# National Safety Standards for Invasive Procedures (NatSSIPS) and Local Safety Standards for Invasive Surgical Procedures (LocSSIPs)

## Final Internal Audit Report

## 2025/26

## Swansea Bay University Health Board

Reasonable Assurance

**Contents**



| | |
|---|---|
| Review Reference | SBU-2526-13 |
| Fieldwork | February 2025 - May 2026 |
| Executive Sign Off | 29 June 2026 |
| Audit Committee | 16 July 2026 |
| Executive Lead | Raj Krishnan, Interim Executive Medical Director |
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# Executive Summary

## Purpose

To review the mechanisms in place within Swansea Bay University Health Board (the 'health board') to ensure compliance with the required clinical procedures in relation to National Safety Standards for Invasive Procedures (NatSSIPS) and Local Safety Standards for Invasive Surgical Procedures (LocSSIPs).

## Overview

The National Safety Standards for Invasive Procedures (NatSSIPs) were introduced to support safer care and reduce patient safety incidents, particularly those where surgical Never Events may occur. Organisations are required to implement LocSSIPs, tailored to local practice, to ensure consistent application of these principles.

Updated standards (NatSSIPs2) were published in January 2023, placing greater emphasis on proportionate processes, standardisation, and learning, while avoiding unnecessary complexity.

We have concluded **reasonable** assurance in this area. The Health Board has established key elements of a sound control framework, including well-embedded procedural safety checks within Theatres, governance arrangements supporting the development and oversight of LocSSIPs, and established processes for audit, training, and incident investigation.

In particular, the WHO Surgical Safety Checklist is fully embedded within the Theatre Operating Management System (TOMS), with strong compliance and system-based controls providing assurance over key procedural stages.

However, while arrangements are in place, they are not consistently applied or fully embedded across all elements of the framework. Opportunities remain to strengthen clarity, consistency, oversight, and the embedding of learning to support full alignment with NatSSIPs2 and maximise patient safety assurance.

The matters requiring management attention include:

- Gaps in detailed LocSSIP documentation, including clarity of controls, governance expectations, and supporting documentation, limit full alignment with NatSSIPs2 and may result in variation in application.
- While a range of training mechanisms are in place, the absence of a formal, mandated, and consistently monitored training framework limits assurance over staff competence and consistency of practice.
- Although a comprehensive audit programme is established, variation in coverage, and limited thematic analysis and use of audit outputs reduce its effectiveness in providing assurance and driving improvement.
- Key documentations supporting Never Event management were not accessible via the intranet at the time of review, limiting staff awareness of and access to essential guidance.
- While incidents are investigated and learning is identified, actions are not always consistently implemented, monitored, and formally closed, limiting assurance that learning is fully embedded and sustained.

## Scope and Limitations

This review focused on arrangements for NatSSIPs and LocSSIPs within Theatres, rather than across the wider health board. Despite this limitation, consideration should be given to the applicability of the findings included at this report to other areas undertaking invasive procedures across the health board.

Full details of matters arising, together with management actions and implementation plans, are detailed within the Findings & Agreed Action Plan.

## Scope & Assurance Summary

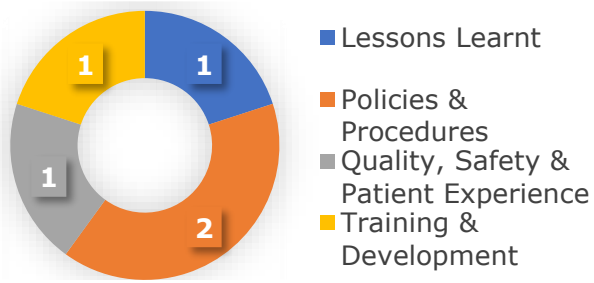
| | Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.) | Related Findings | Assurance |
|---|---|---|---|
| 1 | The processes for developing, approving, reviewing and standardising procedural checklists, LocSSIPs, or standard operating procedures are effective, in line with NAtSSIPs2, and ensure that required safety standards are applied consistently across services. | 1 | **Reasonable** |
| 2 | Roles, responsibilities and expectations for staff involved in invasive procedures are clearly defined, communicated and embedded to support safe and compliant procedural practice. | 1, 2 | **Reasonable** |
| 3 | Procedural checklists are used consistently and appropriately within theatres and other invasive procedure settings, with clear evidence of completion, sign -off, and effective team communication practices. | - | **Reasonable** |
| 4 | Oversight, monitoring and audit arrangements are in place to assess compliance with checklist use, identifying areas for improvement, and support continuous improvement. | 3 | **Reasonable** |
| 5 | Procedural checklist usage is routinely incorporated into investigations of incidents, including Never Events, with learning effectively captured, shared, and acted upon to reduce recurrence and strengthen organisational safety. | 4, 5 | **Reasonable** |

