

## **Bundle BCU Quality, Safety and Experience Committee 15 January 2026**

- 1 PRELIMINARY MATTERS
  - 1.1 13:00 - QS26.1 Welcome & Apologies  
*Caroline Turner, Chair*
  - 1.2 13:05 - QS26.2 Declarations of Interest  
*Caroline Turner, Chair*
  - 1.3 13:06 - QS26.3 Unconfirmed minutes of meeting held 6 November 2025  
*Caroline Turner, Chair*  
QS26.3 QSE Unconfirmed Minutes 06.11.2025 Public V0.3
  - 1.4 13:09 - QS26.4 Public Action Log  
*Caroline Turner, Chair*  
QS26.4 Action Log PUBLIC
  - 1.5 13:13 - QS26.5 Patient Story  
*Angela Wood - Executive Director of Nursing & Midwifery*  
QS26.5 QSE Committee - Patient Story
- 2 STRATEGIC ITEM
  - 2.1 13:33 - QS26.6 Rapid Review - Emergency Department  
*Dr Clara Day, Executive Medical Director*  
QS26.6.1a Rapid Review  
QS26.6.2a Measurement of safety of care within Emergency Pathways  
QS26.6.2b UEC Operational Principles - December 2025  
QS26.6.2c Operational Standards
- 3 GOVERNANCE, RISK & ASSURANCE
  - 3.1 13:53 - QS26.7 Integrated Quality Performance Report  
*Angela Wood - Executive Director of Nursing & Midwifery / Dr Clara Day - Executive Medical Director*  
QS26.7 QSE Committee -Integrated Quality Report V2
  - 3.2 14:23 - QS26.8 Integrated Performance Report  
*Ed Williams, Director of Performance*  
QS26.8a IQPR  
QS26.8b IQPR PDF
  - 3.3 14:43 - QS26.9 Board Assurance Framework  
*Nesta Collingridge, Head of Risk Management*  
QS26.9 QSE Board Assurance Framework January 2026
  - 3.4 14:53 - Break
- 4 IMPROVING QUALITY, OUTCOMES & EXPERIENCE
  - 4.1 15:03 - QS26.10 Challenged Services Update  
*Paolo Tardivel, Interim Executive Director of Transformation and Strategic Planning*  
QS26.10 Challenged Service Update V.2
  - 4.2 15:18 - QS26.11 Women's Services  
*Tehmeena Ajmal, Chief Operating Officer*  
QS26.11 Womens Services Update
- 5 15:33 - FOR INFORMATION
  - 5.1 QS26.12 Corporate Governance Report  
*Pam Wenger, Director of Corporate Governance*  
QS26.12.a Corporate Governance Report  
QS26.12.b JCC Update  
QS26.12c QSE Forward Work Plan

- 5.2 QS26.13 Llais Summary Report  
*Llais*
  - QS26.13.a Llais Monthly Report Summary E
  - QS26.13b Llais Monthly Report Summary W
- 5.3 QS26.14 Quality Delivery Chairs Report  
*Angela Wood, Executive Director of Nursing & Midwifery*
  - QS26.14 Quality Delivery Group Chairs Report
- 6 15:43 - CLOSING BUSINESS
- 6.1 QS26.15 Agree Items for Chairs Report
- 6.2 QS26.16 Review of Meeting Effectiveness
- 6.3 QS26.17 Date of the Next Meeting - 5 March 2026
- 6.4 QS26.18 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 6 November 2025**  
**held via Microsoft Teams**

<b>Committee Members Present</b>	
<b>Name</b>	<b>Title</b>
Caroline Turner	Independent Member (Chair)
Urtha Felda	Independent Member
Mike Larvin	Independent Member
Tehmeena Ajmal	Chief Operating Officer (Part Meeting)
Becky Baker	Head Of Operations & Service Delivery (East Area)
Nesta Collingridge	Head of Risk Management
Clara Day	Executive Medical Director
Fflur Jones	Audit Wales
Mandy Jones	Deputy Executive Director of Nursing
Matthew Joyes	Deputy Director for Legal Services
Joanne Kendrick	Head of Quality
Phylis Makurunje	Aspiring Board Member
Phil Meakin	Associate Director of Governance (Part Meeting)
Jane Moore	Executive Director of Public Health
Teresa Owen	Executive Director of Allied Health Professions & Health Science
Maeve Puleston-Jones	Audit Wales
Geoff Ryall-Harvey	Llais North Wales
Pam Wenger	Director of Corporate Governance
Ed Williams	Director of Performance
<b>In Attendance</b>	
Philippa Peake-Jones	Head of Corporate Governance
Harriet Abbott	Minute Taker

<b>1. PRELIMINARY MATTERS</b>
<p><b>QS25.104 Welcome and Apologies</b></p> <p>Apologies were received for Carole Evanson, Lois Lloyd, Paolo Tardivel, Dyfed Edwards, Jane Wild, Angela Wood, Chris Lothian-Field, and Dave Harries.</p> <p>Becky Baker attended on behalf of Carole Evanson, and Mandy Jones attended on behalf of Angela Wood.</p>
<p><b>QS25.105 Declarations of Interest</b></p> <p>No declarations of interest were received.</p>
<p><b>QS25.106 Unconfirmed Minutes of the Meeting held on 4 September 2025</b></p>



The minutes of the meeting held on 4 September 2025 were reviewed and the following amendments were noted:

- QS25.87: 'AAA Pathway' to be amended to 'Abdominal Aortic Aneurysm open surgery pathway' for clarity.

It was agreed that the minutes of the meeting held on 4 September 2025, subject to the amendments, were a true and accurate record.

The following action was agreed:

- **Action QS25.106.1:** Cycle of business to be reviewed ahead of the next financial year

### QS25.107 Matters Arising & Action Log

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

- Action QS25/60.1: agreed to close

It was resolved that the Committee:

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

*[Geoff Ryall-Harvey joined the meeting].*

### QS25.108 Patient Story

The Deputy Executive Director of Nursing presented the report and the following points were highlighted:

- The item highlighted the importance of gaining patient experience, from both positive and negative aspects to provide opportunity for learning and improvement.
- The use of the Civica survey to gain feedback.
- The feedback within the item was shared with the relevant departments for learning and improvement.
- 11 Claims have been received relating to DVT, to the sum of £6.7million, of which £4.7 million related to hospital acquired thrombosis.
- Deep Vein Thrombosis (DVT) Awareness sessions are available for BCU staff, and the implementation of a mandatory training module is being explored.
- Delayed or misdiagnosis was the most featured contributing factor, highlighting the importance of early detection.
- BCUHB is identified as a DVT exemplar, demonstrating excellence in prevention and management of DVT.

During discussion of the item, the Committee:

- Clarified that the Hospital Thrombosis meeting takes forward any learning regarding DVT and this is shared across BCU sites for continued shared practice and learning.
- Discussed the streamlining processes being used in urgent and emergency care.

- Clarified regarding Same Day Emergency Care Departments (SDEC). SDEC is for patients who can be seen and then discharged, and will then return to hospital for further follow up. This is a form of urgent scheduled care and is established on all BCUHB acute hospital sites.
- Acknowledged the link between claims and patient experience, with learning and improvement.

It was resolved that the Committee:

- **NOTED** the report.

## 2. GOVERNANCE, RISK & ASSURANCE

### QS25.109 Corporate Risk Register

The report was presented and the Head of Risk Management highlighted:

- The Corporate Risk Register (CRR) is being reviewed by each committee prior to submission to the Board.
- The risk relating to timely access to safe and effect care has been consolidated from several operational risks as well as emergency and urgent care.

In discussing the item, the committee:

- Advised that that the CRR will be submitted to the Board in November, following validation from Internal Audit.
- In the last 12 months, there has been limited reduction seen in risks. This is therefore a priority area for the next year.
- Advised that a piece of work has been commissioned with internal audit focusing on regulatory risk to ensure consistency and robustness. This will be submitted to this Committee and then onto Board when complete.
- Advised of a planned development session scheduled for Board in February 2026 focusing on compliance. Further update will be received at this committee following this session.
- Acknowledged the ongoing work and progress on the item, and success with managing internally as well as with Welsh Government.

*[Ed Williams joined the meeting].*

- Advised that performance metrics assist in improving quality of care, as often performance is a quality indicator.
- Advised a Rapid Quality Summit is taking place next week, looking specifically at quality indicators.
- Emphasised the importance of ensuring both quality and performance indicators are reflected with the CRR and Business Assurance Framework (BAF) to manage risk.

It was resolved that the Committee:

- Received **ASSURANCE** and **ENDORSED** the report.

*[Phylis Makurunje joined the meeting].*

### QS25.110 Integrated Quality Report

The Committee received the report and the following points were highlighted:

- Clarified that the MHRA hip replacements alert is being addressed by the Executive Medical Director to ensure assurance.
- Reviewed the largest areas of concern, including increased levels of C-Diff in Wrexham Maelor Hospital (WMH), and that this is being addressed by the Infection Prevention Control Team with the site team.
- Advised that NICE Guidance compliance is being reviewed to identify outliers, to ensure escalation to quality governance and this Committee if required.
- Acknowledged the issues regarding delayed receipt of death certificates that has been identified.
- Advised of some highlighted concerns to be address following an HIW unannounced inspection at WMH Emergency Department.
- Noted that no Prevention of Future Death (PFD) reports have been received during the covered period in the report, but that a report had been received after submission of papers regarding CAMHS referrals.
- Acknowledged concerns raised regarding CAMHS referral processes, and were advised that changes have been made, and an audit is currently being undertaken to ensure changes are embedded.

In discussing the report, the Committee:

- Acknowledged regarding safeguarding, the Child Practice Review published earlier this week. This will be an item on the next Committee agenda.
- Noted the Civica data regarding waiting times within the report.
- Clarified that the data is currently being reviewed by the analysis team to identify trends for relevant services. An update will be included at the next meeting.

The following actions were agreed:

- **Action QS25.110.1:** Child Practice Review to be discussed at the next Committee meeting.
- **Action QS25.110.2:** Civica data and feedback trends to be discussed at the next Committee meeting.

It was resolved that the Committee:

- **NOTED** the report.

### QS25.111 Integrated Performance Report

The Committee received the report, and the Head of Performance highlighted:

- Performance is reported to both the Quality, Safety & Experience (QSE) Committee and the Performance, Finance and Information Governance (PFIG) Committee.
- An important factor in relation to reporting for QSE relates to harm that could result from long wait times.
- IPEDG has formally de-escalated clinical coding due to improvement of performance, and this is now removed from the register.

In discussing the item, the Committee:

- Acknowledged that potential correlation between waiting times and risk.
- Emphasised the importance of effective pathway management.
- Queried the measure in relation to coding errors outlined in the report. It was clarified that this is expected to improve with the recent de-escalation.
- Emphasised the importance of close monitoring of Welsh Risk Pool and ensuring any learning needs and opportunities are addressed.
- Acknowledged in regards to Welsh Risk Pool, that there has been significant reduction in the past 12 months of overdue cases, whilst also noting that some attention is still required in regards to forms that are returned. Improvement is expected to be seen in this area.
- Advised that the format of reporting will be reviewed and improved going forward due to recent appointment of the Senior Reporting Officer.

It was resolved that the Committee:

- **NOTED** the report.

*[Ed Williams left the meeting].*

### **QS25.112 Nurse Staffing Act**

The Committee received the report, and the following points were highlighted:

- The Nurse Staffing Act applies to all medical, surgical and paediatric wards (known as 25b wards).
- The same principles apply to all Health Boards in Wales, and due to the Act, all 25b wards are required to report to the Board. The presented report will be submitted to the Board following review at this Committee.
- An acuity audit is completed biannually, using quality indicators to mandate the Act.

In discussing the item, the Committee:

- Clarified that in the last three years, there has been a £12 million uplift in regards to nurse staffing within BCUHB.
- Requested clarity be provided within the report prior to submission to the Board regarding required budget amendments.

The following actions were agreed:

- **Action QS25.112.1:** Budget arrangements to be clarified within the report prior to submission to Board.

It was resolved that the Committee:

- **RECEIVED** the report.

*[Fflur Jones joined the meeting].*

### **QS25.113 Welsh Risk Pool and Legal & Risk Services Annual Review 2024/25**

The Committee received the report, and the Deputy Director of Legal Services highlighted:

- Consistent number of concerns received.
- There is an approximate 40% claim success rate, which is similar to previous years.
- The highest number of claims relates to Maternity Services, Emergency Departments & Minor Injuries Departments and Orthopaedics.

In discussing the item, the Committee:

- Noted the increasing costs and financial pressures relating to claims.
- Acknowledged the reduction in Personal Injury claims highlighted in the report.
- Clarified the Redress process that applies only in Wales, and advised of an approximate 100% increase in these types of claims within the past year. It was advised that this increase is thought to be linked to the introduction of Duty of Candour in Wales.
- Noted the I-Doe System referenced, and the benefits of this in gaining patient informed consent.
- Advised that an annual assessment is due to take place in regards to the Putting Things Right assurance process. Once concluded, a report will be submitted to this committee to review. This is expected in around six months' time.
- Clarified regarding General Medical Practice Indemnity (GMPI). The Health Board indemnifies GP providers in Wales, and will manage any claims submitted against GP providers.

*[Maeve Puleston-Jones left the meeting].*

- Clarified that the timescales to address with redress will reduce from 12 months to six months, with the claimant limit increasing from £25K to £50K. Following these changes, there is expected to be an increase in cases.
- Advised that the Committee is notified on any regulatory changes or required actions for assurance.

It was resolved that the Committee:

- **RECIEVED** the report.

### **QS25.114 Infection Prevention Annual Report**

The Committee received the report, and the Executive Director of Public Health highlighted:

- BCUHB are one of the most compliant in relation to Welsh Health Boards, with good progress in a number of areas.
- In relation to Healthcare Acquired Infections, there is evidence of good ability to maintain effective interventions and work to prevent or reduce impact of infection.
- A number of issues have been noted around E.coli and C-diff, as well as increasing levels of norovirus.
- Work is ongoing regarding Outreach with care homes, which has resulted in significant gains with confidence of care homes managing Infection Prevention Control (IPC) issues, with hope this will reduce infection rates.

In discussing the item, the Committee:

- Requested the inclusion on future reports of data relating to community acquired infections, to utilise and try to reduce transmission.
- Clarified that future reports will attempt to differentiate between Community Acquired Infections and Hospital Acquired Infections.
- Discussed decant space on hospital sites, and advised that a business case is being drafted for a decontamination model at Wrexham Maelor Hospital.
- Advised that National Cleaning Standards are being reviewed following publication, to identify any required actions for BCU which will be addressed.
- Discussed IPC measures in regards to a number of estates, including Wrexham Maelor Hospital and the new Orthopaedic development in Llandudno Hospital.

*[Fiona Giraud joined the meeting].*

- Reviewed the rates for staff flu vaccination, and noted significant progress against last year's position to date.

It was resolved that the Committee:

- **NOTED** the report.

### 3. IMPROVING QUALITY, OUTCOMES AND EXPERIENCE

#### QS25.115 Perinatal (Maternity & Neonatal) Assurance Self – Assessment Briefing

The Committee received the report, and the Director of Midwifery & Women's Services advised of the following in addition to the presentation:

- The Self-Assessment was commissioned by Welsh Government on Maternity and Neonatal Services to provide assurance to the Cabinet Secretary for Wales. The Self-Assessment will focus on forward view incorporating the voice of patients and the workforce, and will provide assurance on six workstreams detailed within the presentation.
- Each Health Board will receive a findings report and a national thematic review with recommendations to consider.

In discussing the item, the Committee:

- Requested for item to be reported to the Board meeting in January 2026 for assurance.
- Noted the importance of input of minority groups.
- Agreed for the Terms of Reference to be shared with the Head of Corporate Governance and the Executive Director of Allied Health Professionals & Health Sciences.
- Advised that Llais North Wales are continuing to support regarding engagement

The following actions were agreed:

- **QS25.115.1:** Terms of Reference to be shared

It was resolved that the Committee:

- **NOTED** the report.

*[Tehmeena Ajmal joined the meeting].*

### **QS25.116 Updates of Challenged Services**

The Committee received the report, and the Executive Medical Director:

- Advised of a recent visit from the Chief Medical Officer to Ysbyty Glan Clwyd and Oncology, which focused on several areas, including consultant workforce and centralised regional working models.

The following points were also highlighted:

- The importance of clinical leadership with appropriate constraints.
- Ensuring effective use of resources and how these are used to manage waiting lists.

In discussing the item, the committee:

- Found the paper useful in providing a summary of the current position, giving better insight and assurance in key areas.
- Noted the positive engagement with the workforce and clinical leads, and emphasised the importance of empowering leaders and those within the services, as well as the use of coaching, mentoring and sharing of learning and good practice.
- Supported the pan BCU approach now being adopted through a number of services, which will be embedded through the Foundations of the Future framework.
- Were advised by the Director of Corporate Governance that this area, due to the ongoing work and progress, has been de-escalated from the corporate risk register to the operational risk register, and highlighted the importance of ensuring risks are sighted to prevent escalation.
- Noted the improved position within a number of specialities, including plastics and urology, but also noted areas requiring further improvement, such as Orthodontics, but acknowledged that progress was being made.

It was resolved that the Committee:

- received **ASSURANCE** on the report.

*[Tehmeena Ajmal and Nesta Collingridge left the meeting].*

### **QS25.117 Proposed Changes to 'Independent Funding Requests' and 'Prior Approval Requests' Policies**

The Committee received the update, and the following was highlighted:

- The policies included are pan Wales, and have been received via the Joint Commissioning Committee (JCC).
- The updates within the documents relates to the appendices to ensure consistency across Health Boards in Wales.
- Following approval at committee, the updates will be taken to the Board for ratification.

*[Phil Meakin joined the meeting]*

In discussing the item, the Committee:

- Clarified that frequency requests are received is dependent upon NICE guidelines.
- Queried a number of potential inaccuracies within the report regarding a number of job roles/titles referenced, and absence of Mental Health representation. It was agreed for this to be fed back to the authors to ensure accuracy.
- Noted a point highlighted from Llais, referencing variance in exceptionality between England and Wales with services that are required as standard.
- Agreed it would be useful to understand numbers in relation to BCUHB's populations. This will be followed up ahead of discussion at Board, and clarified outside of the meeting to ensure appropriate governance.

The following actions were agreed:

- **QS25.117.1:** Director of Corporate Governance to feedback job role/title inaccuracies referenced and representation within the policy updates to the authors.

It was resolved that the Committee:

- **NOTED** the report and **ENDORSED** the contents, subject to the corrections referenced.

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

The Committee received the update from the Executive Director of Allied Health Professions & Health Sciences, and the following was highlighted:

- The Expert Advisory Group (EAG) was initiated in response to the report of the Royal College of Psychiatrists
- The Independent Chair of the EAG is concluding the final report currently, which will be submitted to the Board following completion.
- Thanks was given to individuals who had been involved the with EAG work, along with Llais who have also been involved throughout the process.
- There is ongoing work to continue engagement with stakeholders involved to continue to support work.
- As referenced in appendix 1, there are 19 improvement actions outstanding relating to the governance aspects. A number of these actions are due to RIGA or further information being required. Previous monthly meetings have been increased to fortnightly, to review and manage outstanding actions, which are scheduled to end in December 2025.

In discussing the item, the Committee:

- Reflected upon Tawel Fan, and the unacceptable standards of care given previously, and acknowledged the importance of the work completed through the EAG for recognition, learning and improvement going forward.
- Acknowledged the time and resources contributed to the project by all those involved.
- Emphasised the importance of revisiting and assessing the progress of embedded changes. It was clarified that the draft outcome framework referenced within the

report would have this purpose, and emphasised the importance of ensuring the data captured accurately reflects the qualitative experience.

- Were advised that work with stakeholders will be taking place, and the Committee will be updated with further work and progress.
- Highlighted the importance of learning from this process and listening to improve services.
- Suggested writing a case study of the approach and stages of work to capture the work's complexity, and recording what has gone well, as well as the challenges faced

It was resolved that the Committee:

- **NOTED** and received assurance regarding the report.

*[Phil Meakin left the meeting].*

#### 4. FOR INFORMATION

##### QS25.119 Corporate Governance Report

The Committee:

- **NOTED** the summary of business considered in private session to be reported in public.
- **NOTED** the forward workplan.

#### 5. CLOSING BUSINESS

##### QS25.120 Agree Items for Referral to Board / Other Committees

- No actions were to be considered or referred to another Committee.

##### QS25.121 Review of Meeting Effectiveness

The Committee advised:

- Preference is for the meeting to be held face to face, but aware of exceptional circumstances due to technical difficulties for today's meeting.
- There was good discussion, and it was helpful to have a variety of executives in attendance.

##### QS25.122 Date of next meeting

15 January 2026

##### QS25.123 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 07.01.2026

### 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 <b>(Pam Wenger)</b>	March 2026	<b>Remain Open</b>  06.11.25 – referenced in 06.11.25 meeting as further action QS25.106.1  07.01.26 – action ongoing
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 Executive Medical Director to check the veracity of colonoscopy data provided in	Exec. Dir. Allied Health Professionals & Health Science <b>(Teresa Owen)</b> <del>Interim COO</del>	17.12.24  May 2025	<b>Remain Open</b> <b>9.12.24</b> TO spoke with Deputy Executive Medical Director. Data/information is being checked by the team. <b>12.2.25</b> Jim McGuigan advised that Imran Devji was aware of this query and



			report, and to escalate concerns if required.	<b>(Imran Devji)</b> Chief Operating Officer – <b>Tehmeena Ajmal</b>		investigating.  Update to be received at meeting  07.01.26 – awaiting update
4	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 be discussed at a future QSE Committee.	Director of Partnerships, Engagement & Communication <b>(Helen Stevens Jones)</b>	January 2025	<b>Remain Open</b>  07.01.26 – awaiting update
<b>Suggest Close</b>						
5	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.
6	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
7	QS25.112.1	06.11.25	<b>Nurse Staffing Act</b> Budget arrangements to be clarified within the report prior to submission to Board	Executive Director of Nursing & Midwifery <b>(Angela Wood)</b>	November 2025	<b>Suggest Close</b>  16.12.25 – Clarified at Executive Committee. Action complete.



8	QS25.115.1	06.11.25	Terms of Reference to be shared	Head of Corporate Affairs <b>(Philippa Peake-Jones)</b>	January 2026	<b>Suggest Close</b> 07.01.26 – TOR shared. Action to Close
9	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	November 2025	<b>Suggest Close</b> 10.12.25 – advised action complete.

**Closed Actions (Closed at 06.11.25 meeting)**

Action No.	Minute Ref.	Date	Agreed Action	Lead	Timescale	Status
1	QS25/83.1	04.09.25	<b>QS25/83 Patient Story – Play Therapy</b> AW to discuss with her Directors of Nursing the possibilities of linking with play specialists, with a view to providing a suite of resources.	Exec. Dir. Nursing & Midwifery ( <b>Angela Wood</b> )	Nov 2025	<b>Suggest close</b> It is not possible to take this forward at this time.
2	QS24/104.1	13.2.25	<b>QS24/104 Meeting Effectiveness</b> To ensure more time allocated to Primary care on COB.	Head of Corporate Governance <b>(Philippa Peake-Jones)</b>	Nov 2025	<b>Suggest close</b> It has been agreed that Primary Care is the responsibility of PPHP and is being taken forward through that Committee
3	QS25/55.1	03.07.25	<b>QS25/55 Matters Arising and Action Logs</b>	Exec. Dir. Nursing & Midwifery ( <b>Angela Wood</b> )	Sept 2025	<b>Suggest close</b> <b>7.07.2025</b> - Angela Wood has discussed



			To discuss how best to support and scrutinise quality of services. An update to be provided at next meeting.	<b>Wood)</b> <b>Dir. Of Commissioning &amp; Performance</b> <b>Stephen Powell</b> All IHC Directors <b>(Vic Peach</b> <b>Gareth Evans</b> <b>Michelle Green)</b>		with Stephen Powell. IHC representatives to attend the commissioning meetings for services aligned to the IHC. Update awaited from Stephen Powell <b>4.9.2025</b> Angela Wood noted that Stephen Powell would not be updating Committee and that she would provide update for the November mtg. <b>29.10.25</b> Confirmation that IHCs are attending the commissioning meetings
3	QS25/59.1	03.07.25	<b>QS25/59 Corporate Governance Review</b> To discuss slight amendments to Annual report and Annual Self-Assessment outside the meeting. to discuss amendments	Chair <b>(Caroline Turner)</b> Head of Corporate Governance <b>(Philippa Peake-Jones)</b>	September	<b>Suggest close</b> <b>4.9.25</b> The Annual Report has been amended and is being signed off
4	QS25/31.2	01.05.25	<b>QS25/31 Overview of Mental Health</b> Invite Board to a session regarding Children's Mental Health Team accessibility – with Vicky Jones, Head Mental Health Strategic Programme	Head of Corporate Governance <b>(Philippa Peake-Jones)</b>	May 2025	<b>Suggest close</b> Transferred to the Board Development
6	QS25/43.1	01.05.25	<b>QS25/43 Review Committee Forward Work Plan</b>	Head of Corporate Affairs <b>(Philippa Peake-Jones)</b>	September 2025	<b>Suggest close</b> <b>03.07.25</b> PP-J confirmed that work continues to align the FWP with the Annual Plan – Updated work plan



						included as part of agenda bundle. <b>4.9.25</b> PP-J confirmed work ongoing to align with revised Cycle of Business Cycle of Business and Forward work plan now aligned
14	QS25/38.1	01.05.25	<b>QS25/38 Board Assurance Framework and Corporate Risk Register (CRR)</b> BAF to include more external validations and also to include mitigations, focussing on challenged services' risks.	Head of Risk Management <b>(Nesta Collingridge)</b>	July 2025	<b>Suggest close</b> <b>03.07.25</b> Work continues, to align the BAF with the Annual Plan.  <b>28.08.25</b> – Informal Executive meetings were held on 16th July and 20th August, which reviewed challenged services risks. Changes to be communicated with the Chair through CRR report and 28th Aug Risk Appetite session.
1	QS25/60.1	03.07.25	<b>QS25/60 Integrated Quality Report</b> To circulate details of the Medical and Healthcare products Regulatory Agency breach.	Clara Day <b>(Sree Andole)</b>  <b>(Clara Day)</b>	July 2025	<b>Suggest close</b> <b>4.9.25</b> Delayed. SA advised it will come to QSE once it has gone through QDG.  A detailed paper is being drafted by Lois.

## Quality Safety & Experience Committee

### STORI GOFALWYR CARERS STORY

<b>Dyddiad y Cyfarfod Date of Meeting</b>	15 January 2025
<b>Statws Cyhoeddi Publication Status</b>	Open/ Public
	Not Applicable
<b>Enw a theitl Awdur(on) yr Adroddiad Report Author name and title</b>	Rachel Wright, Patient and Carer Experience Lead
<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

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

<b>Crynodeb Gweithredol Executive Summary</b>
<p>A patient or carer story is presented to QSE Committee to bring the voice of the people we serve directly into the meeting.</p> <p>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.</p> <p><a href="#">Carers Story Cymraeg final.mp4</a></p>

<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>
N/A		

---

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

---

## STORI GOFALWYR CARERS STORY

### 1. Overview of Carer Story

The story captures the experience of an un-paid carer who received support from Carers Outreach, a registered charity established to support un-paid carers aged 18 and over in Anglesey, Conwy and Gwynedd.

The story shares the positive impact a referral made by nursing staff at Ysbyty Bryn Beryl to Carers Outreach had on the un-paid carer and the cared for.

#### 1.1 Key Messages

- Carers Outreach describe the support they provided to the un-paid carer and the cared for.
- Storyteller was unaware of the support they were entitled to through Carers Outreach, including benefit maximisation and 3<sup>rd</sup> sector referrals.
- The story highlights the clear benefits of staff working together with Carers Outreach to provide wrap around support packages for patients and their carers.

### 2. Summary of Learning and Improvement

The story has been shared with staff from Ysbyty Bryn Beryl for feedback. This experience has been shared across West Integrated Health Community, to promote good practice and to encourage staff to recognise the important role an un-paid carer can play in the admission and discharge process.

On an annual basis the Health Board receives £213,000 Welsh Government funding to support un-paid carers through a Hospital Facilitation Service. This funding is ringfenced for third sector organisations, and is part of North Wales Regional Integrated Funding (RIF). The Health Board has commissioned NEWCIS (Central and East area of North Wales) and Carers Outreach to provide a Hospital Facilitator Service working across acute and community hospitals in North Wales.

The role of an un-paid carer Hospital Facilitator is to work with staff to encourage referrals to support un-paid carers, and to support the un-paid carer whilst the person they are caring for is an inpatient or recently discharge from hospital. The overall aim is to prevent hospital re-admission.

As part of the “What Matters” conversation that takes place between the patient and a nurse, this conversation will identify if the patient has any caring responsibilities, or any other factors to be considered whilst they are an inpatient and as part of the discharge planning process. If it is identified that a patient is being supported by an

un-paid carer, the carer will be offered a referral for support to a carer organisation (NEWCIS/Carers Outreach/NEWCIS) who can guide them through the discharge process. The relevant carer organisation can support the carer by attending discharge planning meetings, being involved in discussions with clinical services to ensure the level of care they require is provided and discuss any other concerns around discharge.

A member of staff from Carers Outreach is based within Ysbyty Gwynedd Discharge Team. This ensures carers are well supported whilst their cared for is in hospital. It also has the benefit of providing ongoing support when the cared for is discharged back to their own home. This holistic support means they can support carers to care for their dependants safely in the community and reduces rates of re-admittance to hospital, whilst also supporting the wellbeing of the carer.

From 1<sup>st</sup> April 2025 – 30 September 2025, Carers Outreach received 315 referrals from Health Board staff to support un-paid carers through the hospital discharge process. Of the 315 referrals, 242 referrals were from individuals accessing the service for the first time.

In total 299 un-paid carers referred by Health Board staff accessed information, advice and assistance (IAA) services to support benefit maximisation. Carers Outreach support community and secondary hospitals to become carer aware, to help staff understand the needs of carers. From 1<sup>st</sup> April 2025 – 30 September 2025, Carers Outreach delivered 6 training sessions across West IHC and engaged with over 71 members of the public from organising information stands across hospital settings.

Posters and leaflets are on display in hospital areas and on ward patient experience boards to promote the services available to un-paid carers and their families. Across community hospitals, Carers Outreach run monthly support groups, including weekly attendance across sites including information stands in reception areas.

The Health Board is represented at the North Wales Regional Carers Group and on the Welsh Government Ministerial Advisory (MAG) Group for un-paid carers. This is to ensure the voices of North Wales patients and their un-paid carers are heard.

In October 2025, the Health Board completed a Carers Wales, Track the Act 2025 information request outlining how un-paid carers are supported at hospital admission and discharge for the person they care for. To support the submission an exercise was undertaken to map out existing support and provision across all community and acute hospitals. Opportunities for improvement were identified from this exercise. The Patient and Carer Experience Team will be leading on this piece of work, to share good practise and to undertake specific project work to increase referrals to carer organisations.

Carers Outreach have developed a strong relationship with the Patient Advice and Liaison Service. This enables our staff to support concerns before they escalate, to

get a better result and outcome for their carers. This means issues are flagged quickly and preventative measures can be implemented to avoid escalation of further complaints.

The Patient and Carer Experience Team extend their gratitude and appreciation to Carers Outreach and the storyteller for sharing their experiences.

### 3. Recommendations

3.1 The Committee is asked to note this report.

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> <ul style="list-style-type: none"> <li>• Creating compassionate culture, leadership, and engagement.</li> <li>• Establishing an effective environment for learning</li> </ul>
<p><b>Yr Egwyddorion Dylunio</b> <b>Design Principles</b></p>	<p>People First</p> <p>Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:</p> <ul style="list-style-type: none"> <li>• Consistency with organisational values.</li> </ul>
<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)</p> <p>Not Applicable</p>
<p><a href="#"><u>Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant</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>

**Wellbeing of Future  
Generations Act – Wellbeing  
Goals**

- A more equal Wales.
- A resilient Wales.

**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>	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
<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>	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
<p><b>Ansawdd</b> <i>A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?</i> <b>Quality</b> <i>Have you undertaken a Quality Impact Assessment Screening?</i></p>	<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:
<p><b>Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant Wellbeing of Future Generations Act – Wellbeing Goals</b></p>	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	
<b>Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog</b> 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?	Do/Yes: <input type="checkbox"/>	Naddo/No: <input checked="" type="checkbox"/>
	Canlyniad/Outcome:	
<b>Asesiad o Effaith ar Ddiogelu Data</b> A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data? <b>Data Protection Impact Assessment</b> Have you undertaken a Data Protection Impact Assessment Screening?	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> A ydych chi wedi ystyried yr effeithiau ar atal twyll? <b>Counter Fraud Impact Assessment</b> Have you considered the counter fraud impacts	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>	There are no specific legal implications related to the activity outlined in this report.	
<b>Enw Da</b> <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.	



---

**Effaith ar Adnoddau**

*(Pobl / Ariannol)*

**Resource Impact**

*(People / Financial)*

There is no direct impact on resources as a result of the activity outlined in this report.



## Quality Safety & Experience Committee

### Quality of Care in Emergency Pathways: summary of Rapid Quality Review and subsequent actions

<b>Date of Meeting</b>	15 January 2026
<b>Publication Status</b>	Open/ Public
	Not Applicable
<b>Report Author name and title</b>	Dr Clara Day, Angela Wood
<b>Lead Executive Team Member name and title</b>	Dr Clara Day, Executive Medical Director

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

#### Executive Summary

Emergency Departments (EDs) and pathways associated with emergency care within acute sites are currently very busy. This is associated with poor performance in national key performance indicators such as ambulance off load times, time to be triaged and seen by a clinician and time in the department. These are surrogates of quality of care but do not completely represent.

