

## **Bundle BCU Quality, Safety and Experience Committee 5 March 2026**

- 1 PRELIMINARY MATTERS
  - 1.1 13:00 - QS26.27 Welcome & Apologies  
*Caroline Turner, Chair*
  - 1.2 13:01 - QS26.28 Declarations of Interest  
*Caroline Turner, Chair*
  - 1.3 13:02 - QS26.29 Minutes of the Previous Meeting - 15 January 2026  
*Caroline Turner, Chair*  
QS26.29 Unconfirmed PUBLIC Minutes 15.01.26
  - 1.4 13:04 - QS26.30 Action Log  
*Caroline Turner, Chair*  
QS29.30 QSE Action Log PUBLIC 2026
  - 1.5 13:09 - QS26.31 Patient Story  
*Angela Wood, Executive Director of Nursing & Midwifery*  
QS26.31 QSE Patient Story Item
  - 1.6 13:24 - QS26.32 Service Presentation  
*Teresa Owen, Executive Director of Allied Health Professionals & Health Sciences*  
QS26.32 QSE SMS
- 2 GOVERNANCE, RISK & ASSURANCE
  - 2.1 13:39 - QS26.33 Integrated Quality Report  
*Angela Wood, Executive Director of Nursing & Midwifery*  
QS26.33 QSE Integrated Quality Report March 26
  - 2.2 14:09 - QS26.34 Integrated Performance Report  
*Ed Williams, Director of Performance & Commissioning*  
QS26.34.1 IQPR Coversheet  
QS26.34.2 IQPR
  - 2.3 14:29 - QS26.35 Corporate Risk Register  
*Pam Wenger, Director of Corporate Governance*  
QS26.35 QSE Corporate Risk Register Report
  - 2.4 14:39 - QS26.36 Challenged Services Update  
*Item jointly presented by:*  
*Paolo Tardivel, Executive Director of Transformation & Strategic Planning*  
*Dr Clara Day, Executive Medical Director*  
*Tehmeena Ajmal, Chief Operating Officer*  
QS26.36 Challenged Services Overview Report QSE March 2026
  - 2.5 14:54 - QS26.37 DECLO ALNET Act - Annual Report  
*Liz McKinney, Designated Education Clinical Lead Officer (DECLO)*  
QS26.37.1 DECLO and ALNET Act  
QS26.37.2 ANNUAL REPORT 2024-2025 - DECLO ALNET Act
  - 2.6 15:04 - BREAK
- 3 IMPLEMENTING THE QUALITY MANAGEMENT SYSTEM (QMS)
  - 3.1 15:14 - QS26.38 Learning Repository  
*Angela Wood, Executive Director of Nursing & Midwifery*  
QS26.38.1 Cover sheet Learning Repository  
QS26.38.2 Learning Repository
- 4 IMPROVING QUALITY, OUTCOMES & EXPERIENCE
  - 4.1 15:29 - QS26.39 Adult Mental Health & Learning Disabilities  
*Teresa Owen, Executive Director of Allied Health Professionals & Health Sciences*

QS26.39.1 QSE Report MHL D

- 5 EFFECTIVE ENVIRONMENT FOR LEARNING & SKILLS DEVELOPMENT
- 5.1 15:44 - QS26.40 Medical Education  
*Dr Clara Day, Executive Medical Director*  
QS26.40 QSE Medical Education
- 5.2 15:59 - QS26.41 Research and Development Annual Report  
*Dr Clara Day, Executive Medical Director*  
QS26.41.1 R&D Cover Sheet  
QS26.41.2 R&D Report
- 6 FOR INFORMATION
- 6.1 16:14 - QS26.42 Corporate Governance Report  
*Pam Wenger, Director of Corporate Governance*  
QS26.42.1 Corporate Governance Report  
QS26.42.2 QSE Forward Work Plan PUBLIC
- 6.2 16:19 - QS26.43 Llais Monthly Report  
QS26.43 Llais Monthly Report Bilingual
- 7 16:21 - CLOSING BUSINESS
- 7.1 QS26.44 Agree Items for Referral to Board / Other Committees  
*Caroline Turner, Chair*
- 7.2 QS26.45 Review of meeting effectiveness  
*Caroline Turner, Chair*
- 7.3 QS26.46 Date of the Next Meeting - 7 May 2026  
*Caroline Turner, Chair*
- 7.4 QS26.47 Resolution to exclude the Press and Public  
*'Those representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960'*

**Betsi Cadwaladr University Health Board (BCUHB)**  
**Unconfirmed Minutes of the Quality, Safety and Experience Committee**  
**held in Public on 15 January 2026**  
**held in the Boardroom, Carlton Court, St Asaph and via Teams**

<b>Members Present</b>	
<b>Name</b>	<b>Title</b>
Caroline Turner	Independent Member (Chair)
Nesta Collingridge	Head of Risk Management
Dr Clara Day	Executive Medical Director
Jody Evans	Regional Risk Manager
Urtha Felda	Independent Member
Dave Harris	Internal Audit (via teams)
Matthew Joyes	Deputy Director of Legal Services
Joanne Kendrick	Head of Quality
Mike Larvin	Independent Member (via teams)
Chris Lothian-Field	Independent Member (via teams)
Jane Moore	Executive Director of Public Health
Teresa Owen	Executive Director of Allied Health Professionals
Paolo Tardivel	Executive Director of Transformation & Strategic Planning
Pam Wenger	Director of Corporate Governance (via teams)
Ed Williams	Director of Performance (via teams)
Angela Wood	Executive Director of Nursing & Midwifery
<b>Committee Support</b>	
Philippa Peake-Jones	Head of Corporate Governance
Harriet Abbott	Minute Taker

<b>PRELIMINARY MATTERS</b>
<p><b>QS26.01 Welcome and Apologies</b></p> <p>Apologies were noted from Dyfed Edwards, Stuart Keen, Tehmeena Ajmal and Geoff Ryall-Harvey.</p>
<p><b>QS26.02 Declarations of Interest</b></p> <p>No declaration of interests were received.</p>
<p><b>QS26.03 Unconfirmed Minutes of the Meeting held on 6 November 2025</b></p> <p>The following amendments to the minutes were agreed:</p> <ul style="list-style-type: none"> <li>Item QS25.113: System name to be corrected to "EIDO".</li> </ul> <p>It was agreed that the minutes of the meeting held on 6 November 2025, subject to the above amendments, were a true and accurate record.</p>

#### QS26.04 Matters Arising & Action Log

Members received the action log and noted progress against the following actions:

- **Action QS25.09.3** Citizens Engagement Report - “Listening to People Framework” to return as part of the Integrated Quality Report at the next Committee meeting.

It was resolved that the Committee:

- **AGREED** to close the actions that were proposed for closure.

#### QS26.05 Patient Story

The Executive Director of Nursing & Midwifery presented the item, which focused on the Carers Outreach Service.

In discussing the item, the Committee:

- Were advised of the Carers Strategy being developed in BCUHB. Updates regarding this will be brought to a future Committee meeting.
- Emphasised the importance of raising the awareness of the service amongst BCU staff, and how use of the service may aid prevention of patient hospital admissions, as well as aid transfer of care. The importance of increasing knowledge of the service across Allied Health Professionals, partner agencies and Local Authorities was also highlighted.
- ML declared an interest – has used the service as is his wife’s main carer.
- Referenced similar services available in North Wales, such as the North East Wales Carers Intervention Service (NEWCIS).
- Referenced the work completed through the North Wales Regional Carers Group, focused on mapping of current support and provision available across hospitals and communities. The outcome of this exercise will be shared with QSE and Planning, Population Health & Partnership Committees once received through the National Carers Report.
- Also made reference to DEWIS and importance of ensuring staff are aware of these resources to aid patient care.

The following action was agreed:

- **Action QS26.5.1:** National Carers Report to be reviewed by PPHP & QSE Committees.

It was resolved that the Committee:

- **NOTED** the current position.

#### STRATEGIC ITEM

#### QS26.06 Rapid Quality Review – Emergency Department

The Executive Medical Director presented the item, and highlighted the following:

- The Rapid Quality Review focused on Emergency Departments, looking at quality in further depth, exploring how this is measured, how it is changing, whilst providing assurance to the Board.
- It is known that there are areas of risk within emergency care that can impact on other aspects of departments
- The Rapid Quality Review was held in November 2025, with attendance from all IHCs. During the review, all IHCs provided responses on their concerns with quality, how quality is measured, how they are assured regarding this and what is needed to further improve quality.
- During the review, the importance of the use of the Datix systems was emphasised in regards to incident management.
- Following the Rapid Quality Review a number of actions were agreed, to which good progress is being made.
- The processes of “boarding” and “forward waiting” referenced in the paper were explained, and it was emphasised that the process of accelerated boarding can only be initiated by the Gold On Call, and is only used in a scenario to de-escalated risk due to large demand in Emergency Departments (ED). Cancer wards and Childrens wards are exempt from this process. If the process is initiated, risk assessments are undertaken and appropriate staffing levels must be in place.
- Noted the recent visits to Ysbyty Gwynedd by Health Education and Improvement Wales (HEIW), referenced in the paper, and were advised that actions following the visits have been implemented. An anonymous system has been rolled out, and over the 6 weeks since implemented, a reduction in incidents has been noted.

In discussion the item, the Committee:

- Noted the improvement in productivity due to the live data implementation. A reduction in ED demand was noted earlier than expected.
- Were advised that ambulance handover time is improving. Over the Christmas period it was expected that the position would worsen due to increased demand and limited primary services, however the position has been seen to improve again.
- Noted further work that is required to ensure Same Day Emergency Care (SDEC) is working as effectively as possible. Pressures remain in place, including staffing levels and increasing demand, however an increased senior management presence is noted. The Chief Executive and Chair of the Board visited acute sites earlier in January, linking in with ED staff. Response to the newly implemented boarding processes has noted some queries, however overall feedback has been positive.
- Noted recent meetings with Local Authority partners ensuring awareness of changes.
- Agreed for a further updated to be brought to a future meeting for assurance through the Integrated Quality Report item.

The following actions were agreed:

- **Action QS26.06.1:** Update of ED Rapid Review to be included in the next Integrated Quality Report.

It was resolved that the Committee:

- **NOTED** the current position.

## GOVERNANCE, RISK & ASSURANCE

### QS26.07 Integrated Quality Performance Report

The Executive Director of Nursing & Midwifery presented the item, and highlighted the following:

- IHCs are being supported to ensure a reduction in the number of overdue open incidents. It was clarified that the majority of incidents are low level incidents.
- An improved position in National Reportable Incidents (NRIs) has been noted, with there being no overdue NRI's locally as of 15.01.26.
- BCUHB is the first Health Board in Wales to implement the ICON Safeguarding programme.
- Challenges continue regarding Infection Prevention Control, although an improved position is noted, with further improvement expected. A number of wards in Ysbyty Gwynedd were closed over the Christmas period due to Norovirus, which covered up to 5 wards (123 beds). This figure is now largely reduced, and as of 15.01.26, 8 beds are affected. Masks were implemented by the Executive Director of Nursing & Midwifery across all clinical areas to reduce transmission of infections. Levels have subsequently reduced, and mask wearing as now been stood down.
- An increased number of open complaints is noted; however, the organisation is still expected to achieve target. Patient experience rating is 85%+. Urgent and Emergency Care patient experience continues to be rated as one of the lowest, and requires improvement.
- HIW actions regarding ED in Ysbyty Gwynedd remain overdue. Actions regarding Cemlyn ward are progressing. The report on Hergest is due to be published on 22 January 2026, and actions regarding Pantomime ward are currently being reviewed.
- With regards to the Ombudsman, one case remains open, with a response due by the end of January, which is expected to close on target. It is noted that fewer cases are being upheld by the Ombudsman.
- It was agreed for an update on mental health services to be included at the next meeting as part of the Integrated Quality Report to show how data from the Quality Management System is impacting on the area.
- One Prevention of Future Death Notice was received, which has been responded to, with recommended changes implemented by the service. Another PFD has been received this week, which will be included in the next report to the Committee.
- Regarding Learning from Events Reports, 12 are overdue as of 12 January 2026. A reduction has been seen over time, reflecting the ongoing work.

*[Ed Williams joined the meeting].*

In discussing the item, the Committee:

- Discussed mortality rates, and were advised that the rate is determined by coding on the system (Relative Adjusted Morality – RAM). Previously issues with coding were identified, and it was advised that this is now 95% complete. Due to the previous coding issues, the RAM was subsequently shown incorrectly and the adjusted deaths was lower than it should have been. It was advised that the recent decrease supports that this was a coding error.
- Noted the higher number of open incidents in central area, compared with other IHCs, although acknowledged this has dropped since the previous month. It was

clarified that there has been a change in the leadership team in the past 12-15 months, and ongoing work to ensure governance, with noted improvement as the backlog of open incidents is reviewed and addressed. Due to this, Central area has the strongest improvement trajectory of the three IHCs.

- Were advised that the previous PFD was dated 24 October 2025, and it was agreed for this to be added to the Integrated Performance Report for clarity.
- Agreed for the redress change process to be a topic for an upcoming development session, which is to be presented by the Executive Medical Director.

The following actions were agreed:

- **Action QS26.07.01:** Update to be given regarding the QMS in relation to Mental Health at a future meeting.
- **Action QS26.07.02:** date of the last Prevention of Future Deaths Notice to be added to the Integrated Performance report for clarity.
- **Action QS26.07.03:** Redress change process to be an item on the QSE development day.

It was resolved that the Committee:

- **NOTED** the current position.

## QS26.08 Integrated Performance Report

*[Chris Lothian Field joined the meeting].*

The Director of Performance and Commissioning presented the item. Highlights included:

- There are noted concerns regarding the increasing number of Ombudsman requests received, with 41 received in month, which is currently the highest in 12 months. The reason for this is currently being explored.
- Regarding Learning from Events reports, areas with high averages include Pressures Ulcers and Patient Safety incidents.
- There is a large level of risk due to the number of patients 100% overdue follow up. At the end of December 2025, 121,000 were 100% overdue follow up.

In discussing the item, the Committee:

- Discussed the “Never Event” cover referenced in the report.
- Noted that whilst the number of Ombudsman requests was at a peak, that 29 out of 41 were not upheld and taken forward. It was added that the Ombudsman has recently adopted a new hybrid way of working, which impacts on what is classed as a contact. This is thought to be a contributor to the higher figures; it was agreed for this to be monitored through the Committee.
- Acknowledged that whilst there are some high averaged for some areas within Learning from Event reports, in regards to some areas, harm is reduced. The Committee were assured that this is being monitored and tracked to attempt to prevent escalation.
- Noted regarding patient safety incidents that it was positive to see that incidents were being reported, and that severity of incidents was low. An increase in severe or catastrophic events has not been noted, and BCUHB is benchmarked similarly with other Welsh Health Boards.

- Noted challenges regarding planned care, and discussed the use of Patient Initiated Follow Up (PIFU), validation methods and potential impact on general practice. It was clarified that assurance is also received at PFIG Committee regarding Planned Care. Work is ongoing to determine potential risk or patient harm due to waiting times, as well as the best use of resources to determine this.
- Agreed for an update on the 100% overdue follow up waiting list to be included in the next report.
- Noted that the percentage of patients offered index colonoscopy was significantly below target. This is a national capacity issue, experienced across Wales. It was agreed for further work to understand trends to take place regarding screening services, and for an update to be given at a future meeting.
- Reviewed the coding errors data from the report, and were advised of a previous backlog. This backlog is currently being addressed, and a reduction in errors is expected. It was requested that this information be reviewed to provide assurance on accuracy.
- Reviewed the information regarding diabetes within the report, and were advised on ongoing work with primary care colleagues to improve knowledge and support. It was agreed for diabetes to be included as a topic at the next Committee development session.
- Requested that future updates include a presentation on the eight components comprising planned care.
- Were advised of the updated version of the performance report being drafted, the version being utilised in the new financial year.

The following actions were agreed:

- **Action QS26.08.01:** Update required regarding number of 100% overdue follow up appointments. Discussion between The Director of Performance and Director of Nursing & Midwifery to agree format outside of meeting.
- **Action QS26.08.02:** Update on screening services to be given at a future meeting.
- **Action QS26.08.03:** Update to be requested from Kathryn Lang for assurance of accuracy of coding data.
- **Action QS26.08.04:** Diabetes to be added as topic for the development session.

It was resolved that the Committee:

- **NOTED** the current position.

*[Nesta Collingridge and Jody Evans joined the meeting].*

### **QS26.09 Board Assurance Framework (BAF)**

The Head of Risk Management presented the item. Highlights included:

- The update presented is from October – November 2025.
- A deep dive has recently been undertaken by the Risk Scrutiny Groups. Feedback from the groups has included the need to look at Out of Area placements to provide assurance.
- A number of risks were reviewed and updates provided, as well as resulting actions.
- Following the recent meeting of Planning, Population Health & Partnership Committee (PPHP), next steps were agreed in regards to the BAF, which will ensure

more assurance is received by the Committees on previously limited assurance areas.

- The BAF will be moving to a portal system, which is expected to aid workflow and sign off, and will be realigned once the IMTP is updated.

In discussing the item, the Committee:

- Were advised that it is expected the BAF will be aligned with the IMTP by the end of March 2026.
- Were advised regarding the item on Learning Repository Development, that this risk was closed in December 2025.
- Were advised of updates against outstanding items, and assured that the risks were being reviewed and managed. 2 out of 6 were still outstanding, with further actions required to allow progression to the next stage. The Executive Director of Nursing & Midwifery and the Chief Operating Officer have met to review how this is managed and delivered operationally.
- A number of elements are being progressed through a link with Mental Health and Physical health, with ongoing work with Primary Care.

It was resolved that the Committee:

- **NOTED** the current position.

*[Nesta Collingridge, Jody Evans and Ed Williams left the meeting, and Paolo Tardivel joined the meeting].*

## IMPROVING QUALITY, OUTCOMES & EXPERIENCE

### QS26.10 Challenged Services Update

The Executive Director of Transformation & Strategic Planning presented the item. The following points were highlighted:

- A number of services are in urgent need of support. This links with work regarding Foundations for the Future and IMTP.
- It was clarified that “Challenged Services” in this context refers to a specific group of services identified by Welsh Government, and does not include all services classed as challenged.
- There is ongoing work to evolve the report further, with the aim of clearer actions and ongoing work.
- Updates were given in regards to each challenged service:
  - Oncology: The service is on track with a number of actions, with three consultant positions being advertised. There has been a “blanket” no change to escalation level for BCU, but there is still scope to see where particular areas could be de-escalated.
  - Orthopaedics: a reduction is noted in regards to follow up appointments, due to ongoing See on Symptoms (SOS) work. Some improvement in re-engagement numbers is also noted. There is a focus to ensure consistency of the roll out across all three IHCs. Positive feedback has been received from patients regarding the introduction of the “My Mobility” app.
  - Orthodontics: A Get It Right First Time (GIRFT) report has been shared, with the need to provide assurance that the included recommendations are embedded

within service. There is a national problem relating to Orthodontics. There will be a focus on this service in next year's IMTP.

- Ophthalmology: the rollout of the One-Stop Pre-Operative Assessment Clinic (POAC) is ongoing with support. All IHC's are in different positions, but all moving in the same direction. Work is paused in the West temporarily, but due to restart in January, with a plan in place to catch up. Capacity and demand analysis has taken place to identify capacity in community and Primary Care to reduce demand within secondary care. This has been successful in reducing some demand.
- Urology: work is ongoing to recommission vasectomy service and use of outsourcing.
- Oncology: ongoing discussions are taking place regarding the emergency rotas and combining to one across BCU, rather than three separate rotas per IHC. It is expected that combining will also be more cost effective. A solution is required over the next 4-6 months.
- Dermatology: workforce issues being experienced with difficulties in recruiting to certain clinical roles. Alternatives are being explored operationally, as well as the service model being reviewed.
- Vascular: moving forward following a recent HIW review, with next steps identified.
- Plastics: the speciality has been put forward for de-escalation from challenged services. Progress is being maintained, with further reduction of waiting list figures seen.

In discussing the item, the Committee:

- Clarified that the challenged services were defined by the Welsh Government when BCUHB was placed in special measures. There is awareness that there are other services within BCU that require improvement that do not come under this category, which are referred to as Other Areas of Concern. It was highlighted that there is a need to provide assurance on these other areas that are not monitored by Welsh Government.
- The Challenged Services Oversight Group met for the first time in November 2025; it looks at Challenged Services, as well as Other Areas of Concern.
- Referenced the need to utilise risk registers, as well as other systems such as QMS, to flag areas of risk. It was suggested to include this topic in an upcoming Committee Development session for further discussion.
- Clarified that a number of the specialities within the challenged services category have difficulties experienced nationally (e.g., orthodontics and ophthalmology). Whereas others experience difficulty locally due to geographical restriction, e.g. plastics.
- Were advised that risk registers and the corporate risk register should feed into clinical services plan approach, with the aim of bridging the gap between the eight challenged services areas, and other areas of concern.

The following action was agreed:

- **Action QS26.10.1:** Utilisation of risk registers and risk flagging to be an item for an upcoming development session

It was resolved that the Committee:

- **NOTED** the report.

*[Paolo Tardivel left the meeting].*

### QS26.11 Women's Services

The Executive Director of Nursing & Midwifery updated on behalf of the Chief Operating Officer. Highlights included:

- The Womens Hub is expected to be fully operational by the end of March 2026, with the project currently on track to open. A visit from the First Minister is scheduled for 12 February. Some delays to the project have been experienced due to funding issues.
- Workforce planning and education leadership with regards to the perinatal workforce plan is underway.
- Work is ongoing in developing a Quality Surveillance dashboard, with Key Performance Indicators (KPIs) identified. The first version is due to go live in January 2026, with work currently on track.
- Some risk is experienced due to financial constraints. This is a common issue across the Health Board currently.

In discussing the item, the Committee:

- Reviewed the impact an electronic health record would have on risk levels experienced, and whether this would reduce risk. National discussion is ongoing, with options being explored, including potential to build on a widely used GP system to enable communication across settings.
- Referenced the importance of noting health inequalities experienced across genders.
- Clarified that the current work focuses on aligning Womens Health Services. Service provision has been mapped across the Health Board, with Primary and Community Care looking to be aligned through Foundations for the Future.
- Agreed for an update on Maternity and Neonatal Services to be received at a future meeting. The Committee were advised that information has been shared with those working on the National Review, which is due to report to the Cabinet Secretary soon. Following receipt of this, an update will come to the Committee.

The following action was agreed:

- **Action QS26.11.1:** an update on Maternity and Neonatal services to be received at a future meeting.

It was resolved that the Committee:

- **NOTED** the report.

### FOR INFORMATION

#### QS26.12 Corporate Governance Report

It was resolved that the Committee:

- **NOTED** the report and appendixes.

### QS26.13 Llais Summary Report

It was resolved that the Committee:

- **NOTED** the report.

### QS26.14 Quality Delivery Chairs Report

It was resolved that the Committee:

- **NOTED** the report.

## CLOSING BUISNESS

### QS26.15 Agree Items for Chairs Report

The Committee wish to Alert members of the Board that:

1. The Challenged Services update was received and felt confident that these areas were now clearly understood. Processes are now developing for capturing services of concern.

The Committee wish to Assure members of the Board that:

1. A paper was received on Quality of Care in Emergency Pathways receiving a summary of Rapid Quality Review and subsequent actions. It was agreed that this would return to Committee after the next meeting.
2. With regards to the Integrated Quality Performance Report in an update to the paper, there were no National Reportable Incidents at the time of the meeting.

The Committee wish to Advise members of the Board that:

1. Carers Story – the experience of an un-paid carer who received support from Carers Outreach was shared. It was recommended that the National Carers Report should be reviewed by PPHP.
2. Integrated Performance Report – further work on Escalated Performance Measures around Access and Activity will be reviewed to ensure that the Committee is receiving the correct information, noting that this would be reviewed as part of the new Performance Reporting.
3. An update on progress was made against Women's Services. Priorities for 2025/26 were received.

It was recommended that the National Carers Report should be reviewed by Planning, Population Health & Partnership Committee.

*[Pam Wenger left the meeting].*



### QS26.16 Review of Meeting Effectiveness

The Committee:

- Reflected that the meeting ran well with full discussion, and assurance given in a number of areas of concern, with positive aspects as shown within reports.
- Advised that further work is needed in regards to action following performance aspects.
- Requested a development session be scheduled in the next quarter.

### QS26.17 Date of next meeting

5 March 2026

### Resolution to Exclude the Press and Public

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

## Quality, Safety and Experience Committee **PUBLIC** Action Log

Updated 25.02.26

### Open Actions

Action No.	Minute Ref.	Date	Agreed Action	Lead	Time scale	Status
<b>Actions to remain open</b>						
1	QS25.106.1	06.11.25	Cycle of Business to be reviewed ahead of the end of financial year	Director of Corporate Governance	May 2026	06.11.25 – referenced in 06.11.25 meeting as further action QS25.106.1  07.01.26 – action ongoing  25.02.26 – COB reviewed and further amendment needed to aligned with IMTP as agreed at Chairs Advisory Group
2	QS25/11.1	20.02.25	<b>QS25/11 Colonoscopy Performance Update</b> Clarify when the Colonoscopy data/paper can be reported back into QSE.	Exec. Dir. of Nursing & Midwifery ( <b>Angela Wood</b> ) to link in with Interim Chief Operation Officer) <b>(Imran Devji)</b> <b>Tehmeena Ajmal</b>	May 2025	<b>Remain Open</b> 24.02.25 From AW - Email sent to Imran, awaiting clarification 03.07.25 AW confirmed that she had met with Tehmeena Ajmal, COO. A further update will be provided at the November meeting.  07.01.26 – awaiting update
3	QS24/121.1	24.10.24	<b>QS24/121 Integrated Performance Report</b> to speak to the Deputy	Exec. Dir. Allied Health Professionals & Health Science	17.12.24	<b>Remain Open</b> <b>9.12.24</b> TO spoke with Deputy Executive Medical Director. Data/information is



			Executive Medical Director to check the veracity of colonoscopy data provided in report, and to escalate concerns if required.	( <del>Teresa Owen</del> ) <del>Interim COO</del> ( <del>Imran Devji</del> ) Chief Operating Officer – <b>Tehmeena Ajmal</b>	May 2025	being checked by the team. <b>12.2.25</b> Jim McGuigan advised that Imran Devji was aware of this query and investigating.  Update to be received at meeting  07.01.26 – awaiting update
4	QS26.5.1	15.01.26	<b>Patient Story:</b> National Carers Report to be reviewed by PPHP and QSE Committees when received.	Exec. Director of Nursing & Midwifery.	TBC	<b>Remain Open</b> Awaiting receipt of report.
5	QS26.07.03	15.01.26	<b>Integrated Quality Report</b> Redress change process to be item on the QSE development day	Exec Director of Nursing & Midwifery	March 2026	<b>Remain Open</b>  12.02.26 – Development Day scheduled for 16.03.26
6	QS26.08.02	15.01.26	<b>Integrated Performance Report</b> Update on screening services to be given at a future meeting	Director of Performance & Commissioning.	March 2026	<b>Remain Open</b>  Awaiting update.
7	QS26.10.1	15.01.26	<b>Challenged Services</b> Utilisation of risk registers and risk flagging to be an item for QSE development session	Exec Director of Nursing & Midwifery	March 2026	<b>Remain Open</b>  12.02.26 – Development Day scheduled for 16.03.26
<b>Suggest Close</b>						
1	Board Meeting 30.01.25	Chair	<b>25/09.03 Citizens Engagement Report</b> A briefing on the new legislation due to be issued, to	Director of Partnerships, Engagement & Communication  ( <b>Helen Stevens Jones</b> )	January 2025	<b>Suggest Close</b>  15.01.26 – “Listening to People Framework” to return as part of the



			be discussed at a future QSE Committee.			quality Update Report at the next  20.01.26 – noted on draft agenda for Mar 26
4	QS26.06.1	15.01.26	<b>Rapid Quality Review – Emergency Department</b> Update of ED Rapid Quality Review to be included in the next Integrated Quality Performance report	Exec Director of Nursing & Midwifery / Exec Medical Director	March 2026	<b>Suggest Close</b> 20.01.26 – to be covered on March agenda.
5	QS26.07.01	15.01.26	<b>Integrated Quality Report</b> Check action for march and demonstration regarding QMS system in relation to Mental Health	Exec Director of Nursing & Midwifery	March 2026	<b>Suggest Close</b> 20.01.26 - to be covered on March agenda.
7	QS26.08.01	15.01.26	<b>Integrated Performance Report</b> Update required regarding no.100% overdue follow up. Discussion between EW and AW outside of meeting to agree format	Exec Director of Nursing & Midwifery / Director of Performance	March 2026	<b>Suggest Close</b> 20.01.26 - to be covered on March agenda.
8	QS26.08.03	15.01.26	<b>Integrated Performance Report</b> Update to be requested from Kathryn Lang for assurance of accuracy of coding data.		March 2026	<b>Suggest Close</b> 20.01.26 - to be covered on March agenda.
10	QS26.11.01	15.01.26	<b>Womens Services Update</b> Update on progress to be brought to future meeting following submission to the Cabinet Secretary	Exec Director of Nursing & Midwifery	March 2026?	<b>Suggest Close</b> 20.01.26 - to be covered on March agenda.



12	QS26.08.04	15.01.26	<b>Integrated Performance Report</b> Diabetes to be added as topic for development session	Exec Director of Public Health	TBC	<b>Suggest Close</b>  12.02.26 – agreed that topic no longer required for discussion at development centre.
13	QS26.17.1	15.01.26	Development Session to be scheduled.	Head of Corporate Governance	March 2026	<b>Suggest Close</b>  12.02.26 – arranged for March.
14	QS26.07.02	15.01.26	<b>Integrated Quality Report</b> Date of the last PFD to be added to the Integrated Performance report for clarity.	Exec Director of Nursing & Midwifery	January 2026	<b>Suggest Close</b>  Complete. To close

**Closed Actions (Closed at 15.01.26 meeting)**

Action No.	Minute Ref.	Date	Agreed Action	Lead	Timescale	Status
1	QS25.110.1	06.11.25	<b>Integrated Quality Report</b> Child Practice Review to be discussed at the next Committee meeting.	Chair	January 2026	<b>Suggest Close</b>  To be added to next QSE agenda  01.12.25 – included on agenda.
2	QS25.110.2	06.11.25	<b>Integrated Quality Report</b> Civica data and feedback trends to be discussed at the next Committee meeting.	Chair	January 2026	<b>Suggest Close</b>  To be added to next QSE agenda  01.12.25 – included on agenda
3	QS25.112.1	06.11.25	Nurse Staffing Act	Executive Director of	Novem	<b>Suggest Close</b>



			Budget arrangements to be clarified within the report prior to submission to Board	Nursing & Midwifery <b>(Angela Wood)</b>	ber 2025	16.12.25 – Clarified at Executive Committee. Action complete.
4	QS25.115.1	06.11.25	Terms of Reference to be shared	Head of Corporate Affairs <b>(Philippa Peake-Jones)</b>	Januar y 2026	<b>Suggest Close</b> 07.01.26 – TOR shared. Action to Close
5	QS25.117.1	06.11.25	<b>Proposed Changes to ‘Independent Funding Requests’ and ‘Prior Approval Requests’ Policies</b> Director of Corporate Governance to feedback job role/title inaccuracies referenced and representation within the policy updates to the authors	Director of Corporate Governance	Novem ber 2025	<b>Suggest Close</b> 10.12.25 – advised action complete.

## Quality Safety & Experience Committee

### Stori un o Gleifion Rhaglen Atal Diabetes Cymru Gyfan

### All wales Diabetes Prevention Programme Patient Story

<b>Date of Meeting</b>	05 March 2026
<b>Publication Status</b>	Open/ Public
	Not Applicable
<b>Report Author name and title</b>	Hannah Hughes – Patient & Carer Experience Manager
<b>Lead Executive Team Member name and title</b>	Angela Wood, Executive Director of Nursing and Midwifery

<b>Report Purpose</b>	For Noting
-----------------------	------------

#### Executive Summary

A patient or carer story is presented to QSE to bring the voice of the people we serve directly into the meeting.

The digital story will be played at the meeting. A short summary of the experience and actions undertaken in response to the story is included in the paper.

#### Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)

Committee / Group / Individuals	Date	Outcome, Evidence and Data
N/A		

#### Acronyms / Glossary of Terms

[All Wales Diabetes Service Patient Story - WELSH SUBTITLES.mov](#)

[All Wales Diabetes Service Patient Story - UPDATED ENGLISH SUBTITLES.mov](#)

## 1. Overview of Carer Story

The story captures the experience of a patient who was invited to attend a lifestyle intervention appointment with the All-Wales Diabetes Prevention Programme (AWDPP) at his GP surgery in Beaumaris following a blood test indicating that he was in a pre-diabetic range.

Following the intervention with the Healthcare Support Worker, the storyteller went on to make many lifestyle changes around nutrition and exercise and following his annual review is no longer pre-diabetic and at risk of type 2 diabetes.

The storyteller describes his positive and supportive experience of accessing the AWDPP service and how transformational this has been for his health and wellbeing.

## 2. Summary of Learning and Improvement

This story has been shared with the Service Improvement Manager for Diabetes Prevention and the local AWDPP Team. This experience will be shared across the Health Board to promote good practice and to promote the All-Wales Diabetes Prevention Programme.

Following the Welsh Government's funding commitment in March 2021, the AWDPP was established to begin the roll out of a national type 2 diabetes prevention programme.

The aim of the AWDPP is to provide an effective, equitable approach to type 2 diabetes prevention delivered through primary care across Wales.

As of 2020, 8% of the population of Wales aged 17 years and over lives with diabetes, of which 90% have type 2 diabetes. The majority of these are preventable with the most significant modifiable risk factors being overweight and obesity. Managing diabetes and its complications puts a considerable burden on healthcare services.

The AWDPP started in the Health Board in 2021 with funding from the AWDPP National Programme and initially covered GP practices in the Anglesey and South Meirionnydd areas only.

Since January 2025, there has been further funding provided through the Strategic Programme for Primary Care (SPPC) and this has led to the significant expansion of the service across the Health Board.

There now 29 GP practices involved in the delivery of the AWDPP and the service is spread evenly across the Health Board, with approximately 10 practices involved in the delivery in each IHC area.

GP practices were approached to see if they would like to be involved in the delivery of the programme through the training and support of Healthcare Support Workers who are already employed within GP practices.

Subsequently, there has been four training cohorts for eligible staff between June and October 2025 and there is now a total of 33 Healthcare Support Workers who have been trained to deliver this programme and to establish the AWDPP model within GP practice.

Each Healthcare Support Worker completes training on the AWDPP, attends a 6-day course in Level 2 Community Food and Nutrition which is accredited by Agored Cymru and a 3-day Motivational Interviewing course to provide training and skills to support the intervention work.

Eligible patients for the AWDPP are identified through searches via the GP practice Emis system to identify patients with a pre-diabetic Hba1c range of between 42-47 mmol/mol. The results data is triaged by the Healthcare Support Worker to remove any patients who may have exclusion factors, for example pregnant women, with the support of a Dietician.

Patients are then contacted by the surgery by letter and invited to take part in the AWDPP lifestyle intervention and patients are invited to opt in by contacting the surgery to book on.

The Healthcare Support Workers arrange clinics and book patients in for a single 30-minute appointment at the surgery. They discuss insulin resistance, blood glucose levels and lifestyle factors including food habits and physical health, using their food and nutrition knowledge and motivational interviewing skills from the training to help patients to understand what pre-diabetes means, understanding the risk of developing diabetes and the implications for their long-term health. They can support referrals to the Health Board Weight Management Programme or Exercise on Referral Scheme. The clinics are intended to be a lifestyle intervention at a critical point in time aimed at the prevention of the development of Type 2 diabetes.

Patients are then invited back a year later for an annual review. A further blood test is taken and the Hba1c level is tested again prior to the appointment. Patients then have a further 30-minute appointment to review their blood test figure against their baseline figure and are offered additional help, support and guidance. Patients whose figures drop below pre-diabetic are taken off the programme and those whose figures may have stayed the same or increased are offered additional support and may be referred on to other appropriate services. The Dieticians are available to guide and support that process.

Since January 2025 the BCUHB AWDPP/SPCC roll out has identified 1878 pre-diabetic patients. Of these, 930 patients were eligible for the programme and offered the brief intervention.

Figures for the national programme present a reduction in the number of individuals progressing from pre-diabetes to Type 2 diabetes and the AWDPP national evaluation demonstrates a 23% reduction in progression to diabetic blood glucose levels among participants.

Evidence from Health Board outcome data is consistent with a 26% reduction in HbA1c levels to within the normal range following engagement with the AWDPP.






The future of the AWDPP service and delivery remains unsure with the confirmed continuation of the funding from the national programme, but with the SPPC funding ending in March 2026.

The Patient and Carer Experience Team extend their gratitude and appreciation to the All-Wales Diabetes Prevention Programme Team and the storyteller for sharing their experience.

### **3. Recommendations**

3.1 The Committee is asked to note this report.



ASSESSMENT	
<b>Link to Strategic Priorities</b>	    
	<p>4. Improving quality, outcomes and experience</p> <p>If more than one applies, please list below:</p> <ul style="list-style-type: none"> <li>• Creating compassionate culture, leadership, and engagement.</li> <li>• Establishing an effective environment for learning.</li> </ul>
<b>Design Principles</b>	<p>People First</p> <p>If more than one applies, please list below:</p> <ul style="list-style-type: none"> <li>• Consistency with organisational values.</li> </ul>
<b>Corporate Risks and Board Assurance Framework</b>	Not Applicable
<b><u>Wellbeing of Future Generations Act – Wellbeing Goals</u></b>	A Healthier Wales
	<p>If more than one applies, please list below:</p> <ul style="list-style-type: none"> <li>• A more equal Wales.</li> <li>• A resilient Wales.</li> </ul>

IMPACT ASSESSMENTS		
<b>Equality</b> <i>Have you undertaken an Equality Impact Assessment Screening (which includes the requirements of the Welsh Language Standards)</i>	Yes: <input type="checkbox"/>	No: <input checked="" type="checkbox"/>
	Outcome:	
	If no, please include rationale:	Not applicable
<b>Socio-Economic Impact Assessment</b> <i>Have you undertaken a Socio-Economic Impact Assessment</i>	Yes: <input type="checkbox"/>	No: <input checked="" type="checkbox"/>
	Outcome:	
	If no, please include rationale:	Not applicable.
<b><u>Quality</u></b> <i>Have you undertaken a Quality Impact Assessment Screening?</i>	<b>Enablers of Quality</b> All Apply	<b>Domains of Quality</b> All Apply
	If more than one applies, please list below:	If more than one applies, please list below:

---

<a href="#"><u>Wellbeing of Future Generations Act – Wellbeing Goals</u></a>	A Healthier Wales	

<b>Environmental /Sustainability Impact (5Rs)</b>	If more than one applies, please list below:	
	No - Not Applicable	
	If more than one applies, please list:	
<b>Armed Forces Covenant Due Regard Duty</b> Have you considered the Armed Forces Covenant Due Regard Duty?	Yes: <input type="checkbox"/>	No: <input checked="" type="checkbox"/>
	Outcome:	
	If no, please include rationale:	
<b>Data Protection Impact Assessment</b> <i>Have you undertaken a Data Protection Impact Assessment Screening?</i>	Yes: <input type="checkbox"/>	No: <input checked="" type="checkbox"/>
	Outcome:	
	If no, please include rationale:	
<b>Counter Fraud Impact Assessment</b> <i>Have you considered the counter fraud impacts</i>	Yes: <input type="checkbox"/>	No: <input checked="" type="checkbox"/>
	Outcome:	
	If no, please include rationale:	
<b>Legal</b>	There are no specific legal implications related to the activity outlined in this report.	
<b>Reputational</b>	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
<b>Resource Impact (People / Financial)</b>	There is no direct impact on resources as a result of the activity outlined in this report.	

# Substance Misuse, Harm Reduction, Enhancing Lives and Helpline Services. QSE Deep Dive



05/03/2026

The Substance Misuse Service (SMS) within Betsi Cadwaladr University Health Board delivers Tier 3 Community Drug and Alcohol Services is underpinned by a clear ethos centred on compassion, dignity and person-centred care. The service adopts a harm reduction approach, working alongside individuals to reduce risk, improve health outcomes and support recovery in a way that reflects their own goals and circumstances.

SMS recognises the complex interplay between substance use, Mental Health, Physical Health and social disadvantage, and therefore prioritises integrated, multi-agency working. Accessibility, non-judgemental practice and strong clinical governance ensure support is safe, inclusive and recovery-orientated.

**SMS Service is central to substance misuse system, stabilising individuals so that wider needs such as Housing, Mental Health and Safeguarding can be addressed. The service is partially commissioned through the North Wales Area Planning Board (APB).**



# GOVERNANCE



GIG  
CYMRU  
NHS  
WALES

Bwrdd Iechyd Prifysgol  
Betsi Cadwaladr  
University Health Board



## **Substance Misuse Service (SMS)**

SMS offers structured treatment via Multidisciplinary Teams with assessment, prescribing and psychological support.

## **Harm Reduction Initiatives**

Harm Reduction focuses on preventing avoidable harm through outreach, needle exchange, naloxone and Blood Borne Virus Testing.

## **Helpline Services**

Helpline Services provide 24/7 advice, reassurance and signposting, easing pressure on Emergency Services.

## **Integrated Support System**

These services work collaboratively to promote early intervention, safe treatment and reduce crisis escalation.



# ACHIEVEMENTS



GIG  
CYMRU  
NHS  
WALES

Bwrdd Iechyd Prifysgol  
Betsi Cadwaladr  
University Health Board



### **Post Conviction Criminal Justice Service Pathway**

Reintegration of Criminal Justice Pathways into NHS delivery enhances care continuity for individuals involved in services.

### **Expanded Therapy Roles**

Occupational Therapy and Physical Health nursing roles expanded to support complex and long-term health needs.

### **Integrated Mental Health Services**

Co-occurring practitioners improve joint working between SMS and Mental Health Services, reducing gaps.

### **Infrastructure and feedback**

Infrastructure developments and staff feedback support safer environments and ongoing system improvements.

### **Domestic Abuse protection Orders**

Substance Misuse Services support the implementation of Domestic Abuse Protection Orders by acting as a clear access point, providing advice, coordination and signposting to ensure timely, safe support, and strengthening multi-agency pathways for a more coordinated response to Domestic Abuse across the Division



# QUALITY INDICATORS



GIG  
CYMRU  
NHS  
WALES

Bwrdd Iechyd Prifysgol  
Betsi Cadwaladr  
University Health Board



### **High Demand and Caseloads**

SMS referrals exceed 1,100 per quarter with caseloads over 4,000 individuals, indicating sustained high demand and complexity.

### **Community Detox and Specialist Services**

Community detox activity increased with pathway strengthening; specialist midwifery referrals and caseloads rose steadily.

### **Testing and Helpline Engagement**

Blood Borne Virus testing peaked at 373 with outreach clinics; helpline contacts climbed over 9,300, driven by telephone demand.

### **Strong Key Performance Indicators (KPIs) and Outcomes**

Key Performance Indicators show strong access times, engagement, substance use reduction, and successful treatment completions.



# Concerns and Incidents:

## Complaints current status April 2025 - to date

Current open complaints: 0

Two formal concerns were received in the period 1<sup>st</sup> April 2025 – 31<sup>st</sup> January 2026. These were in relation to the provision of detox support and the provision of a detox bed. Both complaints were responded to within the required 30 days.

Two Early resolutions were logged, both in relation to communication and closed within 2 days.

Five PALS enquiries were logged, these ranged from support in finding a detox bed, arranging appointments and dissatisfaction at a reduction in medication.

One MSMP enquiry was received in relation to ongoing support.

## Compliments April 2025 - to date

160 compliments received in first 3 quarter

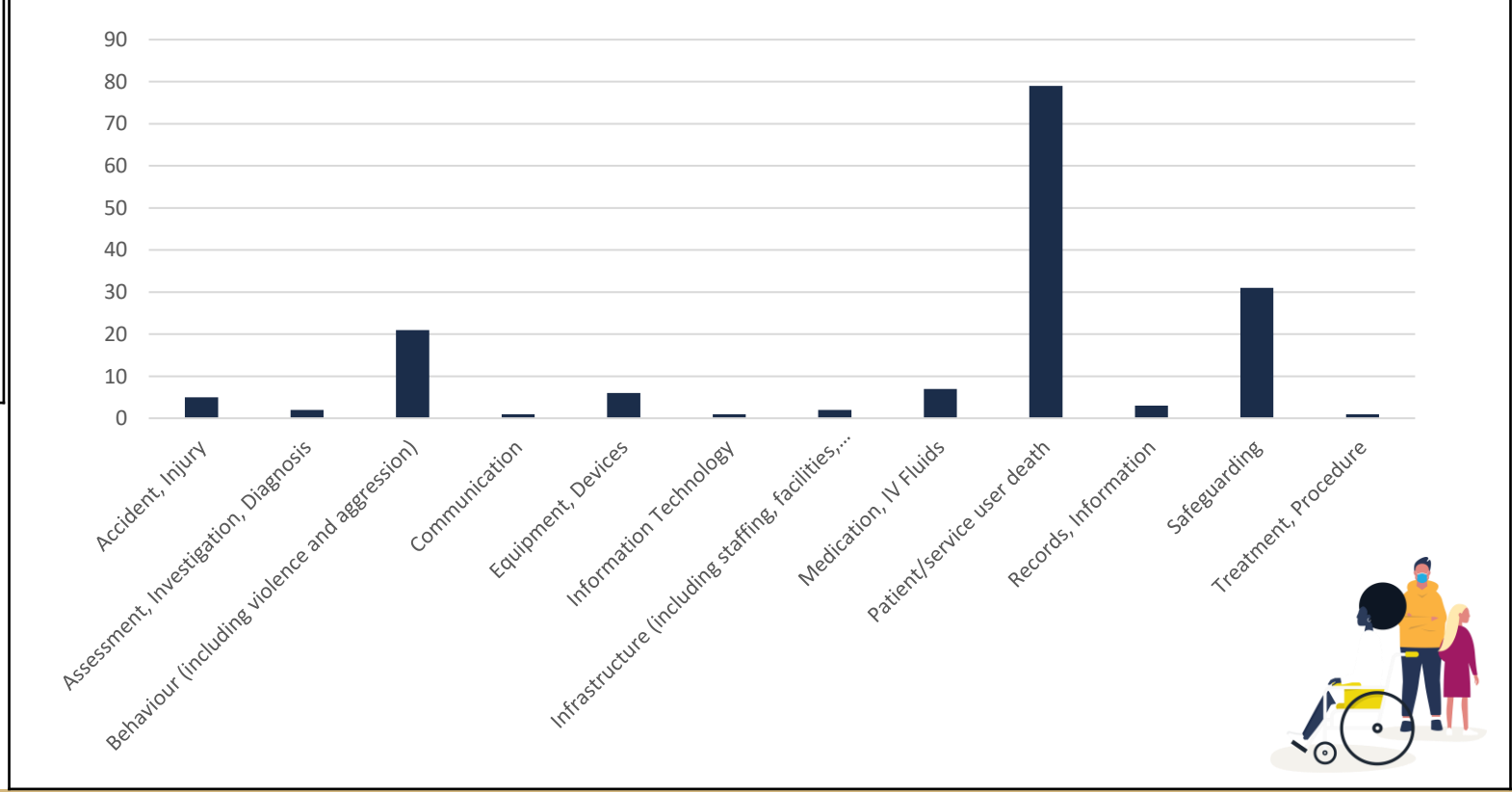
## Civica to date

Seven reported since December 2025  
Fully embedded into letters, waiting rooms and offered to families/carers and patients as a means to offer any feedback.

