Bundle BCU Quality, Safety and Experience Committee 6 November 2025

1 PRELIMINARY MATTERS

1.1 13:00 - QS25/104 Welcome and apologies
Caroline Turner, Chair

1.2 13:02 - QS25/105 Declarations of Interest
Caroline Turner, Chair

1.3 13:02 - QS25/106 Unconfirmed minutes of meeting held 4 September 2025
Caroline Turner, Chair
QS25.106 Unconfirmed minutes of meeting held 4 September 2025

1.4 13:07 - QS25/107 Public Action Log
Caroline Turner, Chair
QS25.107 QSE Action Log PUBLIC

1.5 13:12 - QS25/108 Patient's Story
Angela Wood, Executive Director of Nursing & Midwifery
QS25.108 QSE Patient Story

2 GOVERNANCE, RISK & ASSURANCE

2.1 13:32 - QS25/109 Corporate Risk Register Report
Nesta Collingridge, Head of Risk Management
QS25.109 Corporate Risk Register Report November 2025 v2 PW

2.2 13:42 - QS25/110 Integrated Quality Report
Jointly presented by:
Angela Wood, Executive Director of Nursing & Midwifery
Clara Day, 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
QS25.110a - Integrated Quality Report
QS25.110b Appendix 1 MCCD Submission QR poster
QS25.110c Appendix 2 - Learning lesson of the month

2.3 14:12 - QS25/111 Integrated Performance Report
Ed Williams, Director of Performance
QS25.111a Coversheet IQPR for QSE 06112025 V1
QS25.111b IQPR for QSE 06112025 V1

2.4 14:22 - QS25/112 Nurse Staffing Act
Angela Wood, Executive Director for Nursing & Midwifery
QS25.112 Nurse Staffing QSE Presentation Oct 2025

2.5 14:32 - QS25/113 Welsh Risk Pool and Legal & Risk Services Annual Review 2024/25
Pam Wenger, Director of Corporate Governance
QS25.113a Welsh Risk Pool & L&R Cover Paper V2
QS25.113b Welsh Risk Pool and Legal & Risk Services Annual Review 2024.25

2.6 14:47 - QS25/114 Infection Prevention Annual Report
Angela Wood, Executive Director of Nursing & Midwifery
To include an update on improvements to Staff Vaccinations Programme
Jane Moore, Executive Director of Public Health
QS25.114a IP Annual Report - cover sheet
QS25.114b IPC Annual Report 2024 to 2025
QS25.114c IP Annuanl Report - addendum - Staff Influenza Programme 2025-26

3 IMPROVING QUALITY, OUTCOMES AND EXPERIENCE

3.2 15:02 - QS25/115 Perinatal (Maternity and Neonatal) Assurance Self - Assessment Briefing

Fiona Giraud, Director of Midwifery & Womens Services

QS25.115a Perinatal Assessment Coversheet

QS25.115b National Perinatal Assurance Assessment

3.3 15:17 - QS25/116 Update on Challenged Services
Jointly presented by:
Tehmeena Ajmal, Chief Operating Officer
Clara Day, Executive Medical Director
Paolo Tardivel, Interim Executive Director of Transformation and Strategic Planning

QS25.116 Challenged Services Report

3.4 15:37 - QS25/117 Proposed Changes to 'Independent Funding Requests' and 'Prior Approval Requests' Policies
Clara Day, Executive Medical Director
Sarah Davies, IPFR Development Manager

QS25.117a QSE Coversheet 06.11.25 - IPFR Policy update

QS25.117b Briefing Paper - IPFR and PAR Policy changes - QSE Nov 2025

QS25.117c NHS Wales IPFR Policy - Final - July 2025

QS25.117d NHS Wales Prior Approval Policy - BCUHB FINAL July 2025

3.5 15:52 - QS25/118 Health Board Response to the Royal College of Psychiatrists Invited Review Services Report
Executive Director of Allied Health Professions & Health Science

QS25.118 Health Board Response to the Royal College of Psychiatrists Invited Review Services Report

QS25.118a Health Board Response to the Royal College of Psychiatrists Invited Review Services Report - Appendix 1

4 FOR INFORMATION

4.2 16:02 - QS25/119 Corporate Governance Report
Pam Wenger, Director of Corporate Governance

QS25.119a Corporate Governance Report V2

QS25.119b Appendix A QSE Forward Work Plan - live document

5 CLOSING BUSINESS

5.1 16:04 - QS25/120 Agree items for Referral to Board/Other Committees
Caroline Turner, Chair

5.2 16:06 - QS25/121 Review of Meeting Effectiveness
Caroline Turner, Chair

5.3 QS25/122 Date of Next Meeting
1pm, Thursday, 15 January 2026

5.4 16:08 - QS25/123 Resolution to Exclude the Public
Caroline Turner, 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 held in Public on 4 September 2025
In the Boardroom, Carlton Court, St Asaph and via Teams

Committee Members present	
Name	**Title**
Chris Lothian-Field	Committee Vice Chair, Independent Member – Chairing meeting
Urtha Felda	Independent Member
Professor Mike Larvin	Independent Member
In Attendance	
Angela Wood	Executive Director of Nursing & Midwifery
Emma Adamson	Consultant Midwife
Tehmeena Ajmal	Chief Operating Officer
Ros Alstead	Independent Advisor, Royal College of Psychiatrists Action Plan Response (part meeting)
Sree Andole	Interim Executive Medical Director
Clara Day	Observing as the Incoming Executive Medical Director
Dyfed Edwards	Chair, BCUHB
Adrian Jones	MH&LD, Assistant Director of Nursing (Deputising for Iain Wilkie, Director of Mental Health)
Dave Harries	Head of Internal Audit
Matt Joyes	Deputy Director for Legal Services
Jo Kendrick	Head of Quality
Fiona Lewis	Corporate Governance Officer (Minutes)
Lois Lloyd	Chief Pharmacist
Phylis Makurunje	Aspiring Board Member (observing)
Phil Meakin	Associate Director of Governance, Lead for RCP Action Plan response (part meeting)
Jane Moore	Executive Director of Public Health
Teresa Owen	Executive Director of Allied Health Professionals and Health Science
Philippa Peake Jones	Head of Corporate Governance
Geoff Ryall-Harvey	Llais, North Wales (part meeting)
Paolo Tardivel	Interim Executive Director of Transformation and Improvement
Pam Wenger	Director of Corporate Governance (part meeting)

OPENING BUSINESS
QS25/79 Welcome and apologies Chris Lothian-Field, as Committee Vice Chair, opened the meeting and welcomed all to the meeting.

Apologies were received from Dr Caroline Turner (QSE Chair), Stephen Powell (Director of Commissioning & Performance) and Iain Wilkie (Director of Mental Health & Learning Disabilities) Adrian Jones deputised.

QS25/80 Declarations of Interest

No declarations of interest were raised.

QS25/81 Unconfirmed minutes of meeting held on 3 July 2025

It was resolved that the Committee:

- **Agreed** the Minutes were a true and accurate record of the meeting held on 3 July 2025, once amended to show that both Sree Andole and Phylis Makurunje were in attendance.

QS25/82 Matters Arising and Action Logs

Updates to the Action Log were noted. Executive Director of Nursing and Midwifery to liaise with Performance and Commissioning Team for an update on quality commissioned services. Actions for The Director of Performance and Commissioning will be reviewed and reassigned as needed.

QS25/82.1 Executive Director of Nursing and Midwifery to liaise with Performance and Commissioning Team for an update on quality commissioned services and review and reassign any of The Director of Performance and Commissioning actions.

It was resolved that the Committee

- **Agreed** the updated log.

QS25/83 Patient Story – Play Therapy

A powerful patient story was shared highlighting the experience of a family with a child with additional needs, who had encountered a traumatic blood test, requiring seven staff to restrain the child. This time, the family was supported by a play therapist at Wrexham Maelor Hospital, transforming the experience. Pre-procedure support included familiarisation sessions and a sedative. The procedure was successful with minimal distress.

Committee reflections emphasized the importance of play therapists, holistic care, and compassionate support. Actions proposed included expanding play therapy support, developing resources, exploring third-sector partnerships, strengthening the volunteer strategy, and promoting cultural improvement.

AW agreed to discuss with her Directors of Nursing the possibilities of linking with play specialists, with a view to providing a suite of resources.

Action:

- **QS25/83.1 AW** agreed to discuss with her Directors of Nursing the possibilities of linking with play specialists, with a view to providing a suite of resources.

It was resolved that the Committee

- **Noted** the report.

SERVICE PRESENTATIONS

QS25/84 Women's, Maternity and Gynaecology Services

Emma Adamson, Consultant Midwife, provided a comprehensive update on maternity services, including:

- benchmarking against the Swansea Bay review
- engagement with the National Maternity and Neonatal Review
- assurance on workforce and quality monitoring.

As part of the discussion, the Committee noted:

- consultant availability
- cultural challenges
- a Gap Analysis of National recommendations.
- the importance of compassionate care
- support for vulnerable groups.
- midwifery staffing and proactive recruitment
- the Saving Babies Lives initiative was fully implemented in BCUHB.

It was resolved that the Committee**:**

- **Noted** the information provided**.**

QUALITY CONTROL

QS25/85 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 report covered patient safety, infection control, patient experience, and clinical effectiveness. Highlights included:

Patient Safety

- The number of open incidents was reviewed, ranging from minor issues (e.g. lost name badges) to serious events (e.g. deaths).
- Ongoing concerns were noted in relation Oxygen Cylinder Safety. With the Executive Director of Nursing and Midwifery committed to writing to all registrants to reinforce responsibilities, especially regarding patient movement and medication administration.
- One never event (wrong site surgery) occurred in June. World Health Organization checklist was followed and no significant harm resulted.
- In relation to safeguarding training, level 3 compliance was improving after previous Electronic Staff Record system limitations.

Infection Prevention and Control

- Clostridium difficile noted as a challenge with deep cleaning and cohorting strategies being implemented.

- National Improvement goals for 2025–26 are delayed due to staffing issues at a national level, the Executive Director of Nursing and Midwifery confirmed internal targets were being used in the interim.

Patient Experience

- In relation to complaints performance there was significant improvement noted:
  - 86% closed within 30 working days.
  - Average closure time reduced to 20 days.
  - All divisions exceeded the 75% target.
- Thematic analysis taking place and deep dives into complaint themes (e.g. midwifery, mental health) are underway.
- Civica system used to collect feedback digitally. ED and neonatal services now using SMS-based surveys.
- First Health Board in Wales to implement Swan bereavement nurses. Two Band 7 nurses are now operational.
- The Chaplaincy and Spiritual Care contribution to patient experience was acknowledged.

Clinical Effectiveness

- The Interim Executive Medical Director advised that in relation to Audit Compliance:
  - 9 Tier 1 national audits completed in Q1.
  - 96% NICE guidance compliance.
  - Significant improvements in governance and digital tools (e.g. QR code access for mortality reviews).
- Monthly Learning Initiatives were highlighted noting that topics had included opioid prescribing and MCCD process.

Quality Assurance

- In relation to HIW Reports positive feedback had been received from recent inspections and no immediate assurances required.
- Improvement Plans are being monitored via the Regulation Assurance Group. Scrutiny ensures actions are robust and applicable across services.
- Delays on overdue HIW actions on some of which are due to audit schedules or feasibility concerns (e.g. second maternity theatre). Negotiations with HIW are ongoing.

Organisational Learning

- Update received on the Quality Management System (QMS)**:**
  - Digital maturity assessment app developed and trialled.
  - Rolled out to eight challenge services.
  - Plans to expand and potentially license the tool for wider use.
- Learning Repository is designed to track shared learning and feedback loops.

Legal Update

- Regarding Inquests improvements in information flow noted. One inquest with a negligence finding but no Regulation 28 issued, indicating satisfactory remediation.
- Learning From Events Reports indicate that the number of overdue returns has reduced from 35 to 20. Women's services are facing challenges due to increasing evidence requirements.

As part of the discussion, the Committee:

- Discussed the importance of measuring cultural change, especially in midwifery services.
- Emphasised improvements, particularly in complaints handling.
- Were concerned about complaints relating to attitude and communication as those areas are within the organisation's control.
- Highlighted that to improve clarity and accessibility of reports for public audiences there should be a reduction of the use of acronyms and additional context to data should be included.

It was resolved that the Committee

- **Noted** the report

QS25/86 Integrated Performance Report

In the absence of the Performance Director, the Executive Director of Nursing and Midwifery highlighted provided a summary of key points from the Integrated Performance Report. She noted that much of the content had already been covered in previous agenda items, but highlighted the following:

- Clinical coding progress was reported in recruitment and training, with improvements in coding compliance approaching the 90% target.
- In relation to colonoscopy access, concerns were raised regarding the low compliance (3.9%) with the target for colonoscopy within four weeks of screening. Angela confirmed this was a system-wide challenge and noted that while upper GI nurse endoscopists are in place, lower GI coverage remains a gap. Work is underway to address this through training and workforce development.
- With regards to patient experience feedback, the positive trajectory in Civica feedback responses was good but the emphasis was no on the importance of translating feedback into meaningful service improvements.

Following the presentation, the Committee reflected on:

- The importance of presenting performance data in a way that supports a positive and accurate public narrative about the organisation's progress.
- The need for consistency in how performance data is presented, including clearer context, trajectory, and benchmarking against other Health Boards.

The Committee noted that the Executive Committee were having a session to review the format of both the Integrated Performance and Quality Reports.

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.

QUALITY IMPROVEMENT

QS25/87 Updates of Challenged Services

The Committee received a comprehensive update from The Chief Operating Officer, Executive Director of Transformation and Improvement and The Interim Executive Medical Director on eight services under special measures. The presentation aimed to provide assurance on progress, identify ongoing risks, and highlight areas requiring further support.

The services discussed were:

- Ophthalmology
- Urology
- Vascular
- Dermatology
- Orthopaedics
- Orthodontics
- Plastics
- Oncology

Ophthalmology

- Long waiting times remain a concern
- Variation in service delivery across the three IHCs
- Difficulty in appointing a clinical lead across North Wales
- Workforce planning and job planning are under review
- Estates and digital infrastructure are not fully aligned with service needs
- Cultural resistance to community-based pathways noted

Urology

- Sustainability of on-call rotas is an issue, with a reliance on locums
- Robotic surgery and service configuration challenges persist
- Patient experience concerns due to travel for procedures
- Repatriation of services (e.g., vasectomies) underway
- Business case for a Urology Investigation Unit in Wrexham progressing

Vascular

- Service has improved significantly and is no longer an HIW concern
- AAA pathway temporarily moved to Stoke
- Multi-Disciplinary Team working well with the skill mix under review
- Diabetic foot pathway finalised
- Digital tracking of patient journeys implemented

Dermatology

- Rising demand due to increased awareness and referrals
- Workforce shortages in the West
- Opportunities for productivity improvements and digital solutions
- Workshop planned to address service redesign and referral management

Orthopaedics

- Cold site development planned to improve elective capacity
- Theatre optimisation and day-case surgery expansion in focus
- Challenges with urgent care pressures affecting planned care
- Follow-up pathways under review for evidence-based redesign

Orthodontics

- Significant backlog and workforce shortages
- Lack of alternative skill utilisation

- High strategic risk due to limited capacity and increasing demand
- Opportunities identified in digital infrastructure and workforce planning

Plastics

- Service commissioned externally via JCC; not delivered in-house
- Issues included access inequity, waiting list management, and infrastructure
- Improvements made through WLIs and outreach clinics
- Considered for de-escalation from special measures

Oncology

- Originally escalated due to consultant departures; two have returned.
- National workforce shortages persist
- Increased demand and treatment complexity noted
- Recruitment efforts include international outreach and school engagement
- £10M investment in linear accelerators and Maggie's Centre development
- Also considered for de-escalation from special measures

In discussing the report the Committee:

- Acknowledged the complexity of managing these services and agreed that future updates should focus on exceptions rather than routine reporting. Members praised the structured approach and progress made. Emphasis placed on cultural change, leadership, and sustainability.

- Agreed that challenged services should be monitored through a strategic lens, aligning with IMTP and risk registers. Continued engagement with Welsh Government on service de-escalation should continue. It was noted that workshops and targeted interventions were planned for dermatology and ophthalmology.

It was resolved that the Committee

- **Noted** the presentation.

QS25/88 Tackling Planned Care Challenges

The Chief Operating Officer provided an update on the Health Board's response to the Audit Wales report on Planned Care. This was an All-Wales review, and the BCUHB response had already been reviewed by the Audit Committee. The QSE Committee was asked to consider the safety and quality implications, particularly around patient harm due to long waits.

The key themes and updates provided were:

Infrastructure and Programme Development

- A major change programme has been established to drive improvements in planned care
- The programme includes detailed workstreams and operational deployment plans.
- A more structured approach to activity planning and delivery has been implemented since April 2025.

Capacity and Delivery Confidence

- Core activity targets are being met, with the exception of a few weeks in August.
- Outsourcing remains a challenge due to delays in securing external capacity.

- The team is working on productivity and efficiency improvements, including:
- Optimising theatre use
- Reviewing models of care
- Enhancing estate utilisation

Harm on Waiting Lists

- A methodology to assess unintended harm for patients on waiting lists is being created
- A draft paper has been reviewed by the Executive Team
- The Committee agreed that reporting on harm should be integrated into the Private Quality report, with potential for public reporting once data is aggregated and anonymised

The Committee reflected on the following:

- Acknowledging the scale of the challenge, with up to a third of the population on waiting lists
- Delays can lead to more complex health needs, creating a cycle of increased demand
- The Committee emphasised the importance of cultural change, transparency, and compassionate care
- There was consensus that routine reporting should focus on impact and outcomes, not just activity metrics
- A session with the Executive team is planned to refine the reporting format and ensure alignment between the Quality report and the Integrated Performance report.
- The Committee encouraged continued focus on delivery confidence, patient experience, and strategic alignment with IMTP goals

It was resolved that the Committee

- **Noted** the report

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

QS25/89 Update on the Royal College of Psychiatry (RCP) Action Plan

The Executive Lead introduced Ros Alstead, the Independent Special Advisor and Chair of the Expert Advisory Group (EAG), who presented her last update, and reflected on the work to do towards the end of the work being carried out:

- Thanks were offered to both the People with lived experience as well as Llais for their continued support during the process
- Ward visits informed the improvement plan
- Challenges included achieving consensus among service users
- A new oversight group led by the Chief Executive will be established

Geoff Ryall-Harvey, Llais, confirmed that it had been a complex but worthwhile process.

Committee praised the co-productive approach and learning potential.

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]
[Nesta Collingridge joined the meeting]

ROUTINE REPORTING

QS25/90 Board Assurance Framework

The Head of Risk Management provided a brief update, which included the following:

- One delayed action noted regarding digital capacity for the learning repository.
- Mental health risks progressing as planned.
- Future updates to include IMTP integration.

Action:
It was resolved that the Committee**:**

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

FOR INFORMATION

QS25/94 JCC Quality Safety Outcomes Highlight Report 15.07.25

It was resolved that the Committee

- **Noted** the Report.

QS25/95 Summary of Business to be Reported in Private part of Last Meeting

It was resolved that the Committee

- **Noted** the Report.

QS25/96 Review Committee Forward Work Plan (FWP)

It was resolved that the Committee

- **Noted** the Committee Forward Work Plan.

CLOSING BUSINESS

QS25/98 Agree Items for Referral to Board / Other Committees

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

Date of Next Meeting

13.00 Thursday, 6 November 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.

Quality, Safety and Experience Committee PUBLIC Action Log

Updated 30.10.25

Open Actions						
Action No.	**Minute Ref.**	**Date**	**Agreed Action**	**Lead**	**Time scale**	**Status**
Actions to remain open						
1	QS25/60.1	03.07.25	**QS25/60 Integrated Quality Report** To circulate details of the Medical and Healthcare products Regulatory Agency breach.	Clara Day ~~**(Sree Andole)**~~ **(Clara Day)**	July 2025	**Remain Open** **4.9.25** Delayed. SA advised it will come to QSE once it has gone through QDG. A detailed paper is being drafted by Lois.
2	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 November meeting.
3	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 –	~~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.

				Tehmeena Ajmal		Update to be received at meeting
4	Board Meeting 30.01.25	Chair	**25/09.03 Citizens Engagement Report** A briefing on the new legislation due to be issued, to be discussed at a future QSE Committee.	Director of Partnerships, Engagement & Communication **(Helen Stevens Jones)**	Janu ary 2025	
Actions Proposed for Closure						
1	QS25/83.1	04.09.25	**QS25/83 Patient Story – Play Therapy** **AW** to discuss with her Directors of Nursing the possibilities of linking with play specialists, with a view to providing a suite of resources.	Exec. Dir. Nursing & Midwifery **(Angela Wood)**	Nov 2025	**Suggest close** It is not possible to take this forward at this time.
2	QS24/104. 1	13.2.25	**QS24/104 Meeting Effectiveness** To ensure more time allocated to Primary care on COB.	Head of Corporate Governance **(Philippa Peake-Jones)**	Nov 2025	**Suggest close** It has been agreed that Primary Care is the responsibility of PPHP and is being taken forward through that Committee
3	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	**Suggest close** **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 **4.9.2025** Angela Wood noted that Stephen Powell would not be updating Committee and that she would provide update for the November mtg.

						29.10.25 Confirmation that IHCs are attending the commissioning meetings
3	QS25/59.1	03.07.25	**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 Governance **(Philippa Peake-Jones)**	Septe mber	**Suggest close** **4.9.25** The Annual Report has been amended and is being signed off
4	QS25/31.2	01.05.25	**QS25/31 Overview of Mental Health** Invite Board to a session regarding Children's Mental Health Team accessibility – with Vicky Jones, Head Mental Health Strategic Programme	Head of Corporate Governance **(Philippa Peake-Jones)**	May 2025	**Suggest close** Transferred to the Board Development
6	QS25/43.1	01.05.25	**QS25/43 Review Committee Forward Work Plan**	Head of Corporate Affairs **(Philippa Peake-Jones)**	Septe mber 2025	**Suggest close** **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. **4.9.25** PP-J confirmed work ongoing **to** align with revised Cycle of Business Cycle of Business and Forward work plan now aligned
14	QS25/38.1	01.05.25	**QS25/38 Board Assurance Framework and Corporate Risk Register (CRR)** BAF to include more external	Head of Risk Management (**Nesta Collingridge**)	July 2025	**Suggest close** **03.07.25** Work continues, to align the BAF with the Annual Plan.

			validations and also to include mitigations, focussing on challenged services' risks.			**28.08.25** – 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**
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	**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

			regarding HPI's compliance.			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**	**Exec Dir for Nursing &**	**Sept**	**Suggest close**

			Framework and Corporate Risk Register To meet to discuss Risk Register tolerance thresholds	**Midwifery** **(Angela Wood)** **Exec Med. Dir. (Sree Andole)** **Dir of Commissioning & Performance** **(Stephen Powell)** **Head of Risk Mngt** **(Nesta Collingridge)**	**2025**	**14.08.25 –** Risk session delivered at Informal Executive meeting on 16th July. Further work being undertaken by the Corporate Governance office. **4.9.25** Angela Wood noted that Stephen Powell would not be updating Committee and that she would provide update for the November mtg.
14	**QS25/38.1**	**01.05.25**	**QS25/38 Board Assurance Framework and Corporate Risk Register** BAF to include more external validations and also to include mitigations, focussing on challenged services' risks.	**Head of Risk Management** **(Nesta Collingridge)**	**July 2025**	**Suggest close** **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.

Teitl adroddiad: ***Report title:***	**Pulmonary Embolism Patient Story** **Emboledd Ysgyfeiniol – Stori'r Claf**			
Adrodd i: ***Report to:***	QSE Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	6th November 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 Pulmonary Embolism Patient Story.mov Pulmonary Embolism Patient Story - WELSH 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

The storyteller wished to share her experience of being diagnosed with and treated for a Pulmonary Embolism at Ysbyty Glan Clwyd, to help others with early identification and detection of blood clots.

The BCUHB Thrombosis Specialist Nurses and team would like to share the patient story to support their ongoing commitment to improving Venous Thromboembolism (VTE) prevention and outcomes across the Health Board.

The story was shared for World Thrombosis Day on Monday 13th October 2025.

Key Messages

- Storyteller shares the signs and symptoms that she experienced before being diagnosed with a pulmonary embolism, and explains that she had no traditional risk factors of Pulmonary Embolism.

- Storyteller describes her difficult experience in the Emergency Department of Ysbyty Glan Clwyd. She describes the tests that were undertaken and the support that she received as well as the lack of information and the helplessness of finding things out.

- Storyteller describes her experience in the Same Day Emergency Care Department of Ysbyty Glan Clwyd. She describes the tests that were undertaken and the support that she received as fantastic.

- Storyteller describes the help and support that she accessed to support her physical and mental recovery.

Summary of Learning and Improvement

The patient story has been shared across the Emergency Department and Same Day Emergency Care Department at Ysbyty Glan Clwyd, Emergency Care and the BCUHB Thrombosis Specialist Nurses and team for feedback and learning.

Venous Thromboembolism (VTE) is a condition involving blood clots that can block blood flow in veins, including both Deep Vein Thrombosis (DVT) and Pulmonary Embolism (PE). VTE is the leading cause of preventable death is hospitals with 55-60% of cases occurring during or following hospitalisation (Thrombosis UK, 2024).

Across NHS Wales in 2023, 11 claims related to VTE were submitted for reimbursement totalling £6.7 million, of which £4.7 million was related to Hospital Acquired Thrombosis.

Delayed or missed diagnosis was the most featured contributory factor, highlighting the importance of early detection and a thorough risk assessment as soon as possible after admission to hospital.

A VTE diagnosis can have a significant long-term impact on the health of an individual. The BCUHB Thrombosis Specialist Nurses and team have been tasked with raising the awareness of VTE across the Health Board, including the impact is has on our patients lives and improving compliance with the VTE Risk Assessment Tool.

The storyteller describes her difficult experience in the Ysbyty Glan Clwyd Emergency Department. She describes the tests that were undertaken and the support that she received, but the lack of information and the helplessness of finding things out.

The BCUHB Thrombosis Specialist Nurses have worked in collaboration with the Emergency Department Educational Lead to develop a comprehensive education programme of bespoke and regular training to ensure consistent and up-to-date knowledge around VTE prevention and management for Emergency Department clinicians, including doctors, consultants, and the senior team across the Health Board.

Bespoke education sessions for Emergency Department staff covers the signs and symptoms of VTE, risk factors for VTE, the importance of completing the VTE Risk assessment, thromboprophylaxis practices, the long-term implications of diagnosing a VTE for the patient, post VTE problems and access to a padlet of information to support staff.

The patient story will be an integral and valuable part of these education sessions to reinforce the human impact VTE and will be shared across all training platforms. For assurance, the story has already been used as part of a teaching session within the Ysbyty Glan Clwyd Emergency Department with great impact on the staff present.

The Emergency Department Teaching Lead has implemented a rolling programme of teaching for Emergency Department staff, including standard topics and those which relate to learning events and themes and trends in a proactive way. For assurance, specific training around Pulmonary Embolism has been rolled out to middle grade doctors, new doctors and clinical fellows over the last twelve months in Ysbyty Glan Clwyd.

The Emergency Department at Ysbyty Glan Clwyd maintains close communication with the BCUHB Thrombosis Specialist Nurses and team to continuously improve working practices and pathways. Most recently, the Emergency Department Clinical Governance Lead has worked in collaboration with the Lead Thrombosis Specialist Nurse to develop the DVT pathway, to formalise the inclusion and exclusion criteria, to develop processes and improve patient experience.

General VTE Awareness Sessions are also open to all staff across the Health Board, including clinicians, nurses, and allied health professionals. They are held on a rolling monthly education programme. The team also continue to work with Practice Education Facilitators to deliver VTE education sessions for student communities, ensuring future healthcare professionals are trained to identify and manage VTE. The BCUHB Thrombosis Specialist Nurses and team are proactive in sharing their specialist knowledge to raise the awareness of VTE across Health Board departments and education sessions are supported by high ward and department visibility from the team.

In addition to the education sessions, the BCUHB Thrombosis Specialist Nurses and team train and support departmental VTE Champions across the Health Board. The team liaise with ward managers to identify and nominate champions from their areas which may include nurses, health care assistants and allied health professionals.

All champions attend education sessions and support peer education in relation to VTE by disseminating information into their areas of work. They also help to address training needs, with the roll out of mechanical thromboprophylaxis training. All champions are added to a dedicated Teams channel to support communication around upcoming events and share information.

There is a requirement for two VTE Champions from each clinical area, with more representation in larger clinical areas for assurances, including the Acute Medical Units, Surgical Assessment Units and Emergency Departments. The team regularly attends clinical areas to support the champions also.

The BCUHB Thrombosis Specialist Nurses have recently supported the production of an All-Wales VTE e-learning at the request of Welsh Risk Pool. This has been updated and shared with ESR (Electronic Staff Record) and will be launched imminently across the Health Board.

Currently the module is non-mandatory for clinical and non-clinical staff, but there is ongoing work to push this essential training forward as mandatory training for all staff across BCUHB to support early recognition and appropriate intervention of VTE, as highlighted in the patient story.

BCUHB is proud to be recognised also as a VTE ‘Exemplar Centre’. VTE Exemplar status refers to a recognition awarded to healthcare facilities that demonstrate excellence in the prevention and management of VTE. Achieving this status involves peer review against rigorous standards for VTE risk assessment and prevention, ensuring high-quality care and patient safety. BCUHB is only one of two sites across Wales. This status allows the collaboration and sharing of best practice and to act as a ‘buddy’ site for other areas to come on board. This reinforces the teams continued efforts in education, awareness, and service development across the Health Board.

The storyteller shares the signs and symptoms that she experienced before being diagnosed with a pulmonary embolism and explains that she had no traditional risk factors of Pulmonary Embolism.

The BCUHB Thrombosis Specialist Nurses and team have rolled out a Health Board wide campaign to promote VTE awareness with the public, to promote awareness of the VTE Risk Assessment tool and to empower patients to have informed conversations.

The team hold regular awareness stands in the hospital foyers across Wrexham Maelor Hospital, Ysbyty Glan Clwyd and Ysbyty Gwynedd to engage with both staff and patients. Plans are also underway to extend this outreach to local community events.

The team has also created VTE patient facing information in collaboration with the Emergency Departments. VTE awareness content has now been introduced on waiting area screens across BCUHB Emergency Departments. The team aim to replicate this across Minor Injuries Units, GP surgeries and other community spaces in the future to improve public understanding and early detection of VTE.

The patient story will be used by the BCUHB Specialist Nurses and team to support World Thrombosis Day on Monday 13th October 2025. To highlight this day, the team are holding a week-long of activities, including teaching sessions with staff and engagement sessions with staff and the public at each main hospital site across the Health Board. The patient story and a reflective piece on the week of activities will be shared with all staff via the BCUHB Communications Team and staff bulletin as well as promotion and awareness raising for the public via Health Board social media.

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

Teitl adroddiad: ***Report title:***	Corporate Risk Register Report			
Adrodd i: ***Report to:***	Quality, Safety and Experience Committee (QSE)			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 06 November 2025			
Crynodeb Gweithredol: ***Executive Summary:***	The Committee is asked to **receive assurance and endorse the updated corporate risk register:** Following two informal Executive Committee Development sessions to review the Corporate Risk Register, held on the 16th July and 20th August, it was decided that the current Corporate Risk Register would benefit from consolidation of the current 26 risks to a more strategic Corporate Risk Register for presentation to the Board and oversight at relevant committees. The proposed revised, draft Corporate Risk Register will compromise of 11 strategic risks with a selection of the more operational Corporate Risks de-escalated to be managed operationally at Director level. Of the 11 Corporate Risks, 2 risks will have oversight by the Quality, Safety and Experience Committee (see appendix 2) The Committee is asked to provide any further feedback on each of the Corporate Risks prior to approval by Board for those risks to which the committee has oversight			
Argymhellion: ***Recommendations:***	The Committee is asked to**:** 1. Provide any feedback or **receive assurance** and **endorse** the updated corporate risk register.			
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: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth

	darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	darparu'r mecanweithiau / 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: *'Partial' Escalated to Chief Operating Officer*	
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 EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA 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)***	The Board Assurance Framework has been updated and links of both have been referenced in both strategic risk registers.
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	Corporate risks descriptions presented informally to the Board during the risk appetite session 27 August 2025. Reviewed on two

Feedback, response, and follow up summary following consultation	occasions by Risk Scrutiny Group and Executive Committee Sept and Oct 2025.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	See the individual risks for details of the related links to the Board Assurance Framework.
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Not applicable for this report
Camau Nesaf: ***Next Steps:*** 1. Revised Corporate Risks presented to Board for assurance and endorsement. 2. Approved Corporate Risks to be monitored as business as usual by senior risk leads, Executives, the Risk Scrutiny Group and the Executive Committee	
Rhestr o Atodiadau: ***List of Appendices:*** Appendix 1 – Revised Corporate Risk Register Heat Map – September 2025 Appendix 2 – Revised Corporate Risk Register (QSE) – September 2025	

Revised Corporate Risk Register Dashboard – September 2025

Lead	Ref	Risk Title	Current Score (Impact x Likelihood)	Risk Target Score	Appetite Main Risk Type Appetite Level	Lead Board Committee	Action Progression			Risk Management Commentary
							Total	Completed	Delayed or Overdue	
COO	CRR25-01	Timely Patient Access to Safe and Effective Care	5x4 20	12	Quality (<15) Above Tolerance	Quality, Safety & Experience Committee	5	2	0	
DCG	CRR25-08	Non-Compliance with Regulatory and Legislative Requirements	4x4 16	8	Regulatory (<15) Above Tolerance	Quality, Safety and Experience Committee	8	1	0	

Corporate Risk Register Report

1.0 Purpose

The purpose of this report is to provide an update to the Committee on the Corporate Risk Register to which the Committee has oversight.

1.1 Key Highlights

All risks have been reviewed and updated by the relevant services and approved by Executives.

The following risk was subject to a deep dive at the Risk Scrutiny Group where the group discussed and reviewed, the risks and were presented to the group by the relevant risk lead and service:

- CRR24-06 Value Delivery and Financial Sustainability (September)

The following risks are scheduled to undergo a deep dive at the November 2025 Risk Scrutiny Group following the October Risk Scrutiny Group being stood down as not quorate:

- CRR25-09 (former CRR24-06) Safe Environment
- CRR25-10 (former CRR24-15) Health and Safety

The risks that are overseen by QSE Committee are scheduled for a deep dive at the Risk Scrutiny Group during:

- December 2025 – CRR25-08 'Non-Compliance with Regulatory and Legislative Requirements'
- March 2026 – CRR25-01 'Timely Patient Access to Safe and Effective Care'

1.2 Changes in Score

Risk Ref	Reduced Risks	Lead Exec Director	Previous Risk Score	Current Risk Score
	None			

1.3 New Risks

The risk(s) added to the Corporate Risk Register since the last update are:

Risk Ref	New Risks	Lead Exec Director	Current Risk Score (and IxL)
2025: 2 risks presented to committee refined and consolidated			
CRR25-01	Timely Patient Access to Safe and Effective Care	Chief Operating Officer	20
CRR25-08	Non-Compliance with Regulatory and Legislative Requirements	Director of Corporate Governance	20

1.4 Overdue/Delayed Actions

The corporate risk register was revised during September 2025 which did note no overdue actions, with 1 action as 'Not Started'. Several actions are noted for being due before the end of December 2025.

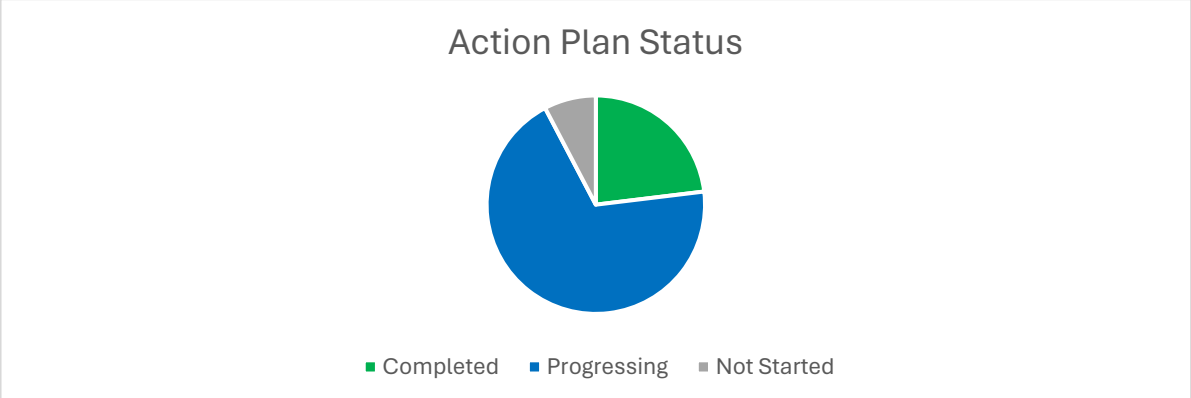
As per the normal cycle of reporting, updates are being sought for current updates on all of these actions. The status of these actions of will be included in the next update/iteration of the risk register.

1.5 Risks above Health Board 24/25 appetite

In 2024 the committee had seven risks reported to committee score **above** the tolerance range set in the appetite. Although some of these are now being managed operationally and remain above appetite. Two corporate risks above tolerance are for the oversight of the Committee.

Risk Ref	New Risks	Lead Exec Director	Current Risk Score (and IxL)	Risk Tolerance Range in Appetite Score
2025: 2 risks presented to committee refined and consolidated				
CRR25-01	Timely Patient Access to Safe and Effective Care	Chief Operating Officer	20	Quality <15
CRR25-08	Non-Compliance with Regulatory and Legislative Requirements	Director of Corporate Governance	16	Regulatory <15

1.6 Action Plan status of Corporate Risks



Of the 2 Corporate Risks, 13 actions have been developed to mitigate the risks 3 actions have been completed, 9 actions are progressing and on track, 1 action has not yet started and relates to CRR25-08.

Next steps

1. Revised Corporate Risks presented to Board for assurance and endorsement.
2. Corporate Risks to be updated and monitored as business as usual by senior risk leads, Executives, the Risk Scrutiny Group and the Executive Committee

Appendix 1 – Revised Corporate Risk Register Heat Map – September 2025

Corporate Risk Register Heat Map Oct 25

Impact							
	Catastrophic	5				Extreme • Timely Patient Access to Safe and Effective Care • Modernising our Infrastructure • Value Delivery and Financial Sustainability • ICT Failure and Cyber	Extreme
	Major	4				• Future Demand & Sustainable Workforce • Population Needs • Leadership and Operating Model • Non-Compliance with Regulatory and Legislative Requirements • Health and Safety	Extreme • Safe Environment
	Moderate	3				• Strategic Change – Impacting Care and Staff Delivery	
	Minor	2					
	Negligible	1					
			1	2	3	4	5
			Rare	Unlikely	Possible	Likely	Almost Certain
			Possibility				

Appendix 2 – Revised Corporate Risks – Quality, Safety and Experience Committee - September 2025.

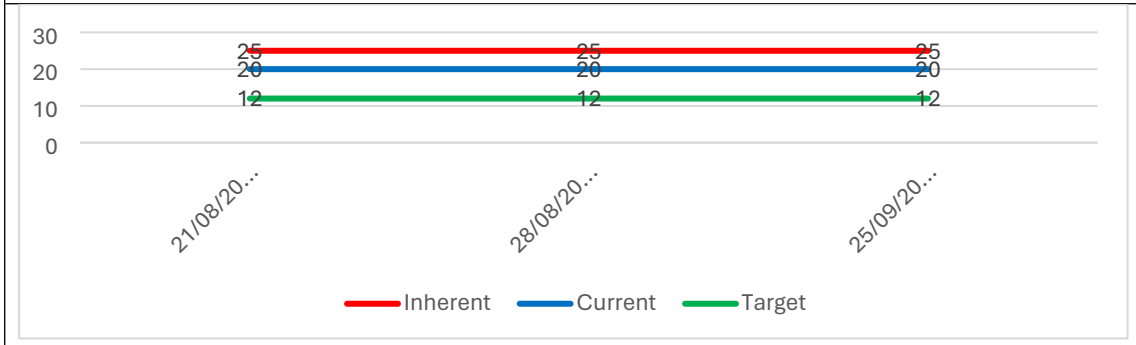
CRR 25-01	**Risk Title: Timely Patient Access to Safe and Effective Care**		**Date Opened:** 21/08/2025 *(version 2 refined from 2023)*
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** New Risk
Date Last Reviewed: 25/09/2025	**Director Lead:** Chief Operating Officer	**Link to BAF**: BAF24-07	**Target Risk Date:** 30/06/2027

There is a risk that patients may not receive timely access to the care they need, which could lead to deterioration in health, poor patient experience, and poorer outcome.
This may be caused by lack of oversight of waiting lists, harm occurring on waiting lists, insufficient communication with clinicians, poor patient experience, and difficulties recruiting to specialist posts.
This may lead to extended waiting lists, patient harm due to delays, and reputational or regulatory consequences.

Mitigations/Controls in place	Additional Controls required
1. System Resilience Hub in place with hospital full protocols and winter/festive plans 2. Major change programmes for UEC and planned care aligned to the Six Goals for Urgent and Emergency Care (UEC) framework and national objectives (such as timely access to care and building community capacity). Governance structure completed, all workstreams now all aligned. 3. Winter Resilience Plan complete evaluation and lessons learnt. 4. Revised Access policy to ensure standardised practice across the Health Board 5. SICAT and GP Out of Hours OOHs joint model providing 24/7 triage and advice 6. Same Day Emergency Care (SDEC) services established at all acute sites 7. Routine clinical prioritisation of patients by risk in line with Referral to Treatment guidance 8. Weekly corporate access meetings and specialty-level access monitoring 9. Outsourcing of radiology reporting and insourcing of CT, MRI, ultrasound 10. Diagnostic Quality Management System accreditation system embedded 11. Welsh Governemnt short-term Neurodevelopment funding to support longest waiters, agency staff, overtime	a. Fragility of UEC and specialist workforce posts, reliance on temporary/secondments b. Fragility of social care provision causing delayed discharge and stranded patients c. Need for demand and capacity modelling and specialty-level trajectories d. Inadequate Neurodevelopment capacity to manage waiting list e. Outdated diagnostic IT systems

Actions	Action Owner	Due Date	Progression Analysis
a Complete recruitment of clinical leads and project management capacity to deliver sustainable specialty models UEC clinical lead appointed to for 4 sessions a week commencing 1st October 2025 until March 2026.	Chief Operating Officer	30/03/2026	Progressing
b Complete demand and capacity analysis across Planned Care to inform forward activity planning	Danielle Edwards,	31/03/2026	Progressing

As part of the planned care programme and major change programme. The Transformation improvement team have provided an allocation of project management and pathway re-design support to the planned care programme to be used flexibly across its delivery.	Programme Director, Planned Care		
d Implement new prudent ND assessment process to streamline and reduce wait times (ND Waiting List) Prudent assessment developed and agreed, to be rolled out across the teams from October 2025.Prudent assessment has been launched last week in September 2025	Louise Bell / Fiona Wright	31/07/2025	Completed
d Stratify ND waiting list to identify and prioritise high-risk children. Work undertaken to stratify the waiting list and identify high risk children. Stratification of Waiting Lists has taken place	Louise Bell / Fiona Wright	30/09/2025	Completed
e Update Failure to act on Diagnostics Procedure to be presented at divisional meeting for discussion on the 10/10/2025	David Fletcher, North Wales Managed Clinical Services	20/10/2025	Progressing



	Impact	Likelihood	Score
Inherent Risk Rating	5	5	25
Current Risk Rating	5	4	20
Target Risk Score	4	3	12
Risk Appetite	Quality <15		Not in Tolerance

Position & Intended Outcome for Risk

The number of Prevention of Future Death (PFD) / Regulation 28 Notices issued to BCUHB since February 2023 currently stands at 32.The Health Board saw a large number issued in 2023/24 (23) which was a significant outlier compared to previous years and other NHS Wales bodies. However, 5 were received in 2024/25 (to date), a significant reduction compared to the number issued in same period of the prior year and more in-line with the average of previous years and other NHS Wales bodies. 9 cases directly related to the

	impact of delays in the health and social care system on the timeliness of responses by the Welsh Ambulance Service. Goal to be in line with WG targets.

CRR 25-08	**Risk Title: Non-Compliance with Regulatory and Legislative Requirements**		**Date Opened:** 21/08/2025 *(version 2 refined from 2023)*
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** New Risk
Date Last Reviewed: 01/10/2025	**Director Lead:** Director of Corporate Governance	**Link to BAF**: BAF24-01	**Target Risk Date:** 30/06/2027

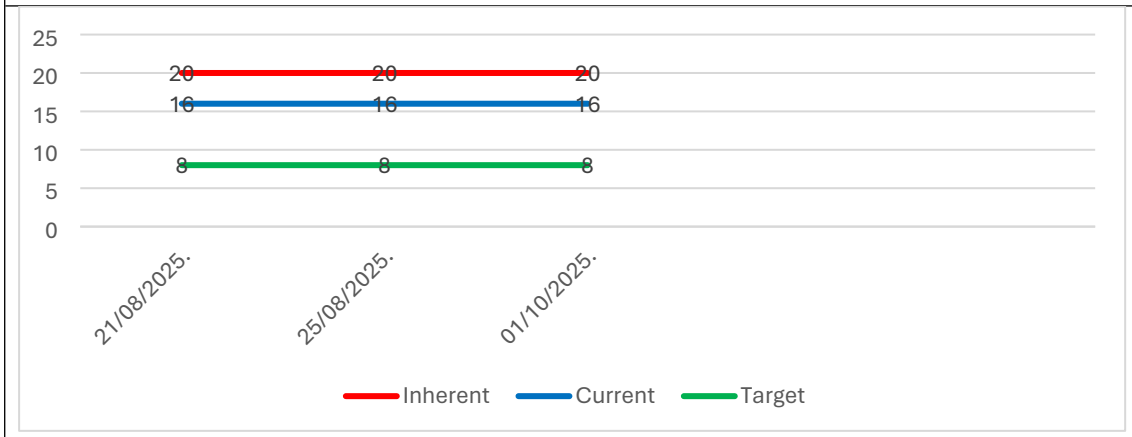
There is a risk that the organisation may fail to comply with regulatory and legislative requirements, which could directly or indirectly impact the safety, quality, and accessibility of patient care.
This may be caused by inefficiencies in managing regulatory complexities, insufficient policy management, managing changes in legislation at pace, insufficient operational assurance across estates, health and safety, and medical devices, and failure to deliver climate/net zero requirements.
This may lead to enforcement action, financial penalties, and loss of public and stakeholder confidence.

Mitigations/Controls in place	Additional Controls required
1. Training, induction and mandatory requirements for staff for highlights legislation and compliance. 2. Monitoring of regulations and legislation by various groups exist such as: Medical Devices Governance & Assurance Group oversees procurement, selection, risk management and safety communication Estates and Health & Safety Committee oversee areas of non-compliance and tracking of action plans. Pharmacy Technical Services and monitoring of compliance in relation to Controlled Drugs. Regulatory Assurance Group for some clinical regulations. (Oversight and gap analysis of all groups required and reflected in the action plan/gaps in controls) 3. Various External peer review programmes e.g. Finance, Counter Fraud, Pharmacy, Imaging and Pathology reporting areas of non-compliance with legisaltion. 4. Regulatory compliance around Health Inspectorate Wales and Care Inspectorate Wales reported to QSE, and to Audit Committee (via the Statutory Compliance Report)	a) Governance and regulatory Executive Delivery Group (EDG) group to be in place to ensure HB wide oversight of all other groups (not just clinical) and tracking non-compliance and a clear route for escalation to the EDG. b) Creation of an electronic system to capture all legislative and regulatory requirements, to capture information in relation to accountability and responsibility for the different elements, to enable the sharing of information, monitoring of progress and production of monitoring reports as necessary c) The QMS system is yet to be fully embedded and will highlight external peer reviews which cite any areas of non-compliance for better oversight by the EDG. d) Lack of consistent medical device training and local governance (from CRR24-14) e) Inadequate workforce capacity in Pharmacy aseptic units; >80% capacity utilisation (from CRR24-28) f) Quality assurance and regulatory compliance gaps in Pharmacy services (from CRR24-28) g) Net zero / climate compliance delivery plan not embedded (consolidated) h) Core Emergency Preparedness policies, templates, and guidance documents

	are still under review, such as the Business Continuity Operational Response Framework.

Actions	Action Owner	Due Date	Progression Analysis
A) Governance and regulatory EDG to be set up to oversee non-compliance (strategic actions from this to be added here going forward)	Glesni Driver, Corporate Office	01/12/2025	Progressing
B)Creation of an electronic system to capture legislative and regulatory information and requirements. Not started due to resource constraints anticipated start date Q1 25/26.	Glesni Driver, Corporate Office	01/11/2026	Not Started
D)Complete audit of medical devices readiness of services. Post-market surveillance audit completed August; three services who make or modify devices need support to ensure compliance. Meetings scheduled with those services, Head of Clinical Engineering and ADAHPS in September / October to facilitate next steps. The audit was circulated widely across the Health Board, prioritising services/pathways most likely to make or modify devices. As there may be other services who fit these criteria, the engagement team have supported ongoing communication into the organisation for awareness. National benchmark audit completed June 2025. Benchmark summary received August 2025. Head of Clinical Engineering working with services to progress improvements. The National audit remains live so we can update as required.	Susan Brierley-Hobson, Therapies & Health Science	16/12/2025	Progressing
A)Review local medical devices groups governance & membership. A proposal was written re these groups being reformed in April 2025. EDAHPHS Teresa Owen and COO Tehmeena Ajmal in discussion re way forward.	Susan Brierley-Hobson, Therapies & Health Science	16/03/2026	Progressing
E)In order for compliance in pharmacy (aseptic production, QA and regulatory staff) Workforce Expansion is required. The delay in initial progress has been due to annual leave in July and August, responding to external audit findings and responding to out of specification environmental monitoring results. Work has restarted but completion will be delayed until end of Nov 2025.	Lois Lloyd , Corporate Office	31/11/2025	Progressing
E) Strengthen pharmacy QMS and regulatory compliance roles	Lois Lloyd , Corporate Office	31/05/2025	Completed

A)Prevent Fraud legislation. Compliance task and finish group to be set up with risk leads appointed to ensure compliance across the HB. Areas of non-compliance or not progressing in a timely manner to be monitored by Finance and EDG.	Danielle Timmins, Finance	31/12/2025	Progressing
Review and update business continuity plans for Pharmacy Technical Services. The Cancer Division have set up a working group to develop and implement a demand and capacity SACT Dashboard, multi-disciplinary group meeting monthly.	Lois Lloyd, Corporate Office	31/12/2025	Progressing
h) A number of Business Continuity Plans (BCP) have been identified as in place however scoping is required to identify all outstanding BCPs (possibility of over 100 BCP, however scoping is required to determine). Continue support is required for the IHCs/ Womens and MH/LD to obtain denominators for accurate reporting, monitoring and compliance rates. The scoping exercise to identify all required BCPs will be completed by March 2026.	Sharon Scott	31/03/2026	Progressing
h) Business Continuity dashboard has been established, a RAG system has been introduced and a % compliance indicator, to be a control once uptake and communicated out.	Sharon Scott	31/12/2025	Progressing



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	2	8
Risk Appetite	Regulatory/Compliance <15		Not in Tolerance

Position & Intended Outcome for Risk

Governance and regulatory EDG to be set up to oversee non-compliance and all operational aspects. This risk to be developed to be more strategic following the group and to report areas of non-compliance to the Executive Committee. Compliance to be tracked and risks mitigated.

Teitl adroddiad: ***Report title:***	QSE Committee – Quality Report			
Adrodd i: ***Report to:***	QSE Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	6th November 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 Clara Day, Executive Medical Director • Teresa Owen, Executive Director of AHPs and Healthcare Science • Dr Jane Moore, Executive Director of Public Health			
Awdur yr Adroddiad: ***Report Author:***	• **Patient Safety:** Chris Lynes, Deputy Director of Nursing (Patient Safety) and Tracey Radcliffe, Head of Patient Safety • **Safeguarding:** Michelle Denwood, Director of Safeguarding • **IPC:** Andrea Ledgerton, Assistant Director of Infection Prevention and Decontamination • **Patient and Carer Experience:** Mandy Jones, Deputy Director of Nursing (Patient Experience) and Leon Marsh, Head of Patient Experience • **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 of Quality and Debbie Kumwenda, Healthcare Law Lead 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:***				
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 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)***	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 **Mortality:** **Appendix 1** MCCD Submission QR poster **Appendix 2** Learning lesson of the month (September) Late diagnosis of Pulmonary Embolism	

QSE Committee – Quality Report – August-September 2025

INTRODUCTION

For the NHS in Wales, quality is 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.

CONTENTS

PATIENT SAFETY

PATIENT SAFETY INCIDENTS

Incidents:
There are currently 5053 open incidents of the 5053, 3205 are overdue which is a similar position to previous months. The number of closed incidents versus the number of opened incidents is a similar number each week.

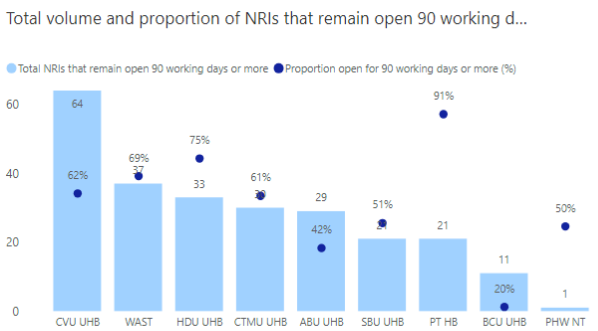
There remains a very high number of open incidents in the Central area (40% of the total open incidents) down by 8% from last month. Trajectories for a 20% reduction of open incidents for each IHC/Division each month is being completed by the Patient Safety team for monitoring of improvement for each of the separate areas.

Oxygen Cylinder improvement work
The short-term task and finish group continues to meet monthly to address key issues relating to oxygen cylinder incidents. Task and finish group to continue until assurance re: action plans is in place, this will be reviewed Jan 2026._Compliance of oxygen cylinder training on ESR in September 2025 was 78.7%. BOC attended the Health Board in September 2025 to demonstrate the latest version of their cylinder and receive feedback. Formal feedback is being sent to the company.

Nationally Reportable Incidents
From 01st August 2025 to 30th September 2025, there were 26 Nationally Reportable Incidents (NRIs) occurring by incident date compared with 22 for the previous reporting period.

The total number of NRI investigations that were open as at the end of September 2025 was 54 with 6 overdue closures. Cancer, Diagnostics, Mental Health and Learning Disability and West currently do not have any overdue.

The proportion of NRIs that remain open for more than 90 days continues to be the best across Wales, with the Health Board having 20% of cases taking longer than 90 days. The median working days to completion is also the lowest at 77 days compared to the All-Wales median of 134 days.



A total of 43 NRI outcome forms were submitted to NHS Wales Performance and Improvement for closure during August and September 2025. Further detail and learning from these closures can be found in the confidential quality report.

Never Events

The Health Board reported one Never Event (ID147218) in August 2025 of a retained swab during varicose vein surgery. Further detail and learning can be found in the confidential quality report.

PATIENT SAFETY ALERTS

The Patient Safety Team have circulated 9 Field Safety Alerts, and 3 internal Safety Alerts for August and September 2025.

Two national alerts have also been received.

MHRA FSN DSI/2025/005 Field Safety Notice Recall.
Profemur Cobalt Chrome Modular Neck Hip Replacements: Higher than anticipated risk of revision surgery, metal-wear effects and component fracture.

- Total of 821 patients in this cohort
    - IHC West x 105
    - IHC Central x 716
    - IHC East x 0
- Information has been shared with relevant stake holders to coordinate response which is recommended to invite all identified patients to attend a clinical review. All affected stock now quarantined

PSA019 - Harm from delayed administration of Rasbricase for tumour lysis syndrome.
Action to review and update guidelines to align with the updated British Society for Haematology (BSH) guidelines and local clinical procedures. Compliance due 28/02/2026.

Pharmacy alerts
There were 6 pharmacy notifications received from Welsh Government.
All alerts were actioned and closed by each site within the specified time.

SAFEGUARDING

1. Safeguarding and Public protection Training Compliance Q2 2025-2026

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

Training is delivered utilising a variety of platforms and materials to support learning and the implementation of safeguarding in all areas.

Quality monitoring and assurance of compliance is also a key consideration and is monitored by audit activities and the findings from Single Unified Safeguarding Reviews

(SUSR's) as training data alone does not evidence the understanding or the application of the training.

Table 1: Jun 25 – September 25

Safeguarding Module	Jun-25	Sep-25	Trajectory
MCA – Level 1	85.9%	85.7%	↓
MCA – Level 2	84.9%	84.7%	↓
Safeguarding Adults – Level 1	88.6%	88.3%	↓
Safeguarding Adults – Level 2	87.6%	86.1%	↓
Safeguarding Children – Level 1	88.9%	89.0%	↑
Safeguarding Children – Level 2	87.8%	88.2%	↑
Safeguarding Children – Level 3	55.4%	60.0%	↑
VAWDASV	78.6%	79.2%	↑

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. The data will be added to the compliance dashboard in due course.

Five Health Economies met or exceeded KPI benchmarks in six out of eight safeguarding modules.

Improvement will be monitored through a structured governance framework that ensures accountability and transparency. All actions identified through audits, reviews, or assurance processes will be assigned clear timescales and responsible leads. Monitoring will occur at multiple levels:

2. 2025 Safeguarding Week

The National Safeguarding Week 2025 will start on Monday, 10th November 2025, with a series of additional events and learning sessions organised in partnership with the North Wales Safeguarding Board.

Key highlights include:

- **Mental Capacity Act 2005 Session (via MS Teams:)** – Exploring when and how capacity assessments should be conducted, using case law and practice reviews.
- **Signs & Indicators of Child Sexual Abuse (Online):** – Guidance on recognising signs and using templates to build a picture of concerns.
- **Safeguarding & Public Protection Poster competition**: Open to all BCUHB IHC's and is a way to encourage creativity and reinforce safeguarding and public protection messages in an accessible and impactful way.
- **Application of Child Sexual Exploitation Risk Questions in Practice:** To strengthen practitioners' ability to identify, assess, and respond to indicators of Child Sexual Exploitation through structured risk questions.

- **Q&A with Independent Reviewing Officers:** Wrexham Local Authority.

3. **Babies Cry, 'I can cope' (ICON)**

In February 2025, the North Wales Safeguarding Board agreed to provide the funding for BCUHB to implement the ICON programme.

ICON is a research-based programme that has been widely implemented in England and Scotland and recommended as best practice in the National Review of Non-Accidental Injury in under 1's. BCUHB will be the first health board in Wales to implement ICON.

ICON is a multi-disciplinary Abusive Head Trauma prevention programme, that aims to support parents and carers in understanding infant crying and managing associated stress, and helping to reduce the risk of abusive head trauma. This is co-ordinated to fit into mainstream service delivery, sharing a simple message during a series of core 'touch points';

- **I** – Infant crying is normal and will stop
- **C** – Comfort methods can sometimes soothe your baby
- **O** – It's OK to walk away for a few minutes if your baby is safe and the crying feels too much
- **N** – Never shake or hurt a baby

Implementation

The launch will take place during Safeguarding Week and the aim is all parent/carers of babies discharged from inpatient Maternity, Neonatal, and Home Birth settings will receive the ICON message through the following core touchpoints:

- Prior to going home from hospital with baby/before the midwife leaves following a home birth (also, when a baby is discharged home from the North Wales Neonatal Units with specific information provided around these babies)
- Within 10 days at home by a Community Midwife
- 10–14 days during the Initial Health Visitor visit
- 3 weeks via a Health Visitor
- 6–8 weeks via a Health Visitor

ICON information and the ICON Crying Plan will be included in the Personal Child Health Record (PCHR – red book) and parent/carers will be signposted to this during the core touchpoints.

Quality and Governance

Phase 2 will commence after the initial implementation and completion of an audit and mid-point evaluation. A further ICON launch will involve the wider paediatric, primary care and multiagency settings.

4. Minister for Children and Social Care

Welsh Government Safeguarding Board Governance and Accountability Arrangements Review.

'Safeguarding people from abuse, neglect, and other forms of harm is a continually evolving area of practice. To ensure our systems remain effective, responsive, and focused on achieving the best outcomes, it is essential that they are subject to regular review and remain fit for purpose'.

In line with this commitment, the Welsh Government are undertaking a review of the current accountability and governance arrangements.

This review will examine:

- The roles and responsibilities of the National Independent Safeguarding Board and Regional Safeguarding Boards.
- The interface between these bodies and the inspectorates relevant to constituent partner agencies.
- The overall effectiveness of these arrangements in protecting people from harm.

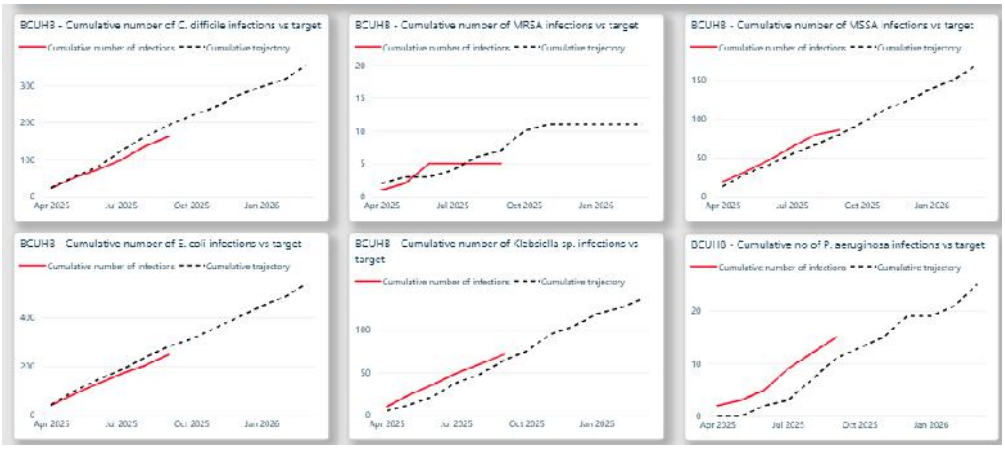
BCUHB Safeguarding and Public Protection Team members, as key stakeholders will be engaged to ensure WG achieve their aims.

INFECTION PREVENTION AND CONTROL

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 several key areas, aiming to reduce the overall number of healthcare-associated infections across both community and hospital settings. As of the end of September 2025, the following changes have been reported:

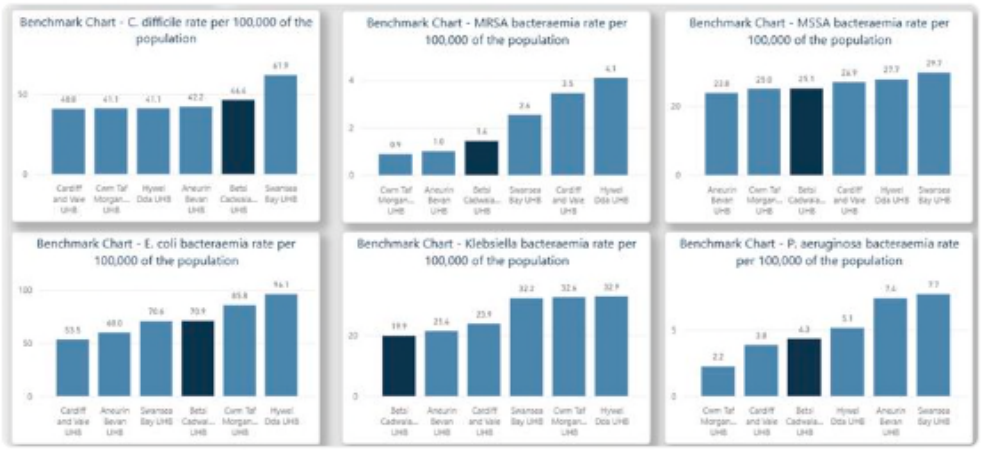
- *Clostridioides difficile* (C. diff): 31 fewer cases (no specific goal set for overall numbers)
- Methicillin-resistant *Staphylococcus aureus* (MRSA): 0 more case (no specific goal set for overall numbers)
- Methicillin -sensitive *Staphylococcus aureus* (MSSA): 6 more cases (no specific goal set for overall numbers)
- Escherichia coli (E. coli): 34 fewer cases (aligned with Goal 1)
- Klebsiella spp.: 7 more cases (aligned with Goal 2)
- Pseudomonas aeruginosa: 4 more cases (aligned with Goal 3).



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

- 1St for Klebsiella
- 3rd. for MRSA, MSSA, Pseudomonas
- 4th for E. coli
- 5th for C. diff

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



As of the end of September 2025, Betsi Cadwaladr University Health Board (BCUHB) has demonstrated positive progress in reducing community onset infections when compared to the same period in 2024/2025 for C. difficile infections, reporting at 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	15.82	29.97	-14.15
Jul	27.22	44.36	-17.14
Aug	25.52	32.42	-6.89
Sep	26.37	28.21	-1.84
Total	**22.48**	**32.66**	**-10.18**

Additionally, for Staphylococcus aureus (combined MRSA/MSSA), BCUHB reported a rate below the improvement goal of fewer than 25 cases per 100,000 population (Goal 10)

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 ↓
Aug	13.61	20.47	-6.86 ↓
Sep	10.55	17.63	-7.08 ↓
Total	**18.45**	**19.65**	**-1.21 ↓**

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

- 83 HO cases of C. diff – 19 cases over the 20% reduction (goal 7)
- 60 HO cases of E. coli – 4 cases over the 10% reduction (goal 2)
- 24 HO cases of Klebsiella – 7 cases over the 20% reduction (goal 6)
- 3 HO case of MRSA – 2 cases over fewer infections (goal 9)
- 25 HO cases of MSSA - 8 cases over fewer infections (goal 9)
- 3 HO case of Pseudomonas – 1 case 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	83	79	4 ↑	64	19 ↑
E.Coli	60	62	-2 ↓	56	4 ↑
Klebsiella	24	22	2 ↑	17	7 ↑
MRSA	3	1	2 ↑	1	2 ↑
MSSA	25	17	8 ↑	17	8 ↑
Pseudomonas aeruginosa	3	2	1 ↑	2	1 ↑
Total	**198**	**183**	**15 ↑**	**157**	**41 ↑**

Outbreaks

During August and September there has been an increase in the number of outbreaks reported due to C. diff, particularly in the East IHC with 15 outbreaks reported in total, these have resulted in 413 bed days lost due to C.diff.

Organism	**No. of outbreaks August**	**No. of outbreaks Sept**	**Total no. of bed days lost**
Norovirus	1	0	0
COVID	3	7	16
Flu	0	1	6
CPE	0	0	0
C.diff	11	4	413
AMR E. coli	0	0	0
MRSA	0	2	0
Total	**15**	**14**	**429**

The outbreaks are being driven largely by toxin negative cases, however this is increasing the bioburden of C. diff spores throughout the environment and therefore increasing the risk of transmission of infection to patients with identical genome sequencing now confirming numerous transmission episodes.

Contributory factors identified are:

- Delayed isolation due to limited availability or inability to step patients no longer requiring isolation out of single rooms
- Inability to perform enhanced cleans on wards where patients with C. diff are being managed
- Inability to perform full ward High Level Disinfection (HLD) due to the lack of decant facilities and/or ineffective HLD technology
- Inability to perform prompt bay to bay HLD due to the inability to ring fence an empty bay

The Infection Prevention Team (IPT) have continued 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 Level 2 *C. diff* outbreak is being managed through an Outbreak Control Group which meets twice weekly
- Staff from BCUHB attended the *C. diff* collaborative in Cardiff on 7th October 2025
- HABITS continues with prompt isolation and associated practices the focus
- A programme of proactive IPT training activity has been developed including single room assessment training
- A cohorting solution in the WMH is currently being explored to provide a medium-term resolution to address delayed isolation and segregation of patients with C. diff
- The 3 IHCs are exploring the ability to 'ring fence' a six bedded decant bay to facilitate prompt HLD 7 days a week in the absence of a full ward decant area.
- Priorities for Targeted Estates Funding are being considered with a plan to make available the most effective HLD technology and to standardise across BCUHB
- The Urinary catheterisation (adults) protocol has now been approved and will be launched imminently

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. diff* 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
- Cohorting Solutions: Actively exploring cohorting solutions for C. diff, as recommended by IP, 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

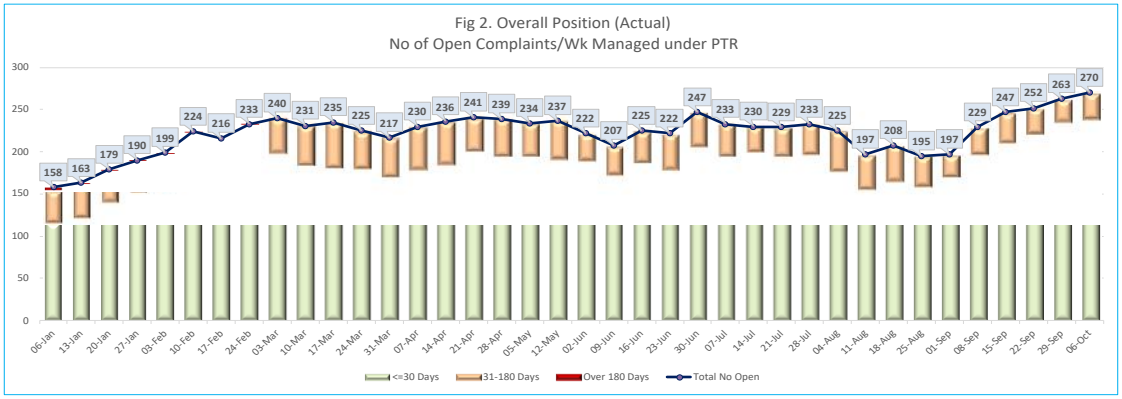
No other patient safety concerns and improvements to report.

PATIENT EXPERIENCE

COMPLAINTS

Complaint's position as of 29th September 2025

- Total Number of open complaints = 270 (an increase from 225 in the previous reporting period)
- Number of Complaints Less than 30 working days = 238 (An increase from 177 from previous reporting period)
- Number of Complaints overdue = 32 (a decrease from 48 from the previous reporting period)
- Compliance with 75% target of overdue complaints = 88.15% (an increase from 78.67% % in the previous reporting period, and above 75% target)

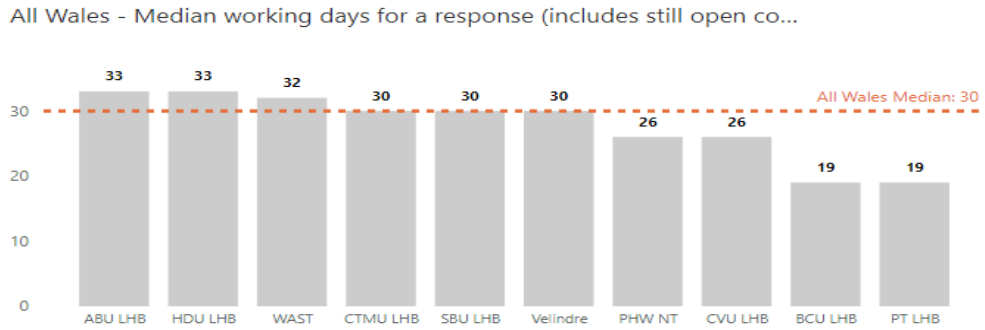


Compliance Breakdown by IHC / Service as of w/c 29TH September 2025

IHC/Service	Compliant <=30 Days	>30 Days	Grand Total
BCUHB	**88.15%**	**11.85%**	**100.00%**
Cancer Services	100.00%	0.00%	100.00%
Corporate Services	53.85%	46.15%	100.00%
Dentistry	50.00%	50.00%	100.00%
Diagnostics and Specialist Clinical Support Services	57.14%	42.86%	100.00%
IHC Central	86.36%	13.64%	100.00%
IHC East	93.90%	6.10%	100.00%
IHC West	93.33%	6.67%	100.00%
Mental Health and Learning Disabilities	100.00%	0.00%	100.00%
Midwifery and Women's Services	90.48%	9.52%	100.00%

Average complaint closure time

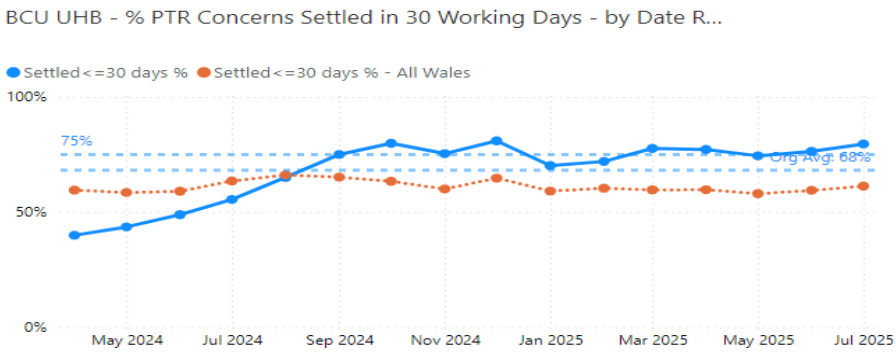
Nationally, since 1st April 2025 we are resolving complaints in 19 working days, the joint best performing health board in Wales



Real Time performance complaint closure performance (National Beacon Dashboard)

The latest update is up to July 2025, with the National Beacon dashboard, where we have performed better than the Welsh National average since September 2024, with organisational average 77% over this time frame

Light blue line = BCUHB / Orange Line = Welsh National Average



Complaint themes

The top 6 high level themes of complaints are, as follows

- Clinical treatment/assessment
- Communication issues
- Patient care
- Attitude and behaviour
- Discharge issues
- Appointments
- Access to services

Theme Analysis

Clinical Treatment and Assessment is the current predominant theme within complaints received. The main theme identified within the category is waiting times.

111 of the complaints open on the 29*th* September 2025 (270 open) relate to Clinical Treatment and Assessment, with 63 complaints received relating to delay/lack of treatment and assessment. 29 complaints received were in relation to incorrect/insufficient treatment and assessment with no rea identified as a key theme, the complaints relate to varying services.

Of the overall 270 complaints open, 116 of those complaints received relate to access to services and delays in clinical treatment and assessment. This equates to 42.96% of the overall open complaints.

PATIENT FEEDBACK

Patient Advice and Liaison Service (PALS)

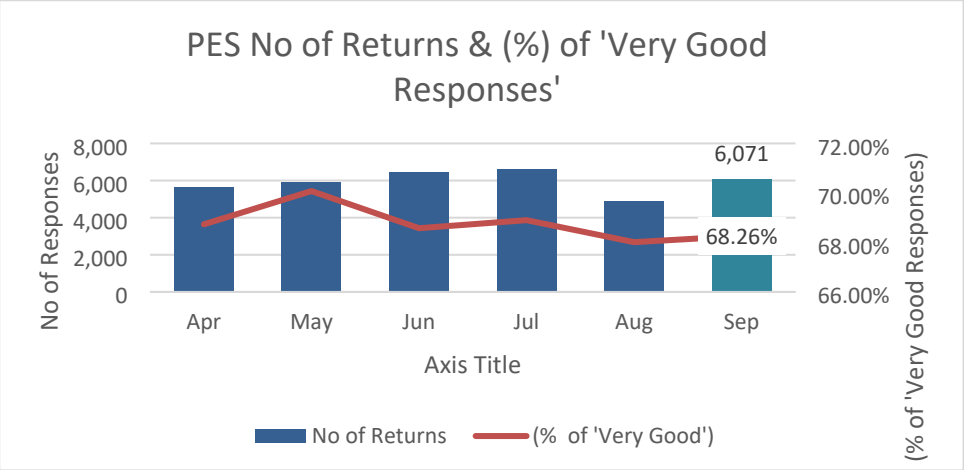
From 1 August 2025 – 30 September 2025, the Patient Advice and Liaison Service (PALS) facilitated the resolution of 1321 enquiries, received 100 compliments in writing and 4 suggestions for improvement. As of 30 September 2025, PALS took on average 5.74 working days to resolve an enquiry (Target 10 Days)

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

- Appointments
- Clinical treatment or assessment
- Communication

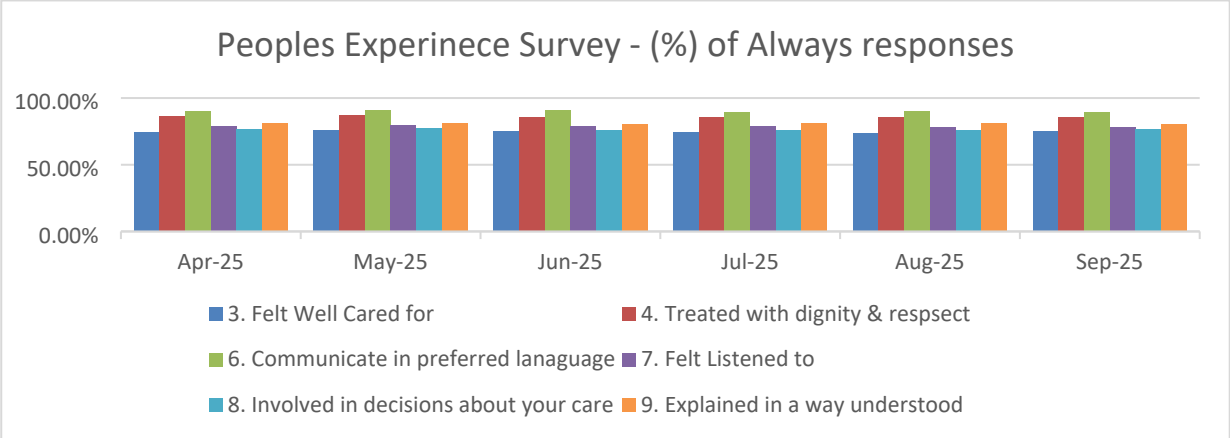
Patient Feedback

From 1 August 2025 – 30 September 2025, 11001 All Wales People's Experience Survey (PES) responses were received via Civica feedback system. 96.72% of respondents shared their experience of accessing services "in the last week/up to a month ago". On average within the reporting period respondents rated their overall experience of accessing Health Board services as 'very good' at 67.66%.



Overall, respondents provided positive feedback in relation with the length of time they waited to access a Health Board service, with 29.56% sharing they waited "about right", 10.35% waiting "a bit shorter than expected" and 32.04% waiting "much shorter than expected".

Overall, 85.38% of people reported always being treated with dignity and respect and 90.18% of people being reported 'always' able to communicate in their preferred language including; Welsh, English, Polish, Romanian, Panjabi, Urdu, BSL, Romanian, Italian, Bengali and Portuguese. These two new survey questions exceed the NHS Wales satisfaction benchmark score of 85%.



What people said was good about their experience:

- *"Appointments were well organised, and I always got two text reminders which were helpful. Treatment by the plaster technicians was excellent, they were friendly, caring, and knowledgeable and made me feel at ease with the treatment and explained everything very clearly" (Ysbyty Glan Clwyd, Main Outpatients).*

- *"I was an emergency admission, my treatment started very quickly. Impressive co-ordination between several specialist teams, nursing staff couldn't have been more helpful or supportive. Overall, my bad situation was dealt with in the best possible way" (Ysbyty Gwynedd, Emergency Department).*

- *"The attention and care from the ambulance to the A and E to the Ffrancon Ward and the theatre was exceptional. There are no words to express how thankful I am to the paramedics, doctors, nurses, healthcare assistants, cleaning staff, cooks, anaesthetist. Everyone was patient and kind, respectful and an absolute STAR! Thank you, a thousand times!" (Ysbyty Glan Clwyd).*

- *"Excellent treatment from wonderful staff. From booking in lady to nurses and radiographer. All lovely and professional people. My injuries were dealt with very quickly. I left hospital with spare dressing and self-care leaflet. One word sums up my visit. EXCELLENT. Big thankyou to all". (Wrexham Maelor Hospital, Emergency Department).*

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. From 1 August 2025 to 30 September 2025, 74 surveys were completed with 68.12% of respondents rating their overall experience of accessing Health Board services as 'very good'.

Key findings:

- 92.28% of respondents were treated well 'all of the time'
- 85.92% of respondents felt everything was explained well so they could understand 'all of the time'
- 79.17% of respondents felt looked after 'all of the time'
- 84.29% of respondents felt listened to 'all of the time'
- 91.55% of respondents said they could use their language to communicate when we gave care 'all of the time'. Languages included English, Welsh, Romanian and Polish
- 81.43% of respondents were involved in decision making about their care 'all of the time'

Patient Communication and Information

The Health Board has a duty to provide quality information, whilst adhering to statutory legislation when producing any form of patient information whether it be verbal or written. The Patient Information Readers Panel continues to meet monthly to review patient information leaflets. Within the reporting period 8 patient information leaflets were reviewed by the Readers Panel.

Below are examples of leaflets approved at Readers Panel:

- Maternity Services Patient Information – Low Dose Aspirin in Pregnancy.
- Maternity Services Patient Information – Low Dose Aspirin in Pregnancy (Easy Read).
- Changes to prescribing of pen needles for injectable diabetes medicines.
- Information for patients having an Ultrasound of the Breast, Chest, and Axilla (armpit).
- Information for patients having a biopsy of the breast.

SWAN Model for End of Life and Bereavement Care

The Macmillan SWAN Specialist Bereavement Nurses have been engaging with third sector organisations, staff, patients, and families to capture feedback to understand how the Health Board can improve end of life experiences. In total 118 feedback responses were received collected from a variety of sources including, surveys, patient/family stories, compliments, staff forum's, analysis of PALS, Complaints and Civica feedback data.

Analysis of feedback identified 6 key themes staff, and the public felt were important in improving end of life experiences. These include:

1. Communication with families and patients
2. Recognition of dying and decision making
3. Bereavement support and follow-up
4. Symptom control & anticipatory medicines
5. Environment & facilities
6. Training & education

This feedback will be used to help inform the implementation of the SWAN Model of Care.

Chaplain & Spiritual Care Service

From 1 August 2025 to 30 September 2025, the Chaplain and Spiritual Care Service responded to 149 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.

Multi-faith events were attended across North Wales fostering inclusivity and support for individuals from diverse religious backgrounds. Imam Khan represented the Health Board at the Eisteddfod 2025, where he led Friday prayers for the Muslim community and participated in a media discussion on spiritual care. Iman Khan also appeared on the Welsh television programme "Pawb ar Farn", contributing to a segment focused on Chaplaincy and Spiritual Care, helping to raise awareness of the service's role within healthcare.

A collaborative art project in currently ongoing with North Wales Adolescent Service (NWAS) in Abergele, creating a spirituality-themed wall hanging with young people. Over a four-week period staff from the Chaplain and Spiritual Care Team have been visiting NWAS engaging with staff and young people to co-create a wall hanging that reflects young people's views and beliefs about spirituality. The artwork, made from various materials, will be displayed in

the Multi Faith Room, and is expected to be completed by Christmas 2025 fostering inclusivity and support for individuals from diverse religious backgrounds.

OTHER PATIENT EXPERIENCE CONCERNS AND IMPROVEMENTS

Nil to report

CLINICAL EFFECTIVENESS

CLINICAL AUDIT

Clinical Audit Performance

13 Tier 1 national clinical audits were published within Quarter 2, with 1 reported and details noted below and 12 scheduled for Quarter 3 reporting.

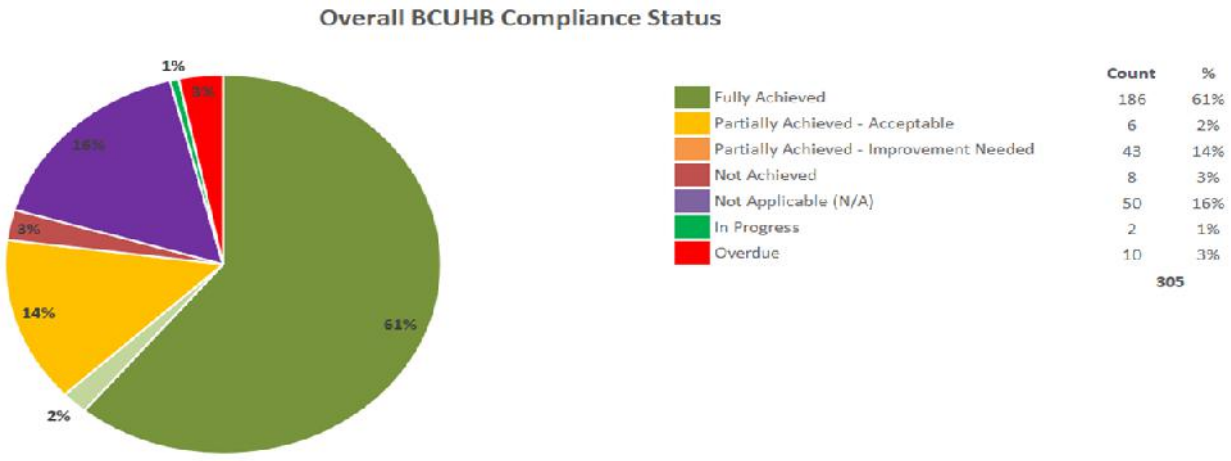
				West	Central	East	
Title of National Audit	Name of report	Date of publication	Date Service Assessment response due	Service Assessment Completed	Service Assessment Completed	Service Assessment Completed	Key Achievements Summary
National Diabetes Foot Care Audit (NDFA)	2024 Dashboard report (2023-2024)	29-Jul-25	23-Sep-25	Yes - Draft	Yes - Draft	Yes - Draft	Good ascertainment rates in Central & East, with actions in place to improve this is the West. Good performance against key indicators, although varied across the three areas. The audit findings and learning from these are discussed via regular meetings with relevant staff

NICE GUIDELINES

NICE Guidelines Compliance - Significant Improvement

- Improved compliance with NICE guidance with proactive support and training provided to departments.
- Outstanding compliance rate of **97%** (only 3% overdue as of September 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

NICE Compliance Data April 2023-September 2025



MORTALITY REVIEW

Corporate Mortality Update:

- Following finalisation of the All-Wales Medical Certification of Cause of Death (MCCD) process, the Corporate Mortality team have been implementing changes and have communicated them to BCU doctors, mortality leads and bereavement teams, as well as updating the mortality intranet page. The BCU provisional MCCD forms are also available via the 'report it' tool on the BCU intranet homepage, and via a QR code link in the below posters. A presentation on the process was also presented by Mortality AMD's during the new doctor induction in August.

- The Grand Round focussing on Medical Certification of Cause of Death was stood down in June, due to impending changes to the final process, and stood down due to unforeseen circumstances in August. This is scheduled for 16th October 13:00-14:00 via teams. The session will be recorded to allow clinicians to listen when they can, and to increase engagement, noted as **Appendix 1.**

- September Mortality learning lesson of the month: Late diagnosis of Pulmonary Embolism noted as **Appendix 2.**

- Potential Next of Kin Family Concerns are captured as Quarterly Data from Medical Examiner Scrutiny Reviews Engagement with the Medical Examiner Service ongoing, which supports continuous learning and quality improvement.

- Engagement with the Medical Examiner Service ongoing, which supports continuous learning and quality improvement.

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

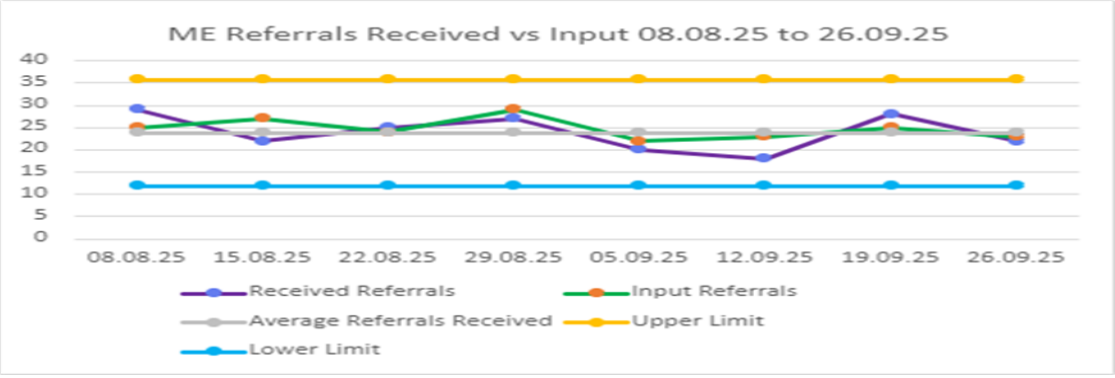
For info: *New Within 2 weeks and & over date received into the Health Board from the MES

MES = Medical Examiner Service. DOD = Date of Death IHC = Integrated Health Community. S&S= Sieve and Sort process recognising if the case needs to be sent to relevant departments or whether the issues/learning is included in another PTR process, in which case the mortality review can be closed.

Date	Input/Output			Backlog				Datix Status										
	Total received per week*	Total input per week	Output Differential	Total w/e Backlog inc compliments	Backlog of cases requiring inputting within 2 weeks from date received by MES	Backlog of cases requiring inputting within 3 weeks from date received by MES	Backlog of cases requiring inputting within 4 weeks and over from date received by MES	Total New cases (awaiting mortality admin s&s)	New Under 2 weeks from date received by MES (awaiting mortality admin s&s)	New Within 3 weeks from date received by MES (awaiting mortality admin s&s)	New Within 4 weeks and over from date received by MES (awaiting mortality admin s&s)	Total Pending Cases awaiting Mortality Clinician Review S&S	Pending Cases Under 2 weeks awaiting Mortality Clinician Review S&S	Pending Cases Within 3 weeks awaiting Mortality Clinician Review S&S	Pending Cases Within 4 weeks awaiting Mortality Clinician Review S&S	Pending scrutiny panel (with IHC's)	Under investigation / action required (with IHC's)	Process completed
08.08.25	29	25	-4	8	8	0	0	5	5	0	0	9	9	0	0	970	169	4151
15.08.25	22	27	5	3	2	1	0	2	2	0	0	12	12	0	0	934	160	4222
22.08.25	25	24	-1	5	5	0	0	7	7	0	0	7	7	0	0	932	160	4247
29.08.25	27	29	2	7	7	0	0	12	12	0	0	16	16	0	0	924	157	4272
05.09.25	20	22	2	7	7	0	0	7	7	0	0	11	11	0	0	847	140	4396
12.09.25	18	23	5	2	2	0	0	12	12	0	0	4	4	0	0	828	140	4437
19.09.25	28	25	-3	5	5	0	0	0	0	0	0	10	10	0	0	789	136	4518
26.09.25	22	23	1	3	3	0	0	6	6	0	0	1	1	0	0	757	136	4589

NEW REVISED RAG Rating Key = Red, Amber, Green and is a form of report where measurable information is classified by colour	
Input/Output	Red = when total output of cases input into Datix is lower than total cases received from Medical Examiner Service per week
	Amber = when total output of cases input into Datix is equal to the total cases received from Medical Examiner Service per week
	Green = when total output of cases input into Datix is more than total cases received from Medical Examiner Service per week
Inputting Backlog	Red = cases within 4 weeks and over from date received by MES that require inputting
	Amber = cases within 3 weeks from date received by MES that require inputting
	Green = cases under 2 weeks and over from date received by MES that require inputting
Datix Status	Red = cases within 4 weeks and over from date received by MES that require corporate mortality/IHC/service review
	Amber = cases within 3 weeks from date received by MES that require corporate mortality/IHC/service review
	Green = cases within 2 weeks from date received by MES that require corporate mortality/IHC/service review

Corporate Mortality Update:



OTHER CLINICAL EFFECTIVENESS CONCERNS AND IMPROVEMENTS

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 97% compliance rate for NICE guidelines represents a significant achievement in clinical standardisation, with continued work from the team engaging with IHCs and Divisions to support them through the process. There is a structured approach to mortality reviews and learning dissemination which enhances patient safety culture across BCUHB.

Operational Excellence

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

QUALITY ASSURANCE

HEALTHCARE INSPECTORATE WALES

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales who inspect NHS services and regulate independent healthcare providers against a range of standards, policies, guidance and regulations to highlight areas requiring improvement. HIW also monitor the use of the Mental Health Act and review the mental health services to ensure that vulnerable people receive good quality of care in mental health services.

Published Reports (0)

There are no published reports for this period.

Announced/Unannounced Inspections (1)

HIW undertook an inspection at Hergest Ward, Ysbyty Gwynedd, from the 8th to the 10th of September 2025. No immediate assurances were issued. The Health Board awaits the improvement plan and draft inspection report from HIW.

Concerns / Requests for Assurance (2)

Emergency Department at Wrexham Maelor, IHC East

Healthcare Inspectorate Wales have raised concerns in September 2025.
The health board issued a response to HIW on 16th September 2025 to confirm:

- Staffing levels were fully established across medical and nursing teams.
- Reinforced patient confidentiality protocols have been undertaken with staff.
- Dynamic risk assessments are maintained and prioritised patients with greatest clinical need.
- Allocated staff are in place to monitor patients outside cubicles and escalate concerns.
- Commitment to improving patient communication during periods of extreme demand.

These actions aim to ensure safe care delivery and mitigate future risks under high-pressure conditions.

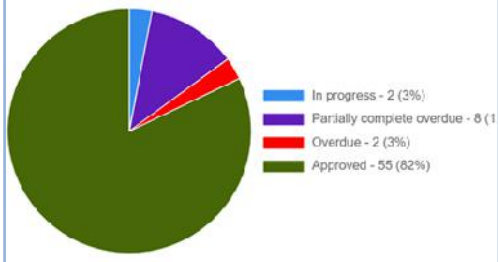
Hergest Ward, Ysbyty Gwynedd, Mental Health and Learning Disabilities

Healthcare Inspectorate Wales (HIW) has raised concerns following an incident involving a detained patient at the Hergest Unit. HIW is seeking assurance from the health board on clinical decision-making, risk assessment processes, and protocols for managing leave in high-risk cases. The Health Board will provide the response as requested by **03 November 2025.**

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 (1)

Service	Lead	Inspection Date	Expected Closure Date	Progress %	Overdue Actions	Action to address overdue actions
Ysbyty Gwynedd, Emergency Department	IHC Director West	14th to 16th April 2025	30th November 2025	82%	2	The two overdue actions pertain to system flow action cards and pain score/analgesia audits. These actions will be closed by the 30th of November



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).

Quality of Care Review Visit	Date	Lead	Position overview / Summary
Enhanced Community Residential Services, Mental Health and Learning Disabilities, Mold (East)	4th July 2025	Responsible Director MHLD	The visit was undertaken by the Health Boards designated Responsible Individual (Head of Quality), in line with the Regulation and Inspection of Social Care (Wales) Act 2016.

			No immediate patient safety issues were identified and recommendations have been made in relation to minor areas for improvement. The full report can be viewed here. Once the improvement plan is completed by the service, the actions will be captured on the Health Boards AMaT system for monitoring and tracking.

QUALITY PEER REVIEWS

No activity to report.

HEALTH AND SAFETY EXECUTIVE / LOCAL AUTHORITY

No activity to report.

PUBLIC SERVICES OMBUDSMAN FOR WALES

PSOW has legal powers to look into 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)

Status: Overdue
Progress Update: 8 of the actions have been completed with 1 remaining action overdue which was due 25 September 2025. The final recommendation in relation to implementing a Commissioning Assurance Framework (CAF) is overdue. The Health Board has requested an extension due to a change to the approach of the work required. The Quality team have informed the Ombudsman's Office of the reasons for the change in approach, the revised timescale and are liaising with the Ombudsman to agree a realistic deadline.

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.

Learning from the Ombudsman

The Quality Team continue to collaborate with other Local Health Boards via the NHS Wales Ombudsman Safety & Learning network, to review published reports and discuss themes for wider learning, working to 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. The Health Board also continue to meet with the Ombudsman's Office quarterly, with the next meeting scheduled for January 2026.

QUALITY DASHBOARD / QUALITY SCORE CARD

The Health Board has officially launched the Quality and Assurance Dashboard in September 2025 following a period of development and testing in 2024 with internal colleagues and stakeholders such as NHS Wales Performance and Improvement, ensuring alignment with the National Beacon Dashboard for Wales.

The dashboard is a single, easy-to-use platform where staff can access key quality related data on Patient Safety, Patient Experience, and Workforce. By turning everyday data into actionable insights, the dashboard supports proactive decision-making, risk mitigation, and improved outcomes for patients across North Wales.

So far during 2025, the Health Board has provided demonstrations of the dashboard to NHS Organisations and stakeholders across Wales.

Recent key developments include the development of a **Quality Score Card**. A Quality Scorecard is a structured tool used by healthcare organisations to monitor, report, and improve performance across key areas of care. It brings together a set of quality metrics, such as patient safety indicators, clinical outcomes, patient experience, and compliance with standards into a single, visual dashboard.

The scorecard provides a snapshot of how well the organisation is delivering safe, effective, and person-centred care. It enables leaders, clinicians, and teams to track progress, identify areas for improvement, and make informed decisions that support better outcomes. The Quality Score Card under development and will be available as part of the Quality Dashboard once approved. The score card will be utilised for future quality reporting to both the Quality Safety and Experience Committee and Board.

ORGANISATIONAL LEARNING

The Learning Repository is a pivotal digital initiative, developed in-house, to capture, validate, and share organisational learning that enhances patient safety and clinical practice.

Phase 1 of the project, focused on Pharmacy and Medicines Management as the pilot area, remains on track for delivery by December 2025. This phase will launch a live, operational repository enabling staff to submit learning, undergo local quality assurance, receive expert review from subject matter experts (SMEs), and publish validated insights via SharePoint. Notifications will be delivered through both email and Microsoft Teams to ensure timely communication and engagement.

To support the wider organisational rollout in 2026 and uphold strong governance, a dedicated Project Board has been established. The board will oversee project management, ensure strategic alignment, and maintain accountability throughout the implementation process.

HEALTHCARE LAW

CORONER AND INQUESTS

Coroners investigate all deaths where the cause is unknown, where there is reason to think the death may not be due to natural causes, or which need an inquiry for some other reason. An inquest is an inquiry held by the Coroner into the circumstances surrounding a death. The inquest does not set out who is responsible for a death. It is not the Coroner's role to determine any civil or criminal liability or to apportion blame.

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

LIABILITY CLAIMS

The Welsh Risk Pool is part of the NHS Shared Service Partnership Legal and Risk service. It provides how all Trusts and Health Authorities in Wales are able to indemnify against risk. The role of the Welsh Risk Pool is to have an integrated approach towards risk assessment, claims management, reimbursement and learning to improve. The team work with NHS colleagues across Wales to promote and facilitate opportunities to learn and support the development and implementation of improvements to enhance patient safety and outcomes.

