Bundle BCU Quality, Safety and Experience Committee 4 September 2025

1 PRELIMINARY MATTERS

1.1 13:00 - QS25/79 Welcome and Apologies
Chris Lothian-Field, Vice-Chair

1.2 QS25/80 Declarations of Interest
Chris Lothian-Field, Vice-Chair

1.3 13:02 - QS25/81 Unconfirmed minutes of meeting held 3 July 2025
Chris Lothian-Field, Vice-Chair
QS25 81.1 Unconfirmed minutes of meeting held 3 July 2025

1.4 13:04 - QS25/82 Matters Arising and Action Log
Chris Lothian-Field, Vice-Chair
QSE Action Log PUBLIC - 28.08.25

1.5 13:09 - QS25/83 Patient's Story - Health Play Specialist
Angela Wood, Executive Director of Nursing & Midwifery
QS25 83.1 Patient Story - Health Play Specialist

2 SERVICE PRESENTATION

2.1 13:29 - QS25/ 84 Women's, Maternity & Gynaecology
Emma Adamson, Consultant Midwife
To include reflections on:
response to Independent Review of Maternity and Neonatal Services, Swansea Bay University Hospital Board, May 2025
BCU's Update on Response to Welsh Government Quality Statement into Maternity and Neonatal Services, Feb 2025
BCU Maternity Services Position in relation to Llais Report into Maternity and Neonatal services, Swansea Bay University Hospital Board, May 2025
QS25 84.1 Independent Review of SBUHB May 2025
QS25 84.2 Quality Statement Local Benchmarking
QS25 84.3 Llais Report QSE August 25 update

3 QUALITY CONTROL

3.1 13:59 - QS25/85 Integrated Quality Report
Jointly presented by:
Angela Wood, Executive Director of Nursing & Midwifery
Sree Andole, Interim Executive Medical Director
Jane Moore, Executive Director of Public Health
Teresa Owen, Executive Director of Allied Health Professionals and Health Science
Matt Joyes, Deputy Director of Legal Services
QS25 85.1 QSE Integrated Quality Report September 2025

3.2 14:29 - QS25/86 Integrated Performance Report
Ed Williams, Director of Performance
QS25 86.1 Cover Sheet
QS25 86.1 Intergrated Performance Report

4 QUALITY IMPROVEMENT

4.1 14:39 - QS25/87 Updates on Challenged Services
Sree Andole, Interim Executive Medical Director
Paolo Tardivel, Interim Executive Director of Transformation and Improvement
QS25 87.1 Update on Challenged Services Report
QS25 87.1 Update on Challenged Services - V0.2

4.2 15:19 - QS25/88 Tackling Planned Care Challenges
Tehmeena Ajmal, Chief Operating Officer
QS25 88.1 Tackling Planned Care Challenges

QS25 88.2 BCU Planned Care Management Response

5 QUALITY ASSURANCE

5.1 15:29 - QS25/89 Update on Royal College of Psychiatrists Action Plan
Phil Meakin, Associate Director of Governance/RCPsych Response Lead
QS25 89.1a Update on Royal College of Psychiatrists Action Plan Report
QS25 89.1b RCP appexdix 1
QS25 89.1c RCP appexdix 2

6 ROUTINE REPORTING

6.1 15:39 - QS25/90 Board Assurance Framework
Nesta Collingridge, Head of Risk Management
QS25.90.1 Board Assurance Framework

7 ANNUAL REPORTING

7.1 15:49 - QS25/91 March 2025 Lymphoedema Wales Clinical Network End of Year Evaluation Framework & Activity Report
Angela Wood, Executive Director of Nursing & Midwifery
QS25 91.1 March 2025 Lymphoedema Wales Clinical Network End of Year
QS25 91.2 Lymphoedema Wales Clinical Network End of Year Evaluation

7.2 15:59 - QS25/92 Draft Annual Duty of Candour Report 2024-25
Angela Wood, Executive Director of Nursing & Midwifery
QS25 92.1 Annual Duty of Candour Report 2024-25 - Draft AW.doc

7.3 16:09 - QS25/93 Draft Annual Putting Things Right Report 2024-25
Angela Wood, Executive Director of Nursing & Midwifery
QS25 93.1 Annual PTR Report 2024-25 - Draft - AW

8 FOR INFORMATION

8.1 QS25/94 JCC Quality Safety Outcomes Highlight Report
Pam Wenger, Director of Corporate Governance
QS25 94.1 JCC Quality Safety Outcomes Highlight Report

8.2 QS25/95 Summary of Business to be Reported from Private
Philippa Peake-Jones, Head of Corporate Governance
QS25.95.1 Summary of Business to be reported from Private 03.07.25

8.3 QS25/96 QSE Forward Work Plan
Philippa Peake-Jones, Head Of Corporate Affairs
Paper to follow

8.4 QS25/97 Llais NW Monthly Report
QS25.97.1 Llais NW Monthly Report 07 2025

9.1 16:19 - QS25/98 Agree Items to be Referred to Board and/or Other Committees
Chris Lothian-Field, Vice-Chair

9.2 16:21 - QS25/99 Meeting Effectiveness
Chris Lothian-Field, Vice-Chair

9.3 Date of Next Meeting
13.00hrs, Thursday, 6 November 2025

9.4 Resolution to Exclude the Press and Public
Chris Lothian-Field, Vice-Chair
'Those representatives of the press and other members of the public be excluded from the remainder of this meeting, having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest, in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960'.

Betsi Cadwaladr University Health Board (BCUHB)
Unconfirmed Minutes of the Quality, Safety and Experience Committee meeting
held in PUBLIC
on 3 July 2025, The Boardroom, Carlton Court, St Asaph

Board Members present	
Name	**Title**
Dr Caroline Turner	Committee Chair, Independent Member
Chris Lothian-Field	Committee Vice Chair, Independent Member
Urtha Felda	Independent Member
Professor Mike Larvin	Independent Member
In Attendance	
Angela Wood	Executive Director of Nursing & Midwifery
Ros Alstead	Independent Advisor, Royal College of Psychiatrists Action Plan Response (part meeting)
Nesta Collingridge	Head of Risk Management
Rhys Davies	Interim Director Of Pharmacy & Medicines Management (part meeting)
Dyfed Edwards	Chair, BCUHB
Gareth Evans	Director, IHC Central
Naomi Holder	Site Director of Nursing (Secondary Care East) (part meeting)
Nicola Jones	Deputy Head of Internal Audit
Matt Joyes	Deputy Director for Legal Services
Nichaela Jones	MH&LD Head of Operations (deputising for Iain Wilkie, Director of Mental Health)
Stuart Keen	Director of Environment and Estates
Jo Kendrick	Head of Quality
Lois Lloyd	Chief Pharmacist / Controlled Drugs Accountable Officer
Phylis Makurunje	Aspiring Board Member (observing)
Phil Meakin	Associate Director of Governance, Lead for RCP Action Plan response
Jane Moore	Executive Director of Public Health
Teresa Owen	Executive Director of Allied Health Professionals and Health Science
Philippa Peake Jones	Head of Corporate Affairs
Stephen Powell	Director of Commissioning and Performance
Maeve Puleston-Jones	Audit Wales (observing)
Geoff Ryall-Harvey	Llais, North Wales (part meeting)
Fiona Lewis	Minute Taker

Agenda Item
PRELIMINARY MATTERS
QS25/52 Welcome and apologies The Chair welcomed all to the meeting. Apologies were received from Pam Wenger (Director of Governance), Iain Wilkie (Director of Mental Health & Learning Disabilities) Nichaela Jones deputised, Dave Harries (Head of Internal Audit) – Nicola Jones deputised, Tehmeena Ajmal (Chief Operating Officer) and Fiona Giraud (Director Of Midwifery & Womens Services).
QS25/53 Declarations of Interest None were received.
QS25/54 Unconfirmed minutes of meeting held on 1 May 2025 **It was resolved that** the Committee: • **Agreed** the Minutes were a true and accurate record of the meeting held 1 May 2025.
QS25/55 Matters Arising and Action Logs Updates to the Action Log were noted. **QS25/55.1** It was noted that **SP, AW** and **IHCs** were to discuss how best to support and scrutinise quality of services. An update to be provided at next meeting. **QS25/55.2** Ophthalmology update to be provided at September meeting, with **NC** ensuring that the update and the Corporate risks are aligned. **It was resolved that** the Committee • **Agreed** the updated log. *[Mike Larvin and Nichaela Jones joined the meeting]*
QS25/56 Patient Story – Carer Aware Approach to Hospital Discharge The Executive Director of Nursing and Midwifery shared an audio-visual story which showcased the positive partnership between the North East Wales Carers Information Services (NEWCIS) and staff at Wrexham Maelor Hospital (including the Patient Liaison Service, PALS), supporting unpaid carers to facilitate the earliest, safe transfer of patients from hospital to their homes. Without this co-operation, patients and their carers can sometimes reach crisis situations, resulting in the patients needing to be readmitted into hospital. Following the presentation, Members noted: • This service was provided at all acute and community hospitals • Work continued to improve the services, in particular more help for young carers

- For patients and carers who are not born in the UK, many face difficulties in understanding the processes to access services. As such, the Organisation needs to ensure it is culturally competent in recognising any barriers they may experience and provide appropriate support to enable them to fully participate and access services.

The Chair thanked The Executive Director of Nursing and Midwifery for bringing this matter to the Committee's attention.

It was resolved that the Committee

- **Noted** the report.

[Stephen Powell, Gareth Evans, Naomi Holder and Rhys Davies joined the meeting]

SERVICE PRESENTATIONS

QS25/57 Integrated Health Community (IHC) - Central

The Director of the IHC Central, the Site Director of Nursing (Secondary Care EAST) and the Interim Director of Pharmacy & Medicines Management jointly made their presentation, highlighting the following:

- Central area had high pockets of elderly population and some of the most deprived areas in Wales.
- There are a number of specialist services in Central, not found elsewhere in North Wales, such as Sub-Regional Neonatal Intensive Care (SuRNICC) and Vascular services.
- The current Governance Structure was under review.
- The progress made regarding the outstanding actions, following the Internal Audit Review in 2024.
- The numerous achievements made over the past 12 months.
- The Central Incident profile including the two Never Events; the Health Acquired Pressure Injuries along with the mitigations and measures put in place; the infection trends; the reduction of and learning from formal concerns, and the increase in appropriate flow to and through community hospitals.
- Primary and Community Care – Regulation 28 notice on the Health Board on 14 February 2025. Healthy Prestatyn Iach (HPI), a CIHC Managed Practice, had not attained its expected compliance – Naomi Holder to provide an update outside of meeting.
- The de-escalation of the Emergency Department at Ysbyty Glan Clwyd as a service of significant concern by the Healthcare Inspectorate Wales (HIW).
- The impact and success that the Therapies teams have had supporting patients to avoid hospital admissions, as well as facilitating earlier and safer discharges.
- Continuing Areas of Concern – Gastroenterology as a fragile service?
- The negative impact of enhanced organisational controls/non-recurrent funding (contracts, Oracle and RIGA)
- The top five risks and plans to mitigate along with emerging and escalating risks to note.

Following the presentation, discussions took place regarding:

- Necessary improvements to avoid breaches of capacity in Pharmacy and the importance of addressing capacity pressures. These included regional actions

already underway to expand outsourcing, advancing workforce recruitment, standardising prescriptions and ensuring they are presented to Pharmacy in a timely manner.
- It was noted that work continues to improve the flow of patients through the hospital – from the front to the back door. Should this not be addressed, waiting times in ED will remain stubbornly high.

ACTIONS:
- **QS25/57.1 NH** to provide update to Members regarding HPI's compliance.

It was resolved that the Committee**:**
- **Noted** the information provided**.**

[Gareth Evans, Naomi Holder and Rhys Davies left the meeting]

QUALITY PLANNING

QS25/58 Executive Summary of the Key Strategies Relating to Women's Health and Perinatal Services

The Executive Director of Nursing and Midwifery presented the paper which provided information about the new strategies and policies relating to women's health and perinatal services across Wales.

The paper referred to the implementation of the Women's Health Plan, with the expectation that there will be a Women's Hub (either virtual or physical) in place by the end of the financial year. It was anticipated that with a Clinical Lead and Steering Group now in place, following appropriate consultation, a bid for up to £300k funding will have been made by September 2025.

Following the Llais review of Women's Services at Swansea Bay in May, a response along with an Action Plan had been requested. It was noted that a response was created and that the Action Plan was going through Governance and would be brought to the Committee at the next meeting for review.

Additionally, the Health Board awaited details from the Welsh Department of Health regarding a one-off independent national maternity and neonatal assessment, which is to be carried out across Wales, following the Cabinet Secretary's announcement in May.

Action:
- **QS25/58.1 FG/AW** to share response and action plan following the Llais Review of Women's Services at Swansea Bay.

It was resolved that the Committee
- **Noted** the report.

[Geoff Ryall-Harvey, Ros Alstead and Phil Meakin joined the meeting]

QS25/59 Corporate Governance Review

Members received the Committee's Annual Report, Annual Self-Assessment and draft Cycle of Business. The Head of Corporate Affairs confirmed the following:

- Primary care would be sitting under the governance of Planning, Population's Health and Partnerships Committee.
- Work will continue to align the Forward Work Plan with the Annual Plan.

Members discussed the following:

- **The Annual Report**
  - Pg 4. Amend 'formation of the Committee' to 'strengthened arrangements of the Committee'.
  - Pg 3. Amend list of 'currently challenged services' so as not to include Ophthalmology, Plastics and Oncology, which the Committee had not reviewed within the period covered by the report.
  - The Chair wished it noted more clearly in the report that the development sessions had been extremely helpful to the Independent Members.
- **The Annual Self- Assessment**
  - The Lead Executive was pleased with the findings of the Annual Self-Assessment, however noted that in future more clarity around wording used would be required to avoid misinterpretation of questions.
  - Chair noted that 'there was uncertainty that the Committee effectively monitors the implementation of Management actions from Audit Reports'.
- **The Draft Cycle of Business**
  - Noted the addition of the Annual Plan to the COB.

ACTIONS:

- **QS25/59.1 CT and PP-J** to discuss slight amendments to Annual report outside the meeting.
- **QS25/59.2 PPJ** to look at amendments to Annual Self-Assessment.

It was resolved that the Committee

- **Approved** the QSE's Cycle of Business 2025-26
- **Approved** the Committee's Annual Report
- **Noted** and **Discussed** the Committee's Self-Assessment

QUALITY ASSURANCE

QS25/60 Integrated Quality Report

The Executive Director of Nursing and Midwifery, The Interim Executive Medical Director, The Executive Director of Public Health, The Executive Director of Allied Health Professionals and Health Science and the Deputy Director of Legal Services provided their insight into their respective sections of the report.

The following areas were highlighted:

- **Patient Safety**
  - Efforts continue to reduce the backlog of open incidents (5,226, with 63% overdue)
  - Downward trend in patient falls with strategic oversight from the Health Board
  - Upward trend in healthcare acquired pressure ulcers, with ongoing efforts to manage and reduce incidents.

- A reduction in National Reportable Incidents compared to the previous period, with a focus on timely and effective management
- Two recorded Never Events, with measures implemented to prevent recurrence.

- **Patient Experience**
  - 533 complaints received with 531 closed and an improvement in the average closure time.
  - Positive feedback on patient care received, with a focus on dignity, respect ad language accessibility.
  - 1,170 PALS enquiries resolved
- **Clinical Effectiveness**
  - ongoing national clinical audits to benchmark performance and identify improvements
  - Improved compliance with NICE guidance with proactive support and training provided to departments
  - With regards to the Mortality Review, engagement with the Medical Examiner Service ongoing, which supports continuous learning and quality improvement.
- **Quality Assurance**
  - Ongoing inspections and Improvement Plans to address issues identified by Healthcare Inspectorate Wales
  - Quality of Care reviews and compliance with regulatory requirements of Care Inspectorate Wales
  - No new public interest reports received from the Public Services Ombudsman for Wales.
- **Healthcare Law**
  - One Regulation 28 Prevention of Future Death Notice received with actions taken to address identified issues.
  - Efforts continue to improve the timeliness of Learning from Events reports, with a significant reduction in overdue reports.

Following the presentation, Members discussed the following:

- significant progress made since the last meeting with regards to the improved monitoring of Clinical Audits.
- there remained a significant number of deaths yet to be coded.
- The Interim Executive Medical Director to circulate details of the Medical and Healthcare products Regulatory Agency (MHRA)breach that had taken place
- The possibility of making the focussed PALS training on patient and carers experience mandatory in the future, which it was agreed would be difficult to facilitate. It was noted that this training is currently being carried out, but at the patients' bedsides.
- The improved relationship between the Health Board and the Coroner's Office, as noted by the Chief Executive Officer, The Executive Director of Nursing and Midwifery and the Deputy Director of Legal Services.
- A question arose regarding understanding staff training in the use of gases.

Action:
QS25/60.1 SA to circulate details of the MHRA breach**.**
QS25/60.2 AW to investigate staff training around the use of gases

It was resolved that the Committee

- **Noted** the report

QS25/62 Update on the Royal College of Psychiatry (RCP) Action Plan

Ros Alstead, the Independent Special Advisor and Chair of the Expert Advisory Group (EAG), presented the report and reflected on the following:

- The EAG is approximately two thirds of the way through the time allotted to it for the work.
- The considerable difficulties around handling the work in a sensitive manner is ongoing, making sure to strike the right balance between pace and momentum.
- Her continued thanks to the Experts by Experience for their input into the process, the Health Board for its support and Geoff Ryall-Harvey, Llais, for his support and guidance.
- Looking at the actions that have come through the Health Board committees, noting that working with patients and families had provided a different perspective.
- Llais due to start visiting wards on 4 July, to access staff and patient input first hand.
- That there was undoubtedly steady but not consistent improvement – therefore still much more to do.
- Her concern regarding the sustainability of raised standards and how they will be monitored and maintained.
- The management of EAG Members' expectations.
- Clarity required regarding improved validation and sustainability of outcomes.

Following the presentation, the Committee:

- Thanked the EAG for their work.
- Noted the enormous amount of learning.
- Asked what the long-term plan is regarding the lack of psychologists
- Was assured that Civica enabled consistent team/patient engagement
- Was assured that the Health Board continued to monitor and support Caniad.
- Was pleased to hear that the teams were invigorated by involvement in the EAG work.

It was resolved that The Committee:

- **Noted and considered** the update from the Chair of the Expert Advisory Group
- **Noted and considered** the update on progress against the Expert Advisory Group Work Programme
- **Noted and considered** the Development of a draft Outcome Framework and Performance Dashboard

[Geoff Ryall-Harvey, Ros Alstead and Phil Meakin left the meeting]

QS25/61 Integrated Quality Performance Report (IQPR)

The Director of Performance presented his report, noting:

- The new style of reporting, especially from a commissioning perspective
- Improved interfacing and early intervention with commission providers to reduce harm to patients on long waiting lists
- Work being done with the Executive Director of Nursing and Midwifery and her team to provide more quality substance to the report.

- the importance of the Quality Impact Assessments to help support decision making.

Following the presentation, the Committee noted:

- the improvements in the quality of the report
- the ongoing work training Coders and catching up with the back-log
- the continuing work regarding the outstanding action relating to triangulating risks with performance
- concern regarding the harm to patients whilst on waiting lists and mitigation being put in place
- understanding what better outcomes look like and how to measure them.

It was resolved that The Committee:

- **Reviewed** the contents of the report and
- **Proposed** actions noted above arising from the report,
- **identified** any additional assurance work or actions it would recommend Executive colleagues to undertake, as noted above.

ROUTINE REPORTING

QS25/63 Board Assurance Framework and Corporate Risk Register

The Head of Risk Management provided an update firstly on the Corporate Risk Register, noting:

- QSE had 15 Corporate risks
- Moving the responsibility of Primary Care and Community Care to the Planning, Population Health and Partnerships was deemed appropriate.
- Seven risks were above tolerance and continued to be monitored and scrutinised.
- The Risk Scrutiny Group (RSG) received a Deep Dive presentation into Vascular Services, where it was scrutinised and challenged. The risk had increased due to sustainability issues in relation to the medical workforce.
- The RSG was also closely monitoring the services with newly escalated risks – Pharmacy and Vascular.

Following the presentation:

- Concern was raised that the Risk Register might be being used to drive transformation and improvements in services.
- The Committee was assured that all eight challenged services were being put through the QMS process
- Members agreed there was more work to do but did acknowledge the improvements in governance, leadership and financial control.
- It was agreed that The Executive Director of Nursing and Midwifery, The Interim Medical Director, The Director of Commissioning and Performance and the Head of Risk Management should meet outside of the meeting, to discuss Risk Register thresholds.

Action:

- **AW, SA, SP** and **NC** to meet to discuss Risk Register thresholds.

It was resolved that the Committee**:**

- **Received assurance** for the progression of the Corporate Risks to which the Committee has overall accountability**.**

[Dyfed Edwards left the meeting]

FOR INFORMATION

QS25/64 JCC Quality Safety Outcomes Highlight Report 20.05.25

It was resolved that the Committee
- **Noted** the Report.

QS25/65 Summary of Business to be Reported in Private part of Last Meeting

It was resolved that the Committee
- **Noted** the Report.

QS25/66 Review Committee Forward Work Plan (FWP)

It was resolved that the Committee
- **Noted** the Committee Forward Work Plan.

QS25/67 Llais NW Monthly Report

It was resolved that the Committee
- **Noted** the Committee Forward Work Plan.

CLOSING BUSINESS

QS25/68 Agree Items for Referral to Board / Other Committees

It was resolved that there were no items for referral to Board or other Committees.
-

QS25/69 Meeting Effectiveness

Members thanked The Director of Commissioning and Performance for both the contents of his report and his attendance at the meeting

QS25/70 Date of Next Meeting

13.00hrs, Thursday, 4 September 2025

Resolution to Exclude the Press and Public

It was resolved that those representatives of the press and other members of the public be excluded from the remainder of this meeting, having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest, in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960.

QSE Committee PUBLIC Action Log

Open Actions						
Action No.	**Minute Ref.**	**Date**	**Agreed Action**	**Lead**	**Time scale**	**Status**
1	QS25/55.1	03.07.25	**QS25/55 Matters Arising and Action Logs** To discuss how best to support and scrutinise quality of services. An update to be provided at next meeting.	Exec. Dir. Nursing & Midwifery **(Angela Wood)** Dir. Of Commissioning & Performance **Stephen Powell** All IHC Directors **(Vic Peach** **Gareth Evans** **Michelle Green)**	Sept 2025	**Remain Open** **7.07.2025** - Angela Wood has discussed with Stephen Powell. IHC representatives to attend the commissioning meetings for services aligned to the IHC. **Update** : awaited from Stephen Powell
2	QS25/59.1		**QS25/59 Corporate Governance Review** To discuss slight amendments to Annual report and Annual Self-Assessment outside the meeting. to discuss amendments	Chair **(Caroline Turner)** Head of Corporate Affairs **(Philippa Peake-Jones)**	Septe mber	**Remain Open** The Annual Report has been amended and is being signed off

3	QS25/31.2	01.05.25	**QS25/31 Overview of Mental Health** Invite Board to a session regarding CMHT accessibility – with Vicky Jones, Head Mental Health Strategic Programme	Head of Corporate Affairs **(Philippa Peake-Jones)**	May 2025	**Remain Open** Included in the Board Development Programme agreed in May 2025.
4	QS25/60.1	03.07.25	**QS25/60 Integrated Quality Report** To circulate details of the MHRA breach**.**	Interim Exec Medical Director **(Sree Andole)**	July 2025	**Remain Open**
5	QS25/43.1	01.05.25	**QS25/43 Review Committee Forward Work Plan**	Head of Corporate Affairs **(Philippa Peake-Jones)**	Septe mber 2025	**Remain Open** **03.07.25** PP-J confirmed that work continues to align the FWP with the Annual Plan – Updated work plan included as part of agenda bundle.
6	QS25/11.1	20.02.25	**QS25/11 Colonoscopy Performance Update Clarify when the Colonoscopy data/paper can be reported back into QSE.**	Exec. Dir. of Nursing & Midwifery **(Angela Wood)** to link in with Interim Chief Operation Officer) **~~(Imran Devji~~)** **Tehmeena Ajmal**	May 2025	**Remain Open** **24.02.25** From AW - Email sent to Imran, awaiting clarification **03.07.25** AW confirmed that she had met with Tehmeena Ajmal, COO. A further update will be provided at the September meeting.
7	QS24/121.1	24.10.24	**QS24/121 Integrated Performance Report** to speak to the Deputy Executive Medical Director to check the veracity of colonoscopy data provided in report, and to escalate concerns if required.	~~Exec. Dir. Allied Health Professionals & Health Science~~ ~~**(Teresa Owen)**~~ ~~Interim COO~~ **~~(Imran Devji~~)** Chief Operating Officer **– Tehmeena Ajmal**	~~17.12 .24~~ May 2025	**Remain Open** **9.12.24** TO spoke with Deputy Executive Medical Director. Data/information is being checked by the team. **12.2.25** Jim McGuigan advised that Imran Devji was aware of this query and investigating. **9.4.25** Update requested.

8	QS25/10.1	20.02.25	**QS25/10 Ophthalmology** Circulate a paper on challenged services, to include Ophthalmology, before 1st May QSE mtg.	Interim Executive Medical Director **(Sreeman Andole)** Head of Risk Management (**Nesta Collingridge)**	~~April 2025~~ July 2025	**Suggest close** **22.4.25** Advised that Deep Dive into Opthalmology will be provided at July meeting. **03.07.25** Update to be provided at September meeting, with assistance from Nesta Collingridge to ensure alignment with Corporate risks. **28.08.25** Challenged services on agenda
9	QS25/55.2	03.07.25	**QS25/55 Matters Arising and Action Logs** Ophthalmology update to be provided at September meeting, with **NC** ensuring that the update and the Corporate risks are aligned.	Exec Med. Dir. **(Sree Andole)** Head of Risk Management **(Nesta Collingridge)**	Sept 2025	**Suggest close** Item on agenda and ophthalmology requested to attend
10	QS25/57.1	03.07.25	**QS25/57 Integrated Health Community (IHC) – Central** Provide update to Members regarding HPI's compliance.	Site Director of Nursing (Secondary Care East) **(Naomi Holder)**	Aug 2025	**Suggest close** **4.8.25** Received confirmation from IHC Central regarding the Reg. 28 Report Response rate. '*This report outlines the significant improvement in our response to Regulation 28 reports over the last 12 months. It details the investment made to improve compliance, a GAP analysis of performance, and how we've strategically prioritised complex reviews to reduce clinical risk and ensure sustainable service delivery. While review compliance improved from 46% to 72% in 12 months*'

11	QS25/58.1	03.07.25	**QS25/58 Executive Summary of the Key Strategies Relating to Women's Health and Perinatal Services** to share response and action plan to the Llais Review of Women's Services at Swansea Bay.	Exec Dir Nursing & Midwifery **(Angela Wood)** Dir of Midwifery & Women's Services **(Fiona Giraud)**	Sept 2025	**Suggest close** Presentation from Maternity and Womens Services will be on agenda for September QSE. **14.08.2025** - On agenda for September meeting. A BCUHB Maternity Governance review panel has been appointed with report and recommendations to be provided to Executive Nurse Director in October 2025.
12	QS25/60.2	03.07.25	**QS25/60 Integrated Quality Report** To investigate staff training around the use of gases	Exec Dir for Nursing & Midwifery **(Angela Wood)**	Sept 2025	**Suggest close** **14.08.2025** - included in September 25 report.
13	QS25/63.1	03.07.25	**QS25/63 Board Assurance Framework and Corporate Risk Register** To meet to discuss Risk Register tolerance thresholds	Exec Dir for Nursing & Midwifery **(Angela Wood)** Exec Med. Dir. **(Sree Andole)** Dir of Commissioning & Performance **(Stephen Powell)** Head of Risk Mngt **(Nesta Collingridge)**	Sept 2025	**Suggest close** **14.08.25** – Risk session delivered at Informal Executive meeting on 16th July. Further work being undertaken by the Corporate Governance office.
14	QS25/38.1	01.05.25	**QS25/38 Board Assurance**	Head of Risk	July	**Suggest close**

			Framework and Corporate Risk Register BAF to include more external validations and also to include mitigations, focussing on challenged services' risks.	Management (**Nesta Collingridge**)	2025	**03.07.25** NC confirmed that work continues, to align the BAF with the Annual Plan. **28.08.25** – NC confirmed informal Executive meetings were held on 16th July and 20th August, which reviewed challenged services risks. Changes to be communicated with the Chair through CRR report and 28th Aug Risk Appetite session.
Closed Actions						
Action No.	**Minute Ref.**	**Date**	**Agreed Action**	**Lead**	**Time scale**	**Status**
1	**QS25/31**	01.05.25	**QS25/31.1** Overview of Mental Health Circulate the Link to the New Strategy	Exec. Dir. Allied Health Professionals & Health Science (Teresa Owen)	May 2025	Mental health and wellbeing strategy 2025 to 2035 | GOV.WALES 26.6.25 Circulated to members
3	**QS25/34**	01.05.25	**QS25/34.1** Integrated Quality Report Ensure Integrated Performance Report be rectified to reflect 1) a Never Event had taken place in March 2025 and 2) the Complaints Compliance figures were updated	Exec. Dir. of Nursing and Midwifery (Angela Wood)	May 2025	17.6.25 J Kendrick, Head of Quality, has linked with the Performance Team. Going forwards reports will be shared between both teams, Quality and Performance to ensure alignment. In addition, the data set will be accessed via the Quality Dashboard and signed off by Head of Quality prior to publication.
9	**QS25/05**	20.02.25	**QS25/05.1** Patient's Story Chief Pharmacist to review	Chief Pharmacist (Lois Lloyd)	July 2025	30.4.25 A review of current arrangements across the Health Board's emergency quadrants has been undertaken to better

			options and mitigation strategies to ensure access to the most frequently used medicines seven days a week in high-demand areas.			understand existing processes. It has identified that frequently used, ready-labelled take-home medicines, such as pain relief and antibiotics are often prepared in advance and stored in automated medicine cabinets for ease of access at any time. These are positioned to support timely discharge within key priority pathways. In parallel, a pharmacy workforce review is in progress as part of a national programme led by the NHS Wales Directors of Pharmacy Peer Group. This includes mapping current staff deployment against demand, and assessing skills and contributions in relation to NHS Wales priorities - particularly within the Emergency Department and Same Day Emergency Care (SDEC). This work is being informed by the recommendations from the Independent Review of Clinical Pharmacy Services in NHS Wales Hospitals. While a 24/7 on-site pharmacy presence may not be required, the emerging strategy is exploring options to ensure timely access to pharmaceutical expertise and medicines every day of the week. This could include enhanced use of automation or appropriate signposting to community pharmacy services.”

Teitl adroddiad: ***Report title:***	**Health Play Specialist - Patient Story**			
Adrodd i: ***Report to:***	QSE			
Dyddiad y Cyfarfod: ***Date of Meeting:***	4th September 2025			
Crynodeb Gweithredol: ***Executive Summary:***	A patient or carer story is presented to QSE to bring the voice of the people we serve directly into the meeting. The digital story will be played at the meeting. A short summary is included in the attached paper.			
Argymhellion: ***Recommendations:***	QSE is asked to note this report.			
Arweinydd Gweithredol: ***Executive Lead:***	Angela Wood, Executive Director of Nursing and Midwifery			
Awdur yr Adroddiad: ***Report Author:***	Chris Lynes, Deputy Executive Director of Nursing Rachel Wright, Patient and Carer Experience Lead Manager Hannah Hughes, Patient & Carer Experience Manager			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				
In line with best practice, a patient or carer story is presented to QSE to bring the voice of the people we serve directly into the meeting, but it is not presented as an assurance item. However, the accompanying paper describes some of the learning and actions undertaken in response to the story.				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Quality			
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	N/A			
Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqlA been identified as necessary and undertaken?***	N/A			
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	N/A			

Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	BAF21-10 - Listening and Learning
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	N/A
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	N/A
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	N/A
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	BAF21-10 - Listening and Learning
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	N/A
Camau Nesaf: Gweithredu argymhellion ***Next Steps: Implementation of recommendations*** N/A	
Rhestr o Atodiadau: I am willing for my story to be shared with: [√] Level 1 – Any Health and Social Care Professionals within BCUHB [√] Level 2 – Researchers for Service Evaluation and improvement beyond BCUHB [√] Level 3 – Meetings and Conferences with anyone present including public and journalists [√] Level 4 – Anyone including Online, Internet, Social Media and CIVICA Play Therapy Patient Story - WELSH SUBTITLES.mov Play Therapy Patient Story - ENGLISH SUBTITLES.mov ***List of Appendices:*** Appendix A- Patient Story Summary	

Betsi Cadwaladr University Health Board

An audio-visual story will be played at the meeting.

Overview of Patient Story

This story was initially collected by a Patient Experience Manager at CAMHS (Child and Adolescent Mental Health Services).

The storyteller describes their experience as a family of a child with additional needs.

The storyteller describes how their daughter was required to have a blood test. The storyteller shared how upsetting they had found a previous blood test, which resulted in their daughter having to be restrained, traumatising both the family and their daughter.

The storyteller describes a positive experience the family had of being supported by a Health Play Specialist on the Childrens Ward in Wrexham Maelor Hospital.

Key Messages

- The lives of families of children with additional needs can often revolve around healthcare co-ordination.
- Both the child and the family had a previous traumatic experience of trying to have bloods taken which resulted in them feeling anxious about having it done again.
- The family felt more confident and re-assured after meeting the Health Play Specialist.
- The Health Play Specialist was able to support the child to be able to successfully have bloods taken and positively impact on the experience for the family.
- Staff demonstrated care and compassion.

Summary of Learning and Improvement

The patient story has been shared across the Children's Ward at Wrexham Maelor Hospital and CAMHS for feedback and learning. The story was presented to the Patient and Carer Experience Group meeting in July 2025, with a recommendation to share this story across Children's Services.

The storyteller describes a previous traumatic experience for both the child and the family of trying to have bloods taken without the support of a Health Play Specialist which resulted in them feeling anxious about having it done again.

Visits to hospital can be challenging, frightening and traumatic. They can be out of the comfort zone for many children and young people and can also be at a time when they are at their most vulnerable.

Play in healthcare is a term used to describe the provision of therapeutic and specialised play, organised as a distinct service and delivered by skilled, professional health play staff within hospitals and other healthcare settings where children are cared for, both as inpatients and outpatients. It is a structured form of play activities designed based on age, development of cognitive functions and the health condition of the child.

Play in hospital can reduce stress and discomfort during medical procedures, help children express and manage emotions, foster dignity, build connection and belonging and preserve a children's sense of childhood. Play can support the understanding of treatments and procedures, facilitate communication and support recovery.

Guidance and Legislation on play in healthcare settings is well documented and includes Play as a Human Right (Article 31 United Nations Convention on the Rights of the Child), NICE Guidelines (2021) and Aim of Paediatric Care (RCPCH, 2015).

The storyteller describes that the Health Play Therapist was able to support the child to be able to successfully have bloods taken and positively impact on the experience for the family.

In Wrexham Maelor Hospital, the Healthcare Play Team is based within the Children's Ward and is made up of three staff: a Play Worker, a Play Assistant, and a Registered Health Play Specialist.

There is only one additional Health Play Specialist in BCUHB working from Ysbyty Gwynedd. Other Registered Health Play Specialists operate from Ty Gobaith and Hope House.

Play Workers hold training in Child Development and provide a safe and welcoming child-friendly environment throughout the ward and play environments to enhance children and young people's hospital experiences. They provide normalisation via recreational and developmental play at the bedside or in a playroom setting. They encourage parents and staff to participate in play and provide activities within patient areas, both planned and ad-

hoc. They provide holistic play for children and families enabling them to feel safe and at ease within the hospital environment. Play Assistants also hold training in Child Development and provide the same role as Play Workers, with the addition of preparation and distraction for children undergoing clinical procedures and prepare children for simple procedures under the supervision of the Play Specialist.

Health Play Specialists differ in that they are highly skilled, hold a Foundation Degree in Health Play Specialism and are registered with the Health Play Specialist Education Trust. They use developmental, therapeutic and specialised play to safeguard children's emotional and mental health during treatment and procedures, throughout their healthcare journeys from birth to 18 years. They offer psychological preparation for various procedures and treatments, post procedural play and support, work with individuals around phobias (e.g. hospitals and needles), 'non-compliance' with treatment plans and work with the family to help them support their child.

Health Play Specialists provide a crucial role, working both independently and as part of a large multi-disciplinary team. They provide support to various teams, including Dermatology, School Nurses / Vaccination Team, Psychology, ENT (Ear Nose Throat) Department, Anaesthetics, Dieticians, Consultants and Clinic Appointments, the Community Dental Team and Community Outpatients as well as other hospitals, including the Royal Manchester and Alder Hey Children's Hospitals.

The storyteller describes that the family felt more confident and re-assured after their experience with the Play Therapist and the care and compassion demonstrated by all staff involved in their daughter's treatment and care.

The Health Board is committed to protecting and supporting the rights of children and young people in North Wales, ensuring children and young people are fully involved in the decisions about their health care and to feel they can share their wishes and views with our staff and services. The Health Board launched a Children's Charter setting out its promises to children and young people of what they should see from us and expect when they are cared for and supported by our health services.

The Children's Charter has a set of standards and values, designed by young people to ensure services are working in a children's rights-based approach. The self-assessment tool is divided into sections based on the individual standards within the Children's Rights Charter. Each section provides a series of statements that guide services in achieving the charter standards. The statements have been developed from children and young people's views of what matters most to them.

The Children and Young People's Services within Wrexham Maelor Hospital have also developed a 'Play Service Charter' which outlines their collective commitment to play and recreation for all children and young people. It supports the right that every child has to play and its commitment to providing play and recreation opportunities within healthcare, providing safe play and recreational areas, encouraging participation and inclusive play, which is supported by trained and experienced staff.

The Healthcare Play Team in Wrexham Maelor Hospital have also shown exceptional dedication to developing the service they provide through promoting the Welsh language and culture to ensure that Welsh and bilingual events are a meaningful and visible part of life on the ward. Every child and family is made to feel represented and included, regardless of their language background. As such, they were shortlisted as finalists for the BCUHB Staff Achievement Awards 2025.

Current developments within the BCUHB Healthcare Play Team include looking to impact on NHS staffing levels which are set in line with the required legal framework. These levels currently don't include Play Team workers or Nursery Nurses and BCUHB is starting to look at this across all Paediatric areas to address how these vital roles can be included.

In addition, the BCUHB Healthcare Play Team are working to adopt the new 'Play Well: Standards and Guidelines' (NHS England and Starlight), which have recently been launched in June 2025. Starlight are the UK's leading charity working to put play at the heart of every child's healthcare. Together with Play Wales and in collaboration with the Society of Health Play Specialists (SOHOS), they have produced a 'Play Well Toolkit' to support the auditing, monitoring and evaluation of services to ensure that children and young people receive high-quality care. These guidelines have already been launched with NHS England and are looking at being implemented within NHS Wales.

The Patient and Carer Experience Team extend their gratitude and appreciation to the storyteller and her family for sharing their experience.

Teitl adroddiad: ***Report title:***	Independent Review of SBUHB May 2025 – BCUHB Maternity Services position against recommendations
Adrodd i: ***Report to:***	Quality, Safety and Experience Committee
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 04 September 2025
Crynodeb Gweithredol: ***Executive Summary:***	The purpose of this report is to provide a local BCUHB Maternity and Neonatal position against the recommendations of an independent review of Swansea Bay University Hospital (SBUHB) Maternity and Neonatal Services. This review was commissioned to examine the safety and quality of maternity and neonatal services at SBUHB between 2019 and 2023, particularly focussing on data reported during those years by the reports of Mothers and Babies – Reducing Risk through audits and enquiries across the UK (MBRRACE-UK). The main purpose of MBRRACE-UK is to conduct robust national surveillance and investigate the deaths of women and babies who die during pregnancy or shortly after pregnancy. Three primary factors led to the decision to commission this review: i. To better understand the reasons behind MBRRACE-UK data and why SBUHB was an (adverse) outlier in some years; ii. The Health Board remained an outlier and did not seem to make progress despite multiple external reviews and recommendations; iii. Some families have raised concerns about the quality of care they had received, the way they had been treated afterwards and the lack of compassion shown in their distress. An initial assessment of the BCUHB local position against the ten priority recommendations identified within the report has been completed and actions identified, which will continue to inform BCUHB Maternity and Neonatal Service priorities. In addition, as a consequence of the Independent Review of Maternity and Neonatal Services at SBUHB, and the Llais Report exploring women and families' experiences of having a baby in SBUHB (attached), an All Wales Maternity and Neonatal Service Assurance Assessment, was commissioned by the Cabinet Secretary for Health and Social Care in May 2025.
Argymhellion:	The Committee is requested to note:

<table>
<tr><td>Recommendations:</td><td colspan="4">The contents of the local response report, the local actions taken to date and the identified future actions
That the progression of several locally identified actions is dependent upon other local and national programmes of work including:
Implementation of a digital maternity system
Quality Statement for Maternity and Neonatal services service specification
All-Wales Perinatal Engagement Framework service specification
Maternity and Neonatal Network Perinatal Workforce plan service specification</td></tr>
<tr><td>Arweinydd Gweithredol:

Executive Lead:</td><td colspan="4">Angela Wood, Executive Director of Nursing and Midwifery</td></tr>
<tr><td>Awdur yr Adroddiad:

Report Author:</td><td colspan="4">Emma Adamson, Consultant Midwife</td></tr>
<tr><td>Pwrpas yr adroddiad:
Purpose of report:</td><td>I’w Nodi
For Noting
☐</td><td colspan="2">I Benderfynu arno
For Decision
☐</td><td>Am sicrwydd
For Assurance
☒</td></tr>
<tr><td>Lefel sicrwydd:

Assurance level:</td><td>Arwyddocaol
Significant
☐
Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol

High level of confidence/evidence in delivery of existing mechanisms/objectives</td><td>Derbyniol
Acceptable
☒
Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol

General confidence / evidence in delivery of existing mechanisms / objectives</td><td>Rhannol
Partial
☐
Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol

Some confidence / evidence in delivery of existing mechanisms / objectives</td><td>Dim Sicrwydd
No Assurance
☐
Dim hyder/tystiolaeth o ran y ddarpariaeth

No confidence / evidence in delivery</td></tr>
<tr><td colspan="5">Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:

Justification for the above assurance rating. Where ‘Partial’ or ‘No’ assurance has been indicated above, please indicate steps to achieve ‘Acceptable’ assurance or above, and the timeframe for achieving this:</td></tr>
<tr><td colspan="2">Cyswllt ag Amcan/Amcanion Strategol:

Link to Strategic Objective(s):</td><td colspan="3">Quality & Safety Framework – Welsh Government

Quality statement for maternity and neonatal services

All Wales Perinatal Engagement Framework</td></tr>
</table>

	Maternity and Neonatal Safety Support Programme HEIW Perinatal Workforce Plan Health and Care Quality Standards
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	e.e. Yr Awdurdod Gweithredol Iechyd a Diogelwch e.g. Health and Safety Executive
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	~~Do/~~Naddo ~~*Y/N*~~ Os naddo, rhowch esboniad yn ymwneud â'r rheswm pam nad yw'r ddyletswydd yn *berthnasol* *If no please provide an explanation as to why the duty does not apply* EQIAs to be completed where applicable for individual workstreams Gweithdrefn ar gyfer Asesu Effaith ar Gydraddoldeb WP7 *WP7 Procedure for Equality Impact Assessments*
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	Do/Naddo *Y/N* Os naddo, rhowch esboniad yn ymwneud â'r rheswm pam nad yw'r ddyletswydd yn *berthnasol* *If no please provide an explanation as to why the duty does not apply* SEIAs to be completed where applicable for individual workstreams Gweithdrefn WP68 ar gyfer Asesu Effaith Economaidd-Gymdeithasol. *WP68 Procedure for Socio-economic Impact Assessment.*
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR)	(crynodeb o'r risgiau a rhagor o fanylion yma) (summarise risks here and provide further detail)

Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)	
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	A number of the priorities for action have associated workforce implications
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	Currently completing workforce assessment against the HEIW Perinatal Workforce plan to identify local gaps against recommendations
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	(crynodeb o sut mae'r papur wedi cael ei adolygu, yr ymateb a pha newidiadau a wnaed ar ôl cael adborth) (summarise where the paper has been reviewed, the response and what changes have made due to feedback)
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Amherthnasol Not applicable
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** Continue to progress identified actions	
Rhestr o Atodiadau: ***List of Appendices:*** 1. The Independent Review of Maternity and Neonatal Services at Swansea Bay University Health Board 2. Llais Report 3. Quality statement for maternity and neonatal services 4. All Wales Perinatal Engagement Framework 5. Maternity and Neonatal Safety Support Programme Phase Two Delivery Plan	

Betsi Cadwaladr University Health Board Maternity Services reflection on The Independent Review of Maternity and Neonatal Services at Swansea Bay University Health Board

The purpose of this report is to provide a preliminary local service position against the ten recommendations made within the Independent Review of SBUHB Maternity and Neonatal Services, published July 2025

Background

This review was commissioned to examine the safety and quality of maternity and neonatal services at Swansea Bay University Health Board (SBUHB) between 2019 and 2023, particularly focussing on data reported during those years by the reports of Mothers and Babies – Reducing Risk through audits and enquiries across the UK (MBRRACE-UK). The main purpose of MBRRACE-UK is to conduct robust national surveillance and investigate the deaths of women and babies who die during pregnancy or shortly after pregnancy

Three primary factors led to the decision to commission this review:

i. To better understand the reasons behind MBRRACE-UK data and why SBUHB was an (adverse) outlier in some years;
ii. The Health Board remained an outlier and did not seem to make progress despite multiple external reviews and recommendations;
iii. Some families have raised concerns about the quality of care they had received, the way they had been treated afterwards and the lack of compassion shown in their distress.

The review has five key components:

- the voices of families sharing their experiences;
- a clinical review of cases undertaken by experienced, independent, clinical team;
- staffing and leadership;
- a governance review of the Health Board's processes;
- an extensive review of data and outcome information

The review was able to take in the views of around 1,180 women and families and analyse 1,430 statements of feedback. The team have also reviewed in depth the care given to138 women and 125 babies. The report explored

It has considered a broad range of evidence in relation to the experiences of women and families, the quality of clinical care, the governance and leadership, the culture, the experiences and competency of staff and the local and national data available. Using evidence in this way provides a rounded understanding across a range of issues:

The resulting report is extensive and whilst the findings are specific to Swansea Bay University Health Board, the review proposes 10 priority recommendations arising from the findings within this report, which can be considered against local service provision in order to provide an initial sense check against highlighted issues.

In response to the independent review, the Llais Report, and other concerns regarding maternity and neonatal service across Wales, Welsh Government announced that a national maternity and neonatal service assurance assessment would be undertaken and the local reflections on the findings of both of those reports ensures that BCUHB Maternity Services continue to proactively engage in identifying progress made to date and areas for improvement.

The ten priority recommendations are:

1. **Establish a single point of access for maternity triage for all women**
2. **Delivery of consistent care with senior clinical staff oversight**
3. **Implementation of Maternity Early Warning Scores (MEWS)**
4. **Improve quality of Investigations**
5. **Delivery of compassionate and trauma-informed care**
6. **Improvements in governance processes**
7. **Attendance for all maternity staff for fetal monitoring training**
8. **Develop and implement a robust process for booking and prioritising women undergoing induction of labour (IOL)**
9. **Review and revise all policies and procedures within the maternity and neonatal service to ensure consistent delivery of care**
10. **Develop and implement a wider engagement plan**

The following section considers these recommendations against local services provision and identifies potential service improvement actions.

BCUHB Local Assessment against 10 priority recommendations made within the SBCUHB Independent Review

	Recommendation	Current Position:	Potential Action(s):	Timeframe
1 Maternity Triage SPOA	**A major focus is required on improving the quality of triage and access to the service in line with guidance from the RCOG and the RCM. A standardised and single contact triage process should be available for all women.**	MOAU assessment / improvement work in progress across all three maternity units, which includes: Monthly BSOTS audit which monitors compliance with initial assessment times Separate triage line pilot Workforce review aligned to HEIW Perinatal Workforce Plan / RCOG Triage good practice paper	Roll out separate triage line to other sites	March 2026
	This must include: improving the quality of calls and women's experiences when contacting the service; increased senior medical input; increased midwifery staffing to ensure all women have an initial assessment within 15 minutes; improvements to the environment (ensuring privacy for triage calls); and monitoring and reporting of the service, including inviting feedback from women		Engage in planned national BSOTS improvement work	National timeframe to be confirmed
	Maternity staffing (including triage) must be informed by improved predictive modelling of demand and capacity data, taking into account: predicted in-month birth rate, local capacity issues, moderated demographic risk and predicted staffing shortfalls and skill mix. This is a sophisticated but essential data modelling requirement		Implementation of All Wales Maternity and Neonatal PREM questionnaires via CIVICA	Sept 2025

	Recommendation	Current Position:	Action(s):	Timeframe
Theme 2 **Consistent care & senior clinician oversight**	**Obstetric care - Senior clinical staff must have a mandatory presence in operative vaginal deliveries; this includes all rotational forceps, or assisted breech deliveries. Complex caesarean sections must also be attended to by senior clinical staff**	Consultants not present for all instrumental births, depends upon complexity, however are available via on-call system	This recommendation to be considered locally by the North Wales Women's Clinical Lead	March 2026
	Neonatal care - Senior oversight of the management of sick babies needs to be more visible within clinical records. This includes clear documentation of thought processes underpinning decision making.	Daily Consultant ward round in YGC and WMH. Registrar or Consultant will review sick babies in YG when required. Medical records are updated during ward round and weekly review summary in medical record Badgernet letter is completed at admission and discharge, including clinical summary	Actions ongoing	
	ITU care - The team must include an intensive care consultant and an obstetric consultant and will ideally also include an anaesthetic obstetric consultant and a senior midwife. These roles should be included in the role and responsibilities of the on-call obstetric team, so as to ensure that women in ITU have at least daily	Enhanced Maternity Care (EMC) available in YGC AIT accessible across all sites	Extend EMC to YG / WMH	March 2026

	contact with the multidisciplinary maternity team.			
	Radiology - There is an urgent need to provide a full-time paediatric radiology service, or, as a minimum, a full-time reporting service.	Full time paediatric radiology service not currently available however there is access to full-time reporting service. Alder Hey also provides specialist reviews	Continue with current service provision	Ongoing

	Recommendation	**Current Position:**	**Action(s):**	**Timeframe:**
3 **MEWS**	**Introduce the current maternity-specific early warning score tool to all areas where pregnant women are cared for (ahead of the introduction of the new pan-Wales MEWS tool).**	MEWS in place across all maternity settings, not currently used elsewhere All Wales MEWS implementation plan in progress supported by BCUHB EWS lead. Includes training, communication plan and pre-implementation baseline audit	Implement All Wales MEWS tool	September 2026
	Maternity early warning scores should be used for all pregnant and recently pregnant women, rather than the National Early Warning Score for adults (NEWS2), wherever they are cared for in hospital		Develop plan for implementation in all areas where pregnant women are cared for	March 2026
			Evaluate implementation impact of standardised MEWS in maternity service	December 2026

	Recommendation	Current Position:	Action(s):	Timeframe:
4 **Improve investigation quality**	**Communication following serious adverse events must be prioritised, and appropriate multidisciplinary reviews conducted within reasonable timescales, and in line with MBRRACE-UK and serious incident review guidance.**	All incidents are reported and managed via Datix system and subject to a management review and / or Make It Safe review, with serious incident review completed as per MBRRACE and local guidance Local multidisciplinary Neonatal death review currently in progress using cases to review governance process with regards to investigation of serious incidents Neonatal governance risk nurse now in post to support a consistent approach to neonatal investigations and reports	All risk midwives to attend IO training	September 2025
			Neonatal governance risk nurse requires IO training	September 2025
			Findings from NND review to be presented to EDON	October 2025
	The Board must ensure that, where there is a clear trigger for independence or external review, this is actioned; examples would be a very serious incident, serious birth injury, maternal death, or mortality review	All inquest cases and maternal deaths trigger independent review. These are also considered where there has been very serious harm and support for identifying incidence which may require an external reviewed is accessed via the Concerns Hub and the Integrated Concerns Operational Group as per Integrated Concerns Policy	PMRT SOP developed and for a full review with Head of Patient Safety and Quality 19/08/25 – to ensure aligned with current BCUHB Integrated Concerns Policy - all such cases would be discussed at	December 2025

			Executive weekly ICOG meeting	
	The Board must ensure greater involvement of families in investigations.	The parent engagement process from MBRRACE is built into our current procedures and all parents are written to informing them of the review and asking them to raise any concerns or issues they have. These will form part of the review with a full response in relation to each question being included in the final report which is provided to the parents However, feedback suggest that there is a lack of timeliness in some cases	Review governance processes for family involvement, to ensure there is an active offer / engagement that is transparent and timely	Ongoing
			Findings of ongoing NND review with respect to family engagement will inform future actions	December 2025
	External input is critical in ensuring that learning from mortality reviews is maximised. Development of reciprocal arrangements with other UK networks to participate in case reviews would ensure a true 'fresh eyes' approach.	Unable to meet this recommendation currently, however this is a common position across all HBs in Wales. Raised with WG, agreement reached on 07/08/25 that at present externality will be partially achieved by ensuring that SI / PMRT panel includes clinicians from different sites Maternity and Neonatal services engage with the national All Wales Morbidity and Mortality meetings to support case discussion and learning	Await national position	Timeline not confirmed

	Recommendation	Current Position:	Action(s):	Timeframe:
5 **Compassionate & trauma informed care**	**Far greater focus is required on the delivery of compassionate care for all. A development programme should be provided for all staff, addressing: team working; compassionate care delivery; just and learning culture; and trauma-informed practice**	Leadership development opportunities available, including MLDG and internal Coaching programme Trauma-informed care discussed as part of 'Informed decision making and personalised care planning' mandatory training sessions PROMPT MDT training well-established across acute and community maternity services which is based on a team working approach MONET training commenced for all neonatal staff, working as a team is embedded in the training Team of the Shift (aligned to MatNeoSSP actions) implemented in YG to support MDT working/communication Maternity psychologist recently appointed	Implement the All-Wales Maternity PREMs questionnaires, via CIVICA	September 2025
			Implement Team of the Shift in YGC / WMH	March 2026
			Planned scoping exercise by maternity psychologist, to identify potential areas for care pathway development	December 2025

	The Health Board must ensure families can trust the mechanisms for debrief, complaints and investigations when things have gone wrong.	Women have access to debrief via well-established Birth Reflections Service Women and families are aware of the various routes to provide feedback, including how to raise a complaint The Duty of Candour Principles and their application has been discussed in training sessions across the service, however there have been instances where this has not been Duty of Candour has not been applied following an incident	Continue to monitor compliance with application of The Duty of Candour Principles	Ongoing
	Healthcare delivery must be culturally informed and culturally sensitive with an enhanced understanding of specific religious needs and cultural practices	Cultural Competency training has been delivered to Community Midwifery Teams	Training to be rolled out to acute settings across Maternity and Neonatal settings	March 2026
			Maternity Access Improvement initiative work to be commenced (MatNeo SSP Phase 2 Priority)	March 2026
	The Health Board must commit to take action where care and behaviours fall below acceptable standards	Actions in response to any incidents of sub-standard care and/or behaviours are taken by line managers, with the support WoD team	Continue monitor themes and trends in relation to sub-standard care and / or behaviours via	Ongoing

		Service user feedback / learning from events shared via various forums to highlight impact of sub-standard care and/or behaviours, including Women's People and Culture meeting and Neonatal Steering Group	Women's People and Culture sub-group and Women's Service Board	
	Timely access to psychological support for women must be available, and all care should be based on trauma-informed principles **December 2025**	There is access to specialist Perinatal Mental Health service for women with moderate to severe mental illness, including psychological trauma. However, lack of equity across North Wales for women not meeting criteria of PNMH team A neonatal psychologist is available across the neonatal service to provide support for both parents and staff A maternity psychologist appointed 04/08/25	Continue to identify and signpost to opportunities for 3rd sector support for women not meeting criteria for specialist support (locality /funding dependent)	Ongoing
			Planned scoping exercise by maternity psychologist, to identify potential areas for care pathway development	December 2025
	Current staffing levels on the postnatal ward must be reviewed; there is currently a clear indication that staffing numbers are insufficient to meet the needs of women and families; this is an area where poor experience is often described.	Maternity Service is Birth Rate Plus compliant as per last assessment (2022) and there is a standard minimum expected PN ward staffing level, with staffing issues reported via Datix	Birth Rate Plus reassessment due however national work ongoing to consider use of alternative	Reassessment due Q4

		Daily staffing levels are formally monitored via operational on call team and escalation policy in place, which includes ability to escalate additional midwives into the acute unit as required to maintain safe staffing levels	workforce calculation tool	

	Recommendation	Current Position:	Action(s):	Timeframe:
6 **Improve governance processes**	**There should be a complete review of governance processes and Board reporting across maternity and neonatal services, including escalation processes, and the structure and terms of reference for all relevant committees. A direct line of sight of maternity and neonatal services through the governance structure is required. This involves definitively ironing out duplication, clear reporting lines and ensuring appropriate clinical representation at key meetings.**	Local multidisciplinary Neonatal death review currently in progress using cases to review governance process with regards to investigation of serious incidents	Findings from NND review to be presented to EDON Key maternity and neonatal quality metrics to be included in QSE sub-committee reporting framework 'Foundations for the Future' organisational structure review in progress	October 2025 December 2025 Ongoing
	A maternity 'real time monitoring' report must be available to the Board at each meeting. The performance and quality	Governance is a standing agenda item at Women's Quality, Safety and Experience and Board meetings and includes performance and quality indicator report;	Implement local Perinatal Surveillance Dashboard	March 2026

	indicators should be supported by qualitative feedback.	this information forms part of reports to Women's Integrated Performance Groups, Patient Safety Group and Integrated Quality, Planning & Delivery Performance and Quality data collected via sharepoint and shared / discussed at various local forums to identify risk / highlight areas of improvement and good practice Women's qualitative feedback shared as a standing agenda item at various forums across Maternity Service and wider health board including QEDG and IQPD	Link with national work to implement All-Wales standardised data set (work ongoing)	March 2026
	The debrief service should be reviewed, to ensure improved access to the service as well as to ensure that all staff recognise their responsibility to respond to traumatic experiences	Women have access to debrief via well-established Birth Reflections Service Safe Care Collaborative Staff debrief initiative implemented to ensure robust processes for staff following an adverse event Staff signposted to TRiM for additional support following an adverse incident	Further work required to embed mechanisms for staff support following an adverse incident	Ongoing

			Maternity Psychologist to include potential for provision of staff support as part of scoping exercise	December 2025
	There should be a full review of the complaints process, to ensure responses are compassionate, timely, and in appropriate detail for the concerns raised	Complaints are managed via the Integrated Concerns Policy and response times are monitored against expected compliance of 75% being responded to within 30 days Neonatal concerns are infrequent and are managed in accordance with the Integrated Concerns Policy. They are managed within each neonatal IHC. Learning is shared via the Neonatal steering group	The Head of Patient Safety for health board is leading a review of the corporate Integrated Concerns Policy	December 2025

	Recommendation	**Current Position:**	**Action(s):**	**Timeframe:**
7 **Fetal monitoring training**	**The service should ensure that all maternity staff attend the All-Wales education programme for the interpretation of fetal heart tracings and have access to cardiograph computerised analysis.**	Well established fetal surveillance education/training programme in place, which includes mandated annual MDT IFS training as per All Wales standards and weekly CTG case discussion Training compliance across all staff groups monitored monthly	Continue to monitor compliance and ensure robust plans in place to action inadequate levels of compliance	Ongoing

	Recommendation	Current Position:	Action(s):	Timeframe:
8 **Booking & prioritisation of IOL processes**	**The induction of labour pathway must also be viewed as a priority, so that women do not experience delays with the process. There needs to be a robust system for the prioritisation of all IOL cases, so that the ones with the greatest clinical need take priority. There is also a need to ensure that induction of labour can be and is scheduled within an appropriate timeframe.**	IOL Improvement initiative underway, which has included process mapping and review of patient information resources IOL queue management considered however not progressed in view of pending implementation of digital system	Implement a digital maternity system Reconsider IOL queue management work as priority in view of first phase of digital system lacking ability to support	March 2026 March 2026

	Recommendation	Current Position:	Action(s):	Timeframe:
9 **Review & revise policies / procedures**	The service needs to review and redesign its approach to ensuring guidelines are in date, including proactively tracking guidelines which may be due to expire, and ensuring that all guidelines have a multidisciplinary review prior to sign off.	Significant work undertaken to review written controlled document governance processes, to ensure that reviews and approvals are timely and based upon most up to date evidence, good level of compliance achieved	Ongoing work to ensure that positive position maintained	Ongoing

		Work is required to review and update all local neonatal guidelines.	Continue to monitor compliance with health board WCD governance processes	

	Recommendation	Current Position:	Action(s):	Timeframes:
10 **Wider engagement plan**	There is a need for a significantly increased level of engagement with women, families and communities who are using the maternity and neonatal services with a particular focus on seldom heard groups.	Proactive engagement with community groups, including NWAS, has taken place to gain feedback from seldom-heard groups and to supplement feedback received via formal routes As part of IOL improvement work, qualitative feedback interviews undertaken in addition to use of questionnaire Business case for MNVP paid chair role currently being review by OLT which will support increased community engagement	Review / formalise engagement strategy (following appointment of MNVP Chair)	March 2026
	Survey data alone is insufficient to provide a true understanding of the lived experiences of women and families using services. The Board should therefore additionally commit to undertaking at least ten qualitative feedback interviews per month with women who have used the service within the last 6-12 months.		Implement All Wales Maternity and Neonatal PREMS questionnaires via CIVICA	September 2025

		Baseline assessment against All Wales Perinatal Engagement framework completed to identify immediate actions Neomates North Wales provides engagement for service improvements from current and veteran neonatal parents. Service user feedback collected via various routes and collated into monthly report for sharing at Women's Quality, Safety and Experience and board meeting Neonatal user feedback collected monthly and shared within IHC Illness and Accident meetings and Neonatal Steering Group	Await associated service specification for All Wales Perinatal Engagement framework	National timeframes to be confirmed

Summary

Whilst the findings of the Independent Review of Maternity and Neonatal Review of Swansea Bay University Health Board (SBUHB0 is specific to a particular health board, it does offer a good opportunity for all maternity and neonatal service in Wales to consider local service provision against the recommendations.

The majority of the ten recommended priority actions within the Independent Review have been highlighted previously in other national reports including the Ockenden (2022) and East Kent (2022) Reports, the Maternity and Newborn Safety Investigations (MNSI) national learning report on factors affecting the delivery of safe care in midwifery units (2024), The All-Party Parliamentary Group (APPG) Birth Trauma Report (2024) and the Llais Report on maternity experiences in SBUHB (2025).

Whilst we now await the completion of the All Wales Maternity and Neonatal Service Assurance Assessment, as commissioned by the Cabinet Secretary for Health and Social Care in May 2025, the findings of this review, along with the priorities for action contained within the Maternity and Neonatal Safety Support Programme (MatNeoSSP) Discovery Phase Report (2023), Quality Statement for Maternity and Neonatal Services (2025), a local Health Inspectorate Wales (HIW) report of services at Ysbyty Gwynedd (2025) and recommendations made following a recent inquest, have prompted other local benchmarking exercises, development of associated actions plans and have informed annual and integrated medium-term plans.

The following appendices are included in the supporting papers:

1. The Independent Review of Maternity and Neonatal Services at Swansea Bay University Health Board
2. The Llais Report
3. Quality statement for maternity and neonatal services
4. All Wales Perinatal Engagement Framework
5. Maternity and Neonatal Safety Support Programme Phase Two Delivery Plan

Teitl adroddiad: ***Report title:***	Quality Statement for Maternity and Neonatal Services - BCUHB Maternity and Neonatal Services position against key actions and quality attributes
Adrodd i: ***Report to:***	Quality, Safety and Experience Committee
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 04 September 2025
Crynodeb Gweithredol: ***Executive Summary:***	The purpose of this report is to provide a local BCUHB Maternity and Neonatal Service position against the 7 key actions and 33 quality attributes contained within the Welsh Government Quality Statement for Maternity and Neonatal Services, published February 2025 The quality statement provides a framework for health boards to support improvement in each unit, focusing on high quality care across Wales and builds on the 5-year vision for the future of maternity care in Wales (2019). Contained within the quality statement are 7 key actions for implementation and 33 quality attributes. The quality attributes for perinatal care in Wales seek to support delivery of the right care, in the right place, the first time, leading to better outcomes and experiences for women, babies and their families during pregnancy, childbirth and the postnatal period and are shaped around the 12 health and care quality standards, which are intended to provide a clear framework to help plan, deliver and monitor healthcare services in Wales. An associated service specification is being developed by the Maternity and Neonatal Network, which will direct and inform strategic and operation service direction and plans.
Argymhellion: ***Recommendations:***	The Committee is requested to note: • the contents of the report, the local actions taken to date and the identified future actions • that the progress of a number of locally identified actions is dependent upon other local and national programmes of work, which include: 1. The implementation of a digital maternity system 2. Quality Statement for Maternity and Neonatal services service specification 3. The All-Wales Perinatal Engagement Framework service specification 4. The Maternity and Neonatal Network Perinatal Workforce plan service specification

Arweinydd Gweithredol: ***Executive Lead:***	Angela Wood, Executive Director of Nursing and Midwifery			
Awdur yr Adroddiad: ***Report Author:***	Emma Adamson, Consultant Midwife			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Quality & Safety Framework – Welsh Government Quality statement for maternity and neonatal services All Wales Perinatal Engagement Framework Maternity and Neonatal Safety Support Programme HEIW Perinatal Workforce Plan Health and Care Quality Standards			
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	e.e. Yr Awdurdod Gweithredol Iechyd a Diogelwch e.g. Health and Safety Executive			
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	~~Do~~/Naddo ~~Y~~/*N* Os naddo, rhowch esboniad yn ymwneud â'r rheswm pam nad yw'r ddyletswydd yn *berthnasol*			

	If no please provide an explanation as to why the duty does not apply EQIAs to be completed where applicable for individual workstreams Gweithdrefn ar gyfer Asesu Effaith ar Gydraddoldeb WP7 *WP7 Procedure for Equality Impact Assessments*
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	Do/Naddo *Y/N* Os naddo, rhowch esboniad yn ymwneud â'r rheswm pam nad yw'r ddyletswydd yn *berthnasol* *If no please provide an explanation as to why the duty does not apply* SEIAs to be completed where applicable for individual workstreams Gweithdrefn WP68 ar gyfer Asesu Effaith Economaidd-Gymdeithasol. *WP68 Procedure for Socio-economic Impact Assessment.*
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	(crynodeb o'r risgiau a rhagor o fanylion yma) (summarise risks here and provide further detail)
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	Several the priorities for action have associated workforce implications
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	Currently completing workforce assessment against the HEIW Perinatal Workforce plan to identify local gaps against recommendations
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	(crynodeb o sut mae'r papur wedi cael ei adolygu, yr ymateb a pha newidiadau a wnaed ar ôl cael adborth) (summarise where the paper has been reviewed, the response and what changes have made due to feedback)

Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Amherthnasol Not applicable
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** Continue to progress identified actions	
Rhestr o Atodiadau: ***List of Appendices:*** 1. Quality statement for maternity and neonatal services 2. All Wales Perinatal Engagement Framework 3. Maternity and Neonatal Safety Support Programme Phase Two Delivery Plan	

Betsi Cadwaladr University Health Board Maternity Services

Quality Statement for Maternity and Neonatal Services

The purpose of this assessment tool is to benchmark current status of BCUHB Maternity Services against the 7 key actions and 33 quality attributes contained within the Quality Statement for Maternity and Neonatal Services, published in February 2025

Background

Quality statements are being developed by the Welsh Government, aligned to the commitment in a healthier Wales (2018) to define the outcomes and standard we would expect to see in high-quality, patient focused services delivered by Welsh health boards and NHS trusts.

The Quality statement for maternity and neonatal services builds on the 5-year vision for the future of maternity care in Wales (2019) and describes what good quality maternity and neonatal services should look like. In order to support the teams in maternity and neonatal units to do what they do best, and deliver optimal outcomes for women, babies and their families, this quality statement provides a framework for health boards to support improvement in each unit, focusing on high quality care across Wales. The quality attributes for perinatal care in Wales seek to support delivery of the right care, in the right place, the first time, leading to better outcomes and experiences for women, babies and their families during pregnancy, childbirth and the postnatal period and are shaped around the 12 health and care quality standards, which are intended to provide a clear framework to help plan, deliver and monitor healthcare services in Wales.

It is expected that health boards undertake a review of their current status against each of the quality attributes described in the quality statement, aligning to their local action plans for MatneoSSP. This will act as a baseline and contribute to the development of, or alignment to, existing improvement plans. Key actions will be set by the Welsh Government and the NHS Wales Executive, aligned to the priorities identified within the discovery report. Health boards will be supported by the NHS Executive to deliver the expectations set out in this document. This will be mainly discharged through the Implementation Network for MatneoSSP and where appropriate the maternity and neonatal strategic network.

BCUHB Maternity Service Position against 7 Key Actions

	Key Action	Aligned to	Current Position	Future actions	LEAD	TIMEFRAME	STATUS
1	**All health boards to deploy the national digital maternity system by end of March 2026**	Quality attribute 29;	Implementation plan in progress In process of recruiting 2 x B6 midwives	Continue implementation plan	Digital Midwife / DDaT	March 2026	
2	**Work in partnership with the NHS Executive to devise an implementation plan to deliver on the perinatal engagement framework commitments. Health boards must ensure they engage with women from Black, Asian, minority ethnic and other under-represented groups majority to improve outcomes by identifying barriers in access to services**	Quality attribute 18; MatneoSSP action 5.2	Baseline assessment against Perinatal Engagement Framework 10 commitments completed Cultural competency training ongoing in Community Midwifery Teams Engagement activities with local community groups, including NWAS MNVP Chair business case submitted to OLT (to support proactive engagement activities)	Cultural competency training to commence in acute settings Commence Maternity Access improvement work Formalise Maternity and Neonatal Engagement Plan (once paid chair in post)	Patient Experience Matron / Consultant Midwife	March 2026	
3	**Ensure a baseline assessment and an associated action plan for neonatal services is developed, seeking support where appropriate to enable care to be delivered in line with the bliss baby charter principles, and commence the journey to accreditation**	Quality attribute 17; MatneoSSP action 7.4	All three units signed up to the Bliss pledge to improvement. YGC and Wrexham have received a bronze accreditation. All three units completed the BAPM Fi Care Framework (neonatal action)	Meeting with Bliss Wales in August to discuss the new Baby Bliss Charter and offer of peer support in North Wales	Neonatal Network Manager	March 2026	
4	**Collaborate with HEIW to prioritise year 1 actions to ensure the perinatal strategic workforce plan is delivered,**	Quality attribute 23; MatneoSSP action 2.1	In process of completing local assessment against HEIW Perinatal workforce plan	Await Maternity and Neonatal Network Workforce service specification to support	Head of Midwifery and Gynaecology Nursing	Complete local assessment	

	noting that this will be a phased approach			further local workforce planning		end of Sept 2025	
5	**All health boards are required to develop a perinatal quality surveillance dashboard with key standardised metrics that inform both network level and national oversight which in turn inform policy direction**	Quality attribute 28; MatneoSSP action 11.7	BCUHB Maternity and Neonatal Services do not currently have a quality surveillance dashboard A maternity dashboard is in use which includes all KPIs	Planning meeting arranged for 11/08	Director of Midwifery	March 2026	
6	**All health boards should ensure that choice of place of birth is offered to encompass all birth settings, noting that this may be in an alternative health board**	Quality attribute 14; MatneoSSP action 10.2	BCUHB Maternity services actively offering 3 options for place of birth with exception of FMU Currently engaged in MUSA improvement programme to optimise MLU offer	Discuss commissioning requirements to support offer of FMU in neighbouring health boards	Consultant Midwife / General Manager and Business Lead	March 2026	
7	**Ensure that 4 of the 5 bereavement pathways are ratified within year 1, with an implementation plan, to ensure a co-ordinated roll out**	Quality attribute 20; MatneoSSP action 13.1	Well established bereavement pathways in use locally Specialist Bereavement / Consultant midwives engaged in national work	Implement All Wales standardised bereavement pathways (awaited)	Patient Experience Matron / Specialist Bereavement Midwives	Dependent upon approval of national pathways	

BCUHB Maternity Service Position 33 Quality Attributes

Standard	Quality Attribute	Current Position	Potential actions/gaps
Safe	**1.** Consistent use of person-centred, evidence-based pathways of care, delivered by a skilled multi professional workforce, supported by robust clinical governance arrangements and escalation pathways from ward to board	Process in place to ensure that guidelines and policies reflect national recommendations and best available evidence Women supported to make personalised care plans, with input from the MDT as required Business case submitted to support establishment of Preconception Clinics across all areas	Implementation of All Wales Standardised MEWS tool planned for 8th September to support identification and escalation of the deteriorating woman Establish Preconception Clinics aligned to the Women's Health Plan
	2. Risk held within the service is systematically assessed, communicated, and escalated within the organisation as well as through national governance systems, with appropriate measures taken to proactively reduce the potential for harm	Maternity Service risks are regularly identified, assessed, communicated, and escalated through various local and pan-service forums, through to board, RMG and nationally where required Internal quality assessments also support the identification of immediate and moderate risks	Implement perinatal surveillance dashboard and digital maternity system to further support early identification of risk
	3. Systematic monitoring of demand and capacity information to inform service design and configuration, with consideration of acuity, complexity, and specialist requirements to enable delivery in line with agreed national standards and recommended staffing ratios	In process of completing local assessment against HEIW Perinatal workforce plan Maternity Services compliant with Birth Rate Plus as per last assessment and RCOG workforce recommendations	Await Maternity and Neonatal Network Workforce service specification Reassessment due however awaiting national steer regarding workforce calculation tool Engage in national BSOTS workstream to support full implementation of the tool

		MOAU review includes consideration of RCOG Maternity Triage Good Practice Paper and BSOTS compliance audit	
Timely	**4.** Systems and processes are in place for effective multi professional and multiagency communication across perinatal services to deliver care in the most appropriate place and time	Systems in place to support effective communication within and between teams / services, however these differ between areas	Implementation of Digital Maternity System (March 2026) to provide enhanced communication and information sharing within and between services Continued improvement required to ensure transitional care offer is consistent across all sites
	5. Timely, robust, and evidence-based assessment is undertaken for all aspects of perinatal care in line with agreed protocols, overseen by skilled and experienced professionals to enable effective decision-making and clinical prioritisation	Antenatal Care Criteria document recently introduced, which aligns with both the All-Wales Maternity Record and the All-Wales Midwifery Led Care Guideline – supports identification of potential complexity and referral to appropriate pathway / clinician Maternity Services utilise a number of assessments / decision making tools, e.g., VTE, aspirin, BRAIN Significant improvements made to guideline governance processes	Implementation of Digital Maternity System (March 2026) will support effective, timely, and standardised assessments, which will be contained within the system Continued focus on guideline governance processes required to ensure that content is reviewed in a timely manner and is based on most up to date evidence
Effective	**6.** Universal care pathways are autonomously provided by midwives to ensure a holistic approach to care, with additionality depending on the level of complexity. Women receive dedicated support from the same midwifery team throughout their pregnancy in line with the continuity of carer model	Continuity of carer is well established in Community Teams, using the buddy system Antenatal Care criteria document enables effective care planning and identification of additional support required depending on complexities National work in progress to support Midwifery Led Care Frameworks	Continuity of carer compliance is monitored via monthly audit

	7. Standardised reporting and multi professional perinatal investigation for adverse events is undertaken, with effective local and national processes in place to share learning, implement changes and reduce the risk of future harm. Openness and transparency are demonstrated in line with the duty of candour and women, parents and families are involved throughout the investigation process	Perinatal investigations following adverse events are carried out using standardised tools, including PMRT Women and families are informed of any investigations into their care and encouraged to participate Duty of Candour training delivered across the service, however instances where not completed appropriately Work in progress to review current governance process following a neonatal death and identify areas for improvement	Utilise findings from NND governance review to inform improved processes across all areas following an adverse event IO training planned for Risk Midwives to help improve quality / standardisation of investigation and reporting
	8. Robust population health strategies are in place to promote health and wellbeing with a focus on prevention, supported by processes for providing guidance, advice, and support. There are effective mechanisms for capturing, monitoring, and evaluating population health data to inform quality improvement initiatives	Women's Services Population health priorities identified via Annual Plan, which include breastfeeding, smoking cessation, and healthy weight; monthly data collected and reported in relation to these Best Start Preconception, Pregnancy and Early Years information hub available to service users via BCUHB internet site, with information translatable into numerous languages Prevention, Population Health and Early Intervention Delivery Group (PDG) recently established (replaces Population Health EDG)	Support needed from BCUHB Public Health Team to map local population need to enable targeted intervention and improvement initiatives

Efficient	**9.** Available resources are used efficiently and sustainably with a view to minimising environmental impact, whilst maintaining a clear focus on delivering person-centred care to maximise outcomes and experiences	Implementation plans in progress to deliver key priorities aligned to phase one of the Women's Health plan for Wales, which include provision of contraception in maternity services Some identified issues relating to efficiency of planned care lists which are currently being explored to identify areas for improvement	Implementation of Digital Maternity System (March 2026) will support improved efficiencies and release time to patient care
Equitable	**10.** Care and treatment are determined by clinical priority and delivered in an equitable way, understanding any additional care needs, with a clear focus on avoiding unnecessary variation and intervention	Antenatal care criteria assessment now includes communication needs to allow effective care planning and prioritisation All Wales standardised NEWTT2 tool now in use which supports identification and escalation of the deteriorating neonate	Implementation of All Wales Standardised MEWS tool planned for 8th September to support identification and escalation of the deteriorating woman Additional focus required on preventing unnecessary obstetric intervention
	11. Women, parents, and families are enabled to communicate in the language and method of choice to meet their individual needs, with the Welsh language actively offered.	Good use of translations services, some gaps continue Antenatal care criteria assessment now includes communication needs to allow effective care planning Some service user feedback received highlighting a lack of consistent offer of care in Welsh	Commence maternity access improvement initiative to support women with communication needs accessing care Review Welsh language offer
	12. Protected characteristics, social and cultural backgrounds and additional care needs are recognised as integral to providing accessible, equitable, and person-centred perinatal services	Cultural Competency training ongoing in Community Midwifery Teams	Implementation of Digital Maternity System (March 2026) will support provision of accessible, equitable, and person-centred perinatal services Cultural Competency training to be delivered in acute settings

			Additional focus required to understand care needs of those with protected characteristics
	13. Equitable access to physical and mental health advice, support, and treatment throughout the perinatal journey regardless of geographical area, recognising this care may not be provided within the health board of residence.	Obstetric clinics available across North Wales Mental health support is available across North Wales from PNMH Team as per criteria Maternity psychologist now in post	Consider potential for use of virtual consultations to support women and families living in rural areas and / or with transport issues Maternity psychologist, supported by maternity services, to undertake scoping exercise to determine potential care pathway development
Person centred	**14.** Appropriate and timely information is provided in multiple languages and formats, and women are supported to make informed decisions throughout their pregnancy, birth planning, birth, and the postnatal period. A range of birth settings are available including hospital, birth centre and home birth	Best Start Hub in use which contains information and guidance for women and families on pregnancy, birth, and the postnatal period and translatable into numerous languages Newly developed / reviewed patient information being developed in a range of formats and languages Women are able to choose to give birth at home, in a alongside midwifery unit or on an obstetric unit. Currently no facility for birth in a freestanding midwifery unit Recent review of antenatal education sessions completed	Engage with local communities to understand care requirements aligned to All Wales Perinatal Engagement Framework (supported by Maternity and Neonatal Voices Partnership paid chair role – business case submitted to support paid element of the role) Review commissioning arrangements with neighbouring health boards to ensure offer of freestanding midwifery unit is available Evaluation of antenatal education sessions required, using service user / staff feedback, +/- further improvements as required
	15. Healthcare professionals respect and support the autonomy of women as decision-makers regarding their own care, and ensure they are made aware of their rights around consent	Recently developed 'Informed decision making and personalised care planning' guideline now in use Consultant midwife clinics established to support women with alternative choice and to provide support to staff providing care	Informed decision making and personalised care planning training to be delivered to obstetric workforce

		Informed decision-making training delivered to all midwives in BCUHB via mandatory training	
	16. Unnecessary separation of mothers and babies should be avoided with transitional care provision consistently available	Transitional care available across all three acute units, however implementation variable	Neonatal Service to consider actions
	17. Parents are supported and empowered to be primary care givers and viewed as equal partners in all aspects of their baby's care. A family integrated care model will be facilitated whilst babies are on the neonatal unit	All three neonatal units have completed baseline assessment against FiCare model to identify areas for improvement	Neonatal Service to consider actions
	18. The all-Wales perinatal engagement framework is implemented to ensure the ideas, feedback and concerns of women, parents and families are heard and acted upon, with consistent use of person-reported experience measures, real-time engagement, and co-production methods. This data is routinely triangulated with other insights, quality metrics and outcome measures.	Baseline assessment against Perinatal Engagement Framework 10 commitments completed Cultural competency training ongoing in Community Midwifery Teams Engagement activities with local community groups, including NWAS MNVP Chair business case submitted to OLT (to support proactive engagement activities)	Cultural competency training to commence in acute settings Commence Maternity Access improvement initiative
	19. Women are supported with their chosen method of feeding and receive the information and guidance required. Breastfeeding is promoted to help to reduce broader health inequalities and contribute to it being viewed as a culturally accepted norm across Wales	Infant feeding teams in place in all maternity units– funding extended until end March 2026	Ensure business case submitted for 26/27 to enable continuation of service beyond March 2026
	20. The national bereavement care pathways are implemented to ensure equitable access to bereavement care and support for women, parents and families who have experienced death of a baby during	Well established bereavement pathways in use locally Bereavement midwives in post on all sites to support women, families, and staff	Develop local implementation plan following publication of All Wales Standardised Bereavement Care pathways (currently out for consultation)

	pregnancy, birth or in the neonatal period, regardless of their geographical area	Bereavement suites on each site Rainbow / Snowdrop clinics established on each site	
Leadership	**21.** Compassionate and inclusive leadership is demonstrated, enabling transformative change in a coordinated way from ward to board, supported by clear lines of communication and escalation, with a named executive board member responsible for perinatal services	Compassionate and inclusive leadership is demonstrated across the service, at all levels Staff are aware of routes of escalation Initiative such as the internal coaching programme supports the development of leadership and transformation skills	Focus on identifying and acting on instances of poor culture, to ensure staff wellbeing and patient safety maintained Improved awareness of clinical staff regrading leadership structures at service / health board level
	22. Robust succession planning is in place for existing and future leaders, with equity of access to developmental opportunities.	Opportunities for professional development of individuals frequently identified and supported External and internal leadership opportunities offered, including MLDG and internal coaching programme	Utilise the HEIW Perinatal Workforce Plan and Maternity and Neonatal Workforce Specification to identify potential gaps and to support succession planning, particularly for senior roles
Workforce	**23.** The national strategic perinatal workforce plan is implemented, ensuring appropriate multi professional staffing across services. Workforce information is readily available and used to support optimal staffing and planning	In process of completing local assessment against HEIW Perinatal workforce plan Maternity Services compliant with Birth Rate Plus as per last assessment (2022)	Await Maternity and Neonatal Network Workforce service specification Reassessment due however awaiting national steer regarding workforce calculation tool – Birth Rate Plus reassessment provisionally arranged February 2026
	24. The workforce undertakes multi professional training and has access to service-specific programmes of continuing professional development to ensure skills are maintained and further developed, as well as aid workforce retention and career progression	PROMPT MDT training well established MONET MDT training recently introduced to Neonatal Services Good opportunities for CPD	Close monitoring of mandatory training compliance and review of TNA to ensure fit for purpose Ensure consistent MDT component of PROMPT

		TNA in place to support maintenance of required skills and competency, compliance monitored monthly Some issues identified with regards to medical training compliance – currently being managed by Clinical Leads and Site Lead Managers Women's Services in Ysbyty Gwynedd has been awarded the overall TEF RCOG award for training in Obs & Gynae AND were highly commended in the overall performance 'small units' category	
Culture	**25.** Perinatal services promote a culture which embodies compassion, empathy kindness and allyship with these values and behaviours actively embraced and demonstrated by all members of the workforce	A culture of compassion and kindness is promoted throughout maternity services, with the senior leadership team acting as role models for staff and students Civility training has been delivered across the service	Continued focus on identifying and acting on instances of poor culture, to ensure staff wellbeing and patient safety maintained
	26. The health, wellbeing and safety of staff is prioritised at all levels of the organisation. Psychological safety is embedded and timely support is available to understood and meet the needs of the workforce	Psychological safety actively promoted throughout training and learning from events activities Safe Care Collaborative hot / cold debrief initiative introduced, however not consistently offered Engagement sessions completed across both acute and community settings, supported by WoD	Further work to embed Safe Care Collaborative hot / cold debrief as routine process following incidents / adverse events
	27. A just, learning and improvement culture is fully embedded in line with service and organisational values and behaviours, and staff at all levels are supported and actively	Speak out Safely service promoted via CSfM	Continue to promote and embed SoS / other routes for escalation

	encouraged to raise any concerns in line with the speaking up		Consider link between safety intelligence and each services' improvement priorities Ensure that learning is shared in a timely and contextual way
Information	**28.** An intelligent suite of nationally agreed process, experience and outcome measures is systematically captured and regularly scrutinised by clinical, managerial, and executive teams, with appropriate escalation and actions taken aligned to local and national assurance and improvement mechanisms	BCUHB Maternity Services currently use a number of service user feedback mechanisms including generalised CIVICA questionnaires, PALS, Birth Reflections, Complaints Currently in the process of implementing All Wales Standardised Maternity and Neonatal PREMS via CIVICA	Implement All Wales PREMS by end September 25 Collate and analyse feedback to identify areas for improvement
	29. Integrated perinatal digital clinical systems are adopted to inform a single national dataset and enable delivery of safe, high-quality, and consistent services where data is available to support shared decision-making, inform service delivery, drive improvements, and contribute to safe and person-centred care.	Integrated perinatal digital clinical systems not currently available	Meeting arranged to plan development of a local perinatal surveillance dashboard
Learning, Improvement and Research	**30.** Women, parents, families, and staff are encouraged and supported to participate in local and national perinatal research to advance knowledge and improve care, experiences, and outcomes.	BCUHB Maternity Services are regularly involved in local and national research programmes Proactive measures have been taken to proactively engage women, families, and staff in improvement activities, including IOL and MLU reviews and development of patient information This is now consistently achieved via MNVP distribution list and social media hubs	Continue to identify national opportunities for research and also encourage original local research opportunities
	31. The workforce is actively engaged in delivering evidence-based local and national	Numerous quality improvement initiatives ongoing, including review of IOL information	Continued focus on how the service can support staff working in all roles to be

	quality improvement initiatives which are informed by feedback from women, parents, and families, as well as insights from national bodies and audit programmes, with consistent approaches to evaluation and sharing learning	provision, MUSA, MOAU review, involving staff in various roles, the BCUHB Transformation Team and service user feedback; releasing staff to maintain involvement can be a barrier Staff engaged in the internal coaching programme are encouraged to identify and progress quality improvement initiatives, supported by senior staff Annual audit programme in place reviewed via Women's CEG	actively engaged in quality improvement initiatives
Whole Systems Approach	**32.** Collaborative working is embedded across professions, services, health boards and wider agencies involved in providing care and support, with a seamless transition between primary, secondary, and tertiary care. This must include strong partnership working for regional services	Maternity service regularly engaged in national workstreams that support the standardisation of care pathways across Wales There a numerous examples of collaborative working at a local level, for example between maternity and PNMH service, and externally for example MDT working for women with complexities and Liverpool Women's Hospital and PTHB Local implementation of Women's Health Plan will support improved transition between primary and secondary care	Implementation of Digital Maternity System (March 2026) will support collaborative working within and across professional boundaries Continue to strengthen external pathways, particularly with third sector agencies by more collaborative working with Patient Engagement Team
	33. Integrated safeguarding systems and processes are in place with all partner organisations to ensure a holistic approach to keeping children and adults safe from violence, abuse, and neglect	Midwifery Safeguarding Team, consisting of Specialist Midwife per site and safeguarding lead, to support safeguarding systems and processes are place Also provide safeguarding training	

The following appendices are included in the supporting papers:

Appendix 3 - Quality statement for maternity and neonatal services

Appendix 4 - All Wales Perinatal Engagement Framework

Appendix 5 - Maternity and Neonatal Safety Support Programme Phase Two Delivery Plan

Teitl adroddiad: ***Report title:***	Llais Report SBUHB May 2025 – BCUHB Maternity Services position update
Adrodd i: ***Report to:***	Quality, Safety and Experience Committee
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 04 September 2025
Crynodeb Gweithredol: ***Executive Summary:***	The purpose of this report is to provide an updated local BCUHB Maternity Services position against the findings of the Llais Report published May 2025. The report was triggered by growing concerns about some maternity and neonatal services across Wales raised through the press, the complaints advocacy service and engagement activities, and the Healthcare Inspectorate Wales (HIW) reports published following inspections of the maternity unit at Singleton Hospital in Swansea, in September 2023 and April 2024. An initial assessment of the local position against the themes identified within the report was completed and actions identified, which will continue to inform BCUHB Maternity Service priorities. The initial assessment was presented at QSE Sub-committee in July 2025. A meeting has been arranged between representatives of the BCUHB Maternity Service and Geoff Ryall-Harvey, North Wales Llais representative For awareness The Independent Review of Maternity and Neonatal Services at Swansea Bay University Health Board was published in July 2025, and there has been local consideration against the findings. In addition, as a consequence of the independent review, a national Maternity and Neonatal Services quality assurance assessment has been initiated by Welsh Government, with terms of reference and details of independent chair awaited
Argymhellion: ***Recommendations:***	The Committee is requested to note: • The contents of the report, the local actions taken to date and the identified future actions • That the progression of a number of locally identified actions is dependent upon other local and national programmes of work, which include: 1. The implementation of a digital maternity system 2. The Quality Statement for Maternity and Neonatal services service specification

	3. The All-Wales Perinatal Engagement Framework service specification 4. The Maternity and Neonatal Network Perinatal Workforce plan service specification			
Arweinydd Gweithredol: ***Executive Lead:***	Angela Wood, Executive Director of Nursing and Midwifery			
Awdur yr Adroddiad: ***Report Author:***	Emma Adamson, Consultant Midwife			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Quality & Safety Framework – Welsh Government Quality statement for maternity and neonatal services All Wales Perinatal Engagement Framework Maternity and Neonatal Safety Support Programme HEIW Perinatal Workforce Plan Health and Care Quality Standards			
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	e.e. Yr Awdurdod Gweithredol Iechyd a Diogelwch e.g. Health and Safety Executive			

Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	~~Do/~~Naddo ~~*Y/N*~~ Os naddo, rhowch esboniad yn ymwneud â'r rheswm pam nad yw'r ddyletswydd yn *berthnasol* *If no please provide an explanation as to why the duty does not apply* EQIAs to be completed where applicable for individual workstreams Gweithdrefn ar gyfer Asesu Effaith ar Gydraddoldeb WP7 *WP7 Procedure for Equality Impact Assessments*
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	Do/Naddo *Y/N* Os naddo, rhowch esboniad yn ymwneud â'r rheswm pam nad yw'r ddyletswydd yn *berthnasol* *If no please provide an explanation as to why the duty does not apply* SEIAs to be completed where applicable for individual workstreams Gweithdrefn WP68 ar gyfer Asesu Effaith Economaidd-Gymdeithasol. *WP68 Procedure for Socio-economic Impact Assessment.*
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	(crynodeb o'r risgiau a rhagor o fanylion yma) (summarise risks here and provide further detail)
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	A number of the priorities for action have associated workforce implications
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith	Currently completely workforce assessment against the HEIW Perinatal Workforce plan to identify local gaps against recommendations

Workforce implications as a result of implementing the recommendations	
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	(crynodeb o sut mae'r papur wedi cael ei adolygu, yr ymateb a pha newidiadau a wnaed ar ôl cael adborth) (summarise where the paper has been reviewed, the response and what changes have made due to feedback)
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Amherthnasol Not applicable
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** Continue to progress identified actions	
Rhestr o Atodiadau: ***List of Appendices:*** 1. Quality statement for maternity and neonatal services 2. All Wales Perinatal Engagement Framework 3. Maternity and Neonatal Safety Support Programme Phase Two Delivery Plan 4. The Independent Review of Maternity and Neonatal Services at Swansea Bay University Health Board	

Betsi Cadwaladr University Health Board Maternity Services

'Having a baby in Neath Port Talbot and Swansea Experiences of maternity and neonatal services in Swansea Bay University Health Board' - LLAIS report May 2025

The purpose of this report is to provide an updated local service position against the findings of the LLAIS Report and against the themes identified within it

Background

The report produced by LLAIS was triggered by growing concerns about some maternity and neonatal services across Wales through the press, the complaints advocacy service and engagement activities, and the Healthcare Inspectorate Wales (HIW) reports published following inspections of the maternity unit at Singleton Hospital in Swansea, in September 2023 and April 2024.