## Incidents April 2025 - to date

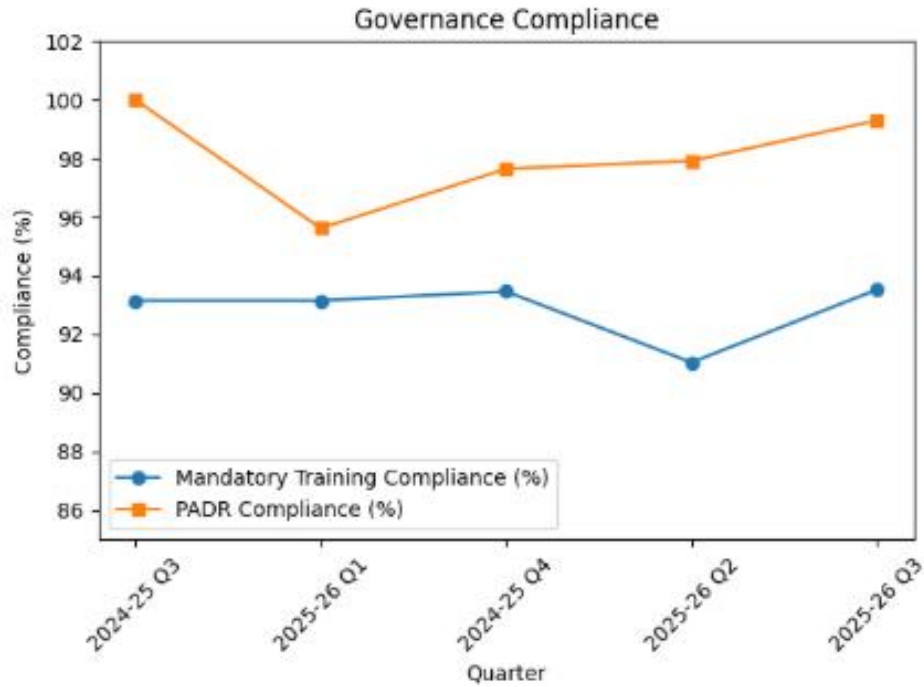
There was a total of 156 incidents reported in the period 1<sup>st</sup> April 2025 – 31<sup>st</sup> January 2026  
 Q1: 40 in total, 22 unexpected deaths  
 Q2: 58 in total, 28 unexpected deaths  
 Q3: 52 in total, 23 unexpected deaths  
 Q4 up to 31<sup>st</sup> Jan 2026: 9 in total, 6 unexpected deaths

**Mortality**  
 There was a total of 79 unexpected deaths reported from 1<sup>st</sup> April 2025 – 31<sup>st</sup> January 2026

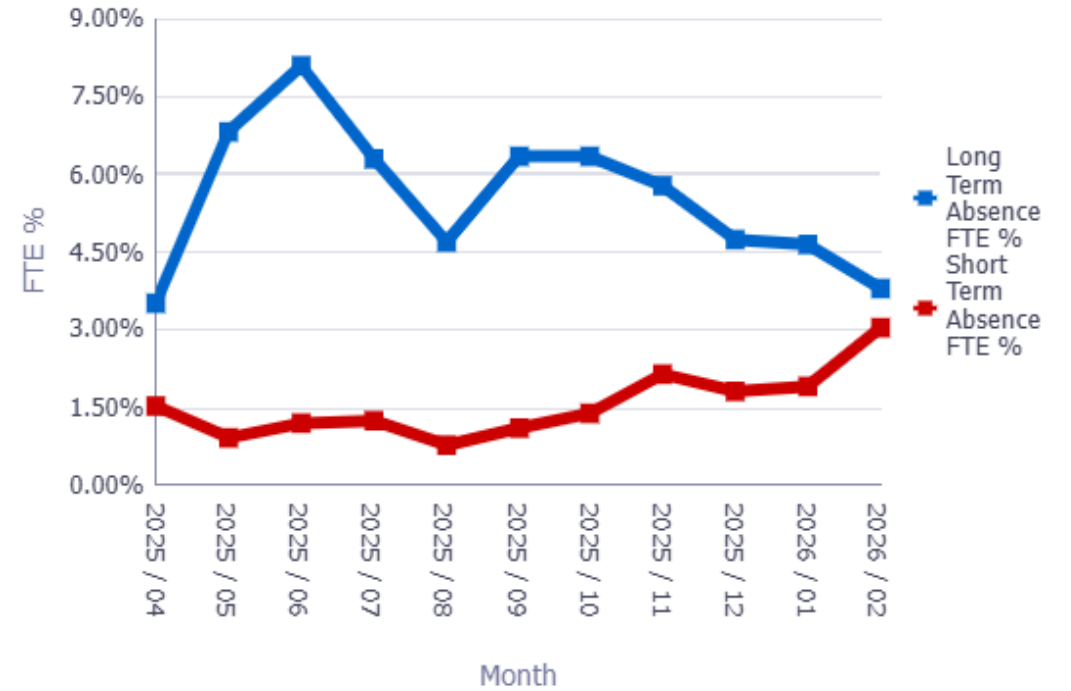


# Compliance:

## Training and PADR Compliance



## Sickness



## Vacancies

1WTE	B6 CJ Worker East
1WTE	B6 OT West
1WTE	8a Service manager – Secondment
1WTE	Band 5 Gwynedd - qualified
1WTE	Band 4 - Helplines supervisor
0.8 WTE	Band 6 nurse - Denbighshire

2.0WTE	Band 4 HRT
1WTE	Band 5 Flintshire
1WTE	Band 6 nurse Gwynedd
1WTE	Band 5 nurse - Denbighshire
1WTE	Band 5 nurse Conwy
1WTE	Band 6 HRT



# PATHWAYS



GIG  
CYMRU  
NHS  
WALES

Bwrdd Iechyd Prifysgol  
Betsi Cadwaladr  
University Health Board



### **Fatal Drug Review Task Group**

A dedicated Multi-Agency Task Group overseeing trends, case reviews, and system-wide actions to reduce preventable drug-related deaths. The group drives coordinated improvements across clinical practice, harm reduction, emergency response, and safeguarding pathways.

### **Physical Health Pathways**

Strengthening Physical Healthcare support for individuals in SMS, including enhanced blood-taking processes, clearer guidance for safe home detoxification, and proactive multidisciplinary discussions to identify deterioration early and escalate clinical concerns appropriately.

### **Buvidal Opioid Treatment**

A fully embedded long-acting Opioid Substitution Treatment Pathway, supported by robust governance, clinical oversight, and regular approval cycles. Ensures consistent prescribing practice, improved treatment stability, and enhanced engagement for people with opioid dependence. This pathway has met its milestones and pathway outcomes, closure document completed and sits as business as usual. Local tracking of home office licence renewal in partnership with pharmacy colleagues.

### **Ketamine Harm Pathway**

An emerging multidisciplinary pathway enabling early identification, assessment, and intervention for young people experiencing ketamine-related harm. Services work collaboratively to respond quickly, provide tailored harm-reduction support, and reduce escalation into acute health or safeguarding crises.



# CONTINUING AREAS OF CONCERN



GIG  
CYMRU  
NHS  
WALES

Bwrdd Iechyd Prifysgol  
Betsi Cadwaladr  
University Health Board



### **Roslin progression**

Progressing the Roslin Development remains a key priority to support the future delivery of SMS. The project is intended to provide an improved, fit-for-purpose environment that supports integrated working, safety, dignity and accessibility. Continued focus is required to secure clarity on timelines and next steps to ensure service stability and to mitigate ongoing pressures associated with current accommodation. This has been a challenging area to progress and further work required.

### **Inpatient Detox provision**

Ensuring ongoing access to safe and appropriate detox provision remains a core priority for SMS. Work is underway to maintain continuity of Detox Services while longer-term arrangements are developed, with a focus on meeting population need, managing risk and minimising disruption for individuals requiring treatment. This includes consideration of commissioning options, interim arrangements and future service models to provide a sustainable and responsive detox pathway for North Wales.

### **Contract Sign off**

The Income Agreement between BCUHB and Wrexham County Borough Council, acting on behalf of the North Wales Area Planning Board (APB), has been a long standing agreement in existence for over a decade. To enable the continuation of North Wales Substance Misuse Services, Harm Reduction, Enhancing Lives Services, and Substance Misuse Liaison Services, in line with revised Scheme of Reservation & Delegation (SORD) governance requirements this needs to now go to Executive Committee. Due to Executive Committee on the 25/02/26.

# FUTURE DEVELOPMENT



GIG  
CYMRU  
NHS  
WALES

Bwrdd Iechyd Prifysgol  
Betsi Cadwaladr  
University Health Board



### **Expanded Psychology Services**

Enhanced psychology provision will strengthen trauma-informed practice across SMS, ensuring individuals with complex and co-occurring Mental Health needs receive consistent, evidence-based therapeutic input. This expansion aims to improve engagement, reduce relapse risk, and support more holistic, person-centred care planning. Sign off for the 25/28 contract has been completed on the 25<sup>th</sup> February 26. these posts can now progress via the Psychology Department

### **Clinical Complex Case Discussion Forum**

The relaunched multidisciplinary forum provides strengthened clinical governance for staff managing high-risk or complex cases. It offers a structured space for shared decision-making, clinical reflection, and escalation, improving safety, consistency, and accountability across services. Terms of reference completed and initial meeting set with projection of monthly meetings established.

### **Investment in Triage Practitioner**

A £58K investment will support a Band 5 Triage and Engagement Practitioner. This role increases frontline clinical capacity, enhances early assessment and intervention, and reduces non-attendance by maintaining quicker, more responsive contact with individuals entering or re-entering treatment. Funding commences from April 2026, review of job descriptions underway.

### **Gambling Treatment Pathway**

Development of a dedicated Gambling Treatment Pathway will allow services to respond proactively to rising demand. This work establishes safe, evidence-based, and sustainable processes for assessment, early intervention, and referral into specialist support where required. Welsh Government have confirmed in February 2026 that BCUHB SMS service won the contract with go live date of the 1<sup>st</sup> April.

# RISKS



GIG  
CYMRU  
NHS  
WALES

Bwrdd Iechyd Prifysgol  
Betsi Cadwaladr  
University Health Board



- **Risk that Adferiad may cease contract for inpatient detoxification** particularly if an increase in contract value cannot be agreed, potentially resulting in loss of service provision. **This is a tier one risk. with current risk rating as 16 (Extreme).**

### Mitigation

- Approval was granted by Executive team to extend the existing contract to maintain continuity
  - Explore spot-purchasing options for detox beds beyond the contract end date of April 2026
  - Undertake longer-term options appraisal, including: Feasibility of retendering the service and exploration of BCUHB developing or supporting its own detox provision as a sustainable future model
- **Domestic Abuse Protection Order Implementation**, There is a risk that the service may not be able to meet the statutory DAPO (Domestic Abuse Protection Order) requirements due to referral levels exceeding current capacity and available resources. This could lead to delays in allocation and non-compliance with legislation. A range of actions have been taken to strengthen governance, develop interim arrangements, and work closely with partners to mitigate this risk. **This is a tier 1 risk with current risk rating as a 6 (Moderate)**

### Mitigation

- Development of an **interim pathway**.
- **Attendance at implementation group** to review progress.
- Continued engagement with **Safe Lives**.
- **Embedding the pathway** and associated processes into **Divisional Governance systems**



## Quality Safety & Experience Committee

### INTEGRATED QUALITY REPORT

<b>Dyddiad y Cyfarfod</b> <b>Date of Meeting</b>	05 March 2026
<b>Statws Cyhoeddi</b> <b>Publication Status</b>	Open/ Public
	Not Applicable
<b>Enw a theitl Awdur(on) yr Adroddiad</b> <b>Report Author name and title</b>	<ul style="list-style-type: none"> <li>• <b>Patient Safety:</b> Chris Lynes, Deputy Director of Nursing (Patient Safety) and Tracey Radcliffe, Head of Patient Safety</li> <li>• <b>Safeguarding:</b> Michelle Denwood, Director of Safeguarding</li> <li>• <b>IPC:</b> Andrea Ledgerton, Assistant Director of Infection Prevention and Decontamination</li> <li>• <b>Patient and Carer Experience:</b> Chris Lynes, Deputy Director of Nursing (Patient Experience) and Leon Marsh, Head of Patient Experience</li> <li>• <b>Clinical Effectiveness:</b> Dr James Risley, Deputy Medical Director (Clinical Effectiveness), and Joanne Shillingford, Head of Clinical Effectiveness</li> <li>• <b>Quality Assurance:</b> Jo Kendrick, Head of Quality, Erika Dennis, Quality Lead Manager, Sarah Musgrave Quality Learning Business Manager</li> <li>• <b>Healthcare Law:</b> Matthew Joyes, Deputy Director for Legal Services and Debbie Kumwenda, Healthcare Law Lead Manager</li> </ul>
<b>Enw a theitl Aelod Arweiniol o'r Tim Gweithredol</b> <b>Lead Executive Team Member name and title</b>	<ul style="list-style-type: none"> <li>• Angela Wood, Executive Director of Nursing and Midwifery (Lead Executive)</li> <li>• Dr Clara Day, Executive Medical Director</li> <li>• Teresa Owen, Executive Director of AHPs and Healthcare Science</li> <li>• Dr Jane Moore, Executive Director of Public Health</li> </ul>
<b>Pwrpas yr Adroddiad</b> <b>Report Purpose</b>	For Noting



### **Crynodeb Gweithredol Executive Summary**

This report provides the Board with assurance, underpinned by analysis, on significant quality issues alongside longer-term data and information on the improvements underway.

### **Ymgysylltu (mewnol/allanol) yr ymgwymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp) Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)**

<b>Pwyllgor / Grŵp / Unigolion Committee / Group / Individuals</b>	<b>Dyddiad Date</b>	<b>Canlyniad, Tystiolaeth a Data Outcome, Evidence and Data</b>

### **Acronymau / Rhestr Termau Acronyms / Glossary of Terms**

LocSSIPs	Local Safety Standards for Invasive Procedures
QMS	Quality Management System
NRI	National reportable Incident
LTP	Listening to People
PES	People's Experience Survey
NICU	Neonatal Intensive Care Unit
SAoC	Service assessment of compliance
HIW	Healthcare Inspectorate Wales
LFERs	Learning from Events Reports
WRP	Welsh Risk Pool
CIW	Care Inspectorate Wales
PSOW	Public Services Ombudsman for Wales

---

## **INTEGRATED QUALITY REPORT**

### **1. Y SEFYLLFA / SITUATION**

- 1.1 For the NHS in Wales, quality is defined as continuously, reliably, and sustainably meeting the needs of the population that we serve.
- 1.2 In achieving this, under the statutory Duty of Quality, Welsh Ministers and NHS bodies will need to ensure that health services are **safe, timely, effective, efficient, equitable, and person-centred**. Underpinning these domains are six enablers, which are **leadership, workforce, culture, information, learning and research** and **whole-systems approach**.
- 1.3 These domains and enablers form the **Health and Care Quality Standards** for Wales introduced in April 2023 through statutory guidance.

### **2. Y CEFNDIR / BACKGROUND**

- 2.1 The Health Board remains committed to delivering high-quality services across all areas of care. To provide assurance and drive continuous improvement, the Health Board routinely monitors a range of quality metrics. These measures enable informed decision-making, support organisational learning, and underpin growth and development
- 2.2 This report summarises the Health Board's current position regarding quality performance and identifies key actions required to strengthen outcomes and achieve sustained improvement.

### **3. MATERION PENODOL I'W HYSTYRIED / SPECIFIC MATTERS FOR CONSIDERATION**

- 3.1 **Never Events:** A recent Never Event involving wrong-site surgery (chest drain insertion) has highlighted a pattern of issues regarding procedures performed outside theatre settings.
- 3.2 **Infection Control:** Four organisms—*C. difficile*, *Klebsiella*, *Pseudomonas*, and MSSA—are currently exceeding their target trajectories for reduction.
- 3.3 **Prevention of Future Deaths (PFD):** A PFD report was issued concerning systemic concerns within the gastroenterology and endoscopy service at Ysbyty Glan Clwyd, including workforce shortages and inadequate infrastructure.
- 3.4 **Public Interest Reports:** There is an outstanding action related to the Commissioning Assurance Framework (CAF). This unfortunately missed the deadline. This is being tracked and monitored and will be subject to Executive

approval and discussion with the Office of the CEO.

#### 4. **RISGIAU ALLWEDDOL / MATERION I'W HUWCHGYFEIRIO** **KEY RISKS / MATTERS FOR ESCALATION**

4.1 **Listening to People (LTP) Regulations:** As the Health Board transitions to the new LTP framework on 1 April 2026, several critical risks have been escalated.

4.1.1 Capacity for "Listening Discussions" and a lack of confirmed divisional scheduling.






4.1.2 Manual calculation of Stage 1 deadlines, which increases the risk of non-compliance.

4.1.3 A short mobilisation timeline with multiple interdependent workstreams nearing their critical path.

4.2 **Complaint Volumes:** There has been an increase in total open complaints (rising to 291), with the rate of new complaints now exceeding the rate of closure. Waiting times account for over half (52.93%) of these open complaints.

#### 5. **ARGYMHELLION / RECOMMENDATIONS**

5.1 The Committee is asked to take the report as assurance. All exceptions noted in this paper are being monitored and have management plans to track completion. These action plans are tracked through core quality forums.

ASESIAD / ASSESSMENT	
<p><b>Cyswllt â'r Blaenoriaethau Strategol</b> <b>Link to Strategic Priorities</b></p>	<div style="display: flex; justify-content: space-around; align-items: center;">      </div> <p>4. Improving quality, outcomes and experience</p> <p>Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:</p> <p>4. Improving quality, outcomes and experience Simplify, Standardise, and Adopt Best Practices</p>
<p><b>Yr Egwyddorion Dylunio</b> <b>Design Principles</b></p>	<p>Simplify, Standardise, and Adopt Best Practices</p> <p>Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:</p>
<p><b>Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd</b> <b>Corporate Risks and Board Assurance Framework</b></p>	<p>Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR) BAF-SP18 and CRR-24-04 – Quality, Innovation and Improvement</p>
<p><a href="#"><u>Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant Wellbeing of Future Generations Act – Wellbeing Goals</u></a></p>	<p>A Healthier Wales</p> <p>Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:</p>

ASESIADAU O EFFAITH / IMPACT ASSESSMENTS							
<p><b>Cydraddoldeb</b> <i>A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o'r Effaith ar Gydraddoldeb (sy'n cynnwys gofynion Safonau'r Gymraeg)</i> <b>Equality</b> <i>Have you undertaken an Equality Impact Assessment Screening (which includes the requirements of the Welsh Language Standards)</i></p>	<table border="1" style="width: 100%;"> <tr> <td style="width: 50%;">Do/Yes: <input type="checkbox"/></td> <td style="width: 50%;">Naddo/No: <input checked="" type="checkbox"/></td> </tr> <tr> <td>Canlyniad/Outcome:</td> <td></td> </tr> <tr> <td>Os naddo, dylech gynnwys y rheswm: If no, please include rationale:</td> <td></td> </tr> </table>	Do/Yes: <input type="checkbox"/>	Naddo/No: <input checked="" type="checkbox"/>	Canlyniad/Outcome:		Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Do/Yes: <input type="checkbox"/>	Naddo/No: <input checked="" type="checkbox"/>						
Canlyniad/Outcome:							
Os naddo, dylech gynnwys y rheswm: If no, please include rationale:							



<b>Asesiad o'r Effaith Economaidd-gymdeithasol</b> <i>A ydych chi wedi cynnal Asesiad o'r Effaith Economaidd-Gymdeithasol?</i> <b>Socio-Economic Impact Assessment</b> <i>Have you undertaken a Socio-Economic Impact Assessment</i>	Do/Yes: <input type="checkbox"/>	Naddo/No: <input checked="" type="checkbox"/>
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
<b><u>Ansawdd</u></b> <i>A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?</i> <b><u>Quality</u></b> <i>Have you undertaken a Quality Impact Assessment Screening?</i>	<b>Galluogwyr Ansawdd Enablers of Quality</b> All Apply	<b>Meysydd Ansawdd Domains of Quality</b> All Apply
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
<b><u>Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant Wellbeing of Future Generations Act – Wellbeing Goals</u></b>	A Healthier Wales	
<b>Effaith Amgylcheddol / Cynaliadwyedd (5Rs) Environmental /Sustainability Impact (5Rs)</b>	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
	No - Not Applicable	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:	
<b>Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog</b> <i>A ydych chi wedi ystyried Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog:</i> <b>Armed Forces Covenant Due Regard Duty</b>	Do/Yes: <input type="checkbox"/>	Naddo/No: <input checked="" type="checkbox"/>
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	



Have you considered the Armed Forces Covenant Due Regard Duty?		
<b>Asesiad o Effaith ar Ddiogelu Data</b> <i>A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?</i> <b>Data Protection Impact Assessment</b> <i>Have you undertaken a Data Protection Impact Assessment Screening?</i>	Do/Yes: <input type="checkbox"/>	Naddo/No: <input checked="" type="checkbox"/>
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
<b>Asesiad o Effaith ar Atal Twyll</b> <i>A ydych chi wedi ystyried yr effeithiau ar atal twyll?</i> <b>Counter Fraud Impact Assessment</b> <i>Have you considered the counter fraud impacts</i>	Do/Yes: <input type="checkbox"/>	Naddo/No: <input checked="" type="checkbox"/>
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
<b>Cyfreithiol Legal</b>	Yes (Include further detail below)	
<b>Enw Da Reputational</b>	Yes (Include further detail below)	
<b>Effaith ar Adnoddau</b> <i>(Pobl / Ariannol)</i> <b>Resource Impact</b> <i>(People / Financial)</i>	Yes (Include further detail below)	
	Implementation of LTP framework April 2026	

## 1. PATIENT SAFETY

### 1.1 PATIENT SAFETY INCIDENTS

#### 1.1.1 Incidents

There are currently 4900 open incidents of these, 58.61% are overdue, which is a slightly improved position to the previous reporting period. The number of closed incidents versus the number of opened incidents is a similar number each week.

Trajectories for a 20% reduction of overdue incidents for each IHC/Division is being completed by the Patient Safety Team for monitoring of improvement for each of the separate areas with the aim to attain compliance of 80% of incidents being closed within 30 days. Statistically the organisation is moving in the right direction.

#### 1.1.2 Oxygen Cylinder Improvement

Following a request to change labels on cylinders to improve safety, BOC (oxygen cylinder supplier) have responded to say that they are unable to change the labelling on cylinders due to the need for a graduated 'switch on' process rather than a hard on/off but also due to their need to meet the requirements of the global market.

BCUHB representatives met with BOC to discuss the way forward. BCUHB decision will be needed to either accept the current labelling of new single valve cylinder or continue with current cylinder design. Compliance against mandatory oxygen e-learning as of end of January 2026 sits at 84% against a target of 85%.

#### 1.1.3 Nationally Reportable Incidents

From 01<sup>st</sup> December 2025 to 31<sup>st</sup> January 2026, there were 14 Nationally Reportable Incidents (NRIs) submitted compared with 18 for the previous reporting period. These can be categorised as follows: -

Assessment, Investigation, Diagnosis n=5  
Maternity adverse outcome, n=4  
Behaviour including violence and aggression n=2  
Infection control n=1.

The total number of NRI investigations that were open as at the end of January 2026 was 47 with 4 overdue closures.

The proportion of NRIs that remain open for more than 90 days is the second best in Wales, and the best of similar size Health Boards, with the Health Board having only 21.5% of cases taking longer than 90 days. The median working days to completion is also the lowest at 75 days compared to the All-Wales median of 125 days.

A total of 34 NRI outcome forms were submitted to NHS Wales Performance and Improvement for closure during December 2025 and January 2026. Further detail and learning from these closures can be found in the confidential quality report.

#### 1.1.4 Never Events

The Health Board reported one Never Events in December 2025 which related to a chest drain being inserted into wrong side of patient (Wrong site surgery)

There is a theme identified relating to chest drains. Although each incident reviewed reflects a different aspect of matters relating to chest drain insertion, it does highlight that although undertaken outside a theatre setting, there are significant patient safety factors for these procedures highlighting the need to follow process in order to mitigate the risk for patients.

The Patient Safety Team are undertaking work around Local Safety Standards for Invasive Procedures (LocSSIPs) and stressing the importance of services ensuring the documentation they use is current and compliant with current national and regulatory guidelines.

Further detail and learning can be found in the confidential quality report.

## 1.2 PATIENT SAFETY ALERTS

There are currently two open national safety alerts (PSA). The Patient Safety Team is actively working to ensure compliance and mitigate associated risks:

- 1.2.1 **PSA019 Delayed administration of RasbriCase:** This alert highlights the harm from delayed treatment for tumour lysis syndrome. An internal alert is being drafted, and work is underway to update local guidelines in line with national standards, with a compliance date of 28 February 2026.
- 1.2.2 **PSA020 – Incorrect Recording of Penicillin vs Penicillamine Allergy** - The ePMA system rollout is underway, and system warnings and reporting options are being explored. Once the rollout is complete, a follow-up meeting will be arranged to review compliance and agree next steps.
- 1.2.3 **Medical beds, trolleys, and rails (MDA/2023/03):** Formal notification of compliance is not required as not circulated via the NHS Performance and Improvement office, as good practice BCUHB will continue to comply with the alert which concerns the risk of death from entrapment or falls. A new Health Board protocol and risk assessment tool has been approved and is being implemented at the ward level.
- 1.2.4 **Profemur Hip Replacements (DSI/2025/005):** This is a Field Safety Notice recall due to a higher-than-anticipated risk of revision surgery and component fracture. This device is no longer in use and patients with the implant have been identified and are being risk assessed for the need for follow up - Completed Project Report submitted regarding management of the National Joint Alert (Profemur Modular Neck Hip System) for Betsi Cadwaladr UHB.

The Patient Safety Team have circulated 22 Safety Alerts for December 2025 January 2026. Field Safety Notices (n=7), Internal Alerts (n=2), Pharmacy Alerts (n=12), Welsh Government Alert (n=1),

### 1.3 SAFEGUARDING

#### 1.3.1 Safeguarding and Public Protection Training compliance.

Safeguarding and Public Protection Training compliance is implemented in line with National Safeguarding Training Strategies. Governance and Reporting are inline with BCUHB governance and the Safeguarding Reporting Framework.

BCUHB Electronic Staff Record (ESR) position for December 2025 – January 2026

**Table 1: BCUHB Safeguarding Training Compliance by Module**

Safeguarding Module	Dec 25	Jan 26	Trajectory
MCA – Level 1	86.1%	86.2%	↑
MCA – Level 2	85.5%	85.6%	↑
Safeguarding Adults – Level 1	88.5%	88.4%	↓
Safeguarding Adults – Level 2	87.2%	87.3%	↑
Safeguarding Children – Level 1	89.6%	89.7%	↑
Safeguarding Children – Level 2	89.1%	89.3%	↑
Safeguarding Children – Level 3	63.3%	64.0%	↑
VAWDASV	80.2%	80.2%	↔

#### 1.3.2 Assurance and Reassurance.

##### ➤ **All Wales: Child Sexual Exploitation Risk Questionnaire (CSERQ)**

BCUHB Safeguarding & Practice Development have developed a training package for the application of CSERQ in Practice. This is to improve staff confidence and competence in using the CSERQ assessment and identification tool.

- The training was launched during Safeguarding Week 2025 and supports the findings highlighted in the recently published Gwynedd Child Practice Review Report; 'Our Bravery Brought Justice'.
- This training is aimed at staff who work with children and young people who may be at risk of Child Sexual Exploitation and Child Sexual Abuse (CSE/CSA).

- 1.3.3 ➤ **Level 3 Safeguarding Adults on ESR:**  
The ability to record both Level 2 and Level 3 Safeguarding Adults Training was implemented on ESR on the 16<sup>th</sup> September 2025
- The trajectory of compliance is positive and formal reporting will be available from Quarter 4.
  - Further work is taking place to ensure assurance against the compliance data as the National Training package is in two parts; Part A and Part B. Target date March 31st 2026.
- 1.3.4 ➤ **Preventing Radicalisation (Prevent Training):**  
The Counter – Terrorism and Security Act 2025 expects Health Services and NHS organisations to comply with the Prevent Duty, which includes the requirement for staff to receive the appropriate prevent awareness training.
- The Home Office training package is ready to be uploaded onto ESR.
- 1.3.5 ➤ **VAWDASV Group 2 ‘Ask and Act’ Training:**  
The Health Board cannot currently report who has completed VAWDASV Group 2 Ask & Act because this training is not set up as a competency in ESR.
- At present, we can report the combined compliance of Group 1 and Group 2 on ESR.
  - Group 2 training package is ready to be uploaded onto ESR

### BCUHB Position

All Mandatory Training requirements are currently under review, and as a result, the attachment of modules to ESR has been paused.

## 1.4 INFECTION PREVENTION AND CONTROL

### 1.4.1 Strategic Improvement Goals (2025-2027)

Performance against the six key HCAI improvement goals is mixed, with three organisms currently exceeding their target trajectories:

Goal Area	Target	Current Status vs. Trajectory
E. coli (Hospital-onset)	10% Reduction	Below trajectory (-2 cases)
MRSA	< Previous Year	Below trajectory (-2 cases)
C. difficile	25% Reduction	Above trajectory (+22 cases)
Klebsiella (Hospital-onset)	10% Reduction	Above trajectory (+8 cases)
Pseudomonas (Hospital-onset)	10% Reduction	Above trajectory (+3 cases)
MSSA	20% Reduction	Above trajectory (+26 cases)

Additionally, a clinician-led audit on hospital-acquired pneumonia is currently in the planning stages.

#### 1.4.2 Outbreak Management

Outbreak activity peaked in December and January, primarily driven by Norovirus and Influenza.

- Impact: 174 total bed days were lost, with Norovirus accounting for 90% (157 days) of this total due to isolation challenges.
- Flu Season Comparison: Overall flu outbreaks are lower this season (18) compared to the 2024/25 season (24).

#### 1.4.3 Key Improvement Initiatives

To address performance gaps and sustain progress, the following strategic actions are underway:

- Strategic Programmes: Participation in the National C. difficile collaborative and development of Phase 2 of the patient-facing HABITS programme.
- Workforce Development: Training focused on Norovirus management and the application of behavioural science to improve IPC compliance and culture.
- Estates & Technology: Secured funding to increase High-Level Disinfection (HLD) technology and progress on new segregation/cohort facilities at Wrexham Maelor Hospital.
- Environmental Standards: Reintroduction of ATP monitoring to verify cleaning efficacy alongside trials of new automated disinfection products.

## 2. PATIENT EXPERIENCE

### 2.1 COMPLAINTS

The following table displays key complaints metrics as of 2<sup>nd</sup> February 2026

Metric	Current Status	Trend (vs. previous period)
<b>Total Open Complaints</b>	291	Increase from 254
<b>Number Overdue</b>	49	Decrease from 50
<b>Compliance with 75% Target</b>	83.16%	Increase from 80.31% (but remains above target)

Between 1<sup>st</sup> December 2025 and 31<sup>st</sup> January 2026 (10 weeks), the Health Board received 654 complaints, an increase from 538 complaints in the last reporting cycle and closed 600 complaints a negative variance of 54.

However, the Health Board are now receiving more complaints than the rate at which we are closing them, (we are receiving on average 65.54 complaints per week and closing 60 complaints per week.) This was expected and anticipated for two principal reasons:

- winter pressures
- increase in patient contacts driven by planned care insourcing which has generated 111 complaints out of over 40,000 contacts since 1<sup>st</sup> September 2025

Plans are in place to mitigate this risk, anticipating future demands, including regulatory changes in April 2026, to provide a greater emphasis on early resolution, for Grade 1 (No Harm) complaints, negating the need for a lengthy investigation, providing timelier responses to people who raise a concern, and increased emphasis on learning and improvement, with a view of reducing complaints coming into the Health Board.

The Health Board's national performance provides significant assurance:

**Average Closure Time:** The Health Board is the best performing health board in Wales, resolving complaints in an average of 20 working days.

**Real-Time Performance:** The Health Board has consistently performed better than the Welsh national average for closing complaints within 30 days of receipt since September 2024.

**Overdue Complaints:** The Health Board performance on overdue complaints remains as the third best in Wales, and significantly better than other health boards of a comparable size. We contribute just 26 complaints of the 1523 that are overdue nationally.

Clinical Treatment and Assessment is the Health Board's biggest theme, with the predominant reason as to why people raise a complaint with the Health Board being waiting times, which account for 158 of the 291 open complaints (52.93%) as of 2<sup>nd</sup> February 2026.

There has also been a rise in complaints relating to attitude and behaviour and communication, both of which can be directly attributed to increased front line pressures.

## 2.2 PATIENT FEEDBACK

- 2.2.1 The Patient Advice and Liaison Service (PALS) resolved 1436 enquiries between December 2025 and January 2026, with an average resolution time of just 4.68 working days against a 10-day target. Top 3 enquiry themes included appointments, communication issues and clinical treatment and assessment. During this period, the service also received 102 written compliments praising general care and respect.

Findings from the All-Wales People's Experience Survey (PES) remain highly positive. Based on 12078 responses, 84.19% of patients rated their overall experience as 'Good' or 'Very Good'. Satisfaction levels were high with people reporting they were 'Always' treated with dignity and respect (85.13%) and being able to communicate in a preferred

language (89.91%) which exceeded the national benchmark of 85% satisfaction. The following quote identifies one of the positive experiences reported:

“Excellent experience from start to finish. My mother was treated with complete respect and dignity from point of entry to the ward. The anaesthetist and surgical team were extremely professional and thorough in explaining risks and procedures. The nursing staff including theatre induction and recovery have been amazing. What a fabulous, caring, professional team.” (Ysbyty Gwynedd, Tudno Ward)

The Easy Read version of the PES also yielded positive results, with 80.77% of respondents sharing a positive experience. Furthermore, the new targeted SMS feedback capturing post-birth and NICU discharge feedback is live, gathering specific feedback in these crucial service areas.

The Health Board is involved in the implementation of new All Wales feedback surveys including; Listening to People Survey focused on the concerns process, National Research Survey and Endoscopy survey due to go live from April 2026.

### 2.2.2 Advocacy and Support

The Health Board's commitment to a positive patient experience is further demonstrated by the ongoing work of the SWAN model for end-of-life care who have launched the model on Pantomime Ward at Wrexham Maelor Hospital, Aran Ward at Ysbyty Gwynedd and Ward 4 and 11 at Ysbyty Glan Clwyd.

The Chaplain and Spiritual Care Service responded to 162 requests for support from staff, patients, relatives, and community faith leaders in the reporting period.

This focus on the patient's experience of care is matched by an equal focus on the effectiveness of the clinical care provided.

## 2.3 OTHER PATIENT EXPERIENCE UPDATES

Nothing further to note.

## 3. CLINICAL EFFECTIVENESS

### 3.1 CLINICAL AUDIT

- 3.1.1 During December and January (Quarter 3 & part of Quarter 4), 5 Tier 1 national clinical audits were published, all are scheduled for reporting during February and March 2026. **18 National Audit reports have been published in Quarter 3, 15 included BCU identifiable data.** The table overleaf outlines the benchmarking information:



Tier 1 Project reference	Title	Performance against	
		National Benchmark	Last BCU report
NCAORP/2025-26-21	National Emergency Laparotomy Audit (NELA) - NELA Year 10 Report	G (YGC data only)	G (YGC Data only)
NCAORP/2025-26-06	National Audit of Inpatient Falls (NAIF) - Stepping towards Improvement (1 Jan-31 Dec 24) <i>* Update noted end of table</i>	R	G
NCAORP/2025-26-09	Stroke Audit (SSNAP) - State of the Nation Report	No comparable data due to change in audit metrics	
NCAORP/2025-26-12	National Bowel Cancer Audit (NBoCA) - State of the Nation Report 2025	G	G
NCAORP/2025-26-15	National Prostate Cancer Audit (NPCA) - State of the Nation Report 2025	G	G
NCAORP/2025-26-20	Renal Registry – 27 <sup>th</sup> Annual Report	No comparable data	
NCAORP/2025-26-21	National Early Inflammatory Autoimmune Disease Audit (NEIAA) - State of the Nation Report 2025	G	G
NCAORP/2025-26-28	National Diabetes Audit: Adolescent and Young Adult (NDA: AYA) - 2024 Dashboard Report	G	G
NCAORP/2025-26-36	National Audit of Cardiac Rehabilitation (NACR) - Quality Outcomes Report 2025	G	G
NCAORP/2025-26-37	National Vascular Registry - State of the Nation Report 2025 <i>** Update noted end of table</i>	R	R
NCAORP/2025-26-38	Myocardial Ischaemia National Audit Project (MINAP) - Annual Report 2025 (2024/2025)	A	G
NCAORP/2025-26-39	National Audit of Cardiac Rhythm Management (NACRM) - Annual Report 2025 (2024/2025)	G	A



NCAORP/2025-26-40	National Audit of Percutaneous Coronary Intervention (NAPCI) - Annual Report 2025 (2024/2025)	G	G
NCAORP/2025-26-41	National Heart Failure Audit (NHFA) - Annual Report 2025 (2024/2025)	G	G
NCAORP/2025-26-27	National Pregnancy in Diabetes Audit (NPID) - 2024 Dashboard Report (2022-24)	A	G
NCAORP/2025-26-44	National Maternity & Perinatal Audit (NMPA) - Induction of labour snapshot report	A	Report has not been published previously
NCAORP/2025-26-45	National Neonatal Audit Programme (NNAP) – 2025 Summary Report	G	A
NCAORP/2025-26-46	National Perinatal Mortality Review Tool - 7th Annual report	Organisation specific data not provided by the report	

### National Audit of Inpatient Falls (NAIF)

\*The main concern that resulted in this audit rated red is the low data submission by the Health Board. This is being addressed to ensure better completion through offer and take up of support and training to staff who enter submissions. Submission to date this year far exceed those in a previous full year which is encouraging.

Service assessment of compliance (SAoC) reporting against key standards following review reports, show that the Health Board continues to demonstrate significant assurance in its approach to preventing inpatient falls, with robust governance arrangements, strong training compliance and improved quality of both risk assessments and post-fall reviews. Both Central and West IHCs report strengthened multidisciplinary learning mechanisms, including weekly Falls Learning Forums and integrated acute–community falls groups. While key risks remain—particularly the lack of flat lifting equipment in West community hospitals and increasing demand for enhanced observation—the Health Board has clear mitigation in place and active improvement programmes underway. No outlier concerns were identified by the National Audit of Inpatient Falls (NAIF), and recent progress has been positively recognised by external stakeholders including the Coroner.

\*\*The publication of the NVR State of the Nation report (November 2025) highlights that BCU vascular services show limited assurance. This report covers care until the end of 2024. It shows significant delays across AAA, carotid, Chronic Limb Threatening ischaemia and revascularisation pathways. Elective AAA treatment waits remain long, and ruptured AAA mortality is well above UK and Wales rates. It should be noted that this report covers the period prior to transfer of AAA services to University Hospitals of

North Midlands. Revascularisation delays are a concern and remain in the most recent data.

The service will be implementing a series of actions to support improvement across all pathways, including running clinical audits for each pathway in order to better understand reasons for treatment delays (**by end of April 2026**). Action plans will be developed (**by end of June 2026**) to enable timely improvement. These improvement plans will be shared with the IHC to provide assurances that appropriate actions are being undertaken which will be overseen by Vascular Network Clinical Audit Group.

Key	Comparison with National Benchmark:	Comparison with Last BCUHB Report:
<b>R</b>	Where BCUHB reported performance is at or above the benchmark in fewer than 50% of KPIs	Where the previously reported BCUHB performance has deteriorated in more than 50% of Key performance indicators (KPIs) according to the latest National audit report
<b>A</b>	Where BCUHB reported performance is at or above the benchmark in 50% to 74% of KPIs.	Where the previously reported BCUHB performance has been maintained or improved in 50% to 74% of KPIs in the latest reporting period.
<b>G</b>	Where BCUHB reported performance is at or above the benchmark in 75% or more of KPIs.	Where BCUHB has maintained or improved in 75% or more of KPIs since the previous reporting period

## 3.2 NICE GUIDELINES

- 3.2.1 The Health Board has achieved a **significant improvement** in recording of compliance with NICE guidelines. This success is largely attributed to the proactive support provided to departments and the successful implementation of the Audit Management and Tracking (AMaT) tool. The team are raising 'Not Achieved' via Strategic Clinical Effectiveness for further support to raise percentage figures. An internal audit has just been completed and response is being prepared.

## 3.3 MORTALITY REVIEW

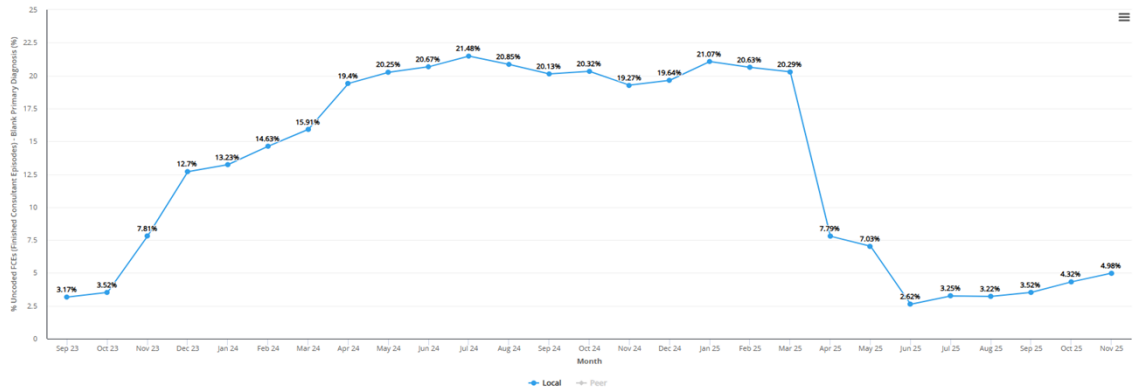
- 3.3.1 **Corporate Mortality Update:** Effect of reduction in coding completion on relative mortality reporting.

Following previous reports on increasing coding completeness, an internal trajectory to increase coding completeness from 75% to 95% over the first two quarters of the year 2025/2026 was set and delivered. To date, BCU has exceeded the national coding target of 95% for every month from June to November 2025.

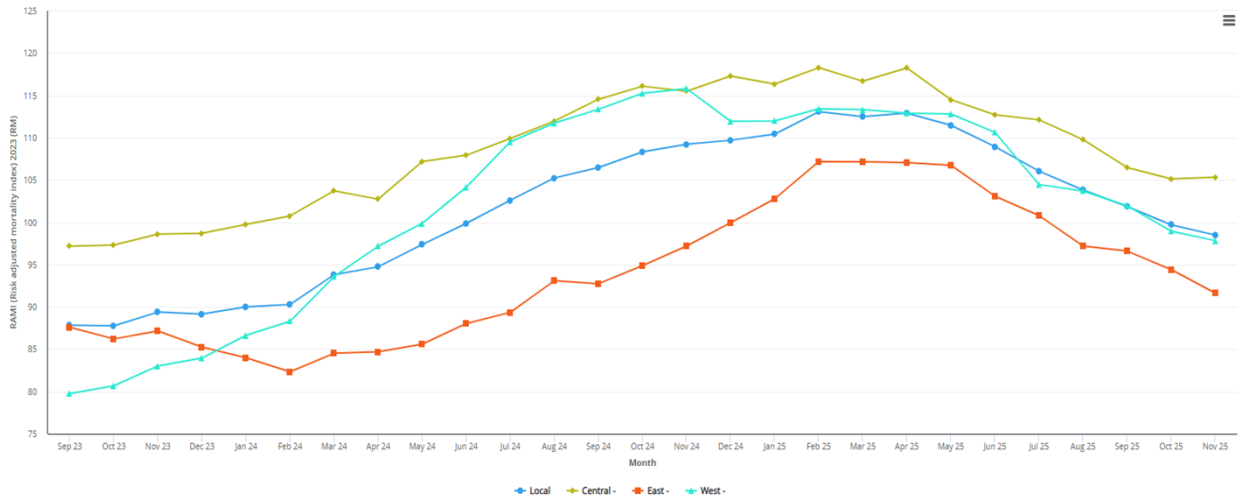
The chart below sets out the percentage of **uncoded** finished consultant episodes as of 20<sup>th</sup> January 2026 (the date our CHKS data was last updated). To meet the 95% coding completeness target, the monthly figure is to be 5% or less. As discussed in previous reports this is important to allow accurate calculation of relative mortality as expected mortality and this RAMI corrects over 12 months. RAMI 12 monthly rolling trend is illustrating this continues to correct.



### % Uncoded Finished Consultant Episodes – i.e., with a blank primary diagnosis



### RAMI 12-month rolling trend – September 2023-November 2025

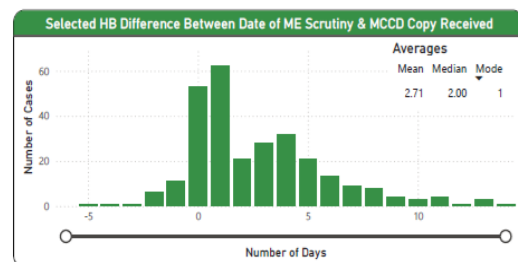
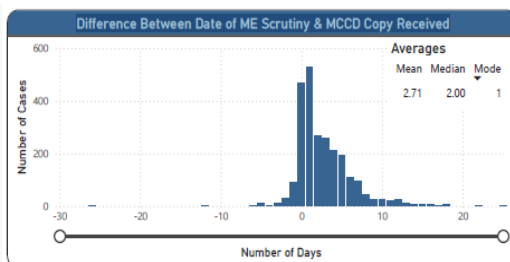


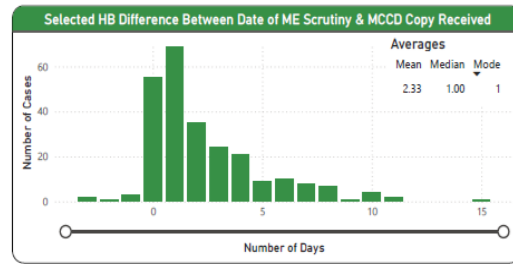
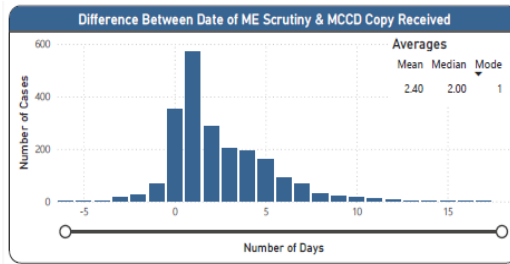
The overall crude mortality rate for BCU was 1.67% between December 2024-November 2025, compared with 1.78% in the previous 12 months, a reduction of 6.09%.

### 3.3.2 Medical certification of cause of death (MCCD) and interaction with Medical Examiners

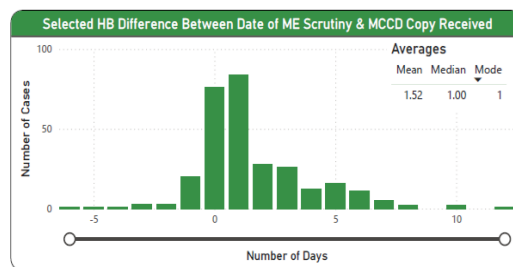
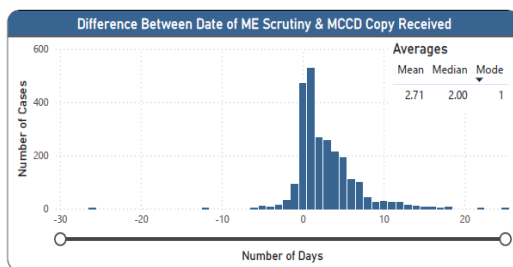
In comparison with other health boards the MES dashboard data shows that BCU are performing well in issuing of death certificate and are not an outlier in Wales.

