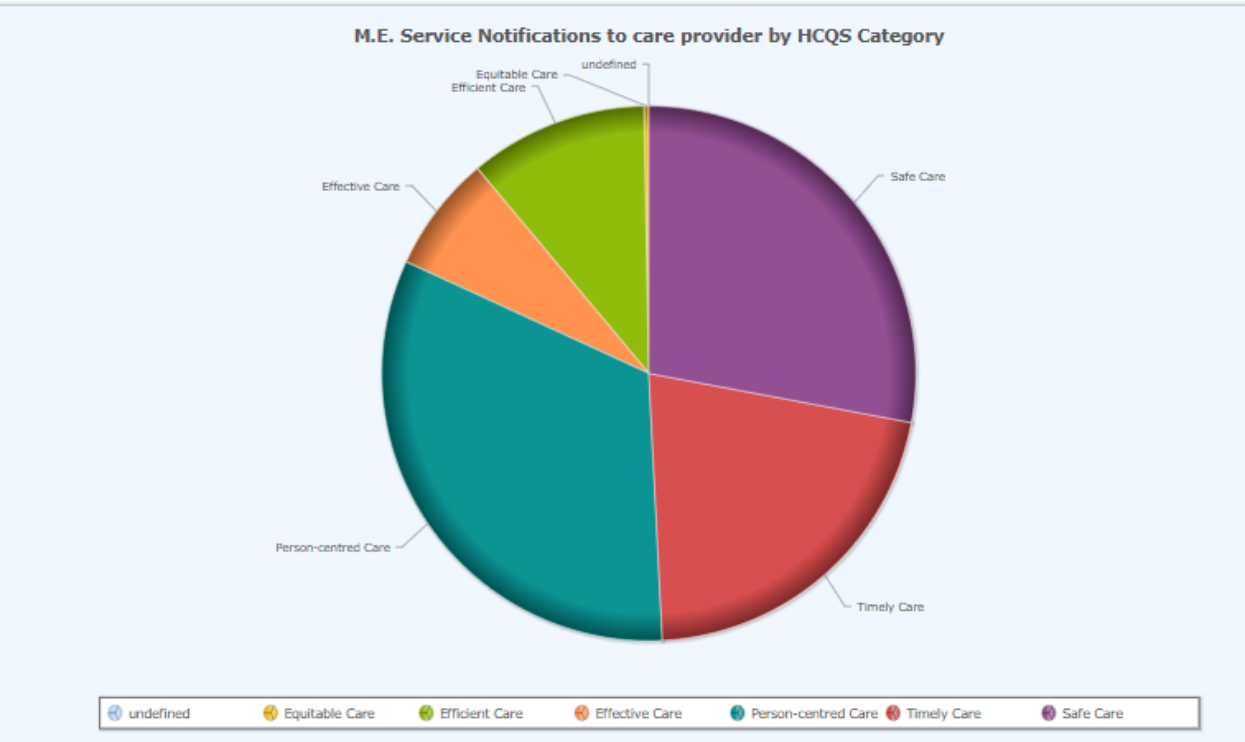
Delays in access to care, diagnosis, and treatment emerged as another significant theme. This included long waits in emergency departments, delayed cancer diagnosis (particularly where negative FIT testing masked other red-flag symptoms), delays to surveillance procedures, and limited access to imaging during periods of maintenance or system pressure. These issues reflect wider system challenges but were frequently identified through Medical Examiner scrutiny, allowing concerns to be captured, shared, and escalated through established governance routes. The service's role in highlighting these delays has supported broader quality improvement and patient safety discussions at Health Board and national levels.

Medication-related risks were also evident, including anticoagulant management, adverse drug reactions, vaccine-related complications, bowel preparation agents, and newer weight-loss medications. In these cases, the Medical Examiner Service ensured appropriate coroner referral, encouraged Yellow Card reporting to the MHRA, and supported consistent recording under iatrogenic injury categories. This has strengthened surveillance of emerging medication risks and contributed to wider patient safety intelligence.

Several themes related directly to death certification quality and process, including formulation of causes of death, correct use of terminology, alignment of durations, and appropriate use of “sudden cardiac death”. The service identified recurring issues where MCCDs were structurally incorrect, inconsistently accepted, or amended retrospectively without clear audit trails. In response, clear guidance, case-based learning, and pragmatic approaches were reinforced to balance legal accuracy with the need to avoid unnecessary delays for families. This work has had a direct impact on improving MCCD quality, reducing rejections, and supporting clinicians to understand the rationale behind Medical Examiner decisions.

Overall, these themes illustrate the Medical Examiner Service's growing role as a system-wide early warning and learning function, rather than simply a certification step. By bringing together clinical scrutiny, family concerns, operational intelligence, and external signals, the service has supported safer care, improved transparency, and stronger governance across Wales. Looking ahead, the continued monitoring of these themes will remain central to the service's quality assurance and improvement approach,

ensuring that learning from deaths meaningfully informs patient safety, service development, and public trust.



8. Engagement and Stakeholder Relationships

The Service has continued to work closely with the following groups:

- Health Boards to align ME activities with mortality review framework and to support clinical and bereavement teams.
- Primary care providers to support integration and early-stage community scrutiny.
- Coroner's Offices to streamline notifications between the services and collaborative working on the ME MCCD cases where required.
- Welsh Government and the National Medical Examiner to embed a system that continues to align with National policy and provide assurance of a working service.
- Faith groups to ensure timely scrutiny of Jewish and Muslim deaths and assurance in the service that faith requests can be managed 7 days a week, 364 days a year (exception of Christmas day)
- Organ and tissue donation teams to ensure that ME scrutiny does not negatively impact on donation pathways
- National Registration Panel for Wales to ensure that certificates sent for registration are at an acceptable minimum standard
- All Wales National Stakeholder Reference group for Death Certification to ensure that the medical examiner service plays an active role in the end-to-end death certification pathway
- Emergency planning teams to ensure that the medical examiner service has robust and in date business continuity plans that align with the wider stakeholder plans and NWSSP planning
- Funeral director services to continue working together to address challenges around the perception of delays within the death certification system

9. Challenges and Opportunities

During 2025–26, the Medical Examiner Service identified improving access to GP records as a key objective to support timely scrutiny, particularly for community deaths. As part of this work, the procurement of the EMIS Web system was completed during the year. This was intended to address ongoing challenges associated with remote access to Vision and EMIS systems, including information governance concerns for GP practices and access delays for the Medical Examiner Service. While system access was not available during 2025–26, the completion of procurement represents a significant milestone. Access to EMIS Web is planned for 2026–27 and is expected to remove the need for manual record sharing, improve reliability of access to clinical records, and support more timely and efficient scrutiny once fully implemented. This digital enhancement aligns with NWSSP's Digital Priorities and drive for Innovation & Excellence by ensuring reliable, secure access to GP records and removing administrative barriers for both practices and Medical Examiner teams

The service operated at full establishment throughout the year. While some Medical Examiners and Medical Examiner Officers left during 2025–26, ME sessions were successfully covered internally as more established MEs sought to develop their Medical Examiner careers and increase their contribution to the service. Staff turnover among Medical Examiner Officers was at 7.5% (3 WTE) and recruitment was managed proactively providing continuity and stability within teams. The service also continued to develop its carer pathway with the Operational Support Officer (OSO) role now embedded, and two OSOs successfully progressing into MEO roles during the year. These initiatives strongly reflect NWSSP's objectives around Our People—working together, investing in staff, and building capability through training, development, and internal talent pathways. In 2025 – 26 there was minimal reliance on bank staff during peak winter pressures in comparison to 2024-25 and this was managed instead through process development, lean working and through agile rostering of MEO and OSO teams. This work supports NWSSP's focus on Value: delivering efficient, cost-effective services while maintaining high resilience. The ability to reassign work across Hubs within the All Wales model further supports Financial Sustainability and improved demand-response capability.

Primary care engagement is now a statutory requirement, and while all deaths are being notified, challenges remain with late notifications from community settings, which can delay access to records and the start of scrutiny. There were 930 late notifications (6.1%) from a primary care setting, and 426 late notifications (3% of deaths)from a secondary care setting. While late notifications remain a challenge, the service actively supports GP practices through real-time guidance — exemplifying NWSSP's Partnership value by collaborating closely with local stakeholders.

The introduction of the new Medical Certificate of Cause of Death (MCCD) has now largely embedded across Wales; however, approximately 25% of MCCDs written between the 1st July 2025 and the 31/03/2026 were returned for correction, reflecting ongoing issues with completeness and accuracy. This has required continued support and feedback to clinicians and has also provided an opportunity to improve standardisation of certification practice across Wales and supports NWSSP's Duty of Quality and improvement agenda.

MCCD Reason for Return					
Reason for Return	1st	2nd	3rd	4th	5th
❑ Patient details incorrect (name, NHS number, DoB, DoD, place of death)	771	108	17	1	
❑ Cause of death incorrectly ordered	556	135	31	6	
❑ Missing durations	540	108	24	8	3
❑ Spelling error	421	58	11	2	
❑ Multiple corrections	329	87	21	6	1
❑ CN1A not reflected on the MCCD	326	44	9	1	1
❑ Occupation not recorded	227	20	3		
❑ Ethnicity question not completed	216	23	8	4	2
❑ Implant section missing information	215	46	12	2	2
❑ Corrections not initialised	157	23	3	1	1
❑ Incorrect Qualifications given	146	25	5		
❑ Crossing out or removal of information	132	32	3		
❑ Implant section contains non hazardous implant	82	19	1		
❑ Cause of death written in wrong column	77	27	6		
❑ Incorrect date of MCCD given	60	5			
Total	5,004	1066	225	49	14

The service has maintained its paper-free model and further reduced its carbon footprint by maximising agile working for Medical Examiners, Medical Examiner Officers, and Operational Support Officers, alongside reduced travel and greater use of digital systems. The expedited scrutiny service continued to function effectively throughout the year, meeting the needs of bereaved families and helping to reduce bottlenecks in the wider death certification process. Operating as a seven-day service, including Bank Holidays, enabled the service to respond promptly to faith-based requests, paediatric cases, and organ donation enquiries when required.

Performance oversight was strengthened through the development of the Medical Examiner Service dashboard, including the introduction of traffic-light indicators that highlight where pressure exists within different parts of the death certification process. This has enabled the service to take early action where issues are within its control and to escalate concerns to external partners where delays sit outside the service. While these issues created pressure for the service, they also provided opportunities for the Medical Examiner Service to offer consistent, real-time advice and guidance to stakeholders during a period of significant change.

Throughout 2025–26, the Medical Examiner Service continued to play a key role in supporting clinician understanding and capability in relation to death certification, contributing directly to NWSSP priorities around quality, workforce development, partnership working, and value. The service delivered a coordinated programme of education and support, including contributions to Grand Rounds, Foundation Year 1 teaching, ad hoc training sessions, and webinars, to help clinicians understand their responsibilities within the death certification process and the role of the Medical Examiner Service.

In line with the NWSSP IMTP focus on working in partnership and improving system quality, joint training sessions were delivered with local Coroners across Wales. These sessions provided a consistent and unified approach between HM Coroners and Medical Examiners, helping to clarify processes, reduce variation, and support clinicians to navigate complex decision-making with confidence. This collaborative approach has

strengthened shared understanding across the system and reinforced clear professional boundaries and responsibilities.

Looking ahead, development work with Health Education and Improvement Wales (HEIW) is underway to further strengthen and formalise training arrangements from 2026–27. This work supports NWSSP's commitment to investing in people and building future capability, with plans to expand structured education and learning opportunities for clinicians involved in death certification.