The Llais project was designed to amplify people's voices and represent the best interests of the people and communities who received maternity and neonatal services provided by or on behalf of Swansea Bay University Health Board. The insights shared reflect real-life pregnancy, birth, and postnatal care experiences of 515 individuals.

Note that since the publication of the report in May 2025, The Independent Review of Maternity and Neonatal Services at Swansea Bay University Health Board, chair by Dr Denise Chaffer, CBE, has also been published. This review was commissioned by Swansea Bay University Health Board (SBUHB) in response to a range of significant concerns about the safety and quality of maternity and neonatal services provided. These concerns were raised by the December 2023 Health Inspectorate for Wales report, MBRRACE UK reports, and directly by families.

BCUHB Maternity Services have also considered the findings of the independent review against local service provision, aligned to the action plan and service priorities already in progress.

The Llais report identified 10 main themes:

1. **Quality of Care**
2. **Clear information and communication**
3. **Being involved in decision making**
4. **Respect and compassion**
5. **Being heard**
6. **Being cared for after giving birth**
7. **Barriers to care for people from ethnic minority backgrounds**
8. **Unsafe care**
9. **Understaffing and work culture**
10. **Raising concerns**

The following section reconsiders these 10 main themes against local services and provides an updated local position against the actions previously identified during the initial assessment.

BCUHB Local Assessment against 10 main themes identified in the Llais Report (2025)

	Issues raised:	Current Position:	Action(s):	Aligns to	RAG Rating
Theme 1 **Quality of Care**	Lack of consistency; inadequate pain relief; 'conveyor belt' type care; inadequate monitoring throughout pregnancy	A 'Supporting informed decision making and personalised care planning' guideline has been developed and associated training delivered via mandatory training and local university, to ensure consistent approach to individualised care planning Implementation of the revised antenatal care criteria risk assessment document to support effective care planning and appropriate pathway recommendations A North Wales Postnatal Forum has been established to monitor themes and trends related to PN care, including issues with analgesia provision and a focus on kind and compassionate care, to identify and inform service improvement, priorities, and principles to improve overall quality of care	Implement a digital maternity system (due March 2026) Implementation and evaluation of MEWS / NEWTT2 tools and Team of the Shift to support the identification and escalation of the deteriorating patient Continue to progress of 'Saving Babies' Lives Care Bundle v3' action plan **August 2025 update –** NEWTT2 now in use across maternity and neonatal services, evaluation required MEWS implementation planned for 8th September; training and baseline assessment of current escalation processes now in progress	**Quality statement for maternity and neonatal services (2025)** **MatNeo SSP Priority for Action 11.2** **CNO EWS Welsh Health Circular** **Saving Babies' Lives Care Bundle V3 Action Plan**	

	Issues raised:	Current Position:	Action(s):	Aligns to	RAG Rating
Theme 2 **Clear information and communication**	Lack of clear information, difficulty accessing midwives; little guidance on pregnancy, birth, and early parenthood, including exercise, birth choices, breastfeeding, and emotional support	Best Start Hub – Preconception, Pregnancy, Early Years and Family information resource available on BCUHB Web pages. The up-to-date evidence-based information is translatable into numerous languages Patient information leaflets which are under review / development are co-produced, with input from Maternity and Neonatal Voices Partnership (MNVP) colleagues and consideration given to translation / communication needs of local population Antenatal education review completed and standardised content developed based on service user feedback	Implement a digital maternity system (due March 2026) Progress induction of labour and midwifery led care improvement projects which focuses on information provision and supporting choice Evaluation of antenatal education sessions to support further improvements which reflect service user feedback **August 25 update –** a number of sections of IOL resource completed. Work ongoing to develop into a user-friendly booklet, also available electronically Linking with Comms / IT to facilitate IOL 'drop in' sessions to improve information provision / aid decision making In process of reviewing AN education feedback to enable	**Quality statement for maternity and neonatal services (2025)** **MNVP Priorities 24 - 25** **HIW Inspection Report 2025** **APPG Birth Trauma Report 2024**	

			evaluation and improvement of updated sessions		

	Issues raised:	Current Position:	Action(s):	Aligns to	RAG Rating
Theme 3 **Being involved in decision making**	Timing of decisions, feeling excluded from the process; restricted birth choices; lack of choice, control, and information	A 'Supporting informed decision making and personalised care planning' guideline has been developed and associated training delivered via mandatory training and local university, to ensure consistent approach to individualised care planning Establishment of Consultant Midwife clinics across all sites to support women making alternative birth choices	Implement a digital maternity system (due March 2026) Progress the induction of labour improvement project, to include a collaborative review of the decision-making aid and leaflet **August 25 update –** Several sections of IOL resource completed. Work ongoing to develop into a user-friendly booklet, also available electronically Linking with Comms / IT to facilitate IOL 'drop in' sessions to improve information provision / aid decision making Consultant Midwife Clinic referral email established to facilitate timely access	**Quality statement for maternity and neonatal services (2025)** **MNVP Priorities 24 - 25** **HIW Inspection Report 2025**	

			‘Supporting informed decision making’ training session to be delivered at clinical audit session (awaiting confirmation of date)		

	Issues raised:	Current Position:	Action(s):	Aligns to	RAG Rating
Theme 4 **Respect and compassion**	Dismissive culture, particularly when raising concerns; lack of compassion; disrespect via use of clinical language	Promotion of RCM Re:Birth project to encourage appropriate and respectful language Civility and informed consent training developed and delivered in Service	Implement a digital maternity system (due March 2026) Implement the All-Wales Maternity and Neonatal PREMs questionnaires, via CIVICA (by September 2025) Ongoing monitoring of service-user feedback to identify themes and trends focused on respect and compassionate care to inform service improvement **August 2025 update –** All Wales Maternity and Neonatal PREMs implementation plan in progress, supported by informatics and DDaT	**Quality statement for maternity and neonatal services (2025)** **All Wales Perinatal Engagement Framework**	

	Issues raised:	Current Position:	Action(s):	Aligns to	RAG Rating
Theme 5 **Being heard**	Not being listened to; inadequate pain relief; dismissed when voicing concerns; being told not in labour	A North Wales Postnatal Forum to monitor themes and trends related to postnatal care, including issues with analgesia provision, to identify and inform service improvement, priorities, and principles to improve overall quality of care Service user feedback obtained via local Civica questionnaire (not maternity specific) Local assessment against the 10 commitments detailed within All Wales Perinatal Engagement Framework has been completed, which informs local service planning and priorities Regular collaboration with service users during quality improvement / service development activities	Implement a digital maternity system (due March 2026) Implement the All-Wales Maternity PREMs questionnaires, via CIVICA (by September 2025) Progress review of Maternity Outpatient Assessment Units across all sites Progress the establishment of paid Maternity and Neonatal Voices Partnership (MNVP) paid Chair position – business case being presented to OLT **August 2025 update -** Continue to await outcome of MNVP paid chair role All Wales Maternity and Neonatal PREMs implementation plan in progress, supported by informatics and DDaT	**Quality statement for maternity and neonatal services (2025)** **All Wales Perinatal Engagement Framework** **MNSI National Learning Review 2024**	

	Issues raised:	Current Position:	Action(s):	Aligns to	RAG Rating
Theme 6 **Being cared for after giving birth**	Feeling neglected, unsupported, and unsafe following birth, particularly following caesarean birth, or baby in SCBU; disjointed postnatal care; inconsistent mental health support; lack of bereavement support	A North Wales Postnatal Forum to monitor themes and trends related to postnatal care, including issues with analgesia provision, to identify and inform service improvement, priorities, and principles to improve overall quality of care Transitional Care Bundle recently developed and implemented Extensive developments to Perinatal Mental Health Service; midwives receive training from the Perinatal Mental Health Team to ensure the prompt identification of women with mental health problems and ensure appropriate individualised support is offered A Bereavement Midwife has been appointed on each site to support families and staff. Bereavement education sessions are delivered are part of the Service mandatory training programme	Implement a digital maternity system (due March 2026) Implementation and evaluation of MEWS / NEWTT2 tools and Team of the Shift to support the identification and escalation of the deteriorating patient **August 2025 update –** NEWTT2 now in use across maternity and neonatal services, evaluation required MEWS implementation planned for 8th September; training and baseline assessment of current escalation processes now in progress Awaiting publication of the All Wales Standardised Bereavement pathways for local implementation	**Quality statement for maternity and neonatal services (2025)** **MatNeo SSP Priority for Action 11.2** **HIW Inspection Report 2025** **CNO EWS Welsh Health Circular**	

		Well established links with Specialist Perinatal Mental Health Team to support women with moderate to severe mental illness			

	Issues raised:	Current Position:	Action(s):	Aligns to	RAG Rating
Theme 7 **Barriers to care for people from ethnic minority backgrounds**	Racial stereotyping, particularly in relation to pain relief; communication difficulties	Cultural competency training currently being rolled out across all Community Midwifery Teams Consultant Midwife, with support from Corporate Engagement Team is seeking proactive community engagement opportunities to ensure women and families from minority groups is received i.e. NWAS, Cymraeg I Blant, Flying Start Local assessment against the 10 commitments detailed within All Wales Perinatal Engagement Framework has been completed, which informs local service planning and priorities	Implement a digital maternity system (due March 2026) Develop a local action plan against awaited recommendations / service specifications associated with the All-Wales Perinatal Engagement Framework and Maternity and Neonatal Quality Statement (Q1 25/26) Deliver the Cultural Competency training to staff in the acute settings across all 3 units Continued engagement in national Maternity and Neonatal Safety Support Programme Maternity Access Card workstream (Phase 2 25/26) **August 2025 update –**	**Quality statement for maternity and neonatal services (2025)** **All Wales Perinatal Engagement Framework** **MatNeo SSP Priority for Action 5.2** **APPG Birth Trauma Report 2024**	

			Maternity Access initiative to be led locally – work to commence in Autumn 2025 following implementation of MEWS		

	Issues raised:	Current Position:	Action(s):	Aligns to	RAG Rating
Theme 8 **Unsafe care**	Being left unattended in labour; concerns being dismissed; lack of adequate monitoring during labour; degrading treatment; unsafe practices; neglect	A 'Supporting informed decision making and personalised care planning' guideline has been developed and associated training delivered via mandatory training and local university, to ensure consistent approach to individualised care planning and to ensure midwives aware of legal requirements of providing information on all material risks Continued engagement in national Maternity and Neonatal Safety Support Programme (Phase 2 25/26) MUSA improvement work in progress to ensure midwifery led unit care provision during the	Implement a digital maternity system (due March 2026) Develop a local action plan against awaited recommendations / service specifications associated with the All-Wales Perinatal Engagement Framework and Maternity and Neonatal Quality Statement Progress the establishment of paid Maternity and Neonatal Voices Partnership paid Chair position – business case being presented to OLT **August 2025 update-** Continue to await outcome of MNVP paid chair role	**Quality statement for maternity and neonatal services (2025)** **All Wales Perinatal Engagement Framework** **MatNeo SSP Priority for Action 5.2** **All Wales Perinatal Engagement Framework**	

		intrapartum phase is safe and effective	Improved systems for data collection and audit in relation to midwifery led units now in place; data to be shared at local and North Wales Intrapartum Forum for learning and improvement Other MUSA work ongoing		

	Issues raised:	Current Position:	Action(s):	Aligns to	RAG Rating
Theme 9 **Understaffing and work culture**	Inconsistent care; unhygienic areas; focus on clinical processes at expense of personal care and compassion; negative culture	Maternity Service, supported by Workforce and Organisation Development team, have facilitated staff engagement sessions to identify areas of negative culture Ongoing participation in infection prevention control processes and senior leadership engagement when receiving feedback from inspections Maternity Services Birth Rate Plus compliant as per previous assessment (2022)	Implement a digital maternity system (due March 2026) Reassessment of workforce provision using Birth Rate Plus methodology to take place in 2025 **August 2025 update–** Local bench marking against HEIW Perinatal Workforce Plan to take place; continue to await the associated Maternity and Neonatal Workforce specification Birth Rate Plus assessment provisionally arranged for February 2026; national conversations ongoing regarding	**Quality statement for maternity and neonatal services (2025)** **MNSI National Learning Review 2024** **HEIW Perinatal Workforce Strategy 2025**	

			use of tool or an alternative in future		
	Issues raised:	**Current Position:**	**Action(s):**	**Aligns to**	**RAG Rating**
Theme 10 **Raising concerns**	Confusion about how to raise concerns; when concerns raised not listened to / no action; where small changes were made, these did not result in system improvements	Work is ongoing to develop a more robust process when sharing service improvements with service users, particularly following serious incidents Work is ongoing to ensure clinical staff are familiar with informal and formal processes for raising concerns, how they can support service users in the process and in a positive resolution	Implement a digital maternity system (due March 2026) A review of serious incident management processes, including mechanisms for service user involvement and feedback (Q1, 2 25/26) **August 2025 update –** Review of maternity and neonatal governance process in progress as part of the MDT neonatal death review commissioned by CEO	**Quality statement for maternity and neonatal services (2025)** **Coroner Feedback – Inquest WING 1875** **HIW Inspection Report 2025**	

Summary

The Llais report does not go so far as to provide specific service recommendations, the emerging themes and trends echo those identified in many of the preceding national reports, and whilst BCUHB Maternity Services has made progress in relation to many of these issues the report provides further opportunity to review current service provision through the lens of the service user.

Identified local actions include to:

- Progress the induction of labour and midwifery led care improvement projects which include a collaborative approach to developing information provision resources to support patient choice
- Evaluate antenatal education sessions to support further improvements which reflects service user feedback
- Evaluate MEWS / NEWTT2 tools and Team of the Shift to support the identification and escalation of the deteriorating patient
- Continue to progress the 'Saving Babies' Lives Care Bundle v3' action plan
- Implement the All Wales Maternity PREMs questionnaires, via CIVICA, with ongoing monitoring of service-user feedback to identify themes and trends related respect and compassion, which will inform service planning and priorities
- Further development of the local Maternity and Neonatal Voices Partnership
- Progress the review of the Maternity Outpatient Assessment Units across all sites
- Develop a local action plan against awaited recommendations / service specifications associated with the All Wales Perinatal Engagement Framework and Maternity and Neonatal Quality Statement
- Deliver Cultural Competency training across all sites
- Continue to engage in national Maternity and Neonatal Safety Support Programme Maternity Access Card workstream
- Progress establishment of a paid Maternity and Neonatal Voices Partnership Chair position
- Reassess the maternity workforce provision using Birth Rate Plus methodology to take place in 2025
- Review the serious incident management processes, focusing on the introduction of mechanisms for service user involvement and feedback as part of the process

Please note the majority of the themes highlighted within the Llais reported have been highlighted in other national reports including the Ockenden (2022) and East Kent (2022) Reports, the Maternity and Newborn Safety Investigations (MNSI) national learning report on factors affecting the delivery of safe care in midwifery units (2024) and The All-Party Parliamentary Group (APPG) Birth Trauma Report (2024) .

Whilst we now await the completion of the national maternity and neonatal service assurance assessment, the findings of this review, along with the priorities for action contained within the Maternity and Neonatal Safety Support Programme (MatNeoSSP) Discovery Phase Report (2023), Quality Statement for Maternity and Neonatal Services (2025), a local Health Inspectorate Wales (HIW) report of services at Ysbyty Gwynedd

(2025) and recommendations made following a recent inquest, have prompted other local benchmarking exercises, development of associated actions plans and have informed annual and integrated medium-term plans.

The following appendices are included in the supporting papers:

Appendix 1 - The Independent Review of Maternity and Neonatal Services at Swansea Bay University Health Board

Appendix 3 - Quality statement for maternity and neonatal services

Appendix 4 - All Wales Perinatal Engagement Framework

Appendix 5 - Maternity and Neonatal Safety Support Programme Phase Two Delivery Plan

Teitl adroddiad: ***Report title:***	QSE Committee – Quality Report
Adrodd i: ***Report to:***	QSE Committee
Dyddiad y Cyfarfod: ***Date of Meeting:***	4th September 2025
Crynodeb Gweithredol: ***Executive Summary:***	This report provides the Committee with assurance, underpinned by analysis, on significant quality issues alongside longer-term data and information on the improvements underway
Argymhellion: ***Recommendations:***	The Committee is asked to note this report
Arweinydd Gweithredol: ***Executive Lead:***	• Angela Wood, Executive Director of Nursing and Midwifery (Lead Executive) • Dr Sreeman Andole, Interim Executive Medical Director • Teresa Owen, Executive Director of Allied Health Professionals and Health Science • Dr Jane Moore, Executive Director of Public Health
Awdur yr Adroddiad: ***Report Author:***	• **Patient Safety:** Chris Lynes, Deputy Director of Nursing and Tracey Radcliffe, Head of Patient Safety • **Patient and Carer Experience,** Chris Lynes, Deputy Director of Nursing and Leon Marsh, Head of Patient Experience • **Safeguarding:** Michelle Denwood, Director of Safeguarding & Public Protection • **IPC:** Andrea Ledgerton, Assistant Director of Infection Prevention and Decontamination • **Clinical Effectiveness:** Dr James Risley, Deputy Medical Director (Clinical Effectiveness), and Joanne Shillingford, Head of Clinical Effectiveness • **Quality Assurance:** Jo Kendrick, Head of Quality and Erika Dennis, Quality Lead Manager • **Healthcare Law:** Matthew Joyes, Deputy Director for Legal Services

Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒

Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐	Derbyniol *Acceptable* ☐	Rhannol *Partial* ☒	Dim Sicrwydd *No Assurance* ☐
	Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, â'r terfyn amser ar gyfer cyflawni hyn:
Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:

There is confidence in the data provided in the report however, the pace of learning and improvement remains a key focus of work. This is being addressed through a range of measures including the actions aligned to Special Measures and the Board Assurance Framework.

Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	• Objective 4 - Improving quality, outcomes and experience • Objective 5 - Establishing an effective environment for learning
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	The Duty of Quality is a statutory requirement under the Health and Social Care (Quality and Engagement) (Wales) Act 2020. The statutory duty of quality requires the decision-making processes by the Health Board take into account the improvement of health services and outcomes for the people of Wales – the duty also includes new Health and Care Quality Standards. Instances of harm to patients may indicate failures to comply with the NHS Wales standards or safety legislation.
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	N/A
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	N/A
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF â'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR)***	BAF-SP18 and CRR-24-04 – Quality, Innovation and Improvement
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	N/A
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	N/A
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	N/A
Cysylltiadau â risgiau BAF: (Neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(Or links to the Corporate Risk Register)*	BAF-SP18 and CRR-24-04 – Quality, Innovation and Improvement
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	N/A
Camau Nesaf: Gweithredu argymhellion ***Next Steps: Implementation of recommendations*** N/A	
Rhestr o Atodiadau: ***List of Appendices:*** QSE Committee Quality Report:	

QSE Committee – Quality Report – September 2025
Reporting period – June - July 2025

INTRODUCTION

For the NHS in Wales, quality is considered to be defined as continuously, reliably, and sustainably meeting the needs of the population that we serve.

In achieving this, under the statutory Duty of Quality, Welsh Ministers and NHS bodies will need to ensure that health services are **safe**, **timely**, **effective**, **efficient**, **equitable** and **person-centred**. Underpinning these domains are six enablers, which are **leadership**, **workforce**, **culture**, **information**, **learning and research** and **whole-systems approach**.

These domains and enablers form the **Health and Care Quality Standards** for Wales introduced in April 2023 through statutory guidance.

This report provides the Committee with key quality related assurances, underpinned by analysis, on significant quality issues arising during the prior period alongside longer-term data and information on the improvements underway.

The report is structured around three components of quality: Patient Safety (including Safeguarding and Infection Prevention and Control), Patient and Carer Experience (including Complaints), Clinical Effectiveness, with a separate section covering Quality Assurance (including Healthcare Regulation) and Healthcare Law. This reflects the organisational management arrangements for quality leadership in the Health Board.

PATIENT SAFETY

PATIENT SAFETY INCIDENTS

There are currently 5135 open incidents, of the 5135, 3164 have been open more than 30 days. This is a similar position to the last reporting period.

Focused workshops led by the Associate Director of Nursing, supported by the Patient Safety Team (PST) are planned in Central IHC as they currently have 41% of the open incidents. A weekly position report has been shared with all IHC's and Divisions, highlighting the need for the interim review to be completed within three working days. The position is being closely monitored and this had improved by 27%.

Oxygen Cylinder improvement work

The oxygen improvement task and finish group continue to drive IHC and Divisional progress with the Health Board improvement plan. The current Health Board wide compliance with oxygen cylinder training on ESR is 75%.

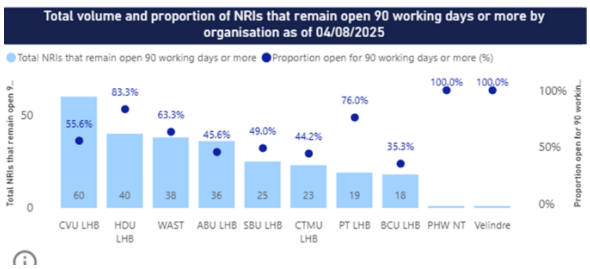
BOC are still progressing with the single valve cylinder and are visiting BCUHB mid-September to demonstrate it to BCUHB services and teams and will also update on cost implications to Health Boards.

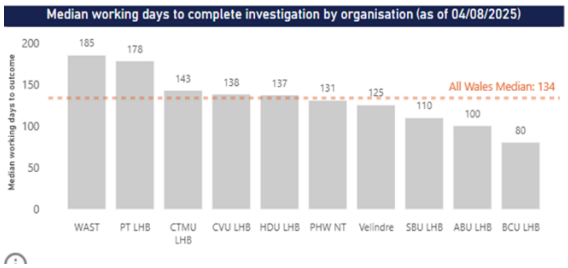
Nationally Reportable Incidents

From 01st June 2025 to 31st July 2025, there were 14 National Reportable Incidents (NRIs) occurring by incident date compared with 24 for the previous reporting period. The Beacon dashboard reports 9 NRI's for BCUHB, which is a combination of late reporting and delayed processing by NHS Wales Performance and Improvement.

The total number of NRI investigations that were open as of the end of July 2025 was 51 with 11 overdue closures. Notably, the West IHC, East IHC and MHLD Division have zero overdue cases. An escalation meeting with the Executive Nurse has taken place with Womens Division as 5 of the overdues were related to Womens Division.

The proportion of NRI's that remain open for more than 90 days are the best across Wales, with the Health Board having 35.3% of cases taking longer than 90 days. Although this is again an increase on the previous reporting period, it is still lower than the next Health Board (in Wales) at 44.2%.





The median working days to completion is also the lowest at 80 days compared to the All-Wales median of 134 days.

Closures – Outcome forms submitted to NHS Wales Performance and Improvement

A total of 35 NRI outcome forms were submitted to NHS Wales Performance and Improvement during June and July 2025.

Never Events

The Health Board reported a Never Event in June 2025, relating to wrong site surgery.

The initial rapid review ascertained that the procedure followed the WHO checklist procedure, however, no pictorial information or photographs were captured.

There was no significant harm to the patient.

PATIENT SAFETY ALERTS

No new Patient Safety Alerts (PSA) or Patient Safety Notices (PSN) were received in this time period.

One internal alert from Pharmacy was circulated relating to Citalopram dosage in the patients over 65 advising the maximum dose is to be restricted to 20mg.

BCUHB have been using the new Once for Wales (OFW) alerts system (new Datix) since the 1st April 2025 and several issues have been identified. The lead from Swansea Bay HB has agreed to meet with the PST to review the issues.

SAFEGUARDING & PUBLIC PROTECTION

Training Compliance Q1 2025-2026

BCUHB's Safeguarding and Public Protection Training activities continue to have a targeted approach to ensure compliance meets the KPI of 85%.

Table 1: March 25 – June 25

Safeguarding Module	Mar-25	Jun-25	Trajectory
MCA – Level 1	84.5%	85.9%	↑
MCA – Level 2	83.5%	84.9%	↑
Safeguarding Adults – Level 1	86.9%	88.6%	↑
Safeguarding Adults – Level 2	86.0%	87.6%	↑
Safeguarding Children – Level 1	87.5%	88.9%	↑
Safeguarding Children – Level 2	86.1%	87.8%	↑
Safeguarding Children – Level 3	50.3%	55.4%	↑
VAWDASV	76.7%	78.6%	↑

Table 1 highlights the overall compliance for all eight Safeguarding modules, which has increased when compared to the end of Q4 2024-25.

- Overall compliance for five of the Safeguarding modules is now above KPI compared to four in March 2025.
- Mental Capacity Level 2 has now reached BCUHB KPI of 85% (July 2025)
- From August 2024 Level 3 Safeguarding Children Training compliance was added to staff profiles on the Electronic Staff Record. This has enabled separate reporting of Level 2 and Level 3 training. It is recognised that the compliance data will improve over the year as it will need time to readjust in line will staff training expectation and compliance.

Compliance by Health Economies

- Mental Health & Learning Disabilities continue to have the highest overall compliance of the eight health economies and remain above target in six out of the eight modules.
- Two of the Health Economies are above KPI in seven out of the eight Safeguarding modules.
- Four of the Health Economies are above KPI in six out of the eight Safeguarding modules.
- Compliance in VAWDASV for Midwifery and Women's Services has increased from 78.7% to 81.3%.

Deprivation Of Liberties Assessments (DOL) Backlog Progress

A significant area of progress relates to the reduction of the DoLS backlog. As of the July 2025 the DoLS backlog stands at 54, a notable improvement from 71 in the previous quarter and an initial backlog of 127 prior to receipt of Welsh Government (WG) funding. It is important to note that the number of applications received can vary month to month and as such, the backlog will fluctuate.

Independent Mental Capacity Advocate (IMCA)

The Health Board hold geographical responsibility for the provision of an IMCA service across North Wales. Meaning that the IMCA service enables the Health Board (HB) and Local Authorities (LA) to meet the statutory requirement of the offer of advocacy services to service users across North Wales. The provision of IMCA and paid RPR services is a statutory obligation introduced under the Mental Capacity Act 2005 (MCA) to ensure individuals are provided with a legal independent safeguard.

Following the commencement of the IMCA contract in 2024-25, the Health Board identified that the tendered financial value for Lot 1a was incorrect. To meet the service requirements, the contract value was increased. This adjustment presented challenges, resulting in significant delays in payments to the IMCA service. The situation required involvement from the Local and National Procurement Team, who sought advice and

support from the NWSSP Legal and Risk (L&R) Services due to the potential risks posed to both the Health Board and vulnerable adults.

The Executive Board are working through the legal and procurement processes to ensure that individuals views are represented in accordance with the Human Rights Act and enabling the Health Board to fulfil its statutory obligations in delivering this essential service.

INFECTION PREVENTION AND CONTROL

Outbreaks

Organism	No. of new Outbreaks June/July 2025	Bay Closures	Full ward Closures	Bed days lost
Norovirus	8	7	1	70
COVID	9	7	2	39
Flu	1	1	0	7
C. diff	5	N/A	1	1
CPE	1	0	1	73
AMR E. coli	0	N/A	N/A	N/A
MRSA	0	N/A	N/A	N/A
Total	24	15	5	180

During July there were a total of 13 newly identified outbreaks. This is a slight increase from 11 outbreaks in June, but with fewer full ward and bay closures. Only one ward was closed due to Carbapenemase Producing Enterobacterales (CPE), this demonstrated a positive operational impact and positive impact on beds lost figures.

Whilst there has been one full ward closure due to Clostridioides difficile (C. Difficile), the increasing number of C. Difficile cases and the environmental bioburden has resulted in high-level recommendations to mitigate risk associated with the current bioburden

Infection Reduction Performance Update – end of July 2025

In the absence of defined Welsh Government Improvement Goals for 2025/2026, Betsi Cadwaladr University Health Board (BCUHB) has established local targets aligned with the reduction goals set for 2024/2025.

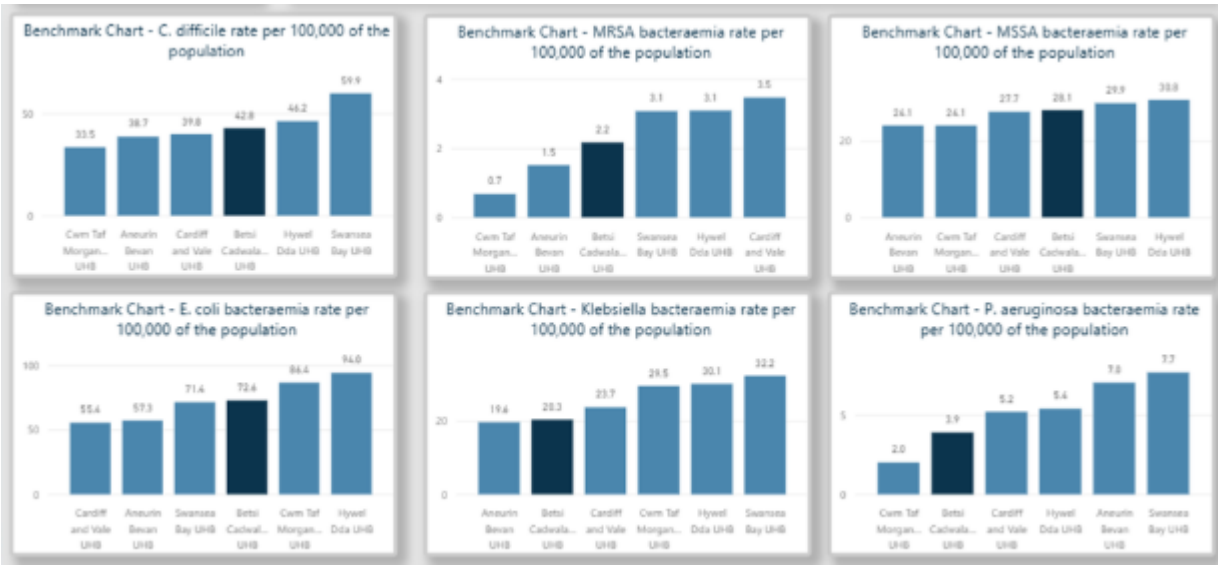
When comparing performance to the same period in 2024/2025, BCUHB has made progress in some key areas, aiming to reduce the overall number of healthcare-associated infections across both community and hospital settings. As of the end of July 2025, the following changes have been reported:

- Clostridioides difficile (C. diff): **25 fewer cases** (no specific goal set for overall numbers).
- Methicillin -resistant Staphylococcus aureus (MRSA): **one more case** (no specific goal set for overall numbers).
- Methicillin -sensitive Staphylococcus aureus (MSSA): **nine more cases** (no specific goal set for overall numbers).
- Escherichia coli (E. coli): **16 fewer cases** (aligned with Goal 1).
- Klebsiella spp.: **11 more cases** (aligned with Goal 2).
- Pseudomonas aeruginosa: **six more cases** (aligned with Goal 3).

When benchmarked against other Health Boards in Wales as of end of July 2025, BCUHB ranked:

- 2nd for Pseudomonas and Klebsiella
- 3rd for MRSA
- 4TH for MSSA, E. coli and C. Difficile

This represents downward trend for MSSA with an improvement in the position for MRSA. Rankings for E. coli, Klebsiella, Pseudomonas and C. Difficile remain stable



Community Onset Infections

As of the end of July 2025, BCUHB has demonstrated positive progress in reducing community onset infections when compared to the same period in 2024/2025 for C. diff infections, reporting at fewer than 25 cases per 100,000 population. (Goal 10). However, for Staphylococcus aureus (combined MRSA/MSSA), there has been an increase in July with BCUHB reporting a rate above the improvement goal of fewer than 25 cases per 100,000 population (Goal 10)

C.diff

Month	CO rate per 100000 25/26	CO rate per 100000 24/25	Yr on Yr 25/26 to 24/25
Apr	17.58	24.68	-7.10 ↓
May	22.12	35.83	-13.71 ↓
Jun	14.07	29.97	-15.91 ↓
Jul	27.22	44.36	-17.14 ↓
Total	**20.32**	**33.82**	**-13.50** ↓

Staph. aureus bacteraemias

Month	CO rate per 100000 25/26	CO rate per 100000 24/25	Yr on Yr 25/26 to 24/25
Apr	24.61	21.16	3.46 ↑
May	15.31	20.47	-5.16 ↓
Jun	29.89	15.87	14.02 ↑
Jul	17.01	22.18	-5.17 ↓
Total	**21.62**	**19.94**	**1.67** ↑

Hospital Onset (HO) Infections:

Compared to the same period for 2024/2025, at the end of May 2025 BCUHB reported:

- 52 HO cases of C. diff –15 cases over the 20% reduction (goal 7).
- 40 HO cases of E. coli – 7 cases over the 10% reduction (goal 2).
- 15 HO cases of Klebsiella – 3 cases over the 20% reduction (goal 6).
- 3 HO case of MRSA – 2 cases over fewer infections (goal 9).
- 17 HO cases of MSSA - 6 cases over fewer infections (goal 9). 3 HO case of Pseudomonas – 2 cases over the 10% reduction (goal 4).

Organism Type	BCU HO Numbers 25/26	BCU HO Numbers 24/25	BCU Year on Year 25/26	BCU HO Trajectory 25/26	BCU Comparison to Trajectory 25/26
C.diff	52	46	6 ↑	37	15 ↑
E.Coli	40	37	3 ↑	33	7 ↑
Klebsiella	15	15	0 →	12	3 ↑
MRSA	3	1	2 ↑	1	2 ↑
MSSA	17	11	6 ↑	11	6 ↑
Pseudomonas aeruginosa	3	1	2 ↑	1	2 ↑
Total	**130**	**111**	**19** ↑	**95**	**35** ↑

Actions to Address the WHC 2024/25 HCAI Improvement Goals:

The Infection Prevention Team (IPT) continue to deliver the Programme of Work for 2025/2026, which has been developed based on the standards within the Code of Practice. In addition to the actions in the Programme of Work, this month the IPT have:

- Introduced an initial visit to any inpatient reported to have C. Difficile on the day of result (Mon –Friday), this also occurs with CPE.
- Reviewed/enhanced the definition of a Period of Increased Incidence to provide an earlier trigger where there is an increased environmental burden of C. Difficile as opposed to linked cases that are of hospital onset.
- Reinforced the recommendation to close bays to facilitate full ward HLD when delayed isolation occur due to C. Difficile was approved at Strategic Infection Prevention Group.
- Asked the Senior Nurses to consider the development of a Post Audit Report Template for wards and departments as part of an improvement initiative to support the IP proactive audit programme that focuses on clinical practices such as peripheral vascular devices, urinary catheters, ANTT, MRSA screening.

Ongoing Strategic Priorities:
High-level improvement plans across all IHCs continue to focus on addressing the following challenges:

- **High-Level Disinfection:** Developing and enforcing comprehensive disinfection programmes to prevent the spread of infections, particularly in wards affected by enteric organism such as C. Difficile and CPE and standardisation of High-Level Disinfection Technology.
- **Reporting:** Gaps in enhanced cleaning and HLD capability are being reported through Local and Strategic Infection Prevention Groups with mitigation to resolve.
- **Cohorting Solutions:** actively exploring cohort solutions for C. Difficile, as recommended by the Infection Prevention Team (IPT), to address the current lack of effective isolation capacity across the acute hospital.
- **Capacity Building:** Increasing isolation capacity within the hospital to better manage infectious outbreaks and improve patient outcomes.
- **Staff Training:** Providing targeted training for staff on infection prevention and control measures and outbreak management to enhance overall preparedness and response.
- **Estates and Facilities:** Improving existing infrastructure to ensure the environment is conducive to infection prevention.

OTHER PATIENT SAFETY CONCERNS AND IMPROVEMENTS

Training for Designated Nursing and Medical Officers (DNOs/DMOs):

A training gap has been identified in relation to Designated Nursing Officers (DNOs) and Designated Medical Officers (DMOs), specifically regarding the safe use and management of medical gas pipeline systems.

There is a need to address this gap through the provision of appropriate training. In the longer term, a sustainable plan will be required to ensure ongoing competency and compliance. This has been escalated to the Health Board Medical Gases Group and subsequently to the Health Board Patient Safety Group.

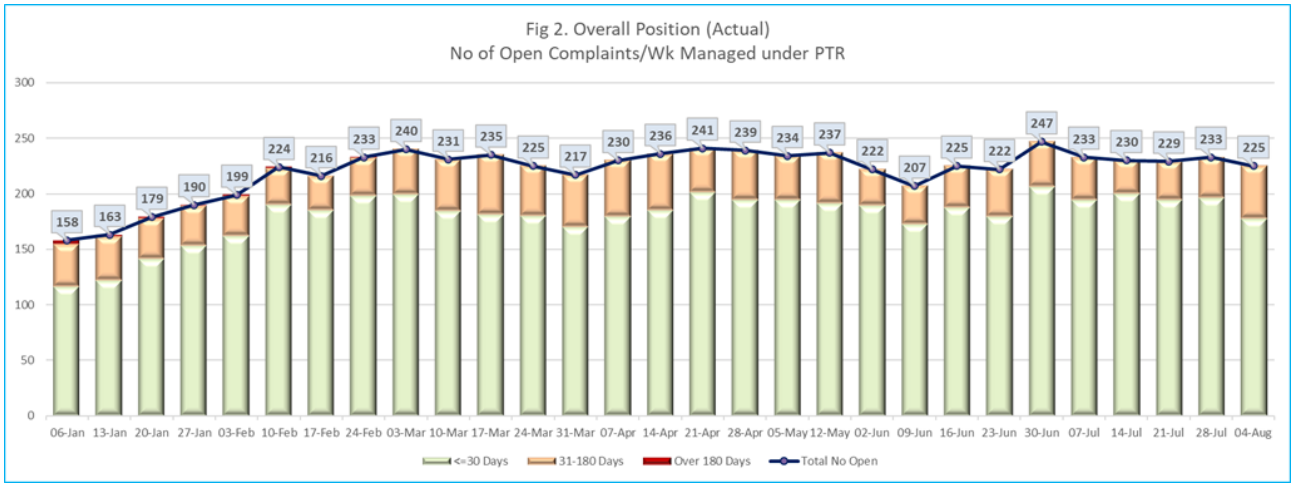
PATIENT EXPERIENCE

COMPLAINTS

Between the 1st June and 4th August, the BCUHB received 517 complaints and closed 506 complaints, a negative variance of 11

Complaint's position as of 4th August, 2025

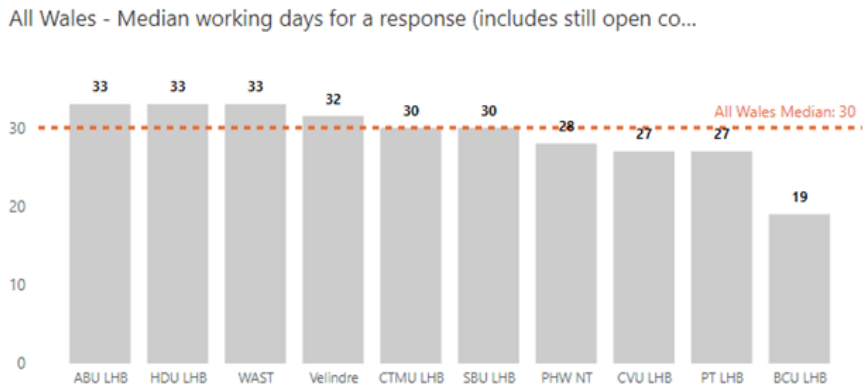
- Total Number of open complaints = 225 (an increase from 165 in the previous reporting period)
- Number of Complaints Less than 30 working days = 177 (An increase from 122 from previous reporting period)
- Number of Complaints overdue = 48 (an increase from 43 from the previous reporting period)
- Compliance with 75% target of overdue complaints – 78.67% (an increase from 73.94% in the previous reporting period, and above 75% target)



Average complaint closure time

As of 4th August 2025, the average number of working days / months a complaint is on average 20.29 working days including historical and backlog complaints in 2024-25 (an improvement from 32.09 working days in the previous reporting period, and below the 30-day target)

Nationally, since 1st April 2025 we are resolving complaints in 19 working days, the best performing health board in Wales



Complaint themes

The main themes of complaints are

Sub Subjects	Count of ID
Delay/Lack of diagnosis	7
Response to Patient needs	7
Delay in appointment/waiting time/transport	7
Attitude/Behaviour of Clinical Staff	8
General care and respect	9
Communication with patient/service user	11
Incorrect/insufficient treatment or Assessment	45
Delay/Lack of treatment or Assessment	72
Grand Total	**166**

Womens and Midwifery - Theme Analysis

Clinical Treatment and Assessment is the biggest theme in Womens and Midwifery, with delay/ lack of treatment and assessment and insufficient treatment and assessment the biggest sub themes of complaints, consistent with complaints raised across the BCUHB. Looking at the year-on-year themes, the following emerging trends are evident within the division.

- Patient Care
- Attitude and Behaviour
- Communication
- Reaction to Procedure / Treatment

Mental Health and Learning Disability (MHLD) - Theme Analysis
Since 1st April, 2025, almost 1 in every 2 complaints have been about clinical treatment / assessment, with communication, patient care and attitude and behaviour the next biggest themes in the division.

PATIENT FEEDBACK

Between the 1 June 2025 – 31 July 2025, the Patient Advice and Liaison Service (PALS) facilitated the resolution of 1324 enquiries, received 114 compliments in writing and 13 suggestions for improvement. As of 30 July 2025, PALS took on average 6.23 working days to resolve an enquiry.

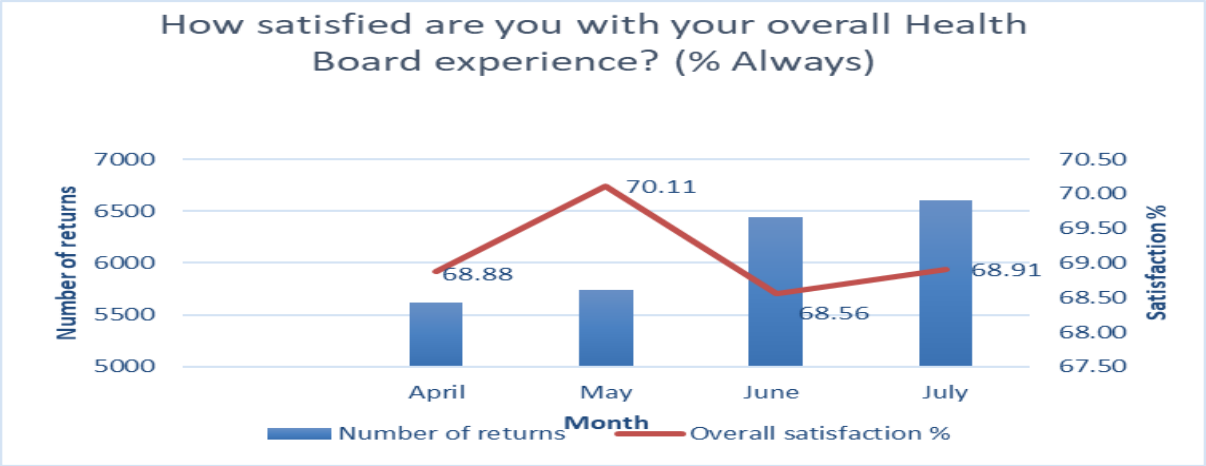
The key themes identified from PALS enquiries within the reporting period include:

- Appointments
- Clinical treatment or assessment
- Communication

PALS Staff visited 3 wards/service areas across Ysbyty Glan Clwyd, Mold Community Hospital and Wrexham Maelor Hospital to undertake 'Care to Share' discovery interviews to capture feedback from patients. Patients shared positive feedback in relation to staff being kind and caring.

Patient Feedback

From 1 June 2025 – 31 July 2025, 13039 All Wales People's Experience Survey responses were received via Civica feedback system. 89% of respondents shared their experience of accessing services "in the last week". On average within the reporting period respondents rated their overall experience of accessing Health Board services as 'very good' at 68.73%.



Overall, respondents provided positive feedback in relation with the length of time they waited to access a Health Board service. 87.51% of people reported always being treated with dignity and respect and 90.80% of people being reported ‘always’ able to communicate in their preferred language including; Welsh, English, BSL, Romanian, Urdu and Portuguese. These two new survey questions exceed the NHS Wales satisfaction benchmark score of 85%.

What people said was good about their experience:

- *‘I left my appointment happy and reassured. I dropped off my prescription letter at my GP Surgery and was very impressed by the whole experience. Thank you!’ (Ysbyty Glan Clwyd Outpatients).*

- *‘I was impressed by the sensitivity of staff by the fact that I am vulnerable to infection and my partner is immune deficient. They went out of their way to ensure I was well cared for, and they explained everything very carefully’ (Ysbyty Gwynedd, Radiology Service).*

- *‘I was amazed how much the Doctor went through the process of my treatment; she was amazing’ (Adult CMHT Wrexham).*

- *‘The whole system of care at Bangor Hospital was exemplary. From A&E, to the ward, to the food, to the operation, aftercare, and consequent discharge - superb! Thank you, we are so lucky to have you’ (Cancer Services, Ysbyty Gwynedd).*

OTHER PATIENT EXPERIENCE CONCERNS AND IMPROVEMENTS

NHS Wales People’s Experience Framework

The NHS Wales Easy Read People’s Experience Survey (PES) went live across the Health Board on 1 July 2025. The survey is available in English and Welsh. The survey questions are worded slightly different than the People’s Experience Survey therefore the data is required to be reported separately.

The Quality Dashboard on Iris is now live for staff to access Civica feedback, PALS enquiry themes and trends and complaints data to support the analysis and triangulation of patient feedback.

Preparatory work is being progressed by the Health Board to launch the All-Wales Maternity and Neonatal surveys via SMS.

All Wales People’s Experience Survey (Easy Read)

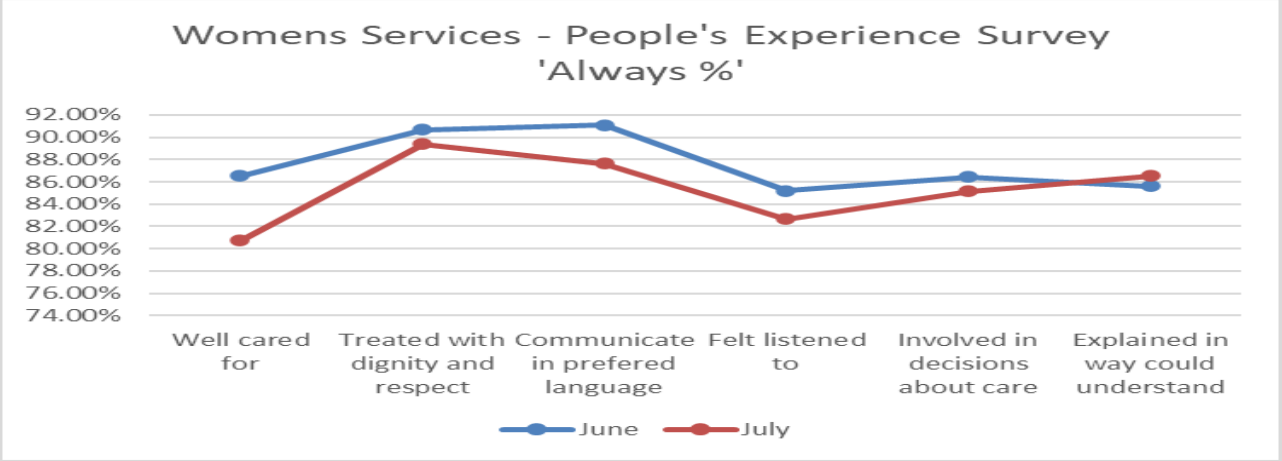
An Easy Read version of the People’s Experience Survey was launched across the Health Board in July 2025. In total 43 surveys were completed with 74.36% of respondents rating their overall experience of accessing Health Board services as ‘very good’.

Key findings:

- 92.31% of respondents were treated well ‘all of the time’
- 84.62% of respondents felt everything was explained well so they could understand ‘all of the time’
- 84.21% of respondents felt looked after ‘all of the time’
- 82.50% of respondents felt listened to ‘all of the time’
- 79.31% of respondents said they could use their language to communicate when we gave care ‘all of the time’. Languages included English, Welsh and Polish
- 73.68% of respondents were involved in decision making about their care ‘all of the time’

Womens and Midwifery Services – In Focus

From 1 June 2025 – 31 July 2025, 812 People’s Experience Survey responses were received via Civica feedback system for Women’s Services. High levels of satisfaction reported have been reported around being treated with dignity and respect and having the ability to communicate in their preferred language



From 1 June 2025 – 31 July 2025, Patient Advice Liaison Service (PALS) received 59 enquiries and 8 compliments related to Women’s Services. The top key enquiry themes include; appointments, clinical treatment and assessment and communication.

Women’s Services are progressing the implementation of the new All Wales maternity survey. Women will receive three SMS messages throughout their pregnancy trimester and there will be a neonatal survey sent to women where appropriate. The service is aiming to launch the SMS surveys in September 2025.

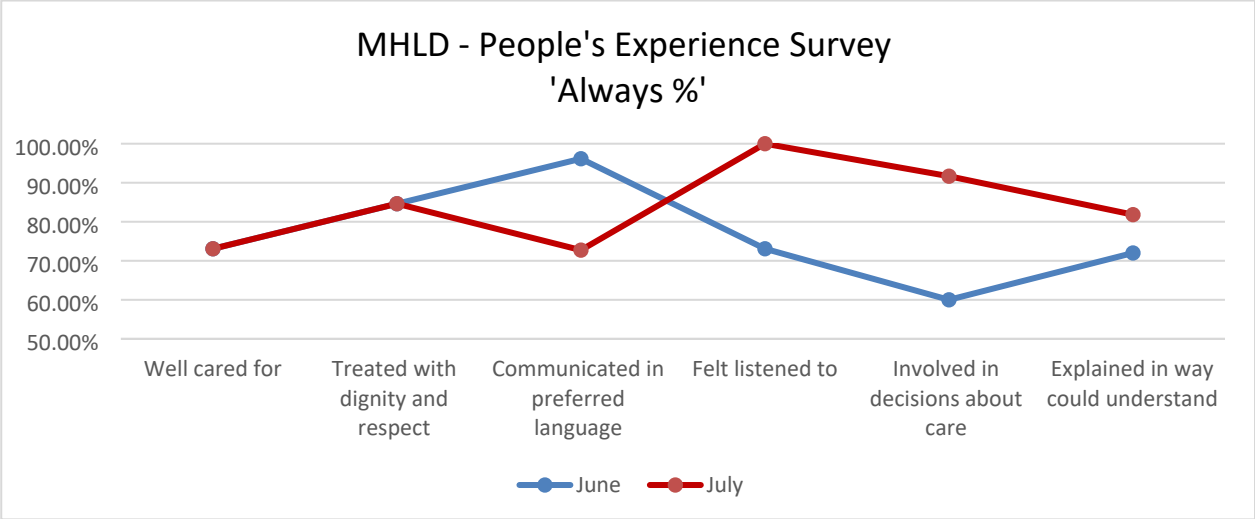
Work continues around improving the experiences relating to the induction of labour and partners staying overnight. The Birth Reflection Service continues to meet with women each month to listen to their experiences and provide support.

Mental Health Learning Disability (MHLD) Service – In Focus

From 1 June 2025 – 31 July 2025, 219 People's Experience Survey responses were received via Civica feedback system for MHLD Service.

MHLD service was the first service within the Health Board to have successfully mapped all its services to CIVICA. A Task and Finish Group was established to drive the enhanced use of CIVICA as a patient feedback tool. Although the service has successfully rolled out mapping of CIVICA to all areas, feedback returns remain low in numbers.

Within the reporting period high levels of satisfaction is reported with respondents always feeling listened to, treated with dignity and respect and being able to communicate in their preferred language.



From 1 June 2025 – 31 July 2025, PALS received 66 enquiries, 1 suggestion for improvement and 1 compliment related to MHLD Services. The top key enquiry themes include; clinical treatment and assessment communication, appointments, and medication.

MHLD Service have re-stablished a Patient and Carer Experience Group made up of staff and key stakeholders such as Caniad, CADMHAS and Adferiad bi-monthly. Llais are working in partnership with MHLD Service visiting inpatient units across North Wales to meet staff and patients to capture feedback and identify opportunities for improvement.

SWAN Model for End of Life and Bereavement Care

Outlined in the Welsh Government ministerial priorities for 2025 – 2028 the Health Board has committed to improve bereavement services by implementing the SWAN model of care across the Health Board. On 23 June 2025, 2 Macmillan SWAN Specialist Bereavement Nurses started in post, based within the Patient Experience Department.

Macmillan SWAN Specialist Bereavement Nurses have been shadowing various clinical roles, attending local Patient and Carer Experience Groups and Ward Manager meetings to introduce themselves, their role and the SWAN concept.

A key priority until September 2025 is to engage with third sector organisations, staff, patients, and families to capture feedback to understand how the Health Board can improve end of life experiences. This feedback will be triangulated with complaints data, incident data and Civica feedback to help shape the model developed.

Chaplain & Spiritual Care Service

From 1 June 2025 to 31 July 2025, the Chaplain and Spiritual Care Service responded to 107 requests for support including out of hours referrals pan North Wales. These requests for support are in addition to daily pastoral work undertaken on wards/units.

Ten multi-faith events were organised across North Wales fostering inclusivity and support for individuals from diverse religious backgrounds. The aim of the events was to create a supportive environment that honours and respects the traditions of faith groups of individuals under our care.

Examples of events organised:

1. Chaplain Manager participated in a flag-raising event for Learning Disability Week at Ysbyty Gwynedd.
2. A series of Chaplaincy shadow training sessions for student nurses and Macmillan SWAN Specialist Bereavement Nurses; highlighting the importance of spiritual care.
3. Multiple flag-raising ceremonies involving hospital Chaplains for Armed Forces Week across Wrexham Maelor Hospital, Ysbyty Gwynedd and Ysbyty Glan Clwyd, involving the Royal British Legion and other community members.
4. Music session for dementia patients at Bryn Hesketh Unit in Colwyn Bay.

The Chaplaincy & Spiritual Care Service has introduced an online referral system for staff, accessible through the Chaplaincy & Spiritual Care Service SharePoint page

CLINICAL EFFECTIVENESS

CLINICAL AUDIT

Clinical Audit Performance

- 9 Tier 1 national clinical audits were published in Quarter 1, with 2 reported and 7 scheduled for Quarter 2 reporting
- Service Assessments of Compliance (SAoCs) demonstrate measurable improvements in clinical outcomes and patient safety initiatives
- Quarterly monitoring through Strategic Clinical Effectiveness Group ensures systematic oversight

(Quarter 1 Audit report included in Confidential Report)

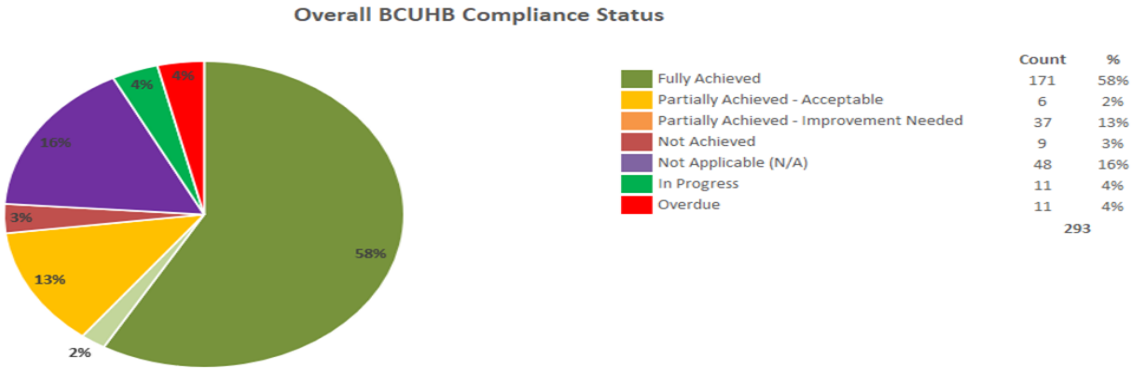
				West	Central	East	
Title of National Audit	Name of report	Date of publication	Date Service Assessment response due	Service Assessment Completed	Service Assessment Completed	Service Assessment Completed	Key Achievements Summary
National Lung Cancer Audit (NLCA)	State of the Nation Report 2025	10-Apr-25	09-Jun-25	Yes - Draft	Yes - Draft	Yes - Draft	Good levels of overall compliance although still concerns re lack of timely capacity in diagnostic services (principally radiology) and oncology services. Learning discussed at Lung Cancer Clinical Advisory Group and used for training and to aid quality improvement
Mothers and Babies: Reducing risk through Audits and Confidential Enquiries across the UK (MBRRACE)	Perinatal Mortality Surveillance UK Perinatal deaths of babies born in 2023 2025 State of the Nation Report	08-May-25	09-Jul-25	No - Overdue	No - Overdue	No - Overdue	Service assessment response, due July 2025, not received. Lack of engagement to requests for a response have been escalated in line witrh CE Team process

NICE GUIDELINES

NICE Guidelines Compliance - Significant Improvement

- Outstanding compliance rate of **96%** (only 4% overdue as of July 2025)
- Marked improvement across all compliance categories since implementation of the Audit Management and Tracking (AMaT) tool
- Services now required to review partially achieved guidelines with six-month review deadlines
- Updated NICE Protocol available on Betsinet for organisational reference

:

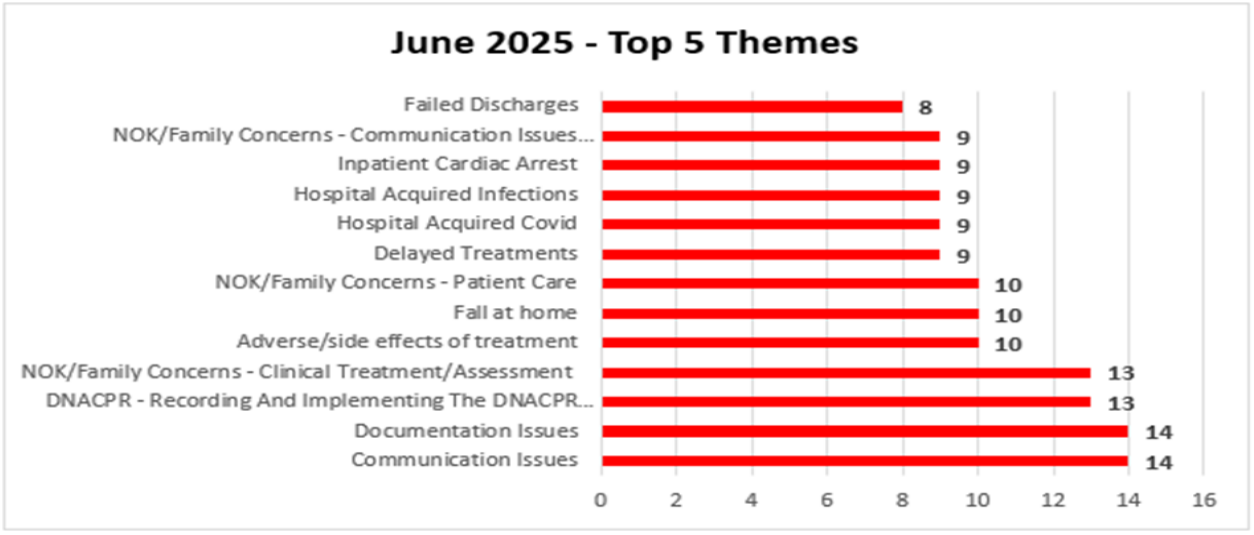


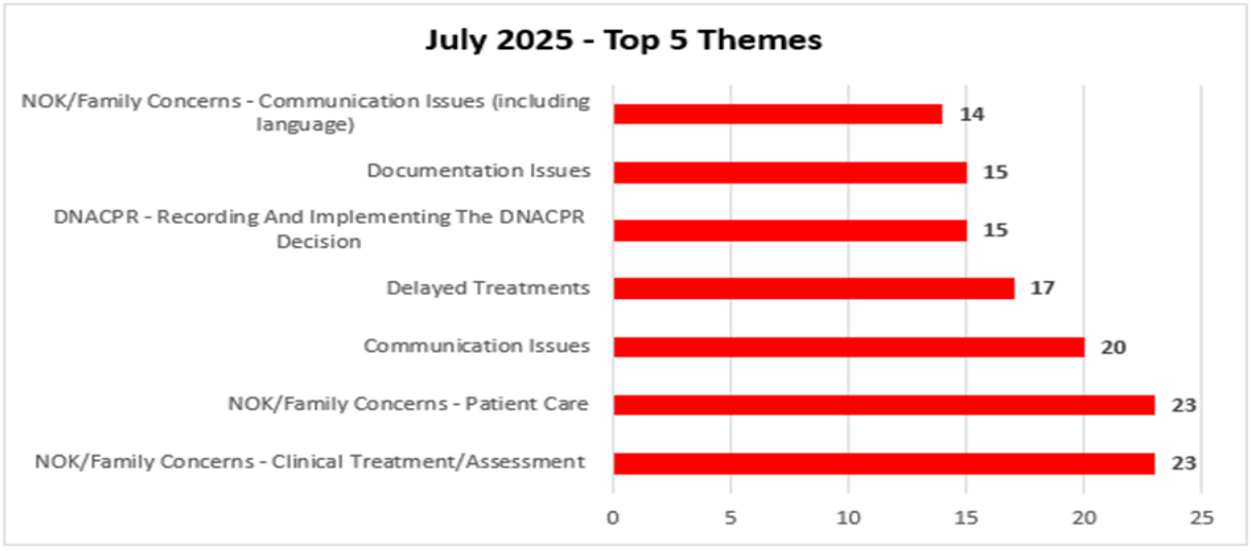
MORTALITY REVIEW

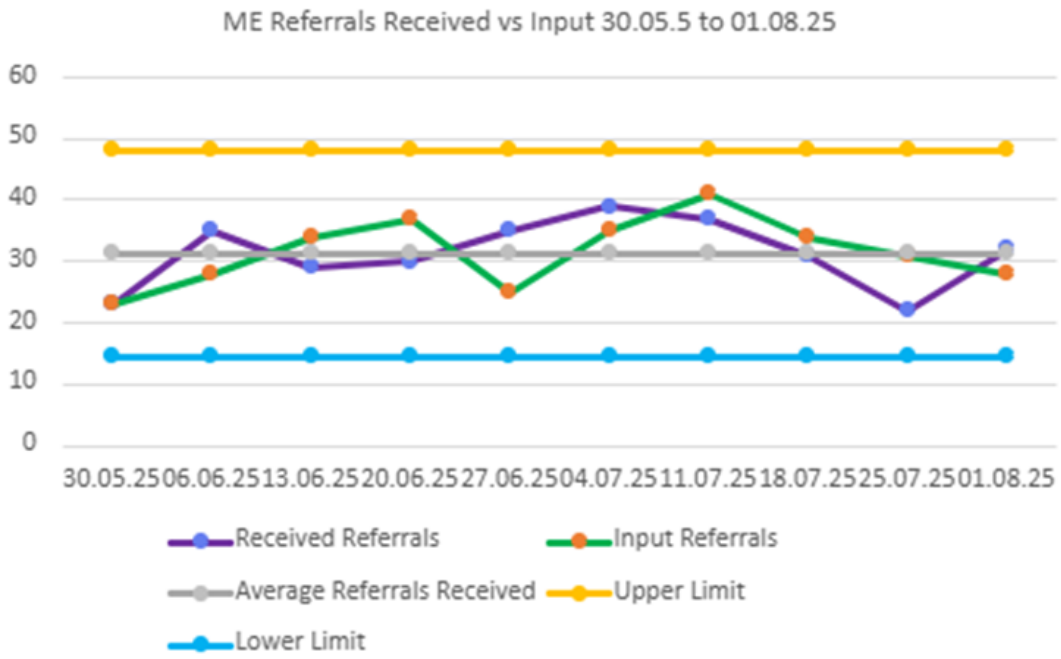
Mortality Management Enhancements

- Successfully implemented All-Wales Medical Certification of Cause of Death (MCCD) process
- Enhanced communication system including QR code access via BCU intranet and poster distribution across Integrated Health Communities
- Launched monthly mortality learning lessons initiative (July: opiate prescribing; August: MCCD process summary)
- Streamlined Grand Round sessions moved to virtual format to increase clinician engagement

Top 5 ME Identified Potential Themes Monthly Data (by date cases have been clinically reviewed by CE mortality):







Strategic Impact

The Health Board demonstrates substantial progress in clinical governance with systematic improvements in audit compliance, mortality review processes, and NICE guideline implementation. The 96% compliance rate for NICE guidelines represents a significant achievement in clinical standardisation, while the structured approach to mortality reviews and learning dissemination enhances patient safety culture across the organisation.

Operational Excellence

Implementation of digital tools (AMaT system, QR codes, virtual sessions) has improved accessibility and efficiency of clinical effectiveness processes, supporting the Health Board's commitment to continuous quality improvement and evidence-based practice.

QUALITY ASSURANCE

HEALTHCARE INSPECTORATE WALES

(1) Ysbyty Gwynedd Maternity Services

HIW have published an inspection report pertaining to the Unannounced Inspection of Ysbyty Gwynedd Maternity Services on the 5th June 2025. The inspection took place from the 18th to 20th February 2025.

HIW issued the service with the following immediate assurances: -

- The Health Board must ensure that: Medical handover between antenatal and intrapartum patient care are effective. clearly and routinely documented and communicated during handover. This is to ensure that all women across the unit are prioritised effectively and in a timely manner, to maintain the safety of mothers and unborn babies

- The Health Board must ensure that: Obstetricians are supported to undertake and complete mandatory training in a timely manner within Ysbyty Gwynedd and across the Health Board's Maternity Services.

- The Health Board must ensure: A risk assessment is completed, and mitigations implemented to minimise the risk of harm and maintain the safety of mothers and babies until training compliance has improved to an appropriate and safe level

(2) Ysbyty Gwynedd, Emergency Department

HIW have published an inspection report pertaining to the Unannounced Inspection of Ysbyty Gwynedd Emergency Department on the 24th July 2025. The inspection took place from the 14th to 16th April 2025

HIW issued the service with the following immediate assurances: -

- HIW requires details on how the Health Board will ensure that measures are in place to maintain the medication room temperature within accepted parameters of between 8 and 25 degrees Centigrade

- HIW requires details on how the Health Board will ensure that the resuscitation trolley is checked regularly and that all items past their expiry date, and items in opened packaging, are removed and replaced.

- HIW requires details on how the Health Board will ensure that the paediatric area is adequately staffed at all times when children are accommodated

As outlined within the inspection reports, the Health Board has taken steps to address the immediate issues raised by HIW. Both the Immediate Improvement Plan and Main

Improvement Plan are being monitored via the Health Boards Regulatory Assurance Group (RAG) which reports to the Executive Delivery Group (EDG), and up to the Quality Safety and Experience (QSE) Committee.

Announced/Unannounced Inspections (1)

HIW undertook an inspection at Ysbyty Cefni, Cemlyn Ward, from the 29th to the 30th of July 2025. The Health Board has received verbal feedback from HIW following the inspection, and immediate assurance plan. This will be reported in the next paper, as the Health Board have not yet received any documentation from HIW.

Concerns / Requests for Assurance (9)

The Health Board received nine concerns/requests for assurance from HIW. All responses from the Health Board receive approval from Responsible Directors and the appropriate Executive Director, prior to submission to HIW. These are subject to oversight and monitoring via the Health Boards Regulatory Assurance Group (RAG) which reports to the Executive Delivery Group (EDG).

HIW Improvement Plans (9)

Service	Lead	Inspection Date	Expected Closure Date	Progress %	Overdue Actions	Action to address overdue actions
Ysbyty Maelor, Emergency Department	IHC Director, East	9th to 11th December 2024	5th September 2025	92%	3	The plan was 78% complete last month and is now 92% complete. The plan remains under review via the Senior Leadership Team meetings.
Carreg Fawr, Bryn Y Neuadd	Responsible Director, Mental Health and Learning Disabilities (MHLD)	29th January 2025	28th August 2025	86%	5	There are five partially complete (overdue) actions. The service is discussing appropriate narrative in order to close these remaining actions.
Radiotherapy Department, North Wales Cancer Treatment Centre (NWCTC)	Responsible Manager, Radiotherapy	28th to 29th January 2025	TBC	90%	1	The overdue action became overdue on 31/05/2025 and is under review by the Radiotherapy Oversight Group.
Ysbyty Gwynedd, Maternity Services	Director of Midwifery & Women's Services	18th to 20th February 2025	16th August 2025	97%	1	The final two actions will be discussed in August RAG, with an aim of closing the plan.
Ysbyty Gwynedd, Emergency Department	IHC Director, West	14th to 16th April 2025	30th November 2025	29%	0	N/A

CARE INSPECTORATE WALES

CIW regulate adult services such as care homes for adults, domiciliary support services, adult placement services and residential family centre services. As the Health Board is one legal entity, it is a registered provider for multiple services which includes Enhanced Community Residential Service (MHLD) and Tuag Adref (across all three Integrated Health Communities).

A visit to Enhanced Community Residential Services (ECRS), a domiciliary provision within the Mental Health and Learning Disabilities Service, was undertaken by the Health Boards Responsible Individual on the 4th July 2025. No immediate patient safety issues were identified. Areas of good practice was recognised, with three recommendations made in relation to areas for improvement.

PUBLIC SERVICES OMBUDSMAN FOR WALES

PSOW has legal powers to investigate complaints about public services and independent care providers in Wales. PSOW investigates complaints from members of the public about alleged maladministration and service failure.

When the Ombudsman investigates a complaint and thinks that something has gone wrong, they prepare a report to summarise their findings. Sometimes, where there is a need for wider learning, or what went wrong was significant, or in the interest of the public, a Public Interest Report (PIR) is issued.

Public Interest Reports (PIRs)

The Health Board has 1 ongoing Public Interest Report issued by the Ombudsman.

PIR received March 2025 (Case ref ID2087 / 202301141)

The Ombudsman upheld the complaints and made a number of recommendations which the Health Board accepted. The Health Board are on track with the action plan, reporting progress to the Health Boards Regulatory Assurance Group, Executive Delivery Group and Quality Safety and Experience (QSE) Committee.

Eight of the actions have been completed with one remaining action due for completion on 25 September 2025. The Health Board wrote to the Liverpool University Hospitals NHS Foundation Trust, and has received their findings and evidence which has been shared with the Ombudsman. The final recommendation deadline in relation to implementing a Commissioning Assurance Framework (CAF) is in progress and on track for completion.

Improvement Focus:

- Strengthening the monitoring and performance review of commissioned care.
- Enhancing proactive referrals and MDT discussions to improve patient outcomes.
- Ensuring comprehensive and timely patient information and consent processes.

- Implementing robust action plans with clear accountability and deadlines
- Implement a Commissioning Assurance Framework (CAF)

Learning from the Ombudsman

The Quality Team continue to collaborate with other Health Boards in Wales via the NHS Wales Ombudsman Safety & Learning network, to review published reports and discuss themes for wider learning. The network also helps identify ways which the Health Board can improve how it captures, tracks and monitors Ombudsman recommendations and compliance.