It is well recognised that the pressure within the EDs is reflective of the need for change across whole system pathways which include reduction in attendance at EDs by ensuring reliable and accessible offers elsewhere, and in increase in system flow by reducing length of stay in bedded areas.

This paper describes a Rapid Quality Review held on 14/11/25 and the outcomes of this. These outcomes link closely to operational activity across the system and are seen to be complementary.

Key actions include:

- Review of outstanding business cases identified by clinical and operational teams relating to emergency pathways
- Formalisation of both forward boarding against discharge to the wards and boarding in extremis
- More formal recording and review of quality and safety of care within emergency pathways including agreed 'must report' events and performance in time critical pathways
- Ensuring Quality, Safety and Experience Committee and Board have sight of quality issues with in emergency pathways



- Explicit expectation of clinical and operational working across the acute sites to decompress emergency pathway risks.

**Rhestr o Atodiadau**

**List of Appendices:**

*Appendix 1: Measurement of safety of care within Emergency Pathways*

*Appendix 2a. UEC Operational Principles – December 2025*

*Appendix 2b. Operational Standards*

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

<b>Committee / Group / Individuals</b>	<b>Date</b>	<b>Outcome, Evidence and Data</b>
Executive Committee	17/12/2025	

**Acronyms / Glossary of Terms**


## **Quality of Care in Emergency Pathways: summary of Rapid Quality Review and subsequent actions**

### **1. SITUATION**

- 1.1 It is acknowledged that there is significant pressure within emergency pathways at BCUHB. Focus has been, in the main, on performance metrics such as ambulance handover times, time to triage, time to be seen by a clinician and time within the department. Although these markers of performance are good surrogates for quality of care, the Clinical Executives felt that they did not entirely capture the concerns associated with quality of care within the emergency pathways at the acute sites. To address more specifically, a Rapid Quality Review, chaired by the Executive Medical Director, was held on 14/11/25. This paper summarises the output and subsequent actions

### **2 BACKGROUND**

- 2.1 Care pathways for patients presenting to Emergency Departments (ED) across BCUHB are currently under extreme pressure. This is resulting in concerns about quality of care within these pathways.
- Waits to be seen can be long, within an overcrowded ED.
  - Ambulance handover delays can be considerable; this means patients are waiting outside the ED in ambulances and has a knock-on effect of increased community risk as ambulance availability reduces.
  - In an attempt to reduce this risk, a 45 min maximum handover has been introduced which has transferred risk into the department with the need to care for patients in non-cubicle areas, so-called 'corridor care'.
  - In addition, ambulance delays mean that patients who would traditionally have arrived by ambulance can self-present within the 'walk-in' category. This leads to considerable variation of acuity within this category which requires change in ED practice to identify those with high acuity presentations.
  - Time to transfer out of ED has increased significantly. Waits of 12 hours or more within the ED are considerable. Evidence suggests an increase in 30 day mortality for patients within this group.
- 2.2 All of the above means that patient safety and patient experience are significantly impacted. Staff are also impacted by trying to provide safe and effective care within an extremely crowded and pressurised environment.
- 2.3 The ED overcrowding is mainly as a result of demand from those who could be seen elsewhere if convenient access available, and poor flow through the acute site with significant delay in discharge for some patients. System wide

work is addressing these and other issues; in the meantime clear markers of quality of care in the ED with improvement where needed are required.

2.4 The Rapid Quality Review meeting had the purpose of:

- Giving specific and focused consideration to quality concerns and risks within the pathways passing through the ED
- Facilitate rapid and collective judgements about quality within these pathways
- Identifies actions within these pathways as a result of the risk identified to
  - Measure quality of care and risk within the ED pathways
  - Improve quality of care and reduce risk within ED pathways

2.5 The Rapid Quality Review meeting worked alongside current operational programmes such as the UEC 6 goals programme. It was intended to be complimentary and to identify any major changes of clinical practice and behaviours required to achieve the stated purpose

2.6 Each IHC was asked to prepare together ahead of the meeting and present as below:

- What are your main concerns re quality of care within ED pathways?
  - This should include information on serious incidents over the last 3 months in addition to review of all incidents reported in ED pathways to give a picture of main concerns
- How do you measure quality of care / risk of harm / actual harm in these pathways?
  - How does this feed into day-to-day operational actions, internal governance and local learning / improvement?
  - Are you satisfied, as accountable clinical leaders with local measurement and governance processes or do you feel change required to improve and if so, what do you intend to do?
- What do you need to do to improve quality of care? Please outline action and then how it will improve care
  - What can you do within acute site?
  - What can you do within IHC?
  - What do you need from partners?
  - What do you need from executive team?

2.7 Attendance at the review was good with senior clinical leadership from all IHC present with significant pre-work ahead of the event. There was also linkage demonstrated between emerging operational plans and quality concerns identified



---

2.8 What are your main concerns re quality of care within ED pathways?

- Agreed that a lot based on 'feel' rather than classification; on risk register re timely care
- Use Datix:
  - Pressure ulcers / falls
  - Violence and aggression
  - Other issues with care
- Complaints: long waits, uncomfortable
- Performance metrics reviewed but perhaps inconsistently

2.9 How do you measure quality of care / risk of harm / actual harm in these pathways?

- How does this feed into day-to-day operational actions, internal governance and local learning / improvement?
- Are you satisfied, as accountable clinical leaders with local measurement and governance processes or do you feel change required to improve and if so, what do you intend to do?

Measured as described

Felt not routinely picking up all quality issues. No 'must report' elements. Not routinely looking at time critical pathways. Considerable concern around End-of-Life patients.

- Governance processes described; all present locally with improved processes over last year. Concern about how to spread learning and indeed to enact changes needed to reduce risk when much out of control of ED
- Unclear as to how escalated beyond IHC at present in a structured way to Executive and Board.
- General mistrust of any change actually happening. Tried to escalate clinically before with no success.

2.10 What do you need to do to improve quality of care? Please outline action and then how it will improve care

- What can you do within acute site?
- What can you do within IHC?
- What do you need from partners?
- What do you need from executive team?

Site plans now in place; differing levels of socialisation

All agreed need a few high impact actions that don't change and are driven through to delivery

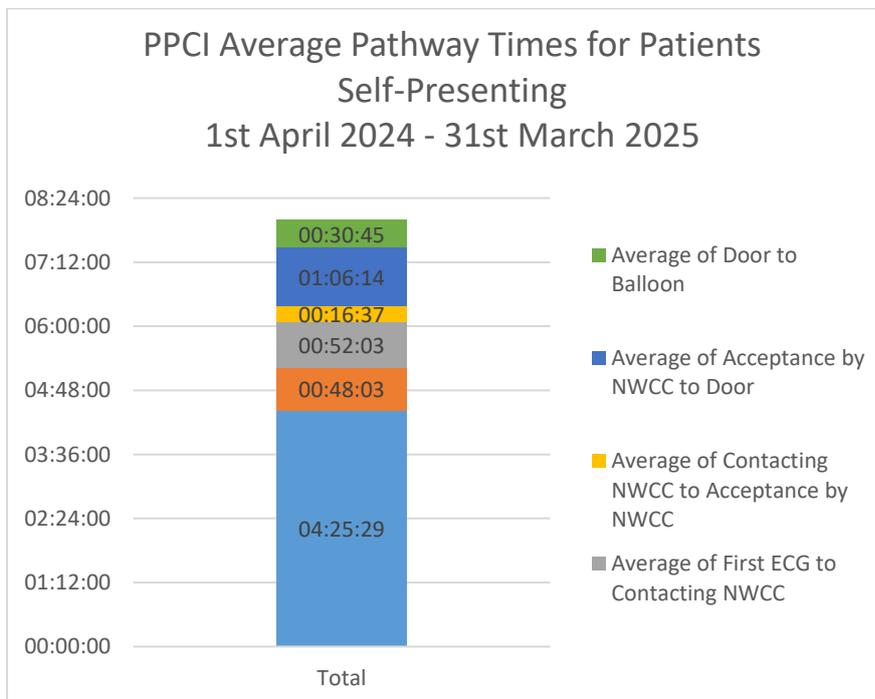
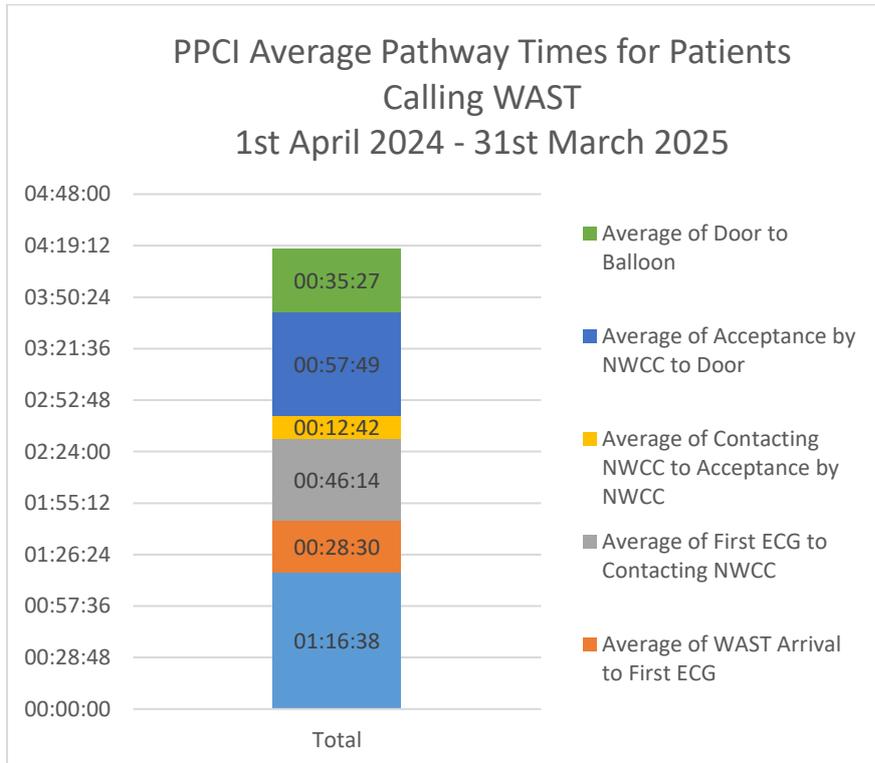
Frustration around constant disabling of Same Day Emergency Care (SDEC) with bedding down

Need clear metrics to deliver against; not just 'we will make ED better'

#### 2.11 From executive / senior leadership teams

- Review where decisions needed and make them: various business cases including those for digital. Includes unfunded beds
- Consistent implementation of 'My next patient' / boarding
- Help with professional standards / behaviour
- Support for defensible care; help for care within a stretched risk framework
- Consideration of 'industrial action style' reset

2.12 Consideration was given to the time-sensitive pathways of myocardial infarction, stroke and fractured neck of femur using national audit data, extended with more contemporaneous data where available. It was noted that there was difference in performances between sites. A particular concern was raised in relation to time to primary coronary angioplasty for patients with myocardial infarction when then self-presented as opposed to when then were conveyed by ambulance. As can be seen in data presented average time to intervention was 4hrs 19 minutes for those being conveyed to the North Wales Cardiac Centre (at YGC) directly by ambulance vs approximately 3 hrs more for those self-presenting at an ED. Attention will be enhanced locally for these pathways.



2.13 Actions were drawn up and agreed. Detail is listed below with progression as of 14/12/25

### 3 SPECIFIC MATTERS FOR CONSIDERATION

#### 3.1 Agreed actions and current progression

Action	Owner	Progress	Next steps
Collate list of 'decisions needed' and progress rapidly with feedback	IHC / executive leadership	List includes: ED business cases for all sites Acute medicine case WM Symphony case EAS case	Being collated with Executive and IHC review with feedback to relevant departments by end of Dec 2025.
Standardisation of process for 'your next patient' and ward boarding with roll out	EDON and IHC / site nursing teams. EMD		Protocol issued week of 1/12/25 with governance sign off before Christmas.
Ensure close working with operational teams at site level so that all aware of actions needed across site	IHC and site teams	IHC have actions plans in place and being implemented	
Emphasis of whole hospital responsibility for ED and need to work to internal professional standards	Executive team	Wider communication w/b 1/12/25	Letter issued w/b 8/12/25 from CEO, EMD, EDON, and COO emphasising operational and professional standards (appendix 1)
Standardisation of methods for recording risk and harm within EDs	Executive team	Issue 'must report' events and other elements week 1/12/2025	Issued w/b 1/12/25 with reporting via weekly Executive Integrated Concerns Oversight Panel meeting beginning w/b15/1/25 (appendix 2)
Clear definition of corridor care and recording of numbers	Executive and DDAT	SOP required for corridor care and ambulance care if not yet done. EDON to chase with IHC DONs	Draft to be in place end of week 15/12/25

<p>Governance escalation route for safety concerns from ward to board</p>	<p>IHC and Executive team</p>	<p>Structured reporting via EICOPs w/b 8/12/25 then to QDG/QSE. Summary of RQR to Board 27/11/25.</p>	<p>IHC to ensure reporting routes in place and sharing of learning across department Full report of RQR to QSE 15/1/26. Reporting of all emergency pathway incidents into executive weekly UEC huddle commenced w/b 1/12/25</p>
---------------------------------------------------------------------------	-------------------------------	-----------------------------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

3.2 In addition to the Rapid Quality Review, Health Education and Improvement Wales (HEIW) made a targeted visit for Medicine at Ysbyty Gwynedd on Wednesday, 26<sup>th</sup> November 2025 following concerns raised in the this year’s GMC survey.

3.3 Requirements from this visit are listed below and relate to concerns raised by resident doctors both into patient safety and into the perceived cumbersome nature of reporting incident by Datix.

- Review reported incidents of patient harm across Acute Internal Medicine in order to look for substantiation of concerns over potential daily incident with report on the outcome of this to HEIW by Tuesday, 13th January 2026.
- Introduce a temporary reporting system, quickly and easily accessible to resident doctors within Acute Internal Medicine, which will allow them to report instances of patient harm over a 4-week period. The data should be collated and discussed with resident doctors in order to verify or reassure regarding the concerns over daily incidences of harm. Provide update on the outcomes of this to HEIW by Tuesday, 13th January 2026.
- The Health Board must ensure all HEIW residents currently in post are assigned a Named Clinical Supervisor. The Named Clinical Supervisor must have appropriate time and training to support residents learning needs.

3.4 A simplified, and if needed, anonymous reporting system has been produced and will be overseen, as with other incidents, in the weekly Executive Integrated Concerns Oversight Panel. The Executive Medical Director will review whether this needs to be continued beyond the initial 4-weeks and whether needs spreading across the other acute sites.

#### 4 KEY RISKS / MATTERS FOR ESCALATION

4.1 Quality of care within emergency pathways is a concern. Current performance metrics are a good surrogate for safe care; for instance:



- 
- 45 min ambulance handover ensures that ambulances are free to return to the community to address urgent need
  - time to triage ensures early pick up and investigation of time critical conditions
  - more than 12 hrs in the department has been shown to be associated with an increased 30 day mortality
- 4.2 However, more specific quality surveillance of emergency pathway care is required and methodology for this, along with governance escalation routes, has been described
- 4.3 It must be emphasised that the best and most effective ways of improving quality of care in Emergency Pathways sit outside of the Emergency Department. In particular, pre-hospital routes of diverting patients from EDs and earlier discharge of patients with prolonged lengths of stay. Whole system working therefore remains vital to improve care quality within very stretched departments..

## 5 **RECOMMENDATIONS**

5.1 The Executive Committee is asked to:

- **NOTE AND SUPPORT ACTIONS DESCRIBED**



ASSESSMENT	
<b>Link to Strategic Priorities</b>	    
	4. Improving quality, outcomes and experience
	If more than one applies, please list below:
<b>Design Principles</b>	Simplify, Standardise, and Adopt Best Practices If more than one applies, please list below:
<b>Corporate Risks and Board Assurance Framework</b>	CRR25-01 Timely patient access to safe and effective care BAF24-07 Not Delivering Timely Access to Care Resulting In Potential Clinical Harm, Poor Delivery of Performance Targets and Reputational Risk
<b><u>Wellbeing of Future Generations Act – Wellbeing Goals</u></b>	A Healthier Wales
	If more than one applies, please list below:

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:	
<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:	
<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:

---

<b>Wellbeing of Future Generations Act – Wellbeing Goals</b>
----------------------------------------------------------------------

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:	No current major change in delivery
<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:	No current major change in delivery
	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:	No current major change in delivery
<b>Legal</b>	Yes (Include further detail below)	
	Previous Regulation 28s issued, Continued coronial interest	
<b>Reputational</b>	Yes (Include further detail below)	
	Considerable public and elected representative concern	
<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.	
	However, review of business cases is part of the action from the RQR and may have an impact	

## Measurement of safety of care within Emergency Pathways

Following Rapid Quality Review on 14/11/25 there will be enhanced reporting and review of safety within Emergency Pathways. This includes Emergency Departments, Acute Medicine and Acute Surgery.

To report through EICOPs weekly.

1. Standardised KPI reporting for context (as per operational meetings)
  - 45 min handover
  - Time to triage
  - Time to clinician review
  - 12 hours in department; admitted and non-admitted
2. Incidents / complaints / concerns as identified via Integrated Concerns Hub
3. Must report events: ED team into Datix at point patient leaves department / ambulance
  - >48 hrs in the department
  - >12 hrs on ambulance
  - >6hrs in dept with End-of-Life diagnosis
4. Incidents as reported by resident doctor process as per HEIW (West)
5. Corridor care numbers (as develops) and audit results of care of intentional rounding
6. Numbers of 'your next patient' use for week as per SOP to be issued
7. Numbers of accelerated boarding in extremis for week as per SOP to be issued



Bwrdd Iechyd Prifysgol  
Betsi Cadwaladr  
University Health Board

**Ein cyf / Our ref:**

☎: 01745 448788 ext 6382

**Gofynnwch am / Ask for:** Emma Hughes

**E-bost / Email:** [emma.hughes19@wales.nhs.uk](mailto:emma.hughes19@wales.nhs.uk)

**Dyddiad / Date:** 05/12/2025

**To:**

IHC SLT

Hospital Management Teams

Dear Colleagues,

Across our acute hospitals, Emergency Departments and those areas directly associated with them remain extremely busy. There has rightly been significant concern about emergency care pathways with some patients having to wait a substantial time to be assessed and, if to be admitted, for a bed. This in turn impacts on delays for ambulance handovers which can increase risk for those awaiting an ambulance within the community. It is likely to become even busier as winter respiratory illnesses hit, and there is a particular concern about the strain of 'flu circulating at present. If you haven't already, please do take up the offer of the 'flu vaccine to protect yourself, your teams and your patients.

We would like to thank you all for your work; we know that everyone is working incredibly hard to provide care for patients, even when the circumstances are difficult. We also know that, in the vast majority of times, once they are seen, patients are very complimentary about the care they receive.

There has been considerable work across the Health Board over the last few weeks to drive forward improvements across the pathways and many of you have been involved in developing refreshed operational plans at each site with a Rapid Quality Review.

Effective discharge will make a significant difference to hospital flow and site pressures. From 8-22<sup>nd</sup> December, there is a national Discharge Winter Sprint Fortnight to reduce the number of patients who are delayed discharge to a more suitable environment for their needs. Plans are currently being developed with increased activity already taking place. Meetings have been arranged with local authorities who will be visiting our EDs and sites to explore all avenues. This will be a major focus of the Discharge Winter Sprint work.

In working together to drive improvements, the attached **operational principles** are designed and should be used to support site flow and relieve site pressure. Please integrate into all working practices. These will be kept under review and feedback will be valuable.

The **timely intervention of clinicians** is imperative to ensure flow and the consistent implementation of the current internal professional standards for clinicians are critical, including:

- timely review of referred patients by senior decision makers
- acceptance of referrals without dispute of ownership

---

**Cyfeiriad Gohebiaeth ar gyfer y Prif Weithredwr / Correspondence address for the Chief Executive:**

Bloc 5, Llys Carlton, Parc Busnes Llanelwy, Llanelwy, LL17 0JG / Block 5, Carlton Court, St Asaph Business Park, St Asaph, LL17 0JG

**Gwefan:** [www.pbc.cymru.nhs.uk](http://www.pbc.cymru.nhs.uk) / **Web:** [www.bcu.wales.nhs.uk](http://www.bcu.wales.nhs.uk)

Mae Swyddfa'r Prif Weithredwr yn croesawu gohebiaeth yn Gymraeg a bydd yn sicrhau y darperir ymateb yn Gymraeg heb oedi.

The Chief Executive's Office welcomes correspondence through the medium of Welsh and will ensure that a response is provided in Welsh without incurring a delay



GIG  
CYMRU  
NHS  
WALES

Bwrdd Iechyd Prifysgol  
Betsi Cadwaladr  
University Health Board

- rapid acceptance of referrals from ED to ward areas
- efficient daily running of board rounds; do they need to be in hospital today?
- ensuring processes in place to facilitate discharge from ward or to discharge lounge early in the day
- ensuring close working with local authorities and shared ownership of prompt complex discharge pathways

Finally, there is an expectation to **implement practices** to manage the risk of patient care across the site. This is in the form of '**your next patient**', where a patient is sent to a ward ahead of a planned definite discharge, and at times, there may be a need to institute **ward boarding of an extra patient**. Risk assessments have been undertaken across sites to ensure clinical and operational teams are able to plan effectively to support flow and balance system risk. This process will enable us to decompress the Emergency Department and aid ambulance release. A standard operating procedure will be issued within the next few days for you to familiarise yourself and share with colleagues.

It is important to note that the safety and effectiveness of the Emergency Pathways is the responsibility of the whole Health Board and the whole site; it relies heavily on the ability to refer on to other departments and the wards to maintain effective flow. In discussing the challenges with many of you, we have heard numerous suggestions and proposals and many of these are within the gift of the IHCs to take forward. Of those which need Executive decision, we are committed to work through these and respond promptly. For example, there is now a solution to the Symphony and the EAS systems.

We will continue to work together and thank you all for your ongoing commitment.

Kind regards,

**Clara Day**  
Executive Medical Director/  
Gyfarwyddwr Meddygol Gweithredol

**Tehmeena Ajmal**  
Chief Operating Officer/  
Prif Swyddog Gweithredu

**Carol Shillabeer**  
Prif Weithredwr/Chief Executive

**Angela Wood**  
Cyfarwyddwr Gweithredol Nyrsio a  
Bydwreigiaeth / Executive Director of Nursing  
and Midwifery

## Operational standards - UEC flow

### Senior presence and oversight

- Senior leadership (Hospital Management Team and Senior Leadership Team) to establish a rota to ensure visibility and engagement in daily operations, providing guidance, support and oversight to their teams.
- Senior leaders to assist site leads and clinical site managers (CSM) in de-escalating the sites to safer levels with collaborative working across the sites between Directorates, hospital management teams and hospital site leads to address the level of risk and pressure in the ED quadrant, including allocation of bed resources

### System resilience planning, escalation and surge management

- Ensure daily and weekend plans are in place 24 hours in advance, ensure appropriate challenge and the development and implementation of comprehensive action plans to facilitate site de-escalation.
- Test and challenge the weekend plan every Thursday afternoon
- Review delivery of weekend plan every Monday afternoon, including any deviation from plans or “red lines”
- Ensure appropriate reference to the NHS Wales Escalation Framework, with a focus on de-escalation
- Implement the optimal hospital flow framework
- Implement boarding policy with consistent monitoring and oversight

### System flow meetings

- Electronic hospital sitrep report to be completed and escalated throughout the day.
- Calculated understanding of how many beds are required to meet current and projected demand by site
- Ensure data is reviewed from ED e.g. patients in the department over 4/12/24 hours, the hospital arrivals screen (HAS) and the WAST community position.
- Senior operational leadership in attendance representing the different directorates
- Focus on action to generate flow in the system
- Ensure clarity about the significance of the status of the emergency department on actions across the wider system
- Proactive challenge when wards declare a poor discharge profile.
- Ensure senior manager of the day and matron of the day roles

## **Wider system support**

- Consistently implement agreed interprofessional standards (IPS)
- Collaborate with primary and community care, WAST and wider social care partners, ensuring that recovery actions are coordinated and collectively owned.

## **Demand and capacity modelling**

- Ensure decisions are supported by demand and capacity modelling
- Develop and utilise predicted demand activity in terms of ED attendance (case mix, acuity and arrival patterns (DTAs from the department, number of discharges and number of moves required each day
- Match capacity to demand and activity profiles

## **Optimal discharge**

- All patients to have an estimated date of clinical optimisation and where possible predicted date of discharge within 24 hours of admission to the ward
- Each patient to be reviewed on the daily board rounds, against red to green criteria, the treatment and discharge plan, “what matters to me” and criteria to reside (i.e.requires an acute setting for care and treatment)
- Daily review of actual against planned discharges
- Ensure implementation of Criteria led (acuity led) discharge (CLD) model
- Ensure application of choice policy once clinically optimised for discharge
- Ensure implementation of the discharge lounge operating procedure, including early identification of suitable patients and proactive planning during morning board rounds
- 30% of discharges to occur before midday with a further 30% by 15.00
- Ensure automatic acceptance of referral to a community hospital with no empty beds overnight

## Quality Safety & Experience Committee

### INTEGRATED QUALITY REPORT

<b>Dyddiad y Cyfarfod</b> <b>Date of Meeting</b>	15 January 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 and Erika Dennis, Quality Lead Manager</li> <li>• <b>Healthcare Law:</b> Matthew Joyes, Deputy Director of Quality and Debbie Kumwenda, Healthcare Law Lead Manager</li> </ul>
<b>Enw a theitl Aelod Arweiniol o'r Tîm 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 QSE Committee 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 Termiau Acronyms / Glossary of Terms**

LocSSIPs	Local Safety Standards for Invasive Procedures
NRI	National reportable Incident

---

## **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. 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: Four reported – one downgraded (wrong site surgery, wrong implant, retained object).
- 3.2 LocSSIPs compliance: Documentation gaps noted.
- 3.3 Oxygen cylinder safety: Labelling concerns unresolved; competency training ongoing.
- 3.4 Flu surge risk: Mask wearing reinstated in clinical areas.
- 3.5 HIW concerns: Cultural issues in Heddfan Unit; Infection Prevention and Control (IPC) in Acute Cardiac Unit.



---

3.6 Listening to People: The NHS Complaints, Incident and Redress Process will come into force on the 1<sup>st</sup> April 2026.

3.7 Trauma Network review: Governance and referral process gaps.

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

4.1 Overdue incidents: 5,014 open incidents, 60% overdue.

4.2 Regulatory compliance: HIW and CIW inspections with overdue actions; Ombudsman recommendations (one overdue).

4.3 Duty of Candour maturity: Currently at operationalising stage; gaps in commissioning and hosting.

4.4 Healthcare Law: Coroner's Prevention of Future Death Notice; 17 overdue Learning from Events Reports with Welsh Risk Pool.

**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	
<b>Cyswllt â'r Blaenoriaethau Strategol</b> <b>Link to Strategic Priorities</b>	    
	<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>5. Establishing an effective environment for Learning</p>
<b>Yr Egwyddorion Dylunio</b> <b>Design Principles</b>	<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>
<b>Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd</b> <b>Corporate Risks and Board Assurance Framework</b>	<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)</p> <p>Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR)</p> <p>BAF-SP18 and CRR-24-04 – Quality, Innovation and Improvement</p>
<a href="#">Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant</a> <a href="#">Wellbeing of Future Generations Act – Wellbeing Goals</a>	<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		
<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:	N/A



<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:	N/A
<b>Ansawdd</b> <i>A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?</i> <b>Quality</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>Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant Wellbeing of Future Generations Act – Wellbeing Goals</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:	N/A



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:	N/A
<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:	N/A
<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	



## PATIENT SAFETY

### PATIENT SAFETY INCIDENTS

#### Incidents

There are currently 5014 open incidents of the 5014, 60% are overdue which is a similar position to previous months. The number of closed incidents versus the number of opened incidents is a similar number each week.

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

#### Oxygen Cylinder Improvement

The Health Board provided feedback to BOC (British Oxygen Company that provides medical gases and associated equipment to the Health Board) in writing following the cylinder demonstration in September 2025 identifying concerns about the cylinder labelling. BOC have responded to say that they are unable to change the labelling 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.

The number of incidents relating to 'no flow' oxygen have reduced from previous reports. The 'No flow Oxygen Improvement group' which is a short-term task and finish group to address key issues is progressing with actions. IHC's and clinical specialties and community sites are working through action plans, with oxygen cylinder practical competencies scheduled to be on ESR by early 2026.

Agency staff training continues, and the competency is now an action on the agency staff onboarding process.

The group will continue until assurance re: action plans is in place; this will be reviewed January 2026. The Health Board compliance with the mandatory oxygen eLearning is 84.35%, an increase from 78.73% as of end November.

#### Nationally Reportable Incidents

From 01<sup>st</sup> October 2025 to 30<sup>th</sup> November 2025, there were 18 Nationally Reportable Incidents (NRIs) occurring by incident date compared with 31 for the previous reporting period. Treatment/procedure issues are the most reported category.

The total number of NRI investigations that were open as at the end of November 2025 was 54 with 4 overdue closures. Cancer, Diagnostics, Mental Health Learning Disability Division and Central and West Integrated Health Communities do not have any overdue currently.

The proportion of NRIs that remain open for more than 90 days continues to be the best across Wales, with the Health Board having only 7% of cases taking longer than 90 days. The median working days to completion is also the lowest at 73 days compared to the All-Wales median of 126 days.

A total of 59 NRI outcome forms were submitted to NHS Wales Performance and Improvement for closure during October and November 2025. Further detail and learning from these closures can be found in the confidential quality report.

### Never Events

The Health Board reported four Never Events in October and November 2025 one of which has been downgraded as NHS Performance & Improvement determined it did not meet the criteria for a Never Event.

Two incidents related to wrong site surgery, one to wrong implant, and one was a retained object

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.

## PATIENT SAFETY ALERTS

There is currently one current national safety alerts. The Patient Safety Team is actively working to ensure compliance and mitigate associated risks:

**Delayed administration of RasbriCase (PSA019):** 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.

In addition, and where 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.

**Medical beds, trolleys, and rails (MDA/2023/03):** This alert 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.

**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. The procurement team is currently identifying and categorising the 821 patients within this cohort to manage follow-up.

The Patient Safety Team have circulated 30 Safety Alerts for October and November 2025. Field Safety Notices (n=18), Internal Alerts (n=4), Pharmacy Alerts (n=6), Welsh Government Alert (n=1), MHRA (n=1).

## SAFEGUARDING

### ICON – Infant Crying Is Normal

This was as a result of recommendations from a Child Practice Review (CPR) commissioned by the North Wales Safeguarding Board. North Wales Safeguarding Board funded the materials and license to the implementation of ICON.

ICON was launched during Safeguarding Week (11th November 2025). An audit and assurance programme are under development to provide assurance and evidence full implementation. The implementation plan will move into Phase 2, which will include partner agencies, and this will be monitored by the North Wales Safeguarding Board.

## INFECTION PREVENTION AND CONTROL

The Health Board has made progress in reducing several key Health Care Acquired Infections (HCAIs). The table below compares performance at the end of November 2025 against the same period in the previous year.

- Clostridioides difficile (C. diff): 20 fewer cases
- Methicillin-resistant Staphylococcus aureus (MRSA): 5 fewer cases
- Methicillin -sensitive Staphylococcus aureus (MSSA): 11 more cases
- Escherichia coli (E. coli): 28 fewer cases
- Klebsiella spp.: 1 less case

When benchmarked against other Welsh Health Boards as of November 2025, our rankings were: **1st** for *Klebsiella*, **2nd** for MRSA and *Pseudomonas*, **3rd** for *E. coli*, **4th** for MSSA, and **5th** for *C. difficile*. This represents a downward trend for MSSA, with an improvement in the position for MRSA, *Pseudomonas* and *E. coli*. Rankings for *Klebsiella* and *C. diff* remain stable.

### Strategic Improvement Goals and Initiatives

Aligned with WHC 2025 039, the Health Board is focused on achieving six key HCAI improvement goals for 2025-2027:

1. Reduce the overall burden of *C. difficile* infection by at least 25%.
2. Achieve a reduction of at least 10% in hospital-onset *E. coli* bloodstream infections (BSI).
3. Achieve a reduction of at least 10% in hospital-onset *Klebsiella spp.* BSI.
4. Achieve a reduction of at least 10% in hospital-onset *Pseudomonas aeruginosa* BSI.
5. Decrease MSSA BSI by at least 20% and ensure fewer MRSA BSI cases than the previous year.
6. Undertake a clinician-led audit on the diagnosis and treatment of hospital-acquired pneumonia.

Outbreak data for October and November 2025 shows a positive trend, with the total number of outbreaks decreasing from 13 to seven. These outbreaks accounted for a total of 91 lost bed days during the period. This indicates that infection control measures, including those targeting a *C. difficile* outbreak in the East IHC, are proving effective.

A wide range of improvement activities are underway, reinforcing our commitment to IPC excellence:

**Strategic Programmes:** Active participation in the National *C. difficile* collaborative, progressing Quality Improvement projects in each IHC, and developing Phase 2 of the patient-facing HABITS programme.

**Estates and Cleaning Technology:** Securing targeted funding to standardise and increase the fleet of High-Level Disinfection (HLD) technology and create a fit-for-purpose cohort area in Wrexham Maelor Hospital. The use of Adenosine Triphosphate (ATP) monitoring has also been reintroduced to verify cleaning efficacy.

**Training and Practice:** A proactive training programme continues, with recent focus on respiratory infections and *C. difficile*. In addition, reviews and clinical trials of new manual cleaning and disinfection products are underway to further manage environmental bioburden.

The proactive management of the clinical environment is intrinsically linked to the experiences of our patients and carers, whose feedback is vital to our improvement journey.

