Bundle Quality, Safety and Experience Committee 17 December 2024

Agenda attachments

QSE Short Agenda 17.12.24 v1.0

1 PRELIMINARY MATTERS

1.1 12:30 - QS24/139 Welcome and apologies - verbal
Chair

1.2 12:31 - QS24/140 Declarations of Interest - Verbal
Chair

1.3 12:32 - QS24/141 Unconfirmed minutes of meeting held on 24 October 2024 - Attached
Chair

QS24 141.1 Unconfirmed QSE minutes 24.10.24 v0.3 public session - CT approved

1.4 12:37 - QS24/142 Matters Arising and Action Logs - Attached
Chair

QS24 142.1 Action Log PUBLIC - updated 9.12.24

QS24 142.2 Flow chart G4 G5 Complaints Process (Action No. 6)

QS24 142.3 Complaints Improvement Deep Dive (Action No. 14)

1.5 12:42 - QS24/143 Patient Story - Attached
Executive Director of Nursing & Midwifery
To be presented by Saffron Roberts, Specialist Nurse, Organ Donation

QS24 143.1 Patient Story - Gareth's Story

2 SERVICE PRESENTATION

2.1 13:02 - QS24/144 Learning and Disabilities Deep Dive - Attached
Executive Director of Allied Health Professionals & Health Science

QS24 144.1 Learning Disbability Services Coversheet

QS24 144.2 Learning Disabilities Presentation

3 QUALITY PLANNING

3.1 13:32 - QS24/145 Clinical Services Plan - Attached
Executive Director Transformation & Strategic Planning

QS24 145.1 Clinical Services Plan

4 QUALITY CONTROL

4.1 14:02 - QS24/146 Integrated Quality Report - Attached
Executive Director of Nursing & Midwifery

QS24 146.1 Integrated Quality Report

QS24 146.2 Integrated Quality Report Appendix

4.2 14:32 - QS24/147 Integrated Performance Report - Attached
Director of Performance & Commissioning

QS24 147.1 Coversheet Integrated Performance Report

QS24 147.2 Integrated Performance Report

5 14:52 - COMFORT BREAK

6 QUALITY ASSURANCE

6.1 QS24/148 Health Board Response to the Royal College of Psychiatrists Invited Review Services Report
Executive Director of Allied Health Professionals and Health Science

QS24 148.1 Health Board Response to the Royal College of Psychiatrists Invited Review Services Report.

QS24 148.2 Appendix 2 RCPysch Delivery Group Chairs Report

QS24 148.3 Appendix 3 Draft Terms of Reference V2

7 QUALITY IMPROVEMENT

7.1 14:57 - QS24/149 Urgent and Emergency Care Deep Dive - Attached
Chief Operating Officer
QS24 149.1 UEC Deep Dive Coversheet
QS24 149.2 UEC Deep Dive Presentation

8 ROUTINE REPORTING

8.1 15:17 - QS24/150 Corporate Risk Register - Attached
Head of Risk Management
QS24 150.1 Corporate Risk Register

9 FOR INFORMATION

9.1 QS24/151 Quality Delivery Group Chairs Assurance Report - Attached
QS24 151.1 QDG Chairs Assurance Report

9.2 QS24/152 Summary of Private Session Items Reported in Public - Attached
Head of Corporate Office
QS24 152.1 QSE Summary of Private session items reported in public

9.3 QS24/153 Review Committee Forward Workplan - Attached
Head of Corporate Office
QS24 153.1 QSE Summary of Private session items reported in public

9.4 QS24/154 Joint Commissioning Committee - Quality and Patient Safety Committee Report Nov 2024
QS24 154.1 JCC Quality Patients Safety Committee Report Nov 2024
QS24 154.2 JCC QPS Summary of Services in Escalation - Appendix 1

10 CLOSING BUSINESS

10.1 15:27 - QS24/155 Agree Items for Referral to Board / Other Committees
Chair

10.2 15:28 - QS24/156 Meeting Effectiveness
Chair

10.3 QS24/157 Date of the Next Meeting
20th February 2025

10.4 Resolution to Exclude the Press and Public
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'.

Agenda Quality, Safety and Experience Committee

Date 17/12/2024
Time 12:30 - 16:14
Location Boardroom, Carlton Court, St Asaph LL17 0JG
Chair Caroline Turner

1 PRELIMINARY MATTERS

1.1 12:30 **QS24/139 Welcome and apologies - verbal**
Chair

1.2 12:31 **QS24/140 Declarations of Interest - Verbal**
Chair

1.3 12:32 **QS24/141 Unconfirmed minutes of meeting held on 24 October 2024 - Attached**
Chair

1.4 12:37 **QS24/142 Matters Arising and Action Logs - Attached**
Chair

1.5 12:42 **QS24/143 Patient Story - Attached**
Executive Director of Nursing & Midwifery

To be presented by Saffron Roberts, Specialist Nurse, Organ Donation

2 SERVICE PRESENTATION

2.1 13:02 **QS24/144 Learning and Disabilities Deep Dive - Attached**
Executive Director of Allied Health Professionals & Health Science

3 QUALITY PLANNING

3.1 13:32 **QS24/145 Clinical Services Plan - Attached**
Executive Director Transformation & Strategic Planning

4 QUALITY CONTROL

4.1 14:02 **QS24/146 Integrated Quality Report - Attached**
Executive Director of Nursing & Midwifery

4.2 14:32 **QS24/147 Integrated Performance Report - Attached**
Director of Performance & Commissioning

5 14:52 **COMFORT BREAK**

6 QUALITY ASSURANCE

6.1 14:57 **QS24/148 Update on the Royal College of Psychiatry Invited Services Review - Attached**
Executive Director of Allied Health Professionals and Health Science

7 QUALITY IMPROVEMENT

7.1 15:17 **QS24/149 Urgent and Emergency Care Deep Dive - Attached**
Chief Operating Officer

8 ROUTINE REPORTING

8.1 15:37 **QS24/150 Corporate Risk Register - Attached**
Head of Risk Management

9 FOR INFORMATION

9.1 QS24/151 Quality Delivery Group Chairs Assurance Report - Attached

9.2 QS24/152 Summary of Private Session Items Reported in Public - Attached
Head of Corporate Office

9.3 QS24/153 Review Committee Forward Workplan - Attached
Head of Corporate Office

9.4 QS24/154 Joint Commissioning Committee - Quality and Patient Safety Committee Report Nov 2024

10 CLOSING BUSINESS

10.1 15:47 **QS24/155 Agree Items for Referral to Board / Other Committees**
Chair

10.2 15:48 **QS24/156 Meeting Effectiveness**
Chair

10.3 QS24/157 Date of the Next Meeting
20th February 2025

10.4 Resolution to Exclude the Press and Public

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'.

12 PRELIMINARY MATTERS

12.6 QS24/163 Board Assurance Framework - Attached

16:04

Head of Risk Management

Betsi Cadwaladr University Health Board (BCUHB)
Minutes of the Quality, Safety and Experience Committee meeting held in public
on 24 October 2024 at the Board Room in Carlton Court, St Asaph

Board Members present	
Name	**Title**
Dr Caroline Turner	Committee Chair
Urtha Felda	Independent Member
Chris Lothian-Field	Committee Vice Chair
Prof Mike Larvin	Independent Member
In Attendance	
Dyfed Edwards	Chair
Dave Harris	Head of Internal Audit
Fflur Jones	Audit Wales
Matt Joyes	Deputy Director for Legal Services
Chris Lynes	Deputy Executive Director for Nursing and Midwifery
David Maslen-Jones	Assistant Director of Occupational Health, Safety and Security
Jane Moore	Acting Executive Director of Public Health
Teresa Owen	Executive Director of Allied Health Professionals and Health Science
Philippa Peake Jones	Head of Corporate Affairs
Pam Wenger	Director of Corporate Governance
Bill Whitehead	Llais, North Wales
Iain Wilkie	Interim Director MHLD
Ed Williams	Acting Director of Performance
Ros Alstead	Special Advisor, Chair of RCPsych Expert Advisory Group
Phil Meakin	Associate Director of Governance

Agenda Item
PRELIMINARY MATTERS
QS24/113 Welcome and apologies **QS24/113.1** Apologies were received from Imran Devji (Interim Chief Operating Officer), Nick Lyons (Executive Medical Director), Angela Wood (Executive Director for Nursing and Midwifery), noting that Chris Lynes (Deputy Executive Director for Nursing and Midwifery) would be in attendance on her behalf. Apologies were also received from Jason Brannan (Deputy Director of People) noting that David Maslen-Jones (Assistant Director of Occupational Health, Safety and Security) would be in attendance in his behalf. The Chair noted Chris Lothian-Field was running a few minutes late. The Committee noted that Independent Member Chris Lothian-Field had agreed to be Vice Chair of the Quality, Safety and Experience Committee.

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QS24/113.2 The Chair, Dyfed Edwards, asked for clarity around the lack of attendance from anyone from the Office of the Medical Director and the Chair of Committee, Caroline Turner, noted that it would leave a gap given what was on the agenda and that there was no one available to attend. The Executive Director of Allied Health Professionals and Health Science apologised and advised that she would take the concerns back to the Executive. It was noted that Ros Alstead and Phil Meakin would be joining the meeting for the Royal College of Psychology Action Plan agenda item.

The Chair welcomed Bill Whitehead attending on behalf of Llais North Wales.

The Chair noted that with approval of the Chair of the Board, Chris Lothian-Field had agreed to become Vice-Chair of the Quality Safety and Experience Committee.

QS24/114 Declarations of Interest

None were received.

QS24/115 Unconfirmed minutes of meeting held on 15 August 2024

It was resolved that the Committee
Agreed the minutes were a true and correct record of the meetings held 15 August 2024 subject to the minor amendments.

QS24/116 Matters Arising and Action Logs

There were no comments on the action log.

Under matters arising it was requested that an update was given in relation to outcomes for women from deprived and ethnically vulnerable communities and were advised that a piece of work was currently being undertaken, with this in mind wished to see it on the forward workplan to return to QSE.

Actions:

Head of Corporate Affairs 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.

It was resolved that the Committee
- **Agreed** the updated log.

QS24/117 Patient Story - My Beautiful Home Birth

[Chris Lothian-Field and Prof Mike Larvin joined the meeting]

The Deputy Executive Director of Nursing and Midwifery introduced the video which provided an insight on a recent excellent, empowering experience of a mother having her fourth child at home with the support of the Llandudno Community Midwifery Team. The Committee noted that the story teller had come forward wanting to share her experience as

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it had been so positive and that the Community Midwifery Team had wanted it shared given that home births had been suspended for nearly two years during Covid.

In discussing the report, the Committee:

- Highlighted that historically North Wales had a relatively low level of home births and that hopefully raising awareness this would improve these numbers.
- Noted the difference in experiences between having to fight for a home birth and water birth 30 years ago and the support now received upon request.
- Were pleased that good data and information was now available on the website with annually, approximately 6,300 people visiting the Betsi Cadwaladr University Health Board website for information before, during, after and between pregnancy.
- Queried how proactive the offer of home birth was, noting that as confidence grows in the service it was likely that proactivity would increase, where appropriate.

It was resolved that the Committee
- **Noted** the report.

SERVICE PRESENTATION

QS24/118 Deep Dive on Complaints - Duty of Care

Members received the presentation and noted the progress in relation to the previous months for completed complaints. In presenting the report, the Deputy Executive Director for Nursing and Midwifery:

- Updated on the current figures given the circulated presentation was out of date as the data was for September and noted that there were 273 outstanding complaints with 78 overdue, many of which were for good reason.
- Highlighted the significant increase of complaints that had been able to be closed week on week, noting that in October above a hundred a week were being closed.
- Shared the success story and how the improvements had happened by working closer with colleagues since April.
- Noted that the target set by Welsh government was to respond to 75% of complaints within 30 days but the Health Board actually managed just over 70% by 14 October and that this figure was down to 65% as of the current week.
- Updated on the top six themes identified in complaints, with delay, lack of treatment and assessment being the highest areas, with communication also being high.
- Shared an update on the improvement collaboratives that had been undertaken in each area which would mean that an understanding of tolerance would be reviewed going forward.
- Updated on the Promote, Prevent and Prepare team (3 P's team) who were ensuring that there was a consistent approach to the experience of patients awaiting planned care treatment.

In discussing the report, the Committee:

- Thanked the Interim Director of Performance for being able to join for the item given the focus on Complaints in the Performance Report.
- Congratulated and thanked the team on the tremendous improvement from 208 overdue complaints down to 78, querying what had changed. It was noted that that

colleges who had been pulled in all directions were now focussing, working together and had reviewed resource.

- Noted the explanation of the grading of complaints, with one or two being simple issues to investigate but fours and fives more complex medical cases.
- Queried the reason that complaints graded four or five were being held against the 30-day response target and noted that this was set out in the Putting Things Right Regulations which was being reviewed by the NHS Executive.
- Understood the once for Wales Datix system was incompatible with the guidance, as it only allows for a 30-day log, even if it is a complex case that is unlikely to meet the 30-day target.
- Queried the involvement of senior clinicians in the complaints process.
- Highlighted that good communication earlier would prevent complaints and wanted a briefing on Putting Things Right for the QSE committee.
- Highlighted concerns raised at a Flintshire meeting whereby the understanding of GDPR was raised as an issue.
- Encouraged the positive learning of the progress of complaints to be shared with the whole of the organisation noting for the future, responding to complainants should be completed prior to leaving.
- Discussed an electronic tracking tool to be made available to the public which would show where they were in the waiting list for Planned Care.
- Noted the thanks from colleagues to the Patient Experience Team and all colleagues who had supported the improved turnaround of complaints.

Actions:

- Deputy Executive Director for Nursing and Midwifery to discuss the GDPR issue raised at the Flintshire event outside of the meeting with Independent Member, Urtha Felda.
- Deputy Executive Director for Nursing and Midwifery to share an updated presentation with the most recent figures.
- Deputy Executive Director for Nursing and Midwifery, in relation to the request for a communications training strategy, share the tool kit which includes the communication plan being developed as part of the implementation of Integrated Concerns Framework.
- Deputy Executive Director for Nursing and Midwifery to consider whether it would be of use to for the Committee to track a complaint from the moment of receipt to completion to understand the pinch points.
- Director of Corporate Governance to discuss with the Chair having a Putting Things Right on a future development session.

QUALITY PLANNING

QS24/119 Presentation of the Nurse Staffing Levels - Autumn 2024

In presenting the report, the Deputy Executive Director for Nursing and Midwifery:

- Noted that there would be an updated presentation circulated following the review by the Executive post paper publication.
- Highlighted the All Wales Acuity Audit and that the acuity levels were raising.

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- Shared the Quality Indicators presented by Integrated Health Community and Division.
- Advised that a number of wards had asked for additional resources and following Executive review the number of registered nurses reduced to 11.78 from 18.73 and the Health Care Support worker reduced to 22.7 from 41.04.
- 11 wards (not 12 wards) requested adjustments and 10 wards had adjustments approved.

In discussing the report, the Committee:

- Highlighted that although the report reflected the wards that came under the Act, a similar review has taken place for the other wards.
- Noted that a similar review was ongoing in relation to the Allied Health Professionals and Mental Health.
- Clarified what the data was indicating, noting the high level of vacancies in Mental Health but that overall, it was an improving picture on the vacancy levels.

Actions:

- Head of Corporate Affairs to report back to the Chair of PFIG that a review of nurse staffing levels for those wards that did not fall under the Act had taken place.
- Deputy Executive Director for Nursing and Midwifery to share an updated presentation with the most recent figures.
- Deputy Executive Director for Nursing and Midwifery to share the staffing levels for those areas not covered in the Act to all Independent Members.

QUALITY CONTROL

QS24/120 Integrated Quality Report

Members received Integrated Quality Report. In presenting the report, the Deputy Executive Director for Nursing and Midwifery highlighted:

- In relation to the Patient Safety Incidents the Integrated Concerns Policy was agreed at Board and implementation had been successful. Staff had come together and a daily hub meeting was taking place to triangulate the moderate and above incidents, complaints four and five and any incident that is received through the Medical Examiner.
- In relation to Oxygen safety, a Welsh Health Circular had been received and a response submitted since the report was published and there is full compliance.
- With regards to Patient Falls it was noted that there was a gradual reduction due to some of the improvement work and that a further update would be given in the private section of the meeting.
- An improvement programme had led to a reduction in the number of Pressure Ulcers but it was noted that one of the issues was the long lies at home waiting for an ambulance.
- An update on the National Reportable Incidents (NRI), current numbers are now 14 overdue in comparison to 22 reported. From an all Wales perspective the Health Board performs well.

In discussing the report, the Committee:

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- Scrutinised the details of falls being reported as one severe and nine moderate but that there were still too many in low. It was noted that focus was now on the severe and moderate falls with specific focus on risk assessments.
- Advised that non-attendance of Manual Handling Training was completely unacceptable specifically if staff had booked themselves on this. It was noted that further work was ongoing to ensure optimisation of training, training was previously booked through ESR, and individuals had a choice of when they booked into their slot yet still did not turn up. An action plan has been implemented, including removing Manual Handling from ESR and providing training in house, and with this intervention over 300 hundred more slots have been opened up and will continue until Christmas.
- Acknowledged that in terms of staffing numbers, the organisation was running very tight and that there was very little slack in the system to enable colleagues to be able to attend training programmes.
- Noted that with regards to the risk assessments for falls, the Nursing Improvement Team had been supporting the wards and that all assessments were done electronically and can be monitored centrally.
- Noted that there were no outstanding alerts with regards to the ongoing oxygen cylinder work.
- Noted that due to concerns being raised regarding the Datix Safeguarding Module, its implementation date had been pushed back. The Deputy Director for Legal Services confirmed that this was a national problem.

In discussing the report, the Committee:

- Noted that the Infection Prevention and Control team still have concerns around CDIF levels. The national HARP team were due to come to help review the current position. National targets have been received and work is currently underway mapping ourselves against our targets.
- The Executive Director of Public Health requested the health protection information be included in future reports. Assistant Director of Health Protection to be asked to provide an update.
- The Chair was pleased to noted that the quality of content included within the Clinical Effectiveness part of the report had greatly improved but regrated that there was no one able to present and respond to questions on this element of the report.
- It was noted that within the Mortality review, there was now a UK-wide requirement for either an independent medical examiner or a coroner to certify all deaths. The potential for increased workloads was mentioned however the Deputy Director for Legal Services understood that it should not directly impact the organisation as NWSSP would be providing a Medical Examiner Service. The situation had yet to be clarified and should be picked up at a future development session.
- The Interim Director of Mental Health and Learning Disabilities noted that there had been a three-day unannounced inspection at the Heddfan Psychiatric Unit in Wrexham. Preliminary verbal feedback had been positive. The inspection report, when received, will be formally shared with the Committee.
- The Committee discussed the Ombudsman's Report:
    - Which showed that only a relatively small number of complaints to the Ombudsman were upheld

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- Which showed that 58% of recommendations complied with on time, which was low in comparison with other Health Boards and needed to be addressed.
- The Chair's draft response was available, and the Director of Governance was pleased that the Committee was spending time considering it. She felt that a close eye should be kept on the number of complaints sent to the Ombudsman as it was a good form of assurance for the Committee and the Board.
- The Committee requested figures or a table showing the number of current complaints and claims, and their status be brought to the Committee

Actions:

- Head of Corporate Affairs to refer the monitoring of Manual Handling Training to the People and Culture Committee.
- Deputy Executive Director for Nursing and Midwifery and the Director of Performance to ensure that there is constancy when reporting National Reportable Incidents as the Integrated performance Report is showing different data to the Integrated Quality Report.
- The Executive Director of Public Health to seek an update on Health Protection for future reports from the Assistant Director of Health Protection.
- The Deputy Director of Legal Services to report back regarding the expected Medical Examiner Service.
- The Deputy Director of Legal Services and the Deputy Executive Nursing Director asked to provide figures showing the number of current complaints and claims, and their status for the December meeting

It was resolved that the Committee

- **Noted** the report.

QS24/121 Integrated Performance Report

Members received the Integrated Performance Report. In presenting the report, the Acting Director of Performance noted that clinical coders have now been commissioned and that the team's morale was improving.

- The Executive Director for Public Health noted that:
  - the Organisation had received a letter from Public Health Wales commending the organisation on its approach and the work being done regarding smoking cessation.
  - BCU came first in Wales with the highest percentage of school children immunised, due to the very targeted approach.
  - there was very good news from Womens' and Children's services New Born screening programme which had been very effective in encouraging the uptake of the new vaccination for Respiratory Syncytial Virus (RSV), a major cause of admittance for very young babies and for the elderly in the winter season

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- as winter approached, flu and covid rates were increasing, however there had been a good uptake of the flu and covid vaccinations provided by a combination of in-house vaccination teams, GPs and community pharmacies.
- data within the report regarding vaccinations referred to 2023 and required updating.

The Assistant Director of Occupational Health, Safety and Security confirmed that the organisation had taken a very pro-active approach regarding staff immunisation and that there had been a good staff uptake.

In discussing the report, the Committee noted the following:

- Concern was raised regarding the 41% of patients offered a colonoscopy procedure, when the target is 90%. The Executive Director of Allied Health Professionals and Health Science to speak to the Deputy Executive Medical Director to check the veracity of data provided in report. Was this a coding issue?
- Concern was raised regarding diabetes. The Executive Director of Public Health confirmed that she had provided a holding position for PFIG but that her team was looking at this as part of the transformation work and agreed to keep the Committee updated.
- The Committee asked why Welsh Ambulance Service Trust WAST) figures had been provided. The Acting Director of Performance agreed to investigate this but felt it was possibly to help understand the ambulance delay figures

Actions:

- The Acting Director of Performance to provide a standalone report on the backlog of clinical coders' work to the December meeting.
- The Acting Director of Performance to provide updated performance data regarding vaccinations.
- The Executive Director of Allied Health Professionals and Health Science to speak to the Deputy Executive Medical Director to check the veracity of colonoscopy data provided in report, and to escalate concerns if required.
- The Executive Director of Public Health confirmed that she would provide an update on Diabetes figures to the Committee.
- The Acting Director of Performance agreed to look at why WAST figures were in the report.

It was resolved that the Committee

- **Reviewed** the structure, components and contents of the report and confirmed agreement to continue with the format.

[The Interim Director of Performance left the meeting]
[Ros Alstead and Phil Meakin joined the meeting]

QUALITY ASSURANCE

QS24/122 Update on the Royal College of Psychology (RCPsych) Response Plan

The Chair welcomed Ros Alstead as Special Advisor and chair of the Expert Advisory Group, a group established to provide oversight of the response to the Royal College of Psychology invited review and to ensure that the outcomes of the review are delivered.

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Ros Alstead has worked as a Mental Health Nurse at executive level and would be working for 2 days per month in her new capacity.

Members received the Update on the RCPsych Response Plan. In presenting the report, The Executive Director of Allied Health Professionals and Health Science confirmed that since the last meeting, significant progress had been made, with help from the Director of Governance. It was noted that:

- All committed to getting the foundations right and much work had taken place with patients and families, past and present, to improve outcomes.
- Summary of the Governance framework was provided, with the Delivery Group already up and running.
- An Evidence of Outcomes Group will be created, for which expressions of interest had been received from staff and hoped families would be represented also.
- Geoff Ryall-Harvey, Llais, was thanked for the work he had been doing with the families and it was noted that they would not be where they were if it had not been for his help and guidance.
- Ros Alstead and Phil Meakin had met with families earlier that day to ensure that the organisation is able to provide the support required for those coming to meetings of the Expert Advisory Group. Patients and families wanted to know how their contribution and experiences would inform the future. It was agreed that to get this process right, there would be no quick-fix and that it would take time, conversations and assurances along with a different approach to the past will be taken to ensure that this work is effective.
- Reporting to QSE would be on a bi-monthly basis.
- The Director of Governance thanked Ros Alstead for her observations and confirmed that the intention was to move slowly, to get the correct governance and possibly have some Independent Members working with the team to support the Expert Advisory Group
- The Chair of the Board thanked Ros Alstead for the work she was doing and expressed the need to involve people to ensure a better service for the future, noting that patients and families had been through some terrible experiencse in the past
- The Executive Director of Allied Health Professionals and Health Science confirmed that the work that MH&LD colleagues are doing will be checked and challenged along the way. The Divisional Senior Leadership team and the Therapists were due to present to another meeting chaired by the Consultant Psychiatrist/Medical Director.
- The Director of Governance noted it was important to get support from both the Engagement team and the Workforce and Organisational Development team to ensure that the most is made of the Organisation's skills around stakeholder management.

Following the discussion, the Committee:

- Were pleased to hear that care was at the centre of the approach to this work, using experience to improve outcomes for the future.
- Asked for a timeframe to be included within the ToR – with Ros Alstead being appointed for 12 months and a review at 9 months.
- Noted that a draft ToR and forward work plan should be brought back to the Committee in December.

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- Suggested that the families meet with the new Dementia Nurse
- Agreed that Ros Alstead should report back to the Committee in December
- Thanked those who had contributed to the very helpful paper, noting it was important to have evidence informing the Outcomes Group.

Actions:

- The Associate Director of Governance to ensure that a timeframe be included into the ToR. Draft ToR and forward work plan to be brought back to the Committee in December
- The Associate Director of Governance to ensure that the families meet with the Dementia Nurse, when she joins the Health Board in the New Year.
- Ros Alstead agreed to report back to the Committee in December, outlining how she envisages the approach moving forward and how she envisages this improving patient care.

It was resolved that the Committee

1. **Noted and received assurance** on updates related to governance and programme arrangements for the Health Board Response to the RCPsych Invited Review Services Report.
2. **Noted** progress against the ten themes identified in the Invited Review Services Report.
3. **Noted** the Draft Terms of Reference for the Expert Advisory Group.

ROUTINE REPORTING

QS24/123 Corporate Risk Register

Members received the Corporate Risk Register. In presenting the report, the Director of Governance confirmed that work continued around evolving Risks outside the Committee tolerance.

It was noted that there had been two changes in Risks – both of which had reduced since the September meeting and had been through the Risk Scrutiny group and Executive Team.

It was noted that during the recent QSE development session, a discussion took place regarding whether certain risks should sit with Performance or Quality Committees – to be discussed during the following week's Chairs' Advisory Group.

Following the discussion:

- The Chair noted that she was pleased that areas of clinical concern had been separated out and asked if there was a corporate risk on Mental Health. The Executive Director of Allied Health Professionals and Health Science agreed to check outside of the meeting and report back.
- It was noted that there was a possibility of being able to use a scanner at the University for diagnostics and the Executive Director of Allied Health Professionals and Health Sciences agreed to take this forward outside of the meeting.

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- It was noted that there was one area of concern where four actions were overdue – without updates, which was unacceptable. The Executive Director of Allied Health Professionals and Health Science noted that the Executive team were aware, but with an interim Chief Operating Officer (COO) now in place, the situation was improving. The Director of Governance noted that one of her team had been tasked with working with the COO to provide an update.
- It was noted that movement around medical devices equipment was expected, but that there was likely to be an ongoing risk, with challenges due to pressures on the Capital budget.

Actions:

- The Director of Governance to discuss at next Chairs' Advisory Group whether certain risks sat is Performance or Quality, or whether they straddled both.
- The Executive Director of Allied Health Professionals and Health Science to look into whether there was a corporate risk on Mental Health.
- The Director of Governance to provide an update on clinical services, following discussions with the COO.

It was resolved that the Committee

- **Received assurance** for the six corporate risks to which the Committee has overall accountability.

ANNUAL REPORTING

QS24/124 Annual Quality Report 2023-24

Members received the Annual Quality Report 2023-24. The Deputy Director of Legal Services presented his report which was approved.

It was resolved that the Committee

- **Approved** the report and its contents.

[*The Director Of Safeguarding And Public Protection joined the meeting]*

QS24/125 Annual Safeguarding and Public Protection Report 2023-24

Members received the Annual Safeguarding and Public Protection Report 2023-24. In presenting the report, the Director of Safeguarding and Public Protection explained the workforce challenges and increase in legal responsibilities.

It was resolved that the Committee

- **Noted** the Annual Report for the period of 2023-2024.

The Director Of Safeguarding And Public Protection left the meeting]

FOR INFORMATION

QS24/126 Quality Delivery Group Chair's Assurance Report

It was resolved that the Committee

- **Noted** the Quality Delivery Group Chair's Assurance Report

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QS24/127 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	
QS24/128 Committee Forward Work Plan **It was resolved that** the Committee • **Noted** the Committee Forward Work Plan	
QS24/129 Cancer Services North Wales - a Road Map for 2024-29 **It was resolved that** the Committee • **Noted** the Cancer Services North Wales - a Road Map for 2024-29	
QS24/130 NHS Wales - Joint Commissioning Committee Quality Committee Chair's Report **It was resolved that** the Committee • **Noted** the Joint Commissioning Committee Quality Committee Chair's Report	
QS24/131 Maternity Services - Learning for Improvement, Examples and Evidence **It was resolved that** the Committee • **Noted** the Maternity Services - Learning for Improvement, Examples and Evidence	
CLOSING BUSINESS	
QS24/131 Meeting Effectiveness It was reported that given the volume of the agenda, there had been some good discussions.	
QS24/132 Date of Next Meeting 17th December 2024	
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.	

DRAFT

QSE Committee PUBLIC Action Log

Open Actions						
Action No.	**Minute Ref.**	**Date**	**Agreed Action**	**Lead**	**Timescale**	**Status**
1	QS24/104.3		**QS24/104 Meeting Effectiveness** Ensure more time allocated to Primary Care on CoB, on a regular basis.	Angela Wood / Philippa Peake-Jones	17.12.24	**16.10.24** CoB will be updated once further conversations have taken place with Executives.
2	QS24/116		**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.	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.
3	QS24/118		**QS24/118 Deep Dive on Complaints – Duty of Care** To discuss the GDPR issue raised at the Flintshire event outside of the meeting with Independent Member, Urtha Felda.	Angela Wood	17.12.24	**4.12.24** Arrangements underway for Chris Lynes to meet with Urtha Felda.
4	QS24/118		**QS24/118 Deep Dive on Complaints – Duty of Care** to share an updated presentation with the most recent figures.	Angela Wood	17.12.24	**Suggest close.** **4.12.24** Information shared post meeting.

5	QS24/118		**QS24/118 Deep Dive on Complaints – Duty of Care** In relation to the request for a communications training strategy, share the tool kit which includes the communication plan being developed as part of the implementation of Integrated Concerns Framework.	Angela Wood	17.12.24	**Suggest close.** **4.12.25** It was confirmed that an integrated training programme for staff across the organisation has commenced initially with overview training of the policy and processes contained within it. This will support them to implement the integrated concerns policy. Subsequent to the launch of the policy, this has been replaced by weekly drop-in sessions with the Patient Safety Team, to discuss any issues or to seek support with regards the processes. Level 2 training has commenced and takes place every Thursday. This is targeted at those responsible for undertaking Learning Reviews and covers the approach, methodology, process and tools to conduct a Learning Review. Level 3 training will be targeted at those responsible for undertaking Learning Investigations. Finalisation of the training pack and tools will be completed December 2024 and training dates are planned for January 2025. Information for the above is available on Betsinet
6	QS24/118		**QS24/118 Deep Dive on Complaints – Duty of Care** To consider whether it would be of use to for the Committee to track a complaint from the	Angela Wood	17.12.24	**9.12.24** First draft complaint flowchart attached to December agenda. Delays relating to PTR, redress independent investigation, police involvement, legal services to be built in.

			moment of receipt to completion, to understand the pinch points.			
7	QS24/118		**QS24/118 Deep Dive on Complaints – Duty of Care** to discuss with the Chair having a Putting Things Right (PTR) on a future Development session.	Angela Wood	17.12.24	**Suggest close.** **4.12.24** Welsh Government Response to Consultation feedback on Draft National Putting Things Right (PTR) Guidance released, which indicates likely changes to the guidance. Consequently action put on hold and added to Forward Workplan.
8	QS24/119		**QS24/119 Presentation of the Nurse Staffing Levels - Autumn 2024** to report back to the Chair of PFIG that a review of nurse staffing levels for those wards that did not fall under the Act had taken place, to share the staffing levels for those areas not covered in the Act to all Independent Members.	Angela Wood	17.12.24	**5.12.24** AW to provide verbal update at December meeting.
9	QS24/119		**QS24/119 Presentation of the Nurse Staffing Levels - Autumn 2024** to share an updated presentation with the most recent figures.	Chris Lynes	17.12.24	**Suggest close.** **9.12.24** Information circulated to IMs
10	QS24/120		**QS24/120 Integrated Quality Report** to refer the monitoring of Manual HandlingTraining to the People and Culture	Philippa Peake-Jones	17.12.24	**Suggest close.** **18.11.24.** Laura Jones has included this on the Forward Workplan for P&C.

			Committee.			
11	QS24/120		**QS24/120 Integrated Quality Report** to ensure that there is consistency when reporting National Reportable Incidents (NRI) as the Integrated performance Report is showing different data to the Integrated Quality Report.	Chris Lynes	17.12.24	**Suggest close.** Head of Patient Safety linking in with Performance team to confirm source of information and align. NHS Executive also have a number of NRI's to close which have been completed by the Health board which gives a different number open on the national beacon dashboard .
12	QS24/120		**QS24/120 Integrated Quality Report** to seek an update on Health Protection for future reports from the Assistant Director of Health Protection. The Deputy Director of Legal Services to report back regarding the expected Medical Examiner Service.	Jane Moore	17.12.24	**Suggest close.** **4.12.24** JM confirmed that action complete and that an update has been provided for the December Integrated Quality Report.
13	QS24/120		**QS24/120 Integrated Quality Report** to report back regarding the expected Medical Examiner Service.	~~Matt Joyes~~ Sreeman Andole	17.12.24	**Suggest close.** **20.11.24** MJ confirmed that the impact on an independent medical examiner certifying all deaths will be monitored and an update given at the April meeting. FL added to the Forward Work Plan noting it is the OMD's responsibility to respond.
14	QS24/120		**QS24/120 Integrated Quality Report** to provide figures showing the number of current complaints and claims, and their status for	Matt Joyes / Chris Lynes	17.12.24	**4.12.24** MJ confirmed that a claims paper was planned for December, but this has been deferred while a review of the process and approach to litigation is underway, due to the transition of legal services to the Director of

			the December meeting			Corporate Governance in October 2024. This has allowed a full review of the process to commence, and will be discussed with the CEO in the New Year. A paper will be brought back to QSE after this has been completed. Awaiting update regarding complaints element.
15	QS24/121		**QS24/121 Integrated Performance Report** to provide a standalone report on the backlog of clinical coders' work to the December meeting.	Ed Williams	17.12.24	**Suggest close.** Kathryn Lang and Dafydd Ap Gwyn providing the clinical coding report.
16	QS24/121		**QS24/121 Integrated Performance Report** to provide updated performance data regarding vaccinations.	Ed Williams	17.12.24	**Suggest close.** Updated performance data regarding vaccinations provided in December's Integrated Performance Report.
17	QS24/121		**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 concerns if required.	Teresa Owen	17.12.24	**9.12.24** TO spoke with Deputy Executive Medical Director. Data/information is being checked by the team.
18	QS24/121		**QS24/121 Integrated Performance Report** To provide an update on Diabetes figures to the Committee as holding position	Jane Moore	17.12.24	**10.12.24** The outputs of the work on diabetes will be available March 2025.

			had been provided to PFIG but that her team was looking at this as part of the transformation work.			
19	QS24/121		**QS24/121 Integrated Performance Report** to look at why WAST figures were in the report.	Ed Williams	17.12.24	**Suggest close.** WAST figures are part of our National Performance Framework of measures. although they are WAST measures, BCU has a responsibility in ensuring ambulances are freed up to be able to respond to other calls, hence the measures are important for our understanding in the 'partnership' with WAST.
20	QS24/122		**QS24/122 Update on the Royal College of Psychology (RCPsych) Response Plan** to ensure that a timeframe be included into the ToR. Draft ToR and forward work plan to be brought back to the Committee in December	Phil Meakin	17.12.24	**Suggest close.** **4.12.24** Draft ToR for the Expert Advisory Group have been updated and are available in the appendix to the HB Response to RCPsych Invited Services Review report.
21	QS24/122		**QS24/122 Update on the Royal College of Psychology (RCPsych) Response Plan** to ensure that the families meet with the Dementia Nurse, when she joins the Health Board in the New Year	Phil Meakin	Feb 2025	**Suggest close.** **4.12.24** Dementia Nurse has now been appointed and the arrangements for this meeting will be concluded when she joins in the new year.
22	QS24/122		**QS24/122 Update on the Royal College of Psychology (RCPsych) Response Plan** to report back to the Committee in December, with	Ros Alstead	17.12.24	**Suggest close.** **4.12.24** RCPsych Invited Services Review Report includes update on how the Special Advisor envisages moving forward and how this will improve patient care.

			how she envisages moving forward and how she envisions this improving patient care.			
23	QS24/123		**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.	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.
24	QS24/123		**QS24/123 Corporate Risk Register** to investigate whether there was a corporate risk on Mental Health.	Teresa Owen	17.12.24	**Suggest close.** **4.12.24** The Head of risk Management confirmed that there is no corporate risk on Mental Health and that she has raised this for discussion at the next Mental Health Risk Meeting for further discussion and also at The Head of Risk Management meeting with key service leads, ahead of the Mental Health Risk Meeting to discuss a gap analysis and review of the risk register to discuss a corporate risk for mental health. A Royal College Psych response plan risk has been developed and included within the

						December paper for Risk Scrutiny Group review and decision to escalate to the corporate risk register.
25	QS24/123		**QS24/123 Corporate Risk Register** to provide an update on clinical services, following discussions with the COO.	Pam Wenger	17.12.24	**Suggest close.** **4.12.24** The Head of Risk Management has provided an update, confirming that five risks from clinically challenged services have been included within the December paper for Risk Scrutiny Group review and decision to escalate to the corporate risk register: 1. Oncology Services 2. Ophthalmology Service 3. Vascular Services 4. Renal Services 5. Orthodontics Services Risks drafted, but remain to be finalised and are with the services for further development and approval: • Urology services • Dermatology & Plastics
Closed Actions						
Action No.	**Minute Ref.**	**Date**	**Agreed Action**	**Lead**	**Timescale**	**Status**
1	**QS24/69.2**	**6.6.24**	**Vascular Action plans via an escalation report/template to be received at QSE**	**Nick Lyons / James Risley**	**August 2024**	**Suggest close** **16.8.24 Vascular Update circulated to Members**
2	**QS24/69.4**	**6.6.24**	**Take outside the meeting the issue of Vascular referral to the wrong place and how often this is happening**	**Nick Lyons / James Risley**	**August 2024**	**Suggest close.** **Unsure as to what this relates.**
3	**QS24/69.5**	**6.6.24**	**Review the Progress update**	**Nick Lyons /**	**August**	**Suggest close.**

			narrative on P1. 07 of the Vascular Action Plan	James Risley	2024	The wording on the P1 . 07 changed to: “work not yet started” – Lessons learnt from the AAA improvement work, which is equally acute, will be applied to this area.
4	QS24/89	15.8.24	QS24/89 Matters Arising and Action Log Add title of agenda item on action log. Requested by Committee members	Fiona Lewis	September 2024	Suggest close. 16.8.24 Actioned.
5	QS24/91.1	15.8.24	QS24.91 Service Presentation from Women’s Services. To ensure ‘The Health Board’ is placed at the top of both ‘Women’s Services Operating Governance Structure’ and ‘Leadership – Women’s Services Management & Leadership Structure’ diagrams.	Fiona Giraud	September 2024	Suggest close. 21.8.24 Actioned.
6	QS24.91.2	15.8.24	QS24.91 Service Presentation from Women’s Services. The Committee asked for more evidence to be included to show if learning was being embedded successfully, leading to improvements. (This should include consideration of pan Health Board learning and how Services can influence the annual planning process.)	Fiona Giraud / Philippa Peake-Jones	October 2024	Suggest close. Paper provided by Fiona Giraud and added to October agenda, for information.
7	QS24/91.6	15.8.24	QS24.91 Service Presentation from Women’s Services.	Pam Wenger / Philippa Peake-	December 2024	Suggest close This will be taken forwards in the planning work

			The Director of Midwifery and Women's Services was asked for her assistance in shaping the organisation's strategies in its 3/5/10 year plans.	Jones		which has now commenced.
8	QS24/91.7	15.8.24	QS24.91 Service Presentation from Women's Services To connect with women who have gone through the service and create links with existing women's community groups to aid improvements.	Fiona Giraud	December 2024	Suggest close. 15.10.24 Paper provided by Fiona Giraud and added to October agenda for information.
9.	QS24/92.1	15.8.24	QS24.92 Integrated Quality Report. It was agreed to hold a Committee Development Session in October. Chair and Committee Secretary to confirm date.	Fiona Lewis	Sept 2024	Suggest close. Development Session arranged for 4.10.24
10.	QS24/92.3	15.8.24	QS24.92 Integrated Quality Report. With regards to the impact of training, a trajectory was requested that shows the relationship between training, delivery and performance.	Angela Wood	October 2024	Suggest close. Full response added to October agenda - item
11.	QS24/92.5	15.8.24	QS24.92 Integrated Quality Report. Regarding a question concerning problems some of the Deaf Community were	Angela Wood	October 2024	Suggest close. 13.9.24. Update received from AW: The Patient and Carer Experience Group has a monthly standard agenda item 'accessible health care' with the particular focus now on

			having making appointments, AW agreed to investigate the situation to ensure it is being appropriately addressed.			**the launch of Sign Live. IHC Patient & Carer Experience Group meetings receive WITS/Accessible Health Care updates from the Patient & Carer Experience Team.** **Below are examples of work being undertaken to meet the needs of the deaf and BSL using community:** • **Introduction of Sign Live in November 2024 – 24/7 access to BSL video interpretation and the ability to telephone the Health Board through a video relay service.** • **Quarterly feedback reports from Centre of Sign Sight and Sound on behalf of the deaf and BSL using community to be reported to the Patient and Carer Experience Group.** • **In partnership with Centre of Sign Sight and Sound, working with the deaf and BSL using community to capturing a series of patient stories to raise awareness and learn from experiences.** • **Deaf awareness and Welsh Interpretation Translation Service training for staff.** **In November, it's national Sensory loss awareness month. The Patient & Carer Experience Team will be working with the Equality & Human Rights Team to promote sensory loss awareness to staff. This includes:** • **Holding a series of bite-sized sessions online and face to face to for staff** • **Promotion of equipment available in hospitals to use for translation e.g. translator on wheels, iPad for 'Insight' app**

						• PALS staff engagement across wards/service areas.
12.	QS24/93.1	15.8.24	QS24/93 Integrated Performance Report EW to discuss with AW how to improve the use of metrics within the report.	Ed Williams / Angela Wood	October 2024	Suggest close. 15.10.24 Update received. Presentation made at Development Session on 4.10.24. As a result, changes to the report were agreed. Some immediate small changes and some that will take time to develop. The minor changes have been made for October's report.
13.	QS24/93.2	15.8.24	QS24.93 Integrated Performance Report. EW agreed to provide information missing on Pg 4 of report.	Ed Williams	October 2024	Suggest close. This information is now included in the October Report.
14.	QS24/93.3	15.8.24	QS24.93 Integrated Performance Report EW agreed to review and include more context into the next report, including how to engage staff and teams with the performance reporting.	Ed Williams / Jane Moore	October 2024	Suggest close. 15.10.24 Update received. Presentation made at Development Session on 4.10.24. As a result, changes to the report were agreed. Some immediate small changes and some that will take time to develop. The minor changes have been made for October's report
15.	QS24/93.9	15.8.24	QS24.93 Integrated Performance Report. Asked Members to look at Liverpool's Women's Hospital's Facebook page, which on one page of infographics shares each month's Early Pregnancy Assessment Unit and Midwifery birth facts. The Committee felt	Fiona Lewis / Helen Stevens-Jones	October 2024	Suggest close 20.8.24 HS-J advised that Comms already have infographics on Maternity. The team is looking at the Liverpool website to make comparison and improve where necessary.

			it should consider this as a form of communication to be adopted by the Communications Department.			
16.	QS24/95.4	15.8.24	QS24/95 Challenged Services Report – Cancer & Oncology. To share the ' Roadmap for Cancer Services in North Wales', as referred to in Item 4.3 of report, with both QSE and The Board.	James Risley / Caroline Williams	Sept 2024	Suggest close. 20.8.24 Item shared.
17.	QS24/98.3	15.8.24	QS24/98 Corporate Risk Register Regarding Pg 6 of report (Pg 326 of bundle), item Ref CRR24-04. MJ to update and circulate.	Angela Wood / Matt Joyes / Phil Meakin	September 2024	Suggest close 17.10.24 MJ confirmed complete following work with the Risk Team. Discussed within the October Development Session
18.	QS24/102.1	15.8.24	QS24/102 Committee Cycle of Business & Committee Workplan As Chair of the Risk Scrutiny Group, AW to keep Committee informed of support for East IHC's in relation to increased demand for Children's Neurodevelopment services which far outweighs its capacity.	Angela Wood	September 2024	Suggest close This has been transferred to the Risk Scrutiny Group's forward work plan.
19.	QS24/102.2	15.8.24	QS24/102 Committee Cycle of Business & Committee Workplan In relation to Mental Health &	Angela Wood / Philippa Peake-Jones /	December 2024	Suggest close These have been added to the cycle of business and will be received in due course

			Learning Disabilities, these need to be added as two separate items (1) Mental Health and (2) Learning Disabilities. Primary Care to be added onto the Cycle of Business. Revised Cycle of Business to be presented at December meeting.			
20.	**QS24/104.2**		**QS24/104 Meeting Effectiveness** **It was agreed to extend the length of future meetings to 4 hours, allowing more time for in-depth discussion.**	**Philippa Peake-Jones / Fiona Lewis**	**October 2024**	**Suggest close** **It was agreed at agenda setting to leave the timing of the meeting as 3.5 hours**

Flow chart G4/G5 Complaint Approvals

Step 1
- Complaint received from a Complainant - **within1 day**

Step 2
- First Contact Form completed by corporate complaints administration and submit for Triage - **within 1 day**

Step 3
- Corporate Complaints team triage complaint (Grade 1- 5) - **within 2 days**

Step 4
- Corporate Complaints team to log the complaint on RL Datix Cymru and allocate the complaint to an Investigaiton Officer (IO) - **within2 days**

Step 5
- Corporate complaints team provides appropriate acknowledgement letter to complainant.- **by Day 5 or sooner**

Step 6
- IO commences their investigations - **Day 5 of complaint being received or sooner**

Key: Orange – Corporate Complaints Blue – IHC / Service Black – Executive Team

Flow chart G4/G5 Complaint Approvals

Step 7
- IHC / Service undertakes Investigation, including attending PTR Clinic. Upon completion of the report, the IO submits the report with Divisional - **Day 5 to 20 (15 days)**

Step 8
- Once the complaint has received Divisional approval, the report is then submitted to Corporate QA inbox BCU.ComplaintsQA@wales.nhs.uk or to Healthcare Law Team, if harm has been identified - **Day 21 - 26 (5 days)**
- **If the complaint identifies harm qualifyng liability above £25,000, this will go to Legal Services**

Step 9
- Upon arrival of the QA'd report, the Corporate Complaints team will produce a Regulation letter to accompany the report. It will then submit the Regulation (Cover letter), Investigation Report and divisional approval to the BCU Approvals hub BCU.ComplaintsApprovals@wales.nhs.uk for Exec Approval. - **Day 27**

Step 10
- Complaint is reviewed by Deputy Executive Director of Nursing, Mandy Jones - **Day 28**

Step 11
- Complaint is reviewed by Exectuive Director of Nursing, Angela Wood - **Day 29**

Step 12
- Upon approval, Corporate Complaints team sends out Investigation report and covering letter to compliainant - **Day 30**

Key: **Orange – Corporate Complaints** **Blue – IHC / Service** **Black – Executive Team**

Flow chart G4/G5 Complaint Approvals

•Corporate Complaints team closes complaint on RL Datix Cymru, with Approved and Signed report uploaded - **Day 30**

Key: **Orange – Corporate Complaints** **Blue – IHC / Service** **Black – Executive Team**

Complaints Improvement Deep Dive

QSE Committee

December 2024

BCUHB OVERALL COMPLAINTS POSITION (as of 2ND December, 2024)

Total Complaints open = 179

Total Complaints Overdue = 43

Compliance = 75.98%

Between 15th April and 2nd December there has been a reduction of 73.36% in total open complaints (672 to 179)

Between 15th April and 2nd December there has been a reduction of 89.95% in overdue complaints (428 to 43)

Number of complaints received (1st April, 2024 to 25th November, 2024) = 1,750

Number of complaints closed (1st April, 2024 to 25th November, 2024) = 2,267

Positive Variance of Closures = 517

BCUHB OVERALL COMPLAINTS POSITION (as of 2nd December, 2024)

Fig 2. Overall Position (Actual)
No of Open Complaints/Wk Managed under PTR

Legend: <=30 Days, 31-180 Days, Over 180 Days, Total No Open

Week	Total No Open
01-Apr	660
08-Apr	654
15-Apr	672
22-Apr	643
29-Apr	558
06-May	596
13-May	598
20-May	574
27-May	549
03-Jun	510
10-Jun	522
17-Jun	499
24-Jun	481
01-Jul	479
08-Jul	499
15-Jul	461
22-Jul	477
29-Jul	483
05-Aug	484
12-Aug	484
19-Aug	460
26-Aug	434
02-Sep	435
09-Sep	431
16-Sep	433
23-Sep	393
30-Sep	373
07-Oct	297
14-Oct	230
21-Oct	217
28-Oct	221
04-Nov	209
11-Nov	182
18-Nov	182
25-Nov	192
02-Dec	179

Produced by the Health Board's Quality Directorate

BCUHB COMPLIANCE PERCENTAGE

Fig 1 - Compliance with Targets 75% of Complaints Closed <=30 Working Days AND <=250 Open Complaints

No of Complaints: 0, 100, 200, 300, 400, 500, 600, 700, 800

(%) Compliance: 0.00%, 10.00%, 20.00%, 30.00%, 40.00%, 50.00%, 60.00%, 70.00%, 80.00%, 90.00%, 100.00%

01-Apr 36.21%
08-Apr 36.54%
15-Apr 36.31%
22-Apr 34.68%
29-Apr 35.13%
06-May 34.40%
13-May 36.96%
20-May 33.97%
27-May 37.52%
03-Jun 39.80%
10-Jun 40.80%
17-Jun 41.28%
24-Jun 43.04%
01-Jul 43.63%
08-Jul 46.69%
15-Jul 45.77%
22-Jul 48.43%
29-Jul 47.00%
05-Aug 45.45%
12-Aug 43.39%
19-Aug 44.35%
26-Aug 43.55%
02-Sep 42.07%
09-Sep 42.92%
16-Sep 45.03%
23-Sep 47.07%
30-Sep 51.74%
07-Oct 58.92%
14-Oct 66.52%
21-Oct 66.82%
28-Oct 63.35%
04-Nov 63.64%
11-Nov 69.23%
18-Nov 72.53%
25-Nov 76.56%
02-Dec 75.98%