When a Health Board complaint is upheld by the Ombudsman, the final report findings and recommendations are presented to the Patient Safety Group and Clinical Effectiveness Group for discussion.

ORGANISATIONAL LEARNING

Quality Management System:

The BCUHB Quality Management System continues to progress at pace. In September 2025 the QMS Group will support the move into the implementation, wider socialisation and embedding stage, with key stakeholder engagement sessions and presentations in core forums throughout the organisation. The QMS group are linked with national forums to align with work across Wales. The Digitalised maturity Assessment App continues to develop with a fully completed user guide and the development of a Quality Impact Assessment to be integrated. The Quality Dashboard is linked to the BCUHB Quality Management System (QMS) Digital App to ensure that as the systems are linked.

The BCUHB Quality Dashboard:

Organisations across Wales have expressed an interest in working with BCUHB to adopt the BCUHB Quality Dashboard and BCUHB QMS digitalised App. Developments of a Quality Scoreboard and also Maternity and Neonatal Dashboard are being progressed to support Data driven monitoring and Improvements.

Learning Repository

The BCUHB Learning Repository is progressing well, with core components now in place to support a secure, scalable, and intelligent learning system across the organisation.
Current focus is on delivering the first version of the system, which includes tools for structured reviews, publishing, and feedback. The repository is designed to support future enhancements such as data-driven insights and cross-departmental knowledge sharing.
Some dependencies remain, including licence access for automation tools. These are being actively managed under the oversight of a dedicated project group, which is ensuring the project stays aligned with strategic goals and timelines.
Overall, the project remains on track to launch the initial version by the end of November 2025.

HEALTHCARE LAW

CORONER AND INQUESTS

There have been no Prevention of Future Death (PFD) Notices issued during the reporting period.

However, one adverse conclusion was reached by the coroner following the June 2025 inquest into the death of a patient at Ty Llewellyn in October 2020, who died from sepsis. The inquest jury found that the death was contributed to by neglect, citing a "gross absence of care" and identifying failings such as a lack of basic medical attention, inadequate monitoring, and poor communication of staff responsibilities. An independent investigation was commissioned at the time, and evidence of learning and improvement was presented during the inquest.

The third “Meet the Coroner Event” of 2025 took place at Ysbyty Gwynedd (and also virtually) in July giving staff an opportunity to understand the role of the coroner, how coroner investigations and inquests work, and to understand the expectations around giving evidence in the coroner’s court.

LIABILITY CLAIMS

The Health Board achieved significant improvement in the number of overdue Learning from Events Reports (LFERs) due with the Welsh Risk Pool (WRP), dropping to just 7 by the beginning of quarter two. Unfortunately, several submissions were deferred by the WRP at its committee meeting in July and the number of overdue forms therefore increased to 35. Focused work is underway within services to provide the additional evidence requested to resubmit, as well as maintaining submissions of those LFER forms becoming due.

4Teitl adroddiad: ***Report title:***	Integrated Quality & Performance Report (IQPR) – Month 4, 2025/26
Adrodd i: ***Report to:***	Quality, Safety & Experience Committee
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 04 September 2025
Crynodeb Gweithredol: ***Executive Summary:***	This Report relates to Month 4, 2025/26. Please note the title of the report has now been amended to IQPR to illustrate that the report has a significant section on quality. The structure of the IQPR is based upon the Quadruple Aims as per the Welsh Government's 'A Healthier Wales's paper and the NHS Wales Performance Framework 2025-26. It identifies where metrics fall within the Special Measures Framework for BCUHB. Where appropriate, performance metrics are linked to items on the Corporate risk Register (CRR). Performance is RAG (Red, Amber Green) rated against the targets set within the NHS Wales Performance Framework 2025-26, or as set by Welsh Government in the Special Measures Framework for BCUHB. However, where appropriate, BCUHB's internal improvement trajectories as submitted and agreed by Welsh Government have also been included. Key areas of escalation are identified within the 'Performance Escalations Report' section at the beginning of the report. (We will continue to strengthen this section to include more information about the plans to mitigate or improve performance). The responsible executive has reviewed the elements of the report that are within their portfolio. Statistical Process Control (SPC) charts have been included where appropriate.
Argymhellion: ***Recommendations:***	The Quality, Safety, & Experience Committee is asked to: Review the contents of the report and to propose any actions arising from the report, or identify any additional assurance work or actions it would recommend Executive colleagues to undertake.
Arweinydd Gweithredol: ***Executive Lead:***	Stephen Powell, Director of Performance & Commissioning

Awdur yr Adroddiad: ***Report Author:***	Ed Williams, Deputy Director of Performance & Commissioning			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☒	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☐ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☒ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	The performance measures included in this report are from the NHS Wales Performance Framework 2025-26.			
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	This report will be available to the public once published for Quality, Safety & Experience Committee			
Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqlA been identified as necessary and undertaken?***	N The Report has not been Equality Impact Assessed as it is reporting on actual performance.			
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal?	N The Report has not been assessed for its			

In accordance with WP68, has an SEIA identified as necessary been undertaken?	Socio-economic Impact as it is reporting on actual performance
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	References to Corporate Risks have been made in the body of the report, where applicable. 24-04 Failure to Embed Learning 24-10 Urgent and Emergency Care 24-11 Planned Care 24-12 Areas of Clinical Concern (encompasses ophthalmology and dermatology) 24-13 Timely Diagnostics
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	The delivery of the performance indicators within our IPR will directly/ indirectly impact upon the financial recovery plan of the Health Board.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	The delivery of the performance indicators within our IQPR will directly/ indirectly impact on our current and future workforce.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	The full report has been reviewed by the Director of Performance and Commissioning.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	Where appropriate, performance metrics have been annotated with the Corporate Risk Register (CRR) reference number as a link to the Board Assurance Framework (BAF).
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Amherthnasol Not applicable
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** ***Implementation of recommendations:*** Continued focus on any areas of under-performance where assurance is not of sufficient quality to believe performance is or will improve as described.	

The Integrated Quality & Performance Report will undergo continuous development and utilise the Performance and Commissioning Directorate's internal Change Advisory Board (CAB) process to modify any reporting metrics and formatting.
Rhestr o Atodiadau: ***List of Appendices: 2*** *1: Summary of Report* *2: Integrated Performance Report in PDF* *3: Escalations from Integrated Performance Report in PowerPoint*

Appendix 1 – Summary of Report

Committee: **Quality, Safety & Experience**

Report title: **Summary of Integrated Performance Report (Month 2)**

Report Author: **Deputy Director of Performance and Commissioning**

1. Introduction

The Performance and Commissioning Directorate continues to develop the Integrated Quality and Performance Report with the key aim being to enable triangulation of intelligence and for focus to be placed upon areas of high performance or those metrics requiring improvement. The 'Integrated Quality and Performance Report' (IPQR) includes a section summarising the areas requiring escalation for Committee members, divided into the following four quadrants;

- Quality (Safety, Effectiveness & Experience) Performance
- Access & Activity Performance
- People & Organisational Development Performance
- Financial Performance

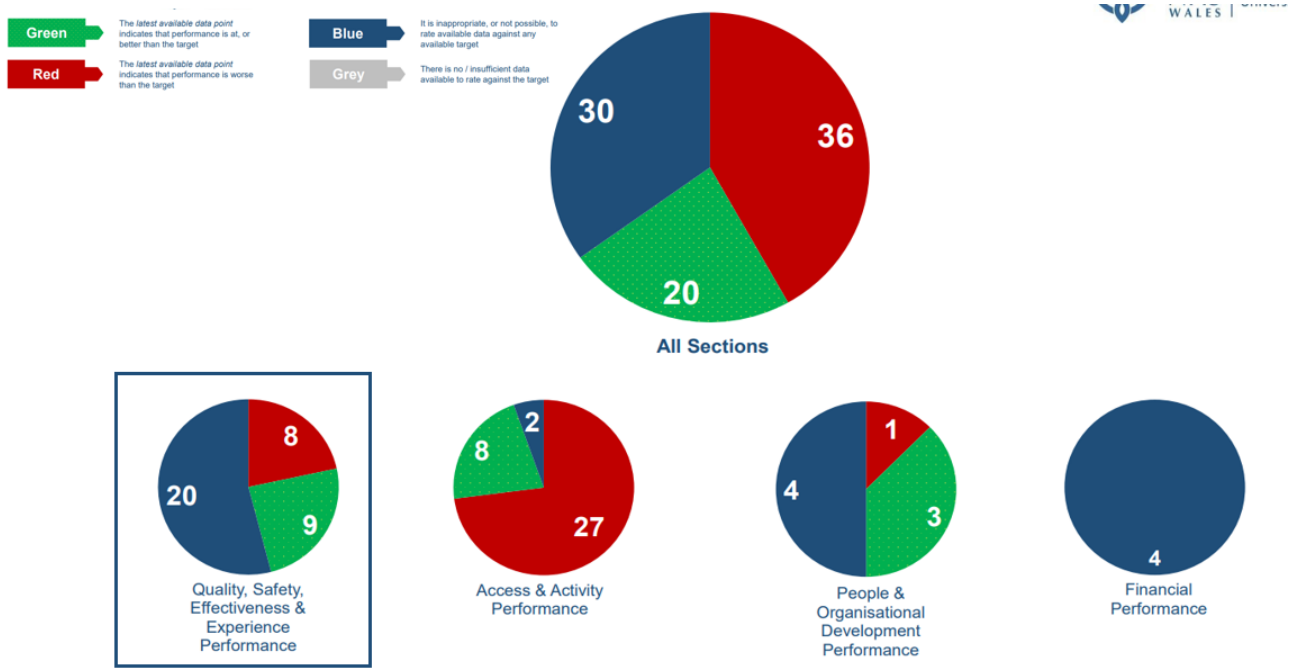
This structure enables an 'at a glance' view of the main concerns or message of the report through review of the initial one-page summary that is split into four quadrants, with the further slides contained within this escalation section articulating in more detail the current performance and actions being taken to support improvements. Following the summary quadrant page, there is a page on each section providing more detail about the measures escalated. This should be the area of most focus in the report.

Only escalations in the Quality quadrant of the IQPR has been included as these are what are in the remit of the Quality, Safety & Experience Committee.

Work is being undertaken to improve the report, for example, re-introducing Mortality Rates, Surgical Site Infection (SSI) rates and developing metrics by rate of per 100,000 population or bed occupancy etc. to improve the intelligence, triangulation and assurance in the report as we go into 2025-26.

2. Overall Summary

Please note that the data for several metrics are published in arrears and/ or on a quarterly basis.



3.1 Quality (Safety, Effectiveness & Experience) Performance

(Corporate Risk 24-04 Failure to Embed Learning)

The key areas highlighted centre upon:-

New Never Event
One new never event was reported for July 2025. The event concerned the retention of surgical swab during a routine surgery. Full details included within the Quality Report.

Learning From Events Reports (LFERs):
There had been a month on month decrease in number of overdue reports since December 2024. However, there were 26 outstanding LFERs at the end of July.

Overdue reports pose a Quality and Safety risk from the perspective that if we haven't completed the reports in a timely manner, how can we embed the learning to prevent future events. There is also the financial risk given that the Health Board can incur a penalty of £2,500 per overdue report. Continued focus is required to address the timely completion of LFERs and recovery of the overdue position. This measure will remain in escalation.

National Reportable Incidents Overdue 90 days:

Performance against this measure has improved significantly compared to the same period in 2024. However, there remains 11 NRIs overdue. As per the Integrated Performance Framework, this measure will remain in escalation until there have been 3 consecutive months of zero overdue NRIs.

Clinical Coding Compliance:

Performance against this measure has improved significantly compared to the same period in 2024. The position for May 2025 was 74.6%, however, it is predicted that the figure for June 2025 will be above 90% and one of the best performing in Wales. Once performance against this measure has achieved the 90% rate for 3 consecutive months, it will be recommended for de-escalation as per the Integrated Performance Framework.

3.2 Access & Activity Performance

Whilst the overall oversight of the metrics within the Access & Activity quadrant fall outside remit of the Quality and Safety Committee, given the extended waiting times both within planned care and urgency and emergency care it is prudent to highlight performance within this area as part of this forum given the potential impact of continued delay on patient pathways.

Key areas of risk include: -

- **Percentage of Ophthalmology R1 patients seen within 25% of their clinical due date** is significantly adverse to target and due to the potential irreversible nature of conditions that some patients in this cohort have, is of concern. Harm reviews for assurance is recommended.
- **Percentage of children and young people waiting less than 26 weeks to start and ADHD or ASD neurodevelopment assessment**
- **Cancer pathways starting definitive treatment within 62 days** metric deteriorating over the last 12 months to a latest performance of 54.6% against a target of 80%
- Continued increase in the number of patients waiting over 8 weeks for a **Diagnostic appointment** and lack of capacity resulting in higher level of **surveillance delays**

Appendix 1 – IQPR for QSE 04.09.2025

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Integrated Quality & Performance Report

Reporting Period: to 31.07.2025

Presented to

Quality, Safety & Experience Committee

Thursday, 4th September 2025

Produced on behalf of the **Quality, Safety and Experience Committee** by the
Performance and Commissioning Directorate and Partners

Table of Contents

Please note that several data items are reported in arrears, and/ or quarterly.

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Performance Escalations Report

Produced on behalf of the **Quality, Safety & Experience Committee**
by the **Performance and Commissioning Directorate and Partners**

Escalated Performance Measures at a Glance

KEY: ◻ **= Better** ❑ **= Worse** than previous reporting period

Quality (CRR 24-04 Failure to Embed Learning)

- ❑ New Never Events: **1** reported in July 2025 (Target 0) Details in Quality Report
- ❑ National Reportable Incidents (NRI): **11** overdue in July 2025 (Target 0)
- ❑ Learning From Events Reports (LFERs): **26** in July 2025 (Target 0)
- ◻ Clinical Coding Compliance: **74.6%** in May 2025 (above trajectory)

People & Organisational Development

- ◻ Personal Appraisal & Development Review (PADR): **81.8%** (Target 85%)
- ❑ Sickness & Absence: **6.0%** (Target Reduce)
- ❑ Agency Spend: **3.7%** (Target Reduce)
- ❑ Staff turnover less than 1 year service: **14%** (Target Reduce)

Access & Activity (CRR 24-10 Urgent and Emergency Care; CRR 24-11 Planned Care; CRR 24-12 Areas of Clinical Concern; CRR 24-13 Timely Diagnostics)

- ◻ CAMHS Part 1b: **50.3%**
- ❑ Neurodiversity: **14.0%**
- ◻ Adult Mental Health Part 1b: **79.6%**
- ◻ Adult Psychology: **75%**
- ◻ Ambulance Handover Delays 4 Hours: **422**
- ❑ ED 12 Hours: **3,848** (◻ 24 Hours **1,669**)
- ◻ Delayed Pathways of Care: **290**
- ◻ Single Cancer Pathway: **54.9%**

Referral to Treatment: ❑ 104 weeks **5,477**; ◻ 156 weeks **384**; ❑ 208 weeks **1**

- ❑ Diagnostics over 8 weeks: **15,055**
- ❑ Follow up Backlog Over 100% due: **97,820**

Finance (CRR 24-05 Financial Sustainability)

Financial Position

- ❑ Year to date – Deficit versus Plan **-£11.4m**
- ❑ In month Variance to plan **-£3.6m**
- ◻ Full year outturn position - **Balanced Position** as per Plan

Savings Position

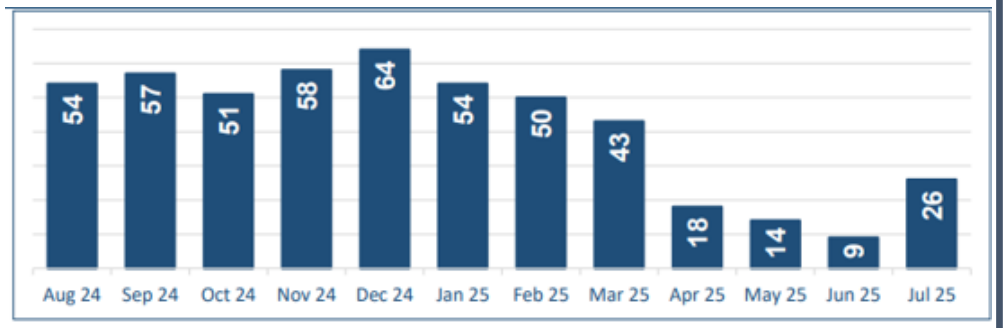
- ❑ Year to Date Savings Delivery including Accountancy Gains v target **-£3.8m**
- ❑ Forecast Savings Delivery including Accountancy Gains v Target **-£14.5m**

Capital Expenditure

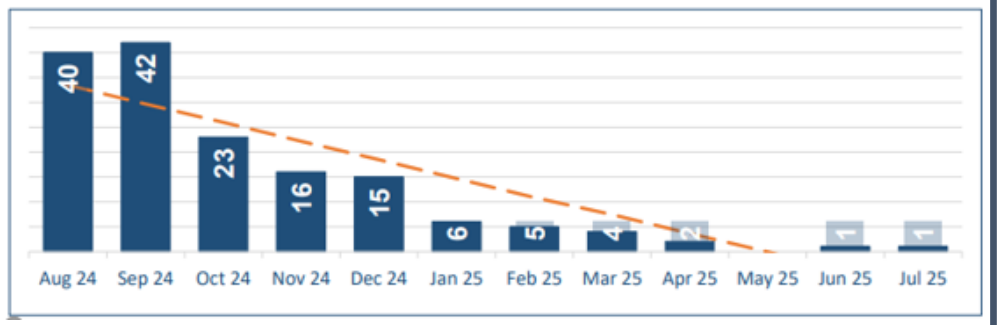
- ◻ Year to Date Plan is £10.4m. Spent £5.1m Underspend **£5.3m**.

Quality: Escalated Performance Measures

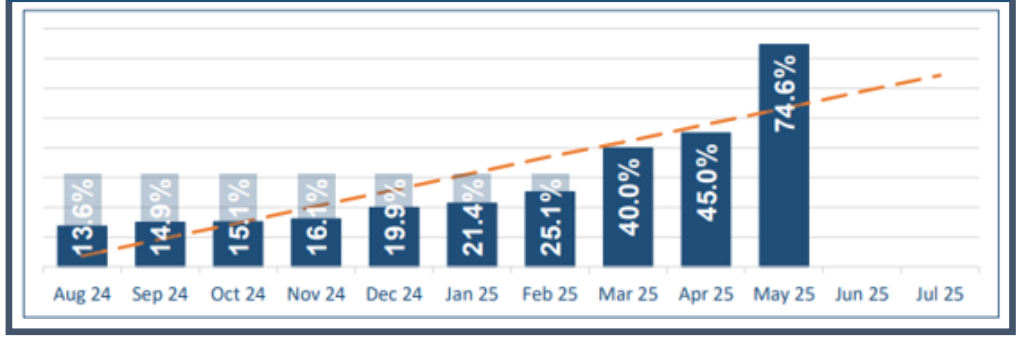
Learning form Events Reports



National Reportable Incidents overdue 90 Days



Clinical Coding Compliance



Learning From Events Reports (LFERs):

There had been a month on month decrease in number of overdue reports since December 2024. However, there were 26 outstanding LFERs at the end of July.

Overdue reports pose a Quality and Safety risk from the perspective that if we haven't completed the reports in a timely manner, how can we embed the learning to prevent future events. There is also the financial risk given that the Health Board can incur a penalty of £2,500 per overdue report. Continued focus is required to address the timely completion of LFERs and recovery of the overdue position. This measure will remain in escalation.

National Reportable Incidents Overdue 90 days:

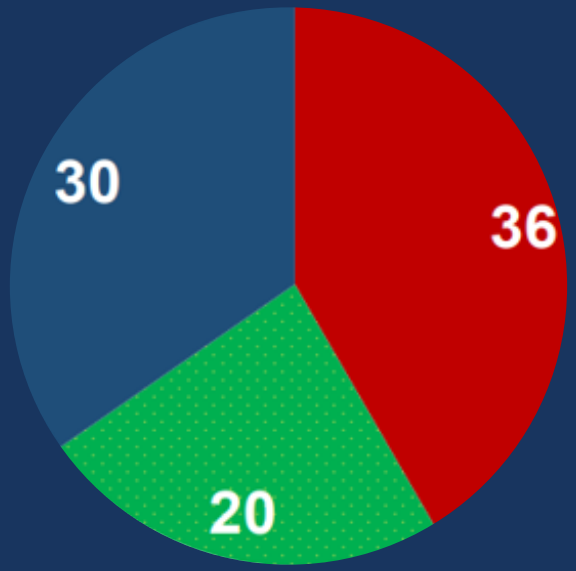
Performance against this measure has improved significantly compared to the same period in 2024. However, there remains 11 NRIs overdue. As per the Integrated Performance Framework, this measure will remain in escalation until there have been 3 consecutive months of zero overdue NRIs.

Clinical Coding Compliance:

Performance against this measure has improved significantly compared to the same period in 2024. The position for May 2025 was 74.6%, however, it is predicted that the figure for June 2025 will be above 90% and one of the best performing in Wales. Once performance against this measure has achieved the 90% rate for 3 consecutive months, it will be recommended for de-escalation as per the Integrated Performance Framework.

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Integrated Quality & Performance Report



Produced on behalf of the **Quality, Safety and Experience Committee** by the
Performance and Commissioning Directorate in partnership with **Health Board Directors**

Summary of Performance to Month 12

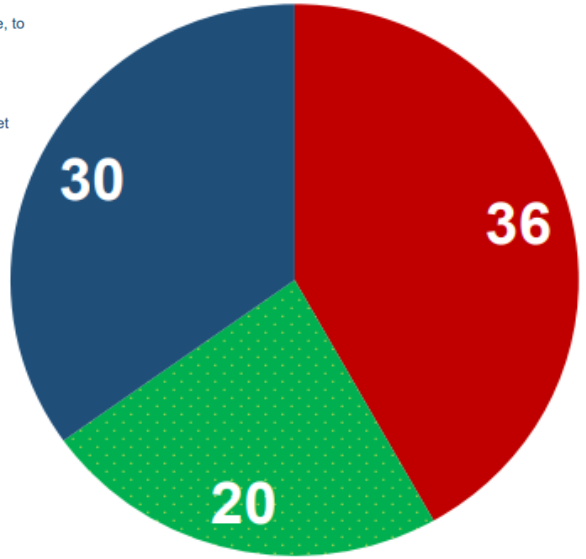
GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Green — The *latest available data point* indicates that performance is at, or better than the target

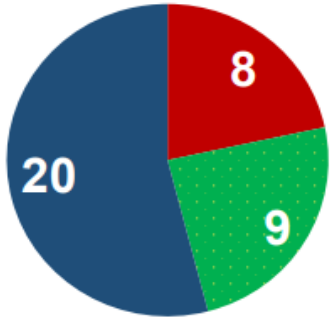
Red — The *latest available data point* indicates that performance is worse than the target

Blue — It is inappropriate, or not possible, to rate available data against any available target

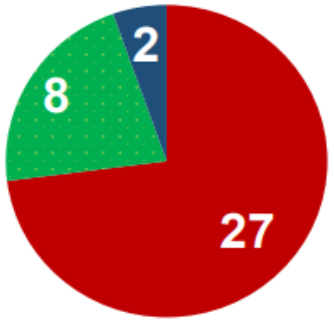
Grey — There is no / insufficient data available to rate against the target



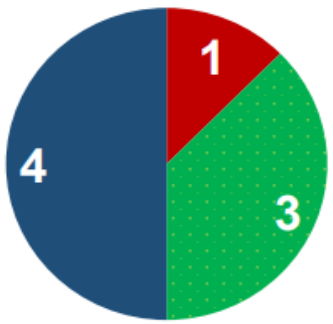
All Sections



Quality, Safety, Effectiveness & Experience Performance



Access & Activity Performance

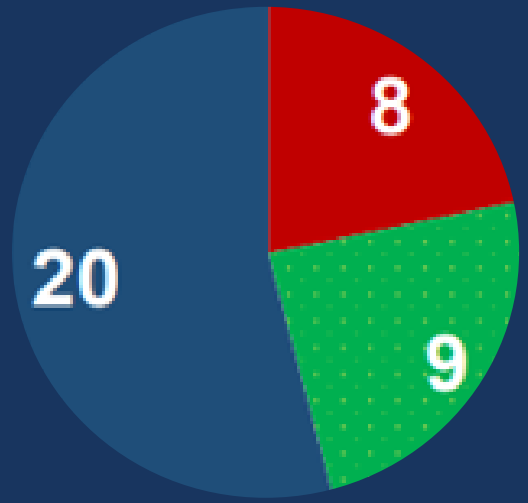


People & Organisational Development Performance

Financial Performance

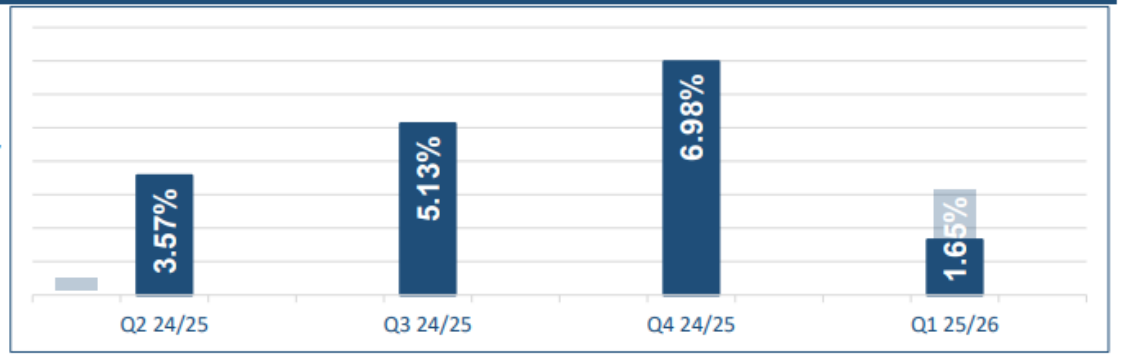
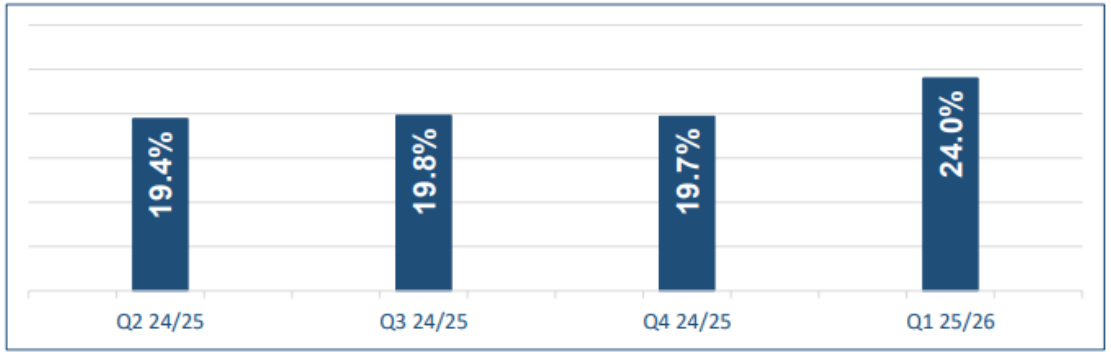
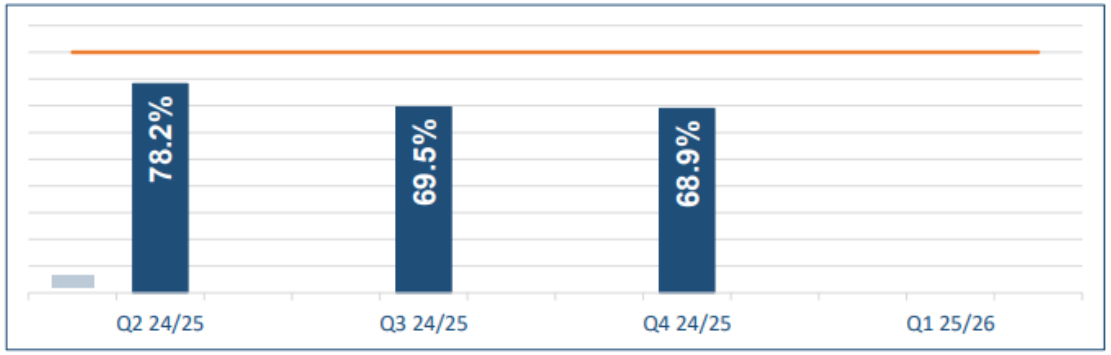
Section 1

Quality, Safety, Effectiveness and Experience Performance



Produced on behalf of the **Quality, Safety & Experience Committee** by the **Performance and Commissioning Directorate i**

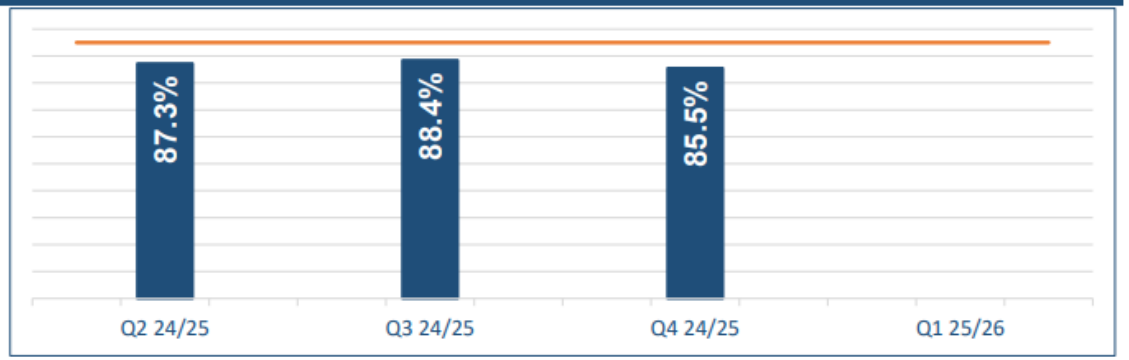
Quality: Performance

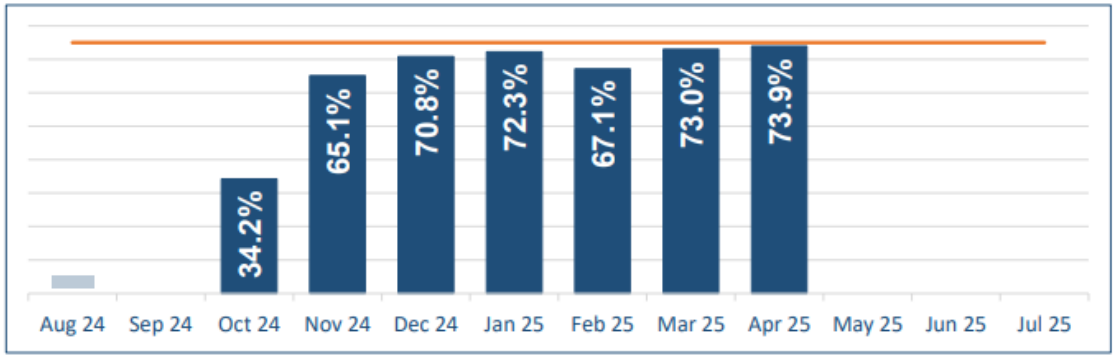
Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank	
-	QSE	Percentage of adult smokers who make a quit attempt via smoking cessation services	5% annual	TBC	1.65%	2nd of 7 (at Dec 24)	
-	QSE	Percentage of adult smokers who made a quit attempt via smoking cessation services who are CO-validated as quit at 4 weeks	40% annual target	TBC	24.0%	3rd of 8 (at Dec 24)	
-	QSE	Percentage of children receiving the Human Papillomavirus (HPV) vaccination by the age of 15	90%	TBC	68.9%	5th of 7 (at Mar 25)	

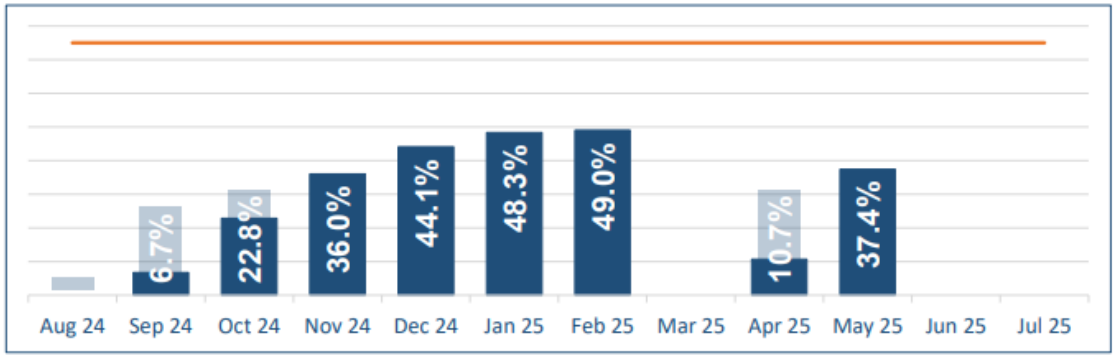
* Wales Ranking may differ as may refer to previous month

Quality: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	QSE	Percentage of children who are up to date with the scheduled vaccinations by age 5 ('4 in 1' preschool booster, the Hib/MenC booster and the second MMR dose)	95%	TBC	85.5%	3rd of 7 (at Mar 25)
-	QSE	Percentage uptake of the influenza vaccination amongst adults aged 65 years and over	75%	TBC	73.9%	1st of 7 (at Mar 25)
-	QSE	Percentage uptake of the COVID-19 vaccination for those eligible Spring and Autumn Booster: All eligible people	75%	TBC	37.4%	5th of 7 (at Apr 25)



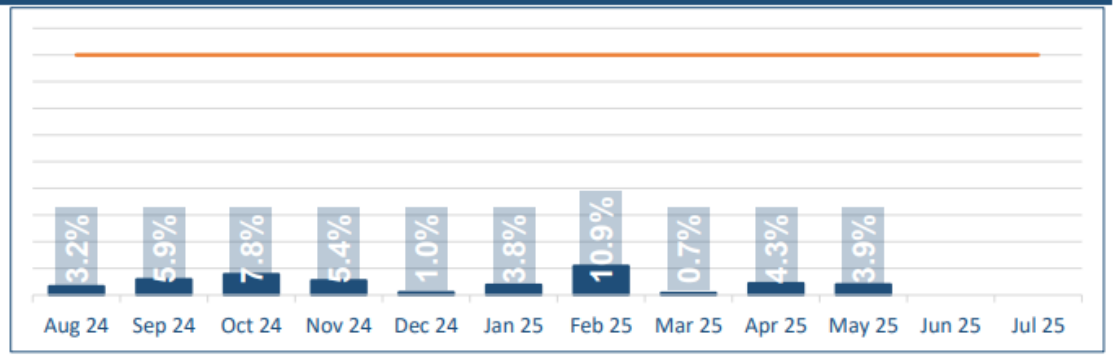


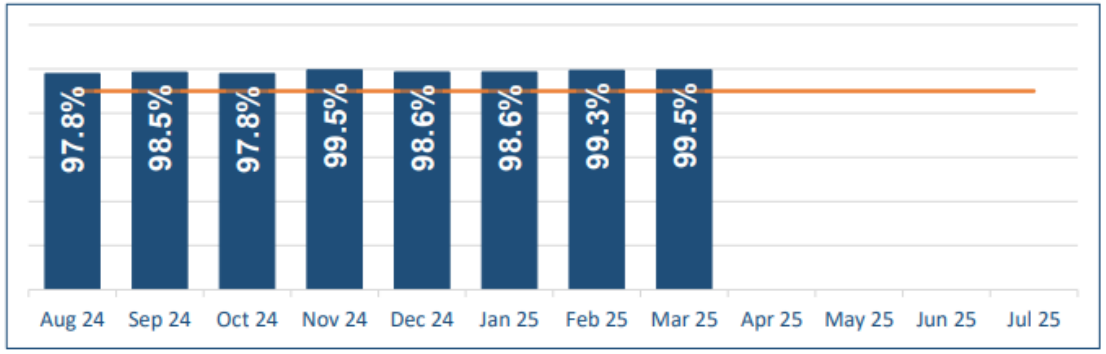


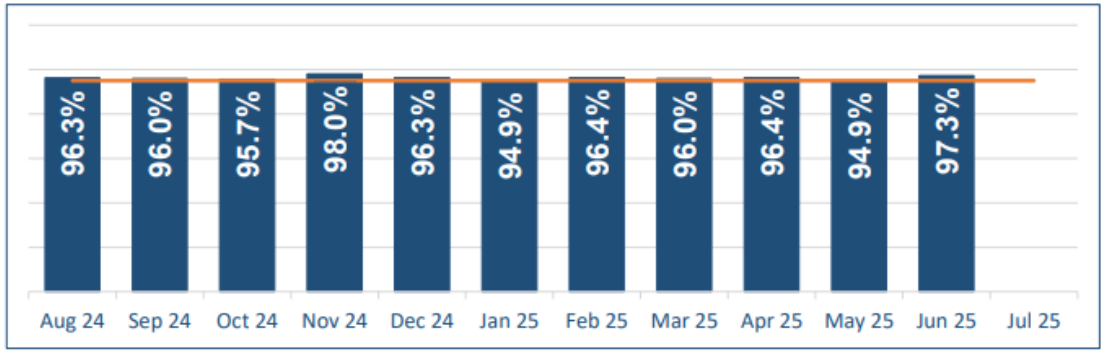
* Wales Ranking may differ as may refer to previous month

Quality: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	QSE	Percentage of patients offered an index colonoscopy procedure within 4 weeks of booking their Specialist Screening Practitioner assessment appointment	90%	TBC	3.9%	6th of 7 (at Mar 25)
-	QSE	Percentage of well babies entering the new-born hearing screening programme who complete screening within 4 weeks	90%	TBC	99.5%	2nd of 7 (at Mar 25)
-	QSE	Percentage of eligible newborn babies who have a conclusive bloodspot screening result by day 17 of life	95%	TBC	97.3%	5th of 7 (at Apr 25)



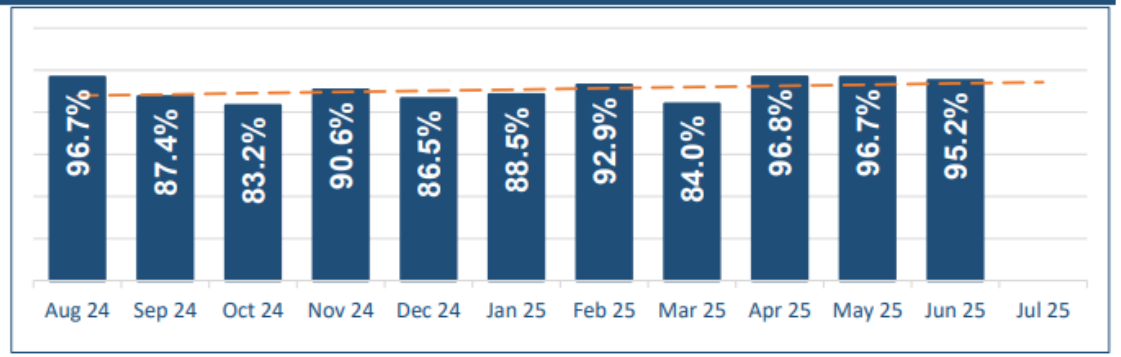


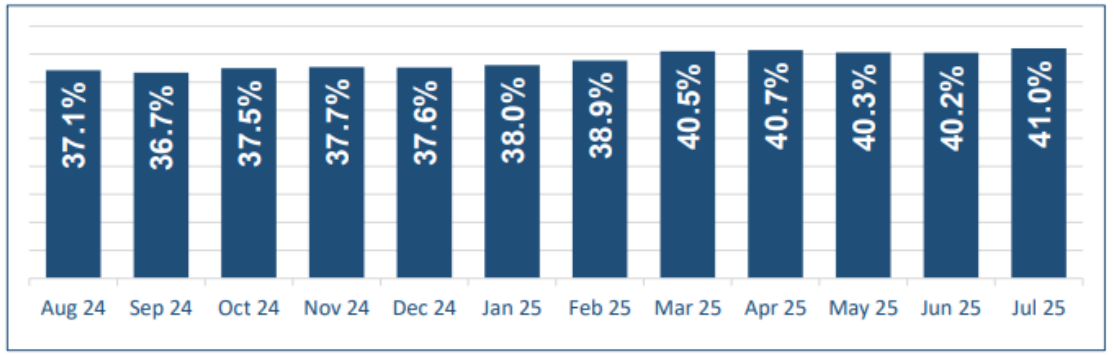


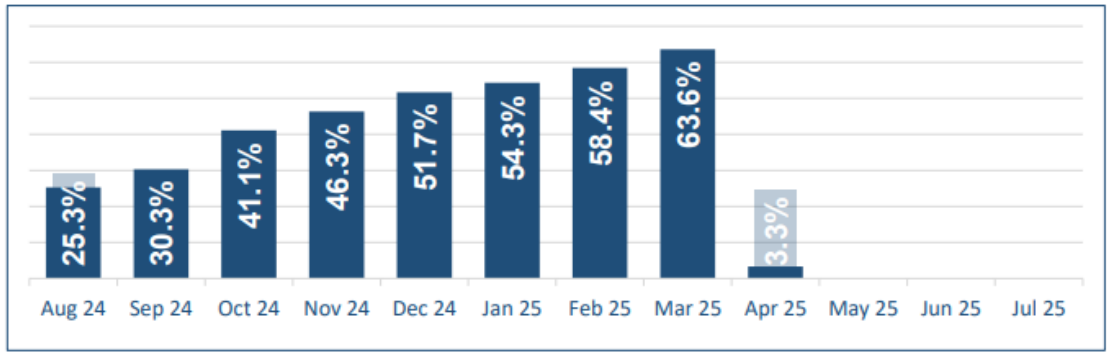
* Wales Ranking may differ as may refer to previous month

Quality: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	QSE	Percentage of people who have been referred to health board services who have completed treatment for substance misuse (drugs or alcohol)	4 qtr imp. trend	TBC	95.2%	5th of 7 (at Mar 25)
-	QSE	Percentage of patients (aged 12 years and over) with diabetes who received all eight NICE recommended care processes	Equival-ent month increase (2025/26 to 2024/25) to 100%	TBC	41.0%	7th of 7 (at Apr 25)
-	PFIG	Percentage of the primary care dental services (GDS) contract value delivered (for courses of treatment for new, new urgent and historic patients)	Increas-ing trend (to 30% (end Sept), then 100% (end Mar))	TBC	3.3%	6th of 7 (at Apr 25)



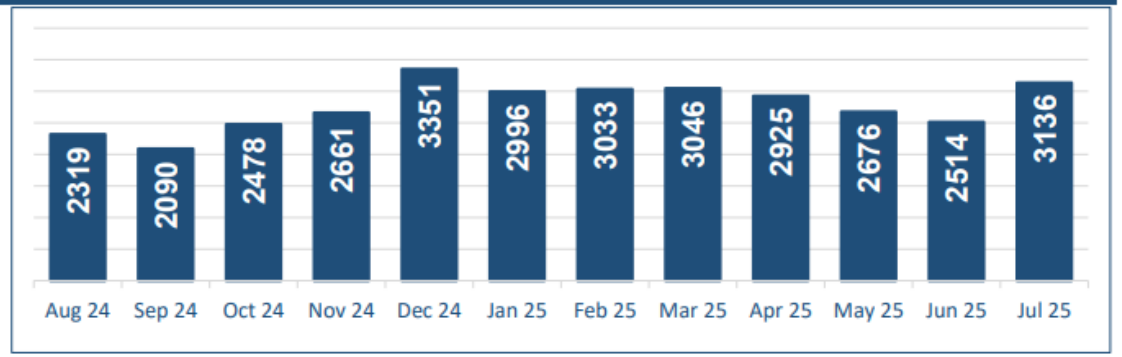


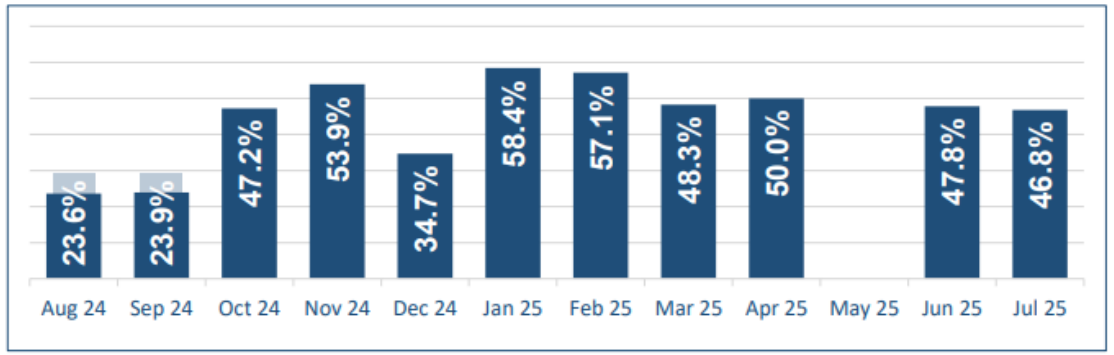


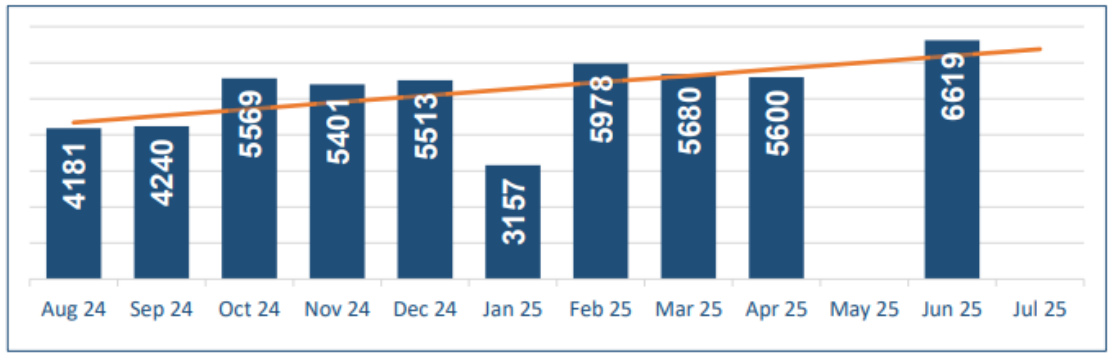
* Wales Ranking may differ as may refer to previous month

Quality: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	PFIG	Number of consultations delivered through the Pharmacist Independent Prescribing Service (PIPS)	Equival-ent month increase (2025/26 to 2024/25)	TBC	3136	1st of 7 (at Apr 25)
-	QSE	Percentage of confirmed COVID-19 cases within hospital which had a definite hospital onset of COVID-19 (>14 days after admission)	Equival-ent month reduct-ion (2024/25 to 2023/24)	TBC	46.8%	3rd of 6 (at Apr 25)
-	QSE	Number of service user feedback experience responses completed and recorded on CIVICA	Increas-ing trend	TBC	6619	2nd of 10 (at Apr 25)



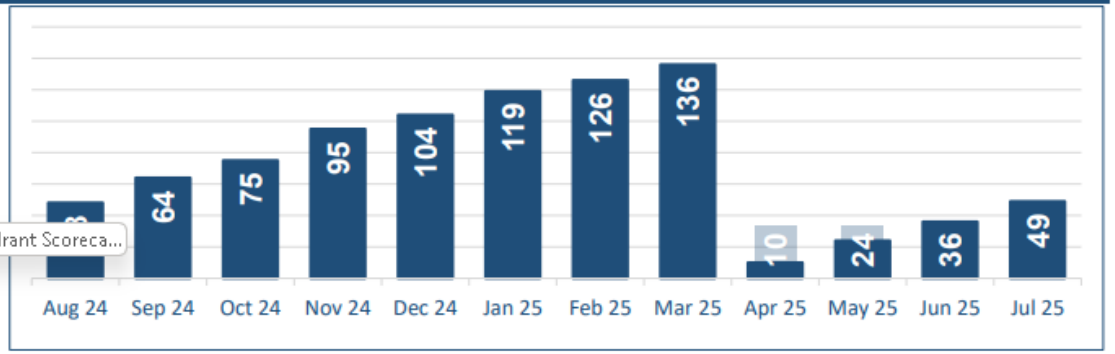


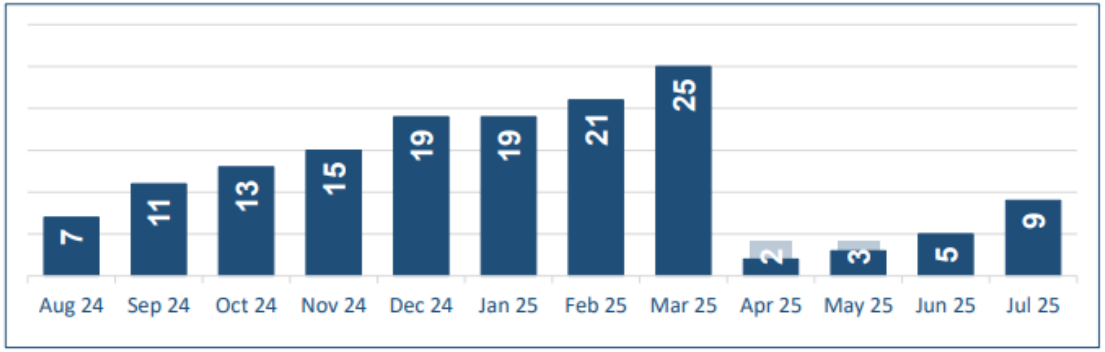


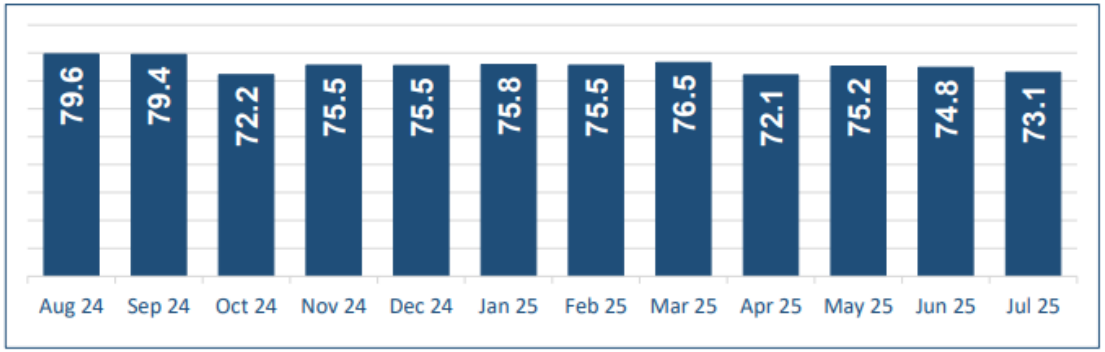
* Wales Ranking may differ as may refer to previous month

Quality: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
CRR: 24-04	QSE	The cumulative number of laboratory confirmed Klebsiella in reporting month	TBC	TBC	49	4th of 6 (at Apr 25)
CRR: 24-04	QSE	The cumulative number of laboratory confirmed Pseudomonas Aeruginosa in reporting month	27	TBC	9	3rd of 6 (at Apr 25)
CRR: 24-04	QSE	The cumulative rate of laboratory confirmed E.coli bacteraemias cases per 100,000 population	67	TBC	73.1	4th of 6 (at Apr 25)



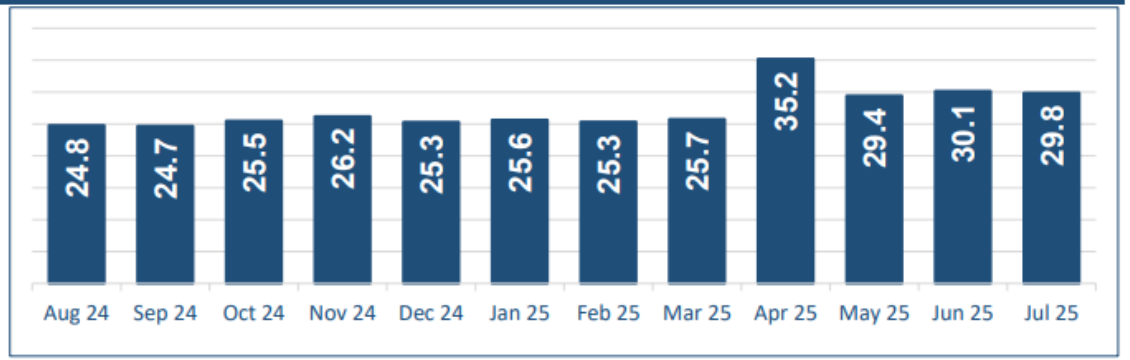


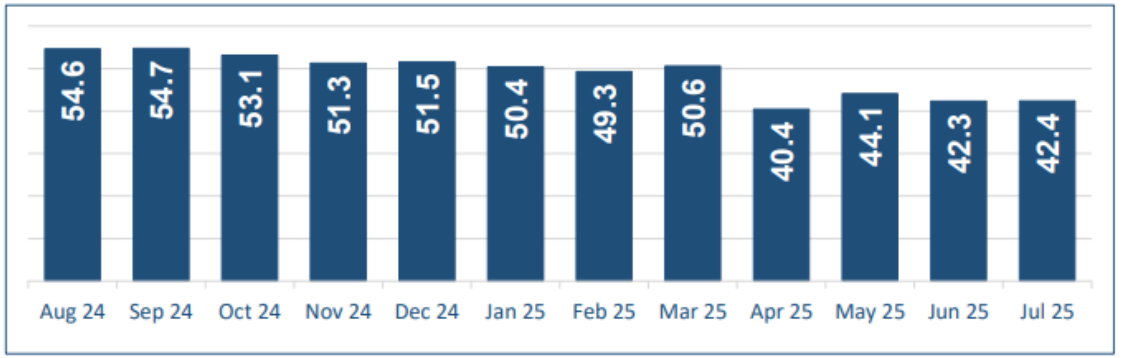


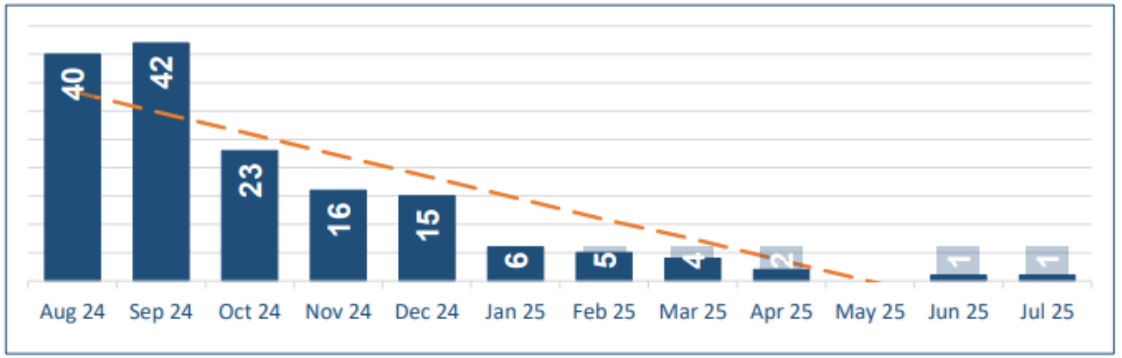
* Wales Ranking may differ as may refer to previous month

Quality: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
CRR: 24-04	QSE	The cumulative rate of laboratory confirmed S. Aureus Bacteraemia (MRSA and MSSA) cases per 100,000 of the population	20	TBC	29.8	6th of 6 (at Apr 25)
CRR: 24-04	QSE	The cumulative rate of laboratory confirmed C.difficile cases per 100,000 of the population	25	TBC	42.4	3rd of 6 (at Apr 25)
CRR: 24-04	QSE	Number of National reportable incidents that remain open 90 days or more	Decreas-ing trend	TBC	1	8th of 10 (at Apr 25)



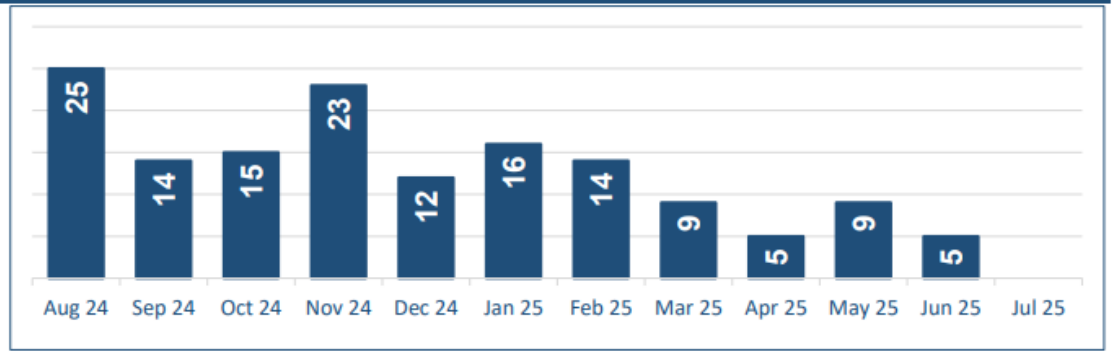


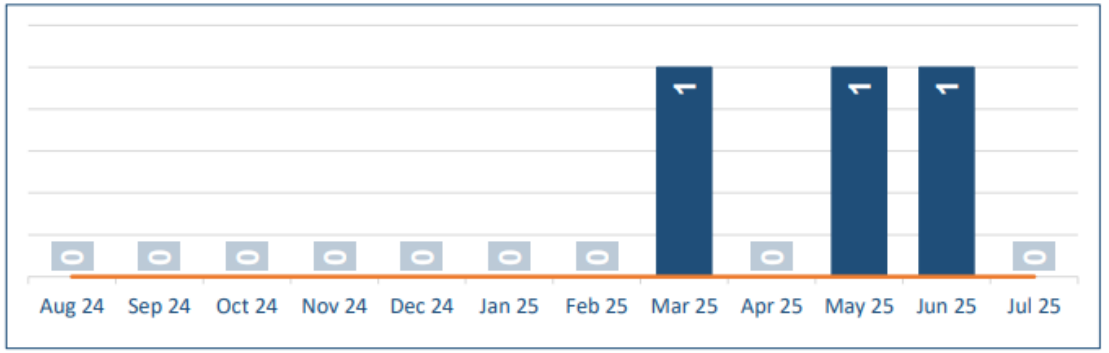


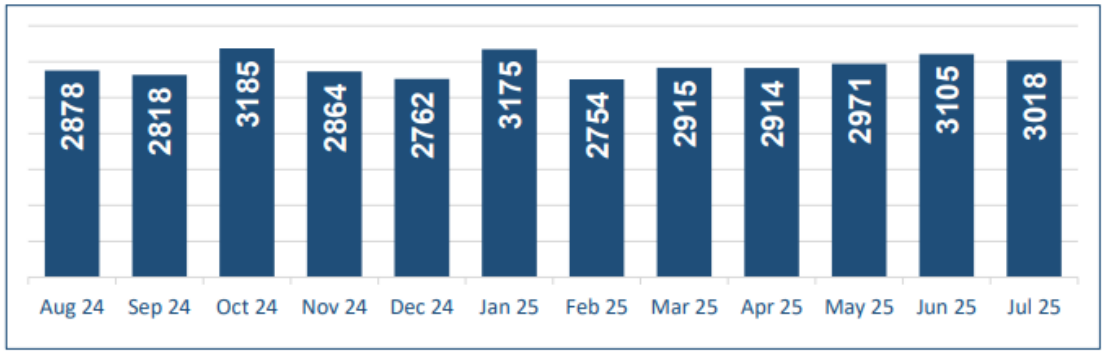
* Wales Ranking may differ as may refer to previous month

Quality: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	QSE	Number of National reportable incidents (NRIs)	N/A	TBC	5	
-	QSE	Number of new never events	0	TBC	0	
-	QSE	Number of patient safety incidents	N/A	TBC	3018	



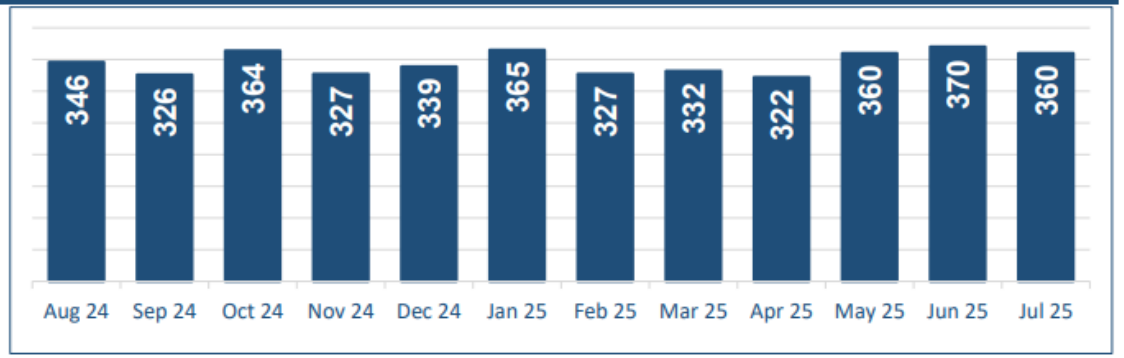


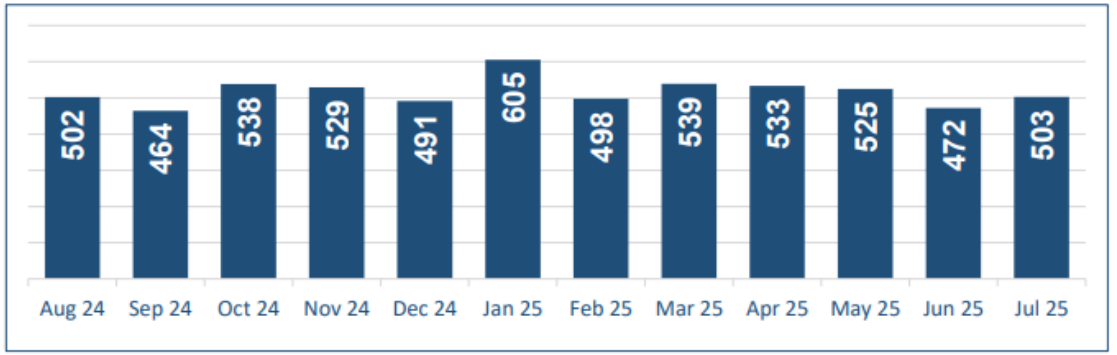


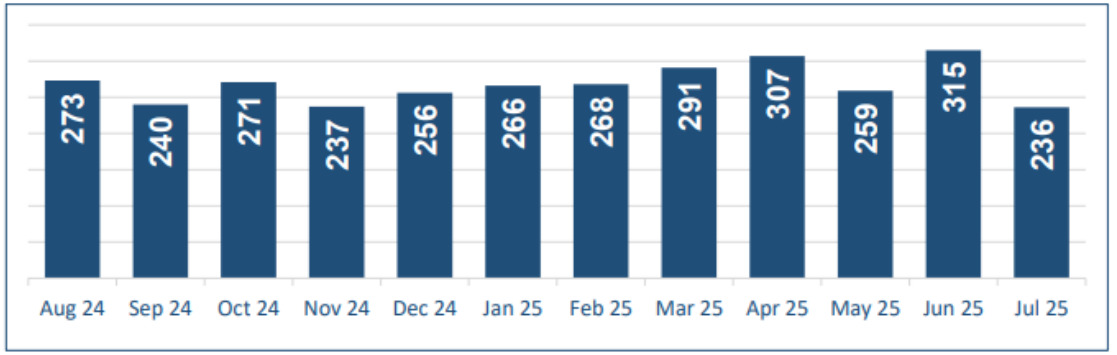
* Wales Ranking may differ as may refer to previous month

Quality: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	QSE	Number of reported falls	N/A	TBC	360	
-	QSE	Number of reported hospital acquired pressure ulcers (HAPU) (excluding new to caseload)	N/A	TBC	503	
-	QSE	Number of reported medication incidents	N/A	TBC	236	



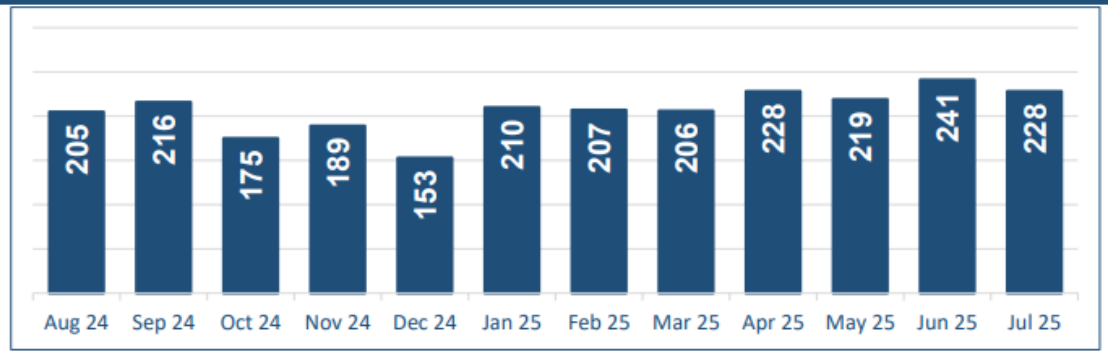


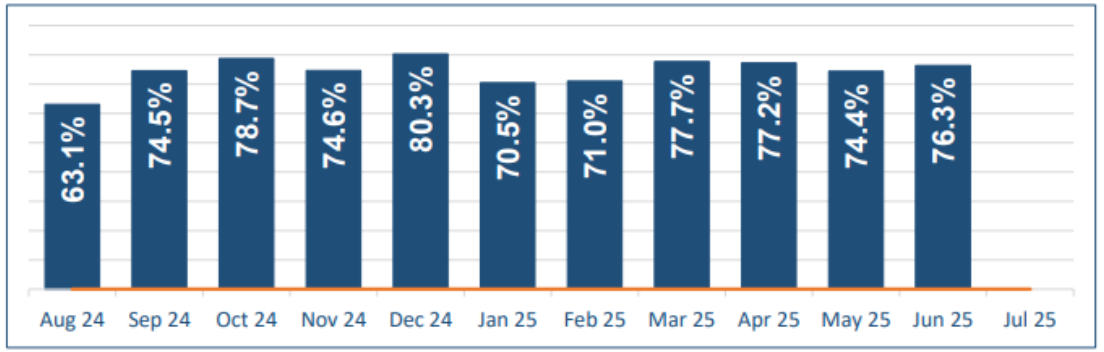


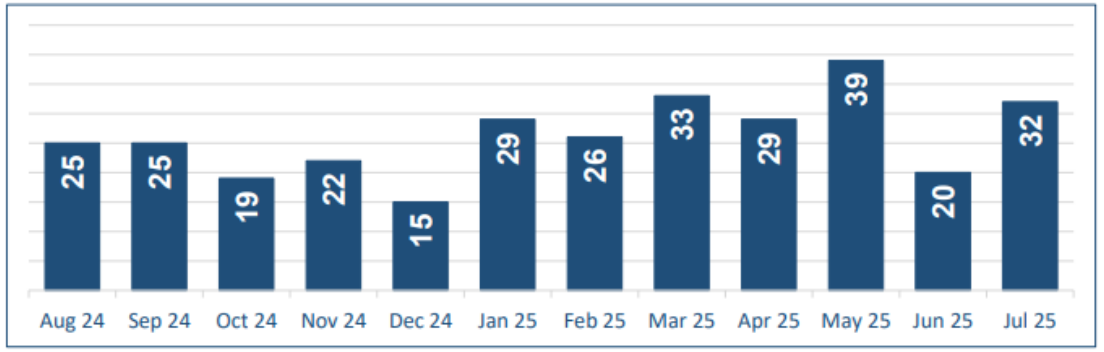
* Wales Ranking may differ as may refer to previous month

Quality: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	QSE	Number of 'Putting Things Right' (PTR) complaints	N/A	TBC	228	
-	QSE	Of the complaints closed, the percentage that were closed within 30 days	75%	TBC	76.3%	
-	QSE	Number of complaints closed as early resolutions	N/A	TBC	32	



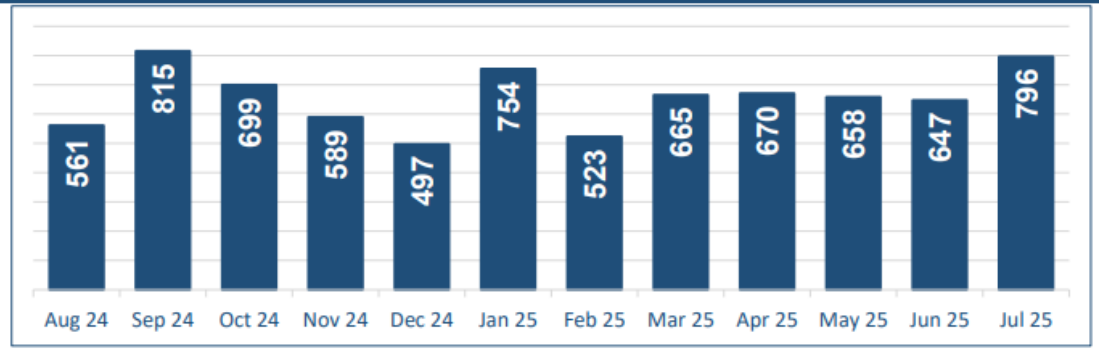


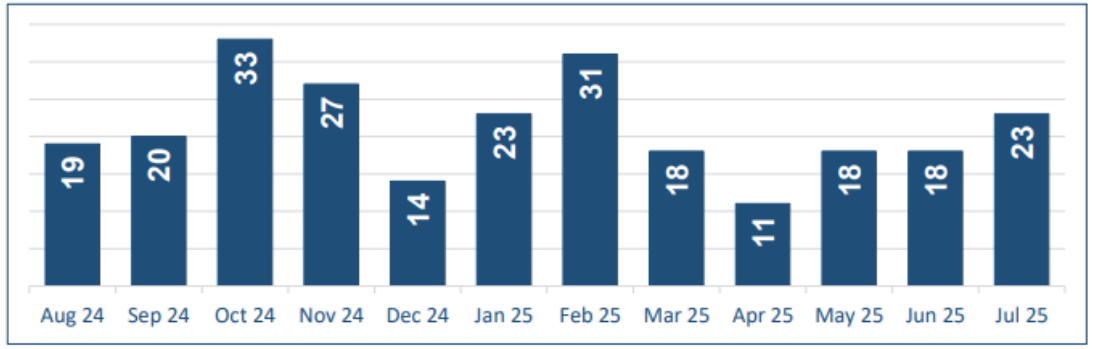


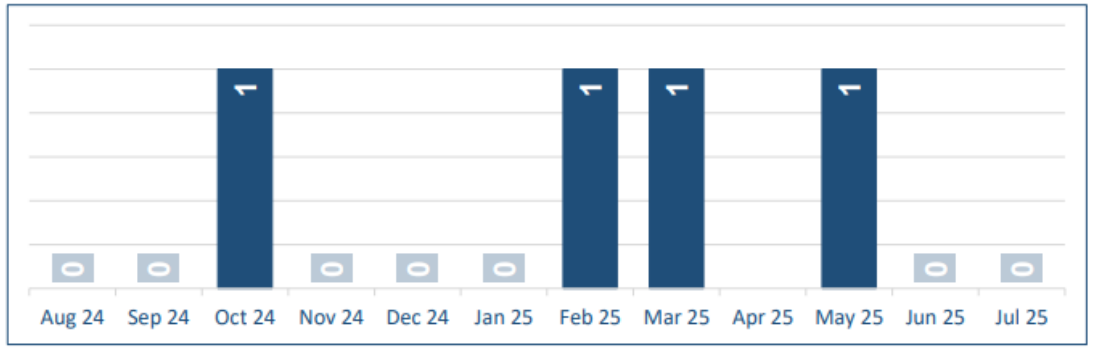
* Wales Ranking may differ as may refer to previous month

Quality: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	QSE	Number of PALS (Patient Advice and Liason Service) contacts	N/A	TBC	796	
-	QSE	Number of new Ombudsman contacts	N/A	TBC	23	
-	QSE	Number of regulation 28 notices	N/A	TBC	0	



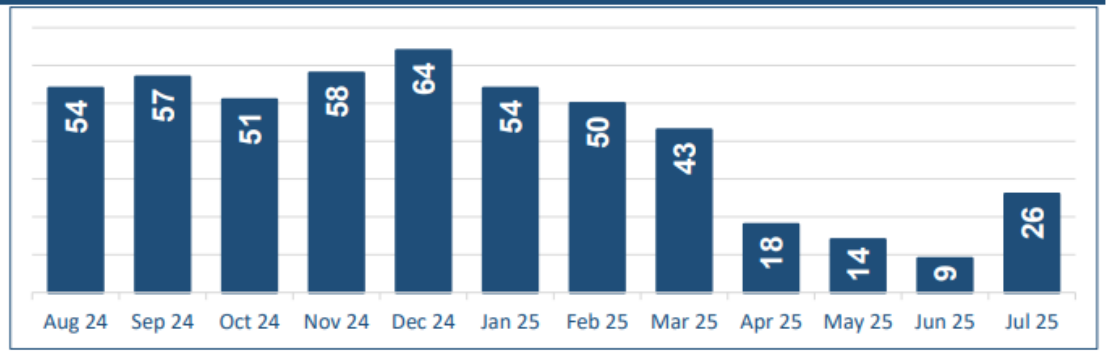


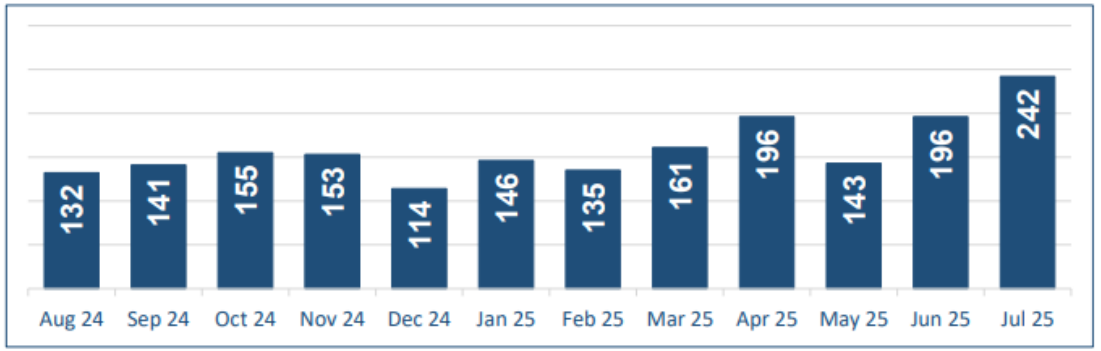


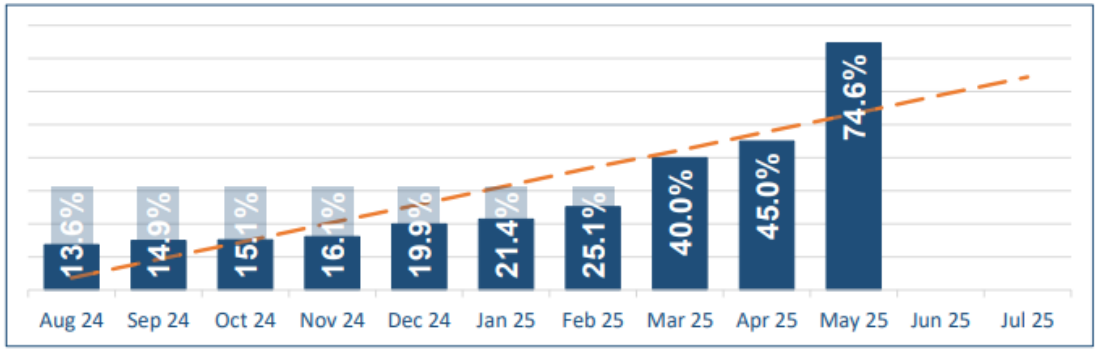
* Wales Ranking may differ as may refer to previous month

Quality: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	QSE	Number of overdue 'Learning from Event Reports' (LFERs)	N/A	TBC	26	
-	QSE	Number of Great-ix submissions	N/A	TBC	242	
-	QSE	Percentage of episodes clinically coded within one reporting month post episode discharge end date	Increas-ing trend (to 95%)	TBC	74.6%	8st of 8 (at Mar 25)



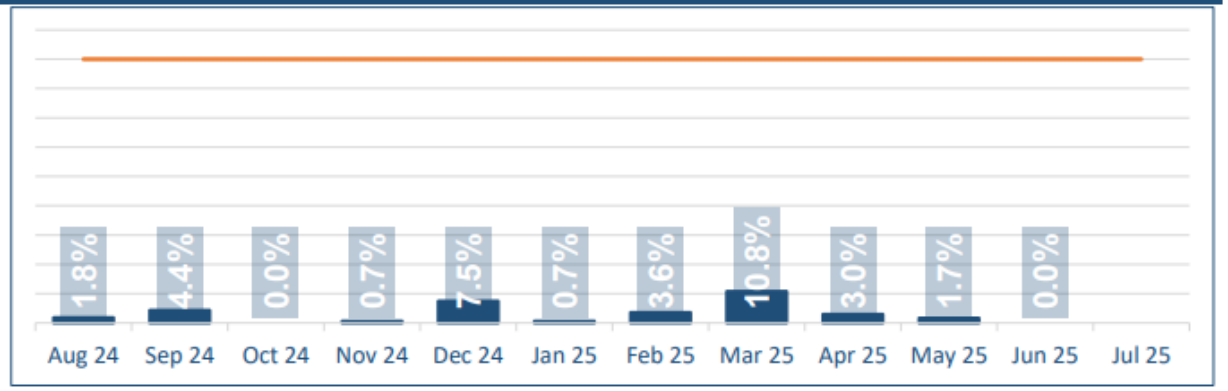




* Wales Ranking may differ as may refer to previous month

Quality: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	QSE	Percentage of all classifications' coding errors corrected by the next monthly reporting submission following identification	90%	TBC	0.0%	8st of 8 (at Mar 25)



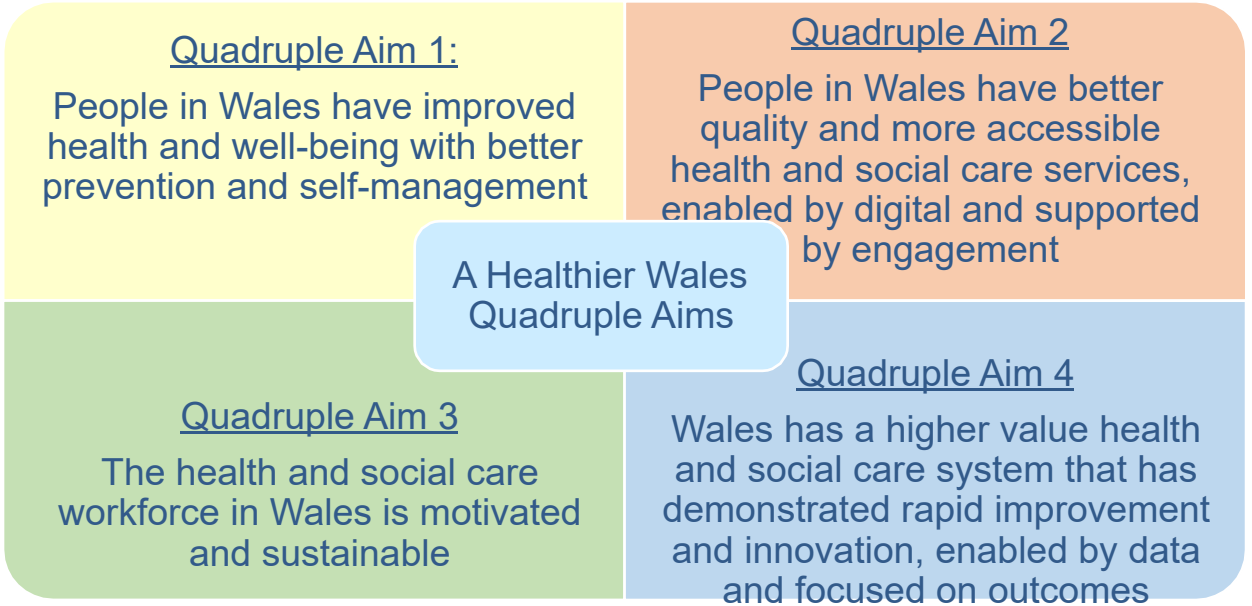
* Wales Ranking may differ as may refer to previous month

Additional Information

NHS Wales Performance Framework 2025-26

The NHS Performance Framework is a key measurement tool for “A Healthier Wales” outcomes, the 2025/26 revision now consists of 53 quantitative measures of which 9 are Ministerial Priorities and require Health Board submitted improvement trajectories.

The NHS Wales Quadruple Aim Outcomes are a set of four interconnected goals or aims that aim to guide and improve healthcare services in Wales. These aims were developed to enhance the quality of care, patient experience, and staff well-being within the National Health Service (NHS) in Wales.



Our Integrated Quality & Performance Report

- **Our Quality, Safety, Effectiveness & Experience Performance**
- **Our Access & Activity Performance**
- **Our People & Organisational Development Performance**
- **Our Financial Performance**

The Integrated Performance Framework (IPF) aims to report holistically at service, directorate or organisation level the performance of the resources deployed, and the outcomes being delivered. Overall performance assessed via intelligence of performance indicators gathered across key domains including quality, safety, access & activity, people, finance and outcomes.

Key for the framework is the system review, reporting, escalation and assurance process that aligns especially to the NHS Wales Performance measures, Special Measure metrics and Ministerial priority trajectories. In the Integrated Performance Review meetings we will address key challenges and provide a robust forum for support and escalation to Executive leads and provide actions and recovery trajectories for escalated metrics.

Red, Amber & Green (RAG) Rating System

Performance is monitored against our Annual Plan but is RAG rated against the Welsh Government targets.