BCU Hospital Data: Acute and Community December 2025:

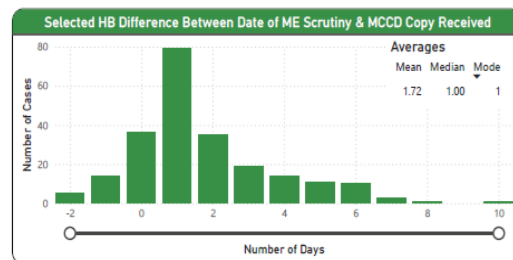
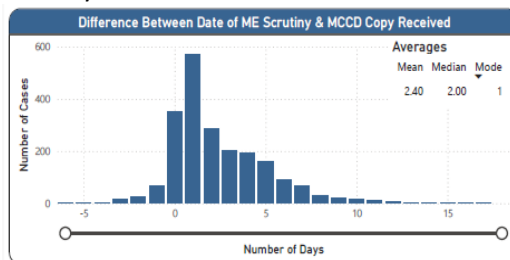




BCU Primary Care Data: Nursing Homes, Care Homes, Home Deaths and Hospice Deaths: December 2025:



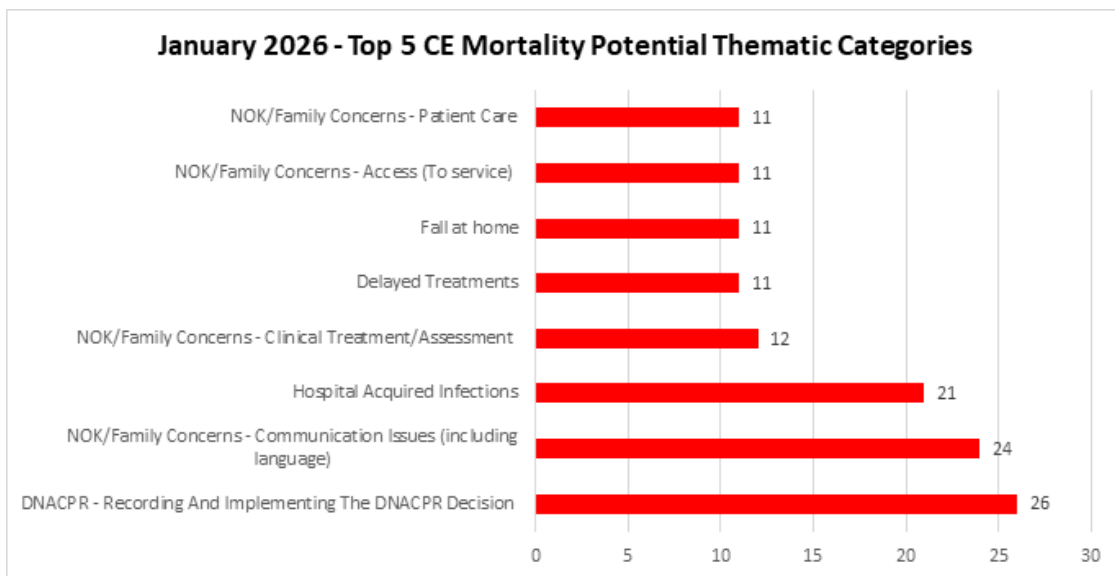
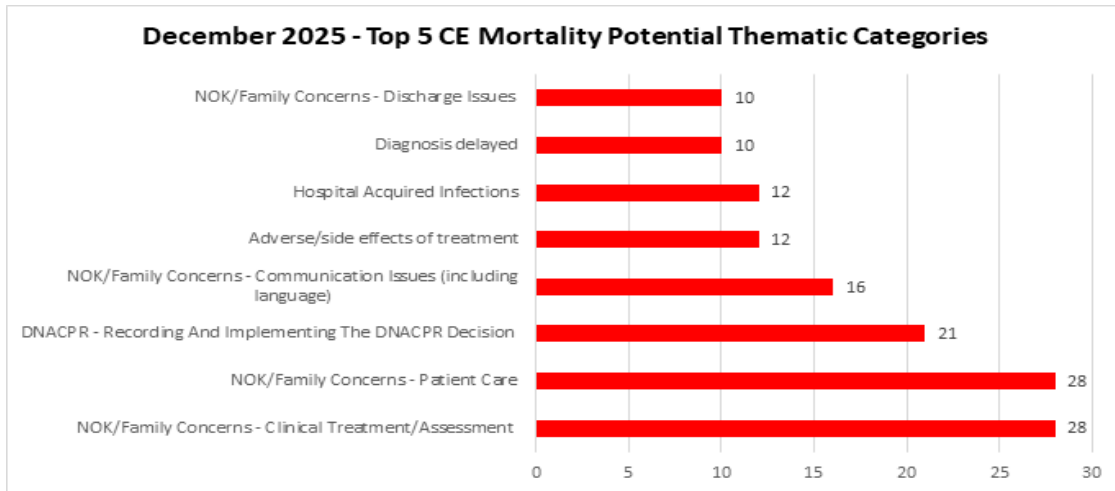
January 2026



### 3.3.3 Learning from all sources of structured mortality reviews

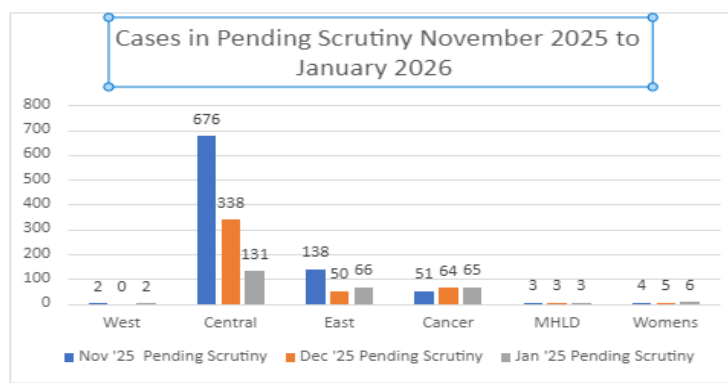
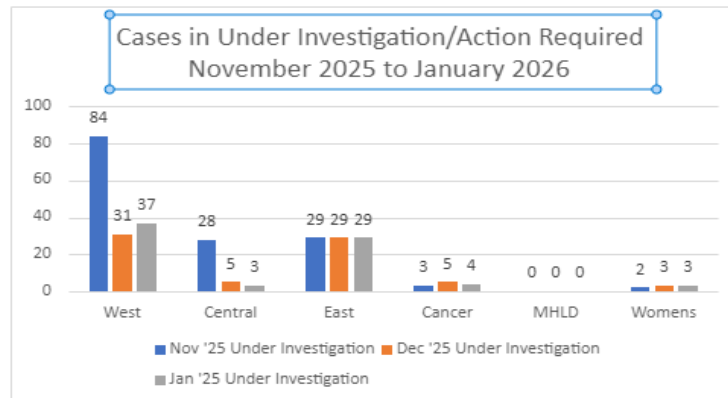
Medical Examiner (ME) scrutiny summaries, Inquest outcomes and related Regulation 28's continue to highlight that all services, particularly WAST, Emergency Departments and General Medicine across BCUHB remain under considerable pressure.

Top 5 MES Identified Potential Themes Monthly Data are as below (by date cases have been reviewed by CE mortality prior to IHC/service review): Strategic Clinical Effectiveness Group has agreed to instigate a quality improvement programme to address discussion and documentation of ceilings of care including 'Not for resuscitation' noting that this is a consistent theme in MES feedback.



### 3.3.4 ME Mortality Cases with IHCs and Services

Mortality reviews within the Health Board are undertaken within each IHC or relevant service group. Processes have been put in place to address the organisational risk relating to a historical backlog of cases requiring IHC mortality panel discussion in Central and East. Graphs below show that East have now reviewed the vast majority of the outstanding cases and Central continue to make significant progress and are on a trajectory to clear the backlog within the next few months. Relevant learning is being highlighted and escalated at relevant forums within the Health Board.



## 4. QUALITY ASSURANCE

### 4.1 HEALTHCARE INSPECTORATE WALES

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

The Quality Assurance Team continue to work with clinical areas to progress action plans, the below are all open HIW improvement plans, with targeted plans to progress completion.

#### 4.1.1 Inspection – Ysbyty Gwynedd Emergency Department (14–16 Apr 2025)

- **Status:** Overdue
- **Recommendations:** 28
- **Actions:** 66 total; 64 completed (97%)
- **Outstanding:** 2 actions remain
- **Closure Date:** Revised to February 2026
- **Governance:** Continuous monitoring via Local HIW Review Meeting, Regulatory Assurance Group (RAG), and Executive Quality Delivery Group (EQDG).

---

### **Inspection – Cemlyn Ward, Ysbyty Cefni (28–29 Jul 2025)**

- **Status:** Overdue
- **Recommendations:** 19
- **Actions:** 41 total; 40 completed (98%)
- **Closure Date:** Revised to February 2026
- **Governance:** Progress monitored through T4 Programme Group, Regulatory Assurance Group (RAG), and Executive Quality Delivery Group (EQDG)

### **Inspection – Hergest Ward, Ysbyty Gwynedd (6<sup>th</sup> to 8<sup>th</sup> September 2025)**

- **Status:** In progress
- **Recommendations:** 26
- **Actions:** 47 total; 28 completed (60%)
- **Closure Date:** 31<sup>st</sup> May 2026
- **Governance:** Progress monitored through Local HIW Review Meeting, T4 Programme Group, Regulatory Assurance Group (RAG), and Executive Quality Delivery Group (EQDG)

### **Inspection – Pantomime Ward, Ysbyty Maelor (14<sup>th</sup> to 16<sup>th</sup> October 2025)**

- **Status:** In progress
- **Recommendations:**
- **Actions:** 42 total; 14 completed (33%)
- **Closure Date:** 31<sup>st</sup> July 2026
- **Governance:** Progress monitored through the Local HIW Review Meeting, East Patient Safety Quality Delivery Group, Regulatory Assurance Group (RAG), which reports directly to the Executive Quality Delivery Group (EQDG).

4.1.2 **Requests for Assurance:** The Health Board responded to requests for assurance from HIW concerning; Heddfan Unit (IHC East), T Block Entrance, Ysbyty Gwynedd, (IHC West), Ward 9, (IHC Central), Community Mental Health, (IHC Central), Ogwen Ward (IHC West) and Ward 12 (IHC Central).

In each case the improvement actions were detailed and HIW were assured by the Health Board response.

### **Concerns / Requests for Assurance (6)**

- **Heddfan Unit, IHC East (Dec 2025)**  
HIW have requested assurance following concerns received relating to staffing levels, neglect of person-centred care, inappropriate comments about the patient and absence of Ward Manager
- **T Block Entrance, IHC West (Dec 2025)**  
Assurance request from HIW highlighted concerns around staff and patients being exposed to second hand smoke outside the main entrance of T Block entrance
- **Ward 9, IHC Central (Dec 2025)**  
Assurance request from HIW in relation to patient care
- **Community Mental Health Conwy (Jan 2026)**

- Assurance request from HIW in relation to safety and wellbeing of a patient
- **Ogwen Ward, IHC West (Jan 2026)**  
Assurance request from HIW in relation to staffing levels, standards of care, dignity and respect, insignificant rehabilitation, communication, poor management and safety issues
  - **Ward 12, IHC Central (Jan 2026)**  
Assurance request from HIW in relation to governance oversight, concerns, staffing, leadership visibility and escalation routes

## 4.2 CARE INSPECTORATE WALES

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

A Quality-of-Care Review for Enhanced Community Residential Services (ECRS) on both **04 July 2025** and **24 November 2025** found no immediate concerns and noted no areas for improvement. The service is progressing well with its improvement plan, which is on track for closure in March 2026.

The next visit is scheduled for 23<sup>rd</sup> February 2026, of which the outcome will be reported to the Regulatory Assurance Group.

## 4.3 QUALITY PEER REVIEWS

- 4.3.1 An exception-based Trauma Network Peer Review, identified gaps in BCUHB transfer documentation, inconsistent MDT communication, and a need for clearer governance. An improvement plan is currently in place with the Health Board Trauma Network team/ IHCs to address these findings. The improvement plan is being monitored through the Regulatory Assurance Group and the service are being supported to progress by the Quality Assurance Team.

## 4.4 PUBLIC SERVICES OMBUDSMAN FOR WALES

- 4.4.1 PSOW has legal powers to investigate complaints about public services and independent care providers in Wales. PSOW investigates complaints from members of the public about alleged maladministration and service failure.  
When the Ombudsman investigates a complaint and thinks that something has gone wrong, they prepare a report to summarise their findings. Sometimes, where there is a need for wider learning, or what went wrong was significant, or in the interest of the public, a Public Interest Report (PIR) is issued.
- 4.4.2 **Final Public Interest Report (Escalated):** There is an outstanding action related to the Commissioning Assurance Framework (CAF). This unfortunately missed the deadline. This is being tracked and monitored and will be subject to Executive approval and discussion with the Office of the CEO.



4.4.3 **New Draft Public Interest Report:** A Draft Public Interest report has been received in January 2026. Subject to consideration of any points which the Health Board or the complainant make in response to the draft report, the Ombudsman considers that this case raises issues of public interest. The draft report has been shared with IHC Directors. The Health Board has responded to the Ombudsman accepting the report and agreed to implement all the recommendations. An action plan has been drafted in preparation for when Ombudsman’s final report is issued.

4.4.4 **Performance Metrics (January 2026):**

	Jan 2026	Dec 2025	Nov 2025	Comments
Total Contacts Received	41 ↑	28 ↓	41	Total number of contacts received from the Ombudsman’s office during each month. This can be either an enquiry, a ‘not to investigate’ letter, an early resolution proposal, or a new full investigation.
New Full Investigations Received by PSOW	3 ↓	4 →	4	
Complaints Upheld / Partially Upheld	2 →	2 ↓	0	Following a full investigation by the Ombudsman, the number of final reports received where the complaint has either been upheld or partially upheld each month.
Average Response Time *				This calculation needs to include recommendations from final reports as well as early resolution proposals. Due to the limitations on Datix, currently unable to extract an ART because there is no facility to add more than one recommendation/deadline for an early resolution proposal on Datix. Some proposals have several recommendations with different deadline dates. Only one date can be added to Datix. In order to develop this function, Once for Wales are improving the Ombudsman page on Datix
PSOW Recommendations Issued	5 ↓	20 ↑	6	Total number of recommendations issued by the Ombudsman each month
Compliance with PSOW Recommendations *	79% ↓	80% ↑	33%	The Quality Team have now developed internal tracking to enable the metric to include full investigations & early resolution proposal recommendation. This percentage is a calculation from the total number of recommendation the Health Board has ongoing and implementing each month.
Number of Final Public Interest Reports Received	0 →	0 →	0	

These metrics demonstrate either an upward or a downward trend despite challenges, such as cases where agreed deadlines are changed by the Ombudsman or dependencies on other NHS bodies for information in cross-border cases.

**Improvement Focus:** Key areas for improvement include:

- Strengthening complaint handling and early resolution to reduce escalation.
- Embedding the Listening to People Framework (2026) to improve responsiveness and empathy.
- Building continuous learning from patient feedback, incidents, and Ombudsman recommendations.
- Integrating Ombudsman reporting into governance systems, with stronger tracking via the Quality Dashboard and escalation to Executive level.
- Enhancing Board oversight by embedding Ombudsman reporting into the Quality, Safety & Experience Committee from December 2025.
- Collaborating with other Welsh Health Boards to benchmark performance and maintaining proactive engagement with the Ombudsman’s Office.

**4.5 QUALITY DASHBOARD/QUALITY SCOREBOARD**

4.5.1 The Quality Assurance team have been tasked by the Executive Director of Nursing with developing an organisational oversight of Quality measures by way of a Quality Score

Card. This will improve the data intelligence to monitor the organisations position and compliance with standards. This tool will provide a structured, visual overview of key quality metrics, strengthening assurance to the Committee and the Board. It is a key component of our Quality Management System and directly supports the statutory Duty of Quality.

#### 4.5.2 Further Dashboard Demonstrations to Cardiff & Vale and Powys

On 3<sup>rd</sup> February and 10<sup>th</sup> February 2026, further dashboard demonstrations have taken place with Cardiff & Vale and Powys Health Boards, offering support and guidance to colleagues in Wales in relation to the development of their own dashboards. This is key to collaboration and the sharing of learning. An All-Wales demonstration is scheduled for 2<sup>nd</sup> March to the Intelligent Monitoring, Dashboards and Data Analysis.

#### 4.5.3 Update on Quality Management System (QMS) Implementation

Progress continues to be made in advancing the QMS programme, including the expansion of the QMS Maturity Assessment tool into Primary Care, Community Services, and CAMHS, alongside strengthened governance and engagement arrangements. Key milestones have been achieved, including advancement of the QMS policy through corporate governance and continued development of the benefits framework following strategic feedback.

Activity is now focused on strengthening organisational engagement, preparing for Board reporting, and developing supporting tools and communications. However, delivery remains constrained by the absence of dedicated funding and long-term resourcing, and wider rollout is dependent on the Foundations of the Future programme and organisational restructure.

An evaluation and QMS Away Day in February will review progress to date, lessons learned, and next steps, informing future planning and ensuring alignment with organisational and national directives. Resource limitations and competing priorities continue to pose risks to delivery and sustainability.

## 4.6 DUTY OF CANDOUR

4.6.1 The Health Board's current maturity for Duty of Candour is rated as 'Yellow/Operationalising' (Average score: 3), which is in line with the national average.

Key strengths were noted in Reporting and Communication.

Gaps remain in Commissioning and Hosting, and an improvement plan is in place with a trajectory to move towards 'Green' (fully compliant) maturity in 2026. This focus is linked to strengthening our processes for managing healthcare law and embedding organisational learning. A Task and Finish Group is in place to focus on strengthening Health Board governance for the duty, and to improve staff engagement and awareness.



## 4.7 ORGANISATIONAL LEARNING

- 4.7.1 The BCUHB digital Learning Repository platform designed to capture, validate, and share organisational learning to strengthen patient safety and clinical practice, has successfully completed Phase 1. The pilot within Pharmacy and Medicines Management progressed as planned and went live in December 2025 with its first learning briefing. The pilot has been successful, supported by ongoing system enhancements and testing to ensure reliability and usability. Governance and strategic oversight continue through the Project Board as preparations progress for the wider 2026 rollout, during which additional early-adopter teams will begin using the system. Work is also underway to determine how the repository will interface with existing learning meetings to ensure insights are captured consistently and integrated into established processes.

## 5. HEALTHCARE LAW

### 5.1 CORONER AND INQUESTS

- 5.1.1 A Prevention of Future Deaths report has been issued by the Assistant Coroner for North Wales (East and Central) following the inquest into the death of a patient who died in August 2024 from natural causes. While the Coroner concluded that delays in endoscopy between April and July 2024 did not affect the outcome for the deceased, the inquest identified significant and longstanding systemic concerns within the gastroenterology and endoscopy service at Ysbyty Glan Clwyd. These include severe workforce shortages with heavy reliance on locum staff, inadequate infrastructure investment despite previous business cases, and substantially extended waiting times against national targets for urgent suspected cancer, urgent non-cancer, and routine referrals. The coroner further expressed concern that these risks are not adequately reflected on the corporate risk register and concluded that the service is not currently fit for purpose, presenting an ongoing risk of harm to patients unless action is taken. . The Executive Medical Director has held a Health Board wide Gastroenterology Rapid Quality Review on 13/02/26 to identify all major concerns and prioritise actions.

The Health Board is required to submit a formal response outlining actions taken or proposed by 10 March 2026.

### 5.2 LIABILITY CLAIMS

- 5.2.1 The Health Board continues to maintain focused oversight of Learning from Events Reports (LFEs) required by the Welsh Risk Pool (WRP). Since the previous reporting period, the number of overdue LFEs has slightly increased to 19, with a concentration across a small number of IHCs/Divisions.

While this represents a deterioration compared to the position reported at the end of November, targeted action remains in place to address delays, reduce the risk of further deferrals, and achieve a more sustainable improvement over the remainder of the year. Importantly, overall performance has improved year-on-year, with 23 WRP penalties applied in the current financial year to date compared with 66 penalties in the previous financial year, reflecting a significant shift from over 70% of submissions historically triggering a penalty to fewer than 10% currently.

Most overdue cases relate to WRP deferrals for further evidence rather than non-submission, with learning themes reviewed alongside wider quality and risk intelligence to ensure organisational learning and improvement.

Process improvements have been implemented to support this position, including the introduction of an earlier internal submission deadline to strengthen assurance and reduce the likelihood of further deferrals, and this remains an area of active Health Board oversight.

### 5.3 OTHER HEALTHCARE LITIGATION ISSUES

- 5.3.1 In relation to Redress, preparations are underway for the implementation of the new *Listening to People (TLP)* framework from 01 April 2026, with the Legal Services Department working alongside the Quality and operational teams to support readiness and transition from the existing arrangements. While the revised framework is intended to support earlier resolution and reduce escalation to litigation, the increase in the redress value threshold and the reduction in timescales for progression and completion of cases are expected to present a challenge to the timely completion of Redress cases, particularly where matters are complex. This risk is recognised nationally and will continue to be monitored through governance arrangements.

The quarterly Legal Report is presented at the Executive Committee and PFIG Committee with detailed reporting on legal activity. A new six-monthly Legal Learning Report is also shared amongst various groups.

### 5.4 UPDATES AS REQUESTED BY COMMITTEE CHAIR

#### 5.4.1 Womens Services

In line with national priorities, BCUHB is committed to launching a dedicated Women's Health Hub by March 2026. The Hub will enhance Primary Care through a cluster-based network of specialist clinicians, providing timely access to expert women's health support across the life course. Its development will be underpinned by co-production, robust engagement, and clear communication to ensure the model reflects the needs and priorities of women, professionals, and wider stakeholders.

#### Current Position

- Grant Funding: Awarded by Welsh Government.
- Ministerial Visit: Date to be confirmed in February 2026, by which time a fully functioning Pathfinder Hub is expected to be operational.
- Pathfinder Hub: The Pathfinder Hub site has been confirmed at Llandudno General Hospital. Work is progressing to recruit the required clinical and operational workforce and to ensure that the estate and digital infrastructure are appropriately prepared to support the model.
- Project Operational Group: Established to progress workforce, estates, and informatics activity required for the establishment of the Pathfinder Hub.
- Full Business Case (FBC): Development of a Business Case has commenced in Q3 to ensure the continuation of the Pathfinder Hub and phased roll-out of the model.

- Primary Care Academy Support: Secured from BCUHB Primary Care Academy to coordinate the allocation of places across all 14 clusters.

#### Next Steps

- Establishment of Pathfinder Hub
- Ongoing engagement, communication, and co-production activities
- Recruit to formalised training programmes
- Launch Consultant Education Programme
- Appoint Women's Health Research Activator
- Progress Business Case to sustain and roll-out activity in 2026/27 (inclusive of data gathering)
- Review of waiting times reviewed and potential fast-track solutions
- Development and implementation of revised multi-professional pathways across the three main priority areas; rollout of education and upskilling programme to support the cluster-based model

#### **5.4.3 National Maternity and Neonatal Assurance Assessment.**

The key findings of the National Maternity and Neonatal Assurance Assessment were presented to the Minister in December 2025. The National Report and Recommendations are expected in March 2026.

#### **5.4.4 Quality Management System (QMS) implementation within Mental Health Division**

Following an initial presentation by Head of Quality to identify interested parties from Performance and Integrated Strategy and Development in early September, a further QMS presentation to the triumvirates and Director team at the MHLD Quality Delivery Group will take place early March.

#### **5.4.5 New NHS Wales Listening to People (LTP) Regulations**

Significant progress has been made across the organisation in preparation for the implementation of the NHS Wales Listening to People (LTP) Regulations, due to go live on 1 April 2025. Recent meetings of the Operational Delivery Group demonstrate strong mobilisation activity, continued clarification of national expectations, and emerging operational risks requiring executive oversight.

- **Regulatory Position and Assurance**

The Health Board has continued to receive updated drafts of the LTP guidance and proposed regulatory amendments from Welsh Government. While the final legislation has not yet been formally released, BCUHB remains confident that preparatory work covers all anticipated requirements. Updates confirm changes in terminology, process structures and complaint categorisation as the system transitions from PTR to LTP.

A comprehensive Key Information Bundle has been developed to support early socialisation of the new framework, including:

- Purpose and principles of LTP
  - People's Charter
  - The new set of 16 national Complaint Standards
  - Process overviews, templates, and compliance tools
- This material is ready for internal circulation and will underpin staff education and mobilisation.
- **Operational Model – Early Resolution and Investigations**

The operational requirements under LTP introduce fundamental changes to complaint handling:

### **Stage 1 – Early Resolution**

- Complaints must now be acknowledged within 5 working days, with efforts made to resolve the issue within 10 working days, beginning from the date of acknowledgement.
- Stage 1 is restricted to Grade 1 (no harm) cases and excludes all discussions relating to qualifying liability, breach of duty or redress.
- A mandatory offer of a Listening Discussion must be included in every acknowledgement letter.

### **Stage 2 – Investigation**

- All Grade 2–5 complaints automatically escalate to Stage 2.
- No national target has been set, but BCUHB will operate to a 60 working day internal standard, with potential alignment to future graded national timescales (30/60/90/120 days).
- Redress thresholds will double from £25,000 to £50,000, with a six-month completion requirement.

BCUHB receives approximately 3,000 complaints annually, and it is expected that 40% (around 1,400 cases) will require Stage 1 handling. Current analysis suggests this is achievable but will require structured scheduling and clear governance.

- **Listening Discussions – Key Workstream**

The introduction of mandatory Listening Discussions is anticipated to be the most operationally challenging aspect of LTP implementation.

These discussions must be offered for all Stage 1 concerns and require:

- Protected time for staff delivering discussions

- Pre-agreed availability to enable Complaints Officers to include confirmed options in acknowledgement letters
- Structured training to support consistency, empathy, and boundaries around scope of discussion
- Prompt recording using the new Listening Discussion Template

Uptake remains unpredictable, with modelling indicating potential demand ranging between 150 and 1,500+ discussions per year. IHC and Divisions have expressed concerns over capacity, and further clarity is required on pathways where complaints are submitted by MS/MP offices or Llais.

- **Datix Readiness**

Following earlier concerns, national confirmation has now been received that Datix will be ready for LTP go-live, and a trial version will shortly be released for testing. Key updates include:

- Stage 1 deadlines must be manually calculated, introducing risk due to the volume of cases and bank holiday variation.
- Stage 2 deadlines can be auto-calculated.
- New fields will capture Listening Discussion offers, scheduling, outcomes, and escalation decisions.

A Datix LTP Working Group will be established to test the module, map workflows, and identify risks. This will be essential to ensuring accurate performance reporting and compliance monitoring through the transition period.

- **Training and Workforce Preparedness**

National training from Academy Wales has been delayed until May 2025, post go-live. In response, BCUHB is developing an internal interim training package for February–March, including:

- Drop-in sessions
- Divisional briefings
- A short accessible LTP summary for frontline staff
- Additional materials for Primary Care to ensure alignment

Listening Discussion skills will be incorporated into this internal programme due to the absence of national provision before April.

- **Mobilisation Workstreams and Communications**

The Health Board has initiated broader mobilisation planning, including:

- Stakeholder and Divisional engagement using the Key Information Bundle
- Policy and template redesign to remove PTR terminology

- Civica survey implementation (linked via QR codes in all letters)
- Contract updates for independent and cross-border providers
- Public-facing communications strategy including posters, leaflets, and digital materials
- Strengthened engagement with the Ombudsman to support PTR→LTP transition

Concerns remain regarding the scale of activity required before 1<sup>st</sup> April and the current pace of work. To support delivery, future meetings will be restructured into focused themed sessions (Datix, training, communications, listening discussions).

- **Key Risks**

Despite the scale of change required, BCUHB is in a strong preparatory position. Significant work remains over the next two months to ensure full compliance and a safe transition from PTR to LTP. Continued oversight by QSE Committee is recommended until post-go-live stabilisation is achieved. The key risks include:

- Capacity for Listening Discussions and lack of confirmed divisional scheduling arrangements
- Manual calculation of Stage 1 deadlines, risking non-compliance
- Variability in demand for early resolution discussions
- Delays in national training, necessitating comprehensive local provision
- Advocacy capacity, particularly for Llais-supported complaints
- Short mobilisation timeline, with multiple interdependent workstreams nearing critical path status

## 5.5 CONCLUSION

- 5.5.1 This Integrated Quality Report provides assurance that the Health Board continues to strengthen its approach to quality, safety, and patient experience, supported by improved data intelligence, maturing quality systems, and targeted action across key risk areas. While notable progress is evident—particularly in complaints performance, national clinical audit outcomes, organisational learning, and preparation for the forthcoming Listening to People Regulations—significant challenges remain, including infection prevention trajectories, ongoing HIW improvement requirements, and systemic risks highlighted through mortality reviews and coronial findings. Continued Executive oversight, robust monitoring through established governance forums, and sustained organisational focus will be essential to achieving the improvements required and ensuring the delivery of safe, effective, and person-centred care for the population we serve.

## Quality Safety & Experience Committee

### INTEGRATED QUALITY AND PERFORMANCE REPORT (IQPR)

<b>Dyddiad y Cyfarfod Date of Meeting</b>	05 March 2026
<b>Statws Cyhoeddi Publication Status</b>	Open/ Public
	Not Applicable
<b>Enw a theitl Awdur(on) yr Adroddiad Report Author name and title</b>	Ed Williams Dirprwy Cyfarwyddwr Perfformiad Deputy Director for Performance
<b>Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol Lead Executive Team Member name and title</b>	Angela Wood Cyfarwyddwr Gweithredol Nyrsio Executive Director of Nursing
<b>Pwrpas yr Adroddiad Report Purpose</b>	For Noting

#### **Crynodeb Gweithredol Executive Summary**

This paper provides an update on quality performance for information and assurance, with the full report included as an appendix and the key messages being;

There are no performance indicators requiring escalated scrutiny in this reporting period. Where measures were in escalation previously, these have now achieved the levels of performance required and have been stood down from escalated status.

Members are asked to note the above and further information that contained within appendix to the report (appendix A – The Integrated Quality & Performance Report) identifying further the wider performance metrics.

**Ymgysylltu (mewnol/allanol) yr ymgwymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp)  
Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)**



<b>Pwyllgor / Grŵp / Unigolion Committee / Group / Individuals</b>	<b>Dyddiad Date</b>	<b>Canlyniad, Tystiolaeth a Data Outcome, Evidence and Data</b>
Not applicable for this report		

**Acronymau / Rhestr Termau  
Acronyms / Glossary of Terms**

A&E	Accident and Emergency
AB	Aneurin Bevan Health Board
ADHD	Attention Deficit Hyperactivity Disorder
ASD	Autistic Spectrum Disorder
BCU/BCUHB	Betsi Cadwaladr University Health Board
C&V	Cardiff and Vale University Health Board
CRR	Corporate Risk Register Reference
CTM	Cwm Taf Morgannwg University Health Board
ENT	Ear, Nose, and Throat
GDS	General Dental Services
GP	General Practitioner
HDda	Hywel Dda University Health Board
HEIW	Health Education and Improvement Wales
IHC	Integrated Health Community
LPMHSS	Local Primary Mental Health Support Services
MH&LD	Mental Health and Learning Disabilities
MMR	Measles, Mumps and Rubella
NHS	National Health Service
NR	non-recurrent



---

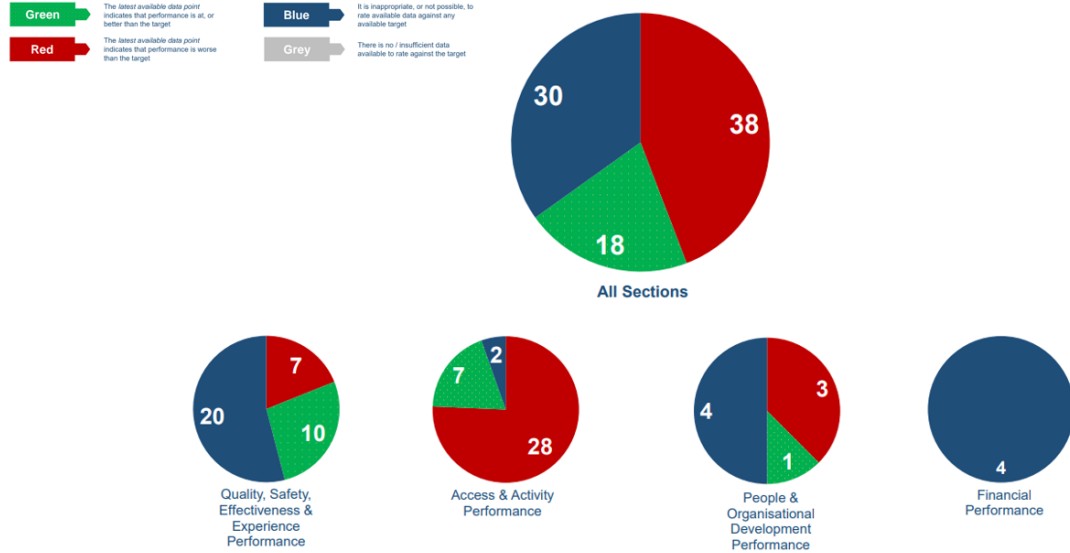
PADR	Performance Appraisal and Development Review
PFIG	Performance, Finance, and Information Governance Committee
QSE	Quality, Safety, and Experience Committee
SB	Swansea Bay University Health Board
SM	Special Measures
WAST	Welsh Ambulance Services NHS Trust
WG	Welsh Government
YTD	year to date



# INTERGRATED QUALITY & PERFORMANCE REPORT

## 1. Y SEFYLLFA SITUATION

### 1.1



1.2 Of the measures from the NHS Wales Performance Framework included in the report, 10 are on target, 7 are off target. This is an improvement from January's report. Whilst the organisation has significantly improved within the Patients Safety, Experience and Quality spaces, it remains clear that there continues to be significant risks to delivery on a number of key metrics within the wider organisation, specifically within Urgent and Emergency Care (details included within the 'Performance at a Glance' page of the report and shown below. Full details can be seen in the IQPR for Performance, Finance and Information Governance Committee (PFIG).

### 1.3

Escalated Performance Measures at a Glance		KEY: ▲ = Better ▼ = Worse than previous reporting period
<b>Quality</b> CRR 24-04 Failure to Embed Learning ▲ There are no measures under the remit of the Quality, Safety and Experience Committee requiring escalated attention or focus in this reporting period.	<b>Access &amp; Activity</b> CRR 24-10 Urgent and Emergency Care, CRR 24-11 Planned Care, CRR 24-12 Areas of Clinical Concern, CRR 24-13 Timely Diagnostics ▲ CAMHS Part 1b Assessments within 28 Days of Referral: <b>54.0%</b> (Target 80%) (ⓐ) ▼ Neurodevelopment Assessment within 26 weeks: <b>11.0%</b> (Target 95%) ▲ Adult Psychological Assessment within 26 weeks: <b>71.6%</b> (Target 95%) (ⓐ) ▼ Ambulance Handover Delays over 45 minutes: <b>2,465</b> (Target 0) MP ▼ Emergency Department waits over 12 Hours: <b>3,826</b> (Target 0) ▼ Emergency Department Waits over 24 Hours: <b>2,134</b> (Target 0) ▼ Emergency Department Waits over 48 Hours: <b>837</b> (Target 0) ▼ Number of patients left without being seen: <b>1,456</b> (Target 0) ▼ Number of patients with Delayed Pathways of Care: <b>322</b> (Target 0) ▼ Percentage compliance 62 Day Single Cancer Pathway: <b>51.2%</b> (Target 75%) (ⓐ) ▲ Referral to Treatment waiting over 52 weeks 1 <sup>st</sup> Appointment: <b>7,014</b> ▲ Referral to Treatment waiting over 104 weeks: <b>3,584</b> MP ▲ Referral to Treatment waiting over 156 weeks: <b>56</b> (Target 0) ▼ Number of patients waiting over 8 weeks for Diagnostics: <b>21,800</b> (Target 0) ▼ Number of patients Over 100% due their clinical follow up: <b>119,302</b> (Target 0) ▼ Number of patients waiting over 14 weeks for therapies: <b>1,518</b> (Target 0) * Internal improvement trajectory for January 2026 is 12% MP = Ministerial Priority	
<b>Finance</b> CRR 24-05 Financial Sustainability <b>Financial Position – January 2026</b> ▼ Year to date – Deficit versus Plan <b>-£17.3m</b> ▲ In-month Variance to plan <b>£0.0m</b> (sustained balance of £0.0m) ▼ Full year outturn position as re-forecast in January <b>-£17.4m</b> (noting significant risks to delivery) <b>Savings Position</b> ▲ In month Savings Delivery including Accountancy Gains v target <b>£6.2m</b> (£2.9m more than the £3.3m target) ▲ Forecast Savings Delivery including Accountancy Gains v Target <b>£42.3m</b> (£8.9m above the target). <b>Capital Expenditure</b> Year to Date Plan is £33.2m. Spent £30.2m Underspend <b>£3.0m</b> .	<b>People &amp; Organisational Development</b> ▼ Personal Appraisal & Development Review (PADR): <b>79.3%</b> (Target 85%) ▲ Sickness & Absence: <b>6.4%</b> (Target Reduce) ▲ Agency Spend: <b>2.5%</b> (Target Reduce)	

- 1.4** The Health Board continues to face significant challenges in attainment of the performance targeted within the national and local plans and escalation continues in these areas as a consequence. However, it is of note that in a number of areas performance continues to improve (based on historic delivery and in year comparison) and in some instances attains national targeted levels.
- 1.5** Throughout 2025-26, plans are being implemented to support delivery priorities to substantially improve elective wait times, outpatients (new & follow up) cancer and 8-week diagnostic performance.
- 1.6** Members are invited to review the detail contained within the performance report to assess areas of key challenge and improvement opportunity, debating delivery on a balanced scorecard.

## **2 Y CEFNDIR BACKGROUND**

- 2.1** The Performance Directorate now reports through to the Executive Director of Finance's portfolio, with development of the Integrated Quality and Performance Report (IQPR) a key objective to ensure the needs of Operational forums, Executive, Committees and the Health Board are met. The development of the report will build on the launch of the Foundations for the Future model for services, which is essential to ensure clarity on roles, responsibilities and accountability.
- 2.2** Statistical Process Control Charts (SPC) will be the main vehicle to report performance (historical, current and future trends) ensuring movements in performance are understood. In January 2026, Welsh Government have indicated the use of 'Making Data Count' methodology within all formal reports which has already been adopted by BCUHB and will be strengthened further in coming months. It is essential the users of the reports can ascertain the impact of key actions expected for future performance, and importantly how this compares to that contained within our Integrated Medium-Term Plans (IMTP) and national expectations.
- 2.3** Initial meetings with the Executive, Senior Leadership and the teams have occurred, with further debate to occur with Health Board colleagues to shape the future report model, the anticipation being this would be supported by;
- 2.3.1** Hierarchical reporting (the information tailored for the audience)
  - 2.3.2** Review of metrics used for assessment, ensuring relevance
  - 2.3.3** Engagement with Operational and Clinical teams, to ensure actions planned to improve performance are quantifiable and thus can be used to forecast delivery

- 
- 2.3.4** A refreshed 'Performance and Accountability Framework' that will enable areas and directorates that require additional support to be identified and escalated
- 2.4** The implementation of 'Foundations for the Future' in providing clarity on roles and responsibilities will support identification of lines of accountability, it is important that the accountability framework recognises high performing areas and differentiates with those requiring support to deliver improvement. Reporting future performance requiring Operational & Clinical colleagues to determine action to be taken and expected impact.
- 2.5** Whilst these developments are progressed, the report will continue to be presented within the current format, each section will endeavour to enhance reporting with inclusion of;
- 2.5.1** A one-page high level summary of matters to be highlighted to members.
  - 2.5.2** Then a page per quadrant, supporting a more focused view of the performance.
  - 2.5.3** Finally, each performance metric is then articulated within the report to provide the detail should officers seek to understand more in regards to a particular metric.

### **3 MATERION PENODOL I'W HYSTRYIED SPECIFIC MATTERS FOR CONSIDERATION**

- 3.1** It remains clear that there continues to be significant risks to delivery on a number of key metrics described within this report. In particular within the Urgent and Emergency Care space.
- 3.2** The Health Board continues to face significant challenges in attainment of the performance targeted within the national and local plans and escalation continues in these areas as a consequence. However, it is of note that in a number of areas performance continues to improve, with members invited to review the detail contained within the summary and full performance report to assess areas of key challenge and improvement opportunity.

### **4 RISGIAU ALLWEDDOL / MATERION I'W HUWCHGYFEIRIO KEY RISKS / MATTERS FOR ESCALATION**

**4.1**






**4.2**

### **5 ARGYMHELLION**

## RECOMMENDATIONS

- 5.1** Gofynnir i'r Pwyllgor/Cyfarfod/Grŵp:  
The Committee/Meeting/Group is asked to:

Review and comment upon the information presented.

ASESIAD / ASSESSMENT	
<b>Cyswllt â'r Blaenoriaethau Strategol</b> <b>Link to Strategic Priorities</b>	     4. Improving quality, outcomes and experience
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
<b>Yr Egwyddorion Dylunio</b> <b>Design Principles</b>	<b>Equity and Accessibility</b> Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
<b>Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd</b> <b>Corporate Risks and Board Assurance Framework</b>	CRR 25-08 Non-Compliance with Regulatory and Legislative Requirements

ASESIADAU O EFFAITH / IMPACT ASSESSMENTS		
<b>Cydraddoldeb</b> <i>A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o'r Effaith ar Gydraddoldeb (sy'n cynnwys gofynion Safonau'r Gymraeg)</i> <b>Equality</b> <i>Have you undertaken an Equality Impact Assessment Screening (which includes the requirements of the Welsh Language Standards)</i>	Do/Yes: <input type="checkbox"/>	Naddo/No: <input checked="" type="checkbox"/>
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
<b>Asesiad o'r Effaith Economaidd-gymdeithasol</b> <i>A ydych chi wedi cynnal Asesiad o'r Effaith Economaidd-Gymdeithasol?</i> <b>Socio-Economic Impact Assessment</b> <i>Have you undertaken a Socio-Economic Impact Assessment</i>	Do/Yes: <input type="checkbox"/>	Naddo/No: <input checked="" type="checkbox"/>
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
<b><u>Answdd</u></b> <i>A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Answdd?</i>	<b>Galluogwyr Answdd Enablers of Quality</b> All Apply	<b>Meysydd Answdd Domains of Quality</b> All Apply

<p><b>Quality</b> <i>Have you undertaken a Quality Impact Assessment Screening?</i></p>	<p>Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:</p>	<p>Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:</p>
<p><b>Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant Wellbeing of Future Generations Act – Wellbeing Goals</b></p>	<p><b>A Healthier Wales</b></p>	

<p><b>Effaith Amgylcheddol / Cynaliadwyedd (5Rs) Environmental /Sustainability Impact (5Rs)</b></p>	<p>Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:</p>	
	<p>No - Not Applicable</p>	
<p><b>Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog A ydych chi wedi ystyried Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog: Armed Forces Covenant Due Regard Duty</b> Have you considered the Armed Forces Covenant Due Regard Duty?</p>	<p>Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:</p>	
	<p>Do/Yes: <input type="checkbox"/></p>	<p>Naddo/No: <input checked="" type="checkbox"/></p>
	<p>Canlyniad/Outcome:</p>	
<p><b>Asesiad o Effaith ar Ddiogelu Data</b> <i>A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?</i> <b>Data Protection Impact Assessment</b> <i>Have you undertaken a Data Protection Impact Assessment Screening?</i></p>	<p>Os naddo, dylech gynnwys y rheswm: If no, please include rationale:</p>	
	<p>Do/Yes: <input type="checkbox"/></p>	<p>Naddo/No: <input checked="" type="checkbox"/></p>
	<p>Canlyniad/Outcome:</p>	
	<p>Os naddo, dylech gynnwys y rheswm: If no, please include rationale:</p>	



<b>Asesiad o Effaith ar Atal Twyll</b> <i>A ydych chi wedi ystyried yr effeithiau ar atal twyll?</i> <b>Counter Fraud Impact Assessment</b> <i>Have you considered the counter fraud impacts</i>	Do/Yes: <input type="checkbox"/>	Naddo/No: <input checked="" type="checkbox"/>
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
<b>Cyfreithiol</b> <b>Legal</b>	Yes (Include further detail below)	
<b>Enw Da</b> <b>Reputational</b>	Yes (Include further detail below)	
<b>Effaith ar Adnoddau</b> <i>(Pobl / Ariannol)</i> <b>Resource Impact</b> <i>(People / Financial)</i>	There is no direct impact on resources as a result of the activity outlined in this report.	

Thursday, 5<sup>th</sup> March 2026

# Integrated Quality & Performance Report

## Quality, Safety and Experience

### Committee



GIG  
CYMRU  
NHS  
WALES

Bwrdd Iechyd Prifysgol  
Betsi Cadwaladr  
University Health Board

# Table of Contents

Title	Page
Cover	1
Table of Contents	2
Performance at a Glance	3
Integrated Quality & Performance Report	7
Summary Pie Charts	8
Section 1: Quality, Safety, Effectiveness & Experience Performance	9
Additional Information (about the Integrated Performance Framework)	23
Further Information and Social Media links	31

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



# Escalated Performance Measures at a Glance

KEY: ■ = Better ■ = Worse than previous reporting period

## Quality

CRR 24-04 Failure to Embed Learning

■ There are no measures under the remit of the Quality, Safety and Experience Committee requiring escalated attention or focus in this reporting period.

## Finance

CRR 24-05 Financial Sustainability

### Financial Position – January 2026

- Year to date – Deficit versus Plan **-£17.3m**
- In-month Variance to plan **£0.0m** (sustained balance of £0.0m)
- Full year outturn position as re-forecast in January **-£17.4m** (noting significant risks to delivery)

### Savings Position

- In month Savings Delivery including Accountancy Gains v target **£6.2m** (£2.9m more than the £3.3m target)
- Forecast Savings Delivery including Accountancy Gains v Target **£42.3m** (£8.9m above the target).

### Capital Expenditure

Year to Date Plan is £33.2m. Spent £30.2m Underspend **£3.0m**.