### Management Actions

**0** High Priority

**5** Medium Priority

### Themes




### Risk Types

Quality or Safety Issues

Legal & Regulatory Non-Compliance

Public Perception & Reputational Risk

# At a Glance: Key LocSSIP Requirements (aligned to NatSSIPs2)

The table below summarises the key NatSSIPs2 requirements as reflected within LocSSIPs, highlighting the core safety checks expected at each stage of the patient pathway and the key areas for assurance.

| LocSSIP | Area | Key Requirement | Focus for Assurance |
|---|---|---|---|
| 1 | Consent, Procedural Verification and Site Marking | Valid consent must be confirmed and the correct procedure site clearly marked and visible to the team, particularly where there is potential for variation (e.g. side or multiple sites). | Clarity and completeness of consent documentation and consistent application of site marking. |
| 2 | Team Brief | A multidisciplinary team brief should be undertaken prior to procedures to confirm roles, identify risks, and ensure shared understanding of the patient, procedure, and operating environment. | Effective team communication, engagement of all staff, and clear understanding of roles and risks. |
| 3 | Sign In | Prior to anaesthesia, checks must be completed using a structured process to confirm patient identity, consent, procedure details, and readiness, with active involvement of the patient where appropriate. | Robust patient identification and consistent completion of pre-procedure safety checks. |
| 4 | Time Out | Immediately before the procedure, the full team must pause to confirm key safety information, including patient, procedure, site, and any anticipated risks or critical steps. | Active team participation, leadership oversight, and consistency of final safety verification. |
| 5 | Implant Verification | Implants must be verified prior to use, including confirmation of type, size, sterility, expiry, and compatibility, to ensure the correct device is selected and safely used. | Reliable verification processes, clear documentation, and minimisation of risk of implant error. |
| 6 | Prevention of Retained Foreign Objects | Clear processes must be in place to account for all items used during procedures, including appropriate counting and reconciliation, with proportionate checks based on procedure risk. | Effective counting processes, reconciliation of items, and safe handover of responsibility. |
| 7 | Sign Out | At the end of the procedure, checks must be completed to confirm outcomes, ensure accurate documentation, and identify any issues prior to transfer of care. | Completion of post-procedure checks and clear communication at transfer of care. |
| 8 | Handover / Debrief | Structured handover and debrief processes should support safe transfer of care, enable reflection on performance, and promote shared learning and continuous improvement. | Effective communication, continuity of care, and capture and application of learning. |

# Findings & Agreed Action Plan

| **Objective 1:** The processes for developing, approving, reviewing and standardising procedural checklists, LocSSIPs, or standard operating procedures are effective, in line with NAtSSIPs2, and ensure that required safety standards are applied consistently across services. | **Reasonable** |
|---|---|

Following the publication of NatSSIPs2 in January 2023, the health board established a Task and Finish Group to update its LocSSIPs (see 'At A Glance', page 3, for a summary of the updated Standards). The group, chaired by the Deputy Group Medical Director (Morriston Cardiac), included representation from anaesthetics, theatre nursing, and quality and safety, and undertook a review across eight areas of the standards.

The review of LocSSIPs was completed in June 2023, with subsequent approval by both the Clinical Outcomes and Effectiveness Group (COEG) and the Patient Safety and Clinical Governance Group (PSCG) in July 2023. We were advised that the standards were published on COIN, the health board's intranet site, in September 2023 to facilitate access for health board staff. However, at the date of fieldwork, our review of the theatre-related documentation identified four dated 2022, indicating that they had not been updated to reflect the revised standards (see **Key Finding 1**). While these documents were not all within the direct remit of Theatres, their presence within the wider set of theatre-related documentation reduces clarity and may impact the consistent application of the updated standards.