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Green

Green = On track
A stable, sustained or improving position that is consistently on or above the **Welsh Government Target** for at least 3 or more consecutive months

Amber

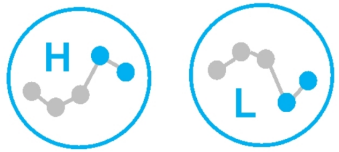
Amber = Early Warning or Off Track and in Exception – Short summary provided
On or above **Welsh Government Target,** but a deteriorating position of 3 or more consecutive months or inconsistently above/on/below the **Welsh Government Target**

Red

Red = Off Track and in Escalation
Consistently below **Welsh Government Target** and below **BCU submitted improvement trajectories – Detailed Exception report provided**

Exception	Escalation
Referring to a deviation or departure from the normal or expected course of action, it signifies that a specific condition or event requires attention or further action to address the deviation and ensure corrective measures are taken.	When a performance matter (exception) does not meet target and hits criteria for a higher level for resolution, decision-making, or further action.
Criteria of an exception	**Criteria for escalation**
Any target failing an NHS Performance target, operational, or local target/trajectory	Any measure that fails a health submitted trajectory as part of the Ministers priorities.
Where SPC methodology reports rule 2, or rule 4 (details on next slide) even if a measure is set target.	Performance recovery failing its Remedial Action Plan (local plan to improve or maintain performance)
Any reportable commissioned metric where performance is not meeting national target	Any significant failure of quality standard e.g. never event or failing accountability conditions.

Interpreting Results of Statistical Process Control (SPC) Charts

Variance			Assurance*		
					
Common cause. No significant change	Special cause for positive change or lower pressure due to Higher (**H**) or Lower (**L**) values	Special cause for negative change or higher pressure due to Higher (**H**) or Lower (**L**) values	Variance indicates inconsistent performance (not achieving, achieving or passing the target rate)	Variance indicates consistent positive (**P**) performance (achieving or surpassing the target on a regular and consistent basis)	Variance indicates consistent negative (**N**) performance (not achieving the target on a regular or consistent basis)

How to interpret variance results

- Variance results show the trends in performance over time
- Trends either show **special cause** variance or **common cause variance**
- **Blue Icons** indicate **positive** special cause variance
- **Orange Icons** indicate **negative** special cause variance **requiring action**
- **Grey Icons** indicate **no significant change**

How to interpret assurance results

- Assurance results demonstrate the likelihood of achieving a target and is based upon the trends over time
- **Blue Icons** indicate an expectation **to** consistently achieve the target
- **Orange Icons** indicate an expectation **not to** consistently achieve the target
- **Grey Icons** indicate an expectation for **inconsistent** performance, sometimes the target will be achieved and sometimes it will not be achieved.

* Assurance based upon observations of the data as presented in the SPC charts only.

Introduction to Integrated Quality & Performance Report (IQPR)

What is an Integrated Quality & Performance Report (IQPR)?

The Integrated Quality & Performance Report (IQPR) combines the areas of Quality, Performance, People and Finance in one overarching report. It provides the reader with a balanced view of performance intelligence and assurances from across the organisation.

The Integrated Performance Framework (IPF)

The Integrated Performance Framework (IPF) for 2023-2027 was ratified by the Health Board on 28th September 2023. The Framework lays the foundations for an integrated approach to performance monitoring, intelligence, management, assurance and improvement. An integral element of the IPF is this new Integrated Performance Report and the governance structure wrapped around it.

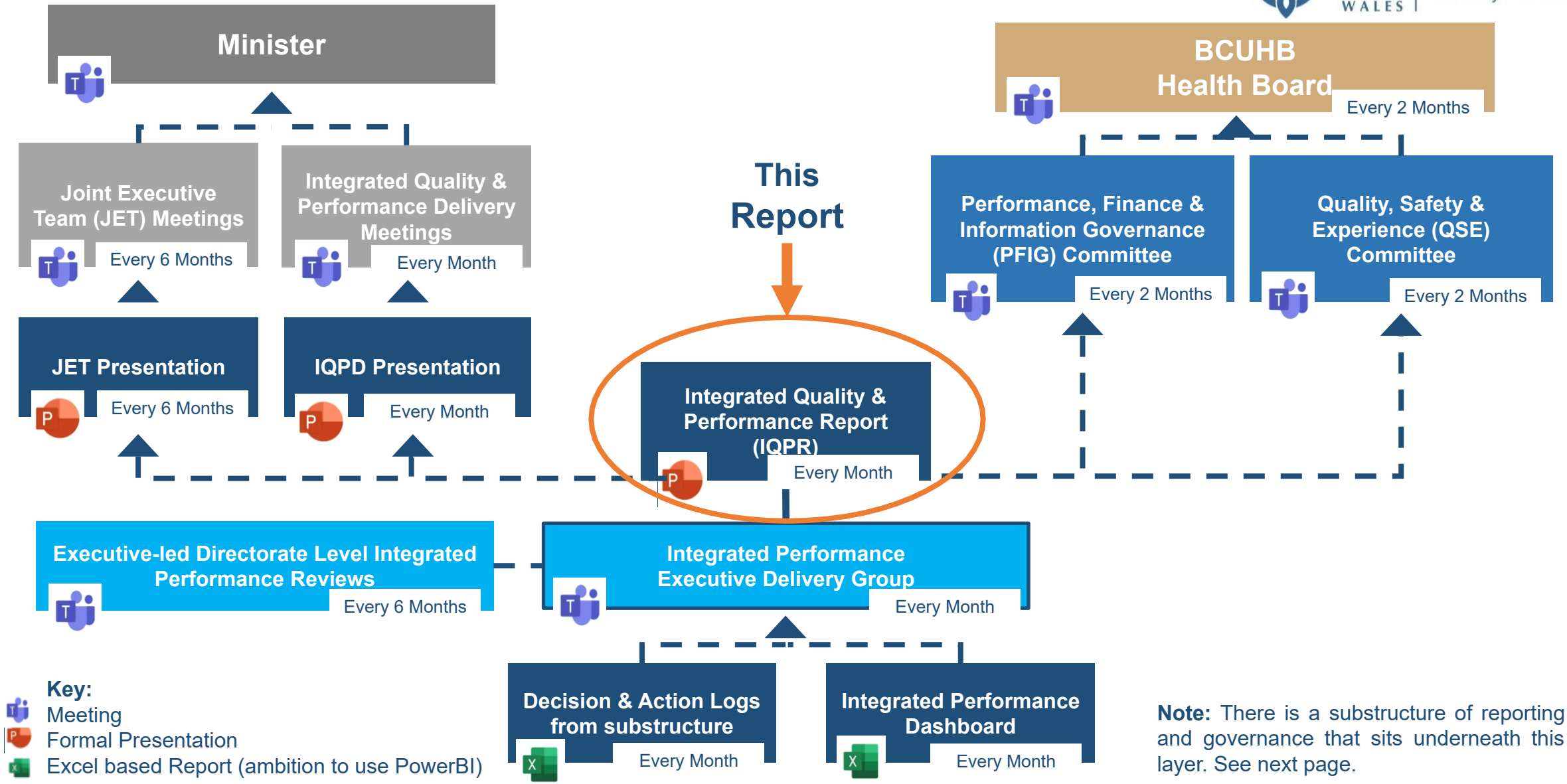
The Integrated Performance Framework sits within a “triumvirate” together with the Integrated Planning Framework and the Risk Management Framework (also ratified at Health Board on the 28th September 2023). This triumvirate of frameworks will encompass the planning, safe delivery and monitoring of the Health Board’s strategic objectives between now and April 2027. Work has also commenced with the corporate directorates working together on the development of an integrated approach to organisational quality surveillance mechanisms. Once this initial phase is complete, we will then begin our work with the services.

Where does the IQPR feature within the Performance Governance Structure

The Health Board’s business rules are designed to highlight potential challenge and provide clear assurance for the Board and Public stakeholders. The IQPR as a function of the IPF contains information on all metrics, including those that are consistently achieving success however, the main focus is on metrics in exception or escalation.

The IQPR will be embedded as the ‘single version of the truth’ and used to report on performance to the Health Board, it’s scrutinising committees namely Performance, Finance & Information Governance (PFIG) Committee and Quality, Safety & Experience (QSE) Committee and externally to Welsh Government. Once published for each Committee/Health Board, the report will be shared across the organisation via BetsiNet (internally), published externally on Betsi Cadwaladr University Health Board’s (BCUHB) external facing website and shared in parts or as a whole on other channels such as social media via our partners in BCUHB’s Communications Team.

The Integrated Performance Reporting & Governance Superstructure

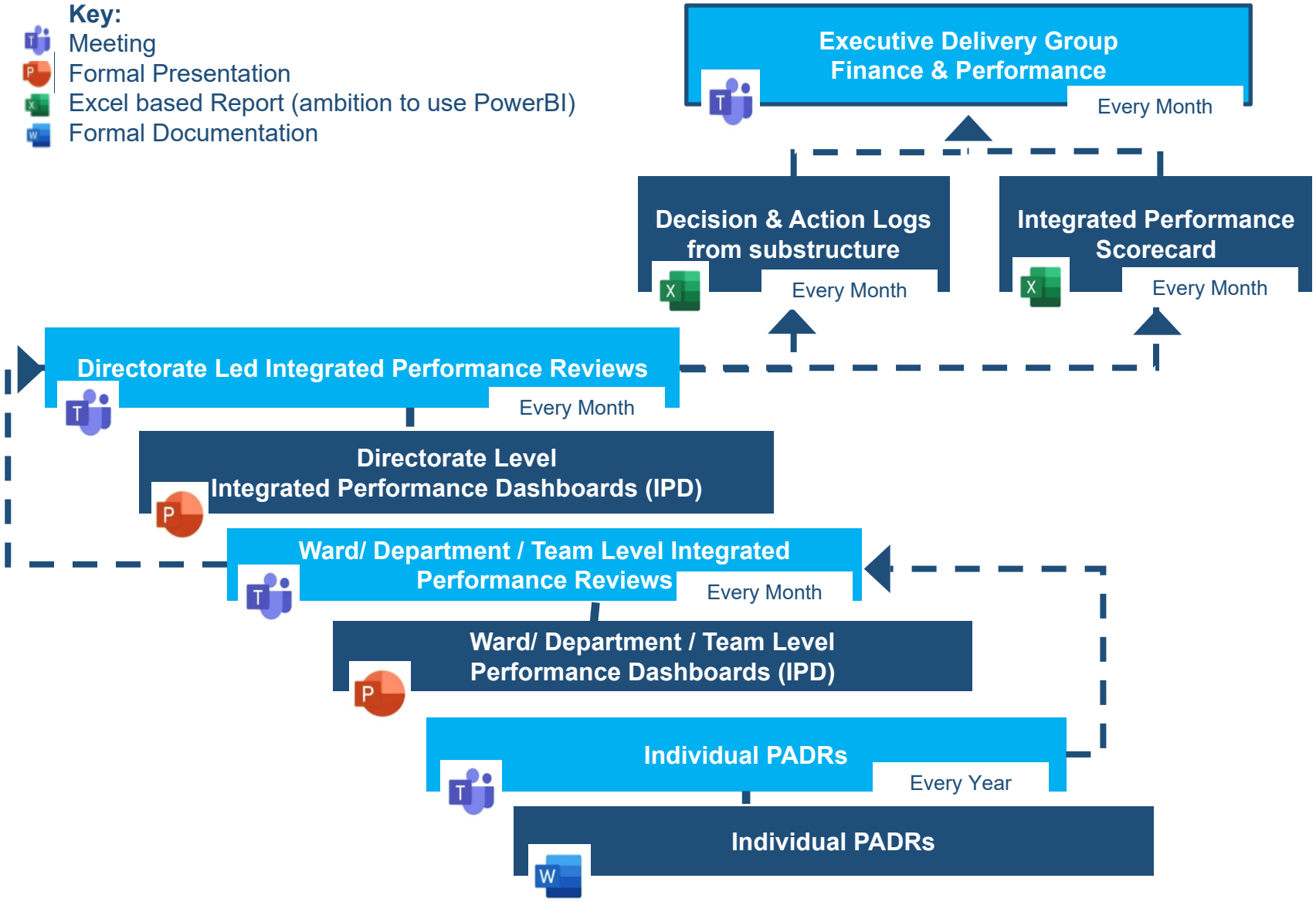


Key:
- Meeting
- Formal Presentation
- Excel based Report (ambition to use PowerBI)

Note: There is a substructure of reporting and governance that sits underneath this layer. See next page.

The Integrated Performance Reporting & Governance Substructure

Key:
- Meeting
- Formal Presentation
- Excel based Report (ambition to use PowerBI)
- Formal Documentation



Note: For Directorate, please think IHC, Pan-BCU services etc. Includes Corporate Services.

Note: There is a superstructure of reporting and governance that sits above this layer. See previous page.

Performance Directorate Outputs

Integrated Performance Reports	Formal and comprehensive reports to the Health Board and its scrutinising committees, Integrated Quality & Performance Delivery Group (IQPD)(Welsh Government) and Joint Executive Team (JET).
Integrated Performance Scorecards	Summary scorecards for– Integrated Performance Executive Delivery Group et al
Integrated Performance Dashboards	Operational level performance dashboards with drill through capabilities. For end of month's submitted position. Ambition for production in PowerBI. – Produced by Digital, Data & Technology (DDAT) in partnership with the Performance Directorate(PI&AD)
Deep Dive Reports	Detailed Deep Dive reports used in accompaniment to Formal Reports, Scorecards and Dashboards to complement data, provide context, add intelligence and provide assurances as appropriate. Used at all levels as necessary, I.e. to support escalation, de-escalation.
Ad-hoc Reports	Ad-hoc reports used outside of the formal channels and for specific queries to complement data, provide context, add intelligence and provide assurances as appropriate. Used at all levels as necessary to provide additional intelligence and assurances as required.

Our Partners

This report has been produced on behalf of the **Health Board** by the **Performance and Commissioning Directorate in** partnership with:

- Integrated Health Communities (West, Centre & East)
- Digital, Data & Technology Directorate (DDAT)
- People & Organisational Development Directorate (POD)
- Adult Mental Health & Learning Disabilities Directorate (AMH&LD)
- Children & Young Adolescent Mental Health Services Directorate (CAMHS)
- Women's Services Directorate (WS)
- Public Health
- Finance Directorate
- Office of the Medical Director (OMD)
- Quality & Patient Experience Directorate (Q&PE)
- Equal Opportunities Team
- Corporate Risk Management Team
- Corporate Communications Team

...and the following as Senior Responsible Officers for the measures within their respective Executive Portfolios.

- Chief Operations Officer
- Executive Director of Finance
- Executive Director for Public Health
- Executive Director for People & Organisational Development
- Executive Director of Mental Health & Learning Disabilities and of Therapies and Health Sciences
- Executive Director of Strategic Planning & Transformation (Acting)
- Executive Director of Nursing & Midwifery
- Executive Medical Director (Interim)

Benchmarking information has been sourced (as identified) from NHS Benchmarking Network, Welsh Government and CHKS

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Further Information on Our Integrated Quality & Performance Report

Further information is available from the office of the Director of Performance and Commissioning for further details regarding this report. And further information on our performance can be found online at:

Our website www.bcu.wales.nhs.uk

Stats Wales https://statswales.gov.wales/Catalogue/Health-and-Social-Care

We post regular updates on what we are doing to improve healthcare services for patients on social media:

follow @bcuhb

http://www.facebook.com/bcuhealthboard

Teitl adroddiad: *Report title:*	Challenged Services		
Adrodd i: *Report to:*	Quality, Safety and Experience Committee		
Dyddiad y Cyfarfod: *Date of Meeting:*	4th September 2025		
Crynodeb Gweithredol: *Executive Summary:*	The purpose of this paper is to provide the committee with an update on the latest progress in relation to Challenged Services. The content of the paper is taken from two sets of presentations to the Welsh Government checkpoint meetings in June and August. The Interim Executive Director of Transformation and Strategic Planning will present these slides to the committee with the support of the Interim Executive Medical Director, outlining the approach that has been taken within the organisation to addressing the challenges faced. Whilst each specialty has its own nuances and challenges, a key piece of learning from this work has been the lack of service planning as a core competency within the organisation. Thematic review across the services also identifies that each has workforce related issues contributing to the fragility, a result of effective workforce planning not being in place. Addressing these issues has been central to the improved position now evident. The meetings with Welsh Government have seen an acknowledgement of progress and an increasing confidence in the Health Board approach with meetings now moving from monthly to quarterly. The progress in Plastics and Oncology has also led to them being identified for immediate consideration for de-escalation out of Special Measures, a significant step forward for the Health Board. These meetings have included clinical representation from within the services demonstrating good alignment between clinicians and managers on the collective issues faced. The improved confidence will also facilitate an important step in moving towards the Health Board engagement with WG being led by clinical and managerial service leads, with support from executive colleagues – this is a critical step in terms of organisational maturity in reducing the reliance on executives to personally drive the change. Further arrangements are being developed to capitalise on progress to date and ensure each service moves to a position of stability and sustainability, of which the Clinical Services Plan phase 2 will be a key component.		
Argymhellion: *Recommendations:*	The Committee is asked to: ▪ **RECEIVE ASSURANCE** on the progress made, whilst acknowledging the challenges that remain		
Arweinydd Gweithredol: *Executive Lead:*	Paolo Tardivel, Executive Director of Transformation & Strategic Planning (Interim) Tehmeena Ajmal, Chief Operating Officer (SRO for Challenged Services) Dr Sreeman Andole, Interim Executive Medical Director (Clinical Lead for Challenged Services)		
Awdur yr Adroddiad: *Report Author:*	Geraint Parry, Assistant Director of Transformation (Interim)		
Pwrpas yr adroddiad: *Purpose of report:*	I'w Nodi *For Noting* ☒	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒

Lefel sicrwydd: *Assurance level:*	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: *Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:*	
Cyswllt ag Amcan/Amcanion Strategol: *Link to Strategic Objective(s):*	To support the Integrated Medium Term Plan (IMTP)
Goblygiadau rheoleiddio a lleol: *Regulatory and legal implications:*	Not applicable
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? *In accordance with WP7 has an EqIA been identified as necessary and undertaken?*	Not applicable
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? *In accordance with WP68, has an SEIA identified as necessary been undertaken?*	Not applicable
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) *Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR)*	Not applicable
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* *Financial implications as a result of implementing the recommendations*	Not applicable
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith *Workforce implications as a result of implementing the recommendations*	Not applicable

Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori *Feedback, response, and follow up summary following consultation*	Not applicable
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) *Links to BAF risks:* *(or links to the Corporate Risk Register)*	Not applicable
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) *Reason for submission of report to confidential board (where relevant)*	Not applicable
Camau Nesaf / *Next Steps:* Implementation of the plans going forward for each programme	
Rhestr o Atodiadau / ***List of Appendices:*** N/A	

Challenged Services Meeting

BCUHB and Welsh Government

20th June 2025 / 15th August 2025

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Planned Care Programme

Workstreams	Deliverables
1) Waiting List Management: Validation	▪ 4D.a.1 - Develop and implement the next stage of the Validation Approach in the Health Board; focusing on delivering high levels of data quality, updated waiting lists and application of waiting list policies. ▪ 4D.a.2 - Implement locally the 8 nationally agreed Interventions Not Normally Undertaken (INNU), and the pipeline of INNUs that follow.
2) Referral Advice and Guidance and Referral Triage/Alternative Pathways	▪ 4D.a.3 - Develop and implement best practice standards (GIRFT/Optimisation Framework) for referral advice and guidance (pre-referral) focusing on high volume, high opportunity specialties as a priority and rolling through other specialties thereafter. ▪ 4D.a.4 - Assess the opportunities for Referral Triage and Alternative Pathways in high volume specialties as a priority; drawing up and commencing the implementation of service redesign proposals, learning from other organisations ▪ 4D.a.5 - Implement the Health Pathways (including Pathway Alliance Programme) in priority specialties ▪ 4D.a.6 - Implement specific specialty 'direct listing', specifically focused on ophthalmology as a priority
3) Booking	▪ 4D.a.7 - Progress the implementation of the new Booking Service, enabling a consistent approach across the organisation. ▪ 4D.a.8 - Review and update outpatient clinic templates, incorporating GIRFT/Optimisation Framework standards, across high priority specialties ▪ 4D.a.9 - Implement a revised DNA/CNA approach, including overbooking mechanisms where DNA/CNA rates are above 5%.
4) Pre-operative and Operative Effectiveness (incl Theatre Utilisation)	▪ 4D.a.10 - Develop and implement the revised model for Pre-Operative Assessment ▪ 4D.a.11 - Identify specialty by specialty high utilisation opportunities to enable focused and targeted approach to achieve the 85% utilisation threshold. ▪ 4D.a.12 - Review each specialty to identify opportunities for increased day case, and minor-ops/procedure room (Right Patient, Right Place-type) approach. Implement priority specialty improvements.
5) Follow-Ups	▪ 4D.a.13 - Undertake a systematic approach to validating, data cleansing all Follow-up lists. ▪ 4D.a.14 - Implement See on Symptoms (SoS) and Patient Initiated Follow-up (PIFU) on all priority specialties (linked to Optimisation Frameworks/GIRFT). ▪ 4D.a.15 - Recalibrate capacity from follow-ups to new appointments in priority specialties, following assessment of opportunity.
6) Integrated planning for Planned Care, Cancer and Diagnostics	▪ 4D.a.16 - Introduce an enhanced demand and capacity modelling approach that takes into account all aspects of planned care and cancer pathways. ▪ 4D.a.17 - Implement a programme of in-year commissioned capacity to support 2025/26 delivery ▪ 4D.a.18 - Develop integrated specialty plans for 2026/27 based on the progress made across specialties in 2025, to include workforce, finance, commissioning aspects.

Performance and day to day delivery
- Must Attends
- Access meetings
- Service operational performance
- Day to day incremental improvements

Deployment

Informing

Change Programme
- Designing systems of work/approaches/policies
- Whole organisation (single approach)
- Long lasting change/change approach
- Programme Plan, scheduled dates, clear leadership, workstreams, highlight reports, benefits tracking, escalations

Link to National Strategic Planned Care Programme

Strategy and Clinical Services Planning

- Development of Strategic Intent with partners, Health Board 10 Year Strategy and Clinical Services Plan progressing.
- Sessions with Board Members and RPB scheduled in June and July with further sessions planned in August and September
- Clinical Services Plan work is split into two phases.
- Phase 1: Addressing urgent issues that don't require full service re-configuration.
- Phase 2: Developing a blueprint for North Wales to create long-term sustainable service models.
- A number of the underlying issues across the Challenged Services relate to having an unsustainable service model, they will be prioritised within Phase 2.

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Ophthalmology - Overview

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Key Issues

1. Delayed access to patient care resulting in patient harm and poor patient experience.
2. Lack of single service model across North Wales.
3. No single Clinical Lead across North Wales to drive and steer improvements.
4. Out of date and unsustainable workforce plan.
5. Ageing estates, equipment and areas of non-compliance with disability access.
6. Delays to implementing national digital infrastructure e.g. e-referral and electronic patient records.

Common improvement areas	Key issue for this specialty
Service model and configuration	Yes
Workforce	Yes
Quality / Standards / Practice /	Yes
Patient Safety / Experience	Yes
Infrastructure – Estates / Digital	Yes

Summary of progress

- Step change in relationships with community Optometrists following improved utilisation of integrated pathways over the last 6 weeks.
- Further Cataracts longest waits outsourcing plan developed, commencing in Q2.
- QMS maturity assessments in progress, informing next iteration of the plan.
- Workforce review underway, Primary Care audit completed identifying Optometrists with higher qualifications to inform a training needs analysis.
- Refreshed arrangements to recruit Clinical lead being progressed.
- Current teach and treat centres progressing well.
- BCU and Community optometrists successful ongoing implementation of cataract refinement to identify patients within 48 hours who could be day case or outsourced. Example of good practice in Wales.
- Harm review process in place as part of core governance.

Ophthalmology – High level plan

Theme	Improvements	Delivery dates	Delivery confidence
Patient Safety / Experience	PSE1: Undertake focussed harm reviews within an integrated concerns management approach (including investigation, learning identification and application, feedback). A harms process is in process of agreement, via BCU Governance sign-off: to inform systematic review	Q4 2025/26	
Service Model and Configuration	SMC1: Outsource cataract longest waiting patients. Contract for 4610 commenced Q2, 2025	Q2 2025/26	
	SMC2: Develop proposals to inform business cases for sustainable regional service delivery models. To be informed by workforce review, which commenced Q1, 2025	Q4 2025/26	
Workforce	W1: Delivering additional capacity through Teach and Treat Independent Prescribing post-graduate and Higher Certificate Glaucoma (Live). Developing post-graduate Medical Retina (including HCQ) courses with Cardiff University.	Q4 2025/26	
	W2: Complete strategic and operational workforce planning review against current and emerging pathways of care, to include development and implementation of integrated training plan (endeavouring need to constantly future proof). Commenced Q1	Q4 2025/26	
Quality / Standards / Practice	QSP1: Reinstate Eye Care Governance meetings to effectively deliver pan BCU clinical sub-specialty networks. Commenced Q2, 25	Q2 2025/26	
	QSP2: Recruit to key clinical leadership roles (Ophthalmologists and Optometry). Funding being clarified by Office of Medical Director	Q3 2025/26	
	QSP3: Deliver Secondary Care integrated pathways with Opticians (glaucoma and retinopathy). Discussion ongoing with Finance regards breakdown of resource. In Q1, 530 additional patient flow to Integrated Pathways delivered. Stand down/transfer of New patient pathways to WGOS completed July 2025	Q4 2025/26	
	QSP4: Deliver WGOS 4 Optician pathways. Primary Care inform that WGOS 4 pathways commenced: Independent prescribing, hydroxychloroquine, glaucoma and medical retina	Q2 – 3 2025/26	
	QSP5: Deliver cataract pathway efficiencies through Cataract Network include:- a. Direct Listing options appraisal completed : with presentation to ECCG for ratification on track for Q2. One-Stop POAC: East established & Central Go Live commenced Q2. West POAC on track for August Q2. HVLC: East & Central commenced Q2. West embedded but challenged due to unplanned Medical circumstances: with sustainability options progressing	Q4 2025/26	
Infrastructure – Estates / Digital	IED1: Collate all relevant estates reviews to identify improvements to existing estates, further estate and modular opportunities. This work will be used to inform the regional service delivery plan	Q3 2025/26	
	IED2: Ensure BCU readiness for national digital enabler e-referral and electronic patient record (EPR) systems. BCU DDAT formulating Implementation plan and related Business Case for Executives	Q4 2025/26	

Urology - Overview

Key Issues

1) Unsustainable use of locum consultants due to recruitment and retention issues related to unattractive on-call rota and lack of robotic surgery provision.
2) Performance – USC pathway within 62 days, 104 week waits, 8-week diagnostic waits, caused by a demand vs capacity mis-match due to rising demand, inefficiencies and inconsistent and out-dated practices.
3) Clinical leadership – No North Wales lead and lack of appointed lead within the West IHC.
4) Poor patient experience due to significant travel to existing outsourcing providers.
5) Lack of Interventional Radiology out of hours and inequity of service provision across North Wales due to differing provision across IHCs.
6) Lack of estates to increase capacity.
7) No contracted Vasectomy provision in Primary Care.

Common improvement areas	Key issue for this specialty
Service model and configuration	Yes
Workforce	Yes
Quality / Standards / Practice /	Yes
Patient Safety / Experience	Yes
Infrastructure – Estates / Digital	Yes

Summary of progress

- Cystectomies now sent to Wirral – bringing service back closer to home, improved patient experience, greater stability and foundation for future expansion.
- Business Case for Urology Investigation Unit in Wrexham has been developed to meet GIRFT recommendation (already in place in West and Centre).
- Urology workshop was held on the 26th June to develop the options for a future service and workforce model (supported by Urology CIN and NHSP&I).
- Specialty Plan has been drafted which sets out a comprehensive strategy to address issues, informed by national priorities and workshop outputs. To be shared with stakeholders and discussed at steering group.
- Urology Steering group has been re-established. To recommence on the 11th September 2025.
- Further pathway development has identified LATP as the current bottleneck in the cancer pathways, SBAR developed and being reviewed by IHCs to address the gap.
- Welsh Clinical Portal electronic referrals implemented for external referrals, using nationally agreed clinical conditions, leading to improve waiting list management and planning.
- SBAR discussed at OLT to recommission Vasectomies in Primary Care; paper outlining options requested for Formal Executive Team meeting
- Strong clinical leadership evident in each site in the absence of a Pan BCU Clinical Lead, acknowledged in the CIN / NHSP&I visit. Medical Director progressing options for appointment of a Pan BCU Clinical Lead.

Urology – High level plan

Theme	Improvements	Delivery dates	Delivery confidence
Service Model and Configuration	SMC1: Develop and agree sustainable on-call rota model, to be discussed at Steering Group in September	Q3 2025/26	
	SMC2: Clarify the case for a robotic assisted surgery platform.	Q3 2025/26	
	SMC3: Commission Vasectomy services in Primary Care.	Q3 2025/26	
Workforce	W1: Recruit a pan BCU clinical lead to support modernization and consistency of practice.	Q3 2025/26	
Quality/Standards/ Practice	QSP1: Develop plan to improve the delays identified with the Prostate Cancer Pathway (LATP).	Q2 2025/26	
Patient Safety / Experience	PSE1: Consolidation of cancer service to the Wirral alongside a robotic training package for Consultants.	Q3 2025/26	
Infrastructure – Estates and Estates	IED1: Development of estate including Urology Investigation Unit in Wrexham.	Q3 2025/26	
	IED2: Implement Digital enablers for improved efficiency: WCP Electronic Referral management, Digital Dictation and My Medical Record.	Q4 2025/26	

Vascular - Overview

Key Issues

1) An unsustainable workforce due to age profile, lack of trainees and UK-wide shortages.
2) Large number of people waiting for appointments and delays to treatment.
3) Challenges impacting Multi Disciplinary Team working.
4) Further work is required to strengthen the clinical strategy and service framework to enable effective integrated working across hub and spoke sites.

Common improvement areas	Key issue for this specialty
Service model and configuration	Yes
Workforce	Yes
Quality / Standards / Practice /	Yes
Patient Safety / Experience	Yes
Infrastructure – Estates / Digital	Yes

Summary of progress

- Strategic workforce plan – kick-off meeting scheduled for 3rd September
- Ongoing work to apply new referral guidance for surgical management of varicose veins, including WLIs to commission additional clinics to review and reduce waiting list
- Pathway progress:
  - Diabetic Foot pathway now agreed and further pathways being developed for approval via Clinical Effectiveness Group.
  - Development of a digital pathway tracker underway and on track with all BCUHB data requirements mapped. Appointment of Data Analyst progressing.
  - Discharge pathway mapped and work underway to support transfer pathway for Limb Ischaemia.
- Successful workshop to review and design clinical, operating and workforce models to ensure sustainability.
- Long term sustainable model for AAA progressing with colleagues from University Hospitals of North Midlands.
- Strengthened MDT approach developing with key delivery partners, with successful workshop on 19th June providing foundations to build further.
- Review of network's clinical, operating and workforce model underway following successful stakeholder workshop. Initial consultation draft to be shared with IHCs by October for comment and consideration.

Vascular – High level plan

Theme	Improvements	Delivery dates	Delivery confidence
Service Model and Configuration	SMC1: Review clinical, operating and workforce models to ensure sustainability and that capacity is able to meet demand.	Q1 2025/26	
	SMC2: Develop long term sustainable model for AAA services.	Q2 2025/26	
	SMC3: Begin implementation of a plan for CLTI to achieve CQUIN aims around re-vascularisation.	Q1 2025/26	
Workforce	W1: Develop and agree strategic workforce plan to address recruitment and retention challenges, and supplement with robust recruitment campaign.	Q3 2025/26	
	W2: Strengthen leadership, training and education to support continued professional development.	Q4 2025/26	
Quality/Standards/ Practice	QSP1: Initiatives to improve theatre and outpatient utilisation.	Q2 2025/26	
Patient Safety / Experience	PSE1: Finalise and implement transfer, discharge and repatriation pathways.	Q3 2025/26	
Infrastructure – Estates and Digital	IED1: Develop Digital Pathway tracker.	Q4 2025/26	

Dermatology - Overview

Key Issues

1) Inability to recruit Consultant Staff (in the West).
2) Increased demands which outstrip the capacity of the current model has led to longer waiting lists.
3) Inability to deliver key performance targets – USC 62-day target, RTT targets due to increasing demand, insufficient capacity, inefficient practices.
4) Delays with access to patient care resulting in harm and poor patient experience.
5) Insufficient current facilities across North Wales to delivery Minor Operative procedures and increase outpatient capacity and enable 'one-stop' approach.

Common improvement areas	Key issue for this specialty
Service model and configuration	Yes
Workforce	Yes
Quality / Standards / Practice /	Yes
Patient Safety / Experience	Yes
Infrastructure – Estates / Digital	Yes

Summary of progress

- Strong focus on waiting list management – on track to deliver zero 104-week waiters by end of Q2.
- Preparation for opening of Connah's Quay in final stages – delays due to inability to recruit to temporary nursing posts.
- Expansion of Teledermoscopy underway – Centre to commence September 25 with x2 Consultants commencing, options being explored to commence in West using BCU resource through additionality.
- High volume one-stop approach for lesions agreed. Increased volumes expected in September.
- Progression of discussions with Primary Care underway with potential for GP with special interests posts.
- Dermatology Workshop arranged 24th September

Dermatology – High level plan

Theme	Improvements	Delivery dates	Delivery confidence
Service Model and Configuration	SMC1: Sustainable Service Model across BCU with shift left to Primary Care service.	Q4 2025/26	
Workforce	W1: Complete strategic and operational workforce planning review.	Q3 2025/26	
	W2: Recruitment of dedicated Dermatology Pharmacists per site to support the management of complex treatment, reducing demand on senior doctors within the team.	Q3 2025/26	
Quality/Standards/ Practice	QSP1: Delivery of high volume 'one-stop' approach for lesions.	Q3 2025/26	
	QSP2: Undertake focused harm reviews with an integrated concerns management approach, to include investigations, learning and feedback.	Q3 2025/26	
Patient Safety / Experience	PSE1: Insource provision to support delivery of Cancer/RTT targets.	Q2 2025/26	
Infrastructure – Estates and Digital	IED1: Expansion of Teledermoscopy.	Q2 2025/26	
	IED2: Introduction of Connah's Quay Health Centre.	Q3 2025/26	
	IED3: Understand primary care facilities provisions to improve partnership working and reduce secondary care referrals.	Q4 2025/26	

Orthopaedics - Overview

Key Issues

1. Delayed cold site optimisation due to estates, service configuration and long waiting acute site need.
2. Slow progression of efficiency measures (HVLC, Day case arthroplasty, HSQ, MOPs).
3. Significant volume of overdue follow up patients.
4. Network Clinical leadership sessions currently assigned to Llandudno orthopaedic project.

Common improvement areas	Key issue for this specialty
Service model and configuration	Yes
Workforce	No
Quality / Standards / Practice /	Yes
Patient Safety / Experience	No
Infrastructure – Estates / Digital	Yes

Summary of progress

1. Arthroplasty procedures in Abergele have shown a gradual rising trend between June 2024 and June 2025.
2. Reducing volumes of 104week cohort all stages across BCUHB (1296 in June 2024 to 454 in June 2025). MOPs rooms operational across all IHCs - 339 hand & wrist MOPs procedures completed in June 24-June 25, compared with 182 from June 23-June 24. HSQ trial in East.
3. Clinical / operational agreement to use SOS for backlog patients following their 12month review. 100% overdue cohort validation complete.
4. Effective leadership in place for specialty and Llandudno orthopaedic project (including Executive oversight) through Llandudno programme board. IHC clinical leads have been stepping up to assist pan-health board delivery, whilst network clinical lead focus is on Llandudno .
5. Progressing opportunities to utilise nursing /AHPs in hands and hip/knee to improve follow up and stage 1 capacity.

Orthopaedics – High level plan

Theme	Improvements	Delivery dates	Delivery confidence
Service Model and Configuration	SMC1: Core theatre sessions shifted to Abergele with acute site backfill for long waiting patients. Also provides a test bed for optimising the Llandudno project. Linked to IMTP 4J.h.8.	Q2 2025/26	
	SMC2: Transition to subspecialty focus pan North Wales enhancing opportunity for standardisation. Linked to IMTP 4J.h.1.	Q3 2025/26	
Workforce	W1: Work with orthopaedic clinical leadership to deliver standardised effective job planning. Linked to IMTP 4J.h.1.	Q3 2025/26	
	W2: Address workforce gaps through approved recruitment / upskilling of existing non-medical workforce. Linked to IMTP 4J.h.2.	Q4 2025/26	
Quality/Standards /Practice	QSP1. Increase MOPs utilisation, Day case arthroplasty, and HVLC. Aiming for BADs rate of 70% (currently 58%) Linked to IMTP 4J.h.8.	Q2 2025/26	
	QSP2: Implement SOS pathways, including application to follow up. Target of 250 backlog patients per week. Linked to IMTP 4J.h.9.	Q2 2025/26	
Patient Safety / Experience	PSQ1: Improve patient care through patient experience data, targeting high incidence areas ie Pressure ulcers. Linked to IMTP 4J.h.10.	Q2 2025/26	
	PSQ2: Improve data quality at a sub-specialty level through more effective coding practices. Linked to IMTP 4J.h.5.	Q3 2025/26	
Infrastructure – Estates and Digital	IED1: Ring-fencing of acute site beds to accommodate the longest waiting patients and completion of the Llandudno orthopaedic unit for cold site sustainability. Linked to IMTP 4J.h.8.	Q4 2025/26	

Orthodontics - Overview

Key Issues

1. National workforce shortages including a lack of Consultant and alternative professional staff, as well as under utilisation of skill mix and workforce retention, succession planning and training of the orthodontic workforce. Loss of one Consultant since GIRFT review and upcoming maternity leave.
2. Backlog demand outstripping capacity across both primary and secondary care, with patients waiting in excess of 156 weeks for initial assessment and outpatient consultation
3. Managing patient harm (physical and psychological) as a result of delays within Orthodontic Services, linked to a corporate risk with score of 20
4. Infrastructure, especially digital, and estate restrictions on expanding orthodontic consultant workforce
5. Lack of a sustainable service model to address current disjointed care across primary and secondary care
6. Concerns about the ability of BCUHB to effectively support the North West Cleft Lip and Palate (Alder Hey) outreach service

Common improvement areas	Key issue for this specialty
Service model and configuration	Yes
Workforce	Yes
Quality / Standards / Practice	Yes
Patient Safety / Experience	Yes
Infrastructure – Estates / Digital	Yes

Summary of progress

1. Collaborative Consultant body working across the three IHCs identified by GIRFT team as good practice.
2. Agreement to form a North Wales Group, an orthodontic network, to support the development and delivery of a sustainable service plan
3. Diversification of orthodontic workforce - training of dental nurse as an orthodontic therapist, one of two we now have in BCUHB.
4. Increasing options for Dentists with Special Interest (DwSI) with treatment plans and follow up service advice overseen by the Orthodontic Consultants.
5. Recent recruitment campaign for a Consultant post with wider range of incentives for candidates.
6. Reduction in waiting list from Jan 25-July 25: s1 52+ (974 to 599); 104+ (591 to 299); 156+ (277 to 127)
7. Updating General Dental Services referral guidelines e.g. stipulating inclusion of photos
8. Creation of an outsourcing process for a cohort of orthodontic patients to reduce overall waiting times – awaiting identification of outsource provider to support
9. Development of a business case for a CBCT with training for consultant orthodontists to be request.

Orthodontics – High level plan

Theme	Improvements	Delivery dates	Delivery confidence
Service model & configuration	SMC1. Consider consolidation of the orthodontic, restorative dentistry and oral maxillo-facial surgery services to become a single networked single service with one operational manager and budget working across the three IHCs	Q4 2025/26	
	SMC2. As part of the 'Foundations for the Future' programme identify the options for the creation of a pan BCU sustainable service operational model	Q4 2025/26	
	SMC3. Introduce a functioning and sustainable multi-disciplinary team (orthodontic, restorative, paediatric, oral surgery, orthognathic and cleft). Increase and encourage the integration and networking between primary care GDS, CDS and secondary care.	Q4 2026/27	
	SMC4. Establish the North Wales Orthodontic network group to oversee the detailed improvement plan for a sustainable service model	Q2 2025/26	
Workforce	W1. Support the recruitment of funded consultant vacancies and initiate a strategic & operational workforce planning review to address recruitment, retention and utilization of alternative and emergent roles.	Q3 2025/26	
Quality/standard/ practice	QSP1. Create a detailed improvement plan including implementation and monitoring of GIRFT recommendations to address the medium and long-term challenges	Q3 2025/26	
Patient Safety/Experience	PSE1. Continue to review the corporate risk for the service, seek additional mitigation measures, learn and act on patient experience to address harm to patients whilst waiting for appointments and treatment	Q4 2025/26	

Plastics - Overview

Key Issues

1. Lack of timely access – high volume of new and follow-up patients waiting over target time
2. Inequity - no theatre provision in Central with patients having to travel to England for treatment; inconsistency in waiting list management with West & Central lists held and reported by BCUHB, East held and reported by Mersey & West Lancs NHS Trust (MWL)
3. Poor infrastructure and operational support in north Wales – inadequate equipment, overbooked clinics, poor patient throughput and no service level agreement

Common improvement areas	Key issue for this specialty
Service model and configuration	Yes
Workforce	No
Quality / Standards / Practice	No
Patient Safety / Experience	Yes
Infrastructure – Estates / Digital	Yes

Summary of progress

1. Timely access - significant reduction in waiting lists due to validation and waiting list initiative (WLI) activity:
   - Total new waiting list reduced from 1014 in Oct 2023 to 380 in June 2025
   - Patients waiting over 104 weeks reduced from 251 in Oct 2023 to 0 in June 2025
   - Patients waiting over 52 weeks for 1st appointment reduced from 214 in Oct 2023 to 47 in June 2025
   - Total un-booked overdue follow-up appointments reduced from 375 (72% of FUWL) in Oct 2023 to 72 (23% of FUWL) in June 2025
2. Inequity - Appropriate accommodation identified in Connah's Quay Medical Centre for additional plastics outreach clinics and theatre provision closer to home for north Wales population; costs shared with MWL; awaiting their contract proposal to JCC for increased activity.
3. Infrastructure and operational support – new agreed clinic templates, theatre equipment and full IT access in place since 2024, increase in theatre throughput from 3 to 4 per list in West from April 2025. 2024/25 SLA agreed – negotiations ongoing re 2025/26 (travel issue outstanding with JCC)

Plastics – High level plan

Theme	Improvements	Delivery dates	Delivery confidence
Quality / standard / practice	QSP1: Review of commissioning arrangements when they change in 2025 (actual date to be confirmed) - it is important to note providers will continue the outreach service irrespective of the commissioning arrangements, linked to IMTP 4J.d.1	Q4 2025/26	
	QSP2: Handover of waiting list management to MWL following agreed threshold as limited demand and capacity information is currently held by BCUHB (Central and West waiting lists are still held by BCUHB even though MWL are the service provider), linked to IMTP 4J.d.2	Q4 2025/26	
Service Model and configuration	SMC1: Develop the proposal to open Connah's Quay as a joint facility with dermatology to provide increased clinic and operating space and capacity including dressing clinics, linked to IMTP 4J.d.3	Q3 2025/26	
Infrastructure – Estates / Digital	IED1: Generate a business case for the expansion of 'My Medical Record' to manage skin cancer follow-up patients. My Medical Record gives access to patients own online health record containing jointly managed information between the patient and the service, linked to IMTP 4J.d.6	Q4 2025/26	
Patient safety and experience	PSE1: Act based on the insights gathered, delivering patient experience improvements such as delivering care closer to home where feasible, through integrated working and pathway development with primary care, linked to IMTP 4J.d.7	Q3 2025/26	

Oncology - Overview

Key Issues

1. Fragile senior medical staffing due to high volume of locums and low number of substantive due to inability to recruit – North Wales has one of the lowest ratio of consultants per 100000 older (>50yrs) population in UK (RCR census 2024). National shortage of Clinical Oncologists – 15% shortfall in Wales and UK (39% in North Wales) in Oct 2024. Locums can leave with very little notice, do not take part in on-call rotas and provide limited-service improvement opportunities.
2. Increasing demand for oncology treatments with increasing numbers of NICE/AWMSG approvals of regimens (predicted 6%-8% increase in demand every year for oncology)
3. Increasing complexity of treatments including toxicity
4. Increasing number of patients remaining under Oncology review – cancer has become a chronic condition

Common improvement areas	Key issue for this specialty
Service model and configuration	Yes
Workforce	Yes
Quality / Standards / Practice /	No
Patient Safety / Experience	No
Infrastructure – Estates / Digital	No

Summary of progress

1. Appointed 2x permanent Consultant Medical Oncologists, appointed 1x fixed term Consultant Clinical Oncologist. Participating in international recruitment of specialist clinical oncology doctors with NWSSP. 4x specialist trainees commencing in 25/26 filling long term gaps (2x clinical, 2x medical). Careers open day planned in September to promote various career options in NWCTC (North Wales Cancer Treatment Centre) to year 10 and above pupils as well as nursing/radiotherapy students – as part of the 25-year anniversary of the unit celebrations.
2. Completed switch of patients receiving Nivolumab IV to subcutaneous releasing capacity for day units and improving patient experience.
3. Expansion of Immunotherapy Toxicity service with clinics taking place in all 3 cancer units to support management of toxicity.
4. Initial meeting to develop clinical strategy completed and further meetings to be arranged – away day in September arranged for Senior Medical input into strategy as well as improving engagement and support. Supports delivery of future improvements, innovation and recruitment opportunities.
5. Approval of £10M by Welsh Government to support replacement of 2x LINAC (radiotherapy) machines.
6. The Maggie's Centre is opening on 25th September at Ysbyty Glan Clwyd – the first centre in North Wales.
7. The NWCTC has been re-designated a Centre of Excellence for the research, treatment and care provided to patients with a brain tumour by the Tessa Jowell Brain Cancer Mission.

Oncology – High level plan

Theme	Improvements	Delivery dates	Delivery confidence
Service Model and Configuration	SMC1: Develop a fully integrated clinical strategy to support future demand and innovation as well as promotion of service for recruitment purposes.	Q4 25/26	
Workforce	W1: Increase the number of substantive oncology consultants to stabilize the workforce.	Q4 25/26	
	W2: Substantive recruitment to the approved establishment of multi-professional roles (e.g. nursing, pharmacy, operational) across oncology to meet current demands, improve service provision and patient safety.	Q3 25/26	
	W3: Explore opportunities for joint consultant oncologist roles with neighboring organisations with the aim to provide greater cover for the rarer tumour sites.	Q4 25/26	
Quality/Standards/ Practice	QSP1: Collaborate with the development of a single Welsh contract for Chemocare (electronic system for prescribing SACT) software to support standardisation and reduction in costs.	Q4 25/26	
	QSP2: Undertake focused harm reviews with an integrated concerns management approach, to include investigations to provide opportunities for learning and service improvement.	Q3 25/26	
Patient Safety/ Experience	PSE1: Establish SABR (Stereotactic Ablative Radiotherapy) service in North Wales commencing with lung cancers (fewer treatments needed) to reduce need for patients to travel to neighboring organisations for treatment.	Q2 25/26	
Infrastructure – Estate and Digital	IED1: Complete a business case for 2 linear accelerators to replace machines which are coming to the end of their safe working life to ensure service longevity and maintain capacity.	Q2 25/26	
	IED2: Engagement with the implementation of the Electronic Health Record to provide improved effectiveness and efficiency which will provide improved patient care and experience.	Q4 25/26	

Archwilio Cymru
Audit Wales

Tackling the Planned Care Challenges – Betsi Cadwaladr University Health Board

Date issued: May 2025

Document reference: 4664A2025

This document has been prepared for the internal use of Betsi Cadwaladr University Health Board as part of work performed/to be performed in accordance with statutory functions.

The Auditor General has a wide range of audit and related functions, including auditing the accounts of Welsh NHS bodies, and reporting to the Senedd on the economy, efficiency, and effectiveness with which those organisations have used their resources. The Auditor General undertakes his work using staff and other resources provided by the Wales Audit Office, which is a statutory board established for that purpose and to monitor and advise the Auditor General.

Audit Wales is the non-statutory collective name for the Auditor General for Wales and the Wales Audit Office, which are separate legal entities each with their own legal functions as described above. Audit Wales is not a legal entity and itself does not have any functions.

In the event of receiving a request for information to which this document may be relevant, attention is drawn to the Code of Practice issued under section 45 of the Freedom of Information Act 2000. The section 45 Code sets out the practice in the handling of requests that is expected of public authorities, including consultation with relevant third parties. In relation to this document, the Auditor General for Wales and the Wales Audit Office are relevant third parties. Any enquiries regarding disclosure or re-use of this document should be sent to Audit Wales at infoofficer@audit.wales.

We welcome correspondence and telephone calls in Welsh and English. Corresponding in Welsh will not lead to delay. Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg. Ni fydd gohebu yn Gymraeg yn arwain at oedi.

Contents

Summary report

About this report

1 This report sets out the findings of work on planned care recovery that we have undertaken at Betsi Cadwaladr University Health Board (the Health Board) to examine the progress it is making in tackling its planned care challenges and reducing its waiting list backlog. The work has been undertaken to help discharge the Auditor General's statutory duty under section 61 of the Public Audit (Wales) Act 2004 to be satisfied that the Health Board has proper arrangements in place to secure the efficient, effective, and economic use of its resources. Our work was delivered in accordance with INTOSAI[1] audit standards. This report excludes any examination of waits relating to cancer diagnosis and treatment, which are the subject of a separate examination by the Auditor General.

2 Tackling the planned care waiting list backlog is one of the biggest challenges facing the NHS in Wales. NHS waiting time targets in Wales have not been met for many years and the COVID-19 pandemic made an already challenging situation considerably worse as planned care services were initially postponed and then slowly re-started to allow the NHS to focus its attention on dealing with those seriously ill with the virus. Since the onset of the pandemic, the overall size of the NHS waiting list has grown significantly and at the end of February 2025 there were 614,150 individual patients waiting for treatment.

3 In April 2022, the Welsh Government published its Programme for Transforming and Modernising Planned Care and Reducing Waiting Lists in Wales. The programme includes £170 million recurring funding to support planned care recovery, together with an additional £15 million funding per year over four years to support planned care transformation. Welsh Government subsequently allocated a further £50 million between September 2024 and October 2024 to reduce the longest waiting times[2]. The programme includes specific targets and Ministerial priorities:

- that no one should wait longer than a year for their first outpatient appointment by the end of 2022 (**target date revised to December 2023**[3]);
- to eliminate the number of people waiting longer than two years in most specialties by March 2023 (**target date revised to March 2024**);
- people should receive diagnostic testing and reporting within eight weeks and therapy interventions within 14 weeks by Spring 2024; and

[1] INTOSAI is the International Organization of Supreme Audit Institutions

[2] Health Secretary response to latest NHS Wales performance data. The £50 million additional allocation comprised £28 million in September and £22 million in October 2024.

[3] Health Boards did not achieve the original targets for first outpatient appointment and number of people waiting longer than two years for treatment. As a result, the Welsh Government agreed to set interim targets (**in bold**, above).

- to eliminate the number of people waiting longer than one year in most specialties by Spring 2025.

4 In May 2022, the Auditor General for Wales published a commentary on "Tackling the Planned Care Backlog in Wales" which estimated that it could take up to seven years for the overall waiting list in Wales to return to pre-pandemic level. The commentary highlighted key areas for action, including:

- having strong and aligned local leadership to deliver the national vision for recovering planned care services;
- having a renewed focus on system efficiencies and new technologies;
- building and protecting planned care capacity; and
- communicating effectively with patients who are waiting for treatment and having systems in place to manage the clinical risks to those patients while they are waiting.

5 Our work has considered the progress Heath Board is making in tackling its planned care challenges and reducing its waiting list backlog, with a specific focus on:

- action that the Health Board has taken to tackle the planned care backlog;
- waiting list performance; and
- understanding and overcoming the barriers to improvement.

6 We undertook our work between October 2024 and February 2025. The methods we used are summarised in **Appendices 1 and 2**. **Appendix 3** provides some additional data analysis on planned care services and **Appendix 4** contains the Health Board's response to any recommendations arising from our work.

7 The Health Board is currently at Level 5 escalation under the NHS Wales escalation and oversight framework and it continues to rely on significant additional non-recurrent strategic funding allocation. Its financial position has a direct bearing on the affordability, sustainability and recovery of planned care services.

Key facts

£114.5m the amount of additional funding the Health Board has received from Welsh Government between 2022-23 and 2024-25 to support planned care improvement.

199,249 the overall size of the waiting list at February 2025.

103% the percentage growth in the overall waiting list between April 2019 and February 2025.

29,553 the number of patient pathways waiting more than 1 year for their first outpatient appointment at February 2025 against a national target of zero waiting. The number of 1 year waits for an outpatient appointment has increased by 22%, since April 2022.

8,304 the number of patient pathways waiting more than 2 years for treatment at February 2025 against a national target of zero waiting. The number of 2-year waits has reduced by 53% since April 2022.

62% the percentage diagnostic test waits that are within 8 weeks at February 2025 against a national target of 100%. The number of ‘over 8 weeks’ diagnostic waits has increased by 23% since April 2022.

89% the percentage of therapy waits that are within 14 weeks at February 2025 against a national target of 100%. The Health Board has achieved an 73% reduction of ‘over 14 weeks’ therapy waits since April 2022.

54,096 number waiting more than one year for treatment at February 2025 against a national target of zero for most specialties by Spring 2025. This has increased by 30% since April 2022.

Key messages

Overall conclusion

8 Overall, we found that **there are significant numbers of long patient waits indicating that the action the Health Board is taking to address this is not having the necessary overall effect. It needs to improve service efficiency, develop sustainable planned care improvements to meet growing demand, and strengthen reporting of harm that occurs as a result of a delay.**

Key findings

Action that the Health Board is taking to tackle the planned care challenge

- Whilst the Health Board has set out plans for securing short-term waiting list improvements, it has yet to sufficiently describe actions needed to secure more sustainable improvements to planned care services.
- Despite a clear structure, the Health Board's Planned Care Program Board lacks delegated decision-making authority to set direction and allocate resources. It needs to strengthen how it uses business cases to drive improvement initiatives and link these cases effectively to an agreed planned care improvement programme. Lack of continuity of senior planned care leadership has been detrimental to improvement.
- The Health Board has received a total of £114.5 million in additional Welsh Government funding. However, this has been allocated primarily towards short-term reactive solutions without investment in longer term service transformation.
- Whilst the Health Board has begun to implement the Getting It Right First Time (GIRFT[4]) recommendations, there remain opportunities to improve efficiencies, particularly in relation to improving utilisation of theatres and outpatient services to improve efficiency and productivity.
- The Health Board is making effective use of day surgery, with 83% of elective surgery performed as day case, the highest in Wales.
- The Health Board has been slow to implement the Welsh Government's Promote, Prevent and Prepare policy fully. Reporting on the incidence of harm associated with planned care waits needs to be improved.

[4] Getting It Right First Time (GIRFT) is a programme that aims to improve the quality and efficiency of hospital care.

Waiting list performance – Is the action taken resulting in improvement?

- In overall terms, the continued growing backlog of people waiting to be treated presents a substantial problem for the Health Board. The size of the waiting list has increased from 98,190 in April 2019 to 199,249 treatment pathways in February 2025.
- The Health Board has not met the recent national planned care recovery targets:
  - The number waiting over a year for their first outpatient appointment has increased from 24,265 patient pathways in April 2022 to 29,553 in February 2025.
  - The number waiting over 2 years for treatment has reduced from 17,500 patient pathways in April 2022 to 8,304 on February 2025.
  - The Health Board did not meet the target of increasing the speed of diagnostic testing and reporting to eight weeks and 14 weeks for therapy interventions by Spring 2024. In February 2025, there remained 10,067 patients waiting over 8 weeks for diagnostics and 1,565 patients waiting for therapies over 14 weeks.

Barriers to improvement

- There are a number of barriers to further planned care improvement. These include growing service demand, capacity to support service transformation and absence of clinical leadership. The Health Board recognises these challenges but has not yet developed an overarching strategy to address these. Initiatives which aim to address immediate capacity challenges are relatively new and short term in nature. Further work is required to develop sustainable and transformative solutions to ensure the Health Board does not continue to face the same or greater challenges in future.

Recommendations

9 We have set out recommendations arising from this audit in **Exhibit 1**. The Health Board's is currently developing its management response.

Exhibit 1: recommendations

Recommendations
Planning R1 Over and above the commitments signalled within its annual plans, the Health Board should develop a detailed Planned Care improvement plan. This should aim to both design and deliver sustainable planned care services in the medium to longer term and to take advantage of opportunities for further regional working. The plan should be costed, with realistic but challenging milestones within it. **(Exhibit 2)**
Demand and capacity R2 The Health Board should ensure that its demand and capacity modelling approach is consistently applied across the organisation and its specialties and used to inform short-term service capacity planning and longer-term service design. This should consider continued growth or expected changes in population demand for planned care services **(Exhibit 2).**
Programme governance and programme business cases R3 The Health Board should strengthen its Planned Care Programme Board to ensure it has the authority to set direction and deliver both transformational change and short-term capacity improvement by: 3.1 Strengthening the Programme Board's delegated authority arrangements to ensure it is the primary forum for all transformational and short-term capacity improvement funding **(Exhibit 3).** 3.2 Developing a clear planned care improvement programme for delivery, monitoring and associated accountability **(Exhibit 3).** 3.3 Improving training for planned care business case development to ensure quality of business cases and timely approval **(Exhibit 3).** 3.4 Prepare business cases earlier in the year or cyclically to align with a multi-year planned care programme to avoid implementation delays **(Exhibit 3).**

Recommendations

Programme Board clinical leadership

R4 The Health Board should review and strengthen its Planned Care Programme Board leadership arrangements by:

- 4.1 Developing a clear remit, authority and accountability for the role of the Clinical Director of Planned Care **(Exhibit 3).**
- 4.2 Appointing clinical leads for all specialties to the Programme Board to support the development of integrated speciality plans **(Exhibit 3).**

Risk management

R5 The Health Board should review and update the Planned Care risk register to ensure controls are effective and that the overall risk levels start to reduce in the next 6 months **(Exhibit 3).**

Monitoring impact of additional funding

R6 The Health Board should strengthen its monitoring of the use and impact of the additional Welsh Government planned care funding **(Paragraph 24).**

Recommendations

Efficiency and productivity

R7 Our work has identified there are opportunities for further efficiency and productivity improvements. The Health Board should:

- 7.1 Ensure there is clear monitoring and reporting on the completion of recommendations arising from the Getting it Right First Time (GIRFT) reviews **(Exhibit 6).**
- 7.2 Develop enhanced measures to reduce the number of short notice surgical cancellations **(Exhibit 6).**
- 7.3 Improve the recording accuracy of surgical cancellation reasons to enable the Health Board to understand and address the root cause of surgical cancellations **(Exhibit 6).**
- 7.4 Develop and implement a plan to improve theatre utilisation rates across the Health Board, with realistic improvement trajectories, with the aim of achieving the GIRFT recommendation of 85% **(Exhibit 6).**
- 7.5 Develop and rollout approaches to increase the use of "virtual" outpatient appointments, where clinically appropriate **(Exhibit 6).**
- 7.6 Develop job planning policy and guidance **(Exhibit 6).**
- 7.7 Ensure job plans are completed annually, utilising team-based job planning where it is appropriate to align consultant capacity to meet service demand **(Exhibit 6).**
- 7.8 Roll out pooled waiting lists across the Health Board particularly focusing on challenged services to ensure it treats its patients in turn **(Exhibit 6).**

Promote, Prevent and Prepare for Planned Care policy

R8 The Health Board complete the establishment of the 'Promote, Prevent and Prepare (3P's) for Planned Care' contact centre and ensure it covers all specialties **(Exhibit 7)**.

Recommendations

Risk of harm

R9 In order to strengthen its arrangements for managing the clinical risks associated with long waits, the Health Board should:

- 9.1 Develop and implement a consistent methodology for assessing the risk of harm to patients caused by long waits across specialties **(Exhibit 7).**
- 9.2 Develop a routine report to be presented at the Quality and Safety Committee that effectively reports risks and actual incidents of harm resulting from delays in access to treatment **(Exhibit 7).**
- 9.3 Develop and implement clinical plans for all challenged services to ensure higher risk patients are prioritised **(Exhibit 7).**

Detailed report

Action that the Health Board is taking to tackle the planned care challenge

10 We considered whether the Health Board is effectively planning and delivering planned care improvement, is appropriately utilising and monitoring the impact of Welsh Government funding and is supporting patients who are at most risk of harm as a result of a delay.

11 We found that **the Health Board's Annual Delivery Plan describes actions for planned care, however these are short-term in nature and lack detail on how successful delivery will be measured. The absence of a dedicated and costed, longer-term plan for planned care recovery means the Health Board has not determined the action needed to deliver more sustainable improvements to planned care services**.

Planned care improvement plans and the programme to deliver them

12 It is important that the Health Board has a clear plan for tackling the waiting list backlog and delivering sustainable planned care improvement. We considered whether the Health Board has:

- clear, realistic and costed improvement plans for planned care that align with the national recovery plan ambitions and Ministerial priorities; and
- appropriate programme management arrangements to support planned care improvement, supported by clear accountabilities and clinical leadership and reporting to committees and the Board.

Planned care improvement plans

13 We found that **the Health Board has appropriately set out its short-term planned care improvement initiatives in its 2025-28 Integrated Medium-Term Plan. However, there is a notable absence of a dedicated short and longer-term plan that supports waiting list recovery and the development of efficient and sustainable planned care services. This is likely to affect the pace of improvement.**

14 The findings that underpin this conclusion are summarised in **Exhibit 2**.

Exhibit 2: the Health Board's approach to planned care improvement planning

Audit question	Yes / No / Partially	Comments
Has the Health Board developed a clear plan to support planned care recovery?	**No**	The Health Board's Annual Plan 2024-25 sets out the priorities for planned care. However, this is overly short-term focussed and lacks the necessary detail on longer-term sustainable planned care services. The Health Board has included planned care improvement requirements for 2025 onwards in its 2025-2028 three-year plan. This sets out six planned care workstreams that focus on short-term improvements and some limited pathway improvements. This includes workstreams on referral management, waiting list management, and outpatient, pre-operative and theatre efficiencies, and development of specialty level improvement plans. At present however, there is no stand-alone planned care recovery plan aligned to a clinical strategy. As a result, there is insufficient planning detail to address growing demand and reshaping services so that they are financially affordable **(Recommendation 1).**
Is the approach for delivering planned care improvement costed and affordable?	**No**	The Annual Plan 2024-25 provides a financial plan for the organisation and sets out the Health Board's over-arching financial position. However, there is no costed planned care plan or route-map to financially sustainable services. This creates a lack of transparency on the affordability of current planned care service delivery **(Recommendation 1).** In the absence of a costed planned care improvement plan, the Health Board relies on short-term business cases which are of varying quality and additional Welsh Government funding.
Are the Health Board's planned care priorities appropriately aligned to the national planned care recovery plan and Ministerial priorities?	**Yes**	The Annual Plan 2024-25 and the more recently developed 2025-2028 three year plan are both sufficiently aligned to the ministerial priorities and the national 'transforming and modernising planned care and reducing NHS waiting lists' recovery plan.

Audit question	Yes / No / Partially	Comments
Has the Health Board set out realistic yet challenging targets and milestones for planned care?	**Partially**	The Health Board has developed improvement trajectories and system indicators aligned to Welsh Government escalation requirements. The improvement trajectories focus on eliminating the number of patients waiting more than 104 weeks. While the Health Board has made ongoing progress by increasing capacity, it is unlikely to meet this target. The Health Board's targets for addressing the growing number of patients waiting more one year are not credible based on growing demand and deteriorating performance.
Are the Health Board's planned care priorities informed by analysis and modelling of capacity and demand?	**Partially**	The Health Board's approach to capacity and demand modelling has focused on improving the quality of waiting list data to assess current and future demand. This analysis has been undertaken by the data performance and planning workstream but has not been rolled out across the organisation and all specialties. Further work is needed to understand core capacity and plan for additional capacity to meet immediate and longer-term requirements. **(Recommendation 2)**
Has the Health Board set out how it will transform its clinical service models to make them more sustainable in the future?	**No**	The Health Board has not set out how it will transform its clinical service models to make them more sustainable in the future. As outlined in its 2025-28 three-year plan, the Health Board intends to develop clinical services in line with its 10-year strategy and clinical services plan. This work will be commencing in 2026.
Are plans for planned care improvements aligned to other key corporate plans such as the IMTP and plans for workforce, digital and estates?	**Partially**	The 2025-28 three-year plan outlines some limited digital, workforce and estates initiatives that will help improve some aspects of planned care service delivery, such as the new orthopaedic facility in Llandudno. However, the plan does not contain the level of detail needed for wider enabling services to support sustainable planned care service development.

Source: Audit Wales fieldwork

Planned care programme delivery and oversight

15 We found that **the current planned care programme arrangements are not effective in delivering planned care improvements. The Programme Board lacks authority and direction and there is insufficient clinical leadership and engagement. The absence of a standalone plan for planned care recovery and transformation compounds the issue**.

16 The findings that have led us to this conclusion are summarised in **Exhibit 3**.

Exhibit 3: the Health Board's approach to the programme management of planned care improvement

Audit question	Yes / No / Partially	Comments
Does the Health Board have a clear and appropriately resourced improvement programme to support planned care recovery?	**No**	The Health Board's Planned Care Programme Board has a clear structure. However, over the last year, the arrangements have lacked sufficient delegated decision-making authority to set direction and allocate resources. It is working in an environment where funding decisions can by-pass the Programme Board, with funding directly provided to the Health Board's Integrated Healthcare Communities. Consequently, the Programme Board has served as a discussion forum without being sufficiently able to provide leadership and direction needed to facilitate change **(Recommendation 3.1).** The Programme Board has lacked clarity on its programme of work due to the absence of an agreed overarching plan. Consequently, the draft terms of reference have been developed in isolation, and do not provide clarity of purpose. Members have raised issues regarding unclear reporting structures. There is no forward work programme to provide adequate assurance on overall progress delivery beyond updates from individual work streams. (**Recommendation 3.2).** Over the last year, the Programme Board has presented several business cases to the Executive team for approval. These cases have varied in quality, resulting in some not being approved. As some of these business cases for new initiatives are developed during the year, the lack of approval can delay implementation, impacting the timeliness of improvement. The Health Board needs to both: • strengthen its training approach for the development of planned care business cases (**Recommendation 3.3**); • prepare business cases much earlier in the year, or ideally on an ongoing cycle linked to a multi-year planned care programme (**Recommendation 3.4**).

Audit question	Yes / No / Partially	Comments
Is planned care recovery supported by clearly defined operational accountabilities and effective clinical leadership?	**No**	There has been a lack of continuity of senior leadership for planned care over the last year. This has seen responsibility move from the Integrated Healthcare Community Director (East) to the Executive Medical Director, then to the Executive Director of Finance in summer of 2024 then to the newly appointed Chief Operating Officer. In addition, in March 2025, the Health Board's Assistant Director for planned care left. There is an urgent need to review Planned Care Programme Board leadership arrangements (**Recommendation 4**). The Heath Board appointed a Clinical Director for Planned Care in October 2024, however, there is limited clarity on this role or remit **(Recommendation 4.1).** Our work also suggests that given the longstanding absence of clinical strategy, that there is a real need for substantive speciality level clinical leads. These leads need to build consensus through the development of integrated specialty plans and drive efficient and affordable pathway changes to sustainably meet growing demand (**Recommendation 4.2**).
Has the Health Board undertaken a risk assessment to understand the issues that could prevent delivery of planned care improvement aims?	**Partially**	The planned care workstreams identify and report risks to the Programme Board, through a risk register. Higher rated risks are effectively escalated to the Executive Team to approve actions to address the risks. The Health Board also identifies planned care risks in the corporate risk register. However, the risk rating has not changed in the last twelve months and remains above risk appetite indicating current controls are not effective. The Health Board needs to ensure that the actions it is taking to address risks are effectively evaluated and monitored and appropriately challenge the impact of actions taken **(Recommendation 5).**
Is performance on planned care recovery routinely reported to the appropriate committee/s and to the board?	**Partially**	Planned care performance is reported to the Board and Performance, Finance and Information Governance Committee. However, with the significant increase in demand and the deterioration in performance, oversight and challenge will need to be strengthened. This will ensure better outcomes and allow for a thorough evaluation of the measures implemented to improve performance.

Source: Audit Wales fieldwork

Utilisation of additional Welsh Government funding

17 We have looked at the Health Board's use of the additional planned care allocation that it has received from the Welsh Government. This section considers:

- the overall amount of additional planned care funding the Health Board has received from Welsh Government over the last three years;
- how the Health Board spent the money; and
- the Health Board's arrangements for overseeing how it has spent additional funding.

Use of additional funding

18 We found that **since 2022-23 the Health Board has received a total of £114.5 million in additional Welsh Government funding. The Health Board is directing its additional Welsh Government funding towards tackling extremely long waits. There is limited use of the funding to support specialty level service transformation**.

19 To support planned care recovery over and above existing funding, the Health Board received a total additional Welsh Government allocation of £114.5 million between 2022-23 and 2024-25 (**Exhibit 4**).

Exhibit 4: the Welsh Government's allocation to the Health Board to support planned care improvement

Financial year	Annual allocation (£m)
2022-23	38.4
2023-24	34.3
2024-25	34.5
Additional in-year Welsh Government allocation	7.3[5]
Total allocated	**114.5**

Source: Health Board financial self-assessment returns

20 The Health Board can appropriately account for the Welsh Government planned care funding it has received. We reviewed the use of the funding in 2023-24 in greater detail (**Exhibit 5**). During that year, the Health Board predominantly used the funding on short-term initiatives rather than service transformation to enable lasting improvement. It used £18.2 million or 64% of total funding allocation on insourcing and outsourcing activity to increase capacity in the short-term.

[5] In December 2024, Welsh Government allocated a further £7.3 million in non-recurrent funding to reduce some of the longest planned care waits in the Health Board.

21 The Health Board continued to adopt the short-term funding model throughout 2024-25. While this will have contributed to limiting further growth in very long waits, it is not providing the sustainable solution needed.

Exhibit 5: use of the 2023-24 Welsh Government additional financial allocation, Betsi Cadwaladr University Health Board

	Performance improvement funding (£m)	Transformation fund (£m)
Mixed specialty insourcing (general surgery, ENT, urology, minor operations and pre-operative assessment)	1.5	
Dermatology contract extension	0.3	
Orthopaedics outsourcing	2.7	
Ophthalmology outsourcing	2.3	
Radiology recovery plan	4.6	
Endoscopy insourcing	5.9	
Planned care corporate capacity	0.7	
Stage 4 efficiencies	0.6	
Waiting list initiatives	1.6	3.8
Regional treatment centre closure	0.2	
Orthopaedic planned care sessions	0.5	
Validation and booking	0.4	
Insourcing internal support costs	1.2	
Additional activity - primary & secondary care drugs		3.2
Abergele high volume low complexity orthopaedics		0.2
Funding as a commissioner[6]	4.5	
Total allocated	**27.0**	**7.2**

Source: Health Board self-assessment returns

[6] This includes specialised services commissioning of £2.85 million and commissioning £1.6 million of planned care services from NHS England.

Monitoring impact of additional funding

22 We have considered the extent that Health Board oversees the use of the Welsh Government planned care financial allocations. We found that the **Health Board has reasonable arrangements to oversee the use of the additional Welsh Government planned care financial allocation, we have not seen evidence of monitoring its expected impact**.

23 The Planned Care Programme Board receives a financial report which provides a breakdown of planned spend for individual schemes from the sustainability fund, including any revised forecasts. The report indicates where planned spend is subject to further business case approval.

24 The Health Board also provides reports on proposed allocation of planned care funding at the Performance Finance and Information Governance Committee. While this reporting includes cost estimates, we have not seen any evidence of a more detailed monitoring whether the proposed investments have delivered the expected improvements **(Recommendation 6).**

Operational management of planned care

25 Alongside the well-planned use of additional funding, health boards' ability to secure meaningful and sustainable planned care improvements will be dependent on them optimising their routine operational arrangements for planned care. In this section we consider the actions the Health Board is taking:

- to maximise its use of existing resources; and
- to protect and increase its planned care capacity.

Maximising the use of existing resources

26 We have examined some opportunities that exist for the Health Board to improve efficiency and productivity, and the actions it is taking to maximise the use of its existing resources. We found **that the Health Board is starting to implement the Getting it Right First Time recommendations and while it has been effective in its use of day case surgery, there remains significant opportunity to improve efficiency.**

27 **Exhibit 6** identifies efficiency and productivity opportunities that could help maximise the use of existing resources within the Health Board to support planned care improvements.

Exhibit 6: efficiency and productivity opportunities

Opportunity area	Audit findings
Responding to Getting it Right First time (GIRFT) reports	The Health Board have received reviews on general surgery, ophthalmology, orthopaedics, urology, gynaecology and operating theatre reviews. It has made variable progress in responding to GIRFT reviews, however the pace of delivery needs to improve particularly in relation to ophthalmology and orthopaedics. Whilst GIRFT was a specific workstream reporting into the Planned Care Programme Board, this has now ceased. Responsibility for implementing the recommendations is delegated to individual services. Consequently, there is now a loss of central reporting and assurance to the Planned Care Programme Board on progress in implementing GIRFT recommendations (**Recommendation 7.1**).
Arrangements for measuring and managing productivity of services	The Health Board has established an Elective Optimisation Programme. This oversees key performance metrics and a number of projects to review and monitor performance and standardise policies and procedures. Task and finish groups have been established with clear aims and performance measures these include: • Theatre dashboard – to monitor theatre utilisation including late starts and early finishes, high flow lists[7] and surgical cancellations. • Policies and procedures – to review policies, standardise and implement best practice across to the Health Board. • Reviewing all sub-speciality pathways to ensure standardised way of working. • Reviewing demand against current capacity to meet future demand. Our analysis of efficiency data below and in **Appendix 3** indicates there remain significant opportunities for improvement in efficiency.

[7] Delivering High Flow Lists - Getting it Right First Time Guidance for Health Bodies

Opportunity area	Audit findings
Reducing the number of cancelled operations	The Health Board, through its Elective Optimisation Programme has begun to scrutinise the high volume of surgical cancellations. **Exhibit 20** shows the total number of cancellations almost reached 4,700 for the 12-month period to February 2025 **(Recommendation 7.2)**. This is the highest of all Welsh health boards. **Exhibits 21** shows the cancellation reasons with "other" being the highest category recorded. This approach to recording cancellations does not assist the Health Board in understanding and addressing the underlying causes of short-term cancellations. The Health Board should prioritise accuracy in reporting to ensure the actions it plans to take are effective and resources allocated appropriately. **(Recommendation 7.3)**
Improving operating theatre utilisation	Whilst the Health Board has strengthened its arrangements for monitoring theatre utilisation, these are yet to improve performance. The Elective Optimisation Programme group is responsible for overseeing theatre utilisation through monitoring of the Theatre Dashboard metrics. The GIRFT target for theatre utilisation stands at 85%. The Health Board's integrated performance report indicates that monthly performance varies between 74% and 67% in the last twelve months with no meaningful improvement. Key contributors affecting theatre utilisation are late and early finishes which have remained significantly above GIRFT targets. **(Recommendation 7.4)**
Making use of "virtual" outpatient appointments	Virtual outpatient appointments can have a positive impact in reducing the need for travel and the risk of healthcare acquired infections. The Health Board recognises the variance in take up and engagement across services post-Covid and the risk of not being able to meet the target of increasing the volume of virtual appointments. **Exhibit 19** shows that virtual appointments are not well adopted by the Health Board, currently the lowest in Wales at 12.2% of all outpatient appointments in the 12-month period to February 2025. **(Recommendation 7.5)**

Opportunity area	Audit findings
Reducing non-attendance at outpatient appointments	The Health Board is working to reduce non-attendance at outpatient appointments. The Health Board introduced its Patient Access to Planned Care Policy in January 2025. This sets out implications for non-attendance and policy exceptions. Weekly reporting and escalation to Access Meetings ensures oversight of "Did Not Attend" (DNA) rates. The Health Board is developing standardised operating procedures (SOPs) for the management, monitoring and reporting of DNAs supported by a move to a centralised management of booking services. **Exhibit 18** shows some recent improvement in outpatient "did not attend" rates to around 5.5% of total outpatient clinic activity. This equates to around 38,400 lost patient appointments in the most recent 12-month period to February 2025 representing a lost opportunity cost of around £5.8 million.
Making more use of day case surgery	The Health Board is performing effectively in its use of day case surgery. **Exhibit 22** indicates that the 83% of the Health Board's elective surgery is day case and is positively the highest in Wales.
Effective consultant job-planning	The Health Board does not have effective consultant job-planning arrangements. At the time of our review there was no agreed Job planning policy in place **(Recommendation 7.6**). A recent internal audit report in January 2025 indicated compliance with Welsh Government requirements[8] for annual job plan review is at 66% against a target of 90%. **(Recommendation 7.7).**
Pooled lists within a Health Board speciality to ensure it treats its patients in turn	There is limited evidence to demonstrate the use of pooled lists by the Health Board, noting some progress in dermatology. The Health Board has identified that it needs to fully roll out the Welsh Admin Portal to enable it to effectively manage and pool waiting lists across Integrated Healthcare Communities. **(Recommendation 7.8).**

Source: Audit Wales fieldwork including analysis of NHS Wales data and Health Board self-assessment and data returns

[8] National consultant contract in Wales

Protecting and increasing planned care capacity

28 We examined the actions that the Health Board is taking to protect planned care capacity by separating out elective and emergency activity. We also looked at the actions the Health Board is taking to increase its planned care capacity.

29 We found that **the Health Board is taking measures to protect its elective capacity, but it needs to do more. Whilst it has secured additional capacity through insourcing, outsourcing and waiting list initiatives, these measures are unsustainable in the longer term.**

30 The Health Board has had some success protecting planned care capacity from wider service pressures in a small number of areas. This is particularly notable where services are physically separated from the major hospital sites. This includes orthopaedics and ophthalmology services in Abergele Hospital and surgical services in Llandudno General Hospital. As highlighted previously, the reasonably high level of day-case surgery also helps to protect planned care services from wider unscheduled care and medical pressures. Nevertheless, short-term surgical cancellation data indicates that the Health Board cancels operations because of unscheduled care pressures and wider capacity issues in hospitals.

31 To further protect services, the Health Board is planning a new elective orthopaedic hub at Llandudno General Hospital. The aim of this initiative is to reduce pressure on planned care services from unscheduled emergency care and reduce waiting times for this challenged service. The Health Board has secured £29.4 million additional Welsh Government capital funding in November 2023. While work is progressing on this facility, it is delayed and the original ambition to open in early 2025 has not been met. It is now unlikely that this will be achieved by the end of 2025.

32 The Health Board is insourcing and outsourcing services as a means to increase planned care capacity to help meet its short-term needs. In 2023-24, the Health Board spent £6.8 million on insourcing and outsourcing contracts for six key specialties, primarily for orthopaedics and ophthalmology with a further £5.9 million allocated to endoscopy diagnostics and £4.6 million on radiology recovery. The Health Board allocated £3.8 million to transform planned care services however it is not clear which initiatives were implemented from this additional funding. The Health Board continues to utilise premium weekend working to increase capacity in the short-term. This is neither financially sustainable nor is it an effective means of improving efficiency and risks reducing staff resilience.

Managing clinical risk and harm associated with long planned care waits

33 Long patient waits increases the risk of preventable irreversible harm. Patients' health may deteriorate while waiting, they may be waiting in pain and with anxiety and uncertainty not knowing when they will finally receive treatment. They may also not be able to work or support or care for others while they are waiting. We considered whether the Health Board has sound arrangements to:

- identify, manage, and report on clinical risk and harm associated with long waits; and
- effectively communicating with patients who are on a waiting list and to manage potential inequalities in access to care.

34 We found that **the Health Board is starting to take action to implement the Welsh Government's Promote, Prevent and Prepare policy, but is yet to be fully rolled out across all specialties. Overall engagement in the implementation of the policy needs to increase with strengthened reporting on actual harm resulting from delays.**

35 The findings which have led us to this conclusion are summarised in **Exhibit 7**.

Exhibit 7: the Health Board's approach to managing clinical risks and communicating with patients on waiting lists

Audit question	Yes / No / Partially	Comments
Has the Health Board implemented the first phase of the Welsh Government's Promote, Prevent and Prepare for Planned Care policy[9]?	**Partially**	The Health Board has been slow to implement the first phase of Welsh Government's Promote, Prevent and Prepare policy (3Ps). Its "Self-Care While You Prepare" service is currently only available to patients in four specialties: general surgery, orthopaedics, ophthalmology and dermatology. The Health Board has experienced delays in recruiting clinical and administrative staff to effectively meet demand and manage risk of harm resulting from delays. The Health Board needs to complete its recruitment and ensure the service covers all specialties **(Recommendation 8).**

[9] Promote, Prevent and Prepare for Planned care policy to ensure that support and information is easily accessible to those waiting for appointments and interventions

Audit question	Yes / No / Partially	Comments
Is the Health Board assessing the risk to patients waiting the longest?	**Partially**	The Health Board uses the DATIX system to record clinical risk resulting from a delay in treatment. However, there is no consistent methodology throughout specialties to assess risk and inform reporting on the risk of harm or instances of recorded harm **(Recommendation 9.1)**.
Is the Health Board capturing and reporting evidence of harm resulting from waiting list delays and is reporting on it to the Quality and Safety Committee?	**No**	We found insufficient arrangements for routinely reporting clinical risks associated with waiting list delays to the Board and its committees. Despite the largest waiting list and some of the longest waits in Wales, there have been no reports to the Quality, Safety and Experience Committee regarding patient harm as a result of delayed treatment **(Recommendation 9.2).**
Is the Health Board effectively balancing the tension between eliminating long waits and managing clinical risks in its approach to prioritising patients?	**No**	The Health Board's primary focus is eliminating long waiting lists. The Health Board should ensure the development of clinical plans for all challenged services to ensure higher risk patients are prioritised appropriately **(Recommendation 9.3)**
Does the Health Board monitor and record how many patients are leaving planned care waiting lists in favour of private treatment?	**No**	The Health Board does not have a mechanism for monitoring and recording the number of patients leaving planned care waiting lists in favour of private treatment.

