Bundle Quality, Safety & Experience Committee 27 October 2023

1 QS23.96 OPENING ADMINISTRATION
- QS23.96 QSE Agenda 27.10.23 v.f

2 09:30 - QS23.97 Welcome, introductions and apologies for absence

3 09:32 - QS23.98 Declarations of interest on current agenda

4 09:34 - QS23.99 Minutes of the last meeting and action log
- QS23.99a Draft QSE Minutes 22.08.23 v4
- QS23.99b Draft Summary Action Log QSE Public - 27.10.23

5 QS23.100 QUALITY SAFETY AND IMPROVEMENT

6 09:44 - QS23.101 Proposed Reporting Cycles for QSE Report
- QS23.101a QSE - Sept 2023 - Cycle of Business
- QS23.101b QSE - Sept 2023 - Appendix Cycle of Business - CoB

7 10:04 - QS23.102 Primary Care Report
- QS23.102 QSE - Primary Care Quality Safety and Experience Monitoring

8 10:24 - QS23.103 Patient Story Annual Report
- QS23.103 Patient Stories Annual Report 2023

9.a 10:44 - QS23.104a Corporate Risk Register
- QS23.104a QSE Committee Coversheet - Corporate Risk Register v1.0

9.b QS23.104b Board Assurance Framework
- QS23.104b QSE Coversheet - Proposed Revised Board Assurance Framework V3

10 11:04 - QS23.105 Patient Safety Report
- QS23.105a QSE Patient Safety Report October 2023
- QS23.105b Patient Safety Report Appendix 2 - TOR
- QS23.105c Patient Safety Report Appendix 2 - COB
- QS23.105d Patient Safety Report Appendix 3 -OLF TOR
- QS23.105e Patient Safety Report Appendix 4 OLF Meeting - Agenda

11 11:24 - QS23.106 Nursing and Midwifery Council (NMC) Fitness to Practise (FtP) Annual Report April 2022 – March 2023
- QS23.106 Nursing and Midwifery Council Annual Report QSE Oct 2023 (002)

12 11:34 - QS23.107 Maternity and Neonatal Safety Support Programme (MatNeoSSP) Update
- QS23.107 QSE committee MatNeo Report Oct 23

13 11:44 - QS23.108 Performance Report Month 5
- QS23.108a QSE Performance Report - 19102023
- QS23.108b QSE 27-10-23 3rd DRAFT Ed

15 12:04 - QS23.110 Nurse Staffing Act Presentation
- QS23.110 Nurse Staffing QSE Presentation Oct 23 (V2)

16 QS23.111 SPECIAL MEASURES

17 12:24 - QS23.112 Special Measures Report (cycle 2) including Output from the Development Sessions on Independent Reviews
- QS23.112 FINAL - 2023-10-27 - QSE Special Measures Update
- QS23.112b Independent Patient Safety Review - Management Response
- QS23.112c Independent Review Management Response - NCCU NHS Executive Mental Health Inpatient Safety Review report. V0.7

18 QS23.113 FOR NOTING

20 QS23.115 CLOSING BUSINESS

21 QS23.116 Reflections on meeting

22 QS23.117 Date of Next Meeting

Agenda Quality Safety Experience Committee

Date 27 October 2023
Time 09:30-13:30
Location Boardroom, Carlton Court, St Asaph
Chair Rhian Watcyn Jones

Agenda item	Item	Lead	Action	Paper/Verbal
1.0 OPENING ADMINISTRATION				
1.1	Welcome, introductions and apologies for absence	Chair	Information	Verbal report
1.2	Declarations of interest on current agenda	Chair	Decision	Verbal Report
1.3	Minutes of the last meeting and action log	Chair	Decision	Paper
2.0 QUALITY SAFETY AND IMPROVEMENT				
2.1	Outline on Reporting Cycles for QSE Report	Executive Director of Nursing & Midwifery	Assurance	Paper
2.2	Summary of Primary Care Quality, Safety and Experience Monitoring	Executive Director of Operations	Assurance	Paper
2.3	Patient Story Annual Report	Executive Director of Nursing & Midwifery	Assurance	Paper
2.4	Risk Register	Interim Board Secretary	Assurance	Paper
2.5	Board Assurance Framework	Interim Board Secretary	Assurance	Paper
2.6	Patient Safety Report	Executive Director of Nursing & Midwifery	Assurance	Paper
2.7	Nursing and Midwifery Council (NMC) Fitness to Practise (FtP) Annual Report April 2022 – March 2023	Executive Director of Nursing & Midwifery	Assurance	Paper
2.8	Maternity and Neonatal Services	Executive Director of Nursing & Midwifery	Assurance	Paper

Agenda item	Item	Lead	Action	Paper/Verbal
2.9	Performance Report Month 5	Executive Director of Finance	Assurance	Paper
2.10	Nurse Staffing Act Presentation	Executive Director of Nursing & Midwifery	Assurance	Paper
3.0 SPECIAL MEASURES				
3.1	Special Measures Report (cycle 2) including Output from the Development Sessions on Independent Reviews	Director of Transformation and Improvement	Assurance	Paper
4.0 FOR NOTING				
4.1	Research Governance Policy	Associate Director, Research and Development Department	Noting	Paper
5.0 CLOSING BUSINESS				
5.1	Reflections on meeting	Chair	Information	Verbal
5.2	Date of Next Meeting	Chair	Information	Verbal

MEMBERS	
Name	**Title**
Rhian Watcyn Jones	Independent Member, Chair
Clare Budden	Independent Member
Prof Mike Larvin	Independent Member
In attendance	
Jason Brannon	Deputy Director of Workforce
Dyfed Edwards	Independent Member/Health Board Chair
Gareth Evans	Acting Executive Director Therapies & Health Science
David Jenkins	Independent Advisor (observing)
Matt Joyes	Associate Director of Quality
Dr Nick Lyons	Executive Medical Director
Phil Meakin	Interim Board Secretary
Teresa Owen	Executive Director of Public Health
Chris Stockport	Executive Director of Transformation & Strategic Planning
Angela Wood	Executive Director of Nursing & Midwifery (Lead Executive)

Betsi Cadwaladr University Health Board (BCUHB)

Minutes of the Quality, Safety & Experience Committee meeting held on 22 August 2023, Boardroom, Carlton Court, St Asaph

Present	
Name	**Title**
Rhian Watcyn Jones	Independent Member, Chair
Clare Budden	Independent Member
In attendance	
Jason Brannan	Deputy Director of People
Nesta Collingridge	Head of Risk Management
Richard Coxon	Interim Head of Corporate Affairs (minutes)
Dyfed Edwards	Independent Member/Chair of Health Board
Adele Gittoes	Interim Executive Director of Operations
Michelle Greene	Integrated Health Community Director East
Sian Hughes-Jones	Head of Nursing for Cancer Services (Observing)
Matt Joyes	Deputy Director of Quality
Dr Nick Lyons	Executive Medical Director
Leon Marsh	Head of Patient Experience
Phil Meakin	Interim Board Secretary
Teresa Owen	Executive Director of Public Health
Geraint Parry	Quality Improvement Fellow
Tracey Radcliffe	Head of Patient Safety
Dr James Risley	Deputy Executive Medical Director
Carol Shillabeer	Interim Chief Executive Officer
Chris Walker	Head of Safeguarding (Adults)
Jane Wild	Associate Member
Edward Williams	Deputy Director of Performance (item QS23.85)
Angela Wood	Executive Director of Nursing & Midwifery

Agenda item	**Action**
OPENING BUSINESS	
QS23.78 Welcome introductions and apologies QS23.78.1 Rhian Watcyn Jones, Independent Member and Chair (Chair) of the Quality, Safety & Experience (QSE) Committee welcomed everyone. QS23.78.2 Apologies were received from: • Gareth Evans, Acting Executive Director Therapies & Health Science • David Jenkins, Independent Advisor. • Prof Mike Larvin, Independent Member • Chris Stockport, Executive Director of Transformation, Strategic Planning & Commissioning QS23.78.3 The Chair welcomed Adele Gittoes (AG), Interim Executive Director of Operations; Sian Hughes-Jones, Head of Nursing for Cancer	

Services (shadowing Angela Wood) and Dr James Risley, Deputy Executive Medical Director to the meeting.	
QS23.79 Declarations of interest on current agenda QS23.79.1 There were no declarations of interest noted.	
QS23.80 Minutes of the last meeting and action log QS23.80.1 The minutes of the meeting held on the 25 July 2023 were approved as an accurate record of the meeting. However the Chair felt that it was unnecessary to state 'as read' in minutes against items.and background information should only be there to support key points and actions. QS23.80.2 The Committee reviewed the action log and agreed the closure of those which had been completed. Clare Budden (CB), Independent Member, thought that the colour coding on the action log could be simplified. QS23.80.3 The Chair asked what had happened with the Health and Safety Executive Prosecution Case on the 3 August. Angela Wood (AW), Executive Director of Nursing & Midwifery responded that BCUHB had been informed by the court a few days before the scheduled date that the judge was on holiday and that the case would be rescheduled for some time in December. The delay was disappointing for everyone involved and BCUHB was awaiting confirmation of a new court date. QS23.80.4 The Chair asked why the Deep Dive in Falls had been postponed until the October meeting. AW responded that an Internal Audit Review into Falls Policy was due but had not yet been received. This would provide a more balanced report hence the reason to postpone until October. QS23.80.5 Phil Meakin (PM), Associate Director of Governance and Interim Board Secretary, reported that the Risk Annual Trends Report would be taken to the Risk Management Group in October then onto the Committee for review. QS23.80.6 AW reported Patient Safety Report would be brought to the meeting in September with Primary Care information included. QS23.80.7 It was noted that Internal Audit does not routinely report to QSE Committee but the Head of Internal Audit is keen to meet with all Committee Chairs to ensure relevant audit information is shared. **PM agreed to arrange a meeting between the Chair and Head of Internal Audit.** QS23.80.8 CB asked how staff members could raise concerns about	**PM**

colleagues' performance, what were staff concerns and where does Whistleblowing where does it fit in? Carol Shillabeer (CS), Interim Chief Executive Officer explained that there were strong processes for oversight within the organisation. The Committee agreed that this would be a good topic for a Board Development session. **ACTION: PM and RC to review action logs across organisation for a consistent approach.** **ACTION: Whistleblowing, raising concerns and oversight for a Board Development Session**	**PM/RC** **PM**
QS23.81 SPECIAL MEASURES	
QS23.82 Special Measures QS23.82.1 The Chair welcomed Geraint Parry (GP), Quality Improvement Fellow who presented the latest Special Measures report which outlined the progress to date on the deliverables associated with the Committee. QS23.82.2 It was noted that the External Review Reports would be discussed in a separate session with reviewers present. QS23.82.3 GP reported that the report highlighted the challenges around clinical engagement and digital solutions and barriers to streamlining processes. The next 90-day cycle planning is underway and it was agreed that although Special Measures status was uncomfortable it was important to get the organisation on track. QS23.82.4 The Committee received the report. **ACTION: Date for External Review Reports session to be arranged**	**PM**
QS23.83 QUALITY SAFETY AND IMPROVEMENT	
QS23.84 Clinical Effectiveness Report QS23.84.1 Dr Nick Lyons (NL), Executive Medical Director, introduced the Clinical Effectiveness Report. The Quarter 3, Quarter 4 Clinical Audit Reports and the Annual Clinical Audit Report for 2022-2023 were submitted to June Strategic Clinical Effectiveness Group (CEG) for discussion and to Quality Development Group on 14 August and now to the Committee for acknowledgement QS23.84.2 There was some discussion around the report which was very detailed. The Chair wanted to know what was going well and if not, what plans were in place to improve or to mitigate. The Committee needed to see assurance and a joined-up governance system and did not need operational detail. QS23.84.3 The Committee noted the report.	

QS23.85 Performance Report Month 3 QS23.85.1 Edward Williams (EW), Deputy Director of Performance presented the report which was in a different format from the more detailed version which would be produced for the Board meetings which was hopefully clearer for Committee members. QS23.85.2 It was noted that the report related to the Month 3 data as Month 4 data was only available that day so too late to circulate before the meeting. QS23.85.3 There was some discussion around rankings and targets and how realistic they are when no Health Board was able to achieve the ambulance turnover and four hour wait targets. Adele Gittoes (AG), Interim Executive Director of Operations, responded that the ambulance turnover and four hour wait targets were a Ministerial priority which BCUHB has to follow. QS23.85.4 The Committee received the report.	
QS23.86 Patient and Carer Experience Report QS23.86.1 Leon Marsh (LM), Head of Patient Experience was welcomed to the meeting to present the Patient and Carer Experience Report which covered the period April to June 2023. It was noted that 570 complaints had been received during this time, 47 of these were managed under Putting Things Right, and an additional 98 were resolved as Early Resolutions. QS23.86.2 It was noted that the majority of the complaints related to Secondary Care Services. The top themes related to: clinical treatment and assessment, poor communication, appointments and medication. Pro-active work is ongoing with the Patient Advice and Liaison Service (PALS) to coordinate with services, addressing recurring themes. Attitude and behaviour issues are common themes across all services. QS23.86.3 It was reported that in the next Special Measures 90-day cycle there would be a Board session on Cultural Behavioural Work within the organisation. QS23.86.4 CB thought it was positive that the organisation has many different ways for patients to give feedback such as texting, message boards and being visible and open. QS23.86.5 AW highlighted that a significant amount of work around effective complaints resolution had been undertaken by the Complaints Team and better use of language in the written responses. It was agreed	

that improving the quality of complaint responses was a good learning development opportunity for staff where required. QS23.86.6 The Committee received the report.	
QS23.87 Infection Prevention and Control Annual Report 2022/23 QS23.87.1 Rebecca Gerrard (RG), Director of Nursing Infection Prevention and Decontamination presented the Infection Prevention and Control (IPC) Annual Report relating to the period April 2022 to March 2023. It was noted that the report sought to provide assurance that the organisation is meeting its statutory requirements in relation to the management of IPC in accordance with the Code of Practice for the Prevention and Control of Healthcare Associated Infections (HCAI) 2014. The report outlined the key achievements and challenges and provided an assessment of performance against national targets in relation to HCAIs and antimicrobial prescribing for the year. QS23.87.2 The Chair was pleased that BCUHB compared well against other Health Boards and noted the ongoing work. AW reported that the Infection Control Group ensured that shared learning and good practice was implemented across the organisation. . QS23.87.3 The Committee noted the report.	
QS23.88 Corporate Safeguarding Annual Report QS23.88.1 Chris Walker (CW), Head of Safeguarding (Adults) joined the meeting to present the Safeguarding and Public Protection Annual Report 2022-2023. QS23.88.2 It was noted that with the introduction of new legislation and an increase in training compliance the service had experienced a significant rise in the level of case work. This was inclusive of case complexity based upon the adaptation of putting new legislation into practice, which has been experienced throughout BCUHB and by our partner agencies. QS23.88.3 CB noted the differences in IHC areas which are managed by different Local Authorities and different levels of deprivation. CW reported that there was both over and under reporting and more training awareness was required. QS23.88.4 The Committee received the report.	
QS23.89 Integrated Health Community (IHC) Report – East QS23.89.1 Michelle Greene (MG), IHC East Director presented the report with information and analysis on the progress of the East IHC in improving quality, patient safety and experience.	

QS23.89.2 MG explained that the three IHCs (West, Central and East) meet regularly both formally and informally to work collaboratively together. She reported that one of the issues she had was maintenance of older buildings in Wrexham and areas which needed to be closed when too expensive to maintain or repair. QS23.89.3 The Chair thanked MG for the report but felt that the report concentrated on risk rather than quality matters. She thought it might be good to meet with the IHC directors together at a future meeting. QS23.89.4 The Committee received the report.	
QS23.90 Risk Register QS23.90.1 Phil Meakin (PM), Interim Board Secretary and Associate Director of Governance introduced the report on progress on the management of the Corporate Risk Register and the new escalated risks, and discussions which took place during the Risk Management Group (RMG) meetings on the 15 June 2023 and the 8 August 2023. It was noted that RMG provided oversight of risk in BCUHB and reviewed escalation and de-escalation of risks. QS23.90.2 The Chair felt that the report was too long and mixed risk with issues but noted that work on refining the register was ongoing and that there would be a Board Development session on the 24 August on Risk Appetite. QS23.90.3 The Committee noted the report.	
QS23.92 CLOSING BUSINESS	
QS23.93 Reflections on meeting QS23.93.1 AG found her first QSE Committee meeting interesting and noted how the reporting system linked with other meetings. Sian Hughes-Jones was asked for her thoughts. She found the meeting very interesting.	
QS23.94 New Risks QS23.94.1 There were no new risks identified during the meeting.	
QS23.95 Date of Next Meeting QS23.95.1 There was a discussion about moving back from a monthly meeting cycle to a bi-monthly meeting cycle to align with Board reporting. It was agreed that the next meeting would be in October to report to the 30 November Board meeting.	

BCUHB QUALITY, SAFETY& EXPERIENCE COMMITTEE - Summary Action Log Public Version				
Officer/s	**Minute Reference and summary of action agreed**	**Original Timescale**	**Latest Update Position**	**Revised Timescale**
AW	**QS23.05** Patient Story**:** Ensure that there is a year-end report received at QSE on Patient Stories.	September	Update - This will come to the October QSE meeting. On agenda.	proposed for closure
AW	**QS23.67** AW to bring a deep dive on falls to the meeting next month explaining how making change and challenge of embedding into practice.	August	Deferred to meeting on the 27.10.23 when audit report will also be included. On agenda.	proposed for closure
TR	**QS23.68** Patient Safety Report: TR to include breakdowns in future reporting	October	On agenda	proposed for closure
AW	**QS23.72** Special Measures Report: AW to discuss Quality Strategy with CEO regarding timings	August	The CEO has identified that the Quality Strategy would progress as part of the cycles of special measures. Work is still progressing in the background to be ready for further consultation when required.	proposed for closure
PM	**QS23.80** PM agreed to arrange a meeting between the Chair and Head of Internal Audit.	October	The meeting between the Chair and Head of Internal Audit took place on the 11.10.23.	Proposed for closure
PM/RC	**QS23.80** PM and RC to review action logs across organisation for a consistent approach.	August	The same action log template is now being used across all committees with only three colours.	proposed for closure
PM	**QS23.80** Whistleblowing, raising concerns and oversight for a Board Development Session	August	This has been added to the list of topics for planned Board Development Session.	proposed for closure
PM	**QS23.82** Date for External Review Reports session to be arranged	August	These took place on the 14 September 2023.	proposed for closure

RAG Status	
	Completed/for closure

	Ongoing
	Outstanding

Teitl adroddiad: ***Report title:***	Proposed Cycle of Business			
Adrodd i: ***Report to:***	QSE Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	27 October 2023			
Crynodeb Gweithredol: ***Executive Summary:***	This report provides the Committee with a proposed Cycle of Business for the Committee			
Argymhellion: ***Recommendations:***	The Committee is asked to approve this proposed Cycle of Business			
Arweinydd Gweithredol: ***Executive Lead:***	Angela Wood, Executive Director of Nursing and Midwifery			
Awdur yr Adroddiad: ***Report Author:***	Matthew Joyes, Deputy Director for Quality 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:***				
N/A – the rating of Acceptable has been given based on this proposed Cycle of Business meeting the Terms of Reference, NHS Wales guidance and recognised best practice				

Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Quality
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.
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?	N/A

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)***	BAF1.2
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)*	BAF1.2
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:*** Proposed Cycle of Business	

INTRODUCTION

This report provides the Committee with a proposed Cycle of Business for the Committee.

ROLE OF THE COMMITTEE

The purpose of the Quality, Safety and Experience (QSE) Committee is to provide advice and assurance to the Board in discharging its functions and meeting its responsibilities with regard to the quality of services including clinical effectiveness, patient safety and patient and carer experience whether delivered directly or through a partnership arrangement.

PURPOSE OF THE CYCLE OF BUSINESS

The Cycle of Business has been developed to help plan the management of Committee matters and facilitate the management of agendas and committee business.

METHODOLOGY

In preparing this draft, the following has been taken into account:

- QSE Committee Terms of Reference (Betsi Cadwaladr University Health Board)
- Good Governance Guide for NHS Wales Health Boards (Welsh Government)
- NHS Wales Governance E-manual (Welsh Government)
- Duty of Quality Statutory Guidance (Welsh Government)
- Examples of other NHS Wales Health Boards quality committee cycles of business.

Under the Duty of Quality introduced by the Health and Social Care (Quality and Engagement) (Wales) Act 2020, and the accompanying Statutory Guidance, the Health Board must have strong internal quality governance arrangements that are structured within a robust quality management system. An effective quality management system has a focus on learning and is driven by the board, and explains how Quality Control, Quality Planning, Quality Improvement and Quality Assurance work together to form an integrated system. As such, the Cycle of Business has been structured around these 4 elements of a quality management system.

RECOMMENDATIONS

The Committee is asked to approve this proposed Cycle of Business.

QUALITY, SAFETY & EXPERIENCE COMMITTEE (QSE)								
Item of Business	**Purpose**	**Lead**	**April**	**June**	**August**	**October**	**December**	**February**
Opening items								
Apologies		Chair	✓	✓	✓	✓	✓	✓
Declarations of Interest		Chair	✓	✓	✓	✓	✓	✓
Minutes from previous Meeting		Chair	✓	✓	✓	✓	✓	✓
Matters Arising & Table of Actions		Chair	✓	✓	✓	✓	✓	✓
Report of the Chair • Chair's Action • Feedback from Board		Chair	✓	✓	✓	✓	✓	✓
Notification of Matters referred from other Board Committees on this or future agendas		Chair	✓	✓	✓	✓	✓	✓
Annual review of ToR		Board Secretary *Head of Corporate Affairs*	✓					
Annual review of CoB		Board Secretary *Head of Corporate Affairs*	✓					
Committee Annual Report		Board Secretary *Head of Corporate Affairs*	✓					
Patient Story		Executive Director of Nursing and Midwifery *Deputy Director of Quality Governance*	✓	✓	✓	✓	✓	✓
Quality Planning								
Quality Strategy Annual Priorities	Agree annual priorities for quality, underpinning delivery of the overall Quality Strategy	Executive Director of Nursing and Midwifery *Deputy Director of Quality Governance*	✓					
Quality Control								
Patient Safety Report	Providing information on key patient safety issues and mitigations including nationally reportable incidents, safety alerts, maternity and neonatal safety and mortality, safeguarding and infection prevention and control	Executive Director of Nursing and Midwifery *Deputy Director of Nursing*	✓		✓		✓	
Patient and Carer Experience Report	Providing information on key patient and carer experience issues and mitigations including complaints, accessible healthcare and patient feedback	Executive Director of Nursing and Midwifery *Deputy Director of Nursing*		✓		✓		✓
Clinical Effectiveness Update Report	Providing information on key clinical effectiveness issues and mitigations including clinical audit, NICE guidelines and external peer reviews. The April report will include the proposal annual clinical audit plan.	Executive Medical Director *Deputy Medical Director*	✓		✓		✓	

QUALITY, SAFETY & EXPERIENCE COMMITTEE (QSE)								
Item of Business	**Purpose**	**Lead**	**April**	**June**	**August**	**October**	**December**	**February**
Clinical Service of Concern Report	Providing information on issues, risks, mitigations and improvements for clinical services of concern (to be decided by the Committee)	Executive Medical Director *Deputy Medical Director*	✓	✓	✓	✓	✓	✓
Quality Delivery Group Chair's Report		Executive Director of Nursing and Midwifery *Deputy Director of Quality Governance*	✓	✓	✓	✓	✓	✓
WHSSC Quality Committee Chair's Report		Executive Director of Nursing and Midwifery *Deputy Director of Quality Governance*	✓		✓		✓	
Commissioned Services Quality Report		Executive Director of Nursing and Midwifery *Deputy Director of Quality Governance*			✓			✓
IHC/Regional Service Quality Deep Dive		Executive Director of Operations *IHC Directors*	✓ East IHC	✓ Central IHC	✓ West IHC	✓ Primary Care Dental	✓ MHLD	✓ Cancer Diagnostics Womens
Quality Assurance								
Corporate Risk Register Report		Board Secretary *Head of Risk Management*	✓	✓	✓	✓	✓	✓
Special Measures Report		Executive Director of Strategy and Transformation *Director of Transformation and Improvement*	✓	✓	✓	✓	✓	✓
Regulatory Report	Providing information on regulatory compliance including new HIW, CIW and PSOW reports (including Public Interest Reports) and action plan progress	Executive Director of Nursing and Midwifery *Deputy Director of Quality Governance*	✓	✓	✓	✓	✓	✓
Healthcare Law Report	Providing information on healthcare legal compliance including inquest activity, new Regulation 28 Notices and action progress and WRP compliance	Executive Medical Director *Deputy Director of Quality Governance*	✓		✓		✓	
Clinical Policy Report		Executive Director of Nursing and Midwifery *Deputy Director of Quality Governance*	✓			✓		
Nurse Staffing Act Report	Statutory bi-annual report	Executive Director of Nursing and Midwifery *Deputy Director of Nursing*	✓			✓		

QUALITY, SAFETY & EXPERIENCE COMMITTEE (QSE)								
Item of Business	**Purpose**	**Lead**	**April**	**June**	**August**	**October**	**December**	**February**
Annual Quality Report	Statutory annual report	Executive Director of Nursing and Midwifery *Deputy Director of Quality Governance*		✓				
Annual PTR Report (including Duty of Candour Annual Report)	Statutory annual report	Executive Director of Nursing and Midwifery *Deputy Director of Quality Governance*		✓				
Safeguarding Annual Report	Statutory annual report	Executive Director of Nursing and Midwifery *Director of Nursing (Safeguarding)*		✓				
IPC Annual Report	Statutory annual report	Executive Director of Nursing and Midwifery *Director of Nursing (IPC)*		✓				
Research Annual Report		Executive Medical Director *Associate Medical Director (Research)*		✓				
Organ Donation Annual Report	Statutory annual report	Executive Director of Therapies and Health Sciences		✓				
Quality Improvement								
Quality Strategy Monitoring Report		Executive Director of Nursing and Midwifery *Deputy Director of Quality Governance*	✓			✓		
Closing items								
Agree Items for referral to Board / Other committees		Chair	✓	✓	✓	✓	✓	✓
Review of Risks highlighted in the meeting for referral to Risk Management Group		Board Secretary *Head of Risk Management*	✓	✓	✓	✓	✓	✓
Agree items for Chairs Assurance Report		Chair	✓	✓	✓	✓	✓	✓
Review of Meeting Effectiveness		Chair	✓	✓	✓	✓	✓	✓
Report items discussed in previous meeting private session		Chair	✓	✓	✓	✓	✓	✓
Date of next meeting		Chair	✓	✓	✓	✓	✓	✓
Private Business								
Apologies		Chair	✓	✓	✓	✓	✓	✓
Declaration of Interests		Chair	✓	✓	✓	✓	✓	✓
Minutes from previous meeting		Chair	✓	✓	✓	✓	✓	✓
Matters arising & Table of Actions		Chair	✓	✓	✓	✓	✓	✓

QUALITY, SAFETY & EXPERIENCE COMMITTEE (QSE)								
Item of Business	**Purpose**	**Lead**	**April**	**June**	**August**	**October**	**December**	**February**
Confidential Quality Report	Providing information on significant quality issues which may be patient identifiable including Nationally Reportable Incidents and significant emerging quality issues	Executive Director of Nursing and Midwifery *Deputy Director of Quality Governance*	✓	✓	✓	✓	✓	✓

Teitl adroddiad: ***Report title:***	Summary of Primary Care Quality, Safety and Experience Monitoring			
Adrodd i: ***Report to:***	QSE Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 24 November 2022			
Crynodeb Gweithredol: ***Executive Summary:***	This report has been written in response to a request to provide a high-level overview how Primary Care services in North Wales are monitored for patient quality, safety and experience, with a focus on GMS access and referrals. The purpose of the paper is to start a discussion about how the QSE committee can support the Primary Care patient quality, safety and experience agenda and gain the necessary assurance in this regard, as a sub-committee of the Board.			
Argymhellion: ***Recommendations:***	The QSE committee should receive regular updates and assurance against the actions highlighted in to improve the monitoring of quality, safety and assurance in primary care under point 7.			
Arweinydd Gweithredol: ***Executive Lead:***	Adele Gittoes, Interim Executive Director of Operations			
Awdur yr Adroddiad: ***Report Author:***	Karen Higgins, Director of Primary Care			
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):***	• Improve the safety and outcomes of care to match the NHS's best • Respect individuals and maintain dignity and care • Listen to and learn from the experiences of individuals			
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)***	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 improvement measures*** .	
Rhestr o Atodiadau:	

1. **Introduction**

This short report will provide a high-level overview how Primary Care services in North Wales are monitored for patient quality, safety and experience, with a focus on GMS access and referrals.

The purpose of the paper is to start a discussion about how the QSE committee can support the Primary Care patient quality, safety and experience agenda and gain the necessary assurance in this regard, as a sub-committee of the Board.

2. **Primary Care Provision in North Wales**

Primary care services provide the first point of contact in the healthcare system, acting as the 'front door' of the NHS. Primary care includes: general practice, community pharmacy, dentistry, and optometry services.

In BCUHB the service provision is as follows:

GENERAL PRACTICE

12 Healthboard **84** Independent

Practice type	West	Centre	East
Inderpendent	24	27	33
Healthboard	4	2	6
Total	28	29	39

PHARMACY

145 Pharmacies

Pharmacies / Services	West	Centre	East
Pharmacies	41	47	57
CCPS	41	46	56
STTAT	37	35	44

OPTOMETRY

69 Practices

Practice/ Service	West	Centre	East
Practices	19	22	28
WECS	19	22	26
LVSW	14	10	5

DENTAL SERVICES

80 GDS Practices **26** CDS Sites

Practices	West	Centre	East
GDS	22	23	35
CDS	8	9	9

Explanation of terms:

Pharmacy

CCPS – Those pharmacies delivering the common ailments service

STTAT – Sore Throat Test and Treat Service

Optometry

WECS – Practices embedding prevention, well-being and quality improvement tools

LVSW – Additional accreditation to provide low vision assessment

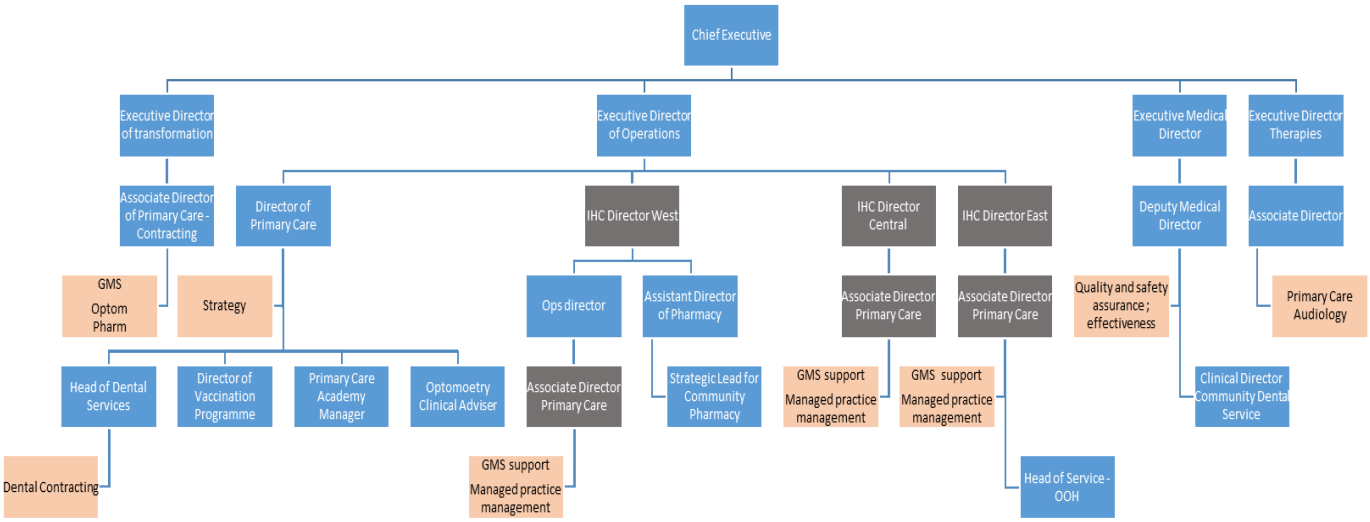
Dental services

GDS – General dental services (independent contractors)

CDS – Community Dental Services (Provided by the Health Board)

3. **Management and Operating Structure**

The structure of primary care in BCUHB is complex with strategy, operational delivery, contracting, and monitoring spread across the organisation. This presents challenges to achieving consistency or service models and for monitoring quality, safety and experience.



4. Monitoring Quality, Safety and Experience of Primary Care in North Wales

To date the monitoring of primary care has been inconsistent in the approach across the region, this does ***not*** detract from good work being carried out locally, as there are clear processes in place.

Quality and safety are monitored and managed through individual IHC quality and safety groups. These cover:

- Risks and issues captured on Datix
- Patient experience
- Quality assurance visit programme (QAVP)
- Post payment verification visits (PPV)
- Safety alerts
- Audits
- Health and safety premises visits

Highlights from these meeting are reported to the QSE committee through the IHCs in the 'Integrated Governance Report Template'. The meetings encompass general practice, community dental services, community pharmacy and with the introduction of new contract reforms, optometry will join the agenda.

In addition to the monitoring carried out in the IHCs there is significant work carried out by the contracting team for GMS, pharmacy and optometry to ensure that all providers deliver their contractual requirements.

Dental contracting and quality are covered in the local IHC meetings but it is also managed through a dedicated pan-BCUHB dental team. There are two regular meetings where quality, safety and experience are discussed, these are:

- Contract Management Group / Dental Contracting Risk Assessment Meeting
- Primary Care Dental Services Quality and Safety Group meeting

For General Dental Services (GDS) providers, quality is measured through:

- Access of care: Measured either by patient metrics if delivering under Contract Reform or by Units of Dental Activity (UDA) if remaining under the 2006 contract. This data is monitored on a monthly basis.
- Treatment and Prevention: This data includes all clinical treatments and prevention provided, such as fluoride varnish applications. It is an expectation for those contracts delivering services under Dental Contract Reform to provide preventative treatment in the form of Fluoride Varnish applications to adults with a caries risk and all children. Providers also have access to this information via eDEN, an online application.
- Risk Assessment meetings: Attendees include; contracting team, dental practice advisors and clinical governance to assist the HB in the assessment of risk and make recommendations for mitigation and improvement.
- Disease outcomes: The introduction of the ACORN toolkit (Assessment of Clinical Oral Risks and Needs) is providing the Health Board with useful information which demonstrates improving oral health of the population and areas where focused intervention initiatives may be required.
- Patient experience: PALS reports are shared with the contracting team on a weekly basis, this information is collated and shared on a monthly and quarterly basis to identify trends and support improvement interventions.

Community Pharmacy services are monitored in IHC meetings, but the service also has its own mechanisms. For example:

- Operational data on the numbers and nature of consultations, to gauge the level of delivery
- Audits are also run on the operational data sets from time to time to delve deeper into the details of service delivery, with any findings from these audits followed up
- Services are also subject to Post Payment Verification, undertaken by Shared Services, who ensure that all claimed service delivery is backed up by appropriate evidence held by the contractor.

In addition, quality is evaluated through intelligence received through clinical governance Issues, or concerns, that have been reported by the pharmacy, other healthcare providers, or raised by patients. As well as following up on individual incidents and complaints, patterns in reports are monitored to identify any sub-optimal performance in a particular premises or company and these are followed up with the contractor as appropriate.

5. General Practice Access

Quality and experience of access is one of the most talked about topics in the media, in Politics, by patients and staff; it is also one of the top themes in patient experience data such as complaints.

The contracting team monitor attainment against the ‘Access Commitment’ which was introduced on 10th May 2022 by Welsh Government. This was introduced to demonstrate to the public what they can expect in terms of access from GP practices. The principles of the Access Commitment are:

- A more planned and forward-looking approach, where contact is supported throughout the day to resolve the issues around the ‘8am bottleneck’ and repeated attempts at contacting and/or obtaining a consultation or other help and support. The release of all appointments at 8am (or other narrow window of time) is no longer acceptable.
- All practices must provide a telephony service (preferably Voice over Internet Protocol solutions or sufficient incoming and outgoing lines) that fully meets the needs of patients.

- All practices must offer a digital means of access in addition to telephone and in-person. The digital platform is for non-urgent access and only necessary for use during core hours.

The commitment was introduced in 2 phases and progress has been monitored through the BCUHB Access Forum managed by the Contracting Team. At the end of 2022/23:

- 97.9% of all practices had achieved all the requirements of phase 1
- 90.6% of all practices had achieved the requirements of phase 2
- 100% of health board managed practices achieved all requirements of phase 2

The next full report is due on 28 November 2024 although the requirements are now part of the GMS contract and the monitoring and reporting may differ.

General Practice in North Wales is performing well under intense pressure – circa 12,400 appointments per day. To contextualise this, it represents close to half the population of North Wales contacting their GP once a month. GMS and Health board practices also carry out the majority of on the day urgent care across North Wales. This incredible effort by a decreasing workforce is not reflected in the persistent negative rhetoric reported in the media, the impact of which is GP staff report declining morale as well as an escalation in aggressive acts from the public.

However, there is unarguable pressure in the system and the following statistics highlight some of the reasons:

- BCUHB primary care services currently have a vacancy rate of 21%fte across clinical and non-clinical roles, equating to 76.4fte vacancies. This is significantly higher than the NHS Wales average, which in December 2022 was estimated to be 5.3%.
- The highest vacancy rates within BCUHB are General Practitioners 37% fte and Nursing 30%fte.
- BCUHB has the lowest number of GPs per capita in Wales at 4.8/10,000 patients compared to the average of 5.1/10,000. A difference of 6.25% and 22.9% lower than the Health Board with the highest number of GPs, Powys at 5.9/10,000.