Claims are restricted by time limits. Typically, a claim must be brought within 3 years of the alleged negligence taking place or from the point of knowledge. A minor will generally have until their 21st birthday to submit a claim. To bring a claim a claimant would need to show there was a 'breach of duty of care' and that 'causation' had taken place. All claims are brought against the Health Board and not against any individual clinicians. Clinical Negligence and Personal Injury Claims are managed by the Healthcare Law Team who work closely with Legal & Risk Services.

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. At the end of September that number had risen to 17 (with over half in one division) and continued focus remains in place with the aim of achieving a sustainable reduction during quarter three.

OTHER HEALTHCARE LITIGATION ISSUES

No further issues to report

Betsi Cadwaladr University Health Board

MCCD COMPLETION

On DAY 1 Doctors must establish and action the following:

1) If the death meets the Notification of Deaths Regulations (2019) criteria, then immediately refer to HM Coroner. If not, see options 2 and 3 below.

2) If the MCCD appears straightforward following discussion with the Consultant or GP in charge of the patient, and you are confident about the likely cause, submit the completed MCCD to the Medical Examiner Service as soon as possible.

3) Where there is a degree of uncertainty about the MCCD, please use the QR Code Microsoft Form to submit a provisional cause of death to the Medical Examiners Service (Response within 1 working day). Submit the MCCD immediately thereafter.

Government guidance for medical practitioners completing medical certificates of cause of death in England and Wales QR Code	CENTRAL AP Notification of Cause of Death to the Medical Examiner QR Code Form	Coroner Website – when is a coroner involved?

Mortality Learning Lesson of the Month

Lessons Learned Summary

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

September 2025: Late diagnosis of Pulmonary Embolism

What happened?

A 35-year-old woman presented to ED with Supraventricular Tachycardia (SVT) after presenting with breathlessness to her GP. Despite signs suggesting pulmonary embolism, the diagnosis was made when the patient was critically unstable, and despite resuscitative efforts she died following cardiac arrest. The coroner ruled the death as natural causes contributed to by neglect.

What did the Medical Examiner (ME) Scrutiny find?

The key issues identified in the case involved a combination of diagnostic and systemic failures.

Clinicians anchored on the GP's initial diagnosis of SVT, which led to a missed opportunity to consider alternative, more serious causes such as pulmonary embolism.

Critical signs on the ECG were overlooked and a haemolysed D-dimer test result was not followed up.

The subsequent coroner's inquest also highlighted lack of senior clinical oversight during the patient's deterioration, poor documentation practices, and inadequate communication with the patient and family.

How was this managed? And/or What can we learn from this death? (What are we going to change?)

Take Home Messages:

- The actions and learning from the case focused on strengthening clinical awareness and improving systemic processes.
- Targeted ED training was introduced, including ECG interpretation modules and enhanced induction for junior doctors, to address diagnostic oversight.
- Protocols were updated to reiterate the importance of comprehensive history-taking. [1]
- The ED handbook was revised to include reminders about assessing past medical history. It had not been noted that patient was on Depo-Provera. [2]
- Staffing levels were increased to support safer care.
- Additionally, VTE training compliance was escalated, with discussions underway to make it mandatory.
- The case was also identified as a valuable learning opportunity to be shared through Grand Rounds and a "Lesson of the Month" initiative to promote wider organisational learning. [3]

References:
1. PE pathway YGC.pptx (sharepoint.com)
2. Risk factors | Background information | Pulmonary embolism | CKS | NICE
3. VTE Risk Assessments (sharepoint.com)

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, 06 November 2025
Crynodeb Gweithredol: ***Executive Summary:***	This Report relates to Month 6, 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:***	Angela Wood, Executive Director of Nursing & Midwifery

Awdur yr Adroddiad: ***Report Author:***	Ed Williams, Deputy Director of Performance			
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 6)**

Report Author: **Deputy Director of Performance**

1. Introduction

The Performance 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.

Appendix 1 Integrated Quality & Performance Report for QSE Committee, Month 6 (September 2025)

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Integrated Quality & Performance Report

Reporting Period: to 30.09.2025

Presented to

Quality, Safety & Experience Committee

Thursday, 6th November 2025

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

Table of Contents

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
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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 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 August 2025 (Target 0)
- ◻ National Reportable Incidents (NRI): **7** overdue in September 2025 (Target 0)
- ❑ Learning From Events Reports (LFERs): **17** in September 2025 (Target 0)
- ◻ Clinical Coding Compliance: **93.3%** in July 2025 (above trajectory)

Finance

CRR 24-05 Financial Sustainability

Financial Position

- ❑ Year to date – Deficit versus Plan **-£15.1m**
- ◻ In-month Variance to plan **-£1.4m** (a £0.9m improvement**)**
- ◻ Full year outturn position - **Balanced Position** as per Plan

Savings Position

- ◻ Year to Date Savings Delivery including Accountancy Gains v target **£6.8m** (£3.5m more than the £3.3m target)
- ◻ Forecast Savings Delivery including Accountancy Gains v Target **£40.0m**

Capital Expenditure

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

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

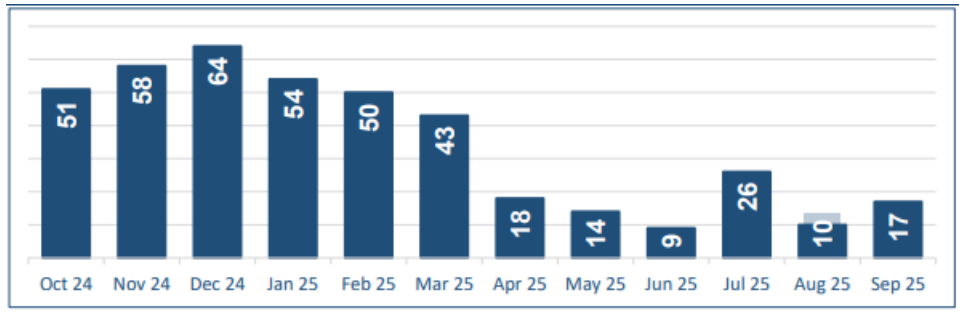
- ◻ CAMHS Part 1b Assessments within 28 Days of Referral: **53.4%** (Target 80%)
- ❑ Neurodevelopment Assessment within 26 weeks: **12.4%** (Target 95%)
- ◻ Adult Mental Health Part 1b Assessments within 28 Days of Referral: **85.1%** .....(Target 80%)
- ◻ Adult Psychological Assessment within 26 weeks: **75%** (Target 95%)
- ❑ Ambulance Handover Delays over 4 Hours: **705** (Target 0)
- ◻ Emergency Department waits over 12 Hours: **3,757** (Target 0)
- ❑ Emergency Department Waits over 24 Hours **1,959** (Target 0)
- ◻ Number of patients with Delayed Pathways of Care: **280** (Target 0)
- ◻ Percentage compliance with 62 Day Single Cancer Pathway: **57%** (Target .....75%)
- ◻ Referral to Treatment waiting over 52 weeks 1st Appointment: **19,319**
- ◻ Referral to Treatment waiting over 104 weeks: **4,525** (Target for end of Q2 ....2,800)
- ◻ Referral to Treatment waiting over 156 weeks: **266** (Target 0)
- ❑ Referral to Treatment waiting over 208 weeks: **1** (Target 0)
- ❑ Number of patients waiting over 8 weeks for Diagnostics: **18,826** (Target 0)
- ❑ Number of patients Over 100% due their clinical follow up: **101,456** (Target 0)

People & Organisational Development

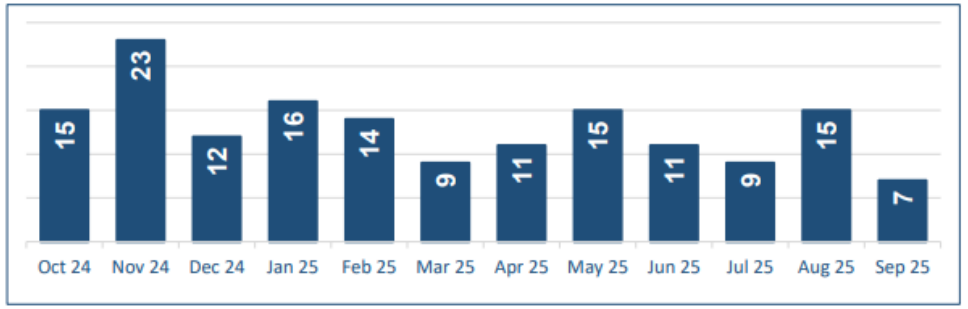
- ◻ Personal Appraisal & Development Review (PADR): **82.6%** (Target 85%)
- ❑ Sickness & Absence: **6.1%** (Target Reduce)
- ◻ Agency Spend: **3.2%** (Target Reduce)
- ❑ Staff turnover less than 1 year service: **14%** (Target Reduce)

Quality: Escalated Performance Measures

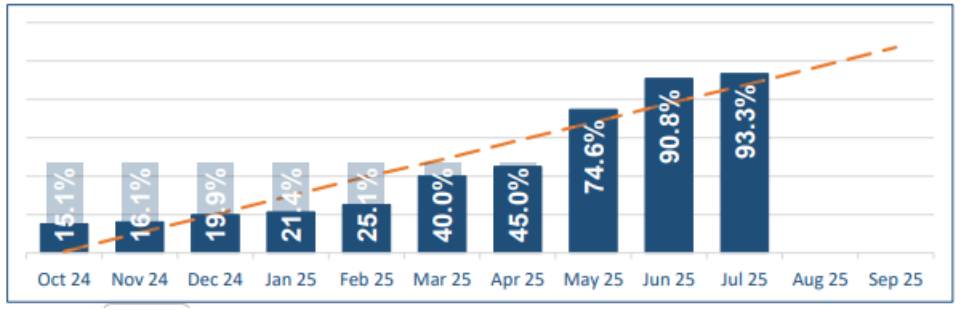
Learning form Events Reports



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, with an increase in July at 26. However, there were 17 outstanding LFERs at the end of September and more detailed information is available in the Quality Report.

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 7 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. More detailed information is available in the Quality Report.

Clinical Coding Compliance:

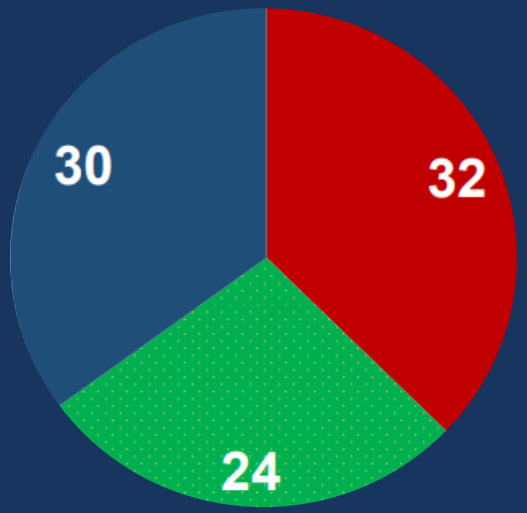
Performance against this measure has continued above trajectory and the yet to be published figures for August indicate, a sustained performance, and one of the best performing in Wales. The latest meeting of the Integrated Performance Executive Delivery Group agreed that this measure should now be de-escalated to Level 1, Standard Monitoring from here on in.

Produced on behalf of the **Quality, Safety & Experience Committee**
by the **Performance Directorate** in partnership with the **Quality Directorate**

Presented on 06.11.2025

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 Directorate in** partnership with **Health Board Directors**

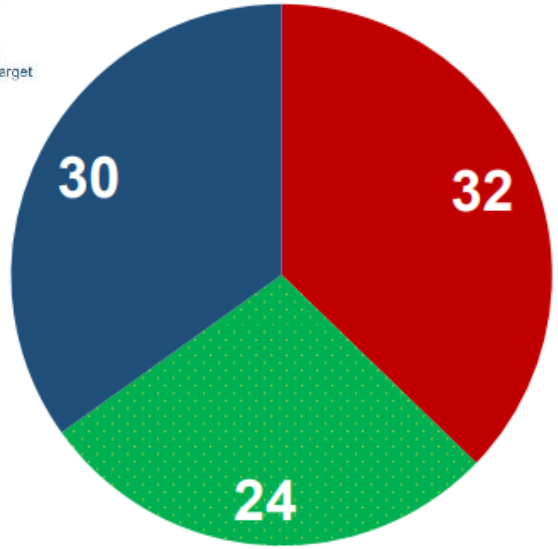
Summary of Performance to Month 12

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

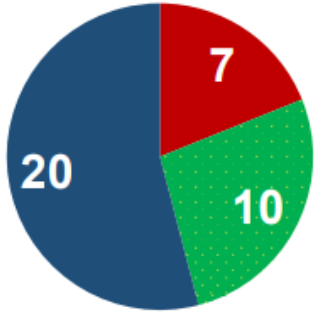
Red — The *latest available data point* indicates that performance is worse than the target

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

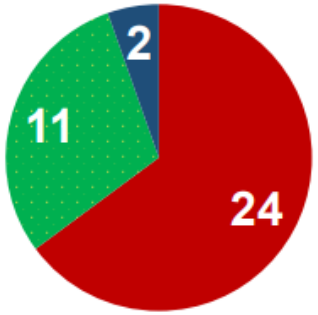
Grey — There is no / insufficient data available to rate against the target



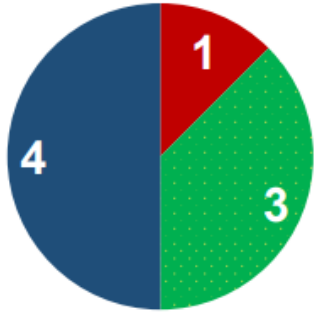
All Sections



Quality, Safety, Effectiveness & Experience Performance



Access & Activity Performance



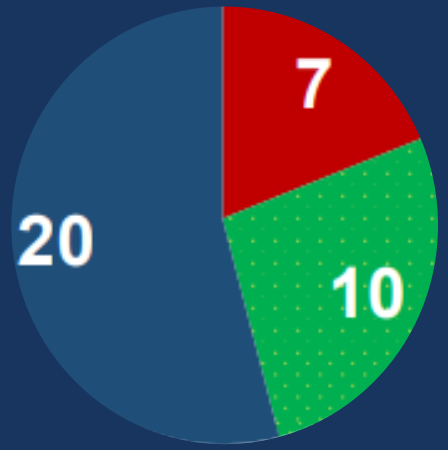
People & Organisational Development Performance

Financial Performance

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

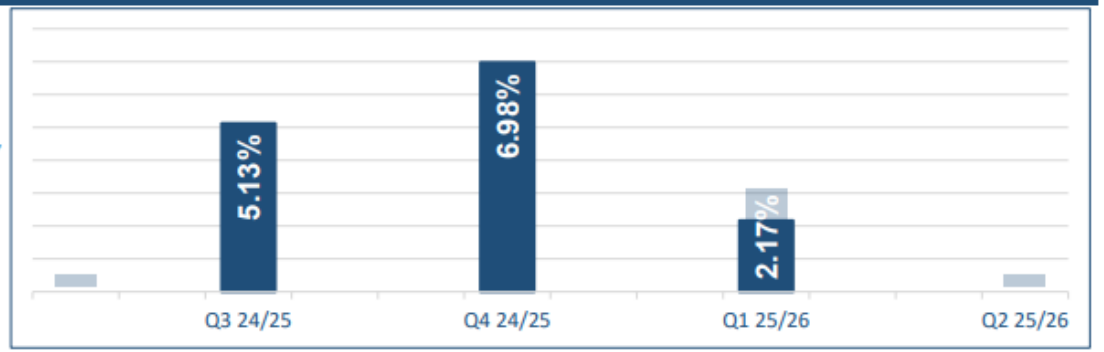
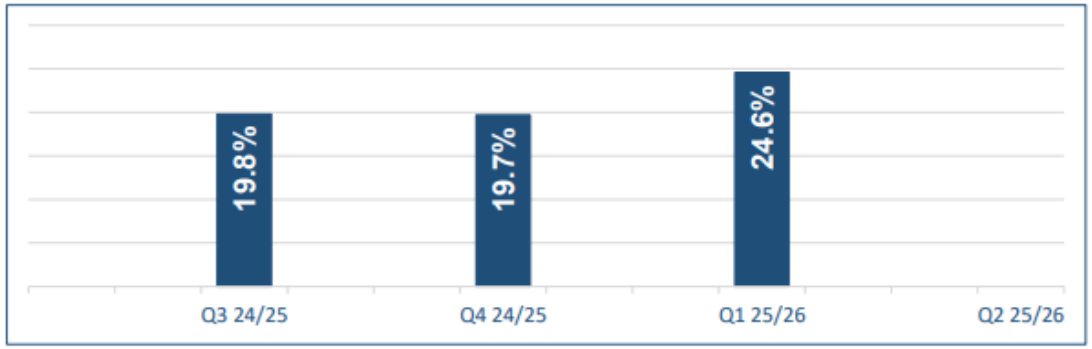
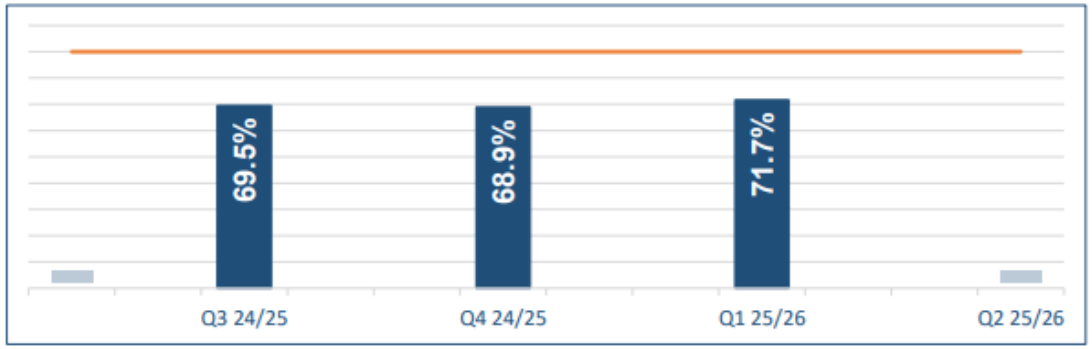
Section 1

Quality, Safety, Effectiveness and Experience Performance



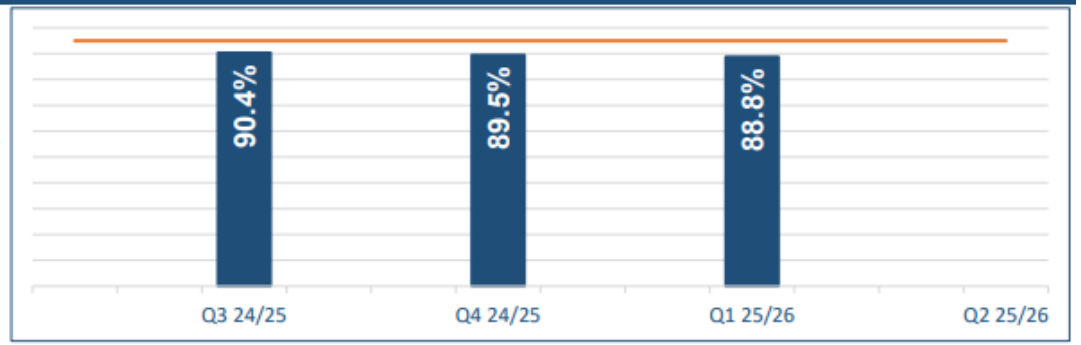
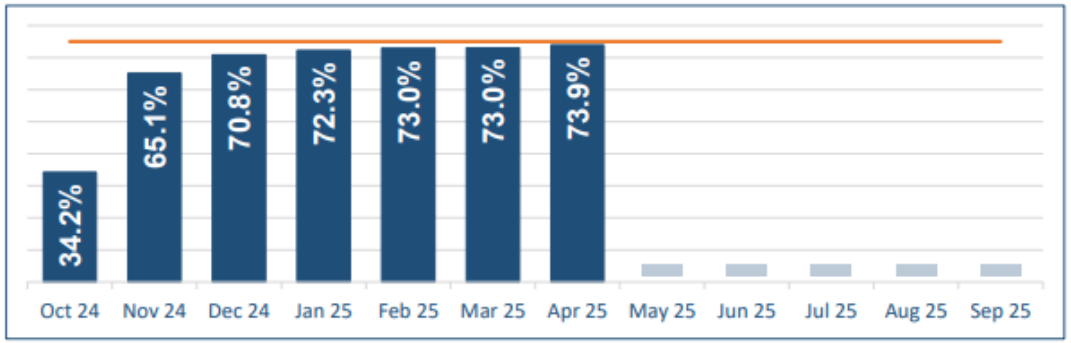
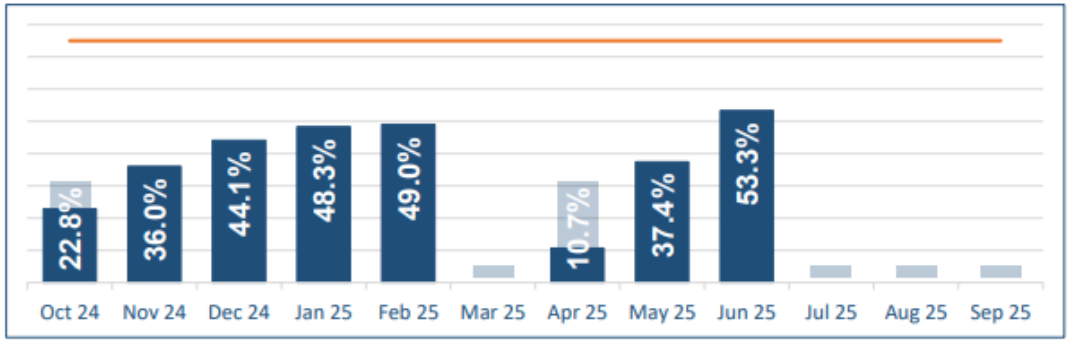
Produced on behalf of the **Quality, Safety & Experience Committee** by the **Performance Directorate i**

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	2.17%	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	24.6%	3rd of 8 (at Dec 24)	
-	QSE	Percentage of children receiving the Human Papillomavirus (HPV) vaccination by the age of 15	90%	TBC	71.7%	5th of 7 (at Mar 25)	

* Wales Ranking may differ as may refer to previous month

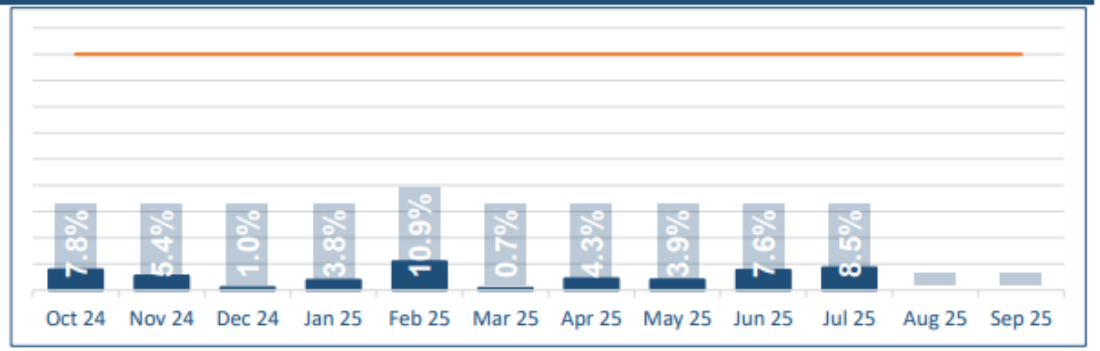
Quality: Performance

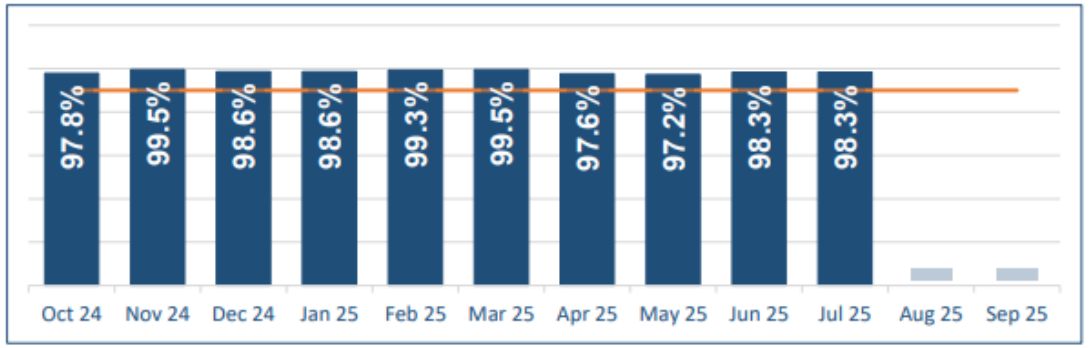
Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank	
-	QSE	Percentage of children who are up to date with the scheduled vaccinations by age 5 ('4 in 1' preschool booster, the Hib/MenC booster and the second MMR dose)	95%	TBC	88.8%	3rd of 7 (at Mar 25)	
-	QSE	Percentage uptake of the influenza 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	53.3%	5th of 7 (at Apr 25)	

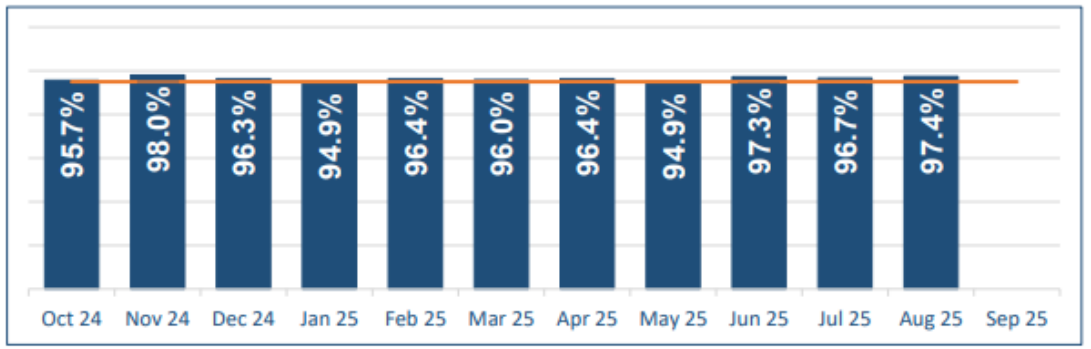
* Wales Ranking may differ as may refer to previous month

Quality: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	QSE	Percentage of patients offered an index colonoscopy procedure within 4 weeks of booking their Specialist Screening Practitioner assessment appointment	90%	TBC	8.5%	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	98.3%	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	97.4%	5th of 7 (at Apr 25)



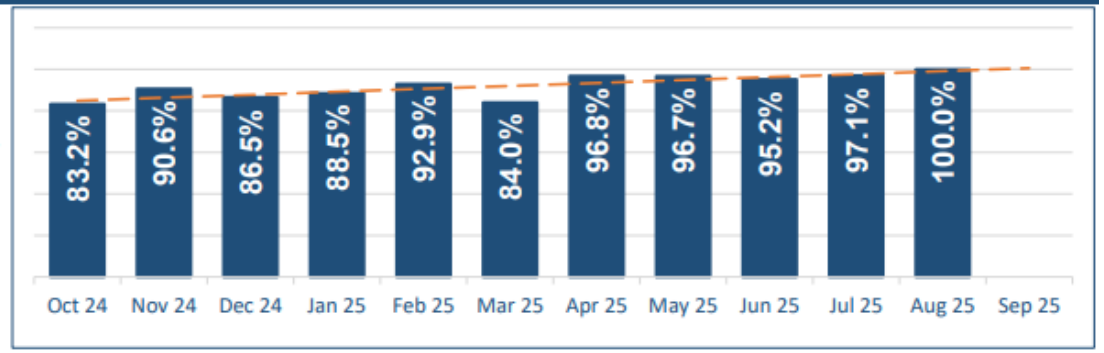


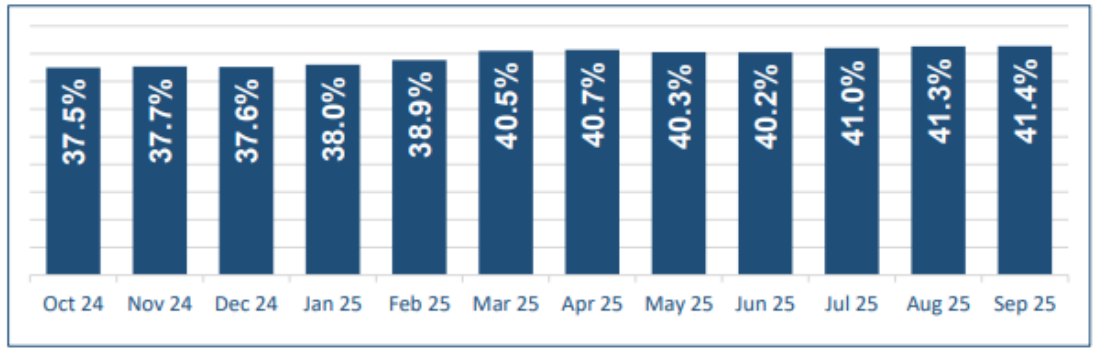


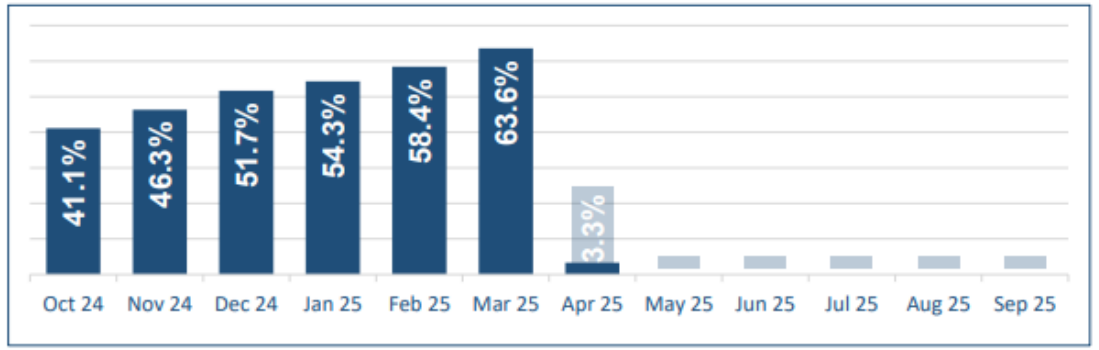
* Wales Ranking may differ as may refer to previous month

Quality: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	QSE	Percentage of people who have been referred to health board services who have completed treatment for substance misuse (drugs or alcohol)	4 qtr imp. trend	TBC	100.0%	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	41.4%	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)





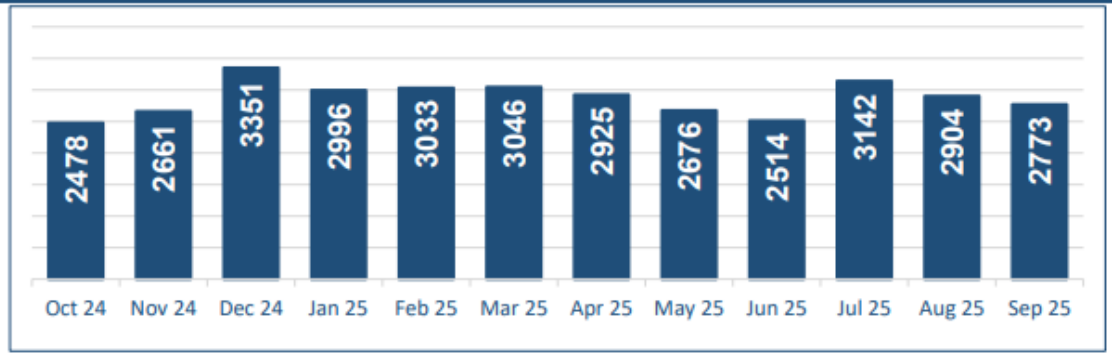


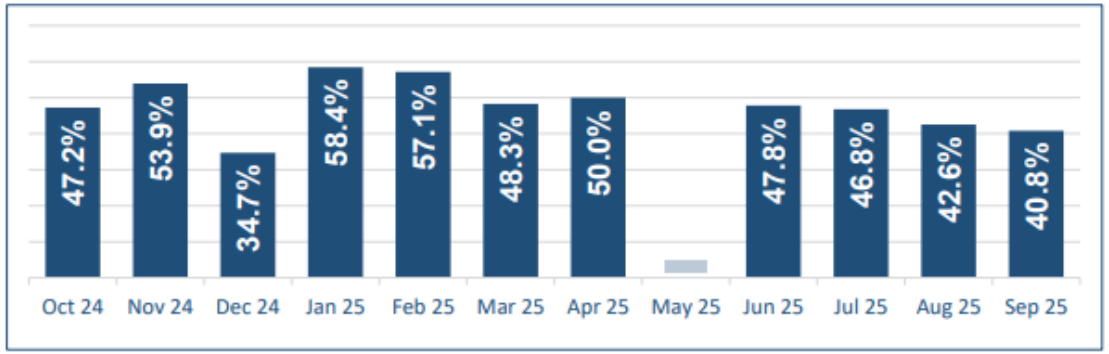
Produced on behalf of the Quality, Safety & Experience Committee by the Performance Directorate

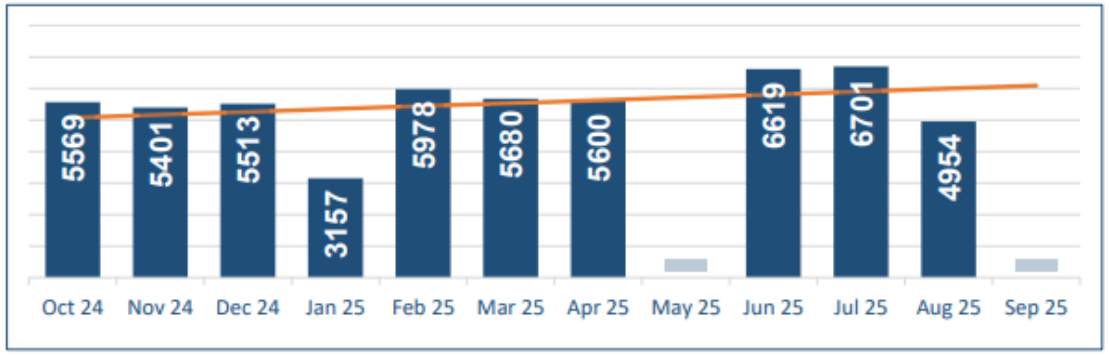
* Wales Ranking may differ as may refer to previous month

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	2773	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	40.8%	3rd of 6 (at Apr 25)
-	QSE	Number of service user feedback experience responses completed and recorded on CIVICA	Increas-ing trend	TBC	4954	2nd of 10 (at Apr 25)



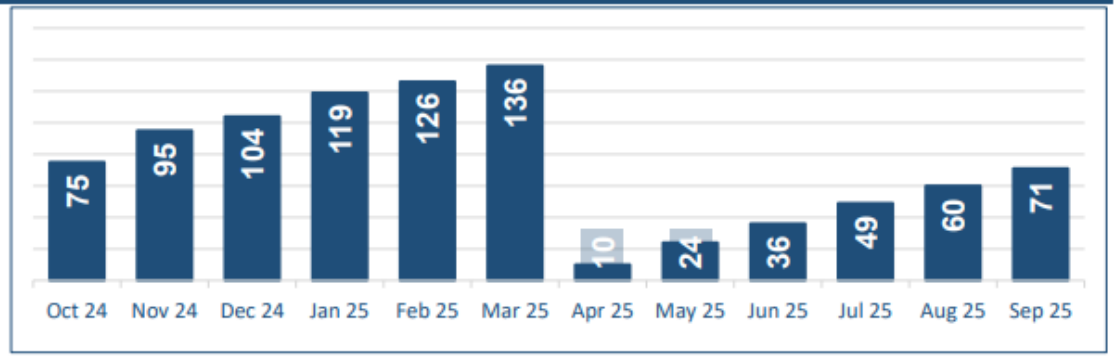


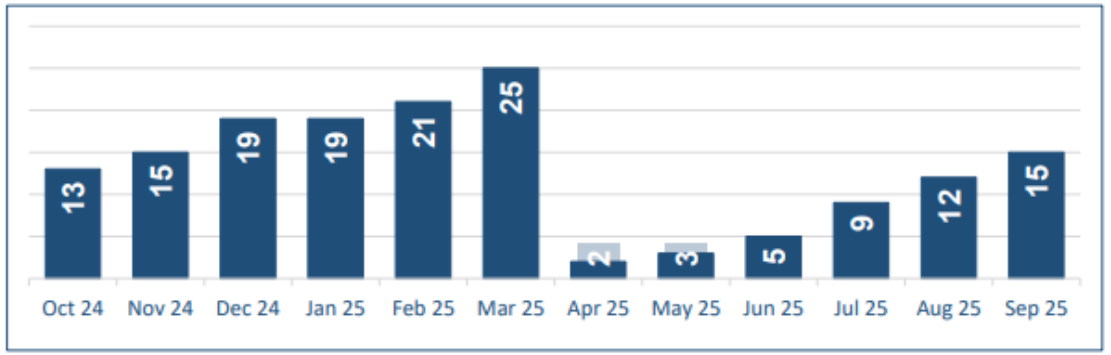


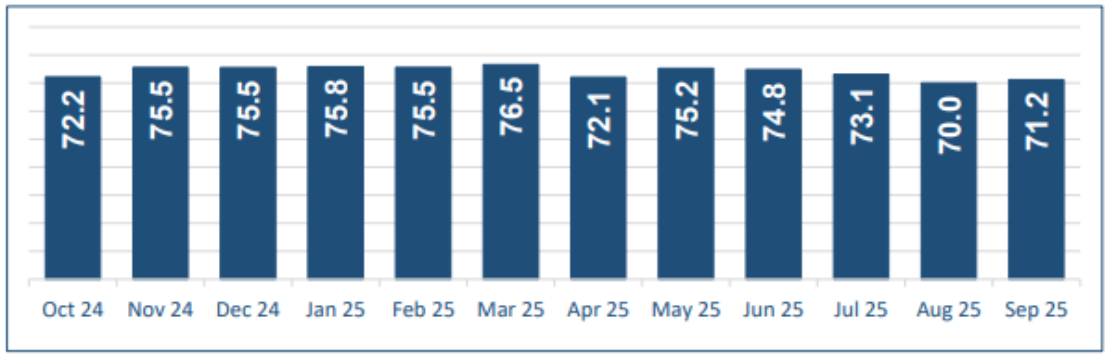
* Wales Ranking may differ as may refer to previous month

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	71	4th of 6 (at Apr 25)
CRR: 24-04	QSE	The cumulative number of laboratory confirmed Pseudomonas Aeruginosa in reporting month	27	TBC	15	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	71.2	4th of 6 (at Apr 25)



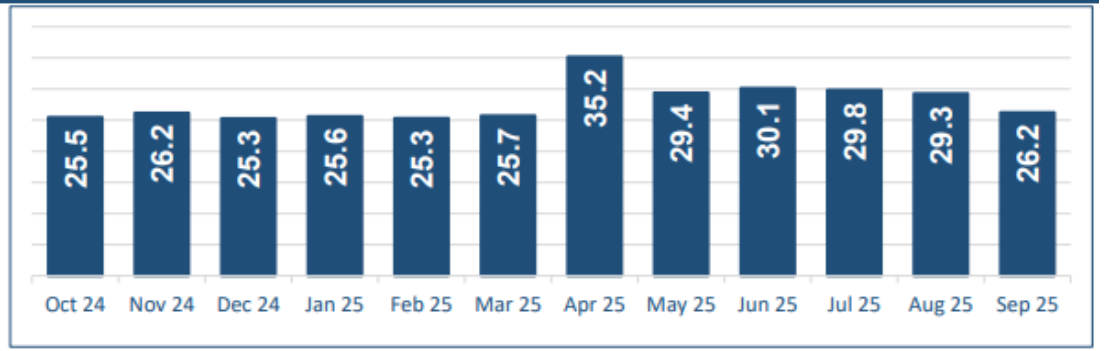


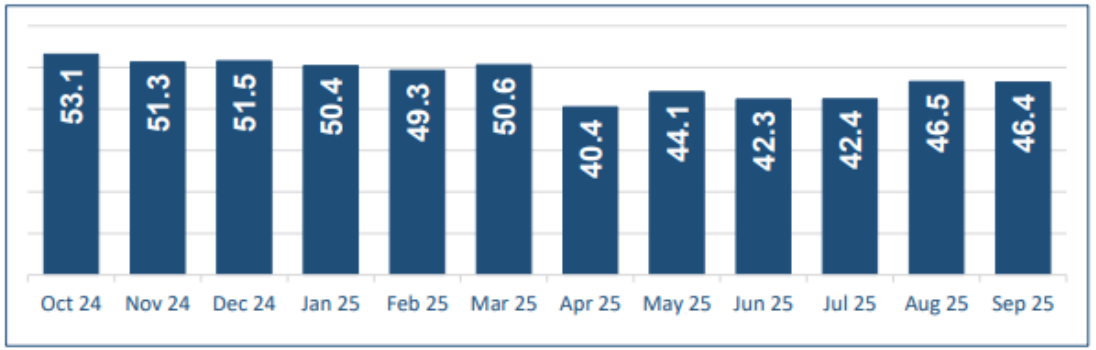


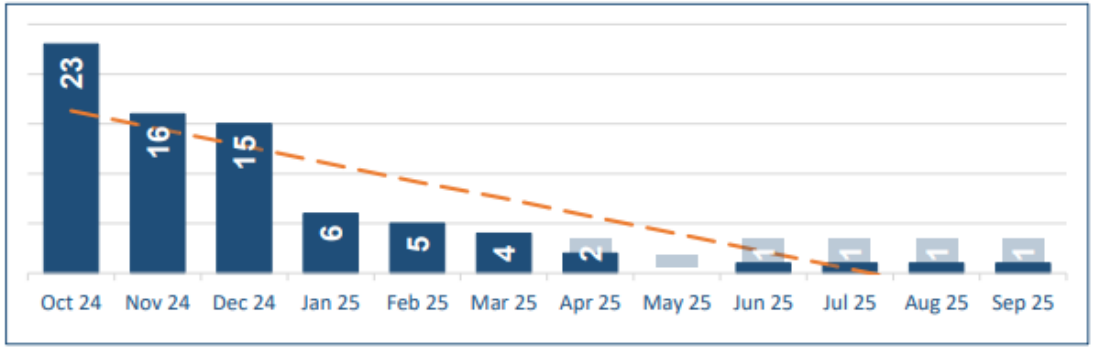
* Wales Ranking may differ as may refer to previous month

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	26.2	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	46.4	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)





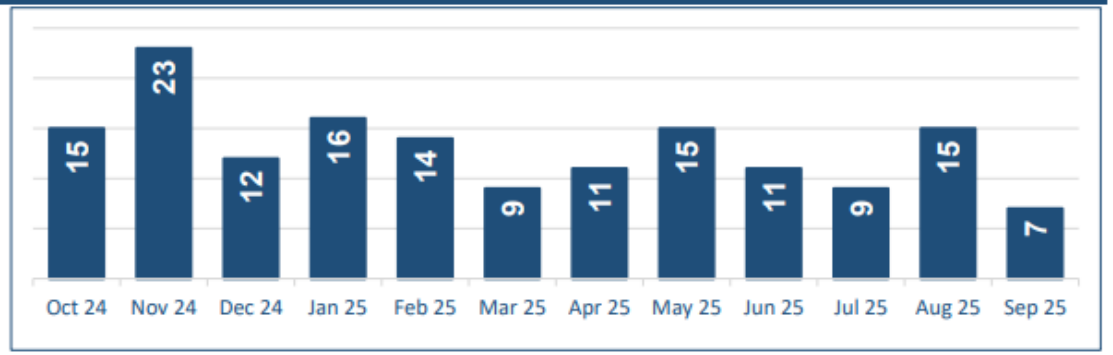


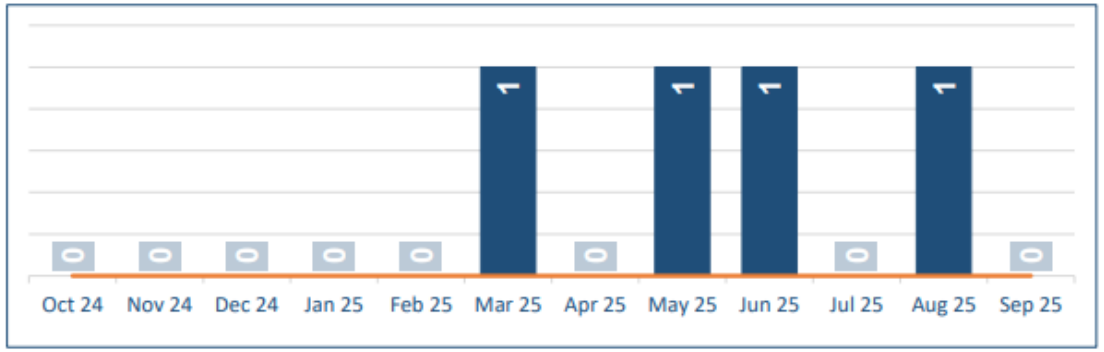
Produced on behalf of the **Quality, Safety & Experience Committee** by the Performance Directorate

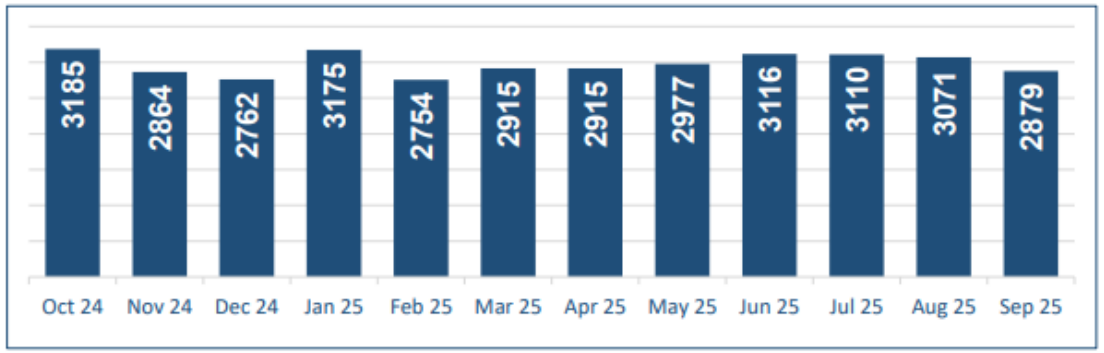
* Wales Ranking may differ as may refer to previous month

Quality: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	QSE	Number of National reportable incidents (NRIs)	N/A	TBC	7	
-	QSE	Number of new never events	0	TBC	0	
-	QSE	Number of patient safety incidents	N/A	TBC	2879	





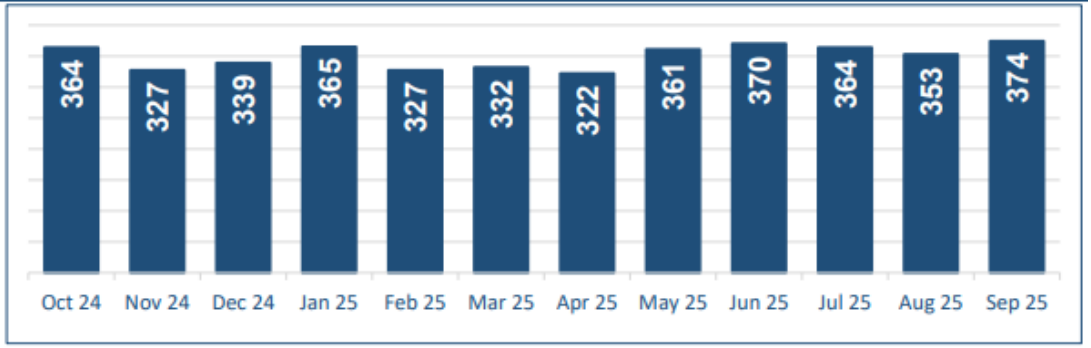


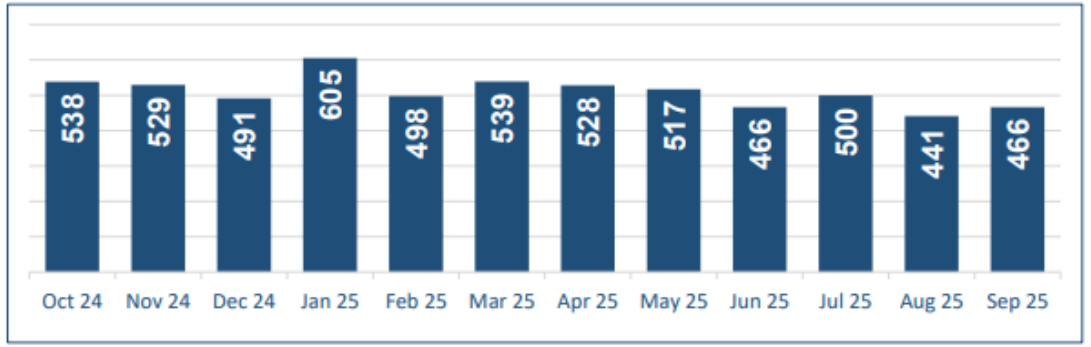
Produced on behalf of the **Quality, Safety & Experience Committee** by the Performance Directorate

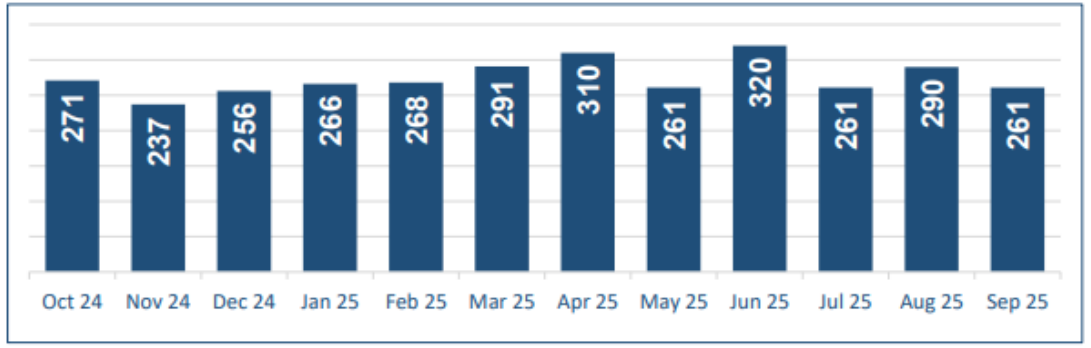
* Wales Ranking may differ as may refer to previous month

Quality: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	QSE	Number of reported falls	N/A	TBC	374	
-	QSE	Number of reported hospital acquired pressure ulcers (HAPU) (excluding new to caseload)	N/A	TBC	466	
-	QSE	Number of reported medication incidents	N/A	TBC	261	



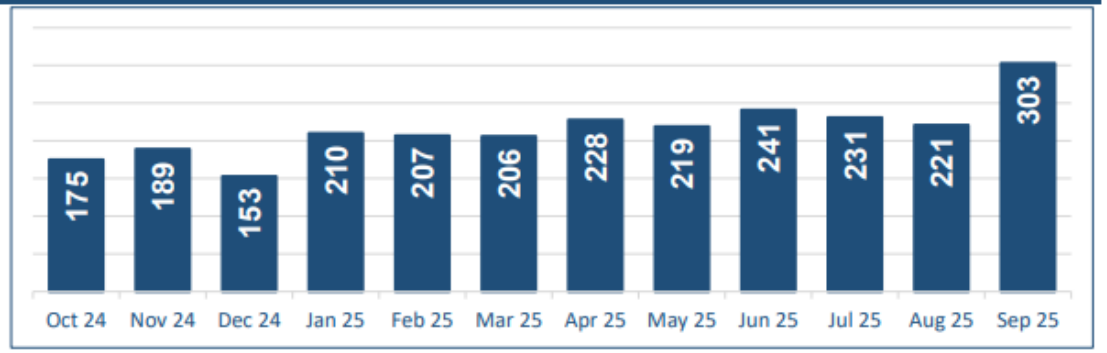


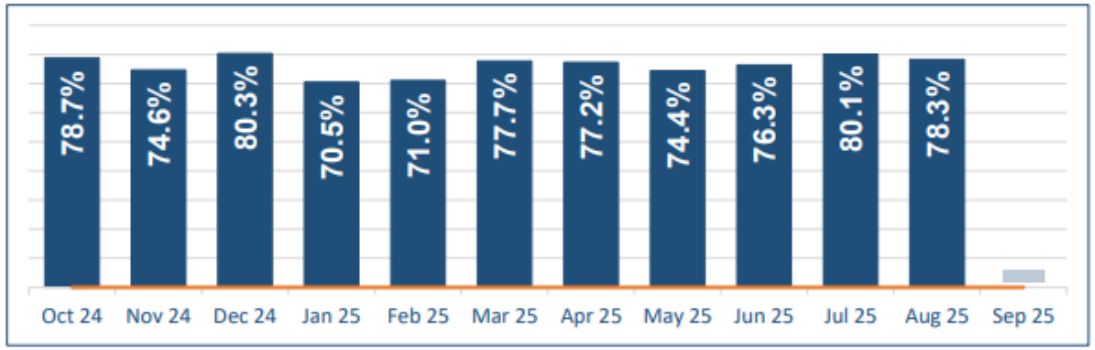


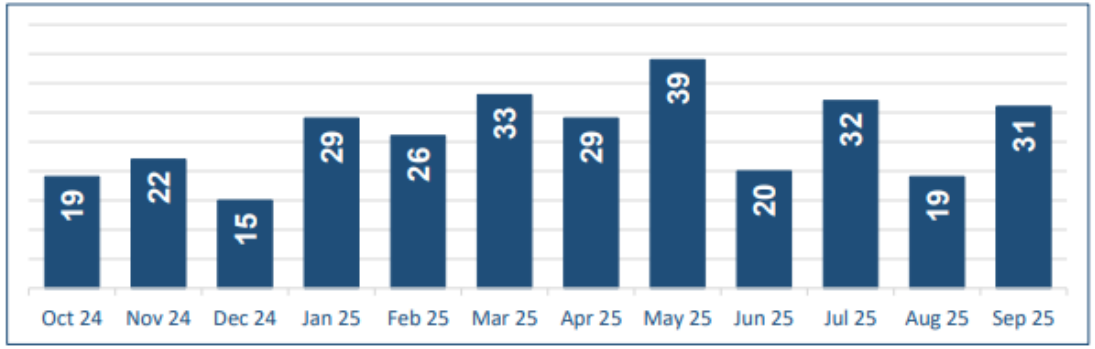
* Wales Ranking may differ as may refer to previous month

Quality: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	QSE	Number of 'Putting Things Right' (PTR) complaints	N/A	TBC	303	
-	QSE	Of the complaints closed, the percentage that were closed within 30 days	75%	TBC	78.3%	
-	QSE	Number of complaints closed as early resolutions	N/A	TBC	31	



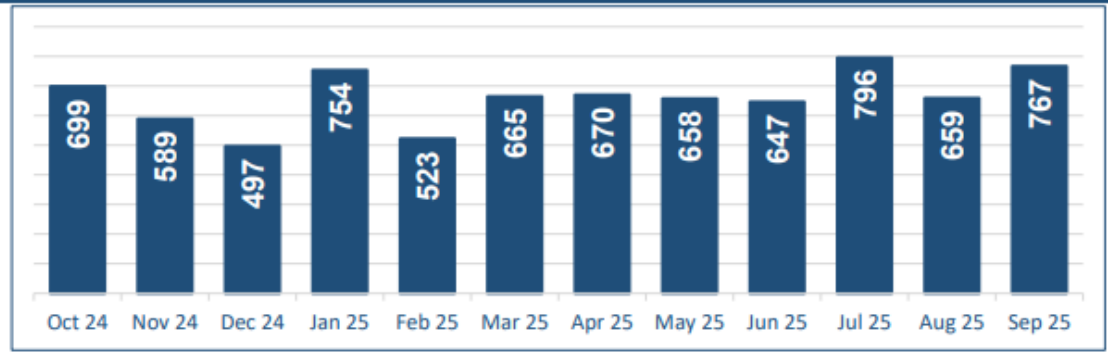


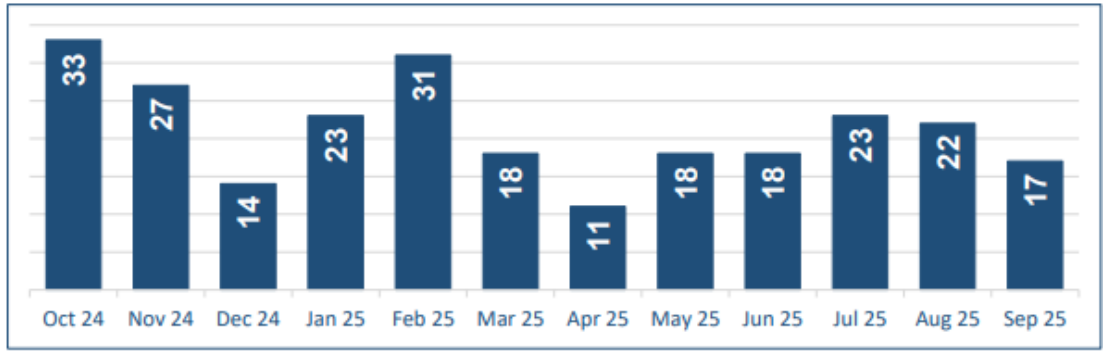


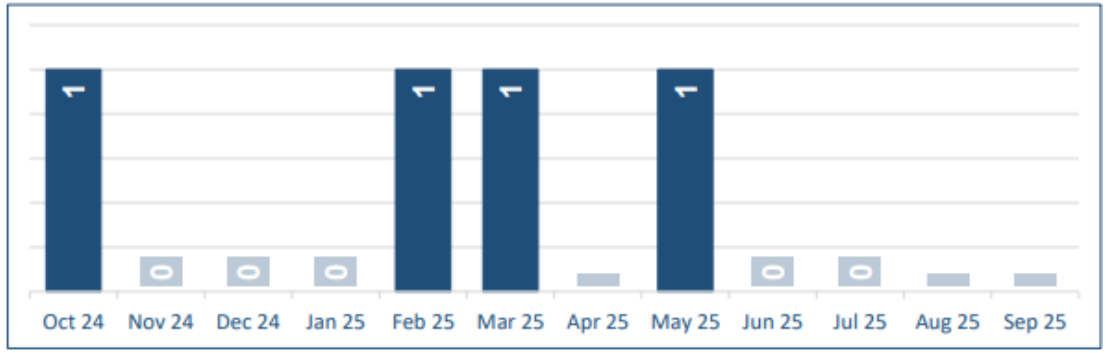
* Wales Ranking may differ as may refer to previous month

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	767	
-	QSE	Number of new Ombudsman contacts	N/A	TBC	17	
-	QSE	Number of regulation 28 notices	N/A	TBC	0	



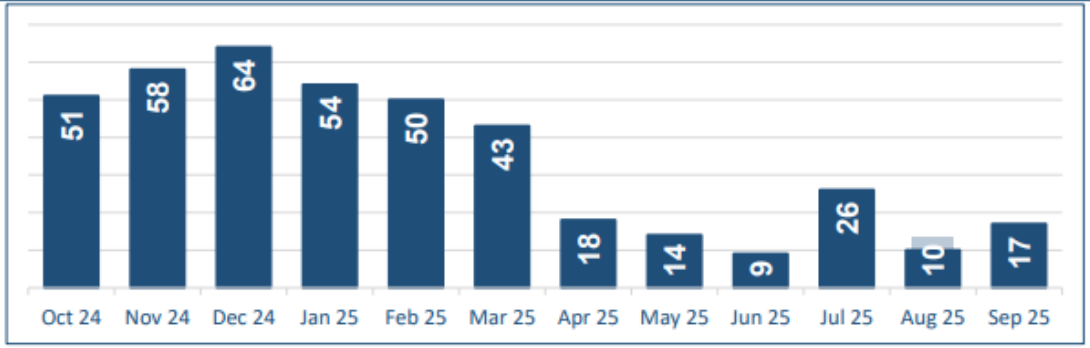


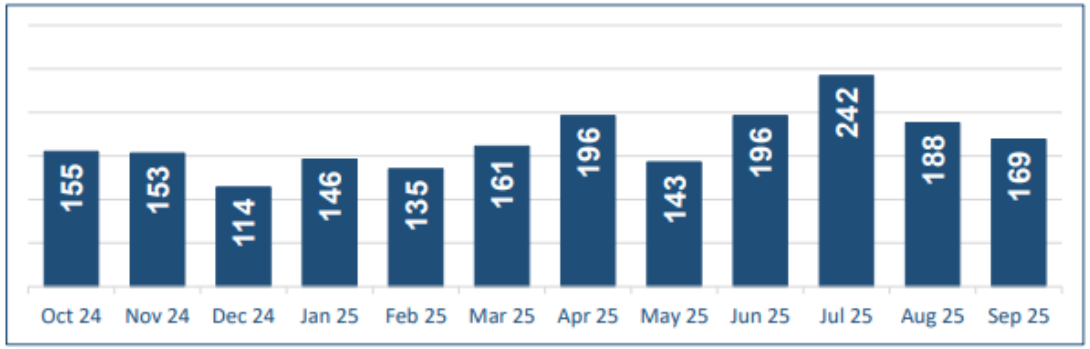


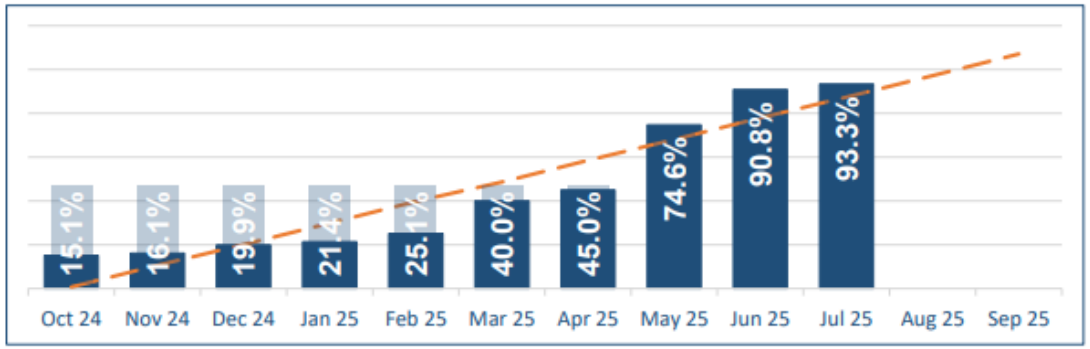
* Wales Ranking may differ as may refer to previous month

Quality: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	QSE	Number of overdue 'Learning from Event Reports' (LFERs)	N/A	TBC	17	
-	QSE	Number of Great-ix submissions	N/A	TBC	169	
-	QSE	Percentage of episodes clinically coded within one reporting month post episode discharge end date	Increas-ing trend (to 95%)	TBC	93.3%	8st of 8 (at Mar 25)



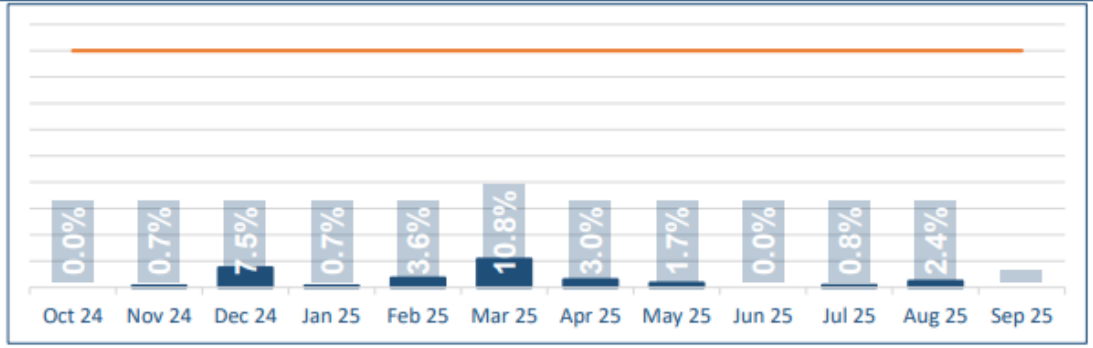




* Wales Ranking may differ as may refer to previous month

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	2.4%	8st of 8 (at Mar 25)

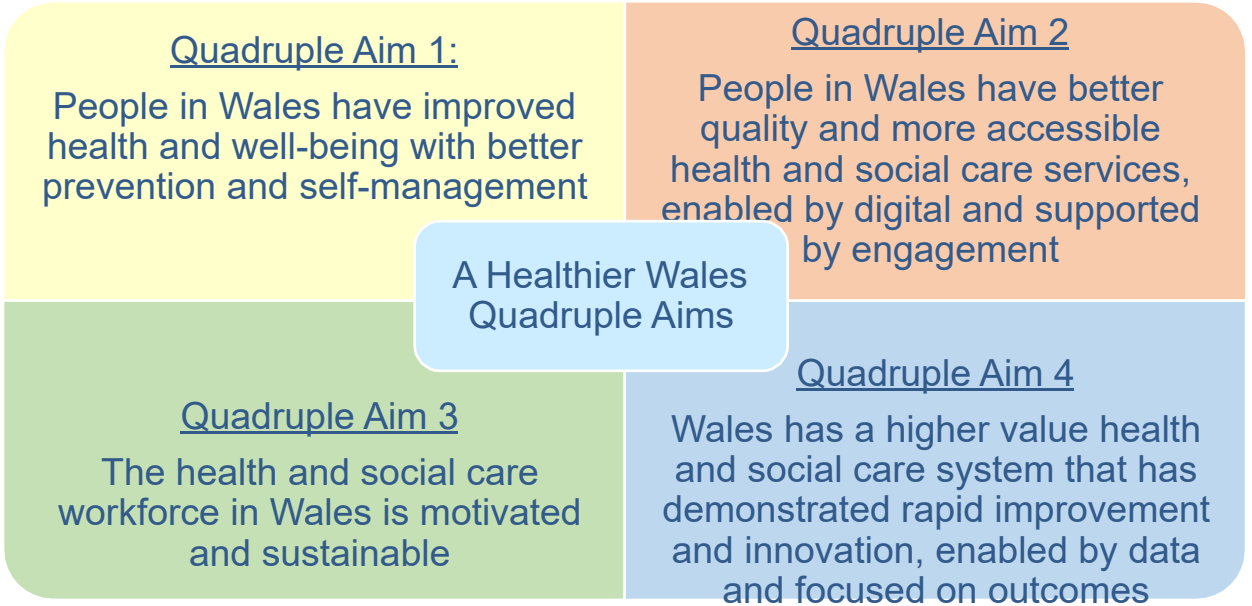


Additional Information

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.

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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

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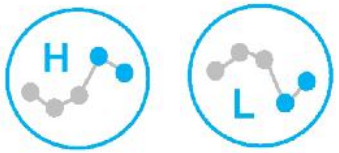
Variance			Assurance*		
					
Common cause. No significant change	Special cause for positive change or lower pressure due to Higher (**H**) or Lower (**L**) values	Special cause for negative change or higher pressure due to Higher (**H**) or Lower (**L**) values	Variance indicates inconsistent performance (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.

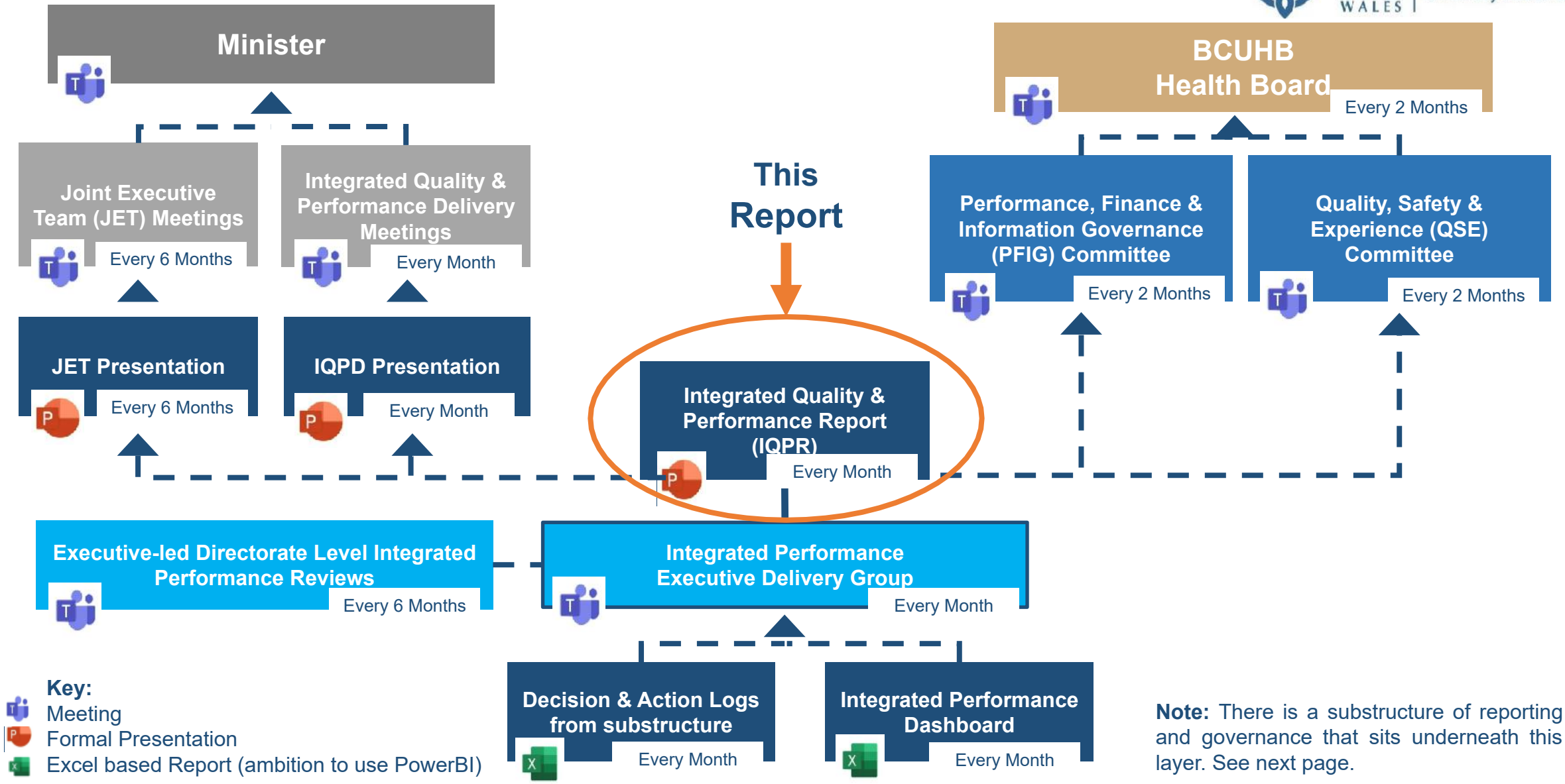
The Integrated Performance Framework sits within a "triumvirate" together with the Integrated Planning Framework and the Risk Management Framework (also ratified at Health Board on the 28th September 2023). This triumvirate of frameworks will encompass the planning, safe delivery and monitoring of the 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

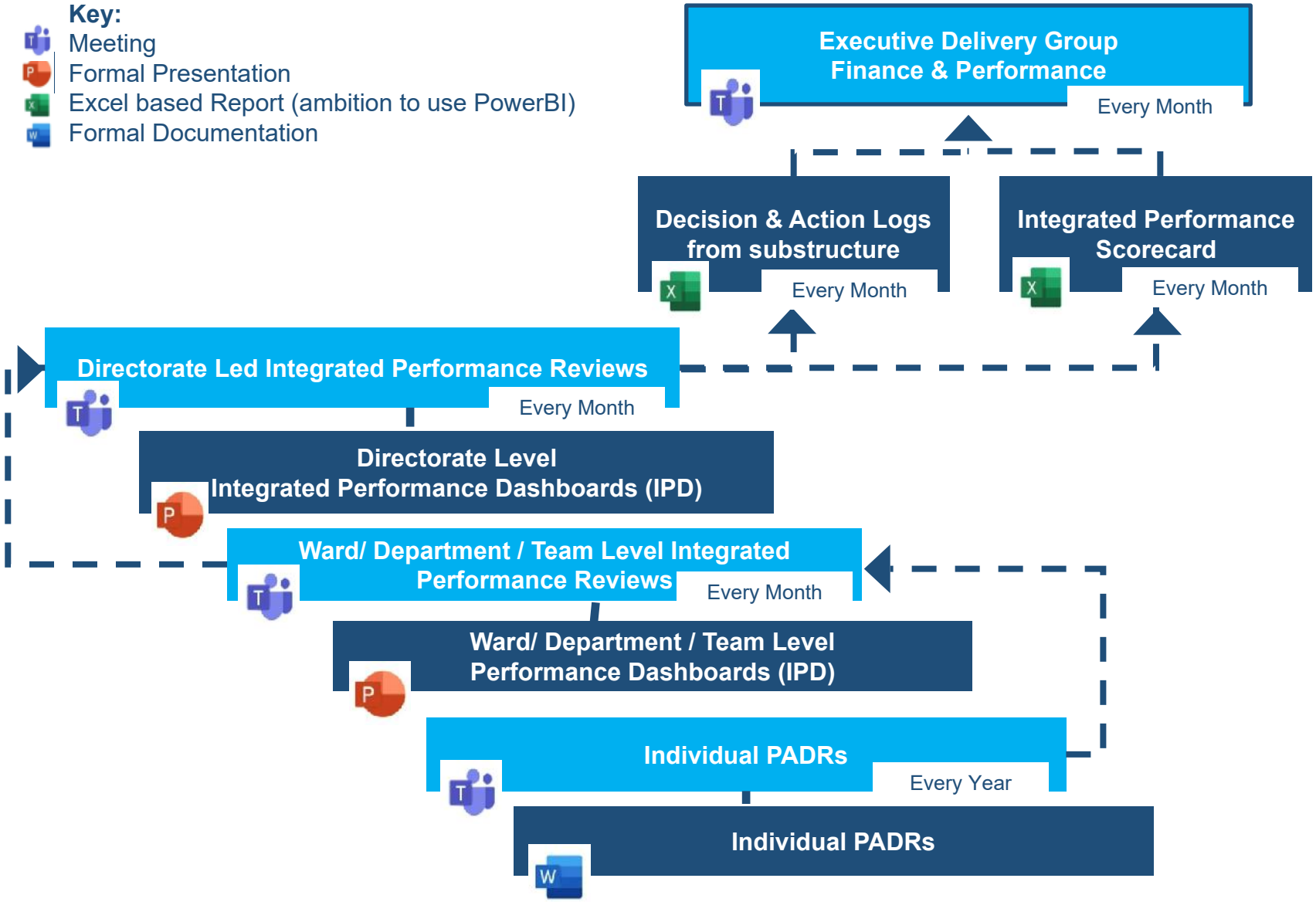


Key:
- Meeting
- Formal Presentation
- Excel based Report (ambition to use PowerBI)

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 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

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Betsi Cadwaladr
University Health Board

Further Information on
Our Integrated Quality & Performance Report

Further information is available 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

Trugaredd
Compassion

Agored
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Presentation of the Nurse Staffing Levels Reporting Period: Autumn 2025

Introduction / Background

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Section 25B of the **Nurse Staffing Levels (Wales) Act 2016** applies to adult acute medical inpatients wards; adult acute surgical inpatient wards; and paediatric inpatient wards.

The Act has two key requirements:

1. **A duty to calculate and take steps to maintain nurse staffing levels**[1]
2. **Apply triangulated methodology to nurse staffing level calculations i.e. Professional Judgement / Patient Acuity / Quality Indicators**

In line with the Act, nurse staffing calculations are to be approved by a designated person who is authorised to undertake this calculation on behalf of the Chief Executive Officer. The designated person should be registered with the Nursing and Midwifery Council and have an understanding of the complexities of setting a nurse staffing level in the clinical environment. Within Welsh Health Boards the designated person is the Executive Director of Nursing.

"The calculation undertaken by the designated person must result in the nurse staffing level for the ward area. In practice, the nurse staffing level will be the required establishment and the planned roster"[2].

[1] Statutory calculations of nurse staffing levels across wards pertaining to Section 25B take place between March/April (reporting to Board in May) and August/September (reporting to Board in November).

[2] Nurse Staffing Levels (Wales) Act 2016: Statutory Guidance

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Section 25C: method of calculation

Section 25C of the Act describes the triangulated method of calculation that must be used for calculating the nurse staffing levels. The triangulated methodology involves collecting, reviewing and interpreting data relating to:

- **Professional Judgement** - applying knowledge, skills and experience in a way that is informed by professional standards, law and ethical principles to develop a decision on the factors that influence clinical decision making
- **Patient Acuity** - an estimate of the amount of care a patient requires based on the intensity, complexity and unpredictability of their holistic needs. In Wales the Welsh Levels of Care is the tool used to assist nurses in measuring the acuity and dependency of their patients.
- **Quality Indicators** – a measure of factors that relate to the delivery of nursing care and are used to demonstrate whether the department delivers good outcomes for patients and staff.

During the process of calculating the nurse staffing levels using the triangulated approach there is no pre-determined hierarchy in terms of the evidence with equal weighting given to all the information that informs this process. The designated person will make the determination of the nurse staffing levels based on an analysis of all the information collected about the ward and the contributions of those staff involved in the process.

Nurse Staffing Levels Calculations Process

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Ward Level Data Collection & Review

Ward Manager presentations to Associate Director of Nursing/Director of Nursing outlining ward acuity/care quality indicators/and applied professional judgement.

Discussion takes place regarding current workforce issues/temporary staffing usage/future workforce needs/staff development & innovation.

Health Board Wide Multi-site, Service Specific Reviews

A Health Board wide (multi-site) review is undertaken to ensure a consistent approach, share good practice/lessons learned/opportunity to improve patient care pathways.

Autumn 2025 reviews were undertaken during the week commencing 15th September.

Review & Approval by Designated Person

Formal presentations were made to the Executive Director of Nursing and Midwifery on 15/10/2025. In attendance was the Executive Director of Finance.

Agreed Nurse Staffing Level calculations will be formally presented to the Board on 27/11/2025.

Acuity Audit Data

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Acuity Audit data

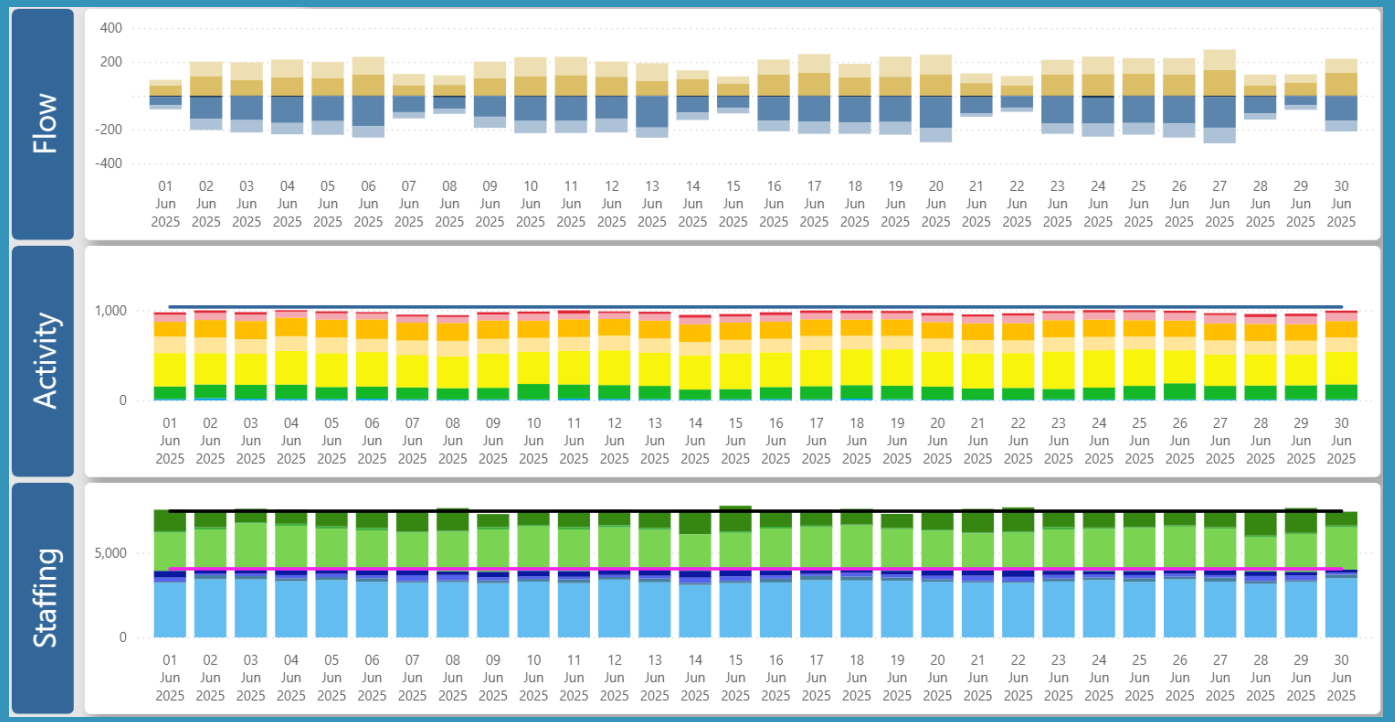
During the months of January and June each year a national acuity audit is held as directed by the Chief Nursing Officer. The acuity audit is used to collect data relating to patient acuity, patient flow and nurse staffing levels.

Patient acuity is assessed using the Welsh Levels of Care evidence-based workforce planning tool. This measure of patients levels of acuity indicates how much care is required in order to determine the nurse staffing level that is required to meet reasonable requirements of care.

This information when used as part of a triangulated approach alongside the use of quality indicators and professional judgement will determine the nurse staffing level for the ward.

Individual BCU ward acuity details can be viewed here

BCUHB Section 25B Wards June 2025 Acuity Audit data



Welsh Levels of Care

The Welsh Levels of Care are summarised opposite, further detailed information can be found here

Level 5	**One to One Care** - the patient requires at least one to one continuous nursing supervision and observation for 24 hours a day
Level 4	**Urgent Care** - The patient is in a highly unstable and unpredictable condition either related to their primary problem or an exacerbation of other related factors.
Level 3	**Complex Care** - The patient may have a number of identified problems, some of which interact, making it more difficult to predict the outcome of any individual treatment
Level 2	**Care Pathways** - The patient has a clearly defined problem but there may be a small number of additional factors that affect how treatment is provided.
Level 1	**Routine Care** - The patient has a clearly identified problem, with minimal other complicating factors.

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Quality Indicators

When calculating the nurse staffing level the quality indicators that are particularly sensitive to care provided by a nurse must be considered. These include patient falls, pressure damage, medication errors and complaints.

The below chart details the total number of patient falls; pressure damage and medication errors that have occurred across BCUHB Section 25B wards, and as recorded within the DATIX system for the period 01/04/2025 – 30/09/2025.

	West	East	Central	Paediatrics	Womens	Cancer
Falls	231	253	317	4	8	32
Pressure Damage	368	242	394	5	14	53
Medication Errors	67	135	149	38	9	18

Data Source: DATIX system as at 06.10.2025

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Approved Nurse Staffing Levels – Autumn 2025 (Summary)

The nurse staffing level calculations undertaken during this reporting period (September 2024 – March 2025) identified a number of wards that require a change to their establishments, with the overall FTE changes summarised in the table below:

Integrated Health Community	Number of Act Wards	Funded Bed Numbers	Required Establishment at the start of the reporting period (October 24)		Required Establishment at the end of the reporting period (September 2025)*		Staffing FTE changes during reporting period 2024 - 2025*		Funded** Establishment (as at September 2025)		FTE Variance between current funded and required (September 2025)	
			RN	HCA	RN	HCA	RN	HCA	RN	HCA	RN	HCA
YMW	14	306	279.17	230.87	279.17	229.45	0	-1.42	279.74	229.45	-0.57	0
YGC	13	311	263.46	254.99	263.46	254.99	0	0	263.46	254.99	0	0
YG	10	239	214.61	206.65	214.61	206.65	0	0	211.87	202.39	2.74	4.26
Womens Gynaecological	2	32	34.11	21.94	34.11	21.94	0	0	34.11	21.94	0	0
Oncology & Haematology	3	38	37.56	34.11	37.56	34.11	0	0	37.57	34.11	-0.01	0
Paediatric Inpatient Wards	3	64	85.29	28.43	85.29	28.43	0	0	85.29	28.43	0	0
BCUHB Total	**45**	**990**	**914.2**	**776.99**	**914.2**	**775.57**	**0**	**-1.42**	**912.04**	**771.31**	**2.16**	**4.26**

Spring 2025 review determined a change in staffing was required across 4 wards within YMW (Arrivals, Pantomime, Prince of Wales & Morris). The EAST SLT pre-empted this change and directed funds from the Covid BAU allocations of 23/24, to fund 30 beds across the YMW site that had been in sustained escalation over a period of years. In July 2025 the funding was recalled to central HB reserves, resulting in these beds resorting back to an unfunded position. However, nurse staffing establishments have been recruited up to the required numbers for the additional 30 beds on a permanent basis.

*Funded establishment sourced from Finance Ledger

Note: The required and funded establishment figures exclude any additional staffing requirements needed to support the unfunded bed base, and also exclude the supernumerary ward manager and ward support staff i.e. housekeepers, dementia support workers etc.

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Section 25B wards requesting a change to nurse staffing levels

During the autumn 2025 reporting period two statutory calculations of nurse staffing levels have taken place, these being spring 2025 (reported to Board in May 2025) and autumn 2025 (to be reported to Board in November 2025).

Across both calculation periods 9 wards have requested changes to their establishments. The changes proposed (identified in red) and those approved following review by the Executive Director of Nursing (identified in green) are summarised in the table below.

Review Period	IHC	Ward	Roster Period	Bed Numbers (actual excluding unfunded)	Current staffing (at time of review)								Proposed staffing (submitted by IHCs for EDoN Consideration)								Supported staffing (following review by EDoN)							
					Early		Late		Twilight		Night		Early		Late		Twilight		Night		Early		Late		Twilight		Night	
					RN	HCA	RN	HCA	RN	HCA	RN	HCA	RN	HCA	RN	HCA	RN	HCA	RN	HCA	RN	HCA	RN	HCA	RN	HCA	RN	HCA
Spring 2025	East	Arrivals	7 Days	26	3	2	3	2	0	0	2	2	5	3	5	3	0	0	3	3	5	3	5	3	0	0	3	3
Spring 2025	East	Morris	7 Days	27	4	4	4	3	0	0	2	4	4	5	4	4	0	0	3	5	4	5	4	4	0	0	3	4
Spring 2025	East	Pantomime	7 Days	27	4	3	3	3	0	1	2	2	5	4	4	4	0	0	3	3	5	4	4	4	0	0	3	3
Spring 2025	East	Prince of Wales	7 Days	27	3	3	3	3	0	0	2	2	4	4	4	4	0	0	3	3	4	4	4	4	0	0	3	3
Spring 2025	West	Hebog	7 Days	27	5	5	5	5	0	0	3	4	5	5	5	5	0	0	4	4	5	5	5	5	0	0	3	4
Spring 2025	West	Glaslyn	Tues - Fri	26	4	6	4	5	0	0	3	4	5	6	5	5	0	0	4	4	4	6	4	5	0	0	3	4
			Sat - Mon		4	5	4	5	0	0	3	4	5	5	5	5	0	0	4	4	4	5	4	5	0	0	3	4
Spring 2025	West	Tegid	7 Days	28	5	4	5	4	0	0	4	3	5	4	5	4	0	0	4	4	5	4	5	4	0	0	4	3
Spring 2025	Cancer	Alaw	Mon - Fri	18	4	3	4	3	1	0	2	2	4	3	4	3	1	0	2	2	4	3	4	3	1	0	2	2
			Sat & Sun		3	3	3	3	1	0	2	2	4	3	3	3	1	0	2	2	3	3	3	3	1	0	2	2
Autumn 2025	East	Arrivals	7 Days	26	5	3	5	3	0	0	3	3	3	2	3	2	0	0	2	2	3	2	3	2	0	0	2	2
Autumn 2025	East	Morris	7 Days	27	4	5	4	4	0	0	3	4	4	4	4	3	0	0	2	4	4	4	4	3	0	0	2	4
Autumn 2025	East	Pantomime	7 Days	27	5	4	4	4	0	0	3	3	4	3	4	3	0	0	2	2	4	3	3	3	0	0	2	2
Autumn 2025	East	Prince of Wales	7 Days	27	4	4	4	4	0	0	3	3	3	3	3	3	0	0	2	2	3	3	3	3	0	0	2	2
Autumn 2025	East	Mason	7 Days	26	4	6	4	5	0	0	3	3	4	6	4	5	0	0	3	4	4	6	4	5	0	0	3	3
Autumn 2025	West	Hebog	7 Days	27	5	5	5	5	0	0	3	4	5	5	5	5	0	0	4	4	5	5	5	5	0	0	3	4
Autumn 2025	Cancer	Alaw	Mon - Fri	18	4	3	4	3	1	0	2	2	4	3	4	3	1	0	2	2	4	3	4	3	1	0	2	2
			Sat & Sun		3	3	3	3	1	0	2	2	4	3	3	3	0	0	2	2	4	3	3	3	0	0	2	2

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Section 25B wards requiring a change to nurse staffing levels

Two statutory nurse staffing level calculations have taken place during this reporting cycle (spring 2025, reported to Board in May 2025; autumn 2025, to be reported to Board in November 2025). Across both calculation periods 9 wards have requested changes to their establishments. The changes approved and the rationale for these, are summarised in the table below.

Integrated Health Community	Number of Act Wards	Number of Wards Requesting Adjustments	Adjustments Approved by Exec DoN	Comments	Funding Received
YWM	14	5	4	Pantomime - staffing reconsidered in spring 2025 with the East IHC SLT directing the funds from the Covid BAU allocations of 23/24, previously held in site reserves, to fully fund the 6 escalated beds, with the funded bed base increasing from 21 to 27. In July 25, the funding was recalled to central HB reserves with the ward reverting to a funded bed base of 21, they continue to support a further 6 unfunded / escalated beds.	Yes - funded for 21 beds however ward continue to support an additional 6 unfunded / escalated beds.
				Morris - staffing reconsidered in spring 2025 with the East IHC SLT directing the funds from the Covid BAU allocations of 23/24, previously held in site reserves, to fully fund the 6 escalated beds, with the funded bed base increasing from 21 to 27. In July 25, the funding was recalled to central HB reserves with the ward reverting to a funded bed base of 21, they continue to support a further 6 unfunded / escalated beds.	Yes - funded for 21 beds however ward continue to support an additional 6 unfunded / escalated beds.
				Prince of Wales - staffing reconsidered in spring 2025 with the East IHC SLT directing the funds from the Covid BAU allocations of 23/24, previously held in site reserves, to fully fund the 8 escalated beds, with the funded bed base increasing from 19 to 27. In July 25, the funding was recalled to central HB reserves with the ward reverting to a funded bed base of 21, they continue to support a further 6 unfunded / escalated beds.	Yes - funded for 21 beds however ward continue to support an additional 6 unfunded / escalated beds.
				Arrivals - staffing reconsidered in spring 2025 with the East IHC SLT directing the funds from the Covid BAU allocations of 23/24, previously held in site reserves, to fully fund the 10 escalated beds, with the funded bed base increasing from 16 to 26. In July 25, the funding was recalled to central HB reserves with the ward reverting to a funded bed base of 16, they continue to support a further 10 unfunded / escalated beds.	Yes - funded for 16 beds however ward continue to support an additional 10 unfunded / escalated beds.
YGC	13	0	-	-	-
YG	10	3	0	-	-
Oncology & Haematology	2	1	1	Alaw -RN staffing adjusted at weekends to support out of hours triage requirements. No change to staffing FTE requirements.	Yes - no change in funded
Womens Gynaecological	3	0	-	-	-
Paediatric Inpatients Wards	3	0	-	-	-
BCUHB Total	**45**	**9**	**5**	-	-

Section 25B wards maintaining the nurse staffing level

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The **Act** requires LHBs and Trusts to take all reasonable steps to maintain the nurse staffing level. "*Maintaining means having the number of registered nurses the required establishment and its planned roster require. The maintenance of the nurse staffing level should be funded from the LHB's (or Trust's) revenue allocation, taking into account the actual salary points of staff employed on its wards*"[1]

The wards detailed below are awaiting associated budgetary uplifts to meet their approved staffing levels.

Integrated Health Community	Ward	Required Establishment Autumn 2025 RN	Required Establishment Autumn 2025 HCA	Current Funded RN	Current Funded HCA	FTE Variance between current funded (Sept 25) and required (autumn 25 reviews) RN	FTE Variance between current funded (Sept 25) and required (autumn 25 reviews) HCA	Date Presented to Board
YG	Hebog	22.74	25.58	22.75	22.74	-0.01	2.84	November 2024 & May 2025
YG	Moelwyn	31.27	22.74	28.43	22.74	2.84	0	November 2024 & May 2025
YG	Prysor	12.79	12.37	12.87	10.95	-0.08	1.42	November 2024 & May 2025

[1] Nurse Staffing Levels (Wales) Act 2016: Statutory Guidance

Recommendations

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- Continue to review the impact of nurse staffing levels within the clinical areas, observing workforce and quality metrics.
- Implement the Calculating & Maintaining Nurse Staffing Levels SOP across all nursing services.
- Continued focus on recruitment and retention and innovation to support workforce utilisation and reporting. The **BCUHB People Strategy & Plan** has been an essential enabler, which is further supported by the **All Wales National Workforce Implementation Plan**; the subsequent **Nurse Retention Plan** and the **Strategic Nursing Workforce Plan**.
- In line with the **Act** and the **Statutory Guidance**, on approval by the Executive Director of Nursing & Midwifery as the nominated Designated Person:
  - Amend budgets to reflect the approved rosters. Nurse staffing levels presented to Board in November 2024 and May 2025 remain unfunded at present.
  - Amend planned roster templates within E-Rostering to reflect the approved nurse staffing levels.
  - Ward Managers to recruit nursing staff in line with approved nurse staffing numbers
  - Ward Managers to ensure public facing boards at ward entrances display the agreed nurse staffing levels

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Diolch / Thank you
Any questions?

Teitl adroddiad: ***Report title:***	Welsh Risk Pool and Legal and Risk Services - Annual Review 2024-2025
Adrodd i: ***Report to:***	QSE Committee
Dyddiad y Cyfarfod: ***Date of Meeting:***	November 2025
Crynodeb Gweithredol: ***Executive Summary:***	This report provides the QSE Committee with a copy of the latest annual review from the Welsh Risk Pool and Legal and Risk Services (both part of the NHS Wales Shared Services Partnership). Legal and Risk Services (L&R) provides professional legal advice and representation for health bodies and general medical practitioners in Wales. L&R is a division of the NHS Wales Shared Services Partnership. The Welsh Risk Pool (WRP) is hosted within L&R and is a mutual risk pool scheme which provides indemnity against risk to all Health Boards, NHS Trusts and Special Health Authorities in Wales. Using an approach which considers causal factors of harm and the cost of improvement, the Welsh Risk Pool focusses on Improving Safety Through Learning. Strategic oversight of the work of the Welsh Risk Pool is provided through the Welsh Risk Pool Committee – which is a sub-committee of the NHS Wales Shared Services Partnership Committee. The Welsh Risk Pool Committee makes decisions in relation to the reimbursement procedures, workplans for reviews and the reimbursement of claims and redress cases. Membership of the Welsh Risk Pool Committee is drawn from Welsh Government and Executive and Independent Members from NHS Wales Health Bodies. Committee members represent their professions rather than individual organisations and a Terms of References outlines the roles and responsibilities of the group. The enclosed reports summarise the activity of the two functions over the last financial year and is provided for information to the Committee (and the wider public). The Annual Review outlines the impact and reach of the Legal & Risk Services teams. The Annual Review outlines the financial position, details the future financial forecast, and summarises the NHS Wales claims & redress caseload. The Annual Review also outlines the work of the Welsh Risk Pool in learning assurance and summarises the progress with Safety & Learning Programmes. The Health Board is active in all of the Safety & Learning Programmes run by the WRP and these link to internal forums and projects. The Health Board continues to work closely with both the WRP and L&R and has regular engagement meetings. In many cases takes, the Health Board takes an active national role, for example: • The Director of Corporate Governance represents their profession across Wales on the Welsh Risk Pool Committee; • The Deputy Director for Legal Services is the national chair of the Once for Wales Concerns System Content and Governance Group; • The Senior Legal Services Manager (Redress) is national co-chair of the Redress Network; • The Senior Legal Services Manager (Claims) is national co-chair of the Claims Network; • The Associate Medical Director (Consent and Ethics) is the national lead for the Decision Making and Consent Programme.
Argymhellion: ***Recommendations:***	The committee is asked to receive this report.

Arweinydd Gweithredol: ***Executive Lead:***	Pam Wenger, Director of Corporate Governance			
Awdur yr Adroddiad: ***Report Author:***	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* ☒ 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:***
N/A

Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Objective 1 - Building an effective organisation
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	Claims in NHS Wales are governed by the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 as well as standards set by the Welsh Risk Pool and UK wide requirements for litigation such as the Civil Procedure Rules.
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)***	N/A

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)*	N/A
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:*** Appendix 1 - Welsh Risk Pool / Legal & Risk Services - Annual Review 2024-2025	

NHS WALES
SHARED SERVICES PARTNERSHIP

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Shared Services Partnership

Welsh Risk Pool and Legal and Risk Services

Annual Review 2024-2025

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Cronfa Risg Cymru
Shared Services Partnership
Welsh Risk Pool Services

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Cyfreithiol a Risg
Shared Services Partnership
Legal and Risk Services

Contents

Foreward

Professor Tracy Myhill, OBE

Chair of NHS Wales Shared Services Partnership

The NHS in Wales undertakes many thousands of consultations, procedures and interventions every year – across primary care, ambulance, hospital-based services and tertiary specialties. The vast majority of patients and their families receive a high standard of care in a timely manner, with good clinical outcomes. The pressure on services, particularly unscheduled care, is well documented and there are a number of initiatives to address the causes of these pressures and to create additional capacity.