No Open | No Overdue | No Closed | Target No Open (BCUB) | % Compliance | Target Compliance

BCUHB OVERALL COMPLAINTS CLOSED / RECIEVED

Fig 4 Overall Positon (Actual)
No of Complaints Received & Closed /WK

140
120
100
80
60
40
20
0

01-Apr 08-Apr 15-Apr 22-Apr 29-Apr 06-May 13-May 20-May 27-May 03-Jun 10-Jun 17-Jun 24-Jun 01-Jul 08-Jul 15-Jul 22-Jul 29-Jul 05-Aug 12-Aug 19-Aug 26-Aug 02-Sep 09-Sep 16-Sep 23-Sep 30-Sep 07-Oct 14-Oct 21-Oct 28-Oct 04-Nov 11-Nov 18-Nov 25-Nov

No Closed   No Received

(as of 2nd December, 2024)

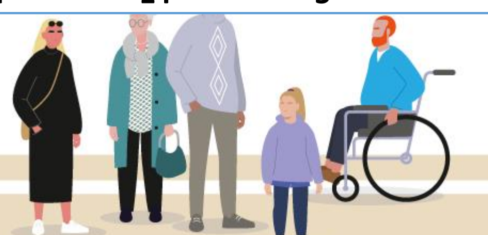
BCUHB Overall Complaints By Grade / Time Open

Calendar Months	Grade 1	Grade 2	Grade 3	Grade 4	Grade 5	Grand Total
<= 1 Mnth	9	36	53	16	1	115
Over 1 Mnth	4	10	13	7	1	35
Over 2 Mnths		1	2	4	2	9
Over 3 Mnths			3	1	3	7
Over 4 Mnths		1		1		2
Over 5 Mnths			1			1
Over 6 Mnths		1	1	1	1	4
Over 7 Mnths				1		1
Over 8 Mnths				1		1
Over 12 Mnths			1	1	1	3
Over 18 Mnths				1		1
Grand Total	**13**	**49**	**74**	**34**	**9**	**179**

(as of 2nd December)

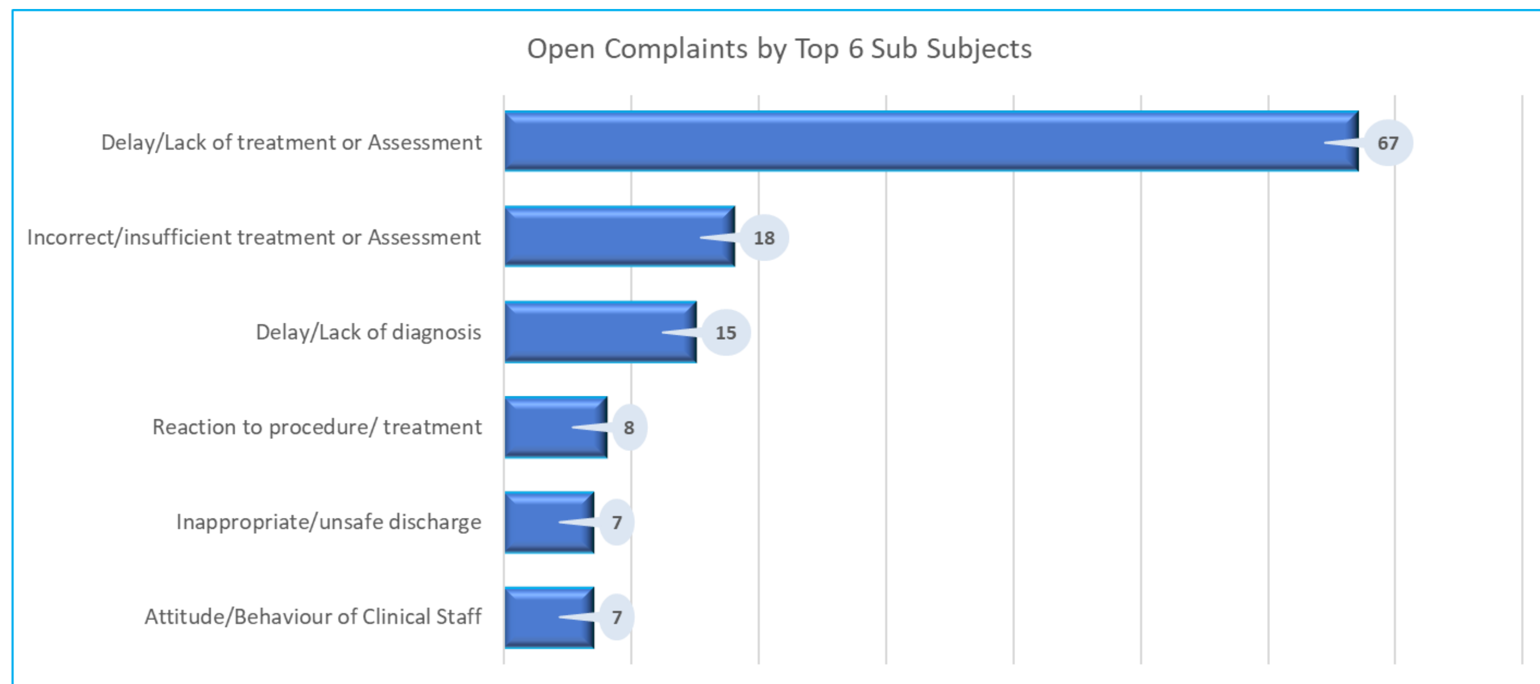
BCUHB Overall Complaints By Service / Time open

Calendar Months	IHC Central	IHC East	IHC West	Mental Health and Learning Disabilities	Midwifery and Women's Services	Diagnostics and Specialist Clinical Support Services	Corporate Services	Dentistry	Cancer Services	Grand Total
<= 1 Mnth	31	36	22	7	11	4	1	2	1	115
Over 1 Mnth	13	7	3	7	1	1	3			35
Over 2 Mnths	6	1	1					1		9
Over 3 Mnths	5	1							1	7
Over 4 Mnths	1				1					2
Over 5 Mnths	1									1
Over 6 Mnths	3								1	4
Over 7 Mnths					1					1
Over 8 Mnths	1									1
Over 9 Mnths										
Over 10 Mnths										
Over 11 Mnths										
Over 12 Mnths	3									3
Over 18 Mnths		1								1
Grand Total	**64**	**46**	**26**	**14**	**14**	**5**	**4**	**3**	**3**	**179**



(as of 2nd December, 2024)

BCUHB Overall Complaints open by top 6 themes



Sub Subjects	Count of ID
Attitude/Behaviour of Clinical Staff	7
Inappropriate/unsafe discharge	7
Reaction to procedure/ treatment	8
Delay/Lack of diagnosis	15
Incorrect/insufficient treatment or Assessment	18
Delay/Lack of treatment or Assessment	67
Grand Total	**122**

Delay / Lack of treatment or assessment is our biggest theme equating for 67 / 179 total open complaints (37.4%)
The top 6 themes equate for 122/179 as detailed above of the total number of open complaints (68.15%)

(as of 2nd December, 2024)

BCUHB Overall Complaints open by top 6 themes broken down IHC (as of 2nd December, 2024)

IHC East	38
Incorrect/insufficient treatment or A	12
Delay/Lack of treatment or Assessm	10
Delay/Lack of diagnosis	3
Inappropriate/unsafe discharge	3
Failure to follow end of life pathway	2
Attitude/Behaviour of Clinical Staff	2
Medication not prescribed	2
Incorrect diagnosis	2
Incorrect medication given	2

IHC Central	56
Delay/Lack of treatment or Assessm	39
Delay/Lack of diagnosis	6
Inappropriate/unsafe discharge	3
Reaction to procedure/ treatment	3
Communication with patient/servic	3
Attitude/Behaviour of Clinical Staff	2

IHC West	26
Delay/Lack of treatment or Assessm	10
Incorrect/insufficient treatment or A	4
Incorrect diagnosis	2
Delay in appointment/waiting time/	2
Delay/Lack of diagnosis	2
Incorrect medication given	1
Compliment regarding clinical treat	1
Handling of patients	1
Address/Location issues	1
Attitude/Behaviour of Clinical Staff	1
Inappropriate/unsafe discharge	1

BCUHB Overall Complaints open by top 6 themes broken down by Division (as of 2nd December, 2024)

Midwifery and Women's Services	14
Delay/Lack of treatment or Assessm	5
Reaction to procedure/ treatment	3
Delay/Lack of diagnosis	2
Incorrect/insufficient treatment or /	1
Insufficient/Incorrect information	1
Delay in appointment/waiting time/	1
Inappropriate information in the rec	1

Diagnostics and Specialist Clinical Sup	5
Incorrect diagnosis	2
Delay/Lack of diagnosis	1
Patient booked into wrong outpatie	1
Test results not acted upon	1

Cancer Services	3
Communication with patient/servic	1
Reaction to procedure/ treatment	1
Delay/Lack of treatment or Assessm	1

Corporate Services	4
Availability of medication	1
Communication with patient/servic	1
Alleged Physical Assault	1
Breach in confidentiality	1

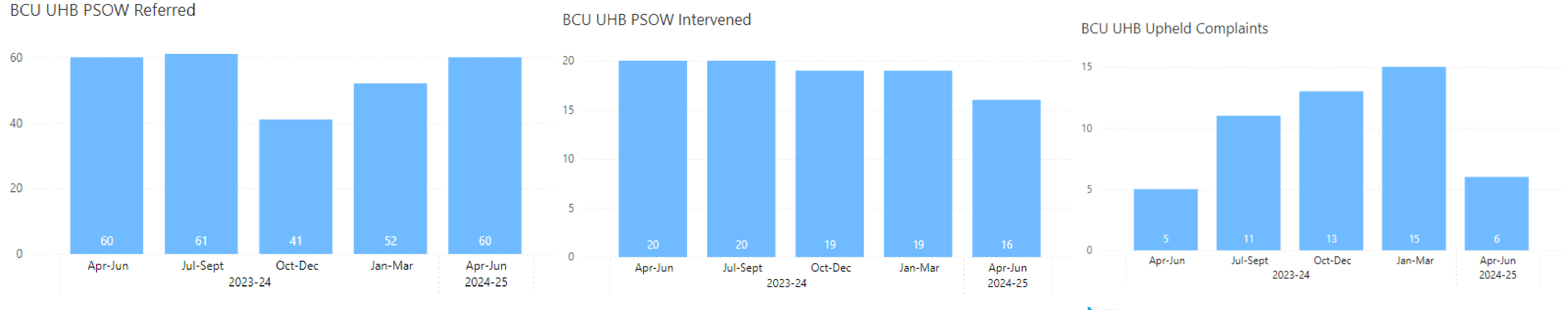
Dentistry	3
Attitude/Behaviour of Clinical Staff	1
Lack of/No funding available under	1
Delay in appointment/waiting time/	1

Mental Health and Learning Disabilitie	14
Inappropriate information in the rec	2
Delay/Lack of treatment or Assessm	2
Response to Patient needs	1
Inappropriate restraint issues	1
Availability of medication	1
Communication with patient/servic	1
Incorrect/insufficient treatment or /	1
Delay/Lack of diagnosis	1
Lack of/No funding for patient outsi	1
Access to own medication	1
Communication with family	1
Attitude/Behaviour of Clinical Staff	1

Assurance - Public Services Ombudsman Wales

Comparing quarter 1 (April-June, 2023) and Quarter 1 (April- June 2024) – Source Beacon Dashboard

- The same number of cases were referred to the Ombudsman (60)
- The PSOW intervened in 4 less cases (20 to 16)
- The PSOW Upheld 1 more complaint (5 to 6)



Assurance – Timely Responses

We are currently closing complaints in an average of 34.74 days, which has reduced from 58.98 days in April, 2024. This, figure includes all complaints so is influenced by long standing complaints to which are longest complaint has been open 393 days, due to complexity and ongoing expert opinions.

The Beacon Dashboard shows the percentage of complaints Resolved within 30 days as follows

April 2021 – 2022 = 61.81%

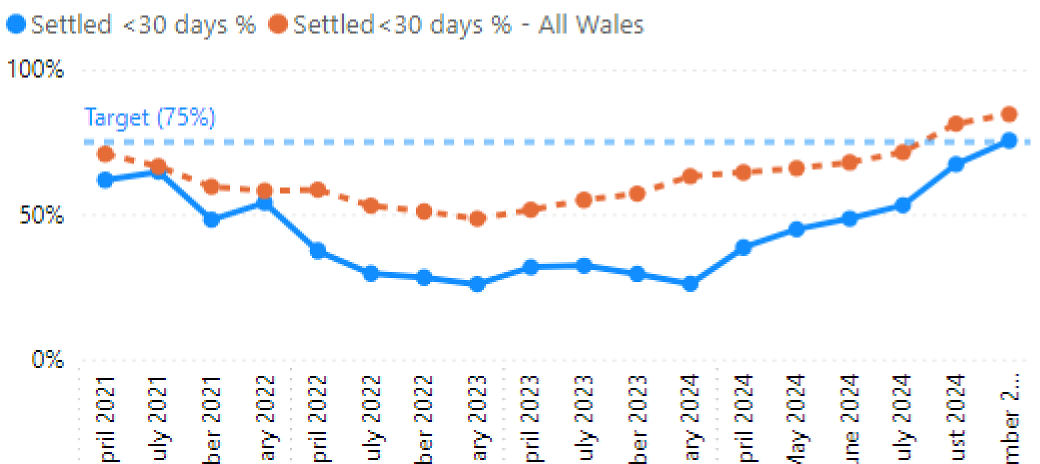
April 2022 – 2023 = 37.43%

April 2023 – 2024 = 38.55%

September 2024 = 75.47%

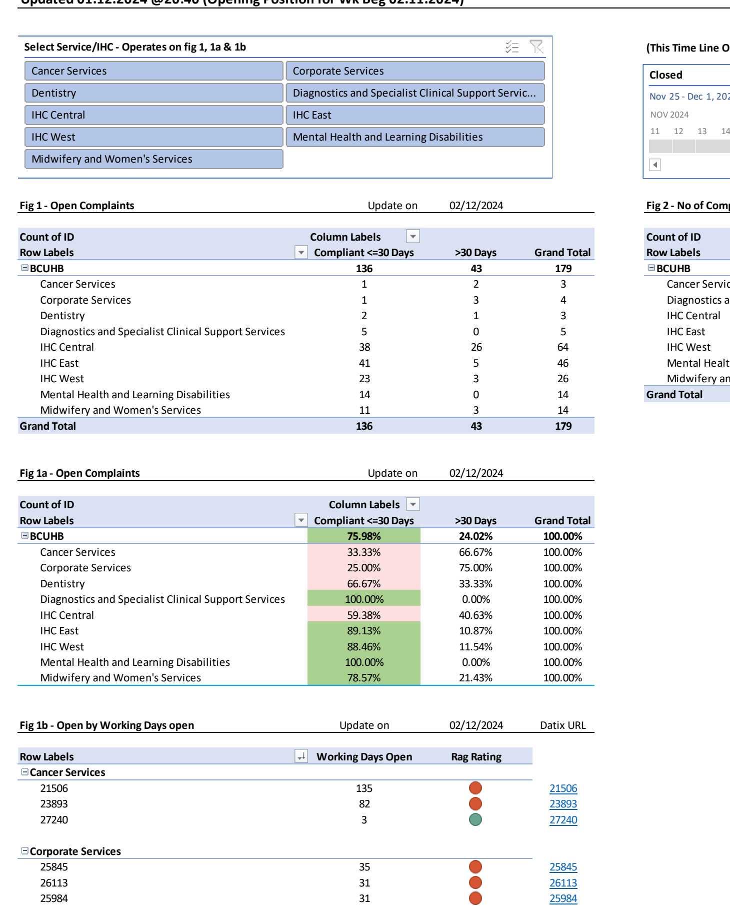
We are resolving more complaints within PTR guidelines, with an expectation that this position will improve further

The national average In September was 84.6%



Assurance – Data

Three times a week data is generated, validated and provided to IHC's / Services – Examples below



Updated 01.12.2024 @20:40 (Opening Position for Wk Beg 02.11.2024)

Select Service/IHC - Operates on fig 1, 1a & 1b

Cancer Services	Corporate Services
Dentistry	Diagnostics and Specialist Clinical Support Servic...
IHC Central	IHC East
IHC West	Mental Health and Learning Disabilities
Midwifery and Women's Services	

Fig 1 - Open Complaints   Update on 02/12/2024

Count of ID / Row Labels	Column Labels: Compliant <=30 Days	>30 Days	Grand Total
BCUHB	136	43	179
Cancer Services	1	2	3
Corporate Services	1	3	4
Dentistry	2	1	3
Diagnostics and Specialist Clinical Support Services	5	0	5
IHC Central	38	26	64
IHC East	41	5	46
IHC West	23	3	26
Mental Health and Learning Disabilities	14	0	14
Midwifery and Women's Services	11	3	14
Grand Total	136	43	179

Fig 1a - Open Complaints   Update on 02/12/2024

Count of ID / Row Labels	Column Labels: Compliant <=30 Days	>30 Days	Grand Total
BCUHB	75.98%	24.02%	100.00%
Cancer Services	33.33%	66.67%	100.00%
Corporate Services	25.00%	75.00%	100.00%
Dentistry	66.67%	33.33%	100.00%
Diagnostics and Specialist Clinical Support Services	100.00%	0.00%	100.00%
IHC Central	59.38%	40.63%	100.00%
IHC East	89.13%	10.87%	100.00%
IHC West	88.46%	11.54%	100.00%
Mental Health and Learning Disabilities	100.00%	0.00%	100.00%
Midwifery and Women's Services	78.57%	21.43%	100.00%

Fig 1b - Open by Working Days open   Update on 02/12/2024   Datix URL

Row Labels	Working Days Open	Rag Rating	Datix URL
Cancer Services			
21506	135		21506
23893	82		23893
27240	3		27240
Corporate Services			
25845	35		25845
26113	31		26113
25984	31		25984
26936	12		26936
Dentistry			
24951	58		24951

(This Time Line Operates on Fig 2 Only)

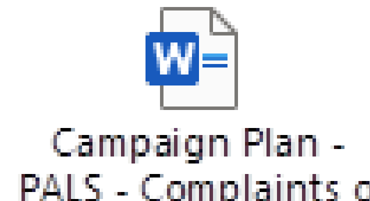
Fig 2 - No of Complaints Closed

Count of ID / Row Labels	Column Labels: Compliant <=30 days
BCUHB	39
Cancer Services	2
Diagnostics and Specialist Clinical Support Services	
IHC Central	10
IHC East	7
IHC West	17
Mental Health and Learning Disabilities	2
Midwifery and Women's Services	1
Grand Total	39

What the data shows us

- We are closing more complaints per week in 2024/2025-Qtrs 1&2 than was the case in 2023/2024-Qtrs 3&4
- We are closing more complaints per week in 2024/2025-Qtrs 1&2 within the target of 30 working days than was the case in 2023/2024-Qtrs 3&4
- We are addressing complaints quicker, with average time to close complaints in 2024/2025-Qtrs 1&2 is less than in 2023/2024-Qtrs 3&4
- We have sustained a reduction in complaints remaining open, which has decreased on a weekly basis in 2024/2025-Qtrs 1&2 compared to 2023/2024-Qtrs 3&4

Assurance – Communication Plan



The Objective of the plan

A relaunch the Health Board's Patient Advice and Liaison Service (PALS) / Complaints through online platforms, ensuring the public how to raise a concern of complaint commenced on 1st October, 2024

Intranet and External Websites

A new "Report it" page is available on Betsi Net, which details how staff can support the public in raising a concern or complaint.

Concerns Portal - Home

A new external public facing web pages are now available to make it easier for people to locate how to make a complaint or raise a concern

Support, Concerns and Complaints: Who to Contact - Betsi Cadwaladr University Health Board

How have we done this?

Business Intelligence

The IRIS Dashboard has enabled complaints performance data to support the complaints trajectories for the IHC and support services since the 1st of June 2024. This is supported by extensive data issued 3 times weekly

Improvement Collaborative

The Complaints Improvement Collaborative which commenced in June 2024 focussing on Tests of Change to support the improvements in the overall complaints position.

Integrated Concerns /Incidents/ Complaints Hub

An integrated approach to the BCUHB management of complaints / mortality and incidents, including standing operating procedures, joint policies and standardised templates, which should improve both efficiency and accuracy has been implemented.

How have we done this?

Scrutiny Meetings

Each Integrated Health Community (IHC) has adopted weekly Putting Thing Right Meetings to manage the progress of complaints received. The Deputy Executive Director of Nursing continues to lead weekly improvement meetings with the services, targeting support to facilitate resolution of complaints.

Planned Care – The 3P's

The patient experience team are working closely with the development of the 3P's approach, which will prioritise, diagnosis and treatment, increase health service capacity and provide better information and support to patients, including setting appropriate expectations and improving communication

Revised Templates

Improved templates incorporating guidance on report writing

Thank you for Listening

Questions?

<table>
<tr><td colspan="2">Teitl adroddiad:
Report title:</td><td colspan="4">Patient Story: Gareth’s Story
Stori Claf: Stori Gareth</td></tr>
<tr><td colspan="2">Adrodd i:
Report to:</td><td colspan="4">QSE Committee</td></tr>
<tr><td colspan="2">Dyddiad y Cyfarfod:
Date of Meeting:</td><td colspan="4">17th December 2024</td></tr>
<tr><td colspan="2">Crynodeb Gweithredol:
Executive Summary:</td><td colspan="4">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.</td></tr>
<tr><td colspan="2">Argymhellion:
Recommendations:</td><td colspan="4">QSE Committee is asked to note this report.</td></tr>
<tr><td colspan="2">Arweinydd Gweithredol:
Executive Lead:</td><td colspan="4">Angela Wood, Executive Director of Nursing and Midwifery</td></tr>
<tr><td colspan="2">Awdur yr Adroddiad:
Report Author:</td><td colspan="4">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</td></tr>
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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
☐
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>
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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>
<tr><td colspan="6">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.</td></tr>
<tr><td colspan="3">Cyswllt ag Amcan/Amcanion Strategol:
Link to Strategic Objective(s):</td><td colspan="3">Quality</td></tr>
<tr><td colspan="3">Goblygiadau rheoleiddio a lleol:
Regulatory and legal implications:</td><td colspan="3">N/A</td></tr>
<tr><td colspan="3">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/A</td></tr>
<tr><td colspan="3">Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal?</td><td colspan="3">N/A</td></tr>
</table>

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: Gareth's Story - ENGLISH SUBTITLES.mov Gareth's Story - 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 and CIVICA ***List of Appendices:*** Appendix A- Patient Story Summary	

Betsi Cadwaladr University Health Board

Gareth's Story / Stori Gareth

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

Overview of Patient Story

Gareth's story is told by his mum and fiancée.

Gareth was a young man who attended Wrexham Maelor Hospital in June 2023. Gareth experienced care in both the Emergency Department (ED) and Intensive Care Unit (ICU).

Gareth unfortunately passed away, but through organ donation, Gareth has saved and transformed four other people and their lives.

Gareth's family approached the Patient and Carer Experience Team as they wanted to share Gareth's story, which touches on aspects of care he received at Wrexham Maelor Hospital as well as the Organ Donation Team.

Key Messages

Emergency Department:
- Escalation of concerns with regards to wait for triage.
- Delay in care and treatment in ED.
- Known medical history of haemophilia – CT scan showed bleed on brain.

Intensive Care Unit:
- Nurses described as wonderful, showing kindness and compassion.
- Privacy provided for family and friends to spend precious time with Gareth to say their goodbyes.
- Familiarity and continuity in Gareth's care.
- Theatre team described as kind, caring and utterly professional.

Organ Donation:
- Organ Donation Specialist Nurse described as professional, compassionate, and sensitive.
- Gareth had agreed to organ donation on three separate occasions. Gareth's family supported the decision he had made in life to become an organ donor.
- Gareth donated his heart, lungs, and kidneys and gave the gift of life to four other people through organ donation.

Summary of Learning and Improvement

The storytellers describe from their perspective delays in communication and treatment in relation to Gareth's care within the Emergency Department in Wrexham Maelor Hospital.

The patient story has been shared widely across the Emergency Department for feedback and learning.

The Emergency Department Matron and Deputy Clinical Director for ED met with Gareth's family in September 2023 to discuss their concerns as part of a Bereavement Recall. (The family did not wish for their concerns to be raised as a formal complaint but requested that Gareth's journey through the Emergency Department was reviewed). The Head of Nursing for Emergency Care and Associate Director of Nursing were updated on the concerns raised and a Make It Safe (MIS) incident investigation review was undertaken and recorded on Datix, a system the Health Board uses to log incidents.

The MIS Review took place in September 2023, by the Head of Nursing for Emergency Care, Emergency Department Matron, Emergency Department Consultant, Lead Manager for Emergency Care and a member of the Clinical Governance team. The MIS Review was presented at the Putting Things Right (PTR) meeting. At the PTR meeting, incidents where learning has been identified are discussed and shared for wider learning across the Integrated Health Community (IHC), and subsequently the Health Board as a whole, where appropriate. This meeting was chaired by the Associate Director of Nursing in October 2023 and the MIS report was discussed with attendees from across the East Integrated Health Community.

The outcome and contents of the MIS Review were initially discussed with the family over the phone in November 2023 to ensure that all queries and concerns had been addressed prior to the final MIS Review document being shared. The final version of the MIS Report was shared with the family in January 2024, with an offer to meet in person to discuss the content of the report. It was also reviewed again at a PTR meeting for shared learning.

The Emergency Department key improvement actions identified and completed following the family's account of their experience:

- Review of processes for allocation to triage overnight, ensuring on the allocation sheet the identification of the triage nurse available to cover during breaks is clearly documented and communicated to staff.
- Review of current escalation process from reception to triage nurse and shift coordinator for 'Red Flag' patients of concern.
- Communications shared with reception staff to reinforce need to escalate patients of concern to Nurse-in-Charge of ED in addition to triage nurse.
- Increased oversight of patients cared for in waiting room, with implementation of a waiting room nurse in the ED overnight.
- Review if / which haematology patients should be flagged (with the addition of an alert) on the symphony system.

Additional areas of improvement identified by the Haematology Service include:

- To place an alert on Synapse for patients with a bleeding disorder.
- To place an action plan on Synapse with necessary information.
- To commence a clinic for patients with bleeding disorders every 3-4 months (from April 2024).
- To provide patients with bleeding disorder card if they don't have any.
- To educate patients more about the alarming signs/symptoms of patients with a bleeding disorder.

- Introduce the local team to make patients aware of help available for their issues locally, and to educate them on whom to contact for assistance.

The storytellers described the wonderful, kind and compassionate care received from the nurses in ICU, both providing familiarity and continuity in Gareth's care and providing support to them as his loved ones.

This patient story has been shared widely with staff members across Critical Care including the Surgical, Anaesthetics and Critical Care Directorate Lead Manager, Critical Care Matron, Clinical Lead and Senior Sisters. The purpose of this is to cascade this story for learning across the three Integrated Health Community teams.

The Critical Care team strive to provide the best possible care for patients, their relatives, carers and visitors. If a patient passes away on Critical Care, the staff focus upon ensuring the patient's comfort and dignity during their last moments and making everything as supportive and calm as possible for their loved ones. Visiting becomes unrestricted during this time, to allow family and friends to spend as much time as they would like to say their goodbyes.

Following the passing of a loved one on Critical Care, relatives are offered a Memory Box. An information booklet is given to the relative to sensitively guide them through the practicalities and requirements following a death. The memory box also contains a lock of their loved one's hair, their hand print, a candle, forget-me-not seeds and a wooden heart which splits into two, a part to stay with the loved one that has passed away and a part for the relatives to keep. A teddy bear is also offered to young children and this can contain the heartbeat of their loved one that has passed away. The relatives are also offered a copy of the 'Patient Diary' that is given to all patients of Critical Care, and is contributed to during their time on the ward by everyone involved with the patient, including nursing staff and loved ones.

The Critical Care Team offer a standard follow-up service to all patients who have had and admission to the Critical Care Unit, regardless of length of stay or level of care, to offer psychological and emotional support to both patients and their relatives. For those relatives who have sadly lost a loved one in Critical Care, a Bereavement Support Service is offered. Relatives are sent a condolence card three weeks following the patient's death, allowing time for a funeral to have taken place. This is not a counselling service, but is an opportunity for relatives to ask questions, receive clarification of the events which occurred whilst their loved one was in Critical Care and to process what happened to their loved one, especially when they lose a loved one quickly. This is a Nurse-led clinic and appointments are tailored to the relative's individual needs. Some relatives need one appointment and others need multiple. They can also be referred on to other agencies for additional help and support.

The team also run a quarterly Wrexham Critical Care Support Group which is held in the community and provides patients and their families the opportunity to meet and talk with others who have shared similar experiences in a relaxed environment. The group is feedback-led and guest speakers arranged. It has also contributed to the development of support relationships outside the group. The group also offers several social media accounts, providing an opportunity for patients and relatives to communicate with both Critical Care and each other.

The Critical Care Team have also set up an annual Bereavement Memorial Service to honour, remember and give thanks for the life of a loved one who has passed away on Critical Care during the last 12 months – all names are read out during the service. The act of remembrance is marked by the lighting of candles, the writing of messages and a memory tree. The service is attended by the Wrexham Wellbeing Choir and provides an opportunity to chat with the Bereavement Team. This years' service will be held on Monday 2nd December 2024 at 7pm at St Giles Parish Church in Wrexham.

To further support patient, relative and carer experiences, the Critical Care Team have recently undertaken a Quality Improvement Project. They have created general information and support guides for relatives when their loved one has been admitted to the unit at Wrexham Maelor Hospital, as well as an information wall along the corridor leading up to the ward with QR codes that can be scanned to access additional information and support. The resources are being supported by the Patient and Carer Experience Team via review at the Health Board Patient Information Readers Panel.

Over the last four years, the team has raised money to create a dedicated Critical Care Garden, the creation of which is imminent. This will offer a bespoke sensory garden that can be accessed by patients, their loved ones, and pets to ease the psychological burden of a long-stay on Critical Care and space for relaxation and contemplation.

The Wrexham Critical Care Team were recently finalists in the BCUHB Achievement Awards 2024 in the 'Extra Mile Award' category which is awarded to an individual / team that has gone beyond the call of duty and their job description, demonstrating core BCUHB values and exceptional commitment to their role and patient care.

Gareth had agreed to donate his organs and the storytellers share that as a family they supported the decision he had made in life to become an organ donor. Gareth donated his heart, lungs, and kidneys and gave the gift of life to four other people through organ donation.

The patient story has been shared across Organ Donation Team including the NHS Blood and Transplant (NHSBT) Service via the BCUHB Specialist Organ and Tissue Donation Nurses and the BCUHB Organ Donation Committee Lead. Services have been asked to cascade Gareth's story across the three Integrated Health Community teams and wider NHS Blood and Transplant Service for learning and to act as a celebration of the lives that Gareth saved.

The Health Board Organ Donation Team comprises three Specialist Organ and Tissue Donation Nurses. They are based at each District General Hospital and accompanied by a Consultant within each site ICU, who acts as lead for Organ Donation. They are supported by the North West Regional Consultant Lead, who is based at Ysbyty Gwynedd.

NHS Blood and Transplant Team reported that during 2023/24 from 15 consented donors, Betsi Cadwaladr University Health Board facilitated 13 actual solid organ donors, which resulted in 32 patients receiving a transplant during this period. Additionally, 20 corneas were received by NHSBT Eye Banks from patients of the Health Board.

When compared with national data for the same period, the Health Board was in line with the national average for the referral of potential organ donors and considered exceptional

for Specialist Nurse presence, when approaching families to discuss organ donation and collaborative working. The Health Board referred 146 patients to NHSBT's Organ Donation Services Team, with 87 patients meeting the referral criteria. A Specialist Nurse was present for all 18 organ donation discussions with families of eligible donors.

In Wales, 44% of the population have registered an NHSBT Organ Donor Register (ODR) opt-in decision, which compares to 42% of the population nationally. This matters because in 2023/24, 154 people benefited from a solid organ transplant in Wales.

The BCUHB Organ and Tissue Donation Committee organises a yearly fundraising and awareness walk up Snowdon to coincide with Organ Donation Week, which takes place during September. The Committee also holds an annual Gift of Life Memorial Service to honour all organ and tissue donors, recipients, and their families from North Wales. This service of remembrance gives thanks for donations that have not only saved lives but also improved the quality of life of so many others. This years' service will be held on Saturday 16th November 2024 at 2pm in St Asaph Cathedral.

Earlier this year there has been a ministerial directive via the Welsh Government relating to 'Martha's Law', otherwise known as 'Call4Concern'. This initiative allows patients and their families to get an urgent clinical review if they believe their concerns about deterioration are not being taken seriously by clinical staff. Ysbyty Gwynedd are currently running the Call4Concern initiative. Due to the recent government direction, there are plans to roll this out across Welsh Health Boards. Welsh Government officials have been working with key stakeholders to develop a plan to introduce this patient safety protocol across Wales.

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 Health Board would like to express its sincerest condolences to Gareth's family at this extremely sad time. The Patient and Carer Experience Team extend their gratitude and appreciation to the storytellers for sharing Gareth's story.

Teitl adroddiad: ***Report title:***	**Learning Disability Services Update – Quality, Safety and Experience**
Adrodd i: ***Report to:***	BCUHB Quality, Safety and Experience Committee
Dyddiad y Cyfarfod: ***Date of Meeting:***	Tuesday, 17 December 2024
Crynodeb Gweithredol: ***Executive Summary:***	Following a request by the Chair of the QSE Committee for an update on Learning Disability Services, this report provides a comprehensive overview of BCUHB Pan North Wales Learning Disability Services aligned to Quality, Safety and Experience. The North Wales Learning Disability Service (NWLDS) is governed by the Health and Care Quality Standards 2023, and ensures the six domains, supported by the six quality enablers, inform quality management practice and underpin strategic plans to continue to meet the needs of the Learning Disability (LD) population of North Wales. The NWLDS work alongside Local Authority Partners, embedding a person-centred ethos ensuring equitable care, which includes the voice of carers and families to ensure positive patient outcomes. The continued development of a whole-systems approach identifies the reduction of known health inequalities, avoidable deaths and the commitment to improve the health of all adults with a learning disability across North Wales.
Argymhellion: ***Recommendations:***	The Committee is asked to note the contents of this report in relation to the Learning Disability commitment to its continuing improvement journey, and specifically: • **Consider** the Learning Disability Update Report in relation to quality, safety and experience alongside longer-term data and the Learning Disability programme priorities for the Health Board's Annual Plan 2025/2026. • **Consider** the approach of Learning Disability Services in the discharge of the outlined actions to address the priorities for service development and quality improvement. • **Consider** progress against the Welsh Government Learning Disability Strategic Action Plan (2022 to 2026). • **Note** the progression of the work to develop the Enhanced Community Residential Services Intermediate Care Business Case.
Arweinydd Gweithredol: ***Executive Lead:***	Teresa Owen, Executive Director of Allied Health Professionals and Health Science
Awdur yr Adroddiad: ***Report Author:***	Nichaela Jones, Interim Head of Operations and Service Delivery, Regional Specialist Services Sean Gallagher, Interim Head of Nursing, Regional Specialist Services

<table>
<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>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

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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="6">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="3">Cyswllt ag Amcan/Amcanion Strategol:

Link to Strategic Objective(s):</td><td colspan="3">• BCUHB’s Three Year Plan 2024-2027
• Outcome 3 - Creating compassionate culture, leadership and engagement
• Outcome 4 – Improving quality, outcomes and experience
• Outcome 5 – Establishing an effective environment for learning</td></tr>
<tr><td colspan="3">Goblygiadau rheoleiddio a lleol:

Regulatory and legal implications:</td><td colspan="3">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 to 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.</td></tr>
<tr><td colspan="3">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/A</td></tr>
</table>

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 21-05: Effective Stakeholder Relationships. • BAF 21-06: Safe and Effective Mental Health and Learning Disability Service Delivery. There is a risk to the safe and effective delivery of Mental Health and Learning Disability Services. • Strategic Priority P18 Quality, Innovation and Improvement.
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	• The Enhanced Community Residential Service (ECRS) Business case is aiming to be a cost saving project. • The Pooled Budget Section 33 agreement has financial contributions committed by both the Ynys Môn Local Authority and BCUHB LD Services Continuing Health Care budget.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	Enhancing / optimising the workforce aligned to the Enhanced Community Residential Service intermediate care provision.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	• Contents were reviewed at the local Learning Disability Service Quality Delivery Group and MH&LD Divisional Leadership meeting. • This paper has been prepared specifically to provide an update for the QSE Committee.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	CRR 24-04 (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:

- To continue to progress actions and recommendations aligned to the Learning Disabilities Strategic action plan (2022 to 2026)
- To await the outcome of the Enhanced Community Residential Services: Intermediate Care Business Case and if approved through usual HB processes to progress with recommendations.

17th December 2024

Learning Disability Services Overview

1. Introduction:

The latest North Wales population assessment (2022) identified that there are around 13,000 people with a Learning Disability in North Wales.

In 2018 BCUHB (Betsi Cadwaladr University Health Board), in partnership with the six Local Authorities and with support from the North Wales Regional Collaboration Unit, developed and commenced implementation of the North Wales Learning Disability Strategy (NWLDS) 2018 to 2023. The delivery of the strategy was initially funded from the Welsh Government "Healthier Wales" initiative. Due to the pandemic, the NWLDS was extended to enable continued delivery of the strategy and the programme of works until 2025. Currently BCUHB, in partnership with the six Local Authorities, are working in collaboration to review the works completed to date to support the evaluation and refresh of the NWLDS.

The strategic priorities aligned to the NWLDS and the Welsh Government Learning Disabilities Strategic Action Plan (2022- 2026) are reflected in the BCUHB Annual Plan, and are monitored and reviewed by the LD (Learning Disability) Improvement Programme Group feeding into Divisional and strategic partner forums. The NWLDS Strategy is included in **Appendix 1**.

BCUHB Learning Disability Services are a pan North Wales provision comprising of LD Inpatient bed provision namely two assessment and Treatment units, one Continuing Healthcare facility, comprising of 4 separate units and a therapeutic support service. These are all based on the Bryn y Neuadd Hospital site. In addition, there are six LD Community Teams co-located with Local Authorities partners and a Pan North Wales provision including Learning Disability Health Liaison, Specialist Behaviour Support Services and the Enhanced Community Residential Service (ECRS).

The North Wales Learning Disability Services (NWLDS), is governed by the Health and Care Quality Standards 2023, and ensures the six domains, supported by the six quality enablers, inform quality management practice and underpin strategic plans to continue to meet the needs of the Learning Disability (LD) population of North Wales. The domains and enablers are listed below:

Health and Care Quality Standard Domains	Health and Care Quality Standard Enablers
Safe	Leadership
Effective	Workforce
Person Centred	Culture
Timely	Information
Efficient	Learning
Equitable	Improvement and Research

The NWLDS in partnership with Local Authority partners, aims to embed a person-centred ethos ensuring equitable care, which recognises that listening to the voice of carers and families is integral to ensuring positive patient outcomes. The continued development of a whole-systems approach focuses on the reduction of known health inequalities, avoidable deaths and the commitment to improve the health of all adults with a learning disability across North Wales.

2. Governance:

Within the Health Board, divisional governance has been established with quarterly reporting into the Mental Health and Learning Disabilities (MH&LD) Service Quality Delivery Group, Divisional Senior Leadership Team (DSLT) and corporate forums.

In addition, quarterly reports are submitted to Welsh Government on the progress aligned to the delivery of the North Wales and Welsh Government LD Strategies, Welsh Government Inpatient and Estates Reviews and the MH&LD Annual Plan.

All Governance reporting is instrumental in enhancing existing BCUHB LD Services to provide preventative and responsive local services, enabling individuals with a learning disability to live fulfilling lives.

3. The focused strategic key priorities and achievements include:

3.1 Implementing pooled budget between BCUHB and Ynys Môn Local Authority.

- This is the first pooled budget (LD) implemented in Wales.
- Formal Section 33 Partnership Agreement signed by both partners.
- Pilot aligned to phase one has been running for one year, focused on a key group of people living in supported living, jointly commissioned by the Local Authority with Continuing Health Care funds.

3.2 Improving the local accommodation offer, step-up and step-down, intermediate care provision through a full business case for Enhanced Community Residential Services (ECRS) -

- Welsh Government commissioned a review into Learning Disability Inpatient environments across Wales during 2023, and subsequently a report has been published: *Improving Environments, Improving Lives*. A response plan has been developed aligned to the ten recommendations of the review, which includes progressing the sustainable development of community services to reduce inappropriate and lengthy stays in a hospital facility.
- The NHS Executive progressed a review and audit of Specialist Learning Disabilities Inpatients Services during 2024. An Action Plan has been developed aligned to the findings which ensures actions are progressed for reducing hospital admissions through increased community-based crisis prevention, early intervention support and the provision of access to high quality, safe and effective specialist care as close to home as possible.
- A recent audit identified 17 hospital placements for people with Learning Disabilities funded by BCUHB and the associated costs.
- The Bryn y Neuadd Feasibility Study carried out in 2023, and Learning Disabilities data has been instrumental in the consideration of the future direction of an

accommodation strategy, ensuring the Health Board continues to meet the needs of people with a learning disability in North Wales.

- A 'service model' proposal has been developed to deliver specialist Health and Social Care provision aimed specifically at supporting people with a learning disability and/or autism who display behaviour that could be construed as challenging. This model involves the development of three sub-regional facilities. The finalised Business Case has recently been presented and agreed at the MH&LD Divisional Senior Leadership Team Meeting and is progressing for approval through the appropriate corporate governance,

3.3 Implementing a whole system approach to ensure equitable services for people with a learning disability so they achieve their optimum health. The following developments have occurred -

- Paul Ridd training is mandatory for all BCUHB staff. The current MH&LD compliance is 77%, and BCUHB compliance is 69%. (Both rates are on the increase).
- Annual Health Checks – The 'Lab in a Bag' is an initiative developed to provide a tool to ensure GP cluster Link Nurses have the equipment and skills to undertake the Annual Health Checks. The pre-pandemic figures reported approximately 1230 individuals had received an Annual Health Check, reducing to 46 at the height of the pandemic. There has since been a steady rise in the uptake of Annual Health Checks with the latest report showing 1679 for 2023/24 period.
- Peer Mentor Programme – A co-produced and successful peer-led health check project which employs people with learning disabilities to promote Welsh Health Checks (WHC) for other people with learning disabilities and their families is underway.
- All the above initiatives have led to positive outcomes with increased accessibility for health checks and awareness of individuals with a learning disability across North Wales, and has resulted in an upward trajectory of 15% increase in WHC completion providing early identification of underlying health conditions.

3.4 Funding from the Learning Disability Transformation Team:

- The funding has enabled the development of resources around 'pain' checks for people with profound and multiple learning disabilities.

4 Quality Indicators:

4.1 Incidents & Concerns

Q1: 186 incidents reported related to LD Services in Q1 2024/25
Q2: 173 incidents reported relating to LD Services (six LD Community Teams, three LD Wards/Enhanced Community Residential Service).

The top three themes for Q1 and Q2 are aligned to violent and aggressive behaviour, safeguarding and accidents/injuries.

Mortality Q2:

- Sadly, there has been one unexpected death. A full incident review was completed as per the BCUHB Integrated Concerns Operational Panel (ICOP) processes. All appropriate action had been taken by the team .
- There were three expected deaths in Q2 – all related to physical health.

Healthcare Acquired Pressure Ulcers (HAPU) Q2:

- One incident was reported within inpatient services. The patient was found to have a moisture lesion present. All HAPU processes were followed.

Falls Q2:

- 13 falls have been reported in total – involving eight inpatients and five service users in the Enhanced Community Residential Service (ECRS). All were graded low/no harm post-investigation.

Concerns:

- Number of open complaints - 0
- One formal complaint was received in the reporting period – the family were unhappy with the current estates environment within LD Inpatient Services, Bryn Y Neuadd site.
- Early Resolutions – 0
- Three feedback items were received via the Patient Advice and Liaison Service (PALS). Two were unresolved which led to a formal concern as noted above, and one was resolved aligned to the patient's care in hospital.

Safeguarding:

- There were 37 safeguarding referrals in Q2. Of these, 33 were from community provision, and four from LD Inpatient Services. The emerging themes were aligned to medication errors, physical behaviour and neglect.

4.2 Compliance:

- The PADR compliance is currently at 98.22%
- Supervision rates are at 96.94%
- Mandatory training is at 91.50%.
  (All consistently over the 85% BCUHB Key Performance Indicator rate).
- The sickness rate is at 9.51%. The highest sickness reason remains as from 'Anxiety and Stress', with staff supported through attendance at work processes, Wellness Action Plans, referrals to Occupational Health and ongoing support from the Wellness, Work and Us service. Recent absence increases have been aligned to 'Coughs and Colds' and also 'Gastrointestinal infections'.
- Currently there are 55 vacancies across LD Services (15% of the LD establishment). Active recruitment is taking place with a review of existing job descriptions for roles that have not been filled for over six months. Additionally, consideration of skill mix and also alternative resource provision is underway.

4.3 Health Equalities Framework: Measuring Outcomes:

- A Health Equalities Framework (HEF) is utilised, capturing outcomes aligned to interventions, with a focus on improving health and reducing inequalities.

5. Challenges:

5.1 Workforce

- There are continued challenges recruiting specialist skilled staff (currently 55 WTE vacancies). There is a supportive divisional focus for recruitment, supported by the MH&LD Recruitment and Retention Group and specific recruitment days being held.
- LD student nurse recruitment is also a focus. Six students are due to qualify in 2025. LD Services are supporting local career development days, with the most recent events held on 20th and 25th November 2024.
- BCUHB are working alongside other Health Boards in Wales to support the development of a Strategic Career Framework for leadership in LD Nursing.

5.2 Estates

- Matching patient clinical needs to the provision of fit for purpose environments, particularly for assessment and treatment is a priority.
- Welsh Government have commissioned a review into LD inpatient environments. '*Improving Environments; Improving Lives*' was a focused review of Learning Disability Inpatient Environments across Wales. The BCUHB Bryn Y Neuadd Feasibility study carried out in 2023, and LD data is instrumental in considering the future direction of the LD accommodation strategy. This LD accommodation strategy was inclusive of inpatient assessment and treatment services, to ensure the Health Board continues to meet the needs of people.
- Capital funding availability remains a challenge.
- An ECRS development plan for intermediate care is within process at present, which the team hope will both enable cost savings and care closer to home.

6. Enhancing the patient journey in Acute General Hospital:

- The Acute Health Liaison Teams are based in all three Integrated Health communities (IHC), supporting people with learning disabilities, their families and carers, as well as health services and professionals.
- Help to provide equitable access to health services and ensure reasonable adjustments are made to care and treatment to ensure the best clinical outcomes for our patients. Regrettably, there are occasions when the care delivered is not at its optimum level. A recent Ombudsman Report received by the East IHC highlighted concerns with care, and concluded that the involvement of the LD Team supporting the ward led to an improvement in the LD care plans in place.
- Health Liaison Teams working alongside the IHCs have worked in partnership to complete an action plan to support sustained learning, inclusive of piloting new documentation with the plan to embed this into a BCUHB wide standard operational procedure. This clearly identifies the prescriptive pathway of care, and relevant training inclusive of the Paul Ridd Mandatory Training. In addition, the LD champions training will enhance the care delivery and patient's journey.

7. Budgetary / Financial Implications:

- Resources for maintaining compliance oversight is overseen by the MHLD Locality Service Quality and Delivery Group (SQDG) and Finance and Performance Group (F&P), escalated to Divisional SQDG and Divisional F&P Meetings.

- The ECRS Business Case is an "Invest to Save" scheme with a projected cost saving year on year going forward.
- The pooled budget approach has demonstrated some cost pressures in the first year due to historical existing commissioning agreements that required review prior to the pilot itself commencing.

8. Risk Management:

- There is one risk on tier 2 of the risk register for LD Services aligned to the GP contract for Bryn Y Neuadd. This is at a sign off stage and is being presented to the Executive Team in December 24.
- Two further Tier 1 divisional level are in place - Access to a Digital Patient Record and the condition of some MHLD divisional estates which includes some of the LD Services.

Appendix 1

NWLDS Strategy 2018 – 2023

NW-Learning-Disabil
ity-Strategy-2018-FIN

Learning Disability Services QSE Update – December 2024

17/12/2024

Introduction to Learning Disability Services - BCUHB

- **Learning Disabilities Strategic Action Plan (2022 -2026)**
- **Learning Disability Delivery and Implementation Plan (2022 to 2026)**
- **Learning Disability Health Improvement Programme (PHW)**
- **North Wales Learning Disability Plan (North Wales LD Partnership Board – People with an LD – Participation Group 6 LA Counties and BCUHB (2018 – 2026)**
- **Social Services and Well-being Act (2014)**
- **NHS Executive Inpatient Review 2024**
- **The Duty of Quality Statutory Guidance 2023 and Health and Care Quality Standards 2023**

The North Wales Learning Disability Services are governed by the Health and Care Quality Standards 2023 to ensure the six domains supported by the six quality enablers inform our quality management practice. These standards also underpin our strategic plans to ensure we meet the needs of the Learning Disability population of North Wales alongside our Local Authority Partners. Our focus is to ensure a person-centred ethos combined with equitable care which includes the voice of carers and families leading to positive outcomes.

OUR VISION

Enhance existing BCHUB Learning Disabilities services in order to provide responsive local services that support individuals with Learning Disabilities to live fulfilled inclusive lives.

Aims & Objectives:

- A more cohesive system approach in the delivery of Learning Disability services
- Ensuring patients receive the appropriate care at the appropriate time, in the appropriate setting by staff with the right skill
- An enhancement of the capacity of community based intermediate care would reduce inappropriate hospital admissions and length of stay
- A shared and agreed vision of how we would like to get from Point A ('where we are now') to Point B ('where we are trying to go')

KEY PRIORITIES

Review of Capacity and Capability	Stronger and Aligned Management and Governance	Engagement with Staff, Users and Stakeholders	Improve the Health of People with a Learning Disability	Reduce the known Health inequalities & Avoidable Deaths	Delivery of Safe, Timely, Efficient, Effective and Equitable Services in Partnership

The Journey

✓ Fit for purpose Assessment & Treatment unit ✓ Inpatient improvement project to enhance existing pathways	✓ Enhance and strengthen Community provision services for complex care ✓ Develop x3 Step up Step down services for complex care ✓ Redesigning ECRS to Core & Cluster	✓ Review Community and Inpatient pathways ✓ Develop & Strengthen Primary Care and DGH pathways	✓ Aligning existing community pathways ✓ Ensure continuity of a Multi agency approach	✓ Prevention and early intervention pathway to be enhanced. ✓ Ensure equity of service with focused outcomes. To ensure individuals have the right support, right time, right place.