Together, these activities demonstrate the service's ongoing commitment to improving quality, supporting the workforce, and contributing to a safer, more consistent death certification system across Wales. The service has continued to adapt and improve its responsiveness, maintaining clarity around its remit while supporting stakeholders through complex changes to death certification. Overall, the Medical Examiner Service has remained resilient, responsive, and focused on continuous improvement throughout 2025–26.

10. Winter Pressures

Winter 2024–25 placed significant pressure on the death certification system, driven by increased mortality rates, workforce strain, and fluctuating demand at a time when statutory reforms were still embedding. These pressures were widely felt across the system and resulted in delays, reduced staff morale, negative media coverage, formal complaints, and escalation to senior leaders, Ministers, and Welsh Government. The Medical Examiner Service responded in the post winter pressures in 2025 by planning for winter 2025-26 and enhancing rota flexibility, activating contingency staffing arrangements, prioritising triage so that the most urgent and time-critical cases were scrutinised first, and strengthening coordination with primary care and hospital teams to manage surges in death volumes. Despite the intensity of these pressures in 2024-25, the service maintained continuity and upheld national standards through the flexibility of the All-Wales operating model during the early part of 2025-26.

Learning from this experience, the service undertook a detailed review of winter performance and used this learning to inform planning for 2025–26. Although overall death rates were lower during the most recent winter, improved performance was not solely attributable to reduced demand. Proactive planning played a key role, including more flexible staffing models, improved rota design, clearer prioritisation of core Medical Examiner activity, and the deliberate movement of non-essential work outside peak winter periods. Stakeholder engagement was also strengthened, with clearer communication and escalation routes across the death certification pathway, supporting earlier identification of pressure points and more timely joint action.

As a result, the service was better prepared to respond to winter pressures during 2025–26, demonstrating improved resilience, smoother case flow, and more timely progression through the death certification process. This reflects a service that has responded directly to the challenges of the previous year, adapted its operating model, and embedded learning to deliver a more sustainable and responsive Medical Examiner Service across Wales

11. Delivery of IMTP Objectives and Service Progress

During 2025–26, the Medical Examiner Service delivered all of its planned IMTP objectives, building on learning from an exceptionally challenging period in 2024–25, when statutory reforms, high mortality rates, and winter pressures placed significant strain on the service and the wider death certification system. The focus for the year was on consolidation, strengthening resilience, and improving consistency, while continuing to support timely and high-quality death certification across Wales. All objectives were delivered as planned and have been agreed to continue into 2026–27 to support further service development.

Under IMTP Objective MES2401 (Review and Amend the Medical Examiner Operational Model), the service undertook a comprehensive review of how it operates, informed by legislative changes and learning from previous winter pressures. Operational processes and standard operating procedures were updated to reflect statutory requirements, changes to systems, and the Medical Examiner's duty to initiate scrutiny. Winter and surge planning was strengthened, additional Medical Examiner and administrative capacity was secured, and performance information—particularly turnaround times—was shared regularly with Medical Directors.

These changes contributed to a more stable and resilient service during winter 2025–26, with turnaround times remaining consistent, service dashboards showing that 99% of service-controlled indicators remained within expected limits, and a notable reduction in complaints from families relating to lack of contact.

Significant progress was also made under IMTP Objective MES2402 (Improve the Quality and Use of Mortality Data). Reporting arrangements were strengthened and embedded, including the introduction of a new Business Intelligence dashboard providing clearer visibility of Health Board performance, scrutiny activity, timeliness, and quality indicators. Medical Examiner data is now routinely used to inform mortality review, patient safety work, winter planning, and wider system oversight. The service also strengthened data-sharing arrangements with national programmes such as Child Death Review Panels and Learning Disability Review teams, ensuring learning from deaths contributes to improvement across the wider health system.

Through IMTP Objective MES2501 (Review and Update Operational Policies and Procedures), all Medical Examiner policies and standard operating procedures were reviewed following statutory implementation. Guidance was updated, refined, archived, or newly developed as needed, and document management was moved to a single shared platform to improve access and version control. This work was supported by training and audit activity to ensure that practice reflected updated guidance, helping to improve consistency and reliability across teams and regions.

Further work to support learning and quality improvement was delivered under IMTP Objective MES2502 (Align Reporting to Duty of Quality Domains). The service worked with national partners to review and refine reporting categories, including Health Care Quality Standards, and to introduce new indicators to strengthen learning from deaths, particularly in community and primary care settings. These changes have been agreed through national governance processes and are scheduled for system implementation from April 2026, with further analytical development planned for 2026–27.

Throughout the year, the service remained aware of ongoing risks, including variation in engagement from care providers and the importance of maintaining clear boundaries around the Medical Examiner

role. These risks were managed through clear governance, regular engagement with Medical Directors and Welsh Government, and nationally agreed frameworks.

Overall, 2025–26 was a year of consolidation and steady improvement, with all IMTP objectives delivered despite the legacy of previous pressures. The Medical Examiner Service is now operating with clearer processes, stronger data, and improved oversight, placing it in a strong position to continue improving quality, timeliness, and learning during 2026–27, while remaining responsive to future system pressures.

12. Quality & Safety

Quality Assurance and Quality Improvement

Throughout 2025–26, the Medical Examiner Service maintained a strong and visible focus on quality assurance and quality improvement, building on learning from the early statutory period and responding to pressures experienced in previous years. Quality processes were embedded into everyday practice, ensuring that improvements were not only identified but acted upon in a timely and consistent way across Wales.

A key development during the year was the continued refinement and implementation of a service-wide Quality Manual. The Quality Manual brings together standards, processes, and expectations for Medical Examiner activity, providing a clear reference point for staff and supporting consistent practice across all regions and care settings. This work supports transparency, accountability, and a shared understanding of quality across the service.

The service also established and expanded a structured internal audit programme, enabling regular review of compliance with national guidance, statutory requirements, and local processes. Audit findings were used constructively to identify areas of good practice, highlight variation, and inform targeted improvement actions. This approach supports assurance while also driving learning and service development.

Learning from cases remained central to the service's quality improvement approach. SBAR-based case reviews were used to support structured reflection on individual cases, particularly where issues such as delayed referrals, certification errors, or process breakdowns were identified. These reviews enabled consistent analysis of what happened, why it happened, and what could be improved, and were used to share learning internally in a supportive and non-blaming way. This approach helped staff understand the wider impact of decisions and strengthened professional development across the Medical Examiner and Medical Examiner Officer workforce.

Quality assurance was further strengthened through ongoing monitoring of key performance indicators, including timeliness, MCCD quality, next of kin contact, and coroner referral practice. The development of the All-Wales Business Intelligence tools supported better oversight of the end-to-end death certification process, enabling early identification of pressure points and targeted intervention where needed.

Together, these quality assurance and quality improvement activities demonstrate a mature and learning-focused service. By embedding quality into daily operations, strengthening audit and review arrangements, and using structured case learning to support staff development, the Medical Examiner Service has continued to improve consistency, safety, and confidence in the death certification process across Wales.

CPD & Training

During 2025–26, the Medical Examiner Service continued to invest in the learning and development of its workforce, recognising that a skilled, confident, and well-supported team is essential to delivering a high-quality service for bereaved families and the wider health system. Following the pressures of previous years and the introduction of statutory reforms, the focus was on strengthening professional capability, maintaining regulatory standards, and supporting staff through structured and accessible development opportunities.

A programme of webinars and learning sessions continued throughout the year, covering key aspects of Medical Examiner practice and emerging areas of learning. These sessions supported shared understanding across the service and provided opportunities for discussion, reflection, and consistent application of guidance. Alongside this, maintaining compliance with the Royal College of Pathologists' Medical Examiner Officer portfolio requirements remained a priority. Good progress was made in supporting MEOs to complete and maintain their portfolios, helping to evidence ongoing competence, support revalidation, and embed reflective practice.

During the year, work also began on the development of a dedicated CPD platform for the service. This platform is intended to provide a central hub for training materials, e-learning resources, and CPD recording, making it easier for staff to access learning opportunities and track their development in one place. This work reflects the service's longer-term commitment to supporting structured learning and career development.

The service further strengthened its approach to bereavement care through targeted training delivered in partnership with Sands, focusing on stillbirth and neonatal death. This training supported staff to develop the skills and confidence needed to provide sensitive, compassionate support to families in particularly complex and distressing circumstances.

In addition to these initiatives, regular CPD sessions continued throughout the year, providing updates on legislation, clinical practice, communication, and professional standards. These sessions supported both individual development and a shared culture of learning across the service.

Together, these activities demonstrate the Medical Examiner Service's ongoing commitment to professional development, reflective practice, and continuous learning. By supporting staff knowledge, skills, and confidence, the service continues to strengthen the quality, consistency, and compassion of the care provided to families across Wales.

Neonatal and Paediatric Deaths

During 2025–26, the Medical Examiner Service continued to consolidate and strengthen its national approach to the scrutiny of neonatal and paediatric deaths, moving from initial statutory implementation to a more mature and embedded model of delivery. This work builds on extensive engagement undertaken prior to September 2024 with the All Wales Neonatal Strategic Group, Child Health Forums, Health Boards, hospices, and bereavement charities including Sands and 2Wish, ensuring that national processes align with local bereavement pathways while maintaining independent scrutiny and a strong focus on families.

Over the reporting period, the service provided proportionate, compassionate scrutiny across a wide range of neonatal and paediatric deaths, including extreme prematurity, congenital anomalies, and palliative, oncological, and other life-limiting conditions. Between January 2025 and January 2026, 80 neonatal and paediatric deaths underwent Medical Examiner scrutiny, comprising 46 neonatal deaths and 34 paediatric deaths. Timeliness remained consistently strong, with medical records accessed within one to two days in most cases, Medical Examiner review often undertaken on the day of notification, families contacted within 24–48 hours, and MCCDs typically completed within one to five days.

A key development during the year was the continued embedding of the prenotification pathway for expected neonatal and paediatric deaths, particularly where life-limiting conditions were identified antenatally. Now routinely used across multiple Health Boards, this approach has improved turnaround times, supported earlier agreement of provisional causes of death, reduced delays in certification, and improved preparedness for both families and clinical teams. Audit evidence confirms that prenotification has become an established model of best practice across Wales.

Significant progress was also made in strengthening service development and resources. The service consolidated its national infrastructure to support consistent scrutiny, underpinned by an expanding suite of centralised resources designed to promote standardisation and shared learning. The Continuing Professional Development (CPD) platform was further enhanced and remains under continuous review. It now includes learning from significant cases, summaries of emerging trends, condition-specific fact sheets, and a growing library of recorded teaching sessions. These resources support Medical Examiners in maintaining high standards of scrutiny in complex cases and will also inform Medical Examiner Officer learning when this resumes in Spring 2026.

Communication and peer learning arrangements were strengthened through the establishment of a dedicated Microsoft Teams channel, providing a structured forum for case discussion, peer support, and reflective practice. This has supported a culture of openness and collective learning across the service. In addition, a comprehensive service-wide update was delivered one year after statutory commencement, reflecting on progress, challenges, and priorities for further development.

Ongoing audit activity continued to inform service improvement. This included review of case timeliness, the quality and consistency of documentation, themes arising from neonatal and paediatric deaths, and feedback from families and professional stakeholders. Audit findings were actively used to refine guidance, identify training needs, and ensure continued alignment with national standards and expectations.

Oversight of neonatal and paediatric cases remains centrally coordinated by the Senior Medical Examiner and Service Lead, ensuring consistent application of legislation, appropriate case determination, and early identification of learning themes. Participation in neonatal and paediatric scrutiny is opt-in for experienced Medical Examiners, prioritising quality and staff wellbeing. Over time, increased exposure to both first and second scrutiny has strengthened confidence and capability, reducing reliance on central oversight while maintaining high standards. Workforce planning continues to focus on resilience, including business continuity arrangements and the phased expansion of the Medical Examiner Officer cohort.