We note that the Theatre LocSSIPs are scheduled for review in 2026, in line with the health board's three-year policy review cycle.

Overall, our review indicates that Theatre LocSSIPs are broadly aligned with NatSSIPs 2 requirements. However, gaps and omissions were identified across six LocSSIPs, primarily relating to: incomplete articulation of key safety controls (including consent, site marking and verification practices); insufficient clarity and consistency within team brief and governance expectations; the need to strengthen documentation and how procedures are applied in practice (particularly in implant verification and retained foreign object prevention); and opportunities to further enhance auditability and learning through improved sign-out and structured handover/debrief processes. These areas require further development to ensure full compliance and consistent application of standards (see **Key Finding 1**).

| Key Findings | | Risk & Impact | Agreed Management Action |
|---|---|---|---|
| 1 | **Alignment of LocSSIPs with NatSSIPs2**<br><br>Appropriate arrangements were established to review and update LocSSIPs following the introduction of NatSSIPs2, and Theatre LocSSIPs provide a broadly effective framework with core safety requirements in place.<br><br>However, full alignment has not been achieved. Some LocSSIPs require strengthening to improve the clarity and consistency of key controls, governance expectations, and supporting documentation, alongside inconsistencies in document currency and accessibility.<br><br>As a result, there is a risk of variation in how procedures are applied in practice and reduced assurance over compliance with NatSSIPs2. Further refinement is required to support consistent application and full alignment with national standards. | Inconsistent application of safety procedures, potentially increasing the likelihood of patient safety incidents and harm. | **Agreed Action:**<br><br>1. Undertake a comprehensive review of all theatre LocSSIPs to ensure full alignment with NatSSIPs2, including clear articulation of safety-critical steps (consent, site marking, implant verification, RFO prevention). In doing so, introduce a standardised LocSSIP template to ensure consistency across sites.<br>2. Strengthen version control and review processes, ensuring all document safe current and accessible, Outdate or duplicate documentation removed.<br>3. Ensure that revised LocSSIPs are brought to the attention of all staff,<br><br>**Expected Evidence of Implementation:**<br><br>1. Updated and approved LocSSIP documents demonstrating full alignment with NatSSIPs2 in a simple template format.<br>2. Version control and governance approval records<br>3. Copies of communication to all relevant staff groups outlining updates and confirming where revised documents can be found. |
| | | **Medium Priority** | **Officer:** Head of Nursing (Theatres)<br><br>**Target Implementation Date:** 31 March 2027 |
| | **Theme:** Policies & Procedures | Control Design | |

| **Objective 2:** Roles, responsibilities and expectations for staff involved in invasive procedures are clearly defined, communicated and embedded to support safe and compliant procedural practice. | **Reasonable** |
|---|---|

**Roles and Responsibilities**

Roles and responsibilities are documented within the Theatre LocSSIPs, with defined expectations at both operational and task level, setting out accountability for key activities. However, our review noted that clarity is not consistent across all documents. In some instances, roles are described in generic or collective terms, with reliance on shared accountability. There is also occasional use of cross referencing (e.g. 'as above') rather than clearly restating responsibilities.

While these arrangements provide a baseline level of governance, further refinement is required to ensure roles and responsibilities are clearly and consistently articulated, supporting accountability and reducing the risk of ambiguity in practice (see **Key Finding 1**).

**Training**

NatSSIPS2 do not prescribe detailed training requirements but state that teams should be trained in safety behaviours and practices, supported by appropriate systems and professional bodies. At present, the health board does not have a formal or mandated approach to NatSSIPs-related training for relevant staff.

The Surgical Training Team is currently developing a database to capture nursing competencies from ESR to improve oversight of compliance with training requirements; however, this is not yet operational.