## Flu

The Infection Prevention team have continued to monitor the number of flu cases and other acute respiratory infections (ARI) closely during October and November,

developing a trigger tool to support decision making and stepping up of any actions particularly associated with mask wearing.

Whilst the number of Emergency Department attendances with ARI have remained low, the number of inpatients affected have increased steadily and considering the headlines on 11<sup>th</sup> December 2025 indicating a sharp rise in the number of cases of flu across England a recommendation was made by the Infection Prevention Team and supported by the Executive Team to deploy mask wearing initially in high-risk areas (EDs, Admission/assessment areas) for staff, patients (if tolerated and does not compromise their care) and the public, and then applied Universal mask wearing latterly in all clinical areas.

## **OTHER PATIENT SAFETY UPDATES**

### **Nurse Staffing Update**

The Nurse Staffing Levels (Wales) Act 2016, requires Health Boards to have regard to providing sufficient nurses to allow the provision of sensitive patient care across all settings. Across BCUHB this process is operationalised through NU28 Nurse Staffing Levels Act Governance and Compliance Policy; and associated Standard Operating Procedure Calculating and Maintaining Nurse Staffing Levels.

Over the past two years the Health Board has invested significantly in nurse staffing, with £12 million across our acute hospital sites. This investment has enabled nursing establishments across wards to be brought up to required levels, supporting successful recruitment, improving patient care and experience, and enhancing staff morale – and as a result, nurse vacancies are at their lowest levels in recent years. A minimum headroom applied to nursing establishments (26.9%), as defined by the Act, also allows for annual leave, sickness absence and other planned and unplanned absences.

In line with the organisations statutory duty, nursing workforce and nurse staffing arrangements across BCUHB are monitored in line with NU43 Nursing & Midwifery Workforce Optimisation Standards Standard Operating Procedure and the Governance and Escalation Framework for the Use of Agency Nursing Staff. These procedures ensure substantive nursing establishments and internal bank are optimised through effective rostering and deployment; and that any exceptional use of nurse agency is risk-assessed, appropriately authorised, and subject to ongoing monitoring and learning.

In the context of sustained operational pressures, this has resulted in a variable escalated bed base of up to 186, of which 162 require additional staffing resource, currently being mitigated through the use of overtime, bank and agency use.

### *Increased Agency Staffing Oversight*

The Health Board has implemented, a clinically-led process for agency authorisation, which includes Executive Director of Nursing (EDON) sign-off. The Governance & Escalation Framework for Agency Nursing Utilisation sets out the authorisation pathway, out-of-hours escalation, and approval requirements.

Rationale for implementation included decreases in nurse vacancies and taking into account the nurse staffing uplift. It was identified that nurse staffing could now be more safely managed internally and reduction on reliance of agency staff was required. It is acknowledged many agency nurses are unfamiliar with the Health Board and often need extra support to navigate local policy and practice, whereas utilising local trained bank staff and permanent staff undertaking additional hours increases confidence in care delivery and reduces risk.

Good roster management to allow safe staffing is being supported and will allow gaps in provision to be managed effectively. Dynamic risk assessments are undertaken to ensure patient safety is fully considered on every shift and assessments made if gaps can be mitigated with redeployment of staff to cover or whether agency requests are required.

In situations where redeployment is required, the organisation recognises a duty of care to ensure that staff are not asked to work outside their scope of practice, that staff understand the limits of their competence, and that managers make decisions that are safe and proportionate. Patient safety and the fundamentals of care remain a priority for us all—this aligns with professional standards.

All nursing staff, whether from ED, inpatient wards, or community settings, hold foundational nursing skills that enable them to contribute to the fundamentals of care and patient experience. These skills include patient comfort and dignity, personal hygiene, nutrition and hydration, mobility and repositioning, reassurance, emotional support, and the monitoring of vital signs and basic observations. It is expected that every registered nurse, regardless of specialty or setting, can deliver the fundamentals of care within their scope of practice in the best interest of patients.

### *Emergency Department Pressures*

Whilst there has been significant investment within Emergency Departments (ED), current system pressures and recommendations of HIW reports, the Kendall Bluck review undertaken in 2019, the Royal College of Nursing corridor care review, and EDON safe staffing review it is identified that further investment is required. A nurse staffing ED business case has been produced outlining the resource implications. During the period, whilst agreement for additional investment is explored, the EDON

has approved the required nurse staffing levels identified in the review to be met through the use of overtime, bank & agency.

During November 2025 across BCUHB nursing services, a total of 697 agency shifts were submitted for approval to the EDON of these, 660 shifts were approved for agency cover immediately.

No requests have been declined by the EDON to date; however, in the requests made for the remaining 37 shifts, IHC senior nursing staff were initially advised to pursue bank/internal options first, with the option to re-submit for review and approval if still required.

In terms of ED agency requests and approvals, 319 shifts were submitted, of which 313 were approved for agency cover immediately. The breakdown is as follows:

- Central: 165 shifts requested, all approved.
- East: 107 shifts requested, 101 approved, 6 advised to pursue bank/internal options ahead of requesting nurse agency.
- West: 47 shifts requested, all approved.

#### *Impact and Further Action*

The introduction of enhanced governance and oversight for agency staffing has delivered measurable improvements in both operational control and patient safety. Early reviews of Datix incident reports show no increase in incidents linked to staffing shortages, reinforcing confidence in the robustness of the new arrangements. Senior nursing leaders continue to engage directly with teams to identify emerging risks and adapt staffing models proactively.

While financial efficiencies have been observed during this period, it is important to emphasise that these outcomes are a secondary benefit—the primary driver remains safe, high-quality patient care. The strengthened processes, including dynamic risk assessment and improved roster management, are designed to ensure that every staffing decision prioritises patient safety and professional standards.

Looking ahead, the Health Board will maintain close monitoring of agency utilisation through EDON-led reviews and regular reporting to senior nursing teams. With anticipated seasonal pressures and increased sickness absence over the Christmas period, proactive measures such as advanced agency bookings and flexible deployment strategies are already in place to mitigate risk.

The next phase will focus on:

- Embedding best practice in roster optimisation to reduce reliance on agency staff further.
- Evaluating patient experience and care outcomes to measure the impact of these changes beyond financial metrics.
- Strengthening workforce resilience through targeted recruitment, retention initiatives, and development of internal bank capacity.

These actions will ensure that the Health Board continues to meet its statutory obligations under the Nurse Staffing Levels (Wales) Act while delivering safe, compassionate care across all settings. The commitment to continuous improvement remains central to our approach, with patient safety and staff wellbeing at the heart of every decision.

## PATIENT EXPERIENCE

### COMPLAINTS

The following table displays key complaints metrics as of 1st December 2025.

Metric	Current Status	Trend (vs. previous period)
<b>Total Open Complaints</b>	254	Decrease from 270
<b>Number Overdue</b>	50	Increase from 32
<b>Compliance with 75% Target</b>	80.31%	Decrease from 88.15% (but remains above target)

Analysis of received versus closed complaints between October and December 2025 shows a positive variance of 25 more closures than new complaints. However, there is a strategic risk as the average weekly rates of receiving (55.5) and closing (56.4) complaints are becoming equal. Mitigation plans are being developed, with a greater emphasis on early resolution to manage future demand.

The Health Board's national performance provides significant assurance:

**Average Closure Time:** We are the best performing health board in Wales, resolving complaints in an average of 18 working days.

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

**Overdue Complaints:** Our performance on overdue complaints is the third best in Wales, and significantly better than other health boards of a comparable size.

The primary theme for complaints is "Clinical Treatment and Assessment." Within this, waiting times are the predominant specific issue, accounting for 136 of the 254 open complaints (53.54%).

## PATIENT FEEDBACK

The Patient Advice and Liaison Service (PALS) resolved 1,551 enquiries between October and November 2025, with an average resolution time of just 5.49 working days against a 10-day target. During this period, the service also received 101 written compliments.

Findings from the All-Wales People's Experience Survey (PES) remain highly positive. Based on 13,370 responses, 85.23% of patients rated their overall experience as 'Good' or 'Very Good'. Satisfaction with being treated with dignity and respect (85.13%) and being able to communicate in a preferred language (90.60%) both exceeded the national benchmark. The following quote identifies one of the positive experiences reported:

*"The Specialist Palliative Care Team and District Nurses were very helpful and supportive through the entire process. They kept in touch regularly, especially those last few days... We felt well supported by the team. While dad was able to communicate, they spoke to him to confirm his wishes and explain what they were doing, we felt that he was being treated with respect at all times and that they were doing the best for him."* (West IHC)

The Easy Read version of the PES also yielded positive results, with 92.85% of respondents sharing a positive experience. Furthermore, new targeted Maternity and Neonatal surveys were launched in November 2025 to gather specific feedback in these crucial service areas.

### **Urgent and Emergency Care Feedback (People's Experience Survey)**

Overall satisfaction of accessing urgent and emergency care has remained below target. The average level of satisfaction is 47.97% of "very good" responses. This is significantly lower than the organisation as whole (excluding Emergency Quadrant).

### **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 and the vital pastoral support provided by the Chaplain & Spiritual Care Service, which responded to 151 requests for support 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.



## OTHER PATIENT EXPERIENCE UPDATES

Nothing further to note

## LISTENING TO PEOPLE: THE NHS COMPLAINTS, INCIDENT AND REDRESS PROCESS

The Welsh Government has implemented a series of changes to National Health Service (NHS Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011. These changes aim to modernise how concerns and complaints about NHS care are raised, investigated, and resolved, ensuring the system is fit for current and future needs. The change in legislation entitled Listening to People: The NHS Complaints, Incident and Redress Process will come into force on the 1<sup>st</sup> April, 2026. The core aims of this new framework are to:

- Enhance safer care delivery through listening and acting on feedback.
- Promote an open and just culture.
- Increase transparency and trust.
- Mitigate future harm and support staff learning.
- Meet legal and ethical standards.

In proactive preparation, the Health Board is reviewing its patient experience services to align with this new framework.

## CLINICAL EFFECTIVENESS

### CLINICAL AUDIT

During Quarter 3, 13 Tier 1 national clinical audits were published. Two have been reported, with good compliance within the Health Board. The remaining 11 scheduled for reporting in December and January 2026.

### NICE GUIDELINES

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 four guidelines currently rated as 'Not Achieved' are under active review with review via Strategic Clinical Effectiveness.

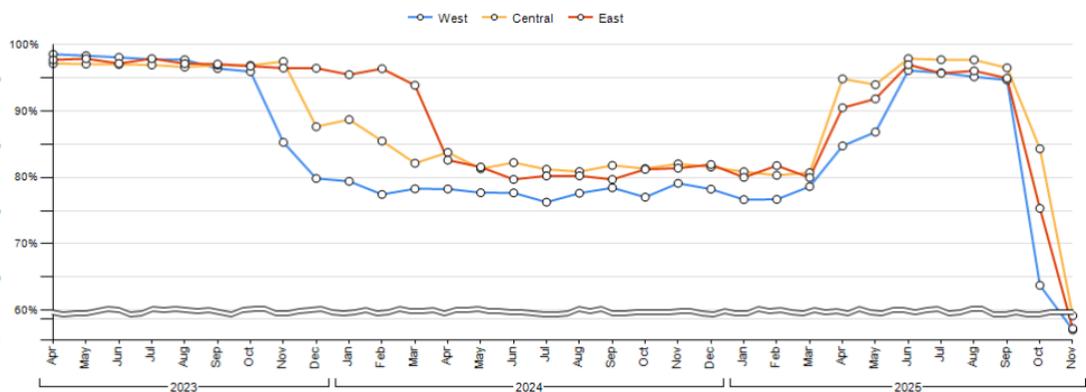
### MORTALITY REVIEW

#### Corporate Mortality Update:

[Effect of reduction in coding completion on relative mortality reporting.](#)

- In August 2024 a reduced local coding completion target of 75% (reduced from 95%) was agreed by the Executive Committee of BCUHB due to workforce issues and related reduction in capacity. Coding completion was 79% for the financial year 2024/25.

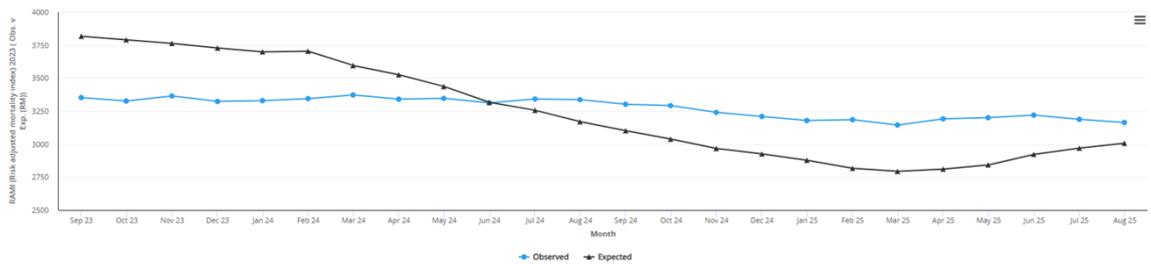
An internal trajectory to increase coding completeness from 75% to 95% over the first two quarters of the year 2025/26 was set and delivered. BCU reached the national target of 95% for August 2025 data, which was submitted in October 2025. A ‘mop up’ exercise will be undertaken to ensure the months of April to July 2025 are all coded to the 95% threshold. The chart below sets out completeness levels as of 27th November 2025.



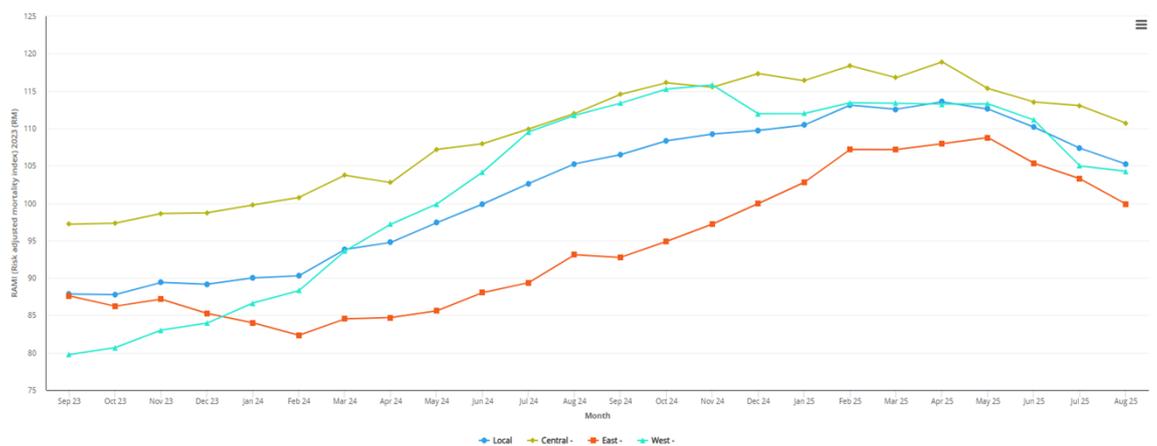
This reduction in coding completeness is likely to account for the observed increase seen in our RAMI (risk adjusted mortality index). RAMI is calculated by using observed deaths / expected deaths. Expected deaths are calculated by computing how many deaths are expected given the recording of factors in coding; this can include age and gender, but also health conditions such as diabetes, heart disease, cancer etc. Reduction in coding completeness will reduce the number of expected deaths.

There has been a reduction in the number of expected deaths in BCUHB since the last quarter of 2023 – the period when coding completeness began to reduce – until around March 2025. The number of expected deaths has a slightly increase from April 2025, coinciding with the 95% coding target being achieved. The number of observed deaths may be decreasing very slightly, from consistently being above 3,250 to being consistently below it after November 2024. Both are expressed as rolling 12-month figures and thus correction will take 12 months from when coding completion was reached.

Observed vs Expected Deaths 12-month Rolling Trend – September 2023- August 2025:



### RAMI 12-month rolling trend – September 2023-August 2025:



This anomaly makes interpretation of relative mortality extremely challenging during this period; this is our main indicator and is a national quality metric. This anomaly has also cropped up in other areas for instance in stroke deaths; again, observed deaths have stayed steady and thus coding completeness is likely also to have impacted here and in other disease / pathway specific measures.

The Executive Medical Director and Associate Medical Director for Mortality are working with analytics colleagues to establish if any other alternative methods can be employed; in the meantime, other assurance processes are in place to review deaths and learning from them, and to track the observed mortality, accepting that this does not adjust for patient mix.

The overall mortality rate for BCU was 1.73% between September 2024-August 2025, compared with 1.80% in the previous 12 months.

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

- Since the change in process introduced in September 2024, there has been considerable work across BCUHB to make the process as smooth as possible meaning relatives can receive accurate death certificates in a timely manner. Work includes:
  - Streamlined processes and local pathways with escalation pathways identified.
  - Emphasis placed on the importance of naming several doctors able to complete MCCD where provisional cause of death submitted and Medical Examiner response needed.
  - A Grand Round focussing on MCCD.
  - Guidance and education delivered to increase understanding of indications for HM Coroner referral.
  - MCCD process included during new doctor induction in August.
  - Close working with colleagues in Digital Data and Technology to allow Medical Examiner Service (MES) access to all relevant patient records where a difficulty had been identified.
- MES dashboard data shows that BCU are performing well in comparison with other Health Boards and are not an outlier in Wales. The below data shows MES comparison data for Health Boards in Wales vs BCUHB for the date of ME scrutiny & MCCD copy received:



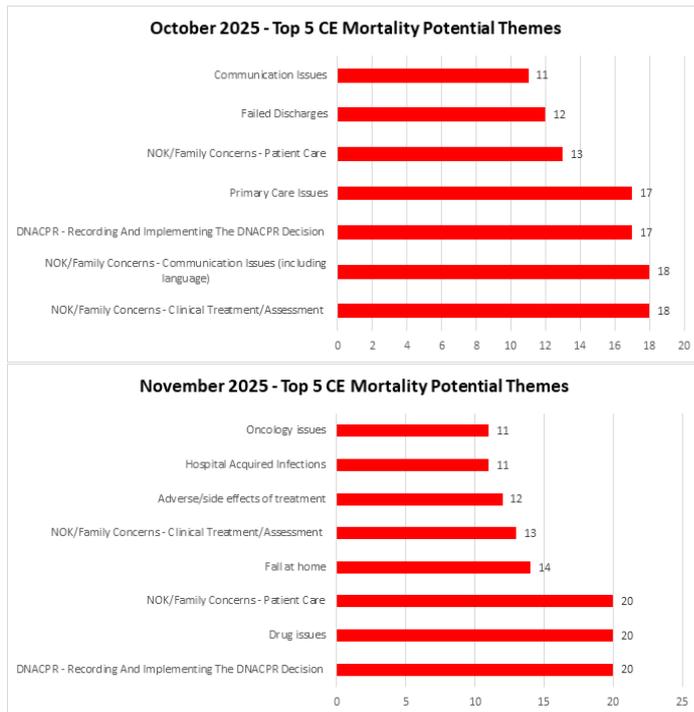
## Learning from Medical Examiners

Main thematic categories are illustrated in the graphs below:

- We have developed an agreed Health Board process for the review of potential concerns relating to care homes raised in scrutiny summaries received from the MES. Where a patient was in non-commissioned bed, we routinely share the information with the local authority and selectively with Care Inspectorate Wales. We have escalated this issue within the National Mortality Network as it is relevant to all Health Boards and Trusts and await an agreed pathway/process Welsh Government.
- 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.

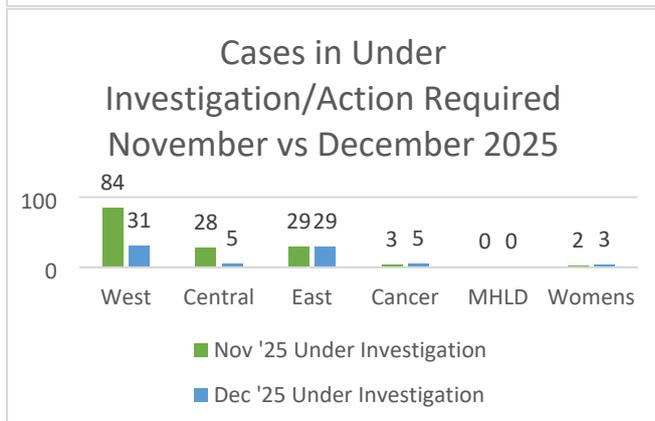
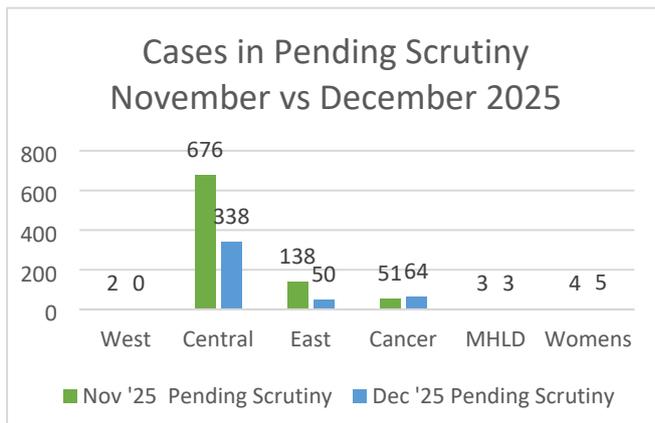
### Top 5 MES Identified Potential Themes Monthly Data (by date cases have been clinically reviewed by CE mortality):



### ME Mortality Cases with IHCs and Services

- The MES provides independent scrutiny of all deaths that occur in Wales that are not referred directly to His Majesty's Coroner for investigation. It aims to improve public safety, ensure death certificates are accurate, as well as avoid unnecessary distress for bereaved persons. Medical Examiners review the medical records, proposed cause of death and discuss with the patient advocate. They look beyond the deceased's final admission, consider the final illness and wider context to determine whether they can support the proposed cause of death and countersign the MCCD and consider if there were problems with any of the care provided to the deceased, this is then fed back in a report (a scrutiny summary) to the HB to enable learning and improvement of care.
- When scrutiny summaries are received, they have immediate clinical review; if any specific and immediate concerns are identified, these cases are escalated to the Integrated Concern's Hub and investigations commissioned as required.
- Mortality reviews within the hospital are undertaken at an IHC level within a mortality review panel. There is primary and secondary care contribution to this process. Vacant mortality posts in Central and East IHCs had led to a

back log of reviews; all are now appointed to and there has been very significant progress in reduction of the backlog and thus sharing of appropriate learning. Graphs below show that East have now reviewed the vast majority of the outstanding cases and Central continue to make significant progress with review of their outstanding cases. We are reassured that relevant learning is being highlighted and escalated. In the West there is no significant backlog. Relevant learning from IHCs and services is being escalated to monthly Learning from Mortality meetings.



## QUALITY ASSURANCE

## HEALTHCARE INSPECTORATE WALES

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

The Quality Assurance Team continue to work with clinical areas to progress action plans, the below are overdue with targeted plans to progress completion

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

- **Status:** Overdue
- **Recommendations:** 28
- **Actions:** 66 total; 62 completed (94%)
- **Outstanding:** 4 actions remain
- **Closure Date:** Revised to January 2026.
- **Governance:** Continuous monitoring via Local HIW Review Meeting, Regulatory Assurance Group (RAG), and Executive Delivery Group (EDG).

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

- **Status:** In Progress
- **Recommendations:** 19
- **Actions:** 41 total; 31 completed (76%)
- **Closure Date:** 16 January 2026
- **Governance:** Progress monitored through T4 Programme Group, Regulatory Assurance Group (RAG), and Executive Delivery Group (EDG).

**Requests for Assurance:** The Health Board responded to three requests for assurance from HIW concerning Clywedog Ward, the Acute Cardiac Unit (IHC East), and the Cardiac Physiology Unit (IHC Central). In each case, improvement actions were detailed, and HIW has not raised further queries on two of the three matters.

### Concerns / Requests for Assurance

- **Clywedog Ward, Heddfan Unit, IHC East (Nov 2025)**  
HIW have requested assurance following concerns received relating to cultural issues, potential delays in Speech and Language Therapy (SALT) and training provision.
- **Acute Cardiac Unit, IHC East (Nov 2025)**  
Assurance request from HIW highlighted concerns around Covid-19 transmission, isolation/testing, exposure, and staff mask compliance. The

Health Board responded with the action it is taking to address the issues. No further requests for assurance received from HIW.

- **Cardiac Physiology Unit, IHC Central (Oct 2025)**  
Assurance request from HIW in relation to training , medical oversight, and culture. The Health Board has responded with the action it is taking to address the issues. HIW has raised no further queries following this response issued on 23 October 2025.

## CARE INSPECTORATE WALES

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

A Quality-of-Care Review for Enhanced Community Residential Services (ECRS) on **24 November 2025** found no immediate concerns and noted no areas for improvement.

A previous Quality of Care Review for ECRS on 04 July 2025 also found no immediate concerns but noted minor areas for improvement. The service is progressing well with its improvement plan, which is on track for closure in March 2026.

## QUALITY PEER REVIEWS

The Quality Directorate provides governance oversight for peer reviews to ensure accountability and monitor improvement actions.

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 development with the Health Board Trauma Network team/ IHCs to address these findings.

## PUBLIC SERVICES OMBUDSMAN FOR WALES

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

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

The Quality Directorate continue to monitor and support all Ombudsman activity.

Public Interest Report: One Public Interest Report has an outstanding action related to the Commissioning Assurance Framework. This is progressing through process. A revised deadline of 31 January 2026 has been agreed with the Ombudsman.

Performance Metrics (2024-25): The Health Board has seen positive trends, including a reduction in complaints investigated by the PSOW (down from 81 to 64) needs periods of time, or months and those upheld (down from 41 to 19), alongside an increase in compliance with recommendations (up from 58% to 65%). These metrics demonstrate progress 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

## QUALITY DASHBOARD/QUALITY SCOREBOARD

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.

### Velindre Trust Quality Team Visit to BCUHB Quality Directorate

On 4 December 2025, the BCUHB Quality Directorate hosted colleagues from the Velindre Trust Quality Team. The purpose of the visit was to provide an overview of the processes and systems used within BCUHB to triangulate quality data and deliver live information to the organisation. Velindre Trust had previously engaged with the NHS Performance and Improvement Team, who highlighted the

developments within BCUHB aimed at supporting a data-informed and learning-focused culture. The visit offered an excellent opportunity to showcase how organisations across Wales collaborate to share learning, strengthen processes, and drive continuous improvement in quality.

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

The BCUHB Quality Management System (QMS) continues to progress well and remains on trajectory. Significant engagement has been achieved with corporate services and early adopter teams, demonstrating strong organisational commitment to embedding the QMS approach and remains aligned with Challenged Services. Plans are in place for a second re-evaluation stage in the New Year to provide assurance that the QMS remains relevant and continues to meet organisational needs. This process will further strengthen governance and ensure continuous development.

The NHS Performance and Improvement Team is working closely with BCUHB on this programme, providing expert support and reinforcing the collaborative approach that underpins this work. The progress to date reflects excellent engagement and a shared ambition to develop a robust, data-informed quality framework across the organisation.

### **DUTY OF CANDOUR**

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

These quality assurance systems are intrinsically linked to our processes for managing healthcare law and embedding organisational learning.

### **ORGANISATIONAL LEARNING**

**The Learning Repository** is an in-house digital platform designed to capture, validate, and share organisational learning to improve patient safety and clinical practice.

**Phase 1**, piloting in Pharmacy and Medicines Management, is on track for December 2025. It will enable staff to submit learning, undergo local quality checks,

receive SME review, and publish validated insights via SharePoint, with notifications through email and Teams. Medicines Management will share learning on insulin administration errors during this phase to strengthen safe practice.

A **Project Board** oversees governance, strategic alignment, and accountability for the wider rollout in 2026. Alongside this, **Thematic Learning Reviews**, commissioned by the Executive Integrated Concerns Panel or triggered by incidents, identify system-level learning, and promote organisation-wide improvement.

The **Organisational Learning Forum** continues to meet regularly, ensuring insights are shared and embedded into clinical practice.

## HEALTHCARE LAW

### CORONER AND INQUESTS

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

During the reporting period, the Health Board received one Prevention of Future Death Notice. This related to a case where a CAMHS referral from May 2022 was closed due to missing contact details, resulting in a 42-day delay before action was taken on a subsequent referral. While not contributory to the death, the coroner raised a concern about the risk of future deaths. The Committee can be assured that the service has already changed its standard operating process to prevent recurrence.

### LIABILITY CLAIMS

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

*Claims are restricted by time limits. Typically, a claim must be brought within 3 years of the alleged negligence taking place or from the point of knowledge. A minor will*

*generally have until their 21st birthday to submit a claim. To bring a claim a claimant would need to show there was a 'breach of duty of care' and that 'causation' had taken place. All claims are brought against the Health Board and not against any individual clinicians. Clinical Negligence and Personal Injury Claims are managed by the Healthcare Law Team who work closely with Legal & Risk Services.*

The Health Board has achieved significant improvement in the number of overdue Learning from Events Reports (LFERs) due with the Welsh Risk Pool (WRP). At the end of November that number stood at 17 (with nearly half in one division) and continued focus remains in place with the aim of achieving a sustainable reduction during quarter three. The latest data from the WRP shows the number of LFERs deferred for further work continues to reduce.

## **OTHER HEALTHCARE LITIGATION ISSUES**

There are no other matters to report. The Quarterly Legal Report is presented at the Executive Committee and PFIG Committee.

## **CONCLUSION**

This Integrated Quality Report provides the Committee with a comprehensive overview of the Health Board's performance, highlighting both areas of strength and areas requiring focused improvement. The data and analysis demonstrate a resilient and proactive approach to managing quality and safety across our services.

Strong performance is evident in our national benchmarking for Nationally Reportable Incidents and complaints management, and considerable progress is being made in clearing historical backlogs in areas such as mortality reviews. While challenges remain, such as the volume of open patient safety incidents, these challenges are being governed through targeted, time-bound action plans, with progress monitored via the Health Board's core assurance frameworks.

Several key strategic initiatives will be pivotal in driving future improvement. The full implementation of the 'Listening to People' framework will transform our approach to patient experience, while the new Quality Score Card will enhance governance and transparency. The rollout of the Organisational Learning Repository will provide a robust mechanism to ensure that lessons are not only identified but are systematically embedded into practice.

In conclusion, this report reaffirms the Health Board's steadfast commitment to providing safe, effective, and person-centred care for the population of North Wales. Through rigorous monitoring, strategic action, and a culture of continuous learning, we will continue to build on our successes and address our challenges to deliver the highest quality of care.



<b>4Teitl adroddiad:</b>	Integrated Quality & Performance Report (IQPR) – Month 8, 2025/26
<b>Report title:</b>	
<b>Adrodd i:</b>	Quality, Safety & Experience Committee
<b>Report to:</b>	
<b>Dyddiad y Cyfarfod:</b>	Thursday, 15 January 2026
<b>Date of Meeting:</b>	
<b>Crynodeb Gweithredol:</b>	This Report relates to Month 8, 2025/26.
<b>Executive Summary:</b>	<p>Please note the title of the report has now been amended to IQPR to illustrate that the report has a significant section on quality. The structure of the IQPR is based upon the Quadruple Aims as per the Welsh Government's 'A Healthier Wales's paper and the NHS Wales Performance Framework 2025-26. It identifies where metrics fall within the Special Measures Framework for BCUHB.</p> <p>Where appropriate, performance metrics are linked to items on the Corporate risk Register (CRR).</p> <p>Performance is RAG (Red, Amber Green) rated against the targets set within the NHS Wales Performance Framework 2025-26, or as set by Welsh Government in the Special Measures Framework for BCUHB. However, where appropriate, BCUHB's internal improvement trajectories as submitted and agreed by Welsh Government have also been included.</p> <p>Key areas of escalation are identified within the 'Performance Escalations Report' section at the beginning of the report. (We will continue to strengthen this section to include more information about the plans to mitigate or improve performance). The responsible executive has reviewed the elements of the report that are within their portfolio.</p> <p>Statistical Process Control (SPC) charts have been included where appropriate.</p>
<b>Argymhellion:</b>	The Quality, Safety, & Experience Committee is asked to:
<b>Recommendations:</b>	Review the contents of the report and to propose any actions arising from the report, or identify any additional assurance work or actions it would recommend Executive colleagues to undertake.
<b>Arweinydd Gweithredol:</b>	Angela Wood, Executive Director of Nursing & Midwifery
<b>Executive Lead:</b>	

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

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

The Integrated Quality & Performance Report will undergo continuous development and utilise the Performance and Commissioning Directorate's internal Change Advisory Board (CAB) process to modify any reporting metrics and formatting.

**Rhestr o Atodiadau:**

***List of Appendices: 2***

*1: Summary of Report*

*2: Integrated Performance Report in PDF*

*3: Escalations from Integrated Performance Report in PowerPoint*

**Appendix 1 – Summary of Report**

**Committee: Quality, Safety & Experience**

**Report title: Summary of Integrated Performance Report (Month 8)**

**Report Author: Deputy Director of Performance**

**1. Introduction**

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

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

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

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

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

**Appendix 1** Integrated Quality & Performance Report for QSE Committee, Month 8 (November 2025)



**GIG**  
CYMRU  
**NHS**  
WALES

Bwrdd Iechyd Prifysgol  
Betsi Cadwaladr  
University Health Board

# Integrated Quality & Performance Report

Reporting Period: to 30.11.2025

Presented to

**Quality, Safety & Experience Committee**

**Thursday, 15<sup>th</sup> January 2026**

# Table of Contents

Title	Page
Cover	1
Table of Contents	2
Performance Escalation Report	3
Integrated 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.