Whilst there is much to be celebrated in NHS Wales, on occasion errors do occur or systems & processes fail which can lead to avoidable harm and the possibility of claims or the need for redress payments. When something does go wrong, NHS organisations must have robust processes to implement improvements and share learning. The Putting Things Right Regulations provide a framework for organisations to investigate what has happened, put preventative measures into place where possible, and achieve a satisfactory resolution for any person affected. These Regulations have been the subject of consultation by Welsh Government and the guidance is currently in the process of being reviewed. It is anticipated that the amendments will be introduced towards the end of 2024/25 and the vision is that these will add further value to patients and their families.

The Welsh Risk Pool has a key role in supporting organisations to manage the financial costs associated with claims & redress cases, and to ensure learning is undertaken and shared across Wales. As has been seen in other modern healthcare systems, the clinical negligence litigation profile in NHS Wales is rising – with legal costs continuing to increase more quickly than inflation. The data shows a gradual increase in clinical negligence matters over the last three years and the most frequently occurring clinical specialties are maternity services, care provided in emergency departments and trauma & orthopaedics. There continues to be a decline in the litigation profile of personal injury claims.

The introduction of the Duty of Candour in Wales is attributed for the increase seen in 2023/24 of cases where redress payments are required. The Putting Things Right process in Wales offers a swift resolution to concerns and every case successfully managed in this way avoids a clinical negligence claim being brought.

NHS Wales is proud to have an entirely in-house legal services team which manages clinical negligence and personal injury cases for health bodies and the professional influence of this service achieves considerable savings to the Welsh taxpayer. Where it is right to do so, we settle cases as promptly as possible. Where it is appropriate, we defend matters.

This approach reduces avoidable costs to NHS Wales. During 2023/24 over a third of clinical negligence claims and almost half of personal injury claims were successfully closed with no damages paid.

A key aspect of the work of the Welsh Risk Pool relates to learning assurance – ensure lessons learned are identified and improvements are implemented, both within the service where the claim originated but also more widely across the health service. The learning process is underpinned by a clinically-led panel which scrutinises all cases and recommends whether the learning is sufficient. There has been an reduction in the number of cases which are approved when first presented to the panel and all organisations must consider steps that can be taken to improve the robustness of learning and improvements before being submitted for consideration.

It is pleasing to see that there has been an impact to clinical outcomes and staff views on safety which have been driven by some of the Safety & Learning initiatives which are coordinated by the Welsh Risk Pool. Most notably, the team has been able to gather data which demonstrates an improvement in clinical outcome measures, including APGAR scores for babies which is a good indicator of health at birth.

Additionally we have shown a sustained improvement in safety attitude amongst staff within our maternity services, using a recognised measurement tool. As more data becomes available, we anticipate seeing further sustained improvements.

The wide experience of the in-house legal service, in all areas of law affecting modern health bodies, provides rapid and effective advice to leaders throughout the NHS in Wales. As well as dealing with clinical negligence, personal injury cases and managing the General Medical Practice Indemnity scheme, the Legal & Risk Service advises on procurement law, contractual matters, property acquisitions and disposals, representation at inquests and managing patients with complex needs in their care. The service remains flexible and adaptable as alternative models of service provision are implemented which present new challenges to organisations.

I remain very proud of the work done by the Welsh Risk Pool and Legal & Risk Services, working in partnership with colleagues across NHS Wales. This report outlines the current financial position and presents a forecast for claims and redress cases. The report also highlights the excellent legal, safety & learning work that the teams do every day. My senior team will be working with every Board in NHS Wales to maximise learning and to improve quality and safety, using the data related to each individual health body.

About Tracy Myhill

Tracy was appointed Chair of NWSSP in 2021 having retired after a 36-year career in the NHS. Tracy's career commenced as a receptionist in Cardiff's Dental Hospital, progressed into the human resources profession, holding roles at local and national level, and to her appointment into Chief Executive roles. She has worked as Chief Executive of the Welsh Ambulance Services University NHS Trust and Chief Executive of Swansea Bay University Health Board.

Our Services

Welsh Risk Pool

Our Services

The Welsh Risk Pool is a mutual organisation which provides indemnity against risk to all Health Boards, NHS Trusts and Special Health Authorities in Wales. Using an approach which considers causal factors of harm and the cost of improvement, the Welsh Risk Pool focusses on *Improving Safety Through Learning*. By understanding the causes of claims and redress cases, we help organisations to identify improvements which are needed in services to enhance the safety of NHS patients, staff and service users.

Reimbursement

We reimburse health bodies for losses and special payments which arise from claims and redress cases in accordance with the procedures approved by the NHS Wales Shared Services Partnership Committee.

Structured Settlement Management

The Welsh Risk Pool administers all long-term Periodical Payments on behalf of Welsh Government for the duration of a structured settlement incurred by an NHS Wales Health Body. This ensures compliance with a court order in a matter and provides funds for ongoing care and support for claimants who have experienced harm. The Welsh Risk Pool team engage with Claimants and their representatives to ensure the ongoing effective management of the settlement.

Decision Making and Consent

Led by the Welsh Risk Pool, the All-Wales approach to Consent to Examination and Treatment provides a national training solution for clinicians involved in the consent process and provides a library of approved consent information leaflets to support clinicians in ensuring patients are fully informed about the risks and benefits of a proposed treatment or procedure. The Welsh Risk Pool supports organisations to comply with regulatory guidance which recognises that the dialogue between healthcare professionals and patients is essential for safe and effective decision making.

Learning Assurance

The National Learning Advisory Panel is a clinically led group which is coordinated by the Welsh Risk Pool and scrutinises the learning from events regarding claims and redress cases to ensure effective local learning is implemented and provides a platform for sharing lessons learned throughout NHS Wales.

Maternity and Neonatal Safety and Learning Programmes

We coordinate the all-Wales approach to obstetric emergency training through PROMPT Wales and Community PROMPT Wales, and to Intrapartum Fetal Surveillance training with 'IFS Wales.' In response to the Maternity and Neonatal Safety Support discovery report, we are developing an innovative training programme for the management of emergencies in neonatal services.

Decision Making and Consent

Led by the Welsh Risk Pool, the All-Wales approach to Consent to Examination and Treatment provides a national training solution for clinicians involved in the consent process and provides a library of approved consent information leaflets to support clinicians in ensuring patients are fully informed about the risks and benefits of a proposed treatment or procedure. The Welsh Risk Pool supports organisations to comply with regulatory guidance which recognises that the dialogue between healthcare professionals and patients is essential for safe and effective decision-making

Once for Wales Concerns Management System

We lead the design, implementation and use of the Once for Wales Concerns Management Systems across health bodies and primary care.

- Datix Cymru, which provides consistency in the platform for capturing, investigating and reporting outcomes of concerns.
- Civica Experience Wales, which provides a platform for real time feedback from service users to be collated and analysed quickly and effectively.
- Eido Centre Wales, which is a platform that provides access to internationally approved consent information leaflets and facilitates uniform access to locally produced patient information.

Safety and Learning Networks

We facilitate forums for practitioners in patient safety, concerns management and service user feedback to drive improvement, learn together and share experience and good practice.

Venous Thrombo-Embolism

In response to the causal factors identified in legal cases and reviews, we coordinate an all-Wales approach to the prevention, management, and reduction of harm associated with venous thromboembolism. This aims to improve patient experience and clinical outcomes. We manage two bespoke e-Learning modules to support staff to recognise and manage VTE.

Radiology Unexpected Findings

We co-ordinate an All-Wales Radiology (unexpected findings) review and associated work strands that have arisen as a result. The review first commenced in 2019 due to the sustained level of legal cases where a key finding was the failure to act on the report of a radiological examination, resulting in delayed or missed diagnosis. The focus of the review is around achieving use of a national standardised electronic system, to reduce the risk and improve patient safety outcomes.

Putting Things Right Assurance

Assurance reviews are conducted on behalf of Welsh Government in relation to the application by health bodies of the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 – known as the Putting Things Right (PTR) Regulations, along with analysis of an organisation's compliance with the WRP Reimbursement Procedures. Bespoke training is provided to colleagues dealing with all aspects of PTR matters throughout Wales, to develop and enhance competence in this sector.

Delegated Case Management

We consider the application of the all-Wales Policy on Indemnity and Insurance and advise health bodies in Wales in respect of indemnity arrangements and agreements between parties in the provision of health and care.

Anti Violence Collaborative

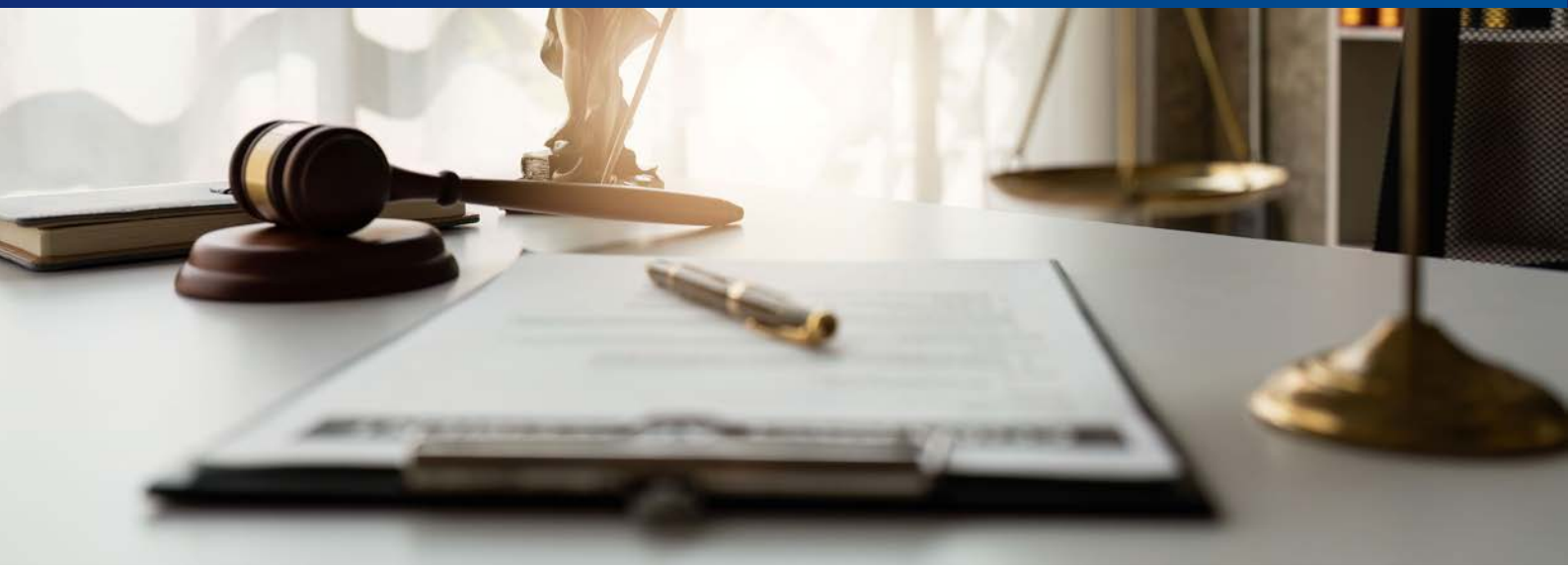
We coordinate Anti-Violence Collaborative Wales (AVC), which is a collaboration between all NHS organisations in Wales, the four Welsh Police Forces, the Crown Prosecution Service in Wales and trade unions and staff associations. The partner organisations are signatories to a memorandum of understanding entitled the 'Obligatory Responses to Violence in Healthcare'. The aim of the collaborative is to reduce incidents of violence and aggression against staff and those who utilise NHS Wales services. Where incidents of violence do occur, the AVC aims to ensure an appropriate response in addressing the issues and facilitate appropriate support for those affected by an incident.

Specialist Investigation Support

We provide support to health bodies regarding complex investigations where the independence of the Welsh Risk Pool adds value. By accessing and utilising the vast experience across NHS Wales, the Welsh Risk Pool can provide independent reviews of cases and, if required, coordinate multi-professional support – including clinical and legal expertise. The Welsh Risk Pool assists health bodies to identify causal factors, system improvements or legal remedy.

NHS Indemnity Enquiries

We consider the application of the all-Wales Policy on Indemnity and Insurance and advise health bodies in Wales in respect of indemnity arrangements and agreements between parties in the provision of health and care.



Legal and Risk Services

Our Services

Legal and Risk Services provides professional legal advice and representation for health bodies and general medical practitioners in Wales. With a breadth of specialist experience, knowledge and understanding of the legal, administrative and policy issues that affect the operation of the NHS in Wales, our teams are able to support organisations in providing safe, efficient and effective healthcare services to the population of Wales.

General Medical Practice Indemnity

A team of highly skilled solicitors with a particular focus and expertise in managing clinical negligence claims arising from primary care practice.

Commercial, Regulatory and Procurement

A team of highly specialised lawyers who support health bodies in managing these issues in a practical and timely manner.

Clinical Negligence

A department of in-house solicitors and legal support staff who manage the clinical negligence caseload across all health bodies. We aim to handle claims proactively, fairly and consistently.

Complex Patient (Court of Protection)

A team of very experienced healthcare lawyers who provide rapid advice to ensure NHS staff are able to comply with legal requirements and deal with complex legal issues regarding the provision of care and treatment.

Employment

A team of solicitors and legal executives advising on high level strategic policy matters, case management and tribunal hearings.

Putting Things Right

We offer a flexible and hands-on approach to health bodies in dealing with matters under the PTR regulations.

General Healthcare Advice

A wide spectrum of issues can be faced by health bodies and clients. This team draw from the diverse experience within Legal and Risk Services to provide timely advice.

Public Enquiry Support

A team of experienced lawyers who support the collation and presentation of evidence and coordinate legal representation in relation to matters investigated as part of public inquiries.

Inquests

Our inquests team offer full support to our clients, from initial investigations through inquest hearings and beyond, providing guidance on evidence gathering and presentation and coordinating representing for hearings.

Personal Injury and Prosecutions

This team have intimate knowledge of the NHS enabling swift and efficient advice on managing claims and providing expert advice on reducing risks in the workplace, enhancing safety of staff. Where enforcement action is taken against a health body, the team provides support to ensure that evidence is gathered, and the organisation is appropriately represented.

Property Acquisitions, disposals and leases

This highly specialised team work closely with Specialist Estates Services to support all health bodies on matters relating to the NHS Wales estate.

GIG CYMRU NHS WALES

Partneriaeth Cydwasanaethau
Gwasanaethau Cyfreithiol a Risg
Shared Services Partnership
Legal and Risk Services

Our Leadership Team

Mark Harris

Mark Harris is the Director of Legal and Risk Services and the Welsh Risk Pool.

Mark has an LLB law degree, an LLM Master's degree in Commercial Law/Marine Affairs and a Postgraduate Certificate in Health Service Management.

Having worked in Legal and Risk for over two decades, Mark has many years' experience of working on a wide array of clinical negligence and general advisory matters. In addition to leading and developing the business, Mark continues to provide legal advice on the wide range of legal conundrums that face NHS bodies in their day-to-day business.

Daniela Mahapatra

Daniela Mahapatra is the Deputy Director of Legal and Risk Services.

Daniela qualified as a Solicitor in 2005., She obtained her LLB law degree at the University of Wales, Swansea, before moving to Cardiff to undertake the Legal Practice Course. Practicing in employment law, Daniela has advised all health bodies in Wales in complex employment cases.

Committed to developing and supporting the diverse team within Legal and Risk Services, Daniela is also a member of the HPMA Wales Committee - arranging various training events for organisations. Daniela has also taught the Employment Law module on the HRM course at the University of South Wales. Daniela is also a mentor as part of the Coleg Y Cymoedd mentoring scheme.

Jonathan Webb

Jonathan Webb is the Head of Safety and Learning and is the operational lead for the Welsh Risk Pool.

Jonathan is a Registered Paramedic, an experienced Clinical Mentor and has worked in the NHS since 1990.

Prior to joining Legal and Risk Services in 2016, Jonathan was Head of Risk Management in an English Acute Trust and has held a similar role in the Channel Islands. Jonathan's role focusses on overseeing the process of scrutinising and sharing lessons learned from claims and redress cases and assurance of organisational processes for Putting Things Right. Jonathan is also the programme sponsor for the Once for Wales Concerns Management System and Chair of Anti-Violence Collaborative Wales.

Sarah Watt

Sarah Watt is the Head of Healthcare Litigation, the strategic lead for clinical negligence claims, Putting Things Right and Public Inquiry work.

Sarah has a LLB law degree, Law Society Finals Examination pass and Level 5 Qualification from the Institute of Leadership and Management.

Sarah joined Legal and Risk Services in 2003 after working for leading UK healthcare law firms. She became a Team Leader in 2005 and was appointed Head of Healthcare Litigation in 2021. Sarah is particularly experienced in high profile investigations, very high value claims and has the work to support health bodies giving evidence to the coronavirus public inquiry.

Sarah Hookes

Sarah Hookes is the Assistant Head of Safety and Learning and coordinates the Safety and Learning Programmes.

A Registered Midwife and trained Nurse, Sarah has over 25 years' experience as a Midwife in North Wales.

Sarah joined the Welsh Risk Pool in 2018 to lead the implementation of PROMPT Wales and remains a key part of the national team. Sarah's role involves the oversight of all of the Safety and Learning Programmes operated by the Welsh Risk Pool – engaging local teams to reduce avoidable harm.

Sue Saunders

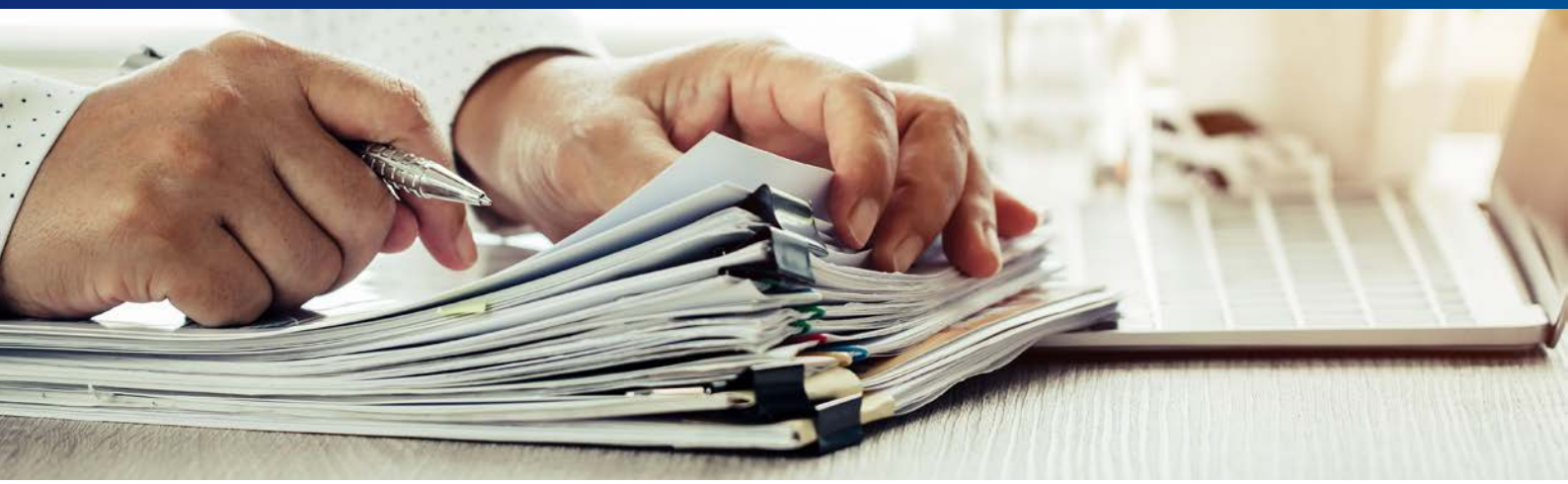
Sue Saunders is the Head of Finance for Welsh Risk Pool and Legal and Risk Services Management Accountant.

A qualified accountant, Sue has many years of experience in NHS accounting and supports health bodies with their financial returns relating to the Welsh Risk Pool to Welsh Government.

The financial functions of the Welsh Risk Pool and Legal and Risk Services are coordinated by the Corporate Finance Team within NHS Wales Shared Services Partnership. Sue is responsible for the Welsh Risk Pool and Legal and Risk accounts.

Chairing the sub-Technical Accounting Group for Welsh Risk Pool matters, Sue ensures that the application of financial principles is consistent throughout NHS Wales.

Welsh Risk Pool Committee



Strategic oversight of the work of the Welsh Risk Pool is provided through the Welsh Risk Pool Committee – which is a sub-committee of the NHS Wales Shared Services Partnership Committee.

The Welsh Risk Pool Committee makes decisions in relation to the reimbursement procedures, workplans for reviews and the reimbursement of claims and redress cases. Membership of the Welsh Risk Pool Committee is drawn from Welsh Government and Executive and Independent Members from NHS Wales Health Bodies. Committee members represent their professions rather than individual organisations and a Terms of References outlines the roles and responsibilities of the group.

Membership of the committee is:

- Chair of Shared Services Partnership Committee *[Chair of WRPC]*
- Welsh Government Finance
- NWSSP Director of Legal and Risk Services
- Managing Director of NHS Wales Shared Services Partnership *[WRP Accountable Officer]*
- NWSSP Medical Director
- NWSSP Deputy Director or Legal and Risk Services
- NWSSP Director of Finance and Corporate Services

And Representatives of:

- Welsh Government Medical Officers
- Health Body Chairs
- Health Body Medical Directors
- Health Body Directors of Finance
- Health Body Audit Committee Chairs
- Health Body Directors of Primary Care
- Health Body Chief Executives
- Health Body Directors of Nursing
- Health Body Directors of Therapies and Health Science
- Health Body Directors of Corporate Governance
- Health Body Directors of Digital Services

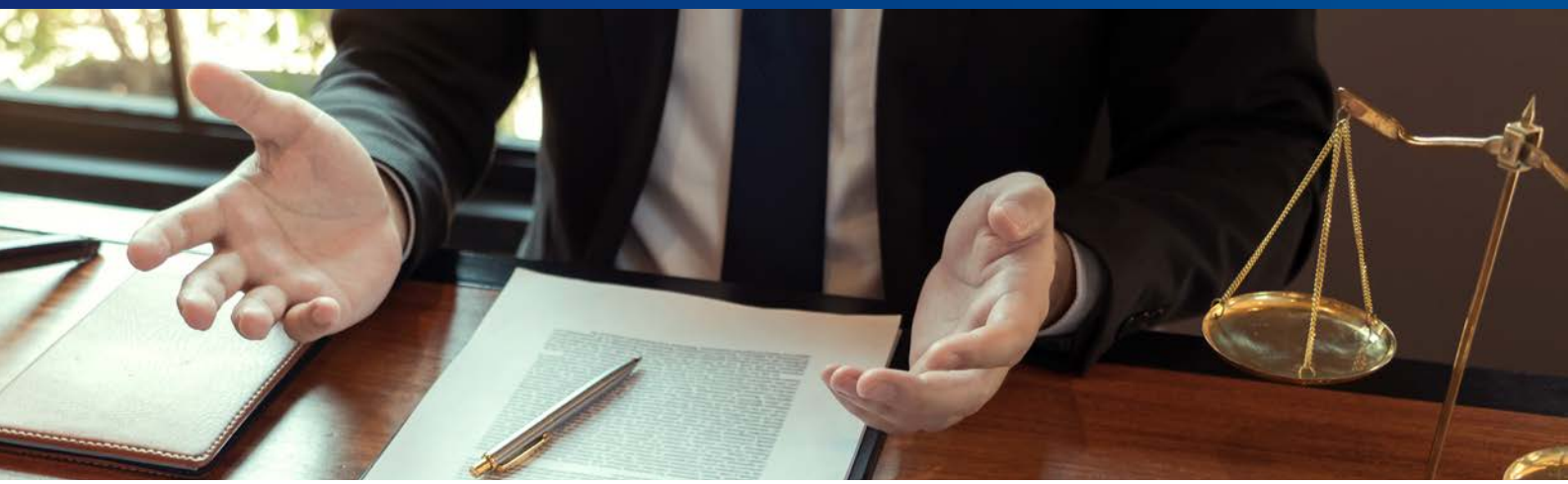
During 2024/25, the Welsh Risk Pool Committee met on six occasions and coordinated the safety and learning workplan and future strategy. **1430** cases were considered by the committee, with a total reimbursement to Health Bodies in 2024/25 of **£114.6m**.

Table.1 outlines the number of cases reviewed and reimbursements approved at each of the meetings during the year.

Welsh Risk Pool Committee 2024/25							
Cases Reviewed & Reimbursements							
Committee Date	May-24	Jul-24	Sep-24	Nov-24	Jan-25	Mar-25	**TOTAL**
Cases Reviewed	230	227	209	240	252	272	**1430**
Reimbursement	£17,205,310.67	£10,938,758.24	£9,464,751.09	£9,948,140.48	£23,011,835.29	£11,953,204.62	£82,522,000.39

Table 1: Number of cases reviewed and Reimbursements by WRPC 2024/25

Our Highlights for 2024/25



Driving improvement in learning information collation.

We successfully introduced the U8 Structured Evidence Collection Checklist – supporting health body corporate teams to collate supporting information and evidence in response to the findings of the National Learning Advisory Panel.

Improving the quality of Learning submissions.

We introduced a checklist for signatories of Learning from Events Reports – to outline the steps they will take to reduce the potential for reports to be red deferred by the panel.

Providing assurance and improvement plans for learning.

We successfully completed a further round of concerns assessments and included a review of the processes which underpin coronial investigations and inquests. Action plans were received from all health boards to ensure continuous improvement.

VTE Awards 2025.

Our Thromboprophylaxis Safety & Learning Advisor, Christine Welburn, was invited to represent the Welsh Risk Pool at the national VTE Awards 2025 hosted at the Houses of Parliament by Thrombosis UK.

Launch of MoNET Wales.

We developed, trialled and implemented a pilot of a Neonatal Multi-Professional emergency training programme, in response to the recommendations within the MatNeo Safety Support Programme.

IFS Wales team present a poster at British Intrapartum Care Society Conference.

The national team returned to the 2024 conference in Ireland, showcasing the vision, development and implementation of this important All-Wales programme.

Sarah Hookes speaks at the prestigious PROMPT Symposium in Bristol.

Sarah was invited by Professor Tim Draycott of the PROMPT Maternity Foundation to showcase the Wales approach to scaling, embedding and sustaining PROMPT Wales over the last seven years.

IFS Wales team present at 'Monitoring May.

The team addressed this 2-day event which attracts a UK-wide audience of clinicians and leaders with a special interest in fetal monitoring. The team were invited back for a second year to update on progress, with great interest shown in our all-Wales approach.

Asst. Head of Safety and Learning joins the Avoiding Brain Injury in Childbirth programme.

Sarah Hookes joined the ABC collaboration, as Senior Clinical Midwifery Advisor with the Royal College of Obstetricians and Gynaecologists. Sarah was able to draw on her extensive experience in NHS Wales of designing, facilitating and implementing training programmes to support the ABC programmes 'Management of impacted fetal head at caesarean birth' and 'Recognition and detection of suspected intrapartum fetal deterioration.'

Sarah Hughes, Operations Manager graduates with BA in Business Management.

For her dissertation module, Sarah carried out a survey on staff perceptions of agile working in NWSSP, which has informed the organisation moving forward. Her dedication to her studies earned her a First Class Honours award.

VTE Wales programme ramps up.

A bespoke training package to support clinicians who are involved in the consent process has been rolled out throughout all health bodies and primary care providers in NHS Wales.

PROMPT Wales collaborate with the Emergency Medical Retrieval & Transfer Service.

Members of the national team joined forces with EMRTS to develop bespoke algorithms to support safe practice and management of pre-hospital maternity emergencies. Now included in their Standard Operating Procedures, the algorithms were launched at 2 EMRTS training days delivered by our team.

Influencing and supporting the People's Experience Survey.

Throughout the year, the Once for Wales team and the People's Experience Feedback Network (formally known as the Service User Feedback Network) were key stakeholders and contributors to the review and development of the new People's Experience Survey and the People's Experience Framework – which was launched by Welsh Government in April 2025.

People's Experience Survey nominated for awards.

The People's Experience Survey, which is a bilingual validated core set of questions has been rigorously tested and validated across all health settings. The PES is award winning, picking up an ISPOR Europe 2024 Research Presentation Award, winning the Health and Care Research Wales, Public Involvement Award and has also been shortlisted for the NHS Wales Awards 2025.

Jonathan Webb speaks at the Connected Healthcare Summit.

The Head of Safety & Learning presented at this international event, outlining the benefits of digital data alignment and achieving measurable improvements in clinical and operational outcomes in safety & learning programmes.

Successful implementation of four national experience surveys.

The Once for Wales team, in conjunction with the Civica Experience system leads, successfully launched four national surveys, gathering valuable all-Wales data on key areas. The surveys were the People's Experience Survey, The Maternity & Neonatal Survey, The Enhanced Community Care Survey and the Looked after Children Survey.

Fantastic take-up of the Emergency Department Survey.

This was the pilot of national surveys and closed to new feedback in March 2025. From its launch in August 2023 up to March 2025, a total of 50,375 completed feedback responses were received. Analysis of this valuable data is ongoing and will be shared widely to support learning and service improvement across NHS Wales.

Inclusion of Restrictive Practices in Once for Wales Data.

In conjunction with NHS Performance & Improvement, the team have developed a process to accurately capture and review the use of Restrictive Practice in our most vulnerable service users – ensuring practices can be better monitored and reviewed to reduce harm to service users and staff.

Launch of Complex Case Support Tools.

During the year, a dedicated team from across NHS Wales and led by our Anti-Violence Collaborative colleagues, developed processes and tools to support our teams when dealing with complex investigations – supporting our work to reduce vexatious and unreasonable demands being placed on concerns teams across Wales.

Official re-launch of the Anti-Violence Collaborative.

Early in the year at a prestigious event held at Welsh Government the AVC partners issued refreshed documents, including the Obligatory Responses to Violence in Healthcare. The NHS Chief Executive, Judith Paget hosted Chief Constables, the Head of the Crown Prosecution Services in Wales and executives from health bodies. The Chair of AVC, Jonathan Webb, addressed the attendees on the workplans to reduce aggression & violence across the NHS.

AVC publishes new guidance and information.

Guides for both NHS staff and police officers have been released - specifically concentrating on the response to violence when mental health is a factor. A simplified form was developed, in conjunction with clinicians and prosecutors, to enhance the operational response to mental health and violence & aggression.

AVC distributes over 400 bilingual posters across NHS Wales.

A range of posters, with links to online supporting information were provided to all health bodies across the NHS Wales footprint, including primary care services – highlighting and reminding our patients, their relatives and our staff that violence or aggressive behaviour in the NHS is unacceptable.

Enhancements to the investigation of V&A Incidents

Following consultation with subject matter experts, improvements were made to the Datix Cymru V&A incident report; helping to identify alleged perpetrators more easily and to collect meaningful data concerning potential hate crimes.

AVC enhances links with JESC.

The team has worked closely with staff in the other 'blue light' services in Wales, with a permanent point of contact with the Joint Emergency Services Group now in place – meaning incidents can quickly be reviewed by appropriate colleagues. The Fire & Rescue Services in Wales are now active members of the AVC, aiming to further reduce unacceptable behaviour towards firefighters in Wales.

Supporting work on unacceptable behaviour.

Team members have been active participants, at the request of Welsh Government, on several work groups focusing on improving the public sector response to incidents of sexual harassment and racist behaviour.

Aiming to expand the impact of the AVC into primary care.

Positive discussions have been held with representatives of primary care clinical colleagues, with the aim of developing support for staff in this vital healthcare sector.

Datix Cymru successfully enhanced.

The quarterly cycle of design review for Datix Cymru has enabled the introduction of a number of enhancement and system improvements. The team has led quality assurance testing and implementation of four system releases across all fifteen Datix Cymru systems in NHS Wales.

Enhancements for Nationally Reportable Incidents.

The Once for Wales team has led the introduction of a system to enable the automatic transfer of Nationally Reportable Incident data from each of the Health Body systems into the NHS Performance & Improvement system - removing the need for local teams to submit forms and the manual entry of data. This provides swift and efficient data on key events across Wales.

Datix Cymru Safeguarding Functionality

The Introduction and ongoing support of the Safeguarding reporting functionality for our early adopter sites in Hywel Dda University Health Board and investigation tools in several other health bodies has enhanced the information available to both health bodies and local authorities, sharing essential information to keep children and vulnerable adults safe.

Enhancing Community Pharmacy Incident Reporting in Datix Cymru

Working in collaboration with Welsh Government, Community Pharmacy Governance Leads and Primary Care Providers, the team have enhanced the system for Incident Reporting – enabling community pharmacies across Wales to share details of incidents with their commissioning health boards and establish monitoring of improvements for patient safety.

Eido Digital Consent Centre Wales launched.

The Once for Wales team oversaw the transition to a new Eido platform for Decision Making & Consent Information. The new platform provides greater flexibility and utilises user- friendly Single Sign-On technology. The system facilitates multiple consent information leaflets to be downloaded or sent electronically in a single communication to a patient who is undergoing a procedure. All the leaflets are available in a bilingual Welsh / English format and a number of alternative languages and accessible formats – including large print and Easy Read.

New Joint Investigation functionality for health bodies.

The Once for Wales team have developed a new joint investigation module – enabling organisations to actively manage, share and learn from joint investigations. Teams from Cardiff & Vale University Health Board and Welsh Ambulance Services University NHS Trust have kindly early adopted this useful technology.

Increased learning reviews by the independent panel.

The Safety & learning Team and the National Learning Advisory Panel reviewed 738 newly submitted Learning from Events Reports — a 19% increase from the cases reviewed in the previous year. Despite the rise in volume, all cases were reviewed within the expected timeframes, ensuing health bodies had assurance of the measures implemented in response to claims and redress cases.

A successful healthcare law conference was held

Led by the commercial and regulatory team, in Autumn 2024. This brought together clients from around Wales to hear the latest in case law impacting NHS services.

Successful support to Health Boards in commissioning disputes

The commercial & regulatory team acted for two separate health boards in funding disputes with English Integrated Care Boards. On each occasion we were successful, which led to both Health Board's receiving substantial reimbursement of fees.

Successful defence of a breach of contract claim.

The commercial & regulatory team was instructed by a Health Board in relation to a claim brought by a contractor for breach of contract, where the contract was terminated due to the contractor's unsatisfactory performance. Proceedings were commenced by the contractor for around £280,000 in respect of sums allegedly due to the contractor under the contract. The claim was defended and compromised at an early stage, where the contractor agreed to withdraw the claim in its entirety and further agreed to pay a sum in respect of the costs in defence.

Support in reducing ophthalmic surgery waiting list.

The commercial & regulatory team assisted a Health Board in respect of two agreements to address the backlog of urgent eye operations; the agreements were essential for the activity to commence.

Costs ordered in employment cases, reducing the financial burden on NHS Wales

The employment team have successfully secured costs orders across numerous cases. This helps to reduce the financial burden on NHS Wales in cases taken to the Employment Tribunal Employment Appeal Tribunal. In some cases, the court has made an order which places a charge on a claimant's property whilst in some instances the amount of costs payable by the claimant to the respondent were agreed without the need for a court hearing.

Successful defence of employment claims.

The employment team has continued to secure successful outcomes across a number cases at final hearings, with some claims being dismissed in favour of health bodies. Whilst aiming to be an employer of choice, NHS Wales organisations defend claims for unfair & wrongful dismissal or discrimination related claims.

Successful finding in a case about Worker status.

The employment team coordinated a matter which related to whether the claimant was a worker. The positive finding was arrived at by the court on the basis that there was no overarching contact and the claimant was only a worker for the duration of a shift or assignment. When the claimant was not performing a shift or session, they were not a worker. There was no umbrella contract therefore and holiday pay only accrued during a shift. Whilst each case is considered on the facts of the matter, the implication of the finding in this case assists the team in guiding health bodies.

Employment team deliver a wide range of training for NHS Wales.

The Team has successfully continued with a training programme of webinars, with a further programme planned.

Property deal maximises space at hospital.

The property team was instructed by Swansea Bay University Health Board on an agreement for lease and a fifteen year lease of Unit 2 Sandringham Park, Swansea Vale, Swansea. The acquisition of this vital space, enables the health board to free up accommodation on the Morriston Hospital site so that it can be used for clinical purposes. It also allows the Health Board to consolidate the medical records service on one site. It was a difficult brief to fulfil as the organization needed good quality, affordable, hybrid building which is a mixture of offices and storage.

Property Team support innovative centre in health board.

Maggie's, the national charity that provides free expert care and support in centres across the UK and online, sought to develop a collaborative working agreement with Betsi Cadwaladr University Health Board (BCUHB) to build a Maggie's Centre on the Glan Clwyd Hospital site from 2018. BCUHB began working with earnest with the team at Maggie's from 2021, and the NWSSP Legal and Risk Team were involved from the outset of the discussion on the principles of working together and the shared vision of the project. The property team continue to provide professional advice and are seen as an instrumental partner in the design and delivery of the project. The team have done far more than provide professional advice; members of the team have given Maggie's confidence through their consistent support for the project, and importantly have supported the BCUHB team by demonstrating compassion, patience and a real understanding of the aims of the project throughout the process of drawing up the legal agreements. Through adopting a values-based approach to working with BCUHB and Maggie's, the property team have helped maintain focus during challenging phases of the project, and have played a key role in creating a trusting environment and secure foundations for the Maggie's – BCUHB partnership to build on.

Supporting the development of the new cancer centre

Velindre University NHS Trust has completed the purchase of the majority of the Whitchurch Hospital site from Cardiff & Vale University Local Health Board (CVUHB) for over £7m. The land purchase was complex, and all parties worked for close to a year to ensure the sale and purchase took place within the financial year.

Completing a lease for a Surgery lease to ensure continuity of service to patients

The property team have supported the lease for Solva's surgery. As the practice at St Davids was being closed and all patients were being transferred to the Solva Surgery practice, completion of the lease at Solva was critical to securing continuity of service for Hywel Dda University Local Health Board (HDUHB). HDUHB needed to carry out essential alterations to the premises in order to cope with the larger number of patients attending and so were under pressure to complete the lease before 1 April. With the assistance of the property team, the lease completed in early March.

Supporting the transition of a former council building for use as a health hub.

The property team completed on the purchase of Caledfryn in Denbigh, a former council office building that has been sold to Betsi Cadwaladr University Health Board (BCUHB) to establish a health & social care hub. The sale was completed on April 2, 2025. The building will be used to consolidate BCUHB services, including a GP surgery, into a single location. The plan is to employ 250 staff at the site. Proposals for the new hub include a mix of children's and adult services, with the Community Resource Team (CRT), midwifery, community mental health and learning disabilities among services expected to be based on site. CRTs are existing partnerships between Health Board community nursing teams and local authority social care professionals, who work collaboratively in a single location. The property team had to work.

Our Caseload

NHS Wales continues to provide a high quality of care every day, with millions of patient-contacts each year. The volume of patients receiving care and treatment continues to rise. The majority of patients and service users receive an excellent standard of care, but on occasion errors do occur and these can lead to claims or redress cases. Harm is caused by multiple factors, including mistakes and failures in the processes and systems which underpin service delivery. The Welsh Risk Pool and Legal and Risk Services play an integral role in supporting all health bodies in NHS Wales in managing cases and learning from mistakes.

The litigation profile represents payments which are taken from public funds that would otherwise be used for healthcare services. Whilst we rightly focus on the financial cost of harm, it is important to recognise that the events which lead to claims and redress cases can involve serious harm to patients, staff and visitors. It is therefore essential that steps are taken to improve processes, education, and learning - sharing outcomes and good practice nationally. The process of learning-from-events aims to ensure that issues which have led to a claim or redress case are identified and learning or improvements put into place to reduce the potential for repeat events.

Claims and Redress Case Profile

The profile of cases managed by the Welsh Risk Pool and Legal and Risk Services relate to clinical negligence, personal injury and redress matters.

The Welsh Risk Pool administers the risk pooling arrangement and meets the cost of financial losses for claims over £25,000 and all reimbursable expenditure on redress cases. The most significant element of expenditure relates to clinical negligence matters.

Clinical negligence and personal injury claims are managed using the legal processes outlined in the pre-action protocols contained in the Civil Procedure Rules issued by His Majesty's Courts and Tribunals Service (HMCTS) which apply in England and Wales. If proceedings are issued, the conduct of the claim is coordinated by a judge.

Redress cases are conducted using the requirements set out in the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011, which are known as the Putting Things Right (PTR) Regulations, and these have a published legal guidance which sets out the expectations required of the parties.

The PTR Regulations, and the associated guidance, are currently under review by Welsh Government. The Welsh Risk Pool and Legal and Risk Services are actively supporting and advising Welsh Government and all Health Bodies in that review.

Clinical Negligence Matters

The number of substantive open clinical negligence cases at the end of each financial year provides a useful indicator of the current clinical negligence caseload pressure experienced by NHS Wales. This is shown in Fig.1. These figures do not include cases from the Scheme for General Medical Practice Indemnity, which are managed separately.

As we have previously reported, there was a spike in cases as we approached 2013 because of a rush by Claimants' solicitors to open new cases before new costs rules came into force. We also changed our methodology for opening new cases from 2017/18 - only accepting those with a letter of claim or that fell into the criteria for early reporting, where health bodies inform us of specific incidents soon after they occur. Prior to that we included matters even if there was not yet a letter of claim, such as pre-action disclosure requests.

There was some disruption to the timing of cases brought during and immediately following the pandemic. Considering the impact of the three-year limitation period (the time period that most claims can be brought against a health body), taking into account limitation waivers that were agreed, we consider that this impact has now largely subsided.

Overall in NHS Wales, recent years have demonstrated an increasing trend of clinical negligence case numbers. 2024/25 highlights a stable position - with claim numbers not increasing further and remaining broadly at the same level as the previous year. A total of 1842 clinical negligence claims were open at 1st April 2025.

Open Clinical Negligence Matters

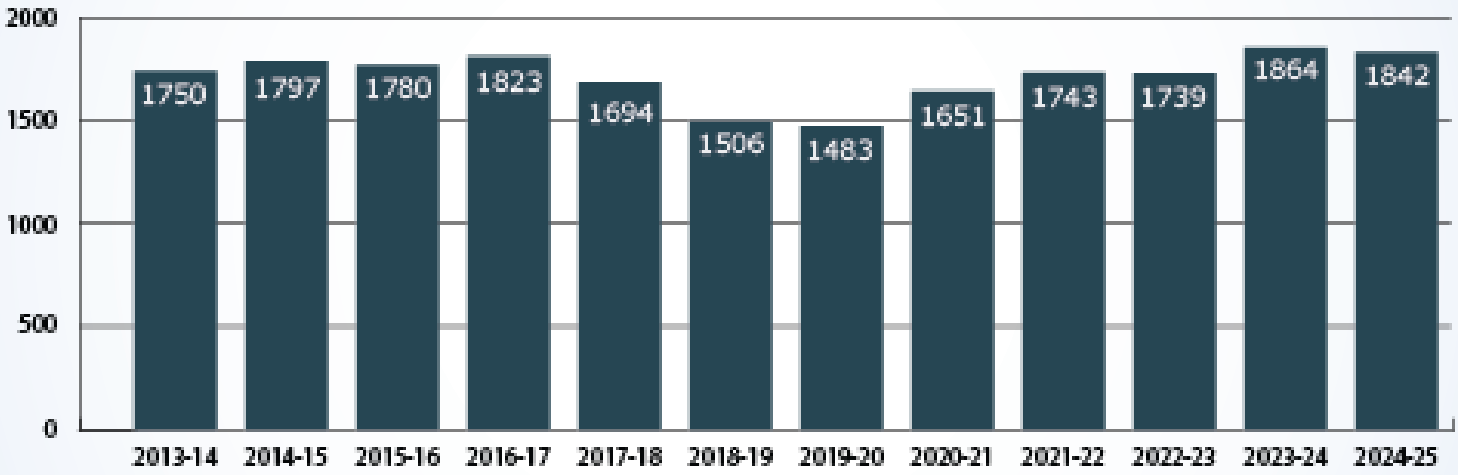


Fig.1 Open Clinical Negligence Matters

An important part of the role of Legal and Risk Services is the careful analysis and investigation of all matters brought against health bodies. We are successful in defending cases where this is appropriate, which reduces avoidable costs for the Welsh taxpayer. Since we restricted our criteria for opening a matter in the main to those where a formal letter of claim has been received, there has been a modest consequential decrease in the number of cases subsequently closed without damages. Fig.2 outlines the proportion of cases which are closed without damages over the last five years. This shows that we are consistently defending well over a third of matters.

Percentage of Clinical Negligence Matters Closed Without Damage

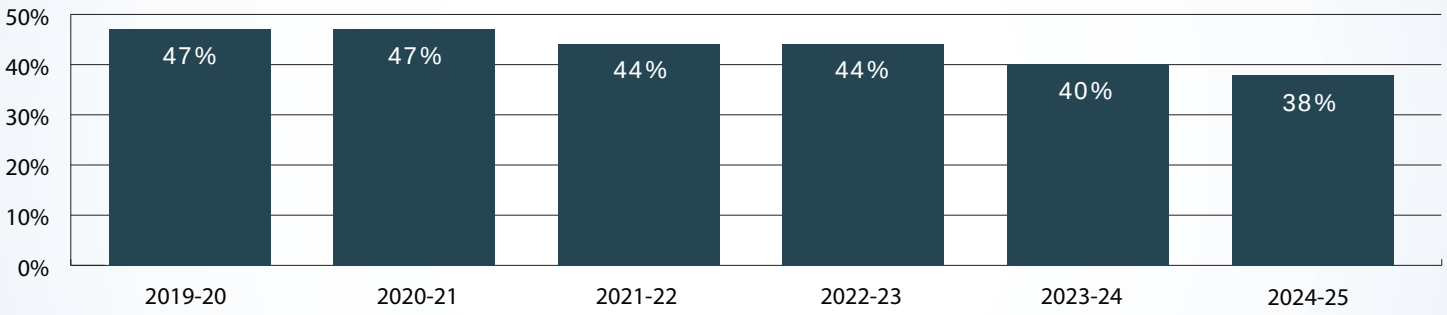


Fig.2 Proportion of Clinical Negligence matters closed without damages paid

Example Case Successfully Defended

Proceedings were brought in respect of a patient who had died following attendance and discharge at A&E. The patient presented to A&E complaining of back pain, shooting pains down his legs and long-term incontinence. Pain control had improved during admission and the patient was discharged in the early hours of the morning with antibiotics, safety netting advice and told to attend his GP for further investigations. However, whilst leaving the hospital the patient used the hospital toilet and suffered a fall. He was taken back to A&E, assessed and then discharged home later.

The patient subsequently deteriorated at home and was readmitted 3 days later. A scan identified a subdural haematoma which required craniotomy and evacuation, following which he made a slow but good recovery. Several years later the patient deteriorated quite significantly, requiring care home placement until his death.

It was alleged that the Deceased should not have been discharged, should have had a falls risk assessment and, had this occurred he would have avoided the fall and subdural haematoma. The matter was carefully investigated by Legal & Risk Services. Factual witness evidence was obtained and expert in the fields of Emergency Medicine, General Medicine, Neurology and Neuro-surgery.

The trial took place, and the judgement was given in favour of the Health Board. It was recognised that the care provided and decisions taken were appropriate. Key to this outcome was the engagement and support of the treating clinicians who gave evidence in court.

This led to a significant financial saving for NHS Wales and highlights our commitment to support our clinicians.

NHS Wales undertakes a wide range of clinical procedures and provides care and treatment in a wide array of clinical settings. Claims may arise from any clinical contact and the Welsh Risk Pool monitors the distribution of the principal clinical specialties identified in a claim.

The most frequently occurring specialty relating to clinical negligence claims is maternity services, which includes obstetrics and midwifery-led services. These represent 18.4% of all clinical negligence cases managed by Legal and Risk Services over recent years. This proportion is consistent with the other NHS nations in the UK. The Welsh Risk Pool has invested significantly to work with clinical teams in maternity and neonatal services across NHS Wales to address the causal factors of claims within this specialty.

The majority of clinical negligence matters relating to maternity services involve harm to a baby and the three-year limitation rule does not apply. These cases can therefore take many years to be brought or to be concluded and most of the current maternity services matters being investigated in 2024/25 have an index date of more than four years earlier.

Many patients present to emergency departments, specialist assessment units and minor injury services and there is widespread recognition of the pressure experienced by these services. Claims related to these settings represent 14.7% of all clinical negligence matters being managed by Legal and Risk Services during 2024/25. This proportion is broadly similar to the previous year.

Matters relating to assessment and treatment, including surgery, in orthopaedic and trauma cases have for some time, consistently been in the top three specialities in which claims are brought. It is recognised that the number of orthopaedic procedures conducted by NHS Wales every year is very large and the proportion of cases which lead to a claim being brought is very low. There has been a reducing trend in the proportion of claims in this specialty during the last three years and in 2024/25, orthopaedics and trauma surgery represented 9.9% of all cases.

Cases involving radiology, including the interpretation of X-rays, CT-scans and MRI imaging, have increased over the previous three years and in 2024/25, this specialty represented 2.9% of clinical negligence claims. The Welsh Risk Pool recognises international shortages of Radiologists and the work being done by the NHS to digitise more work, introducing the Radiology Informatics System (RISP), to streamline services and reduce delays. The UK Health Security Agency (UKHSA) has introduced a new taxonomy for its four-nation review of radiology and imaging incidents. This will become a mandatory element of the Datix Cymru system from 1st August 2025. Analysis of the challenges relating to radiology reports not being followed up when a patient has left the care of a department, has been the subject of a national review by the Welsh Risk Pool Committee, which found an improving but challenging position.

The proportion of matters relating to mental health and psychology services has exceeded the 2% level for the first time in 2024/25 – with this group of specialties accounting for 2% of all clinical negligence matters.

The specialities captured by the Welsh Risk Pool and Legal and Risk Service, relate to a bespoke list that was first utilised in approximately 2000. With the recent introduction of a new electronic Case Management System in April 2025, we will be able to publish specialty data in future using the national NHS Wales list as far as possible – supporting the extrapolation and analysis of claims data against other information sources.

Fig.3 outlines the distribution of the top eleven clinical specialties (those representing 2% of more of all cases) in clinical negligence matters for 2024/25 and also provides a comparison with the values found in previous years. The 'other' category includes the 38 specialties which are included in the current Legal & Risk database.

Principal Clinical Speciality in Clinical Negligence Matters 2021-2025

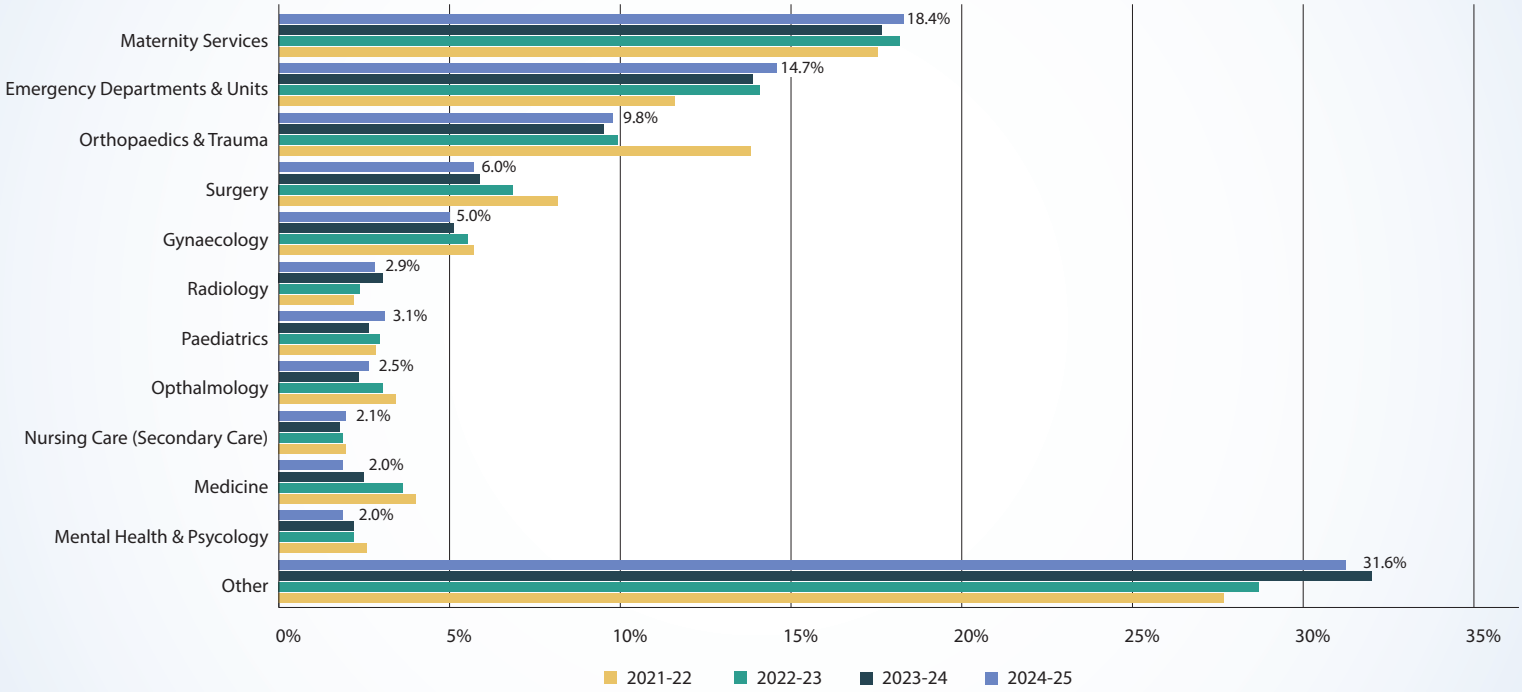


Fig.3 Proportion of Principal Clinical Specialties in Clinical Negligence matters

Table.2 (next page) provides a breakdown of all principal clinical specialities for cases which were open and being investigated or managed at any time in the last four years. The current database includes a category "Other / Unspecified" which is used to highlight those matters which are still being investigated to determine the appropriate specialty or where the correct specialty is not currently shown within the existing database.

	Total 2024/25	% 2024/25	Total 2023/24	% 2023/24	Total 2022/23	% 2022/23	Total 2021/22	% 2021/22
Total Matters	**2423**		**2356**		**2278**		**2250**	
Maternity Services	447	18.45%	422	17.91%	419	18.39%	399	17.73%
Emergency Departments & Units	356	14.69%	333	14.13%	324	14.22%	261	11.60%
Orthopaedics & Trauma	237	9.78%	226	9.59%	226	9.92%	304	13.51%
OTHER / UNSPECIFIED	236	9.74%	175	7.43%	117	5.14%	124	5.51%
Surgery	145	5.98%	142	6.03%	164	7.20%	183	8.13%
Gynaecology	122	5.04%	121	5.14%	123	5.40%	123	5.47%
Urology	74	3.05%	97	4.12%	51	2.24%	48	2.13%
Radiology	71	2.93%	71	3.01%	60	2.63%	52	2.31%
Paediatrics	60	2.48%	67	2.84%	66	2.90%	64	2.84%
Medicine	50	2.06%	60	2.55%	79	3.47%	84	3.73%
Ophthalmology	48	1.98%	54	2.29%	63	2.77%	66	2.93%
Mental Health & Psychology	48	1.98%	43	2.25%	52	2.28%	52	2.31%
Nursing Care (secondary Care)	45	1.86%	48	2.04%	45	1.98%	48	2.13%
Ambulance / Paramedics	45	1.86%	46	1.95%	48	2.11%	28	1.24%
Gastroenterology	42	1.73%	36	1.53%	32	1.40%	26	1.16%
Primary Care & General Practice (exl GMPI)	37	1.53%	36	1.53%	44	1.93%	47	2.09%
Cardiology	36	1.49%	35	1.49%	34	1.49%	32	1.42%
Ear Nose & Throat	32	1.32%	34	1.44%	32	1.40%	34	1.51%
Colorectal Surgery	31	1.28%	33	1.40%	30	1.32%	17	0.76%
Oncology	29	1.20%	33	1.40%	32	1.40%	32	1.42%
Neurology	29	1.20%	30	1.27%	29	1.27%	24	1.07%
Neurosurgery	28	1.16%	24	1.02%	26	1.14%	25	1.11%
Respitatory	20	0.83%	21	0.89%	14	0.61%	8	0.36%
Anaesthetics	20	0.83%	18	0.76%	20	0.88%	18	0.80%
Haematology	15	0.62%	14	0.59%	13	0.57%	12	0.53%
Podiatry	13	0.54%	14	0.59%	9	0.40%	4	0.18%
District Nursing & Health Visiting	12	0.50%	13	0.55%	11	0.48%	8	0.36%
Dermatology	11	0.45%	10	0.42%	11	0.48%	12	0.53%
Pathology, Histology & Microbiology	11	0.45%	10	0.42%	12	0.53%	9	0.40%
Geriatric Medicine	9	0.37%	9	0.38%	10	0.44%	10	0.44%
Rheumatology	8	0.33%	9	0.38%	8	0.35%	6	0.27%
Cardiothoracic Surgery	7	0.29%	7	0.30%	6	0.26%	8	0.36%
Dental	7	0.29%	7	0.30%	4	0.18%	11	0,49%
GP out of hours	7	0.29%	7	0.30%	8	0.35%	8	0.36%
Maxilofacial	6	0.25%	7	0.30%	3	0.13%	10	0.44%
Nephrology	6	0.25%	7	0.30%	10	0.44%	11	0.49%
Physiotherapy	4	0.17%	7	0.30%	11	0.48%	12	0.53%
Oral & Maxilofacial Surgery	4	0.17%	6	0.25%	11	0.48%	10	0.44%
Cytology	4	0.17%	5	0.21%	8	0.35%	7	0.31%
Audiology	3	0.12%	3	0.13%	2	0.09%	1	0.04%
Genetics	3	0.12%	2	0.08%	2	0.09%	2	0.09%
Plastic Surgery	3	0.12%	2	0.04%	3	0.13%	3	0.13%
Administration, Estates & Business Services	1	0.04%	1	0.04%	2	0.09%	3	0.13%
Genitourinary Medicine	1	0.04%	1	0.04%	3	0.13%	3	0.13%
Speech Therapy	0	0.00%	0	0.00%	1	0.04%	1	0.04%

Table.2 Breakdown of Principal Clinical Specialties (4 years)

Quantum

The value of claims gives a useful indication of the impact of litigation on NHS Wales. The cost to the NHS of claims is made of up damages paid to a claimant, the cost of defending a matter, payment of the legal costs of a claimant in cases in which damages are paid and payments to government agencies such as the Compensation Recovery Unit (CRU) which also handles payments for treatment by the NHS in cases where harm is caused. The collective term for all of these payments is the 'quantum' of a case and Legal and Risk Services carefully estimates quantum in each case, with regular reviews at key stages, throughout the time that a matter is open.

As part of the analysis of matters, specialist lawyers at Legal and Risk Services define cases in respect of the probability of settlement. The categories are Remote, Possible, Probable and Certain. The determination for each category is a percentage of the likelihood of the case being settled with damages paid or awarded by a court.

- 0% - 5% Remote
- 6% - 49% Possible
- 50% - 94% Probable
- 95% - 100% Certain

Whilst all cases have the potential for settlement, cases considered Probable or Certain are used to highlight cases which are more likely to result in costs to NHS Wales.

Fig.4 outlines the quantum in clinical negligence claims as at 1st April 2025. Fig.5 outlines the volume of open cases as at 1st April 2025. Table.3 outlines the number and quantum of cases for the top eleven specialties. Table 3a provides a breakdown of the number and quantum of cases for all specialties.

This information shows that Maternity Services represents the largest proportion of cases (n=365) and also has a significant level of quantum (£1.4bn). This shows that Maternity Services cases have an average cost of approximately £4.2m whilst the claims involving Emergency Departments have an average cost of £0.5m per case.

The overall number of cases marked as Probable or Certain has increased from 670 to 869 cases. This is predominantly due to reviews of matters undertaken by legal teams in preparation for the migration to the new case management system (which went live in April 2025), rather than a direct increase in harm cases.

With such a high proportion of the litigation profile, and associated harm, being associated with maternity services, the Welsh Risk Pool focusses a considerable amount of time, effort and resource in supporting maternity and neonatal services; as reducing the claim profile, even by a small volume, has a significant impact on the overall position - along with reducing avoidable harm and impact to women and babies. In examining the Probable and Certain cases, where there is a high likelihood of settlement occurring, Maternity Services represent 19.1% of this group of cases (n=168 of 869 matters), whilst the quantum represents 59.7% of the overall NHS Wales claim profile (n=£1.4bn of £2.4bn). Paediatrics, which include neonatal services, represents 3.6% of all cases (n=32 of 869 matters), whilst the quantum represents 7.5% of all cases (n=£178.8m of £2.4bn).

The Welsh Risk Pool Committee therefore maintains a significant focus on supporting programmes that address the causes of claims in the maternity and neonatal sectors.

Quantum - Clinical Negligence 2024/25

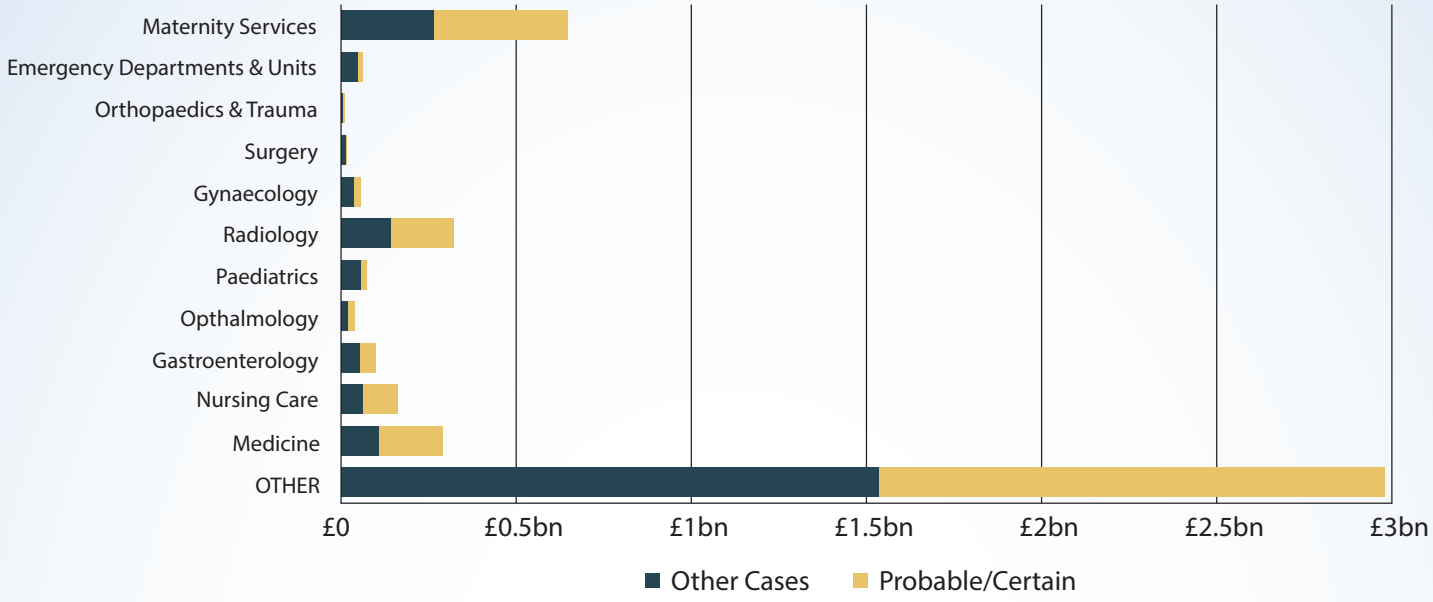


Fig.4 Quantum – Clinical Negligence 2024/25

Proportion of Open Clinical Negligence Cases April 2025

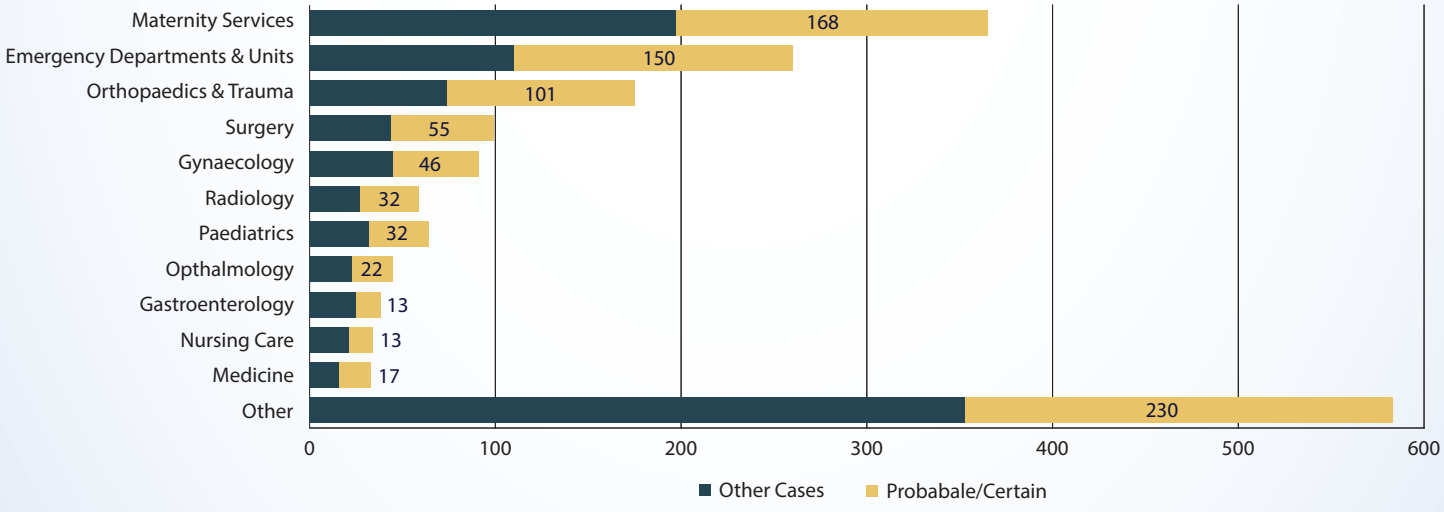


Fig.5 Proportion of open Clinical Negligence Cases Apr 25

	All Cases		Probable / Certain Cases	
Speciality	Number Cases	Total Quantum	Number Cases	Total Quantum
Maternity Services	365	£2,978,505,725.79	168	£1,444,946,127.11
Emergency Departments & Units	260	£291,290,341.50	150	£184,368,661.50
Trauma and Ortopaedics	175	£161,766,084.87	101	£100,438,024.87
Surgery	99	£98,410,938.58	55	£45,963,858.58
Gynaecology	91	£39,093,897.60	46	£21,218,850.22
Urology	59	£73,876,281.40	32	£19,571,561.40
Radiology	64	£321,294,503.92	32	£178,829,623.92
Paediatrics	45	£54,773,564.54	22	£20,016,724.36
Medicine / Medical	38	£17,395,187.28	13	£5,607,694.48
Opthalmology	34	£8,892,160.00	13	£3,226,710.00
Mental Health / Psychiatry	33	£61,201,681.97	17	£13,561,681.97
Nursing Care	583	£646,227,175.64	230	£381,236,342.26
Ambulance / Paramedics	35	£15,794,992.50	15	£5,911,450.00
OTHER	482	£217,094,094.81	128	£103,997,445.42
TOTAL	1846	£4,752,727,543.09	879	£2,418,985,860.67

Table.3 Number and Quantum of Clinical Negligence Cases Apr 25

Table.3a Full outline - Number and Quantum of Clinical Negligence Cases Apr 25 (See next page)

Table.3a	All Cases		Probable / Certain Cases	
Speciality	No of Cases	Total Value	No of Cases	Total Quantum
Maternity Services	365	£2,978,505,725.79	168	£1,444,946,127.11
Emergency Departments & Assessment Units	260	£291,290,341.50	150	£184,368,661.50
Orthopaedics & Trauma	175	£161,766,084.87	101	£100,438,024.87
OTHER	205	£120,311,122.00	34	£19,872,032.00
Surgery	99	£98,410,938.58	55	£45,963,858.58
Gynaecology	91	£39,093,897.60	46	£21,218,850.22
Paediatrics	64	£321,294,503.92	32	£178,829,623.92
Radiology	59	£73,876,281.40	32	£19,571,561.40
Opthalmology	45	£54,773,564.54	22	£20,016,724.36
Gastroenterology	38	£17,395,187.28	13	£5,607,694.48
Nursing Care	34	£8,892,160.00	13	£3,226,710.00
Medicine	33	£61,201,681.97	17	£13,561,681.97
Urology	33	£10,996,612.72	20	£6,423,842.72
Ambulance / Paramedics	28	£14,556,040.34	14	£6,520,300.34
Mental Health & Psychiatry	28	£52,918,150.00	15	£42,779,750.00
Oncology	28	£33,979,980.00	17	£30,907,980.00
Cardiology	25	£12,269,959.28	11	£3,494,998.68
Neurology	25	£143,846,667.60	10	£85,117,767.60
Colorectal Surgery	23	£9,978,179.10	11	£5,970,589.10
Ear Nose & Throat	23	£19,867,468.30	13	£11,866,468.30
Neurosurgery	21	£28,857,147.66	7	£6,127,847.66
Primary Care & General Practice (exlcuding GMPI)	19	£20,797,677.91	12	£16,205,110.73
Anaesthetics	15	£24,293,758.08	10	£9,304,537.48
Podiatry	11	£8,851,400.00	5	£3,323,400.00
Respiratory	11	£5,930,775.00	5	£4,427,000.00
Haematology	10	£3,620,200.00	3	£2,039,220.00
Dental	9	£1,197,800.00	4	£466,160.00
Dermatology	8	£2,968,580.84	2	£622,580.84
Cytology	6	£5,519,000.00	5	£4,809,000.00
Pathology, Histology & Microbiology	6	£8,782,600.00	3	£8,222,600.00
District Nursing	5	£994,500.00	3	£654,500.00
Geriatric Medicine	5	£1,019,000.00	3	£735,000.00
GP Out of Hours	5	£28,101,460.00	3	£27,898,060.00
Maxillofacial	5	£1,099,000.00	3	£379,000.00
Cardiothoracic Surgery	4	£4,802,000.00	3	£4,802,000.00
Nephrology	4	£1,709,250.00	4	£1,709,250.00
Plastic Surgery	4	£515,500.00	2	£180,000.00
Rheumatology	4	£858,592.46	1	£328,592.46
Genetics	3	£220,000.00	1	£160,000.00
Oral & Maxillofacial Surgery	3	£16,516,000.00	1	£15,710,000.00
District Nursing & Health Visiting	2	£57,348,754.35	2	£57,348,754.35
Administration, Estates & Business Services	1	£0.00	1	£0.00
Audiology	1	£1,600,000.00	1	£1,600,000.00
Genitourinary Medicine	1	£190,000.00	0	£0.00
Mobility Services	1	£480,000.00	0	£0.00
Physiotherapy	1	£1,230,000.00	1	£1,230,000.00
TOTAL	1846	£4,752,727,543.09	879	£2,418,985,860.67

Personal Injury Cases

In addition to claims for alleged clinical negligence, the Welsh Risk Pool and Legal and Risk Services deal with matters of public liability, occupiers' and employers' liability brought against NHS Wales health bodies.

At the end of 2024/25 there were 448 open personal injury matters against NHS Wales being handled by the Welsh Risk Pool and Legal and Risk Services. This indicates a steadying of claim numbers after a downward trend in personal injury matters over the last ten years. There was a peak in new personal injury matters opening in early 2013 caused by the introduction of fixed recoverable costs and a change to the law which limited the grounds on which personal injury claims could be brought.

We continue to defend as many cases as appropriate. An example of a case defended at trial is shown here.

Example Case	Member of Staff v An NHS Wales Health Board
Summary	The Claimant alleged that he was pushed over by a violent patient and suffered a severe injury to his left elbow which led to restriction in movement in his left elbow and left shoulder which forced him to retire early.
Steps taken	Witness evidence suggested that the Claimant's injuries pre-dated the assault. In light of this, we instructed inspectors for covert surveillance. This took place and showed the Claimant using both arms freely whilst shopping. Permission to rely on the footage was granted and we invited the Claimant to discontinue his claim within 14 days, on a drop-hands basis.
Outcome	The Claimant accepted the offer and discontinued his claim.
Saving	There was a saving of £150,000 in damages. The costs budget was in the amount of £60,673.40. The total saving was therefore £210,673.40.

Fig.6 shows the number of open personal injury matters since 2012/13. This shows a reducing trend in case volumes, reaching a plateau in 2024/25.

Open Personal Injury Matters

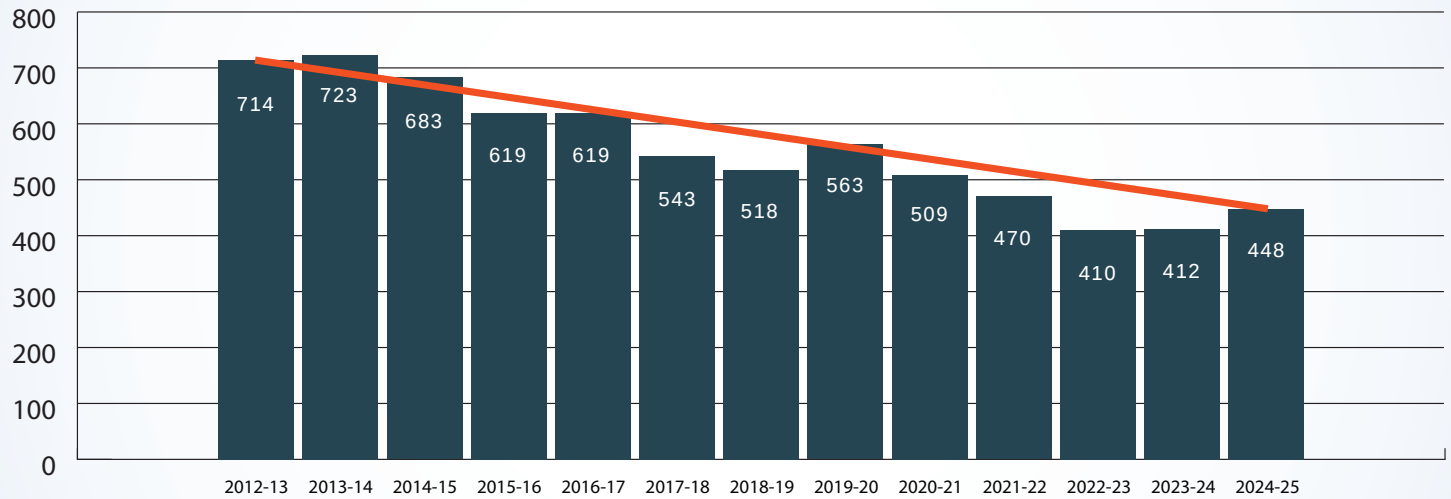


Fig.6 Open Personal Injury matters

Fig.7 shows a continuing positive trend in successfully defended personal injury claims, with around half of all cases closed without damages being paid. This highlights the strong investigative approach taken when claims of this type are received and indicates a good use of public funds in avoiding paying unnecessary sums to settle matters, even where the claim is of low value.

Percentage of Personal Injury Matters Closed Without Damages

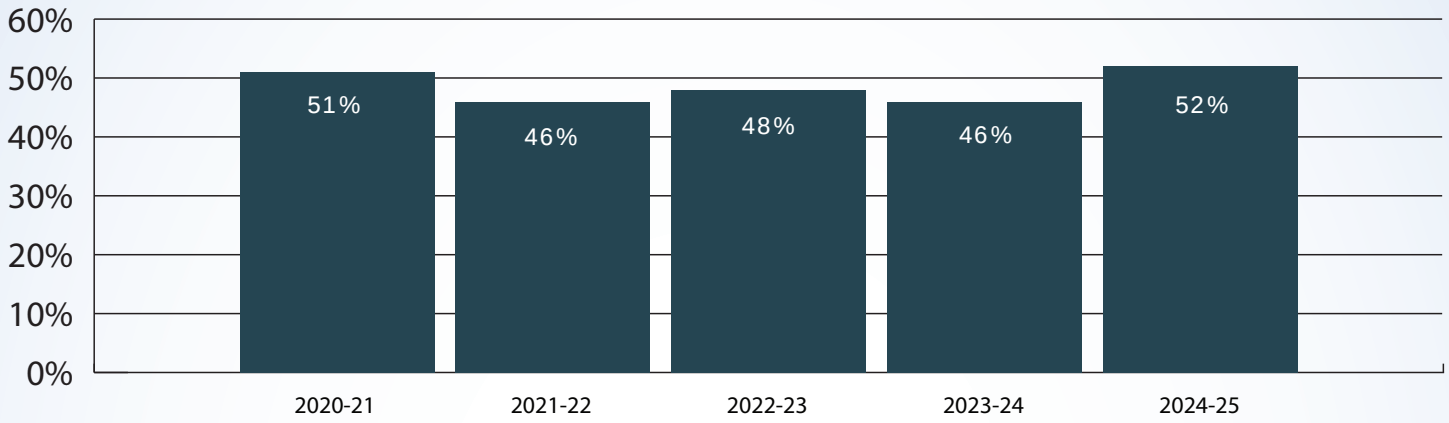


Fig.7 Personal Injury Claims Closed Without Damages

Redress Cases

The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 place duties on health bodies to consider payment of appropriate redress in matters where there is a qualifying liability. The Regulations require health bodies to consider redress in circumstances where harm is alleged, and the likely value of any claim would not exceed £25,000 in damages. Dealing with these cases in this way has a significant impact in reducing the legal costs associated with claims brought in the traditional way and provides an effective resolution for those affected, along with significant savings for the NHS.

Cases that may lead to consideration of redress include incidents reported by staff within organisations and complaints received from service users or their representatives. Health bodies are required to investigate matters and to determine whether there is a qualifying liability. Since 2018, the Welsh Risk Pool has been allocated responsibility for the scrutiny of learning and reimbursement of expenditure incurred by health bodies in relation to redress cases.

Redress cases are managed locally by specialist teams within health bodies. Legal and Risk Services has a specialist team which advises and supports organisations in relation to redress matters. Formal reviews by the Legal and Risk team are required in all cases where a proposed damages payment exceeds £25k, where payments to the UK Government Compensation Recovery Unit exceeds £3k and in all cases where qualifying liability is considered to have been met in a matter relating to the coronavirus pandemic. From 2019, health bodies have been required to provide information on their current caseloads to assist with planning and budgeting. This provides an insight into the progress of matters across NHS Wales.

In 2024/25, a total of 1254 redress cases were being managed by health bodies in NHS Wales. Following a reduction in the overall caseload from during the pandemic, the increase follows the expected trajectory for redress cases – with an expected continuing increase. The period of reduction that has been seen can be attributed to a reduction in incident and complaint investigations during the pandemic. The increase since 2023 can be associated with the introduction of the Duty of Candour in Wales. It is expected that future years will continue to see an increase in the redress caseload. Fig8. outlines the overall redress caseload over the last six years.

Redress Cases for Last 6 Years

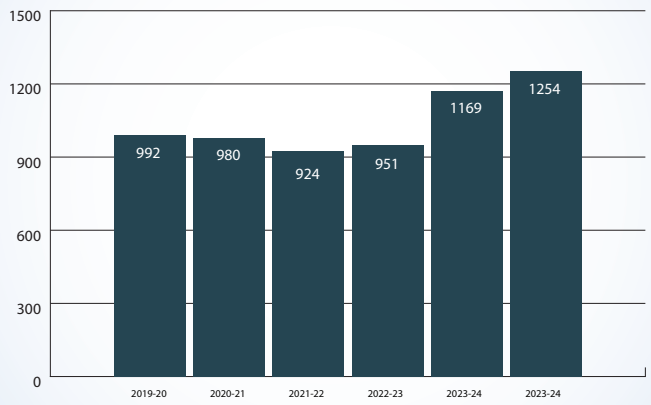


Fig.8 Redress Cases for last 6 years

Considering the clinical speciality to which a redress case relates is a useful indicator of themes and trends. Traditionally, each health body has considered redress cases in relation to its own list of specialties which do not align to provide a national picture. With all organisations now utilising the Once for Wales Concerns Management System to capture and manage redress cases, it is anticipated that a national picture will shortly be available. From case analysis, the most commonly occurring specialities within redress cases continue to be Emergency Department, Orthopaedics, and General Surgery.

Financial Planning

The Welsh Risk Pool receives two funding streams:

- **Departmental Expenditure Limit (DEL)** to meet the in-year costs associated with settled claims. The DEL is funded by a core allocation provided by Welsh Government from the annual healthcare budget. This is augmented via a risk sharing agreement that involves contributions from each health body using a formula depending on the size, claims experience and risk management standards of an organisation.

- **Annually Managed Expenditure (AME)** to meet the cost of accounting for the long-term liabilities of claims. This budget is based on in year estimates provided directly to the Welsh Government by the NHS Wales Shared Services Finance team.

The NHS Shared Services Partnership Corporate Finance Team provides oversight, guidance and financial management of the Welsh Risk Pool DEL and AME budgets.

Analysis of the current budget and use of financial forecasting tools enables the Welsh Risk Pool to confidently plan for settlement of case in-year and prepare for the likely financial requirements in the ensuing years.

2024/25 Budget Position

The Welsh Government core allocation for the year in 2024/25 was £109.435m for clinical negligence, personal injury and redress cases. A risk share charge of £30.478m was implemented via health bodies at the end of the financial year and a small amount of additional funding was provided by Welsh Government in March to support case progression.

The DEL funding for 2024/25 is outlined in Table.4.

WRP DEL Funding 2024/25	£m
Welsh Government Core	109.435
NHS Wales Risk Sharing Agreement	30.478
Welsh Government Additional Funding	5.098
Total Funding	**145.011**

Table.4 WRP DEL funding 2024/25

Within the £145.011m outturn for 2024/25, the redress charge was £2.300m compared to £1.699m in 2023/24. Redress reimbursements totalled £1.469M and the redress creditor increased by £831K in year. Increasing expenditure on redress cases is recognised to have a beneficial effect on reducing the number of claims which are brought.

The DEL position for the year for clinical negligence expenditure is outlined in Table.5, along with the 2023/24 comparative:

WRP DEL Expenditure	2023/24 £m	2024/25 £m
Claims reimbursed and WRP Managed Expenditure	88.721	94.720
Redress Reimbursements	1.477	1.469
Periodical Payments	21.073	24.597
Safety and Learning Programmes	0.4448	0.681
Clinical Negligence Team Funding	0.550	0.702
Movement on Claims Creditor	23.515	22.842
2023/24 expenditure	**135.784**	**145.011**

Table.5 WRP DEL expenditure 2024/25

The creditor movement increased by £22.842m by the end of the financial year with a comparable value of reimbursements paid this year compared to last year; £88.721m in 2023/24 compared to £94.720m in 2024/25.

Settled cases are accumulating in the WRP creditor at a similar rate to last year. An element of the balance will relate to settlements towards the end of the financial year where the Health Board or Trust has not yet had the opportunity to submit returns in order to receive reimbursement. The larger remaining balance will relate to cases where approval of the learning plans has been deferred by the Welsh Risk Pool and these are not being resolved by Health Boards and Trusts as quickly as the previous year.

The creditor movement represents the increase, or decrease, in the total creditor balance since the previous year end date and the total NHS Wales creditor has increased to £178.2544m as at 31/3/2025.

Total provisions have risen to £1.712bn as at 31st March 2025, an increase of £62m in 2024/25. This compares to a previous £155m increase in provisions for 2023/24.

A profile of the provisions over the last five years is shown in Fig.9 and a breakdown of the provisions is shown at Table.6.

It is important to note that the increase in provision values does not directly correlate with increases in total case numbers. Indeed, case numbers reduced slightly during the year.

The primary cause of the increase in the value of provisions this year has been due to an accelerated conversion from a Remote or Possible probability to a Probable or Certain one, continuing a trend that started last year.

Remote and Possible cases are not recognised in the financial provisions due to the uncertainty of liability and quantum value. They are disclosed as contingent liabilities in the notes to the accounts.

The application of financial adjustments for inflation and the discounting of liabilities to net present value has caused negligible movements this year.

The number of Probable and Certain cases managed during the year increased from 744 cases to 812 cases over the 12-month period to 31st March 2025. However, within this increase, the number of high value cases above £1m decreased compared to the end of the previous financial year by 3 - from 141 to 138 cases.

WRP Provisions for Last Five Years

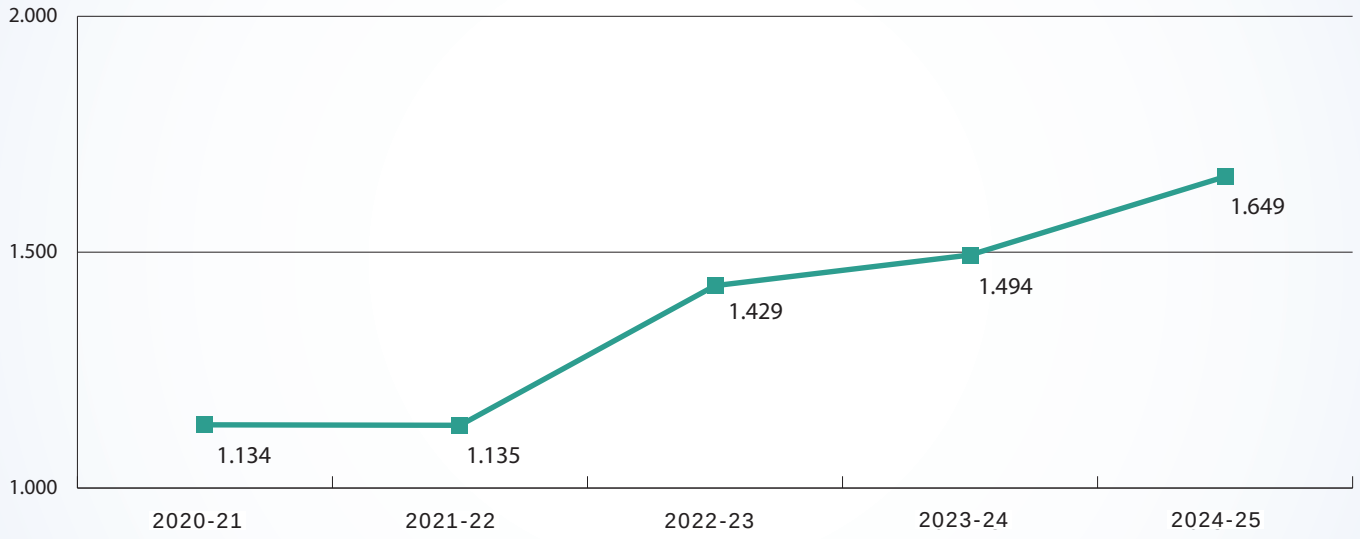


Fig.9 WRP Provisions for last five years

Welsh Risk Pool Provisions	2019/20 £bn	2020/21 £Bn	2021/22 £Bn	2022/23 £Bn	2023/24 £Bn	2024/25 £Bn
Probable an Certain Clinical Negligence Cases	0.676	0.646	0.781	0.836	0.948	0.967
Probably and Certain Personal Injury Cases	0.005	0.008	0.004	0.004	0.004	0.003
Probable and Certain Redress Cases	0.003	0.003	0.002	0.003	0.003	0.003
Defence Legal Fees and Others	0.009	0.009	0.009	0.010	0.010	0.011
Periodical Payment Orders	0.441	0.468	0.632	0.641	0.685	0.728
Total Provisions	**1.134**	**1.133**	**1.429**	**1.494**	**1.649**	**1.712**

Table.6 Breakdown of WRP provisions

Looking Forward - The Forecast

When considering the funds needed for future years, the Welsh Risk Pool and Legal and Risk Services categorise all claims and matters by allocating a rating depending on the likelihood of the case settling. The categories include, Remote, Possible, Probable and Certain and these are outlined in Table 7. For budget planning purposes, Probable and Certain cases are included in the forecast.

Assessment of Probability of Settlement	
0% - 5%	Remote
6% - 49%	Possible
50% - 94%	Probable
95% - 100%	Certain

Table.7 Probably of settlement categories

The core DEL funding for the Welsh Risk Pool for 2024/25 is £109.435m.

Planning and forecasting for the Welsh Risk Pool is included in the NHS Wales Shared Services Partnership Integrated Medium Term Plan (IMTP). The 2024/25 IMTP forecast for 2025/26 showed a resource requirement of £145.491m which, utilising the proven forecasting model, was based on a high-level analysis of previous year trends and average values for cases >£1m and cases <£1m. A more recent review of cases due to settle in 2025/26 has highlighted an emerging change to the claim profile for cases due to settle in year, combined with increasing case values, indicating a potential increased resource requirement for the financial year. Any increased expenditure above the £109.435m allocation is met via application of the risk sharing agreement to NHS Wales. Financial returns are received from Organisations at the end of July 2025 which will inform future year forecasts.

Risk Sharing Agreement

To support the in-year resource requirements, the Welsh Risk Pool requires contributions from its member health bodies to supplement the core allocation provided by Welsh Government.

The Risk Sharing Agreement provides a formulaic approach to calculating the required contributions and considers the size, claims experience and effectiveness of learning for each organisation.

Each of the five measures are outlined in Table.8.

	Measure	Detail	Weighting
A	**HSCS and Prescribing Allocation**	Current measure	**30%**
B	**Claims History**	Last 3 years – rolling basis	**20%**
C	**New Claims transferred from the Service to LARS: Number of New Cases < £25k**	Last 12 months	**10%**
D	**Claims potentially affecting next years' spend:** **1. Cases with cash flows < 1 yr** **2. PPO Allocation Utilisation**	From CN database : 15% Actual Costs : 10%	**25%**
E	**Management of Concerns and Learning from Events** **1. Management of Concerns** **2. Learning from Events**	Annual WRP Inspections: 7.5% 7.5%	**15%**

Table.8 Risk Sharing Agreement Measures

The first measure relates to the **HSCS and Prescribing Allocation** allocated to an organisation by Welsh Government. This is major indicator of the size and complexity of an organisation.

The **claims history** is calculated from total reimbursements paid per organisation over the rolling three-year period to the end of the previous financial year.

Measure C, **cases under £25k**, considers matters which could have been resolved through the redress case management system. The data for this is drawn from the Legal and Risk matter database.

The calculation then considers **claims likely to affect the next year's expenditure**, considering each organisations profile of claims with cash flows, where payments are expected, within the next twelve months. This measure also considers the utilisation of PPOs which is taken from the forecast projections.

The final, and arguably most influential, measure is the **Management of Concerns** and **Learning from Events**. Each year the Welsh Risk Pool undertakes inspections of the processes and arrangements in each health body. The Welsh Risk Pool considers whether health bodies have complied with the WRP Reimbursement Procedures, the Once for Wales Concerns Management System and the guidance for the Putting Things Right legislation. The inspection programme was paused due to the pandemic and recommenced in the autumn of 2022/23. Figures from the 2024 WRP Assessment will feature in the risk sharing agreement for 2025/26. Cost drivers will be updated and Risk Share apportionments will be confirmed in September, following availability of the final Management of Concerns/ Lessons Learned elements. These now include a more comprehensive and appropriate set of measures for the 5th element, 'Lessons Learned', including participation with the PROMPT Wales and Consent programmes.

In relation to the risk sharing agreement, each organisation receives an individual contribution value which is a percentage of the total contributions required.

Welsh Risk Pool Operations

The Welsh Risk Pool Operations team has responsibility for a number of work areas - including the management of Periodical Payment Orders, handling and responding to NHS Wales Indemnity enquiries and the role of client in legacy Former Health Authority Claims. The team consists of experienced paralegal staff and claims managers.

Structured Settlement Orders

Periodical Payment Orders (PPO's) are generally used in cases where a settlement includes a payment for the provision of long-term care and support for a claimant over a sustained period of time. There may be a lump sum payment made at the time a case is settled, with a legal commitment to make a regular payment for the life of a claimant.

The Welsh Risk Pool is responsible for administering the Periodical Payment Orders for all NHS Wales Health Bodies on behalf of Welsh Government. At the end of 2024/25, 34 cases had closed and 12 new matters opened – with a total of 149 active PPO matters. PPO payments made in 2024/25 totalled £24,997,389.88.

The calculation of payments is adjusted each year in accordance with a formula outlined in the relevant court orders. Indices regularly used to adjust payments are the Retail Prices Index (RPI) and Average Salary and Hourly Earnings (ASHE) index.

The payment adjustments are overseen by the NWSSP Corporate Finance Team. Enquiries regarding trusts for the claimants, payments of accounts or in the event of the death of a claimant are dealt with by the WRP Operations team.

NHS Wales Indemnity Enquiries

Health bodies in NHS Wales are exempt from the majority of the requirements for compulsory insurance and are not permitted to purchase commercial insurance for their core activities. The Managing Welsh Public Money guidance outlines that purchasing commercial insurance would not be cost effective for Health Bodies. Instead of purchasing commercial insurance, health bodies apply NHS Indemnity to their activities and are members of the Welsh Risk Pooling scheme.

The application of NHS Indemnity is complex and is outlined in the All-Wales Policy on Indemnity and Insurance – which is overseen by the Welsh Risk Pool Committee. As the models of healthcare evolve and arrangements between bodies and the private sector increase, the indemnity position is increasingly complex.

The Welsh Risk Pool Operations Team receives enquiries relating to NHS Indemnity and works with appropriate legal, procurement and policy teams to incorporate appropriate provisions into memorandums of understanding, service level agreements and contracts.

During 2024/25 the Welsh Risk Pool received **397 enquiries** relating to NHS Indemnity and supported the production of a number of MOUs, SLAs and Contracts in respect of indemnity.

As there is generally no commercial insurance in place, health bodies are unable to provide an enquirer with a certificate of insurance. The Welsh Risk Pool is able to provide a bespoke letter to confirm the indemnity arrangements so that all parties are clear what cover is in place. During 2024/25, the Welsh Risk Pool handled **181 requests** for the Employer's and Public Liability confirmatory letter.

Delegated Cases

The Welsh Risk Pool has delegated responsibility for the management of certain claims brought in NHS Wales. The Welsh Risk Pool team occupies the role of client and instructs the relevant legal team to conduct the matter as appropriate. The NWSSP Scheme of Delegation outlines that responsibility for decisions on settlement of delegated cases are devolved to the Director and Deputy Director of Legal and Risk Services and authorisation of payments in delegated cases is allocated to members of the Welsh Risk Pool team and members of the NWSSP Leadership Team.

There are two main types of delegated case:

Former Health Authority Claims

Former Health Authority Claims are historic matters that involve a liability for a health body in Wales which no longer exists. When NHS Trusts were formed during the mid-1990's, the Health Authorities which they replaced did not transfer their legal liabilities to the new organisation. This means that the Health Boards and Trusts which have subsequently replaced the earlier NHS Trusts do not hold legacy liabilities prior to the establishment of the NHS Trusts. Through its' Establishment Order, Welsh Government has allocated Powys Teaching Health Board (PTHB) with liability for these legacy claims. To reduce the burden on the current Health Board, all Former Health Authority matters are wholly delegated to the Welsh Risk Pool and all costs and payments transacted by the Welsh Risk Pool, whilst PTHB remains the technical defendant.

Former GP Trainee Claims

Former GP Trainee Claims relate to index events prior to the introduction of the General Medical Practice Indemnity Scheme (GMPI) where doctors in training for general practice were employed by Velindre University NHS Trust / NHS Wales Shared Services Partnership as a Single Lead Employer. Liability in these cases is managed by the Welsh Risk Pool directly.

Former Health Authority Cases 2024/25

As part of the governance of these cases, the cases which are closed during a financial year are reported to the Welsh Risk Pool Committee at the end of the year. The information is also shared with PTHB. By way of summary:

- **6** new Former Health Authority Personal Injury cases were received in 2024/25;
- **4** Former Health Authority Cases closed in 2024/2025;
- The number of Former Health Authority Personal Injury cases currently open is **14**;
- There are no Former Health Authority Clinical Negligence cases currently open; and
- **1** Former Health Authority Clinical Negligence case closed in 2024/25 this matter has now settled and proceeded to a PPO.

Former GP Trainee Cases 2024/25

1 new Former GP Trainee case was received in 2024/2025

There were no Former GP Trainee Cases closed or discontinued in 2024/2025

The number of Former GP Trainee cases currently open is 11

Learning Assurance

The Welsh Risk Pool plays a key role in assuring that learning is undertaken and implemented following complaints or incidents which result in a redress, personal injury or clinical negligence claim. Sharing the learning across NHS Wales, is a key aim of the Learning from Events Programme.

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A clinically led and multi-professional Learning Advisory Panel (LAP) was established over 5 years ago, as a recognised subcommittee of the Welsh Risk Pool Committee (WRPC). Chaired by established leaders from the Putting Things Right sector, the Panel meets monthly to scrutinise Learning from Events Reports (LFER), which highlight the learning implemented by health bodies, following a redress or clinical negligence case. During 2024-25, the Panel reviewed 787 cases.

Medical, nursing & midwifery and allied health professional representatives participate in the LAPs, together with colleagues from governance and legal services teams. Medical officers from Welsh Government contribute to each LAP. A diverse range of clinical specialities are represented, which ensures a widespread sharing of the learning.

A separate LAP has recently been established to review the learning implemented following a personal injury claim. This Panel is fully supported by Health and Safety professionals from across Wales and has proven to be very successful.

The role of each LAP is to establish whether the learning implemented following each case, provides assurance that a similar incident is less likely to happen again in the future. If the Panel is assured, it recommends that the LFER is approved. If it is not assured, feedback will be provided and approval of the LFER will be deferred until the feedback is addressed. All LAP decisions must be reviewed, approved and ratified by the WRPC. Health bodies will only be reimbursed by the WRP for monies paid in relation to a claim (damages/costs etc), if the LFER has been approved.

The LAP plays a key role in identifying learning themes across Wales. The new WRP VTE Wales Programme to develop an All-Wales approach for the prevention and reduction of harm associated with venous thromboembolism (VTE), arose as a result of the LAP identifying increased VTE case numbers presenting to them.

Themes, trends and cases of interest are also shared in the quarterly newsletter, Doctrina. This has been well received by clinical leaders and disseminated within teams for wider learning.

