Bundle Quality, Safety and Experience Committee 1 May 2025

1 PRELIMINARY MATTERS

1.1 13:00 - QS25/26 Welcome and apologies
Caroline Turner, Chair

1.2 13:01 - QS25/27 Declarations of Interest
Caroline Turner, Chair

1.3 13:02 - QS25/28 Unconfirmed minutes of meeting held on 20th February 2025
Caroline Turner, Chair
- QS25.28.1 Draft QSE minutes PUBLIC 20.2.25 V0.3 CT approved

1.4 13:04 - QS25/29 Matters Arising and Action Log
Caroline Turner, Chair
- QS25.29.1 QSE Action Log PUBLIC

1.5 13:07 - QS25/30 Patient's Story
Angela Wood, Executive Director of Nursing and Midwifery
- QS25.30.1 Patient Story - My Diabetic Journey

2 SERVICE PRESENTATIONS

2.1 13:37 - QS25/31 Overview of Mental Health Structure - focussing on Community Mental Health
Iain Wilkie, Director of Mental Health
- QS25.31.1 Overview of Mental Health Structure, focussing on CMH
- QS25.31.2 QSE CMHT Presentation 2025

2.2 14:07 - QS25/32 Children's Services - focussing on CAMHS
Andrew Gralton, Associate Director of Childrens' Services
Liz Fletcher, Assistant Director, Children's Services (West)
Alison Cowell, Assistant Area Director, Childrens' Services (Central)
- QS25.32.1 Children's Services, focussing on CAMHS 01.05.25
- QS25.32.2 Children's Services Presentation 01.05.25

3 QUALITY PLANNING

3.1 14:37 - QS25/33 Nursing Staffing Presentation
Angela Wood, Executive Director of Nursing and Midwifery
- QS25.33.1 Presentation of the Nurse Staffing Levels - Spring 2025
- QS25.33.2 Presentation of the Nurse Staffing Levels April 2025

4 14:52 - COMFORT BREAK

5 QUALITY CONTROL

5.1 14:57 - QS25/34 Integrated Quality Report
Angela Wood, Executive Director of Nursing & Midwifery
Sree Andole, Interim Executive Medical Director
Jane Moore, Executive Director of Public Health
Teresa Owen, Executive Director of Allied Health Professionals and Health Science
- QS25.34.1 Integrated Quality Report May 2025
- QS25.34.2 Appendix 1 Final Internal Audit Report 2024-2025
- QS25.34.3 Appendix 2 - Clinical Audit Plan - Tier 2 (2025-2026)
- QS25.34.4 Appendix 3- PSOW Public Interest Report- ID2087

5.2 15:27 - QS25/35 Integrated Performance Report
Stephen Powell, Director of Performance & Commissioning
- QS25.35.1 Coversheet for Integrated Quality Performance Report May 2025
- QS25.35.2 Integrated Quality Performance Report May 2025

6 QUALITY IMPROVEMENT

6.1 QS25/36 Challenged Service - Orthodontics
ITEM DEFERRED

7 QUALITY ASSURANCE

7.1 15:42 - QS25/37 Update on the Royal College of Psychiatry Action Plan
Ros Alstead, Independent Special Advisor
Phil Meakin, Associate Director of Governance

QS25.37.1 Health Board Response to the RCPsych Invited Services Review - V3 25

QS25.37.2 EAG Information Pack V12 for QSE preview 2

8 ROUTINE REPORTING

8.1 16:12 - QS25/38 Board Assurance Framework and Corporate Risk Register
Nesta Collingridge, Head of Risk Management

QS25.38.1 Board Assurance Framework May 2025

QS25.38.2 Corporate Risk Register Report May 2025 v2

9 ANNUAL REPORTING

9.1 16:27 - QS25/39 Committee Annual Report to Board - Verbal Update
Pam Wenger, Director of Corporate Governance

9.2 16:29 - QS25/40 Review Committee Terms of Reference
Pam Wenger, Director of Corporate Governance

QS25.40.1 Quality, Safety and Experience Committee Terms of Reference

10 FOR INFORMATION

10.1 QS25/41 Executive Quality Delivery Group Chair's Assurance Report

QS25.41.1 EQDG Chair's Assurance Report Feb 2025

10.2 QS25/42 Summary of Business to be Reported from Private

QS25.42.1 Summary of Business to be reported from Private 20.02.24

10.3 QS25/43 Committee Forward Workplan

QS25.43.1 QSE Forward Work Plan - live document

10.4 QS25/44 Committee Cycle of Business

QS25.44.1 QSE CoB V0.01 (Live Version)

11 CLOSING BUSINESS

11.1 16:39 - QS25/45 Agree Items for Referral to Board
Caroline Turner, Chair

11.2 16:40 - QS25/46 Meeting Effectiveness
Caroline Turner, Chair

11.3 QS25/47 Date of Next Meeting
1pm, Thursday 3rd July 2025

11.4 16:41 - Resolution to Exclude the Press and Public
Caroline Turner, Chair

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

Betsi Cadwaladr University Health Board (BCUHB)
DRAFT Minutes of the Quality, Safety and Experience Committee meeting held in PUBLIC
on 20th February 2025, The Boardroom, Carlton Court, St Asaph

Board Members present	
Name	**Title**
Dr Caroline Turner	Committee Chair, Independent Member
Chris Lothian-Field	Committee Vice Chair, Independent Member
Urtha Felda	Independent Member
Prof Mike Larvin	Independent Member
In Attendance	
Angela Wood	Executive Director of Nursing & Midwifery
Sreeman Andole	Interim Executive Medical Director (part meeting)
Sue Brierley-Hobson	Assistant Director of Allied Health Professionals and Health Science
Nesta Collingridge	Head of Risk Management
Nicola Jones	Deputy Head of Internal Audit
Matt Joyes	Deputy Director for Legal Services
Jo Kendrick	Head of Quality
Lois Lloyd	Chief Pharmacist
David Maslen-Jones	Associate Director of Occupational Health, Safety and Security
Jane Moore	Executive Director of Public Health
Philippa Peake Jones	Head of Corporate Affairs
Mitch Richardson	Portfolio Office Manager, Transformation and Improvement
Geoff Ryall-Harvey	Llais, North Wales
Pam Wenger	Director of Corporate Governance
Iain Wilkie	Interim Director MH&LD
Ed Williams	Director of Performance
Fiona Lewis	Minute Taker

Agenda Item
PRELIMINARY MATTERS

QS25/01 Welcome and apologies

The Chair welcomed Geoff Ryall-Harvey, attending on behalf of Llais North Wales.

Apologies were received from Jason Brannan (Deputy Director of People) noting that David Maslen-Jones deputised; Stuart Keen (Director of Environment and Estates); Stephen Powell (Director of Performance and Commissioning) – Ed Williams deputised; Dave Harries (Head of Internal Audit) – Nicola Jones deputised, and Imran Devji (Interim Chief Operating Officer).

DRAFT

QS25/02 Declarations of Interest

None were received.

QS25/03 Unconfirmed minutes of meeting held on 17th December 2024

It was resolved that the Committee:

Agreed the Minutes were a true and correct record of the meeting held 24th October 2024, subject to the minor amendments.

QS25/04 Matters Arising and Action Logs

Updates on the Action Log were noted.

The Chair welcomed the updates on two items, noted on the Log.

- **QS24/146.1** The Interim Executive Medical Director confirmed that the Mortality data will be brought to the March Development Session.

It was resolved that the Committee

- **Agreed** the updated log.

QS25/05 Patient Story – My 22 Hours in the Emergency Department

The Executive Director of Nursing and Midwifery shared a cancer patient's experience in Ysbyty Glan Clwyd Emergency Department (ED), highlighting issues with communication, waiting times, and the need for better patient care in corridors.

Following the presentation, the Committee:

- noted that despite the difficult content of the story, the Committee was appreciative such stories were being brought to their attention
- discussed the ongoing work taking place to improve patient experiences and manage risks in Emergency Departments and its corridors
- reviewed Pharmacy availability over weekends and what the options were to enable the service to run 24/7
- noted that apologies had been sent to the patient who was advised that lessons were being learned, as evidenced by the supplemented staffing at EDs, to ensure flexibility which enabled hourly checks of all waiting patients to take place
- noted that as a result of the findings of the recent Royal College of Nursing (RCN) report into Corridor care in Wales, a piece of work had been commissioned across all three main hospitals, to look at where improvements can be made regarding patients being cared for in corridors, and to identify associated risks and mitigations
- remarked that when asked, patients were less concerned about long waits in ED but more anxious about how comfortable they could be, the availability of food

- and drink, opportunities to find out where they were on the ED waiting room list and the possibility of missing being called whilst visiting the toilets
- discussed the need to ensure that appropriate facilities were available for immuno-compromised and neuro-diverse patients attending ED.

Actions:

- **QS25/05.1** Chief Pharmacist to review options and mitigation strategies to ensure access to the most frequently used medicines seven days a week in high-demand areas

It was resolved that the Committee

- **Noted** the report.

QUALITY PLANNING

QS25/06 Children's Services

Item deferred.

QUALITY CONTROL

QS25/07 Integrated Quality Report

Members received the Integrated Quality Report, presented by the Executive Director for Nursing and Midwifery, who highlighted the following:

- **Incidents and Falls:** there had been a notable reduction in patient falls and harm, with ongoing improvements, due to continued Management oversight.
- **Pressure Ulcers:** Following the success in reducing falls, a similar approach had taken place regarding pressure ulcers, with evidence showing positive trends in reducing severity and number of pressure ulcers.
- **National Reportable Incidents (NRIs):** Updates on the status and management of incidents. Following implementation of the Concerns Policy in September, this was now fully embedded with daily hub-meetings and weekly oversight groups. Thanks were offered to the Integrated Health Communities and Divisions for their help in reaching this goal.
- **Never Events:** pleased the note that none recorded since July 2024.
- **Safeguarding:** Implementation of Anti-sexual Harassment Policy and the single unified safeguarding reviews.
- **Infection Control:** Recent meetings between senior nurses and clinicians had taken place to ensure there was appropriate engagement from a medical perspective.
- **Patient Experience:** there had been significant improvements in both complaints handling and patient feedback. The Committee noted that work continued to ensure more compliments were being captured. The introduction of QR codes on wards in January 2025, to easily note compliments (thank you cards, boxes of chocolates, etc) to provide balance, and to share where practices were good and appreciated. A a deep dive into the Patient Advisory Liaison Services (PALS) was requested for a

future Development session. The Llais representative confirmed that both the number of complaints and the speed in which they were being dealt with by the Health Board had reduced, which had not been reflected across the whole of Wales.

Following this section of the report, the Committee discussed:

- The ongoing concern regarding the lack of mandated Falls training for agency staff. Members were advised that before each shifts all registrant nurses use an induction checklist and assess if any agency staff on their shift, and if so if they had received adequate Falls training. If not, the agency nurse was provided with appropriate support.
- The comprehensive safeguarding measures put in place since recent Oxygen cylinder issues, noting favourable comments on recent improvements by the Coroners.

Clinical:

- **Clinical Audits:** Discussion on the need for better resource allocation and engagement in clinical audits. The Committee agreed to focus on and review the Clinical Audit, as a substantive agenda item in a future meeting.
- **NICE Guidance:** Ensuring compliance and addressing gaps in Guidance implementation were discussed.
- **Mortality Reviews:** Plans for a deep dive into mortality data and reviews to be brought to the March Development session.

Quality Assurance Section, including Healthcare Law:

- **Regulation 28 Notices:** No new notices since October, with ongoing work to improve relationships with the Coroners.
- **Claims Management:** Robust management of claims continued, to ensure timely resolution and learning from events.
- **Legislative Changes:** Upcoming changes to the Mental Health Bill expected in 2025, however no date set for expected PTR Regulations changes. It was noted that close work with Welsh Risk Pool (WRP), who were sighted on improvement plans, inevitably helped build WRP's confidence.

Actions:

- **QS25/07.1** The Committee to receive a Deep Dive on PALS at a future Development Session – place on Forward Work Plan.
- **QS25/07.2** The Interim Executive Medical Director working with the Executive Director of Nursing to provide a deep dive into Mortality data, to be presented at the March development Session.
- **QS25/07.3** The Committee to review the Clinical Audit as a substantive agenda item at a future meeting. Interim Executive Medical Director and Director of Corporate Governance to agree a date to add to Forward Work Plan.

It was resolved that the Committee

- **Noted** the report.

QS25/08 Integrated Performance Report

The Director of Performance presented his report, and highlighted the following:

- Learning from Events Reports had been escalated to ensure more scrutiny
- No new Never Events reported since 31.07.24.
- Complaints has been formally de-escalated at Integrated Performance Executive Delivery Group (IPEDG) in January.
- NRIs have been proposed for de-escalation
- Clinical Coding Compliance to remain a significant risk and therefore remained in escalation for assurance.
- It was confirmed that both the Opthalmology R1backlog (over 100% overdue clinical follow-up date) and the Follow-up Backlog (with over 92,000 patients over 100% their clinical follow-up date) had been escalated to the Performance, Finance and Information Governance Committee.
- NRIs open for 90 days or more position had significantly and consistently improved and was being recommended for formal de-escalation to IPEDG on 26.02.25.

Following the presentation, Members discussed the following:

- Concern was raised regarding the financial position and how likely it was that BCU would reach the necessary targets by year-end. Focussed efforts continued to manage expenditure, with all IHC and department Directors made clear of expected savings requests.
- Assurance was received on the mitigations put in place regarding Clinical Coding, along with plans for further enhancements.

The Committee:

- **reviewed** the contents of the report
- **proposed** any actions arising from the report
- **identified** any additional assurance work or actions it would wish Executive colleagues to undertake.

[Ed Williams, Performance Director, left the meeting]

COMFORT BREAK

QUALITY IMPROVEMENT

[Mitch Richardson joined the meeting]

QS25/09 Quality Management System (QMS) Update

The Executive Director of Nursing and Midwifery talked through the original reasoning behind developing the QMS software – the need to create a tool that could be shared with

all services to ascertain where they believed they were from a planning, a control, assurance and improvement perspective.

The new QMS tool had been piloted in four service areas – Vascular, Urology, Women's and Transformation & Improvement – where key learning and outputs were identified, which had shaped further development of the product. Following Maternity agreeing to provide first early implementer case study for sharing and awareness, stakeholder mapping and engagement plan was being formulated.

The Project Steering Group was being refocussed to support with governance, deployment and implementation. It will continue to develop and bolster the QMS 'hub' on Betsinet, to include further information around QMS as a concept, each quadrant and the importance and benefits of a functioning QMS.

The potential for licencing the product was being investigated.

Mitch Richardson provided a thorough demonstration of the system and discussions took place regarding the tool's features - including action tracking, evidence submission, and reporting capabilities.

The QMS was received positively, with the Chair expressing the hope that following its full implementation, there would be a simple chart showing an overall assurance level for each service, ranging from fragile to excellent, highlighting which service required what level of assistance and support.

The Head of Risk Management confirmed that the application of the new QMS had been reviewed from a governance perspective, and it was agreed that this would not only increase quality but would aid governance.

It was resolved that the Committee

- **Noted** the report.

[Mitch Richardson left the meeting]

QS25/10 Opthalmology

The Interim Executive Medical Director provided a verbal interim update, as was agreed with the Chair due to the current staffing challenges.

The update described the challenges faced by Ophthalmology Services, including excessive waiting lists and harm reviews. The Interim Executive Medical Director agreed to provide a detailed paper on all challenged services, including Opthalmology, to the QSE Development session on 25th March 2025.

Action:

- **QS25/10.1** The Interim Executive Medical Director agreed to provide a paper on all challenged services, including Opthalmology, to the QSE Development Session on 25th March 2025.

DRAFT

QS25/11 Colonoscopy Performance Update

Item deferred; however clarification was sought as to when the data/paper can be reported to QSE.

Action:

- **QS25/11.1** The Executive Director for Nursing and Midwifery to link with the Interim Executive Medical Director to clarify when the Colonoscopy data will be presented to QSE, and report back.

QUALITY ASSURANCE

QS25/12 Health Board response to the Royal College of Psychiatry (RCPsych) Invited Review Services Report

The Chair noted that a new phase was being entered, and that now the Action Plan was being delivered, it was time to receive evidence of actions being carried out which improve current services.

The Director for MH&LD presented the update and highlighted the following:

- He wished to thank Llais for their continued support
- that the previous day he, along with the Executive Director for Allied Health Professionals and Health Science and the Vice Chair provided an update to the Minister for Mental Health, which was very well received.
- The report noted that the Health Board Action Deliver Group acknowledged good progress was being made against actions, but that it was unable to assess whether actions taken were meeting the objectives of the Service Review until the Expert Advisory Group comes into full operation.

Action:

- **QS25/12.1** In the next update, Associate Director of Governance to provide evidence of actions being carried out, which improve current services.

It was resolved that the Committee

- **Noted and Considered** the update from the Health Board RCPsych Action Delivery Group
- **Noted and Considered** the update from the Chair of the Health Board RCPsych Expert Advisory Group
- **Noted and Considered** the approach to the development of the Expert Group Work Programme and Outcome Performance Framework
- **Received assurance** on the Health Board response to the RCPsych Invited Review Services Report

DRAFT

ROUTINE REPORTING

QS25/13 Corporate Risk Register

The Head of Risk Management reviewed the Corporate Risk Register and highlighted:

- The Risk Scrutiny Group and the Executive Team approved the closure of the single areas of clinical concern Risk as had been requested by QSE at the previous meeting, with new individual Risks developed for each of the Challenged Services.
- Work still required on some of the clinically challenged services, such as Opthalmology, Renal and Urology; this had been fed back to these services.
- It was noted that the Risk Scrutiny Group had received two deep dives -
    - **Patient Safety and the failure to embed learning** - significant improvements had been recorded, resulting in the risk reducing.
    - **Community and Primary Care**, which resulted in a meeting with both Community leads, in order to identify the exact risks and therefore the mitigation required.

Following the presentation, The Chair was pleased to note that each of the challenged services had been included in the report and individually reviewed.

It was resolved that the Committee:

- **Received assurance** for the progression of the Corporate risks, for which the Committee has overall accountability.

[Liz McKinney, Designated Educational Clinical Lead Officer, joined the meeting]

ANNUAL REPORTING

QS25/14 Designated Educational Clinical Lead Officer (DECLO) Annual Report 2023-2024

Liz McKinney (DECLO) presented the DECLO Annual report 2023-24 and referred to the Additional Learning Act (ALN) and BCU's compliance with it.

A discussion ensued on the demand for ALN services, quality management, and current priorities, and it was noted that BCU was compliant and the ALN Support Team were responsible for assessing incoming applications in and the quality of responses.

Liz McKinney was pleased to note that the ALN team's fixed term contracts had recently been extended, and she was hopeful that in the new financial year these posts would become permanent.

It was noted that there would soon be a legislative review taking place due to the widely acknowledged ambiguities of the legislation, the knowledge that the current system was not working and that the imbalance on statutory responsibilities may have an impact on Health Board statutory duties in the future.

Members were pleased to note that as the ALN is grounded in social and not clinical model of responsibility. Delays in waiting for a neuro diverse diagnosis should not be a barrier for

children receiving their own individual Action Plan. However, some schools require a formal diagnosis to access funding, and doctors require one in order to prescribe appropriate medication.

To ensure that the Committee received the necessary assurance regarding compliance to the Act, it was agreed that the DECLO Annual Report be added to the Cycle of Business.

ACTION:

- **QS25/14.1** Head of Corporate Affairs to add the DECLO Annual Report onto the CoB for November meetings.

It was resolved that the Committee

- **Noted** this report for **assurance** purposes**.**

FOR INFORMATION

QS25/15 Summary of Business to be Reported in Private part of Last Meeting

It was resolved that the Committee

- **Noted** the Summary of Business reported from the Private part of Last Meeting

QS25/16 Review Committee Forward Work Plan

It was resolved that the Committee

- **Noted** the Committee Forward Work Plan

QS25/17 Review Committee Cycle of Business

It was resolved that the Committee

- **Noted** the Committee Cycle of Business

QS25/18 Llais Annual Report and Accounts 2023/24

It was resolved that the Committee

- **Noted** the Llais Annual Report and Accounts 2023/24

CLOSING BUSINESS

QS25/19 Agree Items for Referral to Board / Other Committees

- .To ensure that the All Wales Antisocial Harassment Policy is reviewed at People and Culture Committee.

QS25/20 Meeting Effectiveness

It was reported that despite the size of the agenda, there had been some very good discussions and Llais was appreciative of the opportunity to attend and contribute.
QS25/21 Date of Next Meeting 13.00hrs, Thursday, 1st May 2025
Resolution to Exclude the Press and Public It was resolved that those representatives of the press and other members of the public be excluded from the remainder of this meeting, having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest, in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960.

QSE Committee PUBLIC Action Log

Open Actions						
Action No.	**Minute Ref.**	**Date**	**Agreed Action**	**Lead**	**Timescale**	**Status**
1	QS25/14	20.02.25	**QS25/14.1 DECLO Annual Report** Ensure that DECLO Annual Report is on the Cycle of Business for November meetings.	Head of Corporate Office (**Philippa Peake-Jones**) /	May 2025	**Suggest close.** **20.2.25** Liz McKinney confirmed report will be available for January QSEs.
2	QS25/12	20.2.25	**QS25/12.1 RCPsych Invited Review Services Report** to provide evidence of actions being carried out, which improve current services.	Associate Director of Governance **(Phil Meakin)**	May 2025	**Suggest close.** May's report includes this.
3	QS25/11	20.02.25	**QS25/11.1 Colonoscopy Performance Update** Clarify when the Colonoscopy data/paper can be reported back into QSE.	Exec. Dir. of Nursing & Midwifery **(Angela Wood)** to link in with Interim Chief Operation Officer) **(Imran Devji)**	May 2025	**24.02.25** From AW - Email sent to Imran, awaiting clarification

4	QS25/10	20.02.25	**QS25/10.1 Ophthalmology** Circulate a paper on challenged services, to include Ophthalmology, before 1st May QSE mtg.	Interim Executive Medical Director **(Sreeman Andole)**	~~April 2025~~ July 2025	**22.4.25** Advised that Deep Dive into Opthalmology will be provided at July meeting.
5	QS25/07	20.02.25	**QS25/07.3 Integrated Quality Report** The Committee to review the Clinical Audit as a substantive item – to be included in the forward work plan	Director of Corporate Office **(Pam Wenger)/** Interim Executive Medical Director **(Sreeman Andole)**	Feb 2025	**Suggest close.** **20.2.25** Added to Forward Work Plan.
6	QS25/07	20.2.25	**QS25/07.2 Integrated Quality Report** The Interim Executive Medical Director working with the Executive Director of Nursing to provide a deep dive into Mortality data, to be presented at the March development Session.	Interim Executive Medical Director **(Sreeman Andole)** Exec. Dir. of Nursing & Midwifery **(Angela Wood)**	17.3.25	**Suggest close.** Deep Dive into Mortality Data provided at March Development Session.
7	QS25/07	20.2.25	**QS25/07.1 Integrated Quality Report** The Committee to receive a Deep Dive on PALS at a future Development Session – place on Forward Work Plan.	Head of Corporate Affairs **(Philippa Peake-Jones)**	Feb 2025	**Suggest close.** **20.2.25** Added to Forward Work Plan

8	QS25/05	20.02.25	**QS25/05.1 Patient's Story** Chief Pharmacist to review options and mitigation strategies to ensure access to the most frequently used medicines seven days a week in high-demand areas.	Chief Pharmacist **(Lois Lloyd)**	July 2025	
9	QS24/146.1	17.12.24	**QS24/146.3 Integrated Quality Report** Work with Executive colleagues on the Mortality Data and bring back to QSE Development Session in March.	Exec. Medical Director (**Sreeman Andole)** / (Director of Performance & Commissioning (**Stephen Powell)**	May 2025	**Suggest close.** **19.2.25** Sree is working with Ben Thomas & Gemma on the mortality data, update will be provided at the QSE development session in March.
10	QS24/104.3	15.8.24	**QS24/104 Meeting Effectiveness** Ensure more time allocated to Primary Care on CoB, on a regular basis.	Exec. Dir. of Nursing & Midwifery (**Angela Wood**) Head of Corporate Affairs (**Philippa Peake-Jones**)	17.12.24	**Suggest close.** **16.10.24** CoB will be updated once further conversations have taken place with Executives. **12.2.25** This will take place as part of the annual review of CoBs. Added to Forward Work Plan.
11	QS24/121	24.10.24	**QS24/121 Integrated Performance Report** to speak to the Deputy Executive Medical Director to check the veracity of colonoscopy data provided in report, and to escalate	~~Exec. Dir. Allied Health Professionals & Health Science (**Teresa Owen**)~~ ~~Interim COO **(Imran Devji)**~~	~~17.12.24~~ May 2025	**9.12.24** TO spoke with Deputy Executive Medical Director. Data/information is being checked by the team. **12.2.25** Jim McGuigan advised that Imran Devji was aware of this query and investigating. **9.4.25** Update requested.

			concerns if required.	Chief Operating Officer – **Tehmeena Ajmal**		
Closed Actions						
Action No.	**Minute Ref.**	**Date**	**Agreed Action**	**Lead**	**Timescale**	**Status**
1	QS24/147.2	17.12.24	**QS24/147.2 Integrated Performance Report** Provide members with a briefing on the issues around colonoscopies at the next QSE meeting. To add to Forward Workplan for January 2025.	Executive Director for Allied Health Professionals & Health Science (Teresa Owen) / Interim Chief Operations Offices (**Imran Devji**)	Jan 2025	**17.12.24** Added to Forward Workplan. **8.1.25** Update requested for Feb meeting.
2	QS24/147.1	17.12.24	**QS24/147.1 Integrated Performance Report** Circulate a briefing on the Clinical Coding training via the AAA report to Board.	Head of Corporate Affairs (**Philippa Peake-Jones)**	Jan 2025	**30.1.25** Added to AAA report.
3	QS24/146.2	17.12.24	**QS24/146.2 Integrated Quality Report** Look at bringing Clinical Audit back to a future Committee as a separate item. Pam and Sreeman to confirm timing	Exec. Medical Director (**Sreeman Andole)** / Director of Corporate Governance (**Pam Wenger**)	May 2025	**12.2.25** Transferred to Forward Work Plan.

4	QS24/146.3	17.12.24	**QS24/146.1 Integrated Quality Report** Circulate the Complaint update as received as part of the Action Log to all IM's in the Corporate Governance Weekly meeting.	Head of Corporate Affairs (**Philippa Peake Jones**)	20.12.24	**12.2.25** PPJ has added this to the IM's Teams channel
5	QS24/149.1	17.12.24	**QS24/149.1 Urgent and Emergency Care Deep Dive** Urtha take off line the concern raised in relation to her recent experience in an ED department.	Executive Director of Nursing & Midwifery (**Angela Wood**)		No contact from Urtha regarding this issue
6	QS24/144.2	17.12.24	**QS24/144.1 Learning & Disabilities Deep Dive** Circulate the strategy outside of the meeting	Executive Director for Allied Health Professionals & Health Science (**Teresa Owen**) / Director of Mental Health (**Iain Wilkie**)		**12.02.25** Strategy circulated.
7	QS24/144.1	17.12.24	**QS24/144.2 Learning & Disabilities Deep Dive** Angela to introduce Nichaela Jones to her colleagues in England with regards to digitising the HEF	Executive Director of Nursing & Midwifery (**Angela Wood**)		**1.2.25** Email sent to NHSE as way of introduction.
8	QS24/143.1	17.12.24	**QS24/143.1 Patient Story**	QSE Chair	30.1.25	Included in the AAA report to be referred to

			Refer Organ Donation to the Board as part of the AAA report	**Caroline Turner** Head of Corporate Affairs (**Philippa Peake-Jones)**		Board **17.12.24** Actioned.
9	QS24/116	24.10.24	**QS24/104.3 Matters Arising** To add outcomes for women from deprived and ethnically vulnerable communities to the forward work plan and to check that the DOLs deep dive has been included.	Head of Corporate Affairs (**Philippa Peake-Jones**)	17.12.24	**10.12.24** Both items have been added to Forward Workplan and timings for these will be updated in due course.
10	QS24/123	24.10.24	**QS24/123 Corporate Risk Register** to discuss at next Chairs' Advisory Group whether certain risks sat is Performance or Quality, or whether they straddled both.	Director of Corporate Governance (**Pam Wenger**)	17.12.24	**4.12.24** Following a discussion with both Chair's of PFIG and QSE, the Director of Corporate Governance advised that both risks Diagnostics and Medical devices should remain with QSE as the gaps in controls relate to the service model and regulatory and accreditation requirements and should the risks materialise they both would impact on the quality and safety domain. However, the Executive lead for both risks need to be clarified and confirmed, and this may alter the risks meaning they sit more appropriately with PFIG. This will be discussed and worked through by the Risk Scrutiny Group and Executive Team. **12.2.25** On CAG agenda for 26.2.25.

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

Teitl adroddiad: ***Report title:***	**Stori Denise – Fy Nhaith gyda Diabetes** **Denise's Story – My Diabetic Journey**
Adrodd i: ***Report to:***	QSE Committee
Dyddiad y Cyfarfod: ***Date of Meeting:***	1st May 2025
Crynodeb Gweithredol: ***Executive Summary:***	A patient or carer story is presented to QSE Committee to bring the voice of the people we serve directly into the meeting. The digital story will be played at the meeting. A short summary is included in the attached paper.
Argymhellion: ***Recommendations:***	The Committee is asked to note this report.
Arweinydd Gweithredol: ***Executive Lead:***	Angela Wood, Executive Director of Nursing and Midwifery
Awdur yr Adroddiad: ***Report Author:***	Mandy Jones, Deputy Executive Director of Nursing Leon Marsh, Head of Patient Experience Rachel Wright, Patient and Carer Experience Lead Manager Hannah Hughes, Patient & Carer Experience Project Manager

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

Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***
In line with best practice, a patient or carer story is presented to QSE Committee to bring the voice of the people we serve directly into the meeting, but it is not presented as an assurance item. However, the accompanying paper describes some of the learning and actions undertaken in response to the story.

Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Quality
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	N/A
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	N/A
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal?	N/A

In accordance with WP68, has an SEIA identified as necessary been undertaken?	
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	BAF21-10 - Listening and Learning
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	N/A
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	N/A
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	N/A
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	BAF21-10 - Listening and Learning
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	N/A

Camau Nesaf: Gweithredu argymhellion
Next Steps: Implementation of recommendations
N/A

Rhestr o Atodiadau:

Final My Diabetic Journey - ENGLISH SUBTITLES.mov

Final My Diabetic Journey - WELSH SUBTITLES.mov

I am willing for my story to be shared with:

- ✓ Level 1 – Any Health and Social Care Professionals within BCUHB
- ✓ Level 2 – Researchers for Service Evaluation and improvement beyond BCUHB
- ✓ Level 3 – Meetings and Conferences with anyone present including public and journalists
- ✓ Level 4 – Anyone including Online, Internet, Social Media (Twitter, Facebook etc) and the CIVICA national platform where Health Boards across Wales can access the story

List of Appendices:
Appendix A- Patient Story Summary

Betsi Cadwaladr University Health Board

Stori Denise – Fy Nhaith gyda Diabetes
Denise's Story – My Diabetic Journey

An audio-visual story will be played at the meeting.

Overview of Patient Story

The storyteller is a patient who, in her late 30's, has been recently diagnosed with Type 2 Diabetes.

She describes her 'diabetic journey' where she initially felt shocked and overwhelmed about her diagnosis and unsure about how to manage the condition. She describes the lifestyle changes that she has made, both nutritionally and through physical activity, as well as the role of medication and support from Healthcare Professionals as well as her family, to reduce her HbA1c level (the level of glucose / sugar in her blood). She describes the negative impact of initially deciding to make 'drastic cuts' and nutritional changes and how 'sustainable' changes have now positively led to a 'complete transformation', both in terms of her physical and mental health.

The story will be shared as part of the Public Health Diabetes Transformation Programme, where 'lived experience' stories are being used to inform the process of redesign of care and treatment provided for patients identified as at risk, or living with Diabetes.

Key Messages

- A patient journey with Type 2 Diabetes.
- An initial shock of diagnosis and not experiencing 'typical' diabetic symptoms.
- The initial impact of the diagnosis – feeling overwhelmed, feeling unsure about how to manage the condition, avoiding socialising.
- Starting to manage her condition through medication, nutritional changes and regular physical activity to reduce her HbA1c level.
- The negative impact of making 'drastic cuts' to her nutrition.
- The importance of support from family, friends and professionals and the support she received from her GP, Diabetic Nurse and Diabetes UK.
- Enjoying the 'sustainable' changes that she has made which have led to a 'complete transformation' of her lifestyle and the positive impact that this has had on both her physical and mental health.

Summary of Learning and Improvement

Over the next ten years, the number of people of living with Diabetes in North Wales is expected to rise to around 60,000, which is not only challenging for the health and wellbeing of our communities, but will have a huge impact on our ability to provide care and services.

The Diabetes Transformation Programme, led by BCUHB Public Health Team and supported by colleagues from across clinical and non-clinical services, aims to better plan for and manage services for people living with both Type 1 and Type 2 diabetes. They also hope to increase the focus on prevention and earlier intervention wherever possible.

In April 2025, the 'Diabetes Transformation – A Case for Change' proposal will be shared with Health Board Executives. This presents a comprehensive case for change to address the escalating Diabetes prevalence in North Wales. The proposal aims to set out how we will seek to prevent the anticipated increase in diabetes cases, enhance patient care, address health inequalities, reduce economic burden, and raise public awareness.

Designed from a process of robust stakeholder engagement and consensus, a newly developed Diabetes Care Model includes population-based prevention, integrated primary care, enhanced secondary and specialist care, and workforce and system wide enablers. The expected benefits encompass improved patient outcomes, workforce morale, societal health, and economic efficiency.

The Diabetes Transformation Programme Team have worked with colleagues across the Health Board, partners, and members of the community to co-produce and shape the future model of diabetes prevention and care in the region and across our services.

Following an initial period of discovery and looking at, "what we already know", including gathering staff, clinical and patient and carer feedback, the journey continued with two consensus events held in November and December 2024.

Bringing together clinical and non-clinical colleagues from across the Health Board, Local Authority partners, service users and representatives from community and voluntary sector organisations, Public Health led the discussion to present the scale of the issues faced, feedback gathered and posed questions for attendees to develop and agree principles for change to address the currently unsustainable issue across our population and our services. This also led to the development of the following principles being proposed, which should be considered when considering any changes to how our services are delivered:

1. **Ensuring that the new model is evidence based and evaluated** - using data to understand what is working and where there are inequalities, staying up to date with the latest evidence base and sharing best practice. The need to embrace new technologies and ways of working, willingness to learn.
2. **Being proactive rather than reactive –** Consideration to the prevention of the onset of Type 2 diabetes - e.g. making high quality healthy food more accessible – earlier intervention upon diagnosis.
3. **Improving our communication –** Transparency and clarity around decisions made. Making it easier for staff and patients to navigate the system and reducing variation.
4. **Ensuring our care is holistic –** Engagement with patients and communities to understand what works. Striving for care closer to home, delivered in primary care and community settings, as well as promoting personal ownership and peer support.
5. **Supporting our workforce to care –** Empowering our staff to live healthy lives. Ensuring we have the right staff in the right roles, that people are given the training and development they need, and that there is a plan for the future.

6. **Focusing on sustainability, both financially and environmentally**

A third and final consensus event was held in February 2025 to further inform the aim for better support and care for people with diabetes across all our region and services. .

In addition, the story will have further impact through sharing with the Diabetes Transformation Steering Group with wide representation from the Health Board for dissemination and action.

The Patient and Carer Experience Team will share this feedback and will continue to work with all services to promote the patient experience initiatives outlined above. The Patient and Carer Experience Team extend their gratitude and appreciation to the storyteller for sharing her experience.

<table>
<tr><td>Teitl adroddiad:

Report title:</td><td colspan="4">QS525/31 Overview of Mental Health Structure – Focus on Community Mental Health</td></tr>
<tr><td>Adrodd i:

Report to:</td><td colspan="4">Quality, Safety and Experience Committee</td></tr>
<tr><td>Dyddiad y Cyfarfod:

Date of Meeting:</td><td colspan="4">Thursday, 01 May 2025</td></tr>
<tr><td>Crynodeb Gweithredol:

Executive Summary:</td><td colspan="4">A slide set presentation will be shared with the QSE members to provide an overview of the BCU Mental Health Structure focused towards Community Mental Health Team services and teams.

The purpose of the slide set is to draw to the attention of the Board the ongoing work of the Community Pathway Group, plans in place for a community establishment review and a range of patient quality, safety and experience information.</td></tr>
<tr><td>Argymhellion:

Recommendations:</td><td colspan="4">The Board is asked to:

Recognise the work undertaken to date through the community pathway group to align and sustainably transform community mental health services.</td></tr>
<tr><td>Arweinydd Gweithredol:

Executive Lead:</td><td colspan="4">Teresa Owen, Executive Director of Allied Health Professionals and Health Science</td></tr>
<tr><td>Awdur yr Adroddiad:

Report Author:</td><td colspan="4">Carole Evanson, MH&LD Director of Operations</td></tr>
<tr><td>Pwrpas yr adroddiad:
Purpose of report:</td><td>I'w Nodi
For Noting
☐</td><td colspan="2">I Benderfynu arno
For Decision
☐</td><td>Am sicrwydd
For Assurance
☒</td></tr>
<tr><td>Lefel sicrwydd:

Assurance level:</td><td>Arwyddocaol
Significant
☐
Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol

High level of confidence/evidence in delivery of existing mechanisms/objectives</td><td>Derbyniol
Acceptable
☐
Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol

General confidence / evidence in delivery of existing mechanisms / objectives</td><td>Rhannol
Partial
☐
Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol

Some confidence / evidence in delivery of existing mechanisms / objectives</td><td>Dim Sicrwydd
No Assurance
☐
Dim hyder/tystiolaeth o ran y ddarpariaeth

No confidence / evidence in delivery</td></tr>
<tr><td colspan="5">Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:

Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:</td></tr>
<tr><td colspan="2">Cyswllt ag Amcan/Amcanion Strategol:

Link to Strategic Objective(s):</td><td colspan="3">Together for Mental Health Partnership</td></tr>
</table>

Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	Healthcare Inspectorate Wales Welsh Government Mental Health Measure requirements
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	No, as not required.
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	No, as not required.
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)***	Tier 1 - Risk linked to Central CMHT and this pertains to patients not being seen in a timely manner and the existence of a waiting list Tier 1 – Risk linked to the impact of paper records and not having an Electronic Patient Record Tier 2 - Risk linked to West CMHT and both relate to the withdrawal of the Local Authority from integrated CMHT's
Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith ***Financial implications as a result of implementing the recommendations***	None
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	None
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	None
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	Not applicable
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Not applicable
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** **Implementation of next steps noted in slide set presentation.**	
Rhestr o Atodiadau: Dim ***List of Appendices:*** None	

Quality, Safety and Experience Committee

Mental Health - Focus on Community Mental Health Teams

Presented by:
MH&LD Divisional Director, Iain Wilkie
MH&LD East Head of Operations and Service Delivery, Becky Baker

1st May 2025

CMHTs: INTRODUCTION

The MHLD Division has a range of inpatient, community and specialised commissioned services across North Wales. Community provision includes, but not limited, to Community Mental Health Teams (CMHTs) for adult and older adults, Local Mental Health Primary Care Services (LMHPSS), Home Treatment Teams, Perinatal Services, Rehabilitation Community Teams and First Episode Psychosis Teams. A focus of this paper will be on the 16 adult CMHT's across North Wales.

The Community Mental Health teams offer a range of targeted intervention and support services for people with mental health needs. The support available is tailored to suit individual circumstances, supported by a multidisciplinary team which consists of: Consultant Psychiatrists, Psychiatric Nurses, Occupational Therapists, Psychologists, Wellbeing Practitioners and Health Care Support Workers. The Community Mental Health Services aims include -

- Provide assessment, treatment and intervention for people with short-term or more complex long-term needs within the context of the Mental Health Measure.
- Help people to get long-term personal support and to enable them to live as independently as possible
- Offer advice and share contact details of useful organisations

CMHT LOCATIONS ACROSS NORTH WALES

The Divisional CMHT's are located pan North Wales, providing community support for Adults and Older Adults.

The various locations and local authority areas of each of the teams is shown in the table opposite.

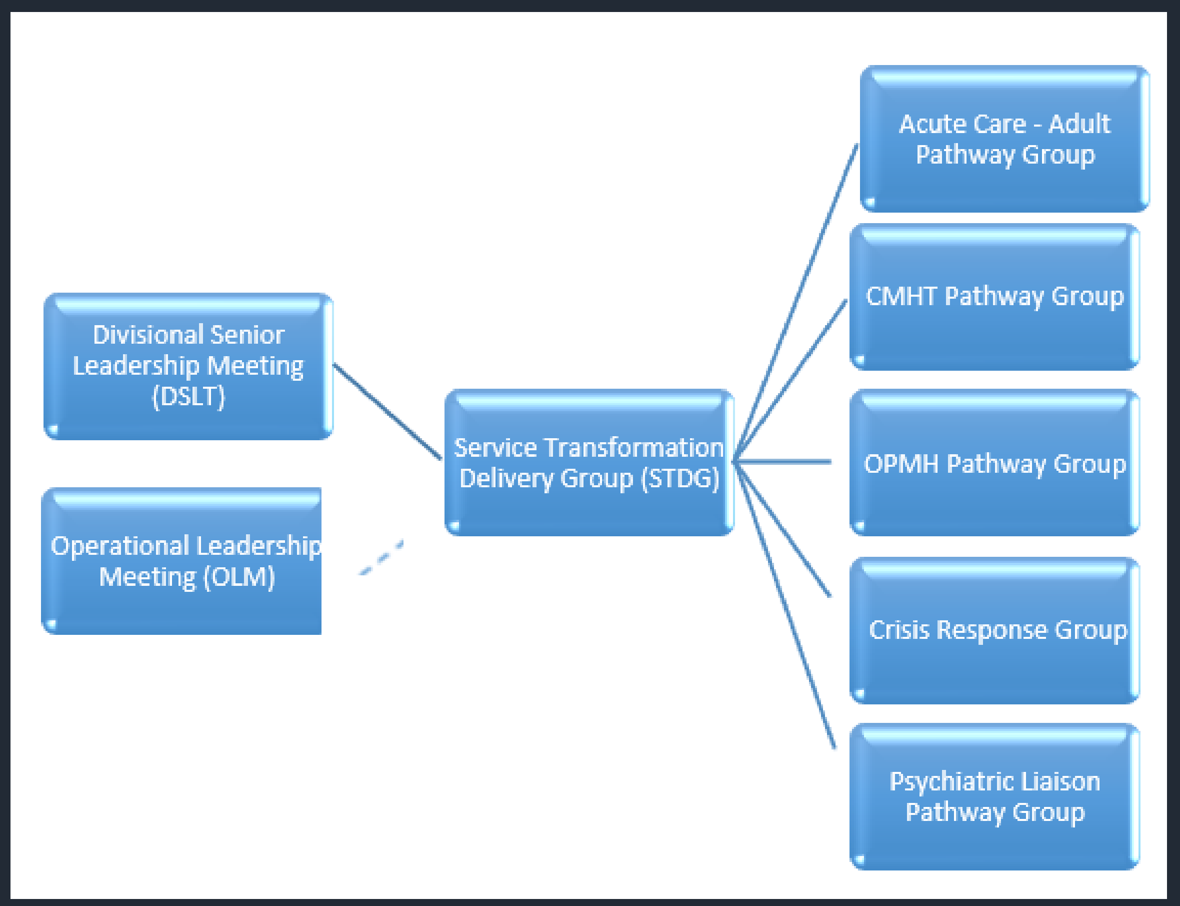
SLT Area	Local Authority	Population size	Community team	Base location
West	Ynys Mon	69,000	Ynys Mon CMHT	Cefni Hospital
West	Ynys Mon		Ynys Mon Older Adult CMHT	Cefni Hospital
West	Gwynedd	117,400	North Gwynedd CMHT	Hergest Unit
West	Gwynedd		South Gwynedd CMHT	Alltwen, Tremadog and Plas Brith, Dolgellau
West	Gwynedd		Gwynedd OPMH Arfon	Hergest Unit, YG
Centre	Denbighshire	96,500	OPMH CMHT Glan Traeth	Rhyl Alexandra Hospital
Centre	Denbighshire		Hafod	Rhyl
Centre	Denbighshire		Tim Dyffryn Clwyd	Denbigh
Centre	Conwy	114,290	CMHT Nant y Glyn	Colwyn Bay
Centre	Conwy		OPMH CMHT Llys Dyffrig	Llandudno
East	Flintshire	155,000	Flintshire CMHT Mold	Pwll Glas Mold
East	Flintshire		Flintshire CMHT Flint	Pwll Glas Mold
East	Flintshire		Flintshire CMHT Aston House	Aston House, Deeside
East	Flintshire		Flintshire OPMH CMHT	Wepre House, Deeside
East	Wrexham	135,117	Wrexham OPMH CMHT	Heddfan Unit, WMH
East	Wrexham		Wrexham CMHT	Ty Gororau, WMH

CMHTs: GOVERNANCE

The Division has three Senior Leadership Teams (SLT's) that oversee the 16 CMHT's. In each of the SLT's there are local governance arrangements that oversee the CMHT ie monitor and review of incidents, complaints, concerns, workforce performance, as example.

In addition, the Division has an CMHT Pathway Group, established in 2023, which meets monthly and reports into the Service Transformation Delivery Group (STDG) and Divisional Directors.

Given the changes to joint working between the Health Board and Local Authority, the CMHT Pathway Group is developing the future CMHT model, and the Division will continue to work closely with partners to progress this.



CMHTs: ACHIEVEMENTS/ PROGRESS – 2024/25

- ✓ Standard Operating Procedure (SOP) ratified for CMHT's to deliver the Mental Health Measure since January 2024
- ✓ Community Mental Health Services Allocating waiting list protocol active since June 2024
- ✓ Transfer and Discharge of Care Protocol reviewed in June 2024 with audits completed on the subsequent use of the checklist
- ✓ Single Point of Assessment & Access (SPOAA) SharePoint reviewed and updated to align all CMHT's across the Division for standardised and consistent approach in the recording of information supporting data collection and capacity and demand
- ✓ Maximising assessment and intervention appointments within existing resources
- ✓ Caseload review undertaken, including performance review and waiting list data reporting
- ✓ Progress made with the Electronic Health Record, including establishment a governance structure and agreement regarding the staff roles and responsibilities of the change team.
- ✓ Recruitment of nine Band 5 Mental Health Wellbeing Practitioners into adult CMHT to support the daily duty officer supporting crisis/ unscheduled care. The Division is currently evaluating the role and impact.
- ✓ Established robust links with the innovative 111+2 service, including ongoing communication and collaboration with internal and external stakeholders
- ✓ Increased focus on physical health monitoring and health promotion

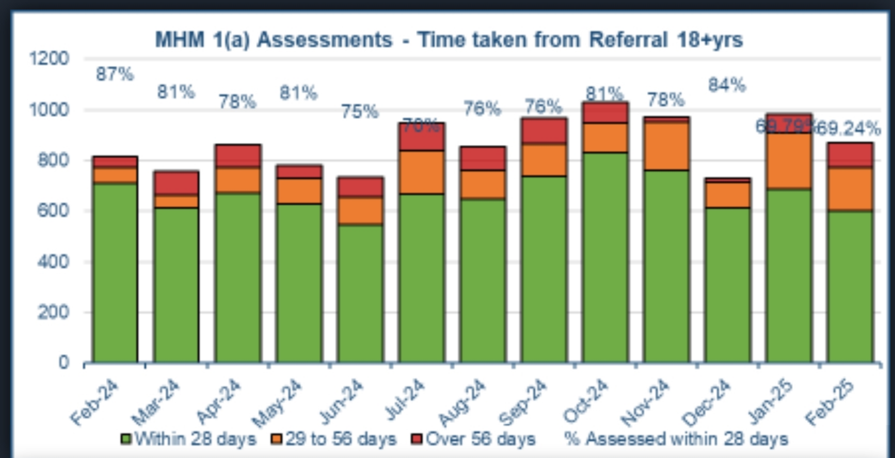
CMHTs: QUALITY INDICATORS

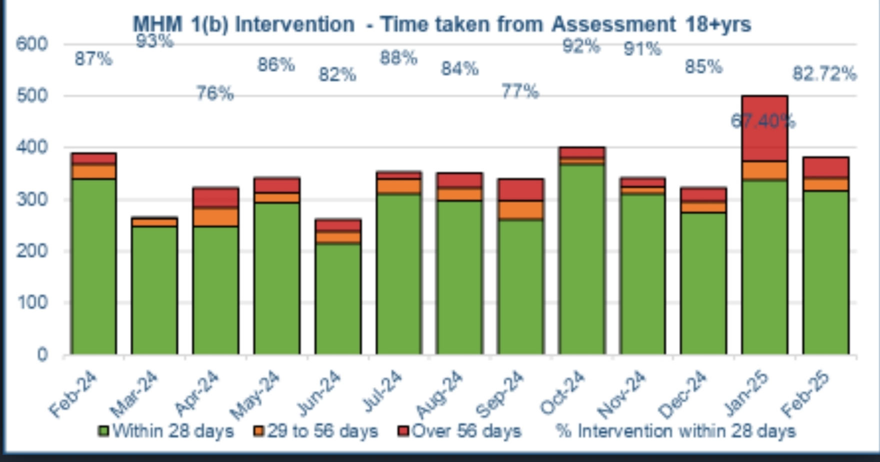
HIW Report (2024) - Nant-y-Glyn CMHT.

- All actions have been completed and improvements implemented.

Mental Health Measure (MHM) Performance

- Part 1a (Assessment)
  - Performance decline in January 2025, with slight increase in February 2025 due to backlog clearance and winter pressures.
  - February 2025: 884 assessments completed, 267 addressing long waiters.
- Part 1b (Intervention)
  - February 2025 - Exceeded 80% compliance target.
  - February 2025 - 352 interventions, with 58 addressing long waiters.

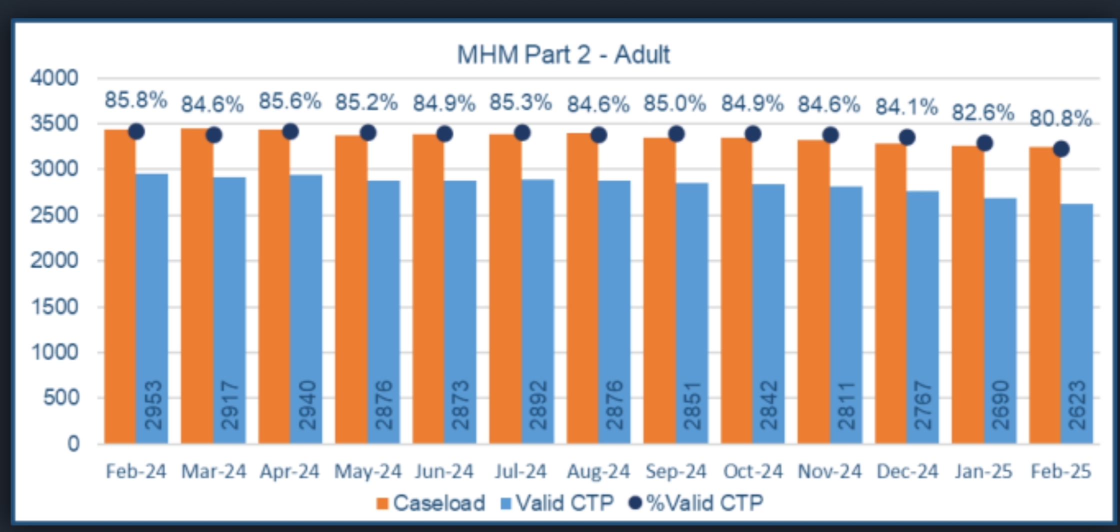




CMHTs: QUALITY INDICATORS

Part 2 of MHM (Care & Treatment Plans)

- February 2025 Performance remains below target, at 80.6%



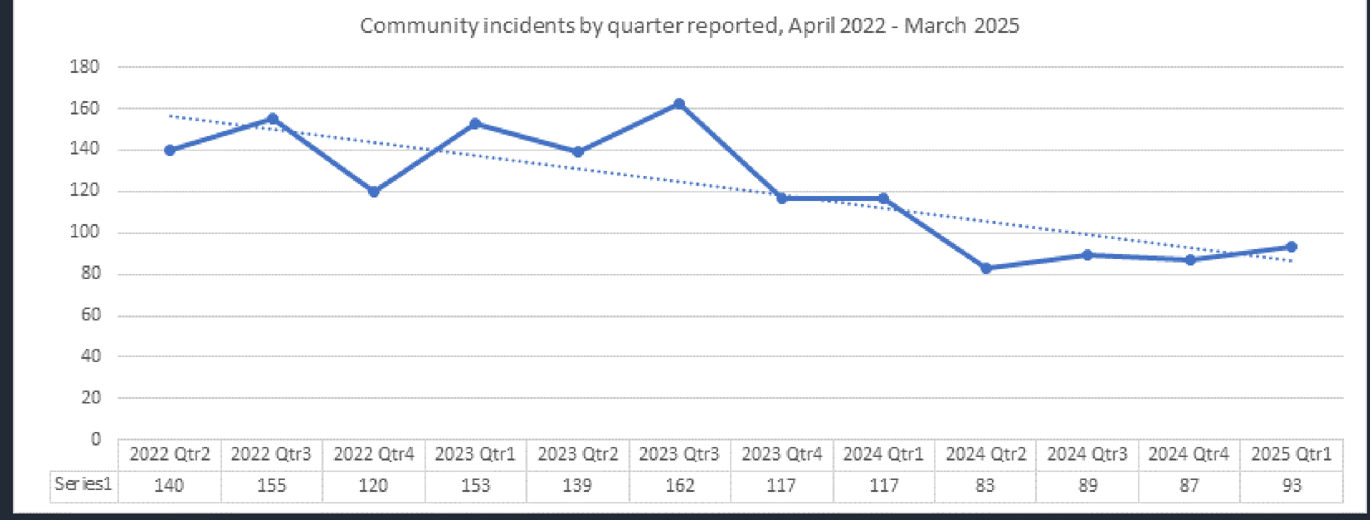
Actions Taken

- Audits targeting underperforming areas.
- Unallocated patient protocol and temporary staffing solutions
- Interim short-term staffing to bring the service back into alignment with MHM performance standards including block booking of agency, additional management capacity added to the West SLT

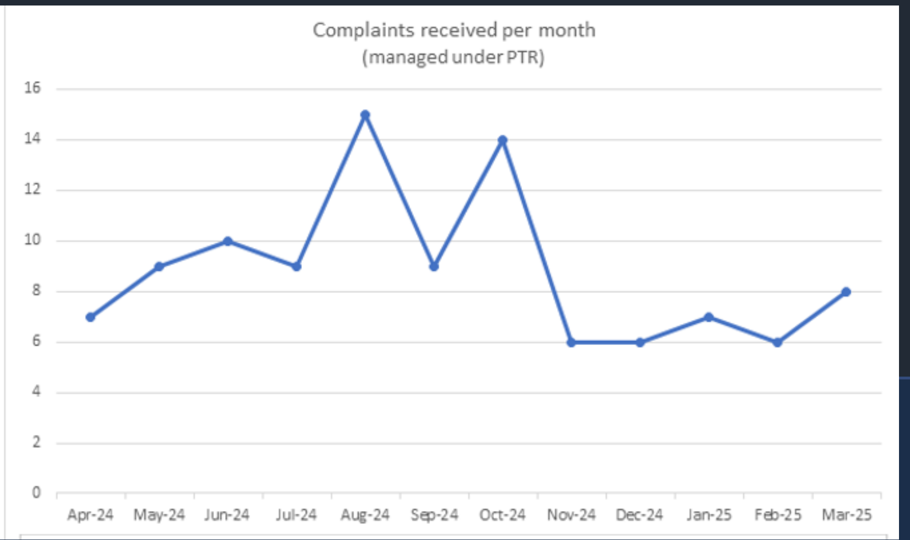
CMHTs: SAFETY INDICATORS

Incident Trends & Monitoring

- DATIX Incident Review: Robust procedures in place at both Senior Leadership Team and Divisional levels.
- Incident Reporting: CMHT incidents have reduced from 140 reported in Qtr2 in 2022 to 93 reported in Qtr1 in 2025.
- Top Incident Categories:
  - Unexpected Deaths
  - Expected Deaths
  - Aggressive/Threatening Behaviour
  - Communication issues



	2022 Qtr2	2022 Qtr3	2022 Qtr4	2023 Qtr1	2023 Qtr2	2023 Qtr3	2023 Qtr4	2024 Qtr1	2024 Qtr2	2024 Qtr3	2024 Qtr4	2025 Qtr1
Series1	140	155	120	153	139	162	117	117	83	89	87	93



Complaints logged against CMHT's relate to care across teams, and are logged only against the primary area of concern. The three main subjects of concerns raised were delay/lack of treatment of assessment (33%), communication with patients (17%) and incorrect/insufficient treatment or assessment (15%)

CMHTs: EXPERIENCE

The MH&LD Division use CIVICA to capture real time patient feedback. Some of the examples from CMHT feedback received during the last year.

Divisional Patient, Carer and Experience Group receive service user feedback reports from across the Division, reporting into DSLT for monitoring and review.

Glan Traeth – You rescued me from a living hell. I feel I can breathe again and feel I'm getting there, slowly but surely. We are so lucky here in North Wales to have you and so do take care of yourself. What a privilege to have had the very best looking after.

East Primary Care Counselling - I feel much better in general and learned a number of coping mechanisms. The EMDR has helped a lot. I also realised how prevalent and pronounced the mental health issues are and could be.'

Gair back i ddiolch o galon am y sesiynau, rwyf wedi eu mwynhau yn fawr as yn ddiolchgar i chwi amdanynt.

I know it's been a while since I stopped coming but I just wanted to let you know that I'm doing much better recently. I've settled down and I'm a lot happier now, the daily hallucinations have subsided and I'm still self-harm free after so long. I'm really just writing to tell you how thankful I am for the things you have told me over the past year, you really pulled me out of a dark place and a lot of the things you've said still stick with me to this day and help me make better decisions for myself.

CMHTs: AREA OF CONCERN + ACTIONS

Current demand – natural variation of referrals into mental health services (1083 referrals February 2024 compared to 1097 referrals in February 2025).

Impact of Local Authority Staff reductions - 5 out of 6 Local Authorities have removed social work staff from CMHTs, reducing resources. Remaining LA (Flintshire) set to remove staff in April 2025.

Mitigation Actions

- Director-level engagement with Local Authorities on model approach.
- Workshop events with Gwynedd and Ynys Mon Local Authorities for collaborative solutions.
- Mental Health Cluster meetings for continued collaboration.
- Bi-weekly SLT staffing meetings to address gaps (bank, overtime, fixed-term staffing and Agency use).
- Ongoing recruitment activity and redeployment of staff to support teams.
- Administration review and increased clinics to meet demand.
- Continuous monitoring of MHM performance via Finance & Performance meetings.
- Monthly recruitment focus meetings for Band 5 nurses and HCAs.

CMHTs: WORKFORCE

CMHT's are supported by a multidisciplinary team consisting of Consultant Psychiatrists, Psychiatric Nurses, Occupational Therapists, Psychologists, and Support Workers. All efforts are made by the Divisions for timely recruitment to all vacancies.

The CMHT current staffing vacancies, as of 28th February 2025, are -

Registered Nurse Vacancies

- Band 5 - 4 WTE
- Band 6 - 12.59 WTE

HCSW Vacancies

Band 3 - 2.74 WTE

Recruitment Updates

- Ongoing recruitment into vacant posts, attendance at recruitment events and on going use of social media to aid recruitment.

Key Development Role

- Band 5 Mental Health Wellbeing Practitioner - supports the Duty Officer role within each CMHT.

Establishment Review

- Adult CMHT Review - Potential budget implications
- Further details to be shared with the Executive Director of Nursing once completed.

CMHTs: RISKS

The Division actively monitors and reviews risks identified for the CMHT's.

Actions include monitoring of waiting lists and putting in place temporary staffing.

Tier 1

- Risk that patients will not be seen in a timely manner in Conwy and Denbighshire due to a waiting list

ACTION – Waiting list is actively monitored by SLT's

- Access to a digital patient record which is integrated into the All Wales Digital Strategy

ACTION – Digitisation of the Electronic Health Records is being progressed by the Health Board with a Project Plan in place

Tier 2

- Withdrawal of Local Authority team from Ynys Môn CMHT

ACTION – Ongoing Health Board and Local Authority engagement workshops to review CMHT model.

CMHTs: Key Points and Moving Forward

To summarise, the Division will be progressing a number of actions for the development of CMHT's moving forward including;

- Complete the staffing establishment review for adult CMHT's – expected date of completion June 2025.
- Continue engagement events between the Health Board and Local Authority on respective team models – in place and ongoing.
- Continue mitigation plans developed by area SLT's to ensure MHLD Division CMHT service provision is maintained and the risks with waiting lists are managed, whilst aiming to reduce – in place and ongoing.
- SLT's to develop plans on how Mental Health Measure timescales will be met – by end of Q2 25/26.
- Drive the future service model development via the Community Pathway Group – expected date of completion mid-2026.
- Continue with the plan for the Electronic Health Records (EHR) – expected date for phased implementation to commence from December 2025.

Teitl adroddiad: ***Report title:***	Children's Services
Adrodd i: ***Report to:***	Quality, Safety and Patient Experience Committee
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 01 May 2025
Crynodeb Gweithredol: ***Executive Summary:***	The purpose of this deep dive presentation into children's services is to provide the board with an account of the service governance, challenges, achievements, quality indicators and risks impacting on children, young people and their families.
Argymhellion: ***Recommendations:***	The Committee is asked to: • **Note** the presentation and discuss areas where further assurance is required
Arweinydd Gweithredol: ***Executive Lead:***	Chief Operating Officer
Awdur yr Adroddiad: ***Report Author:***	Associate Directors for Children's Services: Andrew Gralton, Alison Cowell and Liz Fletcher.

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

Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:

Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:
Children's sits within the IHC structure with accountability through the Directors to the COO. The service is meeting most of the quality standards, is challenged in terms of demand in some parts of the service and the digital infrastructure.

Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	The BCUHB 3year Plan

	Healthy Child Wales Programme Regional Partnership Priorities
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	• Statutory Safeguarding obligations • Mental Health Measure • ISO • Children's Continuing Care • Health and Safety. • Professional registration and codes of conduct • Additional Learning Needs Act
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	Not required for this presentation
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	Not required for this presentation
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)***	• Vacancies and Recruitment • Demand v capacity for Neuro-development assessments • Tertiary capacity for neurology • Retinopathy provision for neonates • Lack of digital record • Challenges in determining a health or social care need as per Children's Continuing Care guidance • Estates provision for workforce and Delivery of service
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	The service strives to deliver within the available core budget and partnership funding. The service has been in receipt of additional funding from WG for CAMHS and ND
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	Workforce is a risk across many disciplines.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	No relevent

<table>
<tr><td>Cysylltiadau â risgiau BAF:
(neu gysylltiadau â’r Gofrestr Risg Gorfforaethol)

Links to BAF risks:
(or links to the Corporate Risk Register)</td><td>See above</td></tr>
<tr><td>Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)

Reason for submission of report to confidential board (where relevant)</td><td>Requested by the Committee</td></tr>
<tr><td colspan="2">Camau Nesaf:
Gweithredu argymhellion

Next Steps: Not applicable</td></tr>
<tr><td colspan="2">Rhestr o Atodiadau:
Dim

List of Appendices:
None</td></tr>
</table>

Children's Services QSE Deep Dive

20.02.24

GOVERNANCE
Children's Services
Quality and Safety Framework

Integrated Health Community
BCUHB Regionally
In Partnership

Children’s Governance – Quality and Safety

- Children’s Services’ governance assurance is achieved at a local, regional and national level.
- Operationally Children’s Services is accountable to the three Integrated Health Communities with Quality and Safety reporting within that structure
- Regionally the Children’s Services IHC Teams work closely together and report to the Children’s Services Group which is supported by Clinical Advisory Groups; and to the Regional Partnership Board.
- Nationally Children’s Services report to a number of national networks and quality assurance bodies eg Maternity/Neonatal network, JCC, CAMHS network, Child Health Network
- All our services participate in a number of national audits/standards

BCUHB
Quality, Safety & Experience

Integrated Health Community Quality, Safety & Experience

IHC Children's Quality, Safety & Experience

IHC Programme Teams:

- CAMHs
- Acute Paediatrics/Neonates
- Community

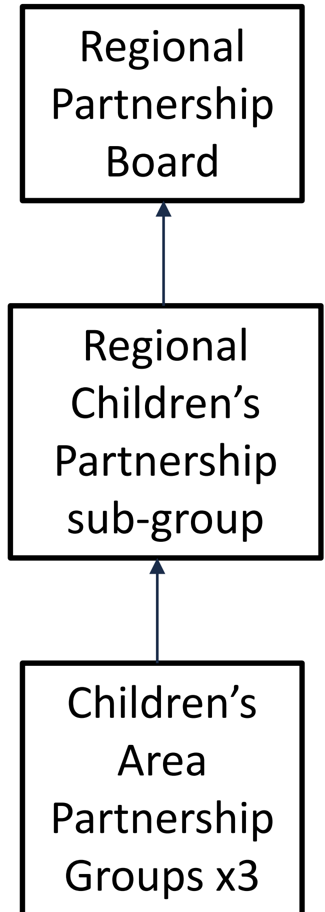
Operational Leadership Group

Regional Children's Service Group

North Wales Clinical Advisory Groups:

- CAMHs
- Acute Paediatrics/Neonates
- Community

North Wales Neonatal Steering Group (Maternity, Obstetrics, Neonatology)



ACHIEVEMENTS

Children’s Services Achievements

- Child’s Voice heard in the BCUHB - Children’s Champion the Board and Children’s Charter adopted by the Board
- Child’s voice heard strategically – NHS Executive Child Health Clinical Network visit, RCPCH visit, Regional Partnership priorities include transformation of support for those who are neuro-diverse.
- Public Protection – significant improvement in MMR uptake following targeted work with the Covid vaccination Team.
- Quality of Care for Children and Young People with emotional or mental health needs – reduction in CAMHS waiting list, Crisis Model redesign leading to reduction in Crisis demand and admissions to Paediatric wards as a consequence of the Alternative to Admission development
- Type 1 diabetes has been increasing nationally year on year, since the pandemic this rose to an increase of 27% – provision of Insulin pumps and Continuous Glucose Monitoring and care provided by specialist diabetes nurses has transformed the quality of life for children and young people
- Development of the All age Mental Health digital information system for records
- Awarded stage 2 accreditation of the UNICEF Neonatal Baby Friendly Initiative accreditation, now working towards stage 3

QUALITY INDICATORS:

Complaints

Incidents

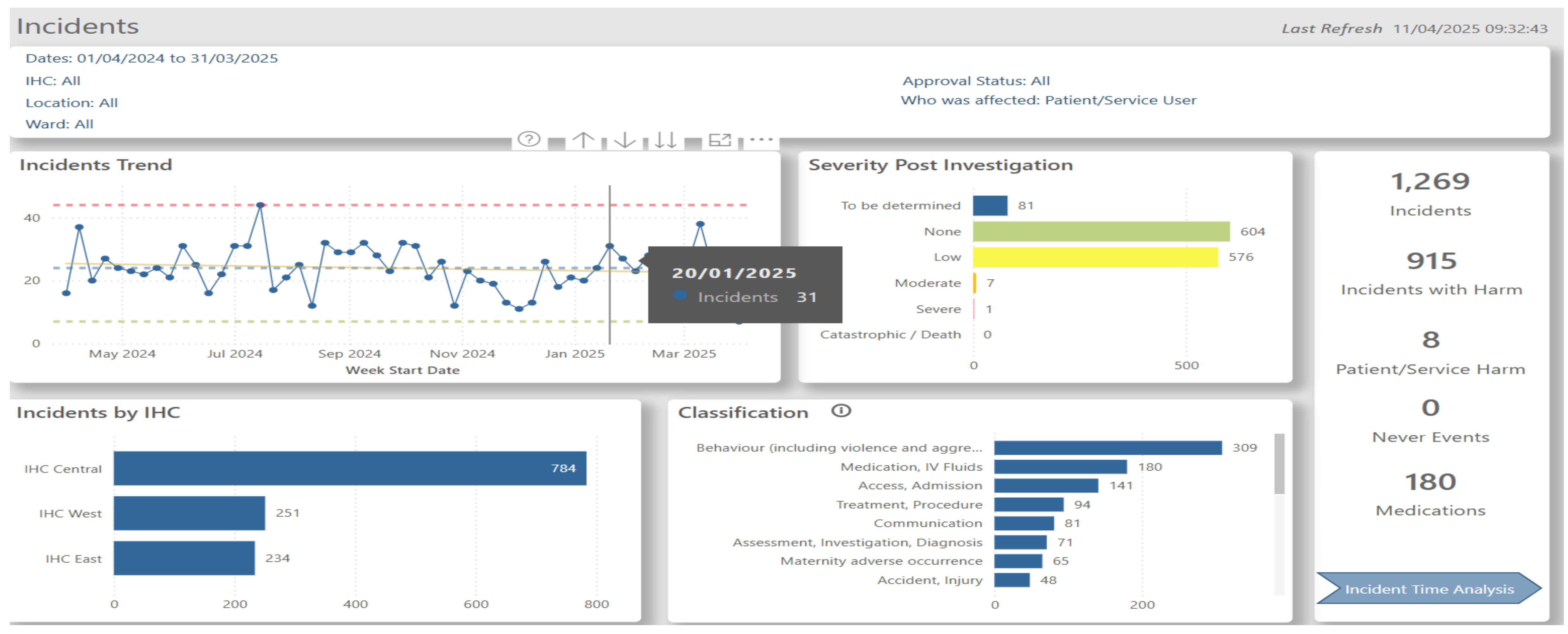
Performance against Standards

National Audits

Children's Service Complaints

- Clinical Assessment/Treatment 54%
- Communication 18%
- Attitude & Behaviour 11%
- Access to services 6%
- Confidentiality 5 %
- Patient Care 2%
- Appointments 1%
- Assault 1%
- Consent 1%
- Referral 1%

Children’s Services Incidents



Performance against Standards – Healthy Child Wales Programme:

	Contact at 10 days	Physical examination at 6 week	Weight and measurement at 6 weeks	Weight and Measurements at 12 weeks	Weight and Measurement at 16 weeks	Contact at 6 months	Health Visitor contact at 15 months	Health Visitor contact at 27 months	Contact at 3.5 years pre school
BCUHB	89.5%	81.6%	77.4%	73.8%	73.4%	85.1%	80.6%	78.1%	72.3%

Performance against Standards - National Neonatal Audit Programme

	Above National Average	Below National Average	Missing Measure Data	Total
SURNICC	16	4	0	20
East	13	6	1	20
West	8	11	1	20

Key Headlines

- Several measures included in PERIPrem Cymru perinatal optimisation bundle have shown and improvement
- Action plan in place with a view to reducing mortality and serious brain injury

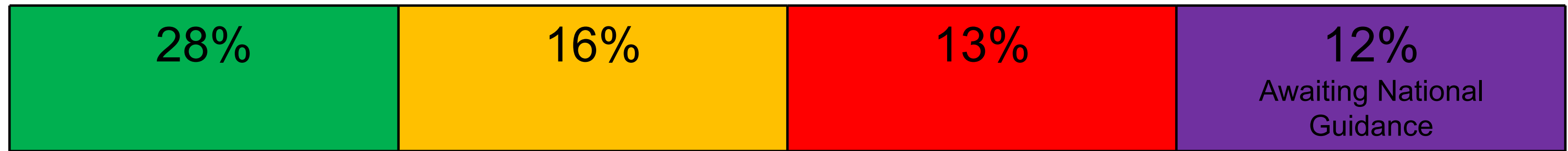
Challenges / Risks / Focus Areas

- Antenatal steroid use in YGC and YG
- Temperature at admission in YGC and YG
- ROP compliance in all three areas
- Small case numbers in SCBU's can be misleading

- **Success**
- Delayed cord clamping improvements in YGC and WMH
- Breast milk use (day 2, day 14 and discharge)
- Parent inclusiveness at ward rounds
- Neonatal nursing staff above national target in all three units
- Bloodstream infections below national target in all three units

Maternity and Neonatal Safety Support Programme

75 Recommendations



- We have introduced a BCU Neonatal lessons learnt news letter for all the Neonatal team from PMRT, SIR and incidences
- We have launched the shared Transitional Care Maternity and Neonatal care bundle in March. BCU are leading the way with Transitional Care in Wales. The shared care bundle ensures written information for Midwifery, Neonatal staff and the parents when a baby is on Transitional Care as well as shared documentation. Maternity, Neonatal, AHP'S and infant feeding teams have worked together on the shared care bundle and education for the staff. The aim is to keep mothers and babies together and reduces separation rates and term admissions.
- The Donor Breast Milk (DBM) hub is located in YGC and is a collaboration with the Chester DBM bank. This helps to reduces our carbon foot print and promote DBM in North Wales

CONTINUING AREAS OF CONCERN - Risks

Continuing areas of concern and risk

RISKS	MITIGATIONS	FURTHER ACTIONS NEEDED
Vacancies in Health Visiting and impact on safeguarding children Recruitment of practitioners with required registration and skill set - (psychology, psychiatry, CAMHS practitioners)	Vacant caseload policy being implemented. Recruitment days in place Locum cover used as required.	Work force planning and Commissioning of trainee places required with HEIW
Demand for assessment and diagnosis of Neuro – diversity	Targeted waiting list management for longest waiters. WG National Transformation Workshop & Regional RPB Transformation Workshop, developed a partnership action plan.	Additional Funding to support the demand
Tertiary provision capacity for specialities - neurology	Urgent advice pathway in place with some face to face appointments	National discussion with JCC
Retinopathy of Prematurity (ROP) sustainability of provision: Inability to screen babies at correct time due to the lack ophthalmologists across the region	Links in place with surgical teams and support sought regionally / from Alder Hey	Awaiting outcome and implementation of Business Case by Surgical speciality
Lack of digital record for children and young people resulting in records being in paper format and a duplicate records held by different disciplines. A number of Child Practice Reviews have recommended that a digital record is developed to ensure good communication supports safeguarding of children.	All practitioners aware of the challenges with paper records and need to communicate effectively as teams using multi disciplinary meetings and verbal and written means. A digital record for mental health is being developed which will include children and young people.	Strategic national digital discussions required
Determining a health or social care need as per WG Children's Continuing Care Guidance is often challenged by the Local Authorities and the Not for Profit Act will impact on placement availability. This is likely to increase the pressures to agree joint funded placements	Children's Services Quality Assurance Panel in place All age Exceptionality Panel being established. Whilst there is no agreed Dispute policy with the Local Authorities in place, escalation is through the IHCs.	Dispute Policy to be refreshed and discussed with the Local Authorities.
Estates – inadequate accommodation (office and clinical)	Short term lease in place in Centre for ND provision	Bid for space in Disability Resource centre at YGC Estates strategy would assist service planning

Conclusion

- Children's services is an integrated service across acute and community within the Integrated Health Communities, closely aligned to the Primary Care and Local Authorities to support partnership working, whilst also working as a network regionally supported by clinical leadership.

- The Child's Voice is paramount and the service endeavours to ensure that is heard.

- Demand particularly around neurodevelopment assessments outstrips capacity and the current service model expects the NHS to address this, it is now an RPB priority.

- Quality of care to our most vulnerable for example neonatal babies, children in crisis is continually improving and progress celebrated.

<table>
<tr><td>Teitl adroddiad:
Report title:</td><td colspan="12">Presentation of the Nurse Staffing Levels</td></tr>
<tr><td>Adrodd i:
Report to:</td><td colspan="12">QSE Committee</td></tr>
<tr><td>Dyddiad y Cyfarfod:
Date of Meeting:</td><td colspan="12">1st May 2025</td></tr>
<tr><td>Crynodeb Gweithredol:
Executive Summary:</td><td colspan="12">The Nurse Staffing Levels (Wales) Act 2016, requires Health Boards to calculate and take all reasonable steps to maintain the nurse staffing levels within Section 25B areas, which are adult acute medical inpatient wards; adult acute surgical inpatient wards; and paediatric inpatient wards.

In accordance with the Act, nurse staffing calculations must be undertaken bi-annually (as a minimum) and are to be approved by a designated person who is authorised to undertake this calculation on behalf of the Chief Executive Officer.

The designated person should be registered with the Nursing and Midwifery Council and have an understanding of the complexities of setting a nurse staffing level in the clinical environment. Within Welsh Health Boards the designated person is the Executive Director of Nursing.

The calculation undertaken by the designated person must result in the nurse staffing level for the ward area. In practice, the nurse staffing level will be the required establishment and the planned roster. The nurse staffing level should be funded from the health boards revenue allocation.</td></tr>
<tr><td>Argymhellion:
Recommendations:</td><td colspan="12">The Committee is asked to receive this presentation to gain assurance that Betsi Cadwaladr University Health Board (BCUHB) is meeting its statutory “duty to calculate and take steps to maintain nurse staffing levels” in all wards that fall under the inclusion criteria of Section 25B of the Nurse Staffing Levels (Wales) Act 2016.</td></tr>
<tr><td>Arweinydd Gweithredol:
Executive Lead:</td><td colspan="12">Mrs Angela Wood, Executive Director of Nursing & Midwifery</td></tr>
<tr><td>Awdur yr Adroddiad:
Report Author:</td><td colspan="12">Mrs Alison Griffiths, Director of Nursing Workforce, Staffing and Professional Standards
Miss Joanna Brown, Nurse Staffing Programme Lead</td></tr>
<tr><td>Pwrpas yr adroddiad:
Purpose of report:</td><td colspan="4">I’w Nodi
For Noting
☐</td><td colspan="4">I Benderfynu arno
For Decision
☐</td><td colspan="4">Am sicrwydd
For Assurance
☒</td></tr>
<tr><td>Lefel sicrwydd:

Assurance level:</td><td colspan="3">Arwyddocaol
Significant
☒
Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau /</td><td colspan="3">Derbyniol
Acceptable
☐
Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau /</td><td colspan="3">Rhannol
Partial
☐
Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau /</td><td colspan="3">Dim Sicrwydd
No Assurance
☐
Dim hyder/tystiolaeth o ran y ddarpariaeth</td></tr>
</table>

	amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	*No confidence / evidence in delivery*

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: *Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:*	
Cyswllt ag Amcan/Amcanion Strategol: *Link to Strategic Objective(s):*	*Nurse Staffing Levels (Wales) Act 2016*[1] Section 25B of the Nurse Staffing Levels (Wales) Act 2016 applies to adult acute medical inpatient wards, adult acute surgical inpatient wards, and paediatric inpatient wards. *A Healthier Wales: Our Plan for Health and Social Care*[2] identifies a requirement to "*drive the changes we need to see in our health and social care system, so that it is able to meet the needs of current and future generations in Wales*" *A Healthier Wales: Our Workforce Strategy for Health and Social Care*[3] draws a direct link between vacancy rates and high agency expenditure. *The Strategic Nursing Workforce Plan*[4] addresses the significant and well documented challenges facing the nursing profession in Wales, setting out the overarching strategic nursing workforce actions of growing the nursing workforce; transforming the nursing workforce and supporting the nursing workforce.
Goblygiadau rheoleiddio a lleol: *Regulatory and legal implications:*	Statutory reporting requirements aligned to the Nurse Staffing Act (Wales) 2016 *"duty to calculate and take steps to maintain nurse staffing levels"*

[1] Nurse Staffing Levels (Wales) Act 2016
[2] A healthier Wales: long term plan for health and social care
[3] A healthier Wales: our workforce strategy for health and social care
[4] Strategic nursing workforce plan

Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? *In accordance with WP7 has an EqIA been identified as necessary and undertaken?*	Not applicable
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? *In accordance with WP68, has an SEIA identified as necessary been undertaken?*	Not applicable
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) *Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR)*	Risk ID1976 - Nurse Staffing (Continuity of service may be compromised due to a diminishing nurse workforce). There is a risk to the provision of high quality safe and effective nursing care due to the number of nursing vacancies across the Health Board. Inability to provide appropriate nurse staffing levels to ensure time to care for patients sensitively can compromise the Health Boards ability to deliver health care effectively, and compromise the reputation of Health Board nursing services. CRR15 Recruitment & Retention (this applies to all staff across the Health Board but the nursing workforce is a significant element of the risk). There is a risk that the Health Board will have difficulty recruiting and retaining high quality staff in certain areas. This may be due to UK shortages for certain staff groups and the rurality of certain areas of the health board. This could lead to poor patient experience and outcomes, low morale and well-being and attendance of staff
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* *Financial implications as a result of implementing the recommendations*	The nurse staffing levels presentation includes details of the whole time equivalent (WTE) changes arising from the nurse staffing level calculations. The associated financial implications of the organisations statutory duty to calculate nurse staffing levels will be included within the annual assurance report for the period 6th April 2024 - 5th April 2025, due to be presented to Board on 29th May 2025.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith *Workforce implications as a result of implementing the recommendations*	Workforce implications relate to the ability to both finance and recruit a sufficient workforce of both registered nurses and healthcare support workers
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori *Feedback, response, and follow up summary following consultation*	*Not applicable*
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) *Links to BAF risks:* *(or links to the Corporate Risk Register)*	As detailed above - Risk ID1976

Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) *Reason for submission of report to confidential board (where relevant)*	*Not applicable*

Camau Nesaf:
Next Steps:
Implementation of recommendations.
Annual assurance report for the period 6th April 2024 - 5th April 2025, to be presented to Board on 29th May 2025.

Rhestr o Atodiadau:
List of Appendices:

Presentation of the Nurse Staffing Levels – Reporting Period Spring 2025

Presentation of the Nurse Staffing Levels

Reporting Period: Spring 2025

Introduction / Background

The Nursing Staffing Levels (Wales) Act became law in Wales in March 2016 and places a duty on Welsh health boards and trusts to ensure that nurses have enough time to care for patients.

The Act consists of 5 sections:

- 25A refers to the health boards'/trusts' overarching responsibility to have regard to providing sufficient nurses in all settings;
- 25B requires health boards/trusts to calculate and take all reasonable steps to maintain the nurse staffing level in all adult acute medical inpatients wards; adult acute surgical inpatient wards; and paediatric inpatient wards. Health boards/trusts are required to inform patients of the nurse staffing level on those wards;
- 25C requires health boards/trusts to use a specific method to calculate the nurse staffing level in all adult acute medical and surgical wards;
- 25D relates to the statutory guidance released by Welsh Government;
- 25E requires health boards/trusts to report their compliance in maintaining the nurse staffing level for each adult acute medical inpatient ward; adult acute surgical inpatient ward; and paediatric inpatient ward.

Section 25B: Duty to calculate and take steps to maintain nurse staffing levels

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

In line with the Act, nurse staffing calculations must be undertaken bi-annually (as a minimum) and are to be approved by a ***designated person*** who is authorised to undertake this calculation on behalf of the Chief Executive Officer.

The designated person should be registered with the Nursing and Midwifery Council and have an understanding of the complexities of setting a nurse staffing level in the clinical environment. Within Welsh Health Boards the designated person is the Executive Director of Nursing.

The calculation undertaken by the designated person must result in the nurse staffing level for the ward area. In practice, the nurse staffing level will be the required establishment and the planned roster. The nurse staffing level should be funded from the health boards revenue allocation.

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

Section 25C: Nurse staffing levels: method of calculation

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

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

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

Section 25A: Duty to have regard to providing sufficient nurses in all settings

All other areas providing care to patients are required to undertake nurse staffing calculations, and whilst these are not legally mandated under section 25A, it is expected that these reviews will be undertaken routinely and in response to changes in patient acuity and / or dependency; when there is a change in the service model or delivery; or when concerns are raised through exception reporting or clinical governance.

Nurse staffing level calculations must reflect an evidence based methodology that reflects due regard for the quality of patient care & outcomes; patient acuity and dependency; and the professional judgement of senior nursing teams i.e. triangulated methodology.

The Post-legislative scrutiny undertaken in 2024 identifies the need for clear operational guidance to support the consistent application of section 25A, including the need to ensure a triangulated approach to nurse staffing level calculations. This work is ongoing at a national level under the auspices of the All Wales Nurse Staffing Programme.

Nurse Staffing Levels Calculations Process

Ward Level

Data Collection & Review

Health Board Wide Multi-site, Service Specific Reviews

Review & Approval by Designated Person

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

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

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

Spring 2025 reviews were undertaken during the week commencing 10th March 2025.

Formal presentations were made to the Executive Director of Nursing and Midwifery on 03/04/2025. In attendance were the nominated deputies for the Executive Directors of People Services; & Finance.

Agreed Nurse Staffing Level calculations will be formally presented to the Board on 29/05/2024.

Extent to which the Nurse Staffing Levels are maintained

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

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

Month	Total number of shifts	Shifts where planned roster met and appropriate		Shifts where planned roster met but not appropriate		Shifts where planned roster not met but appropriate		Shifts where planned roster not met and not appropriate		Data completeness	Shifts where planned roster met but no appropriateness		Shifts where planned roster not met and no appropriateness	
Apr-24	3375	43.73%	1476	9.45%	319	21.21%	716	17.51%	591	91.91%	4.77%	161	3.32%	112
May-24	4185	41.65%	1743	9.08%	380	24.04%	1006	17.59%	736	92.35%	4.37%	183	3.27%	137
Jun-24	4050	41.26%	1671	9.83%	398	25.04%	1014	17.95%	727	94.07%	3.75%	152	2.17%	88
Jul-24	4185	40.65%	1701	9.65%	404	25.09%	1050	17.16%	718	92.54%	4.13%	173	3.32%	139
Aug-24	4185	43.01%	1800	9.87%	413	24.99%	1046	15.99%	669	93.86%	3.54%	148	2.60%	109
Sep-24	4050	44.42%	1799	9.95%	403	21.04%	852	18.67%	756	94.07%	3.19%	129	2.74%	111
Oct-24	4185	43.08%	1803	11.59%	485	21.43%	897	18.92%	792	95.03%	2.99%	125	1.98%	83
Nov-24	4050	46.99%	1903	12.27%	497	19.51%	790	15.63%	633	94.40%	3.01%	122	2.59%	105
Dec-24	4185	40.07%	1677	13.14%	550	22.34%	935	18.78%	786	94.34%	2.77%	116	2.89%	121
Jan-25	4185	42.37%	1773	14.93%	625	19.52%	817	18.81%	787	95.63%	2.13%	89	2.25%	94
Feb-25	3780	44.58%	1685	12.04%	455	18.52%	700	19.58%	740	94.71%	3.04%	115	2.25%	85
YTD Running Total	44415	42.85%	19031	11.10%	4929	22.12%	9823	17.87%	7935	93.93%	3.41%	1513	2.67%	1184

Please note data presented is between 06/04/2024 – 28/02/2025 in line with national reporting guidelines.

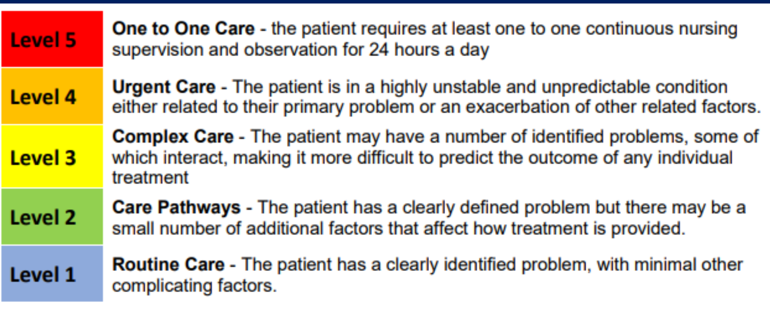
All Wales Acuity Audit

Acuity Audit data

During the months of January and June each year a national acuity audit is held as directed by the Chief Nursing Officer. The acuity audit is used to collect data relating to patient acuity, patient flow and nurse staffing levels. Patient acuity is assessed using the Welsh Levels of Care evidence-based workforce planning tool. This measure of patients levels of acuity indicates how much care is required in order to determine the nurse staffing level that is required to meet reasonable requirements of care.
This information when used as part of a triangulated approach alongside the use of quality indicators and professional judgement will determine the nurse staffing level for the ward.
Individual BCU ward acuity details can be viewed here

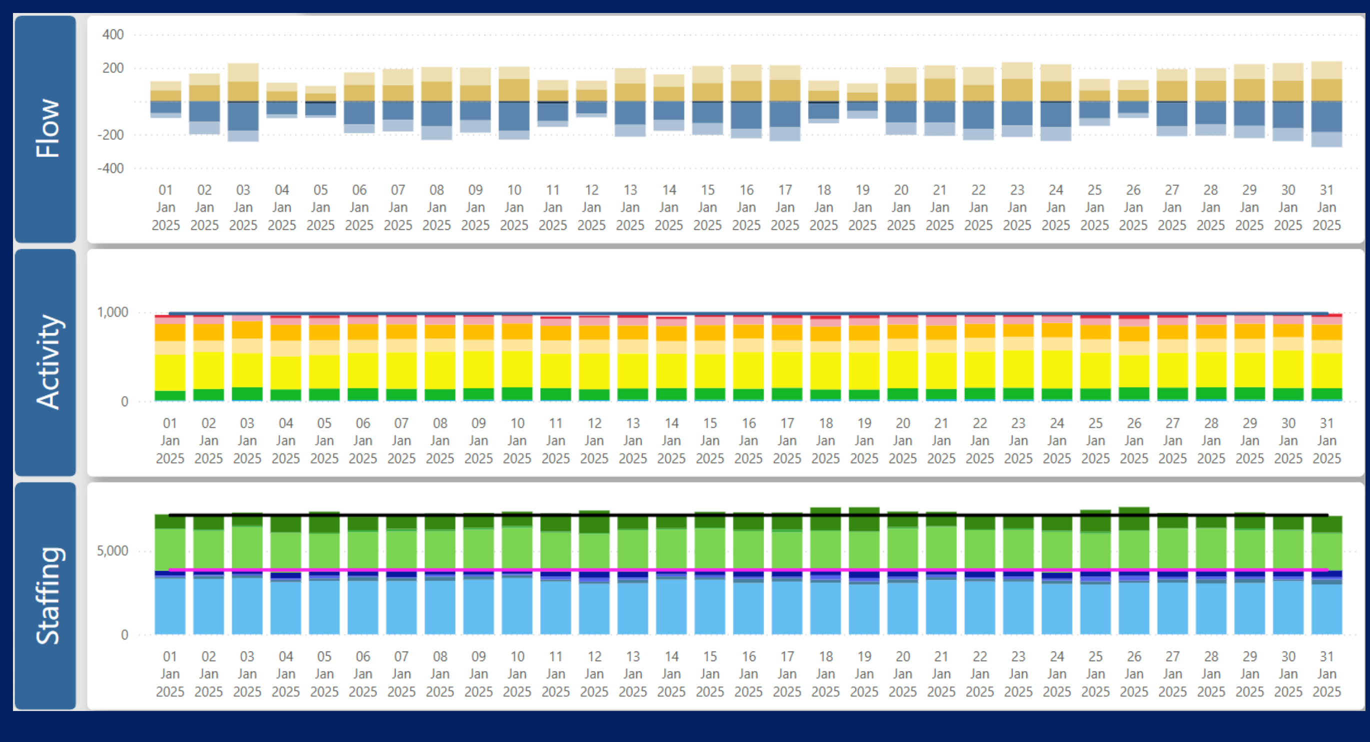
Welsh Levels of Care

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



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

BCUHB Section 25B Wards January 2025 Acuity Audit data



Quality Indicators

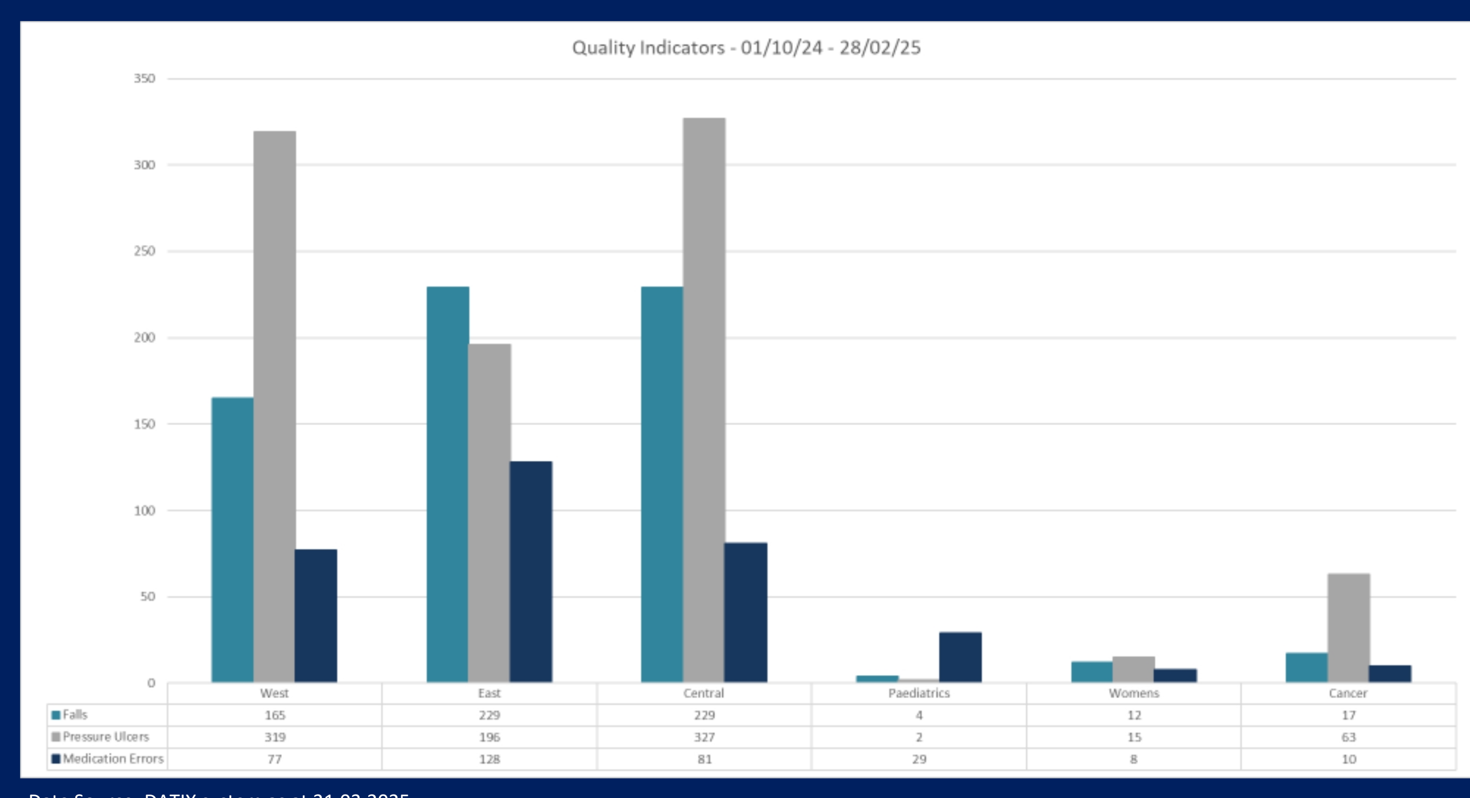
When calculating the nurse staffing level the quality indicators that are particularly sensitive to care provided by a nurse must be considered. These include patient falls, pressure ulcers and medication errors.

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

- patient falls
- pressure ulcers
- medication errors

which have been recorded within the DATIX system for the period 01/10/2024 – 28/02/2025.

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



	West	East	Central	Paediatrics	Womens	Cancer
Falls	165	229	229	4	12	17
Pressure Ulcers	319	196	327	2	15	63
Medication Errors	77	128	81	29	8	10

Date Source: DATIX system as at 21.03.2025

Nurse Staffing Levels Summary

The nurse staffing level calculations undertaken during the Spring 2025 reporting period (October 2024 – March 2025) FTE changes are summarised in the table below:

Integrated Health Community	Funded Bed Numbers	Unfunded Bed Numbers	Required Establishment at the start of the reporting period (September 24)		Required Establishment at the end of the reporting period (March 25)		Staffing FTE changes during reporting period (September 24 - March 25)		Funded* Establishment (as at March 2025)		FTE Variance between current funded and required (March 25)	
			RN	HCA	RN	HCA	RN	HCA	RN	HCA	RN	HCA
YMW	335	24	279.17	230.87	301.92	252.2	22.75	21.33	301.92	249.36	0	2.84
YGC	311	8	263.46	254.99	263.46	254.99	0	0	261.51	256.29	1.95	-1.3
YG	239	19	214.61	206.65	214.61	206.65	0	0	211.87	199.55	2.74	7.1
Womens Gynaecological	32	5	34.11	21.94	34.11	21.94	0	0	34.11	21.94	0	0
Oncology & Haematology	38	2	37.56	34.11	37.56	34.11	0	0	33.3	31.27	4.26	2.84
Paediatric Inpatient Wards	64	0	85.29	28.43	85.29	28.43	0	0	83.46	30.95	1.83	-2.52
BCUHB Total	**1019**	**58**	**914.2**	**776.99**	**936.95**	**798.32**	**22.75**	**21.33**	**926.17**	**789.36**	**10.78**	**8.96**

*Funded establishment sourced from Finance Ledger
**The additional establishment and staffing figures above demonstrate the requirements to permanently establish and recruit to the current unfunded bed base inclusive of a 26.9% headroom.
Note: The required and funded establishment figures exclude any additional staffing requirements needed to support the unfunded bed base, and also exclude the supernumerary ward manager and ward support staff i.e. housekeepers, dementia support workers etc.

Section 25B wards requesting a change to nurse staffing levels

During the spring 2025 reporting period (October 2024 – April 2025) two statutory calculations of nurse staffing levels have taken place, these being autumn 2024 (reported to Board in November 2024) and spring 2025 (to be reported to Board in May 2025).

Across both calculation periods 11 wards have requested changes to their establishments.

The changes proposed (identified in red) and those approved following review by the Executive Director of Nursing (identified in green) are summarised in the table opposite.

Review Period	IHC	Ward	Roster Period	Bed Numbers (Actual excluding Unfunded)	Current Staffing (at time of review)								Proposed Staffing (submitted by IHCs for EDoN Consideration)								Supported Staffing (following review by EDoN)							
					Early		Late		Twilight		Night		Early		Late		Twilight		Night		Early		Late		Twilight		Night	
					RN	HCA	RN	HCA	RN	HCA	RN	HCA	RN	HCA	RN	HCA	RN	HCA	RN	HCA	RN	HCA	RN	HCA	RN	HCA	RN	HCA
Autumn 2024	Central	Ward 2	7 Days	24	4	4	4	4	0	1	3	3	4	5	4	5	0	1	3	3	4	4	4	4	0	1	3	3
Autumn 2024	East	Pantomime	7 Days	21	4	3	3	3	0	0	2	2	4	3	4	3	0	1	2	3	4	3	3	3	0	1	2	2
Autumn 2024	West	Hebog	7 Days	27	5	5	5	5	0	0	3	3	5	5	5	5	0	0	4	4	5	5	5	5	0	0	3	4
Autumn 2024	West	Moelwyn	7 Days	28	6	4	6	4	0	0	4	4	6	5	6	5	0	0	5	5	6	4	6	4	0	0	5	4
Autumn 2024	West	Prysor	Mon - Fri	12 + 1 trolley	3	3	2	2	0	1	2	1	3	3	2	3	0	0	2	2	3	3	2	2	0	0	2	2
			Sat & Sun		3	2	2	2	0	1	2	1	3	3	2	3	0	0	2	2	3	2	2	2	0	0	2	2
Autumn 2024	West	Tegid Ward	7 Days	28	5	4	5	4	0	0	4	3	6	4	6	4	0	0	3	4	5	4	5	4	0	0	4	3
Autumn 2024	Cancer	Alaw	Mon - Fri	18	4	3	4	3	1	0	2	2	4	3	4	3	1	0	2	2	4	3	4	3	1	0	2	2
			Sat & Sun		3	3	3	3	1	0	2	2	4	3	4	3	1	0	2	2	3	3	3	3	1	0	2	2
Spring 2025	East	Arrivals	7 Days	26	3	2	3	2	0	0	2	2	5	3	5	3	0	0	3	3	5	3	5	3	0	0	3	3
Spring 2025	East	Morris	7 Days	27	4	4	4	3	0	0	2	4	4	5	4	4	0	0	3	5	4	5	4	4	0	0	3	4
Spring 2025	East	Pantomime	7 Days	27	4	3	3	3	0	1	2	2	5	4	4	4	0	0	3	3	5	4	4	4	0	0	3	3
Spring 2025	East	Prince of Wales	7 Days	27	3	3	3	3	0	0	2	2	4	4	4	4	0	0	3	3	4	4	4	4	0	0	3	3
Spring 2025	West	Hebog	7 Days	27	5	5	5	5	0	0	3	4	5	5	5	5	0	0	4	4	5	5	5	5	0	0	3	4
Spring 2025	West	Glaslyn Ward	Tues - Fri	26	4	6	4	5	0	0	3	4	5	6	5	5	0	0	4	4	4	6	4	5	0	0	3	4
			Sat - Mon		4	5	4	5	0	0	3	4	5	5	5	5	0	0	4	4	4	5	4	5	0	0	3	4
Spring 2025	West	Tegid Ward	7 Days	28	5	4	5	4	0	0	4	3	5	4	5	4	0	0	4	4	5	4	5	4	0	0	4	3
Spring 2025	Cancer	Alaw	Mon - Fri	18	4	3	4	3	1	0	2	2	4	3	4	3	1	0	2	2	4	3	4	3	1	0	2	2
			Sat & Sun		3	3	3	3	1	0	2	2	4	3	3	3	1	0	2	2	3	3	3	3	1	0	2	2

Section 25B wards requiring a change to nurse staffing levels

During the spring 2025 reporting period (October 2024 – April 2025) two statutory calculations of nurse staffing levels have taken place, these being autumn 2024 (reported to Board in November 2024) and spring 2025 (to be reported to Board in May 2025).

Across both calculation periods 11 wards have requested changes to their establishments. The changes approved following review by the Executive Director of Nursing, and the rationale for these, are summarised in the table below.

Integrated Health Community	Number of Act Wards	Number of Wards Requesting Adjustments	Adjustments Approved by Exec DoN	Comments	Funding Received?
YWM	14	4	4	Pantomime - HCSW staffing reconsidered during autumn 2024 due to patient care needs and harm profile. Further reviewed in spring 2025 following a decision by East IHC SLT to fully fund the wards 6 escalated beds in February 2025, with funded bed base increasing from 21 to 27.	Yes - staffing approved in spring 2025 has been fully funded by IHC
				Morris - staffing reconsidered in spring 2025 following a decision by East IHC SLT to fully fund the wards 6 escalated beds in February 2025, with funded bed base increasing from 21 to 27.	Yes - staffing approved in spring 2025 has been fully funded by IHC
				Prince of Wales - staffing reconsidered in spring 2025 following a decision by East IHC SLT to fully fund the wards 8 escalated beds in February 2025, with funded bed base increasing from 19 to 27.	Yes - staffing approved in spring 2025 has been fully funded by IHC
				Arrivals - staffing reconsidered in spring 2025 following a decision by East IHC SLT to fully fund the wards 10 escalated beds in February 2025, with funded bed base increasing from 16 to 26.	Yes - staffing approved in spring 2025 has been fully funded by IHC
YGC	13	1	0	-	-
YG	10	5	3	Prysor - HCSW staffing reconsidered during autumn 2024 review due to patient care needs	No - awaiting associated budget uplift to approved staffing levels
				Moelwyn - RN staffing reconsidered during autumn 2024 review due to NIV bed staffing requirements	No - awaiting associated budget uplift to approved staffing levels
				Hebog - HCSW staffing reconsidered during autumn 2024 review due to patient care needs.	No - awaiting associated budget uplift to approved staffing levels
Oncology & Haematology	2	1	0	-	-
Womens Gynaecological	3	0	-	-	-
Paediatric Inpatients Wards	3	0	-	-	-
BCUHB Total	**45**	**11**	**7**	**-**	**-**

Recommendations

- Continue to review the impact of nurse staffing levels within the clinical areas, observing workforce and quality metrics.
- Upon ratification ensure the Calculating Nurse Staffing Levels SOP is implemented across all nursing services.
- Continued focus on recruitment and retention and innovation to support workforce utilisation and reporting. The BCUHB People Strategy & Plan is an essential enabler, which is further supported by the All Wales National Workforce Implementation Plan; the subsequent Nurse Retention Plan and the Strategic Nursing Workforce Plan.
- In line with the Act and the Statutory Guidance approval of the nurse staffing calculations by the Executive Director of Nursing & Midwifery, as the designated person. This requires:
  - The budgets to be amended to reflect the approved rosters. During April 2025 the budgets will be uplifted to reflect the nurse staffing levels presented to Board in May 2024. Nurse staffing levels presented to Board in November 2024 remain unfunded at present.
  - The planned roster demand templates to be amended within the rostering system to reflect the approved rosters
  - Ward Managers will process the recruitment of staff, based on the revised nursing establishment (where applicable)
  - Ward Managers will display any changes to the planned roster on the ward boards displayed at the ward entrance

Diolch / Thank you

Any questions?

<table>
<tr><td>Teitl adroddiad:
Report title:</td><td colspan="4">QSE Committee – Quality Report</td></tr>
<tr><td>Adrodd i:
Report to:</td><td colspan="4">QSE Committee</td></tr>
<tr><td>Dyddiad y Cyfarfod:
Date of Meeting:</td><td colspan="4">1st May 2025</td></tr>
<tr><td>Crynodeb Gweithredol:
Executive Summary:</td><td colspan="4">This report provides the Committee with assurance, underpinned by analysis, on significant quality issues alongside longer-term data and information on the improvements underway</td></tr>
<tr><td>Argymhellion:
Recommendations:</td><td colspan="4">The Committee is asked to note this report</td></tr>
<tr><td>Arweinydd Gweithredol:
Executive Lead:</td><td colspan="4">• Angela Wood, Executive Director of Nursing and Midwifery (Lead Executive)
• Dr Sreeman Andole, Interim Executive Medical Director
• Teresa Owen, Executive Director of Allied Health Professionals and Health Science
• Dr Jane Moore, Acting Executive Director of Public Health</td></tr>
<tr><td>Awdur yr Adroddiad:
Report Author:</td><td colspan="4">• Patient Safety: Chris Lynes, Deputy Director of Nursing (Patient Safety) and Tracey Radcliffe, Head of Patient Safety
• Safeguarding: Michelle Denwood, Director of Safeguarding & Public Protection
• IPC: Andrea Ledgerton, Assistant Director of Infection Prevention and Decontamination
• Patient and Carer Experience, Mandy Jones, Deputy Director of Nursing (Patient Experience) and Leon Marsh, Head of Patient Experience
• Clinical Effectiveness: Dr Sreeman Andole, Medical Director (Clinical Effectiveness), and Joanne Shillingford, Head of Clinical Effectiveness
• Quality Assurance: Jo Kendrick, Head of Quality and Erika Dennis, Quality Lead Manager
• Healthcare Law: Matthew Joyes, Deputy Director for Legal Services and Debbie Kumwenda, Healthcare Law Lead Manager</td></tr>
<tr><td>Pwrpas yr adroddiad:
Purpose of report:</td><td>I'w Nodi
For Noting
☐</td><td>I Benderfynu arno
For Decision
☐</td><td colspan="2">Am sicrwydd
For Assurance
☒</td></tr>
<tr><td>Lefel sicrwydd:
Assurance level:</td><td>Arwyddocaol
Significant
☐
Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol

High level of confidence/evidence in delivery of existing mechanisms/objectives</td><td>Derbyniol
Acceptable
☐
Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol

General confidence / evidence in delivery of existing mechanisms / objectives</td><td>Rhannol
Partial
☒
Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol

Some confidence / evidence in delivery of existing mechanisms / objectives</td><td>Dim Sicrwydd
No Assurance
☐
Dim hyder/tystiolaeth o ran y ddarpariaeth

No confidence / evidence in delivery</td></tr>
<tr><td colspan="5">Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:
Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:</td></tr>
<tr><td colspan="5">There is confidence in the data provided in the report however, the pace of learning and improvement remains a key focus of work. This is being addressed through a range of measures including the actions aligned to Special Measures and the Board Assurance Framework.</td></tr>
</table>

Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	• Objective 4 - Improving quality, outcomes and experience • Objective 5 - Establishing an effective environment for learning
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	The Duty of Quality is a statutory requirement under the Health and Social Care (Quality and Engagement) (Wales) Act 2020. The statutory duty of quality requires the decision-making processes by the Health Board take into account the improvement of health services and outcomes for the people of Wales – the duty also includes new Health and Care Quality Standards. Instances of harm to patients may indicate failures to comply with the NHS Wales standards or safety legislation.
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	N/A
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	N/A
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR)***	BAF-SP18 and CRR-24-04 – Quality, Innovation and Improvement
Goblygiadau ariannol o ganlyniad i roi'r ***argymhellion ar waith*** ***Financial implications as a result of implementing the recommendations***	N/A
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	N/A
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	N/A
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	BAF-SP18 and CRR-24-04 – Quality, Innovation and Improvement
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	N/A
Camau Nesaf: Gweithredu argymhellion ***Next Steps: Implementation of recommendations*** N/A	
Rhestr o Atodiadau: ***List of Appendices:*** QSE Committee Quality Report Appendix 1: Clinical Audit Final Internal Audit report 2024-2025 Appendix 2: Clinical Audit Plan Tier 2 Audit (2025-2026) Appendix 3: PSOW Public Interest Report ID2087	

QSE Committee – Quality Report – May 2025
Reporting period – January – March 2025

INTRODUCTION

For the NHS in Wales, quality is considered to be defined as continuously, reliably, and sustainably meeting the needs of the population that we serve.

In achieving this, under the statutory Duty of Quality, Welsh Ministers and NHS bodies will need to ensure that health services are **safe**, **timely**, **effective**, **efficient**, **equitable** and **person-centred**. Underpinning these domains are six enablers, which are **leadership**, **workforce**, **culture**, **information**, **learning and research** and **whole-systems approach**.

These domains and enablers form the **Health and Care Quality Standards** for Wales introduced in April 2023 through statutory guidance.

This report provides the Committee with key quality related assurances, underpinned by analysis, on significant quality issues arising during the prior period alongside longer-term data and information on the improvements underway.

The report is structured around three components of quality: Patient Safety (including Safeguarding and Infection Prevention and Control), Patient and Carer Experience (including Complaints), Clinical Effectiveness, with a separate section covering Quality Assurance (including Healthcare Regulation) and Healthcare Law. This reflects the organisational management arrangements for quality leadership in the Health Board.

CONTENTS

INTRODUCTION 3
CONTENTS 4
PATIENT SAFETY 5
PATIENT SAFETY INCIDENTS 5
PATIENT SAFETY ALERTS 9
SAFEGUARDING & PUBLIC PROTECTION 9
INFECTION PREVENTION AND CONTROL 12
OTHER PATIENT SAFETY CONCERNS AND IMPROVEMENTS 15
PATIENT EXPERIENCE 15
COMPLAINTS 15
PATIENT FEEDBACK 20
PATIENT ADVICE LIASON SERVICE (PALS) 20
OTHER PATIENT EXPERIENCE CONCERNS AND IMPROVEMENTS 22
CLINICAL EFFECTIVENESS 24
CLINICAL AUDIT 24
NICE GUIDELINES 25
MORTALITY REVIEW 27
QUALITY ASSURANCE 31
HEALTHCARE INSPECTORATE WALES 31
CARE INSPECTORATE WALES 35
QUALITY PEER REVIEWS 36
HEALTH AND SAFETY EXECUTIVE / LOCAL AUTHORITY 37
PUBLIC SERVICES OMBUDSMAN FOR WALES 37
ORGANISATIONAL LEARNING 38
HEALTHCARE LAW 39
CORONER AND INQUESTS 39
LIABILITY CLAIMS 40
OTHER HEALTHCARE LEGAL MATTERS 41

PATIENT SAFETY

PATIENT SAFETY INCIDENTS

Incidents

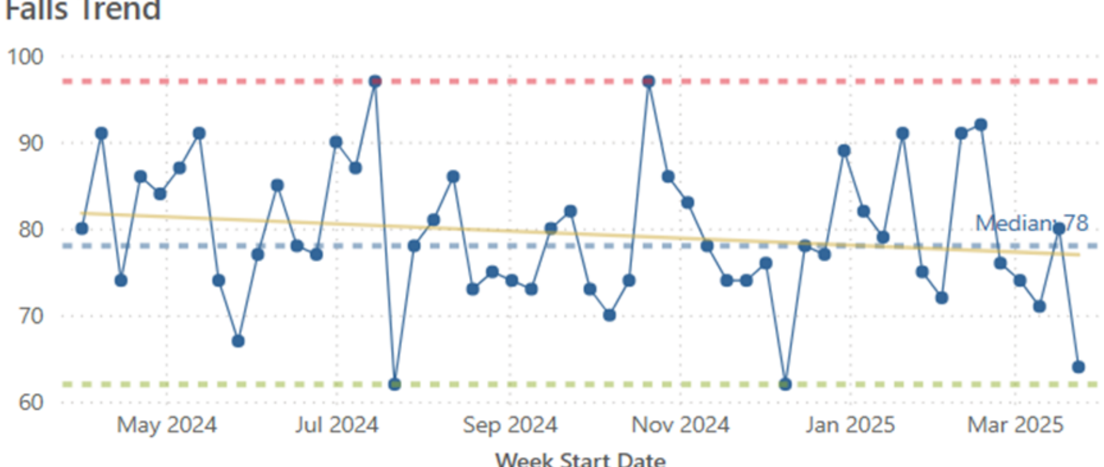
Currently, there are 5,226 open incidents, with 2,964 of these being overdue according to the process review timescales. This means that the total percentage of overdue incidents has now risen to 56%.

Previous workshops conducted across BCUHB, utilising SBAR and risk assessment methodologies, have contributed to a reduction in the backlog. IHC Central has completed and approved the agreed narrative, which is expected to significantly reduce the number of overdue incidents. At present, 38% of the total open incidents are attributed to IHC Central.

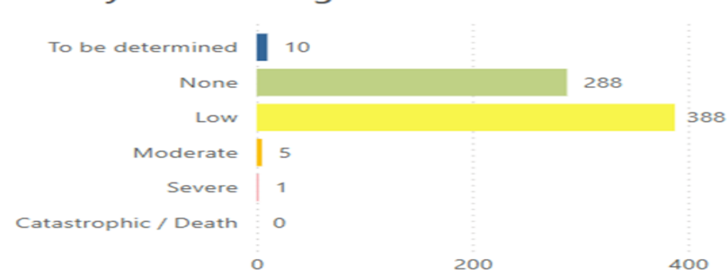
The Investigation Officer Training Programme has commenced, receiving positive feedback from the initial session. Additional sessions are scheduled for April and June. These measures are anticipated to lead to a marked improvement in the management and resolution of incidents.

Patient Falls

The chart below illustrates the number of patient falls reported across BCUHB each week over the past 12 months. The yellow line indicates a downward trend.



In January and February 2025, the patient falls listed below occurred, with the post-investigation level of harm indicated. "To be determined" signifies that the investigation or review is still ongoing.

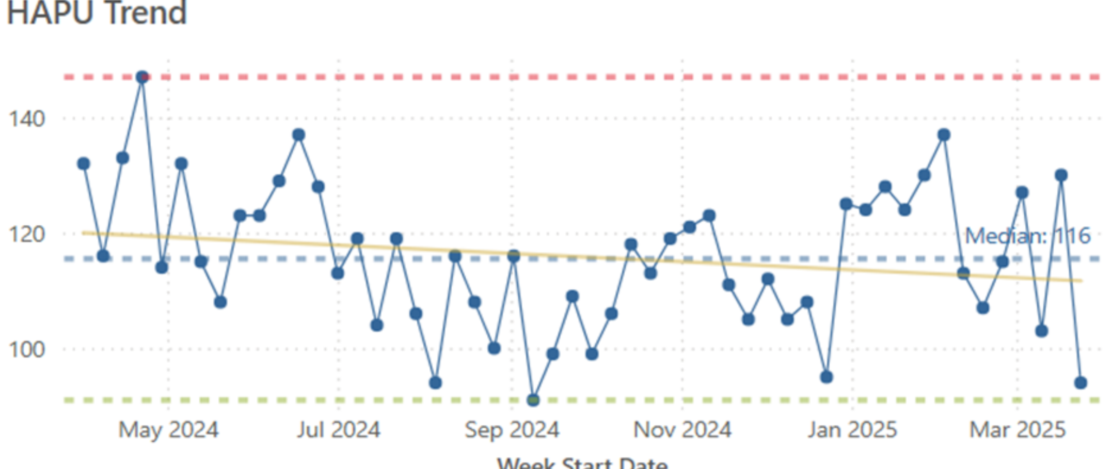


The Health Board Strategic Falls Group meets monthly, chaired by the Head of Patient Safety, with membership extended to representatives from all IHCs and divisions. The group also includes colleagues from Pharmacy, Medical, Health and Safety, and Safeguarding. IHC representatives share areas of good practice, common themes, lessons learned, and key elements of the Health Board improvement plan.

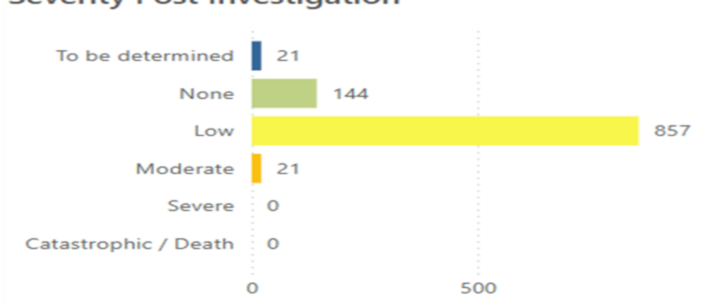
Natalie Lippitt, Ward Manager at Chirk Community Hospital, presented her improvement work on the thorough review of patient falls. Her presentation at the learning panels facilitates shared learning and conclusions. This will be put forward to be presented at the Organisational Learning Forum.

Pressure Ulcers

The chart below illustrates the number of healthcare-acquired pressure ulcers (HAPU) reported across the Health Board each week over the past 12 months. The yellow line indicates a downward trend.



In January and February 2025, the healthcare-acquired pressure ulcers listed below occurred, with the post-investigation level of harm indicated. "To be determined" signifies that the investigation or review is still ongoing.



The Core Level 1 mandatory training for pressure ulcer prevention and management has been developed and approved. This training is currently with the systems team and will be launched shortly.

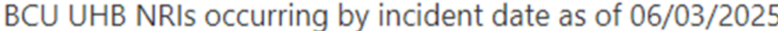
Further discussions with the PST and Quality Directorate are ongoing to explore adapting the Focused Review on the Datix system to the aSSKINg framework. Initial enquiries with other Health Boards across Wales indicate that they also duplicate the Focused Review and aSSKINg when completing the learning review. Initial steps have been taken to draft a form and to determine if this has been discussed within the All-Wales Group.

The All-Wales Pressure Ulcer Reporting and Guidance is still awaiting final approval from the All-Wales Tissue Viability Nursing Group. The chair of the group has not yet confirmed when this will be finalised. Efforts are actively underway to ensure these important guidelines are approved and implemented as soon as possible.

Nationally Reportable Incidents

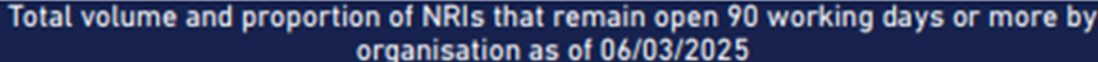
From 1st January 2025 to 28th February 2025, there were 21 National Reportable Incidents (NRIs) recorded by incident date, compared to 31 in the previous reporting period. A total of 83 notifications were submitted. As highlighted in previous reports, notifications for pressure damage and falls occur following a review and discussion at local investigation meetings, where the occurrence is deemed to be avoidable.

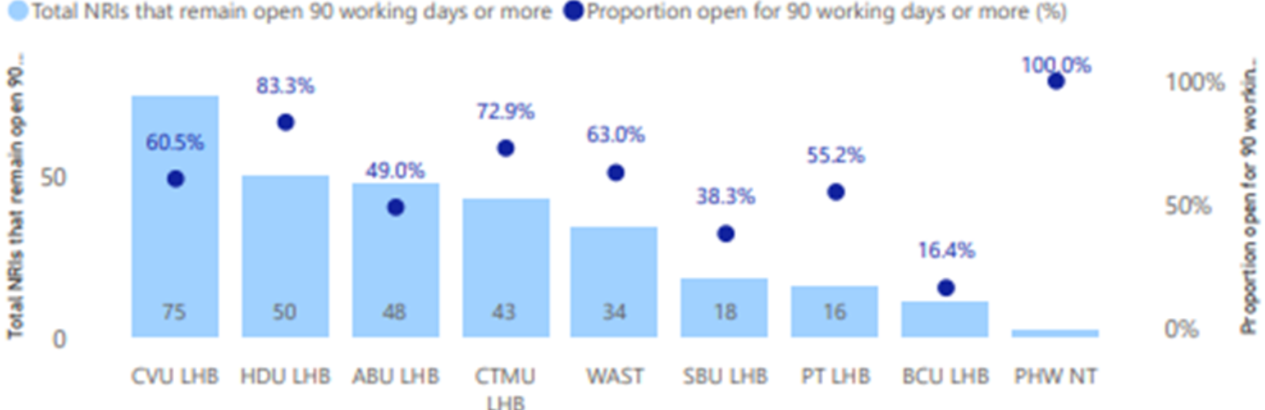
Efforts are actively underway to ensure continuous improvement in incident management and reporting. The focus remains on identifying avoidable incidents and implementing measures to prevent recurrence, thereby enhancing patient safety and care quality.



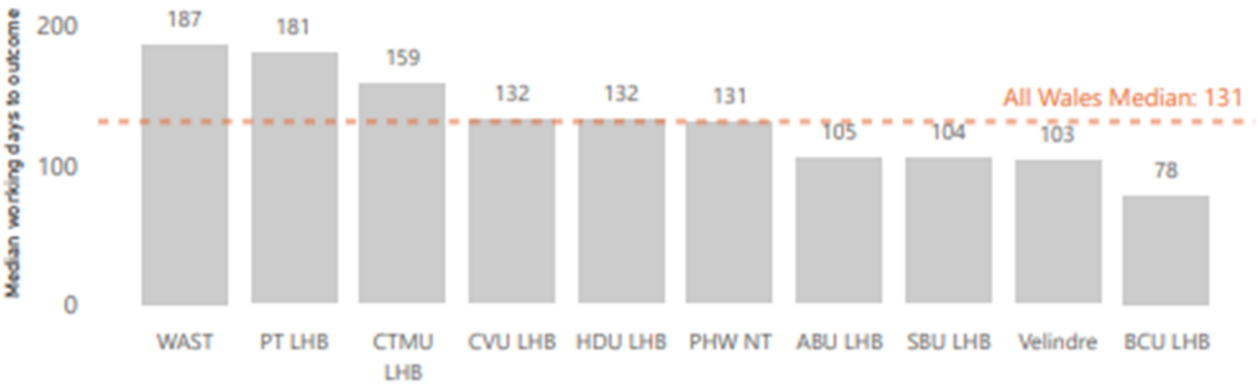
As of the end of February 2025, there were 54 open NRI investigations, with 4 overdues for closure. The proportion of NRIs remaining open for more than 90 days continues to improve and is now the best across Wales. The Health Board has reduced the percentage of cases taking longer than 90 days to 16.4%, down from 19.2% in the previous reporting period.

These improvements reflect ongoing efforts to enhance the efficiency and effectiveness of incident investigations, ensuring timely resolution and better patient outcomes.





Median working days to incident category NRIs investigation completion (includes ongoing open incidents as working days since date reported to NHS Executive) for all NRIs excluding pressure ulcers to date by organisation (as of 06/03/2025)



Closures – Outcome forms submitted to NHS Wales Executive

In January and February 2025, a total of 83 NRI Outcome forms were submitted to the NHS Wales Executive. Of these, 54 forms related to pressure damage and patient falls, while the remaining forms covered other incident categories.

Further details and insights can be found in the confidential quality report.

Never Events

No Never Events were reported in January or February 2025. However, one Never Event occurred in March 2025, which will be included in the next reporting period.

Oxygen Administration Improvement

Incidents where the main handwheel on portable cylinders has not been opened continue to occur. The Welsh Government is responding to the North Wales HMC's request for all Health Boards to review similar incidents. Once for Wales is assisting with data collection, which will be returned to the Health Board for validation.

The oxygen cylinder training for healthcare professionals is now live on ESR, marking a significant step forward in addressing this issue. BOC is progressing with the development of a single valve cylinder, anticipated to be available this summer, although there may be cost implications.

The 'No Flow Oxygen Improvement Group' continues to meet monthly to address key issues and identify further areas for improvement, aiming to reduce associated risks and enhance patient safety.

PATIENT SAFETY ALERTS

Women's Services are currently addressing the risk of oxytocin overdose during labour and childbirth, as outlined in PSA018. Womens Services have been diligently working towards meeting the compliance deadline of 31st March 2025. The Health Board can report compliance has been successfully submitted, demonstrating a strong commitment to patient safety and the well-being of mothers and babies.

SAFEGUARDING & PUBLIC PROTECTION

Safeguarding training remains a key priority for the Health Board and the Safeguarding and Public Protection Team. The Safeguarding Team continue to proactively update and review training packages in light of audit, findings from Safeguarding Reviews and best practice.

In addition, the Safeguarding Team are working with Workforce and Organisational Development (WOD) Systems Teams to individually report Level 2 and Level 3 compliance data. Progress has been made, and the revised data reporting remains in its infancy.

We recognise this will have an impact upon reporting of the compliance data. However, this enables us to report and act as a result of accurate compliance data, and target intervention against quality and performance with a proactive approach.

BCUHB Violence Against Women, Domestic Abuse and Sexual Violence [VAWDASV] Training compliance

Safeguarding Compliance Trend December 2024 to February 2025

Safeguarding Module	Dec-24	Feb-25	Trajectory
MCA – Level 1	83.1%	84.0%	↑
MCA – Level 2	82.1%	83.0%	↑
Safeguarding Adults – Level 1	86.2%	86.6%	↑
Safeguarding Adults – Level 2	85.3%	85.7%	↑
Safeguarding Children – Level 1	86.2%	86.8%	↑
Safeguarding Children – Level 2	84.9%	85.6%	↑
VAWDASV	75.4%	76.2%	↑

Activity

- Primary care sessions across the region are arranged for June 25 and are targeting GP practices and GP's.
- Training for commissioned services for the palliative care sector including hospice staff in 2 regions has taken place.
- The Welsh Government [WG] Ask & Act Champions Training [Group 3], which form part of the WG Violence Against Women, Domestic Abuse and Sexual Violence [VAWDASV] National Training Framework, has been disseminated and a programme of training dates are taking place throughout year.
- We continue to see an improved compliance position and target high risk areas or those with reduced compliance.

Implementation of ICON:

The Safeguarding and Public Protection Team successfully secured funding from the North Wales Safeguarding Board to implement ICON across the Health Board with a vision to promote the key principles on a multi-agency footprint.

ICON is an evidence based public health initiative to prevent Abusive Head Trauma (AHT) in babies and young children, thus reducing death and serious injury leading to long term disability.