GIG  
CYMRU  
NHS  
WALES

Bwrdd Iechyd Prifysgol  
Betsi Cadwaladr  
University Health Board

# Performance Escalations Report



# Escalated Performance Measures at a Glance

KEY: ▲ = Better ▼ = Worse than previous reporting period

## Quality (CRR 24-04 Failure to Embed Learning)

- ▼ New Never Events: **4** reported in this reporting period (Target 0)
- ▼ New Ombudsman Contacts: **41**, highest in over 12 months
- ▼ Learning From Events Reports (LFERs): **15** in November 2025 (Target 0)
- ▼ Healthcare Acquired Pressure Ulcers: Averaging just under 500 a month – no change
- ▼ Patient Safety Incidents: Averaging approximately 100 a day - no change
- ▼ Number of patients Over 100% due their clinical follow up: **101,456** (Target 0) – Need assurance re harm review process

## Finance

CRR 24-05 Financial Sustainability

### Financial Position

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

### Savings Position

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

### Capital Expenditure

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

## Access & Activity

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

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

## People & Organisational Development

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

# Quality: Escalated Performance Measures

## New Never Events

Four new never events were registered within this reporting period however one has since been downgraded as was deemed not to meet the criteria of a Never Event. There remains important learning from this incident which contributes to an ongoing theme identified.

Details of Never Events as below:-

### **Wrong site surgery**

Patient presenting with pleural effusion required aspiration to remove fluid from chest. The registrar on call mistakenly aspirated the right side of the chest instead of the left,

### **Wrong implant/prosthesis**

Whilst undergoing total knee replacement, incorrect tibial insert was inserted.

### **Retained foreign object.**

An ascitic introducer trocar was not removed during the procedure

### **Wrong site surgery (DOWNGRADED)**

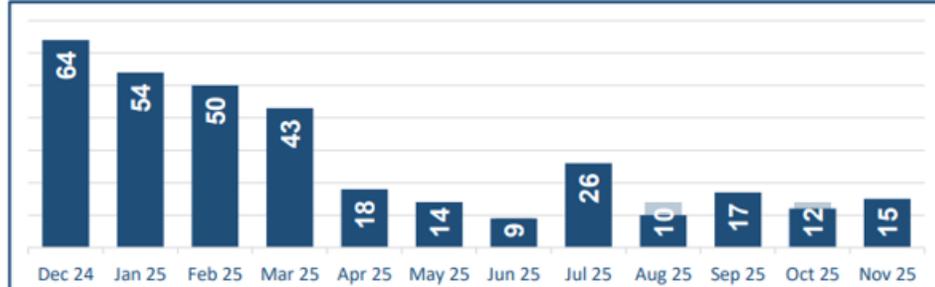
Following Hysteroscopy appointment Mirena Coil inserted without patient consent.

These incidents are currently going through the full investigation process but initial review of the three incidents raised denotes a pattern of failure to follow LocSSIPs along with human error. An internal safety alert has been disseminated, highlighting the need to follow process, the importance of ensuring that documentation used is always current and relevant to clinical pathways.

The Executive Medical Director has requested that LocSSIPs are added to the agenda of the next Strategic Clinical Effectiveness meeting in December to discuss how to lead the improvements required with regards to adherence to LocSSIPs

# Quality: Escalated Performance Measures

## Learning from Events Reports

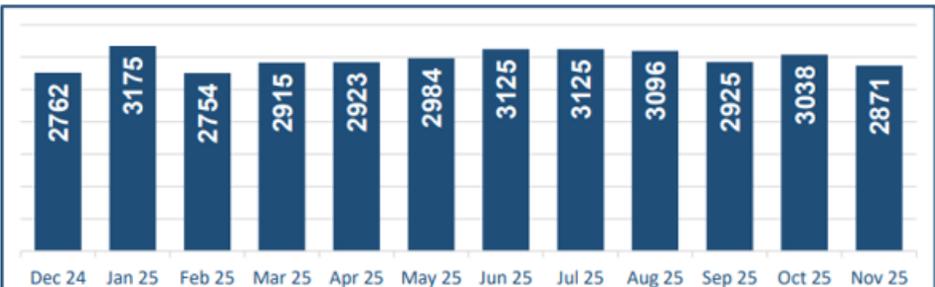


## Learning From Events Reports (LFERs):

There had been a month on month decrease in number of overdue reports since December 2024, with an increase in July at 26. However, there were 15 outstanding LFERs at the end of November and more detailed information is available in the Quality Report.

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

## Patient Safety Incidents



## Patient Safety Incidents:

The average number of patient safety incidents remains just below the 3,000 per month (100 per day) mark.

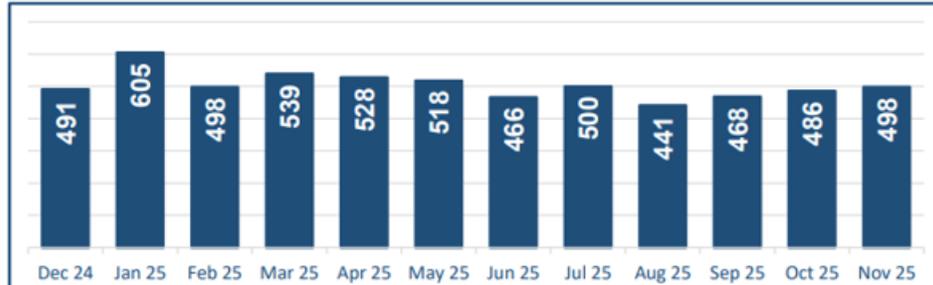
The Health Board promotes a culture of reporting for the purposes of continuous learning therefore a consistent total number of incidents reported is encouraged.

A reduction in the total number of overdue incidents with a trajectory of a 40% reduction by the end of March 2026 has been set. Progress is presented by the operational services to the weekly concerns meeting chaired by the Deputy Executive Director of Nursing.

The most frequent category of reported incidents in November 2025 were pressure damage, slips trips and falls, and medication errors.

# Quality: Escalated Performance Measures

## Healthcare Acquired Pressure Ulcers



## Healthcare Acquired Pressure Ulcers:

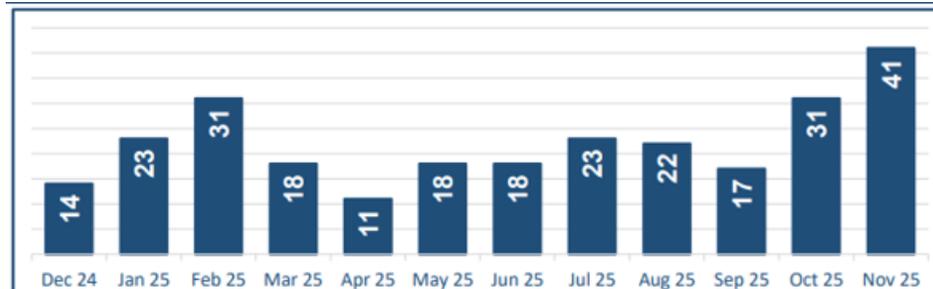
The average number of HAPU cases remains just below the 500 per month mark. There is no visible trajectory of consistent reduction however the data does not reflect those pressure ulcers that were avoidable/unavoidable.

During November 2025, 39 pressure ulcers were deemed avoidable with 45 still being reviewed.

A Health Board pressure ulcer prevention and management plan is in place and monitored in the strategic meeting with operational services reporting on progress.

Discussion has also taken place with DDAT about the addition of the pressure ulcer passport being added to the Welsh Nursing Care Record. This would help with communication between community and acute care areas.

## New Ombudsman Contacts



## New Ombudsman Contacts:

There has been a significant rise in the number of Ombudsman Contacts, with 41 reported for November, the highest number in over a year. The number shown in table show number of contact made over time regardless of whether the Ombudsman decides to investigate. In November of the 41 contacts, the Ombudsman decided NOT to investigate 29 of them.



GIG  
CYMRU  
NHS  
WALES

Bwrdd Iechyd Prifysgol  
Betsi Cadwaladr  
University Health Board

# Integrated Quality & Performance Report



# Summary of Performance to Month 8



GIG  
CYMRU  
NHS  
WALES

Bwrdd Iechyd Prifysgol  
Betsi Cadwaladr  
University Health Board

**Green**

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

**Blue**

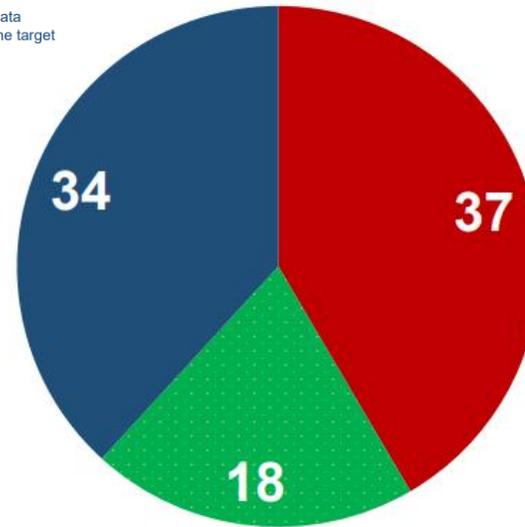
It is inappropriate, or not possible, to rate available data against any available target

**Red**

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

**Grey**

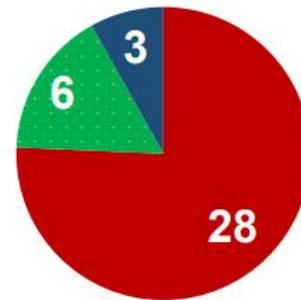
There is no / insufficient data available to rate against the target



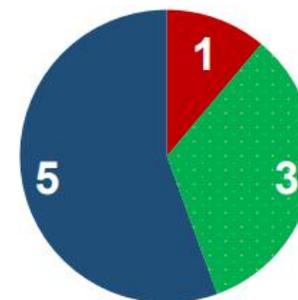
All Sections



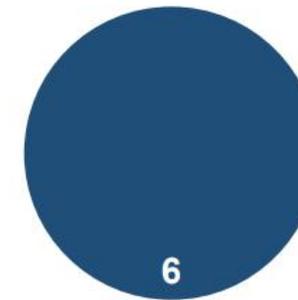
Quality, Safety,  
Effectiveness &  
Experience  
Performance



Access & Activity  
Performance



People &  
Organisational  
Development  
Performance



Financial  
Performance

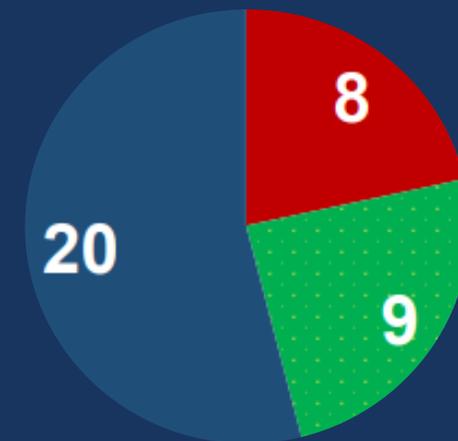


GIG  
CYMRU  
NHS  
WALES

Bwrdd Iechyd Prifysgol  
Betsi Cadwaladr  
University Health Board

# Section 1

## Quality, Safety, Effectiveness and Experience Performance



# Quality: Performance

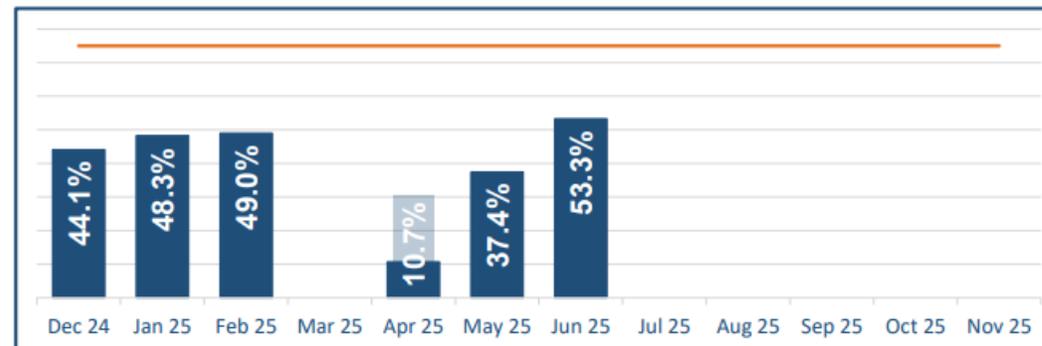
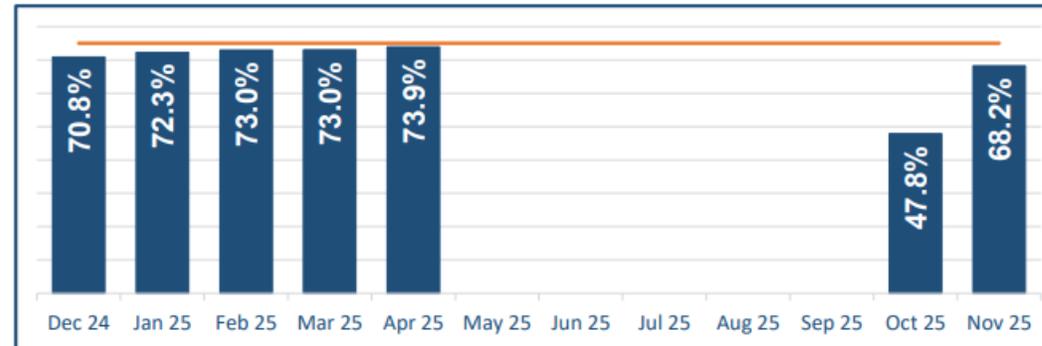
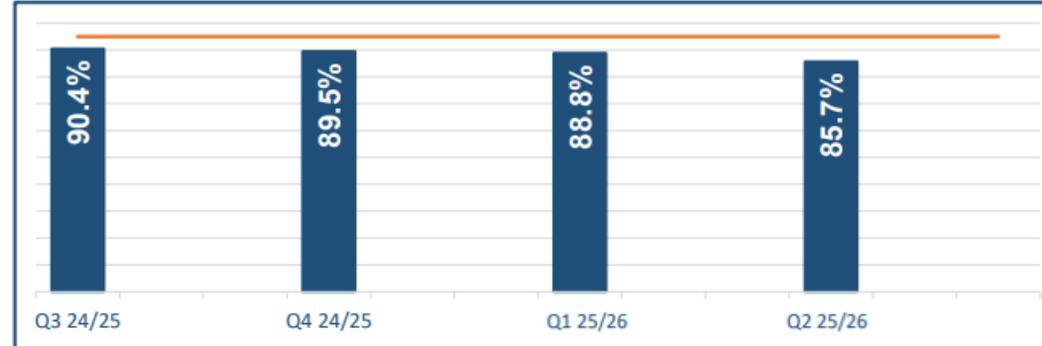


Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank											
-	QSE	Percentage of adult smokers who make a quit attempt via smoking cessation services	5% annual	TBC	4.00%	3rd of 7 (at Jun 25)	<table border="1"> <tr><th>Quarter</th><th>Rate</th></tr> <tr><td>Q3 24/25</td><td>5.13%</td></tr> <tr><td>Q4 24/25</td><td>6.98%</td></tr> <tr><td>Q1 25/26</td><td>2.17%</td></tr> <tr><td>Q2 25/26</td><td>4.00%</td></tr> </table>	Quarter	Rate	Q3 24/25	5.13%	Q4 24/25	6.98%	Q1 25/26	2.17%	Q2 25/26	4.00%
Quarter	Rate																
Q3 24/25	5.13%																
Q4 24/25	6.98%																
Q1 25/26	2.17%																
Q2 25/26	4.00%																
-	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	23.6%	3rd of 7 (at Jun 25)	<table border="1"> <tr><th>Quarter</th><th>Rate</th></tr> <tr><td>Q3 24/25</td><td>19.8%</td></tr> <tr><td>Q4 24/25</td><td>19.7%</td></tr> <tr><td>Q1 25/26</td><td>24.6%</td></tr> <tr><td>Q2 25/26</td><td>23.6%</td></tr> </table>	Quarter	Rate	Q3 24/25	19.8%	Q4 24/25	19.7%	Q1 25/26	24.6%	Q2 25/26	23.6%
Quarter	Rate																
Q3 24/25	19.8%																
Q4 24/25	19.7%																
Q1 25/26	24.6%																
Q2 25/26	23.6%																
-	QSE	Percentage of children receiving the Human Papillomavirus (HPV) vaccination by the age of 15	90%	TBC	72.3%	6th of 7 (at Sep 25)	<table border="1"> <tr><th>Quarter</th><th>Rate</th></tr> <tr><td>Q3 24/25</td><td>69.5%</td></tr> <tr><td>Q4 24/25</td><td>68.9%</td></tr> <tr><td>Q1 25/26</td><td>71.7%</td></tr> <tr><td>Q2 25/26</td><td>72.3%</td></tr> </table>	Quarter	Rate	Q3 24/25	69.5%	Q4 24/25	68.9%	Q1 25/26	71.7%	Q2 25/26	72.3%
Quarter	Rate																
Q3 24/25	69.5%																
Q4 24/25	68.9%																
Q1 25/26	71.7%																
Q2 25/26	72.3%																

# Quality: Performance



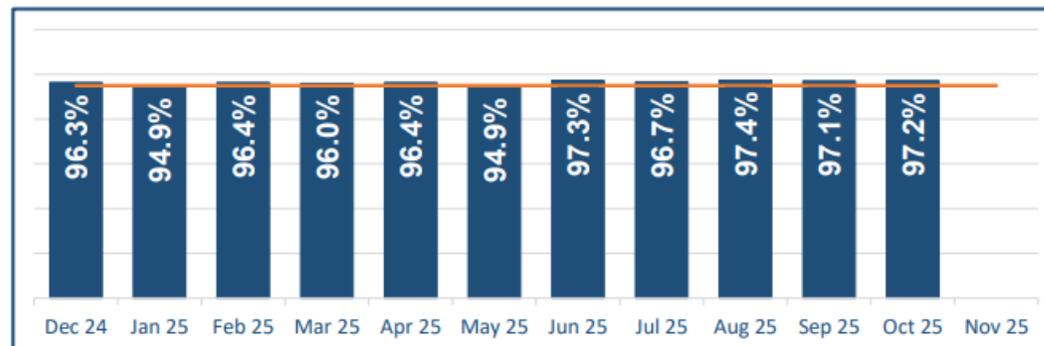
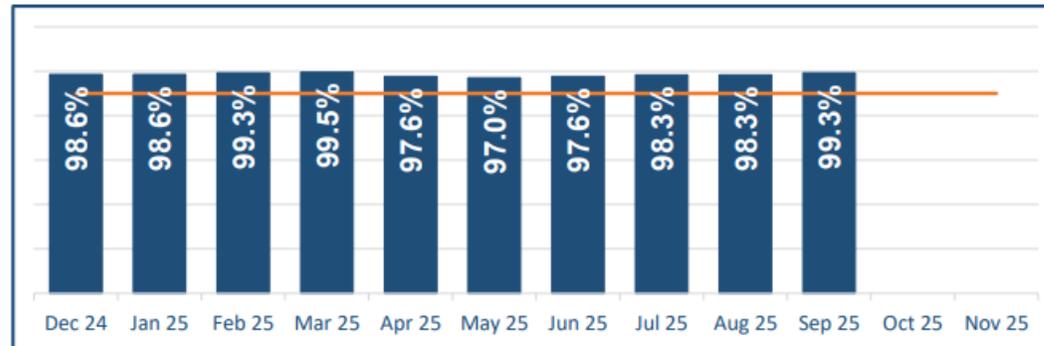
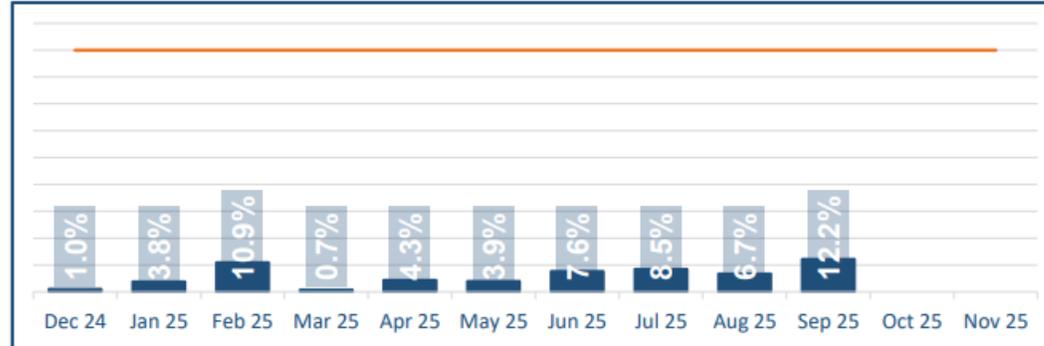
CRR Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	QSE	Percentage of children who are up to date with the scheduled vaccinations by age 5 ('4 in 1' preschool booster, the Hib/MenC booster and the second MMR dose)	95%	TBC	85.7%	2nd of 7 (at Sep 25)
-	QSE	Percentage uptake of the influenza vaccination amongst adults aged 65 years and over	75%	TBC	68.2%	2nd of 7 (at Nov 25)
-	QSE	Percentage uptake of the COVID-19 vaccination for those eligible Spring and Autumn Booster: All eligible people	75%	TBC	53.3%	5th of 7 (at Jun 25)



# Quality: Performance



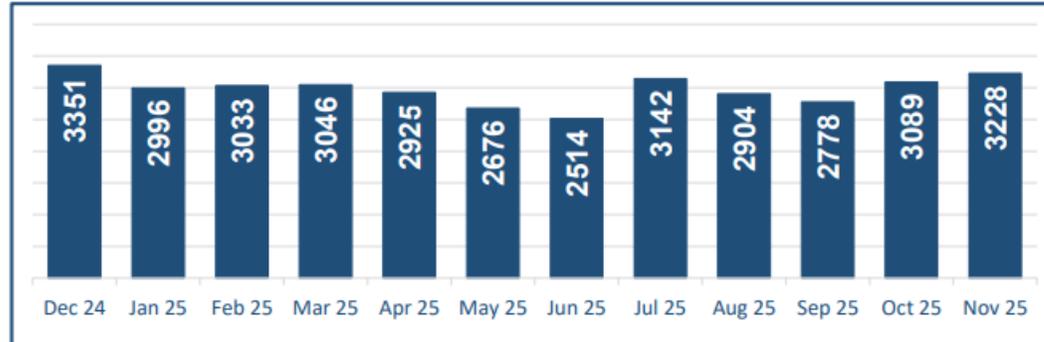
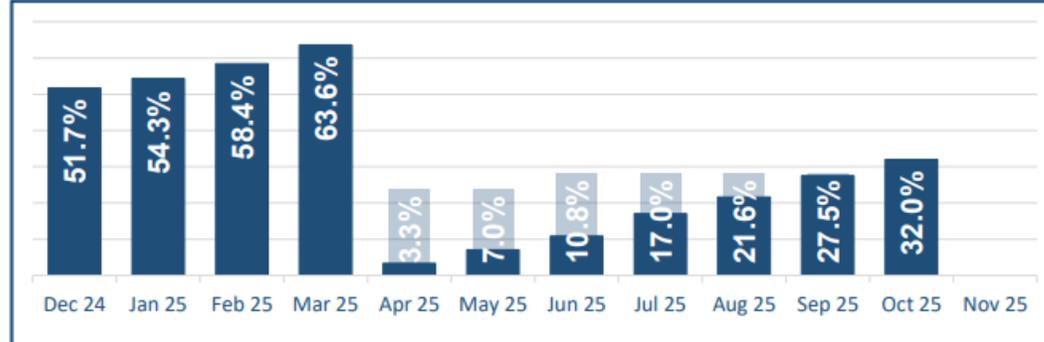
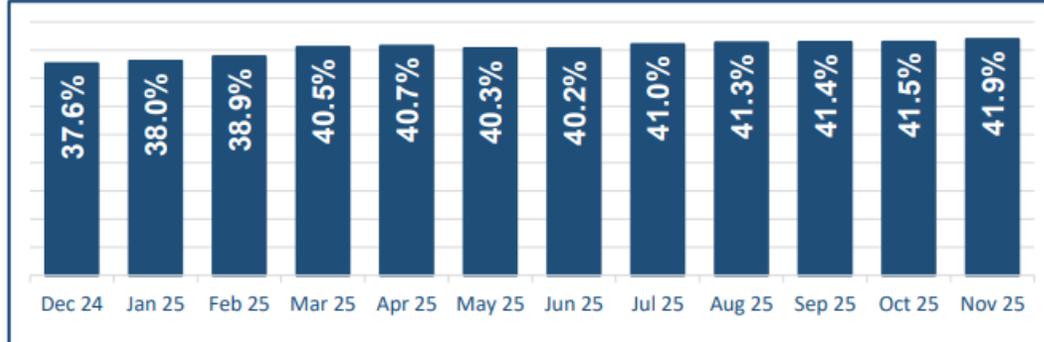
CRR Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	QSE	Percentage of patients offered an index colonoscopy procedure within 4 weeks of booking their Specialist Screening Practitioner assessment appointment	90%	TBC	12.2%	2nd of 7 (at Sep 25)
-	QSE	Percentage of well babies entering the new-born hearing screening programme who complete screening within 4 weeks	90%	TBC	99.3%	2nd of 7 (at Sep 25)
-	QSE	Percentage of eligible newborn babies who have a conclusive bloodspot screening result by day 17 of life	95%	TBC	97.2%	4th of 7 (at Oct 25)



# Quality: Performance



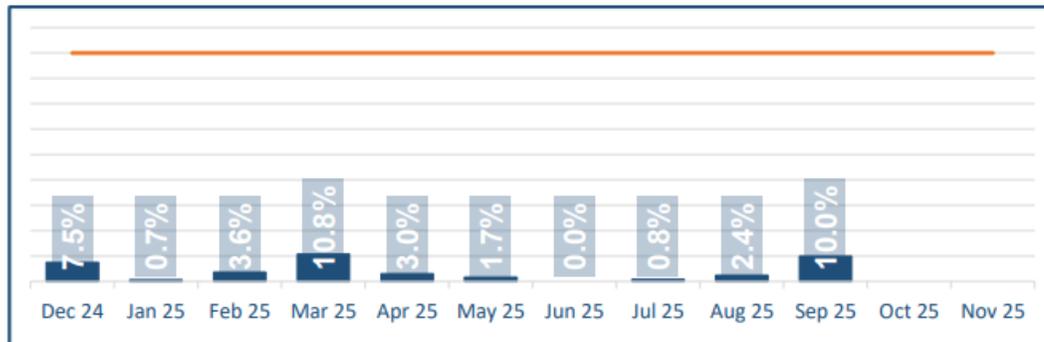
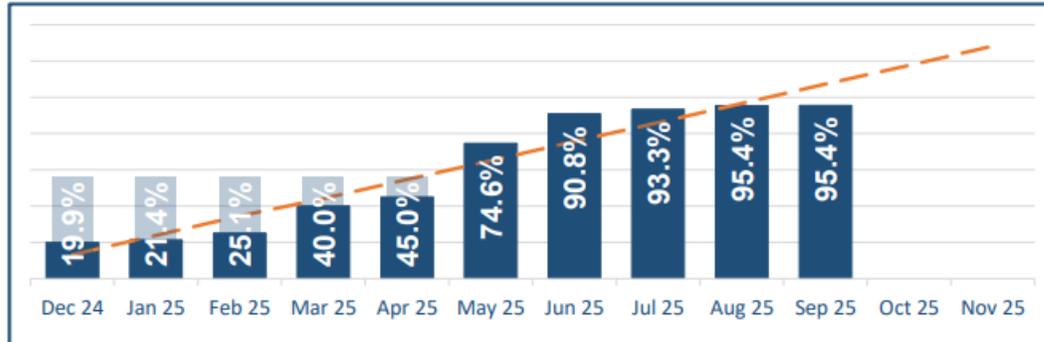
CRR Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	QSE	Percentage of patients (aged 12 years and over) with diabetes who received all eight NICE recommended care processes	Equivalent month increase (2025/26 to 2024/25) to 100%	TBC	41.9%	7th of 7 (at Nov 25)
-	PFIG	Percentage of the primary care dental services (GDS) contract value delivered (for courses of treatment for new, new urgent and historic patients)	Increasing trend (to 30% (end Sept), then 100% (end Mar))	TBC	32.0%	6th of 7 (at Oct 25)
-	PFIG	Number of consultations delivered through the Pharmacist Independent Prescribing Service (PIPS)	Equivalent month increase (2025/26 to 2024/25)	TBC	3228	2nd of 7 (at Sep 25)



# Quality: Performance



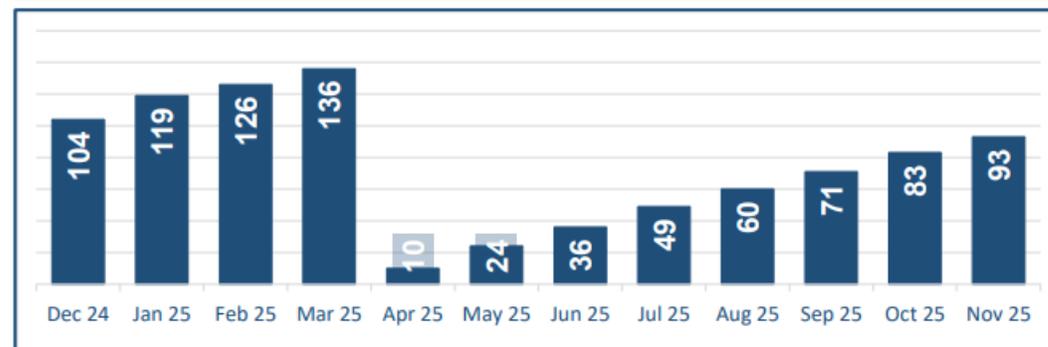
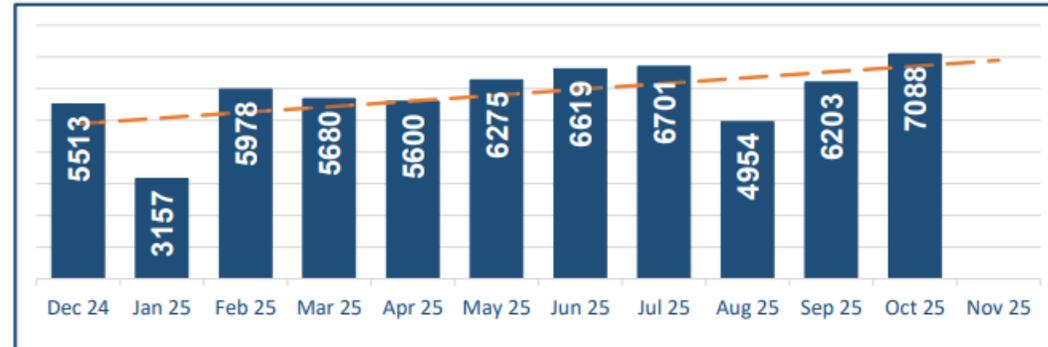
CRR Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	QSE	Percentage of people who have been referred to health board services who have completed treatment for substance misuse (drugs or alcohol)	4 qtr imp. trend	TBC	94.8%	1st of 7 (at Sep 25)
-	QSE	Percentage of episodes clinically coded within one reporting month post episode discharge end date	Increasing trend (to 95%)	TBC	95.4%	4th of 8 (at Sep 25)
-	QSE	Percentage of all classifications' coding errors corrected by the next monthly reporting submission following identification	90%	TBC	10.0%	8st of 8 (at Sep 25)



# Quality: Performance



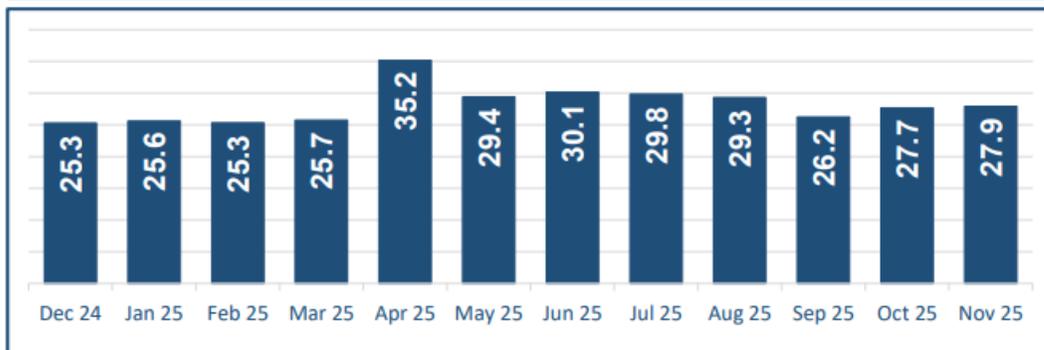
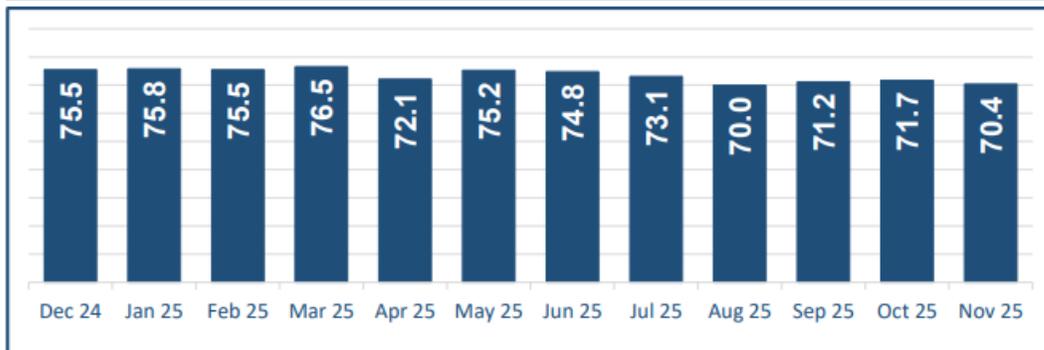
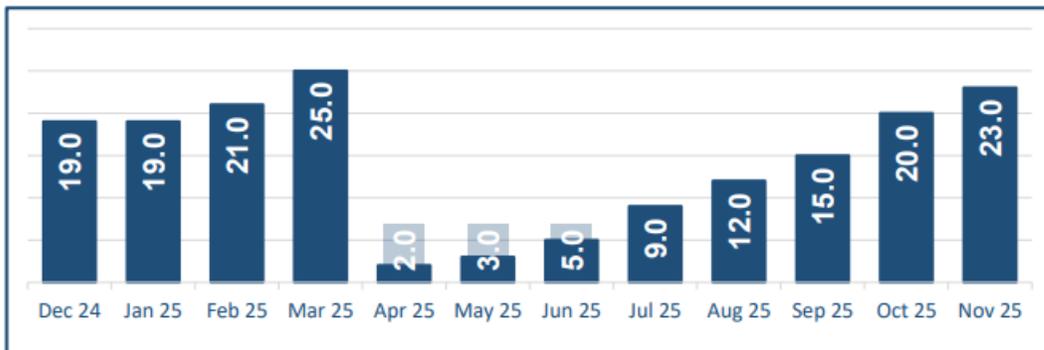
CRR Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	QSE	Percentage of confirmed COVID-19 cases within hospital which had a definite hospital onset of COVID-19 (>14 days after admission)	Equivalent month reduction (2024/25 to 2023/24)	TBC	38.9%	4th of 6 (at Nov 25)
-	QSE	Number of service user feedback experience responses completed and recorded on CIVICA	Increasing trend	TBC	7088	1st of 10 (at Oct 25)
CRR: 24-04	QSE	The cumulative number of laboratory confirmed Klebsiella in reporting month	TBC	TBC	93	6th of 6 (at Nov 25)