Learning Disabilities Annual Plan 2025/2026 – Aligned to the North Wales Learning Disabilities Strategy
Outcome 4 - Improving Quality, Outcomes and Experience

Learning Disability Services Milestones	Target Date	Actions
Continuation process mapping of Learning Disability services	**Q1** **Q3**	• Process mapping exercise for all operational teams across Learning Disability Pathways including review of roles and responsibilities. • Plan and Implement the Reducing Restrictive Practice Framework. Specialist Behaviour Support Service are progressing with review of breakaway / physical intervention training programme in line with Restraint Reduction Network standards. • Specialist Behaviour Support Service have submitted draft SBAR to reduce restrictive practices in the community – awaiting outcome. • Behaviour Management Support Group meeting held weekly to discuss all incidents, review restrictions and reductions.
Progress the Enhanced Community Residential Service (ECRS) intermediate care model	**Q4**	• Ensure the ECRS Business Case for new accommodation is delivered in 2025/26, aligned to the project plan. • Recruitment of the Project Manager to progress all plans. • Completion of the ECRS Operational Framework. • Awaiting sign-off of the business case.
Continue review of the current Learning Disabilities (LD) Inpatient Pathway and existing processes to identify areas of improvement	**Q4** **Q1** **Q2** **Q2**	• Development of measurable service improvement by reviewing current KPIs and metrics, applying increased scrutiny and embedding into practice. • Focused work on providing best quality services for patients including preventative models of care as set out in the Quality Network for Learning Disabilities (QNLD) Standard. • Continue to review the Reducing Restrictive Practice Framework. • Reviewing the effectiveness of the Therapeutic Interventions through the active support model. Multidisciplinary Team members to support delivery and embedding into practice.
Development of measurable service improvement by reviewing current KPIs and metrics, increase scrutiny and embed into practice	**Q1** **Q2**	• The development of the Integrated Care Pathway to enable an aggregation of the nursing care processes to achieve a consistency across the pathways aligned to the teams and the needs of the people we support. • Continue the review of the existing Standard Operating Procedures (SOPs) to reflect the current delivery of Community Learning Disability Services across the Community Teams.

Quality Improvement & Development Initiatives: Achievements to date 2024/2025

Community

- The six Learning Disability Community Teams have mapped the nursing process. Further work can be completed to ensure consistency across the areas to ensure service provision is equitable.
- Sub groups have been set up for the development of Pathways. The SOP has been updated ready for consultation prior to agreement.

Pooled Budget Pilot Ynys Mon

- A formal Section 33 Partnership Agreement has been signed by both partners and the pilot has been running for one year focused on a key group of people in supported living. The review is due by January 2025.

Enhanced Community Residential Services - BCUHB is facing a demand and capacity disparity aligned to locally sourced community provision. This therefore requires a rapid solution to facilitate sustainable robust service provision. The business case (under development) addresses the requirement to support the sustainability of a pan BCUHB enhanced community provision.

- The recent LD Census Audit information identified the data on the 17 hospital placements for people with Learning disabilities funded by BCUHB
- Demand is increasing but we do not have the specialist community-based provision within BCUHB;
- Increased length of stay resulting in increased pathways of care delay with significant financial implications.
- Options were considered to enable a rapid response care provision for people with Learning Disabilities across the North Wales Region. Agreement for the development of three sub-regional facilities, one in the West, one in Central, and one in the East. This will provide an intermediate care model across the region part of a systematic and integrated approach that would maintain skilled support, prevent long term admissions and aid timely discharge.

The Health Equalities Framework (HEF) identifies five areas for intervention in order to improve health and reduce inequalities

- The service user HEF is a new pilot and intended to be completed with/by the service user and the plan is to make this tool available to individuals, services, carers on the same basis as the All Wales Health Profile.
- We want people to own their HEF and use it to tell us what they want to improve on. There is a pilot currently running in Ynys Mon.. Engagement with Improvement Cymru in place to feedback on the study.

Equitable services for people with a Learning Disability to ensure they achieve their optimum health.

- Lab in a Bag has now been fully launched and is embedded in practice - on a three-year rolling programme.
- Paul Ridd training now mandatory and on ESR. (MH&LD 77% , BCUHB compliance 69%)
- Learning Disability Champions are based across wards in the General Hospitals.

Challenges Moving Forward

Workforce

- **Issue**: There are currently 55 vacancies pan Learning Disability Services.
- **Assurance**: Active recruitment is taking place and review of existing job descriptions for roles that have not been filled for over six months. Recruiting specialist skilled staff to work within Learning Disability Services to enable continuation of moving forward with our ambitious programme.

Estates

- **Issue**: Matching the development of clinical responses to the provision of fit for purpose environments, particularly the assessment and treatment unit.
- **Assurance:** Business Case submitted for intermediate care to enable cost savings and care closer to home.

Enhancing the patient journey in Acute General Hospital

- **Issue**: Provide equitable access to health services and ensure reasonable adjustments are made to care and treatment of LD patients attending IHCs.
- **Assurance**: Health Liaison Team alongside IHCs in partnership, have developed an action plan to support sustained learning, inclusive of piloting new documentation aiming to embed this into a BCUHB wide standard operational procedure.

Clinical Services Plan

Proposed approach

Chris Stockport / Angela Wood

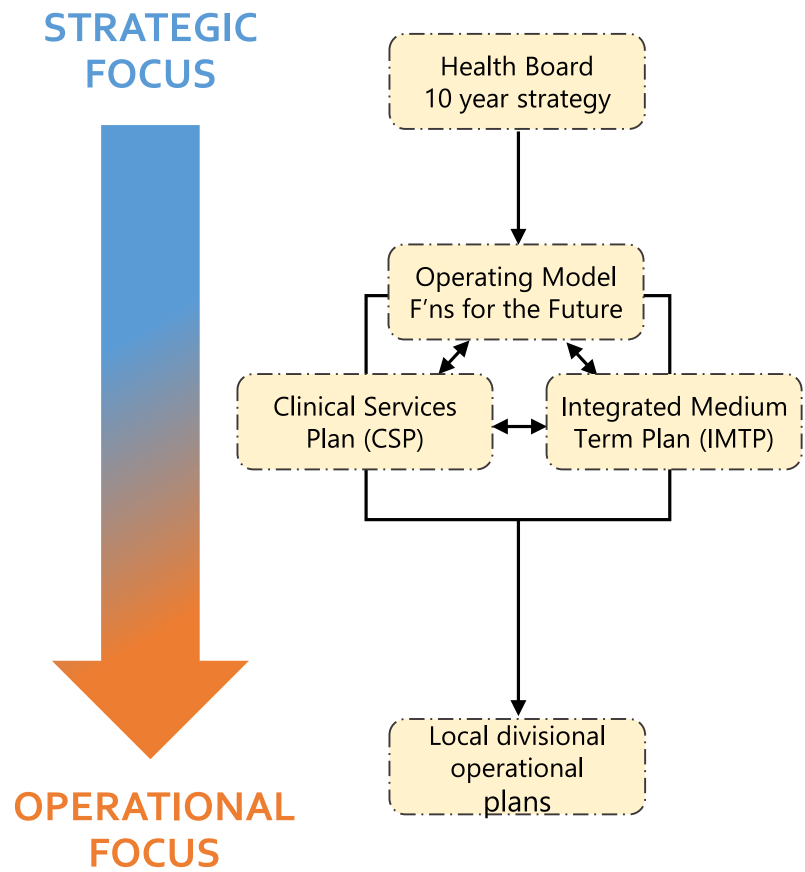
Clinical Services Plan

Will cover:

- Brief outline of what a CSP is and where it fits
- QMS being the core
- Challenges
- Proposed CSP methodology
- The need to prioritise

What is a Clinical Services Plan?

A CSP is about how we configure and approach the delivery of the clinical services we provide in order to best deliver the Health Board strategy and provide a high quality service

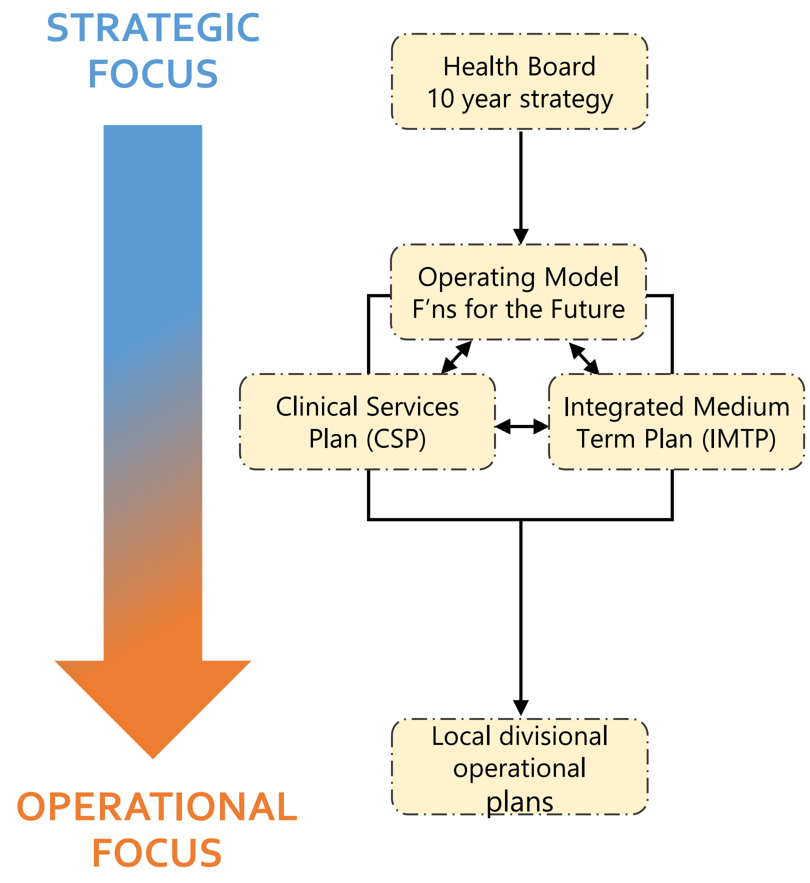


What is a Clinical Services Plan?

A CSP is about how we configure and approach the delivery of the clinical services we provide in order to best deliver the Health Board **strategy** and provide a high **quality** service

The CSP must align in pursuit of delivering the Health Board agreed strategy

Quality – the Quality Management System must underpin everything within the CSP



Quality and Safety: QMS pilot

- ✓ Project lead identified
- ✓ Project group established
- ✓ PID and Comms and engagement plan signed off
- ✓ Initial PDSA completed with vascular and urology
- ✓ Maturity assessment tool trialed and further developed
- ✓ Women's and T&I team brought onboard for testing. Further Fast Followers identified.

Next steps:

- Second PDSA 11.11.24 – 09.12.24
- Analysis of second phase testing and plan for further actions
- Project agreed for entry onto PMO portal w/b 11.11.24
- Comms and engagement plan to be initiated – first phase web page
- Plan for further rollout

Pilot Success Criteria:

- User satisfaction
- Number of issues encountered
- Time taken to complete processes
- Compliance with quality standards

Presenter: Angela Wood

Delivering the Clinical Services Plan

All clinical services should be within scope for the CSP

Getting to the point of having such a mature and encompassing CSP will take time, for many reasons, so a tactical approach to construct the CSP sequentially is required:

- Prioritise services for inclusion against risk/benefit. The QMS helps with this!
- As the 10 yr strategy work develops ensure the CSP is hand-in-glove
- Once we have endorsed an initial CSP, then all significant clinical service redesign must pass through CSP methodology/governance

Prioritisation

(red)	Clinical services currently experiencing significant problems
(orange)	Clinical services where problems are occurring but being mitigated
(yellow)	Clinical services where imminent problems are likely
(light green)	Clinical services operating well, but where we know there are still some opportunities to optimise
(green)	Stable and mature, operating optimally, high QMS indicators, recognised as exemplars

Reactive ↕ Proactive

Service interdependencies also need to be considered, as does risk appetite

Work done so far

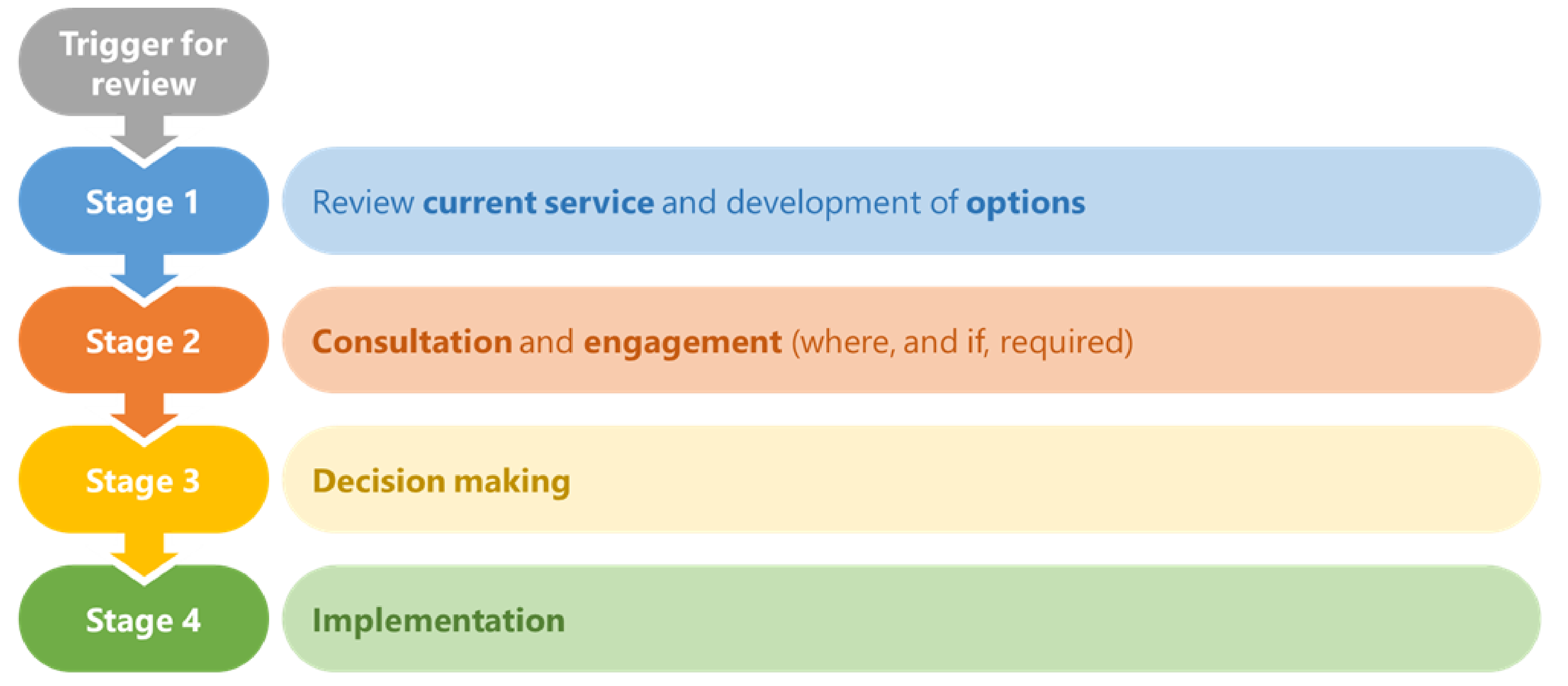
CSP specific

- ✓ Work with Hywel Dda who have done a lot of work in the last 18 months on Clinical Service Planning (and who have a number of very similar challenges to BCU)
- ✓ Establishment of a BCU methodology for CSP
- ✓ Work on 'ground-rules' for how we will approach individual service reviews, including clinical engagement and behaviours within reviews
- ✓ Consideration of our capacity, and our ability to commit greater medical leadership to this work

Enabling work

- ✓ Increasing focus upon the concepts of 'risk appetite'
- ✓ Maturing approach to prioritising risks and benefits
- ✓ QMS methodology designed and trialled
- ✓ Improving focus upon well-being, social determinants, prevention, de-medicalisation, skill-mix
- ✓ Foundations for the Future

Methodology



(Based upon work done by Hywel Dda UHB, supported by the Consultation Institute)

Left shift / de-medicalisation

Service co-dependency

One BCU Integrated system

Not about buildings

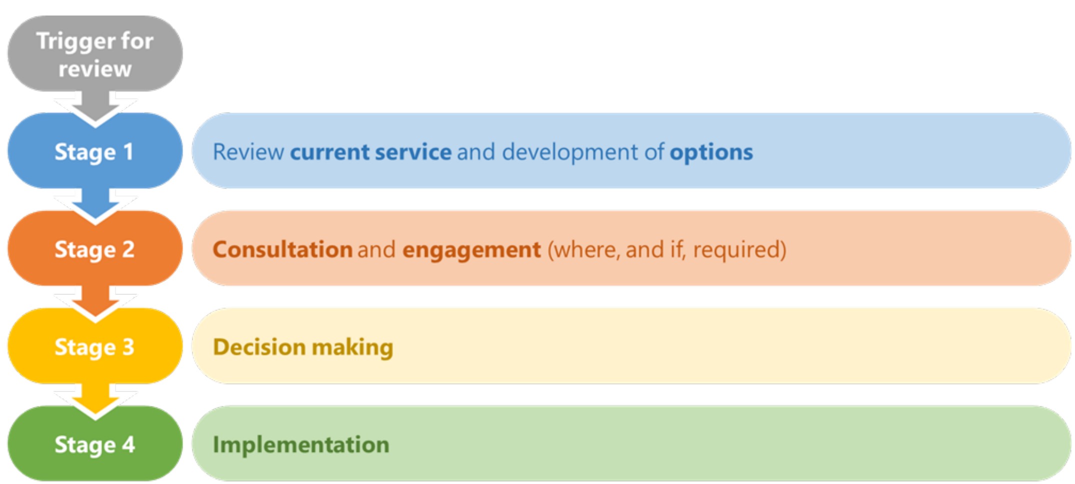
Cognitive biases

An option is only an option if it can be delivered

Next steps

We have selected Urology services as the first area in which to apply the CSP and will be applying Stage 1 of the methodology over the next 6 weeks.

- ✓ This allows us to test the methodology before rolling it out further, applying PDSA
- ✓ It also allows us to include more medical voices in the methodology design before rolling it out further
- ✓ Urology services fall within that highest tranche of services experiencing difficulties
- ✓ We have already commenced trialling the QMS in Urology, allowing us to do this from a 'running start'



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Report to:</td><td colspan="4">QSE Committee</td></tr>
<tr><td>Dyddiad y Cyfarfod:
Date of Meeting:</td><td colspan="4">17th December 2024</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 AHPs and Healthcare Science</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
• IPC: Andrea Ledgerton, Deputy Director of Infection Prevention and Decontamination
• Patient and Carer Experience: Mandy Jones, Executive Deputy Director of Nursing (Patient Experience) and Leon Marsh, Head of Patient Experience
• Clinical Effectiveness: Dr James Risley, Executive Deputy Medical Director (Clinical Effectiveness), and Joanne Shillingford, Head of Clinical Effectiveness
• Quality Assurance: Dr Kath Clarke, Head of Quality and Erika Dennis, Quality Lead Manager
• Healthcare Law: Matthew Joyes, Deputy Director of Legal Services and Debbie Kumwenda, Healthcare Law Lead Manager</td></tr>
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For Noting
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For Decision
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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 PSOW PIR 753	

QSE Committee – Quality Report – December 2024

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.

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PATIENT SAFETY

PATIENT SAFETY INCIDENTS

Integrated Concerns Policy

The implementation of the Integrated Concerns Policy took place on 1st September 2024.

The initial bedding in period has progressed well with good attendance at initial awareness sessions by the IHCs and Divisional teams. In addition, continued awareness and drop in sessions are in place.

The adaptation to the renewed terminology within the process is being well accepted and teams have quickly aligned to the flow of how an incident/complaint/medical examiner report needs to be triangulated for a comprehensive response.

Daily Concerns Hub meetings for IHCs/Divisions to review Incidents/Complaints (Grade 4 & 5) and medical examiner scrutiny letters to start triangulation are in place. There is now one template to use for the learning investigation regardless of whether it is a complaint or an incident.

Incidents:

There are currently 6710 open incidents of these, 3805 are overdue as per process review timescales.

The patient safety team (PST) are currently running the drop-in sessions below and extra training sessions, to provide support. APST representative is also attending local integrated concerns operational groups or relevant meetings.

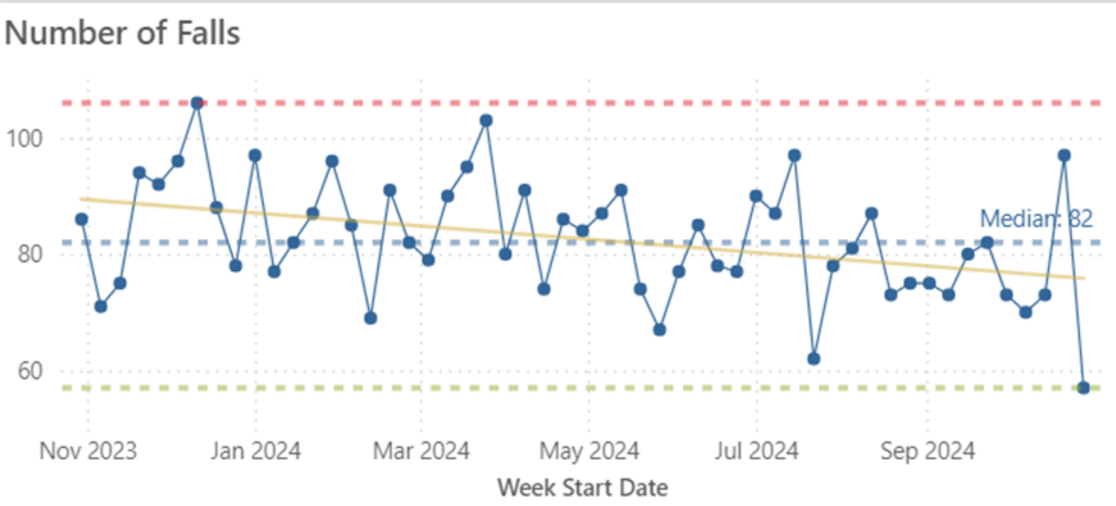
- Weekly Q&A Drop in Session
- Weekly Awareness Session
- Weekly Incident Management Training
- Weekly NRI drop in sessions

The sessions have been well attended, with positive feedback gained from PST questionaries provided at the end of each session.

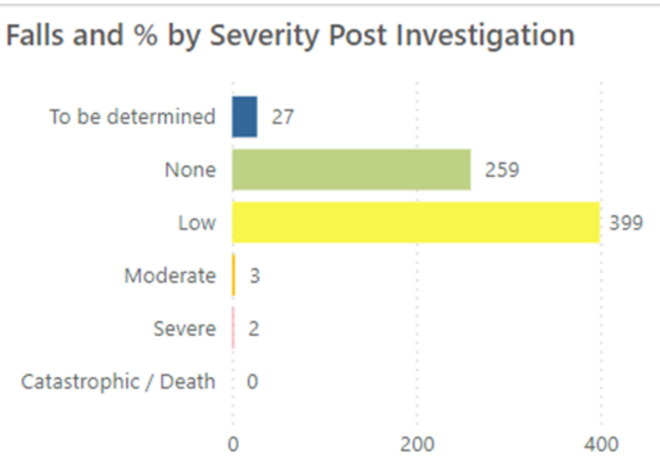
Previous workshops across BCUHB with regards to SBAR and Risk assessment has allowed for the backlog to improve, an IHC Central workshop took place in November.

Patient Falls

The following shows patient falls reported across BCUHB in the previous 12 months; the yellow line shows a downward trend.



In September and October 2024, the graph below identifies the number of patient falls occurring, with a post investigation level of harm as shown, (to be determined means the investigation/review is ongoing).



<u>Improvement Plan:</u>

- E learning Health Board Training:
  September 2024 compliance for part 1a and 1b training has seen improvement with the wards in most cases exceeding the Health Board standard of 85%. Please note work is still ongoing with ESR colleagues undertaking a data cleanse to ensure accuracy.
- Agency Worker induction:
  A Health Board task and finish group has been established to review the process of induction and on boarding of Agency Workers into the Health Board. The TOR includes the Agency Workers training regarding Falls Prevention as the first priority.
- Risk assessments:
  The consistency of the detail and quality of interventions of the Falls and Bone Health Assessment (FBHMA) remains a challenge, although improvements have been seen, as identified by the IHC feedback as part of the monthly Strategic Falls meeting and Accreditation team supportive visits.
  Bedside and Wider Learning Members of the Accreditation team have adapted classroom based sessions to provide ‘bedside learning’ to improve Falls and Patient handling risk assessments. From February 2023 to date the team have also

presented to 475 nursing students for both Universities via a 2 hour interactive training session.

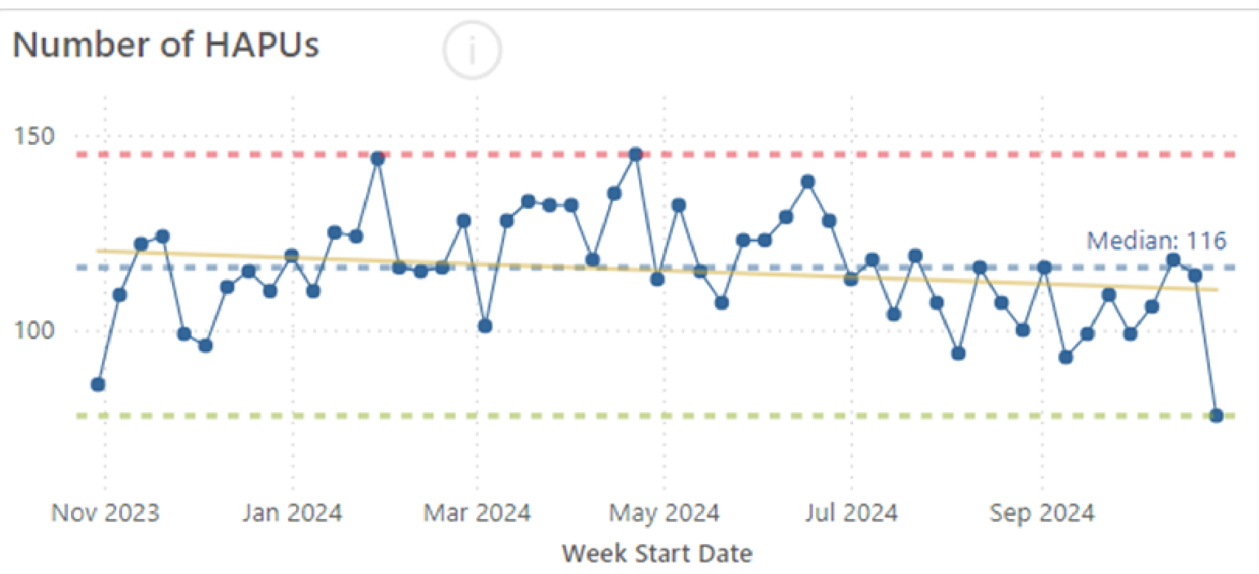
Improvements and other learning identified for prevention of patient falls:

- Maintenance of Observation Levels
- Robust risk assessment documentation must be completed with mitigation identified
- Increased reporting under Community Resource Team (CRT) needed, due to increased patient susceptibility and risk profile following expedited discharge from Acute Hospitals. This should be managed as part of bed capacity, demand, and flow constraints.
- CRT supporting packages of care and identify Physio and OT engagement needs to be positive and timely.

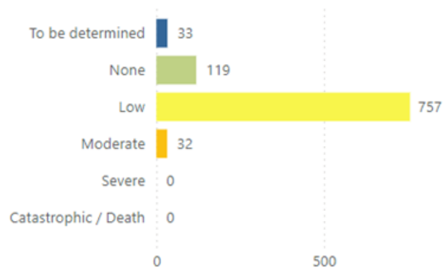
Executive review of falls meetings continue quarterly, with best practice and improvements shared across IHCs and Divisions.

Pressure Ulcers

The following chart shows patient healthcare acquired pressure ulcers (HAPU) reported across the Health Board in the last 12 months; the yellow line shows a downward trend.



In September and October 2024, the chart below identifies patient healthcare acquired pressure ulcers occurring, with a post investigation level of harm shown, (to be determined means the investigation/review is ongoing)



An Executive review meeting was held on 29th July 2024, where the IHC West Director of Nursing was commissioned to lead improvement in the prevention of pressure ulcers.

This has led to a review of the BCUHB improvement plan and policy. The Tissue Viability Intranet page is now being updated incorporating aSSKINg as a tool for assessment and is being incorporated into the review of BCUHB pressure ulcer prevention policy.

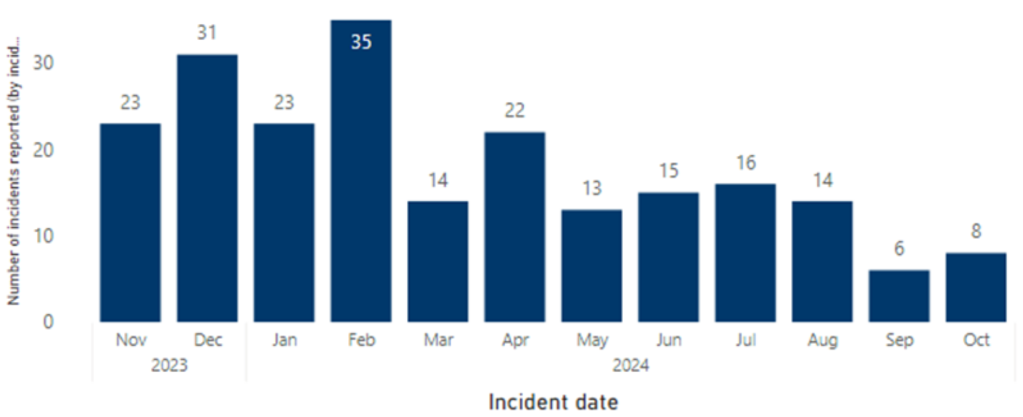
A further Executive review was held on the 4th of November 2024 to track progress with improvements.

Improvements and learning for prevention of pressure damage have identified the following recommendations:

- Ensuring accurate body mapping is undertaken on admission to the service
- Risk assessment skin integrity assessments are undertaken with mitigation
- Patient education and engagement is instigated when patients are non-concordant
- Continued review and re-assessment to be undertaken as clinical presentation alters

Nationally Reportable Incidents

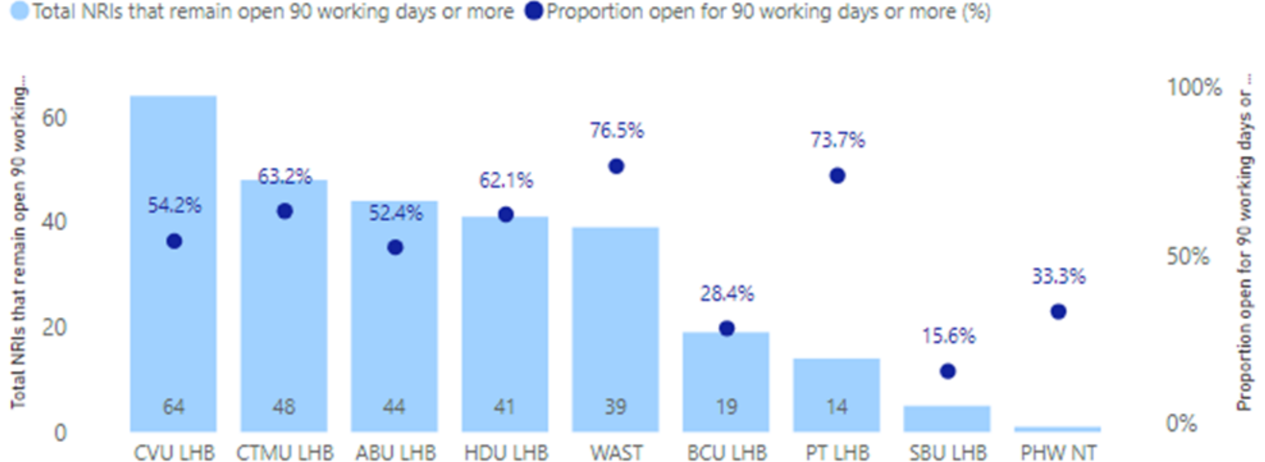
From 01st September – 31st October 2024, 14 National Reportable Incidents (NRIs) occurred, and 37 notifications were submitted. The increase in notifications compared to incidents occurring is due to retrospective reporting of patient falls and pressure damage. These are only notified when the review has been completed and deemed to be avoidable at local harms meetings.



There are currently 54 open NRIs with 12 overdue (down from 22 previous month). This is a significant improvement in the trajectory. The beacon dashboard currently shows 23 open 90 working days or more for BCUHB as of the 10th October 2024 but this is due to a delay in NHS Executive processing the reports following our submission, or there being complex NRIs that have been given 120 days for investigation that are over 90 days but are not overdue.

N.B A meeting with NHS Executive has been arranged as there are discrepancies with numbers open on the beacon dashboard data and datix data, possibly due to time lags between submission and acknowledgement of closure by NHS Wales Executive.

The proportion of NRIs that remain open 90 working days or more is 28.4% (reduction from 47.1%) which is the 2nd lowest across Wales. The median working days that NRIs are completed is 80 which is the lowest across Wales compared to the median of 130 days.



Closures – Outcome forms submitted to NHS Wales Executive
42 NRI Outcome forms were sent to NHS Executive during September and October 2024 of which 13 were for combined forms relating to HAPUs/ falls, and the remaining 29 were outcome forms for all other incident categories.

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

Never Events
No Never Events reported in September or October 2024

PATIENT SAFETY ALERTS

- Oxygen cylinders: regulation 28 report and patient safety notice 041 reminder (WHC/2024/036) Sep 2024
  Compliance completed and submitted.

- MHRA - CPT Hip System Femoral Stem 12/14 Neck Taper: Increased Risk of Postoperative Periprosthetic Femoral Fracture
  Only affects West IHC, awaiting compliance of all actions.

- PSA018 Risk of oxytocin overdose during labour and childbirth
  Women's services leading, deadline 31/03/2025

SAFEGUARDING

Implementation of the Once for Wales Safeguarding Report Form

Update position
The Health Board received notification from Public Health Wales (PHW) on the 1st of October 2024 to confirm the implementation of the Datix Once for Wales Safeguarding

Report Form which was due to be launched on the 1st November 2024, will now not progress.

Although extensive work had been undertaken to support this agenda, the cancellation was due to PHW having received feedback from 11 of the 22 Local Authorities (LA).

The Safeguarding and Public Protection Team had also highlighted concerns regarding the launch date and the Report system.

Following the cancellation of the current system it was agreed at the NHS Wales Safeguarding Network meeting on the 17th of October 2024 that an 'All Wales Agencies Report Form' will be developed to support the Datix Module, as well as the development of a report tool which supports all organisations in a safe and informed way. We remain fully engaged in this work and provide updates as required through agreed governance channels.

Single Unified Safeguarding Review (SUSR)

The Minister for Children and Social Care issued a statement on the 1st of October 2024 announcing the launch of the SUSR in Wales. The purpose of the SUSR is to create a single review process where a multi-agency approach is required, incorporating the following review processes; Adult Practice Review; Child Practice Review; Domestic Homicide Review; Mental Health Homicide Review; and the Offensive Weapon Homicide Review. The final report is then used to inform professional practice and will be submitted into the National Wales Safeguarding Repository. The Repository, when fully implemented will be accessed by Services in Wales to promote ongoing learning from reviews on a National basis. Access will follow agreed governance and meet GDPR.

The Safeguarding and Public Protection Team will be working with the North Wales Safeguarding Board and partner agencies to ensure this process is implemented within agreed timescales.

The North Wales Safeguarding Board are currently delivering training to support staff in the application of the new review process.

During Q3 and Q4, the Team will be engaging with Health Board colleagues to ensure that Governance, Reporting, Training and Policy & Procedures are updated and shared across Divisions and Services. We will also be working with the Safeguarding Board and the Community Safety Partnerships (5 in North Wales).

It is expected that Agencies will provide skilled staff to undertake the SUSR, however it has been acknowledged this will result in an increase in workload and potentially costs. The Safeguarding and Public Protection Team are reviewing what this looks like and what this means for the Health Board.

Due to timescales and the complexity of the Review process we will have two different governance arrangements in place until existing reviews are completed, and all new reviews are commissioned under the new statutory guidance.

It is imperative that all staff groups throughout BCUHB recognise that they have a part to play and their engagement is required to meet the requirements of this statutory activity

The Safeguarding and Public Protection Team remain fully engaged in this work and provide updates as required through agreed governance arrangements.

National Safeguarding Week 11th – 15th November 2024

This year's theme was Safeguarding is Everybody's Business. The Safeguarding and Public Protection Team brought multiple disciplines and agencies together through a myriad of events. There were 12 engagement sessions during the week not including the usual activity of Safeguarding Supervisions. Over 400 people accessed at least one of the available sessions provided by the Safeguarding and Public Protection Team, whether that be one of the 3 conferences covering Adult at Risk, Safeguarding Children, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS), or the many Team events including guest speakers covering developing and pertinent topics such as PREVENT. The Launch of the Domestic Screening Tool (DAST) to replace HITS also took place with great interest and engagement. Significant positive feedback has been obtained from attendees.

Deprivation of Liberty Safeguards (DoLS) - The Review of Current Commissioned Patients.

Following the Court of Protection Seminar hosted by Legal and Risk Services it has been agreed that further action is required by the Health Board in relation to commissioned patients living at home and in the community. This is due to legislation that states all individuals who are deemed to lack the capacity to consent to care and treatment and are not free to leave their accommodation (due to a lack of mental capacity to make an informed decision) should be subject to a Community Court appointed Deprivation of Liberty.

It was agreed at the Mental Health Legislative Committee on the 7th of November that the Deputy Director for Legal Services would lead on this work with support from the Safeguarding and Public Protection MCA/DoLS Team. This work is an objective for 2025-2026.

Domestic Abuse Screening Tool (DAST)

The new Domestic Abuse Screening Tool was devised by a small working party 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 feedback that the National Tool; HITS matrix currently in use was not up to date with the modern aspects relating to domestic abuse. The new DAST was ratified at the Safeguarding, Governance & Performance Group meeting on 30th July 2024.

The DAST was presented to the VAWDASV Steering Group in September 2024, the Tool was well received with excellent feedback. Other Health Boards in Wales are keen to implement this North Wales Tool.

The new Tool was officially launched in Safeguarding week 11th – 15th November 2024 over several Lunch, Learn and Inspire Webinars.

The Tool has been translated into Welsh, an Implementation and Communication Plan has been developed to support next steps and ensure the tool is implemented across the

organisation. Discussions have taken place with BCUHBs Communications Team and an evaluation Tool is under development.

To view the Domestic Abuse Screening Tool, please access the Safeguarding & Public Protection BetsiNet page.

INFECTION PREVENTION AND CONTROL

For the improvement goals set against the 2023/24 outturn, BCUHB are below trajectory for E. coli, Klebsiella and Pseudomonas, and above for MSSA, MRSA and C.diff.
At the end of October 2024 BCUHB were in 1st position for MSSA, Klebsiella and Pseudomonas when compared to other Health Boards, however, were 6th for MRSA, 5th for C.diff (worsening position for both compared to September 2024) and 4th for E. coli (an improving position).

When considering the improvement goals to reduce community and hospital onset cases as outlined in the Welsh Health Circular (WHC) 2024/5 HCAI (Healthcare Acuired Infection)and AMR (Antimicrobial Resistance) Improvement Goals, the Health Board is on trajectory to achieve the improvement goal for:

- All E. coli
- All Klebsiella
- All Pseudomonas
- Hospital onset Pseudomonas
- Hospital onset MSSA

BCUHB is not on track to meet the trajectory for:

- Hospital onset C.diff
- Community onset C.diff
- Hospital onset Klebsiella

Whilst lower than the baseline, BCUHB are not yet on target to achieve the improvement goal for hospital onset E. coli. It is no longer possible for the Health Board to achieve the 2024/2025 improvement goal for MRSA.

Actions to address the WHC 2024/25 HCAI Improvement Goals

- A Learning Review has been conducted across the IHCs, resulting in the development of a definitive improvement plan with measurable outcomes for each IHC. These are to be reported and monitored through the Local IP Groups and escalated to the Strategic Group.
- These reviews will assist in BCU working towards achieving the HCAI improvement goals for 2024/25 with a focus on community and hospital onset infection.
- The Deputy Director of Nursing for IP met with the HARP Lead and has since formally invited for PHW (Public Health Wales) to conduct a supportive external review in light of the increasing C. diff rates and this is scheduled to take place across the 3 IHCs over three days during the week commencing 9th Dec.
- The HABITS campaign continued in September and October; the focus on Standard and Transmission Based Precautions.

- Practice related audits and spot checks have been increased in all areas of concern by the IPT and the Matrons in the East IHC.
- MRSA microteaching sessions have been formally scheduled with attendance recorded across East IHC where most cases of MRSA bacteraemia have been reported.
- Through a weekly Integrated Concerns meeting with Executive Oversight, all significant and catastrophic infection related incidents will be presented. A selected Post infection Review is now being presented at each Local Infection Prevention Group and learning is also being presented at the Strategic Infection Prevention Group and there is a plan to present also at the Organisational Learning Forum.
- An SBAR has been prepared detailing recommendations that BCUHB should follow in preparation for publication of the revised National Cleaning Standards to include convening a Task and Finish Group to undertake a gap analysis against these standards, to ensure that these are being met
- High Level Disinfection in the form of Hydrogen Peroxide Vaporisation or Hypochlorous Acid as advised by the IPT is now in use across East and West and is due to recommence in Central IHC mid-December 2024.
- Each IHC have been asked to provide a nomination for a named ANTT Lead for each site – with a deadline of 28th December.
- A BCUHB Renal Scrutiny Group has been developed to meet quarterly with first meeting scheduled in January 2025.
- A cohort area for managing the AMR Coli outbreak in East has been recommended by the IPT and the IHC are working up a plan to implement this – the areas will also serve as a decant facility for HLD when no longer required for AMR E. coli.

OTHER PATIENT SAFETY CONCERNS AND IMPROVEMENTS

Oxygen Administration Improvement

Oxygen eLearning training package is now with ESR for uploading. Once a launch date is known this will be widely communicated.

BOC have a 'time remaining' digital application that can be used to scan cylinders to work out the time remaining based on the flow rate. Currently the team are liaising with IT to see if it can go on ward iPads.

Missing Patient Review Meeting

The overall number of missing patients being reported to North Wales Police is on a downward trajectory – clarification is being sought whether:

- This is because fewer patients are going missing or
- The same number of patients are going missing but we are managing this differently

Operational / clinical services have been asked to provide some assurance that processes are in place locally to ensure all incidences of missing patients are appropriately reported.

There is currently no routine access to CCTV recordings in place for operational site and clinical management in Ysbyty Glan Clwyd or Wrexham Maelor – Ysbyty Gwynedd have a SOP which enables CSMs to access CCTV. There is a risk that inability to access CCTV might hinder the early resolution of missing patient incidents and reduce our ability to track patient whereabouts during live incidents. A meeting to standardise timely access to CCTV across the Health Board is being arranged.

Medical Devices Governance and Assurance

- There is a risk of not achieving compliance with the new legislation for Medical Device Regulations (MDR) and the In Vitro Diagnostic Medical Device Regulation (IVDR) which came into force from May 2020.
- This is caused by the new regulations placing further legal obligations on the Health Board for medical devices and for in vitro diagnostic devices.

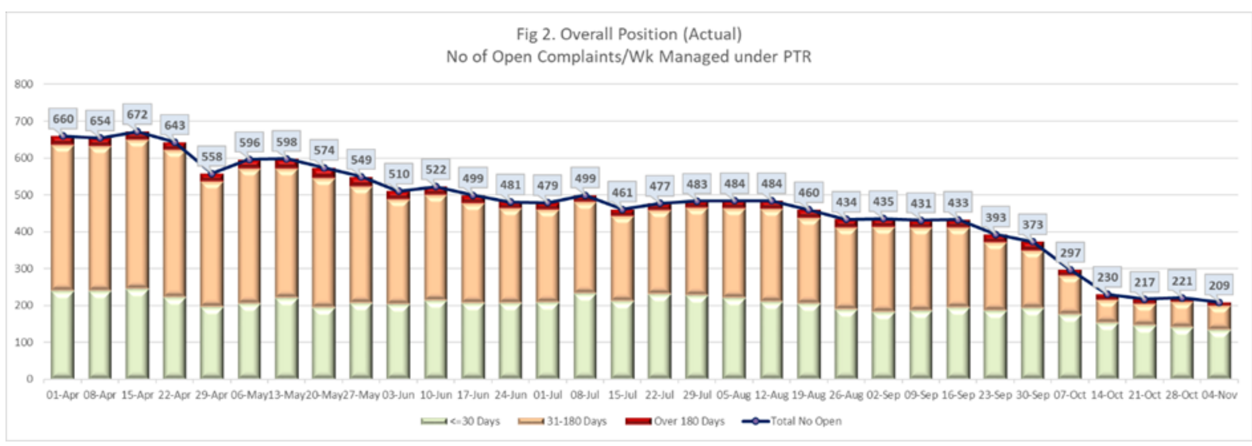
Actions so far:

- Review undertaken by the regulatory and compliance manager in Swansea Bay. Report presented to PSG in July 2024.
- As part of all Wales MDR group work, we have identified all services where the regulations apply.
- A request for funding from Executive team for expert resource to support this work has been made.
- A new appointment to the Head of Clinical Engineering is progressing through A4C matching and vacancy approval.

PATIENT EXPERIENCE

COMPLAINTS

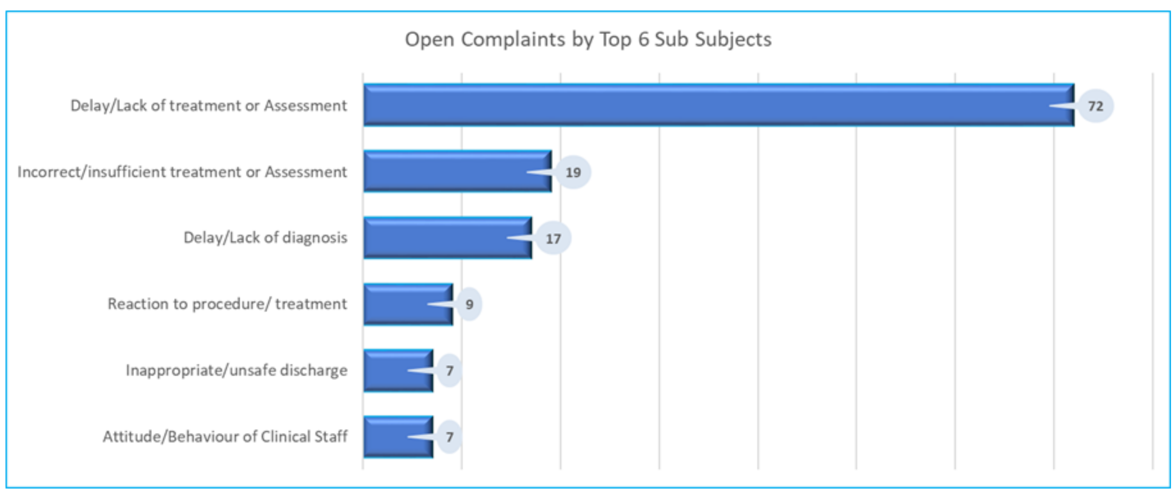
During 1st September 2024 to 31st October 2024, the Health Board **received** 483 complaints, 390 of those were managed under Putting Things Right, an additional 42 were resolved as Early Resolutions and 51 complaints re-opened (re-opened concerns refer to complaints which have been re-opened due to additional questions raised or dissatisfaction with the initial response.



Thematic Analysis

Most of the complaints related to Secondary Care Services with the main themes in relation to:

- Delay/lack of treatment or assessment
- Incorrect insufficient treatment or assessment
- Delay / Lack of diagnosis



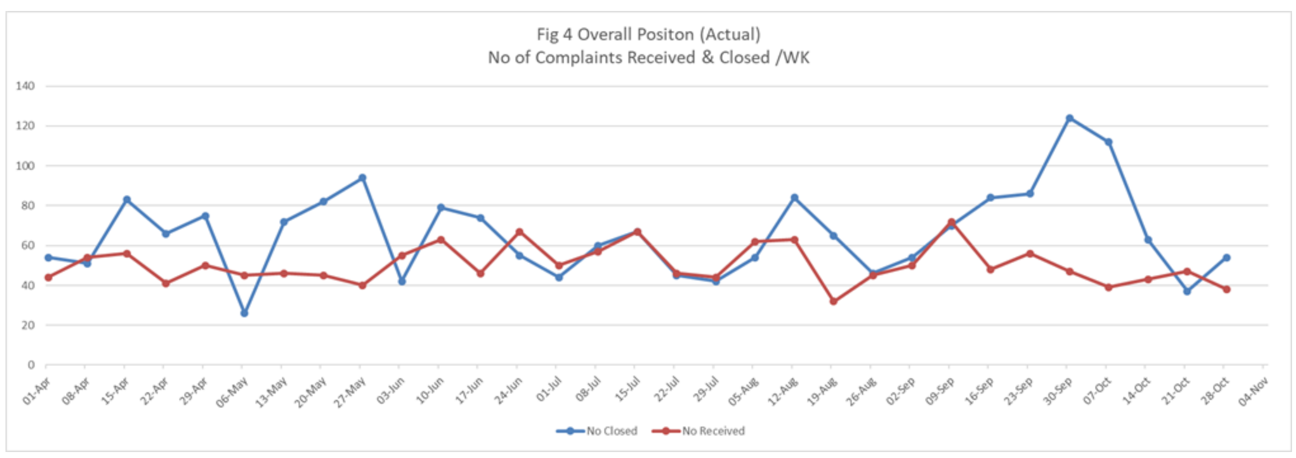
Complaints Performance

There were 209 open complaints at the end of October 2024 with 76 of those overdue and 45 re-opened complaints (not included in the 209)

The complaints compliance performance benchmark is 75% of complaints to have been responded to within 30 working days. At the end of October 2024, the overall BCUHB compliance rate was 63.34%, having fallen from a peak on 14th October of 70% The individual IHC/ Service compliance rates were as follows: -

Trajectories

IHC/Service	<=30 Days	>30 Days	Total	Compliance (%)
Cancer Services	0	2	2	0.00%
Corporate Services	4	2	6	66.67%
Dentistry	4	1	5	80.00%
Diagnostics and Specialist Clinical Support Services	5	3	8	62.50%
IHC Central	30	50	80	37.50%
IHC East	33	9	42	78.57%
IHC West	34	4	38	89.47%
Mental Health and Learning Disabilities	16	0	16	100.00%
Midwifery and Women's Services	7	5	12	58.33%
Total	**133**	**76**	**209**	63.64%



The current compliance as of the 25th November is of 76.53% with a total of 192 Complaints open and 45 of those overdue.