Single Unified Safeguarding Reviews have identified a theme of Abusive Head Trauma in children and recommend the implementation of an evidence-based initiative to prevent future deaths due to AHT.

The launch date will be during Safeguarding Week in November 2025 with full support of the North Wales Safeguarding Board and a Task and Finish Group is in place to support full implementation. Once implemented, this will replace the existing Health Board's Coping with Crying Guidelines.

The ICON programme consists of a series of 'touchpoint' interventions that reinforce the messaging making up the ICON acronym.

- **I**nfant Crying is normal, and it will stop.
- **C**omfort methods can sometimes soothe the baby and the crying will stop.
- It's **O**K to walk away if you have checked the baby is safe and the crying is getting to you.
- **N**ever ever, shake or hurt your baby.

Domestic Abuse Screening Tool

The new Domestic Abuse Screening Tool (DAST) was devised by a small working group within the Safeguarding and Public Protection Team; with consultation with the third sector Domestic Abuse support agencies within North Wales (DASU and Gorwel). This was a result of a consultation process, and it was determined that the current Tool, used on a multi-agency basis did not meet the modern aspects and risks now associated with domestic abuse.

The new Tool was ratified at the Safeguarding, Governance and Performance Group in July 2024 and has received excellent feedback from the National VAWDASV Steering group with a view to being replicated in other Health Boards across Wales.

The Tool was translated into Welsh and officially launched during Safeguarding Week in November 2024.

The Tool received excellent feedback from members of the North Wales Vulnerability and Exploitation Board with Local Authorities keen to look at using the Tool within Social Work practice. The comprehensive Implementation Plan is informing activity and next steps which will include an audit and review to provide assurance against process and implementation.

Domestic Abuse Protection Orders (DAPO) / Domestic Abuse Protection Notices (DAPN)

DAPO/DAPN is a 'pilot' project that is taking place in North Wales, the lead agencies are North Wales Police (NWP), the Home Office (HO), and the Ministry of Justice (MoJ), the activity is related to the Statutory Guidance which was published in November 2024.

BCUHB Safeguarding and Public Protection Team and colleagues from Mental Health and Learning Disability services are fully engaged to support the implementation of the key principles of the pilot and activities which will impact upon clinical practice.

Deprivation of Liberty Safeguards (DoLS) paperwork improvement

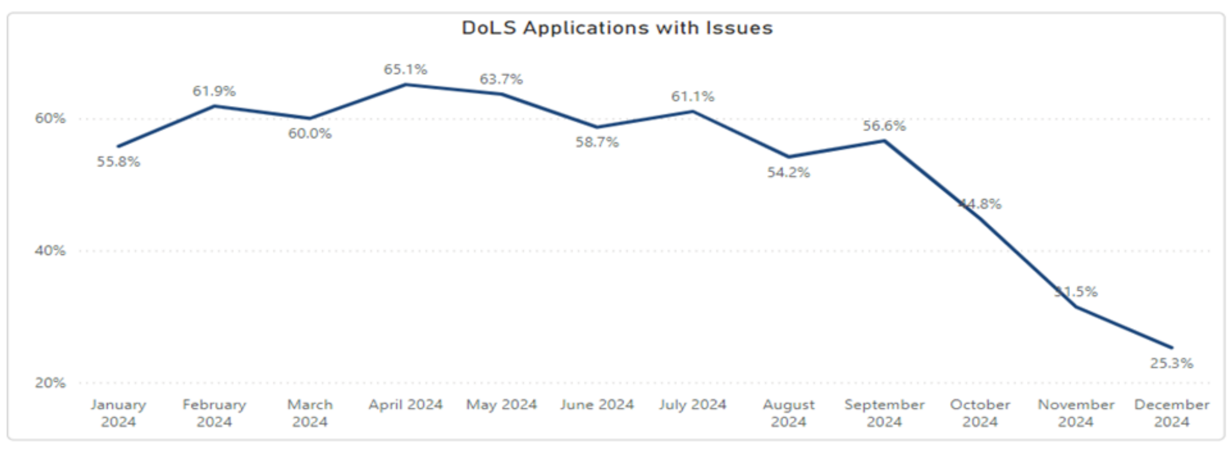
An independent audit undertaken by the NHS Wales Shared Services Partnership Audit and Assurance Services included a review of 573 DoLS applications. The submitted DoLS paperwork on a whole, is of high quality but continued to demonstrate minor errors.

To address the findings of the audit, on receipt of the DoLS Applications, a quality assurance activity takes place and if any areas of improvement are required, immediate steps are taken by the Supervisory Body [DoLS Team] to educate the reporter to correct the documentation. This immediate support improves learning and the implementation of good practice.

Analysis

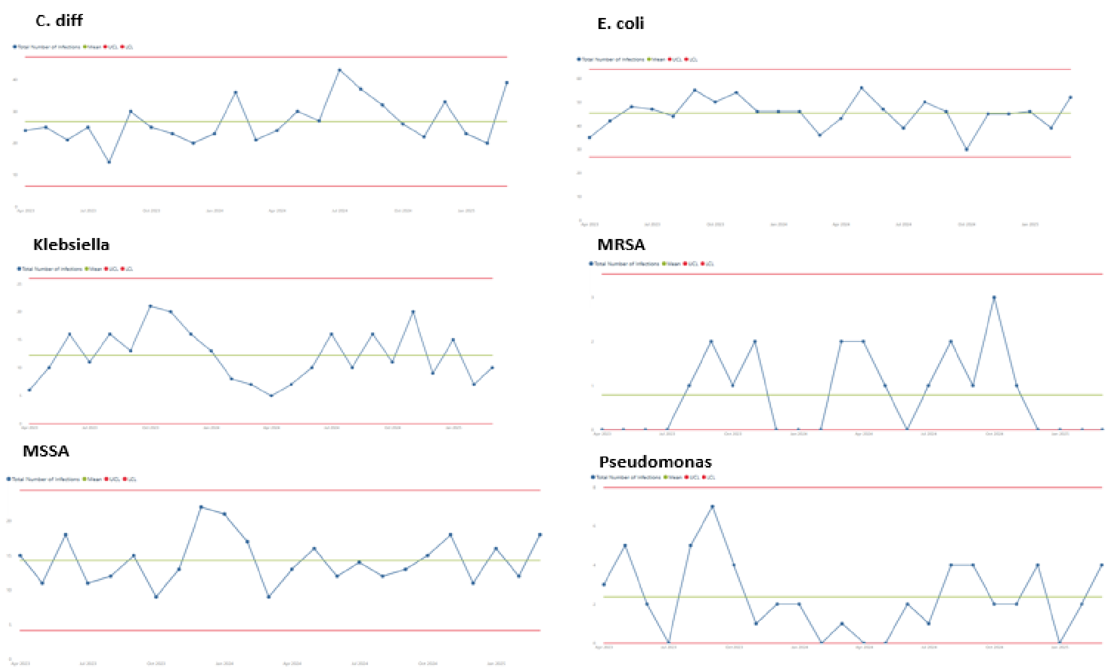
Of all the applications that recorded issues during 2024-25, all of them were rectified within the legislatively approved timeframe. Most of the issues from the applications continue to be minor with minimal amendments required. During December 2024, 25.3% of the applications received were noted to have required improvements. This is a further decrease when compared to November when 31.5% of the applications recorded issues. Errors have reduced by over 50% during 2024-25. Further reporting and auditing remain in place.

This improvement is attributed to the additional WG resource which has enabled enhanced training capacity and greater on-site visibility.



INFECTION PREVENTION AND CONTROL

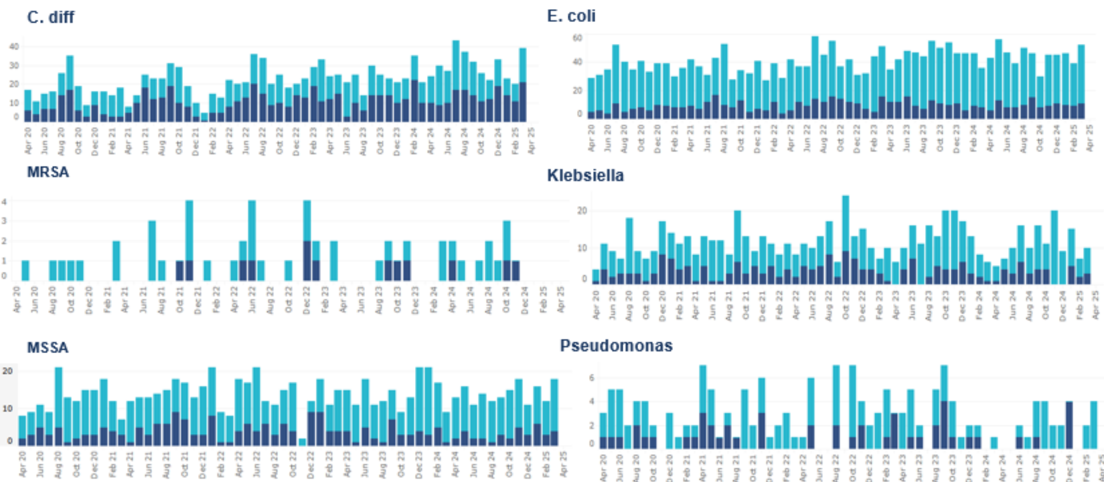
The graphs below illustrate the number of overall infection cases (both community and hospital onset) reported for each of the six key performance indicators during January, February, and March 2025. When compared to Quarter 3 data, there is an improvement in cases of C. difficile, MRSA, Klebsiella, and Pseudomonas. The number of MSSA cases has remained the same, while there has been a decline in E. coli cases.



Performance Indicator	Quarter 3 (total)	Jan 2025	Feb 2025	March 2025	Quarter 4 (total)
C. diff	91	23	20	39	82
MRSA	4	0	0	0	0
MSSA	46	16	12	18	46
E. coli	120	46	39	52	137
Klebsiella	40	15	7	10	32
Pseudomonas	8	0	2	4	6

The graphs and table below provide a comparison of the community onset and hospital onset six key performance indicators during January, February, and March 2025, which can be compared to Quarter 3 2025. Improvements in hospital onset cases are demonstrated in C. Difficile, MRSA, and Pseudomonas, while an increase is reported for MSSA, E. coli, and Klebsiella. For community onset cases, improvements are shown in C. Difficile, MRSA, MSSA, and Klebsiella, with Pseudomonas remaining the same, and an increase reported in E. coli.

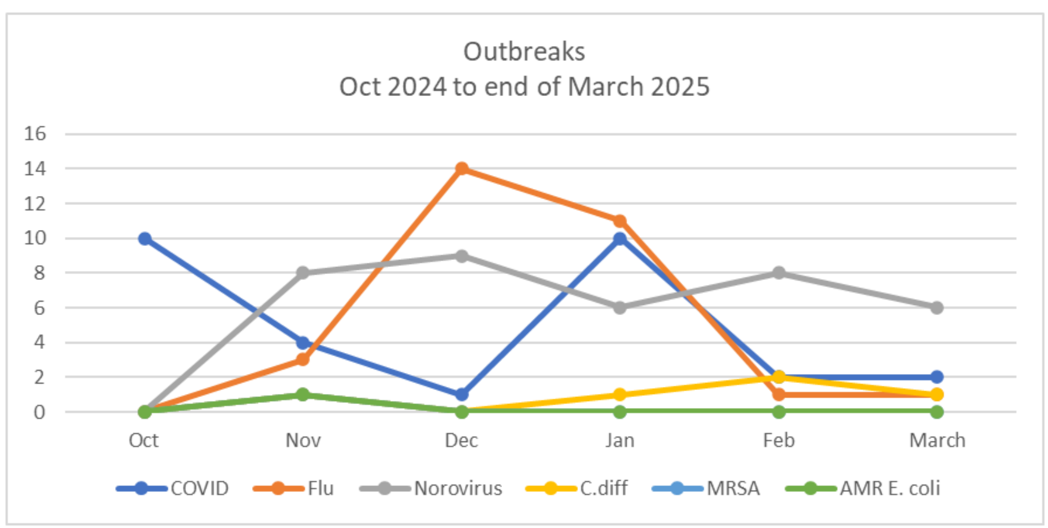
Performance Indicator	Quarter 3 2024 (total)		Jan 2025		Feb 2025		March 2025		Quarter 4 2025 (total)	
	H/O	C/O	H/O	C/O	H/O	C/O	H/O	C/O	H/O	C/O
C. diff	52	39	14	9	11	9	21	18	46	36
MRSA	2	2	0	0	0	0	0	0	0	0
MSSA	12	34	6	10	3	9	4	14	13	33
E. coli	28	92	10	36	9	30	11	41	30	107
Klebsiella	4	36	5	10	2	5	3	7	10	22
Pseudomonas	4	4	0	0	0	2	0	4	0	4



End-of-year data and performance against the WHC 2024/2025 HCAI Improvement goals are now available. Following presentation to the Strategic Infection Prevention Group (SIPG) on 17th April 2025.

The table below details the number of outbreaks reported during January, February, and March 2025, which can be compared with Quarter 3. BCUHB experienced an increased number of outbreaks with increasing bed days lost for Flu, Norovirus, and C. diff. Outbreaks and bed days lost due to COVID were fewer, with no further outbreaks of MRSA or AMR E. coli reported.

Infection	Quarter 3		Jan 2025		Feb 2025		March 2025		Quarter 4	
	No. of Outbreaks	Bed days	No. of Outbreaks	Bed days	No. of Outbreaks	Bed days	No. of Outbreaks	Bed days	No. of Outbreaks	Bed days
COVID	21	102	10	16	2	6	2	3	14	25
Flu	18	32	22	33	2	3	2	20	26	56
Norovirus	17	98	6	69	8	56	9	6	23	131
C.diff	1	4	2	18	2	25	1	10	5	53
MRSA	1	5	0	N/A	0	N/A	0	N/A	0	N/A
AMR E. coli	1	4	0	N/A	0	N/A	0	N/A	0	N/A
Total	59	245	40	136	14	90	14	39	68	265



Actions to address the challenges associated with Infection Prevention and Control

Following a supportive peer review conducted in December 2024 by the Healthcare Associated Infection, Antimicrobial Resistance and Prescribing Programme (HARP) Team, a report was received in March 2025. From this report, the Deputy Director of Infection Prevention and Decontamination has developed a detailed action plan to be endorsed by the Executive Team, addressing the recommendations made throughout the report.

The Infection Prevention Team (IPT) attended their annual away day in March 2025, which allowed them to focus on developing their annual programme of work, including a proactive audit programme that commenced on 1st April 2025.

By the end of April 2025, the IPT will have developed an annual Programme for High-Level Disinfection based on C. diff risk and bioburden for the acute and community hospitals. Progress with this will be monitored through the Local and Strategic Infection Prevention Groups.

East IHC has had its 6-month IPC Learning Review, demonstrating improvement in many indicators and illustrating specific areas needing focus. Central IHC will have its review in May, and West in July. High-level improvement plans from each IHC are focused on exploring solutions to address:

- Decant availability to address reactive and proactive High-Level Disinfection
- Capacity and flow challenges to support prompt isolation
- Cohorting availability when isolation is not possible

Directorate improvement plans have been developed and are focussing on ‘quick wins’ to further demonstrate improvement around the management of invasive devices, ANTT, prescribing, hand hygiene practices and cleaning.

The IPT are working with the university to participate in a Population Health module which will target District Nurses. The IPT would like to focus healthcare practices in the community impacting on community onset infections (particularly blood stream infection).

The next phase of the HABITS campaign will be presented to SIPG in May 2025, with a patient and public facing element to the campaign.

OTHER PATIENT SAFETY CONCERNS AND IMPROVEMENTS

BCUHB commenced treating cancer patients with a new class of bi-specific antibody therapies in the week beginning 10th February 2025.

Bi-specific antibody treatments have been found to be effective and well-tolerated, signifying a new era in cancer treatment options.

It is crucial to recognise that this new class of cancer treatment is associated with toxicities not seen in other systemic anti-cancer therapies. Prompt identification and management are essential to safely achieve this new milestone in cancer treatment.

Dr Heartin, a leading member of the bispecific implementation group, stated, "It is immensely gratifying to introduce bi-specific treatment in North Wales. This will transform the landscape of cancer treatment in both Haematology and Oncological cancer. I am deeply appreciative of the bi-specific group who have worked tirelessly over the past year to enable us to offer T-cell engager therapy to our patients in North Wales."

To minimise the risk from toxicities, bi-specific antibodies will be initiated for our patients within an inpatient setting, supported by a robust haematology or oncology on-call rota. It is important to note that cytokine release syndrome (CRS) and immune effector cell-associated neurotoxicity syndrome (ICANS) can occur after discharge and may present at their local emergency department. We have ensured adequate stock of tocilizumab within ED on all BCUHB sites, on Alaw and Enfys wards, and within the emergency drug cupboards. The ITU has also been involved, and education has been pivotal.

Measures have been implemented to ensure that patients are well-informed about the risks of CRS and ICANS. To help identify patients on bi-specific treatment, they will be provided with wristbands, and flags will be placed on Welsh Clinical Portal (WCP) and Symphony when patients are initiated on bi-specific antibodies.

PATIENT EXPERIENCE

COMPLAINTS

Complaint's position as of 31st March 2025

Total Number of open complaints – 217 (an increase from 165 in the previous reporting period)

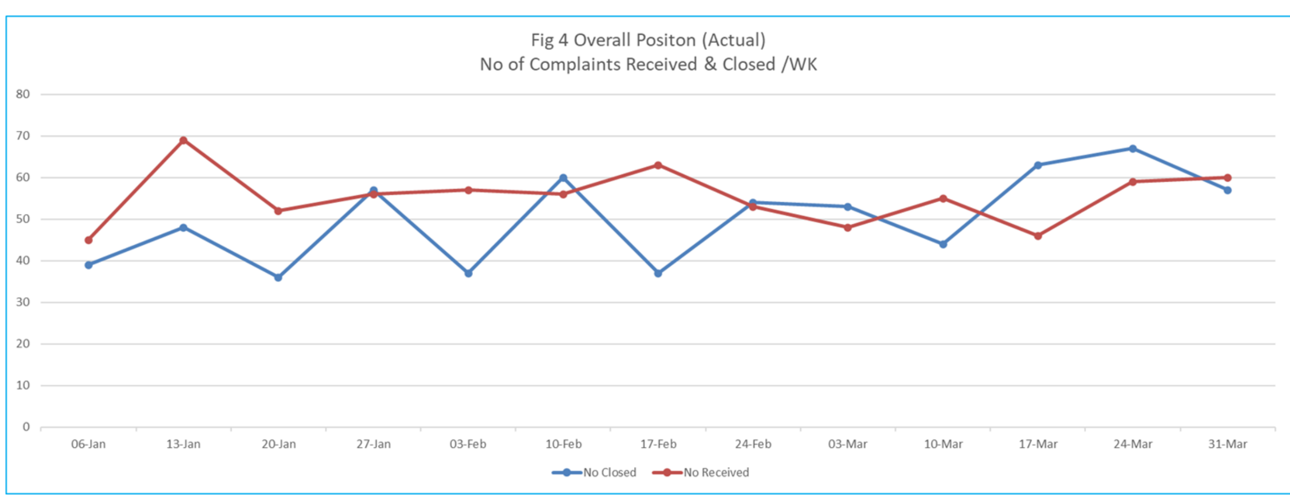
Number of Complaints Less than 30 working days = 170
Number of Complaints overdue = 47
Compliance with 75% target of overdue complaints – 78.34% (an increase from 73.94% in the previous reporting period, and above 75% target)

Compliance Breakdown by IHC / Service as of w/c 31st March 2025

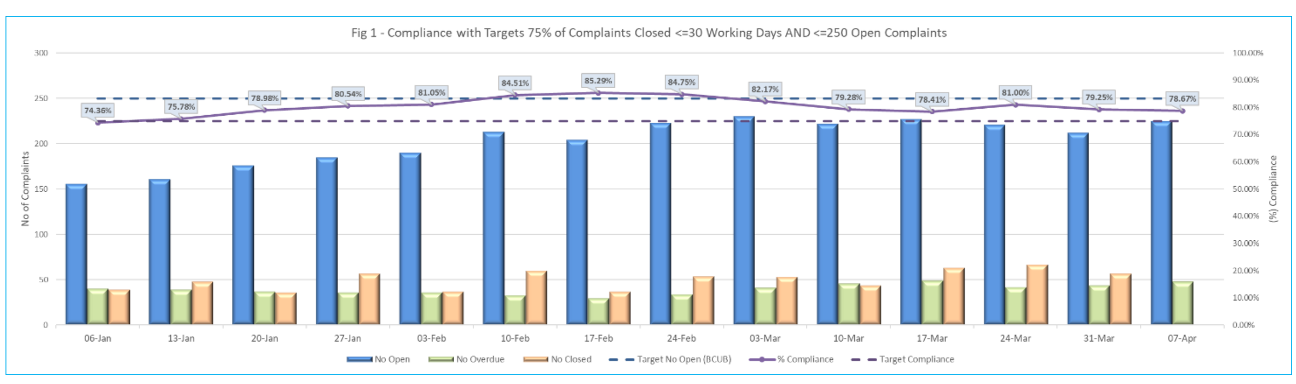
IHC/Service	<=30 Days	>30 Days	Total	(%)
Cancer Services	1	3	4	25.00%
Corporate Services	4	1	5	80.00%
Diagnostics and Specialist Clinical Support Services	5	2	7	71.43%
IHC Central	39	16	55	70.91%
IHC East	51	12	63	80.95%
IHC West	43	2	45	95.56%
Mental Health and Learning Disabilities	11	0	11	100.00%
Midwifery and Women's Services	16	11	27	59.26%
Total	**170**	**47**	**217**	78.34%

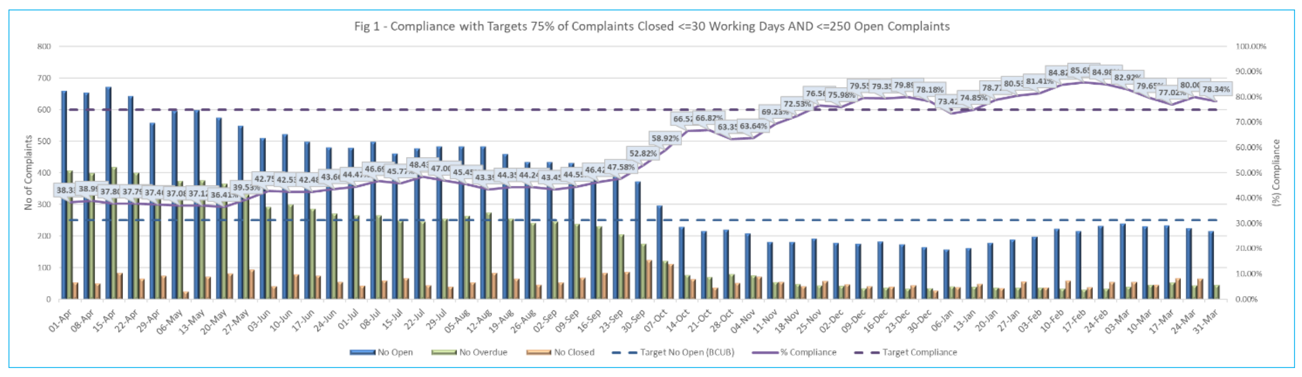
Between the 1st January and 31st March 2025, the BCUHB received 731 complaints and closed 666 complaints, a negative variance of 65.

The chart below provides further detail



2024 – 2025 - Q4 – Total Complaints / Overdue / Compliance





1ST April 2024 to 31st March 2025 – Performance Improvement (A year in Focus)

Between 1st April 2024 and 31st March 2025

The BCUHB received, 2683 complaints:

The BCUHB resolved and closed 3139 complaints

Positive variance = 456

Real Time performance complaint closure performance

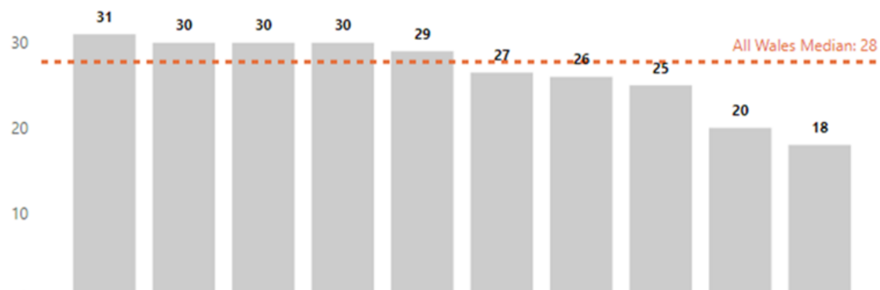
Note: All complaints within the BCUHB are given a 30- working daytime frame aligned to PTR, regardless of the complexity of the complaint.

30 working day PTR Performance (Up to January 2025) - Source National Beacon dashboard.

The average time for a complaint to be closed after being received by the BCUHB is 20.92 working days (Including legacy backlog complaints).

The median closure rate time for the BCUHB IS 26 working days (2 days below the national median average) and 4 days below the PTR guidelines.

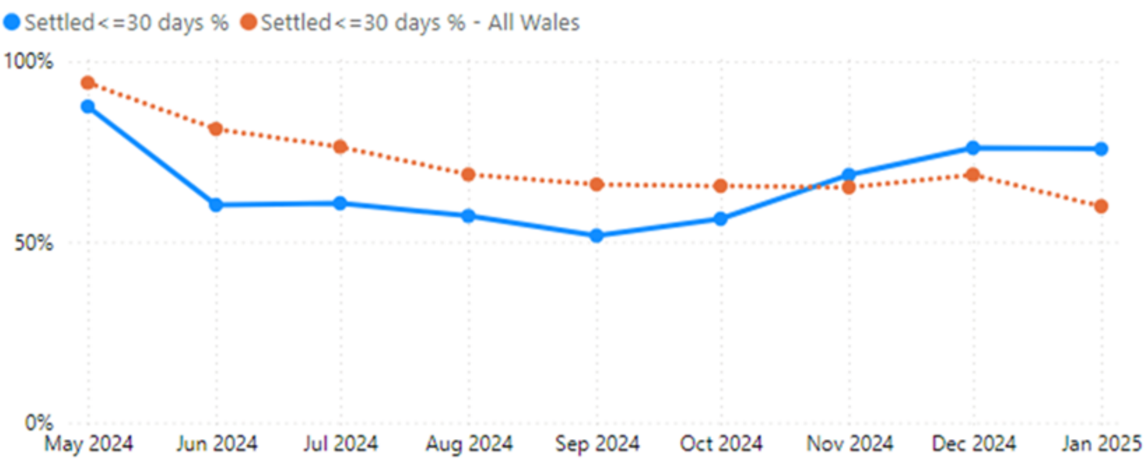
All Wales - Median working days for a response (includes still open co...



Current Performance (up to January 2025) - National Beacon Dashboard

There has been an improvement in the % of complaints settled within the 30-working day PTR timeframe by month of response and for three consecutive moments higher than the Welsh national average (highlighted in green).

Month / Year	% Of complaints closed (BCUHB)	% Of complaints closed (National)
November 2024	68.56%	65.13%
December 2024	76.02%	68.64%
January 2025	75.76%	59.85%



Complaints Overdue by length of time overdue (Long standing complaints)

PTR guidelines states complainants should receive a response within 30 working days to their concerns, with the target set by Welsh Government that 75% of complaints should be responded to within that time frame, allowing discretion for complaints that are complex or awaiting expert opinion.

An important metric in relation to patient experience, the table below outlines the current BCU position and national position.

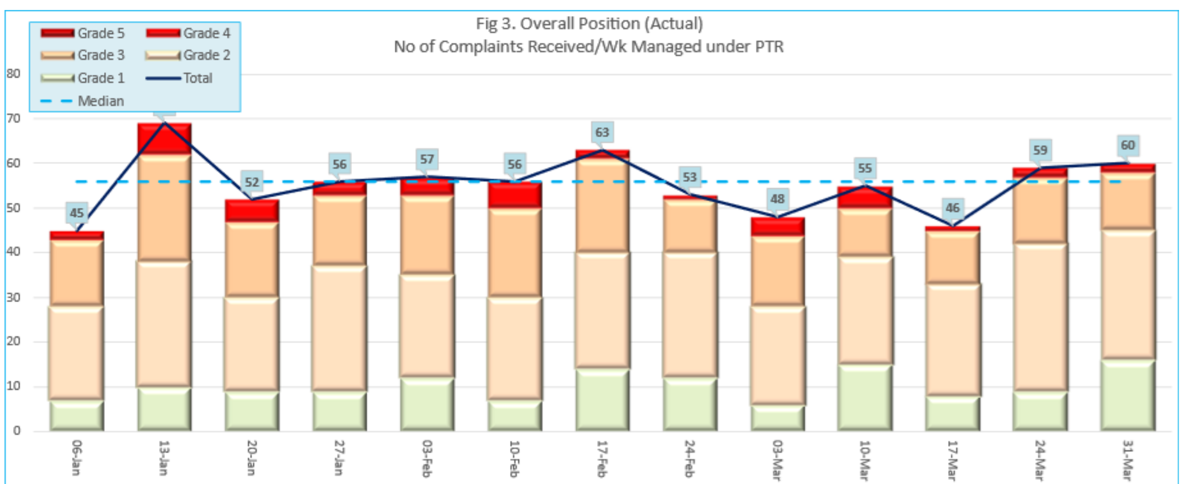
(Source Beacon Dashboard up to and Including January 2025)

All Wales - Open concerns than are now overdue - by time overdue

Organisation	<90 Days	90 to 180 Days	180 to 270 Days	270 to 365 Days	Over 365 Days
ABU	98	109	42	12	2
BCU	47	14			
CAV	64	39	5	2	
CTM	143	135	112	18	
DHCW		1			
HDU	75	84	65	31	17
PHW	1				
SBU	58	59	39	20	10
VEL	1				
WAST	55	19	5	2	1
Total	**542**	**460**	**268**	**85**	**30**

The Corporate Complaints Team are supporting Integrated Health Communities (IHC) and Divisions to monitor and track complaints as part of targeted performance and quality improvement, since April 2024, with the objective to further reduce the number of overall complaints, and those that fall overdue, this includes the introduction of a real time quality dashboard pertaining to complaints performance.

We have seen an increase in the volume of complaints within the BCUHB, (averaging 56) per week in the first 13 weeks of 2025, an increase from an average of 48 in the previous 3 months.



However, performance relating to complaint closures within 30 working days has been maintained, and the number of complaints falling overdue has remained consistent, and low as a proportion of the total number of complaints when comparing nationally, indicates the complaints management system at the BCUHB is robust, and able to cope with seasonal variations and demands, to provide timely resolutions to patients when things go wrong.

Themes and trends of complaints

Our top four themes of complaints are as follows

- Clinical Treatment / Assessment
- Communication Issues (including Language)
- Medication
- Attitude and Behaviour

These four themes account for 80.00% of total BCUHB complaints (180/225).

Out top three sub themes are

- Delay / Lack of treatment assessment (62 complaints)
- Incorrect / Insufficient treatment or assessment (35 complaints)
- Communication with Patient / Service User (21 complaints)

PATIENT FEEDBACK

PATIENT ADVICE LIASON SERVICE (PALS)

From 1 January 2025 – 31 March 2025, the Patient Advice and Liaison Service (PALS) facilitated the resolution of 1712 enquiries, received 80 compliments in writing and 39 suggestions for improvement. PALS took on average 6.27 working days to resolve an enquiry.

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

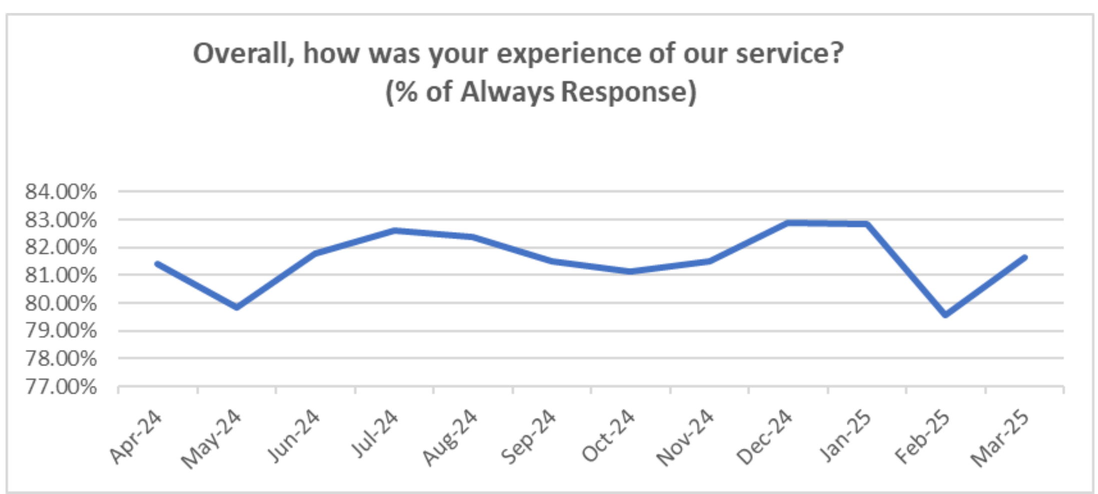
- Appointments
- Clinical treatment or assessment
- Communication

PALS continue to work closely with the 3 P's Waiting List Support Service to support patients who are on a Health Board waiting list with enquiries around their length of wait for treatment, and to provide them with signposting and support to help them keep well whilst waiting.

Patient Feedback

From 1 January 2025 – 31 March 2025, 11879 All Wales Real-Time Patient and Carer Feedback Survey responses were received via Civica feedback system.

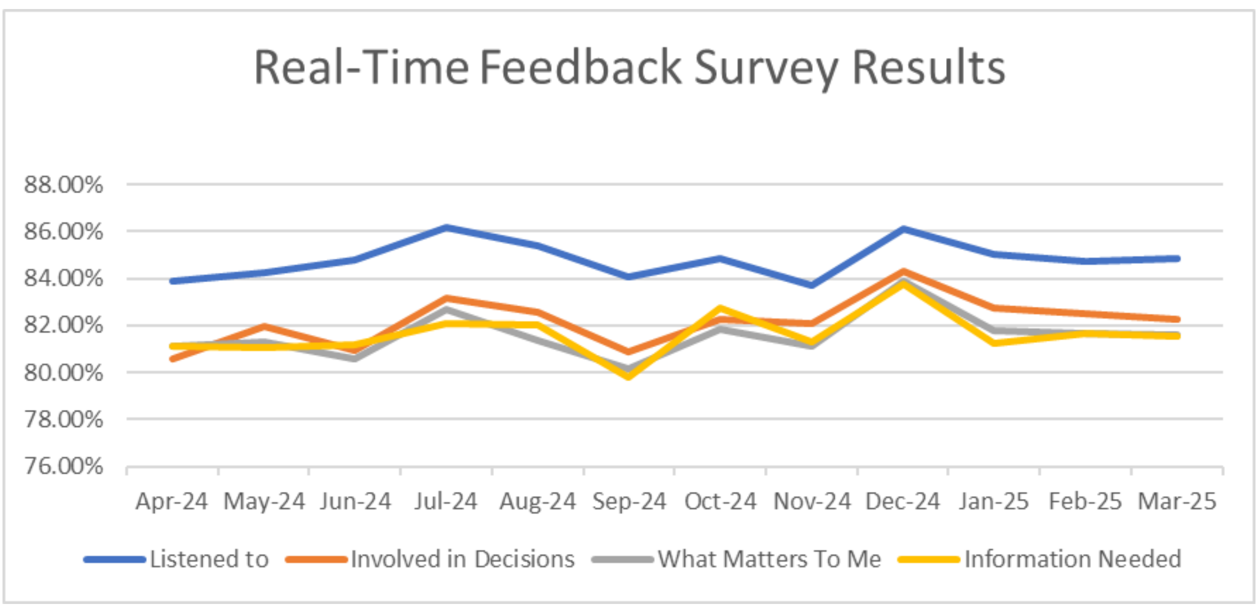
The Health Board continues to make positive progress to achieve the All-Wales satisfaction benchmark of 85%. In March 2025, 81.66% of respondents were 'very satisfied' with their overall experience of accessing Health Board services.



Below are key findings from the All-Wales Real-Time Patient and Carer Feedback Survey within the reporting period:

- 81.70% of staff 'always' introduced themselves
- 81.64% of respondents were 'always' given all the information needed
- 82.53% of respondents were 'always' involved in decisions about care
- 84.87% of respondents 'always' felt listened to
- 81.84% felt staff 'always' took the time to understand what matters to them

Within the reporting period patients reported increased satisfaction in ‘always’ feeling listened to (84.87%).



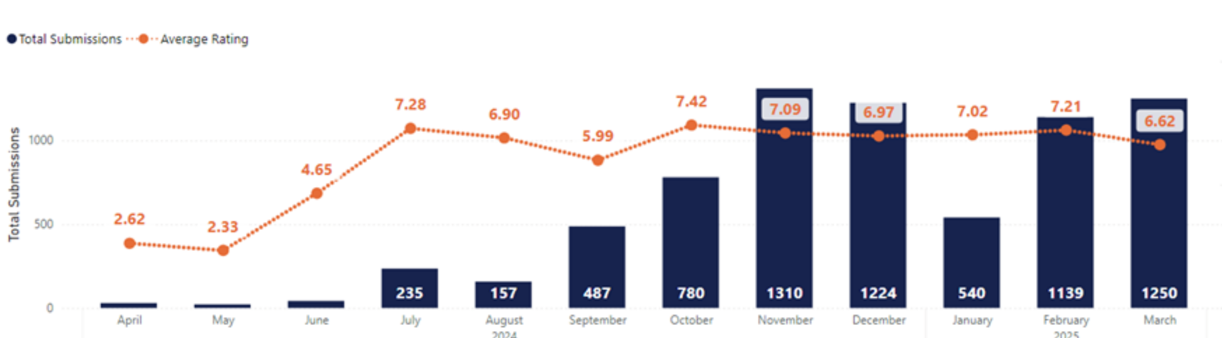
What people said was good about their experience:

- ‘Doctor and nursing staff were all very open and approachable. I had some questions which were answered clearly, and I appreciated their willingness to provide me with information’ (Colwyn Bay Hospital Outpatients).

- ‘My consultant explained my results and ongoing care. I was introduced to my specialist nurse who is monitoring me. She listened to me and discussed personal issues I have and referred me for extra support. My ongoing monitoring was fully explained to me. I feel confident about my care and support’ (Wrexham Maelor Hospital, Shooting Start Unit).

- ‘A lovely, friendly, accepting ward. Everything was explained as far it was at all possible. I am very shy and yet I felt completely at home’ (Conwy Ward, Ysbyty Gwynedd).

From 1 January 2025 – 31 March 2025, 3249 Emergency Department feedback survey responses were collected via Civica feedback system. In March 2025 respondents rated their overall experience of accessing Health Board services as 6.62 out of 10, with 10 being excellent (Beacon Dashboard 10/4/2025).



Below are key findings from the All-Wales Real-Time Emergency Department Feedback Survey:

- 58.81% of respondents 'always' felt well cared for
- 33.56% of respondents felt they waited shorter than expected
- 58.08% of respondents 'always' understood what was happening in their care
- 65.60% of respondents felt things were 'always' explained to them in a way they could understand
- 61.15% of respondents were always involved in decisions about their care

What people said was good about their Emergency Department experience:

- Doctors and Nurses were wonderful. Working under extreme pressure, they always do their best. I cannot say a word against my treatment. The waiting time in A&E is unfortunate but cannot be helped. Thank goodness for the NHS (Ysbyty Glan Clwyd).

- Doctor and nurses were brilliant from start to finish, they put me at ease and explained everything that they were going to do (Wrexham Maelor Hospital).

- The staff were amazing having to deal with many difficult as well as poorly patients. They were friendly, and apologetic about being nursed in the corridor. I felt listened to (Ysbyty Gwynedd).

Although the Health Board was late to implement SMS Feedback surveys, in March 2025 the Health Board is ranked the 2nd highest Health Board in Wales in relation to the volume of Emergency Department feedback captured and has the 4th highest average satisfaction score of 7.11 / 10 across All Wales Emergency Departments (Beacon Dashboard 10/4/25), noting the highest average score is 7.71 / 10.

Average experience rating (for completed surve...

Organisation	Total Submissions (excluding Did not answer)	Average Rating (0-10)
CTMU UHB	11,401	7.71
HDU UHB	2,620	7.70
CVU UHB	5,632	7.42
BCU UHB	7,214	7.11
SBU UHB	1,109	6.42
ABU UHB	755	6.36
All Wales	**28,731**	**7.42**

OTHER PATIENT EXPERIENCE CONCERNS AND IMPROVEMENTS

NHS Wales People's Experience Framework

In preparation for the launch of NHS Wales People's Experience Survey (PES), PALS engaged with services across the BCUHB to promote the new survey which went live on 1 April 2025. Internal communication was shared across the Health Board to raise staff awareness of NHS Wales People's Experience Framework.

In preparation for the new PES Survey and to empower the collection of feedback returns PALS ran a ‘Feedback February’ Campaign focused in West IHC. This involved supporting wards who receive low feedback returns, providing training to increase returns.

To support the All-Wales Compliment Workstream, chaired by the BCUHB Patient and Carer Experience Lead a campaign was launched to promote the submission of compliments via staff. The All-Wales Compliment workstream have agreed a set of compliment reporting themes that will go live on the Datix Cymru System in July 2025. This will support data analysis and enable Health Boards to theme and learn from compliments. PALS will be working with service areas to highlight good practice and learning from compliments.

The Quality Dashboard on Iris is now live for staff to access Civica feedback, PALS enquiry themes and trends and complaints data to support the analysis and triangulation of patient feedback.

Patient Communication and Information

The Health Board has a duty to provide quality information, whilst adhering to statutory legislation when producing any form of patient information whether it be verbal or written.

The Patient Information Readers Panel continues to meet monthly to review patient information leaflets. Within the reporting period 13 patient information leaflets were reviewed by the Readers Panel.

Below are examples of leaflets approved at Readers Panel:

- How to Prevent a Fall in Hospital
- Ty Llewelyn Medium Secure Unit, Information for family and carers
- Monitoring blood glucose when you are receiving steroid therapy
- Gynaecological Cancer Patient Initiated Follow-Up (PIFU)
- Testosterone replacement therapy in menopause

Ongoing work continues to support the production of high-quality patient information through the development of a patient information library for staff to access.

Accessible Health Care

The Accessible Information and Communication Standard for people with sensory loss (Welsh Government 2013) states there should be a variety of contact methods available for individuals with sensory loss to access Health Board services.

To support the implementation of the new NHS Wales Communication Standard an internal Task and Finish Group has been set up with representatives from IHC and Specialist Services, led by the Head of Equality and Human Rights. The Task and Finish Group will report progress into the Patient and Carer Experience Group.

SWAN Model for End of Life and Bereavement Care

Outlined in the Welsh Government ministerial priorities for 2025 – 2028 the Health Board has committed to improve bereavement services by implementing the SWAN Model for End of Life and Bereavement Care.

To support the implementation of the SWAN Model for End of Life and Bereavement Care, in March 2025 the Health Board interviewed and successfully appointed 2 x Band 7 SWAN Bereavement Specialist Nurses.

A working group made up of internal and external stakeholders will be established to plan and oversee the implementation this model. Progress made against the implementation of the SWAN Model for End of Life and Bereavement Care will be reported into BCUHB Bereavement Quality Group and Patient and Carer Experience Group.

Chaplain & Spiritual Care Service

From 1 January 2025 – 31 March 2025, the Chaplain and Spiritual Care Service responded to 244 requests for support pan North Wales. These requests for support are in addition to daily pastoral work undertaken on wards/units.

The Chaplain and Spiritual Care Service have recruited 4 on call Chaplains to cover North Wales out of hours. This includes the recruitment of the Health Board's first Muslim Imam Chaplain.

Five multi-faith events were organised across North Wales fostering inclusivity and support for individuals from diverse religious backgrounds. The aim of the events was to create a supportive environment that honours and respects the traditions of faith groups of individuals under our care.

Examples of events organised:

1. Chaplaincy organised 3 Iftar events at Ysbyty Gwynedd, Ysbyty Glan Clwyd and Wrexham Maelor Hospital for the Muslim Community during the Holy Month of Ramadan. In total 60 people attended the events.
2. Weekly music sessions are held in the Dementia care ward in Ysbyty Gwynedd, working in partnership with the dementia support staff.
3. Training in spiritual care were delivered to the Palliative Care support champions in West IHC.
4. Spiritual/cultural care training was delivered to Midwives pan North Wales.

The Chaplaincy has engaged with and delivered talks to community groups about the work of chaplaincy. During this period - Merched Y Wawr, Mold community charity group received a talk which was very well received.

CLINICAL EFFECTIVENESS

CLINICAL AUDIT

Internal Audit within BCUHB have recently spent time with the Clinical Effectiveness team to review operational compliance with Health Board Policy for Clinical Audit (Tier 2) Organisational Priority and (Tier 3) local clinical audits.
The final report noted five objectives that were reviewed:

1. Appropriate guidance and documentation in place for undertaking of Clinical Audit within the Health Board.
2. An approved Clinical Audit Plan in place, which includes (Tier 2) audits, and resource is identified to progress and complete audits.

3. Progress against delivery of the clinical audit plan is reviewed regularly by an appropriate forum.
4. Learning from clinical audits is documented in line with Health Board guidance and shared at appropriate forums across the Health Board.
5. Local (Tier 3) audits are registered with the Clinical Effectiveness Team, are progressed in line with timescales stated, and appropriate documentation completed.

Recommendations and agreed actions on five objectives above:

1. The Clinical Audit Policy was revised to clarify roles and responsibilities in relation to approval of the plan and assurance provided to committees. Completed.

2. Evidence that the 2025/2026 Tier 2 Clinical Audit Plan is based on an assessment of risks to the Health Board/priorities. Further discussions around risks and reasons for decisions made for those on the plan happened at Strategic Clinical Effectiveness Group (SCEG) meeting on 11th March 2025 and went to the Executive Quality Delivery Group on 14th April for discussion and approval. Also, within the Cycle of Business in SCEG there is a six-monthly review of Tier 2 to ensure that all audits are progressing within the noted timescale, reviewing updates and learning noted, and discussions on any new Tier 2 audits that should be added to the audit plan.

3. This objective was noted as “Reasonable” no agreed management action to be followed.

4. Email evidence demonstrating overdue Service Assessment of Compliance proformas are being progressed. Evidence of escalation where owners have not responded to chaser emails for overdue actions, such as escalation process, emails. Evidence of information on lessons learnt form Tier 2 audits where this has been shared (Minutes of meetings, presentations). Action plans for Tier 2 audits. (Comparable to the Tier 1 procedure), will be in place by 1st April 2025.

5. Reminder to IHCs and Services on their responsibilities relating to Tier 3 audits and the need to ensure timescales etc. are up to date in the E-tool system. Evidence that overdue audits have been followed up by the Clinical Effectiveness team, through email or reporting and the impact this has made on completion rates (reduction in number of audits overdue). This is being rolled out and will be in place 1st April 2025.

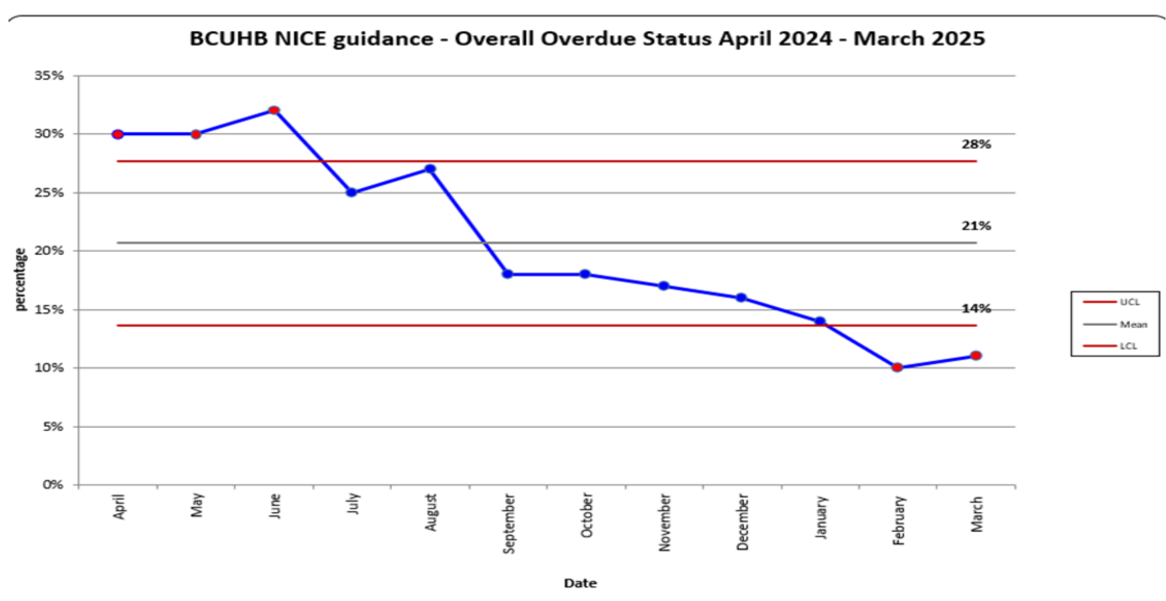
Appendix 1: Clinical Audit Final Internal Audit report 2024-2025
Appendix 2: Clinical Audit Plan Tier 2 (2025-2026)

NICE GUIDELINES

The Clinical Effectiveness Facilitator for NICE (CEF for NICE) is continuously working to support departments with guidance and training where needed, and any overdue guidelines are escalated via the Strategic Clinical Effectiveness Group (SCEG) when necessary. There has been improvement in all aspects of NICE guidance compliance since the introduction of the Audit Management and Tracking (AMaT) tool, as demonstrated below.

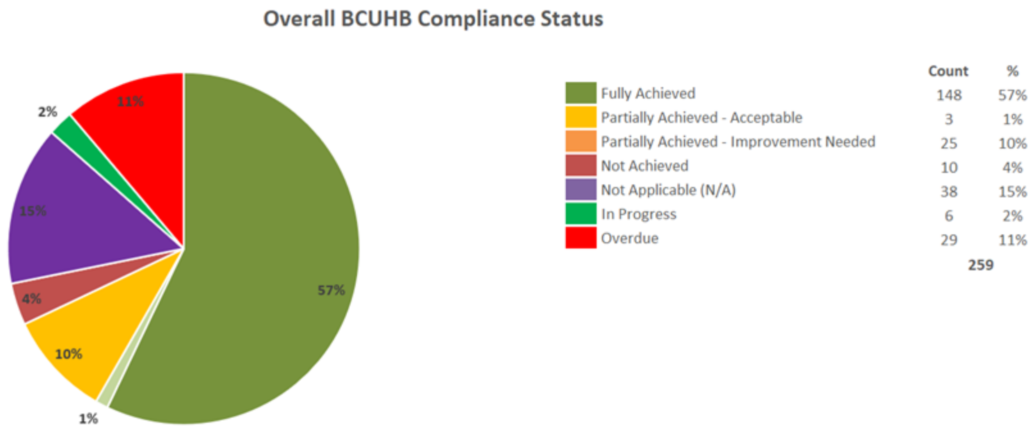
The overall Health Board compliance status is continually improving with only 11% (up to end of March 2025) outstanding as overdue (non-responses). Please see run chart below.

BCUHB NICE (Overdue) run chart for April 2024 – end March 2025



Since April 2023, 1492, statements of compliance have been requested throughout BCU. Of which 40 individual responses are over 12 months overdue (Apr 23/24) and 45 overdues for Apr 24/25.

An escalation process flowchart has been implemented recently (which can be found in the appendices on the updated NICE Protocol link noted below) to streamline the process of dealing with overdue responses and ensure timely responses.



	Count	%
Fully Achieved	148	57%
Partially Achieved - Acceptable	3	1%
Partially Achieved - Improvement Needed	25	10%
Not Achieved	10	4%
Not Applicable (N/A)	38	15%
In Progress	6	2%
Overdue	29	11%
	259	

The recently reviewed **NICE Protocol** has been approved and is now available on Betsinet via the link: NICE Guidance Implementation and Assurance

Health Technology Wales Adoption Audits 2025

HTW published 9 adoption audits in March. These have been circulated to identified leads within relevant services with the expectation to be completed and submitted via AMaT by mid-June 2025. Only one submission is expected per guideline for the Health Board.

MORTALITY REVIEW

Corporate Mortality Update:

- Monthly Learning from Mortality Panel and Reducing Avoidable Mortality Steering Group (LFMP & RAMSG) meetings have been taking place again since January, as well the introduction of a monthly IHC and service mortality process 'housekeeping' meeting, to ensure learning from mortality is taking place and disseminated across the Health Board.

- We have developed a short training video on end of life (EOL) decision-making to support thematic learning within specialty Mortality and Morbidity (M&M) meetings; this is available on the BCU intranet.

- We continue to provide a daily report of cases that have been reviewed by Corporate Mortality Clinical Reviewers to the Integrated Concerns Hub (ICH), ensuring triangulation of the incidents, concerns and mortality process is taking place in a timely manner. The ICH are no longer reporting cases from 'New' which means that all mortality cases discussed will have gone through Clinical Effectiveness Mortality Admin and Clinical Sieve and Sort processes. The mortality process is running alongside this in line with The All-Wales Mortality Framework, where the focus will be learning from cases.

- There is currently **no backlog** of cases awaiting Clinical Effectiveness team mortality processing. Risk mitigation was put in place by a temporary increase in staffing resource, but additional funding is only short term. Workload will continue to be closely monitored. There remains a high number of cases outstanding IHC/service reviews, which has been highlighted to the IHC's and services and will continue to be reported on in the monthly housekeeping meetings. Good progress has been made by East and Central IHC's identifying mortality leads and putting their mortality processes and panels in place, which in turn reduces the organisational risk. West IHC do not have a backlog of cases to review, due to the well-established process they have in place.

- Quarterly data from the ME Service has shown that the percentage of deaths returned to the Health Board for consideration of internal review are below the national average. The profile of related categories of concern is similar across all Health Boards. More detailed analysis of the nature of concerns raised in scrutiny summaries has highlighted concerns around EOL decision-making and broader aspects of advance and future care planning. We plan to routinely share ME feedback with clinicians where possible concerns about any aspect of EOL decision-making. We hope this will promote reflective practice and related discussion in an M&M setting.

- We have recognised from CHKS data, that elective post-op mortality in BCUHB was above baseline between November 2020 and September 2023. On further analysis, rolling mortality for this period is much closer to the national baseline. These trends will be discussed in upcoming surgical M&M meetings and mortality panel meetings in each of our Integrated Health Care Communities. We have asked that local outcome data for the period is formally reviewed. Next steps will then be discussed at our BCUHB Learning from Mortality Panel and Reducing Avoidable Mortality Steering Group Collaborative meeting. Additionally, we do not have access to

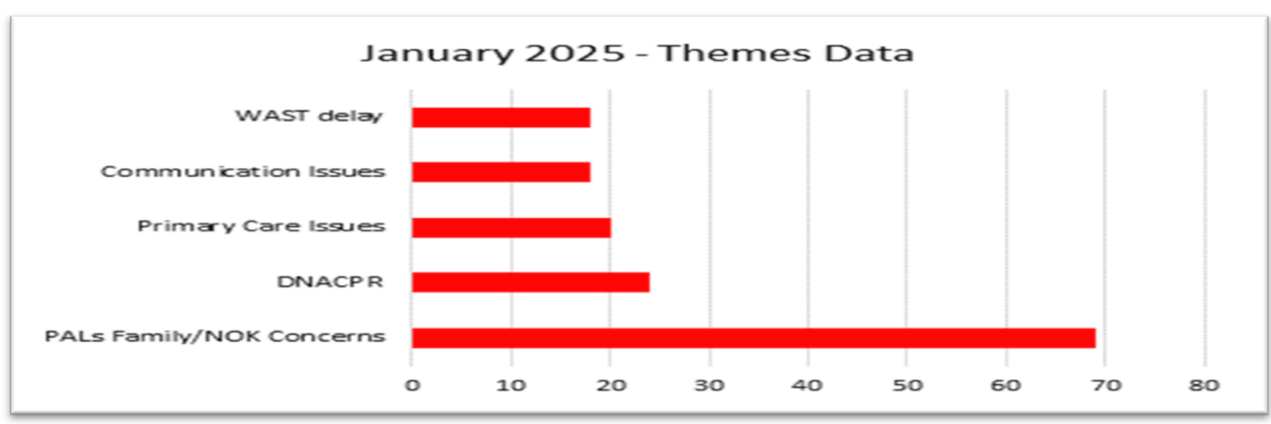
Hospital Standardised Mortality Ratio (HSMR), Summary Hospital-level Mortality Indicator (SHMI), or Dr Foster data. These datasets are crucial for interpreting mortality data as they provide comparative benchmarks and insights into overall hospital mortality performance. The absence of this information limits our ability to fully assess trends and variations in mortality outcomes.

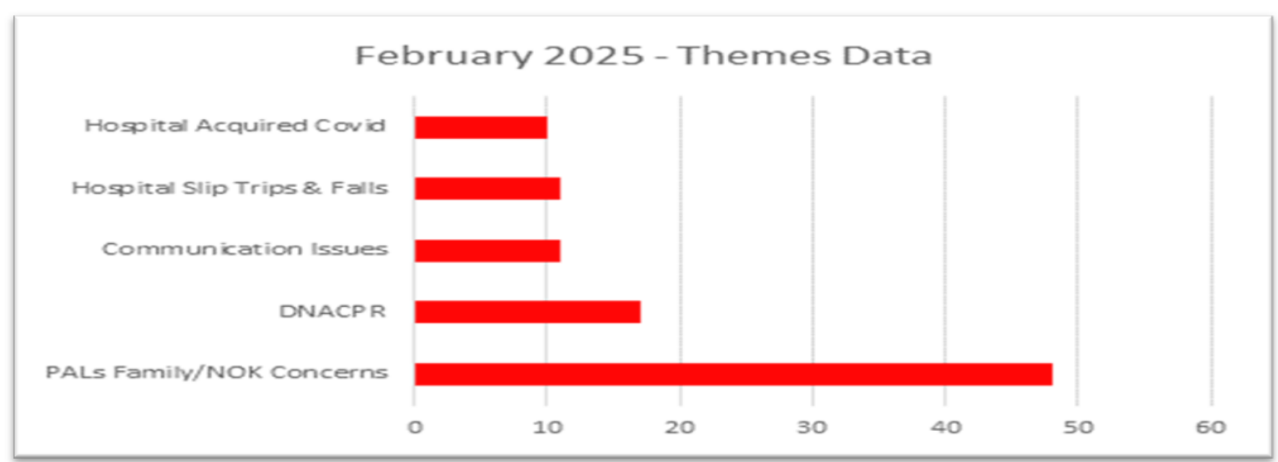
- We have refined mortality review processes so that information relating to common themes are identified and recorded to facilitate appropriate organisational learning and related quality improvement.

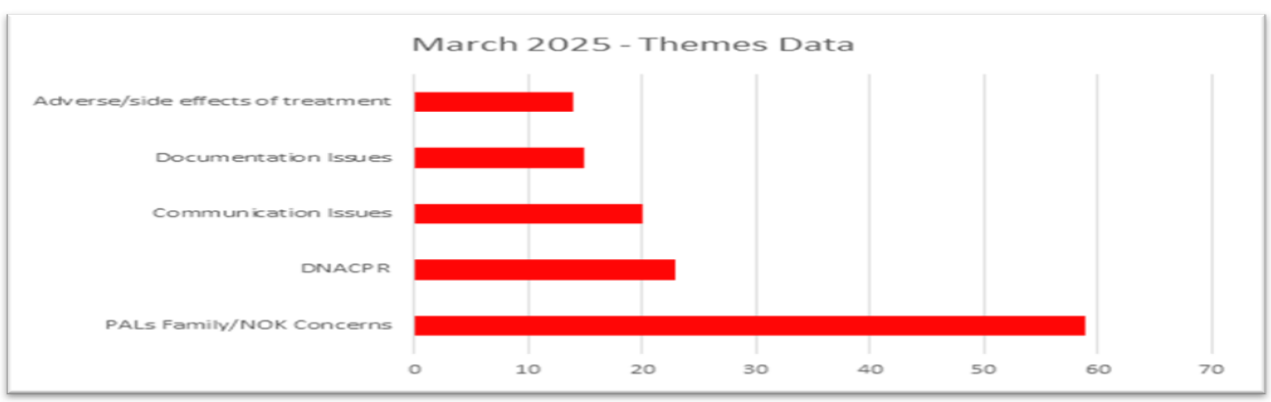
- We have highlighted significant delays in the MCCD process following the rollout of the Medical Examiner Service scrutiny process. Statutory change has introduced multiple steps into the MCCD process and inevitably increased the likelihood of related delays. We continue to work with the ME Service to streamline processes and minimise related delays. Turnaround times for MES review are at least 6 days in most cases. We suspect that this may relate to limited capacity in the system, and it may be necessary for the ME service to acknowledge increased turnaround times so that public expectations can be managed. We are currently waiting for the National Task and Finish Group involved with this piece of work to produce a nationally agreed SOP for the MCCD process.

- At a Health Board level, we are prospectively monitoring and recording timelines so that the reasons for delays can be identified in individual cases and recurrent patterns can be seen and intervention targeted where appropriate. We anticipate that the transparency this provides, will enable us to work with colleagues in the ME service to minimise any delays at any stage in the process.

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







	Input/output			Inputting Backlog				Datix Status										
Date	Total received per week*	Total input per week	Output Differential	Total w/e Backlog inc compliments	Backlog of cases requiring inputting within 1 month from date received by MES	Backlog of cases requiring inputting within 2 months from date received by MES	Backlog of cases requiring inputting within 3 months from date received by MES	Total New cases (awaiting mortality admin s&s)	New Under 1 month DOD (awaiting mortality admin s&s)	New Within 2 months DOD (awaiting mortality admin s&s)	New Within 3 months & over DOD (awaiting mortality admin s&s)	Total Pending Cases awaiting Mortality Clinician Review S&S	Pending Cases Under 1 month awaiting Mortality Clinician Review S&S	Pending Cases Within 2 months awaiting Mortality Clinician Review S&S	Pending Cases Within 3 months awaiting Mortality Clinician Review S&S	Pending scrutiny panel (with IHC's, for IHC's to RAG rate)	Under investigation / action required (with IHC's, for IHC's to RAG rate)	Process completed
10.01 25	35	36	1	8	8	0	0	0	0	0	0	14	14	0	0	1088	216	3106
17.01. 25	26	34	8	4	4	0	0	10	10	0	0	8	8	0	0	1098	203	3135
24.01. 25	28	38	10	7	7	0	0	0	0	0	0	13	9	4	0	1111	209	3157
31.01 25	26	36	10	0	0	0	0	8	7	1	0	7	7	0	0	1121	211	3177
07.02. 25	29	28	-1	0	0	0	0	0	0	0	0	14	13	1	0	1126	209	3206
14.02. 25	24	26	2	5	5	0	0	0	0	0	0	14	14	0	0	1125	213	3225
21.02. 25	19	21	2	5	5	0	0	0	0	0	0	7	7	0	0	1143	213	3235
28.02. 25	25	25	0	4	4	0	0	0	0	0	0	9	9	0	0	1145	211	3258

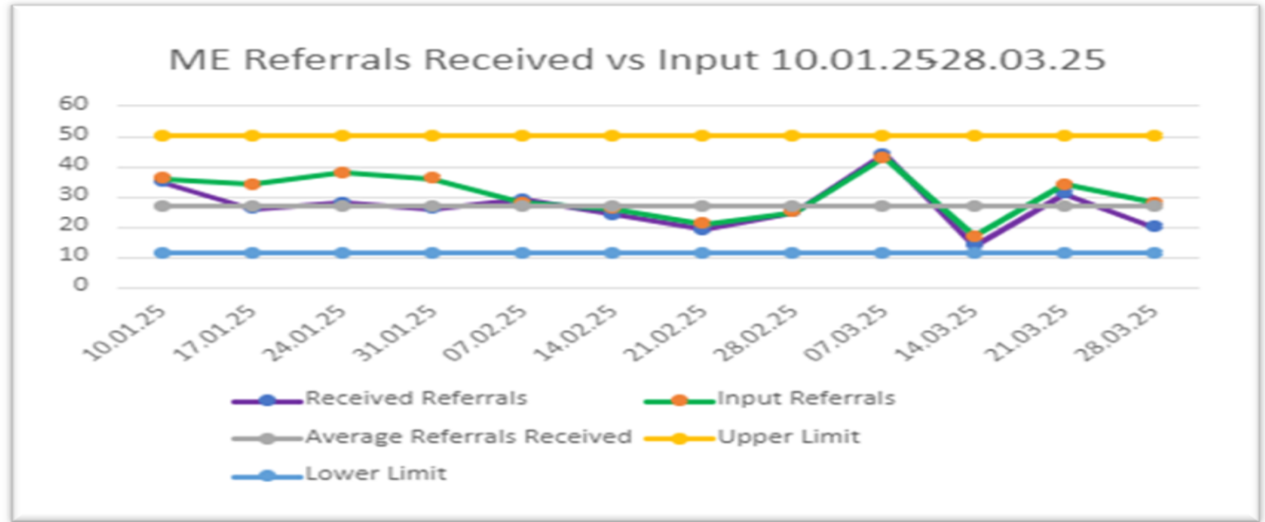
<u>For info: *New Within 3 months & over DOD (awaiting mortality admin s&s)</u> refers to inputted cases being sent to the relevant services/departments and then being closed or sent for Corporate Mortality clinical review. These are included on the risk register and are due to lack of staffing resource.