## Access & Activity

CRR 24-10 Urgent and Emergency Care; CRR 24-11 Planned Care;  
CRR 24-12 Areas of Clinical Concern; CRR 24-13 Timely Diagnostics

- CAMHS Part 1b Assessments within 28 Days of Referral: **54.0%** (Target 80%) IA
- Neurodevelopment Assessment within 26 weeks: **11.0%** (\*Target 95%)
- Adult Psychological Assessment within 26 weeks: **71.6%** (Target 95%) IA
- **Ambulance Handover Delays over 45 minutes: 2,465** (Target 0) **MP**
- Emergency Department waits over 12 Hours: **3,826** (Target 0)
- Emergency Department Waits over 24 Hours: **2,134** (Target 0)
- Emergency Department Waits over 48 Hours: **837** (Target 0)
- Number of patients left without being seen: **1,456** (Target 0)
- Number of patients with Delayed Pathways of Care: **322** (Target 0)
- Percentage compliance 62 Day Single Cancer Pathway: **51.2%** (Target 75%) IA
- Referral to Treatment waiting over 52 weeks 1<sup>st</sup> Appointment: **7,014**
- Referral to Treatment waiting over 104 weeks: **3,584 MP**
- Referral to Treatment waiting over 156 weeks: **56** (Target 0)
- Number of patients waiting over 8 weeks for Diagnostics: **21,800** (Target 0)
- Number of patients Over 100% due their clinical follow up: **119,302** (Target 0)
- Number of patients waiting over 14 weeks for therapies: **1,518** (Target 0)

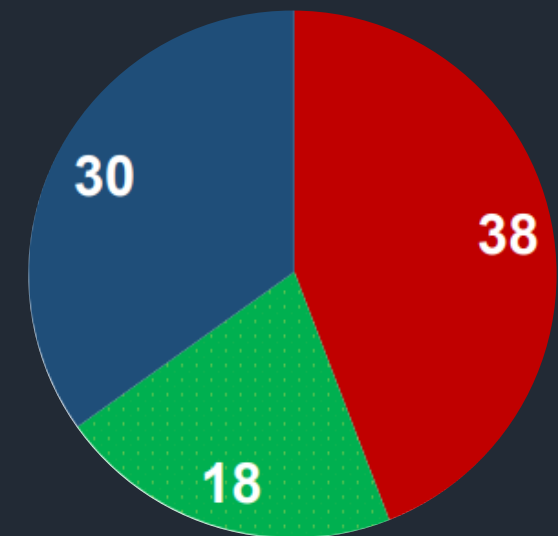
\* Internal improvement trajectory for January 2026 is 12% **MP = Ministerial Priority**

## People & Organisational Development

- Personal Appraisal & Development Review (PADR): **79.3%** (Target 85%)
- Sickness & Absence: **6.4%** (Target Reduce)
- Agency Spend: **2.5%** (Target Reduce)



# Integrated Quality & Performance Report



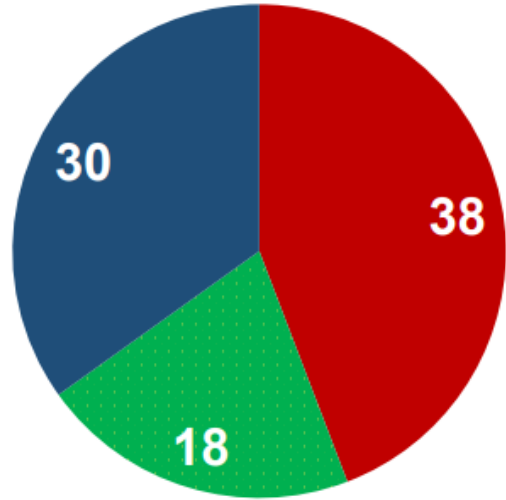
# Summary of Performance to Month 9 (December 2025)

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

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

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

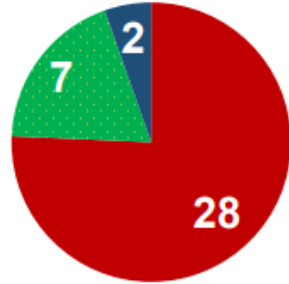
**Grey** → There is no / insufficient data available to rate against the target



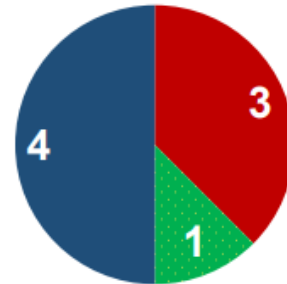
All Sections



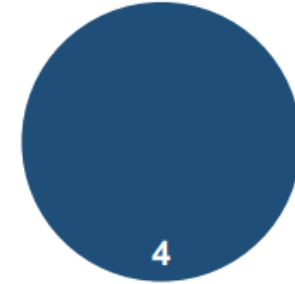
Quality, Safety, Effectiveness & Experience Performance



Access & Activity Performance



People & Organisational Development Performance

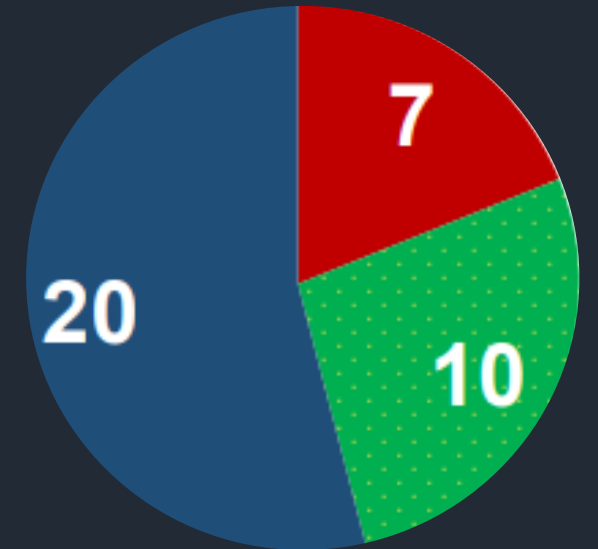


Financial Performance



# Section 1

# Quality, Safety, Effectiveness and Experience Performance



# Prevention and Vaccinations

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	QSE	Percentage of adult smokers who make a quit attempt via smoking cessation services	5% annual	TBC	4.18%	2nd of 7 (at Dec 24)
-	QSE	Percentage of adult smokers who made a quit attempt via smoking cessation services who are CO-validated as quit at 4 weeks	40% annual target	TBC	24.8%	3rd of 8 (at Dec 24)
-	QSE	Percentage of children receiving the Human Papillomavirus (HPV) vaccination by the age of 15	90%	TBC	72.3%	5th of 7 (at Mar 25)

Quarter	Percentage
Q4 24/25	7.03%
Q1 25/26	2.26%
Q2 25/26	4.18%
Q3 25/26	-

Quarter	Percentage
Q4 24/25	19.7%
Q1 25/26	24.8%
Q2 25/26	24.8%
Q3 25/26	-

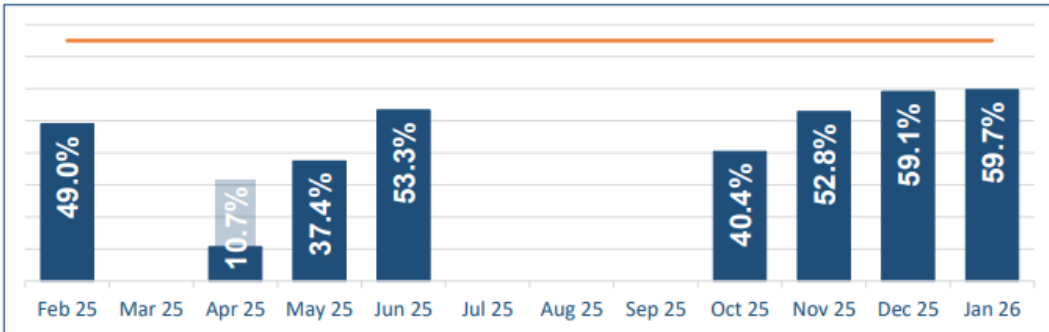
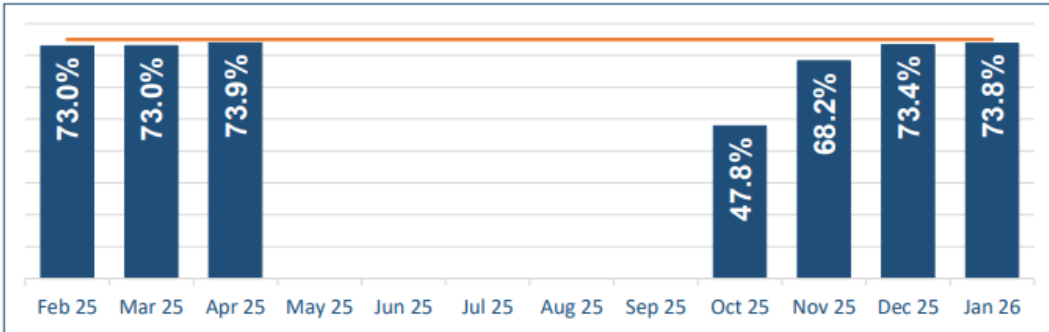
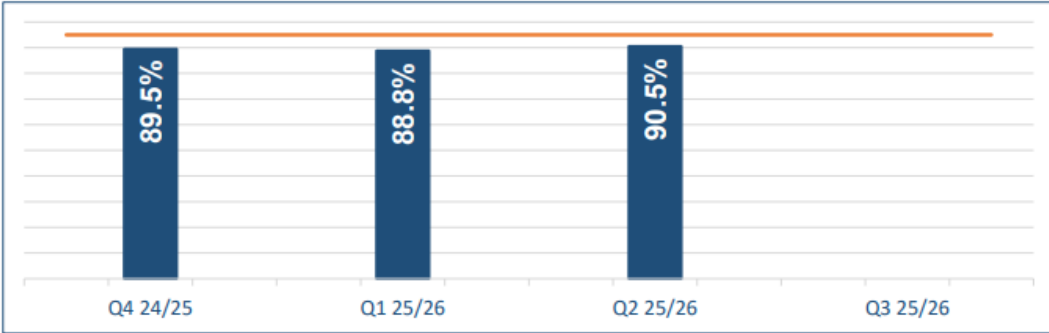
  

Quarter	Percentage
Q4 24/25	70.8%
Q1 25/26	71.7%
Q2 25/26	72.3%
Q3 25/26	-



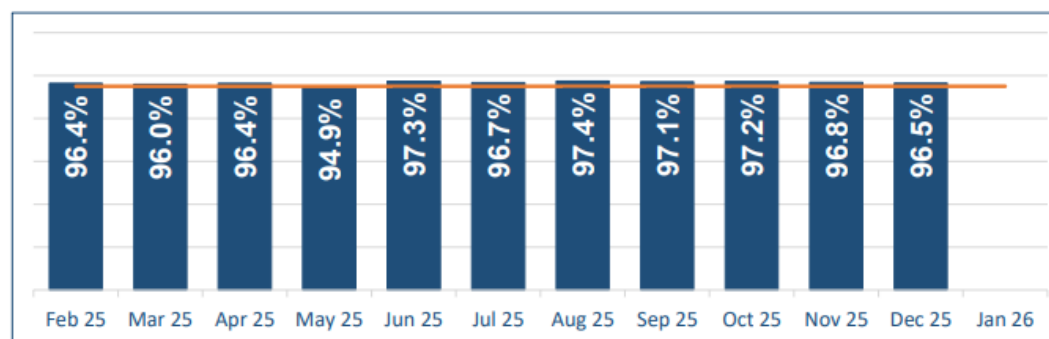
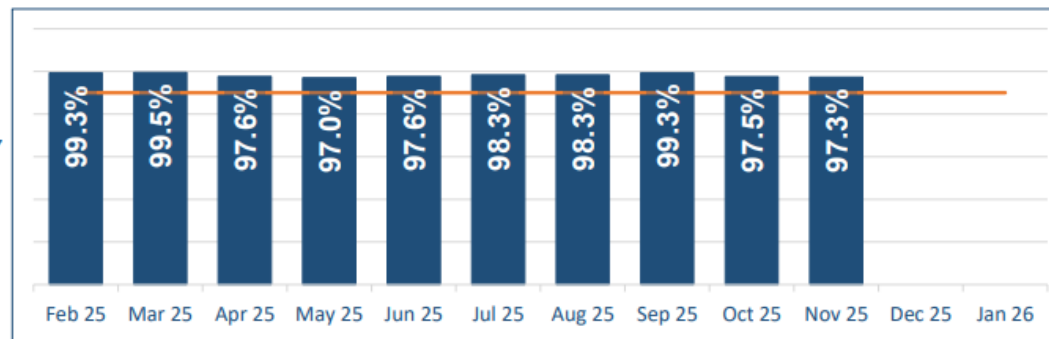
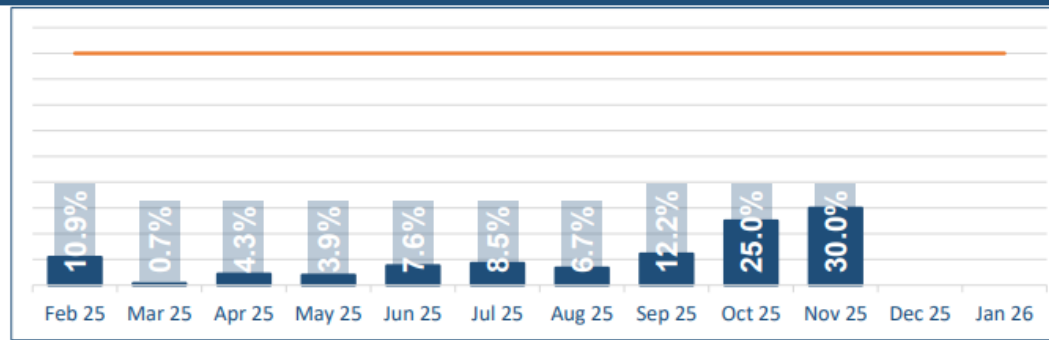
# Prevention and Vaccinations

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	QSE	Percentage of children who are up to date with the scheduled vaccinations by age 5 ('4 in 1' preschool booster, the Hib/MenC booster and the second MMR dose)	95%	TBC	90.5%	3rd of 7 (at Mar 25)
-	QSE	Percentage uptake of the influenza vaccination amongst adults aged 65 years and over	75%	TBC	73.8%	1st of 7 (at Mar 25)
-	QSE	Percentage uptake of the COVID-19 vaccination for those eligible Spring and Autumn Booster: All eligible people	75%	TBC	59.7%	5th of 7 (at Apr 25)



# Prevention and Screening

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	QSE	Percentage of patients offered an index colonoscopy procedure within 4 weeks of booking their Specialist Screening Practitioner assessment appointment	90%	TBC	30.0%	6th of 7 (at Mar 25)
-	QSE	Percentage of well babies entering the new-born hearing screening programme who complete screening within 4 weeks	90%	TBC	97.3%	2nd of 7 (at Mar 25)
-	QSE	Percentage of eligible newborn babies who have a conclusive bloodspot screening result by day 17 of life	95%	TBC	96.5%	5th of 7 (at Apr 25)



# Prevention

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	QSE	Percentage of people who have been referred to health board services who have completed treatment for substance misuse (drugs or alcohol)	4 qtr imp. trend	TBC	100.0%	5th of 7 (at Mar 25)
-	QSE	Percentage of patients (aged 12 years and over) with diabetes who received all eight NICE recommended care processes	Equivalent month increase (2025/26 to 2024/25) to 100%	TBC	41.6%	7th of 7 (at Apr 25)

Month	Percentage
Feb 25	92.9%
Mar 25	84.0%
Apr 25	96.8%
May 25	96.7%
Jun 25	95.2%
Jul 25	97.1%
Aug 25	97.6%
Sep 25	95.9%
Oct 25	92.9%
Nov 25	90.1%
Dec 25	100.0%
Jan 26	-

Month	Percentage
Feb 25	38.9%
Mar 25	40.5%
Apr 25	40.7%
May 25	40.3%
Jun 25	40.2%
Jul 25	41.0%
Aug 25	41.3%
Sep 25	41.4%
Oct 25	41.5%
Nov 25	41.9%
Dec 25	41.9%
Jan 26	41.6%



# Patient Access and Experience

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	PFIG	Number of consultations delivered through the Pharmacist Independent Prescribing Service (PIPS)	Equivalent month increase (2025/26 to 2024/25)	TBC	4196	1st of 7 (at Apr 25)
-	QSE	Number of service user feedback experience responses completed and recorded on CIVICA	Increasing trend	TBC	5449	2nd of 10 (at Apr 25)

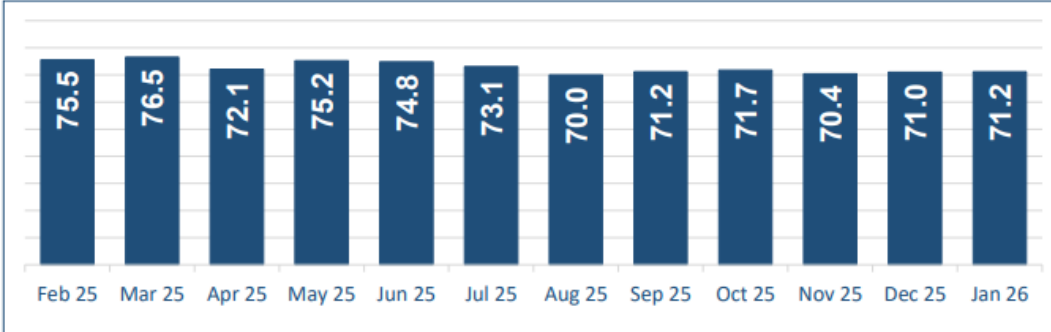
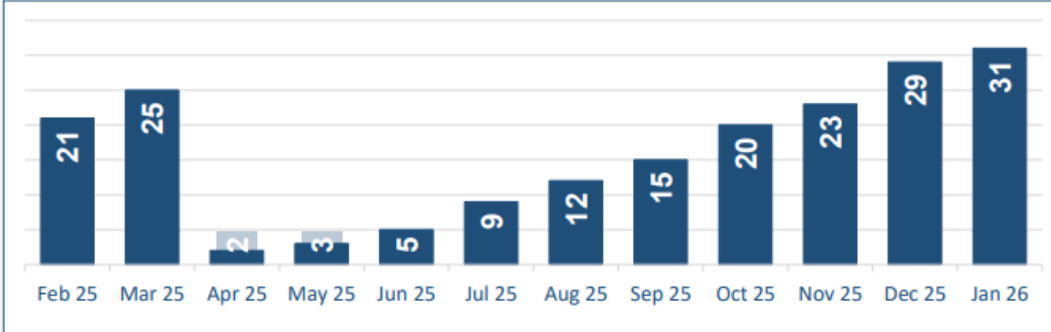
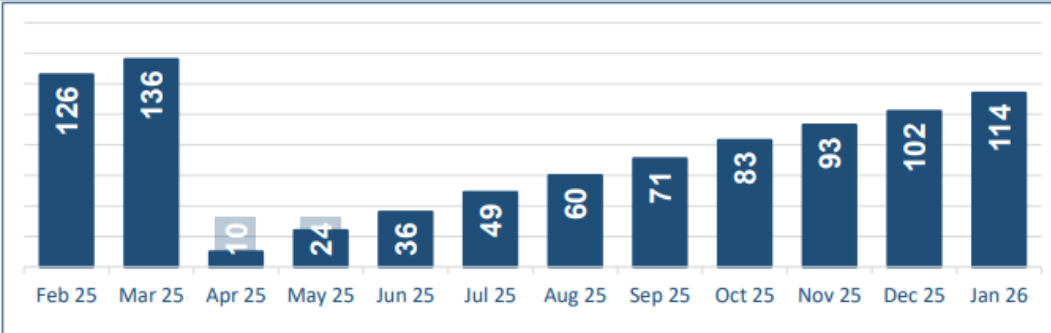
Month	Count
Feb 25	3033
Mar 25	3046
Apr 25	2925
May 25	2676
Jun 25	2514
Jul 25	3142
Aug 25	2904
Sep 25	2778
Oct 25	3089
Nov 25	3228
Dec 25	4196

Month	Count
Feb 25	5978
Mar 25	5680
Apr 25	5600
May 25	6275
Jun 25	6619
Jul 25	6701
Aug 25	4954
Sep 25	6203
Oct 25	7088
Nov 25	6510
Dec 25	5449



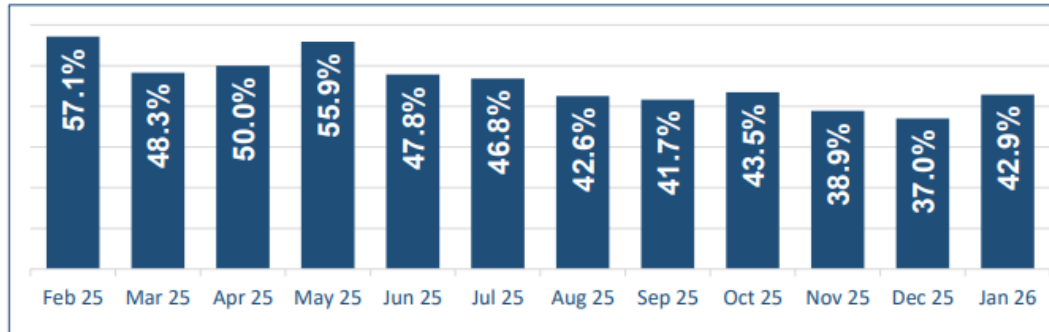
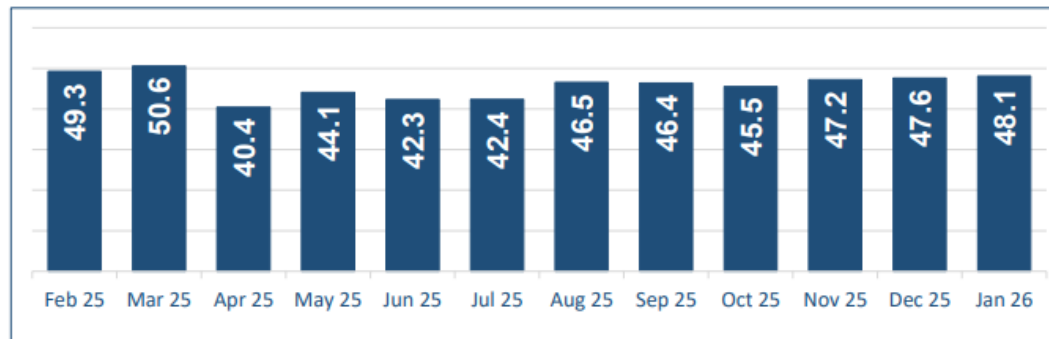
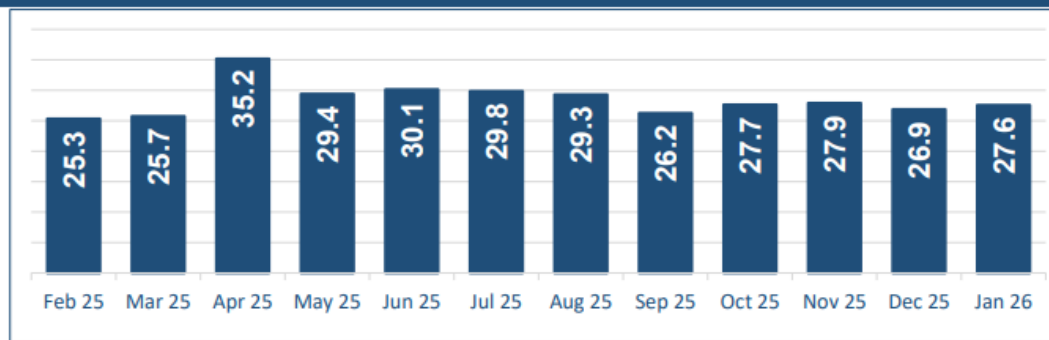
# Infection Prevention and Control 1

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
CRR: 24-04	QSE	The cumulative number of laboratory confirmed Klebsiella in reporting month	TBC	TBC	114	4th of 6 (at Apr 25)
CRR: 24-04	QSE	The cumulative number of laboratory confirmed Pseudomonas Aeruginosa in reporting month	27	TBC	31	3rd of 6 (at Apr 25)
CRR: 24-04	QSE	The cumulative rate of laboratory confirmed E.coli bacteraemias cases per 100,000 population	67	TBC	71.2	4th of 6 (at Apr 25)



# Infection Prevention and Control 2

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
CRR: 24-04	QSE	The cumulative rate of laboratory confirmed S. Aureus Bacteraemia (MRSA and MSSA) cases per 100,000 of the population	20	TBC	27.6	6th of 6 (at Apr 25)
CRR: 24-04	QSE	The cumulative rate of laboratory confirmed C.difficile cases per 100,000 of the population	25	TBC	48.1	3rd of 6 (at Apr 25)
-	QSE	Percentage of confirmed COVID-19 cases within hospital which had a definite hospital onset of COVID-19 (>14 days after admission)	Equivalent month reduction (2024/25 to 2023/24)	TBC	42.9%	3rd of 6 (at Apr 25)



# Patient Safety 1

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	QSE	Number of National reportable incidents (NRIs)	N/A	TBC	6	
-	QSE	Number of new never events	0	TBC	0	
-	QSE	Number of patient safety incidents	N/A	TBC	2988	

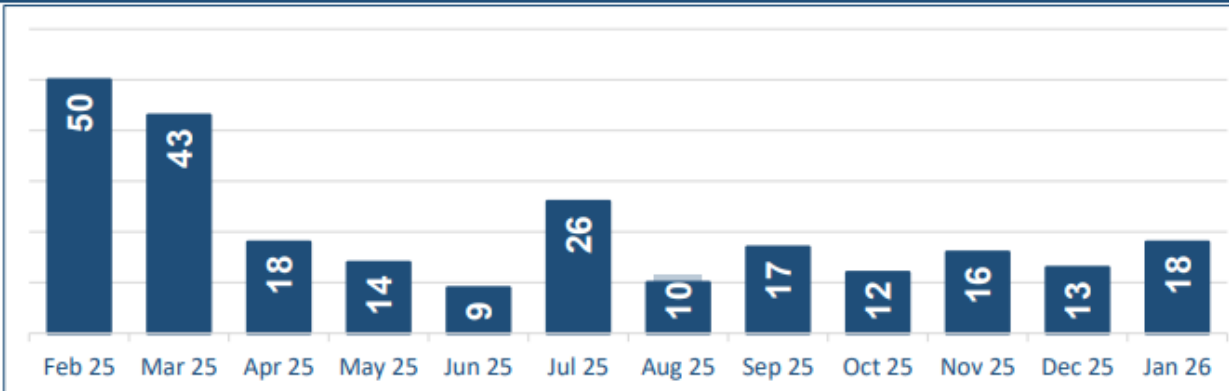
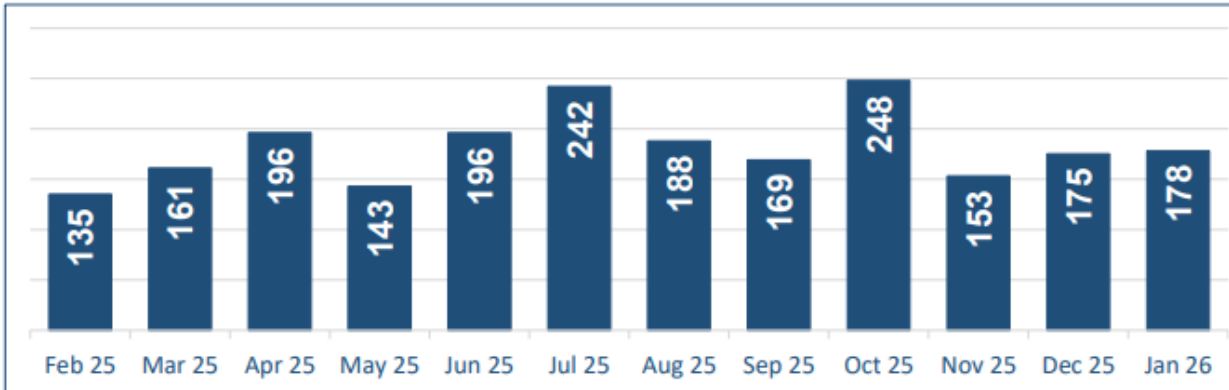


# Patient Safety 2

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank																										
-	QSE	Number of reported falls	N/A	TBC	384	<table border="1"> <caption>Number of reported falls</caption> <thead> <tr><th>Month</th><th>Value</th></tr> </thead> <tbody> <tr><td>Feb 25</td><td>327</td></tr> <tr><td>Mar 25</td><td>332</td></tr> <tr><td>Apr 25</td><td>322</td></tr> <tr><td>May 25</td><td>362</td></tr> <tr><td>Jun 25</td><td>371</td></tr> <tr><td>Jul 25</td><td>364</td></tr> <tr><td>Aug 25</td><td>353</td></tr> <tr><td>Sep 25</td><td>376</td></tr> <tr><td>Oct 25</td><td>369</td></tr> <tr><td>Nov 25</td><td>319</td></tr> <tr><td>Dec 25</td><td>324</td></tr> <tr><td>Jan 26</td><td>384</td></tr> </tbody> </table>	Month	Value	Feb 25	327	Mar 25	332	Apr 25	322	May 25	362	Jun 25	371	Jul 25	364	Aug 25	353	Sep 25	376	Oct 25	369	Nov 25	319	Dec 25	324	Jan 26	384
Month	Value																															
Feb 25	327																															
Mar 25	332																															
Apr 25	322																															
May 25	362																															
Jun 25	371																															
Jul 25	364																															
Aug 25	353																															
Sep 25	376																															
Oct 25	369																															
Nov 25	319																															
Dec 25	324																															
Jan 26	384																															
-	QSE	Number of reported healthcare acquired pressure ulcers (HAPU) (excluding new to caseload)	N/A	TBC	553	<table border="1"> <caption>Number of reported healthcare acquired pressure ulcers (HAPU)</caption> <thead> <tr><th>Month</th><th>Value</th></tr> </thead> <tbody> <tr><td>Feb 25</td><td>498</td></tr> <tr><td>Mar 25</td><td>539</td></tr> <tr><td>Apr 25</td><td>528</td></tr> <tr><td>May 25</td><td>518</td></tr> <tr><td>Jun 25</td><td>466</td></tr> <tr><td>Jul 25</td><td>500</td></tr> <tr><td>Aug 25</td><td>441</td></tr> <tr><td>Sep 25</td><td>468</td></tr> <tr><td>Oct 25</td><td>485</td></tr> <tr><td>Nov 25</td><td>501</td></tr> <tr><td>Dec 25</td><td>522</td></tr> <tr><td>Jan 26</td><td>553</td></tr> </tbody> </table>	Month	Value	Feb 25	498	Mar 25	539	Apr 25	528	May 25	518	Jun 25	466	Jul 25	500	Aug 25	441	Sep 25	468	Oct 25	485	Nov 25	501	Dec 25	522	Jan 26	553
Month	Value																															
Feb 25	498																															
Mar 25	539																															
Apr 25	528																															
May 25	518																															
Jun 25	466																															
Jul 25	500																															
Aug 25	441																															
Sep 25	468																															
Oct 25	485																															
Nov 25	501																															
Dec 25	522																															
Jan 26	553																															
-	QSE	Number of reported medication incidents	N/A	TBC	210	<table border="1"> <caption>Number of reported medication incidents</caption> <thead> <tr><th>Month</th><th>Value</th></tr> </thead> <tbody> <tr><td>Feb 25</td><td>268</td></tr> <tr><td>Mar 25</td><td>291</td></tr> <tr><td>Apr 25</td><td>310</td></tr> <tr><td>May 25</td><td>261</td></tr> <tr><td>Jun 25</td><td>319</td></tr> <tr><td>Jul 25</td><td>265</td></tr> <tr><td>Aug 25</td><td>295</td></tr> <tr><td>Sep 25</td><td>284</td></tr> <tr><td>Oct 25</td><td>286</td></tr> <tr><td>Nov 25</td><td>264</td></tr> <tr><td>Dec 25</td><td>256</td></tr> <tr><td>Jan 26</td><td>210</td></tr> </tbody> </table>	Month	Value	Feb 25	268	Mar 25	291	Apr 25	310	May 25	261	Jun 25	319	Jul 25	265	Aug 25	295	Sep 25	284	Oct 25	286	Nov 25	264	Dec 25	256	Jan 26	210
Month	Value																															
Feb 25	268																															
Mar 25	291																															
Apr 25	310																															
May 25	261																															
Jun 25	319																															
Jul 25	265																															
Aug 25	295																															
Sep 25	284																															
Oct 25	286																															
Nov 25	264																															
Dec 25	256																															
Jan 26	210																															



# Patient Safety 3 and Staff Recognition

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	QSE	Number of overdue 'Learning from Event Reports' (LFERs)	N/A	TBC	18	
-	QSE	Number of Great-ix submissions	N/A	TBC	178	



# Patient Experience

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank																										
-	QSE	Number of 'Putting Things Right' (PTR) complaints	N/A	TBC	273	<table border="1"> <caption>Number of 'Putting Things Right' (PTR) complaints</caption> <thead> <tr><th>Month</th><th>Value</th></tr> </thead> <tbody> <tr><td>Feb 25</td><td>207</td></tr> <tr><td>Mar 25</td><td>206</td></tr> <tr><td>Apr 25</td><td>228</td></tr> <tr><td>May 25</td><td>219</td></tr> <tr><td>Jun 25</td><td>241</td></tr> <tr><td>Jul 25</td><td>231</td></tr> <tr><td>Aug 25</td><td>221</td></tr> <tr><td>Sep 25</td><td>302</td></tr> <tr><td>Oct 25</td><td>279</td></tr> <tr><td>Nov 25</td><td>209</td></tr> <tr><td>Dec 25</td><td>268</td></tr> <tr><td>Jan 26</td><td>273</td></tr> </tbody> </table>	Month	Value	Feb 25	207	Mar 25	206	Apr 25	228	May 25	219	Jun 25	241	Jul 25	231	Aug 25	221	Sep 25	302	Oct 25	279	Nov 25	209	Dec 25	268	Jan 26	273
Month	Value																															
Feb 25	207																															
Mar 25	206																															
Apr 25	228																															
May 25	219																															
Jun 25	241																															
Jul 25	231																															
Aug 25	221																															
Sep 25	302																															
Oct 25	279																															
Nov 25	209																															
Dec 25	268																															
Jan 26	273																															
-	QSE	Of the complaints closed, the percentage that were closed within 30 days	75%	TBC	67.2%	<p>[No Title]</p> <table border="1"> <caption>Percentage of complaints closed within 30 days</caption> <thead> <tr><th>Month</th><th>Value</th></tr> </thead> <tbody> <tr><td>Feb 25</td><td>71.0%</td></tr> <tr><td>Mar 25</td><td>77.7%</td></tr> <tr><td>Apr 25</td><td>77.2%</td></tr> <tr><td>May 25</td><td>74.4%</td></tr> <tr><td>Jun 25</td><td>76.3%</td></tr> <tr><td>Jul 25</td><td>80.1%</td></tr> <tr><td>Aug 25</td><td>78.3%</td></tr> <tr><td>Sep 25</td><td>76.5%</td></tr> <tr><td>Oct 25</td><td>73.5%</td></tr> <tr><td>Nov 25</td><td>74.6%</td></tr> <tr><td>Dec 25</td><td>67.2%</td></tr> <tr><td>Jan 26</td><td>67.2%</td></tr> </tbody> </table>	Month	Value	Feb 25	71.0%	Mar 25	77.7%	Apr 25	77.2%	May 25	74.4%	Jun 25	76.3%	Jul 25	80.1%	Aug 25	78.3%	Sep 25	76.5%	Oct 25	73.5%	Nov 25	74.6%	Dec 25	67.2%	Jan 26	67.2%
Month	Value																															
Feb 25	71.0%																															
Mar 25	77.7%																															
Apr 25	77.2%																															
May 25	74.4%																															
Jun 25	76.3%																															
Jul 25	80.1%																															
Aug 25	78.3%																															
Sep 25	76.5%																															
Oct 25	73.5%																															
Nov 25	74.6%																															
Dec 25	67.2%																															
Jan 26	67.2%																															
-	QSE	Number of complaints closed as early resolutions	N/A	TBC	28	<table border="1"> <caption>Number of complaints closed as early resolutions</caption> <thead> <tr><th>Month</th><th>Value</th></tr> </thead> <tbody> <tr><td>Feb 25</td><td>26</td></tr> <tr><td>Mar 25</td><td>33</td></tr> <tr><td>Apr 25</td><td>29</td></tr> <tr><td>May 25</td><td>39</td></tr> <tr><td>Jun 25</td><td>20</td></tr> <tr><td>Jul 25</td><td>32</td></tr> <tr><td>Aug 25</td><td>19</td></tr> <tr><td>Sep 25</td><td>32</td></tr> <tr><td>Oct 25</td><td>38</td></tr> <tr><td>Nov 25</td><td>35</td></tr> <tr><td>Dec 25</td><td>28</td></tr> <tr><td>Jan 26</td><td>28</td></tr> </tbody> </table>	Month	Value	Feb 25	26	Mar 25	33	Apr 25	29	May 25	39	Jun 25	20	Jul 25	32	Aug 25	19	Sep 25	32	Oct 25	38	Nov 25	35	Dec 25	28	Jan 26	28
Month	Value																															
Feb 25	26																															
Mar 25	33																															
Apr 25	29																															
May 25	39																															
Jun 25	20																															
Jul 25	32																															
Aug 25	19																															
Sep 25	32																															
Oct 25	38																															
Nov 25	35																															
Dec 25	28																															
Jan 26	28																															



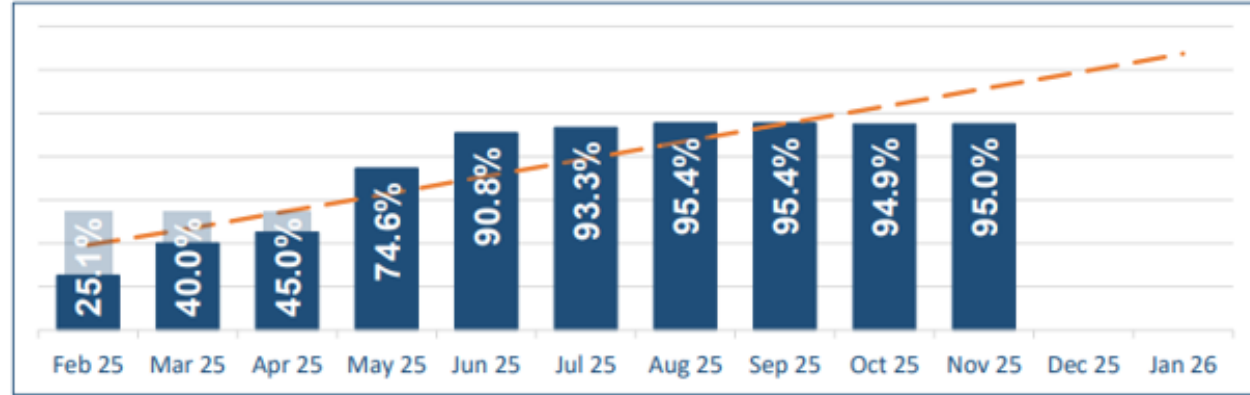
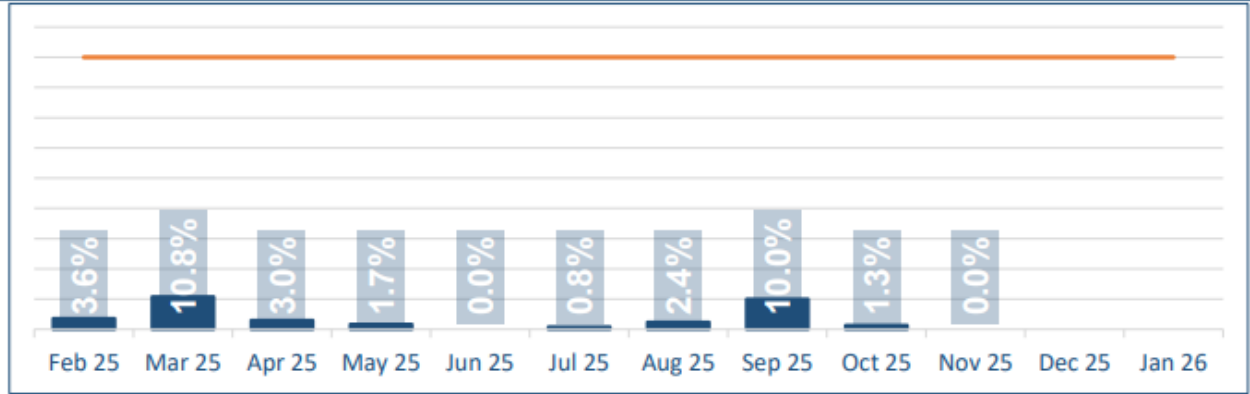
# Patient Experience and Regulation Compliance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank																										
-	QSE	Number of PALS (Patient Advice and Liason Service) contacts	N/A	TBC	611	<table border="1"> <caption>PALS Contacts</caption> <thead> <tr><th>Month</th><th>Contacts</th></tr> </thead> <tbody> <tr><td>Feb 25</td><td>534</td></tr> <tr><td>Mar 25</td><td>668</td></tr> <tr><td>Apr 25</td><td>674</td></tr> <tr><td>May 25</td><td>652</td></tr> <tr><td>Jun 25</td><td>650</td></tr> <tr><td>Jul 25</td><td>796</td></tr> <tr><td>Aug 25</td><td>663</td></tr> <tr><td>Sep 25</td><td>805</td></tr> <tr><td>Oct 25</td><td>949</td></tr> <tr><td>Nov 25</td><td>722</td></tr> <tr><td>Dec 25</td><td>720</td></tr> <tr><td>Jan 26</td><td>611</td></tr> </tbody> </table>	Month	Contacts	Feb 25	534	Mar 25	668	Apr 25	674	May 25	652	Jun 25	650	Jul 25	796	Aug 25	663	Sep 25	805	Oct 25	949	Nov 25	722	Dec 25	720	Jan 26	611
Month	Contacts																															
Feb 25	534																															
Mar 25	668																															
Apr 25	674																															
May 25	652																															
Jun 25	650																															
Jul 25	796																															
Aug 25	663																															
Sep 25	805																															
Oct 25	949																															
Nov 25	722																															
Dec 25	720																															
Jan 26	611																															
-	QSE	Number of new Ombudsman contacts	N/A	TBC	26	<table border="1"> <caption>New Ombudsman Contacts</caption> <thead> <tr><th>Month</th><th>Contacts</th></tr> </thead> <tbody> <tr><td>Feb 25</td><td>31</td></tr> <tr><td>Mar 25</td><td>18</td></tr> <tr><td>Apr 25</td><td>11</td></tr> <tr><td>May 25</td><td>18</td></tr> <tr><td>Jun 25</td><td>18</td></tr> <tr><td>Jul 25</td><td>23</td></tr> <tr><td>Aug 25</td><td>22</td></tr> <tr><td>Sep 25</td><td>17</td></tr> <tr><td>Oct 25</td><td>31</td></tr> <tr><td>Nov 25</td><td>41</td></tr> <tr><td>Dec 25</td><td>28</td></tr> <tr><td>Jan 26</td><td>26</td></tr> </tbody> </table>	Month	Contacts	Feb 25	31	Mar 25	18	Apr 25	11	May 25	18	Jun 25	18	Jul 25	23	Aug 25	22	Sep 25	17	Oct 25	31	Nov 25	41	Dec 25	28	Jan 26	26
Month	Contacts																															
Feb 25	31																															
Mar 25	18																															
Apr 25	11																															
May 25	18																															
Jun 25	18																															
Jul 25	23																															
Aug 25	22																															
Sep 25	17																															
Oct 25	31																															
Nov 25	41																															
Dec 25	28																															
Jan 26	26																															
-	QSE	Number of regulation 28 notices	N/A	TBC	1	<table border="1"> <caption>Regulation 28 Notices</caption> <thead> <tr><th>Month</th><th>Notices</th></tr> </thead> <tbody> <tr><td>Feb 25</td><td>1</td></tr> <tr><td>Mar 25</td><td>1</td></tr> <tr><td>Apr 25</td><td>1</td></tr> <tr><td>May 25</td><td>1</td></tr> <tr><td>Jun 25</td><td>0</td></tr> <tr><td>Jul 25</td><td>0</td></tr> <tr><td>Aug 25</td><td>0</td></tr> <tr><td>Sep 25</td><td>0</td></tr> <tr><td>Oct 25</td><td>1</td></tr> <tr><td>Nov 25</td><td>0</td></tr> <tr><td>Dec 25</td><td>0</td></tr> <tr><td>Jan 26</td><td>1</td></tr> </tbody> </table>	Month	Notices	Feb 25	1	Mar 25	1	Apr 25	1	May 25	1	Jun 25	0	Jul 25	0	Aug 25	0	Sep 25	0	Oct 25	1	Nov 25	0	Dec 25	0	Jan 26	1
Month	Notices																															
Feb 25	1																															
Mar 25	1																															
Apr 25	1																															
May 25	1																															
Jun 25	0																															
Jul 25	0																															
Aug 25	0																															
Sep 25	0																															
Oct 25	1																															
Nov 25	0																															
Dec 25	0																															
Jan 26	1																															



# Clinical Coding Compliance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	QSE	Percentage of all classifications' coding errors corrected by the next monthly reporting submission following identification	90%	TBC	0.0%	8st of 8 (at Mar 25)
-	QSE	Percentage of episodes clinically coded within one reporting month post episode discharge end date	Increasing trend (to 95%)	TBC	95.0%	8st of 8 (at Mar 25)



## Integrated Quality & Performance Report Betsi Cadwaladr University Health Board

Further information is available from the Performance Directorate.  
And further information on our performance can be found online at:



Our website [www.bcu.wales.nhs.uk](http://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](https://twitter.com/bcuhb)



<http://www.facebook.com/bcuhealthboard>



# Abbreviations

Please see below a list of abbreviations commonly found within the report:

A&E	Accident and Emergency	LPMHSS	Local Primary Mental Health Support Services
AB	Aneurin Bevan Health Board	MH&LD	Mental Health and Learning Disabilities
ADHD	Attention Deficit Hyperactivity Disorder	MMR	Measles, Mumps and Rubella
ASD	Autistic Spectrum Disorder	NHS	National Health Service
BCU/BCUHB	Betsi Cadwaladr University Health Board	NR	non-recurrent
C&V	Cardiff and Vale University Health Board	PADR	Performance Appraisal and Development Review
Cmt	committee	PFIG	Performance, Finance, and Information Governance Committee
CRR Ref	Corporate Risk Register Reference	QSE	Quality, Safety, and Experience Committee
CTM	Cwm Taf Morgannwg University Health Board	R	recurrent
ENT	Ear, Nose, and Throat	SB	Swansea Bay University Health Board
GDS	General Dental Services	WAST	Welsh Ambulance Services NHS Trust
GP	General Practitioner	WG	Welsh Government
HDda	Hywel Dda University Health Board	YTD	year to date
HEIW	Health Education and Improvement Wales		
IHC	Integrated Health Community		



## Quality Safety & Experience Committee

### CORPORATE RISK REGISTER

<b>Dyddiad y Cyfarfod</b> <b>Date of Meeting</b>	05 March 2026
<b>Statws Cyhoeddi</b> <b>Publication Status</b>	Open/ Public
	Not Applicable
<b>Enw a theitl Awdur(on) yr Adroddiad</b> <b>Report Author name and title</b>	Jody Evans, Assistant Head of Risk Management.
<b>Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol</b> <b>Lead Executive Team Member name and title</b>	Pam Wenger, Director of Corporate Governance
<b>Pwrpas yr Adroddiad</b> <b>Report Purpose</b>	For Assurance

#### **Crynodeb Gweithredol** **Executive Summary**

The Committee is asked to **receive assurance** of the two updated Corporate Risks and will fall under the remit and oversight of the Quality, Safety and Experience Committee (see appendix 3):

- CRR25-01 'Timely Patient Access to Safe and Effective Care '
- CRR25-08 'Non-Compliance with Regulatory and Legislative Requirements'

No proposed changes in risk scoring. Both risks have a current risk score which sits outside the risk tolerance level set within the risk appetite.

#### **Action Progress**

A total of 25 actions have been developed across the two corporate risks.

- 8 actions are complete
- 17 actions are progressing

A number of additional actions across several risks fall due in March 2026, and these require ongoing monitoring to ensure that timescales remain realistic and achievable.

### Risk Scrutiny and Governance

All corporate risks have been reviewed and updated by Executive Leads. The following risks have undergone recent deep dive review at the Risk Scrutiny Group (RSG):

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

### The Committee is asked to:

- Note progress and receive assurance

**Ymgysylltu (mewnol/allanol) yr ymgwymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp)**  
**Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)**

Pwyllgor / Grŵp / Unigolion Committee / Group / Individuals	Dyddiad Date	Canlyniad, Tystiolaeth a Data Outcome, Evidence and Data
Head of Risk Management	16/01/2026	The Head of Risk Management conducted an assessment on all corporate risks, this has been presented to RSG and the risk leads. The risk action plans are both due to be updated and should be outcome focused and measurable (including metrics where possible), with draft examples sent for both.

### Acronymau / Rhestr Termau Acronyms / Glossary of Terms

CRR	Corporate Risk Register
RSG	Risk Scrutiny Group
BAF	Board Assurance Framework

## Corporate Risk Register



---

## 1. Y SEFYLLFA SITUATION

The purpose of this report is to provide an update to the Committee on the most significant risks to which the committee has overall accountability and oversight of.

Two consolidated Corporate Risks will fall under the remit and oversight of the Quality, Safety and Experience Committee (see appendix 3):

- CRR25-01 'Timely Patient Access to Safe and Effective Care'
- CRR25-08 'Non-Compliance with Regulatory and Legislative Requirements'

## 2. Y CEFNDIR BACKGROUND

Both risks have recently undergone deep-dive review at the December (CRR25-01) and January 2026 (CRR25-08) Risk Scrutiny Group, with further scrutiny scheduled at the March and April 2026 Executive Team Meetings.

Both risks remain above the Health Board's risk tolerance, reflecting the scale of challenges associated with the services. Continued monitoring of associated actions will be required to ensure progress is maintained.

## 3. MATERION PENODOL I'W HYSTYRIED SPECIFIC MATTERS FOR CONSIDERATION

### **Overdue/Delayed Actions**

None

### **Risks above Health Board 25/26 appetite**

All two risks reported to committee score outside the tolerance range set in the appetite

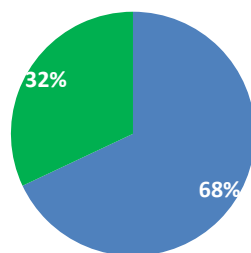
Risk Ref	Risks	Lead Exec Director	Current Risk Score	Risk Tolerance Range in Appetite Score
CRR25-01	Timely Patient Access to Safe and Effective Care	Chief Operating Officer	20	Quality <15
CRR25-08	Non-Compliance with Regulatory and Legislative Requirements	Director of Corporate Governance	16	Regulatory <15

In relation to CRR25-08; the Director of Corporate Governance is reviewing this risk to reflect the risk and controls in place, the risk was considered at the Risk Scrutiny Group and it was agreed to re-frame as there has been some progress in mapping and reporting non-audit bodies through the compliance report.