The Welsh Risk Pool Reimbursement Procedures provide a structured series of standards by which members of the risk pooling scheme should work. Guidance on each step of the process of Learning from Events and Submission for Reimbursement are best achieved; aiming to reduce the potential for the circumstances which led to a claim occurring from being repeated. The procedures provide a period of four calendar months from when the point when a case is settled to prepare and present learning information.

During 2024-2025, the Learning Advisory Panels have been busy. Meeting monthly in a virtual format, the panels reviewed an average of 60 new cases and re-examined previously deferred or rejected.

Table.9 outlines the number of new cases submitted. This shows a 27% increase in new cases in 2024/25 compared to 2023/24. This increase is attributed to the work by all organisations to drive timeliness in learning.

Fig.10 outlines the comparison of when new cases were presented to the panel in 2023/24 and 2024/25. By considering this distribution, it enables planning of panel capacity. Apart from a small reduction in August, the data indicates that there has been a consistent increase in cases distributed throughout the year.

	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Total Number New Cases 2024/25	50	62	51	58	50	62	50	91	70	79	103	61	**787**
Total Number New Cases 2023/24	53	46	39	58	63	51	55	50	68	41	29	65	**618**

Table.9 number of new cases submitted to WRP in 2023-34 and 2024-25

All Wales Comparision of New Cases Submitted to the Learning Advisory Panel 2023-24 and 2024-25

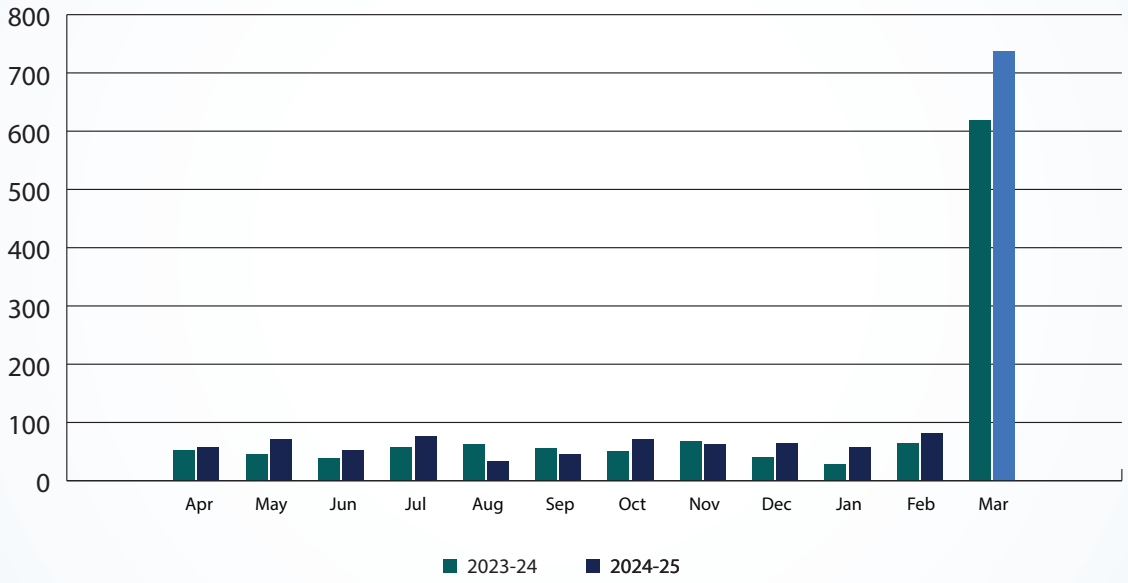


Fig.10 Comparison of New Cases to Panel 2023/24 and 2024/25

Timeliness of the submission of Learning from Events Reports is important in reducing the potential repeat incidents from re-occurring. The WRP Reimbursement Procedures establish a four-month timescale for the submission of an LFER from the decision to settle a case and the NHS Wales Leadership Forum recognised in 2024 that this is a generous deadline, especially considering that learning reviews can and should be taking place well before the decision to settle a legal matter is made.

Table.10 and Fig.11 outline the timeliness of LFER submissions in 2023/24 and 2024/25. This data shows an improvement in timeliness from 28% of LFERs being submitted late in 2023/24 (n=169 of 608) to 18% (n=144 of 787) in 2025/26. Some of the late submissions were significantly late, including several which were over six months late. The improvement seen in timeliness of LFER submissions is predominantly attributed to the imposition of penalties for late submission on organisations, which have reviewed internal processes as a result.

	No. of Missed Standard Deadlines	No. of Achieved Deadlines	Submissions
Submissions 2023-24	169	439	608
Submissions 2024-25	144	643	787

Table.10 Timeliness of LFER Submissions 2023-24 and 2024-25

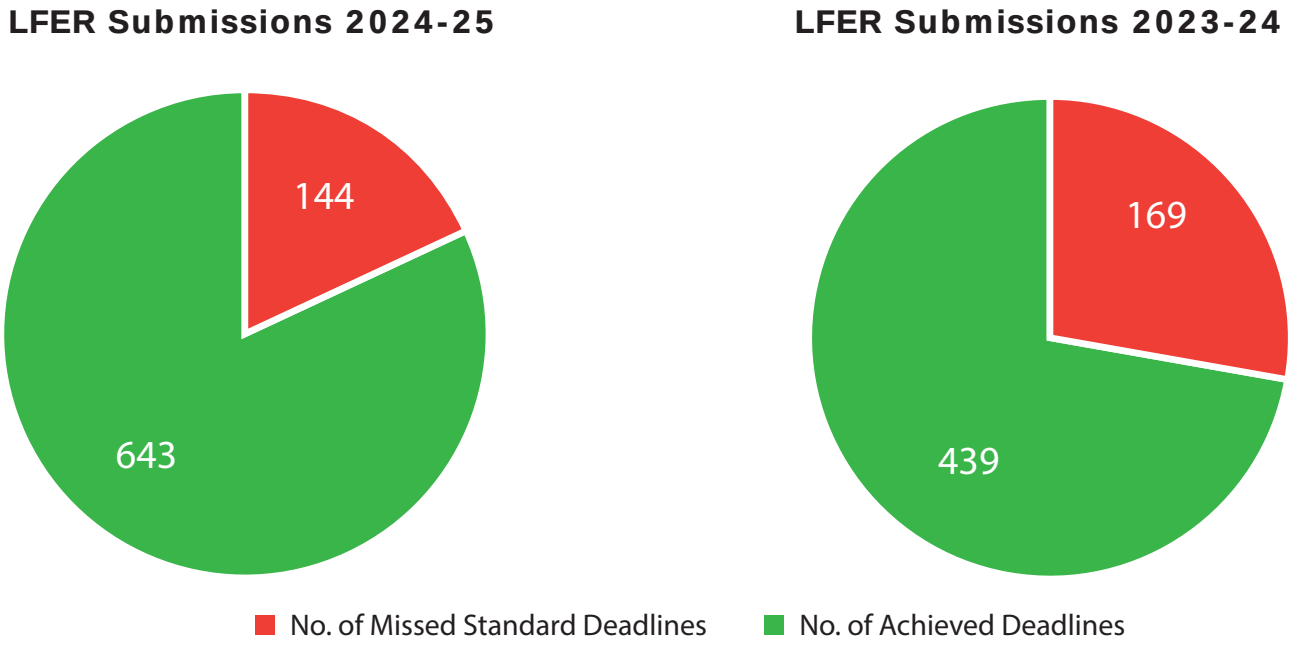


Fig.11 Timeliness of LFER Submissions 2023-24 and 2024-25

The learning in each case is carefully scrutinised by the panel in order to determine whether the actions taken adequately address the issues identified in the matter and whether there is assurance of a sustained improvement. Evidence is also sought to provide clarification of actions and assurance provided by health bodies.

Where a case is considered to have met the criteria, it is approved and requests for reimbursement from the risk pooling scheme will be accepted from the health body for a period of up to two years. After this period, if the legal case remains ongoing, a review of the learning position is requested and considered by the panel.

A case is deferred where the learning is not considered to suitably address the issues identified. If the panel considers that the Learning from Events Report requires further work to identify improvements, it is red deferred and must be reviewed again by the panel.

If the panel considers that the LFER addresses the issues within a case but evidence to support the learning is required, it is amber deferred and approval of the requested evidence is delegated to the Head of Safety & Learning. A summary of outcomes in 2023-24 and 2024-25 is shown in Table.11.

	Apr	May	Jun	Jul
2023/24	618	32.2% (n=199)	28.5% (n=176)	29.3 (n=243)
2024/25	738	16.8% (n=124)	28.7% (n=402)	54.5% (n=402)

Table.11 Decision outcomes for cases 2023/24 and 2024/25

The data presents a year-on-year comparison of panel decisions on new Learning from Events Reports (LFERs) submitted to the Welsh Risk Pool Committee, showing notable shifts in outcomes between 2023/24 and 2024/25. A detailed analysis of approval statuses of LFERs is outlined in Table.12.

In 2023/24, nearly one-third of all new cases (32.2%, n=199) were approved by the panel. However, in 2024/25, this figure dropped significantly to 16.8% (n=124), indicating a halving in the proportion of cases that met the required standards for approval.

The proportion of red deferred cases — those where the learning was deemed insufficient and required substantive further work — remained broadly consistent, at 28.5% (n=176) in 2023/24 and 28.7% (n=212) in 2024/25.

The most marked increase is seen in amber deferred cases, which are those that broadly address the issues but lack evidence to support the learning. These rose sharply from 29.3% (n=243) in 2023/24 to 54.5% (n=402) in 2024/25. This suggests a growing trend of health bodies submitting cases where the intended learning is directionally correct but not yet substantiated with sufficient evidence — potentially due to rushed submissions or misunderstandings about panel expectations.

This data on the quality of learning indicates a decline in the quality or completeness of submissions, which suggests a system-wide need for improved locally applied guidance, corporate support and quality assurance before submission of cases to the panel - to ensure learning is both clearly articulated and appropriately evidenced. The Welsh Risk Pool Committee has commissioned Intensive Support programmes to assist organisations in achieving sustained improvement.

Learning from Events Reports were introduced in 2018 and all organisations have received training and guidance on the preparation and completion of them. The Welsh Risk Pool has introduced innovative strategies such as the Enhancing Learning Organisations programme to support improvement in this area. With increased local scrutiny prior to submission to the Welsh Risk Pool it is anticipated that approval rates at LAP can rise to around 70% in all new cases.

In January 2025 specialist checklists for deferred cases, known as U8 and U9 Checklists, were introduced due to the increasing number of deferred cases.

The U8 Checklist was implemented due to the increasing number of submissions with disorganised additional evidence. It aims to help both health body teams and the Safety & Learning Advisor who is reviewing the evidence, to ensure that all feedback has been fully addressed.

The U9 Checklist was introduced to improve understanding by signatories of LFERs. When signing the governance declaration of the LFER, the signatory is confirming, on behalf of the health body, that the LFER has been completed fully and correctly, and they are giving assurance that learning actions have been implemented to mitigate the risk of a similar incident. If the National Learning Advisory Panel are not assured by the learning actions on the LFER and thus not assured that the health board has mitigated the risk of a similar incident occurring, they will recommend that the LFER is RED deferred. The U9 has been implemented to ascertain why that person signed an LFER, which has resulted in such limited assurance when peer reviewed by the National Learning Advisory Panel and what they have changed with their local processes to ensure that they are less likely to sign-off a potential RED deferred LFER in the future.

	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Total Number New Cases	58	71	52	76	33	66	45	71	62	65	58	81
Number Cases Approved	12	11	10	11	6	16	13	13	7	10	3	12
Number Cases Red Deferred	12	18	12	22	11	13	10	27	15	27	21	24
Number Cases Amber Deferred	34	42	30	43	16	37	22	31	40	28	34	45
Average Number Approved %	20.69	15.49	19.23	14.47	18.18	24.24	28.89	18.31	11.29	15.38	5.17	14.81
Average Number Red Deferred %	20.69	25.35	23.08	28.95	33.33	19.70	22.22	38.03	24.19	41.54	36.21	29.63
Average Number Amber Deferred %	58.62	59.15	57.69	56.58	48.48	56.06	48.89	43.66	64.52	43.08	58.62	55.56
Total Deferred (Amber+ Red) %	79.31	84.51	80.53	85.53	81.82	75.76	71.11	81.69	88.71	84.62	94.83	85.19

Table.12 Proportion of cases approved and deferred in 2024/25

All Wales Number of Cases Approved and Deferred on Initial Presentation to Learning Advisory Panel 2024-25

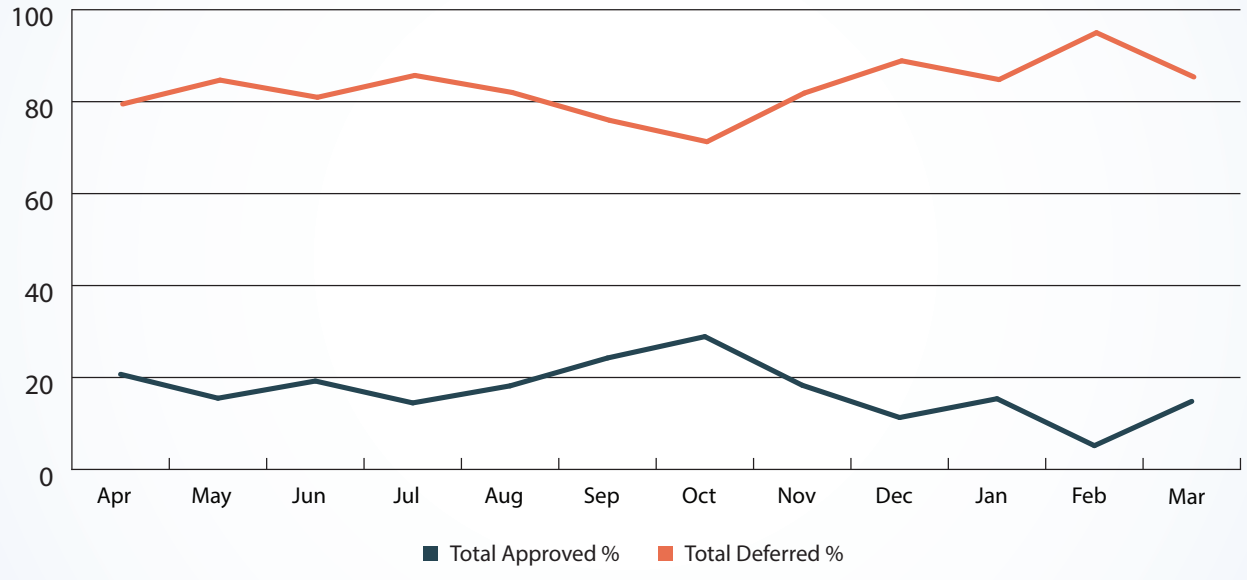


Fig.12 New Cases to Panel 2024/25 Approved and Deferred

Penalties for Quality & Timeliness of Learning

During 2024–25, the Welsh Risk Pool Committee (WRPC) applied penalties to NHS organisations in Wales where there were significant delays either in the submission of Learning from Events Reports (LFERs) or in the timely approval of deferred cases. These measures were taken to reinforce compliance with expected timeframes and to promote timely learning and resolution of learning queries. The penalty is a financial charge taken from the amount of money reimbursed to a health body.

A total of 139 penalties were triggered during the reporting period, of which 6 were subsequently waived following review and acceptance of valid justifications provided by the organisations concerned.

Fig.13 outlines the number of penalties applied each month, categorised by delays relating to LFER submissions and delays in the approval of deferred cases. This highlights that the reasons for the application of penalties has shifted from late submission of information to delays in resolving deferred learning queries.

Whilst the individual value of each penalty is relatively small, staff from a number of corporate teams have reported the positive impact in driving the attainment of learning information when the penalty is internally charged to a budget holder in speciality or service. This internal cross-charging is now expected by the WRP Committee.

It is hoped that with the various strands of improvement work underway, the number of penalties applied will fall.

All Wales Penalties applied in 2024/25

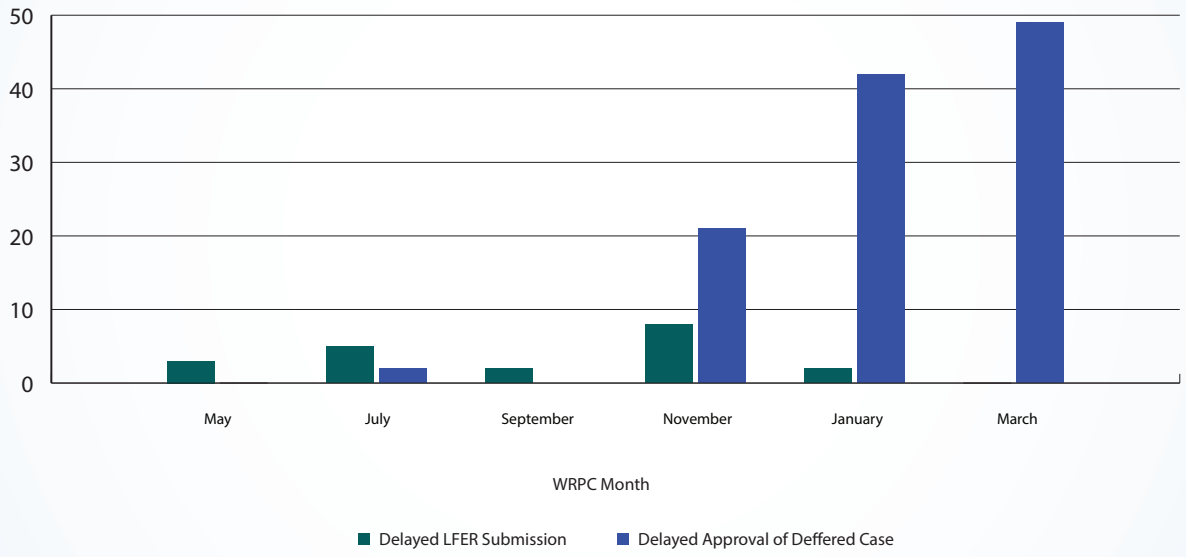


Fig.13 Penalties applied by the WRP Committee

Maternity & Neonatal Safety & Learning Programmes

The data from analysis of current and previous claims caseloads highlights that matters related to maternity & neonatal services represent a disproportionate element of the litigation profile. National and local reviews, and the learning reports produced regarding claims, highlight that positive human factors, situational awareness, culture, team working, systems and processes are all significant contributors to a positive outcome.

The Welsh Risk Pool has rightly placed a lens and emphasis onto solutions to these factors in maternity & neonatal services – aiming to reduce the litigation profile, reduce avoidable harm to women and babies and improve clinical outcomes within this sector. We therefore oversee and quality assure a suite of targeted safety & learning programmes. PROMPT Wales is adapted from the successful PROMPT programme first introduced in North Bristol. IFS Wales has developed and implemented a dedicated training programme for all staff involved in the assessment of women during the intrapartum phase of birth. MoNET Wales is a new and exciting programme, delivering the benefits of the PROMPT-style training to the neonatal sector and was developed in response to recommendations in the MatNeo Safety Support Programme.

Intrapartum Fetal Surveillance - IFS Wales

IFS CYMRU WALES
Cadw Golwg ar y Ffetws yn Ystod Genedigaeth
Intrapartum Fetal Surveillance

Our vision:

A standardised, all Wales training programme in intrapartum fetal surveillance, aiming to improve outcomes for babies and families.

Launched in 2023, the IFS Wales programme was developed to reduce harm associated with fetal surveillance and to address both the financial and human cost of related clinical negligence claims in NHS Wales. A scoping review undertaken in 2023 revealed wide variation in training across Health Boards, prompting the Welsh Risk Pool to commission a standardised, evidence-based training programme.

Developed by a multiprofessional national team, IFS Wales aligns with the revised All Wales Intrapartum Fetal Surveillance Standards (2023) and supports Health Boards in meeting the training requirements set out within them. Informed by the Each Baby Counts report and the Ockenden recommendations, the programme places a strong emphasis on teamworking, communication, and the impact of human factors on clinical decision making and escalation in intrapartum care.

Based on the principle that "teams that work together should train together," the programme is delivered face to face by local facilitators to multiprofessional teams, using an interactive teaching style that incorporates group discussion, collaborative decision making, and case-based learning.

The pilot phase of IFS Wales was delivered across all obstetric-led units between October 2023 and December 2024 and underwent structured evaluation to inform future development. A key aim was to determine the scalability of the programme and its consistency across Health Boards. Evaluation focused on the first two levels of Kirkpatrick's model: participants' immediate reactions to the training (Level 1) and self-reported learning outcomes (Level 2). These were captured through pre- and post-training surveys. The evaluation also incorporated observations by the national team and feedback on facilitator experience, which was collected through surveys and informal discussion.

Findings demonstrated clear, positive outcomes across NHS Wales. More than 1,400 participants attended 59 training sessions, and self-assessed knowledge showed significant improvement across six core areas. Prior to training, only 23.4% of participants rated their knowledge as "very good" or "exceptional," increasing to 72.7% following the session. Those rating their knowledge as "good" or "fair" fell from 72.8% to 27.2%, and "poor" responses decreased from 3.8% to just 0.08%. These figures emphasise the programme's strong impact on improving participant confidence and understanding, demonstrating a clear shift from moderate or low levels of self-assessed knowledge to a more assured and competent grasp of core topics. Participant satisfaction was high, with an average rating of 8.82 out of 10.

Free-text feedback consistently praised the programme's structure, relevance, and multiprofessional approach, with many describing it as engaging, informative, and practical. Observations by the national team confirmed that Health Boards maintained multiprofessional faculty and delegate participation, demonstrating strong alignment with the programme's core principles and ensuring consistent, high-quality delivery.

Following the success of the pilot, IFS Wales has entered its next phase with the launch of a second edition in January 2025. This updated version includes revised session timings and minor structural adjustments to improve delivery. Enhanced facilitator guidance has also been developed to support consistent, high-quality implementation. All changes have been directly informed by feedback gathered during the pilot phase. Evaluation tools have also been refined to assess the next level of Kirkpatrick's model, with a focus on behavioural change in clinical practice. To support continued engagement and shared learning, a new IFS Wales Representative Group has been established.

IFS Wales is now transitioning into a fully embedded national programme and remains a key component of Wales' maternity safety improvement strategy, supporting safer outcomes through consistent, high quality, team based fetal surveillance training.

PROMPT Wales

CYMRU / WALES
PROMPT
PRactical Obstetric Multi-Professional Training
Hyfforddiant Aml-broffesiynol Ymarferol mewn Obstetreg

Our vision:

To reduce avoidable harm and improve perinatal outcomes, through multi professional training to enhance safety, teamwork and communication

PROMPT Wales (Practical Obstetric Multi-Professional Training) is a large-scale maternity safety programme funded by the Welsh Risk Pool and supported by the PROMPT Maternity Foundation. PROMPT is an evidence based, multi-professional training programme which incorporates practical simulation sessions and human factors training and is attended by all members of the maternity team in Wales annually. The PROMPT Wales programme was developed to reduce variation and improve the quality of multi-professional obstetric emergency training across Wales, with the overall aim of improving safety and outcomes in maternity care.

PROMPT Wales was implemented in NHS Wales maternity services in 2019 and is now 'business as usual.' This outstanding achievement is a result of the collaboration between organisations, local faculty teams and the PROMPT Wales National Team. With coordination and oversight from the national team, local training teams who have undergone 'faculty development training' organise and run training in their obstetric units throughout the year.

With a focus on teamworking and the impact of human factors, PROMPT Wales is 'more than just training.' We are striving for improvements in organisational culture, and to enhance multi-professional and intra-professional relationships. We have observed changes in interactions between different staff groups and levels of seniority, which perhaps suggests a flattening of hierarchical behaviour and improved working relationships. It is widely recognised that improvements in clinical care, multi-professional team-working and human factors contribute to safer outcomes in maternity care.

Teams who work together train together, and training is situated in the clinical area to maximise fidelity to practice, to test the systems and processes, and contribute to organisational improvement. Scenario based simulation sessions provide the opportunity for multi-professional teams to practise working together to clinically manage a simulated obstetric emergency, whilst recognising the impact of human factors on safe outcomes. Through PROMPT Wales training, we have been able to promote the use of SBAR (Situation, Background, Assessment, Recommendation) handover – a structured handover process to maximise impact. Staff have a greater understanding of the importance of situational awareness and allocate a lead in an emergency situation who can stand back, take a 'helicopter view' and coordinate the team. The use of algorithms to guide clinical management is now embedded in practice.

Through PROMPT Wales, we can support the embedding of other maternity safety initiatives in NHS Wales such as OBS Cymru – 'the Obstetric Bleeding Strategy in Wales.' This has seen the embedding of measured blood loss and use of the OBS Cymru PPH Management Checklist. In the last academic year, training has had a greater focus on escalation and PROMPT Wales training is supporting the embedding of the new all-Wales Maternity Early Warning Score (MEWS).

PROMPT Wales is quality assured by the national team to support its long-term sustainability and to encourages a culture of accountability, learning, and continuous improvement. The PROMPT Wales Standards, supported by a Welsh Health Circular, are used as a metric to drive improvement and our approach to quality assurance involves the systematic collection of health board data to assess whether services are maintaining the Standards. The Standards set out that a minimum of 95% of midwives, obstetricians and anaesthetists who regularly provide maternity care should undertake PROMPT Wales training annually. Data is provided by Health Boards in September each year and latest data (2023-24 academic year) identified that 93% of staff across NHS Wales who were identified as requiring PROMPT Wales training participated.

The drive for continuous improvement in maternity and neonatal services is critical to the Welsh Risk Pool Committee – as the avoidable harm in these services and the proportion of the litigation profile attributed to this sector needs to be addressed. As part of its incentivisation scheme supported by Welsh Government, the Welsh Risk Pool Committee includes metrics from PROMPT Wales standards as part of the risk sharing agreement – meaning that Health Boards with greater compliance to the standards will contribute less to the risk pooling fund when compared to other organisations.

Our quality assurance framework also includes structured observation of training which includes feedback mechanisms by means of guided practical support and written reports which recognise excellent practice whilst identifying areas where further development would enhance the learning experience. Our framework considers implementation fidelity, quality of delivery, and the application of learning in clinical practice. We are pleased to note the commitment and high standards of training delivered by local faculty teams throughout NHS Wales. To measure the impact on participants experience of PROMPT Wales training, the Welsh Risk Pool Civica team are currently developing a survey to measure participant satisfaction, knowledge and confidence and application of learning in practice. This will run during the 2025-26 programme year.

The PROMPT Wales National Team are committed to supporting Health Boards to maintain an optimal multi-professional local faculty team to enable an adequate multi-professional faculty on all PROMPT Wales training days. The team organise a national Faculty Development event every September, training an additional 40 colleagues annually. The national database of active, local facilitators currently stands at 331. This approach aims to embed a standardised approach to delivery, with an understanding of the PROMPT methodology.

Through our collaborative approach we are beginning to see our aspiration of safer outcomes for women and babies unfold. Since the implementation of PROMPT Wales there has been a statistically significant reduction in APGAR scores less than 7 at 5 minutes in term and preterm babies, and a reduction in rates of postpartum haemorrhage. We acknowledge the OBS Cymru approach to the management of postpartum haemorrhage and are pleased to have further embedded and sustained the OBS Cymru principles through PROMPT Wales training. It is hoped that in time, improvements in care will also see a reduction in maternity litigation in NHS Wales, freeing up much needed expenditure for service delivery.

Community PROMPT Wales

Community PROMPT Wales' is an 'All Wales' maternity safety programme developed by the PROMPT Wales National Team, who recognised a need for bespoke training for community teams which addressed the principle of 'teams who work together, should train together.' The team have since collaborated with the PROMPT Maternity Foundation (PMF) and a new 'Community PROMPT' Training package has been developed, making this available for teams in the UK and internationally.

The programme is designed to improve safety and clinical outcomes for women and babies, while also contributing to a reduction in litigation costs associated with preventable harm. It achieves this through scenario-based emergency simulation sessions and workshops with a strong focus on human factors, communication, and teamwork.

Since its launch in September 2021, Community PROMPT Wales has been mandated by the Welsh Government for annual attendance by all Community Midwives. The programme has expanded to include multi-professional participation, welcoming Paramedics, Technicians, and Maternity and Health Care Support Workers into its training courses across Wales.

A central value of Community PROMPT Wales is its ongoing commitment to Equality, Diversity, and Inclusivity (EDI). Programme materials, including imagery and language, have been reviewed and updated to reflect diversity. Language used in the training aligns with guidance from the Royal College of Midwives (RCM) Re:Birth initiative, supporting respectful, inclusive, and person-centred care.

In the academic year 2023–2024, the programme achieved a 95% participation rate among Community Midwives, with 70 Community PROMPT Wales courses delivered throughout the year. The training continues to be well received, with consistently positive feedback highlighting the relevance, inclusivity, and effectiveness of the sessions:

> *"Brilliant course, with scenarios including paramedics thank you!"*

> *"Great informative course with good balance of immersive hands-on experience."*

> *"I really enjoyed today it was my first community prompt, and I feel much more prepared for home births/ BBAs etc. The facilitators are so knowledgeable and skilled, and you learn a lot from them."*

The quality assurance process is replicated for Community PROMPT Wales and the national team completed another successful round of quality assurance reviews across all Health Boards in Wales. Each Health Board visit demonstrated fidelity to the intended model, improvements in programme delivery and strong alignment with PROMPT Wales principles, highlighting the dedication of Community PROMPT Wales faculty and the value of the quality assurance process. Enhancements have also been made to the Human Factors in the Community presentation, these include integration of the All-Wales Guideline for Maternity Transfers from Community and Freestanding Midwifery Units, as well as the introduction of '999 Scripts' to support clearer and more effective communication with emergency services.

In addition, the Welsh Ambulance Services NHS Trust (WAST) has developed a Red Phone Standard Operating Procedure (SOP) to improve internal processes when an obstetric or neonatal incident is declared in a pre-hospital setting. The PROMPT Wales National Team is working closely with WAST to incorporate this SOP into training simulation scenarios. This collaboration aims to promote use of the Red Phone and clarify the pre-alert process to the receiving obstetric unit during emergency transfers. This is another example of supporting the embedding of an important all-Wales initiative through our training programmes.

Community PROMPT Wales had the privilege of supporting the Emergency Medical Retrieval and Transfer Service (EMRTS) with dedicated training sessions in Dafen (West Wales) and Caernarfon (North Wales). This collaboration reflects the programme's growing national influence and ability to unify maternity and emergency services through shared goals, education, and evidence-based practice.

As part of this partnership, bespoke EMRTS obstetric emergency algorithms were developed by a network of multi-professional clinicians led by the Welsh Risk Pool Safety and Learning Advisors and the PROMPT Wales National Team. These algorithms were introduced during the training day and reinforced through high-fidelity simulation, ensuring continued alignment with Community PROMPT Wales principles. Emphasis remained on multi-professional teamwork, effective communication, and the role of human factors in emergency care.

Feedback from EMRTS participants was overwhelmingly positive, highlighting the relevance, quality, and applicability of the training. This is a testament to the dedication and expertise of the Community PROMPT Wales Faculty and their ability to facilitate meaningful, system-wide improvements in maternal and neonatal care:

> *"Good communication, great teamwork, positive feedback and conversations and learning points around the sims."*

> *"Really engaging and knowledgeable faculty."*

> *"A very well-run course with an exceptionally talented and knowledgeable faculty. Would recommend every EMRTS clinician to attend."*

The PROMPT Wales National Team is proud to support universities across Wales by delivering high-fidelity Community PROMPT Wales training to student midwives and paramedics. These sessions foster early multi-professional collaboration, introducing essential safety behaviours and clinical skills before qualification. This proactive approach helps reduce preventable harm and supports a safer transition into practice for future healthcare professionals.

Community PROMPT Wales continues to play a pivotal role in improving maternity safety across Wales through inclusive, high-quality, and multi-professional training. The programme's national network and partnerships, with services such as WAST, EMRTS, and academic institutions, demonstrate its positive impact on emergency maternity care and education. With a focus on continuous improvement, equity, and teamwork, Community PROMPT Wales is shaping a resilient, person-centred maternity and neonatal care system for the future.

MoNET Wales - Multi-Professional Neonatal Emergency Training

MoNET CYMRU WALES
Hyfforddiant Amlbroffesiynol Newyddenedigol Brys
Multiprofessional Neonatal Emergency Training

Our vision:

A standardised, all Wales training programme for neonatal services, aiming to enhance teamworking across the perinatal sector and improve outcomes for babies and families.

The MoNET Wales programme was rolled out in January 2025 following a period of programme development and collaborations with neonatal stakeholders in 2024. The MoNET Wales programme has been designed by a diverse group of NHS Wales clinicians and coordinated by the Welsh Risk Pool following the publication of the Maternity and Neonatal Safety Support Programme Discovery Report 'Improving Together for Wales'.

The programme aims to address the findings from the 'MatNeo' report, promoting perinatal teamworking and ensuring an understanding of the impact of human factors is threaded throughout the teaching.

The programme was co-designed by a multiprofessional team of nurses and consultants, with expert input and guidance from the Welsh Risk Pool team.

Based on the principle that 'teams that work together, should train together,' the programme is designed to be delivered and attended by the whole multiprofessional team in local units. This significantly differs from other skills training programmes, and the approach has been co-designed by a multi-professional expert group.

The teaching strategy involves interactive presentations and scenario-based learning. Themes from the presentation topics are incorporated into the simulation-based scenarios within the clinical environment, enabling the testing of systems and processes in local units. MoNET Wales promotes an inclusive approach, involving all members of the neonatal team.

The pilot phase commenced in January 2025, with training days now underway across Wales. As part of the implementation strategy, members of the national team attend local training days to provide support and guidance to local faculty teams, to share best practice and ensure fidelity to the MoNET Wales programme. This hands-on approach aims to build faculty confidence and capability, supporting standardised, sustainable delivery across Wales.

MoNET Wales represents a strategic step towards building sustainable, high-quality education across neonatal services in Wales and is supported by the Chief Midwifery Officer and Chief Nursing Officer for Wales.

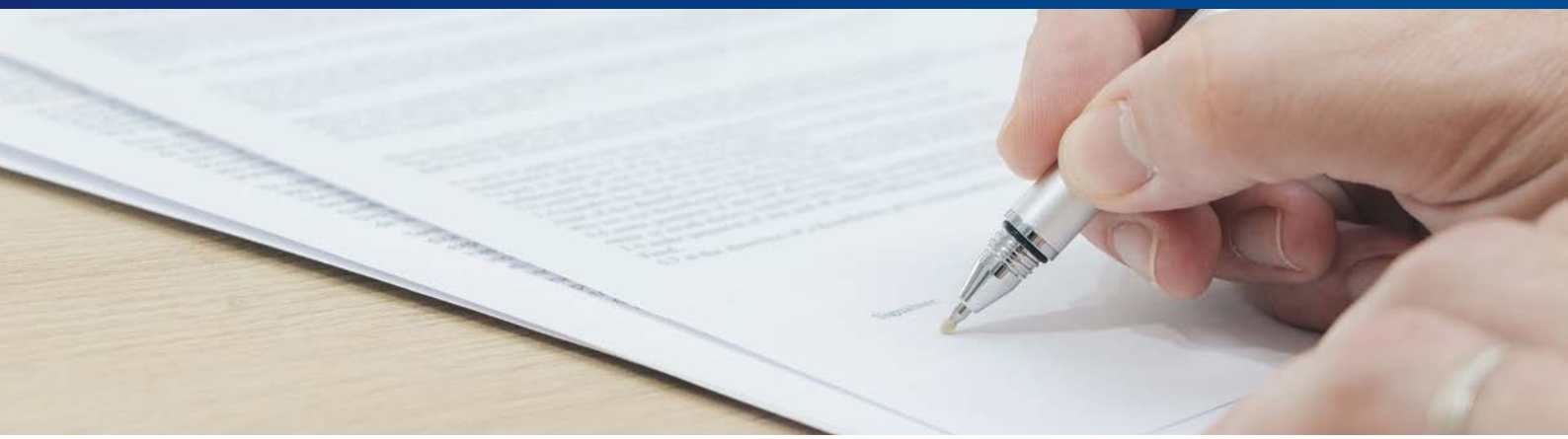
As of 31st March, 85 MoNET Wales facilitators have been trained and accredited, with 28 MoNET Wales programme days delivered across the country since the launch in January 2025 with over 200 NHS Wales neonatal services staff participating.

Of the nine neonatal units in NHS Wales, MoNET Wales has been successfully delivered in eight units. The unit at UHW in Cardiff has yet to carry out training and a supporting plan has been requested from the Health Board.

A comprehensive evaluation is planned at the conclusion of the pilot phase in Q4 of 2025/26. Participant feedback is being collected to analyse the impact and areas for enhancing the programme. An average satisfaction rating of 9.2 out of 10 across all participating units has been achieved so far. Pre and post course topic knowledge and skills, and confidence, is self evaulated by particpants and this demonstrates improvements in each scenario with an enhanced understanding of human factors. The feedback highlights strong initial engagement and perceived value from those attending the training days.

The Welsh Risk Pool leadership team are working with Welsh Government to place the MoNET Wales programme on a similar position to the PROMPT Wales programme with an expectation that all doctors providing neonatal care, and neonatal nurses, participate in MoNET Wales training annually. This may include a Welsh Health Circular or inclusion of the programme in the Quality Statement for Perinatal services.

Decision Making and Consent



The importance of supporting NHS Wales Health Bodies in the area of Decision Making and Consent is driven by the significant number of claims which feature the process of consent in healthcare. During 2024/25, the Welsh Risk Pool reimbursed health bodies in NHS Wales £4,028,701.68 in relation to cases where consent was a direct contributory factor, with over £20m seen in cases where issues regarding consent were a causal factor.

The national programme for Decision Making and Consent, coordinated and funded by the Welsh Risk Pool, supports organisations to comply with regulatory and best practice guidance, with the aim of improving patient safety and reducing the associated litigation profile.

The All-Wales Decision-making and Consent Group continues to provide an effective network through which guidance can be developed and rolled out. In 2024 'Decision-making' was added to the title of the group. Explicit reference to decision-making recognises the importance of shared decision-making undertaken during every consultation with the patient, broadening focus beyond formal consent processes summarised in consent forms.

Gwneud Penderfyniadau a Chydsyniad

Decision Making and Consent

Decision Making & Consent Work Programme

Over the last 5 years the WRP team have developed and rolled out a comprehensive governance framework for NHS Wales. Agreed quality standards have informed the development of related assessments and review of consent practices in Health Boards and Trusts across NHS Wales. The last review and related improvement plans were published in 2023 with a further cycle of assessments planned in 2025. Our All Wales consent peer review assessment tool (2022) and bespoke e-learning package (2023) allow organisations to provide assurance around consent processes and evidence organisational learning where required.

EOL decision-making

Following the Covid 19 pandemic and the publication of a series of regulatory reports reviewing DNACPR decision making, along with advent of the Medical Examiners Service, there has been an increasing focus on end of life decision-making. Recognising the challenges of transforming the legal framework into clinical practice, the WRP National Team developed a short training video in 2024.This video provides a focus for relevant postgraduate training sessions and thematic slots in Mortality and Morbidity meetings. Availability on ESR and Learn@ Wales platforms means that it can also be used to support personal CPD.

Procedure specific patient information leaflets

The Decision Making and Consent Programme continues oversee promote the use of procedure specific patient information leaflets provided within the national download library procured from EIDO Healthcare, ensuring that high quality information is routinely shared with patients across NHS Wales during the consent process. The library covers more than 400 procedures. Leaflets are internationally authored and fully indemnified by EIDO. Documents are available in Welsh, English and multiple other languages, as well as accessible formats such as large print and EasyRead.

Download activity is monitored to drive targeted improvement. The volume of downloads and transmissions of consent information documents has increased significantly over the last five years. Comparison of the 2019 and 2024 usage statistics highlights increased engagement, with some variation amongst different clinical specialties and between health bodies. In 2019, 37,540 leaflets were downloaded across NHS Wales compared with 89,073 in 2024. Engagement is particularly demonstrated in anaesthetics, where 37,500 anaesthetic-related leaflets were downloaded in 2024, compared with only 2064 in 2019.

Recent developments include the transition to an updated platform which now enables the uploading of locally produced and approved consent leaflets. In addition, targeted collaboration between national clinical networks and EIDO Healthcare has also facilitated the review of existing leaflets and the development of 17 new leaflets. Collaboration with the National Endoscopy programme and EIDO Healthcare has facilitated the active review of existing leaflets along with the development of new leaflets on an All-Wales basis where required. Regionalisation of services has been another driver for development of procedure specific leaflets on a national basis.

WRP Risk Management Alert - Consent

In 2020, the WRP Committee issued a Risk Management Alert, further clarified in 2021, stipulating that only procedure specific leaflets produced by EIDO or a recognised professional body should be used where available so that high quality information is consistently shared with patients across NHS Wales during the consent process. The use of locally approved leaflets could only be justified where a relevant leaflet produced by EIDO or a recognised professional body was not available.

Following the alert organisations are required to maintain a library of all approved procedure specific leaflets, which has increased oversight and informed the targeted development of leaflets on an All-Wales basis. The alert will be reissued in 2025.

Learning and Development

Our bespoke e-learning package, launched in 2023 by the Cabinet Secretary for Health and Social Services, underlines the importance of consent and its relevance to all patient facing clinicians. It is now mandated for all patient facing clinicians in 6 Health Boards with a target compliance of >85%. Completion of approved training is also now one of the drivers in the WRP risk sharing agreement. The e-learning package has been well received with excellent feedback from all professional groups, with one anaesthetic colleague stating, “as engaging as mandatory training gets.”

The e-learning is supplemented by webinars on topics such as ‘Informed Consent - Getting it Right’ and ‘Decision Making and Consent - No decision about me without me.’ More recently an innovative learning package in End of Life Decision Making has been developed. Both modules are available on ESR and Learn@Wales.

Peer Review

The national consent peer review assessment tool, updated in 2024, focuses on the whole consent process, rather than the snapshot provided by consent form audits. It references agreed standards and facilitates action planning following discussion and in relevant specialty based clinical governance settings. Feedback continues to highlight the educational value of the exercise. Failure to consistently provide procedure specific patient information leaflets has also been a consistent theme nationally. The national group continue to refine the peer review tool in light of ongoing experience and real-world feedback.

National Clinical Review of consent standards in NHS Wales Health Bodies

The Welsh Risk Pool Committee has commissioned a further national clinical review of consent standards in NHS Wales Health Bodies during 2025. This will consist of self-assessment and collation of evidence by each Health Body. Organisation specific Microsoft SharePoint folders have been set up and nominated leads have been provided access for submission of evidence by 31st July 2025. Analysis will be undertaken by the WRP Safety & Learning Team.

Digital Consent Platforms

Procurement of a platform for NHS Wales would be a natural progression where challenges around integration with other patient information systems and workflow can be addressed in collaboration with DHCW. Digital consent platforms offer clear advantages in terms compliance with governance frameworks and recording of the consent process and dialogue with the patient in particular.

During 2024/2025, the WRP team re-examined digital market suppliers and believe that the previously identified challenges in relation to Digital Consent Platforms can now be addressed with a reasonable prospect of achieving an award to a supplier.

Plans are underway to undertake pilots with key suppliers in 2025/26. We have established a working group with colleagues from DHCW and NHS Performance and Improvement to monitor progress of the pilots and develop a technical specification and related business case for a digital consent platform for NHS Wales.

Programme priorities for 2025-27:

- Lead the procurement of digital consent platform for NHS Wales in collaboration with DHCW and NHS Performance & Improvement, following the 2025-26 pilot.
- Actively monitor leaflet downloads, encourage electronic transmission and implement a system to include locally produced consent leaflets.
- Continue to actively engage with Health Boards and clinical service groups to increase use of the EIDO download library – re-issue WRP alert highlighting required standards for procedure specific information
- Promote use of All-Wales leaflets produced in collaboration between the National Endoscopy programme and EIDO – use as exemplar of best practice
- Undertake a National Clinical Review of consent standards in NHS Wales
- Continue to monitor uptake of training in decision making and consent for all patient facing clinicians (Target compliance > 85%)
- Develop e-learning package on Mental Capacity Act (2005) and decisions about serious medical treatment.

VTE Wales

Our vision:

To develop an all-Wales approach to the prevention and reduction of harm associated with venous thromboembolism, aiming to improve patient experience and outcomes.

VTE CYMRU WALES
Thromboemboleddau Gwythiennol
Venous Thromboembolism

Venous thromboembolism (VTE) is the leading cause of preventable death in hospitals with 55-60% cases occurring during or following hospitalisation (Thrombosis UK, 2024). Many such deaths are preventable if patients receive a VTE risk assessment on admission to hospital and are offered appropriate thromboprophylaxis. Latest available data from the Office of National Statistics shows 2,713 deaths related to VTE in England and Wales in 2022. VTE has remained the leading direct cause of maternal death for many years, however this is now the overall leading cause of maternal death. (MBRRACE, 2024). A VTE diagnosis can also have a significant long-term impact on the health of an individual both physically and psychologically, in many cases resulting in lifelong dependency on anticoagulant medication.

In NHS Wales in 2024, 9 claims directly related to VTE including hospital acquired thrombosis (HAT) were submitted for reimbursement. The total cohort of cases where issues relating to VTE were identified exceeds £7m. Causal factors identified include a lack of clinical examination and a failure to undertake diagnostic investigations, as well as delayed or missed diagnosis of symptoms. Failure to escalate and issues regarding medicines management, along with a lack of VTE risk assessment, documentation and communication also featured. This highlights the importance of a thorough risk assessment, as soon as possible after admission to hospital or by the time of the first consultant review, as required in the NICE guidelines.

Cases presented to the Welsh Risk Pool Committee include matters where there is a failure to recognise the symptoms of a PE or DVT and where there is a failure to complete a thorough risk assessment of a patient on admission. In 2021, having observed an increase in the numbers of redress and clinical negligence cases relating to VTE, the Welsh Risk Pool Committee requested that a review of compliance with the All-Wales VTE Policy was undertaken by the WRP Safety and Learning team. The review identified variation in practice across NHS Wales and issued five recommendations to all Health Bodies to reduce avoidable harm associated with VTE.

The VTE Recommendations:

1. All health bodies within NHS Wales adopt the All-Wales Thromboprophylaxis Policy.

2. All clinical staff undertake All-Wales training, both in relation to the recognition of patients presenting with symptoms of VTE and in the prevention of Hospital Acquired Thrombosis (HAT).

3. All patients receive a documented VTE risk assessment, using a Department of Health Risk Assessment Tool (or similar) on admission, as part of the initial patient clerking.

4. An All-Wales check list for the investigation of a HAT is developed in order to maintain a uniform investigative approach across NHS Wales.

5. VTE risk assessment compliance data and HAT data is shared at appropriate health body governance meetings.

Having also identified a lack of a standardised approach to staff training in VTE prevention, diagnosis and management, the WRP led on the development of 2 e-Learning modules, and these have been available on ESR since 2022. The scheduled review of the ESR VTE e-learning modules by the WRP commenced in March 2025. The two modules will be condensed into one module with updated content covering VTE prevention, diagnosis, management and aftercare. The updated module will bring benefits for clinical staff in practice such as convenience of one module instead of two, concise VTE information for both registered and unregistered clinicians, recognition of theory in practice and promotion of resources for staff and patients.

A VTE Wales Strategy has been produced setting out aims and objectives of the programme. It includes a set of Standards to guide Health Bodies to meet the expectations of the programme, and these will be reviewed by the WRP annually.

A Safety and Learning Advisor with an extensive background in thrombosis was employed, to lead the VTE Wales programme. A scoping review of practice relating to VTE in all organisations was carried out between January and March 2025 and reviewed the following:

- What VTE risk assessment tools are used
- What VTE Patient information leaflets are used
- What system is used to identify potential HATs
- Process for Root Cause Analysis relating to potential Hospital Acquired Thrombosis (HAT)
- Reporting process for HAT data locally
- Whether thromboprophylaxis features on the theatre safety check list
- Arrangements for Local education and promotion
- Compliance with the VTE e-Learning modules
- Any best practice and quality improvement projects

The findings from the scoping review will inform the programme of work scheduled for 2025-26, aiming to address any variation identified and work towards an all-Wales approach, whilst remaining cognisant of the bespoke requirements of the different specialities.

Work on developing a national reporting system for Hospital Acquired Thrombosis (HAT) data is expected to commence in the coming months. This has been identified as one of the priorities. In April 2021, the delivery framework for 2021-2022 removed quarterly reporting of HAT data to Welsh Government and was no longer a Tier 1 priority. Since national HAT reporting ceased, there has been variation in practice regarding governance, completion of investigation into possible HAT cases and HAT reporting. Therefore, by reinstating national HAT reporting it will create a standardised approach to reporting.

This approach will also enable analysis of the data such as identifying themes, high risk characteristics and importantly, reviewing the data regularly will identify opportunities for lessons learned that can be shared across all Health Bodies. Having national reporting of HATs can also serve as a matrix to assess the impact of the VTE Wales programme on clinical outcomes as well as contributing to the direction of the VTE Wales programme.

The WRP recognises that there is some excellent practice existing in NHS Wales in relation to the prevention, recognition and management of VTE. Direct oversight of the VTE Wales programme will be via a WRP VTE Board - reporting to the Welsh Risk Pool Committee. The WRP VTE Board will have wide representation, including leading clinicians from different specialties and other key stakeholders – aiming to drive improvement in the area. The draft Terms of Reference (TOR) for the WRP VTE Board have been written and applications for expressions of interest for the VTE Board membership commenced in March 2025.

Timeline for VTE Wales

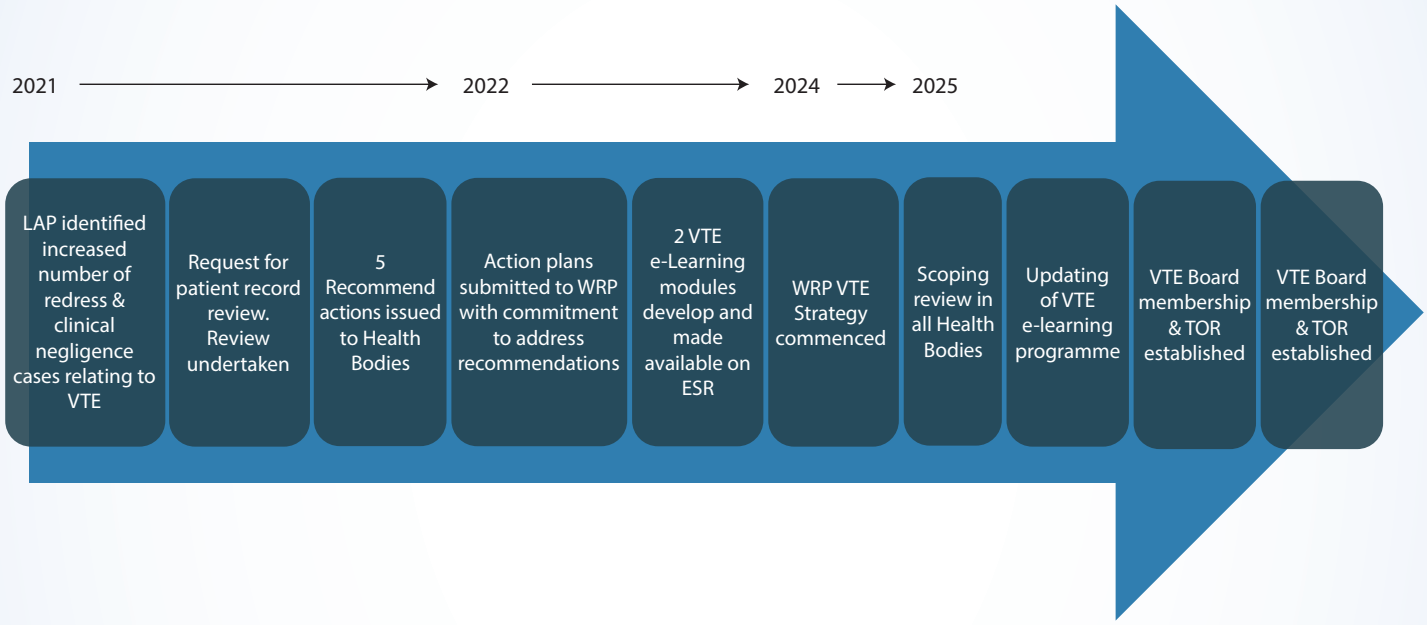


Fig.14: Timescales and Plans for VTE Wales

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Anti-Violence Collaborative Wales

Violence and Aggression (V&A) directed towards NHS Wales staff and those who utilise NHS services in Wales is unacceptable and it is recognised that NHS staff are among some of the professions most likely to face aggression while carrying out their duties.

Where violent and aggressive behaviour is displayed, it is imperative that NHS Wales organisations seek the appropriate response to ensure the wellbeing of all concerned. Staff attending the workplace and those who visit the NHS Wales footprint, whether as a patient or for another reason, should do so confident of their safety.

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 V&A 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.

In June 2023 Jonathan Webb was appointed as the Chair the AVC. An interim National Advisory Team was created with the aim of managing and driving forward the vision of the collaborative. The Team was created by seconding a NHS Violence and Aggression case manager from a health board, a staff support officer from the Royal College of Nursing and a tactical advisor to the Chair who is an experienced V&A leader from the Welsh Ambulance Services University NHS Trust.

Originally formed in 2017, the AVC has coordinated an Obligatory Responses to Violence in Healthcare framework (ORV), which sets out the aims and process by which all of the AVC partners will collaborate. The work of the AVC in the NHS is underpinned by a Welsh Health Circular, which aims to ensure that the organisations which form NHS Wales fully embed the guidance given within the ORV document. All parties are committed to encouraging the most appropriate response to V&A cases to ensure the safety of NHS staff and others.

As of Spring 2025, great progress has been made in all of the projects and collaborative endeavours of the AVC. The offence of causing nuisance or disturbance on NHS premises, as outlined in sections 119 and 120 of the Criminal Justice and Immigration Act 2008, has been given the go ahead by Welsh Government to become active in Wales. This offence is unique in that it empowers NHS staff to proactively tackle those whose behaviour is unacceptable and causes disruption to precious clinical time and services.

For NHS Wales staff and ultimately the Welsh public to benefit from this new power, Senior Safety & learning Advisor Gareth Lewis, supported by senior BCUHB colleague Mike McGee, are developing a suite of training for NHS Wales staff. Adopting a 'train the trainer' methodology, Gareth and Mike are creating a training package which will have a multi-media structure at its core. The vision is for this training to be appropriate and effective for all types of learning styles.

Once training is rolled out across the country, the AVC will provide continuing support to NHS Wales bodies regarding 'Section 119', including quality assurance and consultancy where appropriate.

To ensure a consistent approach by NHS Wales bodies in reducing incidents of violence against staff, The AVC has drafted the first Welsh 'Violence Prevention & Reduction' Standards. It is intended that these standards are trialled by two Welsh health boards through 2025-26. These standards will allow health boards to evaluate their responses to violence and aggression which occur within their footprint, ensuring the most appropriate structures to support victims of violence are in place, and that there are dedicated staff working to actively and proactively reduce the risk of further incidents.

Accuracy in the collection of data relating to violence and aggression incidents is paramount to understand what resources and responses are the most appropriate to be deployed in order to counter such incidents.

The AVC in co-operation with colleagues overseeing Datix Cymru systems and at Cardiff and Vale University Health Board, have developed a practical and straight forward approach to analyse violence incidents reports. Cardiff's data for the financial years 2023 to 2025 was reviewed and highlighted some key factors in incident reporting, particularly with regards to incidents with aggravating 'hate' factors.

The AVC will work with all health boards in Wales through 2025 to ensure all violence and aggression incident reports are reviewed and the accuracy achieved is used as the benchmark for future reporting.

An exciting new development for the AVC in the use of violence data is in its infancy, Professor Simon Moore and his team at Cardiff University's Violence Research Group have expressed an interest in working with the AVC to analyse violence data collected by NHS Wales, with the aim of unravelling possible triggers and causes for offenders' violent behaviour.

The AVC has reached out to the Fire and Rescue services in Wales, via contacts at the Joint Emergency Services Group, and has successfully introduced a colleague from North Wales Fire & Rescue Service to the AVC team to act as a point of contact for Welsh fire and rescue services.

Unfortunately, some case of violence and aggression become extremely complex and troublesome for NHS Wales staff. These types of cases are difficult for a number of reasons, the physical and mental drain on staff, the diversion of valuable resources and the interference in service provision to name just a few.

To be able to effectively tackle these types of incidents, the AVC has been working closely with the Heads of Patient Experience (HoPE) group to create clear guidelines and advice. Allied to this, a Workshop for colleagues in Putting Things Right Teams and other relevant departments was organised by the AVC and held at the Angel Hotel Cardiff in March 2025. Key guest speakers, such as senior CPS prosecutors and senior police officers, attended and discussed aspects of offending and how best to address the problems that are presented.

With the developments in the response to violent behaviour across NHS Wales, in 2025, the AVC proposes a refresh to the existing Violence and Aggression Case Managers Group, this would be in line with the development of the aforementioned violence prevention and reduction standards and with current thinking around reduction of violence as opposed to a 'zero tolerance' mindset.

A particularly acute and topical area for the AVC to respond to is the sexual safety of staff. A vital component in safeguarding staff is the ability for colleagues to report any concerns in a secure and appropriate manner. In close liaison with colleagues within the Legal and Risk Team and at Welsh Government, the AVC is actively involved in the development of appropriate reporting mechanisms and guidance, which will encourage any staff affected by this sensitive topic to report, and where reports are made the most appropriate responses are actioned.

NHS Wales Chief Executive, Judith Paget, Chief Constable Pam Kelly QPM (Gwent Police), Chief Constable Amanda Blakeman KPM (North Wales Police), Chief Crown Prosecutor for Wales, Jenny Hopkins with Chair of Anti-Violence Collaborative Wales, Jonathan Webb

Once for Wales Concerns Management System

The Welsh Risk Pool hosts the Once for Wales Concerns Management System (OfWCMS) which aims to provide consistency in the capture and analysis of data relating to staff and patient safety and service user feedback.

Procured on an all-Wales basis, the system is actually a collection of individual digital systems which are operated locally and designed, developed and maintained by a central team.

The Welsh Risk Pool continues to work with all health bodies and national groups to ensure that the information governance arrangements and cyber security requirements relating to the Datix Cymru and Civica Experience Wales are firmly in place. The National Data Protection Impact Assessments have been reviewed, and a key piece of work is the definition of roles and responsibilities for data sharing at a national level. There is an effective governance process which oversees OfWCMS.

Programme Board. Commissioned by the Welsh Risk Pool Committee, the OfWCMS is overseen by Programme Board, Chaired by Chief Executive of Velindre University NHS Trust Steve Ham. This provides strategic oversight to the programme and ensures organisations are able to demonstrate readiness for implementation of new functionality.

System Rheoli Pryderon Unwaith dros Gyru

Once for Wales Concerns Management System

Programme Steering Group. Additionally, a Steering Group has been formed which oversees the operational elements of the system.

Content and Governance Group. A Content and Governance Group has also been established to monitor requested for system developments and changes in order to maintain the Once for Wales approach.

Workstreams. Each area of functionality is underpinned by a network of group which represents staff and practitioners related to the element of the system being served by the software. The number of workstreams required varies depending on the stage of implementation. Workstreams created to coordinate procurement, ICT integration and report form design have been stood down as the programme has been live since 2021. A number of the workstreams consist of the membership of the Safety and Learning Networks – which means that there is readily available access to expertise on topics when required. The power of collaboration across NHS Wales in developing the Datix Cymru and Civica Experience Wales systems through the OfWCMS workstreams is overwhelming successful. It has created a system for NHS Wales used by NHS Wales.

Datix Cymru. The Datix Cymru product is a cloud-based software tool with multiple modules that have been adapted, configured and implemented specifically for NHS Wales. In addition to replacing the legacy systems used throughout organisations for handling patient safety, health and safety and complaint records, the system has been configured to support specialist services such as the NHS Wales Medical Examiners service.

Core Functionality of Datix Cymru

Datix Cymru

- Incidents
- Inquest Cases
- Safety Alerts
- Risk Registers
- Complaints
- PALS Enquiries
- Mortality Reviews
- Safeguarding
- Redress Cases
- Claims Management
- Medical Examiners
- Cyber Resilience Reports

Fig.15 outlines the core functionality of the software.

The power of the Datix Cymru system enables the creation and configuration of specific Investigation Workflows, which are made available across Wales – delivering consistency in not only data but processes used to determine learning and improvements. This incorporates the Yorkshire Framework of causal factors.

Datix Cymru provide large-scale interactive databases to report, capture, analyse and retain information relating to key parts of the Putting Things Right area. In 2024/2025, over new records were opened. Table.13 outlines the breakdown of the records opened.

Datix Cymru Module	Records Opened
Incidents	189,027
Claims and inquests	3843
Redress	928
Feedback	52,163
Mortality	7,105
Medical Examiner	27,020
Total	**280,086**

Table.13: New Records opened in 2024/25

Datix Cymru Workstreams 2024/25

We have operated a number of dedicated workstreams with the aim of bringing consistency to the development and use of the Datix Cymru system used by all NHS Wales health bodies when handling concerns to investigate and improve quality and safety.

All organisations are represented at each of the workstreams and extensive collaboration, supported by a robust governance process, has led to significant development of the Datix Cymru system.

During 2024/25 two new workstreams have been set to support the development of new functionalities introduced to the Datix Cymru system:

Safeguarding workstream - has recently evolved from a working group to a workstream with its first workstream meeting being held in June 2025. Following a successful pilot, there are currently three organisations actively using the Safeguarding module.

Compliments workstream – was re-established to support NHS bodies to effectively implement the People's Experience Framework. The workstream is working on aligning compliment themes and reporting across Datix Cymru and Civica Experience, ensuring an equitable, accessible platform is available in line with the Duty of Quality, 'Always on Reporting' requirements.

Mortality Workstream – have reviewed and updated V15 of the natreviewing the flow of the report form to align with the Medical Examiner report form. Focus on capturing learning consistently across all functionalities is a key agenda item going forward. A key piece of work for 2024/25 and ongoing for the Mortality Network is compiling a list of Themes, Patterns and Trends that are relatable across other Datix Cymru functionalities, including Redress, Claims/Inquests.

Incident Workstream – as reported last year, a key piece of work in 2023/24 related to the development of Restrictive Practice to align with the National Framework. During 2024/25 this work has progressed with the support of NHS Wales Performance & Improvement, subject matter experts and local leads. In September 2025, a pilot of the redesigned Restrictive Practice form will be rolled out across inpatient Learning Disabilities areas.

The Incident workstream are also working towards a review, redesign and refresh of the Incident report form, to support modernisation of reporting and incident management in line with Quality and Improvement Strategies. A timeout session for the workstream, which will involve key stakeholders such as NHS Wales Performance & Improvement and RL Datix is being planned for late 2025.

Risk Workstream – the functionality is current being piloted by one organisation. The workstream, which is made up of representatives from all organisations which are monitoring and supporting the pilot process.

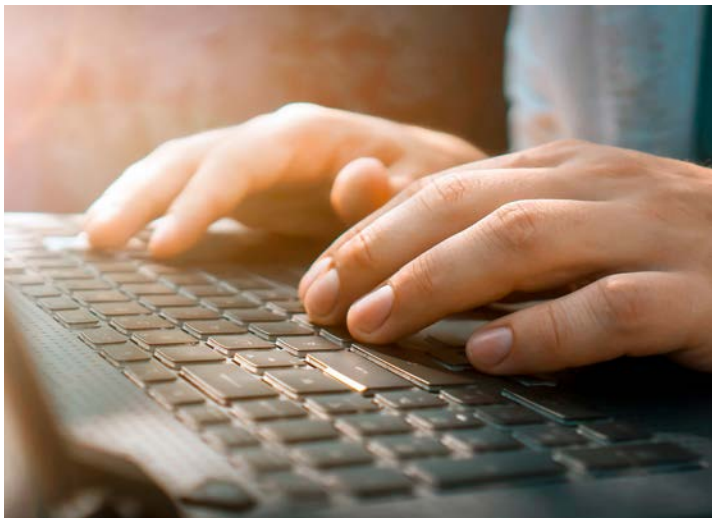
Intelligent Monitoring Dashboard Data Analysis Workstream - have continued to support Safety & Learning Networks to develop National dashboards, the latest of which are being built for Claims and Redress Networks to support the Learning from Events process.

Coding Workstream - are in the process of undertaking a detailed review and refresh of the Accident and Injury codes that sit in V17 of the national codes. This is an extensive piece of work, and each organisation is currently undertaking a risk and benefits analysis to ensure the complex nature and resource commitment is fully appreciated before this work is progressed.

The workstream has recently completed a thorough review of all codes to ensure they have the appropriate combo-linking (a method of simplifying code selection) - to provide accurate reporting across all levels. A key piece of work is ongoing to link with chairs of All Wales groups for specific areas such as, Tissue Viability, Infection Prevention Control, Health and Safety etc to gain assurance that the current codes and codes being requested in the future meet the needs of the services.

Safety Alerts Workstream - since the last Annual Report, the Safety Alerts module has transitioned from pilot stage to go live stage, with all organisations starting to utilise the module for the management of Safety Alerts.

Risk Workstream - the functionality is current being piloted by one organisation. A working group has been set up to support the development of the Risk functionality. It is anticipated that the working group will evolve into the Risk Workstream as the pilot work progresses.



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Datix Cymru Developments 2024/25.

There have been a number of key developments for Datix Cymru in 2024/25:

Active Directory - datix Cymru was using the ADFS system as the authentication tool for users to authenticate into the system – enabling users to log into the software and be allocated appropriate permissions. We have now fully migrated to Microsoft Azure.

Safeguarding - the Safeguarding reporting and management forms have been developed and successfully piloted in Hywel Dda University Health Board. The Once for Wales Concerns Management Central team will continue to work with NHS Wales Performance & Improvement, Public Health Wales and all organisations to standardise and implement this in 2025/2026, with an encrypted email system to support notifications to local authorities.

System Upgrades - the Once for Wales Concerns Management Central Team have supported three Datix Cymru system upgrades, in order to improve and enhance system functionality. A robust quality assurance process is followed by the Central Team prior to any new software release to ensure any operational issues are identified before this is signed off and implemented across all NHS Wales Datix Cymru systems.

Quarterly System Releases - updates to the workflows and data fields within the system are still implemented on a quarterly basis once the Content and Governance Group have approved the adjustments. The Central Team have continued to deliver the quarterly development workplan on time and on budget.

Supporting Primary Care Services - bespoke Incident Reporting Forms for Primary Care Providers have been built in all Health Board systems to support the Duty of Candour Implementation and provide easy accessibility, with a dedicated webpage.

Community Pharmacy - as part of NHS terms of service, community pharmacies are required to report incidents using an approved system. In Wales, this system is the Primary Care Wales Incident Reporting System (DATIX Cymru) and this was introduced in 2021. The Once for Wales Concerns Management Team have undertaken a review of this process and made changes to improve the management of incidents for community pharmacy contractors and the associated Health Board teams.

National Reporting Functionality - interim solutions were established following the discontinuation of the UK National Reporting and Learning System and a new portal functionality to transmit data from health bodies to NHS Wales Performance & Improvement has been designed and successfully implemented – enabling the seamless transfer of data between health bodies and NHS Performance & Improvement.

All-Wales Coding and Categorisation - the Coding Workstream has continued to enhance the national codes to meet the needs of services, and the codes are currently on edition 17. Additionally, work has been completed to combo-link the classification codes. This process smooths the process of code selection by staff and improves data accuracy. Standardisation of terminology has also been a major focus to improve accuracy of reporting. A work programme has been developed to continue enhancements.

Business Continuity - a Datix Down process has been developed for NHS Wales, in the unlikely event the Datix Cymru Incident form was unavailable all organisations would still be able to report Incidents.

Joint Investigation - The Joint Investigation Framework in NHS Wales provides a structured approach for investigating patient safety incidents that involve multiple NHS organisations. It ensures a coordinated and consistent approach to identifying the root causes of incidents, learning from them, and implementing actions to prevent recurrence. In line with the NHS Wales Performance & Improvement Framework, a new Joint Investigation system has been designed to ensure collaborative working and learning outcomes are accessible to Organisations in one place. The system is currently being piloted between two organisations. A meeting has been scheduled in July 2025 for all other organisations to receive a demo of the system.

Datix Cymru Survey

In June and July 2024, a targeted Datix Cymru survey was sent to recent users who were incident reporters or investigators of records in the Datix Cymru systems across NHS Wales.

We received 212 responses to the reporter survey, whilst the investigator survey received 517 responses.

In August 2024, a passive approach was taken with posters that included a QR code and email links were sent to members of the OfW Programme Steering Group for circulation.

During this period, 146 responses were received from reporters, and 82 responses were received from investigators. 1

The survey closed on 31st August 2024. Total figures for the reporter survey received 358 responses, whilst the investigator survey received 599 responses.

Main themes from the feedback -

- Staff recognise that the system is in depth and encourages those responsible for the design to make this as intuitive as possible.
- Many reporters would like IT systems to be able to communicate across health boards and trusts.
- Some staff report that they have experienced difficulty in saving part-complete reports.
- A number of responders feel that 'Near miss' should be a clearer option.
- Responders describe that the system is much improved from earlier versions.
- People felt that Datix Cymru is a great tool for collecting a massive amount of data.
- Many staff felt that the system standardised reporting.
- The survey responses highlighted that with the system being intranet based it is much easier for community staff members.
- The survey showed that Datix Cymru is considered by some to be a supportive resource for determining root cause of incidents.

The Incident workstream has been commissioned by the OfWCMS Programme Board to review the survey feedback and recommend improvements to the system.

Civica Experience Wales

The National Health Service in Wales is a large and complex organisation and accurate and detailed service user feedback is crucial to designing and improving innovative health and care services. The Civica Experience Wales platform was introduced as part of the Once for Wales Concerns Management System programme and by the end of 2022 all Health Boards and Trusts in NHS Wales had implemented the Civica Experience Wales system and had invested in dedicated local system leads to support each organisation's commitment to collecting, analysing and learning from real-time feedback from users of its services and to manage system and data at a local level.

Civica Experience Wales provides a platform for real time feedback from service users to be collated and analysed quickly and effectively across primary & secondary care. The system operates by developing and presenting surveys for completion by service users and utilises a range of contact methods, including SMS text messaging, QR code, Email, Interactive Voice Recognition, (IVR) web-based tools and a dedicated app which can be installed on devices within the organisation.

Online

Tablet and Kiosk - IOS and Andriod App *(Online and Offline, Remote, Config, Video)*

Email - *Survey Links*

QR Codes / NFC Stickers *(e.g. on posters)*

SMS: *Survey Links - link to online survey*

Q&A - Questions and answers as plain text

Phone: *IVR/IVM*

Agent (human) calls

Paper: *Fully managed print and scanning facilities*

Print to PDF + data entry tool

Digital Stores: *Digital Stories Library, which facilitates the uploading, categorisation by theme, consent management and an audit record for stories*

Sentiment Analysis

The platform includes a powerful data sentiment analysis tool, which enables health service leaders to understand detailed information received from service users, adding the ability to recognise the sentiment behind a response. The sentiment analysis of responses enables very rich information to be drawn from the data input by service users and this enables me to provide our service leadership teams with valuable insight into the experiences of patients and relatives. The graphs and data tools are straight forward for managers to access with minimal training needed.

Fig.17 Example of sentiment analysis of positive and negative feedback

Quantitative data helps health bodies understand ‘what’ but only qualitative data helps you understand ‘why’. The sentiment analysis tool provides functionality to analyse emotion, thematically categorise information and show trends.

Example from the Civica Experience Wales system outlining the powerful sentiment analysis tool is shown in Fig.16 and Fig.17.

Example of Sentiment Analysis of Positive and Negative Feedback

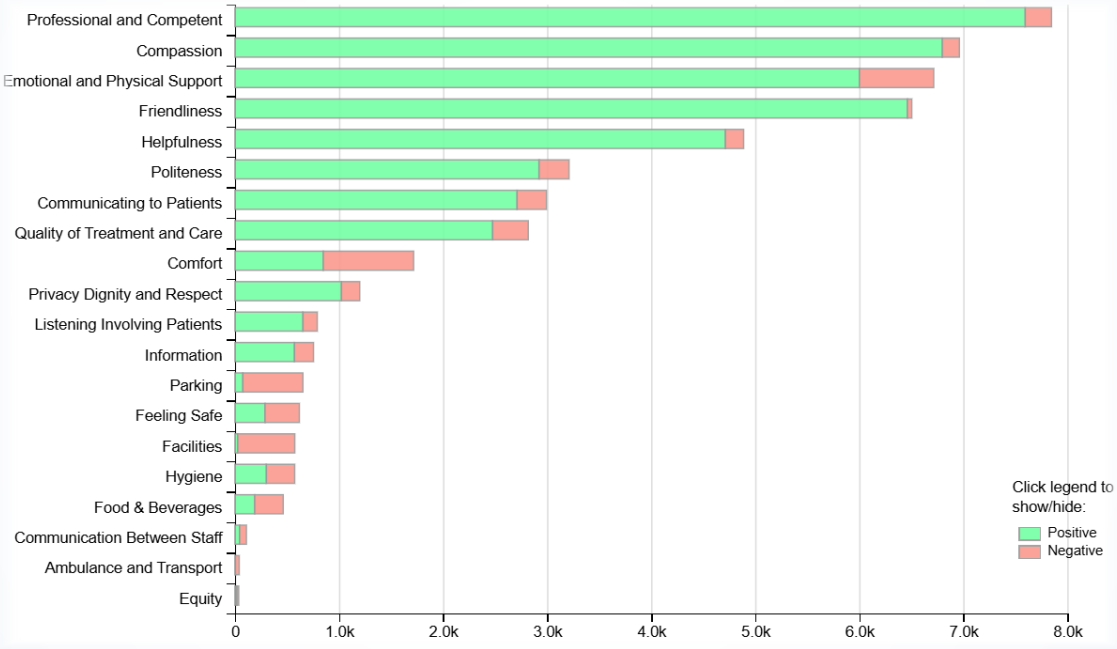


Fig.16 Example of sentiment analysis of positive and negative feedback

Presenting the National Experience Picture

Through the introduction of a common platform, health bodies now have a robust tool to gather feedback from patients, relatives and other users of health and care services across NHS Wales. With all health bodies using one platform, NHS Wales can better support service and quality reviews whilst ensuring a consistent national approach.

Since the introduction of the NHS Executive in April 2023, (now NHS Wales Performance & Improvement), and the reconfiguration of the Civica Experience Wales demonstration system to become a national analytical tool, over 80,000 pieces of service user feedback has been collected and analysed via the national analytical tool.

In August 2023, the National Emergency Department survey was launched across NHS Wales. With organisations using a variety of collection methodologies to gather feedback from service users who had accessed Emergency Departments in Wales, with the locally collected information being presented in the national analytical tool. Data collection included SMS text messages, Interactive Voice Recognition (IVR), QR codes and paper surveys. Between 1st August 2023 to 31st March 2025, 50,375 pieces of feedback were received. Now that this survey has closed, detailed analysis of this invaluable feedback will be being undertaken.

Learning from the all-Wales feedback is shared with all health bodies and also via the Listening and Learning from Feedback Group, which oversees and coordinates this area of work. In addition, data from the national analytical platform is shared with NHS Wales Performance & Improvement to support triangulation of other sources of data through the Beacon dashboard.

The roadmap for current and future national surveys is shown in Fig.18.

National Survey Topic	Position
Palliative End of Life Care	Live (data capture)
Emergency Department	Live (data capture)
Nosocomial Investigation Survey	Complete
Looked After Children	Live (data capture)
Maternity and Neonatal	Live (data capture)
Enhanced Community Care	Live (data capture)
National People's Experience Survey	Live (data capture)

Fig.18 Roadmap for National Surveys

National People's Experience Survey

In April 2025, Welsh Government issued a Welsh Health Circular for the People's Experience Framework and People's Experience Survey.

The People's Experience Survey (PES), which is a bilingual validated core set of questions has been rigorously tested and validated across all health settings. The PES is award winning, picking up an ISPOR Europe 2024 Research Presentation Award, winning the Health and Care Research Wales, Public Involvement Award and also being entered for the NHS Wales Awards 2025.

The PES was launched across NHS Wales using the Civica Experience Wales system in April 2025. This is an important step towards a more inclusive approach, in recognition of the diversity of the population, ensuring it meets the evolving needs of all people using NHS Wales services.

With data flowing from local Civica Experience systems to the national analytical tool on a daily basis, we are facilitating consistent quality engagement and always on reporting, whilst being able to achieve real time analysis of national data.

EIDO Decision Making & Consent Platform

The Once for Wales Concerns Management team provided technical support for Decision Making and Consent colleagues with the launch of the updated EIDO Decision Making & Consent Platform - known nationally as Canolfen EIDO Cymru.

The upgraded platform offers greater flexibility and future functionality to access the EIDO Consent Information Leaflets.

The team supported in the initial testing of the system, curation of a training video and, with help from colleagues in DHCW, organised initially for 25,762 Swansea Bay UHB accounts to have accessibility to the new system, whilst also being responsible for organising accessibility for any cross-organisation user.

Following the successful soft launch of the system in Swansea Bay during 2024-25, the switchover to the new EIDO decision making and consent platform was implemented to the other NHS Wales health bodies and organisations, going live on April 1st 2025 with the first two months of the full launch of the new system resulting in **15,424** Eido Consent Information Leaflets being distributed across Wales. The Once for Wales Concerns Management team provided technical support and assistance to users throughout this period and will continue to do so.

Custom consent information leaflet creation will be introduced in the coming months. The Once for Wales Concerns Management team will develop an information leaflet creation process to enable Health bodies and organisations to submit locally approved information leaflets to be distributed using the EIDO Decision Making & Consent platform.

To help promote good practice and learning, the team will also host and encourage the sharing of these materials to other health bodies and organisations throughout Wales.

The Welsh Risk Pool will encourage all organisations to use the electronic distribution of consent information. Fig.19 and Table.14 outline the method of distribution of leaflets in 2024/25.

Health Body / Organisation	Digital Download	Emailed	HB / Org Total
Aneurin Bevan UHB	1034	318	135
Betsi Cadwaladr UHB	2020	118	2138
Cardiff and Vale UHB	736	150	886
Cwm Taf Morgannwg UHB	848	136	984
Hywell Dda UHB	1215	69	1284
Powys THB	196	37	233
Public Health Wales	12	1	13
Swansea Bay UHB	4982	3552	8534
Total	**11,043**	**4381**	**15,424**

Table.14 Distribution method of consent information leaflets, April and May 2025

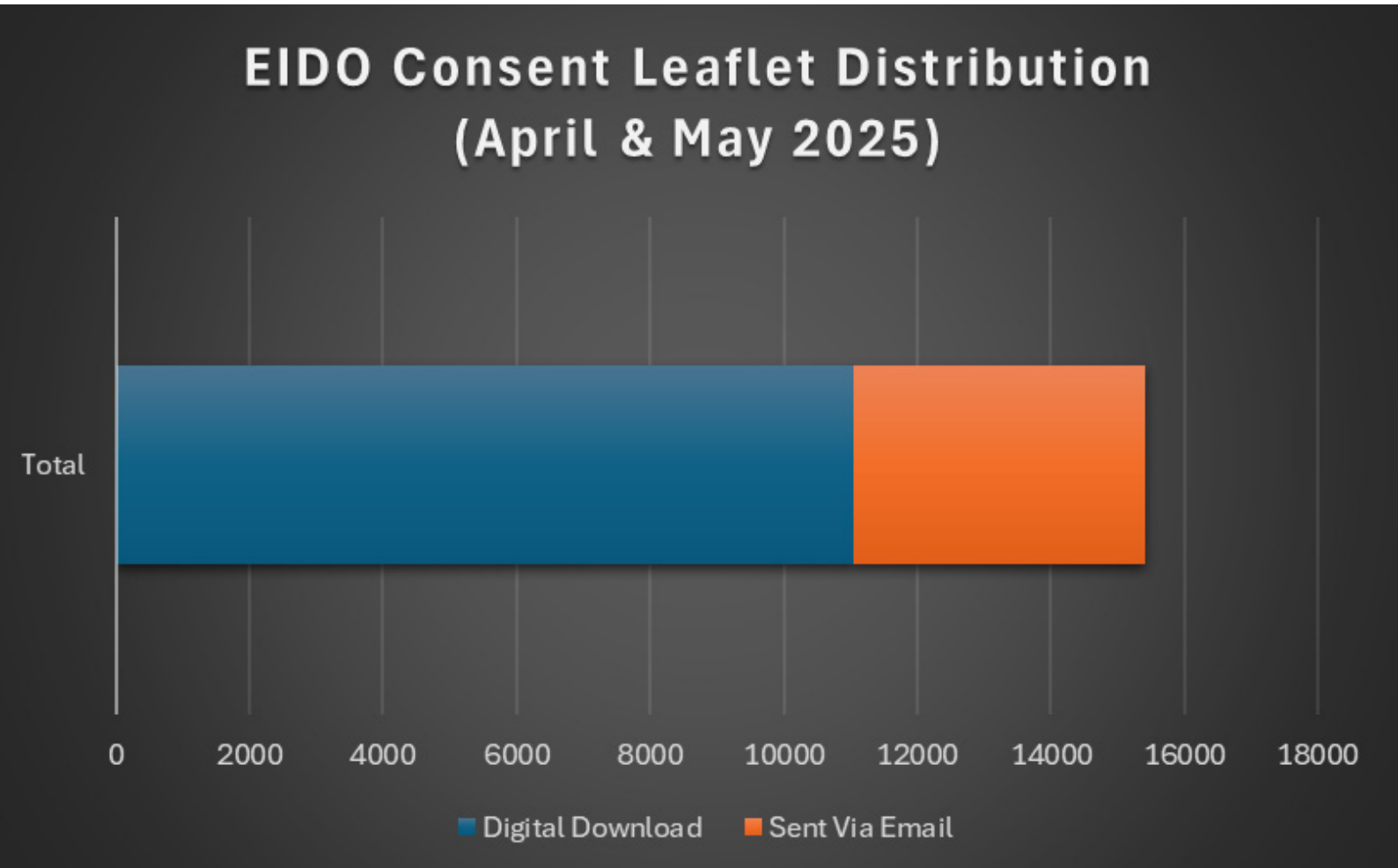
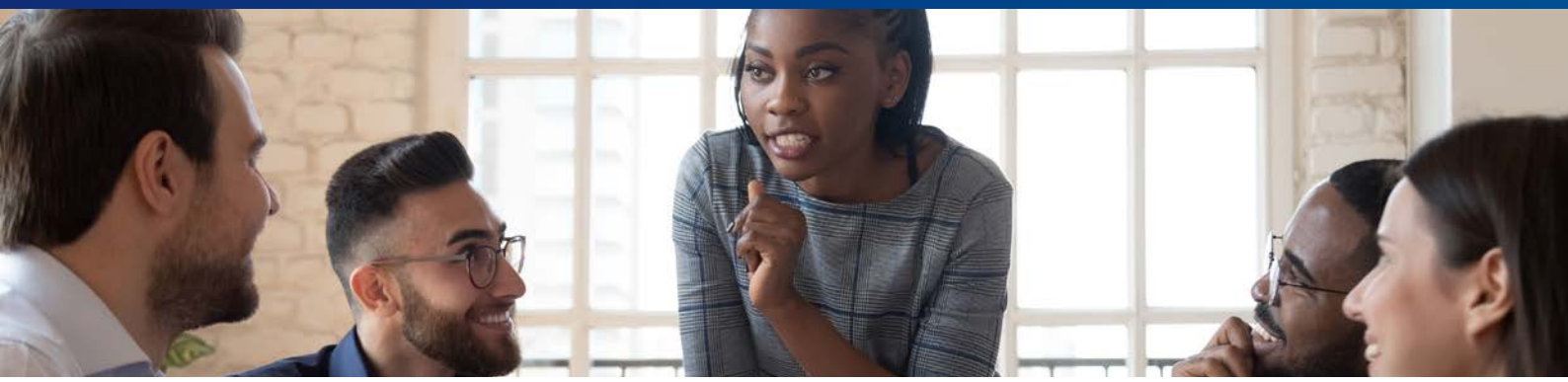


Fig.19 Distribution method of consent information leaflets, April and May 2025

Safety and Learning Networks



Groups to facilitate engagement amongst practitioners who work within the NHS Wales Concerns Management sector have been in place for a number of years. Since the concept of the Safety and Learning Networks, which were developed in 2018, the forums have gone from strength to strength. Wales has a proud history of collaboration amongst the health bodies within its NHS. Networking is a key aspect of this and there have been successful Networks previously within the patient safety and claims sectors. There are also a number of service-related clinical Networks which offer collaboration and sharing to its participants. The Safety and Learning Networks build on this robust and effective background.

The cohort of Safety and Learning Networks provide a solid framework for engagement and collaboration, helping organisations to achieve consistency and improve compliance with PTR requirements.

A review in 2023, in line with adjustments to the national governance structures for NHS Wales, and a further review that was undertaken during 2024/25, in line with an IMTP target, both concluded that the basis of the Safety and Learning Networks is sound and that organisations appreciate the support that the forums offer.

A new Safety and Learning Mortality Review Network was introduced in November 2024 which supports organisations to deliver a consistent and efficient process for managing and learning from Mortality Reviews in line with the national Model Framework.

Co-Chairing a Safety and Learning Network is an excellent development opportunity for staff within health bodies and during 2024/25 we have welcomed new co-chairs to the Redress and Claims Networks.

In line with terminology used in Welsh Health Circular WHC/2024/015, introducing the People's Experience Framework and launched in April 2025, the Service User Feedback Network has been renamed the People's Experience Feedback Network.

Safety and Learning Networks have been established within topic areas where a benefit is anticipated.

- Head of Patient Experience Network
- Complaint Handling Network
- Redress Case Management Network
- Claims Management Network
- Inquest Case Management Network
- NHS Wales Ombudsman Liaison Officer's Network
- People's Experience Feedback Network
- Candour Network
- Network Co-Chairs
- Mortality Review Network

Each network has developed a workplan with key aims identified which are linked to local and national safety and learning priorities to enhance the output from each network. Details of the workplans and discussions on delivery of the aims facilitated via the Network Co-Chairs' meeting and feed into the all-Wales Listening and Learning Group (LLFG), which is a national group that coordinates activity of Health Bodies in response to the Welsh Government commissioned report by Keith Evans "The Gift of Complaints". The Head of Patient Experience (HOPE) Network also provides an oversight and advisory role to the cohort of Safety and Learning Networks.

The work of each Network is steered by the Welsh Risk Pool Committee. Any national group or body can ask a Network to consider a piece of work or project in its workplace – which can include the HOPE Network, the Directors of Corporate Governance Forum, the Executive Director of Nursing Forum, the Listening and Learning from Feedback Group and the Once for Wales Concerns Management System Programme Board or Steering Group. Fig.20 outlines the relationships across the Networks.

Structure of Safety and Learning Networks 2024/25

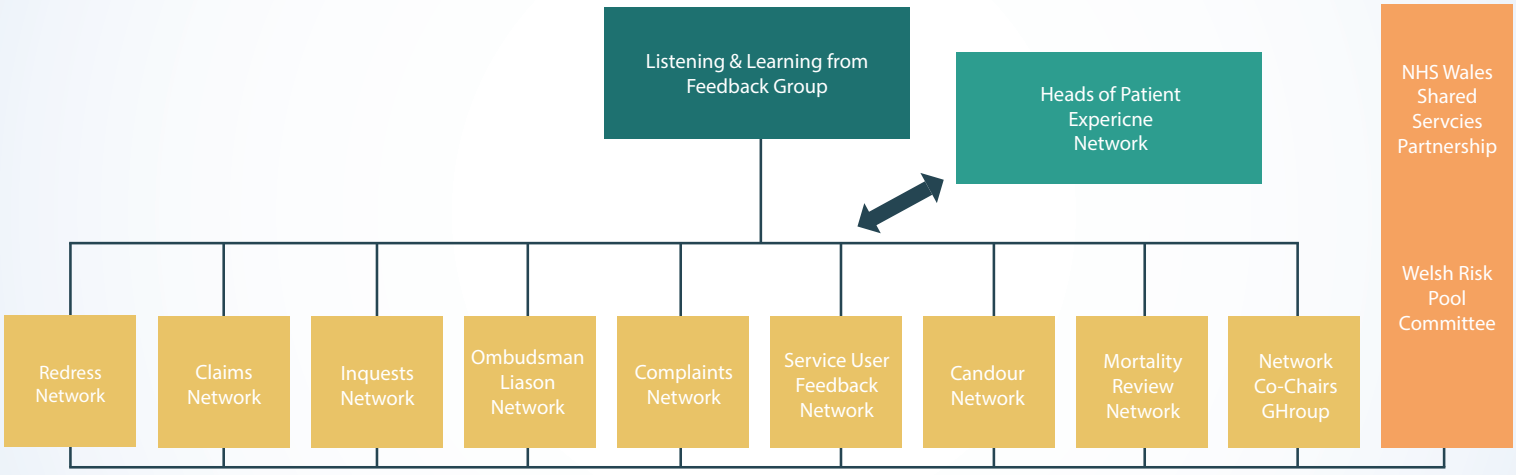


Fig.20 Structure of Safety and Learning Networks 2024/25

The HOPE Network is a key group of senior leaders and includes staff with the Senior Investigation Manager role outlined in the PTR Regulations within their portfolio. It holds **Formal** and **Informal** meetings. Formal HOPE meetings include invitations to representatives of national groups (such as Welsh Government, Welsh Risk Pool and NHS Wales Performance & Improvement) and are intended to provide a platform for organisations to seek views and shape recommendations on policy strategies.

Informal HOPE meetings have a section for health body members, and it excludes the Facilitator and representatives of national groups - enabling a supportive framework to the Network members and providing a safe space for discussion and to help members to coordinate their local activities.

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The Safety and Learning Networks are involved in and have key stakeholder roles in projects such as:

- The People's Experience Feedback Network has been a pivotal leader in the review and refresh of the People's Experience Framework.
- The People's Experience Framework was co-produced by NHS Wales, and this was facilitated by the People's Experience Feedback Network. The framework has been expanded to include a comprehensive set of tools and measures aimed at evaluating and enhancing the quality of health services. The People's Experience Feedback Network will be supporting the implementation of the framework in conjunction with NHS Wales Performance & Improvement.
- The People's Experience Feedback Network has been a key stakeholder group involved in the development and implementation of National surveys, including the People's Experience Survey (PES).
- Heads of Patient Experience Network (HOPE) and the Co-Chairs of the Complaint Handling Network continue to be key stakeholders in the Welsh Government review of the Putting Things Right Regulations. They have undertaken extensive reviews of draft documents and provided comments on amendments to Regulations. HOPE Network members will be key stakeholders in implementation meetings held by NHS Wales Performance & Improvement and will support NHS Wales to achieve a consistent rollout of the new Regulations and guidance.
- The HOPE Network commissioned work to be undertaken to support organisations with the management of Complex Cases. A face-to-face event was held in March 2025, which included representatives from the Police and CPS and representatives from NHS Wales organisations. The outcome of this event was that a Complex Case Management Guidance document, which will include a definition for 'complex case' and the framework for a complex case management multi-disciplinary team meeting is being drafted. A dedicated Complex Case Management website is also being developed and will be the repository for relevant guidance and support documents.
- The Redress, Claims and Inquest Networks have been instrumental in the ongoing development of the Datix Cymru system, along with the development of a Redress Definition and Proforma document to support consistent reporting and management of cases across Wales. National dashboards to support consistent management of Learning from Events Reports (LFER).

- The Inquest Network has received assurance from organisations that an up-to-date Inquest Procedure document is in place. Themes from Regulation 28 reports are being fed into the wider work to compile a list of Themes, Patterns and Trends that can be utilised across all relevant Datix Cymru modules.
- A key aim for the Redress, Claims and Inquest Networks for 2024/25 has been to work collaboratively with Legal & Risk colleagues to review, update and align Injury and Stage History fields.
- The NHS Wales Ombudsman Liaison Officer's Network held a face-to-face event for Complaints Handling and Investigation training in conjunction with the Public Services Ombudsman for Wales (PSOW) in 2024. This resulted in organisations reviewing their current training practices and ensuring that the most up to date information and techniques were being utilised locally. Sharing learning from PSOW reports is a standing agenda item for the network. Themes from the reports are being fed into the wider work to compile a list of Themes, Patterns and Trends that can be utilised across all relevant Datix Cymru modules.
- The Candour Network has developed national dashboards to support organisations to comply with their duty to report.
- The Candour Network has worked collaboratively to produce a 'state of nation' report and have also updated the maturity matrix to provide assurance against 'business as usual' practices across NHS Wales.
- The newly formed Mortality Review Network have set ambitious aims to undertake a scoping exercise to set out what good looks like for Mortality Review Services. Also, working in conjunction with NHS Wales Performance & Improvement, review the National All Wales Learning from Mortality Reviews Model Framework and align local process and the Datix Cymru system to achieve a consistent, robust national process.
- Key aims that cut across most Safety & Learning Networks are oversight and involvement with the Enhanced Learning Programme, Fixed Recoverable Costs, Complex Case Management, the review of Putting Things Right and shared learning.

The Safety and Learning Network meetings remain extremely popular with members and attendance levels are excellent. There are 10 Safety & Learning Networks that meet on a quarterly basis for between 1.5 to 2hrs, with a regular attendance of between 15 & 20 organisational representatives. The Welsh Risk Pool leadership team regularly receive compliments and thanks for providing the network process.

Putting Things Right Assurance

The Welsh Risk Pool conducts assurance reviews on behalf of Welsh Government and NHS Wales Performance and Improvement in relation to the application by health bodies of the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 – known as the Putting Things Right (PTR) Regulations. The assurance reviews also consider an organisation's compliance with the WRP Reimbursement Procedures.

An Assurance Report is provided to each organisation, along with recommendations for continuous improvement, and is considered by the Welsh Risk Pool Committee. The WRP Assessment is used by the Committee when determining members' contributions to the fund as part of the risk sharing agreement.

The review involves analysis of individual case management against both legal requirements and policy criteria. It also examines compliance with the application of the Once for Wales Concerns Management System workflows and completion of essential data fields. The review further facilitates analysis of the efficacy of the Learning from Events process within the organisation and examines how a health body shares and implements good practice between organisations.

The methodology for assessment has evolved during the last few years in line with national policies. The approach is based on peer-review, with senior leaders selected by the Head of Patient Experience Network joining staff from the Welsh Risk Pool in conducting the assessment. Specialist advisors, including legal specialists, join the assessment team as required. This approach is considered to promote sharing of best practice and enable the assessment team to recognise the application of the areas for assessment in operational practice.

For each area for assessment, the Assessment Team considers the available evidence and report assurance to the organisation using the NHS Wales Internal Audit Assurance Framework.

During 2024/25 reviews were held in respect of matters handled during Jan-Mar 2024. These were again based on peer-review, with members of the HOPE Network supporting each review.

The review considers:

- The health body's policies and procedures for handling concerns, claims, inquests, redress and incidents.
- The timeliness of complaint investigations.
- The quality of complaint investigations and responses.
- Arrangements for handling concerns about primary care providers.
- The application of the all-Wales workflow within Datix Cymru for concerns.
- Use of internal and external expert opinion.
- Suitability of decisions whether there is a qualifying liability in a matter.
- Arrangements for sharing lessons from all matters across the organisation.
- Inquest case management
- Redress case management
- Claims case management

The period used for the scrutiny of cases related to matters opened, under investigation, or closed between 1st January 2024 to 31st March 2024. To facilitate sufficient time for case progression, the actual scrutiny of cases took place between June and October 2024.

The period used during the 2024 Assessment programme was selected and agreed in advance with senior leaders from the Putting Things Right sector. It is considered that cases would be sufficiently progressed from initial report and commencement of investigations to facilitate a thorough review following fieldwork taking place during the summer. This period was selected for all organisations to allow a fair comparison between organisations where the outputs of the assessment are used as part of the risk sharing agreement.

The findings of the reports were shared with organisations for factual accuracy considerations before action plans were prepared by Health Board's and submitted to the WRP addressing all recommendations made by the Assessment Team. Final WRP Assessment reports were presented to the Welsh Risk Pool Committee in March 2025 where decisions with regards to individual member scores towards the risk sharing agreement were agreed.

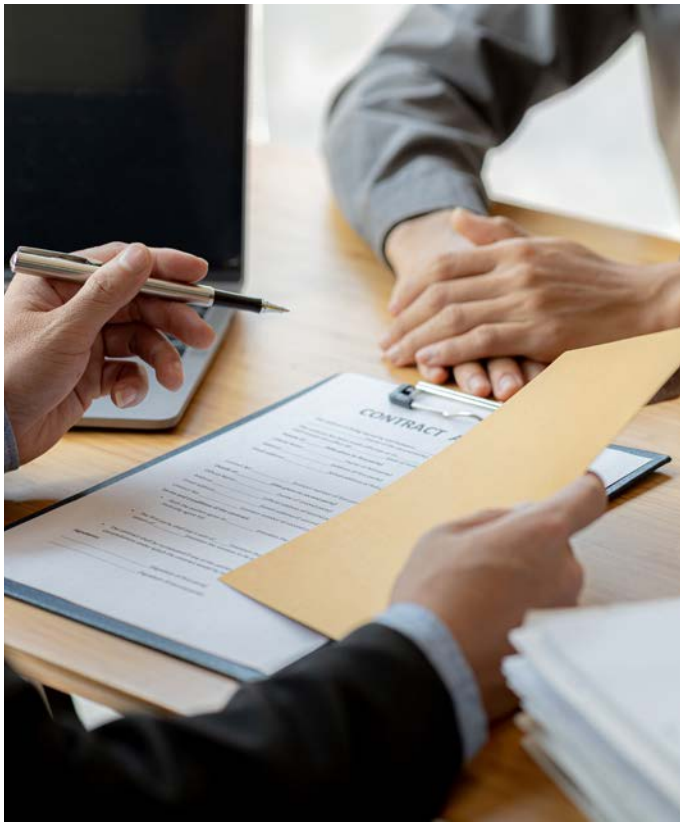
Clinical Negligence Case Management

Our expert teams of clinical negligence lawyers manage all of the clinical negligence claims made against heath bodies in Wales in respect of secondary health care. The caseload is approximately 1850 cases at any time and the potential cost to NHS in Wales is many millions of pounds.

The teams act sensitively and fairly towards those injured and their families, investigate allegations of negligence thoroughly and proportionately, defend those claims which are defensible, settle those which are not quickly and fairly, provide support to NHS staff, and protect the public purse.

