Bundle Quality, Safety & Experience Committee 20 February 2024

1 OPENING ADMINISTRATION

1.1 09:30 - QS24/1 Welcome, introductions and apologies for absence VerbalChair

1.2 09:35 - QS24/2 Declarations of interest relating to agendaVerbalChair

1.3 09:37 - QS24/3 Minutes of MeetingAttachedChair
- QS24.3 - Draft QSE Public Minutes 19.12.23 v0.2

1.4 09:42 - QS24/4 Matters Arising & Table of ActionsAttachedChair
- Summary Action Log QSE Public - 13.02.24

1.5 09:52 - QS24/5 Report of the Chair VerbalChair

1.6 10:02 - QS24/6 Notification of Matters referred from other Board Committees on this or future agendasVerbalChair

1.7 10:04 - QS24/7 Development of Patient Stories Verbal Chair

1.8 10:09 - QS24/8 Committee Terms of Reference AttachedActing Board Secretary
- QS24.8 - Committee Terms of Reference
- QS24.8.1 - Appendix 1 - QSE Committee ToR V9.0

1.9 10:11 - QS24/9 Cycles of Business 2024/25 AttachedActing Board Secretary
- QS24.9 - Cycle of Business
- QS24.9.1 - Appendix 1 QSE Committee CoB 2024-25 Live Document

2 QUALITY CONTROL

2.1 10:13 - QS24/10 Patient Safety, Effectiveness and Experience ReportAttachedExecutive Director of Nursing and Midwifery Deputy Director of Nursing
- QS24.10 - Patient Safety Effectiveness and Experience Report

2.2 10:28 - QS24/11 Quality Delivery Group Chair's ReportAttachedExecutive Director of Nursing and Midwifery Deputy Director of Quality Governance
- QS24.11 - QDG Chairs Report

3 QUALITY ASSURANCE

3.1 10:38 - QS24/12 Special Measures ReportAttachedExecutive Director of Strategy and Transformation Director of Transformation and Improvement
- QS24.12 - Special Measures

3.2 10:53 - QS24/13 Regulatory and Legal Report incl HSE update/ Ombudsman AttachedExecutive Director of Nursing and Midwifery Executive Medical Director Deputy Director of Quality Governance
- QS24.13 Regulatory and Legal Report incl HSE update Ombudsman
- QS24.13.1 - Regulatory Assurance Report - Appendix 2 Annual Letter from Ombudsman
- QS24.13.2 - Regulatory Assurance Report - Appendix 3 Response from HB

3.3 11:13 - QS24/14 Deep Dive report – Central IHCAttachedDirector Central IHC
- QS24.14 Central IHC – QSE Deep Dive
- QS24.14.1 Appendix 1 - Central IHC QSE deep dive 20 02 24 final

3.4 11:33 - QS24/15 Healthcare Acquired Pressure Ulcers (HAPU) deep dive report AttachedExecutive Director of Nursing and Midwifery Deputy Director of Quality Governance
- QS24.15 Healthcare Acquired Pressure Ulcers (HAPU) deep dive report

3.5 11:53 - QS24/16 Corporate Risk Register & Board Assurance FrameworkAttachedActing Board Secretary Head of Risk Management
- QS24.16 BAF
- QS24.16.1 QSE Corporate Risk Register Feb 24 draft v5

4 FOR INFORMAITON

4.2 12:03 - QS24/17 Strategic Operational Health and Safety Group Chairs ReportAttachedAssociate Director People Services - West
- QS24.17 - 2024 02 20_QSE_SOHS Chair's Assurance Report_Inc Appendix 1

5 CLOSING ITEMS

5.1 12:08 - QS24/18 Agree Items for referral to Board / Other committeesVerbalChair

5.2 12:10 - QS24/19 Review of Risks highlighted in the meeting for referral to Risk Management GroupVerbalChair

5.3 12:12 - QS24/20 Agree items for Chairs Assurance ReportVerbalChair

5.4 12:14 - QS24/21 Review of Meeting EffectivenessVerbalChair2

5.5 12:16 - QS24/22 Report items discussed in previous meeting private sessionVerbalChair

5.6 12:18 - QS24/23 Date of next meeting VerbalChair

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

Betsi Cadwaladr University Health Board

Minutes of the Quality, Safety & Experience Committee meeting held on 19 December 2023, Boardroom, Carlton Court

Present	
Name	**Title**
Rhian Watcyn Jones	Independent Member, Chair
Urtha Felda	Independent Member
Prof Mike Larvin	Independent Member
In attendance	
Susan Aitkenhead	External Chair for the Vascular Quality Panel, Office of the Medical Director
Nesta Collingridge	Head of Risk Management
Kevin Conwy	Vascular Lead, Vascular Services
Tom Davis	Interim IHC Medical Director
Cathy Dowling	NHS Executive
Gareth Evans	Interim Executive Director of Therapies
Adele Gittoes	Interim Executive Director of Operations
Steve Grayston	Integrated Health Care, Director Of Allied Health Professionals Strategy (Central)
Elin Gwynedd	Chief of Staff, Corporate Office
Dave Harries	Head of Internal Audit, Audit & Assurance Services
Matt Joyes	Deputy Director of Quality
Fiona Lewis	Corporate Business Officer (Minutes)
Dr Nick Lyons	Executive Medical Director
Teresa Owen	Executive Director of Public Health
Philippa Peake-Jones	Head of Corporate Office
Graham Shortland	Independent Advisor
Dr Chris Stockport	Executive Director Transformation & Strategic Planning
Angela Wood	Executive Director of Nursing & Midwifery

Agenda item	**Action**
OPENING ADMINISTRATION	
QS23.122 Welcome, Introductions and Apologies **QS23.122.1** Rhian Watcyn Jones, Independent Member and Chair (Chair) of the Quality, Safety & Experience (QSE) Committee welcomed everyone, in particular the new Independent Member, Urtha Felda, and Dave Harries, Head of Internal Audit. **QS23.122.2** Apologies were received from Dyfed Edwards (Interim BCUHB Chair); Carol Shillabeer (Acting Chief Executive Officer), Jane Wild (Associate Member) and Jason Brannan (Deputy Director of People). **QS23.122.3** Chair wished to note her thanks to Clare Budden.	

(Independent Member) for her past work for the Committee.	
QS23.123 Declarations of Interest on Current Agenda **QS23.123.1** There were no declarations of interest noted.	
QS23.124 Report of the Chair • Chair's Actions. There were no Chair's actions. • Feedback from Board. There was no feedback noted from the Board.	
QS23.125 **Notification of Matters Referred from other Board Committees on this or Future Agendas.** **QS23.125.1** It was noted that the Falls Audit had been through Audit Committee but that there had yet to be a mechanism agreed upon to pass items between Committees. Dyfed Edwards was aware and matters were in hand to rectify the situation.	
QS23.135 Minutes of the last meeting held on 27.10.23. **QS23.135.1** The Chair reminded Members that in future items will only be placed on an agenda when assurance is required and that any items for information will be circulated as and when ready. **QS23.135.2** The Committee received the draft minutes of its meetings held on 27.10.23 and these were approved as an accurate record subject to the following amendments: • It was noted that the minutes did not include an action to follow up the work being undertaken to create a formal structure for Primary Care. The Interim Director of Operations confirmed that discussions are ongoing and will keep Members updated. • Regarding item QS23.108.3, Members asked to note their assurance that the next iteration, when received, will be scrutinised by other Committees, in particular the Performance, Finance and Information Governance Committee.	
QS23.136 Matters Arising and Table of Actions **QS23.136.1** A discussion took place concerning items noting for closure and whether the current system was appropriate. Item 101.5 was noted as 'proposed for closure' when although actions had been taken, it should read 'ongoing' Members were asked to contact the Interim Board Secretary to advise if any other items were incorrectly labelled. • **Item QS23.72**. This item was noted for closure however Members agreed to form a subsequent action as it was noted that discussions	

remained ongoing with Welsh Government regards whether the Quality Strategy will be a stand-alone strategy or each if each strategy will have a link quality. Executive Director of Nursing & Midwifery to keep Committee updated. • **Item QS23.92.2.3.** Meeting still to be arranged**.** • **Item QS23.101.5.** Until the new coversheet is approved and in use, item to remain open. • **Item QS23.102.8.** This item was noted for closure however Members agreed to form a subsequent action. Director of Primary Care to return with update at April's meeting. • **Item QS23.108.2.** Owner of this action to be amended to read Interim Executive Director of Finance**.** • **Item QS23.108.2** Interim Executive Director of Operations to discuss provision of un-validated figures with the Interim Executive Director of Finance and bring update to next meeting.	**AW** **FL** **PM** **KH** **RC** **AG / RC**
QS23.126 Patient Story In response to a request for a Primary Care story, this was from a local Cardiac Care Clinic (CCC). Cheryl Williams, Advanced Nurse Practitioner (ANP) at the clinic, explained how she believed the CCC helped reduce hospital admissions and provide specialist care closer to home, by providing a link between primary and secondary cardiovascular services. **QS23.126.1** A discussion ensued, providing the following queries - • access to the service? This is via the referrals from local GPs. • replication in other surgeries? It was noted that reliance upon one ANP in a surgery could mean that the service would fail if that ANP were not available. Replication could be possible through specific Workforce training but modelling would be required to identify the nurses who could potentially move into those roles and to produce a business plan. The Executive Medical Director and Executive Director of Nursing & Midwifery agreed to look into ways of replicating the service or similar • too much reliance upon one ANP? One method of avoiding this situation would be to potentially work with the Cardiac centres in each of the Integrated Health Communities (IHCs) to identify a rotation opportunity, to cover long-term sickness, annual leave, etc. **QS23.126.2** The Executive Director Transformation & Strategic Planning was pleased to note what he felt was a perfect example of transformation and a shift into the community. He also noted that there were many examples in non-cardiac environments across North Wales and at a time when the Health Board is under considerable financial pressure, it was so important to recognise the opportunity costs needing to be built into the system to ensure that the organisation provides resources for clinicians to train clinicians to enable these examples to replicate across North Wales. **QS23.126.3** It was noted that this service was not only available to patients of that specific surgery, but also to other cluster GPs and that the	**NL / AW** **AW**

recent development of pan-Cluster Planning Groups were felt to be bringing all clusters in an area together, which in turn informed strategic planning. However, it was also noted that hard decisions needed to be made by the Board to determine where its priorities lie in the current financial situation. The Interim Executive Director of Operations, as Executive lead for Primary Care, confirmed that she and the Interim Executive Director of Therapies were in the process of establishing a Primary and Community Care Board for the Health Board, which intends to bring all the cluster work together and will come through one Board in future. **QS23.126.5** Members asked if there had been any evaluations / outcome assessments / patient satisfaction of these initiatives, as evidence to show if this service improved outcomes for patients and also if there were a depository for comparable good practice ideas and if similar good practices could be shared with the public? The Executive Director Transformation & Strategic Planning confirmed that work was being undertaken to improve the sharing of information and that the Primary Care Academy shared its findings with other Health Boards. This and similar initiatives were being evaluated to consider outcomes, making sure to capture the importance of patients' confidence in their care. The Executive Director of Nursing and Midwifery agreed to do a 'deep dive' evaluation as an update on this Patient Story, and report back with its findings. **QS23.126.6** Chair asked for her thanks to be conveyed to the Practice. **QS23126.7** Chair asked for this item to be a stand-alone item on future agendas and not sit within Opening Administration.	**AW** **PP-J**
CONSENT AGENDA	
QS23.139 Committee Terms of Reference (ToR) and Cycle of Business (CoB) **QS23/139.1** The Interim Board Secretary asked Members to be aware that all Board Advisory Groups and Committees' ToRs and CoBs were being revised, to take to the Board for final approval in January 2024 and asked Members to review the latest versions of the QSE ToR and CoB**,** as uploaded on iBabs, and to return any feedback to him by 2.1.24. **QS23.139.2** Chair wished it noted that both were evolving and not to be viewed as 'final' versions and would be available to review, if required. Chair felt that QSE should have the authority to be able to call on the IHC leads as and when required and this was not currently reflected in the ToR.	**ALL** **PM**
QUALITY CONTROL	
QS23.129 Patient Safety, Effectiveness and Experience Report	

QS23.129.1 The Executive Director of Nursing and Midwifery presented her new style integrated report, in which she noted – • falls and healthcare acquired pressure sores remain the most nationally reported incidents and that improvements in both these areas were noted within the report • there had been one Never Event within the reporting period • the Chief Executive Officer had been in dialogue with the Coroner as Coroner issues continue to be high profile for the Health Board • work continued to reduce both the number of patient safety investigations and complaints • there were no outstanding patient alerts • where items remained amber or were red on the dashboard, exception reports would be provided • the Covid 19 project, whilst this had temporarily gone off trajectory, was now back on course to complete by end of March	AW
QS23.129.2 It was noted that since August 2022, the number of cases closed within 30 working days had improved considerably, from 19% to 42%, whilst appreciating that there was still much work to be done.	
QS23.129.3 It was noted that there had been significant improvements in the East with regards to the reduction of the length of time of overdue complaints cases over the past 12 months. This was not the case in the other 2 IHCs and corporate support continued to be offered.	
QS23.129.4 The Executive Director of Nursing and Midwifery believed that the new-style comprehensive report provided a truer understanding of the current situation, but was a work in progress and welcomed any feedback.	
QS23.129.5 The Executive Director of Nursing and Midwifery confirmed that when rolling out the Call 4 Concern initiative to Central and East, the service would be run by existing staff at no extra cost but that there was no timescale for doing this. The Executive Director of Nursing and Midwifery agreed to keep the Committee updated at the next meeting.	**AW**
QS23.129.6 The Executive Medical Director assured Members that the cause of the wrong scar tissue removal Never Event was due to procedures not being followed as opposed to there being a problem with the procedure itself.	
QS23.129.7 The Executive Medical Director welcomed the Clinical Audit and believed that it showed progress, however he felt that it presented two challenges: • the learning coming out of the Audit needed to be demonstrated more meaningfully • the new style live dashboard presentation of data required work on how to present live audit data in a more meaningful way.	
QS23.129.8 Chair asked to be kept updated with regards to -	

• training issues in Complaints • key recommendations from the Older Persons Commissioner review into Care homes across North Wales and the newly developed Quality Assurance Framework (QAF) and how this develops over the next 12 months.	**AW**
QS23.129.9 The Executive Medical Director confirmed that Health Board had committed to reviewing the backlog of 500+ cases awaiting inquests, to understand whether further investigations and learning need to take place in order to drive improvements in the service. He also wished to note that there had yet to be confirmation of how the reporting was to be brought to QSE. Once a sampling exercise had taken place which should uncover approximately how many cases need to be looked at, it was hoped to bring an update to April's meeting.	**NL / AW**
QS23.129.10 Members, looking for opportunities to publicise good news stories, wished it noted that the organisation does very well with its end of life care and that the Board was looking at mechanisms to ensure positive stories are released to the press.	
QS23.129.11 Members were disappointed to note the number of outstanding service assessment responses from IHCs, demonstrating a lack of engagement from them and sought to understand what mechanisms were in place to rectify the situation. The Interim Executive Director of Operations confirmed that she fully recognised the situation was unacceptable, that a lot of the issues were legacy issues and confirmed that a detailed discussion about IHC engagement had taken place at Audit Committee. She confirmed that she was already in communication with the IHCs to arrange a session where the importance of robust, meaningful audit responses would be outlined. The Interim Executive Director of Operations agreed to keep Members updated.	**AG**
QS23.130 Quality Delivery Group (QDG) Chair's Report **QS23.130.1** The Executive Director of Nursing and Midwifery presented her report and noted – • a summary of the QDG business was identified in the report • a number of conversations around ESR processes and delays in agreeing posts led to an escalation to Executive Director of Finance and the Deputy Director of People. Discussions to take place to speed up the process; Members to be kept updated.	**AW**
QUALITY ASSURANCE	
QS23.131 Corporate Risk Register (CRR) & Board Assurance Framework (BAF). **QS23.131.1** A discussion took place as to the merits of the Board	

Assurance Framework (BAF) and the need to ensure that it does not become a 'paper ticking' exercise. **QS23.131.2** Head of Risk Management presented the report which noted the 19 strategic priorities, as set out in the Annual Plan presented to Welsh Government, and all of the deliverables from within those priorities. The Risk team had been in contact with all the priorities' leads, asking if there was a risk of failure to deliver. Four risks were highlighted • SP1 - Population Health & Health Inequalities. • SP5. Cancer • SP9 Women's • SP18 Quality Innovation As Members did not feel in a position to scrutinise and provide assurance for the Board, a discussion ensued regarding the need for QSE/Board Development sessions to provide clarification. In order to progress the strategic priorities against the BAF and to meet the audit criteria against which the organisation is assessed, both The Interim Board Secretary and the Head of Internal Audit felt that QSE assurance could not be left until March/April to proactively manage the BAF risks. In the interim it was agreed that there should be a bespoke Board Development session for Independent Members, aimed to specifically clarify what a BAF is and details of each BAF related to each IM's Committee. It was noted that the BAF next stage should be held in conjunction with the Quality Management approach of the organisation. In the longer term it was agreed that there should be Strategic Risk Management training for the Board. Head of Risk Management and Interim Board Secretary to arrange. *[Cathy Dowling, NHS Executive, left the meeting]* **QS23.131.3** As owners for all four identified risks were present at the meeting, it was agreed that they would talk Members through theirs: **QS23.131.3.1 SP1. Population Health and Health Inequalities**. The Executive Director of Public Health confirmed that this was a long-term risk and that she believed that the Health Board was at risk of not delivering significant improvements or reducing health inequalities. It was noted that ○ there were some good mitigating control systems in place ○ some very good work taking place in partnerships ○ IHCs have moved forward during 2023 and are paying attention to the commissioning requirements for Public Health ○ They are taking a systems approach however there is a great deal of work to be done. ○ The organisation needs to be more courageous and be more proactive about early intervention Chair noted that the need for more prevention and early intervention was on the Committee's radar and had been discussed once more. She asked for this to be included in the Chair's report and identified as critical when	**NC / PM** **RWC/FL**

looking at the organisation's long term/10 years plan. **QS23.131.3.2 SP5. Cancer.** The Interim Executive Director of Operations confirmed that it should read that The Head of Governance as the responsible executive. Despite being one of the best performing health boards in Wales for cancer services, there were specific areas of concern, such as: • **Neurology** - in terms of specialist urology, despite the huge amount of commissioning work carried out by the Executive Medical Director's team over the previous 6 months. • **Colorectal** – there was a mismatch between capacity and demand in Endoscopy, which had a knock-on effect on Colorectal services. Work ongoing with a clinical team to develop a more sustainable service model. • **Dermatology** – in an effort to reduce the backlog of urgent suspected cancer outpatient referrals, an immediate plan was being actioned. This would not eradicate the problem but would significantly reduce it. Work was ongoing with clinicians and the National clinical leads to provide a sustainable model for Dermatology and once these plans are approved and implemented, the risk will reduce. Chair noted the due dates for items 1 & 2 were November 2023, item 3 had yet to be determined and item 4 was January 2024 and asked if these actions' due dates were to be altered. The Interim Executive Director of Operations indicated that the slight delays in the RIGA process had impacted on items 1 & 2 as they partially relied on the £2m transformation funds for Cancer services, yet to be released, which her understanding was imminent. Item 4 was reliant on WLIs, which were due to start within the week. The Interim Executive Director of Therapies felt that this risk should not be classed as a BAF risk, but rather a CRR Tier 1 risk, because this was a strategic objective with regards to Cancer and felt that more work was required regarding the organisation's ambition for the whole of Cancer – such as pre-habilitation, prevention, genomics and precision medicine. The Interim Executive Director of Operations requested a note from the Interim Executive Director of Therapies, listing his comments. **QS23.131.3.3 SP9. Women's.** The Interim Executive Director of Operations noted that this was more strategic risk, which focussed on National guidance, and was therefore dependent on All Wales' influences. She felt the BAF was self-explanatory, showing the gaps in current controls; that this BAF had gone through Womens' Services Programme Board and as such had been through Multi-Disciplinary Team (MDT) meetings, assessed, discussed and scored and that the organisation's ability to mitigate the gaps in control were National and therefore out of the Health Board's control. However, to alleviate the problems with the National progress, the Executive Director of Nursing and Midwifery	**OBS / NC** **GE / AG**

confirmed that there had been local meetings between the Maternity and Neonatal teams to identify actions that could be put in place immediately. She felt that the scope of the project was wider than Welsh Government had expected, which meant that the resources required were more than anticipated but that work had already begun to identify and implement some of the priority actions. **QS23.131.3.4 Failure to Embed Learning.** The Executive Director of Nursing and Midwifery confirmed that all the identified mitigations were in place. The gaps in controls - the Quality Strategy, the Review Structure, the consistent embedding of learning and the full implementation of the Duty of Quality – were all being worked on and the risk was expected to reduce consistently. Chair confirmed that QSE would continue to take a great interest in this and looked forward to March, when the Quality Strategy would lead the work. She asked The Executive Director of Nursing and Midwifery to provide evidence on an ongoing basis when engagement encourages process changes, with positive results.	**AW**
QS23.132 Special Measures Report **QS23.132.1** The Executive Director of Strategy and Transformation presented the report and confirmed that Cycle 2 had now closed and Cycle 3 predictions within the report were those that had been discussed at Board and allocated to QSE. He was pleased to confirm that as the organisation moved through the three cycles, the language changed from being reactive to being more ambitious and pro-active. **QS23.132.2** Chair was pleased to note that work seems to be on track and how improvements worked across all portfolios. When Members asked if the Health Board would be able to take the initiative with the work regarding electronic healthcare records. The Executive Director of Strategy and Transformation confirmed that the Chief Digital And Information Officer would be explaining to Board at its next Development Session how he feels the organisation could do some work in support of the National work.	
QS23.133 Regulatory Report **QS23.133.1** The Deputy Director of Quality presented the report noting that Health Inspectorate Wales (HIW) had inspected all three of the main Emergency departments over the last year and issued reports into all three. Whilst the reports into Ysbyty Gwynedd and Wrexham Maelor were generally quite positive, the Emergency department at Ysbyty Glan Clwyd was noted as being a 'service requiring significant improvement', resulting in a great deal of support, focus and recruitment being put into the service. To provide assurance, the Executive Director for Nursing and Midwifery commissioned a quality check/mock inspection, which helped to provide a baseline position for improvements and identify where the services needs	

to improve. **QS23.133.2** It was noted that HIW published its review into the Health Board's Vascular Services in June 2023, in which it confirmed that the service would be de-escalated as a Service Requiring Significant Improvement. **QS23.133.3** It was noted that an inspection of the Nuclear medicine Department at YGC found there was good compliance overall with the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R. HIW found arrangements were in place to provide patients visiting the department with safe and effective care. **QS23.133.4** HIW undertook inspections into some of the Mental Health services – Ty Llewelyn Unit, Ablett Unit and Hergest Unit – all of which received relatively positive inspections HIW has raised concerns regarding access to the Community Mental Health Team based at Nant y Glynn. A number of written assurances have been provided to HIW however they intend to undertake an announced visit in 2024. **QS23.133.5** At the Court Hearing on 18.12.23, with regards to the Mental Health breaches, BCUHB pleaded guilty and received a fine of £200,000 plus costs. The Deputy Director of Quality noted that he expected HSE to make a decision in the second quarter of 2024, on any further enforcement actions regarding falls. **QS23.133.6** Despite noting that there had been some high profile inquests recently, the Deputy Director of Quality wished to note that these related back to as long ago as 2016, and that the delays in these cases were caused by both the complexity of the cases and in no small part to Covid-related delays for both the Coroners' and Ombudsman's offices. In mitigation, he also pointed out that there had been a number of improvements in the Inquest process over the last year and that despite the challenges, the organisation had good working relationships with both Coroners in the region.	
QS23.134 Primary Care Report **QS23.134.1** A discussion took place regarding expectations of future Primary Care Reports and Members asked for clarity as to the definition of Primary Care – did this cover GPs, dentists, optometrists, community pharmacists etc? The Chair explained that she felt the Committee and the Board were very much concentrating on both Secondary Care and the acute system and there was concern that this was skewing the system, when 85%+ of contact is in Primary Care. QSE would like to redress the balance within its agendas. **QS23.134.2** The Executive Medical Director advised Members that two	

Associate Directors for Primary Care, had been appointed nationally – Anna Kushkova and Stuart Hackwell - who were very interested in working with Health Boards to develop quality dashboards. Although the organisation already owed many metrics regarding various different pathways, it was felt that as the question was arising nationally, contact with the two new Associate Directors might be the way forward, to ensure that the organisation's approach is in line with that of other Health Boards. **QS23.134.3** Members felt that in order to progress the journey towards improving Primary Care and commissioned services, a definition of Primary Care was needed and asked what data the organisation had to give, in order to gain an insight into quality and safety and patient experience in that area. The Head of Internal Audit confirmed that in the new fiscal year, a full Commissioned Services system review was expected to be taken to Audit Committee. **QS23.134.4** The Interim Board Secretary agreed to contact the two new Associate Directors of Primary Care to ask for their definition as to which services were included Primary Care.	**PM**
QS23.143 Agree Items for Chairs Assurance Report **QS23.143.1** It was noted that; • Cathy Dowling, NHS Executive, joined the meeting • Members felt that there was a needed for clarification of the relationship between the CRR and BAF, and the mechanism of how to report BAF issues – possibly a transferrable action for other Committees? • The long term risk around Population Health and Health Inequalities had been identified as critical and it was felt that this must be included in the Organisation's long term/10 year plan. • A discussion was had regarding the ongoing work around QSE's ToR and CoB. • When discussing The Patient Safety, Effectiveness and Experience Report, requests were made to be kept informed of progress with ongoing inquests • Due to patient-identifiable information being discussed the deep dive into falls will take place in private meeting.	
QS.23.144 Review of Meeting's Effectiveness **QS23.144.1** The Head of Internal Audit felt that the piloted new style agenda format was confusing (with regard to minutes being a consent item), but was appreciative of the rest of the meeting, which included good dialogue and discussions including challenges being put to the executives and executives challenging themselves.	

QS23.144.2 Chair wished to thank both Urtha Felda for her contribution to her first QSE meeting and Head of Governance, for her continued work on CRR and BAF.	
QS23.146 Date of Next Meeting **QS23.146.1** The next meeting will be held on the 20 February 2024.	
QS23.147 Resolution to Exclude the Press and Public - "Those representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicly on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960." *[Meeting ended at 12.45 hrs]*	

BCUHB QUALITY, SAFETY& EXPERIENCE COMMITTEE - Summary Action Log Public Version				
Officer/s	**Minute Reference and summary of action agreed**	**Original Timescale**	**Latest Update Position**	**Revised Timescale**
ACTIONS FROM MEETING HELD ON 27.10.23				
OBS	**QS92.2.3** FL to arrange a meeting for Chair to meet with all 3 IHCs, and the Heads of Womens Services and Mental Health.	November	Meeting took place 26/01/2024 Suggest close	
Phil Meakin	**QS23.101.5** A discussion took place about the quality of papers brought to QSE and Board; there did not appear to be consistency, in particular with regards to levels of assurance noted on covers. It was suggested that report writing might be a very useful topic for a Board Workshop. Phil Meakin, Interim Board Secretary, to look into .	December	A new cover paper is being drafted to ensure the Board/Committee Cover Paper is fit for purpose and has all the statutory reporting requirements included. Further work is ongoing with regards to Board Workshops and Report Writing is highlighted in the OBS review and will be included in the Work Plan.	
~~Adele Gittoes /~~ Russell Caldicott	**QS23.108.2** AG agreed to speak to Russell Caldicott outside of meeting, to discuss options regarding provision of un-validated figures.	February	**19.12.23** Ongoing. Interim Executive Director of Operations to discuss provision of un-validated figures with the Interim Executive Director of Finance and bring update to next meeting.	
Adele Gittoes	**QS23.108.2** AG agreed to ensure Chair invited to her meeting with Russell Caldicott and PFIG Chair, once first draft of new IPF becomes available.	November	Meeting has been held with the PFIG Chair who has an open invitation to meet with AG and RC to work through performance Suggest close	
Rhian Watcyn Jones	**QS23.115.1** Internal Audit to be approached to gain assurance regarding Clinical Audit Strategy	December	PPJ will take this action forward on behalf of the Chair	

	and the quality of commissioned services.			
ACTIONS FROM MEETING HELD ON 19.12.23				
Adele Gittoes	**QS23.135.2** AG to keep Members updated as to creation of formal Primary Care structure		Update to be given at the meeting	
Angela Wood	**QS23.136.1 / QS23.72.** AW to keep Members updated as to Welsh Government's decision if Quality Strategy to be a stand-alone strategy or a strategy that has a link to quality throughout.		There will be one strategy for the whole organisation with quality embedded throughout Suggest close	
Karen Higgins	**QS23.102.8** To update Members as to Diabetic Programme Board which has recently had its inaugural meeting.	April	Update requested	
Angela Wood	**QS23.126.1** With regards to too much reliance on one ANP in a surgery, rotation opportunities to be identified with IHCs to cover long-terms sickness, annual leave, etc.	February	Ongoing discussion Suggest close	
Angela Wood	**QS23.126.5** AW agreed to do a deep dive evaluation of the Patient's Story and report back.	April	Evaluation not complete, once this has been received a deep dive will be scheduled	
Philippa Peake-Jones	**QS23126.7** Patient's Story to be a stand-alone item on future agendas not within Opening Administration.	February	Patient Story discussion on the agenda for 20/2/24	

ALL	**QS23.139.1** Members to review the latest versions of the QSE ToR and CoB**,** as uploaded on iBabs, and to return any feedback to PM by 2.1.24.	2.1.24	Approved at the Board Meeting in January and will be on all agenda's going forward Suggest close	
Phil Meakin	**QS23.139.2** PM to ensure that QSE should have the authority to be able to call on the IHC leads as and when required and reflect this in the ToR.	February	Approved at the Board Meeting in January. Suggest close	
Angela Wood	**QS23.129.1** Where items remained amber or were red on the Patient Safety, Effectiveness & Experience Report dashboard, exception reports would be provided.	February	Now part of normal reporting Suggest close	
Angela Wood	**QS23.129.5.** AW agreed to update the committee as to the date for rolling out the Call 4 Concern initiative to Central and East.	February	It has yet to be identified when the roll out will take place, most likely after the organisational pressures have reduced	
Angela Wood	**QS23.129.8.** AW to provide update to the Committee regarding training issues in Complaints.	February	This now takes place as business as usual Suggest close	
Angela Wood	**QS23.129.8.** AW to provide update to the Committee regarding key recommendations from the Older Persons Commissioner review into Care homes across North Wales and the newly developed Quality Assurance Framework (QAF) and how this develops over the next 12 months.	June	Will be presented at the April meeting	