Existing arrangements include induction workbooks, which cover key elements of the World Health Organization (WHO) Surgical Safety Checklist - primarily Sign-In (LocSSIP 3), Team Brief (LocSSIP 4), and Sign-Out (LocSSIP 7) (see 'At A Glance', page 3, for further detail) - and require staff to confirm they have read all LocSSIPs. In addition, monthly audit days and training sessions are delivered across sites, alongside quarterly multidisciplinary 'Joint Audit Days'. While these provide valuable opportunities for learning, delivery is not standardised and attendance can be constrained by operational pressures, resulting in variability across sites.

We note that a proposal to implement a mandatory theatre safety e-learning module has progressed through governance routes and has been identified as a key learning point following a recent Serious Incident. (See **Key Finding 2**).

| Key Findings | | Risk & Impact | Agreed Management Action |
|---|---|---|---|
| 2 | **Formalisation and Consistency of LocSSIPs Training Arrangements**<br><br>While a range of training and learning opportunities are in place across Theatres services, the health board does not currently have a formal, mandated or consistently monitored framework to ensure all relevant staff are appropriately trained in NatSSIPs/LocSSIPs requirements.<br><br>Training is delivered through a combination of induction, audit days, and multidisciplinary sessions; however, these arrangements vary across sites and are not consistently recorded or assured. Although the need for a standardised approach has been recognised, this has not yet been fully embedded.<br><br>As a result, there is there is limited organisational oversight of staff competence in relation to invasive procedure safety standards, and a reliance on locally delivered and variably applied training approaches increases the risk of variation in the understanding and application of key safety practices. | Risk of variation in staff understanding and application of critical safety practices, potentially reducing consistency and assurance over compliance with NatSSIPs2. | **Agreed Action:**<br><br>1. Development and implementation of a mandatory NatSSIPs/LocSSIPs Training Framework, which will help to enforce mandatory training frequency and induction requirements for all staff groups and alignment of training content with learning from incidents and audit findings.<br>2. Rollout of a standardised e-learning module for all theatre staff and explore integration with ESR to enable. If ESR is unsuitable, a local approach will be developed.<br>3. Monitoring of compliance and reporting at service group level.<br><br>**Expected Evidence of Implementation:**<br><br>1. Established NatSSIPs/LocSSIPs training framework outlining requirements and responsibilities<br>2. Standardised e-learning module for relevant staff, supported by a SOP outlining expectations for completion.<br>*3.* Evidence of completion and compliance reporting through the NPTSSG Quality, Safety and Risk Group (agenda and minutes) |
| | | **Medium Priority** | **Officer:** Head of Nursing (Theatres)<br><br>**Target Implementation Date:** 30 June 2027 |
| | **Theme:** Training & Development | Control Design | |

| **Objective 3:** Procedural checklists are used consistently and appropriately within theatres and other invasive procedure settings, with clear evidence of completion, sign-off, and effective team communication practices. | **Reasonable** |
|---|---|

Discussions with Matrons across all three sites, along with the Head and Deputy Heads of Nursing for Theatres, confirmed that formal checklists are not maintained for each LocSSIP. Instead, LocSSIPs are designed as procedural guides to support day-to-day theatre processes. Management advised that these guides are displayed within theatre environments and are also accessible to staff via the health board intranet and COIN (see *Objective 1*).

The exception relates to LocSSIPs 3, 4, and 7, (see 'At A glance' on page 3), which are incorporated within the WHO Surgical Safety Checklist.

The WHO Surgical Safety Checklist is a structured safety tool used in operating theatres to minimise avoidable harm and promote effective teamwork, communication, and consistency at key stages of the patient pathway. The checklist is completed for every surgical procedure and is undertaken collectively by the theatre team. Completion of the WHO Checklist is recorded within the patient record and embedded within the Theatre Operating Management System (TOMS). Supporting guidance is available via COIN and within TOMS itself (TOMS Scheduler User Guide – Theatre User). The system includes in-built controls that prevent progression until all checklist stages have been completed.