Specialist training in neonatal and paediatric scrutiny was delivered in Autumn 2025, led by senior Medical Examiner leadership with contributions from 2Wish and Sands. This covered case management, common conditions, legal frameworks, communication with bereaved families, and emotional resilience. Training was paused during the winter period due to operational pressures and will resume in Spring 2026, supported by a refreshed programme including palliative care-focused CPD, structured case shadowing, reflective learning, and targeted communication training delivered by Sands.

Recognising the emotional impact of this work, the service maintained robust staff wellbeing and support arrangements, including peer-to-peer networks, structured debriefs, immediate support through the NWSSP Employee Assistance Programme and wellbeing portal, and access to specialist external organisations such as 2Wish, Sands, and Child Bereavement UK. These measures support resilience, reflective practice, and staff wellbeing across the workforce.

Overall, 2025–26 marked a year of consolidation and continued progression in the Medical Examiner Service's approach to neonatal and paediatric deaths. Strong partnerships, embedded resources, structured learning, and sustained focus on staff wellbeing have supported timely, consistent, and compassionate scrutiny. Priorities for 2026–27 will focus on further strengthening workforce resilience, refining guidance and resources, deepening stakeholder collaboration, and ensuring that high-quality, family-centred care remains central to all statutory activity.

Prevention of Future Death Reports (PFDs) and the Role of the Medical Examiner Service

Under Paragraph 7 of Schedule 5 of the Coroners and Justice Act 2009, coroners have a duty to issue Reports to Prevent Future Deaths (PFDs) where they believe that action should be taken to reduce the risk of similar deaths occurring. While the responsibility for issuing PFDs sits with the coroner, the Medical Examiner Service plays a key role in identifying concerns early, supporting families to raise issues, and ensuring that relevant risks are recognised, documented, and escalated appropriately.

During 2025–26, Medical Examiner scrutiny and engagement contributed directly to a number of cases that later resulted in PFDs. In many of these cases, issues were not immediately apparent from the medical records alone and were identified through careful scrutiny, discussion with attending practitioners, and detailed conversations with families. This highlights the value of the Medical Examiner Service as an early safety and learning function within the death certification system.

The themes emerging from PFD-related cases in which the Medical Examiner Service was involved include delays in diagnosis or follow-up, medication and anticoagulation management, ambulance response delays, monitoring and escalation failures, nutrition and hydration concerns, falls and environmental risks, and documentation or decision-making gaps. For example, Medical Examiners identified missed surveillance of Barrett's oesophagus over several years, sub-therapeutic anticoagulation during admission for pulmonary embolism, inappropriate management of alcohol withdrawal, and delays in vascular referral and assessment. In other cases, scrutiny highlighted long ambulance response times, prolonged "long lies", and delays in emergency department assessment and treatment.

Family engagement was central to several referrals that ultimately resulted in PFDs. Medical Examiner Officers spent significant time listening to bereaved families' concerns about care, including nutrition, feeding, post-operative management, and delays to investigations such as OGD. In a number of cases, these concerns were not previously known to clinical teams and were only brought to light through Medical Examiner conversations. This information was then shared with coroners to support informed decision-making and appropriate investigation.

In some cases, Medical Examiner scrutiny identified risks that prompted coroner referral where this was not initially planned, such as unexplained acute kidney injury, complications following procedures, concerns about cardiac monitoring, or time-critical delays in assessment and treatment. In other cases, the Medical Examiner Service supported attending practitioners by clarifying concerns, explaining findings to families, and ensuring that referrals to the coroner were made with clear, well-documented rationale.

Across all PFD-related cases, the Medical Examiner Service focused on ensuring that:

- relevant concerns were identified early and escalated appropriately;
- families were given the opportunity to raise questions and concerns;
- clinical issues were clearly documented and communicated;
- coroners had access to comprehensive and balanced information to inform their investigations.

The examples from 2025–26 demonstrate that the Medical Examiner Service plays a crucial enabling role in the PFD process. While not responsible for issuing PFDs, the service helps ensure that risks to patient safety are recognised, learning is not missed, and opportunities to prevent future harm are acted upon. This work supports wider system learning, contributes to quality improvement, and reinforces public confidence in the scrutiny of deaths across Wales.

14. Summary

The 2025–26 year represents a significant step forward for the All Wales Medical Examiner Service, marking the transition from statutory implementation to a more stable, resilient service model. One of the service's key successes has been its ability to learn from the intense pressures of 2024–25 and translate that learning into tangible improvements. Through earlier planning, more flexible staffing, clearer processes, and stronger stakeholder engagement, the service delivered a noticeably more stable winter period, with improved flow through the death certification system and a measurable reduction in delays between death and MCCD submission.

The service successfully embedded consistent national processes across all regions and care settings, supported by refined standard operating procedures, clearer escalation routes, and improved oversight through dashboards and business intelligence. This consistency has strengthened confidence among clinicians, coroners, registrars, and families, while maintaining local responsiveness through the All-Wales operating model.

Quality has remained a clear strength throughout the year. High standards of Medical Certificate of Cause of Death completion were maintained, supported by routine monitoring, targeted feedback, and structured learning. The service demonstrated strong compliance with National Medical Examiner guidance, including timely scrutiny, appropriate use of exceptional pathways such as Medical Examiner-completed MCCDs, and 100% engagement with a representative of the deceased in scrutinised cases.

The Medical Examiner Service has also increasingly demonstrated its value as a system-wide learning and safety function. Through thematic analysis, Prevention of Future Death-related work, and strengthened mortality feedback pathways, the service has supported earlier identification of risk, clearer escalation, and meaningful learning across Health Boards and partner organisations.

Investment in people has been another key success. Workforce stability was maintained despite ongoing system pressures, supported by internal career development, low reliance on bank staff, and the embedding of new roles such as Operational Support Officers. Training, CPD, and wellbeing support have been prioritised, recognising the complexity and emotional impact of the work, particularly in areas such as neonatal and paediatric deaths.

Finally, the service has continued to modernise its ways of working, maintaining a paper-free model, reducing its carbon footprint through agile working, and laying the groundwork for further digital improvement through initiatives such as EMIS Web procurement and enhanced BI reporting.

Conclusion

The All Wales Medical Examiner Service concludes 2025–26 as a confident, resilient, and well-governed statutory service, firmly embedded within the Welsh health and care system. The year has demonstrated the service’s ability not only to respond to pressure, but to adapt, improve, and deliver sustained change while maintaining compassion, independence, and quality at its core.

By strengthening operational foundations, improving data and oversight, supporting the workforce, and deepening collaboration with stakeholders, the service has improved both the experience of bereaved families and the effectiveness of the death certification process across Wales. Importantly, it has done so while remaining clear about its remit and role, supporting clinicians and coroners without creating unnecessary delay or duplication.

Looking ahead to 2026–27, the service is well positioned to build on this progress. With a stable operating model, a clear focus on workforce development, and continued investment in digital and quality improvement, the Medical Examiner Service will continue

to support safer, more transparent death certification and contribute meaningfully to patient safety, learning, and public trust across Wales.



The report is not exempt

Teitl yr Adroddiad/Title of Report:

**Surgical Materials Testing Laboratory (SMTL)
Annual Briefing 2025-26**

**Arwwinydd/
Lead:** Dr Gavin Hughes, Director of Surgical Materials
Testing Laboratory

**Awdur/
Author:** Dr Gavin Hughes, Director of Surgical Materials
Testing Laboratory

**Swyddog Adrodd/
Reporting Officer:** *For information only*

Pwrpas yr Adroddiad/Purpose of the Report:

This paper provides an overview of the SMTL's achievements and quality and governance arrangements for the period 2025/26. Key areas to note are:

- Retaining UKAS ISO/IEC 17025 accreditation for medical device testing.
- Meeting financial commitments and performance measurements.

For the Committee to receive the SMTL Annual Briefing 2025-26, for information only.

Llywodraethu/Governance:

**Amcanion/
Objectives:** The report supports the delivery of safe, effective and value-based services through independent medical device testing, technical assurance, quality governance and continued accreditation against relevant standards.

**Tystiolaeth/
Supporting
evidence:**

- Appendix 1 - 2025 UKAS Inspection Report for SMTL
- Appendix 2 - 2025 UKAS Schedule of Accreditation for SMTL

Ymgynghoriad/Consultation:

- NWSSP Senior Leadership Group on 25 June 2026
- Velindre Quality Safety and Performance Committee on 9 July 2026

Adduned y Pwyllgor/Committee Resolution (insert ✓):

**DERBYN/
APPROVE**

**ARNODI/
ENDORSE**

**TRAFOD/
DISCUSS**

**NODI/
NOTE**

**Argymhelliad/
Recommendation:** The Committee receives the SMTL Annual Briefing 2025-26, for information only.

Crynodeb Dadansoddiad Effaith/Summary Impact Analysis:

**Cydraddoldeb ac
amrywiaeth/Equality
and diversity:** No direct equality or diversity impacts have been identified. SMTL's work supports consistent access to safe and effective medical devices across NHS Wales.

Cyfreithiol/Legal: The report notes continued compliance with relevant accreditation, regulatory and quality

	requirements, including ISO/IEC 17025 accreditation.
Iechyd Poblogaeth/ Population Health:	SMTL contributes to population health by supporting safe procurement decisions and reducing the risk of unsuitable medical devices being used in clinical settings.
Ansawdd, Diogelwch a Profiad y Claf/ Quality, Safety & Patient Experience:	The work of SMTL directly supports quality, safety and patient experience through medical device testing, adverse incident investigation and technical assurance.
Ariannol/Financial:	There are no new financial implications arising from this report. SMTL met its financial commitments during 2025/26.
Risg a Aswariant/ Risk and Assurance:	Risks are actively managed through the SMTL risk register and established governance arrangements. No significant assurance concerns are raised in this report.
Dyletswydd Ansawdd/Duty of Quality:	The report supports the Duty of Quality by providing assurance on safe, effective, efficient and person-centred services, underpinned by quality management and continuous improvement.
Gweithlu/ Workforce:	Workforce considerations are noted within the report, including resilience, succession planning and continued staff development.
Deddf Rhyddid Gwybodaeth/Freedom of Information Act:	Open. The information is disclosable under the Freedom of Information Act 2000.

SURGICAL MATERIALS TESTING LABORATORY (SMTL) ANNUAL BRIEFING 2025-26

1. SITUATION & BACKGROUND

The Surgical Materials Testing Laboratory (SMTL) is an ISO/IEC 17025-accredited medical device testing laboratory and has been part of NHS Wales Shared Services Partnership (NWSSP) since 2016. Its core role is to provide medical device testing and technical support to NHS Wales. This includes investigating medical device adverse incidents (MDAI) for NHS Wales, as set out in Welsh Health Circular MDA/2004/054 (Wales). Through its rigorous testing and technical assurance functions, SMTL contributes directly to patient safety by identifying products that do not meet specification, preventing their use in clinical settings and supporting safer procurement decisions across NHS Wales.

To support a balanced budget, SMTL also provides commercial testing and technical assurance services to the wider UK health sector and the international medical device industry.

This paper summarises SMTL's achievements and its quality and governance arrangements for 2025/26.

2. ASSESSMENT

This has been another strong year for SMTL, with financial commitments met and performance measures consistently achieved or exceeded.

2.1 Performance Measures

2.1.1 Operational Performance

SMTL submits monthly Key Performance Indicator (KPI) reports to the NWSSP Planning, Performance and Informatics Division. It also reports to senior colleagues through quarterly performance reviews. In 2025/26, SMTL exceeded all reportable KPI targets (Table 1).

Regardless of the KPI target, if an individual project report target is missed, the SMTL manager will produce an exception report setting out the reason, the corrective action and the expected recovery date. Six exception reports were issued during the year, mainly because staff sickness caused minor delays in producing audited test reports. No repeat issues were identified.