Nick Lyons	**QS23.129.9** Following on from the sampling exercise of the 500+ cases awaiting inquests, to bring an update of approximately how many need to be fully reviewed.	February	To be updated in the private session Suggest close	
Adele Gittoes	**QS23.129.11** Following meeting with IHCs where the importance of robust, meaningful audit responses would be outlined, AG agreed to keep Members updated.	February	Update to be given at the Committee Meeting Suggest close	
Angela Wood	**QS23.130.1** Regarding QDG and problems regarding ESR processes causing delays in agreeing posts, AW agreed to keep Members updated as to her discussions with Executive Director of Finance and the Deputy Director of People.	February	The process is being streamlined and a review on the impact will now to be taken through Executive Team Meeting – any safety critical posts are being escalated to Angela directly for action Suggest close	
Phil Meakin / Nesta Collingridge	**QS23.131.2** PM & NC to organise a bespoke Board Development session aimed to specifically clarify what a BAF is and details of each BAF related to each IM's Committee.	February	Draft Strategic risk management training with CEO for comment and for discussion on arranging a date.	
Phil Meakin / Nesta Collingridge	**QS23.131.2** To arrange Strategic Risk Management training for the Board.	February	Draft Strategic risk management training with CEO for comment and for discussion on arranging a date.	
Rhian Watcyn Jones	**QS23.131.3.1** RWJ to ensure Board advised that there needed to be more early intervention to avoid health inequalities.	February		

Gareth Evans / Adele Gittoes	**QS23.131.3.2** GE to provide AG with details of the SP5 Cancer risk and why he believed it should be classed as a CRR Tier 1 risk as opposed to a BAF risk.	February	07.02.2024 Acting EDOTHS provided the interim EDOO with comments on the risk descriptor for the BAF risk for Cancer for consideration when it is next reviewed	
Phil Meakin	**QS23.134.4** PM to contact the two new Associate Directors of Primary Care to define which services are included in Primary Care.	February	Update requested	

RAG Status	
	Completed/for closure
	Ongoing
	Outstanding

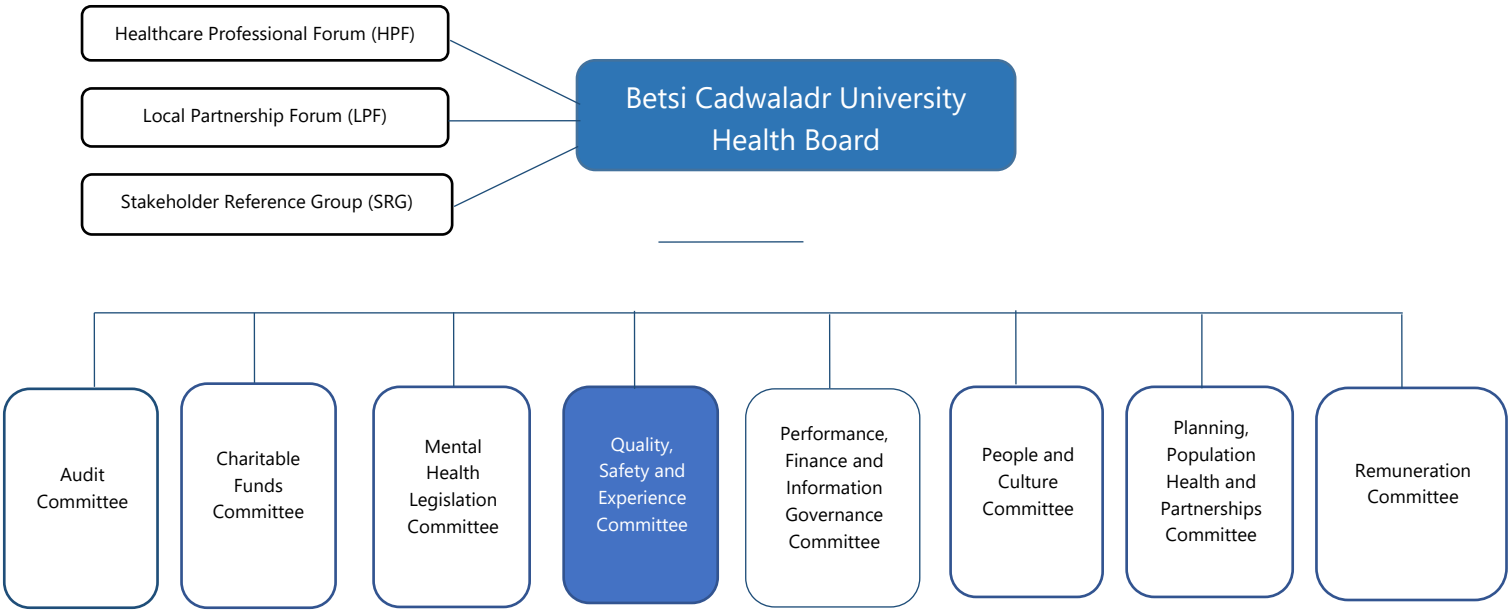
Teitl adroddiad: ***Report title:***	Terms of Reference			
Adrodd i: ***Report to:***	Quality Safety and Experience (QSE) Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Tuesday, 20 February 2024			
Crynodeb Gweithredol: ***Executive Summary:***	The Office of the Board Secretary has worked with Chairs and Committee Executive Leads through December 2023 and January 2024 to ensure that the Health Board has appropriate Terms of Reference and a cycle of business for all of the Committees and Advisory Groups of the Health Board. The Health Board approved the Terms of Reference for all Committees at its meeting on 25 January 2024. The QSE Terms of Reference are attached as Appendix 1. It is proposed that the Terms of Reference will be reviewed on an annual basis and this is included in the Cycle of Business.			
Argymhellion: ***Recommendations:***	The Committee is asked to **note** the Terms of Reference.			
Arweinydd Gweithredol: ***Executive Lead:***	Phil Meakin, Acting Board Secretary			
Awdur yr Adroddiad: ***Report Author:***	Philippa Peake-Jones, Head of Corporate Affairs			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☒	I Benderfynu arno *For Decison* ☐	Am sicrwydd *For Assurance* ☐	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:N/A ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this: N/A***				

Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Strategic Priority P16 Board leadership and governance
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	It is essential that the Health Board has robust arrangements in place to meet the requirements of the Standing Orders
Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqlA been identified as necessary and undertaken?***	N/A
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary ben undertaken?***	N/A
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	Links to the BAF detailed above
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	The effective and efficient governance of an organisation has the potential to leverage a positive financial dividend for the Health Board through better integration of governance process and risk management into business planning, decision-making and in shaping how care is delivered to our patients thus leading to enhanced quality, less waste and no claims.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	Failure to have clear decision making can impact adversely on the workforce.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	Terms of Reference attach reflect updates from Audit Committee and Board Meetings
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	Strategic Priority P16 Board leadership and governance
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	N/A

Camau Nesaf: ***Next Steps:*** The Terms of Reference should now fall into the normal cycle of business with regards to their review.	

QUALITY, SAFETY AND EXPERIENCE COMMITTEE

TERMS OF REFERENCE



Version	Issued to	Date	Comments
V0.01 Draft	Audit Committee	16/11/23	Developed as a first draft for review by Audit Committee on 16/11/23
V0.02 Draft	ToR Meeting with Committee Chair and Executive Lead	15/12/23	Developed as a draft for review with Committee Chair and Executive Lead. The ToR were also reviewed at QSE Committee held on 19/12/23
V0.03 Draft	Health Board	18/01/24	Final Draft for consideration by the Health Board to be held on 25/01/24

1) Introduction

1.1 The Betsi Cadwaladr University Health Board (BCUHB) shall establish a Committee to be known as the Quality, Safety and Experience Committee. The Committee is an independent Committee of the Board and has no executive powers, other than those specifically delegated in these terms of reference. The detailed operating arrangements in respect of this Committee are set out below.

2) Purpose

The purpose of the Quality, Safety and Experience Committee is to provide assurance to the Board on the Quality and Safety of services that are commissioned and provided for the population of North Wales, more specifically to:

2.1 scrutinise, assess and seek assurance in relation to the patient experience, safety, impact, quality and health outcomes of the services provided by the Health Board;

2.2 provide evidence-based and timely advice to the Board to assist it in discharging its functions and meeting its responsibilities with regard to the quality and safety of health care provided and secured by the Health Board;

2.3 provide assurance that the Health Board has an effective strategy and delivery plan(s) for improving the quality and safety of care patients receive, commissioning quality and safety impact assessments where considered appropriate. This includes consideration of the Annual Plan/Integrated Medium Term Plan (IMTP); and

2.4 provide assurance that the organisation, at all levels, has the right governance arrangements and strategy in place to ensure that the care planned or provided is as good as it can be.

3) Responsibilities of the Quality, Safety & Experience Committee and Delegated Powers

The Quality, Safety & Experience Committee is required by the Board to:

3.1 provide advice to the Board on the adoption of a set of key indicators of quality of care against which the Health Board's performance will be regularly assessed and reported on;

3.2 seek assurance on the management of principal risks within the Board Assurance Framework (BAF) and Corporate Risk Register (CRR) allocated to the Committee and provide assurance to the Board that risks are being managed effectively and report any areas of significant concern;

3.3 ensure the right enablers are in place to promote a positive culture of quality improvement based on best evidence;

3.4 seek assurance on delivery against planning objectives aligned to the Committee, considering and scrutinising the processes that are developed and implemented, supporting and endorsing these as appropriate;

3.5 provide assurance that all reasonable steps are taken to prevent, detect and rectify irregularities or deficiencies in the quality and safety of care provided and, in particular, that sources of internal assurance are reliable, there is capacity and capability to deliver and lessons are learned from patient safety incidents, complaints and claims;

3.6 provide assurance to the Board in relation to improving the experience of patients, including those services provided by other organisations or in a partnership arrangement. Patient stories will feature as a key area for patient experience and lessons learnt;

3.7 provide assurance to the Board in relation to its responsibilities for the quality and safety of mental health, primary and community care, public health, health promotion, prevention and health protection activities and interventions in line with the Health Board's strategies. This includes consideration of those health and safety matters which fall under the responsibilities of this Committee;

3.8 ensure that the organisation is meeting the requirements of the NHS Concerns, Complaints and Redress Arrangements (Wales) Regulations;

3.9 approve the required action plans in respect of any concerns investigated by the Ombudsman;.

3.10 agree actions, as required, to improve performance against compliance with incident reporting;

3.11 provide assurance that the Central Alert Systems process is being effectively managed with timely action where necessary;

3.12 provide assurance on the delivery of action plans arising from investigation reports and the work of external regulators;

3.13 approve the annual clinical audit plan, ensuring that internally commissioned audits are aligned with strategic priorities;

3.14 provide assurance that a review process to receive and act upon clinical outcome indicators suggesting harm or unwarranted variation is in place and is operating effectively with concerns escalated to the Board;

3.15 consider advice on clinical effectiveness and, where decisions about implementation have wider implications with regard to prioritisation and finances, prepare reports for consideration by the Executive Team which will collectively agree recommendations for consideration through relevant Committee structures;

3.16 provide assurance in relation to the organisation's arrangements for safeguarding vulnerable people, children and young people;

3.17 approve policies and plans within the scope of the Committee, having taken assurance that the quality and safety of patient care has been considered within these policies and plans;

3.18 assure the Board in relation to its compliance with relevant national practice, mandatory guidance, healthcare standards and duties, including Duty of Quality, Duty of Candour, Quality Standards and Quality Management ensuring the Board is supported to make strategic decisions from a quality perspective;

3.19 develop a work plan which sets clear priorities for improving quality, safety and experience each year, together with intended outcomes, and monitor delivery throughout the year;

3.20 refer quality and safety matters which impact on other Board Committees and receive referrals from other Committees; and

3.21 agree issues to be escalated to the Board with recommendations for action.

4) Membership

4.1 Formal membership of the Committee shall comprise of the following:

MEMBERS
Independent Member (Chair)
2 x Independent Members (one of whom will be designated as Vice Chair)

4.2 The following should attend Committee meetings:

IN ATTENDANCE
Executive Director of Nursing and Midwifery (Executive Lead)
Executive Medical Director
Executive Director of Therapies and Health Sciences
Other Executive Directors as required by the Chair including:
Executive Director of Operations
Executive Director of Workforce and Organisational Development
Executive Director of Public Health
Other BCUHB Senior Managers as required by the Chair and
Chair of Healthcare Professionals Forum (Associate Board Member)
Representative of Llais

4.3 The membership or attendee of the Committee shall be determined by the Board, based on the recommendation of the Health Board Chair, taking into account the balance of skills and expertise necessary to deliver the Committee's remit, and subject to any specific requirements or directions made by the Welsh Government.

4.5 Membership of the Committee will be reviewed on an annual basis.

5) Quorum and Attendance

5.1 A quorum shall consist of no fewer than two of the membership and must include as a minimum the Chair or Vice Chair of the Committee, together with a third of the In-attendance members and a minimum of two Executive Directors one of whom must be a Clinical Executive Director.

5.2 Any senior officer of the Health Board or partner organisation may, where appropriate, be invited to attend, for all or part of a meeting, to assist with discussions on a particular matter.

5.3 The Committee may also co-opt additional independent external 'experts' from outside the organisation to provide specialist skills.

5.4 Should any 'in-attendance' officer member be unavailable to attend, he or she may nominate a deputy to attend in his or her place, subject to the agreement of the Chair.

5.5 The Committee may ask any or all of those who normally attend but who are not members to withdraw in order to facilitate open and frank discussion of particular matters.

6) Agenda and Papers

6.1 The Committee Secretary is to hold an agenda setting meeting with the Chair and/or Vice Chair and the Executive Lead (Executive Director of Nursing and Midwifery) at least six weeks before the meeting date.

6.2 The agenda will be based on the Committee work plan, identified risks, matters arising from previous meetings, issues emerging throughout the year, and requests from Committee members. Following approval, the agenda and timetable for request of papers will be circulated to all Committee members.

6.3 All papers must be approved by the Executive Lead.

6.4 The agenda and papers will be distributed/published seven days in advance of the meeting.

6.5 A draft table of actions will be issued within two working days of the meeting. The minutes and table of actions will be circulated to the Committee Chair and Executive Lead within seven days to check the accuracy, prior to sending to Members to review within the next seven days.

6.6 Members must forward amendments to the Committee Secretary within the next seven days. The Committee Secretary will then forward the final version to the Committee Chair for final review. The process will take no longer than three weeks.

7) In Committee

7.1 The Committee can operate with an In-Committee function to receive updates on the management of sensitive and/or confidential information.

8) Meetings

8.1 The Committee will meet bi-monthly and an annual schedule of meetings will be determined by the corporate calendar.

8.2 The Committee may be convened at short notice if requested by the Chair.

8.3 Any additional meetings will be arranged under exceptional circumstance and shall be determined by the Chair of the Committee in discussion with the Executive Lead.

8.4 The Committee may, subject to the approval of the Health Board, establish groups to carry out on its behalf specific aspects of Committee business.

8.5 Meetings may be held in person where it is safe to do so or by video-conferencing and similar technology.

8.6 The Committee Secretary shall be determined by the Director of Corporate Governance.

9) Reporting

9.1 The Committee, through its Chair and members, shall work closely with the other Committees to provide advice and assurance to the Board through joint planning and co-ordination of Board and Committee business including the sharing of information.

9.2 The Committee Chair, supported by the Committee Secretary, shall:

- report formally, regularly and on a timely basis to the Board on the Committee's activities;
- bring to the Board's specific attention any significant matter under consideration by the Committee; and
- ensure appropriate escalation arrangements are in place to alert the Health Board's Chair, Chief Executive and/or Chairs of other relevant Committee, of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.

9.3 The Committee will undertake an annual review on the effectiveness of its arrangements and responsibilities. The Director of Corporate Governance will oversee this review.

10) Accountability, Responsibility and Authority

10.1 Although the Board has delegated authority to the Committee for the exercise of certain functions, as set out in these Terms of Reference, it retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens through the effective governance of the organisation.

10.2 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

10.3 The requirements for the conduct of business as set out in the Health Board's Standing Orders are equally applicable to the operation of the Committee.

10.4 The Committee shall embed the corporate goals and priorities, e.g. equality and human rights through the conduct of its business, and in doing and transacting its business shall seek assurance that adequate consideration has been given to the sustainable development principle and in meeting the requirements of the well-being of Future Generations (Wales) Act.

11) Review Date

11.1 These Terms of Reference and operating arrangements shall be reviewed on at least an annual basis by the Committee for approval by the Board.

Teitl adroddiad: ***Report title:***	Cycle of Business			
Adrodd i: ***Report to:***	Quality Safety and Experience (QSE) Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Tuesday, 20 February 2024			
Crynodeb Gweithredol: ***Executive Summary:***	The Office of the Board Secretary has worked with Chairs and Committee Executive Leads through December 2023 and January 2024 to ensure that the Health Board has appropriate Terms of Reference and a cycle of business for all of the Committees and Advisory Groups of the Health Board. The Health Board approved the Cycles of Business for all Committees at its meeting on 25 January 2024. The QSE Cycle of Business is attached as Appendix 1. These are being mapped to ensure that governance flows through from the Executive Team Meetings, through the Committees to Board. It is proposed that the Cycle of Business is included on each agenda and kept as a live document. During Committee Meetings agenda items may be requested as one-off items at a future meeting. A record of these will be kept by the Committee Support.			
Argymhellion: ***Recommendations:***	The Committee is asked to **note** the Cycles of Business.			
Arweinydd Gweithredol: ***Executive Lead:***	Phil Meakin, Acting Board Secretary			
Awdur yr Adroddiad: ***Report Author:***	Philippa Peake-Jones, Head of Corporate Affairs			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☒	I Benderfynu arno *For Decison* ☐	Am sicrwydd *For Assurance* ☐	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:N/A				

Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this: N/A	
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Strategic Priority P16 Board leadership and governance
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	It is essential that the Health Board has robust arrangements in place to meet the requirements of the Standing Orders
Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqlA been identified as necessary and undertaken?***	N/A
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary ben undertaken?***	N/A
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	Links to the BAF detailed above
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	The effective and efficient governance of an organisation has the potential to leverage a positive financial dividend for the Health Board through better integration of governance process and risk management into business planning, decision-making and in shaping how care is delivered to our patients thus leading to enhanced quality, less waste and no claims.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	Failure to have clear decision making can impact adversely on the workforce.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	Terms of Reference attach reflect updates from Audit Committee and Board Meetings
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	Strategic Priority P16 Board leadership and governance
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)	N/A

Reason for submission of report to confidential board (where relevant)	
Camau Nesaf: ***Next Steps:*** Cycles of business will be included on each agenda and will be a live document.	

Quality, Safety & Experience Committee Cycle of Business
(April 2024 – March 2025)

Item of Business	Purpose	Lead	April 2024	June 2024	August 2024	Oct 2024	Dec 2024	Feb 2025	Notes
Opening Business									
Apologies			✓	✓	✓	✓	✓	✓	
Declarations of Interest			✓	✓	✓	✓	✓	✓	
Minutes from the Previous Meeting			✓	✓	✓	✓	✓	✓	
Matters Arising & Table of Actions			✓	✓	✓	✓	✓	✓	
Report of the Chair: • Chair's action • Feedback from Board	This can be used as a placeholder if required (by exception)		✓	✓	✓	✓	✓	✓	
Notification of matters referred from other Committees			#	#	#	#	#	#	
Strategic Priorities									
Patient Story		Executive Director of Nursing & Midwifery	✓	✓	✓	✓	✓	✓	
Advanced Practitioner Utilisation in the Health Board		Executive Medical Director	#	#	#	#	#	#	Transferred from Board HB23/251
Quality Planning									
Quality Strategy Annual Priorities	Agree annual priorities for quality, underpinning delivery of the overall Quality Strategy or provide update	Executive Director of Nursing & Midwifery *Deputy Director of Quality Governance*	✓						

Quality, Safety & Experience Committee Cycle of Business (April 2024 – March 2025)									
Item of Business	**Purpose**	**Lead**	**April 2024**	**June 2024**	**August 2024**	**Oct 2024**	**Dec 2024**	**Feb 2025**	**Notes**
Quality Control									
Integrated Quality Report Providing information on key patient safety issues and mitigations in nationally reportable incidents, safety alerts, maternity and neonatal safety and mortality, safeguarding & infection prevention & control		Executive Director of Nursing & Midwifery *Deputy Director of Nursing*	✓	✓	✓	✓	✓	✓	
Integrated Quality Report Providing information on key patient and carer experience issues and mitigations including complaints, accessible healthcare and patient feedback		Executive Director of Nursing & Midwifery *Deputy Director of Nursing*	✓	✓	✓	✓	✓	✓	
Integrated Quality Report Providing information on key clinical effectiveness issues and mitigations including clinical audit, NICE guidelines and external peer reviews. The April report will include the proposal annual clinical audit plan		Executive Medical Director *Deputy Medical Director*	✓	✓	✓	✓	✓	✓	
Clinical Service of Concern Report Providing information on issues, risks, mitigations & improvements for clinical services of concern (to be decided by the Committee)		Executive Medical Director *Deputy Medical Director*	✓	✓	✓	✓	✓	✓	

Quality, Safety & Experience Committee Cycle of Business (April 2024 – March 2025)									
Item of Business	**Purpose**	**Lead**	**April 2024**	**June 2024**	**August 2024**	**Oct 2024**	**Dec 2024**	**Feb 2025**	**Notes**
Quality Delivery Group Chair's Report		Executive Director of Nursing & Midwifery *Deputy Director of Quality Governance*	✓	✓	✓	✓	✓	✓	
National Commissioning Committees Quality Committee Chair's Report		Executive Director of Nursing & Midwifery *Deputy Director of Quality Governance*	✓		✓		✓		
Commissioned Services Quality Report		Executive Director of Nursing and Midwifery *Deputy Director of Quality Governance*	✓					✓	
IHC/Regional Service Quality Deep Dive		Executive Director of Operations *IHC Directors*	✓ East IHC	✓ Cancer Diagnostics Womens	✓ West IHC	✓ Primary Care Dental	✓ MHLD	✓ Central IHC	
Issues Related to Key Risks									
Board Assurance Framework related to Committee		Director of Corporate Governance	✓	✓	✓	✓	✓	✓	
Corporate Risk Register related to Committee		Director of Corporate Governance	✓	✓	✓	✓	✓	✓	
Placeholder for any agenda items deriving from the BAF & CRR		Director of Corporate Governance	#	#	#	#	#	#	

Quality, Safety & Experience Committee Cycle of Business (April 2024 – March 2025)									
Item of Business	**Purpose**	**Lead**	**April 2024**	**June 2024**	**August 2024**	**Oct 2024**	**Dec 2024**	**Feb 2025**	**Notes**
For Assurance									
Special Measures Report		Executive Director of Strategy & Transformation *Director of Transformation and Improvement*	✓	✓	✓	✓	✓	✓	
Regulatory Report (including Human Tissue Authority – October)	Providing information on regulatory compliance including new HIW, CIW and PSOW reports (including Public Interest Reports) and action plan progress	Executive Director of Nursing & Midwifery *Deputy Director of Quality Governance*	✓	✓	✓	✓	✓	✓	
Healthcare Law Report	Providing information on healthcare legal compliance including inquest activity, new Regulation 28 Notices and action progress and WRP compliance	Executive Medical Director *Deputy Director of Quality Governance*	✓		✓		✓		
Clinical Policy Report		Executive Director of Nursing & Midwifery *Deputy Director of Quality Governance*	✓			✓			
Nurse Staffing Act Report	Statutory bi-annual report	Executive Director of Nursing & Midwifery	✓			✓			

Quality, Safety & Experience Committee Cycle of Business (April 2024 – March 2025)									
Item of Business	**Purpose**	**Lead**	**April 2024**	**June 2024**	**August 2024**	**Oct 2024**	**Dec 2024**	**Feb 2025**	**Notes**
		Deputy Director of Nursing							
Annual Quality Report	Statutory annual report	Executive Director of Nursing & Midwifery *Deputy Director of Quality Governance*		✓					
Annual Putting Things Right Annual Report (including Duty of Candour Annual Report)	Statutory annual report	Executive Director of Nursing & Midwifery *Deputy Director of Quality Governance*		✓					
Safeguarding Annual Report	Statutory annual report	Executive Director of Nursing & Midwifery *Director of Nursing (Safeguarding)*		✓					
IPC Annual Report	Statutory annual report	Executive Director of Nursing & Midwifery *Director of Nursing (IPC)*		✓					
Research Annual Report		Executive Medical Director *Associate Medical Director (Research)*		✓					
Organ Donation Annual Report	Statutory annual report	Executive Director of Therapies & Health Sciences		✓					

Quality, Safety & Experience Committee Cycle of Business (April 2024 – March 2025)									
Item of Business	**Purpose**	**Lead**	**April 2024**	**June 2024**	**August 2024**	**Oct 2024**	**Dec 2024**	**Feb 2025**	**Notes**
Cancer Annual Report (to align with Service Update)				✓					
Quality Strategy Monitoring Report		Executive Director of Nursing & Midwifery *Deputy Director of Quality Governance*	✓			✓			
Committee Annual Report to Board		Secretariat						✓	
Review Committee Terms of Reference & Cycle of Business		Secretariat	✓					✓	
Closing Business									
Agree Items for referral to Board / other Committees			✓	✓	✓	✓	✓	✓	
Review of Risks highlighted in the meeting for referral to Risk Management Group			✓	✓	✓	✓	✓	✓	
Agree items for Chairs Assurance Report			✓	✓	✓	✓	✓	✓	
Summary of Private Business to be reported in Public			#	#	#	#	#	#	
Review of Meeting Effectiveness			✓	✓	✓	✓	✓	✓	

Quality, Safety & Experience Committee Cycle of Business (April 2024 – March 2025)									
Item of Business	**Purpose**	**Lead**	**April 2024**	**June 2024**	**August 2024**	**Oct 2024**	**Dec 2024**	**Feb 2025**	**Notes**
Date of Next Meeting			✓	✓	✓	✓	✓	✓	
Private Business									
Confidential Quality Report	Providing information on significant quality issues which may be patient identifiable including Nationally Reportable Incidents and significant emerging quality issues	Executive Director of Nursing & Midwifery *Deputy Director of Quality Governance*	✓	✓	✓	✓	✓	✓	
Immunisation, Public Health and Safety Report (Consent Item)		TBC				✓			
Controlled Drugs Local Intelligence Network Annual Report		TBC		✓					
Strategic Operational Health & Safety Group Chair's Assurance Report (in relation to the remit of the QSE Committee – ie. Where there is relevance to quality & safety of services provided to the Health Board)		Executive Director of Workforce & OD / Deputy Director of Quality		✓			✓		
Update on Progress Monitoring of Case Notes Review	Action plans & progress reported to Board via Chair Assurance Report	Executive Medical Director	✓	✓	✓	✓	✓	✓	

Quality, Safety & Experience Committee Cycle of Business (April 2024 – March 2025)									
Item of Business	**Purpose**	**Lead**	**April 2024**	**June 2024**	**August 2024**	**Oct 2024**	**Dec 2024**	**Feb 2025**	**Notes**
Part B Rolling Programme of Ad-hoc Items (Timing of agenda items to be agreed by the Chair & Executive Lead)									
Radiation Safety									
Covid 19 Inquiry Preparedness									
Ombudsman's Annual Letter and Annual Report									
Primary Care Report (to include a cycle of areas to report on as per themes identified)									
Clinical Audit Plan									
Monitoring compliance - Professional registration and revalidation updates NMC/GMC/HPC/GPhC (Pharmacy)									
Historical Inquest Review	To receive assurance on the Review	Executive Medical Director							
IHC Community Pilots relating to MFD		Executive Director of Nursing and Midwifery							
# = As Required									

Teitl adroddiad: ***Report title:***	QSE Committee – Patient Safety, Effectiveness and Experience Report			
Adrodd i: ***Report to:***	QSE Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	February 2024			
Crynodeb Gweithredol: ***Executive Summary:***	This report provides the Committee with assurance, underpinned by analysis, on significant quality issues alongside longer-term data and information on the improvements underway			
Argymhellion: ***Recommendations:***	The Committee is asked to **note** this report			
Arweinydd Gweithredol: ***Executive Lead:***	• Angela Wood, Executive Director of Nursing and Midwifery • Dr Nick Lyons, Executive Medical Director • Gareth Evans, Executive Director of Therapies and Health Sciences			
Awdur yr Adroddiad: ***Report Author:***	• **Patient and Carer Experience, Safeguarding and IPC Sections:** Mandy Jones, Deputy Director of Nursing (Patient Experience) and Leon Marsh, Head of Patient Experience • **Patient Safety Sections:** Chris Lynes, Deputy Director of Nursing (Patient Safety) and Tracey Radcliffe, Head of Patient Safety • **Clinical Effectiveness Sections:** Dr James Risley, Deputy Medical Director (Clinical Effectiveness), and Joanne Shillingford, Head of Clinical Effectiveness			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☐ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☒ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				
There is confidence in the data provided in the report however, the pace 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 Special Measures and the Board Assurance Framework.				

Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Quality
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	The Duty of Quality is a statutory requirement under the Health and Social Care (Quality and Engagement) (Wales) Act 2020. 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)***	BAF1.2
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	N/A
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	N/A
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	N/A
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	BAF1.2
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	N/A
Camau Nesaf: Gweithredu argymhellion ***Next Steps: Implementation of recommendations*** N/A	
Rhestr o Atodiadau: ***List of Appendices:*** 1. QSE Committee Patient Safety, Effectiveness and Experience Report	

QSE Committee – Patient Safety, Effectiveness and Experience Report – February 2023

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, Patient and Carer Experience and Clinical Effectiveness. This reflects the organisational management arrangements for quality leadership in the Health Board.

An Integrated Quality Dashboard is in development as outlined in the last report. Technical development, testing and data validation is underway. A copy of the “front page” of the dashboard is included at the end of the report, with the caveat the data presented is still being validated.

A separate Regulatory Assurance Report provides the Committee with assurances and analysis on regulatory and healthcare law compliance matters (and any themes across the two reports will be triangulated and captured here in the conclusion).

PATIENT SAFETY

The Patient Safety Group was stood down as it occurred in the period between Christmas and New Year. Issues for escalation and any documents for approval due to the cancellation of the December meeting were reviewed as part of the chair's actions.

PATIENT SAFETY INCIDENTS

Key issues relating to patient safety incidents:

Oxygen Administration

Further patient safety incidents have occurred in the Health Board related to the preparation and administration of oxygen using the portable CD oxygen cylinders. On review, the CD cylinder had not been prepared correctly resulting in 'NO FLOW' of oxygen to the patient.

One incident had a catastrophic outcome and is under investigation. A new alert has been disseminated with a key message to ensure that both controls on the CD cylinder are opened and to feel for the flow of oxygen before administering to the patient.

