Health Board Key Issues Report				
Board Date		28/05/2026		
Date of Committee		07/05/2026	**Report of:**	Quality Safety and Experience Committee
Quoracy met:		Yes		
1	Agenda	The Quality, Safety and Experience (QSE) Committee continues to meet bi-monthly. The Committee considered an agenda which is attached: QSE Committee - BCUHB		
2a	Alert	The QSE Committee wish to Alert members of the Board that: 1. **Urgent and Emergency Care** continues to present significant quality and safety risk, particularly relating to prolonged ED waits, ambulance handover delays, corridor care and patient deconditioning, despite strengthened oversight arrangements. 2. **Integrated Quality Report:** Never Events and system harm risk have increased in the current reporting period, primarily associated with process compliance in highly pressurised environments, indicating ongoing whole-system vulnerability. 3. **Integrated Quality Report/Integrated Performance Report** has emerged as a potential quality and safety risk following complaint escalation, highlighting inconsistent organisational understanding of statutory duties. 4. **Mortality:** The Committee received an updated mortality briefing, was assured that surveillance, investigation and learning arrangements remain robust, and emphasised the importance of continuing to triangulate mortality intelligence with system pressures and quality improvement activity. Attached is the link to this paper for visibility QSE Mortality Paper		
2b	Assurance	The QSE Committee wish to Assure members of the Board that: 1. **Urgent and Emergency Care:** Clinical and executive oversight of UEC has strengthened, with regular, clinically led quality reviews now driving shared learning, scrutiny of harm and focused improvement action across ED sites. 2. **Integrated Quality Report/Regulatory Report:** Quality, regulatory and governance oversight is becoming more integrated, with improved triangulation of internal quality intelligence, HIW requirements, ombudsman activity and coronial concerns.		

		3. **Nurse Staffing Act:** has been maintained, with Nurse Staffing Act requirements met and no additional ward establishment uplifts currently required based on acuity, harm and workforce review. The Committee has asked that a paper return to Committee in relation to the Staffing ratios on the Wards not covered by the Act. 4. **Challenged Services Update (QS26.70):** The Committee noted continued pressure across identified challenged services, was assured that oversight arrangements are strengthening, and emphasised the importance of aligning this work with wider system transformation to support service sustainability and patient safety across North Wales. 5. **Adult Mental Health & Learning Disabilities:** The Committee noted ongoing service pressures, was assured of strengthened strategic and oversight arrangements, and emphasised the importance of community-based, holistic support and continued learning from patient experience to improve quality and outcomes.
2c	Advise	The QSE Committee wish to Advise members of the Board that: 1. **Welsh language statutory duties** should be recognised explicitly as a quality and safety issue, with consideration given to a Board-level briefing to strengthen organisational awareness and reduce future patient harm risk. 2. **Performance and quality reporting** should continue to shift towards clearer forward trajectories, milestones and delivery impact to strengthen early assurance and escalation. 3. **UEC mitigation must increasingly focus on prevention and community capacity**, including frailty support, care home management and alternatives to conveyance, aligned with the Clinical Services Plan and IMTP (Community by Design). 4. **Clinical Services Plan:** The Committee noted the emerging Clinical Services Plan, welcomed strong early clinical engagement, and emphasised the need for continued alignment with wider transformation programmes to support sustainable healthcare delivery across North Wales. This will return to Committee as part of a future Development Session.
2d	Review of Risks	The Committee reviewed the risks within its remit and noted: The Board Assurance Framework has continued to mature, with clearer governance, improved alignment to strategic priorities and increased accountability, while noting that further work is required to strengthen

		ownership, delivery confidence and the impact of assurance actions.
2e	Sharing of learning	The **patient story – "This Too Will Pass" (QS26.62)** reinforced learning on dignity, kindness, stigma reduction and whole-life support, informing service design, workforce education and mental health pathways and should be shared with the Board at the 28 May meeting **https://youtu.be/uliVWOgd-7o**
3	Actions to be considered by the	There were not items for referral. The above Patient Story will be shred at the Board meeting.