GIG CYMRU NHS WALES

Iechyd a Gofal Digidol Cymru

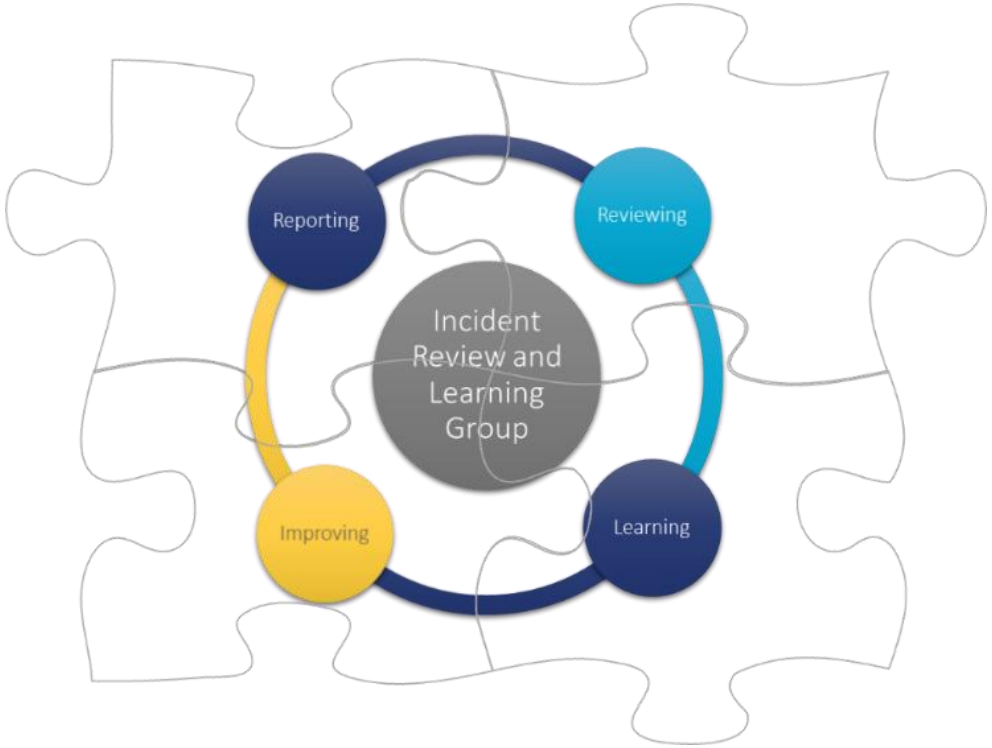
Digital Health and Care Wales

Incident Review & Learning Group

Quarter 3 Report 2025 / 26

IGDC • DHCW

Purpose



The purpose of the Incident Review and Learning Group (IRLG) is to have an organisational wide reporting group which covers all aspects of incident review and associated learning across the organisation, and to make and take forward recommendations for improvement.

This report provides an annual review of activities to provide assurance to the Digital Governance and Safety Committee around the four areas of the group covering:

- Reporting
- Reviewing
- Learning
- Improving

The report includes information on all Early Warning Notifications & National Reportable Incidents by Digital Health and Care Wales (DHCW), any additional reviews undertaken, identification of lessons learned, and recommendations made, feeding into improvements for the organisation to take forward.

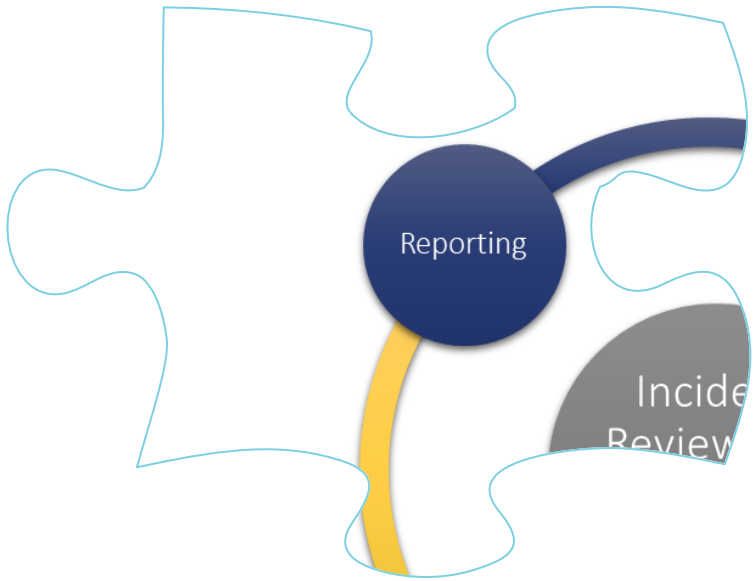
The outcome of reviews will support the work of the Board in the Shared Learning approach.

For governance purposes the IRLG reports to the Digital Governance and Safety Committee.

This report covers the period 1st October 2025 to 31st December 2025 inclusive.

Reporting

Early Warning Notifications and National Reportable Incidents



This section summarizes early warning notifications and national reportable incidents, issued by DHCW to statutory bodies.

Early warning notifications are used in circumstances where the Welsh Government needs to be alerted to an immediate issue of concern or prior warning of something due to happen which might relate to the following:

- has the potential to affect a number of patients/ staff / communities etc.
- has a significant impact on service provision.
- may have an adverse impact in the media.
- might cause national or political embarrassment.
- following an inquest which has resulted in a Regulation 28 or public interest in a Public Services Ombudsman for Wales (PSOW) report OR
- a positive good news story.

Reporting

Early Warning Notifications and National Reportable Incidents

There was one early warning notification issued to Welsh Government, in relation to Information Services issues surrounding Amazon Web Services (AWS) with a total of 6 notifications issued across the year.

New for 25/26 is incidents reportable under the NIS directive. 2 incidents were sent to the Cyber Resilience Unit, but following assessment neither fell in the scope of the NIS Directive. In total there have been 2 notifications across the year.

Of the Complaints, Concerns, and Feedback, there were 7 complaints in relation to NHS Wales App, relating to known issues which are in the process of being resolved, and 9 in relation to the Dental Access Portal. The remainder were in relation to DHCW business or directed to other NHS Wales bodies.