There are other reasons which may be contributing which include:

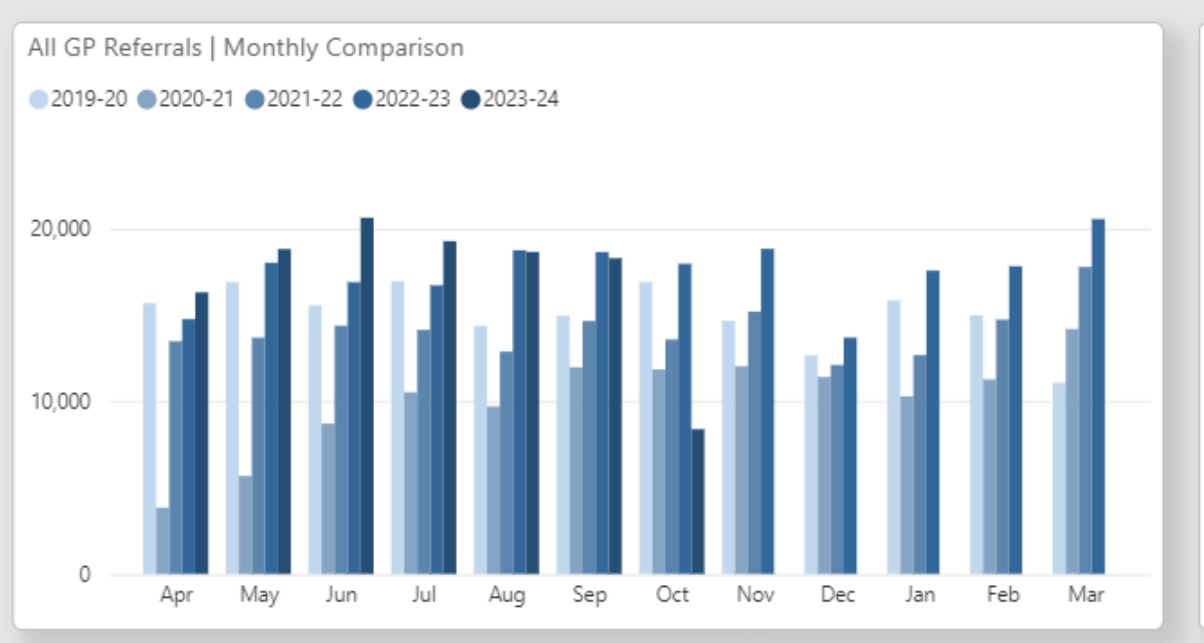
- If patients believe it will be difficult to get an appointment, then their risk threshold for self-care and ‘wait and see’ is reduced. This may explain the increasing number of DNAs which Welsh Government currently quote as being around 80k missed GP appointments every month in Wales.
- The model of care is moving from GP first to one of direct access to the most appropriate professional which may be a nurse, paramedic or physio therapist etc. This change is taking time for staff and patients to adjust to and the cultural shift should not be underestimated.
- The increasing number of people on secondary care waiting lists require additional support in primary care.

6. Referrals

Whilst referral data is reviewed by specialities there is currently no formal processes in place to look at primary care referral data across North Wales in a methodical and standardised way as part of an improvement process. This has been identified by the Planned Care Programme and discussions are taking place to progress this at pace.

One of the biggest barriers has been access to reliable and clear data. To address this, work began in March to ensure that accurate data is presented in a consistent format and can be viewed at different levels i.e. practice, cluster, IHC, and regional. This is nearing completion, following data quality assurance which will be undertaken with system users.

However, we can already see an increase in referrals from primary care as shown in the table below:



The table below shows a sample of real GP referral data from 2022 / 23 (anonymised). The rate is calculated by dividing the number of referrals by the practice population. The North Wales rate is worked out by taking the total referrals and dividing it by the total population. The variance shows how close to the rate each cluster is.

Green = Lower than NW Average
Red = Higher than NW Average

8. Cluster A	9. 205.86	10. -21.31
12. Cluster B	13. 263.41	14. 36.23
16. Cluster C	17. 312.53	18. 85.35
20. Cluster F	21. 180.81	22. -46.36
24. Cluster G	25. 184.81	26. -42.36
28. Cluster H	29. 182.48	30. -44.69
32. Cluster I	33. 213.57	34. -13.60

Once this process is complete we can begin to work with clusters to develop ways of using the data to review the quality and effectiveness of referrals as well as monitor the outcomes of patients entering secondary care and the communication channels in the system.

It is critical that this work progresses with our GP colleagues as it will be most effective in a trusting relationship. Clusters and practices will need to be assured that we will work collectively to understand what the data is indicating and that it is not used as a quality measure in itself.

Examples of considerations when reviewing referral data

- A practice with a high referral rate for CHD could be due to a lack of confidence in clinicians or equally due to specialist knowledge.
- Many people put off visiting their GP during the pandemic and this could explain the increase in referrals now

- The local population demographic must also be taken into account, as those in less affluent area are more likely to present with disease associated with poverty and the accompanying poor health outcomes.
- There is also a risk that data leads us to explore the anomalies / outliers and miss learning from the 'average'

Working with secondary care

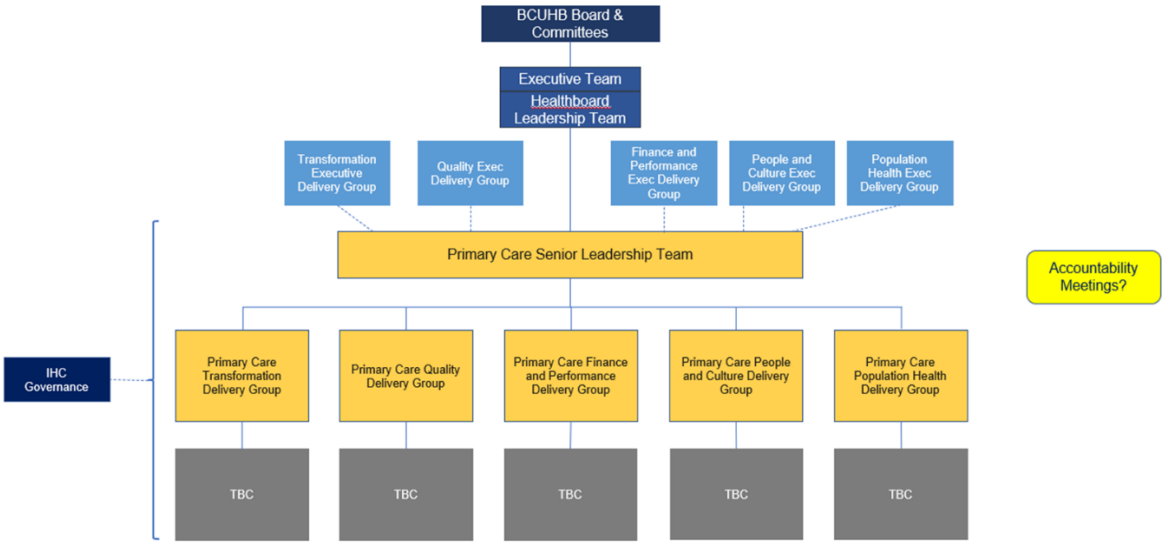
Elective care services in our secondary and acute care settings also have a key role to play in terms of being able to provide necessary feedback and further analysis to help the organisation improve data quality and better manage new demand. The organisation is developing a centrally managed booking, referral and validation function and Primary Care is a key stakeholder in that work. We will use this collaborative opportunity to design sustainable ways of working that are data driven, evidence led and secure the best outcomes for our population.

7. What are we doing to improve the management and monitoring of primary care in BCUHB

There is a considerable amount of time and effort given to monitoring the provision of primary care services in North Wales. However, we cannot easily access a 'whole' view of what is happening and this carries risks, E.g. Identifying recurrent themes; sharing of significant events; providing whole system assurance. Over recent weeks, clinical governance colleagues in the Quality Directorate have been working with primary care colleagues to develop an improved and consistent approach.

- Development of a BCUHB Primary Care Quality Safety Delivery Group which will receive information from all the different forums and committees
- IHCs will have standardised terms of reference and agenda that will mirror that of the regional group
- Local issues will continue to be raised to IHC management level but will also be brought together regionally enabling themes to be identified and learning to be shared

The structure below is a temporary one and we will be establishing a primary care board to which the primary care QSE delivery group will report. This will be chaired by the Interim Executive Director of Operations.



7.1 Referral and pathway improvement is also underway with the Planned Care team. The work will be undertaken with secondary and primary care clinicians and will commence with

dermatology pathways. There are also plans to work with clusters and engage local primary care leaders to support and champion this work.

7.2 This work will contribute to the achievement of priority 2.2 of the annual plan, which is for the Health Board “Review and develop proposals for an integrated Primary Care function within the Health Board that supports and enables effective and joined up primary care commissioning and development*”.*

For the ongoing development of this work, primary care and quality directorate colleagues would welcome the oversight, scrutiny and support of the QSE committee.

Teitl adroddiad: ***Report title:***	Patient Stories Annual Report April 2022 – March 2023			
Adrodd i: ***Report to:***	Quality Safety and Experience Committee (QSE)			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Friday, 27 October 2023			
Crynodeb Gweithredol: ***Executive Summary:***	This report provides the Committee with information and analysis on patient stories captured during 1st April 2022 – 31st March 2023.			
Argymhellion: ***Recommendations:***	The committee is asked to receive this report.			
Arweinydd Gweithredol: ***Executive Lead:***	Angela Wood, Executive Director of Nursing and Midwifery			
Awdur yr Adroddiad: ***Report Author:***	Mandy Jones, Deputy Executive Director of Nursing Leon Marsh, Head of Patient and Carer Experience Rachel Wright, Patient and Carer Experience 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 strength of learning and improvement remains an area of concern and is a key focus of work. As detailed in this report, work is underway to improve both the process and culture regarding patient safety and linked to this the approach to improvement.	
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Quality
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	N/A
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	N/A
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	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:	BAF21-10 - Listening and Learning

(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)***	N/A
Next Steps: N/A	
List of Appendices: Appendix A – List of patient stories captured from April 2022 – March 2023. Appendix B – Learning – Specific Examples	

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

Patient Stories Annual Report April 2022 – March 2023

1. INTRODUCTION

1.1 This report provides the Quality, Safety and Experience Committee with information and analysis on patient stories captured from April 2022 – March 2023. The aim is to provide the committee with assurance on the Health Board's work to improve patient and carer experience.

1.2 Stories are told by individuals from their own perspective regarding a health care setting, or the care they have received. They are used to understand the health care system from the patient's perspective and first hand experiences. Although we use the term 'patient stories', they are not exclusive to patients, they also include carers, relatives, friends, advocates and members of staff. Patient stories have been identified as a powerful tool to understand lived experience.

1.3 There are numerous benefits from recording and sharing patient stories for both the storyteller and the organisation, some of which are summarised below:

Benefits for the storyteller:

- Gives the storyteller a voice
- Helps the storyteller to process their experiences and reflect on their health journey
- The storyteller can feel valued and deeply listened to
- The process can bring resolution in difficult circumstances

Benefits for the organisation:

- Provides valuable insights on how we can improve our health services, identifying areas of poor practice and potential risks
- Provides an opportunity for staff to reflect and take action if improvements are needed to improve the quality of services
- Supports service improvements and can highlight where patients have benefited from service improvements
- Promotes the achievements of patient led quality improvement activities

2. PATIENT STORIES – PERFORMANCE

2.1 During April 2022 to March 2023 the Patient and Carer Experience Team captured 30 patient/carer stories. For a list of the stories captured please see appendix A.

2.2 The majority of the patient stories captured relate to secondary care services. The top story themes relate to clinical treatment and assessment; communication; understanding and involvement in care and co-ordination of care.

2.3 Below is a breakdown of the number of stories captured per Integrated Health Community (IHC) and specialist service from April 2022 – March 2023.

Area	**Number of stories captured**	**Key themes**
IHC Central	14	• Clinical treatment and assessment • Communication (positive and negative) • Understanding and involvement in care (negative) • Appointment/treatment delays (Negative) • Lost property • Estates/site management
IHC East	6	• Clinical treatment and assessment • Communication (negative) • Understanding and involvement in care
IHC West	2	• Clinical treatment and assessment (positive and negative) • Communication (positive) • Understanding and involvement in care
Cancer Services	5	• Communication (positive and negative) • Understanding and involvement in care • Co-ordination of care (negative)
MHLD	3	• Communication (negative) • Co-ordination of care (negative)
Total	30	

2.4 In addition to the 30 patient stories that were captured through the formal patient story methodology process, 29 experiences of patients and relatives who accessed Vascular services across North Wales were also recorded. This was completed as a part of the Royal College of Vascular Surgeons review and was undertaken by the

Patient and Carer Experience Lead. The purpose of this task was to support the review of patient's medical notes whilst ensuing the patient the patient voice was heard throughout the process.

2.5 Within the reporting period requests for patient stories came directly from patients/carers, staff, services, Alzheimer's Society, Llais and recommendations from the Public Service Ombudsman for Wales. PALS Officers identify patient story opportunities through enquiries, patient feedback and hospital engagement activities. The Complaints Team advertising opportunities for patients/relatives to share their experiences through a patient story in the PTR complaint investigation leaflet.

2.6 Patient stories are presented at monthly strategic meetings across the Health Board including Board, QSE and Patient and Carer Experience Group. Patient stories captured within the reporting period helped inform workshops and pathway re-design meetings such as the re-design of the prostate cancer pathway and older person's mental health service.

2.7 To ensure the Patient and Carer Experience Team manage all expressions of interests for patient stories a dedicated patient stories SharePoint page Patient Stories - Home (sharepoint.com) has been developed. All requests for patient stories are submitted via an expression of interest form. This form contains all of the information required to start the process and ensures that the patient has been spoken to in advance and has given consent to be contacted by the team. Expressions of Interest are managed through the dedicated PALS Patient Stories Mailbox: BCU.PatientStories@wales.nhs.uk

2.8 All requests for patient stories are registered on a patient story tracker which is reviewed on a monthly basis to allocate stories to PALS Officers to capture. For requests that do not meet the criteria for a patient story, the Patient and Carer Experience Team will provide an agreed alternative offer so that the patients voice can still be heard and contribute to service improvement. For example, this might include sharing the patient's written information to the service as feedback.

3. LEARNING FROM PATIENT STORIES

3.1 Within the reporting period the Patient and Carer Experience Team celebrated capturing the Health Boards first young person patient story 'Jack's Story,' and its first story captured in Welsh language.

3.2 Learning from this feedback is shared with the team, wider department, and cross IHCs and Pan BCU. Specific projects and activities have been commenced as exampled in Appendix B, and themes are used to inform priorities for work streams.

3.3 Appendix B provides examples of patient stories captured within the reporting period.

4. CURRENT POSITION

4.1 From April 2022 to September 2023 the Patient and Carer Experience Team captured 8 patient/carer stories relating to the following services:

- 1 x Mental Health Service
- 2 x Cancer Services
- 2 x Central Integrated Health Community
- 2 x East Integrated Health Community
- 1 x West Integrated Health Community

4.2 Seven out of the eight patient stories captured relate to secondary care services. The top story themes relate to clinical treatment and assessment and understanding and involvement in care and co-ordination of care.

4.3 From April 2023, significant improvement work has been undertaken to help maximise learning from patient stories, for example one patient story a month is identified and shared across the Health Board for reflection and learning. Pro-active work is being undertaken to link patient stories with campaigns such as Medicine Management Week or with Health Board priorities. Where possible patient stories now include a staff/service perspective of the experience to give the viewers more of a rounded understanding of the experience and to identify service improvements.

4.4 In June 2023, The Patient and Carer Experience Team launched a Patient Stories Toolkit for services to follow to capture their own patient stories. In order to meet the demand in requests to capture patient stories a targeted patient stories training plan is under development and will be implemented over the remainder of the year to empower staff across services to capture patient and carer stories.

4.5 A patient story leaflet has been designed to explain the process of capturing patient stories for patients and relatives. This leaflet has been translated into multiple languages and has been shared with diverse communities across North Wales to encourage patients from protected characteristic groups to share their experiences.

5. FUTURE

5.1 CIVICA All Wales real time feedback system is one method used to provide assurances that the Health Board is listening and learning from patient and carer feedback. This year CIVICA are enhancing their system to include a patient stories module, creating an all Wales patient story library. The library will give Health Boards the opportunity to upload stories to CIVICA, whilst also being able to view other Health Board stories by searching on themes and service areas. Another feature being explored by CIVICA is to create an online portal where patients and carers can record their own short video patient stories.

5.2 To ensure patient stories are shared across the Health Board and are used for learning at every possible opportunity the Patient and Carer Experience Team are building an internal self-service patient story library on SharePoint for staff to access. To support accessibility the Patient and Carer Experience Team are purchasing software to enable video and audio stories to have subtitles and Welsh translation. Once all video and audio stories are accessible, they will be shared on the Health Boards website and on social media.

5.3 The Patient and Carer Experience Team are promoting patient stories across North Wales services to ensure there is a wider representation of stories from primary, secondary and community services.

5.4 Learning from patient stories are monitored and reported into the strategic Patient and Carer Experience Group. It is the role of local IHC and specialist services Patient and Carer Experience groups to identify local actions and learning from patient stories.

6. CONCLUSION

6.1 This report provides the Quality, Safety and Experience Committee with information and analysis on patient stories.

6.2 In order to meet the demand in requests to capture patient stories a targeted patient stories training plan is under development and will be implemented over the remainder of the year to empower staff across services to capture patient and carer stories.

6.3 Significant patient experience improvement activity is underway as detailed in the report to ensure learning is fully embedded across the Health Board.

6.4 The QSE Committee is requested to note the report.

Appendix A

Service area	Summary of Experience	Key Themes
Abergele Eye Hospital	A Patients experience of accessing services at Abergele Eye Hospital.	• Communication (positive) • Staff attitude (positive) • Accessibility in letter font size (negative).
Cardiac Care Clinic Rysseldene GP	Three patients sharing their experience of accessing the Cardiac Care Clinic at their local G.P.	• Care closer to home • Communication (positive) • Co-ordination of care (positive).
Mental Health Service West	An un-paid carer's perspective of supporting her husband whilst accessing mental health support.	• Lack of recognition of being a carer • Co-ordination of care (Negative) • Communication (negative).
Childrens Out Patients at Ysbyty Glan Clwyd	Jack who is twelve years old and has had a fear of needles. Jack shares his experience how staff have helped him overcome this fear.	• First and lasting impressions (positive) • Safe, supportive and healing environment (positive) • Understanding and involvement in care (positive)
Leg Ulcer Clinic, Deeside Community Hospital	Valerie is 84 years old and is a long term patient at Deeside Community Hospital Leg Ulcer Clinic. Valerie has been accessing the service for over 7 years and shares her experience of accessing the clinic throughout Covid-19 pandemic and present date.	• First and lasting impressions (positive) • Safe, supportive and healing environment (positive) • Understanding and involvement in care (positive).
Long Covid Service	Patient journey through long Covid diagnosis.	• Safe, supportive and healing environment (positive) • Understanding and involvement in care (positive) • Communication (positive).
Emergency Department – Ysbyty Glan Clwyd	Patient was admitted to ED, YGC. Patient had items of jewellery on their person at the time of admission. Patient sadly died in ED and was transferred to the care	• Communication (negative) • Staff attitude and behaviour (negative).

Service area	Summary of Experience	Key Themes
	of bereavement services. Family stated that the patient's items of jewellery were missing and were not with the patient on arrival with bereavement services and were not detailed on the documentation completed by staff within ED prior to transfer.	
Mental Health Services – Nant Y Glyn	A young patients experience of access services at Nant Y Glyn Mental Health Services.	• Co-ordination of care (negative) • Staff attitude and behaviour (negative) • Lack of holistic care.
Emergency Department Ysbyty Glan Clwyd	Michelle shares her experience of her mother's care in the Emergency Department and with the Surgical team at Ysbyty Glan Clwyd. Michelle left the hospital waiting on the outcome of her mother's treatment plan and communication of the outcome. Less than 3 hours later, it was decided that Michelle's mother needed an operation. There was no phone call to communicate with Michelle that her mother needed an urgent operation or that she was being moved from ED. The story focuses on the message that "one simple phone call could have avoided a complaint" and that "had any form of communication been put the family's way, this could have been a completely different story".	• Importance of the communication process with patient's relatives during stay. • Difficulties contacting the hospital using the phone numbers provided and the impact this has on communication and the frustration this caused to the family. • Importance of communication process with the patient's relatives when patients require an operation. Ensuring that the next of kin is informed. • Importance of structured communication and clear understanding of who should communicate with the patients next of kin. • The emotional impact on the family not being able to locate their loved one and not being updated on their care. • The importance of staff attitude and professionalism in the patient journey.

Service area	Summary of Experience	Key Themes
Prostate Cancer Pathway Experiences x 3	A series of prostate cancer pathway experience used to support the pathway re-design of the service.	• Communication (positive and negative) • Co-ordination of care (positive and negative) Appointment times/delays.
Deep Vein Thrombosis Service – Ysbyty Glan Clwyd	Catrin shares her experience through diagnosis and treatment of Pulmonary Embolisms (PE) in Ysbyty Glan Clwyd.	• Communication (negative) • Co-ordination of care (negative) • Lack of patient information.
Emergency Department (Ysbyty Glan Clwyd)	Positive feedback regarding the service her daughter received when attending the Emergency Department after having a bad fall.	• Overall excellent experience of busy Emergency Department from perspective of both patient and carer. • Staff provided sensitive and appropriate care. • Staff acknowledged need for patient's loved one to accompany them throughout their journey. • Clinical staff from multiple disciplines attended to patient in a timely manner.
Lymphedema Service Ysbyty Glan Clwyd	Sarah shares her experience of accessing the Lymphedema Service and being supported by	• Lack of patient information available to help patient • Delay in treatment • Negative communication.
Changing facilities Ysbyty Glan Clwyd	A mother sharing her negative experience of the changing places facilities at the hospital during a recent visit. The story highlights accessibility issues when attempting to use the changing room for its designated purpose.	• No specific maintenance schedule for the hoist installed within the room. • Accessibility issues for Sue when attempting to use the changing room for its designated purpose. • Lack of suitable facilities for patients with people with complex needs.
Long Covid Service	A series of staff and patient experiences of co-producing the new service together.	• Positive communication • Involvement in care and decision making.

Service area	Summary of Experience	Key Themes
Vascular Service x 5 Stories	A series of vascular stories shared at Vascular Improvement Meetings.	• Treatment and care (positive and negative) • Negative communication. • Appointment times/delays.
WAST Falls Response Service	BCUHB and WAST pilot falls response project to support patients being cared for at home (where appropriate) rather than in a hospital setting.	• Treatment and care (positive) • Care closer to home.
Wrexham Maelor Hospital	Liz's story describes her gratitude for the good standard of care and support she has received at the Wrexham Maelor Hospital. The East Nutrition Team are highlighted as providing exemplary patient care.	• Liz highlights exemplary ongoing patient care and support received by the East Nutrition Team. • The East nutrition team highlight the importance of their ability to provide care locally to prevent patients travelling long distances for treatment, access for family support and building local relationships with patients.
Wrexham Maelor Hospital	A wife shares her experience of the difficulties she experienced due to restricted visiting due to Covid when her husband who has dementia was admitted through into hospital.	• Dementia patients struggling with hospital admittances when not supported by family/carers • Ward staff not checking medical records for conditions which may impact the patient communicating with staff • Importance of communication from ward staff to family members when visiting restrictions are in place. • Doctors acknowledging that patients with dementia require an advocate present when making clinical decisions.
Gogarth Ward – Ysbyty Gwynedd	Phillip is a 70 year old man with learning disabilities. He has lived with Linda and her husband in their home under the Shared Lives scheme for a number of years. Shared lives is a scheme where the carer shares their family and	• Quality of care negative • Receiving information negative • Communication negative • Nutrition negative • General facilities negative • Staff attitude and approach – negative.

Service area	Summary of Experience	Key Themes
	community life and gives care and support to the person with care needs.	
Cancer Services	A patients journey when accessing Cancer Services	• Co-ordination of care (positive) • Communication (positive and negative).
Prehabilitation Service – Wrexham Maelor Hospital	A patient's positive experience of accessing the Prehabilitation Service.	• Communication (positive) • Caring staff.
Ysbyty Gwynedd	Welsh Language patient story	• Importance of being able to speak Welsh when an inpatient. • Excellent care given by the Health Care Assistant.
Mental Health Services	A patient's experience of accessing Older Persons Mental Health Services in West.	• Communication (negative) • Co-ordination of care (negative) • Appointment delays/waiting times.
Dermatology Cancer Service	A patient's experience of accessing the Dermatology Service in West Integrated Health Community.	• Appointment time/delays • Communication (negative) • Co-ordination of care (negative).

Appendix B

Learning – Specific Examples

Sue's Story

- A mother sharing her negative experience of the changing places facilities at Ysbyty Glan Clwyd during a recent visit. The story highlights accessibility issues when attempting to use the changing room for its designated purpose.

- To ensure this experience does not happen again BCUHB will ensure that the room is always open and available for use. This will be checked by undertaking continual reviews and spot-check of changing room provisions. The changing room facility has now been incorporated into Quality Walkabouts of the hospital with senior staff members on a regular basis. Immediate action was been taken to ensure the safety and servicing of the equipment in the room. Ysbyty Gwynedd and Wrexham Maelor Hospital accessible toilets have been checked. Both hospital sites do not have changing facilities only accessible toilets that do not have equipment in. Signage for the accessible toilets has been checked and is fit for purpose. The Equality and Inclusion Team will now be including changing rooms into their building accessibility audits across North Wales.

Eileen's Story

- Eileen was visiting family for Christmas and became unwell. Eileen was taken to Ysbyty Gwynedd for triage and treatment and then she was admitted to Conwy Ward.

- Eileen shares her experience of how important it was that she was given the opportunity to speak in first language Welsh with staff and other patients. Eileen highlights the exemplary nursing care that she received and her positive experience of patient nutrition and hydration. Eileen's experience demonstrates staff the importance of staff awareness around the importance of the Welsh Active Offer for patients and carers across the Health Board.

- The BCUHB Welsh Strategic Forum operate a Bilingual Monitoring Scheme to monitor Welsh language compliance across the organisation. This includes methodologies such as mystery shoppers reviewing patient facing information and resources such as letters, signage and greetings by staff. Findings of the Bilingual Monitoring Scheme as a result of this story are now reported to local Integrated Health Community Patient and Carer Experience Groups to inform learning and change.

Matthew's Story

- Matthew was diagnosed with Gall bladder issues that eventually needed emergency surgery. He was informed about what she could expect from the procedure, tests, scans but throughout his whole experience he felt he was made to wear a standard fit

gown that did not fit him. Matthew felt it was not dignified for a man of his tall size to be pushed through corridors and departments in a state of near undress that made him uneasy and conscious of his appearance and vulnerability.

- Matthew felt the standard fit gown was compromising his dignity, embarrassing him and making him feel that his needs were not being met from a breakdown of simple staff awareness and lack of available resources. The Patient and Carer Experience Team are working with the Equality and Inclusion Team to use this patient story to run a campaign to help raise awareness of the importance of dignity and respect. As a result of capturing the patient stories discussions are currently taking place with the procurement team to order larger size gowns. As a result of this story a Dignity and Respect Working group is to be set up made up of staff from across services to learn from experiences (PALS, complaints, etc.) happening across the Health Board. The Dignity and Respect working group will report into the Patient and Carer Experience Group.

Antoni's Story

- Antoni is a patient who was offered the opportunity to participate in the new Prehabilitation Service at the Wrexham Maelor. Antoni shares his experience of accessing this service and encourages any patients who find themselves in a similar position to "grasp the opportunity with both hands and go for it", to help get into better shape.

- The Specialist Prehabilitation Service at BCUHB provides support to cancer patients who are waiting for major surgery. The service aims to prepare patients for their upcoming surgical procedure by delivering a 4-week optimisation programme consisting of increasing physical activity, eating well, mental health and wellbeing support and strengthening lung function. Following a successful pilot of the Prehabilitation service at the Wrexham Maelor site, the service is now well established and plans are in place to roll this service out across North Wales to provide equity of access for all BCUHB patients.

Michelle's Story

- Michelle shares her experience of her mother's care in the Emergency Department and with the surgical team at Ysbyty Glan Clwyd. Michelle would like to share this experience with the aim of improvements in communication with the patients' family and to highlight the importance of communication and keeping the family updated. The story focuses on the message that "one simple phone call could have avoided a complaint" and that "had any form of communication been put the family's way, this could have been a completely different story".

- Ysbyty Glan Clwyd has embarked on an ambitious improvement journey, known as the Journey to Excellence. There are a wide range of improvement projects underway

to address the challenges experienced by our patients and our staff, and this includes a programme of work around getting the basics right.

- A recent workshop held with all key stakeholders to review pathways of care and the configuration of our assessment unit space to facilitate a smoother patient journey. For the patient this would include earlier identification of the correct surgical pathway, potentially direct from triage, and receiving her specialty assessment in the Surgical Assessment Unit. This would have provided a more comfortable and appropriate environment and would have contributed towards improved communication. This project also links with existing work underway to improve processes in the ED with a new model known as see and treat, and will provide earlier senior review in ED and improved links to specialty pathways.

Teitl adroddiad: ***Report title:***	Corporate Risk Register Report			
Adrodd i: ***Report to:***	Quality, Safety and Experience Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Tuesday, 31 October 2023			
Crynodeb Gweithredol: ***Executive Summary:***	The purpose of this standing agenda item is to provide an update from the Risk Management Group (RMG) meeting on the 3rd October 2023 and present the Corporate Risk Register (CRR). Following the approval of the Risk Management Framework at Board the Executive Team & QSE have been provided with a consolidated view of all high-extreme operational risks and 16 new strategic risks for consideration which would form a revised Corporate Risk Register.			
Argymhellion: ***Recommendations:***	The Committee is asked to: 1. receive assurances from RMG The Committee is asked to consider: 2. the new approach of consolidating all high-extreme operational risks to thematically formulate strategic corporate risks and if the correct strategic corporate risks have been captured. 3. review the descriptions and provide any feedback to the Head of Risk Management for further refinement prior to Board. 4. review the overall accountable committee for the newly proposed strategic risk. 5. Provide any feedback on gap analysis on any expected operational risks which have not been captured by services.			
Arweinydd Gweithredol: ***Executive Lead:***	Phil Meakin, Interim Board Secretary			
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 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:N/A ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this: N/A***	
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Detailed in the second paper 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?***	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 ben 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)***	See Board Assurance Framework paper which highlights the relation.
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	The effective and efficient mitigation and management of risks has the potential to leverage a positive financial dividend for the Health Board through better integration of risk management into business planning, decision-making and in shaping how care is delivered to our patients thus leading to enhanced quality, less waste and no claims.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	Failure to capture, assess and mitigate risks can impact adversely on the workforce.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	The paper has been submitted to the Executive Team Meeting for discussion and feedback to the Head of Risk Management

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)***	1 high risk has been removed from the appendix which is confidential
Camau Nesaf: ***Next Steps:*** The Risk Management Group will be meeting on the 5th December 2023, therefore an updated position of the risks will be presented during the Quality, Safety and Experience Committee on the 12th December 2023. Feedback to the Head of Risk Management for further refinement of the Corporate Risk Register	
Rhestr o Atodiadau: ***List of Appendices:*** Appendix 1 – Corporate Risk Register Report	

Quality, Safety and Experience Committee
31st October 2023

1.0 Risk Management Group Meeting Summary
2.0 Proposed Revised Corporate Risk Register

1.0 RMG update

1.1 The Risk Management Group met on the 3rd October

1.2 During the Risk Management Group meeting on the 3rd October 2023 a deep dive was undertaken for the following Estates risks:

- Asbestos Management and Control.
- Contractor Management and Control.
- Legionella Management and Control.
- Non-Compliance of Fire Safety Systems.

During the presentation of the four deep dives into the Estate risks, Estates noted a lack of maturity around the relationship between sites and Estates, and blurred lines between the accountability of some of the risks. This was taken as an action to be raised in the Executive Team meeting for further discussion.

1.3 The following risks have been approved by the relevant Executive Directors for de-escalation from Tier 1 Corporate Risks, and were presented to the Risk Management Group on the 3rd October for discussion and de-escalation (Appendix 2):

- Delivery of safe and affective resuscitation may be compromised due to training capacity issues
- Compliance of Women's Services Clinical staff compliant with Manual Handling training has fallen below an acceptable level.
- Potential gap in senior leadership capacity/capability during transition to the new Operating Model.
- Risk that a significant delay in implementing and embedding the new operating model, resulting in a lack of focus and productivity.
- Risk that a loss of corporate memory as a result of the departure of key staff during the transition to the Operating Model,

Removed from de-escalation

- 'Compliance with Birth Rate Plus' was initially due to be presented for de-escalation, however, during the review, the service requested that this is not de-escalated at this time as funding is not secure and has been escalated as a matter of concern to senior finance colleagues and Executive colleagues with the outcome outstanding.

1.4 The following risks were escalated and approved onto the Health Board's risk register and following Executive approval and presentation at the Risk Management Group.

- Vaccination Programme - Inability to increase delivery (Covid 19 programme) capacity by 400% within 7 days due to access to additional resources
- Asylum Seeker Support.
- Falls - Harm to patients from avoidable inpatient falls.

1.5 Work remains ongoing with the People Services team with planned development of the following high risks:

- Financial governance related to staffing.

1.6 RMG received assurances around IHC wests risk management procedures as previously noted as limited assurances by Internal Audit.

1.7 RMG received Risk Register Reports

- Capital and Estates, assurances received.
- Finance, assurances received.
- Partnership, Engagement & Communications, no risk register is maintained by the department, the action for the Corporate risk team to provide the department with risk training and support the development of a risk register was noted.
- The Digital risk register report noted Tier 2-3 risks needed to be reviewed in line with procedures. Assurances were provided that actions would be taken to ensure the register is regularly reviewed.

1.8 Key highlights from the RMG Annual Report have been detailed:

Reporting of Tier 1 high priority risks has increased with more risks being escalated to the Corporate Risk Register. However, Tier 2 and 3 risks have decreased over the past two years.

Timely review rates for Tier 1 risks have improved significantly, with 100% being reviewed on time. However, over half of Tier 2 and 3 risks are still not being reviewed by their target date.

A high number of Tier 1 risks are shown as "being developed" which implies delays in formally escalating and managing high priority risks.

Risk closure rates have improved for Tier 2 and 3 risks, indicating enhanced mitigation.

The majority of risks related to patient care, estates, service delivery, finance and informatics. Resource constraints being noted as a common theme.

Risk management training numbers have reduced, although plans are in place to improve e-learning package and training compliance.

Good progress has been made completing actions from the risk management improvement plan.

RMG meeting frequency and membership attendance declined last year, this is being closely monitored as a result. Assurance reports to RMG have been inconsistent and this is also being monitored closely through the agenda and COB.

1.9 RMG received a Q1 Risk Management Performance and Assurance Report from the Corporate Risk Team. The report analysed risk reporting volumes, risk severity mix, monitoring practices, and mitigation progress across BCUHB's risk register. It evaluated performance against the 2022 risk management strategy key performance indicators. In summary, the analysis showed an increase in reporting of high priority Tier 1 risks, variable compliance with risk review timelines, and good progress on risk closure rates. 50% of lower priority risks- Tier 2 and 3 risks were not being reviewed by their target date.

Key areas for focus were noted as reducing delays in formally escalating and managing Tier 1 high priority risks - a high volume were shown as "being developed". Enhancing risk management training and compliance monitoring. Strengthening governance through more consistent RMG meetings, membership attendance, and standing agenda items.

Increasing regular risk management performance reporting across the Health Board.

Continued focus on risk identification, prioritisation and mitigation, especially for corporate risks related to patient care, workforce, finance etc.

Embedding risk management through all levels of the organisation via training, support, and continuous improvement.

2.0 Corporate Risk Register Report

2.1 Following the approval of the Risk Management Framework, the corporate risk register has been reviewed in order to develop strategic risks.

According to our previous Risk Management Strategy all Tier 1 risks were to be reflected on the corporate risk register. This procedure has now been modified and Tier 1 risks (15-25) can now be locally owned and a consolidated approach can provided the Board with a strategic view. There are currently 123 Tier 1 risks in total which have been analysed and thematically grouped.

A list below of 16 themes and potentially 16 corporate risks have developed from the analysis and a proposed description of the strategic risk has been outlined. Tier 1 risks titles have also been detailed as well as the accountable Executive for the operational risk providing the rationale for the strategic risk.

A committee has been proposed as the accountable meeting to oversee the risk as well as an overarching accountable Executive/Director for the strategic risk.

N.B. some of the Tier 1 risks noted below are ‘problems’ (e.g. inadequate staffing) and the titles will need reviewing however a risk have been further articulated in the body of the operational risk. The corporate risk team will be addressing this through a more robust quality assurance process outline in RM02, Risk Management Procedures, prior to escalation to Executives going forward.

Through reviewing this bird’s eye view of all high-extreme risks, gaps may be apparent. Any noted gaps in Tier 1 risks can be escalated to the Corporate Risk Team to support the progression with a service representative.

2.2 A proposed CRR (Appendix 1) highlights the rationale of the corporate risk through the Tier 1 (high-extreme operational) risk titles.

1. Proposed title.
2. Proposed description.
3. Proposed overall accountable Executive. (Provided for discussion at the Executive Team meeting 25.10.23)
4. Proposed overall accountable Committee.

See Appendix 1 below

Next steps

1. Descriptions and the allocation of the accountable Committee on the risk to be agreed prior to Board approval.
2. Feedback to Head of Risk for further refinement in preparation for approval at Board.
3. Corporate Team to hold 1-1s for all corporate and BAF risks and further develop controls, action plans etc.
4. Corporate Team to monitor and escalate any new Tier 1s to Executives for further information and consolidation with the CRR as per RM02.