Actions requested for assurance:

- Communicate to all staff in handover/safety briefs that;
- *Oxygen is a drug and must be administered by a Registered Healthcare Professional who has completed their medicines management and oxygen competencies.*
- *Health Care Support Workers (HCSW) must not attach oxygen to patients or set flow rates.*
- *HCSWs who escort patients on oxygen on transfer or within a ward/dept e.g. to the bathroom, must complete the HCSW oxygen competencies.*
- *Prior to connecting oxygen to a patient, the Registered Staff must 'Feel for the Flow'*
- Gaps in oxygen competency compliance of Registered Staff and HCSWs must be identified and completed as a matter of urgency.
- Direct staff to MM15 Policy for Administration and use of Emergency and Non-Emergency Oxygen in Adults in Managed Services.

Work continues on having a standardised mandatory e-learning package on the Electronic Staff Record (ESR) and the consideration of changing to digital CD oxygen cylinders which was reported to Patient Safety Group in November 2023. This has been updated with high level trend analysis and a further deep dive into the themes is being undertaken.

Urology Administrative backlog

There have been several incidents reported relating to aspects of the Urology patient pathway not being actioned due to backlogs and staff capacity.

An action was set following a Rapid Learning Panel (RLP) to undertake an audit of the urology administration office to provide assurance that no further radiology reports or other referrals were outstanding review.

Following a search of the office, 100+ radiology reports, internal referrals, histology reports and tertiary centre letters have been identified that have not been reviewed or actioned (subsequently identified circa 300) including:

- 62 radiology reports have been identified with abnormal findings.
- Referrals have been identified dating back to March 2023 that appear not to have been triaged.
- Two further patients with potential harm were identified.

Most recently, it has been identified that there is a backlog of 1,133 letters that have been dictated by clinicians that have not yet been issued, the oldest of which is dated 13th June 2023. Some are awaiting transcription whilst others are awaiting approval. These letters have the potential to include instructions or information regarding ongoing care, medication etc and are currently sitting on electronic patient reported outcome (ePRO).

The overarching issues identified for these incidents is resource and capacity in the Urology administration team.

The actions identified are as follows:

- The administration team are concentrating their efforts on clearing any flagged letters in the first instance.
- Review of the administrative process within Urology to develop, document and implement a robust process for the prioritisation of typing and associated admin tasks.
- Risk around the absence of an auditable process for non-electronic Consultant to Consultant referrals to be raised on the risk register
- Carry out a review of all results that are waiting for filing to ensure that all actions identified have been carried out and escalate any resulting adverse findings
- Discuss the process for the communication of adverse or urgent clinical findings with the Radiology team, with a view to agreeing a robust process going forward.
- General education around the use of the 'Urgent' marker on ePRO and how to process urgent typing requirements.

Onward assurance actions have been identified as follows:

- Define process for the effective management of processes in respect of approval, review and quality assurance.
- Define a competency matrix for all staff in respect of processes.
- Conduct initial assessment against the matrix.
- Carry out remedial action if needed.
- Define onward audit process.
- Conduct audits.

The overall issue and incidents related to patient harm have been reported as National Reportable Incidents (NRI) to the NHS Wales Executive.

To ensure that these issues are not occurring across the Health Board in other areas and Specialisms, and to share lessons learned, a letter was sent to IHC, MHLD and Womens Directors by the Executive Director of Nursing. There was a request to review the issues found and to ask for assurance and confirmation of governance processes, with remedial actions being taken if gaps were found. Responses are due by 31st January 2024.

NRI themes/learning

The main themes of the learning from closed nationally reportable incidents during November/December 2023 were related to management of infection outbreaks and treatment or procedure issues. A more detailed review of these cases is included in the private section of the Committee papers due to potentially identifiable information.

Incident management process

A review of the current incident management process continues with engagement of Integrated Health Communities and Divisions taking place in November/December 2023 and engagement with Llais in January 2024.

A proposal of the initial improvements based on the co-production work with services is being shared with the Patient Safety Group at the end of January 2024.

PATIENT SAFETY ALERTS

Outstanding Alerts:

The following were issued as national alerts in England and subsequently they were issued to Wales very near to the stated compliance date. NHS Wales Executive have been contacted for a revised compliance date.

CEMCPhA 2023 53: National Patient Safety Alert - Potential for inappropriate dosing of insulin when switching degludec - Tresiba products – near to closure.

NatPSA/2023/015/UKHSA: Potential contamination of some carbomer-containing lubricating eye products with Burkholderia cenocepacia – measures to reduce patient risk – near to closure as actions completed by Pharmacy.

Closed Alerts:

One alert was closed:

PSA016: Potential risk of under dosing with Calcium gluconate in severe hyperkalaemia

In progress Alerts and within timescale:

Two alerts are underway:

MDA/2023/03/NatPSA/2023/010/MHRA: Medical beds, trolleys, bed rails, bed grab handles and lateral turning devices: risk of death from entrapment or falls.

PSA017: Identified safety risks with the Euroking maternity information system. Although this system is not used in the Health Board All organisations currently using another Maternity Information System must: re-assess the clinical safety of their Maternity electronic patient record.

SAFEGUARDING

The Safeguarding and Public Protection Team provides oversight and organisational assurance in relation to the Health Board's statutory duty under the Social Service and Wellbeing (Wales) Act 2014 and Wales Safeguarding Procedures 2019, the Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act (MCA) 2005.

Safeguarding Governance Update

A review of SGPG membership will take place in January 2024 to ensure safeguarding reporting and governance is in-line with the Health Board's organisational framework. Health Board Safeguarding documents approved at SGPG are as follows:

- SCHO8 Safeguarding People at Risk Learning Development & Learning Framework/EQIA/7 Minute Briefing
- SCH07 PRUDiC SOP/EQIA /7 Minute Briefing
- SCH02 Monitoring Children Who Was Not Brought to Appointments SOP
- Safeguarding Policy & Procedure Group Terms of Reference

Safeguarding Data

As reported in the December quality report, the Health Board Safeguarding Data, specifically Adult at Risk and Child at Risk, reports to the Quality Delivery Group (QDG) and then subsequently the Quality, Safety and Experience Committee (QSE). The previous reporting framework for safeguarding, although robust, was undertaken on a quarterly basis with individualised data shared amongst respective services on a weekly/monthly basis (this part remains). The Nursing Executive Directorate have facilitated support to ensure that in moving forward all safeguarding data is expedited and reported to them on a monthly basis (via QDG) so existing reporting timeframes are not consistent with this report on this occasion but will be going forward.

For assurance, there have been no reported concerns or issues highlighted with regard to the data for December. All data is received and reviewed by the Safeguarding and Public Protection Team with any areas requiring additional support prioritised internally.

DoLS

Over the last two years, a significant amount of non-recurring Welsh Government (WG) funding has been made available to deliver MCA training and address the DoLS backlog (WG term for applications awaiting authorisation). This funding continues to be fundamental to protect the rights of individuals who lack Mental Capacity under the current DoLS system. WG have confirmed continued funding for 2024/2025 with the view to strengthening the current DoLS system across Wales.

As of the end of Q3, the DoLS Backlog stands at 19 (the number of patients awaiting a DoLS Assessment). Prior to WG funding, the Health Board had a Backlog of 144 cases. The reduction is a testament to the work undertaken by the MCA/DoLS Team. Best Interest Assessors and Section 12(2) Doctors complete additional DoLS Assessments during evenings and weekends to ensure Health Board patients are protected by the Legal Framework.

MCA

Mental Capacity Act training is a key target. The Health Board currently hold a training compliance above 85% across the organisation. To support staff in their knowledge and application of the Act, the Health Board have developed educational materials that include items such as banner pens that hold the principles of the MCA, coffee mugs with MCA guidance, and MCA booklets for employees, MCA easy read guides for patients and carers, posters and other useful resources. The response to the provision of materials has been extremely positive, resulting in proactive engagement and requests from front line colleagues to access training and initiate discussions.

INFECTION PREVENTION AND CONTROL

Lowering the burden of infection

The Health Board is currently above trajectory for all key performance organisms, however when compared to the other acute hospital provider health boards performance is second lowest for *Staphylococcus aureus* bloodstream infections i.e. both MRSA and MSSA. In addition, the Health Board are reporting fewer cases than for the same time period last year and the rate is lower than the all Wales average.

The Health Board are slightly above average for *C. difficile* and 4th highest in Wales, however reporting less cases than for the same time period last year.

For our gram-negative bloodstream infections, the Health Board are slightly above average for all Wales being 3rd for *Klebsiella* and 4th highest for *E. coli* and *Pseudomonas*. As these infections are commonly associated with the urinary tract, each Integrated Health Communities (IHC) is carrying out some focused education and training on the factors that prevent catheter associated urinary tract infections (CAUTI) and there will be a full audit of practice carried out in January.

Cases of Norovirus increased in December, particularly in East andWest, with visiting being restricted for a short period. Respiratory Syncytial Virus (RSV) cases have fallen and COVID-19 has remained low. There has been a small increase in Influenza cases, with the majority in the Central area to date, but numbers remain relatively low at the time of this report.

The Infection Prevention Team and IHC's continue to work closely together to:

- Ensure learning from post infection reviews is cascaded and improvement monitored through local infection prevention groups reporting up to the strategic infection prevention group.
- Deliver a robust audit programme of practices associated with the key infections and feedback performance data to inform improvement.
- Increase awareness through promotional campaigns with the new campaign "HABITS" being formally launched in February to further engage our staff, patients and public.

Optimising the use of antimicrobials

The Health Board are one of just two health boards on target to meet the 25% reduction in antimicrobial usage in the community from the 2013/14 baseline. Secondary care data has also recently been made available; but first analysis identifies WMH has the lowest usage in the Health Board and is below the all Wales average. YG follows the Wales average but antimicrobial usage in YGC is higher. Work is being undertaken to understand the higher prescribing here and implement an action plan for reducing usage.

World Antimicrobial Awareness Week was celebrated in November to help raise awareness and understanding of antimicrobial resistance and encourage best practice among healthcare professionals and the general public. Activities across the Health Board focused on encouraging Start Smart then Focus (SStF) principles, the Antibiotic Review Kit (ARK) and encouraging prompt intravenous to oral switching of antimicrobials via scheduled ward rounds.

Decontamination of reusable medical devices

The Health Board have been looking at decontamination provision across areas and as part of this, its identified the plan at WMH to move decontamination services for endoscopy to new premises near theatres is progressing well, with 4 new washer disinfector machines now on order. A plan is in development to address decontamination issues for endoscopy at YGC and an options appraisal is currently being written.

OTHER PATIENT SAFETY CONCERNS AND IMPROVEMENTS

Falls Improvement Group

The Health and Safety Executive and Internal Audit recommendations around inpatient falls are combined in one overarching improvement plan that is monitored by the monthly Inpatient Falls Group who escalate issues of significance to the Patient Safety Group. Areas of assurance include:

- Falls prevention training compliance for all staff
- Compliance with completion of falls risk assessments using Ward Manager/Matron audits
- Peer review of the quality of falls and patient handling risk assessments
- Evidence of weekly harms/learning meetings
- Evidence of communicating falls risks e.g. safety briefs, handover audits.

A table top review of the Health Board's position against the actions is being held on 29 January 2024 with all operational teams and key leads to ensure that the evidence required is clear and provides assurance of the improvements.

An Executive led review meeting will be held in February 2024 to review the table top findings, discuss barriers and support required with teams and monitor progress on the improvement plan.

Nosocomial Covid-19 Review Project

Funding for the project ceases at end of March 2024 and considerable progress with investigations has been made since the last report.

The current trajectory shows:

- 375 cases remain to be investigated.
- 89.41% cases have been completed.

Operational Progress

Three weekly strategy meetings are in place to provide support to the programme.

Data cleansing is underway of all remaining investigation outcome letters that need to be sent (week commencing 8/1/24).

The team are working to complete 4 new cases per working day to achieve completion by end of February 2024, to focus on finalising outcomes in March 2024.

Communication / Letters update:

Wave 1-3 outcome letters have been distributed with a total of 625 to date:

- Wave 1 outcome letters - 221
- Wave 2 outcome letters - 231
- Wave 3 outcome letters - 173

Wave 4 outcome letters have been data cleansed for posting on 8 January 2024 (total = 132).

A total of 6 phone calls and 6 emails received in response to investigation outcome letters. A total of 13 Civica feedback responses have been received.

A business case is in development to identify funding requests for a part-time manager to support complaints, Public Service Ombudsman Wales, inquests, claims and redress management that will continue after the funding ends. The manager will also finalise the overarching learning and improvement report.

Staff Survey:

A staff story has been obtained (physiotherapist) and is being transcribed for the sharing of learning.

PATIENT EXPERIENCE

COMPLAINTS

During November 2023 to December 2023, the Health Board **received** 363 complaints, 298 of these were managed under Putting Things Right, an additional 52 were resolved as Early Resolutions and 13 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).

The majority of the complaints related to Secondary Care Services. The top themes remain the same from the last report relating to: clinical treatment and assessment (209), poor communication (26), appointments (25) and medication (24). Attitude and behaviour issues are common themes across all services which is consistent with the communication issues.

There were 296 overdue complaints in total at the end of December 2023. This is a reduction of 14% of overdue complaints since January 2023, where the position in January 2023 was 344 overdue complaints.

It should be noted the number of overdue complaints relating to Planned care is 42, giving an overall complaints position of 254 excluding planned care complaints. This would indicate a 26.16% percentage drop of overall complaints when you exclude planned care complaints in comparison to January, 2023. (344 Vs 254)

Each Integrated Health Community (IHC) has adopted weekly Putting Thing Right Meetings to manage the progress of complaints received. The Complaints Team are currently working to trajectories to reduce the overdue complaint number by 20 complaints per month from the overall overdue numbers. It has been identified that the numbers are not reducing to the volume expected due to a high number 'tipping over' and becoming overdue over the week.

The Complaints Team have adopted a targeted approach to ensure that new complaints are closed within the 30-working day timeframe, streamlining the approvals process, ensuring that those due to becoming overdue are prioritised to ensure that deadlines are met.

The number of complaints **closed** from the 01 November 2023 to the 31 December, was 378 complaints of those 303 were managed under Putting Things Right, 56 Early Resolution, and 19 reopened, broken down as follows:

Total complaints closed = 378
Within 30 working days = 151 (39.96%)
Total closed after 40 working days= 197 (52.1%)

Broken down by

PTR = 303 (80.2%)
Early Resolution = 56 (14.8%)
Re-opened = 19 (5%)

The closure rate has fallen from 42% to 39.95%, however as expected within the reporting period due to staff annual leave over the Christmas period, and winter pressures.

A weekly meeting is in place with the Executive Director of Nursing and Midwifery to review grade 1's and 2 complaints received for the previous week, this supports early resolution to low level concerns, personalised letters are produced and submitted to the complainant as a form of resolution.

PATIENT FEEDBACK

Within the reporting period the Patient Advice Liaison Service (PALS) facilitated the resolution of 1,307 enquiries for November to December. The key themes identified from PALS enquiries within this reporting period include:

- Delays in appointments
- Delay in treatment
- Communication with patient/service user

The Patient Advice Liaison Service continue to work with Integrated Health Communities and Specialist Services to identify and support areas where there is an increase in the number of PALS enquiries, with the aim to encourage local resolution to concerns or enquiries.

From November 2023 to December 2023 the Patient and Carer Experience Team received 7,459 patient experience feedback responses via the Civica feedback system.

Key findings from the real-time survey feedback include:

- 88% of patients were satisfied with their overall experience
- 82.26% of staff always introduced themselves
- 84.52% of respondents always felt listened to
- 81.29% of respondents felt that staff took the time to understand what mattered to them as a person and took this into account when planning and delivering their care.

In August 2023, an All-Wales Emergency Department national patient feedback survey was launched. There has been a lower response than anticipated with only 19 responses collected within the reporting period. There needs to be a concentrated effort to improve the feedback response rate, so that patterns and trends and associated learning can be identified, and a sufficient improvement plan put in place.

Key findings from the Emergency Department real-time survey feedback include:

- 70% of patients were satisfied with their overall experience
- 63.16% of staff always introduced themselves
- 73.68% of respondents always felt listened to
- 63.16% of respondents felt that staff took the time to understand what mattered to them as a person and took this into account when planning and delivering their care.

The Patient and Carer Experience Team continue to work with Emergency Departments to explore ways to make survey completion available and easier to patients, relatives and carers who visit our emergency departments through promotional initiatives and providing training to staff.

A patient story was captured for Medicine Safety week from the 6th – 12th November 2023. The story collected relates to a patient's positive experience of receiving care from the Inflammatory Bowel Disease (IBD) Service in Wrexham and the benefits of Non-Medical Prescribing (NMP). The story was shared widely across the Health Board as part of **#MedSafetyWeek**.

The focus on the campaign was on 'who can report' and promotes how patients, Doctors, Pharmacists, Nurses and other Healthcare Professionals can contribute to pharmacovigilance. This story focuses on promoting the work of the Inflammatory Bowel Disease Nurse Specialists and their vital role as Independent Prescribers, supporting medicines safety.

The story also reinforces the importance of 'lived experience' patients being involved in service re-design and improvement projects as part of an increased focus on co-production within the department.

OTHER PATIENT EXPERIENCE CONCERNS AND IMPROVEMENTS

Patient and Carer Experience Training

PALS Officers delivered patient and carer experience training and PALS awareness training to 24 Health Care Support Worker's from Ysbyty Glan Clwyd Emergency Department as part of their training programme.

The Patient & Carer Experience Team continue to train and support staff who are Patient and Carer Champions across the Health Board. Staff who are Patient and Carer Champions are passionate about improving health and delivering excellent patient care. Within the reporting period Wynne Roberts, Chaplain Manager was invited as guest speaker to December's meeting to raise awareness of the Chaplain and Spiritual Care Service.

Small Business Research Initiative (SBRI) Patient Communication Project

The SBRI Patient Communication pilot project in Ysbyty Glan Clwyd is now live with Ward 1 and Ward 9. The aim of the project is to improve communication between the family/relative whilst their loved one is in hospital by providing relatives with daily updates via a digital portal/SMS.

Within this reporting period, 15 patients consented to be involved in the pilot whilst they were an inpatient. Of the 15 patients, 28 family members/relatives signed up to receive daily updates. In total 63 updates were sent out, of which 58 updates provided were general updates (e.g. patient had a good night), 1 update was in relation to discharge information and 4 updates were requesting items from home such as clothing/books.

There is a messaging facility on the portal to enable relatives to send a message to the ward. In total 38 enquiries from relatives were received and actioned by Ward staff. On Christmas Eve, Ward 1 sent a broadcast message out on the portal to all relatives wishing them a Happy Christmas and to remind them of Christmas visiting hours.

The pilot will run for three months with Ward 5 going live in January 2024. The Patient Advice Liaison Service are engaging with relatives to capture their experience of using this system to understand if this has helped improve communication between the ward and relatives.

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 and Carer Experience Team are working with the Radiology Service to review all their patient information documents, including patient letters and patient information leaflets. As part of the review, all patient information documents will be standardised to ensure there is consistent information being given to patients across North Wales.

Following the issue of a Welsh Risk Pool Risk Management Alert RMA2020-01, in relation to improving the use of high-quality procedure-specific patient information leaflets; Welsh Risk Pool has recommended that all Health Boards develop a database of all Health Board written patient information procedure leaflets used for obtaining informed consent. The Patient and Carer Experience Team will be co-ordinating this piece of work pan Health Board to ensure the provision of high quality, accessible information, to all patients in line with Welsh Risk Pool requirements.

Bevan Commission

In collaboration with NHS Wales Health Boards and Llais, the Bevan Commission led on a piece of work to engage citizens across Wales in conversations about the future of health and social care services. Through seven 'town hall' events in each NHS Wales Health Board locality, a national

online event and a survey, the project gathered the insights and views of over two thousand members of the public. The Patient and Carer Experience Team was involved in the planning and supporting the delivery of an engagement session in North Wales for patients.

Following the engagement, a report has been commissioned 'A Conversation with the Public: Challenges and Opportunities for change'. The Patient and Carer Experience Team are analysing the Health Board findings of this report to inform learning and improve patient experience. Please see the link below for the full report and link to the Health Board specific report findings.

https://bevancommission.org/a-conversation-with-the-public-report/

Using people's feedback to drive quality improvement and learning

The Head of Patient and Carer Experience is currently reviewing the National People and Community Framework with all Health Board colleagues across Wales, with the specific task of ensuring Health Boards across Wales use peoples' feedback to drive quality, improvement and learning in relation to patient experience with a specific focus on how;

- The organisation actively and routinely seeks out people and or community feedback to be a learning organisation which is underpinned by quality and service improvement work.
- The organisation can evidence that it uses feedback and staff know that peoples' feedback is central for driving quality improvement.
- People are actively involved in decision making as equal partners.

This work will be directly fed into the Organisational Learning Forum for monitoring, with support from the quality and safety teams.

Chaplain and Spiritual Care Service

During the reporting period the Chaplaincy and Spiritual Care Service have organised and delivered public services across the Health Board.

Memorial Services

During Remembrance Weekend, on Friday 10 November 2023 services were organised across hospital sites where approximately 300 people attended. Support was also provided to community hospitals and on a ward level for local/individual commemorations.

Memorial services were organised at Bangor Cathedral and Wrexham Catholic Cathedral to remember babies who had died in previous years. Over 100 people attended each service. The service allows bereaved families to remember their babies that have died and provides an annual space for the Chaplaincy to continue our long-standing support.

An Organ and Tissue Donation Annual Memorial Service was held at St Asaph Cathedral, where over 100 people gathered for the annual service.

Christmas

The Chaplaincy and Spiritual Care Service organised 17 events over the Christmas period across Health Board settings engaging with approximately 700 relatives, patients, staff, and local residents to celebrate Christmas. The largest event was at Ysbyty Gwynedd where pupils from a local primary school choir joined in the celebrations.

Following the success of the events the Chaplain Service has received an increase in requests for support. As a result of this, monthly drop-in sessions for patients to access have been set up in Hergest Unit, Ty Llewelyn and with the Learning Disability Service based in Bryn Y Neuadd.

The Chaplaincy uses the services of Radio Ysbyty Gwynedd in order to communicate with the patients and the wider community. This Christmas three programmes were produced with guest speakers from the Patient and Carer Experience Department and a Board Christmas Special with Dyfed Edwards, Health Board Chairman and Angela Wood, Executive Director of Nursing and Midwifery Services.

Pastoral Care

During this period the Chaplaincy & Spiritual Care Service has delivered pastoral care to patients across the Health Board, successfully delivering a 24/7 on call system that continues to meet its target of delivering care within 1 hr of the initial request for all end of life or urgent care.

CLINICAL EFFECTIVENESS

CLINICAL AUDIT

Audit is a critically essential element of clinical governance and is required to ensure that the Health Board is meeting national and local standards with regards to providing assurance with the provision of safe patient care.

Tier 1 audits are required annually, determined by Welsh Government, and are mandatory. The audits are focused on the areas that NHS Wales have identified as key to ensuring continued improvements in the quality and safety of healthcare services in Wales.

Tier 2 audits are determined by the Health Board's priorities, high-level risks or concerns. Since 2022/23, a strategic approach to Tier 2 audit has been taken to ensure the focus is on the main Health Board's governance priorities of risk, incidents, and complaints.

Each audit has an accountable lead responsible for delivery, supported by the Deputy Executive Medical Director. Progression of both Tier 1 and Tier 2 audits are monitored quarterly to provide accountability and any assistance that may be necessary to ensure completion against agreed timelines. These reports are submitted to Strategic Clinical Effectiveness Group for discussion and review and then the Quality Delivery Group.

Below is a summary 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 1 and Quarter 2 with an update on key achievements.

				West	Central	East	
Tier 1 Mandatory Audits 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/General update**
National Paediatric Diabetes Audit (NPDA)	Annual report 2021-22: Care processes and outcomes	05-Apr-23	31-May-23	Yes	Yes	No	**West** * Similar or better outcomes than both local and national units in key health checks (foot checks are lower, this will improve with annual review summary in the notes and annual review clinics). * West have one of the lowest mean HbA1c in pump users of all units. * Presented a poster Abstract in the ISPAD international diabetes conference (Nov 2023) **Central** * Increased % of patients have 4+ HbA1c measurements per year – this year it was 69% whereas in previous years this has been around 40% * 100% rate of level 3 carb counting on diagnosis * 100% rate of smoking status/Flu vaccine recommended/ ketone testing **East** Service assessment response, due May 2023, not received from Integrated Health Community (IHC) East, escalated to IHC through local Clinical Effectiveness Group (CEG) Meeting in June. Chair of CEG meeting agreed to contact lead to

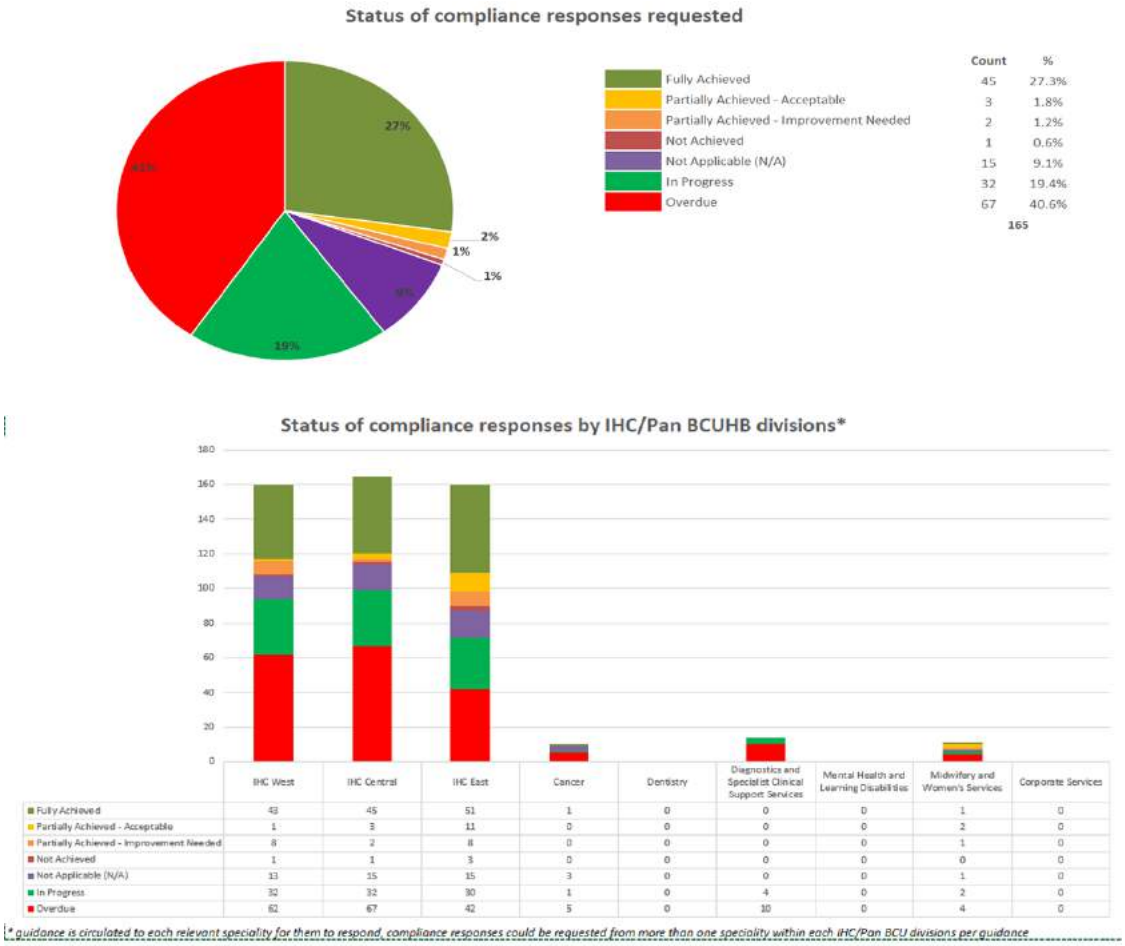
							progress this response. East lead confirmed Completed response to be received in Jan 2024
National Lung Cancer Audit	State of the Nation Report 2023	13-Apr-23	08-Jun-23	Yes	Yes	Yes	Proportion of patients with Non-Small Cell Lung Cancer (NSCLC) undergoing resection surgery has increased from 11.1% to 20.3% which is now above the national benchmark of 17%
National Heart Failure Audit (NHFA)	2023 Summary Report	09-Jun-23	26-Sep-23	Yes	Yes	Yes	• East-Cardiac rehab referrals have increased to 25% which is up from the previous year, however ongoing work continues with cardiac rehab. • BNP blood test has gone live for acute care across the Health Board – recommended by NICE• East -Beta Blocker 91% which exceeds the previous year and exceeds NICE target• Centre- Have good discharge planning and lessons to be learned for North Wales• 81% of patients received an ECHO which exceeds the previous year and with NTproBNP available, this will allow for the appropriate triage of ECHO and facilitate early diagnoses.
National Audit of Cardiac Rhythm Management Devices and Ablation (NACRM)	2023 Summary Report (2021/22 data)	09-Jun-23	26-Sep-23	Yes	Yes	Yes	Draft Service Assessment response received however details still under review, will be included in Quarter 3 report.
National Audit of Percutaneous Coronary Intervention (NAPCI) Audit	2023 Summary Report	09-Jun-23	26-Sep-23	Yes	Yes	Yes	**Centralised North Wales Cardiac** Best performing 60-minute Door to Balloon (DTB) in Wales with 72.16% of patients meeting the target.
Myocardial Ischaemia National Audit Project (MINAP)	2023 Summary Report	09-Jun-23	26-Sep-23	Yes	Yes	Yes	Draft Service Assessment response received however details still under review, will be included in Quarter 3 report.
National Audit of Care at the End of Life (NACEL)	2022/23 Annual Report (Round 4)	13-Jul-23	07-Sep-23	Yes	Yes	Yes	The Health Board's hospitals have access to face-to-face specialist palliative care, 8 hours a day, 7 days a week through clinical nurse specialist support. The UK national average for this service was 60% of health-boards/trusts. The Health Board also has access to a telephone specialist palliative care service (doctor led) available 24 hours a day, 7 days a week.
The National Clinical Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)	Epilepsy12 2023 combined organisational and clinical audits 2020-2022	13-Jul-23	07-Sep-23	Yes	Yes	Yes	The Health Board is compliant with the Welsh standards for the organisational element of the audit. Wales scored 73%. Data completeness was 100% for this cohort. This improves assurance for patient care. The overall case ascertainment for Betsi Cadwaladr University LHB is the same as the national standard. 10 out of 12 Key Performance Indicators were comparable with the mean for Wales overall.