We reviewed a summary of WHO Checklist compliance data for 2025/26, which indicated consistently high levels of completion across all sites, providing assurance over the use of formalised safety checks at key stages of invasive procedures.

| Site | WHO Checklist | | |
|---|---|---|---|
| | Sign-In | Time-Out | Sign-Out |
| **Morriston** | 98.7% | 98.5% | 98.1% |
| **Neath** | 99.7% | 99.7% | 99.7% |
| **Singleton** | 99.7% | 99.2% | 99.2% |
| **Overall health board** | **99.3%** | **99.2%** | **98.9%** |

For the remaining five LocSSIPs, no formal checklist is completed at individual patient, theatre list, or daily activity level. This aligns with national guidance, which does not encourage procedure-specific checklists unless supported by a robust IT solution.

Discussions with Surgical Matrons and clinical staff indicate that associated procedures and expected behaviours are well embedded in routine practice and supported by audit and training activity. However, assurance over consistent application is primarily derived from observation rather than documented evidence. As such, there is an opportunity to further strengthen assurance through proportionate mechanisms, such as targeted audit or observational review.

| **Objective 4:** Oversight, monitoring and audit arrangements are in place to assess compliance with checklist use, identifying areas for improvement, and support continuous improvement. | **Reasonable** |
|---|---|

**Audit Arrangements**

LocSSIP audits were incorporated into the Audit Management and Tracking system (AMaT) in November 2022, which is an online tool designed to support the undertaking of audits, facilitate the collation and monitoring of actions, and improve oversight of audit completion and compliance.

Following the publication of NatSSIPs2 in January 2023 and the health board's implementation of updated LocSSIPs in September 2023, the audit framework required revision. Audit questions were subsequently updated accordingly; however, these changes were not implemented within AMaT until November 2024, representing a delay of 14 months.

The audit programme is structured around LocSSIPs 1–8, with LocSSIP 8 subdivided into three components (8a, 8b and 8c), resulting in 10 discrete audits. The expected standard is that each site completes five of each audit per month (50 audits per month, 600 annually). Local delivery models vary across sites:

- Morriston: Speciality Managers are assigned responsibility for specific LocSSIPs, completing five audits per month, with additional requirements for Cardiac Theatres.
- Singleton: LocSSIPs are allocated across staff, with five audits per month required, including additional areas such as Obstetrics and Day Surgery.
- Neath Port Talbot (NPT): Audits follow a single patient pathway and are completed five times per month across three staff members.

A Standard Operating Procedure (SOP) outlining the audit approach is in place; however, this is currently under review and not yet formally published on the health board intranet.

On a monthly basis, the Surgical Training Team extracts audit data, including audit volumes, locations, responses, and overall compliance rates. These are summarised and circulated to key stakeholders, including Surgical Matrons and senior nursing leadership. Analysis of audit outcomes across 2025/26 (see Appendix A) indicates generally high levels of audit completion across sites, although coverage and compliance vary.

While a significant volume of audit activity is undertaken, there is limited evidence that the data is being consistently analysed to identify themes, trends, and underlying causes of non-compliance. Strengthening the use of audit data to support learning and continuous improvement represents a key area for development (see **Key Finding 3**).

Where full compliance (100%) is not achieved during an audit, actions are identified, assigned a priority rating and allocated to a relevant member of staff within the ward team, along with timelines for completion. The AMaT system provides automated prompts, notifying users of the status of assigned actions (e.g. due or overdue), and issues a weekly summary email to highlight outstanding actions. In addition, overdue actions are captured within the audit data extracts circulated to key stakeholders, supporting oversight and follow up.

**Reporting**

At Service Group level, monthly LocSSIP audit data from Morriston, NPT, and Singleton is collated and reported through within the Quality, Safety and Risk Group of the NPT/Singleton Service Group, which holds overall governance responsibility for theatres. Reporting is largely focused on monthly performance, with limited evidence of trend analysis, benchmarking, or review over time (see **Key Finding 3**). Additionally, no clear evidence was identified to demonstrate consistent escalation of key issues through the wider governance structure.

At organisational level, periodic updates have been provided to COEG since the introduction of NatSSIPs2. These reports indicate that, while overall compliance within Theatres is generally positive, it remains variable. Recurring weaknesses have been identified in critical safety steps, particularly sign-in, handovers, and debriefs, alongside variation across sites. Audit findings have informed strengthened audit approaches, increased oversight, and the development of improvement plans, including proposals for enhanced training to address identified gaps and support patient safety.