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

RAG Rating Key = Red, Amber, Green and is a form of report where measurable information is classified by colour	
Input/Output	Red = when total output of cases input into Datix is lower than total cases received from Medical Examiner Service per week
	Amber = when total output of cases input into Datix is equal to the total cases received from Medical Examiner Service per week
	Green = when total output of cases input into Datix is more than total cases received from Medical Examiner Service per week
Backlog	Red = backlog of cases requiring inputting within 3 months of the receipt from the MES
	Amber = backlog of cases requiring inputting within 2 months of the receipt from the MES
	Green = backlog of cases requiring inputting within 1 month of the receipt from the MES
Datix Status	Red = cases within 3 months from date of death that require corporate mortality review
	Amber = cases within 2 months from date of death that require corporate mortality review
	Green = cases under 1 month and over from date of death that require corporate mortality review

	Input/output			Inputting Backlog				Datix Status										
Date	Total received per week*	Total input per week	Output Differential	Total w/e Backlog inc compliments	Backlog of cases requiring inputting within 2w from date received by MES	Backlog of cases requiring inputting within 3w from date received by MES	Backlog of cases requiring inputting within 4w+ from date received by MES	Total New cases (awaiting mortality admin s&s)	New Under 2w from date received (awaiting mortality admin s&s)	New Within 3w from date received (awaiting mortality admin s&s)	New Within 4w+ from date received (awaiting mortality admin s&s)	Total Pending Cases awaiting Mortality Clinician Review S&S	Pending Cases Under 2w awaiting Mortality Clinician Review S&S	Pending Cases Within 3w awaiting Mortality Clinician Review S&S	Pending Cases Within 4w+ awaiting Mortality Clinician Review S&S	Pending scrutiny panel (with IHC's, for IHC's to RAG rate)	Under investigation / action required (with IHC's, for IHC's to RAG rate)	Process completed
07.03.25	44	43	-1	4	4	0	0	12	12	0	0	17	17	0	0	1151	214	3271
14.03.25	14	17	3	4	4	0	0	0	0	0	0	13	13	0	0	1167	213	3288
21.03.25	31	34	3	5	5	0	0	6	5	1	0	10	7	3	0	1179	216	3304
28.03.25	20	28	8	3	3	0	0	15	15	0	0	3	3	0	0	1176	197	3351

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



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.

Healthcare Inspectorate Wales (HIW) Activity February 2025 to March 2025

Published Reports - 1:

HIW have published an inspection report pertaining to the Unannounced Inspection of the Emergency Department at Wrexham Maelor on the 13th of March 2025. The inspection took place from 9th to 11th of December 2024.

Due to an immediate risk to patient safety, HIW issued the following Immediate Assurances to the Health Board:

- *HIW requires details on how the Health Board will ensure that measures are in place to ensure that medication and intravenous infusions expiry dates are checked on a regular basis, and to remove any items past their expiry dates.*
- *HIW requires details on how the Health Board will ensure that medication is always stored in its original dispensing boxes, along with the relevant information sheets.*

As outlined within the inspection report, the Health Board has taken steps to address the immediate issues raised by HIW. Both the Immediate Improvement Plan and Main Improvement Plan are being monitored via the Health Boards Regulatory Assurance Group (RAG) which reports to the Executive Quality Delivery Group (EQDG), and up to the Quality Safety and Experience (QSE) Committee.

Announced/Unannounced Inspections - 0

The Health Board had no announced or unannounced inspections during March 2025.

Concerns / Requests for Assurance - 1

Upon receipt of a concern, or where their intelligence suggests that there is a risk to patient safety, HIW write to the Health Board to determine whether any action is required. Where the Health Board provides sufficient information to confirm that it has reviewed the matter, acted in the best interests of its patients, and is managing / mitigating risk accordingly. If the Health Board's response does not provide sufficient assurance, HIW will request further information / action.

All responses from the Health Board receive approval from Responsible Directors and the appropriate Executive Director, prior to submission to HIW.

Case 1: IHC East – Further Assurance Request – Gladstone Ward, Deeside Hospital
The Health Board received a letter of further concern from HIW regarding a business case about patient flow on Gladstone Ward, Deeside Hospital.

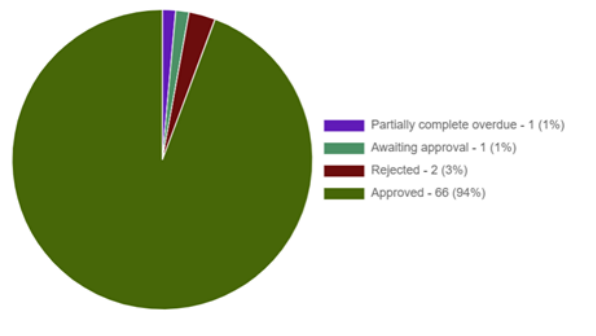
This concern has been responded to and accepted by HIW as providing sufficient assurance.

HIW Improvement Plans Progress:

Analysis of HIW Improvements Plans (7)	
Emergency Department at Glan Clwyd, Improvement Plan	
Inspection Date: 29/04/2024 – 01/05/2024 **Responsible Lead:** IHC Director, Centre **Overall Status:** Overdue	**Position Overview / Summary:** 27 Recommendations 70 Service Improvement actions 94% of plan is complete)

Monitoring and Oversight:
The evidence for the overdue actions is being reviewed at the Hospital Management Team (HMT) Oversight Group.

The plan is receiving scrutiny via the Regulatory Assurance Group (RAG), reporting up to the Executive Delivery Group (EDG).



Gwanwyn and Hydref Ward, Heddfan Unit, Improvement Plan

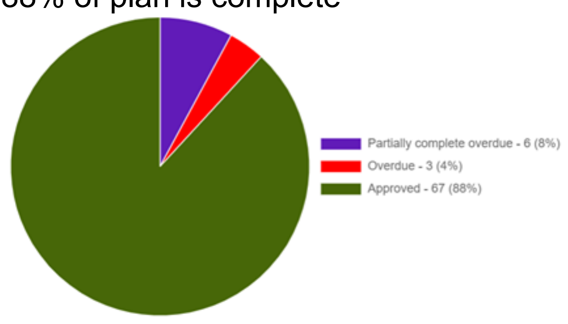
Inspection Date: 21/10/2024 - 23/10/2024
Responsible Lead: Responsible Director, MHLD
Overall Status: Overdue

Monitoring and Oversight:
The plan is being monitored via the Fortnightly Divisional Programme Improvement Delivery Group (PIDG), reporting up to the Local Quality Delivery Group (LQDG).

The plan is receiving scrutiny via the Regulatory Assurance Group (RAG), reporting up to the Executive Delivery Group (EDG).

Position Overview / Summary:

31 HIW Recommendations
76 Service Improvement actions agreed
88% of plan is complete



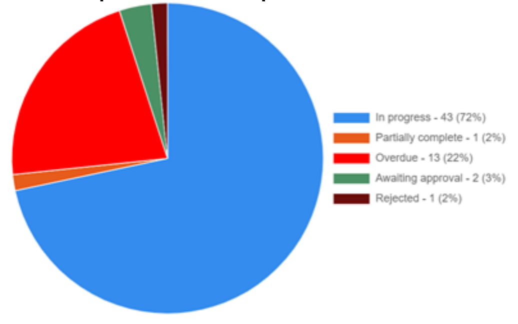
Emergency Department at Wrexham Maelor Hospital, Improvement Plan

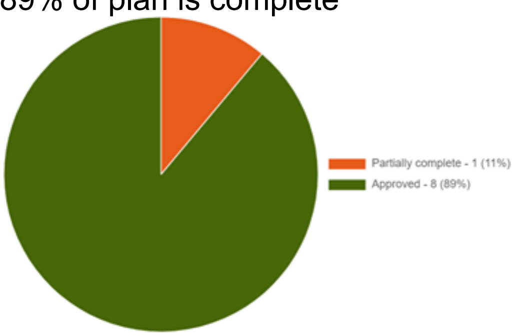
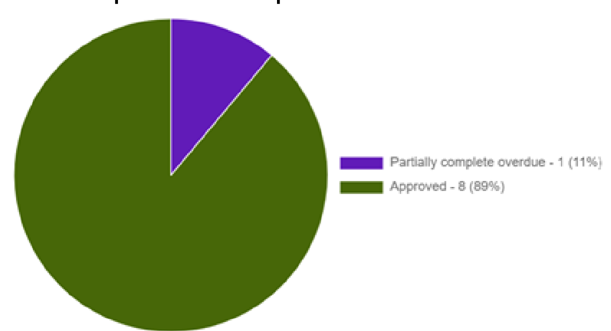
Inspection Date: 09/12/2024 – 11/12/2024
Responsible Lead: Responsible Director, IHC East
Overall Status: In Progress

Monitoring and Oversight:
The plan is receiving scrutiny via the Regulatory Assurance Group (RAG), reporting up to the Executive Delivery Group (EDG).

Position Overview / Summary:

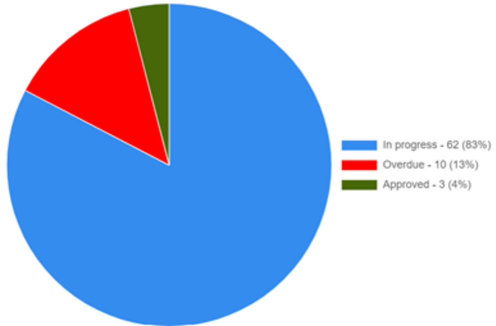
15 HIW Recommendations
60 Service Improvement actions agreed
3% of plan is complete



Emergency Department at Wrexham Maelor Hospital, Improvement Plan	
Inspection Date: 09/12/2024 – 11/12/2024 **Responsible Lead:** Responsible Director, IHC East **Overall Status:** In Progress **Monitoring and Oversight:** The plan is receiving scrutiny via the Regulatory Assurance Group (RAG), reporting up to the Executive Delivery Group (EDG).	**Position Overview / Summary:** 2 HIW Recommendations 9 Service Improvement actions agreed 89% of plan is complete 
Kestrel Ward, North Wales Adolescent Service) at Abergele Hospital, Immediate Improvement Plan	
Inspection Date: 13/01/2025 – 15/01/2025 **Responsible Lead:** Chief Operating Officer and Responsible Director, IHC Centre **Overall Status:** Overdue **Monitoring and Oversight:** The plan is being taken forward via the T4 Programme Group meeting. The plan is receiving scrutiny via the Regulatory Assurance Group (RAG), reporting up to the Executive Delivery Group (EDG).	**Position Overview / Summary:** 5 HIW Recommendations 9 Service Improvement actions agreed 89% of plan is complete 
Kestrel Ward, North Wales Adolescent Service) at Abergele Hospital, Improvement Plan	
Inspection Date: 13/01/2025 – 15/01/2025 **Responsible Lead:** Chief Operating Officer and Responsible Director, IHC Centre **Overall Status:** In Progress	**Position Overview / Summary:** 28 HIW Recommendations 75 Service Improvement actions agreed 4% of plan is complete

Monitoring and Oversight:
The plan is being taken forward via the T4 Programme Group meeting.

The plan is receiving scrutiny via the Regulatory Assurance Group (RAG), reporting up to the Executive Delivery Group (EDG).



Carreg Fawr, Impatient Rehabilitation Unit, Bryn y Neuadd Hospital, Improvement Plan

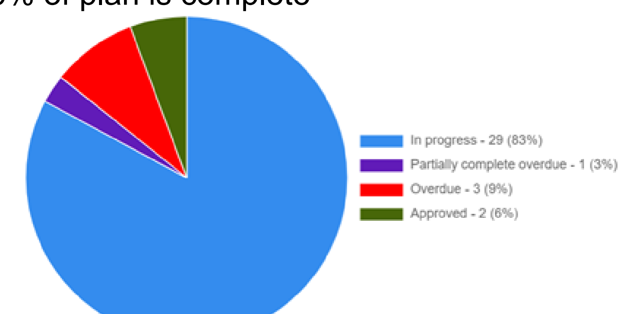
Inspection Date: 21/01/2025 – 23/01/2025
Responsible Lead: Responsible Director, MHLD
Overall Status: In Progress

Monitoring and Oversight:
The plan is being monitored via Programme Improvement Delivery Group.

The plan is receiving scrutiny via the Regulatory Assurance Group (RAG), reporting up to the Executive Delivery Group (EDG).

Position Overview / Summary:

13 HIW Recommendations
35 Service Improvement actions agreed
6% of plan is complete



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).

To strengthen governance and assurance, a Quality-of-Care Review process has been implemented in line with the requirements set out in the Social Care (Wales) Act 2016. A standard six-month service quality review template has been developed for all registered services to complete, aimed at encouraging a culture of quality improvement. This template includes the four well-being areas, alongside a quarterly assurance declaration. These two formal processes support the overall annual declaration made by the Health Board.

The Nursing Professional Education and Revalidation Team have introduced a Social Care Wales Registration Pathway to ensure that all healthcare support staff working in a CIW registered service are regulated with Social Care Wales. This pathway also aims to increase assurance and oversight.

Quality of Care Review Visits

The Health Board aims to undertake six-monthly Quality of Care Review visits. Ahead of a visit, services are asked to complete a Quality-of-Care Review Report, providing an opportunity to demonstrate that they are meeting the four key well-being areas in line with legal requirements. The purpose is to assess their performance and identify opportunities for improvement and development. No immediate issues were raised during the visits undertaken by the Health Board's Responsible Individual in 2024.

The visit schedule for 2025 is underway to ensure that the Health Board meets its legal requirements for undertaking Quality of Care Reviews.

Amendment to CIW Registration

Both IHC Centre and IHC West have made formal requests to amend their service registration with CIW. These requests have been initially reviewed by the Quality Assurance and Regulation Team and the Responsible Individual for the Health Board. The Regulatory Assurance Group has reviewed and approved the requests. The requests have been made in line with the considerations outlined in the Regulation and Inspection of Social Care (Wales) Act 2016, confirming that the services are no longer providing the 'care' and 'support' as set out in the Act.

The Health Board's Responsible Individual has approved the requests, and the Health Board has liaised with CIW regarding the next steps. CIW has advised that the Health Board updates its Statement of Purpose, which will be done as part of the CIW Annual Return in May 2025.

QUALITY PEER REVIEWS

Quality Peer Reviews were introduced at the end of last summer to support services in understanding their compliance with the Health and Care Quality Standards, which were introduced in April 2023 in line with the Duty of Quality in Wales.

The review involves an internal process of self-assessment and mock inspections against core criteria developed based on the approach of Healthcare Inspectorate Wales (HIW). The process remains under development and was implemented to help the Health Board assess its progress against the recommendations issued by HIW following inspections of the Emergency Department at Glan Clwyd in 2022, where the service was subsequently escalated to a Service Requiring Significant Improvement (SRSI). Further reviews have taken place as follows:

- Maternity Services at Ysbyty Gwynedd, West on 18 December 2023.
- Maternity Services at Glan Clwyd Hospital, Central on 17 July 2024.
- Maternity Services at Wrexham Maelor Hospital, East on 26 November 2024.

The focus on Maternity Services stems from the HIW National Review of Maternity Services launched across Wales in 2019. While HIW completed phase one of the review, phase two was paused due to the Covid-19 pandemic. In 2021, HIW decided not to progress with phase two after careful consideration of their risk-based inspection and reviews programme for 2021-22 and their resources. However, during 2024, HIW undertook inspections of maternity services in Wales, including Swansea Bay University Health Board and Cwm Taf Morgannwg University Health Board. HIW subsequently inspected the Health Board's Maternity Services at Ysbyty Gwynedd in February 2025.

Work is underway to plan further reviews, driven by the intelligence held by the Health Board, including service user feedback and key quality metrics, along with intelligence from regulators and third-party organisations. The Quality Team is planning to undertake feedback sessions with colleagues who have participated in the peer reviews to date, in order to further develop the process.

HEALTH AND SAFETY EXECUTIVE / LOCAL AUTHORITY

The Health and Safety Executive (HSE) is a UK government agency responsible for the encouragement, regulation and enforcement of workplace health, safety and welfare, and for research into occupational risks. Within Wales, the HSE enforces health and safety legislation which covers the protection of the public, patients, and staff. Health and safety law is also enforced in Wales by all Local Authorities; and HSE works closely with them to ensure that we work on significant risks and matters of common interest to reduce accidents and ill health and also, to avoid duplication of enforcement effort.

The Health Board appeared before Wrexham Magistrates' Court on 1st April 2025, in relation to a prosecution brought by the Health and Safety Executive (HSE) arising from a failure to prevent and manage inpatient falls.

The HSE provided as evidence three inpatient falls (which occurred in January 2022, June 2022 and January 2023) all resulting in deaths of which two deaths are directly attributable to the fall. These all occurred prior to Special Measures.

The Health Board entered a guilty plea and made legal submissions and statements to the Court including a statement from the Chief Executive expressing the apologies of the Board and a commitment to learn and improve, and a supporting statement from the Executive Director of Nursing and Midwifery setting out the extensive learning and improvement in relation to inpatient falls prevention and management. This improvement was noted by both the HSE and the Court.

The Court awarded a fine of £250,000, with costs of £11,766.90 and a Victim Surcharge of £2,000.

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.

Public Interest Reports (PIRs)

PIR received March 2025 (Case ref ID2087 / 202301141)

The Ombudsman investigation assessed whether the patient received appropriate review and treatment for post-operative fluid collections and pelvic sepsis following her proctectomy in 2019. This included evaluating the adequacy of gynaecological input and whether the

patient was given sufficient time and information to understand the risks of surgical removal of fluid collections, ensuring fully informed consent. Additionally, the investigation reviewed the promptness and appropriateness of treatment for her pain and reduced kidney function following surgery in March 2022, and the provision of timely and appropriate information about her hysterectomy, including post-operative recovery, menopause, and hormone replacement therapy options.

The investigation also examined whether the Health Board handled the complaint in accordance with the PTR (Concerns, Complaints and Redress Arrangements) Regulations 2011.

The Ombudsman upheld the complaints and made several recommendations, which the Health Board accepted. A 'Responsible Lead' within the Health Board has been identified to oversee the implementation of the action plan. Progress is being reported to the Health Board's Regulatory Assurance Group, Executive Quality Delivery Group, and Quality Safety and Experience (QSE) Committee.

Please see Appendix 3 for a copy of the full report.

Public Services Ombudsman for Wales - Average Variance to Target (AVT)

The Ombudsman measures responsiveness using the Average Variance to Target (AVT). This metric is regularly shared with all Health Boards. A positive AVT indicates days over the target date for providing compliance evidence, while a negative AVT indicates days under the target date.

The Ombudsman has recently presented annual data to the Health Board, differing from the previous month-by-month presentation. The Health Board is liaising with the Ombudsman to establish whether monthly data can be provided to better monitor compliance. Monthly meetings are in place between the Health Board and the Ombudsman.

The Health Board continues to collaborate with the Ombudsman’s Complaints Standards Authority to ensure good working practices and facilitate awareness training for staff.

The Quality Assurance and Regulation Team is networking with other Local Health Boards and Trusts to identify improvements in capturing, tracking, and monitoring Ombudsman recommendations and compliance.

ORGANISATIONAL LEARNING

Quality Learning Portal

The Health Board is developing a centralised learning repository, an ambitious and innovative project aimed at enhancing organisational memory through evolving technology. This initiative supports the transition towards becoming a learning organisation and is a crucial deliverable for Outcome 5 of the Special Measures Programme, which aims to make BCUHB a learning and self-improving organisation. Notably, this is the first such system in Wales.

Development of the Quality Learning Portal is progressing well. The first of three applications, designed to enable users to input learning data into the system, is currently undergoing further testing. This application has been rebuilt using the recently updated

'Modern' Power Platform components by Microsoft, enhancing styling, functionality, and responsiveness.

The second application is nearing completion and has also been rebuilt to support the updated Power Platform components. It is expected to enter the testing phase by the end of April. This module will allow the administration team to review and normalise the submitted learning data.

Development of the third application, which will enable the review team to publish the submitted learning within the organisation, began in early May and is anticipated to be completed by the end of June 2025.

Quality Dashboard

Launched in June 2024, the Quality Dashboard is now embedded within the Health Board and is pivotal to understanding the quality of care provided to our population through key quality metrics. This suite of dashboards offers a single, organisation-wide resource for accessing real-time quality information from ward/team to Board.

The dashboard is essential for the Health Board to meet its quality reporting obligations, including 'Always on' reporting, in line with the Duty of Quality for Wales. It routinely collects, analyses, monitors, and makes information about the quality of services readily available. This promotes openness and transparency with the Health Board's population and stakeholders, driving learning and continuous improvement by identifying areas requiring significant change.

The Quality Dashboard is being relaunched across the organisation in April 2025. It supports the following Health Board objectives:

1. Becoming a quality led and data driven organisation

2. Becoming an intelligence led and learning organisation

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.

The Health Board has received two Regulation 28 Prevention of Future Death Notices since the last report.

The first Notice followed an Inquest held on 20th February 2025. The Coroner raised concerns that, in relation to the patient’s care, there was no record of any discussions which

took place been Ysbyty Glan Clwyd and the tertiary specialist hospital and no formal documented process in relation to such referrals and the subsequent advice which was provided and thereafter acted upon.

The second Notice followed an Inquest held on 17th March 2025. The Coroner raised concerns regarding the perinatal mental health service, as follows:

- The service was established across the Health Board around 5 years ago but there is insufficient awareness of the service by Health Professionals including Midwives, Health Visitors and GPs.

- There are only two temporary perinatal Health Visitors across the Health Board and none in the East area.

- The Single Point of Access meetings which occur on a daily basis by way of triaging referrals do not provide written records of the discussions held and decisions made. This means there is no written justification for decisions made or written actions and therefore these discussions and decisions do not form part of any health record for the patient.

At the time of writing this report, responses to the above Notices were still being drafted.

LIABILITY CLAIMS

The Welsh Risk Pool is part of the NHS Shared Service Partnership Legal and Risk service. It provides the means by which 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. In order 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 WRP procedures require a Learning from Events Report (LFER). These are used by the Health Board to report the issues that have been identified from a claim or redress case and to demonstrate with evidence how these have been addressed in order to reduce the risk of reoccurrence and reduce the impact of a future event.

The Health Board has recurring issues with the timeliness of Learning from Events Report (LFER) submissions, with these often delayed within services who struggle to provide evidence of learning and sustained improvement (it is important to note, the period between an adverse event and a claim being settled can be several years).

At the time of writing, 61 LFERs are overdue (down from 86 at the start of the year). The Executive Team (in December 2024) established a recovery trajectory for eliminating this backlog within a maximum of six months.

To support this, a new process has been rolled out (in January 2025) supported by a weekly performance report and bi-weekly escalation meeting. Central IHC, East IHC, and the Women's and Midwifery Division continue to be the main outliers. These three divisions account for 79% of overdue LFERs, with Central IHC alone accounting for 52%. The Mental Health and Learning Disabilities Division, West IHC and Dental Division continue to see excellent performance.

LFER performance is now escalated for oversight by the Executive Performance Group and is part of the Conformance Report to the Audit Committee. Ongoing dialogue with the WRP continues to report on progress.

OTHER HEALTHCARE LEGAL MATTERS

Nil to note

Clinical Audit

Final Internal Audit Report

2024/25

Betsi Cadwaladr University Health Board

Limited Assurance

Contents

Executive Summary 1

Findings & Agreed Action Plan 3

Appendix A 10

Review Reference	BCU-2425-29
Fieldwork	January 2025 – February 2025
Executive Sign Off	March 2025
Audit Committee	April 2025
Executive Lead	Sreeman Andole, Interim Executive Medical Director
Audit Team	Dave Harries, Head of Internal Audit Nicola Jones, Deputy Head of Internal Audit Patrick Williams, Principal Auditor

Executive Summary

Purpose

To review operational compliance with Health Board Policy for Clinical Audit, review and sharing of audit findings and delivery of National (Tier 1), Organisational Priority (Tier 2) and Local (Tier 3) clinical audits.

Overview

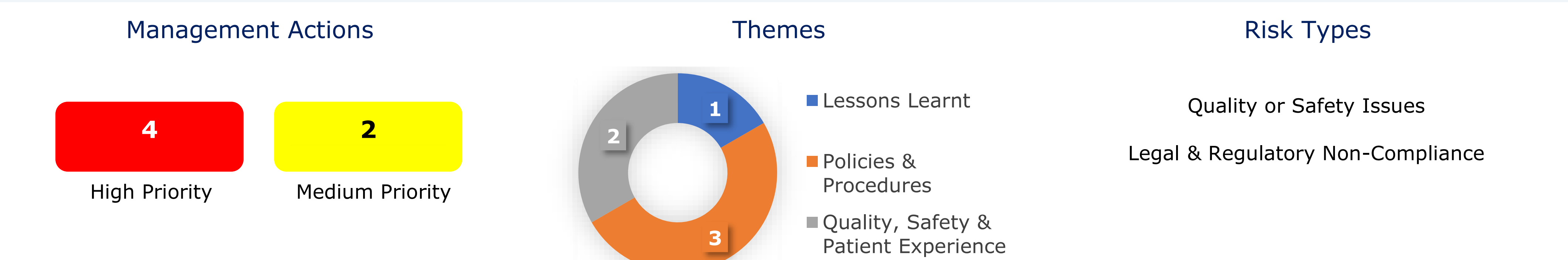
We have concluded **limited** assurance on this area. Whilst there has been progress in addressing issues with clinical audit since our previous reviews in 2022 and 2023, there are still several areas where further improvements are needed. The significant matters requiring management attention include:

- It is unclear how the Tier 2 clinical audit plan for the Health Board has been developed. The audits should be based on Health Board risks and priorities, however there is no formal assessment that has been undertaken that provides a rationale for the areas on the plan.
- There is a lack of evidence to demonstrate oversight and collation of data on lessons learnt and where these are shared, and in developing action plans to address areas of risk.
- A high percentage (75%) of Tier 3 audits have not been undertaken by the agreed completion date. Whilst the Clinical Effectiveness Team are starting to enquire about these, this is a recent process that has not yet resulted in an increase in compliance with audit completion.

Full details of matters arising are detailed within the Findings & Agreed Action Plan.

Scope & Assurance Summary

	Objectives The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.	Related Findings	Assurance
1	There is appropriate guidance and documentation in place for the undertaking of Clinical Audit within the Health Board.	1	**Reasonable**
2	There is an approved Clinical Audit Plan in place, which includes National (Tier 1) audits and Local (Tier 2) audits, and resource is identified to progress and complete audits.	2	**Limited**
3	Progress against delivery of the clinical audit plan is reviewed regularly by an appropriate forum.	-	**Reasonable**
4	Learning from clinical audits is documented in line with Health Board guidance and shared at appropriate forum(s) across the Health Board.	3,4,5	**Limited**
5	Local (Tier 3) audits are registered with the Clinical Effectiveness Team, are progressed in line with timescales stated, and appropriate documentation completed.	6	**Limited**


Management Actions
4
High Priority
2
Medium Priority
Themes
1
2
3
Lessons Learnt
Policies & Procedures
Quality, Safety & Patient Experience
Risk Types
Quality or Safety Issues
Legal & Regulatory Non-Compliance

Findings & Agreed Action Plan

Objective 1: There is appropriate guidance and documentation in place for the undertaking of Clinical Audit within the Health Board.	**Reasonable**

The Clinical Audit intranet page on BetsiNet provides resource for staff, which includes materials such as policies, guidelines, training resources and annual reports. It also features Tier 1 publications of service assessments related to national compliance findings, Tier 2 proformas, and Tier 3 guidance, which includes a registration tool and guidance for writing reports.

The Clinical Audit Policy & Procedure document (MD22) was reviewed and updated in July 2023 and is available on the intranet page; this sets out the process for undertaking clinical audits, encompassing the Welsh Government mandated audits (Tier 1), local priority audits based on Health Board priorities and risks (Tier 2) and arrangements in place for local (Tier 3) audits. Additionally, it includes roles and responsibilities, organisational structures and training information.

The policy states the Audit Committee is the approving committee for the annual audit plan. We are advised this is no longer the process and approval of the plan is via the Executive Quality Delivery Group (EQDG), with the plan and progress provided to the Quality, Safety & Experience (QSE) Committee. The Audit Committee terms of reference states the committee will "seek assurance on an overall Clinical Audit plan, its fitness for purpose and its delivery". This requirement is not reflected in the guidance.

	Key Findings	Risk & Impact	Agreed Management Action
1	**Guidance and documentation** Section 7.3 of the MD22 - Clinical Audit Policy & Procedure document does not accurately represent the current process for approval of the annual clinical audit plan. It states the Audit Committee are responsible for approval, however we are advised the Executive Quality Delivery Group approves the plan. The requirements for the Audit Committee to receive assurance on clinical audit are not reflected in the policy and procedure.	Procedures do not reflect the current process, which could lead the incorrect scrutiny and approval for the clinical audit plan.	**Agreed Action:** This has recently changed and has been confirmed that the principle is that the Executive Quality Deliver Group does the "approving" and Quality Safety Experience Committee does the "assuring". The policy will be reviewed and updated to reflect the recent changes in these procedures.
			Expected Evidence of Implementation: Revised policy clarifying roles and responsibilities in relation to approval of the plan and assurance provided to committees. *All completed and copied to Policies department changes approved for updating on Betsinet. (This has now been completed and revised policy approved and uploaded)*
		Medium Priority	**Officer: Head of Clinical Effectiveness** **Date: 14/3/2025**
	Theme: Policies & Procedures	Control Design	

Objective 2: There is an approved Clinical Audit Plan in place, which includes National (Tier 1) audits and Local (Tier 2) audits, and resource is identified to progress and complete audits.	**Limited**

The Annual Clinical Audit Plan was presented and approved at the Executive Quality Delivery Group (EQDG) on 10 June 2024. The Plan includes Tier 1 audits, presented for information and confirmation to the group, and Tier 2 audits for approval.

The Tier 1 audit plan for 2024/25 lists forty-five national programme audits that the Health Board is required to complete. A further five national audits were not included in the plan, as four were not applicable to the Health Board due to services being commissioned elsewhere, and one the Health Board is not participating in due to there being no service (Falls & Fragility Fractures Audit Programme (FFFAP): Fracture Liaison Service).

Each national audit requires a Health Board lead and project leads for each area (East, Central and West). Out of these forty-five national audits, 28 (62%) had a Health Board lead assigned, while 17 (38%) had not been appointed at the time of writing this report. All audits had area projects leads assigned.

The Tier 2 clinical audit plan includes nine audits, each with an appointed accountable lead. This is a reduction from previous years, we were advised that this is following scrutiny by the Head of Clinical Effectiveness and Deputy Executive Medical Director, which determined that many audits did not meet the necessary criteria (those considered necessary at a corporate level).

Six of the nine audits were carried over from the last year's plan, with the addition of three new audits. We were advised that the Clinical Effectiveness Team contacted those who completed Tier 2 audits the previous year to confirm if they were re-auditing the same areas this year (annual audits). We have not seen any evidence of a formal assessment or risk-based approach that justifies the rationale for these reviews or the other tier 2 audits included in the plan. We note the following, taken from the Strategic Clinical Effectiveness Group (SCEG) Chair's report dated 10 January 2025, to be presented at the Executive Quality Delivery Group on 10 February 2025. *'Tier 2 Audit plan for 2025/2026 needs to develop noting the continuous audits that remain on the plan and new Tier 2 audits identified from specific local risks, strategic interests and concerns. The Group were asked to consider these and come back to February meeting with recommendations that could be discussed further.'.*

Key Findings		Risk & Impact	Agreed Management Action
2	**Development of Tier 2 audit plan** We have been unable to evidence standardised formal assessments being undertaken for the Tier 2 audit plan and it is unclear how the plan has been developed. The audits should be based on Health Board risks and priorities, however there is no formal assessment that has been undertaken that provides rationale for the areas on the plan. *This issue was also raised as a high priority within the 2022 audit review.*	Tier 2 audits are not based on risks to the Health Board, resulting in an increased risk exposure, with resource not focused on areas required.	**Agreed Action:** Through Strategic Clinical Effectiveness Group there has been process where the current Tier 2 audit was reviewed and discussions on which audits needed to be carried over into the new audit plan for 2025-2026. Also as noted above, the group was asked to consider and identify from specific local risk, strategic interest and concerns. In order to capture this a new table for the audit plan has been developed which will provide details needed to provide assurance of the rational.

			Expected Evidence of Implementation: Evidence that the 2025/26 Tier 2 clinical audit plan is based on an assessment of risks to the Health Board/priorities. This is being discussed further around risks and reasons for decisions made for those on the plan at Strategic Clinical Effectiveness meeting 11th March 2025, and will then go to EQDG in April for discussion and approval.
		High Priority	**Officer: Head of Clinical Effectiveness** **Date: 11/4/2025**
	Theme: Quality, Safety & Patient Experience	Control Design	

Objective 3: Progress against delivery of the clinical audit plan is reviewed regularly by an appropriate forum. **Reasonable**

There is evidence of regular reporting on clinical audit activity to the Strategic Clinical effectiveness Group (SCEG), Executive Quality Delivery Group (EQDG) and Quality, Safety & Experience Committee (QSE).

The QSE receives assurance through an integrated quality report, which includes details on Tier one audits. Consideration should be given to including Tier two audits in the report, as these are necessary at a corporate level due to their risk profile or the need for improvement. We note that an update on the development of the Tier 2 audits is to be presented at the QSE on 20 February 2025.

As noted in Objective 1, the Audit Committee terms of reference states the committee will "seek assurance on an overall Clinical Audit plan, its fitness for purpose and its delivery". There has not been regular reporting of the Clinical Audit Plan and progress to the Audit Committee. *A key finding relating to this is raised in objective 1.*

The progression of Tier 1, 2, and 3 audits is monitored in detail through quarterly and annual reports. These reports ensure accountability and provide any necessary assistance to meet agreed timelines. They are submitted to the SCEG for discussion and review, as well as the EQDG.

Monthly clinical effectiveness assurance reports are also provided to the Integrated Health Communities (IHCs) and services, outlining the achievements as well as issues relating to participation, named leads and completion of the service assessment of compliance proformas.

Objective 4: Learning from clinical audits is documented in line with Health Board guidance and shared at appropriate forum(s) across the Health Board.	**Limited**

Tier 1

Service Assessment of Compliance (SAoC) proformas are required to be completed for Tier 1 audits, which capture details of National Audit findings, recommendations, local continuous quality improvement, and where the data was shared within the service. The forms are to be returned within 8 weeks of the audit date of publication.

As of January 6, 2025, 40 SAoCs should have been completed. A review of data provided by the clinical effectiveness team shows that 72.5% have been completed or are going through the approval process, with 27.5% yet to be completed.

We reviewed three of the twelve completed audits to verify that the forms were fully completed and submitted correctly. All three audits had been returned and had the necessary approvals.

Escalation emails are to be sent to the Clinical Directors and Integrated Health Community (IHC) Medical Directors for overdue forms. We reviewed a sample of overdue audits to confirm whether emails were sent. An email was sent for one audit; however, no emails were sent for the other two audits.

The Audit Management and Tracking database (AMaT) has been implemented across the Health Board and now includes the monitoring process for all Tier 1 audits. Additionally, it is used for three selected Tier 2 audits to collate information required for the audits. Evidence was provided showing the entry of the SAoC data into the system and the creation of action plans for each audit. Weekly emails are sent to the owners of overdue actions; however, we are advised that there is no process / escalation where the owner does not respond to these emails.

Tier 2

While we observed monitoring and updates on Tier 2 audits being presented to the SCEG and EQDG within the organisational structure, we have not been able to demonstrate oversight in collecting data on lessons learned/shared and developing action plans to address issues.

Tier 3

Tier 3 audits are recorded via an E-Tool on the intranet site. We reviewed ten out of 95 completed audits from 2024 to verify that completed audit reports were uploaded. All audits reviewed had completed reports, which includes details on performance, outcomes, and learning, as well as information on how these would or have been shared within the departments.

Key Findings		Risk & Impact	Agreed Management Action
3	**Overdue Service Assessment of Compliance proformas** We were unable to observe evidence of escalation emails for overdue SAoCs being sent for two of the three overdue audits we sampled.	Non-compliance with requirements for National mandated audits.	**Agreed Action:** The Clinical Effectiveness Facilitator (CEF) will as part of the SOP ensure the following will be required: * Evidence of email escalations to be saved to the project folder by the CEF team and an update of the SOP to ensure this is part of the process * Schedule regular departmental audits of project folders to confirm that evidence is there – on quarterly basis to be captured with reports produced * Document evidence of escalations in The Audit Management

			and Tracking (AMaT) to make the process transparent – this will show which areas have not replied and ensure that this information is captured by the CEF and monitored properly or escalated as necessary
			Expected Evidence of Implementation: Email evidence demonstrating overdue Service Assessment of Compliance proformas are being progressed. This has now been set up by the team and will be scheduled as part of our process from 1st April 2025
		Medium Priority	**Officer: Head of Clinical Effectiveness** **Date: 1/4/2025**
	Theme: Policies & Procedures	Control Operation	
4	**Escalation process for overdue action plans** For Tier 1 audits, when an action becomes overdue, weekly reminder emails are sent to the action owner generated from the AMaT system. If the owner does not respond, there is no escalation process in place to ensure the action is completed.	Potential for non-compliance with regulatory standards.	**Agreed Action:** We will develop a process for this, to ensure that moving forward that progress is included with Tier 1 improvement actions and included in the Monthly Assurance report that is sent out to IHCs and Divisions. Need to ensure tighter controls are incorporated in our SOPs and that monitored on regular basis to raise and escalate with actions that are overdue
			Expected Evidence of Implementation: Evidence of escalation where owners have not responded to chaser emails for overdue actions, i.e. escalation process, emails. This is being developed now as part of our process and will be in place by 1st April 2025
		High Priority	**Officer: Head of Clinical Effectiveness** **Date:1/4/2025**
	Theme: Policies & Procedures	Control Design	
5	**Lessons learnt shared to appropriate forum** We have not been able to demonstrate oversight in collecting data on lessons learned/shared and in developing action plans to address issues from Tier 2 audits.	Audit findings are not shared with relevant areas / staff, leading to ongoing inefficiencies and potential harm.	**Agreed Action:** Tier 2 audit details have been captured through Strategic CEG updates and within quarterly reports, however going forward there needs to be a more robust process, similar to Tier 1 and Tier 3. A form will be development to roll out from April 2025 to capture learning, where shared and development of actions plans.

			Expected Evidence of Implementation: Evidence of information on lessons learnt form Tier 2 audits where this has been shared (Minutes of meetings, presentations etc. Action plans for Tier 2 audits. (Comparable to the Tier 1 procedure). Will be in place by 1st April 2025
		High Priority	**Officer: Head of Clinical Effectiveness** **Date: 1/4/2025**
	Theme: Lessons Learnt	Control Operation	

Objective 5: Local (Tier 3) audits are registered with the Clinical Effectiveness Team, are progressed in line with timescales stated, and appropriate documentation completed.	**Limited**

Tier 3 audits are registered via the online E-tool available on the clinical audit intranet page. There are mandatory fields that are required to be completed before audits can progress, including related guidance (i.e. NICE guidance), associated risks, project description and details of where findings and results will be presented.

We were provided with details of Tier 3 audits registered between April 2024 and December 2024.

Table 1 Tier 3 registered audits

Total April – December 2024	Complete	Ongoing	Withdrawn
340	95 (27.5%)	243 (71.5%)	2 (0.6%)

Of the 243 ongoing Tier 3 audits, 183 (75.3%) were overdue based on the proposed completion dates. It is recognised by the team that a large number of audits are overdue, and they have recently implemented a new process of contacting areas by email to confirm the reasons for overdue audits, proposed completion dates and the completion of conclusion and impact forms. We are not yet able to determine whether this will have an impact on the overall completion figures going forward.

Tier 3 Local audit registrations and activity are discussed within the monthly clinical effectiveness assurance reports that are also sent to the IHCs and services, as well being monitored through the SCEG and EQDG.

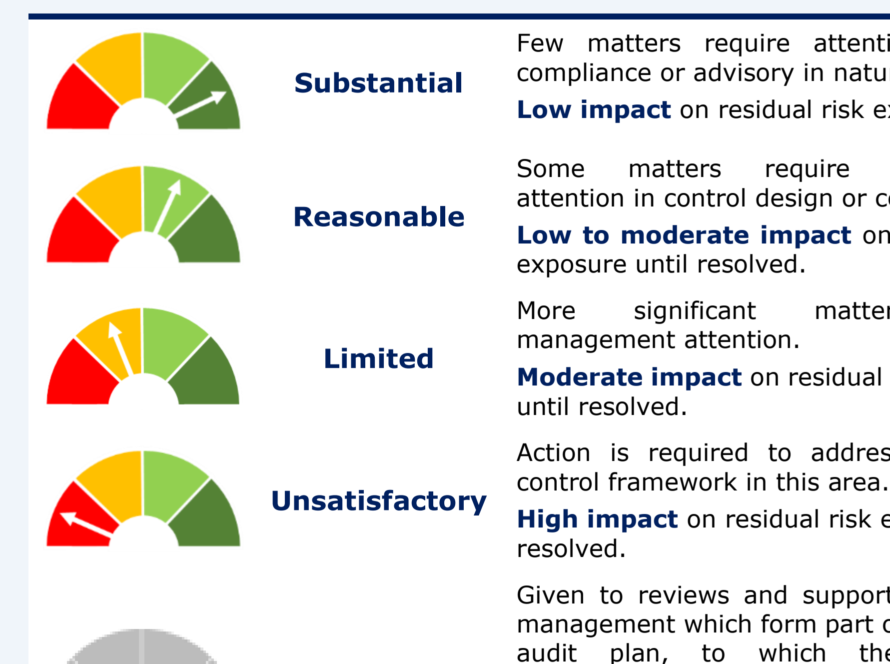
Following a completed audit, the team request a 'conclusion and impact' form, allowing them to better understand the assurance gained and risks identified from this project as well as the learning and where it has been shared. As stated in objective 4 above, all completed audits had submitted the required documentation.

	Key Findings	**Risk & Impact**	**Agreed Management Action**
6	**Overdue Tier 3 audits**	Tier 3 audits are completed in the	**Agreed Action:** Prior to the internal audit, we had already development and were getting these steps in place:

	A large number of Tier 3 audits (183) are overdue with no revised dates of completion. We recognise the clinical effectiveness team have introduced a process to improve completion rates, however Integrated Health Communities (IHCs) and Services are responsible for monitoring their Tier 3 audits, and ensuring the E-tool system is up to date with expected time scales.	appropriate timescale leading to ongoing inefficiencies and potential harm.	The Clinical Effectiveness Department emails auditors that have overdue projects, to ask them to update the e-tool (either with an updated completion date, mark as complete by uploading report or mark as abandoned). This has been agreed within the team that once this has been requested 3 times non-progress will be reported through departmental Clinical Effectiveness NICE/Audit Group (CENAG)and will then be raised within IHC/Divisions/Services
			Expected Evidence of Implementation: Reminder to IHCs and Services on their responsibilities relating to Tier 3 audits and the need to ensure timescales etc. are up to date in the E-tool system. Evidence that overdue audits have been followed up by the Clinical Effectiveness team i.e. through email or reporting and the impact this has made on completion rates (i.e. reduction in number of audits overdue). This is being rolled out and will be in place 1st April 2025
		High Priority	**Officer: Head of Clinical Effectiveness** **Date: 1/4/2025**
	Theme: Quality, Safety & Patient Experience	Control Operation	

Appendix A

Assurance Opinion



Opinion	Description
Substantial	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
Reasonable	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
Limited	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
Unsatisfactory	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
Advisory	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
Medium	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

Disclaimer

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit Committee.

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Betsi Cadwaladr University Health Board, and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

The report is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given with regard to the advice and information contained.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with management of the Betsi Cadwaladr University Health Board. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Public Sector Internal Audit Standards

Audit work undertaken by NHS Wales Audit and Assurance Services conforms with the International Standards for the Professional Practice of Internal Auditing and associated Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

Ref Number	Project Title	Int/ext guidance	Corporate policy	External review	Reaudit / continuous	Risk Register	Which BCUHB priority does this support?	Proposed Start Date	Proposed Finishing Date	Objectives
1	DNACPR Audit	Y	Y	N	Y	N	Decision-making/EOL care	Quarter 2	TBC	Ensuring compliance against All Wales DNACPR policy, which in turn will develop relevant pathways/standard operating procedures as appropriate. Improving documentation of DNACPR and communication with Primary Care. Ensure appropriate Mental Capacity assessment.
2	Antimicrobial Point Prevalence Audit (Inpatients)	Y	N	Y	Y	Y	Keeping People Safe from Avoidable Harm	Nov-25	November 2025 Published by PHW March 2026	To improve compliance and local improvement plans
3	Root Cause Analysis Hospital Acquired Thrombosis (RCA HAT)	Y	Y	Y	Y	Y	Keeping People Safe from Avoidable Harm	Jan-25	Ongoing audit with quarterly reporting schedule	Ensuring compliance against All Wales policy, improving patient experience and patient safety
4	Non-Medical Prescribing (NMP)	Y	Y	?	Y	N	Keeping People Safe from Avoidable Harm	TBC	TBC	To support and improve compliance for the quality standards detailed within MM03
ON HOLD										
To support AMR agenda over 3 acute hospitals, in place of the SSTF audit which has been paused to get more in depth clinical data	Impact of restriction policy	Y	N	Y	Y	Y	Keeping People Safe from Avoidable Harm	TBC	TBC	To improve compliance and local improvement plans
NEWS2 to be launched 30th September 2025	Sepsis	Y	Y	Y	Y	N	Highly reliable clinical care. Reduce patient harms. Quality and Safety	01/11/2025 will keep updated through SCEG	TBC	Promoting and implementing best practice
Once this work is completed and proforma agreed the Tier 2 audit can be rolled out.	Record Keeping - to include reference to documentation of Multi-Disciplinary Teams (MDTs)	Y	Y	N	TBC	N	Highly reliable clinical care. Reduce patient harms	Keep Pending	Keep Pending	Measure compliance with local policy to reduce patient harm

On hold and under review due to lack of developer support from the informatics department. This is currently on the risk register and looking at different options to proceed.	2222 Audit	Y	Y	Y	TBC	Y	Highly reliable clinical care. Reduce patient harms. Quality and Safety	Keep Pending	Keep Pending	Establishment of uniform process for emergency call responses across all sites of BCUHB in line with existing BCUHB Resuscitation Policy

Accountable Lead(s)	**Responsible Corporate Group**	**Risk Assessment** *(see key below)*
Dr Ben Thomas, AMD Law and Ethics	Consent Group	High
Zoe Kennerley, Pharmacist	Antimicrobial Steering Group	Extreme
Delyth Williams Houston (Lead Thrombosis Nurse Specialist)	Patient Safety Group	High
Judith Green (Lead Governance Pharmacist)	Patient Safety Group	High

Zoe Kennerley, Pharmacist	Antimicrobial Steering Group	Extreme
Dr Craig Beaton, Consultant Anaesthetist	Reports from the STEAR Group into the Strategic Patient Safety GroupPatient Safety Group	High
IHC's across BCUHB	Strategic Clinical Effectivenes Group and local CEGs	Reference table below

Christopher Shirley (Professional Development Lead : Resuscitation)	BCUHB Resuscitation Committee	High

The investigation of a complaint against Betsi Cadwaladr University Health Board

A report by the
Public Services Ombudsman for Wales
Case: 202301141

Contents **Page**

Introduction	1
Summary	2
The complaint	5
Investigation	5
Relevant legislation/guidance	7
The background events	10
Ms A’s evidence	17
The Health Board’s evidence	18
Professional advice	19
Comments on the draft report	23
Analysis and conclusions	24
Recommendations	30

Introduction

This report is issued under s.23 of the Public Services Ombudsman (Wales) Act 2019.

We have taken steps to protect the identity of the complainant and others, as far as possible. The name of the complainant and others has been changed as well.

Summary

Ms A complained about the care she received from Betsi Cadwaladr University Health Board ("the Health Board") and Liverpool University Hospitals NHS Foundation Trust ("the First English Trust"). Her concerns included her management and care following surgery for her inflammatory bowel disease in 2019, whether she was properly consented for surgery to address her fluid collections and pelvic infection in March 2022, as well as the post-operative care and treatment and the handling of her complaint.

The investigation found that following Ms A's surgery in 2019 the Health Board's management of her post-operative fluid collections was appropriate, but there were failings in the colorectal care provided by the First English Trust. The Ombudsman noted that Ms A should have been reviewed and monitored more closely, although it could not be definitively said that this would have prevented sepsis.

The Ombudsman also found issues with gynaecological referrals made to another NHS Trust, the appropriateness of an investigative procedure and the lack of preventative antibiotics given. These failings led to persistent infection and ill health for nearly 3 years before definitive surgical treatment in March 2022.

The investigation identified shortcomings in the consent process, and the Ombudsman concluded that Ms A did not give informed consent for the surgery in March 2022. This raised human rights considerations, particularly regarding personal autonomy and the right to respect for private and family life. The injustice for Ms A included not having an opportunity to reconcile herself to the likely outcome of the surgery or to explore options to have biological children in the future. The impact on Ms A, both physically and psychologically, was significant.

The investigation also highlighted a failure to provide information and advice about hormone replacement therapy, leaving Ms A to experience menopausal symptoms without clear management.

In respect of the handling of Ms A’s complaint, the Ombudsman found delays in complaint handling but did not consider the delay unduly excessive. The Health Board relied on the First English Trust to handle parts of the complaint which it was able to do, but there were shortcomings in the First English Trust's response.

The Ombudsman was concerned that in its contract monitoring of commissioned care, the Health Board prioritised financial reporting over patient safety and service quality. She considered that effective contract monitoring might have prevented some failings in Ms A's care.

The Ombudsman made a number of recommendations, which the Health Board accepted.

Within **1 month**:

a) Apologise to Ms A for the failings identified in the report.

b) Share the report with the Chair of the Health Board and the other Board members and its Patient Safety and Clinical Governance Group.

Within **2 months**:

c) As part of its commissioning arrangements, request the First English Trust undertake and evidence the following:

   i. a review of Ms A’s case to see what additional learning could be identified to improve the patient experience;

   ii. a reminder to its clinicians of the relevant guidance around informed consent and their professional obligations when it comes to record keeping to ensure that discussions with patients are documented;

   iii. as a point of learning, it shares with clinicians an anonymised case study of the clinical failings identified in the case at an appropriate clinical forum;

iv. the Colorectal Surgeon is asked, as part of learning and reflection, to share a copy of this report and discuss the steps that she has put in place to improve her clinical practice at her next professional revalidation;

v. a copy of the report is shared at its relevant patient safety governance committee.

In addition, the Health Board should:

d) Seek written assurances from the First English Trust's Chief Executive that it has taken steps to address the clinical failings identified in the report.

e) Share the compliance evidence relating to recommendations c) and d) with the Ombudsman's office.

Within **6 months**:

f) Prioritise, complete and implement a Commissioning Assurance Framework.

The Complaint

1. Ms A complained about care she received from Betsi Cadwaladr University Health Board ("the Health Board") and also care commissioned by the Health Board from an NHS Trust in England, the Liverpool University Hospitals NHS Foundation Trust ("the First English Trust"). The investigation looked at whether Ms A received:

a) Appropriate review and treatment of her post-operative fluid collections and pelvic sepsis (when the body overreacts to an infection originating in the pelvis, causing damage to the organs and tissue) following surgery in 2019, including adequate gynaecological input.

b) Sufficient time and information to understand and consider the risks of the surgical removal of her post-operative fluid collections in March 2022, and to give her fully informed consent before this surgery was carried out.

c) Prompt and appropriate investigation and treatment for her pain and reduced kidney function following surgery.

d) Timely and appropriate information about her hysterectomy (surgery to remove the womb), including advice about post-operative recovery, the menopause and options for hormone replacement therapy ("HRT" – treatment that can help relieve menopause symptoms).

2. The investigation also considered whether the Health Board dealt with Ms A's complaint in line with the National Health Services (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011.

Investigation

3. As part of the investigation, we obtained comments and copies of relevant documents from the Health Board, Liverpool University Hospitals NHS Foundation Trust ("the First English Trust") and Liverpool Women's NHS Foundation Trust ("the Second English Trust") to which Ms A was referred by the First English Trust, and considered those in conjunction

with the evidence provided by Ms A. [In late 2024 an organisational restructure led to the First and Second English Trust coming together under a Group structure. However, this report reflects the position at the time of the events in question.]

4. We also obtained professional advice from 2 of my Professional Advisers, Mr Misra Budhoo, a consultant general and colorectal surgeon ("Colorectal Adviser") and Mr Nitish Narvekar, a consultant obstetrician and gynaecologist ("Gynaecology Adviser"). My Advisers were asked to consider whether, without the benefit of hindsight, the care or treatment had been appropriate in the situation complained about. I determine whether the standard of care was appropriate by making reference to relevant national standards or regulatory, professional or statutory guidance which applied at the time of the events complained about. We have not included every detail investigated in this report, but I am satisfied that nothing of significance has been overlooked.

5. The Health Board has commissioning arrangements in place with the First English Trust, under the terms of an "NHS Standard Contract", which I have considered. As a Welsh patient receiving treatment commissioned by a Health Board in Wales, Ms A's treatment falls within my jurisdiction as set out in Schedule 3 of the Public Services Ombudsman (Wales) Act 2019.

6. The NHS complaints process should not be seen as operating in isolation. A key part of the investigation was to look more widely at the interaction between the complaints process (referred to at paragraphs 2 and 19) and the Health Board's contract monitoring process. This was to ensure that the monitoring in place was sufficiently robust to support the way that the complaints process works with commissioned services.

7. Both Ms A, the Health Board and the First and Second English Trust were given the opportunity to see and comment on a draft of this report before the final version was issued.

Relevant legislation/guidance

8. Article 8 of the European Convention on Human Rights, as enshrined in UK law by the Human Rights Act 1998 (“the HRA”), deals with the right to respect for an individual’s personal autonomy and private and family life. It also protects an individual’s right to control of their body, health and treatment. Although Article 8 is not an absolute right (as a qualified right it can involve the weighing up and balancing of competing rights), a failure to obtain informed consent could contravene Article 8.

9. The FREDA Principles: a set of guiding principles (Fairness, Respect, Equality, Dignity and Autonomy) which were developed to help NHS organisations and clinicians treat patients and their loved ones in a way that protects and respects their human rights.

10. It is not part of my function, as Ombudsman, to make definitive findings about whether a public body has breached its duties under the HRA. However, when considering whether there has been maladministration or service failure on the part of a public body, as Ombudsman I may consider whether human rights have been engaged. I can then comment on whether public bodies have had regard to human rights considerations while performing their functions.

11. My office has issued statutory guidance relating to the “Principles of Good Administration” (2008, updated 2016 and again in 2022) (“the Guidance”), to which bodies within my jurisdiction are also expected to have regard, in order to deliver good administration and customer service. The Guidance sets out the principles of good administration that public sector providers are expected to adopt when it comes to service delivery and dealing with service users. These principles include, for example, public bodies being open and accountable by taking responsibility for their actions. The most recent update reinforces that in commissioning services, a public body should ensure there are “robust governance arrangements in place” since as the body with statutory responsibility for delivering the service, they remain accountable for it, regardless of who is delivering the service in practice.

12. Clinically, my Advisers and I have considered the following guidance from the National Institute of Health and Care Excellence (“NICE”):

- NG125: “Surgical site infections: prevention and treatment” (August 2020) which notes that patients should be given clear, consistent information and advice about wound management throughout all stages of their care.

- NG180 “Perioperative care in adults” (August 2020) which states that patients should be given a point of contact to provide information and support before and after their surgery. It also recommends offering an enhanced recovery programme to people having elective major or complex surgery (such as hysterectomy).

- NG23 “Menopause: diagnosis and management” (December 2019) sets out the management and information to be provided to patients prior to menopause triggering surgery (such as a hysterectomy).

13. In addition, the General Medical Council has produced various guidance for doctors on consenting patients. The 2013 “Good Medical Practice” guidance sets out what is required in terms of the consenting process for doctors to be satisfied they have valid consent from a patient for an investigation or treatment. The 2020 guidance on “Decision-making and consent” expands on this.

14. The guidance requires the discussion on consent to be documented. Where the consenting process is delegated to another person, it says what level of knowledge and training is required of that person. The guidance also makes it clear that the delegating doctor is still responsible for ensuring that the patient has been properly consented.

15. Other guidance such as “Consent: supported decision-making, a Guide to Good Practice” (November 2018), issued by the Royal College of Surgeons, reiterates the need for the consent process to begin “well in advance of the treatment” and that more than 1 discussion may be required for particularly complex or life-changing discussions. It confirms that just because a patient signs a consent form does not mean that legally valid consent for treatment has been obtained.

16. “Obtaining Valid Consent Clinical Governance Advice No. 6” (January 2015), issued by the Royal College of Obstetricians and Gynaecologists (“RCOG”), says that as part of the consenting process, if written consent is to be taken immediately before the operation, the patient must have been given the opportunity to discuss any intervention in a clinic or preoperative assessment unit visit. Otherwise, patients should be advised that they can defer or postpone their treatment to have more time to consider. If the patient’s ovaries are removed without appropriate consent, the doctor should record their decision-making, and reasoning, and ensure that the patient is informed of the event, and why it occurred, as soon as is practical.

17. Other RCOG guidance such as “Abdominal hysterectomy for benign conditions, Consent Advice No. 4” (May 2009), stresses the importance of patients being aware of the nature of the procedure and that the patient’s preferences, in relation to removing or leaving the ovaries alone should be documented, if it is not certain that the ovaries will be removed. The guidance notes that patients should also be advised about the potential psychological and physical impact of the procedure (for example in terms of fertility, sexual and bladder function, and the menopause).

18. Although the NICE and other guidance referred to above is not mandatory, clinicians are expected to have regard to relevant guidance as part of their clinical decision-making. In the event that the decision is made to depart from guidance then the rationale for doing so should be clearly documented.

19. Finally, in terms of the complaints process, I have considered the Welsh Government National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 and accompanying “Putting Things Right” guidance (collectively known as “PTR”). These set out the timescale for a complaint response. They also confirm that complaints about care provided by an English body that has been commissioned by a Welsh body should be dealt with through the English body’s own complaints procedure. However, if it becomes apparent that any care provided or arranged by the English body may have caused

harm to a patient, the English body must notify both the NHS Litigation Authority and the Welsh commissioning body. It is then for the Welsh body to consider whether any harm has been caused and take action as appropriate, although the 2 bodies should co-operate.

The background events

20. In **2016** Ms A, who has a history of chronic inflammatory bowel disease ("Crohn's disease"), had a subtotal colectomy (where the large bowel is removed) at Ysbyty Glan Clwyd ("the Welsh Hospital"). In June **2019** due to recurrent bleeding, Ms A underwent a proctectomy (surgery to remove her rectum and anal canal) at the First English Trust's Royal Liverpool University Hospital ("the English Hospital"). A percutaneous (through the skin) drain was inserted to treat an internal collection of fluid which had developed; a computerised tomography scan ("CT scan" - the use of X-rays and a computer to create an image of the inside of the body) showed that the collection had reduced, and Ms A was discharged on 2 July.

21. On 10 July Ms A attended the Welsh Hospital complaining of pain and feeling generally unwell; a CT scan confirmed that she still had a fluid collection, but it was decided not to intervene because of its small size. Ms A attended a follow-up appointment at the English Hospital on 27 August, when the colorectal surgeon responsible for her care ("the Colorectal Surgeon") noted Ms A's ongoing pain and recurrent fluid collections and planned to carry out blood tests and a further CT scan.

22. On 7 October Ms A returned to the Welsh Hospital again complaining of ongoing pain. Another CT scan showed that the fluid collection had slightly increased; it was described as a complex infection collection in the space in front of Ms A's coccyx and sacrum (bones at the base of the spine). Ms A was advised to wait for her next planned appointment at the English Hospital for review of the collection and appropriate treatment. On 30 October the Colorectal Surgeon wrote to Ms A informing her that there was "no collection seen" on her most recent CT scan and arranging to see her again in 3 months' time.

23. Ms A attended the Welsh Hospital again on 12 December complaining of pain and feeling unwell and “shivery”. As the fluid collection was persisting and forming pockets within Ms A’s pelvis, a drain was inserted, which reduced the collection. Ms A was discharged on 16 December with the drain still in place.

24. Ms A went to the Welsh Hospital again on 19 December reporting more pain and feeling unwell; the collection was still there and there was now infection at the drainage site. Ms A was admitted as an inpatient. On 22 December the drain was flushed out, but it was not draining much fluid. It was decided to treat Ms A with intravenous (“IV”) antibiotics for which she required further interventions. A CT scan on 6 January **2020** showed there was no improvement in the collection and Ms A continued on longer-term IV antibiotics. She was eventually discharged on 15 January and arrangements were made for her to have a further 3-week course of IV antibiotics.

25. Ms A was reviewed by a gastroenterologist (“the Gastroenterologist”) at the English Hospital in February when she complained of continuing pain and also urinary incontinence. An ultrasound scan (the use of high-frequency sound waves to create an image of the inside of the body) showed that Ms A had a prolapsed uterus (when the uterus slips down and bulges into the vagina) and a cyst within the area, although it was noted that the cyst had been present on previous scans and appeared unchanged. The Gastroenterologist sent a referral to the Gynaecology department of the Second English Trust on 4 March.

26. A further referral to Gynaecology at the Second English Trust was made by a urologist on 6 August **2021**, when it was noted that a CT scan had also revealed a polyp (a growth attached to the inner wall of the uterus that expands into the uterus) in Ms A’s uterine cavity. Also, on 19 August the Colorectal Surgeon made a referral to a consultant gynaecologist at the Second English Trust (“the Gynaecologist” is also an Oncologist within the Oncology team). The referral noted that the top of Ms A’s uterus was now possibly affected by the infection and requested a gynaecology view be obtained before proceeding to general surgery to clear the infection. On 29 October a further letter was sent to the Gynaecology department, noting that it was possible Ms A’s ovaries were also affected and requesting the appointment be expedited.