The Corporate Complaints Team are supporting Integrated Health Communities (IHC) and Divisions to monitor and track complaints performance with the objective to reduce the number of overdue complaints.

Between the 15th April 2024 and 25th November 2024;

- BCUHB have achieved a 71.43% reduction in the total of overall complaints from 672 to 182

- BCUHB have achieved an 88.97% reduction in the total number of overdue complaints from 408 to 45.

The average closure rate has improved from 58.9 working days to 34.74 working days

Complaints Referred to Public Services Ombudsman for Wales

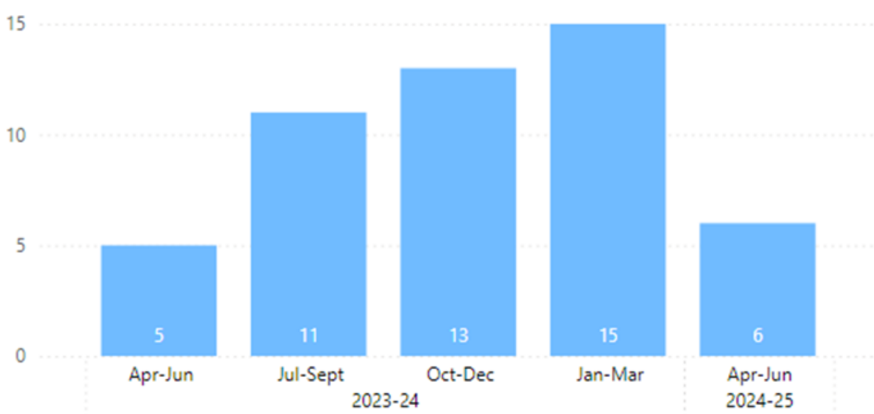
1st September 2024 – 31th October 2024

Less complaints are upheld by the Public Service Ombudsman, reducing from 15 in quarter 4 in 2023-24 to 6 in Quarter 1 2024 -25 when the trajectory improvement work for complaints commenced and this trend is expected to continue. This suggests that despite the significant increase in the number of closures the quality of responses is improved and patients and the PSOW are further satisfied with the responses we are providing, our application of PTR legislation. The Health Board have both dramatically improved closure rates and have also improved quality.

For comparison

- Quarter 4 (Jan – Mar 2024) = 52 Cases referred to the PSOW and 15 upheld = 28.84% of cased upheld

- Quarter 1 (April – June 2024) = 60 cases referred to the Ombudsman and 6 upheld = 10% of cases upheld (reduction of 18.84%).



Complaints Received/Closed

September 2024

During the month of September 2024, the Health Board received 228 complaints and closed 293, creating a negative variance of 65.

Wk Beg	02/09/2024	09/09/2024	16/09/2024	23/09/2024
No Open	435	431	433	393
No Overdue	252	246	238	208
No Closed	54	69	83	87
No Received	50	72	51	55

October 2024 During the month of October 2024, the Health Board received 183 complaints and closed 267, creating a positive variance of 84 which is an improvement on the previous month.

Wk Beg	07/10/2024	14/10/2024	21/10/2024	28/10/2024
No Open	297	230	217	221
No Overdue	122	77	72	81
No Closed	112	64	37	54
No Received	39	43	48	53

Improvement Initiatives

Integrated Concerns Policy

An integrated approach to the BCUHB management of complaints / mortality and incidents, including standing operating procedures, joint policies and standardised templates, which should improve both efficiency and accuracy has been implemented.

Business Intelligence

The IRIS Dashboard has enabled complaints performance data to support the complaints trajectories for the IHC and support services since the 1st of June 2024.

Central Integrated Health Community

To submit all EQ Grade 4 and 5 complaints to the recently implemented generic governance email inbox for the attention of Senior Clinicians to support timely allocation of concerns which will support the Complaints Improvement Trajectory and overall position of complaints management.

Scrutiny Meetings

Each Integrated Health Community (IHC) has adopted weekly Putting Thing Right Meetings to manage the progress of complaints received.

The Deputy Executive Director of Nursing continues to lead weekly improvement meetings with the services, targeting support to facilitate resolution of complaints.

The Executive Director of Nursing commenced escalation meetings from 1st April, 2024 with IHCs and Services who were non-compliant with complaints performance. Currently IHC Central escalation meetings continue more frequently.

Grade 1 and 2 complaints

Work is ongoing to improve efficiency with the complaints management process, to allow IHCs to close Grade 1 and 2 complaints once they have reached conclusion, without the need to go into the corporate QA and Approval process. This will ensure timelier responses for the public to their concerns

Fig 3 - Complaints Open By Length of Time Open by Grade

Last Update -----------> 25/11/2024

No of Open Complaints under PTR	Column Labels					
Calendar Months	Grade 1	Grade 2	Grade 3	Grade 4	Grade 5	Grand Total
<= 1 Mnth	17	35	56	16	1	125
Over 1 Mnth	3	9	10	6	3	31
Over 2 Mnths		1	4	5	2	12
Over 3 Mnths		1	2	1	3	7
Over 4 Mnths				1		1
Over 5 Mnths		1	2		1	4
Over 6 Mnths			2	2		4
Over 7 Mnths				2	1	3
Over 8 Mnths				1		1
Over 12 Mnths			1	1	1	3
Over 18 Mnths				1		1
Grand Total	**20**	**47**	**77**	**36**	**12**	**192**

Effective Communication

The Public Service Ombudsman Wales (PSOW) has recently requested re-assurance that complainants are communicated with once a complaint is submitted. This has been identified as an area for improvement.

A new telephony system has been implemented which has supported a single point of access for patients, carers and families, In October 2024, 651 Calls were handled by the complaints team. This has improved patient experience by increasing opportunities for early resolution.

Planned Care – The 3P's

The patient experience team are working closely with the development of the 3Ps approach (Promote, Prevent, Prepare). We are supporting the promotion of healthy decisions and lifestyles to reduce the risk of developing illness, we are supporting people to prevent their condition getting worse, and supporting patient preparation for treatment to be a success.

The patient experience team are supporting initiatives around shared decision making, clear and concise communication and signposting individuals for support as part of a proactive approach to complaint and concern resolution.

External Review

Welsh Risk Pool require monthly data uploads in relation to BCUHB complaint data for external verification and validation and for national performance monitoring, and the compliance of BCUHB in relation to the regulatory and Putting Things Right (PTR)procedural requirements. We have been compliant with the schedule of uploads.

PATIENT FEEDBACK

Patient Advice and Liaison Service (PALS)

From September to October 2024, the Patient Advice and Liaison Service (PALS) facilitated the resolution of 1156 enquiries, received 123 compliments in writing and 97 suggestions for improvement.

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

- Appointments
- Clinical treatment or assessment
- Access to services

In October 2024, PALS Officers visited 10 wards across Ysbyty Gwynedd, Ysbyty Glan Clwyd, Wrexham Maelor Hospital and Llandudno General Hospital to undertake 'Care to Share' Discovery Interviews.

As part of the 'Care to Share' Discovery Interview process patients were asked a series of qualitative questions to capture their real time experience of being an inpatient. Following the patient interviews, PALS worked with relevant Ward Managers to identify areas of improvement based on patient feedback through 'you said, we did' learning methodology.

Feedback from patients highlighted staff treating patients with kindness and compassionate and noted a high standard of cleanliness of wards. Areas of improvement identified related to call bells not being responded to timely and the quality of food. PALS are working with relevant services to improve these experiences.

PALS have delivered a series of patient experience awareness training to Children's Ward staff in Ysbyty Glan Clwyd, 229 first year nurses attending a Health Board welcome session, and 9 Internationally Educated Nurses as part of their induction.

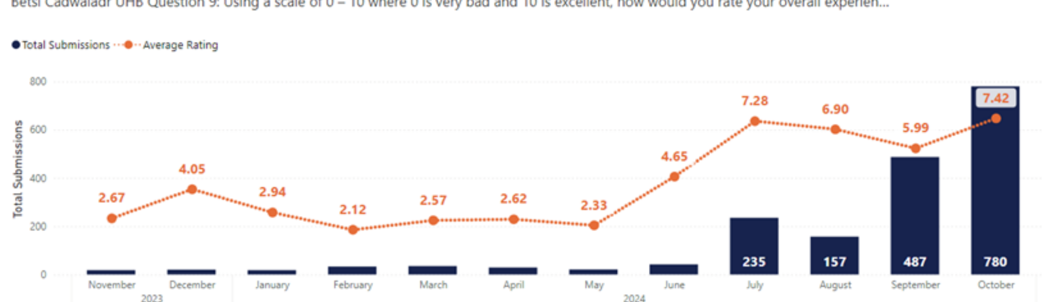
Patient Feedback

From 1 September 2024 – 31 October 2024, 8997 All Wales Real-Time Patient and Carer Feedback Survey responses were received via Civica feedback system. Overall satisfaction levels have remained high with 81.29% of respondents '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:

- 81.44% were always given all the information needed
- 81.70% were always involved in decisions about care
- 84.52% always felt listened to
- 81.03% felt staff always took the time to understand what mattered to them

From 1 September 2024 – 31 October 2024, 1341 Emergency Department feedback survey responses were collected via the Civica Feedback System. The Emergency Department overall satisfaction rating in October 2024, is the highest reported within the last 12 months, with respondents rating their overall experience as 7.58 out of 10, with 10 being excellent.



(Beacon Dashboard 22/11/2024)

On 24th October 2024, the All-Wales Emergency Department survey went live as a SMS feedback survey across all BCUHB Emergency Departments. Prior to the launch of SMS, the average number of Emergency Department feedback responses received per day was 7.95. Following the launch of SMS, the average number of feedback responses increased significantly to 63.8 responses per day. In October 2024, 809 Emergency Department surveys were submitted, of which 75% of the feedback responses were via SMS survey.

Key findings from the All-Wales Emergency Department Real-time Feedback Survey include:

- 54.97% of respondents always felt well cared for
- 25.13% felt they waited 'shorter than expected' to be seen
- 59.28% always felt listened to
- 52.26% always understood what was happening with their care
- 58.65% always felt things were explained in a way that they understood

OTHER PATIENT EXPERIENCE CONCERNS AND IMPROVEMENTS

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 30 patient information leaflets were reviewed by the Readers Panel. Below are examples of leaflets approved at Readers Panel:

- Childrens Glasses
- Information for parents and guardians of babies who require Magnetic Resonance Imaging (MRI) scan

- Information for patients having a Nuclear Medicine whole body bone scan
- Information for patients having a Nuclear Medicine Brain Perfusion Scan
- Information for patients having a Nuclear Medicine Renogram (kidney scan)
- Information for patients having a Nuclear Medicine Amyloid Cardiac scan
- Information for patients having a FDG PET/CT scan (diabetic patients)

Ongoing work continues to support the production of high-quality patient information. The Patient and Carer Experience Team are supporting the Radiology Service who are near completion of reviewing all their patient information leaflets to ensure consistent information is being given to patients across North Wales.

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.

Improvement work is being undertaken to promote ‘digital first’ access to interpretation and translation services to support patients, carers, and relatives.

Chaplain & Spiritual Care Service

From September to October 2024, the Chaplain and Spiritual Care Service responded to 141 requests for support pan North Wales. These requests for support are in addition to daily pastoral work undertaken on wards/units.

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

The Chaplain Manager continues to broadcast a weekly radio show on Radio Ysbyty Gwynedd that can accessed worldwide inviting guests made up of external partners and staff from the Health Board to raise awareness of services e.g., suicide prevention.

The service delivered a half day training session on meeting the spiritual needs of patients and their families to staff at St David’s Hospice, Bangor.

Examples of events organised:

- Music sessions to dementia patients on Glaslyn Ward, Ysbyty Gwynedd, Dolgellau Dementia Services, Tywyn Community Hospital, Holywell Community Hospital and Bryn Hesketh Unit in partnership with PALS
- Caribbean party for patients and their families at Onnen Ward
- Music session with children and young people at North Wales Adolescence Service
- Pastoral care & music sessions with patients from various wards across Wrexham Maelor Hospital
- Kerela/Indian awareness dance event led by staff to celebrate the Onam Festival in Ysbyty Gwynedd main foyer
- Courtyard Open Day in Ysbyty Wrexham Maelor

CLINICAL EFFECTIVENESS

CLINICAL AUDIT

National Clinical Audits (Tier 1) are mandated audits that provide benchmarking reports to help Health Boards clinically monitor performance against national standards and identify areas of improvement. These audits are crucial for maintaining high standards of care and ensuring continuous improvement in the NHS.

Within BCUHB Tier 1 audits are monitored quarterly, a report is collated and shared within the Strategic Clinical Effectiveness Group and then within the Chair's Report in Executive Quality Delivery Group. Noted below are Tier 1 nationally published reports (the information in the report is relating to the care received by patients for the relevant audit topic) during Quarter 2. Service Assessments of Compliance (SAoCs) are requested following the publication by the Clinical Effectiveness Facilitators (Audit) to note key achievements. Please refer to the table below which captures improvements made, impact shown and lessons learnt.

				West	Central	East	
Title of National Audit	**Name of report**	**Date of publication**	**Date Service Assessment response due**	**Service Assessment Completed**	**Service Assessment Completed**	**Service Assessment Completed**	**Key Achievements Summary**
National Diabetes Inpatient Safety Audit (NDISA)	2022-23 Report	08-Jul-24	02-Sep-24	No - Overdue	No - Overdue	Yes - Draft	Service Assessment of Compliance (SAoC) received from East undergoing Clinical Effectiveness Team review, SAoC not received from Central & West, escalated to IHC management structure in line with Clinical Effective Team Process
National Respiratory Audit Programme (NRAP): COPD	Breathing well: An assessment of respiratory care in England & Wales 22/23	11-Jul-24	09-Sep-24	No - Overdue	Yes - Draft	No - Overdue	Service Assessment of Compliance (SAoC) received from Central undergoing Clinical Effectiveness Team review, SAoC not received from West & East, escalated to IHC management structure in line with Clinical Effective Team Process
National Respiratory Audit Programme (NRAP): Adult Asthma	Breathing well: An assessment of respiratory care in England & Wales 22/23	11-Jul-24	09-Sep-24	No - Overdue	Yes - Draft	No - Overdue	Service Assessment of Compliance (SAoC) received from Central undergoing Clinical Effectiveness Team review, SAoC not received from West & East, escalated to IHC management structure in line with Clinical Effective Team Process
National Respiratory Audit Programme (NRAP): Children & Young Peoples Asthma	Breathing well: An assessment of respiratory care in England & Wales 22/23	11-Jul-24	09-Sep-24	No - Overdue	Yes	No - Overdue	Service Assessment of Compliance (SAoC) received from Central. SAoC not received from West & East, escalated to IHC management structure in line with Clinical Effective Team Process
National Respiratory Audit Programme (NRAP): Pulmonary Rehabilitation	Breathing well: An assessment of respiratory care in England & Wales 22/23	11-Jul-24	09-Sep-24	Yes - Draft	Yes - Draft	Yes - Draft	Service Assessment of Compliance undergoing Clinical Effectiveness Team review.
National Clinical Audit of Seizures and Epilepsies for Children and Young People	Epilepsy 12 2024 combined organisational and clinical audits: Report for England and Wales	11-Jul-24	05-Sep-24	Yes - Draft	Yes - Draft	Yes - Draft	Service Assessment of Compliance undergoing Clinical Effectiveness Team review.

Mothers and Babies: Reducing risk through Audits and Confidential Enquiries across the UK - MBRRACE-UK	Perinatal Mortality Surveillance. UK Perinatal deaths of babies born in 2022. State of the Nation report	11-Jul-24	05-Sep-24	Yes - Draft	Yes - Draft	Yes - Draft	Service Assessment of Compliance undergoing Clinical Effectiveness Team review.
NCEPOD Endometriosis	A Long and Painful Road	12-Jul-24	05-Sep-24	Yes - Draft	Yes - Draft	Yes - Draft	Service Assessment of Compliance due September 2024 not received (BCU wide) before the quarter end. North Wales Clinical lead, Women's Services is finalising the submission prior to Clinical Effectiveness review – in progress with draft response received.
Renal Registry	UKKA RR 26th Annual Report	18-Jul-24	17-Sep-24	No - Overdue	No - Overdue	No - Overdue	Service assessment response (BCU wide) due September 2024 not yet received. SAoC to be agreed during the Renal Audit Day 30th October 2024, following discussion of the national report findings and agreement of the organisational recommendations as none are set nationally.
National Pancreatic Cancer Audit (NPaCA)	2024 State of the Nation Report	12-Sep-24	07-Nov-24	No - In Progress	No - In Progress	No - In Progress	Due in Quarter 3
National Ovarian Cancer Audit (NOCA)	2024 State of the Nation Report	12-Sep-24	11-Nov-24	No - In Progress	No - In Progress	No - In Progress	Due in Quarter 3
National Non-Hodgkin Lymphoma Audit (NNHLA)	2024 State of the Nation Report	12-Sep-24	11-Nov-24	No - In Progress	No - In Progress	No - In Progress	Due in Quarter 3
National Audit of Primary Breast Cancer (NAoPri)	State of the Nation Report 2024	12-Sep-24	05-Dec-24	No - In Progress	No - In Progress	No - In Progress	Due in Quarter 3
National Audit of Metastatic Breast Cancer (NAoMe)	State of the Nation Report 2024	12-Sep-24	05-Dec-24	No - In Progress	No - In Progress	No - In Progress	Due in Quarter 3
National Kidney Cancer Audit	State of the Nation Report 2024	12-Sep-24	05-Dec-24	No - In Progress	No - In Progress	No - In Progress	Due in Quarter 3
FFFAP: National Hip Fracture database	A broken hip - Three stops to recovery (1 Jan 23 - 31 Dec 23)	12-Sep-24	16-Dec-24	No - In Progress	No - In Progress	No - In Progress	Due in Quarter 3
National Respiratory Audit Programme (NRAP): Primary Care Wales Audit	Clinical Audit Report 2021-23	12-Sep-24	16-Dec-24	No - In Progress	No - In Progress	No - In Progress	Due in Quarter 3

NICE GUIDELINES

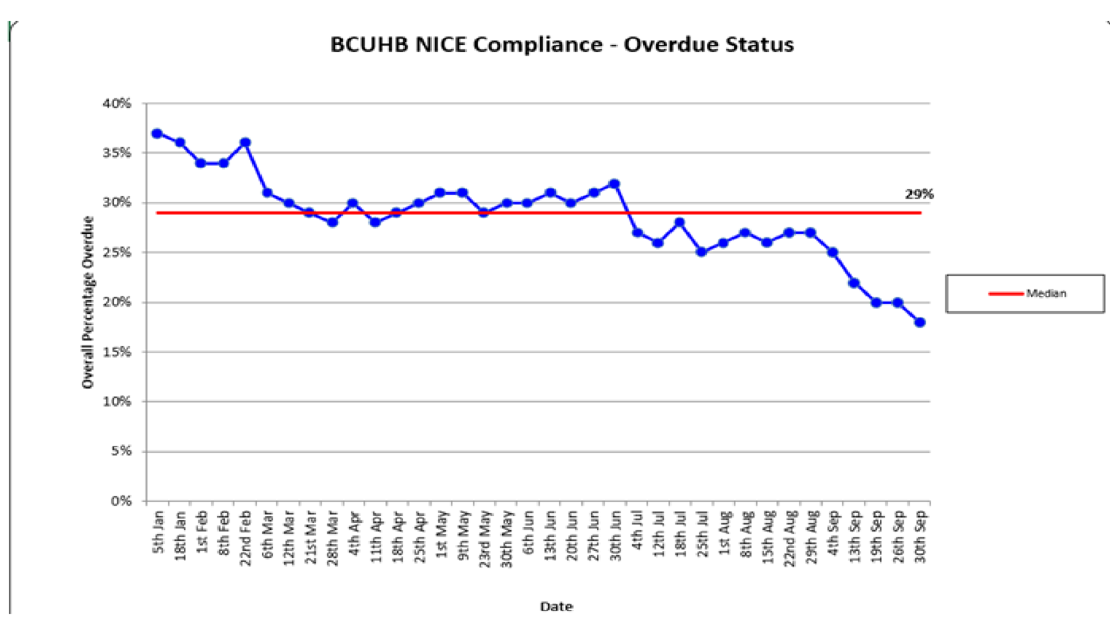
The Clinical Effectiveness Facilitator for NICE (CEF for NICE) is continuously working to support departments with guidance and training where needed, and any overdue guidance is escalated via the Strategic Clinical Effectiveness Group (SCEG) when necessary. There has been improvement in all aspects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

IHCs' updates:

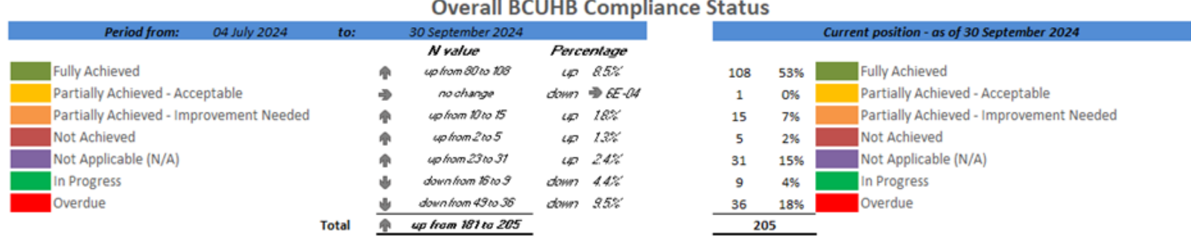
- West – improvements have been made with compliance, face-to-face meetings at Ysbyty Gwynedd have been arranged to meet with Leads and provide training for AMaT, which has helped with compliance percentages, this support will be continued.
- Central – meetings are being set up with DGMs to help with engagement from leads, especially in Medicine and Surgery, using the AMaT system.
- East – compliance and engagement remains high and regular monthly meetings are held.

The overall Health Board compliance status is improving with only 18% outstanding as overdue (non-responses).

BCUHB NICE (Overdue) run chart for 2024



Comparison Chart July – September 2024



Overall BCUHB Compliance Status

Period from: 04 July 2024 to: 30 September 2024

		N value	Percentage	
Fully Achieved	↑	up from 80 to 108	up	8.5%
Partially Achieved - Acceptable	→	no change	down	→ 6E-04
Partially Achieved - Improvement Needed	↑	up from 10 to 15	up	1.8%
Not Achieved	↑	up from 2 to 5	up	1.3%
Not Applicable (N/A)	↑	up from 23 to 31	up	2.4%
In Progress	↓	down from 16 to 9	down	4.4%
Overdue	↓	down from 43 to 36	down	9.5%
Total	↑	up from 181 to 205		

Current position - as of 30 September 2024

N	%	Status
108	53%	Fully Achieved
1	0%	Partially Achieved - Acceptable
15	7%	Partially Achieved - Improvement Needed
5	2%	Not Achieved
31	15%	Not Applicable (N/A)
9	4%	In Progress
36	18%	Overdue
205		

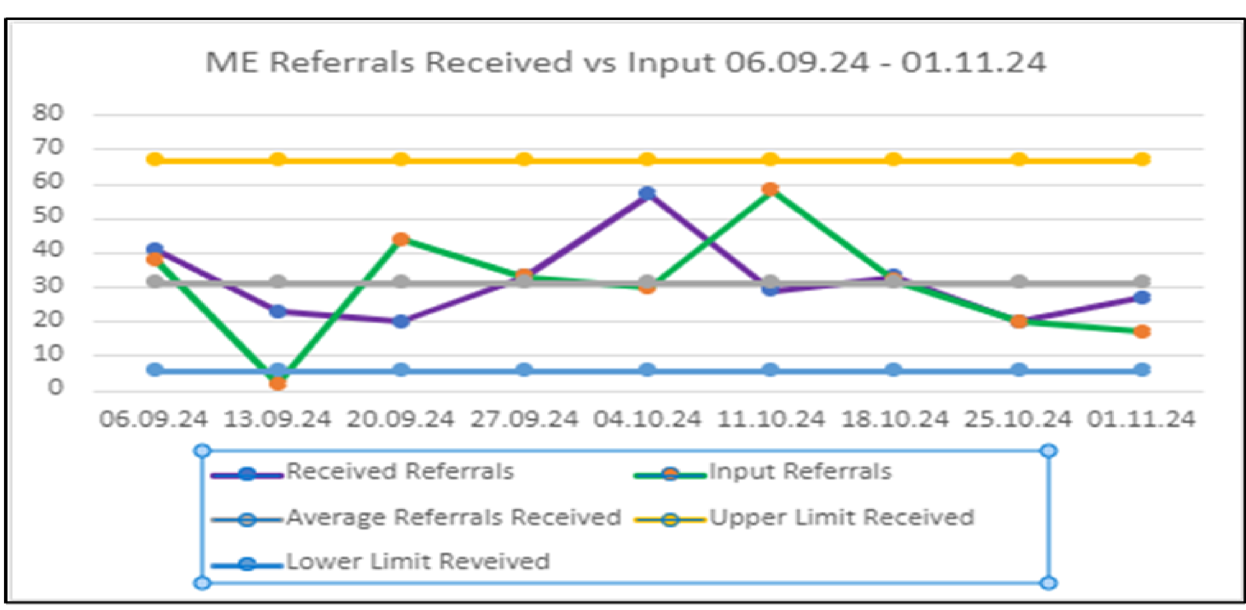
The Clinical Effectiveness Facilitator for NICE has recently presented at the Welsh NICE Health Network to give a brief overview on how the NICE compliance is improving within BCUHB. Primary Care was especially of interest because they were interested how the NICE agenda had been adopted within the BCU GP Managed Practices.

MORTALITY REVIEW

Corporate Mortality Update:

- Monthly Learning from Mortality Panel and Reducing Avoidable Mortality Steering Group meetings will formally re-instate in January 2025 with review of the agenda format, terms of reference and cycle of business. Accountability in terms of reporting back to LFMP will be a key priority as well as wider clinical engagement.
- Following appointment of AMDs for mortality, clinical engagement with the Once for Wales (OfW) group to hone the themes (both in terms of options but also descriptions) is seen as a key opportunity with the aim to glean accurate data extraction from the mortality Datix. This will allow the Health Board to draw upon themes via the Mortality Datix in the future.

- A report of cases that have been reviewed by Corporate Mortality Clinical Reviewers is being provided to the Integrated Concerns Hub daily whilst there is a backlog, to ensure triangulation of the incidents, concerns and mortality process is taking place in a timely manner. When the backlog is down to September 1st, the hub is reviewing cases from this date directly from NEW before any sort and sieve by mortality team, to process through to other PTR processes. The mortality process will run alongside this in line with The All-Wales Mortality Framework, where the focus will be learning from cases.
- A backlog has formed for cases awaiting corporate mortality administrative sieve and sort process, due to the extra resource required for the Integrated Concerns Hub. This poses a risk as mortality cases are now being reviewed later by the mortality team. There has been some risk mitigation due to a temporary increase in staffing resource, but additional funding is only short term. There remains a high number of cases outstanding IHC/service reviews.
- A consolidated improvement plan for the Health Board has been compiled following on from the results of the 2023-24 cycle of the BCUHB audit of compliance of completed DNACPR forms with the All-Wales DNACPR policy and publication of the Health Inspectorate Wales (HIW) Review of DNACPR decision-making in Wales.



	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	Pending Cases Within 2 months awaiting Mortality Clinician Review	Pending Cases Within 3 months awaiting Mortality Clinician Review	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
06.09.24	41	38	-3	5	5	0	0	25	15	10	0	211	33	54	124	750	244	2662
13.09.24	23	2	-21	26	26	0	0	1	1	0	0	214	28	59	127	753	235	2690
20.09.24	20	44	24	2	2	0	0	34	33	1	0	188	28	35	125	773	227	2712
27.09.204.	33	33	0	2	2	0	0	43	43	0	0	161	28	26	107	810	223	2726
04.10.24	57	30	-27	31	31	0	0	51	50	1	0	136	24	28	84	844	219	2740
11.10.24	29	58	29	2	2	0	0	73	73	0	0	109	8	29	72	882	219	2759
18.10.24	33	32	-1	3	3	0	0	72	72	0	0	78	10	17	51	923	219	2781
25.10.24	20	20	0	3	3	0	0	80	76	4	0	36	1	8	27	950	224	2802
01.11.24	27	17	-10	12	12	0	0	59	59	0	0	17	1	9	6	981	224	2828

For info: *New Within 3 months & over DOD (awaiting mortality admin s&s) 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

OTHER CLINICAL EFFECTIVENESS CONCERNS AND IMPROVEMENTS

Below is an update on areas of data collection issues reported for review raised through Quarter 2.

Any concerns are escalated initially to local Clinical Effectiveness meetings, if no improvement is made the IHC/Divisions would note to Strategic Clinical Effectiveness group in form of SBAR or through Chair's report as a risk and put on risk register. Strategic Clinical Effectiveness Group will raise with Quality Development Group.

	West	Central	East
Title of National Audit/ Clinical Outcome Review	**Participation/Data collection issues reported**	**Participation/Data collection issues reported**	**Participation/Data collection issues reported**
National Heart Failure Audit	Data entry not progressing in West as the audit administrator post is vacant. New post holder recruited and expected to take up role in Quarter 3		
Myocardial Ischaemia National Audit Project (MINAP)	Data entry not progressing in West as the audit administrator post is vacant. New post holder recruited and expected to take up role in Quarter 3		
National Clinical Audit of Seizures and Epilepsies for Children and Young People	Audit lead reports that unable to find time to submit data in West and East due to workload		Audit lead reports that unable to find time to submit data in West and East due to workload
National Diabetes Inpatient Safety Audit (NDISA)	**This was included a previous report however an update has been noted.** HARMS element - data submission to this element of the audit not established in all three IHCs since the re-launch in November 2022. However, Central IHC now registered to take part and will commence data collection from November 2024		

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 Activity October to November 2024
Published Reports (0)
Announced/Unannounced Inspections (1) **Unannounced inspection at Heddfan Unit, Mental Health and Learning Disabilities** HIW undertook an inspection at Hydref and Gwanwyn Wards on the Heddfan Unit from the 21st of October to the 23rd of October 2024. Whilst the overall inspection was very positive, HIW issued an immediate assurance as the inspection team identified areas posing immediate risk to patient safety. As such, HIW made the following recommendations to the Health Board which require immediate action: • The Health Board must ensure that all staff on Hydref and Gwanwyn wards are compliant with their RPI training to ensure patient and staff safety is maintained. • The Health Board must implement measures to ensure there are sufficiently trained staff members to manage incidences of restraint on both wards, until all staff have received their training. • The Health Board must ensure restraint incidents are appropriately recorded and provide a full description of the incident, including the actions of staff involved, to support effective governance, oversight and ongoing monitoring. • The Health Board must ensure that our findings in relation to restraint training compliance and incident recording are not systemic across other areas of the organisation. The Health Board submitted an Immediate Improvement Plan to HIW on 01 November 2024 confirming the action it will take to make the required improvements and mitigate any further risks. Whilst it is important to recognise the positive verbal feedback from the inspection in particular around patient care and record keeping, HIW may seek further assurances in relation to the immediate issues as these issues were also identified in a previous inspection at Heddfan Unit in November 2022. The Health Board await the formal inspection report for further context as to the next steps required.

Concerns / Requests for Assurance (3)

Case 1: North Wales Kaleidoscope Project

The Health Board received a letter of concern from HIW regarding the following:

- Health and safety of both staff and patients, due to poorly managed violence within the service
- Lack of transparency regarding employment status of doctors
- Controlled drug prescriptions being pre-signed and left at a variety of locations, for both clinical and admin staff to complete as needed
- Non-prescribing nurses being allowed to alter medication doses, in the absence of any legal mechanisms, such as PGD
- Lack of adherence to All Wales Safeguarding Procedure

This has been responded to collaboratively by the Health Board and North Wales Police; however, it is predominantly North Wales Police as they commission the service. The Health Board's Chief Pharmacist has responded in relation to the prescribing element of the concern, which has been accepted by HIW as sufficient assurance.

Case 2: IHC East, Psychiatric Intensive Care Unit (PICU), Mental Health and Learning Disabilities

The Health Board received a letter of concern from HIW regarding behavioural issues concerning a member of staff working on the PICU Unit.

Case 3: IHC Central, Acute Medical Unit (AMU)

The Health Board received a letter of concern from HIW regarding feedback they were given about the care of patient on the AMU pertaining to lack of kindness and empathy. There were also concerns with regards to having food withheld.

All the above have been responded to by the Health Board and no further requests have been received from HIW at the time of writing this report. The Executive Director of Nursing reviews all responses and teams act on issues that are found to be correctly identified.

Healthcare Inspectorate Wales – Progress with Improvement Plans October to November

Month on month progress rates

Performance Markers		Overall RAG status
⇧	Increase	Complete / Fully Complete (Awaiting Approval)
⇨	Stagnant	In progress
⇩	Decline	Overdue

Performance markers are based on ‘Complete’ and ‘Fully Complete’ actions only *Overall RAG status is based on the overall completion status of the action/improvement plan*			
Service / Area	**Date**	**Responsible Lead**	**Position overview**
Local Review of Discharge Arrangements for Adult Patients from Inpatient Mental Health Services (Action Plan)	Mar 2023	Interim Director, Mental Health and Learning Disabilities	**4%**
Nant Y Glyn Community Health (Improvement Plan)	Jan 2024	Interim Director, Mental Health and Learning Disabilities	
Emergency Department, Ysbyty Glan Clwyd (Immediate Improvement Plan)	Apr 2024	Integrated Health Community Director, Central	**13%**
Emergency Department, Ysbyty Glan Clwyd (Improvement Plan)	Apr 2024	Integrated Health Community Director, Central	**14%**
IR(ME)R, Ysbyty Gwynedd **Note: Recently added to the AMaT system in November. Progress will be shown in next meeting papers**	June 2024	Professional Service Manager, Radiography	

Status Overview

Name of Inspection / Review	Date of Inspection	Responsible Lead	Total recommendations and Actions	Progress Overview
Local Review of Discharge Arrangements for Adult Patients from Inpatient Mental Health Services (Action Plan)	24th March 2023	Interim Director, Mental Health and Learning Disabilities	Total Recommendations 40 Total Service Improvement Actions 206	In progress Partially complete Partially complete (Overdue) – **6** Overdue Rejected Completed (Approved) – **199** Legend: Partially complete (Overdue); Completed (Approved) 97%
Nant Y Glyn Community Health (Improvement Plan)	23rd Jan 2024	Interim Director, Mental Health and Learning Disabilities	Total Recommendations 23 Total Service Improvement Actions 51	In progress- **2** Partially complete **- 1** Partially complete (Overdue)- **7** Overdue Completed (awaiting approval) **1** Rejected Completed- (Approved) **40** Legend: In progress; Partially complete; Partially complete (Overdue); Completed (Awaiting Approval); Completed (Approved) 78%
IR(ME)R Ysbyty Gwynedd	25th June 2024	Professional Service Manager, Radiography	Total Recommendations 18 Total Service Improvement Actions 21	In progress - **4** Partially complete Partially complete (Overdue) Overdue - **17** Rejected Completed (Approved) Legend: In progress; Overdue 81%
Emergency Department, Ysbyty Glan Clwyd (Immediate Improvement Plan)	29th Apr 2024	Integrated Health Community Director, Central	Total Recommendations 6 Total Service Improvement Actions 22	In progress Partially complete - **1** Partially complete (Overdue) - **1** Overdue - **1** Rejected - **1** Completed (Approved) – **18** Legend: Partially complete; Partially complete (Overdue); Overdue; Rejected; Completed (Approved) 82%
Emergency Department, Ysbyty Glan Clwyd (Improvement Plan)	29th Apr 2024	Integrated Health Community Director, Central	Total recommendations 27 Total Service Improvement Actions 70	In progress - **6** Partially complete - **2** Partially complete (Overdue) **- 6** Overdue- **19** Rejected -**2** Completed (Approved) – **35** Legend: In progress; Partially complete; Partially complete (Overdue); Overdue; Rejected; Completed (Approved) 50%

- The Local Review of Discharge Arrangements for Adult Patients from Inpatient Mental Health Services Action Plan is scheduled for closure in November 2024.
- IRMER Ysbyty Gwynedd is now on the AMaT system and the service are in the process of updating each action and submitting the appropriate evidence. The service have confirmed that all actions are complete. The updated actions and evidence submitted, will be reviewed by the Quality Assurance and Regulation Team and reported to the next RAG in December.
- Emergency Department at Glan Clwyd (immediate Improvement Plan) is scheduled for completion by January 2025.
- Emergency Department at Glan Clwyd (Improvement Plan) is scheduled for completion by February 2025, and an update on progress was shared with HIW on 12 November 2024.

The above action plans / improvement plans are reported monthly to the Regulatory Assurance (RAG) Group with exception reports to the Executive Delivery Group. The Quality Assurance and Regulation Team work with Responsible Directors and Service Leads to track and monitor the plans, and present monthly reports on progress to the Group for learning and assurance. Responsible Directors attend RAG to share developments and learning, along with any issues for escalation.

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 help 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) which 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 who are working in a CIW registered service are regulated with Social Care Wales. The pathway also aims to increase assurance and oversight.

Quality of Care Review visits

The first of the six-monthly Quality of Care Review visits took place at Tuag Adref / Home First, IHC East on 29 February 2024 and IHC West on 13 March 2024 with a visit to Enhanced Community Residential Services (ECRS) in Mental Health and Learning Disabilities was scheduled for May 2024, however, was rescheduled for July 2024 which has since taken place.

The next visit to be scheduled is IHC East as it has been six months since their last visit. The service has completed a Quality-of-Care Review Report which is under review by the Health Board’s Responsible Individual ahead of the next visit to the service.

The services are asked to complete a Quality-of-Care Review Report ahead of the visit which helps to demonstrate that they are meeting the four key well-being areas in line with legal requirements. The purpose is for them to assess their performance and look at any opportunities to improve and develop. No immediate issues were raised during the last visits by either the teams or by the Health Boards Responsible Individual (Deputy Director of Quality).

Amendment to CIW Registration

Both IHC Centre and IHC West have made a formal request to amend their service registration with CIW which has been initially reviewed by the Quality Assurance and Regulation Team and the Responsible Individual for the Health Board. The requests are proceeding via the Regulatory Assurance Group.

The request has been made in line with the considerations outlined in the Regulation and Inspection of Social Care (Wales) Act 2016. The Health Boards Responsible Individual will inform CIW and clarify the next steps.

QUALITY PEER REVIEWS

In Quality Peer Reviews were introduced at the end of last summer with the purpose of supporting services to understand how compliant they are against 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 which has been developed based on the approach of Healthcare Inspectorate Wales (HIW).The process remains under development and was put in place with the need to help the Health Board to assess its progress against the recommendations issued by HIW following inspections they undertook of the Emergency Department at Glan Clwyd back in 2022 whereby 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 comes from the HIW National Review of Maternity Services which was launched across Wales in 2019. Whilst HIW completed phase one of the review, phase two was paused due to the Covid-19 pandemic. In 2021, HIW took the decision not to progress with phase two of the review after careful consideration of their risk-based inspection and reviews programme for 2021-22 and their resources. However, HIW have since begun to

inspect maternity services in Wales including Swansea Bay University Health Board and Cwm Taf Morgannwg University Health Board. The intelligence had led to the above reviews, together with the direct support of the Director of Maternity and Women's Services.

Work is underway to plan further reviews, driven by the intelligence held by the Health Board which includes service user feedback and key quality metrics, along with intelligence from regulators and third-party organisations.

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.

Detail can be found in the confidential quality report.

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.

Public Interest Reports (PIRs)

The Health Board currently has one Public Interest Report which remains ongoing:

1. Public Interest Report ID753, IHC East (Gastroenterology): The Health Board received the draft report on 04 June 2024 and commented on the proposed conclusions and recommendations. The report was published on 15 August 2024, and a copy of the final report can be found here. There was a delay in the Ombudsman issuing the final report which is sadly due to a recent bereavement within the family. The Health Board are proceeding with progressing actions to meet the recommendations made by the Ombudsman and reporting to the Regulatory Assurance Group (RAG).

The investigation considered the care and treatment provided by the Health Board between January 2021 and the patient's death on 31 January 2022 from biliary sepsis, and following discharge in January 2021 (after admission with abdominal pain), whether monthly blood tests were an appropriate way to monitor the patient's condition. The Ombudsman upheld these complaints. The Ombudsman did not uphold the complaint that there was a lack of follow-up care following a biliary stent being fitted in November 2021.

The Health Board has written to the family and has issued a fulsome apology in line with the recommendations made by the Ombudsman, along with a financial redress payment of £4,000, reflecting the serious failings and the resulting and lasting significant impact upon the patient and their family. The remaining recommendations are in progress and on track for submission to the Ombudsman by 13 December 2024.

Average Variance to Target (AVT)

The Ombudsman measures responsiveness using a measure called Average Variance to Target (AVT). This is regularly shared with all Health Boards. Anything over a '0' is seen as days over target date on average for the Health Board to provide compliance evidence and anything with a minus indicates the number of days under, on average, a Health Board takes to provide evidence to comply with a target date to provide evidence to comply with a recommendation.

As shown below, the Health Board's AVT is currently 0. Therefore, the Health Boards average for October 2024 is 0 (zero) days, which means that it is responding within the Ombudsman's target date. For context, The NHS average for October is 1.69 compared with 2.43 in September 2024. On average compliance evidence is reaching the Ombudsman's office just over 1.5 days later than the target dates.

The Quality Assurance and Regulation Team have recently networked with other Local Health Boards and Trusts to identify ways which the Health Board can improve how it captures, tracks and monitors Ombudsman recommendations and compliance. The Health Board continues to meet with the Ombudsman's Complaints Standards Authority to ensure good working practices and to facilitate awareness training for staff working within the Health Board.

ORGANISATIONAL LEARNING

The Organisational Learning Forum (OLF) brings together colleagues with a shared interest in and vision for working in new ways to improve safety, practice and processes across our healthcare system. The following is a sample of learning from the last two meetings of the OLF:

- Kirsty Thomson, Head of Charitable Funds and Charitable Partnerships shared information on International Partnerships, which have been established by colleagues in various departments over the years. They are now seeing increased support from Welsh Government and other health organisations in Wales. These partnerships stem from a desire to link with organisations to share learning.

  Awyr Las currently have five active Wales for Africa funds established in Kenya, Sierra Leonne, Ethiopia, Lesotho.

  The group was asked to consider how BCUHB could increase its understanding of International Partnerships, how to learn from them and most importantly how to share the learning effectively. The learning element is currently an area to improve on, with no framework in place.

  The full value of the active partnerships is not measured at the moment. Awyr Las, in collaboration with the Organisational Learning Forum would like to bring together as many people across the organisation as possible to think outside the box on developing partnerships across the world with an effective framework.

A BCUHB executive sponsor will be assigned to support the momentum and raise the profile of International Partnerships

- Ffion Pursglove, Specialist Nurse Medicines Management shared learning and positive action following an incident where an insulin type was incorrectly prescribed and errors were not reported or missed at key points in the process.

  The key learning points from this incident highlighted a regular theme across BCUHB with a gap in knowledge around the different types of insulin. Clear prescription chart annotation of which insulin product is required for the patient is essential. There are multiple types of Humulin insulin, so clarity is vital. Ward staff are asked to ensure that all medications are sent down to pharmacy with the TTO, and, that a thorough check of the prescription chart is made, before administering medication to ensure there have been no changes since the previous administration. Any errors need to be escalated to the Pharmacist or the prescriber as soon as possible to correct it.

  Education is available for staff via an e-learning 'Safe Use of Insulin' but it is not mandatory.

  Ffion shared the proposed actions following a full review of this incident. All staff are strongly advised to complete the safe use of insulin E-learning. Education sessions are available via the DSNs, but they are often not very well attended due to the challenges of competing demands on busy wards.

  Education is also within the Junior doctor's induction. The pharmacist who teaches the junior doctors during their induction has included the safe prescribing of insulin in their presentation and have used this incident as an example. We may need to explore mandatory training for all clinical staff.

  The team are also working alongside the electronic Prescribing and Medicines Administration (ePMA) project to ensure insulin prescribing is safer for the future.

  Ffion and the team will be sharing the learning locally through a medication safety memo and 7 minute briefing to be issued pan BCU. It is a topic in the IHC West Safe Medication Management Incident Review Group which is our scrutiny group for medications. The incident is being included in the FY1 prescribing session delivered by YG Pharmacy Department and is included in the medicine management training sessions to raise awareness. It is also being discussed in Pharmacy patient safety leads meetings and Pharmacy Team Brief.

- Jane Roberts, Head of Nursing for Primary and Community Central, shared insights into how colleagues in Workforce are encouraging managers to think carefully around efforts to support staff through performance management.

  The learning comes after reflecting on the experiences of a BCU colleague undertaking performance management following more than 25 years' experience within the NHS. As part of the process, the colleague engaged in the performance management submitted a lengthy letter reflecting on their own experiences, which highlighted the personal and professional impact of the performance management process.

The experiences brought into focus how the existing policy for capabilities (WP3a) clearly outlines a constructive and positive approach to supporting colleagues through meeting their capabilities. In this instance, the employee taking part in the performance management had not been adequately supported, according to the expectations set out in the policy, which in turn contributed to further challenges in their ability to meet the requirements of their role.

The findings and analysis of this particular case have since lead to a refocus on how performance management is undertaken within the organisation, with a recent presentation to our Heads of Nursing highlighting the obligations of our managers to support colleagues through this process. Issues such as the clear support and documentation of meetings, having an identified line manager to oversee support over the entire process of performance management, and the important of clearly defined SMART goals and KPIs were identified as areas critical to the success of performance management.

Jane summarised by sharing the importance of acknowledging the stress that the performance management has on individuals, and the responsibilities of colleagues in leadership positions to examine their own local procedures and to be assured that they can adequately support colleagues who would benefit from performance management.

A further piece of quality improvement work is also now underway to look at whether ESR systems can be more effective in recording competencies and achievement goals.

- Nia Harris, Organisational Development Manager, shared an update on efforts to redevelop our organisational values.

  As part of a Culture and Leadership Programme to develop a compassionate, inclusive and collective culture for all, the Health Board is revising its organisational values and behaviours.

  Having the right culture in healthcare organisations leads to improved care and positive staff experience. We have lots of information on our current culture through the internal review carried out as part of Special Measures, previous engagements events and staff survey.

  As one of the first pieces of work around the culture, BCU is looking at the values and behaviours we have in the organisation . 18 engagement session occurred across the health board completing on 31st Oct 2024 with an increased face to face presence to reach non-digitally enabled colleagues and multiple drop-in sessions on Microsoft Teams. The feedback form the engagement will once again shape any amendments to the second draft of the Values & Behaviours Framework.

  Amongst other tools we will have an active culture dashboard which will assist in measuring the work and includes staff and patient experiences data. A final version of the Values and Behaviours Framework will be presented at the November board meeting before work will commence to socialise and embed the Framework

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 received one Regulation 28 Prevention of Future Death (PFD) Report since the last report.

In this case, the patient was at Wrexham Maelor Hospital and as a result of being assessed as being at significant risk of falling, they were on an enhanced level of observation. During June 2024, the patient was exhibiting signs of anxiety and agitation and a member of nursing staff asked a doctor to review. As the doctor was too busy to attend the ward, the nurse took the prescription chart to the doctor on another ward and they prescribed a sedative, namely lorazepam, which was administered at 22.40 with a further dose being given at 04.30 the following day. Later that morning the patient had an unwitnessed fall and sustained an injury which resulted in her death. The Coroner found the evidence supports a view that it is probable that she fell as a result of the effects of the sedation.

The Coroner raised concerns through the PFD that the doctor who prescribed a sedative did so without reference to any of the patient's notes other than the prescription chart and as a result was unaware of the enhanced falls risk or any other behavioural issues. Whilst the Coroner recognised that medication changes may be necessary without the doctor being able to review a patient in person, they were concerned that this may occur without the doctor having access to and considering full medical records and risk assessments.

The Health Board has 56 days to respond to all Regulation 28 Notices. Notices are allocated to a lead within the relevant Service, with responses scrutinised and approved by the relevant Executive Director.

A bi-weekly Inquest Oversight Panel was established in autumn last year to provide Executive support to ensuring deadlines were achieved. Whilst more work is needed on timeliness (linked to the new Integrated Concerns Policy), there has been a significant improvement.

Since the last meeting, the Coroner also returned one conclusion with a Neglect rider.

In this case, a patient at Ysbyty Glan Clwyd died in May 2022 from an undiagnosed pulmonary embolism after clinicians believed her to be suffering from supraventricular tachycardia (SVT) (a heart condition). The patient's GP had undertaken an electrocardiogram (ECG) which suggested the patient had SVT and on arrival at YGC, clinicians relied on this incorrect indication which led to the wrong intervention. The coroner concluded the patient's death was due to Natural Causes contributed to by Neglect. The coroner was assured by the learning presented from the Health Board and did not issue a PFD. The coroner will, however, write to the GP surgery to raise their awareness of what has been identified and to understand what learning and change has come about.

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.

There are no significant claims issued to report.

A separate paper is being submitted to the Committee in private with detailed case information on potential high value claims.

The Health Board has several overdue Learning from Events Reports (LFERs) which are due to be submitted to the Welsh Risk Pool (WRP). At the time of writing, this number was 63 with 20 cases at risk of financial penalty for late return. As with other areas of overdue documents (such as incidents and complaints) support is being provided to divisions to facilitate completion and regular reporting and escalation is in place.

A full review of the LFER process is underway and a paper will be submitted to the Executive Team.

OTHER HEALTHCARE LITIGATION ISSUES

The Legal Services Department has now transferred to the Corporate Governance Directorate and is working on an improvement plan for the future, called Transforming Legal Services. The aim of these improvements is to enhance the availability and quality of legal advice and support to clinical and corporate services and to improve the capture of learning from legal cases. The outline of this emerging plan was presented at the Directorate Performance Review with the Executive Team on 01 November 2024. A separate paper to this Committee on claims outlines some of the future plans.

The investigation of a complaint against Betsi Cadwaladr University Health Board

A report by the
Public Services Ombudsman for Wales
Case: 202206250

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Introduction

This report is issued under s23 of the Public Services Ombudsman (Wales) Act 2019.

In accordance with the provisions of the Act, the report has been anonymised so that, as far as possible, any details which might cause individuals to be identified have been amended or omitted. The report therefore refers to the complainant as Mrs L.

Summary

Mrs L complained about the care and treatment her late mother, Mrs K, received from the Health Board between January 2021 and her death on 31 January 2022 from biliary sepsis (a serious infection of the bile ducts). In particular whether monthly blood tests were an appropriate way to monitor her condition from January 2021, and the follow-up care for Mrs K following a biliary stent in November 2021.