We pride ourselves on the close and supportive working relationships we have built with our NHS bodies and healthcare staff over many years. Being "in-house" in NHS Wales means that we are part of one team. This is essential as we are dependent upon the support and co-operation of the claims managers within the NHS bodies, and the NHS staff involved in the claims, to be able to provide an effective, efficient and fair service. We are only able to defend cases to trial with the support of the clinicians and nursing staff involved in the care.

During 2024 a number of cases were defended to trial with judgements in favour of health bodies. The savings to the NHS were approximately £1.8m in Claimant damages and costs. The cases involved a wide of allegations including failures around consent, negligent surgery, delays in treatment, wrong diagnoses and poor decision making in respect of investigations and discharge.



Example of a case

A claim was brought in respect of a ureteric injury sustained during a laparoscopy assisted vaginal hysterectomy and bilateral salpingo oophorectomy. The allegations related to the consent process, the claim being that the Claimant would not have proceeded with the surgery had she known of the risk of the damage to her ureter, and the standard of the surgery itself. It was common ground between the parties that the ureteric injury was as a consequence of thermal injury from the ligature used during the surgery.

The Health Board had admitted that the risk of a ureteric injury, as a matter of fact, was not detailed in the Consent Form. However, the Claimant's own expert stated that he had never known a patient at low risk of ureteric injury to decline or delay their hysterectomy surgery. Therefore, it was considered very unlikely the Court would find the Claimant would not have proceeded to surgery had she been advised of this risk.

In respect of the standard of the surgery, Claimant's expert stated that it is generally accepted in gynaecological practice that ureteric injury at hysterectomy is only acceptable if there is a surgical mitigating factor and, that ureteric injury occurring in an uncomplicated routine hysterectomy is evidence of performance of the operation being performed below the standard of a reasonably competent gynaecologist. This was the basis of his opinion that the surgery was negligently performed. He did not consider that there was a mitigating factor to justify the ureteric injury in this case.

The Defendant's expert disagreed. He considered that the performance of the hysterectomy was to a reasonable standard and the ureteric injury was an unfortunate but recognised complication.

The case went to a trial and Claimant's claim was dismissed.

The Judge found that even if the Claimant was told about the risk of the ureteric injury, she would have proceeded with the surgery and, that the Claimant had not proved the injury was due to negligence.

We are committed to "All Wales" approaches in respect of the management of clinical negligence claims to ensure consistency and efficiency across Wales. We are streamlining processes to save time, money and to speed up the legal process to benefit patients and save legal costs.

We have procured a new case management system and have re-designed this with focus on the key data required for case management, financial management, learning (learning from individual events and trends) and reporting across Wales. In discussion with key stakeholders, we have introduced revised criteria in respect of stages of claim, specialities, nature of allegations/ concerns and patient outcomes. The hope is that these criteria will be adopted more widely across Wales to enhance consistency in reporting and learning.

The nature of the legal claims being brought has changed over the last few years. Claims have become more complex. They are more often pursued against more than one NHS body and/or involve more complex medical conditions and surgeries. In addition, the financial value of claims is increasing year on year.

Every pound paid in respect of legal costs and damages is a pound taken directly from the NHS budget in Wales and therefore diverted from patient care. Managing claims efficiently and carrying out robust investigations into the validity of claims, is essential.

In order to check the validity of some claims, we sometimes use open-source surveillance ie. social media searches and occasionally covert surveillance. We have robust internal processes to ensure compliance with all legal requirements. The use of surveillance has led to significant financial savings.

In addition to managing the clinical negligence claims efficiently and fairly, we assist health bodies and colleagues in the Welsh Risk Pool to identify the pertinent issues in cases – which helps to ensure learning from claims is identified and actioned to prevent future harm to patients, along with reducing the potential for future claims.

Example of a case successfully using surveillance to reduce financial burden on NHS Wales

Following a detailed case review, liability was admitted in respect of a claim which arose from a bowel perforation suffered by the Claimant in May 20 after a caesarean section. The Health Board admitted liability for a failure to effect early surgical review after the patient suffered constipation following the caesarean section, which led to the perforation. As a result, the Claimant suffered from sepsis, a PE and a stoma, she also subsequently developed a large hernia. The only issues to be determined were the Claimant's condition and prognosis, the impact of the injury on her life and the valuation of the claim.

The case was complicated by the Claimant's previous medical history for which she was already in receipt of high rate care and mobility benefits. She already had many significant and serious problems such as being in constant pain, she used a wheelchair for any distance and crutches to get around, she had severe anxiety and could not go out unaccompanied and was unable to lift anything heavy, she required help with cooking, and a carer. The DWP records supported the concerns raised by the care expert instructed by the Health Board that the stoma has had very little impact on the Claimant's day to day functioning.

The Claimant valued the claim in excess of £3 million. The Claimant's claim included future losses such as care, services, aids, transport, therapies, and accommodation. The Claimant asserted that as a result of the index injuries, the hernia in particular, she needed higher levels of care and support as she struggles with everyday chores, such as lifting light objects or picking anything up, she is unable to reach up and lean over, she needs someone to push her in the wheelchair as her ability to propel it herself has deteriorated. She also said she was self-conscious of the large hernia so she wears loose clothing. Following review of the DWP records and concerns raised by our care expert regarding the true extent of the Claimant's injuries, it was decided surveillance evidence should be obtained. Surveillance evidence in the form of a CyberSearch report revealed in some Tik Tok videos a suggestion she may be walking on steep or uneven terrain. Further videos showed the Claimant at a gym with a friend engaged in "step training" and the "exercise spin bikes". She is also seen doing hip thrusts and pull downs. In light of this evidence, covert surveillance was arranged and the recording showed the Claimant on a shopping trip without a wheelchair including walking around a shopping centre pushing a trolley, bending down to reach things, loading shopping bags into her car and unloading them at home. The CyberSearch report and surveillance evidence were sent to the Claimant's solicitors and the claim settled for £315,000. This was a significant financial saving to the NHS.

Legal Costs Management

In addition to the payment of damages in claims which are settled, or where damages are awarded by a court, the Health Boards/ Trusts have to pay the legal costs of claimants as well as incurring the costs of defending cases. In the majority of cases, even when we successfully defend a claim, the legal rules mean that the Health Boards/Trusts are unable to recover the defence costs, apart from in exceptional circumstances. Legal costs are ever increasing and represent an important part of the litigation process. Our lawyers work hard to seek reductions to the amounts paid out in legal costs on each claim, and to deliver direct savings to the NHS in Wales as a result.

We have a dedicated 'Costs and Funding Team' which meets regularly with a view to keeping up to date with key developments in costs matters and disseminating this information to the wider legal team and clients. The Team develops office-wide guidance documents and protocols to streamline the way in which costs are handled and provides and hold regular 'drop in' advice sessions and training.

We have negotiated fixed fee arrangements with several firms of external Costs Lawyers to assist in dealing with costs matters on behalf of health bodies in Wales at lower rates, and in turn, delivering better outcomes. This work is ongoing and the costs team is presently looking to expand the scope and number of fixed fee arrangements giving further opportunity to develop a dedicated team of costs lawyers ready to deal with costs cases, to include high and low value costs claim at competitive rates.

One key firm has been accepting instructions to deal with costs matters valued up to £250,000 on a fixed fee arrangement since March 2022. Across that period, the firm has delivered savings of £7,000,000 across over 310 costs cases for NHS Wales. Between May 2024 to 30 April 2025 the savings equate to £1,100,712, with an average saving of almost 22.2% on the 43 bills of costs advised on.

The 'Costs and Funding Team' also provide training and guidance on the costs budgeting process. This is the court process designed to provide clarity and transparency of a party's legal costs, to promote efficiency and allow early assessment of the merits/costs of a case. The process involves the completion of a complicated precedent giving details of the work already undertaken and that to be undertaken in the future.

Putting Things Right Case Advice

We support health bodies in the management of concerns raised under the Putting Things Right Regulations and provide legal advice, support and training to the local teams who oversee these cases.

All of our lawyers are familiar with the Putting Things Right Regulations, Guidance and processes. We have a cross-team group of lawyers, led by Senior Solicitor Gemma Cooper, who are experts in the law in this area and how this interacts with the Civil Procedure legal processes. We assist health bodies with investigations into concerns raised under the Regulations, the identification of lessons learned and the consideration of issues of qualifying liability and valuation of compensation to be paid by way of Redress. This support is provided in innovative ways tailored to best support individual health bodies including client specific, and All Wales, clinics run by Legal and Risk lawyers.

Being involved in matters early allows us to add value to organisations' decisions regarding the scope of investigations and the evidence to be obtained, facilitating matters being investigated and responded to promptly and appropriately.

We are members of All Wales stakeholder groups and work closely with Welsh Government and the Welsh Risk Pool. We play a key role in the development of the legislation and policy in this area, and our expertise allows us to provide important assistance and guidance with quality assurance work.

We are currently working with health bodies and Welsh Government in respect of the proposed changes to the PTR Regulations and Guidance. We will support health bodies with the implementation of these changes and the additional work these will require of health bodies' teams.

Horizon Scanning the clinical negligence area

The law governing clinical negligence claims is complex and constantly changing. The depth of legal knowledge and experience in the Clinical Negligence Department ensures we are able to adapt and inform quickly.

We pride ourselves on being prepared for the changes and developments we know are coming and, being able to react quickly to those which are unexpected. We raised awareness and advised on the uncertainty introduced into claims management by the planned review, and likely change of, the Personal Injury Discount Rate in January 2024. We are currently considering with clients the legal and workforce implications of the proposed increase in the Redress level from £25,000 to £50,000 next year.

The position in respect of the long-awaited introduction of fixed recoverable costs in clinical negligence claims valued below £25,000 remains very uncertain. There has been no reference to this since the change of government. We were involved in the national Working Group from the outset and continue to liaise with key stakeholders and national groups to ensure the NHS in Wales is prepared if/when this is moved forward.

Supporting the UK Covid-19 Public Enquiry

The UK Covid-19 Inquiry was set up to examine the UK's response to and impact of the Covid-19 pandemic and learn lessons for the future. The Inquiry began on 28 June 2022. Its investigations are organised into Modules. Throughout each of these Modules, the Inquiry hears evidence from witnesses, experts and Core Participants through a series of corresponding hearings.

The Public Inquiry is now fully underway with various Modules opened and public hearings held during 2024/2025, including the key hearing in Module 3 (Impact of Covid-19 Pandemic on Healthcare Systems in the 4 Nations of the UK).

We are advising and representing nearly all health bodies in Wales in respect of the Public Inquiry. A number of Welsh NHS bodies are Core Participants in various Modules, either individually or as part of a group. We have advised and assisted in providing a significant amount of information to the Inquiry Team, numerous witness statements and have supported key NHS Wales leaders required to give oral evidence prior to and during the hearings.

The Inquiry is moving at pace and the timescales set for responses from health bodies have been short. The requests have often arrived without notice. In addition, thousands of documents have had to be provided to the Inquiry team by health bodies, each appropriately reviewed, indexed and redacted to hide personal, sensitive or irrelevant data.

The pressure this has placed on NHS teams and executives, many of whom have not been involved in any legal processes before, cannot be overestimated. At an individual level this has been daunting for some. At an organisational level, the risk of diverting resources away from the post pandemic recovery to respond to the Public Inquiry has been challenging. For one of the Welsh health bodies, this has resulted in a senior lawyer being seconded on a fulltime basis, to provide more effective support during the Inquiry.

We have distinct client Public Inquiry teams to ensure regulatory compliance and client confidentiality whilst, at the same time, working together as much as possible to share learning, knowledge and minimise the legal costs incurred by health bodies. We are very proud of the way all teams within Legal and Risk Services have worked together to support both our health bodies, and each other. We have received excellent feedback on the quality of the service provided.

Due to our unique in-house position, and in-depth knowledge of the structure and processes of the NHS in Wales, we have been able to have high level discussions with the UK Inquiry team and make time and cost saving suggestions on behalf of individual clients and also more generally.

Personal Injury Prosecutions Case Management

The skilled Solicitors, Chartered Legal Executives and Paralegal staff in our Personal Injury and Prosecutions Team are dedicated to supporting all health bodies in Wales. Led by Robert Jenkins, the team has many years of experience in the investigation and defence of personal injury claims brought by staff, visitors to NHS premises and members of the public, the team has also developed considerable skill and experience in supporting health bodies that are the subject of regulatory enforcement action or criminal prosecution.

The claims dealt with can range from relatively low value slip and trip claims to more complex matters such as mesothelioma and incidents resulting in permanent injuries. The team are experts in the investigation of the application of health and safety principles and support health bodies in identifying evidence of reasonable measures taken by organisations to comply with the law.

By conducting as many investigations in house as possible, this reduces the cost burden on organisations for determining the facts of each case and ensuring that statements from those involved are suitable for presentation to court.

Where legal representation is required at court hearings, this is coordinated by our in-house team – providing a seamless service to our clients.

The team also provides advice to clients in the following fields:

- Employers and Public liability
- Work related stress
- Bullying and harassment
- Violence and Aggression
- Industrial disease, including
- Asbestos
- Hearing loss
- Object and person manual handling
- Repetitive strain injury
- Defective equipment
- Infection Control
- Slip and trip cases

Our dedicated team work cohesively to deliver an excellent service to our clients, including a bi-annual education day which aims to enhance the experience and understanding of NHS leaders and claims managers. The team also provides valuable analysis of trends as well as focusing upon learning lessons and giving practical risk management advice in areas that have been identified as vulnerable. We firmly believe that prevention is better than cure.

General Medical Practice Indemnity

Scheme for GMPI

Legal and Risk Services are appointed by Welsh Government to operate the Scheme for General Medical Practice Indemnity (GMPI) and the scheme was launched on 1st April 2019.

GMPI provides clinical negligence indemnity for providers of GP services in Wales in relation to the care, diagnosis and treatment of a patient following incidents which happen on or after 1st April 2019.

The GMPI team aim to resolve any claim for compensation brought by a patient in relation to their clinical care under the NHS as fairly and as quickly as possible. Equally, the team recognises the importance of robustly defending claims where appropriate and protecting GP's, the clinical teams in practices and their reputations.

Full details of the Scheme and Guidance and FAQs can be found on GMPI Website.

Existing Liabilities Scheme

Legal and Risk Services also operate the Existing Liabilities Scheme (ELS), which captures eligible clinical negligence claims made against GPs and practice teams which occurred before the establishment of GMPI. Matters included in the ELS Scheme only include those where a medical defence organisation, which previously provided indemnity in these cases, completed an agreement to transfer these liabilities into the scheme.

the GMPI Team

Legal and Risk Services has established a dedicated Primary Care Clinical Negligence Team, led by Heather Grimbaldeston, which operates all aspects of the Scheme for GMPI and ELS. Consisting of 15 staff, these lawyers and support staff specialise in managing clinical negligence claims against GP practice staff across Wales and work closely with NWSSP's in-house GP advisors.

Learning from Events

A tailored process, developed between the Welsh Risk Pool and the GMPI Team, supports the requirement for GP practices to prepare and present learning from cases where there is a liability, admissions are made, or a settlement is agreed.

The procedure involves the GMPI Team preparing a Learning from Events Report and coordinating the presentation to the National Learning Advisory Panel. GP Practices are required to help identify and commit to implementing improvements and developments in procedures to reduce the potential for the circumstances which led to the claim from reoccurring.

In 2024/25, the GMPI Team coordinated the development of over 50 Learning from Events Reports.

Supporting GP Practices in Wales

Legal and Risk Services aims to continuously improve the service offered by the GMPI Scheme. We meet regularly with stakeholders and are a member of NWSSP's Primary Care Steering Group which supports the development and delivery of primary care services in Wales.

The GMPI team actively supports GP practices:

We operate an email and telephone helpline used by GP Practice staff and Health Boards across Wales seeking information about indemnity arrangements and support with clinical negligence complaints or claims. The helpline dealt with over 1600 communications in 2024/25.

We support GP Practices to respond to patients' clinical concerns by providing guidance and support on the issues raised. The guidance given by the team follows the NHS Wales Putting Things Right (PTR) concerns procedures. To help gain insight into matters raised, the team seeks input from NWSSP's in-house GP Medical Advisors and feeds back to GP Practices any suggested learning or improvement. The team received over 230 new requests to assist GP Practices with patient concerns

We provide all-Wales training sessions and bespoke virtual training to Health Boards and GP's, Trainee GP's and practice teams across Wales. Highlights included our All Wales virtual training on the learning from events process in GMPI matters, training delivered to a Local Medical Committee and on-site training at a Practice.

We launched a GMPI Newsletter "Y Gorwel" / "The Horizon" in 2024-25 for all GPs, GP Practice staff and Health Boards in Wales.

Impact and Reach of our Legal Services

Legal and Risk Services is formed of a number of teams, who work cohesively to provide support to our clients. We are recognised as an in-house legal practice. Our Solicitors are regulated by the Solicitors' Regulation Authority and our Chartered Legal Executives are regulated by CILEx.

Our teams focus on specific areas of law:

Commercial, Regulatory and Procurement Team

Our Commercial, Regulatory and Procurement Team, led by Rhiannon Holtham, has an exceptional number of years of experience in dealing with a vast array of legal disputes, overseeing the procurement process and advising on procedural fairness throughout NHS Wales.

The team advise health bodies throughout Wales on all manner of issues, both contentious and non-contentious, which includes Commercial (contractual arrangements) and public law matters (judicial reviews). We also help the NHS understand the complexities of the maze of regulation that exists.

Below is a non-exhaustive list of some of the topics that we are able to advise on:

- Commercial contracts
- Procurement law (Advice on regulations and procedure)
- Procurement documentation (Advice on drafting Invitations To Tender, Pre-Qualification Questionnaires and Specifications)
- Procurement challenges
- Outsourcing treatment and services
- Intellectual Property
- Regulatory law
- Public contract law (including General Medical Services or General Dental Services Contracts)
- Public/Privatepartnershiparrangements
- Judicial Review of decisions
- Commercial Litigation
- Residency disputes
- Disputes between public authorities regarding funding
- Dispute resolution
- Policy drafting
- Construction
- Criminal
- Civil Fraud
- Injunctions
- Defamation
- Transfer of Undertakings and Protected Employees (TUPE)

- Information law (Data Protection and FOI issues).
- Debt collection
- International law (Memoranda of Understanding and Service Level Agreements with foreign governments).
- Procurement documentation (Advice on drafting Invitations To Tender, Pre-Qualification Questionnaires and Specifications)

Complex Patient (Court of Protection)

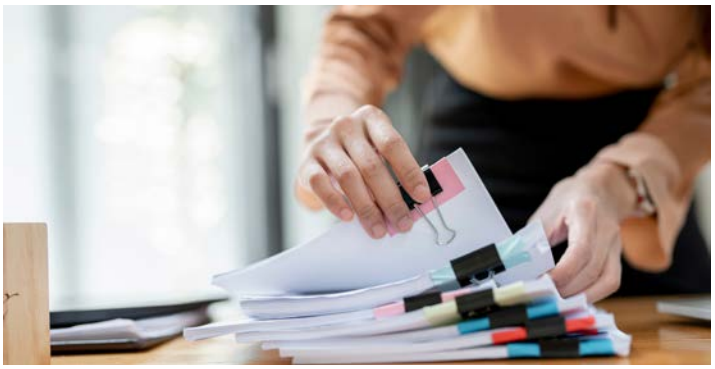
Our Complex Patient team is led by Gavin Knox; a specialist team which is comfortable dealing with highly complex and sensitive clinical situations where a patient's life or liberty might be at stake. Early intervention will often improve outcomes for patients. This may be by helping to ensure health board staff are acting in the best interests of the patient, or by resolving disputes that can in themselves cause distress to the individual.

- Mental Capacity Act and Best Interests for Children - there is a growing need for NHS staff to understand and implement the principles and provisions of the Mental Capacity Act. Our team offers a rapid and reasoned response to any capacity or best interests related query. By engaging early with clinicians, patients and families, we can usually assist in resolving disputes or ethical dilemmas and avoid the need for applications to be made to Court. The same applies to disputes about medical treatment or end of life decisions for children.
- Deprivation of Liberty - The full impact of the Supreme Court decision in Cheshire West, that redefined what amounted to a deprivation of liberty, is still being realised with enormous impact on NHS resources. We help health boards avoid unlawful deprivations and provide representation in the Court of Protection when a patient appeals against their detention.
- End of Life Decision Making (adults and children) - There are no more important decisions than those relating to the end of life. We are regularly instructed where disputes arise between clinicians and patients or their family about what treatment can lawfully be given.
- Mental Health - We help staff navigate the legislation and the difficult conflicts and interfaces with the Mental Capacity Act and Deprivation of Liberty.
- Court of Protection and High Court Applications - Not all issues can be resolved locally and ultimately some decisions need to be made by a Court. Often these can be highly contentious, complex, and emotive cases with the health, liberty or life of a vulnerable adult or child in the balance. We have extensive experience of making applications to both the Court of Protection and the High Court, each with their own particular rules and procedures. We offer a service that aims to resolve disputes quickly and sensitively to preserve therapeutic relationships with patients or families.

The Complex Patient team work on a real-time basis and are often involved in out of normal hours discussions, providing advice to clinicians dealing with these issues on a day-to-day basis. As part of an All-Wales Network the team are using all their specialist knowledge and experience to help Health Board's improve compliance with the Mental Capacity throughout their organisations. The team also work closely with the national group who are responsible for Decision Making and Consent.

In 2024/25 one of the priorities is to help Health Boards to streamline the Discharge process for those patients who lack capacity to make decisions for themselves.

Inquest Team



We have a dedicated team that is able to support health bodies when preparing for and participating in coronial inquiries and inquest hearings.

We support the whole coronial inquiry and inquest process and focus our legal input on those matters which raise complex Human Rights issues - such as suicides, deaths in prison or involving patients in mental health detention, potential gross negligence, or systemic organisational issues.

Our experienced lawyers support health bodies in triaging inquest matters to determine those which will benefit from formal legal input and representation.

We also contribute to all-Wales training in coronial processes, evidence gathering and supporting witnesses to give evidence.

Employment Team

Our Employment Team, led by Sioned Eurig, is formed of very experienced lawyers, who work very closely with People and Organisational Development teams throughout NHS Wales. The team has acted for health bodies in a wide and diverse range of Employment Tribunal and County Court cases. The team has also had the privilege of advising on high level strategic policy issues.

The team can help with all types of employee relations cases and Employment Tribunal claims including:

- Unfair dismissal (conduct and capability)
- Discrimination allegations (disability, sexual orientation, race, age, gender etc)
- Unlawful deduction of wages
- Holiday pay
- Whistleblowing
- Pension
- Agency worker rights
- Doctor disciplinary cases

The team can also help with the with wide range issues facing busy healthcare services:

- Interpretation of policies and procedures on an All-Wales level
- Issues arising out of the employment relationship (including advising on grievances and disciplinary hearings) including termination of employment
- Family friendly policies (i.e. Shared Parental Leave regime)
- Clinician banding appeals
- Severance packages and drafting settlement agreements
- The Transfer of Undertaking (Protection of Employment) Regulations 2006 (TUPE)
- Voluntary Early Release Schemes and queries
- Doctor disciplinary issues
- All Wales matters in association with the Welsh Government
- Employment status
- Consultations, Restructures and Redundancies
- Union Recognition

As well as helping clients to manage cases when things go wrong, the team also works with clients to train Workforce teams and line managers to reduce the risk of claims. Employment law is constantly evolving.

Our Employment team can offer a wide range of educational talks and seminars that can be delivered at our fully equipped premises. We are also able to tailor quarter, half or full day packages at a location to suit our client. Recent topics include:

- Training on the Upholding Professional Standards in Wales Policy (UPSW)
- Disciplinary investigations training
- Employment law updates
- TUPE
- The duty to prevent sexual harassment in the workplace

Following considerable demand, our Employment Team can now offer support and services to primary care GP practices. In 2025/26, we will also be launching a new complex investigations and culture review service for all clients.

Property Acquisitions, Disposals and leases Team

Our property team, led by Rashmi Chakrabarti, provides advice across the NHS Wales estate, delivering a quality service at competitive rates. The team has extensive knowledge and experience in commercial property and of the NHS Wales estate.

The team works closely with NWSSP Specialist Estates team and undertakes a range of work, which encompasses:

- Leasehold acquisition of offices on behalf of NHS Wales health bodies;
- Lease management, including varying principal lease terms and break dates, as well as general management work (licences to alter etc.) in support of tenant works;
- Freehold sales of surplus commercial and residential properties, including provisions to protect future development rights of adjacent land retained by NHS Wales;
- Freehold acquisitions in connection with large-scale developments by NHS health bodies
- General, one-off property queries on sundry matters, including in the primary care field.

Summary of Tables & Figures

GIG CYMRU NHS WALES

Partneriaeth Cydwasanaethau
Gwasanaethau Cronfa Risg Cymru
Shared Services Partnership
Welsh Risk Pool Services

GIG CYMRU NHS WALES

Partneriaeth Cydwasanaethau
Gwasanaethau Cyfreithiol a Risg
Shared Services Partnership
Legal and Risk Services

Welsh Risk Pool and Legal and Risk Services Annual Review 2024-25

August 2025

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Shared Services Partnership

Designed by NHS Wales Shared Services Partnership Communications

Teitl adroddiad: ***Report title:***	Infection Prevention Annual Report 2024/2025
Adrodd i: ***Report to:***	Quality, Safety & Experience Committee
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 06 November 2025
Crynodeb Gweithredol: ***Executive Summary:***	The annual report relates to the period April 2024 to March 2025 and seeks to provide QSE Committee with assurance that the organisation is meeting its statutory requirements in relation to the management of infection prevention and control in accordance with the Code of Practice for the Prevention and Control of Healthcare Associated Infections, 2014 (the 'Code'). A requirement of the Code is that the Board receives an annual Infection Prevention and Control (IPC) Report consisting of an overview and progress on the infection prevention and control arrangements together with other activities and initiatives. Prevention and control of infection is a high priority for Betsi Cadwaladr University Health Board (BCUHB), with a commitment to preventing all healthcare associated infections (HCAI) by adopting a zero tolerance approach to all avoidable infections. The report provides a summary of the achievements and the challenges faced by BCUHB and references keys messages which aims to highlight the areas of focus in terms of how the Health Board is improving quality care through the infection prevention agenda.
Argymhellion: ***Recommendations:***	The Committee is asked to: note and support the 4 key messages that thread throughout the report 1. **Strong Progress in Infection Control and Antimicrobial Stewardship -** BCUHB met or exceeded national targets for reducing key healthcare-associated infections and antibiotic prescribing: 2. **Leadership in Innovation, Education, and Data-Driven Practice -** The Health Board demonstrated system-wide commitment to infection prevention through education, infrastructure, and data collection. 3. **Rising Threats from Resistance and Outbreaks -** Despite progress, antimicrobial resistance and infection outbreaks remain pressing challenges. 4. **Driving Infection Prevention Through Standards and Accountability**- The Health Board is actively

	strengthening the environmental infrastructure and environmental cleanliness as a strategic priority to prevent infection, protect patients, and improve care quality. Through alignment with refreshed National Standards, investment in monitoring tools, and collaboration across Integrated Health Communities, we are driving consistent, accountable cleaning practices across all clinical environments. The Committee is also asked to note the update within the addendum regarding the Staff Influenza Programme 2025/26.
Arweinydd Gweithredol: ***Executive Lead:***	Angela Wood – Executive Director of Nursing and Midwifery Jane Moore – Executive Director of Public Health
Awdur yr Adroddiad: ***Report Author:***	Annual Report – Andrea Ledgerton – Deputy Director of Infection Prevention and Decontamination Addendum – Kailey Ben-Sassi, Strategic and Clinical Lead Immunisation and Vaccination Pharmacist/Deputy Vaccination Programme Director Hannah Aucutt-Bracegirdle, Business 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:

Whilst some reductions in infection were observed relating to those acquired in the community, hospital onset infections had not improved for a number of reportable infections, with the environmental infrastructure (to include lack of single rooms) and cleanliness a contributory factor. Strategic priorities to address these have been highlighted and are being progressed through the IHC Local Infection Prevention Groups and strategic level within their improvement plans. Revised National Cleaning Standards are yet to be finally published however an assessment is now underway to determine what is required for BCUHB to be compliant with these standards.

Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Improving quality, outcomes and experience
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	Not applicable
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
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)***	There is a risk to patient safety due to the increasing number of hospital onset cases of some infections to include those with antimicrobial resistance. It has not been possible for BCUHB to achieve all of the Welsh Government Improvement Goals. There is a risk that the Health Board will be unable to achieve the improvement goals (when set) in 2025/2026. There is a risk to organisational reputation by not taking the necessary steps to achieve future improvement goals
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	There will be capital required to implement infrastructure improvements and increase cleaning/domestic/technology resource, however Healthcare Associated Infections will result in cost savings for BCUHB
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***	The paper has been to the Strategic Infection Prevention Group where it was approved on the 21st August 2025
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	Links to Infection Prevention related risks held on 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)	Not applicable

Camau Nesaf:
Gweithredu argymhellion

Next Steps:

- The IPT to continue to implement the Annual Programme of Work to reduce and prevent avoidable infection
- The IHCs and other services to continue to deliver their improvement plans through the Local and Infection prevention Groups

List of Appendices:

- Appendix A: Strategic Infection Prevention Group Governance and Reporting Arrangements
- Appendix B: Infection prevention and decontamination Corporate Risk Register as at 31/03/2025
- Appendix C: IPT Programme of Work 2025/2026
- Appendix D: IP Team Audit Programme for 2025/26

Addendum – Staff Influenza Programme 2025/26 Update

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Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Infection Prevention and Control Annual Report 2024/25

Author: Andrea Ledgerton
Deputy Director of Nursing, Infection Prevention and Decontamination

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Infection Prevention and Control Annual Report 2024-25

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1.0 Executive Summary

This annual report relates to the period April 2024 to March 2025 and seeks to provide the Board with assurance that the organisation is meeting its statutory requirements in relation to the management of infection prevention and control in accordance with the Code of Practice for the Prevention and Control of Healthcare Associated Infections, 2014 (the 'Code'). A requirement of the Code is that the Board receives an annual Infection Prevention and Control (IPC) Report consisting of an overview and progress on the infection prevention and control arrangements together with other activities and initiatives.

Prevention and control of infection is a high priority for Betsi Cadwaladr University Health Board (BCUHB), with a commitment to preventing all healthcare associated infections (HCAI) by adopting a zero tolerance approach to all avoidable infections.

There are four key messages which you will find threaded through this report which aims to highlight the areas of focus in terms of how the Health Board is improving quality care through the infection prevention agenda:

1. **Strong Progress in Infection Control and Antimicrobial Stewardship -** BCUHB met or exceeded national targets for reducing key healthcare-associated infections and antibiotic prescribing:
2. **Leadership in Innovation, Education, and Data-Driven Practice -** The Health Board demonstrated system-wide commitment to infection prevention through education, infrastructure, and data collection.
3. **Rising Threats from Resistance and Outbreaks -** Despite progress, antimicrobial resistance and infection outbreaks remain pressing challenges.
4. **Driving Infection Prevention Through Standards and Accountability**- The Health Board is actively strengthening the environmental infrastructure and environmental cleanliness as a strategic priority to prevent infection, protect patients, and improve care quality. Through alignment with refreshed National Standards, investment in monitoring tools, and collaboration across Integrated Health Communities, we are driving consistent, accountable cleaning practices across all clinical environments.

1.1 Key Achievements and Challenges

Key Achievements 2024/25

- BCUHB achieved the Welsh Government 2024/2025 Improvement Goals (IG) for the overall numbers of Klebsiella species and Pseudomonas aeruginosa bacteraemia and for reducing hospital onset Pseudomonas aeruginosa bacteraemia by 10%.
- BCUHB had the largest percentage decrease (-45%) compared to other Health Boards with 5 fewer cases than the baseline across the other 6 Health Boards, and with only 3 of the 6 Health Boards achieving this IG
- BCUHB 'age standardised' infection rates for the 6 key reportable organisms were below the All Wales average for Klebsiella species, Pseudomonas aeruginosa and Staphylococcus aureus bacteraemia
- With the exception of MRSA, BCUHB reported fewer over all cases (i.e. hospital and community combined) than in 2023/2024.

- At the end of this 10 year target period, **BCUHB achieved the 25% reduction goal** in prescribing within primary care with a 24.7% reduction (TARGET - Items/1000 STAR-PU) - only 2 Health Boards in Wales achieved this.
- All 3 acute sites achieved the Access target of more than 55% of antibiotics in secondary care were narrow spectrum.
- BCUHB is the only Health Board to collect data relating to oxygen requirements within in-patients with acute respiratory virus infection
- BCUHB were below the acceptable blood contamination rate benchmark rate of <3%,demonstrating a reduction since from the previous year.
- Welsh Government were encouraged by the clear progress made by BCUHB and the North Wales Area Planning Board in responding to the elimination of Hep B and C as a public threat in all areas of the action plan.
- The Quarter 4 HARP report evidenced a reduced rate of caesarean section surgical site infection of 2.0% across BCUHB with inpatient rates extremely low at 0.1%.
- The 'COVID-19 Spring Booster programme' (from 1st April to 30th June 2024), achieved a vaccination uptake of 82% amongst eligible residents and workers in North Wales, exceeding the Welsh national average uptake of 75%. BCUHB recorded the highest volume of vaccination administered per Health Board in Wales. By the conclusion of the COVID-19 Spring 2024 programme, a total of 2,325,897 of vaccinations had been administered in Wales, with 2,292,840 doses delivered by BCUHB.
- The Infection Prevention Team (IPT) continued to lead on the BCUHB-wide 'Infection Prevention HABITS campaign' (launched February 2024) which included other national campaigns and initiatives weaving through it. The logo and messaging around this initiative is well embedded across BCUHB.
- The IPT have conducted a wide range of scheduled and ad hoc teaching sessions across BUCHB.
- The IPT have trained a further 100 Infection Prevention (IP) Champions, with 650 IP champions represented across 663 areas, extending to Care Homes and Managed Practices.
- The IPT completed and reported on a significant number of proactive and reactive ad hoc audits, completing 198 full environmental audits and 17 proactive audits associated with practices
- IPC resource packs for care homes have been developed in partnership with Public Health Wales to ensure that care homes have up to date guidance.
- The bespoke e-learning training package for waste and environmental management has been implemented across the Health Board onto the eLearning platform and is a mandatory part of staff training. Overall average compliance across the Health Board as of March 2025 was 91.4%
- The Authorising Engineer for water in NHS Wales Shared Services Partnership, Specialist Estates Services Team completed their annual review/audit of operational procedures and compliance and reported a compliance rating of 'Green' which maintains the standards set out during the previous year.
- The implementation of segregating and recycling at source in all Community Hospitals, Health Centres, administration buildings, GP practices and Community Dental practices was completed within 2024/2025

- The Operational Estates Department received £150,000 discretionary capital funding within 2024/2025 to improve the hospital environment. Projects to a total of £110,049 were completed.
- The transition to the use of MICAD as the auditing tool used by the Health Board for the monitoring of National Cleaning Standards was completed in September 2024. This has allowed the re-mapping of services, so that the reports now accurately reflect the current clinical layouts. It also provides an opportunity to review the auditing frequencies for each clinical area relevant to the current activities being undertaken within the space, and updated in accordance with national guidelines.
- In 2024/25, 13 out of 14 food outlets scored a '5-star rating' in their food safety assessment by the Food Standards Agency.
- The new modular decontamination area within the modular theatres opened in November 2024 for the provision of decontamination processes for gastro/endoscopy, with four new Endoscopy Washer Disinfectors (EWD's) installed.
- Funding was approved in late 2024 to relocate the Ysybty Glan Clwyd (YGC) endoscopy decontamination unit into an identified space within the current laundry footprint and transfer management to SSD. A programme of development work has since commenced.

1.2 Key Challenges

- In May 2023, it was reported that Wrexham Maelor Hospital (WMH) had the highest rates in Welsh hospitals of resistance to key antimicrobials used in the empiric treatment of *Escherichia coli (E. coli)* blood stream infection. Whilst the overall number of isolates reduced in 2024/2025, the number of associated BSIs increased.
- The new denominator for the Welsh Government improvement goals uses a more quality approach to prescribing which is affected by dose and duration prescribed. Communication of the goals and change in guidelines across all prescribers in BCUHB has proved difficult within current methods.
- High resistance rates to gram negative organisms in North Wales has led to the need to consider carefully choices in empirical guidelines often leading to the need to use less frequently used antimicrobials e.g. Amikacin and Temocillin (compared to the rest of Wales) and higher cost antimicrobials to combat this. The lack of availability of on-site Amikacin testing in BCUHB put patients prescribed Amikacin at increased risk of associated side effects.
- With increasing *C.difficile* rates reported nationally and across BCUHB*, C.difficile* remains a challenge within the hospital infrastructure, the ability to perform high level disinfection (HLD) programmes, enhanced cleaning, domestic resource and capacity the greatest obstacles.
- During 2024/25, there were 716 laboratory confirmed cases of Norovirus compared to 615 in 2023/2024 and 451 in 2022/23, increasing year on year, with more cases being seen all year round, as well as the normal winter peak. There were 46 outbreaks in hospitals across BCUHB compared to 37 in 2023/2024, creating additional pressure on side rooms availability, capacity and patient flow.

- During the 2024/25, a slight increase in *Bordetella pertussis (*whooping cough) cases was observed, with 10 more cases reported in comparison to the 43 reported in 2023/2024.
- During 2024/2025, there was an increase in the number of Carbapenemase Producing Enterobacterales (CPE) cases reported, with a total of 45 cases, a 55% rise compared to the previous year. However, 29 of the 45 cases were detected through enhanced screening surveillance introduced within the renal and critical care settings in 2024/2025.
- Delayed discharge following clinical optimisation is a major challenge for the Health Board; in addition to subsequent pressures on hospital flow, hospital acquired infections in this cohort of patients, including hospital acquired pneumonia (HAP) are also significant.
- Despite there being a small increase in the number of staff vaccinated for influenza during the 2024/2025 flu season, BCUHB were below target of 75% achieving 34.4%.
- BCUHB is the only Health Board in Wales not adhering to Welsh Health Technical Memorandum (WHTM) 01-06 in relation to the decontamination of choledochoscopes. Quotes for decontamination equipment have been obtained for Integrated Health Communities (IHCs) to progress business cases.
- Implementation of segregation and recycling at source within the three Acute Hospitals will be a challenge for the Health Board to achieve by April 2026 due to a number of constraints:
    - No capacity at ward level for extra bin location
    - No resources or funding for the additional collections or bins/skips
    - A considerable additional cost to BCUHB to initially set up
    - Lack of capacity in the waste compounds for additional skips

2.0 Infection Prevention and Control Governance and Delivery Frameworks

The Strategic Infection Prevention Group (SIPG) is authorised by the Quality, Safety and Experience Committee and the Board to support safety throughout BCUHB by monitoring, directing and ensuring assurance of effective Infection Prevention (IP) arrangements throughout the Health Board; and the assurance of compliance with external standards for healthcare providers. It met every month in 2024/25.

SIPG reports through the Group Chair, the Deputy Executive Director of Nursing, to the Executive Quality Delivery Group (EQDG) and onwards to the Quality, Safety and Experience (QSE) Committee (See Appendix A).

Local Infection Prevention Groups (LIPGs) function within each Integrated Health Community (IHC) and within Mental Health and Learning Disabilities (MHLD), Womens Services, Cancer Services and North Wales Community Dental Services (NWCDS) are accountable to SIPG.

Groups reporting to the Strategic Infection Prevention Group include:

- The Decontamination Group
- The Antimicrobial Resistance Steering Group

- The Water Safety Group
- The Ventilation Safety Group
- The Environmental Steering Group
- The Strategic Immunisation Group
- Occupational Health & Wellbeing Team

In October 2024 the Infection Prevention Team (IPT) piloted a Quality Improvement initiative whereby an IP Learning review was conducted across the East IHC. The review was then presented to key stakeholders across the IHC, with the IPT presenting infection data overtime triangulating this with audit data. The learning review utilised the "What" (data), "So What" (thematic analysis) and "Now What" (agreeing next steps) methodology collaboratively with the IHC. Following this, with support from the IPT the East IHC developed a robust, comprehensive improvement plan which focused on agreed high level IP priorities which were monitored through their LIPG and SIPG.

Following a successful pilot, learning reviews were performed for Central and West IHC, MHLD, Cancer Services and a review will performed across Women's Services early in 2025/26 financial year.

The expectation is that learning reviews will be repeated 6 monthly to monitor outcome measures.

The Infection Prevention and Control Team

The Executive Director of Nursing is the appointment lead with Board responsibility for IP and Director of Infection Prevention and Control (DIPC). The IPT is led by the Deputy Director of Nursing for IP and Decontamination and as of the end of March 2025, the IPT nursing team structure and establishment existed of:

- 1 WTE Operational/clinical Service Lead
- 1 WTE Developmental Service Lead
- 2 WTE IP Specialist Matrons
- 2.90 WTE IP Sisters
- 8.45 WTE Infection Prevention Nurses
- 6.6 WTE Infection Prevention Assistant Practitioners

The nursing team are further supported by one WTE Personal Assistant and 3 WTE Secretaries.

The IP Nurses provide routine service during week days 8:30-17:00 and an on-call service at weekends and bank holidays from 09:00-17:00, with the on-call PHW Microbiologists providing cover outside of these hours.
Due to some ongoing long-term sickness and inability to recruit into substantive positions, a risk assessment scoring 12 is still in place (see Appendix B).

Within the IPT there are 2.0WTE Decontamination staff who are specifically designated for the provision of decontamination advice across BCUHB; namely the Decontamination Advisor supported by the Decontamination Sister.

A Consultant Antimicrobial Pharmacist reports to the Deputy Director of IP and Decontamination and leads on strategy for antimicrobial stewardship (AMS) across

the teams in each IHC. The structure within each IHC AMS team varies somewhat, with the workplan, led by the Consultant Antimicrobial Pharmacist, taking into account the varied structure within each IHC and need for BCUHB cross working. The teams are employed and managed by the Pharmacy Department within their IHC structures.

- West IHC: 1 WTE AMS Pharmacist, 1 WTE Specialist Pharmacy Technician
- Centre IHC: 0.8 WTE AMS Pharmacist, 0.69 WTE Specialist Pharmacy Technician, 0.49 WTE AMS nurse
- East IHC: 2 WTE AMS Pharmacists

The IP Nursing Team is further supported by a part time Information Technology Analyst who sits within the Informatics Team and a Healthcare Associated Infection (HCAI) Epidemiologist employed by Public Health Wales (PHW); however, this resource is limited.

Public Health Wales Consultant Microbiologists

The Microbiologists working within BCUHB are employed by Public Health Wales (PHW). At present 1.5 WTE are substantive Consultant Microbiologists, one of which provides four afternoon sessions per week as Infection Control Doctor. There are three long term locum Consultant Microbiologists reflecting long standing challenges in recruitment and retention. This is perhaps, in part due to a lack of a training programme in North Wales. Specialty doctors, Physician Associates, clinical fellows and Senior Biomedical Scientists support the work programme.

Infection Prevention and Control Policies and Guidance

The IPT continue to support evidence-based practice across BCUHB by the development of a comprehensive suite of pan-BCUHB infection prevention written control documents, e.g., protocols, standard operating procedures (SOPs) and guidelines that are approved by LIPGs and SIPG, disseminated through LIPGs and the BCUHB Policies Team Newsletter and available on the Health Board's intranet site.

IP written control documents reflect relevant current legislation, Welsh and UK guidance, Welsh Health Circulars (WHCs) and published professional guidance. The IPT continue to make excellent progress in the review of these to ensure that no written control documents exceed their review dates. Furthermore, a number of new protocols and SOPs have been developed in response to Health Board need.

New policies and protocols in 2024/25 included:

- IPC43 Protocol for the Management of Glycopeptide-resistant *Enterococci* & Vancomycin Resistant *Enterococci*
- IPC44 Protocol for the Identification and Management of Diphtheria Infection
- IPC45 Standard Operating Procedure for Nurse led Faecal Microbiota Transplant (FMT)

New policies and protocols planned for 2025/26 include:

- An overall Strategic Infection Prevention Policy (awaiting publication of the new Code of Practice)
- Protocol for the Management of High Consequence Infectious Diseases (HCID)
- HCAI surveillance and national reporting
- Protocol for the Identification and Management of Tuberculosis

- *Candida Auris*
- Hospital Visiting Policy (contributing to)

3.0 Mandatory Reporting of Health Care Associated Infections and Compliance with Welsh Health Circular 2024/038: AMR & HCAI Improvement Goals

A summary of performance for BCUHB with Improvement Goals for 2024/2025 (published in September 2024) is provided below.

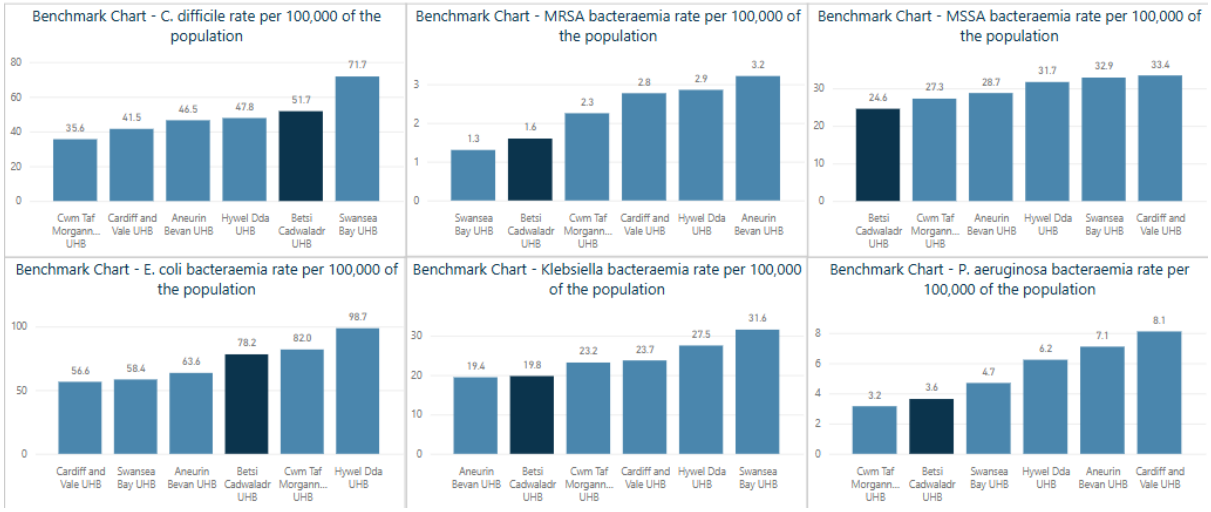
Glossary of Abbreviations

Abbreviation	Definition
C.difficile	Clostridioides difficile
CO	Community Onset
DDD	Defined daily dose
E. coli	Escherichia coli
HCAI	Healthcare Associated Infection
HO	Hospital Onset
IG	Improvement Goal
Klebsiella spp:	Klebsiella species
MRSA	Methicillin Resistant Staphylococcus aureus
MSSA	Methicillin Staphylococcus aureus
P. aeruginosa	Pseudomonas aeruginosa
PC	Primary Care
SC	Secondary Care
WMH	Wrexham Maelor Hospital
YG	Ysbyty Gwynedd
YGC	Ysbyty Glan Clwyd

Using 'crude' data, BCUHB's performance at the end of 2024/25 in comparison with the other main Welsh Health Boards against the 6 reportable infections was ranked:

- 1st for MSSA
- 2nd for MRSA, Klebsiella spp: and *P. aeruginosa*
- 4th for E.coli
- 5th for C. diff

In comparison with the other Health Boards, BCUHB's position this year has improved in relation to *Klebsiella spp. and P. aeruginosa.*



However, using 'age standardised' data, BCUHBs performance at the end of 2023/24 in comparison with other Welsh Health Boards was ranked:
1st for MSSA, *P. aeruginosa,* and *Klebsiella spp.*
2nd for MRSA
3rd for C.difficile
4th for E.coli.

The table below demonstrates that BCUHB achieved 4 of the Improvement Goals set by Welsh Government for 2024/2025. For the 6 reportable infections for which BCUHB did not achieve the IG, fewer cases were reported for 2 of them.

GREEN: Achieved 2024/25 FY IG
AMBER: Did not achieve 2024/25 FY IG, but fewer cases than previous FY
BLACK: Did not achieve 2024/25 FY IG and more cases than previous FY

	C. difficile		*E. coli*		*Klebsiella spp.*		*P. aeruginosa*		*S. aureus*	
HB	**HO**	**CO**	**All**	**HO**	**All**	**HO**	**All**	**HO**	**MRSA HO**	**MSSA HO**
Aneurin Bevan UHB	139	136	376	98	115	39	42	18	10	61
Betsi Cadwaladr UHB	168	187	538	127	136	37	25	6	3	42
Cardiff and Vale UHB	112	98	286	83	120	47	41	27	9	60
Cwm Taf Morgannwg UHB	66	92	364	75	103	28	14	6	2	34
Hywel Dda UHB	78	106	380	60	105	20	24	9	3	37
Swansea Bay UHB	138	137	224	67	121	56	18	8	3	49
All Wales	**713**	**771**	**2,181**	**513**	**708**	**228**	**164**	**74**	**30**	**285**

HO = Number of hospital onset cases HB had from Apr 24 to Mar 25
CO = Number of community onset cases HB had from Apr 24 to Mar 25
All = Number of overall cases HB had from Apr 24 to Mar 25

3.1 AMR Improvement Goals

Goal number	Goal	BCUHB Compliance
1	A reduction in total antimicrobial use in primary care (PC) consistent with a trajectory required to achieve a minimum 10%	At the end of the financial year 2024/25, usage in PC in BCUHB was **above** the target rate of 9,863.6 DDDs/1000 STAR-PU at 10,122,1 DDDs/1000 STAR-PU.

	reduction against the 2019 to 2020 baseline by 2029 to 2030. The measure is Defined Daily Doses and will be reported as DDDs/1000 STAR PU.	The change in denominator to DDDs rather than items means that more focus is put on dose and durations of antibiotics prescribed. The action plan for this target includes a focus on shorter courses for respiratory infections in line with national guidance and a review of long term antimicrobials used for recurrent UTIs.
2	A reduction in total antimicrobial use in secondary care (SC) consistent with a trajectory required to achieve a minimum 5% reduction against the 2019 to 2020 baseline by 2029 to 2030. Reported as DDDs/1000 occupied bed days.	Reported on an annual basis. At the end of the financial year 2024/25, usage in SC in BCUHB was **below** the target rate of 4,137.8 DDDs/1000 occupied bed days at 4,082.7 DDDs/1000 occupied bed days. At the end of the financial year 2024/25, usage in YG (to include Women's and Cancer Services) was **below** the target rate of 4,658.1 DDDs/1000 OBD at 4,361.5 DDDs/1000 OBDs At the end of the financial year 2024/25, usage in YGC (to include Women's and Cancer Services)was **above** the target rate of 4,471.4 DDDs/1000 OBD at 5,417.4 DDDs/1000 OBDs. At the end of the financial year 2024/25, usage in WMH (to include Women's and Cancer Services) was **below** the target rate of 3,512.6 DDDs/1000 OBD at 3,012.4 DDDs/1000 OBDs. Action plans in place for all sites to continue to work towards this goal.
3	Attain a trajectory required to achieve a minimum of 70% of total antibiotic use from the Access category of antibiotics by 2029 to 2030 in both primary and secondary care. Access antibiotics offer the most effective treatment whilst minimising the potential for resistance. The measure is Defined Daily Doses and will be reported as % total antibiotic use.	At the end of the financial year 2024/25, the proportion of total usage from the Access group category was 67.4% in primary care in BCUHB as measured in DDDs. At the end of the financial year 2024/25, the proportion of total usage from the Access group category was 61.9% in secondary care in BCUHB as measured in DDDs. For the individual hospitals the Access group proportions were: • 60.2% YG • 61.2% YGC • 64.4% WMH

3.2 *C. difficile*

I.	Fewer hospital onset (HO) cases than baseline FY For HBs with a 2023/24 FY rate of: >30 per 100,000 population - 20% fewer HO cases
II.	No more community onset (CO) *C. difficile* cases than baseline FY

- Betsi Cadwaladr reported 168 cases of HO *C. difficile* in 2024/25; an increase of 17% (n=+25) compared to the baseline FY (Table 1.).
- The 2024/25 IG for HO *C. difficile* has **not been achieved** by BCUHB (Table 1 & Chart 1), however 5 of the 12 months were below the maximum average monthly number to achieve the HO IG (Chart 2.).
- The rate of HO *C.difficile* per 100,000 population in BCUHB in 2024/2025 was 24.28: similar to the Wales rate (22.53) (Table 2)

- BCUHB reported 187 cases of CO *C. difficile* in 2024/25; an increase of 30% (n=+43) compared to the baseline FY (Table 1).
- The 2024/25 IG for CO *C. difficile* **has not been achieved** by BCUHB (Table 1 & Chart 3).
- Overall, BCUHB reported 355 cases of *C. difficile* in 2024/25. This equates to a rate of 51.30 per 100,000 population; an increase of 24% compared to the previous FY (41.47). (Table 2).
- Monthly numbers ranged from 20 (Feb 25) to 43 (Jul 24), with an average of 29 (Chart 2).

GREEN: Achieved 2024/25 FY IG
AMBER: Did not achieve 2024/25 FY IG, but fewer cases than previous FY
BLACK: Did not achieve 2024/25 FY IG and more cases than previous FY

HO IG			CO IG		
Baseline FY number[2] (IG)[3]	2024/25 FY number[1]	% difference from baseline FY number[4] (n)[5]	Baseline FY number[2] (IG)[3]	2024/25 FY number[1]	% difference from baseline FY number[4] (n)[5]
143 (<115)	168	+17% (+25)	144 (<145)	187	+30% (+43)

[1] **2024/25 FY number** = Number of cases HB had from Apr 24 to Mar 25
[2] **Baseline FY number** = Number of cases HB had from Apr 23 to Mar 24
[3] **IG number** = Maximum number of cases HB could have from Apr 23 to Mar 24 to achieve IG
[4] **% difference from baseline FY** = *((2024/25 FY number - Baseline FY number) / Baseline FY number) * 100)*
[5] **Number (n) difference from baseline FY** = *2024/25 FY number - Baseline FY number*

Table 1: *C. difficile* infections 2024/2025 FY IG

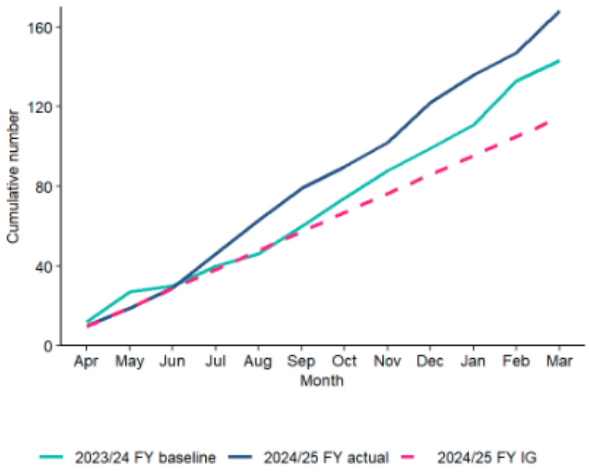


Chart 1: Cumulative monthly number* of HO *C. difficile* infection

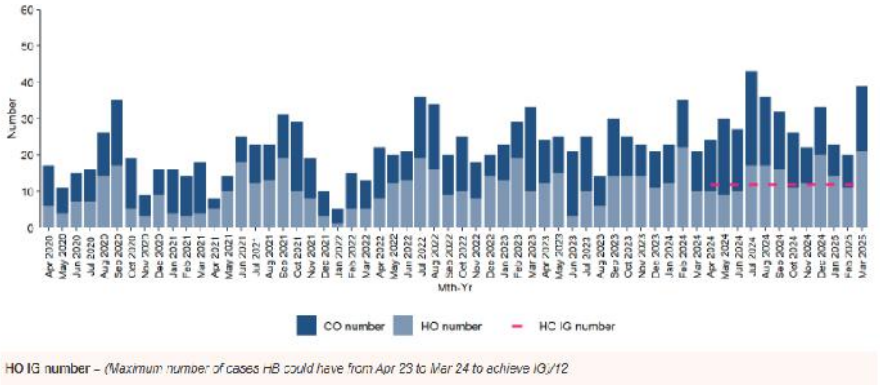


Chart 2: Monthly number of *C. difficile* infections in April 2020 to March 2025

GREEN: Lower rate than previous FY
AMBER: Same rate as previous FY
BLACK: Higher rate than previous FY

Overall rate			HO rate	
2024/25 FY number[1]	2024/25 FY rate[6]	% difference[7] from (Previous FY rate)[8]	2024/25 FY rate[6]	% difference[7] from (Previous FY rate)[8]
355	51.3	+24% (41.47)	24.28	+17% (20.67)

[6] **2024/25 FY rate** = Number of cases HB had from Apr 24 to Mar 25 per 100,000 population (using 2023 mid year population estimate)
[7] **% difference from previous FY rate** = *((2024/25 FY rate - Previous FY rate) / Previous FY rate * 100)*
[8] **Previous FY rate** = Number of cases HB had from Apr 23 to Mar 24 per 100,000 population (using 2023 mid year population estimate)

Table 2: *C. difficile* infection 2024/2025 FY rate per 100,000 population

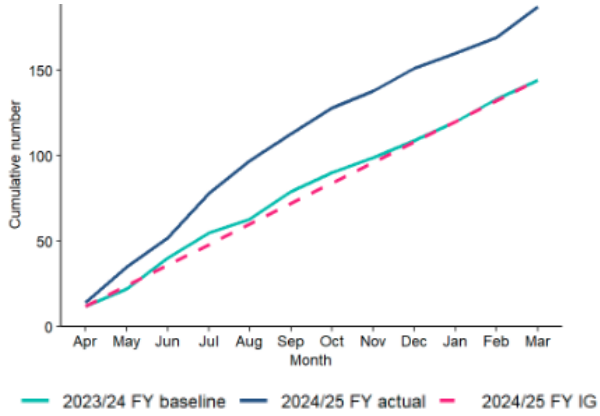


Chart 3: Cumulative monthly number* of CO *C.difficile* infection

3.3 Escherichia coli

***E. coli* bacteraemia**
I. to have fewer overall cases compared to 2023/2024
II. to have 10% fewer hospital onset cases compared to 2023/2024

BCUHB reported 538 cases of *E. coli* bacteraemia in 2024/25; a decrease of 2% (n=-11) compared to the baseline FY (Table 1.).

- The 2024/25 IG for *E. coli* bacteraemia **has been achieved** by BCUHB (Table 1 & Chart 1).
- Monthly numbers ranged from 30 (Oct 24) to 56 (May 24), with an average of 45 (Chart 2).
- The rate of *E. coli* bacteraemia per 100,000 population in BCUHB in 2024/25 was 77.75; above the Wales rate (68.92) (Table 2.).

- BCUHB reported 127 cases of HO *E. coli* bacteraemia in 2024/25; a decrease of 5% (n=-7) compared to the baseline FY (Table 1).
- The 2024/25 IG for HO *E. coli* bacteraemia **has not been achieved** by BCUHB (Table 1 & Chart 3.), however 7 of the 12 months were below the maximum average monthly number to achieve the IG (Chart 2.).
- Monthly numbers ranged from 6 (Apr 24) to 15 (Sep 24), with an average of 11 (Chart 2.).
- The rate of HO *E. coli* bacteraemia per 100,000 population in BCUHB in 2024/25 was 18.35; slightly above the Wales rate (16.24) (Table 2.).

GREEN: Achieved 2024/25 FY IG

AMBER: Did not achieve 2024/25 FY IG, but fewer cases than previous FY

BLACK: Did not achieve 2024/25 FY IG and more cases than previous FY

Overall IG			HO IG		
Baseline FY number[2] (IG)[3]	2024/25 FY number[1]	% difference from baseline FY number[4] (n)[5]	Baseline FY number[2] (IG)[3]	2024/25 FY number[1]	% difference from baseline FY number[4] (n)[5]
549 (<549)	538	-2% (-11)	133 (<119)	127	-5% (-6)

[1] **2024/25 FY number** = Number of cases HB had from Apr 24 to Mar 25

[2] **Baseline FY number** = Number of cases HB had from Apr 23 to Mar 24

[3] **IG number** = Maximum number of cases HB could have from Apr 23 to Mar 24 to achieve IG

[4] **% difference from baseline FY** = *((2024/25 FY number - Baseline FY number) * Baseline FY number) * 100)*

[5] **Number (n) difference from baseline FY** = *2024/25 FY number - Baseline FY number*

Table 1: *E. coli* bacteraemia 2024/2025 FY IG

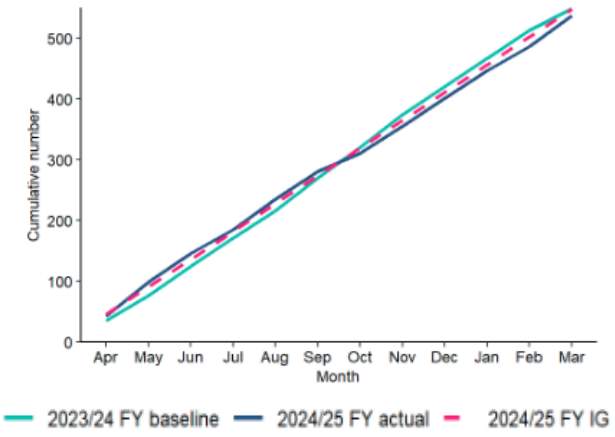


Chart 1: Cumulative monthly number* of *E. coli* bacteraemia

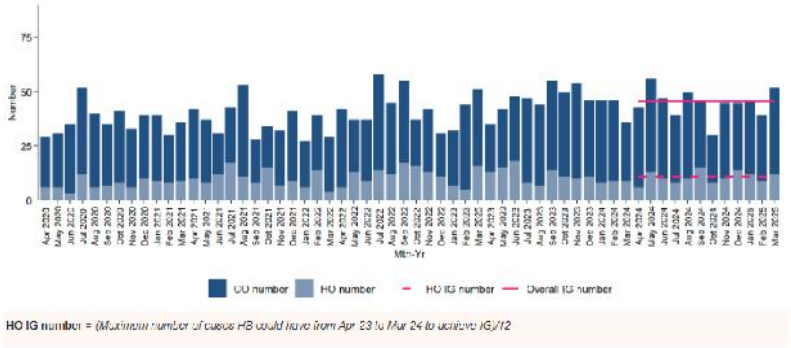


Chart 2: Monthly number of *E. coli* bacteraemia April 2020 to March 2025

GREEN: Lower rate than previous FY
AMBER: Same rate as previous FY
BLACK: Higher rate than previous FY

Overall rate			HO rate	
2024/25 FY number[1]	2024/25 FY rate[6]	% difference[7] from (Previous FY rate)[8]	2024/25 FY rate[6]	% difference[7] from (Previous FY rate)[8]
538	77.75	-2% (79.34)	18.35	-5% (19.22)

[6] **2024/25 FY rate** = Number of cases HB had from Apr 24 to Mar 25 per 100,000 population (using 2023 mid year population estimate)
[7] **% difference from previous FY rate** = *((2024/25 FY rate - Previous FY rate) / Previous FY rate * 100)*
[8] **Previous FY rate** = Number of cases HB had from Apr 23 to Mar 24 per 100,000 population (using 2023 mid year population estimate)

Table 2: *E. coli* bacteraemia 2024/2025 FY rate per 100,000 population

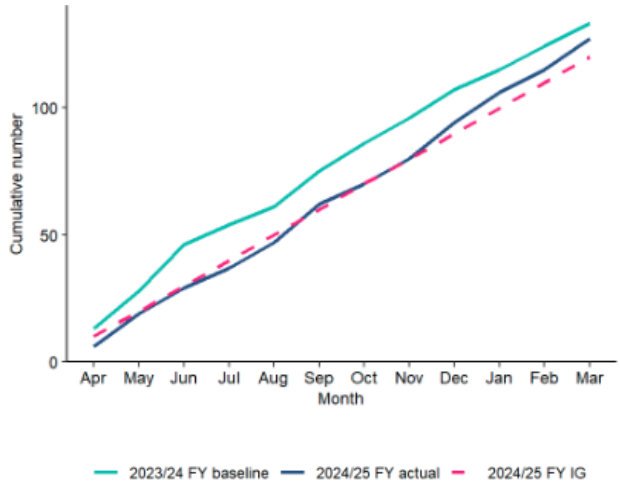


Chart 3 Cumulative monthly number* of HO *E. coli* bacteraemia

3.4 Pseudomonas aeruginosa

P. aeruginosa bacteraemia
I. to have fewer overall cases compared to 2023/2024
II. to have 10% fewer hospital onset cases compared to 2023/2024

- BCUHB reported 25 cases of *P. aeruginosa* bacteraemia in 2024/25; a decrease of 22% (n=-7) compared to the baseline FY (Table 1.).
- The 2024/25 IG for *P. aeruginosa* bacteraemia **has been achieved** by BCUHB (Table 1 and Chart 1.).
- Monthly numbers ranged from 2 to 4, with an average of 2 (Chart 2.).
- The rate of *P. aeruginosa* bacteraemia per 100,000 population in BCUHB in 2024/25 was 3.61; below the Wales rate (5.18) and compared to 4.62 the previous FY (Table 2.)

- BCUHB reported 6 cases of HO *P. aeruginosa* bacteraemia in 2024/25; a decrease of 45% (n=-5) compared to the baseline FY (Table 1 & Chart 3.).
- The 2024/25 IG for HO *P. aeruginosa* bacteraemia **has been achieved** by this UHB (Table 1 & Chart 3).
- Monthly numbers ranged from 0 to 4 (Dec 24), with an average of 1 (Chart 2.).
- The rate of HO *P. aeruginosa* bacteraemia per 100,000 population in BCUHB in 2024/25 was 0.87; below the Wales rate (2.34) and compared to 1.59 the previous FY (Table 2).
- BCUHB had the largest percentage decrease (-45%) compared to other Health Boards with 5 fewer cases than the baseline across the other Health Boards, and with only 3 of the 6 Health Boards achieving this IG

GREEN: Achieved 2024/25 FY IG
AMBER: Did not achieve 2024/25 FY IG, but fewer cases than previous FY
BLACK: Did not achieve 2024/25 FY IG and more cases than previous FY

Overall IG			HO IG		
Baseline FY number[2] (IG)[3]	2024/25 FY number[1]	% difference from baseline FY number[4] (n)[5]	Baseline FY number[2] (IG)[3]	2024/25 FY number[1]	% difference from baseline FY number[4] (n)[5]
32 (<32)	25	-22% (-7)	11 (<9)	6	-45% (-5)

[1] **2024/25 FY number** = Number of cases HB had from Apr 24 to Mar 25
[2] **Baseline FY number** = Number of cases HB had from Apr 23 to Mar 24
[3] **IG number** = Maximum number of cases HB could have from Apr 23 to Mar 24 to achieve IG
[4] **% difference from baseline FY** = *((2024/25 FY number - Baseline FY number) * Baseline FY number) * 100)*
[5] **Number (n) difference from baseline FY** = *2024/25 FY number - Baseline FY number*

Table 1: P. aeruginosa bacteraemia 2024/2025 FY IG

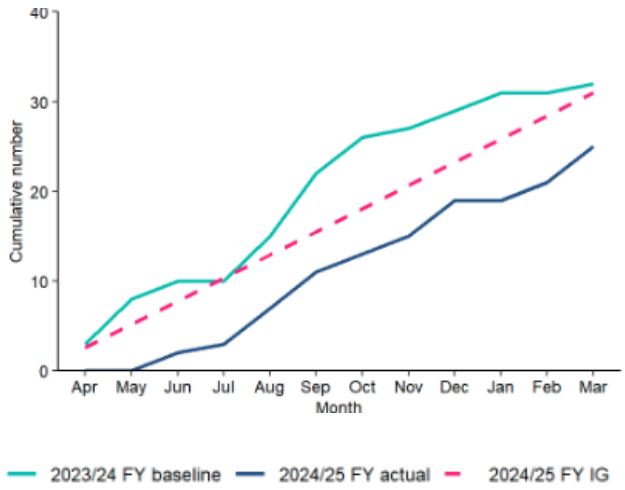
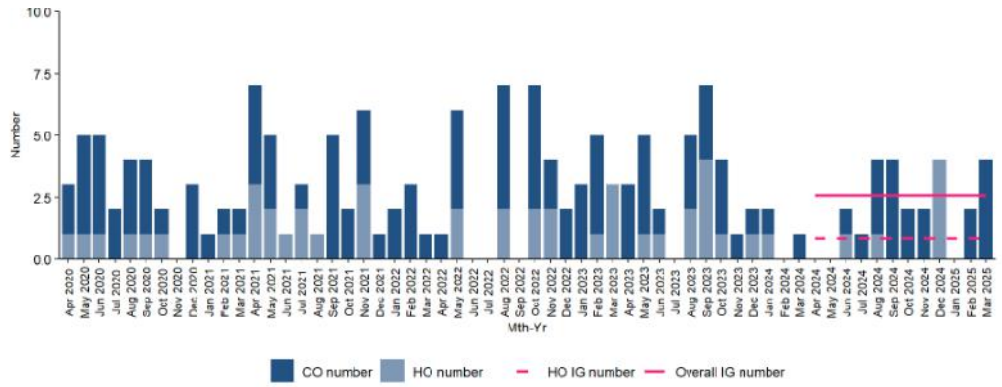


Chart 1: Cumulative monthly number* of P. aeruginosa bacteraemia



HO IG number = *(Maximum number of cases HB could have from Apr 23 to Mar 24 to achieve IG)/12*

Chart 2: Monthly number of P. aeruginosa bacteraemia April 2020 to March 2025

GREEN: Lower rate than previous FY
AMBER: Same rate as previous FY
BLACK: Higher rate than previous FY

Overall rate			HO rate	
2024/25 FY number[1]	2024/25 FY rate[6]	% difference[7] from (Previous FY rate)[8]	2024/25 FY rate[6]	% difference[7] from (Previous FY rate)[8]
25	3.61	-22% (4.62)	0.87	-45% (1.59)

[6] **2024/25 FY rate** = Number of cases HB had from Apr 24 to Mar 25 per 100,000 population (using 2023 mid year population estimate)
[7] **% difference from previous FY rate** = *((2024/25 FY rate - Previous FY rate) / Previous FY rate * 100)*
[8] **Previous FY rate** = Number of cases HB had from Apr 23 to Mar 24 per 100,000 population (using 2023 mid year population estimate)

Table 2: P. aeruginosa bacteraemia 2024/2025 FY rate per 100,000 population

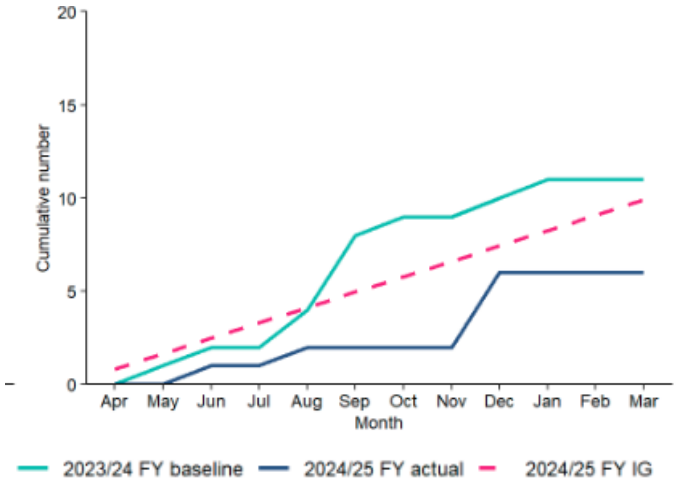


Chart 3: Cumulative monthly number* of HO P. aeruginosa bacteraemia

3.5 Klebsiella species

Klebsiella spp. bacteraemia

I. to have fewer overall cases compared to 2023/2024
II. to have 20% fewer hospital onset cases compared to 2023/2024

- BCUHB reported 136 cases of *Klebsiella spp.* bacteraemia in 2024/25; a decrease of 13% (n=-20) compared to the baseline FY (Table 1.).
- The 2024/25 IG for *Klebsiella spp.* bacteraemia **has been achieved** by BCUHB (Table 1 & Chart 1).
- Monthly numbers ranged from 5 (Apr 24) to 20 (Nov 24), with an average of 11 (Chart 2).
- The rate of *Klebsiella spp.* bacteraemia per 100,000 population in BCUHB in 2024/25 was 19.65; below the Wales rate (22.37) and compared to 22.54 the previous FY (Table 2).

- BCUHB reported 37 cases of HO *Klebsiella spp.* bacteraemia in 2024/25; a decrease of 3% (n=-1) compared to the baseline FY (Table 1.).
- The 2024/25 IG for HO *Klebsiella spp.* bacteraemia **has not been achieved** by the Health Board (Table 1 & Chart 3).
- Monthly numbers ranged from 0 (Dec 24) to 7 (Jul 24), with an average of 3 (Chart 2.).
- The rate of HO *Klebsiella spp.* bacteraemia per 100,000 population in BCUHB in 2024/25 was 5.35; below the Wales rate (7.21) (Table 2).

GREEN: Achieved 2024/25 FY IG
AMBER: Did not achieve 2024/25 FY IG, but fewer cases than previous FY
BLACK: Did not achieve 2024/25 FY IG and more cases than previous FY

Overall IG			HO IG		
Baseline FY number[2] (IG)[3]	2024/25 FY number[1]	% difference from baseline FY number[4] (n)[5]	Baseline FY number[2] (IG)[3]	2024/25 FY number[1]	% difference from baseline FY number[4] (n)[5]
156 (<156)	136	-13% (-20)	38 (<30)	37	-3% (-1)

[1] **2024/25 FY number** = Number of cases HB had from Apr 24 to Mar 25
[2] **Baseline FY number** = Number of cases HB had from Apr 23 to Mar 24
[3] **IG number** = Maximum number of cases HB could have from Apr 23 to Mar 24 to achieve IG
[4] **% difference from baseline FY** = *((2024/25 FY number - Baseline FY number) * Baseline FY number) * 100)*
[5] **Number (n) difference from baseline FY** = *2024/25 FY number - Baseline FY number*

Table 1: Klebsiella spp. bacteraemia 2024/2025 FY IG

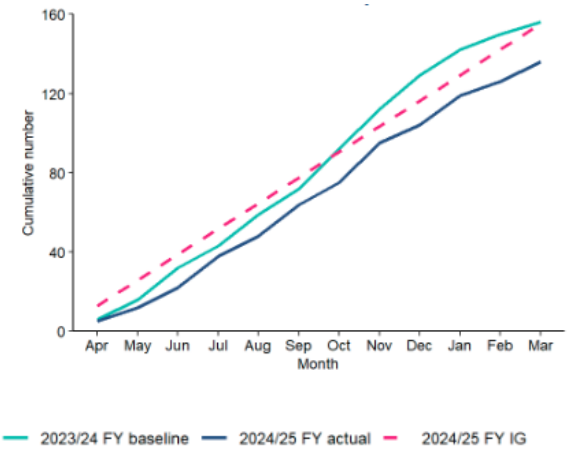
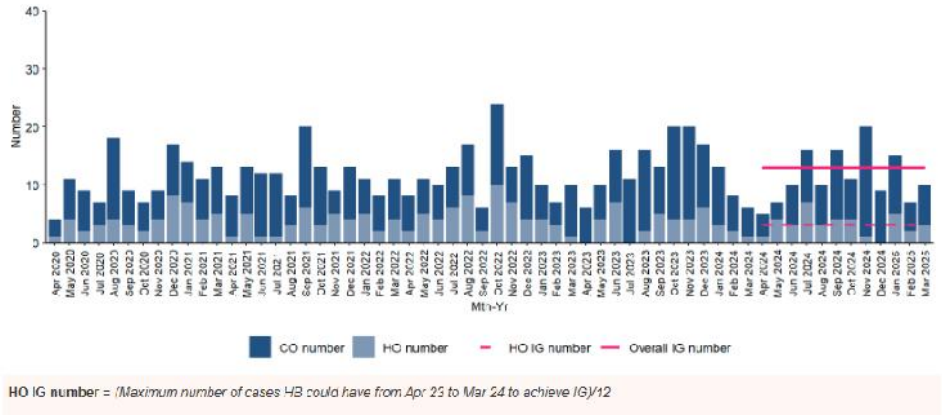


Chart 1: Cumulative monthly number* of Klebsiella spp. bacteraemia



HO IG number = *(Maximum number of cases HB could have from Apr 23 to Mar 24 to achieve IG)/12*

Chart 2: Monthly number of Klebsiella spp. bacteraemia April 2020 to March 2025

GREEN: Lower rate than previous FY
AMBER: Same rate as previous FY
BLACK: Higher rate than previous FY

Overall rate			HO rate	
2024/25 FY number[1]	2024/25 FY rate[6]	% difference[7] from (Previous FY rate)[8]	2024/25 FY rate[6]	% difference[7] from (Previous FY rate)[8]
136	19.65	-13% (22.54)	5.35	-3% (5.49)

[6] **2024/25 FY rate** = Number of cases HB had from Apr 24 to Mar 25 per 100,000 population (using 2023 mid year population estimate)
[7] **% difference from previous FY rate** = *((2024/25 FY rate - Previous FY rate) / Previous FY rate * 100)*
[8] **Previous FY rate** = Number of cases HB had from Apr 23 to Mar 24 per 100,000 population (using 2023 mid year population estimate)

Table 2: Klebsiella spp. bacteraemia 2024/2025 FY rate per 100,000 population

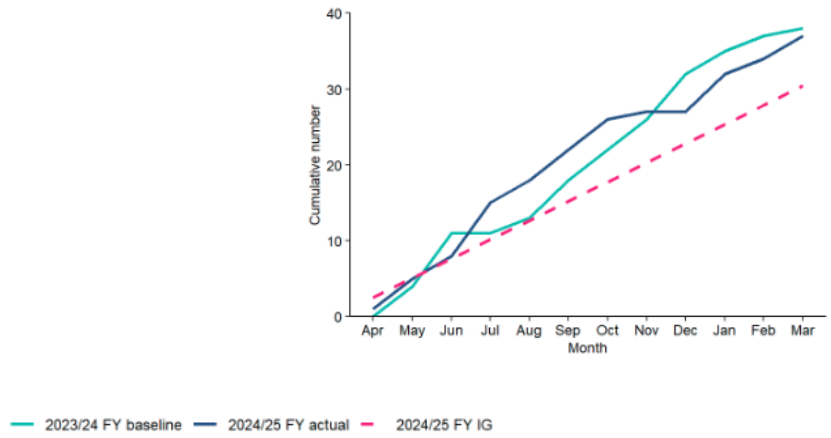


Chart 3: Cumulative monthly number* of HO Klebsiella spp. bacteraemia

3.6 Staphylococcus aureus

Staphylococcus aureus bacteraemia

I. to have fewer HO MRSA bacteraemia compared to 2023/2024
II. to have fewer hospital onset MSSA bacteraemia cases compared to 2023/2024

- BCUHB reported 3 cases of HO MRSA bacteraemia in 2024/25; no change from the baseline FY (Table 1).
- The 2024/25 IG for HO MRSA bacteraemia has **not been achieved** by BCUHB (Table 1 & Chart 1).

- BCUHB reported 42 cases of HO MSSA bacteraemia in 2024/25; an increase of 8% (n=+3) compared to the baseline FY (Table 1).
- The 2024/25 IG for HO MSSA bacteraemia **has not been achieved** by BCUHB (Table 1 & Chart 2).

- The rate of HO *S. aureus* bacteraemia (MRSA+MSSA) per 100,000 population in BCUHB in 2024/25 was 6.50; a 7% increase on the previous FY (6.07).
- Overall (HO+CO), the *S. aureus* bacteraemia rate in BCUHB was 26.01; the same as the previous FY (Table 2).

GREEN: Achieved 2024/25 FY IG
AMBER: Did not achieve 2024/25 FY IG, but fewer cases than previous FY
BLACK: Did not achieve 2024/25 FY IG and more cases than previous FY

HO MRSA IG					
Baseline FY number[2] (IG)[3]	2024/25 FY number[1]	Difference from baseline FY number[4]	Baseline FY number[2] (IG)[3]	2024/25 FY number[1]	% difference from baseline FY number[4] (n)[5]
3 (<3)	3	0)	39 (<3)	42	+8% (+3)

[1] **2024/25 FY number** = Number of cases HB had from Apr 24 to Mar 25
[2] **Baseline FY number** = Number of cases HB had from Apr 23 to Mar 24
[3] **IG number** = Maximum number of cases HB could have from Apr 23 to Mar 24 to achieve IG
[4] **% difference from baseline FY** = *((2024/25 FY number - Baseline FY number) * Baseline FY number) * 100)*
[5] **Number (n) difference from baseline FY** = *2024/25 FY number - Baseline FY number*

Table 1: *S. aureus* bacteraemia 2024/2025 FY IG

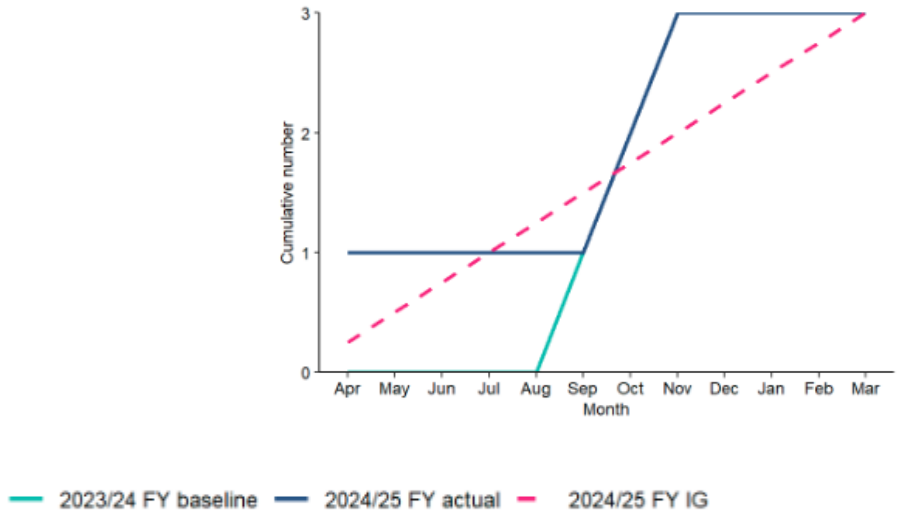


Chart 1: Cumulative monthly number* of HO MRSA bacteraemia

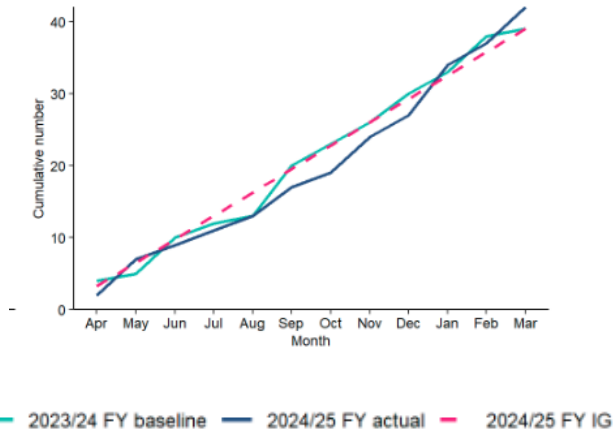


Chart 3: Cumulative monthly number* of HO MSSA bacteraemia

GREEN: Lower rate than previous FY
AMBER: Same rate as previous FY
BLACK: Higher rate than previous FY

Overall rate			HO rate		
2024/25 FY number[1]	2024/25 FY rate[6]	% difference[7] from (Previous FY rate)[8]	2024/25 FY number[1]	2024/25 FY rate[6]	% difference[7] from (Previous FY rate)[8]
180	26.01	0% (26.01)	45	6.5	+7% (6.07)

[6] **2024/25 FY rate** = Number of cases HB had from Apr 24 to Mar 25 per 100,000 population (using 2023 mid year population estimate)
[7] **% difference from previous FY rate** = *((2024/25 FY rate - Previous FY rate) / Previous FY rate * 100)*
[8] **Previous FY rate** = Number of cases HB had from Apr 23 to Mar 24 per 100,000 population (using 2023 mid year population estimate)

Table 2: S. aureus bacteraemia 2024/2025 FY rate per 100,000 population

3. 7 Post Infection Reviews

All NHS organisations are required to complete a post infection review (PIR) for key HCAIs. Within BCUHB the target is to convene a multi-disciplinary team meeting within 72 hours of the reported result to undertake an initial review of the case and determine if it was unavoidable or avoidable. Action plan development addresses any required recommendations to prevent reoccurrence and enhance clinical practice and learning is shared across the organisation. The Datix system is utilised by Ward Managers to upload the completed PIR document. Learning from the PIRs is shared through a number of forums to include LIPG, SIPG, Organisational Learning Forum, and cases of significance or those identified to be catastrophic are presented at the Integrated Concerns Meeting to ensure Executive oversight.

In addition to a PIR the IPT carry out 'deep dives' on each of the key mandatory infections to help identify trends and key learning to take forward, with this available on the IP quality dashboard. This is also presented for discussion at LIPG meetings and issues of significance escalated to the SIPG.

Clostridiodes difficile Infection

For *C.difficile*, deep dives were fully completed for 94% of cases.

- 66% had had a hospital stay in the last 12 months.
- 64% had received antibiotics in the last 3 months.
- 84% of patients were on protein pump inhibitors (PPIs) and 7% had laxatives administered.
- 60% of cases were female.
- Just over half (55%) started with symptoms in the community.
- 18% of cases were a relapse or reoccurrence whereby faecal transplant should be considered. In addition to each IHC having a named lead for carrying out faecal transplants, the IPT are able to provide a nurse led service for this in the West and this will be expanded in early 2025/26 financial year to cover East and Central also. This will lead to a service that is more accessible and reduce waiting times further.
- 50% of cases were considered to be avoidable whereby the PIR identified learning and 43% were unavoidable

In 2024/25 there were nine ward outbreaks associated with *C.difficile*. Six of these where in East and three in Central. Outbreaks lasted an average of 23 days, with 40 patients affected and 59 bed days lost in total due to six full ward closures and three wards having bay closures only.

Escherichia coli Blood Stream Infections

519 (96%) cases had deep dives completed on them:

- 52% male, 48% female
- 96% of patients were from their own home, 4% from a Care/Residential Home
- 78% had community onset, 21% hospital onset (1% not answered).
- 50% had a hospital stay in the last 12 months.
- 29% had a healthcare intervention in the last 7 days.
- 33% had a medical device in the last 3 months.
- 13% had a wound in the last 6 months.
- Only 18% had full compliance with the blood culture pack documentation.
- 49% had E. coli from another specimen site before this BSI
- 10% were classed as avoidable, 87% unavoidable (3% undetermined).
- The top five sources of the BSI was urinary tract (60%), Hepatobiliary (15%), unknown (7%), intra-abdominal (6%) and respiratory tract (3%)
- 13% were healthcare associated
- 19% demonstrated antibiotic resistance with 12% of these multidrug resistant.

Pseudomonas aeruginosa (*P. aeruginosa*) Blood Stream Infections

Deep dives were completed on 24 (96%) infections:

- 46% male, 54% female.
- 100% of patients were from their own home.
- 17 (71%) were community onset, 7 (29%) were hospital onset.
- 67% had a hospital stay in the last 12 months.
- 42% had a healthcare intervention in the last 7 days.
- 11% had a medical device in the last 3 months.
- 29% had a wound in the last 6 months.
- Only 21% had full compliance with the blood culture pack documentation.
- 42% had P. aeruginosa from another specimen site before this BSI
- 21% were classed as avoidable, 79% unavoidable (4% undetermined).
- The top five sources of the BSI was urinary tract (33%), neutropenic sepsis (17%), intra-abdominal (13%), respiratory tract (13%), hepatobiliary (8%)
- 8% were healthcare associated
- No antibiotic resistance demonstrated in any of these cases.

Klebsiella species Blood Stream Infections

Deep dives were completed on 130 (96%) infections:

- 56% male, 44% female
- 89% of patients were from their own home, 9% from Care/Residential Home and 2% not answered

- 97 (75%) were community onset, 30 (23%) were hospital onset with 3 not answered
- 52% had a hospital stay in the last 12 months.
- 35% had a healthcare intervention in the last 7 days.
- 43% had a medical device in the last 3 months.
- 18% had a wound in the last 6 months.
- Only 18% had full compliance with the blood culture pack documentation.
- 35% had Klebsiella spp. from another specimen site before this BSI
- 18% were classed as avoidable, 77% unavoidable (5% undetermined).
- The top five sources of the BSI was urinary tract (48%), respiratory tract (9) intra-abdominal (8%) and undetermined (6%)
- 19% were healthcare associated
- 13% demonstrated antibiotic resistance with 5% of these multidrug resistant.

The achievement of targets relating to infections such as *P. aeruginosa* and *Klebsiella spp*. Klebsiella is challenging due to low numbers and fluctuation of these that impact the ability to demonstrate stabilisation.

Further work planned to reduce gram negative BSIs such as E.coli, P. aeruginosa and Klebsiella spp. includes:

- Task and Finish Groups continue to convene within each IHC with these continuing to implement actions to address the measures required to prevent catheter associated urinary tract infection (CAUTI) and urinary tract infection (UTI) enforcing best practise.
- Six monthly CAUTI audits have continued with significant reduction in CAUTIs reported; 10.1% in Jan 2024, 5.2% in July 2024 and 4.2% in Jan 2025.

Methicillin Resistant *Staphylococcus Aureus* (MRSA)

Deep dives were completed for all 100% of the cases, 7 males and 4 females.

- 10 patients were from their own private address and one had no fixed abode.
- 5 were community onset, 6 were hospital onset.
- 7 had been in hospital in the last 12 months.
- 6 had a healthcare intervention in the last 7 days.
- 4 patients had a medical device (e.g. urinary catheter, vascular cannula) inserted in the last 3 months.
- 7 had had a wound in the last 6 months.
- In only 1 case was there full compliance with the blood culture pack documentation.
- 7 had MRSA from another specimen site before this BSI.
- 6 of the 11 were classed as avoidable, 5 unavoidable.
- The source of the infection for 6 of these cases was skin and soft tissue, 3 device-related, 1 intra-abdominal and one unknown.
- 5 were healthcare associated

In 2024/25 there were six ward outbreaks associated with MRSA positive patients. Three of these where in East and three in Central. Outbreaks lasted an average of 27 days, with 29 patients affected and 5 bed days lost in total due to 1 full ward closures and 1 ward having a bay closure only.

Methicillin Sensitive *Staphylococcus Aureus* (MSSA) Blood Stream Infections

From the deep dive data completed on 169 cases:

- 64% male, 36% female
- 96% of patients were from their own home, 2% from Care/Residential Home and 2% no fixed abode
- 132 (79%) were community onset, 34 (20%) were hospital onset with one not answered
- 42% had a hospital stay in the last 12 months.
- 32% had a healthcare intervention in the last 7 days.
- 31% had a medical device in the last 3 months.
- 26% had a wound in the last 6 months.
- Only 21% had full compliance with the blood culture pack documentation.
- 39% had MSSA from another specimen site before this BSI
- 20% were classed as avoidable, 76% unavoidable (4% undetermined).
- The top five sources of the BSI was skin and soft tissue (35%) followed by unknown (15%), bone and joint (12%), device related and then urinary tract (11%) and respiratory tract (7%)
- 21% were healthcare associated.

3.8 Healthcare Associated Infection, Antimicrobial Resistance and Prescribing Programme (HARP) Supportive Infection Prevention and Control Peer Review

Due to an increase in the number of cases of *C.difficile* infection increasing across Wales and the UK, the Deputy Director of Nursing (DDoN) for IP and Decontamination invited the HARP Team to conduct a supportive peer review of the IP arrangements with a focus on *C.difficile*. The supportive peer review and the agenda was supported by the Executive Director of Nursing and Midwifery and accepted by the HARP team.

The visit took place over three days during the week commencing 2nd December 2024, with a member of the HARP Infection Prevention Team (IPT) visiting the three acute sites accompanied by the DDoN IP and Decontamination. In addition to visiting a number of clinical areas, a formal agenda was set which included meetings with a number of key stakeholders that have a part to play in the IP agenda.

A report was received from the HARP Team with considerations and recommendations made, however concluded that the team were assured with the existing process in place to manage C. difficile infection and other HCAIs. A Health Board action plan was developed following receipt of the report to support implementation of the recommendations and which is monitored through the SIPG.

3.9 Actions to Address the WHC HCAI Improvement Goals for 2025/2026 (not yet published)

In the absence of Welsh Health Circular (WHC) Improvement Goals for 2025/2026, BCUHB trajectories and actions are set on local goals based on the same reduction goals as 2024/25 whilst awaiting further information.

The IPT has commenced delivery of its Programme of Work for 2025/2026, which has been developed based on the standards within the (draft) Code of Practice for the Prevention and Control of HealthCare-Associated Infections: (Appendix C)

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

- Availability of decant space for both reactive and proactive high-level disinfection
- Capacity and patient flow constraints impacting timely isolation
- Cohorting options when isolation is not feasible
- Estates and Facilities-related improvements
- Practice related improvements

To support the standardisation of high-level disinfection practices across BCUHB, East IHC is evaluating the pilot of enhanced UVC technology. Plans are in place to extend this pilot to Central and West IHCs, pending confirmation of implementation dates from the supplier.

5.0 Other Significant Infections

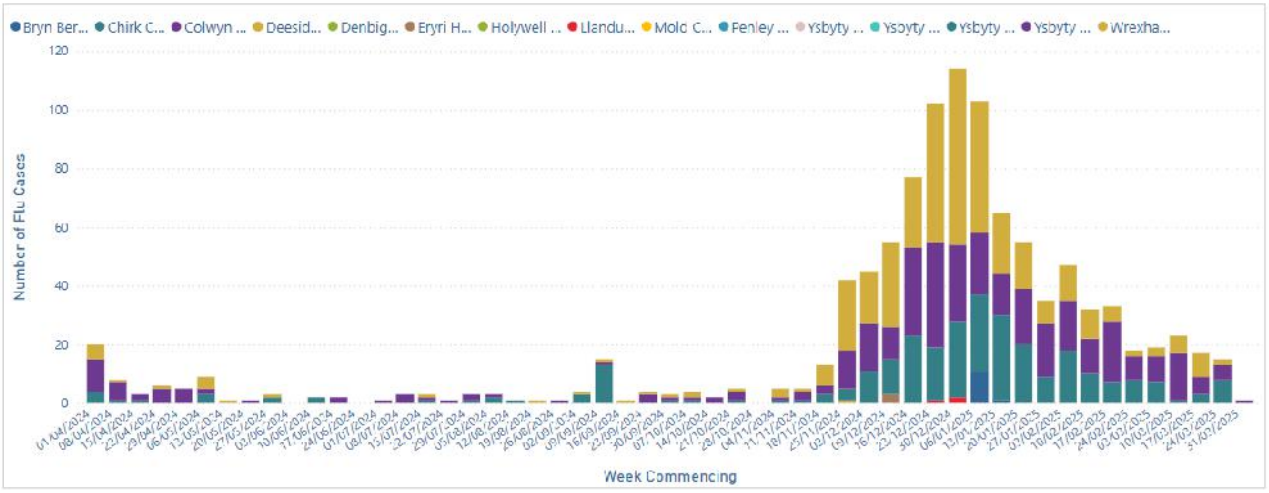
5.1 Acute respiratory Infections (ARI)

5.1.1 Influenza

During the 2024/25 influenza season, BCUHB recorded a total of 935 laboratory-confirmed inpatient cases of influenza. This marks a 52% increase compared to the 616 cases reported in the 2023/24 season. The peak of activity occurred in the final week of December 2024**,** aligning with national trends observed during the same period.

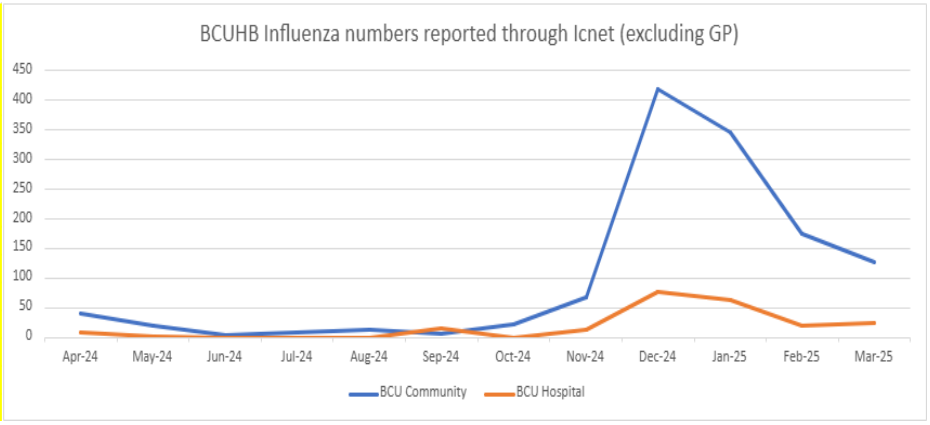
A total of 35 influenza outbreaks were reported throughout the 2024/25 season. These outbreaks had a significant operational impact, leading to 16 full ward closures and a loss of 49 bed days. The first outbreak was reported in September 2024, indicating an earlier start to the season compared to previous years.

Notably, the majority of outbreaks during this season were of hospital-onset origin, in contrast to the community-onset predominance observed in 2023/24. This shift highlights potential changes in transmission dynamics within healthcare settings and underscores the importance of reinforcing IP measures within hospitals.