27. On 16 November the Colorectal Surgeon wrote again to the Gynaecologist asking him to review Ms A's scans and see her urgently. It was noted that Ms A was unable to tolerate a magnetic resonance imaging scan ("MRI scan" - the use of strong magnetic fields and radio waves to produce detailed images of the inside of the body) owing to claustrophobia and it was suggested that the best way to proceed might be an operation with general and gynaecological involvement to clear the infection.

28. The Gynaecologist sought input from a consultant radiologist, who responded on 29 December. He had reviewed Ms A's scans and identified possible fluid build-up in her fallopian tubes and evidence of potentially infectious pockets of fluid, as well as the polyp in the inner lining of Ms A's uterus. He suggested it might be possible to try an MRI scan again with sedation.

29. The Second English Trust arranged for Ms A to undergo a hysteroscopy (where a thin lighted tube is inserted into the uterus with a camera), which would also look at whether to remove the polyp, on 22 January **2022**. The procedure could not be completed because it caused Ms A too much pain. It was noted that Ms A's uterus and cervix were pushed backwards and stuck to the front of her sacrum.

30. Later that month, Ms A was admitted to the Welsh Hospital again with pain and generally feeling unwell. A CT scan showed that she had a mass in her pelvis which was suspected to be a chronic abscess, with a thick capsule (made up of surrounding healthy cells, a wall of tissue surrounds the abscess to stop it infecting neighbouring structures) preventing further percutaneous drainage. The Welsh Hospital contacted the Colorectal Surgeon, who advised that Ms A should be admitted to the English Hospital for surgery to remove the collection. Ms A was discharged from the Welsh Hospital with another drain in place.

31. In early March Ms A received a telephone call from the Colorectal Surgeon; the telephone call was not documented by the Colorectal Surgeon, and the content of the discussion is disputed. On 9 March Ms A was admitted to the English Hospital for surgery to remove the collection. She signed a consent form (at 8:31) that morning, which was completed by a registrar training in colorectal surgery ("the Registrar"). The consent form noted that the operation might involve a total abdominal

hysterectomy and removal of both Ms A's ovaries; it listed the intended benefits of surgery, with the significant, unavoidable or frequently occurring risks also documented. These included bleeding, infection (which was detailed), menopausal symptoms (only if both ovaries were removed) and death. In terms of alternative treatment this was listed as antibiotics, radiological drainage of the tubo-ovarian abscess (a procedure to drain the abscess/inflammatory mass that develops in a fallopian tube and ovary) and no treatment. There was no separate documented consenting discussion note.

32. At 13:03, Urology carried out a procedure where bilateral stents were inserted into Ms A's ureters (a stent is a thin flexible tube that keeps open the ureter, a duct which carries urine from the kidney to the bladder) to allow for identification of the ureters in the surgery that followed.

33. The surgical operation notes indicate that the Colorectal Surgeon was the lead surgeon, supported by the Gynaecologist and the Registrar. Ms A underwent a full hysterectomy and the removal of both fallopian tubes and ovaries as well as the clearance of the collection. The bilateral ureteric stents were subsequently removed. Later, Ms A was given antibiotics and pain relief on the ward; the Registrar did not note any concerns when he reviewed Ms A the following day. A pain review noted some abdominal pain, and that Ms A was unable to breathe deeply or cough, and pain relief was continued.

34. On 12 March nursing staff recorded that Ms A complained of back pain and that she could be given pregabalin (medication used in the relief of nerve pain). It was noted that her urine was still quite blood-stained, although a good amount was being passed. Later that day, Ms A's pain seemed "a lot less severe", although by the evening nurses noted that she still had back pain when she was in bed. The following day, a doctor noted that Ms A reported left-sided "flank pain" (which generally refers to the upper abdomen, back and sides); nursing staff noted that Ms A continued to report pain, which was worse when sitting in a chair. Ms A was able to mobilise to the toilet and around her bed independently.

35. On 15 March a doctor noted that Ms A complained of back pain and was having difficulty mobilising. A pain review noted that Ms A described a “stabbing twisting sensation sometimes radiating from left to right”. By the evening, nursing staff noted that Ms A’s back pain was severe and uncontrolled, radiating from her lower back to both her sides, and she was unable to remain still in bed. An urgent CT scan in the early hours of 16 March showed that both Ms A’s kidneys were swollen with a build-up of urine, and a urine test showed evidence of infection.

36. A referral was made to Urology, and on 17 March stents were inserted to allow urine to drain from Ms A’s kidneys to her bladder. Ms A was discharged on 19 March with outpatient reviews planned with Urology and the Colorectal Surgeon.

Complaint handling

37. Ms A submitted a complaint to the First English Trust via her Advocate and copied it to the Health Board in August 2022. Internal emails confirmed that the Health Board would only respond to the concerns about the Welsh Hospital, as Ms A’s other concerns had already been forwarded directly to the First English Trust.

38. In its response to Ms A, dated 28 October, the Health Board said that non-surgical treatment of Ms A’s fluid collections was recommended when she first presented because it was only 4 weeks after her surgery. When she returned to the Welsh Hospital in October [2019] it advised waiting for her planned review because her symptoms at that time were “minimal”. It apologised for the pain and discomfort Ms A experienced when the drains were inserted in December, but said it was agreed to continue treatment given that she was responding to the antibiotics.

39. The First English Trust responded to Ms A’s complaint in February **2023**. In its complaint response it said that further surgery was not recommended for 3-6 months following a major operation because of the risk of complications. It said that Ms A’s case was discussed extensively at multi-disciplinary team meetings, and that surgery was arranged as soon as it was felt that the benefits outweighed the risks.

40. The First English Trust apologised that the operation, and the possibility that Ms A might need a hysterectomy, was not discussed "closely enough" with her before her surgery. The Colorectal Surgeon had said that this, and the possibility of triggering early menopause, were "likely" discussed during the telephone conversation in early March. The First English Trust added that this "will" have been included as part of the discussion around hysterectomy and removal of the ovaries but acknowledged that it was not able to find documentation of the conversation and details of what specifically was discussed. It accepted that in terms of the telephone call that Ms A had not been given the opportunity to process the information, prepare any questions, or have the opportunity to ask questions at a later date.

41. The First English Trust also apologised that nobody had explained the operation to Ms A or the need to consider HRT after the surgery. It also noted the need to document consent discussions. The First English Trust said that it had created an action plan to address these areas of learning. It added that certain issues (consideration of the need for a hysterectomy and whether it might have been avoided if surgery had been undertaken sooner, and the lack of gynaecology follow-up and HRT advice) should be dealt with by the Second English Trust.

42. In relation to Ms A's concern that no-one had discussed her wish for a family prior to the surgery, the First English Trust commented as follows. It said that the Colorectal Surgeon had advised that family planning had been discussed with Ms A since 2017. It noted that Ms A's Crohn's disease, proctectomy and longstanding pelvis sepsis all have significant implications on the chances of becoming pregnant and that it was documented that Ms A's proctectomy was initially delayed for this reason. The First English Trust said that unfortunately Ms A had 3 emergency admissions due to bleeding and her surgery therefore had to be expedited in 2019. Similarly, the decision to undergo surgery to resolve the collections and prevent significant harm had been taken as a result of Ms A's ongoing pelvic sepsis. It added it was:

> "very sorry to hear that [Ms A] would have liked to have a conversation around the possibility of preserving her eggs and that she did not have the opportunity for this. Unfortunately, egg conservation is usually only considered when a patient is below

the age of 37. We would like to apologise that this was not discussed with her and for the distress that she has experienced as a result of not having this conversation at the time."

43. The First English Trust did not share its complaint response with the Health Board [As the First English Trust's complaint investigation did not identify that Ms A had been caused harm, there was no requirement to do so under PTR, see paragraph 19.]

44. Ms A's Advocate forwarded Ms A's complaint about her other concerns to the Second English Trust. In its response to the complaint (provided only during the course of my investigation) the Second English Trust said the Gynaecologist recalled what was a complex case and that he and the Colorectal Surgeon had discussed the "high chance" of Ms A requiring the removal of her reproductive organs, but that the extent of the inflammation and infection was not fully realised until the operation took place. It said that the Gynaecologist had planned to have a telephone conversation with Ms A to discuss the gynaecological aspects of the operation, but the First English Trust had brought the operation forward at short notice. In any event, it said that it was for the First English Trust to ensure the consenting process was appropriate as they were leading the operation and therefore responsible for Ms A's care.

45. The Second English Trust upheld Ms A's complaint that she was not reviewed by the Gynaecologist following the surgery and that HRT was not discussed with her. It said that Ms A should have been advised about HRT 6 to 8 weeks after her operation. In reaching this conclusion, it noted the Gynaecologist's statement that HRT would not be commenced until the 6 to 8 week post-operative telephone review (for out of area patients) had taken place. This was to exclude any disease that might be identified from the tissue sample taken at the time of the operation for which HRT was not advisable. It was also to ensure that Ms A had recovered from the surgery. The Second English Trust said that at the time it did not hold regular routine ward rounds at the English Hospital, but that it had subsequently introduced them to ensure patients requiring gynaecological input are reviewed and post-discharge follow-up arranged.

Ms A's evidence

46. Ms A said that the insertion of the drains was "horrific" and that having them left in situ was extremely uncomfortable and embarrassing as she needed to carry a pillow everywhere she might need to sit down.

47. Ms A said she was also very unwell with them, and felt they were causing her more harm than good. Ms A said that the drains obviously were not working, and her treatment should have been changed much sooner. She questioned whether this might have prevented the need for such radical surgery and saved her reproductive organs.

48. Ms A recalled that she was a passenger in a car with her elderly parents when the Colorectal Surgeon telephoned her unexpectedly in early March. She was therefore unprepared and unable to ask any questions about what she was told. She remembered the Colorectal Surgeon told her what a large operation it would be, confirmed Ms A did not already have children and said that she might lose an ovary which had not been visible on her last CT scan.

49. Ms A said that she signed the consent form for the surgery as she was getting ready to go into theatre and that she had been anxious and distressed at the time. She said she was unaware that a hysterectomy was a possible outcome and only found out this had happened when a nurse told her after she woke up from the surgery. She said that none of the operating team came to talk to her about it or to review her recovery and she was forced to ask clinicians who had not been involved to explain what had been done. Ms A said she had not known whether the Gynaecologist had been present during the operation until it was confirmed by my office.

50. Ms A said that the district nurse team had advised her after her discharge about what she should and should not do as she recovered as she had not been given that information by the English Hospital. She also said the district nurses had told her that she should have been advised about HRT, which she eventually sought through her GP.

51. Ms A described her whole experience as being "horrific" and said that mentally "I have had so many dark days". She said she had been significantly impacted by the way she had been treated and the outcome

of the surgery; she was devastated as she had wanted to have children. She had since sought counselling and mental health support to help come to terms with the situation. However, she said that there were still trigger points everywhere, as she saw families going out together, babies and children and she referred to the "grieving process" that she was going through. She added in terms of her situation:

> "I'm avoiding people; people ask me about my health and I've lost my confidence as I'm not steady enough to talk about this, I know I'll burst into tears and I don't want to do that. I know I'm a different person, my family keep telling me that. I feel like a shadow of my former self."

The Health Board's evidence

52. In its response to enquiries from my office, the Health Board referred to the terms of its [standard] contract with the First English Trust and other providers and explained the reporting requirements it contained. It said that reports from such providers are reviewed by the Health Board's professional leads. It added that the contract team regularly reviews external sources for any reports relating to providers that may impact on the services commissioned for Health Board patients.

53. In terms of contract monitoring, the Health Board added that it did not currently have regular contract meetings with commissioned providers, such as the First English Trust, but contacted them on an ad hoc basis for any information it might need. The Health Board said that its commissioned providers report financially to the Health Board on the contract each month. These reports are validated and reviewed and any issues arising are raised with the provider. The Health Board noted that the contract covers all aspects of the relationship including performance and quality. The Health Board commented that its Healthcare Contracts section does not receive or review reports on these other areas but would liaise with the provider on contractual issues if any were identified by the relevant department within the Health Board. The Health Board noted that its Head of Healthcare Contracting - Finance was not aware of any such request for this being made in this case.

54. The Health Board said that it was developing a Commissioning Assurance Framework ("CAF") which, when in place, would give greater clarity on the roles and responsibilities for the monitoring of external contracts. The CAF is a continuous assurance process that aims to provide confidence to internal and external stakeholders, and the wider public, that the Health Board is operating effectively to commission safe, high-quality and sustainable services within the resources available. This includes delivering on statutory duties and driving continuous improvement in the quality of services and outcomes achieved for patients. The CAF is designed to place the patient, service quality and patient safety at the heart of commissioned services.

Professional Advice

The Colorectal Adviser

55. My Adviser said that post-operative pelvic collections following a proctectomy are generally best treated non-operatively and it was appropriate to try drainage and antibiotics in the first instance. He concluded that Ms A's treatment from the Welsh Hospital up to February 2022 was clinically appropriate. At that point, consideration for surgical removal of the collection was reasonable, given that non-operative options for treatment had been unsuccessful. My Adviser also said there was no clear gynaecology condition (such as would have necessitated referral to Gynaecology at the Second English Trust) until the polyp was identified [in June 2021].

56. However, in respect of Ms A's care from the First English Trust during this time, my Adviser commented that:

- The Colorectal Surgeon's letter on 30 October 2019 was inaccurate, as every scan showed that the fluid collection was persisting and increasing. Ms A should have been reviewed at that time to consider whether to attempt drainage or monitor her more closely, which might have prevented her from developing sepsis and requiring hospital admission in December.

- It was unclear why Ms A’s care seemed to be overseen by the Gastroenterologist between October 2019 and August 2021. As her ongoing problems were post-operative complications, coordination of her care should have been done jointly with the surgeons.

57. My Adviser has noted that Ms A’s surgery in March 2022 was a complex operation with significant consequences for her. He said the consent form, signed on the day of her surgery, was insufficient to demonstrate appropriate, informed consent for the procedure. He also said that:

- Whilst the operation was brought forward in early 2022, possibly as a result of the hysteroscopy triggering further development of Ms A’s existing infection, it was not an emergency and should only have gone ahead following appropriate discussion and consent.

- There was no apparent documented discussion prior to the day of the surgery about the nature of the operation, the potential that Ms A’s reproductive organs might need to be removed, or the implications of that.

- Consent is a process - not a moment in time based on signing a form prior to surgery, with no other supporting documented discussion, prior to the day of surgery. In Ms A’s case there was no reasonable discussion or time (on the day of the surgery) for Ms A to process the information.

- It was questionable whether the Registrar was a suitable clinician to take Ms A’s consent, given that the Registrar was training in colorectal surgery and had no complex/major gynaecological background. In addition, the Adviser pointed to the inadequate documented discussion as well as the absence of any prior information or discussion with Ms A.

- The responsibility for consent lay primarily with the Colorectal Surgeon as the operating surgeon and the clinician with overall care of Ms A’s admission. However, given that this was a planned procedure, the Colorectal Surgeon should have ensured that the consent process also had appropriate input from the Gynaecologist.

58. My Adviser said that it would not normally be within the remit of a colorectal surgeon to perform gynaecological surgery or provide appropriate gynaecological advice post-operatively. However, the Colorectal Surgeon, as the principal surgeon involved, had direct responsibility for the implications of the operation; and as such should have been directly involved in Ms A's post-operative inpatient care and should have ensured or requested appropriate gynaecological follow-up. This was particularly so, given the implications of the most radical options in terms of the surgery and the damage to Ms A's ureters, a known but uncommon complication of such surgery.

59. My Adviser also considered the action taken in relation to Ms A's complaints of back pain following her operation. He said that the records showed that Ms A was making reasonable progress; there was mention of some pain in the left flank area 4 days post-surgery, but there was little record of back pain until 16 March. He said that symptoms of damage to the ureters usually develop after 6 to 8 days. It was therefore not surprising that Ms A's pain was not reported to be significant until 16 March, and she was treated within 24 hours, which was 8 days after her operation. My Adviser concluded that, in this respect, the care provided was timely and the action taken was appropriate.

60. In reviewing Ms A's case, my Adviser also raised additional concerns. Firstly, he noted that there was no recorded discussion regarding the risks and benefits of Ms A's original surgery in June 2019, despite the proctectomy being a significant operation with serious risks including bladder dysfunction, chronic infection and infertility issues. In addition, the operation notes did not include any information about the role of the Gynaecologist, such as when he arrived and what he did. My Adviser said that the Colorectal Surgeon should have ensured that the Gynaecologist properly documented his involvement and instructions for post-operative management.

The Gynaecology Adviser

61. My Adviser said that given Ms A's case was surgically complex, it was appropriate to treat her collections non-surgically for the initial 6 months after her proctectomy operation. He felt that after that time further surgical management should have been considered and, given

the pelvic pain and other symptoms Ms A experienced, she should have been referred to Gynaecology by the middle of 2020. However, he noted that referrals and reviews at that time would have been impacted by the COVID-19 outbreak and the management of her collections would have remained with the Colorectal Surgeon because they were primarily related to the proctectomy in 2019.

62. My Adviser reflected that it is not unusual for a hysteroscopy to trigger (or exacerbate) a pelvic infection and this should have been considered before it was attempted in January 2022. However, there was no record that this risk was considered, or that alternative options to investigate the nature of the polyp were explored, such as an open MRI scan (using a type of machine with a wider opening and which is more comfortable and easier to tolerate than a traditional scanning machine). He also said that Ms A should have been prescribed prophylactic (preventative) antibiotics, which could have mitigated the risk of infection. In the event, the abandoned hysteroscopy probably caused inflammation and possibly triggered the development of further infection leading to Ms A's admission in the January. However, my Adviser has concluded that it was likely that Ms A would have needed definitive surgery in any event and thus the ultimate outcome might have been the same.

63. Turning to the decision to proceed with surgery and the operation in March, my Adviser said that:

- There was little communication or shared decision-making between the different specialities who were treating Ms A; each clinician seemed to review her in isolation so there was no joined-up thinking or holistic approach to her care.

- There was no record of Ms A's case being discussed in a multi-disciplinary meeting or that the risks and benefits of a hysterectomy were discussed in detail at any point.

- Ms A's operation was not an emergency, and the Gynaecologist was aware of the possibility that he would need to remove her reproductive organs, so he should have obtained her informed consent before it took place.

- Ms A should have been fully involved and informed of the complexity of her condition, the nature of the operation and the available treatment options.

- The complexity and persistence of Ms A's infection and fluid collections were such that open surgery and, ultimately, the removal of her reproductive organs was appropriate.

64. In relation to Ms A's post-operative care, my Adviser said that HRT should have been discussed before the operation took place. Where HRT is agreed, it is standard practice for it to start at the point of discharge, which is generally within 5 days of surgery. If Ms A's case meant there was a variance in normal practice, then the rationale for withholding HRT should have been explained to Ms A and HRT prescribed immediately at the earliest opportunity to do so.

Comments on the draft report

65. The First English Trust acknowledged that Ms A had had a very difficult time and offered its apologies to her for the distress and anxiety that she had encountered in what it acknowledged was a very complex case.

66. The First English Trust said that Ms A had consistent collaborative care at the First and Second English Trust and that the scan results given to Ms A by the Colorectal Surgeon "were true". However, with the benefit of hindsight, tubo-ovarian collection had been the cause of her recurrent infection, and the right procedure had been performed at the time.

67. The First English Trust said that the Registrar, who was a senior registrar, was appropriate to take consent. It noted that consent was completed with Ms A 2 hours prior to her going to theatre and the First English Trust added that "I can assure you there was time to discuss further with the team." The First English Trust said that it accepted that it was a "big" surgery for Ms A and that her post-operative course was not smooth, and that recollection can sometimes not be clear. It added that regular gynaecology involvement post-operatively was now routine, however, multi-disciplinary teams have always been collaborative. The First English Trust acknowledged that communication

had fallen short of the standards of excellence it aims for in its Surgery Division. It also noted that the lessons learnt from Ms A's case would be discussed more widely across teams.

68. The Second English Trust referred to the timeliness of the HRT prescribing. It said that normal practice in general gynaecology after straightforward surgery with benign pathology (no cancerous disease) is to offer HRT before discharge from hospital. However, it added that Ms A's surgery was not straightforward, and her case was complex. Ms A had a complex abdomen with extensive adhesions, and it would not have been possible to eliminate the possibility of pathology such as a low-grade ovarian malignancy or endometriosis. Therefore, it reiterated that waiting until the histology was available and discussing HRT at the post-operative appointment was the normal practice within the oncology team of which the Gynaecologist was a member.

Analysis and conclusions

69. In reaching my conclusions I have considered the advice that I have received from my Advisers, which I accept. However, the conclusions reached are my own. Where there might be slight differences in the views of my Advisers, I have given more weight to the view of the Adviser who works within the same speciality as the clinician who made, or should have made, the decision due to their expertise in this field. I will address each of Ms A's concerns in turn. The Health Board, as commissioner of the care from the First English Trust, is responsible for monitoring the performance of the contract and for any failings which I identify on the part of the First English Trust. It is also responsible for any failings on the part of the Second English Trust to which referrals were made by the First English Trust, as by extension, this care was also undertaken under the terms of the contract with the Health Board.

Whether Ms A received appropriate review and treatment of post-operative fluid collections and pelvic sepsis following surgery in 2019, including adequate gynaecological input

70. The management of Ms A's fluid collections by the Health Board was reasonable. Both Advisers agreed that it was appropriate to attempt to resolve the matter by non-surgical means, by the use of

antibiotics and drainage in the first instance. However, I conclude that there were failings in the First English Trust's care of Ms A during this period. Specifically, the Colorectal Surgeon incorrectly reported the outcome of the October 2019 scan, which affected Ms A's treatment at that time; Ms A should have been reviewed and consideration given to attempting drainage or closer monitoring. I cannot say definitively that this would have prevented Ms A from developing sepsis, but there is a possibility that it might have done. In any event, Ms A's care between 2019 and 2021 should at least have involved surgeons, rather than having been overseen by the Gastroenterologist, since her ongoing problems were related to the surgery.

71. The Gynaecology Adviser has said that Ms A should have been referred to Gynaecology by the middle of 2020. In fact, the Gastroenterologist did make such a referral in March 2020; however, I have seen nothing to suggest that any action was taken in response to that referral, but I am mindful that referrals and reviews at that time would have been affected by the COVID-19 pandemic, and this may account for why it appears to have been missed or overlooked.

72. I turn now to the input from Gynaecology once the further referrals were actioned. I am concerned that, in view of the possibility that a hysteroscopy might trigger or exacerbate a pelvic infection, there was no consideration of the advisability of carrying out this procedure, or exploration of alternative options to investigate the nature of the polyp. In addition, Ms A should have been prescribed prophylactic antibiotics to mitigate the risk of infection. The subsequent decision to proceed with surgery and the operation in March 2022 was made with seemingly little or no communication between the different specialities involved in Ms A's care, and certainly no multi-disciplinary meeting to consider the risks and benefits of a hysterectomy.

73. The failings I have identified, both from a colorectal and gynaecological perspective, amount to service failures. Ms A suffered from persistent infection and associated ill-health for nearly 3 years before definitive surgical treatment was performed. In addition, although it is not possible to say whether the outcome for Ms A would have been

any different but for these failings, Ms A will always wonder whether her hysterectomy could have been avoided. These are considerable injustices to her. I therefore **uphold** this part of the complaint.

Whether Ms A was given sufficient time and information to understand and consider the risks of the surgical removal of her post-operative fluid collections, and to give her fully informed consent before this surgery was carried out

74. I am extremely concerned about the process by which Ms A gave her "consent" for the surgery in March 2022. The relevant guidance makes it clear that consent is not simply a matter of completing and signing a form and to place reliance solely on the form does not show that consent has been adequately given. Instead, consent is a process which should begin well in advance of the day of the surgery; it should ensure the patient is fully aware of what is proposed and the options and the intended benefits and risks of the surgery and is given the opportunity to formulate and ask questions and has time to process that information. It is disappointing that the First English Trust's response does not appear to have recognised this when commenting on the time available to Ms A before she went to theatre for what it accepted was a "big" operation (see paragraph 67).

75. Any discussions should be clearly and separately recorded as part of the consenting process. This did not happen here. Guidance also makes it clear that the doctor [who carries out the surgery] is responsible for ensuring valid consent is given before the treatment. If part of the consent process, as in this case the completion and signing of the consent form, is delegated to another person, that person must be suitably trained and have sufficient knowledge to discuss the operation, alternative options and benefits and harm with the patient. There is no separate documented record that would provide some insight into the consenting discussion that took place on the day of surgery. I am also mindful that Ms A's case was complex, and from a gynaecological viewpoint not straight forward as recognised by the Gynaecologist (see paragraph 44).

76. The responsibility for obtaining Ms A's consent for the operation was primarily that of the Colorectal Surgeon as the operating surgeon and the clinician with overall care of Ms A during her admission,

although there should also have been appropriate input from the Gynaecologist. The situation was not an emergency, and appropriate, informed consent should therefore have been obtained. There is no record of a separate documented discussion that took place with Ms A prior to surgery about the nature of the operation or the possibility that her reproductive organs might need to be removed. I do not accept that the full implications of the surgery were "likely" discussed with Ms A during a telephone call - there is no evidence of this. I am also mindful that Ms A was not expecting the telephone call and had no chance to prepare for it.

77. On the evidence, I conclude that Ms A did not give informed consent for the extensive surgery which was carried out in March 2022. This is a serious failing which amounts to service failure. Although I am not able to make definitive findings of a breach of human rights, it is right that I draw attention to and comment on cases, such as Ms A's, where Article 8 rights are potentially engaged. I accept, based on the advice I have received from the Gynaecology Adviser, that Ms A would have needed definitive surgery and that ultimately the outcome might have been the same. Nevertheless, given that personal autonomy as well as the right to respect for one's private and family life underpins Article 8, Ms A had the right to have a say and to determine what was to happen in terms of her body. This is pivotal to informed consent and a rights based, person centred approach to care, that reflects the core FREDA principles and values.

78. I am mindful that had Ms A been properly consented, it would have given her an opportunity to reconcile herself to the likely outcomes, as there was no immediate urgency to carry out the procedure. It would also have meant that Ms A could have explored options that left open the possibility of having biological children in the future (for example through fertility preservation such as egg freezing and surrogacy). All of this was denied to her.

79. The impact on Ms A both physically and psychologically has been significant. Ms A has been left devastated as she wanted to have children, and she grieves the loss of that opportunity. Moreover, she has needed counselling and mental health support to come to terms with the

situation. I am satisfied that the serious failings identified in Ms A's case have caused her a significant injustice. I **uphold** this element of Ms A's complaint.

Whether Ms A received prompt and appropriate investigation and treatment for her pain and reduced kidney function following surgery in March 2022

80. Ms A's reports of pain following surgery were not thought to be significant until 16 March, some 7 days after her surgery. I accept the advice from the Colorectal Adviser that this timescale reflected the usual time for development of symptoms indicating damage to the ureters and Ms A received prompt and appropriate treatment for this. I therefore **do not uphold** this part of Ms A's complaint.

Whether Ms A received timely and appropriate information about her hysterectomy, including advice about post-operative recovery, the menopause and options for hormone replacement therapy

81. Ms A should have received advice and information about the possible consequences of the surgery before the operation took place. This should have included a discussion about HRT. I have seen nothing to indicate that such a discussion took place. This was a failing. The Colorectal Adviser said that it would not usually be the role of a Colorectal Surgeon to provide appropriate gynaecological advice post-operatively. However, the Colorectal Surgeon was the principal surgeon involved and therefore should have been directly involved in Ms A's post-operative care. If she was not able to provide gynaecological advice, the Colorectal Surgeon should have ensured relevant gynaecological input. I consider it unacceptable that Ms A was obliged to seek information regarding the surgery she had undergone from people who had not been directly involved in the operation, and this must have caused Ms A considerable uncertainty and distress.

82. The failure to provide appropriate information and advice, including HRT, meant Ms A was left to experience menopausal symptoms at the same time as recovering from complex surgery, without a clear idea of her management and why it would be felt advisable for HRT to be delayed until the results of follow-up investigations had been received (see paragraphs 45 and 68). The failings I have identified amount to

service failure and caused Ms A considerable anxiety and distress. This is a further injustice to her. I therefore **uphold** this element of Ms A's complaint.

Whether the Health Board dealt with Ms A's complaint in line with the National Health Services (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011

83. Although there was a delay in the Health Board providing its complaint response to Ms A, the delay was not unduly excessive. It is clear that the Health Board did not see that it had a role to play in Ms A's complaint to the First English Trust that she had copied to the Health Board (see paragraph 37). The Health Board was entitled to rely on the First English Trust to consider the relevant elements of Ms A's complaint under its own complaints procedure, in accordance with the Regulations and guidance. I note that the First English Trust did not respond to Ms A's complaint until more than 6 months after the complaint had been received and did not address (or forward for consideration) the concerns that related to the care it had arranged at the Second English Trust. The First English Trust did identify and apologise for some failings. However, its response was not sufficiently robust and should have more fully identified and acknowledged the extent of the serious failings identified by my Advisers, especially around informed consent for the surgery. However, because the First English Trust's investigation did not identify harm it did not have to bring Ms A's case to the attention of the Health Board. Therefore, the Health Board would not have had sight of the First English Trust's complaint response.

84. Strategically and operationally the complaints process should not be seen as operating in a vacuum. Instead, it should be seen as part of an integrated, joined-up approach to improving patient safety and experience, in which an effective assurance contract monitoring process plays a vital supporting role. This is more so in the case of commissioned healthcare services outside of Wales, where effective contract monitoring provides an additional layer of patient protection/safety, in cases where, as here, the commissioned body does not identify harm.

85. In my view, the Health Board's failure to identify the poor complaint handling by the First English Trust as well as the poor care and other failings identified in Ms A's case, are a reflection of the wholly inadequate contract monitoring arrangements in place at the Health Board. I find it concerning that the Health Board has placed financial reporting at the heart of its contract monitoring, rather than the patient, their safety and the quality of the service. As a result, an important part of the Health Board's monitoring role, which requires it to have rigorous oversight and scrutiny of the commissioned body, has been lost, meaning missed opportunities to identify issues around poor performance. The Health Board should have recognised and addressed this deficiency sooner than it has. It is disappointing that this situation has been allowed to happen and continue for so long, given the Ombudsman's statutory guidance on good administration includes public bodies having both responsibility and accountability for commissioned services. I cannot discount the possibility that had an effective contract monitoring regime been in place then some, if not all of these failings, might have been avoided. This is the injustice for Ms A, as she will have to live with the uncertainty of not knowing whether her care would have been better had an effectively monitored quality assurance process been in place. To that extent, I therefore **uphold** this part of Ms A's complaint.

86. I welcome the fact that the Health Board is working to put in place a CAF. In light of this case, I would urge the Health Board to prioritise its implementation of the CAF, and I have reflected this in my recommendations below.

87. Given the serious and significant healthcare and commissioning failings in this case, I will be sharing this report with Healthcare Inspectorate Wales, the Care Quality Commission in England, and the Parliamentary and Health Service Ombudsman.

Recommendations

88. I **recommend** that the Health Board should:

Within **1 month**:

a) Apologise to Ms A for the failings identified in this report.

b) Share this report with the Chair of the Health Board and the other Board members and its Patient Safety and Clinical Governance Group.

Within **2 months**:

c) As part of its commissioning arrangements, request the First English Trust undertake and evidence the following:

i. a review of Ms A's case to see what additional learning can be identified to improve the patient experience;

ii. a reminder to its clinicians of the relevant guidance around informed consent and their professional obligations when it comes to record keeping to ensure that discussions with patients are documented;

iii. as a point of learning, it shares with clinicians an anonymised case study of the clinical failings identified in this case at an appropriate clinical forum;

iv. the Colorectal Surgeon is asked, as part of learning and reflection, to share a copy of this report and discuss the steps that she has put in place to improve her clinical practice at her next professional revalidation;

v. a copy of this report is shared at its relevant patient safety governance committee.

In addition, the Health Board should:

d) Seek written assurances from the First English Trust's Chief Executive that it has taken steps to address the clinical failings identified in this report.

e) Share the compliance evidence relating to recommendations c) and d) with my office.

Within **6 months**:

f) Prioritise, complete and implement a CAF.

89. I am pleased to note that in commenting on the draft of this report the Health Board has agreed to implement these recommendations.

Michelle Morris

Michelle Morris 25 March 2025
Ombwdsmon Gwasanaethau Cyhoeddus | Public Services Ombudsman

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Teitl adroddiad: ***Report title:***	Integrated Quality & Performance Report (IQPR) – Month 12, 2024/25
Adrodd i: ***Report to:***	Quality, Safety & Experience Committee
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 01 May 2025
Crynodeb Gweithredol: ***Executive Summary:***	This Report relates to the Month 12, 2024/25. 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 2024-25. It identifies where metrics fall within the Special Measures Framework for BCUHB. Where appropriate, performance metrics are linked to items on the Corporate risk Register (CRR). Performance is RAG (Red, Amber Green) rated against the targets set within the NHS Wales Performance Framework 2024-25, or as set by Welsh Government in the Special Measures Framework for BCUHB. However, where appropriate, BCUHB's internal improvement trajectories as submitted and agreed by Welsh Government have also been included. Key areas of escalation are identified within the 'Performance Escalations Report' section at the beginning of the report. (We will continue to strengthen this section to include more information about the plans to mitigate or improve performance). The responsible executive has reviewed the elements of the report that are within their portfolio. Statistical Process Control (SPC) charts have been included where appropriate.
Argymhellion: ***Recommendations:***	The Quality, Safety, & Experience Committee is asked to: Review the contents of the report and to propose any actions arising from the report, or identify any additional assurance work or actions it would recommend Executive colleagues to undertake.
Arweinydd Gweithredol: ***Executive Lead:***	Stephen Powell, Director of Performance & Commissioning

<table>
<tr><td>Awdur yr Adroddiad:

Report Author:</td><td colspan="4">Stephen Powell, Director of Performance & Commissioning</td></tr>
<tr><td>Pwrpas yr adroddiad:
Purpose of report:</td><td>I’w Nodi
For Noting
☐</td><td colspan="2">I Benderfynu arno
For Decision
☒</td><td>Am sicrwydd
For Assurance
☒</td></tr>
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Assurance level:</td><td>Arwyddocaol
Significant
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Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol

High level of confidence/evidence in delivery of existing mechanisms/objectives</td><td>Derbyniol
Acceptable
☐
Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol

General confidence / evidence in delivery of existing mechanisms / objectives</td><td>Rhannol
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☒
Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol

Some confidence / evidence in delivery of existing mechanisms / objectives</td><td>Dim Sicrwydd
No Assurance
☐
Dim hyder/tystiolaeth o ran y ddarpariaeth

No confidence / evidence in delivery</td></tr>
<tr><td colspan="5">Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:

Justification for the above assurance rating. Where ‘Partial’ or ‘No’ assurance has been indicated above, please indicate steps to achieve ‘Acceptable’ assurance or above, and the timeframe for achieving this:</td></tr>
<tr><td colspan="2">Cyswllt ag Amcan/Amcanion Strategol:

Link to Strategic Objective(s):</td><td colspan="3">The performance measures included in this report are from the NHS Wales Performance Framework 2024-25.</td></tr>
<tr><td colspan="2">Goblygiadau rheoleiddio a lleol:

Regulatory and legal implications:</td><td colspan="3">This report will be available to the public once published for Quality, Safety & Experience Committee</td></tr>
<tr><td colspan="2">Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal?

In accordance with WP7 has an EqIA been identified as necessary and undertaken?</td><td colspan="3">N

The Report has not been Equality Impact Assessed as it is reporting on actual performance.</td></tr>
<tr><td colspan="2">Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal?</td><td colspan="3">N
The Report has not been assessed for its</td></tr>
</table>

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

The Integrated Quality & Performance Report will undergo continuous development and utilise the Performance and Commissioning Directorate's internal Change Advisory Board (CAB) process to modify any reporting metrics and formatting.
Rhestr o Atodiadau: ***List of Appendices: 2*** *1: Summary of Report* *2: Integrated Performance Report in PDF* *3: Escalations from Integrated Performance Report in PowerPoint*

Appendix 1 – Summary of Report

Committee: **Quality, Safety & Experience**

Report title: **Summary of Integrated Performance Report (Month 12)**

Report Author: **Director of Performance and Commissioning**

1. Introduction

The Performance and Commissioning 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

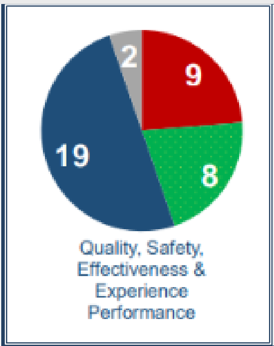
This structure enables an 'at a glance' view of the main concerns or message of the report through review of the initial one-page summary that is split into four quadrants, with the further slides contained within this escalation section articulating in more detail the current performance and actions 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.

2. Overall Summary

Please note that the data for several metrics are published in arrears and/ or on a quarterly basis.



3.1 Quality (Safety, Effectiveness & Experience) Performance

(Corporate Risk 24-04 Failure to Embed Learning)

The key areas highlighted centre upon:-

No new never events have been reported in the period between 31.07.2024 and 31.03.2025.

The number of **national reportable incidents** that remain open 90 days or more continues to demonstrate a decreasing trend. The latest figure from February 2025 of five incidents open demonstrates the significant improvement in year from a level of circa forty incidents per month in quarter 2.

Whilst **complaints** were de-escalated in January 2025, the performance in January and February 2025 was circa 5% below the standard of 75%. This will continue to be closely monitored.

The number of overdue **'Learning from Event Reports' (LFERs)** have decreased month on month during quarter 4, with the latest position of 43 overdue reports illustrating positive improvement from the high point of 64 reports at the end of December. Overdue returns can

- have a possible impact on timely ability to embed lessons learned and organisational learning and

- incur financial penalties at a rate of £2,500 per overdue report

Despite the improvement demonstrated, the but has not reduced at the anticipated pace to deliver aim of eliminating the overdue position by the end of Q1 2025/26. Three divisions account for over 80% of the overdue reports and detailed plans will be required as to recover the overdue position to both avoid potential harm and further financial penalties.

The percentage rate of people **completing treatment for Drug and/or Alcohol Misuse** was highlighted in last QSE report given the decrease in performance to c83% in October. Whilst the current metric performance doesn't deliver national target of four quarter improvement trend the position remains within normal variation with the Health board ranked as 4th of 7 in Wales as at latest benchmark position with Health Board performance above All Wales level of 56.2%.

No further update has been received on the percentage of **patients offered an index colonoscopy within 4 weeks of booking their Specialist Screening Practitioner assessment** with the latest reporting period indicating performance of 3.2% against a 90% target. The overall Wales performance is 15.2% at January 2025 and whilst one Health Board is now achieving a rate of over 70%, five of the seven Health Boards have a rate of less than 11%. Further review is required to understand drivers for current performance and delivery plans moving into 2025/26.

Clinical Coding compliance will remain a significant risk as compliance will remain low into the latter part of 2025-26 against the 95% national target. The position continues to improve from a low of 13.6% to latest position of 21.4% as at January 2025.

3.2 Access & Activity Performance

Whilst the overall oversight of the metrics within the Access & Activity quadrant fall outside remit of the Quality and Safety Committee, given the extended waiting times both within planned care and urgency and emergency care it is prudent to highlight performance within this area as part of this forum given the potential impact of continued delay on patient pathways.

Key areas of risk include: -

- **Percentage of Ophthalmology R1 patients seen within 25% of their clinical due date** is significantly adverse to target and due to the potential irreversible nature of conditions that some patients in this cohort have, is of concern. Harm reviews for assurance is recommended.
- **Percentage of children and young people waiting less than 26 weeks to start and ADHD or ASD neurodevelopment assessment**
- **Cancer pathways starting definitive treatment within 62 days** metric deteriorating over the last 12 months to a latest performance of 53.9% against a target of 80%
- Continued increase in the number of patients waiting over 8 weeks for a **Diagnostic appointment** and lack of capacity resulting in higher level of **surveillance delays**

Integrated Quality & Performance Report

Reporting Period: to 31.03.2025

Presented to

Quality, Safety & Experience Committee

Thursday, 1st May 2025

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

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
Appendix	32

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

Performance Escalations Report

Key Messages

Quality, Safety, Effectiveness & Experience Performance

- **Learning from Events Reports:** Progress made during Q4 in reducing number of overdue LFERs reducing from 64 at end of Q4 to 43 at end of Q4. Continued focus is required to address the timely completion and recovery of the overdue position.
- No **New Never Events** reported since 31.07.2024.
- **Complaints**: Performance remained above 70% but adrift of 75% target during last two months. **(Corporate Risk 24-04 Failure to Embed Learning)**
- **Clinical Coding Compliance** will remain a significant risk moving into new financial year but trajectory indicates improvement towards the end of 2025-26. Position stabilised and showing signs of improvement. Measure will be kept in escalation for assurance.
- Percentage of **patients offered an index colonoscopy within 4 weeks of booking their Specialist Screening Practitioner assessment** appointment has fallen to 3.2% against a 90% target. All Wales performance at latest benchmark point is 15.2%

Our Access and Activity

Detail reported via the Performance, Finance & Information Governance Committee

People & Organisational Development Performance

Detail reported via the Performance, Finance & Information Governance Committee

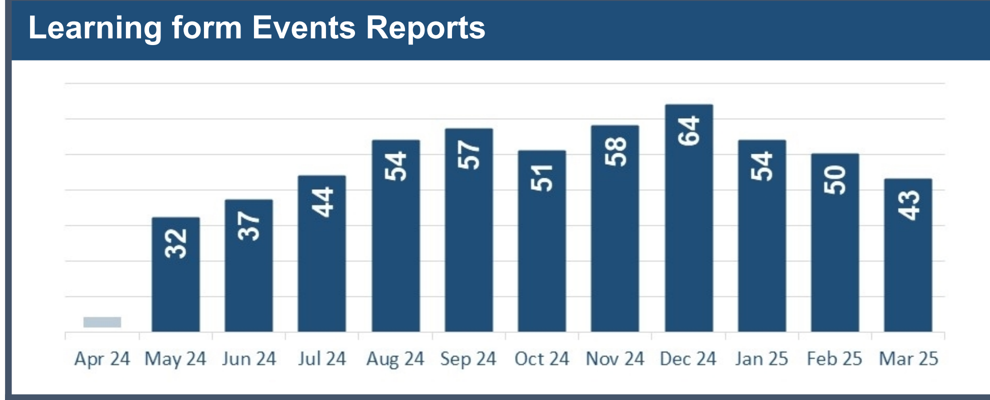
Our Finance (Corporate Risk 24-05 Financial Sustainability)

Detail reported via the Performance, Finance & Information Governance Committee

Quality: Escalated Performance Measures

Corporate Risk 24-04 Failure to Embed Learning

Learning form Events Reports



Learning From Events Reports (LFERs):
There are 43 outstanding LFERs at the end of March. There has been a month on month decrease in number of overdue reports during Quarter 4, but has not reduced at the anticipated pace to deliver aim of eliminating the overdue position by the end of Q1 2025/26.

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.

Index Colonoscopy

Index colonoscopy within 4 weeks of booking their Specialist Screening Practitioner assessment

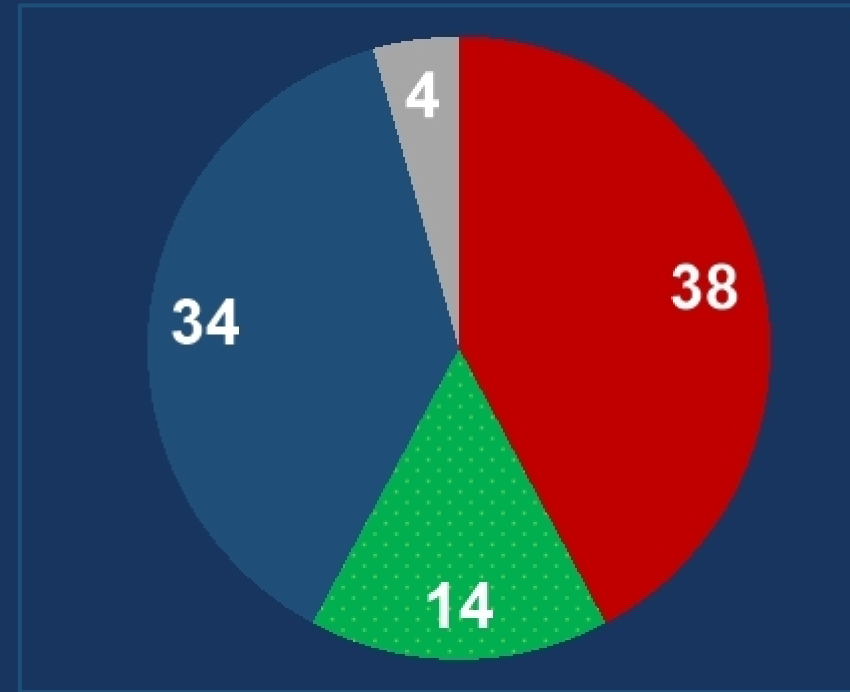
The percentage of **patients offered an index colonoscopy within 4 weeks of booking their Specialist Screening Practitioner assessment** appointment has fallen to 3.2% against a 90% target. All Wales performance at latest benchmark point is 15.2% with five of the seven Health Boards seeing rate of less than 11%. Further review is required to understand drivers for current performance and plans moving into 2025/26.

Completing treatment for Drug and/or Alcohol Misuse

The percentage rate of people completing treatment for Drug and/or Alcohol Misuse

was highlighted in last QSE report given the decrease in performance to c83% in October. Whilst the current metric performance doesn't deliver national target of four quarter improvement trend the position remains within normal variation with the Health board ranked as 4th of 7 in Wales as at latest benchmark position with Health Board performance above All Wales level of 56.2%.

Integrated Performance Report



Produced on behalf of the **Quality, Safety and Experience Committee** by the
Performance and Commissioning Directorate in partnership with **Health Board Directors**

Summary of Performance to Month 12

4
38
34
14

All Sections

2
9
19
8

Quality, Safety, Effectiveness & Experience Performance

3
2
4
28

Access & Activity Performance

1
2
6

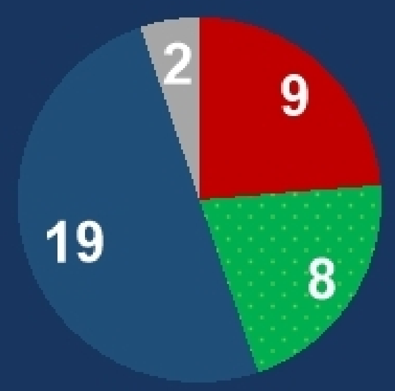
People & Organisational Development Performance

6

Financial Performance

Section 1

Quality, Safety, Effectiveness and Experience Performance



Produced on behalf of the **Quality and Safety Committee** by the
Performance and Commissioning Directorate i

Quality: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	QSE	Percentage of adult smokers who make a quit attempt via smoking cessation services	5% annual	TBC	6.94%	2nd of 7 (at Sep 24)
-	QSE	Percentage of adult smokers who made a quit attempt via smoking cessation services who are CO-validated as quit at 4 weeks	40% annual target	TBC	19.2%	3rd of 8 (at Sep 24)
-	QSE	Percentage of children receiving the Human Papillomavirus (HPV) vaccination by the age of 15	90%	TBC	69.5%	4th of 7 (at Sep 24)

* Wales Ranking may differ as may refer to previous month

Quality: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	QSE	Percentage of children who are up to date with the scheduled vaccinations by age 5 ('4 in 1' preschool booster, the Hib/MenC booster and the second MMR dose)	95%	TBC	88.4%	2nd of 7 (at Sep 24)
-	QSE	Percentage uptake of the influenza vaccination amongst adults aged 65 years and over	75%	TBC	73.0%	2nd of 7 (at Dec 24)
-	QSE	Percentage uptake of the COVID-19 vaccination for those eligible Spring Booster 2023: Aged 75 years & over; residents in care home for older adults and; immunosuppressed aged 5 years & over Autumn Booster 2023: Age range to be confirmed	75%	TBC	49.0%	3rd of 7 (at Dec 24)

86.5%
87.3%
88.4%
Q1 24/25
Q2 24/25
Q3 24/25
Q4 24/25

34.2%
65.1%
70.8%
72.3%
67.1%
73.0%
Apr 24
May 24
Jun 24
Jul 24
Aug 24
Sep 24
Oct 24
Nov 24
Dec 24
Jan 25
Feb 25
Mar 25

13.7%
44.0%
60.6%
6.7%
22.8%
36.0%
44.1%
48.3%
49.0%
Apr 24
May 24
Jun 24
Jul 24
Aug 24
Sep 24
Oct 24
Nov 24
Dec 24
Jan 25
Feb 25
Mar 25

Quality: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	QSE	Percentage of patients offered an index colonoscopy procedure within 4 weeks of booking their Specialist Screening Practitioner assessment appointment	90%	TBC	3.2%	6th of 7 (at Oct 24)
-	QSE	Percentage of well babies entering the new-born hearing screening programme who complete screening within 4 weeks	90%	TBC	98.8%	5th of 7 (at Oct 24)
-	QSE	Percentage of eligible newborn babies who have a conclusive bloodspot screening result by day 17 of life	95%	TBC	96.4%	2nd of 7 (at Nov 24)

* Wales Ranking may differ as may refer to previous month

Quality: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	QSE	Percentage of people who have been referred to health board services who have completed treatment for substance misuse (drugs or alcohol)	4 qtr imp. trend	TBC	92.8%	4th of 7 (at Sep 24)
-	QSE	Percentage of patients (aged 12 years and over) with diabetes who received all eight NICE recommended care processes	Equivalent month increase (2024/25 to 2023/24) to 100%	TBC	40.5%	7th of 7 (at Dec 24)
-	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	63.6%	6th of 7 (at Nov 24)

Measure	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
Substance misuse	88.6%	90.4%	89.5%	90.5%	96.7%	87.4%	83.2%	90.6%	86.5%	88.5%	92.8%	
Diabetes care processes	36.3%	36.4%	36.5%	36.9%	37.1%	36.7%	37.5%	37.7%	37.6%	38.0%	38.9%	40.5%
Dental contract value	3.7%	8.4%	13.7%	19.9%	25.3%	30.3%	41.1%	46.3%	51.7%	54.3%	58.4%	63.6%

* Wales Ranking may differ as may refer to previous month

Quality: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
-	PFIG	Number of consultations delivered through the Pharmacist Independent Prescribing Service (PIPS)	Equivalent month increase (2024/25 to 2023/24)	TBC	2996	1st of 7 (at Nov 24)	2337	2268	2018	2303	2319	2090	2478	2661	3351	2996		
-	QSE	Percentage of confirmed COVID-19 cases within hospital which had a definite hospital onset of COVID-19	Equivalent month reduction (2024/25 to 2023/24)	TBC	50.0%	1st of 6 (at Dec 24)	40.0%	43.3%	41.7%	36.6%	23.6%	22.7%	22.7%	54.9%	34.0%	59.3%	55.6%	50.0%
-	QSE	Number of service user feedback experience responses completed and recorded on CIVICA	Increasing trend	TBC	5978	2nd of 10 (at Dec 24)	5290	4538	4229	5839	4181	4240	5569	5401	5513	3157	5978	

Quality: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
CRR: 24-04	QSE	The cumulative number of laboratory confirmed Klebsiella in reporting month	106	TBC	136	6th of 6 (at Dec 24)
CRR: 24-04	QSE	The cumulative number of laboratory confirmed Pseudomonas Aeruginosa in reporting month	27	TBC	25	3rd of 6 (at Dec 24)
CRR: 24-04	QSE	The cumulative rate of laboratory confirmed E.coli bacteraemias cases per 100,000 population	67	TBC	76.5	4th of 6 (at Dec 24)

Measure	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
Klebsiella	5	12	22	38	48	64	75	95	104	119	126	136
Pseudomonas Aeruginosa	0	0	2	3	7	11	13	15	19	19	21	25
E.coli bacteraemias		84.2	83.3	78.7	79.6	79.4	72.2	75.5	75.5	75.8	75.5	76.5

Quality: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
CRR: 24-04	QSE	The cumulative rate of laboratory confirmed S. Aureus Bacteraemia (MRSA and MSSA) cases per 100,000 of the population	20	TBC	25.7	1st of 6 (at Dec 24)
CRR: 24-04	QSE	The cumulative rate of laboratory confirmed C.difficile cases per 100,000 of the population	25	TBC	50.6	5th of 6 (at Dec 24)
CRR: 24-04	QSE	Number of National reportable incidents that remain open 90 days or more	Decreas-ing trend	TBC	4	6th of 10 (at Dec 24)

Measure	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
S. Aureus Bacteraemia		27.2	25.1	25.1	24.8	24.7	25.5	26.2	25.3	25.6	25.3	25.7
C.difficile		45.9	46.2	52.7	54.6	54.7	53.1	51.3	51.5	50.4	49.3	50.6
National reportable incidents open 90 days or more	35	37	39	40	40	42	23	16	15	6	5	4

Quality: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	QSE	Number of National reportable incidents (NRIs)	N/A	TBC	6	
-	QSE	Number of new never events	0	TBC	0	
-	QSE	Number of patient safety incidents	N/A	TBC	2842	

Measure	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
Number of National reportable incidents (NRIs)	27	19	22	25	25	14	15	23	12	16	11	6
Number of new never events	0	2	0	2	0	0	0	0	0	0	0	0
Number of patient safety incidents	3000	2987	3006	3095	2873	2813	3177	2851	2746	3165	2722	2842

Quality: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	QSE	Number of reported falls	N/A	TBC	330	
-	QSE	Number of reported hospital acquired pressure ulcers (HAPU) (excluding new to caseload)	N/A	TBC	503	
-	QSE	Number of reported medication incidents	N/A	TBC	276	

Measure	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
Number of reported falls	350	361	340	374	345	326	364	327	339	365	327	330
Number of reported hospital acquired pressure ulcers (HAPU) (excluding new to caseload)	570	517	548	501	469	438	500	495	465	569	475	503
Number of reported medication incidents	314	258	266	333	273	240	271	237	252	262	261	276

Quality: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	QSE	Number of 'Putting Things Right' (PTR) complaints	N/A	TBC	209	
-	QSE	Of the complaints closed, the percentage that were closed within 30 days	75.0%	TBC	70.8%	
-	QSE	Number of complaints closed as early resolutions	N/A	TBC	30	

Measure	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
Number of 'Putting Things Right' (PTR) complaints	208	193	219	230	205	216	175	189	153	210	209	209
Of the complaints closed, the percentage that were closed within 30 days	39.9%	43.5%	48.4%	55.7%	63.4%	74.1%	79.4%	74.6%	80.4%	70.0%	70.8%	
Number of complaints closed as early resolutions	38	32	36	49	25	25	19	22	15	28	24	30

Quality: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	QSE	Number of PALS (Patient Advice and Liason Service) contacts	N/A	TBC	665	
-	QSE	Number of new Ombudsman contacts	N/A	TBC	18	
-	QSE	Number of regulation 28 notices	N/A	TBC	1	

Measure	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
PALS contacts		680	596	851	561	815	699	589	497	754	523	665
New Ombudsman contacts	16	13		24	19	20	33	27	14	23	31	18
Regulation 28 notices	0	0	1	2	0	0	1	0	0	0	1	1

Quality: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	QSE	Number of overdue 'Learning from Event Reports' (LFERs)	N/A	TBC	43	
-	QSE	Number of Great-ix submissions	N/A	TBC	161	
-	QSE	Percentage of episodes clinically coded within one reporting month post episode discharge end date	Increasing trend (to 95%)	TBC	21.4%	8st of 8 (at Oct 24)

Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
	32	37	44	54	57	51	58	64	54	50	43

Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
138	142	152	160	132	141	155	153	114	146	135	161

Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
15.0%	13.7%	14.2%	13.6%	13.6%	14.9%	15.1%	16.1%	19.9%	21.4%		

Quality: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	QSE	Percentage of all classifications' coding errors corrected by the next monthly reporting submission following identification	90%	TBC	3.6%	8st of 8 (at Nov 24)
-	QSE	Percentage of calls ended following WAST telephone assessment (Hear and Treat)	>17%	TBC	13.9%	5th of 7 (at Apr 24)

Additional Information

NHS Wales Performance Framework 2024-25

The NHS Performance Framework is a key measurement tool for "A Healthier Wales" outcomes, the 2024/25 revision now consists of 53 quantitative measures of which 9 are Ministerial Priorities and require Health Board submitted improvement trajectories. A further 11 qualitative measures are also currently included of which assurance is sought bi-annually by Welsh Government

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.

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

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

A Healthier Wales Quadruple Aims

Quadruple Aim 3
The health and social care workforce in Wales is motivated and sustainable

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

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

Green = On track
A stable, sustained or improving position that is consistently on or above the **Welsh Government Target** for at least 3 or more consecutive months

Amber

Amber = Early Warning or Off Track and in Exception – Short summary provided
On or above **Welsh Government Target,** but a deteriorating position of 3 or more consecutive months or inconsistently above/on/below the **Welsh Government Target**

Red

Red = Off Track and in Escalation
Consistently below **Welsh Government Target** and below **BCU submitted improvement trajectories – Detailed Exception report provided**

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

Interpreting Results of Statistical Process Control (SPC) Charts

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

How to interpret variance results

- Variance results show the trends in performance over time
- Trends either show **special cause** variance or **common cause variance**
- **Blue Icons** indicate **positive** special cause variance
- **Orange Icons** indicate **negative** special cause variance **requiring action**
- **Grey Icons** indicate **no significant change**

How to interpret assurance results

- Assurance results demonstrate the likelihood of achieving a target and is based upon the trends over time
- **Blue Icons** indicate an expectation **to** consistently achieve the target
- **Orange Icons** indicate an expectation **not to** consistently achieve the target
- **Grey Icons** indicate an expectation for **inconsistent** performance, sometimes the target will be achieved and sometimes it will not be achieved.

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

Introduction to Integrated Quality & Performance Report (IQPR)

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

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

The Integrated Performance Framework (IPF)

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

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

Where does the IQPR feature within the Performance Governance Structure

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

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

The Integrated Performance Reporting & Governance Superstructure

Minister

Joint Executive Team (JET) Meetings
Every 6 Months

Integrated Quality & Performance Delivery Meetings
Every Month

JET Presentation
Every 6 Months

IQPD Presentation
Every Month

This Report

Integrated Quality & Performance Report (IQPR)
Every Month

BCUHB Health Board
Every 2 Months

Performance, Finance & Information Governance (PFIG) Committee
Every 2 Months

Quality, Safety & Experience (QSE) Committee
Every 2 Months

Executive-led Directorate Level Integrated Performance Reviews
Every 6 Months

Integrated Performance Executive Delivery Group
Every Month

Decision & Action Logs from substructure
Every Month

Integrated Performance Dashboard
Every Month

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

Note: There is a substructure of reporting and governance that sits underneath this layer. See next page.

The Integrated Performance Reporting & Governance Substructure

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

Executive Delivery Group Finance & Performance
Every Month

Decision & Action Logs from substructure
Every Month

Integrated Performance Scorecard
Every Month

Directorate Led Integrated Performance Reviews
Every Month

Directorate Level Integrated Performance Dashboards (IPD)

Ward/ Department / Team Level Integrated Performance Reviews
Every Month

Ward/ Department / Team Level Performance Dashboards (IPD)

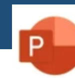
Individual PADRs
Every Year

Individual PADRs

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

Output	Description
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.

Further Information

Our Integrated Performance Report
Betsi Cadwaladr University Health Board

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

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

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

follow @bcuhb

http://www.facebook.com/bcuhealthboard

Appendix

Our Partners

This report has been produced on behalf of the Health Board by the **Performance and Commissioning 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.

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

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

Teitl adroddiad: ***Report title:***	**Health Board Response to the Royal College of Psychiatrists Invited Review Services Report**
Adrodd i: ***Report to:***	**Quality, Safety and Experience Committee**
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 01 May 2025
Crynodeb Gweithredol: ***Executive Summary:***	**Background** The Health Board received the Royal College of Psychiatry (RCPsych) Invited Services Review Report in March 2024. The Health Board is required to progress the improvements recommended in the report and demonstrate that the improvements are meeting the objectives of the recommendations and able to improve the outcome and experience for patients and staff. The last report to this Committee was on the 20 February 2025. The Committee requested that it receive an update at this meeting on evidence of actions being carried out, which improve current services. Therefore this report has focussed on providing the Committee an update on the seventeen improvement actions where evidence of progress has been endorsed by the Health Board Action Delivery Group. This report highlights that the Health Board Action Delivery Group notes good progress against the progression of the improvement actions in the RCPsych Invited Services Review. It is clearly understood that the ability to fully assess whether the actions taken are meeting the objectives of the Service Review will not be clear until the Expert Advisory Group is in full operation. This report also highlights that since the last report to the Quality Safety and Experience Committee the development of an appropriate Expert Advisory Group work programme has been slower to progress and it has been reviewed and reset, reflecting feedback from the Expert Advisory Group Members. It continues to be important that the Health Board takes the appropriate amount of time to make sure that the role of the Expert Advisory Group is clear, operates effectively and has the full engagement of service users, families and experts so that it can independently support the validation that the response to the actions is meeting the objectives of the recommendations and can demonstrate improvements for service users.
Argymhellion: ***Recommendations:***	The Committee is asked to: • **Note and Consider** the update from the Health Board RCPsych Action Delivery Group with an emphasis of demonstrating that there is evidence of actions being carried out which improve current services.

<table>
<tr><td></td><td colspan="6">

- **Note and Consider** the update from the Chair of the Health Board RCPsych Expert Advisory Group
- **Note and Consider** the approach to the development of the Expert Advisory Group Work Programme and Outcome Performance Framework
- **Receive assurance** on the Health Board response to the RCPsych Invited Review Services Report

</td></tr>
<tr><td>Arweinydd Gweithredol:

Executive Lead:</td><td colspan="6">Teresa Owen, Executive Director of Allied Health Professionals and Health Science</td></tr>
<tr><td>Awdur yr Adroddiad:

Report Authors:</td><td colspan="6">Phil Meakin, Associate Director of Governance
Ros Alstead, Special Advisor
Carole Evanson, MHLD Director of Operations</td></tr>
<tr><td>Pwrpas yr adroddiad:

Purpose of report:</td><td colspan="2">I'w Nodi
For Noting
☒</td><td colspan="2">I Benderfynu arno
For Decision
☐</td><td colspan="2">Am sicrwydd
For Assurance
☒</td></tr>
<tr><td>Lefel sicrwydd:
Assurance level:</td><td>Arwyddocaol
Significant
☐

Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol

High level of confidence/evidence in delivery of existing mechanisms/objectives</td><td colspan="2">Derbyniol
Acceptable
☒

Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol

General confidence / evidence in delivery of existing mechanisms / objectives</td><td colspan="2">Rhannol
Partial
☐

Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol

Some confidence / evidence in delivery of existing mechanisms / objectives</td><td>Dim Sicrwydd
No Assurance
☐

Dim hyder/tystiolaeth o ran y ddarpariaeth

No confidence / evidence in delivery</td></tr>
<tr><td colspan="7">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:</td></tr>
</table>

Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:	
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	1. Building an Effective and Accountable Organisation 2. Compassionate Culture, leadership, engagement and workforce capacity and capability 4. Required improvements to transform care and enhance outcomes. 5. Evidence based improvement and innovation
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	None
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	N/A
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	N/A
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	CRR 24-04 (Learning)
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	None to note at this stage
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith	None to note at this stage

Workforce implications as a result of implementing the recommendations	
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	This paper has been prepared following the recommendations agreed at the Health Board, 25 July 2024 and the previous reports to QSE Committee, most recently on 20 February 2025.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	• BAF24-06 Ineffectively Delivering the Required Improvements to Transform Care and Enhance Outcomes • BAF24-05 Ineffectively Engaging with Citizens, Partners and Communities
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Not applicable
List of Appendices: • Appendix 1 –Summary of progress of the RCPsych Invited Services Review • Appendix 2 –Summary of evidence provided to the Delivery Group	

Glossary of Terms Used in This Report

ALN – Alcohol Liaison Nurse
BCUHB – Betsi Cadwaladr University Health Board
CEG – Clinical Effectiveness Group
CTP – Care Treatment Plans
CMHTs – Community Mental Health Teams
DDAT – Digital Data and Technology
DHCW – Digital Health and Care Wales
DSLT – Divisional Senior Leadership Team
DLRRG – Divisional Ligature Risk Reduction Group
HCA – Health Care Assistant
HCSW – Health Care Support Worker
HSE – Health & Safety Executive
HTT – Home Treatment Team
KPI – Key Performance Indicator
LHB – Local Health Board
LOF – Learning Outcomes Framework
MDT – Multi Disciplinary Team
MHLD – Mental Health and Learning Disabilities
NCCU – National Care Commissioning Unit
NHS – National Health Service
NICE – National Institute for Healthcare and Excellence
OD – Organisational Development
PADR – Performance and Development Review
PALS – Patient Advice and Liaison Services
PCE – Patient Care Experience
PST – Patient Safety Team
PTR – Putting Things Right
POMH – Prescribing Observatory for Mental Health
PSOW - Public Services Ombudsman for Wales
R&R – Recruitment and Retention
RMN – Registered Mental Health Nurse
RPharms – Royal Pharmaceutical Society
SLT – Senior Leadership Team MH&LD
SOP – Standard Operating Procedure
SQDG – Service Quality Delivery Group
WARRN – Wales Applied Risk Research Network
WCCIS – Welsh Community Care Information System
WG – Welsh Government

HEALTH BOARD RESPONSE TO THE

ROYAL COLLAGE OF PSYCHIATRISTS INVITED SERVICES REVIEW REPORT

1. INTRODUCTION

The Health Board received the Royal College of Psychiatry (RCPsych) Invited Services Review Report in March 2024. The report noted out of the 84 recommendations identified from the reports, strong evidence was received to show 44% of the recommendations were implemented, 49% had some evidence to show implementation and 7% showed little or no evidence of the report recommendations being implemented. The Health Board is required to progress the improvements recommended in the report and demonstrate that the improvements are meeting the objectives of the recommendations and able to improve the outcome and experience for patients and staff.