Mrs K had pancreatitis (inflammation of the pancreas) in January 2021. An ultrasound scan was undertaken but the Ombudsman found that the scan was inadequate as Mrs K's bile duct was not visible, so it could not be seen whether gallstones were present. The Ombudsman found that given Mrs K's clinical history the most likely cause for pancreatitis was gallstones, but the Health Board had concluded it was steroid induced pancreatitis despite the scan being unclear. The failure to identify Mrs K's gallstones in January 2021 meant her condition remained untreated.

In August, Mrs K developed other symptoms. Scans undertaken in the autumn showed evidence of a blocked bile duct which required surgery in November. The Ombudsman found that she should have been treated sooner and these were further missed opportunities by the Health Board to identify the seriousness of Mrs K's condition.

The surgery did not fully resolve Mrs K's condition, and she sadly died in January 2022.

The Ombudsman concluded that if Mrs K had been treated appropriately at the outset, her pancreatitis would have been treated successfully and her deterioration and death may have been prevented. This was a grave injustice to Mrs K and her family. The Ombudsman also found little to no evidence that the seriousness of Mrs K's condition was appropriately communicated in October to her and her family either before or after treatment.

The Ombudsman found that although the surgery in November was carried out too late for Mrs K, the procedure was performed to the required standard. A further procedure was scheduled for 8 weeks' time, and this was a reasonable amount of time for Mrs K to wait.

The Ombudsman was concerned at the Health Board's seeming lack of candour in its complaint response to Mrs L, and its lack of objective reflection by its clinicians during the Ombudsman's investigation in that it continued to fail to identify and acknowledge failings in Mrs K's care.

The Ombudsman made a number of recommendations, which the Health Board accepted. These included to:

- Provide Mrs L with a full apology from the Chief Executive for the failings identified in this report.

- Pay Mrs L £4,000 financial redress reflecting the serious failings found and the resulting and lasting significant impact upon her and her family.

- Review this case, in line with its legal requirements under the Duty of Candour, to determine how Mrs K's presentation in January 2021 was misdiagnosed owing to inadequate assessment/imaging. The Health Board to report its findings to its Quality and Patient Safety Committee and in its Annual Report on the Duty of Candour.

- Share the Ombudsman's report with the Clinical Director responsible for the consultants involved in Mrs K's care so that its findings are reflected upon and discussed with those consultants.

- Review its handling of Mrs L's complaint in line with the Duty of Candour.

The Complaint

1. Mrs L complained about the care and treatment her late mother, Mrs K, received from the Health Board between January 2021 and her death on 31 January 2022 from biliary sepsis (infection of the biliary tract). In particular:

- Whether, following Mrs K's discharge from hospital in January 2021, monthly blood tests were an appropriate way to monitor her condition.

- Whether there was a lack of follow-up care for Mrs K following a biliary stent being fitted in November 2021.

Investigation

2. I obtained comments and copies of relevant documents from Betsi Cadwaladr University Health Board ("the Health Board") and considered them in conjunction with the evidence provided by Mrs L. I also sought the advice of one of my Professional Advisers, Professor Stephen Ryder, an experienced consultant gastroenterologist ("the Adviser").

3. The Adviser was asked to consider whether, without the benefit of hindsight, the care and 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.

4. I have not included every detail investigated in this report, but I am satisfied that nothing of significance has been overlooked.

5. Both Mrs L and the Health Board were given the opportunity to see and comment on a draft of this report before the final version was issued.

Relevant guidance, legislation and literature

6. Reference is made within this report to the following national guidance:

- British Society of Gastroenterology ("BSG"): UK guidelines for the management of acute pancreatitis 1998 ("the BSG Pancreatitis Guidelines"). These guidelines address the initial steps in diagnosis, investigation and treatment of acute pancreatitis. Specifically, it states that an ultrasound examination of the abdomen might be helpful in confirming a diagnosis but cannot be used for a definitive diagnosis. A computerised tomography scan ("CT scan" - the use of X-rays and a computer to create an image of the inside of the body) is also recommended when there is diagnostic uncertainty.

- BSG: UK guidance on re-starting endoscopy services during the COVID-19 pandemic ("the BSG Endoscopy Guidance") April 2020. This guidance outlines when emergency procedures should still go ahead.

- Steroid Induced Pancreatitis: A Challenging Diagnosis (2020) ("the Case Study"). This case study concluded that increasing doses of steroids may increase the risk of acute pancreatitis.

- Welsh Government - The Duty of Candour Statutory Guidance (2023). This guidance requires local health boards in Wales to talk to service users about incidents that have caused harm, apologise and support them through the process of investigating the incident, and then to learn and improve and find ways to stop similar incidents happening again.

- Public Services Ombudsman for Wales: Groundhog Day 2 - An opportunity for cultural change in complaint handling? (2023). This thematic report built on my predecessor's report from 2017 ("Ending Groundhog Day - Lessons in Poor Complaint Handling"), focusing on how our complaints standards training and the requirements of the Duty of Candour provide a fresh opportunity for change to the ways health boards engage with their patients and respond to complaints.

- Welsh Government National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 ("the Regulations") and accompanying Putting Things Right guidance ("the PTR Guidance"). The Regulations set out specific actions that health bodies should complete when considering complaints, together with timescales for completion. The PTR Guidance says that there may be occasions when it is necessary to secure an independent opinion on a matter relating to a concern, with a view to resolving it. This may include, for example, obtaining a second opinion to aid a patient's understanding of the care they have received.

The background events

7. Mrs K underwent a cholecystectomy (a procedure to remove the gallbladder) in **2013**. She was also known to have rheumatoid arthritis, psoriatic arthropathy (a type of arthritis linked to chronic skin disease) and primary biliary cholangitis (autoimmune disease in which the bile ducts become inflamed and destroyed).

8. On 31 December **2020** Mrs K was admitted to Wrexham Maelor Hospital ("the Hospital") with stomach pains and a raised temperature. She was seen by a consultant in colorectal surgery ("the First Consultant") and was treated conservatively for steroid induced pancreatitis (inflammation of the pancreas) with antibiotics and a double dose of prednisolone (a steroid to reduce inflammation). Mrs K's condition improved and, after stopping antibiotics, she was discharged on 5 January **2021** with instructions to come back for an ultrasound on 8 January. Mrs K was prescribed 10mg of prednisolone, but this was to be reduced over time.

9. Mrs K underwent an ultrasound on 8 January which did not show any biliary obstruction. Mrs K was discharged back to the care of her GP with instructions to carry out monthly blood tests. Mrs L said these were carried out at home by Mrs K's GP.

10. In August, Mrs K appeared jaundiced, and she saw her GP. She was referred to the Gastroenterology Team on 3 September as her blood tests identified elevated liver enzymes (high levels indicate inflammation). Mrs K underwent a CT scan which showed a gallstone in the common bile duct.

11. Mrs K, accompanied by Mrs L, saw a consultant gastroenterologist ("the Second Consultant") in an outpatient clinic on 6 October. She reported recurrent episodes of abdominal pain and a high temperature since her pancreatitis episode in December. Mrs K was noted to be in a poor physical condition and had limited mobility. Mrs K had been given a number of courses of antibiotics and was due to finish a second course of ciprofloxacin (a broad-spectrum antibiotic to treat bacterial infections) the following day. The Second Consultant explained to Mrs K her options to manage her bile duct stones:

- she could do nothing

- attempt an endoscopic retrograde cholangiopancreatography ("ERCP" - an examination of the pancreatic and bile ducts using a thin tube with a light and camera on the end) to try and remove the stone

- an ERCP to put a stent in to prevent bile duct blockage or laparoscopic surgery (a type of keyhole surgery using a camera) to try and remove the stone.

12. The Second Consultant explained to Mrs K the risks and benefits of each option and that she was at very high risk of not surviving the operation in view of her mobility. Additionally, in view of her immunosuppression for her rheumatoid arthritis, Mrs K was at risk of infections causing further significant complications. The Second Consultant said he would also speak to a consultant surgeon regarding Mrs K's options, and he would see her again in a few months.

13. On 15 October Mrs K was admitted to the Hospital by her GP owing to a high temperature, vomiting and pain in her upper abdomen. Mrs K was diagnosed with biliary sepsis. Mrs K underwent an ERCP procedure

on 3 November. It was not possible to remove the bile duct stone owing to its size, so 2 stents were placed to assist the flow of bile into Mrs K's small bowel. The plan was to repeat the ERCP in 8 weeks. Mrs K was discharged on 5 November.

14. Mrs K's liver enzymes were noted to be at normal levels on 22 November, 20 December and 17 January **2022**.

15. On 25 January Mrs K was admitted to the Hospital with further sepsis and COVID-19. The plan to carry out a further ERCP on 26 January was therefore deferred. Mrs K's condition subsequently deteriorated and sadly, she died on 31 January. Her death certificate noted biliary sepsis with rheumatoid arthritis and COVID-19 as contributing factors.

16. Mrs L complained to the Health Board in April. The Health Board responded on 26 August. Mrs L approached me in December.

Mrs L's evidence

17. Mrs L said that there had been opportunities to treat the stones in her mother's bile duct sooner and that her condition was not treated as the medical emergency it should have been.

18. Mrs L said that her mother was not given a discharge letter on 5 January 2021 with information about the bile duct stones or information about how her condition should be monitored and treated. Mrs L said that there was no follow-on care for the 2 stents her mother had fitted in November.

The Health Board's evidence

19. The Health Board said that, although the ultrasound carried out in January 2021 was difficult, there was no evidence of a blocked bile duct at the time. As Mrs K had previously undergone a cholecystectomy, had a normal liver function test ("LFT") prior to admission and had normal LFTs following discharge on 19 January, the likelihood of residual biliary stones was not considered "very high" and an invasive procedure such as an ERCP was not felt to be justified at the time.

20. The Health Board said that the subsequent CT scan and ultrasound in September and October 2021 did show evidence of a blocked bile duct, though it was not totally blocked as Mrs K was not jaundiced and her blood tests did not raise any concerns until September.

21. The Health Board said that there was no indication for Mrs K to undergo an ERCP until the scans evidenced the blocked bile ducts. There was also no indication for these scans until the blood tests in September showed significantly raised liver enzymes, having been normal in April and May. Mrs K underwent her CT scan on 11 September and was seen in clinic just under 4 weeks later. The Health Board said that even had Mrs K been seen earlier, it was debatable whether her ERCP would have taken place sooner. Following her ERCP, the Health Board wrote to Mrs K's GP with details of her care and treatment and the need for a repeat ERCP in 6-8 weeks.

The Health Board's comments on the Ombudsman's Professional Advice

22. Following receipt of the Adviser's advice I shared it with the Health Board. Despite its critical nature, the Health Board's position remained unchanged. It said that as Mrs K had normal LFTs before and after her admission in January 2021, the likelihood of residual biliary stones was not considered to be "very high". The ultrasound was not reported by the Ultrasonographer as "inadequate". The Health Board continued that the diagnosis of "steroid induced pancreatitis" was reasonable in the absence of excess alcohol intake coupled with Mrs K's intake of oral steroids and her not having a gallbladder. Overall, the Health Board commented that it felt the Adviser's comments had been made with the benefit of hindsight and were not supported by the evidence base.

Professional Advice

23. The Adviser said that Mrs K presented with acute pancreatitis in January 2021. He said that whilst the BSG Pancreatitis Guidelines for managing acute pancreatitis were applied generally, there was a very significant deficiency in how the Health Board dealt with Mrs K. The

Adviser said that the ultrasound that Mrs K underwent was inadequate. He said that the point of the ultrasound was to rule out gallstones as a possible cause for Mrs K's pancreatitis. This was a significant issue for Mrs K, as she had previously had a cholecystectomy, but critically there had been a procedure to explore her bile duct for a previous bile duct stone. As such, the probability of her January 2021 pancreatitis being caused by gallstones was very high. The Adviser said that the ultrasound did not see the bile duct owing to overlying bowel gas and the report did not comment on the presence or absence of bile duct dilatation (widening) within the liver. He said that the Clinical Team appear to have accepted this as a "normal" examination. The Adviser said that the diagnosis the Clinical Team arrived at, steroid induced pancreatitis, while being possible, seemed highly unlikely in the clinical context.

24. The Adviser said that steroid induced pancreatitis is a very rare condition and, given Mrs K had been treated on a number of occasions previously with steroids for her arthritis, he did not believe she met the criteria for its diagnosis (see the Case Study, paragraph 6). He added that there was no doubt that, if further imaging by magnetic resonance imaging ("MRI" - the use of strong magnetic fields and radio waves to produce detailed images of the inside of the body) or endoscopic ultrasound had been undertaken in January/February 2021, the common bile duct stone which caused Mrs K's pancreatitis would have been seen at that time. The Adviser said that accepting an inadequate ultrasound examination as "normal" in this clinical context was not an appropriate standard of care. He added that if a diagnosis of steroid induced pancreatitis was thought to be correct, then treating it with a double dose of steroids was incomprehensible.

25. The Adviser said that if a diagnosis of gallstones in the bile duct had been made in January/February 2021, then Mrs K should have been offered an ERCP. Given that Mrs K presented with pancreatitis this would have been an urgent procedure and therefore, even with the COVID-19 restrictions on endoscopy services (the BSG Endoscopy Guidance) she would have accessed an ERCP within a few weeks. The Adviser said this would then have avoided the jaundice and episodes of infection which occurred until she presented again to her GP in August. He said Mrs K's

episodes of infection were cholangitis which was a direct result of a gallstone blocking bile flow out of the bile duct and allowing bacterial infection to lodge in the bile duct.

26. The Adviser said that monthly blood tests were not an appropriate way to monitor Mrs K's condition following her discharge on 5 January. Her underlying primary biliary cholangitis would also potentially elevate her liver enzymes. Liver enzyme abnormalities are not a good predictor of the risk of cholangitis. Mrs K should have undergone proper investigations and had the problem dealt with in January 2021.

27. The Adviser said that he would also be critical of the delay which occurred following Mrs K's presentation to her GP in August with jaundice and being seen in clinic in October. He said jaundice is a "2-week-wait" symptom and Mrs K should have been referred on a cancer pathway. Even if the cause was not cancer, the underlying pathology in someone like Mrs K who was jaundiced could be serious. He added that gallstone obstruction of the bile duct also carries a high mortality rate if untreated, particularly in someone on high levels of immunosuppression.

28. The Adviser said that Mrs K's admission to the Hospital on 15 October owing to cholangitis, and before the ERCP procedure, would have been avoided by either the initial January admission being properly investigated, or a 2-week wait referral being made in August. He added that there was a delay before Mrs K underwent the ERCP, between 20 October and 3 November. He said that, although this was a long wait for someone with a potentially life-threatening illness, it was probably just within the bounds of acceptable practice considering Mrs K was being treated with antibiotics and seemed clinically stable.

29. The Adviser said that Mrs K's ERCP procedure was carried out appropriately. It is not always possible to remove large gallstones from the bile duct during the first procedure. The placement of a stent is usually successful, however, there is small chance (10%) of developing further cholangitis which, sadly, Mrs K did before a further ERCP could take place. The Adviser added that an interval of 3 months to carry out a follow-up ERCP was not unreasonable.

30. The Adviser concluded that there were significant issues with Mrs K's investigations in January 2021. He said that the Health Board needed to recognise this, and that with appropriate investigations and interventions at the time, Mrs K would have almost certainly been treated successfully and not died when she did. He added that the Health Board did not explain the seriousness of the diagnosis clearly when it was made during her admission in October and did not communicate to Mrs K and Mrs L the potential seriousness of cholangitis in someone with background liver cirrhosis and who was immunosuppressed.

The Adviser's views on the Health Board's comments

31. The Adviser reviewed the Health Board's comments on his advice. He said he had considerable concerns that the Health Board's views reflected neither expert opinion nor showed adequate reflection. He said the ultrasound report clearly did not answer the clinical questions posed which were: "is there bile duct dilatation?" and "are there gallstones visible with the bile duct?" The common bile duct was not seen and there was no comment on the intrahepatic duct (within the liver) calibre (its quality) at all. The Adviser said that to assume "no comment" was normal is not justifiable. Ultrasonographers rarely, if ever, report investigations as "inadequate", it is therefore up to the expertise of the referring team to decide if the investigation and its report have answered the clinical questions posed. The Adviser said that he did not think there could be any realistic debate that it did not, and that further imaging to exclude bile duct stones was mandated here.

32. The Adviser added that most people presenting with gallstone pancreatitis have already passed their bile duct stone or will do so without further problems. This does not negate the need to prove whether the stone causing the pancreatitis is still in place. This requires adequate imaging which Mrs K did not have. If a stone is still present in the bile duct on imaging, then removal would normally be recommended. This is not because it will alter the outcome of the present episode of pancreatitis but because it will prevent further later complications, recurrent pancreatitis or cholangitis.

Analysis and conclusions

33. Firstly, I would like to offer my condolences to Mrs L on the sad loss of her mother.

34. The advice I have received is very clear, which is why I have set it out in some detail above. This enables me to be relatively brief in what I have to say here. While accepting that advice in full, the findings set out below are my own. I will address each of Mr L's concerns in turn.

Whether, following Mrs K's discharge from hospital in January 2021, monthly blood tests were an appropriate way to monitor her condition

35. Before I consider whether monthly blood tests were an appropriate way to monitor Mrs K's condition following her discharge from the Hospital in January 2021, I must consider the decisions surrounding Mrs K's ultrasound. Although this specific complaint was agreed with Mrs L at the start of this process, it was the Adviser who raised concerns about the ultrasound when he was asked to comment on the overall care Mrs K received from January 2021 until her sad death.

36. Performing an ultrasound in January 2021 was in line with BSG Pancreatitis Guidelines, however, the ultrasound report is clear that the bile duct was not visible. It could not therefore be seen whether gallstones were present, and I accept the advice that further imaging was required to rule that out. This did not happen. Owing to Mrs K's previous medical history, it seems most likely that her pancreatitis was caused by gallstones, and it was a significant service failure that this was not determined in January 2021, and she was misdiagnosed. I am also concerned that, having shared the Adviser's comments with the Health Board, it remains of the view (paragraph 22) that the outcome of the ultrasound was acceptable and that gallstones were unlikely.

37. The failure to identify Mrs K's gallstones in January 2021 was, in my view, unacceptable and a service failure. I accept the advice that this failure by the Health Board caused Mrs K a continued injustice as her condition remained untreated. In saying this, I am mindful that the episode of care happened during a time when there were still some restrictions in place as a result of the COVID-19 pandemic. As set out in

my Clinical Standards,[1] in arriving at any conclusions, I take full account of the impact that the restrictions in place because of the pandemic would have had. Having done so, I am reassured by the Adviser's comment in paragraph 25 that, even with the COVID-19 restrictions on endoscopy services, Mrs K would have accessed an ERCP within a few weeks.

38. Mrs K subsequently developed jaundice and cholangitis and she endured further delays (paragraphs 27 and 28) before she finally received 2 stents in November. This, however, did not fully resolve Mrs K's condition as she sadly died 6 days after being re-admitted on 25 January 2022. These were further missed opportunities by the Health Board to identify sooner the seriousness of Mrs K's condition.

39. Overall, I am saddened to conclude that, had Mrs K been treated appropriately at the outset, her acute pancreatitis would have been treated successfully and on balance, her deterioration and death might have been prevented. This is a grave injustice, not just to Mrs K, but as an enduring source of distress for Mrs L and her family. It therefore follows that monthly blood tests were not an appropriate way to monitor Mrs K's condition upon her discharge, as there were clearly more appropriate investigations that should have taken place and for that reason I **uphold** this part of the complaint.

Whether there was a lack of follow-up care for Mrs K following a biliary stent being fitted in November 2021

40. As I have identified above, the 2 stents fitted in November were carried out too late for Mrs K, although the procedure was performed to the required standard. However, a further ERCP was scheduled for 8 weeks' time, and I accept that this was a reasonable amount of time for Mrs K to wait. Therefore, I **do not uphold** this complaint.

41. However, I agree with the Adviser (paragraph 30) that there is little to no evidence that the seriousness of Mrs K's condition was appropriately communicated in October to her and her family, including Mrs L, either before or after the ERCP procedure. By November, Mrs K was extremely unwell, and although her chances of developing further cholangitis were,

[1] Clinical Standards - Public Services Ombudsman Wales

in the Adviser's opinion, small, she did develop cholangitis and biliary sepsis prior to her death. This poor communication compounds the injustice for Mrs L that the care and treatment her mother received during the period in question was below the required standard. Although it was not specifically outlined within the scope of the complaint (paragraph 1), I **invite** the Health Board, and relevant clinicians, to consider how they can better ensure patients are fully informed of the seriousness of their illnesses and possible outcomes.

42. I am also concerned at the Health Board's seeming lack of candour in its complaint response to Mrs L, and its lack of objective reflection even during this investigation when it had sight of my Adviser's advice. It is disappointing that the Health Board has still failed to identify and acknowledge the failings in Mrs K's care. In my thematic report on complaint handling last year (see paragraph 6) I recommended that health boards consider whether to provide staff investigating complaints with independent medical advice to provide an independent clinical view to inform complaint responses. It is my view that the Health Board should have undertaken this option as Mrs K's death should have prompted a thorough review. Although not specifically outlined within the scope of the complaint, I will be recommending that the Health Board reviews its handling of Mrs L's complaint in line with its Duty of Candour.

Recommendations

43. I **recommend** that the Health Board, within **1 month** of the date of this report:

a) Provides Mrs L with a fulsome apology, from the Chief Executive, for the failings identified in this report. The apology should make reference to the clinical failings, the impact of these on Mrs K's outcome and the impact on Mrs L and her family.

b) Offers Mrs L financial redress in the sum of £4,000 reflecting the serious failings I have found and the resulting and lasting significant impact upon her and her family.

44. I **recommend** that the Health Board, within **4 months** of the date of this report:

c) Reviews this case, in line with its legal requirements under the Duty of Candour, to determine how Mrs K's presentation in January 2021 was misdiagnosed owing to inadequate assessment/imaging. The Health Board should then report its findings to its Quality and Patient Safety Committee and include its findings in its Annual Report on the Duty of Candour.

d) Shares this report with the Clinical Director responsible for the relevant consultants involved in Mrs K's care so that its findings are reflected upon and directly discussed with those consultants as part of their regular supervision.

e) Reviews its handling of Mrs L's complaint in line with the Duty of Candour. Any improvements it identifies should be fed back into its complaints handling procedure and shared with my office.

45. 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 15 August 2024
Ombwdsmon Gwasanaethau Cyhoeddus/Public Services Ombudsman

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Teitl adroddiad: ***Report title:***	Our Integrated Performance Report – Month 7, 2024/25
Adrodd i: ***Report to:***	Quality, Safety & Experience Committee
Dyddiad y Cyfarfod: ***Date of Meeting:***	Tuesday, 17 December 2024
Crynodeb Gweithredol: ***Executive Summary:***	This Report relates to the Month 7, 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 our IPR 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, we have linked performance metrics 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:***	Russell Caldicott, Interim Executive Director of Finance and Performance

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

Report Author:</td><td colspan="4">Stephen Powell, Director of Performance & Commissioning
Ed Williams, Acting Director of Performance</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">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 IPR 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 and the Interim Executive Director of Finance & Performance.
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 Directorate's 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 7)**

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

Deputy Director of Performance

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.

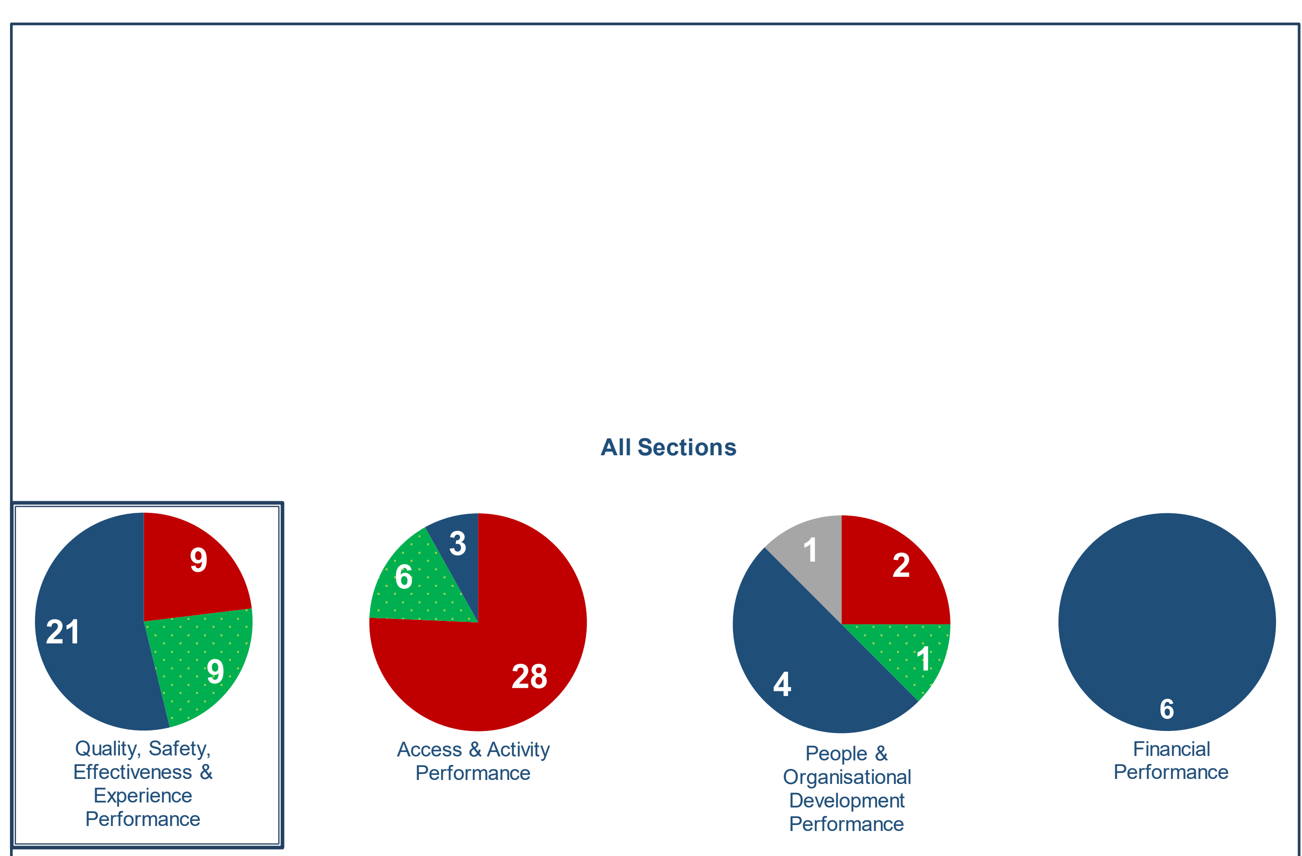
Only escalations in the Quality quadrant of the IQPR has been included as these are what are in the remit of the Quality, Safety & Experience Committee.

On the 4th October 2024, the Acting Director of Performance presented a background on the Integrated Performance Framework to the QSE Committee Development Session. Some changes to the report were agreed, and where possible these have been included in

this iteration of the Report. Further work is being undertaken, for example 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

The key areas highlighted centre upon:-

The Chief Executive Officer, together with support from the Executive Director of Nursing and Midwifery and colleagues throughout the organisation have had intense focus on the reduction of the number of **overdue investigations**, setting a target of 75% of all complaints resolved within 30 days by the 14th October 2024. At the end of October, 75.2% of complaints were closed within 30 days. The intense effort has resulted in a 75% reduction from 672 open complaints in April 2024 to 176, and an 92% reduction in overdue complaints from 408 to 36. **The latest figures at 09.12.2024 state that over 79.5% of complaints are closed within 30 days**, evidence of a sustained improvement. A recommendation to de-escalate this measure will be made at Integrated Performance Executive Delivery Group (IPEDG) on 18.12.2024.

Clinical coding compliance will remain a significant risk as compliance will remain low into the latter part of 2025-26 whilst the backlog is recovered and new staff are trained and working to full potential. As requested at the previous committee meeting in September

2024, A separate paper will be presented to the Committee regarding the impact, risks, mitigations and progress towards improvement.

There were 23 National Reportable incidents (NRIs) that remain open 90 days of more at the end of October 2024. This is a significant improvement The Patent Safety Team (PST) are supporting the progression of all NRIs. Drop-in clinics for staff are held weekly to help focus the outcome from the incident review with any learning which can be shared. The IHCs and Divisions have submitted their reduction plans to the Executive Director of Nursing and Midwifery for onward monitoring of trajectory.

In October 2024 BCU HB received **33 new ombudsman contacts**, the highest number reported in the previous 12 months. **One new Regulation 28 Notice** was received in October 2024.

There has been a significant and consistent reduction in the number of **new Patient Safety Incidents** since a high of 3,667 in July 2024, now down to 3,072. **No new Never Events** were reported in October 2024.

The percentage rate of people **completing treatment for Drug and/or Alcohol Misuse** has been falling for the last couple of months, from a high of 96.7% in August 2024, to 82.7% in October 2024. A recommendation to escalate performance against this measure will be made at Integrated Performance Executive Delivery Group on 18.12.2024.

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. A recommendation to escalate performance against this measure will be made at Integrated Performance Executive Delivery Group on 18.12.2024.

See appendices below.

Appendix 1 – IQPR for QSE 17.12.2024

Integrated Quality & Performance Report

Reporting Period: to 31.10.2024

Presented to

Quality, Safety & Experience Committee

Tuesday, 17th December 2024

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

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

Performance Escalations Report

Key Messages

Quality, Safety, Effectiveness & Experience Performance

- **Complaints**: Lates position, compliance over 79.5% of complaints resolved within 30 days. Measure to be de-escalated at Integrated Performance Executive Delivery Group (IPEDG) 18.12.2024. **(Corporate Risk 24-04 Failure to Embed Learning)**
- **Clinical Coding Compliance** will remain a significant risk through 2024-25 and will recover in 2025-26. Separate paper provided for Committee. Measure will be kept in escalation until improvements seen.
- **National Reportable Incidents** open for 90 days or more has been significantly reduced and this measure is recommended to be de-escalated at IPEDG on 18.12.204.

People & Organisational Development Performance

- **PADR** rate has improved in year but has remained under the WG target of 85%. This work feeds into the ongoing culture work and will be reported as part of the new culture dashboard under development for the organisation.
- **Sickness absence rate** remains below 6.5% however has been steadily increasing over the last three months and was 6.3% for October 2024.
- At 1.7%,**Turnover rate** for nursing aligned with the national and local retention work put in place with a dedicated retention lead coming on-board for the organisation funded by Health Education and Improvement Wales (HEIW).
- At 4.6%, focus continues on reduction of off-contract **agency spend.** Ongoing work taking place around the Welsh Health Circular for agency spend reduction and the Value and Sustainability workforce programme.

(Corporate Risk 24-01 People, Culture and Wellbeing)
(Corporate Risk 24-1 Leadership/Special Measures)

Access & Activity Performance

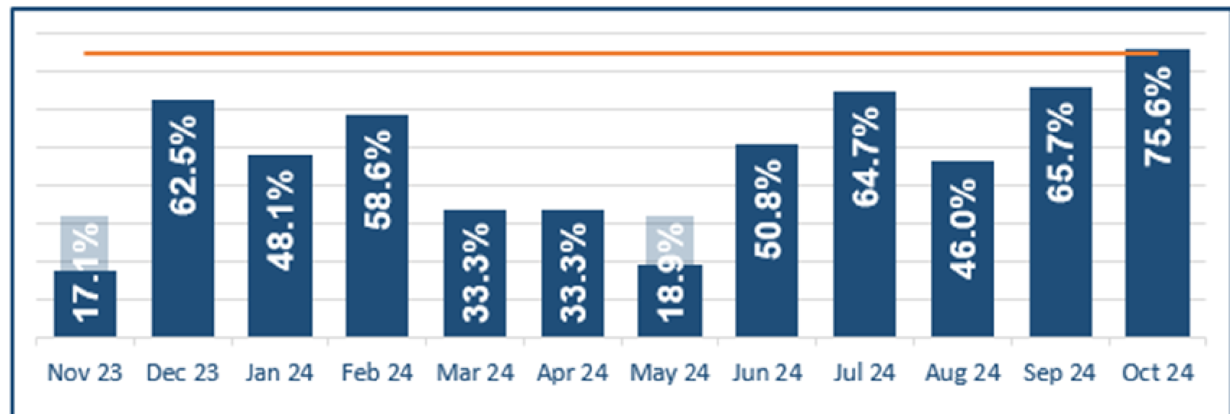
- **Referral to Treatment (RTT):** Planned Care is under escalation and intense executive support. Planned Care funds and additional WG funding is being utilised to eradicate 156 week breaches and to halve the number of 104 week breaches by 31.03.2025. **(Corporate Risk 24-11 Planned Care)**
- **Cancer:** Whilst performance remains below plan, use of Planned Care funds is expected to attain the Welsh Government ask of a 70% delivery by March 2025. **(Corporate Risk 24-11 Planned Care)**
- **Diagnostics waits over 8 weeks:** The number of patients has increased to 8,182 waiting over 8 weeks. **(Corporate Risk 24-13 Timely Diagnostics)**
- **Therapy waits over 14 weeks:** Continued reduction in number of breaches. Nearly all breaches are within Physiotherapy in Central and East.
- **Pathways of Care Delays:** Despite ongoing efforts, the measures taken to reduce assessment delays have not had the desired impact.
- **Ambulance handover waits:** The number of ambulance patient handover over 4 hours remains a concern and is subject to a 12 week improvement plan. **(Corporate Risk 24-10 Urgent and Emergency Care)**

Financial Performance **(Corporate Risk 24-05 Financial Sustainability)**

- The financial plan is to attain a £19.8m deficit following receipt of £82m as a one off allocation from Welsh Government. The plan requiring savings of £48m.
- Delivery of the plan would secure the £82m one off allocation for future years.
- At 31st October 2024 the year to date deficit totals £21.4m, £9.9m over plan
- Drivers of the adverse variance remain savings Continuing Healthcare Pressures, Out of Area Mental Health, Managed Practice, capacity and savings.
- The savings reported total £49.4m (c£1.4m above targeted level)
- Further work continues to reduce costs using the value & sustainability approach (supporting productivity and savings) in mitigation of risks to achievement of outturn (risks valued at c£25m). There remains a substantial risk to not attaining plan and thus securing the one off £82m resource allocation for future years

Quality: Escalated Performance Measures

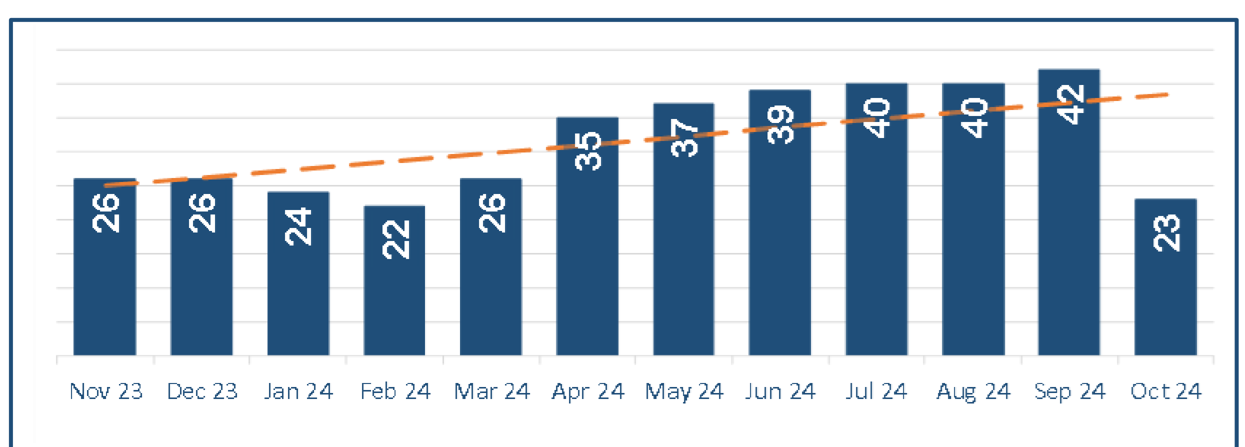
Complaints Overdue (30 days target)



The number of complaint responses completed within 30 days has continued to improve due to the incredible collaboration, support an concerted efforts of all concerned, BCU achieved the 75% target rate set by Welsh Government for October 2024 and the latest figures at 09.12.2024 show a sustained and continued improving position at 79.5%.

Audits and reviews continue to demonstrate that the quality of responses has not been negatively impacted by the increased speed and efficiency in investigating and responding to complaints. Fewer responses have been returned and fewer complaints re-opened.

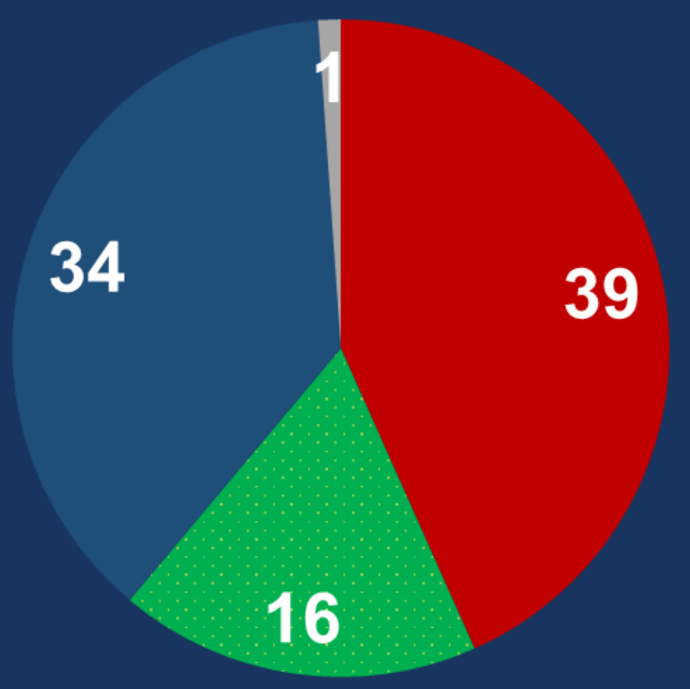
National Reportable Incidents Open Over 90 Days



The number of NRI's open over 90 days has been halved from 42 in September to 23 at the end of October 2024. Furthermore, there has been a significant and sustained reduction in the number of new National Reportable Incidents compared winter 2023-24.

A recommendation will be made to the Integrated Performance Executive Delivery Group (IPEDG) on 18.12.2024 that the de-escalation mechanism be implemented and these two measures be stood down from escalation.

Integrated Performance Report



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

Summary of Performance to Month 11

39
16
34
1

All Sections

9
9
21

Quality, Safety, Effectiveness & Experience Performance

3
6
28

Access & Activity Performance

1
2
1
4

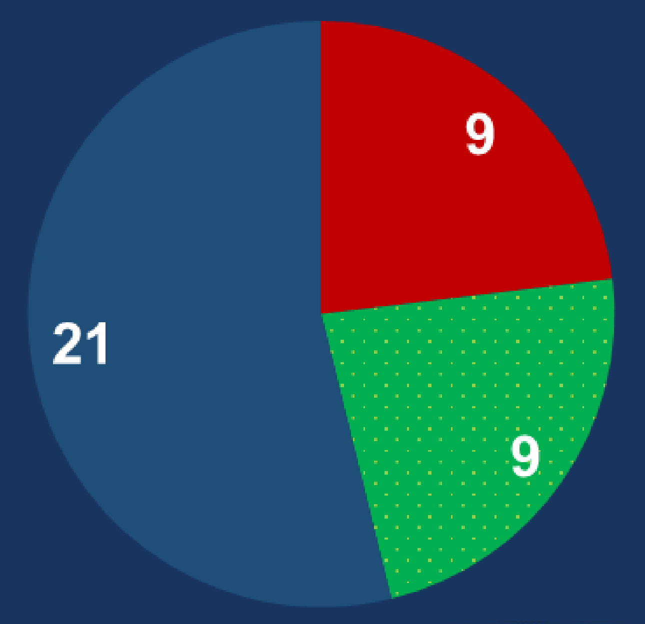
People & Organisational Development Performance

6

Financial Performance

Section 1

Quality, Safety, Effectiveness and Experience Performance



Produced on behalf of the Health Board by the
Performance and Commissioning Directorate in partnership with our **Health Board Directors**

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	2.47%	2nd of 7 (at Jun 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	21.2%	4th of 8 (at Jun 24)
-	QSE	Percentage of children receiving the Human Papillomavirus (HPV) vaccination by the age of 15	90%	TBC	78.2%	

4.87%
6.35%
1.56%
2.47%
Q3 23/24
Q4 23/24
Q1 24/25
Q2 24/25

11.9%
12.9%
21.2%
21.2%
Q3 23/24
Q4 23/24
Q1 24/25
Q2 24/25

75.3%
75.7%
77.9%
78.2%
Q3 23/24
Q4 23/24
Q1 24/25
Q2 24/25

* 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	87.3%	3rd of 7 (at Jun 24)
-	QSE	Percentage uptake of the influenza vaccination amongst adults aged 65 years and over	75%	TBC	34.2%	2nd of 7 (at Mar 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	60.6%	4th of 7 (at Jun 24)

Q3 23/24: 87.6%
Q4 23/24: 86.7%
Q1 24/25: 86.5%
Q2 24/25: 87.3%

Nov 23: 65.1%
Dec 23: 71.1%
Jan 24: 72.2%
Feb 24: 73.2%
Mar 24: 73.9%
Apr 24
May 24
Jun 24
Jul 24
Aug 24
Sep 24
Oct 24: 34.2%

Nov 23: 43.6%
Dec 23: 51.5%
Jan 24: 55.5%
Feb 24: 55.3%
Mar 24
Apr 24: 13.7%
May 24: 44.0%
Jun 24: 60.6%
Jul 24
Aug 24
Sep 24
Oct 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 patients offered an index colonoscopy procedure within 4 weeks of booking their Specialist Screening Practitioner assessment appointment	90%	TBC	3.2%	7th of 7 (at Jul 24)
-	QSE	Percentage of well babies entering the new-born hearing screening programme who complete screening within 4 weeks	90%	TBC	98.5%	4th of 7 (at Jul 24)
-	QSE	Percentage of eligible newborn babies who have a conclusive bloodspot screening result by day 17 of life	95%	TBC	96.3%	4th of 7 (at Aug 24)

	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24
Index colonoscopy within 4 weeks	25.3%	19.4%	9.1%	22.8%	21.7%	5.6%	12.3%	7.4%	4.1%	3.2%		
New-born hearing screening within 4 weeks	99.2%	96.4%	98.3%	99.3%	97.4%	96.2%	98.2%	98.5%				
Bloodspot screening result by day 17	95.6%	97.7%	94.0%	95.4%	97.3%	95.0%	95.5%	97.4%	95.5%	96.3%		

* 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	82.7%	4th of 7 (at Jun 24)
-	QSE	Percentage of patients (aged 12 years and over) with diabetes who received all eight NICE recommended care processes	Equival-ent month increase (2024/25 to 2023/24) to 100%	TBC	37.5%	7th of 7 (at Aug 24)
-	PFIG	Percentage of the primary care dental services (GDS) contract value delivered (for courses of treatment for new, new urgent and historic patients)	Increas-ing trend (to 30% (end Sept), then 100% (end Mar))	TBC	41.1%	6th of 7 (at Oct 24)

	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24
Substance misuse	88.8%	93.8%	92.1%	93.8%	87.1%	88.6%	90.4%	89.5%	90.5%	96.7%	87.4%	82.7%
Diabetes care processes		34.0%	34.1%	34.8%	35.8%	36.3%	36.4%	36.5%	36.9%	37.1%	36.7%	37.5%
Dental contract value	45.2%	51.8%	58.5%	64.5%	70.2%	3.7%	8.4%	13.7%	19.9%	25.3%	30.3%	41.1%

* Wales Ranking may differ as may refer to previous month

Quality: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	QSE	Number of new National reportable incidents (NRIs)	N/A	TBC	8	
-	QSE	Number of new never events	0	TBC	0	
-	QSE	Number of new patient safety incidents	N/A	TBC	3072	

Measure	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24
NRIs	23	31	23	35	14	22	14	15	16	15	6	8
Never events	0	0	0	3	0	0	2	0	3	0	0	0
Patient safety incidents	3554	3387	3602	3343	3428	3503	3531	3500	3657	3339	3205	3072

* Wales Ranking may differ as may refer to previous month

Quality: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	PFIG	Number of consultations delivered through the Pharmacist Independent Prescribing Service (PIPS)	Equivalent month increase (2024/25 to 2023/24)	TBC	2478	2nd of 7 (at Sep 24)
-	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	22.7%	1st of 6 (at Oct 24)
-	QSE	Number of service user feedback experience responses completed and recorded on CIVICA	Increasing trend	TBC	4240	2nd of 10 (at Sep 24)

Measure	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24
PIPS consultations	1416	1677	1812	2100	2342	2337	2268	2018	2303	2319	2090	2478
Hospital onset COVID-19	37.9%	46.3%	37.0%	41.2%	31.0%	40.0%	43.3%	41.7%	36.6%	23.6%	22.7%	22.7%
CIVICA feedback responses	4436	3228	4582	4760	3867	5290	4538	4229	5839	4181	4240	

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	Not avail-able	TBC	75	4th of 6 (at Oct 24)
CRR: 24-04	QSE	The cumulative number of laboratory confirmed Pseudomonas Aeruginosa in reporting month	Not avail-able	TBC	13	3rd of 6 (at Oct 24)
CRR: 24-04	QSE	The cumulative rate of laboratory confirmed E.coli bacteraemias cases per 100,000 population	Not avail-able	TBC	72.2	4th of 6 (at Oct 24)

	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24
Klebsiella	113	129	142	150	157	5	12	22	38	48	64	75
Pseudomonas Aeruginosa	27	29	31	31	32	0	0	2	3	7	11	13
E.coli	79.8	79.4	73.2	79.5	77.8		84.2	83.3	78.7	79.6	79.4	72.2

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	Not available	TBC	25.5	1st of 6 (at Oct 24)
CRR: 24-04	QSE	The cumulative rate of laboratory confirmed C.difficile cases per 100,000 of the population	Not available	TBC	53.1	5th of 6 (at Oct 24)
CRR: 24-04	QSE	Number of National reportable incidents that remain open 90 days or more	Decreasing trend	TBC	23	6th of 10 (at Oct 24)

Month	S. Aureus Bacteraemia rate	C.difficile rate	National reportable incidents open 90+ days
Nov 23	23.4	39.8	26
Dec 23	24.9	39.1	26
Jan 24	26.0	39.0	24
Feb 24	26.3	41.1	22
Mar 24	25.7	40.6	26
Apr 24			35
May 24	27.2	45.9	37
Jun 24	25.1	46.2	39
Jul 24	25.1	52.7	40
Aug 24	24.8	54.6	40
Sep 24	24.7	54.7	42
Oct 24	25.5	53.1	23

* Wales Ranking may differ as may refer to previous month

Quality: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	QSE	Number of new reported falls	N/A	TBC	363	
-	QSE	Number of new reported hospital acquired pressure ulcers (HAPU) (excluding new to caseload)	N/A	TBC	500	
-	QSE	Number of new reported medication incidents	N/A	TBC	262	

Quality: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	QSE	Number of new 'Putting Things Right' (PTR) complaints	N/A	TBC	174	
-	QSE	Of the complaints closed, the percentage that were closed within 30 days	75.0%	TBC	75.6%	
-	QSE	Number of new early resolutions	N/A	TBC	17	

Quality: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	QSE	Number of new PALS (Patient Advice and Liason Service) contacts	N/A	TBC	699	
-	QSE	Number of new Ombudsman contacts	N/A	TBC	33	
-	QSE	Percentage of survey responses rating care as good or very good	N/A	TBC	82.7%	

Measure	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24
Number of new PALS contacts							680	596	851	561	815	699
Number of new Ombudsman contacts	17	18	11	19	22	16	13		24	19	20	33
Percentage of survey responses rating care as good or very good							93.5%	81.7%	82.7%			

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

Presented on 17.12.2024

Quality: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	QSE	Number of regulation 28 notices	N/A	TBC	1	
-	QSE	Number of overdue 'Learning from Event Reports' (LFERs)	N/A	TBC	51	
-	QSE	Number of Great-ix submissions	N/A	TBC	132	

Quality: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	QSE	Percentage of episodes clinically coded within one reporting month post episode discharge end date	Increasing trend (to 95%)	TBC	13.6%	8st of 8 (at Aug 24)
-	QSE	Percentage of all classifications' coding errors corrected by the next monthly reporting submission following identification	90%	TBC	4.4%	8st of 8 (at Sep 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	How to interpret assurance 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**	• 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

BCUHB Health Board – Every 2 Months

Performance, Finance & Information Governance (PFIG) Committee – Every 2 Months

Quality, Safety & Experience (QSE) Committee – Every 2 Months

This Report

Integrated Quality & Performance Report (IQPR) – Every Month

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:***	Tuesday, 17 December 2024
Crynodeb Gweithredol: ***Executive Summary:***	**The purpose of this report is for QSE Committee to receive information to enable it to:** 1. **Note and receive assurance** on updates related to governance and programme arrangements for the Health Board Response to the RCPsych Invited Review Services Report. 2. **Note** progress against the ten themes identified in the Invited Review Services Report. 3. **Approve** the amended Terms of Reference V2 for the Expert Advisory Group **Background** The Board, at its meeting on 25 July 2024, received and considered the Health Board response to the Royal College of Psychiatrists Invited Review Service Report. The full report can be found on the BCU website. It included a high level description of proposed governance arrangements to oversee the response plan delivery. The Board has now agreed that oversight of the response to the RCPsych Report will be through the Quality Safety and Experience (QSE) Committee with six-monthly progress reports, provided to the Board. The next report to Board is scheduled for January 2025. The QSE Committee on the 24 October 2024 received the update on the RCPsych Response Plan from both the Executive Director of Allied Health Professionals and Health Science and the Special Advisor to the Health Board, Ros Alstead. The QSE Committee agreed on the 24 October 2024 to; • A timeframe to be included within the Draft Terms of Reference (ToR) for the Expert Advisory Group – with Ros Alstead being appointed for 12 months and a review point at 9 months.

<table>
<tr><td></td><td colspan="4">

- Noted that a draft ToR and forward work plan should be brought back to the Committee in December 2024.
- Suggested that the families meet with the new Dementia Consultant Nurse.
- Agreed that a report on progress of the development of the Expert Advisory Group should provide a report back to the Committee in December 2024.

The report is drawn from both the Health Board RCPsych Action Delivery Group and the Chair of the Expert Advisory Group. It highlights satisfactory progress in the development of Governance arrangements and satisfactory progress against the RCPsych Invited Services Review actions.

