# Bundle Quality, Safety and Experience Committee 24 October 2024

1 PRELIMINARY MATTERS

1.1 13:00 - QS24/113 Welcome and apologies
*Chair*
*Apologies received from:*
*Angela Wood, Executive Director of Nursing & Midwifery - Chris Lynes, Deputy Executive Director of Nursing & Midwifery to deputise*

1.2 13:01 - QS24/114 Declarations of Interest
*Chair*

1.3 13:02 - QS24/115 Unconfirmed minutes of meeting held on 15th August 2024
*Chair*
QS24 115.1 DRAFT QSE Public Minutes 15.8.24 v0.3

1.4 13:07 - QS24/116 Matters Arising and Action Logs
*Chair*
QS24 116.1 QSE Action Log PUBLIC - updated 17.10.24

1.5 13:12 - QS24/117 Patient Story - My Beautiful Home Birth
*Chris Lynes, Deputy Executive Director of Nursing & Midwifery*
QS24 117.1 Patient Story - My Beautiful Home Birth

2 SERVICE PRESENTATION

2.1 13:22 - QS24/118 Deep Dive on Complaints - Duty of Care
*Chris Lynes, Deputy Executive Director of Nursing & Midwifery*
QS24 118.1 Complaints Improvement Deep Dive

3 QUALITY PLANNING

3.1 13:47 - QS24/119 Presentation of the Nurse Staffing Levels - Autumn 2024
*Chris Lynes, Deputy Executive Director of Nursing & Midwifery*
QS24 119.1 Presentation of the Nurse Staffing Levels - Autumn 2024

4 QUALITY CONTROL

4.1 13:57 - QS24/120 Integrated Quality Report
*Chris Lynes, Deputy Executive Director of Nursing & Midwifery*
QS24 120.1 Integrated Quality Report - QSE Committee - Oct 2024 (1)
QS24 120.2 Integrated Quality Report - Appendix 1 PSOW Annual Letter 2023-24
QS24 120.3 Integrated Quality Report - Appendix 2 Ombudsman Annual Letter - draft Health Board Response

4.2 14:27 - QS24/121 Integrated Performance Report
*Ed Williams, Acting Director of Performance*
QS24 121.1 Coversheet Integrated Performance Report - 24.10.2024
QS24 121.2 Integrated Performance Report - 24.10.2024

5 14:42 - COMFORT BREAK

6 QUALITY ASSURANCE

6.1 14:47 - QS24/122 Update on the Royal College of Psychology Action Plan
*Teresa Owen, Executive Director of Allied Health Professionals and Health Science / Lead for Mental Health*
*Ros Alstead in attendance*
QS24 122.1 Report on RCPsych Invited Servcies Review FINAL (inc Appendix 1)
QS24 122.2 Report on RCPsych Invited Services Review Appendix 2 - HBADG Chairs Report
QS24 122.3 Report on RCPsych Invited Services Review Appendix 3 - Draft Terms of Ref

7 ROUTINE REPORTING

7.1 15:17 - QS24/123 Corporate Risk Register
*Nesta Collingridge, Head of Risk Management*
QS24 123.1 QSE Corporate Risk Register October 24

8 ANNUAL REPORTING

8.1 15:27 - QS24/124 Annual Quality Report 2023-24
*Matt Joyes, Deputy Director for Legal Services*
QS24 124.1 Annual Quality Report 2023-24 - cover sheet
QS24 124.2 Annual Quality Report 2023-24 V0.7

8.2 15:42 - QS24/125 Annual Safeguarding and Public Protection Report 2023-24
*Michelle Denwood, Director Of Safeguarding And Public Protection*
QS24 125.1 Safeguarding and Public Protection Annual Report 2023-2024 cover sheet
QS24 125.2 Safeguarding and Public Protection Annual Report 2023-2024