Of enquiries 41 were in relation to the Dental Access Portal, 5 were in relation to recruitment and 18 were for other DHCW services.

Type	Timescale	Total Notifications	Q1	Q2	Q3	Q4	24/25
Business Continuity	As Required.	-	-	-	-		-
Clinical	7 days	1	1	-	-		1
Cyber Security	3 days	1	1	-	-		1
Health & Safety	10 days	-	-	-	-		-
Information Governance	72 hours	-	-	-	-		-
Information Services	As Required.	1	-	-	1		-
MHRA Reportable Event	2 days	-	-	-	-		-
	10 days	-	-	-	-		-
	30 days	-	-	-	-		-
NIS Directive	As Required.	2	1	1	-		-
Redress	As Required.	-	-	-	-		-
Patient Safety	7 days	-	-	-	-		1
Technical	As Required.	-	-	-	-		-
Welsh Language Standards	As Required.	-	-	-	-		-
Other	As Required.	1	-	1	-		3
Total		6	3	2	1		6

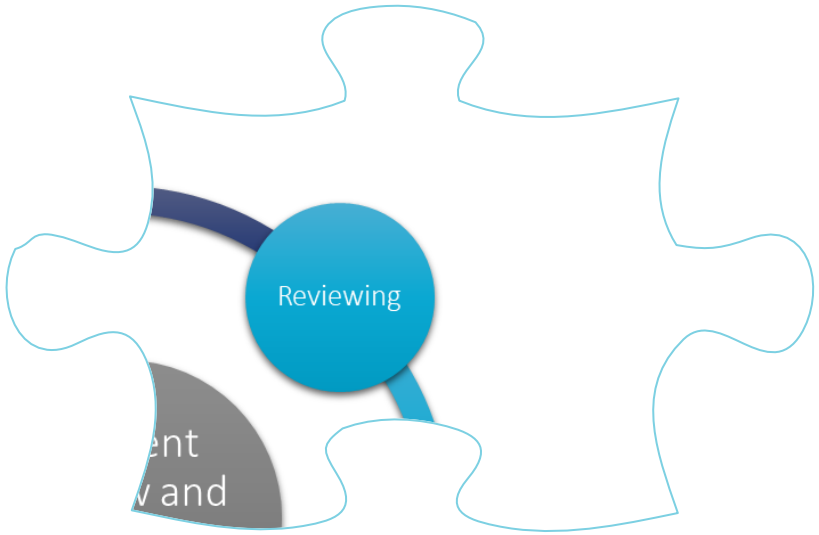
Complaints. Concerns, & Feedback	Formal	99	41	36	22		34
	Enquiries	340	138	138	64		325
	Suggestions	-	-	-	-		1

Status	Definition	Next Steps
Red	Notification was issued outside of timescale	Escalate through IRLG report
Amber	Notification was issued at end of timescale	Consider improvements in reporting
Green	Notification was issued within timescale	No action

Reviewing

Reviews Undertaken

Summary of Reports Received



This section summarizes the review activity within the reporting period for any reports that have come to IRLG.

This includes reviews which were undertaken but were not required to be notified to an appropriate body (typically internal DHCW technical reviews), as well as any commissioned thematic reviews which investigate patterns of incidents, to identify commonality with root causes and contributory factors.

Reviewing

Reviews undertaken this year

The improvement in relation to identifying other areas of learning, is starting to present wider opportunities for learning, including customer engagement, feedback surveys, externally commissioned reviews, and programme and project reports.

Whilst there has been a decline in the number of reports on last year, the December meeting was postponed

Reviews undertaken for this quarter include a Programme Lessons Learned reports for Bridgend Disaggregation, and Digital Maternity, as well as a thematic review surrounding the Incidents caused by Change, as well as lessons learned from audit and a business continuity exercise.

The presentation of these reviews highlights the scope of the group surrounding wider learning.

Review Type	Financial Year 2024/25			
	Q1	Q2	Q3	Q4
Business Continuity	-	-	1	
Clinical	-	-	-	
Complaints	-	-	-	
Cyber Security	-	-	-	
Health & Safety	-	-	-	
Information Governance	-	-	-	
Information Services	-	-	-	
MHRA Reportable Event	-	-	-	
Patient Safety	-	-	-	
Programme Lessons Learned	1	-	2	
Technical (inc. NIS)	2	7	-	
Thematic Reviews	-	-	1	
Welsh Language Standards	-	-	-	
Other Reviews (i.e., Audits)	2	1	1	
Total (FY 25/26)	**5**	**8**	**5**	
Total (FY 24/25)	**9**	**9**	**10**	**5**

Reviewing

Summary of the reports that have been received in the quarter

This slide provides a summary of the reports and presentations that the IRLG has received and the learning that has arisen from them

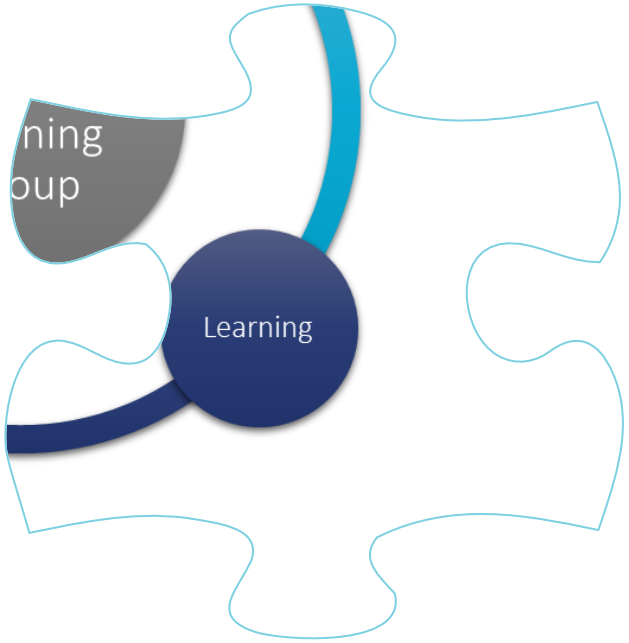
In Quarter 3 the IRLG received and reviewed 6 reports and presentations. A summary of the outcomes is included in this report.