National Dementia Audit (NDA)	National Audit of Dementia Care in General Hospitals 2022-2023 Round 5 Audit Report	10-Aug-23	11-Oct-23	Yes	Yes	Yes	EAST & WEST: Robust dementia governance arrangements in place since January 2023. NDA will be part of the Health Board's Dementia Improvement Plan so is fully integrated into core business. CENTRAL: Significant increase in use the 'Single Question in Delirium' (SQUID) question on admission for delirium screening compared to Round 4 across all 3 sites. Significant rise in use of the 4AT tool in diagnosing delirium across all 3 sites. Excellent compliance with pain assessment & re-assessment in patients with dementia within 24 hours of admission across all 3 sites.
National Joint Registry (NJR)	20th Annual Report 2023 - Surgical data to 31 December 2022	28-Sep-23	06-Dec-23	N/A	N/A	N/A	The National Joint Registry monitors the performance of hip, knee, ankle, elbow and shoulder joint replacement operations to improve clinical outcomes for the benefit of patients, clinicians and industry. The registry collects high quality orthopaedic data to provide evidence to support patient safety, standards of quality of care, and overall cost effectiveness in joint replacement surgery. As this report does not provide the level of data or recommendation, which health services can measure against a Service assessment of compliance is not requested, however the report is monitored by National audit lead in YG.
National Hip Fracture database (Falls & Fragility Fractures Audit Programme)	15 Years of Quality Improvement. The 2023 National Hip Fracture Database Report on 2022. 1st Jan 2022-31 Dec 2022	14-Sep-23	14-Nov-23	In progress	In progress	No	Draft Service Assessment response received for West & Central, however details still under review, no response from East, will be included in Quarter 3 report.

NICE GUIDELINES

From April 2023, NICE guidance is managed on the database Audit Management and Tracking (AMaT), the graphs below show the Health Board's current percentage for guidance published since April.

Designated leads are gradually being registered on AMaT and training is being rolled out as required. This has allowed an overall picture of compliance for the Health Board, however there will need to be a considerable amount of support from all IHCs/Divisions with regard to overdue confirmation on compliance to increase the overall percentage. Below is detail of our current percentage from 1st April 2023 to 31st December 2023.

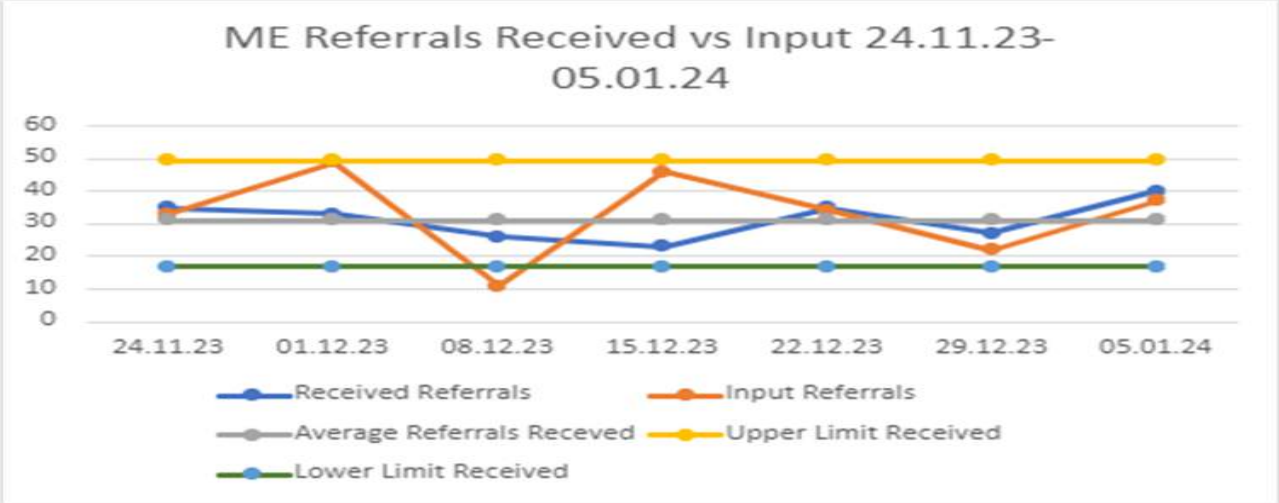


MORTALITY REVIEWS

	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)	Under investigation / action required (with IHC's, for IHC's to RAG)	Process completed
01.12.23	33	49	16	1	1	0	0	377	114	87	176	8	0	1	7	381	197	1698
08.12.23	26	11	-15	16	16	0	0	373	84	98	191	6	5	1	0	394	197	1700
15.12.23	23	46	14	3	3	0	0	380	90	107	183	15	9	0	6	403	198	1719
22.12.23	35	34	-1	2	2	0	0	357	91	109	157	35	14	2	19	411	200	1734
29.12.23	27	22	-5	6	6	0	0	330	90	107	133	52	12	4	36	412	203	1762
05.01.24	40	37	-3	10	10	0	0	367	107	102	158	32	3	5	24	414	204	1779

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 = Red, Amber, Green and is a form of report where measurable information is classified by colour, see RAG rating key.

RAG Rating Key	
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

All services participating in Tier 1 National Clinical Audits and Outcome Reviews are now being asked to complete the Service Assessment form with regard to the recommendations made in the published report for the mandatory National Audit/Review. Within the review information noted to provide assurance, noted below is what is captured:

- Key achievements for the Service
- Where and when the SMART Action Plan was agreed?
- Where has learning from this audit been disseminated?

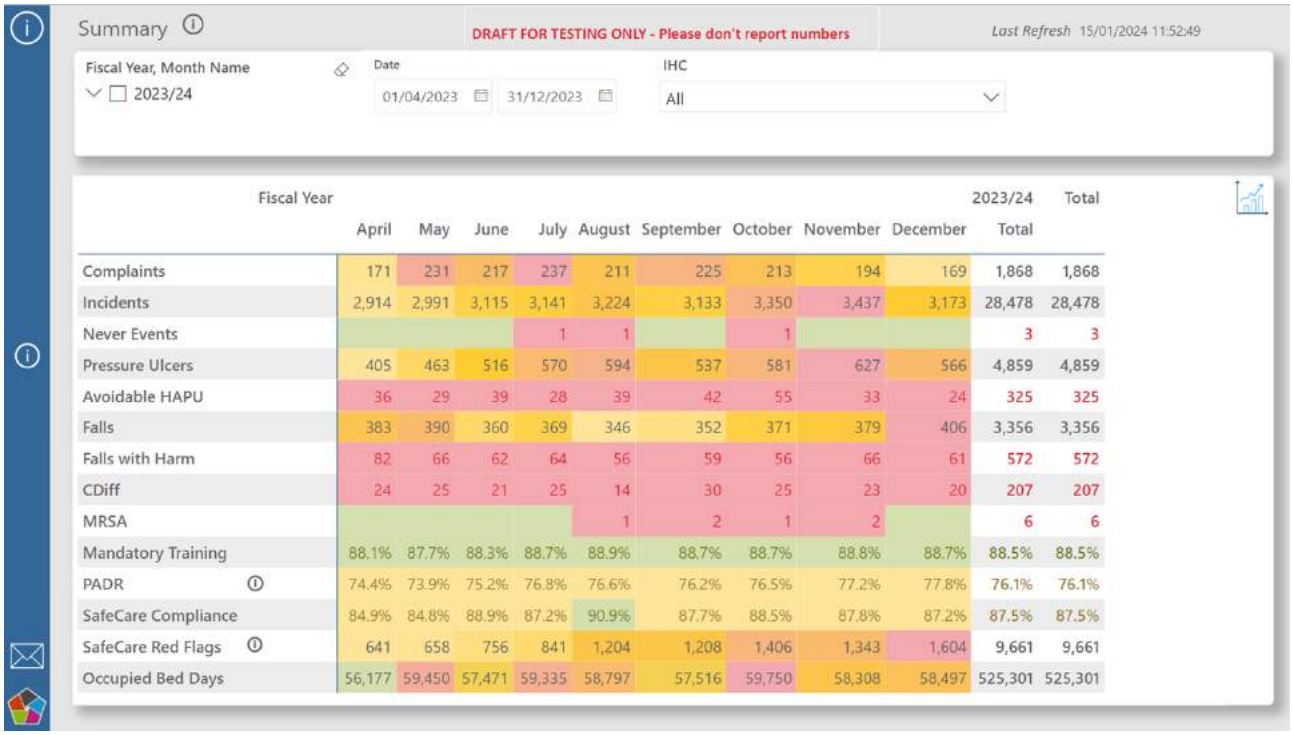
- Request to outline how the National Audit findings and recommendations are used to inform local continuous quality improvement and local audits for the Service?
- Validation of data collected
- Data collection issues
- Improvements achieved (noted in Clinical Audit section above)

Below is update on areas of collection issues reported for review:

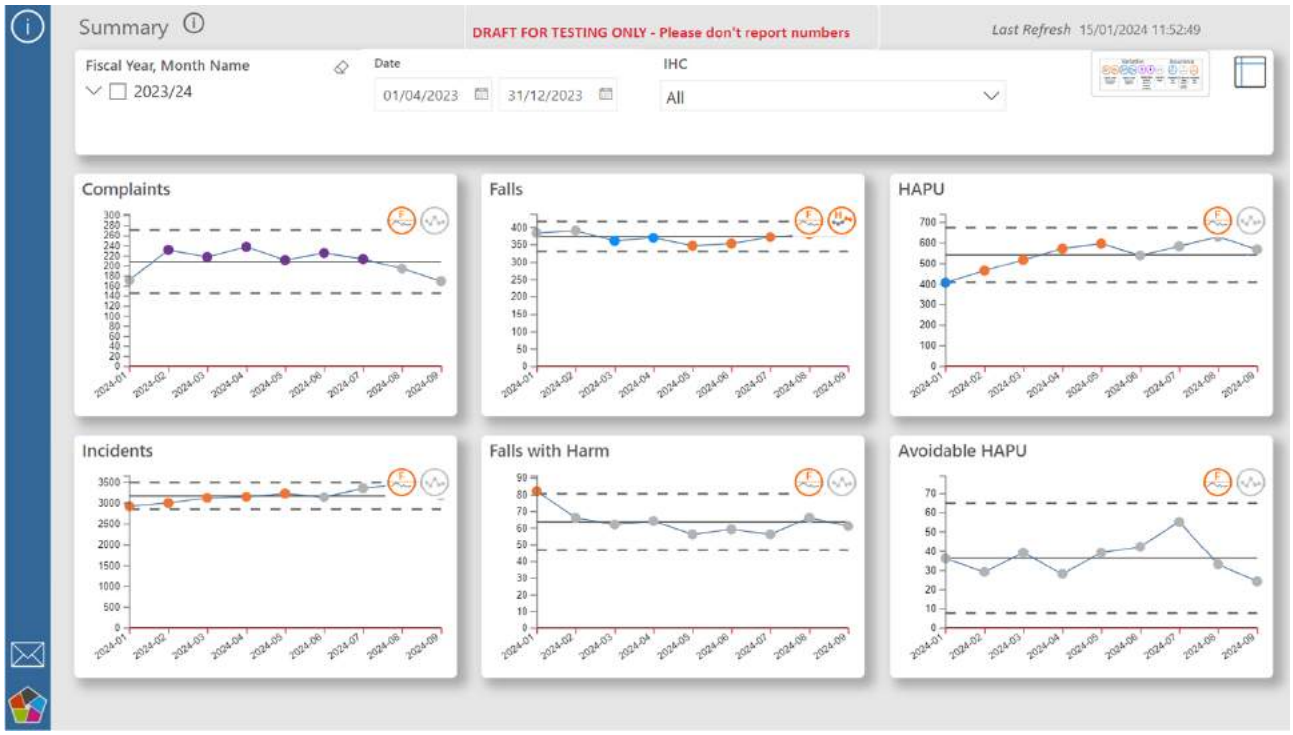
Title of National Audit/ Clinical Outcome Review	East Participation/Data collection issues reported	Central Participation/Data collection issues reported	West Participation/Data collection issues reported
National Emergency Laparotomy Audit (NELA)			The Audit lead raised an issue of data entry by Consultants before stepping away from the role in 2021. West has consistently raised the issue of data entry by Consultants and in 2023 the West Anaesthetic Lead stepped down as a result. SBAR submitted to Strategic Clinical Effectiveness Group in September 2023.
Trauma Audit & Research Network (TARN)			UK Trauma Registry shut down due to cyber-attack on host. No data collection since June 2023 (UK wide). A brief update on TARN was give New Year: • NHS England have confirmed their commitment to standing up an improved replacement to TARN, the National Major Trauma Registry (NMTR). • NMTR team anticipate providing full communications by mid-January 2023. • It is anticipated that 2024 will be a difficult development and recovery year as the new service is developed and capacity re-established; this will be undertaken with the provider network fully involved. • The new NMTR platform is expected to be live for data collection from January. • Detailed plans for on boarding and training on the new platform will be provided in the New Year.
National Diabetes Inpatient Safety Audit (NDISA) (There are two elements to this audit an organisation and a HARMs element) The HARMS element reviews the frequency of 4 harms that can occur in secondary care in patients with Diabetes.	HARMS element - data submission to this element of the audit not established since the re-launch in Nov 2022	HARMS element - data submission to this element of the audit not established since the re-launch in Nov 2022	HARMS element - data submission to this element of the audit not established since the re-launch in Nov 2022
National Respiratory Audit Programme: Adult Asthma	Never submitted data to this audit	No data submitted since Nov 2019	Data submitted up to Feb 2023 (issue raised Oct 23)
National Respiratory Audit Programme: Children and Young People Asthma	Data submitted up to Jul 2023 but struggling to meet the Nov 2023 deadline	Data submitted up to Feb 2023 (issue raised Oct 23)	No data submitted since Nov 2019
National Early Inflammatory Arthritis Audit (NEIAA)	New elements added to this audit which are not being captured due to resources		New elements added to this audit which are not being captured due to resources

National Dementia Audit (NDA)	Not participating in Round 6, there was a decision to pool resources and submit for 1 site only	Not participating in Round 6, HB there was a decision to pool resources and submit for 1 site only	
National Respiratory Audit Programme: Chronic obstructive pulmonary disease (COPD)	Data for respiratory audits has never been submitted due to resources issues. This has been raised at local Clinical Effectiveness Groups, Strategic Clinical Effectiveness Groups and Quality Developemnt Group – **this is across the 3 sites**		

QUALITY DASHBOARD



Fiscal Year	April	May	June	July	August	September	October	November	December	2023/24 Total	Total
Complaints	171	231	217	237	211	225	213	194	169	1,868	1,868
Incidents	2,914	2,991	3,115	3,141	3,224	3,133	3,350	3,437	3,173	28,478	28,478
Never Events				1	1		1			3	3
Pressure Ulcers	405	463	516	570	594	537	581	627	566	4,859	4,859
Avoidable HAPU	36	29	39	28	39	42	55	33	24	325	325
Falls	383	390	360	369	346	352	371	379	406	3,356	3,356
Falls with Harm	82	66	62	64	56	59	56	66	61	572	572
CDiff	24	25	21	25	14	30	25	23	20	207	207
MRSA					1	2	1	2		6	6
Mandatory Training	88.1%	87.7%	88.3%	88.7%	88.9%	88.7%	88.7%	88.8%	88.7%	88.5%	88.5%
PADR	74.4%	73.9%	75.2%	76.8%	76.6%	76.2%	76.5%	77.2%	77.8%	76.1%	76.1%
SafeCare Compliance	84.9%	84.8%	88.9%	87.2%	90.9%	87.7%	88.5%	87.8%	87.2%	87.5%	87.5%
SafeCare Red Flags	641	658	756	841	1,204	1,208	1,406	1,343	1,604	9,661	9,661
Occupied Bed Days	56,177	59,450	57,471	59,335	58,797	57,516	59,750	58,308	58,497	525,301	525,301



Teitl adroddiad: ***Report title:***	Quality Delivery Group – Chair's Report			
Adrodd i: ***Report to:***	QSE Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	20th February 2024			
Crynodeb Gweithredol: ***Executive Summary:***	This report provides the Committee with the Chair's Report from the 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.			
Argymhellion: ***Recommendations:***	The Committee is asked to **note** this report			
Arweinydd Gweithredol: ***Executive Lead:***	Angela Wood, Executive Director of Nursing and Midwifery Dr Nick Lyons, Executive Medical Director Gareth Evans, Executive Director of Therapies and Health Sciences			
Awdur yr Adroddiad: ***Report Author:***	Matthew Joyes, Deputy Director of Quality Governance			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☐ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☒ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				
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.				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Quality			
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	The Duty of Quality is a statutory requirement under the Health and Social Care (Quality and Engagement) (Wales) Act 2020. 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 EqlA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqlA been identified as necessary and undertaken?***	N/A
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	N/A
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	BAF1.2
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	N/A
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	N/A
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	N/A
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	BAF1.2
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	N/A
Camau Nesaf: Gweithredu argymhellion ***Next Steps: Implementation of recommendations*** N/A	
Rhestr o Atodiadau: ***List of Appendices:*** QDG Chair's Report	

Chair's Report

Report to:	Quality, Safety and Experience Committee
Report from:	Executive Quality Delivery Group
Report date:	February 2024 from meeting held January 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	None.
Summary of business conducted – for assurance	• Quality highlight and escalation reports were received from all IHC/Divisions. The format and content of these reports are under review to improve assurances, as part of the wider Special Measures Quality Governance Review. A number of core themes were noted including overdue incidents and complaints across services. • East IHC advised that following a recent patient concern it became apparent that a significant number of letters pertaining to patients under the care of gastroenterology services in the East, had not been finalised and sent to patients, GP and other onward specialities and services. These letters contained information updates but also requests for changes to medications and referrals to other services. A request for the number of unsent letters was made to the EPOC manager, which totalled 728 letters that appeared to require attention. On initial review, 317 of these required further review or action (medication change, for example). The 317 are being clinically validated, for example the request may no longer be relevant due to a recent hospital admission where the recommended medication change was addressed. The process for clinical validation is still ongoing, with weekly updates provided to the IHC PTR meeting. All other specialities were reviewed to ensure that there was no other similar issues. There is a new process in place to ensure that emerging backlogs are reported and escalated. Actual harm to patients is as yet unknown, but this remains under constant review. An Early Warning Notification was submitted to NHS Wales.

	• Central IHC advised inquests continue to be managed and monitored, with support from the Head of Nursing for CHC and Clinical Quality. A new process has been approved at the Quality Operational Delivery Group for the management of inquests and it was reported that this process is effective, with more statements now being received from medics. There are currently 54 open cases for Central. • West IHC advised a recent inquest highlighted lack of triangulation between inquest, concerns, patient safety and mortality. A working process has been developed in West describing steps and action to be taken via Complex Concern review meeting. West have undertaken a number of these reviews with positive initial feedback. Further reviews have been prioritised in accordance with urgency and likely Inquest dates. • MHLD Division advised during November 2023, Safeguarding received 36 Adult at Risk reports from the MHLD Division (41 last month). MH makes up 22.6% of BCU activity for adult at risk and LD have seen a decrease. Allegations of physical abuse are the most prevalent (42.3%) which is a consistent theme. The category other and other patients being the most common reported perpetrator (29/36). The Safeguarding Forum has again placed attention to frequency of reporting adult at risk (patient on patient alleged physical assault). Of the 20 cases of this nature, 10 cases were reported to the Police and 2 did not want Police involvement. It was identified that HON's are to remind to record if a person does not want Police involvement. There has also been a reminder to ensure patient protection plans accompany the adult at risk report. • Women's and Midwifery Division reported the Quality Assurance and Regulation Team undertook an unannounced Quality Check (Mock Inspection) of the Maternity Unit on the Ysbyty Gwynedd sites to assist with identifying any learning and improvement required to support preparations for a future Health Inspectorate Wales (HIW) Inspection, expected in the near future. Whilst the final report is expected in January, the panel provided some very positive and constructive initial feedback, which included: o Unit was very clean, tidy and welcoming o Excellent service user feedback (panel approached patients admitted to ward and reviewed written feedback) o Good evidence of effective MDT working o Incidences of incomplete documentation, including consent forms, however these were areas for the medical improvements. Issue highlighted with Clinical Lead. Consent training was mandated for medical staff by Women's Board in September 2023 o Out of date/out of use documentation available on the ward – immediate actions were taken to remove out of date/ out of use documentation o Lack of wider maternity service/organisational awareness of senior ward staff Partnership working and intelligence sharing in September 2023, identified potential concerns in relation to an increased number of neonatal referrals with HIE into Ty Gobaith.

	Of the 7 cases identified by the Director of Care at Ty Gobaith to the Executive Director of Nursing and Midwifery, at the time of this report have either undergone a review (5 cases) or are currently undergoing (2 cases) a full Serious Incident Investigation. Three cases are from 2022 and 4 cases are from 2023. From the review that has been completed, although there were lessons to be learnt in the cases, there is only one case where the review panel were able to say that the care provided and issues identified had an impact on the outcome of the baby. From the information reviewed there are no clear areas of concern which would have a direct effect on an increase in the number of babies with HIE following delivery. The commission of the review however is good practice, and shows that partnership working and communication across North Wales is open and transparent with concerns raised taken seriously and thoroughly investgated. Following a discussion about the Gynae Cancer pathway it was identified an SBAR would be presented to the Executive Team in January 2024 detailing the significant risk to delivering the North Wales Gynae Cancer Service in line with the Welsh Government Single Cancer Pathway. This is due to emergency and unforeseen sickness and a vacancy gap at Consultant level in Ysbyty Gwynedd. This will place significant risk in terms of clinical outcomes for patients on the Gynae Cancer Pathway. • Cancer Division highlighted that the service aims to offer all patients referred to oncology an appointment with an oncologist within a maximum of 2 weeks of referral (or less depending on clinical need). Unfortunately the current waiting times sometimes exceed this target due to the increase in the number of referrals received and vacancies within the consultant clinical oncologist team. There is currently a national shortage of clinical oncologists which makes recruiting clinical oncologists a challenge. However Cancer Services has recently been successful in recruiting 2 more substantive clinical oncologists which will help to reduce waiting times for the local population. Cancer Services are also experiencing extreme & unprecedented pressure on the Systemic Anti-Cancer Treatment (SACT) service. There has been a surge of new patient referrals with a simultaneous increase in SACT referrals. This is on the background of a service already at capacity. Cancer Services staff are working hard to find solutions, both immediate and medium term, and there are work streams currently underway to take this forward. It should be recognised and staff commended for continuing to keeping the service running and for ensuring the patients get the best experience they can in difficult circumstances. • Diagnostics and Clinical Support Division did not submit a report. • Dental Division advised that the service is not currently collating sufficient data/information for patient experience. Though standard BCU questionnaires are available they are rarely utilised. Improvement plans are being developed through the Dental Community Service Quality & Safety Group. Referrers are experiencing difficulties having their patients seen due to changes to the CDS access criteria. • The Strategic Infection Prevention and Control Group advised the Gram negative bacteraemia position has worsened this month - IHCs need to

	ensure CAUTI groups are established and are progressing with key recommendations. Metis hypochlorus machines have been out of use for several months now due to electrical failure - it is hoped this will be resolved this month. High level disinfection can only currently be done using UV lights, which are less effective for C.difficile. A back-up system for High Level Disinfection is required. In comparison with other Welsh Health Boards, BCU are 2nd for MSSA and Klebsiella, 3rd for MRSA, 4th for E. coli, C. diff and Pseudomonas. • The Strategic Clinical Effectiveness Group advised a Sepsis paper was presented outlining the risks and issues relating to the current Sepsis Screening Tool. This paper has also been presented to, and supported by, the Patient Safety Group. Both SCEG and the PSG support the below recommendations, and sought approval from QDG to implement. As no Executive Director was present, the QDG meeting was not quorate and could not approve so a recommendation was to be made outside of the meeting for Clinical Executive sign off. Agreement and sign off was given by the Executive Director of Nursing and Midwifery outside the meeting.

Teitl adroddiad: ***Report title:***	Special Measures Update			
Adrodd i: ***Report to:***	Quality, Safety and Experience Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	20th February 2024			
Crynodeb Gweithredol: ***Executive Summary:***	The purpose of this paper is to provide an update on Special Measures, outlining the progress to date on the deliverables associated to this Committee.			
Argymhellion: ***Recommendations:***	The Committee is asked to **RECEIVE ASSURANCE** on the progress to date, acknowledging the challenges highlighted and risks to delivery.			
Arweinydd Gweithredol: ***Executive Lead:***	Carol Shillabeer, Chief Executive (Accountable Officer) Dr Chris Stockport, Executive Director of Transformation & Strategic Planning (Lead Executive)			
Awdur yr Adroddiad: ***Report Author:***	Geraint Parry, Special Measures Programme			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	To support Special Measures			
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	Not applicable			

Yn unol â WP7, a oedd 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)***	Not applicable
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	Not applicable
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	Not applicable
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	Not applicable
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	Not applicable
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Not applicable
Camau Nesaf: Gweithredu argymhellion ***Next Steps:*** Implementation of recommendations	

QSE Committee; 20th February 2024

Special Measures Update

1) Introduction

This report presents an update on Cycle 3 (December 2023 to February 2024) as at the end of January.

The report provides an assurance rating against individual milestones supported by narrative update of progress to date and a proactive forward look to the end of the cycle in terms of delivery.

At the point of writing we are – on a calendar basis – approximately two thirds through Cycle 3.

2) Progress to date

Overall, for those milestones within the QSE remit good progress has been made by the end of the 2nd month of this cycle. 7 milestones are already complete, and a further 13 assessed as being on track for completion by the end of the cycle.

There are 8 milestones where delivery is marked as amber because mitigations are in place, or required, to address delays within the cycle. An amber rating indicates that at present those mitigations have a reasonable prospect of course-correcting without significant over-run.

7 milestones are currently rated by the PMO as red; based upon updates received they are not likely to complete as planned by the end of the cycle. These are predominantly related to agreed milestones within the improvement plans for fragile services such as Urology, Ophthalmology and Dermatology.

3) Independent Reviews

With regards to the Independent Reviews pertaining to QSE,

Vascular Review
The Vascular review was presented to a development session in December and the management response will be presented in a separate paper to this committee.

Patient Safety and Mental Inpatient Safety
The already published reviews for Patient Safety and Mental Inpatient Safety continue to be progressed under the thematic approach agreed.

Clinical Governance Review
The review around Clinical Governance remains in the early phase and work around a Quality Management System (QMS) is expected to provide an initial report by May 2024.

4) Recommendations

The Committee is asked to **RECEIVE ASSURANCE** on the progress to date, acknowledging the challenges highlighted and risks to delivery.

Appendix 1 – Summary of Cycle 3 Milestones

Key	Completed	On Track to deliver by end of Cycle	There are risks to delivery by end of Cycle	Will not deliver by end of Cycle

3. Stronger leadership and engagement

Deliverable	Milestones summary text	SRO	Status	Due Date
C1-3.10: Implement plans for integrated electronic patient record	3.10.7 - Finalise, review and agree prioritised service and digital tactical interventions for ED, quantify benefits and develop costed plan for delivery.	Dylan Roberts		31/12/23
	3.10.8 - Draft Strategic Outline Case for Electronic Healthcare Record Systems (EHR) presented to Exec Team, including plan to take forward with wider stakeholders	Dylan Roberts		31/01/24
	3.10.9 Case developed for best of breed Mental Health system in conjunction with DHCW and WG to help address the lack of electronic health care records.	Dylan Roberts		29/02/24
	PMO Assurance Comments: The Draft Strategic Outline Case has been developed and was presented to the Executive Team during January with further consultation underway. Discussions are also progressing between the national team and Mental Health and Learning Disabilities regarding procurement and the Mental Health and Learning Disabilities Digital Steering Group is driving forward the work.			