### Action Plan status of Corporate Risks

#### ACTION STATUS OF CORPORATE RISKS

■ Progressing ■ Completed



Out of the 2 corporate risks, 25 actions have been developed to mitigate the risks, with 17 open actions progressing and on track. 8 actions have been completed

#### 4. RISGIAU ALLWEDDOL / MATERION I'W HUWCHGYFEIRIO KEY RISKS / MATTERS FOR ESCALATION






All risks have been reviewed and updated by the relevant service, with no proposed changes in risk scoring. Both risks have a current risk score which sits outside the risk tolerance level set within the risk appetite.

#### 5. ARGYMHELLION RECOMMENDATIONS

Gofynnir i'r Pwyllgor:

The Committee is asked to:

- **Note** the update on the two strategic risks **CRR25-01** and **CRR25-08** and remaining above the Health Board's risk tolerance.
- **Endorse** both risks for submission to the Board, noting no proposed scoring changes.

ASESIAD / ASSESSMENT	
<b>Cyswllt â'r Blaenoriaethau Strategol</b> <b>Link to Strategic Priorities</b>	     4. Improving quality, outcomes and experience
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
<b>Yr Egwyddorion Dylunio</b> <b>Design Principles</b>	<b>People First</b> Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
<b>Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd</b> <b>Corporate Risks and Board Assurance Framework</b>	Corporate Risks linked to Board Assurance Framework risks: BAF24-06: Not Delivering the Required Improvements to Transform Care and Enhance Outcomes BAF24-07: Not Delivering Timely Access to Care Resulting In Potential Clinical Harm, Poor Delivery of Performance Targets and Reputational Risk
<a href="#">Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant Wellbeing of Future Generations Act – Wellbeing Goals</a>	Not Applicable
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:

ASESIADAU O EFFAITH / IMPACT ASSESSMENTS		
<b>Cydraddoldeb</b> <i>A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o'r Effaith ar Gydraddoldeb (sy'n cynnwys gofynion Safonau'r Gymraeg)</i> <b>Equality</b> <i>Have you undertaken an Equality Impact Assessment Screening (which includes the requirements of the Welsh Language Standards)</i>	Do/Yes: <input type="checkbox"/>	Naddo/No: <input checked="" type="checkbox"/>
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
	Do/Yes: <input type="checkbox"/>	Naddo/No: <input checked="" type="checkbox"/>

<b>Asesiad o'r Effaith Economaidd-gymdeithasol</b> <i>A ydych chi wedi cynnal Asesiad o'r Effaith Economaidd-Gymdeithasol?</i> <b>Socio-Economic Impact Assessment</b> <i>Have you undertaken a Socio-Economic Impact Assessment</i>	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
<b><u>Ansawdd</u></b> <i>A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?</i> <b><u>Quality</u></b> <i>Have you undertaken a Quality Impact Assessment Screening?</i>	<b>Galluogwyr Ansawdd Enablers of Quality</b> All Apply	<b>Meysydd Ansawdd Domains of Quality</b> All Apply
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
<b><u>Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant Wellbeing of Future Generations Act – Wellbeing Goals</u></b>	Not Applicable	

<b>Effaith Amgylcheddol / Cynaliadwyedd (5Rs)</b> <b>Environmental /Sustainability Impact (5Rs)</b>	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
	No - Not Applicable	
<b>Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog</b> <i>A ydych chi wedi ystyried Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog:</i> <b>Armed Forces Covenant Due Regard Duty</b>	Do/Yes: <input type="checkbox"/>	Naddo/No: <input checked="" type="checkbox"/>
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	

Have you considered the Armed Forces Covenant Due Regard Duty?		
<b>Asesiad o Effaith ar Ddiogelu Data</b> <i>A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?</i> <b>Data Protection Impact Assessment</b> <i>Have you undertaken a Data Protection Impact Assessment Screening?</i>	Do/Yes: <input type="checkbox"/>	Naddo/No: <input checked="" type="checkbox"/>
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
<b>Asesiad o Effaith ar Atal Twyll</b> <i>A ydych chi wedi ystyried yr effeithiau ar atal twyll?</i> <b>Counter Fraud Impact Assessment</b> <i>Have you considered the counter fraud impacts</i>	Do/Yes: <input type="checkbox"/>	Naddo/No: <input checked="" type="checkbox"/>
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
<b>Cyfreithiol Legal</b>	There are no specific legal implications related to the activity outlined in this report.	
<b>Enw Da Reputational</b>	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
<b>Effaith ar Adnoddau</b> <i>(Pobl / Ariannol)</i> <b>Resource Impact</b> <i>(People / Financial)</i>	There is no direct impact on resources as a result of the activity outlined in this report.	

## Appendix 1 - Corporate Risk Register Dashboard – Quality, Safety and Experience Committee (QSE) – January 2026

Lead	Ref	Risk Title	Current Score (Impact x Likelihood)	Risk Target Score	Appetite Main Risk Type Appetite Level	Lead Board Committee	Action Progression			Risk Management Commentary
							Total	Completed	Delayed or Overdue	
COO	CRR25-01	Timely Patient Access to Safe and Effective Care	5x4	12	Quality (<15)	Quality, Safety and Experience Committee	11	4	0	Four actions now completed
			20	Above Tolerance	Action plan to be reviewed following feedback.					
DCG	CRR25-08	Non-Compliance with Regulatory and Legislative Requirements	4x4	8	Regulatory (<15)	Quality, Safety and Experience Committee	14	4	0	Following the closure of BAF risk BAF24-01, the remaining 4 open actions transferred onto this risk for continued monitoring. Action plan to be reviewed following feedback.
			16	Above Tolerance	Risk remains elevated due to fragmentation of compliance ownership and variable operational assurance					

### Key:

Executive	
Chief Operating Officer	COO
Director of Corporate Governance	DCG



# Corporate Risks Quality Safety and Experience Committee



### Appendix 3 - Corporate Risk Register QSE Committee – January 2026

CRR 25-01	<b>Risk Title: Timely Patient Access to Safe and Effective Care</b>		<b>Date Opened:</b> 21/08/2025 <i>(version 2 refined from 2023)</i>
	<b>Assuring Committee:</b> Quality, Safety and Experience Committee		<b>Date Last Committee Review:</b> 06/11/2025
<b>Date Last Reviewed:</b> 21/01/2025	<b>Director Lead:</b> Chief Operating Officer	<b>Link to BAF:</b> BAF24-07	<b>Target Risk Date:</b> 30/06/2027
<p>There is a risk that patients may not receive timely access to the care they need, which could lead to deterioration in health, poor patient experience, and poorer outcome.</p> <p>This may be caused by lack of oversight of waiting lists, harm occurring on waiting lists, insufficient communication with clinicians, poor patient experience, and difficulties recruiting to specialist posts.</p> <p>This may lead to extended waiting lists, patient harm due to delays, and reputational or regulatory consequences.</p>			
Mitigations/Controls in place		Additional Controls required	
<ol style="list-style-type: none"> <li>1. <a href="#">System Resilience Hub in place with hospital escalation protocols, daily and weekend plans, and winter/festive plans. Daily Hub + rapid review + weekly executive oversight panels</a></li> <li>2. <a href="#">6 week rapid improvement plan with clinical and operational executive oversight</a></li> <li>3. <a href="#">Quality, professional and operational standards</a></li> <li>4. Major change programmes for Urgent and Emergency Care (UEC) and planned care aligned to the Six Goals for UEC framework and national objectives (such as timely access to</li> </ol>		<ol style="list-style-type: none"> <li>a. Fragility of UEC (Urgent Emergency Care) and specialist workforce posts, reliance on locums' temporary posts.</li> <li>b. Fragility of social care provision causing delayed discharge and stranded patients</li> <li>c. Need for demand and capacity modelling and specialty-level trajectories</li> <li>d. Inadequate Neurodevelopment capacity to manage waiting list</li> <li>e. Outdated diagnostic IT systems causing inefficiencies in reporting and turnaround times with diagnostics.</li> </ol>	



<p>care and building community capacity). Governance structure completed, all workstreams now all aligned.</p> <ol style="list-style-type: none"> <li>5. Winter Resilience Plan complete evaluation and lessons learnt.</li> <li>6. Revised Access policy to ensure standardised practice across the Health Board</li> <li>7. Single Integrated Clinical Assessment Triage (SICAT) and GP Out of Hours (OOHs) joint model providing 24/7 triage and advice</li> <li>8. Same Day Emergency Care (SDEC) services established at all acute sites</li> <li>9. Routine clinical prioritisation of patients by risk in line with Referral to Treatment guidance</li> <li>10. Outsourcing of radiology reporting and insourcing of CT, MRI, ultrasound</li> <li>11. Diagnostic Quality Management System accreditation system embedded</li> <li>12. Welsh Government short-term Neurodevelopment funding to support longest waiters, agency staff, overtime</li> </ol>	<ol style="list-style-type: none"> <li>f. Variation in acute medicine, SDEC (Same Day Emergency Care), frailty pathways across sites, No standardised model yet</li> <li>g. Consistent application of "Our Next Patient Please" flow model.</li> <li>h. Health Board improvement goal for Colostrum Difficile Infection (CDI) reductions in 2025/2026 to reduce the number of cases within the Health Board.</li> </ol>		
Actions	Action Owner	Due Date	Progression Analysis
<p>b) Implement reset fortnight 8-22 December focusing on improving number and timeliness of discharges, delivering 45-minute ambulance handover, and improve ED performance</p> <p>Second winter Sprint 22 January – 4 February, supported by 3 diagnostics to target ongoing actions</p>	<p>Chief Operating Officer</p>	<p>08/12/2025</p>	<p>Complete</p>



<p>b) Complete demand and capacity analysis across Planned Care to inform forward activity planning</p> <p>As part of the planned care programme and major change programme. The Transformation improvement team have provided an allocation of project management and pathway re-design support to the planned care programme to be used flexibly across its delivery.</p>	<p>Programme Director, Planned Care</p>	<p>31/03/2026</p>	<p>Progressing</p>
<p>e) Update Failure to act on Diagnostics Procedure to be presented at divisional meeting for discussion on the 10/10/2025</p> <p>This action is delayed due to service focus on 8-week backlog reduction and supporting OPD programme. Proposed revise due date to Q1 2026-27</p>	<p>Associate Director, North Wales Managed Clinical Services</p>	<p>30/06/2026</p>	<p>Progressing (revised date from 20/10/2025)</p>
<p>b) Deliver December "Discharge Fortnight" - Intensive cross-sector focus to maximise discharge, unblock flow, reduce LOS, and significantly improve bed availability.</p>	<p>Chief Operating Officer</p>	<p>31/01/2026</p>	<p>Complete</p>
<p>Issue Quality Standards (Clinical Execs) and Operational Standards (COO)</p> <p>Define practice expectations to standardise risk, quality, and operational performance.</p> <p>Issued and integrated into daily actions</p>	<p>Chief Operating Officer</p>	<p>31/01/2026</p>	<p>Complete</p>



g) Patient flow improvements: Implement “Our Next Patient Please” Move patients to wards ahead of predicted discharges; reduce ED congestion. Develop draft Single Point of Access for alternative pathways & Primary Care redirection. Reduce unnecessary ED attendance; strengthen community pathways.  SOP finalised	Chief Operating Officer	31/01/2026	Progressing
e Implementation of Health Board improvement goal for CDI (Colostrum Difficile Infection) reductions in 2025/2026	Deputy Director Of Nursing Infection Prevention and Decontamination	31/03/2026	Progressing
Planned care harms reviews on impact on patient safety and experience	Programme Director, Planned Care	TBC	Progressing
Review opportunities to redesign and reconfigure ED quadrant linked to capital programme development.	Chief Operating Officer	30/06/2026	Progressing
Winter plan developed with partners throughout Dec 2025	Chief Operating Officer	15/01/2026	Complete
Review opportunities to redesign and reconfigure ED quadrant linked to capital programme development	Chief Operating Officer	30/06/2026	Progressing



<p>21/08/2025. 28/08/2025. 25/09/2025. 28/11/2025. 21/01/2026.</p> <p>— Inherent — Current — Target</p>				
		<b>Impact</b>	<b>Likelihood</b>	<b>Score</b>
	<b>Inherent Risk Rating</b>	5	5	25
	<b>Current Risk Rating</b>	5	4	20
	<b>Target Risk Score</b>	4	3	12
<b>Risk Appetite</b>	Quality <15		Not in Tolerance	
<b>Position &amp; Intended Outcome for Risk</b>				
<p>The number of Prevention of Future Death (PFD) / Regulation 28 Notices issued to BCUHB were: 23 in 2023-24; 7 in 2024-25; 3 in 2025-26 to date. In 2023 the Health Board was an outlier and 9 cases directly related to the impact of delays in the health and social</p>				

care system on the timeliness of responses by the HB and Welsh Ambulance Service and ongoing work is required to resolve the underlining delays to treatment. The goal being to be in line with WG targets.

Intended Outcome:

By 2027, patients consistently receive timely, effective, and safe care, evidenced by:

- Reduction in long-wait patients (>104 weeks) and breaches of national access standards.
- Fewer harm events linked to delayed care.
- Improved quality metrics including length of stay, readmission rates, and patient-reported outcome measures (PROMs).
- Reduction in regulatory and legal cases associated with delayed access.
- A demonstrable shift in focus from access process metrics to sustained improvement in patient safety, experience, and outcomes.

CRR 25-08	<b>Risk Title: Non-Compliance with Regulatory and Legislative Requirements</b>		<b>Date Opened: 21/08/2025</b> <i>(version 2 refined from 2023)</i>
	<b>Assuring Committee:</b> Quality, Safety and Experience Committee		<b>Date Last Committee Review:</b> 06/11/2025
<b>Date Last Reviewed:</b> 18/12/2025	<b>Director Lead:</b> Director of Corporate Governance	<b>Link to BAF:</b> BAF24-01	<b>Target Risk Date:</b> 30/06/2027
<p>There is a risk that the organisation may fail to comply with regulatory and legislative requirements, which could directly or indirectly impact the safety, quality, and accessibility of patient care.</p> <p>This may be caused by inefficiencies in managing regulatory complexities, insufficient policy management, managing changes in legislation at pace, insufficient operational assurance across estates, health and safety, and medical devices, and failure to deliver climate/net zero requirements.</p> <p>This may lead to enforcement action, financial penalties, and loss of public and stakeholder confidence.</p>			
<b>Mitigations/Controls in place</b>		<b>Additional Controls required</b>	

<ol style="list-style-type: none"> <li>1. Training, induction and mandatory requirements for staff for highlights legislation and compliance.</li> <li>2. Monitoring of regulations and legislation by various groups exist such as:             <ul style="list-style-type: none"> <li>– Medical Devices Governance &amp; Assurance Group oversees procurement, selection, risk management and safety communication</li> <li>– Estates and Health &amp; Safety Committee oversee areas of non-compliance and tracking of action plans.</li> <li>– Pharmacy Technical Services and monitoring of compliance in relation to Controlled Drugs. Regulatory Assurance Group for some clinical regulations. (Oversight and gap analysis of all groups required and reflected in the action plan/gaps in controls)</li> </ul> </li> <li>3. Various External peer review programmes e.g. Finance, Counter Fraud, Pharmacy, Imaging and Pathology reporting areas of non-compliance with legislation.</li> <li>4. Regulatory compliance around Health Inspectorate Wales and Care Inspectorate Wales reported to QSE, and to Audit Committee (via the Statutory Compliance Report)</li> </ol>	<ol style="list-style-type: none"> <li>a) Improved escalation routes, governance, oversight and monitoring of non-compliance. Governance and regulatory Executive Delivery Group (EDG) group to be in place to ensure HB wide oversight of all regulatory activity and inspections (not just clinical) and tracking non-compliance with a clear route for escalation of non-compliance to the EDG and route of escalation.</li> <li>b) Creation of an electronic system to capture all legislative and regulatory requirements, to capture information in relation to accountability and responsibility for the different elements, to enable the sharing of information, monitoring of progress and production of monitoring reports as necessary</li> <li>c) The Quality Management system is yet to be fully embedded and will highlight external peer reviews which cite any areas of non-compliance for better oversight by the EDG.</li> <li>d) Lack of consistent medical device training and local governance</li> <li>e) Inadequate workforce capacity in Pharmacy aseptic units; &gt;80% capacity utilisation</li> <li>f) Quality assurance and regulatory compliance gaps in Pharmacy services</li> <li>g) Net zero / climate compliance delivery plan not embedded (consolidated)</li> <li>h) Core Emergency Preparedness policies, templates, and guidance documents</li> </ol>
---	--



	are still under review, such as the Business Continuity Operational Response Framework.			
<b>Actions</b>	<b>Action Owner</b>	<b>Due Date</b>	<b>Progression Analysis</b>	
<p>A) Governance and regulatory EDG to be set up to oversee non-compliance (strategic actions from this to be added here going forward)</p> <p>The Executive Committee has agreed the formation of a governance and regulatory group, and work to make the necessary arrangements will continue during February 2026 once TOR (Terms of Reference) and membership approved.</p>	Head of Statutory Compliance and Inquiries	31/03/2026	Progressing (revised date from 01/12/2025)	
<p>B) Creation of an electronic system to capture legislative and regulatory information and requirements.</p> <p>On Track: procurement of system underway. System design will take place Jan-Feb, contract awarded and then can be piloted Aug 2026 before being rolled out in Nov 2026.</p>	Head of Statutory Compliance and Inquiries	01/11/2026	Progressing	
<p>D) Complete audit of medical devices readiness of services. Post-market surveillance audit completed August; three services who make or modify devices need support to ensure compliance. Meetings scheduled with those services, Head of Clinical Engineering and ADAHPS in September / October to facilitate next steps. The audit was circulated widely across the Health Board, prioritising services/pathways most likely to make or modify devices. As there may be other services who fit these criteria, the engagement team have supported ongoing</p>	Assistant Director Of Ahps And Health Science, Therapies & Health Science	31/03/2026	Complete	



<p>communication into the organisation for awareness. National benchmark audit completed June 2025. Benchmark summary received August 2025. Head of Clinical Engineering working with services to progress improvements. The National audit remains live so we can update as required.</p> <p>Audit completed by end Q2 2025, with report submitted to Executive Committee Q3 2025.</p>			
<p>A) Review local medical devices groups governance &amp; membership. A proposal was written re these groups being reformed in April 2025. EDAHPHS (Executive Director of Allied Health Professions &amp; Health Science) and COO (Chief Operating Officer) in discussion re way forward.</p> <p>Action on track</p>	<p>Assistant Director Of Ahps And Health Science, Therapies &amp; Health Science</p>	<p>16/03/2026</p>	<p>Progressing</p>
<p>E)In order for compliance in pharmacy (aseptic production, QA and regulatory staff) Workforce Expansion is required.</p> <p>Regarding outstanding posts to be recruited to. YMW band 3 to 4 uplifts, still progressing, one post to be appointed to in Jan 2026, due to another member of the team resigning (they were eligible for the band 4) the 2<sup>nd</sup> post will need to be</p>	<p>Chief Pharmacist, Corporate Office</p>	<p>31/01/2026</p>	<p>Progressing (revised date from 30/11/2025)</p>



<p>advertised again as a staff development role. YG will appoint to the band 3 position in Jan 2025. YGC band 7 post – no change in position from November 2025 update. All other posts recruited to.</p>			
<p>A) Prevent Fraud legislation. Compliance task and finish group to be set up with risk leads appointed to ensure compliance across the HB. Areas of non-compliance or not progressing in a timely manner to be monitored by Finance and EDG.</p> <p>Service currently working at 50% capacity currently due to long term sickness within the team. Some progress made in that risks have been identified and reviewed by Counter Fraud but no risk owner allocated in order for the first task finish meeting to take place.</p>	<p>Head of Local Counter Fraud, Finance</p>	<p>31/03/2026</p>	<p>Progressing (revised date from 31/12/2025)</p>
<p>Review and update business continuity plans for Pharmacy Technical Services. The Cancer Division have set up a working group to develop and implement a demand and capacity SACT Dashboard, multi-disciplinary group meeting monthly.</p> <p>Pharmacy Technical Services business continuity/contingency plans have been reviewed and updated and includes actions to be taken in the event of service failure whether that be a planned or unplanned event.</p>	<p>Chief Pharmacist, Corporate Office</p>	<p>31/12/2025</p>	<p>Complete</p>
<p>h) A number of Business Continuity Plans (BCP) have been identified as in place however scoping is required to identify all outstanding BCPs (possibility of over 100 BCP, however scoping is required to determine). Continue support is required for the IHCs/ Womens and MH/LD to obtain denominators for accurate reporting,</p>	<p>Deputy Head of Emergency Preparedness</p>	<p>31/03/2026</p>	<p>Complete</p>



<p>monitoring and compliance rates. The scoping exercise to identify all required BCPs will be completed by March 2026.</p> <p>We have now received a denominator number from IHC Centre (46). We are now working with individual services offering supporting workshops to review/amend and create BCPs, this is across all 6 areas. 3 IHCs, Womens, MH/LD and Corporate.</p> <p>Complete</p>	Resilience & Response		
<p>h) Business Continuity dashboard has been established, a RAG system has been introduced and a % compliance indicator, to be a control once uptake and communicated out. <a href="#">BCP Dashboard in place and reporting monthly by email to leads and CCAG group members.</a></p> <p>Complete</p>	Deputy Head of Emergency Preparedness Resilience & Response	31/12/2025	Complete
<p>Ensure the Wholesale Distribution Authorisation (WDA(H) is upheld to enable the lawful procurement, storage, and supply of medicinal products to organisations outside the Health Board's legal entity</p>	MSO/ Lead Governance Pharmacist - Policies	31/03/2026	Progressing



<p>The Wholesale Distribution Authorisation (WDA(H)) remains compliant and upheld following the MHRA inspection in November 2025. The inspection has been formally closed with a low site risk rating and a 3–5 year inspection cycle. The MHRA-approved action plan is largely complete, with the Quality Management System strengthened through monthly QMS meetings, formal governance arrangements and standardised agendas. Remaining actions are progressing and are primarily dependent on external factors or sequencing (including an SLA with Mountain Rescue, delivery of calibrated data loggers to enable temperature mapping, and completion of governance training), with revised timescales extending into early 2026 where appropriate. Overall, regulatory assurance is strong and outstanding actions are focused on resilience and embedding good practice rather than addressing compliance concerns.</p>			
<p>New approach for Health and Safety Management System being developed aligned to NHS Employers Health and Safety Standards, to include Violence Prevention and Reduction Standards. In-house security service model not being pursued. 22/01/2025: Extension of current Security SLA and Technical specification awaiting sign off.</p>	Head of Health, Safety and Security	31/03/2026	Progressing (revised date from 31/12/2025)
<p>Review Integrated Performance Framework and finalise the redesign of reporting structures/timings to enhance transparency. Due to be updated ahead of March 2026 Board</p>	Director Of Performance	31/03/2026	Progressing
<p>Reviewing current systems to have a more effective way of tracking and reporting audit recommendations. Corporate Governance (policies/tracking) /Risk Management and System to be approved for procurement 22/12/25, new software in place by 30/04/25 but piloted end of 2026 which will support automated tracking. This will not be embedded until 2026-2027</p>	Head of Statutory Compliance and Inquiries	30/09/2026	Progressing



<p>Executive Team recruitment ongoing with some progress made on appointments. Director of People and OD in progress with interim arrangements in place</p>	<p>Interim Executive Director of People Services and Organisational Development</p>	<p>31/03/2026</p>	<p>Progressing</p>																								
<table border="1"> <caption>Risk Score Data</caption> <thead> <tr> <th>Date</th> <th>Inherent</th> <th>Current</th> <th>Target</th> </tr> </thead> <tbody> <tr> <td>21/08/2025</td> <td>20</td> <td>16</td> <td>8</td> </tr> <tr> <td>25/08/2025</td> <td>20</td> <td>16</td> <td>8</td> </tr> <tr> <td>01/10/2025</td> <td>20</td> <td>16</td> <td>8</td> </tr> <tr> <td>01/12/2025</td> <td>20</td> <td>16</td> <td>8</td> </tr> <tr> <td>18/12/2025</td> <td>20</td> <td>16</td> <td>8</td> </tr> </tbody> </table>	Date	Inherent	Current	Target	21/08/2025	20	16	8	25/08/2025	20	16	8	01/10/2025	20	16	8	01/12/2025	20	16	8	18/12/2025	20	16	8	<p>Impact</p>	<p>Likelihood</p>	<p>Score</p>
Date	Inherent	Current	Target																								
21/08/2025	20	16	8																								
25/08/2025	20	16	8																								
01/10/2025	20	16	8																								
01/12/2025	20	16	8																								
18/12/2025	20	16	8																								
<p>Inherent Risk Rating</p>	<p>4</p>	<p>5</p>	<p>20</p>																								
<p>Current Risk Rating</p>	<p>4</p>	<p>4</p>	<p>16</p>																								
<p>Target Risk Score</p>	<p>4</p>	<p>2</p>	<p>8</p>																								
<p>Risk Appetite</p>	<p>Regulatory/Compliance &lt;15</p>		<p>Not in Tolerance</p>																								
<p><b>Position &amp; Intended Outcome for Risk</b></p>																											

---

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

## Quality Safety & Experience Committee

### CHALLENGED SERVICES UPDATE

<b>Date of Meeting</b>	05 March 2026
<b>Publication Status</b>	Open/ Public
	Not Applicable
<b>Report Author(s) name and title</b>	Geraint Parry, Interim Assistant Director Transformation & Improvement Julie Ward-Jones, Head of Improvement
<b>Lead Executive Team Member name and title</b>	Paolo Tardivel, Executive Director of Transformation & Strategic Planning (Interim) Tehmeena Ajmal, Chief Operating Officer Clara Day, Executive Medical Director
<b>Report Purpose</b>	For Noting

#### Executive Summary

##### Purpose of the paper

This paper provides an update on the eight Welsh Government identified challenged services under enhanced monitoring and provides assurance to the Committee on progress, remaining risks, and the effectiveness of actions underway to improve safety, quality and sustainability across these specialties. Eight specialties—Vascular, Ophthalmology, Plastics, Oncology, Dermatology, Urology, Orthodontics and Orthopaedics—continue to experience significant operational pressures driven by rising demand, workforce shortages, estate limitations and inconsistent pathway models. Despite this, all services have demonstrated measurable progress, with improvements most evident in waiting times, leadership strengthening and diagnostic/treatment capacity growth.

##### Key findings / highlights

- **Waiting time improvements** achieved across several services, including reductions in long waits in Vascular, Dermatology, Ophthalmology, and Orthodontics.

- **Workforce strengthening**, particularly in Oncology where five new consultants have been appointed, and a leadership post established in Urology.
- **Better demand and capacity management**, supported by expanded insourcing/outsourcing (e.g., cataracts, diagnostics, orthodontic first appointments).
- **Enhanced data quality and digital developments**, including progress with Electronic Patient Record systems (e.g. OpenEyes) and utilisation of My Medical Record.
- **Estates developments** such as the activation of Connah’s Quay Health Centre supporting Dermatology and Plastics, improving local access and throughput.

**Committee recommendation / ask**

The Committee is asked to **note** the progress made across all eight challenged services, **receive assurance** that risks are being appropriately managed, and **endorse** the continued delivery of the improvement plans aligned to the IMTP and Clinical Services Plan.

**Engagement (internal/external) undertaken to date (including receipt/ consideration at Committee/Group)**

Committee / Group / Individuals	Date	Outcome, Evidence and Data

**Acronyms / Glossary of Terms**

WG	Welsh Government
IMTP	Integrated Medium Term Plan
CSP	Clinical Services Plan
MDT	Multidisciplinary Team
CLTI	Chronic Limb-Threatening Ischaemia
AAA	Abdominal Aortic Aneurysm
SAS	Specialty Associate Specialist and Specialist
SOP	Standard Operating Procedures
MDT	multidisciplinary team
POAC	pre-operative assessment clinic
HVLC	high volume low complexity
WGOS	Welsh General Ophthalmic Services
HCQ	Hydroxychloroquine
IVT	intravitreal therapy



GIG  
CYMRU  
NHS  
WALES

Bwrdd Iechyd Prifysgol  
Betsi Cadwaladr  
University Health Board

---

EPR	Electronic Patient Record
JCC	NHS Wales Joint Commissioning Committee



Urology – Challenged Service Update		Common improvement areas	Key issue for this speciality	RAG
<b>Executive Summary</b> Urology services in North Wales are under pressure due to increasing demand, staffing challenges and limited facilities, but important progress is being made. Work is underway to increase diagnostic capacity, improve cancer pathways, strengthen clinical leadership and plan long-term service improvements. These changes aim to reduce waiting times, improve patient experience and ensure more reliable, sustainable care for the future.		Service Model & Configuration	Yes	Yellow
		Workforce	Yes	Yellow
		Quality/Standards/Practice	Yes	Green
		Patient Safety/Experience	Yes	Green
		Infrastructure – estates & digital	Yes	Yellow
Issue	Progress	Impact (actual and potential)		
1. Unsustainable use of locum consultants due to recruitment and retention issues related to unattractive on-call rota and lack of robotic surgery provision	<ul style="list-style-type: none"> <li>Data collection to be completed at the end of February 2026 to inform out of hours demand followed by urgent analysis of findings</li> <li>Options appraisal for new model to be reconsidered, informed by findings of the review</li> </ul>	Better understanding of workload enabling smarter rota design		
2. Lack of recruited clinical leadership pan BCU and vacancy within West IHC	<ul style="list-style-type: none"> <li>Clinical leadership has strengthened, with clinical leads in place across all the IHCs</li> </ul>	Improved oversight, governance an alignment of urology pathways region wide.		
3. No contracted vasectomy provision in primary care	<ul style="list-style-type: none"> <li>Full tender programme for commissioned Vasectomy service agreed with procurement, with tender to be issued by mid-March 2026</li> </ul>	Potential to increase capacity and improve local access for patients.		
4. Performance – waiting time delays in urgent suspected cancer, first	<ul style="list-style-type: none"> <li>Diagnostic capacity has increased through insourced Local Anaesthetic Trans perineal Biopsy (LATP) with pathway redesign for prostate cancer</li> </ul>	Reduction of LATP waits to 15 days expected by year- end		



Issue	Progress	Impact (actual and potential)
appointments and diagnostics caused by rising demand, inefficiencies and inconsistent and out dated practices	<p>progressing, including LAMP coding, improved reporting, and development of non-medical biopsy workforce.</p> <ul style="list-style-type: none"><li>• Flexible cystoscopy insourcing support approved to the end of March 2026:<ul style="list-style-type: none"><li>○ 104 + week waits ( un-booked patients ) reduced from 1272 (March 2025) to 385 (February 2026)</li><li>○ 52 + week waits for first appointment (un-booked patients) reduced from 1855 (March 2025) to 119 (February 2026)</li></ul></li></ul>	(national optimum pathway is 7 days) with further work to reduce waits supported through the Prostate Cancer Pathway redesign group
5. Poor patient experience due to significant travel to existing outsourcing providers	<ul style="list-style-type: none"><li>• Access to radical prostate cancer treatment is improving through commissioning work with Wirral partners and University College London Hospitals (UCLH). Start date to commission 30 prostatectomies from UCLH to Wirral to be agreed following March 2026 discussion (delayed by Wirral due to operational challenges within the trust).</li></ul>	Reduction in travel burdens and enabling timelier treatment. Treatment nearer to home
6. Lack of interventional radiology out of hours and inequity of service provision across North Wales due to differing provision across IHCs	<ul style="list-style-type: none"><li>• The Diagnostic Management Team is developing a paper for Executives outlining out-of-hours interventional radiology requirements for urology and proposed next steps.</li></ul>	Current mitigation through escalation via silver and gold on call
7. Lack of estates to increase capacity	<ul style="list-style-type: none"><li>• Future service resilience is being prepared for through a business case for a Urology Investigation Unit; to be considered for 2026/27.</li><li>• My Medical Record (My MR) embedded with support for digital integration with national team and Digital Health &amp; Care Wales (DHCW)</li></ul>	3947 patients now remotely tracked for PSA via MyMR.



Ophthalmology– Challenged Service Update		Common improvement areas	Key issue for this speciality	RAG
<b>Executive Summary</b> Ophthalmology remains a service with significant challenges; these include long waits, workforce and leadership gaps, ageing infrastructure and data-quality issues. Recent progress in Teach & Treat capacity (allowing optometrists to improve skills while providing faster patient care), cataract efficiency and data improvement is beginning to strengthen demand management; however, sustained focus is still required to stabilise the workforce, strengthen leadership and deliver estates and digital upgrades to ensure a safe, consistent and sustainable service across the Health Board.		Service Model & Configuration	Yes	Green
		Workforce	Yes	Green
		Quality/Standards/Practice	Yes	Green
		Patient Safety/Experience	Yes	Yellow
		Infrastructure – estates & digital	Yes	Yellow
Issue	Progress	Impact (actual & potential)		
1. Delayed access to patient care resulting in patient harm and/or poor patient experience	<ul style="list-style-type: none"> <li>Delivered reductions in patient wait times through Glaucoma Teach &amp; Treat expansion: Four graduates now seeing patients resulting in a reduction of 700 long-waiting patients.</li> <li>Outsourcing/insourcing of 995 patient cataract first appointments (as of December 2025) to further reduce waiting times for those waiting the longest.</li> <li>Embedding One-Stop (pre-operative assessment clinic) POAC and HVLC (high volume low complexity) surgery models pan BCU (7–8 patients per list) targeted by the end of March 2026, increasing throughput and shortening delays across key pathways.</li> </ul>	Reduction in patient waiting time. Improving the access to patient care and timely treatment, helping to reduce patient harm, improve patient outcomes and enhancing patient experience.		

Issue	Progress	Impact (actual & potential)
2. Data quality & completeness with an impact on sub-speciality cohort identification and ability to report regionally	<ul style="list-style-type: none"> <li>Developed a multi-professional case-note review proposal and completed data quality scope to address clinical coding anomalies, improving data quality and insights through re-coding.</li> </ul>	Enables accurate referral management and treatment listing; more accurate performance reporting, demand and capacity leading to better quality planning
3. Ageing estates, equipment and areas of non-compliance with disability access	<ul style="list-style-type: none"> <li>Lead adopter of national e-referral.</li> <li>Implementation of the 'Open Eyes' Electronic Patient Record in progress</li> <li>Successful West IVT (intravitreal therapy) clean room business case</li> </ul>	Improved waiting list management and increased treatment capacity
4. Lack of recruited pan- BCU clinical lead (Ophthalmology & secondary care Optometrist)	<ul style="list-style-type: none"> <li>As we move into the Foundations for the Future consultation and the 2026/27 implementation phase, appointing a short-term clinical lead would be challenging. Therefore, a proactive approach is taken by working closely with all clinicians to drive pathway development and advance ongoing improvements in eye-care delivery.</li> </ul>	Clinical ownership and broader engagement with pathway development.
5. Unsustainable workforce plan: with retire & return and locum reliance for core delivery	<ul style="list-style-type: none"> <li>Workforce planning dashboard development</li> <li>Primary care extended workforce delivering WGOS (Welsh General Ophthalmic Services) pathways</li> </ul>	Workforce can be aligned to service needs through identification of gaps, pressures and opportunities for redesign
6. Lack of a single service model across North Wales	<ul style="list-style-type: none"> <li>Advanced WGOS (Welsh General Ophthalmic Services) Independent Prescribing, HCQ (hydroxychloroquine) and Medical Retina pathways, with WGOS Glaucoma onboarding underway.</li> </ul>	Improved patient safety and flow by directing patients for the right care and treatment



Vascular - Challenged Service Update		Common improvement areas	Key issue for this speciality	RAG
<b>Executive Summary</b> Significant progress has been made across the Network most notably in relation to the management of waiting list and reflects a commitment of the vascular workforce to reducing waiting times and improving patient experience and outcomes. Work is underway to review our workforce model, which will enable this reduction in waiting times to be maintained, and support the service to tackle know challenges with consultant recruitment.		Service Model & Configuration	Yes	Yellow
		Workforce	Yes	Yellow
		Quality/Standards/Practice	Yes	Green
		Patient Safety/Experience	Yes	Yellow
		Infrastructure – estates & digital	Yes	Yellow
Issue	Progress	Impact (actual and potential)		
1. Unsustainable workforce due to consultant age profile and UK-wide vascular shortage, and lack of surgical speciality trainees	<ul style="list-style-type: none"> <li>Prepared a preliminary training programme for Specialty, Associate Specialist and Specialist (SAS) doctors</li> <li>Operational workforce plan development scheduled for March 2026</li> </ul>	Improved job satisfaction and morale leading to retention of SAS grade doctors.		
2. Large number of people waiting for appointments leading to delays in assessments and/or treatment	<ul style="list-style-type: none"> <li>Planned Care insourcing work for stage 1 patients, and WLI (waiting list initiatives), supported by nurse-led clinics for urgent review and patient follow-up.</li> <li>Commenced work to support development of 'Hot Clinics' for Critical Limb Ischaemia with the aim to significantly reduce waiting lists</li> <li>Developed clinical audit tools, supporting continuous improvement, for key vascular pathways: Chronic Limb-Threatening Ischaemia (CLTI), Abdominal Aortic Aneurysm (AAA), Amputation and Carotids.</li> </ul>	Decrease in the number of patients waiting more than 52 weeks for first appointment from 1065 (February 2025) to 237 (December 2025).		



Issue	Progress	Impact (actual and potential)
	<ul style="list-style-type: none"><li>Exploring with Vascular Nurse Specialists the establishment of nurse-led claudication clinics.</li></ul>	
3. Challenges impacting working relationships across the Multidisciplinary Team	<ul style="list-style-type: none"><li>Created Standard Operating Procedures (SOPs) with accompanying audit tools to strengthen multidisciplinary team (MDT) working, and enhancing the role of vascular leaders.</li><li>Commenced implementation of actions to address cultural and behavioural challenges, including meeting with individual clinicians to share learning.</li></ul>	Strengthened leadership and the ability to affect change; reduction in concerns in relation to professional conduct; clearer pathways, processes and role expectations.
4. Further work required to strengthen clinical strategy and service framework to ensure seamless integrated working	<ul style="list-style-type: none"><li>Reviewed multi-disciplinary diabetic foot services across all three sites to support the development of a consistent model and shared decision making leading to better patient outcomes.</li></ul>	Consistent model across network; improved shared decision-making leading to better patient outcomes
5. Lack of estates to increase capacity	<ul style="list-style-type: none"><li>Mapped community hospital clinic availability in the West and exploring options to expand use of community spaces in the Central area.</li></ul>	Increased clinic capacity delivering care closer to home
6. Suspension of new FY1s rotating into the service	<ul style="list-style-type: none"><li>Developed a Safe Learning Charter for the vascular network as well as initiating discussions on establishing a dedicated educational lead role.</li></ul>	Fostering of a positive safety and continuous learning culture to support the return of FY1s.



Dermatology - Challenged Service Update		Common improvement areas	Key issue for this speciality	RAG
<b>Executive Summary</b> The Dermatology service is identified as a challenged service area due to rising demand, workforce shortages, and performance pressures in planned care, diagnostics, and cancer pathways. Skin disease is among the most common reasons for GP consultation, and skin cancer now accounts for approximately half of all cancers in the UK. Over the past decade, referrals—particularly urgent suspected cancer (USC)—have increased significantly, driven by public awareness and education. While some primary care practices manage non-cancerous lesions locally, secondary care services remain heavily relied upon for urgent, complex, and chronic dermatological conditions.		Service Model & Configuration	Yes	Yellow
		Workforce	Yes	Yellow
		Quality/Standards/Practice	Yes	Yellow
		Patient Safety/Experience	Yes	Green
		Infrastructure – estates & digital	Yes	Yellow
Issue	Progress	Impact (actual and potential)		
1. Inability to recruit Consultant staff (in the West IHC)	<ul style="list-style-type: none"> <li>Agreement to progress with interim service model (Network approach) ahead of broader Clinical Services Plan work in phase 2</li> <li>Progressing an Equality Impact Assessment</li> </ul>	Address short-term fragility and provide a clearer understanding of patient and workforce impacts whilst long-term plans develop.		
2. Increased demands which outstrip the capacity of the current model has led to longer waits	<ul style="list-style-type: none"> <li>Improvements across referral management supported by Community Health Pathways (CHP) in a number of sub specialities.</li> <li>Downward trend in upgrading of referrals through robust triage and availability of images provided by Primary Care.</li> <li></li> </ul>	Ability to return referrals to primary care with supporting approved pathways.		



Issue	Progress	Impact (actual and potential)
3. Inability to deliver key performance targets	<ul style="list-style-type: none"><li>Continued improvement in referral to treatment (RTT) &gt;104 week waiting time position.</li><li>Teledermoscopy expanded supporting a reduction in cancer first-outpatient waits.</li><li>Expansion into routine and urgent appointments to maximise utilisation of medical photography capacity.</li></ul>	General dermatology RTT wait <36 weeks. Reduction in wait for first outpatient for cancer from > 2000 to 1189 Increase number of patients through Teledermoscopy pathway and direct to minor operating procedures
4. Delays with access to patient care resulting harm and poor patient experience	<ul style="list-style-type: none"><li>Weekend one stop urgent skin cancer clinics delivered to support significant reduction in urgent cancer backlog.</li></ul>	Improved patient experience through same day diagnostics
5. Insufficient current facilities across North Wales to deliver Minor Operative Procedures and increase outpatient capacity and enable 'one stop' approach.	<ul style="list-style-type: none"><li>Connah's Quay Health Centre live 12/02/2026 for outpatients, live 17/02/2026 for Minor Operative Procedures.</li><li>From 23/02/2026 Connah's Quay fully utilised through agency locum/WLI sessions to reduce treatment targets across North Wales.</li><li>Ongoing job plan discussions to utilise through core activity from April 2026.</li></ul>	Reduction in waiting times. Activity undertaken on a non-acute site contributing to improved patient experience.



Plastics - Challenged Service Update		Common improvement areas	Key issue for this speciality	RAG
<b>Executive Summary</b> Plastic Surgery services in North Wales are becoming more stable, with all issues related to the 2025/26 contract now resolved and no patients waiting longer than 104 weeks to be seen. While the waiting list has been maintained rather than reduced, overall progress is positive, and work continues to expand clinic capacity and finalise long term plans to support sustainable, high quality care for patients across the region.		Service Model & Configuration	Yes	
		Workforce	No	
		Quality/Standards/Practice	No	
		Patient Safety/Experience	Yes	
		Infrastructure – estates & digital	Yes	
Issue	Progress	Impact (actual and potential)		
1. Lack of timely access – high volume of new and follow up patients waiting over target time	<ul style="list-style-type: none"> <li>Waiting list position maintained with zero patients waiting &gt; 104 weeks.</li> <li>Reduction in number of un-booked follow up appointments maintained.</li> </ul>	Reduction in waiting times for new and follow up patients		
2. Inequity – no theatre provision in Central IHC with patients having to travel to England for treatment.	<ul style="list-style-type: none"> <li>Connah’s Quay facility to trial single plastics outpatient clinic in February 2026</li> <li>Updated capacity and demand work to be finalised with costs of proposed Connah’s Quay activity to be included in NHS Wales Joint Commissioning Committee (JCC) IMTP (with financial impact considered by the Health Board as a 99% risk share agreement).</li> </ul>	Increased capacity, reduction in waiting times		
3. Poor infrastructure and operational support in north Wales	<ul style="list-style-type: none"> <li>All outstanding issues relating to 2025/26 contract now resolved.</li> <li>Travel funding issues for visiting surgeons have been resolved</li> </ul>	Secured continuity of care for local patients		



Oncology - Challenged Service Update	Common improvement areas	Key issue for this speciality	RAG
<p><b>Executive Summary</b> Oncology services in North Wales are making encouraging progress, with medical recruitment strengthening a previously fragile workforce, improving stability, continuity and future capacity of the service. As cancer care becomes more complex and demand continues to grow, the service is improving capacity through new models and planning upgrades that will modernise treatment pathways. These developments aim to create a more sustainable, resilient service that can deliver safer, faster and more modern cancer care for local people.</p>	Service Model & Configuration	Yes	Green
	Workforce	Yes	Yellow
	Quality/Standards/Practice	No	White
	Patient Safety/Experience	No	White
	Infrastructure – estates & digital	No	White
Issue	Progress	Impact (actual and potential)	
<p>1. Fragile senior medical staffing due to high volume of locums and low number of substantive due to inability to recruit</p>	<ul style="list-style-type: none"> <li>Five new consultant appointments - three permanent Medical Oncologists, one fixed term Clinical Oncologist, and one fixed term Specialist in Clinical Oncology.</li> <li>Four new specialist trainees starting in 2025/26, two trainees intending to remain post completion, and active interest from two potential future consultant applicants.</li> </ul>	<p>Stable workforce contributing to improved performance, patient safety and patient experience</p>	
<p>2. Increasing demand for oncology treatments with increasing numbers of NICE/AWMSG (All Wales Medicines Strategy Group) approvals of regimens</p>	<ul style="list-style-type: none"> <li>Performance against the three SACT (chemotherapy) treatment targets continues to improve with over 90% of routine patients being seen within 21 days and 81% of urgent patients within 14 days.</li> <li>Welsh Government (WG) has approved investment of £10 million to replace two ageing radiotherapy machines by 2026.</li> </ul>	<p>Improved access to treatments and reduction in delays for patients</p>	

Issue	Progress	Impact (actual and potential)
3. Increasing complexity of treatments including toxicity	<ul style="list-style-type: none"> <li>2026/27 priorities agreed with plan to scope further options for roll out of SABR (stereotactic ablative radiotherapy) and increasing SACT (chemotherapy) capacity in all day units</li> <li>A clinical strategy group is now fully established and developing a new long term plan, due for completion by March 2026,</li> </ul>	To guide future service improvements and support recruitment by clearly setting out the vision for oncology care in North Wales.
4. Increasing number of patients remaining under oncology review – cancer has become a chronic condition	<ul style="list-style-type: none"> <li>Test of concept commenced with non-medical prescriber -led clinics in place of historically consultant led.</li> </ul>	Increased capacity to see patients across a diverse workforce.