Appendix 1-CRR Titles, Descriptions, and Underlying Operational Risks

1	Financial Sustainability			Committee
Strategic	There is a risk to the **financial sustainability** and performance of the Health Board. This could be driven by a failure to deliver £38.7m in planned **savings** and **disinvestment**, coupled with potential non-funding of the £134.2m forecast deficit by Welsh Government. This could be caused by the lack of fully formed savings plans, workforce and healthcare spending commitments limiting flexibility, and limited income generation opportunities. The impact could further deteriorate the deficit position, potentially impacting on service delivery if savings aren't achieved, rejection of the financial plan by Welsh Government, and significant reputational damage.			PFIG
Operational Risks Consolidated	4861	Risk of failure to achieve the initial financial plan for 2023/24 (£134.2m deficit), because of failure to achieve the level of	Executive Director of Finance	Overall Risk Lead
	4862	WG cash funding for 2023/24		Executive Director of Finance
	4859	Risk of the cost of planned care recovery exceeding the £27.1m funded from WG which is included in the budget		
	4860	Financial outturn for 2022/23		
2	Suitability and Safety of Sites			Committee
Strategic	There is a risk that the poor condition, suitability and safety of the **estates** and infrastructure across BCU could severely impact on service delivery, staff and patient safety. This could be caused by aging and **unsuitable buildings**, **backlog maintenance** issues, non-compliance with regulations, inadequate space capacity, and lack of capital funding. The impacts may include inability to meet service needs, reduced access to diagnostics and treatment, risks of infection, fire, asbestos, legionella and other hazards, increased costs, regulatory enforcement action, and significant reputational damage. This presents risks to the continuity of care, patient outcomes, staff wellbeing, and the Health Board's ability to provide safe, therapeutic environments across the region.			PFIG
Operational Risks Consolidated	4843	Risk of compromise to patient care, safety and quality due to environmental and capacity issues at Shooting Star Unit.	Executive Director of Nursing and Midwifery	Overall Risk Lead
	4959	Radiopharmacy Production Unit	Executive Medical Director	Executive Director of Finance (Director of Estates)
	4835	Risk of service failure due to poor/aging ventilation systems in the endoscopy unit	Executive Director of Finance	
	1672	Residential Accommodation - Public/Private Sector Partner Procurement		
	3600	Lack of capacity to deliver clinical care across NWMCS due to lack of suitable accommodation	Executive Director of Therapies & Healthcare Sciences	
	4838	YGC FLOOD Risk of damage to equipment, infrastructure, injury to staff/patients and increased waiting lists		

	3019	Asbestos Management and Control	Executive Director of Finance	
	3020	Contractor Management and Control		
	3023	Legionella Management and Control.		
	3024	Non-Compliance of Fire Safety Systems		
	2724	Fire Safety and Infrastructure Non-compliance - Ysbyty Gwynedd		
	4251	Non-compliance of North Wales Adolescent Service Bedroom Fire Doors	Director of Mental Health and Learning Disabilities	
3	Availability and Integrity of Patient Information			Committee
Strategic	There is a risk of compromised patient safety and substandard care due to lack of access to complete, accurate and timely patient information. This could be caused by fragmented systems and data repositories, incomplete or poor-quality record keeping, inadequate storage and archiving, incompatible systems, and lack of integrated electronic records. The impacts may include patient harm, inability to make fully informed clinical decisions, delays to treatment, unnecessary duplicate testing, non-compliance with legislation, and reputational damage. This presents risks to patient care quality, safety and experience, legislative duties, information security, productivity and value for money.			PFIG
Operational Risks Consolidated	2819	Informatics - Patient Records pan BCUHB	Chief Digital and Information Officer	Overall Risk Lead
	4595	Retention and Storage of Patient Records		Executive Director of Finance (Chief Digital and Information Officer)
	4603	Risk of Lack of access to clinical and other patient data		
	4766	Duplicate Hospital Numbers		
	4576	Risk of inability to provide general X-Ray services using Computed Radiography (CR)	Executive Director of Therapies & Healthcare Sciences	
	4420	Non-compliance with the subject access rights of an individual under the Data Protection Act	Executive Medical Director	
	4604	Risk of poor clinical recording of patient information		
4	Failure to Learn			Committee

Strategic	There is a risk that the Health Board could fail to meet requirements for **timely review and learning** from **mortality cases**, inspections, **incidents** and **complaints**. This could be caused by insufficient resources, lack of unified processes, outdated IT systems, duplication of effort, and overreliance on single personnel. The impacts may include missed opportunities for improvement, lack of family/carer engagement, potential patient harm events going undetected, non-compliance with national mortality review framework, and reputational damage.			QSE
Operational Risks Consolidated	3025	Failure to learn from mortality reviews	Executive Medical Director	Overall Risk Lead
	4519	Mortality Review Risks to include Datix Module		Executive Director of Nursing and Midwifery
	4520	Mortality staffing and level 1 reviews		
	Not on datix	Learning from incidents, internal & external recommendations, safety alerts etc	Executive Director of Nursing and Midwifery	
	3795	Complaints timeliness to completion	Executive Director of Nursing and Midwifery	
	3759	Achieving Deadlines - Meeting Complaint Compliance		
5	Harm from Falls			Committee
Strategic	There is a risk that patients could suffer harm as a result of slips, trips and **falls** within Secondary Care acute sites. This may be caused by patients acuity/clinical condition/frailty alongside contributory factors such as **reduced staffing**, segregated areas and **premises** which do not allow for ease of oversight, access to **manual handling training** or delays in risk assessment completion or reduced observation. Could lead result in poorer patient health outcomes, extended hospital stay, regulatory compliance and litigation and associated financial impact.			QSE
Operational Risks Consolidated	4748	Compliance of Women's Services Clinical staff compliant with Manual Handling training has fallen below an acceptable level.	Executive Director of Nursing and Midwifery	Overall Risk Lead
	3869	Increased risk of falls in Emergency Care		Executive Director of Nursing and Midwifery
	3893	Non-compliant with manual handling training resulting in enforcement action and potential injury to staff and patients	Executive Director of Workforce and Organisational Development	
	4562	FALLS - Compliance with HSE improvement notice for fall and manual handling risk assessment	Executive Director of Nursing and Midwifery	
6	Safeguarding			Committee

Strategic	There is a risk that BCU may fail in its statutory duties to protect **vulnerable** groups from harm. This could be caused by gaps in **safeguarding governance**, insufficient workforce training and engagement, complexity of legal frameworks, and lack of resources to manage growing demand. The impact may be harm to at-risk adults, children or young persons, victims of violence/abuse, patients unlawfully detained, financial penalties, reputational damage and non-compliance with Social Services, Wellbeing (Wales) Act 2014 and the Health Board's reputation.			QSE
Operational Risks	3766	There is a risk that patient and service users may be harmed due to non-compliance with the SSW (Wales) Act 2014	Executive Director of Nursing and Midwifery	Overall Risk Lead
	2548	There is a risk that the increased level of DoLS activity may result in the unlawful detention of patients.		Executive Director of Nursing and Midwifery
7	Staffing			Committee
Strategic	There is a risk that BCU **staffing** shortfalls across multiple professional groups and specialties could severely **impact service delivery** and patient **care**. This is driven by shortages in several staffing groups, recruitment and retention challenges, high workload and poor staff wellbeing. The impact could include increased waiting times, delayed treatment, reduced service access, risks to patient safety, lower quality of care, higher spend on agency staff, increased staff and patient complaints, regulatory non-compliance and significant reputational damage.			QSE
Operational Risks Consolidated	3766	There is a risk that patient and service users may be harmed due to non-compliance with the SSW (Wales) Act 2014	Executive Director of Nursing and Midwifery	Overall Risk Lead
	4431	Potential increase in mortality rates due to insufficient staff to provide the acute Heart Failure pathway for patients		Deputy Director of Workforce
	4773	Compliance with Birth Rate Plus		
	4432	Oncology workforce will be unable to deliver service due to reduce workforce which will impact patients care and treatment	Executive Medical Director	
	3947	There is a risk in relation to the recruitment and supply of senior doctors.	Director of Mental Health and Learning Disabilities	
	4726	Critical Care Consultant Establishment is Inadequate	Executive Medical Director	
	4939	Risk to Patient Care under Hepatology	Executive Medical Director	
	2758	Failure to implement new NICE approved treatments due to reduced staffing levels within pharmacy team	Executive Director of Therapies & Healthcare Sciences	
	4564	Risk of failure to support BCU wide Radiology Informatics Systems and key deliverables		

	4669	SLT acute care		
	4285	Failure to meet patient care due to SLT staffing vacancy rate		
	4671	SLT Stroke Care		
8	Staff safety and Wellbeing			Committee
Strategic	There is a risk to staff wellbeing and safety such as potential injuries to staff, high workload, general staff shortages, acuity of patients increasing overtime, current organisational culture, perceived slow recruitment, frequent line management changes and low compliance with one to ones, supervision and staff development. The impact could be absence from work, an associated impact on service delivery, increased sickness, staff burnout, poor morale, recruitment or retention difficulties, higher staff turnover, increased reliance on agency use and subsequently a financial impact.			PFIG (PPPH)
Operational Risks	4771	Risk of muscular skeletal injuries to portering staff from excessive handling of patient records to and from patient records	Executive Director of Workforce and Organisational Development	Overall Risk Lead
	2070	Risk of compromise to staff welfare across the West IHC		Deputy Director of Workforce
9	Population Health			Committee
Strategic	There is a risk the Health Board fails to adequately allocate resources, including transformation capacity, to improve health outcomes for the population and reduce inequalities. This could be caused by the financial and resource constraints of the Health Board as well as the socioeconomic factors like poverty, lack of investment in proactive education and prevention strategies, and limited access to necessary services such as specialist weight clinics. The impact could be continued high rates of chronic illnesses like diabetes, cardiovascular disease and cancer as well as preventable morbidity and mortality rates and future increased demand on services.			QSE
Operational Risks Consolidated	4200	Residents in north Wales are unable to achieve a healthy weight due to multifactorial and complex system wide factors that promo	Executive Director of Public Health	Overall Risk Lead
	4201	Lack of Specialist Weight Management Services (Children and Adults)	Executive Director of Public Health	Executive Director of Public Health
	1642	Smoking Cessation	Executive Director of Public Health	
10	Community Care Provision			Committee

Strategic	There is a risk of fragility across health and social care community provision in North Wales. This is caused by internal staffing resources to support children **CHC package reviews**, SLT staff **provision** to support **schools**, staff deployment to covid and **screening** services for **asylum seekers**, **primary care** provision to support discharge general independent sector fragility and particularly external support from independent services such as **pharmacy** and domiciliary **care packages**. The impacts may include extended hospital stays, delayed discharges, avoidable admissions, gaps in care, substandard packages, regulatory breaches, and deteriorating population health outcomes. This presents risks to patient flow, performance, care standards, partnerships, value for money, and the sustainability of community models.			PFIG
Operational Risks Consolidated	4738	Limited access to GA Paediatric Dentistry	Director of Primary and Community Care	Overall Risk Lead
	4598	Risk to sustainable provision of Children's Continuing Care Packages (West)	Executive Director of Nursing and Midwifery	Executive Director of Operations (Director of Primary Care)
	3263	Lack of available domiciliary care provision	Executive Director of Nursing and Midwifery	
	4688	The independent sector response to admission avoidance and timely discharge will not be robust enough to ensure optimal flow	Executive Director Transformation, Strategic Planning, And Commissioning	
	Not on datix	Pharmacy clinic space-lack of impacting on service delivery by pharmacies	Director of Primary Care	
	4684	Insufficient grip and control on the contracting and commissioning of care packages for people eligible for Continuing Health Ca	Executive Director Transformation, Strategic Planning, And Commissioning	
	4696	Asylum Seeker Support for the Flint Area	Deputy Chief Executive Officer/Executive Director Of Integrated Clinical Services	
	4666	SLT Staffing Special Schools	Executive Director of Therapies & Healthcare Sciences	
	4960	SLT in mainstream schools	Executive Director of Therapies & Healthcare Sciences	

	4337	Inability to increase delivery capacity by 400% within 7 days due to access to additional resources	Deputy Chief Executive Officer/Executive Director Of Integrated Clinical Services	
11	Urgent and Emergency Care			Committee
Strategic	There is a risk of mortality in relation to **critically ill** patients being seen in a **timely** manner through unscheduled **care** routes. This may be caused by delayed dispatching of ambulances, ambulance queues at emergency departments, Out of Hours access and EDs and UTCs being at capacity. This could impact on pressures for other services, reputation and litigation implications.			PFIG
Operational Risks Consolidated	3873	Inability to deliver safe, timely and effective care - Wrexham Emergency Department.	Executive Director of Nursing and Midwifery	Overall Risk Lead
	4486	Delays with time critical transfers from the ED to specialist services	Executive Director Transformation, Strategic Planning, And Commissioning	Executive Director of Operations (Director of Unscheduled & Emergency Care)
	4490	Temporary Suspension of Home Birth Service due to WAST provision	Executive Director of Nursing and Midwifery	
	4583	Risk of Emergency Department becoming unsafe due to the Ambulance Release Protocol	Executive Director of Nursing and Midwifery	
	4864	Flow out from the Emergency Units resulting in length of stay in EU being > 12 hours.	Deputy Chief Executive Officer/Executive Director Of Integrated Clinical Services	
	4866	Inability to manage ambulance demand in a safe timely fashion.		
	4867	Inability to deliver safe timely care in Emergency Units		
	4260	Stage 1 Validation: Patient Deterioration Statements		
12	Planned Care			Committee
Strategic	There is a risk that patients could experience **long waits** and **delays for planned** care services, resulting in failure to meet national access targets. This could be caused by insufficient capacity, staffing shortages, increasing demand, and backlogs exacerbated by COVID. The impact would be worsening patient outcomes and experiences, increased complaints, financial penalties for target breaches, and reputational damage.			PFIG

Operational Risks Consolidated	2512	Delivery of Planned Care	Executive Director of Nursing and Midwifery	Overall Risk Lead
	1161	Failure to deliver timely access for patients to all Elective Planned Care Specialties.	Executive Director of Nursing and Midwifery	Executive Director of Operations (Director of Planned Care)
	4948	Risk to delay of patients requiring orthopaedic surgery at YGC	Executive Medical Director	
	4714	Risk of avoidable harm due to the protracted length of time patients are waiting to be seen or treated	Deputy Chief Executive Officer/Executive Director Of Integrated Clinical Services	
	4863	Loss of beds due to the number of Medically fit for discharge patients (MFFD) across BCUHB.	Deputy Chief Executive Officer/Executive Director Of Integrated Clinical Services	
	4411	Waiting List Backlog Physiotherapy Centre Area	Executive Director of Therapies & Healthcare Sciences	
13	Specialist Medicine			Committee
Strategic	There is a risk of service failure and patient harm across multiple **specialist medicine services**. This could be caused by **severe staffing shortages**, lack of capacity, **unsustainable demand**, estates and equipment deficits, and delays in care. The impacts may include irreversible sight loss for ophthalmology patients, delayed diagnosis and treatment of skin cancers for dermatology patients, worsening patient outcomes and experiences, increased complaints, and reputational damage. This impacts patient safety, public health outcomes, healthcare access targets, staff wellbeing, and the financial sustainability of specialist medicine services.			QSE
Operational Risks Consolidated	**Ophthalmology**			Overall Risk Lead
	2498	Risk that the Ophthalmology Service within the West IHC is unable to deliver safe, effective and timely care	Executive Director of Nursing and Midwifery	Executive Director of Operations
	4693	Age related Macular Degeneration (AMD) and Intra Vitreal Injection Service (IVT)	Deputy Chief Executive Officer/Executive Director Of Integrated Clinical Services	
	4694	Risk of Irreversible Sight-Loss from Delayed Care for “New” and “Follow-Up” Glaucoma Patients	Deputy Chief Executive Officer/Executive	

			Director Of Integrated Clinical Services	
	Dermatology			
	4643	Risk of delayed access to dermatology expertise for the population in the West	Executive Medical Director	
	4199	Dermatology - Unsustainable Service		
14	Timely Diagnostics			Committee
Strategic	There is a risk of delay in diagnostics, service failure, poor performance or disruption to **radiology** and **pathology** services across. This could be caused by shortages of specialist staff, aging or inadequate IT systems and infrastructure, and insufficient governance structures. The impacts may include delays in diagnosis, treatment and discharge, increased outsourcing costs, patient harm events, preventable deaths, regulatory non-compliance, and significant reputational damage.			QSE
Operational Risks Consolidated	4521	Risk of non-compliance and regulatory breaches due to no governance support team	Executive Director of Therapies & Healthcare Sciences	Overall Risk Lead
	4842	Risk of failure to report on radiology examinations due to not having adequate workstations leading to late reporting of images		Executive Director of Therapies & Healthcare Sciences
	4925	Diagnostic Reporting Service - Clinical Workstations and Technology		
	4184	Results Management pan BCU	Executive Medical Director	
	4625	Pathology Laboratory Information Management System LIMS2 (formerly LINC)	Executive Director of Therapies & Healthcare Sciences	
15	Harm from the Medical Devices/Equipment			Committee
Strategic	There is a risk of harm and infection from aging, **unsuitable** or unreliable **medical equipment** and devices. This could be caused by equipment breakdowns, **lack of replacement funding**, ineffective cleaning and **decontamination**, insufficient **staff training**, improper use and poor traceability. The impacts may include inability to deliver essential services, delays in diagnostic and treatment leading to incidents and poor patient outcomes, increased costs and reputational damage.			QSE
Operational Risks Consolidated	4552	Risk to staff and patient safety due to failing mobile shelving unit and contamination of sterile equipment	Executive Director of Nursing and Midwifery	Overall Risk Lead
	4363	Risk of loss of traceability of medical devices reprocessed in SSDs Pan BCUHB due to existing electronic system is unsupported.		Executive Director of Therapies & Healthcare Sciences
	4935	Risk of service failure due to endoscopy unit patient trolleys being condemned and no longer fit for purpose		

	3820	Risk of service failure and harm to patients due to poor decontamination unit infrastructure		
	4553	Failure to deliver surgical intervention due to aging/obsolete equipment		
	1087	There is a risk to patient safety if staff are not trained and competent in the use of high risk medical devices		
	4879	Risk of device failure, infection and loss of traceability due to use of re-usable screws,pins,plates and k-wires	Executive Medical Director	
	4775	Lack of Cystocopy Stacker Equipment	Executive Medical Director	
	4946	There is a risk that ultrasound may not be able to provide Womens gynae scans	Executive Director of Therapies & Healthcare Sciences	
16	Leadership/Special Measures			Committee
Strategic	There is a risk that a lack of robust and consistent leadership could contribute to safety and quality across the Health Board. This could be caused by inadequate governance arrangement across the Health Board. This could have an impact on the sustainability of staffing and subsequently patient care and safety and service delivery.			AC
Operational Risks Consolidated	4480	Risk that a lack of robust and consistent leadership can contribute to safety and quality concerns	Executive Director of Workforce and Organisational Development	Overall Risk Lead
	3969	Declaration of Interests and Gifts and Hospitality	Board Secretary	Deputy Director of Workforce

Teitl adroddiad: ***Report title:***	Board Assurance Framework
Adrodd i: ***Report to:***	Quality, Safety and Experience Committee
Dyddiad y Cyfarfod: ***Date of Meeting:***	Tuesday, 31 October 2023
Crynodeb Gweithredol: ***Executive Summary:***	The purpose of this report is to highlight progress and to seek assurance from the Committee on the approach taken to have an effective BAF related to the strategic priorities for the 2023/24 Annual Plan. It's mandatory for NHS bodies to have a Board Assurance Framework (risks, controls and action plans in relation to strategic objectives). The Committees have a key role in providing assurance to the Board and this report highlights work on this. As per the 23/24 Annual Plan Organisational Deliverables proposed risk descriptions have been provided and also the relationship with the proposed corporate risk register and Tier 1 risks.
Argymhellion: ***Recommendations:***	The Committee is asked: 1. To be assured that the monitoring of risks in relation to delivering on the Annual Plan, Board Assurance Framework (BAF) enabled by the planning team, performance team and corporate risk team and is underway. 2. To note that requests have been made to all leads on their risk score in relation to deliverables on the Annual Plan. Where high risks are being identified by leads an individual BAF risk report is to be completed. 3. To note that Executives will be asked to review these individual BAF risk reports to which they are overall accountable for prior to submission to committee. 4. To note that Executives are asked to work closely with the risk team and provide any feedback to the Head of Risk Management as to where anticipated high risks may be and support the facilitation of reviewing the individual risk reports encouraging progress with the identified action plan. 5. To consider the example BAF risk report that has been completed in Appendix 2.
Arweinydd Gweithredol:	Phil Meakin, Board Secretary

Executive Lead:				
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 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: N/A ***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):***	BAF highlights the link between Tier 1 (high-extreme operational) risks and Corporate Risk Register (CRR).			
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?***	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 ben 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)	Corporate Risk Register and BAF paper prepared for Executive Team /QSE			

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 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***	N/A
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	Initial paper for feedback from Executive Team prior to submission to Performance Finance and IG Committee and Audit Committee. QSE papers due for submission same day as the Executive Team.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	BAF paper which further links Tier 1 and Corporate Risk Register.
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	
Camau Nesaf: ***Next Steps:*** Submission for further discussion at Committees and ongoing feedback to Head of Risk for further refinement. Hold 1-1s for all corporate and BAF risks and further develop controls, action plans etc. Corporate Team to monitor and escalate any new BAF risks to Executive Team for review.	
Rhestr o Atodiadau: ***List of Appendices:*** Appendix 1 – Overview of possible BAF Risks & Progress Appendix 2-BAF Risk reports SP13-Digital SP16-Board Leadership & Governance	

Introduction/Background

1. The purpose of the Board Assurance Framework (BAF) is to inform and assure the Board with controls and action plans for identified high-extreme risks that relate to any possibilities of not delivering on the Annual Strategic Priorities of the Health Board. This is a mandatory framework required by all NHS bodies.

   The purpose of this report is to highlight progress and to seek assurance from the Committee on the approach taken to have an effective BAF related to the strategic priorities for the 2023/24 Annual Plan.

   The corporate risk team will work closely with the Executive Director Transformation and Strategic Planning and Director of Transformation & Improvement to ensure progress on the Annual Strategic Priorities and monitoring of any risks.

   Following the 22/23 archive of the BAF and previous strategic priorities. The 23/24 Annual Plan has been reviewed in order to develop possible descriptions for BAF risks. Not all the descriptions below will be a high risk. Only those which are thought to be high risk will be further developed to ensure they have controls and action plans in place for close monitoring by the Board.

   All leads in relation the Annual Plan strategic priority deliverables have been contacted to further understand the risks they face in not achieving their priorities.

   An overview of possible BAF descriptions has been provided and the relationship with corporate risks and Tier 1 (high to extreme operational) risks has been outlined. Where risks emerge leads will be asked to provide Committees and Board with an update on their risk score. Where risks are deemed to be high or extreme a risk template will be completed which outlines controls/mitigations, trend in monitoring risk score.

   High risks have been identified by the leads of the following strategic priorities and controls and action plans are in the process of being developed:

   SP1-Prevention and Health Protection
   SP2-Primary Care
   SP9-Women's Services
   SP18-Quality, Innovation and Improvement

   Completed Risk Reports:

   SP13-Digital-This strategic priority has been a consistent priority since 2021 so this risk was opened in 2022 in relation to the previous BAF. The description, controls and action plan have been updated and the scored has increased from 16 to 20 in Oct 23.
   SP16- Board Leadership & Governance-Score 16 New strategic priority and risk recently opened.

   Executives will be asked to review their individual BAF risk reports prior to submission to the Board. Overall accountable Executives has been adopted from the Annual Plan however the overall committee for risks are to be agreed but a proposal outlined below.

2. Body of report

Appendix 1 outlines each strategic priority, provides a standardised description in relation to the possible non-deliverable of the priority. It further highlights the possible rational for progressing the risk as high if a corporate risk has been identified and also Tier 1 (high-extreme operational) risks. This may also further highlight gaps where Executives may be aware of high risks but services have not documented any Tier 1 risks on the risk register.

Appendix 1- Outline of BAF risks and progress

Appendix 2-BAF Risk Reports

Next steps

1. Ongoing monitoring of risks in relation to the Annual Plan Strategic Deliverables.
2. Risk scores for all to be monitored and Board to be provided with updated scores in relation to each as well as a risk report where high risks have been identified.

Appendix 1-Outline of BAF risks and progress

BAF Risk	**Strategic Priority P1 Prevention and Health Protection**				
	BAF Risk	SP01	**Description**	**Progress**	Overall BAF Risk Lead
			There is a risk of failing to effectively implement the prevention and health promotion initiatives across priority areas such as healthy weight, smoking cessation, early years, vulnerable groups, community health, immunisation, and health protection services may lead to poor health outcomes, increased demand on treatment services, and widening health inequalities across the population.	Lead contacted- High Risk identified. Controls drafted to be scored determined and review by Executive.	Executive Director of Public Health
Other Linked Risks	Corporate Risk	Population Health / Community Care Provision / Financial Sustainability			Overall Accountable Committee
	Tier 1 Operational Risks	4200	Residents in North Wales are unable to achieve a healthy weight due to multifactorial and complex system wide factors that promo		PPPH (QSE)
		4201	Lack of Specialist Weight Management Services (Children and Adults)		
		1642	Smoking Cessation		
BAF Risk	**Strategic Priority P2 Primary Care**				
	BAF Risk	SP02	**Description**	**Progress**	Overall BAF Risk Lead
			There is a risk of failing to make progress in transforming and integrating primary and community services may impact on the ability to shift care closer to home and out of hospital settings.	Lead contacted- Karen Higgins, High Risk identified. Controls to be drafted and scored determined. Meeting scheduled 01/11/23.	Executive Director Integrated Clinical Services
Other Linked Risks	Corporate Risk	Community Care Provision / Staffing			Overall Accountable Committee
	Tier 1 Operational Risks	Not on datix	Pharmacy clinic space-lack of impacting on service delivery by pharmacies		PFIG

		Not on datix	Sustainability of staffing in primary care		
BAF Risk	**Strategic Priority P3 Planned Care**				
	BAF Risk	SP03	**Description**	**Progress**	Overall BAF Risk Lead
			There is a risk of failing to establish and deliver a comprehensive Planned Care Strategic Plan and Programme could impede our ability to sustainably address backlogs and drive improvements in planned care.	Lead contacted- Rhys Blake score to be determined.	Executive Director Integrated Clinical Services
Other Linked Risks	Corporate Risk	Planned Care			Overall Accountable Committee
	Tier 1 Operational Risks	2512	Delivery of Planned Care		PFIG
		1161	Failure to deliver timely access for patients to all Elective Planned Care Specialties.		
		4948	Risk to delay of patients requiring orthopaedic surgery at YGC		
		4714	Risk of avoidable harm due to the protracted length of time patients are waiting to be seen or treated		
		4863	Loss of beds due to the number of Medically fit for discharge patients (MFFD) across BCUHB.		
		4411	Waiting List Backlog Physiotherapy Centre Area		
BAF Risk	**Strategic Priority P4 Urgent and Emergency Care**				
	BAF Risk	SP04	**Description**	**Progress**	Overall BAF Risk Lead
			There is a risk of failing to establish and deliver comprehensive Unscheduled Care Strategic Plan and Programme could impede our ability to respond to urgent and clinical care needs of the population and drive improvements in emergency care.	Lead contacted- Geraint Farr, score to be determined.	Executive Director Integrated Clinical Services

Other Linked Risks	Corporate Risk	Urgent and Emergency Care			Overall Accountable Committee
	Tier 1 Operational Risks	3873	Inability to deliver safe, timely and effective care - Wrexham Emergency Department.		PFIG
		4486	Delays with time critical transfers from the ED to specialist services		
		4490	Temporary Suspension of Home Birth Service due to WAST provision		
		4583	Risk of Emergency Department becoming unsafe due to the Ambulance Release Protocol		
		4864	Flow out from the Emergency Units resulting in length of stay in EU being > 12 hours.		
		4866	Inability to manage ambulance demand in a safe timely fashion.		
		4867	Inability to deliver safe timely care in Emergency Units		
		4260	Stage 1 Validation: Patient Deterioration Statements		
BAF Risk	**Strategic Priority P5 Cancer**				
	BAF Risk	SP05	**Description**	**Progress**	Overall BAF Risk Lead
			There is a risk of failing to effectively strengthen the Board arrangements following special measures and implement critical governance, accountability, planning, and performance improvements.	Lead contacted	Executive Director Integrated Clinical Services
Other Linked Risks	Corporate Risk	Specialist Medicine / Timely Diagnosis			Overall Accountable Committee
	Tier 1 Operational Risks	4935	Risk of service failure due to endoscopy unit patient trolleys being condemned and no longer fit for purpose		PFIG
		4843	Risk of compromise to patient care, safety and quality due to environmental and capacity issues at Shooting Star Unit.		
		2758	Failure to implement new NICE approved treatments due to reduced staffing levels within pharmacy team		
		4643	Risk of delayed access to dermatology expertise for the population in the West		

		4432	Oncology workforce will be unable to deliver service due to reduce workforce which will impact patients care and treatment		
BAF Risk	**Strategic Priority P6 Mental Health**				
	BAF Risk	SP06	**Description**	**Progress**	Overall BAF Risk Lead
			There is a risk of failing to progress and deliver on the priorities within the North Wales Mental Health Strategy could impede our ability to provide high quality and timely mental health services.	Lead contacted-Iain Wilkie, score to be determined for P6-8	Executive Director of Public Health
Other Linked Risks	Corporate Risk	Some MH links to Staffing/ Estates			Overall Accountable Committee
	Tier 1 Operational Risks	4843	Risk of compromise to patient care, safety and quality due to environmental and capacity issues at Shooting Star Unit.		PPPH & QSE
		4251	Non-compliance of North Wales Adolescent Service Bedroom Fire Doors		
		Not on datix	MH Leadership Team sustainability		
		3929	There is a risk to patient safety within MHLD inpatient units presented by access to low height and other ligature anchor points		
BAF Risk	**Strategic Priority P7 Substance Misuse**				
	BAF Risk	SP07	**Description**	**Progress**	Overall BAF Risk Lead
			There is a risk of failing to deliver on actions in relation to implementing the Welsh Government's Substance Misuse Delivery Plan, reducing blood borne viruses, supporting people with co-occurring needs, and developing a community substance misuse hub.	Lead contacted-Iain Wilkie, score to be determined for P6-8	Executive Director of Public Health
Other Linked Risks	Corporate Risk		None		Overall Accountable Committee
	Tier 1 Operational Risks		None		PPPH & QSE

BAF Risk	**Strategic Priority P8 Learning Disability**				
	BAF Risk	SP08	**Description**	**Progress**	Overall BAF Risk Lead
			There is a risk of failing to deliver on actions in relation to implementing the Learning Disability strategy, improving inpatient care units, and enhancing community services.	Lead contacted-Iain Wilkie, score to be determined for P6-8	Executive Director of Public Health
Other Linked Risks	Corporate Risk		None		Overall Accountable Committee
	Tier 1 Operational Risks		None		PPPH & QSE
BAF Risk	**Strategic Priority P9 Women's Services**				
	BAF Risk	SP09	**Description**	**Progress**	Overall BAF Risk Lead
			There is a risk of failing to effectively implement critical actions to improve maternity, neonatal, and women's health services and outcomes.	Lead contacted-Fiona Giraud, Drafted provided to be reviewed by Executive.	Executive Director Integrated Clinical Services
Other Linked Risks	Corporate Risk	Staffing / Urgent and Emergency Care			Overall Accountable Committee
	Tier 1 Operational Risks	4773	Compliance with Birth Rate Plus		PFIG (PPPH)
		4490	Temporary Suspension of Home Birth Service due to WAST provision		
BAF Risk	**Strategic Priority P10 Childrens Services**				
	BAF Risk	SP10	**Description**	**Progress**	Overall BAF Risk Lead

			There is a risk of failing to deliver on the priorities within neurodiversity and Child and Adolescent Mental Health Services (CAMHS)	Lead contacted	Executive Director Integrated Clinical Services
Other Linked Risks	Corporate Risk		None		Overall Accountable Committee
	Tier 1 Operational Risks		None		PFIG
BAF Risk	**Strategic Priority P11 Wider Delivery**				
	BAF Risk	SP11	**Description**	**Progress**	Overall BAF Risk Lead
			There is a risk of failing to deliver on the priorities within the Special Measures Response Plan and address critical service issues in a timely manner could jeopardise our ability to sustainably exit special measures.	Lead contacted- Paolo and Dylan Roberts, Controls to be drafted and scored determined.	Executive Director of Transformation and Strategic Planning
Other Linked Risks	Corporate Risk	Leadership/Special Measures			Overall Accountable Committee
	Tier 1 Operational Risks	4480	Risk that a lack of robust and consistent leadership can contribute to safety and quality concerns		AC
BAF Risk	**Strategic Priority P12 Workforce**				
	BAF Risk	SP12	**Description**	**Progress**	Overall BAF Risk Lead
			There is a risk of failing to effectively address workforce priorities such as international recruitment, staff development, impeding service delivery and staff wellbeing.	Lead contacted- Steven Gregg-Rowbry & Nick	Deputy Director of Workforce

	Corporate Risk	Staff safety and Wellbeing / Staffing		Graham, Controls to be drafted and scored determined.	Overall Accountable Committee
	Tier 1 Operational Risks		14 Tier 1 risks mainly relate to particular staffing groups.		PFIG (PPPH)
BAF Risk	**Strategic Priority P13 Digital, Data & Technology**				
	BAF Risk	SP13	**Description**	**Progress**	Overall BAF Risk Lead
			There is a risk of failing to meet the digital strategic and operational objectives caused by having inadequate arrangements for the identification, commissioning and delivery of Digital, Data and Technology enabled projects and change.	High risk has increased from 16 to 20 in Oct 23 and risk report attached. This risk was opened in 2022 and remains the same but has been reviewed in relation to the 23/24 Annual plan and updated with further actions and controls.	Chief Digital and Information Officer
Other Linked Risks	Corporate Risk	Availability and Integrity of Patient Information			Overall Accountable Committee
	Tier 1 Operational Risks	2819	Informatics - Patient Records pan BCUHB		PFIG
		4595	Retention and Storage of Patient Records		
		4603	Risk of Lack of access to clinical and other patient data		
		4766	Duplicate Hospital Numbers		
		4576	Risk of inability to provide general X-Ray services using Computed Radiography (CR)		
		4420	Non-compliance with the subject access rights of an individual under the Data Protection Act		
		4604	Risk of poor clinical recording of patient information		
BAF Risk	**Strategic Priority P14 Estates & Capital**				
	BAF Risk	SP14	**Description**	**Progress**	Overall BAF Risk Lead

			There is a risk of failing to deliver and provide a safe and compliant built environment, equipment and digital landscape due to limitations in capital funding, adversely impacting on the Health Board's ability to implement safe and sustainable services.	Leads contacted, likely high risk	Executive Director of Finance
Other Linked Risks	Corporate Risk	Suitability and Safety of Sites / Financial Sustainability			Overall Accountable Committee
	Tier 1 Operational Risks		12 Tier 1 risks mainly relate to safety of sites		PFIG
BAF Risk	**Strategic Priority P15 Partnerships**				
	BAF Risk	SP15	**Description**	**Progress**	Overall BAF Risk Lead
			There is a risk of failing to effectively implement regional priorities, responding to Welsh Government integration and collaboration initiatives, and collaborating with Public Services Boards.	IHC Directors contacted, currently reviewing risk score collaboratively	Executive Director Integrated Clinical Services
Other Linked Risks	Corporate Risk	Some links to Population Health / Community Provision			Overall Accountable Committee
	Tier 1 Operational Risks		None		AC
BAF Risk	**Strategic Priority P16 Board Leadership & Governance**				
	BAF Risk	SP16	**Description**	**Progress**	Overall BAF Risk Lead
			There is a risk of failing to effectively strengthen the Board arrangements following special measures and implement critical governance, accountability, planning, and performance improvements.	Lead Phil Meakin, Paolo & Nesta, scored determined	Board Secretary

Other Linked Risks	Corporate Risk	Leadership/Special Measures		as 16 and paper attached. Proposed to be de-escalated as IMs are recruited as this would reduce the score to 12 and no longer be a high or extreme risk of delivery.	Overall Accountable Committee
	Tier 1 Operational Risks	4480	Risk that a lack of robust and consistent leadership can contribute to safety and quality concerns		AC
BAF Risk	**Strategic Priority P17 Organisational Development**				
	BAF Risk	SP17	**Description**	**Progress**	Overall BAF Risk Lead
			There is a risk is failing to implement critical workforce and organisational development actions from the Special Measures plan to move from stabilisation to sustainability.	Lead Nick Graham and Jason Brennan contacted	Deputy Director of Workforce
Other Linked Risks	Corporate Risk	Leadership/Special Measures			Overall BAF Risk Lead
	Tier 1 Operational Risks	4480	Risk that a lack of robust and consistent leadership can contribute to safety and quality concerns		PFIG (PPPH)
BAF Risk	**Strategic Priority P18 Quality, Innovation & Improvement**				
	BAF Risk	SP18	**Description**	**Progress**	Overall BAF Risk Lead
			There is a risk of failing to effectively strengthen governance arrangements following special measures and implement clinical governance, embed learning and improve governance around incidents.	Discussed with Matt Joyce, likely high risk, risk report underway.	Executive Director of Transformation and Strategic Planning
Other Linked	Corporate Risk	Failure to Learn			Overall Accountable Committee

	Tier 1 Operational Risks	3025	Failure to learn from mortality reviews		QSE
		4519	Mortality Review Risks to include Datix Module		
		4520	Mortality staffing and level 1 reviews		
		Not on datix	Learning from incidents, internal & external recommendations, safety alerts etc		
		3795	Complaints timeliness to completion		
		3759	Achieving Deadlines - Meeting Complaint Compliance		
BAF Risk	**Strategic Priority P19 Social & Civic leadership and responsibility**				
	BAF Risk	SP19	**Description**	**Progress**	Overall BAF Risk Lead
			There is a risk of failing to deliver on actions relating to improving organisational impact on the Foundational Economy, progressing equality, diversity and inclusion objectives, strengthening the Welsh language and culture within the organisation.	Ceri Harris and Eleri Hughes to be contacted.	Deputy Director of Workforce & Executive Director of Public Health
Other Linked Risks	Corporate Risk		Some links to Population Health / Financial Sustainability		Overall Accountable Committee
	Tier 1 Operational Risks		None		QSE

Appendix 2 -BAF Risk Reports

<table>
<tr><td rowspan="4">BAF
SP13</td><td colspan="2">Executive: Director of Digital (Chief Digital Information Officer (CDIO)</td><td>Date Opened: July 2022</td></tr>
<tr><td colspan="2">Committee: Performance, Finance and Information Governance Committee (Will revert to Partnerships, People and Population Health Committee or equivalent once the meetings recommence)</td><td>Date Last Reviewed: October 2023</td></tr>
<tr><td>Strategic Priority: P13
Digital, Data & Technology</td><td>Link to CRR: Availability and Integrity of Patient Information
Link to Tier 1’s: 2819, 3659, 4595, 4603, 4766</td><td>Last Reviewed by Committee: 02.11.23
Target Risk Date: May 2024</td></tr>
<tr><td colspan="4">There is a risk of failing to meet the digital strategic and operational objectives caused by having inadequate arrangements for the identification, commissioning and delivery of Digital, Data and Technology enabled projects and change.</td></tr>
</table>

Mitigations/Controls in place	**Gaps in Controls**	**Current Risk Score**
These are measures/interventions implemented by the Health Board to reduce either the likelihood of a risk and/or the magnitude/severity of its potential impact were it to be realised. 1. Minimal controls in place with the introduction of rigour and governance to the commissioning of new Digital, Data and Technology project requests through a Project and Portfolio Management function that will ensure prioritisation, impact assessment in terms of deliverability, best use of technology, interoperability, longevity and value for money. This includes insisting that for all new projects the business change element and service design aspect up front which includes the users is built in. 2. Where possible the Health Board will bring in the necessary expertise from external service providers that the Health Board do not currently possess. 3. To set the expectations with the Health Board and Welsh Government on the inability to effectively architect and deliver Digital, Data and Technology projects and realise benefits in line with the strategy of the Health Board.	1. Funding currently not secured to implement the new operating model. 2. Unable to deliver new models of care with local and national strategies. 3. No clear technology plan, future blueprints or architectural considerations with due regards for the whole. 4. No single integrated digital health care record to address the fragmented care record concerns to deliver the special measures framework requirements. 5. Unable to replace or decommission obsolesce systems due to no funding to manage replacement or consider new ways of working. 6, Significant gaps in workforce in specific patient records and IT areas, which is resulting in	Impact: 4 | Likelihood: 5 | Score: 20 Movement since last Qtr: Increased likelihood from 4 to 5 since August 2023. NB. The tolerate score for this risk is 16 which is a high level of tolerance for the risk due to an inability to fund necessary resources.

	decreased support for the Health Board which will impact on patient care.	