# Quality: Performance



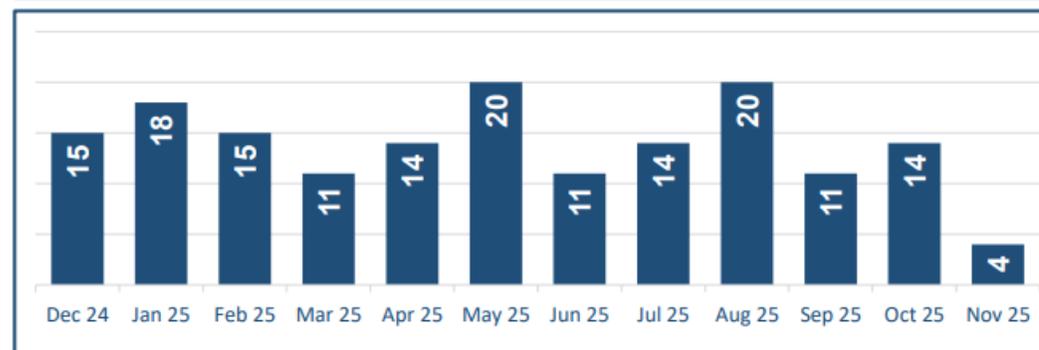
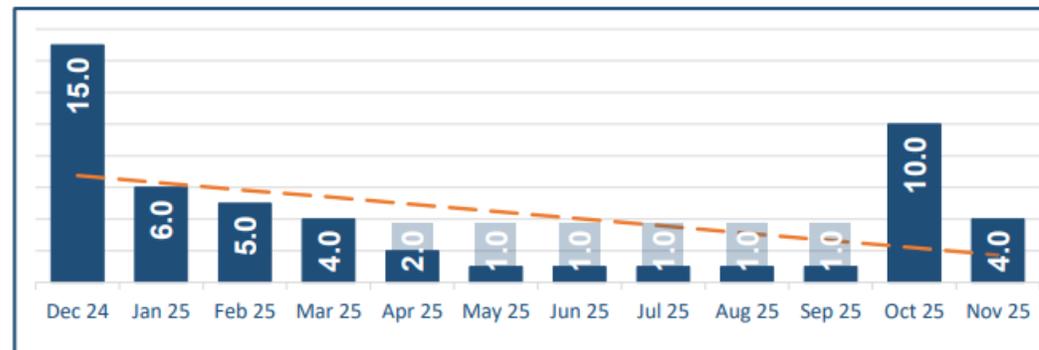
CRR Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
CRR: 24-04	QSE	The cumulative number of laboratory confirmed Pseudomonas Aeruginosa in reporting month	27	TBC	23	5th of 6 (at Nov 25)
CRR: 24-04	QSE	The cumulative rate of laboratory confirmed E.coli bacteraemias cases per 100,000 population	67	TBC	70.4	3rd of 6 (at Nov 25)
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	27.9	3rd of 6 (at Nov 25)



# Quality: Performance



CRR Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
CRR: 24-04	QSE	The cumulative rate of laboratory confirmed C.difficile cases per 100,000 of the population	25	TBC	47.2	5th of 6 (at Nov 25)
CRR: 24-04	QSE	Number of National reportable incidents that remain open 90 days or more	Decreasing trend	TBC	4	8th of 12 (at Nov 25)
-	QSE	Number of National reportable incidents (NRIs)	N/A	TBC	4	Local Metric



# Quality: Performance



CRR Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	QSE	Number of new never events	0	TBC	1	Local Metric
-	QSE	Number of patient safety incidents	N/A	TBC	2871	Local Metric
-	QSE	Number of reported falls	N/A	TBC	317	Local Metric

Month	Value
Dec 24	0
Jan 25	0
Feb 25	0
Mar 25	1
Apr 25	0
May 25	1
Jun 25	1
Jul 25	0
Aug 25	1
Sep 25	0
Oct 25	3
Nov 25	1

Month	Value
Dec 24	2762
Jan 25	3175
Feb 25	2754
Mar 25	2915
Apr 25	2923
May 25	2984
Jun 25	3125
Jul 25	3125
Aug 25	3096
Sep 25	2925
Oct 25	3038
Nov 25	2871

Month	Value
Dec 24	339
Jan 25	365
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	317

# Quality: Performance



GIG  
CYMRU  
NHS

Bwrdd Iechyd Prifysgol  
Betsi Cadwaladr  
University Health Board

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank																										
-	QSE	Number of reported healthcare acquired pressure ulcers (HAPU) (excluding new to caseload)	N/A	TBC	498	<table border="1"> <caption>HAPU Counts</caption> <thead> <tr><th>Month</th><th>Count</th></tr> </thead> <tbody> <tr><td>Dec 24</td><td>491</td></tr> <tr><td>Jan 25</td><td>605</td></tr> <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>486</td></tr> <tr><td>Nov 25</td><td>498</td></tr> </tbody> </table>	Month	Count	Dec 24	491	Jan 25	605	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	486	Nov 25	498
Month	Count																															
Dec 24	491																															
Jan 25	605																															
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	486																															
Nov 25	498																															
-	QSE	Number of reported medication incidents	N/A	TBC	247	<table border="1"> <caption>Medication Incident Counts</caption> <thead> <tr><th>Month</th><th>Count</th></tr> </thead> <tbody> <tr><td>Dec 24</td><td>256</td></tr> <tr><td>Jan 25</td><td>266</td></tr> <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>280</td></tr> <tr><td>Nov 25</td><td>247</td></tr> </tbody> </table>	Month	Count	Dec 24	256	Jan 25	266	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	280	Nov 25	247
Month	Count																															
Dec 24	256																															
Jan 25	266																															
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	280																															
Nov 25	247																															
-	QSE	Number of 'Putting Things Right' (PTR) complaints	N/A	TBC	212	<table border="1"> <caption>PTR Complaint Counts</caption> <thead> <tr><th>Month</th><th>Count</th></tr> </thead> <tbody> <tr><td>Dec 24</td><td>153</td></tr> <tr><td>Jan 25</td><td>210</td></tr> <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>212</td></tr> </tbody> </table>	Month	Count	Dec 24	153	Jan 25	210	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	212
Month	Count																															
Dec 24	153																															
Jan 25	210																															
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	212																															

# Quality: Performance



Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	QSE	Of the complaints closed, the percentage that were closed within 30 days	75%	TBC	73.5%	Local Metric
-	QSE	Number of complaints closed as early resolutions	N/A	TBC	33	Local Metric
-	QSE	Number of PALS (Patient Advice and Liason Service) contacts	N/A	TBC	944	Local Metric

Month	Percentage
Dec 24	80.3%
Jan 25	70.5%
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%

Month	Count
Dec 24	15
Jan 25	29
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	33

Month	Count
Dec 24	497
Jan 25	754
Feb 25	523
Mar 25	665
Apr 25	670
May 25	658
Jun 25	647
Jul 25	796
Aug 25	659
Sep 25	767
Oct 25	944

# Quality: Performance



Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	QSE	Number of new Ombudsman contacts	N/A	TBC	41	Local Metric
-	QSE	Number of regulation 28 notices	N/A	TBC	0	Local Metric
-	QSE	Number of overdue 'Learning from Event Reports' (LFERs)	N/A	TBC	15	Local Metric

Month	Value
Dec 24	14
Jan 25	23
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

Month	Value
Dec 24	0
Jan 25	0
Feb 25	1
Mar 25	1
Apr 25	0
May 25	1
Jun 25	0
Jul 25	0
Aug 25	0
Sep 25	0
Oct 25	0
Nov 25	0

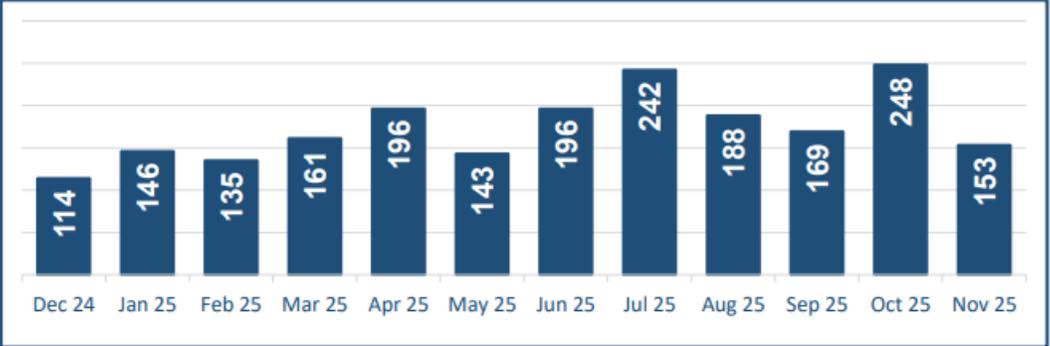
  

Month	Value
Dec 24	64
Jan 25	54
Feb 25	50
Mar 25	43
Apr 25	18
May 25	14
Jun 25	9
Jul 25	26
Aug 25	10
Sep 25	17
Oct 25	12
Nov 25	15

# Quality: Performance



Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	QSE	Number of Great-ix submissions	N/A	TBC	153	Local Metric



\* Wales Ranking may differ as may refer to previous month

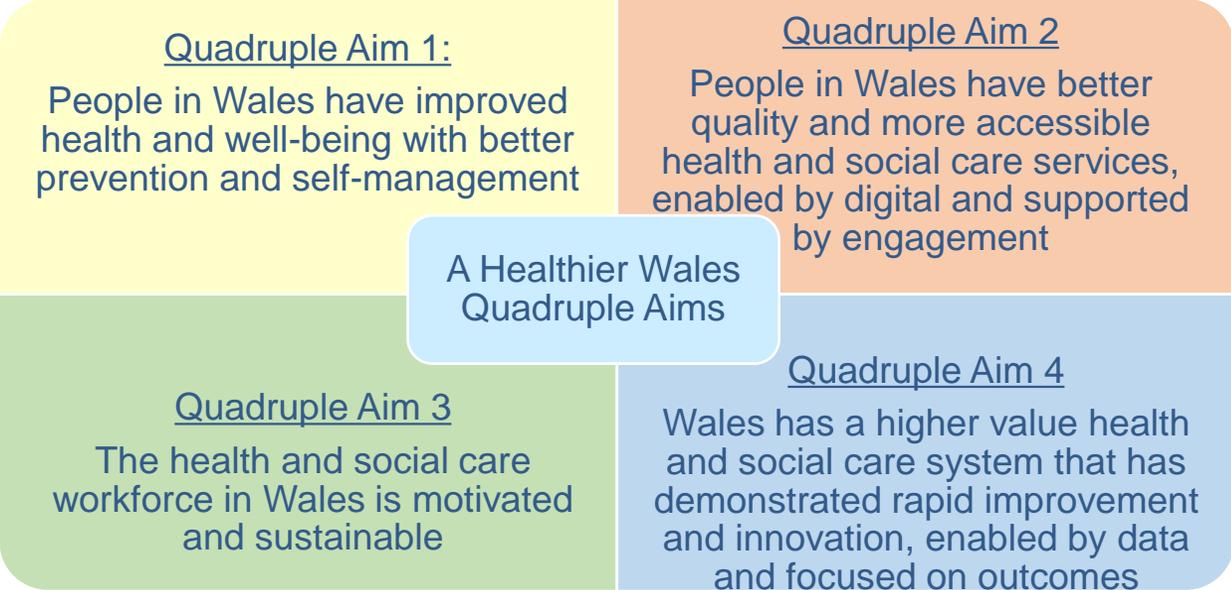


# Additional Information

# NHS Wales Performance Framework 2025-26

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

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



## Our Integrated Quality & Performance Report

Our Quality, Safety, Effectiveness & Experience Performance

Our Access & Activity Performance

Our People & Organisational Development Performance

Our Financial Performance

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

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

# Red, Amber & Green (RAG) Rating System

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

Green	<p><b>Green = On track</b></p> <p>A stable, sustained or improving position that is consistently on or above the <b>Welsh Government Target</b> for at least 3 or more consecutive months</p>
Amber	<p><b>Amber = Early Warning or Off Track and in Exception – Short summary provided</b></p> <p>On or above <b>Welsh Government Target</b>, but a deteriorating position of 3 or more consecutive months or inconsistently above/on/below the <b>Welsh Government Target</b></p>
Red	<p><b>Red = Off Track and in Escalation</b></p> <p>Consistently below <b>Welsh Government Target</b> and below <b>BCU submitted improvement trajectories – Detailed Exception report provided</b></p>

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

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

How to interpret variance results	How to interpret assurance results
<ul style="list-style-type: none"> <li>Variance results show the trends in performance over time</li> <li>Trends either show <b>special cause</b> variance or <b>common cause variance</b></li> <li><b>Blue Icons</b> indicate <b>positive</b> special cause variance</li> <li><b>Orange Icons</b> indicate <b>negative</b> special cause variance <b>requiring action</b></li> <li><b>Grey Icons</b> indicate <b>no significant change</b></li> </ul>	<ul style="list-style-type: none"> <li>Assurance results demonstrate the likelihood of achieving a target and is based upon the trends over time</li> <li><b>Blue Icons</b> indicate an expectation <b>to</b> consistently achieve the target</li> <li><b>Orange Icons</b> indicate an expectation <b>not to</b> consistently achieve the target</li> <li><b>Grey Icons</b> indicate an expectation for <b>inconsistent</b> performance, sometimes the target will be achieved and sometimes it will not be achieved.</li> </ul>

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



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

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

## The Integrated Performance Framework (IPF)

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

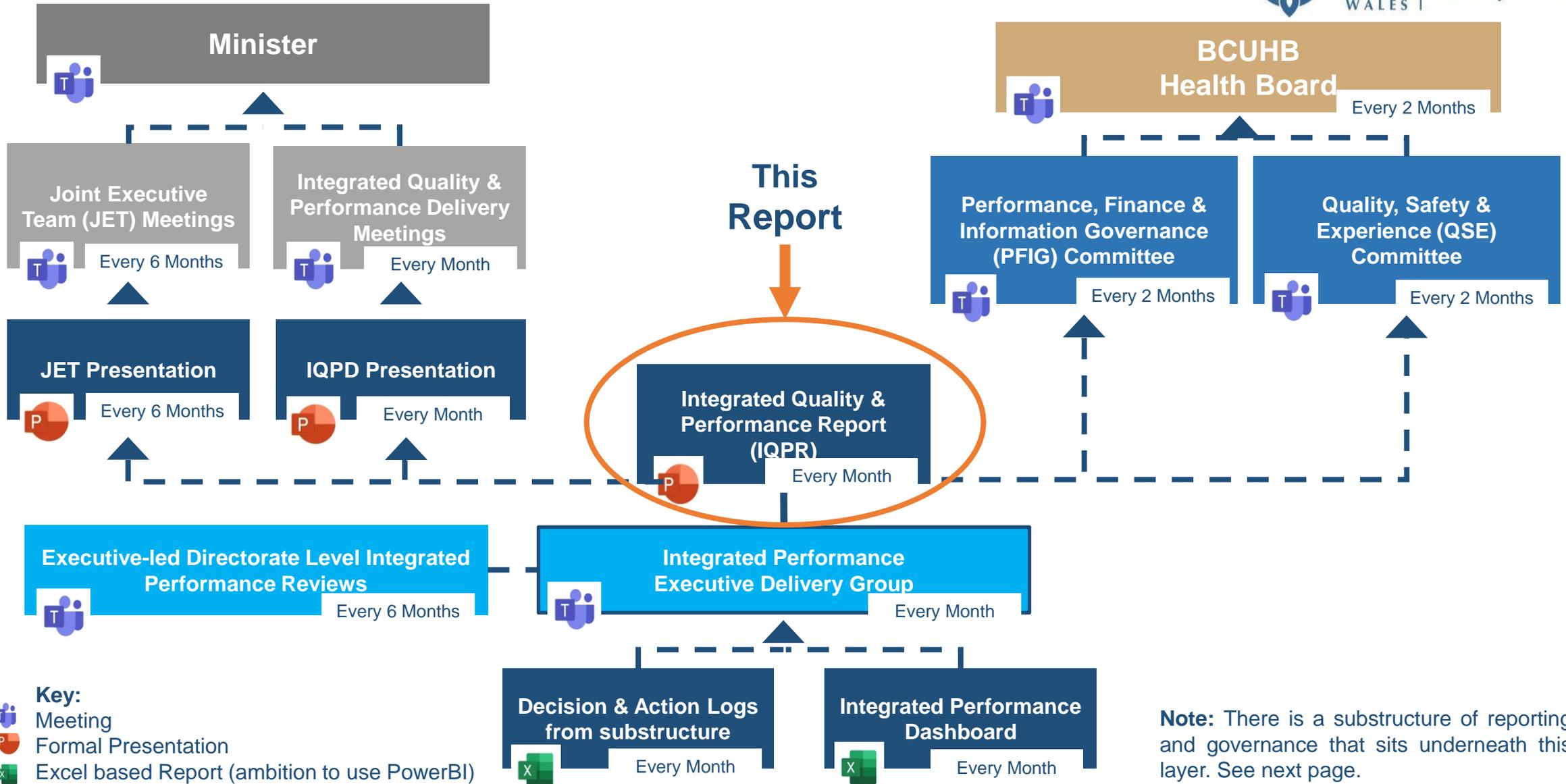
The Integrated Performance Framework sits within a “triumvirate” together with the Integrated Planning Framework and the Risk Management Framework (also ratified at Health Board on the 28<sup>th</sup> September 2023). This triumvirate of frameworks will encompass the planning, safe delivery and monitoring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

## Where does the IQPR feature within the Performance Governance Structure

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

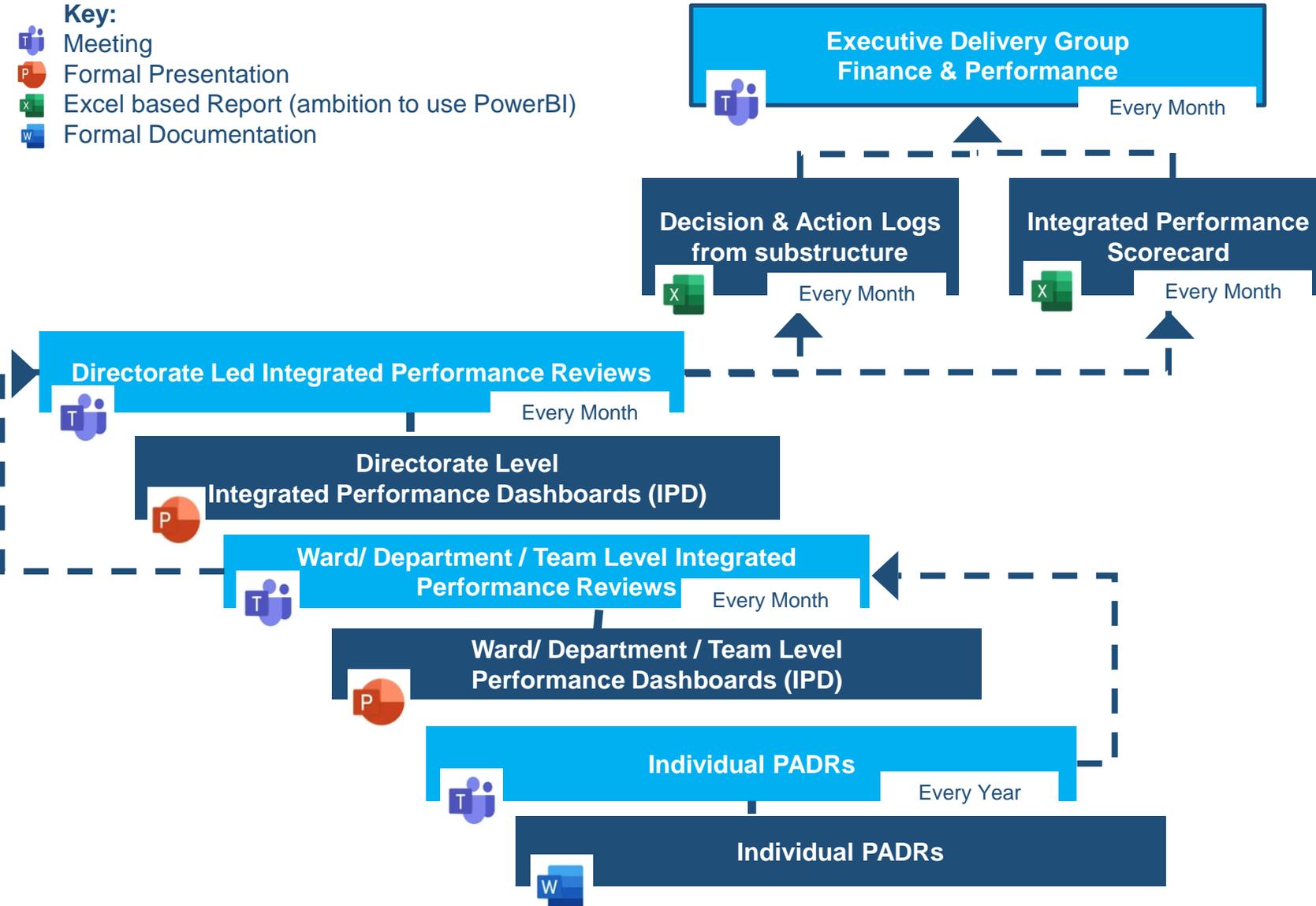
The IQPR will be embedded as the ‘single version of the truth’ and used to report on performance to the Health Board, it’s scrutinising committees namely Performance, Finance & Information Governance (PFIG) Committee and Quality, Safety & Experience (QSE) Committee and externally to Welsh Government.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

# The Integrated Performance Reporting & Governance Superstructure



# The Integrated Performance Reporting & Governance Substructure

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



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

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

# Performance Directorate Outputs

## Integrated Performance Reports



Formal and comprehensive reports to the Health Board and its scrutinising committees, Integrated Quality & Performance Delivery Group (IQPD)(Welsh Government) and Joint Executive Team (JET).

## Integrated Performance Scorecards



Summary scorecards for– Integrated Performance Executive Delivery Group et al

## Integrated Performance Dashboards



Operational level performance dashboards with drill through capabilities. For end of month's submitted position. Ambition for production in PowerBI. – Produced by Digital, Data & Technology (DDAT) in partnership with the Performance Directorate(PI&AD)

## Deep Dive Reports



Detailed Deep Dive reports used in accompaniment to Formal Reports, Scorecards and Dashboards to complement data, provide context, add intelligence and provide assurances as appropriate. Used at all levels as necessary, i.e. to support escalation, de-escalation.

## Ad-hoc Reports



Ad-hoc reports used outside of the formal channels and for specific queries to complement data, provide context, add intelligence and provide assurances as appropriate. Used at all levels as necessary to provide additional intelligence and assurances as required.

# Our Partners



GIG  
CYMRU  
NHS  
WALES

Bwrdd Iechyd Prifysgol  
Betsi Cadwaladr  
University Health Board

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

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

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

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

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



GIG  
CYMRU  
NHS  
WALES

Bwrdd Iechyd Prifysgol  
Betsi Cadwaladr  
University Health Board

## Further Information on Our Integrated Quality & Performance Report

Further information is available on our performance can be found online at:



Our website [www.bcu.wales.nhs.uk](http://www.bcu.wales.nhs.uk)

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

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



follow @bcuwb



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

<b>Teitl adroddiad:</b> <i>Report title:</i>	Board Assurance Framework		
<b>Adrodd i:</b> <i>Report to:</i>	Quality, Safety and Experience Committee (QSE)		
<b>Dyddiad y Cyfarfod:</b> <i>Date of Meeting:</i>	Thursday, 15 January 2026		
<b>Crynodeb Gweithredol:</b> <i>Executive Summary:</i>	<p>The purpose of this paper is to provide assurance to the committee on the progression of the Board Assurance Framework (BAF) risks.</p> <p>The Board Assurance Risks were developed by the Board in October 2024, aligned to the Health Board's five strategic objectives within the Integrated Medium-Term Plan (IMTP). These risks are recognised as due for review. Once the 10-year strategy has been finalised, the Board Assurance Framework (BAF) will be refreshed and realigned to reflect the longer-term strategic direction.</p> <p>The BAF has been updated bi-monthly by Executive leads and reported to the Executive Committee, with the last formal review by Board Committees in April 2025 and presentation to the full Board in May 2025, in line with the Risk Management Framework.</p> <p>Each risk has been reviewed and rated by its respective lead committee, with oversight provided by the Risk Scrutiny Group through monthly deep dives. Recent deep dives during the December 2025 meeting:</p> <ul style="list-style-type: none"> <li>BAF24-06 (3) (Mental Health and Learning Disabilities). 'Risk of insufficient focus on Mental Health, wellbeing and Learning Disabilities'.</li> </ul> <p>BAF24-06 (1) 'A loss of organisational focus on patient safety and quality of care' is scheduled for deep dive at the March 2026 Risk Scrutiny Group.</p> <p>The Board Assurance Framework, as per cycle of risk reporting, bi-annually to the Board, next BAF report in full to the Board Jan 2026.</p>		
<b>Argymhellion:</b> <i>Recommendations:</i>	<p>The Committee is asked to:</p> <ul style="list-style-type: none"> <li>To <b>receive</b> and <b>consider</b> the contents and assurance rating of the Board Assurance Framework.</li> </ul>		
<b>Arweinydd Gweithredol:</b> <i>Executive Lead:</i>	Pam Wenger, Director of Corporate Governance		
<b>Awdur yr Adroddiad:</b> <i>Report Author:</i>	Nesta Collingridge Head of Risk Management		
<b>Pwrpas yr adroddiad:</b> <i>Purpose of report:</i>	I'w Nodi <i>For Noting</i> <input type="checkbox"/>	I Benderfynu arno <i>For Decision</i> <input checked="" type="checkbox"/>	Am sicrwydd <i>For Assurance</i> <input type="checkbox"/>
<b>Lefel sicrwydd:</b>	Arwyddocaol	Derbyniol	Rhannol   Dim Sicrwydd

<b>Assurance level:</b>	<p align="center"><b>Significant</b></p> <p align="center"><input type="checkbox"/></p> <p>Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol</p> <p><i>High level of confidence/evidence in delivery of existing mechanisms/objectives</i></p>	<p align="center"><b>Acceptable</b></p> <p align="center"><input checked="" type="checkbox"/></p> <p>Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol</p> <p><i>General confidence / evidence in delivery of existing mechanisms / objectives</i></p>	<p align="center"><b>Partial</b></p> <p align="center"><input type="checkbox"/></p> <p>Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol</p> <p><i>Some confidence / evidence in delivery of existing mechanisms / objectives</i></p>	<p align="center"><b>No Assurance</b></p> <p align="center"><input type="checkbox"/></p> <p>Dim hyder/tystiolaeth o ran y ddarpariaeth</p> <p><i>No confidence / evidence in delivery</i></p>
<p><b>Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:</b></p> <p><b><i>Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this: N/A</i></b></p>				
<p><b>Cyswllt ag Amcan/Amcanion Strategol:</b></p> <p><b><i>Link to Strategic Objective(s):</i></b></p>	<p>Detailed in the BAF report and how the CRR aligns to the revised BAF</p>			
<p><b>Goblygiadau rheoleiddio a lleol:</b></p> <p><b><i>Regulatory and legal implications:</i></b></p>	<p>It is essential that the Board has robust arrangements in place to assess, capture and mitigate risks, as failure to do so could have legal implications for the Health Board.</p>			
<p><b>Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal?</b></p> <p><b><i>In accordance with WP7 has an EqlA been identified as necessary and undertaken?</i></b></p>	<p>Not applicable for this report</p>			
<p><b>Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal?</b></p> <p><b><i>In accordance with WP68, has an SEIA identified as necessary ben undertaken?</i></b></p>	<p>Not applicable for this report</p>			
<p><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)</b></p> <p><b><i>Details of risks associated with the subject and scope of this paper, including new risks( cross reference to the BAF and CRR)</i></b></p>	<p>Board Assurance Framework paper</p>			
<p><b>Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith</b></p> <p><b><i>Financial implications as a result of implementing the recommendations</i></b></p>	<p>The effective and efficient mitigation and management of risks has the potential to leverage a positive financial dividend for the Health Board through better integration of risk management into business planning, decision-making and in shaping how care is delivered to our patients thus leading to enhanced quality, less waste and no claims.</p>			
<p><b>Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith</b></p> <p><b><i>Workforce implications as a result of implementing the recommendations</i></b></p>	<p>Failure to capture, assess and mitigate risks can impact adversely on the workforce.</p>			

<p><b>Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori</b></p> <p><b><i>Feedback, response, and follow up summary following consultation</i></b></p>	<p>Risk Scrutiny Group feedback 09/12/2025</p> <p>The Risk Scrutiny Group provided some minor feedback during the deep dive to strengthen some of the gaps in controls for care out of area, management and tracking of patient outcomes with related actions which will be reflected in the next report.</p>
<p><b>Cysylltiadau â risgiau BAF:</b> (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)</p> <p><b><i>Links to BAF risks:</i></b> (or links to the Corporate Risk Register)</p>	<p>Board Assurance Framework risks linked to corporate risks</p>
<p><b>Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)</b></p> <p><b><i>Reason for submission of report to confidential board (where relevant)</i></b></p>	
<p><b>Camau Nesaf:</b></p> <p><b><i>Next Steps:</i></b></p> <ol style="list-style-type: none"> <li>1. The actions within the BAF will all be reviewed in line with the final version of the Strategic Plans to ensure full alignment.</li> <li>2. Business as usual reporting and monitoring: Bi-monthly Review at Risk Scrutiny Group and Executive Committee, monitoring of actions within risks. Reporting to Committee quarterly and Board bi-annually as per Risk Management Framework.</li> </ol>	
<p><b>Rhestr o Atodiadau:</b></p> <p><b><i>List of Appendices:</i></b> Appendix 1 – QSE risks only, Board Assurance Framework</p>	



# Board Assurance Framework





# Board Assurance Framework Report

## Purpose

The Board Assurance Framework (BAF) serves as a strategic tool, designed to support the Health Board (BCUHB) in achieving its overarching goals and objectives. The BAF provides a structured approach for identifying, managing, and mitigating risks that may impact the successful delivery of our strategic priorities. Through clear alignment with our organisational strategy and key initiatives, the BAF enables us to maintain an accountable, transparent, and proactive approach to risk management.

The purpose of this BAF is threefold:

- To provide assurance that effective controls are in place to manage risks to our strategic objectives.
- To support informed decision-making by presenting clear, current risk insights to the Board and stakeholders.
- To align risk management efforts across the organisation, ensuring consistency with our vision of delivering high-quality, accessible healthcare services.

By integrating the BAF with our strategic priorities and operational plans, we can ensure that our risk management efforts directly support our mission to improve health outcomes, enhance patient safety, and foster a culture of accountability within BCUHB.

The purpose of this paper is to seek the Board's agreement on the proposed assurance ratings for each of the Board Assurance Framework (BAF) risks, following review by the Committee's responsible for the risks.

Board Assurance risks were developed by the Executive Team based on the Health Board's 5 strategic objectives. The BAF was approved by the Board 30 Jan 2025 and will be subsequently updated by action handlers and Executives on an on-going basis.

### 1.1 Key Highlights

The full Board Assurance Framework was reviewed and updated by each responsible Executive and presented to the Risk Scrutiny Group during the November 2025 meeting, and following review and approval by the Executive Committee will be reported as usual reporting cycle to Board Committees and presentation to the Board during the January 2026 Board meeting.

### 1.2 Changes in Score

None

### 1.3 Risks above Health Board appetite

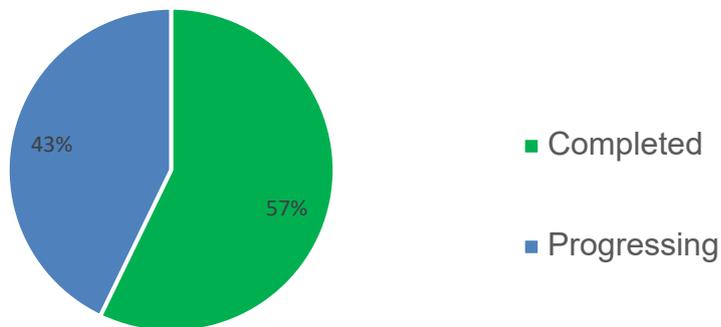
One risk for oversight by QSE continues to be above tolerance.