9 FOR INFORMATION

9.1 QS24/126 Quality Delivery Group Chair's Assurance Report
QS24 126.1 QDG Chair Report Sept 2024

9.2 QS24/127 Summary of Business to be Reported in Private part of Last Meeting
QS24 127.1 QSE Private session items reported in public

9.3 QS24/128 Committee Forward Work Plan
QS24 128.1 QSE Forward Work Plan

9.4 QS24/129 Cancer Services North Wales - a Road Map for 2024-29
QS24 129.1 Cancer Services for North Wales - a roadmap for 2024-29 - FINAL Jan 24

9.5 QS24/130 NHS Wales - Joint Commissioning Committee Quality Committee Chair's Report
QS24 130.1 JCC Quality & Patient Safety Committee Report
QS24 130.2 JCC Quality & Patient Safety Committee Report - Appendix 1

9.6 QS24/131 Maternity Services - Learning for Improvement, Examples and Evidence
QS24 131.1 Maternity Services - Learning for Improvement, Examples & Evidence

10 CLOSING BUSINESS

10.1 15:57 - QS24/131 Meeting Effectiveness
*Chair*

10.2 QS24/132 Date of Next Meeting - 17th December 2024

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

**Betsi Cadwaladr University Health Board (BCUHB)**
**DRAFT Minutes of the Quality, Safety and Experience Committee meeting held in public on**
**15th August 2024 13:00 to 16:30 hrs**
**The Board Room, Carlton Court, St Asaph**

| **Committee Members Present** | |
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| **Name** | **Title** |
| Caroline Turner | Independent Member/Chair of Quality, Safety and Experience Committee |
| Mike Larvin | Independent Member (via Teams) |
| Urtha Felda | Independent Member (via Teams) |
| **In Attendance** | |
| Angela Wood | Executive Director of Nursing and Midwifery (Executive Lead) |
| Dr James Risley | Deputy Executive Medical Director (deputising for Executive Medical Director) via Teams |
| **Other Executive Directors as required by the Chair** | |
| Dr Jane Moore | Executive Director of Public Health |
| Teresa Owen | Executive Director of Allied Health Professionals & Health Science |
| **Other BCUHB Senior Managers as required by the Chair** | |
| Nesta Collingridge | Head of Risk Management (part of meeting, via Teams) |
| Iain Wilkie | Interim Director of Mental Health & Learning Disabilities |
| Fiona Giraud | Director of Women's Services (part of meeting) |
| Matthew Joyes | Deputy Director of Quality |
| Phil Meakin | Associate Director of Governance |
| Ed Williams | Director of Performance (part of meeting) |
| David Maslen-Jones | Assistant Director of Occupational Health, Safety And Security (deputising for Deputy Director of People) (via Teams) |
| Fiona Lewis | Minute Taker |
| **Observing** | |
| Dyfed Edwards | BCUHB Chair (part of the meeting) |
| Fflur Jones | Audit Wales |
| Bill Whitehead | Deputising for Geoff Ryall-Harvey (Llais) |

| **Agenda Item** | **Action** |
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| **OPENING BUSINESS** | |
| **QS24/86 Welcome, introductions and apologies for absence**<br><br>**QS24/86.1 C**hair welcomed everyone present, noting Teresa Owen's first meeting in her new role as Executive Director of Allied Health Professionals & Health Science, and Dr Jane Moore's first meeting in her substantive role | |