4. Improved access, outcomes and experience for citizens

Deliverable	Milestones summary text	SRO	Status	Due Date
C1-4.5a: Vascular improvement plan	4.5a.8 Continued Executive Team review of Vascular Steering Group progress and priorities	Nick Lyons		31/01/24
	4.5a.9 Integrated Vascular hub and spoke: North Wales Vascular Service Specification, outlining roles and responsibilities of Hub and Spoke sites, to be revised in light of other improvements made and presented to Vascular Steering Group	Nick Lyons		31/01/24
	4.5a.10 Welsh Government Phase 2 audit of anonymised case files completed	Nick Lyons		29/02/24
	4.5a.11 Updated Vascular Integrated Improvement Plan, which incorporates all outstanding, and new improvement recommendations, and service level priorities developed and approved by Vascular Steering Group	Nick Lyons		29/02/24
	4.5a.12 17 vascular related pathways approved by Strategic Clinical Effectiveness Group for implementation including audit and evaluation cycles	Nick Lyons		29/02/24
	4.5a.13 Emergency Diabetic Foot Pathway implemented and clinical audit cycle in place to monitor improvements in access, outcomes and experience	Nick Lyons		29/02/24
	PMO Assurance Comments: The Vascular plan remains under regular review and part 1 of the Independent Review has reported and is progressing in terms of response. The second part, which is the phase 2 audit of case notes, remains on track following the final series of review meetings. The Clinical Effectiveness Group (CEG) has sought additional information regarding submitted pathways and this will be provided in their February meeting, remaining on-track, except for the			

	Emergency Diabetic Foot Pathway where further amendments are required. This may now lead to a delay in implementation of that Pathway.			
C1-4.5b: Urology improvement plan	4.5b.7 Updated Urology Improvement Plan, including both the GIRFT and RCS recommendations, presented to Executive Team for agreement on priorities of the service.	Nick Lyons		19/01/24
	4.5b.8 Recruitment completed of dedicated expert clinical support to advise, support and implement the Urology Improvement Plan	Nick Lyons		31/12/23
	4.5b.9 Delivery commenced of the Urology Improvement Plan and improvements in consistency of delivery in quality standards and access to urgent and elective pathways across N Wales starting to be realised	Nick Lyons		19/01/24
	4.5b.10 Plan agreed with the national robotic programme to ensure effective and sustainable use of the north Wales robot, to enable improved access for our population	Nick Lyons		31/01/24
	PMO Assurance Comments: There are some challenges in this area with milestone dates that cannot be fully mitigated to return to being on track by the end of the cycle. Initial discussions regarding dedicated expert clinical support were ultimately unsuccessful and alternative options are now being explored. With regards to robotic provision discussions continue regarding a viable platform and options are being reviewed with the national programme. There is no firm date for conclusion at this stage.			
C1-4.5c: Ophthalmology improvement plan	4.5c.7 Ophthalmology Train and Treat implemented	Adele Gittoes		29/02/24
	4.5c.8 Ophthalmology Pan BCU Clinical Lead appointed	Adele Gittoes		29/02/24
	4.5c.9 Ophthalmology R1 Clinical validation (Longest-Waiting R1s) completed	Adele Gittoes		29/02/24
	4.5c.10 Development commenced of an outline 5-year eye care plan based on an integrated sustainable model.	Adele Gittoes		29/02/24
	PMO Assurance Comments: Overall there are challenges within Ophthalmology in achieving the February milestones. Whilst extensive efforts have taken place across the cycles, with different options explored, the appointment of a clinical lead by the end of the cycle will now not be completed. Recruitment delays at Cardiff University to support Train and Treat led to this activity being carried forward from Cycle 2, and whilst progress is now occurring there remains some risks to delivery within the revised timescales. With validation, further assurance is required before it can be confirmed that this will or will not complete by the end of the cycle. A comprehensive pan BCU improvement plan in place and being actively monitored through the BCU Ophthalmology Improvement Group, with short, medium and longer-term elements. This has been informed by visits to exemplar sites, and on-going away days.			
C1-4.5d: Oncology improvement plan	4.5d.7 Review of Oncology completed at Exec Team with respect to readiness for transitioning towards standardisation	Nick Lyons		29/02/24
	PMO Assurance Comments: The 5 year Cancer Services roadmap has been shared with the Executive Team for comments.			
C1-4.5e: Dermatology improvement plan	4.5e.5 Complete a clinically led options appraisal to address medium term risk pan BCUHB in relation to Dermatology Cancer	Adele Gittoes		29/02/24
	4.5e.6 Teledermoscopy model implementation commenced (subject to outcome of WG bid)	Adele Gittoes		29/02/24
	4.5e.7 Dermatology improvement plan and delivery framework further strengthened	Adele Gittoes		29/02/24
	4.5e.8 Pan BCU Dermatology Clinical Lead appointed	Adele Gittoes		29/02/24

	4.5e.9 Delivery commenced of an immediate plan to reduce the backlog with a maximum scope of an additional c.2000 patient appointments, dependent on WLIs.	Adele Gittoes		29/02/24
	PMO Assurance Comments: Significant work is underway to strengthen leadership and the service model. Until these issues are resolved the delivery of the Special Measures milestones remain at risk, and Cycle 3 work is unlikely to conclude on time.			
C1-4.5f: Plastics improvement plan	4.5f.4 Contract with St Helens & Knowsley in place, with a consistent partnership clinical model and data sharing model operating across BCUHB	Adele Gittoes		29/02/24
	4.5f.5 Initial review of Plastics patients completed, as agreed with WHSSC and St Helens & Knowsley	Adele Gittoes		29/02/24
	PMO Assurance Comments: As at the end of January the review of patients is almost complete. 809 cases have been reviewed with a risk stratification undertaken with nine patients awaiting a review. The Service Level Agreement remains with the provider for final approval and further work required to ensure that this concludes by the end of the cycle.			
C1-4.7: Mental Health Inpatients Safety review - phase 2	4.7.5 NCCU Action Plan Delivery Group fortnightly meetings held.	Teresa Owen		31/12/23
	4.7.6 MH&LD evidence log and repository developed.	Teresa Owen		31/12/23
	4.7.7 MH&LD NCCU update report submitted through appropriate governance routes to provide an overview of progress made with implementation of action plan.	Teresa Owen		29/02/24
	PMO Assurance Comments: The NCCU Patient Safety Delivery Group continues to meet fortnightly, with a sub group meeting weekly to quality assure updates and evidence aligned to action plan progress. This all continues to be managed via the agreed governance routes and all activities are on track.			
C1-4.8a: CAMHS improvement plan	4.8a.7 Delivery of the agreed BCU performance trajectories for the Mental Health Measure for December, January, February.	Adele Gittoes		29/02/24
	4.8a.8 Focused review of CAMHS service model across BCU undertaken	Adele Gittoes		29/02/24
	PMO Assurance Comments: A focused review has taken place and a delivery model for early intervention, prevention and promotion has been drafted for consultation. The Enhanced Crisis and Unscheduled Care model has been finalised and approved along with the Tier 4 specialist service specification. Trajectories were not met in January however there is an improving position with forecasts indicating they will be met in February.			
C1-4.8b: Neurodiversity improvement plan	4.8b.6 ND tender for private provision of assessments awarded	Adele Gittoes		29/02/24
	PMO Assurance Comments: The tender process has taken place and awaiting approval. Following a mid-cycle review discussions are underway regarding the strengthening of this area with an additional milestone.			

5. A learning and self-improving organisation

Deliverable	Milestones summary text	SRO	Status	Due Date
C1-5.2: Effective procedures for learning from incidents and preparing for inquests and HSE	5.2.8 A central and digital learning repository and cascade system prototype developed, based on Office 365	Angela Wood		29/02/24
	5.2.9 Comprehensive review completed of current PTR processes including incidents, claims, inquests (to include PFDs), complaints and subsequent learning. The process will support the implementation of the Duty of Quality utilising the Health and Care Quality Standards to drive continual improvement to meet the needs of the population	Angela Wood		29/02/24
	5.2.10 As part of the integrated performance framework, the first part of the Quality Dashboard will be live	Angela Wood		29/02/24
	PMO Assurance Comments: The draft investigation process was presented at the Patient Safety Group on the 29th January and the final report is due by the end of February. Further testing is also planned around the Quality Dashboard during February. Work is underway on the central learning repository, also aligned to the learning framework, however this will not conclude until March (and so slightly outside of cycle). The Learning from Inquest Investigations programme is underway and starting to generate learning already.			
C1-5.3: Clinical Governance review	5.3.2 To have fully supported and engaged with the review process as directed by the reviewing team, ensuring all key staff are available as required once ToRs agreed and review commenced. It is unknown at this time what format the review will take. Ensure the learning and actions from the Patient Safety Review are covered by this work	Angela Wood		29/02/24
	PMO Assurance Comments: Meetings with the national team took place during December and Terms of Reference agreed. Work is underway with the Independent Advisor. Progress is also being made around the development of a Quality Management System, with NHS Wales colleagues presenting to the Executive Team as well as the Senior Leadership team. Targeting taking a draft Quality Management System (QMS) proposal to Board in May.			

Teitl adroddiad: ***Report title:***	QSE Committee – Regulatory Assurance Report			
Adrodd i: ***Report to:***	QSE Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	February 2024			
Crynodeb Gweithredol: ***Executive Summary:***	This report provides the Committee with assurance and analysis on significant regulatory matters and issues.			
Argymhellion: ***Recommendations:***	The Committee is asked to note this report.			
Arweinydd Gweithredol: ***Executive Lead:***	Angela Wood, Executive Director of Nursing and Midwifery Dr Nick Lyons, Executive Medical Director			
Awdur yr Adroddiad: ***Report Author:***	Matthew Joyes, Deputy Director of Quality Governance Erika Dennis, Lead Quality Assurance and Regulation Manager			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☐ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☒ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/ tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				
There is confidence in the data provided in the report however, the pace 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 Special Measures and the Board Assurance Framework.				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Quality			
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	The Duty of Quality is a statutory requirement under the Health and Social Care (Quality and Engagement) (Wales) Act 2020. 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 EqlA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqlA been identified as necessary and undertaken?***	N/A
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	N/A
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	BAF1.2
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	N/A
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	N/A
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	N/A
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	BAF1.2
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	N/A
Camau Nesaf: Gweithredu argymhellion ***Next Steps: Implementation of recommendations*** N/A	
Rhestr o Atodiadau: ***List of Appendices:*** 1. QSE Committee Regulatory Assurance Report 2. Ombudsman Annual Letter 3. BCUHB Response to Ombudsman Annual Letter	

QSE Committee – Regulatory Assurance Report – February 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 a summary of quality related regulatory assurances. This is the second version following a refresh of the report and feedback is welcomed on its style and content to inform ongoing improvement. The report covers the period of December 2023.

The Health Board's new Regulatory Assurance Group is maturing having been established at the start of 2023. The group is providing central oversight and coordination of quality related regulatory matters to strengthen the approach to quality governance. The group, and the work of the Quality Governance Department, has focused significantly on improving process and evidence.

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.

One inspection report was published in relation to the unannounced inspection of Morris Ward, Wrexham Maelor Hospital which took place 12 and 13 September 2023. This report can be accessed here.

Two concerns / requests for assurance were received from HIW;

Case one: a paediatric case relating to child protection concerns. This particular case involved a 48 hour Make it Safe meeting which concluded that there were no immediate issues. There were however, areas of learning identified and therefore a Serious Incident Review (SIR) and rapid learning panel was recommended along with a referral to North Wales Safeguarding Board. Further reviews took place which were led by the Health Board Executive Director of Nursing and Midwifery and Deputy Executive Medical Director and involved the Senior Paediatric Team, Senior Safeguarding Team, Clinical Director of Paediatrics. A Child Protection Peer Review meeting took place to discuss the safeguarding issues and learning points. The panel concluded that there were no immediate issues for the Paediatric Team to address.

Case two: a surgical case where the family of the patient approached HIW to express concerns in relation to care and treatment after the patient was admitted to ITU. The main areas of concern were in relation to the administration of medication, patient dignity, nutrition and DNACPR. The Health Board conducted a review and identified areas for learning but not neglect in relation to care and treatment. The patient has since sadly passed away for which the Health Board have offered condolences and support to the patient's family.

HIW will be providing an announced visit to Nant-y-Glynn Community Mental Health Team on 23rd and 24th January 2024. A number of written assurances about Nant-y-Glyn have been provided to HIW prior to this planned inspection. The Health Board Patient Experience Team and Caniad had planned to undertake a session to support with preparations prior to the inspection around patient experience which did not go ahead. The plan is to undertake the session in February and support with any improvement work required following the inspection.

The Health Board continues to meet with the relationship team at HIW to ensure good working practices.

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 standard six month service quality review template is being developed for all registered services to complete, alongside a quarterly assurance declaration. These two formal processes support the overall annual declaration made by the Health Board.

Work is underway with the Nursing Professional Education and Revalidation Team to ensure that all healthcare support staff who are working in a CIW registered service are regulated with Social Care Wales.

HEALTH AND SAFETY EXECUTIVE / LOCAL AUTHORITY

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

The Health Board attended court in December 2023 facing charges under the Section 3 of the Health and Safety at Work etc Act 1974 following a serious incident in mental health services in April 2021. The Health Board entered a guilty plea and was sentenced to a fine of £200,000 plus costs and surcharge. The court was presented with a bundle of evidence demonstrating the improvements made since the incident.

HIS MAJESTY'S CORONER

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

During December 2023, the Health Board has received 2 Regulation 28 Prevention of Future Death Notices. The first Notice relates to theatre management processes, and the second relating to pressures within the Emergency Department at Ysbyty Glan Clwyd. Responses to both are in the process of being explored and drafted. A response was issued in December relating to one earlier Notice, which also raised concerns about the Emergency Department at Ysbyty Glan Clwyd. The response detailed the operational and improvement work underway to support the department manage pressures.

The Health Board shares the ongoing and serious concerns raised by HM Senior Coroners regarding investigation quality and evidence of learning. In response, a full review of the investigation process is underway by the Patient Safety Team. Consideration is also underway at present regarding how assurance of learning and supporting evidence can be strengthened, and a proposal is being developed which will be reported to a future Committee meeting.

The Health Board continues to meet with the two Senior Coroners to ensure good working practices.

PUBLIC SERVICES OMBUDSMAN FOR WALES

PSOW has legal powers to look into complaints about public services and independent care providers in Wales.

No Pubic Interest Reports were published.

The Ombudsman measures responsiveness using a measure called Average Variance to Target (AVT). This is regularly shared with all health boards. The Health Board AVT is currently -2 (i.e. submissions are on average 2 days ahead of a deadline).

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. The Chief Executive also held their regular meeting with the Ombudsman.

The Annual Letter from the Ombudsman was received, and responded to. A copy of both letters is attached. Due to an oversight in the corporate office this was not forwarded to the Quality Governance Department for action, hence a slight delay in responding to the Ombudsman for which an extension was proactively requested and granted.

The Health Board continue to make changes to ensure that we comply with the recommendations made within the Ombudsman's report, Groundhog Day 2: an opportunity for cultural change. An update was provided within the Health Board's response to the annual letter.

WELSH RISK POOL

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.

The Health Board has a number of overdue Learning from Events Reports which are due to be submitted to the Welsh Risk Pool (WRP). This is mainly due to delays within services in providing evidence of learning. There is a risk of financial penalty for delayed forms. As with other areas of overdue documents (such as incidents and complaints which both remain unacceptably high) support is being provided to divisions to facilitate completion and regularly reporting and escalation is in place.

Ombwdsmon
Ombudsman
Cymru • Wales

Ask for: Communications
01656 641150
Communications
@ombudsman.wales

Date: 17 August 2023

Dyfed Edwards
Betsi Cadwaladr University Health Board
By Email only: dyfed.edwards@wales.nhs.uk

Annual Letter 2022/23

Dear Dyfed

I am pleased to provide you with the Annual letter (2022/23) for Betsi Cadwaladr University Health Board which deals with complaints relating to maladministration and service failure, and the actions being taken to improve public services.

This letter coincides with my Annual Report – "A year of change – a year of challenge" – a sentiment which will no doubt resonate with public bodies across Wales. My office has seen another increase in the number of people asking for our help – up 3% overall compared to the previous year, and my office now receives double the number of cases we received a decade ago.

Last year, I met with public bodies across Wales last year – speaking about our casework, our recommendations, and our proactive powers. The current climate will continue to provide challenges for public services, but I am grateful for positive and productive way which Health Boards communicate with my office.

Colleagues from my Improvement Team meet regularly with Betsi Cadwaladr University Health Board to discuss compliance with our recommendations and our complaints standards work, and we would like to pass on our thanks to Matthew Joyes and his team for the constructive and candid way these discussions are conducted.

926 complaints were referred to us regarding Health Boards last year – an increase of 21% compared to the previous year. During this period, we intervened in (upheld, settled or resolved at an early stage) 30% of Health Board complaints - a similar proportion to previous years.

Supporting improvement of public services

Our *Groundhog Day 2: An opportunity for cultural change in complaint handling?* report issued in June, highlighted the complaint handling failings we identified in cases involving health boards across Wales during the preceding 12 months. Our recommendations to the Health Board were aimed at ensuring that, as the new Duties of Candour & Quality are introduced within your organisation, that the opportunity for a cultural change is taken - to promote openness and candour with service users and ensure there is systemic learning when things have gone wrong.

I trust that, in line with our recommendations to the Health Board, the report has or will soon be considered by your Quality & Patient Safety Committee and it will:

- review the resources available to your complaints team
- review arrangements for accurately compiling complaints data
- consider whether the option to provide staff investigating complaints with independent medical advice, is considered on a case by case basis
- reflect upon the lessons highlighted in this report when scrutinising their performance on complaint handling
- ensure that lessons learned from the PSOW's findings and recommendations are included in their Health Board's annual report on the Duty of Candour and Quality.

Despite the challenges of last year, we have pushed forward with our proactive improvement work and launched a new Service Quality process to ensure we deliver the standards we expect.

Last year, we also began work on our second wider Own Initiative investigation – this time looking into carers assessments within Local Authorities. This investigation will take place throughout the coming year, and we look forward to sharing our findings.

The Complaints Standards Authority (CSA) continued its work with public bodies in Wales last year, with more than 50 public bodies now operating our model policy. We've also now provided more than 400 training sessions since we started in September 2020.

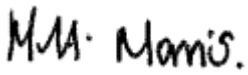
We continued our work to publish complaints statistics into a second year, with data now published twice a year and we included information about Health Boards for the first time in 22/23. This data allows us to see information with greater context – for example, last year 8% of Betsi Cadwaladr University Health Board's complaints were referred to PSOW.

I would encourage Betsi Cadwaladr University Health Board, to use this data to better understand your performance on complaints.

Further to this letter can I ask that Betsi Cadwaladr University Health Board takes the following actions:

- Present my Annual Letter to the Board at the next available opportunity and notify me of when these meetings will take place.
- Update my office on how the Health Board has complied with the recommendations in our report: *Groundhog Day 2: an opportunity for cultural change?* by **1 December 2023**.
- Continue to engage with our Complaints Standards work, accessing training for your staff, fully implementing the model policy, and providing complaints data.
- Inform me of the outcome of the Council's considerations and proposed actions on the above matters at your earliest opportunity.

Yours sincerely,



Michelle Morris
Public Services Ombudsman

cc. Carol Shillabeer, Chief Executive, Betsi Cadwaladr University Health Board.
By Email only: carol.shillabeer3@wales.nhs.uk

Ombwdsmon
Ombudsman
Cymru • Wales

Factsheet

Appendix A - Complaints Received

Health Board	Complaints Received	Received per 1000 residents
Aneurin Bevan University Health Board	166	0.28
Betsi Cadwaladr University Health Board	225	0.33
Cardiff and Vale University Health Board	137	0.28
Cwm Taf Morgannwg University Health Board	134	0.30
Hywel Dda University Health Board	104	0.27
Powys Teaching Health Board	23	0.17
Swansea Bay University Health Board	137	0.36
Total	926	0.30

Ombwdsmon
Ombudsman
Cymru • Wales

Appendix B - Received by Subject

Betsi Cadwaladr University Health Board	Complaints Received	% share
Ambulance Services	0	0%
Appointments/admissions/discharge and transfer procedures	4	2%
Clinical treatment in hospital	111	49%
Clinical treatment outside hospital*	9	4%
Complaints Handling	50	22%
Confidentiality	1	0%
Continuing care	0	0%
COVID19	4	2%
De-registration	0	0%
Disclosure of personal information / data loss	1	0%
Funding	0	0%
Medical records/standards of record-keeping	4	4%
Medication> Prescription dispensing	0	0%
Mental Health	14	6%
NHS Independent Provider	1	0%
Non-medical services	2	1%
Nosocomial COVID	2	1%
Other	8	4%
Out Of Hours	0	0%
Parking (including enforcement and bailiffs)	0	0%
Patient list issues	7	3%
Poor/No communication or failure to provide information	0	0%
Prisoner Care	1	0%
Referral to Treatment Time	2	1%
Rudeness/inconsiderate behaviour/staff attitude	3	1%
Total	**225**	

Ombwdsmon
Ombudsman
Cymru • Wales

Appendix C - Complaint Outcomes
(* denotes intervention)

Betsi Cadwaladr University Health Board		% Share
Out of Jurisdiction	39	17%
Premature	26	11%
Other cases closed after initial consideration	77	33%
Early Resolution/ voluntary settlement*	52	23%
Discontinued	3	1%
Other Reports - Not Upheld	6	3%
Other Reports Upheld*	26	11%
Public Interest Reports*	2	1%
Special Interest Reports*	0	0%
Total	**231**	

ombwdsmon.cymru
holwch@ombwdsmon.cymru
0300 790 0203
1 Ffordd yr Hen Gae, CF 35 5LJ
Rydym yn hapus i dderbyn ac ymateb i ohebiaeth yn y Gymraeg.

ombudsman.wales
ask@ombudsman.wales
0300 790 0203
1 Ffordd yr Hen Gae, CF 35 5LJ
We are happy to accept and respond to correspondence in Welsh.

Ombwdsmon
Ombudsman
Cymru • Wales

Appendix D - Cases with PSOW Intervention

	No. of Interventions	No. of Closures	% Of Interventions
Aneurin Bevan University Health Board	48	160	30%
Betsi Cadwaladr University Health Board	80	231	35%
Cardiff and Vale University Health Board	30	129	23%
Cwm Taf Morgannwg University Health Board	37	141	26%
Hywel Dda University Health Board	41	100	41%
Powys Teaching Health Board	5	23	22%
Swansea Bay University Health Board	33	134	25%
Total	**274**	**918**	30%

Ombwdsmon
Ombudsman
Cymru • Wales

Information Sheet

Appendix A shows the number of complaints received by PSOW for all Health Boards in 2022/23. These complaints are contextualised by the number of people each health board reportedly serves.

Appendix B shows the categorisation of each complaint received, and what proportion of received complaints represents for the Health Board.

Appendix C shows outcomes of the complaints which PSOW closed for the Health Board in 2022/23. This table shows both the volume, and the proportion that each outcome represents for the Health Board.

Appendix D shows Intervention Rates for all Heath Boards in 2022/23. An intervention is categorised by either an upheld complaint (either public interest or non-public interest), an early resolution, or a voluntary settlement.

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

Bloc 5, Llys Carlton, Parc Busnes Llanelwy, Llanelwy, LL17 0JG

Block 5, Carlton Court, St Asaph Business Park, St Asaph, LL17 0JG

Michelle Morris,
Public Services Ombudsman for Wales,
1 Ffordd yr Hen Gae,
PENCOED,
Cardiff,
CF35 5LJ

Sent via email to:
Matthew.Harris@Ombudsman.wales

Ein cyf / Our ref: CS/EH(CE23/1310)
☎**:** 03000 852633
Gofynnwch am / Ask for:
Quality Assurance and Regulation Team
E-bost / Email:
BCU.Ombudsman@wales.nhs.uk
Dyddiad / Date: 5th December 2023

Dear Michelle,

Re: Ombudsman Annual Letter 2022/23

Thank you for your annual letter (2022/23) in respect of Betsi Cadwaladr University Health Board dated 17th August 2023. The Board and I value the strong relationship between our organisations. Your work continues to highlight the experiences of our patients and their families, and is a key contribution to our learning and improvement.

I note the actions you have outlined for the Health Board to take, and would like to update you on our considerations and proposed actions against each as requested:

1. **Present the Annual Letter to the Board and share any feedback from them with your office.**

   The annual letter will be received by the Board via the Quality, Safety and Experience Committee in December 2023. The Committee scrutinises our performance and outcomes in respect of patient experience and complaint handling. We are grateful for the information presented in your Annual Letter, which continues to assist us in monitoring the performance of complaints management within the Health Board.

2. **Update my office on how the Health board has complied with the recommendations in our report: Groundhog Day 2: an opportunity for cultural change?**

   I am pleased to confirm that as a Health Board we continue to make changes to ensure that we comply with the recommendations made in your report. Our aim is to learn from Ombudsman cases and to inform how we comply with the new Duty of Candour and Duty of Quality, to ultimately provide the highest quality of healthcare we can to our patients.

I can confirm our updated position is as follows:

- **Review the resources available to your complaints team**

The complaints team structure is currently under review to ensure that the Health Board has the adequate resource and capacity to support effective complaint management and resolution aligned to the Putting Things Right (PTR) Regulations.

As part of the Health Board's Special Measures Programme, an independent review has been undertaken in relation to patient and public engagement and a further review undertaken into patient safety. A review into quality governance is also due to start this month. Collectively these reviews will help us shape our approach to quality in the future, of which hearing and acting upon patient feedback and complaints will be a core component.

- **Review arrangements for accurately compiling complaints data**

To support with the arrangements of producing accurate complaints data which are consistently reported, the Health Board are currently implementing a Quality Dashboard which includes complaints. Whilst the dashboard is still in its infancy, it includes the minimum quality and safety data sets to be used consistently across the organisation. It also provides triangulation of key quality metrics and data, and enables us to compare our data at a national level. It is also key to the 'always on' reporting, in line with the Duty of Quality, and will help to drive learning and improvement.

A new Quality Informatics and Learning Team is in place. The team have recently produced a procedure for quality systems such as Datix and Civica which outlines our standardisation of data analysis, reporting and dashboards. The team are also working with colleagues across the organisation to develop our own organisational learning framework and approach to learning for the future. In August of this year, the team also introduced Great-ix (learning from excellence) which provides staff with the opportunity to report episodes of good practice and to celebrate the good work that takes place in the organisation.

Our complaints team have taken a proactive approach to data and work closely alongside our Quality Informatics and Learning Team and the Once for Wales Concerns Systems Team, to improve the accuracy of data and reporting.

- **Consider whether the option to provide staff investigating complaints with independent medical advice, is considered on a case by case basis**

As part of our redress process, we do as a Health Board seek independent medical advice where required in order to provide an objective investigation. This is done in-line with the PTR Regulations and Welsh Risk Pool processes. We provide a weekly

Putting Things Right Clinic led by our in-house Healthcare Law Team and the NHS Wales Legal and Risk Services to support Investigating officers with objectivity and legal advice on breach of duty and harm.

- **Reflect upon the lessons highlighted in the report when scrutinising performance on complaint handling**

We have increased scrutiny in our quality assurance process for complaints, and have provided staff training on the duty of candour ensuring that the duty is explained at every opportunity when raising a complaint. An information resource on the duty is available on our intranet.

In cases which require early intervention or an opportunity to discuss resolution on a face to face basis, support is provided by the Patient Advice and Liaison Service (PALS) or the Patient and Carer Experience Team.

Llais advocacy services have been invited to our patient experience and complaints training, job interviews, and to work with us in co-production on the service delivery plan for the Patient and Carer Experience Department.

We have reflected on the wording in our investigation reports to ensure that the complaint responses are empathetic and compassionate.

We continue to report on our progress against the recommendations in your report for oversight and monitoring, to our Patient and Carer Experience Group and Patient and Carer Experience Department Business Meeting.

3. **Continue to engage with your Complaints Standards work, accessing training for staff, fully implementing the model policy, and providing complaints data.**

The Health Board has received a number of training sessions from your Complaints Standards Authority (CSA) team, most recently in September 2023, which focused on training for senior clinical staff. This was well received. The information presented to our staff reminded them of the opportunities available to us for earlier intervention and resolution for our patients and their families as we appreciate the time it takes to further investigate their concerns and the impact that this has on them.

We are liaising with your CSA team to arrange future sessions for all our staff across the health board and welcome your support with raising awareness of your role, how your organisation operates and most importantly, how your work can inform our learning and improvement as an organisation and support us to deliver higher quality healthcare. PSOW training will continue to be part of our regulatory training programme.

Our Deputy Director of Quality, and Quality Assurance and Regulation Team, meet quarterly with Matthew Harris and Lowri Russell from your office. These meetings continue to be key to ensuring that our respective data positions align accurately, particularly for annual reporting purposes, and that we continue to respond to your requests in a timely manner.

I am also pleased to hear that our Health Board continue to perform above the PSOW variance to target which is your measure of how health boards perform against the target dates to provide evidence to comply with the recommendations you make to us.

This year we introduced a Regulatory Assurance Group which, is chaired by our Executive Director of Nursing and Midwifery. The group oversees regulatory compliance which includes PSOW, and provides an opportunity for support and escalation to our executive team. This has had a positive impact our organisational awareness of PSOW and our obligations, and has led to improvement with compliance and has also informed changes to our internal process for PSOW; from how we work with our staff to how we track and monitor performance and compliance.

We continue to review both our complaints process and our PSOW process, and look forward to working with your office to inform any future changes we make.

4. **Inform me of the outcome of the Board's considerations and proposed actions on the above matters by 30 September.**

I hope my response considers and addresses the points in your annual letter. I will of course update you on any further outcome of the Board's considerations following the annual letter being received at the Quality Safety and Experience Committee in December.

In addition, we are currently developing a proposal to establish an Investigations and Learning Team which will initially undertake a retrospective review of significant cases over the last 6 years, to ensure our investigations, action plans and evidence of improvement is of an acceptable standard. This may include cases which patients have brought to you. In doing this work we will be fully mindful of your independent nature and our obligations and the exemptions under PTR. This work is principally to give us assurance that we have conducted rigorous reviews leading to learning and improvement, and the findings of your reports to the Health Board on our complaint handling processes will inform this work and the standards we will assess ourselves against. The learning from this work will lead to future improvements in our processes including the complaints process.

I would again want to reiterate how much the Board values the relationship with your office, and we particularly thank you for the support from your Complaints Standards Authority Team.

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

We are continuing to improve our approach to complaints handling in order to enhance the experience of our patients and their loved ones, and we look forward to continuing to work with you and your team.