The Quality and Safety Committee has also received highlight reports and updates, which identify wider weaknesses in LocSSIP implementation. These indicate that full assurance cannot be provided across all services where NasSSIPs2 apply, particularly outside of theatre settings.

| Key Findings | | Risk & Impact | Agreed Management Action |
|---|---|---|---|
| 3 | **Effectiveness of Audit and Governance Arrangements**<br><br>A comprehensive programme of LocSSIP audits is in place across all theatre sites, supported by the AMaT system, with generally high levels of audit activity and established reporting mechanisms.<br><br>However, the effectiveness of these arrangements is limited by variation in audit coverage and delivery, with evidence of gaps where some LocSSIPs and theatre areas are not consistently audited. In addition, changes to the audit framework following the introduction of NatSSIPs2 were not implemented in a timely manner.<br><br>While significant volumes of audit data are collected, there is limited evidence of consistent thematic analysis, trend review over time, or benchmarking across sites. As a result, opportunities to maximise the value of audit activity in identifying recurring issues, driving targeted improvement, and strengthening organisational assurance are not fully realised. | Gaps in audit coverage and limited analysis reduce the effectiveness of oversight, limiting assurance over compliance and the identification and resolution of recurring issues. | **Agreed Action:**<br><br>1. Complete review and publish SOP for AMaT<br>2. Review and standardise the LocSSIP audit programme ensuring full coverage across all sits and specialities and a consistent delivery model.<br>3. Implement a periodic review of compliance with the Audit Programme and SOP, with appropriate reporting and escalation of the findings through the NPTSSG Quality, Safety and Risk Group.<br>*4.* Implement a periodic review of audit findings to identify themes and trends, with appropriate reporting and escalation of the findings through the NPTSSG Quality, Safety and Risk Group*.*<br><br>**Expected Evidence of Implementation:**<br><br>1. Updated and approved audit SOP published on the Surgical Services SharePoint site.<br>2. Revised audit plan/programme demonstrating full coverage across all theatres and LocSSIPs.<br>3. Periodic reports on compliance with audit programme and SOP received by NPTSSG Quality, Safety and Risk Group.<br>4. Periodic reports on audit findings and outcomes, identifying themes and trends, received by NPTSSG Quality, Safety and Risk Group. |
| | | **Medium Priority** | **Officer:** Quality and Safety Lead (Theatres) |
| | **Theme:** Quality, Safety & Patient Experience | Control Operation | **Target Implementation Date:** 30 June 2027 |

| **Objective 5:** Procedural checklist usage is routinely incorporated into investigations of incidents, including Never Events, with learning effectively captured, shared, and acted upon to reduce recurrence and strengthen organisational safety. | **Reasonable** |
|---|---|

The NHS Wales National Policy on Patient Safety Incident Reporting (issued May 2023) provides a consistent framework for the reporting, management, investigation, and learning from patient safety incidents, with expectations for timely reporting, proportionate investigation, learning dissemination, and organisational improvement.

The health board has established supporting arrangements through its Never Event Incident Management Protocol and the Standard Operating Procedure (SOP): Never Events in SBUHB Operating Theatres.

The SOP provides the primary operational framework for managed Never Events within theatres, including clear roles, defined timelines, rapid review processes, and structured investigation and learning. This includes consideration of procedural checklist use (e.g. WHO checklist) as part of incident review.

The organisational protocol provides the overarching governance framework, setting out requirements for escalation, executive oversight, formal investigation (via Patient Safety Incident Investigation Team - PSIIT), and communication with stakeholders.

Together, these arrangements provide a complementary framework, combining frontline operational response with corporate governance and oversight. However, neither document was accessible via COIN or the health board intranet at the time of review (see **Key Finding 4**), limiting staff awareness and accessibility.

Since 2023, seven theatre-related Never Events have been reported, all linked to weaknesses in safety procedures. Review of the two most recent incidents (April and May 2025) confirmed that procedural checklist compliance was considered as part of the investigation and reflected within Datix documentation.