Actions and Due Date

Costed proposals (£1.7m recurrent) and plans have been produced, validated and presented to Partnerships, People and Population Health Committee and Board for the implementation of a new operating model for Digital, Data and Technology which requires new capabilities and capacity to effectively deliver. This includes new functions for: Intelligence and Insight, Digital Project Management Office, Architecture Software engineering, service design and clinical change. These proposals were dependent on funding £500K of which was provided by the Health Board with due regards to other priorities for investment.	April 2023
Alternative plans to be developed within the current funding constraints that will have a small but positive impact over time.	April 2024
Commission external service providers to fill the gaps in capabilities and skills to support the delivery of objectives and special measures requirements.	April 2024

Lines of Defence			Overall Assessment
1	**2**	**3**	**Next steps:**
1. Digital, Data and Technology Objectives and Operating Plan reviewed quarterly by Digital Senior Leadership Team.	1. Regular Assurance Reporting to Partnerships, People and Population Health Committee and Executive Management Team in its absence.	1. Benchmarking the service against external assessments, e.g. Gartner Group IT Score. 2. National Cyber Security Centre. 3. Cyber Essentials+ 4. Information Governance Toolkit. 5. Access to external service providers to support in critical areas. 6. Government Digital Service Digital, Data and Technology roles and possibly SFIA assessments.	The Board previously agreed a high risk tolerance score of 16, which may need to be reviewed. Risk has increased in likelihood due to significant financial pressures and Health Board.

BAF SP16	**Executive:** Board Secretary		**Date Opened:** 19 October 2023
	Committee: Audit Committee		**Date Last Reviewed:** Not yet taken place
	Strategic Priority: P16 Board leadership & governance	**Link to CRR:** Leadership/Special Measures **Link to Tier 1's:** 4480	**Last Reviewed by Committee:** 16.11.23
			Target Risk Date: 31 January 2024 to review score. If progress made below then recommend a reduction to a score of 12 (3 x 4) by end of February 2024

There is a risk of failing to effectively strengthen the Board arrangements following special measures and implement critical governance, accountability, planning, and performance improvements.

Mitigations	**Gaps in Controls**	**Current Risk Score**		
This refers to the process of reducing risk exposure and minimising its likelihood and/or lessening or making less severe its impact were it to materialise. Types of risk mitigations include the 5Ts (treat, tolerate, terminate, transfer or take opportunity). 1. The development and agreement of the Special Measures "**Governance and board effectiveness domain"** deliverables and milestones that give clarity on what needs to be delivered by when. This includes development of Board Development and Board Induction products to support Board arrangements. This is detailed in the action section. 2. Close working with Welsh Government on the recruitment of new Board members through the public appointment process. 3. Comprehensive response to the Board Effectiveness Review by Audit Wales that aligns to the Special Measures approach.	1. Welsh Government control the public appointment process but we have weekly catch ups to counter this. 2. The implementation of the review of the OBS is reliant upon following the organisational change policy and this will impact timescales for that part of the improvements 3. The appointment of some Executive appointments is reliant on the timely review of the Exec Portfolio review	Impact	Likelihood	Score
		4	4	16
		Movement N/A		

Actions and Due Date

	Target Date
SM Ref no C1-1.3: Implement phase 1 induction for all Board members	Nov-23
SM Ref no C1-1.4: Develop phase 1 Board development programme	Dec-23
SM Ref no C1-1.5: All committees with assigned IMs operational, including ToR, Corp Calendar and Workplans	Mar-24
SM ref no C1-1.6: Design Risk management framework and commence implementation	Dec-23

SM ref no C1-1.7: Permanent Chair/IM/CEO/Exec recruitment – dependent on Exec Portfolio Review and Senior HR Cases	Mar-24
SM ref no C2-1.8: OBS team – implement interim and design permanent structure	Dec-23
SM ref no C2-1.9: Policy management and implementation/audit approach	Oct-23
Feedback from Audit Wales follow up review – December 2023	Dec-23
Scrutiny of progress through Audit Committee	November 2023, January 2024 and March 2025
Assurance on progress through Board	November 2023, January 2024 and March 2026

Lines of Defence			Overall Assessment
1	**2**	**3**	If the above deliverables are put into place then a score of 12 could be achieved by March 2024 or earlier if new Committees and OBS Team are in place by February 2024 Next steps • Executive Team to review • Audit Cttee to scrutinise on 16 Nov 2023 • Board receive report on 28 November 2023 • Deliver plans as outlined above.
• Special Measures meeting and assurances to committees on 90 day plan etc • OBS Team Meetings	• Committees and Board • Audit Committee in November, January and March • Board in November, January and March • Executive Team Meetings • Throughout 2023/24.	• Welsh Government • Audit Wales follow up reviews	

Teitl adroddiad: ***Report title:***	Patient Safety Report			
Adrodd i: ***Report to:***	Quality Safety and Experience Committee (QSE)			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Friday, 27 October 2023			
Crynodeb Gweithredol: ***Executive Summary:***	This report provides the Health Board with information and analysis on significant patient safety issues arising during the prior three month period, alongside longer-term trend data, and information on the improvements underway.			
Argymhellion: ***Recommendations:***	The Committee is asked to receive this report.			
Arweinydd Gweithredol: ***Executive Lead:***	Angela Wood, Executive Director of Nursing and Midwifery			
Awdur yr Adroddiad: ***Report Author:***	Tracey Harris, Deputy Head of Patient Safety			
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 strength of learning and improvement remains an area of concern and is a key focus of work. As detailed in this report, work is underway to improve both the process and culture regarding patient safety and linked to this the approach to improvement.				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Quality			
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	Instances of harm to patients may indicate failures to comply with the NHS Wales Health and Care Standards of health and 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)***	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: ***List of Appendices:*** Appendix 1 – Quality Dashboard Draft Appendix 2 - Patient safety Group ToR and Cycle of Business Appendix 3- Organisational Learning Forum (OLF) ToR Appendix 4 – OLF sample agenda	

INTRODUCTION

This report outlines the activity in Patient Safety in the period July to September 2023. The report identifies themes and actions taken to make improvement, whilst providing information as appendices on the governance arrangements in place to support the agenda.

Patient safety is focused on the prevention of harm to patients by improving the way in which care is delivered so that errors are reduced, learning occurs from the errors that do occur, and a culture of safety is fostered.

A draft of the Quality Dashboard being developed to support data presentation and oversight is identified at Appendix 1

A monthly Patient Safety Group has now been meeting for 6 months and quarterly deep dives are presented from all operational areas to review progress, identify areas for escalation and areas of learning. (Appendix 2)

A monthly Organisational Learning Forum has also been established to learn from Patient Safety incidents, alerts and Harm. (Appendix 3)

DATIX INCIDENTS

The table below identifies the incidents that have occurred during 2022/2023 to date:

	Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023	Sep 2023	Total
Primary Care West	23	25	33	34	32	18	165
Primary Care Central	24	27	33	44	32	28	164
Primary Care East	21	29	29	35	38	20	152
IHC West (Excluding Primary Care)	634	673	682	724	689	762	4164
IHC Central (Excluding Primary Care)	945	963	893	907	903	851	5462
IHC East (Excluding Primary Care)	786	700	729	696	803	787	4501
MHLD	505	466	579	563	607	504	3224
Midwifery & Womens	147	188	208	234	188	182	1147
Other (Including Dentistry, Cancer, Diagnostics, etc)	170	226	234	222	232	272	1356
High level service recorded only	25	38	49	42	52	48	256
Total	**3280**	**3335**	**3469**	**3501**	**3576**	**3472**	**20633**

NATIONALLY REPORTABLE INCIDENTS (NRI)

July to September 2023: 44 notifications submitted to NHS Executive this represents 0.4% of the total incidents occurring during this period.

Of these, 22 incidents are pre 1st April 2023, the rational for this is due to awaiting completion of a closure form following local harms review or reopened following downgrade as per NHS Wales Executive request.

18 Early Warning Forms were also submitted for this period.

Total number of NRI investigations overdue as of 11th October 2023 is 27 (total open = 44)

The NRIs reported during this period can be themed as follows:

	Total
Absconding or missing patient/service user	1
Clinical assessment, clinical diagnosis	6
Infection outbreak / period of increased incidence	1
Physical assault (physical contact)	1
Self-harm / self-injurious behaviour	1
Slip, trip or fall	2
Treatment or procedure issues	2
Unexpected death	3
Pressure ulcer	27
Total	44

The Deputy Executive Director of Nursing for patient safety continues to lead weekly improvement meetings with services and the patient safety team are targeting support to facilitate completion.

Detailed below are the comparison in incidents and key actions related to our top three Harms by reported incident numbers.

April - June 2023	None	Low	Mod	Severe	Cata	Total
Slip, trip or fall	238	716	209	14	2	1179
Assessing and recognising patient/service user deterioration	0	1	7	2	1	11
Pressure Damage, Moisture Damage	153	1530	690	29	0	2402

July – Sep 2023	None	Low	Mod	Severe	Cata	Total	% Difference from April – June
Slip, trip or fall	188	739	182	9	0	1118	< 5%
Assessing and recognising patient/service user deterioration	1	4	6	2	3	16	> 6%
Pressure Damage, Moisture Damage	172	1814	692	26	0	2704	> 22%

Falls - Key actions:

- Draft Internal Audit report completed and currently being reviewed for accuracy, final report is scheduled for December 2023 Audit Committee;
- HSE Notice of Contravention, Health Board response provided by 20th September 2023 areas for improvement included completion and quality of Falls and Bone Health Multifactorial Assessment, training of Agency workers and post fall patient review and investigation
- Health Board improvement plan aligned to the HSE Notice of Contravention actions and the recommendations of the Internal Audit report will be overseen by Patient Safety team and the Strategic Inpatient Falls group as an agenda item;
- Health Board Mandatory Falls E learning modules hosted on the National ESR platform compliance by Health Board employees is above 95% this training is required 2 yearly basis;
- Risk ID 4562 -relates to accuracy and completion of the Falls and Bone Health Multifactorial Assessment for all Adult Inpatients has been reviewed and accepted by the Health Board Risk Management group with a current score of 20, and a target score of 9.

Healthcare Acquired Pressure Ulcers (HAPU) – Key actions

- Welsh Nursing Care Record (WNCR) repositioning and skin assessment record launched Feb 2023. Strategic HAPU group to determine way forward with paper based Intentional rounding; This will discussed further in October HAPU Improvement meeting as WNCR suggest some wards are still using both electronic and paper version.
- SBAR submitted to Deputy Director of People outlining the benefits of making Tissue Viability training mandatory for Clinical Staff (currently it is optional or at manager discretion); still awaiting outcome of this proposal.
- Secondment post for HAPU lead interviews held and appointed to Cathy Lloyd who has taken up this position and commenced in August 2023
- Draft generic Health Board Champion role and framework currently being tested before Implementation in one area in IHC West for Tissue Viability Champion in preparation for implementation as part of the planned HARMS/HAPU Collaborative Autumn 23. Initial feedback from staff is positive all feedback in regards to the ethos and understanding of the champion role in its generic format has been well received by staff. This will be discussed in October HAPU Improvement meeting

Recognition and escalation of deteriorating patient – Key actions

- The Patient Safety Group received the report from the STEAR with the requirement that the UKST sepsis tool is adopted across BCUHB
- Audit of Sepsis is then devolved back to local departments
- The monitoring, diagnosis and treatment thresholds for sepsis has been challenging in Wales since 2018 and only incremental progress has been made.
- BCUHB continues to use SIRS criteria (1991) which has been outdated since 2001. NICE, UK Sepsis trust (UKST) and the Association of Royal Medical Colleges (AoRMC) guidelines have moved on multiple times through 3 improvements in the Sepsis tools recommended. The most recent NICE guideline (51) was published in 2018 endorsing the current UKST tool and the AoRMC statement in Sept 22 agreed with this approach as being important to improve sepsis outcomes and antibiotic stewardship.
- There is a requirement for the BCUHB to be brought in line with these recommendations and changes in practice in the management of sepsis.

NEVER EVENTS

A total of 2 Never Events have been reported by the Health Board within this reporting period
Key reporting themes comprise of:
Wrong site surgery: Two incidents reported Aug 2023

Key issues include:

Utilisation of pre-procedure checklist
Monitoring and updating of Local Safety Standards for Invasive Procedures (LocSSIPs)
Utilisation of LocSSIPs in practice

PATIENT SAFETY ALERTS AND NOTICES

The Health Board has no overdue Alerts or Notices currently

LEARNING FROM NOSOCOMIAL COVID-19 REVIEWS

The NNCP Learning Plan consists of identified themes and trends which have been extrapolated from clinical investigations into waves 1- 4 of the Covid-19 pandemic, contact with families and staff feedback.

The Learning Plan also aims to include a digital story which has been delayed at the request of the participating relative; it is anticipated that this will be achieved by early December 2023.
An interim Learning Report using investigators' narratives has been produced in August 2023, based on n=564 completed reviews (cycle 1: November 2022 & cycle 2: April 2023).

A draft Learning from Staff Experience survey administered via online 'Once for Wales' CIVICA platform has been produced in September 2023 with n=142 responses. The final version of this report is expected to be circulated by end of October 2023.

Outline Analysis of Themes Identified:

a) Clinical Investigations

Inadequate record keeping and substandard documentation
Inadequate social distancing
Covid-19 Testing and Patient Status – failures to determine
Failure to isolate infected patients
Failure to follow IPC precautions
Coordination of care and Timely delivery of care and treatment
Excessive movement of patients across clinical pathways
Poor communication with Service Users and across Services
Inadequate staffing / skill mix
PPE availability
Environmental cleanliness
Visiting

b) Contact with Families

Failures in communication
Lack of compassionate care and maintaining dignity (attitudes of staff)
Patient care delays including failure to diagnose and treat in a timely manner

c) CIVICA Survey for Investigation Outcomes

The communication plan is being finalised for distribution of Wave 1-2 outcome letters, which it is anticipated will roll out at the end of October 2023. Families will receive the CIVICA survey via QR code 1 week following receipt of outcome letters, and data received

will be amalgamated and analysed for presentation in accordance with agreed governance reporting of learning outcomes.

ALL WALES MEDICAL EXAMINER SERVICE (MES)

The Corporate Mortality Team and IHC's are supporting the roll out of the Medical Examiner Service (MES) provision in all BCU Emergency Departments, Primary Care and Community Hospitals (including Mental Health) within North Wales. The Health Board are currently receiving approximately 40 cases from the MES to review each week; this is thought to increase as the rollout develops. Processes have matured allowing the triangulation between mortality, inquests and other PTR routes.

Recent work has seen the Corporate Mortality Team cross reference Medical Examiner themes to the Health Board received Regulation 28's for April 2021-September 2023, which shows strong trends and themes for Mental Health and Emergency Care.

The well attended multi-disciplinary *Learning from Mortality Panel* and *Reducing Avoidable Mortality Steering Group Collaborative* meeting continues to meet on a monthly basis. The meeting format has recently undergone a change of agenda, seeing reports tabled for the IHC's and services/departments on a regular basis, to ensure widespread learning, reflective practice, improve accountability and assurance of the IHC process and to provide the opportunity of escalation to the Strategic Clinical Effectiveness Group if required.

Several themes have emerged where specific actions and communication is required to improve patient safety. Whilst some are unique (such as lack of governance around transplant referral), others provide evidence to support ongoing work around 'Flow' issues, Falls' and 'Hospital Acquired Pressure Ulcers' (HAPU's). The identification of issues around Do Not Attempt Cardiopulmonary Resuscitation (DNACPR), and Mental Health Capacity have fed into a wider review and actively contributed to an All Wales thematic review.

The Corporate Mortality Team work closely with the Patient Advocate Liaison Service (PALS), Complaints and Patient Experience teams to ensure next of kin/relative concerns and compliments are addressed or fed-back to the Health Board in a timely manner. PALS and Complaints are one of the services who are providing a quarterly update of ME cases at the LFMP & RAMSG Collaborative meetings.

The Corporate Mortality Team are continuing to work with the All Wales team to improve functionality of the All Wales process and Datix software package, such that themes and trends can be easier analysed. This is set to be completed by September 2024. Health Boards have requested support from Welsh Government to identify and support resource requirements for Mortality structures, which the Delivery Unit acknowledges and supports.

CONCLUSION

This report provides the Health Board with information and analysis on patient safety matters including Nationally Reportable Incidents, Never Events and Patient Safety Alerts

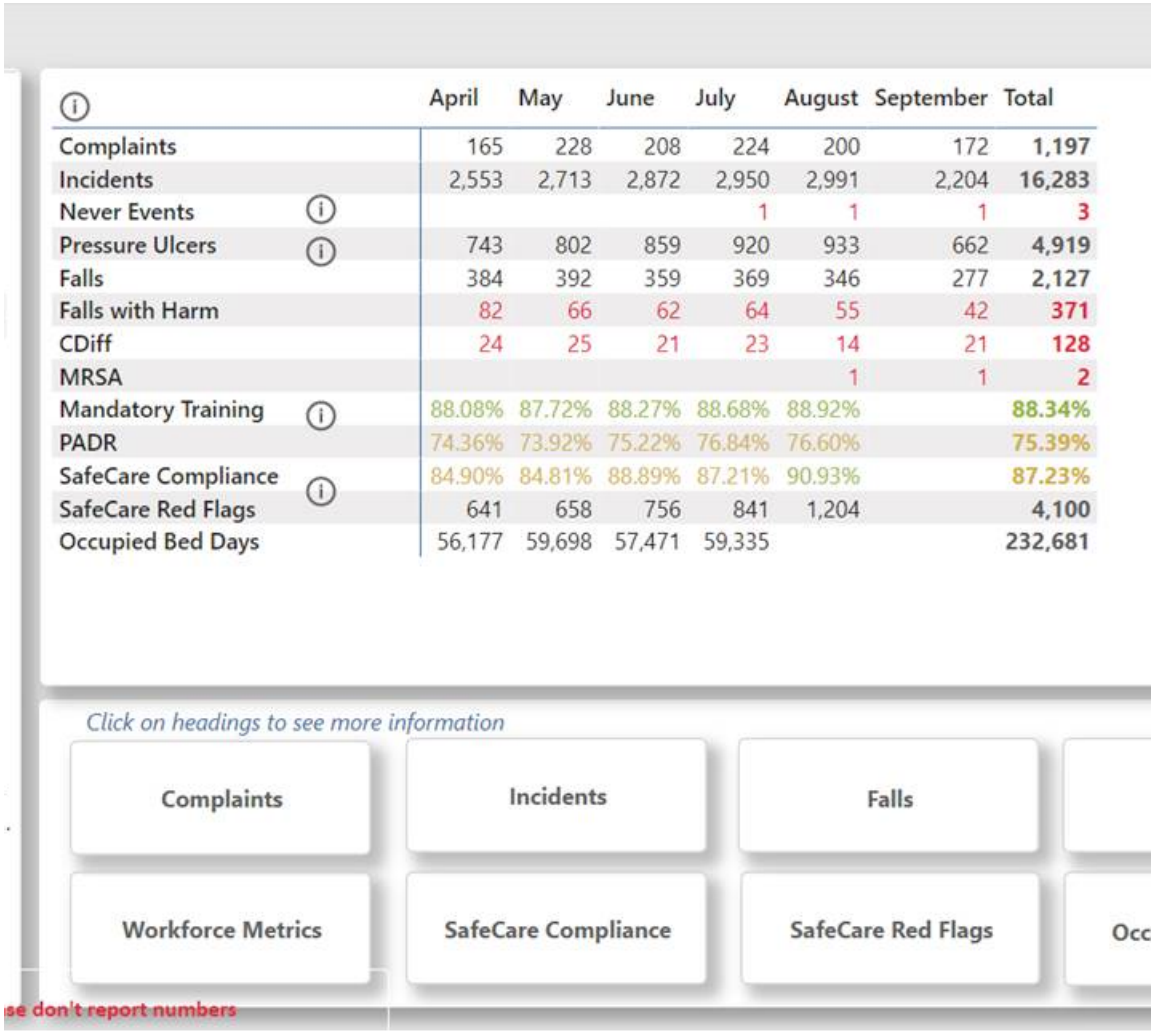
The key points of note are:

- The overall rate of overdue NRIs has demonstrated some improvement but the number of overdue incident investigations, and consequently closure within the target timeframe is still below expectation. Services report clinical and operational pressure as being the main cause. Support is being provided.

- The main themes remain falls, healthcare acquired pressure ulcers, and the recognition and escalation of deteriorating patients. Improvement work for all these areas is progressing under the leadership of senior clinical staff.

Appendix 1

Screenshot of Draft Quality Dashboard



	April	May	June	July	August	September	Total
Complaints	165	228	208	224	200	172	1,197
Incidents	2,553	2,713	2,872	2,950	2,991	2,204	16,283
Never Events				1	1	1	3
Pressure Ulcers	743	802	859	920	933	662	4,919
Falls	384	392	359	369	346	277	2,127
Falls with Harm	82	66	62	64	55	42	371
CDiff	24	25	21	23	14	21	128
MRSA					1	1	2
Mandatory Training	88.08%	87.72%	88.27%	88.68%	88.92%		88.34%
PADR	74.36%	73.92%	75.22%	76.84%	76.60%		75.39%
SafeCare Compliance	84.90%	84.81%	88.89%	87.21%	90.93%		87.23%
SafeCare Red Flags	641	658	756	841	1,204		4,100
Occupied Bed Days	56,177	59,698	57,471	59,335			232,681

Health Board Patient Safety Group

Terms of Reference

1.0 INTRODUCTION

1.1 The Executive Director of Nursing and Midwifery, as executive lead for quality, has established the Patient Safety Group (PSG). The PSG is a formal sub group of the Health Board Quality Delivery Group (QDG) and is the single point of focus for all patient safety related activity across the Health Board. The detailed terms of reference and operating arrangements in respect of these meetings are set out below in the Terms of Reference document.

1.2 The PSG has a direct line of accountability to the Health Board Quality Delivery Group with its reports being received at QDG, and to the Quality, Safety and Experience (QSE) Committee of the Health Board via the Patient Safety Report. It will also receive and provide reports to Board Committees, the Executive Team, the Health Board Leadership Team and other Health Board Delivery Groups as needed.

2.0 PURPOSE

2.1. The purpose of the PSG is to ensure the Health Board provides safe services to the people it serves in accordance with safety related standards. Specifically the group will:

- Approve procedures related to patient safety and recommend for approval to the QSE Committee polices related to patient safety;
- Seek assurance on the safety of services being provided to patients;
- Identify risks and opportunities for improvement in patient safety;
- Commission and provide coordination of initiatives and work to improve patient safety;
- Provide direction to IHCs and Regional Services on the actions needed to improve patient safety.
- Support the delivery of the requirements of the Clinical Governance, Patient Experience and Safety Special Measures Domain as identified by the Chair of the Quality Delivery Group.

3.0 DELEGATED POWERS

3.1 The PSG is empowered by the Executive Director of Nursing and Midwifery and QDG to:

- Approve procedures related to patient safety and recommend for approval to the QSE Committee polices related to patient safety;

- Seek evidence based assurance from clinical and corporate services in relation to patient safety;
- Commission and provide coordination of initiatives and work to improve patient safety
- Provide direction to clinical and corporate services in relation to improving patient safety;
- Support the effective operational management of the Health Board, enabling issues related to patient safety to be anticipated, discussed and actions agreed;
- Enable and support the appropriate integration, connection and liaison between individual services, between clinical and corporate functions and between strategic and operational matters;
- Make management decisions on issues within the remit of the PSG, in-line with the Board's Scheme of Delegation.

4.0 AUTHORITY

4.1. The PSG is in effect an extension of the QDG, and derives its authority from and is therefore accountable to the Executive Director of Nursing and Midwifery. The PSG will work closely with the QDG and other groups.

4.2. The PSG has responsibility for co-ordinating and providing the QDG and QSE Committee with evidence based assurance regarding patient safety in the Health Board.

4.3. The PSG is authorised to investigate or have investigated any activity within its terms of reference. In doing so, PSG shall have the right to inspect any records or documents of the Health Board relevant to the PSG's remit and ensuring patient/client and staff confidentiality, as appropriate. All employees are directed to cooperate with any legitimate request made by the PSG.

4.4. The PSG will engage with employees, committees or groups as set up by the Board or by the Executive Team to assist in expediting its role.

4.5. The PSG may obtain outside legal or other independent professional advice via the Deputy Director of Quality if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements;

4.6. The PSG will review risks from the appropriate Risk Registers and advise the QDG, the Risk Management Group (where over the score of 15) and QSE Committee on the appropriateness of the scoring and mitigating actions in place.

5.0 MEMBERSHIP

5.1 The core members of the QDG are:

Deputy Executive Director of Nursing - Chair
Deputy Executive Medical Director(s) – Vice Chair
Deputy Director of Quality
Head of Patient Safety
Medication Safety Officer
Assistant Medical Director (Mortality)
Senior representative of Safeguarding and Public Protection
Senior representative of Infection Prevention and Control
Senior representative of Risk

Senior representative of Health, Safety and Security
Senior representative of Estates and Facilities
Senior representative of East IHC
Senior representative of Central IHC
Senior representative of West IHC
Senior representative of Women's and Midwifery Services
Senior representative of Diagnostic and Clinical Support Services
Senior representative of Cancer Services
Senior representative of Mental Health and Learning Disability Services
Senior representative of Dental Services
Senior representative of Primary Care Services
Chair's of the sub-groups if not already a member

5.2 Other officers will attend as required by the Chair of the PSG, as well any others from within or outside the organisation whom the Chair of the PSG considers should attend, taking into account the matters under consideration at each meeting.

5.3 The membership of PSG shall be determined by the Chair of the PSG taking account of the balance of skills and expertise necessary to deliver the PSG's remit and subject to any specific directions made by the QDG.

5.4 Subject to approval by the Chair of the PSG, nominated deputies are permitted and will have the full voting rights and accountability of the member for whom they are deputising.

5.5 The Deputy Director of Quality and their Office shall act as secretariat for the meeting.

6.0 MEETINGS

6.1 At least one third of core members must be present to ensure the quorum of the PSG, one of whom must be the Chair or Vice-Chair.

6.2 Where members are unable to attend a meeting, a nominated deputy should be asked to attend, at the discretion of the meeting Chair.

6.3 Decisions shall be made by consensus, where a vote is required a simple majority of those in attendance will confirm the decision, provided that the meeting Chair is in agreement.

6.4 Where the PSG is unable to make a decision, the meeting Chair may refer the matter to the QDG.

6.5 There may, occasionally, be circumstances where decisions, which would normally be made by the PSG, need to be taken between scheduled meetings. In these circumstances, the Chair of the PSG, supported by the secretariat, may deal with the matter on behalf of the group. The secretariat must ensure that any such action is formally recorded and reported to the next meeting for consideration and ratification. Chair's Action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

6.6 The Deputy Director of Quality, as secretariat, will develop and maintain a Cycle of Business for the PSG which shall be approved by the Chair of the PSG.

7.0 RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES

7.1 The PSG will engage with other groups to ensure the connection and consideration of programmes of work.

7.2 PSG members are directly accountable to the Chair for delivering the functions set out in the Terms of Reference.

7.3 The PSG shall embed the Health Board's values, standards, priorities and requirements across all aspects of its work.

8.0 REPORTING AND ASSURANCE ARRANGEMENTS

8.1 The PSG shall:

- provide a Chair's Assurance Report that will be shared with the QDG (additionally, a Patient Safety Report is provided to the QSE Committee which will include details of the work of the PSG);
- bring to the QDG or QSE Committee's specific attention to any significant matters under consideration by the PSG;
- ensure appropriate escalation arrangements are in place to alert the Executive Team, or Chairs of relevant Board Committees / other groups of any urgent or critical matters that may affect the operation and/or reputation of the Health Board.

9.0 REVIEW

9.1 These terms of reference and operating arrangements shall be reviewed after 6 months by the PSG and any changes recommended to the QDG for approval

Version 0.3

21 April 2023

Appendix 1 - Cycle of Business

Meeting:	Patient Safety Group
Version:	V0.3
Last updated:	Thursday, 22 June 2023

Item	Lead	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Procedural items – opening													
Introduction by the Chair	Chair	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Confirmation of quoracy	Chair	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Declarations of interest	Chair	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Apologies for absence	Chair	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Minutes of the previous meeting	Chair	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Action tracker	Chair	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Annual review of terms of reference	Chair	✔											
Annual review of cycle of business	Chair	✔						✔					

Item	Lead	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standing items – Patient Safety Reports													
Urgent issues by exception	IHC/Service reps	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Deep Dive Patient Safety Reports from: - Each IHC	Eact IHC rep	✔			✔			✔			✔		
Deep Dive Patient Safety Reports from: - Central IHC	Central IHC rep		~~✔~~	✔		~~✔~~	✔			✔			✔
Deep Dive Patient Safety Reports from: - West IHC	West IHC rep			✔			✔			✔			✔
Deep Dive Patient Safety Reports from: - MHLD	MHLD rep	✔			✔			✔			✔		
Deep Dive Patient Safety Reports from: - Womens and Midwifery	W&M rep		✔			✔			✔			✔	
Deep Dive Patient Safety Reports from: - Cancer	Cancer rep			✔			✔			✔			✔
Deep Dive Patient Safety Reports from: - Diagnostics and Clinical Support	D&CS rep	✔			~~✔~~	~~✔~~	✔	~~✔~~		✔			✔
Deep Dive Patient Safety Reports from: - Dental	Dental rep		✔			✔			✔			✔	

Standing items – Chair's Reports													
Chair's Reports from Sub-Groups: - Falls Improvement Group - Medication Safety Improvement Group - HAPU Improvement Group - Inpatient Nutrition, Catering Hydration Improvement Group - STEAR Improvement Group - Incident Learning Panel - Medical Gasses Group - Medical Devices Group - Nosocomial COVID Group - Safe Care Collaborative - WAST/BCU Incidents (added June 23)	Sub-group chair Sub-group chair Sub-group chair Sub-group chair Sub-group chair Sub-group chair Sub-group chair Sub-group chair Sub-group chair Sub-group chair Sub-group chair	After each meeting – dates to be aligned											
Standing items – Regular Reports													
Safety Alerts	Head of Patient Safety	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Procedures for approval	Head of Patient Safety	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Policies for recommending approval to the QSE Committee	Head of Patient Safety	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Ad-hoc items													
Ad hoc items submitted by members and approved for the agenda by the Chair													
Procedural items – closing													
Any other business	Chair	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔

Confirmation of actions	Chair	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Identification of risks	Chair	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Items for the Chair's Report	Chair	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Date and time of the next meeting	Chair	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔

Appendix 2 - TERMS OF REFERENCE

NAME OF GROUP:	**BCUHB Organisational Learning Forum**
GROUP STATUS	The Organisational Learning Forum is a sub- group of the Executive Delivery Group for Quality
REPORTING TO	The Group is accountable to the Executive Delivery Group for Quality and the Group Chair will report regularly on the Group's proceedings. The notes of the Group's meetings shall be formally recorded and made available to EDG members.
PURPOSE	To provide the Executive Delivery Group for Quality which reports to the Quality Safety and Experience Committee (QSE) with information about learning in relation to litigation, experience, incident investigations (Serious & RED), inquests and deaths, including thematic learning across these five domains. A sixth domain will also capture routine learning points to share and embed in practice as an iterative process. The Group will correlate information and support the Integrated Health Communities (IHC's) and Divisions to identify themes and mechanisms to enable learning to be embedded across the organisation in order to avoid repeat of incidences of patient harm, positively contributing to the Health Boards Quality Improvement initiatives.
GROUP DUTIES:	*All duties apply across all 5 domains; complaints, claims, inquests, incidents (REDs and SIs) and deaths:* To collate and share learning information. This will be shared with the IHC's, MH&LD Division and women's division, hosted services and Quality and Safety Group. The forum will support identification and sharing of learning applicable across the organisation, with the expectation that IHCs and Regional Services will work to turn this learning into improvement action and provide assurance of this back to the forum". The learning improvement delivery plan will demonstrate any audit requirements of an Action and feed into the Clinical Effectiveness Unit. The forum will be a platform for engagement with the IHC's and Divisions to support learning actions, activities and initiatives. The IHC's and MH&LD,hosted services and women's Divisions will be supported to identify their themes and trends; The group will identify themes and trends across

	services and ensure learning is shared and implemented, sustained, monitored and evidenced. The forum will provide a supportive environment to share progress of implementation of learning from actions. The forum will work closely with the IHC, MH&LD, hosted services and Womens Divisional Triumvirate/Governance Leads to agree a methodology that enables assurance to be provided in relation to completion and validation of improvement or delivery plans across the five domains, and agree escalation process if assurance / evidence of learning cannot be achieved. The forum will provide an environment where ideas can be shared and collaboration can take place across services that promotes a culture of learning for safe, quality patient care. The forum will work with educators, practitioners and others to scope mechanisms for embedding learning and evaluation of these A standardised approach of identifying intended learning outcomes and intended measurement approaches will be promoted, including PROMS, in all learning and development initiatives. Ensure robust systems to gather evidence or implementation and sustainability of learning over time Foster innovation around development of creative approaches to embedding and sustaining learning in practice Promote family, carer and patient involvement in promoting learning Encourage and promote recognition of patient and carer centred care through informal and formal routes. Support, contribute to and facilitate shared learning events to enable organisational learning. Learning will be shared from key clinical effectiveness issues; audit and mortality as well as safety and patient experience. The learning will be shared with the Patient and Carers Experience Committee.
MEMBERSHIP:	The Group shall consist of representatives from both Corporate and IHC and Divisional teams as follows: • Deputy Executive Nurse Director (Chair) • Associate Medical Director

	• Director of Nursing Quality Assurance and Learning • Head of Patient Safety • Head of Patient Experience • AHPs Representatives • Learning from Deaths Nurse - Medical Examiner's Office or Medical Examiner • Patient Safety Team Lead • IHC and MH &LD. hosted services and women's Divisional representative from all Clinical Services • Head of Clinical Effectiveness • Pharmacy Governance Representative • Education Team Directors Nursing, AHPs, Medical • Academic Representation • Learning from Deaths BCU group rep • Learning from Falls BCU group rep • Non-Medical Consultant Practitioner Representative Members or their deputy will be expected to attend at least 80% of meetings per annum.
ATTENDEES:	The following are expected to attend each meeting: A representative from: • Legal Affairs Team • Patient Safety Team • Patient Experience Team • Medical Examiner's team Those in attendance do not count towards the quorum.
LEAD OFFICER:	Deputy Executive Nurse
MEETING ADMINISTRATION:	Notice of meetings will be given at least seven working days in advance unless members agree otherwise. The agenda shall be pre-determined by the Group. Items for inclusion on the agenda shall be submitted at least 7 working days prior to the meeting. The agenda and papers will normally be circulated five working days prior to the meeting. Notes will be taken by specified administrative support. Notes will be sent to the Group's members within 7 working days of the meeting to which they relate.
SERVICED BY:	Secretary to the Deputy Nurse Director.
FREQUENCY OF MEETINGS:	Meetings shall usually be held monthly for a maximum two hours.