The last report to this Committee was on the 20 February 2025. The Committee considered the report and clarified it receive a report to evidence that improvement actions are being carried out, which will improve current services.

2. PURPOSE OF THIS REPORT

The purpose of this report is to provide information that will enable the Committee to:

- **Note and Consider** the update from the Health Board RCPsych Action Delivery Group, with an emphasis of demonstrating that there is evidence of actions being carried out which improve current services.
- **Note and Consider** the update from the Chair of the Health Board RCPsych Expert Advisory Group
- **Note and Consider** the approach to the development of the Expert Advisory Group Work Programme and Outcome Performance Framework
- **Receive assurance** on the Health Board response to the RCPsych Invited Review Services Report.

3. BACKGROUND

The Board recently received a comprehensive report on the Health Board response to the RCPsych Invited Services Review at its meeting of the 30 January 2025 and at the Quality Safety and Experience Committee on 20 February 2025.

This report highlights that the Health Board Action Delivery Group has received and considered evidence of progress against the improvement actions, whilst clearly understanding that the ability to assess whether the actions taken are meeting the objectives of the Service Review will not be clear until the Expert Advisory Group is in full operation and able to support the assessment of the evidence provided.

4. ADDITIONAL BACKGROUND

As a reminder, the ten themes (Table 1 below) are outlined below.

Table 1: The ten themes

The Ten Themes
○ Theme 1 – Patient and user centred care ○ Theme 2 – Legislation and clinical guidance ○ Theme 3 – Governance ○ Theme 4 – Staffing ○ Theme 5 – Management Structure ○ Theme 6 - Clinical services organisation. ○ Theme 7 - Training and development ○ Theme 8 – Leadership and staff engagement ○ Theme 9 – Resources ○ Theme 10 – Physical environment

5. UPDATE FROM HEALTH BOARD ACTION DELIVERY GROUP

5.1. Evidence of Progress Against the Improvements of RCPsych Invited Services Review

The information in this section of the report contains details of the seventeen RCPsych evidence submissions that have been endorsed for approval by the Health Board Action Delivery Group and highlights the work that has taken place to evidence improvement actions in the Invited Services Review. The detailed evidence has progressed through the agreed “management arm” of the governance process and will now be shared through the “assurance arm” of the governance process (the Expert Advisory Group).

The section below highlights the current position of progress against each theme as at the end of March 2025. Appendix 2 provides a summary of the evidence received for the seventeen improvement actions where evidence has been received and endorsed by the Health Board Action Delivery Group.

The information provided in section 5.1.1 to 5.1.10 will form part of a pack to the Expert Advisory Group members.

5.1.1. Theme One Outcome – Patient and User Centred Care

Improved older adult and dementia care through a skilled workforce, improved communication, engagement and partnership working both strategically and operationally with service user, families, carer and wider stakeholder and partners.

There are seven agreed actions to deliver this outcome. Five of the seven action owners have submitted evidence and are awaiting approval through the agreed governance route for approval and final sign off.

The recruitment process for the MH&LD Consultant Nurse for Dementia progressed as planned. The role was advertised on Trac, closing on August 2024, with interviews held in September 2024. The panel included key MH&LD and BCUHB representatives alongside a Bangor University Lecturer. A Values-Based Interview was also conducted, receiving positive feedback.

The post was successfully appointed to and the candidate was due to commence in January 2025. Regrettably, this applicant withdrew and the second appointable candidate was offered the post and is due to commence in June 2025. The evidence of improved outcomes for patients and service users will be developed and captured following her commencement in post.

The use of CIVICA, the Health Board's patient, carer and service user feedback system, will allow the Division to listen, learn and act on feedback to ensure that managers and Health Care Professionals are able to utilise feedback in real time to improve services in order to provide a safer, more positive experience. The Health Board can collect both quantitative and qualitative data to turn in to valuable insights.

CIVICA takes into account many aspects of a patient's experience, such as: Were they listened to? Were they treated with dignity and respect? Were they treated and seen in a clean and safe environment? Were they involved as much as they wanted to be in decisions about their care and treatment? Were they given the opportunity to speak in Welsh? The data will allow the Health Board to identify any issues and to better understand a patient's journey through our services, alongside those of their family and carers.

MH&LD Division have developed a meeting schedule for Llais to meet with each of the five local area triumvirates (Head of Operations, Head of Nursing and Clinical Director), along with a dedicated MH&LD Director Meeting. The schedule ran from November 2024 to March 2025, with a three-month review period to inform a further 12-month plan. To date, meetings with the West and Central triumvirates have occurred.

An internal audit of DoLS and the Mental Capacity Act (MCA) was completed in 2024, and a separate DoLS Audit has been undertaken specific to MH&LD Services. The findings identified from the audit were detailed in a MH&LD 7-minute briefing shared across safeguarding Forums and Case Supervision Sessions.

Quarterly and real-time audits of DoLS applications are conducted to enhance compliance, with findings reported to governance groups, including the Mental Health Legislation Committee (MHLC) and Safeguarding Forum. Audits of all DoLS applications are also undertaken on receipt

of each respective application. Immediate feedback is offered to the referring individual or service. The quality of the reports and compliance with the legal framework is also reported into the MHLC.

5.1.2 Theme Two Outcome – Legislation and Clinical Guidance

Improved processes in place for sharing and embedding wider learning from incidents and audit activity which informs training, clinical practice and appropriate action to reduce incidents and risks.

The Antipsychotic Audit was undertaken and the findings were discussed at the Clinical Effectiveness Group (CEG) and included as a Tier 2 Audit in the 2024-25 MH&LD Annual Audit Plan. Tier 2 Audits are MH&LD Divisional priority audits, and additional audits may be added throughout the year as informed by Concerns Process, External Reviews, and Ombudsman Reports, Inquest Findings or new divisional risks.

The MM52 Guideline on antipsychotic use in dementia has now been reviewed and will imminently be activated for use in the Health Board to improve experiences and outcomes for the use of antipsychotics in the management of behavioural and psychological symptoms of dementia. A Consultant Psychiatrist is leading the audit regionally and due to present the findings to CEG.

5.1.3 Theme Three Outcome – Governance

For our patients to receive seamless care co-ordination through a fit for purpose, fully adopted Electronic Patient Record System in addition to an effective MH&LD Governance Framework from Ward to Board.

The Patient and Carer Experience Team's new telephony system has gone live improving the caller experience with dedicated options for key services. Staff received training ahead of the launch, and the system directs callers to the BCUHB website for further information. The service has been promoted via SharePoint and social media, with ongoing updates. A review of the first three weeks showed that PALS received 2,088 enquiries, with 297 made via phone, showing a gradual increase in telephone usage. All staff training, including guides and videos, has been completed, and managers and supervisors have received training on the Supervisor Agent Tool for call monitoring and quality assurance. From December 2024, activity and audit reports will be generated to analyse call patterns, optimise staffing, and enhance the patient experience.

Plans for the digitisation of MH&LD Services have rapidly evolved. BCUHBs Digital, Data and Technology (DDaT) Service have supported the Division and Child and Adolescent Mental Health Services (CAMHS) colleagues in the development of a comprehensive business case specific to BCUHB. A Senior Reporting Officer (SRO) was appointed from within the Division to support this major change. Due to the comprehensive business case submitted and the support this has garnered, the Health Board have been successful in securing £12 million Welsh Government funding for an Electronic Patient Record (EPR) System, this will be transformative for patients and staff. The Programme Board is well established with input from across specialities, services and input from the National Team.

The expectations are that by the end of April 2025 the procurement evaluation plan will be complete. The teams will be holding user engagement workshops and interviews which will

support the development of the Digital Benefits Strategy. The procurement and award of contract is targeted for completion in November 2025.

5.1.4 Theme Four Outcome – Staffing

To have in place a fully appointed substantive divisional structure, with an effective and efficient recruitment and retention plan focusing on attraction strategies to enable the Division to have the right staff, with the right skills at the right time to meet the mental health needs of the population of North Wales currently and in the future.

The MH&LD Division continues to progress the recruitment and retention activities aligned to the MH&LD Recruitment and Retention (R&R) Plan, with quarterly reporting through due governance including any agreed area of focus as determined by the Divisional People and Culture Delivery Group.

The MH&LD Recruitment and Retention Group has recently concentrated on streamlining the HCA recruitment process, with HCAs transitioning from bank to substantive roles. The Step into Work and HCA Career Pathway supports local communities, student work experience, and career progression in line with safer staffing reviews. Governance matters are reflected through Chairs Assurance Reports, while an R&R Infographic highlights key successes, including 4,000 online enquiries, 400+ job applications, and a reduction in MHLD divisional vacancies from 15.4% in October 2023 to 12.9% reported in February 2025. Targeted recruitment efforts include virtual events, social media campaigns, and attendance at job fairs. Monthly local meetings ensure timely recruitment, budget allocation, and reduced agency reliance. A recent report detailing the Division's approach to reduce reliance on agency has been progressed and communicated with the Health Board (with support from Workforce and OD Teams).

The recruitment to the critical role of MH&LD Director of Nursing is ongoing and the Health Board is undertaking a further recruitment campaign to progress this appointment.

To further support the Division, a review of cover arrangements is underway when Dementia Support Workers are vacant or on sick leave to ensure continuity of service provision. The Division has developed a proposal to support the recruitment of an additional dedicated Dementia Practice Educator for MH&LD.

As mentioned earlier in the report the MHLD Teams look forward to the commencement of the MH&LD Consultant Nurse Dementia and how the role supports the post evidence of improved outcomes for patients and service users.

On 28 March 2025, Iain Wilkie, Director for MH&LD provided a high level presentation to members of the Expert Advisory Group containing information in relation to recruitment and retention, which was also complemented by a presentation on Staff wellbeing initiatives. This took place at Ysbyty Bryn Y Neuadd.

5.1.5 Theme Five Outcome – Management Structure

To have in place a fully appointed substantive management structure, with an effective and efficient recruitment and retention plan focusing on attraction strategies to enable the Division to

have stable leadership to support meeting the mental health needs of the population of North Wales currently and in the future.

The Division has two improvement actions to deliver against this outcome. Both actions are in progress and within deadline. So far the Division has developed the Terms of Reference to progress the divisional interim posts. The terms of reference are progressing through divisional governance for approval and sign off. The objective is to make a reduction of 25% of interim posts. Progress on this will be able to reported to the next Committee Report.

A scoping exercise of current Fixed Term Contracts and seconded posts within the Division is currently underway to facilitate a greater understanding of the current position. To date, nine interim staff have been recruited to substantive posts following various recruitment activity.

5.1.6 Theme Six Outcome – Clinical Services Organisation

All patients will have access to multi-disciplinary support based on need to improve patient outcomes and patient experience.

The Division has six actions aligned to this outcome. The appointment to the position of MH&LD Consultant Nurse Dementia will be pivotal to delivering this outcome. The role will support the strategic direction for the development of dementia roles and responsibilities in Practice Development Nurse Role.

The newly appointed MHLD Consultant Nurse Dementia will support the continuation of monthly Consultant Nurse Dementia led network meetings with MH&LD and Health Board Activity Coordinators. The role will provide the focus to ensure the Centre and East Memory Assessment Units attain Memory Service National Accreditation Programme (MSNAP) to mirror colleagues in the West who have already achieved this accreditation. The Memory Services National Accreditation Programme (MSNAP) adopts a multi-disciplinary approach to quality improvement in Memory Services by using a set of quality standards. The MH&LD Memory Services (MAS) are at different points regarding MSNAP accreditation. West is fully accredited and Central has undergone substantive improvements enabling the service position to be able to undertake the MSNAP accreditation process in 2025/26. East requires ongoing improvements to achieve accreditation via MSNAP. Both Central and East are affiliated with MSNAP via regional MAS funding enabling access to training and resources.

The Consultant Nurse Dementia will progress a pilot scheme for in reach workers in care homes. The scheme will review and measure impact and outcomes and carry out options appraisal to expand to all care homes to facilitate consistency of service provision.

As part of the Crisis Care Pathway development, BCUHB are looking at options to implement an alternative out of hours community response to crisis through the development of a ‘Sanctuary’ or ‘Safe Haven’ type service. The principal ethos behind the Together 4 Mental Health Programme and the Crisis Care Concordat is to work collaboratively with numerous partners, stakeholders and service users across traditional boundaries. This transformational change will enable the delivery of enhanced community mental health support ensuring timely access to safe, effective, high-quality care for people in mental health crisis. Sanctuary Services aim to provide practical, holistic,

person-centred support to people at risk of mental health crisis through the provision of a range of interventions in order to lessen hospital admissions and reduce risk.

The Division has progressed the development of an options appraisal to consider extending a regional pilot of applied behaviourists working with patients with complex needs. Support and direction has been provided from BCUHB Consultant Nurse Dementia until the MH&LD Consultant Nurse Dementia is appointed.

5.1.7 Theme Seven Outcome – Training and Development

To ensure a skilled and developing workforce through the completion of identified training and learning opportunities including a programme of regular Divisional Learning Events with external speakers to enable an increase in networking with other organisations both within Wales and nationally.

Three key actions are aligned to this outcome. This will include a programme of regular Divisional Learning Events.

The Wellness, Work and Us Team have progressed a range of activity to support both recruitment and retention of staff across the Division. This includes the provision of wellbeing support, counselling and coaching activities. In addition, a "Job Satisfaction" questionnaire was undertaken to understand the reasons that staff stay in the Division. The next steps the Division are progressing are to create "Staff Voice" Workshops to ensure the team continue to listen to staff, act on feedback with tangible evidence to support any improvement activity.

The Health Board has established processes for HCSW/HCA to develop and the MHLD Division can make best use of these processes to support the HCSW/HCA workforce into gaining a Registered Nurse qualification. The Division has an established Recruitment & Retention Group that has provided focus to this 'grow your own' activity.

In addition, further work is ongoing to explore how Band 3 HCA's whom have been successfully appointed to the talent pool can commence on MH&LD bank whilst awaiting allocation to an appropriate vacant post within the Division. This could be utilised to temporarily fill vacancies that are going through recruitment and also provide an opportunity for staff to undertake trial shifts within areas where vacant posts exist.

Led by the Division's Governance Lead a rolling programme of Divisional Learning Events has been developed. The previous Division's Learning Event in September 2024 was well received and had positive feedback. The events include key external speakers and included topical themes within the Health Board.

To support networking through partnership working the Division has numerous well established meeting and see networking as a key mechanism for driving meaningful change and a forum for individuals to come together, share ideas and raise awareness of challenges. The team collaborate and co-operate with organisations at national and local level to improve outcomes and in partnership with their patients and communities.

5.1.8 Theme Eight Outcome – Leadership and Staff Engagement

To ensure our MH&LD staff receive a clear and consistent level of information appropriate to their needs, underpinned by a communication and engagement strategy and action plan. This will support a culture of openness and honesty with the ability to challenge safely.

MH&LD have four actions to support delivery of this outcome. Two actions are awaiting formal approval following evidence submissions and the remaining two are in progress and within the deadline for delivery.

The focus of the implementation of the MH&LD Communication and Engagement Plan is to ensure our plans and priorities are informed by what matters to stakeholders. The intention is that this will help build deeper connections leading to greater customer satisfaction by engaging with them meaningfully at various touchpoints. The plan will ensure that engagement efforts are aligned and consistent across the Division and by strategically planning how to engage with our citizens we will be able to create more meaningful interactions leading to increased participation. The plan will bring structure, clarity and strategy to engagement efforts helping maximising relationships and achieving desired outcomes.

In support of the plan senior leadership connectedness to the wards and services will enhance and strengthen its effectiveness by ensuring there is clear visibility, communication and engagement by the Senior Leadership Team (SLT) from Ward to Board. This is underway with an SLT walkabout schedule where two members of the SLT will attend a variety of services and sites. During each walkabout there is either a Drop in session for patient, family, staff or carer to meet with the SLT or an “Ask DSLT” staff session. During these sessions a feedback form has been developed, with a QR code, for anyone in attendance to provide feedback.

All feedback received will be reviewed and themed and appropriate information will be shared across the Division. This process will evolve as more SLT walkabout sessions are held, and lessons learnt incorporated to either improve or enhance this initiative.

5.1.9 Theme Nine Outcome – Resources

For our inpatients to be able to access multi-disciplinary support to improving their health which includes psychological therapies.

The Health Board has one improvement action to support the delivery of this outcome. The action was to review the role of the pharmacy to consider rolling out across the Division this action is in progress and due to be delivered within the deadline. The expansion of the pharmacy provision across the Division will enable community pharmacists to provide care for patients without the need to always visit their GP.

The role of pharmacy will be focusing on Acute Care roles in line with the Royal Pharmaceutical Society (RPharms) Hospital Service Review over the next six months, and produce a recommendation for the Division in collaboration with the IHC Pharmacy Leads.

5.1.10 Theme Ten Outcome – Physical Environment

A MH&LD Capital and Estates Strategy which will ensure that we have short, medium and long term plans so estates and all patient environments remain fits for purpose currently and in the future.

A Tripartite Ligature Assessment Audit was completed and discussed in the Ligature Risk Management Group on 25/09/24. While initially part of the National Care Commissioning Unit (NCCU) Action Plan, it is now embedded in routine compliance monitoring.

Key findings of the Tripartite Ligature Assessment Audit include 93.1% compliance with annual ligature assessments, improved adherence to risk standards, and 529 staff are currently trained in ligature awareness, these include domestic and estates staff.

To strengthen the escalation of outstanding environmental work from local areas to Capital Estates a MH&LD Controlled Memo has been circulated aligned to the timely reporting of ligature assessment requirements. This will ensure the appropriate governance routes will be sought into Divisional Estates & Capital Group (DECG).

Significant work has been delivered through an internal NCCU Inpatient Safety Group from November 2023 onwards. This has helped inform an approach for audit and training.

To ensure environments remain fit for purpose an audit methodology has been approved, the findings from these audits are presented and discussed in Ligature Risk Management Group. The audits form part of usual business for checking overall compliance with ligature standards. The audit demonstrates that ward areas have ligature assessments in place.

An audit process has been developed aligned to the Environmental Ligature Risk Assessment Training. This ensures a robust process of ligature assessment has been completed, including knowledge and skills, completion of the audit checklist, completing the ligature footprint and reviewing the assessments monthly. The first annual audit report was completed in November 2023 and reported through Divisional governance in January 2024. In addition to the above, All Wales Standards of Practice have published a document aligned to reducing harm from ligatures in Mental Health and Learning Disability. Work is ongoing to establish links with other Welsh Health Boards and a Mental Health Trust in England to progress benchmarking and to enable the sharing of good practice.

The Division has completed an analysis of all the high, medium and low risk ligatures, including the current mitigation that is in place. This analysis has been completed by an internal tripartite group (MH&LD Clinical, Estates, Health and Safety) reviewing all ward inpatient ligature assessments and the external assessments of ligature. This analysis was presented in DSLT in January 2024, with the recommendation that the tripartite develop an audit tool, agree 'buddy' areas and allocate project support including an industry expert on ligature, followed by a programme of audit to ensure all ligature risks are identified timely and effectively mitigated.

There is scrutiny on Capital Planning and Operational Estates aligned to ligature risks given the competing financial priorities for the Health Board. There is an active risk management process informing the prioritisation of capital plans which is managed through the monthly Divisional

Estates and Capital Group, scrutinised and approved via our Senior Leadership Team as well as the BCU Capital Estates Team.

6. REPORT FROM THE CHAIR OF THE EXPERT ADVISORY GROUP (SPECIAL ADVISER)

The role of the Special Adviser to the Board has three core functions:

- to advise the Board,
- to support the delivery of the RCPsych report and
- to Chair the Expert Advisory Group which comprises of a small group of people with lived experience comprising of family members and two current service users alongside Geoff Ryall Harvey Regional director of Llais and four health board staff including the dementia nurse consultant, Head of Patient experience and Director of Mental health and Associate Director of Governance.

The last report highlighted the importance of getting the foundations of engagement and support right. This includes understanding people's areas of interest associated with the RCPsych report and also agreeing how we intend to work individually and together as individuals as part of a group. During the period since the last report to this Committee, officers of the Health Board have listened and learnt more about the pace and different levels of involvement group members are asking for. This has changed over time due to health status and other commitments of members. The Expert Advisory Group also had to reflect, learn and set standards for styles of engagement and communication to accommodate people preferences, not overwhelm people, and ensure Group members and staff feel supported. To support this, we have developed our protocol for visits and engagement led by the Head of Patient Experience which is in its final draft for approval within the Health Board and by the Expert Advisory Group.

The Expert Advisory Group has three main tasks.

The main one is to support the validation of the improvements reported through the Health Board Action Delivery Group. This will be progressed by looking at information provided by the Health Board which has already been reviewed by the Health Board Action Delivery group. The validation has not yet commenced as the Work Programme to support this is not yet approved. In order to triangulate information provided and build in some direct assurance rather than re-assurance, one or two members of the EAG members supported by Llais and Health Board staff will make visits to wards and teams to understand more about improvements which have been reported. This tailored work programme will be distributed to Group members according to interests' expertise and availability. For example, the Tawel-fan families are keen to look at older peoples Mental Health services.

Further sources of information to support the triangulation of findings will be identified through a series of seminars available to all members which will enable a deeper understanding of areas which were highlighted and lacked assurance in the RCPsych report. This includes areas which have continued to be concerns for people with lived experience, given the outcome of the RCPsych report. These areas include workforce recruitment and retention and safe staffing, service user and family experience and safety, falls, medication management and physical health management in mental health, dementia care and training, staff kindness and a good environment including ligatures.

Group members have different experiences and appetite for their chosen level of involvement and this has led to the adaption of our draft programme of visits that was compiled following the first set of meetings. An adapted programme meeting these requirements will be fulfilled over the next three months.

Work to develop the RCPsych Performance framework and Outcomes Framework continues within the Health Board. This will support a sustainable approach in measuring and demonstrating improvement in real time for the future. An update on this work will be provided to the Health Board Action Delivery Group on 28 April 2025.

7.SUMMARY

The current and next five month focus is to support the assessment, through a Work Programme where progress has been made and where further attention is required to deliver the sustaibale and embedded improvements in care for the population of North Wales. The continued focus of Health Board members, colleagues and the stakeholders in the Expert Advisory Group continues to be important as the Health Board focusses on demonstrating improvement and learning from feedback.

8.NEXT STEPS

- Continue to progress the Improvement Actions in the RCPsych Invited Services review.
- Continue coproduction of a tailored Work Programme for Expert Advisory Group Members Expert Advisory Group Work Programme and report progress at the Health Board RCPsych Action Delivery Group on 28 April2025
- Share progress of the 17 Improvement Actions considered by the Delivery Group to EAG Members (through the Chair of the Expert Advisory Group)
- Complete proposal for the Outcome and Performance Framework and present at the Health Board RCPsych Action Delivery Group on 28 April 2025

9.RECOMMENDATIONS

This report asks the Committee to:

- **Note and Consider** the update from the Health Board RCPsych Action Delivery Group
- **Note and Consider** the update from the Chair of the Health Board RCPsych Expert Advisory Group
- **Note and Consider** the approach to the development of the Expert Advisory Group Work Programme
- **Receive assurance** on the Health Board response to the RCPsych Invited Review Services Report

10.APPENDICES

Appendix 1 – Extract from Board Report from 30 January 2025 showing key progress of the RCPsych Invited Services Review (Follows this report below)

Appendix 2 –Summary of evidence provided to the Health Board Action Delivery Group

Royal College of Psychiatrists' Invited Review Services Report
Mental Health and Learning Disability services in Betsi Cadwaladr University Health Board
Progress Update Report - as at 14 February 2025

Date	14/03/2025	Period	Month 8/ Mar 2025	Author	Adrianne Jones, MH&LD Operational Business Lead	MH&LD Lead	Carole Evanson, Director of Operations	Senior Responsible Owner	Teresa Owen, Executive Lead.	RAG	Current month: Green	RAG Last Month: Green

CURRENT STATUS SUMMARY

80 action in total - 40 actions pending approval, 30 actions in progress and due within deadline, and 10 action in progress, albeit not to deadline.

Action Status	Completed	Evidence submitted, pending approval	In progress and due within deadline	In progress, but not to deadline	Overdue and no recent progress
Theme 1	0	11	2	2	0
Theme 2	0	4	3	2	0
Theme 3	0	7	5	2	0
Theme 4	0	3	2	3	0
Theme 5	0	0	3	0	0
Theme 6	0	4	3	0	0
Theme 7	0	2	1	1	0
Theme 8	0	5	2	0	0
Theme 9	0	1	4	0	0
Theme 10	0	3	5	0	0
Total	0	40	30	10	0
Change from previous month	No Change	Increased by 8 from previous month	Reduced by 6 from previous month	Decreased by 2 from previous month	No change

RCPsych Response Plan status - Mar 25

0, 0%
0, 0%
10, 13%
30, 37%
40, 50%

Actions completed
Evidence submitted pending approval
Actions in progress and due within deadline
Action in progress, albeit not to deadline
Overdue and no recent progress

Number of Health Board Wide Actions
34
Number of MH&LD Divisonal Actions
46

ACTION RECOVERY & MITIGATION

Themes

Theme	
1.Patient and user centred care	Evidence submitted to close 11 actions
2.Legislation and clinical guidelines	Evidence submitted to close 4 actions
3.Governance	Evidence submitted to close 7 actions
4.Staffing	Evidence submitted to close 3 actions
5.Management structure	
6.Clinical services organisation	Evidence submitted to close 4 actions
7.Training and development	Evidence submitted to close 2 action
8.Leadership and Staff Engagement	Evidence submitted to close 5 actions
9.Resources	Evidence submitted to close 1 action
10.Physical Environment	Evidence submitted to close 3 actions

KEY MILESTONES/DELIVERABLES - IMPLEMENTATION & OVERSIGHT

Milestone	Date	Status
1. RCPsych Response Plan Approved by Health Board	30/05/24	Complete
2. The Board received the Health Board Response, Governance Framework agreed by Board and Exec Team approved ToR for HB	25/07/24	Complete
3. Board appoints Ros Alstead as Independent Chair of Expert Advisory Group and Adviser to the Board	02/09/24	Complete
4. Governance Framework meetings established and all ToR's agreed and reporting cycle agreed and implemented	30/09/24	Complete
5. Inaugural Expert Advisory Group will meet (Chaired by an Independent Advisor with family and stakeholder membership)	08/10/24	Complete
5. Develop performance metrics to measure the impact of improvements	31/12/24	Ongoing development
6. Report into QSE 24/10/25	26/10/24	Complete
7. Report into QSE 17/12/25	17/12/24	Complete
8. Report into QSE 19/2/26	19/02/25	Complete
9. Report into Health Board meeting 6 monthly 30/1/25	30/01/25	Complete
9. Report into Health Board meeting 6 monthly 30/7/25	31/12/25	
10. Completion of all actions	31/01/26	In progress
11. Evaluation, summary report and post action review.	31/01/26	
12. Future developments/next Steps		

PROGRESS SINCE LAST MONTH

13 Evidence submissions were reviewed at PIDG meeting held in March 25
8 actions endorsed for approval at PIDG, six of which were due for completion 31/3/25 - 10 Actions remain in progress not to deadline.

Following review at PIDG/RAG, the following actions were endorsed for approval -

- 6.1 - Desk top audit of Multi-disciplinary (MDT)ward round in line with the Terms of reference to ensure assurance.
- 7.1 - Further develop and implement networking opportunities of ward staff working across the Division to promote and enable sharing of best practice.
- 8.3 - Agree the 12 month Divisional Senior Leadership Team Walkabout schedule for 24/25
- 2.5 - Continue with the projected policy review, as provided as part of the National Collaborative Commissioning Unit (NCCU) Action plan.
- 4.4 - Communicate Dementia Essential study days to all MH&LD staff to increase awareness and attendance
- 6.2 - Develop dementia roles and responsibilities within Practise Development Nurse role.
- 6.3 - Development of options appraisal to support consideration for extending regional pilot of applied behaviourists working with patients with complex needs.
- 6.4 - Continue monthly Consultant Nurse Dementia led network meeting with all MH&LD Activity Coordinators to ensure patients have improved patient outcomes and patient experience.

NEXT MONTHS ACTIVITIES

1. Progress completion of 10 actions in progress, albeit not to deadline
2. Progress March 2025 MH&LD and Health Board actions
3. Continue peer reviews undertaken by Evidence of Outcomes Group, to ensure transparency, honesty and assurance from the evidence approval process.
4. Continue to progress the Outcomes Framework to measure the impact of outcomes, outputs and benefits to patients, workforce and service
5. Progress the further development of the Work Programme and Evidence Pack for the Expert Advisory Group aligned to any feedback received from meetings held during March.

CHALLENGES, RISKS & ESCALATIONS

Updated Risks and Issues Log to be reviewed and considered at each HBADG meeting.

LESSONS LEARNED AND IMPACT THIS MONTH

• A Ward Round audit was completed in December 2024 following approval of audit methodology. The aim of the audit was to measure compliance with BCUHB Mental Health and Learning Disabilities Ward Round Terms of Reference (TORS) and to determine current status and representation in ward rounds across all Adult Acute wards. All wards demonstrated that there was a weekly schedule for when ward round occurs and that patients and ward staff were aware of when to expect ward round. Three recommendations noted from the Audit which will be progressed through due Divisional Governance.

• Following the success of DSLT Walkabout Schedule during the last 12 months, the schedule for 25/26 period has been approved. This will continue to include the ASK DSLT virtual staff engagements sessions, the Service User, Family and Carer Drop in Sessions and also the "You said/We did" feedback posters shared with staff on a quarterly basis.

• There has been a further deduction in the number of out of date MH&LD Written Control documents including policies, reducing from 43 (52%) in August 2024 to 32 (38%) in February 2025.

• BCU Activity Coordinators attended orientation meetings and events during 2024. There was good attendance at full development days on 17.6.24 (their role in teaching) and 23.1.25 (training day) with the live evaluation from the development days and reflective discussion at year-end was reported very positive.

GIG
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WALES
Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Royal College of Psychiatry Invited Service Review

Draft Improvement Actions Information Pack

Table of Contents

1. **RCPsych Evidence Submissions Endorsed for Approval** 3
2. **Work Programme** 11
3. **Performance Dashboard** 11
4. **Glossary** 12

1. RCPsych Evidence Submissions Endorsed for Approval

The RCPsych Response Plan includes 80 actions that have been developed to ensure improvement across the ten themes identified. This evidence pack includes details of the first tranche of seventeen evidence forms that are ready for the Expert Advisory Group to check and challenge the evidence submitted.

1.1 Progress the recruitment of the MH&LD Consultant Nurse for Dementia.

Evidence has been provided to the Health Board Action Delivery Group

The recruitment process for the MH&LD Consultant Nurse for Dementia progressed as planned. The role was advertised on Trac, closing on 28/08/24, with interviews held on 18/09/24 at Old Trust Headquarters, Wrexham Maelor Hospital. The panel included key MH&LD and BCUHB representatives alongside a Bangor University Lecturer. A Values-Based Interview was also conducted, receiving positive feedback.

The post was successfully appointed and was due to commence in January 2025. The applicant withdrew and a second candidate was appointed and is due to commence in June 2025. The post evidence of improved outcomes for patients/service users will be developed and captured following her start in post.

1.5 Plan and attend bi-monthly engagement meetings with Head of Operations and Llais.

Evidence has been provided to the Health Board Action Delivery Group

Divisional contact was made with Llais, and a proposed meeting schedule was developed to engage with each of the five local area Triumvirates, along with a dedicated MH&LD Director Meeting. The schedule will run from November 2024 to March 2025, with a three-month review to inform a further 12-month plan. Email correspondence has confirmed availability for all meetings, with minor amendments pending before calendar invites are issued.

1.13 Undertake a Quality, Compliance and Outcomes Audit of the DoLS

Evidence has been provided to the Health Board Action Delivery Group

An internal audit of DoLS and MCA was completed in February 2024, with actions signed off in April. A separate MH&LD-specific audit led to a 7-minute briefing shared across Safeguarding Forums and Case Supervision Sessions.

Quarterly and real-time audits of DoLS applications are conducted to enhance compliance, with findings reported to governance groups, including the MHLC and

Safeguarding Forum. DoLS and MCA remain a Tier 1 Risk on the Corporate Risk Register.

The UK and Welsh Governments acknowledge ongoing challenges, with further consultation expected under the leadership of Stephen Kinnock MP.

2.6 Continue to complete annual audits of antipsychotic medication prescribing, presenting findings to the Clinical Effectiveness Group to agree and learning to be implemented from the annual reviews.

Evidence has been provided to the Health Board Action Delivery Group

The Antipsychotic Audit findings were discussed at the Clinical Effectiveness Group (CEG) in January 2024 and included as a Tier 2 Audit in the 2024-25 MH&LD Annual Audit Plan. The MM52 Guideline on antipsychotic use in dementia is under review, with Dr. Andy Chatfield, Consultant Psychiatrist, leading the audit regionally and planning to present findings to CEG in April 2025.

Following the review of the Antipsychotic Audit at the PIDG meeting, the Antipsychotic Audit Task & Finish Group ensured MDT completion. The first consultant presentation to the PMG Pathway Group was in November 2024, followed by monthly updates to support implementation.

3.13 Implementation of the Telephony System to support an improved single point of contact for the public to raise concerns/enquiries.

Evidence has been provided to the Health Board Action Delivery Group

The Patient and Carer Experience Team's new telephony system has gone live, improving the caller experience with dedicated options for key services. Staff received training ahead of the launch, and the system directs customers to the BCUHB website for further information. The service has been promoted via SharePoint and Social Media, with ongoing updates. A review of the first three weeks showed that PALS received 2,088 enquiries, with 297 made via phone, showing a gradual increase in telephone usage. All staff training, including guides and videos, has been completed, and Managers and Supervisors have received training on the Supervisor Agent tool for call monitoring and quality assurance. From 1st December 2024, activity and audit reports will be generated to analyse call patterns, optimise staffing, and enhance the patient experience.

4.3 Continue to progress the recruitment and retention activities aligned to the MH&LD Recruitment and Retention plan, with quarterly reporting through due

governance with any agreed area of focus as determined by the Divisional Service, People and Culture Group.

Evidence has been provided to the Health Board Action Delivery Group

The MH&LD Recruitment and Retention Group has recently focused on streamlining the HCA recruitment process, with four HCAs transitioning from bank to substantive roles. The Step into Work and HCA Career Pathway SBARs support local communities, student work experience, and career progression in line with safer staffing reviews. Governance is maintained through Chairs Assurance Reports, while an R&R Infographic highlights key successes including 4,000 online enquiries, 400+ job applications, and a reduction in divisional vacancies.

Targeted recruitment efforts include virtual events, social media campaigns, and attendance at job fairs. Monthly local meetings ensure timely recruitment, budget allocation, and reduced agency reliance.

10.2 Progress Environmental Ligature Risk Assessment Audit

Evidence has been provided to the Health Board Action Delivery Group

The Ligature Assessment Audit was completed and discussed in the Ligature Risk Management Group on 25/09/24. While initially part of the NCCU Action Plan, it is now embedded in routine compliance monitoring.

Key findings include 93.1% compliance with annual ligature assessments, improved adherence to risk standards, and 457 staff trained in ligature awareness.

Recommendations include continuing Environmental Risk Assessment Training, ensuring relevant staff attend, conducting 6/12 re-audits, and focusing the next audit on bedrooms and bathrooms, as only 48% of this audit covered these higher-risk areas.

1.3 iCAN teams to attend CMHT's and other opportunities such as Third Sector, Local Authorities and other partnership areas including Together for Mental Health Partnership Board (T4MHPB), supported by the corporate planning team, to present activity locally to strengthen partnership working and improve awareness.

Evidence has been provided to the Health Board Action Delivery Group

The ICAN Dashboard has been strengthened to give an overview of current activity and performance and outcomes measures achieved during the reporting period.

Workshops held during September 2024 with Primary Care, Mental Health, Local Authority, Allied Health Professionals and Third sector partners to help inform our approach to Tier 0/1 Service Strategy and the development and our approach to commissioning services going forward.

3.14 Commence a formal campaign to promote how to raise concerns.

Evidence has been provided to the Health Board Action Delivery Group

There has been successful relaunch the Health Board's Patient Advice and Liaison Service (PALS) through online platforms, ensuring the public are directed and guided in how to raise a concern of complaint. A new "Report it" page is now available on Betsi Net, which details how staff can support the public in raising a concern or complaint. The number of visitors to the new PALS and Complaints webpage: 1559 (an average of 390 page visits per week) page visits since its launch on the 1st October 2024. In October 2024, 5095

All Wales Real-Time Patient and Carer Feedback Survey responses were received via Civica. Overall satisfaction levels have remained high with 80.94% of respondents 'very satisfied' with their overall experience of accessing Health Board Services.

8.1 Implement the MH&LD Communication and Engagement Plan. (Form part of the Health Board overall Citizen Engagement Commitments, ensuring that plans and priorities are informed by what matters to citizens)

Evidence has been provided to the Health Board Action Delivery Group

Significant progress has been made in implementing the MH&LD Communication and Engagement Plan, in alignment with the Health Board's broader Citizen Engagement Commitments. A robust and sustained approach is being taken to ensure that divisional plans and priorities are shaped by what matters most to staff, service users, and carers. This ongoing and iterative process has already seen the commencement of both staff and service user engagement activities, including Channel Audit Events and co-produced sessions with Caniad and Co-production Wales.

Leadership visibility has been enhanced through Director and Senior Leadership Team (DSLT) walkabouts and virtual "Ask DSLT" Sessions. An NHS Staff Survey Engagement Plan has been delivered, with results shared via infographics and staff briefings to support transparency and improvement. Collaboration with the Corporate Communications and Engagement Team has been strengthened to ensure consistent messaging, while a structured process has been introduced to manage divisional intranet content. Communications have also supported the Divisional Recruitment and Retention Strategy by promoting the benefits of working within the Division. In addition, cross-divisional collaboration has begun, and ongoing advice and guidance continues

to be provided in partnership with the Staff Retention Lead, in line with the National Retention Plan.

See Appendix 3 for Evidence submission form link.

3.10 The development of an Integrated Complaints/Incidents/Mortality Review Management Framework. To implement an Integrated Framework aligning the Patient Safety and Experience Departments ensuring a consistent 5 step approach to the management of Complaints, Incidents and Mortality Reviews further streamlining the process and improving the process for staff and patients.

Evidence has been provided to the Health Board Action Delivery Group

An Integrated Complaints/Incidents/Mortality Review Management Framework, including an implementation plan, has been approved. The framework aims to align the Patient Safety and Experience Departments with a consistent 5-step approach to streamline processes and improve the experience for both staff and patients. The need for this change is supported by feedback from the Board, the Quality, Safety and Experience Committee, His Majesty's Senior Coroners, Ombudsman Reports, Internal Audit findings, and the Learning from Investigations Project. It is designed to ensure compliance with the Putting Things Right Regulations and the Duty of Candour Procedure while anticipating future updates from Welsh Government.

Key progress to date includes the development of the integrated policy, establishment of daily integrated meetings and weekly Executive Escalation Meetings. There is weekly circulation of incidents data, complaints compliance, and PALS themes and trends to drive learning and improvement. Bi-weekly Heads of Service Meetings have been launched to triangulate learning across Patient Safety, Quality, and Experience, and training has been provided to the Administrative Complaints Team to support the centralised hub.

Implementation began on 1 September 2024, with full embedding expected to take several months, overseen by the Executive Director of Nursing and Midwifery and supported by a Multi-Disciplinary Working Group. We continue to await updated PTR Guidance and the new Patient Experience Framework from Welsh Government, which may require further policy adjustments once issued.

2.1 Undertake an Audit of falls data from Datix to highlight key learning to adopt into training, development and Improvement

Evidence has been provided to the Health Board Action Delivery Group

MH&LD Falls Audit was undertaken in August 2024. The Falls Audit Report was subsequently and presented in Clinical Effectiveness & Policy Group and then circulated to the Division.

Recommendations have been progressed including the identification and development of Falls Champions and Falls Bulletin.

3.7 Establish a Health Board Oversight Group to ensure delivery of the Response plan including the approach for evidence submission to discharge actions.

Evidence has been provided to the Health Board Action Delivery Group

A proposal to establish a Governance Framework to support delivery of the Health Board Response Plan was submitted to the Quality, Safety and Experience (QSE) Committee on 15 August 2024 and includes the below;

- Health Board Action Delivery Group established, with its first meeting held on 30/09/2024.
- Regulatory Assurance Group (RAG) and MH&LD Programme Improvement Delivery Group (PIDG) meetings held in September 2024, with Chairs' Assurance Reports fed into the Action Delivery Group.
- Expert Advisory Group (EAG) established, with its first meeting held on 08/10/2024. Terms of Reference reviewed by QSE Committee on 24/10/2024.

On 30/01/2025, the Health Board received a report providing assurance on progress. It confirmed that the Governance Framework has been established and is fully operational, with all key components in place and functioning as intended.

This framework supports coordinated delivery, oversight, and evidence submission aligned to the discharge of actions within the Response Plan.

See Appendix 3 for Evidence submission form link.

1.6 Further develop the model of patient and carer engagement to ensure people with lived and living experience of our services are at the heart of the planning, delivery and evaluation of services as equal partners in the care that they receive, building on current good practice that exists across Wales and further afield.

Evidence has been provided to the Health Board Action Delivery Group

The development of the Service User and Carer Engagement Strategy is progressing well, with a clear and inclusive approach in place. A Divisional Service User and Engagement Task and Finish Group has been established to lead this work, with the

aim of developing a consistent and systematic approach to service user involvement across Mental Health Services.

Co-production is central to the strategy, with significant input from people with lived experience, carers, and staff through a series of Lived Experience Engagement Events. These events, supported by Caniad and facilitated by Co-Production Lab Wales, have taken place across North Wales and virtually, receiving positive feedback from participants who have expressed a strong desire to stay involved in the strategy's development.

A draft strategy is ready for consultation with further engagement on the proposed delivery model planned for Q1/Q2 2025. Strong partnerships with the Corporate Patient Services, Communications, and Engagement Teams have supported this work, and Co-Production Wales has recognised BCUHB as leading the way in co-production across Health Services in Wales.

See Appendix 3 for Evidence submission form link.

1.10 Continue engagement with Tawel Fan families via the Expert Advisory Group monthly meetings.

Evidence has been provided to the Health Board Action Delivery Group

A proposal to establish a Governance Framework outlining the role of the Expert Advisory Group (EAG) was submitted to the Quality, Safety, and Experience Committee on 15/08/2024. The EAG is being established with the involvement of families, both historically and currently, as well as service users, with an Independent Advisor appointed to chair the group.

The first meeting with families and service users took place in October 2024, followed by two additional meetings in December 2024 and January 2025. The Health Board Action Delivery Group has received monthly updates on the progress of these meetings, and a report was presented to the Health Board on 30/01/2025, providing assurance that the Governance Framework has been established and fully implemented.

See Appendix 3 for Evidence submission form link.

3.11 Implementation of an agreed training plan for the Corporate and Operational teams in relation to Complaints Management and Patient Advice and Liaison Service (PALS).

Evidence has been provided to the Health Board Action Delivery Group

Weekly Incident/Complaint Management awareness sessions are being offered to all staff across BCUHB to increase understanding of patient safety incidents that lead to

complaints. These sessions include a PowerPoint presentations, promotional posters, and Teams invites. Specific complaints management training has been delivered, including a session on PTR compliance by the Healthcare Law Team.

The Head of Patient and Carer Experience attended national training delivered by PSOW in Cardiff in November 2024 and will roll it out across BCUHB once additional details are received from Welsh Government on the National People's Experience Framework and revised PTR Guidelines.

In 2023, PALS delivered training to 570 staff, and 532 staff have been trained from April 2024 to present. New complaints training is being rolled out, with guidance on report writing and response tips provided to investigating officers. The Head of Patient and Carer Experience is also attending national training on managing complex complaints in March 2025, further supporting the link between patient experience, healthcare quality, and organisational culture.

See Appendix 3 for Evidence submission form link.

3.12 Improve Complaints performance trajectory to achieve 75% of complaints responded to within less than 30 working days in line with PTR Guidance.

Evidence has been provided to the Health Board Action Delivery Group

Between 15/04/2024, and 03/04/2025, significant improvements were made in complaint management at BCUHB. The total number of open complaints decreased by 64.29%, from 672 to 240, while overdue complaints fell by 90.42%, from 428 to 41. The percentage of overdue complaints as part of the total complaints improved from 33.97% in May 2024 to 82.92% by March 2025. Monthly updates show consistent performance, with 87.46% of complaints resolved within 30 working days as of October 2024, a continuous improvement trend.

A summary of complaints by service is shared with key staff three times a week, with 82.92% of complaints not overdue as of March 2025. The average time to close complaints has significantly reduced from 58.98 days in April 2024 to 20.07 days in March 2025. A major theme for complaints is delay/lack of treatment, which accounts for 33.75% of complaints. To address this, new initiatives such as the 3P's initiative, is due to launch in April 2025. New developments include the creation of internal and external patient experience webpages, a Quality Dashboard for real-time complaint data, and a communication campaign to raise awareness of the complaints process.

Public Services Ombudsman for Wales (PSOW) data shows that, despite a higher number of complaints closed in 2024, the number of complaints referred to the PSOW remained relatively stable, with only 0.57% of complaints upheld by the PSOW, indicating increased satisfaction with complaint responses.

2. Work Programme

A Work Programme to run from March to August 2025 is being co-developed, to enable the Expert Advisory Group members to assess progress against the improvement actions set out in the Invited Services Review by a series of site visits, focused presentations and seminars. The Work Programme also includes sessions to review the Evidence Packs to ensure that the Expert Advisory Group is provided with the documentation and evidence to check and challenge evidence that has been submitted to close any actions. The Special Advisor to the Health Board, Ros Alstead, has previously reported to the Health Board that the Expert Advisory Group members have articulated clear areas of interest, specifically the patient and carer experience in:

1. Older Peoples Mental Health
2. Adult Mental Health and
3. A cross cutting theme of Governance and Leadership.

The draft Work Programme, included in Appendix 1, has been reviewed and discussed with the Expert Advisory Group at their meeting held 21/03/2025 to enable input from the group to ensure the programme meets their requirements and expectations.

The group agreed the Work Programme will evolve as progress is made with the RCPsych Response Plan and evidence if reviewed by the Expert Advisory Group.

In addition, and in order to support the Work Programme, a Supportive Visit Protocol is being developed in collaboration with Llais and the Health Board.

3. Performance Dashboard

The Health Board RCPsych Action Delivery Group commissioned a Task and Finish Group to identify a set of performance measures that would provide an indication that change in areas relating to the RCPsych Report Themes was happening. These performance measures have been identified and are in the process of being developed into a Performance Measure Dashboard so that we have a consolidated visual that can be monitored as the impact of the response plan actions is sustained.

The dashboard will form part of a suite of both quantitative and qualitative information that when assessed together will provide a crucial holistic view of the impact the actions are having. The aim is that the service users, their families and other key

stakeholders can assess the suite of information to provide them with the assurance that what matters to them is improving.

Below is an example of one of the dashboard visuals that provides performance measures for Theme 1 – Patient and User Centred Care, across a six-month period. This will be supported by associated graphs to provide more context.

The data set for the circa twenty performance indicators is currently being collated as we on-board the remaining themes into the Performance Measure Dashboard. The dashboard needs to be of value and shaping it with feedback from the key stakeholders will be critical to this.

THEME 1 PATIENT AND USER CENTRED CARE - INDICATIVE PERFORMANCE MEASURES - MH&LD DIVISIONAL LEVEL	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Period Trend
Number of people waiting for initial assessment less than 28 days (4 weeks)	212	233	210	202	222	212	
Number of people waiting for initial assessment between 29 to 56 days (5 - 8 weeks)	174	145	135	136	156	135	
Number of people waiting for initial assessment greater than 56 days (8 weeks)	186	166	102	106	156	132	
CIVICA: Were you 'always' involved in decisions about care?	77.7%	74.7%	75.6%	83.8%	83.3%	76.9%	
CIVICA: Did staff 'always' take time to understand what matters to you?	75.3%	67.1%	75.7%	86.0%	84.6%	81.1%	
CIVICA: % that rated their experience as excellent	55.4%	52.8%	59.8%	65.0%	64.1%	57.4%	
Number of CIVICA returns	85	72	112	101	78	54	
Falls with Low Harm	28	15	15	23	28	23	
Falls with Moderate Harm	2	0	1	1	0	0	
Falls with Severe Harm	0	0	0	0	0	0	
Falls that led to catastrophic/death	0	0	0	0	0	0	

4. Glossary

ALN – Alcohol Liaison Nurse
BCUHB – Betsi Cadwaladr University Health Board
CEG – Clinical Effectiveness Group
CTP – Care Treatment Plans
CMHTs – Community Mental Health Teams
DDAT – Digital Data and Technology
DHCW – Digital Health and Care Wales
DSLT – Divisional Senior Leadership Team

DLRRG – Divisional Ligature Risk Reduction Group
HSE – Health & Safety Executive
HTT – Home Treatment Team
KPI – Key Performance Indicator
LHB – Local Health Board
LOF – Learning Outcomes Framework
MDT – Multi Disciplinary Team
MHLD – Mental Health and Learning Disabilities
NCCU – National Care Commissioning Unit
NHS – National Health Service
NICE – National Institute for Healthcare and Excellence
OD – Organisational Development
PADR – Performance and Development Review
PALS – Patient Advice and Liaison Services
PCE – Patient Care Experience
PST – Patient Safety Team
PTR – Putting Things Right
POMH – Prescribing Observatory for Mental Health
PSOW - Public Services Ombudsman for Wales
SLT – Senior Leadership Team MH&LD
SOP – Standard Operating Procedure
SQDG – Service Quality Delivery Group
WARRN – Wales Applied Risk Research Network
WCCIS – Welsh Community Care Information System
WG – Welsh Government

<table>
<tr><td>Teitl adroddiad:

Report title:</td><td colspan="4">Board Assurance Framework</td></tr>
<tr><td>Adrodd i:

Report to:</td><td colspan="4">Quality Safety and Experience (QSE) Committee</td></tr>
<tr><td>Dyddiad y Cyfarfod:

Date of Meeting:</td><td colspan="4">Thursday, 01 May 2025</td></tr>
<tr><td>Crynodeb Gweithredol:

Executive Summary:</td><td colspan="4">The purpose of this paper is to seek the Committee’s agreement on the proposed assurance ratings for each of the Board Assurance Framework (BAF) risks, ahead of submission to the Board.

The proposed assurance ratings have been approved by individual committees responsible for the risk.

The Board Assurance Framework will be submitted to the Board in May 2025.</td></tr>
<tr><td>Argymhellion:

Recommendations:</td><td colspan="4">The Committee is asked to:

• To receive and consider the contents and assurance rating of the Board Assurance Framework.</td></tr>
<tr><td>Arweinydd Gweithredol:

Executive Lead:</td><td colspan="4">Pam Wenger, Director of Corporate Governance</td></tr>
<tr><td>Awdur yr Adroddiad:

Report Author:</td><td colspan="4">Nesta Collingridge Head of Risk Management</td></tr>
<tr><td>Pwrpas yr adroddiad:

Purpose of report:</td><td>I’w Nodi
For Noting
☐</td><td colspan="2">I Benderfynu arno
For Decision
☒</td><td>Am sicrwydd
For Assurance
☐</td></tr>
<tr><td>Lefel sicrwydd:

Assurance level:</td><td>Arwyddocaol
Significant
☐
Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol

High level of confidence/evidence in delivery of existing mechanisms/objectives</td><td>Derbyniol
Acceptable
☒
Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol

General confidence / evidence in delivery of existing mechanisms / objectives</td><td>Rhannol
Partial
☐
Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol

Some confidence / evidence in delivery of existing mechanisms / objectives</td><td>Dim Sicrwydd
No Assurance
☐
Dim hyder/tystiolaeth o ran y ddarpariaeth

No confidence / evidence in delivery</td></tr>
<tr><td colspan="5">Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:

Justification for the above assurance rating. Where ‘Partial’ or ‘No’ assurance has been indicated above, please indicate steps to achieve ‘Acceptable’ assurance or above, and the timeframe for achieving this: N/A</td></tr>
</table>

Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Detailed in the BAF report and how the CRR aligns to the revised BAF
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	It is essential that the Board has robust arrangements in place to assess, capture and mitigate risks, as failure to do so could have legal implications for the Health Board.
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	Not applicable for this report
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary ben undertaken?***	Not applicable for this report
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	Board Assurance Framework paper
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	The effective and efficient mitigation and management of risks has the potential to leverage a positive financial dividend for the Health Board through better integration of risk management into business planning, decision-making and in shaping how care is delivered to our patients thus leading to enhanced quality, less waste and no claims.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	Failure to capture, assess and mitigate risks can impact adversely on the workforce.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	Executive Committee feedback 26/03/2025 informed this version of the BAF and suggested ratings agreed.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	Board Assurance Framework risks linked to corporate risks
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	

Camau Nesaf: ***Next Steps:*** 1. Assurance ratings to be presented to the Board for agreement. 2. Business as usual reporting and monitoring: Bi-monthly Review at Risk Scrutiny Group and Executive Team meeting, monitoring of actions within risks. Reporting to Committee quarterly and Board bi-annually as per Risk Management Framework.	
Rhestr o Atodiadau: ***List of Appendices:*** Appendix 1 – QSE Board Assurance Framework	

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 Committee's agreement on the proposed assurance ratings for each of the Board Assurance Framework (BAF) risks, ahead of submission to the Board.

Introduction

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

What is Assurance in Relation to Board Assurance Risks?

In the context of the Board Assurance Framework, **assurance** refers to the level of confidence the Committee can place in the effectiveness of the current risk treatment strategies to mitigate identified threats to strategic objectives. It is based on the extent of evidence available—internal or external—that demonstrates that key controls are in place and working effectively, and that actions to address gaps are progressing as intended.

Assurance levels help the Board determine whether risks are being managed effectively and inform decisions about resource allocation, priority areas, and potential escalations.

The four levels of assurance used are as noted in the key on page 6 of this report.

Proposal from the Executive Committee

Following its review, the Executive Committee proposes that the majority of the risks on the Board Assurance Framework are currently suggested to be rated as having *Limited Assurance*.

Rationale for Proposed Rating

The recommendation of **Limited Assurance** reflects a realistic and cautious assessment of the current position. Specifically:

- While some progress has been made on risk treatment strategies, there remain to be identified **key gaps in controls** that remain unresolved.
- More **evidence is required** particularly external or independent validation that controls are fully effective.
- Several actions remain as progressing and not yet complete before the risk scores can be confidently reduced.
- As such, the **likelihood of these risks materialising remains**, and further assurance is required before a higher assurance rating can be justified.

This rating encourages focused attention and targeted action in key areas while recognising that progress is underway.

Recommendation

The Committee is asked to **review and agree** the proposed assurance ratings on behalf of the Board for each risk on the Board Assurance Framework. If agreed, these ratings will be presented to the Board for agreement.

Next Steps

- Committees will be asked to score level of assurance in relation to risks.
- The Board Assurance Framework will be maintained and reported to the Risk Scrutiny Group; Executive Team (bi-monthly) and Committees (quarterly) and Board (quarterly) as per the Risk Management Framework on an on-going basis.

Board Assurance Framework (BAF): April 2025

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
Frequency 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
Probability 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): April 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	19/03/2025	4x 3= 12	**4x 3= 12**	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	19/03/2025	5x 4= 20	**5x 4= 20**	3x 3= 9
BAF24-03	Not Achieving Long Term Financial Sustainable	Executive Director of Finance	Performance, Finance and Information Governance	20/10/2024	19/03/2025	5x 4= 20	**5x 4= 20**	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	19/03/2025	4x 4= 16	**4x 4= 16**	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	19/03/2025	2x 3= 6	**2x 3= 6**	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	19/03/2025	5x 4= 20	**5x 4= 20**	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	19/03/2025	4x 4= 16	**4x 4= 16**	4x 2= 8
BAF24-08	Not Implementing Evidenced Based Improvement and Innovation	Executive Director of Nursing & Chief Digital & Information Officer	Planning, Population Health & Partnership	20/10/2024	19/03/2025	4x 3= 12	**4x 3= 12**	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.

Principal risk (what could prevent us achieving this strategic objective)	**BAF24-06: Not Delivering the Required Improvements to Transform Care and Enhance Outcomes** 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.			**Strategic objective**	4. To Improve Quality, Outcomes and Experience (4A Patient Experience; 4B Prevention; 4I Adult Mental Health, Learning Disability)
Lead Committee	Quality, Safety and Experience Committee / Planning, Population Health & Partnership Committee	**Risk type**	Quality		
Risk Lead	Executive Director of Nursing Executive Director of Public Health Executive Medical Director Executive Director of Allied Health Professionals and Health Science	**Risk appetite**	Open 15-19		
Related Corporate Risks:	**CRR24-02** Patient Safety /**CRR24-04** Failure to Embed Learning/ **CRR24-08** Delivering a population health approach to health and wellbeing/ CRR24-18 Managing Outbreaks				

Chart: 25, 20, 15, 10, 5, 0; 17/10/2024, 18/10/2024; Current 20, 20; Tolerable 15, 15; Target 10, 10. Legend: Current, Tolerable, Target

Risk rating				**Review Dates**	
	Current exposure	**Tolerable**	**Target**		
Consequence	5. Catastrophic	5. Catastrophic	5. Catastrophic	**Initial date of assessment**	20/10/2024
Likelihood	4. Somewhat likely	3. Possible	2. Unlikely	**Last reviewed by Committee:**	17/12/2024 (Private)
Risk rating	20. High	15. High	10. Medium	**Last updated by Executive:**	04/04/2025

Board Assurance Framework (BAF): April 2025

Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** 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)** (**Evidence** 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

Threat: 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	• Patient incident/feedback systems and policies
	• Data analysis and learning at service level
	• Datix Reporting
	• Staff training - falls, HAPU, etc
	• Quality governance arrangements at Health Board, IHC/division & service levels including:
	  ○ Local and Exec PSE Groups
	  ○ Local and Exec Quality Delivery Groups
	  ○ Clinical audit programme & monitoring arrangements
	  ○ Ward accreditation/ metrics and programme
	
	• Integrated Concerns Policy and Toolkit
	• Concerns Hub
	• 72 hr incident reviews
	• Sign-off process for incidents and Nationally Reported Incidents
	• Executive Led Oversight Group
	• Quality assurance visits
	• Internal Reviews against External National Reports
	• Getting it Right First Time (GIRFT)
	• Localised deep dives, reports and action plans
	• Operational grip on workforce gaps
	• Patient Advice and Liaison Service Activity
	• Comprehensive Cultural Competence training and awareness
		• Inconsistent collection of real-time patient feedback
		• Delays in addressing patient concerns or complaints.
		• Operational oversight of sustainable change, evidence of learning and improvement measures
			Management:
			• Learning from deaths Report to QC and Board
			• Quarterly Strategic Priority Report to Board;
			• Divisional risk reports to SRG bi-annually;
			• Guardian of Safe Working report to Board
			• Quality and Governance Reporting Pathway;
			Quality Safety and Experience Committee reports include:
			  ○ Safeguarding Annual Report to QSE
			  ○ Infection Control Annual Report
			  ○ Health and Safety Annual Report
			  ○ Bi monthly Quality Report
			  ○ Deep dive Reports
			  ○ Risk Management Report
			  ○ Integrated Performance Report
			
			Risk and compliance:
			• Quality Dashboard
			• Annual Quality Report & Duty of Candour
			• Corporate Risks
			• Ombudsman Annual Letter
			
			Independent assurance:
			• Health Inspectorate Wales Reports
			• Care Inspectorate Wales Reports
			• Coroners reports:
			• Internal Audit reports.
			• Royal College Reports
			• Llais Reports
			
			Screening Quality Assurance Services assessments and reports of:
			• Antenatal and New-born screening
			• Breast Cancer Screening Services
			• Bowel Cancer Screening Services
			• Cervical Screening Services
			
			External Accreditation/Regulation annual assessments and reports of;
			• Pathology (UKAS)
			• Endoscopy Services (JAG)
			• Medical Equipment and Medical Devices (BSI)
			• Blood Transfusion Annual Compliance Report (MHRA)
				Limited Assurance Internal Audit report for Limited Assurance: Lessons Learnt, Falls, Deprivation of Liberty
				
				Ombudsman recommendations to be managed.
				
				Services maintaining a proactive for complaint management and strategic oversight.
				