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| as Executive Director of Public Health. Apologies were noted from Chris Field, Jane Wild, Pam Wenger, Nick Lyons (James Risley to deputise), Dave Harries, Philippa Peake-Jones, Jason Brannan (David Maslen-Jones to deputise) and Carole Evanson. | |
| **QS24/87 Declarations of Interest on current agenda**<br><br>**QS24/87.1** There were no declarations of interest made in respect of items on the agenda. | |
| **QS24/88 Draft minutes of the previous meeting.**<br><br>**QS24/88.1** The draft minutes of meeting held on 6th June 2024 were **approved,** with the following amendment to item QS24.68.3<br><br>**QS24/68.3** The Executive Director of Nursing and Midwifery confirmed that the Improvement Plan regarding Pressure Ulcers had been circulated and that work continued on Incident Management and reporting of Hospital Acquired Pressure Ulcers (HAPUs). Work was ongoing to create a joint process across incident management for inquests, NRIs and complaints; a draft of which will be presented to Board in July. Deputy Director of Quality to circulate, when available, the national report on HAPU that is currently being populated | |
| **QS24/89 Matters Arising and Table of Actions**<br><br>**QS24/89.1** Following a detailed discussion, updates provided within the action log were **agreed**. | |
| **QS24/90 Patient's Story**<br><br>**QS24/90.1** The Committee was provided with a patient's story, which described her experience going through both the BCU services and the National Welsh Gender Service, noting some of the challenges along with the positive outcomes experienced whilst accessing the Trans & Gender Diverse Voice Service.<br><br>**QS24.90.2** The key messages from the story were:<br>• lengthy wait to access the services<br>• impact waiting for treatment was having on both the patient's physical and mental health.<br>• However, once accessing services, she found the service provided very supportive, useful resources were available which she had been unaware of previously.<br>• Her increased confidence in social situations and her feeling that she is on an upwards trajectory. | |

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| **QS24/90.2** The Committee thanked Robyn for sharing her story and were advised that it would be shared across the Health Board. Despite the fact that this service is small, it demonstrated that it had a significant impact on her and others accessing it in North Wales.<br><br>**QS24/90.3** Members were pleased to note the useful information contained within the report, and felt that hearing the patient's words describing the positive effects along with clearly explained clinical, positive outcomes were very helpful.<br><br>**QS24/90.4** The Committee wished to thank the production team for their effective use of illustrations and background, which clearly displayed the compassionate care provided.<br><br>**QS24/90.5** It was noted that work needs to be done to raise awareness of and access to specialist services as it was felt that the positive impact of such small services was far more wide ranging, and thanks were sent to the Speech and Language therapists team for their good work.<br><br>**It was resolved that** the Committee:<br>• **Noted** the Patient Story | |
| **QS24/91 Service Presentation from Women's Services**<br><br>**QS24/91.1** The Director of Midwifery and Women's Services made her presentation, highlighting:<br><br>• The Women's Services governance structure, which showed the service is compliant with Workforce governance requirements. A request was made to ensure that the Health Board is added to the top of the Governance structures.<br>• the report provided national benchmarks, which showed the improvements made and the organisation's willingness to learn.<br>• that to maintain the whole-system approach, the report included key strategy documents, including The Quality Statement for Women and Girls' Health, the MatNeo Quality Statement, The MatNeo Engagement Framework and the HEIW Perinatal Workforce 10-year Plan<br>• that to emphasise the Service's learning, the report included more Maternity and Gynaecology national benchmarking.<br>• the inclusion of the Service's Annual Plan, which included major strategies used to inform the updates.<br>• The provision of single-page plans, which have proven to be extremely helpful and regularly referenced to by clinical colleagues and operational staff, as they show the understanding and learning from where a strategy originates, culminating into service development. | **FG** |