QUORUM:	A quorum shall be made up of four corporate members comprising representatives from all four areas (i.e. Legal Affairs, Patient Safety and Patient Experience and Medical Examiner's Office (MEO) and at least 3 of 4 IHC Divisions represented. No business should be conducted unless a quorum is present. If a particular IHC or Clinical Division is absent from a meeting, they must attend the subsequent meeting.
MONITORING AND REVIEW	The Group's Terms of Reference, including membership, will be subject to annual review via self- assessment by its members and this will be reported, together with any agreed actions to the Executive Delivery Group for Quality.
DATE APPROVED	TBC
NEXT REVIEW DATE:	TBC

Aappendix 3 - Organisational Learning Forum (OLF)

Agenda

Monday 16th October 2023 at 2pm – 3:30 pm

Boardroom, Carlton Court/MS Teams

Ref	Title of item	Paper/verbal	Presented by	Attachment
	Welcome and introduction of members present	Verbal	Chair	
	Apologies: Mandy Jones, Chris Lynes	Verbal	Chair	
Agenda Items				
	Minutes from previous meeting	Verbal	Chair	2023-08-21 OLF Meeting - Minutes.
	Actions from previous meeting	Verbal	Chair	OLF Meeting - Action Log.docx
	Feedback from Inquests	Presentation	Rachel Bowen	
	SEIPs & 7 min briefing and evaluation YG pilot	Presentation	Ffion Pursglove	
	Draft Questions for Learning / Learning repository	Presentation	Reena Cartmell	
	Learning from Civility Matters	Verbal / Presentation	Sarah Musgrave	
	Mortality Themes	Verbal	Rachel Jones	Mortality Themes Report 2023 Final V

	Standing Agenda Items			
	Learning from IHCs / Divisions	Verbal	IHC Directors	
	Learning From Patient and Carer Experience Update	Verbal	Rachel Wright	
	Learning from Patient Safety Incidents	Verbal	Tracey Radcliffe	
	Learning from Mortality Reviews	Verbal	Damian McKeon / Rachel Jones	
	Learning from Professional Investigations Update	Verbal	Nursing / Medical / AHP	
	Learning from Inquests and Claims	Verbal	Debbie Kumwenda	
	Dissemination of Information Framework	Verbal		
	Any Other Business	Verbal	All	
Close 15:30				

Report title:	Nursing and Midwifery Council (NMC) Fitness to Practise (FtP) Annual Report April 2022 – March 2023
Report to:	Quality, Safety and Patient Experience Committee
Date of Meeting:	Friday, 27 October 2023
Executive Summary:	This paper provides a summary of Nursing and Midwifery regulatory activity for the past 12 months
Recommendations:	The Committee is asked to note the content of the report. The report has been presented at the Nursing Business meeting on 7th July 2023
Executive Lead:	Angela Wood, Executive Director of Nursing and Midwifery
Report Author:	Anne-Marie Rowlands, Director of Nursing Professional Regulation and Education

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

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*

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:
This paper provides a summary of key regulatory highlights with further detail contained below

Link to Strategic Objective(s):	People and Culture Quality and Safety
Regulatory and legal implications:	Nursing and Midwifery Order 2001 The Nursing and Midwifery Council (Emergency Procedures) (Amendment) Rules 2020 Order of Council 2020 The Nursing and Midwifery Council (Coronavirus) (Amendment) (No.2) Rules Order of Council 2020. NMC Code (2018)
Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)	Risk 3243: NMC Temporary CoVid register Risk will close on 30th September 2024 when the NMC Temporary Register closes
Financial implications as a result of implementing the recommendations	N/A
Workforce implications as a result of implementing the recommendations	Registrants are required to have an active NMC registration and are fit to practice (NMC

	Code (2018). Registration is also a requirement of their employment contract
Feedback, response, and follow up summary following consultation	N/A
Links to BAF risks: (or links to the Corporate Risk Register)	N/A
Reason for submission of report to confidential board (where relevant)	Not applicable
Next Steps: Note level of assurance through systems and processes in place within the health board	
List of Appendices: NMC Annual Report April 2022 to March 2023	

NMC Annual Report April 2022 to March 2023

This paper provides a summary of key health board regulatory activity for nurses and midwives.

1.0 Fitness to Practise (FtP)

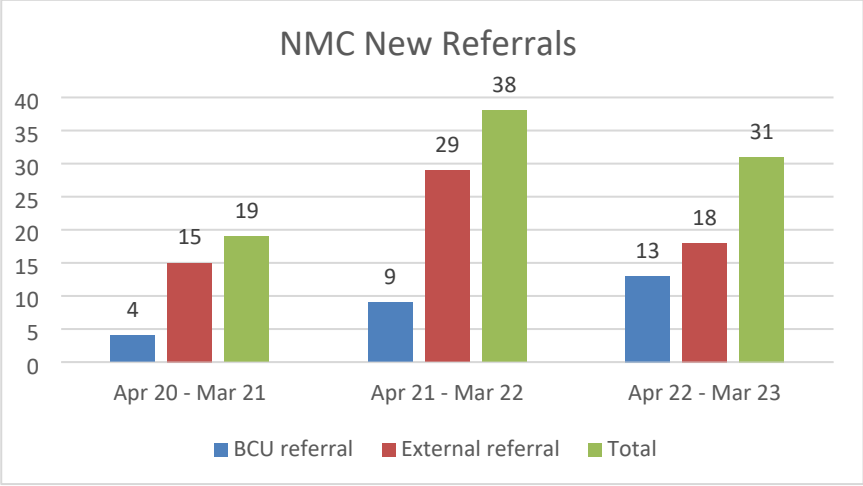
Safe and competent registered nurses and midwives is a requirement of the NMC Code, of which employers have duty to support registrant to improve practice, where safe and appropriate to do so. If practice cannot be resolved locally or concerns are sufficiently serious to require immediate regulatory action, the health board has a duty to inform the NMC who can take regulatory action to protect the public.

Within the health board all NMC regulatory matters are managed by the Director of Nursing Professional Regulation and Education as delegated by the Executive Director of Nursing and Midwifery. All employer referrals are discussed with the Executive Director of Nursing and Midwifery and subsequently the NMC Employer Link Service who advice on the appropriateness of referrals. The Health Board Referral of Registrants to the Nursing and Midwifery Council Standard Operating Procedure (NU18) has clear referral triggers to ensure all employer referrals are managed equitably and registrants with protected characteristics are not disproportionately referred to the NMC, which has been a trend nationally.

For all employees, People Services are involved and Safeguarding (as appropriate) with a risk assessment completed locally on support required for employee, and any restrictions necessary to safeguard registrants and patients whilst concerns are investigated.

1.1 NMC referrals

For the period April 2022 – March 2023 there were 31 new referrals as shown in the graph below. This represents a decrease on the previous 12 months



A review of the referral source, rationale for referral and NMC outcome (if known) is outlined in the table below.

Referral Source: Employer - Thirteen		
Referral Rationale	**BCU processes**	**NMC outcome**
Conduct (behaviour to patient and staff)	Concluded - dismissal	Interim suspension order. Referred to FtP Hearing
Conduct out of work (patient relationship)	Concluded – employed	Screening stage
Conduct in work (behaviour, medication errors)	Resigned before process concluded	Case with investigation team

Conduct in work (failure to escalate, medication errors)	Resigned before process concluded	Screening stage
Conduct in work (failure to escalate, medication errors	Resigned before process concluded	Interim conditions of practice. With Case Examiners
Conduct in work (falsification of documentation)	Concluded - dismissed	Interim conditions of practice. Screening stage
Conduct in work (behaviour to patient)	Resigned before process concluded	Closed – limited evidence available
Conduct in work (patient and staff)	Concluded - dismissed	Closed – no further action
Conduct in work (patient and staff)	Concluded – sanction	Screening stage
Conduct out of work (patient relationship)	Concluded - dismissal	Concluded – removed from register
Conduct in work (behaviour to patient)	Ongoing – risk assessment	Interim suspension order. Screening stage.
Conduct in work (behaviour to patient)	Concluded - dismissed	Closed – removed from NMC Temporary Register
Conduct in work (medication error)	Stopped from working	Closed (Interim suspension order in place, other employer)
Referral Source: Anonymous – Five		
Referral Rationale	**BCU processes**	**NMC outcome**
Conduct (health, medication and behaviour)	Ongoing – risk assessment	Screening stage
Conduct out of work (driving related)	Concluded - employed	Closed – no further action
Conduct in work (record keeping, medication errors	Concluded - employed	Closed – no further action
Conduct in and out of work (Behaviour to colleagues, driving related)	Concluded – employed	Closed – no further action
Conduct in work (Dishonesty and behaviour to colleagues)	Concluded - employed	Closed – no further action
Referral Source: Self - Five		
Referral Rationale	**BCU processes**	**NMC outcome**
Conduct out of work (personal life)	Ongoing – risk assessment	Screening stage
Conduct out of work (driving related)	Concluded - employed	Closed – no further action
Conduct out of work (driving related)	Concluded - employed	Screening stage
Conduct in work (substance related)	Concluded - resigned	Screening stage
Conduct out of work (patient relationship)	Concluded – employed	Closed – no further action
Referral Source: Other (Police, Colleague, Other Employer) - Five		
Referral Rationale	**BCU processes**	**NMC outcome**
Conduct out of work (driving related)	Ongoing – risk assessment -	Screening stage
Conduct out of work (substance related)	Ongoing – risk assessment	Screening
Conduct in work (dishonesty previous employment)	No longer employed	Investigation stage
Conduct in work (behaviour to colleague)	Concluded – employed	Screening stage

Conduct in work (behaviour to colleague)	Concluded – employed	Screening stage
Referral Source: Patient - Three		
Referral Rationale	**BCU processes**	**NMC outcome**
Conduct in work (patient care)	Concluded – sanction	Closed – no further action (links to open BCU referral)
Midwifery care	Risk assessment in place	Screening stage
Care of child	Not working as Registered nurse	Closed – no further action

1.3 NMC Investigation Processes

The NMC continue to work proactively to reduce their FTP caseload. The Director of Nursing Professional Regulation and Education meets regularly with the Regulation Adviser (Wales) to review NMC referrals, discuss progress and raise any concerns. The NMC view the health board as proactive in seeking NMC advice and responsive to NMC information submission deadlines.

Currently there are twenty-four referrals that remain open within NMC processes with a referral date prior to April 2022. The Health Board has submitted all requested information to assist the NMC with fulfilling their statutory obligations in investigating the alleged concerns. The delays are due to the significant length of time NMC investigations take to conclude.

The NMC referrals include ten health board referrals, twelve external referrals and two self-referrals (in line with registrants' duty to declare under the NMC Code).

The cases are at the following stages within the NMC processes:

- Thirteen cases at Screening stage,
- Three cases at Investigation stage,
- Two cases confirmed a case to answer and awaiting Fitness to Practise (FTP) Committee,
- Four cases confirmed a case to answer and pending FTP Hearing date or FTP Hearing date confirmed.

1.4 NMC referral Trends

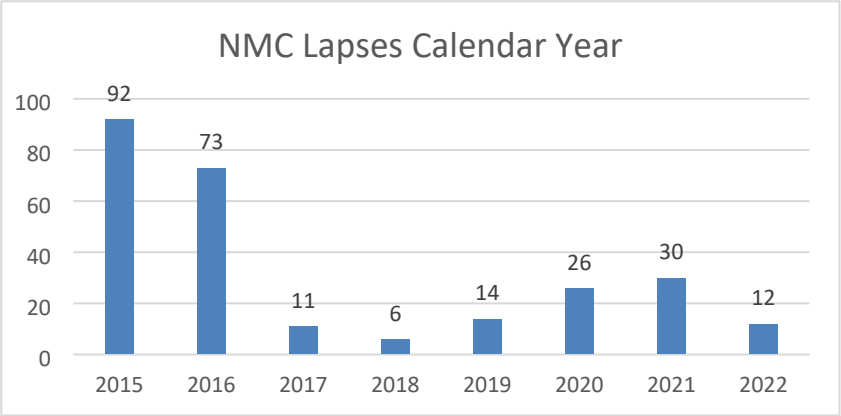
NMC data United Kingdom wide, indicates that member of the public, employer and anonymous referrals are the top three referral sources of which health board referral trends are similar. In relation to comparison across Wales the health board do not hold this data, nor is it held nationally within Wales. The NMC have advised that is difficult to draw direct comparison due to the variance in size of the nursing and midwifery workforce and some of the FtP referrals may sit with health boards and relate to registrants not employed by these health boards (e.g., registrants employed by an agency).

2.0 Registration and Revalidation

There are a number of corporate systems in operation to provide increased assurance that NMC expiry dates are known and acted upon. These include registrant and manager ESR notifications and People Services data cleanse of NMC expiry dates. Corporate Nursing monthly notifications to Directors of Nursing and Heads of Service has been in place since 2017, with the evident reduction in lapses as a result.

2.1 NMC lapses

NMC lapses are shown by calendar year below:



A root cause analysis is requested for all lapses so that trends and learning can be identified and action taken to address. Reasons remain the same as in previous years

- Revalidation - failure to complete in time, despite support
- Direct debit failure, error by registrant with renewal dates
- Bank worker inactive but not removed from Temporary Staffing system.
- Voluntary lapse due to pending retirement

2.2 NMC Temporary Register

The NMC temporary register remains open until September 2024. The NMC applied changes to the register in March 2023, with the requirement that registrants must undertake appropriate training and continuing professional development to practise safely and effectively. A review of Electronic Staff Record was completed in March 2023 and a total of seven employees noted to be on the temporary register. Three no longer working, one works in an HCA role, one successfully returned to full NMC registration and two working in BCUHB still on temporary register. The temporary staffing team have submitted leavers for those staff no longer actively working

3.0 Learning

Learning from Professional concerns is an agenda item on the Organisational Learning Forum and work is underway to triangulate and learn from employee relations, safeguarding and professional concerns.

Teitl adroddiad: ***Report title:***	Maternity and Neonatal Safety Support Programme (MatNeoSSP) Update			
Adrodd i: ***Report to:***	Quality, Safety and Experience Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Friday, 27 October 2023			
Crynodeb Gweithredol: ***Executive Summary:***	The purpose of the report is to provide an update of the MatNeo SSP programme in Wales, a summary of the Discovery Phase Report, including the identified 134 priorities for action and the local Maternity and Neonatal Service position against these actions.			
Argymhellion: ***Recommendations:***	The Committee is requested to note the content of the report and the recommended priorities for action and the local actions taken to date. The Committee is requested to note that the short term actions, as defined within the report, will inform the Maternity and Neonatal service annual planning for 24/25.			
Arweinydd Gweithredol: ***Executive Lead:***	Angela Wood, Executive Director of Nursing and Midwifery			
Awdur yr Adroddiad: ***Report Author:***	Emma Adamson, Consultant Midwife			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☒	Am sicrwydd *For Assurance* ☐	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Quality & Safety Framework – Welsh Government			
Goblygiadau rheoleiddio a lleol:				

Regulatory and legal implications:	
Yn unol â WP7 (sydd bellach yn cynnwys WP68), a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 (which now incorporates WP68) has an EqlA been identified as necessary and undertaken ?***	Naddo *N* An EQIA will be completed for the implementations of the recommendations made for services in the MatNeoSSP Discovery Phase Report, which will inform the Service's Prioritised Annual Plan for 2024-2025
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***	A number of the priorities for action have associated financial implications, however awaiting confirmation from Welsh Government regarding funding sources/streams
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	A number of the priorities for action have associated workforce implications, however awaiting confirmation from Welsh Government regarding funding sources/streams
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
Next Steps: ***Implementation of recommendations***	
Rhestr o Atodiadau: ***List of Appendices:*** MatNeoSSP Discovery Phase Report	

MatNeo Safety Support Programme Update – October 2023

1. Introduction

A MatNeo Safety Support Programme (SSP) update has been submitted to the Committee for consideration as a standing agenda item as recommended in the Discovery Phase Report and as detailed in the actions contained within Priority 1.1:

> *'Ensure Executive Board members and senior leaders are visible to, and have visibility of, maternity and neonatal services'*

a) Ensure maternity and neonatal services are a standing agenda item at all Health Board Quality and Safety Meetings.
b) Ensuring discussion of themes, learning and action resulting from reported incidents,
c) and review of the standardised perinatal quality surveillance dashboard

2. Background

The introduction of the MatNeo Safety Support Programme was instigated by Welsh Government (WG) in January 2022, who commissioned Improvement Cymru to undertake a Discovery Phase Report in response to Action 6 of Welsh Governments Quality & Safety Framework, with the aim of leading an

'All-Wales improvement approach & maximizing the opportunity for learning from independent reviews of maternity & neonatal services to improve outcomes for women, babies & their families in Wales.'

The Discovery Phase of the work was conducted from December 2022 to February 2023 and explored the landscape of maternity and neonatal services in Wales, including detailed views of work culture, leadership and learning alongside workforce and clinical outcome measures.

During the Discovery Phase, the team considered:

- Care pathways for women throughout the pregnancy and neonatal care journey, where this was needed
- How these care pathways worked within and between maternity and neonatal services
- Evidence of good and innovative practice which could be shared
- Areas for improvement, both locally and nationally

This approach of looking at maternity and neonatal services together, is unique but essential as these services are inextricably linked. Close collaboration and partnership working is necessary to create and sustain the conditions for care excellence.

The project considered services related to antenatal care, birth, postnatal care, and neonatal care. This scope has also meant the team have considered the health of women before they became pregnant and wider socio-economic factors, which have an influence on the care and services needed for women and babies.

To meet the objectives of the programme, Improvement Cymru elected to use three tools which, when combined, provide the clearest overview of the culture of safety.

The 3-step model for this discovery work can be summarised as:

Stage 1 – looking at services through the lens of the 'Framework for Safe, Reliable and Effective Care', published by the Institute for Healthcare Improvement. This provided an understanding of the culture of patient safety within organisations by considering the dimensions which can best promote and embed a culture of patient safety

Stage 2 – a 'trigger tool' methodology to quantify and measure instances of good, reliable practice, as well as to identify variation or deficits which could lead to harm

Stage 3 – site visits to all Health Boards and WAST to triangulate information obtained from the framework and trigger tool, alongside meeting teams, executive and local leads. The data from these tools was analysed to derive the priorities for action for a national improvement programme as part of the second phase of this programme

The findings are structured around the five principles of maternity care set out in the Welsh Government's Maternity Care in Wales: a five-year vision for the future (2019-2024), which have been adapted to include neonatal care.

The overall vision set out by Welsh Government is that: "Pregnancy and childbirth are a safe and positive experience, and parents are supported to give their child the best start in life." The vision document states that, "High performing multi-professional teams will deliver family centred care within Health Boards which display strong leadership within a culture of research and development, continuous learning, best practice and innovation."

The five principles of maternity care designed to achieve the vision are: *family centred care*; *safe and effective care*; *continuity of carer*; *skilled multi-professional teams*; and *sustainable quality services*. These principles have been used within the Discovery Phase Report to structure the findings, exploring each one in the context of maternity and neonatal services and to headline priorities for action.

The findings of the Discovery Phase were published in July 2023 (Appendix 1)

3. The MatNeo Safety Support Programme Discovery Phase Report and Findings

3.1 Priorities for Action

A total of 16 headlines were featured in the report, each containing a number of priorities and subsequent actions.

Headlines	Priorities	Actions
1. Leadership and Team Working	3	7
2. Workforce	4	13
3. Education and Training	4	4
4. Research	1	3
5. Pre-pregnancy and Pregnancy Care	3	12
6. High Quality Care in All Midwifery Led Settings	3	4
7. Keeping Families Together and Providing Support	5	13

8. Optimising Breastfeeding	5	7
9. Transitional Care	1	2
10. Continuity of Carer	2	3
11. Patient Safety and Governance	12	34
12. Improving Clinical Standards and Outcomes	3	12
13. Bereavement Care	3	7
14. Planning Maternity Services	2	2
15. Planning Neonatal Services	6	7
16. In-utero Transfers and Neonatal Transport	2	4

A total of **134** actions were identified for implementation at local or national or both, with suggested timescales of **short term** (6 – 12 months), **medium term** (1 – 2 years) and **long term** (up to 3 years), each with suggested resources implications.
An initial mapping exercise of these identified actions against current BCUHB Maternity and Neonatal Service position demonstrated the following:

Local Maternity Service Actions			
	SHORT TERM (6 – 12 months)	MEDIUM TERM (1 – 2 years)	LONG TERM (up to 3 years)
GREEN	14	23	0
AMBER	7	7	2
RED	10	5	0

Local Neonatal Service Actions			
	SHORT TERM (6 – 12 months)	MEDIUM TERM (1 – 2 years)	LONG TERM (up to 3 years)
GREEN	2 (2)	5 (5)	0
AMBER	2 (4)	(7)	2 (3)
RED	2 (12)	9 (10)	2 (3)

Priorities for Action are monitored via a master tracker and progress on actions are monitored and reported quarterly via Women's Service Board. Please see summary at Appendix 2

4. Next Steps

Following the publication of the Discovery Phase Report, WG requested comments from health boards regarding proposed timescales, repsonsibility allocation and suggested resource implications. A joint response was submitted by BCUHB Maternity and Neonatal Services on the 21st August 2023. It is anticipated that this may result in some of the parameters being revised, however there has been no further update from WG to date.

Whilst awaiting a steer from WG, BCUHB Maternity and Neonatal Services have idenified some actions identified for early adoption and implementation with minimal resource required, which would result in an immediate impact.
These include:

- the addition of the MatNeo SSP as a standing agenda item at the health board QSE Committee, to ensure consideration of the broader health board impact, at board level;
- the identification of 'Speak Up Safely' Champions in all areas to support psychological safety and promote a learning culture:
- review of the current homebirth service provision in BCUHB, which has resulted the development of an action plan and the move towards reinstating of the active offer of homebirth

Local MatNeo SSP Safety Local Safety Champion Roles have been extended to March 2023. The local champions, in Maternity and Neonatal services, are working on local quality improvement projects in line with those identified as potential spread and scale opportunities from the National

Learning Event held in April 2023, and these are included as areas for priority in the report. The Champions are planning to present and update on the Maternity and Neonatal Safety Support Programme at the BCUHB Perinatal Conference in November 2023

In addition, 30 of the actions recommended by the Discovery Phase Report have been included in the Women's Service Annual Plan for 24/25, with consideration given to associated capital estates, workforce and financial requirements.

The NHS Executive will be leading on Phase 2 of the Maternity and Neonatal Safety Support Programme and planning for this is underway, with the expectation that from April 2024 there will be a three year proposed programme of work. The aim of the work undertaken during this phase will deliver improvement and sustainable change within Maternity and Neonatal Services in Wales, with a focus on patient safety and culture.

5. Budgetary / Financial Implications

Within the Discovery Phase Report each action is stated as either 'resource needed' or 'minimal resource.' Comments were submitted by BCUHB Maternity and Neonatal services challenging the suggested resource requirement of a number of actions and as previously mentioned, a response from WG is anticipated.

6. Risk Management

There is one risk on the Women's Service Risk Register linked to the MatNeo Safety Support Programme – ID 4490 Temporary Suspension of Homebirth Service Provision; however this has been patially mitigated by ongoing review of local and national position, careful care planning for those women who make an informed decision to give birth at home during the suspension and the development and delivery of a Community Midwifery Homebirth Reimplementation Support Plan.

7. Recommendations

The Committee is requested to note the context of the update and the following actions:

- Actions recommended by the Discovery Phase Report will be included in the Women's Service Annual Plan for 24/25, with consideration given to associated capital estates, workforce and financial requirements
- IHCs will consider the MatNeoSSP Discovery Phase Report and Priorities for Action relating to Neonatal Services, as part of their Annual Plans for 2024-2025

The Committee are requested to agree to support the actions contained within Priority 1.1 of the overall report, ensuring Executive Board members and senior leaders are visible to, and have visibility of, maternity and neonatal services, by:

d) Ensuring maternity and neonatal services are a standing agenda item at all Health Board Quality and Safety Meetings.
e) Ensuring discussion of themes, learning and action resulting from reported incidents,
f) and reviewing the standardised perinatal quality surveillance dashboard

Appendices

1. MatNeo Safety Support Programme Discovery Phase Report, July 2023

MatNeoSSP Cymru Discovery Phase Repc

2. *Summary of Short term Amber and Red Actions:*

PRIORITY	***ACTION(s)***	***RESOURCE***	***RAG RATING***	
			Maternity	***Neonatal***
1.1 Ensure Executive Board members and senior leaders are visible to, and have visibility of, maternity and neonatal services:	A. Ensure maternity and neonatal services are a standing agenda item at all Health Board Quality and Safety Meetings	Minimal		
	C. Implement quarterly standardised leadership walk-arounds	Minimal	-	
	D. All Health Boards to appoint and resource Obstetric and Neonatal Consultant Safety Leaders and a neonatal senior nurse to sit at a senior level within the organisation on Quality and Safety Boards and committees	Resource needed		
2.3 Local workforce planning and team structures ensure sufficient capacity and prudent use of skills for high quality care:	D. Health Boards to undertake annual working patterns survey to explore inefficiencies and use results to review system waste and ensure prudent deployment of all roles	Minimal	-	
	E. All NICus to have a Clinical Director/Lead or equivalent post with a minimum of two funded sessions to deliver against recommendations	Resource needed	-	
	F. All Maternity units to have a Clinical Director with sessional allocation in line with RCOG recommendations	Resource needed	-	
	G. All Health Boards must allocate adequate SPA time for consultants	Resource needed		-
2.4 Prioritise the wellbeing and safety of staff and patients through team culture and support mechanisms:	I. NHS Wales to ensure provision of psychological support, within each maternity department and neonatal unit for all maternity and neonatal staff	Resource needed		
	L. All maternity and neonatal units should appoint a Freedom to Speak Up Champion	Minimal		
	M. All maternity and neonatal units should implement an annual validated psychological safety survey	Minimal		
4.1 Establish & deliver a Maternity and Neonatal research strategy for Wales to improve both short term neonatal and longer	C.Ensure that members of the perinatal team who wish to be active researchers have support from their Clinical Leads/Directors with consideration of recognised research time in their job plans	Resource Needed		

term child and adult outcomes:				
5.2 Review access to maternity care for all women, regardless of ethnicity, geography or socio-economic status or other protected characteristic:	B. All Health Boards to: a. co-produce communications tailored for ethnic minority women in their communities, b. ensure rapid access to advice if women from an ethnic minority background are concerned about their health, c.and ensure all staff have a lower threshold to review, admit and consider multidisciplinary escalation in women from an ethnic minority background	Minimal		-
	C. Ethnicity must be accurately recorded at booking and data used to monitor outcomes for women of different ethnic origins	Minimal		-
	E. All women with limited English language skills should be provided with a co-produced, maternity access card to advise them on how/where to attend an obstetric unit in case of a concern	Minimal		-
	G. Maternity Voices Partnerships in each Health Board should consider becoming Maternity and Neonatal Voices Partnerships to reflect the common goals of both service	Minimal		
	H. Each Health Board should engage with their local Maternity Voices Partnership volunteers to create points of contact in harder to reach communities	Minimal		-
	I. Each Health Board to establish paid Chair & Deputy Chair Maternity Voices Partnership positions to embed co-production of services	Resource Needed		-
7.1 Families to be supported and enabled to stay together (where possible) when their baby requires support, investigation, or treatment:	D. Ensure adequate facilities and support provision for wider family members, e.g., playrooms and additional support for siblings	Resource Needed	-	
	G. Where possible transcutaneous bilirubinometers to be used in the community alongside awareness of challenges for diagnosis of jaundice in ethnic minority babies. Explore introduction of home phototherapy	Resource Needed		-
7.3 FiCare to be fully embedded in practice in all NHS Wales Neonatal Units:	J. FiCare resources to be allocated and training to be facilitated for all units	Minimal	-	
8.1 Ensure opportunities for breastfeeding are optimised for all women:	A. All neonatal units to employ at least one funded infant feeding lead post	Resource Needed	-	
	C. All neonatal units to record expressed breastmilk volumes	Minimal	-	
	D. Share findings/learning nationally and use data to inform quality	Minimal	-	

8.3 Ensure NHS Wales has an infant feeding educated workforce: 8.4 Ensure monitoring and evaluation of process and outcome indicators for successful breastfeeding:	E. All units alongside their Infant Feeding Leads to develop unit-level plans to maximise early colostrum and early breast pump	Resource Needed	-	
10.2 Maximise continual risk assessment throughout pregnancy to ensure women birth in their place of choice:	C. Health Boards to implement All Wales Midwifery-Led Care Guideline (6th Edition) guidance to ensure all women have the choice to birth in a Midwifery Led setting	Minimal		-
11.11 Ensure Executive Boards are aware of maternity & neonatal metrics, outcomes, safety and governance issues:	GG. All Health Boards to ensure recorded justification and decision making to support any local deviation from nationally agreed protocols/guidance/best practice	Minimal	-	
12.1 Optimise Maternity & Neonatal Outcomes:	A. Ensure that perinatal quality improvement is embedded and sustained as a cultural and behavioural norm throughout NHS Wales	Minimal		
	B. Ensure all instances where babies were not born in the right place (e.g., <32 weeks) are subject to robust local and national review	Minimal	-	
	C. All Health Boards to establish and sustain mechanisms for maternity and neonatal teams to work together across service boundaries	Minimal		
	I.All NHS Wales maternity and neonatal units to ensure that a designated Quality Improvement Midwife/Nurse and senior consultant	Resource Needed		
13.2 All maternity and neonatal units to ensure specialist bereavement posts are created/ sustained within workforce plans:	F. Health Boards to ensure each Neonatal unit has a named Bereavement Lead	Resource Needed	-	

Teitl adroddiad: ***Report title:***	Performance Report – Month 5, 2023/24
Adrodd i: ***Report to:***	Quality, Safety & Experience Committee
Dyddiad y Cyfarfod: ***Date of Meeting:***	Friday, 27 October 2023
Crynodeb Gweithredol: ***Executive Summary:***	This Report relates to the Month 5, 2023/24 This paper provides Committee members with an update of performance against the Health Board's Key Performance metrics, the key measures contained within the 2023/24 National Performance Framework and Welsh Government Ministerial Priority Measures under the Quadruple Aims set out in "A Healthier Wales". Key areas of improvement are identified with actions and mitigations being taken by operational teams detailed in the 'Exception Reports' contained within the Report. This narrative has been approved by the respective Executive Director. The key focus points in this report are: • Poor and deteriorating performance against the clinical coding within 1 month of discharge measure • Number of complaints open over 30 days • CAMHS and Neurodevelopment performance This will be the last presentation of the report in this format. The new Integrated Performance Report (IPR) designed in line with the newly agreed Integrated Performance Framework (IPF) will be presented at the next meeting on the 12th December 2023.
Argymhellion: ***Recommendations:***	The Committee is asked to: Review the contents of the report and confirm agreement to any actions proposed, or identify any additional assurance work or actions it would recommend Executive colleagues to undertake.
Arweinydd Gweithredol: ***Executive Lead:***	Russell Caldicott, Interim Executive Director of Finance and Performance
Awdur yr Adroddiad: ***Report Author:***	Ed Williams, Acting 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 2023-24.			
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	This report will be available to the public once published for the Quality, Safety & Experience Committee			
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 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? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	N The Report has not been assessed for its 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)	The pandemic has produced a number of risks to the delivery of care across the healthcare system			

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 delivery of the performance indicators contained within the annual plan will have direct and indirect impact on the financial recovery plan of the 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 contained within our annual plan will have direct and indirect impact on our current and future workforce.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	This report has been reviewed in parts (narratives) by senior leads across the Health Board and relevant Directors. And the full report has been reviewed by the report author.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	This QP report provides an opportunity for areas of under-performance to be identified and subsequent actions developed to make sustained improvement.
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 isn't of sufficient quality to believe performance is or will improve as described.	
Rhestr o Atodiadau: ***List of Appendices:*** *Quality and Performance Report in PowerPoint/ PDF*	

Integrated Performance Report

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

Performance to 31 August 2023
(Where published)

Presented on 27 October 2023

Quality, Safety and Experience

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Section 1

BCU Performance

Performance Framework KPI Summary

(published early June 2023 by WG)

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

BCU Performance Framework KPI Summary
(published position September 2023)

	No. measures where target has been achieved or the actions required are back on track	No. measures where the majority of actions required are on track but there is scope to improve	No. measures where the target has not been achieved or the actions required are not back on track and improvements are required	Target/ Compliance not currently available
Quadruple Aim 1: People in Wales have improved health and well being with better prevention and self management	3	0	5	2
Quadruple Aim 2: People in Wales have better quality and more accessible health and social care services, enabled by digital and supported by engagement	11	0	14	0
Quadruple Aim 3: The health and social care	2	0	2	0
	3	0	11	1
Summary	19	0	32	3

Section 2

NHS Wales Performance Framework Metrics

Quadruple Aims 1-4

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NHS Wales Performance Framework Metrics

(Latest data as published August 2023)

Quadruple Aim 1:
People in Wales have improved health and well-being with better prevention and self-management

Percentage uptake of the influenza vaccination amongst adults aged 65 years and over	Committee	Target		Sep-23	Oct-23	Nov-23	Dec-23		Compliance			Rank
	QSE		Actual									
			Trajectory									

Note: Data reflects the last week of each month. Applicable during: 01.09.2023 - 31.03.2024. Age range to be confirmed.

Percentage uptake of the COVID-19 vaccination for those eligible - spring booster	Committee	Target			Apr-23	May-23	Jun-23	Jul-23	Compliance			Rank
	QSE		Actual		14.3%	50.5%	68.9%	67.1%				3rd out of 7 health boards
			Trajectory									

Note: Data reflects the last week of each month. Applicable during: 01.04.2023 - 30.06.2023. Includes: aged 75 years & over; residents in care home for older adults and; immunosuppressed aged 5 years & over.

Percentage uptake of the COVID-19 vaccination for those eligible - autumn booster	Committee	Target		Sep-23	Oct-23	Nov-23	Dec-23		Compliance			Rank
	QSE		Actual									
			Trajectory									

Note: Data reflects the last week of each month. Applicable during: 01.09.2023 - 31.03.2024. Age range to be confirmed.

Percentage of patients offered an index colonoscopy procedure within 4 weeks of booking their Specialist Screening Practitioner assessment appointment	Committee	Target		Mar-23	Apr-23	May-23	Jun-23	Jul-23	Compliance	12 month trend		Rank
	QSE		Actual	19.4%	22.8%	15.5%	16.5%					1st out of 7 health boards
			Trajectory									

Percentage of well babies entering the new-born hearing screening programme who complete screening within 4 weeks	Committee	Target		Mar-23	Apr-23	May-23	Jun-23	Jul-23	Compliance	12 month trend		Rank
	QSE		Actual	97.1%	96.1%	98.1%	97.8%	95.8%				3rd out of 7 health boards
			Trajectory									

Percentage of eligible new-born babies who have a conclusive bloodspot screening result by day 17 of life	Committee	Target		Mar-23	Ap-23	May-23	Jun-23	Jul-23	Compliance	12 month trend		Rank
	QSE		Actual	97.2%	94.2%	96.4%	95.8%	95.7%				6th out of 7 health Boards
			Trajectory									

Percentage of adult smokers who make a quit attempt via smoking cessation services	Committee	Target	5%	Q4 21/22	Q4 22/23	Q1 23/24	Q2 23/24	Q3 23/24	Q4 23/24	Compliance	12mth Trend - Comparison with Same Period Previous Year	Rank
	QSE		Actual	4.43%	4.29%	1.4%						4th out of 7 health boards
			Trajectory									

Percentage of people who have been referred to health board services who have completed treatment for substance misuse (drugs or alcohol)	Committee	Target		Q4 21/22	Q1 22/23	Q2 22/23	Q3 22/23	Q4 22/23	Q1 23/24	Compliance	12mth Trend	Rank
	QSE		Actual	68.2%	64.9%	65.6%	67.4%	61.2%	63.9%			3rd out of 7 health boards
			Trajectory									

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)	Committee	Target	95%	Q4 21/22	Q1 22/23	Q2 22/23	Q3 22/23	Q4 22/23	Q1 23/24	Compliance	12mth Trend	Rank
	QSE		Actual	92.2%	92.0%	90.7%	91.2%	90.9%	92.6%			2nd out of 7 health boards
			Trajectory									

Percentage of girls receiving the Human Papillomavirus (HPV) vaccination by the age of 15	Committee	Target	95%	Q4 22/23	Q1 23/24	Q2 23/24	Q3 23/24	Q4 23/24	Q1 23/24	Compliance		Rank
	QSE		Actual		84.2%							5th out of 7 health boards
			Trajectory									

NHS Wales Performance Framework Metrics

(Latest data as published August 2023)

Quadruple Aim 2:
People in Wales have better quality and more accessible health and social care services, enabled by digital and supported by engagement

	Committee	Target		Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Compliance	12 month trend	Rank
Number of consultations delivered through the Pharmacist Independent Prescribing Service (PIPS)	PFIG	Increase	Actual	1,212	1,104	1,251	1,325	1,337				1st out of 7 health boards
			Trajectory									

	Committee	Target		Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Compliance	12 month trend	Rank
Percentage of mental health assessments undertaken within (up to and including) 28 days from the date of receipt of referral for people age under 18 years	PFIG	80%	Actual	61.1%	80.2%	66.2%	53.0%	58.3%				6th out of 7 health boards
			Trajectory									

Note: AB unable to submit since Aug-22, therefore Jul-22 data rolled over

	Committee	Target		Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Compliance	12 month trend	Rank
Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS for people age under 18 years	PFIG	80%	Actual	35.1%	54.4%	41.1%	44.1%	44.2%				5th out of 7 health boards
			Trajectory									

Note: AB unable to submit since Aug-22, therefore Jul-22 data rolled over. C&V are currently experiencing data quality issues with their MHM Part 1b da

	Committee	Target		Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Compliance	12 month trend	Rank
Percentage of mental health assessments undertaken within (up to and including) 28 days from the date of receipt of referral for adults age 18 years and over	PFIG	80%	Actual	74.9%	70.4%	77.6%	80.0%	83.9%				5th out of 7 health boards
			Trajectory									

	Committee	Target		Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Compliance	12 month trend	Rank
Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS for adults age 18 years and over	PFIG	80%	Actual	85.3%	86.3%	82.7%	82.2%	84.9%				5th out of 7 health boards
			Trajectory									

NHS Wales Performance Framework Metrics

(Latest data as published August 2023)

Quadruple Aim 4:
Wales has a higher value health and social care system that has demonstrated rapid improvement and innovation, enabled by data and focused on outcomes

	Committee	Target		Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Compliance	12 month trend	Rank
Percentage of episodes clinically coded within one reporting month post episode discharge end date	PFIG		Actual	70.5%	63.4%	61.3%	49.1%					8th out of 8 organisations
			Trajectory									

	Committee	Target		Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Compliance	12 month trend	Rank
Percentage of all classifications' coding errors corrected by the next monthly reporting submission following identification	PFIG		Actual		0.9%	6.1%	12.1%	0.8%				8th out of 8 organisations
			Trajectory									

	Committee	Target		Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Compliance	12 month trend	Rank
Percentage of health board residents in receipt of secondary mental health services who have a valid care and treatment plan for people aged under 18 years	PFIG		Actual	93.2%	93.6%	88.7%	89.2%	96.3%				4th out of 7 health boards
			Trajectory									

	Committee	Target		Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Compliance	12 month trend	Rank
Percentage of health board residents in receipt of secondary mental health services who have a valid care and treatment plan for adults 18 years and over	PFIG		Actual	85.1%	83.8%	85.0%	85.6%	84.7%				4th out of 7 health boards
			Trajectory									

	Committee	Target		Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Compliance	12 month trend	Rank
Number of patient experience surveys completed and recorded on CIVICA	QSE		Actual									
			Trajectory									

Note: Number of surveys completed and recorded varies between organisations due to the number of different surveys undertaken by each and the different survey methods e.g. SMS, QR code etc. New measure - data will be included in the next few months.