Orthodontics - Challenged Service Update		Common improvement areas	Key issue for this speciality	RAG
<b>Executive Summary</b> Orthodontic services in North Wales continue to face major pressures, with a large treatment backlog and ongoing shortages of specialist staff. Recent insourcing has improved first appointment waiting times, but it has also revealed a significant number of patients now needing treatment that current capacity cannot support. Work is underway to strengthen leadership, improve clinical space and equipment planning, and develop a clearer service model for the future, all aimed at improving patient access, safety, and overall experience.		Service Model & Configuration	Yes	Yellow
		Workforce	Yes	Red
		Quality/Standards/Practice	Yes	Yellow
		Patient Safety/Experience	Yes	Yellow
		Infrastructure – estates & digital	Yes	Yellow
Issue	Progress	Impact (actual and potential)		
1. National and local workforce shortages including senior medical staff	<ul style="list-style-type: none"> <li>Appointment of a restorative dentistry consultant has boosted recruitment prospects. New adverts featuring improved incentives and digital infrastructure aim to fill remaining gaps</li> <li>Work force review planning</li> </ul>	Increased capacity to deliver care and treatment and reduce waiting times and improve patient safety and experience		
2. Backlog demand outstripping capacity across both primary and secondary care	<ul style="list-style-type: none"> <li>Insourcing has cleared the longest waits, putting the service on track to delivery zero Stage 1 (first appointment) waits by March 2026.</li> <li>Significant follow-up treatment lists (following insourcing conversion) to be visible via the North Wales Orthodontic Group to enable better demand and capacity analysis and planning.</li> </ul>	Timely access to first appointment and follow-up treatment		



Issue	Progress	Impact (actual and potential)
3. Managing patient harm as a result of delays within Orthodontic services	<ul style="list-style-type: none"><li>Insourcing initiative has delivered first full risk assessment of long waiting patients.</li></ul>	Eliminating 'unknown' risks by identifying urgent needs and clarifying future treatment demand.
4. Infrastructure, especially digital and estate restrictions on expanding consultant work force	<ul style="list-style-type: none"><li>Work is underway to standardise clinical spaces, supported by an ongoing inventory of sites and equipment.</li></ul>	Identification of current space constraints and gaps to better understand opportunities for improvement in room utilisation
5. Lack of a sustainable service model to address current disjointed care across primary and secondary care	<ul style="list-style-type: none"><li>The new North Wales Orthodontics Group unites leaders (operational and clinical) across the region, providing structured oversight and the foundation for a unified regional model.</li><li>Comprehensive improvement plan developed including GIRFT recommendations to address short-, medium- and long-term challenges.</li></ul>	A sustainable service model to reduce clinical variation and inconsistencies across the service



Orthopaedics - Challenged Service Update		Common improvement areas	Key issue for this speciality	RAG
<b>Executive Summary</b> The Orthopaedics Network continues to make progress in reducing follow-up backlogs, standardising clinical pathways, and improving patient experience across BCUHB. Key actions this period include advancing implant rationalisation, supporting backlog reduction across sites, and strengthening coding quality. Despite capacity challenges, teams remain focused on meeting the March 2026 104-week target through a combination of core activity, insourcing, outsourcing, and care transfers.		Service Model & Configuration	Yes	Yellow
		Workforce	Yes	Yellow
		Quality/Standards/Practice	Yes	Green
		Patient Safety/Experience	Yes	Green
		Infrastructure – estates & digital	Yes	Yellow
Issue	Progress	Impact (actual and potential)		
1. Delayed cold site optimisation due to estates, service configuration and long waiting acute site need	<ul style="list-style-type: none"> <li>Hip implant rationalisation decision in principle for Llandudno unit, with further discussions starting for knee implants</li> <li>Medical travel agreement to be reached via Llandudno project board.</li> <li>Reduction in &gt;104 week waiting list continues (365 December 2025, 333 January 2026)</li> </ul>	Reduction in unwarranted variation, supporting standardised pathways. Securing better value without compromising quality		
2. Slow progression of efficiency measures (HVLC, day case arthroplasty, HSQ and MOPs)	<ul style="list-style-type: none"> <li>Clinical condition coding – including MOPs coding - continues.</li> <li>Planned Care supporting improvement in efficiencies</li> </ul>	Improved data quality to support demand and capacity analysis and improved efficient planning		








Issue	Progress	Impact (actual and potential)
3. Significant volume of overdue follow-up patients	<ul style="list-style-type: none"><li>Spread of follow-up backlog reduction (SOS) initiative (in West IHC) commenced with clinical conversations taking place with East and Centre IHCs and roll out planned for March 2026.</li></ul>	Reduction in waiting times for follow-up patients
4. Network clinical leadership sessions currently assigned to Llandudno orthopaedic project	<ul style="list-style-type: none"><li>IHC clinical leads providing support with pan BCU delivery.</li></ul>	Clinical ownership and broader engagement with pathway development.



Bwrdd Iechyd Prifysgol  
Betsi Cadwaladr  
University Health Board

---

ASSESSMENT	
<b>Link to Strategic Priorities</b>	    
	<p>4. Improving quality, outcomes and experience</p> <p><i>If more than one applies, please list below:</i></p>
<b>Design Principles</b>	<p>Choose an item.</p> <p><i>All design principles apply</i></p>
<b>Corporate Risks and Board Assurance Framework</b>	<p><i>CR25-5 Strategic Change – impacting care and staff delivery</i></p>
<b><u>Wellbeing of Future Generations Act – Wellbeing Goals</u></b>	<p>Not Applicable</p>



IMPACT ASSESSMENTS		
<b>Equality</b> <i>Have you undertaken an Equality Impact Assessment Screening (which includes the requirements of the Welsh Language Standards)</i>	Yes: <input type="checkbox"/>	No: <input checked="" type="checkbox"/>
	Outcome:	
	If no, please include rationale:	<i>Not applicable</i>
<b>Socio-Economic Impact Assessment</b> <i>Have you undertaken a Socio-Economic Impact Assessment</i>	Yes: <input type="checkbox"/>	No: <input checked="" type="checkbox"/>
	Outcome:	
	If no, please include rationale:	<i>Not applicable</i>
<u>Quality</u> <i>Have you undertaken a Quality Impact Assessment Screening?</i>	<b>Enablers of Quality</b> Whole-systems Perspective	<b>Domains of Quality</b> All Apply
<u>Wellbeing of Future Generations Act – Wellbeing Goals</u>	Not Applicable	
<b>Environmental /Sustainability Impact (5Rs)</b>	No - Not Applicable	
<b>Armed Forces Covenant Due Regard Duty</b> <i>Have you considered the Armed Forces Covenant Due Regard Duty?</i>	Yes: <input type="checkbox"/>	No: <input checked="" type="checkbox"/>
	Outcome:	
	If no, please include rationale:	<i>Not applicable</i>
<b>Data Protection Impact Assessment</b> <i>Have you undertaken a Data Protection Impact Assessment Screening?</i>	Yes: <input type="checkbox"/>	No: <input checked="" type="checkbox"/>
	Outcome:	
	If no, please include rationale:	Not applicable
<b>Counter Fraud Impact Assessment</b> <i>Have you considered the counter fraud impacts</i>	Yes: <input type="checkbox"/>	No: <input checked="" type="checkbox"/>
	Outcome:	

	If no, please include rationale:	<i>Not applicable</i>
<b>Legal</b>	There are no specific legal implications related to the activity outlined in this report.	
<b>Reputational</b>	Yes (Include further detail below) If the challenges outlined in this report are not adequately addressed then the organisation is likely to remain in Special Measures status, and thus contributing to the ongoing negative perception of healthcare delivery in North Wales	
<b>Resource Impact</b> <i>(People / Financial)</i>	Yes (Include further detail below) Current workforce levels are insufficient in a number of the Challenged Services to meet demand and provide an effective and efficient service pan BC	

## Quality Safety & Experience Committee

### Additional Learning Needs and Educational Tribunal Act: Annual Report and Current Priorities

<b>Date of Meeting</b>	05 March 2026
<b>Publication Status</b>	Open/ Public
	Not Applicable
<b>Report Author(s) name and title</b>	Liz Mckinney, Designated Education Clinical Lead Officer (DECLO)
<b>Lead Executive Team Member name and title</b>	Teresa Owen, Executive Director for Allied Health Professionals and Health Science

<b>Report Purpose</b>	For Noting
-----------------------	------------

#### Executive Summary

##### Overview

This paper summarises the annual report prepared by the Designated Education Clinical Lead Officer (DECLO) on BCUHB's performance against its statutory duties under the Additional Learning Needs and Education Tribunal (Wales) Act for the period 1st September 2024 – 31st August 2025. This paper also highlights current priorities for the Health Board.

During year four of implementation, the Health Board sustained high levels of compliance, consistently above 95%. A vacancy in the team's secretary role toward the end of the period temporarily affected performance. Temporary mitigations were put in place to stabilise capacity.

##### Current priorities

- Strengthening the ALNET team through a sustainable workforce model.
- Restoring full Quality Management System activity to support continuous improvement.
- Continuing active involvement in national workstreams, including the legislative review and Key Performance Indicator (KPI) development.

##### Key risks and challenges

- Workforce pressures that may affect statutory processes.
- Reduced Quality Management System activity while essential functions are prioritised.
- Sector-wide challenges related to interpretation and resourcing of the legislation.

**Recommendation**

The Committee is asked to note the strong performance in year four and support the proposed actions to maintain compliance throughout year five.

**Engagement (internal/external) undertaken to date (including receipt/ consideration at Committee/Group)**

Committee / Group / Individuals	Date	Outcome, Evidence and Data
ALNET Act team meeting – discussion of annual report and current priorities	02/12/2025	Outcome: Draft ALNET Act Annual Report (version 1) and current priorities provisionally agreed. To be taken forward to the ALNET Act Steering Group on 8/1/2026 for feedback and approval.
ALNET ACT Steering group - discussion of annual report and current priorities	08/01/2026	Outcome: Feedback collated. ALNET Act Annual Report (version 2) and current priorities agreed. Report and current priorities to be presented to EDAHPHS followed by QSE Committee (5/3/2026).
1:1 meeting between Liz McKinney (DECLO) and Teresa Owen (Executive Director of Allied Health Professionals and Health Science) – discussion of draft report to QSE regarding annual report and current priorities.	27/1/2026	Outcome: Feedback collated. ALNET Act Annual Report (version 3) and report for the QSE Committee finalised. Report to go to Executive Committee on 11/2/2026 prior to QSE Committee.
Executive Committee - Presentation of report providing a preview of planned report for QSE committee.	11/2/2026	Outcome: The Committee noted high statutory compliance despite rising demand, acknowledged temporary workforce pressures that affected performance, and agreed that sustained compliance requires stable, recurrent staffing. Members also recognised emerging national guidance that may broaden expectations and reaffirmed the need for needs-led ALN support.

**Acronyms / Glossary of Terms**

ALN	Additional Learning Needs
ALP	Additional Learning Provision
ALNET (Act)	Additional Learning Needs and Education Tribunal (Wales) Act 2018
DECLO	Designated Education Clinical Lead Officer
FEI	Further Education Institution
KPI	Key Performance Indicator
PLASC	Pupil Level Annual School Census
QMS	Quality Management System
RAG	Regulation Oversight and Assurance Group

**Report Title: Additional Learning Needs and Educational Tribunal Act: Annual Report and Current Priorities**

## 1. SITUATION

1.1 BCUHB is required to meet its statutory responsibilities under the Additional Learning Needs and Education Tribunal (Wales) Act (ALNET Act). The aim of this report is to provide:

- a high-level overview of the Health Board’s performance in delivering its ALNET Act duties during year four of implementation (1<sup>st</sup> September 2024–31<sup>st</sup> August 2025) as outlined in the annual report (Appendix A).
- the current position regarding BCUHB’s compliance with statutory duties.
- emerging challenges and risks.
- key priorities required to maintain compliance and support the continued progression of quality assurance and improvement activity.

## 2. BACKGROUND

2.1 The ALNET Act commenced on 1st September 2021, supported by the statutory Additional Learning Needs Code for Wales. Phased implementation concluded on 31st August 2025, with full enactment effective from 1st September 2025. The ALNET Act helps ensure that children and young people with additional learning needs (ALN) receive the right support at the right time, enabling them to participate fully in education, achieve their potential, and experience improved long-term wellbeing.

2.2 Health Board duties under the ALNET Act include:

- notifying Local Authorities of children under compulsory school age who may have ALN (Section 64 of the ALNET Act)

- responding within six weeks to Local Authority requests for information or other help to support ALN processes (Section 65 of the ALNET Act)
- responding within six weeks to referrals asking NHS services to consider whether an intervention may constitute NHS Additional Learning Provision (ALP) (Section 20 of the ALNET Act)
- securing NHS ALP as identified in response to a section 20 referral and, where identified, taking all reasonable steps to deliver it in Welsh where required.
- contributing to early dispute resolution and Education Tribunal processes.

2.3 A report was presented to the QSE Committee in February 2025 outlining the headlines from the 2023–2024 annual report (year three of delivery) and highlighting key priorities. It was agreed that the DECLO would provide annual updates to the QSE committee. The annual report from the DECLO and ALNET Act team spans an *academic* year (i.e., from 1<sup>st</sup> September through to the end of August the following year) to align with the implementation of the legislation.

2.4 During year four of delivery (1st September 2024 – 31st August 2025), BCUHB's implementation of the ALNET Act continued to be guided by clear standards, robust reporting arrangements, and an embedded Quality Management System (QMS). Alongside this, the Health Board remained actively involved in national workstreams, including the development of key performance indicators in preparation for an anticipated Data Provision Notice from Digital Health and Care Wales during 2026–2027.

2.5 Performance was monitored through regular DECLO reporting into established governance groups, ensuring appropriate oversight and escalation. The QMS provided an integrated framework for planning, monitoring, assurance, and continuous improvement of ALNET-related activity.

2.6 Year four delivered strong outcomes despite a significant increase in demand. Statutory compliance reached 96% for Health Board responses to Section 65 requests and 99% for responses to Section 20 referrals. More than 1,000 children and young people were supported under the Act during this period. Progress was also made in strengthening governance, embedding quality processes, securing interim workforce stability through temporary contract extensions, and sustaining multi-agency collaboration across education, health, and third-sector partners.

2.7 From August 2025 onwards, local and national challenges emerged. Within BCUHB, the primary issue concerned workforce stability within the ALNET Act support team, leading to variability in compliance. One reporting month fell to 58%, though mitigations put in place have resulted in current average compliance levels of 81% for Section 65 requests and 80% for Section 20 referrals.

- 2.8 To mitigate the impact of the vacancy and release capacity, QMS activity within the ALNET Act team has been temporarily paused since August 2025, with plans to reinstate QMS activity from March 2026.
- 2.9 Following BCUHB's investment review and subsequent executive discussions, the Project Manager post for the ALNET Act team was confirmed as permanent from 1st November 2025. The Team Secretary post remained fixed term and was vacant from 28 July 2025 until a recent fixed-term appointment in February 2026.
- 2.10 Nationally, challenges have arisen following the ALNET legislative review, particularly relating to multi-agency collaboration, areas of legislative ambiguity, and variation in interpretation of key duties - most notably those relating to Health Boards under Section 20. Welsh Government has convened a multi-agency group to address these issues and develop a clearer health policy position to promote consistency. BCUHB continues to be actively involved in this work.

### **3. SPECIFIC MATTERS FOR CONSIDERATION**

- 3.1 According to the Pupil Level Annual School Census (PLASC), there are 10,170 children and young people with ALN in North Wales, a conservative figure as the census excludes learners attending Further Education Institutions (FEIs). Demand on the Health Board relating to statutory ALNET Act duties has increased significantly from year three (2023–2024) to year four (2024–2025), with activity rising by 25% under Section 65 of the Act and 76% under Section 20 of the Act. A further increase is anticipated in year five, as the phased implementation of the Act is now complete. The ALNET Act is critical in ensuring children and young people with additional learning needs receive timely, equitable support that enables them to access education, achieve their potential, and experience improved long-term wellbeing.
- 3.2 It is important that BCUHB remains fully aware of its statutory duties under the ALNET Act and the requirement for these to be met. A Data Provision Notice is expected to be issued by Digital Health and Care Wales during the academic year 2026–2027, requiring the Health Board to have robust systems for local data capture and national reporting. This will occur alongside continued growth in demand and potential changes to the parameters of statutory duties for Health Boards following the Legislative Review, with scope for the remit of responsibilities to widen beyond current interpretation of the legislation.
- 3.3 BCUHB will need to consider securing a sustainable ALNET Act workforce to meet rising statutory demand, prepare for forthcoming national reporting requirements, and deliver on the Health Board's strategic objectives for safe, compliant, and sustainable services.






## 4. KEY RISKS

4.1 There is a risk that compliance with statutory duties may be compromised if workforce instability within the ALNET Act support team continues. The temporary pausing of quality-improvement workstreams within the Quality Management System (QMS) created short-term capacity to cover workforce gaps, which have now been partially addressed through recruitment to a fixed-term post. However, sustainable long-term workforce solutions would support ongoing compliance in the future.

## 5. RECOMMENDATIONS

The Committee is asked to:

- **Note** the current risks to statutory compliance and quality oversight.
- **Support** securing sustainable workforce solutions for the ALNET Act team.
- **Agree** that the ALNET Act delivery risk should remain under scrutiny given the statutory, governance, and reputational implications.

ASSESSMENT	
Link to Strategic Priorities	    
	1. Building an effective organisation
	4. Improving quality, outcomes and experience
Design Principles	Equity and Accessibility Consistency with Organisational Values
Corporate Risks and Board Assurance Framework	<b>Tier 1 risk - ID 5248 Risk Grading: 20</b> The risk created by not having an ALN Act support team indicates an 'extreme' risk score of 20 (consequence=4; likelihood=5). The consequence score is high due to the risk of <i>multiple breaches</i> in <i>statutory duty</i> . The risk would be mitigated by a stable ALN Act support team which would reduce the risk to <i>moderate</i> with a score of 6 (consequence=2; likelihood=3).
<a href="#">Wellbeing of Future Generations Act – Wellbeing Goals</a>	A More Equal Wales
	A Heathier Wales A Wales of Cohesive Communities

IMPACT ASSESSMENTS		
<b>Equality</b> <i>Have you undertaken an Equality Impact Assessment Screening (which includes the requirements of the Welsh Language Standards)</i>	Yes: <input checked="" type="checkbox"/>	No: <input type="checkbox"/>
	Outcome:	Permanent solutions for the ALN Act support team to be identified and secured.
	If no, please include rationale:	
<b>Socio-Economic Impact Assessment</b> <i>Have you undertaken a Socio-Economic Impact Assessment</i>	Yes: <input checked="" type="checkbox"/>	No: <input type="checkbox"/>
	Outcome:	Permanent solutions for the ALN Act support team to be identified and secured.
	If no, please include rationale:	
<b>Quality</b> <i>Have you undertaken a Quality Impact Assessment Screening?</i>	<b>Enablers of Quality</b> All Apply	<b>Domains of Quality</b> All Apply
<b>Wellbeing of Future Generations Act – Wellbeing Goals</b>	A More Equal Wales	
	A Healthier Wales	
	A Wales of Cohesive Communities	
	A Globally Responsible Wales	
<b>Environmental /Sustainability Impact (5Rs)</b>	No - Not Applicable	
<b>Armed Forces Covenant Due Regard Duty</b> <i>Have you considered the Armed Forces Covenant Due Regard Duty?</i>	Yes: <input checked="" type="checkbox"/>	No: <input type="checkbox"/>
	Outcome:	Health Board duties under ALNET Act must have due regard to the Armed Forces Covenant ensuring Service children are not disadvantaged by the impacts of service life.
	If no, please include rationale:	
<b>Data Protection Impact Assessment</b> <i>Have you undertaken a Data Protection Impact Assessment Screening?</i>	Yes: <input checked="" type="checkbox"/>	No: <input type="checkbox"/>
	Outcome:	WASPI development (ongoing)
	If no, please include rationale:	
<b>Counter Fraud Impact Assessment</b> <i>Have you considered the counter fraud impacts</i>	Yes: <input type="checkbox"/>	No: <input checked="" type="checkbox"/>
	Outcome:	



	If no, please include rationale:	A Counter Fraud Impact Assessment has not been completed as this is not a new major spend proposal.
<b>Legal</b>	Yes (Include further detail below)	
	There is the possibility of legal challenge in relation to breach of statutory duties. BCUHB will engage with Education Tribunal Activities as required.	
<b>Reputational</b>	Yes (Include further detail below)	
	Reputational risk associated with the impact non-compliance with statutory duties.	
<b>Resource Impact</b> (People / Financial)	Yes (Include further detail below)	
	Workforce funding (Project Manager and Secretarial support) requires recurrent solution to maintain compliance; short-term mitigations have capacity impacts.	

References:

1. Welsh Government (2018), *Additional Learning Needs and Educational Tribunal (Wales) Act 2018.*
2. Welsh Government (2021), *Additional Learning Needs Code for Wales 2021.*
3. Stats Wales (2025), *Pupil Level Annual School Census.*

Appendix:

A: Annual Report 2024 – 2025: Designated Education Clinical Lead Officer (DECLO) and Additional Learning Needs (ALN) Act Team. *See separate document.*



Bwrdd Iechyd Prifysgol  
Betsi Cadwaladr  
University Health Board

# Annual Report – Designated Education Clinical Lead Officer (DECLO) and Additional Learning Needs (ALN) Act Team

Reporting Period: 1<sup>st</sup> September 2024 – 31<sup>st</sup> August 2025

Author: Liz McKinney, Designated Education Clinical Lead Officer (DECLO)

Version: 3.0

Date: January 2026



## CONTENTS

1. Executive Summary
2. Introduction and Purpose
3. Legislative Context
4. BCUHB's Strategic Approach to ALN Implementation
5. Progress in Year Four (September 2024 - August 2025)
6. Data and Delivery
7. Challenges, Risks, and Mitigations
8. Priorities for Year five (September 2025 - August 2026)
9. Summary and Conclusions
10. References

### 1. EXECUTIVE SUMMARY

This report provides an annual update on the implementation of the Additional Learning Needs and Education Tribunal (Wales) Act 2018 (the ALNET Act) by Betsi Cadwaladr University Health Board (BCUHB) during year four of delivery (September 2024 – August 2025), marking the final year of the national phased transition to the Additional Learning Needs (ALN) system.

#### 1.1 Key Achievements during year four (September 2024 – August 2025):

- BCUHB maintained high compliance with statutory duties:
  - **96%** for Section 65 requests (information/advice to Local Authorities).
  - **99%** for Section 20 referrals (consideration of NHS Additional Learning Provision).
- Governance was strengthened through bi-monthly reporting from the BCUHB's ALNET Steering Group to the health board's Regulatory Assurance Group.
- A Quality Management System was embedded to structure planning, monitoring, and improvement activities for the ALNET Act within BCUHB.
- Workforce development and multi-agency collaboration progressed, including engagement with Local Authorities, Further Education institutions, and third-sector partners.
- BCUHB contributed to national priorities including the Welsh Government's Legislative Review of the ALNET Act and the work to develop Key Performance Indicators.

#### 1.2 Demand and Impact:

- During year 4 (September 2024-August 2025) there was an increase in statutory activity under the ALNET Act:
  - Section 64 notifications increased by 54% (118 cases).
  - Section 65 requests increased by 25% (1,813 cases).
  - Section 20 referrals increased by 76% (302 cases).

#### 1.3 Challenges and Risks:

- The ALNET Act team have experienced workforce instability due to non-recurrent funding and fixed-term contracts, resulting in vacancies and reduced compliance in August 2025.

- Broader system challenges have been experienced due to legislative ambiguities and inconsistent interpretation of statutory duties across Wales. Welsh Government has undertaken a review of the ALN legislative framework, with published outputs emerging in 2025.

#### 1.4 Priorities for Year Five (September 2025 – August 2026):

- Secure sustainable workforce model for BCUHB’s ALNET Act team.
- Resume full Quality Management System activity.
- Respond to outcomes of the legislative review.
- Support final development of national Key Performance Indicators (KPIs).

#### 1.5 Conclusion:

Despite rising demand and resource challenges, BCUHB delivered strong compliance and governance during year four, while contributing to national policy development. Continued collaboration, workforce stability, and strengthened data systems will be critical to meeting statutory obligations and improving outcomes for children and young people with ALN in year five of the ALNET Act delivery.

## 2. INTRODUCTION

### 2.1 Purpose of report

The purpose of this report is to provide an annual update in relation to the implementation by BCUHB of the Additional Learning Needs and Education Tribunal Act for Wales (2018) following year four of implementation (academic year September 2024 - August 2025).

### 2.2 Scope

This annual report covers BCUHB’s responsibilities, activity, progress and challenges in implementing the Additional Learning Needs and Education Tribunal (Wales) Act 2018 during year four of the national ALN transformation programme (academic year 2024–2025). Priorities for year five (academic year 2025-2026) are also identified.

## 3 LEGISLATIVE CONTEXT

### 3.1 The Additional Learning Needs and Education Tribunal (Wales) Act, 2018

The Additional Learning Needs and Education Tribunal (Wales) Act 2018<sup>1</sup> (hereafter referred to as the ALNET Act) came into force in Wales on 1st September 2021. The aim of the ALNET Act is to transform education for children and young people with Additional Learning Needs (ALN) by removing barriers to learning and enabling every learner to reach their full potential. The accompanying ALN Code for Wales<sup>2</sup> provides statutory guidance on implementing the Act. The phased implementation period concluded on 31st August 2025, with full enactment effective from 1st September 2025.

<sup>1</sup> Welsh Government (2018), Additional Learning Needs and Educational Tribunal (Wales) Act 2018

### 3.2 Implications for the Health Board

<sup>2</sup> Welsh Government (2021), Additional Learning Needs Code for Wales 2021.

The Act places statutory duties on the health board, including:

- Appointing a Designated Clinical Lead Officer (DECLO) to oversee and coordinate the Health Board’s functions under the ALNET Act.
- Notifying the Local Authority of children under compulsory school age who have, or are likely to have, ALN (section 64 of the legislation).
- Responding within six weeks to requests from Local Authorities for information, advice, or other help in relation to children and young people, or more general matters, to support the Authority’s functions under the ALNET Act (section 65 of the legislation).
- Responding within six weeks to referrals from Local Authorities or colleges asking for consideration of whether an NHS treatment or service is Additional Learning Provision (ALP) due to it being of benefit in addressing the ALN of a child or young person (section 20 of the legislation).
- Deciding whether the identified NHS ALP should be provided in Welsh.
- Securing delivery of the NHS ALP, including taking all reasonable steps to secure the provision in Welsh if this has been identified.
- Supporting early dispute resolution and contributing evidence, information, and assistance in appeals to Education Tribunals, including consideration of Tribunal Panel recommendations.

### 3.3 Description of ALN Act sections containing statutory duties for Health Boards

SECTION	DESCRIPTION
<b>Section 20</b>	Requires NHS bodies to consider whether any NHS treatment or service could help meet a child or young person’s Additional Learning Needs when asked to do so by Local Authorities or Further Education Institutions. A response must be provided promptly and no later than six weeks from receipt of the request.
<b>Section 64</b>	Requires NHS bodies to notify the child’s parents and the local authority if, during normal health-care contact with a child under compulsory school age, the opinion is formed that the child has, or probably has, Additional Learning Needs.
<b>Section 65</b>	Requires NHS bodies to ensure that they provide information, advice, or other assistance - whether relating to an individual child or young person, or to more general matters - when requested by a local authority, in order to support the authority in exercising its functions under the ALNET Act. A response must be provided promptly and no later than six weeks from receipt of the request.
<b>Section 76</b>	Requires NHS bodies to engage with the Education Tribunal for Wales, including providing relevant evidence when required and responding to Tribunal recommendations relating to Additional Learning Needs provision.

## 4. BCUHB’S STRATEGIC APPROACH TO ALNET ACT IMPLEMENTATION

### 4.1 Standards

BCUHB’s approach to implementing the Additional Learning Needs and Education Tribunal (Wales) Act 2018 during the academic year 2024-2025 continued to be grounded in the statutory requirements set out within the ALNET Act and Code. Standards relating to compliance, timeliness, quality of health information and advice, and the identification and provision of ALP remained central to the Health Board’s responsibilities.

Clinical standards within each BCUHB service supporting children and young people with ALN continued to follow established professional guidance, evidence-based practice, and relevant clinical governance frameworks. These

standards ensured that ALN-related activity was embedded within routine clinical pathways and aligned with broader quality and safety expectations across the organisation.

During year four, national work progressed to develop key performance indicators (KPIs) and compliance measures through collaboration between Designated Education Clinical Lead Officers (DECLOs), Welsh Government, NHS Performance and Improvement, Digital Healthcare Wales, and the Welsh Informatics Standards Board. This work is expected to lead to a Data Provision Notice to formalise ALNET Act KPIs for Health Boards during academic year 2025-2026.

#### 4.2 Reporting arrangements

During year four (September 2024 – August 2025), the reporting arrangements to support oversight and governance of the ALNET Act implementation within BCUHB were as follows:

- Matters related to performance and compliance were reported by the DECLO on a bi-monthly basis to the BCUHB ALNET Act Steering Group for the purpose of assurance, scrutiny, and escalation as appropriate.
- Chair's report from BCUHB's ALNET Steering group was submitted to the Regulatory Assurance Group (RAG) on a bi-monthly basis.
- Matters of significance regarding ALNET Act were escalated by RAG to BCUHB's Quality Delivery Group, as appropriate and required.
- Compliance updates and issues of significance were reported by the DECLO to the Executive Director of Allied Health Professionals and Health Science on a monthly basis.

#### 4.3 Quality Management System

During year four, the work of the DECLO and ALNET Act Team was firmly embedded within a Quality Management System (QMS) to structure activity around the Health Board's Duty of Quality. QMS provided a systematic approach to planning, monitoring, and improving ALN-related activity across the academic year, factoring in the four QMS quadrants as below:

- **Quality Planning:** Planning via an annual team engagement event, structured around five core workstreams: Workforce; Governance; Operationalisation; Multi-agency working; Engagement.
- **Quality Control:** Regular monitoring processes implemented to track performance, identify issues, and ensure consistency across services.
- **Quality Assurance:** Detailed analysis of key operational areas to support the identification of trends, risks, and opportunities for improvement.
- **Quality Improvement:** Insights from planning, control, and assurance activities used to inform ongoing improvement work, ensuring that BCUHB continues to strengthen its ALN delivery model.

### 5. PROGRESS IN YEAR FOUR (SEPTEMBER 2024 – AUGUST 2025): Achievements, milestones, and developments

#### 5.1 Maintenance of compliance

- From 1<sup>st</sup> September 2024 – 31<sup>st</sup> August 2025, BCUHB achieved an overall compliance rate of **96%** in relation to statutory duties under section 65 of the ALNET Act (responding to requests from Local Authorities for information or other help).
- From 1<sup>st</sup> September 2024 – 31<sup>st</sup> August 2025, BCUHB achieved an overall compliance rate of **99%** in relation to statutory duties under section 20 of the ALNET Act (responding to referrals from Local Authorities to consider whether there is an NHS treatment or service that could be of benefit in addressing ALN).

## **5.2 Strengthening of Governance and Oversight**

- A full year of reporting into RAG provided a framework of robust checks, challenge, and assurance to strengthen the governance and oversight of ALNET Act matters.
- A workable Quality Management System approach was established and embedded to structure the work of the DECLO and ALNET Act Team.

## **5.3 Workforce Development**

- A 'compassionate leadership' approach was firmly embedded within the team.
- The ALNET Act team Project Manager became a Culture Change Leader for BCUHB.
- An extension of ALNET Act support staff fixed term contracts was secured to the end of August 2025 (an extension of up to five months for some staff).

## **5.4 Multi-Agency Collaboration and Engagement with partners in health, education and third sector organisations**

- Regular strategic collaboration with Local Authority ALN Leads across North Wales.
- Strong links established with the North Wales Association of Special School Heads Forum.
- Regular engagement established with ALN leads across the Further Education Institutions in North Wales.
- Collaboration with senior leaders in NHS England to address cross-border complexities.
- Continued liaison and links with voluntary organisations supporting children, young people, and families.
- DECLO membership at the Childrens Regional Partnership Board was established.

## **5.5 Engagement with Children, Young People, and Families**

- Feedback from families was obtained to support future web-page development.
- New bilingual feedback mechanisms were introduced using CIVICA.

## **5.6 Learning from involvement in the Education Tribunal for Wales procedures and processes**

- BCUHB were involved in five tribunal cases during academic year 2024-2025.
- The learning obtained was shared within strategic and operational forums.
- Training and guidance were updated to incorporate learning.

## **5.7 Learning to support multi-agency collaboration**

- A systematic literature review was conducted to establish factors that influence multi-agency collaboration.
- The findings were used to inform and update training packages for BCUHB staff.

## **5.8 Engagement with national priorities**

- BCUHB submitted feedback to Welsh Government in response to a legislative review of the ALNET Act.
- BCUHB contributed to the research commissioned by Welsh Government regarding a review of ALNET Act implementation.
- BCUHB continue to be involved in the development of national KPIs to capture NHS compliance against statutory duties.

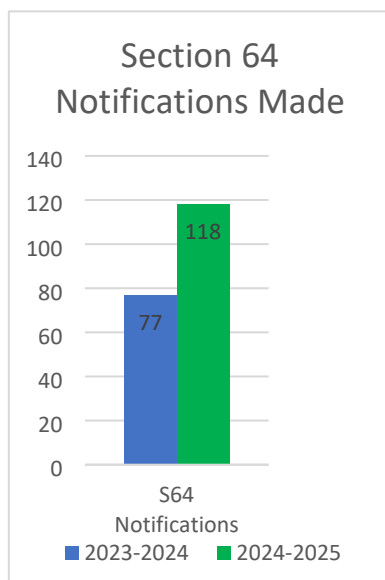
## **6. DATA, DELIVERY & IMPACT**

## 6.1 Demand

- According to the Pupil Level Annual School Census<sup>3</sup>, 10170 children and young people have ALN in North Wales. This figure does not include young people with ALN in Further Education Institutions in North Wales (data regarding this group of young people is not currently available).
- Academic Year 2024-2025 was the final year of the phased implementation of the ALN system, with all children moving over to the system by the end of August 2025, leading to an increase in statutory duties for health boards.

## 6.2 Notifications from BCUHB to Local Authorities regarding pre-school children with potential ALN (Section 64 of ALNET Act)

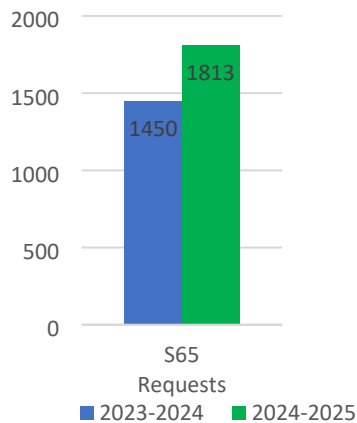
- During the academic year 2024-2025, **118** notifications under section 64 of the ALNET Act were made by BCUHB to Local Authorities regarding pre-school children with potential ALN who were not yet within the ALN system.
- The number of notifications made under section 64 of ALNET Act increased by over 54% compared with data from the previous year (academic year 2023-2024).



## 6.3 Requests for information or other help (Section 65 of ALNET ACT): Demand and Compliance

- During the academic year 2024-2025, **1813** statutory requests were received by BCUHB from Local Authorities asking for information or other help under section 65 of the ALN Act to support over 700 children and young people within the ALN system.
- BCUHB complied with the statutory duty to respond promptly, and no later than 6 weeks, in 96% of cases.
- The number of requests to BCUHB under section 65 of ALNET Act increased by over **25%** compared with data from the previous year (academic year 2023-2024).  
Stats Wales (2025), Pupil Level Annual School Census.

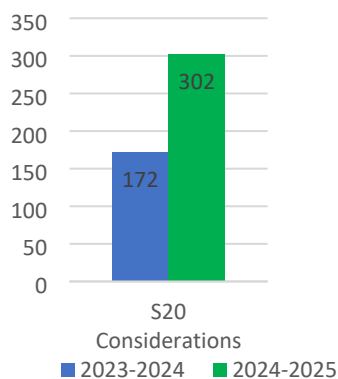
### Section 65 ALNET Act Requests Received



#### 6.4 Referrals to consider NHS additional learning provision (Section 20 of ALNET Act): Demand and Compliance

- During the academic year 2024-2025, **302** statutory referrals relating to over 200 children were received by BCUHB from Local Authorities asking for consideration of whether there is a treatment or service that may be of benefit in addressing a child or young person’s ALN (i.e., NHS Additional Learning Provision).
- BCUHB complied with the statutory duty to respond promptly, and no later than 6 weeks, in **99%** of cases.
- The number of referrals to BCUHB under section 20 of ALNET Act increased by nearly **76%** compared with data from the previous year (academic year 2023-2024).

### Section 20 ALNET Act Referrals



## 7. CHALLENGES, RISKS, AND MITIGATION

### 7.1 Workforce (ALNET Act Team) Challenges

- At the commencement of the academic year 2024-2025, the following workforce were in place to support BCUHB’s delivery of the ALNET Act:

Post	WTE	Tenure	Funding
DECLO	1.0	Permanent	Cost Pressure for EDAHP&HS directorate
Project Manager	0.65	Fixed term	RIGA (non recurrent)
Team Secretaries	1.56	Fixed term	RIGA (non recurrent)

- In September 2024 a paper was submitted to BCUHB’s Executive Team by the DECLO to escalate risks regarding the fixed-term nature of contracts due to the non-recurrent funding underpinning the ALN Act Team.
- In March 2025, the fixed term contracts of the secretaries and the project manager were extended to the end of the academic year (31<sup>st</sup> August 2025).
- Unfortunately, the staff in post within the team secretary roles left during July 2025 to pursue permanent employment (one via BCUHB’s redeployment scheme; one via resignation to take up a permanent post externally).
- The posts have been vacant since the end of July 2025. It was not possible to advertise the vacant posts within the academic year due to awaited outcomes from BCUHB’s review of investments process - which had been delayed.
- The DECLO and project manager covered the essential team secretary tasks (processing statutory requests and referrals under ALNET Act) during August 2025 as a temporary measure to mitigate risks.
- The impact of the vacant team secretary posts resulted in a decline of compliance against statutory duties in August 2025. A further impact was a pause to quality assurance and quality improvement activities in order to release capacity from the DECLO and Project Manager to cover essential secretary tasks.
- The impact of the fixed term nature of posts is recorded on the risk register.

## 7.2 Risks

The risk linked with workforce was logged on the risk register during academic year 2024-2025 as follows:

- There is a risk that BCUHB will fail to comply with the Additional Learning Needs and Education Tribunal (ALNET) Act legislation.
- This may be caused by the fact that BCUHB’s ALNET Act team secretaries and project manager posts are not underpinned by permanent funding resulting in fixed-term contracts for current staff.
- This could lead to serious breaches of ALNET legislation, impacting on the outcomes of vulnerable children and young people with additional learning needs, potential legal challenge via judicial reviews, involvement in education tribunals, increase in complaints, negative impact on BCUHB reputation, negative impact on partnerships, negative impact on staff security and wellbeing, conflict with BCUHB’s values.

Impact assessments were submitted to BCUHB’s planning team as part of the review of investments in July 2025.

## 7.3 General Challenges

In October 2024, it was recognised at a national level that there were a number of challenges in relation to ALNET Act implementation across education and health services, particularly in relation to consistent understanding and application of the legislation across Wales. As a result, the Cabinet Secretary for Education announced a legislative review.

BCUHB provided a response to Welsh Government as part of the legislative review in March 2025. The cabinet secretary released a statement in July 2025 announcing feedback from the process would be shared in Autumn 2025 (within year 5 of ALNET Act delivery).

BCUHB recognised a number of challenges as follows:

- ambiguities within the legislation in a general sense, leading to differing interpretation across Wales and within the geographical footprint of North Wales.
- conflicts with other relevant legislation (e.g., NHS Act)
- capacity and resource issues within the NHS (no additional funding has been allocated to support health boards to implement the ALNET Act).
- ambiguities in interpretation of the roles and responsibilities for NHS bodies under the ALNET Act.

## **8. PRIORITIES FOR YEAR FIVE (SEPTEMBER 2025-AUGUST 2026)**

- Explore and pursue workforce stability within ALNET Act team (Project Manager and Secretary roles).
- Restart QMS activity once capacity allows.
- Engage in next steps within BCUHB and at a national level following the release of outcomes from the legislative review.
- Engage in the final stages of developing of national KPIs.

## **9. SUMMARY AND CONCLUSION**

During academic year 2024–2025, BCUHB continued to implement its statutory responsibilities under the Additional Learning Needs and Education Tribunal (Wales) Act 2018, marking the final year of the national phased transition to the ALN system.

The Health Board maintained strong levels of compliance with its statutory duties, achieving 96% compliance for Section 65 requests and 99% compliance for Section 20 referrals, despite significant increases in demand across all areas of ALN-related activity. Governance arrangements were strengthened through consistent reporting to the ALNET Steering Group and Regulatory Assurance Group, while the introduction of a Quality Management System provided a structured and systematic approach to planning, monitoring, and improving ALN-related work.

Year four also saw notable progress in workforce development, multi-agency collaboration, and engagement with children, young people, and families. BCUHB contributed actively to national priorities, including the Welsh Government's legislative review and the development of national KPIs. Learning from tribunal involvement and a systematic review of multi-agency collaboration further informed improvements to training and operational practice.

However, the year was also characterised by significant challenges, particularly relating to workforce stability within the ALNET Act Team. The reliance on non-recurrent funding and fixed-term contracts led to vacancies in key administrative roles, resulting in reduced compliance during August 2025 and a temporary pause in quality assurance and improvement activities. Broader system-wide challenges such as legislative ambiguities, resource constraints, and inconsistent interpretation of statutory duties across Wales were also recognised and escalated through national review processes.

As BCUHB moves into year five (academic year 2025–2026), priorities will focus on securing a stable and sustainable workforce model, re-establishing full Quality Management System activity, responding to the outcomes of the Welsh Government's legislative review, and engaging in the final development of national KPIs.

Continued collaboration with partners, alongside strengthened governance and data systems, will be essential to ensure that the Health Board can meet its statutory obligations and contribute effectively to improving outcomes for children and young people with Additional Learning Needs across North Wales.

## 10. REFERENCES

1. **Welsh Government (2018), *Additional Learning Needs and Educational Tribunal (Wales) Act 2018.***
2. **Welsh Government (2021), *Additional Learning Needs Code for Wales 2021.***
3. **Stats Wales (2025), *Pupil Level Annual School Census.***

## Quality Safety & Experience Committee

### PROGRESS WITH DEVELOPMENT OF BCUHB LEARNING REPOSITORY

<b>Dyddiad y Cyfarfod Date of Meeting</b>	05 March 2026
<b>Statws Cyhoeddi Publication Status</b>	Open/ Public
	Not Applicable
<b>Enw a theitl Awdur(on) yr Adroddiad Report Author name and title</b>	Reena Cartmell Director of Nursing Quality Assurance and Organisational Learning
<b>Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol Lead Executive Team Member name and title</b>	Angela Wood, Executive Director of Nursing and Midwifery (Lead Executive)

<b>Pwrpas yr Adroddiad Report Purpose</b>	For Noting
---	------------

<b>Crynodeb Gweithredol Executive Summary</b>
The presentation outlines progress in developing a single Learning Repository to improve organisational learning and strengthen patient safety. The model brings together learning from multiple sources into one system, supporting clearer themes and better feedback to services. The Committee is asked to note progress and support the next steps.

<b>Ymgysylltu (mewnol/allanol) yr ymgwymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp) Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)</b>		
<b>Pwyllgor / Grŵp / Unigolion Committee / Group / Individuals</b>	<b>Dyddiad Date</b>	<b>Canlyniad, Tystiolaeth a Data Outcome, Evidence and Data</b>

<b>Acronymau / Rhestr Termiau Acronyms / Glossary of Terms</b>	
N/A	



---

## **PROGRESS WITH DEVELOPMENT OF BCUHB LEARNING REPOSITORY**

### **1. Y SEFYLLFA / SITUATION**

- 1.1 The Health Board is developing a central Learning Repository to strengthen organisational learning and support safer care. The presentation outlines the proposed model, core functions, and implementation approach.

### **2. Y CEFNDIR / BACKGROUND**

- 2.1 Special Measures highlighted inconsistent learning processes and fragmented systems. The Learning Repository will provide a single platform to collate learning from incidents, complaints, audits, and other intelligence, enabling clearer themes and improved feedback to services. The presentation summarises the learning model, data flows, categorisation approach, and plans for sharing learning across the organisation.

### **3. MATERION PENODOL I'W HYSTYRIED / SPECIFIC MATTERS FOR CONSIDERATION**






- 3.1 The Committee is asked to consider the resource, digital and governance support required to implement the Learning Repository effectively. Clear ownership, sustained analytical capacity, and alignment with the Quality Management System will be essential to ensure the repository delivers consistent thematic learning and supports meaningful improvement.

### **4. RISGIAU ALLWEDDOL / MATERION I'W HUWCHGYFEIRIO KEY RISKS / MATTERS FOR ESCALATION**

- 4.1
- Delivery requires strong executive support and engagement across services.
  - Digital and analytical capacity is needed to maintain the system and produce thematic insights.
  - Resource requirements for ongoing governance and operational support must be confirmed.
  - The initiative is central to addressing recurring themes identified in reviews and regulatory feedback.

### **5. ARGYMHELLION / RECOMMENDATIONS**

- 5.1 The Committee is asked to note contents of presentation.

ASESIAD / ASSESSMENT	
<p><b>Cyswllt â'r Blaenoriaethau Strategol</b> <b>Link to Strategic Priorities</b></p>	<div style="display: flex; justify-content: space-around; align-items: center;">      </div> <p>4. Improving quality, outcomes and experience</p> <p>Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:</p> <p>4. Improving quality, outcomes and experience <b>Simplify, Standardise, and Adopt Best Practices</b></p>
<p><b>Yr Egwyddorion Dylunio Design Principles</b></p>	<p>Simplify, Standardise, and Adopt Best Practices</p> <p>Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:</p>
<p><b>Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd</b> <b>Corporate Risks and Board Assurance Framework</b></p>	<p>Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR) BAF-SP18 and CRR-24-04 – Quality, Innovation and Improvement</p>
<p><a href="#"><u>Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant Wellbeing of Future Generations Act – Wellbeing Goals</u></a></p>	<p>A Healthier Wales</p> <p>Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:</p>

ASESIADAU O EFFAITH / IMPACT ASSESSMENTS		
<p><b>Cydraddoldeb</b> <i>A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o'r Effaith ar Gydraddoldeb (sy'n cynnwys gofynion Safonau'r Gymraeg)</i> <b>Equality</b> <i>Have you undertaken an Equality Impact Assessment Screening (which includes the</i></p>	<p>Do/Yes: <input type="checkbox"/></p>	<p>Naddo/No: <input checked="" type="checkbox"/></p>
	<p>Canlyniad/Outcome:</p>	
	<p>Os naddo, dylech gynnwys y rheswm: If no, please include rationale:</p>	

<p>requirements of the Welsh Language Standards)</p>		
<p><b>Asesiad o'r Effaith Economaidd-gymdeithasol</b> <i>A ydych chi wedi cynnal Asesiad o'r Effaith Economaidd-Gymdeithasol?</i> <b>Socio-Economic Impact Assessment</b> <i>Have you undertaken a Socio-Economic Impact Assessment</i></p>	<p>Do/Yes: <input type="checkbox"/></p>	<p>Naddo/No: <input checked="" type="checkbox"/></p>
	<p>Canlyniad/Outcome:</p>	
	<p>Os naddo, dylech gynnwys y rheswm: If no, please include rationale:</p>	
<p><b><u>Ansawdd</u></b> <i>A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?</i> <b><u>Quality</u></b> <i>Have you undertaken a Quality Impact Assessment Screening?</i></p>	<p><b>Galluogwyr Ansawdd Enablers of Quality</b> All Apply</p>	<p><b>Meysydd Ansawdd Domains of Quality</b> All Apply</p>
	<p>Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:</p>	<p>Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:</p>
<p><b><u>Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant Wellbeing of Future Generations Act – Wellbeing Goals</u></b></p>	<p>A Healthier Wales</p>	
<p><b>Effaith Amgylcheddol / Cynaliadwyedd (5Rs) Environmental /Sustainability Impact (5Rs)</b></p>	<p>Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:</p>	
	<p>No - Not Applicable</p>	
	<p>Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:</p>	
<p><b>Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog</b> <i>A ydych chi wedi ystyried Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog:</i></p>	<p>Do/Yes: <input type="checkbox"/></p>	<p>Naddo/No: <input checked="" type="checkbox"/></p>
	<p>Canlyniad/Outcome:</p>	
	<p>Os naddo, dylech gynnwys y rheswm:</p>	

<b>Armed Forces Covenant Due Regard Duty</b> Have you considered the Armed Forces Covenant Due Regard Duty?	If no, please include rationale:	
<b>Asesiad o Effaith ar Ddiogelu Data</b> <i>A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?</i> <b>Data Protection Impact Assessment</b> <i>Have you undertaken a Data Protection Impact Assessment Screening?</i>	Do/Yes: <input type="checkbox"/>	Naddo/No: <input checked="" type="checkbox"/>
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
<b>Asesiad o Effaith ar Atal Twyll</b> <i>A ydych chi wedi ystyried yr effeithiau ar atal twyll?</i> <b>Counter Fraud Impact Assessment</b> <i>Have you considered the counter fraud impacts</i>	Do/Yes: <input type="checkbox"/>	Naddo/No: <input checked="" type="checkbox"/>
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
<b>Cyfreithiol Legal</b>	Yes (Include further detail below)	
<b>Enw Da Reputational</b>	Yes (Include further detail below)	
<b>Effaith ar Adnoddau</b> <i>(Pobl / Ariannol)</i> <b>Resource Impact</b> <i>(People / Financial)</i>	Yes (Include further detail below)	
	Implementation of LTP framework April 2026	

Date 5th March 2026

# BCUHB Learning Repository

Supporting safer care through better organisational learning



GIG  
CYMRU  
NHS  
WALES

Bwrdd Iechyd Prifysgol  
Betsi Cadwaladr  
University Health Board

# Executive Summary



## The Context

Since being placed in **Special Measures** in February 2023, the Health Board has recognised an **urgent need** to improve how we learn from experiences.