Yours sincerely

Dyfed Edwards
Cadeirydd / Chair

c.c Carol Shillabeer, Chief Executive
Dr Nick Lyons, Deputy Chief Executive, Executive Medical Director and executive lead for PSOW
Matthew Joyes, Deputy Director of Quality Governance

Teitl adroddiad: ***Report title:***	Central IHC – QSE Deep Dive			
Adrodd i: ***Report to:***	QSE			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 22 February 2024			
Crynodeb Gweithredol: ***Executive Summary:***	Overview of current position in relation to Quality and Safety – Central IHC			
Argymhellion: ***Recommendations:***	N/A			
Arweinydd Gweithredol: ***Executive Lead:***	Angela Wood, Executive Director of Nursing and Midwifery			
Awdur yr Adroddiad: ***Report Author:***	Simon Newman, IHC Central Director of Nursing Libby Ryan-Davies, IHC Central Director			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☐ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***				
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	e.e. Yr Awdurdod Gweithredol Iechyd a Diogelwch			

	e.g. Health and Safety Executive
Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqlA been identified as necessary and undertaken?***	Do/Naddo *Y/N* Os naddo, rhowch esboniad yn ymwneud â'r rheswm pam nad yw'r ddyletswydd yn *berthnasol* *If no please provide an explanation as to why the duty does not apply* Gweithdrefn ar gyfer Asesu Effaith ar Gydraddoldeb WP7 *WP7 Procedure for Equality Impact Assessments*
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?***	Do/Naddo *Y/N* Os naddo, rhowch esboniad yn ymwneud â'r rheswm pam nad yw'r ddyletswydd yn *berthnasol* *If no please provide an explanation as to why the duty does not apply* Gweithdrefn WP68 ar gyfer Asesu Effaith Economaidd-Gymdeithasol. *WP68 Procedure for Socio-economic Impact Assessment.*
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)***	(crynodeb o'r risgiau a rhagor o fanylion yma) (summarise risks here and provide further detail)
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	(crynodeb o sut mae'r papur wedi cael ei adolygu, yr ymateb a pha newidiadau a wnaed ar ôl cael adborth)

	(summarise where the paper has been reviewed, the response and what changes have made due to feedback)
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Amherthnasol Not applicable
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** ***Implementation of recommendations***	
Rhestr o Atodiadau: Dim ***List of Appendices:*** *Presentation – Appendix 1*	

Central IHC
QSE Deep Dive

20.02.24

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

GOVERNANCE

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

Quality and Safety Governance Structure

ACHIEVEMENTS

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

- Holywell Hospital - Improvement Project
- Childrens Services – Neonatal Lactation Consultant
- Abergele Hospital - Glaucoma Advanced Nurse Practitioner
- Morfa ward Llandudno Hospital – successful HIW inspection
- YGC ED – Dog Bite Pathway
- ICU YGC – ‘what good looks like’

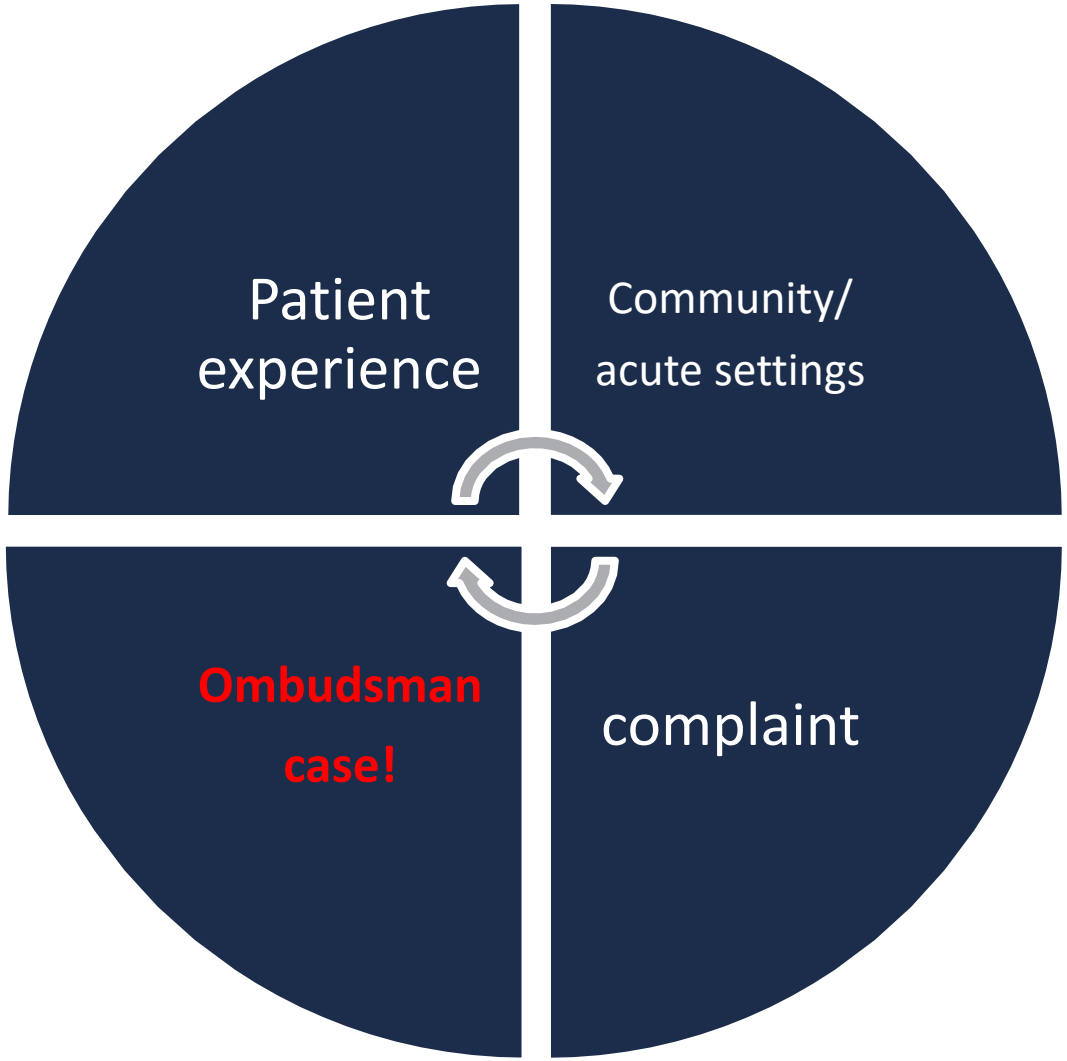
Patient Story

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

Preservation of dignity

Poor communication

Lack of follow-up



If the **learning** is not **embedded**, the cycle will repeat

QUALITY INDICATORS

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

JANUARY 2023

Inquests

HAPU

Falls

Overdue complaints

NRIs

LFERs

Medication Incidents

Infection Prevention

Ombudsman cases

FEBRUARY 2024

Overdue complaints

Falls

Inquests

Medication Incidents

Ombudsman cases

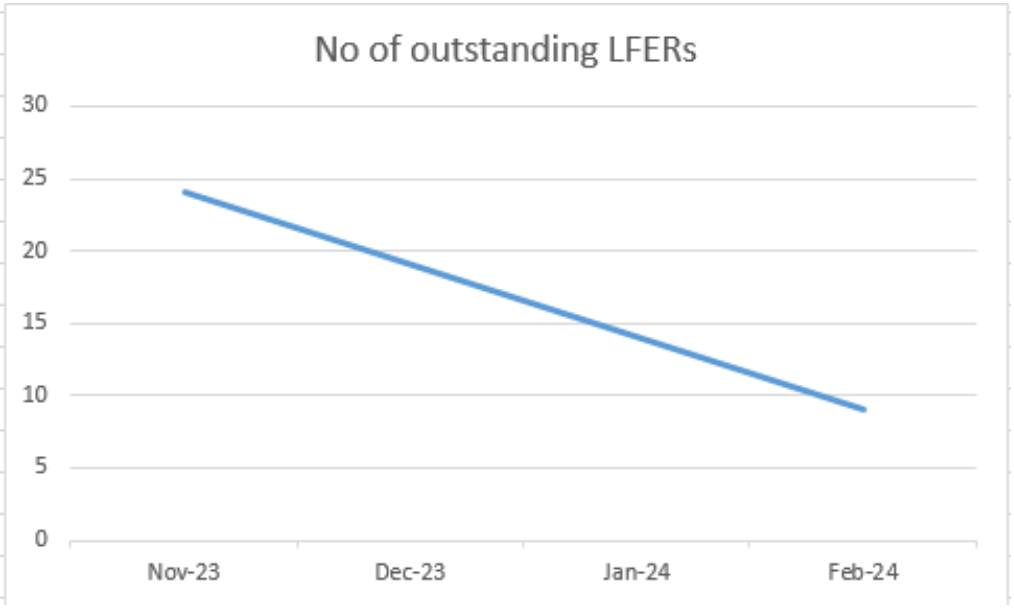
NRIs

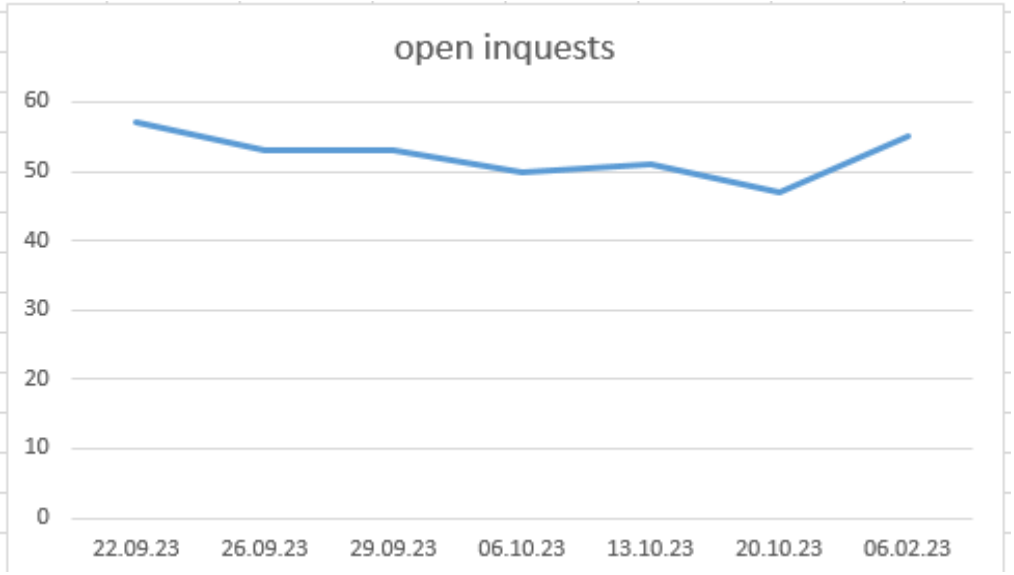
HAPU

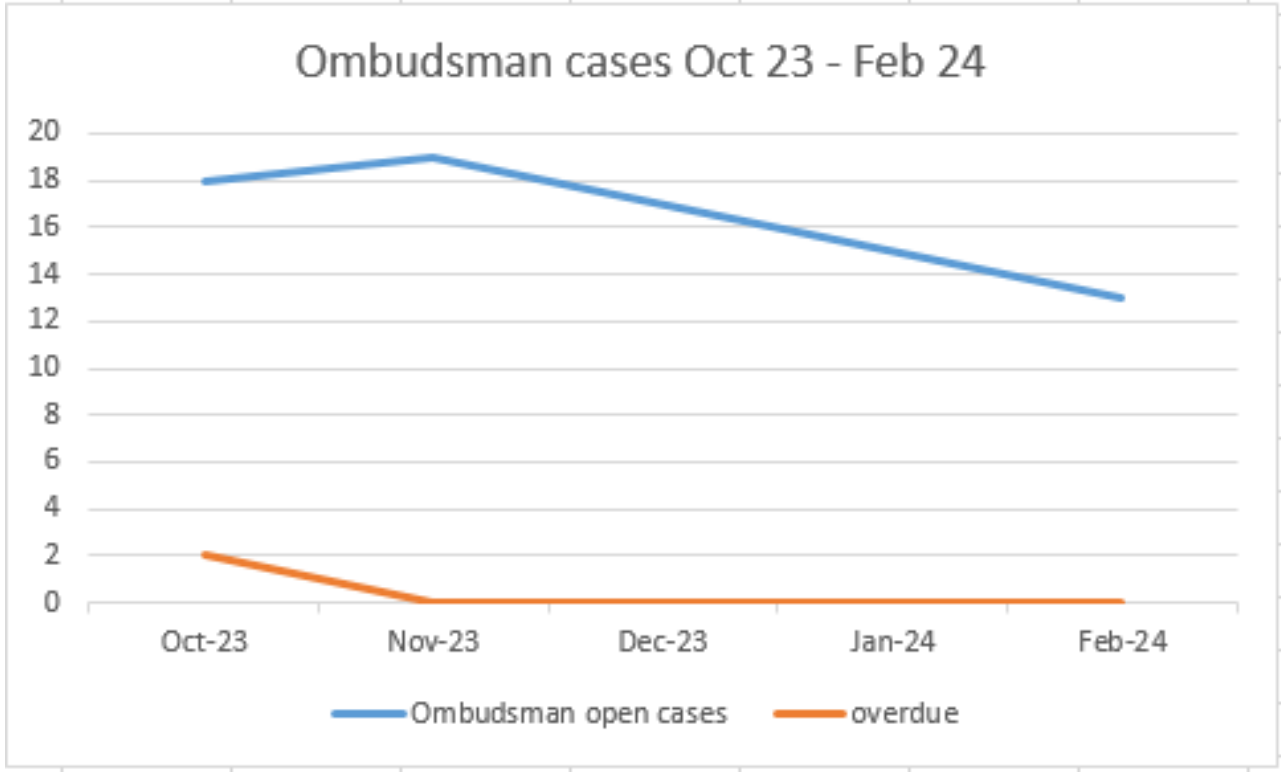
Infection Prevention

LFERs

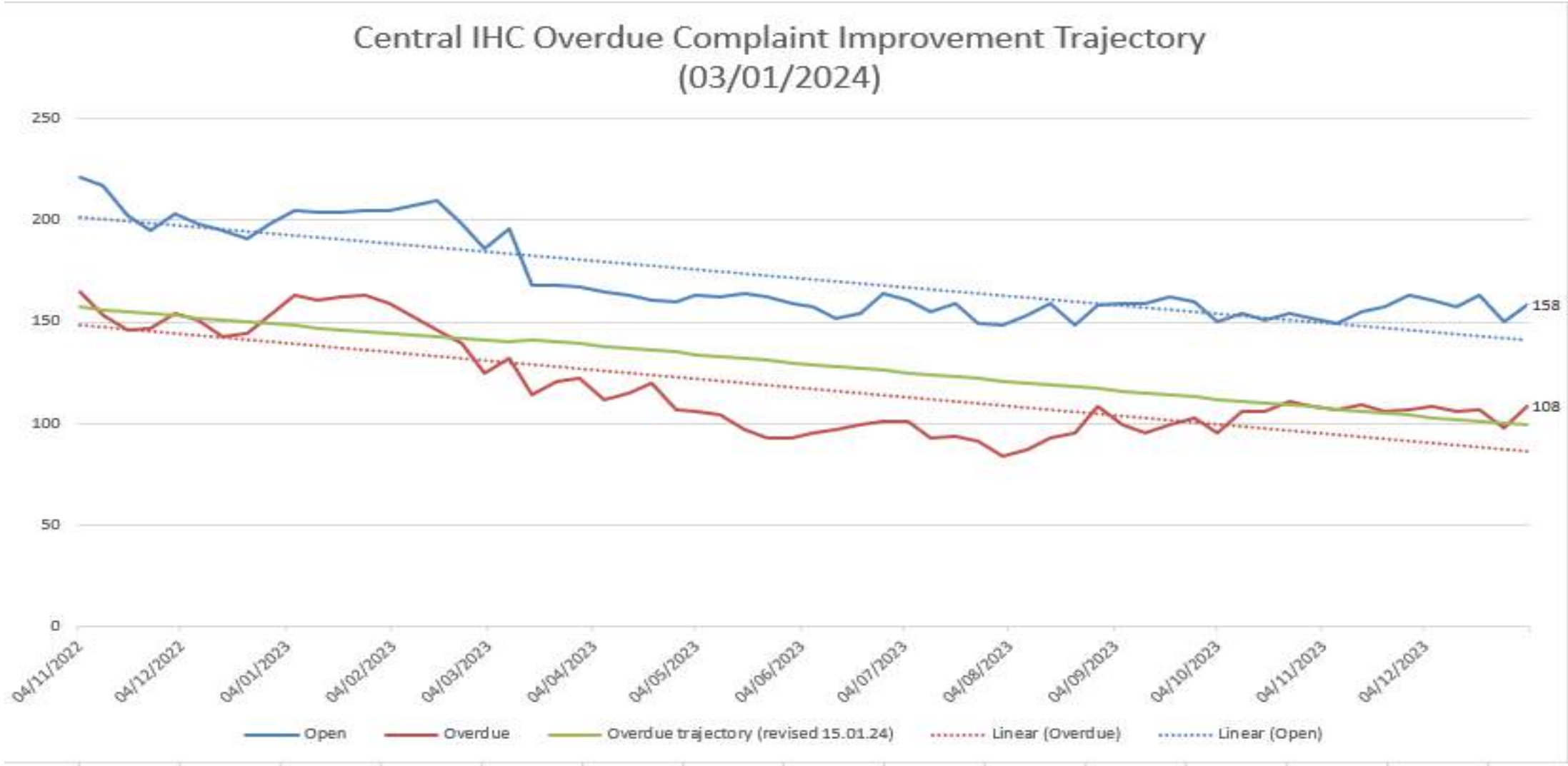
We have focused primarily on the quality indicators that are overdue and have a reputational and financial risk for the organisation – Ombudsman cases and Welsh Risk Pool and Coroner.







Overdue complaints Trajectory



CONTINUING AREAS OF CONCERN

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

- Managed Practices
- YGC ED – HIW
- Vascular Services
- NWAS – environmental challenges

Teitl adroddiad: ***Report title:***	**Adult Inpatient Healthcare Acquired Pressure Ulcer (HAPU) Deep Dive**			
Adrodd i: ***Report to:***	PRIVATE Quality Safety and Experience Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Click here to enter a date.			
Crynodeb Gweithredol: ***Executive Summary:***	This report provides an overview of the work being undertaken to address the incidence of Hospital Acquired Pressure Ulcer (HAPU) in the organisation. It identifies the areas of work being undertaken and actions that form the Improvement Plan developed. Increased resources and attention to this area demonstrates the Boards commitment to addressing and how it is striving to reduce the incidence and related harm.			
Argymhellion: ***Recommendations:***	To note the report and receive future information of incidence and progress against plans.			
Arweinydd Gweithredol: ***Executive Lead:***	Angela Wood, Executive Director of Nursing and Midwifery			
Awdur yr Adroddiad: ***Report Author:***	Angela Wood, Executive Director of Nursing and Midwifery			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☒	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☐	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☐ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☒ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				
The improvement work and related timescales are included in the paper at: • Section 4 - Current Position • Section 6 - Opportunities for Improvement				
Cyswllt ag Amcan/Amcanion Strategol:	Duty of Quality, Health and Social Care (Quality and Engagement) (Wales) Act 2020.			

Link to Strategic Objective(s):	
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	Instances of harm to patients may indicate failures to comply with the NHS Wales Health and Care Standards of health and safety legislation.
Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqlA been identified as necessary and undertaken?***	N/A
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	N/A
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR)***	No current risks within the tier 1 risk registrar
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	Potential additional resources required across the Health Board to accelerate improvements in line with HAPU Improvement plan and to reduce harm from HAPU
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	There will be additional resources/ refocused resources required across the Health Board to accelerate improvements in line with Pressure Ulcer Improvement Plan
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	N/A
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	N/A
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** ***Continued implementation of recommendations of HSE Notice of Contravention***	
Rhestr o Atodiadau: ***List of Appendices:***	

Healthcare Acquired Pressure Ulcers (HAPU) Deep Dive
February 2024

1. Background

Pressure ulcers are among the most commonly reported safety incidents within in the Health Board and to Welsh Government. They represent a major burden of sickness and reduced quality of life for individuals, their carers and families.

The identification of underlying risk factors together with evidence based interventions to reduce their impact has been shown to reduce the incidence of Healthcare Acquired Pressure Ulcers (HAPU). The use of these interventions to reduce the incidence of HAPU is challenging. Success requires a multi-disciplinary safety culture in order to nurture vigilance and appropriate management intervention to do the right thing in the avoidance of avoidable pressure damage in all staff at the patient interface. Strong leadership coupled with organisational oversight will support this, with evidence based resources and clear, unambiguous measurement of performance in order to improve patient safety.

Preventing HAPU is everyone's business; doctors, nurses, allied health professionals of all grades and disciplines have an important role to play in preventing the resulting harm from pressure ulcers

2. Organisational Context

In demonstrating the Health Board commitment to quality and patient safety in reducing the incidence of healthcare acquired pressure ulcers, the HAPU Strategic group was established in April 2022, to supervise local improvement programs in line with the strategic improvement plan which identified a trajectory of elimination of avoidable HAPU and 50% reduction in all HAPU.

Meetings seek assurance from all Integrated Health Communities (IHCs) and Divisions in reporting from local HAPU harm meetings, outlining themes and trends from HAPU incidents with any breach in management of HAPU or best practice noted, to improve underpinning knowledge of common themes and to ensure remedial actions are established within areas. Agreed membership of local Harm groups include Heads of Nursing, Tissue Viability Nurses (TVNs), Safeguarding and Governance alongside matron and ward managers.

The IHCs weekly Harms meeting offers an opportunity to review all aspects of both good practice and areas for learning; the function of each IHC group is to oversee the progress of the quality improvement priority for HAPU, to allow for a focused review and identify opportunities of learning. Currently, the data for the numbers of reported HAPU is gleaned via patient safety software 'Datix'.

Incidents relating to all HAPU shows 7397 were reported April – December 2023. This includes reported related to patients admitted with pressure ulcers/damage.

The clarification of avoidable HAPU reported from the local HAPU groups for the same period has shown some improvement variation but it still remains relatively static.

Aspects of HAPU development which would constitute being it 'avoidable' include:

- Lack of risk assessment (not completed in a timely manner)
- Inappropriate support surface (pressure mattress)
- Gaps in intentional rounding
- Completion of documentation.

Data cleansing within Datix is required to extract incidents which have not received full and sufficient investigation to provide a full themes and trend analysis

3. Pressure Ulcer Management

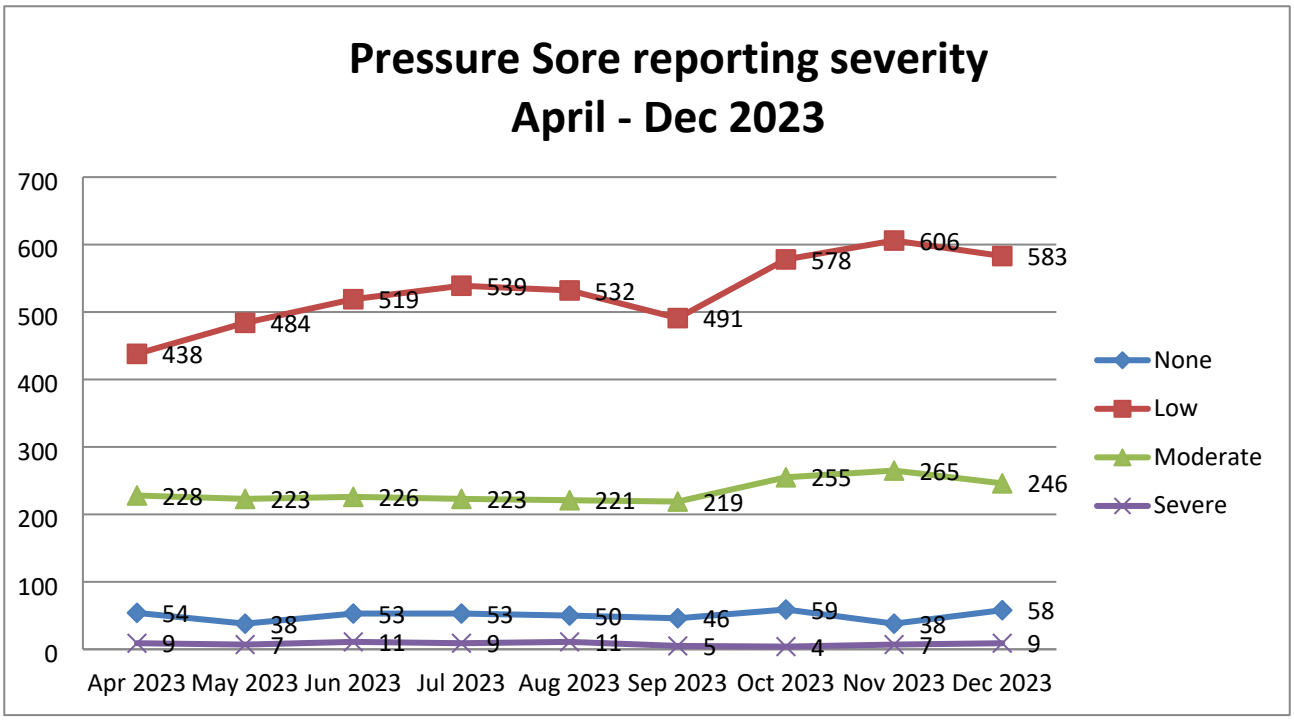
The HAPU collaborative was established within clinical areas prior to the Covid pandemic. This provided an opportunity for teams to identify their themes requiring improvement via focused self-assessment tools and utilisation of quality improvement tools and techniques.

This has continued through the HAPU delivery plan self-assessment, enabling areas to review themes and opportunities for learning and development concerning pressure ulcers. Completion of and return of the self-assessment to the HAPU lead nurse and strategic group is low overall. NB: The weekly and monthly audit can assist managers to provide indication of compliance of care delivery to patients at risk which may precipitate further deterioration of pressure ulcers

Analysis of the reported HAPU data across all IHCs and Divisions demonstrates common themes which include:

- Delays in moving patients into the Emergency Departments in times of increased demand, repositioning patients in ambulances becomes problematic
- Sourcing of pressure relieving mattresses in a timely manner
- Delay Tissue Viability Nurse (TVN) referral
- Purpose T (Risk assessment) completion
- Variation in the correct classification of pressure ulcers NB: medical photographs are required as part of the TVN referral

Analysis of the HAPU dashboard for reporting pressure ulcers through the recording in Datix indicates there is a level of education required for clinical staff in the reporting of Grade 3 (and above) pressure ulcers as ‘Low harm’. A traffic light system guide has been developed in order to raise staff awareness of this issue. A data cleansing exercise is currently progressing in order to align incident reporting at the correct level for appropriate review



A daily review of Datix within the IHCs and Divisions with Heads of Nursing and Matrons allows insight into the HAPU incidents reported enabling an initial review within the target timescale of 24 hours of reporting and a focused review within 72 hours as per NU03 Prevention and management of Pressure Ulcer protocol. This will aim to improve risk identification for the patient, highlights interventions required to reduce HAPU deterioration in line with the objectives of the improvement plan.

The Health Board Incident Learning Panel (ILP) provides a review of the HAPU incidents reported as nationally reportable Incidents (NRIs) linking some frequently reported issues where level of assurance from the evidence provided of action taken is minimal.

The HAPU lead nurse is currently addressing these with the overarching improvement plan, in addition to attendance at each of the HAPU meetings on each site and communication with the Nurse Directors/Head of Nursing where action is required

The Health Board *Purpose T* (assessment tool) eLearning is a platform provided to all clinical staff as a means of refreshing learning; Training is accessible through the Electronic Staff Record (ESR) and although not currently mandated, ward managers attending the harms meeting have advocated their staff to complete this, although there is no evidence available of current compliance. The *Purpose T* risk assessment is now aligned with nursing risk assessments onto Welsh Nursing Clinical Record (WNCR) thus enabling completion within the required timeframe. Failure to complete risk assessments within the first six hours of admission into a clinical area is frequently identified as a theme in avoidable HAPU developing.

The HAPU lead nurse attends all weekly IHC Harms review meetings and has advised that all nursing and Health care staff revisit this risk assessment training alongside the WNCR training to refresh and establish an understanding to reduce the non-compliance of completion and updating records as required.

Overall, in terms of quality, accuracy and documentation of interventions implemented in pressure area care plans and risk assessments, some areas require further support to achieve the objectives identified within the HAPU improvement plan

4. Context and Background to current position:

January 2015: NUO3 Prevention and Management of Pressure Ulcer Protocol first made operational this has been reviewed periodically and changes made as below:

- 25/01/2019
- 01/12/2022
- 24/05/2023
- 05/06/2023

April 2022: Health Board Strategic Group, to supervise local HAPU improvement programs, was established with the formulation of the Pressure Ulcer Improvement plan. Membership was agreed and HAPU leads identified across all areas.

July 2023: NU38 Standard Operating Procedure (SOP) to Promote Patient Co-operation and Self-Management to Reduce the Risk of and Treat/Manage Pressure Ulcers became operational.

September 2023: HAPU Lead Nurse appointed in secondment position for 6 months until March 2024.

October 2023: ESR data analysis focusing on *Purpose T* (pressure ulcer risk assessment) completion across the Health Board. However, it was not possible currently to establish the total compliance figures.

Additional ESR learning modules (e.g. pressure ulcer prevention) indicate a small percentage of staff have enrolled and completed. These modules have been shared with ward managers since reviewing this data to encourage completion.

The HAPU Lead Nurse and Tissue Viability lead has requested consideration to be given to a standardised training package that would encompass all elements of pressure ulcer care and management.

November 2023: Identification that medical photographs are inconsistently used for classification/deterioration of HAPU.

Discussion with WNCR programme leads as to the possibility of uploading these to WNCR: This is not currently feasible. IHC West have addressed the issue and now have all ward areas equipped with access to cameras and there has been an increase in compliance of obtaining medical photograph when reporting pressure ulcer from these areas. This is being explored by the other IHCs. Clinical staff must correctly classify the grade of pressure Ulcers as part of the TVN referral, this would make the use of photographs invaluable**.**

A TVN Task and finish group will formulate guidance to ensure all IHCs/Divisions will follow due process to ensure pressure ulcers are photographed and correct classification is promoted.

December 2023: A scoping exercise of dynamic mattress storage/accessibility has been completed which shows there is little or no storage on the acute sites for pressure relieving mattresses to enable timely patient transfer on to the appropriate support surface.

Factors include increased patient demand and escalation areas utilised to support each site. There is no evidence of an established process across the Health Board for acute areas to escalate to obtain mattresses.

This is being addressed by the newly established Bed and Mattress steering group, chaired by the Executive Director of Nursing and the Infection Control team.

January 2024: Tissue Viability Nurse (TVN) referrals (Incident thematic review): The HAPU Lead Nurse is currently working with the Quality Team in implementing a trial of a prompt for TVN referral/review on Datix. So when an incident is reported as moderate and above, it will notify the TVN and administration team. Development is being progressed through a Task and Finish Group. A request has been submitted to Once for Wales (OfW) concerns management system to implement in February 2024.

5. Current Position

The monthly ward manager and matrons audits allows oversight of compliance of pressure ulcer prevention and interventions within the Harm Free care electronic system questions, with 1 to 5 being specific to pressure ulcer risk assessments This allows for an overview of compliance and areas where improvements are required.

Agency and bank workers compliance with E learning modules is a challenge to monitor and implement. All bank workers complete Health Board mandatory training as part of their induction programme as they have a formal contract with the Health Board. The *Purpose T* risk assessment could be aligned to this enabling them to have the correct level of understanding in pressure ulcer prevention and treatment and this is being explored. Agency staff training and compliance proves more challenging to ensure it's undertaken and compliance due to individual contracting across agencies

6. Compliance Data

The development of a quality dashboard, which includes the *Purpose T* risk assessment is now completed as part of the Welsh Nursing Care Record, this dashboard will provide compliance with completion of all Adult Inpatient risk assessment but will not identify the quality of completion and interventions. This qualitative data would need to be captured via audit. Later plans will be the development of the repositioning chart onto the dashboard which will provide data on the frequency of repositioning of patients aligned to their risk of pressure ulcers.

Plans for the TVN team to recommence review of the HAPU delivery plan self-assessment on a quarterly basis are progressing led by the HAPU lead nurse, which will enable the team to audit learning requirements within areas and focus on areas of specific within their training sessions.

The TVN team are to also completing a review of Practice Development Nurses teaching to align consistent delivery of current All Wales Tissue Viability training when providing support to specific areas within the IHC.

The HAPU Lead nurse has disseminated the policy NU38 across all IHC and Divisions along with the All Wales Patient Information leaflets, which are now available in all areas for all patients. This encourages a person-centred approach to involve the patient in the continuum of shared decision making about their treatment in regards to pressure ulcer prevention and treatment and the consequent health outcomes, and to negotiate further progress. This will also aim to encourage empowerment and patient expertise, to promote self-management and co-operation with patients and their prescribed treatment plans, to reduce the risk treat and manage pressure ulcers towards an agreed outcome

7. Staff Education:

As there is no current Mandatory Tissue Viability training (pressure ulcer prevention, care and treatment) across the organisation. There is a training package, which addresses all aspects of TV but this non-mandatory. There are also some ESR modules that are in use alongside Purpose T training.

In addressing this in the short term, the TVN along with the HAPU lead nurse are re-developing the Tissue Viability intranet page. This will be a repository for validated training videos, education packages etc. which will be accessible and enable all staff to access. The site will also include guides to the process reporting of HAPU.

Tissue Viability referrals are increasing and greater demand on the service of a small team, HAPU prevention and treatment is one part of the role alongside other areas of wound care.

In aiming to mitigate against this and support the clinical teams the following actions are in place:

- Training sessions have been organised for link nurses, however this is poorly attended and increased focus and importance needs to be attributed from the IHCs
- Implementation of the Ward Champions framework to enable staff to attend sessions - Our Champions will play a vital role in engaging and working alongside TV team
- Learning Improvement Programme which will cover the four main reported harms incidents
- Review of the Tissue Viability Service referral process to ensure timely review.