Approximately 15% of influenza cases were hospital onset (from samples collected 48 hours after admission) in comparison to 11% in 2023/24

	BCU	
	Community	Hospital
Mar-24	174	14
Apr-24	41	9
May-24	19	2
Jun-24	4	0
Jul-24	9	0
Aug-24	13	0
Sep-24	7	15
Oct-24	21	0
Nov-24	68	13
Dec-24	419	77
Jan-25	345	62
Feb-25	175	19
Mar-25	127	25



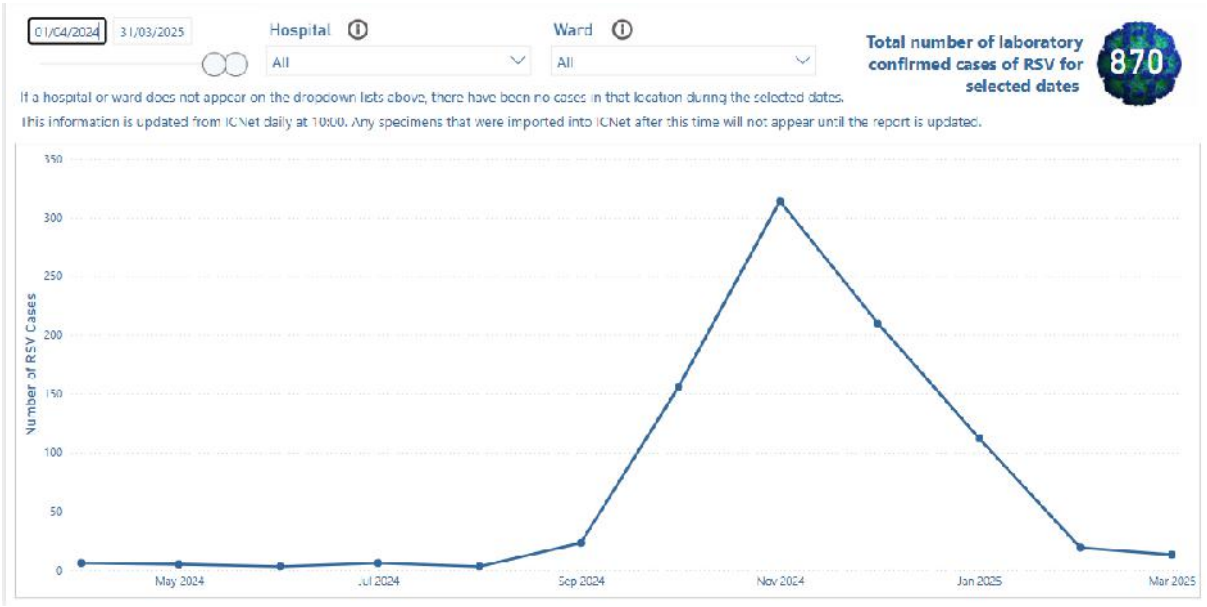
Despite a higher number of community-onset influenza cases, the Central IHC reported a lower proportion of hospital-onset cases. A similar trend was observed during the 2023/24 season. This may be attributed to better access to isolation facilities in the Central IHC compared to the East and West IHCs, which have more limited capacity for patient segregation.

The majority of outbreaks in 2024/25 were reported in the West IHC, correlating with a slightly higher number of hospital-onset cases reported in the West. The distribution pattern underscores the importance of isolation ability and IP strategies in mitigating hospital transmission of influenza.

Influenza cases	Hospital	Community	Total
Central	69 (11.4%)	533 (88.5%)	602
East	83 (15.5%)	452 (84.5%	535
West	72 (18%)	330 (82%)	402

5.1.2 Respiratory Syncytial Virus

A slight decrease in the number of respiratory syncytial virus (RSV) cases were reported during the 2024/25 season, with 870 laboratory confirmed cases in comparison to 907 reported during 2023/24.

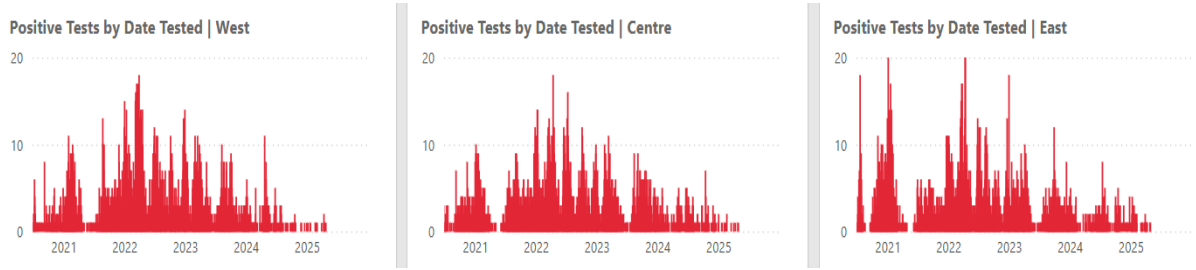


However, the number of patients aged 18 years or older has increased, compared to the numbers in the previous season 2023/24.

Numbers of laboratory confirmed cases of RSV by Age group	0 to 17yrs old	18yrs or greater
2023/24	640	267
2024/25	503	365

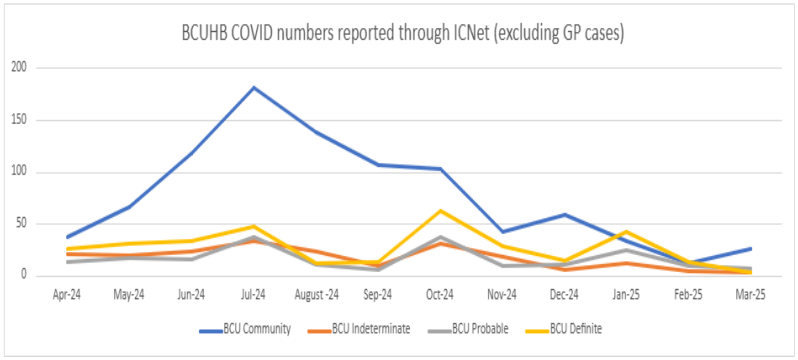
5.1.3 COVID- 19

During the 2024/25 reporting period, the number and severity of COVID-19 cases declined significantly, showing an approximate 25% reduction compared to the previous year. A total of 1,660 confirmed cases were reported in 2024/25, down from 2,190 cases in 2023/24 (data extracted from ICNet).



During 2024/25, COVID-19 peaked during July 2024, with the numbers reducing afterwards.

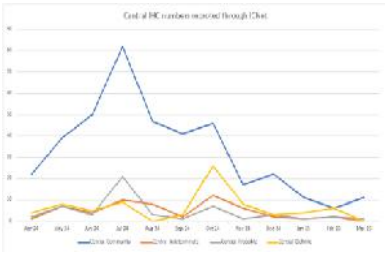
	BCU			
	Community	Indeterminate	Probable	Definite
Apr-24	37	21	14	26
May-24	67	20	17	31
Jun-24	118	24	16	34
Jul-24	182	34	38	48
Aug-24	138	23	11	12
Sep-24	107	9	6	13
Oct-24	103	31	37	63
Nov-24	42	18	10	28
Dec-24	59	6	11	15
Jan-25	34	12	25	43
Feb-25	12	4	9	13
Mar-25	26	3	7	3

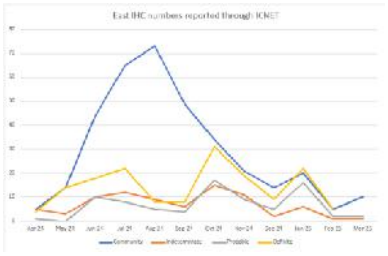


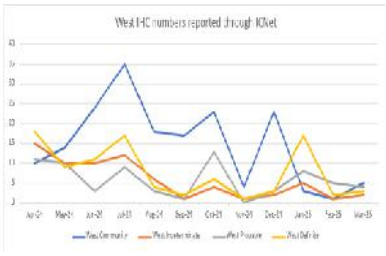
COVID-19 cases were not evenly distributed across the IHCs.

- East reported the highest number of cases: 674
- Central reported 577 cases
- West reported the lowest: 449

Central recorded the fewest healthcare-associated infections, with only 128 probable and definite cases**,** compared to East: 236 healthcare-associated cases, West**:** 163 healthcare-associated cases. This could again account for the increased availability of single rooms to include with ensuite facilities within the Central IHC.







Oxygen requirements in in-patients with acute respiratory virus infection

Throughout FY 2024/25, the IPTs have reported patient level indicators of oxygen requirements for any patient who tests positive for at least one of three key respiratory pathogens: influenza, COVID-19, and RSV. This data is collected manually from the wards and is analysed by the Healthcare Epidemiologist. The data do not distinguish between oxygenation required for non-respiratory virus infections (e.g. post-surgical recovery) and that required due to respiratory infection. Patients may be infected with multiple organisms which could influence oxygen requirement.

Based on the data collected, a fortnightly report was prepared during the Winter season and cascaded to the SIPG, and surveillance leads in the communicable disease control centre (CDSC) at PHW. A full annual report of this data will be made available upon further data analysis.

In FY 2024/25, a total of 1,776 hospital admissions had data collected on oxygenation use. Of those, 95 (5.3%) were collected in response to a positive RSV test, 585 (32.9%) for influenza, and 1,096 (61.7%) for COVID-19. Of those 1,776 admissions, 672 (37.8%) required oxygen due to one of the three respiratory pathogens during the admission. Of those 672 admissions, 599 (89.1%) required oxygen at point of admission or first positive specimen result.

The highest burden of new oxygen requirement in adults was seen in week 2 of 2025 (06/01/2025 – 12/01/2025), in which most of the burden was related to influenza infection. The peak of new COVID-19 related oxygen requirement was in week 25 of 2024 (17/06/2024 – 23/06/2024). RSV, whilst generating considerably less new oxygenation requirement in adults, peaked in week 3 of 2025 (13/01/2025 – 19/01/2025) (Figure 1).

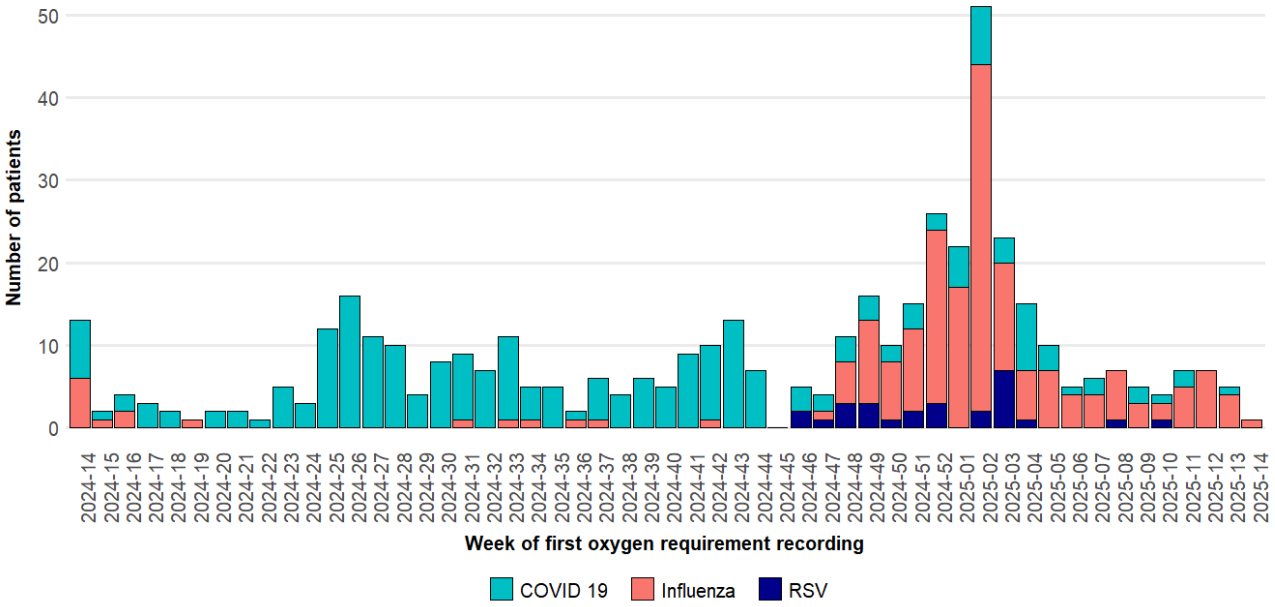


Figure 1: *Total daily number of adult inpatients newly diagnosed with COVID-19, RSV or influenza requiring oxygenation at, or shortly after, diagnosis, stratified by virus type. Data on oxygenation manually collected on the day of positive test at the earliest opportunity. Data collected at three acute sites across BCUHB, includes patients diagnosed on admission and subsequently admitted and those diagnosed as inpatients.*

Explanatory note: *Whenever a new case of RSV, COVID or Influenza is diagnosed in an inpatient the IPT visit the patient and manually record the oxygenation status on that day (or within approx. 24 hours/at earliest opportunity to review). Emergency Department (ED) cases who are not admitted are not included, those that remain in ED >24 hours are included. Figure 1 is a measure of the incidence of oxygenation requirements for these patients on the day of the positive test. Data quality is affected by weekends.*

In paediatric inpatients, the highest burden of first oxygen requirement was seen in week 44 of 2024 (28/10/2024 – 03/11/2024), most of which was related to RSV. Small numbers occlude any other discernible patterns in paediatric data.

In adults, the proportion of adults requiring oxygen peaked at 51.9% (95%CI: 40.4%-63.3%) in week 14 of 2024 (01/04/2024 – 07/04/2024). However, the highest 4 week rolling average was in week 5 of 2025 (27/01/2025 – 02/02/2025) with a figure of 47.4% (95%CI: 43.8%-50.9%), highlighting a sustained increase in the proportion of patients requiring oxygen throughout January and February of 2025 (Figure 2).

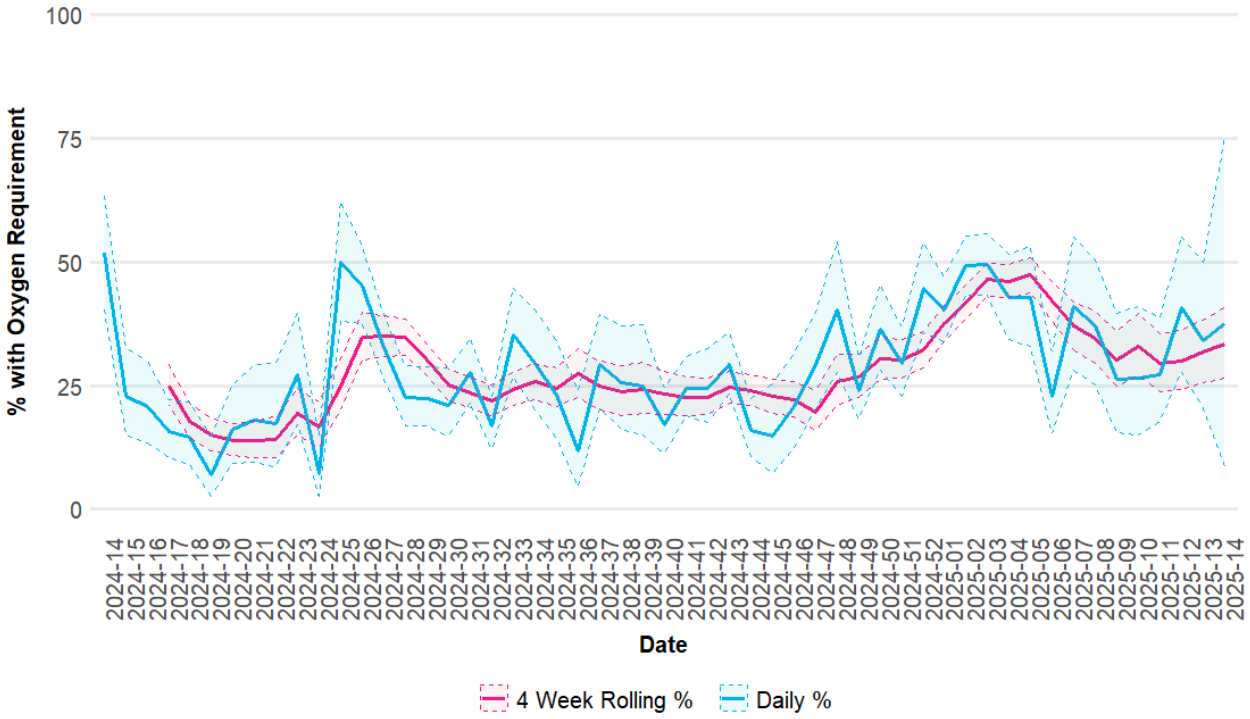


Figure 2: *Proportion of adult cases of COVID, RSV or influenza requiring oxygenation. Daily proportion and seven day rolling average proportion shown. Shaded areas indicate 95% confidence intervals. This view is generated from the denominator of the number of active cases amongst inpatients and the numerator, the number of these patients requiring oxygen as per previous definitions.*

5.1.4 *Bordetella pertussis*

During the 2024/25 FY, a slight increase in *Bordetella pertussis* (whooping cough) cases was observed, with 10 more cases reported in comparison to the 43 reported in 2023/24. All 53 cases were under the age of 16.

Of these, 25 cases were identified through hospital-based testing:

- Glan Clwyd Hospital: 8 cases
- Wrexham Maelor Hospital: 7 cases
- Ysbyty Gwynedd: 10 cases

The age range of these patients was 10 weeks to 10 years. Among them:

- 17 patients were discharged the same day.
- 8 patients required hospital admission for more than 24 hours,
    - 4 patients had a hospital stay of over 5 days.

- 1 child had a prolonged hospital stay of 15 days, primarily due to underlying medical conditions.

None of the patients required critical care intervention during this period. There were no issues identified with adherence to personal protective equipment (PPE) or with isolation of the cases. The main concern identified at the early stages

The remaining 28 cases were reported via GP surveillance:

- Central IHC: 14 cases
- East IHC: 3 cases
- West IHC: 11 cases

5.2 Clinically Significant Antimicrobial Resistant Organisms

Clinically Significant Antimicrobial Resistant Organisms (CSARO) that are antimicrobial resistant organisms, also termed Multidrug Resistant Organisms (MDRO), are defined as organisms that have become resistant to one or more antimicrobials from three or more antimicrobial categories or classes and also other micro/macro-organisms that have developed multi-drug and chemical resistance. CSARO's have the ability to cause harm, increase morbidity and mortality and the more resistant the organism, the fewer options there are available for treatment. Hence surveillance of and their prevention and control in any healthcare setting is key to reducing harm and preventing avoidable HCAIs, increased incidents and outbreaks.

'Standards for the Identification, Management and Treatment of CSARO' were published by PHW in August 2023 along with 'Guidance on the Management of CSAROs'. Health Boards have been requested to ensure they have robust processes and systems in place to identify, manage and treat these pathogens.

The IPT at BCUHB carried out a gap analysis to identify areas of non-compliance and this was presented to SIPG in March 2024. An SBAR was requested to identify the highest risk areas and priority areas for action for escalation to the EQDG. There are three main areas rated red that require additional resource for BCUHB to fully comply with the CSARO standards. These are:

1. Additional side rooms (preferably ensuite) are required within YG and WMH.
2. Additional Facilities staff are required to meet all of the requests for enhanced cleaning and high-level disinfection (HLD) related to patients, incidents and outbreaks associated with CSARO.
3. Decant facilities need to be identified and ring-fenced in each acute site, to enable HLD to occur.
4. Increased medical support for the Antimicrobial Stewardship Group (ASG) and the Antibiotic Resistance Group along with further education and training for staff in antimicrobial stewardship.

5.2.1 Carbapenemase Producing Enterobacterales/Carbapenemase Producing Organism

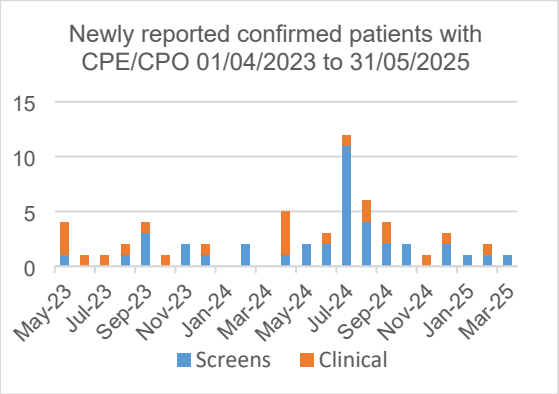
Carbapenemase Producing Enterobacterales (CPE)/Carbapenemase Producing Organism (CPO) are a group of bacteria that are very resistant to antibiotics, including

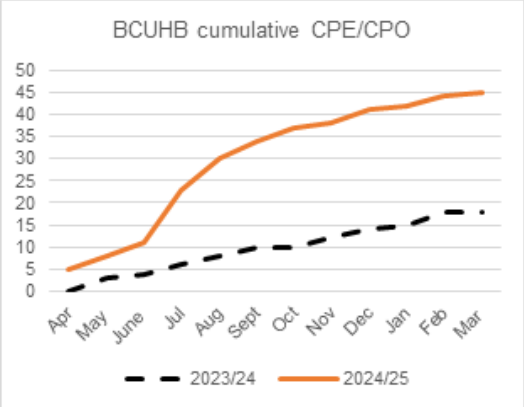
carbapenems. CPE (including *E. coli* and *Klebsiella*) are regarded as the biggest threat as the resistance genes can transmit vertically and horizontally, thereby rapidly spreading between different strains of bacteria.

During 2024/25, there was an increase in the number of CPE/CPO cases reported, with a total of 45 cases, a 55% rise compared to the previous year. The Health Board comprehensive screening programme is established (ITU and Renal) in addition to admission screening for patients admitted from outside the Health Board. As part of the screening programme, 29 of the 45 cases were detected.

As in previous years, the OXA-48-like gene remained the predominant resistance mechanism, accounting for 19 of the total cases.

While previous concerns around CPE have been focused in the East IHC, the West reported a higher number of cases during the last year.





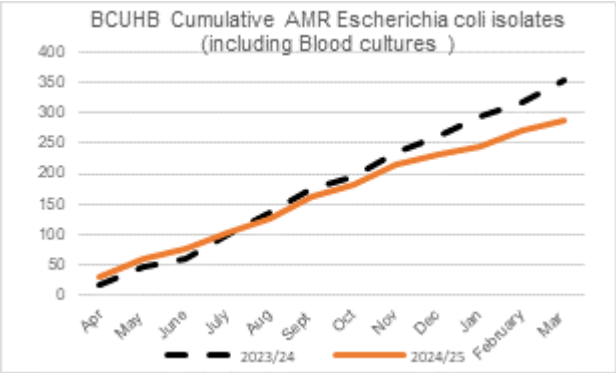
5.2.2 Multi Drug resistant *Escherichia coli*

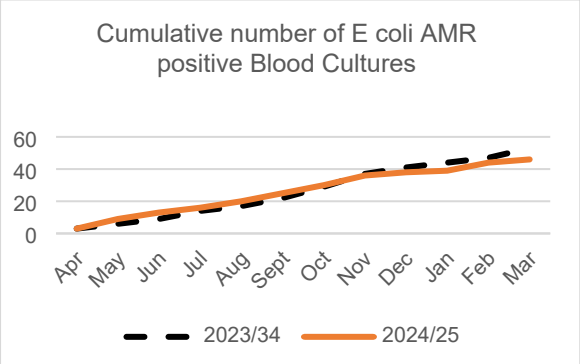
Routine surveillance of bloodstream infections caused by *E. coli* is a mandatory component of the surveillance programme reported monthly to PHW. Following the identification in May 2023 of a strain at WMH exhibiting elevated resistance to key antimicrobials, specifically the combination of gentamicin, ciprofloxacin, and piperacillin-tazobactam (Tazocin), enhanced investigation and surveillance measures were implemented, as detailed in last year's report.

During 2024/25, a total of 288 patients were identified with *E. coli* (from isolates) exhibiting this resistance pattern, compared to 354 cases in the previous year. While

this represents a decrease in overall case numbers, concern remains high. The East IHC continues to be a key area of focus, reporting rates approximately three times higher than other IHCs within the Health Board.

Although there has been a slight reduction in the total number of *E. coli* infections, the number of bloodstream infections associated with antimicrobial-resistant *E. coli* continues to rise, highlighting the ongoing need for targeted interventions and enhanced antimicrobial stewardship.

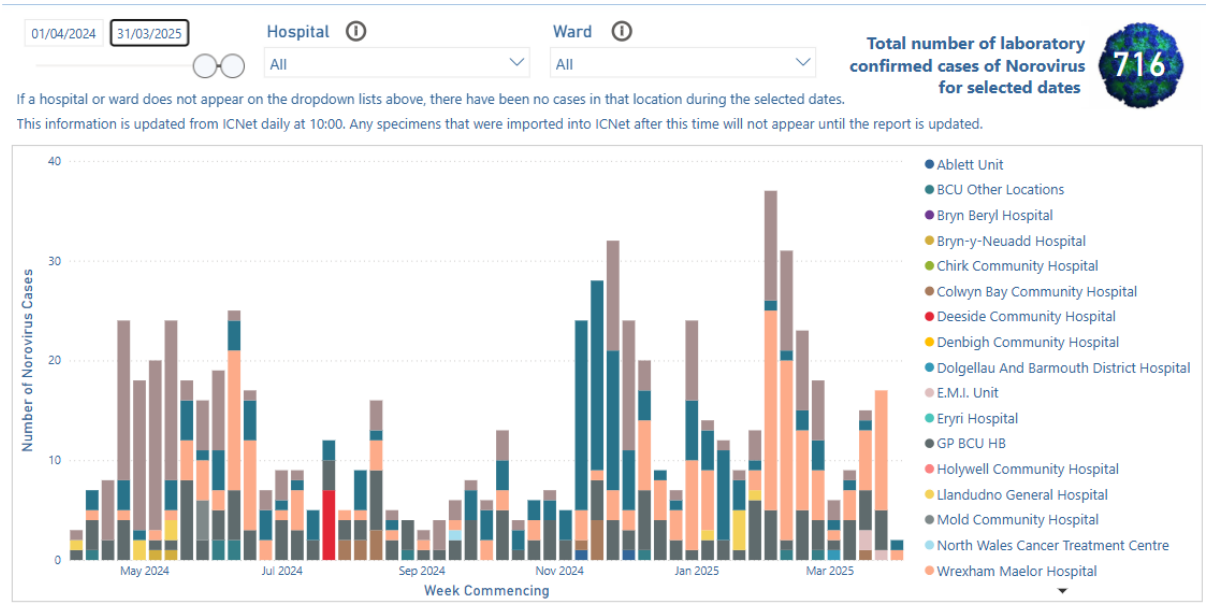


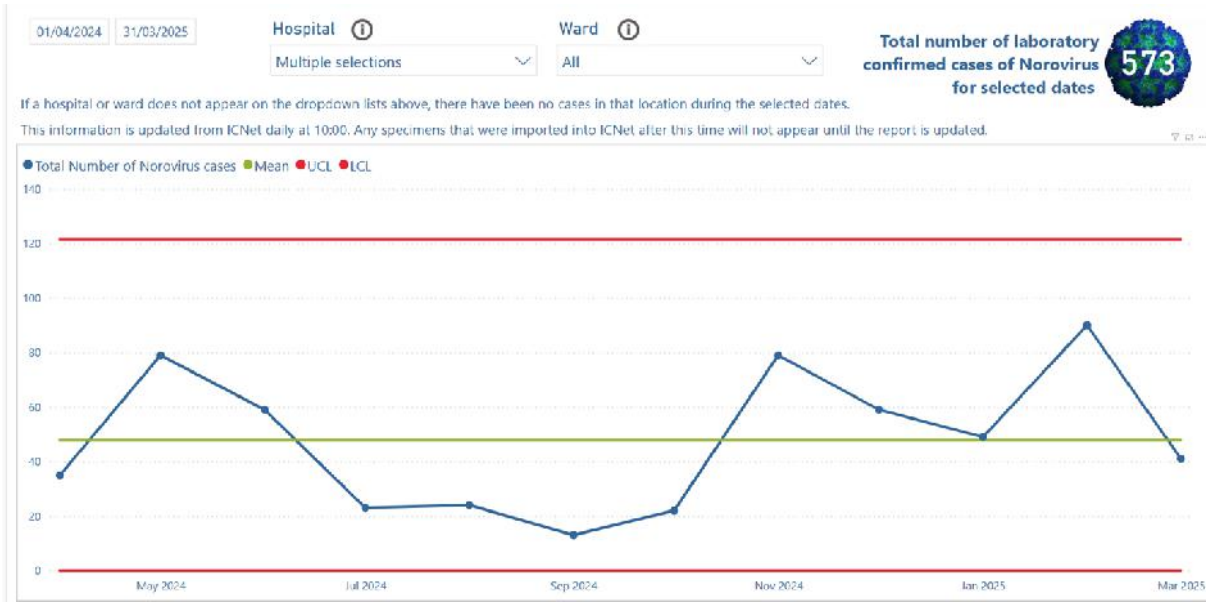


5.3 Norovirus

During 2024/25, there were 716 laboratory-confirmed cases of Norovirus across BCUHB, an increase from 615 cases in 2023/24**.** Although there was greater seasonal fluctuation, the majority of cases continued to occur during the typical winter period.

A total of 46 outbreaks were reported, with 30 resulting in full ward closures in hospitals across the Health Board. These closures placed additional strain on single room availability and impacted patient flow.





Of the 573 Norovirus cases seen in hospital, 464 (80.9%) were hospital onset i.e. from samples collected 48 hours after admission.

Location	Hospital Onset	Community onset	Total
Central	138 (74.2%)	48 (25.8%)	186
East	153 (83.6%)	30 (16.4%)	183
West	173 (88.7%)	22 (11.3%)	195
Total	464 (80.9%)	109 (19.1%)	573

Numbers were lower in Central, which is probably related to the better isolation facilities to include ensuite facilities in the acute site compared to West and East.

5.4 Blood culture data

In 2024/25, 22,861 blood culture samples were taken demonstrating a slight increase in the numbers.

- 8.7% (1989) were positive.
- 45% (10318) were taken in the EDs; 4245 in WM ED, 3841 in YGC ED and 2232 in YG ED.
- *E. coli* was the most common BSI accounting for 628 (31.6%) of the 1989 positive samples. 231 were from East, 228 from Central and 169 from West.

Blood culture contamination rate: a contaminant is defined as a microorganism that is introduced into the culture during either specimen collection or processing and that may not be pathogenic for the patient. Organisms classed as contaminants in blood cultures include *Staphylococci*, aerobic spare-bearing bacilli (ASB), *Corynebacterium* spp., and *Micrococcus* spp. Most of these organisms are present on the skin as normal commensal flora.

Contamination due to skin flora especially in a single culture, makes interpretation difficult and may result in excessive and sometimes unnecessary use of antibiotics, with the risk of promoting bacterial resistance, increased morbidity and mortality, extended hospital stays, and increased costs.

Factors associated with blood culture contamination include poor technique and procedure used to collect blood, lack of dedicated phlebotomists and improper skin antisepsis.
The acceptable blood contamination rate benchmark is <3%.

During 2024/25, 2.8% (578/22861) of all blood cultures taken were classed as contaminants demonstrating a reduction from the previous year: 2.7% at Central IHC, 2.3% at East IHC and 2.7% at West. Blood culture training continues to be delivered across the health board to improve the contamination rate.

5.5 Eliminating Hepatitis B and C as a public health threat in North Wales, Action Plan Progress Update (2024/25)

In May 2024, BCUHB and the North Wales Area Planning Board submitted a 3-year Hepatitis B and C Elimination Joint Recover Plan to Welsh Government. This 3-year plan builds upon the strong foundation established in the initial plan submitted to Welsh Government in 2023.
In responding to the plan, Welsh Government were encouraged by the clear progress made in all areas of the plan. Areas of success included the completion of the North Wales element of the national Hepatitis C re-engagement project, achievement of treatment referral targets through substance misuse services, increase in the offer and uptake of Hepatitis B vaccinations, and the continued support and development of the Health Protection Service for key elimination activities including targeted sampling in probation services, enhancing sampling capacity through substance misuse services and the coordination of a TB 'Find and Treat' event in Wrexham which included blood borne virus (BBV) testing.
In their response, Welsh Government also highlighted several challenges where further action is needed, including continued uptake and investment into Needle and

Syringe Provision, and increasing BBV testing in substance misuse services and community pharmacies.
The BCUHB Elimination Steering Group will continue to monitor and oversee key actions, taking into consideration the feedback from Welsh Government.

5.6 Nosocomial infections in patients experiencing delayed discharge
Collaborative work between PHW and BCUHB in auditing harms observed in-patients in Ysbyty Gwynedd (in 2022) experiencing delayed hospital discharge reported a concerning number of infections following a decision that the patient was medically fit for discharge. The data on harms clearly showed a considerable burden of bacterial and viral infections, and of clinical cases of hospital acquired pneumonia (HAP) experienced by the cohort of delayed discharge patients.

The observed incidence of HAP (0.37 per 100 bed days of delayed discharge) was of particular concern, for every 300 days of delayed discharge experienced by the hospital one new HAP might be expected. 300 days of delayed discharge were reached within a few days under conditions observed in the audit. HAP was associated with high mortality within the hospital spell. HAP remains poorly monitored due to the relatively low number of patients in whom a causative organism is observed.

Delayed discharge following clinical optimisation is a major challenge for the health board; this audit demonstrated that in addition to subsequent pressures on hospital flow, hospital acquired infections in this cohort are also significant.

6.0 Caesarean section Surgical Site Infection (CSSI) Surveillance
CSSI Data

Consistent data collection, with data quality consistently was at 100% for all of 2024.

The most recently published HARP report for Quarter 4 2024 evidences a reduced rate of CSSI of 2.0% across BCUHB.

Inpatient rates of CSSI remain extremely low at 0.1% and are associated with women who have systemic infection at the time of procedure.

Most commonly, BCUHB infections are defined as late community onset, more than 5 days following hospital discharge.

The themes for 2024 identified through report analysis continue to include the use of non-standard wound closure, the rate of infection associated with staples is around 4.3%, which has significantly reduced since 2023. The rate of infection is also increased with repeated caesarean section delivery.

Betsi Cadwaladr UHB						
Q1 2024 - Q4 2024	**2.0%**	↓ 50%		100%		100%
Q1 2021 - Q4 2023*	**4.1%**			100%		96%

**Previous three years data for the hospital/health board.*

Overall SSI rate

	Betsi Cadwaladr UHB	
Valid forms received	2155	
Forms where inpatient and post-discharge SSI are completed, or there is a post-discharge SSI.		
Overall SSI rate	44	2.0%
= number of SSI / valid procedures x 100		
Hospital onset (inpatient)	3	0.1%
Community onset	3	0.1%
Late community onset	35	1.6%
Infection diagnosed 5 or more days after hospital discharge.		
Unknown onset	3	0.1%

Improvements for 2025

Areas of learning from 2024 have significantly improved outcomes for patients, the focus for 2025 is to maintain the standard achieved, whilst focusing on improvements in the two areas identified above.

- Focus on those undergoing repeat caesarean section
- Continue to decrease the use of non-standard wound closure

7.0 Vaccination Programmes delivered in BCUHB 2024 - 2025

COVID-19 Vaccination Programme

COVID-19 Vaccination Spring 2024 Programme

The COVID-19 Spring 2024 Programme, which took place from 1st April to 30th June 2024, successfully administered a total of 66,919 vaccine doses to the eligible citizens of North Wales (as defined in accordance with national guidance). The programme achieved a vaccination uptake of 82% amongst eligible residents and workers in North Wales, exceeding the Welsh national average uptake of 75%. BCUHB recorded the highest volume of vaccination administered per Health Board in Wales.

By the conclusion of the COVID-19 Spring 2024 booster programme, a total of 2,325,897 of vaccinations had been administered in Wales, with 2,292,840 doses delivered in its entirety by BCUHB Vaccination Team.

The tables below illustrate the outcomes of the COVID-19 Spring Booster Programme.

BCUHB Spring Booster 2024 campaign End Figures			
	01/04/24 – 30/06/24		
	Cohort Size	**Uptake Figure**	**%**
Over 75s	57,653	46,557	81%
Immunosuppressed	15,043	12,208	81.2%
Care Home Residents	4,168	3,637	87%
Housebound	4,746	4,517	95.2%
Totals	**81,610**	**66,919**	**82.2%**

Table 1- by eligibility criteria

All-Wales Spring Booster 2024 campaign End Figures			
	01/04/24 – 30/06/24		
	Offers Made	Uptake Figure	%
Aneurin Bevan UHB	98.6%	48,611	77.1%
Betsi Cadwaladr UHB	97.7%	66,919	82.2%
Cardiff & Vale ULHB	99.6%	33,512	81.5%
Cwm Taf Morgannwg ULHB	98.9%	34,965	77.1%
Hywel Dda ULHB	54.8%	27,311	51%
Powys Teaching HB	98.3%	15,174	88.9%
Swansea Bay ULHB	98.4%	30,058	74.8%
Totals	**91.6%**	**253,993**	**75%**

Table 2 uptake figures by Health Board

The COVID-19 Spring 2025 Campaign will commence 1st April 2025 running until 30th June 2025. A total of 100,867 citizens are eligible to receive a single dose of the COVID-19 vaccine with a Welsh Government uptake target of 75%. Strategies to improve uptake include, reviewing areas with lower vaccination rates, mobilising clinics to improve equity and ease of access, issuing physical invitation letters to all eligible individuals, in line with NICE recommendations.

COVID-19 Vaccination Autumn 2024 Programme

The COVID-19 Autumn 2024/25 Programme, which ran from 1st October 2024 to 31st March 2025, administered a total of 142,583 vaccine doses to the eligible population of North Wales (as defined in accordance with national guidance).

The Autumn 2024 programme was administered by the Health Board Vaccination Team in conjunction with primary care stakeholders (GP Practices and Community Pharmacies).

The overall uptake amongst eligible citizens was 56.49% against a Welsh Government uptake target of 75%. When excluding individuals who had declined a vaccination and were recorded as ‘opted out’ or ‘suspended’ on the Welsh Immunisation System, the adjusted uptake rose to 73%. The programme recorded a Did Not Attend (DNA) rate of 41.3%

The service is aiming to improve upon the previous year’s uptake and meet or exceed this target for 2025/26.

The tables below illustrate the outcomes of the COVID-19 Autumn Programme.

Areas	Covid-19 Vaccination	
BCUHB	All Eligible	Opted-in
East	57%	69%
Centre	59%	74%
West	56%	76%

Table 1: COVID-19 Vaccination Administered per Area

LIVE Autumn 2024/25 Covid-19 Vaccines Administered as of 03/04/25										
Areas	House Bounds		Care Homes		Over 65s		Immunosuppressed		Clinically Vulnerable	
BCUHB	4,875	91%	4,121	91%	101,102	65%	11,740	54%	20,617	29%
East	1,649	100%	1,419	99%	8,870	58%	4,603	53%	8,627	29%
Centre	1,865	100%	1,558	91%	4,023	59%	3,725	57%	6,441	32%
West	1,361	89%	1,144	98%	2,581	56%	3,057	41%	4,935	25%

Table 3: COVID-19 Vaccinations Administered per area and priority group

Influenza Vaccination Programme

Please note, the reporting for national uptake is only available until the end of February. The decision was made to cease reporting influenza immunisation data earlier this year however, the final staff data will be published in the Annual Seasonal Influenza Report in the summer.

Adult

The Health Board's influenza vaccination uptake was 34.3% as of the end of February 2025 compared to the overall uptake in Wales at 33.9%.

Health Board	Patients aged 65y and older			Patients aged 6m to 64y at risk		
	Immunised (n)	Denominator (n)	Uptake (%)	Immunised (n)	Denominator (n)	Uptake (%)
Aneurin Bevan UHB	92,770	127,299	72.9	37,883	93,357	40.6
Betsi Cadwaladr UHB	125,346	171,662	73.0	47,159	104,697	40.3
Cardiff and Vale UHB	61,129	87,359	70.0	22,991	69,667	33.0
Cwm Taf Morgannwg UHB	67,448	97,257	69.4	26,452	74,796	35.4
Hywel Dda UHB	67,017	102,519	65.4	17,958	55,930	32.1
Powys Teaching HB	27,883	40,268	69.2	7,803	19,035	41.0
Swansea Bay UHB	57,873	84,432	68.5	18,770	55,695	33.7
Wales	**499,466**	**710,796**	**70.3**	**174,016**	**473,177**	**36.8**

Data source: General Practice data collected through Audit+ Data Quality System.

Table 1 Uptake of influenza immunisation in patients aged 65y and older and in those aged 6m to 64y at clinical risk (Data is correct as of 25/03/2025).

Children

The final uptake of the nasal flu vaccine in the school programme for North Wales is 57%. Primary Care Schools reported an uptake of 63% and Secondary Schools reported a 50% uptake.

Staff

As of the end of February the Health Board's influenza uptake was 34.4% compared to the overall uptake in Wales of 33.9%. When comparing the staff flu programme for 2023/24 and 2024/25, there has been a slight improvement in uptake this year. Due to WIS data loss issues reported to Cadan, approximately 900 vaccinated staff details have been lost. This issue is still under investigation and remains unresolved. The tables below illustrate the outcomes of the staff flu vaccination programme.

	2023/24	2024/25
Total given to employees	6,914	7,156
Percentage overall	33.6%	34.4%
Total vaccines given overall	9,000	9,595

Table 1: Total number of Influenza vaccine administered in 2023/24 and 2024/*25*

Health Board	Total Staff			Staff with direct patient contact[1]		
	Immunised (n)	Denominator (n)	Uptake (%)	Immunised (n)	Denominator (n)	Uptake (%)
Aneurin Bevan UHB	5670	15196	37.3	3891	10399	37.4
Betsi Cadwaladr UHB[5]	7138	20782	34.3	5094	14567	35.0
Cardiff and Vale UHB[5]	6143	17426	35.3	4294	12356	34.8
Cwm Taf Morgannwg UHB	4441	12892	34.4	2975	8785	33.9
Hywel Dda UHB	3630	12161	29.8	2553	8322	30.7
Powys Teaching HB[3]	858	2224	38.6	469	1402	33.5
Swansea Bay UHB	4851	14733	32.9	3338	10143	32.9
Velindre NHS Trust	968	1863	52.0	533	940	56.7
Welsh Ambulance Service NHS Trust	1285	4442	28.9	-	-	-
Public Health Wales NHS Trust[2]	395	2614	15.1	338	1473	22.9
Wales	35379	104333	33.9	23485	68387	34.3

[1] Combined figures for: Additional Prof Scientific and Technical, Additional Clinical Services, Allied Health Professionals, Medical and Dental, Nursing & Midwifery Registered staff groups.

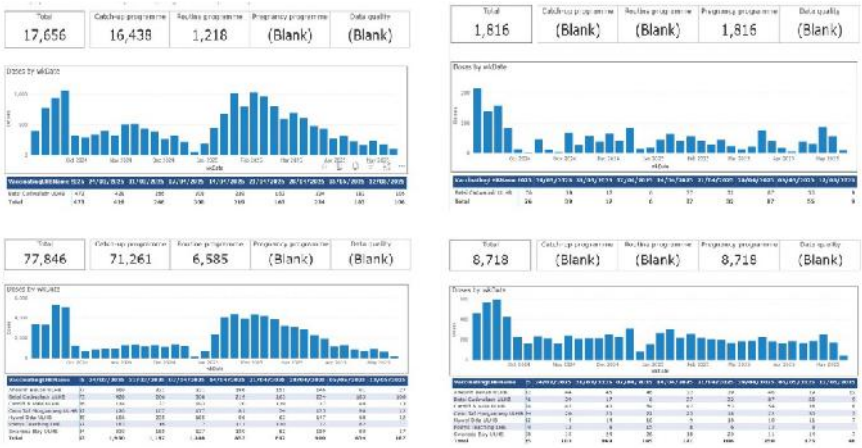
- Public Health Wales figures do not currently include staff vaccinated by health boards under service level agreements and will underestimate coverage.

** Data for Betsi Cadwaladr UHB, Cardiff & Vale UHB and Powys Teaching HB are until end of January 2025.*

Table 2: Uptake of staff influenza immunisation by Welsh Health Board (Data correct as of 31/03/2025)

Respiratory Syncytial Virus (RSV) Vaccination Campaign (RSV)

The RSV vaccination campaign was introduced on 1st September 2024. GP surgeries continue delivering the RSV older adult programme for those turning 75 years of age.



RSV Uptake Data for Maternal and Older Adults Programmes (National and BCUHB, as of 12/05/25).

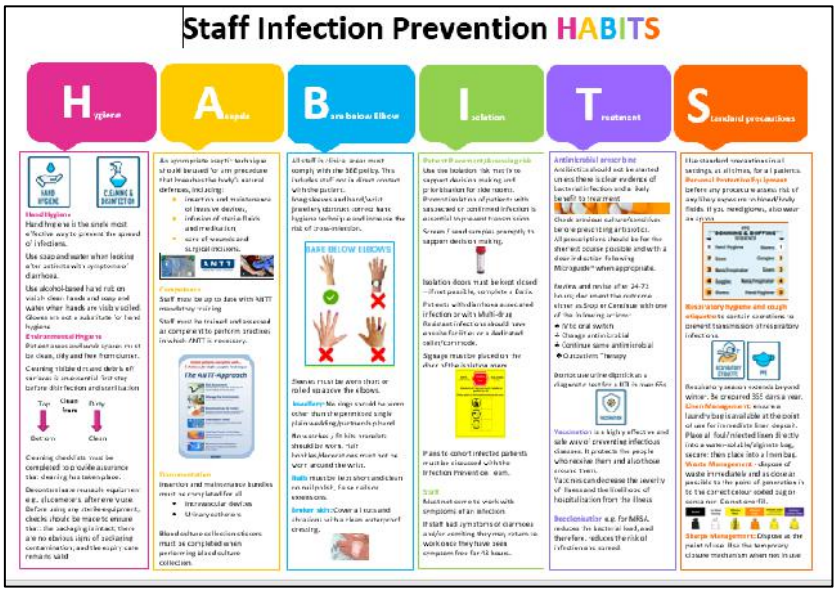
Winter Respiratory Vaccination Planning 2025/2026 (COVID-19 Vaccination and Flu Vaccination)
Progress has been made in developing and implementing a more effective and efficient integrated cluster working model with primary care stakeholders. This initiative is continuing, emphasising a cluster approach to the Winter Respiratory Vaccine Framework, prioritising the co-delivery of COVID-19 and Flu vaccinations. This effort supports the local implementation of the National Immunisation Framework.

8.0 Education and Training in Infection Prevention and Control

8.1 Infection Prevention Campaigns and Awareness Events

HABITS Campaign 2024

The IPT continued to lead on the BCUHB-wide Infection Prevention HABITS campaign (launched February 2024) which included other national campaigns and initiatives weaving through it. The staff focussed 'Phase 1 of the HABITS campaign' promoted the basic principles of IP encouraging staff to 'get into the HABIT' of practicing these principles at all times, with a different letter from the mnemonic HABITS featuring bi-monthly.

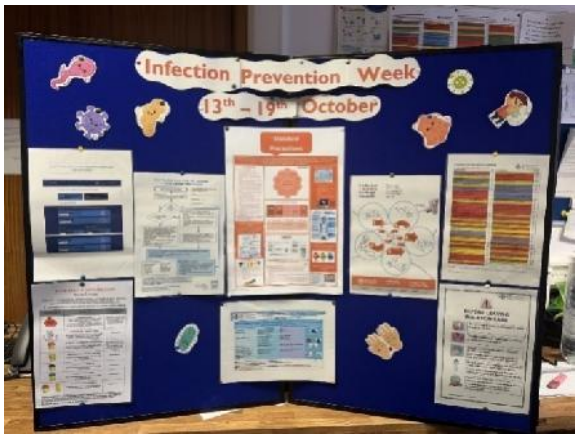


During June 2024, the IPT promoted good practices in isolation as part of the "I" for Isolation HABITS Campaign. The BCUHB Isolation Matrix, Standard Operating Procedure and Isolation posters were promoted along with ward and scenario based interactive training.

In August 2024, as part of the "T" for Treatment HABITS Campaign, PHW Consultant Microbiologist Dr Silvia Murray gave an insightful presentation to new junior doctors

about the impact on antimicrobial resistance (AMR) and anticipated 10 million deaths by 2050.

October 2024 saw the promotion of the “S” for Standard Precautions HABITS Campaign which also coincided with International Infection Prevention Week 2024. The IPT delivered a BCUHB-wide campaign which focused on best practice relating specifically to personal protective equipment, waste and linen management, respiratory and cough etiquette, hand hygiene, sharps safety, and occupational exposure management and prevention. The IPT undertook promotional activities, such as campaign stands, trolley dashes and quizzes and games.



After completing the full cycle of the Phase 1 HABITS Campaign in November 2024, the second cycle commenced with “H” for Hand Hygiene featuring again during January - March 2025.

Phase 2 of the HABITS Campaign will be launched within BCUHB during 2025/26 focusing on patient/public messaging both inside and outside of the healthcare premises. Key strategies that will be employed include the delivery of an extensive poster campaign throughout the Health Boards healthcare facilities, such as within elevators, corridors and public toilets. Furthermore, key messaging/photographs from prominent individuals will be displayed throughout the organisation. Additional initiatives include engagement with children by the launch of a hand hygiene poster competition within the children’s wards, use of media/ social media platforms to support key messaging and utilising QR codes on patient appointment letters for

patients attending for planned admission which links to HABITS information, videos and guidance.

The IPT are currently exploring the feasibility of the adoption of the HABITS Campaign as an All-Wales approach along with an application for funding via Welsh Government to support the extension of the HABITS Campaign to include a more patient/public focus (phase 2) nationally.

World Hand Hygiene Day May 2024

BCUHB participated in the World Health Organisation (WHO) Save Lives: Clean Your Hands campaign which promotes a global profile on the importance of hand hygiene within health care. The IPT used the event to reinforce excellent practices in hand hygiene amongst ward/department-based staff, reminding staff to be 'bare below the elbows' and used the UV lightbox to support staff to wash their hands more effectively. In addition, an audit of patient hand hygiene was undertaken and recommendations instigated to support good hand hygiene practices amongst our patients.

International Sharps Injury Prevention Awareness Month was the focus for December

During December, results of the Sharps Bin Audit undertaken within the acute hospitals and a number of community sites was shared, highlighting the need for improvements regarding the 'Temporary Closure' and signing and dating bins accurately. Sharps safety posters were disseminated to support staff re-education. Data on sharps injuries is reported to SIPG on a monthly basis and key issues and/or trends acted upon. To further drive forward improvements, during 2025/26 the IPT will support Occupational Health & Wellbeing Service to develop a specific improvement plan and a joint Infection Prevention/Occupational Health & Wellbeing group will be formed.

'Message of the Moment'

Throughout 2024/25, key messaging using 'Message of the Moment' educational posters have been issued BCUHB-wide to support staff in addressing lessons learnt from HCAI post infection reviews, audits, and IPT observations of practice within wards/departments. Topics included CPE screening, personal protective equipment, and MRSA screening.

Ward/Department Declutter Campaign May 2024

As part of the "H" for Hygiene HABITS Campaign during May 2024, the Infection Prevention Team launched a competition to establish which wards/departments were the tidiest and clutter free. Keeping our wards and departments clutter-free is crucial to ensure that our patients feel cared for in an organised, clean and tidy environment, whilst supporting our domestic services colleagues to maintain good standards of environmental cleanliness.

The IPT were pleased to announce that Fynnon A Holywell Community Hospital and Ward 5 YGC were amongst some of the winners.

8.2 Compliance with Mandatory Infection Prevention Training

Competency Name	Infection Prevention and Control Level 1 - 3 Yearly	Infection Prevention and Control Level 2 - 3 Annual	Aseptic Non-Touch Technique - 3 Yearly*
Staff Group			
Medical and Dental	64.6%	59.12%	68.97%
Nursing & Midwifery Registered	88.27%	83.7%	85.26%
Additional Clinical Services (Non-Nursing)	89.52%	82.82%	81.98%
Additional Clinical Services (Nursing)	89.81%	85.94%	85.45%
Allied Health Professionals	88.18%	82.73%	83.13%
Add Prof Scientific & Technic	81.3%	75.36%	78.08%
Healthcare Scientists	85.34%	79.06%	63.94%
Estates & Ancillary	91.37%	76.05%	N/A
Administrative & Clerical	87.96%	N/A	N/A
Students	95%	90%	90%

Training levels amongst medical staff remains low despite being highlighted at various forums.

Donning and doffing of PPE is included as part of the IP mandatory training and not reported separately.

Two individuals, nominated by the IHC's attended a 'train the trainer' education session hosted by Sheffield University approved by Public Health Wales on Enhanced PPE ensemble for High consequence infectious diseases (HCIDs). Throughout 2025/26, the individuals will be responsible for training a limited number of 'super users' within high risk/front door areas that will disseminate HCID PPE training within their area.

8.3 Aseptic Non-Touch Technique Training

Aseptic Non-Touch Technique (ANTT) is a core clinical skill used to minimise the risk of HCAI by the use of a defined set of six principles to maintain an aseptic field and protecting key parts during common clinical procedures such as intravenous line maintenance, peripheral intravenous cannulation and wound management. All staff

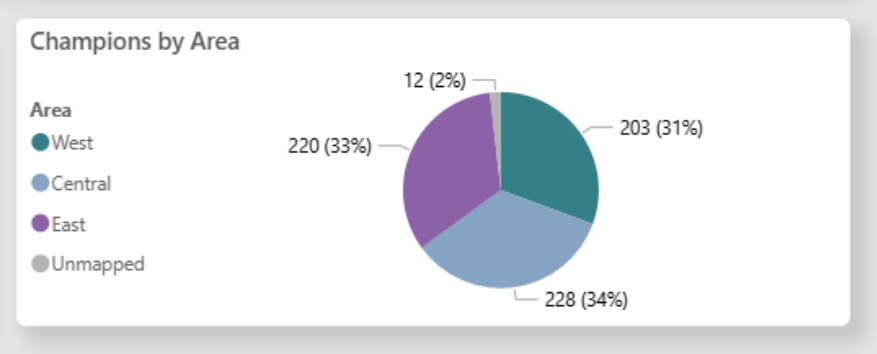
who perform invasive and non-invasive clinical procedures, from major surgery to care in the community, including the maintenance of indwelling medical devices must undergo ANTT training.

ANTT training consists of an online theory course (recorded on ESR) and practical competency assessment (not currently recorded on ESR). In line with All Wales recommendations, BCUHB's ANTT Framework utilises a 'Key Trainer' and 'Key Assessor' model to cascade train those staff that require it.

A pan BCUHB ANTT task and finish group, that reports to SIPG, was established February 2025 to address identified issues and implement actions in relation to amending the frequency of training from 3 yearly* to 2 yearly (as agreed at SIPG), utilisation of ESR for the recording of practical ANTT competency, and development of a more robust directory of 'Key Trainer' and 'Key Assessor' across staff disciplines. Work will continue throughout FY 2025/26 to further strengthen ANTT compliance within BCUHB.

8.4 Infection Prevention Champions

The IPT have trained 650 IP Champions across 663 areas across BCUHB. The IP Champions programme has now also been extended to Care Homes and Managed GP practices. This is an increase from 550 IP Champions in 2023/24.



Fortnightly drop-in sessions continue to be held via Teams with IPT members enabling them to ask questions and seek further support, in addition to the delivery of ad-hoc sessions on current topical issues, e.g., Mpox, HABITS, environmental cleanliness.

It is acknowledged that as staff move roles inside and outside of BCUHB, the IP Champions membership will be outdated. To address this, the IPT will perform a membership data cleansing exercise every 6 months to ensure it remains current and up to date.

8.5 Ad hoc Infection Prevention Training Sessions

Throughout 2024/25 the local IPTs delivered a wide range of teaching sessions between them including:

- MRSA screening
- CPE

- Norovirus
- Multi-drug resistant *E.coli*
- Mpox/High Consequence Infectious Diseases (HCID)
- Stream/right patient right place
- Use of Isolation Matrix and SOP
- ANTT Assessor training
- Intravenous access insertion, maintenance and ANTT
- Hand hygiene
- Personal protective equipment (PPE)
- Relaunch of the urinary catheter passport
- All aspects of the HABITS campaign
- Delivery of education sessions relating to topical issues at Harm Free Care (East/Central) and Health Board days (West)
- Grand Round presentations
- Infection prevention refresher sessions for designated departments, e.g., Womens services, Theatres
- Infection prevention refresher sessions for Practice Development Nurses
- Infection prevention refresher for healthcare support workers (HCSW)
- Basics of infection prevention for student nurses on induction
- Basics of infection prevention for work experience students
- Infection prevention for junior doctors
- Infection prevention for medical students (year 3)
- Infection prevention for biomedical scientists (year 2)
- Infection prevention for neurophysiology students
- Dynamic mattress decontamination in conjunction with company representatives

In addition to formal ad-hoc training sessions, the IPT utilised opportunities to deliver education at meetings and forums when participating in or presenting learning from post infection reviews, audit reports and IHC Learning Reviews.

8.6 Executive Director of Nursing and Midwifery Professional Seminars and Conference

The IPT delivered informative presentations at the Executive Director of Nursing and Midwifery's Professional Seminars. 'Bouncing Back from the Pandemic: BCUHB Resilience in Infection Prevention' examined the challenges of infection prevention and HCAI performance over changing landscapes, including antimicrobial resistance, the pre and post COVID-19 era and implications of High Consequence Infectious Diseases (HCID). The interactive session considered how we respond to new infection prevention challenges whilst maintaining excellent practice as we continue 'business as usual'.

The IPT was invited to promote IPT practices during the Nursing and Midwifery Conference in May 2024. An interactive display stand was utilised to showcase innovative IP related initiatives including adenosine triphosphate (ATP) hygiene monitoring which assesses the performance of a cleaning process beyond visible means providing a scientific measure of total cleanliness.

8.7 Infection Prevention Massive Open Online Course

Infection Prevention Massive Open Online Course (MOOC) is an online programme run by Bangor University over eight weeks. The course aims to provide enhanced infection prevention knowledge, understanding and application aimed at registered practitioners and senior level staff in supervisory roles who are responsible for ensuring compliance with good IP practice e.g., ward and departmental clinical managers.

The majority of Band 4-7 members of the IPT have completed the MOOC with the exception of those individuals currently studying at a more advanced level or new staff members (where completion has been included as a personal objective within their PADR).

Whilst attempts have been made to obtain figures for non-IPT staff groups within BCUHB that have completed the MOOC, it has not been possible to source these.

Planned activity for 2025/26

- Development of a programme of IPC education in the form of microteaching for clinical staff
- Development of a guidance sheet for pharmacists on how to maintain infection prevention practices in community pharmacists
- Plan and facilitate an IPC study day on one day across each site
- Launch an innovative Infection Prevention Induction Booklet for new starters
- Consider the implementation of ANTT Accreditation across the clinical areas
- Introduction of Decontamination Champions in areas responsible for decontamination of medical devices.
- Embed and encourage use of the Behavioural Science tool within the IPT

9.0 Education and Support in Social Care/Care Homes

The North Wales response to preventing, containing and managing the spread of infectious diseases in care homes and other closed care settings continues to be, multi-agency and multi-disciplinary.

Key Achievements:

- The Quality Development Team have developed and updated the Clinical Quality Support Tools (CQSTs) for IP control and management for all care homes across North Wales. This Clinical Quality Development Tool is now being used by both our BCU Health Protection Services and CHC Practice Development Nurses across North Wales for both Nursing and residential care homes.
- The Operational implementation has now been transferred over to the BCUHB Health Protection services who are carrying out proactive visits and offering support to residential care homes and Domiciliary care services across North Wales.
- The new IPC Resource packs for all care homes and Domiciliary care services have been developed by BCU Health Protection Services to ensure

that the care homes have up to date guidance and evidenced based practice.

- The COVID-19 vaccination programme is ongoing and delivered by our BCUHB COVID Vaccination teams. They continue to offer an in-house service for both staff and residents within the health and social care sector. Accessing vaccinations for staff and residents in care homes was much improved with good uptake and minimal delays experienced. This is currently continuing for our spring and autumn booster campaigns for social care.
- The flu campaign programme for 2024/2025 has now been completed and the quality development team are working closely with the community pharmacy teams looking at lessons learnt and currently remain the highest in Wales for administration of flu vaccinations for social care staff across Wales.

Health Board	Social Care Staff			
	Domiciliary Carers	Carers in a Care Home	Unpaid Carers	Total
Aneurin Bevan UHB	141	144	749	1,034
Betsi Cadwaladr UHB	196	1,088	1,204	2,488
Cardiff & Vale UHB	77	226	635	938
Cwm Taf UHB	176	112	874	1,162
Hywel Dda UHB	59	109	512	680
Powys Teaching HB	40	53	145	238
Swansea Bay UHB	72	117	712	901
Wales	**761**	**1,849**	**4,831**	**7,441**

- Build on improving Flu Vaccination uptake in care homes across North Wales by re-evaluating the 2024/2025 flu campaign. Flu Campaign Webinars for All Nursing and Residential Care Homes and Domiciliary Care are currently being arranged to support 2025-2026 campaign following lessons learnt and promoted the importance of having the Flu and COVID-19 vaccines and ultimately increase the Flu vaccine uptake within the care homes.
- The Quality Development team also promoted the flu campaign by holding three educational webinars for care home managers and clinical leads in July, and working very closely with COVID-19 vaccination colleagues to deliver this across north Wales for social care.
- The Quality Development Team will continue to promote the eLearning Flu/COVID-19 1 module and send the most up to date NICE guidance with the specific recommendation for health and social care staff (Quality statement 4: Vaccinating health and social care staff | Flu vaccination: increasing uptake | Quality standards | NICE) for information in line with the Welsh health circular for 2025/2026 flu campaign.
- The Quality Development Team have developed a monthly Provider briefing for care homes across North Wales, where we have a dedicated section for IP under the BCU Health Protection team heading to share evidenced based practice, this was greatly enhanced when information from local and national guidance changed.
- Scabies information has been provided to ensure care home staff were aware of scabies outbreaks and information on who to contact.

- IP training for care homes across North Wales has been re-focused following a scoping exercise to ensure we have equitable training. Further work is required with our partners e.g., nursing homes to support them with IP education programmes to implement the safe clean care campaign in care homes.
- The BCUHB Quality Development Team have also worked in partnership with PHW to promote IPC webinars which have been held over 2024/2025 as well as promoting the eLearning links on their website. This is shared with our local authority members of staff as part of our quality assurance framework training and education group which is held monthly.
- The Quality Development Team are working closely with the all Wales IPC leads to review Infection prevention e-learning modules for social care and will promote when released on PHW website for 2025/2026.

Planned activity for 25/26

- Re-Launch of the catheter passport to help improve urinary catheter care for care homes.
- Develop and link in with our BCUHB Antimicrobial Stewardship Nurse to develop webinars around Improving the timely diagnosis and appropriate treatment of urinary tract infections in Nursing Homes which includes, Prevention is better than cure, 'SKIP the DIP' and a better understanding around urine sampling for residents living in a care home or their own home.
- Working alongside the BCUHB Antimicrobial Stewardship Nurse to support the launch of the Care Home UTI assessment tool
- Delivery of ANTT training, supported by Practice Development Nurses, using eLearning element on the all Wales eLearning platform and the 'train the trainer' approach for completing competencies within the care home.
- Further work is required with our partners to support with IP education programmes to implement the HABITS campaign in replace of Safe Clean Care in our Nursing homes.
- Working alongside national groups to support care homes with Peer-to-Peer vaccinations for Nursing homes across North Wales in 2026 to support with IP/Cold Chain will need to be considered.
- Continue to work alongside the BCUHB Health Protection services and CHC Practice development teams in order to reflect evidence based practice when annually reviewing the BCU Clinical Quality Support tools used in our care homes across North Wales.

10.0 Infection Prevention and Control Team Audits

The IPT completed and reported on a significant number of proactive and reactive audits of practice and the environment in 2024/25. Several were also strengthened to ensure they were in line with national standards.

The IPT have delivered a regular proactive audit programme throughout 2024/2025 auditing staff hand hygiene monthly, commode cleanliness (and practices associated with cleaning of a commode) every other month and mattress and pressure relieving cushion audits quarterly.

All audit data is submitted into the IRIS system by the IPT, with ward level staff and senior managers able to access the system/dashboard to extrapolate their own results/reports.

Staff Hand Hygiene

Average Score

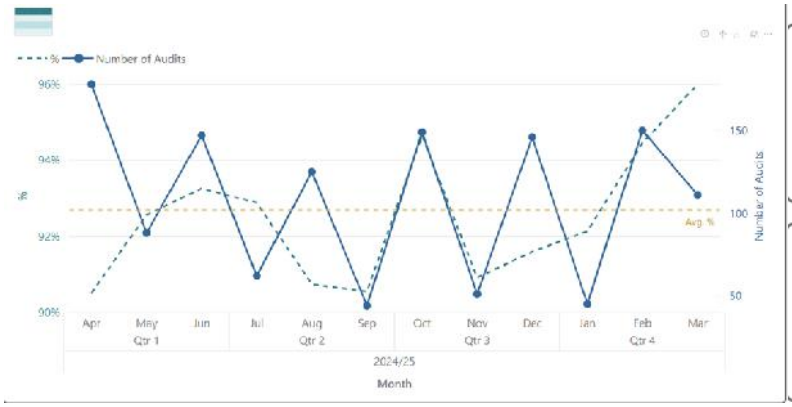
83%

Number of Audits

2,233

- 88% of staff were observed to perform hand hygiene when the opportinuty arose (i.e. in line with the WHO 5 Moments for Hand Hygiene)
- 97% were observed to decontaminate all areas of their hands in line with the six step process.
- 8 observations answered NO to ‘skin covered with a waterproof dressing’ if required.
- 98% of staff used the most appropriate product for hand hygiene.
- 94% of staff were observed to be ‘bare below the elbow’.

Commodes



Average Score

93%

Number of Audits

1,296

Observe 3 Staff:

Question	Total no. Staff	Yes	No
Are staff wearing a clean apron and gloves for the decontamination procedure?	409	393 (96.1%)	16 (3.9%)
Are commodes and bedpan holders decontaminated in area away from clean equipment?	656	643 (98%)	13 (2%)

Is hand hygiene completed before and after decontamination of commode or bedpan holder?	408	400 (98%)	8 (2%)
Do staff demonstrate the correct decontamination procedure in line with BCUHB standard?	471	434 (92.1%)	37 (7.9%)

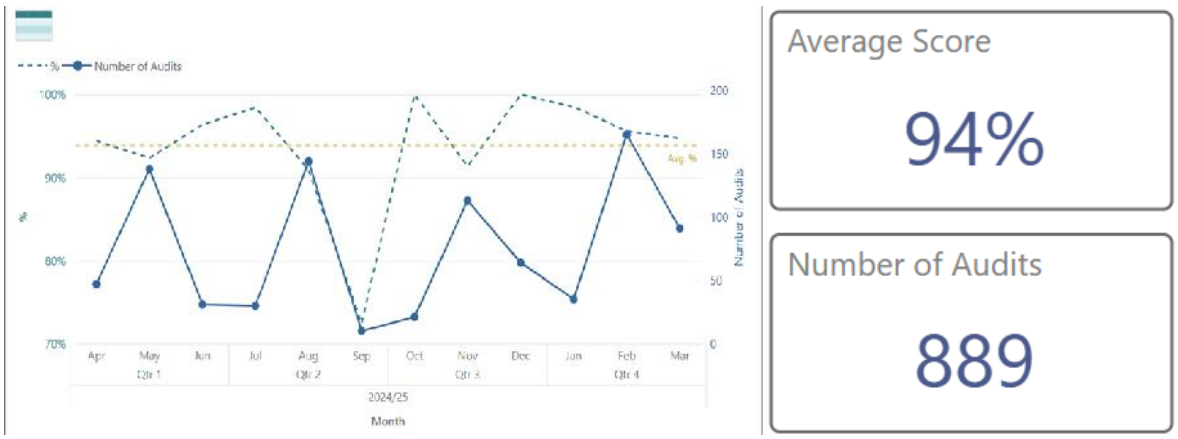
Observation of Area:

Question	Total no. Staff	Yes	No
Is there access to disinfectant wipes or Actichlor plus, warm water, and correct waste disposal (orange bags)?	1269	1259 (99.2%)	10 (0.8%)

Observe all Commodes:

Question	Total no. Staff	Yes	No
Are commodes in a good state of repair (free from rust/scratches)?	2418	2385 (98.6%)	33 (1.4%)
Are stored commodes labelled as clean with indicator tape labelled correctly?2415	2415	2195 (90.9%)	220 (9.1%)
Are stored commodes visibly clean?	7253	6734 (92.8%)	519 (7.2.%)

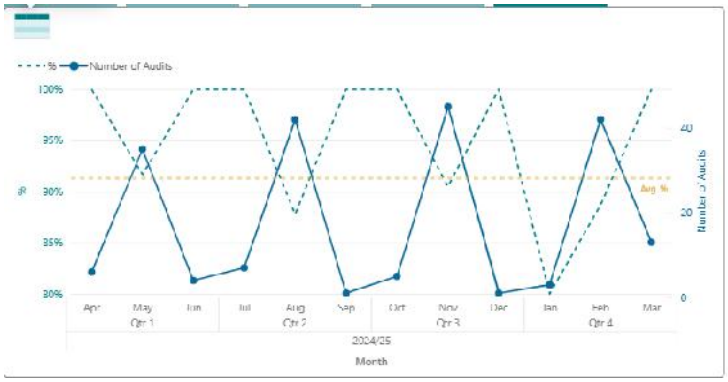
Mattress Audit



- 23 mattresses were observed to have a breach in integrity to the outer cover.
- 43 mattresses were observed to have staining on the outer cover that could not be removed with cleaning.
- 4 mattresses with removable covers were observed to have a compromised fastening e.g., broken zip.
- 69 mattresses were observed to have signs of staining, ingress of fluid or malodour inside.

- 3 mattresses with non-removal mattress covers e.g., no zip, failed the water penetration test.

Pressure Relieving Cushions



- Total of 8 pressure relieving cushion covers were observed to have a breach in integrity to the outer cover.

The table below shows a summary of other proactive audits performed but are not available via the electronic quality dashboard.

Audit	Date	Key findings
Catheter associated urinary tract infection (CAUTI)	July 2024 and Jan 2025	• July 24 - 14.4.% of patients had a urinary catheter • 5.2% of them had a CAUTI • Jan 25 - 15.5.% of patients had a urinary catheter 4.2% them had a CAUTI • Whilst an ongoing reduction in CAUTI rates is demonstrated, there is a need to reinforce the HOUDINI principles and embed daily reviews of the need for a urinary catheter • To repeat the audit in July 2025
Patient hand hygiene audit	May 2024 Oct 2024	• Compliance improved in the East in Oct 2024 compared to May 2024 • There were missed opportunities for patients to be supported with hand hygiene and offered hand wipes
Hand hygiene by staff group	Feb 2025	Pan BCUHB hand hygiene by staff group compliance: 189 Staff audited Nursing total - 78 Medical total - 67 AHP's (Allied Healthcare Professionals) total - 20 Estates & facilities total - 7

		Other - 17 Compliance amongst staff groups: • Nursing 79% compliance • Medical 30 % compliance • AHP's 80% compliance • Estates & facilities 15% compliance • Other 41% compliance The most commonly missed opportunity to undertake hand hygiene was after patient contact and after contact with the patient's immediate environment. Repeat August due 2025
Peripheral vascular devices audit	May 2024 Nov 2024 and Jan 25	• An increase in the number of peripheral vascular devices at any one time was observed compared to the previous year where 33% of patients had one or more devices. There were 60% in May 2024 and 62% in January 2025. • Improved compliance with device management was observed by Jan 2025 with each IHC. However only marginal improvements identified in the West. • There is a plan to bring local learning from these audits to do some further improvement work through the development of a post audit report for wards and departments
Compliance with MRSA screening	Dec 24-Jan 25	• Increased compliance identified since Oct 2023 • Further focused is required on all aspects of screening criteria in particular with wound screening compliance.
Bristol Stool chart audit	June 2024 Dec 2024	• Overall compliance improved from 70% in June 2024 to 85% December 2024. • With only a marginal increasing in compliance in Central • Some areas within the East IHC still using paper versions of the charts as opposed to the Welsh Nursing Care Record
Audit of sharps bins and macerators/commodes in sluices	Sept 2024 Daniel Healthcare	• Lack of use of the temporary closure mechanism • Signature and date of assembled sharps boxes **Good practice:** • Correct display of sharps safety posters

		• Staff knowledge of 'what to do in the event of need stick injury' **Commodes** • Failures noted due to damaged areas **Macerators** • Most in good working order • Mostly manual operated not touchless • Recommendations given re those identified as damaged to be replaced
Flushing of little-used water outlets	July 2024 Jan 2025	• Compliance with flushing of infrequently used outlets in line with the SOP demonstrated no significant improvement or decrease in compliance • July 2024- 84% compliance with a total number of infrequently used outlets of 168 • Jan 2025- 83% compliance with a total number of infrequently used outlets of 137 • Improvement identified with the review of infrequently used water outlets and permanent removal of the outlets by estates teams
Personal protective equipment audit	September 2024 March 2025	• A total of 72 areas and 191 observations made across BCUHB with an overall compliance of 67% • A total of 114 areas and 339 observations made across BCUHB with an overall compliance of 91% • Despite improvements with overall PPE compliance in March 2025 compared to September 2024 a common theme emerged, this being the underuse of PPE.

Full Ward/Departmental Audits
Each year, the IPT are required to perform a full ward/departmental audit in all inpatient areas and high-risk departments to include emergency department, theatres, endoscopy, radiology, Urology Day units, renal dialysis and outpatient oncology services.

The audit pays particular attention to the environment and compliance scores are as follows:

- 90% - 100% is green with a full audit scheduled for the following year
- 79% - 89% is amber with a repeat audit scheduled in 6 months

- ≤78% is red requiring a repeat audit within one month

East	Number of areas	No. of audits completed	Green	Amber	Red	No. reaudited (Red and Amber)	No. improved to green
Inpatient	44	37	15	11	11	11	3
High Risk	7	7	3	4	0	1	1
Outpatient (inc HMP) Including MIU's/IV suite/ UDU's	37	18	7	3	8	4	4
BCU Manged practices	13	3	0	0	3	0	0
Central	**Number of areas**	**No. of audits**	**Green**	**Amber**	**Red**	**No. reaudited (Red and Amber)**	**Improved to green**
Inpatient	44	42	28	19	4	18	2
High Risk	13	11	6	7	0	6	2
Outpatient Including MIU's/IV suite/ UDU's	29	26	16	6	4	10	1
BCU managed practices	2	2	0	1	1	7	Due May 2025
West	**Number of areas**	**No. of audits**	**Green**	**Amber**	**Red**	**No. reaudited (Red and Amber)**	**Improved to green**
Inpatient	37	37	2	18	17	19	11
High Risk	11	11	4	5	2	4	3
Outpatient Including MIU's/IV suite/ UDU's	11	4	2	1	1	Due to be repeated in May '25	Due to be repeated in May '25

BCU Managed Practices	4	0	N/A	N/A	N/A	N/A	N/A

11.0 Estates

11.1 Water

The management arrangements for Water Safety Systems within BCUHB are contained within ES02 Policy for the management of Safe Water Systems which is published on BetsiNet.
Guidance on the management arrangements is contained within Welsh Health Technical Memorandum (WHTM 04-01) and HSG274.

During 2024-2025 the Water Safety Group (WSG) reviewed a number of key documents to support the safe use of water systems at department level, the documents are available on the BCUHB BetsiNet site:

- ES02 Policy for the management of Safe Water Systems
- Standard Operating Procedure (SOP) for Management of Little Used Outlets
- Standard Operating Procedure (SOP) for Management of Pseudomonas (Operational Estates)
- Training document for Ward level staff on management of water safety

NHS Wales Shared Services, Special Estates Services Authorising Engineer (Water) Annual Report
The Authorising Engineer is appointed by the Deputy Duty Holder (Director of Environment and Estates) and is a named representative of the NWSSP Specialist Estates Services Team. They conduct an annual review/audit of operational procedures and compliance and submit a report to the WSG. The report for 2024-2025 reported a compliance rating of Green, which maintains the standards set out during the previous year.

2023	2024
Performance of Water safety Compliance Contractor has been maintained. **WSG meetings held regularly and good attendance from members.** **1 Site Audit completed.** **2 DRP Assessments completed.**	**Performance of Water safety Compliance Contractor has been maintained.** **WSG meetings held regularly and good attendance from members.** **1 Site Audit completed.** **1 DRP Assessments completed.**
	
Green	**Green**

A key document that was developed following the internal audit review was the development of a BCUHB Water Safety Training Programme for non-estates staff, the content of the programme has been approved by both the WSG and SIPG and is currently being mobilised across the Health Board.

11.2 Ventilation

BCUHB acknowledges its responsibilities under the Health and Safety at Work Act 1974 and supporting legislation relevant to this discipline, (including The Control of Substances Hazardous to Health (COSHH) Regulations 2000 and subsequent approved codes of practice such as L8 and published guidance documentation such as Health Technical Memorandum (HTM) 03-01 Specialised Ventilation Systems for Healthcare Premises and HTM 04-01, The Control of Legionella), to ensure that it meets the criteria and standards for Ventilation Systems within its control.

The ES05 Policy for the Management of Ventilation Systems was developed to ensure compliance with existing legislation, helping ensure that good practice standards are applied to all ventilation systems in use within the organisation. The policy is published on BetsiNet.

During 2024-25, the Ventilation Safety Group has supported redevelopment projects and reviewed information on verification of critical ventilation systems and this includes a review of isolation rooms within the SuRNICC at Ysbyty Glan Clwyd, which is being modified from being a Positive Pressure Ventilated Lobby (PPVL) to a Negative Pressure (NP) facility. This work is currently being tendered.

NHS Wales Shared Services, Special Estates Services – Authorising Engineer (Ventilation) Annual Report

The Authorising Engineer, Ventilation is and has been appointed by the Deputy Duty Holder (Director of Environment and Estates) and is a named representative of the NWSSP, Specialist Estates Services team.

11.3 Waste Management

Environmental & Waste Training

ISO 14001:2015 Standard places more emphasis on training and competency of any persons that can have an impact on the Environmental Management System.

The bespoke e-training package for waste and environmental management has been implemented across the Health Board onto the eLearning platform and is a mandatory part of staff training. Compliance across the Health Board as of March 2025 overall compliance average is 91.4%

Corporate Environmental Objectives Programme

The Environmental Objectives Programme were approved for 2022 to 2025. Environmental objectives helped with demonstrating continual improvement and meet the requirements of our Environmental Management System and the Decarbonisation Action Plan. These objectives will be reviewed in 2025/2026.

Waste Management

The Welsh Government waste/recycling code of practice came into force on 6th April 2024 for business, public and third sector organisations in Wales. The

implementation of segregating and recycling at source in all Community Hospitals, Health Centres, administration buildings, GP practices and Community dental practices was completed within 2024/2025. Environment Officers have worked with the current waste contractor to ensure a smooth transition.

Implementation of segregation and recycling at source within the 3 Acute Hospitals will be a challenge for the Health Board to achieve by April 2026 due to the below constraints.

- No capacity at ward level for extra bins
- No resources or funding for the additional collections or bins/skips
- A considerable additional cost to BCUHB to initially set up
- Lack of capacity in the waste compounds for additional skips

11.4 Environmental Improvement Works

The Operational Estates Department within BCUHB received £150,000 discretionary capital funding in 2024/2025 to improve the hospital environment. The projects were presented to each LIPG for approval.

Operational Estates completed the below projects to a total value of £110,049. During the year, Operational Estates experienced difficulty with completing projects to the allocated budget, this was due to the unavailability of decant facilities and pressures within clinical areas to release space.

Projects completed are listed below:

SCC - West	
Community- Eryri Padarn clean utility upgrade	£21,459
MHLDS - Mesen Fach Kitchen	£15,025
YG - St David OPD	£11,010
SCC - East	
Brynteg clinic upgrade	£27,000
SCBU IPS Panel	£5,994
Childrens OPD clinical room	£7,549
Cardiology Flooring	£6,200
Cunliffe Ward storage Sluice	£6,611
Pantomime Ward storage Sluice	£9,201

Examples of some of the improvements are illustrated below.

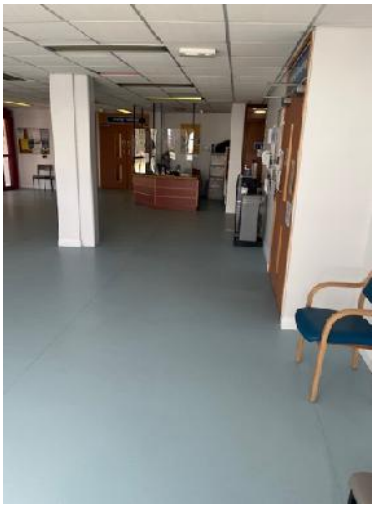
Eryri, Padarn Ward Clean Utility

All non-clinical wall and base units removed and replaced with Sterling Medical clinical units and worktops, new clinical free standing storage units, new CD cupboard and décor (IT cable in containment and floor now cleaned, boxing closed up)



Ysbyty Gwynedd, St David's OPD new flooring décor and blinds





Bryn y Neuadd Mesen Fach Patients Kitchen New cabinets, flooring decoration and oven



11.5 Risk Register
A number of IP related risks are part of the Operational Estates Risk Register; they are reviewed regularly. Specific elements included are ventilation and control of contractors.

12.0 Facilities
Changes to Operational Facilities Structures
2024/2025 saw Operational Facilities processes mature under closer working relationships with IHC leadership teams under the new Stronger Together Structure. However, as a look forward to 2025/2026, with the recruitment of a new Director of the Environment, the previous re-structuring may be reversed in late summer 2025 with executive discussions underway to potentially realign Operational Facilities from IHCs to the Environment directorate, which will also include Operational Estates and Planning and Health & Safety.

12.1 Management Arrangements

Operational Facilities provide Domestic Services, Catering and Portering Services across the Health Board. Operational Facilities serve 3 geographical areas that align to the three IHCs East, Centre and West. The Heads of each Operational Facilities Team work closely with the IHC leadership with Managers from the Domestic Service maintaining regular contact with their IHCs and IPT.

All Health Board staff have a responsibility for the cleaning and maintenance of their workplace and have a role to play in providing continuous improvement in environmental cleanliness. Environmental cleanliness is imperative for the prevention of the spread of infection and patient safety and overall quality of the patient's experience.

12.2 Refresh of National Standards for Cleaning
An All Wales Task and Finish Group was set up in early 2023 to review and update the National Standards for Cleaning in NHS Wales (2009) document. This work is led by the HCAI Delivery Board on behalf of Welsh Government. BCUHB had representatives on the task and finish group: Deputy Director of Nursing Infection Prevention and Decontamination and Head of Facilities for IHC East. As anticipated, the Standards comprises of 10 separate standards in similar format to the All Wales Covid 19 Addendum Key Standards for Environmental Cleanliness (published September 2020) and the National Standards for Cleaning in Wales – ADDENDUM - Key Standards for Environmental Cleanliness (published in December 2021).
Failure to provide effective cleanliness services in compliance with robust National Standards of Cleanliness across the NHS in Wales increases the risk of exposure to HCAI's at substantial cost and patient harm. There is a recommendation to review current strategies and proactively aim at improving environmental cleanliness as a patient safety initiative.
The Board are awaiting final publication of the refreshed Standards and a task and finish group is being convened to assess their impact.

12.3 Reduced COVID-19 addendum funding
In December 2023 the Heads of Facilities undertook a piece of work to identify the additional funding which was required to bring Domestic services in line with the

frequencies that were expected to be contained in the refreshed National Standards, and this was presented in an SBAR. The recommendations made within this SBAR have not progressed as the Health Board awaited the Revised National Cleaning Standards.

As the minimum cleaning frequencies in the Standards are not as anticipated, there is a need to review the recommended frequencies in the Standards in conjunction with the IPT and repeat this piece of work during 2025/26

12.4 Support for High Level Disinfection

The IPT strongly recommend Hydrogen Peroxide Vaporisation (HPV) as the most effective decontamination to remove *C.difficile* spores from the environment. However the technology used differs across each IHC. East IHC have recommissioned their HPV machines which are now functional, West are exploring recommissioning their machines not in use, whilst Central are considering next steps to source the equipment.

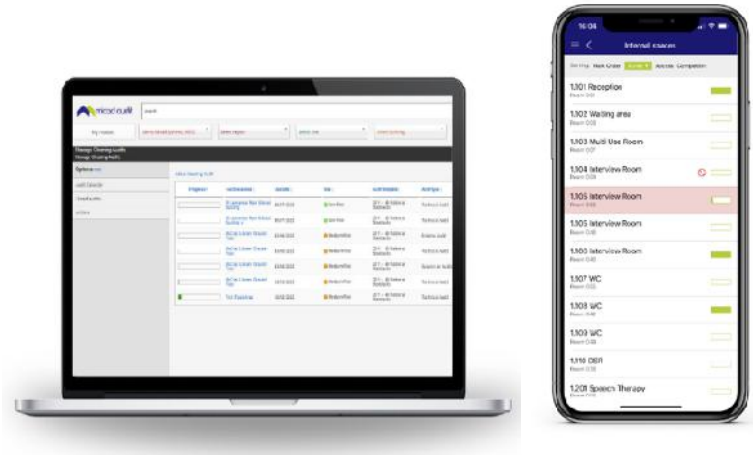
IHC	HPA	HPV	UVC
Central	3	0	5
East	4 (not currently in use within East as awaiting further review/guidance)	4 units operational	4
West	6	0	3 (not currently in use within West - not commissioned).

The ability to perform proactive full ward High Level Disinfection (HLD) is hindered due to lack of decant availability across all acute and community hospitals and the IHCs are exploring options to accommodate this wo allow for an uninterrupted programme of full ward HLD. The risk is currently mitigated by performing reactive and proactive bay to bay HLD, with the commissioned equipment available to each IHC.

12.5 Monitoring against National Standards of Cleaning (NSoC) in Wales

The National Standards for Cleaning, Wales (2009) stipulate that continuous monitoring of environmental cleanliness is undertaken.

The transition in the auditing tool used by the Health Board to MICAD audit completed in September 2024. This transition has allowed the re-mapping of services, so that the reports now accurately reflect the current clinical layouts. It also provided an opportunity to review the auditing frequencies for each clinical area relevant to the current activities being undertaken within the space, and updated in accordance with national guidelines.



The Domestic Supervisors facilitate the audit process with support from Nursing and Estates colleagues. Senior Nursing Leads, Operational Estates Managers and Domestic Services Managers are provided with reports following each audit for their respective responsibility elements. The reports inform the basis for an improvement plan required by each manager. Where the results fall below the target score, a follow-up audit may be undertaken to check that failures have been rectified within agreed timescales.
Monthly Compliance Reports are provided to Heads of Facilities and IP leads to give assurance that areas are audited in line with agreed frequencies. Audit scores are also provided. A summary of these reports is reviewed at the IHC and other services LIPGs.

12.6 Current Establishment Gapped Posts
In addition to the work described above relating to the implementation of MICAD as a tool to support BCUHB to meet Nationally mandated standards, over the preceding 12 months there have been significant real-world staffing deficits in Domestic Services. Furthermore, the existing staff deficits are expected to be exacerbated by the newly revised National Standards of Cleanliness which have recently been released in a final iteration but not yet published. The current staff deficits in Domestic Services are as follows:

IHC	WTE Shortfall	Notes
Centre	40.00 WTE	
East	14.00 WTE	Shortfall against establishment (March 2025). Actively recruiting to 10wte
West	22.16 WTE	

Please note that the above figures are estimations only and are subject to change following the implementation of the new 2025 National Standards of Cleaning.

To support the retention of staff, Facilities have recently started to work with local colleges to offer Level 2 qualification to members of the Domestic Services teams with

seventeen Domestic Assistants/Supervisors signing up to commence their assessments.

12.7 Forensic Cleanliness Auditing

Both Adenosine Triphosphate (ATP) Testing units and Ci-Fi Torches have been utilised by IPT and Domestic teams as required for auditing and education purposes.

Partnership working is ongoing with Staffordshire University under a Memorandum of Understanding with their Centre for Crime, Justice and Security. Research continues into best use of a forensics torch to support cleanliness auditing within healthcare settings.

The IPT is keen expand its use of ATP to support the monitoring of cleaning process throughout 2025/26, however, in the absence of a dedicated budget for this, resources would been to be agreed.

12.8 NWSSP Linen Services

The North Wales Laundry is located on the Ysbyty Glan Clwyd site and is run as part of the All Wales Laundry Service (North Wales Shared Services Partnership). The Laundry provides linen services for all Health Board sites as well as all Wales Ambulance NHS Trust sites in North Wales. The Laundry produces over six million individual pieces of linen per year.

The table below describes the breakdown of linen items processed in 2024/25:

Site	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	
Central IHC													Total
Abergele	5,376	4,390	4,580	6,737	4,962	4,039	6,411	4,610	4,228	4,609	5,471	4,922	60,335
BTW Llandudno	100	150	120	155	150	120	150	120	120	165	120	120	1,590
Bryn Hesketh Unit	1,405	1,961	1,123	2,072	2,340	1,509	1,336	1,387	1,503	1,324	1,497	1,435	18,892
Colwyn Bay	4,003	5,028	3,753	4,167	5,265	4,371	4,952	4,231	4,281	4,843	4,545	3,883	53,322
Denbigh	3,145	3,692	2,522	2,577	3,536	2,232	2,900	3,311	2,268	3,187	2,657	2,700	34,727
YGC Ablett Unit	5,543	6,385	4,505	5,363	6,816	5,213	5,263	5,065	5,271	5,294	5,419	5,413	65,550
YGC	161,352	167,294	143,152	168,469	162,129	153,598	162,578	148,768	146,612	142,659	144,934	152,809	1,854,354
YGC Mortuary	420	677	499	490	603	480	480	600	419	656	535	505	6,364
YGC Residences	1,143	1,019	734	620	956	893	687	1,787	828	817	745	643	10,872
Llandudno	10,649	11,256	9,396	11,817	10,211	10,512	9,617	10,882	10,335	10,651	10,296	10,388	126,010
NWAS	57	155	204	240	239	275	346	310	280	395	345	305	3,151
Royal Alex	108	390	235	278	230	246	255	265	185	260	255	230	2,937
Ruthin	2,763	3,540	2,341	2,867	3,779	2,646	2,262	3,183	2,810	3,067	2,721	2,473	34,452
Tan Y Castell	693	690	468	461	725	518	533	798	447	623	556	513	7,025
YGC Ty Nerys Unit	150	375	290	204	340	215	210	350	125	235	265	230	2,989
East IHC													
Chirk	2,148	2,947	2,382	2,300	2,939	2,410	3,025	2,351	2,306	2,877	2,264	2,283	30,232
Coed Celyn	210	208	153	139	240	88	136	167	64	109	113	115	1,742
Croes Newydd	1,812	1,804	1,997	2,460	2,641	2,690	2,489	2,317	2,729	2,472	2,480	2,202	28,093
Deeside	4,949	6,493	4,960	5,421	6,618	5,064	6,365	5,110	5,251	6,161	4,887	4,704	65,983
Heddfan Unit	2,301	1,982	2,047	2,041	2,554	2,122	2,763	3,048	2,259	3,054	2,314	1,995	28,480
Holywell	5,214	5,969	4,639	4,567	5,682	4,500	5,399	4,845	4,920	6,091	4,530	4,855	61,211
Mold	4,901	6,207	4,740	4,793	6,075	4,595	4,725	6,121	4,394	6,287	4,219	4,363	61,420
Penley	609	837	696	651	778	727	770	700	500				6,268

The following additional items have also been processed in 2024/2025 as part of the NWSSP Laundry cleaning:

- Pan BCU - 1,492, 904 Microfibre Mops & Cloths
- Pan BCU – 1,369 Dynamic Mattresses

12.9 Food Safety

Over recent years, BCUHB Facilities Management Services in partnership with the Primary Authority Scheme (PAS) provider Wrexham County Council (WCC), have developed a robust food safety system which merged 21 food safety policies and associated documentation into one.

The objectives which formed the agreement of activity are:

- To provide expert advice with the updating of the BCUHB Catering Strategy in relation to the Food Safety Act and associated regulations and guidelines. The PAS advises on the strategic direction for both Acute and Community Hospitals which may require different methods of food delivery dependant on the type of patient. The advice will also include satellite ward/department and retail catering.
- To support the maintenance of the BCUHB Food Safety Management System to cover both primary and satellite catering facilities to achieve the performance indicator set by the organisation to have all catering outlets at a Food Safety Score of level 5.
- To provide expert advice on Food Standards and new/changes in food safety legislation and regulations e.g. Allergens, labelling.
- The training of Nursing, Catering and Non-Clinical staff on the BCUHB Food Safety Management System and Food Hygiene to a level which matches their job description and employment personal specification in relation to food service.
- To provide expert advice with the prioritising of catering equipment and kitchen infrastructure to support the writing of business justification cases for the modernisation and replacement of equipment and premises in line with the BCUHB catering strategy. The business justification cases will form the case of need for requesting capital funding.
- To conduct a programme of audits and associated compliance checks on Health Board catering premises to support continuous improvement in relation to the BCUHB Food Safety Management System.
- Undertake other activities which sit within the scope of the primary authority scheme agreement requested by the Health Board.

Food Safety Scores at time of writing are given below:

Location	Rating	Date	Status
Anglesey & Gwynedd (West IHC)			
Ysbyty Gwynedd	5	27/03/24	→
Ysbyty Bryn Beryl	5	12/03/24	↑
Ysbyty Dolgellau	3	30/01/25	↓
Ysbyty Tywyn	5	11/10/23	→
Ysbyty Alltwen	4	13/12/24	↑
Ysbyty Cefni	5	15/01/25	→
Eryri Hospital	5	20/02/24	↑
Penrhos Stanley Hospital	5	22/01/25	→
Bryn y Neuadd	5	04/02/25	→

Conwy & Denbighshire (Centre IHC)			
Ysbyty Glan Clwyd	5	14/08/25	➔
Child Adolescent Unit Catering, Abergele Hospital	5	17/10/24	➔
Denbigh Infirmary	5	13/01/23	➔
Llandudno Hospital	5	16/01/25	➔
Colwyn Bay Hospital	5	08/03/24	➔
Ruthin Hospital	5	23/09/24	➔
Wrexham & Flintshire (East IHC)			
Wrexham Maelor	5	10/12/24	↑
Deeside Community Hospital	5	12/03/24	➔
Mold Community Hospital	5	23/02/24	➔
Chirk Community Hospital	5	12/11/24	➔
Holywell Community Hospital	5	13/02/25	➔
Penley Hospital	5	19/04/24	➔

Key	
No Change	➔
Increase	↑
Decrease	↓

Food Safety Training
BCUHB are committed to ensuring that Catering staff receive the highest quality Food Safety training through the Primary Authority with training capability often exceeding Food Safety Legislation.

Ward Kitchens
The responsibility for the management of ward kitchens sits with the Ward Manager. Regular ward kitchen audits are carried out by ward staff with support from the Health Boards Catering Departments who continue to undertake ad-hoc audits to ensure compliance in line with the Food Safety Act.

A digital auditing method using MICAD Audit has recently been successfully trialled on the three wards in the Mental Health Learning Disabilities unit in West, instead of using the paper system of auditing ward kitchens. There are plans to expand on this successful trial by rolling out the digital auditing system for use in MHLDs in East and Central.

12.10 Facilities Risk Management
Of the risks currently on the Facilities Risk Register those with an IP aspect are as follows:

Risk 4695 NWSSP Laundry – This risk continues to be managed by way of BCUHB Operational Estates partnering with NWSSP via the NWSSP Committee and by the Facilities Business Support team facilitating reviews of operational solutions along with a medium term review of the Service

Level Agreement and Memorandum of Temporary Occupation. Updates will be reported in the Strategic Infection Prevention Group.

Risk 4463 Central IHC – Domestic Services 7 day service pressure – This risk continues to be managed by Head of Facilities for the Central Area with unfunded service support demands being reported via the LIPG.

Risk 4465 West IHC - Domestic Services – Recruitment - This risk continues to be managed by the Head of Facilities West Area with service support shortfalls being reported via the LIPG.

Risk 4456 East IHC - Domestic Services – Enhanced Cleaning Requests - This risk continues to be managed by the Head of Facilities East Area with unfunded service support demands being reported via the LIPG.

Risk 4466 West IHC – Domestic Services 7 day service pressure - This risk continues to be managed by the Head of Facilities West Area with unfunded service support demands being reported via the LIPG.

13 Decontamination of Re-usable Medical Devices

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13.1 Decontamination Advice

BCUHB's IPT provides professional decontamination advice to clinical and estates teams to ensure the safety of patients and staff, through the roles of a Decontamination Advisor and a Decontamination Sister. They, along with the IPT, report to and are directed by the Deputy Director of Nursing Infection Prevention and Decontamination who took on the role in September 2024.

The decontamination of reusable medical devices, and the assurance required to meet relevant standards is becoming increasingly complex. Ensuring BCUHB's compliance in this area is extensive and challenging and this is being mitigated and the workload has been partially alleviated by other IPT members handling less specialised decontamination related queries.

There is currently no overall Strategic or Operational Decontamination Lead. Although this responsibility was assigned to the Interim Chief Operating Officer (COO) in 2024, since leaving the Health Board and the appointment of a new COO, a decision has yet to be made as to which Executive will oversee decontamination within their portfolio. In the meantime, responsibility continues to be devolved to the individual IHCs for management.

The Strategic Review of the Decontamination of Medical Devices conducted by NHS Wales Shared Services Partnership – Specialist Estates Services (NWSSP-SES) in August 2022, stipulates the need for a clear Health Board wide collaborative management strategy. As each IHC currently operates with different standards and systems, each decontamination department has been asked to ensure that fully documented risk assessments and Business Continuity Plans are in place.

13.2 The Decontamination Group

The structure, governance and reporting process was reviewed during 2024/2025, resulting in an Operational Decontamination Group meeting every two months. Decontamination leads/users for each of the departments with decontamination

responsibility provide a highlight report to the group, to include risks, escalation and progress and mitigation with key priorities.

These reports are then sent to relevant service leads (e.g. Heads of Nursing) for presentation to LIPG every other month to ensure a focused discussion around decontamination. Both LIPG and ODG then reporting to SIPG.

The revised reporting structure at ODG and also through LIPG, provides strengthened assurance around the risk and mitigation of decontamination processes particularly in relation to the issues raised below.

13.3 Audit

The Decontamination Advisor/Sister provides essential assurance of compliance in relation to the decontamination of reusable medical devices through six-monthly audits. These audits are now RAG-rated and include a “bedside” clean audit to verify decontamination processes. The six-monthly audit programme and associated documents are currently being reviewed and updated to incorporate feedback, action planning, reporting, and monitoring.

The audits continue to highlight several infrastructure and resource challenges, including outdated automatic washer disinfectors (AWDs), autoclaves, and facilities such as air-handling units. These pose significant risks due to their age or obsolescence and may require substantial capital investment, potentially disrupting service continuity. These issues are recorded on the risk register.