SMTL sends customer questionnaires after each project, using a 5-point Likert scale across eight questions. Feedback remains very positive, with most clients giving the highest rating in all categories and an overall satisfaction score of 96.9% in 2025/26.

Table 1: SMTL reportable Key Performance Indicators

Key Focus Area	Description of Key Performance Indicator	Responsibility	Frequency	Target	2025/26
Customers/Excellence	% of Trending/Surveillance and Monitoring reports completed within 14 days from receipt into the laboratory	NWSSP	Monthly	91%	100%
Customers/Excellence	% of Investigation reports completed within 40 days from receipt into the laboratory	NWSSP	Monthly	91%	100%
Customers/Excellence	% delivery of audited reports on time (Commercial)	NWSSP	Monthly	92%	100%
Customers/Excellence	% delivery of audited reports on time (NHS)	NWSSP	Monthly	92%	99%
Excellence	Annual UKAS accreditation	NWSSP	Annual	Attained	ATTAINED
Excellence	UKAS findings addressed on time (Annual)	NWSSP	Annual	Completed	COMPLETED
Excellence	Completion of Internal Audits on schedule	NWSSP	Annual	Completed	COMPLETED
Value for Money	Production of Evidence Reviews	NWSSP	Annual	5	ATTAINED (6)
Customers/Excellence	% delivery of Technical Assurance evaluations on time	NWSSP	Monthly	90%	100%
-	Sickness & Absence	NWSSP	Monthly	3.30%	2.61%
-	88% PADRs delivered on time	NWSSP	Monthly	88%	97%
-	85% Statutory & Mandatory Training Compliance	NWSSP	Monthly	85%	99%

2.1.2 Project Management – Integrated Medium-Term Plan (IMTP)

Delivery against our IMTP was strong, with 5 of the 7 objectives achieved. The delayed projects have been reprofiled into 2026/27, with governance oversight in place.

We have previously reported that deployment of the new Laboratory Information Management System (LIMS) was deliberately deferred to allow robust QA assessment before launch. Good progress was made in 2025/26, with two of the three elements now live and full implementation expected in Quarter 2 of 2026/27.

Development of the All-Wales MDAI reporting system was further delayed by external factors and is now paused until our partner Health Board recruits to the vacant post needed to progress the clinical element.

2.1.3 Laboratory Activity and Performance

In 2025/26 the laboratory undertook 168 testing projects, with 69 projects performed for NHS Wales. The laboratory produced 712 test reports, processing over 133,000 samples from 1803 products received.

In 2025/26, SMTL performed several laboratory testing programmes for NWSSP Procurement Services. A major testing programme supported the All-Wales Wound Management Contract (SMTL reference PROJ-67). The laboratory received more than 1,700 samples and assessed them using internal methods and European Standard EN 13726 physical and biological tests. As in previous contract exercises, testing identified numerous products that did not meet specification and could have affected patient outcomes if used clinically. These products were excluded from the tender process and the manufacturers were notified of the technical failures.

SMTL also leads medical device technical discussions in NWSSP Procurement Services working groups that are responsible for drafting product specifications. Several medical device groups are currently sitting in preparedness for tenders exercises due in 2026-27:

- AWC Urology [PROJ-134]
- AWC Anti-Embolism Hosiery [PROJ-156]
- PPE Stockpile SMTL reference [PROJ-218]
- Examination Gloves P/ 7341 [PROJ-256]
- Surgeons Gloves P/ 6905 [PROJ-9]
- AWC Airway Management [PROJ-334]

SMTL undertook monitoring exercises on vaginal specula (PROJ-29) and pH indicator strips that are used to support nasogastric tube placement during enteral feeding (PROJ-109). These monitoring exercises are typically undertaken where there are concerns about product consistency, or where devices have been implicated in patient safety incidents and ensure that we have continued confidence on stock held in NWSSP Procurement Services stores.

To check storage stability, SMTL tested the alcohol concentration of hand sanitiser held in NHS Wales pandemic stock (PROJ-241). The analysis showed that although some products contained less alcohol than claimed, all remained above the minimum concentration recommended by Public Health Wales, providing reassurance about the pandemic stock performance.

SMTL's R&D department leads technical assurance projects for the laboratory. During the past financial year, the team has completed 17 technical assurance projects to support our NHS Wales colleagues. The SMTL Director and R&D department continue to participate in Welsh Government working groups established to replenish NHS Wales pandemic PPE stock,

where SMTL are responsible to perform the necessary technical assurance checks before procurement.

SMTL presented at four conferences and education events and produced six evidence reviews, including three for the Evidence Based Procurement Board (EBPB). Dr James Evans, SMTL's R&D Manager, also published a paper on the economic and clinical benefits of using atraumatic needles instead of conventional needles for diagnostic lumbar puncture (<https://pubmed.ncbi.nlm.nih.gov/41792808/>), arising from an EBPB project.

2.1.4 Medical Device Adverse Incident Reporting (MDAI)

During 2025/26, the laboratory completed 121 adverse incident investigations involving medical devices, broadly in line with 2024/25 figures. The majority of reports were related to compression garments for lymphoedema treatment, which may reflect SMTL's close collaboration with Lymphoedema Network Wales and the associated reporting from this clinical group. SMTL are currently engaging with the garment manufacturers on potential design changes which are aimed to reduce failures rates and improve patient outcomes.

2.1.5 Staff

The workforce remained broadly stable. Staffing levels were consistent, with 21.92 WTE permanent staff, two fixed-term posts and one bank staff member used as required. We were also supported to make one fixed-term post permanent to strengthen the QA department and retaining staff to provide backfill during two periods of maternity leave. Staff sickness levels were higher than usual, with two episodes of long-term absence having a disproportionate impact in our small team.

Our senior management team completed a workforce strategy assessment to identify short to medium-term challenges for SMTL workforce planning and service delivery over the next one to three years. The key issues identified were IT resilience, succession planning and reliance on single-handed specialties across departments. We are working with our People and Organisational Development colleagues to mitigate these risks, however the current economic climate may impact development opportunities. Positive staff survey results reflect the work of the senior management team to make SMTL an inclusive and supportive place to work.

SMTL recruited to a vacant post and appointed Dr Rowena Riley as Research and Development (R&D) Officer. This further strengthens our collaboration with Cardiff University School of Medicine, where three SMTL staff contribute as lecturers on the MSc Wound Healing and Tissue Repair course.

2.1.6 Finance

SMTL was able to meet its financial commitments and commercial income was comparable with recent years. SMTL collaborated closely with several Welsh employers which generated approximately 10% of the laboratory income. Pay was under-forecast by design to provide cover for periods of staff sickness.

Financial pressures across the medical device and PPE sectors may reduce spending on research, product development and external testing, which could affect future commercial income. At the same time, SMTL's testing teams are developing new wound dressing and viral/bacterial barrier methods to support testing of new PPE products for NHS Wales contracts. Once established, these methods could also create new commercial opportunities.

2.2 SMTL Quality Assurance

2.2.1 Internal Audits

SMTL operates a rolling program of quality system audits throughout the year. All 15 internal audits were completed on schedule, with no major anomalies identified and all corrective actions completed within the expected timescales.

2.2.2 Quality System Review (QSR)

The Laboratory Director chaired the annual Quality System Review (QSR) in January 2026. The QSR is intended to ensure the laboratory's quality arrangements continue to meet both operational needs and UKAS requirements. Six improvement actions were identified to reduce reliance on legacy IT systems, strengthen resilience, improve laboratory efficiency and tighten control of internal audit schedules.

SMTL received five complaints since the last report. Three complaints were upheld and resolved within the agreed timescales for acknowledgement, formal response and confirmation of satisfaction with remedial action. No further complaints or concerns have been received into SMTL.

In addition to the annual QSR, SMTL's Quality Assurance and Operations Managers chair the monthly Technical Group (TG) and Senior Management Team (SMT) meetings. While these forums cover a wide range of laboratory activities, they consistently review learning from incidents, complaints, and customer feedback. This insight is used to drive service improvement, with actions implemented through the change control process to prevent recurrence.

2.2.3 Risk Register

SMTL has five current risks relating to IT resilience, facilities, workforce and budget. These are actively managed through the SMTL risk register, with mitigating actions in place and regular review through TG and SMT governance arrangements. Facilities incidents are recorded in Datix and NWSSP Specialist Estate Services colleagues are actively monitoring progress on remedial actions. Following mitigation, all risks are currently rated as moderate.

2.2.4 Inter-Laboratory Comparisons and Proficiency Testing Schemes

ISO/IEC 17025 requires laboratories to have procedures to monitor the validity of results. Where available and appropriate, UKAS expects this to include comparison with the performance of other laboratories through proficiency testing (PT) or other inter-laboratory comparisons (ILC). These schemes help laboratories demonstrate technical competence to both customers and the accreditation body.

SMTL participated in several external PT and ILC schemes across biological, physical and environmental testing departments. No anomalous results or corrective actions were identified, demonstrating SMTL's technical competence and strengthening the laboratory's credibility and reputation in medical device testing.

2.2 UKAS Audit 2025

A surveillance assessment of SMTL was carried out by UKAS inspectors in September 2025. Compared with previous years, the audit differed in two notable respects, with a new lead inspector appointed and the inspection was observed by UKAS's new Head of Calibration,

Inspection and Testing. The audit involved rigorous scrutiny, including a thorough review of all aspects of our quality management system and testing capabilities at the Princess of Wales, Bridgend and IP-5, Newport laboratories.

Seven findings were identified during the audit. Two were classified as recommendations, while five require evidence to be submitted to UKAS for closure. All were assessed as low-risk, reflecting the strength of our quality management system and the professionalism and competence of our staff.

The UKAS 2025 Accreditation Report and Schedule of Accreditation are provided in Appendices 1 and 2 respectively. Credential verification is available via [Verify UKAS](#).

2.3 Customer Service Excellence (CSE) Standard Audit

SMTL maintained accreditation with the CSE Standard. An external audit of accreditation took place in September 2025 with no anomalies or outstanding actions recorded.

2.4 ISO 14001 Audit

In preparation for the external audit, NWSSP performed an internal audit of SMTL in preparation with no anomalies or corrective actions identified.

2.5 Client Audits

SMTL have not had any external client audits in the previous 12 months.

3. RECOMMENDATION

The Committee is asked to receive the SMTL Annual Briefing 2025-26, for information only.