While initial responses and learning processes are established, implementation of identified actions is not consistently completed or formally evidenced. For the incidents reviewed, actions had not yet been fully implemented, formally evidenced, or closed at the time of review, and in one case, action tracking was incomplete within reporting updates (see **Key Finding 5**). These findings are consistent with wider organisational themes identified in the health board's Learning from Incidents and Concerns audit (SBU-2425-08: issued May 2025: reasonable assurance), which highlighted variability in how learning is captured within Datix, inconsistency in the development and monitoring of action plans, and limited evidence of systematic sharing and reporting of learning. This reinforces the need to ensure that actions arising from Never Events are clearly defined, consistently tracked, and fully implemented.

The health board has established structured forums, including quarterly Patient Safety Congresses and service-level summits, to support the sharing of learning from incidents. These arrangements demonstrate a commitment to promote staff engagement, reflection, and continuous improvement and demonstrate a commitment to strengthening organisational safety culture. However, further work is required to ensure learning is consistently embedded and evidenced in practice (see **Key Finding 5**).

| | Key Findings | Risk & Impact | Agreed Management Action |
|---|---|---|---|
| 4 | **Accessibility of Never Event Guidance**<br><br>The health board has established clear and complementary frameworks for managing Never Events through its organisational protocol and Theatre SOP.<br><br>However, key guidance documents were not accessible via COIN or the health board intranet at the time of review, limiting staff awareness of and access to essential guidance.<br><br>This may impact the consistent application of incident management processes and the embedding of learning. | Inconsistent application of incident management processes and reduced effectiveness of organisational learning, potentially increasing the likelihood of repeated incidents | **Agreed Action:**<br><br>1. The Never Events in SBUHB Operating Theatres SOP will be published on COIN/intranet and clearly signposted from the NPTSSG Surgical Division SharePoint site.<br>2. Issues highlighted relating to the availability of the Never Event Incident Management Protocol will be brought to the attention of the Head of Quality & Safety to address. |
| | | | **Expected Evidence of Implementation:**<br><br>1. The Never Events in SBUHB Operating Theatres SOP available on COIN/intranet<br>2. Correspondence with the Head of Quality & Safety regarding the availability of the Never Event Incident Management Protocol. |
| | | **Medium Priority** | **Officer:** NPTSSG Service Group Governance Lead<br><br>**Target Implementation Date:** 31 December 2026 |
| | **Theme:** Policies & Procedures | Control Operation | |
| 5 | **Embedding and Closure of Learning following Patient Safety Incidents**<br><br>Procedural checklist use is appropriately considered as part of Never Event investigations, supported by established governance arrangements and structured investigation processes.<br><br>However, while learning is identified, it is not consistently embedded in practice. Actions arising from incidents are not always fully implemented, formally evidenced, or closed; and reporting does not consistently provide a complete view of progress.<br><br>These findings align with wider organisational themes identified in the health board's Learning from Incidents and Concerns audit (SBU-2425-08), which highlighted variability in the capture of learning, inconsistency in the development and monitoring of action plans, and limited evidence of systematic sharing and reporting.<br><br>As a result, while processes are in place to investigate incidents and identify learning, arrangements to ensure that learning is | Learning from incidents is not fully implemented or sustained, increasing the likelihood of recurrence, and reducing organisational assurance and governance oversight over patient safety improvements. | **Agreed Action:**<br><br>1. Introduction of standardised action plan templates and reporting to ensure full visibility of progress and completion through the monthly governance meetings and NPTSSG Quality, Safety and Risk Group.<br>2. Strengthening mechanisms for sharing and embedding learning including Patient Safety Congress outputs; and team brief/debrief integration. |
| | | | **Expected Evidence of Implementation:**<br><br>1. Standardised action plan templates demonstrating clear ownership, timescales and status, with evidence of completed and formally closed actions through monthly governance meetings (minutes demonstrating monitoring and challenge of progress).<br>2. Evidence of learning being shared and embedded across relevant services |

| | Key Findings | Risk & Impact | Agreed Management Action |
|---|---|---|---|
| | consistently tracked, implemented, sustained and translated into improved practice are not fully embedded. | **Medium Priority** | **Officer:** Head of Nursing (Theatres)<br>**Target Implementation Date:** 30 June 2027 |
| | **Theme:** Lessons Learnt | Control Operation | |