The goal is to move from fragmented data to a **consistent, reliable** way to capture and share learning.



## The Solution

The **Learning Repository** is a new **central library** that collects inputs (incidents, feedback, audits) and converts them into quality-assured learning themes.

It provides a **single source of truth** for the organisation.



## The Impact

By identifying **system-wide patterns** rather than isolated incidents, we support **joined-up working**, transparency, and **better decision-making**.



## The Timeline

Currently in **early-adopter testing (Pharmacy pilot)**.

Full **roll-out programme** begins **early 2026**.



GIG  
CYMRU  
NHS  
WALES

Bwrdd Iechyd Prifysgol  
Betsi Cadwaladr  
University Health Board



# A central, shared library accessible to all staff

**Open Access:**  
Transparent and accessible learning for all staff members, regardless of department.



**User-Centric:**  
Designed with easy navigation and categorisation.

The Learning Repository / Single Source of Truth

**Clarity:** The interface and content use everyday language to ensure messages are understood immediately.



**Single Source:**  
A definitive library that prevents conflicting information.

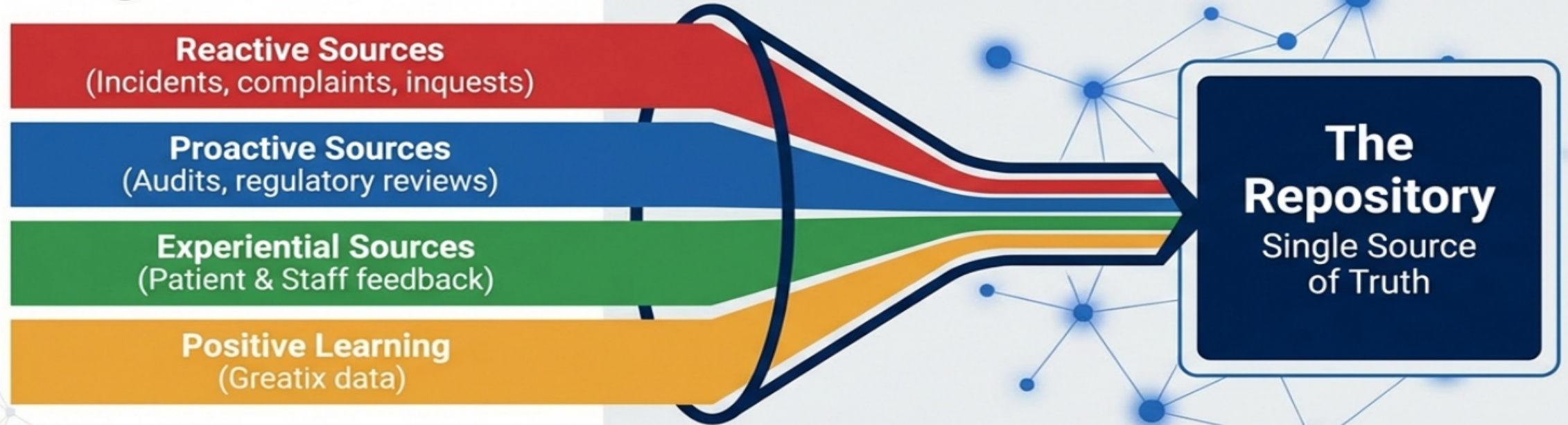


GIG  
CYMRU  
NHS  
WALES

Bwrdd Iechyd Prifysgol  
Betsi Cadwaladr  
University Health Board



# Aggregating diverse data streams into a single source of truth



**Strategic Note:** Currently, we are capturing learning inputs from established existing groups to feed into the repository.



# A quality-assured lifecycle ensures only validated learning is shared



# Content formats tailored for different consumption needs



## 1. Learning Snips

Quick, bite-sized insights.  
Designed for rapid consumption  
by busy frontline staff.



## 2. Learning Modules

A deeper dive into specific topics.  
Used when comprehensive  
understanding is required.



## 3. Learning Paths

Structured learning journeys.  
A curriculum-based approach  
for complex subjects.



GIG  
CYMRU  
NHS  
WALES

Bwrdd Iechyd Prifysgol  
Betsi Cadwaladr  
University Health Board



# Built-in intelligence for monitoring and distribution

## Smart Distribution

Automated notifications ensure the right teams see the right information immediately.



## Dashboards

Insightful visualisations to show trends and risks in real-time.



## Audit Trail

Full visibility of who has accessed learning to track engagement.



## Searchability

An easy-to-search layout ensuring historical lessons are never lost.



**Pilot Status: Active**

# Pilot Case Study: Pharmacy

## 1. Context

The Pharmacy team is the first group testing the new process.

## 2. The Use Case

They are specifically using the Repository to generate learning from "critical medication omissions".

## 3. The Strategy

This approach supports a safe and controlled rollout, allowing us to refine the QA and notification processes before onboarding the wider organisation.

**TESTING IN  
PROGRESS**



GIG  
CYMRU  
NHS  
WALES

Bwrdd Iechyd Prifysgol  
Betsi Cadwaladr  
University Health Board



Thank you  
Any Questions?



GIG  
CYMRU  
NHS  
WALES

Bwrdd Iechyd Prifysgol  
Betsi Cadwaladr  
University Health Board



## Quality Safety & Experience Committee

### QS26.Adult Mental Health & Learning Disabilities

<b>Dyddiad y Cyfarfod</b> <b>Date of Meeting</b>	05 March 2026
<b>Statws Cyhoeddi</b> <b>Publication Status</b>	Open/ Public
	Not Applicable
<b>Enw a theitl Awdur(on) yr Adroddiad</b> <b>Report Author name and title</b>	Zoe Prince, Director of Nursing, MHLD Carole Evanson, Director of Operations, MHLD
<b>Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol</b> <b>Lead Executive Team Member name and title</b>	Teresa Owen, Executive Director of Allied Health Professions & Health Science

<b>Pwrpas yr Adroddiad</b> <b>Report Purpose</b>	For Approval
---	--------------

#### **Crynodeb Gweithredol** **Executive Summary**

The Mental Health & Learning Disabilities (MHLD) Division continues to operate in a highly pressured and complex environment.

Over the past year, the improvement agenda has moved from planning to delivery, driven by the findings of several external reports. Governance has strengthened, leadership accountability is clearer, and there is increasing evidence of positive impact for both patients and staff. However, significant challenges remain, particularly in Community Mental Health Team (CMHT) capacity, waiting times, ligature risk reduction, and the consistency of service user experience.

This paper sets out the Division's improvement journey aligned to aspects of quality, safety, and experience - what has improved, what needs to be strengthened, and what will be done next, to enable QSE to take assurance that the Division knows its business and has credible plans.

#### **QSE priority headlines:**

- Mental Health Measure (MHM): Part 1 performance is improving with reduced long waits overall, but variation between localities persists, especially in the West

- driven by workforce fragility and CMHT pressure. Strengthened triage/Standard Operating Procedures (SOPs) and digital preparations for Electronic Health Record (EHR) are supporting improvement.

- Community Mental Health Teams (CMHTs): High demand and complex caseloads impact access, care coordination and communication. A short-term recovery plan is in place; longer-term redesign (Open Access demonstrator and crisis alignment) is underway. Risks and mitigations are set out for assurance.
- Mortality: The Divisional Mortality Group is finalising Q3/Q4 thematic work; a full Mortality Report will come to QSE in April 2026 (agreed with the Quality Team). Early themes include communication with families and documentation. No Prevention of Future Deaths notices have been received since early 2025.

**Ymgysylltu (mewnol/allanol) yr ymgwymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp)**

**Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)**

<b>Pwyllgor / Grŵp / Unigolion Committee / Group / Individuals</b>	<b>Dyddiad Date</b>	<b>Canlyniad, Tystiolaeth a Data Outcome, Evidence and Data</b>
The report will be received at DSLT 24 <sup>th</sup> February 2026 in advance of the QSE Meeting on the 05 March 2026	24/02/2026	

**Acronymau / Rhestr Termiau**

**Acronyms / Glossary of Terms**

ACIG	Actions from Complaints and Incidents Group
CLDT	Community Learning Disability Team
CMHT	Community Mental Health Team
DNA	Did Not Attend
DSLT	Divisional Senior Leadership Team
EAG	Expert Advisory Group
EHR	Electronic Health Record
GP	General Practitioner
HB	Health Board
HIW	Health Inspectorate Wales
HSE	Health & Safety Executive
HSE NOC	Health & Safety Executive Notice of Contravention
ICOP	Integrated Concerns Operational Procedure
IMHA	Independent Mental Health Advocate
MDT	Multi-Disciplinary Team
MHA	Mental Health Act
MHLD	Mental Health & Learning Disabilities
NEWS2	National Early Warning System 2

NRI	National Reportable Incidents
OOA	Out of Area
PALS	Patient Advice and Liaison Service
PIDG	Programme Improvement Development Group
PROMS	Patient Reported Outcome Measures
PTR	Putting Things Right
QDG	Quality Delivery Group
QR	Quick Response
RCPsych	Royal College of Psychiatrists
ReQoI	Recovery of Quality of Life
RPI	Restrictive Physical Intervention
SITREP	Situation Report
SOPs	Standard Operating Procedures
WTE	Whole Time Equivalent

## MHLD QUALITY, SAFETY AND EXPERIENCE COMMITTEE REPORT.

### 1. Y SEFYLLFA SITUATION

This report provides an update on the three core domains of Quality, Safety and Experience within the Mental Health & Learning Disabilities (MHLD) Division. It brings together key issues, progress, and remaining risks across the system, with focused sections on Community Mental Health Teams (CMHTs), the Mental Health Measure (MHM) and a brief update on mortality, alongside a broader overview of the Division's ongoing improvement journey.

### BACKGROUND Y CEFNDIR

#### BACKGROUND

The Division continues its journey of rebuilding safe, consistent, recovery-focused Mental Health and Learning Disability Services across North Wales. Over the past two years, improvement work has shifted from planning to delivery, with clearer governance, stabilised leadership structures and increased engagement with people who use our services.

In 2024-25 services were under intense pressure with variation in access and experience, particularly in community pathways. External scrutiny (RCPsych Review, HIW, HSE) has focussed the improvement programme.

Over the last year the Division has consolidated governance (ward-to-board), Multi-Disciplinary Team (MDT) processes, learning cycles (incidents, complaints, mortality), and service user engagement, with visible impact in parts of the system. However, CMHT capacity, waiting times and consistency of care coordination remain the most material risks to quality, safety, and experience.

The team are accelerating delivery in 2026/27 through (i) short-term recovery in CMHTs, (ii) community redesign via the Open Access demonstrator, (iii) digital readiness for the Mental Health EHR and (iv) working to complete priority actions in HSE NOC ligature, RCPsych building blocks and PTR/NRI timeliness.

## **2 Quality / Ansawdd**

### **2.1 RCPsych Invited Review – Progress and Patient Impact**

The Health Board received a comprehensive update on 29<sup>th</sup> January 2026 confirming progress across the nine building blocks and 80 improvement actions. Impacts include more consistent clinical standards, stronger ward-to-Board governance, improved MDT working, and more reliable learning from incidents, complaints, and reviews. The Mental Health Oversight & Development Group, chaired by the CEO, provides additional grip and pacing. Risks remain around uneven adoption and the need to translate system changes into consistent patient experience. Mitigation includes targeted support to areas where additional support is needed and outcome-tracking via Quality Delivery Group (QDG) and Programme Improvement Development Group (PIDG).

## **3. Deep Dive: Community Mental Health Teams (CMHTs)**

This is an area of significant interest to QSE and an important marker of patient access and quality.

This matters because CMHT performance is the primary determinant of access, equity, and experience for most patients. Demand, acuity, and workforce gaps, especially in the West, continue to drive waiting times and variation. This is the most material operational risk in MHLD.

### **3.1 Current position**

Teams deliver multidisciplinary support across all six local authorities (covering Primary/Secondary Care and crisis activities). Pressures arise from high demand, complex caseloads and resource shifts aligned to local wellbeing models. Joint working with local authorities is underway, to review and redesign how teams continue to work together.

Operational challenges are amplified by staff holding multiple roles (care coordinator, caseload, crisis duty) which impacts consistency of care coordination and communication. Understanding these competing demands on an individual as well as a team are key to informing improvements around Part 2 of the Mental Health Measure and more broadly caseloads and demand. Whilst the Division has been consistent in overall performance against the Measure, compliance has not been achieved consistently across teams.

---

### **3.2 What has improved**

Clearer referral and triage SOPs, improved risk assessment aligned to the All-Wales Safety Planning Model and better alignment of Part 1/Part 2 reporting. Short-term data fixes are in place while the EHR is procured (implementation expected to begin Q1/Q2 2026/27, subject to Welsh Government approval). A strengthened crisis model, with investment into the Home Treatment Team to support patients closer to home and reduce admissions.

### **3.3 What needs strengthening**

As at 19<sup>th</sup> February 2026 there are 355 patients waiting in excess of the 28-day target for an assessment and 415 in excess of the 28-day target waiting for an intervention. Workforce fragility, particularly in the West, due to a smaller team with differing staffing model, continues to contribute to operational challenges. Improved communication with patients and families also needs strengthening (feedback from engagement events).

### **3.4 Next Steps (assurance for QSE)**

Short-term recovery plans across localities to reduce the number of patients waiting over 28 days and stabilise care coordination. These plans are being worked through, noting that these are short to medium term solutions, with the implementation of Phase 2 crisis/CMHT alignment with the Open Access Model to offer same-day, needs-led support and simplify access, as part of the longer-term strategic plans for the redesign of Mental Health Services in North Wales. A Business Case is being developed for a Recovery College aligned to the new Welsh Government strategy.

Divisional activity to support workforce capacity and recruitment and retention has included, through 2024-2026, implementation of the All-Wales Mental Health Safecare for Mental Health Acute and Older Adult Wards for the nursing element of inpatient wards. Safecare enables the Division to benchmark across other similar wards in BCU and enable intelligence on acuity and safer staffing. Safecare information will form part of the new MHLI Inpatient Safer Staffing Review, due to commence in March 2026. There has been a compliance improvement in completing the Safecare System at 83.12% as of 1<sup>st</sup> February 2026 compared to 66% in December 2025.

Digital readiness has been assessed for the implementation of the Mental Health EHR to standardise records, reduce duplication and provide real-time access to risk and care plans. Following the completion of a detailed tender exercise and Procurement Assurance activity, an updated Business Case (including refined Implementation and Business as Usual resources) and the Procurement Outcome Report were approved at the BCUHB Health Board Meeting on 29<sup>th</sup> January 2026. Due to the value of the contract, the Health Board is now seeking Welsh Government approval to appoint the supplier. Once approval is received, the suppliers will be informed of the procurement outcome.

Anticipated timescales are as follows:

Activity	Anticipated timescales
WG approval to appoint the supplier (As in excess of £1m)	February 2026
Standstill Period	10 days
Commercial Execution with supplier	Quarter 1 2026/27
Implementation and Mobilisation	Quarter 2 2026/27

Readiness activities continue such as engagement, process mapping, recruitment to the change team and end user device procurement. The implementation of this digital platform will address many of the quality and safety issues presented with a paper-based system such as timeliness of completing live records and communication of clinical information.

Oversight sits with SQDG/PIDG and risks are on the Divisional Risk Register with monthly review. The Division seeks continued QSE support for the CMHT Recovery and Open Access business cases.

#### 4. Deep Dive: Mental Health Measure (MHM)

The Mental Health Measure is intended to ensure that where mental health services are delivered, they focus more appropriately on people's individual needs.

Part 1 – Assessment & Intervention. Overall performance has strengthened with reduced long waits. Variation remains between localities (Anglesey and the West in general are the most challenged). Process improvements and triage changes are helping, but workforce capacity is the limiting factor. As noted in 3.4 above, divisional activity is progressing to support workforce capacity and recruitment and retention.

Part 2 – Care & Treatment Planning and Care Coordination. More challenged due to caseload complexity, workforce fragility and variation in MDT availability. Consistency in care coordination remains a core focus of the CMHT recovery plan and redesign.

Part 3 - Self-referral. An individual who has previously been treated in secondary care can request an assessment, should they feel their health is deteriorating. On discharge from services, all patients are advised of their right under Part 3. The number of patients that refer themselves back into service is low, which accords with the position in Health Boards across Wales. Throughout 2025 MHLD have arranged 90 Part 3 assessments across the Division as a whole. Of the 90 patients, 66 patients

were assessed, the remaining cancelled or did not attend (DNA). Following assessment, 27 patients were returned into services.

Patients often take the previous referral path (via GP) to refer into service despite their right to access. To support better uptake, the Community Transformation Group have redesigned patient discharge letters to include information on patients' rights under Part 3, together with in-hours and out-of-hours contact numbers, '111 press 2' and CALL helpline numbers. A QR code is also included on these letters directing patients to a BCU website support page.

Part 4 - Independent Advocacy for inpatients/individuals subject to the Mental Health Act (MHA) 1983. It is the only part that directly amends the Mental Health Act for people in Wales and it does so by extending the right to IMHA to all people admitted to Psychiatric Hospitals. Specifically, it extends the right to:

- patients on the shorter-term, emergency sections of the Act (principally Sections 4 and 5), and
- patients in hospital voluntarily or "informally" (in other words, not subject to the Mental Health Act).

BCU commissions both statutory and non-statutory advocacy services to ensure patient rights are upheld and supported. BCU are fully compliant with this.

Part 5 - Cooperative and joint working between Local Health Boards and local authorities. Collaborative work between the Health Board and individual Local Authorities is progressing, with a focus on reviewing and redesigning joint working arrangements following the withdrawal of Local Authority staff from CMHTs.

Part 6 - Miscellaneous and supplemental. This outlines specific administrative details and regulations.

Whilst the Mental Health Measure has 6 Parts, the scrutiny from the Welsh Government and NHS Performance & Improvement is mainly on Parts 1 and 2.

With regards to the continuing work aligned to Parts 1 and 2, immediate next steps are consideration of capturing all primary care activity on the Mental Health Measure SharePoint site, with additional data quality elements to aid data entry and improve quality of reporting. The benefit of this can be then considered for other parts of the service, but this will be dependent on the implementation of the EHR. Having a more consistent approach will mean assurance around any changes in delivery performance, both positive and negative.

The Division has seen significant improvement over the last two years with more regional teams moving into compliance and reducing the number of long waits (patients waiting in excess of the 28 days target). Expectations to deliver the special measure target of 65% for both Part 1a and 1b of the MHM have been exceeded consistently, and the Division is working towards sustained delivery of the NHS Performance Framework target of 80%.

In addition to the Wales Mental Health Measure performance for Part 1, the Division monitors by local area to ensure a consistent and equitable offer for patients, monitoring waiting lists as well as compliance.

As at 19<sup>th</sup> February 2026 there were 355 patients waiting in excess of 28 days for an assessment and 415 patients waiting in excess of 28 days for an intervention - see regional split in table below.

Part 1	Patients waiting in excess of 28 days for assessment	Patients waiting in excess of 28 days for intervention
Anglesey	318	226
Gwynedd	16	95
Conwy	3	17
Denbighshire	18	48
Flintshire	0	26
Wrexham	0	3

The Division needs to reduce these numbers further, but also needs to address the regional variance. There is a different staffing model in the West, and this smaller team is more acutely impacted by absences and vacancies. Short/medium term recovery plans are in place to address this, while longer-term strategic plans for the redesign of Mental Health Services in North Wales are developed.

The MHLD Community Transformation Pathway Group is well developed, and this group provides opportunity for staff from across the teams, to share successes, report on issues, compare practice and consider and agree national and local requests for information and change. The group has recently reviewed its work over the year to reflect on benefits and consider the next steps

The Division would want to highlight to QSE members that a coherent plan is in place which includes a focus on immediate operational recovery plus longer-term redesign and digital enablement to secure sustainable compliance with Parts 1 and 2.

There is a risk is ongoing variation, with key mitigations aligned to targeted workforce actions, "Open Access" and EHR standardisation.

## 5. Mortality – Update and Next Steps

The Divisional Mortality Group continues to strengthen thematic review, with learning fed into Clinical Effectiveness, the Divisional Learning Forum, ACIG and PIDG. Q3/Q4 2025/26 thematic analysis is being finalised. A full Mortality Report will be presented to QSE in May 2026; this approach and timing have been agreed with the Quality Team. There have been no Prevention of Future Deaths notices since early 2025.

Many individual reviews did not identify direct failings in care or clear breaches of duty and care was often compassionate, proportionate and aligned with professional standards. Overall, however, early themes include communication with families, documentation, quality of risk formulation and timeliness of reviews. The Division embeds learning via targeted audit and Divisional Learning Events (the next events are scheduled for April and October 2026).

## **6. Safety / Diogelwch**

### **6.1 HSE Notices of Contravention (NOC)**

#### **Health and Safety Executive - Notice of Contravention (NOC)**

Following an incident on Tegid Ward in 2024 and subsequent HSE investigation, two NOCs were issued in 2025 (ligature risks/mandatory training). Action plans for ligature, training, and the external review are monitored via fortnightly PIDG Meetings. Ligature-reduced assets have been piloted; the Division is working with the Health Board on the wider ligature programme, including establishing a Ligature Programme Board and appointing a Ligature Operational Lead.

With regards to training, 357 inpatient staff have completed ligature awareness/cutter training. All-Wales ligature policy/procedure and environment assessment documentation are being implemented and in December 2025 compliance with annual environmental assessments was 93%.

For QSE assurance, oversight and delivery grip have strengthened, however programme level HB actions (governance and resourcing) remain critical. The Division requests that QSE notes the progress and supports HB-wide ligature arrangements to sustain compliance.

### **6.2 Physical Health and Safer Care**

The Physical Health Procedure for mental health settings and NEWS2 is in place across inpatient areas. Engagement continues with the Health Board's Oxygen Safety Improvement Plan, recognising the number of incidents relating to oxygen safety are low in MHL. In 2025, 25 Oxygen incidents were reported, however none of these related to oxygen flow or resulted in harm to the patient due to the use of oxygen. Patient falls are monitored via ICOP/IHC, with falls training compliance at 93.86% in February 2026.

The Division is engaged in the Datix Cymru Pilot for Learning Disabilities (LD) Services. In December 2025 93 Mental Health (MH) restraints were recorded (down from 109) and seven LD restraints (six linked to one patient). RPI compliance was at 86% overall, with LD inpatient services at 61% against the 85% target, with improvement actions ongoing.

---

A MHLD Risk Governance Audit 3 Report received 5<sup>th</sup> February 2026 noted a significant improvement on the previous audit, with the Division now moving into the 'Advanced' category of risk governance maturity for achieving consistently high standards of risk governance over the last two years.

### **6.3 Health Inspectorate Wales (HIW)**

There is one active plan (Hergest Unit) with 68% of actions completed (10<sup>th</sup> February 2026) and four actions are overdue but in progress. Inspectors highlighted strong compassion and professionalism, while required improvements include therapeutic activity, record keeping and aspects of environment. These are being addressed as part of the action plan work.

A joint HIW/CIW review of Conwy Community Learning Disability Team (CLDT) was undertaken in February 2026, with a formal report expected in March 2026.

## **7. Experience / Profiad**

### **7.1 Service User Engagement**

Seven engagement events have taken place across North Wales over an eight-month period, attended by 230+ people with lived experience. Feedback from these sessions has provided a clear indication on the best approach to engagement, involvement, and co-design of Mental Health services in a meaningful way, and in the development of a North Wales Recovery College approach. A Recovery College business case has been co-produced and funding opportunities are currently being explored.

### **7.2 CIVICA – Patient and Carer Experience**

All services are now mapped to CIVICA for monthly reporting and improved visibility across pathways. Response rates are improving since the introduction of the Easy Read survey launched in April 2025, Feedback Friday has been expanded and QR codes embedded in letters and displayed in clinical areas. In December 2025 85% people/patients rated experience "good/very good" (low response numbers are acknowledged). Collaboration with PALS continues to enable real-time feedback and increase leadership visibility.

### **7.3 Out of Area (OOA) Placements**

The OOA placement numbers are reducing, in order to improve experience and continuity of care. A strengthened SITREP and a dedicated action group provide oversight and earlier escalation. Work is progressing to develop a road map to reduce the OOA position to zero. The Division currently on target to reduce the OOA position to 10 by the end of March 2026. This is reduced from a peak of 38 OOA beds in August 2025/26. Focus remains on close monitoring, proactive discharge, and shorter length of stay where appropriate.



---

## 7.4 Putting Things Right (PTR), NRIs and Inquest

There are no overdue complaints. Thirteen complaints are open (all within timescale), 208 complaints were closed in 2025 (on average 23 working days). Themes are access to services, care coordination (workforce/role mix), contact difficulties, neurodevelopmental delays, and medication issues. Approximately a quarter referenced challenges meeting neurodivergent needs, and additional staff training around this is being strengthened.

Regarding NRIs, six cases are currently under review and 20 NRIs/Early Warnings were closed in 2025. Themes identified include communication, contacting services, documentation/record-keeping, observation practice and risk formulation.

Six inquests were held in January 2026. The outcomes were as follows: one was misadventure, two were suicide, three are pending. No Prevention of Future Deaths reports have been received since early 2025.

## 8. Workforce and Culture

Medical workforce remains challenging, while nursing vacancies have trended downward in 2025/26 and have remained at their lowest level for over twelve months at 6.7%, equating to 63.1 WTE. The Division has recruited fourteen International Nurses into positions, with a further six due to commence in March 2026. In addition, the Division is expecting a new cohort of student streamliners in March 2026 and progressing for the following cohort in September 2026. The Division remains focussed on improving the position via the MHL D Recruitment & Retention Working Group.

The Wellness, Work & Us (WW&U) Programme has supported 580+ staff with 1:1 support and improved counselling access (wait times for WW&U at 11 days compared to 91-121 days for HB Occupational Health), leadership development, cultural work and Staff Connect supports retention and experience.

The Divisional Senior Leadership Team (DSL T) has a Visibility Walkabout schedule which includes drop-in sessions for patients, families, and carers, providing an opportunity to meet, discuss any concerns and provide feedback to members of the DSL T on patient experience, whilst using Mental Health and Learning Disability Services across the whole Division. PALS support has been provided to enable a joint approach to receipt of real-time patient feedback. This has been operating regularly since mid-2024.

## 9. Divisional Learning

Learning is captured and applied through a Divisional Learning Forum, ACIG and PIDG (fortnightly) and Mortality Group. Themes from 2025 include communication,

expectation management, documentation, therapeutic observation standards and risk formulation. Divisional Learning Events are scheduled for April and October 2026 to embed system-wide learning.

## **10. The focus for the Next Quarter is:**

- CMHT recovery progress (access, care coordination, communication) and Open Access demonstrator milestones.
- Full Mortality Report to QSE (To be confirmed, potentially May 2026) and subsequent learning actions.
- PTR, inquest and NRI timeliness - sustained performance and evidence of learning application.
- HSE ligature actions - programme governance and delivery updates.
- Mental Health EHR implementation plan and readiness.
- RCPsych priority closure evidence and HIW action plan progress (Hergest).

## **11. MATERION PENODOL I'W HYSTYRIED /SPECIFIC MATTERS FOR CONSIDERATION**

1. Note progress and the remaining HB-level actions required to complete the HSE Ligature Programme (Programme Board, Operational Lead, estate standards).
2. Note the Mortality reporting position (full report April 2026 QSE - approach agreed with the Quality Team).
3. Note the CMHT recovery and Open Access proposals to address access, variation, and experience risks.

## **12. RISGIAU ALLWEDDOL / MATERION I'W HUWCHGYFEIRIO KEY RISKS / MATTERS FOR ESCALATION**






- HSE NOC (Ligature) - residual risk until HB Programme arrangements are fully implemented and sustained.
- CMHT modernisation - risk to safety and experience arising from delays and variation in access and coordination.
- Mortality learning - recurring themes (communication, documentation, risk formulation) require sustained practice change.

## **13. Recommendations / Argymhellion**

The Committee is asked to:

---

1. Support the progress to date and endorse continued delivery of RCPsych, HSE NOC actions and CMHT redesign.
2. Note the Mortality reporting plan (full report to next QSE meeting) and alignment with the Quality Team.
3. Support the direction of travel for Open Access and EHR enablement as levers to reduce variation and improve safety and experience.

ASESIAD / ASSESSMENT	
<b>Cyswllt â'r Blaenoriaethau Strategol</b> <b>Link to Strategic Priorities</b>	     4. Improving quality, outcomes and experience
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
<b>Yr Egwyddorion Dylunio</b> <b>Design Principles</b>	Choose an item. Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below: People First Equity and Accessibility
<b>Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd</b> <b>Corporate Risks and Board Assurance Framework</b>	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)  Risks relate to CMHT access/variation, HSE ligature compliance, and delivery of improvement programmes (cross-reference Divisional and Corporate registers).

ASESIADAU O EFFAITH / IMPACT ASSESSMENTS		
<b>Cydraddoldeb</b> <i>A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o'r Effaith ar Gydraddoldeb (sy'n cynnwys gofynion Safonau'r Gymraeg)</i> <b>Equality</b>	Do/Yes: <input type="checkbox"/>	Naddo/No: <input checked="" type="checkbox"/>
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	EQIA impacts are considered in any of the necessary policy changes and adaptations

<i>Have you undertaken an Equality Impact Assessment Screening (which includes the requirements of the Welsh Language Standards)</i>		
<b>Asesiad o'r Effaith Economaidd-gymdeithasol</b> <i>A ydych chi wedi cynnal Asesiad o'r Effaith Economaidd-Gymdeithasol?</i> <b>Socio-Economic Impact Assessment</b> <i>Have you undertaken a Socio-Economic Impact Assessment</i>	Do/Yes: <input type="checkbox"/>	Naddo/No: <input checked="" type="checkbox"/>
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	SEIA impacts are considered in any of the necessary policy changes and adaptations.
<u><b>Ansawdd</b></u> <i>A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?</i> <u><b>Quality</b></u> <i>Have you undertaken a Quality Impact Assessment Screening?</i>	<b>Galluogwyr Ansawdd Enablers of Quality</b> Choose an item.	<b>Meysydd Ansawdd Domains of Quality</b> All Apply
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
<u><b>Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant Wellbeing of Future Generations Act – Wellbeing Goals</b></u>	Not Applicable	

<b>Effaith Amgylcheddol / Cynaliadwyedd (5Rs) Environmental /Sustainability Impact (5Rs)</b>	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
	No - Not Applicable	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:	
<b>Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog</b>	Do/Yes: <input type="checkbox"/>	Naddo/No: <input checked="" type="checkbox"/>
	Canlyniad/Outcome:	

<p>A ydych chi wedi ystyried Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog: <b>Armed Forces Covenant Due Regard Duty</b> Have you considered the Armed Forces Covenant Due Regard Duty?</p>	<p>Os naddo, dylech gynnwys y rheswm: If no, please include rationale:</p>	<p>Considered as part of access and communications standard; no specific impacts identified in this update.</p>
<p><b>Asesiad o Effaith ar Ddiogelu Data</b> <i>A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?</i> <b>Data Protection Impact Assessment</b> <i>Have you undertaken a Data Protection Impact Assessment Screening?</i></p>	<p>Do/Yes: <input type="checkbox"/> Canlyniad/Outcome:</p>	<p>Naddo/No: <input checked="" type="checkbox"/></p>
<p><b>Asesiad o Effaith ar Atal Twyll</b> <i>A ydych chi wedi ystyried yr effeithiau ar atal twyll?</i> <b>Counter Fraud Impact Assessment</b> <i>Have you considered the counter fraud impacts</i></p>	<p>Do/Yes: <input type="checkbox"/> Canlyniad/Outcome:</p>	<p>Naddo/No: <input checked="" type="checkbox"/></p>
<p><b>Cyfreithiol</b> <b>Legal</b></p>	<p>There are no specific legal implications related to the activity outlined in this report.</p>	
<p><b>Enw Da</b> <b>Reputational</b></p>	<p>Yes (Include further detail below) No specific legal implications beyond HSE NOC compliance; reputational risk remains should progress stall</p>	
<p><b>Effaith ar Adnoddau</b> <i>(Pobl / Ariannol)</i> <b>Resource Impact</b> <i>(People / Financial)</i></p>	<p>Within existing resources unless otherwise stated in CMHT/Open Access /EHR business cases.</p>	

## Quality Safety & Experience Committee

### Update on Postgraduate Medical Education

<b>Dyddiad y Cyfarfod Date of Meeting</b>	05 March 2026
<b>Statws Cyhoeddi Publication Status</b>	Open/ Public
	Not Applicable
<b>Enw a theitl Awdur(on) yr Adroddiad Report Author name and title</b>	Ms Emma Woolley Associate Medical Director for Medical and Dental Education
<b>Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol Lead Executive Team Member name and title</b>	Dr Clara Day- Executive Medical Director
<b>Pwrpas yr Adroddiad Report Purpose</b>	For Noting

### Crynodeb Gweithredol Executive Summary

BCUHB is commissioned by HEIW to provide the postgraduate medical training of approximately 500 resident doctors that meet the General Medical Council standards for the learning environment as detailed in [Promoting excellence - GMC \(gmc-uk.org\)](http://www.gmc-uk.org).

This paper:

- explains the GMC-led quality assurance process for formal training posts
- outlines how GMC standards for education include domains relating to patient safety and culture in the Health Board
- highlights the financial and workforce risks to the Health Board
- identifies the departments and services in BCU that are failing to meet or are carrying risks to attaining the GMC standards
- outlines the actions and mitigation in place to manage risk
- highlights selected case studies for success in meeting GMC standards

**Ymgysylltu (mewnol/allanol) yr ymgwymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp)**  
**Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)**

<b>Pwyllgor / Grŵp / Unigolion Committee / Group / Individuals</b>	<b>Dyddiad Date</b>	<b>Canlyniad, Tystiolaeth a Data Outcome, Evidence and Data</b>
Executive Committee	11/02/2026	For assurance

**Acronymau / Rhestr Termiau**  
**Acronyms / Glossary of Terms**


## Educational Governance – Postgraduate Medical Training Environment BCUHB

### *‘Resident doctors are the ears and eyes of the hospital’*

The General Medical Council is the statutory body responsible for the standards of medical education and training of doctors in the UK.

In Wales, HEIW are accountable to the GMC for the quality management of medical education and training posts. BCUHB, as a Local Education Provider (LEP), is commissioned to provide the postgraduate medical training of approximately 500 resident doctors and as part of the service level agreement must meet the GMC standards for the learning environment as detailed in [Promoting excellence - GMC \(gmc-uk.org\)](#).

The majority of teaching and learning occurs in the practice of delivering healthcare to our patients and thus these training grade posts provide a considerable service element. The majority of posts are funded by HEIW, a budget that is currently worth £17,966,959.

Thus, failure to meet GMC standards threatens recognition of training posts and has both a service and financial implication for the HB.

We are currently commissioned to provide posts for:

- **176** Foundation year 1 and 2 trainees
- **304** Specialty Core and Higher trainees
- **2** GP trainees in HB managed practice (A further **135** GP trainees posts are hosted in independent GP practices)

BCUHB also hosts **14** specialty trainees from the North West region of England

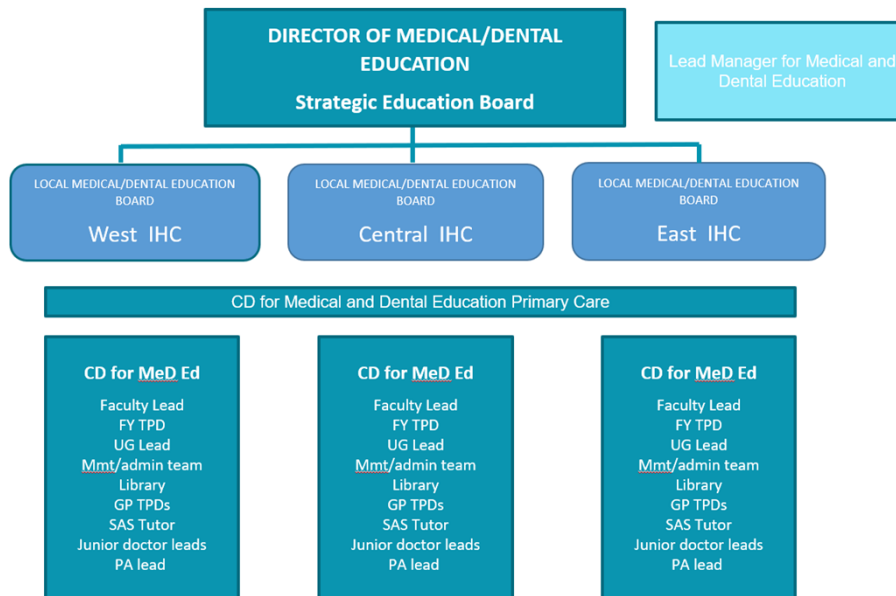
Each trainee requires a nominated Educational Supervisor and 1 to 3 Named Clinical Supervisors to oversee their learning and progress within clearly defined GMC approved curricula. BCUHB has signed up to the nationally agreed tariff of 0.25 of an Supporting Professional Activity (SPA) in job plans for each role per trainee. Supervisors must be GMC recognised trainers and have to maintain this accreditation on an annual basis.

Trainees, trainers and departments are supported by Medical Education teams based at all 3 main hospital sites and a primary care Clinical Director (CD) for Medical & Dental Education. All 3 IHCs have a dedicated Medical Education team with a CD for Medical & Dental Education and lead manager who oversee education quality, risk, and wellbeing needs. Medical Education teams report to the Director of Medical and

Dental Education and overall Lead Manager for Medical & Dental Education on behalf of the Executive Medical Director.

## Local Educational Governance

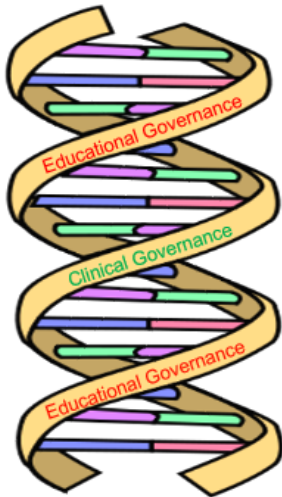
The figure below outlines the governance and reporting mechanisms with Medical & Dental Education.



## BCUHB Organisational Governance and Stakeholder Reporting

Governance outside of the local department has been fragmented as each education department interacts differently with the IHC leadership (see shaded area in diagram below). Educational governance has worked best where a clinical department's clinical lead, education lead and specialty manager understand and take responsibility for the management of education threats, risks and quality improvement in partnership with the medical education team. It has also been difficult to ensure the correct audience for Medical & Dental Education Reporting at pan-BCUHB level. It is hoped that the establishment of the Education Steering Committee, future operating model and a final governance structure will address this. In the meantime this overview is provided for Quality Safety and Experience Committee, with Medical Education a key pillar of Clinical Governance.

## GMC survey and responding to HEIW risk register



As part of its quality assurance function, the GMC undertake an annual survey of all trainees and trainers throughout the UK which generates the majority of the data used by HEIW to highlight potential risks and areas of good practice. It is important to understand that the **GMC consider a good teaching and learning environment cannot exist within a healthcare setting that is not providing safe, effective and quality patient care.** The survey questions are therefore wide-ranging and not restricted to pure medical teaching activities. It is also important to understand that medical education in this sense is **not** just the formal, stand-alone teaching sessions provided by an LEP but the learning that must take place in the clinical environment in which developing

doctors learn the practice of medicine i.e., busy and often pressured clinical services.

It also surveys GMC accredited trainers/supervisors.

The annual survey therefore provides insights and data into the functioning of the whole Health Board in its endeavour to provide healthcare for our North Wales's population as regards:

- Safety and quality
- Culture
- Staff well-being
- Recruitment and retention
- Finance and performance
- Clinical effectiveness
- Bullying and undermining

The survey usually runs from March to May and the results released to HEIW and the HB in July. The raw data requires careful interpretation due to the limitations of statistical representation, which is a collaborative undertaking between the HEIW Quality Assurance group and the Medical Education team in BCUHB.

Following analysis of the survey results and data from other sources, HEIW issue three risk reports to the HB per year and the HB must provide a response providing assurance that threats and risks are being addressed or adequately mitigated. This is led by the Director of Medical Education/Lead Manager on behalf of the EMD via liaison with department leads and through investigation of concerns. The HEIW Quality Unit carry out targeted visits where it has been deemed necessary via the risk register.



In general, scores relate to the learning environments of particularly challenged clinical services, often reflecting workload and staffing issues.

The HEIW risk matrix is on the right. There is no further explanation provided by HEIW as to what the risk is 'to' or 'of'.

**Table One: Risk Assessment:**

		SEVERITY OF IMPACT			
		1 = Minor	2 = Moderate	3 = Significant	4 = Major
PROBABILITY OF RISK	1 = Unlikely	1	2	3	4
	2 = Moderate	2	4	6	8
	3 = Likely	3	6	9	12
	4 = Almost Certain	4	8	12	16

SCORE	RISK CATEGORY	RESPONSE
1 – 5	LOW	Local review which may require further information or action with monitoring in place.
6 – 8	MEDIUM	Further information or action required within prescribed timeframe and ongoing monitoring.
9 – 16	HIGH	Urgent action may be required and there is close monitoring of the action plan.



The current HEIW risks for BCUHB are detailed in the table below

Level of risk	East		Central		West	
<b>RED: Range 9-16</b>	T&O	<b>Risk rating of 9</b> Continue to monitor	Medicine	<b>Risk rating of 9</b> Targeted visit incoming	Medicine	<b>Risk increased to 9</b> Following targeted visit and raising of patient safety concerns
<b>Orange: Range 5-8</b>	General Surgery	<b>Risk rating of 8</b> Reduced following detailed action plan. Trainer and trainee risk	Oncology	<b>Risk rating of 8</b> Monitor improvements for sustainability	T&O	<b>Risk rating of 8</b> Further evidence of progress required
	Medicine	<b>Risk rating of 8</b> Enhanced monitoring and targeted visits stepped down. Close monitoring needed	General Surgery	<b>Risk rating of 8</b> Continue to monitor	General Surgery	<b>Risk increased to 8</b> Faculty team update required
	Psychiatry	<b>Risk rating of 8</b> Feedback required against action plan	T & O	<b>Risk rating of 6</b> Outcome of investigation awaited	Psychiatry	<b>Risk rating of 6</b> Feedback monitoring required
	Obs & Gynae	<b>Risk rating of 6</b> Action plan monitoring required	Psychiatry	<b>Risk rating of 6</b> Action plan awaited	Paediatrics	<b>Risk rating 6</b> Continue to monitor
			Emergency Medicine	<b>Risk rating of 6</b> Monitor improvements for sustainability		
			Histopathology	<b>Risk rating 6</b> Trainer risk. Job planning information required to close		
		Dermatology	<b>Risk rating 6</b> Continue to monitor			
<b>Yellow: Range 1-4</b>	Intensive Care Medicine	<b>Risk rating of 4</b> Pending closure	Paediatrics/Neonates	<b>Risk reduced to 4</b> Faculty team to continue to monitor	Urology	<b>Risk rating of 4</b> Monitor via resident feedback
	ENT	<b>Risk rating of 4</b> Pending closure	Vascular	<b>Risk reduced to 4</b> No trainees in place but remains on the register to prompt conversations around reintroduction		

## Immediate and urgent concerns

- Acute Medicine at YG – the recent targeted visit highlighted trainee concerns regarding patient safety reporting in the Acute Internal Medicine service. This has been investigated swiftly by the IHC and a response provided to HEIW which confirmed that the incidence of reported patient safety incidents is consistent with the formal Datix recording and there is no increased incidence of significant patient safety issues at the YG site
- Targeted visit to YGC Medicine – the feedback and inability to provide assurance has triggered a targeted visit due in March 2026.

- Trauma and Orthopaedics – All 3 IHCs – the same themes have emerged at all 3 sites, namely increasing patient acuity and thus workload with no corresponding workforce model to support
- Vascular – currently not recognised as a training site with both Foundation and Middle Tier trainees currently removed because of concerns related to the training environment. The Vascular Improvement Plan includes actions to ensure that the department will be in future be able to meet GMC standards.

## Areas of particular success

### Closed risks

Following improved results on the 2025 survey and/or other evidence HEIW have closed below risks:

- Emergency Medicine East (originally red risk with targeted visit status)
- Ophthalmology Central

**Reduced Risks** (reflecting embedding of good educational governance and engagement from combined clinical and managerial team members)






- General Surgery East
- General Psychiatry East
- Urology West

The annual GMC Survey also provides us with an opportunity to identify departments that are statistically 'above outliers' compared to the UK and thus providing training of a particularly high standard. For the year 2025 these include:

- Clinical Radiology East (4 domains including overall satisfaction)
- Emergency Medicine East (Teamwork and 7 domains for FY2 doctors)
- Care of the Elderly West (7 domains)
- Paediatrics East (6 domains)
- Renal medicine East (7 domains)

NB –

1. This report does not include the education and training of medical students on placement in the HB which is also subject to the same GMC standards. The expansion of the North Wales Medical School is welcomed but will bring extra pressures on the learning environment in BCUHB
2. The new Welsh Resident doctors' contract for August 2026 is likely to impact the HB's ability to meet GMC standards particularly as regards rotas and Educational Development Time.

ASESIAD / ASSESSMENT	
<b>Cyswllt â'r Blaenoriaethau Strategol</b> <b>Link to Strategic Priorities</b>	     <b>4. Improving quality, outcomes and experience</b>
	<p>Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:</p>
<b>Yr Egwyddorion Dylunio</b> <b>Design Principles</b>	<p>Consistency with Organisational Values Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:</p>
<b>Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd</b> <b>Corporate Risks and Board Assurance Framework</b>	N/A
<a href="#">Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant Wellbeing of Future Generations Act – Wellbeing Goals</a>	Not Applicable
	<p>Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:</p>

ASESIADAU O EFFAITH / IMPACT ASSESSMENTS		
<b>Cydraddoldeb</b> <i>A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o'r Effaith ar Gydraddoldeb (sy'n cynnwys gofynion Safonau'r Gymraeg)</i> <b>Equality</b> <i>Have you undertaken an Equality Impact Assessment Screening (which includes the requirements of the Welsh Language Standards)</i>	Do/Yes: <input type="checkbox"/>	Naddo/No: <input checked="" type="checkbox"/>
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	This report is purely administrative in nature and submitted for information only.
<b>Asesiad o'r Effaith Economaidd-gymdeithasol</b> <i>A ydych chi wedi cynnal Asesiad o'r Effaith Economaidd-Gymdeithasol?</i>	Do/Yes: <input type="checkbox"/>	Naddo/No: <input checked="" type="checkbox"/>
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm:	This report is purely administrative in nature



<p><b>Socio-Economic Impact Assessment</b> <i>Have you undertaken a Socio-Economic Impact Assessment</i></p>	<p>If no, please include rationale:</p>	<p>and submitted for information only.</p>
<p><b><u>Ansawdd</u></b> <i>A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?</i></p> <p><b><u>Quality</u></b> <i>Have you undertaken a Quality Impact Assessment Screening?</i></p>	<p><b>Galluogwyr Ansawdd Enablers of Quality</b> Learning, Improvement &amp; Research</p> <p>Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:</p>	<p><b>Meysydd Ansawdd Domains of Quality</b> All Apply</p> <p>Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:</p>

<p><b>Effaith Amgylcheddol / Cynaliadwyedd (5Rs)</b> <b>Environmental /Sustainability Impact (5Rs)</b></p>	<p>Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:</p> <p>No - Not Applicable</p> <p>Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:</p>	
<p><b>Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog</b> <i>A ydych chi wedi ystyried Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog:</i></p> <p><b>Armed Forces Covenant Due Regard Duty</b> <i>Have you considered the Armed Forces Covenant Due Regard Duty?</i></p>	<p>Do/Yes: <input type="checkbox"/></p> <p>Canlyniad/Outcome:</p> <p>Os naddo, dylech gynnwys y rheswm: If no, please include rationale:</p>	<p>Naddo/No: <input checked="" type="checkbox"/></p> <p>This report is purely administrative in nature and submitted for information only.</p>
<p><b>Asesiad o Effaith ar Ddiogelu Data</b></p>	<p>Do/Yes: <input type="checkbox"/></p> <p>Canlyniad/Outcome:</p>	<p>Naddo/No: <input checked="" type="checkbox"/></p>

<p><i>A ydych chi wedi cynnal prawf Sgrinio o'r Aseiad o Effaith ar Ddiogelu Data?</i> <b>Data Protection Impact Assessment</b> <i>Have you undertaken a Data Protection Impact Assessment Screening?</i></p>	<p>Os naddo, dylech gynnwys y rheswm: If no, please include rationale:</p>	
<p><b>Asesiad o Effaith ar Atal Twyll</b> <i>A ydych chi wedi ystyried yr effeithiau ar atal twyll?</i> <b>Counter Fraud Impact Assessment</b> <i>Have you considered the counter fraud impacts</i></p>	<p>Do/Yes: <input type="checkbox"/></p>	<p>Naddo/No: <input checked="" type="checkbox"/></p>
	<p>Canlyniad/Outcome:</p>	<p>This report is purely administrative in nature and submitted for information only.</p>
<p><b>Cyfreithiol</b> <b>Legal</b></p>	<p>There are no specific legal implications related to the activity outlined in this report.</p>	
<p><b>Enw Da</b> <b>Reputational</b></p>	<p>There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.</p>	
	<p>Internal information sharing.</p>	
<p><b>Effaith ar Adnoddau</b> <i>(Pobl / Ariannol)</i> <b>Resource Impact</b> <i>(People / Financial)</i></p>	<p>There is no direct impact on resources as a result of the activity outlined in this report.</p>	



## Quality Safety & Experience Committee

### MEWNOSODWCH DEITL YR ADRODDIAD RESEARCH AND DEVELOPMENT ANNUAL REPORT 2025

<b>Dyddiad y Cyfarfod</b> <b>Date of Meeting</b>	05 March 2026
<b>Statws Cyhoeddi</b> <b>Publication Status</b>	Open/ Public
	Not Applicable
<b>Enw a theitl Awdur(on) yr Adroddiad</b> <b>Report Author name and title</b>	Dr Lynne Grundy Associate Director, Research and Development (R&D)
<b>Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol</b> <b>Lead Executive Team Member name and title</b>	Dr Clara Day Executive Medical Director
<b>Pwrpas yr Adroddiad</b> <b>Report Purpose</b>	For Noting

#### **Crynodeb Gweithredol** **Executive Summary**

The Annual Report outlines the Research and Development (R&D) activities undertaken by Betsi Cadwaladr University Health Board (BCUHB) in 2024/2025.