In total 19 reports and presentations have been received and reviewed across the reporting year.

Meeting Date	Report Title	Presented By	Report Type
27/10/2025	Change Management Incident Review	Service Management	Thematic Review
27/10/2025	ISO 20000 Lessons Learned	Service Management	Audit Learning
27/11/2025	Welsh PAS Disaggregation	Service Transformation	Programme Learning
27/11/2025	Digital Maternity	Service Transformation	Programme Learning
27/11/2025	Exercise Pegasus	Emergency Planning	Continuity Learning

Learning

Lessons Identified Through Review
Contributory Factors Framework
Recommendations from Review



This section summarises some of the reviews that have been undertaken over the last quarter, and highlights some of the lessons learned, recommendations, and actions undertaken.

As part of the implementation of the contributory factors framework, these are also covered to report on the high-level domains

Learning

Lessons Identified Through Review

Incidents caused by Change: Thematic Review

Over the past 12 months, DHCW had encountered several Major Incidents (MIs) associated with unsuccessful changes, leading to operational disruptions and safety concerns.

Eleven of these incidents were directly attributable to inadequate impact assessments or an inability to foresee the unintended consequences of system changes.

Although previous incident reviews have been conducted to address these issues, the fundamental cause relating to the application of the change management process by teams had yet to be thoroughly examined.

The Incident Response and Learning Group (IRLG) requested a thematic review to examine the application of the change management process by teams, rather than evaluating the process itself.

This review aimed to identify areas for improvement and assess the effectiveness of previous recommendations.

A summary of some of the lessons learned were:

Finding Summary	Lesson Learned	Follow Up Action
Change Management Process & Training	Strong peer review, clear training, and consistent process discipline are essential to prevent avoidable change failures.	Enforce technical peer reviews for all Major and Significant change activity. Training to be included in team onboarding practices.
Problem Management	Treat misconfigurations as formal Problems and drive them through active problem management to ensure true root-cause resolution.	Promote adoption across the organisation
Security & Access Controls	All security-related changes must be formally logged and tightly access-controlled to protect the integrity of live systems.	Correct behaviours and apply consistency of process
Communication & Stakeholder Engagement	Every change must include clear impact assessment and stakeholder communication, with urgent risks escalated through the e-CAB process to ensure controlled, informed decision-making.	Undertake a Stakeholder Engagement Review.
Risk Assessment & Policy Adherence	Deviations from SOPs must be fully assessed, and all work must follow the correct change category to ensure strict policy adherence.	Add to the ITSM Tool impact analysis question set.
Change Planning & Timing	Avoid normal working hours when performing high-risk changes such as failover testing.	Communicate importance of performing high impact risk changes outside of normal working hours
Change Impact Assessment & Testing	Thoroughly assess dependencies and rigorously test all changes in controlled, non-production environments—including performance validation—to prevent hidden risks from reaching live systems.	Encourage use of dependency mapping. Include performance validation and load testing as part of Change planning.

Learning

Lessons Identified Through Review

Bridgend Disaggregation: Lessons Learned Review

The Programme was initiated in response to the boundary change on 1st April 2019, which transferred responsibility for ICT health services in Bridgend from Swansea Bay University Health Board (formerly ABMU) to Cwm Taf Morgannwg University Health Board (CTM).

Digital Health and Care Wales (DHCW), as the national digital delivery organisation, was tasked with managing the digital implications of this change.

The objective of the Programme was to safely and effectively realign digital services and patient data to reflect the new Health Board boundaries. This included the complex task of disaggregating Bridgend's patient data from Swansea Bay's WelshPAS instance and migrating it into CTM's WelshPAS instance, ensuring continuity of care, clinical visibility, and data integrity throughout.

The programme became a high-priority deliverable within DHCW's portfolio and collaborating organisations, with a targeted go-live milestone of May 2025.

This review identified the lessons learned following successful completion of this programme.

A summary of some of the lessons learned were:

Finding Summary	Lesson Learned
Collaboration	From Project Initiation, there was a requirement for DHCW to collaborate at both an Organisational and National level to enable completion of project deliverables and objectives.
Communications	A clearly defined communications approach and executed plan provided project assurance surrounding stakeholder engagement. Comprising of circulation of frequent formal notifications and regular involvement in workstream Task and Finish Groups.
Operational	The integration of new infrastructure creates a challenge for the skills and capabilities of everyone involved. Predicting cost, quality and time requirements should not be under-estimated and is imperative, along with a robust evaluation and approval procedure.
Planning	Complex interdependencies within the Project forced activity timescales to change, which risked impacting wider-DHCW plans and deliverables. Adaptive management, informed options appraisal and swift decision making retained crucial cooperation.
Resources	Consistent, dedicated Project and Technical resources were of huge benefit but, exposed the Project to Risks, Issues and Dependencies relating to single points of failure. Future projects should utilise skilled, DHCW resources to gain value from knowledge and experience.
Testing	An appropriate amount of forethought and prioritisation is essential when deciding requirements, developing tender specifications and aligning timescales with business processes; all of which impact the critical path.

Learning

Lessons Identified Through Review

Digital Maternity: Lessons Learned

The Digital Maternity Cymru (DMC) Programme was established in 2023 following a “discovery” phase project in 2022. Its purpose was to procure an all-Wales digital maternity system and app/portal.