7. Conclusion

There is a significant amount of work being undertaken across BCU to address what is one of the biggest harms the Health board encounters. Increased focus and resource has been aligned to the work in the last 12 months and a comprehensive improvement plan developed.

Going forward the rates and harm profile will be scrutinised by QSE as part of the quality dashboard and updates on completion of the plan will be given as part of future Patient Safety, Experience and Effectiveness papers.

Teitl adroddiad: ***Report title:***	Board Assurance Framework			
Adrodd i: ***Report to:***	QSE			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Tuesday, 20 February 2024			
Crynodeb Gweithredol: ***Executive Summary:***	The purpose of this report is to provide QSE Committee with information and assurance of the management of four Board Assurance Framework risks identified, as a requirement of a completed Board Assurance Framework (BAF) but in relation to the 23/24 Annual Plan Organisational Deliverables. The report evidences movement in the BAF risk scores reflecting an improved focus from Risk owners and the Risk Management Team			
Argymhellion: ***Recommendations:***	The Committee is asked to note and **receive assurance** on the management of four BAF risks to which it has oversight of..			
Arweinydd Gweithredol: ***Executive Lead:***	Phil Meakin, Acting Board Secretary			
Awdur yr Adroddiad: ***Report Author:***	Nesta Collingridge, Head of Risk Management			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☒	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: BAF risks to be reviewed and aligned to Objectives				

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):***	Appendix 2 -BAF highlights the link between Tier 1 risks and CRR.
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	It is essential that the Board has robust arrangements in place to assess, capture and mitigate risks, as failure to do so could have legal implications for the Health Board.
Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqlA been identified as necessary and undertaken?***	N/A
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary ben undertaken?***	N/A
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	CRR and BAF paper prepared for committee
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	The effective and efficient mitigation and management of risks has the potential to leverage a positive financial dividend for the Health Board through better integration of risk management into business planning, decision-making and in shaping how care is delivered to our patients thus leading to enhanced quality, less waste and no claims.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	N/A
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	BAF risks approved by Executives as the lead for the risk
Cysylltiadau â risgiau BAF:	BAF paper which further links Tier 1 and CRR.

(neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	N/A
Camau Nesaf: ***Next Steps:*** 1. Corporate Team to monitor and escalate any new BAF risks to Executives for review. 2. Align the BAF with the Strategic Objectives of the Health Board upon approval by the Board	
Rhestr o Atodiadau: ***List of Appendices:*** Appendix 1- BAF Risk Overview Appendix 2 - QSE BAF Risk Reports	

Introduction/Background

1. The purpose of the Board Assurance Framework (BAF) is to inform and assure the Board with controls and action plans for identified high-extreme risks that relate to any possibilities of not delivering on the Annual Strategic Priorities of the Health Board. The Committee is asked to note that work is now underway to develop "Strategic Objectives" and these will replace the "Annual Strategic Priorities" when they are approved by the Board. This report only considers BAF risks that the QSE Committee has oversight of. Further to feedback received at the Health Board meeting of the 25 January 2024 a clearer summary table of BAF risks has been produced in collaboration with the Audit Chair and the Risk Management Team.

   Where risks are deemed to be high or extreme a risk report (Appendix 2) outlines controls/mitigations and action plans in relation to ensuring deliverable of the plan.

   In the last iteration of this report on the 19/12/23 QSE received 4 strategic priorities risks which scored as high:

   SP1-Prevention and Health Protection
   SP5-Cancer
   SP9-Women's
   SP18-Quality Innovation and Improvement

Since the previous report all deliverable points have been reviewed and progress is being made across three of the four priorities to reduce the risk.

Three risks are being recommended to the Executive Team on 14 February2024 for being moderated down and an update on this can be provided at the meeting

SP1- Prevention and Health Protection- Progress is delayed but most actions now completed. Score revised now from 15 to 12, so no longer a high risk and can be reviewed for closure from the Board Assurance Framework (scores 15>).

SP9- Women's Services- remains to have an 'Amber' Delivery Confidence with multiple proposed delays from Q2/Q3/Q4 to Q1/Q3/Q4 (23/24). 1 action completed, 2 Amber, 2 Red. Progress is delayed but most operational actions now completed. Score revised now from 16 to 12, as likelihood is now a 3 so no longer a high risk and can be reviewed for closure from the Board Assurance Framework (scores 15>).

SP18-Quality Innovation and Improvement -Score reduced from 25 to 20.There are still several actions delayed but delivery confidence is now positive.

One strategic deliverable plans where scores remain the same.

SP5- Cancer -Most actions completed however delay of significant action around funding to improve pathways meaning non-compliance with National standards. Score remains at 20.

Summary

QSE is asked to receive assurance on the management of all four identified high risks to which the Committee has oversight for.

Appendix 1 – BAF Risk Overview.

Appendix 2- BAF Risk Reports
SP1-Prevention and Health Protection
SP5-Cancer
SP9-Women's
SP18-Quality Innovation and Improvement

Next steps

1. BAF risks to be received regularly at Risk Management Group and Executive Team in line with the Committee cycles.
2. Ongoing monitoring of risks in relation to the Annual Plan Strategic Deliverables until the Strategic Objectives are approved by the Board.
3. Risk scores for all to be monitored and Board to be provided with full BAF risk report.

Appendix 1- Strategic Priority Risk scoring further highlights progress.

Appendix 2 - QSE BAF Risk Reports

Appendix 1 - Strategic Priority Risk scoring and progress.

Title	Executive	Score	Revision	Annual Plan Analysis	Risk Management Commentary
Strategic Priority P1 Prevention and Health Protection	Executive Director of Public Health	12	↓	Overall 'Amber' Delivery Confidence With 2 priorities delayed from Q3 to Q4 (23/24). 6 actions completed, 2 Amber, 1 Red.	Risk score moderated down as most actions completed.
Strategic Priority P5 Cancer	Executive Director of Operations	20	↔	Overall 'Amber' Delivery Confidence With 1 priority delayed from Q3 to Q1 (24/25). 3 actions completed, 2 Amber, 0 Red.	Delivery Confidence to be monitored and risk updated accordingly
Strategic Priority P9 Women's Services	Executive Director of Operations	12	↓	Overall 'Amber' Delivery Confidence With delays from Q2/Q3/Q4 to Q1/Q3/Q4 (23/24). 1 action completed, 2 Amber, 2 Red.	Likelihood reduced from 4 to 3 changing the overall score from a 16 to a 12. Several Operational actions completed and red actions to be rolled over but confidence has increased.
Strategic Priority P18 Quality, Innovation and Improvement	Executive Director of Nursing and Midwifery	20	↓	Overall 'Green' Delivery Confidence with 1 action delayed from Q3 to Q4 (23/24). 0 actions completed, 0 amber, 0 red. 6 actions remain underway and on track for delivery at the end of Q4 at which time the risk score will be reviewed."	Risk score has been subsequently been reduced from 25 to 20. Reconsider impact of 5 in following iteration of report and provide rationale if remains.

Appendix 2

<table>
<tr><td rowspan="4">BAF
Prevention and Health Protection</td><td colspan="2">Executive: Executive Director of Public Health</td><td>Date Opened: March 2023</td></tr>
<tr><td colspan="2">Committee: PPPH (Quality, Safety and Experience Committee)</td><td>Date Last Reviewed: 8th February 2024</td></tr>
<tr><td>Strategic Priority:
SP1</td><td>Link to CRR: Population Health
Link to Tier 1's: 4200/4201/1642</td><td>Committee Review Date: 19/12/2023</td></tr>
<tr><td></td><td></td><td>Target Risk Date: 31 March 2024</td></tr>
<tr><td colspan="4">There is a risk that the Health Board fails to adequately plan for and deliver improvement of population health and reduce health inequalities. This may be caused by a lack of provision for sustainable services and targetted programmes of activity, and capacity, financial and resource constraints within the Health Board. This may contribute to poorer health outcomes and widening inequalities alongside increasing demand on services across North Wales.</td></tr>
<tr><td>Mitigations/Controls in place</td><td>Gaps in Controls</td><td colspan="2">Current Risk Score</td></tr>
<tr><td>1. Population Health Exec Delivery Group (PHEDG) provides strategic direction and monitors delivery of the Population Health Services.
2. There are a number of key strategy documents specific to local needs developed with partners e.g. including weight, smoking, infant feeding, mental health and wellbeing, immunisations and reducing alcohol intake.
4. Integrated Health Community plans reflect local priorities based on data and evidence.
5. Population Needs assessment informs local planning.
6. Progress reports to Public Health Wales (PHW) in regard to activity funded by PHW and links to national programmes of work.
7. Progress reports to Arts Council of Wales in regard to activity funded by Arts Council.
8. Building a Healthier North Wales Partner Network meets three times per year to share learning and develop network.
9. Engagement and contribution to Regional Partnership Group.
10. Engagement and contribution to Public Services Boards.
11. Strategic partnership with Actif North Wales.</td><td>1. In order to implement a system wide approach, it is necessary for commitment from partners wider than the Health Board to prioritise the implementation of evidence informed practices and proposals.
2. Inadequate resources and multiple constraints including finance.
3. System wide change cannot be implemented within 1-3 years as is well documented through evidence and research.
4. Prevention, health inequalities, improving health and wellbeing should be strengthened through integration into all planning and decision making frameworks, with sufficient weighting.
5. Robust intelligence and data availability at local level to support planning and decision making
6. Executive Director of Public Health tenders notice to step down.
7. Public Health funding provided by the Health Board is subject to RIGA which</td><td colspan="2"><table><tr><td>Impact</td><td>Likelihood</td><td>Score</td></tr><tr><td>4</td><td>3</td><td>12</td></tr></table>Quarter 3 activity:1. Help Me Quit Services are operational and have delivered the Tier 1 performance target.
2. Whilst there has been much activity both within the health board and with our partners, the recruitment to Smoke Free Environment Officers has been paused given the financial position within the Health Board for 23/24. This will be reviewed in line with any confirmed Prevention and Early Years funding made available by Welsh Government for 24/25 alongside the Public Health priorities and associated work plan.
3. Best Start area of BCUHB webpages (Preconception, Pregnancy, Early Years and Family) completely refreshed with almost 60 new pages developed in partnership with professionals, including new Preconception pages.
4. Good progress against the Healthy Schools grant funded plan with confirmed funding for 24/25
5. The Arts in Health Strategic Approach (3 years) was launched with partners in December 2023.
6. Arts in Health Projects are underway with a focus on Ty Llewelyn and Neuro-diverse children and progressing to plan with reporting to the funding</td></tr>
</table>

12. Regular meetings with Welsh Government in relation to Prevention and Early Years funded activity. 13. The Deputy Director of Public Health commenced in post (October 2023) 14. The Strategic Partnership Manager commenced in the seconded post (October 2023)	would have consequences on several programmes of work in 24/25.	organisation (Arts Council Wales and Baring Foundation). 7. ICL Programme continues progression within the constraints of financial position which has led to some of the initial deliverables within the business case being reviewed and revised. During Q3 ICL multi agency workshops took place across each of the local authorities as per the programme plan, with high profile attendees (Board members, Senedd members, Local Authority and Third Sector Board members). 8. Autumn 23/24 COVID Vaccination Programes are on track to complete in line with National Direction which closes on the 31st March 2024. The main delivery phase of the COVID vaccination programme is now complete, The Welsh average for delivery is 58.2% of the targeted cohorts, BCUHB is the 2nd best performing Health Board with 59.9% of eligible citizens vaccinated, only behind Powys.

Actions and Due Date
Continue to deliver in year actions which support the All Wales Tobacco Control plan including smoke free regulations
Continue to deliver in year actions which support the All Wales Weight Management Pathway
Commence implementation of the in year actions from the Arts in Health 3 year Strategic Plan 31st March 2024
Continue to implement the in year actions from the Infant Feeding Strategic plan
Share report and recommendations for service provision following Gypsy Roma Traveller needs analysis 31st March 2024
Together with partners and as part of the work of the Area Planning Board, implement the in year actions which support the Alcohol Strategy for North Wales 31st March 2024

Lines of Defence			**Overall Assessment**
1	**2**	**3**	

1. Local Public Health Team 2. Public Health Performance and Risk Management Group 3. Population Health Executive Delivery Group 4. Public Health Consultants attend Integrated Health Community Senior Meetings	1. QSE Board 2. PPPH Committee	1. Internal Audit	**Impact reduced from 5 to 4 meaning Score of 12,** multiple constraints including finance, impacting on risk of deliverables identified in the annual plan and failure to meet adequate levels of delivery across a range of targeted prevention and health improvement activities.

BAF SP5	**Executive:** Executive Director of Operations		**Date Opened:** October 2023
	Committee: Quality, Safety and Experience Committee		**Date Last Reviewed:** 08/02/2024
	Strategic Priority: **Cancer**	**Link to CRR:** Special Measures **Link to Tier 1's:** None	**Last Date Reviewed at Committee:** 19/12/23
			Target Risk Date: April 2024

There is a risk of failing to achieve the aims and actions outlined in the cancer strategic priority plan such as maintain access standards, further develop and implement the Cancer Strategic Plan for North Wales and implement immediate targeted actions to improve access in diagnostics and key specialities.

Mitigations/Controls in place	Gaps in Controls	Current Risk Score
These are measures/interventions implemented by the Health Board to reduce either the likelihood of a risk and/or the magnitude/severity of its potential impact were it to be realised. 1. Draft Cancer Strategy for North Wales developed by North Wales Cancer Partnership Board highlighting key challenges and resulting strategic aims for cancer for the next 5 years 2. Workstreams underway as part of Special Measures programme to support vulnerable services, including dermatology & plastics, urology and oncology 3. New services to improve cancer pathways in place via investment from the Performance Fund Suspected Cancer Pathway (SCP) allocation, including straight to test lung and neck lump pathways, rapid diagnosis clinics, additional breast cancer capacity and increase in tracking teams 4. Pathway reviews commenced to assess compliance with national optimal pathways for cancer and identify areas of improvement; prostate and colorectal reviews completed with breast and gynaecology underway	1. Cancer Partnership Board funding not secured – proposal to fund via Performance Fund SCP allocation but remains subject to Recurrent Investments Group for Assurance process. 2. Lack of operational plans to implement vision set out in the Cancer Strategy for North Wales; in particular no agreed model for services likely to require reconfiguration across IHCs including potentially colorectal, dermatology, urology, breast	Impact: 4 | Likelihood: 5 | Score: 20 Movement since last Qtr.: 3 actions completed, 2 Amber, 0 Red. However, 1 action in relation to funding (likelihood of 5) has impact on non-compliance with national suspected cancer pathway.

5. Service improvement work underway to implement streamlined pathways in dermatology, lung, gynaecology, colorectal and prostate cancer 6. Patients on suspected cancer pathway tracked and delays escalated; suspected cancer patients prioritised within available capacity	3. Lack of medical workforce in vulnerable services in particular urology, dermatology, oncology, gastroenterology and some specialist radiology posts 4. Service improvements funded via Performance Fund allocation vulnerable due to RIGA process 5. Lack of new funding to implement service expansion in line with demand, and further service improvements identified via pathway review work	

Actions and Due Date	
1. Present case for continued funding of Cancer Partnership Board to lead the implementation of the Cancer Strategy for North Wales as part of RIGA process.	**November 2023**
2. Present case for continued funding of service improvements via RIGA process.	**November 2023**
3. Complete work to secure vulnerable services as part of special measures programme.	**TBD**
4. Identify increased capacity to reduce current backlog of patients still active over day 62 on a suspected cancer pathway, in particular within dermatology.	**January 2024**

Lines of Defence			**Overall Assessment**
1	**2**	**3**	

Strategy monitored at North Wales Cancer Partnership Board Performance monitored at weekly corporate access meeting and local IHC performance meetings	Reporting line for North Wales Cancer Partnership Board to be confirmed Performance reported to Health Board's PFIG and Board	External scrutiny and support from Welsh Government and Wales Cancer Network.	Service improvements funded via Performance Fund allocation vulnerable due to RIGA (recurrent investments group for assurance) process where funding allocated in 2021 is under internal review. Likelihood of 5 remains, impact 4 due to **non-compliance with national** suspected cancer **pathway** due to current pressures within the dermatology service.

BAF SP9	**Executive:** Executive Director Operations		**Date Opened:** October 2023
	Committee: Partnerships, People and Population Health Committee		**Date Last Reviewed:** February 2023
	Strategic Priority: Women's	**Link to CRR:** Staffing/Financial Sustainability **Link to Tier 1's:** 4490/ 4773	**Last Date Reviewed at Committee:**
			Target Risk Date: April 2024

There is a risk of failing to effectively implement critical actions to improve maternity, neonatal, and women's health services and outcomes.

Mitigations / Controls in place	**Gaps in Controls**	**Current Risk Score**
1. Local Maternity and Neonatal Strategic Plan mapping exercise of the National programme and recommendations has been undertaken to identify actions and resource requirements against 31 'short-term' maternity actions and 6 'short-term' neonatal actions. 2. On-going engagement with Welsh Government (WG). NHS Executive commissioned to undertake Phase 2 (implementation) of the Maternity and Neonatal Safety Support Programme. The network will be providing the clinical and management leadership on the design and delivery of the Programme. 3. Maternity and Neonatal Safety Support Programme actions have been included in the Women's Service Delivery Plan 23/24 under Transforming Maternity Services (Priority 1). Progress is monitored quarterly and reported to the Women's Transformation Group and Women's Service Delivery Board and upwardly via lines of defence. Any outstanding will translate to 24/25 Service Delivery Plan 4. Digital Maternity Cymru National Programme Board established with appropriate BCUHB representation. 5. Local Digital Maternity Cymru working group established ahead of the required governance structure for the implementation of the Maternity Information System. 6. Digital Health and Care Wales (DHCW) have confirmed Health Board funding has for 24/25 to support the Clinical Maternity Informaticist Lead (Band 8a) and Project Manager (Band 7) to support the national programme team 7. Service is planning for pre-implementation phase and required resource for this phase will be submitted as an Informatics Capital and Resource requirement.in Q4 24/25 In relation to the Quality Statement Women's, this is a Corporate Strategic Action for all Services led by the Health Board which will be supported by Women's Services. The service continue to develop the WG funded projects e.g. pelvic health and endometriosis services.	1. Awaiting clarification from the Welsh Government as to how the NHS Executive will manage Phase 2/ Implementation of the project and actual recommendations/ actions required for implementation by Health Boards. This has resulted in a significant delay in clarification for Health Boards and Service provider. In addition to the 134 recommendations the NHS Executive identified 3 priorities for action to be progressed during the transition phase (up to end March 2024 – on track to deliver in Q4 23/24). These include ATAIN, MEWOS Chart and PeriPrem Passport. All actions in progress no risks Delivery of National Digital Maternity Cymry Programme delayed. Likely implementation is Q4 24/25. 2. No confirmed funding for Maternity and Neonatal Safety Support Programme implementation phase and recommendations.	Impact: 4 | Likelihood: 3 | Score: 12 Movement since last Qtr: **Likelihood reduced from 4 to 3 changing the overall score from a 16 to a 12.** Action plan below 1 out of 5 completed with several short-term operational actions completed, 2 further controls added.

	3. Funding for the local Informatics capital and resource requirements for Digital Maternity Cymru Programme not confirmed. 4. No nationally confirmed funding for implementation of the system as confirmed at the DMC National Project Board on 8/2/24. 5. Quality Statement for Women and Girls' Health - Confirmation of Corporate Executive Lead required. Also awaiting further National steer on prioritisation of the 10-year Women's Plan. No funding confirmed to date.	

Actions and Due Date	
Action Detail	**Due Date**
Digital Midwife appointed to interface with the Digital Health Care Wales National team and local support for the pre-implementation planning.	Completed
Remaining Maternity and Neonatal Strategic Plan outstanding actions will be rolled over into 24/25 Women's Service Delivery Plan – implementation resource impact has been considered as part of the planning for 24/25.	March 2024
Clarification from WG as to how the NHS Executive will manage Phase 2 Implementation and prioritisation of the recommendations – update received see above.	March 2024
Local Capital and Resource requirements for Digital Maternity Cymru to be included in 24/25 planning to inform 25/26.	March 2024
Quality Statement for Women and Girls' Health (issued by WG). NHS Executive commissioned to lead on the development of a National Women's Health Network and 10-year Women's service plan. An Executive lead will need to be identified to locally lead on the Plan.	March 2024

Lines of Defence			**Overall Assessment**
1	**2**	**3**	

1. Women's QSE 2. Women's Risk Management Group 3. Women's Integrated Performance Group 4. Women's Senior Leadership Team meeting 5. Women's Service Delivery Board 6. Women's Transformation Delivery Group	1. BCUHB Quality Executive Delivery Group 2. QSE Committee 3. Executive Accountability Meetings	1. Welsh Government Digital Cymru Programme Board 2. National Maternity and Neonatal Safety Support Programme Board 3. IQPD	Further steer is required from NHS Executive (delegated by WG) in relation to the Maternity and Neonatal Safety Support Programme on prioritisation of recommendations made in the Discovery Phase. Local funding to deliver the priorities is to be confirmed. Short-term actions as detailed in the Maternity and Neonatal Safety Support Programme are progressing well within target and 15 green, 7 amber, and 9 on red. Delivery of the short term Maternity (6-12 months) have been included in the 23/24 Women's Service Delivery Plan and will translate into the 24/25 plan. Further steer is required from NHS Executive (delegated by WG) in relation to the Quality Statement for Women and Girls' Health, development of the National Women's Health Network and Women's 10 Year Service Plan. BCUHB Executive Lead also needs to be identified.

BAF SP18	**Executive:** Executive Director of Nursing and Midwifery		**Date Opened:** 19/10/2023
	Committee: QSE		**Date Last Reviewed:** February 2024
	Strategic Priority: SP18 Quality, Innovation and Improvement	**Link to CRR:** Failure to Embed Learning **Link to Tier 1's:** 3025/4519/ 4520/3795/3759	**Last Date Reviewed at Committee:** 19/12/2023
			Target Risk Date: **April** 2024

There is a risk of failing to effectively strengthening governance arrangements following special measures and implement robust quality governance, improve organisational learning, and improve the handling of incidents, inquests, claims, mortality reviews and complaints.

Mitigations/Controls in place	**Gaps in Controls**	**Current Risk Score**
These are measures/interventions implemented by the Health Board to reduce either the likelihood of a risk and/or the magnitude/severity of its potential impact were it to be realised. 1. Putting Things Right and clinical review processes and monitoring 2. Risk management processes 3. Audit programmes & monitoring arrangements 4. Patient and carer feedback and involvement processes 5. Senior sign-off process for National Reportable Incidents (NRIs) and Complaints 6. Clinical policies, procedures, guidelines, pathways, supporting documentation & IT systems 7. Clinical staff recruitment, induction, mandatory and professional training, registration & re-validation 8. Defined nurse staffing levels for all wards & departments as per Nurse Staffing Act 9. Ward accreditation schemes and ward manager/matron checks/audits. 10. Tracking of regulatory action plans 11. Internal Reviews against External National Reports 12. Getting it Right First Time (GIRFT), localised deep dives, reports and action plans 13. HIW, Ombudsman, Coroner NHS Wales Exec and WG engagement Meetings	1. Need to develop a Quality Management System (QMS) setting out an integrated approach to Quality Planning, Control, Assurance and Improvement 2. Need for clarity on quality leadership, structures and accountabilities 3. Need to review the quality governance framework of meetings and reporting 4. Need to develop a quality learning framework, aligned to the overall learning organisation programme 5. Need to review Putting Things Right and clinical review processes and monitoring 6. Need for resolution of outstanding overdue positions for incidents, complaints, claims, mortality reviews and inquests	Impact: 5 | Likelihood: 4 | Score: 20 Movement since last Qtr: Score moderated to confirm that the score moved from its previous proposed score of 25 to a confirmed score of 20. 6 actions remain underway and on track for delivery at the end of Q4 at which time the risk score will be reviewed. The Risk Management Group and the Executive Team have reviewed this risk and are clear that the likelihood score is 4.

<table>
<tr><th colspan="4">Actions and Due Date</th></tr>
<tr><th colspan="3">Action Detail</th><th>Due Date</th></tr>
<tr><td colspan="3">1. 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.</td><td>March 2024</td></tr>
<tr><td colspan="3">2. Best practice guidance will be issued to IHCs and Regional Divisions to support effective local quality governance arrangements.</td><td>March 2024</td></tr>
<tr><td colspan="3">3. 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.</td><td>December 2023</td></tr>
<tr><td colspan="3">4. 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.</td><td>March 2024</td></tr>
<tr><td colspan="3">5. The approach to quality assurance will be reviewed and refreshed and a new regulatory procedure and quality assurance procedure will be developed.</td><td>March 2024</td></tr>
<tr><td colspan="3">6. The new Quality Strategy will be developed through a co-design process.</td><td>March 2024</td></tr>
<tr><td colspan="3">7. 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.</td><td>March 2024</td></tr>
<tr><th colspan="3">Lines of Defence</th><th>Overall Assessment</th></tr>
<tr><th>1</th><th>2</th><th>3</th><td rowspan="2">Target date revised from March to April 2024. Impact of 5 to be reviewed in following report.</td></tr>
<tr><td>1. Service and IHC Quality Groups
2. Putting Things Right and clinical review processes and monitoring
3. Ward accreditation schemes and ward manager/matron checks/audits
4. Organisational Learning Forum
5. Quality systems – RLDatix, Greatix, Civica Experience and AMAT</td><td>1. Quality, Safety and Experience Committee oversight of quality issues
2. Quality reporting to Board
3. Executive performance reviews with IHCs
4. Clinical audit
5. Patient and Carer Experience Group and oversight/assurance reporting
6. Patient Safety Group and oversight/assurance reporting</td><td>1. Internal audit
2. HSE inspections
3. HIW/CIW inspections
4. PSOW investigations
5. WG performance monitoring and assurance
6. Welsh Government Reviews
7. Royal College Reviews</td></tr>
</table>

	7. Clinical Effectiveness Group and oversight/assurance reporting 8. Regulatory Assurance Group and oversight/assurance reporting 9. 7. Annual Quality Report, Annual Putting Things Right Report and Annual Duty of Candour Report 10. Risk Management Group Report 11. Executive Team Report		

<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, 20 February 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 to which QSE has oversight of..

Four risks have been attached in Appendix 2 yet partial assurance is noted as the Committee is yet to receive four further corporate risks to which it has overall accountability for: Community and Primary Care Provision, Areas of Clinical Concern, Timely Diagnostics & Harm from the Medical Devices/Equipment.</td></tr>
<tr><td>Argymhellion:

Recommendations:</td><td colspan="4">The Committee is asked to receive assurance for the four corporate risks to which the Committee has overall accountability.</td></tr>
<tr><td>Arweinydd Gweithredol:

Executive Lead:</td><td colspan="4">Phil Meakin, Acting Board Secretary</td></tr>
<tr><td>Awdur yr Adroddiad:

Report Author:</td><td colspan="4">Nesta Collingridge Head of Risk Management</td></tr>
<tr><td>Pwrpas yr adroddiad:

Purpose of report:</td><td>I’w Nodi
For Noting
☐</td><td colspan="2">I Benderfynu arno
For Decision
☒</td><td>Am sicrwydd
For Assurance
☒</td></tr>
<tr><td>Lefel sicrwydd:

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

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

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

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

No confidence / evidence in delivery</td></tr>
<tr><td colspan="5">Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: Partial Assurance is noted as the Committee is yet to recieve four Corporate risks Community and Primary Care Provision, Areas of Clinical Concern, Timely Diagnostics & Harm from the Medical Devices/Equipment.</td></tr>
</table>

Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this: N/A	
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Links to the BAF detailed in respective CRR reports
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	It is essential that the Health Board has robust arrangements in place to assess, capture and mitigate risks, as failure to do so could have legal implications for the Health Board.
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	N/A
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary ben undertaken?***	N/A
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	Links to the BAF detailed in respective CRR reports
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	The effective and efficient mitigation and management of risks has the potential to leverage a positive financial dividend for the Health Board through better integration of risk management into business planning, decision-making and in shaping how care is delivered to our patients thus leading to enhanced quality, less waste and no claims.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	Failure to capture, assess and mitigate risks can impact adversely on the workforce.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	Individual Executive Sign off of CRR reports, Review at Risk Management Group 06/02/2024
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)	See the individual risks for details of the related links to the Board Assurance Framework.

Links to BAF risks: *(or links to the Corporate Risk Register)*	
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	N/A
Camau Nesaf: ***Next Steps:*** Completion of outstanding Corporate Risks Quarterly Submission of Corporate Risks to the Board	
Rhestr o Atodiadau: ***List of Appendices:*** Appendix 1 –Dashboard Appendix 2 – Corporate Risk Register Report: **1. Patient Safety-Falls** **2. Safeguarding** **3. Failure to Embed Learning** **4. Population Health**	

Corporate Risk Register Report

Following the approval of the Risk Management Framework, the corporate risk register has been reviewed in order to develop strategic risks and take a consolidated view of high and extreme risks (Tier 1). This report only considers risks that the QSE Committee has oversight of. Further to feedback received at the Health Board meeting of the 25 January 2024 a clearer summary table of risks has been produced in collaboration with the Audit Chair and the Risk Management Team.

Some risks remain to be in development and subsequently yet to be approved by Executives.

- Community and Primary Care Provision
- Areas of Clinical Concern
- Timely Diagnostics
- Harm from the Medical Devices/Equipment

Corporate Risks Dashboard (Appendix 1) below provides a list of the 8 corporate risks to which the committee is accountable and progress.

The Committee is asked to note:

Failure to Embed Learning – Following a close review of this risk at the Executive Team meeting the current score has been considered at Risk Management Group on 6 February 2024 and at Exectuive Team on 14 February 2024 and is proposed that the score will retain a score of 20 (Likelihood = 4 x Impact = 5)

Next steps

1. Individual risk leads are asked to work on the corporate risks which are currently in draft and progress these to submission to respective Executive Leads.
2. The corporate risk team have taken onboard feedback from the Board and Executive team on updating the corporate template below to further highlight rationale, the committee will note this change in following iterations of this report.
3. Risk Management Group and Executive Team to receive comprehensive corporate risk report for further scrutiny.