	Committee	Target		Mar-24	Apr-24	May-23	Jun-23	Jul-23	Aug-23	Compliance	12 month trend	Rank
Cumulative number of laboratory confirmed bacteraemia cases - Klebsiella sp	QSE		Actual	144	6	16	32	43	59			6th out of 6 health boards
			Trajectory									

Note: 12 month trend is based on the monthly number of cases. Data is provisional. Target is for achievement for Mar-24. Measure not applicable to Powys as HB has no acute hospitals.

	Committee	Target		Mar-24	Apr-24	May-23	Jun-23	Jul-23	Aug-23	Compliance	12 month trend	Rank
Cumulative number of laboratory confirmed bacteraemia cases - Aeruginosa	QSE		Actual	38	3	8	10	10	15			6th out of 6 health boards
			Trajectory									

Note: 12 month trend is based on the monthly number of cases. Data is provisional. Target is for achievement for Mar-24. Measure not applicable to Powys as HB has no acute hospitals.

	Committee	Target		Mar-24	Apr-24	May-23	Jun-23	Jul-23	Aug-23	Compliance	12 month trend	Rank
Cumulative rate of laboratory confirmed bacteraemia cases per 100,000 population - E-coli	QSE		Actual	73	61	66	71	73	73			3rd out of 6 health boards
			Trajectory									

NHS Wales Performance Framework Metrics

(Latest data as published August 2023)

Quadruple Aim 4:
Wales has a higher value health and social care system that has demonstrated rapid improvement and innovation, enabled by data and focused on outcomes

	Committee	Target		Mar-24	Apr-24	May-23	Jun-23	Jul-23	Aug-23	Compliance	12 month trend	Rank
Cumulative rate of laboratory confirmed bacteraemia cases per 100,000 population - S.aureus bacteraemia	QSE		20									
		Actual			26.02	22.18	25.16	23.46	23.13			2nd out of 6 health boards
		Trajectory										

Note: 12 month trend is based on the monthly cases per 100,000 of the population. Data is provisional. Target is for achievement for Mar-24. Measure not applicable to Powys as HB has no acute hospitals.

	Committee	Target		Mar-24	Apr-24	May-23	Jun-23	Jul-23	Aug-23	Compliance	12 month trend	Rank
Cumulative rate of laboratory confirmed bacteraemia cases per 100,000 population - C.difficile	QSE		25									
		Actual			41.63	41.80	40.03	39.67	37.07			4th out of 6 health boards
		Trajectory										

Note: 12 month trend is based on the monthly cases per 100,000 of the population. Data is provisional. Target is for achievement for Mar-24. Measure not applicable to Powys as HB has no acute hospitals.

	Committee	Target		Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Compliance	12 month trend	Rank
Percentage of confirmed COVID-19 cases within hospital which had a definite hospital onset (>14 days after admission)	QSE		Reduce									
		Actual		36.4%	37.7%	35.3%	38.5%	35.8%	37.9%			3rd out of 6 health boards
		Trajectory										

	Committee	Target		Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Compliance	12 month trend	Rank
Number of National Reportable Incidents that remain open 90 days or more	QSE		Reduce									
		Actual		37	35	33	34	24	18			6th out of 11 organisations
		Trajectory										

Section 3
Exception Reports

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Elective and Planned Care

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% of patients offered index Colonoscopy within 4 weeks of booking specialist screening Practitioner appt

Issues

As part of the bowel screening optimisation plan the number of lists required each week increases significantly over the next three years resulting in the need to increase capacity across the health board. From October 23, the age expansion (invite 51 to 54 year olds) and FIT positivity threshold reduction from 150ug/g to 120ug/g has come into force. See table below on required lists.
Capacity for the increase in these lists remains an issue across all sites.

Actions

Workforce has been expanded with the Specialist screening practitioners (SSPs), administration teams and two endoscopists.

Increase required in the number of lists running per week across the health board.

SBAR completed providing current position and possible further solutions.

Mitigations

- Temporary additional lists are taking place via the endoscopy insourcing companies.

Betsi Cadwaladr UHB					
	Year 3 *Oct 23 to Sept 24*	Year 4 *Oct 24 to Sept 25*	Year 5 *Oct 25 to Sept 26*	Oct 26 to Sept 27	Oct 27 to Sept 28
Index procedures	1,504	2,300	2,300	2,300	2,300
Repeat procedures	356	545	545	545	545
Surveillance procedures	99	157	156	241	368
Total Procedures	**1,959**	**3,002**	**3,001**	**3,086**	**3,213**
*Lists per week	12	18	18	19	20

Site	Total number of patients	Total wait - within 28 days	Under 28 days from 1st apt to offered procedure date		%	%
YG	40	10	13		25.00%	32.50%
YGC	31	7	13		22.58%	41.94%
WXM	43	13	25		30.23%	58.14%
Total	**114**	**30**	**51**		**26.32%**	**44.74%**

Adult Mental Health Services

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University Health Board

What the data tells us

- There has been a month on month sustained improvement from January 2023 to June 2023 in percentage rate of patients being assessed within 28 days of referral to Adult mental health services culminating in achievement of the 80% target for the first time in over 12 months.
- Whilst the percentage rate of patients commencing therapeutic interventions within 28 days of assessment remains above the 80% target, it should be noted that there has been a fall from 86% in April 2023 to 82.7% and 82.1% in May and June 2023 respectively. Without mitigation, continuing on this trajectory could result in a breach of the 80% target in the autumn.

Issues

Performance has further improved in July increasing to 83.95% against part 1a and 84.8% against part 1b of the Mental Health Measure (MHM), exceeding the 80% compliance target. Three out of six areas (Conwy, Flintshire & Wrexham) are now reporting as compliant against both parts of MHM part 1, demonstrating reduction in the waiting list with each reporting single figures waiting over 28 days at the end of July. We are not yet fully compliant for MHM Part 2 but performance has steadily increased to 84.68% against a 90% target.

Actions

Staffing pressures remain a primary factor in our ability to attain compliance, with particular challenges in Ynys Mon and Denbighshire areas. Recruitment to full establishment within our Local Primary Mental Health Support Services (LPMHSS) will support improved delivery against the measure and also support the pace and progress of the work underway through our Adult Community Pathway Transformation Group. The implementation of the new Service Operating Procedure detailing the Delivery of Core Community Mental Health Services for Adults in North Wales will also support.

Mitigations

We remain focused on our waiting list reduction and continue to routinely monitor referrals against staffing availability. We have seen a month on month increase in referrals since the start of the year. We are improving overall waiting list management with proportionate activity against long waiters and new referrals, whilst maintaining safe practice around clinical prioritisation and regular contact with patients on the waiting list. Work to improve the recording of Care and Treatment Plans (CTP), part 2 of the MHM, continues. We have been successful in attracting Service improvement Funding to support the development of community crisis care within Community Mental Health Teams (CMHT's) which is currently being managed by care co-ordinators. This will release capacity of the CMHT service delivery to enable care co-ordinators to focus on ensuring CTPs are undertaken and recorded.

% people referred to HB services who have completed treatment for substance misuse (drugs or alcohol)

Issues

We are pleased to report that 4 out of 6 areas are achieving 100% compliance as at August 2023. There has been a slight deterioration on the previous month for Conwy and Flintshire for the percentage of people referred to HB services who have completed treatment for substance misuse. Conwy and Flintshire were both reporting at 100% in the previous month and performance and compliance are routinely high across all teams and any areas of non-compliance are analysed to be understood.
In Flintshire there have been a high number of deaths which are recorded as a negative outcome, this is going through review and no correlation or service delivery issues noted.
For Conwy we noted that the number of patients who did not attend were higher than the month previous. This has been investigated and established as incorrect coding.

Actions

Issues that have impacted the Conwy data are being reviewed and service level discussions and actions in place to ensure that correct closure reasons (coding) is applied and reflects the service level delivery accurately.

Issues that have impacted Flintshire compliance have been reviewed to understand cause and correlation to service delivery. There has been a thematic review of deaths which is reported through to our Putting things Right (PTR) forum.

Mitigations

We have a dedicated performance business support manager who provides reports and analyses our position against all the national Substance Misuse performance indicators. This is routinely monitored by the individual team managers and discussed at service level. This is reported up to and discussed at divisional level and we also do comparative analysis against other non-health board Substance Misuses Services. In this comparison we are generally in a very favourable positions, currently green against others providers who at the end of August are red.

Through analysis the Business support Manager will highlight any areas for improvement and this is discussed with team leaders for investigation and action. We have a robust process in place where new clinical and non-clinical staff are trained in the appropriate knowledge for service delivery, recording and reporting against the KPIs.

Child and Adolescent Mental Health Services (CAMHS)

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Children & Adolescent Mental Health Service

What the data tells us

There has been a significant reduction in performance against the number of children being assessed within 28 days of referral to the Children & Adolescent Mental Health service (CAMHS) since April 2023 at 80.1% to 52.9% reported for June 2023.
Whilst the percentage rate of children commencing therapeutic interventions within 28 days of assessment, at 44% shows improvement compared to May 2023 at 41.4%, it should be noted that there has been a fall from 54.4% in April 2023.
However, performance against both metrics is significantly (twice as good) as it was for the same period in 2022.

Issues

- MHM Part 1 regional delivery at 58% reported in July, below forecast delivery of 80% compliance, impact seen due to activity undertaken related to backlog of patients waiting over 28 days.
- Risk to commissioning additional specialist therapists to support ongoing improved Part 1b delivery
- Workforce remains unstable across Central and East with vacancy factor of 30% impacting on capacity for assessment and therapy

Actions

- Internal and external provider activity monitored against agreed trajectories in each IHC.
- IHC recovery plans under development to deliver part 1a in line with submitted trajectories and with a view to implementing improvement on part 1b trajectory by way of stretch targets
- Exploration of additional requirements by IHC to deliver gaps in capacity to support reduction in therapy backlog waiting lists.

Mitigations

- Utilisation of robust forecasting tool to so support corrective actions on a weekly basis across IHCs
- Workforce stabilisation plan under development through transformation programme
- Weekly regional monitoring by regional Senior Children's Services Leads to review performance position and monitor progress against Special Measures programme and milestones achievement against 90 day plan.

Neurodevelopment

What the data tells us

Whilst performance remains well below the 80% target rate for the number of children and young people waiting less than 26 weeks to start an ADHD or ASD neurodevelopment assessment there has been a small but continuous improvement since April 2023 (37%) and June 2023 at 39%.
Statistically however, performance against this measure remains largely unchanged in the 12 months from July 2022 to June 2023.

Issues

- 39% of children waiting within target in June 23; increasing waiting list and demand, limited internal capacity and the absence of any external provision. Currently slightly off target in terms of internally agreed trajectories (July 23), this should be recoverable in the coming months. *some internal capacity was used due to previous external contract issues.
- Performance/waiting list position is anticipated to continue to decline, this also reflects the All Wales position.
- Tender process for external supplier is taking longer than anticipated, and will not meet Demand & Capacity Gap/address the waiting list backlog
- Service model no longer fit for purpose, requires significant financial/ resource investment going forward. BCU improvement funding to support development of improvement plan now available

Actions

- Monthly reporting and monitoring mechanisms in place against agreed trajectory
- As part of Special Measures reporting, ND plan on a page and Programme of work has been agreed, escalated concerns re: release of BCU improvement funding delaying recruitment of key posts to undertake this work. Milestones for the second cycle have now been agreed.
- Working with informatics colleagues to enhance ND monthly reporting/development of a forecasting tool
- WG funding (until march 25) relating to the WG ND Improvement Programme, for piloting new ways of working has been agreed and will be taken forward over the coming months

Mitigations

- Tender process, for external/additional capacity underway and supported by procurement
- Improvement of data/performance forecasting.
- Weekly regional monitoring by regional Senior Children's Services Leads to review performance position and monitor progress against Special Measures programme and milestones achievement against 90 day plan.
- Demand and Capacity review undertaken by NHS executives, report due in September.
- Continued work with WG ND Improvement Programme, to aid the development of a regional service model

Quality

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Issues

A total of 2 Never Events have been reported since April 2023.
Key reporting theme is surgical safety
Key issues include:

- Utilisation of pre-procedure checklist
- Monitoring and updating of Local Safety Standards for Invasive Procedures (LocSSIPs)
- Utilisation of LocSSIPs in practice

Actions

- Review of Local Safety Standards for Invasive Procedures (LocSSIPs) library
- Each IHC/Division to provide a position report to SCEG
- All incidents reported are impartially investigated

Mitigations

- LocSSIP library has been developed and available on the intranet
- Both LocSSIPs and NatSSIP2 are utilised in many departments
- List of procedures undertaken outside of theatres is available to steer oversight of LocSSIP requirement from departments

Complaints open over 30 days

Issues

- The number of overdue investigations remain a challenge. There has been a reduction from 359 overdue investigations as of January 2023 to 269 (current position).
- Improvement in the reduction in the number of complaints has remained invariable over quarter 2 due to the number of complaints tripping overdue.

Actions

- Early intervention by working with services to promote local complaint resolution to prevent Early Resolutions becoming Managed under PTR.
- Use of pro-active alerts to ensure clinical services are sighted on complaint timescales and concerns which will become overdue.
- Targeted intervention with services who have the highest numbers of concerns and PALS enquiries to improve the patient experience to prevent complaints.

Mitigations

Weekly Complaints Scrutiny Meeting with IHC and Specialist Services Leads to review complaints most overdue including those tripping over to becoming overdue in the next week. Weekly review of low level complaints received during the previous week with the objective of closing the complaints at the earliest opportunity. Weekly Harm Free Care Forum to discuss the Grade 4's & 5 complaints for early intervention and assurance. Quarterly Data Submission to the NHS Executive which is scrutinised by the Welsh Risk Pool prior to submission to ensure data validation and robust complaint management.

Number of National Reportable incidents that remain open 90 days or more

Issues

- 94 NRI's have been reported to the NHS Wales Executive from April 2023
- There are currently 28 overdue NRI's.
- Top 3 incident type reported April 2022 to present:
  - Pressure damage
  - Patient falls
  - Assessment, investigation and diagnosis

Actions

- The Head of Patient Safety supports teams at the BCU concerns and incidents improvement meeting on weekly basis to provide support to the IHC/service Nurse Directors.
- Patient Safety Team support the Completion of Notifications, Combination, and Closure forms to ensure the correct information is captured for assurance to the NHS Executive.

Mitigations

- Weekly meeting with Deputy Executive Director of Nursing to monitor progress and provide support to services where required.
- Daily sense checking of reported incidents which require NRI. Daily sever and catastrophic call with service Governance teams.
- Executive approval of NRI submissions to NHS Executive.

Number of patient experience surveys completed and recorded on CIVICA

Issues

- From 1st April 2023 – 30th September 2023, 18,984 feedback responses were completed pan BCUHB. This is a significant increase due to the implementation of the SMS feedback survey launched in June.
- Satisfaction levels have increased; 78% of survey respondents felt their overall experience of BCUHB services was very good; 82% of respondents felt always listened to, with a further 82% of respondents feeling that staff always took the time to understand what matters to them as a person and took account of this when planning and delivering care.
- Limited experiences (4%) shared from relatives and carers.
- All Wales Emergency Department (ED) survey adopted across BCUHB 1st September 2023 - response rates remain low with only 27 surveys.

Actions

- Patient and Carer Experience Team to work with Integrated Health Communities, specialist services and third sector groups to encourage feedback from carers/relatives.
- The Patient and Carer Experience Team to work with EDs to promote the new All Wales Emergency Department survey.
- Developing a phased approach ensuring all services utilising Civica and guidance on analysing feedback.

Mitigations

- Attendance at All Wales Civica System Leads meeting ensuring involvement of system improvements and sharing of good practice.
- Developing a BCUHB Civica Task Group focusing upon utilisation of feedback data to improve Health Board services and visibility of Civica feedback system.
- Support the facilitation of capturing feedback from patients, relatives and carers across BCUHB by installation of Civica feedback kiosks across community, acute and departmental waiting areas including Emergency Departments.

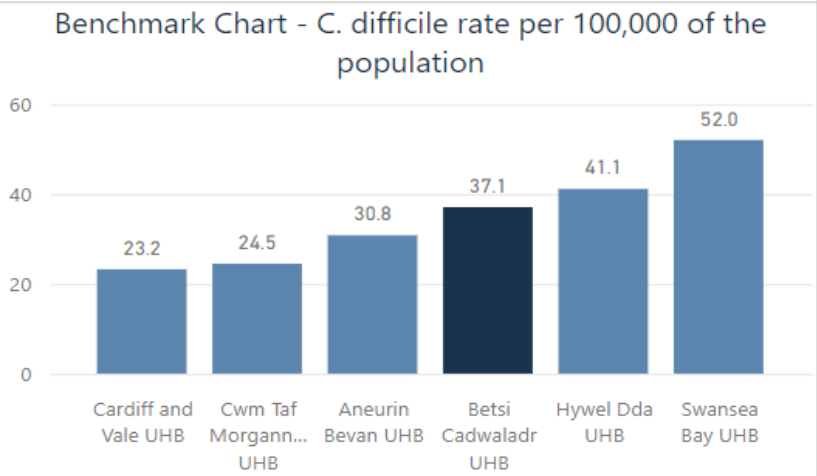
Prevention and Screening

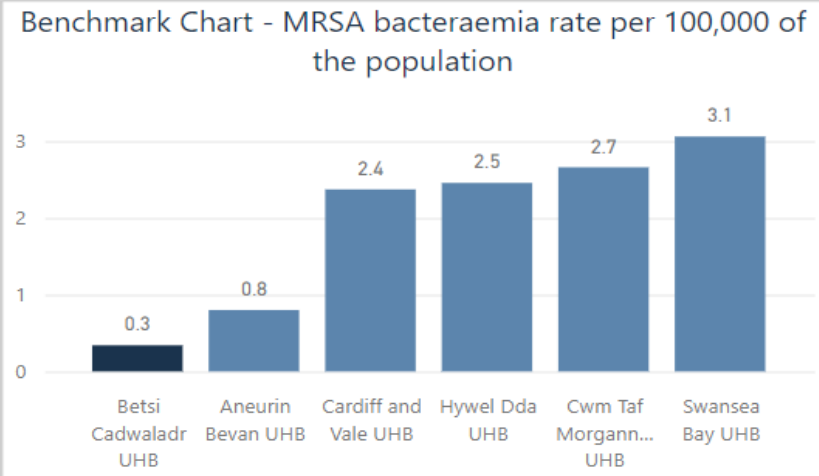
Klebsiella sp, Pseudomonas aeruginosa, E-coli, S.aureus bacteraemias (MRSA and MSSA), C.difficile

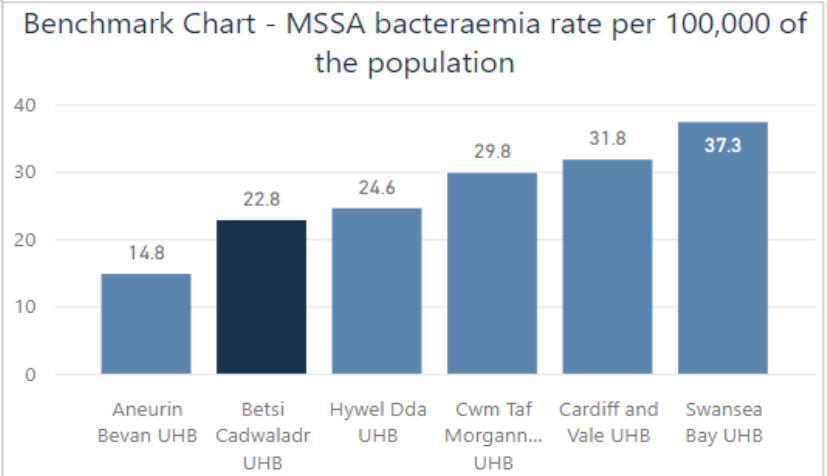
MMM-YY

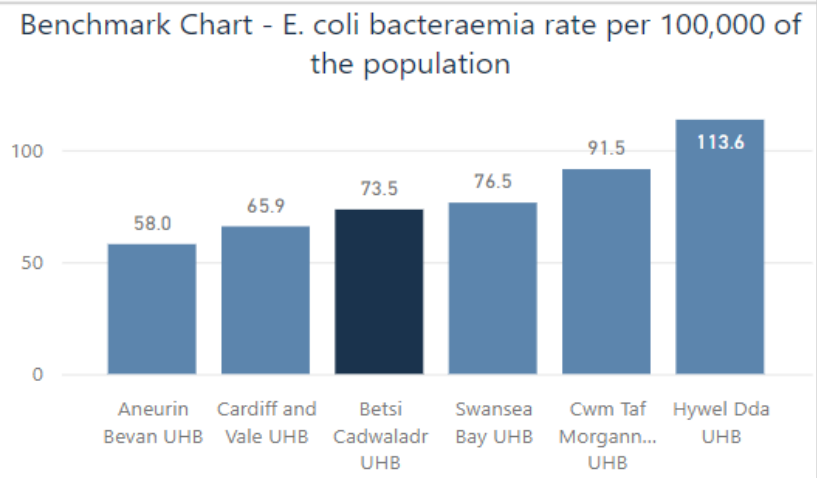
All

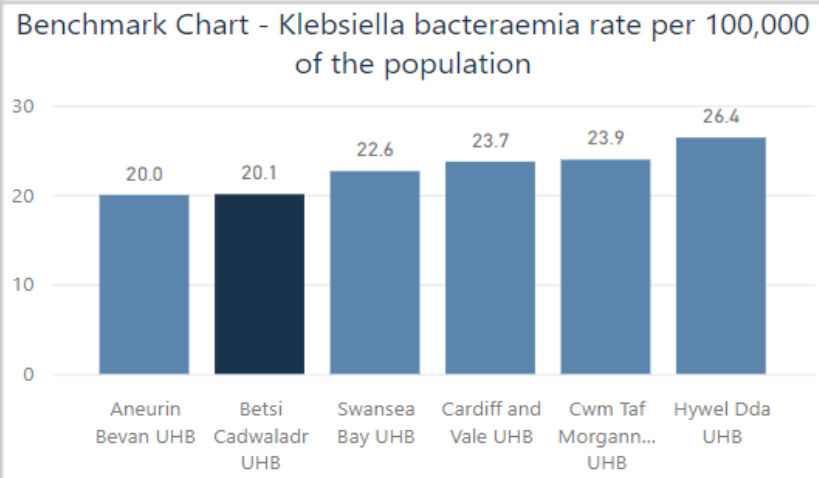
The charts below are set by default to show data for the year to date
To view data for a specific month, pick that period from the drop down list to the left

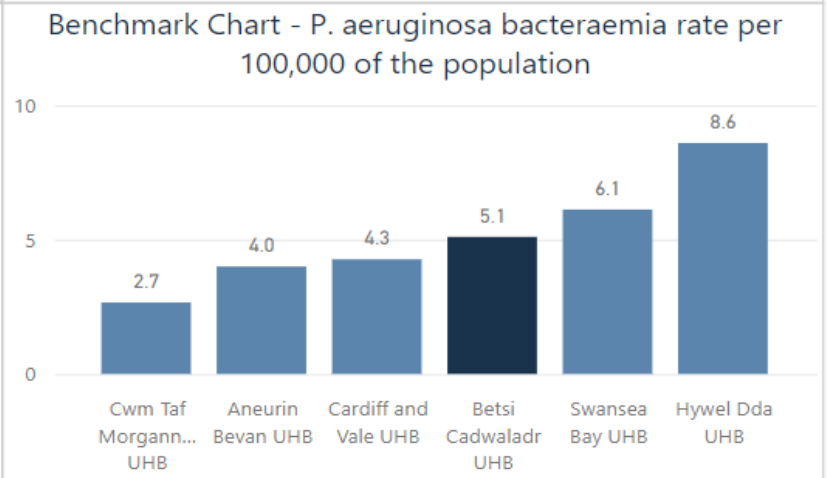












Klebsiella sp, Pseudomonas aeruginosa, E-coli, S.aureus bacteraemias (MRSA and MSSA), C.difficile

Issues

- BCUHB are currently above trajectory for all six mandatory healthcare associated infections (HCAI).
- However, in comparison with other Welsh Health Boards, BCUHB are 1st for MRSA bacteraemia, 2nd for MSSA and *Klebsiella,* 3rd for *E.coli* and 4th for *P. aeruginosa* and *C.difficile* and rates for *C.difficile* and MRSA bacteraemia are lower than in 2022/23.
- BCUHB, especially Wrexham Maelor, have high rates of antimicrobial resistance (AMR) in *E.coli* bacteraemia isolates; many of the gram negative infections are associated with urinary catheters.

Actions

- An IPC Conference was held on 4th October 2023 with a 'Back to Basics' theme and attended by over 100 clinical staff from across BCUHB. Further materials, posters and communications are planned to involve all staff, patients and visitors at BCUHB.
- In relation to AMR, BCUHB is working to strengthen all Infection Prevention and Control (IPC) measures to reduce spread, use Antibiotic Stewardship to reduce selection for these clones and conduct further investigation and monitoring of cases to better understand spread and evaluate control measures.
- A detailed SBAR and action plan has been drafted and a multi-disciplinary working group established to drive forward the measures required.
- An audit of urinary catheter care took place earlier this year to identify the specific areas for improvement and the current IPC campaign is focussed on urinary catheter management.

Mitigations

- Acute sites have a reactive and proactive programme to carry out a High level disinfection of inpatient areas. Enhanced cleaning levels are requested where there are patients with infections.
- When a new HCAI is identified, the IP team check antibiotic resistance levels to identify multi-drug resistance. Inpatients with a multidrug resistant (MDR) strain are prioritised for isolation in side rooms.
- Following identification of HCAIs, BCUHB complete a Patient Infection Review (PIR) and a multi-disciplinary team meeting is rapidly convened to undertake a full review of the case and identify any lessons to learn and prevent reoccurrence. Key information from each case is also collated onto a separate database enabling it to be interrogated to identify key themes and areas for focus. Each of the three healthcare communities select two cases to present to the monthly Corporate HCAI Review meetings for wider learning across the organisation.
- Regular audits of IPC practices including hand hygiene, personal protective equipment and cleanliness of mattresses and commodes are carried out to ensure standards are being adhered to and where there could be improvements.

% of confirmed COVID cases within hospital which had a definite hospital onset of COVID

Issues

- In line with an increase in COVID positive cases in the community, the numbers of inpatients with COVID that were classed as 'definite hospital onset' have increased since July.
- The % that had a definite hospital onset fell in September compared to August.

Actions

- A Datix incident report is completed where there has been a definite hospital onset of COVID to enable a review of the case and identify any lessons to learn and prevent reoccurrence.
- The Infection prevention and control (IPC) team has sent out communications this week to remind staff of the current IPC measures required for the prevention and management of all Acute Respiratory Infections, including COVID. This includes guidance on patient and staff testing, guidance for visitors, patient assessment and placement, IPC precautions and guidance on when to wear a face mask.
- The IPC team support site managers with patient placement and help them prioritise the most infectious patients for side rooms.
- The fit testing team will be visiting teams across North Wales over the coming days to raise awareness about fit testing compliance for FFP3 masks.
- Members of staff who have not yet had a COVID-19 Autumn booster will receive an invitation to get their vaccine shortly.

Mitigations

- Vaccination sessions for COVID and flu are being widely promoted and made available in a variety of settings to maximise uptake, including at the IPC Conference on the 4th October.
- Patients are triaged at the point of entry; those with respiratory infection symptoms are assessed in a segregated area or single room away from other patients pending their test result.
- Infectious patients are isolated in single rooms away from other patients or cohorted with others with the same infection.
- As a minimum, contact and droplet IPC precautions are applied when caring for patients with known or suspected COVID.
- Staff continue to wear facemasks when working in respiratory care pathways and when caring for patients with suspected/confirmed COVID.
- Inpatients with suspected or confirmed COVID are provided with a facemask on admission and advised on when and how to wear it.
- A risk assessment is carried out on staff who have had COVID and are well enough to return to work within 10 days, but will be coming in to contact with people who are at higher risk of becoming seriously unwell if they catch COVID (e.g. patients with cancer).

What the data tells us

- The COVID Autumn Programme includes 305,168 eligible citizens in North Wales. BCUHB is on track to achieve the Welsh Government 75% uptake target by 31st March 2023 with the majority of vaccine delivered before mid December. Cohorts included are the over 65's, those living in Adult Care homes, immunosuppressed and clinically vulnerable from the age of 12, and carers supporting those clinically vulnerable groups. The priority order of delivery is to Care homes and housebound citizens following the COVID variant of interest (BA2.86) that changed the planned order at the start of the programme. BCUHB has significantly more care homes than other Health Boards and we have committed and are on track to offering all Care homes an appointment visit by the 15th October, with 87.5% of residents offered a vaccine and a take up rate of 66.2%. We will be offering additional 'mop-up' sessions to those residents that were not well enough to have a vaccine at the time of first visits. The main clinics for the wider eligible cohorts at multiple vaccination sites started in earnest on the 2nd October, where we will be vaccinating circa 20,000 citizens a week. All eligible citizens will have an appointment offer by the 31st January 2024.

Issues

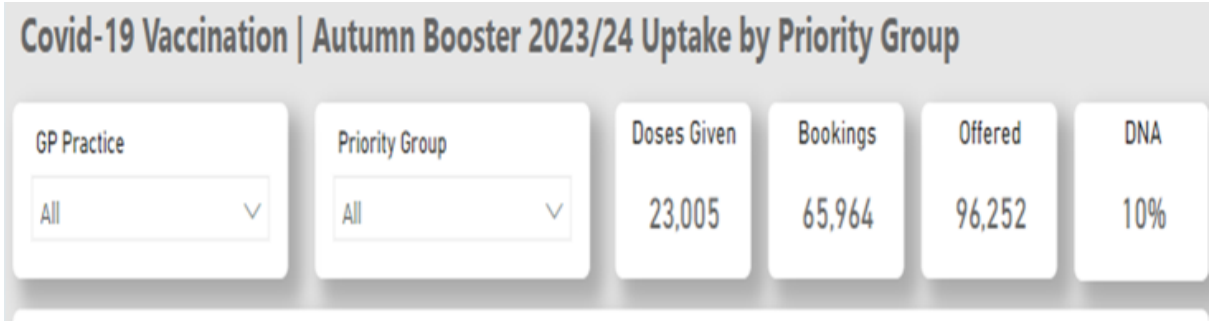
- The COVID virus is still unpredictable in nature and is yet to settle in to annual pattern as seen in other viruses. This uncertainty has and does pose a continual operational challenge in the effective delivery of the COVID vaccine, with National decisions on when and who to vaccinate coming with often little notice to prepare impacting on outcomes. These late changes also impact on the funding decisions and what level of support the Health Board needs to have in place to support successful programme outcomes in 24/25.

Actions

- BCUHB has representation in the NHS Executive meetings that are focussing on the future development of immunisations under the National Immunisation Framework that is looking to build on the success of the COVID models and how this can be incorporated in to the wider immunisation requirements for the Citizens of North Wales.

Mitigations

- Blanket changes to the use of bank/agency of staff due to the financial pressures in the wider Health Board have a detrimental impact on the delivery of the service due to the additional time added to the process. The COVID vaccination programme is a very high volume service with specific timescales that any additional delays in decision making can mean 100's if not 1000's of vaccinations can be missed.
- An open Bank request is being but forward to Establishment Control to enable where needed the bringing in of short term resource. This is all within planned budgets.



% of eligible new-born babies who have a conclusive bloodspot screening result by day 17 of life

What the data tells us

- 95.6% (September 2022 – August 2023 data extracted)

This is above the performance indicator standard >95% set by Newborn Bloodspot Screening Wales (NBSW)

Issues

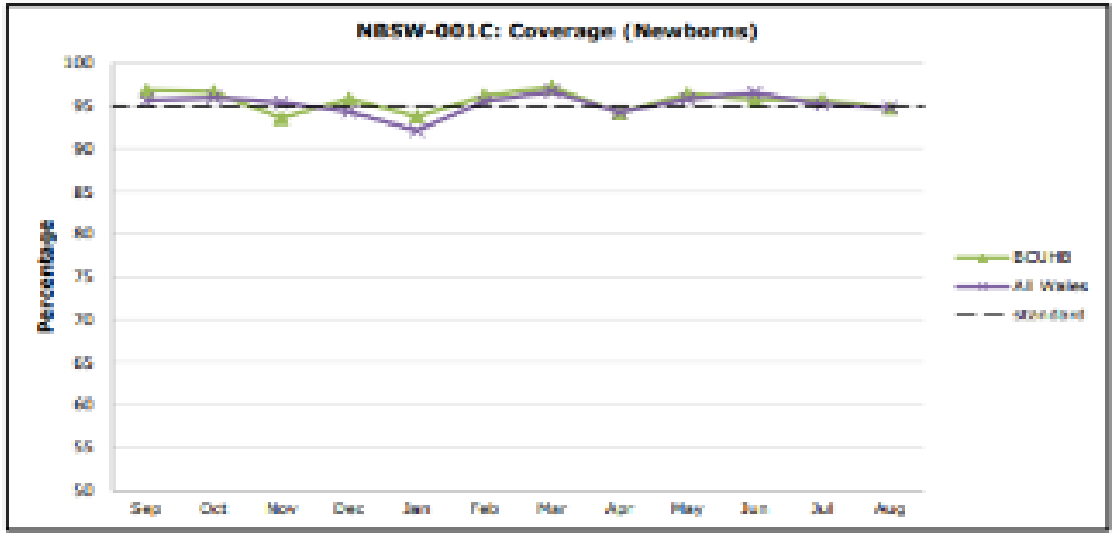
- Communication from other Health Boards is not always received to notify BCUHB that a baby with a local address has had screening received elsewhere. I.e. if a baby is being cared for in a SCBU across the border

Actions

- Continue to work locally to chase up babies who have not had a newborn bloodspot screening card send to the lab in Cardiff by Day 17 of life
- Continue to work closely with NBSW and failsafe processes to action updates for non-screened babies within BCUHB

Mitigations

- Newborn bloodspot screening can be opted out of by parents following informed consent process
- Failsafe measures exist to track reasons for all babies where screening cards are not received to processing lab in Cardiff
- Babies can move out of health board following birth for a number of reasons i.e. for specialist healthcare, social reasons, family moves



NBSW-001C: Coverage (Newborns)

2022-23	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
BCUHB	96.9	96.6	93.6	95.9	93.8	96.2	97.2	94.2	96.4	95.8	95.7	94.8
All Wales	95.7	96.0	95.4	94.3	92.1	95.6	96.7	94.3	95.8	96.6	95.2	94.9

Numerator: Babies with completed testing within 17 days of birth

2022-23	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
BCUHB	523	487	469	484	452	455	418	441	462	455	446	490
All Wales	3388	3396	3411	3236	3305	3110	3063	3161	3097	3396	3208	3298

Denominator: Eligible newborn babies

2022-23	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
BCUHB	540	504	501	504	482	473	430	468	477	475	466	517
All Wales	3496	3524	3526	3349	3385	3336	3333	3292	3188	3366	3330	3422

Number of consultations delivered through the Pharmacist Independent Prescribing Service (PIPS)

Issues

- Some independent prescribers working in Community Pharmacy are leaving the sector for roles in general practice, or the Health Board. This is ultimately driven by a significant shortage of pharmacists in North Wales and the wider UK.
- There is limited awareness of the service amongst some healthcare professionals and the wider public, despite a number of campaigns.
- Some pharmacist independent prescribers lack confidence in Managing the full range of conditions included in the service and offer a reduced breadth of service as a consequence.

Actions

- We are supporting pharmacists to access training as independent prescribers.
- We are working with Bangor University to establish a School of Pharmacy to address wider staff shortages.
- We are raising awareness of PIPS, and support the understanding of how to use the service availability tool, amongst healthcare professionals to promote referrals.
- We are working with independent prescribing pharmacists to support access to training and opportunities to build confidence and broaden competence.