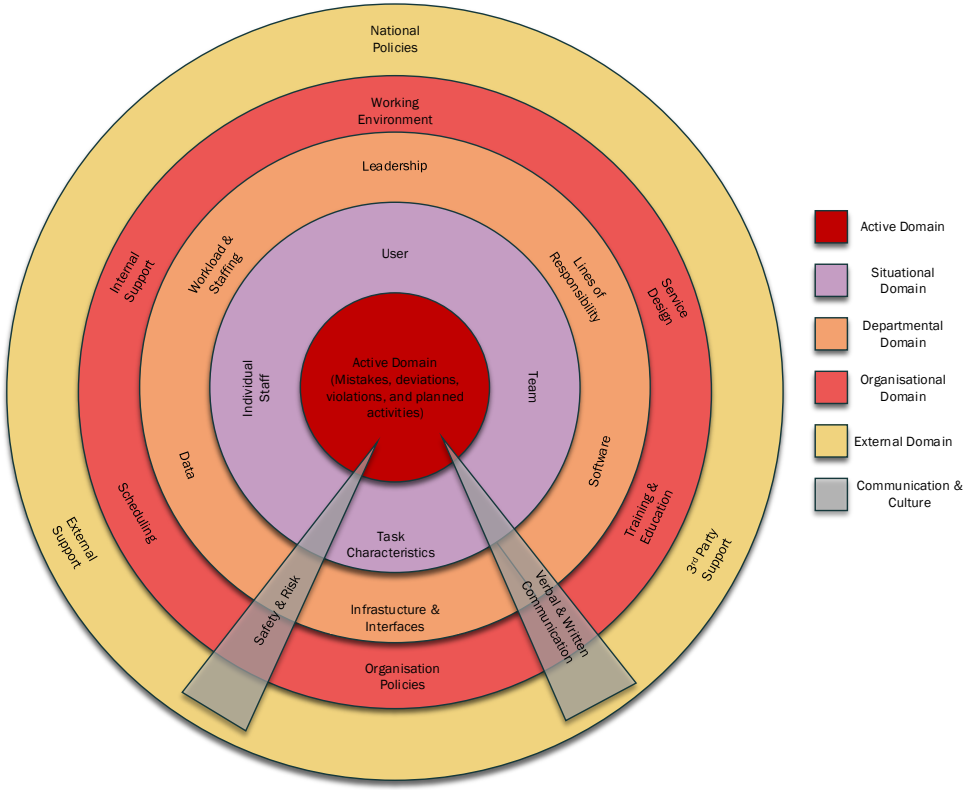
The Programme commenced the procurement of a national system in October 2024, the first phase of evaluation was completed in December 2024, and the outcome was a decision to terminate the procurement process.

Considering reviews of the Programme and dialogue with stakeholders across NHS Wales, Welsh Government wrote to Digital Health and Care Wales on 01 May 2025 to confirm that the Digital Maternity Cymru Programme should be closed and a report produced that includes lessons learned so that this can provide insights for future initiatives.

A summary of some of the lessons learned were:

Area	Lesson Learned	Recommendations
Strategic frameworks	Early adoption of a clear framework approach could have strengthened health board buy-in and reduced ambiguity in requirements, increasing the chances of a successful procurement.	Secure formal, organisation-wide buy-in at the outset of any procurement activity to ensure alignment and programme success.
Contractual frameworks	Supplier feedback showed that the service management requirements were disproportionate compared with what the market could realistically provide.	Review comparable frameworks to ensure requirements drive strong supplier performance without imposing unnecessarily punitive terms.
Supplier Engagement	Supplier engagement began too early, creating concerns about compliance with procurement rules and highlighting the need for clearer processes and timing.	Work with Welsh Government and NHS Wales Shared Services Partnership to embed this learning into future guidance and policy.
Procurement Timescales	Delays led to an expedited procurement process that reduced the quality of supplier responses, limited competition, and contributed to early termination.	Set and agree realistic procurement timelines from the outset, ensuring they reflect the scale, complexity, and volume of requirements.
Investment	Although completing an OBC was required for a high-value procurement, there was no shared agreement on the approach, leading to prolonged development, multiple revisions, and a delay of over 12 months.	Programmes should recognise and plan for business case requirements from the outset to avoid unnecessary delays.
Timescales	The original timelines were overly optimistic and did not reflect the complexity, scale, or realistic implementation durations demonstrated by existing health board experience.	Programmes should apply stronger optimism-bias adjustments and use real-world data from comparable projects when developing plans and investment cases.
Requirements	Requirements development was fragmented across multiple individuals, and inherited documentation required extensive rework, made harder by inconsistent engagement from key contributors.	Ensure requirements are built on clear user stories and that all technical and clinical contributors understand the process and time commitment needed from the outset.

Background



- The Contributory Factors Framework (CFF) is a tool which uses an evidence base for optimizing learning and addressing causes of incidents.
- The underlying aim of the tool is not to ignore individual accountability, but to try to develop a more sophisticated understanding of the factors that cause incidents.
- These factors can then be addressed through changes in systems, structures, processes and local working conditions.
- Finding the true causes of incidents offers an opportunity to address systemic flaws effectively.

- A definition of the domains is in the appendix at the end of this report

Learning

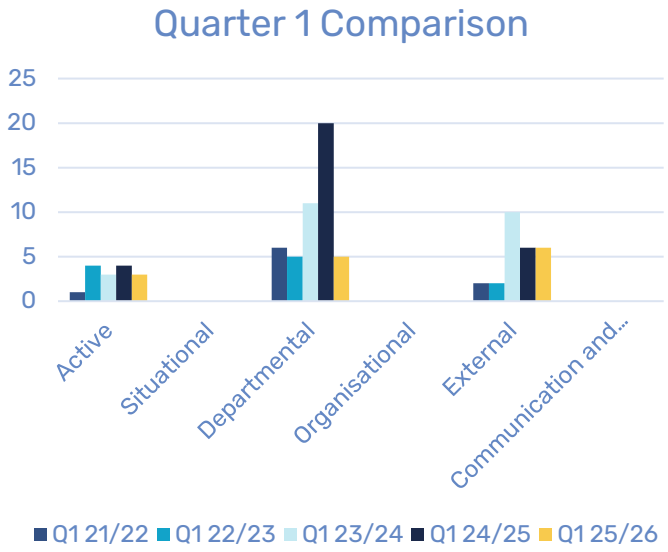
Contributory Factors

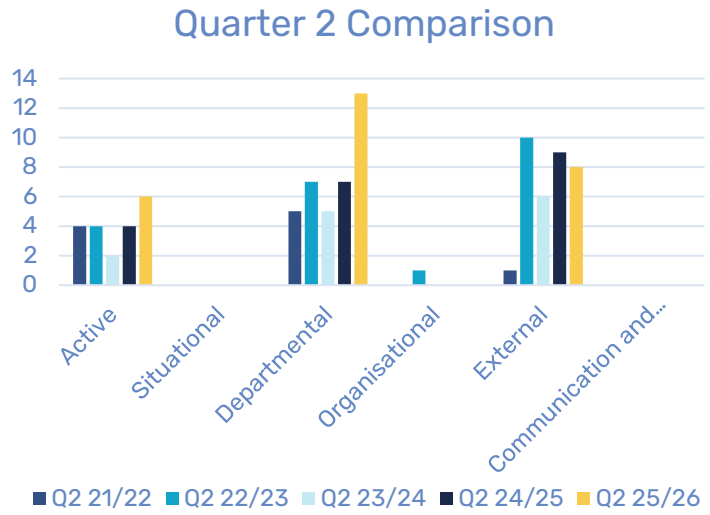
For **Active Domain** factors, as the organisation moves towards the target operating model, there is an identified requirement to review the approach for competency and awareness to ensure that relevant processes are trained out, and that competencies are recorded appropriately. This is being managed under Improvement 5.