Corporate Risk Register Dashboard

Lead	Ref	Risk Title	Current Score (Likelihood x Impact)	Risk Target Score	Appetite Main Risk Type Appetite Level	Lead Board Committee	Head of Risk Management Comments
EDoN	CRR24-02	Patient Safety-Falls	5 x 4 = 20 ⟷	12	Quality 3 - Open	QSE	Escalated from operational risk as of Dec 23. Inherent and current score of 20, further controls to be reviewed to reduce current score. 3 actions due to be completed in Dec 23 and 3 in Jan 24, progress required and possible revision of target date if actions not completed.
EDoN	CRR24-03	Safeguarding	4 x 4 = 16 ⟷	12	Quality 3 - Open	QSE	Action plan requires further development as some do not impact on the score to reduce it. 5 Actions due in March to reduce the score but does not address the main gap in control (staffing resources) to better control risk.
EDoN	CRR24-04	Failure to Embed Learning	4 x 5 = 20 ⟷	5	Quality 3 - Open	QSE	New CR as of Dec 23, 7 actions identified 6 are due in March 2024. Controls further refined following Executive Team review 17/01/23 and score moderated to 20. The action plan progress should be monitored if March 24 is still achievable for the majority of actions.
EDoPH	CRR24-08	Population Health	5 x 4 = 20 ⟷	12	Quality 3 - Open	PPPH (QSE)	Inherent and current score of 20, further controls to be considered to reduce current score. Target date 2026 (could have annual interim targets and actions to demonstrate movement for discussion at ET).
EDoO	CRR24-09	Community & Primary Care Provision	TBD	TBD	Quality 3 - Open	QSE	Risk under development by the service.

EDoO	CRR24-12	Areas of Clinical Concern (encompasses ophthalmology and dermatology)	TBD	TBD	Quality 3 – Open	QSE	Risk under development by the service.
EDoTH	CRR24-13	Timely Diagnostics	TBD	TBD	Reputational 4 – Seek	QSE	Risk under development by the service.
EDoTH	CRR24-14	Harm from the Medical Devices/Equipment	TBD	TBD	Quality 3 – Open	QSE	Risk under development by the service.

Key:

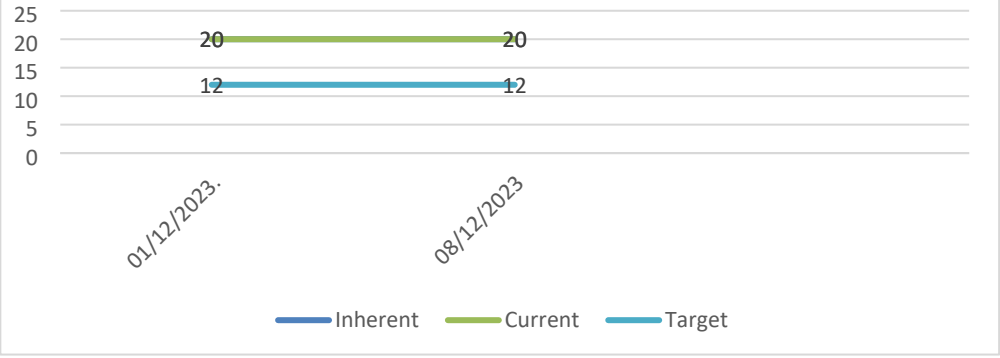
Executive	
Executive Director of Workforce	EDoW
Executive Director of Nursing & Midwifery	EDoN
Executive Director of Finance	EDoF
Chief Digital Information Officer	CDIO
Executive Director of Public Health	EDoPH
Executive Director of Operations	EDoO
Executive Director of Therapies and Allied Health Professions	EDoTH

CRR 24-02	**Patient Safety - Falls**			**Date Opened:** 01/12/2023
	Assuring Committee: Quality, Safety and Experience Committee			**Date Last Reviewed:** 08/12/2023
	Director Lead: Executive Director of Nursing and Midwifery	**Link to Datix IDs**	**4748/3869/3893/4562**	**Date Last Committee Review:** 19/12/2023
		Link to BAF	**N/A**	**Target Risk Date:** 01/02/2024

There is a risk to patient safety, in particular harm, as a result of slips, trips and **falls** within Secondary Care acute sites. This may be caused by patients acuity/clinical condition/frailty alongside contributory factors such as **reduced staffing**, segregated areas and **premises** which do not allow for ease of oversight, compliance with **manual handling training,** compliance of falls risk assessment and subsequent implementation of mitigating actions. This could result in poorer patient health outcomes, extended hospital stay, regulatory non-compliance and litigation and associated financial impact.

Controls in place	Assurances	Additional Controls required	Actions and Due Date
1.Mandatory E learning modules (1a and 1b) for Falls Prevention launched and monitoring in place for completion via the Strategic Inpatient Falls Group. Health Board compliance currently 1a 93.83%, 1b 94.55%. 2. Manual Handling training data cascaded monthly to respective IHC's/Division Director of Operations to include compliance, Did Not Attend rates and available capacity for upcoming 2 months. 3. Welsh Nursing Care Record (WNCR) has been implemented which has an electronic version of the Falls and Bone Health Multifactorial Assessment (FBHMA) that is identified on the dashboard if not completed and monitored for compliance by the Ward Manager. 4. How to /good practice guide developed and implemented to support with completion and quality of FBHMA across all Adult Inpatient wards: 5. Peer review process in place for 3 months to improve quality of the FBHMA across adult inpatient wards. 6. Falls review groups in place across the Health Board with exception reporting, updating of improvements to Strategic Inpatient Falls Group.	1. Strategic Inpatient Falls Group - Integrated Health Community (IHC) and Divisional falls review groups report to the falls leads who report to the strategic group. 2. Ward accreditation metrics 3. Ward accreditation review process 4. Peer reviews	1. Falls prevention and management policy to be ratified and relaunched - has been updated to include a clear step by step approach to completion of the Falls and Bone Health Multifactorial Assessment (FBHMA) and post falls management and currently under review with Patient Safety Group. 2. Assurance and training of agency workers. 3. Improved compliance with manual handling training. 4.Sustained improvement in the quality of completion of FBHMA.	1.New updated and revised Falls Prevention and Management Policy NU06 reviewed in BCUHB Patient Safety Group to be ratified and re-launched 30/12/2023. - Completed 2.Audit of Ward Managers induction checklist for agency staff to ensure falls training has been completed 13/12/2023. 3.Capacity within the Manual Handling training team to be optimised with focused recruitment drive for Band 6 posts (x3) supported by workforce 01/01/2024. 4. Manual Handling corporate team to progress contract arrangements for

6. Temporary staffing team have ensured Nurse Agencies have access to BCUHB e-learning packages and are encouraged to complete.			external training facilities to support capacity by December 2023. 30/12/2023. 5. Outcome of peer review pilot to be evaluated and recommendation presented to the Strategic Inpatient Falls Group for sustainable model 01/02/2024. 6. The Welsh Nursing Care Record currently does not auto populate with Patient details such as mobility status from the admission assessment section into the FBHMA. This will be a future enhancement to the Welsh Nursing Care Record on an all-Wales basis. 01/02/2024.



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	low level		1-8

Overall Assessment

1 out of 6 actions have been completed, 1 was to be progressed in Dec, now overdue and remaining actions to be completed by February 2024 in order to reduce this score down to the target of 12. This is in line with the Falls Internal Audit limited assurance report. The Falls Group also have oversight of the gaps in controls and is working to mitigate these. Further work required on current score and controls to reduce the risk score.

CRR 24-03	**Safeguarding**			**Date Opened:** 07/12/2023
	Assuring Committee: Quality, Safety and Experience Committee			**Date Last Reviewed:** 09/02/2024
	Director Lead: Executive Director of Nursing and Midwifery	**Link to Datix IDs**	**3766/2548**	**Date Last Committee Review:** 19/12/2023
		Link to BAF	**N/A**	**Target Risk Date:** 31/03/2025

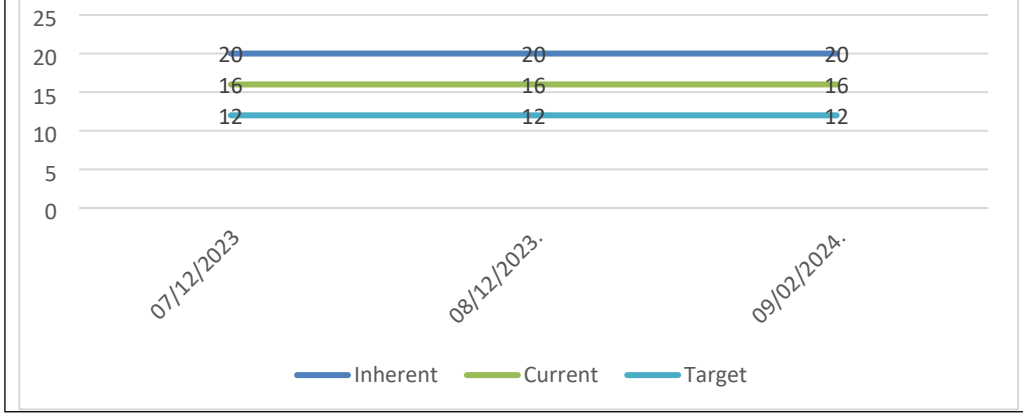
There is a risk that BCU may fail in its statutory duties to protect **vulnerable** groups from harm. This could be caused by gaps in **safeguarding governance**, **insufficient** workforce **training** and engagement, complexity of legal frameworks, and lack of resources to manage growing demand. The impact may result in harm to at-risk adults, children or young persons, victims of violence/abuse, patients unlawfully detained, financial penalties, reputational damage and non-compliance with Safeguarding legislation which includes but is not exclusive to the Social Services and Wellbeing (Wales) Act 2014, the Deprivation of Liberty Safeguards, and the Mental Capacity Act.

Controls in place	Assurances	Additional Controls required	Actions and Due Date
1. Standardised formal reporting and escalation of activity, mandatory compliance and exception reports are presented in line with Health Board Governance and Reporting Frameworks. 2. Audit findings and data are monitored and escalated. Risk Management has been embedded into the processes of the reporting framework. 3. BCUHB mandatory safeguarding training is in place for all staff. 4. Welsh Government interim monies has supported temporary the implementation of additional Mental Capacity Act (MCA) training, the completion of Deprivation for Liberty (DoLS) applications, and strengthened the implementation of Court of Protection DoL for 16/17-year-olds. 5. BCUHB local work programmes are in place and aligned to the National Strategies which are regularly reported to Welsh Government. 6. Safeguarding support the Sexual Abuse Referral Centre (SARC) implementation, compliance and accreditation but the accountability remains with the Central Integrated Health Community (IHC).	1. The risks is monitored monthly and reviewed at the Safeguarding Governance and Performance Group and scrutinised at QSE/RMG. 2. Mental Capacity Act training compliance and the DoLS backlog is monitored and reported into Welsh Government. 3. This risks are regularly monitored and reviewed by the statutory engagement with the North Wales Safeguarding Board. 4. BCUHB are fully engaged in National and Regional Forums to provide assurance of the implementation of legislation.	1. New legislation and statutory guidance driven by case law, UK and Welsh Government impacts upon the organisation and the date of implementation is not within BCUHB control. 2. The increase in safeguarding activity with enhanced complexity has resulted in the delay of the implementation of strategic and operational interventions. 3. Local Authorities frequently develop independent local guidance which requires duplication of implementation across BCUHB. This is time consuming and can result in reduced compliance. 4. The rise in the number of DoLS assessments has resulted in a backlog. Current post holders work additional hours, weekends and evenings. There are local and national staffing challenges with regard to the recruitment of Safeguarding, MCA and DoLS specialist staff. This is recognised by Public Heath Wales and WG. We support flexible working arrangements within the team to ensure staff retention. The team and service is experiencing a high sickness position. A risk assessment and an	1. The Ockenden Review (2018) Recommendation 6 recorded that for an organisation such as BCUHB a significant amount of work was still needed to be done to strengthen safeguarding services. A review of the safeguarding team and structure is underway. Action Due 31/03/24 Update February 2024: A review of the safeguarding team structure has started, a report will be submitted in March 2024 2. National development and implementation of Single Unified Safeguarding Review (SUSR). Action Due 31/03/25 Update February

7. Fully engaged and supporting the Single Unified Safeguarding Review led by Welsh Government and the Home Office/Central Government for the re-write of Safeguarding and Homicide Reviews.		amendment to the service delivery structure is in place to mobilise staff where required. 5. There is a lack of governance and reporting of Court of Protection activity relating to a Community setting. Immediate safeguards are in place and work is taking place to develop a standard procedures.	2024: SUSR training has been approved by WG. BCUHB attending this month. 3. Implementation and monitoring of the 'Workforce Safeguarding Responsibilities SoP, Section 5 Allegations or Concerns about Practitioners and Those in Positions of Trust. Action Due 31/03/24 Update February 2024: Approved at SGPG being shared at QDG this month. 4. North Wales Sexual Assault Referral Centre (SARC) to meet the National Service ISO Specifications. Action Due 31/03/24 Update February 2024: Discussions ongoing 5. Development of a DoLS/CoP DoL Standard Operating Protocol (SoP) for assessing existing BCUHB funded patients in community settings and for assessing future funded patients. Action due 31/03/24 Update February 2024: Action on target

	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	3	12
Risk Appetite	low level		1-8

Overall Assessment



Five out of six actions to support controls in relation to this risk are due in March 2024 but this will not necessarily resolve the main gap in control around staffing resources. Gaps in controls have been well identified and have further mitigations noted.

CRR 24-04	**Failure to Embed Learning**		**Date Opened:** 19/10/2023
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Reviewed:** 18/01/2023
	Director Lead: Executive Director of Nursing and Midwifery	**Link to Datix IDs: 3025/4519/4520/3795/ 3759**	**Date Last Committee Review:** 19/12/2023
		Link to BAF: SP18 - Quality, Innovation and Improvement	**Target Risk Date:** March 2024

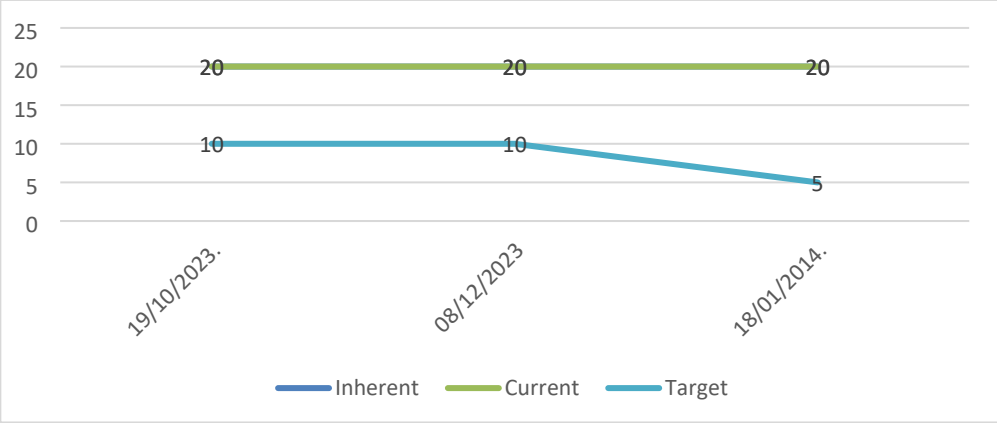
There is a risk that the Health Board could fail to meet requirements for **timely review and learning** from mortality cases, claims, inspections, incidents and complaints. This could be caused by insufficient resources, lack of unified processes, outdated IT systems, duplication of effort, and overreliance 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.

Controls in place	**Assurances**	**Additional Controls required**	**Actions and Due Date**
1. Putting Things Right and clinical review processes and monitoring 2. Risk management processes 3. Audit programmes & monitoring arrangements 4. Patient and carer feedback and involvement processes 5. Senior sign-off process for National Reportable Incidents (NRIs) and Complaints 6. Clinical policies, procedures, guidelines, pathways, supporting documentation & IT systems 7. Clinical staff recruitment, induction, mandatory and professional training, registration & re-validation 8. Defined nurse staffing levels for all wards & departments as per Nurse Staffing Act 9. Ward accreditation schemes and ward manager/matron checks/audits. 10. Tracking of regulatory action plans	1. Service and IHC Quality Groups (with reporting) 2. Quality Delivery Group, its sub-groups (with reporting) and the Quality, Safety and Experience Committee oversight of quality issues 3. Quality reporting to Board 4. Executive performance reviews with IHCs 5. Clinical audit and Internal audit 6. Regulatory Assurance Group and oversight/assurance reporting 7. Annual Quality Report, Annual Putting Things Right Report and Annual Duty of Candour Report 8. Regulatory inspections and investigations – HSE, HIW, CIW, PSOW 9. WG performance monitoring and assurance 10. Welsh Government Reviews	1. Development 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. Review of the quality governance framework of meetings and reporting 4. Development of a quality learning framework, aligned to the overall learning organisation programme 5. Review of Putting Things Right and clinical review processes and monitoring	1. 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. – March 2024 2. Best practice guidance will be issued to IHCs and Regional Divisions to support effective local quality governance arrangements. – March 2024 3. A Quality Dashboard will be developed underpinned by a series of specialist dashboards (i.e. falls, complains, etc). These

11. Internal Reviews against External National Reports 12. Getting it Right First Time (GIRFT), localised deep dives, reports and action plans 13. HIW, Ombudsman, Coroner NHS Wales Exec and WG engagement Meetings	11. Royal College Reviews	6. Resolution of outstanding overdue positions for incidents, complaints, claims, mortality reviews and inquests	dashboards will create a single version of the truth using agreed metrics directly connected to the quality systems for real time data. – December 2023 4. 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. – March 2024. 5. The approach to quality assurance will be reviewed and refreshed and a new regulatory procedure and quality assurance procedure will be developed. – March 2024 6. The new Quality Strategy will be developed through a co-design process. – March 2024 7. 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. – March 2024

	Impact	Likelihood	Score
Inherent Risk Rating	5	4	20
Current Risk Rating	5	4	20
Target Risk Score	5	1	5
Risk Appetite	low level		1-8

Overall Assessment



N.B. Inherent and Current score lines stacked as both are 20.

Six out of seven actions to support controls in relation to this risk are due in March 2024. Gaps in controls have been well identified and have further mitigations noted.

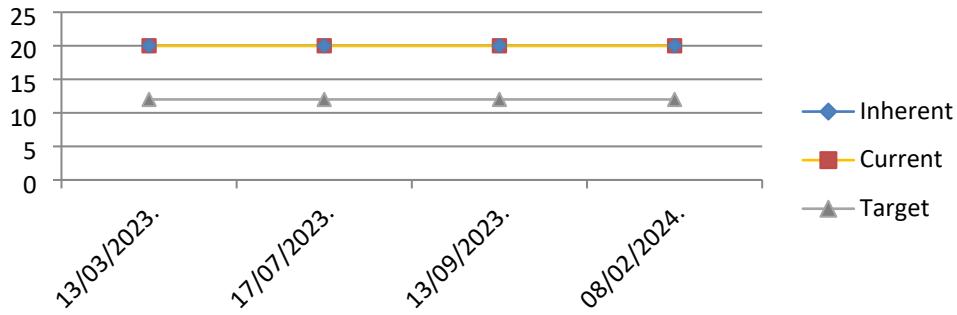
CRR 24-08	**Director Lead:** Executive Director of Public Health			**Date Opened:** November 2023
	Assuring Committee: Quality, Safety and Experience Committee			**Date Last Reviewed:** 8th February 2024
	Risk Title: Population Health	**Link to Datix IDs**	1642/4200/4201	**Last Committee Review:** December 2023
		Link to BAF	SP1	**Target Risk Date :** March 2026

There is a risk that the Health Board fails to adequately support the improvement of population health and reduce health inequalities. This may be caused by a lack of sustainable services, financial and resource constraints within the Health Board, dependency on grant funding to support prevention activity and demand for delivering the urgent and immediate healthcare needs of the population.
Population health improvement and protection may also be impacted by population behaviours and beliefs, modifiable risk factors, wider determinants of health (eg Housing, Education, Employment), the local demographics, the living environment, food production and consumption, local planning, socio-economic factors or the accesibility of health care services.
This may lead to continuation and increases in largely preventable non-communicable diseases including Type 2 Diabetes, Respiratory conditions, Cardiovascular disease, Cancer, Musculoskeletal conditions, mental health and wellbeing and multiple co-morbidities. It may also lead to to increasing rates of infectious disease such as: Hepatitis, Measles, Mumps, Rubella, HIV, E-Coli, sexually transmitted infections. Failure to address the risk could potentially lead to avoidable morbidity and mortality within the population of North Wales

Controls in place	Assurances	Gaps in Controls	Actions and Due Date
1. Population Health Executive Delivery Group (meets monthly) provides strategic direction. 2. PPPH Committed has oversight and received regular reports. 3. Welsh Government provides oversight of grant funded activity supporting prevention and early years. 4. The Executive Director of Public Health provides consistency to the regional strategic approach for North Wales in the form of expertise and prioritisation and through leadership of the Public Health Team. The Deputy Director of Public Health is	1. Risks linked to CRR24-09 are reviewed and monitored via the Population Health Executive Delivery Group and the Public Health Senior Leadership Team. 2. Health Board progress is reported to Regional Partnership Board and PPPH Committee. 3. The Public Health Team provide the Health Board, its partners and the public with evidence informed information and approaches to improve health and wellbeing. 4. The Public Health Team support population needs analysis and provide professional expertise to support the development of Health Board and partner plans.	1. In order to implement a system wide approach it is necessary for commitment from partners wider than the Health Board to prioritise the implementation of evidence informed practices and proposals. 2. The North Wales region is not operating at the pace or scale required to meet the current and forecast needs of the population. Resources and current pressures for all partners and the Health Board presents significant challenge to increasing the activities required. 3. It is acknowledged that this is a long term risk which cannot be	Actions supporting mitigation of this risk are via delivery of a range of specific strategies, plans and frameworks (some of which are continuous by nature of the work) which include: 1. Tobacco Control Legislation (including Smoke Free Sites) / Welsh Government Tobacco Control Plan 2. All Wales Weight Management Pathway 2021 3. Infant Feeding Strategy 2019 (current refresh underway to 2025) 4. Health Care Public Health Programme (also linked to Special Measures Plans and chronic disease pathways)

currently Acting Executive Director of Public Health. 5. Consultants in Public Health are linked to delivery of key programmes of work, Public Health Wales and with IHC areas, providing expertise. 6. Public Health Team provide review and feedback on planning applications. 7. Health Protection Team work in partnership with Local Authorities to provide expertise and management of cases.	5. Prevention is embedded in the Living Healthier, Staying Well Strategy and a 'life-course' approach is promoted. 6. Representation by senior Public Health team members at Public Service Boards, Partner Boards, Regional Partnership Board and National forums. 7. A 'Whole System Approach' is being implemented across a number of key priority areas. 8. A number of national programmes of work are underway including implementing the Weight Management Pathway and Smoke Free Sites regulations. 9. Annual development of Public Health work plan to reflect current and emerging need. 10. National Performance Framework measures. 11. . The Health Protection Team have established funding in 24/25 Health Board allocation. 12. Grant funding (Welsh Government, Public Health Wales, Arts Council for Wales) has been secured for 24/25 for a number of small projects	mitigated and fully evidenced within 1-3 years as is well documented through evidence and research. As a Health Board we will work with partners to implement the approaches (many of which are long term approaches) which support the strongest evidence base for success. 4. Investment in prevention within the health board through investment of core funding. 5. Commitment from partners within the health board area to population health and prevention activity due to financial and capacity constraints 6. The failure to recognise the risk associated with the demographic profile and current prevalence of chronic conditions and how further demand due to a lack of prevention could risk overwhelming the system in the future. 7. There is no secured long term funding to support implementation and growth of the whole system approach across North Wales at scale. 8. The current cost of living crisis will adversely affect those most at risk.	5. Together for Mental Health Strategy (local / national) 6. Well North Wales targeted partner programmes 7. Health Board Annual Plan / 3 year milestones and associated activity 8. Working in partnership across BCUHB, PHW and LA to reduce the risk associated with infectious diseases 9. Immunisation Strategy 2023-2026 10. Actions as per detailed within specific risks linked to this CRR.

		9. The current financial position of the Health Board and its partners will impact on investment into key business cases which support this work. 10. The current position of the Health Board within escalatory measures and short term focus to meet ministerial and special measures priority actions may reduce focus on longer term priority work. 11. The availability of data to support strategic focus at the local level and planning is not available. 12. The Deputy Director of Public Health post is currently vacant as the post holder is Acting Executive Director of Public Health.	



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	low level		1-8
Overall Assessment			

- *stark and persistent health inequalities, with female and male healthy life expectancy almost 17 and 12 years lower in the most deprived areas compared to least deprived.*
- *the gap between the least and most deprived areas in Wales, for premature deaths from non-communicable diseases, increasing in*

	recent years, and now almost two and half times greater in the most derived areas, compared to the least - *around one third of people following less than three of the five healthy behaviours, including 14% of adults in Wales smoking with higher rates reported among people living in the most deprived areas* Public Health Wales (Public Health Wales. 2023. Our Strategic Plan 2023-2026, p7) The population health of North Wales is worsening and has significant impact on demand for services and potentially on the wider community due to the loss of people from the workforce, and through the subsequent economic impacts on our communities through loss of involvement. Worsening health outcomes, increasing ill health and widening inequalities directly affects the Health Board ability to deliver excellent healthcare services meaning the Health Board purpose must retain clear focus on improving the health and wellbeing of the population

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

To improve health and provide excellent care

Advisory Group Chair's Report to QSE 20.02.24

Name of Advisory Group:	Strategic Occupational Health and Safety (SOHS) Group

Meeting date:	Monday, 18 December 2023

Name of Chair:	Acting Chair, David Maslen-Jones, Acting Associate Director of Health, Safety and Security

Responsible Director:	Jason Brannan, Deputy Director of People

Summary of Items for Escalation	The Following Items were raised at SOHSG and require escalation, a report has been completed to summarise key health and safety team activities and areas for escalation. 1.1 Quoracy of SOHSG For the third time this year the SOHSG group meeting (which performs the function of the Health and Safety committee was not quorate there being no Executive Director as chair or vice chair. This in turn means that the existing terms of reference were again carried over as they cannot be revised until The Executive accountable for Health & Safety is made known. In the past both Jason Brannan and Georgina Roberts have stood in as chair, but unavailable on this occasion 1.2 Health & Safety Policy The H&S policy HOS01 is extant until the end of December, which has been raised at three previous SOHSG meetings and at Trade Union Partnership Forum. It is difficult to revise it at the present time as there is no current reporting structure which defines where H&S will sit going forward. A request is made to extend the existing policy for reporting for six months (Appendix 1). 1.3 Participation of IHC's in SOHSG There is concern regarding the lack of representation from IHC's and some services at SOHSG. At today's meeting, whilst reports of IHC's safety groups were received, nobody attended to present despite their being issues for escalation. Minuted items were unable to be discussed because of this and therefore carried over to next quarter, amongst which were the issues of the identification of site responsible persons for H&S and Fire (carried over now for three meetings). Our Trade Union Partners also expressed their displeasure at the lack of

	commitment to individual IHC meetings taking place as some are frequently cancelled as not being seen as a priority. 1.4 RPI Training **Restrictive Physical Intervention Training (RPI)**: There is currently no training outside of MHLD for RPI, the new policy states that all staff who undertake these activities must be trained. Whilst there is a training team in MHLD, who have been asked to identify what additional capacity would be needed to deliver training to the wider Health Board. The alternative is for the personal safety team to deliver this, however, this would require additional resource, as there are currently only two trainers within the team. Both teams have been requested to provide costs to the Executives. The current training needs analysis shows this is around an additional 750 staff who would require training. 1.5 Counselling Provision QSE is asked to note that With the Removal of the Staff Counselling Route through RCS, the waiting list for staff counselling has risen from two weeks to ten weeks and it is expected that with seasonal trends (higher referrals in January and February) the situation will escalate further. QSE is asked to note that there is now an escalation pathway to Mental Health Services should an individual be at high risk. 2 Goblygiadau Cyllidebol / Ariannol / Budgetary / Financial Implications There are no budgetary implications associated with this paper, other than the need to secure additional counselling provision for staff members. This has not as yet been quantified. 3. Rheoli Risg / Risk Management There are two risks 1) Security Services No. 21-12 and 2) Health and Safety No. 21.13 (previously in the BAF) These Are 21:13: ***"There is a risk that the Health Board fails in its statutory duty to provide safe systems of delivery and work in accordance with the Health and Safety at Work Act 1974 and associated legislation that could result in avoidable harm or loss"*** They relate to DATIX Now 5040 and 5041 These are recorded and managed through Datix and escalated, requiring sign off by an Executive Director as they currently score as high risk.
Key advice / feedback for the QSE Group:	Please Note This meeting was not quorate in the absence of an Executive Director

Targeted Intervention Improvement Framework Domain addressed	Leadership (including governance, transformation and culture)
Planned business for the next meeting:	In addition to the standing agenda items ▪ A review of the past 12 months HSE enforcement action ▪ Amended terms of reference to be agreed in line with the Strategic Occupational Health and Safety Group
Date of next meeting:	To be confirmed

Disclosure:
Betsi Cadwaladr University Health Board is the operational name of Betsi Cadwaladr University Local Health Board

Appendix 1

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

Health & Safety - Request for Executive Board to Approve a Six Month Extension to Health Board Health & Safety Policy

Situation	At the current time the Health Board Health & Safety Policy is due for review at the end of December 2023: It is a statutory requirement: The law states that every business must have a policy for managing health and safety. “A health and safety policy sets out your general approach to health and safety. It explains how you, as an employer, will manage health and safety in your business. It should clearly say who does what, when and how” (HSE). This policy sets out executive responsibility and delegation in respect of health and safety risks. At the current time there is no executive level reporting line for health and safety as the Associate Director for Occupation Health, Wellbeing, Health & Safety and Security previously reported to the Executive Director of Workforce & Organisational Development. It is impossible to re- write the existing Health & Safety policy until such time as the new corporate hierarchy is decided upon.
Background	This issue regarding policy expiry was first raised at the Strategic Occupational Health & Safety Group (SOHSG) in August 2023. At this time, QSE stated that they no longer required the provision of a report from SOHSG and to only report by exception. The Previous Associate Director for H&S resigned and left post in early July 2023. The now Acting Associate Director was unfortunately off work from August through to the end of October, hence this issue was not picked up, although raised at SOHSG. The need for a valid and current Health and Safety Policy is an essential cornerstone of Health & Safety within the Health Board. Current HSE Interest in respect of the Health Board at the current time requires that we are seen to be compliant with the Law
Assessment	The Policy cannot be re-written and ratified by the end of December even were the new governance arrangements in place before that date.

	Compliance with the Health and Safety Policy is at present the subject of a thorough Internal Audit. Existing routes for raising this issue through QSE are not possible within the given timeframe. Having taken advice from the Associate Director of Governance it has been suggested that this short paper be submitted for approval.
Recommendation	That the Board approve a six month extension to the existing Health and Safety policy until June 2024.

Authors:

David Maslen-Jones ,
Acting Associate Director of Occupational Health, Wellbeing, Safety and Security