Source: Audit Wales fieldwork

Waiting list performance – Is the action taken resulting in improvement?

36 We analysed current 'Referral to Treatment'[10] waiting list performance and trends to determine whether the Health Board is:

- reducing the overall levels of waits; and
- meeting Ministerial priorities and Welsh Government national targets.

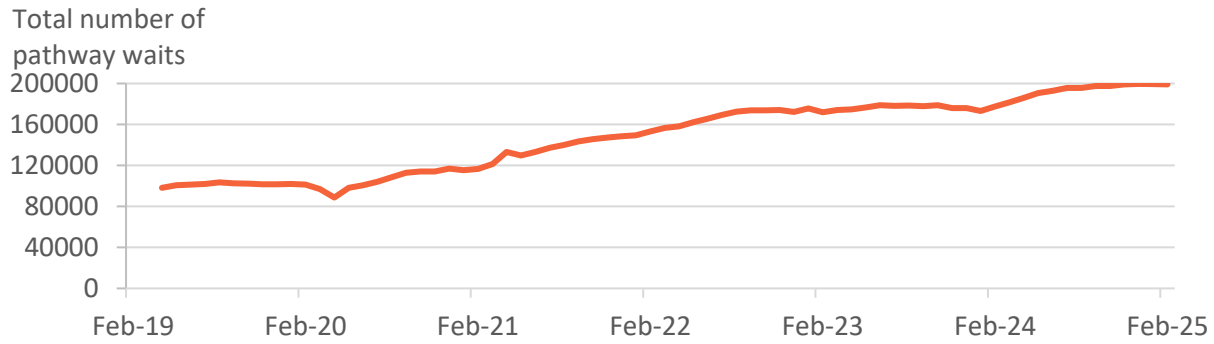
37 We found that **the Health Board has increasing numbers of waits and at the same time is not meeting Welsh Government performance targets. The growing number numbers of patients waiting over a year for treatment is of significant concern**.

The scale of the waiting list

38 Across Wales, the scale and extent of waits substantially increased following the Covid-19 pandemic. We have looked at these changes in terms of the overall size of the waiting list. We have also considered both the volume of waits for diagnostics and therapy services and trends in referral rates. We found that **the continued growing backlog of people waiting to be treated presents an increasing and significant challenge for the Health Board. There are now nearly 200,000 open treatment pathways[11].**

39 **Exhibit 8** shows the overall trend of planned care waits for the Health Board since April 2019. This shows an increase in the size of the waiting list from 98,190 in April 2019 to 199,249 treatment pathways in February 2025. The action that the Health Board is taking to reduce the overall numbers of people waiting is not resulting in sufficient impact.

Exhibit 8: Planned care waiting list size, Betsi Cadwaladr University Health Board

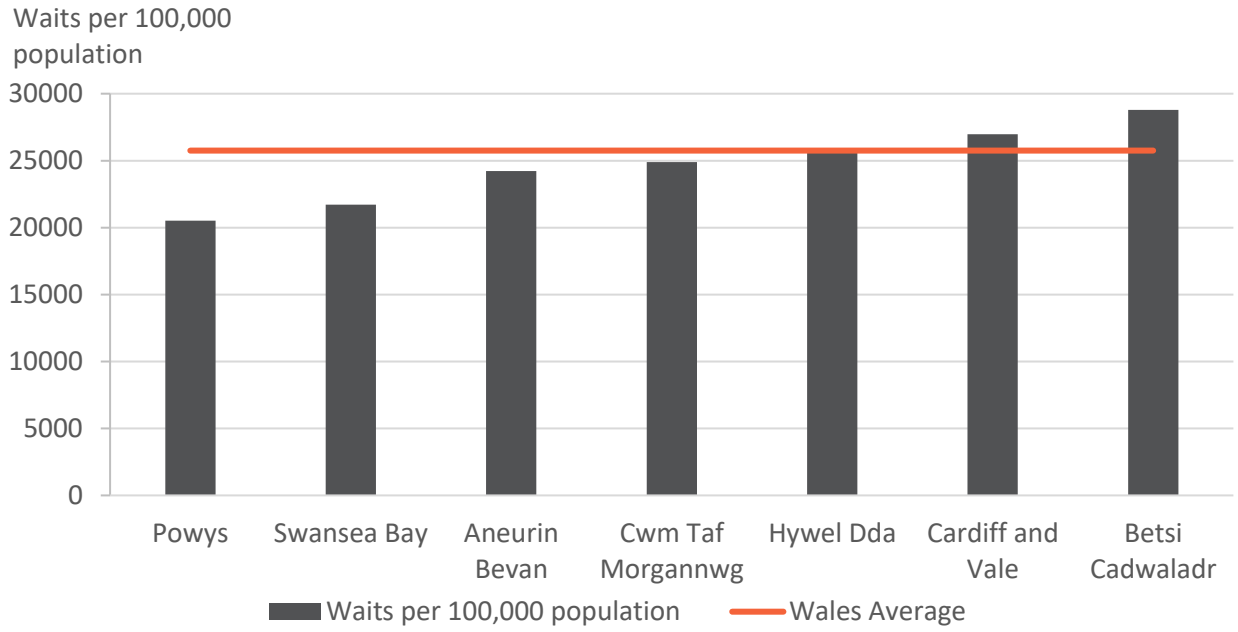


Source: Welsh Government, Stats Wales

[10] Referral to Treatment is how the NHS records the timeliness of planned care. It starts when a Health Board receives a referral and finishes when it has treated the patient. During that patient pathway, the NHS records distinct stages, including new outpatient appointment, diagnostic, follow up appointment or therapeutic intervention and treatment.

40 **Exhibit 9** provides a comparative picture of the volume of waits across Wales. It shows that the Health Board has a higher proportion of waits compared with other health boards in Wales.

Exhibit 9: Waits per 100,000 population, by health board of residence, February 2025



Source: Welsh Government, Stats Wales. Note: Powys data is for December 2024.

Performance against national targets/priorities

41 We looked at the progress that the Health Board is making against the Welsh Government's aims[12]. These are:

- No one waiting longer than a year for their first outpatient appointment by the end of 2022 (**target date revised to December 2023**[13]).
- Eliminate the number of people waiting longer than two years in most specialties by March 2023 (**target date revised to March 2024**[6]).
- Increase the speed of diagnostic testing and reporting to eight weeks and 14 weeks for therapy interventions by Spring 2024.
- Eliminate the number of people waiting longer than one year in most specialties by Spring 2025.

[12] We have not included the Welsh Government performance on Cancer services as this is outside the scope of this review.

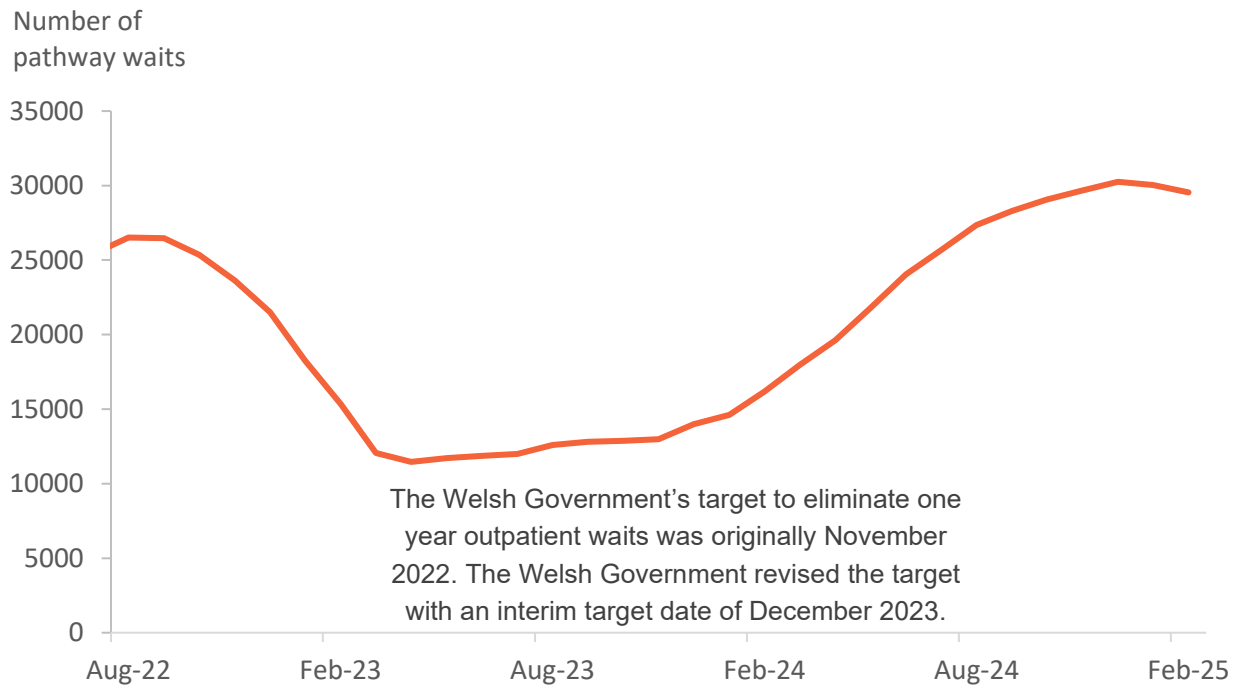
[13] Health boards did not meet the original targets for first outpatient appointment and number of people waiting longer than two years. As a result, the Welsh Government agreed to set interim targets (**in bold**, above).

42 We found that **the Health Board did not meet the Welsh Government's targets and despite making reasonably good progress initially performance has recently deteriorated.**

No one waiting longer than a year for their first outpatient appointment

43 **Exhibit 10** shows Health Board waiting list performance for first (new) outpatient appointments. The Health Board failed to meet the revised December 2023 Welsh Government target to ensure no one waited more than a year for their new outpatient appointments. While initially improving, the Health Board did not achieve the Welsh Government's target to eliminate outpatient waits that are over a year. Performance substantially deteriorated during 2023 and 2024, and it is only recently starting to marginally improve.

Exhibit 10: the number of first (new) outpatient appointments waits that are over a year since referral, Betsi Cadwaladr University Health Board



Source: Welsh Government, Stats Wales

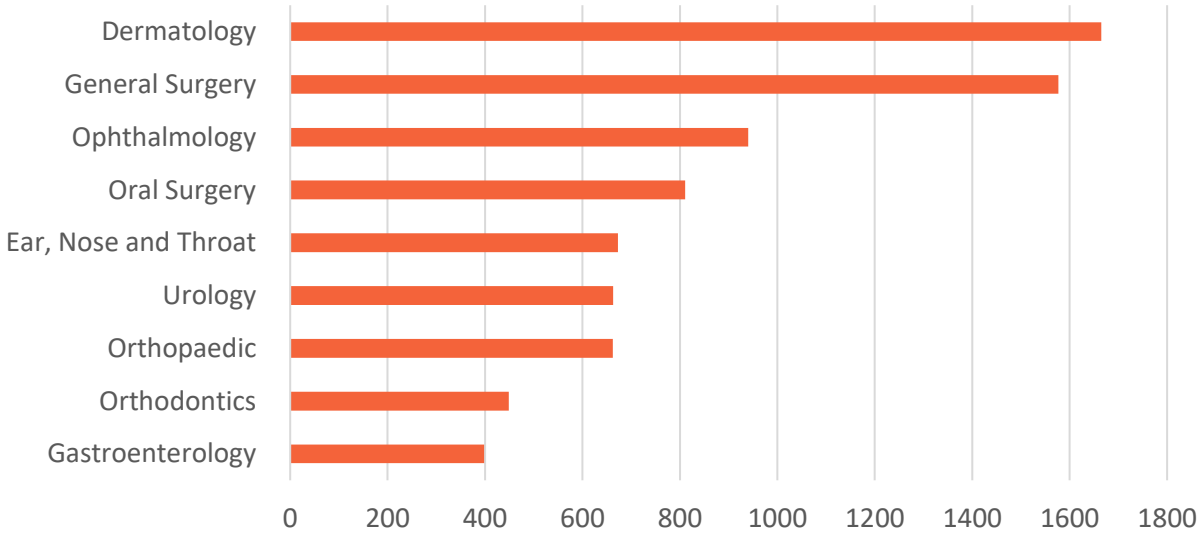
Eliminate the number of pathways longer than two years in most specialties by March 2023

44 **Exhibit 11** shows that the Health Board did not meet the revised Welsh Government target to eliminate waits over 2 years by March 2024 and early performance improvement has not been maintained. Of those waits currently over 2 years, **Exhibit 12** shows that extreme waits are across a range specialties, but include dermatology, general surgery, ophthalmology and oral surgery.

Exhibit 11: the number of planned care waits over 2 years, Betsi Cadwaladr University Health Board

Source: Welsh Government, Stats Wales

Exhibit 12: the number of planned care waits over 2 years by specialty as of February 2025, Betsi Cadwaladr University Health Board

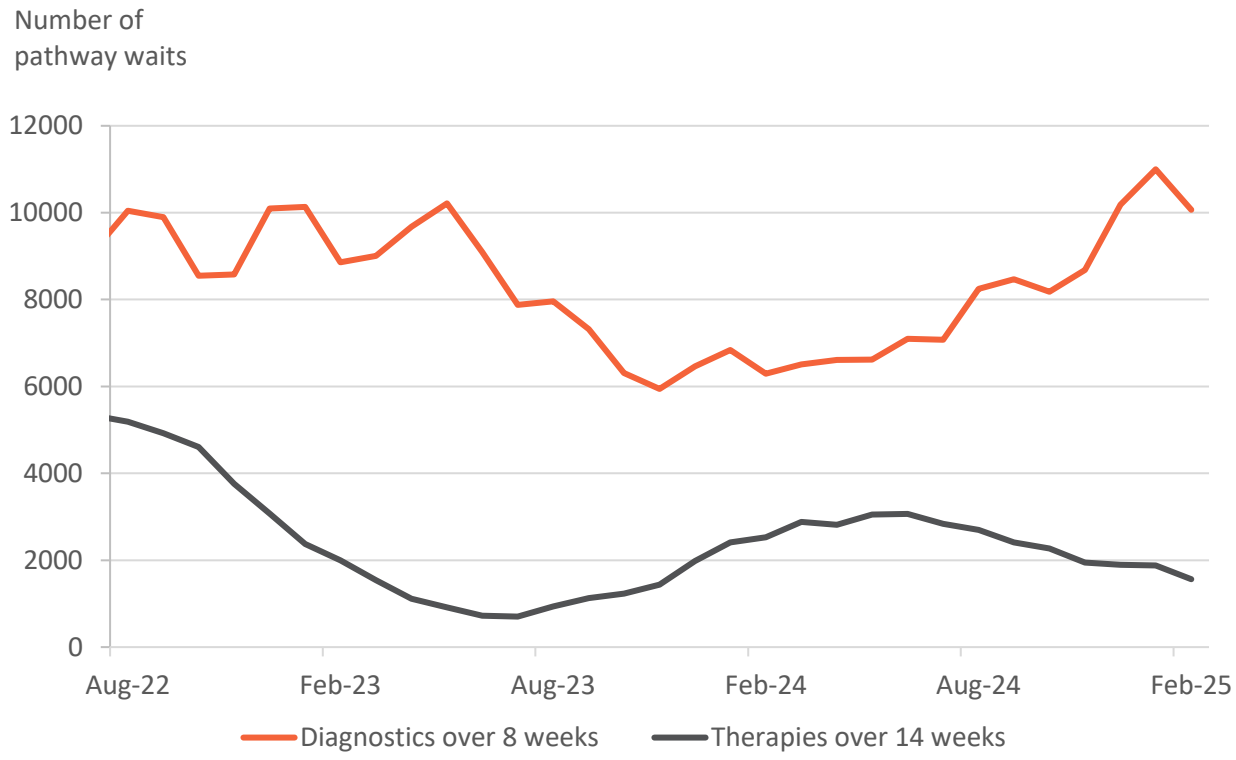


Source: Welsh Government, Stats Wales

Increase the speed of diagnostic testing and reporting to eight weeks and 14 weeks for therapy interventions by Spring 2024

45 The Welsh Government sought to increase the speed of diagnostic testing and reporting to eight weeks and 14 weeks for therapy interventions by Spring 2024. The Health Board is not meeting its targets for therapy or diagnostic waits (**Exhibit 13**). Of its diagnostic services, diagnostic endoscopy and to an extent neurophysiology diagnostics are of greatest concern because of the volume and proportion of very long waits in these areas. Physiotherapy waits also appear to be a challenge for the Health Board.

Exhibit 13: the number of diagnostic and therapy pathway waits that breach Welsh Government targets (Diagnostic waits is an 8-week target, therapies waits is a 14 week target), Betsi Cadwaladr University Health Board

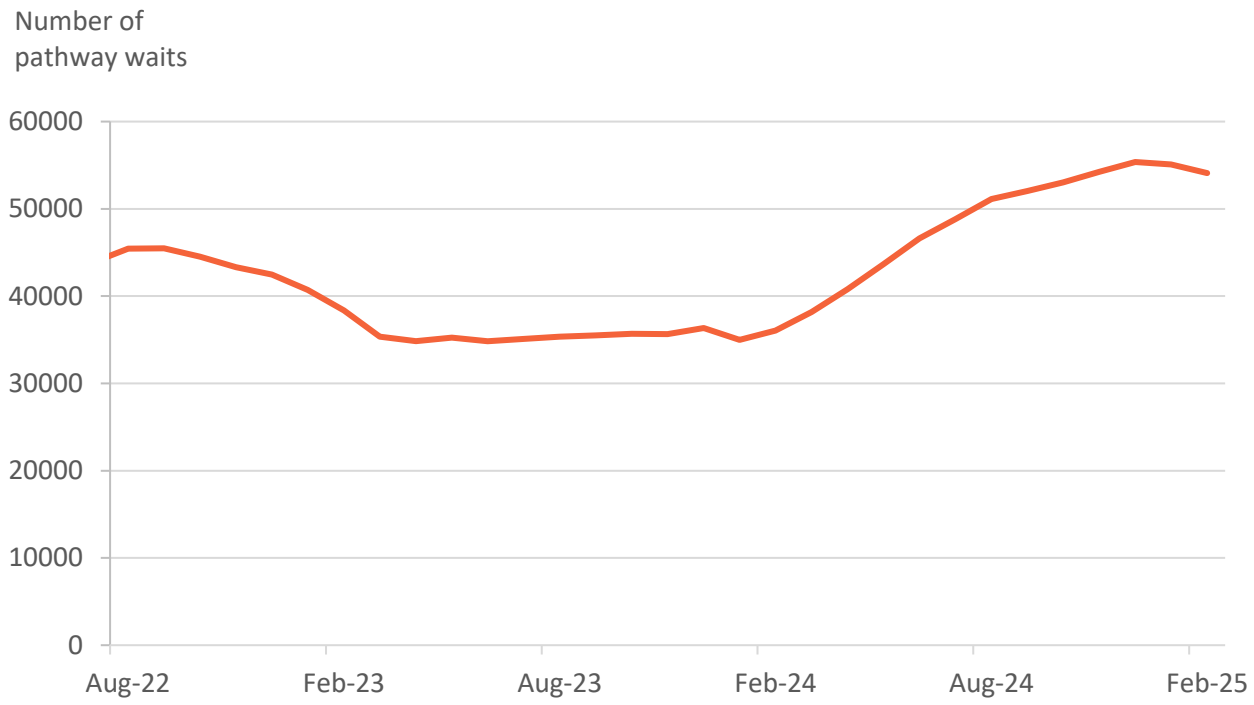


Source: Welsh Government, Stats Wales

Eliminate the number of people waiting longer than one year in most specialties by Spring 2025

46 The Welsh Government's longer-term ambition was to eliminate waits over 1 year in most specialties by the Spring of 2025. **Exhibit 14** shows deterioration in performance in 2024 reaching the highest ever recorded level of one year waits at the Health Board in December 2024. The position has marginally improved since.

Exhibit 14: the number of pathway waits that are over a year, Betsi Cadwaladr University Health Board



Source: Welsh Government, Stats Wales

Barriers to further improvement

47 We have considered the factors that are affecting the Heath Board's ability to tackle its waiting list backlog and secure sustainable improvements in planned care, together with actions that it is taking to address them.

48 We found that the Health Board recognises the barriers to improvement but is significantly affected by increasing service demand, capacity pressures and a lack of clinical leadership to drive change and recovery.

49 Our fieldwork has found challenges in the following areas:

- **Demand for planned care services** – There is significantly increasing demand for services. The Health Board is making some progress in reducing the number of extreme waits, however referral levels are increasing (**Exhibit 16, Page 39**). At the same time, our analysis of the levels of medical and surgical admissions indicates that service activity is slightly lower than 2019 levels (**Exhibit 17, Page 39**). This suggests an increasing gap between demand and supply which the Health Board must address.
- **Workforce capacity** – The Health Board has identified that staffing issues are a further challenge to delivery. This includes recruitment to key roles such as anaesthetists and some wider theatre staffing. This has contributed to difficulties optimising theatre capacity.
- **Capacity to support transformation** - The Health Board has deliberately focused on addressing immediate demand and reducing waiting lists without appropriate analysis of its core capacity. This alongside wider resourcing challenges is limiting opportunities for more long-term transformation work and the ultimate need to implement sustainable modernised services.
- **Clinical leadership –** The absence of a Medical Director and shortage of clinical leadership in the planned care programme, particularly for challenged services has impeded delivery progress.
- **Clinical strategy –** The Health Board does not have an overall clinical strategy and individual service plans for challenged services to support planned care recovery. As a result, the Health Board is adopting an ineffective reactive approach which lacks clarity and consistency across the Integrated Health Communities.

50 The Health Board has begun to take action to address some of these barriers. To address issues with theatre utilisation it has established the Elective Optimisation Programme to scrutinise performance and drive change, as described in **Exhibit 6.** The Health Board is also taking action to increase the use of the Abergele hospital for ophthalmology procedures.

51 The Health Board has recently identified short-term measures to address capacity issues in response to increased demand in dermatology including additional locum recruitment and the use of minor operation procedures at Connah's Quay Health Centre.

52 The actions the Health Board has taken, including the appointment of an Interim Medical Director are at their early stages and further work is required to ensure the Health Board does not continue to face the same or greater challenges in future.

Appendix 1

Audit methods

Exhibit 15 sets out the methods we used to deliver this work. Our evidence is based on the information drawn from the methods below.

Exhibit 15: audit methods

Element of audit methods	Description
Documents	We reviewed a range of documents, including: • Planned care programme initiation document. • Annual plan. • Performance, Finance and Information Governance committee papers • Planned care programme board papers • Quality, Safety and Equality Committee papers • Public Board meeting papers. • Executive team papers • GIRFT reviews • Corporate risk register • Planned care programme risk register • Performance reports • Terms of reference • Internal audit reports
Self-assessment	We issued and then analysed a self-assessment completed by the Health Board.
Interviews	We interviewed the following: • Interim Director of Finance – Senior Responsible Officer for planned care. • Interim Chief Operating Officer • Assistant Director for planned care. • Integrated Health Community – Planned Care Director. • Lead Clinical Director for planned care • Outpatient Lead • Finance Lead for planned care • Quality, Safety and Equality Committee Chair

Element of audit methods	Description
	• Promote, Prevent, Prepare Lead
Observations	We observed the Planned Care Programme Board in December 2024.
Data analysis	We analysed key data on: • waiting list performance; • financial spend; and • outpatient and inpatient efficiencies.

Appendix 2

Audit criteria

Main audit question: **Is the Health Board effectively managing its planned care challenges?**

Level 2 questions	Level 3 questions	Audit Criteria (what good looks like)
Is the Health Board's waiting list performance improving?	What is the scale of the challenge? Is the Health Board meeting Welsh Government targets/ambitions?	The Health Board has: • made progress reducing the overall number of referral to treatment waits for planned care services; and • met Ministerial priorities and national targets that were set by the Welsh Government.
Does the Health Board have a clear plan and a programme of action to support planned care waiting list recovery?	Does the Health Board have a clear, realistic, and funded plan in place for planned care recovery? Is there a clear programme structure to deliver planned care improvement?	The Health Board has: • clear, realistic and funded plan in place for planned care recovery in the short and longer-term; and • a programme structure that appropriately supports the delivery of the plan.

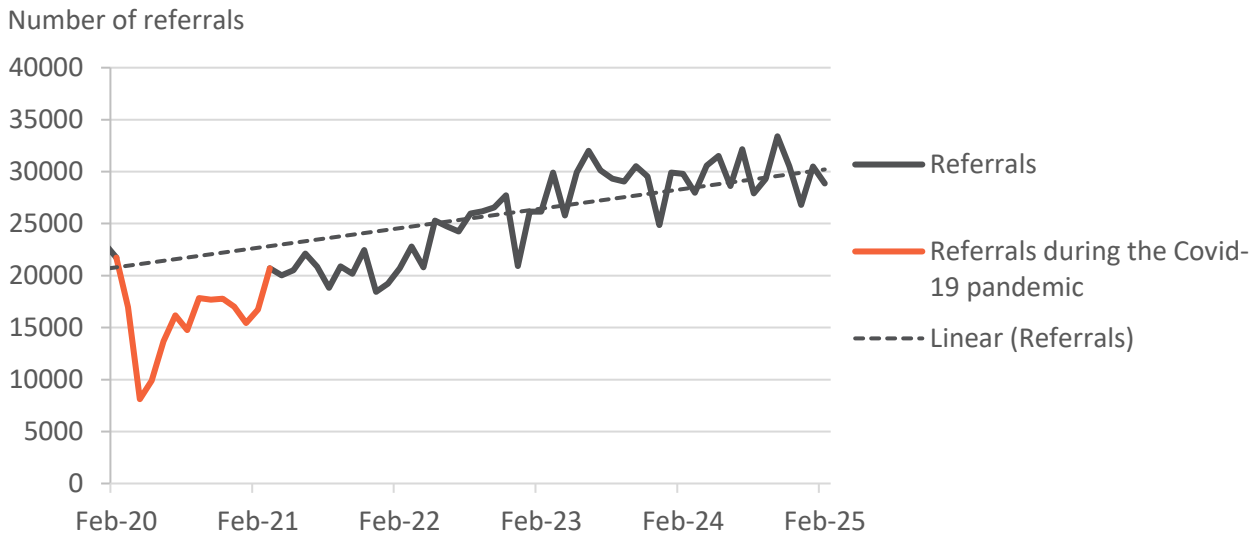
Level 2 questions	Level 3 questions	Audit Criteria (what good looks like)
Is the Health Board maximising the impact of its funding to address the planned care backlog?	Is it clear what additional monies have been received by the Health Board? Is it clear what the additional waiting list monies has been spent on? Did the Health Board aim to use all the money on planned care improvement? Can the Health Board clearly demonstrate that the money has resulted in performance improvement, enabled service efficiency and/or new ways of working? Is the Health Board's overall financial position affecting its ability to deliver sustainable planned care recovery?	• There is sufficient evidence that the Health Board spent the money as intended by the Welsh Government (i.e. addressing waits and transforming services). • The Health Board can clearly demonstrate that the spend has resulted in improvement. • The Health Board's overall financial position is not affecting its ability to support planned care recovery.
Does the Health Board have effective operational management arrangements to drive improvement and	Is the Health Board improving its operational management of planned care services? How does the Health Board capture information on clinical risk relating to long planned care waiting lists?	The Health Board is: • improving the operational management of planned care services; and • capturing information and managing clinical risks and harm related to long planned care waiting lists.

Level 2 questions	Level 3 questions	Audit Criteria (what good looks like)
management of clinical risks?	How does the Health Board capture information on clinical risk relating to long planned care waiting lists? Is the Health Board sufficiently managing clinical risks resulting from delays to treatment? Is the Health Board proactively ensuring clear routes of communication when patients are concerned that they are deteriorating?	The Health Board: • has sound arrangements to identify, capturing, and report on clinical risk and harm associated with long waits; • is proactively managing clinical risks resulting from delays to treatment and effectively communicating with patients.
Does the Health Board sufficiently understand barriers to improvement and what needs to be done to address them?	Does the Health Board understand the barriers it has experienced to improvement in planned care performance? (Capacity, funding, recruitment & retention, estates/use of facilities, commissioning external healthcare?) What mechanisms and interventions have been put in place by the Health Board to address these barriers? Is the Health Board learning and sharing good practice where things have gone well?	The Health Board has: • identified its risk and barriers and acted on these to address long planned care waiting lists in the short-term and sustainable service models in the longer term. • good arrangements for seeking good practice and sharing and applying learning to improve planned care services.

Appendix 3

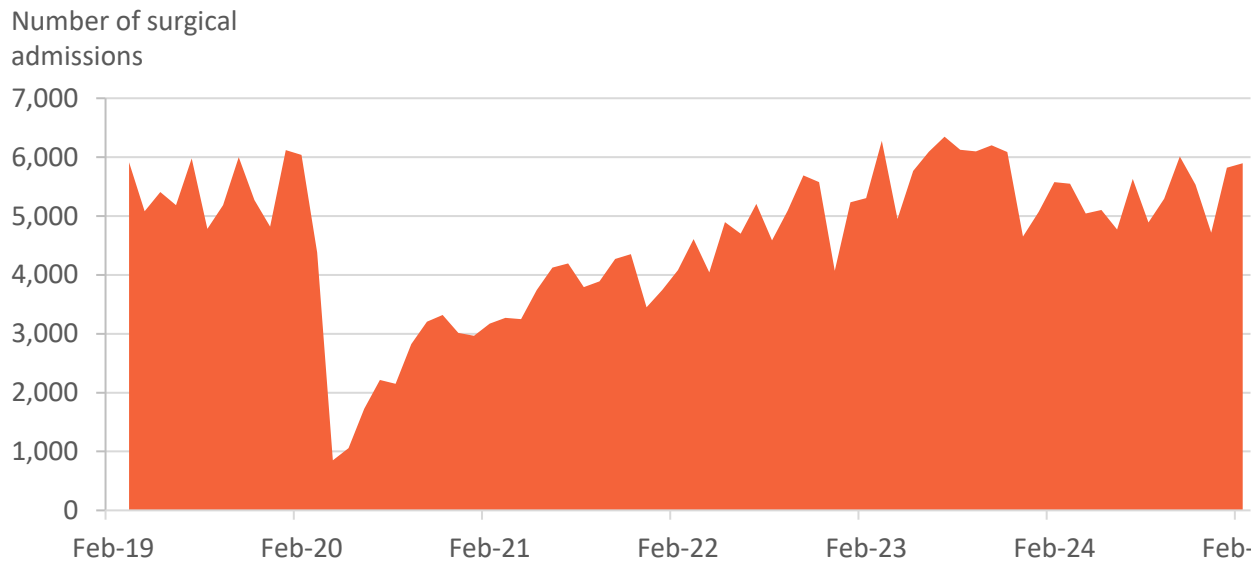
Additional data analysis on planned care

Exhibit 16: trend of monthly referrals to Betsi Cadwaladr University Health Board



Source: Welsh Government, Stats Wales

Exhibit 17: monthly elective medical and surgical admission levels, Betsi Cadwaladr University Health Board

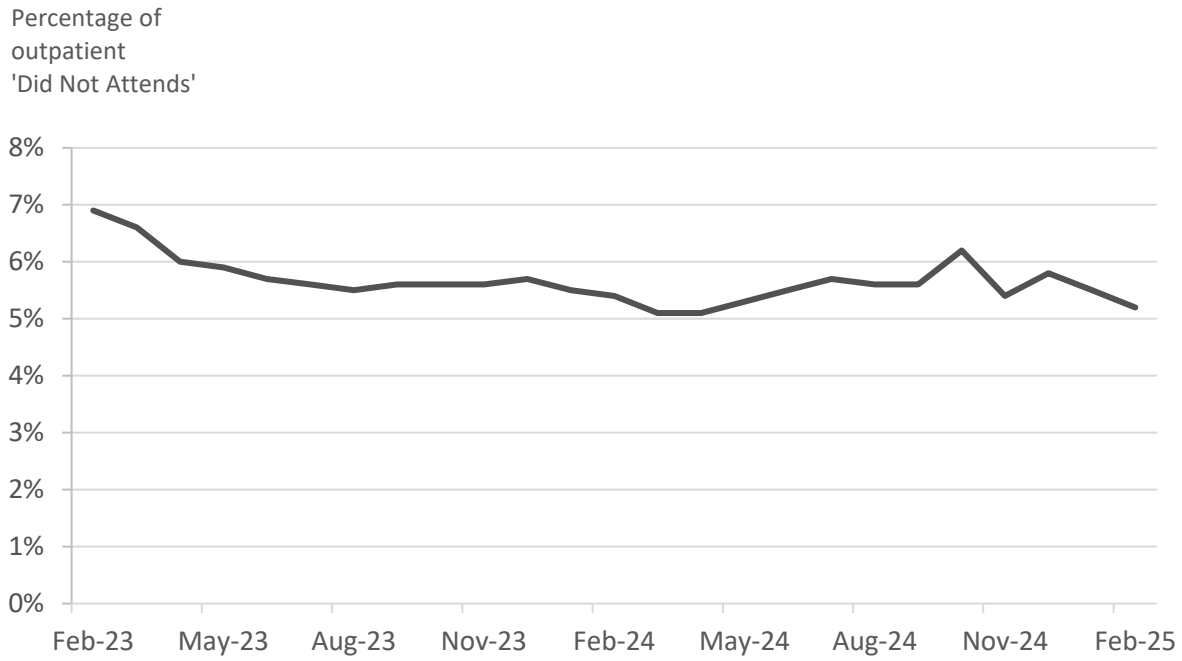


Source: Digital Health and Care Wales secondary care dashboard

Outpatient services

53 Outpatient appointments where a patient 'did not attend' is inefficient. **Exhibit 18** shows that the Health Board's 'Did Not Attends' is around 5.5% of total outpatient clinic activity. This equates to around 38,400 lost patient appointments in the most recent 12-month period to February 2025. It represents a lost opportunity cost of around £5.8 million (£150 per appointment[14]). If the Health Board could reduce its outpatient Did Not Attends by 20%, it could potentially save around £1.15 million.

Exhibit 18: the number and percentage of outpatient 'Did Not Attends', Betsi Cadwaladr University Health Board

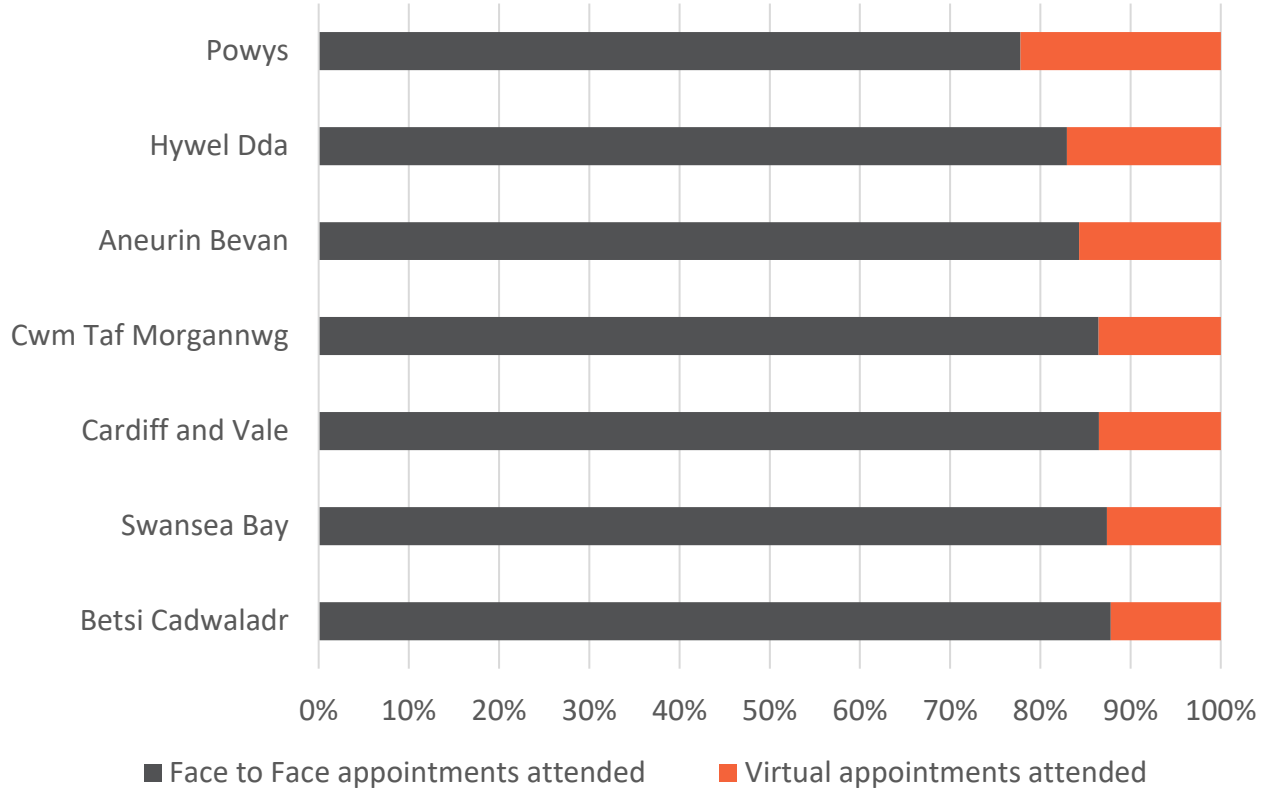


Source: Digital Health and Care Wales secondary care dashboard and datasets

54 NHS bodies can use virtual outpatient appointments for some but not all patients. **Exhibit 19** shows that the 'virtual' consultation approach is not well-adopted in most health boards and is the lowest in Betsi Cadwaladr University Health Board.

[14] We have adjusted the 2018 NHS England cost of an outpatient appointment (£120) by Bank of England CPI rates to estimate current average outpatient costs in 2024.

Exhibit 19: proportion of outpatient attendances that are virtual appointments, from April 2024 to February 2025

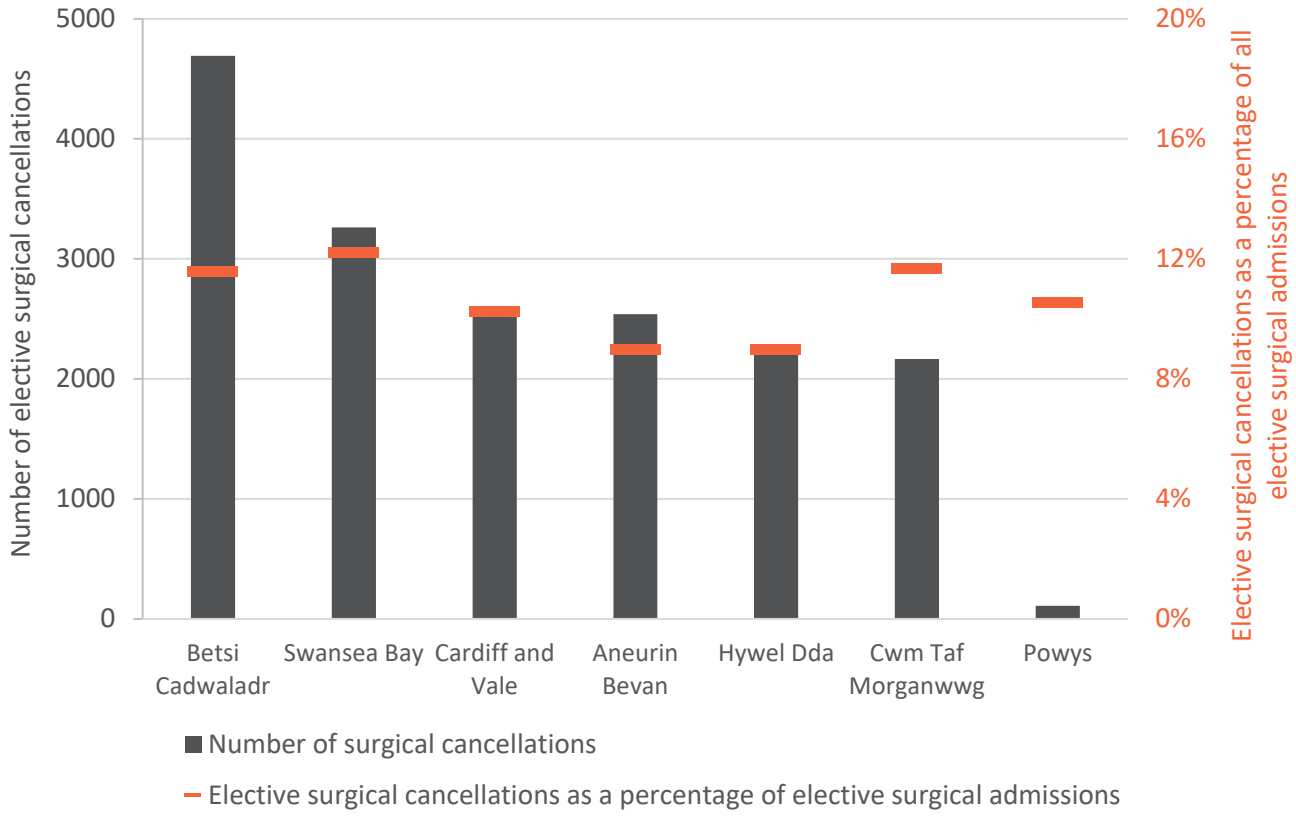


Source: Digital Health and Care Wales secondary care dashboard and datasets

Surgical cancellations

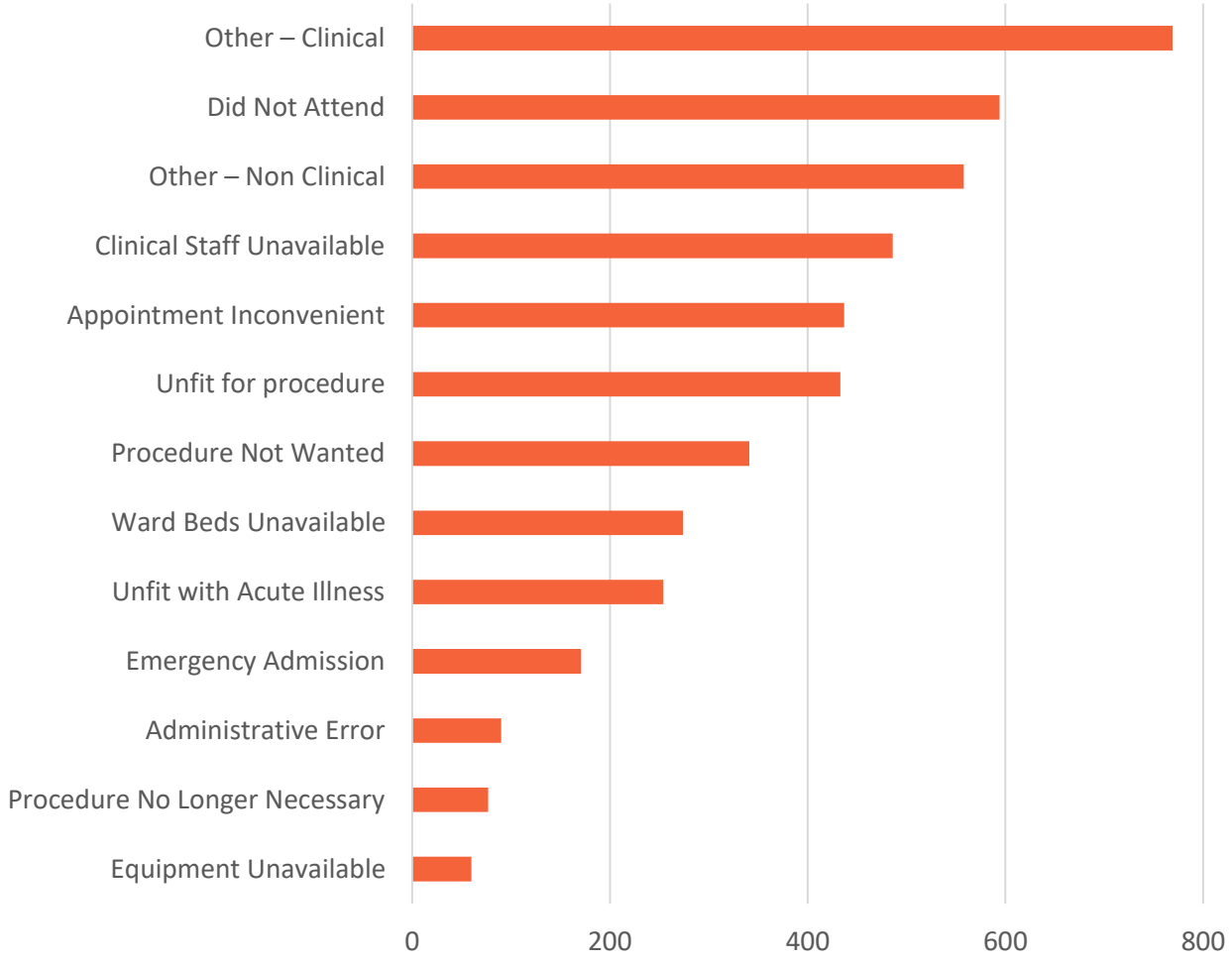
55 Short notice cancellations result in significant inefficiency because operating theatre sessions cannot be easily backfilled with other patients. The total number of surgical cancellations for the Health Board was almost 4,700 for the latest 12 month published data (March 2024 to February 2025) (**Exhibit 20**). **Exhibit 21** identifies the cancellation reasons.

Exhibit 20: the number of short notice (within 24 hours) surgical cancellations alongside cancellations as a percentage of all elective surgical admissions, March 2024 to February 2025



Source: Health Board submissions to the Welsh Government and Digital Health and Care Wales

Exhibit 21: number of short notice (within 24 hours) surgical cancellations for the latest 12-month reporting period (March 2024 to February 2025), by reason, Betsi Cadwaladr University Health Board

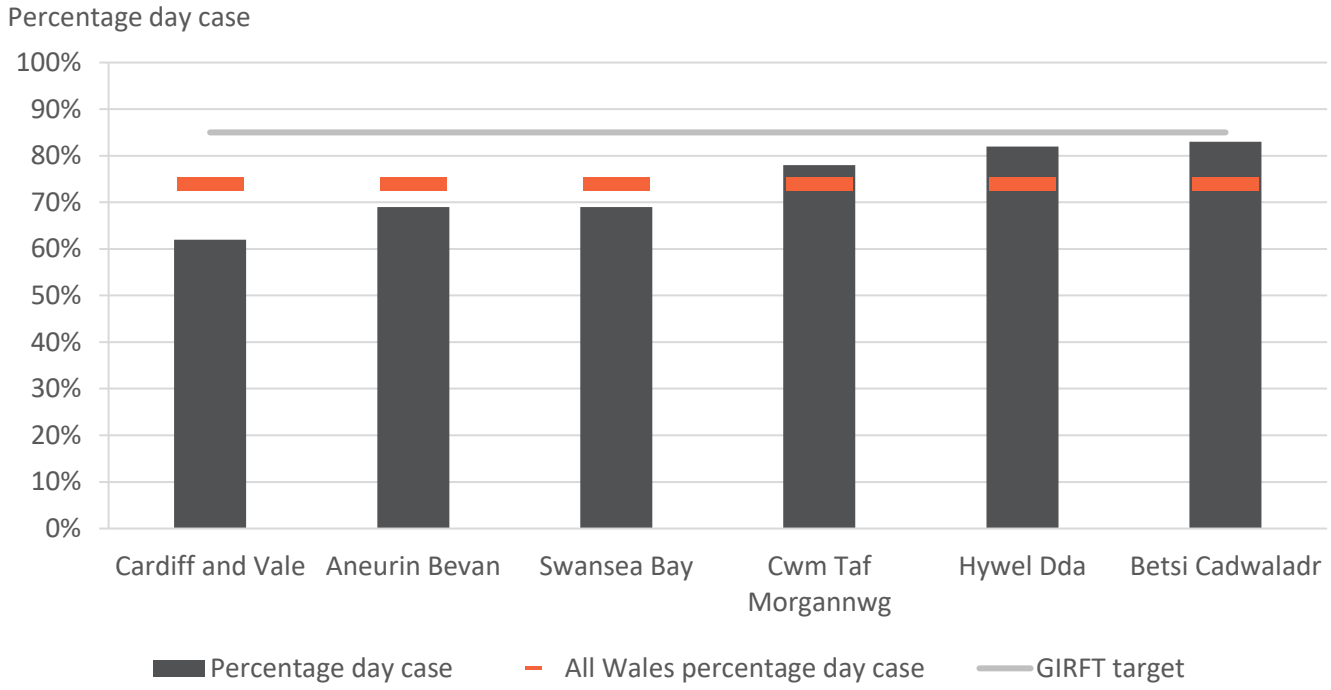


Source: Health Board submissions to the Welsh Government

Day case surgery

56 Day case surgery offers the potential for improved efficiency, lower costs, lower carbon footprint per patient[15] and a better patient experience when compared with inpatient services. Getting It Right First Time recommends that on average 85% of all elective[16] surgery should be day case[17]. Our analysis in **Exhibit 22** indicates that 83% of the Health Board's elective surgery is day case and positively is the highest in Wales.

Exhibit 22: proportion of elective surgery undertaken by Health Boards as day case for the period April 2024 to February 2025



Source: Digital Health and Care Wales secondary care dashboard and datasets

[15] Paper outlines GIRFT's 'unique position' in supporting the NHS drive for net zero carbon emissions - Getting It Right First Time - GIRFT

[16] Elective surgery is the type of surgery associated with a planned care patient pathway.

[17] Getting it Right First Time - Elective Recovery High Volume Low Complexity guidance for health systems

Audit Wales

Tel: 029 2032 0500

Fax: 029 2032 0600

Textphone: 029 2032 0660

E-mail: info@audit.wales

Website: www.audit.wales

We welcome correspondence and telephone calls in Welsh and English.
Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

The management response to audit recommendations

Exhibit 23 below sets out the Health Board's response to our audit recommendations.

Recommendation	Management response	Completion date	Responsible officer
Planning R1 Over and above the commitments signalled within its annual plans, the Health Board should develop a detailed Planned Care improvement plan. This should aim to both design and deliver sustainable planned care services in the medium to longer term and to take advantage of opportunities for further regional working. The plan should be costed, with realistic but challenging milestones within it. (Exhibit 2)	The Health Board has identified Planned Care as a Major workstream (one of four) with the Chief Executive to Chair the Planned Care Project Board that will oversee delivery of the major program with 6 workstreams; 1- RTT Waiting List Management 2- Referral Management 3- Booking 4- Pre-operative and post operative effectiveness 5- Follow ups 6- Integrated Planned (Planned Care, Diagnostics & Cancer) The Planned Care Board will oversee development and implementation of plans.	October 2025	Executive Director of Transformation and Improvement
Demand and capacity R2 The Health Board should ensure that its demand and capacity modelling approach is consistently applied across the organisation and its specialties and used to inform short-term	The Operational teams are (in conjunction with the Director of Performance) developing demand and capacity plans to support in year and future modelling of Integrated Medium Term Plans (IMTP).	December 2025	Chief Operating Officer (COO)

Recommendation	Management response	Completion date	Responsible officer
service capacity planning and longer-term service design. This should consider continued growth or expected changes in population demand for planned care services **(Exhibit 2).**			
Programme governance and programme business cases R3 The Health Board should strengthen its Planned Care Programme Board to ensure it has the authority to set direction and deliver both transformational change and short-term capacity improvement by: 3.1 Strengthening the Programme Board's delegated authority arrangements to ensure it is the primary forum for all transformational and short-term capacity improvement funding **(Exhibit 3).** 3.2 Developing a clear planned care	The Planned Care Board will oversee the development of Planned Care enhanced delivery in 2025/25 (see R1). It is of note that the Planned Care Programme Board is to be Chaired by the Chief Executive, with delivery of improvements through the Executive Director of Transformation and Delivery. In addition, this Committee has Welsh Government membership and will oversee use of the Planned Care Fund totalling £34m. 3.1 to be reviewed in conjunction with the revisions to the Standing Orders and scheme of Reservation and Delegation	October 2025 Plan developed October 2025	Executive Director of Planning, Transformation and Improvement Director of Corporate Governance

Recommendation	Management response	Completion date	Responsible officer
improvement programme for delivery, monitoring and associated accountability **(Exhibit 3).**	As noted previously	See above	See above
3.3 Improving training for planned care business case development to ensure quality of business cases and timely approval **(Exhibit 3).**	Business Case development is being pursued within the Directorate for Transformation and Improvement, with a Business Case proforma under review.	January 2026	Executive Director of Planning, Transformation and Improvement
3.4 Prepare business cases earlier in the year or cyclically to align with a multi-year planned care programme to avoid implementation delays **(Exhibit 3).**	The Planning cycle will engage with the wider organisation as an ongoing as opposed to an annual process, this change key in determining the ability of the Health Board to prioritise resources for future financial years, aligning to Strategic Plans.	January 2026	Executive Director of Planning, Transformation and Improvement
Programme Board clinical leadership R4 The Health Board should review and strengthen its Planned Care Programme Board leadership arrangements by:	Programme Board formed and appointments / governance and oversight of the leadership with progress in regards to appointment of clinical leads continuing		

Recommendation	Management response	Completion date	Responsible officer
4.1 Developing a clear remit, authority and accountability for the role of the Clinical Director of Planned Care **(Exhibit 3).**	Clinical Director of Planned Care appointed and remit clarified within the Programme Boar.	August 2025	Chief Executive Officer
4.2 Appointing clinical leads for all specialties to the Programme Board to support the development of integrated speciality plans **(Exhibit 3).**	Progress made in appointments for Clinical leads, further appointments to be completed.	December 2025	Chief Executive Officer
Risk management R5 The Health Board should review and update the Planned Care risk register to ensure controls are effective and that the overall risk levels start to reduce in the next 6 months (Exhibit 3).	Planned Care Delivery is referenced within the Corporate Risk Register. A delivery Director appointed to monitor delivery and report on performance and operational delivery the responsibility of the Chief Operating Officer	October 2025	Executive Director of Finance & Chief Operating Officer
Monitoring impact of additional funding **R6** The Health Board should strengthen its monitoring of the use and impact of the additional	Planned Care Fund utilisation is reported within the Planned Care Program Board, with allocation and use supported through the Integrated Performance, Executive Delivery	Ongoing	Executive Director of Finance

Recommendation	Management response	Completion date	Responsible officer
Welsh Government planned care funding (Paragraph 24).	Group and the Performance, Finance and Information Governance Committee.		
Efficiency and productivity R7 Our work has identified there are opportunities for further efficiency and productivity improvements. The Health Board should:	The below improvements are contained within the overall planning. These workstreams referred to in section R1 will deliver against the specific elements listed below;		
7.1 Ensure there is clear monitoring and reporting on the completion of recommendations arising from the Getting it Right First Time (GIRFT) reviews **(Exhibit 6).**	Speciality demand and capacity plans to include reference to GIRFT and optimum levels of performance (access and quality of care) for our local population. This will feature within the demand and capacity modelling.	December 2025	Chief Operating Officer
7.2 Develop enhanced measures to reduce the number of short notice surgical cancellations **(Exhibit 6).**	Planned Care Programme Board to review utilisation of clinics in addition to factoring improvements into demand and capacity modelling.	October 2025	Chief Operating Officer
7.3 Improve the recording accuracy of surgical cancellation reasons to enable the Health Board to understand	Planned Care Programme Board to review utilisation of clinics in addition to factoring improvements into demand and capacity modelling.	October 2025	Chief Operating Officer

Recommendation		Management response	Completion date	Responsible officer
	and address the root cause of surgical cancellations **(Exhibit 6).**			
7.4	Develop and implement a plan to improve theatre utilisation rates across the Health Board, with realistic improvement trajectories, with the aim of achieving the GIRFT recommendation of 85% **(Exhibit 6).**	As above	November 2025	Chief Operating Officer
7.5	Develop and rollout approaches to increase the use of "virtual" outpatient appointments, where clinically appropriate **(Exhibit 6).**	As above	November 2025	Chief Operating Officer
7.6	Develop job planning policy and guidance **(Exhibit 6).**	Reporting to Planned Care Programme Board, the newly appointed Medical Director will lead in this area.	December 2025	Medical Director
7.7	Ensure job plans are completed annually, utilising team-based job planning where it is appropriate to align	A rolling process of review will be put in place.	January 2026	Medical Director

Recommendation	Management response	Completion date	Responsible officer
consultant capacity to meet service demand **(Exhibit 6).** 7.8 Roll out pooled waiting lists across the Health Board particularly focusing on challenged services to ensure it treats its patients in turn **(Exhibit 6).**	Treat in turn is a key element of delivery of improved access for routine patients waiting an extreme amount of time. Pooled lists for BCUHB and then booking based on treat in turn essential as we look to deliver improved access to our local population. Initially we would look to complete this during 2025/26. However, Foundations for the Future will support delivery through changing operational structures.	November 2025	Chief Operating Officer
Promote, Prevent and Prepare for Planned Care policy R8 The Health Board complete the establishment of the 'Promote, Prevent and Prepare (3P's) for Planned Care' contact centre and ensure it covers all specialties **(Exhibit 7).**	Work has progressed in regards to development of the '3P's' for the Health Board, the policy being developed at this time. Work to continue into 2025/26 and complete in the later quarter of the financial year.	November 2025	Chief Operating Officer
Risk of harm R9 In order to strengthen its arrangements for managing the clinical risks associated with long waits, the Health Board should:			

Recommendation		Management response	Completion date	Responsible officer
9.1	Develop and implement a consistent methodology for assessing the risk of harm to patients caused by long waits across specialties **(Exhibit 7).**	This methodology is currently being worked on with the Clinical Executive of the Health Board.	October 2025	Executive Director of Nursing
9.2	Develop a routine report to be presented at the Quality and Safety Committee that effectively reports risks and actual incidents of harm resulting from delays in access to treatment **(Exhibit 7).**	The Health Board reports routinely to the Quality, Health & Safety Committee matters. As above.	November 2025	Executive Director of Nursing
9.3	Develop and implement clinical plans for all challenged services to ensure higher risk patients are prioritised **(Exhibit 7).**	Plans under development with a focus placed upon challenged specialities.	November 2025	Chief Operating Officer

Teitl adroddiad: ***Report title:***	**Health Board Response to the Royal College of Psychiatrists Invited Review Services Report**
Adrodd i: ***Report to:***	**Quality, Safety and Experience Committee**
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 04 September 2025
Crynodeb Gweithredol: ***Executive Summary:***	**Background** The Health Board received the Royal College of Psychiatry (RCPsych) Invited Services Review Report in March 2024. The Health Board is required to progress the improvements recommended in the report and demonstrate that the improvements are meeting the objectives of the recommendations and able to improve the outcome and experience for patients and staff. The last report to this Committee was on the 3 July 2025. The Committee received an update on the progression of the improvement actions in the RCPsych Invited Services Review and received an update on the Expert Advisory Group work programme and approach to outcomes framework. The Board received a report as recently as 31 July 2025. This report provided a detailed analysis of progress against the ten themes of the RCPsych Invited Services Review as well as setting out proposals for oversight of the response to the Review once the Special Advisor to the Health Board completes her work during September 2025. This report highlights the progress against the Expert Advisory Group work programme in relation to the oversight of the RCPsych Invited Services Review, including an overview of a Draft Outcomes Framework that will be further developed with stakeholders. The report also highlights an overview of progress against the improvement actions of the Invited Services Review as at 18 July 2025.
Argymhellion: ***Recommendations:***	The Committee is asked to: • **Note and Consider** the update on the RCPysch Invited Services Review • **Note and Consider** the next steps related to the oversight of the RCPsych Invited Services Review • **Note and Consider** the development of a Draft Outcome Framework and Performance Dashboard prior to early development with stakeholders • **Receive assurance** on the Health Board response to the RCPsych Invited Review Services Report.
Arweinydd Gweithredol: ***Executive Lead:***	Teresa Owen, Executive Director of Allied Health Professionals and Health Science
Awdur yr Adroddiad: ***Report Author:***	Ros Alstead – Special Advisor Phil Meakin – Associate Director of Governance

Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☒	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒

Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r	Rhannol *Partial* ☒ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau /	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth

	mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	*No confidence / evidence in delivery*

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***	
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	1. Building an effective organisation 2. Developing strategy and long lasting change 3. Creating compassionate culture, leadership and engagement 4. Improving quality outcomes and experience 5. Establishing an effective environment for learning
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	None
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	N/A
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	N/A
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	CRR 24-04 (Learning)
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	None to note at this stage
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	None to note at this stage
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	This paper has been prepared following the recommendations agreed at the Health Board, 25 July 2024, January 2025 and 31 July 2025 and the previous reports to the Quality, Safety and Experience Committee, most recently on 3 July 2025.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:***	• BAF24-06 Ineffectively Delivering the Required Improvements to Transform Care and Enhance Outcomes

(or links to the Corporate Risk Register)	• BAF24-05 Ineffectively Engaging with Citizens, Partners and Communities
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Not applicable
Rhestr o Atodiadau: ***List of Appendices:*** • Appendix 1 – Summary of progress against the themes improvement actions outlined in the RCPsych Invited Services Review report • Appendix 2 – Outline of the Draft Outcomes Framework and associated Performance Dashboard.	

Glossary of MHLD Terms (RCPsych Response Related)

ALN – Alcohol Liaison Nurse
BCUHB – Betsi Cadwaladr University Health Board
BI – Business Intelligence
CEG – Clinical Effectiveness Group
CTP – Care Treatment Plan
CMHTs – Community Mental Health Teams
DDAT – Digital Data and Technology
DHCW – Digital Health and Care Wales
DOLS – Deprivation of Liberty Safeguards
DSLT – Divisional Senior Leadership Team
DLRRG – Divisional Ligature Risk Reduction Group
EAG –Expert Advisory Group
HCA – Health Care Assistant
HCSW – Health Care Support Worker
HSE – Health & Safety Executive
HTT – Home Treatment Team
KPI – Key Performance Indicator
LHB – Local Health Board
LA – Local Authority
LOF – Learning Outcomes Framework
MAPP – Managing Attendance Performance Prompt
MCA – Mental Capacity Act
MDT – Multi Disciplinary Team
MHLD – Mental Health and Learning Disabilities
NCCU – National Care Commissioning Unit
NHS – National Health Service
NICE – National Institute for Healthcare and Excellence
OD – Organisational Development
PADR – Performance and Development Review
PALS – Patient Advice and Liaison Services
PCE – Patient Care Experience
PST – Patient Safety Team
PTR – Putting Things Right
POMH – Prescribing Observatory for Mental Health
PSOW - Public Services Ombudsman for Wales
QMS – Quality Management System
R&R – Recruitment and Retention
RMN – Registered Mental Health Nurse
RCollPsych – Royal College of Psychiatry
RPharms – Royal Pharmaceutical Society
SLT – Senior Leadership Team MH&LD
SOP – Standard Operating Procedure
SQDG – Service Quality Delivery Group
WARRN – Wales Applied Risk Research Network
WCCIS – Welsh Community Care Information System
WOD – Workforce and Organisational Development

WG – Welsh Government

HEALTH BOARD RESPONSE TO THE

ROYAL COLLAGE OF PSYCHIATRISTS INVITED SERVICES REVIEW REPORT

1. INTRODUCTION

The Health Board received the Royal College of Psychiatry (RCPsych) Invited Services Review Report in March 2024. The Health Board is required to progress the improvements recommended in the report and demonstrate that the improvements are meeting the objectives of the recommendations and able to improve the outcome and experience for patients and staff.

The last report to this Committee was on the 3 July 2025. The Committee received an update on the progression of the Improvement Actions in the RCPsych Invited Services Review and received an update on the Expert Advisory Group work programme and approach to outcomes framework.

The Board received a report as recently as 31 July 2025. This report provided a detailed analysis of progress against the ten themes of the RCPsych Invited Services Review as well as setting out proposals for oversight of the response to the Review once the Special Advisor to the Health Board completes her work during September 2025.

This report highlights the progress against the Expert Advisory Group work programme in relation to the oversight of the RCPsych Invited Services Review and includes an overview of a Draft Outcomes Framework and associated Performance Dashboard that will be shared and developed with stakeholders.

The report also highlights an overview of progress against the improvement actions of the Invited Services Review as at 18 July 2025

2. PURPOSE OF THIS REPORT

The purpose of this report is to provide information that will enable the Committee to:

- **Note and Consider** the update on the next steps and oversight of the RCPsych Invited Services Review
- **Note and Consider** the development of a Draft Outcome Framework and Performance Dashboard prior to development with stakeholders
- **Receive assurance** on the Health Board response to the RCPsych Invited Review Services Report reported to the Health Board Action Delivery Group

3. BACKGROUND

As a reminder for the members reading this report, the ten themes (Table 1 below) are outlined below.

Table 1: The ten themes

The Ten Themes
○ Theme 1 - Patient and user centred care ○ Theme 2 - Legislation and clinical guidance ○ Theme 3 - Governance ○ Theme 4 - Staffing ○ Theme 5 - Management structure ○ Theme 6 - Clinical services organisation. ○ Theme 7 - Training and development ○ Theme 8 - Leadership and staff engagement ○ Theme 9 - Resources ○ Theme 10 - Physical environment

4. UPDATE FROM THE EXPERT ADVISORY GROUP

This part of the report provides an update from the Special Advisor on progress towards implementing the recommendations and improvement actions arising from the independent Royal College of Psychiatrists Invited Review, published at the end of 2023. This role provides advice and expertise in mental health. The advisor supports and advises board members, the executive team and Health Board teams leading and delivering the RCPysch Invited Service Review improvement actions.

The advisor also chairs the Expert Advisory Group (EAG) which was set up to involve people with lived experience most impacted by this review. This includes a small number of experts by experience including two with current experience, and four family members (who agreed to become re- involved) all whom experienced serious care failings highlighted through the Ockenden, Holden and other external inquiries and reports. The EAG also includes four health board staff with areas of relevant areas of expertise and two staff from Llais, including the North Wales Llais Director who is the Vice Chair of the EAG.

4.1 Expert Advisory Group work and programme since the last Quality Safety and Experience Committee.

The last report to the Quality Safety and Experience Committee on 3 July 2025 and the Board report on 31 July 2025 highlighted a detailed update from the Health Board Special Adviser on the work of the Expert Advisory Group (EAG) up to the end of June 2025.

Since the 3 July there have been a further three EAG meetings following an agreed work programme of nine meetings that has been agreed with members of the Group. The following areas of interest were presented by Health Board colleagues and information shared with the Group members. **Table 1** below summarises this information.

Table 1 – Expert Advisory Groups held since the last Quality Safety and Experience Committee

Expert Advisory Group Date	Expert Advisory Group Areas of Interest
3 July 2025 – Optic Centre, St Asaph	• Clinical Services Organisation • Management Structure Leadership and Resources • Governance – Ward Accreditation
15 August 2025 – Llais Offices, Bangor	• Physical Health • Physical Environment • Patient Records and Digital
21 August 2025 – Llais Offices, Bangor	• Llais arranged visits - Overview • Sustainability – Draft Outcomes Framework and Performance Measures • Recap - Clinical Services Organisation • Recap - Management Structure Leadership and Resources

The EAG has been well supported by Health Board teams including project support through the Associate Director of Governance, the Mental Health and Learning Disabilities (MHLD) service, the Transformation and Improvement teams, Digital Data and Technology teams, Estates, Health and Safety and the Corporate Nursing and Quality teams amongst many.

This report has been drafted prior to the final EAG meeting on 21 August 2025. A verbal update can be provided at the Quality Safety and Experience Committee if required by the Chair of the Quality Safety and Experience Committee.

4.2 Key Matters Arising from the Expert Advisory Group Meetings

In the last report to the Quality, Safety and Experience Committee on 3 July 2025 the Special Advisor requested that it would be helpful if the Evidence of Outcomes group could more clearly set out the requirements and further evidence which must be met for the improvement actions to be approved. It appeared that many actions have progressed but lack a clear indication of how they will be sustained. This has been addressed, and the Evidence of Outcomes Group have approved a template to enable this work. This was received at the Health Board Action Delivery Group on 12 August 2025 and will be reported to the Health Board Action Delivery Group on the 25 August 2025.

The Expert Advisory Group have been involved in the development of visits which they could participate in if they wished to. Three visits took place during July 2025 to the facilities at the Hergest, Heddfan and Ablett Units. These visits were led by the Llais Regional Director and supported by Llais volunteers. An overview of the findings were presented to the Expert Advisory Group on the 21 August 2025.

The meeting on the 15 August was well attended by EAG members and Health Board colleagues presented updates through presentation with opportunities for questions and answers. The Group noted significant progress on “Digital and Patient Records”. A further presentation was made by Health Board colleagues from the Estates team, the Health and Safety team and the Mental Health and Learning Disabilities (MHLD) service on the physical

environment and this provided some significant evidence of a joined up approach by the Health Board to address significant risks in the Physical Environment. Finally, a presentation was received on the Physical Health policy and strategy by the MHLD Consultant Psychiatrist. Follow up activity is required by EAG members to understand how this work is aligned to the Mental Health Measures Act requirements.

The meeting of the 21 August 2025 has not taken place at the time of finalising this report. The plan is to begin engagement on the early stages of the development of an Outcomes Framework and Performance Dashboard.

4.3 Expert Advisory Group Work Programme - Next Steps

The last formal meeting of the Expert Advisory Group is due to take place on the 21 August 2025 before new arrangements are put in place for the oversight and development of the recommendations as set out in the RCPsych Invited Services Review. This was set out in the Board paper of the 31 July 2025.

The Health Board Special Advisor is due to complete her appointment as Chair of the Expert Advisory Group at the end of August 2025. This will result in a summary report from the Special Advisor outlining an assessment of progress, including feedback received from the Expert Advisory Group. A date for the receipt of this report will be agreed with the Special Advisor and will be reported through the Quality Safety and Experience Committee in November 2025 and the Board meeting in January 2025. It is also proposed to support a Board Development seminar during December 2025, subject to the agreement of the Chair of the Health Board.

It is clear that members of the EAG will wish to contribute to this report and a number of individual meetings with EAG members will be facilitated to support this during September 2025 to capture feedback that is related to the RCPsych Invited Services Review. The Health Board continues to be very grateful for the dedication of Group members and it is important to capture their feedback in the final report.

In order to facilitate this work the Special Advisor alongside Vice Chair of the EAG (the Regional Director for Llais) have been summarising their findings from the EAG work programme and sharing these with the wider membership of the Group. This will allow for the wider Group membership to consider this feedback and complement this information with their expert experience. This work is set to be completed during September 2025.

5.PROPOSALS FOR THE FUTURE OVERSIGHT AND DEVELOPMENT OF MENTAL HEALTH SERVICES

The Board Report on 31 July 2025 outlined the proposal for the future oversight and development of Mental Health Services. The proposal is for the development of a Mental Health Oversight and Development Group that will report into the Executive Committee.

The precise scope and membership of the Executive level Group is currently being determined by the Chief Executive and the Executive Director of Allied Health Professionals and Health Science and consideration is already being given to the optimal framework for the work. The following areas that were reported to the Board are highlighted in **Table 2** below.

Table 2 – Scope of the Mental Health Oversight and Development Group

• **Mental Health strategy and service models -** This work will align with the new 10 year all Wales Mental Health and Wellbeing Strategy 2025-2035, which aims to improve wellbeing for the people of Wales and improve outcomes for people accessing support for their mental health. • **Patient/carer involvement** – The work will build upon the foundations set during the EAG period and the valuable feedback and experiences shared by EAG members and Llais colleagues. • **Estates** – Given the recent appointment of a Health Board Director of Estates and Environment, there is an opportunity to further develop the work within the MHLD division to ensure an improved estate for patients and staff, with a clear prioritised and deliverable development plan to support future services. • **Standards of Clinical Practice** – This is a key opportunity to utilise and embed the Quality Management System approach to support and develop mental health clinical pathway work – community and secondary care. • **Workforce** – By fully understanding the workforce establishment/baseline, the focus would be on workforce planning and modernisation to match the ambitions of the service model work. • **Leadership and Management** –The Mental Health team has had a positive focus in recent years on stabilisation, and there is an opportunity to now consider training requirements and succession planning arrangements in mental health. • **Culture Work** – The recent staff survey has demonstrated some positive early signals for the MHLD division. An action plan is already in place, however a focussed cultural work programme approach could yield further progress at pace. • **Performance visibility** – The RCPsych response work has enabled work to progress on a data dashboard which is described briefly in Section 7 of this report. This has been a significant step for the division, and this approach now requires HB support to embed fully at all levels within the organisation. • **'Key programmes'** – the redevelopment of the Ablett Unit is a key service change programme as is the Electronic Health Record development as an enabler for service transformation.

6. EVIDENCE OF PROGRESS AGAINST THE IMPROVEMENTS OF RCPSYCH INVITED SERVICES REVIEW

The Board meeting on the 31 July 2025 provided a summary by theme of progress against the Invited Services Review and a trajectory of improvement actions illustrating the plan to receive evidence of progress by the end of December 2025.

One of the focus areas of the new Mental Health Oversight and Delivery Group will be to provide an assessment of progress against the improvement actions received by the current Health Board Action Delivery Group to date and to focus on the completion of the remaining improvement actions identified in the report. The Chief Executive and Executive Director of Allied Health Services and Health Science will consider the appropriate mechanism to progress this work. Progress on this will be reported through to Executive Team and assurance can continue to be given through a report to the Quality Safety and Experience Committee

Appendix 1 provides a detailed update on progress against improvement actions by theme. The detailed evidence has progressed through the agreed "management arm" of the governance process and is shared through the "assurance arm" of the governance process (the Expert Advisory Group).

The Programme Team has summarised progress in the ten theme areas that is reviewed at the Health Board Action Delivery Group and rated delivery confidence in improvement actions being progressed. There is a high degree of confidence in all themes aside from Theme 9 where medium confidence is noted. This is due to the extra time needed to consider and develop a proposal to ensure/secure resources/funding. The confidence level relates to the ability of improvement actions to be progressed and received for review by the Health Board by December 2025, noting that feedback from the Expert Advisory Group will influence the assessment of progress against a number of these improvements during August 2025.

7. DEVELOPMENT OF THE OUTCOME FRAMEWORK AND PERFORMANCE DASHBOARD

At the meetings of the Health Board in January 2025 and July 2025, the Board noted the importance of developing an Outcomes Framework and accompanying Performance Dashboard that can illustrate progress against the improvements reported in the Invited Services Review.

Further to the development of the RCPsych Invited Services Review response plan and associated improvements, a Health Board task and finish group was commissioned to identify a set of outcomes and associated performance indicators that could be adopted to provide a demonstrative proxy measure of the positive impact resulting from the progress on the response plan. The objective being to develop a RCPsych Business Intelligence (BI) Performance Dashboard that could be presented and also for transferring into any bespoke reports that may be required within the overall governance framework. This commissioned work has been developmental and dynamic in its development.

There is a DRAFT Outcomes Framework that is at an early stage of its development and this draft will be shared with stakeholders at the beginning of a wider engagement process. The draft version is attached in Appendix 2. A wider socialisation of this draft with stakeholders will be of benefit to the final version to be deployed.

The DRAFT Outcomes Framework and associated Performance Dashboard reflects areas of interest that the Expert Advisory Group agreed during its work programme and is focussed on three key themes related to the care we provide to the public and patients of North Wales:

- Public and Patients
- Workforce
- Services

These three DRAFT strategic outcomes are set out on in **Appendix 2** with underpinning thematic outcomes and their performance indicators. Each indicator has a measure from August 2024 where possible to provide a trajectory that will be developed within a Business Intelligence Performance Dashboard. Each page also includes the work that took place with the Service Users and their Families to identify what matters to them most within in each theme. (The indicators are specific to the MH&LD Service). They also remain dynamic and developmental as further feedback shapes the approach and additional measures are made possible.

The next steps in socialising and maturing the Framework and Dashboard needs to be a staged approach, but at pace and with oversight/direction from the forthcoming ‘Mental Health Oversight and Development Group’.

8.NEXT STEPS

- For the Special Advisor to oversee the production of her summary report during September 2025 ready for reporting through to the Quality Safety and Experience Committee in November 2025 and Health Board meeting in January 2026.
- Progress the detailed arrangements for the development of the Mental Health Oversight and Development Group.
- Continue the focus on the progression of the RCPsych Improvement Actions in line with the trajectory shared at the Health Board in July 2025.
- Socialise work on the Draft Outcomes Framework and Performance Dashboard and report on progress at the Quality Safety and Experience Committee in November 2025.

9.RECOMMENDATIONS

This Committee is asked to;

- **Note and Consider** the update on the RCPysch Invited Services Review
- **Note and Consider** the next steps related to the oversight of the RCPsych Invited Services Review
- **Note and Consider** the development of a Draft Outcome Framework and Performance Dashboard prior to early development with stakeholders
- **Receive assurance** on the Health Board response to the RCPsych Invited Review Services Report.

11.APPENDICES

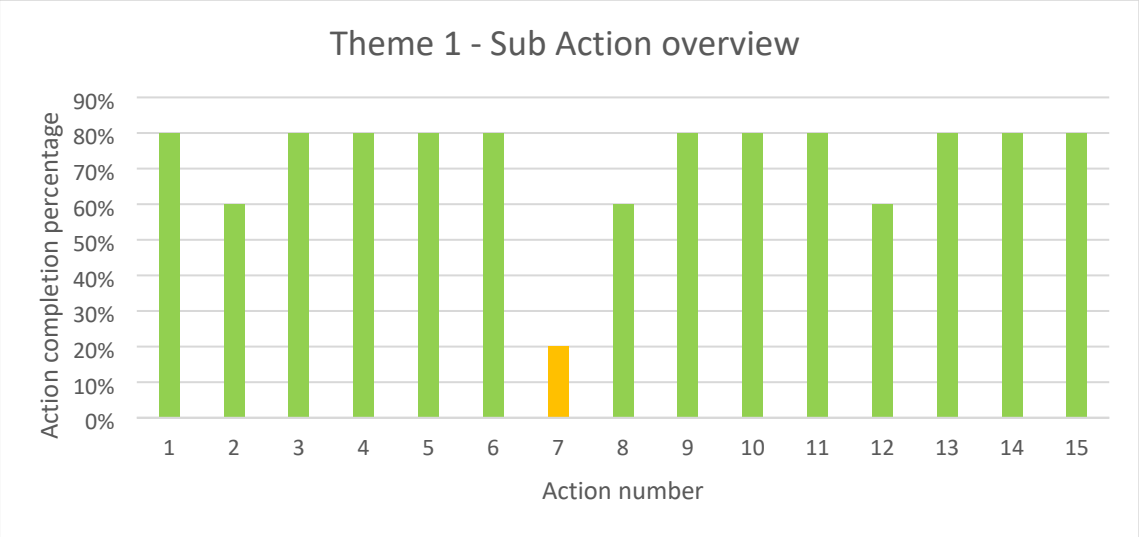
- **Appendix 1** – Summary of progress against the themed improvement actions outlined in the RCPsych Invited Services Review report
- **Appendix 2** – Outline of the Draft Outcomes Framework and associated Performance Dashboard

APPENDIX 1

Summary of progress against the themes improvement actions outlined in the RCPsych Invited Services Review report

RCPsych Theme 1 Sub Objective Assurance Report			
Report Compiled for	**QSE**	**Date**	**19th August 2025**

Sub Objective Theme 1 Overview - Patient and user centred care



NOTE – purpose is to provide Priority owners of a health check of their priority performance

Theme 1 Report

Theme	Theme Delivery Confidence	Theme 1 - Update
1	High	There are seven MH&LD actions and eight Health Board wide actions to deliver this outcome. In total, fourteen action owners have submitted evidence and are awaiting approval through various stages of the agreed governance route for approval and final sign off. One action remains in progress, albeit not to deadline which is aligned to reviewing the Local Authority (LA) working model in Community Mental Health Teams to ensure collaborative partnership working.