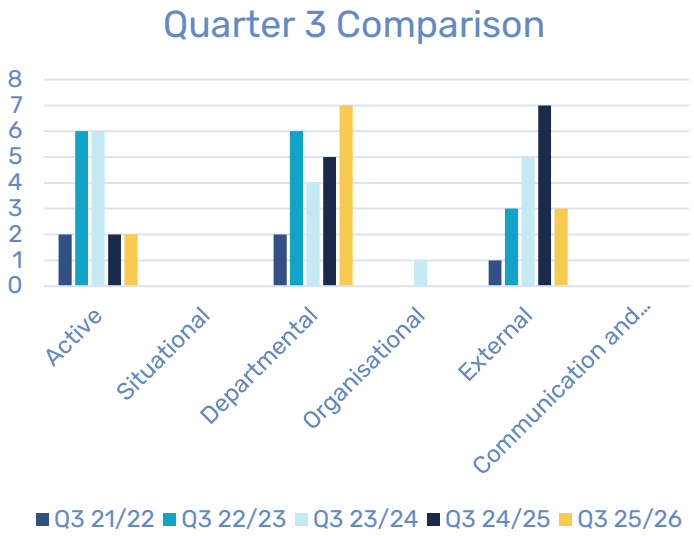
For factors within the **Departmental** Domain including infrastructure, interfaces, data, and software. Further improvements in Problem Management techniques, notably root cause analysis and pro-active problem management, as well as improvements in Change Management should lead to additional improvements in the technical development of products and services.

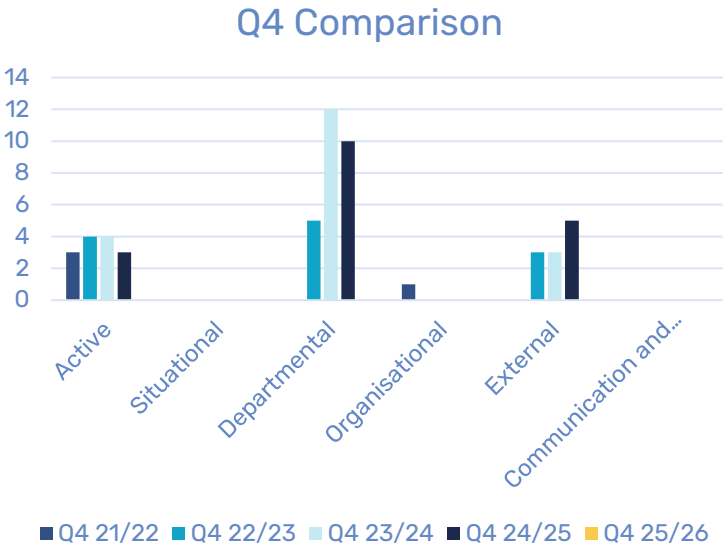
The **External Domain** covers incidents where the contributory factor has been identified as with either a supplier (for example a software bug, or wide area network outage) or is within the local health board or stakeholder organisation (for instance local network issues or application of patching locally).

For factors within this domain improvements will also be sought through SLA and Engagement Meetings, the Service Management Board governance structure, and through supplier management with third party suppliers.









Learning

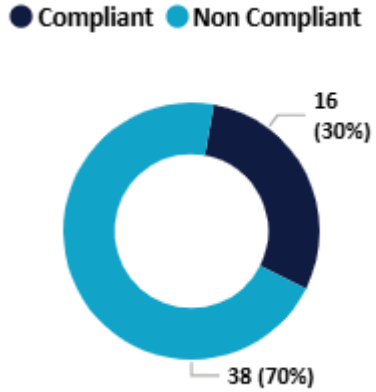
Recommendations from Review

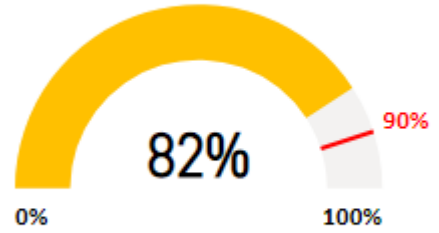
Following each technical review that is undertaken a report is completed which may result in recommendations being made.

These recommendations are recorded on iPassport as non-compliances

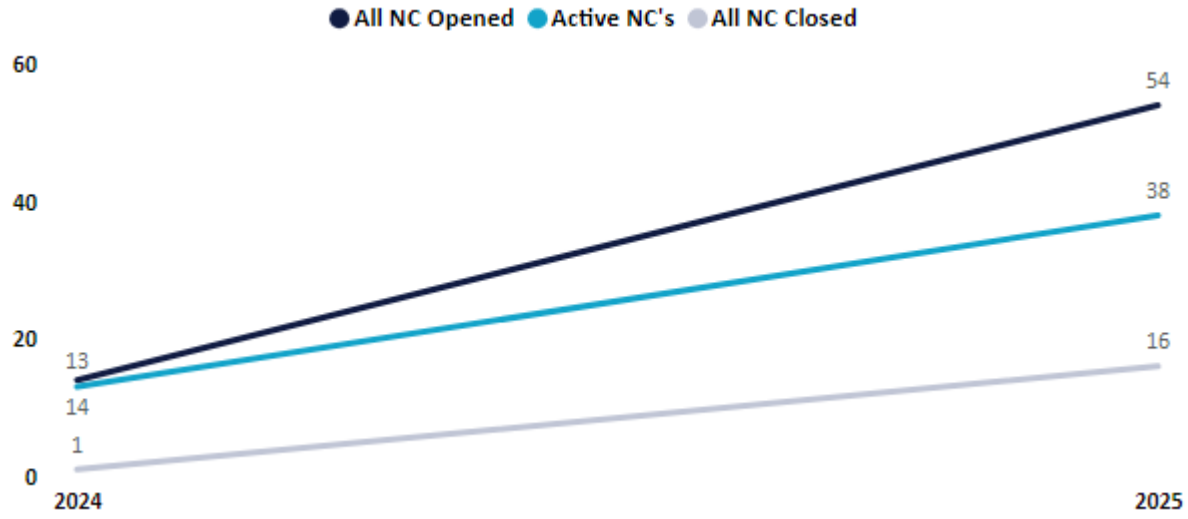
The outcome from these recommendations' feeds into the identification of improvements.