BCUHB continues to deliver high quality research across a wide range of clinical areas in secondary and primary care. The report contains examples of the many successes which impact positively on our patients, as well as highlighting our collaborative work and our future priorities.

Key opportunities moving forward include increasing commercial research, increasing grant applications, and increasing joint appointments with the North Wales Medical School and local partner universities.

**Ymgysylltu (mewnol/allanol) yr ymgwymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp)**



---

<b>Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)</b>		
<b>Pwyllgor / Grŵp / Unigolion Committee / Group / Individuals</b>	<b>Dyddiad Date</b>	<b>Canlyniad, Tystiolaeth a Data Outcome, Evidence and Data</b>
Executive Committee	13/08/25	Noted with some recommendations

<b>Acronymau / Rhestr Termau Acronyms / Glossary of Terms</b>	

---

## Research and Development Annual Report 2025

### 1 Y SEFYLLFA SITUATION

1.1 Research is a key driver in providing evidence based improved prevention, diagnosis, treatment and care options for patients. There is a growing body of evidence demonstrating that research active organisations provide better care and have better patient outcomes than those NHS organisations that conduct less research.

1.2 There is a growing body of evidence demonstrating that research active organisations provide better care and have better patient outcomes than those NHS organisations that conduct less research, and that a culture of innovation and research can make our NHS a more attractive place to work and support Wales to fill critical vacancies across the health service.

### 2 Y CEFNDIR BACKGROUND

2.1 Funding for research delivery in BCUHB is provided by Welsh Government through Health and Care Research Wales. The funding has to be used to support the delivery of high quality research. Commercial trials also fund the costs for research delivery, and provide capacity and capability funding to enable us to reinvest in wider research development.

2.2 This report covers the period April 2024 to March 2025, and sets out:

- the strategic landscape nationally and locally
- research funding streams
- research performance against key performance indicators
- governance process
- examples of key achievements 2024/2025
- key objectives/forward plan 2025/2026

### 3 MATERION PENODOL I'W HYSTYRIED SPECIFIC MATTERS FOR CONSIDERATION

3.1 There continue to be opportunities to increase research activity in BCUHB, which will have positive effects on our patients and colleagues; objectives in our three-year plan for 2025/2026 include:

- increasing commercial research and innovation activity
- increase the number of joint appointments and honorary research appointments with our academic partners
- progress the local implementation of the NHS R&D Framework and Embedding Research in the NHS Programme
- development of an innovation support infrastructure

#### **4 RISGIAU ALLWEDDOL / MATERION I'W HUWCHGYFEIRIO KEY RISKS / MATTERS FOR ESCALATION**

4.1 Lack of capacity within support services to support research activity

4.2 Lack of time for health care professionals to act as Principal Investigators






#### **5 ARGYMHELLION RECOMMENDATIONS**

5.1 Gofynnir i'r Pwyllgor/Cyfarfod/Grŵp:

The Committee/Meeting/Group is asked to:

- note the contents of the Annual Report
- note the potential to further develop opportunities to collaborate with both commercial and non-commercial partners
- note the opportunity to work closely with our local universities and Commercial partners



ASESIAD / ASSESSMENT	
<b>Cyswllt â'r Blaenoriaethau Strategol</b> <b>Link to Strategic Priorities</b>	     <b>Choose an item.</b>
	Establishing an effective environment for learning
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
<b>Yr Egwyddorion Dylunio</b> <b>Design Principles</b>	<b>Consistency with Organisational Values</b> Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below: Compassion Openness Respect
<b>Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd</b> <b>Corporate Risks and Board Assurance Framework</b>	Corporate Risk 5642 in relation to lack of Pharmacy capacity <b>BAF Threat:</b> Ineffective university partnerships, inadequate joint investment in research, and supporting academic career development to sustain a joint effective environment for learning.
<a href="#">Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant</a> <a href="#">Wellbeing of Future Generations Act – Wellbeing Goals</a>	A Healthier Wales
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:

ASESIADAU O EFFAITH / IMPACT ASSESSMENTS		
<b>Cydraddoldeb</b> <i>A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o'r Effaith ar Gydraddoldeb (sy'n cynnwys gofynion Safonau'r Gymraeg)</i> <b>Equality</b> <i>Have you undertaken an Equality Impact Assessment Screening (which includes the requirements of the Welsh Language Standards)</i>	Do/Yes: <input type="checkbox"/>	Naddo/No: <input checked="" type="checkbox"/>
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not applicable
	Do/Yes: <input type="checkbox"/>	Naddo/No: <input checked="" type="checkbox"/>

<b>Asesiad o'r Effaith Economaidd-gymdeithasol</b> <i>A ydych chi wedi cynnal Asesiad o'r Effaith Economaidd-Gymdeithasol?</i> <b>Socio-Economic Impact Assessment</b> <i>Have you undertaken a Socio-Economic Impact Assessment</i>	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not applicable
<b><u>Ansawdd</u></b> <i>A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?</i> <b><u>Quality</u></b> <i>Have you undertaken a Quality Impact Assessment Screening?</i>	<b>Galluogwyr Ansawdd Enablers of Quality</b> Learning, Improvement & Research	<b>Meysydd Ansawdd Domains of Quality</b> All Apply
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
<b><u>Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant Wellbeing of Future Generations Act – Wellbeing Goals</u></b>	A Healthier Wales	

<b>Effaith Amgylcheddol / Cynaliadwyedd (5Rs)</b> <b>Environmental /Sustainability Impact (5Rs)</b>	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
	No - Not Applicable	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:	
<b>Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog</b>	Do/Yes: <input type="checkbox"/>	Naddo/No: <input checked="" type="checkbox"/>
	Canlyniad/Outcome:	

<p>A ydych chi wedi ystyried Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog: <b>Armed Forces Covenant Due Regard Duty</b> Have you considered the Armed Forces Covenant Due Regard Duty?</p>	<p>Os naddo, dylech gynnwys y rheswm: If no, please include rationale:</p>	<p>Not applicable</p>
<p><b>Asesiad o Effaith ar Ddiogelu Data</b> <i>A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?</i> <b>Data Protection Impact Assessment</b> <i>Have you undertaken a Data Protection Impact Assessment Screening?</i></p>	<p>Do/Yes: <input type="checkbox"/></p>	<p>Naddo/No: <input checked="" type="checkbox"/></p>
	<p>Canlyniad/Outcome:</p>	
	<p>Os naddo, dylech gynnwys y rheswm: If no, please include rationale:</p>	<p>Not applicable</p>
<p><b>Asesiad o Effaith ar Atal Twyll</b> <i>A ydych chi wedi ystyried yr effeithiau ar atal twyll?</i> <b>Counter Fraud Impact Assessment</b> <i>Have you considered the counter fraud impacts</i></p>	<p>Do/Yes: <input type="checkbox"/></p>	<p>Naddo/No: <input checked="" type="checkbox"/></p>
	<p>Canlyniad/Outcome:</p>	
	<p>Os naddo, dylech gynnwys y rheswm: If no, please include rationale:</p>	<p>Not applicable</p>
<p><b>Cyfreithiol Legal</b></p>	<p>Yes (Include further detail below)</p>	
	<p>Health Research Authority UK Policy Framework for Health and Social Care Research The Medicines and Healthcare Products Regulatory Agency Related research legislation and policy</p>	
<p><b>Enw Da Reputational</b></p>	<p>Yes (Include further detail below)</p>	
	<p>Active participation in research promotes a positive reputation with our patients and population A research active organisation attracts high calibre staff</p>	
<p><b>Effaith ar Adnoddau</b></p>	<p>Yes (Include further detail below)</p>	



---

*(Pobl / Ariannol)*  
**Resource Impact**  
*(People / Financial)*

Increasing commercial research activity generates income that can be reinvested into research.

Drug trials offer cost savings and cost avoidance



GIG  
CYMRU  
NHS  
WALES

Bwrdd Iechyd Prifysgol  
Betsi Cadwaladr  
University Health Board

# Annual Report 2025

## Research & Development



# Table Of Contents

Introduction.....	1
Strategic Overview.....	2-3
R&D Funding Streams.....	4
Performance.....	5-9
Research Governance.....	10-11
Key Achievements.....	12-15
Key Objectives/Forward Plan 2025/26.....	16

# Introduction

This report covers the period April 2024 to March 2025, and will set out:

- the strategic landscape nationally and locally
- research funding streams
- research performance against key performance indicators
- governance process
- examples of key achievements 2024/2025
- key objectives/forward plan 2025/2026

Research is a key driver in providing evidence based improved prevention, diagnosis, treatment and care options for patients. There is a growing body of evidence demonstrating that research active organisations provide better care and have better patient outcomes than those NHS organisations that conduct less research.

Opportunities for greater development through research provides an enhanced job role which in turn develops leaders and critical thinkers who contribute positively to the environment that they are working in. The Cross-Party Group on Medical Research Inquiry Report; How Medical Research Benefits the People of Wales(2023) says a culture of innovation and research can make our NHS a more attractive place to work and support Wales to fill critical vacancies across the health service.

Board level research and development (R&D) representation in Betsi Cadwaladr University Health Board (BCUHB) is through the Executive Medical Director who is the executive lead for R&D, and the Independent Member Board Champion for research.

# Strategic Overview

## National Strategies

A research active organisation is a distinguishing character of University Health Boards and a key enabler for NHS Wales to deliver 'A Healthier Wales.'

Key national strategic drivers include; Health and Care Research Wales Research matters: our plan for improving health and care research in Wales 2022 – 2025, Tackling cancer through research, and the NHS R&D Framework.

The NHS R&D Framework, published by Health and Care Research Wales (supported by the Welsh Government) sets out what research excellence looks like in NHS organisations and aims to make research a core part of clinical care and organisational culture rather than a stand-alone activity, aiming to embed and integrate research into everyday NHS services across Wales.

To help organisations embed the Framework a national Embedding Research in the NHS Programme has been developed, with national projects focused on engagement, workforce development, economic impact measurement and clinical academic development.

Each NHS organisation in Wales is accountable for local implementation of the Framework. The organisations are assessed against the ten themes within the framework.

1. **Strategy** - A clear R&D strategy aligned with organisational goals and plans.
2. **Governance and leadership** - Strong leadership at board and executive levels championing research.
3. **Partnership and collaboration** - Effective engagement with universities, industry, funders and other partners.
4. **Research support** - Systems, processes and resources that support research delivery.
5. **Research delivery** - Carrying out high-quality research that influences care, policy and outcomes.
6. **Finance** - Effective use and management of research funding and resources.
7. **NHS Workforce** - Developing research skills and protected time for staff to conduct research.
8. **Public involvement and participation** - Meaningful involvement of patients and the public in research.
9. **Communications and engagement** - Clear communication about research activity, value and opportunities.

10. **Research impact** - ensuring that research carried out within NHS Wales makes a real, demonstrable difference to patients, services, policy and the wider health and care system

## Local Strategy

The BCUHB Research and Innovation Strategy has been in place since 2020, with strategic objectives being:

- Build a strong community
- Maximise impact of research and innovation (R&I)
- Realise benefits for the region
- Innovation Readiness

Significant progress has been made against these objectives, although implementation was delayed due to the pandemic.

## BCUHB Strategic intentions



From 2026 R&D will develop a strategic plan which aligns with BCUHB’s approach of having a single overarching strategy that informs the development of programme, service, and locality strategic plans.

## R&D Funding Streams

Research and development (R&D) delivery in Wales is funded by Welsh Government through Health and Care Research Wales (HCRW). This funding allows us to employ dedicated research teams that work in collaboration with clinical teams to establish and conduct high quality research.

In addition, we generate revenue for commercial trials income, which funds the research activities and provides additional funding to reinvest in R&D and increase our capacity and capability. Funding opportunities are also available through grant awards and personal development awards.

**Table i Research funding 2024/2025**

Welsh Government delivery funding	£2,206,146
Commercial research funding, *grants, other external funding	£817,640
Total external R&D funding	£3,023,786

\*Grant bids won during 2024/2025 totalled £331,988. Grants may span more than one financial year.

### Economic benefits

Research studies, particularly drug trials, also offer cost savings and/or cost avoidance locally. For example, the trial drugs, which are often high cost, are provided free of charge, and often standard care drugs are not required.

Often research studies also result in less bed days required, less investigations and provision of care closer to home. Currently these benefits are not measured.

A national workstream tasked to capture the economic benefit of research trials is currently underway in Wales, with BCUHB staff contributing.

# Performance

R&D performance is measured locally and nationally. National key performance indicators (KPIs) that are reported through a national Business Intelligence dashboard include:

- Number of research studies open and in follow up (commercial and non-commercial)
- Recruitment to commercial and non-commercial studies
- Study set up time
- Recruitment to time and target (RTT).

## Activity

In the year 2024/2025, in BCUHB we recruited 3257 participants to portfolio non-commercial (n=105) and commercial studies (n=9), and 261 participants to non-portfolio studies.

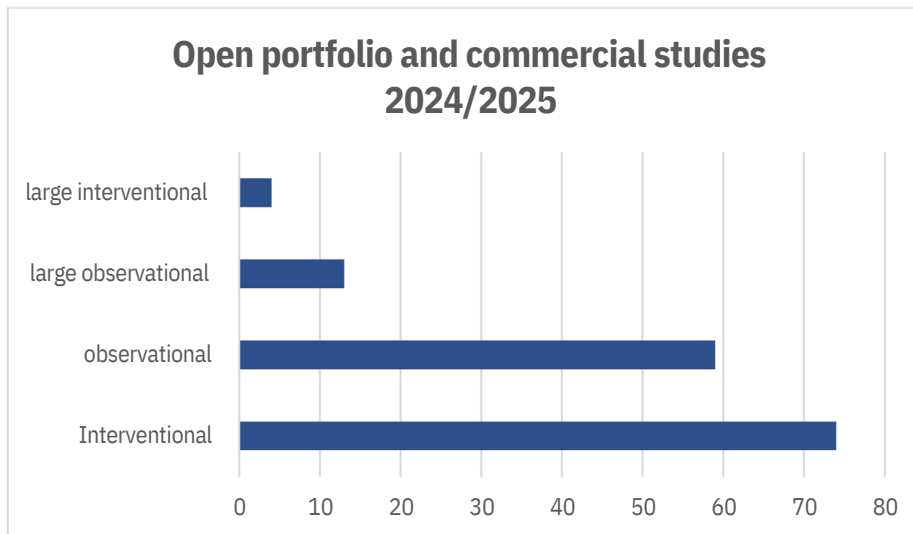
There were 274 research studies open to recruitment or in follow up. Of these 207 are portfolio studies, and 67 are non-portfolio studies. Each study has a named Principal Investigator (PI) from the Health Board (n=202) or Chief Investigator (CI) (n=41). Some PIs and CIs run more than one study. Research activity was undertaken in 28 specialty areas across BCUHB. The biggest area of activity is in cancer and haematology (28% of activity). We also have strengths in cardiology, respiratory, musculoskeletal and anaesthesia, perioperative medicine and pain management.

Our top research active specialties are shown below

Managing Specialty	Interventional	Observational
Trauma and Emergency Care	54	635
Cancer	128	760
Anaesthesia, Perioperative Medicine and Pain Management	43	301
Musculoskeletal and Orthopaedics	5	124
Ear, nose and throat	122	6
Cardiovascular	17	100

Over the previous three-year period, Cancer has consistently been the most research active.

The graph below shows the distribution of open portfolio and commercial studies



In 2024/2025 our commercial activity increased, compared to the previous year. Nine studies were open and recruited compared with eight the previous year, and recruitment was up from 145 participants to 181 participants. Activity breakdown is given below.

**Table ii Commercial Activity**

Specialty	Number of studies	Number recruited
Respiratory	1	87
Infection	2	64
Cancer	3	12
Cardiology	1	11
ENT	1	6
Primary Care	1	1

Our set up time in 2024/2025 was the best in Wales. Our RTT (closed studies) was 87%.

**Table iii National Key Performance Indicators (KPIs)**

Key Performance Indicator	Performance	Rating
Set up time	48 days	
Recruitment to time and target, studies closed in last 6 months	87%	

**Table iv Key actions in the three-year plan for 2024/2025**

Action	Progress
5B.4: Increase honorary research appointments and clinical academic posts	Seven honorary appointments were made to our research active staff. A joint appointment in Cancer was advertised, but not successfully appointed as yet.
5B.5: Generate additional RD&I commercial opportunities in device and technology development, learning from successful models elsewhere	A proposal was taken to the executive team for consideration, informed by the Hywel Dda model. A decision has not yet been made by the executive team.
5B.6: Build further upon a number of already research-rich primary care practices to expand the opportunity that directly managed primary care can provide in research and innovation delivery	*We introduced a primary care incentive scheme which was taken up by eight practices across BCUHB. The funding scheme will provide support either for those taking their first steps into research, or to progress the research portfolio for more established practices.

\* Practices were invited to apply for funding at the levels described below. The Primary Care Academy worked with us to introduce this scheme. It will be evaluated at the end of the funding period, in order to plan further initiatives.

Fiunding Level	Expected research delivery	Financial award
Level 1	Practices have access to all benefits except the financial award. There is no set target for study delivery	£ 0
Level 2	Practices are expected to recruit into 2 or more studies during the funding period and have access to all benefits.	£2,000
Level 3	Practices are expected to recruit into 5 or more studies during the funding period and have access to all benefits	£5,000

In addition to a financial incentive, benefits of being part of the scheme include:

- Access to a Research Masterclass and supporting materials
- Potential to increase revenue through participation in commercially sponsored studies
- Peer support from other practices in the PCCRF scheme
- Access to support from an experienced Research Nurse/Research Officer in the BCUHB R&D delivery team

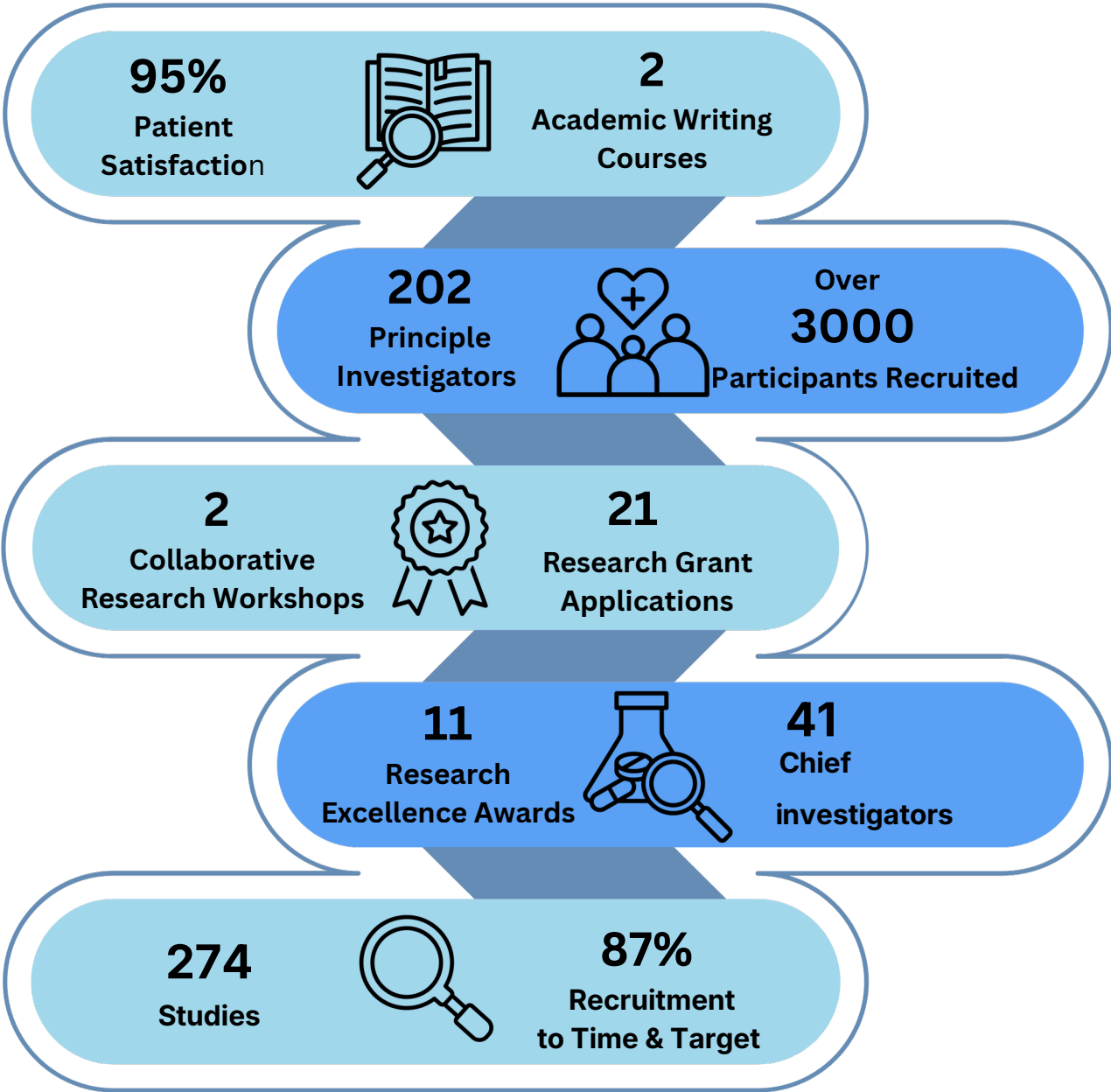
## **Annual Review with Welsh Government against NHS R&D Framework**

We had our annual review with Welsh Government and HCRW colleagues in March 2025 where we presented our achievements and challenges. Challenges include the capacity in support departments to support research activity, and time for clinical colleagues to deliver research.

The review received positive feedback. We were asked to consider alignment of the R&D Strategy with the NHS R&D Framework and Embedding Research Programme and raising the profile of research within the Health Board. Critical Milestones have been identified following the review as:

- Strategy realignment
- Board-level research visibility enhancement
- Prepare for NHS R&D Framework self-assessment (March 2026)
- Shadow reporting of cancer research metrics (from April 2025). This has now been deferred

Enhancing research impact



# Research Governance

Research governance is essential in ensuring that the public have confidence in and benefit from research that meets high scientific, ethical and financial standards, with transparent decision-making processes, clear allocation of responsibilities and robust monitoring arrangements.

A suite of BCUHB R&D policies and Standard Operating Procedures (SOPs) are available on the BCUHB website.

## Approvals

Regulatory and governance approvals to undertake research are obtained through the UK wide Integrated Research Application system (IRAS). Ethical approval from an appropriate NHS Research Ethics Committee is required for most types of research involving patients and users of the NHS. Once an IRAS application has been reviewed by the appropriate bodies, Health Research Authority /Health and Care Research Wales approvals will be issued. Local BCUHB R&D set up processes focus on set up and delivery, to ensure appropriate local considerations and set up of the research study.

## Risk Assessment

As part of the local process for approval, a risk assessment is undertaken so that foreseeable risks and inconveniences can be weighed against the anticipated benefit for individual participants and the general population as a whole. A study must only be initiated and continued if the anticipated benefits justify the risks. Studies are categorised into low, moderate and high risk categories. Depending on the categorisation, an appropriate monitoring plan is put in place.

## Monitoring and Auditing

Within BCUHB, the R&D audit programme monitors legislation applicable to research, good clinical practice and our institutional policies and SOPs for research are followed. Audits may also be triggered if an issue of concern has been highlighted with a specific study or study procedure/system, or if documented evidence is required on a particular issue.

Follow up feedback highlights the positives, summarise the points discussed and agreed, including corrective and preventative actions to be taken and any lessons learnt are shared appropriately.

The Senior Management Team review all audits, and any risks are escalated to the Strategic Clinical Effectiveness Group, or if a local issue, the local Clinical Effectiveness Group. A recent MHRA inspection triggered by a protocol breach was reported through SCEG and QDG committees.

Research governance is being reviewed locally to ensure that appropriate systems and reporting is in place.

### Governance reporting structure



# Key Achievements

## National collaborations

In February 2025, we were invited to present at the BioWales conference in London, an important event that showcases the thriving Welsh life science sector and promotes opportunities for, collaborations in research and innovation.

In March 2025, we participated in the Nation-to-Nation Innovation Learning Event in Scotland as part of our ongoing commitment to building networks and collaborations across the UK. This event brought together researchers, leaders and innovators from both Scotland and Wales.

## The R&D Excellence Awards

The annual Research and Innovation Symposium and Awards were held in December 2024, celebrating the outstanding achievements of our researchers and innovators across BCUHB.

Chaired by Dr Lynne Grundy, Associate Director of Research and Development, with guest speakers including Jonathan Moore, Co-Dean for Research, College of Medicine and Health at Bangor University, Sion Charles, Head of Strategy and Service Planning, ARCH, Helen Grindell, Head of Research Support & Operations for Health & Care Research Wales and Natalie Pryor, Evaluation & Innovation Project Manager, Regional innovation Co-ordination Hub. This year's judges were Dr. Bryan Griffiths, Professor Chris Hopkins, Pryderi ap Rhisiart, and Dr Zoe Hoare.

The Awards featured five categories:

### Emerging Researcher Award

Winner – Dr Manohar Joishy - For the Paediatric Research Portfolio Development

Runner-Up – Hannah Wilson - For the STEPS II Trial

**Commendation** - Caroline Mulvaney-Jones and Julia Roberts - For excellent research facilitation

## Research Excellence Award

Winner - The Haematology Team, YGC - For going above and beyond on a daily basis to offer patients the opportunity to participate in clinical trials.

Runner-Up - Rachel Manley - For excellent leadership skills

## Emerging Innovator Award

Winner – Stephanie Rees - For reducing environmental toxicity through innovative handwashing solutions.

Runner-Up - Lou Rodrigues - For the creation of the BetterByBetsi Community Network

## Innovation Excellence Award

Winner - Christopher Goodwin - For the OPAT project in Pharmacy Technical Services

Runner-Up – Luke McDonald - For creating an innovative Project Management System using Microsoft PowerApps

## Regional Leadership Awards

West Winner – Dr Christian Subbe

Central Winner - Lona Tudor-Jones

East Winner - Dr Yee Ping Teoh



## Patient Impact examples

It is important to be able to demonstrate the impact that R&D activity has on our patients and the organisations. Examples during 2024/25 include:

- medications dispenser enabling patients in rural areas to access their prescribed medication out of hours
- norovirus vaccine trial which could lead to a reduction in hospital admissions in the future
- exploring Functional Electrical Stimulation in Parkinson's Disease
- understanding escalation area and corridor care in UK emergency departments.

### **REMEDY : A Ground-breaking Solution for Medications in Dolgellau**

The REMEDY machine, the first of its kind in Europe, is set to be trialled in Dolgellau, where residents often face 50-mile journeys to access pharmacies that remain open overnight or on Sundays.

Individuals who contact NHS 111 out-of-hours and need urgent medication will have the option to collect their prescriptions from this innovative machine, conveniently located outside Dolgellau Hospital. Dr Rebecca Payne, co-led the study alongside Professor Dyfrig Hughes and Dr Adam Mackridge from Betsi Cadwaladr Health Board. The machine is designed to issue medication after a telephone consultation. It stocks a variety of medications, including antibiotics, steroids, and inhalers.

About 70% of people who call NHS 111 are managed by phone. However, for those living in areas like Dolgellau, where no pharmacy services are available overnight or on Sundays, accessing medication can be incredibly difficult. The REMEDY machine addresses a real patient need.

When a clinician working in NHS 111 assesses a patient over the phone and determines they need medication, they can log into the machine remotely. It generates a pin code that can be shared with the patient via phone or text. The patient can then enter the code at the machine to receive their prescribed medication.

Prior to the REMEDY machine's arrival, patients often had to travel as far as Bangor, 50 miles away, to access medicines when local pharmacies were closed. Local resident Jane Jardine expressed her relief, noting, "It's a nightmare trying to get medication and see a doctor, so I think the machine is a brilliant idea." Another local resident, Llinos Rowlands, echoed this sentiment, stating, "If it brings medicine at no extra cost and helps people, it's a good thing"

The REMEDY machine is a joint project between Betsi Cadwaladr University Health Board and Bangor University, funded by Health and Care Research Wales.

## **UNCORKED-Understanding Escalation Area and Corridor Care in UK Emergency Departments**

Due to demands on space many emergency departments in the UK care for patients in areas not originally designed for this purpose. These areas are collectively known as escalation areas and can include hospital corridors. The UNCORKED study aims to estimate the proportion of patients that experience care in these areas and describe which patients do so in terms of basic information such as age, diagnosis and where they move to from the ED.

The information was gathered over a two week period at five designated snapshot times. This research will provide important information to help develop future research into the effects of this care. It will also give clinical leaders a real-world picture of how often emergency departments are over capacity.

## **Patient Feedback**

Research participant feedback was collated from a period from September – December 2024 from a sample across BCUHB hospital sites from various open and recruiting non-commercial and commercial trials. 61 feedback forms were returned from 16 clinical research studies.

95% of patients agreed or strongly agreed that they were satisfied with their treatment

*“The staff were very informative, and kept me informed on a regular basis. Always felt I could ask questions”.*

*“I was fully informed of my treatment, as was my family”.*

*“Everything- the care I received was 100% plus I excellent professional efficient and caring in the extreme”.*

Areas that could be improved were feedback to the appropriate teams and included:

- Initially a lot of information to digest maybe a pictorial flowchart overview could give an introduction to the proposal and trial.
- Waiting time could be improved on-Send appointment by email
- Feedback from patients will continue to be gathered to ensure we are providing a quality service and to identify any improvements we can make.

## Key Objectives/Forward Plan 2025/26

We will continue to work with Welsh Government and HCRW to meet national KPIs which include an increase in cancer research activity. We will also be subject to UK targets for set up time and RTT.

Locally, within our three-year plan, the research and innovation delivery priorities 2025/2026 are:

- Increasing commercial research and innovation activity. Increasing commercial activity will enable re-investment in capacity and capability building in BCUHB.
- Increase the number of joint appointments and honorary research appointments with our academic partners. This will strengthen our capacity to lead local research, as well as supporting local recruitment and retention.
- Progress the local implementation of the NHS R&D Framework and Embedding Research in the NHS Programme. This includes work on progressing job planning for all staff which recognises research activity appropriately.
- Development of an innovation support infrastructure and expert panel with M-SParc, OpTIC Technology Centre, Bangor University and Wrexham University, supported by Welsh Government. This will support the aim to provide clarity with regard to clear pathways for innovation, including adoption and spread and scale.



## Quality Safety & Experience Committee

### CORPORATE GOVERNANCE REPORT

<b>Dyddiad y Cyfarfod Date of Meeting</b>	05 March 2026
<b>Statws Cyhoeddi Publication Status</b>	Open/ Public
	Not Applicable
<b>Enw a theitl Awdur(on) yr Adroddiad Report Author name and title</b>	Philippa Peake-Jones, Head of Corporate Governance
<b>Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol Lead Executive Team Member name and title</b>	Pam Wenger, Director of Corporate Governance

<b>Pwrpas yr Adroddiad Report Purpose</b>	For Noting
---	------------

<b>Crynodeb Gweithredol Executive Summary</b>
Members are asked to: <ul style="list-style-type: none"> <li>• <b>NOTE</b> the summary of business considered in private session to be reported in public</li> <li>• <b>NOTE</b> the forward workplan</li> </ul>

<b>Ymgysylltu (mewnol/allanol) yr ymgwymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp) Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)</b>		
<b>Pwyllgor / Grŵp / Unigolion Committee / Group / Individuals</b>	<b>Dyddiad Date</b>	<b>Canlyniad, Tystiolaeth a Data Outcome, Evidence and Data</b>
Not applicable for this report		

<b>Acronymau / Rhestr Termiau Acronyms / Glossary of Terms</b>



---

## CORPORATE GOVERNANCE REPORT

### 1. Y SEFYLLFA SITUATION

- 1 The Health Board is required to act according to its Standing Orders. This report contains information to allow the Health Board to conform to this.
- 2 It is essential that the Board has robust arrangements in place for Corporate Governance and failure to do so could have legal implications for the Health Board.

### 3 Y CEFNDIR BACKGROUND

- 3.1 The purpose of this report is to provide the Committee with an update on key corporate governance matters.

### 4 MATERION PENODOL I'W HYSTYRIED SPECIFIC MATTERS FOR CONSIDERATION

#### 4.1 Summary of Business Considered in Private

- 4.1.1 Standing Order 6.5.3 requires the Board to formally report any decisions taken in private session to the next meeting of the Board in public session. This principle is also applied to Committee meetings.
- 4.1.2 The below item was considered in private at the meeting held on 15 January 2026:
  - QS26.24 Integrated Quality Performance Report
  - QS26.25 Mental Health Update
  - QS26.26 North Wales Vascular Network Update

#### 4.2 Committee Forward Work Plan

- 4.2.1 The Forward Work Plan sets out the Committee's priorities and scheduled business outside of the normal Cycle of Business, helping ensure a structured, timely, and transparent approach to decision-making and oversight. It collates suggested referral items from other Committees and the Board.






### 5 RISGIAU ALLWEDDOL / MATERION I'W HUWCHGYFEIRIO KEY RISKS / MATTERS FOR ESCALATION

5.1 There are no matters for escalation.

## 6 ARGYMHELLION RECOMMENDATIONS

6.1 Gofynnir i'r Pwyllgor/Cyfarfod/Grŵp:  
The Committee/Meeting/Group is asked to:

- **NOTE** the matters considered in Private at the 15 January 2026.
- **NOTE** The Committee forward workplan.

ASESIAD / ASSESSMENT	
<b>Cyswllt â'r Blaenoriaethau Strategol</b> <b>Link to Strategic Priorities</b>	    
	1. Building an effective organisation  Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
<b>Yr Egwyddorion Dylunio</b> <b>Design Principles</b>	Simplify, Standardise, and Adopt Best Practices Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
<b>Fframwaith Risgiau</b> <b>Corfforaethol a Sicrwydd y Bwrdd</b> <b>Corporate Risks and Board Assurance Framework</b>	BAF24-01 Building an Effective and Accountable Organisation  CRR-16 – Leadership/Special Measures

ASESIADAU O EFFAITH / IMPACT ASSESSMENTS		
<b>Cydraddoldeb</b> <i>A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o'r Effaith ar Gydraddoldeb (sy'n cynnwys gofynion Safonau'r Gymraeg)</i> <b>Equality</b> <i>Have you undertaken an Equality Impact Assessment Screening (which includes the requirements of the Welsh Language Standards)</i>	Do/Yes: <input type="checkbox"/>	Naddo/No: <input checked="" type="checkbox"/>
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not necessary for this report
	Do/Yes: <input type="checkbox"/>	Naddo/No: <input checked="" type="checkbox"/>

<b>Asesiad o'r Effaith Economaidd-gymdeithasol</b> <i>A ydych chi wedi cynnal Asesiad o'r Effaith Economaidd-Gymdeithasol?</i> <b>Socio-Economic Impact Assessment</b> <i>Have you undertaken a Socio-Economic Impact Assessment</i>	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not necessary for this report
<b><u>Ansawdd</u></b> <i>A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?</i> <b><u>Quality</u></b> <i>Have you undertaken a Quality Impact Assessment Screening?</i>	<b>Galluogwyr Ansawdd Enablers of Quality</b> All Apply	<b>Meysydd Ansawdd Domains of Quality</b> All Apply
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
<b><u>Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant Wellbeing of Future Generations Act – Wellbeing Goals</u></b>	Not Applicable	

<b>Effaith Amgylcheddol / Cynaliadwyedd (5Rs)</b> <b>Environmental /Sustainability Impact (5Rs)</b>	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
	No - Not Applicable	
<b>Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog</b> <i>A ydych chi wedi ystyried Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog:</i> <b>Armed Forces Covenant Due Regard Duty</b>	Do/Yes: <input type="checkbox"/>	Naddo/No: <input checked="" type="checkbox"/>
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not necessary for this report



Have you considered the Armed Forces Covenant Due Regard Duty?		
<b>Asesiad o Effaith ar Ddiogelu Data</b> <i>A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?</i> <b>Data Protection Impact Assessment</b> <i>Have you undertaken a Data Protection Impact Assessment Screening?</i>	Do/Yes: <input type="checkbox"/> Canlyniad/Outcome:	Naddo/No: <input checked="" type="checkbox"/>
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not necessary for this report
<b>Asesiad o Effaith ar Atal Twyll</b> <i>A ydych chi wedi ystyried yr effeithiau ar atal twyll?</i> <b>Counter Fraud Impact Assessment</b> <i>Have you considered the counter fraud impacts</i>	Do/Yes: <input type="checkbox"/> Canlyniad/Outcome:	Naddo/No: <input checked="" type="checkbox"/>
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not necessary for this report
<b>Cyfreithiol Legal</b>	There are no specific legal implications related to the activity outlined in this report.	
<b>Enw Da Reputational</b>	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
<b>Effaith ar Adnoddau</b> <i>(Pobl / Ariannol)</i> <b>Resource Impact</b> <i>(People / Financial)</i>	There is no direct impact on resources as a result of the activity outlined in this report.	

**Quality Safety and Experience Committee – Non-Routine Committee Business Forward Plan - PUBLIC**

(1 April 2024 – onwards)

This forward plan is only to be used for one-off Adhoc items that do not require inclusion as routine business on the Annual Committee Cycle of Business.

Date of Request	Origin of Request	Requestor	Item Summary / Title	Nature of Request	Lead Officer	Executive Lead	Intended Meeting Date	Status
23.02.26	Email Request	Chairman	Experience Item	Discussion on MHLD patient story item video.	Exec Director of Allied Health Professionals & Health Sciences	Exec Director of Allied Health Professionals & Health Sciences	May 2026	Include in agenda setting for May meeting.
19.01.26	Board Meeting 27.11.25	Board Meeting	Urgent & Emergency Care	Update to be received at QSE regarding safety elements	Chief Operating Officer	Chief Operating Officer	Mar 2026	20.01.26 – included on March agenda
06.01.26	Verbal Request	Executive Medical Director	Medical Education	Update - deferred from January 26 meeting	Executive Medical Director	Executive Medical Director	Mar 2026	20.01.26 – included on March agenda
30.12.25	Email Request	Head of Corporate Governance	DECLO-ALNET Act annual report	Annual Report update	DECLO (Liz McKinney)	Executive Director of Allied Health Professions & Health Science	Mar 2026	To be added to March agenda 20.01.26 – included on March agenda
18.12.25	PFIG Meeting 18.12.25	Chair of PFIG	Paper Update on 100% overdue follow ups	Paper update requested during PFIG meeting 18.12.25	Chief Operating Officer	Chief Operating Officer	Mar 2026	To be added to March agenda 20.01.26 – included on March agenda 29.1.26 – QSE review evidence of harm as a result of delays to follow up appointments.
30.01.25	Board Meeting 30.01.25	Chair	25/15.1 Improving Quality Report	QSE Committee to review patient feedback data and discuss how this can be addressed to provide longer term solutions to improve performance.	Head of Corporate Governance	Director of Corporate Governance	May 2025	The Performance Framework is being reviewed and due to return to Board
07.05.24	Transfer Log AC24.60.1.8	Audit Committee		Quality, safety and commissioned services. The Committee agreed to a 6-month deferral requesting that the review take place before the end of the current financial year - it was agreed to inform the QSE of this decision and for the QSE committee to drive	Director of Governance / Head of Corporate Governance	Director of Corporate Governance	Jan 2026	This matter has been escalated 01.12.25 – added to draft agenda 20.01.26 – included on March agenda

				progress on recommendations from the May 23 report.				
10.12.24	Email from Executive Director of Nursing & Midwifery re Action from Oct – Deep Dive on Complaints – Duty of Care.	Executive Director of Nursing & Midwifery	PTR guidance update for Development Session	Once Welsh Government releases new PTR guidance, to return to a Development Session.	Executive Director of Nursing & Midwifery	Executive Director of Nursing & Midwifery	March 2026	<b>17.3.25</b> Leon Marsh confirmed that guidance still in draft, with no further updates. Current schedule being embedded is Dec 25.
2.12.25	COB and moved to forward work plan at agenda setting.	Executive Director of Allied Health Professions & Health Science	Adult Mental Health & Learning Disabilities <ul style="list-style-type: none"> <li>• Mental health crisis</li> <li>• Perinatal and Eating Disorder Service</li> </ul>	Item came from COB	Executive Director of Allied Health Professions & Health Science	Executive Director of Allied Health Professions & Health Science	To be advised	
2.12.25	COB and moved to forward work plan at agenda setting.	Executive Medical Director	Controlled Drugs Accountable Officer Report	Item came from COB	Executive Medical Director	Executive Medical Director	July 2026	Consider for March 26 meeting.  20.01.26 – to be included on Jul 26 agenda to align with last years reporting schedule
2.12.25	COB and moved to forward work plan at agenda setting.	Executive Director of Nursing & Midwifery	Children & Young People <ul style="list-style-type: none"> <li>• Childrens Charter</li> <li>• Youth Board</li> </ul>	Item came from COB	Executive Director of Nursing & Midwifery	Executive Director of Nursing & Midwifery	To be advised	
2.12.25	COB and moved to forward work plan at agenda setting.	Executive Director of Nursing & Midwifery	Pharmaceutical Services <ul style="list-style-type: none"> <li>• Independent Review of Hospital Clinical Pharmacy Services</li> <li>• Radiopharmacy Services</li> </ul>	Item came from COB	Executive Medical Director	Executive Medical Director	To be advised	

**Completed items**

28.11.25	Email Request	Director of Corporate Governance	JCC Highlight Report	Highlight report from recent JCC meeting/s	Director of Corporate Governance	Pam Wenger	Jan 2026	To be added to next agenda  Will come as part of the corporate governance report.  On January agenda
05.11.25	Email Request	Chairman/ Director of Corporate Governance	Child Practice Review Briefing	A briefing capturing the recent report and underlining the steps being taken as a Health Board	Angela Wood/Helen Stevens-Jones	Pam Wenger	January 2026	This came to Committee in October and the briefing has been shared
30.10.25	Verbal request	Head of Corporate Governance	NHS Wales JCCQC Chair's Report	Item deferred from Nov 25 meeting to Jan 26 as update not available. To be added "for information" section.	Director of Corporate Governance (Pam Wenger)	Pam Wenger	January 2026	To be added to next agenda  This will come via the Corporate Governance Report

### Mewn ffigyrau

Nifer y gweithgareddau ymgysylltu	Nifer y newid gwasanaethau	Nifer y cynrychioliadau	Nifer yr achosion eiriolaeth	Nifer y bobl yr ymgysylltwyd a hwy
9	5	8	254	48

## Themâu allweddol:

### Cynrychiolaeth:

- Cais am Fapiau Safle Ysbytai gael eu hanfon at gleifion gyda llythyrau apwyntiad.
- Sganio PET-CT ym Maelor Wrecsam ddim yn weithredol.
- Pryderon gan gleifion ynghylch oedi wrth dderbyn triniaeth oherwydd nad oes sgan PET-CT ar gael yng Ngogledd Cymru.
- Pryderon gan gleifion meddygfa Hanmer bod cais am portacabin ychwanegol wedi'i wrthod a bydd yn cyfyngu ar y gwasanaethau a ddarperir i gleifion.
- Nodiadau cofnod claf ar gyfer claf â dementia.
- Trefniadau presgripsiwn ailadrodd ar gyfer cyffuriau gwrth-wrthod yn dilyn trawsblaniad aren.
- Pryderon parcio ym Maelor Wrecsam.

### Eiriolaeth Cwynion

- Diagnosis wedi'i fethu / oedi cyn diagnosis (Meddyg Teulu ac Ysbyty)
- Triniaeth / Gofal yn yr Ysbyty
- Gwasanaethau Mamolaeth
- Oedi cyn triniaeth
- Mynediad at apwyntiadau Meddyg Teulu
- Cefnogaeth Tîm Iechyd Meddwl Cymunedol

### Ymgysylltu:

- Trafodaeth Iechyd Merched
- Trafodaeth gyda Sefydliad DPJ a'u gwaith
- Prosiect Meddwl Ymlaen Gwynedd a Môn
- Newid Gwasanaeth Sgrinio Clyw Newydd-anedig Iechyd Cyhoeddus Cymru

### Yn cynrychioli Llais:

- Grŵp Llywio Ysbyty Tywyn
- Pwyllgor Ansawdd, Diogelwch a Phrofiad BIPBC
- Digwyddiad Maniffesto Llais
- Mapio Rhanddeiliaid Ysbyty Penley
- Cyfarfod gyda Phrif Weithredwr BIPBC a Llais



### In figures

No. engagement activities	No. service changes	No. representations	No. open advocacy cases	No. people engaged with
9	5	8	254	48

### Key Themes:

#### Representation

- Request for Hospital Site Maps to be sent to patients with appointment letters.
- PET-CT Scanning at Wrexham Maelor not operational.
- Concerns from patients regarding delay in receiving treatment due to no PET-CT scan available in North Wales.
- Concerns from patients of Hanmer GP practice that application for additional portacabin has been refused and will restrict the services provided to patients.
- Patient record notes for patient with front temporal dementia.
- Repeat prescription arrangements for anti-rejection drugs following kidney transplant.
- Wrexham Maelor parking concerns.

#### Complaints Advocacy

- Missed diagnosis / delays in diagnosis (GP and Hospital)
- Treatment / Care at Hospital
- Maternity Services
- Delay in treatment
- Access to GP appointments
- Community Mental Health Team Support

#### Engagement

- Women's Health Discussion
- Discussion with DPJ Foundation and their work
- Mind our Futures Gwynedd and Môn Project
- Public Health Wales Newborn Hearing Screening Service Change

#### Representing Llais

- Tywyn Hospital Steering Group
- BCUHB Quality Safety and Experience Committee
- Llais Manifesto Event
- Penley Hospital Stakeholder Mapping
- Meeting with Chief Executive BCUHB and Llais



If you would like further information about any of the above please contact us on [northwalesyourvoice@llaiscymru.org](mailto:northwalesyourvoice@llaiscymru.org)