In response, the Decontamination Advisor, in collaboration with an Endoscopy Unit manager, have developed a training matrix document. This has been commended by the Authorising Engineer for Wales (AE(D)). Initially implemented across the Health Board for all services decontaminating flexible endoscopes, the training matrix will soon be extended to all other relevant services.

13.4 Sterile Services Departments

Sterile Services Departments (SSD) services continue to be provided from each of the 3 acute sites who are all registered with the Medicines and Healthcare Products Regulatory Agency (MHRA); this a WG requirement.

All 3 SSDs are currently managed by IHC Theatre Managers who lack the appropriate training, qualifications, and experience required for this field. Additionally, it presents a conflict of interest when a Theatre Service oversees an SSD department that provides services back to them. The Decontamination Advisors recommend appointing a single, dedicated BCUHB SSD Manager with overall responsibility for the SSD services across the three sites. Furthermore, the grading and banding of local SSD managers should align with their responsibilities, experience, and qualifications, in accordance with WHTM 01-01 guidance. There is a plan to discuss this with the Executive Lead for Decontamination once agreed.

Engineering services, including sterilisers and disinfectors, are approaching or have reached end-of-life and will require replacement over the next 5–10 years. The SSD unit at WMH is the current priority for replacement. In September 2023, concerns were raised by the SSD at YGC regarding inconsistent completion of machine testing and

estates-related works. While these issues persist, the Estates team has been providing support by offering overtime on weekends to carry out the necessary testing. At WMH and YGC SSD's, steam supply and quality failures are ongoing. Mitigating measures are in place, supported by a risk assessment developed in collaboration with the Authorised Engineer for Wales. Rectification work is planned to proceed through the Targeted Estates Fund allocated to BCUHB for Decontamination and is also recorded on the Risk Register. Meetings have been held with the Estates team to prioritise and address the backlog of outstanding work.

13.5 Scopes and Probes

13.5.1 Endoscopy

BCUHB has committed to enter the national agreement in development for the All-Wales systems within sterile services. This agreement is to be implemented across all three endoscopy areas in the near future.

East/Wrexham Maelor Hospital (WMH)

The new modular decontamination area within the modular theatres opened in November 2024. The remit is to undertake the decontamination processed for gastro/endoscopy, with four new Endoscopy Washer Disinfectors (EWD's) installed. It is hoped that the decontamination of nasendoscopes for Ear, Nose and Throat (ENT) can also be undertaken in this new facility moving forwards. Discussions are ongoing in relation to this recommendation.

West/Ysbyty Gwynedd (YG):

The Institute for Healthcare Engineering and Estate Management (IHEEM) Decontamination Annual report from NWSSP in January 2024 scored BCUHB Amber and the team are making good progress working through the recommendations; a new capital bid has been submitted for the 5th EWD, however has been unsuccessful the financial year 2025/26. The current 4 Getinge EWDs have been experiencing chemical/mechanical faults on a regular basis, which has caused significant capacity issues for the department.

A recommendation has been made by the Decontamination Advisors to purchase an Ultra Violet (UV) cabinet at all 3 sites across BCUHB to enable the decontamination of the Transoesophageal Echocardiogram (TOE), in line with the WHTM 01-06 a quotation for the purchase of these cabinet shas been circulated to all Hospital Management Teams.

According to WHTM 01-06 single use endoscope buttons is the recommendation, however in the West during their monthly Endoscopy User Group meetings it was decided due to cost and sustainability, the service would prefer to use reusable buttons, a risk assessment has been developed.

Central/Ysbyty Glan Clwyd (YGC):

In December 2023, PHW, NWSSP and Bowel Screening services raised concern regarding the ongoing lack of plan/progress to upgrade and provide compliant decontamination facilities in endoscopy. Although previous requests had been submitted for Discretionary Capital Funding they had not been prioritised and taken forward. The latest report following the IHEEM Decontamination Audit undertaken during September 2023 scored Red/Amber, highlighting the significant concerns

raised with the current decontamination infrastructure (especially as the increasing demands for diagnostic services was expanding), and requested that urgent consideration was given to move decontamination to a purpose designed facility or modular-facility that presents a segregated environment compliant to relevant standards. The report was shared with NHS Wales Health Collaborative and Bowel Screening teams.

A letter was subsequently issued by Bowel Screening to the IHC leads to seek assurance that the risk to patients was being effectively managed and addressed. Following an options appraisal it was agreed to relocate the decontamination unit into an identified space within the current laundry footprint and transfer management to SSD for which funding was approved in late 2024 and a programme of development work commenced. However, the air handling unit that feeds SSD and the new proposed Endoscopy Decontamination unit needs to replaced/upgraded or a new stand-alone unit installed to handle the extra load that will be imposed on it once Endoscopy Decontamination opens. Unfortunately, this was not in the original scope of works and has to be factored into the design.

A specialist ventilation engineer has been commissioned to produce a report and recommend next steps. In addition it has been highlighted that there are electricity supply concerns to the area therefore a report into this has been commissioned along with possible solutions. A project group has been set up to discuss these issues. All of this has impacted on the development programme and we are now looking at completion end of February 2026. Meanwhile YGC continue to demonstrate risk identification and reduction in decontamination processes with regular feedback to Bowel Screening Wales (BSW).

13.5.2 Choledochoscopes.
BCUHB is the only Health Board in Wales not complying with WHTM 01-06 regarding the decontamination of choledochoscopes. WHTM 01-06 requires the need to sterilise the choledochoscopes following disinfection, however, no SSD service across BCUHB has access to a low-temperature steriliser to facilitate this process which deems the full reprocessing of this Endoscope as incomplete. In East, single-use endoscopes are now being used, which eliminates the decontamination risk. In Central however, reusable endoscopes remain in use and are only disinfected rather than sterilised. Despite this, low scores have been reported on risk assessments corelating with the absence of any associated infection. The issue has been escalated to the EQDG.

In England, it is estimated that more sites are sterilising choledochoscopes than not, with a 70/30 split. Those sites not currently sterilising have added the issue to their risk registers and included the purchase of sterilisers in their capital plans. Up-to-date quotes have been obtained to support IHCs in progressing business cases. Decontamination Advisors have also requested strengthened training assurance around out-of-hours use of these endoscopes.

As highlighted at the Decontamination Group meeting in March 2025, single-use choledochoscopes are now utilised by WMH however YGC continue to reprocess without the final stage of sterilisation. YG do not use choledochoscopes for their Surgical procedures.

13.5.3 ENT Nasendoscopes:

WMH

Non-lumened nasendoscopes used by the ENT service should be decontaminated using automated methods in accordance with WHTM 01-06. However, WMH conducted a risk assessment, approved by the local Clinical Effectiveness Group, and decided to utilise the manual 'Tristel 3 Stage Wipe' system without the recommended double sink 'pre-wash and rinse' process advised by the Decontamination team.

WMH ENT has experienced significant issues with all 12 new STORZ nasendoscopes purchased in March 2024 with all having required repair or replacement. It is hoped that the available capacity at the new Modular unit can be utilised to eliminate the current manual process, thereby reducing the risk of cross-contamination.

YGC

YGC currently use the double-sink method and, whenever possible, single-use nasendoscopes. The endoscopy options appraisal for the relocation and centralisation of decontamination facilities at YGC SSD will include all services that use flexible endoscopes, including nasendoscopes. This approach will therefore address all current associated risks.

YG

At YG, the endoscopy service is awaiting the installation of a fifth EWD to enable the decontamination of ENT scopes within their own facility. Currently, ENT nasendoscopes are periodically decontaminated through the centralised endoscopy decontamination unit using an EWD. However, when this central unit lacks capacity, the ENT Outpatients Department (OPD) reverts to using the Tristel three-stage wipe system to manage additional demand.

Both WMH and YG have seen a significant increase in the use of nasendoscopes during ENT clinics, and additional scopes are now required to meet this growing demand.

13.5.4 Urology scopes:

YGC

Two new EWD's were purchased and installed in November 2024. YGC are currently awaiting funding for a drying cabinet for the Theatre service.

WMH

At WMH, theatre decontamination remains on the first floor to accommodate urology and theatres endoscopes.

YG

All cystoscopes are currently being reprocessed in the centralised decontamination within the Endoscopy Department; however, demand has increased significantly, the purchase of the 5th EWD is essential to increase decontamination capacity.

13.5.5 Ultrasound probes

The Decontamination Advisors have requested a review of all decontamination procedures related to ultrasound probes to minimise the risk of decontamination failures. As a result, an SOP has been developed, which includes guidance on actions to take in the event of a decontamination failure. This SOP aligns with the Wales

Healthcare Technical Memorandum (WHTM) 01-06 Part F, which covers the decontamination of semi-critical, semi-invasive, and non-invasive ultrasound probes. The guidance has supported the standardisation of decontamination processes for ultrasound probes.

To reduce the risk of damage to current probes, Incidin Oxy-wipes are now used for decontamination, as outlined in the SOP. Additionally, six-monthly decontamination audits are being carried out to provide assurance on training, compliance, and adherence to relevant policies and procedures.

13.5.6 Trans-oesophageal echocardiogram (TOE) probes

Whilst mitigation is in process, the recommendation to purchase an ultra-violet cabinet +/- a low temperature steriliser to align with the WHTM 01-06 guidance continues to be explored by each IHC. This issue has been added to the overarching Decontamination Risk 4325 which is currently scoring a 12.

13.6 Ophthalmology

Following an MHRA alert regarding Ophthalmology “Phaco” handpieces, guidance from the IHEEM Decontamination Technical Platform (DTP) has led to a change in how these instruments are managed post-surgery. The Decontamination Advisors have confirmed that there are no current issues across BCUHB. However, YG need to purchase a flushing device to comply with the updated guidance. None of the three Ophthalmology Units across BCUHB have a dedicated decontamination room/area to undertake decontamination processes, all sites have adopted decontamination recommendations to mitigate the risks.

13.9 Community Dental Services

A rolling programme of improvement works continues across the Community Dental Service (CDS) in line with WHTM 01-05. All mobile dental units have been condemned due to unsuitability and non-compliance with required standards. Several sites including HMP Berwyn, Buckley, Wrexham, and Llanfair PG are experiencing significant ventilation issues, resulting in the temporary suspension of clinics. Discussions to resolve these issues are ongoing.

14.0 Antimicrobial Resistance and Prescribing Programme

14.1 Primary Care Antimicrobial Prescribing

In July 2019, Welsh Government introduced antimicrobial improvement goals for the 2023/24 financial year (WHC/2019/019). The goal for primary care was a 25% reduction in total antimicrobial volume against a 2013/14 baseline.

At the end of this 10 year target period, ***BCUHB achieved the 25% reduction goal*** *with a 24.7% reduction (TARGET - Items/1000 STAR-PU).*

This is a phenomenal achievement from the GP practices across BCUHB, with only 2 Health Boards in Wales achieving this target.

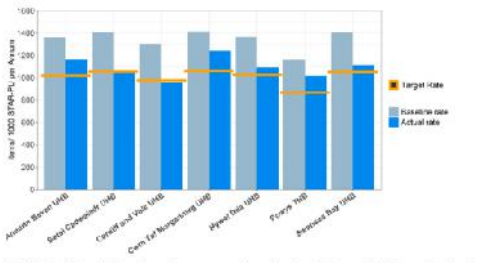
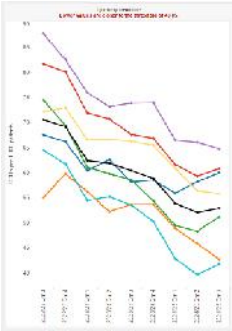


Figure 1: Total antimicrobial volume improvement goal by Health Board for the period ending March 2024 (final position)

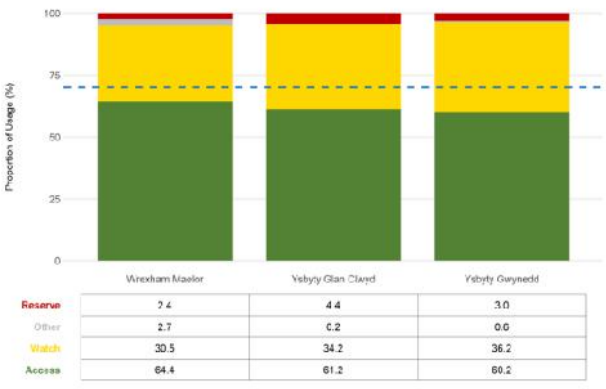


BCUHB has seen a marked reduction in the prescribing of 4C antimicrobials and is currently under the all Wales average (broad spectrum antibiotics with an increased risk for C.*diff* infections). 4C antimicrobials refer collectively to four broad-spectrum antibiotics, or groups of antibiotics: co-amoxiclav, cephalosporins, fluoroquinolones and clindamycin. This was one of the targets included in the primary care incentive scheme in 2024/25. (BCUHB can be seen in green in the graph below).

A new target has been set through the Welsh Health Circular to the Health Boards to achieve
a minimum 10% reduction against the 2019/20 baseline by 2029/30. (Target - DDDs/1000 STAR PU). This target will include prescribing from across primary care including GP in hours, community pharmacies and other independent prescribers. The AMS team plan to engage with all of these groups as part of the work plan.

14.2 Secondary Care Antimicrobial Prescribing

The WHO categorises antibiotics into three broad groups [AWaRe: Access, Watch and Reserve] based on their spectrum, anticipated risk of resistance development, risk of toxicity, and risk of causing healthcare-associated infections.
For the last antimicrobial prescribing goals (ending March 2024), all acute sites in BCUHB achieved the target of ≥55% of total antibiotic usage was within the WHO Access category with Wrexham Maelor hospital (WMH 64.9%), Ysbyty Glan Clwyd (YGC 59.7%), and Ysbyty
Gwynedd (YGB 59.5%).



The new target set in the Welsh Health Circular is to achieve a minimum of 70% of total antibiotic use from the Access category of antibiotics by 2029/30. The measure is Defined Daily Doses and will be reported as % total antibiotic use, (another change in denominator). At the end of the financial year 2023/24, the proportion of total usage from the Access group category was 61.9% in secondary care across BCUHB. The figure shows antimicrobial usage by AWaRe categories 2023/24 in the 3 acute sites.

14.3 Antimicrobial Stewardship in Primary care

Primary care AMS staffing provision has diversified with the appointment of a new primary care antimicrobial specialist pharmacy technician BCUHB IHC West. Although BCUHB achieved the minimum 25% reduction rate by 2023/24, the change in denominator for the next targets taking into account dose and duration has led to an uptick in some of the antimicrobial usage data. The AMS team have produced a detailed workplan to tackle some of these areas including utilisation of electronic

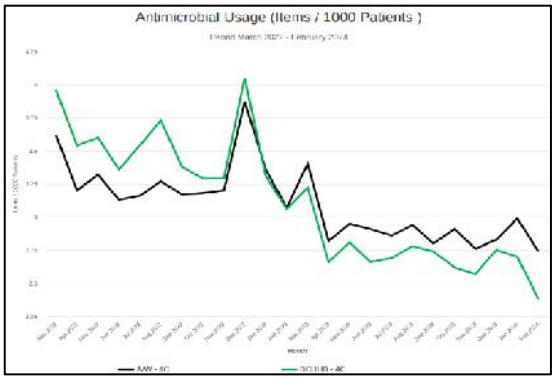
messages to prompting correct duration prescribing, education sessions and regular guideline reviews in line with national guideline updates.

Collaborative working with the national lymphoedema service led by the AMS team has provided 1221 patients in BCUHB with support and management of recurrent cellulitis. Pre intervention these patients had 1140 episodes of cellulitis leading to 648 hospital admissions, following referral to this service and awareness raising from the AMS team 12 months later there were 28 episodes of cellulitis reported in this cohort and 6 hospital admissions. This important collaboration has reduced exposure to antibiotics to these patients. An educational event from this team was incorporated into the incentive scheme in 24/25.

For 2025/2026, antimicrobial prescribing targets are included in the Local Enhanced Clinical Effectiveness Service (LECES) with the aim to incentivise prudent prescribing, maximise cost effectiveness, increase patient safety and promote best practice in relation to antimicrobial prescribing.
Targets included within the LECES include:

- Reduce Total antibacterial items per DDDs/1000 STAR PU (or remain in the lowest prescribing quartile).
- At least 75% of amoxicillin, clarithromycin and doxycycline prescriptions should be 5 vs 7 days in line with national prescribing indicators for lower respiratory tract infections.
- Clinical reviews of patients prescribed antibiotics for recurrent urinary tract infections in line with national guidelines to improve patient safety and minimise the risk of antimicrobial resistance.

A reduction in 4C prescribing has been removed in view of the reduction in prescribing rates (see graph below). The quinolone audit was included as an alternative, to support adherence to the new MHRA warning.



14.4 Antimicrobial Stewardship in Secondary Care
The challenges with timely data with regards to secondary care antibacterial usage has made it difficult to determine and monitor whether local antimicrobial stewardship activities are having an impact. It is hoped that the introduction of electronic prescribing (ePMA) will help AMS team identify areas of high prescribing and be able to target interventions in these areas.

With challenges in the AMS and IPT team staffing the support for the Start Smart Then Focus audit (SSTF) data collection has been withdrawn and it was decided to pause this audit programme while ePMA is established following a lack of engagement from clinical teams at ward level.

The audit covers five key areas of antimicrobial prescribing governance;

- The infection is recorded as either Possible or Probable as per ARK principles.
- An indication for the antimicrobial is documented on the drug chart.
- The antimicrobial prescribed is in accordance to health board guidelines, cultures and sensitivities or following advice from a consultant microbiologist.
- A senior review is carried out within 72 hours.
- A review/stop date is clearly documented on the drug chart.

Antimicrobial stewardship multidisciplinary team ward rounds are conducted regularly on each acute site. The rounds consist of antimicrobial pharmacists, physician associates and consultant microbiologists who review patients on broad spectrum antibiotics. During the ward rounds, interventions are made, and the nature of the intervention is recorded. *C. difficile* ward rounds

The AMS team continue to support antimicrobial stewardship education and training programmes throughout BCUHB and higher education institutions. For BCUHB, regular teaching sessions are provided to junior doctors, nurses and pharmacists on prudent antibiotic prescribing. Work has been established on trying to standardise antimicrobial stewardship education & training provided by the AMS team. We are currently collecting data on the teaching provided to allow for a gap analysis to be undertaken.

A quality improvement project has been led by the AMS nurse alongside ward 12 in YGC focussing on nurse led intravenous to oral switching of antibiotics. Timely intravenous to oral switching of antibiotics has potential significant benefits and early analysis has demonstrated possible financial benefits with regards to drug expenditure and reduction in nurse time. This project successfully increased the review of antibiotics and is now in the process of being spread across other wards in YGC and BCUHB.

The annual Point Prevalence Survey (PPS) of Antimicrobial Prescribing in 2024 highlighted areas for improvement for BCUHB, with the antimicrobial prescribing rates for Ysbyty Gwynedd (YGB) and Ysbyty Glan Clwyd (YGC) above the Welsh average. A targeted audit will be carried out to understand the current use of BCUHB restricted antimicrobials in response to the increase in prescribing from the PPS.

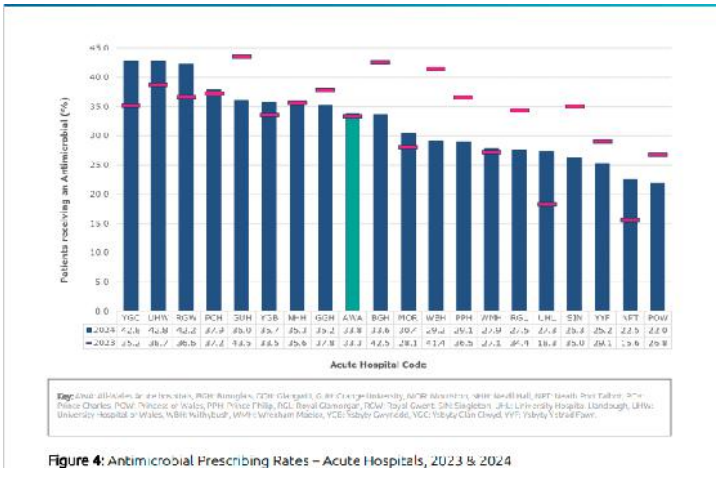


Figure 4: Antimicrobial Prescribing Rates – Acute Hospitals, 2023 & 2024

14.5 Antimicrobial Prescribing Guidelines

BCUHB Antimicrobial Guidelines for specific body systems are in place for primary care secondary care and dental services. These are based on national evidence-based guidelines and local antimicrobial resistance patterns with adaptation by the antimicrobial stewardship group. Several guidelines have been reviewed, updated and published during 2024/25. In 2024 the guideline provider Microguide® was bought out by Eolas and the AMS team migrated all guidelines to the new platform which is available on a smartphone device or via BetsiNet, facilitating easy access of antimicrobial guidelines at the point of prescribing. Work is planned to gather user feedback from BCUHB prescribers to continually improve the platform.

14.6 Antibiotic Resistance and Monitoring

There is continued concern regarding levels of Gram-negative bacteria resistance across BCUHB with clear variation between hospitals. *E.coli* resistance in blood cultures and urinary samples remains a concern with resistance rates greater than the all-Wales average for most broad-spectrum antibiotics tested.

The availability of the PHW Llygad platform has supported the review of antimicrobial resistance data at a local level, however there remains issues with access. There is a recommendation for a resistance working group to be established to anticipate arising issues. Overall, there is a need for greater emphasis of antimicrobial stewardship from all individuals to tackle this threat.

The lack of certain antibiotic therapeutic blood level monitoring being available in BCUHB continues to be a major issue and therefore limits guideline change and safe use of certain antibiotics in BCUHB.

14.7 World Antibiotic Awareness (WAAW) week 18-24 November 2024

Activities across the health board focused on encouraging SSTF principles and encouraging prompt IV to Oral switching of antimicrobials.

In all three acute sites in BCUHB, organised promotional stands to share key public messages, antimicrobial prescribing and resistance resources. Each hospital also organised & participated in multi-disciplinary IV to oral ward rounds contributing to the All-Wales data collection.

In primary care resources for promoting AMS were circulated to all primary care contractors including a poster for common infections and their durations, a resource to aid reception staff to manage patient expections for antibiotics.

14.8 AMR International Work

The Commonwealth Partnerships for Antimicrobial Stewardship 2.0 (CwPAMS) completion of the project following the grant of £96,000 being awarded over 2 years 2023-2025. The hub and spoke model is being used, with Kamuzu Central Hospital in Lilongwe being a hub for 3 district hospitals, Mchinji, Dedza and Ntcheu, as well as the other tertiary hospitals in Malawi in Mzuzu, Zomba and Queen Elizabeth hospital in Blantyre. Over 420 healthcare professionals were trained in AMS using the train the trainer model.

All 7 hospitals now have trained AMS committees and have done the following:

- Completed a Global Point Prevalence Survey (Global-PPS) of antimicrobial usage in the hospitals, identifying areas where antimicrobial stewardship could be improved: for example, reduced usage or oral administration.

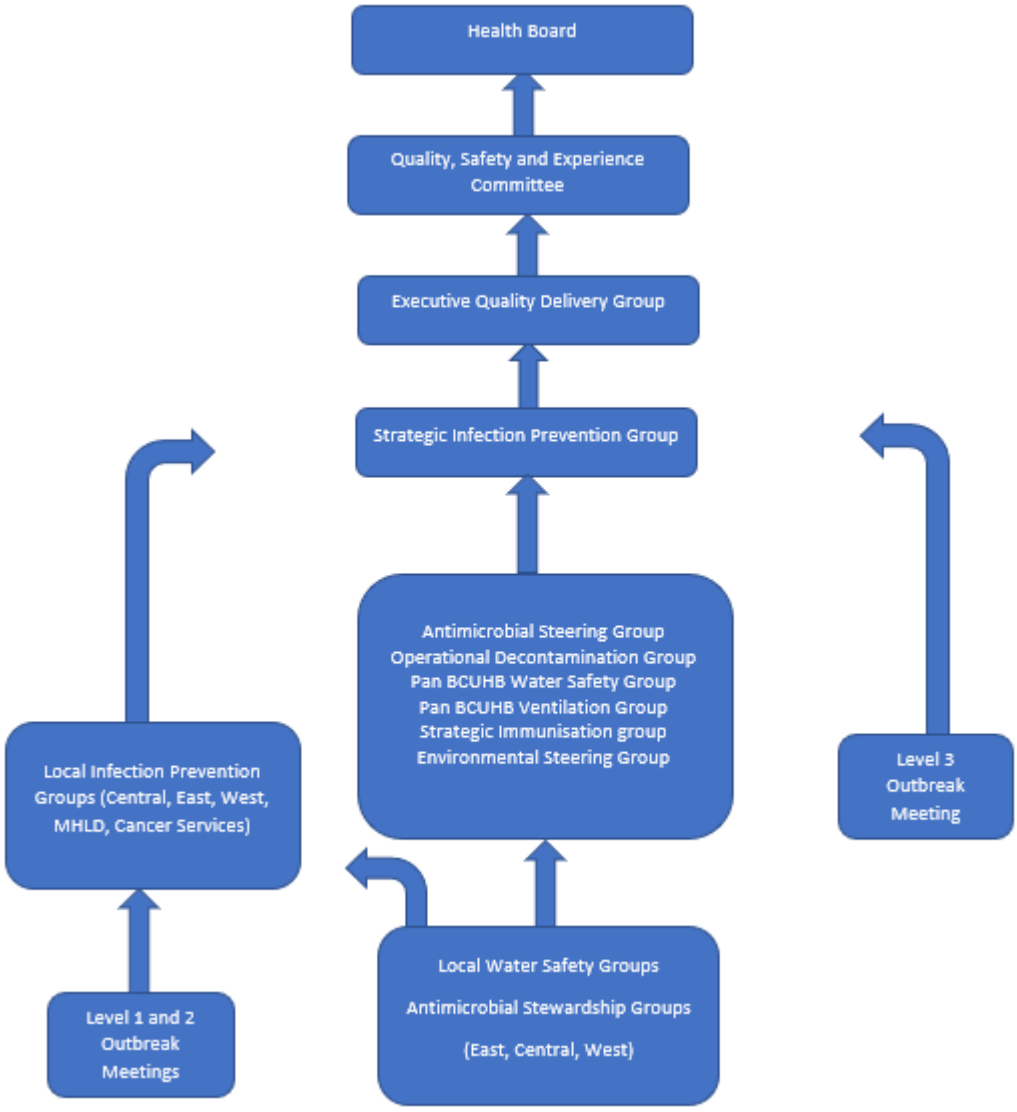
- Developed and supported implementation of a toolkit to guide these improvements, including tools for ongoing audit.
- Engaged with national pharmacy groups and lead, including within the Ministry of Health in Malawi, to ensure the partnership's work aligns to national plans and is embedded as standard practice.
- 5 members of the team from Malawi were awarded an African Leadership Fellowship and successfully led workstreams throughout the project.
- The Malawi team also visited the UK to experience how AMS is implemented in UK healthcare systems, this included a site visit to Ysbyty Gwynedd, Dolgellau medical centre and Penygroes community pharmacy.

The project has been shortlisted for an Antibiotic Guardian Award, the winner will be announced in June 2025.

15.0 Appendices

Appendix A

Strategic Infection Prevention Group Governance and Reporting Arrangements



Appendix B

The Infection prevention and decontamination Corporate Risk Register as at 31/03/2025 is below:

ID	Title	Date Opened	Current Score
4978	Air mattress infection risk	12/10/2023	12
4971	Decontamination issues related to the side panels of the Hill Rom 900 beds	02/10/2023	9
4241	Inability to deliver timely Infection Prevention & Control services due to limited capacity	10/12/2021	12
4325	Potential that medical devices are not decontaminated effectively so patients may be harmed. (Following a review with the new Head of Risk this risk assessment was downgraded to tier 2 in July 2023 as mitigations and controls had been strengthened and there was not sufficient evidence to keep the high score.)	21/02/2022	12
5450	Potential transmission of HCID due to lack of available PPE and speciality training	09/12/2024	10

Appendix C – IPT Annual Programme of Work

The Programme of Work 2025/26 is based around the headings in the new (not yet published) Code of Practice.

Standard 1 **Appropriate organisational structures and management systems for IPC are in place:**		
Priority		**Actions**
1	Improve governance and engagement at IPC forums	Review SIPG Terms of Reference
		Review LIPG Terms of Reference
2	Decontamination governance/ assurance structure	Strengthen reporting process to Operational Decontamination Group to LIPG to SIPG
3	Enhance the Post Infection Review Process across BCUHB	a) Support the Clinical Directors/IPC Medical Leads to agree and implement a PIR process that is fit for purpose for each IHC that engages medical staff
		b) Review and revise the PIR proforma for C.diff
		c) Review and revise the PIR proforma for S. aureus BSI
		d) Review and revise the PIR proforma for Gram negative BSI

4	Raise profile of IPC	Develop a process and simple proforma to implement Director level walkabouts with the IPT for presentation/discussion/approval at LIPGs
		Establish Director/IPT Lead walkabouts
5	Review Environmental audit tool/process	Explore feasibility of developing the tool within the IRIS dashboard
6	Enhance IPC decision making for clinical and operational teams	Develop and launch an Infection Prevention Acuity Matrix which will provide triggers for decision making
7	Faecal Microbiota Transplant	Further develop the nurse led service to optimise the delivery of an FMT service
8	Enhance IRIS Dashboard	a) Enhance IP quality dashboard within IRIS to improve triangulation of audit compliance data with infection incidents e.g. C.diff with hand hygiene compliance and antimicrobial prescribing, blood stream infections with ANTT training compliance
		b) Split CAUTI/UTI data to within the deep dive questions
Standard 2: All care equipment including medical devices is decontaminated effectively and safe at the point of use		
1	Decontamination Action Plan	Review and update the PAN BCUHB 2023 Decontamination Action Plan
		Present and oversee at Decontamination Group, LIPGs, SIPG and to the Executive with Decontamination in their portfolio
2	Enhance decontamination audit Process	Undertake a review of the auditing process to include reporting and monitoring of progress with actions
3	IPT engagement /Involvement	Deliver a training session to all Band 4 and Band 6s to allow them to participate in the 6-monthly decontamination audits

4	Decontamination Champions	a) Draw up a proposal/SBAR to introduce decontamination champions in areas responsible for decontamination of medical devices
		b) Implement Decontamination Champions
5	Bedspace cleaning team	Prepare and present an SBAR to consider investment of a dedicated rapid response team to support whole bedspace cleans at point of discharge/transfer
6	Dynamic Mattresses	Work with the Head of Facilities Oversight to prepare an SBAR with a recommendation to move to rental dynamic mattresses and/or external decontamination
Standard 3: All physical environment is maintained and cleaned to a standard that facilitates effective IPC and minimises the risk of infection		
1	Align 'Which Clean do I Mean' protocol with the National Cleaning Standards	Review the Which Clean do I Mean protocol including the cleaning checklists to ensure that these are aligned to the National Cleaning Standards
2	Explore enhanced HLD Technology	Support/complete and evaluate a pilot of enhanced UVC technology on each of the three acute sites
3	Quantitative and Quality Assurance re cleaning/ decontamination	Revisit the ATP SBAR and undertake a scoping exercise to understand the cost pressure for purchase of the consumables to sit within the IPC budget
4	Bedspace Cleaning	Revisit & implement standardised bed cleaning checklist or flowchart
Standard 4: Suitable, timely and accurate information on infection is available and communicated to staff, service users and their visitors and those responsible for providing care to others		

1	Build repository of Information leaflets	Identify which information leaflets are available on the PHW/HARP website to understand which information leaflets need to be produced locally
		Designate and oversee IPT members to develop agreed information leaflets locally to ensure a full repository of leaflets
2	IPC Pages/Up to date information on BCUHB website	In collaboration with the communications team, develop an IPC page to be available to the public on how the Health Board manages infection prevention and control and how we are performing against national HCAI reduction expectations
3	Public Facing HABITS	Develop phase 2 of HABITS to focus on visitors and the general public
4	Alerting processes	Explore further solutions to alert staff of IPC related issues through “Right patient Right place” etc.
		Develop a process to ensure the IPT can be alerted of CPE readmission/contacts
Standard 5: All staff employed to provide care in all settings are fully engaged in preventing and controlling infection		
1	Proactive Audit Programme	a) Demonstrate completion of a robust proactive audit programme to include timely feedback to those who need to know - aligned to the HABITS campaign
2	Staff education	b) Develop a list of outstanding/required Microteaching sessions allocating development of these to individuals within the team
		c) Ensure that there is a repository of all required microteaching sessions
		d) Develop a programme of IPC education in the form of microteaching for clinical staff

		Develop a guidance/crib sheet for pharmacists on how to maintain IP in community pharmacists Plan and facilitate an IPC study day on one day across each site (? On each site or a Central venue only)
		Explore an approach to accessing the IP Induction Booklet for new starters and launch
3	Investment in ANTT training	a) Complete a review of role/position staff groups and complete data cleanse to ensure all relevant staff groups who require ANTT training are identified
		b) Using the ANTT cascade model, ensure all grades of staff are included in the training model
		c) Appoint ANTT leads/key trainer for each discipline in each acute and community sites.
		d) Work collaboratively with the Workforce Team to include an additional competency to ESR to record practical ANTT training/assessment competency
		e) Commence roll out ANTT cascade training methodology
		f) Create a standard statement to be include in appraisal documentation relating to ANTT compliance
4	Investment in ANTT	Roll out ANTT accreditation
Standard 6: Suitable and sufficient isolation facilities are provided to support effective IPC		
1	Enhance IPC decision making for clinical and operational teams	Develop and launch an Infection Prevention Acuity Matrix which will provide triggers for decision making
2		

	Improve the segregation of inpatients with suspected or confirmed infections	IPT to conduct a scoping exercise of alternative 'mobile' solutions to support the segregation of patients with suspected or confirmed infections (e.g. pods, temporary screens, freestanding (drop and go) isolation units)
Standard 7: Evidence based IPC policies are in place: are accessible and reviewed regularly		
1	IPC related policies and procedures	a) Undertake a review of all IPC related policies to ascertain which need to remain as a policy and those that can be redefines at a protocol/procedure/guideline etc
		b) Develop and launch an overarching Infection Prevention and Control Policy
		c) Develop and launch a Candida auris protocol
		d) Develop and launch a BCUHB ANTT policy that describes ANTT principles and terminology describing asepsis procedures and aligns them to department/disciplines
2	Proactive Audit Programme	Demonstrate completion of a robust proactive audit programme to include timely feedback to those who need to know (to include ANTT training compliance)
Standard 8: Operational systems and processes are in place that provide staff from the risk of exposure to infections that can be transmitted in the workplace		
1	Vaccination	Each IPT to identify an Influenza Lead who will be responsible throughout flu season to vaccinate staff whilst promoting uptake and attending wards/departments/face to face meeting and teaching sessions
2	HCID Preparedness	Each member of the IPT will be trained to be a "super trainer" to allow them to be competent to monitor donning and doffing practices associated with the HCID ensemble (not necessarily to deliver training)
3	Sharps safety/NSI	a) Quarterly IPT/ OH&W Services meetings to be established to review sharps injury data, key themes and instigate corrective solutions

		b) IPT to work collaboratively with Occupational Health & Wellbeing Services to develop a comprehensive suite of needlestick prevention posters/resources
Standard 9: All staff are trained, educated and competent in IPC as appropriate for their role		
1	IP Competency	a) Ensure all members of the IPT are familiar with the HEIW IP Framework
		b) Develop and introduce local IPT competency profiles for all Bands/roles within the IPT
2	Face to face education	Arrange and facilitate biannual face to face education half day for the full team
3	Behavioural science implementation	a) Share the Behavioural Science tool with the IPT and LIPGS
		b) Arrange for the IPT to receive an educational session on behavioural science
		c) Embed and encourage use of the Behavioural Science tool within the IPT
4	QMS	Arrange for a session on the Quality Management System Framework to be delivered to the IPT
5	Regular educational sessions	Establish a timetable of developmental/educational sessions for the IPT – to include IPT members presenting to each other to support presentation development
1	Incident reporting	Agree a process for reporting (via DATIX), investigating and sharing learning of antimicrobial use incidents that are associated with the acquisition of HCAIs
2	Raise public awareness	a) Develop an information leaflet for patients around AMR

		b) In collaboration with the communications team, develop a page on the BCUHB website to raise awareness around AMR referring also to the reduction goals
3	Community Nurse Stewardship	Liaise with District Nurse/Community Leads to understand prescribing process in community nursing to explore the possibility of auditing compliance
Standard 11: The organisations strategy to deliver a net zero health service is compatible with maintaining the prevention and control of infection		
1	QMS project – Gloves Off	Explore through the BCUHB Quality Management System Framework how the IPT can commence a QI project that focuses on the “Gloves off” initiative
2	Reduce carbon footprint through innovation	a) Conduct a scoping exercise to assess the carbon footprint of key products used for IPC and HCAI prevention
		b) Horizon scanning for new developments and innovation that support more sustainable IPC

Appendix D

Proactive audit programme

Proactive Infection Prevention Annual Audit Programme 2025/26

The programme below must be followed as a matter of routine to:
- Provide quality assurance around IPC practices to LIPGs and SIPG
- Support your Post Infection Reviews
- Allow you to identify concerns around practices and support implementation of improvement plans

Feedback must be provided in real time to Departmental Manager/Ward Sister/Nurse in Charge and followed up with an email to include Senior Nurses/Managers

Audit	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
Hand Hygiene	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Patient Hand Hygiene	✓						✓					
PPE						✓					✓	
Commode	✓		✓		✓		✓		✓		✓	
Mattress		✓			✓			✓			✓	
Pressure Relieving Cushion		✓			✓			✓				
CAUTI				✓								✓
PVC Audit		✓						✓				
Fans	✓											
Water Flushing				✓						✓		
Isolation						✓						
Cleaning Checklists		✓					✓					
Bristol Stool Chart			✓						✓			
MRSA Screening and decolonisation			✓						✓			
CPE Screening						✓						✓
Full IPC ward/departmental												

Reactive and Adhoc Audit Programme

Infection Prevention Rapid Reviews

These should be completed reactively when there is an issue of concern in a particular area

Feedback must be provided in real time to Departmental Manager/Ward Sister/Nurse in Charge and followed up with an email to include Senior Nurses/Managers

	Hand Hygiene	Patient HH	PPE	Commode	Mattress	Cushion	Snap Shot Catheter counts/ passport	Snap Shot PVC counts/bundles audit	Snap Shot MRSA Screening	Water Safety checklist	CPE checklist	Snap shot cleaning checklist audit
ARI outbreak	✓	✓	✓	✓	✓	✓	✓	✓				
Norovirus outbreak	✓	✓	✓	✓	✓	✓						
PII diarrheoa	✓	✓	✓	✓	✓	✓						✓
C.diff	✓	✓	✓	✓	✓	✓						✓
CPE	✓	✓	✓	✓	✓	✓	✓		✓		✓	✓
MRSA BSI	✓		✓		✓	✓	✓	✓	✓			
New Hospital onset MRSA isolate	✓		✓		✓	✓	✓	✓	✓			
HA MSSA BSI	✓		✓				✓	✓				
HA Klebsiella (BSI)	✓		✓				✓	✓				
HA Ecoli (BSI)	✓		✓				✓	✓				
HA AMR Ecoli	✓		✓				✓	✓				✓
Ps. Aeruginosa (Augmented care)	✓	✓	✓		✓	✓	✓	✓		✓		
Other for discussion with site lead												

Staff Influenza Programme 2025/26

Update

Title: Staff Influenza Programme	
Authors: Kailey Ben-Sassi, Strategic and Clinical Lead Immunisation and Vaccination Pharmacist/Deputy Vaccination Programme Director Hannah Aucutt-Bracegirdle, Business Manager	
Division/Area/Department: Integrated Vaccination Service	
Date: 20th October 2025	**Version: v0.1**
Publication/Distribution: QSE Committee	
Purpose of the document: To inform the QSE Committee of the progress made with the delivery of Staff Influenza Programme within Betsi Cadwaladr University Health Board	

Key Message

Latest Uptake Position

As of 20th October 2025, 24% of BCUHB staff have received a flu vaccination. This compares favourably to the same date last year, when only 12% of staff had been vaccinated.

Overview

In response to a decline in flu vaccination rates among health and social care workers, staff aged under 65 commenced vaccination earlier than the traditional start date of 1st October. The standard start date still applied for the older adult and at-risk workforce.

An uptake target of 75% has been set for the 2025/26 staff flu programme. A total of 21,300 BCUHB staff are eligible for vaccination this winter. Last year, BCUHB achieved an uptake rate of 34%**,** the highest in Wales. While this achievement is recognised, continued efforts are needed to ensure convenient access and effective communication of the benefits of vaccination to encourage participation.

The influenza vaccination programme at BCUHB is led by the Health and Well-being at Work team and delivered through over 300 peer vaccinators, vaccinators within the Health Protection Service, and the Integrated Vaccination Team.

Reporting

- Weekly executive reporting- including analysis of staff sickness and vaccination uptake
- Weekly flu -lead staff meetings to coordinate delivery, share best practice, and address emerging issues. Each directorate has a representative invited to attend this meeting

Communications

- Distribution of posters, stickers, and flu vaccinator badges across all sites
- Peer-led delivery and engagement initiatives
- Executive photos and video messages endorsing the campaign (see Appendix 1)
- Patient story shared to highlight the importance of vaccination from lived experience (see Appendix 2)
- 'Five Ways to Get Your Flu Vaccine' campaign outlining accessible routes for staff (see Appendix 3)

Strategies to Optimise Uptake for Winter 25/26

- Targeted text messaging via ESR – bilingual, behaviourally informed messages (developed with PHW Behavioural Science Unit) encourage staff to book vaccinations. Linked to a dedicated landing page with a video message from the Chief Executive and vaccination details. The campaign will be reviewed and may be repeated in mid–late November.
- Chief Medical Officer letter highlighting the responsibility of staff to support the health board winter resilience planning by up-taking the offer of a flu vaccine – shared via BetsiNet updates (w/c 13th October), and featured in the Weekly Bulletin (w/c 20th and 27th October). Additional executive leadership messages will reinforce this communication.
- Staff sickness reporting – to inform monitoring and support directorates to extrapolate poor vaccine uptake with increased sickness is being considered

Challenges

Central Procurement of Flu

The introduction of a central procurement national model this winter required additional planning to ensure logistics and distribution align with BCUHB's geographically diverse and demographically varied workforce.

Welsh Immunisation System (WIS)

Recording vaccinations in WIS at the point of delivery ensures accurate, timely data and prevents duplicate entries. However, many peer vaccinators lack direct WIS access, requiring paper records to be generated and submitted. This results in a data reporting lag and presents clinical governance considerations regarding secure record management.

Appendices

1. Appendix one : Executive photos and video recordings - 'We thought she may not make it': why the flu vaccine matters to me

2. Appendix two: Patient Story - "My body was shutting down – you don't understand how serious flu can be." - Betsi Cadwaladr University Health Board

3. Appendix three: Five ways to get your staff flu vaccine

Teitl adroddiad: ***Report title:***	Perinatal (Maternity and Neonatal) Assurance Self -Assessment Briefing			
Adrodd i: ***Report to:***	Quality, Safety and Experience Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 06 November 2025			
Crynodeb Gweithredol: ***Executive Summary:***	The Welsh Government has commissioned an Independent Oversight Panel to undertake a comprehensive All-Wales Maternity and Neonatal Assurance Assessment. The assessment aims to provide assurance to the Cabinet Secretary for Health and Social Services regarding the delivery of safe, high quality, and comprehensive care in maternity and neonatal services across Wales. The assessment will focus on being forward-looking and will consider the voices and experiences of women, parents, families and the maternity and neonatal workforce in Wales. The assessment will provide real-time assurance. The findings of this assessment will identify strengths, opportunities for improvements, and areas of potential concerns requiring prompt action. The Oversight Panel is expected to give initial advice to the Health Secretary by the end of the year. The enclosed presentation details the Assessment's; • Objectives • Methodology • 6 Workstreams informing the Assessment. • National and Local Critical Paths in the Assessment. • Organisational Self-Assessment and Questions for Board.			
Argymhellion: ***Recommendations:***	The Committee is requested to; note the content of the presentation and expect a Health Board specific Report in conclusion of the Assessment in addition to a National Report and Recommendations in Q4 of 2025/26.			
Arweinydd Gweithredol: ***Executive Lead:***	Tehmenna Ajmal, Chief Operating Officer			
Awdur yr Adroddiad: ***Report Author:***	Women's Senior Leadership Team			
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, 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):***	Improving Quality, Outcomes and Experience – IMTP 2025-28 (Section 4k – Women's Maternity and Neonatal Priorities. The Board's overarching strategic intent is articulated through the Integrated Medium-Term Plan (IMTP) 2025-28 which reflects and operationalises both the Welsh Government's 'Maternity Care in Wales – A Five-Year Vision for the Future' (2019-2024) and the Quality Statement for Maternity and Neonatal Services (2025). The IMTP therefore sets out the priorities, attributes, policies and key priorities for maternity and neonatal care and underpins its commitment to delivering equitable, high-quality perinatal services across North Wales.
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	
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?***	Yes Undertaken Nationally by NHS Performance and Improvement Team, responsible of the Assessment.
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?***	Yes Undertaken by the NHS Performance and Improvement team responsible of the 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)***	• BAF24-07 – Workforce and Culture • CRR25-02 – Workforce Sustainability and Future Demand. • CRR25-03 – Population Needs • CRR25-07 – Leadership and Operational Model.

Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	To be confirmed in conclusion of the National Assurance Assessment and Recommendations made for Services.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	To be confirmed in conclusion of the National Assurance Assessment and Recommendations made for Services.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	
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:*** ***Implementation of recommendations***	
Rhestr o Atodiadau: Dim ***List of Appendices:*** *None*	

Perinatal (Maternity and Neonatal) Assurance Assessment

Health Board Briefing Pack

October 2025

CONTENT

1. Background

- Welsh Government has requested NHS Wales Performance and Improvement (NHSP&I) to undertake a comprehensive **national assurance assessment** of perinatal (maternity and neonatal) services across Wales. (forToRs – please see Appendix 1)

- This assessment will focus on being **forward-looking,** designed to provide assurance to the Cabinet Secretary for Health and Social Services as to whether services are delivering **safe, high-quality care** in line with the National Quality Statement and Standards and whether learning from previous reviews in Wales and across the UK has been effectively embedded.

- It will be overseen by an independent chair and oversight panel.

- Professor Sally Holland, a leading care academic with expertise in child and family welfare, protection, public involvement, equality, diversity and inclusion, has been appointed as the Chair.

- The final report will be presented to the Minister in Q4 of 2025/26.

2. Objectives

The objectives of the assurance assessment are to:

- Provide a current-state assessment of the quality and safety of perinatal services in each health board across Wales, supplemented by a national overview.
- Undertake a national whole-system, evidence-informed quality and safety assessment of perinatal services in partnership with women and families, staff, providers and system leaders, with outputs described at a health board and national level, in a report for the Cabinet Secretary for Health and Social Care.
- Ensure that any emerging safety and quality risk or concerns are acted on and rapidly improved, so services are consistently safe and of high quality.
- Assess any variation in care quality and outcomes across the range of perinatal pathways.
- Ensure that exemplary practice is identified and shared for national adoption.
- Ensure insights from women and families, service users, staff, providers, and system leaders inform evidence-based recommendations.
- Further develop actionable assurance measures that support sustainable improvements and equitable care. The assessment will be undertaken against key criteria in the national Quality Statement and Quality Standards, together with the supporting enabling actions.

3 Methodology

The approach will incorporate a multi-method assessment to allow triangulation of evidence against the NHS Wales Quality Statement. This process will consist of individual workstreams and developed in collaboration with the independent chair and the expert panel. The workstreams will incorporate:

- The views of women and families
- A desktop review of national and health board data held by NHSP&I
- A desktop review of national (UK) recommendations in previous maternity and neonatal reviews, and the impact.
- Family engagement events, to include ethnic minority, seldom heard communities and inequalities groups.
- Healthcare professional engagement events.
- Data from organisational self-assessments.
- Clinical site visits across maternity and neonatal pathways, antenatal care, postnatal, labour ward and community.

Any safety and quality concerns as well as areas related to exemplary practice highlighted through the process to the assessment panel must be escalated to ensure immediate action.

4. Workstreams

The assessment is structured around six workstreams, each led by an independent expert and overseen by the Independent Chair.

1) Assessment of the data and evidence related to maternity and neonatal services.
2) Reviewing previous maternity service reviews form across the UK in the last 10 years.
3) Healthcare organisation leadership, culture and governance.
4) Women, Parent and Family Engagement.
5) Understanding the experience of staff in perinatal service.
6) Site Visits.

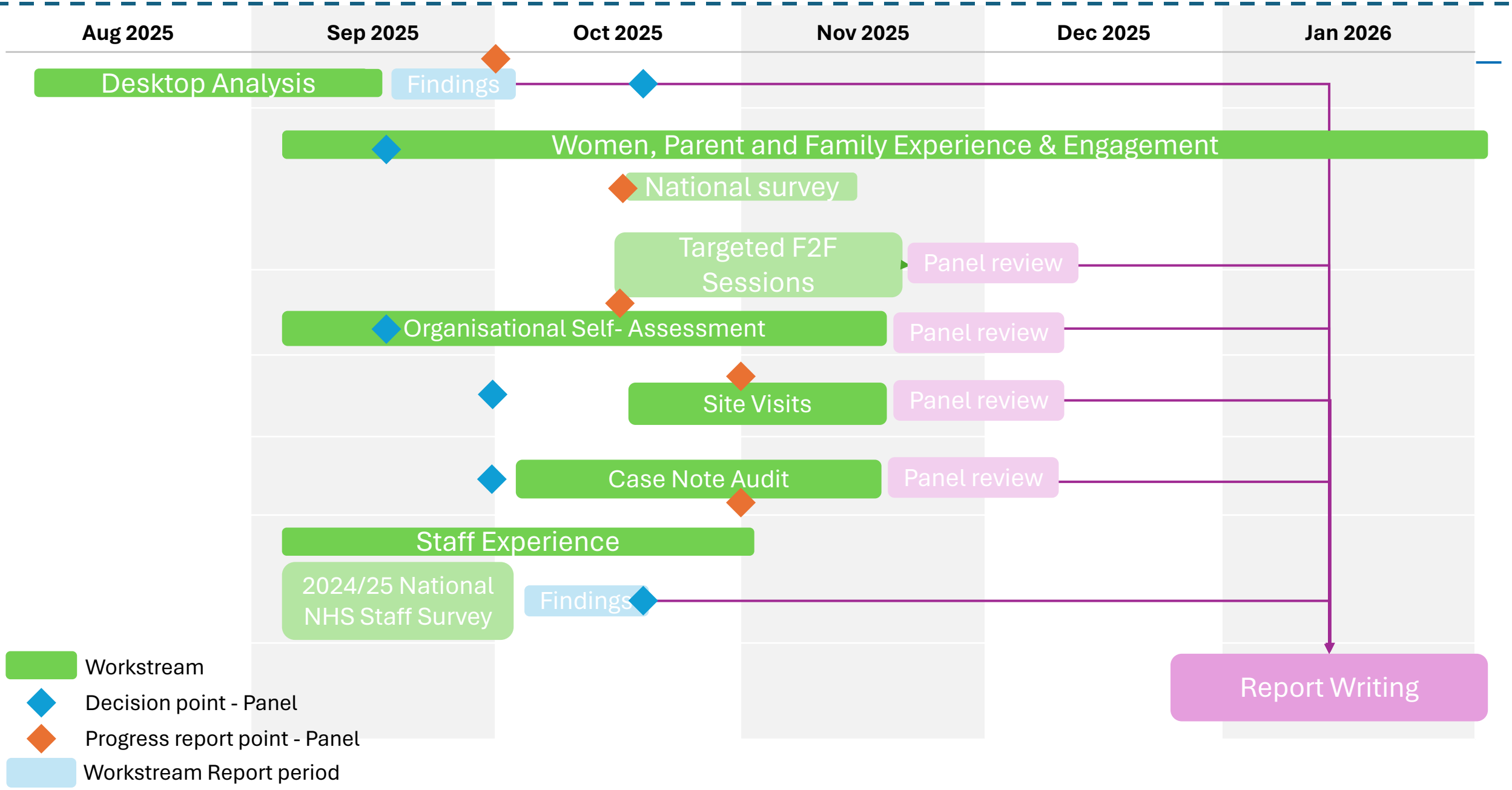
Updates

- The first two workstreams are underway – (Assessment of data/evidence and review of previous maternity reviews over 10 years)

- The remaining three workstreams run concurrently, as the engagement phase and will require significant engagement from Health Board teams, as well as from women, parents and families who use services. Planning meeting with NHSI&P Team w/c 13/10/25. ToRs and communication strategy for these workstreams awaited.

- The **'Health care organisation leadership, culture and governance'** workstreams methodology was confirmed in a suite of documents to all Heath Boards on 3rd October 2025.

5 Critical Path



Local Critical Path

Organisational Self- Assessment - the submission date has been revised to the 31/10/25

Staff Engagement Field Work Sessions - the National Oversight Team and Lead will be on Site as confirmed below;

4/11/25 – Wrexham Maelor

5/11/25 – YGC

6/11/25 – YG

User/Community Group Listening Sessions will be undertaken across the 3 Communities Areas on the same days by a separate national team and lead.

15 Steps to Perinatal Service /Walkabouts - A National Team with a designated lead will be visiting Sites as confirmed below;

12/11/25 – Wrexham Maelor

13/11/25 – YG

14/11/25 – YGC

Please note ToRs for all the Assurance Assessment Workstreams, including the above, have been added to the NPAA section/tile on the BetsiNet Pages.

Formal Communications to support this Field Work is awaited from NHSPI Team.

6. Healthcare Organisational Leadership, Culture and Governance Workstream

This includes a self-assessment designed to capture perspectives at three levels;

- Board/Executive
- Service
- Unit

This structure enables detailed analysis and is designed to inform organisational improvement prioritise and action plans to spread good practice, as well as highlight areas of national focus and learning.

Methodology

- Each Health board has been given access to a dedicated ‘SharePoint’ Site containing the self-assessment template and a folder for uploading supportive evidence.

- The intelligence and evidence submitted in response to the self-assessment has to be relevant and provides a transparent perspective of the Heath Board's position.

- Deadline for completion and submission is Friday 31st October 2025.

- Following submission, the Organisation Self-Assessment Workstream Panel Lead will arrange a formal discussion with members of the Health Board to review the evidence submitted.

7. Self-Assessments – Matrix and Open Test Questions

Includes 8 Domains

1. Organisational Culture and Values
2. Clinical and Professional Leadership
3. Governance and Accountability Structures
4. Quality of Care and Women, Parent and Family Outcome
5. Staff Experience, Voice and Engagement.
6. Women, Parent, Family and Community Involvement.
7. Equity, Diversity and Inclusion
8. Learning, Improvement and innovation Capacity

This section will be completed and validated by Services IHCs and the Executive Lead, to include the additional open text questions for Director of Midwifery/Head of Neonatal Services, by 16/10/25

8. Self Assessment – Open Text Questions for Board

This section will be co-ordinated by the Health Board's Director of Governance and signed off by the CEO for submission by 31/10/25.

The questions for Board are as follows;

1) Do you have a vision and strategy specifically for your maternity and neonatal service? How was this developed and who was involved (partners and all stakeholders).

- Does this vision and strategy capture sustainability factors (financial, quality or both) associated with its effective delivery.
- How does your maternity and neonatal vision and strategy take account of the risks associated with the risks, such as geographical provision of maternity and neonatal services; considering the models of care associated geographical risk and workforce modelling (isolation and activity)
- How does this vision and strategy consider the evolution of maternity and neonatal care provision and the associated workforce modelling or strategic risks?
- How often is this strategy reviewed following approval; what triggers a review and when was the last review completed?

8. Self Assessment – Open Text Questions for Board

2) **How does Maternity and Neonatal services feed into the Board Assurance Framework and management of risk processes? How is the Board assured that it has a clear line of sight to maternity and neonatal services** (are there multiple layers of committees between the Board and those with day-to-day responsibility? Is there a service manager with knowledge of current practice in the room for all discussions about maternity?)

3) **How is the Board assured that:**

- Escalation processes are robust, both internally within the Health Board and externally with wider partners and regulators.
- Once escalated the necessary response and actions are triggered and acted upon, both internally within the Health Board and externally with wider partners and regulators.

4) **What maternity and neonatal outcomes do the Board monitor and with what frequency? What actions have resulted from monitoring outcomes?**

5) **When did the Board last have a substantive discussion about maternity services, what was discussed and what actions resulted?**

8. Self Assessment – Open Text Questions for Board

6) **Who on the Board has a lead for the maternity services? How regularly do members of the board (executive and non-executive) visit maternity services, when did they last conduct a site visit and what were the outcome of the visit(s)?**

7) **At what level of seniority is the most senior midwife appointed and what service areas does that role cover in terms of responsibility and oversight?**

8) **When was the last time the Health Board proactively requested external input or peer review and how does the Health Board embrace peer review comparisons to consider the effectiveness and safety of their own maternity and neonatal service? Please provide examples.**

9) **What is your process for Quality Impact Assessments, by whom and what decision regarding maternity services have you not taken as a result of a QIA?**

10) **How are you assured where matters of conduct (racism; bullying; sexual-discrimination; harassment etc) are raised they are appropriately managed? And what is your longest outstanding disciplinary**

Appendix 1 – All Wales Perinatal Maternity and Neonatal Assurance Assessment – Terms of Reference

Microsoft Edge
PDF Document

Teitl adroddiad: *Report title:*	Challenged Services Report
Adrodd i: *Report to:*	Quality, Safety and Experience Committee
Dyddiad y Cyfarfod: *Date of Meeting:*	6th November 2025
Crynodeb Gweithredol: *Executive Summary:*	The purpose of this paper is to provide the committee with an overview of current progress and assurance regarding more detailed scrutiny that has already taken place via the Executive. This follows the Deep Dive undertaken at the September QSE and regular assurance will now be provided via this report following prior scrutiny at Executive level. Recent weeks have seen a continued maturing of the organisational approach and oversight arrangements. The Welsh Government (WG) touchpoint meetings have moved to a quarterly basis as previously indicated and confidence in local mechanisms grows. The most recent touchpoint meeting in October saw some positive progress noted and also marked an important transition as the presentations to WG were led by operational and clinical leads from the service, with executive colleagues in attendance to support, pivoting from the previous executive led approach. As the WG meetings reduce in frequency, the Strategic Planning and Service Change group has also approved the strengthening of local scrutiny with the implementation of a monthly oversight group, chaired by the Chief Operating Officer. This will provide an important balance of challenge and support and ensure known issues continue to be addressed and that any emerging issues are surfaced in a timely manner. Membership will also include the Executive Medical Director and colleagues from the Risk Management team as part of triangulating clinical risk with the Board Assurance Framework and the Corporate Risk Register, and supporting a smooth transition to the Clinical Services Plan phase 2. In acknowledging the maturing oversight arrangements, it is also important to recognise that a number of challenges do remain across services which are being closely managed. Orthodontic services remain particularly challenged and Welsh Government have convened a national work group to support, which augments a local group. Workforce challenges and recruitment are a particular constraint however despite these challenges the service has made improvements in waiting times. The service model within Dermatology remains in need of significant reconfiguration however a recent multi-professional workshop marked an important point in reviewing options and work has been agreed around five priority pathways. Some junior workforce challenges are a particular concern in Vascular however the final of the four inquests following the Royal College review has now been held with a narrative conclusion reached and marking a key juncture. Plastics and Oncology were identified for consideration for de-escalation at the August WG meeting and the Health Board has been engaging with that process through the supply of key information. Further information is expected around the outcome following the next tripartite meeting in November.

<table>
<tr><td></td><td colspan="4">Overall, there is increased confidence in the management of the issues, and the executive retains a firm handle in delving into areas. Progress is being made whilst acknowledging that there remains a lot to do to reach a truly stable position.</td></tr>
<tr><td>Argymhellion:
Recommendations:</td><td colspan="4">The Committee is asked to:

▪ RECEIVE ASSURANCE on the progress being made and the mechanisms in place at Executive level to scrutinise concerns and expedite issues.</td></tr>
<tr><td>Arweinydd Gweithredol:
Executive Lead:</td><td colspan="4">Paolo Tardivel, Executive Director of Transformation & Strategic Planning (Interim)
Tehmeena Ajmal, Chief Operating Officer
Clara Day, Executive Medical Director</td></tr>
<tr><td>Awdur yr Adroddiad:
Report Author:</td><td colspan="4">Geraint Parry, Assistant Director of Transformation (Interim)</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">To support the Integrated Medium Term Plan (IMTP)</td></tr>
<tr><td colspan="2">Goblygiadau rheoleiddio a lleol:
Regulatory and legal implications:</td><td colspan="3">Not applicable</td></tr>
<tr><td colspan="2">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?</td><td colspan="3">Not applicable</td></tr>
<tr><td colspan="2">Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal?</td><td colspan="3">Not applicable</td></tr>
</table>

In accordance with WP68, has an SEIA identified as necessary been undertaken?	
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	

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

Health Board Challenged Services Progress Report

October 2025

Trugaredd Compasssion

Agored Openness

Parch Respect

SECTION 1 - EXECUTIVE SUMMARY

The Health Board currently has 8 clinical services which have been designated as 'Challenged Services of Concern' by Welsh Government (WG) as outlined within the detail of the report.

The national scrutiny continues via Touchpoint meetings which are now held quarterly, with 4 specialties reviewed each time, and the most recent meeting in October focused on Urology, Vascular, Ophthalmology and Dermatology. At this meeting the Health Board transitioned to a position that had been planned for some time for the presentations to be led by the service via operational and clinical leads as opposed to an executive led approach. This marks a continuation of the Health Board journey in line with the All Wales Escalation and Intervention Framework – to date the heightened escalation and scrutiny had determined a need for direct control via the Executive however this shift in approach, with key executive colleagues remaining in attendance to support marks a significant point in the BCU improvement journey.

Traction is being seen across all services although the scale of improvement differs. Plastics and Oncology are considered to have made the furthest progress against the de-escalation criteria and are being actively considered for de-escalation. An important factor to note if this outcome is achieved is that these services will not move down the de-escalation ladder to Level 4 but will be considered suitable for removal from the Special Measures categorisation. There will of course remain issues to resolve and these will be tracked via business as usual monitoring under the banner of the Integrated Performance Framework.

Orthodontics remains amongst the most challenged areas with significant recruitment challenges within a national market that has equal challenges and Welsh Government are providing support in this area. The Clinical Implementation Networks continue to bring their expertise to bear and a number of multi-professional workshops have been held over recent months. These are beginning to yield positive outcomes in relation to clinical engagement and commencing constructive discussions around long term sustainability for services and how these can both be addressed in both the short term whilst also considering the longer term outlook via the Clinical Services Plan phase 2.

SECTION 2 – PORTFOLIO HIGHLIGHTS

Service	Overall Delivery Confidence	Resource	Finance	Plan	Progress	Risks / Issues
Oncology						

- Joint Commissioning Committee (JCC) have approved North Wales Cancer Treatment Centre (NWCTC) to be a provider of lung SABR (stereotactic ablative body radiotherapy) enabling patients to be treated locally rather than travel to Clatterbridge – first patient identified to commence in November 2025.
- Ongoing focus on recruitment of medical workforce and future workforce planning. Careers Open Day on 28/09/2025 attracted 125 visitors who toured NWCTC and met various professions and university representatives– feedback very positive with the aim to make this an annual event.
- SACT (Systemic Anti-Cancer Therapy) waiting time to commence first treatment maintained at 3 weeks with urgent patients being accommodated as appropriate –a reduction from 6 weeks reported in May 2025.

Positive feedback from WG with good progress being made in relation to workforce sustainability and the recent update highlighting ongoing service innovation. WG are currently assessing performance of both chemotherapy and radiotherapy waiting times to decide if this service could be de-escalated from Special Measures.

Orthopaedics						

- Good engagement with West IHC operational and clinical teams for initiation of 'follow-up' backlog reduction with Seen on Symptoms (SOS), with a roll out plan for Central and East IHCs.
- Value and Sustainability team working with procurement and network (local and national), and engaging with clinical leads and teams on implant rationalisation value opportunities.
- Supported by improvement activities within the Planned Major Change Programme core work streams such as Health Screening Questionnaire (HSQ), High Volume Low Complexity (HVLC) lists and referral management, ensuring synchronicity of activity.
- Therapy Led Community Appointments Days (CAD) in place with multi-professional teams including community third sector and local authority partners to ensure a holistic approach for musculoskeletal (MSK) patient cohorts to support the prevention of deteriorating MSK health. Commenced in the West area as a test of change in January 2025 and colleagues now looking to roll out following discussions with IHC Directors of Therapies and attendance at recent 'Spread and Scale' academy event in Cardiff in October 2025.

Positive feedback from WG that there is good line of sight towards making this service sustainable. Good use of Allied Health Professionals (AHPs) in East IHC (Wrexham) and potential to spread this to other sites and progress in developing minor operating procedures (MOPs).

Orthodontics						

- North Wales Orthodontic Group continues to meet to explore options to address immediate issues within workforce e.g. Impact on capacity of impending maternity leave of consultant orthodontist, with locum job description going out to advert and insourcing partner identified for stage 1 activity. Highly motivated workforce looking to drive changes despite the constraints.

Service	Overall Delivery Confidence	Resource	Finance	Plan	Progress	Risks / Issues
• Despite pressures, positive reductions have been noted in Stage 1 waiting lists between January 25 and October 25 as follows: 52+ weeks 974 to 431; 104+weeks 591 to 251; 156+weeks 277 to 71. • GIRFT report signed off with aim to integrate recommendations for implementation and monitoring into a detailed improvement plan to address medium and long term challenges. Orthodontics remains a significant area of concern, with continued challenges relating to workforce, backlog and access to waiting times across primary and secondary care; infrastructure (estate and digital) and the lack of a sustainable service model. The workforce challenges reflect a national shortage including a lack of consultant and alternative professional staff, compounded locally with the loss of a Consultant since the GIRFT review (January 2025) and upcoming maternity leave. Despite the challenges there has been a reduction in waiting times for those waiting over 104 and 52 weeks for their first appointment but there remains a number of patients waiting over 156 weeks. Work is ongoing to optimise the referral processes and the use of insourcing opportunities to help with demand.						
Ophthalmology						
• Following a successful procurement process, an additional Outsourcing contract commenced to meet Welsh Governments (WG) aim of treating 4610 additional patients with cataracts by the end of March 2026. To date, 2394 patient's appointments have been delivered. • Cataract one-stop Pre-operative assessment clinics (POAC) embedded in East and Central with roll out commencing in West. • BCU & community optometrists ongoing implementation of cataract refinement enabling effective streaming of patients to High Volume Low Complexity (HVLC) pathway. • Holywell Teach and Treat course for Higher Certificate Medical Retina, commenced Go Live with 2 students in October 2025: with 3 additional to join by Summer term 2026. This BCUHB and Cardiff University partnership resource will provide a minimum average of 125 patient appointments per student/annum with a maximum capacity* of 17 students (10 Independent Prescribing, 4 Glaucoma, 3 Medical Retina) students/ year". *Capacity capped by a combination of HEIW funding, Teach & Treat staffing and room capacity. • Challenges relating to Optometry lead spanning Primary and Secondary care and requirement for further discussions to ensure greater integration in line with other Heath Boards. Eye care services across North Wales are facing significant systemic challenges that continue to impact patient safety, service quality and operational sustainability. The Speciality plan contains a number of actions to address patient harm and experience, fragmented service delivery, workforce gaps and infrastructure (physical and digital) limitations and delays. This includes activities such as the development of integrated training plans and the delivery of Wales General Ophthalmic Services (WGOS) pathways, seeing a shift towards primary care services.. As with other Challenged Services, the Planned Care Major Change Programme is supporting a number of key improvements including POAC and HVLC.						

Urology

- Local Anaesthetic Transperineal Prostate biopsy (LATP) progress: a paper to reduce delays in prostate biopsy diagnostics was approved by both the Prostate Cancer Pathway Forum and the Steering Group; three non-medical staff have joined the national LATP training programme, supporting a sustainable model outlined in the LATP paper.
- Agreement reached to advance major urology cancer surgery with Wirral, including commissioning RAS (Robotic Assisted Surgery) prostatectomies and planning for repatriation through partnership working.
- Following recruitment to the clinical lead post in the West IHC, there is now a clinical lead in place for all three IHCs.
- Digital enablers progressing well with electronic referrals, digital dictation and My Medical Record being in place by the end of the financial year.

The current healthcare delivery model in North Wales faces significant challenges impacting sustainability, performance, leadership, and patient experience. The reliance on locum consultants is unsustainable, driven by difficulties in recruitment and retention linked to an unattractive on-call rota and the absence of robotic surgery capabilities. Performance metrics show delays in the Urgent Suspected Cancer (USC) pathway, excessive 104-week waits, and unmet 8-week diagnostic targets. The Urology Specialty Plan, provides a roadmap to address leadership (pan BCU) and recruitment gaps, improvements in patient experience, clinical variation and infrastructure issues and this is being driven forward by the re-established Urology Steering Group with support from the national Clinical Lead who assumed the initial chairing of the group.

Dermatology

- Preparation for opening of Connah's Quay in final stages with Infection, Prevention and Control recommendations being processed. Discussion with Landlord has taken place and is now waiting on agreement of shared tenant to go-ahead with changes.
- Workshop held 24th September 2025: service model options appraisal being developed and Task & Finish Groups to implement 5 priority clinical pathways: Teledermoscopy, referral management, SOS and PIFU (Patient initiated follow up), Minor Surgery Directed Supplementary Service (DSS), and acute inpatient referral management. These form the first priority areas as part of developing an overall shift to a more primary care focused service model.
- Maintenance of 104 week waiting list target with national insourcing contract to support Referral to Treatment (RTT) delivery.
- Teledermoscopy advanced across North Wales but work continues to further expand its implementation.
- Linking with the Quality Directorate to identify themes of patient harm within dermatology and developing actions plans for mitigation.

As with other Challenged Services, workforce shortages and recruitment difficulties (especially in the West) are limiting clinical capacity and service resilience. This is impacting the ability of the service to meet the rising demand within the current capacity. The successful workshop in September resulted in clear outcomes to support the implementation of a sustainable service model; this will need strategic and operational workforce planning to support and compliment the new clinical pathways.

Vascular

- The final of 4 inquests following the Royal College review has now been heard by the Coroner. The learning from this, and other patient safety and experience cases, will continue to be reflected and acted upon through continuous improvement.
- Capacity to undertake urgent and routine patient reviews created through development of Advanced Nurse Practitioner (ANP)/ Vascular Nurse Specialist (VNP) hot clinics at YGC. Next steps are to scope role of PIFU and SOS clinics in West.
- Application of Evidence Based Intervention Wales (previously known as Interventions Not Normally Undertaken (INNU)) policy and revised referral guidance for surgical management of varicose veins has successfully reduced the 104+ week waits (from 140 in June 2025 to 37 in October 2025)
- Commissioning arrangement with UHNM (Royal Stoke) for Abdominal Aortic Aneurysms (AAA) is maintained. External review completed and meeting in place to review findings. Internal review of service activity and performance data in progress, to support review and help inform next steps.
- Following successful workshop, a proposed model which supports the strengthening of the current network approach to enable greater integration and use of resources is being developed for consultation with IHCs by the end of October 2025. This review of the clinical model will include the strengthening of Multi-Disciplinary Team (MDT) arrangements and this will align to work around the broader clinical service plan.

The service holds risks relating to waiting times, lack of vascular training and vascular access for renal patients. Mitigating actions, as well as strategic plans, include: developing workforce sustainability of both medical and nursing staff, reducing waiting times, improving MDT collaboration and decision making, co-producing a unified and integrated clinical strategy, exploring opportunities to use community facilities to expand service capacity and address risk associated with junior doctor rotation suspension through strengthened training and targeted recruitment.

Plastics

- Recruitment to Connah's Quay minor operating facility nursing team; once facility opened to Dermatology, to agree a start date with JCC and MWL for plastics
- Increase in waiting list over summer period (from 380 in April to 487 in October), with no waits over 104 weeks maintained. WLI clinics in both Central and West in October to recover position
- Confirmation from JCC that commissioning arrangement will not change until 2027 (deferred from 2026); formal request sent to JCC to facilitate handover of waiting list to MWL as per RTT guidance. Correspondence returned from JCC that this will take place post the Connah's Quay opening when capacity and demand is in balance.

Positive feedback from WG: considerable progress has been made in this area. Subject to a final review of de-escalation criteria and confirmation of arrangements for Connah's Quay Medical Centre, it was felt that this service could be de-escalated from Special Measures. Awaiting a decision by WG following submission of Specialty plan and update on Connah's Quay opening.

Teitl adroddiad: ***Report title:***	**Proposed changes to the NHS Wales Policies**: **1. "Making Decisions on Individual Patient Funding Requests (IPFR)"** **2. "Prior Approval Requests (PAR)"**			
Adrodd i: ***Report to:***	QSE Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	6 November 2025			
Crynodeb Gweithredol: ***Executive Summary:***	This report • provides context and background to the recent review of the above Policies; • highlights the key changes to note • outlines the timescale for rollout and operational implications			
Argymhellion: ***Recommendations:***	To note this report; and To endorse these versions of the all-Wales Policies for funding individual treatments for operational use within BCUHB			
Arweinydd Gweithredol: ***Executive Lead:***	• Executive Medical Director; ***Dr Clara Day***			
Awdur yr Adroddiad: ***Report Author:***	Sarah Davies, IPFR Development Manager, on behalf of Dr Jim McGuigan, Deputy EMD and Chair of the BCUHB IPFR Panel			
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:***				
There is confidence that the revisions to these Policies have been made for the purpose of greater clarity regarding interpretation of the decision-making criteria, without fundamentally changing the core aspects of the Policies. The operational procedures required to be compliant with the Policies remain unchanged.				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	1. Building an effective organisation 3. Improving quality outcomes and experience			

Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	NHS in Wales has introduced these Policies on decision making for IPFRs and PARs to ensure a consistent and equitable approach across Wales. These Policies provide an open, transparent, fair, clearly understood and easily accessible process for all Health Boards to follow The All-Wales IPFR Policy has been in place since 2011 and was last updated in 2017. The PAR Policy was introduced in March 2018. Both are subject to regular review. The latest revisions to the IPFR Policy were prompted in response to a Judicial Review of one decision for IPFR, made by the WHSSC (now NWJCC) Panel in 2022. The review also includes other minor updates deemed relevant. The revisions to the PAR Policy were made following routine review.
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 – the need for an EqIA is considered from an an All-Wales perspective and will not be the responsibility of an Individual Health Board.
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)***	N/A
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)*	N/A
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*** These revised Policies are currently being endorsed by NWJCC and each Health Board across NHS Wales. Once all Health Boards have approved the Policies a date for rollout will be agreed. They are expected to be fully operational by October 2025	
Rhestr o Atodiadau: ***List of Appendices:*** 1. Briefing Paper 2. NHS Wales Policy "Making Decisions on Individual Patient Funding Requests (IPFR)", July 2025 3. NHS Wales Policy "Prior Approval Requests", July 2025	

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Report Briefing Paper for updated NHS Wales IPFR Policy

Author Sarah Davies
IPFR Development Manager
BCUHB

Document Title:	**Proposed changes to the NHS Wales Policies :** **1. "Making Decisions on Individual Patient Funding Requests (IPFR)"** **2. "Prior Approval Requests (PAR)"**
Date of Document:	**September 2025**

Situation : How these updates came about, why they need approval now

The current version of the NHS Wales Policy, "Making Decisions on Individual Patient Funding Requests (IPFR)" has been in place since June 2017. The NHS Wales "Prior Approval Request (PAR) Policy" was introduced in March 2018. Both are subject to regular review but opportunities for review were delayed during the Covid-19 pandemic.

In July 2022, following a judicial review of a case considered by the NWJCC[1] (formerly WHSSC[2]) Panel, the Welsh Government supported a review of the IPFR Policy and associated Terms of Reference (ToR) for the IPFR Panels. There followed a lengthy period of engagement, consultation and development, involving all Health Boards, the NWJCC, Welsh Government and legal advice. During this time, the PAR Policy was also revised, so that the two policies remain compatible.

In July 2025, the final versions of the revised Policies were agreed. The proposed versions are accepted by the IPFR Policy Implementation Group as being fit for purpose.

These Policies are required to be approved and adopted by all Health Boards prior to being implemented operationally across NHS Wales at an agreed date.

This briefing paper is to outline the key changes within the agreed updated IPFR Policy.

Background:

IPFRs are defined as

> *requests to a Health Board or NWJCC to fund NHS healthcare for individual patients who fall outside the range of services and treatments that a Health Board has arranged to routinely provide, or commission*.

This can include a request for any type of healthcare including a specific service, treatment, medicine, device, or piece of equipment.

PARs are defined as

> *requests for a patient to receive routine treatment outside of local services or established contractual arrangements*.

This can include (but not limited to) requests for 2nd or specialist opinion, referral due to lack of local or commissioned service, continuity of care with an external treating team.

Both Policies are operated consistently across Wales with each Health Board and NWJCC having their own panel. For governance, the IPFR process is supported by the:

- **IPFR Policy Implementation Group,** whose role is to facilitate the implementation of the Policy, provide and develop assurance systems and guidance to aid the decision-making process. The group membership comprises of a senior member from each HB and NWJCC who are responsible for IPFR.

[1] NHS Wales Joint Commissioning Committee
[2] Welsh Health Specialised Services Committee

Members from AWTTC[3] and Health Technology Wales also attend. The BCUHB member of the Group is the IPFR Development Manager, Sarah Davies.

- **AWTTC** which provides a national quality function to assess IPFR cases, ensuring compliance to the IPFR process. AWTTC are responsible for writing the annual IPFR reports and arranging the annual IPFR training workshop, which are both supported by the IPFR Policy Implementation Group.

These arrangements have been formally in place since 2017.

Feedback and evidence from the national quality assurance group over the years indicates positive improvement in compliance to the policy criteria; improvement in consistency in approach to the IPFR process; and minimal requests for a review of the process followed in making decisions.

The processes are well established and operating consistently across Wales, minimising the potential for 'postcode lottery' with decisions made on behalf of individual patients.

Assessment: The main changes to note are:

1. Individual Patient Funding Requests (IPFR)

- Revisions to the section explaining how IPFR decisions are made, with more explanation of the criteria to be considered.
  - **Primary criteria** relate to whether available guidelines (eg from NICE or AWMSG) recommend NOT to use an intervention; or if the intervention has NOT been appraised hence no guidelines are in place.
  - **Further criteria** require the objective assessment of the clinical circumstances of the patient; the potential for significant clinical benefit; and whether the value for money of the intervention is likely to be reasonable.
- The 'decision making guide' has been retained and updated, but is now an appendix rather than embedded with the core Policy.
- Updated Terms of Reference for the NWJCC IPFR Panel.
- Inclusion of the Terms of Reference for the IPFR Policy Implementation Group.
- Removal of surplus, convoluted, passages referring to legal challenge.
- Simplification of references to Health Board complaints processes and referrals to Public Services Ombudsman for support.

2. Prior Approval Requests (PAR)

- Organisational change from WHSSC to NWJCC
- Clarity on exclusions which will not be considered
  - retrospective requests;
  - requests for healthcare travel costs;
  - referrals related to participation in a clinical trial. These are included in the research costs, or facilitated via Health and Care Research Wales.

Recommendation:

To approve and endorse the implementation of the updated NHS Wales IPFR and PAR Policies for operational use within Betsi Cadwaladr University Health Board as part of the all Wales rollout.

[3] All-Wales Therapeutics and Toxicology Centre

NHS WALES POLICY
MAKING DECISIONS ON INDIVIDUAL PATIENT FUNDING REQUESTS (IPFR)

Reference Number	Policy Reference (as per individual Health Board)	**Version Number**	FINAL July 2025
Linked Documents	Health Board Policies on Interventions Not Normally Undertaken (INNU)		

Classification of Document: Clinical Policy

Area for Circulation: Health Boards and Primary Care providers across Wales

NHS Wales Joint Commissioning Committee (JCC)
Public Health Wales (PHW)
Public Domain via Internet Sites

Policy Development: All Wales IPFR Policy Implementation Group
NHS Wales Joint Commissioning Committee

Consultation: Legal Advice from Welsh Health Legal & Risk Services
NHS Wales Medical Directors Stakeholder groups

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Lead Health Board Contact: **IPFR Team, Betsi Cadwaladr University Health Board**
Block 22, Glan Clwyd Hospital,
Sarn Lane, Bodelwyddan, LL18 5UJ
BCU.IPFR@wales.nhs.uk
Tel: 03000 846880

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1 INTRODUCTION

1.1 Background

In 2010, the Director General, Health and Social Services, Chief Executive, NHS Wales requested that Health Boards would work together with the Welsh Health Specialised Services Committee (WHSSC) and Public Health Wales (PHW) to develop an All-Wales policy and standard documentation for dealing with individual patient funding requests (IPFR) for treatment. This policy has been in place since September 2011.

1.1.1 In October 2013, The Minister for Health and Social Services announced a review of the IPFR process in Wales. An independent review group was established to explore how the current process could be strengthened.

1.1.2 In April 2014, the "Review of the IPFR process" report was published. The report concluded that the IPFR process in Wales is comprehensive and supports rational, evidence-based decision making for medicine and non-medicine technologies which are not routinely available in Wales. The review group also made a number of recommendations to strengthen the IPFR process.

1.1.3 In September 2016, following the 2014 review and implementation of its recommendations, the Cabinet Secretary for Health, Well-being, and Sport agreed the time was right for a new, independent review of the IPFR process. The panel would be independent of the Welsh Government and encompass a range of expertise and knowledge.

The "Independent Review of the Individual Patient Funding Requests Process in Wales" report was published in January 2017.

1.1.4 Following a Judicial Review in December 2021, the Welsh Government in July 2022 agreed that a specific and limited review would be undertaken to put beyond doubt how the policy should be interpreted. In 2024 the commissioning responsibilities of WHSSC were transferred to the NHS Wales Joint Commissioning Committee (JCC).

1.2 Purpose of this Policy

1.2.1 To ensure an open, transparent, fair, clearly understood and easily accessible process is followed, the NHS in Wales has introduced this Policy on decision making for IPFR's. It describes both the principles underpinning how decisions are made to approve or decline individual patient requests for funding and the process for making them.

1.2.2 Continuing advances in technology, changing populations, better information and increasing public and professional expectations all mean that NHS Health Boards have to agree their service priorities for the application of their financial and human resources. Agreeing these priorities is a complex activity based on sound research evidence where available, sometimes coupled with value judgments. It is therefore important to be open and clear about the availability of healthcare treatments on the NHS and how decisions on what should be funded by the NHS are made.

1.2.3 A comprehensive range of NHS healthcare services are routinely provided

locally by primary care services and hospitals across Wales. In addition, the JCC, working on behalf of all the Health Boards in Wales, commissions a number of more specialist and highly specialist services at a national level. However, each year, requests are received for healthcare that fall outside this agreed range of services. We refer to these as Individual Patient Funding Requests (IPFR).

1.2.4 Each Health Board in Wales has a separate Policy called 'Interventions Not Normally Undertaken' (INNU) setting out a list of healthcare treatments that are not normally available on the NHS in Wales. This is because:

- There is currently insufficient evidence of clinical and/or cost effectiveness; and/or
- The intervention has not been reviewed for the indication under consideration by the National Institute for Health and Care Excellence (NICE) or the All-Wales Medicines Strategy Group (AWMSG); and/or One Wales Medicines process or Health Technology Wales.
- The intervention is considered to be of relatively low priority for NHS resources.

1.2.5 The INNU policy should be read together with this policy on making decisions

1.2.6 The challenge for all Health Boards and JCC is to strike the right balance between providing services that meet the needs of the majority of the population in the geographical area for which it is then given responsibility, whilst having in place arrangements that enable it to accommodate people's individual needs. Key to this is having in place a comprehensive range of policies and schedule of services that the Health Board and/or JCC has decided to fund to meet local need within the resource available. To manage this aspect of the Health Board and JCC's responsibilities, there will always need to be in place a robust process for considering requests for individual patient funding within the overall priority setting framework. Demand for NHS services is always likely to exceed the resources available and, as a result, making decisions on IPFR are some of the most difficult a Health Board or JCC will have to make.

1.2.7 In line with the requirements of the Equality Act 2010 and the Welsh Government guidance 'Inclusive Policy Making' issued in May 2010, a detailed equality impact assessment has been completed to assess the relationship between this policy and the duties of the Act.

1.3 Explaining Individual Patient Funding Requests (IPFR)

1.3.1 IPFRs are defined as requests to a Health Board or JCC to fund NHS healthcare for individual patients who fall outside the range of services and treatments that a Health Board or JCC has arranged to routinely provide, or commission. This can include a request for any type of healthcare including a specific service, treatment, medicine, device or piece of equipment.

Such a request will normally be within one of the three following categories.

- a patient and NHS clinician have agreed together that they would like treatment that is either new, novel, developing or unproven and is not within the Health Board's routine schedule of services and treatments for example, a request to use a cancer drug that has yet to be approved by the Health Board for use in that particular condition).

- a patient and NHS clinician have agreed together that they would like treatment that is provided by the Health Board in certain clinical circumstances but is not eligible in accordance with the clinical policy criteria for that treatment (for example, a request for treatment for varicose veins for cosmetic reasons alone).

- a patient has a rare or specialist condition that falls within the service remit of the JCC but is not eligible in accordance with the clinical policy criteria for treatment (for example, a request for plastic surgery where the indication is personal preference rather than medical need).

1.3.2 IPFRs should not be confused with requests for packages of care for patients with complex continuing healthcare needs – these are covered by separate Continuing Healthcare arrangements. Further information can be obtained from the Health Board's Nursing Department.

1.3.3 IPFRs should also not be confused with treatments that have already been provided or administered outside of NHS funded care. Requests **will not** be considered for retrospective funding.

1.3.4 If the clinical circumstances for the specific individual patient have changed, an IPFR application form describing / explaining / justifying:

i. why the patient is likely to gain significant clinical benefit from the proposed intervention; and
ii. demonstrating that the value for money of the intervention for that particular patient is likely to be reasonable,

then a case may be submitted to the Health Board or JCC for consideration for further prospective funding. For example, if a patient funds a treatment themselves and their clinician believes they can demonstrate that the patient has gained significantly more clinical benefit from the intervention than would normally be expected for that treatment, an IPFR can be submitted for consideration.

1.3.5 The three categories of treatment described in 1.3.1 will only potentially be funded in specific clinical circumstances. It is important to note that the NHS in Wales does not operate a blanket ban for any element of NHS healthcare but equally the granting of funding in one case does not mean that funding will be provided for the same treatment for other patients. We will consider each IPFR on its individual merits and in accordance with the arrangements set out in this policy. We will determine if the patient should receive funding based on the significant clinical benefit expected from the treatment and whether the cost of the treatment is in balance with the expected clinical benefits.

1.3.6 In this policy, the words "significantly different to the general population of patients" means that the patient's condition does not have substantially the same characteristics as other members of that population. For a patient to be significantly different, their particular clinical presentation is unlikely to have been considered as being part of the population for which the policy was made.

1.3.7 In practice, it is not always practical to determine the "benefit" of an intervention in numerical terms in the same way, for example as NICE or the AWMSG. In these situations, a description of the benefit should be used to

enable IPFR panels to compare the description of the incremental clinical benefit likely to be obtained.

In general, the clinician should compare the benefits of the intervention being requested with what he or she considers to be the next best alternative, which may in some cases be best supportive care.

1.3.8 Whether an intervention provides "value for money" is assessed conceptually in terms of the incremental cost per incremental quality-adjusted life year (QALY) of benefit. Whilst "reasonable" value for money is to be interpreted in the same way that "cost-effective" is used in the Health Technology Appraisal (HTA) process operated by NICE, AWMSG and HTW.

1.3.9 Recognising that it can never be possible to anticipate all unusual or unexpected circumstances, this policy aims to establish a clear guide to making decisions on IPFRs to determine whether the evidence that the patient is likely to gain a significant clinical benefit, and the value for money of the intervention for that particular patient is likely to be reasonable, has been presented.

Please refer to the decision-making factors in Appendix one. These are factors the panel may consider when looking at the significant clinical benefit expected by the treatment, and whether the cost of the treatment is in balance with the expected benefits.

2 THE LEGAL CONTEXT OF THIS POLICY

2.1 Health Boards exercise functions delegated to them by the Welsh Ministers under various statutes and in particular under the National Health Service (Wales) Act 2006 and under secondary legislation made under that Act.

2.2 In addition to specific statutory obligations, Health Boards are public bodies, which are required to comply with their legal obligations to act in accordance with the rights of individuals under the European Convention of Human Rights as defined in the Human Rights Act 1998 and under common law.

2.3 Health Boards must therefore be able to demonstrate that their decisions are within their powers and comply with their legal obligations. In terms of the exercise of their powers, they must show that they have considered all relevant issues in the decision-making process, giving them appropriate weight and that those decisions are rational, logical, lawful and proportionate.

Careful consideration needs to be given in relation to all decisions; particular care may need to be given in the following circumstances:

- when evidence is not clear or conclusive.
- when the issue is controversial and may not have the support of NICE, AWMSG or HTW.
- when life or death decisions are involved.
- when limiting access to specific services or treatments.
- when setting priorities.
- when other Health Boards or JCC may have used their discretion to make a different decision on a specific topic.

2.4 It is lawful for JCC and Health Boards to adopt policies about which treatments will, and which will not, be routinely funded. It is also lawful for JCC and Health Boards to adopt this policy to define the circumstances in which a decision can be made to fund an intervention for a patient where the patients are lawfully

2.5 denied funding for the same intervention as a result of policies or as a result of an absence of a policy approving funding for that intervention.

2.6 Consistency in policy and approach, together with clarity about clinical criteria for treatment and a consistent approach to dealing with IPFR requests should reduce the need for patients to go through a review or appeal process at any level. This should be the desirable outcome as far as it is possible.

3 PRINICIPLES UNDERPINNING THIS POLICY

The principles underpinning this policy and the decision making of the Health Board are divided into five areas - the NHS Core Values, the Prudent Healthcare Principles, Evidence-based Considerations, Ethical Considerations and Economic Considerations.

3.1 NHS Core Values are set out by the Welsh Government as;

- Putting quality and safety above all else: providing high value evidence-based care for our patients at all times.
- Integrating improvement into everyday work and eliminating harm, variation and waste.
- Focusing on prevention, health improvement and inequality as key to sustainable development, wellness and wellbeing for future generations of the people of Wales.
- Working in true partnerships with partner organisations and with our staff
- Investing in our staff through training and development, enabling them to influence decisions and providing them with tools, systems, and environment to work safely and effectively.

3.2 Prudent Healthcare Principles

- Achieve health and wellbeing with the public, patients and professionals as equal partners through co-production.
- Care for those with the greatest needs first, making the most effective use of all skills and resources.
- Do only what is needed, no more, no less; and do not harm.
- Reduce inappropriate variation using evidence-based practices consistently and transparently.

3.3 Evidence-Based Considerations

3.3.1 Evidence-based practice is about making decisions using quality information, where possible, and recognising areas where evidence is weak. It involves a systematic approach to searching for and critically appraising that evidence.

3.3.2 The purpose of taking an evidence-based approach is to ensure that the best possible care is available to provide interventions that are sufficiently clinically effective to justify their cost and to reduce inappropriate variation using evidence-based practices consistently and transparently.

NICE issue Technology Appraisals and the All-Wales Medicines Strategy Group and Health Technology Wales issue guidance which Health Boards and JCC are required to follow.

3.3.3 Additionally, a central repository for evidence-based appraisals is available which provides support for clinicians making an application. This is located on the shared database. Users are able to upload and access the information

available which will continue to be developed over time as evidence /new reports are produced.

3.3.4 It is also important to acknowledge that in decision making there is not always an automatic "right" answer that can be scientifically reached. A "reasonable" answer or decision therefore has to be reached, though there may be a range of potentially reasonable decisions. This decision is a compromise based on a balance between different value judgements and scientific (evidence-based) input. Those vested with executive authority have to be able to justify, defend and corporately "live with" such decisions.

3.4 Ethical Considerations

3.4.1 Health Boards and JCC are faced with the ethical challenge of meeting the needs of individuals within the resources available and meeting their responsibility to ensure justice in the allocation of these resources ('distributive justice'). They are expected to respect each individual as a person in his or her own right.

3.4.2 Resources available for healthcare interventions are finite, so there is a limit to what Health Boards and JCC can routinely fund. That limitation is reasonable providing it is fair, and not arbitrary. It must be based on the evidence both about the effectiveness of those interventions and their cost. A cost-effective intervention is one that confers a great enough benefit to justify its cost. That means policies must be based on research, but research is carried out in populations of patients, rather than individual patients. That leaves open the possibility that what is true for patients in general is not true about a specific individual patient. Fairness therefore also requires that there must be a mechanism for recognising when an individual patient will benefit from a particular intervention more than the general population of patients would. Identifying such patients is the purpose of the IPFR process.

3.4.3 Welsh Government communications set out six ethical principles for NHS organisations and these underpin this policy. They are:

- treating populations and particular people with respect.
- minimising the harm that an illness or health condition could cause.
- fairness.
- working together.
- keeping things in proportion; and
- flexibility

3.5 Economic Considerations

3.5.1 It is a matter for Health Boards and JCC to use its discretion to decide how it should best allocate its resources. Such resources are finite and difficult

balancing decisions have to be made. Health Boards and JCC must prioritise the services that can be provided whilst delivering high-quality, cost-effective services that actively avoid ineffective, harmful, or wasteful care that is of limited benefit. The opportunity cost associated with each decision has also to be acknowledged i.e., the alternative uses to which resources could be put.

4 MAKING DECISIONS ON IPFR

4.1 In line with the principles set out earlier in this document, Welsh Government communications set out the key factors for 'good decision making'. These are:

- openness and transparency.
- inclusiveness.
- accountability.
- reasonableness.
- effectiveness and efficiency.
- exercising duty of care.
- lawful decision making; and
- the right to challenge and appeal

This policy aims to ensure that the Health Board and JCC has a clear and open mechanism for making decisions that are fair, open, and transparent. It enables those responsible for decision making to demonstrate that they have followed due process, considered the above factors, and have been both rigorous and fair in arriving at their decisions. It also provides a clear process for challenge and appeal.

4.2 In accordance with Welsh Government communications, NICE definitions, and the criteria set out in this policy, Health Boards and JCC should make decisions on IPFRs based on; the evidence presented to demonstrate the expected significant clinical benefit, and the evidence presented outlining the patient's individual clinical circumstances. Decisions should be undertaken whilst taking into reasonable account the evidence base, and the economic and ethical factors below:

- **evidence-based considerations** – clinical and cost effectiveness; service and policy implications.
- **economic considerations** – opportunity cost; resources available; and
- **ethical considerations** – population and individual impact; values and principles; ethical issues.

Non-clinical factors (such as employment status) will not be considered when making decisions on IPFR.

This Policy does not cover healthcare travel costs. Information on patients' eligibility for healthcare travel costs to receive NHS treatment under the care of a consultant can be found on the Welsh Governments' healthcare costs website.

4.3 The following criteria must be used by all Health Board and JCC IPFR Panels when making IPFR decisions. It is the responsibility of the referring clinician to ensure that sufficient information is placed before the panel to allow the panel to be able to determine whether the criteria are satisfied.

A patient will only be entitled to NHS funding for the requested intervention or drug if the panel conclude that the criteria under **either (a) or (b)** below are satisfied:
(a) If guidelines (e.g. from NICE or AWMSG) recommend NOT using the intervention/drug, or the clinical access criteria of an applicable policy are not met: I. The clinician must demonstrate that the patient's clinical circumstances are significantly different to other patients for whom the recommendation is not to use the intervention. II. The clinician can demonstrate that the patient is likely to gain significantly more clinical benefit from the intervention than would normally be expected from patients for whom the recommendation is not to use the intervention, and III. The IPFR panel must be satisfied that the value for money of the intervention for that particular patient is likely to be reasonable.
(b) If the intervention has NOT been appraised (e.g. in the case of medicines, by AWMSG or NICE), and there is no applicable policy in place: I. The clinician can demonstrate that the patient is likely to gain significant clinical benefit, and II. The IPFR panel must be satisfied that the value for money of the intervention for that particular patient is likely to be reasonable.

4.4 An IPFR panel is required to decide whether the application fulfils Part A or Part B and then consider the application against the relevant criteria. A panel may only approve applications which meet all of the applicable criteria above. It is however the responsibility of the requesting clinician to demonstrate the clinical case for the patient in respect of the criteria outlined.

4.5 Considerations under Part A

4.5.1 Where a recommendation has been made not to use an intervention, the panel is required to consider whether the patients' clinical circumstances are significantly different to other patients for whom the recommendation is made not to use the intervention'. That process will usually require a comparison between the patient for whom treatment is being requested, and other patients with the same medical condition who could have been offered the requested intervention if the relevant guidance and/or applicable policy allowed.

4.5.2 The panel next should consider whether there is a significant difference between the clinical circumstances of the patient for whom funding is being requested, and the comparator group, and whether the patient is likely to gain significantly more clinical benefit from the intervention than would normally be expected for patients for whom the recommendation has been made not to use the intervention. If, but only if, both of these criteria are

met on the facts of an individual Part A case, the panel will then consider whether the intervention is deemed value for money as described at paragraph 4.7 below.

4.6 Considerations under Part B

4.6.1 In the absence of any appraisal or applicable policy, the panel need to consider whether the referring clinician has provided sufficient evidence to conclude that the patient is likely to gain significant clinical benefit from the intervention requested. If this criterion is met on the facts of an individual Part B case, the panel will then consider whether the intervention is deemed value for money as described below.

4.7 Value for money

4.7.1 The assessment as to whether the intervention provides "value for money" is a matter of judgement for the panel. The panel should reach a decision exercising its broad discretion to decide whether the value for money of an intervention for a particular patient is likely to be reasonable.

4.7.2 The panel should consider the likely overall costs to the NHS of the requested intervention compared with the next best alternative treatment that is routinely funded on the NHS. The panel should in a similar way consider the overall benefit (effectiveness) of the intervention compared with the next best alternative treatment that is routinely funded on the NHS. If the requested intervention is estimated to be more effective and less costly (than the alternative treatment) then it is likely to represent value for money. If the treatment is less effective and more expensive, then it is unlikely to be deemed value for money. If the treatment is more effective and more costly or less effective and less costly then the panel will need to make a judgement as to whether the treatment is likely to represent value for money. For any scenario, other factors may affect treatment choice, and these should be documented as part of the discussion.