Mitigations

- We are working with community pharmacy companies to create joint roles and support recruitment and retention.
- A live service availability tool has been developed, which links directly to the NHS 111 directory of service and website, meaning the data are available to NHS 111 Call Handlers, other health professionals, and the public. Mandated completion of the service availability tool has been proposed by NHS members as a discussion point for national contractual framework negotiation for the 2024/25 round of negotiations, which are due to start shortly.
- A service specification has been developed to support collaborative working and additional training to build confidence, develop links with other local providers, and broaden scope of practice. We are working with Health Education and improvement Wales to develop professional development resources, and support structures, to support building confidence and broadening competence.

Further Information

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University Health Board

NHS Welsh Government Delivery Framework Metrics (Latest data as published September 2023)

Quadruple Aim 1

Quadruple Aim 1: People in Wales have improved health and well-being with better prevention and self-management							
Measure	Target	Current Data		Measure	Target	Current Data	
		Period	Value			Period	Value
% of adult smokers who make a quit attempt via smoking cessation services	5% annual target	2022/23	4.17%	% uptake of the COVID-19 vaccination for those eligible - Spring Booster (Mar-23 to Jun-23)	75%	Jun-23	67.1%
% people referred to HB services who have completed treatment for substance misuse (drugs or alcohol)	4 quarter improvement trend	Q1 23/24	59.6%	% uptake of the COVID-19 vaccination for those eligible - Autumn Booster (Sep-23 to Mar-24)	75%	Sep-23	
% children up to date with vaccinations by age 5 ('4 in 1' preschool booster, Hib/MenC booster, 2nd MMR)	95%	Q1 23/24	89.7%	% patients offered index colonoscopy within 4 wks of booking Specialist Screening Practitioner appt	90%	Jun-23	10.6%
% of girls receiving the Human Papillomavirus (HPV) vaccination by the age of 15 (Q1 & Q4 23/24)	90%	Q1 23/24	85.3%	% well babies entering new-born hearing screening programme who complete screening within 4 wks	90%	Jun-23	96.8%
% uptake of the influenza vaccination amongst adults aged 65 years and over (Sep-23 to Mar-24)	75%	Sep-23		% of eligible new-born babies who have a conclusive bloodspot screening result by day 17 of life	95%	Jul-23	96.6%

Quadruple Aim 2

Quadruple Aim 2: People in Wales have better quality and more accessible health and social care services, enabled by digital and supported by engagement									
Measure		Target	Current Data		Measure	Target	Current Data		
			Period	Value			Period	Value	
% of GP practices that have achieved all standards set out in the National Access Standards for In-hours GMS		100%	2022/23	95.5%	Number patients spent 12 hrs or more in emergency care from arrival to admit, transfer or discharge	Imp trajectory towards 0 by Mar-24	Aug-23	10,085	
% primary care dental services (GDS) contract value delivered (new, new urgent and historic patients)		Month on month inc 30% Sep-23,100% Mar-24	new measure - data will be inc. in the next few months		% of patients starting first definitive cancer treatment within 62 days from point of suspicion	Imp trajectory towards 80% by Mar-26	Jul-23	56.6%	
Num of patients referred from primary care (optometry & GP) into secondary care Ophthalmology services		Imp trajectory towards reduction by Mar-24	Jul-23	6,391	Number of patients waiting more than 8 weeks for a specified diagnostic	Imp trajectory towards 0 by Mar-24	Jul-23	46,555	
Number of consultations delivered through the Pharmacist Independent Prescribing Service (PIPS)		Increase compared to same month prev year	Jul-23	5,904	% of children (aged under 18 years) waiting 14 weeks or less for a specified Allied Health Professional	12 month improvement trend		86.3%	
% LPMHSS assessments within 28 days from referral	Under 18 years	80%	Jul-23	73.1%	Number of patients waiting more than 14 weeks for a specified therapy (inc. audiology)	Imp trajectory towards 0 by Mar-24		8,318	
	18 years and over			42.9%	Number of patients waiting over 52 weeks for a new outpatient appointment	Imp trajectory towards 0	Jul-23	50,885	
% theraputic interventions started within 28 days following LPMHSS assessment	Under 18 years			67.7%	Number of patients waiting more than 36 weeks for a new outpatient appointment			108,138	
	18 years and over			73.0%	Number of patients waiting for a follow-up outpatient appointment who are delayed by over 100%	Imp trajectory towards 0	Aug-23	242,417	
% of emergency responses to red calls arriving within (up to and including) 8 minutes		65%	Aug-23	50.4%	Number of patients waiting more than 104 weeks for referral to treatment	Imp trajectory towards 0	Jul-23	27,681	
Median emergency response time to amber calls		12 month improvement trend	Aug-23	01:20:38	Number of patients waiting more than 52 weeks for referral to treatment			133,205	
Median time from arrival at an emergency department to triage by a clinician		12 month reduction trend	Aug-23	20	% of patients waiting less than 28 days for a first appointment for sCAMHS	80%	Aug-23	74.5%	
Median time from arrival at an emergency department to assessment by a senior clinical decision maker				81	% of children/young people waiting <26 weeks to start an ADHD/ASD neurodevelopment assessment		Jul-23	34.3%	
% of patients spend less than 4 hrs in emergency care from arrival until admit, transfer or discharge		Imp compared to same month prev year or 95%	Aug-23	69.0%	% of patients waiting less than 26 weeks to start a psychological therapy in Specialist Adult Mental Health		Jul-23	61.0%	

Quadruple Aim(s) 3 and 4

Quadruple Aim 3: The health and social care workforce in Wales is motivated and sustainable							
Measure	Target	Current Data		Measure	Target	Current Data	
		Period	Value			Period	Value
% of sickness absence rate of staff	12 month reduction trend	Jun-23	6.37%	Agency spend as a percentage of the total pay bill	12 month reduction trend	Jun-23	4.6%
Turnover rate for nurse and midwifery registered staff leaving NHS Wales	Roll 12 mnth reduction against 19/20 baseline	May-23	10.60%	% headcount by organisation who have had a PADR/medical appraisal in the previous 12 months	85%	Jun-23	70.2%

Quadruple Aim 4: Wales has a higher value health and social care system that has demonstrated rapid improvement and innovation, enabled by data and focused on outcomes								
Measure		Target	Current Data		Measure		Target	Current Data	
			Period	Value				Period	Value
% of episodes clinically coded within one reporting month post episode discharge end date		Maintain 95% or 12 month imp trend	Jun-23	75.2%	Cumulative number of laboratory confirmed bacteraemia cases:	Klebsiella sp	513	Apr-23 to Aug-23	289
% of all classifications' coding errors corrected by the next monthly reporting submission following		90%	Jul-23	28.4%		Aeruginosa	165		63
% of calls ended following WAST telephone assessment (Hear and Treat)		17%	Jul-23	14.0%	Cumulative rate of laboratory confirmed bacteraemia cases per 100,000 population:	E-coli	67.00		74.49
Number of Pathways of Care delayed discharges		12 month reduction trend	Aug-23	1,552		S.aureus bacteraemias (MRSA and MSSA)	20.00		26.42
% HB residents who have a valid care & treatment plan	Under 18 years	90%	Jul-23	93.7%		C.difficile	25.00		33.13
	18 years and over			76.3%	% R1 ophthalmology appointments attended within target date or within 25% beyond of clinical target date		95%	Aug-23	63.1%
Number of patient experience surveys completed and recorded on CIVICA		Month on month improvement	new measure - data will be inc. in the next few months		Number of ambulance handovers over 1 hour		Imp trajectory towards 0 by Mar-24	Aug-23	5,666
% of confirmed COVID cases within hospital which had a definite hospital onset of COVID		Reduction compared to same month 22/23	Aug-23	41.5%	Number of National Reportable incidents that remain open 90 days or more		12 month reduction trend	Aug-23	229

Report as at: 20 Sep 23

Target delivered:

Target not delivered:

Blank cell: no data currently available

Trend / target compliance not currently available:

Performance has improved over the last 12 mths:

Performance has deteriorated over the last 12 mths:

Performance has remained static over last 12 mths:

Integrated Performance Report
Betsi Cadwaladr University Health Board

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

- Our website www.bcu.wales.nhs.uk
- Stats Wales https://statswales.gov.wales/Catalogue/Health-and-Social-Care

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

follow @bcuhb

http://www.facebook.com/bcuhealthboard

Presentation of the Nurse Staffing Levels

Reporting Period: Autumn 2023

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Introduction / Background

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**
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.

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).

Section 25C: Nurse staffing levels: 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

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 2023 reviews were undertaken during the week commencing 11th September.

Review & Approval by Designated Person

Formal presentations were made to the Executive Director of Nursing and Midwifery on 05/10/2023. In attendance were nominated deputies for the Executive Directors of People Services; & Finance

Agreed Nurse Staffing Level calculations will be formally presented to the Board on 30/11/2023.

Extent to which the Nurse Staffing Levels are maintained

A real time view of staffing is provided by the RL Datix (formally Allocate) E-Rostering SafeCare system. This provides the ward manager/shift lead with the opportunity to record whether or not staffing was appropriate to meet the needs of the patients on a shift by shift basis. Any concerns relating to nurse staffing levels are to be escalated in line with NU28 Nurse Staffing Levels Policy.

The table below details the extent to which the planned roster was met across the adult medical & surgical wards and paediatric wards pertaining to Section 25B of the Act 2016 and the appropriateness of the staff on duty to meet patient care needs. The table is based on the Early, Late and Night shifts and is inclusive of both substantive and temporary staffing as recorded on the rosters.

Month	Total number of shifts	Shifts where planned roster met and appropriate		Shifts where planned roster met but not appropriate		Shifts where planned roster not met but appropriate		Shifts where planned roster not met and not appropriate		Data completeness	Shifts where planned roster met but no appropriateness		Shifts where planned roster not met and no appropriateness	
Apr-23	3345	27.29%	913	7.44%	249	27.41%	917	23.89%	799	86.04%	5.23%	175	8.55%	286
May-23	4123	30.05%	1239	9.22%	380	23.09%	952	22.46%	926	84.82%	6.26%	258	8.71%	359
Jun-23	3990	29.02%	1158	6.02%	240	28.55%	1139	26.29%	1049	89.87%	3.78%	151	6.29%	251
Jul-23	4185	32.31%	1352	6.67%	279	29.87%	1250	20.26%	848	89.10%	4.42%	185	5.93%	248
Aug-23	4185	31.88%	1334	8.39%	351	28.48%	1192	20.79%	870	89.53%	3.66%	153	5.73%	240
YTD Running Total	19828	30.24%	5996	7.56%	1499	27.49%	5450	22.65%	4492	87.94%	4.65%	922	6.98%	1384

Please note data presented is between 06/04/2023 – 31/08/2023 in line with national reporting guidelines.

06/04/23 – 30/06/23 figures for Central & West Paediatric wards reported from HCMS system, with East Paediatric ward reported via the SafeCare system.
01/07/23 onwards all Paediatric ward data reported via the SafeCare system.

Aran Ward YG not included in above data as stepped up as Act ward from Sept 2023

All Wales Acuity Audit

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.

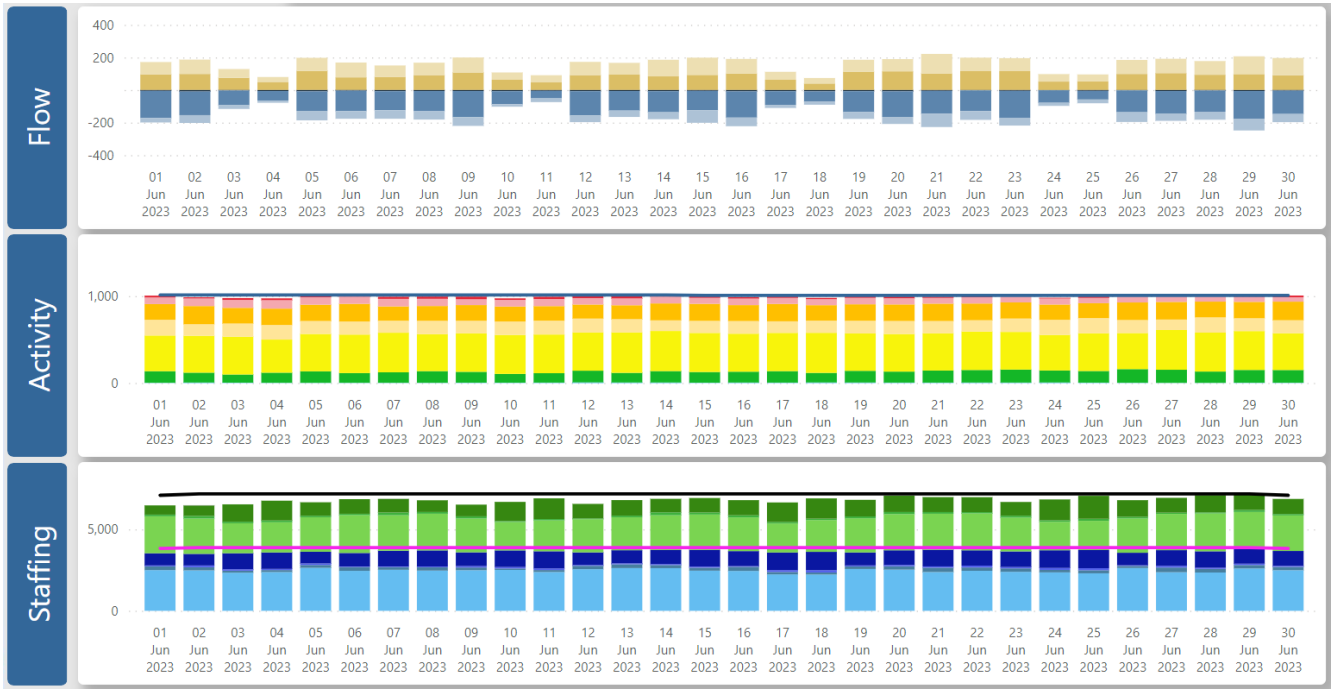
Individual BCU ward acuity details can be viewed **here**

Welsh Levels of Care

The Welsh Levels of Care are summarised below, 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.

BCUHB Section 25B Wards June 2023 Acuity Audit data



Quality Indicators

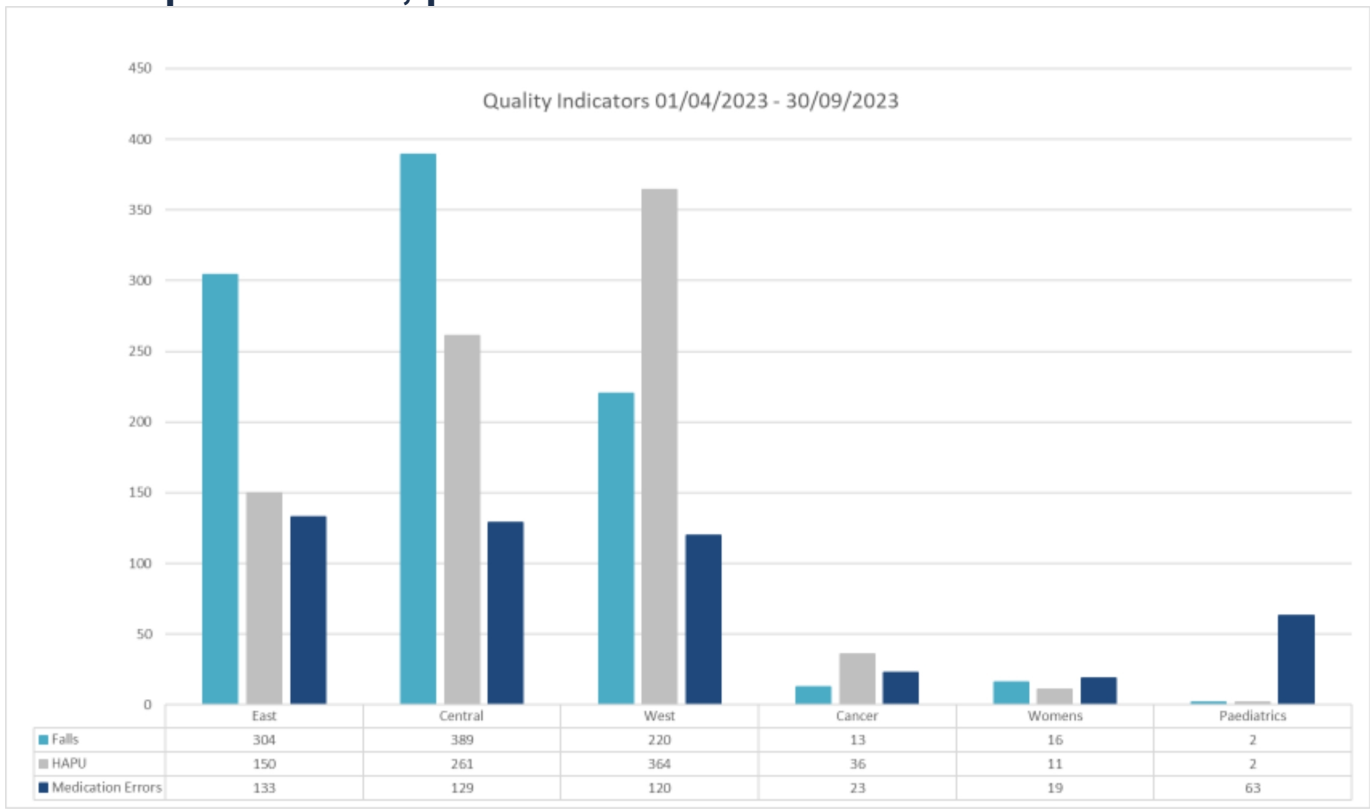
When calculating the nurse staffing level the quality indicators that are particularly sensitive to care provided by a nurse must be considered. These include patient falls, pressure ulcers and medication errors.

The chart opposite details by Integrated Health Community / division the total number of:

- patient falls
- pressure ulcers
- medication errors

which have been recorded within the DATIX system for the period 01/04/2023 – 30/09/2023.

Data is based on only those wards to which Section 25B of the 2016 Act pertains.



	East	Central	West	Cancer	Womens	Paediatrics
Falls	304	389	220	13	16	2
HAPU	150	261	364	36	11	2
Medication Errors	133	129	120	23	19	63

Date Source: DATIX system as at 02.10.2023

Approved Nurse Staffing Levels – Autumn 2023 (summary)

The nurse staffing level calculations undertaken during this reporting period (October 2022 – September 2023) identified a number of wards that require a change to their establishments with the overall proposed 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 22)		Required Establishment at the end of the reporting period (September 2023)*		Staffing FTE changes during reporting period 2022 - 2023*		Funded** Establishment (as at September 2023)		FTE Variance between current funded and required (September 2023)	
			RN	HCA	RN	HCA	RN	HCA	RN	HCA	RN	HCA
YMW	14	303	277.14	219.9	279.17	229.45	2.03	9.55	277.14	219.9	2.03	9.55
YGC	11	308	261.51	253.56	264.23	258.88	2.72	5.32	261.51	253.56	2.72	5.32
YG	13	263	207.51	195.71	228.83	218.01	21.32	13.77	228.92	217.91	-0.09	0.1
Womens Gynaecological	2	32	11.37	5.69	33.87	21.9	22.5	16.21	36.11	18.66	-2.24	3.24
Oncology & Haematology	3	38	33.3	31.27	33.3	31.27	0	0	33.3	31.27	0	0
Paediatric Inpatient Wards	3	64	83.46	31.27	83.46	31.27	0	0	80.98	28.95	2.48	2.32
BCUHB Total	**46**	**1008**	**874.29**	**737.4**	**922.86**	**790.78**	**48.57**	**44.85**	**917.96**	**770.25**	**4.9**	**20.53**

* Required establishment at the end of the reporting period and staffing FTE changes during the reporting period both include the addition of three new Act wards. New Act wards from Spring 23 are Ffrancon ward YG and Bromfield ward (both Womens Gynecological) YWM and from Autumn 23 Aran ward YG.
** Funded establishment sourced from Finance Ledger
Note: The required and funded establishment figures exclude supernumerary ward sister/charge nurse and ward support staff i.e. housekeepers, dementia support workers etc.

Section 25B wards requiring a change to nurse staffing levels

During this reporting period (October 2022 – September 2023) two statutory calculations of nurse staffing levels have taken place, these being Spring 2023 (reported to Board in May 2023) and Autumn 2023 (to be reported to Board in November 2023).

11 wards requested changes to their establishments during this reporting period. The changes approved following review by the Executive Director of Nursing are summarised in the table below:

Integrated Health Community	Number of Act Wards	Number of Wards Requesting Adjustments	Adjustments Approved by Exec DoN	Comments
YWM	14	4	4	Cunliffe - HCA staffing was reconsidered in both Spring 23 and Autumn 23 due to harm profile.
				Bersham - staffing reconsidered during Spring 23 as part of ongoing stroke services redesign.
				U5 - staffing reconsidered during Spring 23 following an increase in beds
				Prince of Wales - staffing reconsidered during Spring 23 following site reconfiguration and change in ward
YG	11	5	0	
YGC	13	2	2	ABH Ward 6 - staffing reconsidered during Autumn 23 as part of the ongoing orthopaedic surgical services review
				Ward 14 - staffing reconsidered during Spring 23 as part of ongoing stroke services redesign.
Oncology & Haematology	2	0	-	-
Womens Gynaecological	3	0	-	-
Paediatric Inpatients Wards	3	0	-	-
BCUHB Total	**46**	**11**	**6**	**-**

Recommendations

Office of the Executive Nurse Director:

- Continue to review the impact of nurse staffing within the clinical areas and quality metrics.
- Continue to work closely with clinical teams to review any correlation between clinical incidents and the number of red flags being raised.
- Continue with the work underway to link the Quality and Workforce metrics to enable review of the data (Exec. Nurse Dashboard)
- Continued focus on recruitment and retention and innovation to support workforce utilisation and reporting.
- Corporate finance teams will work with operational finance teams to adjust budgets as part of the annual planning cycle to reflect the revised approved rosters.
- The E-Rostering team will adjust roster demand templates to reflect the agreed ‘planned rosters’
- Ward Managers will process the recruitment of staff, based on the revised nursing establishment (where applicable)
- Ward Managers will display any changes to the planned roster on the ward boards displayed at the ward entrance

Diolch / Thank you

Any questions?

Teitl adroddiad: ***Report title:***	Special Measures Update			
Adrodd i: ***Report to:***	Quality, Safety and Experience Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	27th October 2023			
Crynodeb Gweithredol: ***Executive Summary:***	The purpose of this paper is to provide an update on Special Measures, outlining the progress to date on the deliverables associated to this Committee.			
Argymhellion: ***Recommendations:***	The Committee is asked to **RECEIVE ASSURANCE** on the progress to date, acknowledging the areas of challenge, the process for independently assessing evidence within the PMO, along with processes for how changes are managed.			
Arweinydd Gweithredol: ***Executive Lead:***	Carol Shillabeer, Chief Executive (Accountable Officer) Dr Chris Stockport, Executive Director of Transformation & Strategic Planning (Lead Executive)			
Awdur yr Adroddiad: ***Report Author:***	Geraint Parry, Special Measures Programme			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	To support Special Measures			

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)***	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: Gweithredu argymhellion ***Next Steps:***	

Quality, Safety and Experience Committee

Special Measures Update

1) Introduction

This report presents an update on the Special Measures deliverables aligned to this Committee, building on the approach developed during the first 90-day cycle (June to August 2023).

The report reviews the progress being made during the second 90-day cycle (September to November 2023) and describes the transition from cycle 1 to cycle 2.

2) Background

The background to the Health Board escalation into Special Measures and the resultant organisational response has been covered in previous committees. It has previously been agreed that a summary will be provided to each committee that covers the deliverables for which the committee has agreed to provide oversight, and that the committee will then invite relevant colleagues to attend for any particular deep dives that they wish to undertake.

3) Progress to date

The table at the end of this paper provides an update on the relevant deliverables agreed for QSE oversight. The table has been collated from the weekly reporting received from respective teams and from the tracking against the milestones which have been agreed.

Independent Reviews
A process is in place for the development and then delivery of recommendations associated to reviews received. As members will be aware the first 2 reviews under the remit of this committee (Patient Safety Review and Mental Health Inpatient Safety Review) were presented to a development session of the committee on the 14th September.

A management response has been undertaken following that session and is covered via separate papers being submitted to this committee, all as part of a thematic approach to addressing root causes.

The following 3 reviews will also be brought to this committee in due course and a brief update is reported below:

- **Vascular Review** – report expected into the Health Board during October
- **Stocktake Review of Progress Against Previous Mental Health Reviews** – expected in December in line with initial expectations
- **Clinical Governance Review** – this review is yet to be commissioned. The Terms of Reference are currently being agreed

Cycle 3 and Standardisation Phase Preparation

Whilst monitoring arrangements are in place for Cycle 2, preparation is also underway around developing plans for Cycle 3 (December 2023 to February 2024) and beyond to ensure that early traction is maintained. Discussions have begun with colleagues including due consideration for how we prepare for the standardisation phase in April, where the intention is for stronger alignment between Special Measures priorities and the Annual plan. This reflects the fact that Special Measures is a level of escalation and that the ultimate success will be dependent on how we can integrate it effectively into Business as Usual activities.

4) Portfolio Management Office (PMO) Assessment

The table provides details of the progress against deliverables and milestones and is complemented by the objective assessment that is undertaken by the PMO on behalf of the organisation, to ensure that a robust assurance process is in place and that progress is verified.

Overall, solid progress has continued in most areas and it is evident that there has been some early success in Cycle 2, including Board approval of the Risk Management Framework and key appointments to solidify the workforce challenges in Oncology. The halfway point of this cycle has now passed and with many milestone dates weighted towards the end of the cycle there will be a requirement for continued focus throughout the remaining weeks to ensure delivery.

5) Change Control

As part of Special Measure governance arrangements any proposed changes require approval through a change control process. This is approved through the Special Measures Senior Responsible Officer (SRO) before being submitted to the Board for final approval.

Any milestones scheduled for cycle 1 that did not conclude within the originally intended timescales have been mapped during the transition to cycle 2 in order to ensure that no milestones were overlooked. More information is provided in Appendix 1 in relation to those pertinent to this committee, and these will be submitted to the Board for approval along with those mapped to other committees.

No further requests have been received during cycle 2 for any further changes.

6) Recommendations

The Committee is asked to **RECEIVE ASSURANCE** on the progress to date, acknowledging the areas of challenge, the process for independently assessing evidence within the PMO, along with processes for how changes are managed.

Table 1: QSE Oversight Report – QSE 27 October 2023

Outcome 1: A well-functioning Board

Deliverable brief summary	Lead Executive	Delivery Confidence	Update
1.6 Risk: Design Risk Management Framework and commence implementation	Phil Meakin		**Summary extracted from team updates** Building upon the Board session around risk appetite during cycle 1 this work progressed to the development of a new Risk Management Framework. This was approved at September Board and is now progressing to implementation.
			PMO Assessment Clear evidence of progress made and formal confirmation received that the framework was approved. Plans for the remainder of this cycle appear well on track.

Outcome 3: Stronger leadership and engagement

Deliverable brief summary	Lead Executive	Delivery Confidence	Update
3.8 Clinical Engagement: Consider outcome of clinical engagement fieldwork.	Gareth Evans		**Summary extracted from team updates** The field work previously described concluded within the expected timescales and no work was required to carry forward. This work then resulted in a paper with recommendations for improvement which was discussed at an informal executive team session in September. The next phase of this work is to progress alignment with the organisational development plan and is on track to deliver on the cycle 2 commitments.
			PMO Assessment All evidence submitted in line with agreed milestone dates.

3.10 Address the fragmented care record concerns: Implement plans for integrated electronic patient record.	Dylan Roberts		**Summary extracted from team updates** The work in cycle 1 to identify tactical interventions that can be implemented in ED within the next 6-12 months has been completed. An evaluation is well underway to develop a prioritised list by the end of cycle 2. The strategic work for an electronic patient record (EPR) has progressed beyond the initial procurement delays and a partner has been appointed. The first draft of an outline case is expected by the 15th December and has therefore been mapped into cycle 3.
			PMO Assessment Full set of reports for the tactical work received. Evident that procurement delays have been overcome as partners are now in place. High degree of assurance that cycle 2 milestones will be delivered, and early progress will materialise within cycle 3 around the strategic case.

Outcome 4: Improved access, outcomes and experience for citizens

Deliverable brief summary	Lead Executive	Delivery Confidence	Update
Service Improvements: **4.5a Vascular Improvement Plan**	Nick Lyons		**Summary extracted from team updates** The vascular review is yet to be received within the organisation therefore interdependent actions cannot be progressed at this stage. A decision was taken to merge the existing vascular review deliverable (4.4) into the improvement plan work for purposes of clarity. Whilst awaiting the review the existing vascular Improvement plan remains in place and is reviewed regularly by the vascular steering group, and is being scheduled for an executive team discussion by the end of this cycle. A number of pathways have been distributed at final draft stage for comment and approval is anticipated before the end of October.
			PMO Assessment Work in this area is progressing following the earlier de-escalation by HIW. There will be a requirement for a timely refresh of the plan based on any recommendations from the review, and any concerns regarding operational detail will need to be escalated via the executive team review in November, however it is evident that strong progress is being made with pathway development. There is a requirement for the Board to keep this plan under regular review given historic challenges and therefore this may be a suitable candidate for the committee to consider inviting the team to present an update on progress to date.

Service Improvements: **4.5b Urology Improvement Plan**	Nick Lyons		**Summary extracted from team updates** The Royal college of Surgeons (RCS) review has now been received and circulated to key stakeholders, which completes the first milestone within cycle 2. Comments are due back by the 20th October and this will ensure that the recommendations can be incorporated into the Urology Improvement plan ahead of the deadline for the next milestone on the 16th November.
			PMO Assessment Documented evidence that the first milestone within cycle 2 has been completed. Updates received provide high degree of confidence that future milestones will be met.

Service Improvements: **4.5c Ophthalmology Improvement Plan**	Adele Gittoes		**Summary extracted from team updates** Having experienced challenges to date in appointing a clinical lead from within BCU consideration is now being given to recruitment to this lead externally through the use of existing Consultant vacancies. The Eye care improvement group met on the 13th October and the long-term sustainable service model was a key feature of these discussions. Further work being progressed at pace over the next 4 weeks ahead of a planned away day. Additional capacity has also been secured in community optometry.
			PMO Assessment Evident via narrative update that work is proceeding on a number of fronts with the eye care group initiated ahead of schedule. The majority of milestones are towards the end of the cycle and alternative plans to appoint a clinical lead external to the Health Board are unlikely to conclude within the cycle due to recruitment timescales.

Service Improvements: **4.5d Oncology Improvement Plan**	Nick Lyons		**Summary extracted from team updates** Following a competitive interview process a new Clinical Radiotherapy Lead has been appointed and commenced in the role on the 1st October.
			PMO Assessment First milestone within Cycle 2 has completed ahead of schedule and firm evidence provided. Continuing to build upon the foundations laid within Cycle 1 around workforce challenges.

Service Improvements: **4.5e Dermatology Improvement Plan**	Adele Gittoes		**Summary extracted from team updates** A clinical planning meeting was held on the 11th October and a series of actions have been agreed. These include agreement to develop a hub and spoke model in the short term and to develop feedback and communications with Primary Care to improve referral management. Internal and external solutions are also being explored with regards to increasing capacity, however this is likely to require investment in the short term.
			PMO Assessment Evident that challenges in the West make this is a fragile service across BCU and impacted delivery within cycle 1 Early progress has been made during cycle 2, in particular through a clinically led planning meeting, and there are a number of milestones due within this cycle which will be dependent upon the outcomes agreed in that meeting being progressed in a timely manner.

Service Improvements: **4.5f Plastics Improvement Plan**	Adele Gittoes		**Summary extracted from team updates** A draft Service Level Agreement (SLA) has been issued to the provider which will be the subject of joint review during October. This is supplemented by demand and capacity work undertaken with the Welsh Health Specialised Services Committee (WHSSC) in order to commission additional activity to the address the backlog, and WHSSC will also be consider refreshed commissioning volumes on a more substantive basis.
			PMO Assessment Work towards delivering the first milestone in cycle 2 has progressed well with a draft SLA in place and progressing towards conclusion and an agreed contract.

4.7 MH Inpatients Safety Review: Phase 2	Teresa Owen		**Summary extracted from team updates** The action plan aligned to the 8 recommendations from the NCCU review has been developed through the agreed inpatient safety action group. This is at the final stages of ratification prior to submission.
			PMO Assessment Agreed actions are in place and remaining activities relate to approval prior to submission, and appear well on track to deliver inside this cycle.

Service Improvements: **4.8a CAMHS Improvement Plan**	Adele Gittoes		**Summary extracted from team updates** IHC Recovery plans have been developed and are being implemented and trajectories are being updated as part of finalising the regional plan to submit to the executive team. Challenges remain in relation to vacancies, with the new establishment control measures creating some delays as requests are evaluated. A workforce stabilisation plan is also being developed for longer term stability.
			PMO Assessment Evident that the service is well sighted on its challenges with recovery plans being developed. The plan continues to be tested and refined in line with cycle 2 requirements and the executive team review of the plan in November is also in the process of being scheduled.

4.8b Neurodiversity Improvement Plan	Adele Gittoes		**Summary extracted from team updates** Tender documents for private provision of assessment are now being progressed through the Health Board governance processes for approval. The tender paper is also being reviewed through a series of senior meetings including the Executive team meeting on the 25th October and through to PFIG on the 2nd November. Further work is also underway assessing population data along with scoping of new service delivery models.
			PMO Assessment Progression of tendering process evident, along with a series of review stages. Scheduling of executive team review of the improvement plan during November is also underway. Some risks remain extant in relation to the award of the tender.

Outcome 5: A learning and self-improving organisation

Deliverable brief summary	Lead Executive	Delivery Confidence	Update
5.2 Learning from Incidents: Effective procedures for learning from incidents, and preparing inquests and HSE	Angela Wood		**Summary extracted from team updates** The Executive team received a presentation on the National learning work undertaken, which was delivered by colleagues from NHS Wales executive, and a draft Terms of Reference is now in the process of being agreed with the CEO. A draft Standard Operating Procedure (SOP) will be presented to the Executive team on the 25th October. Some specific work is also underway around learning from incidents in the Adolescent Service.
			PMO Assessment Evident through narrative update and through confirmation of executive team business that the Health Board is fully engaged with national pilot around learning. Approval of SOP at executive team will fall marginally beyond the original milestone date, however provided this is approved this works remains well on track within expected timeframes.

Appendix 1

Change Log Activity - QSE

The Special Measures Change Control process outlines the steps to be taken when a modification is suggested for a Deliverable, Milestone, or a Special Measures process after it has received Board approval.

The table below provides a change log specific to the QSE Committee, highlighting updates pertinent to the committee from the broader Special Measures Change Control Register, which is presented to the Board for approval.

Several milestones did not conclude by the end of Cycle 1 and therefore require transition to Cycle 2, and a small number into cycle 3. A mapping exercise was conducted to confirm that no milestones were overlooked. This process is governed by the Special Measures Change Control process, which mandates approval from the Special Measures Senior Responsible Officer (SM-SRO) and formal ratification via a Board meeting. Please refer to the table below for details relevant to this committee.

Change Log Table

Outcome	Deliverable	Cycle 1 Milestone	Replaced in Cycle 2	Replaced in Cycle 3
1. A well-functioning Board	1.6 Risk	1.6.2 Develop risk management framework and approach with Audit Committee and Risk Management Group through July and (targeting Board in September)	1.6.3 Board approval of Risk management framework at Sep Board	
3. Stronger leadership and engagement	3.10 Address our fragmented care record concern	3.10.1 1st Draft of Outline Case for the organisation wide Electronic Patient Record (EPR) approach		3.10.7 1st Draft of the outline case for the organisation wide Electronic Patient Record (EPR) approach completed

		3.10.2 1st draft of outline case for Tactical ED service blueprint (that can be delivered in 6-12 months)	3.10.5 Outline case for Tactical ED service blueprint (that can be delivered in 6-12 months) completed	
4. Improved access, outcomes and experience for citizens	4.4 Vascular Review	4.4.2 Receive, review and digest report and recommendations	4.5a.6 Vascular review reports and recommendations (parts 1 and 2) received	
		4.4.3 Create an action plan to address recommendations and commence implementation	4.5a.7 Actions to address Vascular Review recommendations incorporated into the Vascular improvement plan and implementation commenced	
	4.5a Service improvements - Vascular	4.5.a.3 Staffing model addressed, including ward 3 nursing	4.5a.7 Actions to address Vascular Review recommendations incorporated into the Vascular improvement plan and implementation commenced	
	4.5e.4 Agreed plan in place for Dermatology in the West, whilst wider Dermatology model is worked through	4.5e.4 Agreed plan in place for Dermatology in the West, whilst wider Dermatology model is worked through	4.5b.6 Actions to address Urology review recommendations incorporated into the Urology improvement plan	
		4.5e.4 Agreed plan in place for Dermatology in the West, whilst wider Dermatology model is worked through	4.5b.5 Royal College of Surgeons Urology review and recommendations received	
		4.5e.4 Agreed plan in place for Dermatology in the West, whilst wider Dermatology model is worked through	4.5b.6 Actions to address Urology review recommendations incorporated into the Urology improvement plan	
	4.5e.4 Agreed plan in place for Dermatology in the West, whilst wider Dermatology model is worked through	4.5e.4 Agreed plan in place for Dermatology in the West, whilst wider Dermatology model is worked through	4.5c.6 Integrated Eye Care service model and associated delivery plan development commenced	

	4.5e Service improvements - Dermatology	4.5.e.1 Commence recruitment process for Pan BCU Clinical Lead	4.5e.4 Agreed plan in place for Dermatology in the West, whilst wider Dermatology model is worked through	
		4.5.e.2 New recruitment model in place	4.5e.5 Complete a clinically led options appraisal to address medium term risk to pan BCUHB in relation to Dermatology Cancer	
		4.5.e.3 Refreshed integrated improvement plan	4.5e.5 Complete a clinically led options appraisal to address medium term risk to pan BCUHB in relation to Dermatology Cancer	
	4.8a CAMHS action plan	4.8a.1 Refresh and agree CAMHS Recovery plan	4.8a.6 Test, and then refine, the CAMHS Recovery Plan	
		4.8a.3 Ensure CAMHS is covered in Operating Model Stocktake (Deliverable 3.2)	3.2.4 Insights gathered, key themes and next steps for operating model structure stock take reviewed by Executive team	
	4.8b Neurodiversity action plan	4.8b.2 Award of ND tender for private provision of assessments	4.8b.6 ND tender for private provision of assessments awarded	
5. A learning and self-improving organisation	5.2 Learning from incidents	5.2.2 Development of a learning framework/model for patient safety and experience	5.2.5 Fully engaged with pilot of National Learning Framework alongside NHS Executive Wales	
		5.2.4 Create SOP, governance and single central repository for responses to enable extraction of themes and learning	5.2.6 Revised SOP for inquests (incl monitoring system) agreed by Executive Team	
	5.3 Clinical Governance Review	5.3.1 The progress of this task relies on the outcome of the Patients Safety review. At present, it is not clear whether this review is needed and if so, when work will start and what the duration will be. This is reflected in the overall delivery confidence.		5.3.1 Clinical Governance Review supported and enabled

Appendix 2

Cycle 2 Milestones relating to QSE

1. A well-functioning Board

Exec Lead	Milestone	Due Date	Why it's important to track
C1-1.6: Design Risk management framework and commence implementation			
Phil Meakin	1.6.3 Board approval of Risk management framework at Sep Board	30/09/2023	To ensure a common understanding across Board members on how the organisation identifies, manages and mitigates risk. To enable delivery of necessary actions to implement and embed robust risk management processes.
Phil Meakin	1.6.4 Commence implementation of risk management framework implementation plan (developed during this cycle)	30/11/2023	To enable delivery of necessary actions to implement and embed robust risk management processes.