				• Nursing & Midwifery Vision
				• Allied Health Professional Strategy
				• Clinical services plan
					Limited Assurance

			• Ionising Radiation (Medical Exposure) Regulations		

⬆	**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	Chris Lynes	Complete	31/03/2025
	Expand real-time feedback systems across all services (SMS texting for priority areas e.g. ED)	Chris Lynes	Complete	31/12/2024
	Quality Management System in development. – pilots in urology and vascular	Chris Lynes	Complete	31/03/2025
	Reduced response times for addressing patient complaints.	Chris Lynes	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 31/06/25	Chris Lynes	Delayed	30/06/2025

Teitl adroddiad: ***Report title:***	Corporate Risk Register Report (March 2025)
Adrodd i: ***Report to:***	Quality, Safety and Experience Committee (QSE)
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 01 May 2025
Crynodeb Gweithredol: ***Executive Summary:***	The purpose of this standing agenda item is to provide an update position of the Corporate Risk Register to which the Committee has oversight. Five risks reported to committee score above the tolerance range set in the appetite (scores of 20): • **CRR24-09 –** 'Primary Care', • **CRR24-13 –** 'Timely Diagnostics', • **CRR24-19 –** 'Community Care Provision', • **CRR24-21** – 'Ophthalmology Service' • **CRR24-27**– 'Neurodevelopmental Waiting Lists'. (Newly Escalated Risk) All risks have been reviewed and updated by the relevant service, with no proposed changes in risk scoring. • **CRR24-20 '**Oncology Services' – Extension to Target risk due date approved, changed from the 31/04/2025 to 31/03/2026 to align with action due dates and allow implementation of identified actions required. Gaps in assurance for Corporate Risks: • **CRR24-25** 'Dermatology & Plastic Surgery Services' – The committee is asked to note the lack of update and developments since the last iteration of the Corporate Risk.
Argymhellion: ***Recommendations:***	The Committee is asked to **receive assurance** for the progression of the corporate risks to which the Committee has overall accountability.
Arweinydd Gweithredol: ***Executive Lead:***	Pam Wenger, Director of Corporate Governance
Awdur yr Adroddiad: ***Report Author:***	Nesta Collingridge Head of Risk Management

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

Lefel sicrwydd:	Arwyddocaol *Significant*	Derbyniol *Acceptable*	Rhannol *Partial*	Dim Sicrwydd *No Assurance*

<table>
<tr><td>Assurance level:</td><td>☐
Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol

High level of confidence/evidence in delivery of existing mechanisms/objectives</td><td>☒
Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol

General confidence / evidence in delivery of existing mechanisms / objectives</td><td>☐
Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol

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Dim hyder/tystiolaeth o ran y ddarpariaeth

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Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:</td></tr>
</table>

Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Links to the BAF detailed in respective CRR reports
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	It is essential that the Health Board has robust arrangements in place to assess, capture and mitigate risks, as failure to do so could have legal implications for the Health Board.
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	Not applicable for this report
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary ben undertaken?***	Not applicable for this report
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	Links to the BAF detailed in respective CRR reports
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	The effective and efficient mitigation and management of risks has the potential to leverage a positive financial dividend for the Health Board through better integration of risk management into business planning, decision-making and in shaping how care is delivered to our patients thus leading to enhanced quality, less waste and no claims.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	Failure to capture, assess and mitigate risks can impact adversely on the workforce.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	Individual Executive Sign off of CRR reports, Review at next Risk Scrutiny Group and subsequent Executive Team Meeting.

<table>
<tr><td></td><td></td></tr>
<tr><td>Cysylltiadau â risgiau BAF:
(neu gysylltiadau â’r Gofrestr Risg Gorfforaethol)

Links to BAF risks:
(or links to the Corporate Risk Register)</td><td>See the individual risks for details of the related links to the Board Assurance Framework.</td></tr>
<tr><td>Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)

Reason for submission of report to confidential board (where relevant)</td><td>Not applicable for this report</td></tr>
<tr><td colspan="2">Camau Nesaf:

Next Steps:
1. Further scrutiny of all corporate risks by Executive Team as per normal reporting cycle.
2. Submission of Corporate Risks to Board.</td></tr>
<tr><td colspan="2">Rhestr o Atodiadau:

List of Appendices:
Appendix 1 – Corporate Risk Dashboard (March 2025) – Quality, Safety and Experience Committee (QSE)

Appendix 2 – Corporate Risk Register Report (March 2025) - Quality, Safety and Experience Committee (QSE)</td></tr>
</table>

Corporate Risk Register

Corporate Risk Register Report

1.0 Purpose

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

There are 13 Corporate Risks for Quality, Safety and Experience Committee oversight and assurance. The full details of those risks are highlighted in Appendix 2 and include evidence of controls in place, additional controls required and actions with due dates:

- CRR24-02 – Patient Safety
- CRR24-04 – Failure to Embed Learning
- CRR24-09 – Primary Care
- CRR24-13 – Timely Diagnostics
- CRR24-14 – Harm from Medical Devices/Equipment
- CRR24-19 – Community Care Provision
- CRR24-20 – Oncology Service
- CRR24-21 – Ophthalmology Service
- CRR24-22 – Orthodontics Service
- CRR24-23 – Vascular Service
- CRR24-24 – Renal Service
- CRR24-25 – Dermatology & Plastic Surgery Service
- CRR24-26 – Urology Service

2.0 Key Highlights

The group is asked to **consider and note** updates to the Corporate Risk register entries, with the full details of the risks included within Appendix 2 – Full Corporate Risk Register:

- **CRR24-20 '**Oncology Services' – Extension to Target risk due date approved, changed from the 31/04/2025 to 31/03/2026 to align with action due dates and allow implementation of identified actions required.

The following risks were subject to a deep dive at the February 2025 Risk Scrutiny Group where the group discussed and reviewed, the risks and were presented to the group by the relevant risk lead and service:

- **CRR24-09 –** Primary Care
- **CRR24-19** – Community Care Provision

Further planned deep dives into the following Corporate Risks are scheduled to be undertaken during the April 2025 Risk Scrutiny Group:

- **CRR24-21** – Ophthalmology Service
- **CRR24-23** – Vascular Services
- **CRR24-24** – Renal Services

2.1 Changes in Score

None

2.2 New Risks

The risk(s) added to the Corporate Risk Register since the last update are (full details within Appendix 2):

Risk Ref	New Risks	Lead Exec Director	Current Risk Score (and IxL)
CRR24-27	Neurodevelopment Waiting List	Chief Operating Officer	**20 (5x4)**

2.3 Overdue/Delayed Actions

The corporate risk register report was produced at the beginning of **March 2025** for review and approval by the Executive Team. At the time of producing two actions was 'overdue' however some actions are noted for being completed end of March 2025.

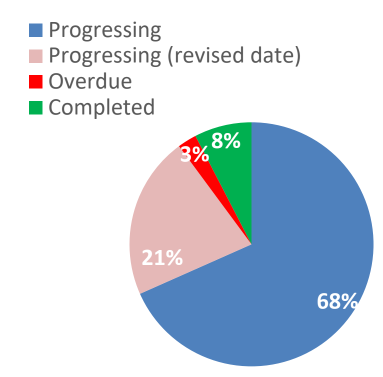
As per the normal cycle of reporting, the May 2025 updates are being sought for current updates on all of these actions. The status of these actions of will be included in the next update/iteration of the risk register.

2.4 Risks above Health Board 24/25 appetite

Five risks reported to committee score above the tolerance range set in the appetite.

Risk Ref	Risks	Lead Exec Director	Current Risk Score	Risk Tolerance Range in Appetite Score
CRR24-09	Primary Care	Executive Director of Operations	**20**	**Quality <16**
CRR24-13	Timely Diagnostics	Chief Operating Officer	**20**	**Quality <16**
CRR24-19	Community Care Provision	Chief Operating Officer	**20**	**Quality <16**
CRR24-21	Ophthalmology Service	Chief Operating Officer	**20**	**Quality <16**
CRR24-27	Neurodevelopment Waiting List	Chief Operating Officer	**20**	**Quality <16**

2.5 Action Plan status of Corporate Risks



Out of the 14 (including 1 newly escalated risk) corporate risks, 88 actions have been developed to mitigate the risks. 15 actions have been completed, 54 actions are progressing, with 17 actions progressing with revised due dates, 2 actions are currently overdue and to be reviewed during next iteration for May 2025 update.

Next steps

1. Further scrutiny of all corporate risks by Executive Team as per normal reporting cycle.
2. Submission of Corporate Risks to Board

Appendix 1 - Corporate Risk Register Dashboard (March 2025) – Quality, Safety and Experience Committee

Lead	Ref	Risk Title	Current Score (Impact x Likelihood)	Risk Target Score	Appetite Main Risk Type / Appetite Level	Lead Board Committee	Risk Management Commentary
EDoN	CRR 24-02	Patient Safety	4 x 4 = 16 ⬌	12	Quality / Open <16	Quality, Safety and Experience Committee	Opened Dec 23. Risk revised to become broader patient safety risk, 3 actions identified, 1 completed, and 2 actions progressing (1 with revised due dates).
EDoN	CRR 24-04	Failure to Embed Learning	5 x 3 = 15 ⬌	5	Quality / Open <16	Quality, Safety and Experience Committee	Opened Dec 23, 4 actions identified, 1 completed, 1 progressing with 2 revised due date. Reduction in current risk score from 20 to 15 – September 2024.
EDoO	CRR 24-09	Primary Care	4 x 5 = 20 ⬌	12	Quality / Open <16	Quality, Safety and Experience Committee	Opened Feb 24, 5 actions identified, all 5 progressing, with 3 revised due dates. The **inherent and current risk scores are both 20**, indicating the controls are not yet reducing the risk. **Risk Score above tolerance set in risk appetite.**
COO	CRR 24-13	Timely Diagnostics	5 x 4 = 20 ⬌	5	Quality / Open <16	Quality, Safety and Experience Committee	Opened Feb 24, 6 actions progressing, with 2 revised date. **Risk Score above tolerance set in risk appetite.**
EDoTH	CRR 24-14	Harm from the Medical Devices/ Equipment	4 x 4 = 16 ⬌	8	Quality / Open <16	Quality, Safety and Experience Committee	Opened Feb 24, 5 actions identified, all 3 progressing with revised due dates, with 2 closed actions.
COO	CRR 24-19	Community Care Provision	4 x 5 = 20 ⬌	12	Quality / Open <16	Quality, Safety and Experience Committee	Risk reviewed Jan 2025, 8 actions identified, 2 actions completed, with 6 actions progressing.

							New risk developed by the services and approved by the Executive Director of Transformation and Strategic Planning. Risk since transferred over to the Chief Operating Officer.
EMD	CRR 24-20	Oncology Services	3 x 5 = 15 ⬌	9	Quality Open <16	Quality, Safety and Experience Committee	Risk approved Nov 24, 4 actions in total, 1 action progressing with 3 actions progressing with revised dates **Extended the Target risk due date to allow sufficient time to complete and implement identified actions, from the 30/04/2025 to the 31/03/2026**.
COO	CRR 24-21	Ophthalmology Services	4 x 5 = 20 ⬌	9	Quality Open <16	Quality, Safety and Experience Committee	Risk approved Nov 24, 5 actions in total, 3 progressing with 2 overdue actions. **Risk Score above tolerance set in risk appetite. Partially updated, no update on actions**
COO	CRR 24-22	Orthodontic Services	4 x 4 = 16 ⬌	4	Quality Open <16	Quality, Safety and Experience Committee	Risk approved Nov 24, 12 actions in total, 8 completed actions, 4 progressing.
COO	CRR 24-23	Vascular Services	4 x 4 = 16 ⬌	12	Quality Open <16	Quality, Safety and Experience Committee	Risk approved Nov 24, 9 actions in total, 9 progressing.
COO	CRR 24-24	Renal Services	4 x 4 = 16 ⬌	12	Quality Open <16	Quality, Safety and Experience Committee	Risk approved Nov 24, 4 actions in total, 4 progressing.
EMD	CRR 23-25	Dermatology & Plastic Surgery Services	3 x 5 = 15 ⬌	9	Quality Open <16	Quality, Safety and Experience Committee	Risk approved Nov 24, 5 actions in total, 5 progressing. No update from service.
EMD	CRR 24-26	Urology Services	4 x 4 = 16 ⬌	6	Quality Open <16	Quality, Safety and Experience Committee	Risk approved Nov 24, 4 actions in total, 1 completed actions, 3 progressing.

COO	CRR 24-27	Neurodevelopmental Waiting List	5 x 4 = 20 ⬌	15	Quality Open <16	Quality, Safety and Experience Committee	New risk approved Mar ’25. 14 actions identified, all progressing.

Key:

Executive	
Executive Director of Workforce	EDoW
Executive Director of Nursing & Midwifery	EDoN
Executive Director of Finance	EDoF
Chief Digital Information Officer	CDIO
Executive Director of Public Health	EDoPH
Executive Director of Operations	EDoO
Executive Director of Therapies and Allied Health Professions	EDoTH
Executive Director of Transformation and Strategic Planning	EDTSP
Chief Operating Officer	COO

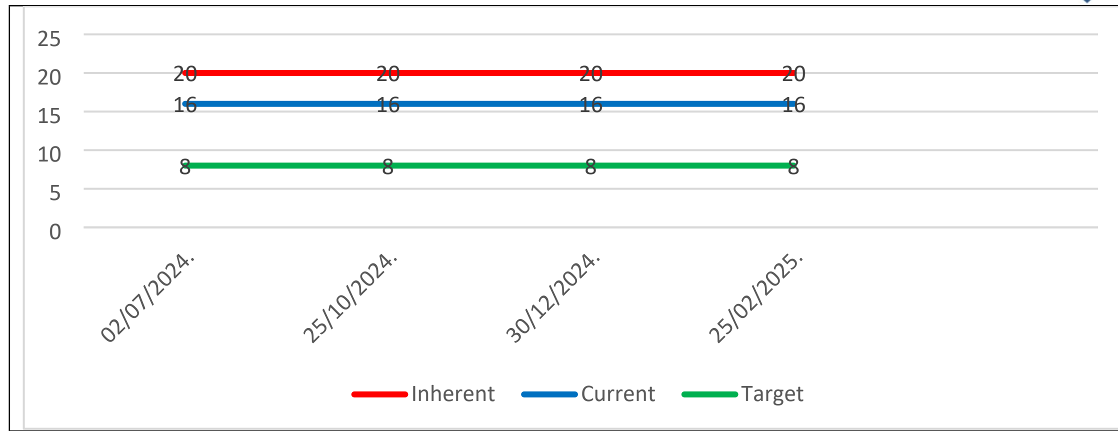
Appendix 2 – Corporate Risk Register Report (March 2025) – Quality, Safety and Experience Committee

<table>
<tr><td rowspan="2">CRR 24-02</td><td colspan="2">Risk Title: Patient Safety</td><td>Date Opened: 02/07/2024</td></tr>
<tr><td colspan="2">Assuring Committee: Quality, Safety and Experience Committee</td><td>Date Last Committee Review: 20/02/2025</td></tr>
<tr><td>Date Last Reviewed: 25/02/2025</td><td>Director Lead: Executive Director of Nursing and Midwifery</td><td>Link to BAF: BAF24-06</td><td>Target Risk Date: 30/09/2025</td></tr>
<tr><td colspan="4">There is a risk that patients may experience preventable harm and a poor experience whilst receiving care due to inadequate preventative measures, not following correct procedures , adhering to best practice and/or learning from concerns . This could lead to poor quality of care resulting in severe complications, prolonged hospital stays, decreased quality of life, psychological distress, reputational damage, increased costs, and potential legal and financial consequences for the organisation.</td></tr>
<tr><td colspan="2">Mitigations/Controls in place</td><td colspan="2">Additional Controls required</td></tr>
<tr><td colspan="2">1. Policies and Procedures to support risk assessment, guidance and escalation in place e.g.NU06 Prevention and Management of Adult Inpatient Falls, NU03 Pressure Ulcers, MM01 Medicines, National Early Warning Score.
2. Review of patient safety incidents at a local level supported by integrated concerns meetings and harms reviews for learning meetings.
3. Strategic groups that report into the Health Board Patient Safety Group, e.g. Falls Group, Prevention and Management of Pressure Ulcers Group, Improving Nutrition and Catering Standards, Safer Medicines Steering Group, Sepsis Triggers Escalation & Antibiotic Stewardship Review for learning and improvement.
4. Escalation to Quality Delivery Group and Quality, Safety and Experience Committee.
5. Cycle of business to Patient Safety Group that includes IHC/Divisional deep dives of progress and action.
6. BCUHB wide Improvement plans for falls, Hospital Acquired Pressure Ulcers, Nutrition and Medicines safety
7. Incident management process including rapid reviews, focused reviews and learning panels.</td><td colspan="2">a. Sustained compliance of >85% of patient safety related mandatory training
b. Timely update of policies and procedures in line with evidence based practice and as per governance cycle for review.
c. Continue to undertake the bi-annual nurse staffing reviews to ensure we have the levels of staffing required to meet acuity as per NSA and clinical judgment.
d. Continued work on the 6 goals and Urgent and Emergency Care pathways to reduce the risk of patient safety incidents.
e. Continued work on the planned care delays and backlog harms reviews associated with long delays.
f. Continued work with People services to ensue robust assurance measures are in place for our temporary workforce to ensure they have the skills and competencies required to maintain patient safety.</td></tr>
</table>

8. All Staff induction, training and competency
9. Organisational Learning Forum for shared learning and improvement
10. Regular patient safety incident alerts issued to staff as and when required
11. Integrated concerns policy and framework implementation.
12. Bi-annual Nurse Staffing reviews are undertaken in line with the Nurse Staffing Levels (Wales) Act 2016 for all acute adult medical and surgical inpatient wards, and paediatric inpatient wards (Section 25B). Additionally, and in keeping with the principles of the legislation nurse staffing reviews are also undertaken in other areas of the Health Board such as Community Hospitals, Mental Health, and other 24hr services.
13. Roster Policy WP28A in place and monthly roster KPI reports are issued to the Directors of Nursing to enable roster performance to be actively managed. Additionally allocate Safe Care compliance reports are also sent to the Directors of Nursing, to enable maximum utilisation of nursing workforce.

Actions	**Due Date**	**Progression Analysis**
Workshops to be held across BCUHB to reduce backlog of open incidents using approved methodology to improve immediate learning. This includes setting of trajectories for improvement, cluster reviews and drop in clinics. .	15/01/2025	Complete
Strategy for increasing compliance with patient safety related mandatory training. Positive increase noted in compliance and will be ongoing as oxygen administration mandatory training is delivered.	31/03/2025	Progressing (revised date from 30/01/2024)
Deliver all the actions from the Internal Audit of falls. Combined HSE and Internal Audit action plan in place. Evidence compiled for action plan and submitted and reviewed at bi monthly to Falls Steering Group.	31/03/2025	Progressing

	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	2	8
Risk Appetite	Quality		<16



Position & Intended Outcome for Risk

There are circa 38,000 patient safety incidents reported in the last financial year of which approximately 25% graded as moderate harm or above by the reporter. Feedback has also been received from His Majesty's Coroner in the form of regulation 28 prevention of future deaths around risks from timely investigation and implementation of actions to improve patient safety.

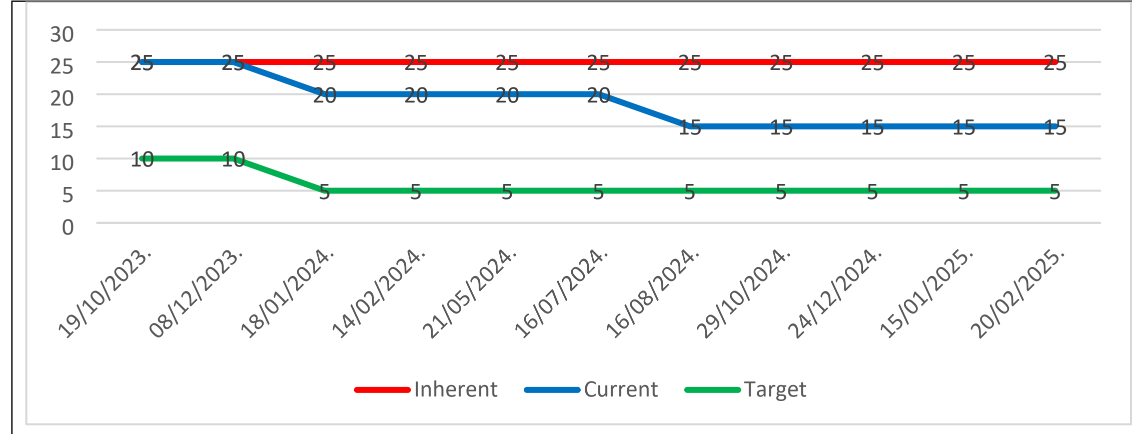
To support the planned target score improvement have been noted in the reduction of all open incidents, NRI and overdue NRI .Falls and HAPU as our highest number of incidents are on a reducing trajectory .
No Reg 28 or Never events have been reported in 2025.
Reduction in RIDDOR reportable incidents noted .

<table>
<tr><td rowspan="2">CRR 24-04</td><td colspan="2">Risk Title: Failure to Embed Learning</td><td>Date Opened: 19/10/2023</td></tr>
<tr><td colspan="2">Assuring Committee: Quality, Safety and Experience Committee</td><td>Date Last Committee Review: 20/02/2025</td></tr>
<tr><td>Date Last Reviewed: 20/02/2025</td><td>Director Lead: Executive Director of Nursing and Midwifery</td><td>Link to BAF: BAF24-06</td><td>Target Risk Date: 30/09/2025</td></tr>
<tr><td colspan="4">There is a risk that the Health Board could fail to meet requirements for timely review and learning from mortality cases, claims, inspections, incidents and complaints. This could be caused by insufficient resources, lack of unified processes, outdated IT systems, duplication of effort, and overreliance on single personnel. The impacts may include missed opportunities for improvement, lack of family/carer engagement, potential patient harm events going undetected, non-compliance with national frameworks or legislation, and reputational damage.</td></tr>
<tr><td colspan="2">Mitigations/Controls in place</td><td colspan="2">Additional Controls required</td></tr>
<tr><td colspan="2">1. Clinical policies, procedures, guidelines, pathways, supporting documentation & IT systems. Integrated Concerns Policy
2. Senior sign-off process for National Reportable Incidents (NRIs) and Complaints
3. Clinical staff recruitment, induction, mandatory and professional training, registration & re-validation
4. Putting Things Right and clinical review processes and monitoring
5. Quality governance framework of meetings and reporting structured
6. Quality Dashboard and access to quality data from ward/team to Board
7. Patient and carer feedback and involvement processes
8. Defined nurse staffing levels for all wards & departments as per Nurse Staffing Act
9. Ward accreditation schemes and ward manager/matron checks/audits.
10. Getting it Right First Time (GIRFT), localised deep dives, reports and action plans
11. Organisational Learning Forum (OLF): This forum promotes sharing of learning for continuous improvement and encourages sharing best practices and lessons learned to enhance safety and quality
12. Organisational Learning Forum (OLF) Betsinet shared learning page
13. Exec Oversight Group: This group provides strategic direction and high-level oversight for risk management, ensuring alignment with organisational goals and adequate resource allocation. It also monitors and adjusts risk mitigation strategies.</td><td colspan="2">a. Implementation of a Quality Management System (QMS) setting out an integrated approach to Quality Planning, Control, Assurance and Improvement (dashboard completed).
b. Clarity on quality leadership, structures and accountabilities
c. Development of a quality learning framework, aligned to the overall learning organisation programme
d. Resolution of outstanding overdue positions for incidents, complaints, claims, mortality reviews and inquests
e. Ongoing embedding and training of a new Learning from Events (LEFR) process to improve divisional ownership and completion of a recovery plan to address the overdue position
f. Medical engagement to ensure active participation and commitment from medical staff in learning and improvement.
g. Integration of LFER/Claims – To enhance the management and resolution of claims, ensuring they are addressed promptly and effective
h. Ensure learning from deaths – Provide the mortality panel with access to a process that ensures thematic learning from deaths is taken forward to facilitate continuous improvement.</td></tr>
</table>

14. Inquest Review Group**:** Focused on cases with significant adverse outcomes, this group conducts thorough investigations to recommend changes in policies and practices, ensuring accountability and transparency. 15. Rapid Review Process: Designed for urgent issues, this process uses streamlined methods to quickly identify risks and implement corrective actions, minimizing the impact of emerging risks. 16. New Thematic Review Group: This group conducts in-depth reviews of specific themes or patterns, developing targeted recommendations to address systemic issues and continuously improve the organisation.	

Actions	**Due Date**	**Progression Analysis**
A central and digital library of learning will be established which will be launched alongside a revised approach to the collation, analysis and dissemination of learning. Development work continues with a revised aim of May 2025. Work continues to develop the new Quality Learning Portal. Due to other work pressures, development on the Solution has slowed and little progress has been made since the previous update. These additional work pressures are being addressed, and the development continues on the admin app that will allow administrators to review learning prior to being published to the organisation. The first of three apps, which will allow users to enter learning into the system, is currently being tested. The second app is due to be completed by the end of December, with the final part of the Solution due to be complete early in the New Year. Whilst this is later than hoped in the original ambitious plan, this work is an entirely new project being developed and the first of its kind in Wales, so an agile development approach is being taken to ensure the solution is reliable, sustainable and delivers a real benefit to BCUHB.	31/05/2025 – delayed due to DDAT priorities	Progressing (Date Revised from 31/03/2025)
Implementation of the new/approved QMS Framework within the identified pilot sites. Implementation of the QMS progressing in the test sites with other early adopters identified, this will be ongoing.	31/03/2025	Progressing
Implementation of the new Learning from Events Report (LFER) process	31/01/2025	Completed
Delivery of overdue LFER recovery plans by each IHC/Division to eliminate the overdue position	31/06/2025	Progressing

		Impact	Likelihood	Score
	Inherent Risk Rating	5	5	25
	Current Risk Rating	5	3	15



Target Risk Score	5	1	5
Risk Appetite	Quality		<16

Position & Intended Outcome for Risk

Learning is now being embed through Organisational Learning Forum (OLF) and the Integrated Concerns Forum (ICF), complaints and incidents position on a positive improvement trajectory. The monitoring of the sustained improvement is required prior to de-escalating the risk. Improvement trajectory for complaints reached with performance currently over 75% - sustainability will be monitored weekly. The number of Prevention of Future Death (PFD) / Regulation 28 Notices issued to BCUHB since February 2023 currently stands at 32.The Health Board saw a large number issued in 2023/24 (23) which was a significant outlier compared to previous years and other NHS Wales bodies. However 5 were received in 2024/25 (to date), a significant reduction compared to the number issued in same period of the prior year and more in-line with the average of previous years and other NHS Wales bodies. Coroners have raised a number of common themes through these Regulation 28 reports, the quality of investigations and effectiveness of actions being the most common. The Health Board completed a Learning from Investigations Programme to assess and improve its investigation process and improve the assurances it can take on existing action plans. The programme had direct oversight from the Chief Executive and wider executive team and reported to the Quality, Safety and Experience Committee with a clear escalation process in place. The learning from this programme directly informed the new Integrated Concerns Policy which was approved by the Board in July and launched in September 2024 providing a new, integrated approach to patient safety investigations, complaint investigations and mortality reviews.

<table>
<tr><td rowspan="2">CRR 24-09</td><td colspan="2">Risk Title: Primary Care</td><td>Date Opened: 08/02/2024</td></tr>
<tr><td colspan="2">Assuring Committee: Quality, Safety and Experience Committee</td><td>Date Last Committee Review: 20/02/2025</td></tr>
<tr><td>Date Last Reviewed: 04/03/2025</td><td>Director Lead: Executive Director Transformation and Strategic Planning</td><td>Link to BAF: BAF24-07</td><td>Target Risk Date: 31/03/2026</td></tr>
<tr><td colspan="4">There is a risk that the Health Board’s ability to meet its statutory obligation to provide primary care services will be impacted by growing patient demand, workforce and financial pressures. This could be caused by financial pressures due to factors such as rising operational costs and insufficient funding. This could lead to ineffective or failing primary care function would increase the likelihood of declining population health, poor service performance, regulatory non-compliance, poor staff morale and an increase in activity in other parts of the system such as emergency departments.</td></tr>
</table>

Mitigations/Controls in place	Additional Controls required
1. Primary Care Board established in 2024 to ensure executive oversight of services. 2. Primary Care sub groups established in 2024 that focus on specific key elements of service overview including governance and quality, workforce and contracting. 3. Primary care team working closely with national team to deliver Strategic Programme for Primary Care (SPPC) in North Wales Focuses on elements including Accelerated Cluster Development, Pan-Cluster Planning Groups, Primary Care Professional collaboratives and the Primary Care Academies. 4. Established Cluster and Collaborative Leads across the 14 cluster areas in BCU. 5. Pan Cluster Planning Groups (PCPGs) are now in place across each IHC in the Health Board, and are supported by the Local Authorities and Public Health.	a. Primary care plan needed to set out long term strategy for services b. Programme management approach needed to monitor and drive strategic and operational priorities. c. Consistent approach to managing primary care services across BCU is needed. Currently most services are managed at an IHC level. d. A clear governance framework is needed for each primary care service that will ultimately feed into the Primary Care Board. This will allow risk and other areas of assurance to be discussed and monitored. e. Developing stronger working relationships with internal and external stakeholders in order to optimise the management of services and patient flow in the wider system

Actions	Due Date	Progression Analysis
Primary Care strategic plan	31/03/2025	Progressing

A plan needs to be created that looks at all areas of primary care, and describes what the long term strategy is and how it will be delivered.		
Implementation of recommendations from the National Strategic Programme for Primary Care. Workshop planned to review the recommendations and programme of work for 24/25 in April	31/03/2025	Progressing (revised date from 30/06/2024)
Primary Care Academy to utilise SPPC monies to further progress multi-professional working Work ongoing to develop local health board response to the national strategy and year 1 priorities as set out by HEIW/SPPC.	31/03/2025	Progressing (revised date from 31/12/2024)
A review of cluster monies spend to allow introduction of new roles, ways of working and models of service delivery	31/03/2025	Progressing (revised date from 31/12/2024)
Deep dive / diagnostic into general dental and community dental services Report is with Executives for consideration	31/03/2025	Progressing

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20 20 20 20 20 20
12 12 12 12 12 12
08/01/2024. 29/02/2024 27/08/2024 23/10/2024. 06/01/2025. 03/03/2025
Inherent Current Target

N.B. Inherent and Current score lines stacked as both are 20.

	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	5	20
Target Risk Score	4	3	12
Risk Appetite	Quality		<16

Position & Intended Outcome for Risk

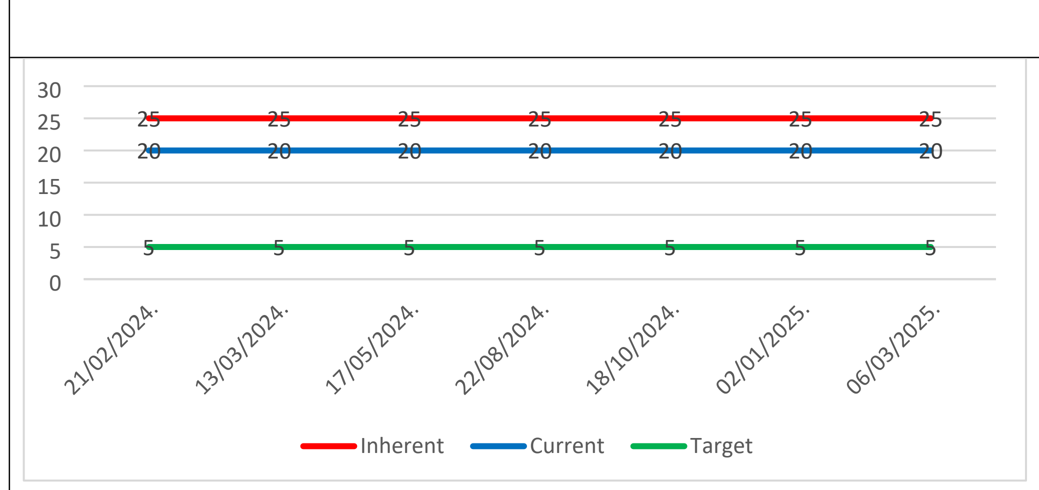
This risk sits across all primary care services within BCU. The risk of having an ineffective or failing primary care function would increase the likelihood of declining population health, poor service performance, regulatory non-compliance, poor staff morale and an increase in activity in other parts of the system such as emergency departments.

<table>
<tr><td rowspan="2">CRR 24-13</td><td colspan="2">Risk Title: Timely Diagnostics</td><td>Date Opened: 21/02/2024</td></tr>
<tr><td colspan="2">Assuring Committee: Quality, Safety and Experience Committee</td><td>Date Last Committee Review: 20/02/2025</td></tr>
<tr><td>Date Last Reviewed: 06/03/2025</td><td>Director Lead: Chief Operating Officer</td><td>Link to BAF: BAF24-07</td><td>Target Risk Date: 31/12/2025</td></tr>
<tr><td colspan="4">There is a risk of delay in diagnostics, service failure, poor performance or disruption to radiology, pathology and other diagnostic services across BCU. This could be caused by shortages of specialist staff, aging or inadequate IT systems and infrastructure, and insufficient governance structures. The impacts may include delays in diagnosis, treatment and discharge, increased outsourcing costs, patient harm events, preventable deaths, regulatory non-compliance, and significant reputational damage. There is also additional risk related to clinicians failing to act on results of diagnostic tests leading to patient harm and increased litigation</td></tr>
</table>

Mitigations/Controls in place	Additional Controls required
1. Insourcing of CT, MRI and ultrasound to deliver required capacity 2. Significant guidance and steer with National Imaging Programme workforce work. 3. Outsourcing of radiology reporting to maintain Welsh government turnaround times 4. Waiting list & capacity and demand management is in place to monitor radiology required resources. 5. New all Wales contract with Everlight from 1st November 2024 to maintain provision of radiology reporting 6. Active participation by pathology in the nation pathology programme 7. Diagnostic services have well embedded QMS (Quality Management System) systems for accreditation and regulation. Supporting the BCU QMS development with knowledge and learning 8. Endoscopy insourcing 9. OBC for PETCT/Nuclear Medicine consolidation approved by board and submitted to WG	a. Replacement of Radiology Informatics System (RISP) – implementation underway go live delayed till July 2025 b. Replacement of LINC (national pathology IT system) - Contract signed with current supplier plans to implement by September 2025 being progressed nationally c. Radiology workforce model not suitable for meeting the current demands being placed on the service from both clinical activity and supporting activity required to deliver service e.g. governance, regulatory and accreditation requirements d. Escalate to BCU Clinical Effectiveness Group – issues around failure to act. Procedure MD (Office of the Medical Director) 23 – 'Mitigation of the risk of failure to act on diagnostic results' needs updating which is being led by the Executive medical director. Discussions held with OMD and a plan is being put in place for a task and finish group to update procedure MD23 - Revision drafted and almost ready for wider consultation e. PHW Collaborative Executive group. f. Diagnostic Strategy for BCU needs to be developed g. Work commenced on new radiology staffing model for the identification of significant restructuring of the service with succession planning, career development, staff wellbeing etc.

	h. Complete demand and capacity reviews across diagnostic services to identify improvement plans i. Progression the development of the medical illustration service to support the teledermoscopy service j. Complete estates reviews for all diagnostic services, with prioritisation and progression of identified improvement projects k. Progression of Regional Diagnostics Hub project within the Planned Care Programme l. Progression of diagnostic business cases e.g. Endoscopy, Nuclear Medicine / PET-CT and Digital Cellular Pathology business cases m. Identify capacity for work focused on transformational change including opportunities for AI

Actions	Due Date	Progression Analysis
Replacement of Radiology Informatics System (RISP) – implementation with anticipated go live date of the 19/05/2025. Delayed till July 2025	01/07/2025	Progressing (revised date from 14/04/2025)
Replacement of LINC (national pathology IT system) - Contract signed with current supplier plans to implement by September 2025 being progressed nationally	30/09/2025	Progressing
Procedure MD23 (Mitigation of the risk of failure to act on diagnostic results) to be updated	31/12/2025	Progressing
Radiology workforce revised model to be developed by June 2025	30/06/2025	Progressing
Diagnostic Strategy to be developed by diagnostic group	30/06/2025	Progressing (Revised date from 30/09/2024)
Escalate failure to act risks to CEG	31/03/2025	Progressing



	Impact	Likelihood	Score
Inherent Risk Rating	5	5	25
Current Risk Rating	5	4	20
Target Risk Score	5	1	5
Risk Appetite	Quality		<16

Rationale for Corporate Risk

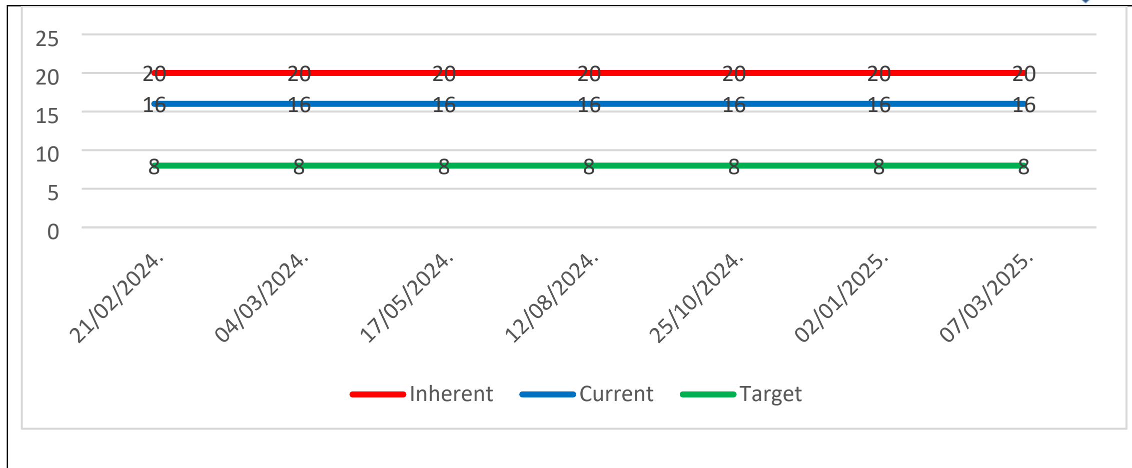
Increasing demand for both radiology and pathology and other diagnostic services. Outdated IT infrastructure in both Radiology and Pathology that carry significant clinical and operational risks. – National programmes in place to resolve these issues. Additional work required to mitigate the risks from failure to act and update procedure MD23. Waiting lists longer than the national targets which results in delay in diagnosis which results in harm to patients. In addition, staffing stress related to demand in the service leading to burn out. 31st January 6,801 diagnostic waits over 8 weeks with Endoscopy (2,163) and Cardiology (1,552) being the largest. Endoscopy capacity at most risk as the insourcing into Wrexham stopped as of 1st April 2024. Demand in radiology continues to increase.
MDT demand in terms of numbers of patients on an MDT is at unsafe levels.
Workforce and organisation development have escalated risks within DSCSS about the health and wellbeing of the radiology senior team due to the number of competing priorities and the unsustainable amount of TOIL being accrued and unable to be taken by radiology SMT to manage the higher number of major projects and the operational delivery

<table>
<tr><td rowspan="2">CRR 24-14</td><td colspan="2">Risk Title: Harm from the Medical Devices/Equipment</td><td>Date Opened: 21/02/2024</td></tr>
<tr><td colspan="2">Assuring Committee: Quality, Safety and Experience Committee</td><td>Date Last Committee Review: 20/02/2025</td></tr>
<tr><td>Date Last Reviewed: 07/03/2025</td><td>Director Lead: Executive Director of Allied Health Professions & Health Science</td><td>Link to BAF: BAF 24-07</td><td>Target Risk Date: 31/03/2026</td></tr>
<tr><td colspan="4">There is a risk of harm and infection from aging, unsuitable or unreliable medical equipment and devices. This could be caused by equipment breakdowns, lack of replacement funding, ineffective cleaning and decontamination, insufficient staff training, improper use and poor traceability. The impacts may include inability to deliver essential services, delays in diagnostic and treatment leading to incidents and poor patient outcomes, increased costs and reputational damage.</td></tr>
<tr><th colspan="2">Mitigations/Controls in place</th><th colspan="2">Additional Controls required</th></tr>
<tr><td colspan="2">1. Medical Devices Governance and Assurance Group leads on selection and procurement, processes and procedures of significance, learning from incidents, safety communications and risk management of medical devices.
2. Annual capital planning process reflects known priorities taking account of key pieces of equipment due for replacement with a risk assessment that support the overall outcome.
3. Scrutiny and assessment of the capital programme at Capital Programme Management Team (CPMT) and Capital Investment Group (CIG).
4. Welsh Government Capital review meeting to escalate and discuss potential risks and requirements for key medical equipment e.g. Linac.
5. An effective medical devices management system is utilised through Electric Biomedical Engineer Department (EBMD)
6. EBMD uses the management system to monitor the condition and performance of medical devices including device failures and issues; utilisation, performance, maintenance; repair and calibration history.
7. Audits on affected equipment in line with regulatory compliance completed.</td><td colspan="2">a. Internal risk assessment and priorities are flagged in the context of fully depreciated equipment (£34.659m) to understand priorities and potential risks.
b. Lack of medical device training and good governance of safety of equipment has been lacking and documented as a risk since 2016.
c. Robust risk assessments of how often certain equipment breaks down, the scale of difficulty sourcing spare parts to be considered for included in requests for capital replacement to be taken forward as part of the 26/27 submission for capital bids.
d. The number of capital bids not approved now exceeding circa £30million in capital and resources required. Backlog of equipment beyond end of life, some 10 years+. SBAR submitted to Executive Director AHPS and Health Science for escalation to Executive team.
e. Medical Device regulations work ongoing – see additional risk ID 5282 ‘Medical Devices Regulations 2002(SI 2002 No 618, as amended) (UK MDR 2002) compliance’. External review completed. Workplan now needs to be developed following review of current preparedness</td></tr>
</table>

8. Radiology fully engaged with the National Imaging Capital Equipment Group peer review programme. 9. External links with National Imaging and Pathology Diagnostic Programmes are documented and appropriately reported through correct channels to ensure transparency and potential benchmarking. 10. Working group assessing compliance with the Medical Devices Regulations and confirm governance arrangements for medical devices	

Actions	**Due Date**	**Progression Analysis**
CPMT and CIG to review annual planning process to ensure risk scoring to inform prioritisation	31/03/2025	Progressing (Revised from 31/03/2024)
Medical physics have been tasked with testing all ultrasound equipment to ensure its safety and will consider compliance. Medical Physics are working through the ultrasound Quality Assurance and testing. Full testing programme in place across BCU and assurance being provided to the BCU ultrasound Governance group	31/03/2025	Completed
Directorate teams to review their medical devices capital replacement plans to ensure all services have a medical device replacement programme in place. Directorate teams are linking with Capital to update their replacement plans.	31/03/2025	Progressing (Revised from 31/09/2024)
Recruitment to Head of Clinical Engineering and associated posts within the medical devices team Head of Clinical Engineering appointed start date being agreed post holder will review of regulations and compliance, chair of local medical devices group and risk management	06/03/2025	Completed
Long term management plans with equipment, regulation and compliance and discussions around improving governance	30/06/2025	Progressing

	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20



Current Risk Rating	4	4	16
Target Risk Score	4	2	8
Risk Appetite	Open		<16

Position & Intended Outcome for Risk

Significant capital funding required, robust controls and governance required to ensure safety of equipment, £33M represents the value of capital medical equipment which is fully depreciated and at end of life. Intended outcome to ensure compliance and any gaps in medical device regulation supported by robust process for medical equipment capital replacement.

<table>
<tr><td rowspan="2">CRR 24-19</td><td colspan="2">Risk Title: Community Care Provision</td><td>Date Opened: 01/05/2024</td></tr>
<tr><td colspan="2">Assuring Committee: Quality, Safety and Experience Committee</td><td>Date Last Committee Review: 20/02/2025</td></tr>
<tr><td>Date Last Reviewed: 21/02/2025</td><td>Director Lead: Executive Director Transformation and Strategic Planning</td><td>Link to BAF: BAF24-07</td><td>Target Risk Date: 31/03/2026</td></tr>
<tr><td colspan="4">There is a risk that the Health Board may not be able to provide safe, effective and timely care to patients in the community, and the Health Board not fully meeting its obligation to commission and provide accessible and high-quality community care, Discharge To Recover and Assess, Care Home support services and continuing health care (CHC) services. This may be caused by insufficient provision of care in the community, the fragility of independent providers (domiciliary care and care homes), delays of joint assessments, staffing shortages and gaps in service provision out of hours. This may also be caused by a lack of investment in services and skill mix development, restrictions in IT systems and communication between different parts of the integrated team. This may lead to unnecessary admissions, delayed transfers of care, increased length of stay in hospital and poorer outcomes for patients, people not receiving end of life care in their place of choice.</td></tr>
</table>

<table>
<tr><th>Mitigations/Controls in place</th><th>Additional Controls required</th></tr>
<tr><td>6. Daily patient flow meetings including focus on long-stay patients and partnership with Local Authorities
7. Primary Care Board has been established with the first meeting held May 2024, monthly meetings planned moving forwards. Community Care is reporting into the Primary Care Board around this risk.
8. Community Resources Team model bringing together agencies and professionals supporting locality populations.
9. North Wales care homes single action plan overseen by Regional Commissioning Board and Regional Partnership Board.
10. Care home Quality Assurance Framework and tools in place
11. Established Continuing Healthcare (CHC funding) teams and processes including escalation where delays occur
12. Agreed joint escalation processes with Local Authorities for care homes of concern
13. Greater Health Board oversight of Community Care issues and risks via PPHP Committee with first report to committee during April 2024 with further reporting in June 2024.</td><td>a. Escalation and sustainability report requires commissioning to address risks associated with workforce and workload pressures allows for early identification and management.
b. Programme management to be implemented to monitor and drive strategic priorities.
c. Community Care Quality and Delivery Group to be established or investigate feasibility of implementing Community Care reporting to Primary Care Quality and Delivery Group
d. Strategy, focus and resources including staff, training and IT to deliver joined up planning, innovation and delivery for place based, integrated prevention, health and care services across NHS/Local Authorities to deliver on place based care and care closer to home.
e. Additional Resourcing of CIVICA system (scheduling system for District Nurses), access to EMIS (GP Patient record system)</td></tr>
</table>

	community for teams. Connecting Care Implementation for community services. f. Financial systems that support transformative systems in line with Primary Care Model for Wales outcome 13. g. Improved joint planning with local Mental Health services. h. Improved planning for access to diagnostics in the community setting i. Community Care and CHC services audits of sustainability matrix ongoing periodically – Programmes to be put in place to undertake the audits j. Equity of resource to support community care and CHC transformation, innovation, management and governance. k. Improved discharge planning and support in line with All Wales good practice guidance, this is being taken forward by UEC workstream 4 l. Implementation of Pathways of Care Regional Action Plan m. Develop surge plans jointly with Local Authorities for winter pressures – did not happen to be progressed again. n. Complete pre-placement agreements with all providers and implement strengthened contract monitoring

Actions		**Due Date**	**Progression Analysis**
1	Community Care and CHC strategic plan to be drafted to inform the Health Board strategic plans.	31/03/2025	Progressing
2.	Programme management to be implemented to monitor and drive strategic priorities. Raised through 25/26 Ministerial Template process that programme management approach is required but not in place, a request has been made through the planning process for identified Executive Leadership and Programme Management Resource.	31/10/2025	Progressing
3	Community Care and Continuing Healthcare services audits of sustainability matrix ongoing periodically – Audit programme already in place, this is now available to view on IRIS dashboard	31/03/2025	Complete

4.	Equity of resource to support community care and Continuing Healthcare transformation, innovation, management and governance. Value and Sustainability CHC Group established and will finalise priorities for 25/26	31/03/2025	Progressing
5	Establish a health board group to agree a strategy, vision and aligned resources to deliver joined up planning, innovation and delivery for place based, integrated prevention, health and care services across NHS/Local Authorities to deliver on place based care and care closer to home.	30/06/2025	Progressing
6	Joint commissioning plan with Local Authorities to increase domiciliary care capacity Following evaluation panels there is now a list of domiciliary care workers that are able to provide the more complex care. All will go on the new framework that is due to go live April 2025. 97 providers have now been successful and contracts will be issued on 11/3/25	25/04/2025	Progressing
7	Review of community services model and development of business case to address gaps in capacity (linked to action 8.) Linked to action 2.	31/03/2026	Progressing
8	Determine required level of Quality Assurance Framework increased frequency of visits, resource requirement and plans to implement. Final version of SOP for Clinical Quality Support Tools under the QAF is awaiting approval at the next Patient Safety Group on January 28th.	28/02/2025	Complete

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01/05/2024. 30/08/2024 15/01/2025. 21/02/2025.
Inherent Current Target

	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	5	20
Target Risk Score	4	3	12
Risk Appetite	Quality		<16

Position & Intended Outcome for Risk

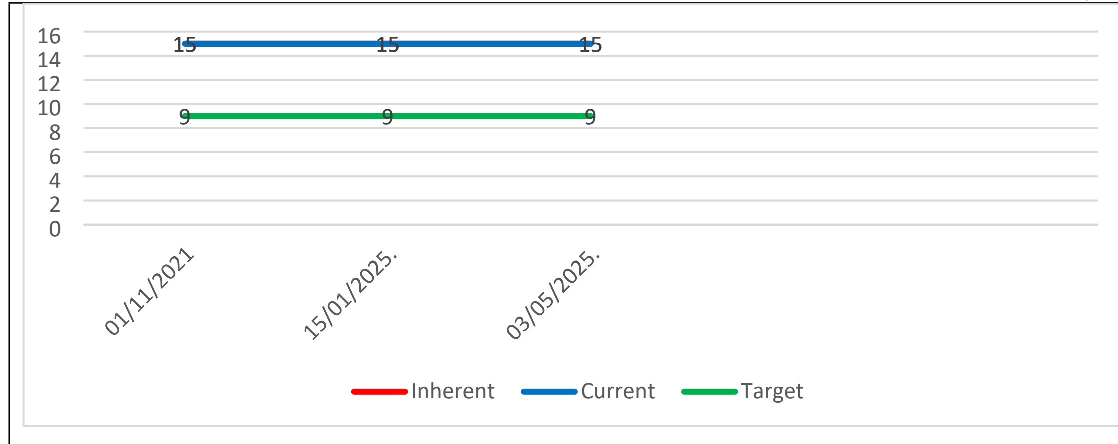
	The data on reduced care home placement, number of care homes in escalation due to quality concerns, significant numbers of patients delayed in hospital awaiting domiciliary care and reablement packages, and a current inability to meet Welsh Government unscheduled care targets - all of which indicate risk of harm due to insufficient safe provision in the community. – Wider impacts resulting in the impacted access to and delivery of Community Care and CHC services is severely impacted and is affecting patient flow through secondary care, Primary care and Emergency/Urgent Service delivery, LA Care provision delivery and exacerbating patients' health conditions. Recognition of inherent score currently further controls needed. Lack of adequate investment and provision in domiciliary care. The Ministerial Priorities referred to - Building Community Capacity.

<table>
<tr><td rowspan="2">CRR 24-20</td><td colspan="2">Risk Title: Oncology Services</td><td>Date Opened: November 2024</td></tr>
<tr><td colspan="2">Assuring Committee: Quality, Safety and Experience Committee</td><td>Date Last Committee Review: 20/02/2025</td></tr>
<tr><td>Date Last Reviewed: 20/02/2025</td><td>Director Lead: Executive Medical Director</td><td>Link to BAF: BAF24-07</td><td>Target Risk Date: 31/03/2026</td></tr>
<tr><td colspan="4">There is a risk that patients may not experience a safe, effective and timely Oncology service provided by the Health Board. This may be caused by reduced substantive medical workforce, demands for oncological care, increasing numbers of NICE approved treatments for cancer, and patients remaining within the service due to ongoing/long term oncological treatment. This could lead to poor patient outcomes, failure to meet Single Cancer Pathway target of 62 days and detrimental impact on the organisations reputation to the public, government and others.</td></tr>
<tr><th colspan="2">Mitigations/Controls in place</th><th colspan="2">Additional Controls required</th></tr>
<tr><td colspan="2">1. Medical locums in place to support gaps in substantive provision
2. Escalated requirement to support recruitment of medical oncology trainees within next 12 months
3. Supporting 2 NHS Locums to complete Certificate of Eligibility of Specialist Registration (CESR) and additional competencies to be eligible to become substantive in the future.
4. Development plan in place for 2 Senior Clinical Fellows with aim to train them to become substantive Consultants within 2-3 years.
5. Systemic anti-cancer treatment (SACT) Operational group established to improve processes and systems – collaboration with pharmacy.
6. Radiotherapy Oversight meeting established to monitor progress against plan and maintenance of target.
7. Developed extended non-medical nursing roles to support medical gaps including immunotherapy toxicity, cancer of unknown primary and metastatic breast and colorectal services.
8. Developed an extended non-medical radiotherapy role to support prostate cancer patients who require radiotherapy
9. Clinical Leads (Joint role) appointed.</td><td colspan="2">a. Remaining substantive medical vacancies unfilled despite active recruitment – in line with national picture of vacancies and report by Royal College of Radiologists for Clinical Oncologists, medical locums use 34% - 50%.
b. Lack of available high-quality data to provide robust capacity and demand modelling per tumour site, per clinical/medical oncologist
c. Recurrent funding needs to be secured for 7 consultants and a number of temporary nursing and administrative roles (and other elements subject to RIGA)
d. Inability to respond effectively to increasing demand for oncological treatments and new NICE-approved regimes
e. Home care service is saturated meaning no further treatments can be transferred out of the day units to release capacity (this would also release funding as VAT is exempt).
f. Lack of physical estate to expand services and/or recruit more staff.
g. Outsourcing opportunities for the highest risk tumour sites, remains a gap, further exploration required.</td></tr>
</table>

	h. Gap and lack of clinical oncology trainees with multiple gaps limiting ability to 'grow our own'. i. Collaboration with recruitment agencies to explore overseas consultant opportunities. j. There is an aim to implement nursing staff rotational opportunities to improve cover arrangements and skill mix but this is limited due to vacancies and amount of fixed term funded posts

Actions	**Due Date**	**Progression Analysis**
Establish potential of a joint Consultant Oncologist role with Bangor University A Meeting was held, and the plan is for the university to provide 4 sessions to support a full-time position. Professor-level post agreed with medical school, job description awaiting approval from Royal College – position confirmed	30/04/2025	Progressing (revised date from 30/01/2025)
Complete Planning to repatriate the delivery of Stereotactic Ablative Radiotherapy into the Health Board A letter is being submitted to the Joint Commissioning Committee requesting approval to proceed according to the established process commence as per process. Meeting arranged awaiting approval.	30/04/2025	Progressing
Establish potential of undertaking shared recruitment with other cancer centres Discussions need to be initiated to address operational concerns, particularly the high risks associated with specific tumour sites Initial conversations have happened with Clatterbridge but needs further executive to executive conversations – date to complete needs to be extended	30/08/2025	Progressing revised date from 30/04/2025)
Work with informatics to support development of quality data Regular meetings are being held, and training plans are being developed to support correct use of the Welsh Patient Administration System. National queries have been raised regarding the duplication of work with SACT on Chemocare and WPAS, however, it is necessary to establish a secure link between the systems to improve quality and efficiency. Process mapping has been undertaken identifying areas to be resolved. Specific Oncology training for managing the waiting list has been undertaken; data quality issues regarding BANO has been resolved as backlog has been agreed to be removed by the 'robot'; plan to improve more data issues has been established for 25/26	31/03/2026	Progressing (revised date from 31/03/2025)

	Impact	Likelihood	Score
Inherent Risk Rating	3	5	15
Current Risk Rating	3	5	15



Target Risk Score	3	3	9
Risk Appetite	Quality		<16

Position & Intended Outcome for Risk

The combination of multiple factors, *including;*

- the inability to recruit substantially to Senior Medical posts,
- increasing reliability on availability of Locums
- large number of temporary staff, as a result of RIGA
  and increasing demand for oncological treatments, which has resulted in service gaps which have increased waiting times for patients to be seen and treated.

Delays to commencing treatment will result in significant patient harm and potentially premature death**.** NICE approved regimes indicate optimum time frames and that delay will decrease effectiveness of treatment. In general research has shown that every 4 week delay to commence (any cancer) treatment increases the likelihood of death by 10%. Escalation paper to Executive Lead and Chief Operating Officer indicated waiting times in east and centre were now 6 weeks (Dec 24)

Waiting times to see a Consultant following referral range from 0 to 12 weeks depending on tumour site and clinical priority. The aim is to see patients within 2 weeks, so that treatment can commence quickly. This is not reported externally.

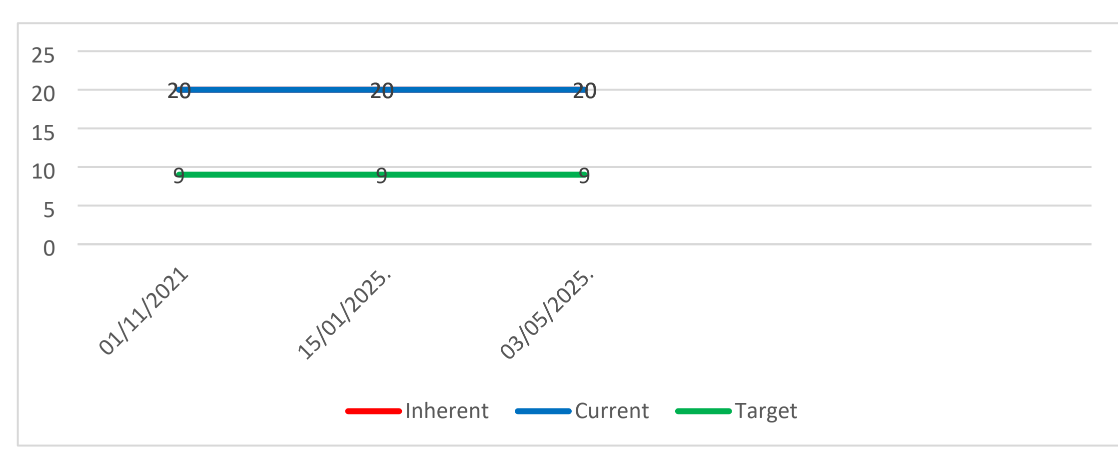
Extreme risk within gynae, breast and upper GI remain as a result of unavailability of suitable locums and lack of capacity within current staffing. The highest risk is with the availability of a consultant to cover the medical oncology element of care to patients with a gynae cancer in East.

<table>
<tr><td rowspan="2">CRR 24-21</td><td colspan="2">Risk Title: Ophthalmology Services</td><td>Date Opened: November 2024</td></tr>
<tr><td colspan="2">Assuring Committee: Quality, Safety and Experience Committee</td><td>Date Last Committee Review: 20/02/2025</td></tr>
<tr><td>Date Last Reviewed: 05/03/2025</td><td>Director Lead: Chief Operating Officer</td><td>Link to BAF: BAF24-07</td><td>Target Risk Date: 31/12/25</td></tr>
<tr><td colspan="4">There is a risk that patients may come to harm casued by the lack of a sustainable service model, unmanaged demands and the current capacity not being able to meet incoming demands. This could lead to, and result in, increased waiting lists and an increased risk of harm including irreversible sight loss, and litigattion due to prolonged wait times.</td></tr>
</table>

Mitigations/Controls in place	Additional Controls required
1. Train and Treat initiative in place to increase the number of procedures that can be done in a community/high street optometry setting. Train and Treat embedded and successfully expanded to two site delivery (Deeside Glaucoma and Holywell Hospital Independent Prescribing: meeting delivery targets. 2. Outsourcing solution for cataract procedures in place. 3. Development of High flow lists for cataracts in place with West	a. Appoint Health Board clinical lead to secure professional oversight and leadership b. Development of a sustainable service model c. Ensure specialty demand, capacity and planning is delivered along with further mitigations to be developed to close any gaps in delivery. d. Release planned care funding to cover funding cut in RIGA2 process, this will enable significant positive mitigation for loss of high risk follow ups

Actions	Due Date	Progression Analysis
b. Convene a Health Board wide Ophthalmology summit to identify subspecialty leads to support service redesign, agree priorities and initiate work plan Sustainability plan informing Speciality Plan development. Funding clarification being explored with Clinical Lead Operations. New date to be determined with COO.	28/02/2025 to be revised	Overdue
c.Development of High flow lists for cataracts in place progression in Central and East. Pathway currently being reviewed against All Wales pathway to inform short medium and long term improvement plan, initial draft to be delivered March 25.	31/03/2025	Progressing
a.To Appoint a Health Board Clinical Lead Office of Medical Director is progressing recruitment. (progression/funding clarification being explored with Clinical Lead Operations)	30/06/2025	Progressing (revised date from 31/12/204)

b. Develop a work programme for service design and development (output of summit). New date to be determined with COO.	28/02/2025	Overdue
d.Resource activity as previously identified and reinstate eye care performance fund that has been reduced through RIGAII financial prioritisation funding clarification being explored with Clinical Lead Operations	01/04/2025	Progressing



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	5	20
Target Risk Score	3	3	9
Risk Appetite	Quality		<16

Position & Intended Outcome for Risk

Significant harm may occur including irreversible sight loss in high risk R1 & R2 patients (Glaucoma and Retinopathy). Large volume of patients on Patient Treatment List currently stands at 23,544 un-booked of which 963 are 2 years+

<table>
<tr><td rowspan="2">CRR 24-22</td><td colspan="2">Risk Title: Orthodontics Services</td><td>Date Opened: November 2024</td></tr>
<tr><td colspan="2">Assuring Committee: Quality, Safety and Experience Committee</td><td>Date Last Committee Review: 20/02/2025</td></tr>
<tr><td>Date Last Reviewed: 12/03/2025</td><td>Executive Lead: Chief Operating Officer</td><td>Link to BAF:</td><td>Target Risk Date: 31/03/2026</td></tr>
<tr><td colspan="4">There is a risk that patients under the Orthodontics Service may come to harm, this could be caused by the lack of consultant capacity to provide an effective and timely Orthodontics service care provided by the Health Board, backlog demand outweighs capacity available in both primary and secondary care, driving less favourable patient outcomes (psycho-social vulnerability amongst younger patient groups). Less conservative/preservative treatment options – meeting urgent need. Increased chance of requiring intervention general anaesthetics, intravenous antibiotics. This may lead to reputational damage and increased litigation.</td></tr>
</table>

Mitigations/Controls in place	Additional Controls required
1. Appropriate referrals pathway/ triage implementation (as per national pathway) 2. Dentist with Specialist Interest (DESI) and Tier 2 – wider, easily accessible pathways 3. PAN BCUHB approach dating patients according to length of wait into additional Waiting List Initiative (WLI) activity 4. Health prevention/promotion within primary care 5. Reviewing Academy Model to increase attractiveness of North Wales as a place to work to include upskilling/additional training for suitable Health Care Practitioners 6. Supporting hosting of undergrad training in North West Wales, online Continued Professional Development and microcredentials course for local people (including consideration for maternity leave, single parent etc.)	a. Continued shortfall of workforce across BCUHB needs recruitment strategy b. Continued conversations with external providers indicates limited outsourcing opportunity c. No restorative consultant service available d. No proactive comms to patients and stakeholders agreed e. Current service provision indicates ongoing service delivery shortfalls with recovery in excess of 5 years

Actions	Due Date	Progression Analysis
Agreement of BCUHB to advertise Consultant Orthodontists at top of scale following submission of SBAR in September 2023	31/07/2024	Complete

Successful appointment of 0.7 WTE Consultant Orthodontist	31/08/2024	Complete
Attempted but unsuccessful recruitment of Agency & NHS Locums Unable to complete	31/12/2025	Progressing
Review of workload of consultants across BCUHB to improve equity of access within BCUHB	28/02/2024	Complete
Temporary allocation of 2 additional sessions from Ysbyty Glan Clwyd to support patients in active treatment in Ysbyty Gwynedd up until Maternity commenced February 2024	28/02/2024	Complete
SBAR & options appraisal submitted for consideration of a primary/secondary care dental review in 2021, 2023, 2024	31/12/2024	Complete
Restorative Consultant re-advertisement	31/12/2025	Progressing
Submission of executive paper requestion stakeholder comms in relation to Orthodontic service provision in March 2024	31/03/2024	Complete
Orthodontic & Oral Surgery 'Getting it Right first time' (GIRFT) review	31/12/2024	Complete
National Benchmarking of service model and approach to service recovery for RTT stage 1 patients	31/12/2024	Complete
SBAR submission recommendation 2024: Continued procurement exercise to determine full treatment plan capacity with external providers-funding noted as available	31/12/2025	Progressing
GiRFT Recommendations following completion of the review. Report to be formally signed off by Health Board and to then implement the recommendations for service improvement.	TBC	Progressing

	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	2	2	4
Risk Appetite	Quality		15-19

Rationale for Corporate Risk

Waiting lists and waiting times have continued to grow with patients waiting in excess of 156 weeks for initial clinical assessment. Impact of vacant sessions across Health Board on capacity provision with limited opportunity to resolve the backlog position with a current BCUHB active workforce establishment at 2.2 WTE.