# Appendix A: Summary of LocSSIP Audit Coverage, Compliance and Key Risks (2025/26)

The table below summarises audit completion, compliance levels, and key risks identified across theatre sites for 2025/26, supporting the findings on audit effectiveness and oversight.

| Site | Audit completion (% and volume) | Compliance (% non-compliant) | Key Gaps and Risks / Identified | Coverage and Consistency |
|---|---|---|---|---|
| Morriston | 541 / 600 (91%) | 3.33% (20 cases) | • Incomplete coverage across some LocSSIPs.<br>• Low completion for LocSSIP 8a & 8c.<br>• Four LocSSIPs audited less than once across more than 10 theatres | 17 theatres; audit volumes range from 16–66; inconsistent coverage and application across areas. |
| Neath | 506 / 600 (84%) | 5.33% (32 cases) | • Low audit coverage LocSSIP 5 (15%).<br>• Slightly reduced compliance for LocSSIP 8c (87%).<br>• Sampling approach may not consistently capture implant procedures. | Even distribution of audits; generally consistent delivery model. |
| Singleton | 533 / 600 (88%) | 10.5% (63 cases) | • Concentration of non-compliance in LocSSIPs 2, 3, and 8a (85%).<br>• Lower compliance in Obstetrics implant procedures (50%). | Issues driven by quality of compliance; recurring themes observed. |

**Summary Analysis**

Analysis of audit outcomes for 2025/26 indicates that, while overall audit completion is high across sites, coverage and consistency vary, with evidence of gaps where some LocSSIPs and theatre areas are not regularly audited.

Compliance levels are moderate to strong overall; however, performance is not consistent across all standards or sites, with recurring areas of non-compliance. In particular, weaker performance is evident in communication-based safety processes (e.g. Sign-In, Team Briefs, handovers and debriefs), which aligns with themes identified through audit reporting. In addition, variation in audit coverage, sampling limitations, and concentration of non-compliance in specific areas reduces the level of assurance that can be derived from audit activity.

Audit findings are translated into actions where non-compliance is identified. These actions are assigned a priority rating, allocated to responsible staff, and supported by defined completion timescales within the AMaT system. The system provides automated notifications and regular summary updates to support completion, and overdue actions are included within audit reporting to support oversight. While these arrangements support the identification and tracking of actions, there is an opportunity to further strengthen assurance through consistent monitoring, escalation, and use of audit outputs to drive sustained improvement.

There is also limited evidence of corporate-level reporting and systematic analysis of audit results, including trends and themes over time, or benchmarking across sites, which reduces the effectiveness of oversight and organisational learning.

Overall, these factors indicate that, while audit arrangements are established and operating, their effectiveness in providing consistent assurance and driving improvement is not fully realised, supporting the findings set out in Key Finding 3.

# Appendix B: Assurance Opinion & Prioritisation of Findings

## Assurance Opinion

| | | |
|---|---|---|
|  | **Substantial** | Few matters require attention and are compliance or advisory in nature.<br>**Low impact** on residual risk exposure. |
|  | **Reasonable** | Some matters require management attention in control design or compliance.<br>**Low to moderate impact** on residual risk exposure until resolved. |
|  | **Limited** | More significant matters require management attention.<br>**Moderate impact** on residual risk exposure until resolved. |
|  | **Unsatisfactory** | Action is required to address the whole control framework in this area.<br>**High impact** on residual risk exposure until resolved. |
|  | **Advisory** | Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate.<br>These reviews are still relevant to the evidence base upon which the overall opinion is formed. |

## Prioritisation of Findings

| Priority | Explanation |
|---|---|
| **High** | Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance. |
| **Medium** | Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance. |

## Disclaimer

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit Committee.

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of Swansea Bay University Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

The report is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given with regard to the advice and information contained.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with management of Swansea Bay University Health Board. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

## Public Sector Internal Audit Standards

Audit work undertaken by NHS Wales Audit and Assurance Services conforms with the International Standards for the Professional Practice of Internal Auditing and associated Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.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