Name & Address of Organisation	NHS Wales Shared Services Partnership trading as Surgical Materials Testing Laboratory Princess of Wales Hospital Coity Road Bridgend Mid Glamorgan CF31 1RQ	Type of Assessment	Surveillance
		UKAS Reference Number	5527
		Date(s) of Assessment	10/09/2025-12/09/2025
Assessment Location(s)	Princess of Wales Hospital Coity Road Bridgend Mid Glamorgan CF31 1RQ IP5 Imperial Park Celtic Way Newport NP10 8BE	Project References	313385-02-01
Assessment Standard / Criteria	ISO / IEC 17025:2017 (Testing)	Schedule Issue No(s)	#1492 Iss 034
Name & Role of UKAS Assessment Team	David Phillips (AM / LA ISO 17025(T)17) Lorraine Wadley (TA ISO 17025(T)17) Chris Arthur (TA ISO 17025(T)17)	Date(s) of Assessment Plan	V1 15th July 2025 V2 8th Sept 2025
		No. of (M) Findings: Action Mandatory	5
Name of Organisation Representative(s)	Dr Gavin Hughes Paul Edwards	No. of (M) Findings: Require Evidence to UKAS	5
Report Issued By	David Phillips	No. of (R) Findings: Action Recommended	2
Report Issued Date	24 th Sept 2025	Method of Reviewing Evidence	Remote
Report Acknowledged By		Quote for Reviewing Evidence	0.25 Days CA Quote to follow
Report Acknowledged Date		Agreed Action Completion Date	17 th Oct 2025
Report Acknowledged Method	Return Email	Please return evidence to: Assessment Portal Audit Comply Customer Portal Home - Dashboard	

AREAS SAMPLED AT ASSESSMENT (marked as 'X')			
ORGANISATION		IMPARTIALITY & INTEGRITY	
Legal Status	X	Independence, Impartiality & Integrity	X
Liability Cover (CB / IB only)	N/A	Confidentiality	X
Management of Finances (CB/IB only)	N/A	EVALUATION PROCESSES	
Resources	X	Design & Development of Methods / Schemes	X
Organisation Structure	X	Enquiries, Tenders, Contracts	X
Responsibility & Authority	X	Planning & Resource Allocation	X
MANAGEMENT		Testing	X
Management System Including Documented Policies & Procedures	X	Reports & Certificates	X
Roles & Responsibilities for Quality	X	Decisions / Opinions	X
Control of Documents and Records	X	Certification & Maintenance of Certification (CB only)	N/A
Management of Subcontractors and Purchases	X	TECHNICAL COMPETENCE	
Service to Clients (Test / Cal only)	X	Personnel	X
Handling of Complaints / Appeals / Disputes	X	Methods / Schemes	X
Control of Nonconforming Items Dealing with Corrective & Preventive Actions and Improvements	X	Facilities / Equipment (Test/Cal/IB only) / Environmental conditions (Test/Cal only)	X
Internal Audit and Management Review	X	Assurance of Quality of test / calibration Cooperation (IB only)	X
Supervision & Monitoring of Staff	X	Witnessed Activities	X
Conditions for Granting & Maintaining Certification (CB only)	N/A	*OTHER (specify)	

*Delete as applicable

EXECUTIVE SUMMARY

The laboratory is well established with a mature QMS and this along with well trained staff, appropriate facilities and equipment, with demonstrable support from both laboratory and senior management means the laboratory was able to demonstrate significant compliance with a wide range of the requirements of the accreditation standard. No significant weaknesses were identified, a common theme around the use of unaccredited providers of traceability was seen for some devices, and while classified as low risk given that well known and established providers were used, the laboratory should ensure that where sources of accredited traceability are not available they may wish utilise the guidance in TPS 41 to ensure appropriate traceability is not only established but that it is sourced from competent providers.

All staff witnessed and interviewed were suitably competent, well trained and knowledgeable of the products and the standards for the testing of the products. The laboratories (both Bridgend and Newport) were well laid out with good separation between rooms and appropriate conditions in place where required, with these suitably monitored. A small number of improvement actions and recommendations were raised, however none of the findings raised can be considered a risk to accredited activities and are fairly minor in nature but when actioned will give further improvement to an already significantly compliant laboratory.

The implemented QMS continues to be effective and suitably meet the requirements of the accreditation standard. The implemented QMS is appropriately structured to cover both sites and site-based activity. The implementation of the document control module of the proposed new LIMS has had no discernible impact on conformity of the QMS.

The three level audit process provides extensive coverage and challenge to accredited technical activity and a corresponding high level of confidence in the output from accredited activities. Further underpinning this is the evidence that where non-conformities are identified they are minor in nature and robustly documented, investigated and addressed with appropriate and proportional corrective actions. This allows the laboratory to demonstrate it undertakes accredited activity in a low risk and consistent manner.

The laboratory implements a number of techniques to assure results that are appropriate to the varied nature of the physical and microbiological testing the laboratory is accredited to undertake. A significant internal audit is undertaken on completion of every project for all activity to ensure compliance with QMS requirements and procedures, this provides significant assurance. The laboratory implements suitable intermediate equipment checks, with the data from these checks recorded and suitably analysed.

PT / ILC activity is undertaken in accordance with a defined procedure that includes the use or predetermined requirements such as use of Z scores. Activity is planned using independent plans separate covering all three department, with complaint results achieved. This demonstrates the results from Inter-laboratory testing are suitably analysed and the laboratory implements a comprehensive framework of appropriate techniques to derive significant assure as to the validity of results output from accredited test activities.

As seen in previous assessments, the laboratory demonstrated excellent levels of competence and conformity with the requirements of the accreditation standard and this is being maintained while implementing parts of a new LIMS system within the laboratory. The wider implementation of the LIMS system to cover actual accredited technical activities offers potentially significant compliance and efficiency benefits to the laboratory but this introduction will need to be performed in a thoughtful and controlled manner to ensure the excellent performance demonstrated during the assessment is maintained in the future.

RECOMMENDATION

Accreditation is to be maintained for the technical activities documented within the current schedule of accreditation #1492 Iss 034 subject to the satisfactory discharge of those mandatory findings that require evidence to be supplied within the agreed timescale. For those findings identified as without evidence, then a submission of actions proposed or taken is to be provided on the assessment portal.

Changes to the schedule are outlined in Next Step #3.

This will be subject to ratification by an independent UKAS decision maker.

NEXT STEPS

1. Evidence should be submitted using the assessment portal which contains all improvement actions raised. This can be accessed using the link [Audit Comply Customer Portal | Home - Dashboard](#). A description of the actions taken along with the evidence supplied can be entered for each individual action, along with the option to upload and allocate evidence. Any issues with access or requests for further training material can be logged by emailing PortalSupport@ukas.com.
2. It is expected that the lab will address the findings raised in accordance with their corrective action procedure and/or the procedure for dealing with non-conforming work. Please ensure that an appropriately robust and detailed evaluation of the root cause, impact and extent of the findings raised is included in the assessment portal submission.
3. UKAS to update the schedule of accreditation #1492 Iss 035 with the changes detailed below.

Items in **blue** are additions, those in **red** are removals.

Legal Entity: The ultimate legal entity of Velindre University NHS Trust is to be included on the schedule of accreditation, in addition to the existing organisation information as NHS Wales Shared Services Partnership (NWSSP), which SMTL is part of, is hosted by the above legal entity.

Extensible Bandages

Elastic Properties BS 7505:2025 – Locations B and N

Vaginal Speculums

TM-334 **Location N**

Wound Dressings

Fluid retention Test - TM507 **Location N**

Absorption under Compression – TM508 **Location N**

Free swell absorptive capacity – TM101 **Location N**

Absorbency and fluid retention – TM404 **Location N**

Absorbency under compression - TM-414 **Location N**

Health and Safety Considerations

Relevant risks were considered and shared with the assessment team. There were no significant issues to report. All activities assessed were suitably covered by those detailed in HSE 1005. No additional PPE was required, with laboratory coats supplied to the assessment team when required. A site induction was undertaken covering identified risks and the mitigations .

SCOPE

This assessment was undertaken to confirm the competence and conformity of the QMS and accredited technical activities performed by the laboratory, for testing as detailed in the schedule of accreditation # 1492, Issue 034 to the requirements of ISO / IEC 17025:2017 and UKAS. The structure of the visit was described in the assessment plans below:



2025 SU2 SMTL
5527 Bridgend - New



2025 SU2 SMTL
5527 Bridgend - New

ORGANISATION

In advance of the assessment visit the laboratory shared a summary update document, with this discussed at the opening meeting. There is currently an independent review into hosting arrangements within the Welsh NHS underway, the review has been completed, and the final report has been provided to the Welsh Assembly for consideration. Currently there is no impact on the ultimate legal entity Velindre University NHS Trust, the laboratory will advise if there is to be any changes of legal entity or status.

There are currently three vacancies within the organisation, with these being actively recruited for. In addition, three temporary members of staff are employed, with the laboratory looking to make these permanent appointments. Updates and transition a new LIMS are progressing well, with the QMS document control module now enabled, and the laboratory continues to move towards a full rollout in a graduated manner, replacing the now obsolete Linux system that has extremely limited support.

GENERAL REQUIREMENTS

Impartiality (4.1)

NWSSP intranet contains suitable information and policies regarding impartiality. All staff complete risks to impartiality questionnaires, SOP 139 for impartiality on starting employment, and there is a routine 6-monthly review to remind staff to notify their manager of any changes, this is an automated process and examples of completion relating to the quality assurance function were confirmed. Changes to declarations are reviewed at management meetings on a monthly basis.

There is an appropriate NHS Wales external escalation (whistleblowing) service via NHS speaking safely process. The quality policy within section 2.1 of the QM also contains suitable commitments by laboratory management to operate in an impartial manner. The laboratory is suitably structured to protect impartiality with the Laboratory Director responsible for all activity and is the main conduit between the wider NWSSP organisation, with all reporting lines aligning to the single director and no others to the wider NWSSP organisation. The above framework allows the laboratory to demonstrate it suitably meets the requirements of the accreditation standard.

Confidentiality (4.2)

Section 2.1 of the QM contains appropriate commitments to maintain confidentiality. In addition, there are specific requirements relating to patient confidentiality imposed on patient information that the laboratory may become aware of as part of its day-to-day activity. The QM details suitable arrangements for the release of confidential information, including where it can, or cannot inform the customer of its release as appropriate.

Appropriate access controls are implemented, both physical and IT, and both the current NHS Wales system and the legacy system, utilise appropriate user hierarchy to restrict access, and confidential data stored in these locations that can only be accessed by SMTL personnel, and access permissions to both systems are confirmed by the laboratory. All staff are made aware of confidentiality requirements, and sign Confidentiality Agreement SOP-248, with examples seen suitably completed from both ends of the tenure spectrum, with the oldest over 20 years, and while differing agreements have been used as documents have been updated, they suitably meet the requirements for legally binding agreements.

Overall, an effective framework of measures is implemented to protect confidential information, both commercial and patient, though the laboratory may wish to consider retrospectively implementing the new impartiality / confidentiality agreement framework for staff whose employment start point pre-dates its introduction **Recommendation NC- 1736503.**

STRUCTURAL REQUIREMENTS

Legal Entity (5.1)

Section 4 of the Quality Manual CD-01 confirmed that the SMTL laboratory is part of the NWSSP, who themselves are hosted by Velindre University NHS trust, with the trust being the ultimate legal entity, established by statutory instrument, The Velindre National Health Service Trust (Establishment) Order 1993 legislation and having legal responsibility for NWSSP and SMTL

Defined Part of Legal Entity

Surgical Materials Testing Laboratory (SMTL) – Part of NHS Wales Shared Service Partnership (NWSSP)
Princess of Wales Hospital
Coity Road
Bridgend
Mid Glamorgan
CF31 1RQ

Legal Entity

Velindre University NHS Trust (VUNHST)
Unit 2 Charnwood Court
Parc Nantgarw
Nantgarw
Cardiff
CF15 7QZ

The above aligns with the legal entity details contained in the most up to date F044 UKAS customer agreement signed by the organisation's representative, and the documented legal entity continues to suitably meet the requirements of the accreditation standard. The organisation's representative, who has signed the UKAS customer agreement, is also confirmed as an active director of the above legal entity within the current organisation chart, providing a further link and assurance to the responsibility for accredited activity of the legal entity.

As discussed, and agreed with the laboratory, the ultimate legal entity of Velindre University NHS Trust is to be included on the schedule of accreditation, in addition to the existing organisation information as NHS Wales Shared Services Partnership (NWSSP), which SMTL is part of, is hosted by the above legal entity.

Defined Range of Activities (5.3)

Section 2.2 of the QM details the high-level split between Surgical Material & Medical Devices, with a specific link to the UKAS website and associated published schedule of accreditation. The laboratory maintains a list of issued test methods TMs with an explicit maker for accredited activity to demonstrate appropriate compliance and awareness of the range of activities it is accredited to perform, and evidence of its effective and compliant implementation was provided by the fact that no findings were raised by any assessor covering claims of accreditation or reference to accreditation.