The increase in the recommendations from previous quarter (23) is as a result of recommendations from reports including the Data Centre Technical Review and the Change Management Thematic Review



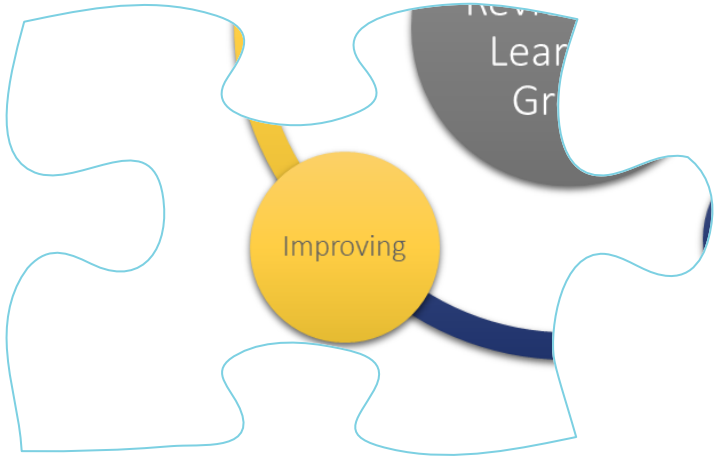


Active Non-Compliances



Improving

Continual Improvement



Continuous or continual improvement is an ongoing process of identifying, analysing, and making incremental improvements to systems, processes, products, or services.

Its purpose is to drive efficiency, improve quality, and value delivery while minimizing waste, variation, and defects. The continual improvement process is driven by ongoing feedback, collaboration, and data.

This section provides a summary of the improvements that have been identified through review, or by IRLG members.

Improving

Continual Improvement

There are currently 3 improvements being progressed by the IRLG.

Further improvements will be captured throughout the year, both as a result from review as well as through audit and SWOT exercises

4 improvements completed last year are being monitored for effectiveness and sustainability.

1 improvement has been marked as completed and will now be monitored for effectiveness and sustainability.

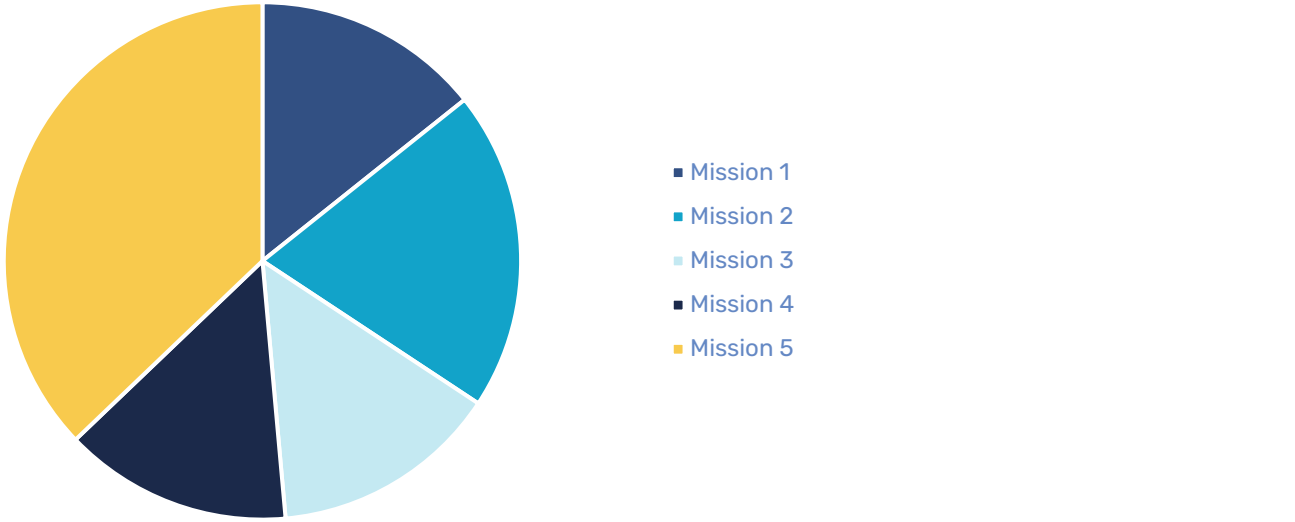
Each improvement is aligned to supporting one or more of DHCW's 5 missions (top graph), as well as aligning with one of the four dimensions of Service Management (bottom graph).