Individual Priority Milestones Report

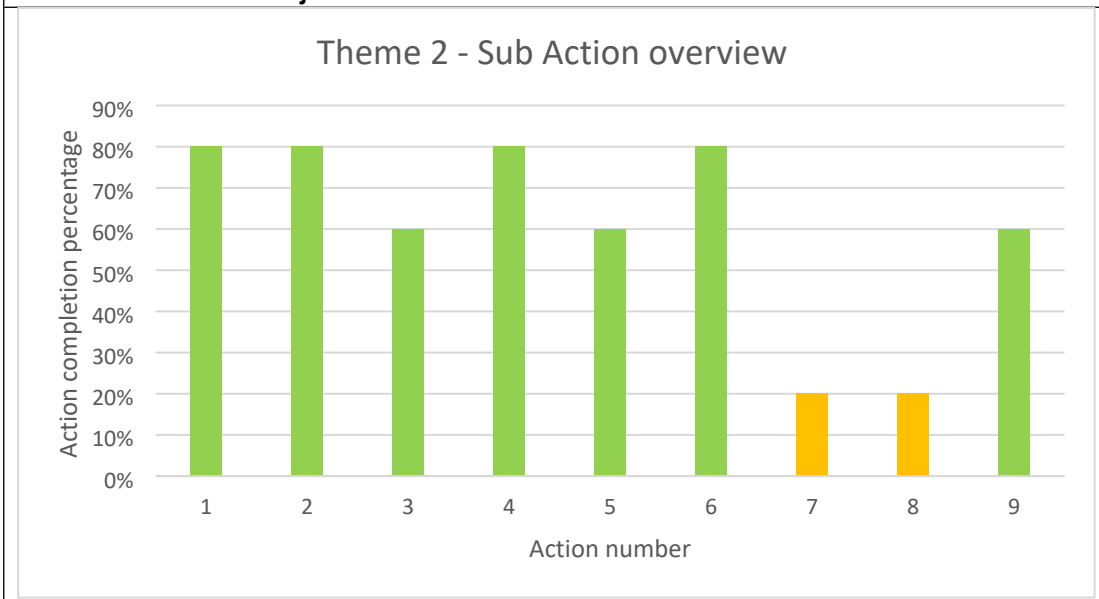
Priority	Action	Assigned Too	Action Completion %	Current Delivery Confidence	Action Update
1.1	Progress the recruitment of the MH&LD Nurse Consultant Dementia.	Assistant Director of Nursing	100%	High	Awaiting EAG Chair review but clearly actioned
1.2	Achieve Finding the light in Dementia Care training compliance across the MH&LD Division to 85% for Tiers 1, 2 and 3	Training, Development and Wellbeing Lead	60%	High	Awaiting strengthening following EoOG peer review
1.3	iCAN teams to attend CMHT's and other opportunities such as Third Sector, Local Authorities and other partnership to present activity	Head of Integrated Strategy and Development	80%	High	Awaiting final assessment

	locally to strengthen partnership working and improve awareness.				
1.4	Use data to capture real time patient feedback and experience through the MH&LD Patient Carer Experience group to embed patient and carer centred care and demonstrate commitment to becoming an intelligence leg and learning organisation.	Assistant Director of Nursing	80%	High	Awaiting final assessment
1.5	Plan and attend bi-monthly engagement meetings with Head of Operations and Llais.	Head of Operations and Service Delivery	80%	High	Awaiting final assessment
1.6	Further develop the model of patient and carer engagement to ensure people with lived and living experience of our services are at the heart of the planning, delivery and evaluation of services as equal partners.	Assistant Director of Nursing	80%	High	Awaiting final assessment
1.7	Review Local Authority (LA) working model in Community Mental Health Teams to ensure collaborative partnership working .	Director of Operations	20%	Medium	Action in progress, amended action completion date to 1/9/25
1.8	Develop and improve Dementia care data to provide consistent Welsh Government reporting from reliable and accurate data.	BCUHB Dementia Improvement Manager	60%	High	Awaiting strengthening following EoOG peer review
1.9	Promote HB uptake of "Finding the light in Dementia Care" Training for all tiers, calculate current compliance baseline as at June 2024, agree compliance target and measure improvement in compliance during the next six months.	BCUHB Consultant Nurse Dementia	80%	High	Awaiting final assessment
1.10	Continue engagement with Tawel Fan families via the Expert Advisory Group monthly meetings.	Director Of Partnerships, Communications and Engagement	100%	High	Awaiting final assessment
1.11	Continue engagement activities from Llais Wales, Patient Advice & Liaison Service, Canaid, wider partners and stakeholders aligned to patients and carer co-working.	Director Of Partnerships, Communications and Engagement	80%	HIgh	Awaiting final assessment
1.12	Organise opportunities to include Local Authority colleagues in	Director Of Partnerships, Communications and Engagement	80%	High	Awaiting final assessment

	Operational an strategic planning meetings.				
1.13	Undertake a Quality, Compliance and Outcomes audit of the DoLS applications in line with DoLS Legislation to inform Safeguarding training developments to highlight the required learning outcomes evidence by recognised themes.	Director of Safeguarding and Public Protection/Head of Safeguarding Adults	80%	High	Awaiting final assessment
1.14	Develop Data Incidents tool to support identification of incidents and those resulting in Harm involving patients with Dementia.	Director of Safeguarding and Public Protection/Head of Safeguarding Adults	80%	High	Awaiting final assessment
1.15	Develop supporting materials to support the application of Mental Capacity Act (MCA) and Deprivation of Liberty Safeguard (DoLS).	Director of Safeguarding and Public Protection/Head of Safeguarding Adults	80%	High	Awaiting final assessment

RCPsych Theme 2 Sub Objective Assurance Report			
Report Compiled for	**QSE**	**Date**	**19th August 2025**

Sub Objective Theme 2 Overview - Patient and user centred care



NOTE – purpose is to provide Priority owners of a health check of their priority performance

Theme 2 Report		
Theme	**Theme Delivery Confidence**	**Theme 2 - Update**

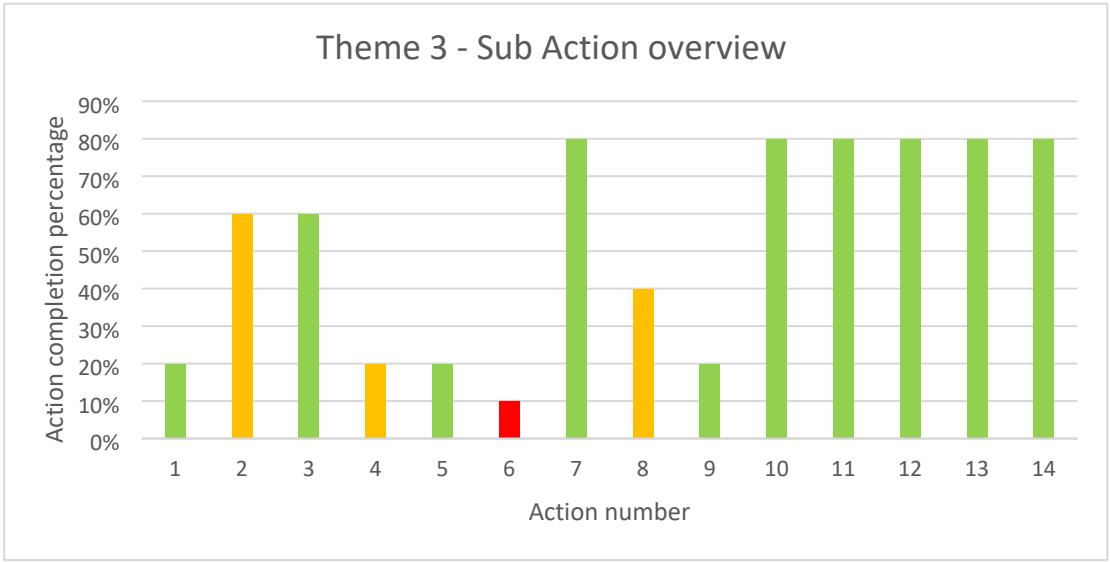
2	High	There are nine Health Board wide actions to deliver this outcome. In total, seven action owners have submitted evidence and are awaiting approval through various stages of the agreed governance route for approval and final sign off. Two actions remain in progress, albeit not to deadline

Individual Priority Milestones Report					
Priority	**Action**	**Assigned Too**	**Action Completion %**	**Current Delivery Confidence**	**Action Update**
2.1	Undertake an Audit of falls data from Datix to highlight key learning to adopt into training, development and Improvement	Assistant Director of Nursing	80%	High	Awaiting final assessment
2.2	Increase attendance at current "Tool Box" talks by consideration of establishing MH&LD Divisional Learning Forums developed across all teams. Monitor, review and report into monthly Service Quality Delivery Group (SQDG).	Governance Lead	80%	High	Awaiting final assessment
2.3	Increase deteriorating patient training compliance across the Division from current level to 85% compliance. Monitor and review at MH&LD Training and Development Group meeting.	Training, Development and Wellbeing Lead	60%	High	Awaiting strengthening following EoOG peer review
2.4	Complete consultation and approval of Physical health Strategy in preparedness for implementation.	Medical Director)	80%	High	Received at EAG. Now awaiting final assessment
2.5	Continue with the projected policy review, as provided as part of the National Collaborative Commissioning Unit (NCCU) Action plan.	Head of Governance	60%	High	Awaiting final assessment
2.6	Continue to complete annual audits of antipsychotic medication prescribing, presenting findings to the Clinical Effectiveness Group to agree and learning to be implemented from the annual reviews	Deputy Medical Director	80%	High	Awaiting final assessment
2.7	Consider and agree use of tool for monitoring antipsychotic medication in inpatient settings.	Medical Director	20%	Medium	Action remains in progress
2.8	Progress the adoption of Learning Organisation Framework within	Senior Organisational	20%	Medium	Action remains in progress, amended closure date of 1/8/25

	MH&LD with direct support from BCUHB to enable learning to be shared, embedded and sustained within the Division and the wider Health Board.	Development Manager			
2.9	Undertake an audit of DoLS to highlight the required learning outcomes evidence by recognised themes / trends to integrate into Safeguarding /MCA/DoLS Training	Director of Safeguarding and Public Protection/Head of Safeguarding Adults	60%	High	Awaiting final assessment

RCPsych Theme 3 Sub Objective Assurance Report			
Report Compiled for	**QSE**	**Date**	**19th August 2025**

Sub Objective Theme 3 Overview - Patient and user centred care



NOTE – purpose is to provide Priority owners of a health check of their priority performance

Theme 3 Report		
Theme	**Theme Delivery Confidence**	**Theme 3 - Update**
3	High	There are 14 actions to deliver this outcome. In total, seven action owners have submitted evidence and are awaiting approval through various stages of the agreed governance route for approval and final sign off. Seven actions remains in progress, three of which are not to deadline

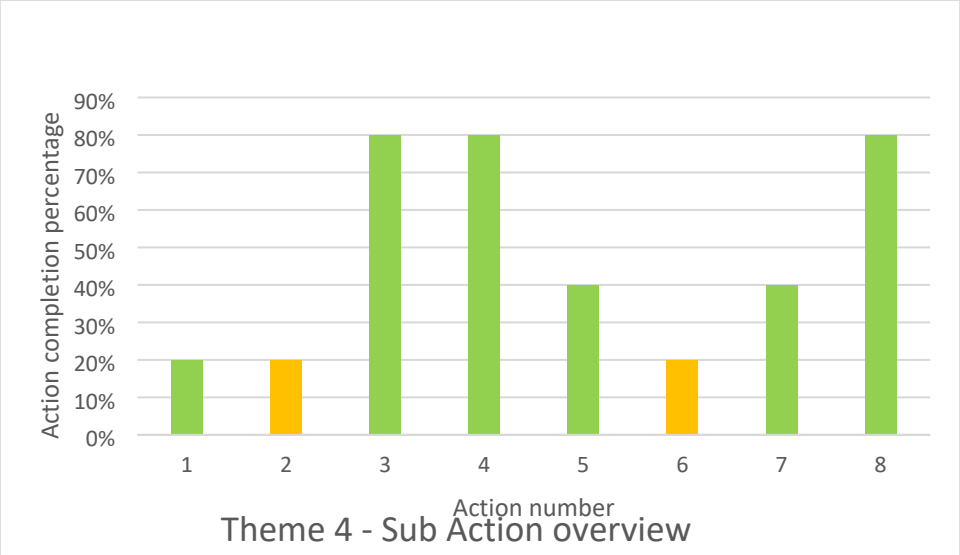
Individual Priority Milestones Report					
riority	**Action**	**Assigned Too**	**Action Completion %**	**Current Delivery Confidence**	**Action Update**
3.1	Progress the approval of the Electronic Patient records business	Head of Planning and Performance	100%	High	Action in progress and to deadline, action completion date 31/12/25. Presented at EAG on 15 August 2025

	case to enable national procurement of an optimum system to replace Welsh Community Care Information System (WCCIS).				
3.2	Audit on call medical staff to ensure they have their own personal login for Paragon.	Head of Operations and Service Delivery, SCS	60%	Medium	Awaiting strengthening following EoOG peer review. Presented at EAG on 15 August 2025
3.3	Progress the development of the MH&LD specific Ward Accreditation process and implement across all inpatient ward areas.	Practice Development Nurse	60%	High	Action in progress and to deadline, action completion date amended to 1/8/25
3.4	Deliver engagement and socialisation activities aligned to the outcome of the MH&LD Operating Model review	MH&LD Director	20%	Medium	Action in progress and to deadline, action completion date amended to 30/9/25
3.5	Develop and implement a robust process for sharing all learning from Serious Untoward Investigations with MH&LD and the wider Health Board.	Head of Governance	60%	High	Action in progress and to deadline, action completion date amended to 30/9/25
3.6	Develop a portal to communicate monthly Putting Things Rights learning in line with the Learning Organisational Framework to promote a lessons learnt knowledge.	Head of Governance	10%	Low	In progress, not to deadline. Consider change request to remove action as HB action will progress activity.
3.7	Establish a Health Board Oversight Group to ensure delivery of the Response plan including the approach for evidence submission to discharge actions.	BCHUB Associate Director of Governance	80%	High	Awaiting final assessment
3.8	Support with engagement events aligned to the MH&LD Operating Model to ensure all staff, partners and wider stakeholder are kept updated on progress with implementation.	Director Of Partnerships, Communications and Engagement	40%	Medium	Awaiting Strengthening. Will continue to evolve as Operating Model is confirmed
3.9	Support from Digital, Data Technology and Procurement colleagues to progress the implementation of Mental Health electronic patient records and change process	Chief Digital And Information Officer	80%	High	Action in progress and to deadline, action completion date 31/12/25 Presented at EAG on 15 August 2025

3.10	The development of an Integrated Complaints/Incidents/Mortality Review Management Framework. To implement an Integrated Framework aligning the Patient Safety and Experience Departments	Deputy Director of Quality	80%	High	Awaiting final assessment
3.11	Implementation of an agreed training plan for the Corporate and Operational teams in relation to Complaints Management and Patient Advice and Liaison Service (PALS).	Head of Patient & Carer Experience	80%	High	Awaiting final assessment
3.12	Improve Complaints performance trajectory to achieve 75% of complaints responded to within less than 30 working days in line with PTR Guidance.	Head of Patient & Carer Experience	80%	High	Awaiting final assessment
3.13	Implementation of the Telephony System to support an improved single point of contact for the public to raise concerns/enquiries.	Lead Complaint Manager and Patient & Carer Experience Lead	80%	High	Awaiting final assessment
3.14	Commence a formal campaign to promote how to raise concerns.	Lead Complaint Manager and Patient & Carer Experience Lead	80%	High	Awaiting final assessment

RCPsych Theme 4 Sub Objective Assurance Report			
Report Compiled For	**QSE**	**Date**	**19th August 2025**

Sub Objective Theme 4 Overview - Patient and user centred care



NOTE – purpose is to provide Priority owners of a health check of their priority performance

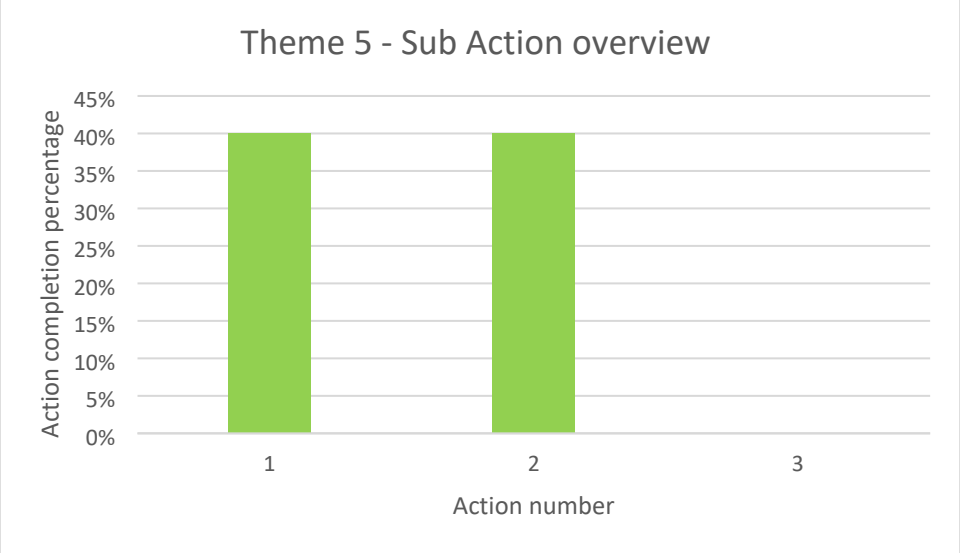
Theme 4 Report		
Theme	**Theme Delivery Confidence**	**Theme 4 - Update**
4	High	There are seven MH&LD actions to deliver this outcome and one Health Board actions to deliver this outcome. In total, five action owners have submitted evidence and are awaiting approval through various stages of the agreed governance route for approval and final sign off. Three actions remains in progress, albeit not to deadline which are aligned to the recruitment of a MH&LD Director of Nursing (that is now out to advert), a Consultant Psychiatrist for the Hergest Unit and progressing the funding the Wellness, Work and Us Service

Individual Priority Milestones Report					
Priority	**Action**	**Assigned Too**	**Action Completion %**	**Current Delivery Confidence**	**Action Update**
4.1	Recruit to the position of MH&LD Director of Nursing post.	MH&LD Director	20%	High	In progress and due within deadline (30/11/2025) Interviews held on 15 August 2025
4.2	Recruit dedicated Consultant Psychiatrist for the Hergest Unit.	Medical Director	20%	Medium	In progress and due within deadline (30/10/2025)
4.3	Continue to progress the recruitment and retention activities aligned to the MH&LD Recruitment and Retention plan.	MH&LD Operational Business Lead	80%	High	Awaiting final assessment
4.4	Communicate Dementia Essential study days to all MH&LD staff to increase awareness and attendance	Director of Nursing	80%	High	Awaiting final assessment Received at EAG
4.5	Implement a review process of cover arrangement when Dementia Support Workers are vacant to ensure continuity of service provision.	Director of Nursing	60%	High	Awaiting strengthening following EoOG peer review
4.6	To progress the Business Case substantive funding for the MH&LD Wellness, Work and Us Service.	Director of Nursing	20%	Medium	In progress but not to deadline
4.7	Development of an options appraisal to support consideration for	Director of Nursing	40%	High	Awaiting strengthening following EoOG peer review

	recruitment of a dementia practice educator for MH&LD.				
4.8	Raise awareness and attendance of Health Board staff at Dementia Essentials study days.	BCUHB Consultant Nurse Dementia	80%	High	Awaiting final assessment

RCPsych Theme 5 Sub Objective Assurance Report			
Report Compiled For	**QSE**	**Date**	**19th August 2025**

Sub Objective Theme 5 Overview - Patient and user centred care



NOTE – purpose is to provide Priority owners of a health check of their priority performance

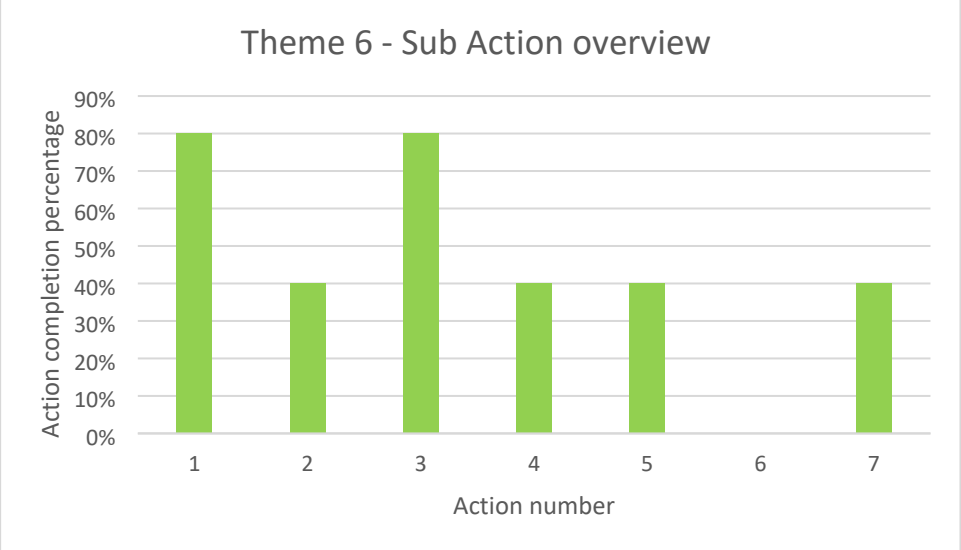
Theme 5 Report		
Theme	**Theme Delivery Confidence**	**Theme 5 - Update**
5	High	The Division has two improvement actions and the Health Board has one. One action owner has submitted evidence and this action is awaiting approval through various stages of the agreed governance route for approval and final sign off. Two actions are in progress and within deadline.

Individual Priority Milestones Report					
Priority	**Action**	**Assigned Too**	**Action Completion %**	**Current Delivery Confidence**	**Action Update**
5.1	Continue to progress recruitment of interim posts to substantive posts aligned to the MH&LD Operating Model	MH&LD Director	40%	High	Awaiting strengthening following EoOG peer review

	and in line with the wider Operating Model review, aiming to reduce interim posts by 25% by 31/3/25				
5.2	Ensure that older adults mental health services are represented in the Directorate management structure.	Medical Director	40%	High	Awaiting strengthening following EoOG peer review
5.3	Support to progress recruitment of interim posts to substantive posts aligned to the MH&LD Operating Model.	Associate Director For People - Pan	60%	High	In progress, but not to deadline (31/03/2025)

RCPsych Theme 6 Sub Objective Assurance Report			
Report Compiled for	**QSE**	**Date**	**19th August 2025**

Sub Objective Theme 6 Overview - Patient and user centred care



NOTE – purpose is to provide Priority owners of a health check of their priority performance

Theme 6 Report		
Theme	**Theme Delivery Confidence**	**Theme 6 - Update**
6	High	The Division has one action in progress not to deadline, 6.5 - Ensure all Centre and East Memory Assessment units attain Memory Service National Accreditation Programme (MSNAP) accreditation. Action 6.6 - Progress the

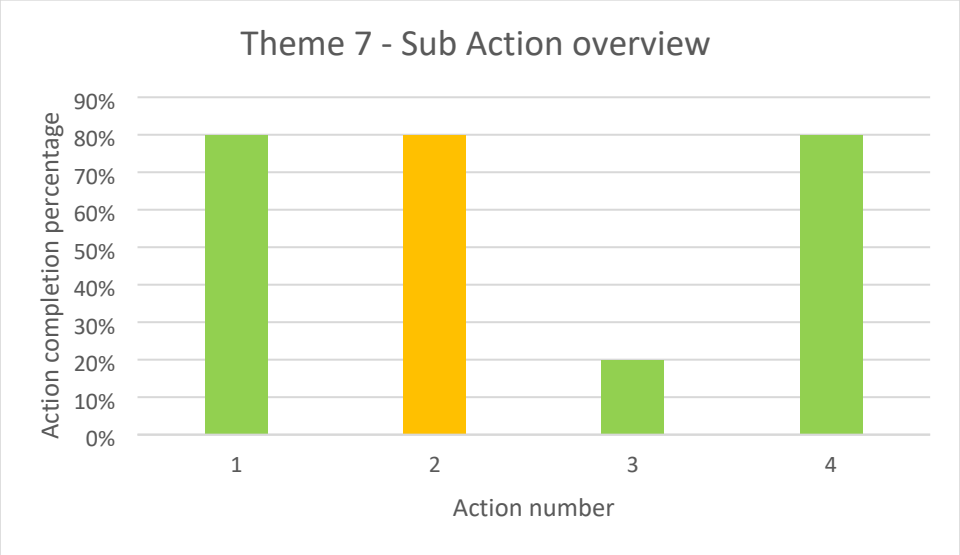
		pilot scheme for in-reach workers in care homes, review and measure impact and outcomes and carry out options appraisal to expand to all care homes to enable consistency of service provision is due October 2025.

Individual Priority Milestones Report					
Priority	**Action**	**Assigned Too**	**Action Completion %**	**Current Delivery Confidence**	**Action Update**
6.1	Desk top audit of Multi-disciplinary (MDT)ward round in line with the Terms of reference to ensure assurance.	Medical Director	80%	High	Awaiting final assessment
6.2	Develop dementia roles and responsibilities within Practise Development Nurse role.	MH&LD Consultant Nurse Dementia	40%	High	Awaiting strengthening following EoOG peer review
6.3	Development of an options appraisal to support consideration for extending regional pilot of applied behaviourists working with patients with complex needs	MH&LD Consultant Nurse Dementia	80%	High	Awaiting final assessment
6.4	Continue monthly Consultant Nurse Dementia led network meeting with all MH&LD Activity Coordinators to ensure patients have improved patient outcomes and patient experience.	MH&LD Consultant Nurse Dementia	40%	High	Awaiting strengthening following EoOG peer review
6.5	Ensure all Centre and East Memory Assessment units attain Memory Service National Accreditation Programme (MSNAP) accreditation.	MH&LD Consultant Nurse Dementia)	40%	High	Awaiting strengthening following EoOG peer review
6.6	Progress the pilot scheme for in reach workers in care homes, review and measure impact and outcomes and carry out options	MH&LD Consultant Nurse Dementia	0%	Medium	In progress, not to deadline. Consider change to close action as requested by TW.

	appraisal to expand to all care homes to enable consistency of service provision.				
6.7	Continue monthly Consultant Nurse Dementia led network meeting with all MHLD Activity Coordinators to ensure patients have improved patient outcomes and patient experience.	MH&LD Consultant Nurse Dementia	40%	High	Approved by Evidence of Outcomes Group Awaiting HBADG and final assessment

RCPsych Theme 7 Sub Objective Assurance Report			
Report Compiled for	**QSE**	**Date**	**19th August 2025**

Sub Objective Theme 7 Overview - Patient and user centred care



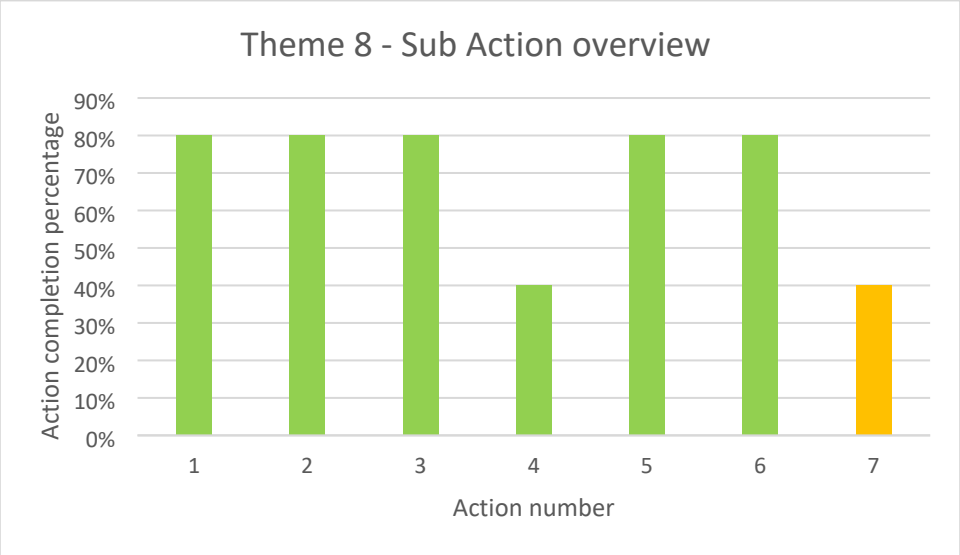
NOTE – purpose is to provide Priority owners of a health check of their priority performance

Theme 7 Report		
Theme	**Theme Delivery Confidence**	**Theme 7 - Update**
7	High	Four key actions are aligned to this outcome, three for MH&LD and one for the Health Board. A Divisional Learning Event is currently being planned for September 2025, aiming to have two events per year. This will enable a wide variety of stakeholder engagement as well as themed topics that will support learning and improvement across the Division.

Individual Priority Milestones Report

Priority	Action	Assigned Too	Action Completion %	Current Delivery Confidence	Action Update
7.1	Further develop and implement networking opportunities of ward staff working across the range of Divisional service to promote and enable sharing of best practice.	Director of Nursing	80%	High	Awaiting final assessment
7.2	Implement an agreed HCA career pathway to "Grow your own" MH&LD nurses for the future in collaboration with Health Board, aligned to the annual plan.	Assistant Director of Nursing	80%	Medium	Awaiting final assessment
7.3	Develop Divisional Learning Events rolling programme plan to include key external speakers to aid staff development. Link in with Workforce and Organisational Development (WOD) colleagues regarding future themes from leadership events	Governance Lead	60%	High	In progress, not to deadline (01/07/2025)
7.4	Review of Dementia Support Worker/Activity Coordinator Job Description to reduce variation in roles.	BCUHB Consultant Nurse Dementia	80%	High	Awaiting final assessment

RCPsych Theme 8 Sub Objective Assurance Report			
Report Compiled For	**QSE**	**Date**	**19th August 2025**
Sub Objective Theme 8 Overview - Patient and user centred care			



NOTE – purpose is to provide Priority owners of a health check of their priority performance

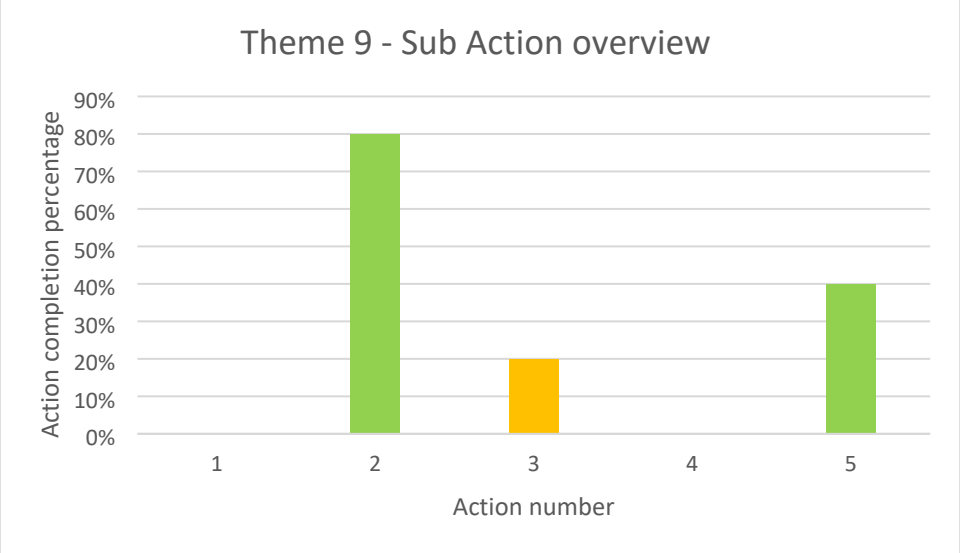
Theme 8 Report		
Theme	**Theme Delivery Confidence**	**Theme 8 - Update**
8	High	There are seven actions across the Health Board to support delivery of this outcome. Six actions are awaiting formal approval following evidence submissions and the remaining one is in progress albeit not within the deadline for delivery. These are outlined below, including HEIW training, Cultural Change Leaders, MAPP, Staff Survey and Divisional SLT walkabout.

Individual Priority Milestones Report					
Priority	**Action**	**Assigned Too**	**Action Completion %**	**Current Delivery Confidence**	**Action Update**
8.1	Implement the MH&LD Communication and Engagement Plan. (Form part of the Health Board overall Citizen Engagement Commitments, ensuring that plans and priorities are informed by what matters to citizens)	Head of Integrated Strategy and Development	80%	High	Awaiting final assessment
8.2	Capture the themes and feedback from the bi-monthly "Ask Divisional Senior Leadership Team" virtual sessions to develop a "You said, we did, we are going to do"	Director of Operations	80%	High	Awaiting final assessment

	staff engagement. Report updates into Tier 1 Divisional meeting and include summaries in the MH&LD Staff Briefing.				
8.3	Agree the 12 month Divisional Senior Leadership Team Walkabout schedule for 24/25, incorporating all lessons learnt from current arrangements.	Director of Operations	80%	High	Awaiting final assessment
8.4	Commitment to develop leadership and management training using the Health Board Compassionate Leadership model and develop a variety of staff feedback mechanisms, including pulse surveys, to measure and monitor culture within teams to build and create a compassionate and high performing culture.	MH&LD Director	40%	High	Awaiting strengthening following EoOG peer review
8.5	Support with the implementation of the MH&LD Communication and Engagement Plan.	Director Of Partnerships, Communications and Engagement	80%	High	Awaiting final assessment
8.6	Analyse staff survey findings, capture themes and agree actions and how we will strengthen communication and engagement with staff to improve and learn from good practice.	Director Of Partnerships, Communications and Engagement	80%	High	Awaiting final assessment
8.7	Support the creation of a culture within the MH&LD service that is consistently compassionate and high performing.	Associate Director For People - Pan	40%	Medium	Evidence submitted to EOG, awaiting peer review

RCPsych Theme 9 Sub Objective Assurance Report			
Report Compiled For	**QSE**	**Date**	**19th August 2025**

Sub Objective Theme 9 Overview - Patient and user centred care



NOTE – purpose is to provide Priority owners of a health check of their priority performance

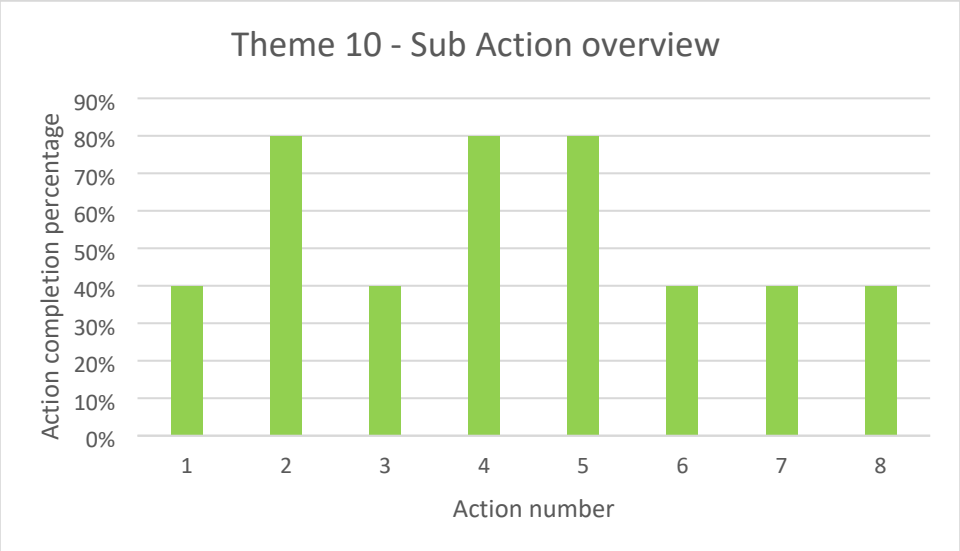
Theme 9 Report		
Theme	**Theme Delivery Confidence**	**Theme 9 - Update**
9	High	There are five improvement actions across the whole Health Board to support the delivery of this outcome. The response to the RCPsych Invited Services review highlights that the Therapy Services gap analysis is underway. The Health Board supports the vital contribution Therapy Services can make to achieve the aspirations of the refreshed Health Board Clinical Services plan: to supporting the delivery of integrated mental and Physical Health Services and which meet the needs of our population.

Individual Priority Milestones Report					
Priority	**Action**	**Assigned Too**	**Action Completion %**	**Current Delivery Confidence**	**Action Update**
9.1	Review the role of pharmacy to consider further developing across the Division.	Consultant Mental Health Pharmacist	0%	High	In progress, not to deadline. Should be a HB action - consider change request.
9.2	Review the demand and capacity arrangements for therapeutic options available to all inpatient units to identify any gaps and agree next steps.	Assistant Director of Allied Health Professionals (AHPs) and Health Sciences	80%	High	Awaiting final assessment

9.3	For any identified gaps in therapeutic provision across inpatients units develop a business care where relevant for therapeutic staffing by accessing WG Improvement Funds.	Assistant Director of Allied Health Professionals (AHPs) and Health Sciences	20%	Medium	In progress and due within deadline. Change control approved to amend completion date of 31/10/25
9.4	Ensure this is regularly reviewed with a clear escalation procedure if further equipment/facilities are needed to ensure swift resolution.	Assistant Director of Allied Health Professionals (AHPs) and Health Sciences	0%	Medium	In progress and due within deadline. Change control approved to amend completion date of 31/10/25
9.5	Dedicated resource from the Health Board Transformation and Improvement team to support with development of the action plan and for the transformation/improvement activity required.	Director Of Transformation & Improvement	60%	High	Awaiting Peer Review

RCPsych Theme 10 Sub Objective Assurance Report			
Report Compiled For	**QSE**	**Date**	**19th August 2025**

Sub Objective Theme 10 Overview - Patient and user centred care



NOTE – purpose is to provide Priority owners of a health check of their priority performance

Theme 10 Report		
Theme	**Theme Delivery Confidence**	**Theme 10 - Update**

10	High	There are eight Health Board wide actions to deliver this outcome. In total, seven action owners have submitted evidence and are awaiting approval through various stages of the agreed governance route for approval and final sign off. One action remains in progress, albeit not to deadline which is aligned to progressing necessary Divisional Capital Estates works as part of the annual plan to ensure all works are captured.

Individual Priority Milestones Report					
Priority	**Action**	**Assigned Too**	**Action Completion %**	**Current Delivery Confidence**	**Action Update**
10.1	Strengthen escalation of any outstanding remedial environmental estates works from local area Estates meeting through to the MH&LD Capital and Estates meeting.	Head of Operations and Service Delivery	80%	High	Awaiting strengthening following EoOG peer review Presented at EAG on 15 August 2025
10.2	Progress Environmental Ligature Risk Assessment Audit, report outcome through Tier 1 meeting to progress actions to completion.	Governance Lead	80%	High	Awaiting EAG approval Presented at EAG on 15 August 2025
10.3	Provide six monthly update on progress of NCCU Action plan.	Director of Operations	40%	High	Awaiting strengthening following EoOG peer review
10.4	Support progressing necessary actions for any outstanding remedial environmental MH&LD estates works escalated to the Divisional Estates and Capital Group or the Divisional Ligature Risk Reduction Group using a Tripartite approach within their area of expertise to enable safe environments to be maintained.	BCHUB Estate Operations Manager	80%	High	Awaiting final assessment Presented at EAG on 15 August 2025
10.5	Support progressing necessary Divisional Capital Estates works as part of the annual plan to ensure all works are captured.	BCHUB Head of Capital Development	80%	High	Awaiting final assessment Presented at EAG on 15 August 2025
10.6	Support from Health and Safety aligned to ensuring an	BCHUB Assistant Director Of	60%	High	Awaiting strengthening following EoOG peer review

	appropriate physical environment for patient including the ligature tripartite risk assessments.	Occupational Health, Safety And Security Corporate Office			Presented at EAG on 15 August 2025
10.7	Support from Health and Safety to continue to provide advice, support and lead on the Ligature Environmental Risk Assessment training for staff.	BCHUB Assistant Director Of Occupational Health, Safety And Security Corporate Office	60%	High	Awaiting strengthening following EoOG peer review Presented at EAG on 15 August 2025
10.8	Support from Health and Safety to continue to undertake ad-hoc health and safety inpatient inspections.	BCHUB Assistant Director Of Occupational Health, Safety And Security Corporate Office	60%	High	Awaiting strengthening following EoOG peer review Presented at EAG on 15 August 2025

APPENDIX 2

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Royal College of Psychiatry Invited Review Service Report

Response Plan

Draft Outcomes Framework

Draft Version, July 2025

Contents Table

Background

In 2024, the Royal College of Psychiatry **(RCPsych)** was commissioned by the Welsh Government to undertake an external Invited Review Service **(IRS)** of how Betsi Cadwaladr University Health Board **(BCUHB)** had implemented the findings from four previous Mental Health Reports and the extent to which these had been maintained and integrated into 'business as usual' practices. The review reflected serious and outstanding concerns about board effectiveness, organisational culture, service quality and reconfiguration, governance, patient safety, operational delivery, leadership and financial management. In October 2024, the development of this outcomes framework was commissioned, alongside the development of a visual business intelligence dashboard of performance indicators to enable this framework to be realised in the short, medium and long term. A task and finish group led this work, very much through a staged process of discover, design, develop and deliver. This has been shaped along the way by the Health Board Action Delivery Group and other key stakeholder feedback.

Document Purpose

The purpose of this document is to provide a means to understand and measure the expected impact of the improvement actions developed across the ten themes within the RCPsych report and the difference they will make to our service users, their families/carers, the staff involved in their care and the systems supporting their care. Identifying key outcomes within this document is critical in setting out what difference the changes will make and enable the development of indicators that can be measured and monitored. The development of this framework seeks to highlight that the oversight of progress in achieving the outcomes is enabled for short, medium and long term sustainability and it will drive shared responsibility and accountability both within the Mental Health and Learning Disabilities **(MH&LD)** division and across BCUHB services.

Involving Service Users and their Families

People with lived experience of our services need to be at the heart of the planning, delivery and evaluation of our services as equal partners in the care that we provide. This is the vision that drives the development of our Service User and Carer Strategy. Capturing what matters the most to the people who access our services and their families and the outcomes they expect throughout this framework is critical to making the right changes and sustainable improvements.

Throughout the development of the response plan, involvement of service users and families has been paramount. An Expert Advisory Group has been developed with service users and families to consider what it is that matters to them most in respect of the improvements and to support the Health Boards review of progress against them. The feedback gained so far from the service users and their families is illustrated against each of the three strategic outcomes. The Health Board will continue to engage with the range of service user and carer forums within the services including the Expert Advisory Group to further develop this framework as we embed the improvements into business as usual.

Framework Audience

This framework is intended to support the communication of the intended outcomes, the performance indicators and measures underpinning them to those involved across the RCPsych governance structure. This framework will provide the wider MH&LD Division, the Health Board, key stakeholders and the service users and their families with the assurance that we are clear on the change we expect to see from the improvements being made and we know how we are going to measure and monitor them. It is also expected to facilitate the teams within MH&LD and the Health Board as we shift into the improvements being sustained as business as usual, this includes the staff who have been involved and have contributed to the development of the outcomes and indicators within this framework

Developing an Outcomes Framework

To be able to understand and evidence the changes being made relies on a set of clear and concise outcomes which are measurable and appropriate at a high level for flexibility but require some context so that they are more able to be meaningfully measured and delivered on the ground. The indicators need to demonstrate the shift towards the outcome and the measures need data that is easy to collect. Measures may need to be proxy measures that may have a specific plan to develop further, recognising that developing new data sets takes time.

Outcomes are clear statements about what is ultimately needing to be achieved. They are the difference that will be made as a result of actions or interventions. These can be high level strategic outcomes at a population or organisation level or outcomes at a more granular level.

Performance Indicators (Quantitative) set out the change that needs to happen to achieve the outcome, driven by the implementation of actions or interventions.

Performance Measures (Quantitative) are how we will review and track the performance indicators to ensure that change happens and is sustained.

It has been recognised that developing an outcomes-based performance approach to the implementation of the response to the RCPsych Invited Services Review Report will require regular data collection and reporting systems to be developed. Where it identifies opportunities for new data collections or different methods to improve systems, data quality issues and avoid duplication this will

be escalated as required. This framework will therefore be dynamic and developmental as we explore, learn and improve on this approach.

Strategic Outcomes

The scope of the work within the RCPsych Response Plan is broad and vast which has resulted in a set of high-level strategic outcomes that have been shaped around three distinct areas being Public/Patients, Service and Workforce.

Thematic Outcomes and Indicators

The RCPsych report was structured against ten themes, therefore, to underpin the strategic outcomes a set of thematic outcomes have been developed allowing the development of a set of performance indicators. Each indicator will be allocated a specific measure that will demonstrate a trajectory that can be monitored, providing an indication as to whether the response plan is contributing to a positive position in the short, medium and long term. It is worthwhile to note that many of the indicators, although attached to a single theme within this framework, are actually cross-cutting and will demonstrate the position against a number of themes.

The aim is to maintain an initial focus on a limited number of performance indicators, however, there may be other key indicators to on-board into the framework as progress is made.

Wider Quantitative and Qualitative Assurance

How the range of stakeholders are assured that the improvements are being achieved and delivering the desired outcomes is wider than the performance measures alone. Information has been developed that will include the evidence that the 80 improvement actions within the response plan are progressing or have been completed and it will also include progress against the RCPsych work programme in respect of the visits and presentations being scheduled for key stakeholders for example the Llais engagement visits. The totality of the assurance being provided is as follows:

Evidence of Actions	Outcomes & Performance Indicators/Measures	Site/Service Visits (and other forms of feedback)	Presentations

Note - Consider reflecting the approach in shifting to the forward-looking approach to assurance.

Outcome Structure

Three strategic outcomes are set out on pages 5,6,7 with the underpinning thematic outcomes and their performance indicators. Each indicator has a measure from August 2024 where possible to provide a trajectory that will be developed within a Business Intelligence Performance Dashboard. Each page also includes the work that took place with the Service Users and their Families to identify what matters to them most within in each theme. **Please note that the indicators below are specific to the MH&LD Division.** They also remain dynamic and developmental as further feedback shapes the approach and additional measures are made possible, therefore, the measures are as at the date of this Framework version.

Strategic Outcome 1

Strategic Outcome 1: Our Mental Health and Learning Disabilities services will deliver the best care for our **public and patients.**

Theme 1 - Patient & User Centred Care - Outcome:
Improved care for those accessing our mental health services.

Indicators:
- Increase in excellent patient experience responses
- Increase in positive patient reported outcomes responses
- Decrease in patient incidents with harm

Theme 3 - Governance - Outcome:
Seamless Care Co-ordination for our Patients

Indicators:
- Increase in complaints closed within 30 days compliance
- Increase in electronic health record implementation

Theme 6 – Clinical Services Organisation - Outcome:
Improved integrated clinical delivery for our patients.

Indicators:
- Decrease in memory assessment waiting times
- Increase in memory assessment service accreditations

Theme 10 – Physical Environment - Outcome:
Improved estates and environments for our patients

Indicators:
- Increase in compliance with tri-partite anti-ligature assessments
- Increase in completed external review response actions
- Increase in progress against funded capital & estates plans (tbc)

What our Service Users and Families tell us what matters to them within this strategic outcome:

Service users and families are engaged with teams and are safe and protected from harm.

Current patients and families know what the experience of service users and families is.

There are effective processes to raise issues and concerns and address problems quickly.

Service users and families are engaged and involved in the person's care.

Staff are consistently kind and caring and set a good impression.

There is an understanding of how the mortality review process works in AMH and OPMH now.

Measures and outcomes are developed to help understand progress in sustaining good care and continuous improvement and learning in mental health teams.

Clinical disciplines are effectively involved in care, treatment and leadership.

Staff have adequate specialty knowledge e.g., dementia, AMH/OPMH specialties.

There are improvements in oversight and assurance arrangements related to the case mix of patients and function of wards in OPMH and AMH and culture of care e.g. recent experience on a AMH ward.

Current infrastructure supports good care including quality, location and use of current estate and equipment being fit for purpose and supporting, safety (e.g., ligature removal and plan), dignity and good clinical outcomes and experience standards.

Current patients and their families see improvement inpatient record keeping and management. Is it effective (including the introduction of the new electronic health

Strategic Outcome 2

Strategic Outcome 2: Our Mental Health and Learning Disabilities **workforce** will meet the needs of our public and patients.

Theme 4 – Staffing - Outcome:
Improved recruitment and retention of our workforce.

Indicators:
- Decrease in vacancy rate
- Decrease in turnover rate
- Decrease in sickness rate

Theme 5 – Management Structure - Outcome:
Improved stability of our management workforce.

Indicators:
- Increase in substantive appointments to interim roles
- Increase in senior leadership team visibility
- See leadership & engagement theme for further indicators

Theme 7 – Training & Development - Outcome:
Improved knowledge and skills set of our workforce.

Indicators:
- Increase in Dementia Awareness Training Compliance
- Increase in WARRN Training Compliance
- Increase in RPI Training Compliance
- Increase in Ligature Awareness Training Compliance

Theme 8 – Leadership & Staff Engagement - Outcome:
Improved culture of compassionate leadership and communication across our workforce.

Indicators:
- Increase in positivity scores to the staff survey leadership and engagement questions.

What our Service Users and Families tell us what matters to them within this strategic outcome:

There are improvements in staffing levels in respect of being safe and supporting good care, benchmarked with similar organisations, and minimising the use of temporary staff and interims.

Clinical disciplines are effectively involved in care, treatment and leadership.

Staff have adequate specialty knowledge e.g. dementia, AMH/OPMH specialties.

There are improvements in oversight and assurance arrangements related to the case mix of patients and function of wards in OPMH and AMH and culture of care e.g. recent experience on a AMH ward.

Staff feel well supported and trained and does education and training meet expected standards

Understanding what staff say about their experience in teams.

Strategic Outcome 3

Strategic Outcome 3: Our Mental Health and Learning Disabilities and wider Health Board **services** will continuously learn and improve.

Theme 2 - Legislation & Clinical Guidelines - Outcome:
Improved sharing and embedding of learning.

Indicators:
- Increase in compliance with 'in date' written control documents
- Decrease in patient falls with harm
- Decrease in risk level of open risks

Theme 9 – Resources- Outcome:
Improved access to multi-disciplinary care.

Indicators:
- Increase in ward accreditation outcome (inc MDT communication)
- Increase in multi disciplinary ward round constitution

What our Service Users and Families tell us what matters to them within this strategic outcome:

Treatment processes show good outcomes for service users and families based on best evidence and benchmarked with best practice internally and externally.

Clinical disciplines are effectively involved in care, treatment and leadership.

There are improvements to physical health care and interventions, end of life care, management of medical emergencies and planned health checks.

There are improvements in safe and effective medicines management in teams and reducing medication errors and polypharmacy.

People are safeguarded from harm and abuse including self-harm and violence towards others and reduction and oversight of restrictive practices.

Current infrastructure supports good care including quality, location and use of current estate and equipment being fit for purpose and supporting, safety (e.g., ligature removal and plan), dignity and good clinical outcomes and experience standards.

Current patients and their families see improvement inpatient record keeping and management. Is it effective (including the introduction of the new electronic health record (EPR).

Framework Mobilisation

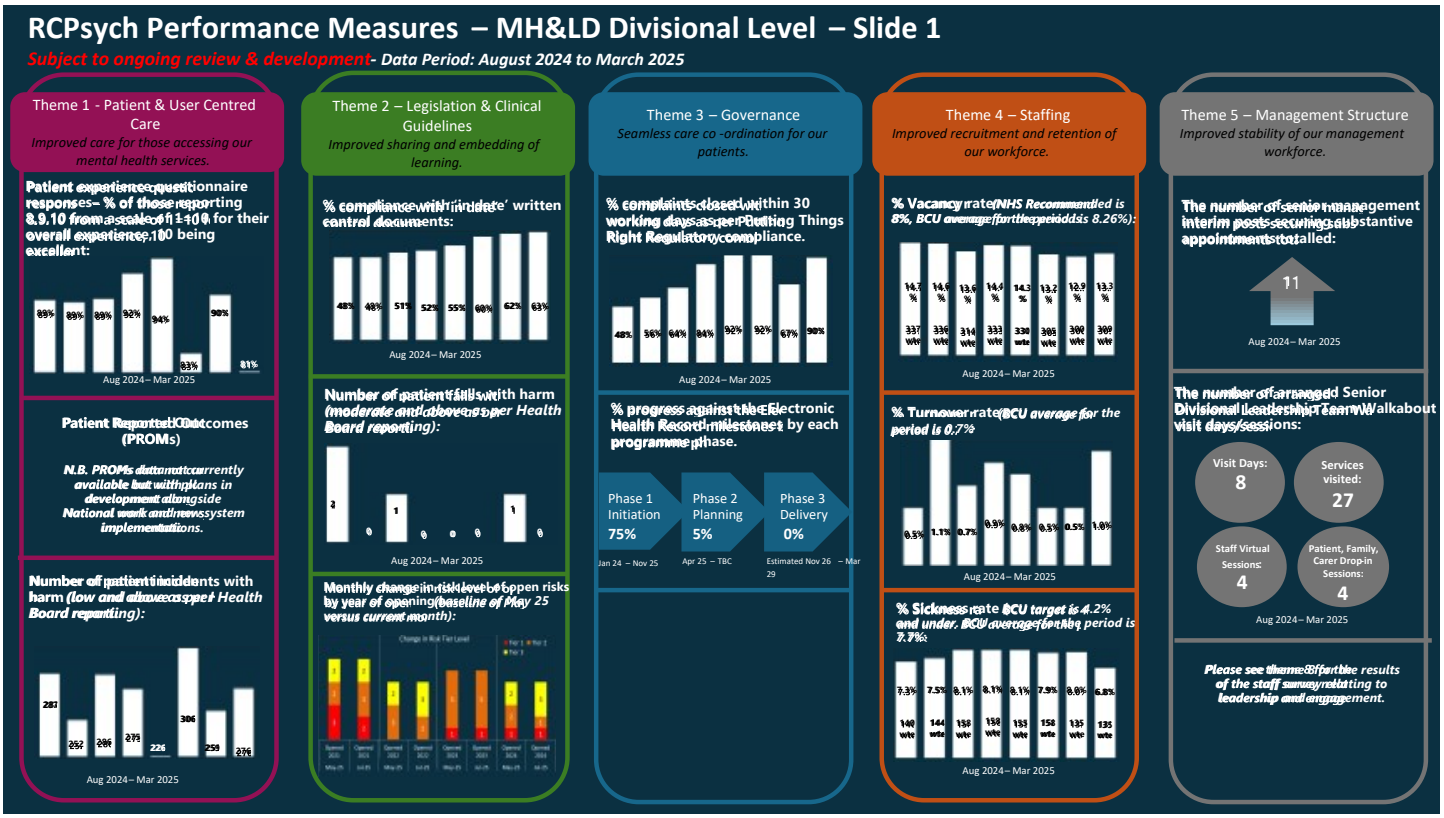
A suite of measures will be developed into a Business Intelligence Performance Dashboard that will provide a view of each performance measure across a range of levels i.e. by Health Board, by MH&LD, by Service. The dashboard will be made available via the BCUHB intranet based IRIS dashboard platform for ease of access along with other key organisational performance dashboards. A system will be developed to feed the dashboard with the data and given the measures are a mix of current reported measures and local measures, this will need to be resourced and managed appropriately. The output within the dashboard can be used to shape a range of specific reports depending on the requirements and audience and again, this will need to be resourced and managed appropriately.

Framework Future (needs input - align to BAU plan)

The framework may need two versions with the second version looking forward in an approach that fits the future governance etc. The performance measures in whatever form they take will need to be subjected to an appropriate governance route for review, scrutiny and most importantly identifying areas for deep dives and corrective action? It is critical that the performance reporting which has a purpose does actually result in action where the dial does not move in the right direction. The approach in monitoring the outcome measures may differ on a short, medium and long term basis with a fundamental aim of embedding routine monitoring into business as usual.

ASSOCIATED DRAFT PERFORMANCE DASHBOARD

FIGURES FOR ILLUSTRATION ONLY



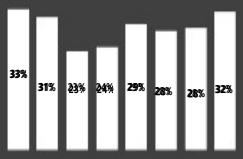
RCPsych Performance Measures – MH&LD Divisional Level – Slide 2 – FOR ILLUSTRATION

Subject to ongoing review & development - Data Period: August 2024 to March 2025

Theme 6 – Clinical Services Organisation

Improved integrated clinical delivery for our patients.

Memory Assessment Service Waiting Times - % of patients waiting 57 days and over for assessment:



Aug 2024– Mar 2025

Memory Assessment Service Accreditation current position by area (Green: achieved Amber: working towards Red: not started):

West | Centre | East

N.B. Ongoing discussions re: measurable & meaningful data potential relating to this theme.

Theme 7 – Training & Development

Improved knowledge and skills set of our workforce.

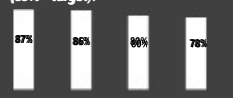
Dementia Awareness % Training Compliance (85%+ *target*):

Aug 2024– Mar 2025

Welsh Applied Risk Research Network % Training Compliance (85%+ *target*):

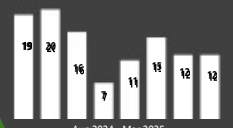
Aug 2024– Mar 2025

Restrictive Physical intervention % Training Compliance (bi-monthly) (85%+ *target*):



Aug 2024– Mar 2025

Environmental Ligature Awareness Training (number of those trained



Aug 2024– Mar 2025

Theme 8 – Leadership & Staff Engagement

Improved culture of compassionate leadership and communication across our workforce.

The change in positivity scores to leadership & engagement questions in the staff survey between 2023 and 2024 was:

0.6% — **My line manager encourages me in my work:** 78.7% to 79.3%

4.5% — **My line manager takes a positive interest in my health & wellbeing:** 65.4% to 69.9%

3.5% — **My line manager values my work** 76.7% to 80.2%

1.4% — **Overall Staff Engagement** 62.5% to 63.9%

1.3% — **Overall Compassion and Inclusivity** 74.0% to 75.3%

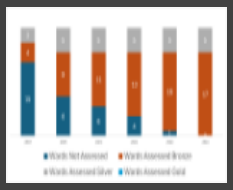
2023 MH&LD response rate: 301 / 14.6%

2024 MH&LD response rate: 353 / 16.9%

Theme 9 – Resources

Improved access to multi-disciplinary care.

Annual Ward Accreditation rating position up to 2024 *(ward accreditation currently paused/under review hence data only showing up to 2024).*



N.B. Currently exploring measurable MDT working at a range of levels as part of the ward round audit.

Theme 10 – Physical Environment

Improved estates and environments for our patients.

The monthly % position of annual ward tripartite and ligature assessments (completed and submitted):

Aug 2024– Mar 2025

% progress against to one external review recommendation actions NCCU, RCPsych and HIW current inspections:

NCCU 98% | RCPsych 70% | HIW 80%

July 2025

N.B. Currently exploring measurable data potential relating to capital works within this theme.

Teitl adroddiad: ***Report title:***	Board Assurance Framework			
Adrodd i: ***Report to:***	Quality, Safety and Experience Committee (QSE)			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 04 September 2025			
Crynodeb Gweithredol: ***Executive Summary:***	The purpose of this paper is to provide assurance to the committee on the progression of the Board Assurance Framework (BAF) risks. Each risk has been reviewed and rated by its respective lead committee, with oversight provided by the Risk Scrutiny Group through monthly deep dives. Recent deep dives focused on: • **BAF24-06:** Transforming Care and Enhancing Outcomes (Patient Safety & Public Health). The Risk Scrutiny Group holds a deep dive on each BAF risk monthly for oversight with BAF24-06 (Mental Health and Learning Disabilities) due for deep dive in December 2025. Half of the risk actions have been completed and the other half progressing with one delayed action, demonstrating good progress overall. N.B. The Board Assurance Framework will only be submitted to the Board in September 2025 by point of escalation to the Board through the Audit Committee chair's assurance report as per cycle of risk reporting (bi-annually to the Board, next BAF report in full to the Board Jan 2026). N.B. BAF24-06 (Public Health) risk for oversight by Planning, Population Health and Partnership Committee has been removed from this paper.			
Argymhellion: ***Recommendations:***	The Committee is asked to**:** • To **receive** and **consider** the contents and assurance rating of the Board Assurance Framework.			
Arweinydd Gweithredol: ***Executive Lead:***	Pam Wenger, Director of Corporate Governance			
Awdur yr Adroddiad: ***Report Author:***	Nesta Collingridge Head of Risk Management			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☒	Am sicrwydd *For Assurance* ☐	
Lefel sicrwydd:	Arwyddocaol	Derbyniol	Rhannol	Dim Sicrwydd

Assurance level:	*Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	*Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	*Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	*No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this: N/A***	
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Detailed in the BAF report and how the CRR aligns to the revised BAF
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	It is essential that the Board has robust arrangements in place to assess, capture and mitigate risks, as failure to do so could have legal implications for the Health Board.
Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqlA been identified as necessary and undertaken?***	Not applicable for this report
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary ben undertaken?***	Not applicable for this report
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	Board Assurance Framework paper
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	The effective and efficient mitigation and management of risks has the potential to leverage a positive financial dividend for the Health Board through better integration of risk management into business planning, decision-making and in shaping how care is delivered to our patients thus leading to enhanced quality, less waste and no claims.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	Failure to capture, assess and mitigate risks can impact adversely on the workforce.

Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	Risk Scrutiny Group feedback 09/07/2025 The Risk Scrutiny Group held a deep dive on the 'Not Delivering Strategic Development and Digital Transformation' risk. Suggested updates on the controls and actions are yet to be completed. Wider suggestions made by the group around the impact score not being reduced for the target will be feedback when requesting updates.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	Board Assurance Framework risks linked to corporate risks
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	

Camau Nesaf:

Next Steps:

1. Delayed risk actions to be monitored.
2. The actions within the BAF will all be reviewed in line with the final version of the Strategic Plans to ensure full alignment.
3. Business as usual reporting and monitoring: Bi-monthly Review at Risk Scrutiny Group and Executive Committee, monitoring of actions within risks. Reporting to Committee quarterly and Board bi-annually as per Risk Management Framework.

Rhestr o Atodiadau:

List of Appendices:

Appendix 1 – QSE risks only, Board Assurance Framework

Board Assurance Framework

Board Assurance Framework Report

Purpose

The Board Assurance Framework (BAF) serves as a strategic tool, designed to support the Health Board (BCUHB) in achieving its overarching goals and objectives. The BAF provides a structured approach for identifying, managing, and mitigating risks that may impact the successful delivery of our strategic priorities. Through clear alignment with our organisational strategy and key initiatives, the BAF enables us to maintain an accountable, transparent, and proactive approach to risk management.

The purpose of this BAF is threefold:

- To provide assurance that effective controls are in place to manage risks to our strategic objectives.
- To support informed decision-making by presenting clear, current risk insights to the Board and stakeholders.
- To align risk management efforts across the organisation, ensuring consistency with our vision of delivering high-quality, accessible healthcare services.

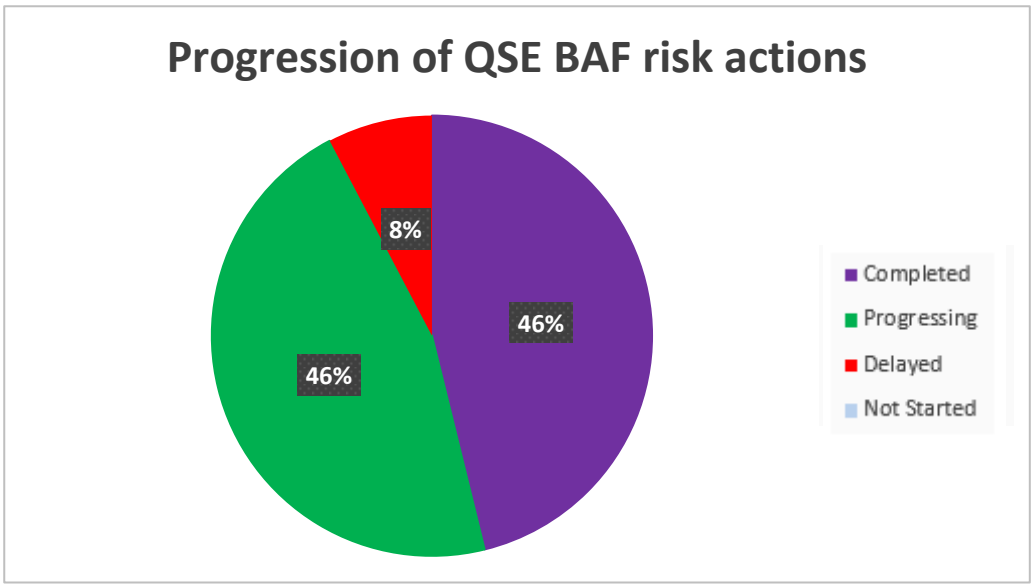
By integrating the BAF with our strategic priorities and operational plans, we can ensure that our risk management efforts directly support our mission to improve health outcomes, enhance patient safety, and foster a culture of accountability within BCUHB.

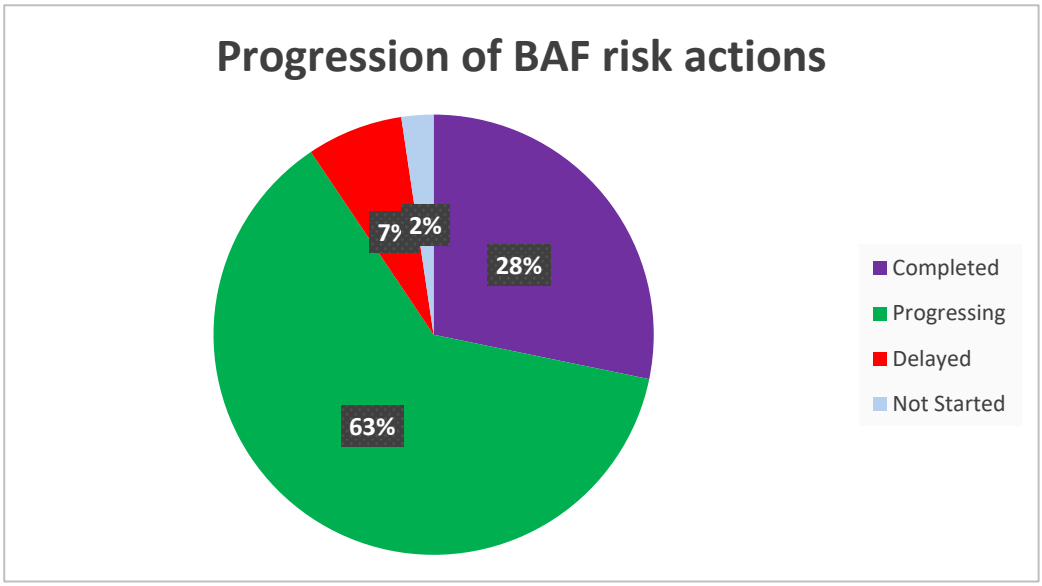
The purpose of this paper is to seek the Board's agreement on the proposed assurance ratings for each of the Board Assurance Framework (BAF) risks, following review by the Committee's responsible for the risks.

Board Assurance risks were developed by the Executive Team based on the Health Board's 5 strategic objectives. The BAF was approved by the Board 30 Jan 2025 and will be subsequently updated by action handlers and Executives on an on-going basis.

Key Highlights

Over a quarter of BAF actions have been completed since the last report to the committee, demonstrating good progress. Minimal revised actions. However, Quality, Safety and Experience Committee have oversight of one delayed action to which they are responsible for.





Next Steps

- Delayed risk actions to be monitored by the Risk Scrutiny Group and Executive Committee.
- The actions within the BAF will all be reviewed in line with the final version of the Strategic Plans to ensure full alignment.
- The Board Assurance Framework will be maintained and reported to the Risk Scrutiny Group; Executive Committee (bi-monthly) and Committees (quarterly) and Board (bi-annually) as per the Risk Management Framework.

Board Assurance Framework (BAF): July 2025

The key elements of the BAF are:

- A description of each Principal (strategic) Risk, that forms the basis of the HBs risk framework (with corresponding corporate and operational risks)
- Risk ratings – current (residual), tolerable and target levels. Risks are scored in line with the HB approved scoring matrix.
- Clear identification of strategic threats and opportunities that are considered likely to increase or reduce the Strategic Risk, within which they are expected to materialise
- A statement of risk appetite for each threat and opportunity, to be defined by the Lead Committee on behalf of the Board (Averse = aim to avoid the risk entirely; Minimal = insistence on low-risk options; Cautious = preference for low risk options; Open = prepared to accept a higher level of residual risk than usual, in pursuit of potential benefits)
- Key elements of the risk treatment identified for each threat and opportunity, each assigned to an Risk Lead and individually rated by the lead committee for the level of assurance they can take that the strategy will be effective in treating the risk (see below for key)
- Sources of assurance incorporate: (1) Management (those responsible for the area reported on); (2) Risk and compliance functions (internal but independent of the area reported on); and (3) Independent assurance (Internal audit and other external assurance providers).
- Unlike corporate risks where target dates are key for mitigation, risks will remain reported as the Board seeks assurance accordingly until the risk is sufficiently mitigated. Actions are based on quarters for the year.
- Board committees should review the BAF with particular reference to comparing the tolerable risk level to the current exposure risk rating.
- The RACI clarifies roles and responsibilities for tasks and deliverables and is utilised for sub-risks however the responsibility of the overall BAF risks of the lies with the **Executive Team** and accountability lies with the lead committee.

Likelihood score and descriptor					
	Very unlikely 1	**Unlikely 2**	**Possible 3**	**Somewhat likely 4**	**Very likely 5**
Frequency How often might/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally or there are a significant number of near misses / incidents at a lower consequence level	Will probably happen/recur, but it is not a persisting issue/ circumstances	Will undoubtedly happen/recur, possibly frequently
Probability Will it happen or not?	Less than 1 chance in 1,000 (< 0.1%)	Between 1 chance in 1,000 and 1 in 100 (0.1 - 1%)	Between 1 chance in 100 and 1 in 10 (1- 10%)	Between 1 chance in 10 and 1 in 2 (10 - 50%)	Greater than 1 chance in 2 (>50%)

Key to lead committee assurance ratings:

 **Substantial Assurance**	The Committee is satisfied that there is reliable evidence supporting the effectiveness of the current risk treatment strategy in mitigating the threat, with minimal gaps in control. While the majority of actions have been addressed, some minor actions may still require completion before the risk score is reduced. However, the Committee has good assurance regarding action progress. Likelihood of risk materialising: Low.
 **Reasonable Assurance**	The Committee has seen sufficient evidence that the most significant actions to reduce the risk have been completed. There is assurance that the planned actions within the current risk treatment strategy are appropriate, with the majority of control and assurance gaps having been addressed. Likelihood of risk materialising: Low to moderate.
 **Limited Assurance**	The Committee does not have sufficient evidence for assurance that the current risk treatment strategy is effectively mitigating the threat. There remains to be some key gaps in controls that require management attention, and further external validation is needed. Until further controls are in place, there remains a number of actions to reduce the score. Likelihood of risk materialising: Moderate.
 **Unsatisfactory Assurance**	The Committee has no/little evidence for assurance that the current risk treatment strategy is effectively managing the threat. There remains to be several key gaps in controls that require management attention, and further external validation is needed. Until further controls are in place, there remains a number of actions to reduce the score. Likelihood of risk materialising: High

Board Assurance Framework (BAF): July 2025

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

This BAF includes the following Risks to the HBs strategic priorities:

Reference	Principal risk: There is a risk of…	Lead Executive	Lead Committee	Initial date of assessment	Last reviewed by Executive Team	Previous risk score (at previous review/update) C x L	Current risk score C x L	Target risk score C x L
BAF24-01	Not Fully Building an Effective and Accountable Organisation	Director of Corporate Governance and Executive Team oversight	Performance, Finance and Information Governance	20/10/2024	21/07/2025	4x 3= 12	**4x 3= 12**	2x 2= 4
BAF24-02	Not Delivering Strategic Development and Digital Transformation	Executive Director of Transformation and Strategic Planning & Chief Digital & Information Officer	Planning, Population Health & Partnership	20/10/2024	21/07/2025	5x 4= 20	**5x 4= 20**	3x 3= 9
BAF24-03	Not Achieving Long Term Financial Sustainability	Executive Director of Finance	Performance, Finance and Information Governance	20/10/2024	21/07/2025	5x 4= 20	**5x 4= 20**	3x 3= 9
BAF24-04	Not Establishing a Compassionate Culture, Leadership, Engagement and workforce capacity and capability	Deputy Director of People Services	People & Culture	20/10/2024	21/07/2025	4x 4= 16	**4x 4= 16**	3x 3= 9
BAF24-05	Not Engaging with Citizens, Partners and Communities	Director of Partnerships/Communications and Engagement	Planning, Population Health & Partnership	20/10/2024	21/07/2025	2x 3= 6	**2x 3= 6**	2x 2= 4
BAF24-06	Not Delivering the Required Improvements to Transform Care and Enhance Outcomes	Executive Director of Nursing Executive Director of Public Health Executive Medical Director Executive Director of Allied Health Professionals and Health Science	Quality, Safety and Experience / Planning, Population Health & Partnership	20/10/2024	21/07/2025	5x 4= 20	**5x 4= 20**	5x 2= 10
BAF24-07	Not Delivering Timely Access to Care Resulting In Potential Clinical Harm, Poor Delivery of Performance Targets and Reputational Risk	Chief Operating Officer	Performance, Finance and Information Governance	20/10/2024	21/07/2025	4x 4= 16	**4x 4= 16**	4x 2= 8
BAF24-08	Not Implementing Evidenced Based Improvement and Innovation	Executive Medical Director & Chief Digital & Information Officer	Planning, Population Health & Partnership	20/10/2024	21/07/2025	4x 3= 12	**4x 3= 12**	3x 2= 6

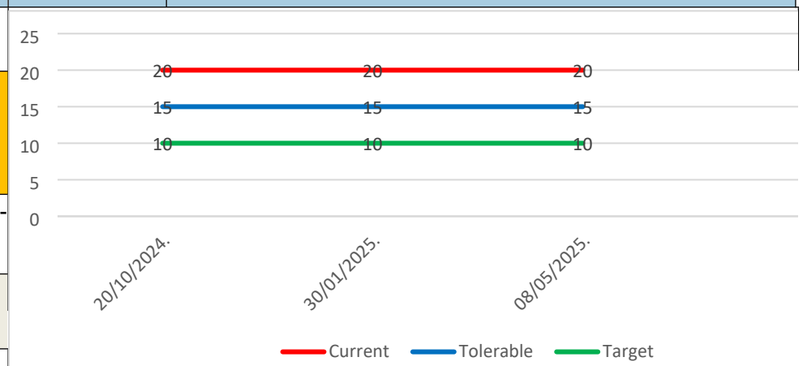
Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Appendix 1 – QSE risks only, Board Assurance Framework

4: Improving quality, outcomes and experience

Objective area 4 covers a large thematic area where improvements are required to improve clinical performance across a number of key areas. The Health Board wishes to build further upon good work commenced that takes a pathway focused approach to this.

Principal risk (what could prevent us achieving this strategic objective)	**BAF24-06: Not Delivering the Required Improvements to Transform Care and Enhance Outcomes** Risk of ineffectively delivering consistent high quality of patient care across the HB resulting in incidents of avoidable harm and poor clinical unmet patient needs, regulatory non-compliance, and reputational harm.			**Strategic objective**	4. To Improve Quality, Outcomes and Experience (4A Patient Experience; 4B Prevention; 4I Adult Mental Health, Learning Disability)
Lead Committee	Quality, Safety and Experience Committee / Planning, Population Health & Partnership Committee	**Risk type**	Quality		
Risk Lead	Executive Director of Nursing Executive Director of Public Health Executive Medical Director Executive Director of Allied Health Professionals and Health Science	**Risk appetite**	Open <16		
Related Corporate Risks:	**CRR24-02** Patient Safety /**CRR24-04** Failure to Embed Learning/ **CRR24-08** Delivering a population health approach to health and wellbeing/ CRR24-18 Managing Outbreaks				



Risk rating				**Review Dates**	
	Current exposure	**Tolerable**	**Target**		
Consequence	5. Catastrophic	5. Catastrophic	5. Catastrophic	**Initial date of assessment**	20/10/2024
Likelihood	4. Somewhat likely	3. Possible	2. Unlikely	**Last reviewed by Committee:**	01/05/2025
Risk rating	20. High	15. High	10. Medium	**Last updated by Executive:**	08/05/2025

Board Assurance Framework (BAF): July 2025

Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps and issues** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
Responsible:	Deputy Executive Director of Nursing	Accountable:	Executive Director of Nursing	Responsible Committee	Quality, Safety and Experience Committee
Threat: A loss of organisational focus on patient safety and quality of care leading to increased incidence of avoidable harm, exposure to 'Never Events', higher than expected mortality, and significant reduction in patient satisfaction	• Integrated Concerns Policy and daily Hub meetings in place to review all concerns of moderate , grade4/5 and above • Patient incident/feedback systems and policies • Data analysis and learning at service level • Datix Reporting • Patient safety Staff training - Quality governance arrangements at Health Board, IHC/division & service levels including: ○ Local ICOG and Exec EICOG Groups ○ BCUHB patient safety, infection prevention , safeguarding and patient experience groups ○ BCUHB SCEG, meetings ○ Local and Exec Quality Delivery Groups ○ Clinical audit programme & monitoring arrangements ○ Ward accreditation/ metrics • Integrated Concerns Policy and Toolkit • Concerns Hub • Rapid review Sign-off process for incidents and Nationally Reported Incidents • Executive Led Oversight Group • Quality assurance visits • Internal Reviews against External National Reports • Getting it Right First Time (GIRFT) • Localised deep dives, reports and action plans • Operational grip on workforce gaps • Patient Advice and Liaison Service Activity • Comprehensive Cultural Competence training and awareness	• Operational oversight of sustainable change, evidence of learning and improvement measures	**Management:** • Learning from deaths Report to QC and Board • Quarterly Strategic Priority Report to Board. • Divisional risk reports to SRG bi-annually. • Guardian of Safe Working report to Board • Quality and Governance Reporting Pathway. Quality Safety and Experience Committee reports include: ○ Safeguarding Annual Report to QSE ○ Infection Control Annual Report ○ Health and Safety Annual Report ○ Bimonthly Quality Report ○ Deep dive Reports ○ Risk Management Report ○ Integrated Performance Report ○ Duty of Quality annual report **Risk and compliance:** • Quality Dashboard • Duty of Candour • Corporate Risks • Ombudsman Annual Letter **Independent assurance**: • Health Inspectorate Wales Reports • Care Inspectorate Wales Reports • Coroners' reports: • Internal Audit reports. • Royal College Reports • Llais Reports • Ombudsman Screening Quality Assurance Services assessments and reports of: • Antenatal and New-born screening • Breast Cancer Screening Services • Bowel Cancer Screening Services • Cervical Screening Services External Accreditation/Regulation annual assessments and reports of; • Pathology (UKAS)	Limited Assurance Internal Audit report for Limited Assurance: Lessons Learnt, Falls, Deprivation of Liberty 1 action outstanding in the DOLS plan then closed Internal Audit review of the Falls audit to be completed in Q1 to ensure actions are completed • Nursing & Midwifery Vision Embedding (launched May 2025) • Allied Health Professional Strategy • Clinical services plan	**Limited Assurance**

			• Endoscopy Services (JAG) • Medical Equipment and Medical Devices (BSI) • Blood Transfusion Annual Compliance Report (MHRA) • Ionising Radiation (Medical Exposure) Regulations		

	Plans to improve control (are further controls possible in order to reduce risk exposure within tolerable range?)	**Action Handler**	**Status of Actions**	**Date when action will be completed**
	Civica mapping of services to improve consistency of levels of feedback	Chris Lynes	Complete	31/03/2025
	Expand real-time feedback systems across all services (SMS texting for priority areas e.g. ED)	Chris Lynes	Complete	31/12/2024
	Quality Management System in development. – pilots in urology and vascular	Chris Lynes	Complete	31/03/2025
	Reduced response times for addressing patient complaints.	Chris Lynes	Complete	31/03/2025
	Learning Repository Development – Delayed due to Digital Team capacity, Digital lead now allocated time to complete and progressing with a revised completion date from 31/12/2024 to 31/06/25	Chris Lynes	Delayed	30/06/2025

Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps and issues** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**

Responsible:	Director of Mental Health & Learning Disabilities	Accountable:	Executive Director of Allied Health Professionals and Health Science	Responsible Committee	Quality, Safety and Experience Committee

Threat: Risk of insufficient focus on Mental Health, wellbeing and Learning Disabilities in the Health Board strategy, planning and operations leading to sub optimal patient outcomes, lack of an holistic approach, regulatory non-compliance and reputational harm.	• Alignment with Welsh Government National strategies for Mental Health and wellbeing, Learning Disabilities and Substance Misuse • Adherence to Royal College and Clinical standards • National NHS Executive Mental Health and Learning Disabilities (MHLD) Strategic Improvement Programme • Established Royal College Psychiatry Improvement programme with Health Board wide reporting and governance • Established reporting through existing HB Governance Frameworks, Oversight committees and routine audits to ensure compliance and monitor progress. • Inclusion in Health Board Annual Plan and monitoring mechanisms • Inclusion in organisational Major change programme, oversight and reporting	• Recruitment and Retention challenges impacting on workforce including interim posts • Engagement and collaboration with physical health services • ‘Foundations for the Future’ programme maturity • Insufficient focus on health inequalities • Lack of integrated Electronic Health Record and other digital systems • Limited visibility of Mental health and Learning disabilities data at Board level • Current risk to balanced financial position • Greater focus on community and earlier intervention services	**Management:** • External reviews in 2023-24, undertaken as part of Special Measures all recommendations completed and managed. • Performance Management and reporting • Civica and patient reporting metrics **Risk and compliance:** • Compliance with Royal College Standards • Audit Reports **Independent assurance:** • Development of co-produced Patient Carer engagement work • Expert advisory group • External reviews • National and Local performance reporting • Together 4 Mental Health Partnership Board in place	• Lack of integrated patient care records impacting on care, planning and reporting • Increasing the scope of performance reviews focusing on patient pathways. • Improving our real time patient data • Visibility of community mental health activity	**Limited Assurance**

	• Clinically led Physical health work stream in MHLD • Primary care pathways • Crisis Care Concordat in place				

	Plans to improve control (are further controls possible in order to reduce risk exposure within tolerable range?)	**Action Handler**	**Status of Actions**	**Date when action will be completed**
	Recruitment plans for substantive workforce	Carole Evanson	Progressing	31/09/2025
	Increased pathways with Primary care	Alberto Salmoiraghi	Progressing	31/12/2025
	Active engagement with the Foundations for the future programme	Carole Evanson	Progressing	31/10/2025
	Electronic Health Record programme with MHLD as early adopter	Iain Wilkie	Progressing	31/03/2026
	Enhanced Savings plans	Nicola Hyde	Progressing	31/03/2026
	Responsive annual plan	Vicky Jones	Complete	31/03/2025
	Implementation of Communication strategy, will remain dynamic and developmental	Vicky Jones	Complete	31/12/2025
	Alignment with Learning Disabilities national programme- Improving Care Improving lives review	Carole Evanson	Progressing	31/03/2026

Teitl adroddiad: *Report title:*	Lymphoedema Service: End of Year Evaluation Framework & Activity Report 2024-2025
Adrodd i: *Report to:*	Quality and Safety Committee
Dyddiad y Cyfarfod: *Date of Meeting:*	4th September 2025
Crynodeb Gweithredol: *Executive Summary:*	The end-of-year report provides an update on the progress achieved by the Betsi Cadwaladr University Health Board (BCUHB) Lymphoedema Service during 2024– 2025, in alignment with the Lymphoedema Wales Clinical Network (LWCN) Evaluation Framework. Activity Caseload 2,372 increasing from 2,272 reported in 23-24. Referrals 1,377 with discharges 318. 'New Patient' breaches were 157 (12%) of new patient appointments. This is positive and reflects the service's commitment to timely and effective patient care Referrals Referral rates for patients have consistently been lower when adjusted for the size of the BCUHB population, compared to other lymphoedema services. Follow up appointments Patient Initiated Follow Up (PIFU) continues to be embedded, creating capacity so reducing follow up appointments by 16%. Discharges Discharges are the lowest in Wales — a positive position, as this reflects the ongoing specialist input that is required for the higher complexity of presenting cases (e.g. poly-morbidity, patient choice, frailty, vulnerability) and prevents unscheduled admissions to acute services for instances such as cellulitis and falls. Did Not Attend / Could Not Attend BCUHB continues to report the lowest 'Did Not Attend' (DNA) and 'Could Not Attend' (CNA) rates in Wales. Intensive Treatments Sixteen percent of recorded activity was classified as 'Intensive Treatments'. This was the highest reported rate in Wales and is considered a positive reflection of effective specialist service delivery. Health Board Staffing Levels BCUHB had the lowest Whole-Time Equivalent (WTE) vacancy rate among the Health Boards (HBs) in Wales, with staff retention being recognised as a strength. PROMs and PREMs BCUHB remains the only Health Board in Wales using the standalone LYMCALC programme.