Ref	Title	Lead Exec Director	Current Risk Score (and IxL)
BAF24-06	Not Delivering the Required Improvements to Transform Care and Enhance Outcomes	Executive Director of Nursing and Midwifery Executive Director of Public Health Executive Medical Director Executive Director of Allied Health Professionals and Health Science	20

### 1.4 Progression of QSE BAF risk actions

14 actions have been identified, of which 8 actions have been completed with 6 actions progressing.

Progression of QSE BAF risk actions



By way of assurance on escalation the corporate team are assigned all risks in the planning portal and therefore will be able to monitor delays, blocks, low confidence and risks through the IMTP portal.

### Next Steps

- Delayed risk actions to be monitored by the Risk Scrutiny Group and Executive Committee.
- The actions within the BAF will all be reviewed in line with the final version of the Strategic Plans to ensure full alignment.
- The Board Assurance Framework will be maintained and reported to the Risk Scrutiny Group; Executive Committee (bi-monthly) and Committees (quarterly) and Board (bi-annually) as per the Risk Management Framework.

The key elements of the BAF are:

- A description of each Principal (strategic) Risk, that forms the basis of the HBs risk framework (with corresponding corporate and operational risks)
- Risk ratings – current (residual), tolerable and target levels. Risks are scored in line with the HB approved scoring matrix.
- Clear identification of strategic threats and opportunities that are considered likely to increase or reduce the Strategic Risk, within which they are expected to materialise
- A statement of risk appetite for each threat and opportunity, to be defined by the Lead Committee on behalf of the Board (Averse = aim to avoid the risk entirely; Minimal = insistence on low-risk options; Cautious = preference for low risk options; Open = prepared to accept a higher level of residual risk than usual, in pursuit of potential benefits)
- Key elements of the risk treatment identified for each threat and opportunity, each assigned to an Risk Lead and individually rated by the lead committee for the level of assurance they can take that the strategy will be effective in treating the risk (see below for key)
- Sources of assurance incorporate: (1) Management (those responsible for the area reported on); (2) Risk and compliance functions (internal but independent of the area reported on); and (3) Independent assurance (Internal audit and other external assurance providers).
- Unlike corporate risks where target dates are key for mitigation, risks will remain reported as the Board seeks assurance accordingly until the risk is sufficiently mitigated. Actions are based on quarters for the year.
- Board committees should review the BAF with particular reference to comparing the tolerable risk level to the current exposure risk rating.
- The RACI clarifies roles and responsibilities for tasks and deliverables and is utilised for sub-risks however the responsibility of the overall BAF risks of the lies with the **Executive Team** and accountability lies with the lead committee.

Likelihood score and descriptor					
	Very unlikely 1	Unlikely 2	Possible 3	Somewhat likely 4	Very likely 5
<b>Frequency</b> How often might/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally or there are a significant number of near misses / incidents at a lower consequence level	Will probably happen/recur, but it is not a persisting issue/ circumstances	Will undoubtedly happen/recur, possibly frequently
<b>Probability</b> Will it happen or not?	Less than 1 chance in 1,000 (< 0.1%)	Between 1 chance in 1,000 and 1 in 100 (0.1 - 1%)	Between 1 chance in 100 and 1 in 10 (1- 10%)	Between 1 chance in 10 and 1 in 2 (10 - 50%)	Greater than 1 chance in 2 (>50%)

Key to lead committee assurance ratings:



**Substantial Assurance**

The Committee is satisfied that there is reliable evidence supporting the effectiveness of the current risk treatment strategy in mitigating the threat, with minimal gaps in control. While the majority of actions have been addressed, some minor actions may still require completion before the risk score is reduced. However, the Committee has good assurance regarding action progress. Likelihood of risk materialising: Low.



**Reasonable Assurance**

The Committee has seen sufficient evidence that the most significant actions to reduce the risk have been completed. There is assurance that the planned actions within the current risk treatment strategy are appropriate, with the majority of control and assurance gaps having been addressed. Likelihood of risk materialising: Low to moderate.



**Limited Assurance**

The Committee does not have sufficient evidence for assurance that the current risk treatment strategy is effectively mitigating the threat. There remains to be some key gaps in controls that require management attention, and further external validation is needed. Until further controls are in place, there remains a number of actions to reduce the score. Likelihood of risk materialising: Moderate.



**Unsatisfactory Assurance**

The Committee has no/little evidence for assurance that the current risk treatment strategy is effectively managing the threat. There remains to be several key gaps in controls that require management attention, and further external validation is needed. Until further controls are in place, there remains a number of actions to reduce the score. Likelihood of risk materialising: High

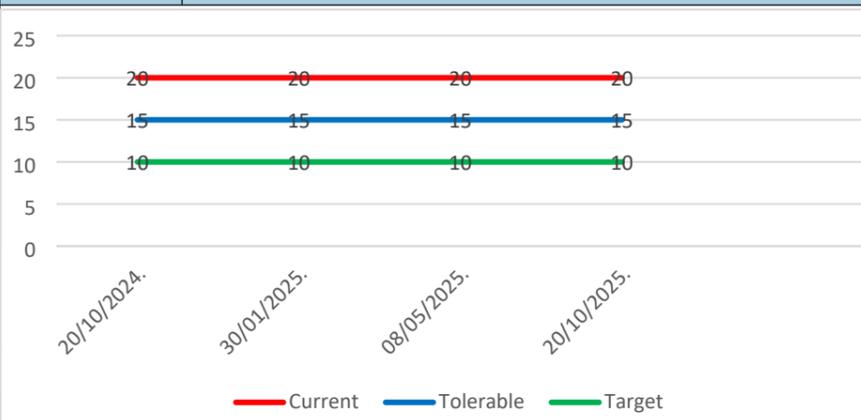
# Board Assurance Framework (BAF): July 2025

This BAF includes the following Risks to the HBs strategic priorities:

Reference	Principal risk: There is a risk of...	Lead Executive	Lead Committee	Initial date of assessment	Last reviewed by Executive Team	Previous risk score (at previous review/update) C x L	Current risk score C x L	Target risk score C x L
BAF24-01	Not Fully Building an Effective and Accountable Organisation	Director of Corporate Governance and Executive Team oversight	Performance, Finance and Information Governance	20/10/2024	21/07/2025	4x 3= 12	<b>4x 3= 12</b>	2x 2= 4
BAF24-02	Not Delivering Strategic Development and Digital Transformation	Executive Director of Transformation and Strategic Planning & Chief Digital & Information Officer	Planning, Population Health & Partnership	20/10/2024	21/07/2025	5x 4= 20	<b>5x 4= 20</b>	3x 3= 9
BAF24-03	Not Achieving Long Term Financial Sustainability	Executive Director of Finance	Performance, Finance and Information Governance	20/10/2024	21/07/2025	5x 4= 20	<b>5x 4= 20</b>	3x 3= 9
BAF24-04	Not Establishing a Compassionate Culture, Leadership, Engagement and workforce capacity and capability	Deputy Director of People Services	People & Culture	20/10/2024	21/07/2025	4x 4= 16	<b>4x 4= 16</b>	3x 3= 9
BAF24-05	Not Engaging with Citizens, Partners and Communities	Director of Partnerships/Communications and Engagement	Planning, Population Health & Partnership	20/10/2024	21/07/2025	2x 3= 6	<b>2x 3= 6</b>	2x 2= 4
BAF24-06	Not Delivering the Required Improvements to Transform Care and Enhance Outcomes	Executive Director of Nursing Executive Director of Public Health Executive Medical Director Executive Director of Allied Health Professionals and Health Science	Quality, Safety and Experience / Planning, Population Health & Partnership	20/10/2024	21/07/2025	5x 4= 20	<b>5x 4= 20</b>	5x 2= 10
BAF24-07	Not Delivering Timely Access to Care Resulting In Potential Clinical Harm, Poor Delivery of Performance Targets and Reputational Risk	Chief Operating Officer	Performance, Finance and Information Governance	20/10/2024	21/07/2025	4x 4= 16	<b>4x 4= 16</b>	4x 2= 8
BAF24-08	Not Implementing Evidenced Based Improvement and Innovation	Executive Medical Director & Chief Digital & Information Officer	Planning, Population Health & Partnership	20/10/2024	21/07/2025	4x 3= 12	<b>4x 3= 12</b>	3x 2= 6

### 4: Improving quality, outcomes and experience

Objective area 4 covers a large thematic area where improvements are required to improve clinical performance across a number of key areas. The Health Board wishes to build further upon good work commenced that takes a pathway focused approach to this.

<b>Principal risk</b> (what could prevent us achieving this strategic objective)	<b>BAF24-06: Not Delivering the Required Improvements to Transform Care and Enhance Outcomes</b>			<b>Strategic objective</b>	4. To Improve Quality, Outcomes and Experience (4A Patient Experience; 4B Prevention; 4I Adult Mental Health, Learning Disability)
	Risk of ineffectively delivering consistent high quality of patient care across the HB resulting in incidents of avoidable harm and poor clinical unmet patient needs, regulatory non-compliance, and reputational harm.				
<b>Lead Committee</b>	Quality, Safety and Experience Committee / Planning, Population Health & Partnership Committee		<b>Risk type</b>	Quality	
<b>Risk Lead</b>	Executive Director of Nursing Executive Director of Public Health Executive Medical Director Executive Director of Allied Health Professionals and Health Science		<b>Risk appetite</b>	Open <15 Above Tolerance	
<b>Related Corporate Risks:</b>	CRR25-01, Timely Patient Access to Safe and Effective Care; CRR25-03, Population Needs				
<b>Risk rating</b>			<b>Review Dates</b>		
	<b>Current exposure</b>	<b>Target</b>	<b>Initial date of assessment</b>	20/10/2024	
<b>Consequence</b>	5	5	<b>Last reviewed by Committee:</b>	21/08/2025	
<b>Likelihood</b>	3	2	<b>Last updated by Executive:</b>	20/10/2025	
<b>Risk rating</b>	20	10			

Strategic threat (what might cause this to happen)	Primary risk controls (what controls/ systems & processes do we <b>already</b> have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Gaps in control (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	Sources of assurance (and date) ( <b>Evidence</b> that the controls/ systems which we are placing reliance on are effective)	Gaps in assurance / actions to address gaps and issues (Insufficient evidence as to effectiveness of the controls or negative assurance)	Assurance rating
Responsible:	Deputy Executive Director of Nursing	Accountable:	Executive Director of Nursing	Responsible Committee	Quality, Safety and Experience Committee
<p><b>Threat:</b> A loss of organisational focus on patient safety and quality of care leading to increased incidence of avoidable harm, exposure to 'Never Events', higher than expected mortality, and significant reduction in patient satisfaction</p>	<ul style="list-style-type: none"> <li>• Integrated Concerns Policy and daily Hub meetings in place to review all concerns of moderate , grade4/5 and above</li> <li>• Patient incident/feedback systems and policies</li> <li>• Data analysis and learning at service level</li> <li>• Datix Reporting</li> <li>• Patient safety Staff training - Quality governance arrangements at Health Board, IHC/division &amp; service levels including:                             <ul style="list-style-type: none"> <li>○ Local ICOG and Exec EICOG Groups</li> <li>○ BCUHB patient safety, infection prevention , safeguarding and patient experience groups</li> <li>○ BCUHB SCEG, meetings</li> <li>○ Local and Exec Quality Delivery Groups</li> <li>○ Clinical audit programme &amp; monitoring arrangements</li> <li>○ Ward accreditation/ metrics</li> </ul> </li> <li>• Integrated Concerns Policy and Toolkit</li> <li>• Concerns Hub</li> <li>• Rapid review Sign-off process for incidents and Nationally Reported Incidents</li> <li>• Executive Led Oversight Group</li> <li>• Quality assurance visits</li> <li>• Internal Reviews against External National Reports</li> <li>• Getting it Right First Time (GIRFT)</li> <li>• Localised deep dives, reports and action plans</li> <li>• Operational grip on workforce gaps</li> <li>• Patient Advice and Liaison Service Activity</li> </ul>	<ul style="list-style-type: none"> <li>• Operational oversight of sustainable change, evidence of learning and improvement measures</li> <li>• <a href="#">Harm review process to be approved for the planned care major change programme</a></li> </ul>	<p><b>Management:</b></p> <ul style="list-style-type: none"> <li>• Learning from deaths Report to QC and Board</li> <li>• Quarterly Strategic Priority Report to Board.</li> <li>• Divisional risk reports to SRG bi-annually.</li> <li>• Guardian of Safe Working report to Board</li> <li>• Quality and Governance Reporting Pathway.</li> </ul> <p>Quality Safety and Experience Committee reports include:</p> <ul style="list-style-type: none"> <li>○ Safeguarding Annual Report to QSE</li> <li>○ Infection Control Annual Report</li> <li>○ Health and Safety Annual Report</li> <li>○ Bimonthly Quality Report</li> <li>○ Deep dive Reports</li> <li>○ Risk Management Report</li> <li>○ Integrated Performance Report</li> <li>○ Duty of Quality annual report</li> </ul> <p><b>Risk and compliance:</b></p> <ul style="list-style-type: none"> <li>• Quality Dashboard</li> <li>• Duty of Candour</li> <li>• Corporate Risks</li> <li>• Ombudsman Annual Letter</li> </ul> <p><b>Independent assurance:</b></p> <ul style="list-style-type: none"> <li>• Health Inspectorate Wales Reports</li> <li>• Care Inspectorate Wales Reports</li> <li>• Coroners' reports:</li> </ul>	<p>Limited Assurance Internal Audit report for Limited Assurance: Lessons Learnt, Falls, Deprivation of Liberty</p> <p><a href="#">All actions on track or closed</a></p> <ul style="list-style-type: none"> <li>• Nursing &amp; Midwifery Vision Embedding (launched May 2025)</li> <li>• Allied Health Professional Strategy</li> <li>• Clinical services plan</li> <li>• <a href="#">Harms review process to be approved for planned care</a></li> </ul>	<p><b>Limited Assurance</b></p>

	<ul style="list-style-type: none"> <li>Comprehensive Cultural Competence training and awareness</li> </ul>		<ul style="list-style-type: none"> <li>Internal Audit reports. <b>Patient Experience –Reasonable</b></li> <li>Royal College Reports</li> <li>Llais Reports</li> <li>Ombudsman</li> </ul> <p>Screening Quality Assurance Services assessments and reports of:</p> <ul style="list-style-type: none"> <li>Antenatal and New-born screening</li> <li>Breast Cancer Screening Services</li> <li>Bowel Cancer Screening Services</li> <li>Cervical Screening Services</li> </ul> <p>External Accreditation/Regulation annual assessments and reports of;</p> <ul style="list-style-type: none"> <li>Pathology (UKAS)</li> <li>Endoscopy Services (JAG)</li> <li>Medical Equipment and Medical Devices (BSI)</li> <li>Blood Transfusion Annual Compliance Report (MHRA)</li> <li>Ionising Radiation (Medical Exposure) Regulations</li> </ul>		
--	------------------------------------------------------------------------------------------------------------	--	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	--

↑	Plans to improve control (are further controls possible in order to reduce risk exposure within tolerable range?)	Action Handler	Status of Actions	Date when action will be completed
	Civica mapping of services to improve consistency of levels of feedback	Deputy Executive Director of Nursing	Complete	31/03/2025
	Expand real-time feedback systems across all services (SMS texting for priority areas e.g. ED)	Deputy Executive Director of Nursing	Complete	31/12/2024
	Quality Management System in development. – pilots in urology and vascular	Deputy Executive Director of Nursing	Complete	31/03/2025
	Reduced response times for addressing patient complaints.	Deputy Executive Director of Nursing	Complete	31/03/2025
	Learning Repository Development – Delayed due to Digital Team capacity, Digital lead now allocated time to complete and progressing with a revised completion date from 31/12/2024 to 31/11/25	Deputy Executive Director of Nursing	Progressing	31/11/2025
	Harms review process to be approved for planned care activity	Programme Director Planned Care	Progressing	30/11/2025

Strategic threat (what might cause this to happen)	Primary risk controls (what controls/ systems & processes do we <b>already</b> have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Gaps in control (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)			Sources of assurance (and date) ( <b>Evidence</b> that the controls/ systems which we are placing reliance on are effective)	Gaps in assurance / actions to address gaps and issues (Insufficient evidence as to effectiveness of the controls or negative assurance)	Assurance rating
Responsible:	Director of Mental Health & Learning Disabilities	Accountable:	Executive Director of Allied Health Professionals and Health Science	Responsible Committee	Quality, Safety and Experience Committee		
<p><b>Threat:</b> Risk of insufficient focus on Mental Health, wellbeing and Learning Disabilities in the Health Board strategy, planning and operations leading to sub optimal patient outcomes, lack of an holistic approach, regulatory non-compliance and reputational harm.</p>	<ul style="list-style-type: none"> <li>Alignment with Welsh Government National strategies for Mental Health and wellbeing, Learning Disabilities and Substance Misuse</li> <li>Adherence to Royal College and Clinical standards</li> <li>National NHS Executive Mental Health and Learning Disabilities (MHL) Strategic Improvement Programme</li> <li>Established Royal College Psychiatry Improvement programme with Health Board wide reporting and governance</li> <li>Established reporting through existing HB Governance Frameworks, Oversight committees and routine audits to ensure compliance and monitor progress.</li> <li>Inclusion in Health Board Annual Plan and monitoring mechanisms</li> <li>Inclusion in organisational Major change programme, oversight and reporting</li> <li>Clinically led Physical health work stream in MHL</li> <li>Primary care pathways</li> <li>Crisis Care Concordat in place</li> </ul>	<ul style="list-style-type: none"> <li>Recruitment and Retention challenges impacting on workforce including interim posts</li> <li>Engagement and collaboration with physical health services</li> <li>'Foundations for the Future' programme maturity</li> <li>Insufficient focus on health inequalities</li> <li>Lack of integrated Electronic Health Record and other digital systems</li> <li>Limited visibility of Mental health and Learning disabilities data at Board level</li> <li>Current risk to balanced financial position</li> <li>Greater focus on community and earlier intervention services</li> </ul>			<p><b>Management:</b></p> <ul style="list-style-type: none"> <li>External reviews in 2023-24, undertaken as part of Special Measures all recommendations completed and managed.</li> <li>Performance Management and reporting</li> <li>Civica and patient reporting metrics</li> </ul> <p><b>Risk and compliance:</b></p> <ul style="list-style-type: none"> <li>Compliance with Royal College Standards</li> <li>Audit Reports</li> </ul> <p><b>Independent assurance:</b></p> <ul style="list-style-type: none"> <li>Development of co-produced Patient Carer engagement work</li> <li>Expert advisory group</li> <li>External reviews</li> <li>National and Local performance reporting</li> <li>Together 4 Mental Health Partnership Board in place</li> </ul>	<ul style="list-style-type: none"> <li>Lack of integrated patient care records impacting on care, planning and reporting</li> <li>Increasing the scope of performance reviews focusing on patient pathways.</li> <li>Improving our real time patient data</li> <li>Visibility of community mental health activity</li> </ul>	<p><b>Limited Assurance</b></p>

Plans to improve control (are further controls possible in order to reduce risk exposure within tolerable range?)	Action Handler	Status of Actions	Date when action will be completed
Recruitment plans for substantive workforce. Now- completed, Director of Nursing successfully recruited with anticipated start date 17th November 25. Recruitment activity remains business as usual but progress made across the division and plan now in place.	Director Of Operations MHL D	Complete	31/09/2025
Increased pathways with Primary care	Consultant Psychiatrist/medical Director	Progressing	31/12/2025
Active engagement with the Foundations for the future programme now completed as MHL D formally engage with aspects of the programme and will be Business as usual until FftF is rolled out.	Director Of Operations MHL D	Complete	31/10/2025
Electronic Health Record programme with MHL D as early adopter	Interim Director MHL D	Progressing	31/03/2026
Enhanced Savings plans	Chief Finance Officer	Progressing	31/03/2026
Responsive annual plan	Head Of Integrated Strategy And Development	Complete	31/03/2025
Implementation of Communication strategy, will remain dynamic and developmental	Head Of Integrated Strategy And Development	Complete	31/12/2025
Alignment with Learning Disabilities national programme- Improving Care Improving lives review	Director Of Operations MHL D	Progressing	31/03/2026

## Quality Safety & Experience Committee

### CHALLENGED SERVICES UPDATE

<b>Dyddiad y Cyfarfod</b> <b>Date of Meeting</b>	15 January 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>	Geraint Parry, Interim Assistant Director Transformation & Improvement Julie Ward-Jones, Head of Improvement
<b>Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol</b> <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>Pwrpas yr Adroddiad</b> <b>Report Purpose</b>	For Noting

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

The purpose of this paper is to provide a Portfolio overview of the Challenged Services. The report provides a high-level summary of progress along with key challenges and escalations.

The report builds on previous updates provided to committee alongside the regular Welsh Government touchpoint meetings. Progress continues across each of the services and whilst systemic challenges remain across some areas there is increasing evidence of plans being developed to address these. Multi-Professional workshops have been taking place across services to commence a more strategic focus on future models as this work transitions into Clinical Services Plan Phase 2.

There are a number of services that have an urgent need for support to move to regional working as part of the solution to some of their pressing issues. This links to Foundation for the Future (FftF) structures, IMTP service planning, elements of the Major Change Programme work around Value and Sustainability and Planned Care, but all linked to the Clinical Service Plan.

The Strategic Planning and Service Change Group will also receive an update on this work at its January 2026 meeting where the contents of this report will be reviewed as part of executive assurance up to Committee. In further strengthening of arrangements the first Challenged Services Oversight Group took place in late November where more detailed scrutiny is taking place with the services and support provides to unblock challenges.

**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>





GIG  
CYMRU  
NHS  
WALES

Bwrdd Iechyd Prifysgol  
Betsi Cadwaladr  
University Health Board

# Health Board Challenged Services

## Progress Report

November 2025



**Trugaredd**  
Compassion



**Agored**  
Openness



**Parch**  
Respect

## SECTION 1 - EXECUTIVE SUMMARY

Eight clinical specialties within the Health Board remain designated as Challenged Services of Concern by Welsh Government (WG). These services continue to be subject to enhanced external scrutiny through quarterly WG Touchpoint meetings, alongside strengthened internal oversight arrangements.

The Challenged Services Oversight Group, established by the Strategic Planning and Service Change Group (SP&SCG), convened for the first time in November 2025, and is scheduled monthly following the January 2026 meeting. The Group provides a clear governance framework to ensure that each specialty has a credible, deliverable plan in place, and that progress is monitored with appropriate escalation and course correction. Early priorities include strengthening clinical leadership, improving support for direct patient care, and clarifying operational leadership roles from the Integrated Health Communities to ensure that service environments, logistics, and workflows enable safe and reliable delivery.

Challenged Service Specialty Planning documents, developed in early 2025 to identify key issues and outline high-level improvement actions, are currently undergoing a structured review, and are being fed into the Integrated Medium Term Planning (IMTP) cycle. Recommendations will be presented to the Oversight Group in January 2026, with a focus on enhancing their contribution to sustainable Quality Management Systems and ensuring alignment with the Clinical Services Plan.

Across planned care and diagnostic pathways, the Health Board continues to make steady progress, with improvements in backlog reduction and pathway redesign. However, significant risks remain. Workforce shortages continue to impact service resilience, compounded by national recruitment challenges. Estates and clinic capacity constraints also limit the pace of improvement. Targeted insourcing, pathway transformation, and strengthened governance arrangements are helping to mitigate these risks.

At the time of reporting, the Health Board is awaiting confirmation from Welsh Government regarding potential de-escalation of Oncology and Plastics from Special Measures status.

## SECTION 2 – PORTFOLIO HIGHLIGHTS

Challenged Services programme status **submitted via November 2025 highlight reports**

Service	Overall Delivery Confidence	Resource	Finance	Plan	Progress	Risks / Issues
<b>Oncology</b>	<span style="color: green;">■</span>	<span style="color: orange;">■</span>	<span style="color: orange;">■</span>	<span style="color: green;">■</span>	<span style="color: green;">■</span>	<span style="color: orange;">■</span>
<p>The service aims to stabilise the senior medical workforce by recruiting more substantive consultant medics within financial year 25/26. This is on track with the release of 3x Medical Oncology Consultant adverts, although there remains a risk to this due to the national shortage of suitable consultants (especially for specific tumour sites).</p> <p>The first SABR (Stereotactic Ablative Radiotherapy) patient received treatment for their lung cancer in BCUHB. The service has commenced so that patients can receive this treatment in north Wales and not have to travel to Liverpool. Further tumour sites will be considered as part of phase 2 of the project.</p> <p>A Clinical strategy working group has been established to support the development and delivery of a sustainable clinical strategy for Oncology, with the aim to develop a strategy by March 2026.</p> <p>The Health Board continues to wait on a decision by Welsh Government (WG) in relation to the de-escalation of Oncology from being a Challenged (fragile) service.</p>						
<b>Orthopaedics</b>	<span style="color: green;">■</span>	<span style="color: orange;">■</span>	<span style="color: green;">■</span>	<span style="color: green;">■</span>	<span style="color: orange;">■</span>	<span style="color: green;">■</span>
<p>The West Integrated Health Community (IHC) has progressed its See on Symptoms (SOS) follow-up reduction work, where letters are sent to appropriately identified patients (an initial test cohort prior to spread and scale) on the waiting list asking them to contact the service only if they still need care. This has generated a 2% re-engagement rate meaning 98% of patients did not need further follow-up, suggesting that most scheduled appointments were unnecessary. A low engagement rate is seen as a positive result when accompanied alongside clear patient information and is aligned with national (UK) expectations for safe, efficient, follow up re-design. Roll out of this approach has commenced with the East IHC agreeing to adopt the same backlog reduction approach. IHCs are also utilising core, insourcing and outsourcing opportunities to achieve Q3 and Q4 waiting time targets.</p> <p>A decision in principle for main and second provider has been made around hip implant rationalisation for the Llandudno unit pending approval from the Llandudno Project Board, with further discussions planned for knee implants.</p> <p>Uptake of the new Minor Operating Procedures (MOPs) coding practice is increasing across the West enabling greater visibility and accuracy of activity levels to inform more robust demand and capacity analysis.</p> <p>My Mobility App continues to gain traction in the East, giving patients a more supported, convenient, and personalised recovery experience, offering tailored education and reminders and a way of communicating with their care team.</p>						

## Orthodontics

A mini workshop around Orthodontic Services in north Wales was held recently to review the Orthodontic Getting it Right First Time (GIRFT) recommendations to inform short, medium and long-term planning. The discussion highlighted a number of strengths and opportunities, enabling future improvements to build on a foundation of strong workforce cohesion, with an established team. The plan will encompass workforce & training, clinical service delivery (including Multi-Disciplinary Team working and estates/capital requirements), digital & systems development, governance, and finance, initially focussing on contributing to the IMTP 2026/2027, whilst outlining a sustainable long-term vision for Orthodontics.

Insourcing is currently in place for those patients waiting for a new appointment (resulting in a reduction in waits for first appointments) but a number of these patients will convert to follow up appointments and treatment pathways that will continue to place a significant demand on the service. Steps to mitigate and provide sustainable solutions for this are included in the planning cycle described above.

## Ophthalmology

Progress has been made across data quality, clinical capacity, and demand management initiatives. The Pan-BCU Cataract Network continues to support the Integrated Health Community (IHC) rollout of the One-Stop Pre-Operative Assessment Clinic (POAC) and High Volume, Low Complexity Model, with Central now fully embedded, East in the embedding phase, and West temporarily paused to manage the return of 104-week outsourcing activity with the aim to recommence during January 2026. In addition, within Q3, 2,000 cataract cases were re-coded, with further work underway to enhance data accuracy and enable more efficient HVLC streaming and outsourcing through appropriate listing and scheduling of cases based on complexity.

To support the progressive reduction of secondary care demand, additional capacity has been created in community and primary care: four optometrists have successfully achieved the Glaucoma Higher Certificate through the Deeside Teach & Treat programme, contributing to a reduction of more than 700 appointments from the >104-week backlog with Teach & Treat (Glaucoma, Prescribing, Medical Retina) funded by WG through to the end of Q4, the Wales General Ophthalmic Service (WGOS) Urgent Independent prescribing, HCQ (hydroxychloroquine) and Medical Retina pathways are live with glaucoma onboarding underway, and post-graduate optometry students are delivering over 80 appointments per week within community optician practices.

## Urology

The service is currently awaiting on the diagnostic department to develop a paper for SLA (service level agreement) provision for out of hours interventional radiology; mitigation, whilst waiting, is that each individual case for out of hour interventional radiology is escalated via the BCU HB on call (silver/gold) to support with transfers to the North West. This causes delays as there is the requirement for decision through escalation and delays in the hospital accepting as there is no formal SLA/agreement in place.

A vasectomy paper has been submitted to the Executive team with agreement to proceed with commissioning commitments for vasectomy services going forward.

A MyMR (My Medical Record – a national programme supporting remote monitoring of PSA results and reducing the need for face to face follow up) integration paper has been submitted to DHCW (Digital Health and Care Wales) and meetings held locally to progress.

There has been some significant work on local anaesthetic trans perineal prostate (LATP) biopsies (a procedure for prostate cancer diagnosis) including training, pathway mapping (including insourcing responsibilities) and improved waiting list coding to support more accurate demand management. This work will increase capacity and reduce the time waiting for a diagnosis. Insourcing is currently supporting LATP activity whilst the training is being undertaken with sign off planned for the end of January 2026.

### **Dermatology**

Dermatology services in North Wales face ongoing pressures due to workforce shortages—especially in the West where there are challenges recruiting to senior clinical posts. To address the current challenges recruitment continues and interviewing for x3 specialty doctors will be taking place in January 2026, and an interim service model has been agreed to support the service whilst progress is made through Foundations for the Future and the Clinical Service Plan to provide sustainable long-term model.

Despite these challenges, waiting times for patients waiting over 52 and 104 weeks have improved through national insourcing support. Patients on a suspected cancer pathway waiting over 62 days has reduced from 1380 to 1325, and urgent suspected cancer (USC) first outpatient appointment within 14 days has reduced from 1874 to 1698 (within the reporting period of November 2025).

Work is underway to streamline referrals and expand Teledermoscopy services (introduced at all three sites) to reduce unnecessary outpatient appointments and speed up treatment for patients who need further care.

### **Vascular**

The Vascular Service, through its BCUHB Vascular Improvement Group, is strengthening its structured improvement programme to address the findings from Health Inspectorate Wales (HIW) standards, professional bodies and previous external reviews, continuing its journey from reactive compliance toward a proactive, high performing service with strong clinical ownership and measurable impact on patient outcomes.

The next phase of the programme focuses on socialising the consolidated improvement plan, refining actions, and strengthening leadership and engagement across the service. This includes circulating the plan for review, holding a deep-dive operational team meeting to assign leads, and identifying priorities specifically related to spoke sites. Consultant engagement will be supported through an away day to build consensus, alongside dedicated sessions for specialty doctors and juniors. An engagement roadmap and visual summary of the seven themes (Governance and Quality, Model of Care, Planning and Resources, Pathways, Culture and Behaviour, Workforce and Patient Safety) will be developed, a workforce development deep dive prepared, and the overall plan embedded into governance processes to ensure sustained delivery and oversight

Historic risks have reduced from 12 to 3; with remaining risks including clinic capacity, estates limitation and sustainability of nurse-led clinics, with mitigation plans in place. This includes the increase in use of Hot clinics,(fast-track, senior -led clinics for urgent patient assessment) and enabling direct GP referrals and exploration of HealthCare Assistant support.

Workforce challenges include two substantive consultant vacancies which are currently being covered by locums, with one post approved by the Vascular society and the second being followed up. Interviews have been held for x three specialty doctor posts with a high degree of confidence that they will be filled.

### Plastics

Plastics continue to maintain progress for this reporting period (November 2025);, achieving a 4% reduction in the overall waiting list this month, including a 33% drop in patients waiting over one year, while maintaining zero patients waiting over 104 weeks. Patients in the Central area have begun transferring to East to help balance waiting times across the sites. Waiting list initiatives continue to support waiting list reduction in the West IHC with further discussions needed to ensure sustainability.

Ongoing discussions with Joint Commissioning Committee (JCC) in relation to consultant travel costs, with agreement needed prior to Service Level Agreement sign off by Mersey and West Lancashire via a funding approval request by JCC of the BCUHB Operational Leadership Team.

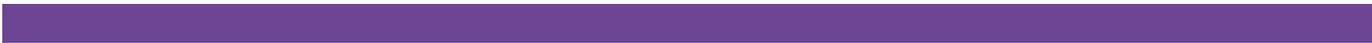
ASESIAD / ASSESSMENT	
<b>Cyswilt â'r Blaenoriaethau Strategol</b> <b>Link to Strategic Priorities</b>	     4. Improving quality, outcomes and experience
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
<b>Yr Egwyddorion Dylunio</b> <b>Design Principles</b>	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 Corfforaethol a Sicrwydd y Bwrdd</b> <b>Corporate Risks and Board Assurance Framework</b>	<p style="color: red;">Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR)</p> <p style="color: red;">Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR)</p> CR25-5 Strategic Change- impacting care and staff delivery
<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:	<i>Not applicable</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>	Do/Yes: <input type="checkbox"/>	Naddo/No: <input checked="" type="checkbox"/>
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	<i>Not applicable</i>

<i>Have you undertaken a Socio-Economic Impact Assessment</i>		
<b><u>Ansawdd</u></b> <i>A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Aseiad 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> Whole-systems Perspective	<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) 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 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?	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
<b>Aseiad o Effaith ar Ddiogelu Data A ydych chi wedi cynnal prawf Sgrinio o'r Aseiad o Effaith ar Ddiogelu Data? Data Protection Impact Assessment</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 applicable

<i>Have you undertaken a Data Protection Impact Assessment Screening?</i>		
<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:	Not applicable
<b>Cyfreithiol Legal</b>	There are no specific legal implications related to the activity outlined in this report.	
<b>Enw Da 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>Effaith ar Adnoddau (Pobl / Ariannol) Resource Impact (People / Financial)</b>	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 BCU	



## Quality Safety & Experience Committee

### PROGRESS AGAINST THE WOMEN'S SERVICES PRIORITIES FOR 2025/26

<b>Dyddiad y Cyfarfod Date of Meeting</b>	15 January 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>	Women's Service Senior Leadership Team
<b>Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol Lead Executive Team Member name and title</b>	Tehmeena Ajmal Chief Operating Officer

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

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

This report provides an update to BCUHB's Quality, Safety and Experience (QSE) Committee on the progress made against Women's Services priorities for 2025/26, as outlined in Section 4.K of the Annual Plan. It covers achievements to date, outstanding deliverables, and key risks.