RESOURCE REQUIREMENTS

Personnel (6.2)

Job descriptions for technical manager and physical testing manager are suitably compliant including a person specification. These specifications include detailed roles and responsibilities along with additional authorities and responsibilities documented in section 4.1.6 of the QM and this includes formal deputisations along with approved signatory status in 4.1.5.

The laboratory maintains appropriate training records including objective evidence of competence. Ongoing monitoring is undertaken with 12 months the maximum time to have not completed a test method or participated in test witnessing or PT, where 12 months has elapsed, reauthorisation via one of the above methods is required.

A high-level system for recording and monitoring competence is implemented in the legacy Linux system, with appropriate categories of authorisation, and there are suitable requirements for supervision of staff. In addition, the staff maintain paper-based training records that contain contemporaneous evidence of competence. Initial authorisation is undertaken using sign off against witnessed audits or PT / ILC, with ongoing competence via these methods or audit of a completed project as all completed work is fully audited and records of these audits maintained as evidence of competence. The high-level system also includes reference to version control where methods / SOP is updated, to ensure staff are trained and authorised on the updated methods.

Staff are suitably authorised for the requirements for 5.2.5 and 5.2.6 of the accreditation standard. The implemented processes allow the laboratory to demonstrate an effective and robust system for the authorisation of staff, and ongoing monitoring of competence, with staff demonstrating competence and ability to perform accredited testing during the witnessed assessment process, further validating the framework described above.

Facilities and environmental conditions (6.3)

Section 6 of the QM details appropriate and compliant requirements relating to environmental and facilities requirements for accredited testing, with reference to both accredited sites including ongoing monitoring of ambient conditions applied to testing and incompatible activities. A detailed record of factors and references is included in the QM section. There is a specific section in 6.1.3 of the QM to document controlled laboratory requirements, with further granular detail added in section 6.14 again covering both locations. The same logging system is in place for IP5 Newport and POW Bridgend which can be accessed from either site. Data shows good level of control in line with reported conditions seen throughout.

Section 6.1.5 details a compliant set of access requirements including an authorised personnel list, appropriate requirements for visitor access including confidentiality, this was seen to be effectively implemented during the assessment.

The laboratory documents a set of housekeeping and preventative maintenance tasks within SOP-422 for the Bridgend site and SOP-531 and SOP-533 of the IP5 Newport Site. Suitable records of this activity are maintained and were reviewed demonstrating these activities are up to date and being performed in line with the documented requirements.

The above provides appropriate levels of evidence and assurance that the laboratory maintains appropriate and compliant facilities and environment, which allow for the suitable realisation of the required test methods across both accredited sites and demonstrates suitable compliance with the relevant requirements of the accreditation standard.

Equipment (6.4)

Section 6.2 of the QM contains a suitable and compliant set of requirements including a specific requirement for suspect equipment. Equipment database RT allows for appropriate records to be maintained for all equipment and database includes performance requirements and acceptance criteria. Cal data reviewed for # 585 and seen confirmed on yearly basis and approved against the acceptance criteria as per SOP-032.

SOP-036 contains a suitable set of equipment procedures including use of RT ticket system used for managing equipment issues. QM confirms that section 7.9 non-conforming testing shall be implemented as per SOP-434 and impact and extent are required to be considered and appropriate corrective actions implemented.

Maintenance records are established for critical climatic conditioning equipment including both preventive planning and activity undertaken. RT system also used for asset management. Asset #709 reviewed and seen that it has suitable recall and planning function for periodic activity along with the ability to store records of this and unplanned activity.

All equipment reviewed at both sites were maintained and calibrated to plan, all uniquely labelled with calibration status. Accredited calibration companies are used to provide metrological traceability to national/international standards. Equipment well maintained and suitable for the tests performed, with appropriate maintenance and calibration records established.

All reagents and buffers used in protein extraction are made following recipes documented in the method SOP, well labelled with prepared/expiry date and stored correctly to maintain their integrity.

As below some minor findings relating to source and range of equipment traceability will need to be addressed however these are of very low risk and unlikely to affect the overall result output by accredited activity.

Metrological traceability (6.5)

QM section 6.3 contains a suitable set of requirements for establishing compliant metrological traceability, though linked to the two findings described below, the laboratory may wish to add more explicit guidance as to the requirements to consider when using non-accredited providers of metrological traceability, linked to the requirements of UKAS document TPS 41

Recommendation NC- 1736505.

The vast majority of items and materials used in the performance of accredited test activity had appropriate and compliant traceability established. Two instances of the use of non-traceable / accredited providers of traceability were raised for the BioTeK ELx808 microplate reader and Orbital Agitator (940) is currently used at 30rpm but is calibrated from 50 rpm upwards and is done so by a non-accredited calibration.

Externally provided products and services (6.6)

Supplier authorisation and management are undertaken in accordance a defined procedure SOP-196 that includes a set of supplementary processes covering subcontract of testing and services along with ordering of goods. Initial basis of approval is 9001 certification and / or 17025 accreditation where appropriate. An electronic supplier register is maintained, with supporting records such as certificates and schedule of accreditation maintained, along with complete records of all purchase orders raised.

The register is reviewed by the technical manager and the QA department monthly against all suppliers used in the month along with an overall annual review, suitably meeting the requirements for ongoing evaluation of supplier performance. Any suppliers that are not used in the annual period are highlighted as overdue and requiring completion before use. Selection of calibration suppliers reviewed were all suitably present on the register and evidence of review when used was also maintained. A recent internal audit finding documented the use of suppliers not on the list, this was suitably addressed, and no further instances were observed and the use classified as low risk by the relevant technical assessor.

PROCESS REQUIREMENTS

Review of request, tenders and contracts (7.1)

The laboratory has a robust system in place for establishing contracts using RFW Job Sheets which are used as the contracts, which are completed by the customer and signed by laboratory. This includes the T&Cs, statement of test required and the client's acceptance/signature.

The contract review process used at this laboratory is effective, and comprehensive contract review records are maintained, suitably demonstrating compliance with the requirements of the accreditation standard.

Selection, verification and validation of methods (7.2)

Within physical testing, all the standards listed are currently the latest versions other than the BS 7505 standard which is being updated following this assessment as per the schedule review. Supplementary test methods are well detailed and suitably controlled, and have validation performed where required and appropriate.

Method SOPs now have a section that clearly states the changes made when a new revision is issued. This focusses the user to better check on any technical changes for reference. If training/PT is required after any change this is indicated. The SOP is available and used for reference throughout the analytical stages of the testing to ensure a consistent approach, as evidenced during assessment.

There have been no changes to test methods apart from the buffer change covered below. The method TM 230 follows Annex A of BS EN 455-3:2023. The main change is the buffer now used which had to be changed due to supply issues with TES. Validation report P6989 reviewed to confirm this was performed in 2024 by sourcing different alternative buffers (as allowed by Annex A) and validating six different glove products (powdered and unpowdered), selecting PBS to further investigate for fitness for purpose. Comparative work performed with PBS and previous buffer TES confirmed that PBS-M (Melford) gave concordant results for powder-free gloves.

The above demonstrates the laboratory utilise the most up to date and appropriate methods for testing and undertakes suitable validation of methods in a timely and appropriate manner in compliance with accreditation standard requirements.

Handling of test items (7.4)

There is a key procedure No:042 Sample Handling that covers receipt and storage of samples prior to and during the program of testing which covers submissions from NHS Wales Shared Services Partnership Procurement Sourcing contract testing and from private manufacturers. Some tested are not in their 'final' format as covered in contract specifications.

Samples are delivered to the Bridgend site for booking into system and assigning a PID and project number. There is a SMTL Projects Database that generates the coversheets for the project and worksheet is printed. Conditions for transportation between sites is documented. There are secure locations (Sample Room) at both sites for the storage of products.

There is a section for deviating samples in SOP-42 with examples of departures/abnormalities. The customer does not provide a submission / request form with their products in all cases and the risks from this discussed i.e. how the expected tests are applied, and the report is issued to correct customer. Reassurance provided that all submissions are clearly identifiable and any issues are followed up prior to commencement of testing.

Retention post analysis has a specified time frame to allow for any follow-up after report has been released or if customer wishes products to be returned to them. There is a clear waste disposal policy. Overall, the documented and implemented processes suitably meets the requirements of the accreditation standard.

Technical records (7.5)

Section 7.4 of the QM has an appropriate set of requirements for the creation and maintenance of compliant technical records with all records stored within a unique project folder and identified with the unique project number. The laboratory has established an appropriate and compliant process for the protection of technical records that suitably covers amendments SOP-145 and with retention periods documented in SOP-058.

SOP-058 also contains a suitable process along with explicit authorisation for deletion and disposal of old records. Finally, there is specific guidance and a compliant procedure SOP-077 Data Handling covering calculations undertaken using existing programs / spreadsheets, along with the creation and authorisation process for new items.

Controlled technical worksheets are used to provide full traceability throughout all processes. These are stored on SharePoint and provide an audit trail throughout all processes especially protein extraction of gloves which as listed above has numerous documents. The laboratory maintains suitably detailed and compliant technical records for all activity completed including work sheets for calculations and measurements made along with equipment used and copies of quotes, communications and reports (when completed). Any changes are correctly made so as not to obliterate any data. Locked cells are implemented on spreadsheets/databases to ensure no inadvertent changes are made.

The above demonstrates the laboratory has implemented a compliant and effective system for creation, protection and retrieval of technical records suitably demonstrating compliance with the requirements of the accreditation standard.

Evaluation of Measurement Uncertainty (7.6)

Section 7.5 of the QM documents a compliant set of requirement and policy supported by a supplementary technical procedure SOP-47, confirming that UoM evaluation are undertaken in accordance with accepted M3003 methodology. The procedure includes guidance where the nature of the test methods or samples make evaluation difficult.

The laboratory has established generally appropriate and compliant MOU budgets for the technical activity subject to assessment with these having suitable, however as raised by the technical assessor within the physical testing area, some minor improvements in identification of contributions is required in a very small number of cases.

Ensuring the validity of results (7.7)

Section 7.6 of the QM describes a detailed set of techniques implemented in line with the requirements of the accreditation standard and appropriate to the varied nature of the physical and microbiological testing the laboratory is accredited to undertake.

A significant internal audit is undertaken on completion of every project for all activity to ensure compliance with QMS requirements and procedures, this provides significant assurance. The laboratory implements suitable intermediate equipment checks, with the data from these checks record and suitably analysed.

PT / ILC activity is undertaken in accordance with a defined procedure SOP-160 that include the use or predetermined requirements such as use of Z scores. Activity is planned using independent plans separate covering all three departments.

Reviewed last activity covering physical gloves testing EN455-2:20204 all z scores less than 1 covering various test methods where applicable using appropriate and suitably homogeneous samples. Environmental undertake three-monthly activity through LGC 001 who are an accredited provider to 17043:2023 with good Z scores achieved.

Additional activity was seen within microbiology. Test assurance is performed to the required standard using well established processes. All reference cultures are handled correctly to ensure they maintain their cultural characteristics. New stocks are acceptance checked prior to use.

In addition, a new PT from Argentina has been sourced following interrogation of EPTIS and participated in for gloves covering endotoxin, powder -free and leachable proteins – PT South Quality SAS June. Their provider's report is clear, and they confirm they follow ISO 17043 guidelines which includes homogeneity and statistical result analysis using z-scores. Finally, the laboratory continues to seek further opportunities to participate in PT or ILC activity with other providers.

The above demonstrates the results from Inter-laboratory testing are suitably analysed and the laboratory implements a comprehensive framework of appropriate techniques to derive significant confidence in the validity of results produced by accredited test activity.