	Ethnicity data was cited as being absent, this data is collected and forwarded since the completion of the report. <u>Peer Review</u> A peer review audit of patient case notes provided positive feedback, with no recommendations made.			
Argymhellion: *Recommendations:*	For the Committee to note the report and progress.			
Arweinydd Gweithredol: *Executive Lead:*	Angela Wood, Executive Director of Nursing and Midwifery.			
Awdur yr Adroddiad: *Report Author:*	Paula Lawrence, Clinical Lead Manager, Lymphoedema			
Pwrpas yr adroddiad: *Purpose of report:*	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: *Assurance level:*	Arwyddocaol *Significant* ☒ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☐ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: *Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:*				
Cyswllt ag Amcan/Amcanion Strategol: *Link to Strategic Objective(s):*	This report demonstrates progresses through and upholds all 5 objectives of the 3 Year Plan.			
Goblygiadau rheoleiddio a lleol: *Regulatory and legal implications:*				
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? *In accordance with WP7 has an EqIA been identified as necessary and undertaken?*	N/A			
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? *In accordance with WP68, has an SEIA identified as necessary been undertaken?*	N/A			

Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) *Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR)*	No risks identified currently
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* *Financial implications as a result of implementing the recommendations*	VBHC funding may be sought in the 2026
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith *Workforce implications as a result of implementing the recommendations*	None
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori *Feedback, response, and follow up summary following consultation*	N/A
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) *Links to BAF risks:* *(or links to the Corporate Risk Register)*	N/A
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) *Reason for submission of report to confidential board (where relevant)*	
Camau Nesaf: *Next Steps:*	
Rhestr o Atodiadau: *List of Appendices:*	

Lymphoedema Wales Clinical Network

2024-25 End of Year Evaluation Framework & Activity Report

Betsi Cadwaladr University Health Board

April 2024 – March 2025

Version No.	1.0 FINAL 14.07.2025
LEAD DIRECTORS:	Russel Caldicott- Exec Director of Finance Angela Wood- Exec Director of Nursing Denise Roberts- Head of capital, governance and BI Tracy Radcliffe- Head of Patient Safety Neil Windsor- Director Transformation and Improvement
REPORTING OFFICER:	Dr Melanie Thomas – Clinical Director Lymphoedema Wales Clinical Network
DISTRIBUTED TO:	Paula Lawrence- Lead Nurse Lymphoedema

Contents

Executive Summary and Recommendations

- Lymphoedema referral rates remain low when adjusted for the size of the population. The Clinical Lead Manager is working with GP Academies to raise awareness ensuring timely and appropriate referrals.
- Further, currently GPs cannot refer directly digitally using WAP. This is being investigated. Lymphoedema Patient Self-Referral also went live in June 2025, so this may support the referral rate.
- There were only 157 New Patient breaches in 2024-25 which is 12% of new patient appointments-this is positive and reflects the service's commitment to timely and effective patient care.
- PIFU continues to be embedded, creating capacity for the service. Follow-up appointments decreased by 16% in 2024-25.
- Discharges in BCUHB are the lowest in Wales- this may suggest that the complexity and service model are different. Contrary to opinions that all PIFU patients return to service quickly, only 58% required an additional appointment. PIFU prioritises when patients need support and maintains capacity in the service. Historically, PIFU patients are logged into BCUHB as Project B patients.
- BCUHB has the lowest Did Not Attend and Could Not Attend rates in Wales. We believe this is due to the Service Model of numerous community clinics resulting in reduced travel as well as the rapport staff have with their patients.
- Intensive treatments involve more than a treatment follow up appointment in that patients attend for specialist interventions. There are discrepancies within all Wales data accurately recording what constitutes an Intensive Treatment as it seems many clinicians are recording treatments as a Follow Up. In BCUHB, 16% of the activity recorded was for Intensive Treatments. This is the highest in Wales, which we feel is much more accurate than other Health Boards. Work is underway to resolve this inaccuracy.
- Positively, BCUHB has a lower WTE vacancy amongst the HBs in Wales at 15%. Staff sickness and recruitment delays obviously cause a decrease in capacity, which caused the New Patient breaches.
- BCUHB remains the only HB in Wales using the standalone LYMCALC Programme and patients are not registered to Lymphoedema in WPAS/ WNCR. This is a risk as well as PROMS and PREMS not being able to be disseminated digitally. The Clinical Lead Manager has raised concerns locally.
- National patient level data has allowed us to identify the prevalence of lymphoedema in GP Clusters. In BCUHB, it ranges from 10.31 in South Meirionnydd to 2 per 1,000 people in Conwy West. This information may be used to support dedicated training and raise awareness.
- The peer review was very positive and suggested recommendations on communication letters and recording BMI have been suggested.

Summary of Activity Data:

Active caseload 24-25:	**2,372**	**Active caseload 23-24:**	**2,272**
Referrals 24-25:	**1,377**	**Discharges at this period:**	**318**

Purpose

This end-of-year report provides an update on the progress achieved by the Betsi Cadwaladr University Health Board (BCUHB) Lymphoedema Service during 2024–2025, in alignment with the Lymphoedema Wales Clinical Network (LWCN) Evaluation Framework.

Background

The LWCN Evaluation Framework, initially developed in 2020, was designed to support the implementation of the Value-Based Lymphoedema Business Case and to integrate seamlessly within the portfolio of work. This framework serves as a strategic tool for LWCN clinicians, managers, operational leads, and individuals responsible for overseeing Health Board (HB) Lymphoedema Service delivery. It is also relevant to stakeholders such as the Welsh Government, HB Senior Directors, Value-Based Healthcare Teams, and others with a vested interest in lymphoedema care and service improvement.

This report is sectioned into the Evaluation Frameworks objectives and outcomes.

Evaluation Framework Objective 1

Provide an equitable and sustainable lymphoedema provision across Wales.

Outcome 1

All new patients referred to a Lymphoedema Service are assessed in accordance with the new standardised patient pathway.

Referrals

Between April 1st, 2024, and March 31st, 2025, the BCUHB Lymphoedema Service received 1,377 new patient referrals - a 15% increase from 2023–24, which saw 1,202 referrals. While this growth is encouraging, the referral rate remains low when adjusted for the size of the BCUHB population. When comparing annual referrals per 100,000 population, BCUHB averages 200, which is the lowest in Wales and significantly lower than other HBs such as HDUHB (457), Powys (413), and SBUHB (442). This discrepancy suggests that individuals with lymphoedema in the BCUHB area may not be accessing the service at the same rate as in other regions. This highlights a potential need for increased education and awareness among healthcare professionals (HCP) and the public to ensure timely and appropriate referrals to BCUHB **(Table 1).** There of course may be other reasons for the low referral rate in that BCUHB, HCP may be already educated so treating lymphoedema patients themselves negating the need for a referral. The BCUHB Clinical Nurse Manager is working with the GP Academy to ensure the right patients are being referred. Further,

GPs currently cannot refer directly digitally using WAP this is being investigated. Positively, in June 2025 patients can also self-refer into all Lymphoedema Services in Wales.

Table 1: Referrals amongst HB

HB	Appts for new referrals	Total referrals	Monthly mean referrals	Population	Annual referrals per 100k population
AB	1,474	1,584	132	588,303	269
BC	1,273	1,377	94	687,098	200
CTM	928	1,026	86	442,123	232
CV	1,489	1,437	120	492,046	292
HD	1,309	1,747	146	382,518	457
PT	471	552	46	133,557	413
SB	1,664	1,678	140	379,765	442
Total	**8,362**	**9,401**	**763**	**3,105,410**	**303**

During the pandemic referral numbers to Lymphoedema Services in Wales did decrease but have steadily increased since 2021 **(Table 2).**

Table 2: New Referrals over the last 5 years

	2019/2020	2020/21	2021/22	2022/23	2023/24	2024/25
AB	1,302	609	871	1,151	1,381	1,584
BC	1,349	689	1,028	1,110	1,202	1,377
CV	1,082	597	886	1,055	1,566	1,437
CTM*	936	520	817	1,053	1,571	1,026*
HD	959	670	905	1,648	1,572	1,747
PT	399	404	320	254	385	552
SB	1,615	1,082	1,491	1,564	1,866	1,678
Total	**7,642**	**4,571**	**6,318**	**7,835**	**9,543**	**9,401**

***CTM have over 1,000 New patient referrals on a waiting list if the additional 1,000 were to be included then the total number of patients would be over 10,000 per annum.**

When a new patient is seen by the Lymphoedema Service, their care is categorised according to clinical need - typically as routine, urgent, or advanced disease/end-of-life. As shown in **Table 3,** some patients may also receive intensive treatment at their initial appointment, with 23 individuals receiving such care during the reporting period.

Additionally, referrals rebooked refer to patients who initially did not attend their scheduled appointment (Did Not Attend – DNA) but were subsequently rebooked and seen by the service- thus stopping the clock to prevent a breach being recorded. CTMUHB has prioritised all urgent referrals, resulting in the highest number of urgent patients seen in Wales - 456 individuals. While this reflects a strong commitment to prioritising assumed clinical needs, it may also suggest that referrers are increasingly marking referrals as urgent to ensure patients are seen, potentially distorting the true clinical picture. Without accurate Patient Reported Outcome Measures, true needs will not be captured just on a referral form.

Table 3: Types of New Referral Appointments seen

	AB	BC	CTM	CV	HD	PT	SB	Total
New referral (routine)	1,316	786	446	1,198	887	407	1,407	6,447
New referral (urgent)	116	101	456	121	359	48	221	1,422
New referral (advanced disease/ end of life)	1	13	25	22	44	11	23	139
New referral (Not recorded) or OGEP	0	359	0	0	0	0	0	113
New referral (rebooked)	41	0	1	143	18	5	10	218
New referral intensive Rx	0	14	0	5	1	0	3	23
Total New referrals	**1,474**	**1,273**	**928**	**1,489**	**1,309**	**471**	**1,664**	**8,362**

Breaches New Patient Referrals

New patient referrals to the BCUHB Lymphoedema Service should be triaged according to the standardised New Patient Pathway into standardised or non-standardised referral. A virtual appointment with the patient ensures a PROM completion and then the patient is categorised into advanced disease, urgent, or routine. The expected waiting times for each category are:

- Routine referrals: within 12 weeks.
- Urgent/intensive referrals: within 4 weeks.
- Advanced disease/ end of life referrals: within 2 weeks.

During the 2024/25 reporting period, there were 157 breaches all of which were routine referral categories **(Table 4).** The reason for this was staff sickness or waiting for vacant posts to be filled. Only 12% is positive and reflects the service's commitment to timely and effective patient care.

Table 4: New Referral Breaches

HB	New referral appts**	Routine breach	Urgent/intensive breach	End of life breach	Total breaches	% of new referral appts breached
AB	1,474	0	0	0	0	0
BC	1,273	157	0	0	157	12%
CTM*	928	325	366	4	695	75%
CV	1,489	2	8	2	12	8%
HD	1,309	195	41	4	240	18%
PT	471	13	4	2	19	4%
SB	1,664	137	39	5	181	11%
Total	**8,362**	**829**	**458**	**17**	**1,304**	**15%**

***CTM have new referrals not registered so an additional 1,000 patients are breaching ** New referral appts exclude 'Rebooked' new referral appointments because these are not included in breaches**

Types of Lymphoedema HB Appointment Activity

As lymphoedema is a chronic condition, a patient may require numerous appointments before becoming confident and competent to self-manage. **Table 4** demonstrates the different types of appointments per HB. These appointments exclude On the Ground Clinical Education Programme (OGEP) patients and risk reduction patients. In total over 40,000 appointments have been made by HB Lymphoedema Services. In BCUHB, just over 6,300 appointments have been recorded **(Table 5).** CTMUHB has the highest ratio in follow-ups relative to new patient referrals (4.36), suggesting a high demand for ongoing care or potentially inefficiency to discharge to PIFU if a patient is suitable. HDUHB shows the lowest ratio (1.77), which might indicate either more efficient discharge to PIFU or fewer chronic cases. BCUHB has a ratio of 2.8. Garment fitting/advice appt are in essence a FU treatment appointment so will be changed as such in 2025-26.

Table 5: All HB Appointments

Appt type	AB	BC	CTM	CV	HD	PT	SB	Total
New referrals	1,474	1,273	928	1,489	1,309	471	1,664	8,362
Follow up appt	5,383	3,564	4,048	3,955	2,311	1,353	5,569	26,183
Intensive Appt	332	1,275	249	387	183	19	554	2,999
PIFU reassessment appt within 2yrs	59	26	151	156	121	64	185	762
Garment fitting/advice appt	255	449	217	303	182	344	320	2,070
Not recorded	24	1	16	30	32	40	85	228
Total	**7,527**	**6,342**	**5,609**	**6,320**	**4,138**	**2,291**	**8,377**	**40,604**

Supporting value-based health care, sustainability and decarbonisation, appointments for patients can be virtual (if appropriate), negating the need to travel to hospital. In 2024-25 nearly 10,000 appointments were virtual **(Table 6)**. Virtual appointments can improve accessibility and convenience, patient engagement, and have shown comparable clinical effectiveness and are time and cost efficient. BCUHB completed 605 virtual appointments in 2024-25. This is positive.

Table 6: Virtual Appointments by HB

	2023/2024	2024/2025
AB	1,259	2,082
BC	695	605
CTM	831	516
CV	1,808	2,042
HD	2,142	1,331
PT	259	670
SB	2,143	2,526
Total	**9,137**	**9,772**

Positively, since the introduction of the new patient pathway and Patient Initiated Follow Up (PIFU) the numbers of FU appointments have decreased by 11% in LWCN

which is important to release capacity into the system **(Table 7)**. In BCUHB, FU appointments decreased from 5,802 to 4,865 (16% decrease).

Table 7: FU Activity over last 3 years

	2022/2023	2023/2024	2024/2025
AB	4,107	4,183	5,774
BC	4,723	5,802	4,865
CTM	4,863	4,716	4,448
CV	2,829	4,260	4,498
HD	4,758	4,964	2,615
PT	1,025	1,033	1,436
SB	7,672	8,565	6,308
Totals	**29,977**	**33,523**	**29,944**

Home Visit Activity

Even though there is criterion for providing home visits, the numbers remain over 4,000, which is around 10% of the workload. Home visits are time-consuming and must be justified in providing value for the patient and the NHS.

BCUHB has one of the lowest home visit rates in Wales and maybe related to having very local clinics in all areas. In **Table 8,** extrapolating the data shows that most home visits are for FU appointments not New Patients.

Table 8: Numbers of Home Visits for LWCN

	2022/2023	2023/2024	2024/2025		24-25 HV- FU	24-25 HV-NP
AB	608	554	951		844	107
BC	289	438	404		349	55
CTM	548	541	608		521	87
CV	456	743	752		610	142
HD	1,155	697	584		464	120
PT	258	229	333		286	47
SB	1,128	1,182	580		546	34
Total	**4,442**	**4,384**	**4,212**		**3,620**	**592**

Reviewing all appointments in BCUHB **(Table 9)** over the year shows the split between Face-to-Face, virtual, intensive and Home Visits as 72%, 7% 16%, and 5% respectively.

Intensive treatment is the highest % in Wales, but we do believe that data collection is slightly skewed on what constitutes an intensive treatment. Work is underway with all Lymphoedema Clinical Leads to establish more standardised data collection.

Table 9: BCUHB Types/locations of Appointments over 2024-25

Appt type	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025
Face to face	482	397	571	537	580	539	522	463	570	437	639	482
Virtual	39	45	47	48	43	82	82	39	72	47	61	39
Home visit	32	34	31	48	46	32	60	36	28	14	43	32
Intensive treatment	112	102	134	148	133	137	110	95	88	79	137	112

Across all HBs in Wales, a consistent trend is evident in appointment distribution: FU appointments make up the largest proportion, followed by New Patient appointments. Intensive treatments remain comparatively low throughout the country, except for BCUHB. **(Figure 1).**

Figure 1: Distribution of appointments in Lymphoedema Services in Wales

Distribution of appointments among patients

Since April 1st, 2024, we have captured patient-level activity allowing us to better understand the numbers of appointments each patient receives. While the number of appointments typically reflects individual patient needs and treatment plans some anomalies exist such as low intensive treatment numbers reported yet patients receiving over 30 appointments etc.

44% of patients received one appointment followed by 32% receiving two, 14% having three appointments and 5% receiving four. The most extreme case was one CTMUHB patient receiving 107 appointments **(Table 10).**

We will interrogate data further next year by categorising lymphoedema severity along with appointment types. BCUHB data seems accurate in line with their high intensive treatment numbers.

Table 10: Number of appointments per patient in LWCN

Number of appts	AB	BC	CTM	CV	HD	PT	SB	Total	% of appts
1	1,595	1,299	1,156	1,017	873	268	1,644	7,852	44
2	1,202	823	839	785	465	231	1,305	5,650	32
3	433	327	386	451	259	150	514	2520	14
4	134	142	147	171	113	82	163	952	5
5	49	73	29	68	57	42	76	394	2
6	20	35	9	34	19	30	16	163	1
7	10	24	7	16	9	10	27	103	1
8	11	14	4	11	6	9	24	79	0
9	7	7	3	4	4	2	13	40	0
10	3	8	2	3		2	7	25	0
11 to 20	11	24	5	10	7	3	14	74	0
21 to 30	2	16	1	3	2		2	26	0
31 to 40		2	1					3	0
43		1						1	0
48		1						1	0
52				1				1	0
54		1						1	0
71				1				1	0
108			1					1	0

Could Not Attend / Did Not Attends (CNA/DNA)

Out of all appointments in LWCN in 2024-25, 85% of patients attended. The highest attendance was in BCUHB at 91% and lowest in ABUHB and HDUHB at 82%. Could Not Attends varied from 3-10% and Did Not Attends from 6-13% **(Table 11).**

Table 11: CNA and UTA rates in LWCN

HB	Total appts (n)	Attended (n)	DNA (n)	CNA (n)	Attended (%)	DNA (%)	CNA (%)
AB	7,527	6,160	992	375	82	13	5
BC	6,342	5,740	420	182	91	7	3
CTM	5,609	4,724	568	317	84	10	6
CV	6,320	5,397	765	158	85	12	3
HD	4,138	3,391	375	372	82	9	9
PT	2,291	1,932	134	225	84	6	10
SB	8,377	7,161	832	384	86	10	5
Total	**40,604**	**34,505**	**4,086**	**2,013**	**85**	**10**	**5**

On the Ground Education Programme (OGEP) Activity

In six of the seven HBs in Wales, OGEP is operational. OGEP stands for the On the Ground Education Programme, a value-based initiative developed by LWCN. Its primary aim is to improve lymphoedema care delivery across Wales by embedding clinical lymphoedema educators directly into community settings.
Key features of OGEP include:

- Upskilling community nurses through one-to-one and group education in chronic oedema management.
- Supporting the implementation of the Wet Leg Care Pathway.
- Improving patient outcomes by promoting earlier intervention and more effective care.
- Reducing unnecessary GP visits, hospital admissions, and dressing costs.
- Enhancing the sustainability of services by reducing travel and freeing up community nurse time.

OGEP has shown measurable improvements in both clinical outcomes and cost-efficiency and is recognised as an innovative model for delivering education and care in real-world settings. BCUHB won the nursing award in 2024-25 and the whole Wales wide team won an NHS Award. A full report of the outcomes of OGEP 2024-25 will be disseminated shortly but key highlight activity is portrayed in **Table 12.** When a patient is ready to be transferred to the Lymphoedema Service the HB adds them in as New Patient activity.

Table 12: OGEP Activity across LWCN*CV and SB reduced capacity due to staffing issues

OGEP HB	AB	BC	CTM	CV*	HD	SB*
Total No. Individual Patients Seen in 2024-25	175	246	263	73	716	160
Total number patient contacts	256	595	432	138	1,145	226
Total number HCPs educated in sessions	298	516	10	60	276	109
No. patients seen in Wound Clinic	28	21	0	0	2	38
No. patients seen in Community	147	225	263	62	714	122
No. patients seen in Leg Clubs	0	0	0	11	0	0

Outcome 2

All patients assessed within LWCN will be coded within the All-Wales Lymphoedema Severity Classification. All patients should receive specialist management and suitable patients should receive intensive treatments.

Severity Classification

During each appointment, the severity of a patient's lymphoedema is recorded. To maintain a sustainable balance between capacity and demand, especially in anticipation of future increases, services must focus on empowering patients with 'At Risk' or 'Mild' and 'Moderate' lymphoedema to self-manage their condition and place them on the PIFU pathway. PIFU can be seen promptly if their condition changes, or they feel the need for further support or additional compression garments.

Table 13 reports on activity broken down by patient severity across all HB Lymphoedema Services. Many services still have high percentages of Mild patients that should be discharged to PIFU. An average of 41% have severe complex lymphoedema- in BCUHB this is 36%, however 26% are unknown. This unknown data is historic and will not be evident in 2025-26, which suggests the complexity will rise significantly. Other reasons not recorded or unknown- would be for patients who had a virtual appointment and severity not yet coded.

Table 13: Categories of Lymphoedema Severity across Wales

	AB	BC	CTM	CV	HD	PT	SB	Average Wales
1 at risk	5%	4%	3%	6%	4%	4%	5%	5%
2 Mild	15%	8%	35%	22%	17%	42%	29%	22%
3 Moderate	31%	26%	14%	35%	22%	24%	20%	25%
4 Severe	10%	11%	3%	10%	4%	7%	3%	7%
5 Complex	22%	18%	28%	16%	32%	7%	27%	23%
5w Complex with wound	12%	7%	12%	9%	18%	11%	13%	11%
Unknown	6%	26%	6%	4%	3%	4%	3%	8%

Interrogating the data further has established correlations between lymphoedema severity and population health. Unsurprisingly, it transpires that lymphoedema complexity is linked with living in the most deprived quintiles, having a higher Rockwood frailty score and having higher Body Mass Index (BMI) **(Figures 2,3,4).**

This picture suggests that the more complex lymphoedema patients have other factors contributing to the condition. When a patient is categorised as Severe or Complex+- Wounds, they may require intensive treatments to improve outcomes.

As previously discussed, further work is needed to understand the data collected surrounding Intensive Treatment as numbers are consistently lower than expected.

Figure 2: Lymphoedema Severity and Deprivation

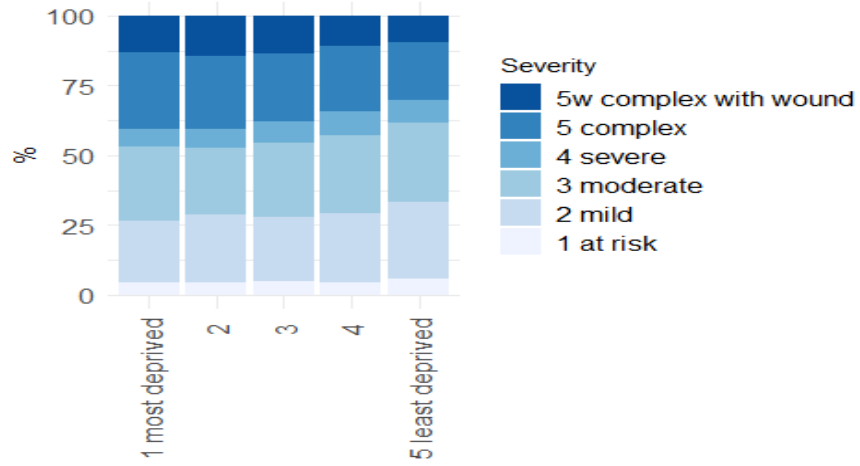


Figure 3: Lymphoedema Severity and Frailty

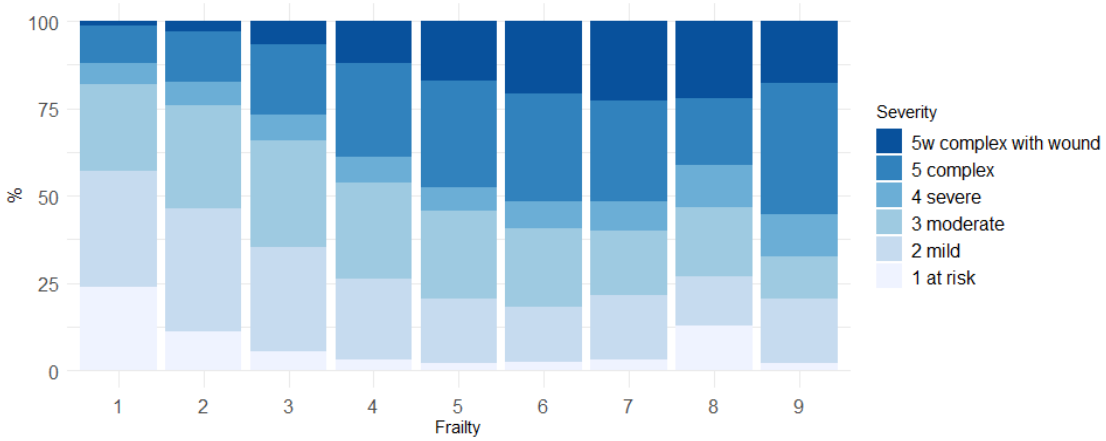
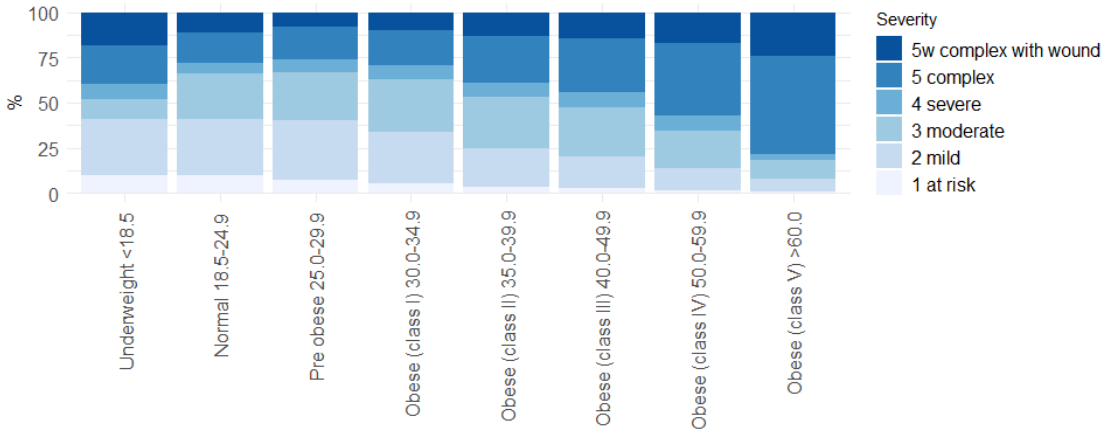


Figure 4: Lymphoedema Severity and BMI



Intensive Treatments

During 2024-25 the number of intensive treatments provided in LWCN was 3,022. In BCUHB 1,289 Intensive treatments were completed. In **Table 14**, the proportion of appointments that are intensive and the number of intensive appointments per 100 high grade patients (severe, complex, complex with wound) are demonstrated. In BCUHB, 15% of all patient activity was for Intensive Treatments- this is the highest in Wales as previously reported. Further, for every 100 High grade complexity patients they all receive intensive treatments.

Table 14: Numbers of Intensive Treatments and against numbers of high-grade complexity patients

HB	Appts (n)	Intensives (%)	Intensives (n)	Distinct high-grade complexity patients	Intensives per 100 HG patients
AB	7,503	4%	332	1,733	19
BC	6,341	20%	1,289	1,231	100
CTM	5,593	4%	249	1,206	21
CV	6,290	6%	392	975	40
HD	4,106	4%	184	1,019	18
PT	2,251	1%	19	266	7
SB	8,292	7%	557	1,829	31

Currently, we have five categories for Intensive Treatment- Multi Layer Lymphoedema Bandaging (MLLB), Manual Lymphatic Drainage (MLD), Lymph Assist (machine which stimulates lymphatics and Decongestive Lymphatic Therapy (DLT) which is MLLB and MLD combined. MLLB is the most common intensive treatment provided by HBs with over 1,500 sessions provided.

Adding to the lack of clarity, 22% of Intensive Treatments are recorded as unknown and in BCUHB 288 there were other treatments **(Table 15).**

During a FU appointment treatments are also provided thus there may be confusion in recording accurately.

Table 15: Different types of Intensive Treatments provided by HB

Health board	DLT	Lymph assist	MLD	MLLB	Other Rx	Unknown	TOTAL
AB	1	11	39	103	2	176	332
BC	0	12	7	968	288	14	1,289
CTM	0	9	2	136	2	100	249
CV	0	4	30	158	2	198	392
HD	0	48	16	11	37	72	184
PT	0	0	0	4	0	15	19
SB	95	64	98	187	22	91	557
							3,022

Work is being undertaken to investigate further the collection and reporting of treatments to better understand the wide variety of treatments.

Outcome 3

After receiving appropriate assessment and treatment, patients will be empowered to self-manage and placed on Patient Initiated Follow Up (PIFU) pathway or discharged as appropriate.

Discharges

To maintain capacity and meet the ongoing demands once a patient is confident to self-manage, they should be placed on the PIFU pathway. In BCUHB it is called Project B, but it is PIFU in essence. Patients who are categorised as At Risk, Mild, Moderate or even those static Complex patients could be PIFU. **Table 16** reports on the number of discharges across Wales. BCUHB discharged a total of 318 patients in 2024-25- this is the lowest in Wales and is not 100% accurate as the numbers of RIP are certainly higher than 7. Discussion has been made to improve this data capture.

PIFU numbers are much lower than expected but maybe complexity is different as well as the service model which requires further analysis.

Table 16: Lymphoedema Discharges

Discharge code	AB	BC	CTM	CV	HD	PT	SB	Total
1 -At Risk	36	47	69	274	53	22	133	634
2 -Self-managing/PIFU	785	104	939	870	1,392	294	2,028	6,412
3- Deteriorated due to other factors	11	3	3	22	45	10	77	171
4- Out of area	7	8	4	11	4	4	10	48
5- Declined treatments	41	71	51	80	65	25	199	532
6- DNA - Discharge	332	35	88	258	134	3	307	1,157
7- Inappropriate referrals	5	14	2	8	34	7	22	92
8 Deceased	33	7	5	127	20	4	174	370
9- No contact made from the patient	33	29	0	33	5	1	5	106
Total	**1,283**	**318**	**1,161**	**1,683**	**1,752**	**370**	**2,955**	**9,522**

Reviewing the PIFU data over the last few years does show progression as documented in **Table 17.** BCUHB PIFU rate is low overall and maybe related to data retrieval.

Table 17: Numbers of PIFU Discharges Recorded amongst HB

	2022-23	2023-24	2024-25
AB	154	363	785
BCU	138	158	104
CTM	266	1,136	939
CV	512	575	870
HD	356	1,272	1,392
Powys	159	214	294
SB	491	883	2,028

Contrary to HB Services' suggestion that the PIFU return rate is high, the actual data tells a different story. As shown in **Table 18,** only 58% of BCUHB patients enrolled in the PIFU pathway during 2024–25 returned for a subsequent appointment. It is important to remember that PIFU places the patient in control when they need to be

seen. Numbers and % of PIFU returns may be different in HBs depending on severity of lymphoedema, compliance of patients and other reasons and should not be benchmarked against each other.

Table 18: PIFU Return Data

HB	Appts discharged to PIFU	% of appts discharged to PIFU	PIFU reassess Appts	PIFU garment Appts	PIFU total appts	Total PIFU appts per PIFU discharge
AB	774	10%	59	127	186	24%
BC	104	2%	26	28	54	52%
CTM	866	15%	151	49	200	23%
CV	853	14%	156	123	279	33%
HD	1,361	33%	121	44	165	12%
PT	294	13%	64	62	126	43%
SB	1,813	22%	185	173	358	20%
Wales	**6,065**	**15%**	**762**	**606**	**1,368**	**23%**

Outcome 4

Patients requiring additional specialist lymphoedema management have access to the National Lymphoedema Team, including psychological support, nutrition and surgical options.

National Lymphoedema Team Specialist Clinics

In addition to core service delivery, the national lymphoedema team operates a range of specialist clinics that are not reflected in the HB figures previously presented. These clinics covering Complex Cases, Lipalgia Syndrome, Surgical Pathways, Psychology, Nutrition, Heart Failure Collaboration, Compression Garment Programme, research activity and Children and Young People are held across Wales and represent a vital extension of the national lymphoedema strategy.

Each clinic is designed to address specific patient needs, offering targeted, multidisciplinary support that enhances both clinical outcomes and patient experience. Importantly, these clinics routinely collect both clinical and patient-reported outcomes, ensuring that care remains responsive, data-driven, and aligned with what matters most to individuals.

Outcomes and insights from these clinics are regularly reviewed and reported through programme steering groups, which feed directly into the National Portfolio Strategy Board. This governance structure ensures that local innovations and patient experiences inform national planning and continuous service improvement.

A comprehensive summary of all national clinics, including outcome data and service developments, is available in the LWCN Annual Reports. These reports provide transparency, showcase impact, and support the ongoing evolution of value-based lymphoedema care in Wales.

Table 19 provides all HB activity within these specialist clinics completed in 2024-25. Nearly 3,200 patient contacts have been completed in 2024-25 by the National Lymphoedema Team this is excluding the National Cellulitis Improvement Programme (NCIP) which is reported separately, and reports have already been distributed.

It is important to note that work programmes are spread across HBs and change on an annual basis on funding streams and opportunities.

Table 19: National Lymphoedema Team Activity

HB	Complex/ Health Board work	Surgical/ MDT/scanning	CYP	Psychology	Nutrition	Heart Failure	Compression Garment Programme/ Research
AB	159	28	100	57	0	30	10
BC	23	11	18	127	3	0	2
CTM	286	27	39	39	10	0	110
CV	119	31	58	101	0	28	103
HD	82	21	69	22	5	334	46
PT	77	3	0	10	0	0	18
SB	135	31	89	72	16	42	602

Outcome 5

All Lymphoedema Services have adequate registered and unregistered staff to safely manage their caseloads supported by administration.

Health Board Staffing Levels

Adequate staffing is essential for all HB Lymphoedema Services to deliver timely, efficient, and safe care. When workforce capacity is compromised due to vacancies or long-term staff sickness services are at risk of breaching waiting time targets. These breaches not only affect patient outcomes but also place additional strain on other NHS services, including community care and wound management.

To assess workforce stability, this section presents the mean monthly Whole Time Equivalent (WTE) alongside WTE fulfilled. The latter accounts for long-term absences and unfilled posts, offering a more realistic view of available staffing. However, it does not capture the impact of short-term sickness or annual leave, which can further reduce day-to-day capacity.

It is important to note that OGEP staff are included in staffing levels to ensure consistency and comparability across Health Boards. OGEP staff are often pulled back into HB Lymphoedema Services in times of crisis thus are included.

Understanding and addressing workforce gaps is critical to maintaining service quality, reducing harm, and supporting wider NHS systems. Sustained investment in recruitment, retention, and staff wellbeing is essential to ensure that lymphoedema services remain resilient and responsive. ABUHB currently reports the lowest WTE vacancies among HB in Wales. This strong staffing position is reflected in their consistent record of nil breaches, highlighting the direct correlation between workforce capacity and service Performance. BCUHB has a 15% vacancy factor which explains the 12% of New Patient breaches.

As shown in **Table 20** the total number of staff working in HBs in LWCN should be 96.3WTE but in 2024-25 there were 19.7WTE vacancies/ freezes which is a 21%

average in posts not in situ which can directly impact service delivery, patient outcomes, and the wider NHS system.

Table 20: WTE of all Staffing and Vacancies in LWCN (includes registered, unregistered and administrative)

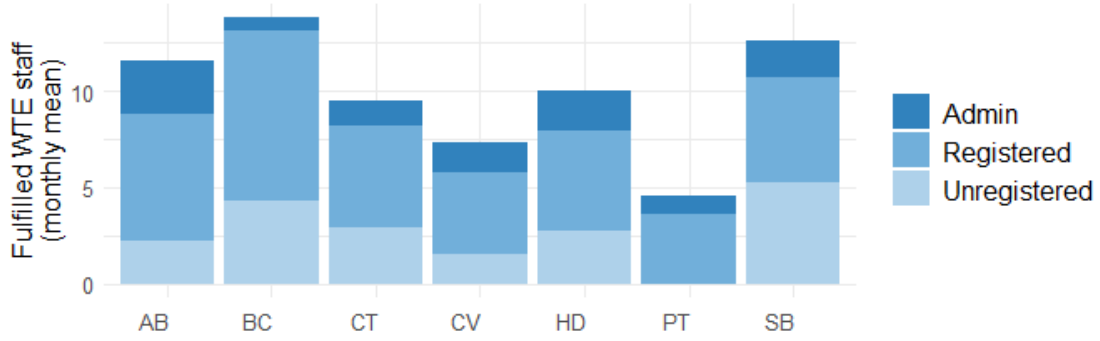
HB	Funded WTE posts	WTE fulfilled	WTE vacancies	WTE vacancies (%)
AB	14.5	13.6	-0.9	6%
BC	18.3	15.5	-2.8	15%
CTM	15.7	10.5	-5.2	35%
CV	11.3	9.7	-1.6	14%
HD	11.7	10.0	-1.7	14%
PT	5.6	4.6	-1.0	18%
SB	19.2	12.7	-6.5	34%

While the overall WTE vacancy rate provides a useful headline figure, it is important to recognise that not all vacancies have equal operational impact. The current WTE vacancy figure includes all staff groups-registered professionals, unregistered staff, and administrative support.

This becomes particularly problematic when vacancies are concentrated within a single staff group. For example, if all registered professionals in a service are absent due to vacancies, maternity or long-term sickness, the service may be unable to deliver any clinical care, regardless of the presence of unregistered or administrative staff. Similarly, the absence of administrative staff can severely disrupt referral processing, appointment scheduling, and patient communication - functions that are essential to safe and efficient service delivery.

To better reflect these nuances, future workforce reporting should consider vacancy distribution by staff group, not just total WTE. This will support more accurate risk assessment and service planning.

Figure 5: Split of Registered, Unregistered and Administrative staff in Lymphoedema HBs 2024-25



As illustrated in **Figure 5**, there are clear variations in the distribution of registered, unregistered, and administrative staff across HB Lymphoedema Services. These differences are not reflective of patient need or clinical complexity but rather stem from historical funding arrangements and legacy staffing models.

Despite increasing demand and rising patient acuity, staffing levels are unlikely to change due to the constraints of ongoing austerity measures. This mismatch between workforce composition and service need risks exacerbating inequities in access, quality, and outcomes across Wales. To ensure equitable and sustainable care, future workforce planning must be informed by population need, service demand, and clinical complexity**,** rather than historical precedent.

It is important to recognise that within each HB Lymphoedema Service, some registered professionals also hold management responsibilities, which limits their availability for direct clinical care. While these individuals are counted within the registered workforce, their time is not wholly dedicated to patient-facing activity.

Neither are these managers admin- hence to improve transparency and better reflect operational reality, from 2025–26 onwards, LWCN will represent management roles separately in workforce reporting. This change will support more accurate workforce planning and help align staffing models with clinical demand. BCUHB employ clinical technicians who complete clinical and admin roles thus they do not employ specific administrators.

Figure 6: Number of Appointments per clinician in 2024-25 excluding OGEP

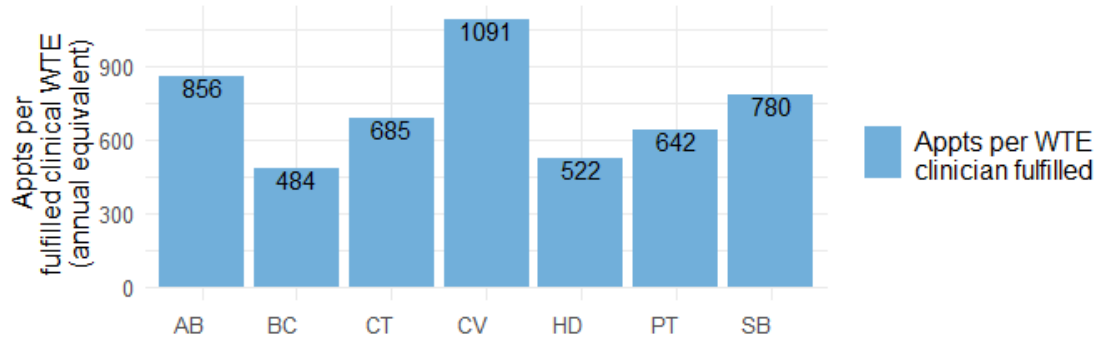
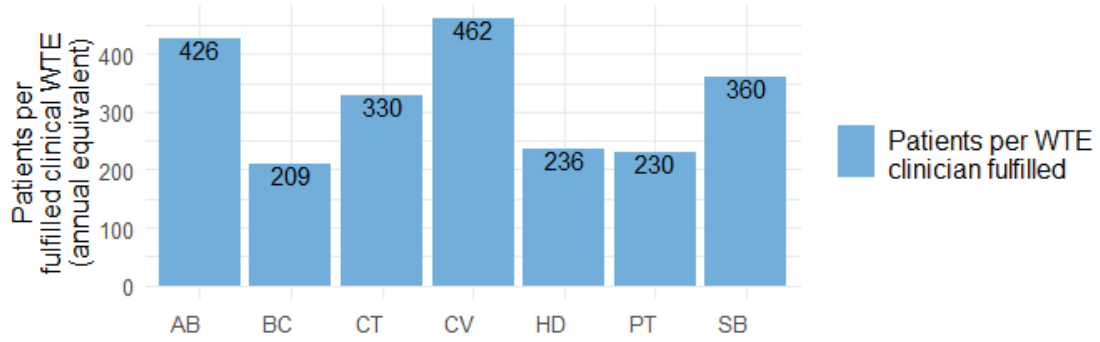


Figure 7: Number of individual patients per clinician



Figures 6 and 7 demonstrate the numbers of appointments and patients per clinician. Again, there is great disparity between HBs for example CVUHB have on average 462

patients per clinician and see over 1,000 appointments each compared to BCUHB which has 209 and 484 appointments. We need to understand if quality, safety and effectiveness is impacted by higher or lower numbers. For example, as CVUHB are seeing double than BCUHB are patient outcomes comparable? Is there more clinical errors or risks in higher workload environments? Is there less efficient documentation or more staff sickness or burnout/ retention etc. These are areas that need further investigation.

High numbers of contacts do not mean a better clinical outcome or service. Further investigation suggest that Powys has the highest appointment to patient ratio at 2.79 allowing more FU per patient. ABUHB has the lowest at 2.0 possibly due to more efficient case resolution. CVUHB leads in the demand for appointments and BCUHB has the lowest.

Outcome 6

Care provided by each Health Board is tailored to their individual population health needs

Patient Demographics

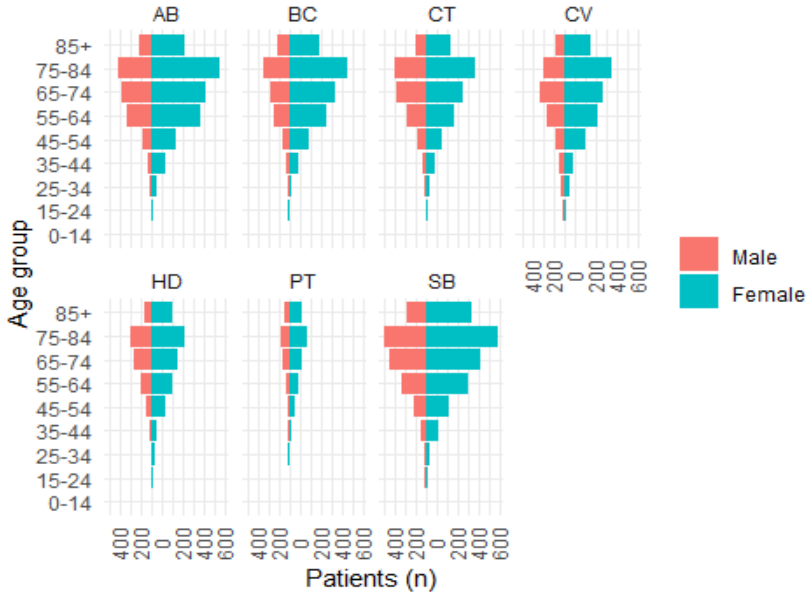
Patient level activity has been captured for each HB Lymphoedema Service. Age, sex and WIMD are based on patients' first appointment as shown in **Table 21.** Sex and age of patients are similar across all HBs.

Lymphoedema based on data appears to be more evident in women over the age of 75. Interestingly, CTMUHB patients are 40% male compared to BCUHB which are only 30% **(Figure 8).**

Table 21: Sex and Age of Patients in LWCN

Variable	Category	AB	BC	CTM	CV	HD	PT	SB	Wales
Sex	Male	33%	28%	40%	31%	35%	31%	36%	34%
	Female	67%	70%	60%	69%	62%	69%	63%	65%
	Unknown	1%	2%	0%	1%	3%	1%	1%	1%
Age	18-24	1%	1%	1%	1%	1%	0%	1%	1%
	25-34	2%	1%	2%	3%	2%	2%	1%	2%
	35-44	5%	4%	4%	6%	4%	3%	5%	5%
	45-54	10%	9%	9%	11%	10%	8%	9%	10%
	55-64	20%	18%	18%	18%	16%	14%	17%	18%
	65-74	23%	23%	25%	23%	23%	23%	23%	23%
	75-84	27%	29%	29%	25%	27%	30%	28%	28%
	85+	12%	14%	12%	13%	14%	21%	17%	14%
	Unknown	1%	2%	1%	1%	3%	1%	1%	1%

Figure 8: Age and Sex in Lymphoedema Services in Wales



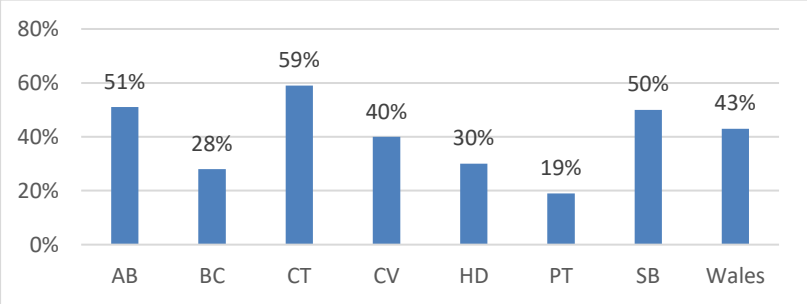
Deprivation Quintiles

Research indicates that individuals living in the most deprived areas tend to present with more complex lymphoedema cases, and cellulitis is also more prevalent due to poorer health in general. In LWCN, most patients do reside in the top two quintiles except for Powys and BCUHB **(Table 22 and Figure 9).** We do need to understand more about the quintiles in each HB and in 2025-26 we will delve into the data further.

Table 22: Deprivation Quintiles in LWCN

Variable	Category	AB	BC	CTM	CV	HD	PT	SB	Wales
WIMD quintile	1 most deprived	28%	11%	26%	27%	9%	7%	28%	22%
	2	23%	17%	33%	13%	21%	12%	22%	21%
	3	20%	23%	13%	12%	32%	28%	15%	19%
	4	14%	27%	14%	13%	30%	39%	13%	18%
	5 least deprived	15%	19%	13%	34%	4%	10%	21%	18%
	Unknown	2%	4%	1%	1%	4%	3%	1%	2%

Figure 9: Lymphoedema patients residing in top two deprived areas



By deepening our understanding of population health, we can better identify areas with low referral rates and proactively support them through targeted education initiatives

aimed at specific GP clusters **(Table 23).** Data this year has allowed us to identify the prevalence of lymphoedema in GP Clusters. In BCUHB it ranges from 10.31 in South Meirionnydd to 2 per 1,000 people in Conwy West. This information supports where to offer more targeted education as highlighted by the correlation between deprivation and complex health needs, such as lymphoedema and cellulitis.

In 2025-26 this data will be drilled down to GP Practice level.

Table 23:GP Clusters with Lymphoedema patients

HB	Cluster	LO patients (n)	Population	LO pts per 1,000 pop.
BCUHB	South Meirionnydd	194	18,913	10.3
	Dwyfor	249	37,469	6.6
	Central & South Denbighshire	228	42,341	5.4
	South Flintshire	237	52,337	4.5
	Central Wrexham	208	58,160	3.6
	South Wrexham	180	52,764	3.4
	North West Flintshire	127	40,724	3.1
	North & West Wrexham	114	36,546	3.1
	Anglesey	201	66,074	3.0
	North Denbighshire	185	61,732	3.0
	Arfon	196	67,550	2.9
	North East Flintshire	179	62,497	2.9
	Conwy East	136	52,488	2.6
	Conwy West	126	64,063	2.0

Ethnicity

Based on the patient's self-identified ethnicity using the ONS ethnicity categories **(Table 24)**, data has been captured for the first time which highlights low ethnicity across Wales:

- Asian, Asian British, Asian Welsh (Asian).
- Black, Black British, Black Welsh, Caribbean or African (Black).
- Mixed Or Multiple (Mixed).
- White (White).
- Other Ethnic Group (Other).

In BCUHB, this has not been reported.

Table 24: Ethnicity in LWCN

Variable	Category	AB	BC	CTM	CV	HD	PT	SB	Wales
Ethnicity	Asian	0	0	0	2	0	0	0	1
	Black	0	0	0	1	0	0	0	0
	Mixed	0	0	0	1	0	1	0	0
	White	99	0	99	89	96	98	98	81
	Other	0	0	0	5	0	0	0	1
	Unknown	1	100	1	2	4	1	1	17

In BCUHB, 85% of the lymphoedema population has a BMI of 25 or over. 74% have a BMI over 30 **(Table 25).** Lymphoedema and obesity are intrinsically linked, thus it is important that weight management is initiated with all patients.

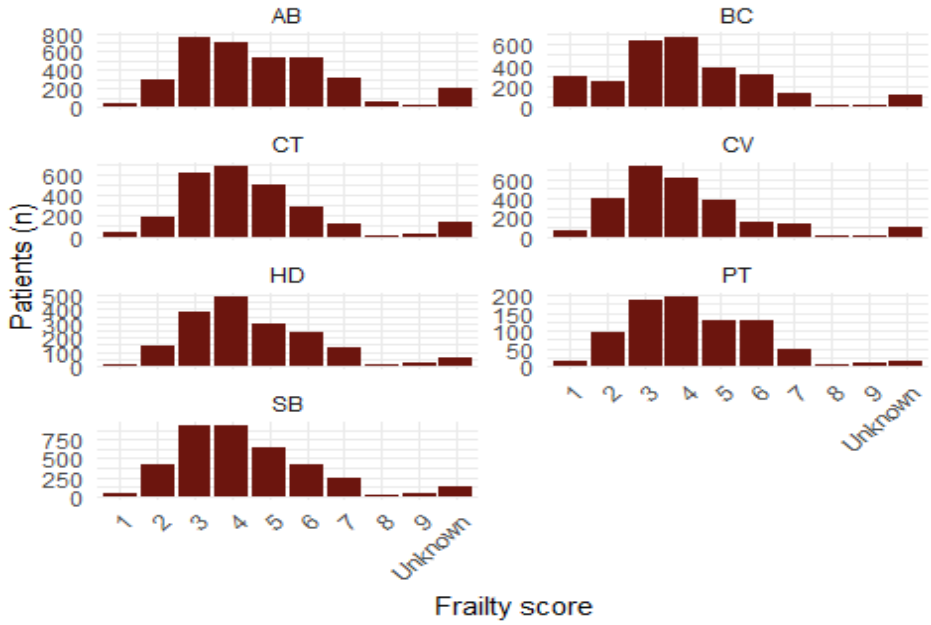
Table 25: BMI in LWCN

Variable	Category	AB	BC	CTM	CV	HD	PT	SB	Wales
	Underweight <18.5	0%	1%	1%	1%	1%	1%	1%	1%
BMI	Normal 18.5-24.9	7%	10%	7%	10%	22%	13%	9%	10%
	Pre obese 25.0-29.9	14%	15%	13%	13%	15%	12%	16%	14%
	Obese (class I) 30.0-34.9	26%	19%	19%	20%	15%	23%	27%	22%
	Obese (class II) 35.0-39.9	19%	17%	16%	22%	16%	19%	21%	19%
	Obese (class III) 40.0-49.9	21%	20%	20%	19%	14%	14%	16%	18%
	Obese (class IV) 50.0-59.9	7%	7%	8%	5%	5%	5%	5%	6%
	Obese (class V) >60.0	2%	3%	3%	3%	6%	3%	2%	3%
	Unknown	5%	7%	12%	7%	5%	9%	3%	6%

Frailty

As shown in **Figure 10,** frailty is apparent in 58% of the lymphoedema population, i.e. frailty 4 is vulnerable or more.

Figure 10: Frailty in LWCN



Although LWCN sees lymphoedema patients' other causes can be logged such as lipalgia syndrome or vascular oedema. In BCUHB 77% are lymphoedema and low numbers of lipalgia syndrome, yet 15% are logged ad vascular patients (highest in Wales). 81% of swelling occurs in the lower limbs and 21% of work is related to cancer patients **(Table 26).**

Table 26: Diagnosis Type, location and category

Variable	Category	AB	BC	CTM	CV	HD	PT	SB	Wales
Diagnosis	lymphoedema	93%	76%	94%	92%	91%	95%	94%	91%
	Lipalgia syndrome	2%	4%	2%	2%	1%	1%	1%	2%
	Lymph and lipalgia syndrome	2%	1%	2%	1%	2%	2%	1%	1%
	Vascular	1%	15%	0.2%	3%	3%	1%	2%	4%
	None	1%	2%	1%	1%	2%	1%	2%	1%
	not specified	1%	2%	1%	1%	1%	0.3%	1%	1%
Location	Arm(s)	9%	9%	7%	7%	8%	7%	6%	8%
	Leg(s)	86%	81%	89%	89%	83%	88%	90%	87%
	Head/neck	0%	2%	1%	1%	3%	1%	1%	1%
	Trunk	1%	2%	1%	1%	3%	2%	1%	1%
	Genitals	0%	0%	0%	0%	1%	0%	0%	0%
	Multiple	1%	1%	3%	1%	2%	3%	2%	2%
	Not specified	2%	5%	0%	1%	0%	0%	1%	2%
Type	adult non-cancer	83%	79%	85%	85%	76%	81%	88%	83%
	adult cancer	17%	21%	15%	15%	24%	19%	12%	17%

Evaluation Framework Objective 2

Lymphoedema management across Wales is patient centered and focused on value.

Outcome 8

LWCN will collect and apply patient-reported outcome measures (LYMPROM) and patient-reported experience measures (LYMPREM) to support value-based care in lymphoedema management

PROMs and PREMs

LYMPROM and LYMPREM are used routinely to triage, facilitate shared decision making, support service improvements and evidence of the need for new projects and intervention. In 2024-25 five HB are implementing outcomes measures as shown in **Table 27**. Digital data collection has proved challenging this last year due to a change in platform, but we are hopeful that data analysis and downloading will be available in the LWCN dashboard soon.

BCUHB has not yet enrolled into a digital platform for PROMS and PREMS. Hopefully, this will change in 2025-26.

Table 27: Numbers of PROMS/ PREMS collected in 2024-25

PROMS/PREMS across health boards

Health Board	Current PROM/PREM platform		Completed in 24-25	Completed in 23-24	
ABUHB	Promptly (since Mar-25)	LYMPROM	2,102	2,383	
		LYMPREM	1,876	1,237	
BCUHB	Paper-based				
CTMHB	Promptly (since Jul-24)	LYMPROM	n/a	1,223	Awaiting data for 24-25
		LYMPREM	584	176	Awaiting data from Feb-25 onwards
CVUHB	Promptly (since Feb-25)	LYMPROM	875	455	
		LYMPREM	236	41	Only Feb & Mar-25
HDUHB	Promptly (since Jun-24)	LYMPROM	800	1,307	
		LYMPREM	555	956	Only since Jun-24
PTHB	Paper-based				
SBUHB	Promptly (since Nov-24)	LYMPROM	588	2,932	Only since Nov-24
		LYMPREM	482	1,824	Only since Nov-24

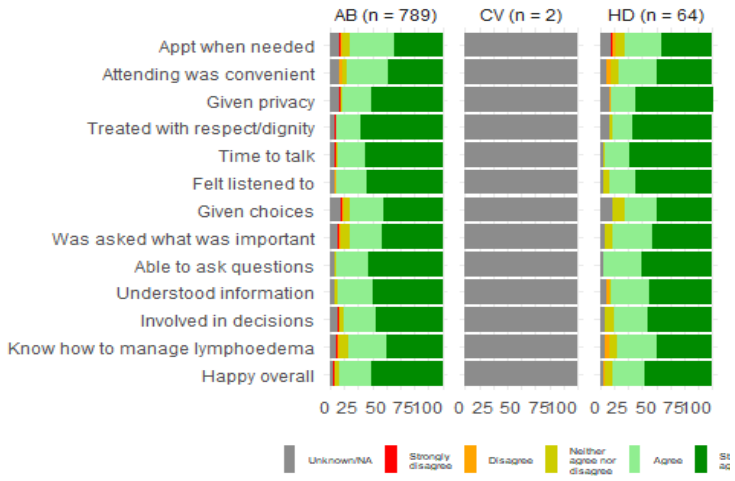
The impact of lymphoedema remains problematic in heaviness, home life, body image, walking, anxiety, holidays, hobbies and shopping for clothes **(Table 28).**

Table 28: Impact of lymphoedema on Lymprom

	Number of patients	Pain	Heaviness	Home life	Personal care	Work	Finances	Body image	Intimacy	Walking	Anxiety	Holidays	Hobbies	Shopping
Arm/Hand only	331	4	5	4	3	3	0	5	3	1	4	4	1	5
Arm/Hand + other	724	6	6	6	5	4	0	7	6	4	6	6	5	7
Head/Neck only	101	4	3	3	2	1	0	7	5	1	5	2	0	1
Head/Neck + other	103	4	3	3	2	1	0	7	5	1	5	2	0	1
Leg/Foot only	1,251	6	6	6	5	4	0	6	5	7	6	6	6	8
Leg/Foot + other	3,314	6	6	6	5	4	0	7	5	7	6	6	6	8
Male	1,518	5	5	5	5	2	0	5	4	7	5	5	5	6
Female	3,066	6	7	6	5	4	0	7	6	7	7	6	6	8
<=30 years	39	6	7	7	4	6	1	9	8	7	8	7	6	8
31 to 40 years	97	6	7	6	5	6	2	8	8	6	6	6	6	8
41 to 50 years	179	6	6	6	5	5	3	8	8	7	7	7	6	8
51 to 60 years	451	6	6	6	5	6	2	7	7	7	6	6	7	7
60+ years	1,436	5	5	5	5	4	1	5	5	7	5	5	6	7

LYMPREMs have been completed in ABUHB, CVUHB and HDUHB totaling 855 responses. Positively, most responses are positive **(Figure 11).**

Figure 11: Lymprem question responses by health board



Peer Review

In February and March 2025, a random sample of active lymphoedema case notes were reviewed across all HB. Reviews were conducted by 3–4 clinical staff per site using a standard Peer Review Form. Since the last Peer Review in 2023:

Changes from the last Peer Review 2023

- Improvement in patients having face-to-face appointments in the last 2 years from 97% to 98%
- Slight deterioration in signed and dated documentation from 99% in 2016, to 95% this year
- A lymphoedema communication letter was sent to 74% of patients, an excellent improvement from 2023 where this was 40%
- Positive improvement of LYMPROM use as 44% completed the form as opposed to 17% in 2023
- Small change from 53% to 73% where full limb volume measurements were taken. 100% were calculated. Only 11% recorded rationale for not doing full limb measurements
- Reduction in recorded BMI from 91% in 2016 to 78% this year.

Teitl adroddiad: **Report title:**	Draft Duty of Candour Report			
Adrodd i: ***Report to:***	Quality, Safety and Experience Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 04 September 2025			
Crynodeb Gweithredol: ***Executive Summary:***	Beth yw pwrpas y papur, a yw'n eitem sefydlog/untro? Pa gamau sydd angen i 'r Bwrdd eu cymryd gyda'r adroddiad hwn? *What is the purpose of this paper, is it a standing/one off item?* *What is required from the Board as a result of this report?* The draft Duty of Candour Report is being presented to QSE Committee for their consideration and feedback prior to the report being finalised.			
Argymhellion: ***Recommendations:***	Gofynnir i 'r Bwrdd: Nodi/cymeradwyo .... *The Board is asked to:* *Note/approve ….* QSE Committee is asked to note the draft report and provide feedback to help shape and finalise the report.			
Arweinydd Gweithredol: ***Executive Lead:***	Angela Wood, Executive Director of Nursing and Midwifery			
Awdur yr Adroddiad: ***Report Author:***	Joanne Kendrick, Head of Quality			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☐ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, â'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***				
Goblygiadau rheoleiddio a lleol:	Health and Social Care (Quality and Engagement) (Wales) Act 2020			

Regulatory and legal implications:	
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	Do/Naddo *N* Os naddo, rhowch esboniad yn ymwneud â'r rheswm pam nad yw'r ddyletswydd yn *berthnasol* *If no please provide an explanation as to why the duty does not apply* Gweithdrefn ar gyfer Asesu Effaith ar Gydraddoldeb WP7 *WP7 Procedure for Equality Impact Assessments*
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	Do/Naddo *N* Os naddo, rhowch esboniad yn ymwneud â'r rheswm pam nad yw'r ddyletswydd yn *berthnasol* *If no please provide an explanation as to why the duty does not apply* Gweithdrefn WP68 ar gyfer Asesu Effaith Economaidd-Gymdeithasol. *WP68 Procedure for Socio-economic Impact Assessment.*
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF â'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR)***	(Crynodeb o'r risgiau a rhagor o fanylion yma) (Summarise risks here and provide further detail)
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	(Crynodeb o sut mae'r papur wedi cael ei adolygu, yr ymateb a pha newidiadau a wnaed ar ôl cael adborth) QSE
Cysylltiadau â risgiau BAF: (Neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(Or links to the Corporate Risk Register)*	
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)	Amherthnasol

Reason for submission of report to confidential board (where relevant)	Not applicable
Camau Nesaf: **Gweithredol argymhellion** ***Next Steps:*** ***Implementation of recommendations***	
Rhestr o Atodiadau: Dim ***List of Appendices:*** *None*	

Annual Duty of Candour Report 2024 -2025

Duty of Candour

The Duty of Candour, as with the Duty of Quality, has been introduced through the Health and Social Care (Quality and Engagement) (Wales) Act 2020 and came into force in April 2023. The duty requires NHS organisations in Wales to be open and honest about the care and treatment patients receive.

What does it mean?

Even when the Health Board does its very best to prevent harm, people may experience harm. This is why the Duty of Candour is in place. If the care provided has caused moderate harm, severe harm or death to a patient, this means that the organisation's health and care professionals must tell its patients or someone acting on their behalf that harm has been caused.

By being open and honest, it will give people confidence and trust in the care and treatment they received from the Health Board.

What is meant by moderate or severe harm?

- **Moderate harm** is when the NHS treatment the patient has received has caused or contributed to causing them harm, leading to further treatment. At this stage, harm can be serious, but not permanent.

  For example, a patient is given medicine that they are allergic to, even though it is written in their notes as an allergy. The patient gets a reaction because of the medicine. They need to stay in hospital for 4 or more days before they recover.

- **Severe harm** is serious harm which has caused or contributed to the patient suffering a permanent disability or loss of function.

  For example, a patient is given medicine they are allergic to, even though it is written in their notes as an allergy. This may lead to brain damage or other permanent organ damage.

- **Death** is where a patient has died which was caused or contributed to, by their NHS care and treatment.

  For example, a patient is given medicine they are allergic to, even though it is written in their notes as an allergy. This leads to their death

The Health Boards approach to the Duty of Candour

What has been achieved so far?

The Health Board has a dedicated Duty of Candour SharePoint page on our intranet which provides a host of training materials, which has been both locally and nationally produced, together with access to templates and help guides and videos to assist services to operationalise the Duty of Candour. Local governance teams within the Health Board provide support and review cases with IHCs and Divisions. Members of the Corporate Integrated Quality, Safety, Experience Team assist with queries. Ongoing work has been done to bring together relevant corporate services such as Health care law in order to ensure processes and procedures are followed and monitored.

What has challenged the Health Board?

Accurate grading of incidents and progression through the review process continues to be a challenge for the Health Board. However, the ratification and implementation of the Integrated Concerns Policy along with its associated operational support structure is working to improve not only the processes being followed but the data quality.

The reporting system Datix Cymru, which is the system where Duty of Candour is recorded, has undergone some upgrade work following areas for improvement being identified, a large-scale review of the Duty of Candour section on the incident module took place in 2024-2025 with the approved changes due to be implemented in Datix in the summer of 2025. The Health Board played a key role in the further development of the module and provides ongoing support to various Network meetings in connection with further development of Datix in other modules and Duty of Candour monitoring and processes as a whole.

Where Duty of Candour has been triggered during 2024 -25

During the reporting year 2024-25, the Duty of Candour (DoC) has come into effect in respect of the provision of health care by the Health Board. The Duty of Candour was triggered on 350 occasions (excluding primary care which are reported further on in this section).

Figure 1 below demonstrates number of times per month Duty of Candour was triggered. Average number of times Duty of Candour triggered per month = 29.12.

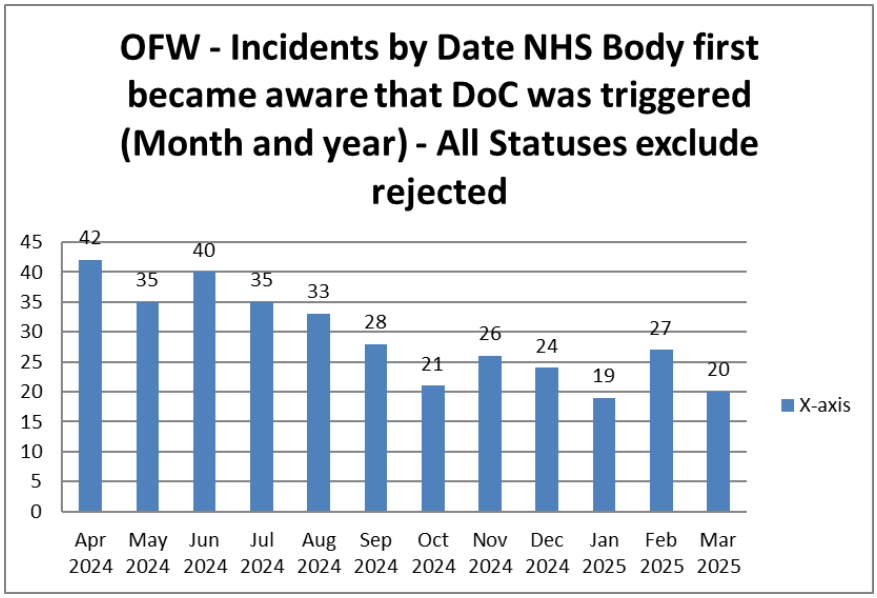


Figure 1: Duty of Candour Incidents by Month

Figure 2 below demonstrates number of times per month Duty of Candour was triggered, broken down by level of Harm.

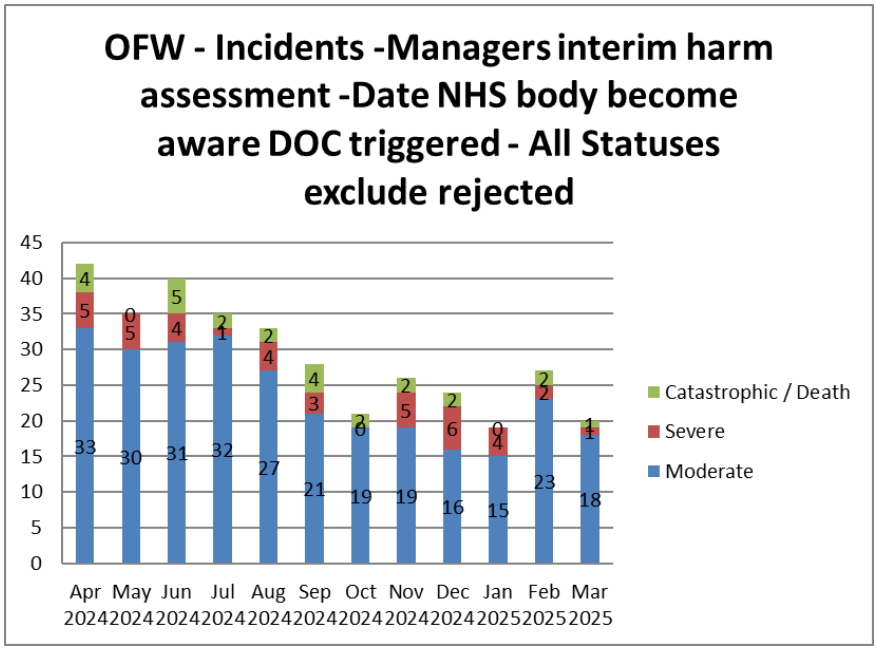


Figure 2: Monthly Duty of Candour Incidents by Level of Harm

Noticeably, the largest proportion of incidents that have triggered Duty of Candour following managers interim harm assessment, fall into the moderate category.

Historically, a severity of moderate would have been selected when the reviewer was unsure about severity, or, felt that the incident was significant enough to warrant a severity of moderate despite a patient not actually coming to any harm. This is not Health Board policy. It is a misunderstanding of the implications with regards to Duty of Candour and a clear indication of requirement for training in aligning allocating severity of harm according to national guidance on definitions.

It is therefore thought that the number of incidents that are categorised as moderate after initial review is inflated, and support is required for services to understand the importance of accurately assessing the harm according to the definition of moderate as detailed in the policy.

The Duty of Candour legislation mandates that once triggered, the Health Board must inform patient/relative that harm may have been caused via “in person” notification and followed up with a written notification. The patient/relative should also be informed of the outcome of any investigation unless they stipulate that they do not wish to be informed.

Datix Cymru concerns management system, is used by the Health Board to record when the “in-person” and written notifications are completed and when any final response of an investigation is shared with patient/relative.

Of the **350** occasions where Duty of Candour was triggered, 224 records have been closed and of the closed incident records:

- 190 “in person” notifications are recorded as completed **(85%)**
- 107 written notifications are recorded as completed **(48%)**
- 50 final responses sent **(22%)**

(It is possible that the actions required by the Duty of Candour have been completed in additional cases, but not recorded on the Datix Cymru system).

This position is recognised by the Health Board as requiring focus and a refresh across the Health Board, there is ongoing work to improve the process and provide increased training.

In addition, ongoing validation work has identified that for the 2024/25 financial year several incidents reported as moderate or above (**n=307**), have not yet undergone an initial management review. In addition, a further 807 incidents with no or low harm recorded by the reporter have yet to undergo a management review to assess the harm level. Had the management review been completed, and assessment of harm remained at moderate or above, a proportion of this number would also have triggered Duty of Candour. This matter has been escalated through the Quality and Safety Group meeting and a Task & Finish group stood up to address the backlog and also ensure the process is streamlined.

There is some evidence that users of the system had discovered ways in which to

by-pass certain sections of the investigation form within Datix Cymru and process not being followed. This is most likely due to conflicting priorities of staff having to use the system and the increasing mandatory fields that need to be completed in order to close an incident and the time taken to complete those fields.

Since updating Datix to Form 4A at the start of April 24, this workaround by staff is no longer possible and staff are unable to close incidents without the management review being completed. A recent survey of the users of the Datix Cymru system, two years after it being introduced will be shared with the OFWCMS team in due course.

The top classification of incidents where Duty of Candour was triggered are:

- **Pressure damage/moisture damage** (n=145)
- **Accident/Injury such as falls** (n=46)
- **Treatment, procedure** (n=40)
- **Assessment, Investigation, Diagnosis** (n=40)

The numbers of pressure ulcers where Duty of Candour has been triggered accounts for 41% of the total. It is worth noting that Duty of Candour is triggered where harm may have been caused and further investigation in these cases could lead to a conclusion that harm was unavoidable.

Steps the Health Board are taking to prevent similar circumstances from arising in the future.

There are various improvement initiatives taking place across the Health Board in relation to the main themes for incidents listed above with focused improvement work is in place, reporting to key strategic groups such as the Health Board's **Strategic Falls Group** and the **Strategic Health Care Acquired Pressure Ulcer (HAPU) Group** where sharing of good practice and patient safety alerts takes place to help triangulate patient safety information to inform key learning and improvements.

Learning from Duty of Candour cases is now formally incorporated into the Health Board's learning forums. This ensures that key insights and reflections are shared widely to support continuous improvement in practice. Furthermore, this learning will be included in the Health Board's central Learning Repository upon its launch later this year, providing a structured and accessible resource for ongoing organisational development."

Preparing the Primary Care Provider Duty of Candour Reports

With effect from April 2023, Primary Care providers must prepare a report in respect of the health care they provide under a contractual or any other arrangement, with the Health Board. The report will confirm whether during the reporting year, the Duty of Candour has been triggered in respect of the provision of health care by the primary care provider

This section remains under progress and will confirm the following as outlined in the duty;

If Duty of Candour has been triggered, the report must:

1. Specify how often this has happened during the reporting year,
2. Give a brief description of the circumstances in which the Duty of Candour was triggered,
3. Describe any steps taken by the provider with a view to preventing similar circumstances from arising in future.

The reports from Primary Care providers must be provided to the Health Board no later than 30th September each year and will be included in this section of the report, where a summary of the primary care reports will be provided.

From Investigation to Improvement: Learning from Ombudsman Findings

Betsi Cadwaladr University Health Board remains committed to openness, transparency, and continuous improvement in patient care. As part of this commitment, the Health Board has actively engaged with the Public Services Ombudsman for Wales, who investigates complaints from patients and the public regarding service failures. This engagement has led to strengthened governance and enhanced collaboration, ensuring that lessons learned from Ombudsman investigations are embedded into service improvements.

To support this, the Health Board's **Regulatory Assurance Group, Patient Safety Group, and Clinical Effectiveness Group** collectively review, monitor, and share learning from Ombudsman findings. This structured approach enables the Health Board to identify areas for improvement and implement necessary actions to enhance patient experience and safety.

Ombudsman Reports and Transparency

When the Ombudsman investigates a complaint and determines that something has gone wrong, a report is prepared summarising the findings. In cases where wider learning is required, the issue is significant, or it is in the public interest, a Public Interest Report (PIR) is issued under section 23 of the Public Services Ombudsman (Wales) Act 2019.

During 2024-25, the Ombudsman issued four Public Interest Reports. One Public Interest Report was issued with a specific request that the Health Board share the findings within its Duty of Candour Annual Report. This transparency is fundamental to ensuring the public is reassured that learning is taking place and that meaningful improvements are being made.

One such case, Case **202206250**, involved a complaint raised by Mrs L regarding the care and treatment of her late mother, Mrs K, who suffered from biliary sepsis. The Ombudsman found that the Health Board failed to identify and treat her condition appropriately, leading to a grave injustice for Mrs K and her family. The report highlighted missed opportunities in diagnosing and treating her pancreatitis, inadequate communication with her family, and a lack of candour in the Health Board's response to the complaint. The Ombudsman recommended that the Health Board acknowledge these failings and ensure that lessons learned are incorporated into service improvements.

The Health Board accepted the recommendations made by the Ombudsman within the report and provided a fulsome apology to Mrs L. Key learning which has been taken forward includes:

- Ensuring completion of imaging is an absolute necessity.
- Communication is key and we all have a duty to ensure this is robust and fully documented.

Further details and the Ombudsman's Final Public Interest Reports can be accessed

on the Health Board's website or the Public Services Ombudsman for Wales website by searching their 'Publications' page.

One particular investigation Report **Case 202400693**, was also issued with a specific request that the Health Board share the findings within its Duty of Candour Annual Report. Under the Public Services Ombudsman (Wales) Act 2019, the Ombudsman investigates complaints where individuals believe they have suffered injustice or hardship due to the actions of a public body.

During 2024-25, The Public Services Ombudsman for Wales investigated concerns about the care Mrs A received during her hospital stay. The investigation found that:

- There were delays in providing Mrs A with a hospital bed, administering antibiotics and pain relief, and carrying out a clinical review.
- A critical failure occurred when the surgical team did not respond, and this was not escalated to a senior clinician. As a result, Mrs A did not receive timely treatment.
- If the issue had been escalated, she would likely have received earlier antibiotics and a senior surgical review, which could have improved her outcome.
- The delay in pain relief caused her unnecessary distress.

The Ombudsman found these failings were serious and unacceptable, as they compromised good clinical care. This caused significant injustice to Mrs A and her family, who must now live with the knowledge that opportunities to improve her care were missed. As a result, the complaint was upheld.

The Health Board accepted the recommendations made by the Ombudsman within the report and provided a fulsome apology to Mrs C. Key learning which has been taken forward includes:

- Improved recording of referrals to surgery via the electronic patient management system within the Emergency Department
- Established regular safety and escalation huddles for handover and escalation reporting in the Emergency Department

Strengthening Complaints Handling and Service Improvement

In response to Ombudsman findings, the Health Board has strengthened its complaints handling process to ensure concerns raised by patients are addressed promptly. Lessons learned from Ombudsman investigations have been actively integrated into service improvements, leading to the development of the Integrated Concerns process. This approach fosters a culture of accountability and continuous learning, reaffirming the Health Board's dedication to providing safe, high-quality care.

You can read more about how the Health Board is improving is complaints process and other improvement initiatives to improve the quality of care it delivers to its patients, in the Annual Quality Report 2024-25.

Annual Report
Putting Things Right
(PTR)
2024 - 2025

Putting Things Right (Wales)

Putting Things Right (PTR) is the process in NHS Wales through which concerns and complaints are investigated, providing an easy-to-access way of raising concerns and complaints. It aims to ensure there is proper investigation when a concern or complaint is raised, and that lessons are learned after mistakes have been made. Information about the problems identified should be shared with the patient, and where possible, there should be an immediate correction of things that have gone wrong.

PTR arrangements are governed by the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 ("the PTR regulations").

Concerns are issues identified from patient safety incidents, complaints and, in respect of Welsh NHS bodies, claims about services provided by a Responsible Body in Wales.

The information below will describe how the Health Board performed on Putting Things Right during 2024-25.
.

Incidents

Most incidents that are recorded are classed as 'none' or 'low' in that no significant harm was caused by the event that occurred.

A total of **43325 incidents** were recorded in **2024/25**, an increase in number from the previous year of **41,690**. Of these, **36938** incidents were reported as affecting patients/service users.

Incident themes / trends

The classification of the patient/service user incidents reported along with reporters view on level of harm are shown below in table below.

Table : The total number of incidents, by classification, BCUHB.

	None	Low	Moderate	Severe	Catastrophic	Total
Access, Admission	540	551	168	40	21	1320
Accident, Injury	1054	3624	660	54	6	5398
Assessment, Investigation, Diagnosis	329	660	362	102	24	1477
Behaviour (including violence and aggression)	813	1904	441	37	10	3205

Communication	271	443	187	21	2	924
Consent, Mental Capacity Act (including DoLS)	21	22	8	3	0	54
Equipment, Devices	193	342	99	11	2	647
Infection Prevention and Control	71	535	102	1	3	712
Information Governance, Confidentiality	86	151	22	3	0	262
Information Technology	176	58	21	4	0	259
Infrastructure (including staffing, facilities, environment, security)	114	97	56	12	2	281
Maternity adverse occurrence	500	728	94	7	8	1337
Medication, IV Fluids	1155	1640	481	58	3	3337
Monitoring, Observations	40	77	75	10	3	205
Nutrition, Hydration	24	77	29	5	0	135
Patient/service user death	23	11	25	2	284	345
Pressure Damage, Moisture Damage	1363	9485	2515	73	1	13437
Records, Information	263	249	64	10	0	586
Safeguarding	117	220	88	24	2	451
Transfer, Discharge	197	474	205	37	12	925
Treatment, Procedure	332	776	436	80	17	1641
Total	7682	22124	6138	594	400	36938

The Patient Safety Team monitor incidents to identify themes and where these need to inform organisational priorities. The most reported incidents relate to pressure damage and patient falls. It should also be noted that the significant number of patient deaths reported are of patients under mental health services that are subsequently downgraded following investigation and review of contribution and omission.

Improvement work

Core level mandatory training for pressure ulcer prevention and management has now been developed and approved. This is now with the systems team and will be launched imminently. Development has now progressed to Level 1 for Healthcare Professionals with responsibility of undertaking risk assessments and planning care for pressure ulcer prevention and management and Level 2 for Registered Healthcare Professionals holding a caseload of patients with pressure ulceration.

Following a presentation by BCUHB Tissue Viability Nurses, at the All-Wales sub group for Education, the All-Wales Tissue Viability Nurses Forum have requested to work with our Health Board Tissue Viability Nurses to lead with the development of the mandatory training on an All Wales level. To note, no other Health Board have an e-learning platform or mandatory requirement for pressure ulcer prevention and management.

Weekly reviews across each integrated health community (IHC) and Division have adopted the title Pressure Ulcer Learning Forum and follow the aSSKINg framework (aSSKINg - assess risk; skin assessment and skin care; surface; keep moving; incontinence or increased moisture; nutrition and hydration assessment / support; and give information).with an agreed terms of reference in place. Data is extracted from themes and trends to inform improvement focus across the Health Board.

The Health Board have moved away from the term non concordance and all staff are adopting a patient centred approach to Pressure Ulcer Prevention and Management incorporating the aSSKINg framework. This ensures prevention and management is individualised.