#### **Key Strategic Priorities**

The key strategic priorities are as follows:

1. **Women's Health Hub** – Establish a fully operational hub by March 2026 as a Ministerial Priority. The hub will deliver integrated, community-based care across North Wales, focusing on menstrual health, menopause, and contraception.
  - **Progress:** Discovery and design phases completed; funding and accommodation secured; pathfinder hub planned for Llandudno General Hospital.
  - **Risks:** Workforce availability, financial constraints, IT interoperability, and limited resources to implement the local plan.
2. **Preconception Strategy** – Align with the Women's Health Plan to improve preconception health and care.
  - **Progress:** Local Strategy published in 2023; update underway to reflect national priorities.
  - **Risks:** Delayed implementation plan due to limited workforce and unidentified funding and resources.

3. **Perinatal Engagement Framework** – Deliver commitments for equitable service user engagement.
  - **Progress:** Baseline assessment completed, cultural competency training delivered, introduction of maternity surveys ongoing.
  - **Risks:** Lack of funding for Maternity and Neonatal Voices Partnership Chair role; IT challenges impacting full survey implementation.
4. **Perinatal Workforce Plan** – Collaborate with HEIW to address workforce gaps and training needs.
  - **Progress:** Recruitment planning, education initiatives, and leadership development underway.
  - **Risks:** Medical Recruitment and re-current funding.
5. **Perinatal Quality Surveillance Dashboard** – Develop a dashboard for local and national oversight by March 2026.
  - **Progress:** Design initiated; KPI sources identified. First example to be available in January 2026.
  - **Risks:** Competing demands may delay compliance.
6. **Infant Feeding & Lactation Support Service** – Secure recurrent funding for equitable implementation across three Integrated Health Communities.
  - **Risks:** Lack of confirmed funding threatens the continuum of the current service, impacting on breastfeeding outcomes and health equity.

### **Overall Position**

Significant progress has been made, particularly in Women's Health Hub development, workforce initiatives, and engagement frameworks. However, delivery risks remain high due to specific workforce availability, financial constraints, IT challenges, and dependency on national plans.

### **Recommendations**

The Committee is asked to:

1. Note the national requirements and expectations set out in the Women's Health Plan, Quality Statement for Maternity and Neonatal Services, and associated frameworks.
2. Recognise the need for continued investment in workforce development, leadership and digital infrastructure to mitigate delivery risks and achieve strategic objectives.
3. Note the progress made to date against the Priorities outlined in Section 4.K of the Annual Plan.

**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>
BCUHB QSE Committee	3.7.25	Executive Summary of the Key Strategies and Policies Relating to Women's Health and Perinatal Services in Wales
Women's Service Board	28.11.25	Quarterly Progress Update provided and noted
Women's Health Local Executive Lead Programme Management Group	16.12.25	Update on delivery of the Women's Health Hub SBAR provided and noted

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

MNVP	Maternity and Neonatal Voices Partnership
HEIW	Health Education and Improvement Wales
KPI	Key Performance Indicator
MatNeoSSP	Maternity and Neonatal Safety Support Programme Discovery

# PROGRESS AGAINST THE WOMEN'S SERVICES PRIORITIES FOR 2025/26

December 2025

## 1. Introduction

Section 4.K of the BCUHB Annual Plan sets out the delivery priorities for Women's Services for 2025/26. In line with these commitments, the Quality, Safety and Experience (QSE) Committee has requested a formal update on progress against these priorities. This report provides an overview of the current position, highlights key achievements to date, identifies outstanding deliverables expected by March 2026, and any potential risks to delivery. Specifically, the Committee has sought assurance on the following priority areas:

- 4K.1 - Support the local establishment of a Women's Health Hub by March 2026 as a Ministerial Priority; dependent on the prioritisation of available resources. Principles of which will focus on preventative based women's health initiatives, accessibility to information and services with care as close to home as possible.
- 4K.4 - Support the implementation of the Preconception Strategy to include preventative based women's health initiatives.
- 4K.7 - Work in partnership with the NHS Executive to develop an implementation plan to deliver the Perinatal Engagement Framework Commitments.
- 4K.8 - Collaborate with HEIW to prioritise year 1 actions to ensure delivery of the Perinatal Workforce Plan.
- 4K.9 - Develop a Perinatal Quality Surveillance Dashboard with key standard matrix with both network and national oversight in line with policy direction.
- 4K.10 - Progress the business case to support the equitable implementation of a specialist infant feeding-lactation support service team in the 3 IHC areas - to improve breastfeeding outcomes in North Wales.

## 2. 4K.1 - Support the local establishment of a Women's Health Hub by March 2026 as a Ministerial Priority; dependent on the prioritisation of available resources. Principles of which will focus on preventative based women's health initiatives, accessibility to information and services with care as close to home as possible

<https://executive.nhs.wales/functions/networks-and-planning/womens-health/the-womens-health-plan-for-wales>

The Welsh Government launched the Women's Health Plan for Wales in December 2024. The Plan outlines the NHS Executive's approach to improving health outcomes and healthcare services for women in Wales.

The Plan will be delivered over ten years, through short (up to 2yrs), medium (3-5yrs), and long term (6-10yrs) actions. It will follow a life course approach, with a focus on delivery of services from 16 years of age - which mean that 'women's health' is broader than Gynaecology and Maternal Health related conditions. The Plan includes sixty-eight actions across eight key priority areas which underpins the 10 Year Vision for the Plan. These are;

- Menstrual Health
- Endometriosis and Adenomyosis
- Contraception, Post-Natal Contraception and Abortion Care
- Preconception Health
- Pelvic Health and Incontinence
- Menopause
- Violence against Women and Girls
- Ageing Well and Long-Term Conditions Across the Life Course (includes; Diabetes, ME/CFS, Cardiovascular Disease, Cancer, Musculoskeletal conditions, end of life care).

## 2.1 Current Position

As defined in the BCUHB Annual Plan, one of the key strategic commitments for 2025/26 is to establish a Women's Health Hub in every Health Board area by March 2026. These Hubs will provide integrated, accessible care for women across the life course, addressing key health needs in a coordinated and person-centred way.

It has been confirmed that a BCUHB Ministerial Visit will take place on 12 February 2026, at which point a fully functioning Hub is expected to be operational. Given the extremely tight timescale for delivery, a dedicated project group has been established and meets weekly to drive this strategic priority forward. The group is focused on ensuring that the Hub is ready for implementation and meets the expectations set out in the Annual Plan.

The BCUHB Women's Health Hub is being designed as an integrated, community-based model that bridges the gap between primary, community, and secondary care, alongside other services as required. The aim is to provide holistic, person-centred care across a woman's life course. The model will operate flexibly, combining fixed "hub and spoke" clinics, mobile "travelling clinician" services, and nurse-led "one-stop shop" clinics to ensure maximum accessibility across North Wales. This approach is still under development and will continue to evolve, informed by learning and experience as implementation progresses.

Our model will be shaped by ongoing engagement with local women, staff, and third-sector organisations. This engagement will help address local challenges such as long waiting times, inequitable access, and fragmented services. The Hub will focus on core areas including menstrual health, menopause, and contraception, with the potential to expand into other areas as the model matures.

We are committed to delivering care closer to home by enhancing primary and community capacity through upskilling staff, improving clinical pathways, and fostering multidisciplinary collaboration. The Hub will also seek to maximise technological opportunities, streamline data sharing, and enhance continuity of care. These developments will ensure that the Women's Health Hub delivers integrated, accessible, and high-quality services for women across North Wales.

## **2.2 Key Achievements to Date**

### **Q1 Discovery Phase:**

- Population Health Assessment - undertaken by Public Health Colleagues
- Capacity and Demand Modelling Exercise
- Stakeholder Mapping Exercise undertaken
- Local Executive Delivery Group Convened

### **Q2 Design Phase:**

- Engagement Strategy developed and engagement events commenced
- SBAR proposal developed and submitted
- Early benefits realisation work commenced

### **Q3 Design and Approval Phase:**

- Funding for the pathfinder model secured
- Accommodation for the Pathfinder Hub secured at Llandudno General Hospital
- Project delivery group convened
- Work commenced to support PREM & PROM to enable us to evaluate the model

### **Outstanding Actions for Q4:**

- Establishment of Pathfinder Hub in readiness for the Ministerial Visit
- 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

## **2.3 Potential Risk to Delivery**

Potential risks include insufficient numbers of qualified clinicians to support the proposed model and the possibility of no additional funding in the upcoming or future financial years. This also poses a reputational and clinical risk if the project begins but is halted post the end of March 2026.

To mitigate this risk, a Business Case is being developed to secure funding for the continuation and phased roll-out of the Women's Health Hub in 2026/27. This will enable the Health Board to sustain service delivery while pursuing recurrent, long-term funding solutions.



### 3. 4K.4 - Support the implementation of the Preconception Strategy to include preventative based women’s health initiatives

Within The Women’s Health Plan for Wales (2025) Preconception Health has been identified as one of eight priority areas, recognised as being crucial for ensuring healthy pregnancies and maternal wellbeing and connects with core themes such as access to quality healthcare, mental health support, and education on maternal and child health.

The preconception period is the time before a woman becomes pregnant, which can in the broadest sense commence any time from menarche. It is, however, often ‘narrowly’ thought of as the time that women and their partners self-identify that they want to become pregnant and begin to think how their health might impact on their chance to conceive, their pregnancy, and the health of their baby.

#### 3.1 Preconception Health

Describes “the health of women and men during their reproductive years, which are the years when they can have a child”

Good preconception health encompasses two main concepts:

##### 1. Planning pregnancy

Enabling women and their partners to choose if and when to start or grow their families

##### 2. Fit for pregnancy

Recognising that many pre-pregnancy health behaviours and risk factors are amenable to change. The Preconception Health actions identified within the Women’s Health Plan are as follows:

Time Frame	Action	Accountability and Partnerships
 Short	Develop high quality accessible evidence-based information on preconception care available via an NHS Wales women’s health website including “Planning for Pregnancy” toolkit.	Women’s Health Network / Welsh Government
 Short	Carry out a ‘listening exercise’ to find out what preconception means to people including health care professionals.	Women’s Health Network / EDI Champion / PHW
 Short	Provide training, tools and resources for frontline professionals to support them to deliver preconception care.	GP Practices / Primary Care Clusters / Health Boards
 Medium	Develop ‘preconception indicators’ by improving the quality and completeness of information gathered at booking in the maternity services dataset.	Health Boards / Maternity Network
 Medium	Collaborate across Networks to create a joined-up approach to managing the emerging risks for preconception health, including mental health, epilepsy, and type 2 diabetes, substance misuse, alcohol services and rare diseases.	NHS Wales Executive / Women’s Health Network
 Medium	Health Boards to ensure they have a ‘preconception strategic plan’ in place to develop a ‘preconception health policy’ to support and co-ordinate a whole system approach.	Health Boards
 Long	Develop measurable indicators of ‘preconception health’ at national and local levels.	Women’s Health Network / NHS Wales Executive
 Long	Develop a whole systems approach to preconception health, working in partnership to consider wider determinants, such as housing, education, income, work and relationships.	Welsh Government / NHS Wales Executive

### 3.2 Current Position

In 2023 BCUHB published its Preconception Strategy, aligned to a number of other key policies and adopts a life course approach to preconception care which encourages health improvement for individuals across the different stages of their lives, providing universal support for everyone and targeted support for individual needs. This strategic plan was informed by service user engagement and provides the vision to improve preconception health and care across North Wales.

The aims of this strategic plan is to:

- Increase awareness and understanding of the importance of preconception health and care
- Promote a life course approach to preconception that recognises the needs of different people at different stages of life
- Increase the opportunities for preconception support and care to be embedded into current service provision
- Promote a collective way of working among partners to ensure a whole system approach to preconception health and care between services

Despite its publication more than two years ago, an implementation plan has not yet been developed, due to significant changes within the BCUHB Public Health Team. Work has begun on updating the strategy to reflect the Women's Health Plan, with the aim of developing an implementation plan in 2026/2027.

### 3.3 Potential Risk to Delivery

Whilst an implementation plan has not been developed BCUHB has already progressed a number of the identified actions, via collaborative development of the Preconception Strategy.

However, there is a risk that there will be a lack of workforce and or financial resource to deliver an implementation plan due to the competing demands. In an attempt to mitigate these risks, the local Preconception Strategy implementation plan must strongly align to the Women's Health Plan priorities and health board improvement strategies.

## **4. 4K.7 - Work in partnership with the NHS Executive to develop an implementation plan to deliver the Perinatal Engagement Framework commitments**

The All Wales Perinatal Engagement Framework, published in 2025, sets out the minimum standards for high quality service user engagement across Wales and provides details of the 10 commitments health boards are expected to implement, the requirements to meet these commitments and defines what good looks like. This ensures an equitable, inclusive approach so all women, parents and families are engaged at every stage of their journey, to enable improvements in service provision and to inform policy. Locally a baseline assessment of the local service offer against these commitments was completed shortly following the publication of the framework and included identified actions to meet the commitments. These include the following:



- Appointment of a Paid Maternity and Neonatal Voices Partnership Chair

Progress has and continues to be made against all actions, with the exception of the appointment of a paid Maternity and Neonatal Voices Partnership (MNVP) Chair role - however, a business case has been developed but funding has not yet been identified. The role would significantly support a number of other actions within the framework, including the ability to link more closely with the community and proactively engage with women from underserved groups and those with protected characteristics. In the interim the Service is pursuing charitable funds as an option to support an immediate solution.

- Introduction of the All Wales Maternity Survey

Phases 3, 4 and 5 of the All Wales Maternity Surveys hosted by Civica, have been implemented in November 2025, with initial user feedback now being received. Work is ongoing to implement phases 1 and 2 – however, this has been delayed due to ultrasound system changes and access to software.

- Cultural Competency Training

Cultural Competency training has been completed in Community Midwifery teams, with a plan to extend the training into acute areas.

#### 4.1 Key Risks to Delivery

There have been difficulties accessing the software which will enable the linking of the Civica and ultrasound systems, which has resulted in a delay in the implementation of phases 1 and 2 of the All Wales Surveys.

The Cultural Competency training is delivered by Diverse Cymru, an external organisation, and has financial and workforce resource considerations. Whilst this has been included within the service IMTP for 2026/2027, there is a risk that the training will not be funded given the current financial position. Alternative solutions are being explored in partnership with third sector colleagues.

An All Wales implementation plan to inform the delivery of the commitments is still outstanding therefore there is a risk that locally identified actions will not align to the national plan in 2026/27.

## **5. 4K.8 - Collaborate with HEIW to prioritise year 1 actions to ensure delivery of the Perinatal Workforce Plan**

The Perinatal Workforce Plan sets out how NHS Wales will develop and grow the workforce over the next three years to deliver personalised, equitable, and safe care for women, babies, and families.

From a national perspective the plan outlines 25 actions for completion in Year 1, 11 of which have been completed nationally supported by Health Boards and the remaining 14 on track to be completed in Q4 25/26.

Local actions to reflect the HEIW plan include the following:

- Active engagement with national retention programmes.

- Recruitment planning continues across the three acute sites to address workforce gaps, while a local workforce planning group has been established and scenario-based modelling initiated to inform future requirements.
- Development of a workforce dashboard remains pending.
- Midwifery sonographers have been introduced to support capacity and demand.
- Local education and training initiatives have been introduced.
- Bereavement care pathways are now embedded across all acute sites.
- The transitional care model has been introduced across all acute Units, with further embedding and standardisation planned.
- A bespoke Leadership and culture programme has strengthened team development approach through an internal coaching programme with civility training available to for the multidisciplinary team, although post-incident support mechanisms require further embedding.

### 5.1 Risks to Delivery

Workforce gaps persist at Consultant level, which the Service have mitigated with the appointment of a Medical Workforce Lead who will actively drive recruitment and workforce planning to maintain safe and sustainable staffing levels.

## 6. 4K.9 - Develop a Perinatal Quality Surveillance Dashboard with key standard matrix with both network and national oversight in line with policy direction

As per the 7 key actions contained within the Welsh Government Quality Statement for Maternity and Neonatal Service (2025), all health boards are required to develop a perinatal quality surveillance dashboard with key standardised metrics that inform both network level and national oversight which in turn inform policy direction. This action is aligned to quality attribute 28 and MatneoSSP action 11.7. Expected completion is end of March 2026.

An example perinatal dashboard formed part of the Maternity and Neonatal Safety Support Programme Discovery Phase Draft report and in the absence of key standardised metrics being provided by Welsh Government, this has been used to direct development of a local dashboard. An early example is expected in January 2026.

It has been agreed locally that a standalone dashboard will be produced, the link to which will be hosted by the Corporate Quality Dashboard Site. Maternity Services are currently working with Quality and Digital, Data and Technology colleagues to identify the sources of each of the KPIs and to consider any additional relevant to include.

### 6.1 Key Risks to Delivery

Work is progressing to develop the dashboard within the expected timeframe, however due to competing demands there is a potential risk that the dashboard may not be operational by end of March 2026. The Women's Service will continue to drive progression to enable local and national service oversight and improvement.



## **7. 4K.10 - Progress the business case to support the equitable implementation of a specialist infant feeding-lactation support service team in the 3 IHC areas - to improve breastfeeding outcomes in North Wales**

The Welsh Government Prevention and Early Years (PEY) Grant underpins a range of work focused on prevention and early intervention, supporting Health Board services to deliver evidence-based initiatives that improve health and well-being outcomes. This year, the grant funded staff to help women initiate breastfeeding and to feel confident continuing after discharge from the postnatal wards, while also reducing inequalities through improved access to support.

Work is currently progressing on developing a business case to secure recurrent funding for the equitable implementation of a specialist infant feeding and lactation support service team across the three Integrated Health Communities (IHCs) in North Wales. This initiative is a key strategic priority aimed at improving breastfeeding outcomes and ensuring consistent, high-quality support for women and families.

The proposed model will provide continuity of specialist expertise to complement existing maternity and community services, addressing current gaps in provision and reducing variation in access. It will focus on early intervention, continuity of care, and targeted support for women with complex feeding needs, underpinned by evidence-based practice and aligned with national guidance.

### **7.1 Key Risks to Delivery**

The primary risk to delivery is the lack of confirmed recurrent funding stream to establish a substantive specialist infant feeding and lactation support service. Without this financial commitment, the Health Board will be unable to implement an equitable model across the three Integrated Health Communities (IHCs), resulting in continued variation in access to specialist support. This would negatively impact on breastfeeding initiation and continuation rates, limit early intervention for complex feeding needs, and undermine efforts to reduce health inequalities across North Wales.

## **8. Conclusion**

This report provides an update on the Women's Services' priorities as outlined in Section 4.K of the Annual Plan. Significant achievements have been made, including the ongoing development of the Women's Health Hub pathfinder model, progress on the Preconception Strategy, implementation of key actions within the Perinatal Engagement Framework, and delivery of workforce training initiatives. However, several challenges remain, particularly around workforce availability, IT interoperability, and financial constraints. The lack of confirmed recurrent funding to establish a substantive specialist infant feeding and lactation support service poses a significant risk to improving breastfeeding outcomes and to reducing health inequalities. Continued focus on engagement, co-production, and alignment with national strategies will be essential to ensure successful delivery of the key priorities by March 2026.

## 9. Recommendations

The Committee is asked to:

1. Note the national requirements and expectations set out in the Women's Health Plan, Quality Statement for Maternity and Neonatal Services, and associated frameworks.
2. Recognise the need for continued investment in workforce development, leadership and digital infrastructure to mitigate delivery risks and achieve strategic objectives.
3. Note the progress made to date against the Priorities outlined in Section 4.K of the Annual Plan.



ASESIAD / ASSESSMENT	
<b>Cyswllt â'r Blaenoriaethau Strategol</b> <b>Link to Strategic Priorities</b>	     <p>4. Improving quality, outcomes and experience</p>
	<p>Os oes mwy nag un yn berthnasol, rhestrwch hynny isod:</p> <p>If more than one applies, please list below:</p> <ul style="list-style-type: none"> <li>• Building an effective organisation</li> <li>• Developing strategy and long-lasting change</li> <li>• Establishing an effective environment for learning</li> </ul>
<b>Yr Egwyddorion Dylunio</b> <b>Design Principles</b>	<p>People First</p> <p>Os oes mwy nag un yn berthnasol, rhestrwch hynny isod:</p> <p>If more than one applies, please list below:</p> <ul style="list-style-type: none"> <li>• Inclusive Design</li> <li>• Wise Sending</li> <li>• Equity and Accessibility</li> <li>• Consistency with Organisational Values</li> </ul>
<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</a> <a href="#">Wellbeing of Future Generations Act – Wellbeing Goals</a>	<p>A Healthier Wales</p> <p>Os oes mwy nag un yn berthnasol, rhestrwch hynny isod:</p> <p>If more than one applies, please list below:</p> <ul style="list-style-type: none"> <li>• A more Equal Wales</li> <li>• A Prosperous Wales</li> <li>• A Wales of Cohesive Communities</li> <li>• A Resilient Wales</li> </ul>

ASESIADAU O EFFAITH / IMPACT ASSESSMENTS		
<b>Cydraddoldeb</b> <i>A ydych chi wedi cynnal prawf Sgrinio o'r Aseiad o'r Effaith ar Gydraddoldeb (sy'n cynnwys gofynion Safonau'r Gymraeg)</i> <b>Equality</b> <i>Have you undertaken an Equality 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:	This report is purely administrative in nature and submitted for information only. All new developments within the



Screening (which includes the requirements of the Welsh Language Standards)		Service will be subject to an EIA screening.
<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:	This report is purely administrative in nature and submitted for information only. All new developments within the Service will be subject to an Socio-Economic IA.
<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> 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:
<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>This report is purely administrative in nature and submitted for information only.</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>This report is purely administrative in nature and submitted for information only.</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>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><b>Effaith ar Adnoddau</b> <i>(Pobl / Ariannol)</i> <b>Resource Impact</b> <i>(People / Financial)</i></p>	<p>Yes (Include further detail below)</p> <p>People:</p> <ul style="list-style-type: none"> <li>• <b>Clinical Staff Shortages:</b> Limited availability of qualified clinicians to support the Women's Health Hub and perinatal services.</li> <li>• <b>Training Requirements:</b> Need for formal training programmes, consultant education, and cultural competency training.</li> <li>• <b>Dependency on External Providers:</b> Cultural competency training delivered by Diverse Cymru, requiring funding and scheduling.</li> </ul> <p>Financial:</p> <ul style="list-style-type: none"> <li>• <b>Funding Uncertainty</b></li> </ul>	



GIG  
CYMRU  
NHS  
WALES

Bwrdd Iechyd Prifysgol  
Betsi Cadwaladr  
University Health Board



## Quality Safety & Experience Committee

### CORPORATE GOVERNANCE REPORT

<b>Dyddiad y Cyfarfod</b> <b>Date of Meeting</b>	15 January 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>	Philippa Peake-Jones, Head of Corporate Governance
<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 Noting
-----------------------------------------------------	------------

<b>Crynodeb Gweithredol</b> <b>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)</b> <b>Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)</b>		
<b>Pwyllgor / Grŵp / Unigolion</b> <b>Committee / Group / Individuals</b>	<b>Dyddiad</b> <b>Date</b>	<b>Canlyniad, Tystiolaeth a Data</b> <b>Outcome, Evidence and Data</b>
Not applicable for this report		

<b>Acronymau / Rhestr Termiau</b> <b>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 6 November 2025:

- Confidential Quality Report
- Ombudsman's Annual Report
- Llais NW Monthly Report

#### 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 6 November 2025 meeting.
- **NOTE** The Committee forward workplan.

ASESIAD / ASSESSMENT	
<b>Cyswllt â'r Blaenoriaethau Strategol</b> <b>Link to Strategic Priorities</b>	     <p>1. Building an effective organisation</p>
	<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>Simplify, Standardise, and Adopt Best Practices 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>	<p>BAF24-01 Building an Effective and Accountable Organisation  CRR-16 – Leadership/Special Measures</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:	Not necessary for this report



<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:	Not necessary for this report
<b><u>Answadd</u></b> <i>A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Answadd?</i> <b><u>Quality</u></b> <i>Have you undertaken a Quality Impact Assessment Screening?</i>	<b>Galluogwyr Answadd Enablers of Quality</b> All Apply	<b>Meysydd Answadd 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	
	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:	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.	

## Joint Commissioning Committee

### Highlight Report from the Quality, Safety and Outcomes Sub-Committee

<b>Dyddiad y Cyfarfod / Date of Meeting</b>	06/10/2025
<b>Statws Cyhoeddi / Publication Status</b>	Open/ Public
	Not Applicable
<b>Awdur yr Adroddiad / Report Author</b>	Gareth Mitchell, Corporate Governance Manager, NWJCC
<b>Cyflwynydd yr Adroddiad / Report Presenter</b>	Susan Elsmore, Chair of Sub-Committee and Lay Member, NWJCC
<b>Noddwr yr Adroddiad / Report Sponsor</b>	Carole Bell, Director of Nursing and Quality, NWJCC

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

<b>Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)</b>		
<b>Committee / Group / Individuals</b>	<b>Date</b>	<b>Outcome</b>
Health Boards		Noted

## 1. SITUATION/BACKGROUND

This report had been prepared to provide NWJCC Joint Committee Members with a summary of the key issues considered by the Quality, Safety and Outcomes (QSO) Sub-Committee at its public meeting on 6 October 2025.

Key highlights from the meeting are reported in Section 2.

## 2. HIGHLIGHT REPORT

(Links to reports highlighted - [October 2025 - NHS Wales Joint Commissioning Committee](#)).

Status	Update
Alert / Escalate	
Advise	<p>Reports from each of the Directors of Commissioning were received. The following items were discussed and referred to the Joint Committee for noting.:</p> <p><a href="#">Director of Commissioning for Specialised Services</a></p> <ul style="list-style-type: none"> <li>The significant risk in relation to the Blood and Marrow Transplantation (BMT) and Chimeric Antigen Receptor T-cell Therapy (CAR-T) services delivered by Cardiff and Vale University Health Board (CVUHB); and the linked service at Swansea Bay University Health Board (SBUHB). While the service currently holds Joint Accreditation Committee of the European BMT Society (JACIE) accreditation, existing facilities do not meet the standards required. A JACIE inspection had taken place, and the final report was awaited.</li> <li>Significant risks reported across the Specialist Services portfolio including plastic surgery outreach clinics and PET-CT for prostate cancer.</li> <li>An overview of progress within the Phase 2 review of Cardiac Commissioning. This included confirmation that a demand and capacity review for the programme had commenced and that an inaugural Project Delivery Board was scheduled during October to oversee this work.</li> <li>Escalation Trajectories for specialist services in escalation are attached as <b>Appendix 1</b> for information.</li> </ul> <p><a href="#">Director of Commissioning for Ambulance Services/111 Report</a></p> <ul style="list-style-type: none"> <li>The implementation of phase two of the ambulance response model was discussed. This included confirmation that traditional Amber and Green Categories would be replaced with Orange (time-sensitive), Yellow (assess-and-respond), and Blue (non-emergency transport) to better reflect clinical need. Enhanced clinical screening would also ensure that patients with conditions like stroke or ST-Segment Elevation Myocardial Infarction received timely and appropriate care, while the Red category continued to target life-threatening emergencies. This phase aimed to improve resource use, reduce unnecessary hospital conveyance, and deliver better clinical outcomes. Plans were in place to deliver a 'go live' date in early December 2025.</li> <li>Non-Emergency Patient Transport Service (NEPTS) is facing increased demand pressure. This was contributing to</li> </ul>

Status	Update
	<p>increased travel distances, rising provider costs, and inefficiencies at the interface between Health Boards and the ambulance service. Assurance and working groups had been set up to co-ordinate and drive improvements in this area.</p> <ul style="list-style-type: none"> <li>• An update was given in relating to the EMRTS Judicial Review claim. It was acknowledged that an application had been made by the claimant to the Court of Appeal to determine whether the appeal had sufficient grounds to proceed.</li> <li>• The 111 service remained challenging. Further work had been undertaken on call handling capacity, and a 111 Re-roster Project Board had been established to support this. Clinical call-back performance, however, was reported to have improved.</li> </ul> <p>Members discussed capacity issues within the NEPTS service and the ongoing work to develop a dashboard to identify performance issues including to track the number of bookings/cancelations in real time with a need for updates to be shared at a future meeting on this important piece of work.</p> <p><a href="#">Director of Commissioning for MHLDVG Report</a></p> <ul style="list-style-type: none"> <li>• A recent visit to Rampton High Secure Hospital had identified significant improvements in patient care.</li> <li>• Significant issues have been identified following a review of the Caswell Clinic would require immediate action and close monitoring thereafter. A meeting had taken place with the SBUHB Executive Team to escalate identified concerns. An official report and action plan had been commissioned and would be shared with SBUHB for action as a matter of urgency. Any impact on escalation levels at the Caswell Clinic would be reported at the next Committee meeting.</li> <li>• Urgent repairs required at the Uned Gobaith Perinatal Inpatient Mental Health Unit at Tonna Hospital. Committee members noted that plans were being formulated to secure alternative capacity for patients given the necessity of a temporary 6-week closure of the unit to complete the required maintenance work.</li> </ul> <p>The <a href="#">Incident and Concerns Report</a> highlighted 7 new incidents reported for the period spanning July-August and 6 new complaints, four had been closed and two remain open.</p>
<b>Assure</b>	<p>The <a href="#">JCC Risk Register - QSO risks</a> were received. The Committee received an update about the risks allocated to it from the NWJCC Operational Risk Register (ORR) as at the 31 August 2025. Members <b>noted:</b></p>

Status	Update
	<ul style="list-style-type: none"> <li>• Twenty risks (scoring 15/25 or over) were recorded within the ORR, eleven of which were assigned to the Committee for assurance and review.</li> <li>• Two new risks were added to the ORR since the previous update, two risks had been de-escalated, and one risk had been closed.</li> </ul> <p>The <a href="#">Regulator Report (Healthcare Inspectorate Wales (HIW) / Care Quality Commission (CQC)</a> was received. An update on regulatory activity was provided. Members noted updates from HIW and the CQC and acknowledged ongoing collaboration with HIW to improve reporting and assurance processes.</p> <p>Members highlighted the need for future reports to provide greater specificity in relation to areas of concern raised by regulators.</p>
<p><b>Inform</b></p>	<p><b>Patient Story – Cystic Fibrosis (CF)</b></p> <p>A CF patient shared her story and personal experiences of the care received from NHS Wales, illustrating the benefits of shared decision-making and patient engagement. The story included a trial drug that had dramatically changed the patient’s quality of life to the extent that she had successfully completed a cross-Atlantic rowing challenge, the first person with CF ever to do so.</p> <p><a href="#">All Wales Individual Patient Funding (IPFR) Report</a></p> <p>The IPFR report would be a standing item at all future QSO meetings. It was agreed that outcome data would be added into the report, going forward. Financial elements of IPFR would continue to be reported to the Planning, Performance and Finance Sub-Committee as part of the NWJCC Finance Report.</p> <p><a href="#">NWJCC Policy Group Report</a></p> <p>As per the NWJCC governance arrangements, the NWJCC Policy Group Report was received and noted at the meeting (this was a 6-monthly scheduled report).</p> <p><a href="#">Welsh Kidney Network (WKN) Report</a></p> <p>Despite a recent change in governance arrangements (and the Network becoming a part of the NWJCC Specialised Services Directorate), the WKN Report would still be presented as a separate agenda item at the QSO meeting to fully capture work undertaken across the Network. The report was noted at the meeting and members discussed the use of outcome data for service planning, the national system used to track patient journeys and transplant decisions and the effectiveness of kidney</p>

Status	Update
	transplants in terms of survival rates as well as wider economic benefits.
<b>Appendices</b>	None.