The updates provided also highlight the importance of clarifying the processes and performance data that will enable the Governance framework to function effectively and the next steps to achieve this.
</td></tr>
<tr><td>Argymhellion:

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

1. Note and receive assurance on updates related to governance arrangements for the Health Board Response to the RCPsych Invited Review Services Report.
2. Note progress against the ten themes identified in the Invited Review Services Report.
3. Approve the amended Terms of Reference V2 for the Expert Advisory Group</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 Authors:</td><td colspan="4">Phil Meakin, Associate Director of Governance
Carole Evanson, MHLD 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
☐</td><td>Derbyniol
Acceptable
☒</td><td>Rhannol
Partial
☐</td><td>Dim Sicrwydd
No Assurance
☐</td></tr>
</table>

	Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
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):***	1. Building an Effective Organisation 2. Compassionate Culture, leadership and engagement 4. Improving quality, outcomes and experience 5. Effective environment for learning
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?	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)***	Strategic Priority P18 Quality, Innovation and Improvement
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 ***Workforce implications as a result of implementing the recommendations***	None to note at this stage
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 the 24 October 2024.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	CRR 24-04 (Learning)
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 against the Invited Services Review – as at 15 November 2024**	

Appendix 2 – Chairs Report – Health Board Action Delivery Group

Appendix 3 – Terms of Reference Version 2 – Expert Advisory Group

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 purpose of this report is to provide information that will enable the Committee to:

- **Note and receive assurance** on updates related to governance arrangements for the Health Board Response to the RCPsych Invited Review Services Report.
- **Note** progress against the ten themes identified in the Invited Review Services Report.
- **Approve** the amended Terms of Reference V2 for the Expert Advisory Group

This report highlights that the Health Board Action Delivery Group notes progress against these actions but it is clearly understood 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. 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 and experts so that it can independently validate that the response to the actions is meeting the objectives of the recommendations and can demonstrate improvements for service users. This report contains a draft Terms of Reference for the Expert Advisory Group in Appendix 3 and reflects the feedback from the QSE Committee on the 24 October 2024, and engagement with stakeholders since that meeting.

The Health Board RCPsych Action Delivery Group is accountable to the Executive Team and will also will make reports to the QSE Committee. The Expert Advisory Group has a direct line of accountability to the QSE Committee with its reports being received at the QSE Committee. Once the Expert Advisory Group is fully established there will be one agenda item for QSE Committee with two sections (Section 1. A report from the Health Board RCPsych Action Delivery Group and Section 2. A report from the Expert Advisory Group).

2. ADDITIONAL BACKGROUND

As a reminder, the ten themes (Table 1 below) are outlined below.

Table 1: The ten themes

The Ten Themes	Key Focus of Reports to the Expert Advisory Group
○ 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	What is progressing effectively? What is the evidence of progress and improved outcomes? What is progressing but needs additional support/focus to demonstrate evidence of improved outcomes? What is not progressing effectively and what action is needed to progress

3. UPDATE ON GOVERNANCE AND PROGRAMME ARRANGEMENTS

3.1.1 Health Board RCPsych Action Delivery Group (HBADG)

The third meeting of the HBADG was held on 25 November 2024. The Group received a full update on the status of the Invited Services Review actions as at 15 November 2024.

Sections 4 of this report describes the progress against the Invited Services Review actions. Appendix 2 contains a Chairs Report from the HBADG Meeting on the 25 November 2024 that is being received at Executive Team on 18 December 2024.

Other than the progress described above the HBADG highlighted the following

3.1.2 Development of an Outcome Performance Dashboard

The Delivery Group received an update on "work in progress" relating to the development of an Outcome Performance Dashboard to demonstrate progress against the actions. The progress was welcomed. The key feedback was that the outcome dashboard approach needs to be aligned with what the Expert Advisory Group needs to review and must be kept as straightforward as possible. It must allow the Expert Advisory Group the opportunity to assess progress against the key themes of the review whilst being available.

3.1.3 Governance Arrangements - Progress of Evidence of Outcomes Group – See section 3.2 below.

3.1.4 Risk Log Established

It was agreed at the November Delivery Group to develop a Risk Log. The Programme Team has completed an intial risk log for consideration by this Group and for oversight by the Executive Team. The development of a Draft Corporate Risk was also proposed and this is being considered at the Risk Scrutiny Group in December 2024. The risk relates to

the reputational impact of not making sufficient progress against the RCPsych Invited Services Review if processes and information are not aligned and streamlined suffciently to produce the information that would validate progress against the actions. The HBADG supported the risk log that was presented. The detail is provided in Appendix 2.

3.1.5 Resource To Support the RCPsych Invited Services Review

The HBADG received a report outlining the resource requirements to enable satisfactory progression of actions in the Invited Services Review and address the risks idetified in the risk log. Proposals were approved and have been escalated to the Executive Team to confirm arrangements.

- **Administrative support** to help embed the Governance Framework and arrange meetings. This has been agreed with the Director of Governance for 1.5 days per week to be reviewed after 3 months.
- **Day to day Project Management support** for the progressisng of actions and provision of aligned information to support the Governance Groups.
- **Engagement Support** to ensure consistent and timely communications are made with the Expert Advisory Group and Llais.

3.1.6 Proposal to secure emotional and practical support to the Expert Advisory Group – See Section 5 below

3.2 Development of a Pilot "Evidence of Outcomes" Group (EoOG)

The QSE Committee received a report regarding the establishment of this Group on the 24 October 2024 meeting. The EoOG review, check and challenge evidence of progress from action owners. The first pilot meeting took place in October 2024 and a second pilot meeting took place on 3 December 2024. This will support and validate actions the Health Board is taking to meet the objective of the recommendations that were made and able to improve outcomes for Patients, workforce and services.

During November 2024, the Evidence of Outcome Group members reviewed the evidence of 13 actions against the following questions in Figure 2 below (the Health Board Special Advisor has been sighted on these questions) and provided feedback to the meeting on 3 December for peer review. As a result of this work further information was requested from Action Owners to improve the responses.

Figure 2. Questions that Evidence of Outcome Group Uses to Review Information

Does the information provided give you assurance that the action has been taken as set out in the RCPsych Invited Services Review Response? **Is there evidence of an improved outcome for patients/service users OR progress made towards improving outcomes?** **Is there evidence that it is embedded into the work of the Health Board to demonstrate 2 above?** **What, if anything, would you find useful to better meet the three questions above?**

A further 7 actions have been allocated to the members of the Group on 3 December 2024 to provide feedback by 14 December 2024. A report on the Pilot EoOG feedback for all 20

actions will be provided to the Delivery Group on the 30 December 2024. This can then be used to provide a richer source of information to give validation of progress.

The Chair of the Expert Advisory Group has welcomed the support of an Independent Member to act as a "sounding board" as the Health Board develops the Evidence of Outcome Group and the Expert Advisory Group.

4.SUMMARY OF PROGRESS AGAINST THE INVITED SERVICES REVIEW AS AT 15 NOVEMBER 2024.

The progress of improvements and actions against the Invited Services Review response plan was reported to the Health Board RCPsych Action Delivery Group (HBADG) on the 30 November 2024. Appendix 1 summarises progress. A Chairs Report from HBADG is attached in Appendix 2. Prior to the HBADG receiving this update progress against the actions was received at the MH&LD Programme Improvement Delivery Group (PIDG) and the Health Board Regulatory Assurance and Oversight Group (RAG) so that the evidence of progress could be reviewed (whilst awaiting for the Expert Advisory Group to fulfil its role).

4.1. What is Progressing Effectively?

In summary, the update in the report to the Delivery Group illustrates continued positive progress overall against the actions of the Invited Services Review. The Group noted that the report also outlined the need for greater focus from action owners to provide updates on the progress made to the Programme Team (and the information required to evidence that progress). Figure 3 below highlights the status actions by theme.

Figure 3 – Summary of Action Progress By Theme

Action Status	Completed	Evidence submitted, awaiting formal approval	In progress and due within deadline	In progress, but not to deadline	Overdue and no recent progress	Total number of actions
Theme 1	0	4	11	1	0	16
Theme 2	0	3	5	1	0	9
Theme 3	0	3	7	5	0	15
Theme 4	0	2	5	1	0	8
Theme 5	0	0	3	0	0	3
Theme 6	0	0	6	1	0	7
Theme 7	0	1	3	0	0	4
Theme 8	0	2	3	1	0	6
Theme 9	0	1	2	1	0	4
Theme 10	0	3	5	0	0	8
Total	0	19	50	11	0	80

Total number of actions due to commence within timeframe.	0
Total number of RCPsych actions included in the plan	80

It should be noted at this stage that 30 actions are due to be progressed by March 2025 and therefore additional communication and engagement with action owners is required to safeguard progress against the Invited Services Review if positive progress is to continue.

It should also be noted at this stage, that whilst the Expert Advisory Group is developing the approach for how it will consider progress against the actions of the Invited Services Review, the work to evidence progress against the actions should continue.

For A summary of improvements and actions that have progressed to date include the following;

- The recruitment of a MH&LD Consultant Nurse for Dementia has progressed and the successful candidate is due to commence in January 2025.

- Improved Mental Capacity Act (MCA) Training compliance has led to an increase in Deprivation of Liberty Safeguards (DoLS) applications. This has demonstrated an improvement in MCA/DoLS awareness by the Division thus ensuring that patients are better protected by respective legislative frameworks.

- The Patient and Carer Experience Team have introduced a new telephony system which gives customers an improved caller experience, with options now available for callers and also signposts customers to BCUHB website for further information. The team are reviewing the telephony call data to help further understand caller experience and team performance.

- A five step approach to the management of Complaints, Incidents and Mortality Reviews has been developed aligned to streamlining the process for staff and patients (whilst aligning with Health Board processes). Implementation of this approach commenced during September 2024 and the Health Board continues to focus on embedding the five steps to illustrate continued and sustained improvement.

- A Peer Review Environmental Ligature Risk Assessment Audit has been completed across all inpatient units across the Division. Audit findings were discussed in the MH&LD Ligature Risk Management Group on 25 September 2024 to agree next steps including continuation of the programme of Environmental Risk Assessment training and a re-audit to be completed on a six-monthly basis with a focus on bedrooms and bathrooms.

4.2. What is the Evidence of Progress and Improved Outcomes?.

At this reporting point it is proposed that there is an acceptable level of assurance of progress against the **actions** that have been taken up to 15 November 2024, as set out in the detailed response plan and as reported above. The work of the Evidence of Outcome Group (Pilot phase) is supporting the provision of information that evidences actions taken and sustained improvement.

The key matter is being able to demonstrate that the work being undertaken is leading to an improvement in **outcomes** for service users and workforce. At the last QSE Committee members received an update in relation to this and that advice and support from the Performance team has been established to clearly demonstrate improvements on outcomes, outputs and benefits – both quantative and qualitative. This is one of the key milestones for alignment to the Response Plan.

The Delivery Group on 25 November 2024 received an update on “work in progress” relating to the development of an Outcome Performance Dashboard to demonstrate

progress against the actions. The progress was welcomed. The key feedback was that the outcome dashboard approach needs to be aligned with what the Expert Advisory Group needs to review and must be kept as straightforward as possible. It must allow the Expert Advisory Group the opportunity to assess progress against the key themes of the review. As described in the Next Steps part of the report this alignment of outcome performance measures is a key focus for December and January.

4.3. What is progressing but needs additional support/focus to demonstrate evidence of improved outcomes?

The governance arrangements that have been established allow early identification of actions where additional support or focus is needed. The HBADG received an escalation in regards to Action 9.3 which relates to. "Development of Business Cases related to Therapeutic provision in inpatient settings." This was reported to QSE Committee on 24 October 2024. Since that update the matter was escalated to Executive Team and work has commenced by Therapies Senior Managers with MH&LD Senior Managers working together to establish proposals.

There are eleven actions in progress "albeit not to deadline", (seven MH&LD actions and four Health Board wide actions). This reflects an increase from five actions in the October 2024 update. The Programme Team has escalated this position to the Executive Team (18 December 2024) via the Chairs Report of the HBADG to ensure that actions are progressed and any issues escalated to the relevant Executive Lead and Action owner. This includes the offer of additional guidance on the information to be provided.

This means that the date of completion of this action will be reviewed and reported back through the Health Board Action Delivery Group in December 2024. An update can be provided to the QSE Committee in February 2025.

4.4. What is not progressing effectively and what action is needed to progress

This section of the report will be more effective once the Expert Advisory Group has the opportunity to review how the information provided by action owners meets the objective of the action. Is it really making a difference and improving outcomes for patients and workforce?

Actions that are being developed and progressed by the MH&LD Division are being effectively progressed in the meantime. Health Board wide actions have required additional support to ensure co-ordinated responses by multi-disciplinary teams. The HBADG has recognised this and taken action to ensure this through escalation to the Executive Team that will be received on the 18 December 2024.

5.Development of the Expert Advisory Group

As previously reported, the ability for the Expert Advisory Group to assess progress against the RCPysch Invited Service Review report will determine how effectively progress against the recommendations can be tested by the QSE Committee and the Board in due course. The work to progress actions and reporting to this Delivery Group whilst this is being developed will continue. This principle has been agreed with the Executive Directors, Chair of the Expert Advisory Group and in a Board Development session in November 2024.

Since the last meeting of QSE Committee on 24 October 2024 completion of the first round of engagement and discovery meetings took place on the 5th November 2024 and a second

round of meetings of Expert Advisory Group members with Llais has taken place (on the 13th and 17th December 2024) with the Chair (Ros Alstead) and Associate Director of Governance.

An action from the last QSE Committee was for the Special Advisor to the Health Board to report in December 2024 on how the Expert Advisory Group moves forward and how she envisages this improving patient care. This information in the report has been provided to the Expert Advisory Group and endorsed by the Special Advisor.

After the first round of engagement meetings in October and November 2024, the Special Advisor and Llais were able to identify particular areas of focus (related to the scope of RCPsych Invited Services Review) that the members of the Expert Advisory Group have articulated at those meetings. In the second round of meetings (13th and 17th December 2024) members of the Group were presented with an approach by which they can review the progress against the actions of the RCPsych Invited Services Review. This report to the Committee has been written before those second round of meetings has taken place but the summary below highlights the approach.

5.1 Summary of Initial Approach to Develop The Role of the Expert Advisory Group

During the first round of engagement meetings, members of the Expert Advisory Group started to share ideas and experiences that are most important to focus on from their perspective so they can find out more about the improvements resulting from the actions in the Health Board's response to the RCPsych Invited Services Review. The Special Advisor has the agreement of the Group to help her assess the extent to which improvements have been made in these areas. They have not been prioritised; this will happen through more discussion with the Expert Advisory Group members when they meet on 13th and 17th December 2024.

5.2 Key Feedback from Members of the Expert Group

Patient and Family Centred Care was the main focus, learning from past experiences and looking forward to improving the **experience of patients' service users and families now and in the future.** There was agreement service users and families want to focus on:

- Older Persons Mental Health wards (main priority for families) and Adult Mental Health wards and community team (main priority for service users). This fits with the RCPsych invited review recommendation about the need to drive up standards in core mental health services.
- Some members valued working together, sharing perspectives and experiences. This may not suit everyone, and the approach of the Expert Advisory Group needs to accommodate this.
- Members want to gain assurance not re-assurance, so the approach and activities undertaken need to reflect this and go beyond reviewing papers for comment and approval thereby receiving reassurance. The Delivery Group need to be able to provide the Expert Advisory Group with the ability to assess the extent to which improvements have been made with guidance from the Special Advisor.
- The work the group undertakes will seek to understand the progress against the recommendations in the RCPsych review questions and highlight areas which are important to the service user and family experts, most of which are referenced in the RCPsych Invited Services Review recommendations and actions.

5.3 Approach To Progressing this Approach and Improving Patient Care

The ten themes which the RCPsych team used to format their recommendations are used in the information provided to the Expert Advisory Group to bring together areas of interest into a wider theme. After listening to the advisory group members a number of key enquiry areas have been drafted by the Special Advisor to the Health Board that reflect those early conversations. A cross reference has then been made to the existing agreed actions in the RCPsych Action Plan. A key next step is to align and agree the information that is produced to understand the extent of progress.

The Special Advisor emphasises that it will be important to discuss which of the areas or themes the Group needs to focus on itself and what will be coming through the response plan actions, (the majority are covered in this response plan.) We will aim to use information which is already produced and not add to much extra work to busy teams, reducing the time and focus for improvement.

The ten themes used by the RCPsych are a good way for us to review the actions from the Health Board as they come through and agree the measures and outcomes to support good care going forward. From this a forward work plan will be developed. A forward work plan will developed after these second round of meetings on the 13 and 17 December 2024.

5.4 Securing Support for the Expert Advisory Group Members

The need for additional emotional and practical support to members of the Group is important to ensure that members of the Group are as able to fulfil their role.

The Associate Director of Governance has developed a support proposal that the QSE Committee is asked to note. This proposal was approved by the Health Board Action RCPsych Delivery Group on 25 November 2024 and will be provided to the Executive Team for information and oversight. It includes enhanced Psychological Support and the availability of Patient Advice and Liaison Team (PALS) being available on site at meetings (and virtually). It also includes additional engagement support to allow Group members to take part in meetings from a location of their choosing and therefore IT support and Engagement support will be provided where this is required.

5.5 Draft Terms of Reference for the Expert Advisory Group

The Draft Terms of Reference for the Expert Advisory Group have been developed reflecting feedback from the last QSE Committee on 24 October 2024 and the first round of meetings with members of the Expert Advisory Group. QSE Committee are asked to note the tracked change amendments as requested and further feedback that has been received through engagement with stakeholders since the last QSE Committee. The amended Terms of Reference are attached in Appendix 3.

Once approved the Terms of Reference will be received by the Expert Advisory Group. The QSE Committee is asked to consider the amendments and approve the Version 2 Draft Terms of Reference They key changes to the Terms of Reference are highlighted in Table 2 below.

Table 2 Summary of Changes to Terms of Reference for Expert Advisory Group

Proposed Amendment	Page Number of Draft Terms of Reference Version 2
Length of appointment for Independent Advisor confirmed as 12 months and referenced in the Terms of Reference	**Page Number 7** **Section 10.1**
Review Period of 9 months for the arrangements and Terms of Reference of the Expert Advisory Group.	**Page Number 7** **Section 10.1**
Amended to confirm that there are 3 x Representatives (including families) of previous service users	**Page Number 4** **Section 6.1**
Dispute resolution process clarified	**Page Number 6** **Section 7.7**
Meetings can be facilitated with individual members of the Group at the discretion of the Chair of the Group	**Page Number 7** **Section 7.1 and 7.2**

6. NEXT STEPS

- Received approved Terms of Reference at the meeting with the Expert Advisory Group.
- Executive Leads to meet on 9 December 2024 to progress options for consideration and approval to the Delivery Board on the alignment of outcome measurements and resource with the Governance Groups on 30 December 2024.
- The Special Advisor and Executive Leads to meet in January 2025 to confirm the proposed approach to alignment of outcome measurements and resource with the Governance Groups.
- To report on the agreed approach above in reports to QSE Committee and the Board.
- Further develop the "Evidence of Outcomes Group" Terms of Reference for consideration by the Health Board Action Delivery Group on 30 December 2024.
- A further (scheduled) QSE Committee on 20 February 2025 will receive an updated position on progress against a single agenda item with two reports

1. The Health Board RCPsych Action Delivery Group
2. The Expert Advisory Group

7. RECOMMENDATIONS

This report asks the Committee to;

- **Note and receive assurance** on updates related to governance arrangements for the Health Board Response to the RCPsych Invited Review Services Report.

- **Note** progress against the ten themes identified in the Invited Review Services Report.
- **Approve** the amended Terms of Reference V2 for the Expert Advisory Group

APPENDIX 1

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 15 November 2024

Date	15/11/2024	Period	Month / Nov 2024	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 - 19 actions pending approval, 50 actions in progress and due within deadline, and 11 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	4	11	1	0
Theme 2	0	3	5	1	0
Theme 3	0	3	7	5	0
Theme 4	0	2	5	1	0
Theme 5	0	0	3	0	0
Theme 6	0	0	6	1	0
Theme 7	0	1	3	0	0
Theme 8	0	2	3	1	0
Theme 9	0	1	2	1	0
Theme 10	0	3	5	0	0
Total	0	19	50	11	0
Change from previous month	No Change	Increased by 6 from previous month	Decreased by 8 from previous month	Increased by 6 from previous month	No change

RCPsych Response Plan status

- 0, 0%
- 0, 0%
- 19, 24%
- 11, 14%
- 50, 62%

Legend: Actions completed; Evidence submitted pending approval; Actions in progress and due within deadline; Action in progress, albeit not to deadline; Actions not yet commenced

Number of Health Board Wide Actions
34
Number of MH&LD Divisonal Actions
46

ACTION RECOVERY & MITIGATION

Progress on 75 (↑2) of the 80 actions underway and due within deadline. Outcomes to be independently reviewed

Themes

Theme	
1.Patient and user centred care	Evidence submitted to close 4 action
2.Legislation and clinical guidelines	Evidence submitted to close 3 action
3.Governance	Evidence submitted to close 3 actions
4.Staffing	Evidence submitted to close 2 actions
5.Management structure	
6.Clinical services organisation	
7.Training and development	Evidence submitted to close 1 action
8.Leadership and Staff Engagement	Evidence submitted to close 2 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	Meetings ongoing
6. Report into QSE 24/10/25	26/10/24	Complete
7. Report into QSE 17/12/25	17/12/24	
8. Report into QSE 19/2/26	19/02/25	
9. Report into Health Board meeting 6 monthly 30/1/25	30/01/25	
10. Completion of all actions	31/12/25	
11. Evaluation, summary report	31/01/26	
12. Future developments/next Steps	31/01/26	

PROGRESS SINCE LAST MONTH

Evidence submitted to PIDG and RAG reviewed in meetings held in November - 13 in total.
5 actions endorsed for approval at PIDG and 2 actions reviewed at RAG - 11 Actions remain in progress not to deadline.
Following review at PIDG/RAG, the following actions were endorsed for approval -

- 1.5 - Plan and attend bi-monthly engagement meetings with Head of Operations and Llais.
- 1.4 - Use data to capture real time patient feedback and experience (Dec Action)
- 2.1 - Undertake an Audit of falls data from Datix
- 7.2 - Implement an agreed HCA career pathway to "Grow your own" MH&LD nurses
- 8.2 - Capture the themes and feedback from the bi-monthly "Ask Divisional Senior Leadership Team" virtual sessions
- 8.5 - Corporate support with the implementation of the MH&LD Communication and Engagement Plan
- 8.6 - Analyse staff survey findings, capture themes and agree actions

Following evidence reviewed at PIDG/RAG during meeting further information requested for the following -

- 1.2 - Achieve Finding the Light in Dementia Care training compliance at 85% - awaiting staff attendance list
- 2.2 - Increase attendance at current "Tool Box" talks - awaiting staff attendance list
- 3.12 - Improve Complaints performance trajectory to achieve 75% - awaiting achievement
- 3.14 - Commence a formal campaign to promote how to raise concerns - awaiting evidence
- 4.6 - Progress Business Case for funding MH&LD Wellness, Work and Us Service - awaiting funding
- 8.1 Implement the MH&LD Communication and Engagement Plan - awaiting evidence.
- 9.3 Develop a business care for gap in therapeutic staffing - awaiting outcome of options appraisal

NEXT MONTHS ACTIVITIES

1. Progress completion of 11 actions in progress, albeit not to deadline
2. Progress November and December MH&LD and Health Board actions
3. Continue to mature Evidence of Outcomes Group, review testing of the concept to ensure transparency, honesty and assurance from the evidence approval process.
4. Continue to progress the development of performance metrics to measure the impact of outcomes, outputs and benefits to patients, workforce and service
5. Commence development of QSE paper in preparation for the meeting due to be held 17/12/24

CHALLENGES, RISKS & ESCALATIONS

Resource Planning paper to be considered at HBADG meeting, including emotional support to the members of the Expert Advisory Group.

Risks and Issues Log to be reviewed and considered.

LESSONS LEARNED AND IMPACT THIS MONTH

- Fall Audit completed to improve the quality of record-keeping and the documentary evidence upon which our patient care is based. The audit will ensure that all staff can readily care for patients who are high risk of falls confidently, with all the information required to enable them to mitigate and identify risks where able to do so. Falls procedure included in MH&LD Staff Briefing as policy of the month to raise awareness, Fall Champions posters and workshop details shared. In addition as Fall Bulletin has been developed which has been shared with all staff across the Division.

- The MHLD Division has made the best use of these processes to support the HCSW workforce into gaining a Registered Nurse qualification. The Division has an established Recruitment & Retention Group providing focus to this 'grow your own' activity, with a number of HCSW's supported to enter into a Registered Nurse training programme over the previous years and this commitment continues. This activity will support HCSW retention, career progression and skill development having a positive impact on our workforce.

- The development and implementation of a clear and comprehensive framework for senior leadership connectedness to the wards and services was developed as part of the NCCU Action Plan. To address this action a MH&LD SLT Walkabout Schedule has been developed for the next 12 months, commencing April 2024 until March 2025. The Walkabouts included "Ask DSLT" virtual staff engagement sessions, where staff were able to ask members of the DSLT any questions directly, and also be updated on any activity across the Division. In addition, Drop in Sessions for patients, families and carers were also incorporated in the schedule and posters were developed and shared prior to each session with internal and external partners and stakeholders.

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

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

Report title:</td><td colspan="4">Chairs Report – Health Board RCPsych Action Delivery Group</td></tr>
<tr><td>Adrodd i:

Report to:</td><td colspan="4">Executive Team Meeting</td></tr>
<tr><td>Dyddiad y Cyfarfod:

Date of Meeting:</td><td colspan="4">Wednesday, 18 December 2024</td></tr>
<tr><td>Crynodeb Gweithredol:

Executive Summary:</td><td colspan="4">The third Health Board RCPsych Action Delivery Group met on 25 November 2024. Whilst this is a Chairs Report it seeks to provide some additional important detail for the Executive Team to consider in regard to progress made against the RCPsych Invited Services Review including:
• Overview of progress against the Invited Services review actions as at 15 November 2024.
• Update on the development of the Expert Advisory Group that was given at the Delivery Group.
• The work being undertaken to streamline the processes required to provide assurance on progress against the Invited Services Review.
• A proposal to secure the appropriate resource to support continued progress against the Invited Services Review.
• Being sighted on a proposal to provide emotional support to the members of the Expert Advisory Group.
• The development of risks associated with the RCPsych response programme and consideration of a Draft Corporate Risk.</td></tr>
<tr><td>Argymhellion:

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

1. Note and Receive the Chairs Report
2. Note the updates provided in the report
3. Consider the escalations in the report including the Actions and Decisions identified in the escalation section below.</td></tr>
<tr><td>Arweinydd Gweithredol:

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

Report Author:</td><td colspan="4">Phil Meakin, Associate Director or Governance</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>
</table>

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***	
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Improving Quality, Outcomes and Experience
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	
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?***	
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)***	The paper sets out the agreement in the meeting to develop a draft risk for the Corporate Risk Register related to the response to the Invited Services Review.
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	Not applicable
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	Not applicable
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	Reflects agenda of Health Board RCPsych Action Delivery Group of 25 November 2024.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	

Camau Nesaf: ***Next Steps:*** • Continue the maturity of the Expert Advisory Group (EAG) and Evidence of Outcomes Group (including mapping of process and development of Corporate Calendar by 30 December 2024.) • Continue development of the Outcomes Performance Measures and report back to January 2025 Health Board Action Delivery Group (making sure there is an alignment and streamlining of information) • Clarify what is required to all action owners in relation to evidence of progress to be provided and the timelines for each action by 1 December 2024 • Report to the Executive Team in December 2024 • Report on progress to the QSE Committee on 17 December 2024. • Follow up on discussions made on Resources to support the Response to the Invited Services Review. Specifically Project support to progress Health Board wide actions.
Rhestr o Atodiadau: ***List of Appendices:*** Appendix 1 – The update to the Invited Services Review Appendix 2 – Proposal for securing appropriate resource to support the Invited Services Review Appendix 3 – Proposal to secure emotional and practical support to the Expert Advisory Group Appendix 4 – The Programme Risk Register Summary

Chair's Report

Report to:	Executive Committee, 4 December 2024
Report from:	**Health Board Royal College of Psychiatry (RCPsych) Action Delivery Group**
Report date:	18 December 2024
Presented by:	Teresa Owen, Executive Director of Allied Health Professionals and Health Science

Quality risks:
Please include all open risks scored 15+ overseen by the group - this data can be taken from Datix.

ID	Title	Date Opened	Current Score	Last Reviewed
	Not Applicable - See update on risks below			

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	1. There is an **ACTION** required for RCPsych Response plan "action owners" to be reminded of the completion date of their actions and requirements to provide assurance on their progress. A reminder of this responsibility will be sent to each owner of a "Health Board wide" action by 29 November 2024. The responsible Executive is asked to ensure that the action lead understand what is required. 2. There is a an **ACTION** for members of the Delivery Group to streamline the process for how progress against the Invited Services Review is received and validated. This meeting will take place on 9 December 2024. 3. There is a **DECISION** required to support the provision of appropriate resource to support the RCPsych Invited Service Review. This proposal is contained in Appendix 2 and summarised in the Chairs Report. It specifically asks Executive Team to approve the provision of day to day Project Management to assist in the delivery of Health Board wide actions. 4. There is an **ACTION** required for Executive Team members to be sighted on the proposals to provide emotional and practical support to the Expert Advisory Group members. This proposal is contained in Appendix 3 5. There is an **ACTION** for Executive Team to receive and consider the Risk Log for the RCPsych Invited Services Review. This is contained in Appendix 4 and to note that a Corporate Risk has been drafted and will be reviewed at the Risk Scrutiny Group on 10 December 2024.
Summary of business conducted	**Introduction** The following agenda items were considered by the Health Board Action Delivery Group (The Delivery Group). The meeting was quorate and was provided with the information required to fulfil its role. **Progress against the actions contained in the ten themes – Action Required** Appendix 1 provides an comprehensive overview of the summary of progress as at 15 November 2024. This was considered and endorsed in the Delivery Group. Noting the following points. There are eleven actions in progress albeit not to deadline, seven MH&LD actions and four Health Board wide actions. This reflects an increase from five actions in the October 2024 update. In summary, the update in the report to the Delivery Group illustrates continued positive progress overall against the actions of the Invited Services Review. The Group noted that the report also outlined the need for greater focus from action owners to provide updates on the progress made to the Programme Team (and the

	information required to evidence that progress). It should be noted at this stage that 30 actions are due to be progressed by March 2025 and therefore additional communication and engagement with action owners is required to safeguard progress against the Invited Services Review if positive progress is to continue. (in the escalation above) It should also be noted at this stage, that whilst the Expert Advisory Group is developing the approach for how it will consider progress against the actions of the Invited Services Review, the work to evidence progress against the actions should continue. **Governance Arrangements – Development of the Expert Advisory Group – Action Required** As previously reported, the ability for the Expert Advisory Group to assess progress against the RCPysch Invited Service Review actions will determine how effectively progress against the recommendations can be judged by the QSE Committee and the Board in due course. The work to progress actions and reporting to this Delivery Group whilst this is being developed will continue. This principle has been agreed with the Executive Directors, Chair of the Expert Advisory Group and in a Board Development session in November 2024. Since the last meeting of this Group all initial meetings of Expert Advisory Group members have taken place with people who have expressed an interest in being part of this Group during October and November with the Chair (Ros Alstead) and Associate Director of Governance. The second round of meetings with the Expert Advisory Group members are booked in for the first and second week of December. Stakeholders will be presented with an approach by which they can review the progress against the actions of the RCPsych Invited Services Review. The Associate Director of Governance has developed a support proposal for the members of the Group to note. It was requested at the meeting that the Executive Team be sighted on the proposals. This is contained in Appendix 3 Finally, the Draft Terms of Reference for the Expert Advisory Group have been developed reflecting feedback from the last Health Board Action Delivery Group and have been shared with the members of the Expert Advisory Group for comment by 5th December 2024. Once feedback has been collated they will be received at the QSE Committee on 15th December 2024. **Development of an Outcome Performance Dashboard** The Delivery Group received an update on “work in progress” relating to the development of an Outcome Performance Dashboard to demonstrate progress against the actions. The progress was welcomed. The key feedback was that the outcome dashboard approach needs to be aligned with what the Expert Advisory Group needs to review and must be kept as straightforward as possible. It must allow the Expert Advisory Group the opportunity to assess progress against the key themes of the review whilst being available. **Governance Arrangements - Progress of Evidence of Outcomes Group** The first “pilot” meeting of this Group took place on 25 October 2024 where 13 Evidence submission forms for Health Board wide actions and MH&LD actions were shared with the group to commence their review. In order to support the process of ensuring actions taken meet the objective of the recommendations, the peer review included four questions – • Does the information provided give you assurance that the action has been taken as set out in the RCPsych Invited Services Review Response?

- Is there evidence of an improved outcome for patients/service users OR progress made towards improving outcomes?
- Is there evidence that is embedded into the work of the Health Board to demonstrate point 2 above?
- What, if anything would you find useful to better meet the three questions above?

This will enable measurable information to be gathered to improve the outcomes for Patients, workforce and services   The Evidence of Outcomes Group will continue to mature, including consideration of a service user representation on this Group.

It is proposed to hold this meeting bi-monthly to allow for peer review comments. However information can be shared with members of the Group in-between meetings. A full end to end process mapping, including the role of the Evidence of Outcomes Group is being developed and will be reported to the next Delivery Group on 30 December 2024.

Like the point above the key feedback was that the process needs to be kept as simple and streamlined as possible. There is a risk that has been developed to articulate this.

Risk and Issues Log – Action Required

It was agreed at the last Delivery Group to develop a Risk Log. The Programme Team has completed an intial risk log for consideration by this Group and is attached in Appendix 4. Executive Team are asked to note the development of a DRAFT Corporate Risk that is being considered at the Risk Scrutiny Group in December 2024.

The risk relates to the reputational impact of not making sufficinet progress against the RCPsych Invited Services Review if processes and information are not aligned and streamlined suffciently to produce the information that would validate progress against the actions.

The group supported the risks that were presented and Risk 1 was broadened out to reflect the risk that the Group felt was present. This is reflected in the Appendix 4.

Resource To Support the RCPsych Review – Decision Required

The Delivery Group received a report outlining the resource requirements to enable satisfactory progression of actions in the Invited Services Review and address the risks idetified in the risk log. This is contained in Appendix 3 below and is summarised as:

1. Administrative support to help embed the Governance Framework and arrange meetings. This has been agreed with the Director of Governance for 1.5 days per week to be reviewed after 3 months.
2. Day to day Project Management support to support the progressisng of actions and provision of aligned information to support the assurance process and support the streamlining of process and information. This needs to be considered and reviewed with the Director of Transformation and Improvement.   Specifically the Exective Team is asked to consider the recommendation from the Delivery Group to approve project management to support the delivery of the Health Board wide actions.
3. Engagement Support to ensure consistent and timely communications are made with the Expert Advisory Group and Llais.   Agreement was made on this during the meeting and the approach will be agreed by the Director of Partnerships and Engagement.

Proposal to secure emotional and practical support to the Expert Advisory Group – Action Required

	The Associate Director of Governance met with the Head of Adult Mental Health Clinical Psychology and Psychological Services 6 November 2024 to consider the support that would be needed for members of the Expert Advisory Group and family members who are supporting this role. This briefing identifies two distinct areas for initial support. 1. Access to Clinical Psychologists 2. Access to Patient Advice and Liaison Service (PALS) members of staff The Action was taken for the Executive Team to be sighted on this support. The full details are in Appendix 3. **Next Steps agreed at the meeting** • Continue the maturity of the Expert Advisory Group (EAG) and Evidence of Outcomes Group (including mapping of process and development of Corporate Calendar by 30 December 2024.) • Continue development of the Outcomes Performance Measures and report back to January 2025 Health Board Action Delivery Group (making sure there is an alignment and streamlining of information) • Clarify what is required to all action owners in relation to evidence of progress to be provided and the timelines for each action. • Report to the Executive Team in December 2024. • Report on progress to the QSE Committee on 17 December 2024. • Follow up on discussions made on Resources to support the Response to the Invited Services Review.

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 15 November 2024

Date	15/11/2024	Period	Month / Nov 2024	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 - 19 actions pending approval, 50 actions in progress and due within deadline, and 11 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	4	11	1	0
Theme 2	0	3	5	1	0
Theme 3	0	3	7	5	0
Theme 4	0	2	5	1	0
Theme 5	0	0	3	0	0
Theme 6	0	0	6	1	0
Theme 7	0	1	3	0	0
Theme 8	0	2	3	1	0
Theme 9	0	1	2	1	0
Theme 10	0	3	5	0	0
Total	0	19	50	11	0
Change from previous month	No Change	Increased by 6 from previous month	Decreased by 8 from previous month	Increased by 6 from previous month	No change

RCPsych Response Plan status

Status	Value
Actions completed	0, 0%
Evidence submitted pending approval	19, 24%
Actions in progress and due within deadline	50, 62%
Action in progress, albeit not to deadline	11, 14%
Actions not yet commenced	0, 0%

Number of Health Board Wide Actions
34
Number of MH&LD Divisonal Actions
46

ACTION RECOVERY & MITIGATION

Progress on 75 (↑2) of the 80 actions underway and due within deadline. Outcomes to be independently reviewed

Themes

Theme	Evidence
1.Patient and user centred care	Evidence submitted to close 4 action
2.Legislation and clinical guidelines	Evidence submitted to close 3 action
3.Governance	Evidence submitted to close 3 actions
4.Staffing	Evidence submitted to close 2 actions
5.Management structure	
6.Clinical services organisation	
7.Training and development	Evidence submitted to close 1 action
8.Leadership and Staff Engagement	Evidence submitted to close 2 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	Meetings ongoing
6. Report into QSE 24/10/25	26/10/24	Complete
7. Report into QSE 17/12/25	17/12/24	
8. Report into QSE 19/2/26	19/02/25	
9. Report into Health Board meeting 6 monthly 30/1/25	30/01/25	
10. Completion of all actions	31/12/25	
11. Evaluation, summary report	31/01/26	
12. Future developments/next Steps	31/01/26	

PROGRESS SINCE LAST MONTH

Evidence submitted to PIDG and RAG reviewed in meetings held in November - 13 in total.
5 actions endorsed for approval at PIDG and 2 actions reviewed at RAG - 11 Actions remain in progress not to deadline.
Following review at PIDG/RAG, the following actions were endorsed for approval -

- 1.5 - Plan and attend bi-monthly engagement meetings with Head of Operations and Llais.
- 1.4 - Use data to capture real time patient feedback and experience (Dec Action)
- 2.1 - Undertake an Audit of falls data from Datix
- 7.2 - Implement an agreed HCA career pathway to "Grow your own" MH&LD nurses
- 8.2 - Capture the themes and feedback from the bi-monthly "Ask Divisional Senior Leadership Team" virtual sessions
- 8.5 - Corporate support with the implementation of the MH&LD Communication and Engagement Plan
- 8.6 - Analyse staff survey findings, capture themes and agree actions

Following evidence reviewed at PIDG/RAG during meeting further information requested for the following -

- 1.2 - Achieve Finding the Light in Dementia Care training compliance at 85% - awaiting staff attendance list
- 2.2 - Increase attendance at current "Tool Box" talks - awaiting staff attendance list
- 3.12 - Improve Complaints performance trajectory to achieve 75% - awaiting achievement
- 3.14 - Commence a formal campaign to promote how to raise concerns - awaiting evidence
- 4.6 - Progress Business Case for funding MH&LD Wellness, Work and Us Service - awaiting funding
- 8.1 Implement the MH&LD Communication and Engagement Plan - awaiting evidence.
- 9.3 Develop a business care for gap in therapeutic staffing - awaiting outcome of options appraisal

NEXT MONTHS ACTIVITIES

1. Progress completion of 11 actions in progress, albeit not to deadline
2. Progress November and December MH&LD and Health Board actions
3. Continue to mature Evidence of Outcomes Group, review testing of the concept to ensure transparency, honesty and assurance from the evidence approval process.
4. Continue to progress the development of performance metrics to measure the impact of outcomes, outputs and benefits to patients, workforce and service
5. Commence development of QSE paper in preparation for the meeting due to be held 17/12/24

CHALLENGES, RISKS & ESCALATIONS

Resource Planning paper to be considered at HBADG meeting, including emotional support to the members of the Expert Advisory Group.

Risks and Issues Log to be reviewed and considered.

LESSONS LEARNED AND IMPACT THIS MONTH

- Fall Audit completed to improve the quality of record-keeping and the documentary evidence upon which our patient care is based. The audit will ensure that all staff can readily care for patients who are high risk of falls confidently, with all the information required to enable them to mitigate and identify risks where able to do so. Falls procedure included in MH&LD Staff Briefing as policy of the month to raise awareness, Fall Champions posters and workshop details shared. In addition as Fall Bulletin has been developed which has been shared with all staff across the Division.

- The MHLD Division has made the best use of these processes to support the HCSW workforce into gaining a Registered Nurse qualification. The Division has an established Recruitment & Retention Group providing focus to this 'grow your own' activity, with a number of HCSW's supported to enter into a Registered Nurse training programme over the previous years and this commitment continues. This activity will support HCSW retention, career progression and skill development having a positive impact on our workforce.

- The development and implementation of a clear and comprehensive framework for senior leadership connectedness to the wards and services was developed as part of the NCCU Action Plan. To address this action a MH&LD SLT Walkabout Schedule has been developed for the next 12 months, commencing April 2024 until March 2025. The Walkabouts included "Ask DSLT" virtual staff engagement sessions, where staff were able to ask members of the DSLT any questions directly, and also be updated on any activity across the Division. In addition, Drop in Sessions for patients, families and carers were also incorporated in the schedule and posters were developed and shared prior to each session with internal and external partners and stakeholders.

Appendix 2 – Proposal for securing appropriate resource to support the Invited Services Review

Teitl adroddiad: ***Report title:***	**Resource Planning for the Response to the RCPsych Invited Services Review.**
Adrodd i: ***Report to:***	Health Board RCPsych Action Delivery Group
Dyddiad y Cyfarfod: ***Date of Meeting:***	25th November 2024
Crynodeb Gweithredol: ***Executive Summary:***	The Invited Services Review is a key priority for the Health Board. It is a Tier 2 Major Change Programme. There are 80 actions in the RCPsych Response plan aligned to ten themes. There are 46 actions that are considered to be "MHLD Actions" and 34 of the actions are classed in the plan as Health Board wide actions. **One of the key actions in the RCPsych Action Delivery Group is Action Number 9.5 "*Dedicated resource from the Health Board Transformation and Improvement team to support with development of the action plan and for the transformation/improvement activity required*"** The Purpose of this Report is to seek mitigation against a risk that has been identified by the Programme Group by setting out key resource requirements and escalating these matters to the Delivery Group. *The Risk 2024 – 001 - "There is a risk that the Health Board wide related actions of the Plan are not effectively progressed leading to less progress made against the Plan, because there is not adequate resource arrangements"* This paper sets out an analysis of programme resource requirements and proposals to address them which include: • Additional administrative support requirements in the arranging of meetings and following up actions and evidence with Health Board action owners • Consideration of the Transformation and Improvement Programme support to optimise its impact. • Health Board action owners and Executive leads to be aware of their requirements to update the Programme Teams on progress against their actions • For support on complex stakeholder engagement from the Engagement Teams
Argymhellion: ***Recommendations:***	The Group is asked to: • **Consider and review the resource requirements set out in the report** • **Note and Consider proposals for the support that needs to be provided to Expert Advisory Group Members**
Arweinydd Gweithredol: ***Executive Lead:***	Teresa Owen, Executive Director of Allied Health Professionals and Health Science Angela Wood, Executive Director of Nursing.

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

Report Authors:</td><td colspan="4">Carole Evanson, Interim Director of Nursing/Interim Director of Operations, MH&LD
Phil Meakin, Associate Director of Governance
Adrianne Jones, MH&LD Operational Business Lead</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
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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">1. Building an Effective Organisation
2. Compassionate Culture, leadership and engagement
4. Improving quality, outcomes and experience
5. Effective environment for learning</td></tr>
<tr><td colspan="2">Goblygiadau rheoleiddio a lleol:

Regulatory and legal implications:</td><td colspan="3">None</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/A</td></tr>
<tr><td colspan="2">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?</td><td colspan="3">N/A</td></tr>
</table>

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)***	Strategic Priority P18 Quality, Innovation and Improvement
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 ***Workforce implications as a result of implementing the recommendations***	None to note at this stage
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	This paper has been prepared following the meetings that have taken place so far in relation to the response to the plan. Initial draft has been shared with Director of Governance, Director of Partnerships and Engagement, Executive Director of Allied Health Professionals and Health Sciences and Director of Transformation and Improvement.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	CRR 24-04 Failure to Embed Learning
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:

List of Appendices:
Appendix 1 – Detailed Analysis of Programme Resource

RCPsych Invited Services Review Response
Resourcing Considerations

1. Background

- The Invited Services Review is a key priority for the Health Board. It is a Tier 2 Major Change Programme. There are 80 actions in the RCPsych Response plan aligned to ten themes. There are 46 actions that are considered to be "MHLD Actions" and 34 of the actions are classed in the plan as Health Board wide actions.
- MHLD are leading the response on the MHLD actions and also updating the plan with regard to progress made on the Health Board wide actions.
- The awareness of Health Board actions and monitoring of progress is a risk that was raised with the Health Board RCPsych Delivery Group. In the short term the Associate Director (AD) of Governance has been supporting this.
- A Governance Framework has been established and is being implemented. The Associate Director of Governance is leading on this work for an agreed period of 1.5 days per week.
- A key part of the Governance Framework is the development of three new Groups
  - A Health Board RCPsych Action Delivery Group
  - A Health Board RCPsych Evidence of Outcome Group
  - An Expert Advisory Group (a sub group of QSE Committee)
- These groups require support to establish and to maintain. The development of the Expert Advisory Group involves very sensitive and involved interaction with current service users and Tawel Fan family members. The Group is Chaired by Ros Alstead, Special Advisor to the Board. Initial interactions with this group is via Llais and their support has been extremely effective so far. It is clear though that the communications with stakeholders and the subsequent arrangement of support and meetings is sensitive and time consuming.
- **One of the key actions in the RCPsych Action Delivery Group is Action Number 9.5 "*Dedicated resource from the Health Board Transformation and Improvement team to support with development of the action plan and for the transformation/improvement activity required" (Action owner – Director of Transformation and Improvement"***

2. Risks Associated With Resource

- There is a risk that the Health Board wide related actions of the Plan are not effectively progressed leading to less progress made against the Plan, because there is a gap in the provision of day to day Project Support arrangements for the development of the "Health Board wide" actions. The AD of Governance is currently fulfilling this role to mitigate this risk. There is a diseconomy of scale arising from this arrangement.
- Allied to this, there is a risk that the MHLD Teams do not have adequate Programme support arrangements to Programme Manage support all MHLD AND Health Board wide actions.
- There is an emerging risk that in the short term, the development of the Evidence of Outcomes Group and work related to the Expert Advisory Group will not be effectively resourced. This may only be a short term issue but clarity is needed to make sure that the risks can be addressed and mitigated.
- There is a risk that the level of engagement required to effectively support the Expert Advisory Group is not adequate and this could lead to less effective progress on the ability of the group to validate the actions that the Health Board is taking.

3. Resource Plan Summary

- To mitigate these risks a resource estimate is set out for consideration in Appendix 1. It has been shared with Director of Governance, Director of Partnerships and Engagement, Executive Director of Allied Health Professionals and Health Sciences and Director of Transformation and Improvement.

4. Analysis

The above modelling shows that the key time commitments relate to the following areas. Green indicates an assessment of adequate provision. In summary there is an approximate shortfall of 15-

20 hours per week in Project administration and support that would reduce the risk of this plan not making effective progress and meeting the needs of the governance framework. In relation to stakeholder engagement – There is a need to ensure that the expertise of the Health Board is "plugged in" to this work and this many require a communications and engagement lead to support the work of the Expert Advisory Group and actively

Governance and Report Writing
-Establish the framework
Maintain framework
first line of defence to ensure adherence to the Plan

Project suppport and Administration of Health Board wide actions
- suporting action owners and governance leads to progress against the plan
-Processing evidence of outcomes
arranging meetings, administration tasks

Project Support and adminsistration of MHLD actions
- suporting action owners and governance leads to progress against the plan
-Processing evidence of outcomes
arranging meetings, administration tasks

Day to Day Programme Management Governancre and Leadership Suport and Direction
-Overview of the Plan
-Ensuring progress
-MHLD Actions
Health Board Wide

Stakeholder Management and Communication
-Liaising with Expert Advsory Group
-Link up with other areas of work in Engagement

Health Board Wide Support to Stakeholders
-Psychologfical Support
-PALS Support

managing expectations.

5. Proposals To Support Effective Management of Resource

- Discuss with Exec Director of AHP&HS, Director of Partnerships and Engagement and Director of Governance options to provide support for Project administration arrangements.
- Enforce the agreement that each month RCPsych Plan "cut-off date" should be 11TH of each month. This should avoid multiple updates needed.
- Limit AD of Governance role to establishment of Governance Framework, Report writing and first line of defence to make sure that "outputs are improving outcomes." Including direct engagement with Expert Advisory Group (Oversight of the Programme for Health Board wide actions)
- Discuss stakeholder management support with Director of Partnerships and Engagement so that resource can be provided to support the stakeholder management and administration related to the day to day management of the Expert Advisory Group
- Clear paper in report from this Group to Executive Team requesting that Exec Directors "own" more proactively the actions that fall in their portfolio with the requirements associated with that.
- MHLD Teams to consider availability of additional programme support, 10 hours per week, to meet the needs of the Programme, approaching T&I teams if needed.
- When these proposals have been considered the findings can be provided to the Director of Transformation and Improvement for consideration of how the T&I support is optimally provided.
- A proposal for the emotional support required for members of the Expert Advisory Group has been developed and is attached in Appendix 2. It is proposed to include this in the Chair's Report to the Executive Team.