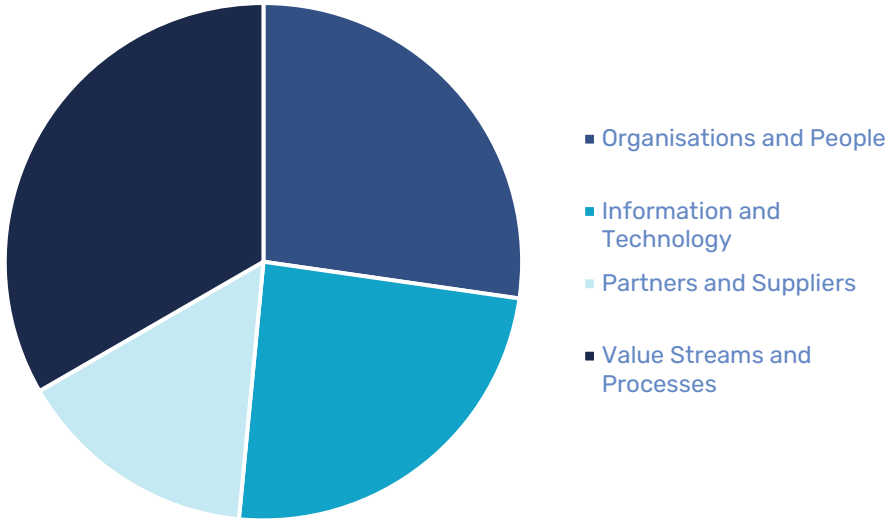
Completed Improvements this quarter

- Improvement 11: Review of Clinical Impact

Completed Improvements being monitored this year include

- Improvement 3: Change Success Review
- Improvement 7: LHB Relationship Management
- Improvement 9: Supplier Management
- Improvement 13: Review of Service Portfolio





Improving

Continual Improvement

Of the 13 improvements that have been identified through IRLG, 9 are of medium or high complexity, meaning that without associated resources being made available to support them, the associated benefits may not be fully realised.

If 9 of the improvements are implemented correctly, then the potential cost reduction / cost saving benefits related to those improvements would be realised.

If 12 of the improvements are implemented correctly, then medium to high user experience / user satisfaction related to those improvements would be realised.

This could be further measured through the implementation of experience level management (XLM).

A report on the effectiveness of this improvement approach will be undertaken in Q2

Improvement Complexity

High Complexity
Medium Complexity
Low Complexity

Cost Reduction Benefits

High Cost Reduction
Medium Cost Reduction
Low Cost Reduction

User Experience Benefits

High User Experience
Medium User Experience
Low User Experience

IMTP Reference	N/A

Improvement 1: Major IT Incident Management

Theme	Major IT Incident Management		
Commencement Date	13/12/2022	**Current Status**	On Hold pending OCP
Owner	Service Management	**Stakeholders**	Operational Support Teams
Description	A working group was established to review all aspects of DHCW's Major IT Incident Management process including the effectiveness of its incident response structure (Bronze, Silver, Gold), communications, process management, reporting and review, and stakeholder engagement. Outputs included the development of simplified workflows, clearer role profiles, improved reporting and escalation lines, communication templates as well as the development of training materials and periodic testing of aspects of the end-to-end process		
Improvements Implemented	• IT Process Lead and team for Major Incident Management appointed through Organisational Change Process • A root and branch review of DHCW's approach to Major Incident Management is in progress. • Internal Task Force within ESM convened		
Planned Activities FY 25/26	• Development and delivery of On-Call Competency training programme as part of a wider improvement around training		

DHCW Missions	Mission 1	Mission 2	Mission 3	Mission 4	Mission 5
Service Management Dimensions		Value Streams & Processes	Information & Technology	Organisations & People	Partners & Suppliers
Complexity	High	**Cost Reduction**	Medium	**User Experience**	High

Improvement 5: Training on ITSM Processes

Theme	Implementation of Contributory Factors Framework		
Commencement Date	13/12/2022	**Current Status**	In Progress
Owner	Service Management	**Stakeholders**	Operational Support Teams
Description	Following review of contributory factors in the active domain, in relation to errors and deviations from working practices, feedback from staff, and the outcomes from audits relating to the Service Management standard (ISO 20000). This improvement is for the development of training material around the Service Management practices, and the capture of the delivery of that training to staff within their electronic staff record (ESR) This improvement will also support the professionalism agenda with the People and Organisational Development Strategy by using the SFIA 8 framework to assess course content. Finally, the approaches taken in the improvement could also help to drive forward similar requirements from other Organisational Standards		
Improvements Implemented	• Baselined ITIL 4 Capability Assessment undertaken to identify priorities • Training content for Incident Management based on ITIL 4 best practice methodology developed • Training content for Change Management based on ITIL 4 best practice methodology underway • Training needs analysis for ITSM developed – to be reviewed to align with SFIA 9 and GDAD+		
Planned Activities FY 25/26	• Further development and delivery of course content • Implementation of competency-based assessments against key roles • Monitoring of training progress through internal monthly reports		

DHCW Missions	Mission 1	Mission 2	Mission 3	Mission 4	Mission 5
Service Management Dimensions		Value Streams & Processes	Information & Technology	Organisations & People	Partners & Suppliers
Complexity	High	**Cost Reduction**	Medium	**User Experience**	High

Improvement 10: Clinical Strategies

Theme	Implementation of Clinical Strategies		
Commencement Date	08/01/2024	**Current Status**	Ongoing
Owner	Clinical Directorate	**Stakeholders**	All Staff
Description	Within the Clinical Directorate Sub Strategies, there are programmes of improvement being identified. These will be established with updates being discussed at IRLG.		
Improvements Implemented			
Planned Activities FY 25/26	• This is a new improvement, but is also linked to Improvement 4: Promotion of Lessons Learned (internally and externally)		

DHCW Missions	Mission 1	Mission 2	Mission 3	Mission 4	Mission 5
Service Management Dimensions		Value Streams & Processes	Information & Technology	Organisations & People	Partners & Suppliers
Complexity	Medium	**Cost Reduction**	Medium	**User Experience**	Medium

Improvement 10: Clinical Strategies

Theme	Implementation of Clinical Strategies		
Commencement Date	08/01/2024	**Current Status**	Ongoing
Owner	Clinical Directorate	**Stakeholders**	All Staff
Description	Within the Clinical Directorate Sub Strategies, there are programmes of improvement being identified. These will be established with updates being discussed at IRLG.		
Improvements Implemented			
Planned Activities FY 25/26	• This is a new improvement, but is also linked to Improvement 4: Promotion of Lessons Learned (internally and externally)		

DHCW Missions	Mission 1	Mission 2	Mission 3	Mission 4	Mission 5
Service Management Dimensions		Value Streams & Processes	Information & Technology	Organisations & People	Partners & Suppliers
Complexity	Medium	**Cost Reduction**	Medium	**User Experience**	Medium