The Health Board are currently exploring the adaptation of the focused review on the Datix system to the aSSKINg framework which when reviewed promotes the identification of learning and areas for improvement in pressure ulcer prevention. This has been raised with other Health Boards across Wales who are supportive of the approach.

The Health Board's Strategic Falls Group continues to lead on the multidisciplinary implementation of reduction of inpatient falls with a focus on risk assessment, ensuring the appropriateness of the environment and use of resources to improve patient safety. This approach enables the group to identify any emerging themes and trends or hotspots and to make recommendations for improvements.

The BCUHB Falls policy has been kept under regular review and provides a clear set of standards for staff across the Health Board. A standard operating procedure has been developed and approved in December 2024 relating to increased patient cohort observations – known as "Baywatch." This document sets out the steps and processes to minimise the risk of falls through increased observation of patients who have been assessed and deemed to be at high risk of falls.

Falls eLearning modules (1A and 1B) were developed by the Health Board in collaboration with Wrexham County Borough Council. Following development, the Health Board took the decision to make the eLearning module 1A mandatory for all staff regardless of their role. This was implemented in January 2022. The Health Board is the only board in Wales to take this approach to falls training as mandatory for all staff. The Chair of the All-Wales Inpatient Falls Network has commended the Health Board on this approach. Falls eLearning module 1B is mandatory for all staff whose role requires conducting falls risk assessments.

To ensure agency staff are competent in falls related skills, training was provided to the agencies in January 2024 and Agency workers are now required to complete the eLearning module 1A and 1B with access via an all-Wales learning platform.

The Health Board has developed a live dashboard to support our wards with their monitoring of risk assessment completion. The dashboard was launched on 10 May 2024. The Health Board was the first in Wales to develop this use of the data within the Welsh Nursing Care Record.

On a monthly basis, all ward managers and matrons complete a set of audits which include questions relating to the quality and accuracy of the falls risk assessments, and interventions following assessment. The audits are a random sample of 3 inpatient nursing records. This audit data is then used to support focused quality improvement at ward level.

The Health Board have conducted three separate analyses to determine the impact of new reviews, policies, and learning initiatives on patient falls across the Health Board. Using monthly data from April 2023 to December 2024, we performed statistical tests to compare the number of falls before and after the interventions.

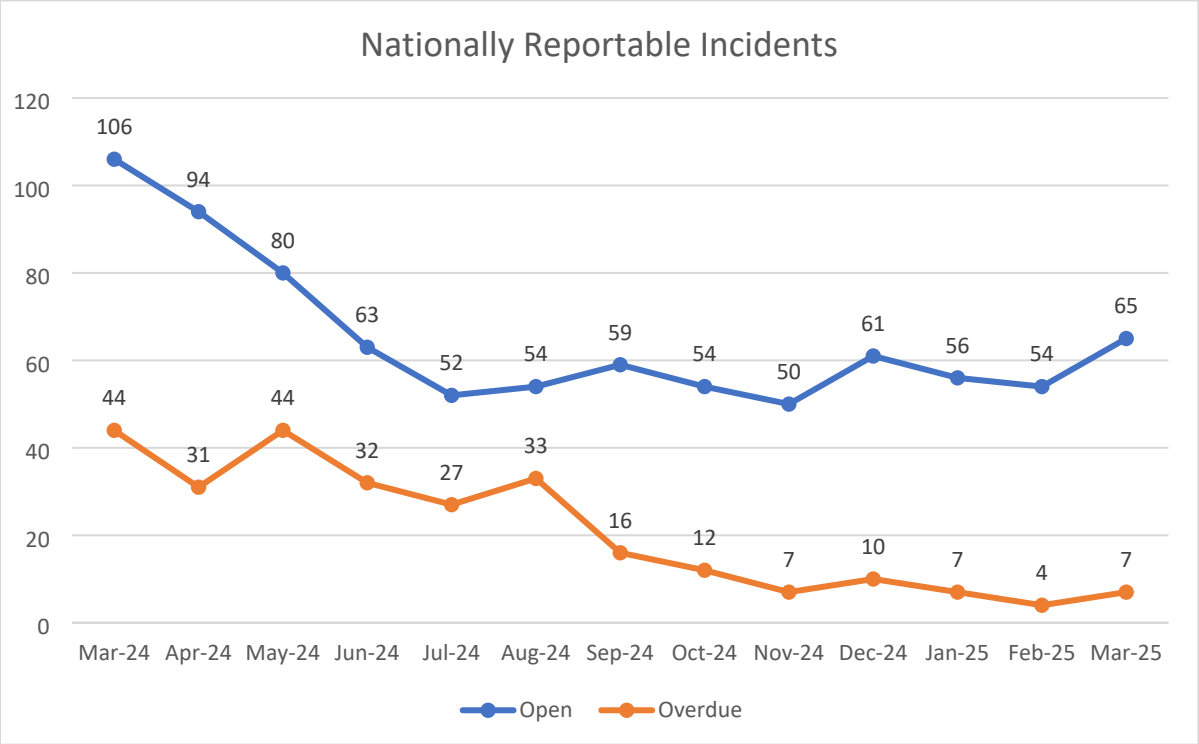
The results showed statistically significant reductions in the overall number of falls (p-value = 0.009897), falls causing moderate or more severe harm as reported (p-value = 0.0002), and falls causing moderate or more severe harm as confirmed after investigation (p-value = 0.0001). A p-value less than 0.05 (which is what was found) means that the difference in the number of harmful falls is statistically significant. This means it is very unlikely that the difference happened by chance. These findings indicate that the initiatives have had a real, positive impact on reducing patient falls and improving patient safety.

There was renewed focus during the last 12 months in relation to the administration of oxygen via a portable cylinder. As part of a continuous learning and improvement cycle to reduce the risk of incidents occurring, many interventions have been implemented including the launch of a mandatory e-Learning package for registered healthcare professionals.

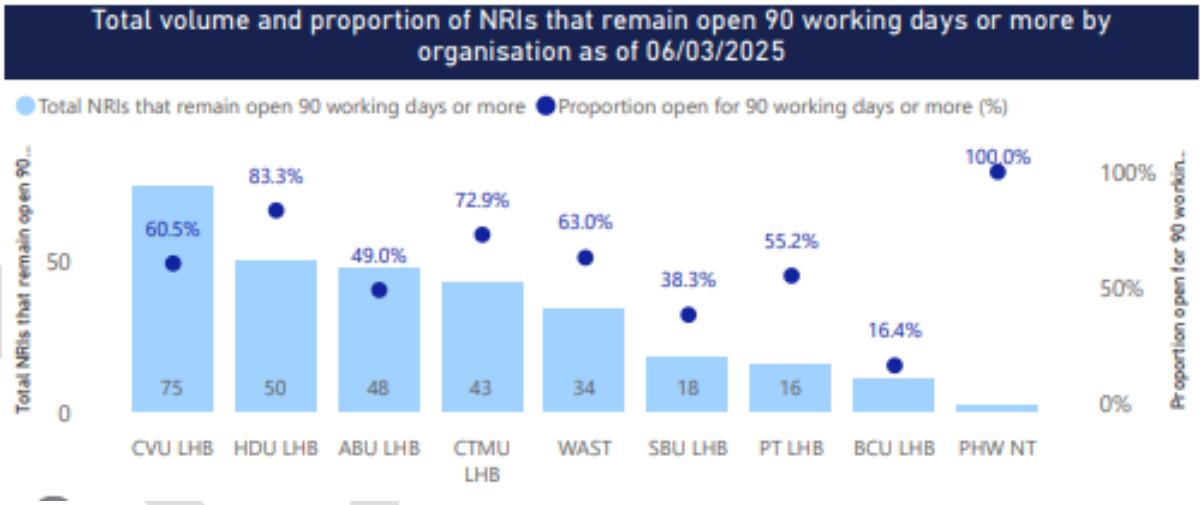
Nationally Reportable Incidents (NRI)

A subset of patient safety incidents require national reporting to NHS Wales Performance and Improvement. The reporting of patient safety incidents at a national level provides oversight and assurance relating to incidents that cause the most harm to patients and service users during healthcare, or that cause high levels of service impact, disruption or risk. A safety incident should be nationally reported if it is assessed or suspected an action or inaction in the course of a patient or service user's treatment or care, in any healthcare setting, has, or could have caused or contributed to their severe harm or death.

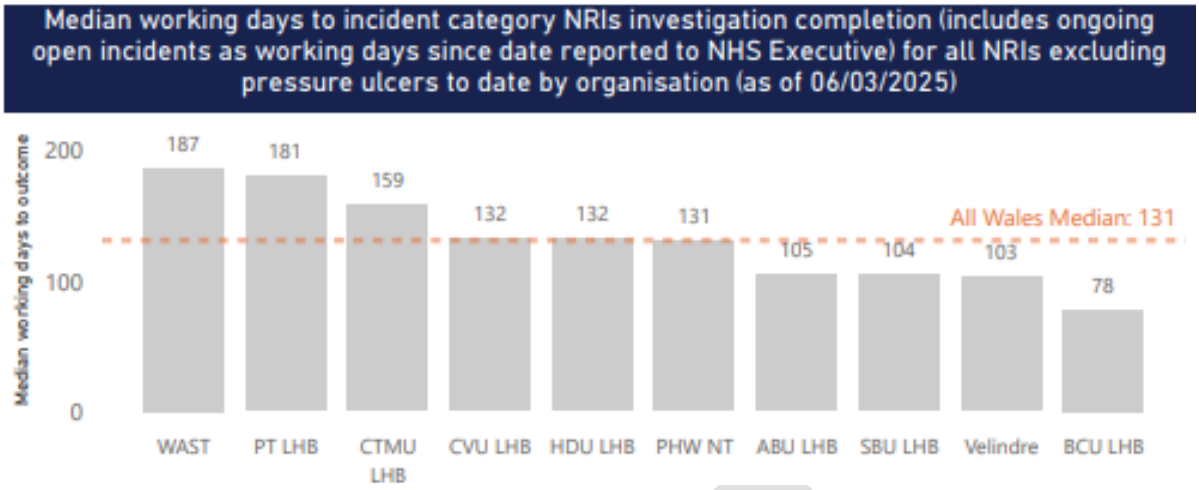
At the end of March 2024 there were 106 NRIs open with 44 overdue closure. As of the end of March 2025 this has reduced to 65 and 7 respectively.,



The proportion of NRIs that remain open for more than 90 days also improved and is the best across Wales, with the health board having 16.4% of cases taking longer than 90 days



The median working days taken to completion of NRI investigation is 78 for BCUHB, which is again the lowest across Wales (compared to the All-Wales Median of 131 days).



Improvement Work

In order to maintain progress on and focus on improvement relating to NRIs and timeliness of investigations, the Deputy Executive Director of Nursing continues to lead weekly improvement meetings with the services. Trajectories of zero overdue cases are set, with the IHCs/Divisions reporting on their progress and/or barriers to completion.

Members of the Patient Safety Team (PST) have provided targeted support through teaching sessions to facilitate completion of NRI reporting and processes for closure.

There are also now well-established arrangements where PST staff members regularly attend and contribute to IHC/divisional meetings, with members of the team allocated to link in with and support their nominated service. This arrangement facilitates a two-way process for communication and feedback.

As the number of overdue incidents are reducing, effort is moving on to cases which are not yet overdue, in order to focus on pulling cases through the investigation process and outcome wherever possible, to pre-empt or prevent any delays in meeting investigation deadlines and providing timely feedback to those affected by the incident.

Never Events

In **2024/25**, 5 **'never events'** were reported.

Table : The total number of Never Events reported, by area, BCUHB

	IHC Central	IHC East	IHC West	MHLD	Total
Administration of medication by wrong route	0	0	1	0	1
Overdose of insulin due to abbreviations or incorrect device	0	0	0	1	1

Retained foreign object post procedure	0	1	1	0	2
Wrong site surgery	1	0	0	0	1
Total	**1**	**1**	**2**	**1**	**5**

Never Event improvements

The theme of medication administration never events has seen cross BCUHB improvement actions in relation to segregation of parenteral and enteral syringes to support the selection of the correct syringe. There has also been segregation of different preparations of controlled drugs within the designated storage area, i.e. Injectables separated from oral preparations. The Pharmacy department is also supplying oxycodone liquid with a bung inserted into the bottle which is only compatible with enteral syringes (purple) to prevent mis-selection of the drug.

The main contributory factor within the learning from these incidents relates to following the correct procedures and distraction during the task. There is a need to 'stop the line' when distractions occur as the contributor with human factors forming part of the root cause. Learning has identified the systems and processes which can assist in the clear process for completion of tasks, or if they already exist, exploration of why they were not followed.

Complaints

Betsi Cadwaladr University Health Board (BCUHB) provides complaint responses in accordance with the NHS Concerns, Complaints and Redress Arrangements (Wales) Regulations 2011 – Putting Things Right (PTR). Aligned to the PTR, process we endeavour to provide resolutions to complaints as soon as possible and where appropriate, these cases are managed as an 'early resolution,' meaning that they are resolved within two working days of receipt and to the satisfaction of the complainant. Complaints that have not been resolved within this timescale or that are more complex requiring further investigation, or reference that harm has been or may have been caused have a target response time of 30 working days.

Complaints are treated as learning opportunities by the Health Board and provide a rich tapestry of peoples' experiences across a wide variety of issues, all of which are responded to via a person-centered approach. The detail of the concerns is categorised in relation to the principal subject, in accordance with Welsh Government reporting requirements, to support the identification of emerging themes and specific areas of concern which result in focused and evidence-based improvement work across the health board.

In April, 2024 the Health Board embarked on an ambitious plan to improve the experience of people who raised a complaint or concern, led by the executive team, seeking improvements in complaints performance and the quality of complaint responses, to investigate once, investigate well and to put things right when they go wrong.

Improving patient experience is a priority for the Health Board, and we have collectively taken responsibility to improve the complaints process and performance, so that the people of North Wales prosper and have a healthcare service that works for them, to improve relationships with public, including building their trust and confidence, in a system that puts things right when they go wrong.

The goal for all Health Board services, Integrated Health Communities and other Specialist Services, has been to achieve simultaneously, a reduction in both the number of open complaints and overdue complaints. Specifically, to ensure that 75% of complaints processed under PTR were acknowledged, investigated and responded to within 30 working days and resulted in the learning necessary to improve patient experience.

Key Achievements

The Patient Experience Team have achieved between 1ST April, 2024 and 31st March, 2025

- An 67.12% decrease in the total number of open / active complaints from 660 to 217*
- An 88.45% decrease in the total overdue complaints from 407 to 47*
- An increase in the number of complaints being resolved within 30 working days from 38.33% to 78.34%*
- A 43.47% Increase the average number of complaints resolved per week from 46 to 66
- Compliance Figure 78.34%*

*Data as of 31st March 2025

Milestone Achieved - All IHC & Divisions in the Health Board are achieving compliance of 75% or higher as of 18th June 2025

IHC/Service	<=30 Days	>30 Days	Total	(%)
Cancer Services	7	1	8	87.50%
Corporate Services	3	1	4	75.00%
Dentistry	1	0	1	100.00%
Diagnostics and Specialist Clinical Support Ser	7	2	9	77.78%
IHC Central	53	10	63	84.13%
IHC East	46	9	55	83.64%
IHC West	32	9	41	78.05%
Mental Health and Learning Disabilities	21	1	22	95.45%
Midwifery and Women's Services	17	5	22	77.27%

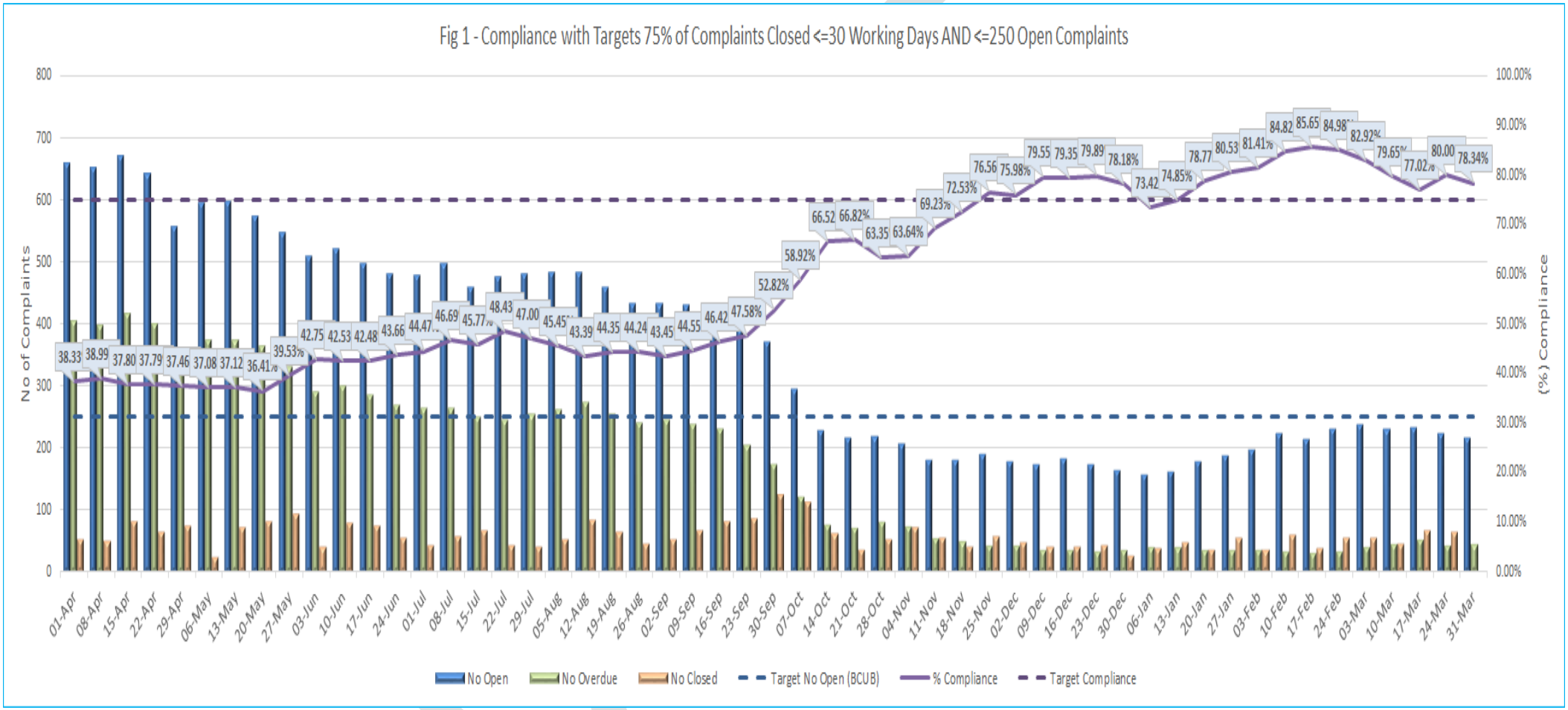


Fig 1 - Compliance with Targets 75% of Complaints Closed <=30 Working Days AND <=250 Open Complaints
No of Complaints
(%) Compliance
No Open
No Overdue
No Closed
Target No Open (BCUB)
% Compliance
Target Compliance

Management of Complaints

Every complaint received by the Health Board is fully acknowledged, robustly investigated and subsequently the complainant is provided with a comprehensive response that addresses the matters raised. There are a small number of complaints where a failure in care has been identified and considered to be a breach of the Health Board's Duty of Care. Any such case that has, or may have, caused harm is investigated with complete transparency to identify root causes, failures in process or potential risks so that the Health Board can eliminate or mitigate the opportunity for any similar breach of care in the future, to learn, to change and improve patient experience.

Within a context of increased activity during 2024/2025 the Health Board received 2,983 complaints, an increase from 2,588 during 2023/2024, as outlined below

Complaints Received

Financial Year	2023/2024	2024/2025
Complaint Type		
Managed through PTR	2,049	2,412
Early Resolution	408	342
Reopened	131	229
Total	**2,588**	**2,983**

During 2024/2025 the Health Board closed 3,498 complaints, an increase from 2,416 in 2023/2024, and this represents a positive variance of 515 of complaints of all types closed

Complaints Closed

Financial Year	2023/2024	2024/2025
Complaint Type		
Managed through PTR	1,860	2,900
Early Resolution	419	357
Reopened	137	241
Total	**2,416**	**3,498**

During 2024/2025 The average number of complaints of all types received per week was 56.28 an increase from 49.77 per week in 2023-24

Sub-Type	2023/2024	2024/2025
ALL Complaints	49.77	56.28
PTR	39.40	45.51
Early Resolutions	7.85	6.58
Reopened	2.85	4.49

Complaint themes & Trends

The majority of the complaints received during 2024/2025 relate to secondary care services with the top 5 themes being;

- clinical treatment / assessment (**1,347**),
- communication issues (**341**)
- attitude and behaviour (**207**).
- medication (**158**)
- appointments (**135**)
- patient care (**108**).

The ranking of themes (subjects) and sub-themes (sub-subjects) was the same for 2024/2025 as 2023/2024,

Top 6 Subjects for *ALL* Complaints Received

Subject	2023/2024 Rank	2024/2025 Rank	cf
Clinical treatment/Assessment	1st	1st	«
Communication Issues (including Language)	2nd	2nd	«
Attitude and Behaviour	3rd	3rd	«
Medication	4th	4th	«
Appointments	5th	5th	«
Patient Care	6th	6th	«

Top 6 Sub-Subjects for *ALL* Complaints Received

Subject	2023/2024 Rank	2024/2025 Rank	cf
Delay/Lack of treatment or Assessment	1st	1st	«
Incorrect/insufficient treatment or Assessment	2nd	2nd	«
Attitude/Behaviour of Clinical Staff	3rd	3rd	«
Communication with patient/service user	4th	4th	«
Delay in appointment/waiting time/transport	5th	5th	«
Delay/Lack of diagnosis	6th	6th	«

Further detail of the top 5 themes (subjects) and associated sub-themes (sub-subjects) for all complaint types received in 2024/2025 are detailed below.

Top 5 Complaint Subjects & Subjects for Complaints (ALL types) received in 2024/2025

Complaint Subjects & Sub-Subjects	Total
Clinical treatment/Assessment	1,347
Delay/Lack of treatment or Assessment	773
Incorrect/insufficient treatment or Assessment	347
Delay/Lack of diagnosis	93
Reaction to procedure/ treatment	75
Incorrect diagnosis	52
Compliment regarding clinical treatment/assessment	3
Unintended retention of a foreign object after surgery/procedure	3
Remote clinical triage/treatment issue	1
Communication Issues (including Language)	341
Communication with patient/service user	240
Communication with family	83
Insufficient/Incorrect information	13
Communication between Services/Departments	3
Welsh language issues	1
Communication with External Agencies or Other NHS Organisations	1
Attitude and Behaviour	207
Attitude/Behaviour of Clinical Staff	185
Attitude/Behaviour of Non-Clinical Staff	22
Medication	158
Access to own medication	28
Delay/Frequency in providing medication	26
Medication not prescribed	23
Availability of medication	23
Incorrect medication given	23
Incorrect dosage given	15
Prescription incorrect	7

Poor pain control	4
Allergies not considered	4
Side effects not explained	3
Lack of/No funding of medication	1
Patients being given medication but not being observed taking it	1
Appointments	135
Delay in appointment/waiting time/transport	89
Appointment cancelled	20
Cancelled appointment/transport	8
Patient lost to follow-up	6
Location of appointment unsuitable	4
Capacity of clinics	3
Continuity of staff	2
Patient booked into wrong outpatient clinic	2
Test results not available in clinic	1
Total	**2,188**

NB; this is not the same as the total number of complaints received or closed in 2024/2025.

Complaints By Grade

Complaints managed under PTR are graded against nationally set levels of severity and this is then reviewed as part of the investigation. Figs 8 & 9 below, provides a breakdown of severity grading for complaints, following investigation and closure.

Complaints Grading after investigation for ALL complaint types (Early Resolution, Managed Under PTR & Reopened) for 2024/2025

Grading @ Outcome	2024/2025
Grade 5	24
Grade 4	40
Grade 3	444
Grade 2	2,005
Grade 1	984
(blank)	1
Total	**3,498**

Complaints Grading after investigation for complaint types managed under PTR (Managed Under PTR & Reopened) for 2024/2025

Grading @ Outcome	2024/2025
Managed through PTR	**2,900**
Grade 5	24
Grade 4	39
Grade 3	431
Grade 2	1,807
Grade 1	598
(blank)	1
Reopened	**241**
Grade 4	1

Grade 3	13
Grade 2	197
Grade 1	30
Total	**3,141**

Sustainability

Underpinning the improvement in complaint management was the development of a new integrated concerns, incidents and complaints policy and process, which is compliant with national legislation and best practice, supporting Integrated Health Communities and Divisions to understand their responsibility and accountability when investigating complaints.

A revised suite of complaint response templates and associated guidance has been developed to provide clearer responses written with compassion and care. Following a detailed investigation an action plan is documented and actions implemented to ensure positive changes are made to improve patient safety and experience, as part of a collective commitment for continuous improvement and to meet the Health Board's ambition to become a learning organisation, built on a foundation of transparency, openness and improvement.

The Patient Experience Team proactively support IHC and Divisions to reduce the overdue complaint numbers, including complaints trajectory modelling, aligned to the Quality Dashboard, providing real time performance data, designed to improve complaints management performance, ensuring more timely responses, and sustainability of improvement initiatives.

To support the achievement of the key performance indicators mandated under PTR and NHS Wales performance framework, each Integrated Health Community (IHC) / Division has adopted weekly Putting Thing Right Meetings to manage the progress of complaints received. In addition, a weekly improvement meeting chaired by the Deputy Executive Director of Nursing supports early intervention to ensure complainants receive a timely resolution.

A thematic analysis is conducted on a weekly basis to identify areas of concern and any regular recurrences are shared systematically with the Health Board Executive Team and senior management teams within those services to investigate and identify opportunities for improvement. The themes of learning are captured and reported at the Patient and Carer Experience Group (PCEG) and Organisational Learning Forum (OLF) with key initiatives discussed with a focus on sharing good practice to improve patient experience.

During the 2024/2025 period, there is clear evidence of significant progress in the complaints handling process. The service has demonstrated enhanced capability in responding to complainants more promptly and consistently meeting the key performance target of investigating and resolving non-complex complaints within 30 working days.

This marks not only a statistical improvement compared to 2023/2024, but also a tangible enhancement in the overall quality of the complaints process. The approach has become more effective in engaging with complainants, accurately identifying

issues, and conducting thorough, one-time investigations. As a result, patients are experiencing a more responsive and satisfactory resolution process.

Redress

The redress process is managed by the Redress Team within the Health Board's Legal Services Department.

The NHS Concerns, Complaints and Redress Arrangements (Wales) Regulations 2011 require the Health Board to consider whether there is a qualifying liability in tort, whenever there has been an allegation of harm made within a complaint, or a patient safety incident has resulted in moderate harm, severe harm or a death.

A qualifying liability will be established if the Health Board has both failed in its duty of care to a patient, and the breach of duty has been causative of the harm that the person has suffered. It is only when both these tests are satisfied that redress can be considered.

Redress can include one or more of the following:

- A full explanation of what happened;
- An apology;
- An offer to provide care or treatment (where appropriate);
- A report on action which has been, or will be taken to prevent similar cases arising; and/or
- Financial compensation.

During 2024-25:

- **40** offers of financial redress were accepted totalling **£295,539**
- **7** other offers were made and are waiting to be accepted totalling **£42,300**
- **11** redress apologies (without financial redress) were issued
- **9** cases were removed from redress to continue as clinical negligence claims
- **1** case was concluded denying liability following expert report being obtained
- **15** independent clinical experts were instructed as part of the redress process

If investigations are unable to come to a conclusion internally, independent clinical experts are instructed jointly with the complainant or their representative to provide a report on the extent of the harm caused, and/or the patient's condition and prognosis as a direct result of the breach of duty. The expert reports are subsequently used to determine an appropriate offer of redress.

Each matter settled as a redress case instead of a clinical negligence claim saves the Health Board a significant amount in legal costs as well as providing patients with a quicker resolution.

The redress arrangements should not be engaged where it is considered at the investigation stage that the amount of financial compensation that would be awarded would exceed the current limit of £25,000. Examples of such cases would involve complaints or incidents about any life changing or life limiting events such as birth injuries; significant brain or spinal injury such as stroke cases; amputations; loss of vision/hearing; patients requiring multiple surgeries because of alleged negligence; death of a patient with dependents; missed cancer cases.

In these cases, the issues raised are still investigated fully but do not consider qualifying liability. A factual report coming to no conclusion as to breach of duty or causation (qualifying liability) is prepared and issued with a response directing complainants to legal firms to pursue a clinical negligence claim. 135 of these responses were issued in 2024-25, which is a 93% increase compared to 70 during the previous year. This is largely due to the Duty of Candour prompting an increasing number of cases to enter the Redress process.

The Health Board is closely following proposed changes to the NHS Concerns, Complaints and Redress Arrangements (Wales) Regulations 2011 and we will asses the impact on the redress process during the year.

The Welsh Risk Pool undertake an annual Concerns Assessment, which includes reviewing redress case management. In the most recent report, a rating was given of Reasonable Assurance.

Learning

Learning is considered throughout each investigation to identify issues to be addressed to reduce the risk of reoccurrence and to improve the quality and safety of healthcare provided by the Health Board. This is formalised within the Learning from Events Reports (LFER) which are required to be submitted to the Welsh Risk Pool within four calendar months of a qualifying liability being confirmed.

A new LFER process was introduced within the Health Board this year which has improved both the quality of LFERs and submission times, ensuring more deadlines have been met and improving the quality of learning. The Health Board has presented on its improvement work in this area at several national meetings.

During 2024-25, **51** redress Learning from Events Reports were submitted compared to 28 in the previous year.

Once the learning is approved by the Welsh Risk Pool, the cost of the case will be reimbursed to the Health Board on receipt of a Case Management Report. **45** redress Case Management Reports were submitted.

The Redress Team work closely with colleagues within the Integrated Health Communities (IHCs)/Divisions, the Complaints Team and the Patient Safety Team and provide a link to NHS Wales Shared Services Legal & Risk whenever more specialist advice is required, to ensure patients and their families receive appropriate redress as quickly as possible.

Claims

The claims process is managed by the Litigation Team within the Health Board's Legal Services Department.

In addition to the management of claims, the Legal Services Department also manage all Inquests that have been opened by HM Coroners, supports the wider clinical staff with Court of Protection and other Healthcare Law matters, and supports general legal advice queries that includes reviewing statements for police matters and family law proceedings.

In October 2024, the Legal Services Department transferred to the Corporate Governance Directorate and the service is developing and implementing a Transforming Legal Services Plan to strengthen the access to, and the quality of, all legal advice and functions. Over the next year, the department will deliver a range of transformations to improve the legal support and processes available to clinicians and managers. Creating a dedicated Litigation Team to handle all claims against the Health Board was a key action and has seen improvements in the quality of case and financial management. The Welsh Risk Pool annual Concerns Assessment for 2024 gave a rating of Limited Assurance for claims management, and the changes made are aimed to address those findings. The Health Board continues to work very closely with partners in NWSSP Legal and Risk Services and the Welsh Risk Pool.

In 2018 the Welsh Government decided to establish a discretionary state-backed scheme of indemnity provision for General Practitioners on the Welsh Medical Performers Lists, their staff and those engaged by the GP practice. The scheme is known as General Medical Practice Indemnity (GMPI). Under the scheme, in relation to incidents occurring on or after 1 April 2019, the Health Board provides an indemnity arrangement and will be the named Defendant for clinical negligence litigation rather than the General Medical Practices themselves.

During the financial year **2024-25**, **358** cases have been opened which is a very slight increase on those opened compared to last year's figure (353).

The total this year includes **313 Clinical Negligence claims** and **45 Personal Injury claims**.

The total amount paid by the Health Board during **2024/25** for Clinical Negligence claims amounted to **£22,847,718** and for Personal Injury Claims the sum was **£259,907**. This included Damages, Claimant's Costs and Defence Costs for all claims.

There is a structured approach to the management of clinical negligence and personal injury claims within the Health Board. The emphasis on timeliness, transparency and learning continues.

Claims themes / trends

Throughout **2024-25**, the Health Board has noticed **trends in claims** in the following areas:

- Claims brought in relation to alleged failed 'Treatment/Procedures' and failures in relation to 'Assessment/Investigation/Diagnosis' continues to be the highest

category types received for clinical negligence claims.

- For personal injury claims, the trend continues to be slips and trips, violence/aggression manual handling matters.
- The most frequently occurring specialities seen in clinical negligence cases continues to be: Emergency Departments, Obstetrics, Gynaecology, Surgery and Trauma & Orthopaedics. The number of matters occurring in the emergency department has increased, which is likely to be associated with the pressures seen in unscheduled care settings.
- Although not the highest in number, Birth Injury claims account for the largest settlement amounts paid for Clinical Negligence Claims.
- There has not been an increase in claims which are directly related to Covid-19, although action through 'test cases' by some staff and patient groups across the UK continue to be explored.

Learning and Improvement

A key aspect of the Health Board's collaboration with the Welsh Risk Pool (WRP) is the Learning from Events Reports (LFERs). These reports are required to be submitted within four calendar months of a qualifying liability being confirmed or decision to settle a claim. The WRP reviews these submissions to ensure that lessons are identified and that learning is shared throughout the Health Board to foster a culture of continuous improvement and risk reduction.

In January 2025, the Health Board implemented a revised LFER process. This new process has resulted in significant improvements in both the quality of the reports and the timeliness of their submission. As a result, a greater number of submission deadlines have been successfully met, demonstrating enhanced compliance and operational efficiency. We recognise there is still work to be done, but it is an area of increased focus and improvement.

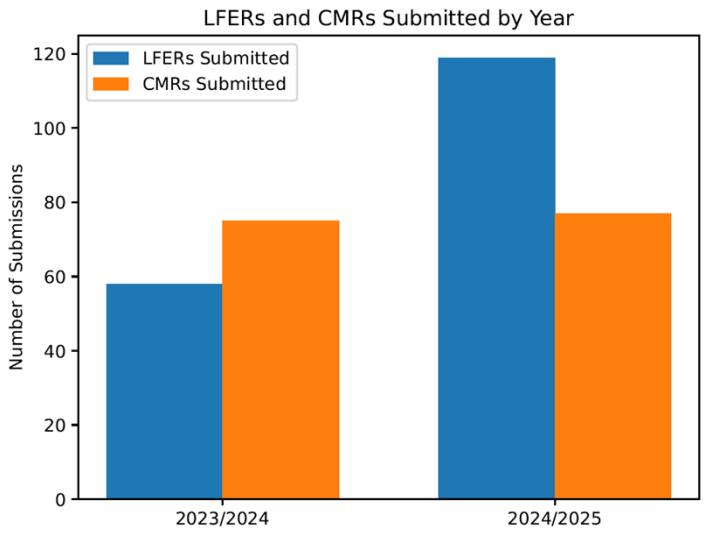
The Health Board is actively engaged in the national learning and improvement programmes led by the Welsh Risk Pool including:

- Intrapartum Fetal Surveillance (IFS) Wales is a multiprofessional national team of clinical experts have developed an innovative full day educational programme which aligns with the revised All Wales Intrapartum Fetal Surveillance Standards (Wales Maternity and Neonatal Network, 2022), supporting Health Boards to achieve the Welsh standards related to training.
- PROMPT Wales (PRactical Obstetric Multi- Professional Training) is an evidence-based training programme which was implemented in NHS Wales maternity services in 2019. Funded by the Welsh Risk Pool, PROMPT Wales is coordinated by a National Team who support local faculty teams to organise and deliver training in their own unit to their own maternity teams.
- The Welsh Risk Pool supports organisations to comply with regulatory and best practice guidance through the Decision Making and Consent Programme - which recognises that effective dialogue between healthcare professionals and patients is crucial for safe and effective decisions making. The programme has undertaken a series of work streams with the implementation of a new e-learning package and consent webinar programme, along with the introduction of a peer review assessment - which underlines the importance of shared decision making, providing practical guidance to inform and improve clinical practice.

- WRP co-ordinate the All-Wales Radiology (unexpected findings) review and the associated work strands that have arisen as a result. The review first commenced in 2019 due to the sustained level of legal cases where the key issue was the failure to act on the findings of a radiological examination - resulting in delayed or missed diagnosis and potential or actual harm to a patient.
- The Anti-Violence Collaborative Wales (AVC) is a collaboration of all NHS Wales organisations, the Police in Wales, the Crown Prosecution Service in Wales and trade union and staff support organisations. Its aim is to support NHS Wales and emergency services organisations to reduce and manage violence and aggression incidents. Facilitating collaboration with Criminal Justice Service partners, NHS Wales bodies, emergency services organisations and Welsh Government, the AVC promotes violence reduction strategies and communication with service users.

LFER Submissions to the Welsh Risk Pool (WRP) during 2024-25

- **119** LFERs were submitted to request approval of learning. This compared to **58** in the previous financial year, which is an increase of 105%.
- **77** CMRs (Case Management Reports) were submitted to WRP to request reimbursement of monies paid in claims.



Fixed Recoverable Costs (FRC) Legislation

The FRC regime currently targets clinical negligence claims valued between £1,501 and £25,000. It aims to reduce litigation costs and streamline case handling but there has been discussion to increase this figure to £50,000.

There have been some delays to the proposed FRC which was originally scheduled for April 2024. The Court's Civil Procedure Rules Committee is finalising the rules. A stocktake is planned for October 2025, with a full review expected in 2026.

QUOCS Costs Shifting

Qualified One-Way Costs Shifting (QOCS) is a costs protection regime that applies to clinical negligence and personal injury claims. It generally protects claimants from paying the defendant's legal costs if the claim fails, subject to specific exceptions.

Following the reforms in 2023, Claimants now face real financial consequences if they fail to beat a defendant's Part 36 offer—even if they win the case. This has led to more cautious litigation strategies and earlier settlements.

Public Service Ombudsman Wales

The Public Services Ombudsman for Wales (PSOW) has legal powers to investigate complaints about care providers in Wales. We are still awaiting the final data from the PSOW of the number of cases for **2024/2025.**

Public Interest Reports

Occasionally, the Ombudsman may produce a public interest report.

A Public Interest Report is a formal report published when the Ombudsman believes that the findings of an investigation are so significant that they should be brought to the attention of the public, the Welsh Parliament (Senedd), or other relevant authorities. These reports typically arise from serious service failures by public bodies in Wales, such as local councils, Health Boards, or housing associations that have caused injustice to individuals or raised broader concerns about public service delivery.

The authority to issue a Public Interest Report comes from **Section 23 of the Public Services Ombudsman (Wales) Act 2019**. This Act expanded the Ombudsman's powers and modernised the complaints process in Wales. Under this legislation, the Ombudsman can:

- Investigate complaints made by members of the public.
- Initiate investigations without a complaint (known as "own initiative" investigations).
- Publish reports when it is in the public interest to do so.

During this period the Health Board received **4 public interest reports**. An action plan was developed for all 4 cases. At the time of writing, the recommendations made by the Ombudsman for three of these cases were carried out and evidence of compliance has been submitted to the Ombudsman's office. The following cases were issued as Public Interest Reports during 2024/25:

Case 1: ID1962 / 202300527

The Ombudsman investigation considered:

a) Whether there was a failure to fully support the patient, in respect of her personal care, nutrition and hydration and communication with her.

b) Whether there was a failure to monitor and manage the patient's pain.

c) Whether there was a failure to monitor and manage the patient's epilepsy.

The investigation also considered whether the Health Board dealt with the complaint in line with the PTR (Concerns, Complaints and Redress Arrangements) Regulations 2011.

The Ombudsman has confirmed compliance has been met on 23 October 2024 and closed the case. The Health Boards Quality Safety and Experience (QSE) Committee and Board have been sighted on this case.

Case 2: ID5663 / 202207270

The Ombudsman investigation considered whether:

a) The urological symptoms displayed at the patients' attendance at Wrexham Maelor Hospital Emergency Department on 19 April 2022 should have led to an urgent suspected cancer referral.

b) The Health Board's management of the patient's care was clinically appropriate, and in line with the single cancer pathway (between April 2022 and February 2023 when a complaint was submitted to the Ombudsman).

c) The likely waiting time for the biopsy (August 2022) was appropriate.

d) The Health Board communicated appropriately with Mr B and Mrs B, including sharing information about the investigations undertaken, and the patient's treatment plan (between April 2022 and February 2023 when a complaint was submitted to the Ombudsman).

e) The Health Board managed Mrs B' complaint, submitted in November 2022, in line with Putting Things Right (the NHS complaints process).

The Ombudsman has confirmed compliance has been met on 1 October 2024 and closed the case. The Health Boards Quality Safety and Experience (QSE) Committee and Board has been sighted on this case.

Case 3: ID753 / 202206250

The Ombudsman investigation considered:

The care and treatment Mrs L received from the Health Board between January 21 and her death on 31 January 2022 from biliary sepsis. In particular:

a) Whether, following discharge in January 2021 (following her admission with abdominal pain), monthly blood tests were an appropriate way to monitor Mrs L's condition.

b) Whether there was a lack of follow-up care for Mrs L following a biliary stent being fitted in November 2021.

The Ombudsman has confirmed compliance has been met on 24 March 2025 and closed the case. The Health Boards committee and board has been sighted on this

case.

Case 4: ID2087 / 202301141

The Ombudsman investigation considered whether the patient received:

(a) Appropriate review and treatment of her post-operative fluid collections and pelvic sepsis following her proctectomy in 2019, including adequate gynaecological input.

(b) Sufficient time and information to understand and consider the risks of the surgical removal of her post-operative fluid collections, and to give her fully informed consent before this surgery was carried out.

(c) Prompt and appropriate investigation and treatment for her pain and reduced kidney function following surgery in March 2022.

(d) Timely and appropriate information about her hysterectomy, including advice about post-operative recovery, menopause and options for hormone replacement therapy.

The Ombudsman upheld the complaints and made several recommendations which the Health Board accepted. The Health Board is on track with the action plan, reporting progress to the Health Boards Regulatory Assurance Group, Executive Delivery Group and Quality Safety and Experience (QSE) Committee.

Collaboration with the Ombudsman

The Health Board continues to meet with the Ombudsman's Complaints Standards Authority to ensure good working practices and to facilitate awareness training for staff working within the Health Board.The organisation also continues to network with other Local Health Board Trusts to identify ways in which the Health Board can improve how it captures, tracks and monitors Ombudsman recommendations and compliance.

Additionally, it has strengthened its complaints handling process, ensuring that concerns raised by patients are addressed promptly and that lessons learned from Ombudsman investigations inform service improvements. This has led to the Integrated Concerns process.

Summary

During the 12-month period of 2024/25 the Health Board has made significant and sustained improvements with regards to complaints compliance, with the national 75% compliance target achieved throughout the year. This has led to the Health Board becoming one of the best performing Health Boards in Wales and has led to an improved patient and carer experience. The Health Board has also made significant improvements in its National Reportable Incidents position regularly performing best in Wales for timeliness and total numbers as per the national Beacon dashboard. A significant focus for 24/25 has been the embedding of learning from our concerns and this will continue as a priority into 25/26.

The timely submission of Learning From Events Report forms has seen a significant

improvement but will remain and area of focus for the Health Board going into 25/26 to ensure the improvement is sustained. The Transforming Legal Services Plan will also see full reviews of the redress and claims processes to ensure they are complaint, efficient and effective.

Agenda Item
6.1.2

Joint Commissioning Committee

Quality Safety and Outcomes Sub-Committee Highlight Report 02 June 2025

Dyddiad y Cyfarfod / Date of Meeting	15/07/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Helen Tyler, Head of Governance and Risk
Cyflwynydd yr Adroddiad / Report Presenter	Susan Elsmore, Lay Member
Noddwr yr Adroddiad / Report Sponsor	Carole Bell, Director of Nursing and Quality

Pwrpas yr Adroddiad / Report Purpose	For Noting Choose an item.

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
N/A		Choose an item.

1. SITUATION/BACKGROUND

This report had been prepared to provide a summary of the key issues considered by the Joint Commissioning Committee Quality, Safety and Outcomes sub-committee at its meeting on 2 June 2025.

Key highlights from the meeting are reported in Section 3.

2. PURPOSE

The Purpose and Role of the Joint Committee and the sub-committees are set out in Paragraphs 2.18 and 2.20 of the JCC Standing Orders.

The Quality and Safety Outcomes Committee Terms of Reference can be found here.

3. HIGHLIGHT REPORT

RAG Rating	Highlight
Alert / Escalate	• Members heard about the tragic experience of the Maxwell family. A patient in need of urgent medical attention, waited six hours for an ambulance. Despite multiple calls and visible deterioration, the ambulance arrived too late. The patient passed away, and her family was left devastated, not only by the loss but also by the traumatic aftermath, including a post-mortem that prevented them from saying goodbye properly. Her son, who performed cardiopulmonary resuscitation (CPR) before the ambulance arrived, expressed deep emotional trauma and a loss of trust in emergency services. • Members commented on listening and learning from the ambulance patient story and deep dive, proposing to take this separately to JCC and to reflect on how this story could be uses as a catalyst for change, with a commitment to follow up and demonstrate tangible improvements. Members highlighted the erosion of public trust and the need to rebuild it through transparency, responsiveness, and improved outcomes. • Concerns were raised about the timing of risk updates not aligning with directorate reports and the lack of detail in control statements and action plans, particularly for high-risk areas such as neonatal services.
Advise	• The Director of Ambulance and 111 from NWJCC and WAST colleagues provided member with a Quality Assurance Deep Dive presentation which focused on the internal and external assurance arrangements for WAST. Key risks identified by WAST were noted as below: • Transfers of Care Delays at Emergency Departments. • Workforce Constraints – Utilisation, absence, and abstraction. • Digital Infrastructure Challenges – Affecting operational efficiency. • Strategic Quality Plan and Quality Management System – Ensuring continuous improvement.

RAG Rating	Highlight
	Several forward-looking initiatives WAST would be pursuing was highlighted: • Clinical Advisory Group (CAG) – Supports alignment with national policy, quality, ethics, and population health. • Value-Based Healthcare – Informing investment decisions and improving outcomes. Digital Innovation – Leveraging AI and smartphone technology for remote and prehospital care. • System-Wide Enablement – Using 111Wales and clinical infrastructure to support broader NHS Wales goals. Members found the deep dive informative and expressed an interest in further exploring innovation, recognising that maintaining current practices will not resolve existing issues capacity. • Members received the Welsh Kidney Network (WKN) report which provided a briefing on the current Quality and Patient Safety issues within the WKN commissioned services. The following points were noted: • Two new National Reportable Incidents (NRIs): a delay in referral for investigation of a suspicious finding on a chest X-ray, which turned out to be a lung carcinoma, and an error in plasma administration which delayed an incompatible plasma exchange, patient receiving compatible rather than incompatible plasma. • An update on Risk Ref 65 was provided - Kidney Dialysis capacity across Wales. This risk has been included within NWJCC Integrated Medium Term Plan (IMTP) submission for 2025/2026 covering growth including the Independent Service Providers (ISPs). • An update on Carbapenemase-producing organisms (CPO) and Carbapenemase Producing Enterobacteriaceae (CPE) work with Healthcare Associated Infection & Antimicrobial Resistance Programme (HARP), Public Health, and standardising guidelines was provided. • Members noted the extensive data available to the renal department, with an aim to leverage IT solutions to identify CPO tests and analyse the frequency of positive outcomes. • Positive progress in transplant work-up, pre-emptive transplantation, and live donor transplantation was highlighted. Members noted Wales' leadership in some respects but there was further work required and it was agreed to present cost-effectiveness and quality of life benefits of transplants and home therapies including benchmarking across the UK and variances across Wales for transplants and home dialysis to a future meeting.

RAG Rating	Highlight
	• The Director of Commissioning for Specialised Services provided updates on various specialist services including: • The Neonatal escalation ongoing; paediatrics de-escalated. • PET-CT supply issue resolved. • DBS service review underway. • Cardiff & Vale to extend thrombectomy hours from 1 July. • Concerns raised about auditory implant service recruitment delays. • A report for the Commissioning for Ambulance and 111 services was received. The quality and safety dashboard, which includes high-level reports on quality domains was highlighted. • The Director for Mental Health and Vulnerable Groups report was presented. The following points were highlighted: • Gender services update in preparation for next QSO. • Perinatal review shared. • Concerns about St Andrew's provider; quality assurance ongoing. • Caswell Clinic occupancy and commissioning arrangements discussed.
Assure	Members received the risk register as at 30 April 2025, highlighting the risks relating to the Quality Safety and Outcomes assigned for monitoring and scrutiny purposes. The following areas were highlighted: • **78 Ambulance Capacity** - Deep dive conducted; remains the highest scoring risk at 25. • **79 Type A aortic dissection** - Continued collaboration with Cardiff & Vale and Swansea Bay UHBs, • **65 Renal Dialysis** - Submitted into IMTP 2025/26; awaiting outcome, • **55 Neonatal Workforce** - Reviewed by Women & Children's commissioning team; Level 3 escalation meeting held in May 2025, • **56 Neonatal Infection Control** - Reviewed by Women & Children's commissioning team; further update expected, • **82 Neurorehabilitation at SBUHB** – Risk increased from 12 to 16 Continued collaboration with Cardiff & Vale and Swansea Bay UHBs, • **83 Paediatric Orthopaedic Surgical Service** – New risk added, service under internal discussion.
Inform	• The forward plan of business for the next twelve months was presented noting that it was a work in progress and

RAG Rating	Highlight
	would be used to support Agenda planning for future meetings. • A report outlining recent incidents and concerns reported to the JCC from provider and commissioned services covering the period March 2025 was received. • An update on the Regulator Report (Healthcare Inspectorate Wales (HIW) / Care Quality Commission (CQC) regulatory activity was provided noting the ongoing collaboration with HIW to improve reporting and assurance processes.
Appendices	None

4. ASSESSMENT

Objectives / Strategy	
Dolen i Amcan (au) Strategol CBC Link to JCC Strategic Objectives(s)	Improve Equity and Population Health
	Ensure Quality
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A More Equal Wales
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Whole-systems Perspective
	If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /*	Person Centred
	If more than one applies please list below: Equitable

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

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: N/A
Cydraddoldeb *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /* **Equality** *Have you undertaken an Equality Impact Assessment Screening?*	Yes: ☒	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE	If no, please include rationale below: N/A
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Joint Committee as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

5. RECOMMENDATIONS

The Joint Committee is asked to:

- **Note** the highlights outlined in Section 3 of this report.

Cyfarfod a dyddiad: **Meeting and date:**	Quality, Safety & Committee 4 September 2025
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Summary of business considered in private session to be reported in public
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Pam Wenger, Director of Corporate Governance
Awdur yr Adroddiad **Report Author:**	Philippa Peake-Jones, Head of Corporate Affairs
Craffu blaenorol: **Prior Scrutiny:**	None
Atodiadau **Appendices:**	None

Y/N to indicate whether the Equality/SED duty is applicable **N**

Argymhelliad / Recommendation:

The Committee is asked to note the report.

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		**Ar gyfer Trafodaeth For Discussion**		**Ar gyfer sicrwydd For Assurance**		**Er gwybodaeth For Information**	✓

Sefyllfa / Situation:

To report in public session on matters previously considered in private session.

Cefndir / Background:

Standing Order 6.5.3 requires the Board to formally report any decisions taken in private session to the next meeting of the Board in public session. This principle is also applied to Committee meetings.

Asesiad / Assessment

The Committee considered the following matters in private session:

3 July 2025

- Confidential Quality Report
- Controlled Drugs Accountable Officer Report

- Research & Development Annual Report
- Vascular Service Update (including services now offered in Stoke)
- Draft Annual Reports –
    - Quality 2024-25
    - Duty of Candour 2024-25
    - Putting Things Right 2024-25

Monthly report: Regional activities >North Wales<

Reporting period: (July 2025)

Contents

Headlines

No. engagement activities	No. visits	No. consultations	No. service changes	No. representations	No. open advocacy cases	No. people engaged with
17	3	0	3	10	237	442

Networks

Partners engaged with this month:

Partner name	New partner (Y/N)	Existing partner (Y/N
Betsi Cadwaladr University Health Board	N	Y
Gwynedd Council	N	Y
Ynys Môn Council	N	Y
Conwy Council	N	Y
Denbighshire Council	N	Y
Flintshire Council	N	Y
Wrexham Council	N	Y
Royal British Legion	N	Y
SAAFA	N	Y
Veterans NHS Wales	N	Y
Medrwn Môn	N	Y
Age Alliance Cymru	N	Y
Woody's Lodge	N	Y
Kidney Wales	N	Y
Bevan Commission	N	Y
Pride Wrecsam	N	Y

Flintshire Local Voluntary Council	N	Y
Shelter Cymru	N	Y
Sexual Health NHS Wales	N	Y
Fast Track North Wales	N	Y
North Wales Police	N	Y
North Wales Fire Service	N	Y
Unite Community Cymru	N	Y
Unique	N	Y
Stonewall	N	Y
North Wales Trans Intersex Non-binary Network	Y	N
Prifysgol Wrecsam	N	Y
LGBTQ+ Youth Group one to one support	Y	N

Regional activities

>north wales< Engagement activities

(Engagement activities include hosting events or workshops, attending partner events/networks, meetings, profile raising activities, information sharing and promotion of Llais.

NOTE: new sections below for entering Visits and Representing Llais at formal meetings)

No. relating to health	4
No. relating to social care	0
No. relating to both health and social care	13
Total No. engagement activities	17

Activity	**Type** (H/SC/ Both)	**Strategic priority aligned with**	**Host** (Llais/ external/joint)	**No. people engaged with**	**No. partners engaged with**	**Outcomes** (what happened as a result of the engagement activity? Any follow up actions?)
EAG Patient Stories	H		Llais	5	1	Request from a member of the EAG to share personal patient story. BCUHB have agreed this would be very impactful story "living with bi-polar disorder". Possibility to undertake the work with Llais to demonstrate partnership working and co-production
Sharing Llais NW June Monthly Report with key stakeholders.	Both		Llais	40	5	Feedback received from Chair of BCUHB thanking Llais for sharing the information set out clearly and is useful
Woody's Lodge Caergybi	Both		Joint	1	1	Promote the Veterans Public Forum in Wrexham on 29/07/2025
Dwyfor / North Meirionnydd Temporary Residents Pharmacy Service	H					Discussions around the funding for pharmacies with high tourism and the model; of care needed for a temporary period. Llais raised local concern that the Temporary Residents service funding (enabling visitors to receive pharmacy based minor healthcare problem services) is ceasing this summer, after which there are fears for diversion of numbers of patients to one or other of the two MIUs or to A&E Bangor” At the meeting we heard that the cluster has agreed to fund a service from Llanbedrog Pharmacy again this year, adding a second

Activity	**Type** (H/SC/ Both)	**Strategic priority aligned with**	**Host** (Llais/ external/joint)	**No. people engaged with**	**No. partners engaged with**	**Outcomes** (what happened as a result of the engagement activity? Any follow up actions?)
						pharmacist to help manage the increased demand over the summer months. As with any cluster-funded pilot, there is an expectation that a longer-term funding plan will be considered
Holyhead Integrated Health and Wellbeing Hub	H		External	1	1	General update around the services that are needed due to the fragility of primary care services. Received a progress report from the Director of Estates – work is now progressing well
Llais North Wales Volunteers Forum	Both		Llais	14	1	Presentation from Kidney Wales. Advocacy Update - PSOW Public Interest Report Update on: Llais Local Ynys Môn Public Forum Ynys Môn Bevan work following public forum Kinmel Bay Llais Local Wrexham Public Forum Wrexham Tywyn Hospital Penley Hospital Visits to MH units to support the work of the EAG
Woody's Lodge Colwyn Bay	Both		Joint	1	1	Promote the Veterans Public Forum in Wrexham on 29/07/2025

Activity	**Type** (H/SC/ Both)	**Strategic priority aligned with**	**Host** (Llais/ external/joint)	**No. people engaged with**	**No. partners engaged with**	**Outcomes** (what happened as a result of the engagement activity? Any follow up actions?)
Royal British Legion	Both		Joint	2	1	Further discussions re. the Armed Forces Covenant and the Veterans Public Forum in Wrexham on 29/7/2025
Co-production Lab Wales session	Both		External	2	2	Self-reflection as to performance around co-production, feeding into the work of the Bevan Exemplar project in Kimel Bay
Age Alliance Wales Event	Both		External	50	10	GP issues Cataracs YG Parking Podiatry Mental Health Appointment Reminders
Citizen's Experience paper for BCUHB	H		External	1	1	Request from BCUHB for information on what people are sharing with us and key themes to be included in their Citizen's Experience paper for BCUHB Execs and Board. RD shared update following the MHLD visits and key themes included in monthly reports and engagement activities
Bevan Community Co-Design Workshop	Both		External	20	5	• To bring partners (including community groups) together to create a 'Co-pro Kinmel Bay' plan • Using outputs of self-assessment audits – addressing identified weaknesses and building on identified strengths. • Test event helping to build trust & ensure

Activity	**Type** (H/SC/ Both)	**Strategic priority aligned with**	**Host** (Llais/ external/joint)	**No. people engaged with**	**No. partners engaged with**	**Outcomes** (what happened as a result of the engagement activity? Any follow up actions?)
						community identified priorities remain on the PSB radar long term. • Outputs – to identify strengths to be amplified (and how?) and opportunities to be mitigated through improved collaborative community conversations / co-design
Anglesey Older People's Council	Both		External	15	1	Presentation on the work of Llais in North Wales. From discussions with Members the following representations will be made to BCUHB and the Regional Director will return to a future meeting to give an update. • Park and Ride system for all three DGH sites • Uniform Posters - suggest reinstating of the information poster explaining what different uniforms mean. • Staff Identification - Ask BCUHB to remind all staff about clearly displaying their ID badges and introducing themselves to patients / families. • Contact the Engagement Officer (West) to offer Llais support to the application for the renovations to the foyer at Ysbyty Gwynedd to include café / shop.
Non-Emergency Patient Transport	Both		Llais	35		Email to Volunteers and Advocacy staff asking them to share any concerns or

Activity	**Type** (H/SC/ Both)	**Strategic priority aligned with**	**Host** (Llais/ external/joint)	**No. people engaged with**	**No. partners engaged with**	**Outcomes** (what happened as a result of the engagement activity? Any follow up actions?)
						complaints about the non-emergency patient transport service in the region. This is at the request of the National Team. Responses to be shared as and when any are received.
Pride Wrecsam	Both		External	181		Awaiting Report
Men's Health and Well-being in rural Anglesey (Medrwn Môn and BCUHB)	Both		External	40	40	Event to Connect and Support, focusing on Men's Health and Wellbeing on Ynys Môn. Arranged in conjunction by Medrwn Môn and BCUHB
Veterans Public Forum	Both		Llais	32	10	Public Forum on the Armed Forces Covenant. Presentations from: BCUHB Royal British Legion Veterans NHS Wales

>north wales< Visits

(Visits to health or social care premises)

No. relating to health	3
No. relating to social care	0
No. relating to both health and social care	0
Total No. Visits	3

What we heard:

- *When sharing what you've heard, wherever possible state how many people expressed the opinion by using (x -) e.g. there were concerns about access to dentistry (x 6)*
- *Try and keep points concise where possible.*
- *Please state if event was hosted by us, a partner or jointly hosted.*
- *Copy and paste the tables below based on the number of activities where people shared information with us.*

Group/event/activity name	***MH Visits – Heddfan Unit Wrexham***
Working well	• The ward allows open visiting, and they can also accommodate relatives to stay on the ward if needed.
Needs improvement	• Hydref outside area needs attention (weeding and painting). One patient unhappy that he is expected to do the weeding because he has said that he likes gardening. • Key fobs to rooms not available to all. Have to re-order at times, when patients fail to return them when discharged. • Patient room searched without explanation from staff. Staff acknowledged that an explanation should have been given. • Patient struggle to sleep on Hydref Ward due to noise.

	• Staff said that they get no support from the hospital to maintain the outside areas.

Group/event/activity name	***MH Visits – Hergest Unit Bangor***
Working well	•
Needs improvement	• Cynan outside space is overgrown. The grass is only cut once a year. • Patients unable to use gym equipment as it posed a risk to them and would require an equipment trained member of staff to escort them. • Most bedrooms are shared rooms (4 people per room) building does not allow for single rooms as there is not enough space. • Only two shower rooms in Aneurin ward, which isn't enough for 17 people to share. • Unit lacks welcoming atmosphere and emotional warmth.

Group/event/activity name	***MH Visits – Ablett Unit Glan Clwyd***
Working well	• Patients spoke highly of the staff, describing them as friendly and responsive. • Patients were generally positive about the food, saying there was a variety of choice. • Patients said they enjoyed the available activities, including painting and bingo. • Staff flexible with visiting times. While there are restrictions, they said staff accommodated visitors whenever possible. • Patients felt listened to. • One patient said a concern about her medication was escalated and resolved quickly, positively impacting her wellbeing.
Needs improvement	• One patient, a Welsh first-language speaker, said that they didn't think there were any Welsh-speaking staff on the ward. They said that if there were, they must prefer speaking English, as they hadn't been given the opportunity to use Welsh. • One patient suggested more cups of tea. • Patients would like a chair in their room, as some only have a bed. • Patients noted the absence of a gym. One patient said, "It's just so boring here," and mentioned that the TV in the communal lounge was rarely on, as some patients preferred it off. They explained that the sound quality was poor when it was on due to the wall-mounted

	casing. She suggested having set TV times throughout the day so patients would know when they could watch it, and others who did not want it on could avoid the area, potentially reducing conflict. • A patient told use their mobile phone had been recalled in other units, patients can borrow a hospital iPad for an hour each day. Did this arrangement exist at the Ablett. • One patient raised the issue of the absence of sanitary bins in the toilets, saying it was embarrassing to have to hand sanitary products to staff. They explained that they had raised the concern previously and was told that staff also found it uncomfortable, and that the issue had been escalated. *Matron explained that sanitary bins had been removed after a patient attempted to use the plastic liner bag to harm themselves. The bags posed a risk as they could be used either as a ligature or to suffocate. As a result, a blanket ban was implemented while safer alternatives are being explored. Matron confirmed that following incidents like this, the unit typically enforces such measures for all patients until a suitable and safe solution is identified.*

Group/event/activity name	***Pride Wrecsam***
Working well	• Cancer care at Clatterbridge was fantastic, just the travel there is exhausting • My GP is very good, even though I haven't seen one for a while. • I have been to Gobowen for three operations. Staff there are excellent – would recommend. The food is also good there and there's plenty of parking • Plas y Bryn GP surgery – I have no complaints. • Wrexham Pharmacy is very good.
Needs improvement	• The waiting list for a trans operation to have testosterone is years on the NHS, I'm going private. My friend went on the list at 16 yrs old and had the op when they were 22 yrs old. I'm on the waiting list since I was 15 yrs old, I'm now 17 yrs old, and can't wait anymore. It's causing me mental health problems. The long waiting list is causing so many suicides. There is no support offered whilst waiting on the list. • Unable to get an NHS Dentist in Wrecsam.

	• Forge Road surgery Wrecsam – can't get through on the phone system. You're never able to see anyone. • There's no mental health support in Wrecsam, only CAMHS but the waiting list is so long. • There's no transport for cancer patients to Ysbyty Maelor. • Husband has Alzheimer's and Dementia; there's a 2 month wait for a continence service assessment. • There isn't much difference in costs compared to seeing a private Dentist – last week I paid £300 to fix a tooth with an NHS Dentist, I'll have to do DIY fillings at this rate. • Meddygfa Gwydir Llanrwst and the Clinic in Holywell – both awful. Very poor service. • Forge Road surgery – can't even get past receptionist, if they answer your call that is. • Porthmadog GP surgery – I don't bother phoning the GP for an appointment anymore, I know I won't get one. • Waiting times at Ysbyty Maelor is awful, no quality of life • Alyn Family Doctors Llay – unable to get an appointment with a GP.

>north Wales< Consultations

(Responses made to external consultations on regional matters)

No. relating to health	0
No. relating to social care	0
Total No. consultations	0

>Region name< Service Changes

(This should include Llais' involvement in service changes - including service reorganisation, reconfiguration, service redesign, service variation, service improvement, or service expansion)

Name of body	Type (H/SC)	Level (Up to 4, 8 or 12 weeks)	Involvement (Active / Monitoring)	Service change overview	Status/Outcomes
BCUHB	H			In-patient ward Tywyn Hospital	Working with BCUHB as they work up issues paper
BCUHB	H			Penley Community Hospital	Working with BCUHB as they work up issues paper
Hywel Dda University Health Board	H			Clinical Service Plan	Working with Llais colleagues and Hywel Dda HB. Will be attending public engagement event on 4 August 2025.

>north Wales< - Representations

(Representations made to NHS bodies and local authorities, and those acting on their behalf or working jointly e.g,. Regional Partnership Boards regarding the provision of health or social services. The overall purpose of these representations is to support the process of co-development of health and social care services by amplifying and reinforcing the voice of the citizen.

Representations should be put forward in a format which has some degree of permanency about it and lends itself to being recorded and tracked through the relevant regional team, local authority and NHS body systems e.g. emails, reports, communicated verbally in a formal meeting where minutes are taken.)

No. relating to health	9
No. relating to social care	1
Total No. representations	10

Name of body	New/ ongoing	Type (H/SC)	Source (engagement, advocacy, partner working)	Method (email, letter, minuted in meeting)	Concern (brief overview, inc. CRM No.)	Status/Outcomes
BCUHB	New	H	Engagement	Email	Concerns raised following visit to MH Unit by Llais regarding patient safeguarding. RER-250725-2259	Concerns raised with MH Managers and directly with Ward Manager during visit
BCUHB	New	H	Engagement	Email	Client needs to see specialist due to ear obstruction that is causing considerable pain, GP has made a referral to see specialist but will have to wait around a month. Suggest attend A&E, not wishing to sit and wait in A&E RER-250728-2261	Awaiting Response from BCUHB
BCUHB	New	H	Engagement	Email	YM Older Persons Council have asked Llais to get a response to the issue below and report back to the next meeting • Provide a Park & Ride system for all three DGH sites	BCUHB Acknowledgement received reference LL25_021

Name of body	New/ ongoing	Type (H/SC)	Source (engagement, advocacy, partner working)	Method (email, letter, minuted in meeting)	Concern (brief overview, inc. CRM No.)	Status/Outcomes
					RER-250730-2268	
BCUHB	New	H	Engagement	Email	YM Older Persons Council have asked Llais to get a response to the issue below and report back to the next meeting • Staff Identification – suggested reinstating of the information poster explaining what different uniforms mean. RER-250730-2272	BCUHB Acknowledgement received reference LL25_021
BCUHB	New	H	Engagement	Email	YM Older Persons Council have asked Llais to get a response to the issue below and report back to the next meeting • Ask BCUHB to remind all staff about clearly displaying their ID badges and introducing themselves to patients / families. RER-250730-2269	BCUHB Acknowledgement received reference LL25_021

Name of body	New/ ongoing	Type (H/SC)	Source (engagement, advocacy, partner working)	Method (email, letter, minuted in meeting)	Concern (brief overview, inc. CRM No.)	Status/Outcomes
Kinmel Bay Town Council	Ongoing	H	Engagement	Email	Email asking for an update on the Representations made to BCUHB following the Public Forum in Kinmel Bay RER-250729-2264	Reminder sent to BCUHB that no response has been received. RD able to update on other developments and offered to attend a future Town Council meeting once a response has been received by BCUHB
BCUHB	New	H	National Team	Email	National Representations - Vascular Services in relation to: Leg ulcers (i.e. non-healing wounds located below the knee and above the foot) Foot ulcers in individuals without diabetes Lower limb oedema/lymphoedema in individuals without cancer	Acknowledgement received LL25_019

Name of body	New/ ongoing	Type (H/SC)	Source (engagement, advocacy, partner working)	Method (email, letter, minuted in meeting)	Concern (brief overview, inc. CRM No.)	Status/Outcomes
					1. Service Provision Do you provide vascular services directly through your Health Board, or are these services commissioned externally? If commissioned, please specify the provider(s). 2. Patient Numbers How many patients are currently being supported by your Health Board through these services? 3. Patient Experience Do you collect patient experience or feedback within these services? If so, how is this information used to inform and improve service delivery? 4. Waiting Times What are the current	

Name of body	New/ ongoing	Type (H/SC)	Source (engagement, advocacy, partner working)	Method (email, letter, minuted in meeting)	Concern (brief overview, inc. CRM No.)	Status/Outcomes
					waiting times for both assessment and treatment within these services? RER-250710-2230	
BCUHB	New	H	National Team	Email	Request for latest PATIENT and Duty of Quality Annual Reports. RC-250709-2224	Awaiting Response
Social Services (x6)	New	SC	National Team	Email	Request for 2024/25 Social Services Annual Report RC-250709-2224	Awaiting Response
NHS Wales	New	H	Partner Working	Email	Working with Legs Matter to look at how leg ulcers are treated in Wales. Looking for comparative data in relation to: Leg ulcers (i.e. non-healing wounds located below the knee and above the foot) Foot ulcers in individuals without diabetes Lower limb	Response Received: there is no national (or local registers) of venous ulcers. We only know about them if they are referred. There is a big concern because many are managed in the community by district nurses and we know nothing about them.

Name of body	New/ ongoing	Type (H/SC)	Source (engagement, advocacy, partner working)	Method (email, letter, minuted in meeting)	Concern (brief overview, inc. CRM No.)	Status/Outcomes
					oedema/lymphoedema in individuals without cancer 1. Service Provision Do you provide vascular services directly through your Health Board, or are these services commissioned externally? If commissioned, please specify the provider(s). 2. Patient Numbers How many patients are currently being supported by your Health Board through these services? 3. Patient Experience Do you collect patient experience or feedback within these services? If so, how is this information used to	The lymphoedema service may have data on non-cancer lymphoedema. Questions to be asked of individual health boards across Wales

Name of body	New/ ongoing	Type (H/SC)	Source (engagement, advocacy, partner working)	Method (email, letter, minuted in meeting)	Concern (brief overview, inc. CRM No.)	Status/Outcomes
					inform and improve service delivery? 4. Waiting Times What are the current waiting times for both assessment and treatment within these services? RER-250704-2197	

>north wales< - Representing Llais

(Representing Llais at formal meetings and working groups)

No. relating to health	7
No. relating to social care	0
No. relating to both health and social care	2
Total No. Representing Llais activities	9

Name of committee, meeting or working group	Frequency of attendance	Type (H/SC)	Contribution (voting, observing)	Status/Outcomes
Royal College of Psychiatry Review EAG Adults Mental Health Adults Mental Health	Fortnightly	H	Contributing	On-going support from Llais to facilitate group meetings with BCUHB and those with lived experiences
Quality Safety and Experience Committee	Monthly	H	Contributing	Wide range of issues discussed (agenda and papers available on the BCUHB website) presented on the progress of the Expert Advisory Group on Mental Health
Penley Steering Group	Ad-hoc	H	Contributing	Llais attended to advise on good practice for engagement with local people. • Comms and Engagement: this has been paused as external advice is awaited around the engagement activity. The planned drop-in session had been cancelled. The survey is now live and has received 147 responses. BCUHB is currently mapping the groups it needs to reach out to. • EQIA: this will be developed retrospectively • Urgent closure document to be produced and shared.
Strategic Planning and Service Change BCUHB	Monthly	H	Contributing	Discussion on: Penley and Tywyn Service Changes and timelines. Strategy Development Clinical Services Plan phase 1

Name of committee, meeting or working group	Frequency of attendance	Type (H/SC)	Contribution (voting, observing)	Status/Outcomes
				BCUHB key programmes progress report Llais involvement service change framework Hywel Dda CSP Public Consultation Better Care Powys
Regional Partnership Board	Monthly	Both	Contributing	Key messages: - BCUHB: 3-year Strategic Intent & IMTP. - BCUHB Winter Planning. - Endorsed the Well North Wales Task and Finish Scoping Study - Endorsed in principle the Developing a Whole System Prevention Framework through an engagement event. - Agreement on revised governance arrangements reached by Board. - Board noted receipt of the neurodivergence Improvement Programme 2025-26 Priorities Letter. - Discussions are ongoing between Care Forum Wales and the Health Board as a continuation to push for the adoption of a nationally recognised methodology for the calculation of CHC fees is sought.
BCUHB Engagement Working Group	Monthly	H	Contributing	Discussion on: - Engagement Framework and Principles - Patient Experience Review

Name of committee, meeting or working group	Frequency of attendance	Type (H/SC)	Contribution (voting, observing)	Status/Outcomes
				- Terms of Reference review - Summer Engagement Activity
Patient and Carer Experience Group	Monthly	H	Contributing	Complaints: majority of complaints are about waits for planned care which tallies with one of the things we have been hearing from the public. Llais reported the themes arising from complaints and engagement, and the use of templates by the HB when responding to complaints, sometimes there is a lack of care to ensure the template has been changed before the response goes out. Llais also raised that one complaint response said a person had received a visit from Mental Health as a result of the complaint, in order to discuss it, but that the person had not been given the opportunity to have an advocate present for that meeting. BCUHB Head of Patient & Carer Experience Officer will feed this back to teams. Reports from various teams around BCUHB showed positive feedback from a lot of patients in surveys. Play Therapist at Wrexham Maelor PCE Team working more flexibly to

Name of committee, meeting or working group	Frequency of attendance	Type (H/SC)	Contribution (voting, observing)	Status/Outcomes
				capture patient stories in evenings and weekends. Presentation on SWAN pathway for end of life.
Denbighshire PCPG	Quarterly	Both	Contributing	Themes from discussions: Mental Health Pharmacy Value of small grants – benefits, isolation, costs, value for money (DVSC) Outcomes: Consensus on the level of funding for PCPG September 2025. Use planning framework from September 2024. Date of next meeting - 29/9/25
BCUHB AGM	Annually	H	Observing	Formal presentation of the Annual Accounts and Report, did not contribute at the meeting but did network with a range of NHS and LA colleagues.

>north Wales< - Complaints Advocacy

Total no. new cases opened this month	63
Total no. cases closed this month	90
Total no. open advocacy cases	237

Emergent themes

(Please briefly highlight the key themes that are emerging from complaints advocacy cases this month)

The following themes were identified:

- Dignity of care at Hospital
- Poor Care (maternity)
- Lack of CAHMS and Neurodiverse support
- Waiting times for treatment
- Communication
- Errors in diagnosis
- GP dismissal of symptoms
- Mental Health

East IHC area

- Lack of communication from the paediatric department following tests ECG, x-rays, scans and other tests done at Wrexham Hospital on 19-month baby. Parents have been waiting for diagnosis/treatment of multiple conditions for over 12 months.
- Ongoing complaint regarding poor care after miscarriage.

Centre IHC area

- Failure of CMHT to wrongly assess patient for EMI care home care. This resulted in patient having respite care in a residential care home. Patient suffered a fall which caused a severe head injury and patient was taken to cross-border trauma head injury hospital.

West IHC area

- Ongoing complaint re. dissatisfactory care during pregnancy when patient experienced reduced foetal movements.
- Concerns regarding the care of an elderly patient during hospital admission. Treatment plan was not followed.

- Lack of CAHMS and Neurodiverse support. Wants assistance in obtaining melatonin medication for help in sleeping. Hospital said there is a 12-month waiting list for melatonin.
- Hospital has refused to conduct further scanning for goitre in patient's neck. Still awaiting referral to Alder Hey.
- Client woke up during orthopaedic surgery at YG.
- Patient had a lymph node removed from throat in April 25 and was told cancer was suspected. Patient has not been given clear results or answers.
- Patient had emergency surgery for an ectopic pregnancy and a fallopian tube was removed. Patient was told at an appointment last week that the lab results showed that the foetus was not in the tube and was most likely in the ovary. Patient has not been given clear results or answers.

Primary Care

- Patient has received an appointment with a surgeon but believes they have been mixed up with another patient.
- Wants to complain about GP receptionist refusal to book an appointment, despite caller being advised by NHS111 that their child needed to see a GP. Receptionist insisted they should go to hospital.
- Dentist is refusing to repair a veneer that has been badly positioned, despite patient offering to pay for it to be done on a private basis. Dentist will not offer an explanation for their decision.
- Complaint regarding attitude of GP practice manager.
- Unhappy with GP issuing incorrect antibiotics.
- Patient who was schizophrenic had neck pain symptoms dismissed/attributed to his mental health. He was found dead and had an undiagnosed tumour.
- GP surgery dismissing symptoms and not providing treatment and pain relief. Patient paid for a private MRI scan which showed bulging discs on back. Patient unable to move GP practices because other nearest surgery has no space.
- Would like some help and support on a complaint that needs raising involving GPs at Llangollen Medical Practice with regards to clinical neglect.
  Agency carer singlehandedly hoisted patient while their colleague attended to an emergency alarm call in care home. Patient's legs were hit on a bedside cabinet whilst hoisting alone. A family member visited later that day and noticed the patient was flushed and opened the windows and removed the bed covers to cool the patient down. Family member raised concerns that the patient had bruises on their legs. Over a period of 9 days two GPs and two District Nurses attended the home to visit the patient and diagnosed cellulitis. GP sent patient for an x-ray and the consultant said injury to both legs was horrific. Injury needed

vascular surgery and amputation. Due to patient's vascular dementia and age, it was decided not to operate. Patient was put in plaster cast from hip to toes and commenced end of life pathway. Family member has made a complaint and has requested an advocate to attend a meeting at the GP practice with them.

HMP Berwyn Prison

- Prisoner states that they do not have access to vital support and medication for long standing mental health conditions at HMP Berwyn and wants to see another clinal team.

Welsh Ambulance

- NHS 111 option 2 staff were rude on the telephone and have informed patient that as the patient had recorded the call, they intend to take legal action.

Mental Health

- Patient started to open up and engage with CAMHS but the service delays and follow up appointments and lack of support has pushed the patient away from the help they need.
- Patient was incorrectly diagnosed by a psychiatrist and prescribed the wrong medication for over 8 years, which caused a clot on their lung.
- Complaint regarding treatment of patient when they were sectioned at specialist eating disorder unit.
- Complaint regarding patient being discharged from mental health unit, after panel deciding patient should not be sectioned. Patient was readmitted a few days later.

Cross Border

Countess of Chester

- Patient was moved to a side room in hospital, despite being a falls risk. Patient subsequently fell and hit their head.

Enquiries

- Caller received a financial settlement for medical negligence, in 2019. They continue to have health problems and wanted to know if they could make a further claim.
- Caller has just submitted a complaint about record of ME diagnosis being missing from their medical notes.

- Caller has sent FLR letter to the health board in June and it has not been acknowledged.
- Caller's partner has had an amputation and wanted to know if they could have some hands-free crutches.
- Wants advocacy support/advice on complaints process. Complaint already submitted.
- Caller is dissatisfied with the standard of care provided by GP.
- Patient is in MH secure unit and his clothes and toothbrush are being kept from them. They want it sorted out today.
- Email enquiry asking how to make a complaint about hospital.
- Assistance in locating NHS dental records due to medical negligence which may have happened over 17 years ago.
- Patient has been referred to the CDS by GP multiple times, but they keep refusing the referral and say treatment can be done by their usual dentist. Patient has been de-registered from the NHS dentist. They have ed EDS via NHS 111, but they can't treat the issue as they only provide urgent care.
- Patient had made a complaint 12 months ago and received a reply and wanted information.
- Would like information of how to make a complaint about a hospital.
- Patient has been having trouble contacting dentist.
- Would like information regarding the advocacy service. Caller is requesting that advocate can get respite for them from social services in Gwynedd.
- Infected with Hep B in 1999. NHS told patient they didn't have Hep B. Patient wants to sue NHS as the incorrect information was given to them.
- Caller has been referred to Orthopaedics for shoulder repair but has not yet had an appointment.
- Caller had moved to a new GP practice and the new practice will not allow him to order his repeat prescription electronically.
- Letter cc'd to Llais following an email to Cabinet Secretary for Health & Social Care regarding poor communication and waiting times in North Wales Hospitals.
- Caller's adolescent child has been discharged from Mental Health Team after 1 telephone assessment and no formal discharge letter or explanation. Dr who assessed them has now left.
- Caller was too afraid to phone and cancel an appointment at the hospital as they have been bullied by the staff there in the past; caller had mental health issues.
- Caller is unable to get a GP appointment despite trying on the phone several times. They need a referral for a heart scan.
- Patient was given an appointment for July which was cancelled and rescheduled for August; this was cancelled at short notice.
- Possible misdiagnosis of cancer and subsequent treatment which has left patient disabled. The original diagnosis was some time ago but the caller had only become aware of it recently and was looking for advice.

- Patient has had their registration turned down 3 times even though their family members are registered with the same surgery. Would like advice of how to register with a GP.
- Caller has made a formal complaint regarding a CPN and received a response from the Health Board. They are dissatisfied with the response but does not wish to refer the case to PSOW.
- Caller has found a gap in their GP records from childhood and thinks it's because they were in hospital with TB. Wants to access their hospital records.
- Caller is awaiting a biopsy in mouth and has been told there will be several weeks' wait.
- Wanted advice about making a complaint. Patient attended a clinic appointment, but it was for the wrong patient, and they had a wasted journey.
- Caller was looking for advocacy support.

IMPACT

Activity (what did you do?)	Outcome (what was the result?)	Impact (what's the difference it made?)
Public Forum Wrexham	***Feedback received from attendees:*** • It was a really great afternoon – well done for organising it so well! • Congratulations on the event yesterday. I definitely think it championed North Wales Llais to the Exec board and Llais nationally to those who never knew about it. Well done again. I do think that Llais should thank you both for all the work you have done to achieve this.	

BCUHB Mental Health Progress Board Report	***Extract from the Report:*** Llais staff are also instrumental in supporting EAG members which has been important, valued and greatly appreciated. The North Wales Regional Director of Llais is the Vice Chair of the Group. The Health Board is also very appreciative of the significant support provided by Llais to formulate the approach reflected in this report and the opportunity it has given to fully understand the concerns of families and current service users. The commitment and engagement of members of Llais and the Expert Advisory Group is greatly appreciated by the Health Board and the colleagues that they have met with so far	