Appendix 1 of report

Current Resource Estimate

Key Work Required	Proposed Owner and Support PM – Phil Meakin AJ – Adrianne Jones	Approximate Time in hours Required per week	Comments/Mitigations
Set up and embed Governance Framework	PM (AJ support)	3	Will reduce by February
Updating the Response Plan for MHLD Actions	AJ (PM support)	TBC	Plan cut-off date of 11 of each month to reduce burden
Updating the Response Plan for Health Board wide actions	Individual Action Owners Phil Meakin to develop awareness and is filling short term gap	1-2	The Lead Officer should take responsibility for updating the action plan. Support needed to ensure information on progress arrives in the right format.
Managing and updating responses from action owners (MHLD)	AJ	TBC	Plan cut-off date of 11 of each month to reduce burden
Arranging Delivery Group Meetings Supporting Delivery Group Meetings	Proposal to provide support from Directorate	2	Once a month meetings
Arranging Expert Advisory Group Meetings Supporting Advisory Group Meetings	Fiona Lewis (Corporate Governance)	2	Once a month meetings
Arranging Evidence of Outcome Group Meetings Supporting Evidence of Outcome Group Meetings	Melissa Williams (MW) (MHLD)	2	Once a month meetings
Arranging MH&LD Programme Improvement Delivery Group (PIDG)	AJ	4	Meeting every fortnight
Project Support for MHLD Actions	MW	TBC	
Project Support for Health Board related actions and their progress through the o Evidence of Outcome Group o HB RCPysch Action Delivery Group o Expert Advisory Group	PM in short term. Action owners ongoing	3-5 (12-15 hours per month)	Short term for PM but needs solution in longer term. Briefing of Execs so they can oversee or MHLD Team?
Engagement support for Expert Advisory Group	Ros Alstead with Phil Meakin	4 hours for PM	May not reduce but we should seek support from Director of Partnerships and Engagement
Engagement Support for Evidence of Outcomes Group	Adrianne Jones and Phil Meakin	2 hour each	May not reduce

Reports for QSE, Board and/or RAG	PM Lead AJ – with support	2 (8 hours per month)	Average figure – Higher some weeks
Reports for Expert Advisory Group	PM Lead AJ Support	1 (4-6 hours per month)	Not fully known but initially will be high
Reports for Health Board Action Delivery Group	PM Lead AJ – with support	1 (6 hours per month)	
Reports for Evidence of Outcome Group	AM Lead MW with support PM Governance support and advice	2 (6 hours per months)	
Transformation and Improvement Teams	Providing support to PM and AJ on measurement and assurance requirements	3-6	Estimate

Appendix 3 – Proposal to secure emotional and practical support to the Expert Advisory Group

RCPsych Invited Services Review
Providing Support for Members of the Expert Advisory Group

1. Introduction and Background

The Health Board is in the process of establishing an Expert Advisory Group and the Chair (Ros Alstead) has been working with the Directorate of Corporate Governance to establish membership of this group will include current and previous service user representation. This includes individuals who have been impacted by the Tawel Fan group.

The Special Advisor has arranged initial discussion meetings with stakeholders, experts and Health Board staff and these meetings took place (with Llais present) on 24th October 2024 and 6 November 2024.

During these meetings it was agreed that the Health Board would review the support available to members of the Expert Advisory Group to enable them to fulfil their role as reviewers of progress in the Health board against the Invited Services Review. This was further discussed at a meeting with the Executive Director of Allied Health Professionals and Health Science and the Health Board Special Advisor on 30 October 2024 and it was agreed that we would approach Adult Mental Health Clinical Psychology and Psychological Services to establish a support "offer" that could be reviewed at the RCPsych Delivery Group and Executive Team.

Four members of the group have received support as family members of the Tawel Fan group and this would continue. There are also two members of the group who are current Service Users who receive services from MHLD. The support that is in scope of this proposal is related to their support that they are giving to the Expert Advisory Group.

The Associate Director of Governance met with the Head of Adult Mental Health Clinical Psychology and Psychological Services 6 November 2024 to consider the support that would be needed.

2.Requirement For Support

This briefing identifies two distinct areas for initial support.

3. Access to Clinical Psychologists
4. Access to Patient Advice and Liaison Service (PALS) members of staff

4.1 Access to Clinical Psychologists

The proposal is to support the members of the Expert Advisory Group with the access to this support from BCUHB provision. The principle of the support is that there needs to be a “clinical lens” and “trauma lens” on the support provided to individuals and the BCUHB AMH Clinical Psychologists are best equipped for this role. Knowledge and expertise in understanding both ‘normal’ responses to trauma and unprocessed psychological consequences to trauma are essential to providing this support.

This proposal is to support members of the Group from BCUHB. provided this is agreed with the members themselves as best meeting their needs. This should facilitate joined up care and access to support and psychological expertise in in BCUHB. It is noted that the service does currently provide support to some members of this group. AMH Clinical Psychologists have other expertise in responding ‘in vivo’ as they were called upon to support families during the feedback of the HASCAS report in Oriel House. They have also organised and provided the Health board’s psychological response for major disasters such as the Manchester Arena bombing.

It is proposed to provide access to Clinical Psychologists at meetings of the Expert Advisory Group. In addition to provide access to a point of contact for Clinical Psychologists in-between meetings if required. This access to Clinical Psychologists will allow them to be placed on a pathway to other services if required.

It should be noted that if members of the Expert Advisory Group establish the need for support from outside of BCUHB due to the experience they have had of services from BCUHB then there would be a cost implication that this Group would need to be aware of.

2.2 Patient Advice and Liaison Services (PALS)

It was recognised from the first meeting with the Expert Advisory Group members that there are current issues that arise where early facilitation of issues can be supported. The PALS service is also very skilled and talking to patients/service users and families and can provide a good listening and follow up service.

It is proposed to have a single point of access for the PALS Team available in-between and at meetings of the Expert Advisory Group.

2.3 Partnership and Engagement Team

The current team have experience of working with Patients and the Associate Director of Governance will share this proposal to establish any new links that may be required.

3.Next Steps

For this proposal to be considered by the Health Board RCPsych Action Delivery Group and then an update on the proposal overseen by the Executive Team.

Following this for the support to be mobilised as required.

Appendix 4 – Programme Risk Log

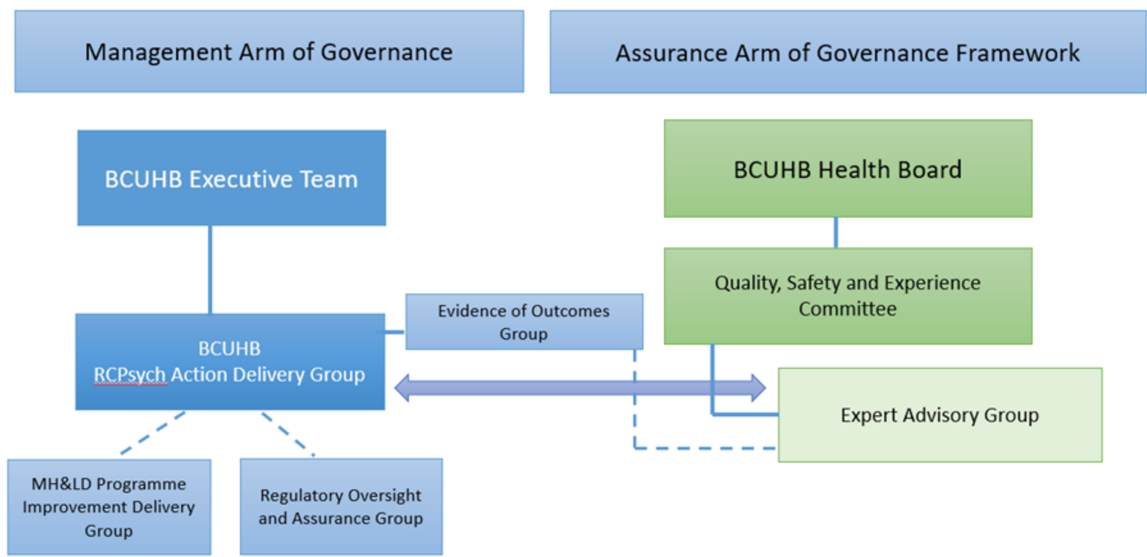
Risk Log v execs.xlsx

Health Board Royal College of Psychiatrists Invited Services Review Expert Advisory Group

Draft Terms of Reference Version 2

1.0 INTRODUCTION

Figure 1 – Governance Framework for the Health Board Response to the RCP Invited Services Review



1.1 The Quality Safety and Experience (QSE) Committee can establish sub groups and associated governance arrangements, including in this case a time limited Advisory Group which is a sub group of the QSE Committee. The detailed terms of reference and operating arrangements in respect of the meetings and business of the Group are set out below in these Terms of Reference document. The Expert Advisory Group has a direct line of accountability to the QSE Committee with its reports being received at the QSE Committee.

1.2 In May 2023, as part of Special Measures, the Welsh Government commissioned the Royal College of Psychiatry (RCPsych) to review the extent to which recommendations from previous Mental Health reports have been implemented and the extent to which these have maintained and consistently integrated into "business as usual" practices.

1.3 The Board has agreed that an Expert Advisory Group be established that will be Chaired by an Independent Advisor and with and its membership reflecting current and previous family and service user representatives so that actions responding to

the recommendations are influenced by and reflect the lived experience of service users and their families.

1.4 For the purpose of clarity, it is noted in these Terms of Reference that there is a Health Board Invited Services Review Action Delivery Group that formally reports into the Executive Team (and is accountable to the Executive Team).

2.0 PURPOSE

2.1. The purpose of this Group is to provide objective assessment that is informed by service user and expert experience to the QSE Committee (on behalf of the Board) so that the Health Board response to the Invited Service Review is delivering sustainable change with transparent and accountable progress against the ten themes identified in the Royal College of Psychiatrists (RCPsych) Invited Services Review. This will include consideration of the experience of care as a result of the actions taken and of the likely medium term, longer term and future impact.

2.2 The Expert Advisory Group will enable people with lived experience and their families to express what safe and reliable care looks like to them and will also enable input from external experts on best practice nationally and internationally. This will enable the Group to take a view on the sustainability and effectiveness of the Health Board's proposed responses to the agenda set by the Invited Services Review and also of the Health Board's strategic objectives and plans.

2.3 This will include providing a view as to whether the specific actions taken address the relevant recommendations appropriately and whether they resonate with the experience of service users and their families. It will also include identifying what is progressing effectively (in terms both of action and of improved outcomes), what is progressing but needs additional support/focus to demonstrate evidence of improved outcomes and what is not progressing effectively as well as providing a view as to the action needed where progress is inadequate..

2.4 Specifically the group will:

- Recommend approval and keep under review these Terms of Reference.
- Advise whether the reported progress against the recommendations evidence meets the objectives of the recommendations and is evidenced by real time information and the experience of service users.
- Bring together representatives of service users and their families, professional experts and Health Board staff to establish the above points.
- Advise the QSE Committee on whether changes and actions to meet the Invited Review recommendations are equitable, sustainable and embedded in every day practice across the whole Health Board through the implementation of a programme of reviewing information..
- Review progress on the development of an evidence bank to store actions and accomplishments for each of the recommendations across the ten themes with access to Health Board staff to provide oversight and further assurance.

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- Assess whether inter-dependencies and commonalities with other pieces of work are considered i.e. Health and Safety Executive Notice of Contravention, Special Measures/Annual Delivery Plan and the Menta Health and Learning Disabilities Improvement Plan.
- Assess whether governance arrangements provide robust assurance that recommendations are being implemented.

Additionally, this group will:

- Promote improvement skills and knowledge based on service users experience that can be enacted at every level, from the top tiers through to front line staff.
- Recognise the importance of creating a workplace culture that is conducive to improvement.
- Ensure that all members of the Group have the time, space, permission, encouragement and skills to collaborate on planning and delivering improvement.
- Seek expert guidance and support from within BCUHB where it seems appropriate to the group. This would be made by a request to the Health Board RCPsych Action Delivery Group

3.0 DELEGATED POWERS

3.1 The Expert Advisory Group is established by the QSE Committee to:

- Assess whether there is sustainable and effective improvement in Services resulting from the recommendations and actions arising the RCPsych Invited Services Review maintaining the trust of patients and public throughout its delivery against these recommendations.
- Recommend where it deems it appropriate the stopping, starting or extending of work on key matters.
- Investigate and act upon any activity within its Terms of Reference with particular reference to the recommendations cited within the RCPsych Invited Services Review, and the ongoing Improvement and development agenda.
- Seek evidenced based assurance from clinical and corporate services in relation to the delivery against the recommendations of the RCPsych Invited Services Review.
- Seek evidenced based assurance that there is compliance with all appropriate legislation and regulatory requirements related to delivery against the recommendations of the RCPsych Invited Services Review.
- Provide constructive feedback to clinical and corporate services in relation to delivery against the recommendations of the RCPsych Invited Services Review.
- .
- Act as the forum in which representatives of service users and their families, professional experts and BCUHB members of staff attending the Group can formally raise concerns and issues for discussion relating to the response to the recommendations of the review;

4.0 AUTHORITY

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4.1. The Group derives its authority from the QSE Committee and is therefore accountable to the Chair of the QSE Committee.

4.2. The Group has responsibility for co-ordinating and providing the QSE Committee with evidence based assurance regarding the Health Board response to the RCPsych Invited Services Review.

4.3. The Group will engage with employees, committees or groups as set up by the Board or by the Accountable Officer to assist in expediting its role. For clarity this will be provided through the Health Board RCPsych Action Delivery Group

4.4. The Group will, where appropriate, recommend courses of action to the QSE Committee within the remit of the Group's 'business.

4.5 The Group will make recommendations and assessments on issues within the remit of the Group, in-line with the Board's Scheme of Delegation.

5.0 WAY OF WORKING

5.1 The Group may, subject to the approval of the Chair of the Group and the Executive Director of Allied Health Professionals and Heath Science, establish the ability for individual members of the group to carry out tasks (in line with these Terms of Refence) on its behalf.

5.2 These arrangements may result in establishing time limited or task limited activity to support the purpose of the group. The intention being to support the effective understanding of whether there is sustainable improvement in place arising from the actions taken in response to the recommendations of the Invited Service Review.

6.0 MEMBERSHIP

6.1 The core members of the Expert Advisory Group (Health Board RCPsych)

Independent Special Adviser to the Board - Chair
Llais Senior Director – Vice Chair
An Independent Clinical Adviser (Psychiatrist)
An Independent Clinical Adviser (Dementia)
3 x Representatives (including families) of previous service users
2 x Representatives of current service users
Associate Director of Governance - BCUHB
Standing Invitees
Executive Director of Allied Health Professionals and Health Science
Executive Director of Nursing and Midwifery (or representative)
Director of Partnerships and Engagement
Director of Operations MH&LD

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Director of Nursing for MH&LD
MH&LD Operational and Business Lead
A Senior Nurse specialist on Learning and Development

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

6.3 The membership of the Group shall be determined by the Chair of the Group taking account of the balance of skills and expertise necessary to deliver its remit and subject to any specific directions made by the QSE Committee.

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

6.5 The Directorate of Corporate Governance shall act and provide secretariat for the meeting.

7.0 MEETINGS (Including Attendance)

7.1 These Terms of Reference allow for meetings to take place with individual representatives of current or previous service users in individual meetings and/or if required, to meet with all representatives of current or previous service users in a single meeting. This will be at the discretion of the Chair of the Group.

7.2 Where meetings do take place with individual representatives of current or previous service users then the Chair or Vice Chair of the Delivery Group plus the individual representative must be present.

7.3 Where meetings take place with all representatives of current or previous service users then at least one third of core members must be present to ensure the quorum of the Delivery Group, one of whom must be the Chair or Vice-Chair.

7.4 Where members are unable to attend a meeting, a nominated deputy should be asked to attend, at the discretion of the meeting Chair. The Chair will initiate action in the event that a members fails to attend, or sends a representative to three consecutive meetings.

7.5 Members have a collective responsibility for the operation of the group. They will participate in discussion, review evidence, and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view.

7.6 Where the Group is unable to reach a collective view, the meeting Chair may refer the matter to the QSE Committee.

7.7 Where there is a matter for concern or dispute derived from a collective view or agenda item of the meeting, the meeting Chair will seek to address the issue and

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where required escalate to the Executive Director for Therapies and Allied Health Professionals and this will be logged by the Associate Director of Corporate Governance.

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

7.9 This is a time limited Group. The Group will be scheduled to meet 12 times a year (monthly) with a minimum of 6 meetings at appropriate times in the reporting cycle for the QSE Committee. The Chair is able to schedule additional meetings if in their opinion that is required.

8.0 RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES

8.1 The Expert Advisory Group is a time limited Group and it will provide a Chair's Report that will be reported to the QSE Committee and other fora as required and agreed by the Chair of the Group.

8.2 The Group will engage with the Health Board RCPsych Action Delivery Group to ensure the connection and consideration of programmes of work.

8.3 Group members are directly accountable to the Chair (an Independent Advisor) for delivering the functions set out in the Terms of Reference.

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

9.0 REPORTING AND ASSURANCE ARRANGEMENTS

9.1 The Advisory Group shall:

- Report on progress against the Invited Services Report to QSE Committee on a bi-monthly basis.
- Provide a Chair's Report that will be shared with other fora, and stakeholders as determined by the Chair of the Group to support common understanding of delivery against the recommendations of the Invited Services Review.
- Bring to the Health Board RCPsych Action Delivery Group specific attention to any significant matters under consideration by the Group;.

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- Ensure appropriate escalation arrangements are in place to alert the Chair of the QSE Committee to any urgent or critical matters that may affect the purpose of this Group and/or reputation of the Health Board.

9.2 For the purpose of clarity, it is noted in these Terms of Reference that there is a Health Board Invited Services Review Action Delivery Group that formally reports into the Executive Team. This Delivery Group will also provide a report under the same agenda item (Health Board Response to the Invited Services Review) to the QSE Committee.

9.3 Members, or those attending are expected to communicate any development, decisions and or recommendations arising from the work delivered that may affect their area of responsibility.

9

10.0 REVIEW ARRANGEMENTS

10.1 These terms of reference and operating arrangements shall be reviewed after 9 months into the appointment of the Chair by the Group and any changes recommended to the QSE Committee for approval. This Group is established on a time limited basis and the end point of the Group will be reviewed and considered by the Chair as and when required.

10.2 The minutes, Risk Log and associated action plans of the meeting and issues of significance shall be formally reported to the Delivery Group subject to the Health Board's Information Governance Policies.

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Version 0.4

Drafted: 8 December 2024

Draft approved by the QSE Committee:

Received by the Expert Advisory Group:

Teitl adroddiad: *Report title:*	Urgent & Emergency Care Deep Dive			
Adrodd i: ***Report to:***	Quality, Safety and Experience Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Tuesday, 17 December 2024			
Crynodeb Gweithredol: ***Executive Summary:***	*The paper provides an overview of the work to improve the Urgent and Emergency Care system, covering* *1) Revised governance structure* *2) Achievements and progress to date* *3) Quality indicators* *4) Areas of concern* *5) Update on corporate risk for Urgent & Emergency Care* *UEC is one of 4 Major Change Programmes reflecting the high level of priority for the Health Board. The presentation outlines the recent developments and the early impact of work in progress. This is aligned to the winter resilience plan approved at Board in November 2024.* *The committee is asked to note the progress made so far and the next steps transitioning into 2025/26.*			
Argymhellion: ***Recommendations:***	*The Committee is asked to:* ***Receive Assurance** from the update provided and the actions taken to mitigate risks to patient safety, experience and outcomes across Urgent and Emergency Care pathways particularly during winter 2024/25.*			
Arweinydd Gweithredol: ***Executive Lead:***	Imran Devji – Interim Chief Operating Officer			
Awdur yr Adroddiad: ***Report Author:***	Alison Bishop – Programme Director – UEC Improvement			
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	Derbyniol *Acceptable* ☐ Lefel gyffredinol o hyder/tystiolaeth o ran	Rhannol *Partial* ☒ Rhywfaint o hyder/tystiolaeth o ran	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth

	darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	darparu'r mecanweithiau / 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):***	To support the delivery of the Annual Plan Implementation of the 6 Goals for Urgent and Emergency Care 2021 - 2026
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	Health and Safety Executive Qulaity Safety Executive
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)***	The following risks are associated with Corporate Risk 24-10
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	Not applicable
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	Not applicable
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	Not applicable
Cysylltiadau â risgiau BAF:	1.2 Risk of the provision of poor standards of care to the patients and population of North

(neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	Wales, falling below the expected standards of quality and safety, resulting in deterioration of care and haem to patients and services. 1.3 Failure to effectively manage unscheduled care demand and capacity infrastructure, adversely impacting on the quality of care and patient experience
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Not applicable

Camau Nesaf:
Gweithredu argymhellion

Next Steps:
Implementation of recommendations

Rhestr o Atodiadau:
Dim

List of Appendices:
None

Guidance:

CYFARFOD CYHOEDDUS BWRDD Y CYFARWYDDWYR
RHOWCH Y DYDDIAD
TEITL YR ADRODDIAD

BOARD OF DIRECTORS MEETING IN PUBLIC
INSERT DATE
REPORT TITLE

1. **Cyflwyniad / Cefndir**
   Y cyd-destun sy'n esbonio pam fod yr adroddiad yn cael ei gyflwyno i'r Bwrdd/Pwyllgor, unrhyw gamau ymgynghori blaenorol, a'r pwrpas o'i gyflwyno i'r Bwrdd

   Introduction/Background
   Set the scene on why the report is submitted to the Board/committee, where it has been previously in terms of consultation, and the aim for its submission to Board

2. **Corff yr adroddiad / *Body of report***

3. **Goblygiadau Cyllidebol / Ariannol / *Budgetary / Financial Implications***
   3.1 Nid oes goblygiadau cyllidebol yn deillio o'r papur hwn. Mae'r adnoddau ar gyfer cynnal cydymffurfiaeth yn cael eu goruchwylio gan ...
   There are no budgetary implications associated with this paper. Resources for maintaining compliance oversight are overseen by …
   3.2 NEU Mae'r goblygiadau cyllidebol yn cael eu lliniaru'n llawn/rhannol drwy ...
   OR Budgetary implications are and fully/partially mitigated via….

4. **Rheoli Risg / Risk Management**

   Mae un risg ar Datix sy'n gysylltiedig â'r maes hwn, sef risg ID xxxx. Mae hon yn risg rannol

   There is one risk on Datix linked to this area which is risk ID xxxx. This risk is partially

5. **Goblygiadau Cydraddoldeb ac Amrywiaeth / *Equality and Diversity Implications***

   5.1 Os yw'r adroddiad hwn yn ymwneud â 'phenderfyniad strategol', h.y. bydd y canlyniad yn effeithio ar sut mae'r Bwrdd Iechyd yn cyflawni ei bwrpas statudol dros gyfnod sylweddol o amser ac ni ystyrir iddo fod yn benderfyniad 'o ddydd i ddydd', mae'n rhaid i chi gynnwys Dyletswydd Economaidd-gymdeithasol (SED), Asesiad o Effaith Cydraddoldeb (SEIA) yn ogystal ag asesiad Effaith Cydraddoldeb (EqIA) fel atodiad.

   If this report relates to a 'strategic decision', i.e. the outcome will affect how the Health Board fulfils its statutory purpose over a significant period of time and is not considered to be a 'day to day' decision, then you must include a Socio-economic Duty (SED) Impact Assessment (SEIA) as well as a completed Equality Impact (EqIA) as an appendix.

   5.2 Mae angen cydymffurfiaeth EqIA yn unol â Gweithdrefn WP7 er mwyn sicrhau bod cydraddoldeb a hawliau dynol yn cael eu hymgorffori i brosesau penderfynu a datblygu polisi'r sefydliad.
   EqIA compliance is required in accordance to Procedure WP7 to ensure equality and human rights are embedded into organisational decision-making and policy development processes.

UEC
QSE Deep Dive

17.12.24

GOVERNANCE

Urgent and Emergency Care
Major Change Programme – System Resilience

A clear governance arrangements from this winter (2024/25) ensuring:

- An integrated approach through aligning the national Urgent and Emergency care (UEC) programme such as 6 goals, 10 best practice standards to the BCUHB UEC major change programme
- 4 distinct workstreams reflecting the patient pathway
- Incorporates the appreciation of interdependencies between UEC and planned care mitigating negative impact on patient safety, experience and clinical outcomes
- A clear model for UEC delivery from operational, tactical and strategic oversight
- A strong North Wales system partnership commitment as a platform for our citizens
- Delivery of the UEC major change programme with an improvement lens co-produced with our colleagues informed by patient stories and lived experience. This is primed to align with the Quality Management System
- UEC dashboard to monitor delivery and assurance on progress both internally and externally
- Plans to align with population health programme including deprivation scores and attendance patterns to understand current inequity of access with mitigations – fully developed by 2025/26

Urgent and Emergency Care
Major Change Programme - UEC Improvement

INTERNAL REPORTING

CEO Weekly Performance Meeting

COO IMPROVEMENT HUDDLES (Leads only)
WS 2/3 Weekly
WS 3 /4 Fornightly

UEC DESIGN & DELIVERY GROUP Weekly

WS Leads – Progress updates
IHC's " So what" Impact

REGIONAL PARTNERSHIP BOARD

National Six Goals Programme

Major Change Programme -UEC (including Six Goals Programme)

Programme Director

Senior Programme Manager

Programme Manager

Programme Manager

Workstream 1 SUPPORT AT INDIVIDUAL'S FRONT DOOR

Workstream 2 HOSPITAL FRONT DOOR

Workstream 3 HOSPITAL FLOW

Workstream 4 DISCHARGE FROM HOSPITAL

Project support

Project support

East Integrated Health Community

Central Integrated Health Community

West Integrated Health Community

Planning/Informatics/Finance/Performance

STRATEGIC

TACTICAL

OPERATIONAL

Planning

Annual Plan

Workstram Plan

Operational Plan

Urgent and Emergency Care
Major Change Programme – System Resilience

A System Resilience Hub will be created across BCUHB that will bring a consistent approach to the management of whole system flow across the HB.

The key principles of the Resilience Hub will be:

- Act as a patient and population champion, ensuring patient safety is at the centre of decision making.
- Uses data driven performance incorporating hard and soft intelligence to provide high level analysis of opportunities to improve patient care throughout unplanned care pathways.
- Act tactically to promote adequate resource allocation across pathways (with local operational responsibility remaining with Integrated Health Communities and Pan BCU services).
- Promote system working, partnership, transparency and collective ownership for North Wales.
- Seek active assurance from services regarding preparing for and mitigating system pressures and mitigating foreseeable circumstances where patient care and experience may be at risk.

Action plan for implementation:

- Agree Standard operating model (Opening hours 0800 to 1800 Monday -Friday and potential challenged weekends based on system pressures).
- Put into place governance arrangements, including user group to support ongoing development
- Review and development of live data feeds
- Develop policies and procedures, including for example, review of escalation management, mutual aid

Detailed implementation plan to be developed with a likely shadowing of current model in December and full go-live in January

Urgent and Emergency Care
Major Change Programme - UEC Model

UEC IMPROVEMENT PROGRAMME/
Six Goals of Urgent and Emergency Care

OPERATIONAL PERFORMANCE
Ministerial Priorities

SYSTEM ESCALATION

IMPROVEMENT

INFORMATION

PLANS

ACTION

WORKSTREAM 1
Moving to patient front door

WORKSTREAM 2
ED/EQ

WORKSTREAM 3
Hospital Flow

WORKSTREAM 4
Discharge to the community

IMPROVED AMBULANCE HANDOVER WAITS

IMPROVED 12 HOUR BREACHES

Time to triage

Time to 1st Clinican

IMPROVED POCD

Reduction in overall numbers

Reduction in delay days

Reduction in assessment delays

Site Sitreps

IHC Sitreps

BCU Sitrep
10am System Resilience Meetings

All Wales Sitrep
11am Chaired by ODU

Shared Learning

Urgent and Emergency Care
Major Change Programme - UEC Workstreams

UEC Workstream 1 Support at the 'Individuals front door' 6 goals – PG1 & 2	UEC Workstream 2 Hospital Front Door 6 goals – PG3 & 4	UEC Workstream 3 Hospital Flow 6 goals – PG5	UEC Workstream 4 Discharge into the community 6 goals – PG6
Reduction in demand by focusing on high volume, high impact pathways; 1. Falls in the community 2. Breathing problems	Increased utilisation and 'ring fencing' of SDEC Improved urgent speciality consultations, review and job planning Ensuring consistent approach to streaming, deflection & navigation	Simple discharge processes including pharmacy Shared models of risk across the system	Reducing the number of clinical optimised patients within acute hospitals by; 1. Considering different models of community care 2. Taking a risk balanced approach 3. Looking at opportunities to better utilise community wards/green wards approaches

ACHIEVEMENTS

Urgent and Emergency Care
Major Change Programme – Achievements

Programme Support / Delivery

- **Key appointments made** in governance structure to support drive of major change programme – Programme Director UEC Improvement & System Resilience Lead.
- **Governance structure** proposed with IHC Directors and well received – programme support aligned to each work stream supported by dedicated improvement resource (2 days per week within IHC).
- Developing **workstream delivery plans** for quarter 3 & 4 based on current work being delivered within each IHC and moving towards a pan BCU approach through Q4 and into next year.
- Working with planning colleagues on detailed **delivery plan for 25/26** to ensure alignment of BCUHB operational vision and national 6 Goals focus.
- Commencing **site visits and Gemba walks** week commencing 2nd December to raise the visibility of the programme with front line colleagues.
- **Key workshop held with Local Authority Partners,** facilitated by **Regional Partnership Board** looking at alternative ways of working focused on quick wins prior to winter.
- **Working with Regional Partnership Board** to ensure drive and pace of the 50 day challenge, aligned to UEC programme and workstreams.
- **Key workshop held with WAST** looking at alternative ways of working to address falls and breathing problems in the community to avoid conveyance.
- **HIW report** for Ysbyty Glan Clwyd articulated improvements resulting in the Emergency Department being de-escalated.

Urgent and Emergency Care
Major Change Programme – Achievements

Operational Delivery

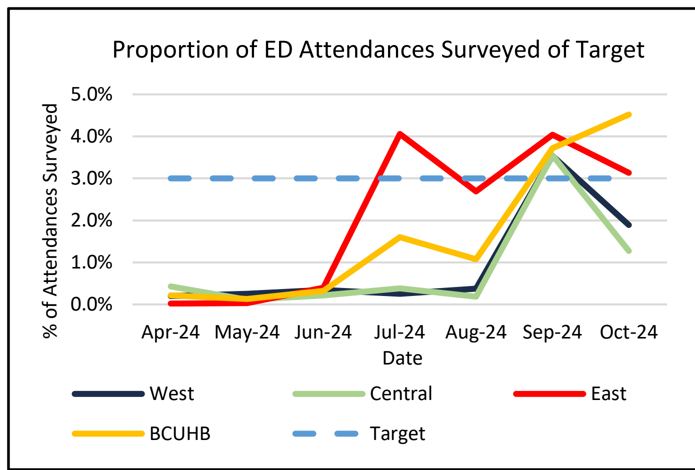
- Secured funding from national 6 goals funding for **2 x B6 optimal flow training posts** - advert live with closing date of 29/11 to work with front line staff to scale up awareness and embedding of the SAFER patient bundle to facilitate improved flow.
- 2 X **discharge training sessions held by Age Cymru** – over 40 colleagues attended - sharing what is available in the community to support discharge home for simple discharges.
- **Patient deconditioning awareness training being** rolled out in West and plan to roll out wider across other sites – reducing deconditioning for inpatients which impacts on length of stay.
- Deep dive undertaken with information colleagues to understand **shift in earlier discharges** seen at acute and community sites. Working with operational teams to understand what is driving this.
- **Review of funded bed base** across each IHC acute and community site including escalation capacity – working with planned care colleagues to ensure capacity appropriately utilised over winter period.
- **Care Home awareness sessions** to promote what the difference is between a Nursing home and Residential home, their legal registration requirements and develop professional relationships and trust between providers and the Health Board.
- **Adverse discharge meetings** - successful meeting in place in the West which is vastly improving trust and discharges. Plans to implement with Central and the East in December/January.
- Monthly deep dive of census data for **>100 days LoS** following census sign off 4th Weds of month – to ensure all opportunities for discharge are taken and reducing the days delays related to Pathways of Care Delays (PoCD).
- **MHLD delays** – delays identified as a key component of those >100 days, meeting to review processes and blockages
- **Focus on joint assessment delays -** IHC will gather data around what is causing the delay and the length of time awaiting a BI/MDT to ensure reduction in days lost whilst waiting for MDT meeting / BI process to be progressed.
- **Top three admissions from a Care Home** are Respiratory, Urine Tract Infections and Falls. The Care Home Quality team are working to develop key programmes to support Care Homes to manage these conditions – webinars, provider brief.
- **Out of hour's palliative care pathway** developed to enable Care Homes to access palliative care clinical care and advice 24/7
- 4 live pilot sites running within residential care homes in Gwynedd, Anglesey & Wrexham delivery a **Trusted Assessor** approach to reduces assessment delays.

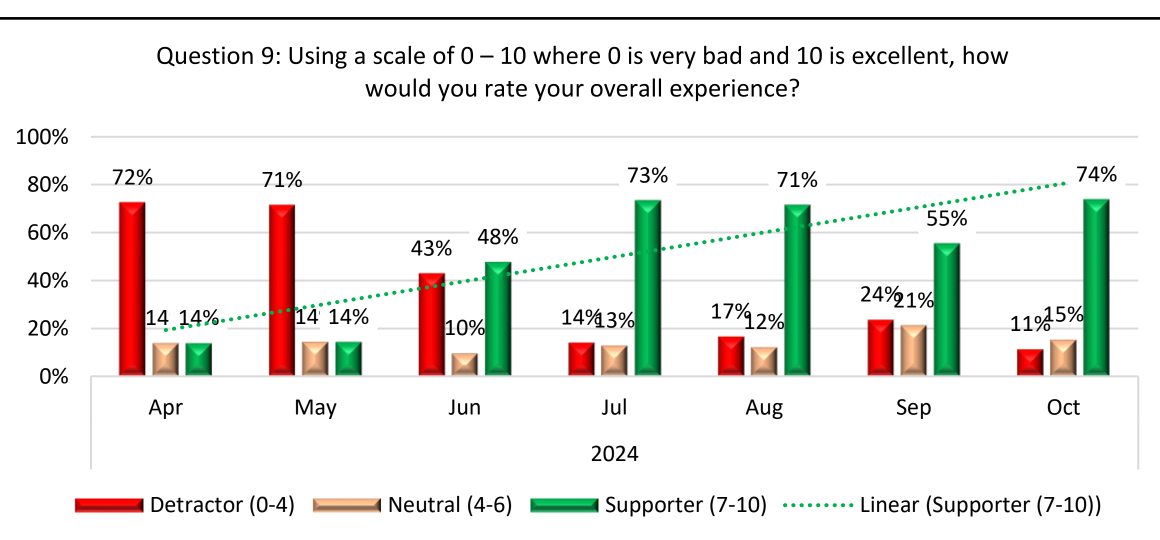
QUALITY INDICATORS

Urgent and Emergency Care
Quality Indicators – Emergency Department

SMS Patient Experience Survey

- Emergency Department attendees are contacted post visit to participate
- **Improved participation** from September 2024 – target 3% of all attendees
- Questions asked
  - Did you feel you were listened to?
  - Were you able to speak Welsh to staff if needed?
  - If you asked for assistance, did you get what you needed?
  - Were you involved as much as you wanted to be in decisions about your care?
  - On a scale of 0-10 how would you rate your overall experience?
  - How was the time you waited? Too long? About right?
  - Did you feel well cared for?
  - Did you understand what was happening with your care?
  - Were things explained in a way you could understand?
- Comments used to drive improvement – **74% scored 7 and above in Oct 24** compared to 14% in April 24



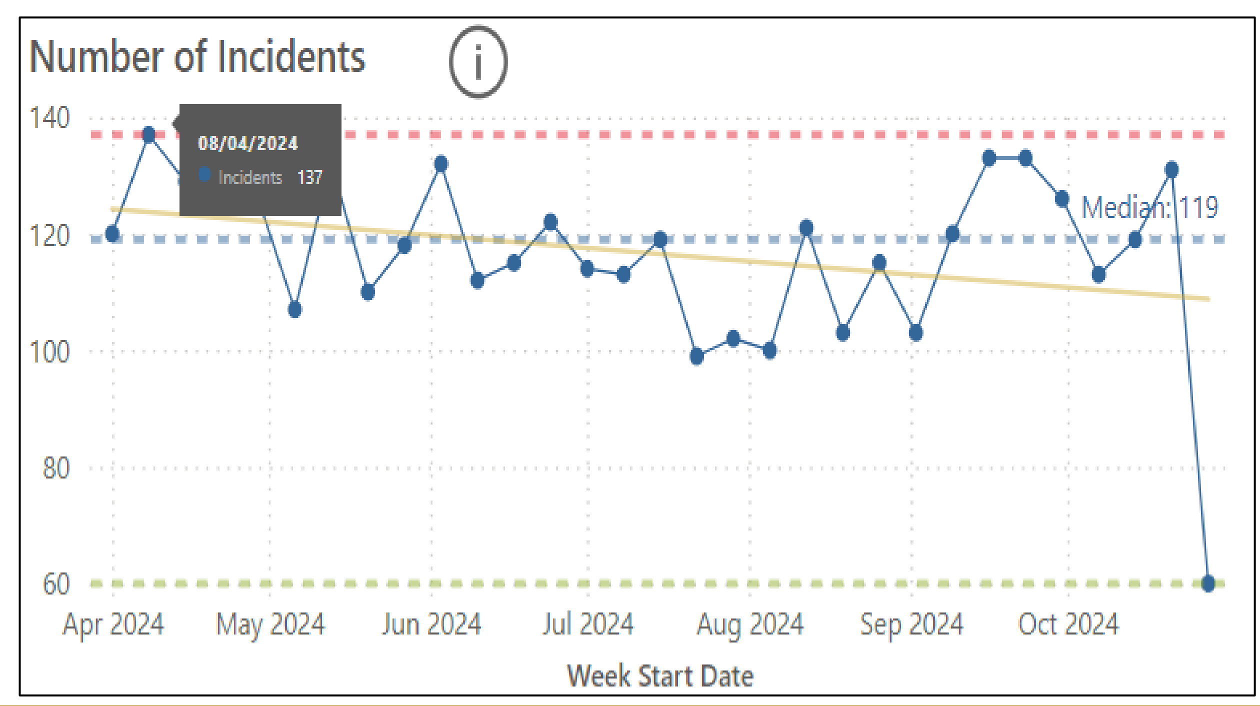


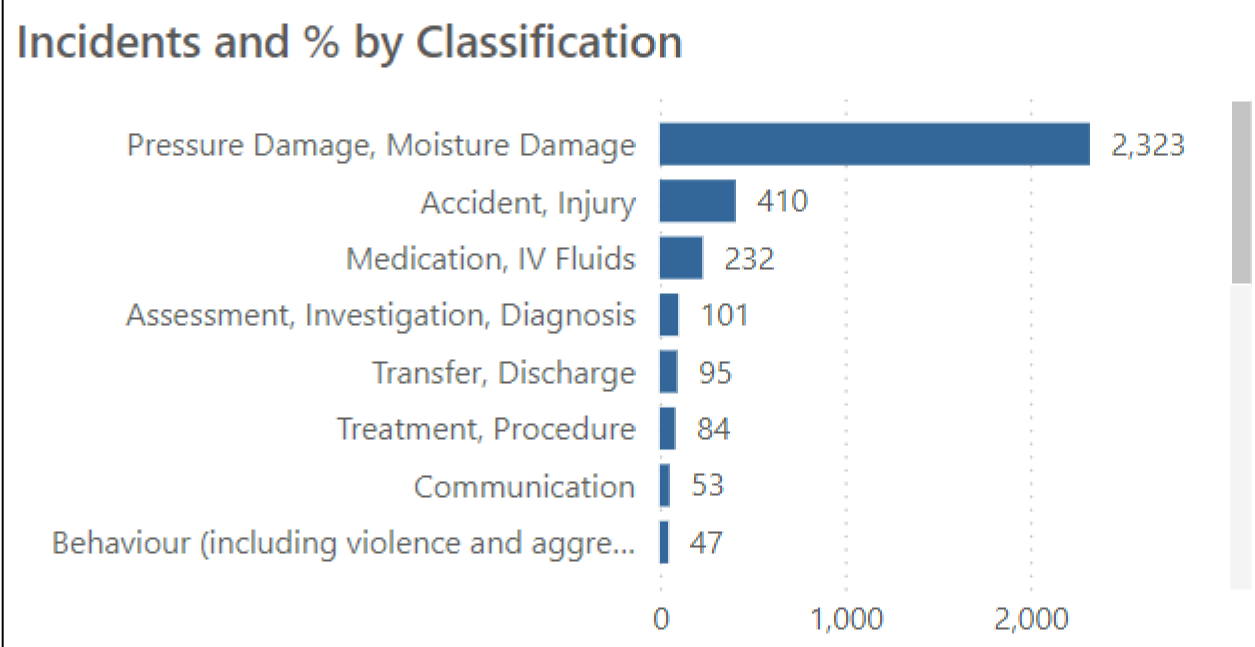
Average experience rating (for completed surveys only) between Apr-24 to Oct-24 as of 31/10/2024		
Organisation	Total Submissions (excluding Did not answer)	Average Rating (0-10)
HDU UHB	1,556	7.72
CTMU UHB	6,695	7.66
CVU UHB	3,380	7.37
BCU UHB	1,751	6.94
ABU UHB	133	6.81
SBU UHB	640	6.43
All Wales	**14,155**	**7.45**

Urgent and Emergency Care
Quality Indicators – Emergency Department

Datix Incidents

- Incidents reported across all Emergency Departments , weekly numbers from April 2024
- **Incidents decreasing** consistently from April to end August
- **Improved position** from April 2024 – target 3% of all attendees
- Overall trend is still **improvement** year to date
- Majority incidents reported are **pressure damage**
- **11 nationally reportable incidents** this year to date





CONTINUING AREAS OF CONCERN

Urgent and Emergency Care
Areas of Concern

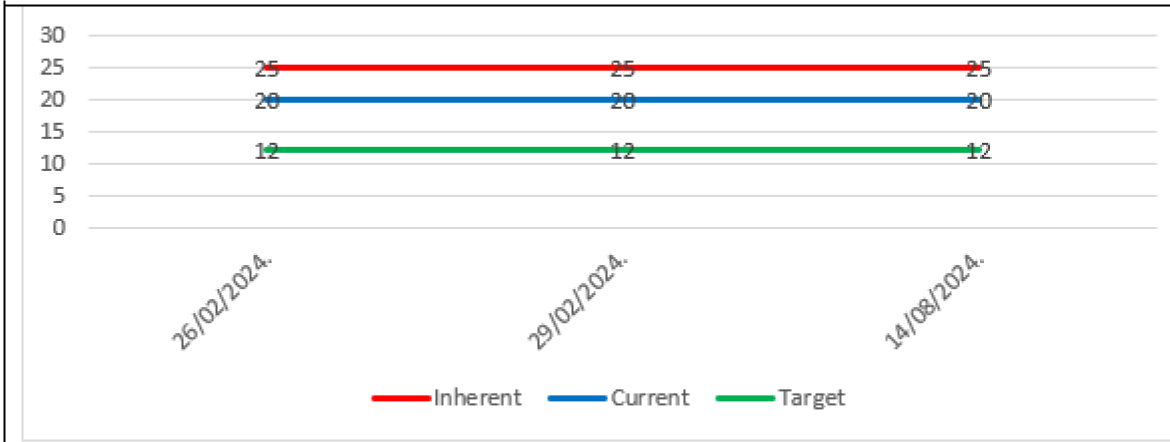
Concern	Mitigation / Controls in Place
Ambulance handover delays remain challenging at Ysbyty Gwynedd and Ysbyty Wrexham Maelor.	System escalation hub with consistent management of daily local and national flow calls commenced 2nd December with action based focus. Ysbyty Glan Clwyd has seen improvement on recent weeks and learning is being shared to improve position at the other sites. Rapid stocktake of direct access pathways available to WAST colleagues and utilisation to ensure all pathways are fully utilised as an alternative to Emergency Departments.
Emergency Department 4 & 12 hour performance challenging across all sites due to poor patient flow.	Hospital Full protocols refreshed to support rapid de-escalation during periods of peak demand.
Number of Clinically Optimised patients within acute sites – numbers are reducing slowly but not at the required pace.	Reviews of long length of stay (LoS) patients in place across all sites (Acute and Community), reviewing patients with a LoS > 21days and escalating concerns to Hospital Leadership Team/IHC Director/COO where appropriate. Workstream 4 – Discharge to Community meeting weekly to drive pace through PDSA cycles and sharing learning.
Data integrity on STREAM – recording of discharge to recover and assess pathways (D2RA) and predicted date of discharge (PDD) compliance and accuracy of recording continues to be a challenge which results in poor discharge.	Secured temporary funding (through to end March 25) from National 6 Goals Programme for 2 WTE band 6 trainers, interviews to be held w/c 8th December . Trainers will deliver training on SAFER patient bundle to help improve flow and education to ward staff on patient flow, D2RA pathways, board rounds etc and explain the importance of reporting.

RISKS

Urgent and Emergency Care Corporate Risk

Corporate Risk 24-10

- Risk remains as **red risk score 20**
- **Key actions** are in progress to mitigate the risk
  - Key interim appointments made and postholders in place – **Programme Director – UEC Improvement & System Resilience Lead**
  - Revised **Governance Structure** for Major Change Programme – UEC developed – single delivery plan being progressed with associated workstream delivery plans
  - Ongoing discussions with **Regional Partnership Board** to incorporate all UEC improvement actions within singular UEC delivery plan - **whole system approach**
  - **Winter Resilience Plan** submitted to Executive Team November 2024
  - **GIRFT/SEDIT** visits and reports of all Emergency Departments completed – dashboard now live and recommendations incorporated into workstream 2 plan
  - Working with governance and quality colleagues to review **outstanding audit and HIW reports -** incorporating outstanding actions into UEC delivery plan



	Impact	Likelihood	Score
Inherent Risk Rating	5	5	25
Current Risk Rating	4	5	20
Target Risk Score	4	3	12
Risk Appetite	Open		15-19

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

Report title:</td><td colspan="4">Corporate Risk Register Report</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">Tuesday, 17 December 2024</td></tr>
<tr><td>Crynodeb Gweithredol:

Executive Summary:</td><td colspan="4">The purpose of this standing agenda item is to provide an update position of the Corporate Risk Register which QSE has oversight

• The Committee is asked to note and discuss the following risk which sits above the risk appetite of the Health Board:
- CRR24-09 Primary Care
- CRR24-13 Timely Diagnostics

Appendix 1 - Risk Dashboard, Quality, Safety and Experience Committee
Appendix 2 - Corporate Risk Register Report Quality, Safety and Experience Committee</td></tr>
<tr><td>Argymhellion:

Recommendations:</td><td colspan="4">The Committee is asked to receive assurance for the six corporate risks to which the Committee has overall accountability.</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>
</table>

<table>
<tr><td colspan="2">Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: N/A

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

Link to Strategic Objective(s):</td><td>Links to the BAF detailed in respective CRR reports</td></tr>
<tr><td>Goblygiadau rheoleiddio a lleol:

Regulatory and legal implications:</td><td>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.</td></tr>
<tr><td>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>Not applicable for this report</td></tr>
<tr><td>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?</td><td>Not applicable for this report</td></tr>
<tr><td>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)</td><td>Links to the BAF detailed in respective CRR reports</td></tr>
<tr><td>Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith

Financial implications as a result of implementing the recommendations</td><td>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.</td></tr>
<tr><td>Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith

Workforce implications as a result of implementing the recommendations</td><td>Failure to capture, assess and mitigate risks can impact adversely on our workforce.</td></tr>
<tr><td>Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori

Feedback, response, and follow up summary following consultation</td><td>Individual Executive sign off of CRR reports, Review at Risk Scrutiny Group 10/09/2024.</td></tr>
</table>

Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	See the individual risks for details of the related links to the Board Assurance Framework.
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Not applicable for this report

Camau Nesaf:

Next Steps:

- Community Care and Six Separate Areas of Clinical Concern Corporate Risks all to be further developed and to be reviewed at Risk Scrutiny Group.

Rhestr o Atodiadau:

List of Appendices:

Appendix 1 – Risk Dashboard, Quality, Safety and Experience Committee

Appendix 2 – Corporate Risk Register Report, Quality, Safety and Experience Committee

Appendix 3 – Board Assurance Framework, Quality, Safety and Experience Committee (private)

CORPORATE RISK REGISTER REPORT (AS AT END OF NOVEMBER 2024)

1) INTRODUCTION AND BACKGROUND

There are 6 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
- CRR24-12 - Areas of Clinical Concern
- CRR24-13 - Timely Diagnostics
- CRR24-14 - Harm from Medical Devices/Equipment

2) KEY HIGHLIGHTS

The corporate risk dashboard (Appendix 1) below provides a list of the 6 corporate risks to which the Quality Safety and Experience (QSE) Committee has within its remit.

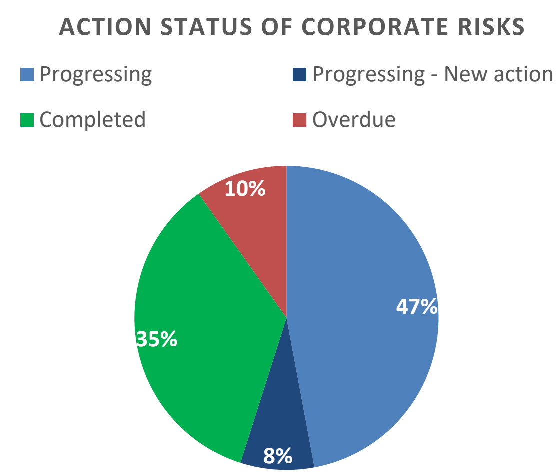
The Committee is asked to discuss the risks which are above tolerance of the risk appetite of the Health Board (Appendix 2)

- CRR24-09 'Primary Care' (risk score 20, above tolerance 15-19).
- CRR24-13 'Timely Diagnostics' – Following review the risk appetite for the risk has been amended from Reputational (Appetite level 20-25) to Quality (Appetite Level 15-19) resulting in the current risk score (20) falling above the tolerance set in risk appetite.

The committee is asked to note the following development;

- CRR24-12 'Areas of Clinical Concern' - the risk is currently being split into 6 separate risks that will focus on specific services. Six draft operational risks have been received in order to separate this corporate risk in relation to the key challenged services.
    - Urology services
    - Oncology services
    - Ophthalmology
    - Vascular services
    - Orthodontics
    - Dermatology & Plastics
- The 'Community Care' corporate risk also remains ongoing for further development of as a standalone Corporate risk. Following initial presentation to development session to the committee, it remains to be further developed and an update has been requested for the January Risk Scrutiny Group.

The committee is asked to receive assurance of the 6 corporate risks, noting 51 actions have been developed to mitigate the risks. 18 actions have been completed, 24 actions are progressing and on track with 4 new actions identified. There are 5 actions are overdue, with 4 related to CRR24-12 'Areas of Clinical Concern', however these are being changed as the risk is separated into 6 clinical services risks.



Next steps

1. Continued scrutiny of the actions, controls and progress of all corporate risks by Executives, Risk Scrutiny Group and Executive Team.
2. Further development of the 'Areas of Clinical Concern' risk.