Improvement 9: Enhancing Learning Programme

Theme	Implementation of Contributory Factors Framework		
Commencement Date	08/01/2024	**Current Status**	On Hold pending PHW review
Owner	Patient Safety	**Stakeholders**	All Reviewers
Description	This improvement relates to the Enhanced Learning Programme being driven by Public Health Wales, focusing on learning and improvement across NHS Wales. The primary focus of this is on clinical learning, however, will also include learning from DHCW. The programme is in a stage of development and this improvement will look to increase awareness and ties between DHCW and the Local Health Boards Clinical Safety Teams.		
Improvements Implemented			
Planned Activities FY 25/26	• This is an externally driven improvement, but is also linked to Improvement 4: Promotion of Lessons Learned (internally and externally), and Improvement 7: Local Health Board Relationship Management		

DHCW Missions	Mission 1	Mission 2	Mission 3	Mission 4	Mission 5
Service Management Dimensions		Value Streams & Processes	Information & Technology	Organisations & People	Partners & Suppliers
Complexity	Medium	**Cost Reduction**	Medium	**User Experience**	Medium

Improvement 7: Local Health Board Relationship Management

Theme	Local Health Board Relationship Management		
Commencement Date	01/10/2023	**Current Status**	Completed
Owner	Service Accounts	**Stakeholders**	External Stakeholders
Description	Through the Contributory Factors Framework, the External Domain covers incidents where the contributory factor has been identified as with either a supplier (for example a software bug, or wide area network outage) or is within the local health board or stakeholder organisation (for instance local network issues or application of patching locally). For factors within this domain improvements will also be sought through SLA and Engagement Meetings, and (where applicable) Service Management Boards.		
Improvements Implemented	• Development of a template for National Service Management Board for LHBs to report local incidents. • Reminder within SLA meetings of local incidents • Encourage greater ownership and sharing lessons learned leading to local improvement activities. • Encourage peer review through the Service Management Board (where applicable)		
Planned Activities FY 24/25	• Identify scope and scale through existing reporting lines. • Raise awareness of LHB responsibilities in line with current SLA • Raise awareness of local incidents impacting national services through SLA and Engagement Meetings		

DHCW Missions	Mission 1	Mission 2	Mission 3	Mission 4	Mission 5
Service Management Dimensions		Value Streams & Processes	Information & Technology	Organisations & People	Partners & Suppliers
Complexity	Low	**Cost Reduction**	Medium	**User Experience**	Medium

Improvement 8: Supplier Management

Theme	Supplier Incident Management		
Commencement Date	01/10/2023	**Current Status**	Completed
Owner	Commercial Services	**Stakeholders**	Service Management Contract Managers
Description	Through the Contributory Factors Framework, the External Domain covers incidents where the contributory factor has been identified as with either a supplier (for example a software bug, or wide area network outage) or is within the local health board or stakeholder organisation (for instance local network issues or application of patching locally). For factors within this domain improvements will also be sought through supplier management with third party suppliers.		
Improvements Implemented	This is a new improvement identified in October 2023		
Planned Activities Next Quarter	Focussing initially on supplier related incidents, tighten contractual arrangements through: • Identify scope and scale through existing reporting lines. • Review contractual provisions. • Review and identify improvements around delivery of training to contract owners. Commercial Services Representation on IRLG		
Planned Activities FY 25/26	• Raise awareness of supplier responsibilities in line with current contracts • Raise awareness of supplier incidents impacting national services through Contract Review Meetings and (where applicable) Service Management Boards		

DHCW Missions	Mission 1	Mission 2	Mission 3	Mission 4	Mission 5
Service Management Dimensions		Value Streams & Processes	Information & Technology	Organisations & People	Partners & Suppliers
Complexity	Medium	**Cost Reduction**	High	**User Experience**	Medium

Improvement 11: Review of Clinical Impact

Theme	Review of Clinical Impact Statements for Incidents		
Commencement Date	08/01/2024	**Current Status**	Completed
Owner	Service Management / Clinical Informatics	**Stakeholders**	Operational Support Teams Clinicians
Description	This collaboration between Clinical Informatics and Service Management is, initially, to capture general clinical impact statements for Clinical systems within the Service Catalogue to enable operational support teams and those on the management on call rota to have an early indication of the potential impact following system failure. The purpose of this is to be able to then provide a more appropriate and business focussed response. Future improvements will be identified to also cover other areas of business impact		
Improvements Implemented	• Overview of Service Portfolio presented to Clinical Informatics Team • Update of Incident Review Template to include greater emphasis on clinical impact. • Review of Service Management developed processes to incorporate greater emphasis on understanding of clinical impact • Inclusion of a new field within the ITSM Toolset to notify Clinical and Patient Safety Teams of P1s and P2s at point of logging.		
Planned Activities FY 24/25	• Develop Clinical Impact Statements within the Service Portfolio for all Clinical category systems • Identification and capture of Clinical Lead within the Service Portfolio • This is also linked to Improvement 1: Major IT Incident Management and Improvement 13: Review of Service Portfolio		

DHCW Missions	Mission 1	Mission 2	Mission 3	Mission 4	Mission 5
Service Management Dimensions		Value Streams & Processes	Information & Technology	Organisations & People	Partners & Suppliers
Complexity	Medium	**Cost Reduction**	Low	**User Experience**	High

Appendix A - Definitions
Contributory Factors Framework Domains

- There are six domains
  - **Active Domain:** these relate to any factors around the immediate incident, and covers two areas; active failures, so those which were a direct cause, or planned activities which nevertheless resulted in an incident being raised
  - **Situational Domain:** these relate to any factors around the team responsible, or the task being undertaken
  - **Departmental Domain:** these relate to any factors around the management tier, available resources, and some of the direct environmental factors such as infrastructure, applications, data, or interfaces
  - **Organisational Domain:** these relate to any factors at an organisational level, including organisational policies, training and design
  - **External Domain:** these relate to any factors out of the direct control of the organisation, such as third parties, support from external stakeholders and national (All Wales) policies
  - **Communication and Culture:** these are factors that cross all domains and cover the safety and risk culture of the organisation as well as communication