Reporting of results (7.8)

Section 7.8 of the QM documents an extensive and compliant set of requirements for the creation of accredited technical reports aligned with details in in SOP-047. The layout / content of the report is listed in the method SOP for clarity and also covers the requirements of ISO/IEC 17025 and GEN 6.

The reports reviewed are clear and unambiguous and provide the customer all the information to interpret their results. Opinions and interpretations are not provided but any deviations from the test method are included as a specific requirement.

There is an amendment process for reports but as there are a number of internal checking processes it is rare that a supplementary report is issued due to laboratory error but usually when customer requests a change in product/batch information. The amended report clearly identifies what the change is for clarity.

Correct use of accreditation symbol (with number) and appropriate format with authorisation by Gavin Hughes. Where necessary and where statements of compliance are being given the lab report the probability of the result in graphical form to explain to the customer the margin of potential error once the Uncertainty of measurement is considered on the test as a binary statement.

There are sufficient authorised personnel who sign and release reports i.e. Laboratory Director or Laboratory Manager/deputy.

- **Amendments to reports (7.8.8)**

Section 7.7.9 of QM contains a compliant set of requirements including update and unique reference to the new version number and documentation of any required changes, through in practice the process is sparingly used.

Complaints (7.9)

The laboratory QM section 7.8 suitably references the handling of complaints with an overarching non-conformance procedure SOP-423. This includes a specific complaints section with the QM detailing suitable authority and responsibility for managing complaints, and for impartiality of outcome. Complaints are recorded and managed in accordance with procedure in JIRA ticket system.

The laboratory has received three complaints, two have been investigated, with only one of these upheld and one investigation underway.

CON-07 – Wrong calculation option used large aperture not small aperture. Suitably investigated and detailed outcome documented. New code for smaller aperture created and updated procedure to ensure correct use. Appropriately cleared, though as raised in section 8.7 of the report, evidence relating to the consideration of any wider impact and extent was not available at the time of assessment.

CON-08 – Related to equipment purchased, not accredited, currently being investigated but suitably recorded and managed.

CON-09 – Incorrect standard used. RFW supplied to laboratory, and the basis of testing required an older version, customer insisted it had asked for newer version. Suitably rejected as customer had agreed to the old version as part of the contract review process – Not upheld and suitably detailed records of complaint and investigation maintained.

The above demonstrate the laboratory implements a compliant process for managing complaints, and suitably records and addresses complaints where received, though the laboratory will need to ensure evidence of all activity relating to complaints is suitably maintained.

Nonconforming work (7.10)

Identified non-conforming work is handled in accordance with procedure SO-423. The process utilises the JIRA ticket system, with instances recorded and suitably managed within the system including maintenance of appropriate evidence. The laboratory has established a compliant procedure which includes responsibility and authorities for managing NCR, actions based on risks, impact evaluation, acceptability, notification, resumption authority.

One instance of nonconforming work relating to complaint CON-07 and the use of an incorrect aperture size was recorded, suitably addressed and subject to appropriate corrective and preventative action as required by the accreditation standard, though as raised in section 8.7 of the report, evidence relating to the consideration of any wider impact and extent was not available at the time of assessment.

Control of data and information management (7.11)

The current Linux system is being phased out with a new NHS LIMS system being evaluated, with the laboratory checking that this is fit for purpose before fully implementing. Current system meets the requirements of the standard. All project folders are scanned for safe storage; records are maintained securely. Overall data is very well managed with numerous checks which also provides impartiality to the whole process.

MANAGEMENT SYSTEM REQUIREMENTS

Options (8.1)

The laboratory system is structured around Option A and is to be assessed against Option A.

Management system documentation (8.2)

The Laboratory has established an appropriate and compliant QMS consisting of high-level quality policy and quality manual and a detailed set of supplementary quality and technical procedures / SOPs along with suitably controlled forms and worksheets. The established QMS also covers the laboratory's multi-site operation allowing for alignment in methods and processes where possible and also suitable divergence where required, and the established procedures include areas such as transfer and handling of samples between sites.

The laboratory has recently implemented the document management module of the proposed new LIMS, with documents reviewed and updated as required, demonstrating solid commitment to continuously improve the management system. Despite the changes to the structure and control mechanism of the QMS, all documentation, processes, systems, records, related to the fulfilment of the requirements of the accreditation standard were included in, referenced from, or linked to the management system, and these were readily available to staff as appropriate, and at both main sites where accredited activity takes place.

Control of management system documents (8.3)

There is an appropriate process for document control including authorisation of documents and handling of obsolete documents within the QM, with this process now having been transferred to the document control module of the proposed new LIMS system.

Backstop of 3 years for Test Methods and Standard Operating Procedures for review and update, though the laboratory also utilises change driven events which is managed using a change note record which can be implemented when necessary. Documents are being moved over to new system. Many have transitioned across to the new database i.e. method SOPs as reviewed and equipment records.

Actions to address risks and opportunities (8.5)

As Documented in QM section 8.4 risks and opportunities are identified from various sources including customer feedback, internal audits, complaints and management review with these deposited into a register, and this register used to review and agree next steps. Improvements are considered and where selected for implementation, these managed and controlled using the register with dates and responsibilities assigned, or if no further action is taken the rationale behind that decision is documented. Any risks are scored based on impact and extent and this score is then reevaluated when mitigations have been implemented to demonstrate the reduction in risk, impact and extent, and hence the effectiveness of the implemented mitigation. The above process suitably meets the requirements of the accreditation standard.

Improvement (8.6)

Feedback from a customer (8.6.2)

Feedback is undertaken in accordance with a defined procedure SOP 388 and requested for all customers on a monthly basis where the customer have been active. Contemporary evidence of the sending of requests and the feedback received is suitably maintained and analysed. Feedback is recorded and discussed at the monthly management meeting and used as opportunity for improvement, with all received feedback recorded and discussed.

31 requests for feedback in the last twelve months. Last review July 2025 with feedback exclusively positive. The process of requesting feedback, and the receipt and analysis of feedback, along with the opportunity for improvement it provides is suitably handled in a compliance with the requirements of the accreditation standard.

Corrective actions (8.7)

Section 8.6 of the QM requires appropriate corrective action to be implemented without delay, and this is handled in accordance with procedure SO-423. The process utilises the JIRA ticket system, with actions recorded and suitably managed within the system including maintenance of appropriate evidence, including review of the effectiveness of implement actions.

While the process is suitably compliant, the laboratory could not provide records confirming that the impact of the identified non-conformance referenced in complaint CON-07 on all other previously completed testing was considered and addressed **Finding NC- 1736502**.

Internal audits (8.8)

Section 8.7 Internal Audits within the QM contains suitable requirements to audit activity on three levels covering system, witnessed technical audits and project audits. The laboratory maintains suitable audit plans covering both system and technical audits, with these seen to be up to date.

Example of audit covering Equipment Dec 2024 AUD-09, suitably recorded and minor actions raised and suitably closed out, includes confirmation of the effectiveness of the charges.

Aud-16 Suppliers – Three suppliers not on supplier's register, confirmed as added to the list and all purchases are checked on a monthly basis so impact and extent covered.

Finally, the laboratory internally audits every project on completion and before release to the customer time. In terms of witnessing these are conducted every 2 years and if staff haven't performed a test in 12 months, they have to perform a PT to ensure on-going competence and conformance with internal processes and the accreditation standard.

The three level audit process provide extensive coverage and challenge to accredited technical activity and a corresponding high level of confidence in the output from accredited activities. Further underpinning this is the evidence that where non-conformities are identified they are minor and robustly documented, investigated and addressed with appropriate and proportional corrective actions. This allows the laboratory to demonstrate it undertakes accredited activity in a low risk and consistent manner suitably meets the requirements of the accreditation standard.

Management Reviews (8.9)

The laboratory undertakes a compliant and effective management review process as the SMTL quality system review. The last activity was completed on the 30th of January 2025 with appropriate attendance / representation by senior management and departmental leaders.

Management review is undertaken in accordance with a defined and controlled minutes template and any actions and decisions arising from the meeting are suitably recorded with responsibilities and agreed action dates, and suitable contemporaneous minutes were maintained for the above activity.

In addition to the formal annual review, there is a supplementary monthly management review meeting where actions raised are considered on an ongoing basis. The above demonstrates the laboratory undertakes a suitably compliant management review process that meet accreditation standard requirements.

EVALUATION PROCESSES - TECHNICAL ACTIVITIES

Technical Assessors Report – Chris Arthur – Physical Testing

Detailed in the Assessors Report embedded below is the evidence of competence and conformity from technical evaluation process.



2025 SU2 SMTL
5527 Bridgend - New

Technical Assessors Report – Lorraine Wadley - Microbiological

Detailed in the Assessors Report embedded below is the evidence of competence and conformity from technical evaluation process.



2025 SU2 SMTL
5527 Bridgend - New

References

- ISO/IEC 17025:2017 General requirements for the competence of testing and calibration laboratories.

Relevant Publications

Accreditation Logo & Symbols. The National Accreditation Logo and Symbols: conditions for use by UKAS and UKAS accredited organisations. (Feb 2024)

[National accreditation logo and symbols: conditions for use \(www.gov.uk\)](http://www.gov.uk)

M3003 - The Expression of Uncertainty and Confidence in Measurement (Edition 5, October 2022)

[M3003 Expression of Uncertainty and Confidence in Measurement \(ukas.com\)](http://ukas.com)

GEN 4 - UKAS Policy and General Guidance on the Implementation and Management of Flexible Scopes of Accreditation (Edition 1, October 2019)

[GEN 4 UKAS Policy on Flexible Scopes \(ukas.com\)](http://ukas.com)

GEN 6 – Reference to Accreditation and Multilateral Recognition Signatory Status by UKAS Accredited Bodies (Edition 2, December 2022)

[GEN 6 Reference to Accreditation \(ukas.com\)](http://ukas.com)

ILAC-G8:09/2019 - Guidelines on Decision Rules and Statements of Conformity

[Publications - UKAS \(ukas.com\)](http://ukas.com)

ILAC-17:01/2021 - ILAC Guidelines for Measurement Uncertainty in Testing

[Publications - UKAS \(ukas.com\)](http://ukas.com)

Laboratory Related Publications

LAB 5 - Reporting calibration results (Edition 5, January 2025)

[LAB 5 Reporting Calibration Results \(ukas.com\)](http://ukas.com)

LAB 12 - The expression of Uncertainty in Testing (Edition 4, April 2022)

[LAB 12 Expression of Uncertainty in Testing \(ukas.com\)](http://ukas.com)

LAB 13 - UKAS Guidance on the Application of ISO/IEC 17025:2017 Dealing with Expressions of Opinions and Interpretations (Edition 4 November 2022)

[LAB 13 Opinions and Interpretations \(ukas.com\)](http://ukas.com)

LAB 14 - Guidance on the calibration of weighing machines used in testing and calibration laboratories (Edition 7 November 2022)

[LAB 14 Calibration of weighing machines \(ukas.com\)](http://ukas.com)

LAB 15 - Traceability: Volumetric Apparatus (Edition 5, Dec 2023)

[LAB 15 Traceability - Volumetric Apparatus \(ukas.com\)](http://ukas.com)

LAB 48 - Decision Rules and Statements of Conformity (Edition 5 July 2024)

[LAB 48 Decision Rules and Statements of Conformity \(ukas.com\)](http://ukas.com)

TPS Publications

TPS37 - Simplified Test Reports (Edition 5, October 2020)

[TPS 37 Simplified Test Reports \(ukas.com\)](#)

TPS 41 - UKAS Policy on Traceability of Measurement. (Edition 6, December 2022)

[TPS 41 UKAS Policy on Metrological Traceability \(ukas.com\)](#)

TPS 47 UKAS Policy on Participation in Proficiency Testing (Edition 5, January 2023)