Appendix 1 - Corporate Risk Register Dashboard – 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	CRR24-02	Patient Safety	4 x 4 = 16 ⟷	12	Quality Open 15-19	Quality, Safety and Experience Committee	Opened Dec 23. Risk revised to become broader patient safety risk, 10 actions identified, 3 completed, and 7 actions progressing. Integrated concerns policy and framework has been implemented and in place since last iteration of the risk.
EDoN	CRR24-04	Failure to Embed Learning	5 x 3 = 15 ⟷	5	Quality Open 15-19	Quality, Safety and Experience Committee	Opened Dec 23, 14 actions identified, 11 completed (rolled into QMS action), 1 progressing with revised due date and 2 new actions identified. Reduction in current risk score from 20 to 15 – September 2024.
EDoO	CRR24-09	Primary Care	4 x 5 = 20 ⟷	12	Quality Open 15-19	Quality, Safety and Experience Committee	Opened Feb 24, 10 actions identified, 3 completed, 6 progressing, with 1 revised due date and 1 new action identified. 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.**
EDoO	CRR24-12	Areas of Clinical Concern (encompasses ophthalmology and dermatology)	5 x 3 = 15 ⟷	12	Quality Open 15-19	Quality, Safety and Experience Committee	Opened Feb 24, 6 actions identified, 2 progressing with 4 actions currently overdue in relation to the action due date. **Six draft operational risks received in order to separate this corporate risk in relation to the key challenged services.**

EDoTH	CRR24-13	Timely Diagnostics	5 x 4 = 20 ⟷	5	Quality Open 15-19	Quality, Safety and Experience Committee	Opened Feb 24, 6 actions identified, 0 completed, 4 actions progressing, 1 action overdue and 1 new action developed. **Risk Score above tolerance set in risk appetite.**
EDoTH	CRR24-14	Harm from the Medical Devices/Equipment	4 x 4 = 16 ⟷	8	Quality Open 15-19	Quality, Safety and Experience Committee	Opened Feb 24, 5 actions identified, 1 completed, 4 progressing with revised due dates.

Key:

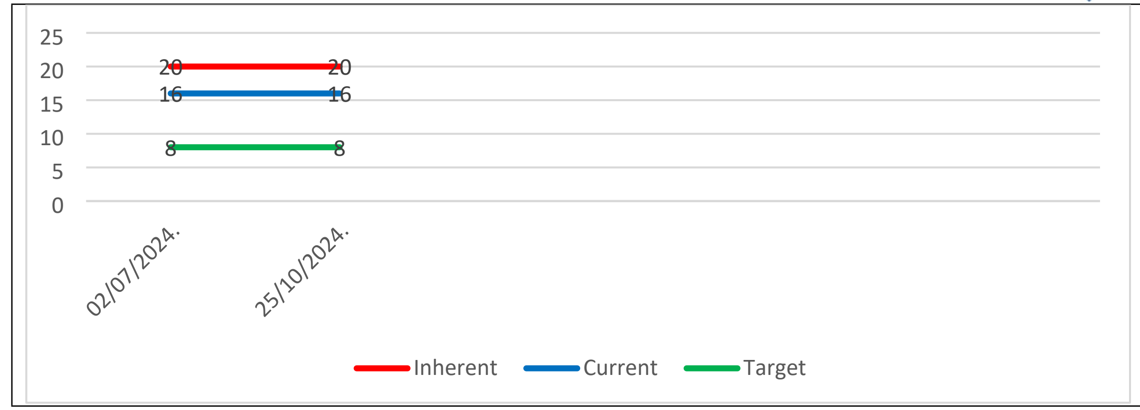
Executive	
Executive Director of Workforce	EDoW
Executive Director of Nursing & Midwifery	EDoN
Executive Director of Finance	EDoF
Chief Digital Information Officer	CDIO
Executive Director of Public Health	EDoPH
Executive Director of Operations	EDoO
Executive Director of Therapies and Allied Health Professions	EDoTH

Appendix 2 – Corporate Risk Register Report – Quality, Safety and Experience Committee

<table>
<tr><td rowspan="2">CRR24-02</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: New Revised Risk</td></tr>
<tr><td>Date Last Reviewed: 25/10/2024</td><td>Director Lead: Executive Director of Nursing and Midwifery</td><td>Link to BAF:</td><td>Target Risk Date: 31st March 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 ‘Putting things Right (PTR) meetings and harms review for learning meetings.
3. Strategic groups that report into the Health Board Patient Safety Group, e.g. Falls Group, Healthcare Acquired Pressure Ulcers (HAPU)Group, 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 PSG that includes IHC/Divisional deep dives of progress and action.
6. BCUHB wide Improvement plans for falls and HAPUs
7. Incident management process including Make it Safe and learning panels.
8. 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 has been implemented and in place.</td><td colspan="2">1. Sustained compliance of >85% of patient safety related mandatory training
2. Timely update of policies and procedures in line with evidence based practice and as per governance cycle for review.
3. Continue to fully roll out safe care to ensure we have the levels of staffing required to meet acuity as per NSA and clinical judgment
4. Further development and Delivery of the 6 goals programme to support Unscheduled care delivery at the front door and reduce our number medically optimised patients to ensure patients are in the right place at the right time.</td></tr>
</table>

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. This has been completed apart from within Central IHC, escalated and awaiting dates.	30th November 2024	Progressing (revised date from 30/09/2024)
Implement the Integrated concerns policy and framework to include toolkits for timely review of learning and action. Integrated concerns policy and framework has been implemented	31st August 2024	Complete

Strategy for Increasing compliance with mandatory training			31st January 2025	Progressing
Full rollout of the learning repository and learning framework to learn from incidents and harm - Learning framework currently being piloted in MHLD division. Learning framework currently being piloted in MHLD division. 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.			31st March 2025	Progressing (Revised date from 30th October 2024.)
Delivery of the key agreed priorities within the 6 goals programme			TBC	Progressing
Deliver all the actions from the Internal Audit of falls Combined HSE and Internal Audit action plan in place. Evidence is being compiled for action plan and submitted and reviewed at bi monthly to Falls Steering Group.			31st March 2025	Progressing
Deliver all the actions from the Internal audit on learning Only one action now outstanding which is the learning repository			31st March 2025	Progressing
Implement the Quality Management System as agreed in Board in May 2024 Project resource identified along with Project Lead. PID developed and due for sign off in November 2024 by Steering Group and SRO. The test beds for QMS Maturity Assessment have undergone PDSA Cycle 1 with a refined iteration of the maturity assessment being tested across those and further test bed services during November 2024. PDSA Cycle 2 to be completed by end of December 2024. Comms and engagement plan drafted and due to be approved in November 2024 by Steering Group and SRO with contained work to begin immediately following sign off..			31st March 2025	Progressing
Implement the Quality Dashboard			31st March 2025	Complete
Continue with the Inquest investigation review programme stage 2 from Jan 2024 This is completed – Sept 1st 2024 when the new policy was implemented			31st March 2025	Complete
		Impact	Likelihood	Score
	Inherent Risk Rating	4	5	20
	Current Risk Rating	4	4	16



Target Risk Score	4	2	8
Risk Appetite	Quality		15-19

Rationale for Corporate 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.

<table>
<tr><td rowspan="2">CRR 24-04</td><td colspan="2">Risk Title: Failure to Embed Learning</td><td colspan="2">Date Opened: 19/10/2023</td></tr>
<tr><td colspan="2">Assuring Committee: Quality, Safety and Experience Committee</td><td colspan="2">Date Last Committee Review: 15/08/2024</td></tr>
<tr><td>Date Last Reviewed: 29/10/2024</td><td>Director Lead: Executive Director of Nursing and Midwifery</td><td>Link to BAF: SP18 - Quality, Innovation and Improvement</td><td colspan="2">Target Risk Date: 31/03/2025</td></tr>
<tr><td colspan="5">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="3">Additional Controls required</td></tr>
<tr><td colspan="2">1. Putting Things Right and clinical review processes and monitoring
2. Quality governance framework of meetings and reporting structured
3. Risk management processes
4. Quality Dashboard and access to quality data from ward/team to Board
5. Audit programmes & monitoring arrangements
6. Patient and carer feedback and involvement processes
7. Senior sign-off process for National Reportable Incidents (NRIs) and Complaints
8. Clinical policies, procedures, guidelines, pathways, supporting documentation & IT systems
9. Clinical staff recruitment, induction, mandatory and professional training, registration & re-validation
10. Defined nurse staffing levels for all wards & departments as per Nurse Staffing Act
11. Ward accreditation schemes and ward manager/matron checks/audits.
12. Tracking of regulatory action plans
13. Internal Reviews against External National Reports
14. Getting it Right First Time (GIRFT), localised deep dives, reports and action plans
15. HIW, Ombudsman, Coroner NHS Wales Exec and WG engagement Meetings
16. Integrated Concerns Policy implemented.</td><td colspan="3">1. Implementation of a Quality Management System (QMS) setting out an integrated approach to Quality Planning, Control, Assurance and Improvement
2. Clarity on quality leadership, structures and accountabilities
3. Development of a quality learning framework, aligned to the overall learning organisation programme
4. Resolution of outstanding overdue positions for incidents, complaints, claims, mortality reviews and inquests</td></tr>
<tr><td colspan="3">Actions</td><td>Due Date</td><td>Progression Analysis</td></tr>
<tr><td colspan="3">The Quality Governance Framework will be reviewed and refreshed and will include greater clarity on the roles, responsibilities and authorities of all groups including the reporting expectations, process and templates. This will include mapping meetings into an overall cycle and introducing standard templates and a single document repository
This work is being taken forward with the support of the NHS Wales Executive as part of the Quality Governance Intervention, who are currently observing to inform their recommendations.
Revised to September - pending full review of Quality Governance Framework. EQDG ToR drafted and on hold pending wider review by new Director of CG.</td><td>30/09/2024

(30/07/2024)</td><td>Completed</td></tr>
</table>

Best practice guidance will be issued to IHCs and Regional Divisions to support effective local quality governance arrangements Each IHC and Division now have a QSE/Equivalent group in place and also have local Integrated Operational Concerns meetings established in line with the new Policy.	30/09/2024	Completed
A Quality Dashboard will be developed underpinned by a series of specialist dashboards (i.e. falls, complains, etc). These dashboards will create a single version of the truth using agreed metrics directly connected to the quality systems for real time data Dashboard launched and live from June 2024	31/05/2024	Completed
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 February 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	28/02/2025	Progressing (Date Revised from April 2024)
The approach to quality assurance will be reviewed and refreshed and a new regulatory procedure and quality assurance procedure will be developed This work is being taken forward with the support of the NHS Wales Executive as part of the Quality Governance Intervention, who are currently observing to inform their recommendations, therefore the work will take slightly longer and a revised date of 30 June This action is being discontinued with the work rolled into the QMS (see below).	30/06/2024	Completed (action rolled into QMS action)
The new Quality Strategy will be developed through a co-design process A refreshed approach to planning arising from Special Measures - a separate Quality Strategy will not be produced and quality will be part of the overall organisational strategy underpinned by a QMS, see below. A quality section for the ongoing planning process has been written and submitted – May 2024 – Revised date from 03/24 to 05/24 due to external dependencies. This action is being discontinued with the work rolled into the QMS (see below).	31/05/2024	Completed (action rolled into QMS action)
A Quality Management System will be developed in line with the Duty of Quality, which will describe how Quality Planning, Quality Control, Quality Assurance and Quality Improvement will work together as a collective quality system The Quality Management System was approved at Board in May 2024.	31/05/2024	Completed (Date Revised from March 2024)
The Terms of Reference and Cycle of Business for the Organisational Learning Forum is being refreshed and revised to build on and strengthen the work of the group.	30/07/2024	Completed
Develop a new Integrated Concerns Policy. A project has been commissioned to develop a new, integrated approach to Investigating and Learning from Incidents, Complaints and Mortality Reviews This new policy is due at Board for approval in July 2024	31/07/2024	Completed
A Learning from Investigations Project has been commissioned to review all open cases due at inquest and to ensure the investigations and evidence of learning is robust. Phase 1 of this project is due for completion by the end of June 2024. The learning from this work will inform the new Investigating and Learning from Incidents, Complaints and Mortality Reviews Policy and process.	30/06/2024	Completed
Delivery of cultural learning improvement projects such as the embedding of Greatix (Learning from Excellence), patient safety and experience training. and development of a Civility Saves Lives champions programme	31/07/2024	Completed

Delivery of improvement activity to reduce the overdue complaint, overdue investigation and overdue open incident position	31/12/2024	New Action
Implementation of the new/approved QMS Framework within the identified pilot sites	31/12/2024	New Action
Implementation of the new/approved Integrated Concerns Policy Integrated Concerns Policy implemented on the 1st of September The new policy in on Betsi net for reference.	31/12/2024	Completed

	19/10/2023.	08/12/2023.	18/01/2024.	14/02/2024.	21/05/2024.	16/07/2024.	16/08/2024.	29/10/2024.
Inherent	25	25	25	25	25	25	25	25
Current	25	25	20	20	20	20	15	15
Target	10	10	5	5	5	5	5	5

	Impact	Likelihood	Score
Inherent Risk Rating	5	5	25
Current Risk Rating	5	3	15
Target Risk Score	5	1	5
Risk Appetite	Open		15-19

Rationale for Corporate Risk

Significant backlog of incidents waiting investigation and new cases demonstrating learning has not been embedded, alongside identified concerns with process and systems to manage concerns and embed learning

<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: 15/08/2024</td></tr>
<tr><td>Date Last Reviewed: 23/10/2024</td><td>Director Lead: Executive Director Transformation and Strategic Planning</td><td>Link to BAF: N/A</td><td>Target Risk Date: 31/03/2025</td></tr>
<tr><td colspan="4">There is a risk of the Health Board not fully meeting its legal obligation to provide accessible and high-quality primary care.

This may be due to the sustainability of primary care professions, patient access, timely diagnosis, and appropriate healthcare utilisation. This may result in a demoralised primary care workforce, increased strain on emergency services, prolonged hospital stays, preventable admissions, lapses in care, regulatory non-compliance, and declining population health indicators. Consequently, there is a cascading effect on patient flow, service performance, care quality, collaborative partnerships, cost-effectiveness, and the viability of primary care and community care models. The ultimate consequence is a rise in mortality rates, treatment delays, and extended hospitalisations, exacerbating patients' health conditions.</td></tr>
</table>

<table>
<tr><th>Mitigations/Controls in place</th><th>Additional Controls required</th></tr>
<tr><td>1. Escalation and sustainability report to address risks associated with workforce and workload pressures allows for early identification and management.
2. Programme management implemented to monitor and drive strategic priorities.
3. Primary Care Quality and Delivery Group established Q3 23/24
4. Primary Care Board has now been established with the first meeting held May 2024. Sub group reporting into the Primary Care Board.
5. Primary Care contractor services audits of sustainability matrix ongoing periodically – Programmes in place to undertake the audits
6. Greater Health Board oversight of Primary Care issues and risks via PPHP Committee with first report to committee during April 2024 with further reporting in June 2024 and December 2024
7. Improved visibility of primary care via IQPD process.</td><td>1. Strategy and resources to support introduction of new roles, ways of working and models of service delivery.
2. Equity of resource to support primary care transformation, management and governance.
3. Strategy, focus and 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.</td></tr>
</table>

Actions	Due Date	Progression Analysis
Primary Care Board established Primary Care Board has now been established with the first meeting held May 2024, monthly meetings planned moving forwards. Sub group reporting into the Primary Care Board.	30/05/2024	Completed
Primary Care strategic plan	31/03/2025	Progressing

National Primary Care model being reviewed with HB input which will inform the Betsi Strategic plan.		
Escalation and sustainability implementation Primary Care contractor services audits of sustainability matrix ongoing periodically – Programmes in place to undertake the audits which were included in the annual delivery plan.	30/06/2024	Completed
Health Board Managed Practices – recommendations for improved governance report Managed practices governance and assurance sub group reporting into Primary Care Board	31/01/2024	Completed
Focused on implementation of recommendations from the National Strategic Programme for Primary Care. July workshop planned to review the recommendations and programme of work for 24/25	31/03/2025	Progressing (revised date from 30/06/2024)
Primary Care academy to utilise SPPC monies to further progress multi-professional working Work on going to develop local health board response to the national strategy and year 1 priorities as set out by HEIW/SPPC. Update expected nationally in November 2024.	31/12/2024	Progressing
a review of cluster monies spend to allow introduction of new roles, ways of working and models of service delivery	31/12/2024	Progressing
Primary Care plan/strategy drafted to lay ground work for pathway to true Partnership and integrated working, with joint planning and decision making across Local Authorities/NHS for health, care and prevention.	31/03/2025	Progressing
Place based person centred provision to be at the forefront of planning, transformation and innovation in all health and social care plans.	31/03/2026	Progressing
Deep dive / diagnostic into general dental and community dental services (scope to be defined)	31/03/2025	New action

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		15-19

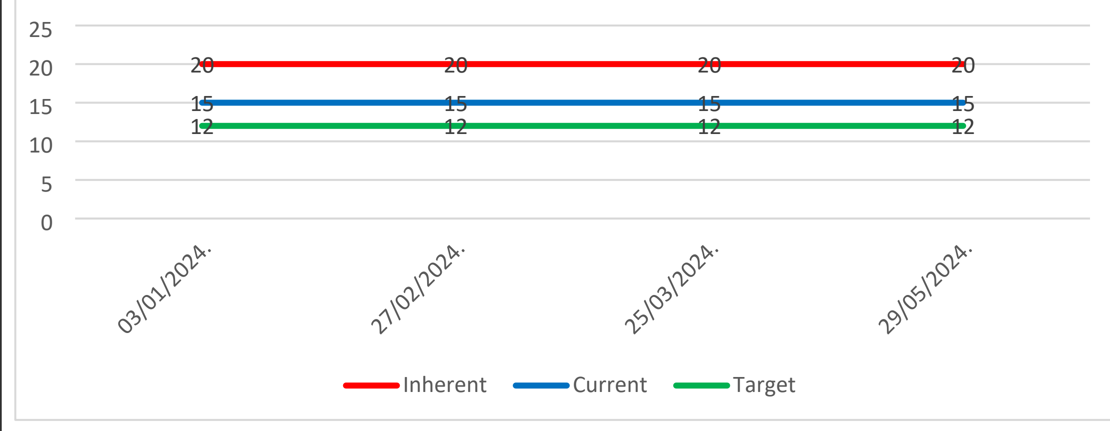
	Rationale for Corporate Risk
	Optometry reform delivery compromised, continue to have further managed practices and financial implications to the Health Board. Dental access compromised. Recognition of inherent score currently further controls needed.

N.B This CRR 24-12 has not been updated following it been separated into six operational corporate risks (drafts received)

<table>
<tr><td rowspan="2">CRR 24-12</td><td colspan="2">Risk Title: Clinical Areas of Concern</td><td>Date Opened: 15/12/2023</td></tr>
<tr><td colspan="2">Assuring Committee: Quality, Safety and Experience Committee</td><td>Date Last Committee Review: 15/08/2024.</td></tr>
<tr><td>Date Last Reviewed: 29/05/2024</td><td>Director Lead: Executive Medical Director/ Executive Director of Operations</td><td>Link to BAF: N/A</td><td>Target Risk Date: 01/03/2025</td></tr>
<tr><td colspan="4">There is a risk of service failure leading to patient harm across a number of fragile clinical specialties. This could be caused by staffing shortages, clinical leadership gaps, lack of productivity, demand backlog, increasing patterns of demand and estates and equipment deficits. The impact may be delayed diagnosis and treatment of significant conditions. This impacts patient safety, healthcare access and public health outcomes.</td></tr>
</table>

Mitigations/Controls in place	Additional Controls required
1. Strategic Improvement Groups for the fragile clinical specialities. 2. Progress review groups for ophthalmology, dermatology and urology to develop and review progress of improvement plans. 3. Improvement plans for fragile specialities for specialities with clinical leadership. 4. Prioritising/triaging cases in specialities with backlog.	1. Implement plans for integrated electronic patient records 2. Dermatology, ophthalmology, urology continue to have clinical leadership gaps 3. Address lack of consistent medical cover in some specialities. 4. SLA for services provided by non-BCUHB organisations 5. Development of clinical model/pathways for fragile specialities with limited leadership incorporating relevant GIRFT and College recommendations 6. Clinical validation of waiting lists.

Actions	Due Date	Progression Analysis
Engagement with National Procurement Processes (i.e. eye record system) and National Programmes (i.e. Robotics) Ongoing engagement with Welsh Government is taking place and is satisfactory.	01/07/2024	Overdue
Ongoing recruitment for substantive medical leadership roles. Now recruited into an Ophthalmic Clinical lead role (May 2024). Start date to be confirmed. In addition the team has now had authorisation to appoint a Clinical Lead for Dermatology	01/01/2025	Progressing
Recruitment efforts including substantive, locum and agency staff. Work continues on a cycle of recruitment. Locum dermatological cover in Ysbyty Gwynedd from June 2024 has been confirmed in May 2024.	01/01/2025	Progressing
SLAs to be signed off through governance structures Work has now commenced on the process to implement a Dermatology Outsourcing SLA with national lead input. In relation to governance. Updates and any approvals will be sought through the Executive Team. (for SLA approval)	01/08/2024	Overdue
Clinical pathway events Engagement during May 2024 with NHS Wales Executive on the development of the Community Clinical Pathway system. This will be received at Executive Team for consideration.	30/07/2024	Overdue
Non-clinical and clinical validation exercises Andrew Oxberry from BCUHB has commenced work on this and this will be able to reported at the next update to this risk.	30/07/2024	Overdue



	Impact	Likelihood	Score
Inherent Risk Rating	5	4	20
Current Risk Rating	5	3	15
Target Risk Score	4	3	12
Risk Appetite	Open		15-19

Rationale for Corporate Risk

The impact of the inherent risk has not been altered by current actions, although its likelihood has been reduced by the identification of the clinical issues and improved governance around the services.

- Ophthalmology R1 seen within 25% over their clinical due date - NHS Wales Performance Framework 2024-25 Target improve to 95%
- Cancer 62 Days - NHS Wales Performance Framework 2024-25 Target improvement trajectory to 80% by 31.03.2026

<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: 24/10/2024</td></tr>
<tr><td>Date Last Reviewed: 18/10/2024</td><td>Director Lead: Executive Director of Allied Health Professions & Health Science</td><td>Link to BAF: N/A</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 and pathology services across. This could be caused by shortages of specialist staff, aging or inadequate IT systems and infrastructure, and insufficient governance structures. The impacts may include delays in diagnosis, treatment and discharge, increased outsourcing costs, patient harm events, preventable deaths, regulatory non-compliance, and significant reputational damage. There is also additional risk related to clinicians failing to act on results of diagnostic tests.</td></tr>
<tr><td colspan="2">Mitigations/Controls in place</td><td colspan="2">Additional Controls required</td></tr>
</table>

1. Insourcing of CT, MRI and ultrasound to deliver required capacity 2. Work commenced on new radiology staffing model for the identification of significant restructuring of the service with succession planning, career development, staff wellbeing etc. 3. Significant guidance and steer with National Imaging Programme workforce work. 4. Outsourcing of radiology reporting to maintain Welsh government turnaround times 5. Waiting list & capacity and demand management is in place to monitor radiology required resources. 6. New all Wales contract with Everlight from 1st November 2024 to maintain provision of radiology reporting 7. Active participation by pathology in the nation pathology programme	1. Replacement of Radiology Informatics System (RISP) – implementation underway go live planned for April 2025 2. Replacement of LINC (national pathology IT system) - Contract signed with current supplier plans to implement by September 2025 being progressed nationally 3. 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 4. 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. 5. PHW Collaborative Executive group. 6. Diagnostic Strategy for BCU needs to be developed 7. Radiology Information System Programme to go live 28.4.2025 8. Discussions held with OMD and a plan is being put in place for a task and finish group to update procedure MD23 - mitigation of the risk of failure to act.

Actions	Due Date	Progression Analysis
Replacement of Radiology Informatics System (RISP) – implementation with anticipated go live date of the 14/04/2025.	14/04/2025	Progressing
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	30/09/2024	Overdue
Escalate failure to act risks to CEG	31/03/2025	New Action

Date	Inherent	Current	Target
21/02/2024.	25	20	5
13/03/2024.	25	20	5
17/05/2024.	25	20	5
22/08/2024.	25	20	5
18/10/2024.	25	20	5

	Impact	Likelihood	Score
Inherent Risk Rating	5	5	25
Current Risk Rating	5	4	20
Target Risk Score	5	1	5
Risk Appetite	Quality		15-19

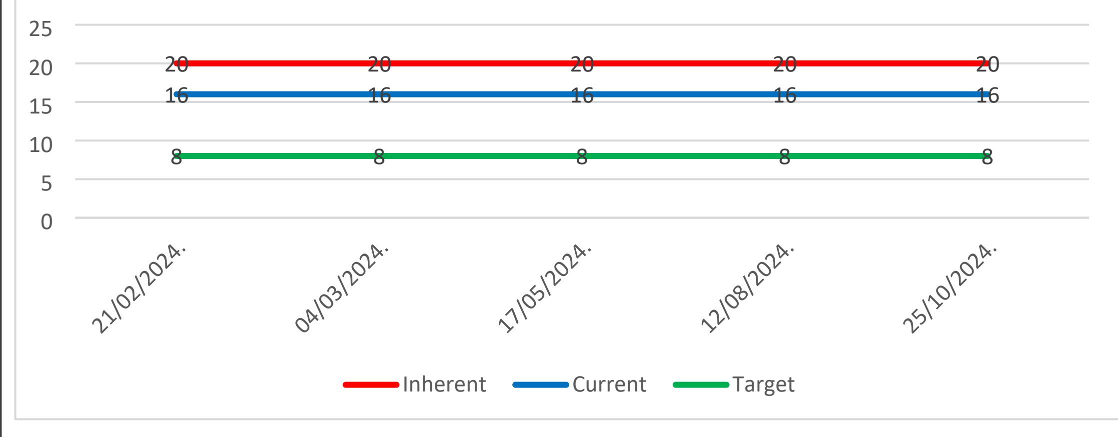
Rationale for Corporate Risk

Increasing demand for both radiology and pathology
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: 24/10/2024</td></tr>
<tr><td>Date Last Reviewed: 25/10/2024</td><td>Director Lead: Executive Director of Allied Health Professions & Health Science</td><td>Link to BAF: N/A</td><td>Target Risk Date: 31/03/2025</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 EBME.
6. EBME 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">1. Internal risk assessment and priorities are flagged in the context of fully depreciated equipment (£34.659m) to understand priorities and potential risks.
2. External links with National Endoscopy and Diagnostic Programmes are documented and appropriately reported through correct channels to ensure transparency and potential benchmarking.
3. Lack of medical device training and good governance of safety of equipment has been lacking and documented as a risk since 2016.
4. 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.
5. 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+.
6. Medical Device regulations work ongoing – see additional risk ID 5282 ‘Medical Devices Regulations 2002(SI 2002 No 618, as amended) (UK MDR 2002) compliance’.</td></tr>
</table>

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)
Review of internal Medical Device Governance and Assurance group membership and communication to ensure all opportunities and risks are reported and escalated as appropriate. MDGAG has now been established with new Terms of Reference.	31/02/2024	Complete
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.	31/03/2025	Progressing (Revised from 31/09/2024)
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 Recruitment to Head of Clinical Engineering is progressing, currently with job evaluation.	31/03/2025	Progressing (Revised from 31/09/2024)



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	2	4	8
Risk Appetite	Open		15-19

Rationale for Corporate 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.

<table>
<tr><td>Teitl adroddiad:
Report title:</td><td colspan="4">Quality Delivery Group – Chair's 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">17th December 2024</td></tr>
<tr><td>Crynodeb Gweithredol:
Executive Summary:</td><td colspan="4">This report provides the Committee 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="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
Teresa Owen, Executive Director of AHPs and Healthcare Science</td></tr>
<tr><td>Awdur yr Adroddiad:
Report Author:</td><td colspan="4">Angela Wood, Executive Director of Nursing and Midwifery (Chair)</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="5">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>
<tr><td colspan="2">Cyswllt ag Amcan/Amcanion Strategol:
Link to Strategic Objective(s):</td><td colspan="3">Outcome 4 - Improved access, outcomes and experience for citizens

Outcome 5 - Recognition of BCU as a learning and self-improving organisation</td></tr>
<tr><td colspan="2">Goblygiadau rheoleiddio a lleol:
Regulatory and legal implications:</td><td colspan="3">The Duty of Quality is a statutory requirement under the Health and Social Care (Quality and Engagement) (Wales) Act 2020.</td></tr>
</table>

	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:
QDG Chair's Report

Chair's Report

Report to:	Quality, Safety and Experience Committee
Report from:	Executive Quality Delivery Group
Report date:	November 2024
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	**Central IHC** Corridor Care – The ED at Glan Clwyd Hospital is currently raising concerns concerning the corridor care that is being given. Patient's dignity and privacy is not consistently being addressed, which is affecting the patient's experience. Teresa Owen and Angela Wood are in discussions to address this issue. **East IHC** HMP Berwyn - Issues have been raised around the failed Health & Wellbeing appointments due to enablement by HMPPS and DNA of patients ED – There are currently prolonged length of stays for patients in the ED awaiting admission into Mental Health beds. Sustained crowding in the ED, affecting the quality and safety of care provided and staff wellbeing. Resulting in increased use of escalation staffing to achieve the safest staffing levels to prevent harm to patients and staff.
Summary of business conducted – for assurance	**West IHC** Incidents, these are improving. NRI's, there are 5 cases pending all have progressed and 1 is under review and in date. There are no recent never events, last one was in May. Inquests, there are 111 open inquest files. Mortality reviews are on track. External reviews have been completed.

	Central IHC Rounds for Accountability Reviews have now started where the top risks are being reviewed. Regarding incidents, there has been a slight improvement however; there is some work to be done. The overdue clinics are completed. NRI's, there are 5 overdue, 1 was submitted on the 11th November 2024 and 1 is due to be completed. Inquests, no PFDs, received good feedback from the coroner on how staff presented themselves while in attendance. Never Events, nothing to report for this month In relation to Duty of Candour, the Quality Team have asked for a register to be pulled together and this is a work in progress. Complaints have improved, however this is also a work in progress and there is some way to go to get to a better position. **East IHC** The top risks remain unchanged, extreme risks identified are within the Dentistry Service and ED. The lack of a functioning Discharge Lounge is preventing flow first thing in the morning and causing issues across weekends too. There has been an increase in HAPU's, and Falls have increased within the Community. 34 open concerns and 6 overdue. **MHLD** In relation to the Risk Register for MHLD, this currently has 3 risks submitted, 23 under review and 1 awaiting a decision to close. Incidents there were 427 reported in September and 9 incidents were graded as catastrophic. Inquests there were 12 for the month of September 7 were drug related, 1 accidental death, 1 drug and alcohol related, 1 narrative and 2 were adjourned. MHLD currently have 83 WCD's including Medicines Management. 12 of which are coming up for review and redevelopment. 40 currently progressing through ratification process including consultation and there are 31 uploaded that are live and 10 awaiting upload. Regarding Achievements, on the 30th September 2024, there was a report on the One Show about the 111 press 2 service based in the Heddfan unit in Wrexham. The report was very positive and included a woman who had used the service, and said it had a positive impact on her mental health and wellbeing. **Womens** 1 risk has been submitted and 13 are under review and 2 awaiting on a decision to close. Incidents, there are 248 currently open, 92 are for Management Review, 93 are Under Investigation and 63 are Awaiting Closure. NRI's there are currently 11 open, 2 of which are overdue, which includes 1 case awaiting NRI closure and 7 are in date. Inquests, there are currently 6 open within the Womens Services.

	Emerging issues, the service has commissioned an external review of 6 Ureteric injury cases, which is being completed by a Professor in Birmingham, which has commenced. Concerns, there are 16 Open Concerns with 6 overdue. Central 1 with General Surgery, 1 awaiting input from Risk and Governance Team, 1 awaiting Clinical review and 1 with QA. West there is 1 awaiting External Review and 1 being drafted. **Cancer** There were 19 risks submitted, 1 is being developed and 18 are under review. There are no Never Events and no NRIs. Regarding Incidents, Cancer Services currently have 350 open with 237 overdue. No Inquests and no ME Notifications requiring further investigation. Concerning complaints, there are 2 formal complaints open. Regards to the Ombudsman, 1 case remains open. The response is being reviewed and will be sent onto the complainant and Ombudsman notified. In relation to Achievements, huge congratulations have been given to the Shooting Star Unit on achieving a score of 99% on a recent Health and Safety Review. This outstanding accomplishment reflects SSU's unwavering dedication and commitment to maintaining the highest standards of care and safety within the department.

Cyfarfod a dyddiad: **Meeting and date:**	Quality, Safety & Experience Committee 17th December 2024
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:

24th October 2024

- Quality Report
- Welsh Risk Pool and Legal and Risk Services – Annual Review 2023-2024

Cyfarfod a dyddiad: **Meeting and date:**	Quality, Safety & Experience Committee 17th December 2024
Cyhoeddus neu Breifat: **Public or Private:**	Public
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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**	✓

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Asesiad / Assessment

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24th October 2024

- Quality Report
- Welsh Risk Pool and Legal and Risk Services – Annual Review 2023-2024

Reporting Committee	**Quality and Patient Safety Committee (QPSC)**
Chaired by	**Ian Green**
Lead Executive Director	**Director of Nursing & Quality**
Date of Meeting	**4th November 2024**

Summary of key matters considered by the Committee and any related decisions made

1. PATIENT STORY

Members received a video of a patient and donor's experience whist undergoing a Bone Marrow Transplant. The service is commissioned from Cardiff & Vale University Health Board in the South and The Christie in the North. The video demonstrated the needs for a whole team approach and the support the patients receive during and after the transplant. As well as outlining the process the Lead clinician spoke about the need to increase the bank of donors. A member of the Joint Commissioning Committee (JCC) Quality Team attended a celebration event when the donor visited Wales to be reunited with the recipient one year after his transplant.

2. WELSH KIDNEY NETWORK REPORT

Members received a report outlining the current Quality and Patient Safety issues within the Welsh Kidney Network (WKN) and a summary of risk register was provided. Concerns were raised regarding the importance of early intervention and the role of public health going forward. The Committee were reassured that the appointment of a Public Health Advisor was progressing within the JCC and an update would be provided at the next meeting.

3. COMMISSIONING TEAM AND NETWORK UPDATES

Reports from individual Commissioning Teams were received and taken by exception. Members noted the information presented and a summary of the services in escalation as attached. The key points for each service are summarised below and updates regarding services in escalation are attached in the tables at the end of the report.

4.1 Cancer & Blood
Plastic Surgery
It was noted that the JCC had agreed additional funding that will achieve the Key Performance Indicators (KPI) for identified higher priority patients (including

paediatric patients and patients waiting for Deep Inferior Epigastric Perforator (DIEP) reconstruction after cancer surgery) awaiting plastic surgery. The trajectory is currently being finalised however, the committee requested that in the meantime any direct harm to paediatric patients needed to be considered and escalated appropriately.

Neuroendocrine Tumours

Cardiff & Vale University Health Board received confirmation from the European auditors on the 3rd October that following submission of their annual return data they have maintained the European Neuroendocrine Tumour Society (ENETS) certificate for another year. This maintains accreditation status as a European Centre of Excellence.

4.2 Cardiac

Obesity Surgery Waiting Times

It was reported that there had been no improvement in the waiting list positon for Salford which was resulting in an inequity of service provision between the North and South Wales obesity services. As a result the JCC Senior Leadership Team endorsed a proposal submitted by the Commissioning Team for a portion of the resource allocated to SBUHB to be used to support the recruitment of an additional dietician. This will enable the Welsh Institute of Metabolic and Obesity Surgery (WIMOS) to undertake a number of additional procedures for BCHUB and North Powys patients. The Committee asked if the NHS England service needed to be placed into escalation as a direct result and it was agreed that the Commissioning Team would now consider this as a matter of urgency.

Cardiac Surgery

Cardiff and Vale Cardiac Surgery Service was de-escalated from Level 2 to Level 1 of the Escalation Framework in May 2024. The JCC team have been informed that the Health Board are undertaking an internal review of cardiac services following a number of incidents. The team will request the Terms of Reference and ensure that the JCC are fully sighted on the timescales of the review and its findings.

4.3 Neurosciences and Long-Term Conditions

Deep Brain Stimulation

It was noted that significant progress had been made with North Bristol to secure the pathway for South Wales patients and will monitored over the coming months.

4.3 Women & Children

Children's Hospital For Wales

A reset meeting took place on the 18th September to consider the services in escalation and undertake a collaborative approach to agreeing the way forward. Further work was required to agree the data set for monitoring and the next

escalation meeting is scheduled for 25th November. A detailed update with actions is provided in the escalation table.

Wales Fertility Institute
Members noted the significant work that had been undertaken to improve the service. The risk score has been reduced from 15 to 8, following receipt of 3 months comprehensive dataset received from the provider. The Commissioning Team reviewed the evidence and the level of escalation has been reduced from three to one as a result. Quarterly meetings will continue to be held and data submissions will be required in order to ensure the service remains at an appropriate level of service provision with reduced risks. A Letter has been sent to provider to inform them of the decision to reduce the level of escalation.

Infection Prevention & Control Issues
The committee were given an update on the two Methicillin-resistant Staphylococcus aureus (MRSA) outbreaks in the neonatal units in SBUHB and CVUHB. The JCC Quality team we part of the outbreak meetings and will continue to provide support into the units. Welsh Government are aware of the position. Further work will need to be undertaken to fully understand if the units are outliers and what actions are required to prevent further outbreaks and transmission.

4.4 Mental Health
High Secure Services
The service at Rampton High Secure Unit remains in enhanced monitoring via NHS England & the Care Quality Commissioning (CQC) due to significant staffing issues. There are beds available but all admissions are managed via this process. There is one Welsh patient awaiting admission. The Commissioning Team continue to have oversight of commissioning of high secure services via the National Oversight Group (NOG) which include fortnightly SITREP's, site visits and Bi Monthly Strategic Executive Information System (StEIS) meetings.

4.5 Intestinal Failure (IF) – Home Parenteral Nutrition
Members received an update on the quality issues for services relating to the Intestinal Failure Commissioning Team Portfolio.

5.0 OTHER REPORTS RECEIVED

Members received reports on the following.

5.1 Services in Escalation Summary
Members noted that there were a number of examples given where services had been in escalation for a considerable length of time and in some instances this was due to a lack of data being submitted in a timely fashion by the provider.

The committee requested that any delays were escalated to the JCC Senior Leadership team and the provider Health Bards made aware at Executive Level.

A copy of each of the services in escalation is attached to the report at **Appendix 1.**

5.2 Quality and Safety Report - Ambulance and 111

A report providing an update on quality and safety matters for the Ambulance and 111 commissioned services was received. The committee received a copy of the Quality Dashboard which has been produced in line with the requirements of the Duty of Candour and the Duty of Quality and reports around the Six Quality Domains.

Regulation 28

The committee was informed that it had recently received a regulation 28 order as a result of a delay of an ambulance getting to a patient. This would need to be considered in a system wide approach and joint working with the NHS Executive and WAST was required. A further update would be provided at a future meeting.

5.3 Incident and Concerns Report

Members received a report outlining the incidents and concerns reported to JCC and the actions taken for assurance. This excluded both Mental Health and Ambulance as they were included within their separate reports. Work is planned to align the processes going forward.

5.4 Joint Commissioning Committee Risk Register

The risk register for the JCC was presented to the committee, which encompasses risks scoring 15 and above taken from the commissioning teams and directorate risk registers across the former EASC, NCCU and WHSSC predecessor organisation risk registers. This Risk Register was approved by the JCC in September 2024, and considered by the CTM Hosted Bodies Audit and Risk Committee (ARC) in August October. Members noted the significant amount of work done to bring this together, mindful there was still a lot of work to be done with scores and assessing risks to ensure consistency across the range of NWJCC services.

A summary of the risks related to the Ambulance and 111 service was presented to the Committee and a paper was due to be received by the JCC next week.

5.5 Policy Group Report

Members received an update on activity and output from the JCC Policy Group during the period 01 July 2024 – 30 September 2024 together with an updated overview of all JCC policies and service specifications including those published during the current financial year. The Committee acknowledged the significant work that had been undertaken.

6. ANY OTHER BUSINESS

QUALITY SAFETY AND OUTCOMES SUB COMMITTEE (QSOSC) Terms of Reference & Operating Arrangements (Schedule 3.1 of the Standing Orders)

A discussion took place regarding the Terms of Reference for the new Quality Safety and Outcomes Committee and the changes to the membership following the appointment of Independent Members for the JCC. The Chair assured the Committee that the JCC would continue to work with the Health Board Board Secretaries to ensure that a Chairs Report would still be made available to the Health Boards QPS for assurance purposes. As the meetings would be held in public the papers would be readily available and anyone could attend as an observer.

It was noted that the Director of Nursing wrote the Health Board QPSC members on the 25th October outlining progress and changes in establishing the new Joint Commissioning Committee (JCC) Quality, Safety and Outcomes (QSOSC) sub-committee and thanked them for their significant contribution and commitment to the Committee. The Chair also took the opportunity to thank them personally at the meeting.

Key risks and issues/matters of concern and any mitigating actions

- Confirmation of appointment of Public Health expertise into the JCC
- Assurance on any harm resulting in delays in plastic service for paediatrics to be confirmed
- Note position of obesity pathway and consider if the service for North Wales patients' needs to go into the escalation process.
- Escalation objectives to be agreed for services in escalation in Childrens Hospital for Wales
- Risks relating to ambulance services will be considered by the JCC next week
- Continue to input into the MRSA outbreaks within the neonatal units and provide an update to the next meeting

Summary of services in Escalation

- Attached (**Appendix 1**)
- Escalation to SLT if delay in data information received into JCC

Matters requiring Committee level consideration and/or approval

None

Matters referred to other Committees

As above.

Confirmed minutes for the meeting are available upon request

Date of Next Scheduled Meeting	TBC

Executive Director Lead: Carole Bell
Commissioning Lead:
Commissioning Team: Women and Children

Date of Escalation Meetings: 10/10/23, 19/12/23, 16/05/24
Date Last Reviewed by Quality & Patient Safety Committee: 02/09/24

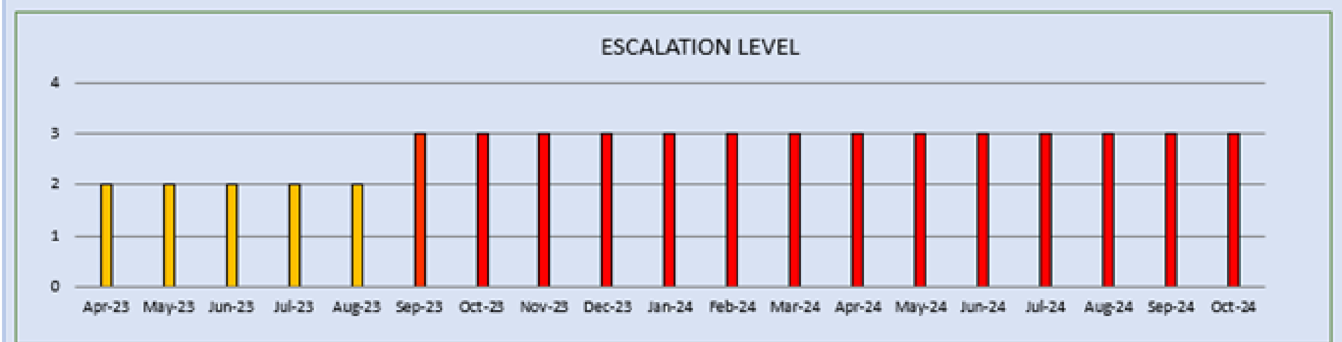
Service in Escalation: Paediatric Intensive Care

Current Escalation Level 3

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↔ OCT 2024
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level
April 2023	**2**
September 2023 – Increased level from 2 to 3	**3**

Rationale for Escalation Status :

Following concerns regarding bed availability due to workforce shortages, refusal rates and pressure sore incidents the service was escalated to level 2. There was limited progress over a 3 month period against the objectives therefore the decision was taken to further escalate to level 3.

Background Information:

There is a risk that a Paediatric intensive care bed, in the Children's Hospital for Wales, will not be available when required due to constraints within the service. There is a consequence that Paediatric patients requiring intensive care will be cared for in, inappropriate areas where the necessary skills or equipment is not available or the patient being transferred out of Wales. The availability of a bed and staffing constraints have been brought to the attention of JCC through various routes including HiW and the daily SITREP.

JCC assurance and confidence level in developments:

Low – HB have submitted draft action plan, a final version has been requested. The escalation is predominantly linked to workforce and the lead in time for mitigations is medium term, in particular the recruitment of International

Actions:

Action	NWJCC Lead	Action Due Date	Completion Date
Requested demand and capacity plan from HB to develop sustainable contracting framework for PIC and HD	Senior Planning Manager	30 June 2024	
Requested sight of the Pressure Sore report presented to the HB Quality and Patients Safety Committee.	Senior Planning Manager	-	17th July 2024
Re-set meeting to discuss and agree actions/objectives in collaboration with the health board	Senior Planning Manager	18th September 2024	18th September 2024

Nurses. New streamliners have begun in the HB and although supernumerary at present and will not directly fill PIC vacancies it will support the wider workforce challenges across the Children's Hospital. JCC are still awaiting detailed demand and capacity in order to develop a sustainable contracting framework for Paediatric Intensive Care and High Dependency. Escalation status being discussed at executive level within the JCC.

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

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

Escalation meeting to discuss detail and progress against action plan (monthly)	Senior Planning Manager	-	25th November 2024

Plot Area

Issues/Risks:

Executive Director Lead: Carole Bell
Commissioning Lead:
Commissioning Team: Women and Children

Date of Escalation Meetings: 10/10/23, 19/12/23, 16/05/24
Date Last Reviewed by Quality & Patient Safety Committee: 02/09/24

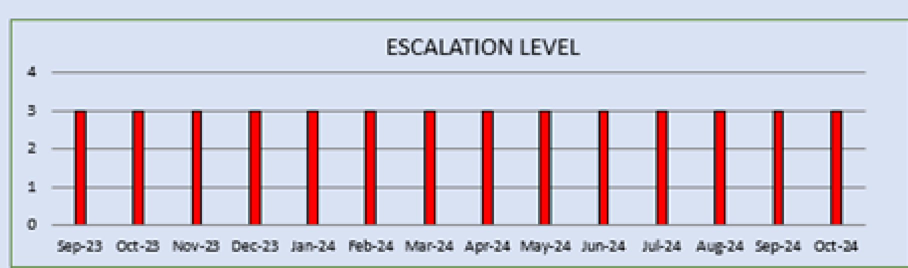
Service in Escalation: Neonatal Intensive Care Unit

Current Escalation Level 3

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↔ OCT 2024
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level
September 2023	3

Ratio Plot Area **Escalation Status :**

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

Background Information:

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

NWJCC assurance and confidence level in developments:

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

The Paediatric and Neonatal Escalation Reset Meeting is to take place on the 18th September where an overview of the service will be discussed to gain an understanding from the health boards perspective of where they feel they are in the process, rather than discussing actions and objectives. The overarching

Actions:

Action	NWJCC Lead	Action Due Date	Completion Date
Working with C&V UHB executive team to develop a plan to implement new baseline as all other HBs are in a position to go live	Director of Planning	16th August 2024	See comment in development section
Re-set meeting to discuss and agree actions/objectives in collaboration with the health board	Senior Planning Manager	18th September 2024	18th September 2024
Escalation meeting to discuss detail and progress against action plan (monthly)	Senior Planning Manager	-	25th November 2024

objectives for the service are in the development phase and when agreed within the commissioning team they will be shared with the health board for comments and then presented at the reset meeting, to ensure they are agreed collaboratively. New executive leads for both organisations will be agreed as part of this process to ensure all are in agreement. Actions/Objectives agreed on the 18th September in collaboration with the health board. Monthly escalation meetings to re-commence on the 25th November to monitor progress. Working with C&V UHB executive team to develop a plan to implement new baseline as all other HBs are in a position to go live – Phase 1 implementation paper to be taken to management group on 28th November to recommend a way forward to progress with the implementation of the new baseline.	

Issues/Risks:

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

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

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

JCC assurance and confidence level in developments:	14th March 2024			

Executive Director Lead: Iolo Doull
Commissioning Lead:

Commissioning Team: Women and Children

Date of Escalation Meetings: 07/08/23, 19/09/23, 10/10/23, 07/12/23, 15/02/24, 14/03/24, 11/04/24, 08/05/24, 13/06/24, 18/07/24, 08/08/24, 12/09/24
Date Last Reviewed by Quality & Patient Safety Committee: 02/09/24

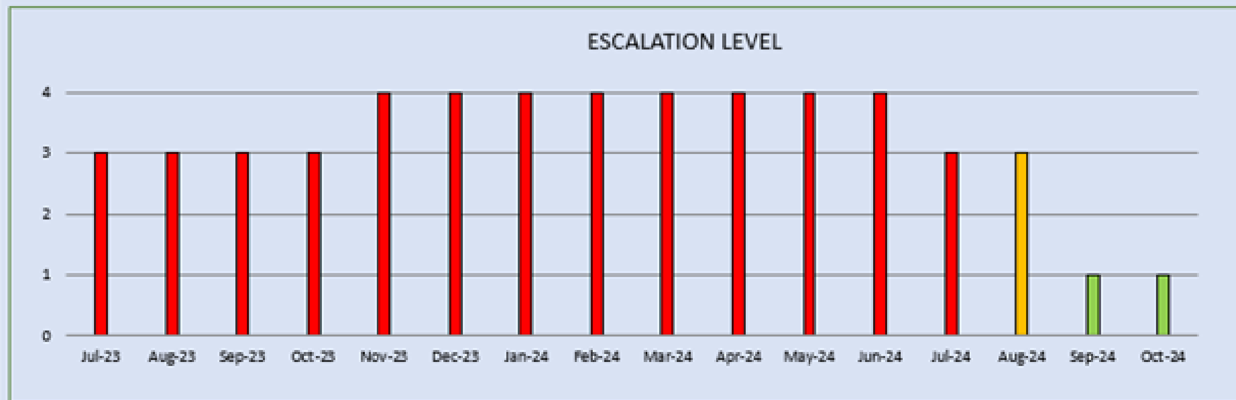
Service in Escalation: Wales Fertility Institute

Current Escalation Level 1

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↓ SEPT 2024
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level
July 2023 – JCC escalation	3
November 2023 – JCC escalation	4
July 2024 – JCC escalation	3
September 2024 - JCC escalation	1

Rationale for Escalation Status :
Concerns from a number of routes with regards to the service including the JCC contract monitoring data submission; adherence to JCC policies and HFEA performance outcomes below National average.

Background Information:
A number of concerns regarding the safety and quality of service had been raised through different routes, including HFEA re-inspection report January 2023, JCC quality and assurance meetings and WFI IPFR requests regarding Wales Fertility Institute leading to the escalation of the service.
There is a risk the Wales Fertility Institute (WFI) in Neath & Port Talbot Hospital is not providing a safe and effective service due to 7 major concerns identified during a relicensing inspection by HFEA in January 2023. There is a consequence that families who have treatment at this centre are not receiving the quality of care expected from the service and in turn impacting outcomes.

Actions:

Action	Lead	Action Due Date	Completion Date
Monthly escalation meeting to review progress against Action Plan Escalation meeting 19th September 2023 10th October 2023 7th December 2023 15th February 2024	Assistant Specialised Planner	Monthly	13 June 2024