### 3. ASSESSMENT

Objectives / Strategy	
<b>Dolen i Amcan (au) Strategol CBC</b> <b>Link to JCC Strategic Objectives(s)</b>	Maximise Value
	Ensure Quality; Reduce Duplication; Improve Equity & Population Health; Facilitate Integration
<b>Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals</b> <a href="https://www.futuregenerations.wales/150623-guide-to-the-fg-act-en.pdf">150623-guide-to-the-fg-act-en.pdf</a> <a href="https://www.futuregenerations.wales/">(futuregenerations.wales)</a>	A Resilient Wales
	A Healthier Wales
<b>Dolen i Hwyluswyr Ansawdd</b> (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / <b>Link to Enablers of Quality</b> <a href="https://www.gov.wales/guidance/duty-of-quality-statutory-guidance">(<a href="https://www.gov.wales/guidance/duty-of-quality-statutory-guidance">Duty of Quality Statutory Guidance</a> (gov.wales))</a>	Leadership
	Culture and Valuing People; Learning, Improvement and Research; Whole-systems Perspective
<b>Dolen i Feysydd Ansawdd</b> (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / <b>Link to Domains of Quality</b> <a href="https://www.gov.wales/guidance/duty-of-quality-statutory-guidance">(<a href="https://www.gov.wales/guidance/duty-of-quality-statutory-guidance">Duty of Quality Statutory Guidance</a> (gov.wales))</a>	Effective
	Efficient; Equitable; Person-centred; Timely; Safe
<b>Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)</b>	No - Not Applicable

Impact Assessment		
<b>Ansawdd</b> <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /</i> <b>Quality</b>	Yes: <input type="checkbox"/>	No: <input checked="" type="checkbox"/>
	Outcome:	If no, please include rationale below: This is a summary of the

<i>Have you undertaken a Quality Impact Assessment Screening?</i>		latest meeting of the JCC
<b>Cydraddoldeb</b> <i>Ydych chi wedi ymgymryd â Sgrinio Aseiad o'r Effaith ar Gydraddoldeb? /</i>	Yes: <input checked="" type="checkbox"/>	No: <input checked="" type="checkbox"/>
<b>Equality</b> <i>Have you undertaken an Equality Impact Assessment Screening?</i>	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE	If no, please include rationale below: This is a summary of the latest meeting of the JCC
	Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE	
<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 Joint Committee as a result of the activity outlined in this report.	
<b>Effaith Adnoddau</b> <i>(Pobl / Ariannol) /</i>	Yes (Include further detail below)	
<b>Resource Impact</b> <i>(People / Financial)</i>	The performance of the services will be used to develop the IMTP and identify the areas where resources may be required.	

#### 4. RECOMMENDATIONS

The Health Board is asked to:

- **Note** the highlights outlined in Section 3 of this report.

Executive Director Lead: Melanie Wilkey  
 Commissioning Lead: Amy Lewis  
 Commissioning Team: Women and Children

Service in Escalation:  
 Neonatal Intensive Care Unit

Current Level 3 Escalation

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↔ September 2025
↔	Escalation remains the same	
↑	Escalation level escalated	

Date of Escalation Meetings: 10/10/23, 19/12/23, 16/05/24, 25/11/24, 15/01/25, 18/03/25, 20/05/25, 01/07/25

Date Last Reviewed by Quality & Patient Safety Committee: 04/08/25

Escalation Trajectory:



Escalation History:

Date	Escalation Level
September 2023	3

Rationale for Escalation Status:

High levels of cot closures reported across all three levels of care, blood stream infection rates and progress implementing the new cot configuration.

Background Information:

There are currently two risks on the CRAF relating to Neonatal services at Cardiff and Vale UHB, lack of cot availability due to workforce and the service being a negative outlier status for blood stream infections, on the National Neonatal Audit Programme (NNAP). Limited progress has also been made against implementing the workforce required to support the cot configuration.

NWJCC assurance and confidence level in developments:

Low / Medium – First draft of an action plan has been received however further detail has been requested. The mitigations required to support safe staffing levels and improvements against infection rates requires a robust workforce plan which has a medium to long term lead time for completion. Escalation status being discussed at executive level within the JCC.

The Paediatric and Neonatal Escalation Reset Meeting is to take place on the 18th of September where an overview of the service will be discussed to gain an understanding from the health boards perspective of where they feel they are in the process, rather than discussing actions and objectives. The overarching objectives for the service are in the development phase and when agreed within the commissioning team they will be shared with the health board for comments and then presented at the reset meeting, to ensure they are agreed

Actions:

Action	NWJCC Lead	Action Due Date	Completion Date
Working with C&V UHB executive team to develop a plan to implement new baseline as all other HBs are in a position to go live	Director of Planning	16 <sup>th</sup> August 2024	See comment in development section
Re-set meeting to discuss and agree actions/objectives in collaboration with the health board	Senior Planning Manager	18 <sup>th</sup> September 2024	18 <sup>th</sup> September 2024
Escalation meeting to discuss detail and progress against action plan (every 6 weeks)	Head of Commissioning	-	4 <sup>th</sup> November 2025

collaboratively. New executive leads for both organisations will be agreed as part of this process to ensure all are in agreement.

Actions/Objectives agreed on the 18<sup>th</sup> of September in collaboration with the health board. Monthly escalation meetings to re-commence on the 25<sup>th</sup> of November to monitor progress.

Working with C&V UHB executive team to develop a plan to implement new baseline as all other HBs are in a position to go live – Phase 1 implementation paper to be taken to management group on 28<sup>th</sup> November to recommend a way forward to progress with the implementation of the new baseline.

15<sup>th</sup> January escalation meeting. Health board presented their progress against the agreed actions/objectives. Progress acknowledged. JCC to assess progress report against the objectives. Decision made service to remain at escalation level 3 as more data required ensuring that the improved position is sustained prior to considering de-escalation.

Conversations ongoing regarding implementing phase 1, both internally in the JCC and with the health board. If phase 1 is not implemented as previously agreed by Joint Committee, then there will need to be appropriate communication to all the health boards to advise. The commencing of Phase 2 has been delayed due to the OCP process.

18<sup>th</sup> March escalation meeting. Health Board presented their progress against the agreed actions/objectives. Progress acknowledged. JCC to assess progress report against the objectives. The escalation level was discussed in the W&C commissioning team meeting on 19<sup>th</sup> March. The team agreed that the service should remain at escalation level 3.

20<sup>th</sup> May escalation meeting. Health Board presented their progress against the agreed actions/objectives. Progress acknowledged. JCC to assess progress report against the objectives. Executive Director lead agreed to progress finance conversations around funding. The escalation level was discussed in the W&C commissioning team meeting on 21<sup>st</sup> May. The team agreed that the service should remain at escalation level 3.

The delay in implementation by the Health Board of the Phase 1 revised cot configuration and agreement on next steps is currently with the Senior Leadership Team. A paper to provide an update to Joint Committee on Phase 1 implementation is in development. Phase 2 under discussion due to delays with the implementation of Phase 1.

1<sup>st</sup> July escalation meeting held. Health Board presented their progress against the agreed actions/objectives. Progress acknowledged. JCC to assess progress report against the objectives. Executive Director lead agreed to progress finance conversations around funding, as meeting not yet taken place. The escalation level was discussed during the meeting and there was agreement that the service should remain at escalation level 3.

The delay in implementation by the Health Board of the Phase 1 revised cot configuration and agreement on next steps is currently with the Senior Leadership Team. A paper to provide an update to Joint Committee on Phase 1 implementation has been written and is with the Director of Commissioning for Specialised Services. Phase 2 under discussion due to delays with the implementation of Phase 1.

2<sup>nd</sup> September update – The escalation meeting scheduled for the 23<sup>rd</sup> of September has been stood down. This is for the JCC to work through the funding matters internally. An internal workshop to discuss Phase 1 progression and the funding matters has been arranged for the 22<sup>nd</sup> of October 2025. The next scheduled escalation meeting is the 4<sup>th</sup> of November. The service remains at escalation level 3.

**Issues/Risks:**

March 24 - The service have not submitted an action plan despite being in escalation since Sept 23, they are unable to increase their cot numbers based on the new cot configuration and reported that they cannot safely deliver on the cots that they are currently commissioned, no progress made with exec to exec meeting, possibility that outsourcing from the service may be required, the service remains at escalation level 3 but if there are no improvements increasing the escalation will be considered.

May 24 - Through quarterly assurance meetings with all neonatal units in the South & West of Wales it has been reported that there has been increased pressure across the network for cot availability

July 24 – Temporary closure of Princess of Wales (PoW) Maternity and Neonatal unit for essential maintenance work from September to December. JCC currently commission 4 High Dependency (HD) cots within the PoW and Prince Charles Hospital (PCH) sites within CTMUHB. PCH are able to flex their cot base from 15 cots to 19 to provide HD capacity and Special Care based on clinical need. Consultation and communication with all stakeholders is underway alongside Maternity users who this will impact upon. Swansea Bay University Health Board and Cardiff and Vale have been asked to support the delivery of maternity care based on demand and demographics of the planned maternity users. Work is currently underway within CMTUHB to gain the appropriate data and demographics of the women currently booked to birth during this period. The Welsh Ambulance Service and the Neonatal network are working with CMTUHB to ensure safe delivery and appropriate preparation of pathways to enable safe transfer and clear guidance for the maternity users and clinical teams. Ongoing weekly project meetings have been put in place, NWJCC have been invited to attend these. Updates from these will be shared within the NWJCC to understand the impact this will have on current commissioned cots. An early warning notification has gone to Welsh Government.

Executive Director Lead: Melanie Wilkey  
 Commissioning Lead: Emma King  
 Commissioning Team: Cardiac

Service in Escalation:  
 Bariatrics

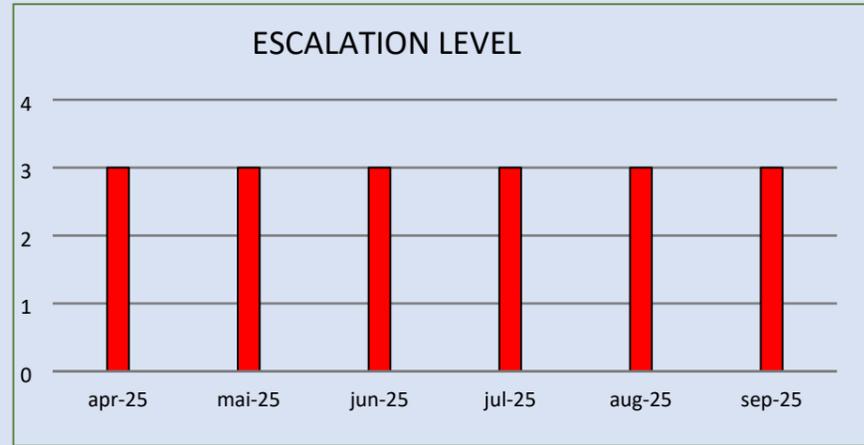
**Escalation Trend Level**

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↔ September 2025
↔	Escalation remains the same	
↑	Escalation level escalated	

Date of Escalation Meetings:  
 Date Last Reviewed by Quality & Patient Safety Committee: 04/08/25

<b>Current Level 3</b>	<b>Escalation</b>
------------------------	-------------------

**Escalation Trajectory:**



**Escalation History:**

Date	Escalation Level
April 2025	3

**Rationale for Escalation Status :**

Update April 2025 – The process for the escalation of the Salford obesity surgery service to Level 3 of the NWJCC Escalation Framework was initiated in December 2024 and endorsed by the NWJCC Senior Leadership Team in January 2025. The service has been subject to formal escalation arrangements due to our long-standing concerns with the obesity surgery waiting list and activity levels.

**Background Information:**

The process for the escalation of the Salford obesity surgery service to Level 3 of the NWJCC Escalation Framework was initiated in December 2024 and endorsed by the NWJCC Senior Leadership Team in January 2025.

**NWJCC assurance and confidence level in developments:**

Low - A letter was sent to Salford in February informing them of the escalation and process (no response has yet been received). A chasing communication was sent by the Director of Commissioning for Specialised Services in April 2025. An escalation meeting will be arranged with the Salford service as soon as a response has been received from Salford.

**September 2025 Update – Correspondence was received from Salford on 25<sup>th</sup> September 2025 to serve notice of 6 months on the contract for bariatric services. Work will progress to look at alternative commissioning options and ensuring patients currently on the waiting list are not adversely affected by this change.**

**Actions:**

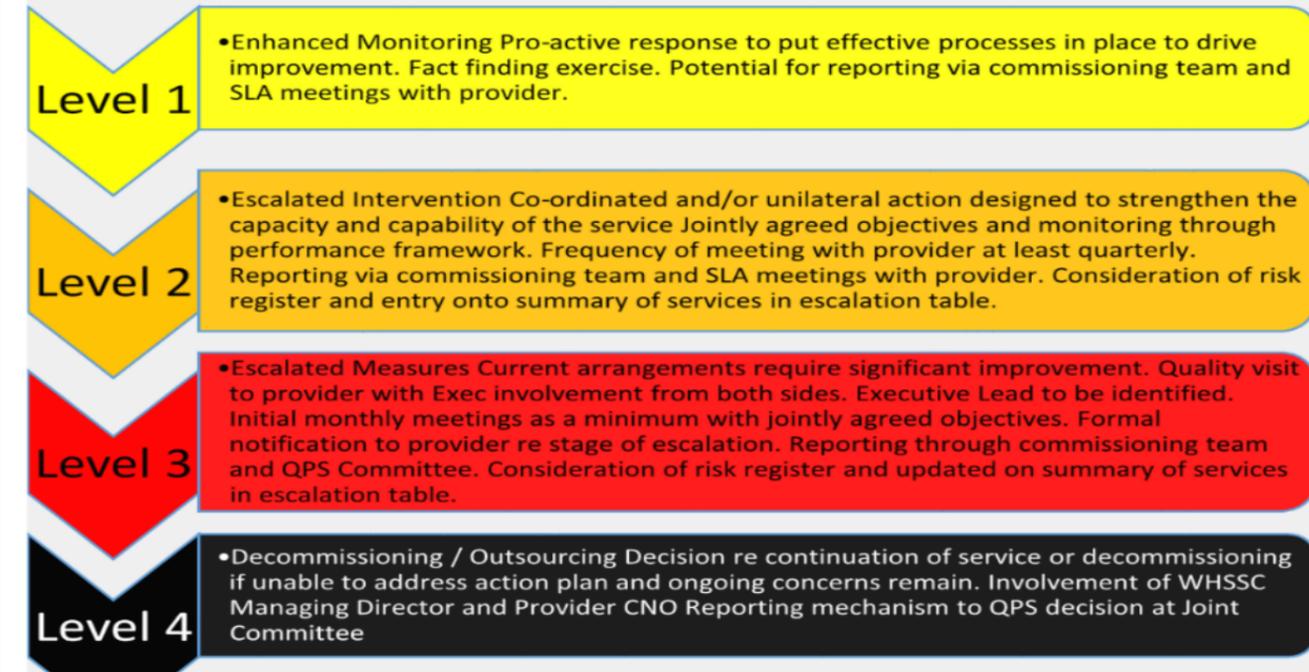
Action	NWJCC Lead	Action Due Date	Completion Date
Escalation endorsed by SLT	Director of Commissioning	Jan 25	Jan 25
Escalation letter sent to Salford	Director of Commissioning	Feb 25	Feb 25
Follow up email sent to Salford	Director of Commissioning	April 25	April 25
Head of Commissioning for Cardiac has contacted the Commissioning Lead for Obesity Services (Greater Manchester ICB) in NHSE	Head of Commissioning	July 25	July 25
SBUHB to provide service for 15 patients from this catchment area	Head of Commissioning	March 26	March 26
A follow up letter has been sent to Salford requesting an urgent response to the escalation letter	Director of	September 25	September 25

		Commis sioning		
--	--	-------------------	--	--

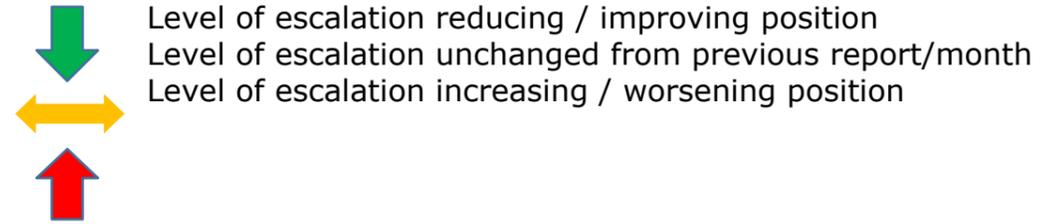
**Issues/Risks:**  
September 25 – Notice served by Salford requires alternative provision to be sought before 1<sup>st</sup> April 2026.

<b>Level 1 ENHANCED MONITORING</b>	<p>Any quality or performance concern will be reviewed by the Commissioning Team. Enhanced monitoring is a pro-active response to put effective processes in place to drive improvement. It is an initial fact finding exercise which should ideally be led by the provider and closely monitored and reviewed by the commissioning team. The enquiry will lead to one of the following possible outcomes:</p> <ul style="list-style-type: none"> <li>• No further action is required routine monitoring will continue. The concern which raised the indication for inquiry will be logged and referred to during the routine monitoring process to ensure this has not developed any further.</li> <li>• Continued intervention is required at level 1 and a review date agreed.</li> <li>• Escalation to Level 2 if further intervention is required</li> </ul> <p>There is the potential for reporting via commissioning team report to Quality Patient Safety Committee and through SLA meetings with provider</p>
<b>Level 2 ESCALATED INTERVENTION</b>	<p>Escalated intervention will be initiated if Level I Enhanced Monitoring identifies the need for further investigation/intervention. There should be a Co-ordinated and/or unilateral action designed to strengthen the capacity and capability of the service. At this stage there should be jointly agreed objectives between the provider and commissioner and monitored through the relevant commissioning team. Frequency of meeting with provider should be at least quarterly and possible interventions will include</p> <ul style="list-style-type: none"> <li>• Provider performance meetings</li> <li>• Triangulation of data with other quality indicators</li> <li>• Advice from external advisors</li> <li>• Monitoring of any action plans</li> </ul> <p>A risk assessment should be undertaken and logged on the Commissioning Team Risk Register. Where appropriate the risk will be included on the JCC Risk Management Framework. Reporting is via commissioning team report to Quality Patient Safety Committee report and SLA meetings with provider. The investigation will lead to on to the following possible outcomes:</p> <ul style="list-style-type: none"> <li>• Action plan and monitoring are completed within the allocated timeframe, evidence of progress and assurance the concern has been addressed. De-escalation to Level 1 for ongoing monitoring.</li> <li>• If the action plan is not adhered to and further concerns are raised by the Commissioning team or by the provider team or further concerns are identified it may be necessary to move to Level 3 Escalated Measures</li> </ul>

<p><b>Level 3 ESCALATED MEASURES</b></p>	<p>Where there is evidence that the Action Plan developed following Level 2 has failed to meet the required outcomes or a serious concern is identified a service will be placed in escalated Level 3. At this stage the quality of the service requires significant action/improvement and will require Executive input. In addition to routine reporting through QPS a formal paper will be considered by the JCC Corporate Directors Group (CDG) and an Executive Lead nominated. Formal notification will be sent to the provider re the Level of escalation and a request made for an Executive lead from the provider to be identified. An initial meeting will be set up as soon as possible dependant on the severity of the concern. Meetings should take place at least monthly thereafter or more frequently if determined necessary with jointly agreed objectives.</p> <p>Provider representation will depend on the nature of the issue, but the meetings should ideally comprise of the following personnel as a minimum:</p> <ul style="list-style-type: none"> <li>• Chair (JCC Executive Lead)</li> <li>• Associate Medical Director - Commissioning Team</li> <li>• Senior Planning Lead – Commissioning Team</li> <li>• JCC Head of Quality</li> <li>• Executive Lead from provider Health Board/Trust</li> <li>• Clinical representative from provider Health Board/Trust</li> <li>• Management representative from provider Health Board/Trust</li> </ul> <p>An agreed agenda should be shared prior to the meeting with a request for evidence as necessary.</p> <p>At the conclusion of the meeting a clear timeline for agreed actions will be identified for future monitoring and confirmed in writing if appropriate. Reporting will be through commissioning team to QPS Committee. Consideration of entry on the risk register and summary of services in escalation table for Chairs report to Joint Committee. Consideration to involve and have a discussion with Welsh Government may be considered appropriate at this stage. If there is ongoing concern relating patient care and safety with no clear progress, then further escalation will be required to Level 4. On the other hand, if progress is made through the escalation Level 3 evidence of this should be presented to CDG/QPS and a formal decision made with the provider to de-escalate to Level 2.</p>
<p><b>Level 4 DECOMMISSIONING/OUTSOURCING</b></p>	<p>4 Where services have been unable to meet specific targets or demonstrate evidence of improvement a number of actions need to be considered at this stage. This stage will require notification and involvement of the JCC Managing Director and CEO from the provider organisation. Both Quality Patient Safety Committee and Joint Committee should be cited on the level of escalation.</p> <p>The following areas will need to be considered, and the most appropriate sanction applied to help resolve the issue:</p> <ol style="list-style-type: none"> <li>1. De-commissioning of the service</li> <li>2. Outsourcing from an alternative provider. This may be permanent or temporary</li> <li>3. Contractual realignment to take into account the potential need to maintain and agree an alternative provider.</li> </ol> <p>Involvement with Welsh Government and the Community Health Council is critical at this stage as often there are political drivers and levers that need to be considered and articulated as part of the decision making. Moving in and out of escalation and between Levels In addition to the Levels described above the process has introduced a traffic light guide within each level. The purpose of this is to help demonstrate the direction of travel within the level. It sets out an approach to help identify progress within the level and lays out the steps required for movement either upwards (escalation) or downwards (de-escalation) through the level. At every stage a red, amber or green colour will be applied to the level to illustrate whether more or less intervention is in place. Red being a higher level of intervention moving down to green. It will also help determine the easing of the escalated measures described and inform movement within the stages of escalation. As the evidence and understanding of the risks from a provider and commissioner become evident decisions can be made to reduce the level of intervention or there may be a need to reintroduce intervention should conditions worsen and trigger the re-introduction of measures if progress is unacceptable. In this way organisations will be able to understand what is being asked of them, progress will be easily identified, and it will help avoid any confusion. It will also help in the reporting to provide assurance that action is being taken to meet the agreed timescales.</p>



**SERVICES IN ESCALATION**



### Quality Safety and Experience Committee – Non-Routine Committee Business Forward Plan

(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
06.01.26	Verbal Request	Executive Medical Director	Medical Education	Update - deferred from January 26 meeting	Executive Medical Director	Executive Medical Director	Mar 2026	To be deferred to March agenda.
30.12.25	Email Request	Head of Corporate Governance	DECLO-ALNET Act annual report	Annual Report update	DECLO	Executive Director of Allied Health Professions & Health Science	Mar 2026	To be added to 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
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 progress on recommendations from the May 23 report.	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
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	Adult Mental Health & Learning Disabilities	Item came from COB	Executive Director of Allied Health	Executive Director of Allied Health	To be advised	

		Professions & Health Science	<ul style="list-style-type: none"> <li>Mental health crisis</li> <li>Perinatal and Eating Disorder Service</li> </ul>		Professions & Health Science	Professions & Health Science		
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	To be advised	Consider for March 26 meeting.
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

### In figures

No. engagement activities	No. representations	No. service changes	No. open advocacy cases	No. people engaged with
18	7	1	272	312

### Key Themes:

#### Engagement

- Access to GP appointments
- Concerns re Urology Services
- Concerns about communication with hospital Consultants.
- Neurodiversity Assessment Waiting Times Survey
- Same Day Emergency Care Survey
- Positive experiences heard about Ysbyty Penrhos Stanley, Llangefni District Nurses and Alaw Ward Ysbyty Gwynedd.
- Difficulties getting services commissioned for gender reassignment treatment.

#### Complaints Advocacy

- Complaints Advocacy
- Delays in diagnosis / treatment
- Neurodevelopmental Assessments
- ED waiting times.
- GP communication / access
- ENT Services



#### Representing Llais

- Denbighshire Social Services
- North Wales Gender Identity Stakeholder Meeting
- Strategic Development Event BCUHB in partnership with Bevan Commission
- Wrexham Social Services
- Tywyn Hospital Balanced Room 2
- BCUHB Patient and Carer Experience Group
- Flintshire Social Services
- Penley Balanced Room 2
- Conwy Social Services

#### Representation

- Request for update on establishment of Women's Health Hubs.
- Request for information on level 3 Weight Management Activity.
- Neurodiversity Assessment Waiting Lists
- How BCUHB are meeting the new 45 minute handover target set out for Ambulances.
- Vaccination arrangements at Chirk Medical Practice.
- St David's Hospice Holyhead proposed closure.

If you would like further information about any of the above please contact us on [northwalesyourvoice@llaiscymru.org](mailto:northwalesyourvoice@llaiscymru.org)

### Mewn ffigyrau

<u>Nifer y gweithgareddau ymgysylltu</u>	<u>Nifer y cynrychioliadau</u>	<u>Nifer y newidiadau gwasanaeth</u>	<u>Nifer yr achosion eiriolaeth</u>	<u>Nifer y bobl yr ymgysylltwyd a hwy</u>
18	7	1	272	312

## Themâu allweddol:

### Ymgysylltu:

- Mynediad at apwyntiadau Meddyg Teulu
- Pryderon ynghylch Gwasanaethau Wroleg
- Pryderon ynghylch cyfathrebu gyda Ymgynghorwyr mewn ysbyty.
- Arolwg Amseroedd Aros Aseu Niwroamrywiaeth
- Arolwg Gofal Brys ar yr Un Diwrnod
- Profiadau cadarnhaol a glywyd am Ysbyty Penrhos Stanley, Nyrsys Ardal Llangefni a Ward Alaw Ysbyty Gwynedd.
- Anawsterau wrth gomisiynu gwasanaethau ar gyfer triniaeth ailbennu rhywedd.

### Eiriolaeth Cwynion

- Oedi wrth wneud diagnosis / triniaeth
- Aseuadau Niwroamrywiaeth
- Amseroedd aros Adran Achosion Brys.
- Cyfathrebu / mynediad at feddygon teulu
- Gwasanaethau ENT



### Yn cynrychioli Llais:

- Gwasanaethau Cymdeithasol Sir Ddinbych
- Cyfarfod Rhanddeiliaid Hunaniaeth Rhywedd Gogledd Cymru
- Digwyddiad Datblygu Strategol BIPBC mewn partneriaeth â Chomisiwn Bevan
- Gwasanaethau Cymdeithasol Wreccsam
- Ysbyty Tywyn Ystafell Gytbwys 2
- Grŵp Profiad Cleifion a Gofalwyr BIPBC
- Gwasanaethau Cymdeithasol Sir y Fflint
- Ystafell Gytbwys 2 Penley
- Gwasanaethau Cymdeithasol Conwy

### Cynrychiolaeth:

- Cais am y wybodaeth ddiweddaraf ar sefydlu Canolfannau Iechyd Menywod.
- Cais am wybodaeth ar Weithgaredd Rheoli Pwysau Iefel 3.
- Rhestrau Aros Aseu Niwroamrywiaeth
- Sut mae BIPBC yn cyrraedd y targed trosglwyddo 45 munud newydd a osodwyd ar gyfer Ambiwlans.
- Trefniadau brechu ym Meddygfa'r Waun.
- Hosbis Dewi Sant Caergybi.

Os hoffech ragor o wybodaeth am unrhyw un o'r uchod, cysylltwch â ni ar [northwalesyourvoice@llaiscymru.org](mailto:northwalesyourvoice@llaiscymru.org)



## Quality Safety & Experience Committee

### CHAIR'S REPORT FROM EXECUTIVE QUALITY DELIVERY GROUP

<b>Dyddiad y Cyfarfod</b> <b>Date of Meeting</b>	15 January 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>	Angela Wood, Executive Director of Nursing and Midwifery
<b>Enw a theitl Aelod Arweiniol o'r Tîm 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</li><li>• Dr Clara Day, Executive Medical Director</li><li>• Teresa Owen, Executive Director of AHPs and Healthcare Science</li></ul>
<b>Pwrpas yr Adroddiad</b> <b>Report Purpose</b>	For Noting

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

This paper provides an update and outline of key items discussed, noted and escalated at the November Executive Quality Delivery Group meeting held on 10<sup>th</sup> November 2025.

IHC and Division reports were received along with a number of Chair's reports from identified Patient Safety and Quality groups reporting into the Executive Quality Delivery Group.

Details of risk registers were included in IHC/Divisional Reports with assurance received that these are being reviewed and managed.

Learning from incidents and actions in place to mitigate future occurrences were shared and noted.

Three clinical guidelines were considered and approved.



QSE Committee are asked to note the report.

**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 Quality Delivery Group	10-11-25	Meeting held, minutes taken and circulated along with identified actions.

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

EQDG	Executive Quality Delivery Group
IHC	Integrated Health Community

## CHAIR'S REPORT FROM EXECUTIVE QUALITY DELIVERY GROUP

### 1. SITUATION

- 1.1 The EQDG is the clinical executive led quality group in the Health Board through which all other quality-related groups report.

### 2 BACKGROUND

- 3 IHC and Division reports were received along with a number of Chair's reports from a number of Patient Safety and Quality groups reporting into the Executive Quality Delivery Group.

- 3.1 A summary of which can be seen below.

### 4 SPECIFIC MATTERS FOR CONSIDERATION

#### 4.1 Central IHC

Two longstanding gastroenterology risks, originating in 2018 and 2019, remain outstanding. In addition, a new risk has been identified within the Emergency Department concerning the absence of out-of-hours gastrointestinal treatment. Critical staffing challenges within Pharmacy Production and the Cancer Pharmacy teams were also highlighted and are being actively monitored.

#### 4.2 East IHC

High-risk areas include gastroenterology and IBD services, primarily due to staffing constraints, alongside infection prevention concerns arising from a prolonged *Clostridioides difficile* outbreak. Capacity pressures and the inappropriate use of Mental Health rooms within the Emergency Department were also noted. Further meetings and discussions have been convened to maintain robust executive oversight and ensure appropriate mitigation measures are in place.

#### 4.3 MHLD

Ligature risks remain a key priority following receipt of an HSE Notice of Contravention. Mitigation actions include equipment upgrades and capital planning, which are being overseen by the Ligature Board. Areas for improvement were identified in safeguarding compliance and infection prevention audits, with progress updates scheduled for reporting at the next EQDG meeting.

#### 4.4 West IHC

Significant work has been undertaken to address the top risks, and progress

has been achieved. The West area continues to maintain a stable position in relation to Quality indicators, with no escalations reported.

#### 4.5 **Diagnostics & Clinical Support**

Key risks continue to centre on digital systems, estates, and diagnostic capacity. While the radiology risk system is fully operational, significant issues persist within pathology systems. Mortuary capacity has reached 285 spaces, and this is being closely monitored to ensure continuity of service.

#### 4.6 **Midwifery and Womens**

The internal leadership programme for Midwives has been completed, with results and analysis to follow next month. The Perinatal Mental Health Midwives have been shortlisted for a Royal College of Midwives award, highlighting strong performance in this area. National smoking rates remain high, and work continues with *Help Me Quit* and through stillbirth reviews, while birth weight and mental health reporting are being closely monitored via audits and collaboration with Perinatal Mental Health teams. Compliance with concerns reporting has temporarily fallen to 75% due to capacity pressures, though improvement actions are underway. Clinical effectiveness data shows caesarean section rates have risen to 48.5%, likely linked to elective requests, with ongoing focus on informed decision-making. Staff engagement for the national perinatal assurance assessment has been successfully completed, and preparations for the forthcoming *15 Steps* review are progressing well.

#### 4.7 **Sharing of Learning**

##### **Emergency Department Incident Data**

A presentation was delivered outlining a significant increase in violence and aggression incidents at YWM, with 147 cases reported, alongside smaller rises at YGC and YG. Contributory factors include mental health challenges, alcohol consumption, and extended waiting times. A body-worn camera pilot is currently in progress at YWM. Further analysis has been incorporated into the Urgent and Emergency Care programme.

### 5 **KEY RISKS / MATTERS FOR ESCALATION**

5.1 There were no key risks or matters for escalation.

### 6 **RECOMMENDATIONS**

6.1 The Executive Committee is asked to:

- **NOTE** the report



ASESIAD / ASSESSMENT	
<b>Cyswilt â'r Blaenoriaethau Strategol</b> <b>Link to Strategic Priorities</b>	     <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>5. Establishing and effective environment for learning</p>
<b>Yr Egwyddorion Dylunio</b> <b>Design Principles</b>	<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>
<b>Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd</b> <b>Corporate Risks and Board Assurance Framework</b>	<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)</p> <p>Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR)</p> <p>BAF-SP18 and CRR-24-04 – Quality, Innovation and Improvement</p>
<a href="#">Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant</a> <a href="#">Wellbeing of Future Generations Act – Wellbeing Goals</a>	<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		
<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>Do/Yes: <input type="checkbox"/></p>	<p>Naddo/No: <input type="checkbox"/></p>
	<p>Canlyniad/Outcome:</p>	
	<p>Os naddo, dylech gynnwys y rheswm: If no, please include rationale:</p>	<p>N/A</p> <p>EQIAs were undertaken and submitted with the written control documents for consideration of the EQDG.</p>



<i>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:	N/A Integrated Assessment Screening Tool documentation was completed and submitted with the written control documents for consideration of the EQDG.
<u><a href="#">Ansawdd</a></u> <i>A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?</i> <u><a href="#">Quality</a></u> <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:
<u><a href="#">Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant Wellbeing of Future Generations Act – Wellbeing Goals</a></u>	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><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><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><b>Cyfreithiol Legal</b></p>	<p>Yes (Include further detail below)</p>	
	<p>The Duty of Quality is a statutory requirement under the Health and Social Care (Quality and Engagement) (Wales) Act 2020.</p> <p>The statutory duty of quality requires the decision-making processes by the Health Board take into account the improvement of health services and outcomes for the people of Wales – the duty also includes new Health and Care Quality Standards.</p> <p>Instances of harm to patients may indicate failures to comply with the NHS Wales standards or safety legislation.</p> <p>In addition, the Duty of Candour is a fundamental principle in healthcare that requires healthcare professionals and organisations to be open and transparent when things go wrong.</p>	



	The legislation mandates that providers are open and transparent with service users and emphasises the importance of honest and accountability ensuring that patients are informed about any mistakes or incidents that may affect their care.
<b>Enw Da Reputational</b>	Yes (Include further detail below)
	Please see Legal above.
<b>Effaith ar Adnoddau</b> <i>(Pobl / Ariannol)</i> <b>Resource Impact</b> <i>(People / Financial)</i>	Yes (Include further detail below)
	Please see Legal above. All healthcare professionals have a duty of candour to be honest when things go wrong, undertake reflection and note learning.