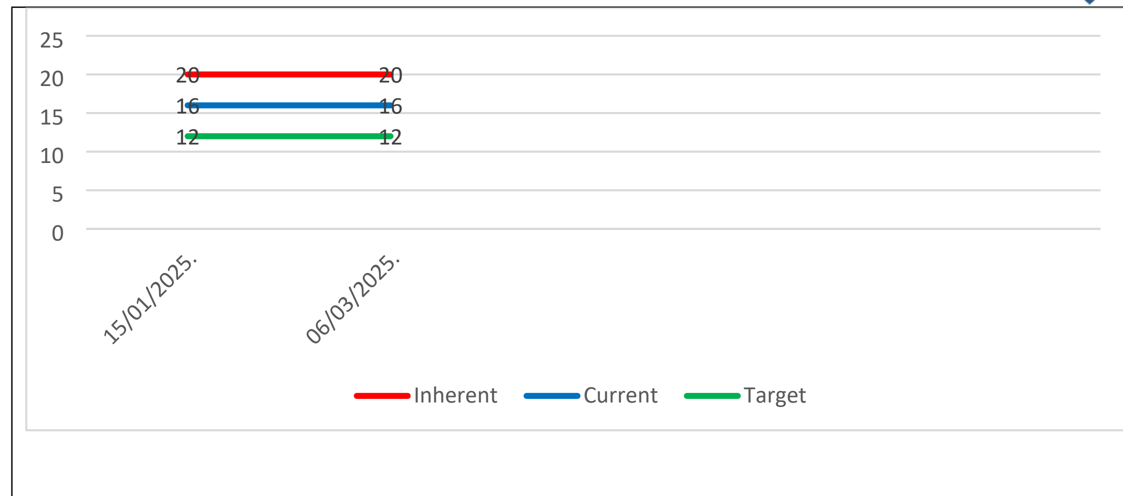
	Poor provision in some geographical areas. Lack of stability from Welsh Government around future Dental contracts. Patients awaiting treatment completion are dating back to referrals first received in 2017 highlighting significant delays in treatment pathways. Patients awaiting Patients referred for Max Fax treatment (waiting up to 156 weeks) are being returned to Orthodontics due to timescale lapsed since orthodontic referral. No current service provision for Restorative Dentistry for new or existing patients across BCUHB. Delays in Orthodontic provision impact surgical cleft optimisation delivered via Alder Hey Cleft outreach service. Clinical risk being held within the waiting lists. National shortage in Orthodontic consultants Infrastructure & estate restrictions on expanding Medical workforce. Current model of care is disjointed and lacking fluidity between primary & secondary care. Delay in sustainable service planning across BCUHB. Patients and parents reports the mental and physical challenges associated with unaddressed orthodontic issues as a result of delays into teenage years. Parents have reported orthodontic related bullying which has resulted in their child's withdrawal from education and social aspects of their childhood; also the inability to meet ministerial targets as required by Welsh Government.

<table>
<tr><td rowspan="2">CRR 24-23</td><td colspan="2">Risk Title: Vascular Services</td><td>Date Opened: November 2024</td></tr>
<tr><td colspan="2">Assuring Committee: Quality, Safety and Experience Committee</td><td>Date Last Committee Review: 20/02/2025</td></tr>
<tr><td>Date Last Reviewed: 06/03/2025</td><td>Director Lead: Chief Operating Officer</td><td>Link to BAF: BAF24-07</td><td>Target Risk Date: 31/03/2026</td></tr>
<tr><td colspan="4">There is a risk that individuals may expeirence preventable harm and a poor experience whilst receiving care from the North Wales Vascular Service.This may be caused by current and projected future staffing challenges,a lack of capacity across the network a lack of clarity with regards secondary care and/ or end-to-end, vascular pathways. This could lead to increased morbidity and mortality, poor quality of care, reduced quality of life, psychologcial distress, difficulties recruiting and retaining staff, staff health and well-being, reputational damange, increased costs, increased legal and financial claims.</td></tr>
</table>

Mitigations/Controls in place	Additional Controls required
1. Management of bed base through assessment of clinical risk in place. 2. Optimising and streamlining management of inpatients and ensuring clear communication across site to ensure timely transfer and repatriation 3. Additional funding to support delivery of robust vascular services across hub and spoke sites, approved. This will allow capacity to be increased in key areas (i.e., Cardio Pulmonary Exercise Testing and Ward 3 staffing) and a number of agency/ locum appointments to be made permanent 4. Weekly case-note audits in place to monitor standards of record keeping, with results discussed at clinical governance meetings 5. Pathways are co-designed with an extensive group of delivery partners across the 3 sites 6. Local Vascular Delivery Groups in place for 2/3 IHCs (West and Central) in order to proactively identify performance concerns and manage risk 7. Development of Abdominal Aortic Aneurism (AAA) Quality Improvement programme. 8. Consultant vascular surgeon is picking up IR sessions 9. Weekly Multi-Disciplinary Team meeting to allocate patients onto the waiting list and ensuring consultants are aware of patients that need	a. Development of Vascular Intranet pages to help share information, including clinical pathways, with staff, in a way that is simple and accessible b. Local vascular delivery groups to be operational across each IHC. c. Review of AAA surveillance protocol / pathway, to include management of persons turned down for AAA repair d. Implementation of deep-dive audit tool to enable quality audit of case notes e. Workforce and resource review to support development of Phase 2 Business Case f. Development of vascular workforce strategy aimed at improving recruitment. g. Improve the way that information relation to service quality via patient, carer and staff satisfaction and well-being questionnaires is used to inform continuous improvement h. Development of Quality dashboard, to support improved use of service and outcome data

Interventional Radiology provision and/or can have an open Abdominal Aortic Aneurism (AAA)repair? 10. Enhanced clinical and programme governance to ensure learning from events and focus on quality	

Actions	Due Date	Progression Analysis
Finalise vascular intranet page as key place for network and wider Health Board staff to access the full range of information, policies, procedures and pathways relating the vascular network	31/03/2025	Progressing
Work with East IHC Medical Director to establish Local Vascular Delivery Group	31/03/2025	Progressing
Review AAA surveillance protocol / pathway to ensure timely monitoring of persons with an AAA not identified by Welsh Abdominal Aortic Aneurism screening programme.	31/03/2025	Progressing
Strengthen information, advice and support provided to people turned down for AAA repair, and ensure 'register' of persons turn down is maintained	30/05/2025	Progressing
Implement quarterly quality audit tool to enable network to proactively identified areas for improvement	31/03/2025	Progressing
Work with key delivery partners to develop a (Phase 2) vascular and diabetic foot business case	31/03/2026	Progressing
Develop and implement vascular training and workforce strategy to improve recruitment and retention across the network	31/03/2026	Progressing
Revised patient, carer and staff satisfaction and well-being questionnaires to be regularly disseminated, and findings analysed in order to inform continuous improvement	31/03/2026	Progressing
Build pan-BCU and local quality dashboard to support improved use of service and outcome data	30/03/2026	Progressing
Impact	Likelihood	Score



Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	3	12
Risk Appetite	Quality		<16

Rationale for Corporate Risk

Demand for vascular care in North Wales is increasing, however, recruitment to vascular services is not increasing as at the same rate. Whilst this is a UK-wide issue, the history of vascular services in North Wales, makes recruitment and retention across the network a particular concern. Whilst the network has been successful in embedding a wide-ranging improvement programme, the impact of this unstable workforce risks undermining the quality and safety of care provided, both now, and in the future. Work ongoing to develop a workforce framework for the service to allow monitoring.

<table>
<tr><td rowspan="2">CRR 24-24</td><td colspan="2">Risk Title: Renal Services</td><td>Date Opened: November 2024</td></tr>
<tr><td colspan="2">Assuring Committee: Quality, Safety and Experience Committee</td><td>Date Last Committee Review: 20/02/2025</td></tr>
<tr><td>Date Last Reviewed: 06/03/2025</td><td>Director Lead: Chief Operating Officer</td><td>Link to BAF: BAF24-07</td><td>Target Risk Date: 31/03/2026</td></tr>
<tr><td colspan="4">There is a risk that individuals may expereince preventable harm, and have a poor experience whilst waiting for dialysis. This may be caused by extended waiting times for vascular access procedures, a lack of capacity, inequity in resource allocation across the Health Board. This could lead to, increased hospital admissions, longer hospital stays, increased morbidity and mortality, poor quality of care, reduced quality of life, psychologcial distress, reputational damange, increased costs, legal costs and financial claims.</td></tr>
</table>

Mitigations/Controls in place	Additional Controls required
1. Close regular scrutiny of waiting lists at a vascular and renal network level. 2. Informal management of waiting lists on a networked basis to support prioritisation of cases, where possible 3. Additional capacity provided by Locum Consultant.	a. Formal agreement to the establishment of a single Pan-BCU list, rather than 3 separate Integrated Health Community (IHC) Clinic and Theatre lists. b. Additional capacity to support reduction of current wating list in the East, to a more manageable position. c. Recruitment to 2x vacant Consultant posts d. Re-allocation of resources across the Network, to enable equitable access to interventions locally.

Actions	Due Date	Progression Analysis
Submit Waiting List Initiative request to facilitate additional theatre lists, in order to reduce current backlog 2 requests submitted, one declined due to lack of Theatre staff availability, and awaiting confirmation on 2nd request	01/04/2025	Progressing (revised date from 30/12/2024
Undertake Workforce review across entire Service to ensure equity across the Region	30/05/2025	Progressing (revised date from 30/12/2024
Review Theatre provision, particularly in relation to overrunning lists, which result in Renal access patients being cancelled	30/05/2025	Progressing (revised date

Theatre utilisation group, first meeting 19/02/2025, has been established and will lead on this work.		from 30/12/2024
Work with new Locum consultants to ensure cover for any vacant theatre lists and clinic sessions	30/05/2025	Progressing

25
20
15
10
5
0
20 20
16 16
12 12
15/01/2025
06/03/2025.
Inherent Current Target

	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	3	12
Risk Appetite	Quality		<16

Rationale for Corporate Risk

There is currently a significant backlog of people waiting for Vascular Access Clinics and Theatre Appointments in the East IHC. This situation has arisen for a variety of reasons, but principally, because:

a. Higher **demand** in the East due to its larger population size, together with the fact that it has the largest dialysis unit.
b. An inequity in **capacity** across the three IHCs to support renal access – the East having the fewest number of clinics sessions and theatre lists.

Reducing the current backlog and waiting list is critical to preventing further in-line sepsis. A peer review of Renal Vascular Access (2022) concluded that whilst BCU outcomes from renal vascular procedures were excellent, further work was required in order to:

- Ensure a dedicate group of Vascular Surgeons to complete renal access procedures – with flexibility to move across sites
- Dedicated Clinics for Renal VANS alongside surgeons (on each site)
- Dedicated Theatre lists on each site – reflecting the demand of each site's renal population

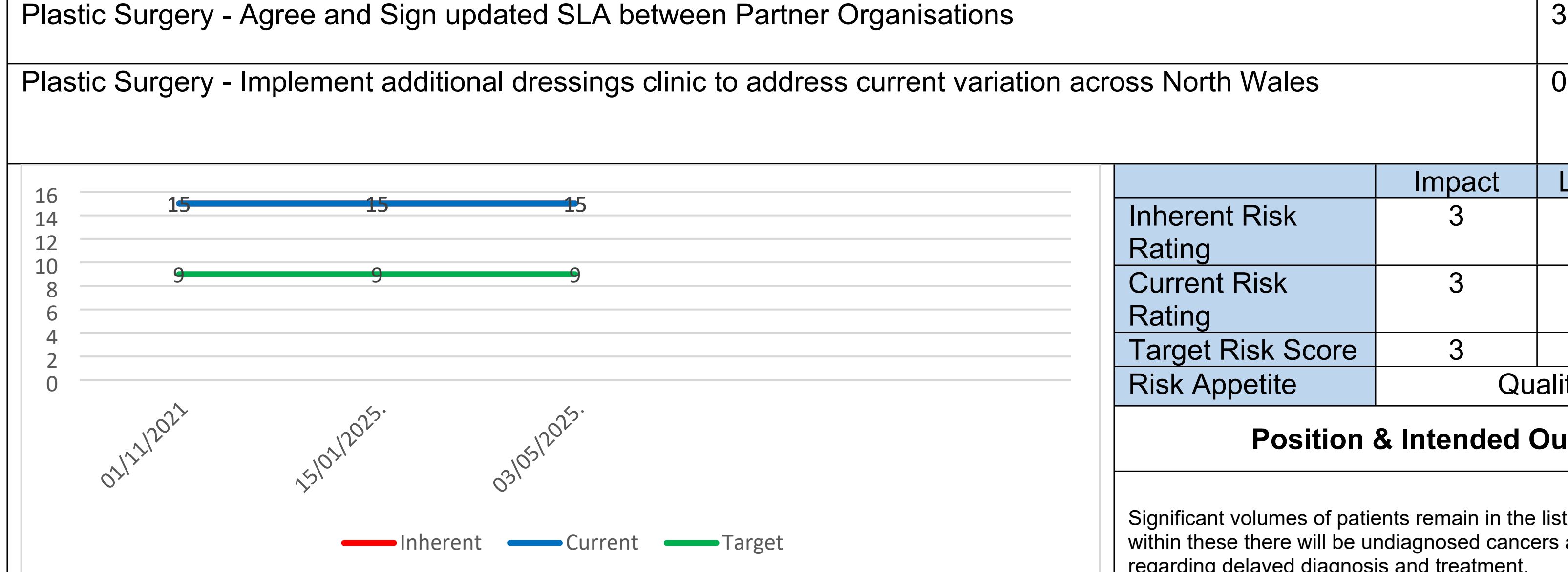
Whilst these recommendations have been implemented in Central and West IHCs, it has not been possible to secure such provision in the East.

<table>
<tr><td rowspan="2">CRR 24-25</td><td colspan="2">Risk Title: Dermatology and Plastic Surgery Services</td><td>Date Opened: November 2024</td></tr>
<tr><td colspan="2">Assuring Committee: Quality, Safety and Experience Committee</td><td>Date Last Committee Review: 20/02/2025</td></tr>
<tr><td>Date Last Reviewed: 08/01/2025</td><td>Director Lead: Executive Medical Director</td><td>Link to BAF: BAF24-07</td><td>Target Risk Date: 010/7/2025</td></tr>
<tr><td colspan="4">There is a risk that patients for the Dermatology and Plastic Surgery Services will come to harm, this may be caused by lack of a sustainable service model, unmanaged demand and current capacity not able to meet incoming demand, this may lead to increasing waiting list increasing risk of harm caused by length of wait.</td></tr>
</table>

Mitigations/Controls in place	Additional Controls required
1. Prioritisation of urgent suspected cancer to mitigate clinical risk 2. Provision of Waiting List Initiative activity to provide short term additionality 3. Development of insourced arrangements to provide interim additional capacity for a 12-18 month period 4. Appointment of clinical leads to support service redesign 5. Introduction of Teledermoscopy with a commensurate increase in treatment capacity (minor operating procedures)	a. Appoint a specialty managerial lead to take forward service redesign. b. Approve and implement increased treatment capacity.

Actions	Due Date	Progression Analysis
Dermatology - Maintain support for the Clinical Leads in Dermatology as part of a single Dermatology Service for North Wales. Monitoring BAU.	30/06/2025	Progressing
Dermatology – Fund requisite MoPS Minor Operating Procedure capacity to support expansion of Teledermoscopy	01/07/2025	Progressing
Dermatology - Establish the viability of an expanded GP with Special Interest Model for referrals to Secondary Care	30/06/2025	Progressing

Plastic Surgery - Agree and Sign updated SLA between Partner Organisations	30/04/2025	Progressing
Plastic Surgery - Implement additional dressings clinic to address current variation across North Wales	01/07/2025	Progressing



	Impact	Likelihood	Score
Inherent Risk Rating	3	5	15
Current Risk Rating	3	5	15
Target Risk Score	3	3	9
Risk Appetite	Quality		<16

Position & Intended Outcome for Risk

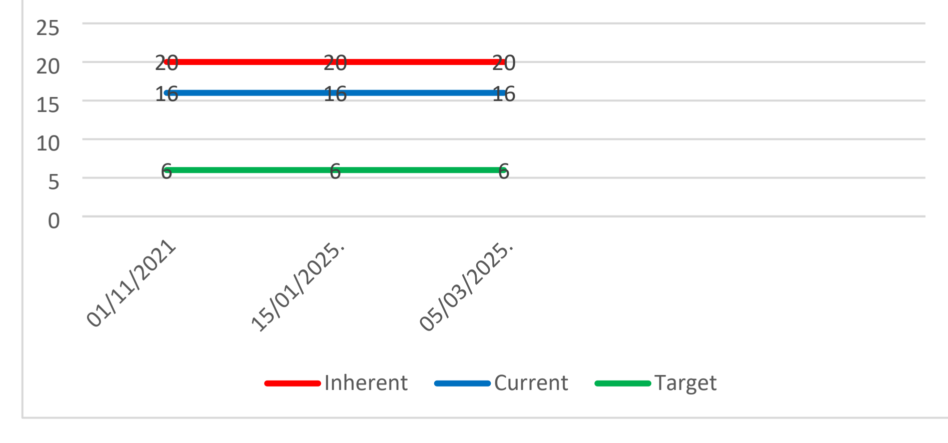
Significant volumes of patients remain in the list (currently 13,212 unbooked), within these there will be undiagnosed cancers and the obvious risk follows regarding delayed diagnosis and treatment.

<table>
<tr><td rowspan="2">CRR 24-26</td><td colspan="2">Risk Title: Urology Services</td><td>Date Opened: November 2024</td></tr>
<tr><td colspan="2">Assuring Committee: Quality, Safety and Experience Committee</td><td>Date Last Committee Review: 20/02/2025</td></tr>
<tr><td>Date Last Reviewed: 05/03/2025</td><td>Director Lead: Executive Medical Director</td><td>Link to BAF: BAF24-07</td><td>Target Risk Date: 31/12/2025</td></tr>
<tr><td colspan="4">There is a risk of increased avoidable harm caused by unsustainable service configuration for Urology in North Wales This could be caused by the inability to recruit to consultant posts driven by unattractive on call rota and lack of recognised best practice equipment (robotic assisted surgery), the lack of specialist knowledge for cancer pathways, issues with access to estates and a lack of network clinical leadership. This may lead to the inability of the Health Board to deliver timely and appropriate care on a pan-North Wales level. As detailed in the RCS and GIRFT reviews, there is a need to develop a provision within a network model to ensure that the service achieves the recommendations from external reviews and complies with national/professional guidance.
If the actions within the Urology Improvement Plan are not achieved, the ability to mitage the known risks will not be possible, which will have an adverse impact on patients access to the service in North Wales, as well as the reputation of the Health Board.</td></tr>
</table>

Mitigations/Controls in place	Additional Controls required
1. High use of locum provision 2. Outsource of service, case by case, whilst commissioning discussions take place. 3. Anuual commissioning of service in place 4. Commission of Robotic Assisted Surgery prostates to UCL 5. Office of the Medical Director currently supporting with Clinical Lead input 6. Monthly meeting with Welsh Government and NHSE to provide assurance and update on the risks currently identified and actions within the Improvement Group.	a. Agree mitigation to move to 2 site model if staff becomes unsafe at 1 site. b. Review purchase of an appropriate Robotic Assisted Surgery platform for prostatectomies c. Clinical facilities and equipment investment identified in the Urology Improvement Plan under the Planned care theme not yet in place

Actions	Due Date	Progression Analysis
Scoping, development and implementation of a revised network model of care for on call.	01/04/2025	Progressing

Review current outsource provision and align Multi-Disciplinary Team meeting for in-reach support in specialist discussion and decision. Review current outsourced/commissioned agreements to provide care closer to home and review opportunities to repatriate cancer procedures at BCU. New arrangements being onboarded with Arrowe Park	01/12/2024	Complete
Cancer services with support from the OMD to advertise for a Urology Cancer lead.	01/11/2025	Progressing
Agreement to fund the MyMR PSA tracking license internally through the Planned Care funds for 24/25 whilst Digital, Data a Technology colleagues look at the integration with AB colleagues and supplier.	01/04/2025	Progressing



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	2	3	6
Risk Appetite	Quality		<16

Rationale for Corporate Risk

Urology service is one of the areas of Clinical Concern and has been subject to an invited review by The Royal college of Surgeons. The identified risk for the services are:

- Increased financial expenditure due to locum provision on the on call rota
- Fragile Out Of Hours on-call rota across BCU
- Delay in patient care with an inability to meet targets for cancer diagnosis and treatment.
- Failure to deliver care closer to home.
- Difficulty in recruiting to provide a sustainable cancer service

<table>
<tr><td rowspan="2">CRR 24-27</td><td colspan="2">Risk Title: Neurodevelopment Waiting List</td><td>Date Opened: 02/05/2024</td></tr>
<tr><td colspan="2">Assuring Committee: Quality, Safety and Experience Committee</td><td>Date Last Committee Review: New Risk</td></tr>
<tr><td>Date Last Reviewed: 11/03/2025</td><td>Executive Lead: Chief Operating Officer</td><td>Link to BAF:</td><td>Target Risk Date:02/05/2027</td></tr>
<tr><td colspan="4">There is a risk that the Health Board may not meet the target set by the Welsh Government (WG) for Neurodevelopment (ND) services which requires that 80% of assessments commence within 26 weeks of the date of referral. Currently Children and young people referred into the service now will not be seen (not assessed) before their 18th birthday. This could be caused by an increase in demand on the service without the support and funding to increase capacity within the team. This may lead to children and young people not being assessed in a timely manner.</td></tr>
</table>

Mitigations/Controls in place	Additional Controls required
1. BCUHB transformation programme commenced, and a full programme of work has been developed to support the move to a needs led service. 2. Welsh Government have issued short term funding to support longest waiters on the list, the service are looking to staff overtime, Agency staff and waiting list validation.	1. Programme Manager essential for delivery of revised service model – only approved until end June 25. 2. Support from external stakeholders (Schools, Local Authority and Third sector) for a new service model to implement significant change. 3. The National work programme needs to be implemented at pace with the recognised changes required in BCUHB. 4. Profile of Needs Training has commenced with Conwy and Denbighshire Local Authorities to support Children on the waiting list and will be rolled out to all local authorities as their capacity allows. 5. Recurrent funding is required to allow the team to recruit to substantive posts and funding often given with short notice/time limited with specific aim, such constraints become difficult to navigate. 6. Approval of a Business case to support additional staffing structures, and support the improvement programme. 7. Greater engagement with external stakeholders such as schools and upskilling staff.

	8. An agreed current plan to address the backlog waiting list, excessive backlog would require £20m* investment based on current model (e.g. if outsourced). 9. A consistent Executive Director to lead on ND challenges 10. The Regional Partnership Board workshop in March 2025 will produce short, mid and long term actions with regards to providing support, information and advice for those both on the waiting list and those at early identification. This will include support from Third Sector, Local Authority and Education colleagues. 11. Agree a transfer policy for Children and young people approaching 18 - to Adult Mental Health Services/Integrated Autism Service . 12. Development of a new prudent assessment to standardise the process and align to best practice. The prudent assessment process will allow all assessment processes to be streamlined and aligned across the Region and reduce inequity. 13. The ND services across the Region have an approximate workforce of 70 staff including Clinical and Non-clinical which is in adequate to support the demand on the service. However, additional staffing would not be supported by the current Health Board Estate. 14. A single digital information system in place to support the sharing of information across teams eg ND teams, CAMHS, Therapies, Education, Social care 15. The Health Board compliance against the Welsh Government 26 week target currently stands at 11% against the target of 80 %

Actions	**Due Date**	**Progression Analysis**
The Regional Partnership Board have agreed to prioritise ND services for 2025-2026 as part of their work plan. The ND programme team are working with the Regional Partnership Board and wider stakeholders eg schools, Local authorities and Third Sector to agree a cohesive way of working to support Children and Young People on the waiting list	**31/03/2026**	Progressing

Work with one Local Authority to train staff to undertake profiling for children on the waiting list. This will provide support for Children, young people and their families whilst waiting for assessment. This will be a pilot project with Ynys Mon and further roll out with other local authorities as they have capacity to support the process. The aim would be for all local authorities to be trained in profiling by March 2026.	30/06/2025 (pilot) March 2026	Progressing
Agreement and production of a new draft service model with key partners to promote a whole system approach embedded within a social model of disability that focuses on changing attitudes, environments and systems in collaboration with all stakeholders..	April 2026	Progressing
Commence implementation of a new service model to support CYP with early support and intervention. This should reduce referral numbers	31/03/2028	Progressing
Development of agreed Transfer policies between Child and Adult Services to provide support and timely assessment for those moving into adulthood.	31/03/2026	Progressing
Maintain close working relationships with the National Programme of work and the Regional Partnership Board to ensure a consistent approach to whole system approach.	31/03/2026	Progressing
Ensure recommendations from the National event in Lampeter are reviewed and implemented as necessary following their release from Welsh Government. Actions will be measured and reviewed	31/12/2025	Progressing
Submission of Business case to support key roles including the programme and operational staffing (Clinical Lead). Approval will be required by the Health Board	30/07/2025	Progressing
Validation of current waiting list (waiters over 3 years) to ensure all patients wish to remain on the list. Currently 600 patients on the long waiters list.	30/06/2025	Progressing
Identification of an Executive Lead for the service to support the programme of work	31/05/2025	Progressing
Implement new prudent assessment process to decrease the length of the process and provide a more streamlined process for CYP and their families. Revised assessment processes are currently being identified by our Clinical Leads	31/07/2025	Progressing
Stratification of the waiting list to identify those at greater risk and agree their prioritisation. It is envisaged that this work will support those most in need and allow a more timely assessment.	30/09/2025	Progressing
Approval of waiting list options paper by ND Strategic Improvement and Development Group. Prudent assessment (streamlined processes aligned to NICE guidance) options will be measured during the monthly performance meeting.	30/05/2025 Ongoing	Progressing
Funding is being used from Welsh Government to support pilot projects, with the aim to develop new ways of working, increase capacity/support for Children and Young People on the waiting lists. All projects are currently undergoing evaluation via the Regional Partnership Board and findings are expected by the end of April for approval to continue funding in 2025/2026	30/04/2025	Progressing

To be completed following escalation approval		Impact	Likelihood	Score
	Inherent Risk Rating	5	4	20
	Current Risk Rating	5	4	20

	Target Risk Score	5	3	15
	Risk Appetite	Quality		<16
	Rationale for Corporate Risk			
	Waiting list time approaching 20 years for new referrals based on current capacity, with an average monthly capacity gap of approximately 200 assessments. A key ministerial priority for 2025/26 is to deliver an improvement in the target compliance rate to 15% by Q4, for which additional investment will be required. The pressures on the ND waiting list are national with no Health Board in Wales meeting the WG 26-week target, BCUHB are currently the second worse performer against the target. There was a significant increase in demand during the Covid pandemic with accepted referrals rising by 130% from 20/21 to 22/23 , and a further increase of 43% in accepted referrals from 22/23 to 23/24. – Year to date in 24/25 accepted referrals are 10% lower partially due to demand management initiatives implemented The ND waiting list is forecast to be over 7,000 by the end of March 25. Whilst the target date for this risk is identified as 2027, it must be noted that delivery of a supported and sustainable service will not be achievable within this timescale due to current capacity, funding and support required from external partner organisations. The above actions have been identified to support the mitigation of the current risk.			

GIG
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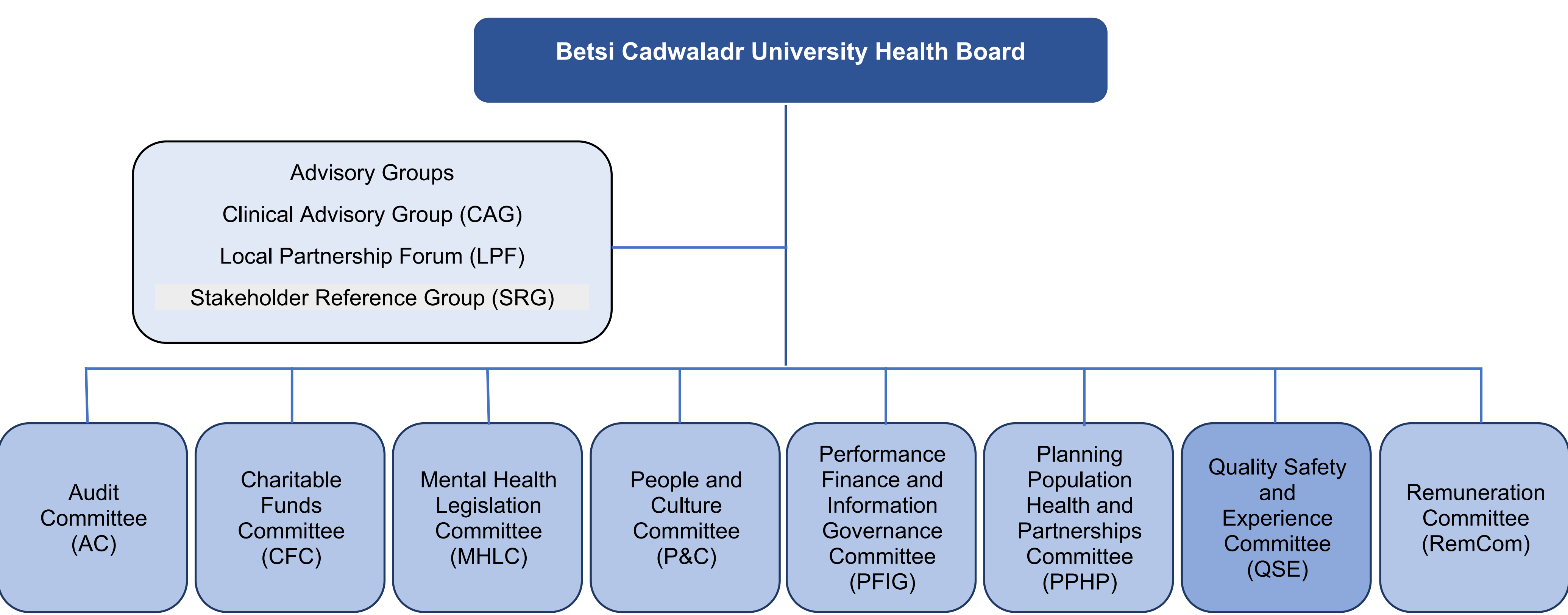
WALES
Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

QUALITY, SAFETY AND EXPERIENCE COMMITTEE

Terms of Reference & Operating Arrangements

(Schedule 3.5 of the Standing Orders)

Date approved by Health Board :



Version Control

Version	Issued to	Date	Comments
V0.01	Executive Committee		

TERMS OF REFERENCE

1 INTRODUCTION

1.1 The Betsi Cadwaladr University Health Board (BCUHB) Standing Orders provide that "The Board may and, where directed by the Welsh Government must, appoint Committees of the Board either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees

1.2 In accordance with Standing Orders (and the BCUHB scheme of delegation), the Board shall nominate annually a committee to be known as the Quality, Safety and Experience Committee. The detailed terms of reference and operating arrangements set by the Board in respect of this committee are set in this document.

1.3 Due to the nature of the business being considered at the RC these meetings will be held in private and papers/minutes will not be made publically available. A summary highlight report will be received at the Public Board meeting that follows.

2 PURPOSE

2.1 The purpose of the Committee is to act on behalf of the Board to:

2.2 scrutinise, assess and seek assurance in relation to the patient experience, safety, impact, quality and health outcomes of the services provided by the Health Board;

2.2 provide evidence-based and timely advice to the Board to assist it in discharging its functions and meeting its responsibilities with regard to the quality and safety of health care provided and secured by the Health Board;

2.3 provide assurance that the Health Board has an effective strategy and delivery plan(s) for improving the quality and safety of care patients receive, commissioning quality and safety impact assessments where considered appropriate. This includes consideration of the Annual Plan/Integrated Medium Term Plan (IMTP); and

2.4 provide assurance that the organisation, at all levels, has the right governance arrangements and strategy in place to ensure that the care planned or provided is of a high standard.

3 DELEGATED POWERS

With regard to its role in acting on behalf of the Board, and in providing advice and assurance to the Board, the Quality, Safety and Experience Committee will comment specifically upon:

3.1 provide advice to the Board on the adoption of a set of key indicators of quality of care against which the Health Board's performance will be regularly assessed and reported on;

3.2 seek assurance on the management of principal risks within the Board Assurance Framework (BAF) and Corporate Risk Register (CRR) allocated to the Committee and provide assurance to the Board that risks are being managed effectively and report any areas of significant concern;

3.3 ensure the right enablers are in place to promote a positive culture of quality improvement based on best evidence;

3.4 seek assurance on delivery against planning objectives aligned to the Committee, considering and scrutinising the processes that are developed and implemented, supporting and endorsing these as appropriate;

3.5 provide assurance that all reasonable steps are taken to prevent, detect and rectify irregularities or deficiencies in the quality and safety of care provided and, in particular, that sources of internal assurance are reliable, there is capacity and capability to deliver and lessons are learned from patient safety incidents, complaints and claims;

3.6 provide assurance to the Board in relation to improving the experience of patients, including those services provided by other organisations or in a partnership arrangement. Patient stories will feature as a key area for patient experience and lessons learnt;

3.7 provide assurance to the Board in relation to its responsibilities for the quality and safety of mental health, primary and community care, public health, health promotion, prevention and health protection activities and interventions in line with the Health Board's strategies. This includes consideration of those health and safety matters which fall under the responsibilities of this Committee;

3.8 ensure that the organisation is meeting the requirements of the NHS Concerns, Complaints and Redress Arrangements (Wales) Regulations;

3.9 approve the required action plans in respect of any concerns investigated by the Ombudsman;

3.10 agree actions, as required, to improve performance against compliance with incident reporting;

3.11 provide assurance that the Central Alert Systems process is being effectively managed with timely action where necessary;

3.12 provide assurance on the delivery of action plans arising from investigation reports and the work of external regulators;

3.13 approve the annual clinical audit plan, ensuring that internally commissioned audits are aligned with strategic priorities;

3.14 provide assurance that a review process to receive and act upon clinical outcome indicators suggesting harm or unwarranted variation is in place and is operating effectively with concerns escalated to the Board;

3.15 consider advice on clinical effectiveness and, where decisions about implementation have wider implications with regard to prioritisation and finances, prepare reports for consideration by the Executive Team which will collectively agree recommendations for consideration through relevant Committee structures;

3.16 provide assurance in relation to the organisation's arrangements for safeguarding vulnerable people, children and young people;

3.17 approve policies and plans within the scope of the Committee, having taken assurance that the quality and safety of patient care has been considered within these policies and plans;

3.18 assure the Board in relation to its compliance with relevant national practice, mandatory guidance, healthcare standards and duties, including Duty of Quality, Duty of Candour, Quality Standards and Quality Management ensuring the Board is supported to make strategic decisions from a quality perspective;

3.19 develop a work plan which sets clear priorities for improving quality, safety and experience each year, together with intended outcomes, and monitor delivery throughout the year;

3.20 refer quality and safety matters which impact on other Board Committees and receive referrals from other Committees; and

3.21 agree issues to be escalated to the Board with recommendations for action.

4 AUTHORITY

4.1 The Committee may investigate or have investigated any activity (clinical and non-clinical) within its terms of reference. It may seek relevant information from any:

- Employee - and all employees are directed to cooperate with any legitimate request made by the Committee; and
- Other committee, sub-committee or group set up by the Board to assist it in the delivery of its functions.

4.2 It may also obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements.

5 SUB-COMMITTEES

5.1 The Committee may, subject to the approval of the Health Board, establish sub-committees or task and finish groups to perform specific aspects of Committee business.

6 MEMBERSHIP

6.1 Formal membership of the Committee shall comprise of the following:

MEMBERS

6.2 The following should attend Committee meetings:

IN ATTENDANCE

6.3 The attendance of the Committee shall be determined by the Board, based on the recommendation of the Health Board Chair, taking into account the balance of skills and expertise necessary to deliver the Committee's remit, and subject to any specific requirements or directions made by the Welsh Government.

6.4 Other Directors/Officers will attend as required by the Committee Chair, as well as any others from within or outside the organisation whom the Committee considers should attend, taking into account the matters under consideration at each meeting.

5. COMMITTEE MEETINGS

5.1 Quorum

- A quorum shall consist of no less than to of the membership, and must include as a minimum the Chair or Vice Chair of the Committee.

5.2 Frequency of meetings

- The Committee will meet bi-monthly and an annual schedule of meetings will be determined by the corporate calendar.
- Any additional meetings will be arranged under exceptional circumstance and shall be determined by the Chair of the Committee in discussion with the Executive Lead.

5.2 Withdrawal of individuals in attendance

- The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

5.3 Meeting arrangements

- The agenda and papers will be distributed/published seven days in advance of the meeting.
- The Director of Corporate Governance is to hold an agenda setting meeting with the Chair and/or Vice Chair and the Executive Director Nursing and Midwifery at least six weeks before the meeting date.
- The agenda will be based on the Committee work plan, identified risks, matters arising from previous meetings, issues emerging throughout the year, and requests from Committee members.

6. REPORTING AND ASSURANCE ARRANGEMENTS

The Committee, through its Chair and members, shall work closely with the other Committees to provide advice and assurance to the Board through joint planning and co-ordination of Board and Committee business including sharing information.

6.1 The Committee Chair, supported by the Committee Secretary, shall:

- Report formally, regularly and on a timely basis to the Board on the Committee's activities;
- Bring to the Board's specific attention any significant matter under consideration by the Committee; and
- Ensure appropriate escalation arrangements are in place to alert the Health Board's Chair, Chief Executive and/or Chairs of other relevant Committee, of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.

6.2 The Committee will undertake an annual review on the effectiveness of its arrangements and responsibilities. The Director of Corporate Governance will oversee this review.

7. RELATIONSHIP WITH THE BOARD AND ITS COMMITTEES/GROUPS

Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these Terms of Reference, it retains overall responsibility and accountability for these matters.

7.1 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these Terms of Reference.

7,2 The Committee, through its Chair and members, shall work closely with the Board's other committees, including joint (sub) committees and groups to provide advice and assurance to the Board through the:

~ Joint planning and co-ordination of Board and Committee business and
~ Sharing of information

In doing so, it will contribute to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance arrangements.

7,3 The Committee will consider the assurance provided through the work of the Board's other committees and sub groups to meet its responsibilities for advising the Board on the adequacy of the Health Board's overall system of assurance.

7.4 The Committee shall embed the Health Board's corporate standards, priorities and requirements, e.g. equality and human rights through the conduct of its business.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

8.1 The requirements for the conduct of business as set out in the Health Board's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum

9. REVIEW

These Terms of Reference and operating arrangements shall be reviewed on at least an annual basis by the Committee for approval by the Board.

10. CHAIR'S ACTION ON URGENT MATTERS

10.1 There may, occasionally, be circumstances where decisions which would normally be made by the Committee need to be taken between scheduled meetings. In these circumstances, the Committee Chair, supported by the Director of Corporate Governance as appropriate, may deal with the matter on behalf of the Board – after first consulting with **all** Members of the Committee. The Secretariat must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

10.2 Chair's action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

<table>
<tr><td>Teitl adroddiad:
Report title:</td><td colspan="12">Executive Quality Delivery Group – Chair's Report</td></tr>
<tr><td>Adrodd i:
Report to:</td><td colspan="12">QSE Committee</td></tr>
<tr><td>Dyddiad y Cyfarfod:
Date of Meeting:</td><td colspan="12">1st May 2025</td></tr>
<tr><td>Crynodeb Gweithredol:
Executive Summary:</td><td colspan="12">This report provides the Formal Executive Team with the Chair's Report from the Executive Quality Delivery Group (QDG). The QDG is the clinical executive led quality group in the Health Board through which all other quality-related groups report.</td></tr>
<tr><td>Argymhellion:
Recommendations:</td><td colspan="12">The Formal Executive Team are asked to note this report.</td></tr>
<tr><td>Arweinydd Gweithredol:
Executive Lead:</td><td colspan="12">Angela Wood, Executive Director of Nursing and Midwifery (Lead Exec)
Teresa Owen, Executive Director of AHPs and Health Science
Sree Andole, Interim Executive Medical Director
Dr Jane Moore, Executive Director of Public Health</td></tr>
<tr><td>Awdur yr Adroddiad:
Report Author:</td><td colspan="12">Angela Wood, Executive Director of Nursing and Midwifery (Chair)</td></tr>
<tr><td>Pwrpas yr adroddiad:
Purpose of report:</td><td colspan="4">I'w Nodi
For Noting
☐</td><td colspan="4">I Benderfynu arno
For Decision
☐</td><td colspan="4">Am sicrwydd
For Assurance
☒</td></tr>
<tr><td>Lefel sicrwydd:

Assurance level:</td><td colspan="3">Arwyddocaol
Significant
☐
Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol

High level of confidence/evidence in delivery of existing mechanisms/objectives</td><td colspan="3">Derbyniol
Acceptable
☐
Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol

General confidence / evidence in delivery of existing mechanisms / objectives</td><td colspan="3">Rhannol
Partial
☐
Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol

Some confidence / evidence in delivery of existing mechanisms / objectives</td><td colspan="3">Dim Sicrwydd
No Assurance
☐
Dim hyder/tystiolaeth o ran y ddarpariaeth

No confidence / evidence in delivery</td></tr>
<tr><td colspan="13">Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:

Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:

There is confidence in the data provided in the report however, the strength of learning and improvement remains an area of concern and is a key focus of work. This is being addressed through a range of measures including the actions aligned to the Board Assurance Framework.</td></tr>
</table>

Cyswllt ag Amcan/Amcanion Strategol: *Link to Strategic Objective(s):*	Outcome 4 - Improved access, outcomes and experience for citizens Outcome 5 - Recognition of BCU as a learning and self-improving organisation
Goblygiadau rheoleiddio a lleol: *Regulatory and legal implications:*	The Duty of Quality is a statutory requirement under the Health and Social Care (Quality and Engagement) (Wales) Act 2020. The statutory duty of quality requires the decision-making processes by the Health Board take into account the improvement of health services and outcomes for the people of Wales – the duty also includes new Health and Care Quality Standards. Instances of harm to patients may indicate failures to comply with the NHS Wales standards or safety legislation.
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? *In accordance with WP7 has an EqIA been identified as necessary and undertaken?*	N/A
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? *In accordance with WP68, has an SEIA identified as necessary been undertaken?*	N/A
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) *Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR)*	BAF-SP18 and CRR-24-04 – Quality, Innovation and Improvement
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* *Financial implications as a result of implementing the recommendations*	N/A
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith *Workforce implications as a result of implementing the recommendations*	N/A
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori *Feedback, response, and follow up summary following consultation*	N/A
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) *Links to BAF risks:* *(or links to the Corporate Risk Register)*	BAF-SP18 and CRR-24-04 – Quality, Innovation and Improvement
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) *Reason for submission of report to confidential board (where relevant)*	N/A
Camau Nesaf: *Next Steps:* N/A	
Rhestr o Atodiadau: *List of Appendices:* EQDG Chair's Report	

Chair's Report

Report to:	Quality, Safety and Experience Committee
Report from:	Executive Quality Delivery Group
Meeting date:	10th February 2025
Presented by:	Angela Wood, Executive Director of Nursing & Midwifery

Quality highlights and escalations:
Please include matters of escalation (for action/decision and for information) and a short summary of all business conducted by the group, organised by the domains set out below.

Issues for escalation – requiring action/decision	None.
Issues for escalation – for information	**Womens and Midwifery** The highest risk remains with the gynae oncology establishment, which is seeking support through outreach efforts. **Cancer** The first patients are being treated with new bispecific regimes, following extensive staff training. **Central IHC** Corridor Care – The ED at Glan Clwyd Hospital is currently raising concerns in regards to the corridor care that is being given. Patient's dignity and privacy is not consistently being addressed, which is affecting the patient's experience. The EDON is working with IHC Directors to consider options and mitigate risks. **East IHC** High prevalence of patients presenting within the ED, and being admitted onto the assessment wards with underlying infections which are not being isolated on arrival in ED, or handed over to the assessment units. Prolonged length of stays for patients in the ED awaiting admission into Mental Health beds.

	The ability to deliver safe, timely and effective care remains a significant concern, particularly in the emergency departments, where actions for improvement are being considered and progressed. Executive leads are working with IHC Directors to consider options and mitigate risks. **MHLD services** In December 2024, a catastrophic incident was reported involving a non-suspended ligature. It was not reported a ligature incident on Datix due to the requirements of the reporting process; the incident was reported as an unexpected inpatient death, which does not make the "ligature" option available on the report, as this is only available for reports of self-harm. This has been reported as an NRI and will be subject to full external review.
Summary of business conducted – for assurance	**Quality Highlight Reports** **Womens and Midwifery Services** **Risks –** 5 open 2 overdues **Incidents –** 287 Open. 127 under management review process,108 under investigation,52 awaiting closure. The main themes include CT interpretation, poor or missing documentation, and delayed escalation, these are all monitored through quality and safety boards with weekly SLT reports. **Concerns –** 20 open concerns, 8 overdue and robust plans in place to address these. **NRI's –**8 open, 0 overdue **Never Events –** 0 never events **Inquests –** 6 open, all in progress. Infection prevention efforts have resulted in no outbreaks and low infection rates for caesarean section wounds. Despite challenges, staff efforts during difficult conditions have been praised, with effective cross-border support and teamwork. HIW inspections have resumed within maternity services, with a recent inspection in Swansea. Three peer reviews have been completed in BCUHB, with actions in progress to ensure that BCUHB services are aligned to future HIW inspections. **MHLD Services** No representative in attendance – (December data) **Risks –** 27 open **Incidents –** 403 incidents reported. The top 5 themes that emerged from the incidents were Aggressive/threatening behaviour, physical assault, Self-harm/self-injurious behaviour, Slip, trip or fall and restrictive practices.

	14 incidents were reported which involved the use of a ligature; 11 of these were in inpatient settings and 3 in a commissioned placement. **Concerns-** 14 open, 0 overdue **NRI's –** 2 open, 1 overdue **Never Events-** None **Inquests –** Not included in report **Cancer Services** **Risks – 14** open **Incidents –** 198 open cases, 157 overdue plans in place to address the number of overdues. Noted theme in Radiotherapy, related to unsigned treatment regimes. **Concerns-** 5 open, 2 overdues **NRI's –** 1 open **Never Events-** No never events A representative for Cancer Services at the CEG meeting to be determined during the absence of a clinical lead and ensure that inclusion continues whilst Clinical lead identified. An infection deep dive was conducted, with an improvement plan in progress, jointly with IPT. **East IHC** **Risks –** 130 open, top 3 remain: the challenges in restorative dentistry and risks around medication reconciliation, Pharmacy colleagues are supporting to identify specific hotspots. The ability to deliver safe, timely and effective care remains a significant concern, particularly in the emergency departments, where actions for improvement are being considered and progressed. **Concerns-** 56 open, 10 overdues **NRI's –** 9 open, none overdue **Never Events-** none for service **Inquests –** 28 actives, 45 awaiting dates Escalated unfunded beds at the Maelor site, totalling 44, are being addressed with plans to recruit substantively. Improvements in CAMHS meeting targets are noted, though challenges persist and work continues. **Central IHC** **Risks –** 122 open, concerns have been raised about delays and follow-ups in ophthalmology, which is on the risk register. A proposal is being worked on to address the backlog, though long-term issues related to workforce requirements remain. **Incidents –**2072 open, plans in place to reduce with trajectory being monitored weekly **Concerns-** 46 open concerns

NRI's – 16 open, 3 overdues
Never Events- none for service
Inquests – 33 open and progressing

Improved governance position in relation to significant reduction in concerns reaching 75% compliance

Opening of Alternatives to Admission hub for NWAS in December

West IHC

Risks – 19 open, 5 overdue
Incidents – 495 open
Concerns- 19 open
NRI's – 6 open, 0 overdue
Never Events- None
Inquests – 82 open

Reported downward trend of avoidable pressure ulcers by 3.4%, with positive improvements noted. New steering groups have been established for various areas of learning, including nutrition and hydration, deteriorating patients and dementia care.

Safeguarding training compliance remains a challenge, particularly in medical and dental areas, and violence against women and domestic abuse training falls short across the IHC. Assurance was noted that processes are being put in place to address these issues, especially engaging medical and dental colleagues.

Porth Maddock's achievement of 100% compliance in safeguarding training.

Diagnostics and Clinical Support

The identification of Reinforced Autoclaved Aerated Concrete (RAC) in the biochemistry lab at the Wrexham Maelor site was a major concern and is currently scored as a 15 on the risk register. Mitigations were implemented in early January, and a follow-up survey confirmed that evacuation is not necessary. Additional support for the ceiling has been added and a report will be provided in due course to support the development of an action plan for removing the RAC concrete. Immediate risks are being averted, allowing normal operations to continue.

2 major IT installations in Pathology and Radiology present some challenges with meeting scheduled implementation dates.

The HTA inspection report received in January identified 11 findings, including 9 major shortfalls. An action plan has been agreed with priority on security and access to the mortuary. Positive progress has been made at the Wrexham site with a new access system, work with the remaining sites is in progress.

Cellular Pathology recognised for outstanding innovation. The Cellular Pathology team has been recognised again with their ground-breaking work in Artificial Intelligence (AI) and digital pathology innovation and collaboration. At the recent Allied Health Professionals (AHP) and Health Sciences Services (HSS) Research & Innovation Conference, they won Best Innovation category with their poster, "Breast AI: A Game Changer", showcasing the transformative potential of artificial intelligence in breast pathology. Also, the team was also shortlisted for a Modernising Diagnostics Award at the prestigious HSJ Awards for their remarkable work on the All-Wales Cellular Pathology Collaboration. This initiative is revolutionising cellular pathology across Wales.

Dental

Dental access for general public, starting February 12th, a Health Board-wide dental access portal will go live, allowing individuals to register on a waiting list managed by the Health Board. This will roll out in phases and allocate dental practices based on priority status.

Risk pertains to the electronic patient management system. A business case for a new system has stalled and is linked to a patient list review. Data sorting is necessary before migrating to a new system, and review of available funding.

Consultant and Paediatric dentistry a deep dive report on structure and leadership is planned. This issue is compounded by demand and capacity challenges, with 2,600 children waiting for general anaesthesia (GA) sessions. The bottleneck is due to delays in assessment and consent, leading to session cancellations despite high demand. All efforts are being made to increase activity and efficiency. Collaboration with secondary care colleagues in oral maxillofacial surgery is ongoing with arrangements being made for sharing GA facilities to address theatre capacity. A detailed report on children GA is to be prepared and presented to QDG.

NHS Executive Review of Neurodevelopmental (ND) Services

Progress update for action plan related to NHS Executive review of Neurodevelopmental Services across Wales and was initially presented to QDG in July 2024.

All recommendations from the full report were accepted by the ND service and are being monitored internally. Positive progress has been made, but challenges remain, including transitioning young people into adult MHLD care services.

The waiting list position remains the most significant of the recommendations. The team currently lack the capacity to meet demand, with a waiting list including 2,739 children, leading to increased waiting times as well as an increase in complaints.

	WG allocated BCUHB with £340,315K to address the longest waiters and the team are currently looking at appointing agency staff to utilise this short-term funding. The team have developed a draft business case to support further service change. The recommendations remain incorporated into, and aligned to, the BCUHB ND Transformation Programme for progression. **Policies Approved** • MM42 – Unlicensed Medicines Policy • MHLD0084 – Physical Health in a Mental Health Setting • All Wales Policy: Independent Authorisation of Blood Component Transfusion (IABT) (replaced PA04 Procedure for non-medical authorisation of blood products

Cyfarfod a dyddiad: **Meeting and date:**	Quality, Safety & Assurance Committee
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Summary of business considered in private session to be reported in public
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Pam Wenger, Director of Corporate Governance
Awdur yr Adroddiad **Report Author:**	Philippa Peake-Jones, Head of Corporate Affairs
Craffu blaenorol: **Prior Scrutiny:**	None
Atodiadau **Appendices:**	None

Y/N to indicate whether the Equality/SED duty is applicable	**N**

Argymhelliad / Recommendation:

The Committee is asked to note the report.

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		**Ar gyfer Trafodaeth For Discussion**		**Ar gyfer sicrwydd For Assurance**		**Er gwybodaeth For Information**	✓

Sefyllfa / Situation:

To report in public session on matters previously considered in private session.

Cefndir / Background:

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.

Asesiad / Assessment

The Committee considered the following matters in private session:

20 February 2025

- Confidential Quality Report

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

(1 April 2024 – 31 April 2025)

This forward plan is only to be used for one-off Adhoc items that do not require inclusion as routine business on the Annual Committee Cycle of Business.

Date of Request	Origin of Request	Requestor	Item Summary / Title	Nature of Request	Lead Officer	Executive Lead	Intended Meeting Date	Status
30.01.25	Board Meeting 30.01.25	Chair	**25/09.01 Citizens Engagement Report**	Patient Experience to be discussed at a QSE Committee Development Session.	Head of Corporate Affairs **(Philippa Peake-Jones)**	Pam Wenger	March 2025 Development Session	
30.01.25	Board Meeting 30.01.25	Chair	**25/09.03 Citizens Engagement Report**	A briefing on the new legislation due to be issued, to be discussed at a future QSE Committee.	Head of Corporate Affairs **(Philippa Peake-Jones)**	Pam Wenger	May 2025	
30.01.25	Board Meeting 30.01.25	Chair	**25/15.1 Improving Quality Report**	QSE Committee to review patient feedback data and discuss how this can be addressed to provide longer term solutions to improve performance.	Head of Corporate Affairs **(Philippa Peake-Jones)**	Pam Wenger	May 2025	
20.2.25	QSE Meeting 20.2.25	Chair	**QS25/07.1** Integrated Quality Report	The Committee to review the Clinical Audit as a substantive item.	Interim Executive Medical Director **(Sree Andole)**	Interim Executive Medical Director **(Sree Andole)**	March 2025 Development Session	
13.2.25	QSE Action Log	Chair	**QS24/104** Meeting Effectiveness	To ensure that more time allocated to Primary Care on CoB, on a regular basis.	Head of Corporate Affairs **(Philippa Peake-Jones)**	Exec. Dir. of Nursing & Midwifery (**Angela Wood)**	May 2025	
13.2.25	QSE Agenda 20.2.25	Interim COO	**QS25/06** Deep Dive into Childrens Services (CAMHS)	Item deferred due to sickness.	COO	COO	May 2025	
7.2.25	TRANSFER LOG MH24/32.2	MHLC	**MH24/32.2** Translation Services	To ensure that patients are provided with the opportunity to communicate in their preferred language. The action was deemed complete and was moved to the QSE transfer log.	Executive Director for Allied Health Professionals & Health Science (**Teresa Owen**)	Executive Director for Allied Health Professionals & Health Science (**Teresa Owen**)	May 2025	
07.05.24	TRANSFER LOG AC24.60.1.8	Audit Committee		Quality, safety and commissioned services. The Committee agreed to a 6-	Director of Governance **(Pam Wenger)**	Director of Governance **(Pam Wenger)**	May 2025	**10.12.24** Now the new Director of Performance and

				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.	/ Head of Corporate Affairs **(Philippa Peake-Jones)**			Commissioning has started with the Health Board, this will be taken forward within his remit.
22.10.24	PPHP 22.10.24	PPHP	Developing our Partnerships	Add Llais Experience paper to CoB annually, in February.	Head of Corporate Affairs **(Philippa Peake-Jones)**	Director of Governance **(Pam Wenger)**	May 2025	**10.03.25** Added item onto COB.
11.06.24	QSE Agenda Setting	Chair	Primary Care	Update on ongoing work	Head of Primary Care	Executive Director of Nursing & Midwifery (**Angela Wood)**	~~December 2024~~ February 2024	**Dec 2024** It was suggested at QSE Development Session that this item should come to a joint PFIG & QSE Development Session. Due to timing issues, this has not been managed to be scheduled before Christmas.
26.09.24	Board	Director of Corporate Governance / Executive Director of Nursing & Midwifery	Monitoring of Patient safety & experience	Arrange for QSE Committee workplan to include monitoring of patient safety and experience across EDs reporting	Director of Corporate Governance (**Pam Wenger**) / Exec. Dir. of Nursing & Midwifery (**Angela Wood)**	Director of Corporate Governance **(Pam Wenger)**	February 2025	
15.10.24	Email between Teresa Owen and Pam Wenger	Director of Corporate Governance	Governance of DECLO role	To provide an update and ensure appropriate governance of DECLO role, regulation and plans	Designated Education Clinical Lead Officer **(Liz McKinney)**	Exec. Dir of Allied Health Professions & Health Science **(Teresa Owen)**	~~December 2024~~ May 2025	**Feb 2025** Added to 20.02.25 agenda
16.10.24	Email from Chief Operating Officer	Chief Operating Officer	Challenged Services – Dermatology (Plastics)	Update on service.	Head of Planned Care	Executive Medical Director	~~February 2025~~ May 2025	**Jan 2025** Not to be provided until a clinical lead is in place.
16.10.24	Call for Papers inadvertently omitted request for Deep Dive to Children's Services	COB	Service presentation from Children's Services – with particular	Update on service with particular emphasis on CAMHS	Assistant Area Directors - Children (Pan-BCU)	Assistant Area Directors - Children (Pan-BCU)	~~February 2025~~ May 2025	**10.2.25** Received request to defer item to May 2025.

	for October 2024 meeting		emphasis on CAMHS.					
24.10.24	Deputy Director for Legal Service's action from October meeting – QS24/120.	Chair	Update on Impact of Independent Medical Examiner certifying deaths.	To provide an update once the impact of an independent medical examiner certifying all deaths has been assessed.	~~Deputy Director of Legal Services~~ Executive Medical Director	~~Director of Corporate Governance~~ Executive Medical Director	May 2025	
29.11.24	Email from Deputy Director for Legal Services	Deputy Director for Legal Services & Director of Corporate Governance	Clinical Negligence Claims	Update. Item removed from Dec 24 agenda by Deputy Director for Legal Services following discussions with Director of Corporate Governance. Further work is required. Meeting with CEO in the new year around wider claims work and the paper would be written after this.	Deputy Director for Legal Services	Director of Corporate Governance	May 2025	
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, this to be a topic at a Development session.	Executive Director of Nursing & Midwifery	Executive Director of Nursing & Midwifery	~~March 2025~~ March 2026	**17.3.25** Leon Marsh confirmed that guidance still in draft, with no further updates. Current schedule being embedded is Dec 25.
17.12.24	QSE Meeting	The Executive Director of Allied Health Professionals and Health Science	The Executive Director of Allied Health Professionals and Health Science, Director of Performance & Commissioning and the Executive Medical Director	To meet outside meeting to address the challenges causing delays relating to index colonoscopy patients and to provide a briefing to next Development session	The Executive Director of Allied Health Professionals and Health Science	The Executive Director of Allied Health Professionals and Health Science	March 2025 Development Session	
8.1.25	Email between Chief Pharmacist and Director of Corporate Governance	Director of Corporate Governance	Pharmacy & Medicines Management Deep Dive	Pharmaceuticals item removed from Feb's agenda. To split in two - Pharmacy & Medicines Management Deep Dive	Chief Pharmacist	Executive Medical Director	July 2025	

8.1.25	Emails between Chief Pharmacist and Director of Corporate Governance	Director of Corporate Governance	Controlled Drugs Accountable Officer report must be an item in Private session	Pharmaceuticals item removed from Feb's agenda. To split in two – (see above) with Controlled Drug Accountable Officer report.	Chief Pharmacist	Executive Medical Director	May 2025 must be an item in Private session	**17.3.25** Added to May 25 agenda.

Quality Safety and Experience – Annual Cycle of Committee Business

(1st April 2024 to the 31st March 2025)

The Annual Cycle of Committee Business has been developed to help plan the management of Committee matters and facilitate the management of agendas and committee business. The Annual Cycle of Committee Business will be complemented by a "Non-Routine Committee Business (Forward Work Plan)" for 'one-off' Ad-hoc items raised during meetings.

The role of the Committee is set out in the Health Board's standing orders and the Terms of Reference, both of which are available here:

The **Quality Safety and Experience Committee** meets bi-monthly

Committee Chair: • Caroline Turner **Committee Vice Chair** • Christopher Lothian-Field	**Members** • Mike Larvin • Urtha Felda	**In Attendance** • Angela Wood (Executive Director of Nursing and Midwifery) – Exec Lead • Sreeman Andole (Interim Executive Medical Director) • Teresa Owen (Executive Director of Allied Health Professionals and Health Science) • Jane Moore (Interim Executive Director of Public Health)	**Preliminary matters to be included on agenda:** Welcome & Apologies Declarations of Interest Unconfirmed minutes of meeting held on xxxx Matters Arising & Action Log

AGENDA ITEM	**MAY (Q1)**	**JULY (Q1)**	**SEPTEMBER (Q2)**	**NOVEMBER (Q3)**	**JANUARY (Q3)**	**MARCH (Q4)**
PRELIMINARY MATTERS						
PATIENT STORY						
Patient Story						
SERVICE PRESENTATIONS – 30 mins						
IHC East						
Womens, Maternity and Gynaecology						
Children's						
IHC West			*			
Pharmaceutical Services						
Mental Health						
IHC Central		2025				
Learning Disabilities			2025			
QUALITY PLANNING						
Clinical Services Plan *Executive Medical Director*						
Nursing Staffing (April & October)						
QUALITY CONTROL						
Integrated Quality Report • Patient Safety • Patient Experience • Clinical Effectiveness (Audit work) • Safeguarding • IPC • Regulatory • Legal *Executive Director of Nursing and Midwifery*						
Integrated Performance Report *Director of Performance*						
QUALITY IMPROVEMENT						
Quality Management System *Executive Director of Nursing & Midwifery*						
Challenged Services *Relevant Executive Director*	Orthodontics	Vascular Stroke (2025)	Cancer Oncology	Dermatology (Plastics)	Urgent and Emergency Care	Ophthalmology

DRAFT

Note 1

AGENDA ITEM	MAY (Q1)	JULY (Q1)	SEPTEMBER (Q2)	NOVEMBER (Q3)	JANUARY (Q3)	MARCH (Q4)
QUALITY ASSURANCE						
Update on the Royal College of Psychiatry Action Plan *Lead for Mental Health*						
ROUTINE REPORTING						
Corporate Risk Register						
Internal Audit Reports (as and when required)						
ANNUAL REPORTING						
Committee Annual Report to Board						
Review Committee Terms of Reference						
Annual Quality Report • Duty of Candour • Putting Things Right (PTR)		Draft	Final			
Ombudsman Annual Letter						
Organ Donation						
Infection Prevention Control (IPC)						
Safeguarding			Possibly October			
Medicine Management (Controlled Drugs)						
Research and Development		2025				
Designated Educational Clinical Lead Officer (DECLO) *Executive Director of Allied Health Professionals & Health Science*						
FOR INFORMATION						
Any Clinical Policy (to be identified)						
NHS Wales – Joint Commissioning Committee Quality Committee Chairs Report						
Quality Delivery Chairs Assurance Report						
Summary of Business to be Reported from Private						
Review Committee Workplan						
Review Committee Cycle of Business						
CLOSING BUSINESS						
Agree Items for Referral to Board / Other Committees						
Meeting Effectiveness						
Date of the Next Meeting						
Resolution to Exclude the Press and Public						
PRIVATE AGENDA						
Confidential Quality Report						
BAF Appendix – for noting						

NB

Add DECLO Annual Report to the January meetings.

Ensure more time allocated to Primary Care on a regular basis.

WORKING DRAFT

Developing our Partnerships Ensure that a Llais experience paper is included on the QSE / PPHP CoB annually.	PPHP Committee 22.10.24	QSE Committee	PP24/74.1	LJ checked with Geoff Ryall-Harvey, GR-H confirmed the Llais Annual Report / Experience Paper will go to QSE & PPHP in April / May 2025 – LJ & FL to include on CoB / forward plans. **12.2.25** added to FWP.

WORKING DRAFT

Note 1