2. A clear, deliverable plan for 2023/24

No deliverables from Outcome 2 fall under the remit of this committee

3. Stronger leadership and engagement

Exec Lead	Milestone	Due Date	Why it's important to track
C1-3.8: Consider outcome of clinical engagement field work			
Gareth Evans	3.8.5 Outcome of clinical engagement field work considered by Executive Team and aligned to the organisational development plan	30/11/2023	Clinical engagement is key to the successful operation of the organisation and is a vital part of developing the organisation's culture. The organisational development plan will provide a strong focus on having a clear plan for improving leadership, culture and engagement.
C1-3.10: Implement plans for integrated electronic patient record			
Dylan Roberts	3.10.5 Outline case for Tactical ED service blueprint (that can be delivered in 6-12 months) completed	30/11/2023	Ensuring systems and processes work as effectively as possible in ED is a core enabler for delivery high quality, timely and safe urgent and emergency care

Dylan Roberts	3.10.6 Prioritised list of tactical interventions from ED service blueprint evaluated	30/11/2023	Identifying the full list of identified problems and prioritised list of actions to ensure systems and processes work as effectively as possible in ED is a core enabler for delivery high quality, timely and safe urgent and emergency care

4. Improved access, outcomes and experience for citizens

Exec Lead	Milestone	Due Date	Why it's important to track
C1-4.5a: Vascular improvement plan			
Nick Lyons	4.5a.6 Vascular review reports and recommendations (parts 1 and 2) received	30/11/2023	These reviews will provide important insights into the areas that need further improving in our Vascular services
Nick Lyons	4.5a.7 Actions to address Vascular Review recommendations incorporated into the Vascular improvement plan and implementation commenced	30/11/2023	These reviews will provide important insights into the areas that need further improving in our Vascular services
Nick Lyons	4.5a.8 Continued Executive Team review of Vascular Steering Group progress and priorities	30/11/2023	These reviews will provide important insights into the areas that need further improving in our Vascular services
C1-4.5b: Urology improvement plan			
Nick Lyons	4.5b.5 Royal College of Surgeons Urology review and recommendations received	31/10/2023	These reviews will provide important insights into the areas that need improving in our Urology services
Nick Lyons	4.5b.6 Actions to address Urology review recommendations incorporated into the Urology improvement plan	16/11/2023	These reviews will provide important insights into the areas that need improving in our Urology services
Nick Lyons	4.5b.7 Updated Urology Improvement Plan, including both the GIRFT and RCS recommendations, presented to Executive Team for agreement on priorities of the service.	30/11/2023	These reviews will provide important insights into the areas that need improving in our Urology services

C1-4.5c: Ophthalmology improvement plan			
Adele Gittoes	4.5c.5 Integrated Eye Care Group established to oversee development and delivery of eye care service model	30/11/2023	This will ensure there is the right clinical and operational team involved in improving our Ophthalmology services
Adele Gittoes	4.5c.6 Integrated Eye Care service model and associated delivery plan development progressed	30/11/2023	This will ensure there is the right clinical and operational team involved in improving our Ophthalmology services
Adele Gittoes	4.5c.7 Ophthalmology Train and Treat implemented	14/11/2023	This will enable more patients with ophthalmology conditions to be treated closer to home by optometrists, getting more convenient and faster care.
Adele Gittoes	4.5c.8 Ophthalmology Pan BCU Clinical Lead appointed	30/11/2023	This will ensure there is the right clinical leadership in improving our Ophthalmology services
Adele Gittoes	4.5c.9 Ophthalmology R1 Clinical validation (Longest-Waiting R1s) completed	30/11/2023	This will ensure that every patient is on the optimal pathway and that those that need to be seen most urgently are for the services concerned
C1-4.5d: Oncology improvement plan			
Nick Lyons	4.5d.4 Establish long term Clinical Oncologist on-call cover for Saturdays as part of job planning	30/11/2023	Ensuring that the Oncology service has sufficient resource with the right skills in the right place at the right time to delivery high quality, timely and safe care
Nick Lyons	4.5d.5 Appoint Clinical Radiotherapy Lead, with a key responsibility being to support liaison and working with other welsh cancer centres	30/11/2023	Ensuring that the Oncology service has sufficient resource with the right skills in the right place at the right time to delivery high quality, timely and safe care
Nick Lyons	4.5d.6 Explore joint appointment opportunities with Bangor University	30/11/2023	Ensuring that the Oncology service has sufficient resource with the right skills in the right place at the right time to delivery high quality, timely and safe care
C1-4.5e: Dermatology improvement plan			
Adele Gittoes	4.5e.4 Agreed plan in place for Dermatology in the West, whilst wider Dermatology model is worked through	30/10/2023	The Dermatology service in the West is fragile and this action will ensure a safe interim service is operating whilst a more longer term plan for the whole Health Board is designed and agreed
Adele Gittoes	4.5e.5 Complete a clinically led options appraisal to address medium term risk pan BCUHB in relation to Dermatology Cancer	31/10/2023	To effectively manage the medium term risk, to ensure provision of high quality, timely and safe care in Cancer
Adele Gittoes	4.5e.6 Teledermoscopy model implementation commenced (subject to outcome of WG bid)	30/11/2023	This will enable more patients with dermatology conditions to be treated closer to home by primary care clinicians, getting more convenient and faster care.

Adele Gittoes	4.5e.7 Dermatology improvement plan and delivery framework further strengthened	30/11/2023	Dermatology services are currently fragile and this will address this with changes that make the service more sustainable and lead to better and more timely care
Adele Gittoes	4.5e.8 Pan BCU Dermatology Clinical Lead appointed	30/11/2023	This will ensure there is the right clinical leadership in improving our Dermatology services, leading to faster improvements
C1-4.5f: Plastics improvement plan			
Adele Gittoes	4.5f.4 Contract with St Helens & Knowsley in place, with a consistent partnership clinical model and data sharing model operating across BCUHB	30/10/2023	To ensure that there is smooth transfer of patients between the two organisations
Adele Gittoes	4.5f.5 Initial review of Plastics patients completed, as agreed with WHSSC and St Helens & Knowsley	30/11/2023	To establish if any harm has occurred as a result of delays in referrals
C1-4.7: Mental Health Inpatients Safety review - phase 2			
Teresa Owen	4.7.4 Action plan agreed by MHLD SLT to fully address the recommendations of the NCCU/NHSE Mental Health Inpatient Safety review	31/10/2023	To ensure the insights and recommendations from the review translates into improved services
C1-4.8a: CAMHS improvement plan			
Adele Gittoes	4.8a.5 Executive Team review held on CAHMS improvement progress and priorities	30/11/2023	This will ensure there is the right clinical and operational team involved in improving our CAHMS services
Adele Gittoes	4.8a.6 Test, and then refine, the CAMHS Recovery plan	30/11/2023	This will ensure there is the right clinical and operational team involved in improving our CAMHS services
C1-4.8b: Neurodiversity improvement plan			
Adele Gittoes	4.8b.4 Executive Team review held on ND improvement progress and priorities	30/11/2023	This will ensure there is the right clinical and operational team involved in improving our ND services
Adele Gittoes	4.8b.5 Continuous review and update of the ND Programme Plan	On-going	This will ensure there is the right clinical and operational team involved in improving our ND services
Adele Gittoes	4.8b.6 ND tender for private provision of assessments awarded	30/11/2023	This will ensure there is the right clinical and operational team involved in improving our ND services

5. A learning and self-improving organisation

Exec Lead	Milestone	Due Date	Why it's important to track
C1-5.2: Effective procedures for learning from incidents and preparing for inquests and HSE			
Angela Wood	5.2.5 Fully engaged with pilot of National Learning Framework alongside NHS Executive Wales	10/11/2023 .	This will be one of the key foundational building blocks of the organisation truly becoming a learning and self-improving organisation
Angela Wood	5.2.6 Revised SOP for inquests (incl monitoring system) agreed by Executive Team	20/10/2023	This will ensure that the organisation improves its processes in relation to inquests
Angela Wood	5.2.7 Refined SOP for escalating coronial matters regarding concerns/breaches/progress to the Executive Medical Director implemented, enabling proactive management prior to Coroner intervention	30/11/2023	This will ensure that the organisation improves its processes associated to matters related to the Coroner

Teitl adroddiad: ***Report title:***	Independent Review Management Response: Patient Safety Review			
Adrodd i: ***Report to:***	QSE Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	27 October 2023			
Crynodeb Gweithredol: ***Executive Summary:***	This report provides the initial management response following the Patient Safety Review.			
Argymhellion: ***Recommendations:***	The Committee is asked to note this report.			
Arweinydd Gweithredol: ***Executive Lead:***	Angela Wood, Executive Director of Nursing and Midwifery			
Awdur yr Adroddiad: ***Report Author:***	Matthew Joyes, Deputy Director for Quality 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):***	To support Special Measures			

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)***	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: Gweithredu argymhellion ***Next Steps:*** Implementation of recommendations	

QSE Committee, 27 October 2023

Special Measures Independent Reviews - Management Response

Patient Safety Review

1) Background and context

On 27 February 2023, the Minister for Health and Social Services announced that she was escalating the intervention status of the Health Board (BCUHB) to Special Measures with immediate effect. This decision reflected serious and outstanding concerns about board effectiveness, organisational culture, service quality and reconfiguration, governance, patient safety, operational delivery, leadership, and financial management. A number of Independent Advisors (IAs) were appointed to form a BCUHB improvement and support team to provide the support and advice necessary to enable BCUHB to implement the changes required to deliver improvements. The support and advice in this instance refer to an objectively derived blend of measures (monitoring, assurance, evaluation, guidance, encouragement, and support) which in combination will provide assurance to stakeholders (including patients, staff and the wider public).

Discussions with staff and previous Independent Members (IMs) disclosed a number of concerns around BCUHB affiliated patient safety, although no details were shared about these concerns. The Minister when escalating the Health Board to Special Measures requested that a separate assessment be conducted into whether or not these concerns were valid and if so whether further investigation was required.

This report provides the initial management response following this Patient Safety Review.

The Committee is reminded that a Clinical Governance Review is also due to start with strong interdependences, and this review will form long term support, therefore the actions around the wider quality agenda will grow as this further review commences.

2) Overview from Development Session

The Independent Advisor who led on the review presented the report to the Committee in a development session on 14 September 2023. This allowed the Committee to hear from the lead and to ask questions.

The review has not made specific recommendations but rather areas of focus. These areas of focus align fully to the overarching themes identified from all of the collective reviews undertaken as part of Special Measures to date (see below for mapping).

However as mentioned earlier, a number of other complimentary reviews are imminent or underway such as the Clinical Governance Review and Executive Portfolio Review and therefore the attached initial management response will develop to include actions aligned and linked to that wider work.

Where the areas of focus detailed in the report already show alignment to other reviews and improvement activity (such as the Executive Portfolio Review) then actions are not included here to avoid duplication).

3) Key Themes from the Review

Themes from reviews received to date	Applicable to this review *Check box if applicable*
1. Data, Intelligence & Insight Ensuring that there is an organisation wide approach with prioritised interventions into improving our data, intelligence and insight tools and capabilities. This will be a key enabler for sustainable improvement as well as supporting identification of future potential services of concern.	☒
2. Culture Defining, engaging and committing to the long-term work necessary to improve the culture of the organisation. Integrated into our broader organisational development plan across Culture, Leadership and Engagement.	☒
3. Risk Management Reviewing and refining our approach and appetite to risk, including how risks are identified, managed, mitigated, reported and monitored.	☒
4. Patient, Family, Carer Involvement A single coordinated approach to maximise involvement and engagement with our patients and their families and carers, using their experiences to guide our ongoing service improvement.	☒
5. Operating model Ensuring our operating model is designed to best deliver our strategic priorities, with clarity for everyone across all levels of the organisation on the roles and responsibilities, systems and processes within divisions and Pan BCU services.	☒
6. Organisation Governance and compliance Ensuring organisation wide visibility and understanding of governance best practice and ensuring adherence to it.	☒
7. Integrated Planning A well understood integrated approach to planning as a discipline, as well as contributions to our annual planning process.	☒

4) Recommendations

The committee is asked to **APPROVE** the management response in readiness for onward publication into the public domain.

Table 1: Management Response Action Plan

Delete boxes for themes that are not applicable to this review

Data, Intelligence and Insight					
Ref	**Action**	**Lead**	**Deadline**	**RAG status[1]**	**Progress Update**
	A Quality Dashboard will be developed underpinned by a series of specialist dashboards (i.e. falls, complains, etc). These dashboards will create a single version of the truth using agreed metrics directly connected to the quality systems for real time data. This will be fully aligned with an overarching integrated, balanced score-card style dashboard in development.	Deputy Director of Quality Governance	31 Dec 2023		An initial draft of the dashboard has been developed and is being reviewed for presentation as a first draft to the executive sponsor (the Executive Director of Nursing and Midwifery) ahead of an initial pilot and subsequent roll-out.
	To support the above, a quality data catalogue will be developed from an initial set of core measures, to be extracted from the quality systems in real-time and fed into the data warehouse.	Deputy Director of Quality Governance	31 Dec 2023		An initial link has been made between the Datix system and the data warehouse ahead of further testing and development.

	A Quality Systems User Group will be established to ensure wider engagement in the development and management of quality systems.	Deputy Director of Quality Governance	30 Nov 2023		The group has been established and held its first introductory meeting. The terms of reference will be developed in co-design with all key stakeholders and submitted to the Quality Delivery Group.
	As part of the re-alignment of portfolios in the quality function, a Quality Informatics Team will be established to provide greater analytical support and greater oversight of quality data alongside support to services. This team will closely link with the Business Intelligence and performance functions.	Deputy Director of Quality Governance	31 Dec 2023		The initial team has been pulled together and are now reviewing procedures and working practices.
	A Quality Surveillance Group will be established to undertake triangulation of quality data (including soft intelligence) which feed into the new Service of Concern Process being developed.	Deputy Director of Quality Governance	31 Dec 2023		
	A central and digital library of learning will be established which will be launched alongside a revised approach to the collation, analysis and dissemination of learning.	Deputy Director of Quality Governance	31 Mar 2024		

	A new Quality Report for the Executive Team will be established to improve visibility and assurance of quality.	Deputy Director of Quality Governance	30 Nov 2023		
	The Board Quality Report will be reviewed and refreshed to improve visibility and assurance of quality.	Deputy Director of Quality Governance	31 Dec 2023		

[1] **RAG status definitions: Green**: On track, **Amber**: Off track with mitigations in place to bring back on track, **Red**: Off track without mitigations in place to bring back on track

Culture

Ref	Action	Lead	Deadline	RAG status[1]	Progress Update
	Work will continue during 2023/24 to embed the Duty of Candour and Duty of Quality into everyday practice. This will be reported through to the QSE Committee.	Deputy Director of Quality Governance	31 Mar 2024		Duty of Candour training and Duty of Quality training continues to be rolled-out. An initial audit of compliance with the Duty of Candour has been completed.
	A Learning Organisation Framework will be developed, alongside a readiness assessment tool, that will inform future system and culture changes requires to become a learning organisation.	Deputy Director of People	31 Mar 2024		A draft framework has been developed which consists of key building blocks. A workshop with clinicians, leaders and staff is being arranged for November 2023 to ensure this work progresses in co-design with staff.
	A Just and Restorative Learning Culture Programme Plan will be developed to inform the future roll-out of this work.	Deputy Director of People	31 Mar 2024		An initial programme plan is being developed by the Associate Director of People, Senior OD Manager and Deputy Director of Quality Governance. An initial area of focus will be employee relation investigations.
	A Learning from Excellence process will be developed, to embrace the concepts of Safety II thinking.	Deputy Director of Quality Governance	31 Aug 2024		A "Great-ix" reporting tool, and associated cascade process for the learning, has been established and is now in place.

	The Human Factors Programme will be reviewed and refreshed alongside the launch of Civility Saves Lives training and champions.	Deputy Director of Quality Governance	31 Dec 2023		A Civility Saves Lives seminar was held with around 500 staff attending and two workshops have been held to train champions.

[1] **RAG status definitions: Green**: On track, **Amber**: Off track with mitigations in place to bring back on track, **Red**: Off track without mitigations in place to bring back on track

Risk Management

Ref	Action	Lead	Deadline	RAG status[1]	Progress Update
	A Quality Impact Assessment process, procedure and tool will be developed and launched aligned to the Duty of Quality and national guidance.	Deputy Director of Quality Governance	31 Dec 2023		
	A review of the concerns about specific services/specialities mentioned in the report will take place to ensure these are being assessed and reported, or to make recommendations for further analysis (this will be reported to the Quality Delivery Group).	Deputy Director of Quality Governance	31 Mar 2024		
	The approach to quality assurance will be reviewed and refreshed and a new regulatory procedure and quality assurance procedure will be developed.	Deputy Director of Quality Governance	31 Jan 2024		A new Regulatory Assurance Group has been established and the AMaT system now embedded for tracking regulatory actions. A "mock inspection" methodology has also been trialled for future use.

[1] **RAG status definitions:** **Green**: On track, **Amber**: Off track with mitigations in place to bring back on track, **Red**: Off track without mitigations in place to bring back on track

Patient, Family, Carer involvement

Ref	Action	Lead	Deadline	RAG status[1]	Progress Update
	A Real Time Feedback Task Group will be established to review the current approach to capturing patient and carer feedback and make recommendations for future development.	Deputy Director of Nursing (Patient Experience)	31 Dec 2023		Meetings for the task group have been set.

[1] **RAG status definitions:** **Green**: On track, **Amber**: Off track with mitigations in place to bring back on track, **Red**: Off track without mitigations in place to bring back on track

Operating Model					
Ref	**Action**	**Lead**	**Deadline**	**RAG status[1]**	**Progress Update**
	The roles of locally based quality support teams will be reviewed and proposals made for the best alignment.	Deputy Director of Quality Governance	30 Nov 2023		
	A review of the safeguarding concern detailed in the report will take place with recommendations for further work reported to the Quality Delivery Group.	Deputy Directors of Nursing	30 Jan 2024		

[1] **RAG status definitions:** **Green**: On track, **Amber**: Off track with mitigations in place to bring back on track, **Red**: Off track without mitigations in place to bring back on track

Integrated Planning

Ref	Action	Lead	Deadline	RAG status[1]	Progress Update
	The new Quality Strategy will be developed through a co-design process.	Deputy Director of Quality Governance	31 Mar 2024		
	A Quality Management System will be developed in line with the Duty of Quality, which will describe how Quality Planning, Quality Control, Quality Assurance and Quality Improvement will work together as a collective quality system	Deputy Director of Quality Governance	31 Mar 2024		This work will be undertaken with support from the NHS Wales Executive National Quality Team as part of the Clinical Governance Review.

[1] **RAG status definitions:** **Green**: On track, **Amber**: Off track with mitigations in place to bring back on track, **Red**: Off track without mitigations in place to bring back on track

Organisation Governance and Compliance

Ref	Action	Lead	Deadline	RAG status[1]	Progress Update
	The Quality Governance Framework will be reviewed and refreshed and will include greater clarity on the roles, responsibilities and authorities of all groups including the reporting expectations, process and templates. This will include mapping meetings into an overall cycle and introducing standard templates and a single document repository.	Deputy Director of Quality Governance	31 Dec 2023		
	Best practice guidance will be issued to IHCs and Regional Divisions to support effective local quality governance arrangements.	Deputy Director of Quality Governance	31 Jan 2024		
	The QSE Committee cycle of business will be reviewed and refreshed.	Board Secretary	31 Oct 2023		A proposed cycle of business has been developed and approved by the Executive Director of Nursing and midwifery (as executive lead) and is being submitted to the QSE Committee in October 2023.

	The Putting Things Right Policy will be reviewed and updated.	Deputy Director of Quality Governance	31 Dec 2023		
	The Complaints Procedure and process will be reviewed and updated to ensure the process is effective and a focus is place on learning.	Deputy Director of Nursing (Patient Experience)	30 Jan 2024		
	The Incident Procedure and process will be reviewed and updated to ensure the process is effective and a focus is place on learning.	Deputy Director of Nursing (Patient Safety)	31 Dec 2023		The procedure is currently being drafted to take into account feedback and a workshop is being held in October 2023.
	The Claims Procedure and process will be reviewed and updated to ensure the process is effective and a focus is place on learning. This work will align with the national claims learning programme being undertaken by the Welsh Risk Pool.	Deputy Director of Quality Governance	30 Jan 2024		

	The Redress Procedure and process will be reviewed and updated to ensure the process is effective and a focus is place on learning. This work will align with the national claims learning programme being undertaken by the Welsh Risk Pool.	Deputy Director of Quality Governance)	30 Jan 2024		
	The Inquest Procedure and process will be reviewed and updated to ensure the process if effective and a focus is place on learning. This will take into account feedback from HM Senior Coroners.	Deputy Director of Quality Governance)	30 Nov 2023		A procedure has been developed and is being presented to the Executive Team for approval in October 2023.

[1] **RAG status definitions: Green**: On track, **Amber**: Off track with mitigations in place to bring back on track, **Red**: Off track without mitigations in place to bring back on track

Teitl adroddiad: ***Report title:***	Independent Review Management Response. National Collaborative Commissioning Unit (NCCU) and the NHS Executive Performance and Assurance Division Mental Health Inpatient Safety Review report.			
Adrodd i: ***Report to:***	BCUHB Quality, Safety and Experience Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	27 October 2023			
Crynodeb Gweithredol: ***Executive Summary:***	Welsh Government, as part of the Special Measures intervention, commissioned the National Collaborative Commissioning Unit (NCCU) and the NHS Executive Performance and Assurance Division to undertake a joint quality and safety review and inspection of all inpatient Mental Health & Learning Disability (MHLD) units. Joint inspections were held during April and May 2023, and the report was received by the Health Board in June 2023. The report contained 8 recommendations. Colleagues from the National Collaborative Commissioning Unit (NCCU) and the NHS Executive Performance and Assurance Division attended the QSE Committee (Development Session) on 15th September 2023 to present and discuss the review report findings with members.			
Argymhellion: ***Recommendations:***	The committee is asked to approve the management response.			
Arweinydd Gweithredol: ***Executive Lead:***	Teresa Owen, Executive Director of Public Health and Lead for Mental Health and Learning Disabilities.			
Awdur yr Adroddiad: ***Report Author:***	Carole Evanson, MH&LD Director of Operations. Adrianne Jones, MH&LD Operational Business Lead.			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***	
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	To support Special Measures
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)***	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:***	Not applicable

(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)***	Not applicable
Camau Nesaf: Gweithredu argymhellion ***Next Steps:*** To progress implementation of NCCU Action Plan.	

BCUHB Committee Development Session – QSE, 27th October 2023.

Special Measures Independent Reviews - Management Response

National Collaborative Commissioning Unit (NCCU) and the NHS Executive Performance and Assurance Division Mental Health Inpatient Safety Review.

1) Background and context

On the 27 February 2023, the Minister for Health and Social Services announced that she was escalating the intervention status of Betsi Cadwaladr University Health Board to special measures. There had also been a number of high profile inquests and incidents relating to the Mental Health Service within the Health Board. Following these incidents, the coroner has raised a number of concerns. These included:

- Concerns that it has taken the Health Board a considerable amount of time to update and provide an Action Plan in relation to the death of a patient, with the most recent version of the Action Plan still containing outstanding actions although the patient died over two years ago.

- Concerns that learning and actions arising from the action plan were not more quickly addressed, with added concerns that if the learning, actions and changes are taking so long then there is a risk that deaths will continue in the interim.

- That there is an evident lack of overall strategic direction to investigations and learning.

In reponse to the above concerns, Welsh Government, as part of the Special Measures intervention, commissioned the National Collaborative Commissioning Unit (NCCU) and the NHS Executive Performance and Assurance Division to undertake a joint quality and safety review and inspection of all inpatient Mental Health & Learning Disability Units. Joint inspections were held during April and May 2023, and a report was received by the Health Board June 2023. This report contains eight recommendations.

Colleagues from National Collaborative Commissioning Unit (NCCU) and the NHS Executive Performance and Assurance Division attended the QSE Committee on 15th September 2023 to present and discuss the review report findings.

2) Overview from Development Session

The National Collaborative Commissioning Unit (NCCU) and the NHS Executive Performance and Assurance Division presented their findings under the following three headings –

- Leadership and Culture
- Process and Oversight
- Observation of Environment

The key messages were shared and discussed, with eight recommendatons noted -

Recommendation 1:

- The Health Board must ensure that all relevant staff are appropriately trained to undertake ligature risk assessment with consideration to this being a peer review process across the Division. The Health Board and the Division must also ensure that all identified risks are mitigated, as soon as possible.

Recommendation 2:

- The Division must ensure that processes are in place to confirm that all physical health monitoring documentation is completed, as prescribed, by staff who are appropriately trained to do so. The Division must also ensure that any escalation of physical health issues of patients are considered, within an appropriate timescale, by the MDT (Multidisciplinacy Team).

Recommendation 3:

- The Health Board and Division should continue to strengthen the escalation and governance arrangements from the Ward to the Board, ensuring there is clear communication and tracking of actions to completion.

Recommendation 4:

- The Division must ensure that all staff are aware of and follow the most current operational policies and procedures, and that staff are maintaining vigilance in enacting them.

Recommendation 5:

- The Division should ensure that all inpatient staff, including temporary staff, are suitably trained to meet the needs of the patients, and that all staff are aware of any potential areas of risk and the actions to be taken if a hazard or risk is discovered.

Recommendation 6:

- The Division must ensure that care and treatment plans reflect the current needs and intended outcomes of patients admitted to inpatient services, including how risk and safety is managed during the admission.

Recommendation 7:

- The Division should continue to strengthen the opportunities to receive feedback from service users, family and carers.

Recommendation 8:

- The Welsh Government and then Health Board should consider a follow up review to ensure that improvements have been sustained and outstanding actions have been completed or are progressing towards completion.

The actions to address each of the above recommendations are included in the NCCU Action Plan and have been aligned to seven cross cutting themes as noted in section 3 below.

3) Key Themes from the Review

Each of the overall themes are applicable to this review, as reflected in the table. The NCCU Action Plan has been mapped to the eight withrecommendations. As part of the implementation this is supplemented by ensuring that delivering the individual actions also addresses the root causes reflected in these themes. This includes ensuring collaboration with other Services across the organisation.

Themes from reviews received to date	Applicable to this review *Check box if applicable*
1. Data, Intelligence & Insight Ensuring that there is an organisation wide approach with prioritised interventions into improving our data, intelligence and insight tools and capabilities. This will be a key enabler for sustainable improvement as well as supporting identification of future potential services of concern.	☐
2. Culture Defining, engaging and committing to the long-term work necessary to improve the culture of the organisation. Integrated into our broader organisational development plan across Culture, Leadership and Engagement.	☒
3. Risk Management Reviewing and refining our approach and appetite to risk, including how risks are identified, managed, mitigated, reported and monitored.	☒
4. Patient, Family, Carer Involvement A single coordinated approach to maximise involvement and engagement with our patients and their families and carers, using their experiences to guide our ongoing service improvement.	☒
5. Operating model Ensuring our operating model is designed to best deliver our strategic priorities, with clarity for everyone across all levels of the organisation on the roles and responsibilities, systems and processes within divisions and Pan BCU services.	☒
6. Organisation Governance and compliance Ensuring organisation wide visibility and understanding of governance best practice and ensuring adherence to it.	☒
7. Integrated Planning A well understood integrated approach to planning as a discipline, as well as contributions to our annual planning process.	☐

4) Recommendations

The committee is asked to **APPROVE** the management response in readiness for onward publication into the public domain.

Table 1: Thematic Management Response Action Plan

Patient, Family, Carer Involvement

Ref	**Action:** A single coordinated approach to maximise involvement and engagement with our patients and their families and carers, using their experiences to guide our ongoing service improvement.	NCCU/NHS Executive report Recommendation Reference	Lead	Deadline	RAG status[1]	Progress Update
01	Capture whether care provision is caring and effective and agree how this is to be measured. Record findings and feedback on safety.	3.6	Deputy Director of Nursing	31/12/23		On track
02	With the support of the Patient Experience Team (PALS), review Patient/family experience of safety planning, both in hospital, and in home treatment.	6.10	Head of Nursing for each area	30/04/24		On track
03	Review, adopt best practice and improve mechanisms to capture and act on patient, family and carer feedback – including: 1) Incorporating tablet based feedback collection in team bases and in-patient areas where patients are seen clinically 2) Utilising data in service redesign 3) Considering national patient feedback through Patient/Carer experience group 4) Capture local evidence such as PALS feedback and Feel Good Fridays during walkabouts.	7.2 7.3 7.8 3.7	Head of Integrated Strategy and Development Head of Nursing	31/12/23		On track

04	Patient Experience Team (PALS), together with CANIAD, undertake to review the current approach and to recommend stronger alignment of the division to corporate Patient Carer Experience processes	7.1	Head of Integrated Strategy and Development	30/04/24		On track

[1] **RAG status definitions:** **Green**: On track, **Amber**: Off track with mitigations in place to bring back on track, **Red**: Off track without mitigations in place to bring back on track

Organisation Governance and Compliance

Ref	**Action:** Ensuring organisation wide visibility and understanding of governance best practice and ensuring adherence to it.	NCCU/NHS Executive report Recommendation Reference	Lead	Deadline	RAG status[1]	Progress Update
01	Review, refresh, deliver, track and evidence learning associated to the following areas of induction and training, across both BCU and bank staff: 1) Environmental Ligature Risk Assessment 2) Communication techniques for deteriorating patients 3) End of life policy 4) Physical Health Assessment, monitoring and recording 5) Divisional policies 6) Relational and environmental security 7) Outcome focussed care and treatment planning 8) WARRN training requirements 9) Restrictive Physical Intervention 10) Clinical Risk 11) Suicide prevention/awareness 12) Improving the quality of care and treatment plans 13) Importance of working to the ratified or approved draft of the most recent policies and procedures	1.1/1.2/1.3/1.4 and 1.6 2.7 2.12 2.14 4.5/4.6 5.1 5.2/5.3 5.2/5.5/6.1/6.2/6.8/6.9 5.6 2.1/5.9/6.3 6.4 5.2/5.3/6.8/6.11 4.1/4.3/4.5/4.6	Assistant Director of Nursing	31/12/23		On track
02	A programme of audit improvement and simplification, supported by new tools and a revised framework, feeding into relevant training and governance, across the following areas:		Deputy Director of Nursing &	31/12/23		On track

	1) Quality & Safety/clinical risk audits 2) Peer audits of in-patient environments 3) Physical Health Monitoring 4) Use of Clozapine in Adults 5) Older Persons anti-psychotic medication 6) Policy understanding and consistency of application 7) Joint safety plans 8) Care and Treatment Plans	1) 2.1 2) 1.8/2.2 3) 2.4 4) 2.10 5) 2.11 6) 2.14 7) 6.7 8)5.2/5.3/6.8/6.11	Governance Project Lead			
03	Ensure key Groups (e.g. Physical Health Group, Ligature Risk Reduction Group, Learning and Action Group) operate effectively, receive and scrutinise the relevant information and have their feedback cascaded through appropriate governance channels	1.6	Assistant Director of Nursing & Medical Director	30/11/23		On track
04	Ensure capital planning reflects significant mitigations of divisional risk and that operational estates functions are effective in each area of identified environmental. Including ensuring plans are in place for wards to promote the psychological/physical/sexual safety of patients in terms of layout and use.	1.7	Head of Integrated Strategy and Development & Assistant Director of Nursing	31/12/23		On track
05	Review, adopt best practice and improve pathways and processes relating to the following areas: 1) Acute Care Pathway to accurately record the Physical Health Baseline Assessment 2) Management and escalation of the deteriorating patient 3) Admission processes to provide access to multi-disciplinary professionals 4) Reporting on Datix, escalation of incidents, acute care meetings, safety huddles, local, divisional PTR 5) Ongoing thematic analysis of learning and actions as in Divisional Improvement Plan 6) Outcome focussed care and treatment planning 7) Roster management and contingency supply and escalation	1) 2.5/6.5 2) 2.6 3) 2.18 4) 3.2 5) 3.9 6) 5.2/5.3 7) 5.7	Deputy Director of Nursing	31/12/23		On track

06	Review, refresh and ensure compliance with the following key frameworks and policies: 1) Physical Health Policy, to include the deteriorating patient 2) Framework for senior leadership connectedness to wards	Recommendation 3 2.14 3.3	Head of Governance	31/12/23		On track
07	Ensure appropriate documentation and record keeping in relation to all critical areas (e.g. clinical risk and physical health monitoring) is being used and that appropriate short term system solutions are explored	5.9	Deputy Director of Nursing & Head of Integrated Strategy and Development	31/12/23		On track
08	Chairs Assurance report from the MH&LD Learning and Actions group will be provided to appropriate Divisional and Corporate Governance forums, to update on progress of the NCCU Action Plan.	Recommendation 3 4.1	Head of Governance	31/12/23		On track
09	Work with the Office of the Board Secretary to ensure the timeliness of Board approval of policies, with monthly progress reporting to MH&LD SQDG.	Recommendation 4 4.1	Head of Governance	31/12/23		On track

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Culture

Ref	**Action:** Defining, engaging and committing to the long-term work necessary to improve the culture of the organisation. Integrated into our broader organisational development plan across Culture, Leadership and Engagement.	**NCCU/NHS Executive report Recommendation Reference**	**Lead**	**Deadline**	**RAG status[1]**	**Progress Update**
01	1) Ward to Board process needs to be formalised where required, linking in the Governance Framework and reporting cycle development.	3.1	Head of Governance	31/1/24		On track

	2) Develop a clear and comprehensive framework for senior leadership connectedness to wards 3) Enhance staff engagement by increasing Senior Leadership Team (SLT) walkabouts and the recording of staff discussions. 4) Formalise senior leadership visibility both in area and the division via a "walkabout type process" in the areas of staff, patient and carer feedback, advertised with a written feedback record provided in a "You Said, We did" format. 5) Continue to communicate the 'policy of the month' in the staff briefing and ensure dissemination to all staff Division wide. 6) Ensure staff in all areas are aware of the location of the directory/compendium of MH&LD Divisional Policies (Betsinet and MH&LD Hub).	3.3 3.4 3.5 4.8 4.5				
02	Review induction of new starters and ensure that all staff are aware of the importance of current policies and working to the ratified or approved draft of the most recent policies and procedures, and ensure adherence to policy forms part of Staff Connect Day.	4.4	Training, Development and Wellbeing Lead	30/11/23		On track
03	Identify locations where staff have no access to Betsinet, and introduce policy audit whereby policy folders are sampled and tested with variations recovered and themes for learning shared to ensure most recent version is in place.	4.7	Head of Governance	31/12/23		On track

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Risk Management

Ref	**Action:** Reviewing and refining our approach and appetite to risk, including how risks are identified, managed, mitigated, reported and monitored.	NCCU/NHS Executive report Recommendation Reference	Lead	Deadline	RAG status[1]	Progress Update
01	A process map/flow diagram to be developed clearly detailing reporting on Datix, escalation of incidents, acute care meetings, safety huddles, local, Divisional PTR	3.2	Head of Governance	30/11/23		On track
02	Strengthen monitoring of open action plans – SUIs, Regulation 28, HIW and ensure learning is communicated by an agreed process and ensure reporting is embedded in the Governance Framework	3.8	Head of Governance	31/1/24		On track
03	Support ongoing thematic analysis of learning and actions as in Divisional Improvement Plan 2023	3.9	Head of Governance	31/1/24		On track
04	To ensure all agency, bank and locum staff, who work across MH&LD, have training needs clearly identified. To ensure this includes MH&LD induction, physical health monitoring and recording, Restrictive Physical Intervention, moving and handling.	5.6	Deputy Director of Nursing	30/4/24		On track

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Operating Model

Ref	**Action:** Ensuring our operating model is designed to best deliver our strategic priorities, with clarity for everyone across all levels of the organisation on the roles and responsibilities, systems and processes within divisions and Pan BCU services.	NCCU/NHS Executive report Recommendation Reference	Lead	Deadline	RAG status[1]	Progress Update
01	Development of a Communication and Engagement Plan for the Division in order to strengthen two- way communication from Board to Ward and vice versa with the need to involve communications lead for MH&LD in aligning to Health Board process.	4.0	Head of Integrated Strategy and Development	31.1.24		On track

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