4.7.3 Where presented as part of the evidence, an incremental cost effectiveness ratio ("ICER") and quality- adjusted life year (QALY) may be considered by the panel provided this is relevant to the individual case and there is appropriate expertise by the group to do so. When assessing this evidence, the panel should consider relevant thresholds in relation to NICE and AWMSG when considering if the intervention is a cost-effective option.

4.8 When making decisions, the panel are entitled to have regard to the factors set out at Appendix 1 to this policy, if the panel consider that addressing those issues may assist the panel in coming to decisions on the criteria set out at paragraph 4.3 above. The panel is not obliged to consider all the factors set out Appendix 1 to this policy and may consider that some of the factors are not relevant to the facts of an individual case or do not assist the panel in coming to its decision on those criteria.

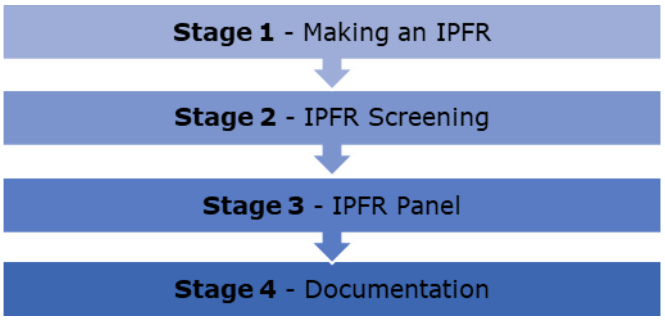
5 HOW TO MAKE A REQUEST FOR FUNDING UNDER THIS POLICY

5.1 Information on how to make an IPFR

A patient leaflet is available explaining how an individual patient funding request (IPFR) can be made. These can be downloaded from the Health Board, JCC or AWTTC website. Further information can be obtained from the IPFR Coordinator.

Copies of this policy and the IPFR application forms can also be obtained via the website, or by contacting the IPFR Coordinator.

5.2 Summary of the IPFR Process



5.3 Stage 1 Making an IPFR

The patient and their NHS clinician (agree together that a request should be made). The IPFR application form is completed by the clinician on the patient's behalf. This will ensure that adequate clinical information is provided to aid the decision-making process.

The requesting clinician must sign the application form to indicate that the patient is aware and agrees with the submission of the request. In doing so, the clinician is providing confirmation that the patient is fully informed of the treatment request and all its associated implications.

Ideally, applications for specialised and tertiary services should be completed by the patient's secondary care clinician, unless extenuating circumstances dictate otherwise. This is to ensure that all pertinent information is included in the form thereby avoiding the delay that will arise from the need to request further information before the application can be processed. All IPFR applications should demonstrate support from the relevant clinical lead, head of department or multi-disciplinary team (MDT). Where relevant, advice may also be sought from the internal clinical team.

It is necessary for clinicians to provide their contact details as there may be times when additional clinical information is required during a panel meeting to aid a decision.

The application form is sent to the IPFR Coordinator electronically or in hard copy so that the authorised consent of the clinician is recorded.

The IPFR application form must be completed in full to enable the IPFR Panel to reach a fully informed decision.

Should the IPFR Coordinator receive an application form which has not been completed sufficiently enough to determine whether or not the request can be screened out or taken to the IPFR Panel, or if the incorrect form is completed, the form should be returned to the requesting clinician **within three working days**.

The requesting clinician is responsible for completing and re-submitting the application form **within ten working days**. Should this time elapse, a chaser letter will be sent providing a **further ten working days** to make a submission.

Where the information has still not been provided in the time set, the case shall be closed, and the requesting clinician notified accordingly.

5.4 Stage 2 Screening of the IPFR

The IPFR application will be considered by the IPFR Senior Officer to determine whether the application needs to be screened out because:

a) The request meets pre-agreed criteria for a service already commissioned/provided and can automatically be funded
b) an alternative and satisfactory clinical solution is found
c) The request represents a service development which needs to be passed to the relevant Division or Directorate for action.

The IPFR Senior Officer should then communicate the outcome of the screening stage to the requesting clinician using a standard letter, **within five working days** of the decision being made. This letter will also include reasons for the decision and information on any further courses of action required.

5.5 Stage 3 Considerations by the IPFR Panel

Requests that are not screened out will be considered at a meeting of the IPFR Panel. The IPFR Coordinator will ensure that the panel has all of the information needed to reach a decision and will ensure that each case is anonymised before each meeting.

Panels will convene at least once per month in order to ensure that applications are dealt with in a timely manner. The volume and urgency of applications may require panels to meet more frequently as and when required.

The panel will consider each IPFR on its own merits, using the criteria set out in paragraph 4.3 of the Policy. Where possible, they should set out their assessment of the likely incremental clinical benefit and their broad estimate of the likely incremental cost so that their judgements on value for money are clear and transparent. The IPFR Coordinator or Senior Officer will complete a record of the panel's discussion on each IPFR, including the decision and a detailed explanation for the reason for that decision.

A standard decision letter should be prepared to communicate the decision to the requesting clinician. Correspondence will also be sent to the patient to inform them that a decision has been made, and their clinician will contact them within 5 working days to discuss. If this has not happened, patients are encouraged to contact their clinician.

These letters will be sent **within five working days** of the panel's decision and will also include information on how to request a review of the process where a decision has been made to decline the request.

5.6 Who will sit on the IPFR Panel?

The Health Board will appoint core members of the IPFR Panel which will comprise:

- Executive Public Health Director (or deputy – Public Health Consultant)
- Executive Medical Director (or deputy - Associate/Assistant Medical Director)
- Executive Director of Nursing (or deputy – Assistant Director of Nursing)
- Director of Therapies & Clinical Science (or deputy - Assistant Director of Therapies)
- Director of Pharmacy and / or Chief Pharmacist or deputy; and
- Two lay representatives.

The Chair of the Panel will be selected from the group of core members and must have a clinical background (with the exception of JCC – see Terms of Reference at Appendix 3).

Each organisation may also wish to appoint up to a further two Panel members at the discretion of the Chair of the Panel, for example a member of the Ethics Committee, Primary Care Director, or Director of Planning.

Please refer to the Terms of Reference at Appendix 2 and 3 for details of the Health Board and JCC IPFR Panel.

5.7 What about clinically urgent cases?

The IPFR Policy and process allows for clinically urgent cases, as deemed by the requesting clinician, to be considered outside of the normal screening and panel processes. In these circumstances, the Chair or Vice Chair of the IPFR panel is authorised to make a decision outside of a full meeting of the panel, within their delegated financial limits. Any such decisions will be made in line with the principles of this policy, considering the clinical urgency of the request outlined in the application form by the clinician. Those marked urgent will be considered within 24-48 hours (working days only) as per the application form.

5.8 Can patients and clinicians attend the IPFR Panel?

Patients are not permitted to attend IPFR Panels. The reasons are that it would make the process less fair because it would draw to the attention of panel members characteristics of the individual patient that should not influence their decision-making. The IPFR process is anonymous therefore allowing patients to attend would jeopardise this level of scrutiny. The IPFR Panel will normally reach its decision on the basis of all of the written evidence provided, including the IPFR application form and other documentary evidence which is provided in support. Patients and clinicians are able to supply any written statements they feel should be considered by the Panel**. Any information provided which relates to non-clinical factors will not be considered.** Local Llais teams are able to support patients in making such statements if required.

The IPFR Panel may, at its discretion, request the attendance of any clinician to provide clarification on specific issues and/or request independent expert clinical advice for consideration by the panel at a future date. The Chair of the IPFR Panel, may also contact the referring clinician to get more clarification in respect of an individual referral.

The provision of appropriate evidence to the IPFR Panel will be entirely at the Chair of the IPFR Panels discretion.

5.9 Documentation

The IPFR Coordinator will maintain a confidential electronic record of all requests. A separate, confidential hard copy file may also be maintained. This information will be held securely in compliance with Data Protection requirements and with Caldicott Guidance.

The IPFR Administration Team retains a record of the IPFR application and subsequent decision and any outcome data that is provided by the clinician. Data will be retained to help inform future planning requirements by identifying patient cohorts both at a local and national level. Data will also be used for the production of an annual report on IPFR's every year as required by the Welsh Government. This will not include any identifiable data and will use aggregated data.

In addition, a central repository for clinical evidence will be available and will develop over time as and when new evidence reports are produced / become available.

Any information will be held in line with the NHS Information Governance Retention Policy

6 HOW TO REQUEST A REVIEW OF THE PROCESS

If an IPFR is declined by the panel, a patient and their NHS clinician have the right to request information about how the decision was reached. If they are unhappy with the decision the NHS clinician on behalf of the patient can either:

Resubmit an IPFR application, but only if there is either significant new clinical information or a significant change in clinical circumstances, or

If the patient and their NHS clinician feel the process has not been followed in accordance with the IPFR policy, a review hearing can be requested (see below).

The review process for an application for funding under the IPFR policy does not conflict with a patient's ability to make a complaint about the care that has been arranged in relation to a IPFR funding decision. This is best achieved through the Health Boards or JCC's Putting Things Right process which can be found at

https://www.gov.wales/nhs-wales-complaints-and-concerns-putting-things-right (see section 9).

6.1 The 'review period'

There will be a period of **25 working days** from the date of the decision letter during which they may request a review by the review panel ('the review period").

The letter from the Health Board or JCC that accompanies the original

decision will state the deadline for any review request. In calculating the deadline, Saturdays, Sundays, and public holidays in Wales will not be counted.

6.2 Who can request a review?

A review can be requested either (a) by the original requesting clinician on the patient's behalf or (b) by the patient with the original requesting clinician's support. **The review request form must be completed by the clinician**. Both the patient and their clinician must keep each other informed of progress. This ensures the patient is kept informed at all times, that the clinician/patient relationship is maintained, and review requests are clinically supported. Patients are able to access advocacy support at any stage during this process.

6.3 What is the scope of a review?

It does not constitute a review of the merits of the original decision. It has the restricted role of hearing review requests that fall into one or more of three strictly limited grounds. A review request on any other ground will not be considered.

The 3 grounds are:

Ground One: *The Health Board or JCC has failed to act fairly and in accordance with the All Wales Policy on Making Decisions on Individual Patient Funding Requests (IPFR).*

Health Boards and JCC are committed to following a fair and equitable procedure throughout the process. A patient who believes they have not been treated fairly by the Health Board or JCC may request a review on this ground. This ground relates to the procedure followed and not directly to the decision and it should be noted that the decision with which the patient does not agree is not necessarily unfair.

Ground Two: *The Health Board or JCC has prepared a decision which is irrational in the light of the evidence submitted*

The review panel will not normally entertain a review request against the merits of the decision reached by the Health Board or JCC. However, a patient may request a review where the decision is considered to be irrational or so unreasonable that no reasonable Health Board or JCC could have reached that conclusion. A claim that a decision is irrational contends that those making the decision considered irrelevant factors, excluding relevant ones, or gave unreasonable weight to particular factors.

Ground Three: *The Health Board or JCC has not exercised its powers correctly.*

Health Boards and JCC are public bodies which carry out its duties in accordance with the Statutory Instruments under which it was established. A patient may request a review on the grounds that the Health Board or JCC has acted outside its remit or has acted unlawfully in any other way.

6.4 How is a review request lodged?

A review request form should be completed and logged with the IPFR Coordinator of the Health Board or JCC within the review period. The review request form must include the following information:

- The aspect(s) of the decision under challenge and
- The detailed ground(s) of the review request

The review request form should be sent to the IPFR Coordinator so that the signatures of both the patient and their clinician are recorded. A scanned version sent electronically will also be acceptable as long as signatures are present.

If the patient signature cannot be obtained in a timely manner or at all, the requesting clinician can sign to indicate that the patient is aware and agrees with the submission of the request. In doing so, the clinician is providing confirmation that the patient is fully informed of the treatment request and all its associated implications.

6.5 Initial scrutiny by the IPFR Senior Officer

The review documents lodged will be scrutinised by the IPFR Senior Officer who will look to see that they contain the necessary information. If the review request does not contain the necessary information or if the review does not appear to the IPFR Senior officer to fall under any one or more grounds of review, they will contact the referrer (patient or their clinician) to request further information or clarification.

A review will only be referred to the review panel if, after giving the patient and their clinician an opportunity to elaborate or clarify the grounds of the review, the Chair of the review panel is satisfied that it falls under one or more of the grounds upon which the review panel can hear the review.

The Chair of the review panel may refuse to consider a review that does not include all of the above information.

6.6 What is the timescale for a review to be heard?

The review panel will endeavor to hear a review **within 25 working days** of the request being lodged with the Health Board. The date for hearing any review will be confirmed to the patient and their clinician in a letter.

This review process allows for clinically urgent cases, as deemed by the referring/supporting clinician, to be considered outside of the panel process by the Health Board's Chair together with a clinical member of the review panel. Any such decisions will be made in line with the principles of this policy.

6.7 Who will sit on the Review Panel?

The Health Board will appoint members of the review panel. The panel will comprise (see Terms of Reference at Appendix 4 for full details);

- Health Board Independent Board Member – Lay (Chair of the Review Panel)
- Health Board Independent Board Member (with a clinical background)
- Health Board Executive Director, or deputy (with a clinical background)
- Representative from Llais
- Chair of the Local Medical Committee, or deputy
- JCC Representative at Director level (where applicable)

The Health Board will intend to inform the patient and their clinician of the membership of the review panel as soon as possible after a review request has been lodged. None of the members of the review panel will have had any prior involvement in the original submission.

In appointing the members of the review panel, the Health Board will endeavor to ensure that no member has any interest that may give rise to a real danger of bias. Once appointed, the review panel will act impartially and independently.

6.8 Can new data be submitted to the review panel?

No, because should new or additional data become available then the IPFR application should be considered again by the original panel in order to maintain a patient's right to review at a later stage.

6.9 Can patients attend review panel hearings?

At the discretion of the panel, patients and/or their unpaid representative may attend review panel hearings as observers but will not be able to participate. This is because the purpose of a review hearing is to consider the process that has been followed and not to hear new or different evidence.

If new or different evidence becomes available, the case will automatically be scheduled for reconsideration by the IPFR Panel. Patients and/or their unpaid representatives are able to make their written representations to this IPFR Panel in order for their views to be considered.

It is important for all parties to recognise that review panel hearings may have to discuss complex, difficult and sensitive information in detail and this may be distressing for some or all of those present. Patients and/or their unpaid representatives should be aware that they will be asked to retire at the end of the review panel discussion in order for the panel to make their decision.

6.10 The decision of the review panel hearing

The IPFR Senior Officer will complete a record of the review panel's discussion including the decision and a detailed explanation for the reason for the decision. They will also prepare a standard decision letter to communicate the decisions of the panel to the patient and referring/supporting clinician. The review panel can either;

- uphold the grounds of the review and ask the original IPFR Panel to reconsider the request; or
- not uphold the grounds of the review and allow the decision of the original IPFR Panel to stand.

There is no right to further review unless new and relevant circumstances emerge. Should a patient be dissatisfied with the way in which the review panel carried out its functions, they are able to make a complaint to the Public Services Ombudsman for Wales.

6.11 After the review hearing

The Chair of the review panel will notify patients and their clinicians of the review panel's decision in writing. This letter should be sent **within five working days** of the panel and will also include information on how to make a complaint to the Public Services Ombudsman for Wales www.ombudsman-wales.org.uk.

6.12 How will JCC undertake a review?

As the JCC is a collaborative committee arrangement to support all Health Boards in Wales, it will not be able to constitute a review panel. JCC will therefore refer any requests it receives for a review of its decisions to the Health Board in which the patient resides. A JCC representative who was not involved in the original panel will become a member of the review panel on these occasions.

The Health Boards IPFR Senior Officer will be present at these review hearings to advise on proceedings as per their governance role. In the interests of transparency, and not to confuse the applicant, the JCC Senior IPFR Officer will be responsible for circulating the review documentation to review panel members, clerking the hearing, and preparing the standard decision letter to communicate the decision of the review panel to the patient and clinician.

7 QUALITY ASSURANCE

The IPFR Quality Assurance Advisory Group was established in 2017 to monitor and support all IPFR panels to promote quality in decision making and consistency across Wales. The Group meets quarterly to assess anonymised random sample IPFR reports in relation to their completeness, timeliness, and efficiency of communication in line with the NHS Wales IPFR policy process.

8 REVIEW OF THIS POLICY

8.1 This Policy should be reviewed every 3 years or as required to reflect changes in legislation or guidance. The review will be undertaken by the All-Wales IPFR Policy Implementation Group. Any changes made will be undertaken in line with the groups Terms of Reference (see appendix 5) and authorised by the responsible Health Board and JCC Committee. Any delay in conducting a review will not prevent JCC or a Health Board from being able to rely on this policy.

8.2 Any of the following circumstances will trigger an immediate review of the linked INNU Policy:

- an exemption from a treatment policy criterion has been agreed.
- new scientific evidence of effectiveness is published for all patients or sub- groups.
- old scientific evidence has been re-analysed and published suggesting previous opinion on effectiveness is incorrect.
- evidence of increased cost effectiveness is produced.

- NHS treatment would be provided in all (or almost all) other parts of the UK.
- a National Service Framework recommends care.

9 MAKING A COMPLAINT

9.1 Making an IPFR does not conflict with a patient's ability to make a complaint through the Health Boards or JCC's Putting Things Right process, details of which can be found at https://www.gov.wales/nhs-wales-complaints-and-concerns-putting-things-right

9.2 If it is not possible to resolve a concern through local resolution the person raising the concern can refer the matter to the Public Services Ombudsman for

Wales (PSOW). Further information is available on the Ombudsman's website www.ombudsman-wales.org.uk.

Patients are able to access advocacy support at any stage during this process.

APPENDIX 1: DECISION MAKING FACTORS

Panels may find it useful to consider these factors, but they are not required to look at every factor set out in the table. Furthermore, there may be factors in the table that are not relevant to the individual case. The factors in the table are optional and cannot change the meaning of the criteria under paragraph 4.3 of the Policy.

IPFR Panel Decision-Making Factors	**IPFR Panel Evidence for Consideration in Decision-Making**
PART 9A - SIGNIFICANTLY DIFFERENT AND SIGNIFICANT CLINICAL BENEFIT	
Is the clinical presentation of the patient's condition significantly different in characteristics to other members of that population for whom the recommendation is not use the intervention? Does this presentation mean that the patient will derive a greater clinical benefit from the treatment than other patients with the same condition at the same stage and for whom the recommendation is not to use the intervention?	Consider the evidence supplied in the application that describes the specific clinical circumstances of the IPFR: • What is the clinical presentation of this patient? • Is evidence supplied to explain why the clinical presentation of this patient is significantly different to that expected for this disease and this stage of the disease? This is in context of the population for whom the treatment is not recommended. • Is evidence supplied to explain why the clinical presentation means that the patient will gain a significantly greater clinical benefit from the treatment than another patient with the same disease at the same stage? This is in context of the population for whom the treatment is not recommended.
PART 9B - SIGNIFICANT CLINICAL BENEFIT	
Does the presentation of the patient's condition mean they are likely to gain significant clinical benefit from the intervention requested?	Consider the evidence submitted in the application that describes the specific clinical circumstances of the IPFR: • What is the clinical presentation of this patient? • Does the evidence provided explain why this patient is likely to gain a significant clinical benefit when compared to next best alternative for this patient, which may in some cases be best supportive care?
EVIDENCE BASED CONSIDERATIONS	
Does the treatment work? What is the evidence base for clinical and cost effectiveness?	Consider the evidence supplied in the application, and supplementary evidence (where applicable) supplied by professional advisors to the Panel: • What does NICE recommend or advise? • What does the AWMSG recommend or advise? • What does the Scottish Medicines Consortium recommend or advise? • What does Public Health Wales advise? • Is there advice available from the One Wales Medicines process or Health Technology Wales? • Is there peer reviewed clinical journal publications available? • What information does the locally produced evidence summary provide? • Is there evidence from clinical practice or local clinical consensus? • Has the rarity of the disease been considered in terms of the ability for there to be comprehensive evidence base available? • Does the decision indicate a need to consider policy or service change? If so, refer to service change processes.
ECONOMIC CONSIDERATIONS	
Is it a reasonable cost? What is the cost of the **treatment** and is the cost of the treatment likely to be reasonable? Is the cost of the treatment in balance with the expected clinical benefits?	Consider the evidence supplied in the application, and supplementary evidence (where applicable) supplied by professional advisors to the Panel: • What is the specific cost of the treatment for this patient? • What is the cost of this treatment when compared to the alternative treatment they will receive if the IPFR is declined? • Has the concept of proportionality been considered? (Striking a balance between the rights of the individual and the impact on the wider community), in line with Prudent Healthcare Principles. • Is the treatment reasonable value for money?

ETHICAL CONSIDERATIONS	
How has the decision been reached? Is the decision a compromise based on a balance between the evidence-based input and a value judgement?	Having considered the evidence base and the cost of the treatment requested, are there any ethical considerations that have not been raised in the discussions? • Is the evidence base sufficient to support a decision? • Is the evidence and analysis of the cost sufficient to support a decision? • Will the decision be made on the basis of limited evidence and a value judgement? If so, have you considered the values and principles and the ethical framework set out in the policy? • Have non-clinical factors been excluded from the decision? • Has a reasonable answer been reached based on the evidence and a value judgement after considering the values and principles that underpin NHS care?

APPENDIX 2

TERMS OF REFERENCE – INDIVIDUAL PATIENT FUNDING REQUEST PANEL (Health Board)

PURPOSE

The Health Boards IPFR Panel is constituted to act as a Committee of the Health Board and holds delegated Health Board authority to consider and make decisions on requests to fund NHS healthcare for patients who fall outside the range of services and treatments that a Health Board has agreed to routinely provide.

The IPFR Panel will normally reach its decision on the basis of all of the written evidence which is provided to it, including the request form itself and any other documentary evidence which is provided in support of the application.

The IPFR Panel may, at its discretion, request the attendance of any clinician to provide clarification on any issue or request independent expert clinical advice for consideration by the Panel at a further date. The provision of appropriate evidence to the Panel will be entirely at the Panel Chair's discretion.

SCHEME OF DELEGATION REPORTING	MEMBERSHIP AND ATTENDANCE
The IPFR Panel cannot make policy/commissioning decisions for the Health Board. Any policy proposals arising from the panels considerations and decision will ultimately be reported to the Health Board's Quality & Patient Safety Committee for ratification. Financial authorisation is as follows: - The Panel's authorisation limit will be set at the delegated financial limit as per the individual Health Board structure. - Any decisions resulting in a financial cost in excess of this must be reported to the Health Board Chief Executive for budget authorisation.	• Executive Public Health Director or deputy • Executive Medical Director or deputy • Executive Director of Therapies and Health Science or deputy • Director of Pharmacy and/or Chief Pharmacist or deputy • Executive Director of Nursing or deputy • Two Lay Representatives A further two panel members may be appointed at the discretion of the panel Chair, for example a member of the Ethics Committee, Primary Care Director, or Director of Planning. In Attendance: • IPFR Coordinator • Finance Advisor (if required) • Senior Pharmacist (if required)

PROCEDURAL ARRANGEMENTS

Quorum: Chair or Vice Chair plus 2 panel members with a clinical background.

Meetings: The IPFR Panel will normally be at least once per month, either virtually, face to face or a combination of both.

Urgent Cases: Provision will be made for occasions where decisions may need to be made urgently. In these circumstances, the Chair or Vice Chair

of the IPFR Panel is authorised to make a decision outside of a full meeting of the Panel, within their delegated financial limits.

Recording: The IPFR Coordinator will document the meetings to ensure panel discussions and decisions are appropriately recorded.

Training: All Panel members will receive a local induction.

Panel members should have the opportunity to attend a separate annual refresher session to ensure all members maintain the appropriate skills and expertise to function effectively.

Panel Interest: At the start of the meeting members must declare any personal or prejudicial interests relating to the discussions of the panel.

Consensus: IPFR panel members will seek to achieve decisions by consensus where possible. If the panel is equally split the Chair of the Panel will make the final decision

APPENDIX 3

TERMS OF REFERENCE – INDIVIDUAL PATIENT FUNDING REQUEST PANEL (JCC)

PURPOSE

The NHS Wales Joint Commissioning Committee's IPFR Panel is managed by NHS Wales Joint Commissioning Committee and holds delegated authority to consider and make decisions on requests to fund NHS healthcare for patients who fall outside the range of services and treatments that a Health Board has agreed to routinely provide.

The IPFR Panel will act at all times in accordance with the All-Wales IPFR Policy taking into account the appropriate funding policies agreed by JCC.

The IPFR Panel will normally reach its decision on the basis of all of the written evidence which is provided to it, including the request form itself and any other documentary evidence which is provided in support of the application.

The IPFR Panel may, at its discretion, request the attendance of any clinician to provide clarification on any issue or request independent expert clinical advice for consideration by the Panel at a further date. The provision of appropriate evidence to the Panel will be entirely at the Panel Chair's discretion.

SCHEME OF DELEGATION REPORTING	**MEMBERSHIP AND ATTENDANCE**
The IPFR Panel cannot make policy/commissioning decisions for the Health Boards. Any policy proposals arising from the Panel's considerations and decisions will be reported to the JCC for ratification. Financial authorisation is as follows: **Individual Patient Packages** The JCC scheme of delegation states that financial approval is required for individual NHS patient treatment charges outside of LTS's and SLA's concerning one off treatment costs exceeding £750,000. Therefore, any approved IPFR treatment exceeding £750,000 needs to be reported to the Joint Committee. **Lifetime costs** The JCC scheme of delegation states that financial approval is	• Independent Chair (from open recruitment) • 2 Lay representatives** • Health Board nominated clinician or clinician deputy. • 2 Vice Chairs (appointed from within the panel membership) • JCC Medical Director or nominated deputy. • JCC Director of Nursing or nominated deputy. A further two panel members from the NHS in Wales may be appointed at the discretion of the Chair of the Panel in conjunction with the JCC Medical and/or Director of Nursing, for example a member of an ethics committee. In attendance from JCC • IPFR Coordinator • Finance Advisor (if required) • Governance Advisor (if required) • Other JCC staff as and when required to clarify on policy/commissioning arrangements/evidence evaluation For particularly complex cases the IPFR Panel may invite other individuals with clinical, pharmacy or commissioning expertise and skills, unconnected with the requesting provider to support decision making.

required for individual NHS patient treatment charges outside of LTS's and SLA's for lifetime costs exceeding £100,000,000. Therefore, any approved IPFR exceeding £1,000,000 needs to be reported to the Joint Committee. Any decisions resulting in a financial cost in excess of these limits must be reported to the Chief Commissioner for authorisation and the relevant Health Board for information and if over £1 million to the Joint Committee for approval or ratification (if a Chairs action was undertaken).	

** **Definition: Not registered as a healthcare professional, either lay (not currently healthcare worker) or lay plus (no healthcare experience ever) (Health Research Authority 2014) will be eligible.**

PROCEDURAL ARRANGEMENTS

Quorum: The Panel will be quorate with 4 of the 7 Health Boards representatives, 1 JCC Clinical Director or deputy and the Chair or Vice Chair.

Meetings: The IPFR panel will normally be held as a minimum once per month, either virtually, face to face or a combination of both.

Urgent Cases: Provision will be made for occasions where decisions may need to be made urgently.

Where possible, a virtual panel will be held to consider urgent cases. If this is not possible due to the urgency of the request, or availability of panel members, then the Chief Commissioner with either the Medical Director or Director of Nursing and Quality and the Chair of the JCC Panel (or a vice chair) are authorised to make a decision outside of a full meeting of the Panel, within their delegated financial limits, on behalf of the Panel.

	Urgent cases will be reported at the next scheduled IPFR panel. An electronic National IPFR database of all cases will be maintained by AWTTC.
Recording:	The IPFR Coordinator will document the meetings to ensure panel discussions and decisions are appropriately recorded.
Training:	All Panel members will receive a local induction programme. Panel members should have the opportunity to attend a separate annual refresher session to ensure all members maintain the appropriate skills and expertise to function effectively.
Members Interest:	At the start of the meeting members must declare any personal or prejudicial interests relating to the discussions of the panel.
Consensus:	IPFR Panel members will seek to achieve decisions by consensus where possible. If the panel is equally split the Chair of the Panel will make the final decision.
Reporting:	The IPFR Chair shall: Report formally, regularly and on a timely basis to the Collaborative Commissioning Leadership Group (CCLG) on IPFR activities. Bring to the CCLG's attention any significant matters and ensure appropriate escalation arrangements are in place.
Review of the TOR:	The Terms of Reference of the JCC Panel will be reviewed in line with the All-Wales IPFR Policy.

APPENDIX 4

TERMS OF REFERENCE – REVIEW PANEL

PURPOSE

The IPFR Review Panel are constituted to act as a Committee of the Health Board and holds delegated Health Board authority to review (in line with the review process outlined in this policy) the decision-making processes of the Individual Patient Funding Request (IPFR) Panel.

The Review Panel may uphold the decision of the IPFR Panel or, if it identifies an issue with the decision-making process, it will refer the issue back to the IPFR Panel for reconsideration.

The Review Panel will normally reach its decision on the basis of all of the written evidence which is provided to it and will not receive any new information.

SCHEME OF DELEGATION REPORTING	**MEMBERSHIP AND ATTENDANCE**
The Review Panel has delegated authority from the Board to undertake reviews, limited to the purpose set out above. In exceptional circumstances, the Review Panel may also wish to make a recommendation for action to the Board. The action can only be progressed following its ratification by the Board (or by its Chief Executive in urgent matters).	• Independent Board Member – Lay (Chair of the Review Panel) • Independent Board Member (usually with a clinical background) • Executive Director or deputy (with a clinical background) • Representative from Llais • Chairman, Local Medical Committee, or deputy • JCC representative at Director level (as required) In Attendance: • IPFR Senior Officer (governance advisor) • JCC IPFR Senior Officer (as required)

PROCEDURAL ARRANGEMENTS

Quorum: As a minimum, the Review Panel must comprise 3 members (one of whom must have a clinical background, one must be an Independent Board Member, and one must be a Health Board Officer).

Meetings: As required.

Urgent Cases: It is recognised that provision must be made for occasions where reviews need to be heard urgently and before a full panel can be constituted. In these circumstances, the Health Board's Chair can undertake the review together with a clinical member of the Review Panel. This ensures both proper accountability of decision making and clinical input.

Recording: The IPFR Senior Officer will clerk the meetings to ensure a proper record of the review discussion and outcome is made.

See detail under section 6.12 on how JCC will undertake a review.

APPENDIX 5

NHS Wales Individual Patient Funding Request (IPFR)
Policy Implementation Group

Terms of reference

1. Purpose of the Group

The purpose of the NHS Wales IPFR Policy Implementation Group (PIG) is to facilitate the commitment made by Health Boards and the Joint Commissioning Committee (JCC) to adhere to the NHS Wales IPFR Policy, providing and developing assurances systems and guidance to aid the decision making process. This includes areas relating to IPFR's, requests for routine treatment out of area, Interventions Not Normally Undertaken (INNU) and requests for treatment in other parts of the European Economic Area (EEA). The group will:

- Provide strategic leadership for the development and implementation of the IPFR policy and supporting documentation across all Health Boards and the JCC.
- Share good practice across all Health Board areas and promote continuous improvement.
- Review all policies that refer to IPFR to ensure that the policies are up to date, consistent and coherent.
- Provide a forum in which to share advice, support and assistance to ensure deliverance of a consistent process across Wales.
- Explore opportunities to ensure the IPFR process is widely understood by patients and clinicians, providing support on the process and application of IPFR's.
- Use best efforts to ensure the quality of data collection is in line with local and national reporting requirements.
- Monitor identified and emerging risks and advise on their prevention, mitigation and management.
- Work with and support the All Wales Therapeutics and Toxicology Centre on the development of the annual report in relation to IPFR's.
- Utilise the IPFR process to help inform key issues relating to possible future regional and / or national commissioning opportunities.
- Ensure active participation of key stakeholders when and where appropriate.

2. Membership of the Group

The IPFR network group will comprise of;

- A senior IPFR co-ordinator or nominated deputy from each Health Board and JCC.
- A senior member or nominated deputy from the AWTC

Other members may be included in the group as and when required.

3. Chair

The group will be chaired by an appointed member of the group.

The Chair will provide direction on the implementation of all decisions made by the group in relation to the development of the All-Wales policy, related guidance and assurance mechanisms.

All activities carried out under the auspices of the IPFR Policy Implementation Group are to be undertaken with prior agreement from the group members.

4. Frequency of Meetings

The group will meet bi-monthly. However, due to the nature of the work, the group may be required to meet more frequently on occasions, with additional work being done between meetings via email whenever possible.

The Terms of Reference will be reviewed periodically and amended accordingly.

5. Quorum

The quorum will be made up of any 5 members of the IPFR Policy Implementation Group.

NHS WALES PRIOR APPROVAL POLICY

Reference Number	Policy Reference (as per individual Health Board)	**Version Number**	FINAL July 2025
Linked Documents	Individual Patient Funding Request (IPFR) Policy Health Board Policies on Interventions Not Normally Undertaken (INNU)		

Classification of Document: Clinical Policy

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Development Group: All Wales IPFR Policy Implementation Group

Consultation: Commissioning / Planning Managers
IPFR Panel Members
NHS Wales Medical Directors

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Lead Health Board Contact: IPFR Team, Betsi Cadwaladr University Health Board
BCU.IPFR@wales.nhs.uk
Tel : 03000 846880
Block 22, Glan Clwyd Hospital,
Sarn Lane, Bodelwyddan. LL18 5UJ

Review Date July 2028

1.0 INTRODUCTION

1.1 Background

1.1.1 In September 2016, following the 2014 review and implementation of its recommendations, the Cabinet Secretary for Health, Well-being and Sport agreed the time was right for a new, independent review of the Individual Patient Funding Request (IPFR) process. The review panel would be independent of the Welsh Government and encompass a range of expertise and knowledge.

1.1.2 The "Independent Review of the Individual Patient Funding Requests Process in Wales" report was published in January 2017 and made a number of recommendations to support the IPFR process. This includes the development of a clear and consistent national process for dealing with requests to access routine services outside of Local Health Board's existing arrangements (including those of the NHS Wales Joint Commissioning Committee)

1.2. Purpose of this policy

1.2.1 Continuing advances in technology, changing populations, better information and increasing public and professional expectations all mean that NHS Health Boards have to agree their service priorities for the application of their financial and human resources. Agreeing these priorities is a complex activity based on sound research evidence where available, sometimes coupled with value judgments. It is therefore important to be open and clear about the availability of healthcare treatments on the NHS and how decisions on what should be funded by the NHS are made.

1.2.2 Health Board's in Wales have a statutory responsibility to provide healthcare that meets the needs of their local populations in accordance with the NHS (Wales) Act 2006, the Well-being of Future Generations (Wales) Act 2015, Social Services and Wellbeing (Wales) Act 2014 and Cross Border Healthcare Services (April 2013). They achieve this by either directly providing healthcare or by commissioning healthcare from other service providers. In addition, the NHS Wales Joint Commissioning Committee (NWJCC), working on behalf of all Health Board's in Wales, commissions a number of more specialised services at a national level. The use of the term 'Health Board' throughout this policy includes NWJCC unless specified otherwise.

1.2.3 Consequently, patients should not be able to access healthcare services elsewhere unless **all** treatment options available within locally provided services or those commissioned by Health Boards have been exhausted and it is **clinically appropriate** to do so.

1.2.4 Each Health Board in Wales has a separate policy setting out a list of healthcare treatments that are not normally available on the NHS in Wales. This is because: -

- There is insufficient evidence of clinical and/or cost effectiveness

- The intervention has not been reviewed by the National Institute for Health and Care Excellence (NICE) or the All-Wales Medicines Strategy Group (AWMSG)'
- The intervention is considered to be of relatively low priority for NHS resources

The relevant policy for the patients' Health Board titled 'Interventions Not Normally Undertaken' (INNU) should be read together with this policy.

1.2.5 For the purpose of this policy, a prior approval is normally defined as a request for a patient to receive routine treatment outside of local services or established contractual arrangements. Such a request will normally fall within one of the following categories: -

- Second opinion
- Lack of local/commissioned service provision/expertise
- Clinical continuity of care (considered on a case-by-case basis)
- Transfer back to the NHS following self-funding in the private sector
- Re-referral following a previous tertiary referral
- Students
- Veterans

Further detail is provided in Section 5.

Requests **will not** be considered for retrospective funding.

1.2.6 This policy sets out to deliver the national context and provide clarity for referring clinicians and patients. Additional policy processes outlining specific commissioning, contractual and additional prior approval requirements may be in place and will vary across each Health Board.

1.2.7 For instances where funding is required for NHS healthcare for individual patients who fall outside the range of services and treatment that a Health Board has arranged to routinely provide, the Individual Patient Funding Request (IPFR) policy should be followed. Such a request would normally fall within one of the following categories: -

- A patient requires a treatment which is new, novel, developing or unproven and is not within the Health Board's routine schedule of services and treatment,
- A patient requires a treatment which is outside of existing clinical policy criteria,
- A treatment is required for a patient with a rare or specialist condition and is not eligible for treatment in accordance with the clinical policy criteria.

2.0 AIMS AND PRINCIPLES

2.1 Health Board's in Wales have a responsibility to secure services for their patients. Patients registered with a GP in Wales who are resident in Wales do not have a statutory right to choose which hospital they are referred to. The Welsh Governments view is that in general, Health Boards can best organise services to meet the needs of their patients when such services

are provided in Wales. This ensures equity in terms of access, convenience, and affords each Health Board the opportunity to strengthen and improve the quality of their local services thus providing a net gain for the whole community.

2.2 However, patients who are registered with a Welsh GP but are resident in England, or patients who are resident in Wales but registered with an English GP (Cross Border Patients) may have a specific right to choose their secondary care provider. The cross-border arrangements are specific to those Health Boards that share a border with England i.e. Betsi Cadwaladr University Health Board, Powys Teaching Local Health Board and Aneurin Bevan University Health Board the detail of which can be found in the Responsible Body Guidance for the NHS in Wales.

2.3 Each Health Board aims to ensure the establishment of simple uniform arrangements based around high quality, sustainable local services for their patients. Where these cannot be provided by the Health Board's own services for reasons such as resource, expertise or capacity, the Health Board will look to plan and secure necessary services with other appropriate NHS providers through its agreed care pathways. Where the service cannot be provided by the Health Board or contracted provider, the Health Board will plan to secure services from other appropriate providers.

The principles underpinning this policy include: -

2.4 **NHS Core Values** – set out by the Welsh Government as;

- Putting quality and safety above all else; providing high value evidence-based care for our patients at all times.
- Integrating improvement into everyday working and eliminating harm, variation and waste.
- Focusing on prevention, heath improvement and inequality as key to sustainable development, wellness and wellbeing for future generations of the people of Wales.
- Working in true partnerships with partner organisations and with our staff; and
- Investing in our staff through training and development, enabling them to influence decisions and providing them with the tools, systems and environment to work safely and effectively.

2.5 **Prudent Healthcare Principles**

- Achieve health and wellbeing with the public, patient and professionals as equal partners through co-production.
- Care for those with the greatest needs first, making the most effective use of all skills and resources.
- Do only what is needed, no more, no less; and do no harm.
- Reduce inappropriate variation using evidence-based practices consistently and transparently.

2.6 **Cross Border Healthcare Arrangements**

- Enable Cross Border patients to exercise their right of choice to a secondary care provider either in England or within the Health Board.

3.0 SCOPE OF THE PRIOR APPROVAL POLICY

3.1 This policy applies to: -

- The registered population within the geographical catchment area of the Health Board to whom it has a statutory responsibility for arranging services as outlined in the Local Health Boards (Directed Functions) (Wales) Regulations 2009. (*The Who Pays? Determining Responsibility for payments to providers in August 2013 states that although the Health Board has commissioning responsibility for English resident Welsh registered patients, they are the legal responsibility of the relevant CCG*)
- Secondary Care referrals only made by General Practitioners, Consultants and other clinically qualified health professionals with referral rights within the Health Board area.
- Tertiary referrals only made by consultants and clinical gatekeepers.

Please note - it is the clinician's responsibility to complete the application form. This ensures that adequate clinical information is provided to aid the decision-making process.

4.0 EXCLUSIONS

4.1 This policy does not apply to the following services: -

- Emergency Treatment
- Urgent suspected cancer referrals. All referrals for urgent suspected cancer must be **referred by e-referral** into the appropriate Health Board's respective tumour sites which have been set up in accordance with NICE guidelines. If a Cross Border patient has requested to be referred to a local hospital in England, then the referral will be made.
- Community based services such as district nursing.
- Looked After Children
- Requests for treatment in countries of the European Economic Area.
- The specialised services pathways established as part of the arrangements under The National Health Service Joint Commissioning (Wales) Regulation 2024.
- Requests which are judged to fall under IPFR or INNU.
- Reimbursement for private treatment

4.2 This policy does not apply to the following cohorts of patients: -

- Patients diagnosed with HIV/AIDS as outlined in the Welsh Governments HIV Actions Plan for Wales 2023-2026.

4.3 This policy does not apply to the following factors: -

- Non-clinical factors (such as employment status) will not be considered when making decisions on prior approval requests.
- Waiting time factors will not be considered when considering prior approvals as this will theoretically prioritise some patients over others who are in the same clinical position.
- Patient choice. The NHS in Wales does not operate a system of patient choice. However, cross border patients may be able to choose their secondary care provider.

4.4 This policy does not cover healthcare travel costs. Information on patient eligibility for healthcare travel costs to receive NHS treatment under the care of a consultant can be found on the Welsh Government's 'healthcare costs' website.

4.5 Referrals related to **participation (or potential participation) in a clinical trial**

No Prior Approval, or Individual Patient Referral Funding (IPFR) application is required if the purpose of the referral is clinical trial related i.e. if a patient wishes to participate (or explore potential participation) in an 'interventional' research study outside of Wales i.e. studies where the research protocol includes a treatment or intervention not otherwise available to the patient outside of a trial. There should be no barrier to a patient being seen by the trial site for this purpose, and no funding needs to be exchanged or be provided for the site to accept the referral.

The UK Policy is that costs associated with the referral are a research cost and as such must be met by the trial site (via the study grant for non-commercial studies, or by the commercial Sponsor for industry funded studies). This includes visits to the trial site at pre-screening stages prior to commitment or recruitment to the trial being confirmed, including where referrals that are more speculative for a range of potential trials open at the provider site, and includes the consultation costs and associated travel costs. The referring clinician will need to be assured that the patient at least broadly meets (or has potential through further screening/assessment to meet) the eligibility criteria for one or more trials that are open to recruitment at the provider organisation before a referral is made.

Note: If any support is required to expedite the referral, or if provider site requires more information on the UK Policy position, please escalate to Research-FundingSupport@wales.nhs.uk

5.0 GUIDING PRINCIPLES AND CRITERIA

5.1 **Second Opinion**

If a second opinion is required for routine treatment out of area, the requesting clinician must demonstrate that the patient has exhausted all local options where possible. The patient should first receive a second opinion from a consultant colleague within the same Health Board and then from a Health Board or English NHS Trust with whom a contractual agreement is held.

Please note; if a second opinion is approved, this does not automatically mean that funding will be provided for additional appointments and/or treatment.

5.2 **Lack of local service provision/expertise**

The NHS secondary care consultant or other care provider, for example a GP or dentist, with the support of an NHS secondary care consultant where available, needs to demonstrate that all local and locally commissioned service provision has been exhausted in order for an external referral to be considered for an 'expert' opinion. In addition, for reasons due to lack of local expertise, the clinician must demonstrate that the referral being made is to an 'expert' within that specific clinical speciality.

5.3 **Clinical continuity of care**

Whilst the Health Board understands the importance of continuity, we must endeavour to deliver the patient's care locally. Where comparable services are available locally, the patient will be referred to those services in the first instance. Clinical advice will be sought to ensure local services meet the needs of the patient's clinical condition.

Consideration for a patient to remain with an existing provider will only be given if their specific clinical condition warrants continuity of care and that there are circumstances, which if unaddressed, are likely to have a serious impact on the patient's continuing health and wellbeing.

Before funding on this basis can be considered, a comprehensive report/letter from the existing clinician highlighting the specific clinical reasons why the patient should remain under their care would be required.

If a patient moves into a Health Board's area, they will be expected to access local services. However, in some instances, patients may request to remain with an existing care provider based on 'continuity of care'. As outlined above, clinical information will be required to support the reasons for this.

5.4 **Transfer back to the NHS following self-funding in the private sector**

If a patient has self-funded their own referral/treatment in the private sector, the Health Board cannot be expected to fund ongoing treatment in the private sector. To ensure equity, all such referrals will be declined and the clinician advised to refer the patient to local or commissioned NHS services.

If, however, there is no local or locally commissioned service provision for the proposed treatment, the request for a referral to an external NHS consultant will be considered, based on the clinical information provided. The patient will be expected to receive all treatment with an NHS provider and should be added to the appropriate waiting list accordingly.

5.5 **Re-referral following a previous tertiary referral**

If a service is not available locally or within existing commissioned services, the Consultant/Clinical Gatekeeper may wish to refer a patient to a specialist centre for clinical advice and/or potential treatment. Following

the assessment/treatment, and when clinically appropriate, the patient should be discharged back to local services.

Patients frequently request to return to the same specialist centre for a 'new episode of care' based on 'clinical continuity'. When comparable services are available locally, patients will be expected to access the local services.

5.6 **Students**

Students who register with a GP in Wales where they are receiving further or higher education become the responsibility of the Local Health Board in that area and should be treated in accordance with the principles outlined with the Responsible Body Guidance for the NHS in Wales.

5.7 **Veterans**

The treatment of veterans should be undertaken in accordance with the principles outlined within WHC (2023) 022 Armed Forces Covenant – Healthcare Priority for Veterans

6.0 PROCESS UNDERTAKEN WHEN CONSIDERING A PRIOR APPROVAL REQUEST

6.1 Prior approval requests can be sent to BCU.IPFR@wales.nhs.uk

6.2 All prior approval requests are considered on their own merits using the guiding principles and criteria outlined in this document. Decisions are based on the clinical circumstances of the individual patient. It is therefore important to ensure that adequate clinical information is provided to aid the decision-making process.

6.3 Where the patient does not meet the guiding principles outlined above, the prior approval request will be declined.

6.4 Should an application be received which has not been completed sufficiently enough to determine whether or not the request meets the guiding principles and criteria, or the incorrect form has been completed, the form will be returned to the requesting clinician within five working days of receipt.

6.5 Prior approval requests made directly by a patient, or a patient representative will not be accepted. If a direct request is received, the patient will be advised to contact their GP or Hospital Consultant. Requests for referrals will not be accepted to private providers. The NHS cannot pay for or subsidise private hospital treatment.

6.6 A formal process will be held on a regular basis to ensure that correctly submitted and completed applications are considered in a timely manner. The volume and urgency of applications may require a decision more frequently as and when required.

6.7 A standard decision letter notifying the requesting clinician of the decision will be sent.

7.0 HOW TO REQUEST A REVIEW OF THE PROCESS

If a prior approval request is declined, a patient and/or their NHS clinician have the right to request information about how the decision was reached. If the patient and their NHS clinician feel the process has not been followed in accordance with this policy, they can ask for that decision to be reviewed.

8.0 WHAT IS THE SCOPE OF A REVIEW

There will be a period of 25 working days from the date of the decision letter during which a review may be requested.

The request for a review form should be completed clearly outlining the grounds for the review and sent to the Prior Approval team. The review panel will endeavour to meet within one month of the request being logged by the Health Board. Following the review, a decision letter will be issued to notify the patient and their clinician of the review panel's decision.

If new or additional information becomes available, the application will be reconsidered.

9.0 REVIEW PANEL MEMBERSHIP

The review panel should comprise: -

- Chair
- Senior Clinical Representative
- Senior Management Representative

10.0 CONFIDENTIALITY AND INFORMATION GOVERNANCE

In operating the prior approval policy, the Health Board will have due regard to the need to ensure that patient confidentiality is maintained at all times.

Each Health Board must comply with the requirements of the Data Protection Act and Caldicott Principles of Good Practice.

11.0 REVIEW OF THIS POLICY

This policy will be reviewed every 3 years or as required to reflect changes in legislation and guidance.

12.0 MAKING A COMPLAINT

Making a request for a prior approval does not conflict with a patient's ability to make a complaint to the Public Services Ombudsman for Wales. Further information is available on the Ombudsman's website www.ombudsman-wales.

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, 06 November 2025
Crynodeb Gweithredol: ***Executive Summary:***	The Health Board received the Royal College of Psychiatry (RCPsych) Invited Services Review Report in March 2024 and provided a response that was approved by the Board in July 2024. The Health Board is required to progress the improvements recommended in the response 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 4 September 2025. The Quality Safety and Experience Committee received an update on the progression of the Improvement Actions in the RCPsych Invited Services Review response plan and received an update on the Expert Advisory Group work programme and approach to outcomes framework. This report is being received by the Quality Safety and Experience Committee at a significant point. This is because the Expert Advisory Group (EAG) Programme has been completed on the 21 August 2025 and individual meetings with EAG members are in their final stages that will help inform the Special Advisor to the Health Board in the drafting of her final report to the Board on 29 January 2026. Alongside this, the next phase of the oversight of the RCPsych improvements is taking shape through the development of the Mental Health and Learning Disabilities (MHLD) Oversight and Development Group. This report highlights the concluding work with the EAG individual members, the timescales for the writing of the report to Board and the development of the MHLD Oversight and Development Group. It also provides an update on the work to develop the Outcomes Framework and a summary of progress against the ten themes of the RCPsych Invited Services Review.
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 through the Mental Health and Learning Disabilities Oversight and Development Group • **Note and consider** the development of the Draft Outcome Framework and Performance Dashboard • **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 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):***	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)	CRR 24-04 (Learning)			

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***	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 4 September 2025.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	• BAF24-06 Ineffectively Delivering the Required Improvements to Transform Care and Enhance Outcomes • 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
List of Appendices: • Appendix 1 – Summary of progress against the themes improvement actions outlined in the RCPsych Invited Services Review report	

Glossary of Terms Used in This Report

ALN – Alcohol Liaison Nurse
BCUHB – Betsi Cadwaladr University Health Board
CEG – Clinical Effectiveness Group
CTP – Care Treatment Plan
CMHTs – Community Mental Health Teams
DDAT – Digital Data and Technology
DHCW – Digital Health and Care Wales
DSLT – Divisional Senior Leadership Team
DLRRG – Divisional Ligature Risk Reduction 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
LOF – Learning Outcomes Framework
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
R&R – Recruitment and Retention
RMN – Registered Mental Health Nurse
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
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 and provided a response that was approved by the Board in July 2024. The Health Board is required to progress the improvements recommended in the response 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 4 September 2025. The Committee received an update on the progression of the Improvement Actions in the response to 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 on 31 July 2025 and the final report is due to be received by the Board on 29 January 2026.

This report is being received by the Quality Safety and Experience Committee at a significant transition point. This is because the Expert Advisory Group (EAG) programme has been completed on the 21 August 2025 and individual meetings with EAG members are in their final stages. This will help inform the Special Adviser to the Health Board in drafting her final report to the Board on 29 January 2026. Alongside this, the next phase of the oversight of the RCPsych improvements is taking shape through the development of the Mental Health and Learning Disabilities (MHLD) Oversight and Development Group.

This report highlights the concluding work with the EAG individual members, the timescales for the writing of the report to Board and the development of the MHLD Oversight and Development Group. It also provides an update on the work to develop the Outcomes Framework and a summary of progress against the ten themes of the RCPsych Invited Services Review.

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 RCPysch Invited Services Review
- **Note** the next steps related to the oversight of the RCPsych Invited Services Review through the Mental Health and Learning Disabilities Oversight and Development Group
- **Note and consider** the ongoing development of the Draft Outcome Framework and Performance Dashboard
- **Receive assurance** on the Health Board response to the RCPsych Invited Review Services Report

3. ADDITIONAL BACKGROUND

As a reminder, 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 Adviser. The Special Adviser role provides advice and expertise in mental health. The adviser supports and advises board members, the executive and Health Board teams leading and delivering the RCPysch Invited Service Review improvement actions.

The adviser also chaired the Expert Advisory Group (EAG) which was set up to involve people with lived experience most impacted by this review. This included 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 Progress since the last Quality Safety and Experience Committee.

The last report to the Quality Safety and Experience Committee on 4 September 2025 highlighted the final meetings and content of the EAG Work Programme up to the 21 August 2025, which was the formal end of the EAG Work Programme.

Since the 21 August 2025 meetings, individual meetings have been arranged with current EAG Group members so that there is an opportunity for members to consider the Work Programme and highlight any particular matters for the Special Adviser to consider to support the drafting of her report. Some members of the Group are having two meetings which have been facilitated, and allowed additional consideration of matters raised by Group members.

These meetings have taken place during September and October 2025 with 4 members of the EAG and a further member of the Tawel Fan Families who has

generously given their time over the last 12 months to receive information and provide valuable feedback on the Invited Services Review. There are two further individual meetings scheduled for 31 October 2025 and 6 November 2025.

Dependent on the matters raised, these meetings have been supported by the Associate Director of Governance, Llais members of staff, the MHLD Consultant Nurse for Dementia and the BCUHB Head of Patient Experience.

4.2 Key Matters Arising from the Individual Expert Advisory Group Meetings

These rounds of individual meetings will completed by the 6 November 2025. The individual meetings have given the opportunity for the Health Board to recognise and thank members for their support as a member of the EAG and to receive and listen to feedback by finding out more about the areas where members feel progress is being made and areas where members felt there is more to be done.

The meetings also sought to gain feedback on what has worked well (and what hasn't worked well) in relation to the EAG format and what can be learned to improve involvement and engagement. Finally, to set out the next steps/timescales for the final report from the Special Adviser.

It is clear from initial feedback that the EAG Work Programme set out to focus on areas of interest, related to the RCPsych Invited Services Review. From the final meetings of the EAG Programme it has become clear that related and important matters have been raised from this engagement and these are being documented and will support the final report to be presented to the Board.

The Special Adviser has recognised that by involving people with lived and living experience and reviewing the evidence, the approach aimed to be a reality check, linking the past with the present. Detailed narratives from the Group provided rich sources to learn from and cross check that what is reported on paper resonates with those things that have not worked well in the past (focussing where possible on the RCPsych areas of work).

4.3 Development of the Special Advisor Report - Next Steps

The Health Board Special Adviser is now due to complete her formal appointment as Chair of the Expert Advisory Group at the end of November 2025. This will result in a final report from the Special Advisor outlining an assessment of progress, including a reflection of feedback received from the Expert Advisory Group.

A date for the receipt of this report will be agreed with the Special Adviser and will be formally reported through to the Board in January 2025. A Board Development session has now been arranged for Board Members during December 2025 subject to the final agreement of the Chair of the Health Board which will be a valuable opportunity for more detailed consideration for both Quality Safety and Experience Committee and Board members.

The Health Board continues to be very grateful for the dedication of Group members and their experience is important to reflect in the final report.

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

The proposal for the future oversight and development of Mental Health and Leaning Disability Services was reported at the 4 September 2025 meeting of the Quality Safety and Experience Committee. This is through the development of a Mental Health Oversight and Development Group (the Group) that will report into the Executive Committee. The last report to the Quality Safety and Experience Committee provided an overview of the scope of this Group.

This is an important development as the Group will be able to provide oversight and development of those RCPsych Invited Services Review improvements that have commenced and provide focus on developing those improvements that continue to need to have focus.

A draft Terms of Reference for the Group has been developed and been shared with the Chief Executive and Executive Director of Allied Health Professionals and Health Sciences and dates for the first meeting by the end of November 2025. The precise scope and membership of the Executive level Group will be finally being determined by the Chief Executive according to those Terms of Reference.

6. PROGRESS AGAINST THE RESPONSE TO THE INVITED SERVICES REVIEW

At the 4 September 2025 meeting the Quality Safety and Experience Committee were provided with 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 and Learning Disabilities Oversight and Delivery Group will be to assess progress against the improvement actions received by the current Health Board Action Delivery Group to date and to focus on the completion of any remaining improvement actions identified in the report. The Chief Executive and Executive Director of Allied Health Professionals and Health Sciences will consider the appropriate mechanism to progress this work. Progress on this will be reported through to Executive Committee 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 and how it has progressed against the agreed “management arm” of the governance process. Most notably it shows the improvement actions that have been through the Evidence of Outcomes Group, which is a peer group of BCUHB colleagues from across the whole organisation. The peer group provides rigour and challenge to ensure that the final documents on progress made for each improvement can be evidenced.

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 continues to be a high degree of confidence in all

themes aside from Theme 9 where there is medium confidence. As previously reported, this is due to the extra time needed to consider and develop a proposal to ensure/secure resources. 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

7. DEVELOPMENT OF THE OUTCOME FRAMEWORK

At the 4 September 2025, Quality Safety and Experience Committee members received an update on the Draft Outcomes Framework and accompanying Performance Dashboard that can illustrate progress against the improvements reported in the Invited Services Review. 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

Since the last Quality Safety and Experience Committee the Health Board has sought additional engagement in the individual meetings with EAG members and has also arranged additional engagement from Caniad so that a wider group of people with lived experience of Health Board services have an opportunity to influence the Draft Outcomes Framework and accompanying Performance Dashboard. It is important that the Health Board takes time to engage fully on this. Initial feedback from EAG members stresses the importance of “Qualitative Feedback” that highlights the patient/public experience.

The next steps in socialising and maturing the Framework and Dashboard needs to be a staged approach, but at pace and will require a more refined group to complete the Framework and Dashboard.

8.NEXT STEPS

- Commence the meetings of the Mental Health Oversight and Development Group and formalise the Terms of Reference.
- Continue focus on the progression of the RCPsych Improvement Actions until the end of December 2025.
- Socialise work on the Draft Outcomes Framework and Performance Dashboard and report on progress at the Quality Safety and Experience Committee in January 2026.
- The Special Adviser to attend a Board Development in December 2025.
- A report to the Quality Safety and Executive Committee in January 2026.
- The Special Adviser to submit the report to the Board in January 2026.

9.RECOMMENDATIONS

This report asks the Committee 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 through the Mental Health and Learning Disabilities Oversight and Development Group
- **Note and consider** the development of the Draft Outcome Framework and Performance Dashboard
- **Receive assurance** on the Health Board response to the RCPsych Invited Review Services Report

10. APPENDICES

- Appendix 1 – Summary of progress against the themed improvement actions outlined in the RCPsych Invited Services Review report.

APPENDIX 1 – Detailed Update on Improvement Actions

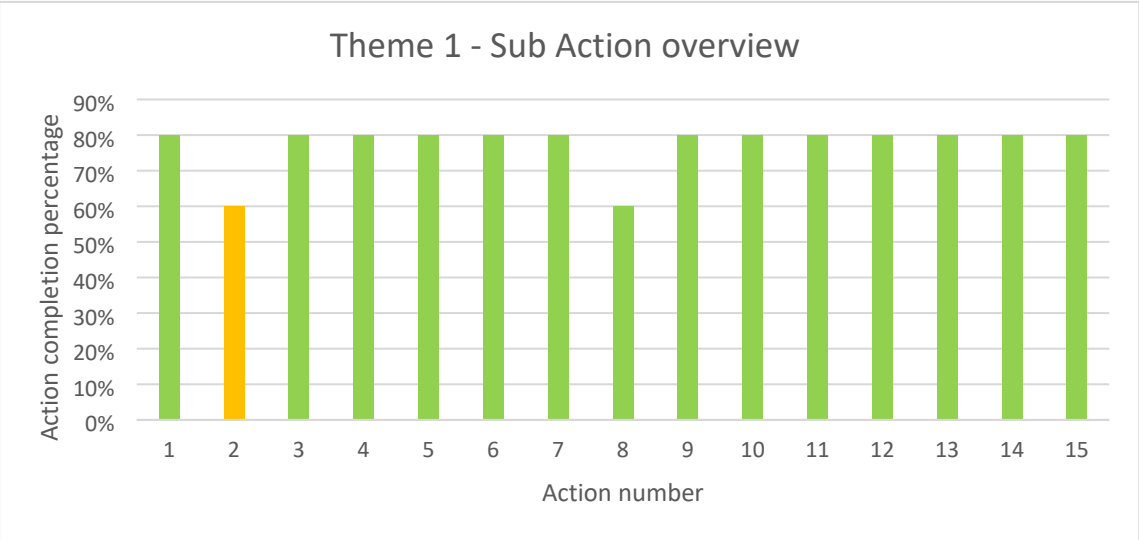
Glossary

EoOG - Health Board Evidence of Outcome Group

MHLD 0DG – Mental Health and Learning Disabilities Operational Development Group

RCPsych Theme 1 Sub Objective Assurance Report			
Report Compiled By	**Melissa Williams**	**Date**	**29th October 2025**

Sub Objective Theme 1 Overview - Patient and user centred care



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, thirteen action owners have submitted evidence and are the agreed governance route for final sign off. Two actions remain in progress, albeit not to deadline these are aligned to reviewing the Local Authority (LA) working model in Community Mental Health Teams to ensure collaborative partnership working, which is due for review by the EoOG on the 18/11/2025 and achieving 85% compliance in FTLID training, this has been agreed to have continuous oversight through the newly established MHLD Oversight and Development Group.

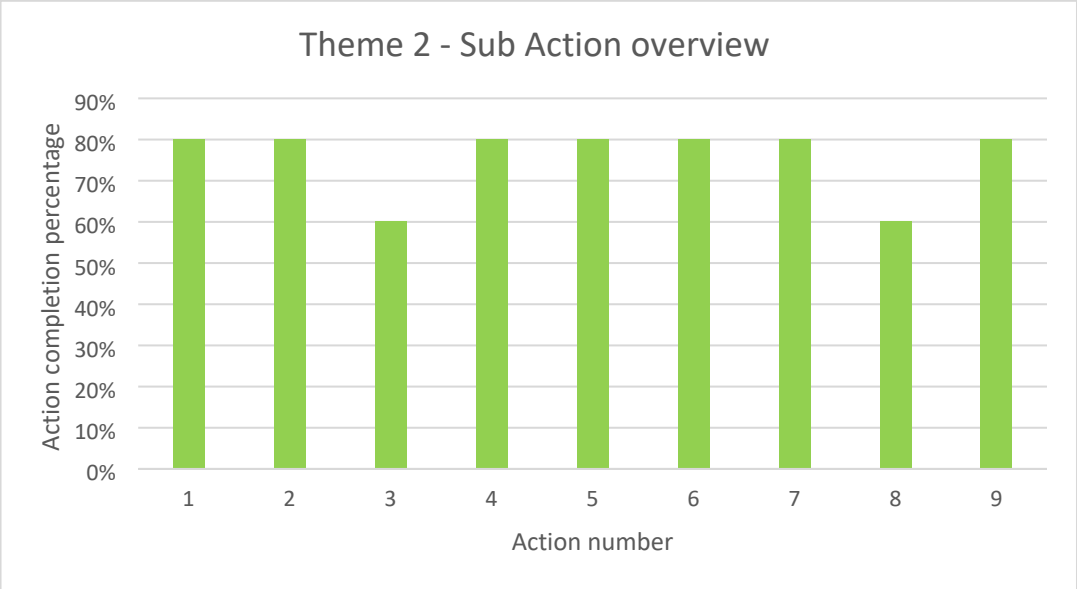
Priority	Action	Assigned Too	Date Reviewed by EoOG	Planned date to be reviewed by EoOG	Current Delivery Confidence	Action Update

1.1	Progress the recruitment of the MH&LD Nurse Consultant Dementia.	Assistant Director of Nursing (Adrian Jones)	25/10/2024		**High**	Endorsed by EoOG
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 (Isabelle Hudgell)	07/10/2025	TBC	Medium	Reviewed by EoOG and further review and oversight by the MHLD ODG to ensure full delivery of action.
1.3	iCAN teams to attend CMHT's and other opportunities such as Third Sector, Local Authorities and other partnership to present activity locally to strengthen partnership working and improve awareness.	Head of Integrated Strategy and Development (Vicky Jones)	07/01/2025		High	Endorsed by EoOG
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 (Adrian Jones)	07/01/2025		High	Endorsed by EoOG
1.5	Plan and attend bi-monthly engagement meetings with Head of Operations and Llais.	Head of Operations and Service Delivery (Carole Evanson)	03/12/2024		High	Endorsed by EoOG
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 (Adrian Jones)	04/02/2025		High	Endorsed by EoOG
1.7	Review Local Authority (LA) working model in Community Mental Health Teams to ensure collaborative partnership working.	Director of Operations (Carole Evanson)	21/10/2025		High	Endorsed by EoOG
1.8	Develop and improve Dementia care data to provide consistent Welsh Government reporting from reliable and accurate data.	BCUHB Dementia Improvement Manager (Luke Pickering Jones)	N/A	18/11/2025	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 (Tracey Williamson)	07/01/2025		High	Endorsed by EoOG
1.10	Continue engagement with Tawel Fan families via the Expert Advisory Group monthly meetings.	Director Of Partnerships, Communications and Engagement (Helen Stephen Jones)	04/02/2025		High	Endorsed by EoOG
1.11	Continue engagement activities from Llais Wales, Patient Advice & Liaison Service, Caniad, wider partners and stakeholders aligned to patients and carer co-working.	Director Of Partnerships, Communications and Engagement (Helen Stephen Jones)	04/02/2025		High	Endorsed by EoOG
1.12	Organise opportunities to include Local Authority colleagues in Operational an strategic planning meetings.	Director Of Partnerships, Communications and Engagement (Helen Stephen Jones)	04/03/2025		High	Endorsed by EoOG
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 (Chris Walker)	01/04/2025		High	Endorsed by EoOG
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 (Chris Walker)	01/04/2025		High	Endorsed by EoOG
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 (Chris Walker)	01/04/2025		High	Endorsed by EoOG

RCPsych Theme 2 Sub Objective Assurance Report			
Report Compiled By	**Melissa Williams**	**Date**	**29th October 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 the agreed governance route for approval and final sign off. Two actions remain in progress, albeit not to deadline.

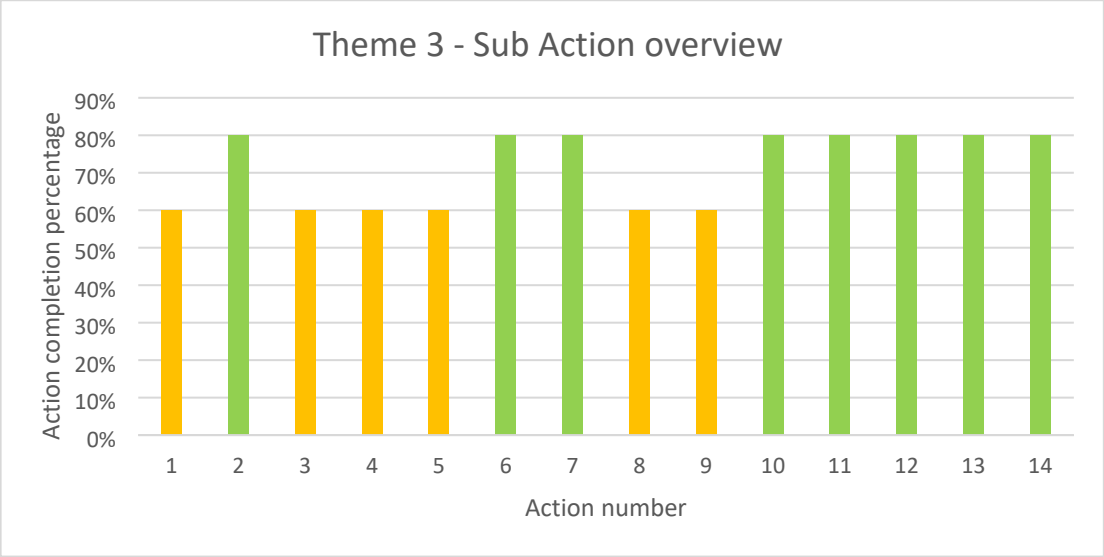
Priority	Action	Assigned Too	Date Reviewed by EoOG	Planned date to be reviewed by EoOG	Current Delivery Confidence	Action Update
2.1	Undertake an Audit of falls data from Datix to highlight key learning to adopt into training, development and Improvement	Assistant Director of Nursing (Adrian Jones)	03/12/2024		High	Endorsed for approval by EoOG
2.2	Increase attendance at current "Tool Box" talks by consideration of establishing MH&LD	Governance Lead (Francine Moore)	06/05/2025		High	Endorsed for approval by EoOG

	Divisional Learning Forums developed across all teams. Monitor, review and report into monthly Service Quality Delivery Group (SQDG).					
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 (Isabelle Hudgell)	N/A	N/A	High	Awaiting further input from HB ESR Team to create mandatory training for the MHLD to monitor compliance, to be monitored through MHLD ODG.
2.4	Complete consultation and approval of Physical health Strategy in preparedness for implementation.	Medical Director (Alberto Salmoiraghi)	03/06/2025			Endorsed for approval by EoOG
2.5	Continue with the projected policy review, as provided as part of the National Collaborative Commissioning Unit (NCCU) Action plan.	Head of Governance (Francine Moore)	03/06/2025			Endorsed for approval by EoOG
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 (Chair of CEG, Anita Pierce)	25/10/2024			Endorsed for approval by EoOG
2.7	Consider and agree use of tool for monitoring antipsychotic medication in inpatient settings.	Medical Director (Alberto Salmoiraghi)	21/10/2025			Endorsed for approval by EoOG
2.8	Progress the adoption of Learning Organisation Framework within MH&LD with direct support from BCUHB to enable learning to be shared, embedded and	Senior Organisational Development Manager (Jason Brannan)	21/10/2025	04/11/2025	High	Evidence submitted, awaiting peer review.

	sustained within the Division and the wider Health Board.					
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 (Chris Walker)	25/10/2024		High	Endorsed for approval by EoOG

RCPsych Theme 3 Sub Objective Assurance Report			
Report Compiled By	**Melissa Williams**	**Date**	**29th October 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, eight action owners have submitted evidence and are awaiting approval through various stages of the agreed governance route for approval and final sign off. Six actions remains in progress, three of which are not to deadline.

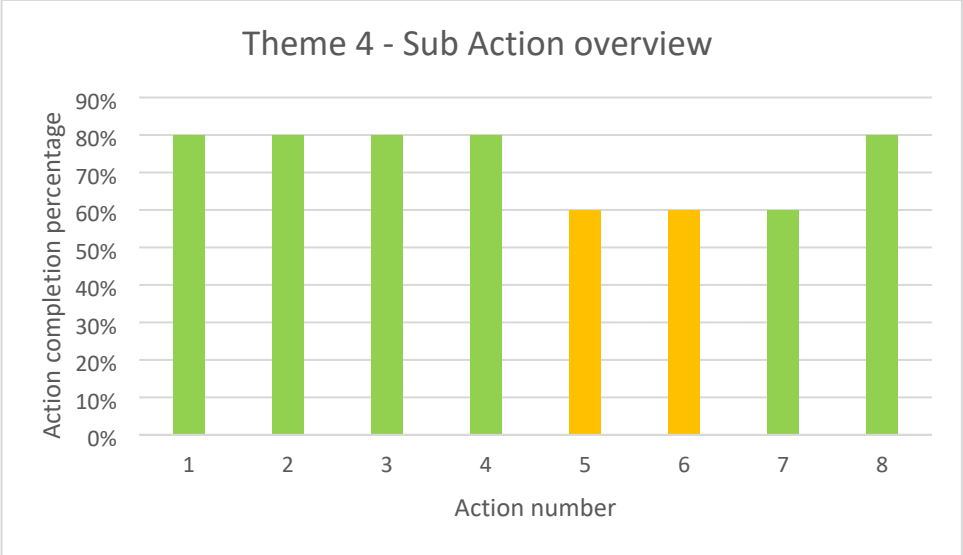
Priority	Action	Assigned Too	Date Reviewed by EoOG	Planned date to be reviewed by EoOG	Current Delivery Confidence	Action Update
3.1	Progress the approval of the Electronic Patient records business case to enable national procurement of an optimum system to replace Welsh Community Care Information System (WCCIS).	Head of Planning and Performance (Chris Lindop)		04/11/2025	High	Action in progress and awaiting peer review
3.2	Audit on call medical staff to ensure they have their	Head of Operations and Service Delivery, SCS (Will Williams)	07/10/2025		High	Endorsed for approval by EoOG

	own personal login for Paragon.					
3.3	Progress the development of the MH&LD specific Ward Accreditation process and implement across all inpatient ward areas.	Practice Development Nurse (Awen Surgery)		02/12/2025	High	Action in progress and further evidence expected at EoOG 02/12/2025
3.4	Deliver engagement and socialisation activities aligned to the outcome of the MH&LD Operating Model review	MH&LD Director (Iain Wilkie)		04/11/2025	High	Action awaiting peer review
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 (Francine Moore)	21/10/2025		High	Reviewed by EoOG requires further strengthening, meeting to be arranged to discuss
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 (Francine Moore)	21/10/2025		High	Endorsed for approval by EoOG
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 (Phil Meakin)	03/12/2024		High	Endorsed for approval by EoOG
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 (Helen Stephen Jones)		TBC	Medium	Awaiting Strengthening
3.9	Support from Digital, Data Technology and Procurement colleagues to progress the implementation of Mental Health electronic patient	Chief Digital And Information Officer (Dylan Roberts)		04/11/2025	High	Action awaiting peer review

	records and change process					
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 (Matthew Joyce)		25/10/2024	High	Endorsed for approval by EoOG
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 (Leon Marsh)		07/01/2025	High	Endorsed for approval by EoOG
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 (Leon Marsh)		07/01/2025	High	Endorsed for approval by EoOG
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 (Leon Marsh)		25/10/2024	High	Endorsed for approval by EoOG
3.14	Commence a formal campaign to promote how to raise concerns.	Lead Complaint Manager and Patient & Carer Experience Lead (Leon Marsh)		07/01/2025	High	Endorsed for approval by EoOG

RCPsych Theme 4 Sub Objective Assurance Report			
Report Compiled By	**Melissa Williams**	**Date**	**29th October 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

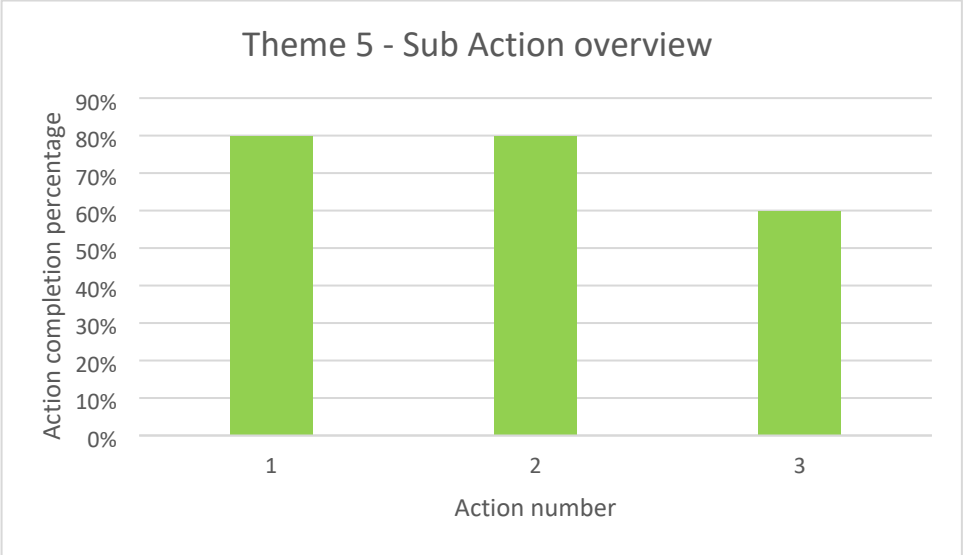
Theme	Theme Delivery Confidence	Theme 4 - Update
4	High	There are seven MH&LD actions to deliver this outcome and one Health Board actions to deliver this outcome. In total, six action owners have submitted evidence and are awaiting approval through various stages of the agreed governance route for approval and final sign off. Three actions remains in progress, albeit not to deadline.

Priority	Action	Assigned Too	Date Reviewed by EoOG	Planned date to be reviewed by EoOG	Current Delivery Confidence	Action Update
4.1	Recruit to the position of MH&LD Director of Nursing post.	MH&LD Director (Iain Wilkie)	21/10/2025		High	Endorsed for approval by EoOG
4.2	Recruit dedicated Consultant Psychiatrist for the Hergest Unit.	Medical Director (Alberto Salmoiraghi)	21/10/2025		High	Endorsed for approval by EoOG
4.3	Continue to progress the recruitment and retention activities aligned to the MH&LD Recruitment and Retention plan.	MH&LD Operational Business Lead (Adrianne Jones)	25/10/2024		High	Endorsed for approval by EoOG
4.4	Communicate Dementia Essential study days to all MH&LD staff to increase awareness and attendance	Director of Nursing (Carole Evanson)	01/04/2025		High	Endorsed for approval by EoOG

4.5	Implement a review process of cover arrangement when Dementia Support Workers are vacant to ensure continuity of service provision.	Director of Nursing (Carole Evanson)		04/11/2025	Medium	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 (Carole Evanson)		04/11/2025	Medium	Awaiting peer review
4.7	Development of an options appraisal to support consideration for recruitment of a dementia practice educator for MH&LD.	Director of Nursing (Carole Evanson)		02/12/2025	High	Awaiting strengthening following EoOG peer review
4.8	Raise awareness and attendance of Health Board staff at Dementia Essentials study days.	BCUHB Consultant Nurse Dementia (Tracey Williamson)	04/03/2025		High	Endorsed for approval by EoOG

RCPsych Theme 5 Sub Objective Assurance Report			
Report Compiled By	**Melissa Williams**	**Date**	**29th October 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

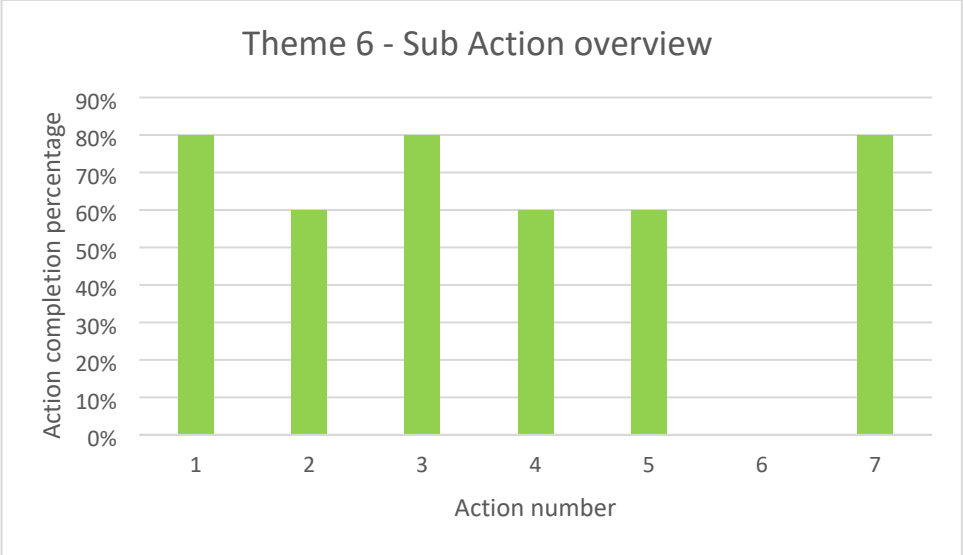
Theme 5 Report		
Theme	**Theme Delivery Confidence**	**Theme 5 - Update**
5	High	The Division has two improvement actions and the Health Board has one. Three action owners have submitted evidence, two of which are awaiting approval through various stages of the agreed governance route for approval and final sign off. One action remains in progress awaiting peer review by the EoOG.

Priority	Action	Assigned Too	Date Reviewed by EoOG	Planned date to be reviewed by EoOG	Current Delivery Confidence	Action Update
5.1	Continue to progress recruitment of interim posts to substantive posts aligned to the MH&LD Operating Model and in line with the wider Operating Model review, aiming to reduce interim posts by 25% by 31/3/25	MH&LD Director (Iain Wilkie)	02/09/2025		High	Endorsed for approval by EoOG
5.2	Ensure that older adults mental health services are represented in the Directorate management structure.	Medical Director (Alberto Salmoiraghi)	12/08/2025		High	Endorsed for approval by EoOG

5.3	Support to progress recruitment of interim posts to substantive posts aligned to the MH&LD Operating Model.	Associate Director For People - Pan (Jason Brannan)		04/11/2025	High	Awaiting peer review

RCPsych Theme 6 Sub Objective Assurance Report			
Report Compiled By	**Melissa Williams**	**Date**	**29th October 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

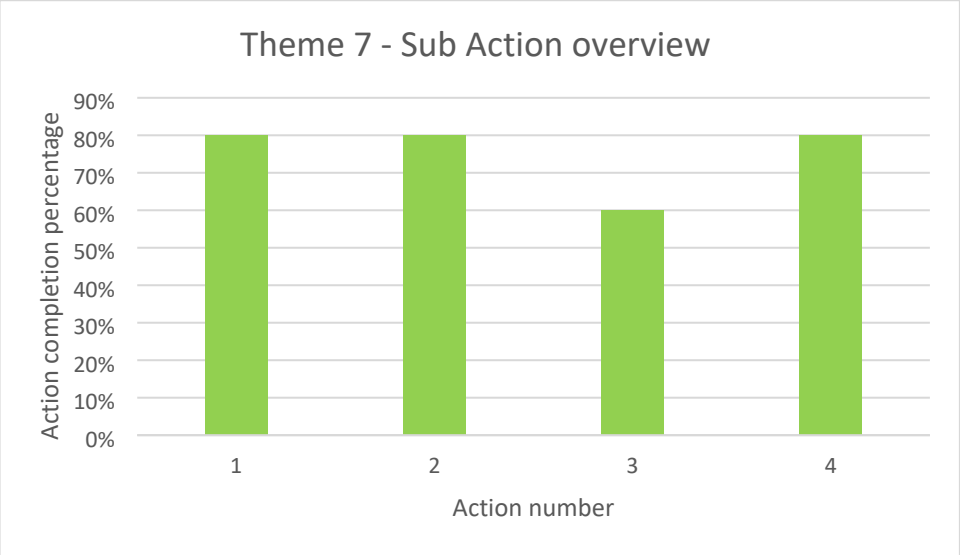
Theme 6 Report		
Theme	**Theme Delivery Confidence**	**Theme 6 - Update**
6	High	The Division has one action in progress not to deadline, Action 6.6 - Progress the pilot scheme for in-reach workers in care homes, review and measure impact and outcomes and carry out options appraisal to expand to all care homes to enable consistency of service provision. The remaining three actions are awaiting further strengthening by the action lead and due for review by the EoOG on the 02/12/2025.

Priority	Action	Assigned Too	Date Reviewed by EoOG	Planned date to be reviewed by EoOG	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 (Alberto Salmoiraghi)	01/04/2025		High	Endorsed for approval by EoOG
6.2	Develop dementia roles and responsibilities within Practise Development Nurse role.	MH&LD Consultant Nurse Dementia (Tracey Williamson)		02/12/2025	High	Awaiting strengthening following EoOG peer review
6.3	Development of an options appraisal to support	MH&LD Consultant	04/03/2025		High	Endorsed for approval by EoOG

	consideration for extending regional pilot of applied behaviourists working with patients with complex needs	Nurse Dementia (Tracey Williamson)				
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 (Tracey Williamson)		02/12/2025	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 (Tracey Williamson)		02/12/2025	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 appraisal to expand to all care homes to enable consistency of service provision.	MH&LD Consultant Nurse Dementia (Tracey Williamson)		02/12/2025	Medium	In progress, not to deadline.
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 (Tracey Williamson)	04/03/2025			Endorsed for approval by EoOG

RCPsych Theme 7 Sub Objective Assurance Report			
Report Compiled By	**Melissa Williams**	**Date**	**29th October 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

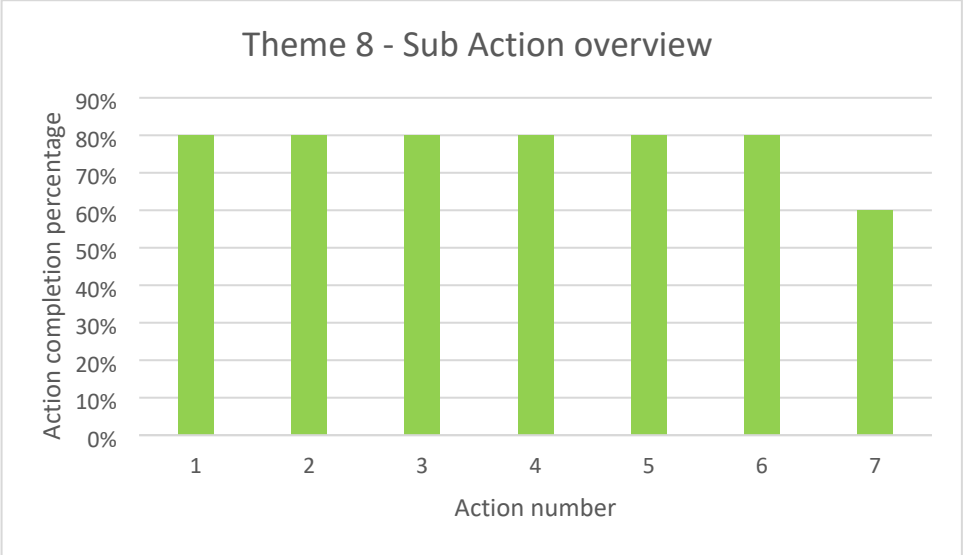
Theme 7 Report		
Theme	**Theme Delivery Confidence**	**Theme 7 - Update**
7	High	Four key actions are aligned to this outcome, three for MH&LD and one for the Health Board. A Divisional Learning Event is currently being planned for September 2025, aiming to have two events per year. This will enable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

Priority	Action	Assigned Too	Date Reviewed by EoOG	Planned date to be reviewed by EoOG	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 (Carole Evanson)	01/04/2025		High	Endorsed for approval by EoOG
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 (Adrian Jones)	03/06/2025		High	Endorsed for approval by EoOG
7.3	Develop Divisional Learning Events rolling programme	Governance Lead (Francine Moore)		07/10/2025	High	Awaiting strengthening

	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					
7.4	Review of Dementia Support Worker/Activity Coordinator Job Description to reduce variation in roles.	BCUHB Consultant Nurse Dementia (Tracey Williamson)	04/03/2025		High	Endorsed for approval by EoOG

RCPsych Theme 8 Sub Objective Assurance Report			
Report Compiled By	**Melissa Williams**	**Date**	**29th October 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

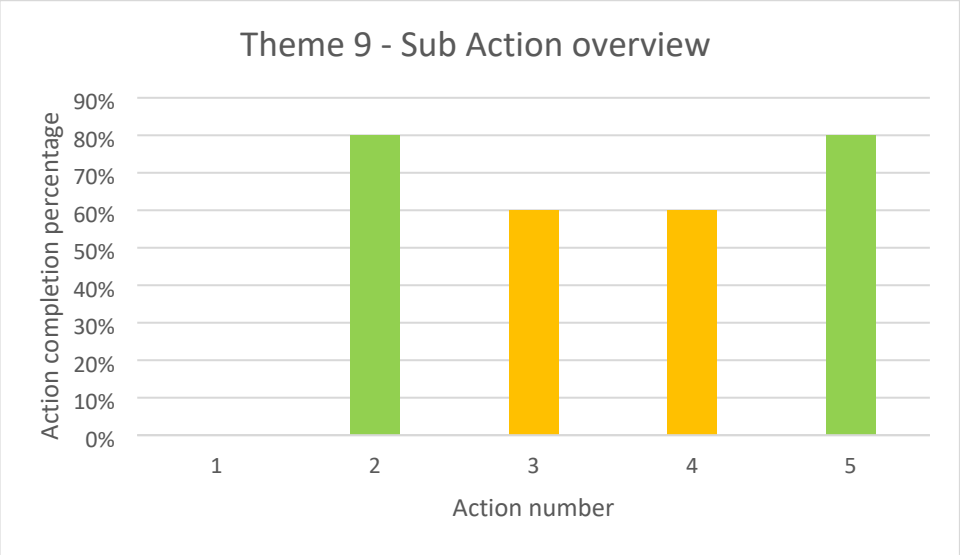
Theme	Theme Delivery Confidence	Theme 8 - Update
8	High	There are seven actions across the Health Board to support delivery of this outcome.. Six actions are awaiting formal approval following evidence submissions and the remaining one is in progress albeit not within the deadline for delivery, evidence has been submitted and is in review by the EoOG.

Priority	Action	Assigned Too	Date Reviewed by EoOG	Planned date to be reviewed by EoOG	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 (Vicky Jones)	03/12/2024		High	Endorsed for approval by EoOG
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" staff engagement. Report updates into Tier 1 Divisional	Director of Operations (Carole Evanson)	03/12/2024		High	Endorsed for approval by EoOG

	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 (Carole Evanson)	01/04/2025		High	Endorsed for approval by EoOG
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 (Iain Wilkie)	07/10/2025		High	Endorsed for approval by EoOG
8.5	Support with the implementation of the MH&LD Communication and Engagement Plan.	Director Of Partnerships, Communications and Engagement (Helen Stephen Jones)	03/12/2024		High	Endorsed for approval by EoOG
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 (Helen Stephen Jones)	03/12/2024		High	Endorsed for approval by EoOG
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 (Jason Brannan)	07/10/2025	04/11/2025	High	Awaiting peer review, triangulate with existing evidence for 8.4,8.5 and 8.6

RCPsych Theme 9 Sub Objective Assurance Report			
Report Compiled By	**Melissa Williams**	**Date**	**29th October 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

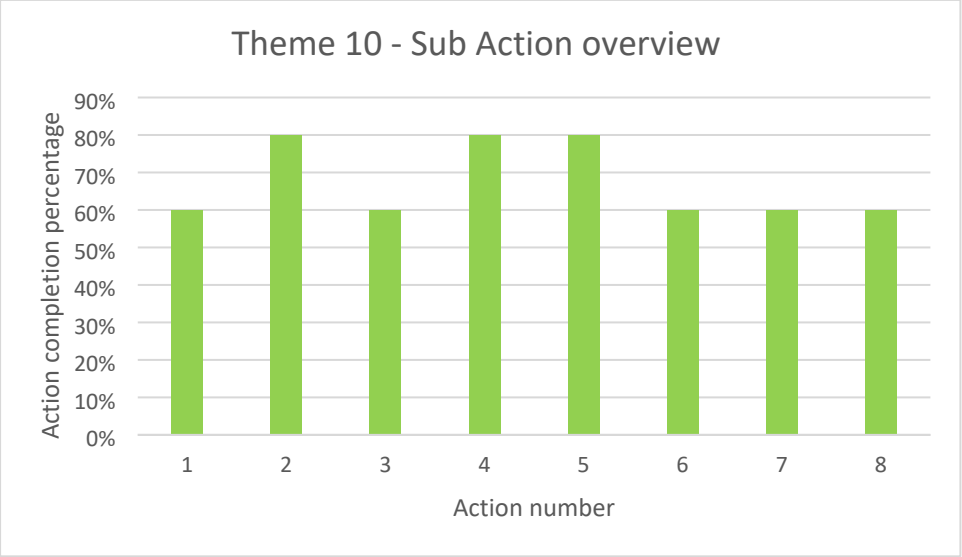
Theme 9 Report		
Theme	**Theme Delivery Confidence**	**Theme 9 - Update**
9	High	There are five improvement actions across the whole Health Board to support the delivery of this outcome. The response to the RCPsych Invited Services review highlights that the Therapy Services gap analysis is underway. 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.

Priority	Action	Assigned Too	Date Reviewed by EoOG	Planned date to be reviewed by EoOG	Current Delivery Confidence	Action Update
9.1	Review the role of pharmacy to consider further developing across the Division.	Consultant Mental Health Pharmacist (Liz Bond)			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	Assistant Director of Allied Health Professionals (AHPs) and	25/10/2024		High	Endorsed for approval at EoOG

	all inpatient units to identify any gaps and agree next steps.	Health Sciences (Susan Brierley-Hobson)				
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 (Susan Brierley-Hobson)		04/11/2025	Medium	Evidence submitted, awaiting peer review by EoOG
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 (Susan Brierley-Hobson)		04/11/2025	Medium	Evidence submitted, awaiting peer review by EoOG
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 (Paolo Tardivel)	05/08/2025		High	Endorsed for approval at EoOG

RCPsych Theme 10 Sub Objective Assurance Report			
Report Compiled By	**Melissa Williams**	**Date**	**29th October 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. All action owners have submitted evidence and are awaiting approval through various stages of the agreed governance route for approval and final sign off. Five actions require strengthening and are due to be reviewed by the EoOG on 18/11/2025.

Priority	Action	Assigned Too	Date Reviewed by EoOG	Planned date to be reviewed by EoOG	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		18/11/2025	High	Awaiting strengthening following EoOG peer review
10.2	Progress Environmental	Governance Lead	25/10/2024		High	Endorsed for approval at EoOG

	Ligature Risk Assessment Audit, report outcome through Tier 1 meeting to progress actions to completion.	(Francine Moore)				
10.3	Provide six monthly update on progress of NCCU Action plan.	Director of Operations (Carole Evanson)		18/11/2025	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 (Arwel Hughes)	01/04/2025			Endorsed for approval at EoOG
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 Developme nt (Daniel Eyre)	01/04/2025			Endorsed for approval at EoOG
10.6	Support from Health and Safety aligned to ensuring an appropriate physical environment for patient including the ligature tripartite risk assessments.	BCHUB Assistant Director Of Occupation al Health, Safety And Security Corporate Office	21/10/2025	18/11/2025	High	Strengthened evidence presented, requires further information before endorsing for approval, actions to be completed and brought back to 18/11/2025 EoOG
10.7	Support from Health and Safety to continue to provide advice, support and lead on	BCHUB Assistant Director Of Occupation	21/10/2025	18/11/2025	High	Strengthened evidence presented, requires further information before endorsing for

	the Ligature Environmental Risk Assessment training for staff.	al Health, Safety And Security Corporate Office				approval, actions to be completed and brought back to 18/11/2025 EoOG
10.8	Support from Health and Safety to continue to undertake ad-hoc health and safety inpatient inspections.	BCHUB Assistant Director Of Occupation al Health, Safety And Security Corporate Office	21/10/2025	18/11/2025	High	Strengthened evidence presented, requires further information before endorsing for approval, actions to be completed and brought back to 18/11/2025 EoOG

Teitl adroddiad: ***Report title:***	**CORPORATE GOVERNANCE REPORT**			
Adrodd i: ***Report to:***	Quality, Safety and Experience Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 06 November 2025			
Crynodeb Gweithredol: ***Executive Summary:***	The objective of this report is to provide the Committee with an update on a range of key Corporate Governance matters as well as providing assurance.			
Argymhellion: ***Recommendations:***	Members are asked to: • **NOTE** the summary of business considered in private session to be reported in public • **NOTE** the forward workplan			
Arweinydd Gweithredol: ***Executive Lead:***	Pam Wenger – Director of Corporate Governance			
Awdur yr Adroddiad: ***Report Authors:***	Philippa Peake-Jones – Head of Corporate 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 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*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*

		mechanisms / objectives	*mechanisms / objectives*	

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 work links to all strategic objectives of the Health Board as Corporate Governance is a key enabler for them.
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	The Health Board is required to act according to its Standing Orders. This report contains information to allow the Health Board to conform to this. It is essential that the Board has robust arrangements in place for Corporate Governance and 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?***	This is 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 been undertaken?***	This is 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)***	
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	The effective management of Governance 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 and less waste

Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	Failure to have effective Corporate Governance can impact adversely on the workforce.
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)*	BAF24-01 Building an Effective and Accountable Organisation CRR-16 – Leadership/Special Measures
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Not applicable
Next Steps: • To continue to improve and report on Corporate Governance	
List of Appendices: **Appendix 1:** Quality Safety and Experience forward workplan	

CORPORATE GOVERNANCE REPORT

1. INTRODUCTION

The purpose of this report is to provide the Committee with an update on key corporate governance matters.

2. SUMMARY OF BUSINESS CONSIDERED IN PRIVATE

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.

The below item was considered in private at the meeting held on 4 September 2025:

- Confidential Quality Report

3. COMMITTEE FORWARD WORK PLAN

The Forward Work Plan sets out the Committee's priorities and scheduled business outside of the normal Cycle of Business, helping ensure a structured, timely, and transparent approach to decision-making and oversight. It collates suggested referral items from other Committees and the Board.

4. RECOMMENDATIONS

Members are asked to:

- **NOTE** the matters considered in Private at the 4 September 2025 meeting.
- **NOTE** The Committee forward workplan.

Quality Safety and Experience Committee – Non-Routine Committee Business Forward Plan

(1 April 2024 – 31 April 2025)

This forward plan is only to be used for one-off Adhoc items that do not require inclusion as routine business on the Annual Committee Cycle of Business.

Date of Request	Origin of Request	Requestor	Item Summary / Title	Nature of Request	Lead Officer	Executive Lead	Intended Meeting Date	Status
30.01.25	Board Meeting 30.01.25	Chair	**25/15.1 Improving Quality Report**	QSE Committee to review patient feedback data and discuss how this can be addressed to provide longer term solutions to improve performance.	Head of Corporate Affairs **(Philippa Peake-Jones)**	Pam Wenger	May 2025	The Performance Framework is being reviewed and due to return to Board
07.05.24	TRANSFER LOG AC24.60.1.8	Audit Committee		Quality, safety and commissioned services. The Committee agreed to a 6-month deferral requesting that the review take place before the end of the current financial year - it was agreed to inform the QSE of this decision and for the QSE committee to drive progress on recommendations from the May 23 report.	Director of Governance **(Pam Wenger)** / Head of Corporate Affairs **(Philippa Peake-Jones)**	Director of Governance **(Pam Wenger)**	Jan 2026	This matter has been escalated
10.12.24	Email from Executive Director of Nursing & Midwifery re Action from Oct – Deep Dive on Complaints – Duty of Care.	Executive Director of Nursing & Midwifery	PTR guidance update for Development Session	Once Welsh Government releases new PTR guidance, to return to a Development Session.	Executive Director of Nursing & Midwifery	Executive Director of Nursing & Midwifery	March 2026	**17.3.25** Leon Marsh confirmed that guidance still in draft, with no further updates. Current schedule being embedded is Dec 25.