[TPS 47 UKAS Policy on Participation in Proficiency Testing \(ukas.com\)](#)

TPS 57 UKAS Policy on Selection and Use of Reference Materials (Edition 5, Dec 2023)

[TPS 57 Use of Reference Materials \(ukas.com\)](#)

TPS 63 UKAS Policy on Deviating Samples (Edition 3, August 2023)

[TPS 63 UKAS Policy on Deviating Samples \(ukas.com\)](#)

TPS 68 UKAS Policy on Accreditation of Infrequently Performed Conformity Assessment Activities (Edition 2, Jun 2020)

[TPS 68 Infrequently Performed Activities \(ukas.com\)](#)

Appendices (Embedded)

Cause and Extent
-Guidance.pdf

END OF REPORT

Schedule of Accreditation

issued by

United Kingdom Accreditation Service

2 Pine Trees, Chertsey Lane, Staines-upon-Thames, TW18 3HR, UK

 1492 Accredited to ISO/IEC 17025:2017	Velindre University NHS Trust Hosting NHS Wales Shared Services Partnership and operating as Surgical Materials Testing Laboratory (SMTL) Issue No: 036 Issue date: 21 November 2025	
	Princess of Wales Hospital Coity Road Bridgend South Wales CF31 1RQ	Contact: Dr Gavin Hughes Tel: +44 (0)1656 752820 Fax: +44 (0)1656 752830 E-Mail: smtl.info@wales.nhs.uk Website: https://nwssp.nhs.wales/ourservices/smtl/
Testing performed by the Organisation at the locations specified		

Locations covered by the organisation and their relevant activities

Laboratory locations:

Location details	Activity	Location code
Address Princess of Wales Hospital Coity Road Bridgend Mid Glamorgan CF31 1RQ Local contact Dr Gavin Hughes Tel: +44 (0)1656 752820 Fax: +44 (0)1656 752830 Email: smtl.info@wales.nhs.uk Website: https://nwssp.nhs.wales/ourservices/smtl/	<u>Surgical Materials & Medical Devices:</u> Physical Mechanical Safety Health and Hygiene	B
Address IP5 Imperial Park Celtic Way Newport NP10 8BE Local contact Dr Gavin Hughes Tel: +44 (0)1656 752820 Fax: +44 (0)1656 752830 Email: smtl.info@wales.nhs.uk Website: https://nwssp.nhs.wales/ourservices/smtl/	<u>Surgical Materials & Medical Devices:</u> Physical Health and Hygiene	N

Site activities performed away from the locations listed above:

Location details	Activity	Location code
Controlled Clean Rooms Local contact Dr Gavin Hughes Tel: +44 (0)1656 752820 Fax: +44 (0)1656 752830 Email: smtl.info@wales.nhs.uk Website: https://nwssp.nhs.wales/ourservices/smtl/	Classification of Air Cleanliness Active Air and Surface Microbiological Monitoring	S1



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Issue No: 036 Issue date: 21 November 2025

Testing performed by the Organisation at the locations specified

DETAIL OF ACCREDITATION

Materials/Products tested	Type of test/Properties measured/Range of measurement	Standard specifications/ Equipment/Techniques used	Location Code
EXTENSIBLE BANDAGES	<u>Physical Testing</u> Elastic properties	BS 7505:2025 BS 7505:1995 (on unwashed samples) TM-393	B, N
MEDICAL SPECIMEN CONTAINERS FOR MICROBIOLOGY	<u>Safety Testing</u> Leak testing	BS EN ISO 6717:2021 Annex C TM-18	B
COMPRESSION HOSIERY	<u>Physical Testing</u> Graduated Compression Hosiery, Anti-Embolism Hosiery and Graduated Support Hosiery – Compression, durability and stiffness	BS 661210:2018 +a1:2022 TM-487	B, N
MEDICAL DEVICES (GENERAL)	<u>Safety Testing</u> Endotoxin testing by quantitative kinetic turbidimetric method	British & European Pharmacopoeia Bacterial Endotoxin Test USP Transfusion and Infusion Assemblies and Similar Medical Devices TM-254 including RO water	B
Samples types including Gowns	<u>Health and Hygiene</u> Estimation of bioburden	BS EN ISO 11737-1:2018 TM-345	B, N
VAGINAL SPECULUMS	Speculum Break Testing	Documented In-House Method TM-334	B, N



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Issue No: 036 **Issue date:** 21 November 2025

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Materials/Products tested	Type of test/Properties measured/Range of measurement	Standard specifications/ Equipment/Techniques used	Location Code
MEDICAL GLOVES	<u>Biological Testing</u>		
	Extractable Protein	BS EN 455-3:2023 Annex A TM-230	B
	Determination of Removable Surface Powder	BS EN 455-3:2023 Section 5.2	B
		BS EN ISO 21171:2006 TM-391	B
	Endotoxins	BS EN 455-3:2023 Section 5.1	B
		European Pharmacopoeia TM-254	B
	<u>Physical Testing</u>		
	Dimensions	BS EN 455-2: 2024 TM-343	B, N
	Labelling	BS EN 455-2: 2024 & BS EN 455-3:2023 TM-392	B, N
	Perforations	BS EN 455-1:2020 +A1 :2022 TM-22	B, N
	Force at Break	BS EN 455-2:2024 TM-342	B, N



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Materials/Products tested	Type of test/Properties measured/Range of measurement	Standard specifications/ Equipment/Techniques used	Location Code
WOUND DRESSINGS	<u>Physical Testing</u>		
	Free swell absorptive capacity	BS EN 13726:2023 Annex B TM-507	B, N
	Fluid retention capacity	BS EN 13726:2023 Annex C TM-507	B, N
	Absorption under compression	BS EN 13726:2023 Annex D TM-508	B, N
	Fluid Handling Capacity	BS EN 13726:2023 Annex E & N TM-509	B
	Fluid donation of amorphous hydrogel dressings	BS EN 13726:2023 Annex F TM-510	B
	Dispersion characteristics of gelling dressings	BS EN 13726:2023 Annex G TM-511	B
	Moisture vapour transmission rate of a wound dressing when in contact with vapour	BS EN 13726:2023 Annex H TM-512	B
	Moisture vapour transmission rate of a wound dressing when in contact with liquid	BS EN 13726:2023 Annex I TM-512	B
	Waterproofness	BS EN 13726:2023 Annex J TM-513	B, N
	Extensibility and permanent set	BS EN 13726:2023 Annex K TM-514	B



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Materials/Products tested	Type of test/Properties measured/Range of measurement	Standard specifications/ Equipment/Techniques used	Location Code
WOUND DRESSINGS (cont'd)	<u>Physical Testing</u> (cont'd)		
	Air Expulsion for Fluid Handling Capacity Testing	BS EN 13726:2023 Annex O TM-500	B
	Adhesiveness	BP 1993, Vol 2, App XX H, Test 1	B
		BP 1993, Addendum 1996, App XX H, Test 1 TM-186	B
		BP 1993, Vol 2, App XX H, Test 2 TM-175	B
	Dispersion characteristics	BS EN 13726-1:2002 Section 3.6 TM-112	B
	Dispersion/solubility of hydrogel dressings	BS EN 13726-1:2002 Section 3.7 TM-116	B
	Free swell absorptive capacity	BS EN 13726-1:2002 Section 3.2 TM-101	B , N
	Fluid handling capacity	BS EN 13726-1:2002 Section 3.3 TM-390	B
	Absorbency and fluid retention	Documented In-House Method TM-404	B , N
	Absorbency under compression	Documented In-House Method TM-414	B , N
	Fluid affinity of amorphous hydrogels	BS EN 13726-1:2002 Section 3.4 TM-238	B



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Materials/Products tested	Type of test/Properties measured/Range of measurement	Standard specifications/ Equipment/Techniques used	Location Code
WOUND DRESSINGS (cont'd)	<u>Physical Testing</u> (cont'd)		
	Conformability for primary wound dressings	BS EN 13726-4:2003 TM-396	B
	Moisture vapour transmission of Permeable Film Dressings	BS EN 13726-2: 2002 TM-394	B
	Waterproofness	BS EN 13726-3: 2003 TM-395	B, N
	<u>Biological Testing</u>		
	Test for Bacterial Penetration of Film Dressings	Documented In-House Method TM-43	B , N
URETHRAL CATHETERS	<u>Health and Hygiene</u>		
	Surface finish	BS EN ISO 20696:2018 Section 5.4 TM-309	B
	Dimensions	BS EN ISO 20696:2018 Section 5.5 TM-300	B
	Strength	BS EN ISO 20696:2018 Section 6.1 Annex A TM-301	B
	Connector security	BS EN ISO 20696:2018 Section 6.2 Annex B TM-302	B
	Occlusion of drainage eyes and leakage from balloons	BS EN ISO 20696:2018 Section 6.3 Annex C TM-303	B
	Balloon recovery volume	BS EN ISO 20696:2018 Sections 6.4.2 Annex D TM-304	B



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Testing performed by the Organisation at the locations specified

Materials/Products tested	Type of test/Properties measured/Range of measurement	Standard specifications/ Equipment/Techniques used	Location Code
URETHRAL CATHETERS (cont'd)	<u>Health and Hygiene</u> (cont'd)		
	Flow rate	BS EN ISO 20696:2018 Section 6.5 Annex E TM-305	B
	Symbols and labelling	BS EN ISO 20696:2018 Sections 5.5, 7.2, 7.3 TM-308	B
URINE COLLECTION BAGS	<u>Health and Hygiene</u>		
	Physical, mechanical: Rated and test Volume	BS EN ISO 8669-2:1997: Section 6.1 TM-286 & TM-297	B, N
	Freedom from leakage without load	BS EN ISO 8669-2:1997: Section 6.2 TM-287	B, N
	Freedom from leakage under load	BS EN ISO 8669-2:1997: Section 6.3 TM-288	B, N
	Freedom from leakage under impact	BS EN ISO 8669-2:1997: Section 6.4 TM-289	B, N
	Non-return valve	BS EN ISO 8669-2:1997: Section 6.5 TM-290	B, N
	Strength of attachment systems of bags provided with cutouts	BS EN ISO 8669-2:1997: Section 6.6 TM-291	B, N
	Strength of attachment systems of bags provided with button and buttonhole systems	BS EN ISO 8669-2:1997: Section 6.7 TM-292	B, N
	Strength of integral suspensory systems	BS EN ISO 8669-2:1997: Section 6.8 TM-293	B, N



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Materials/Products tested	Type of test/Properties measured/Range of measurement	Standard specifications/ Equipment/Techniques used	Location Code
URINE COLLECTION BAGS (cont'd) Disposable Pulp Products	<u>Health and Hygiene</u> (cont'd)		
	Strength of attachment of the inlet tubing	BS EN ISO 8669-2:1997: Section 6.9 TM-294	B, N
	Pressure/time required to initiate flow into the bags and filling rate	BS EN ISO 8669-2:1997: Section 6.10 TM-295	B, N
	Dimensions	BS EN ISO 8669-2:1997: Annex A TM-296	B, N
	Water retention tests	PAS 29:1999 TM:491	B, N
	Maceration Test	PAS 29:1999 TM-492	B
CONTROLLED CLEAN ROOMS	<u>Physical Testing</u>		
	Classification of air cleanliness	BS EN ISO 14644-1:2015 and current GMP guidance TM-266	S1
	<u>Health and Hygiene</u>		
	Active air and surface microbiological monitoring	Documented In-House Method, TM-354, based on current GMP guidance	S1
FLUIDS	Total Viable Count by filtration or spread plate method of Fluid Samples (potable and process water, aqueous solutions and liquids or powders reconstituted in water or aqueous diluents only)	Documented In-House Method, TM-372	B, N
END			