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| • the work being done regarding local implementation of Preconception Care, as part of the 10-year plan, to see if the strategy can be adopted nationally.<br>• there were Concerns regarding the Single Cancer Pathway and Planned Care.<br>• The new risk for escalation to Corporate Risk Register - Urgent Patients Backlog Waiting Lists and the increasing complexities with the waits being seen currently.<br>• the greatly reduced numbers in all 3 key KPIs for Clinical harms and prevention numbers<br>• other programmes of work to reduce harm include the national SSP programme, which looked at reducing variation and introducing the National Maternity Early Warning Score (MEWS) tool.<br>• piece of work being carried out to improve infections prevention and control (IPC) targets.<br>• all stillbirths and neonatal deaths are thematically reviewed with all recommendation from the recently completed 2023 review being put into an improvement plan.<br>• a recovery plan had been instigated following the national benchmarks, which showed the service had seen a decline in its performance. It was noted that they had lost some key clinicians and were in the process of re-appointing to these posts.<br>• all patient experience and feedback is themed and taken into an improvement plan. All learning from patient stories, which are shown at the beginning of all major meetings, is cascaded across the service.<br><br>**QS24/91.2** The Committee thanked the Director of Midwifery and Women's Services Members for her excellent presentation and balanced and informative report, asking to be kept informed as to the successful implementation of the improvement plans described in the report; she agreed to provide live examples within her next report to the committee<br><br>**QS24/91.3** Members asked for information regarding the outcomes for women from deprived and ethnically vulnerable communities and were advised that a piece of work was currently being undertaken with this in mind.<br><br>**QS24/91.4** It was noted that the recurrent funding business case request had not been supported, but that funding had been sourced on a non-recurrent basis. The Committee wished to note that it was very aware of the wider pressures on budgets.<br><br>**QS24/91.5** It was noted that BCUHB is the only Health Board in Wales that had fully implemented the Saving Babies' Lives initiative established in England a number of years ago, which incorporated sound, evidence-based measures to enable the demonstration of improvements in both pre and post-natal care. The initiative was adopted by BCUHB following an increase | **FG** |

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| in stillbirths in 2019 and following the dramatic reduction of stillbirths in North Wales, MatNeo now recommend its implementation throughout Wales.<br><br>**QS24/91.6** Based on knowledge of the national policies that influence and shape the Health Board's delivery of Women's services, The Director of Midwifery and Women's Services was asked for her assistance in shaping the organisation's strategies in its 3/5/10 year plans. Head of Corporate Office to ensure this happens.<br><br>**QS24/91.7** Members asked if there could be opportunities to connect with women who have gone through the service to help improve the provision and if links with existing community groups could become a permanent feature to aid improvement.<br><br>**It was resolved that** the Committee:<br>**received assurance** from the **Service Presentation from Women's Services**<br><br>*[Fiona Giraud, Director for Women's Services and Midwifery, left the meeting].* | **PW / PPJ**<br><br>**FG** |
| **QS24/92 Integrated Quality Report (IQR).**<br><br>**QS24/92.1** Chair thanked The Executive Director of Nursing and Midwifery (EDoN) for her report, which contained a great deal of positives and useful detail; she also thanked the Deputy Executive Medical Director (DEMD) for the information contained in the Clinical Effectiveness part of the report. It was noted that there is to be a Committee Development Session in October – date to be confirmed.<br><br>**QS24/92.2** The EDoN was pleased to note that the report had more balance, now that it included more Clinical Effectiveness information, and thanked the DEMD for his hard work in facilitating this. The EDoN also noted that information concerning successes and improvements, as had been previously requested by Members, was being included in the report, and that more work was being done to link the report to the Quality Management System work, to identify how it dovetails into the IQR and feeds through to Board.<br><br>**QS24/92.3** The EDoN highlighted information within the report, in particular:<br><br>• the developments surrounding oxygen usage and mandatory training, following work carried out with British Oxygen Company (BOC); also feedback from The Coroner regarding this work.<br>• the reduction in patient falls and the positive feedback from both the Coroner and the Health Service Executive (HSE) following the extensive work undertaken across the Health Board to reduce falls.<br>• the evidenced improvements in Manual Handling<br>• the work that had recently begun on the Executive-led quarterly review on Hospital Acquired Pressure Ulcers (HAPU), similar to that | **FL** |

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| carried out around the reduction of Falls; there was a great deal of energy being put into this by both the Integrated Health Care (IHC) directors and divisions, to develop and improve systems to reduce HAPUs.<br>• Members were shown the newly developed dashboard, created by the Deputy Director of Quality's team and IT, which staff will have access to. The dashboard will provide real-time data from the Datix system, about incidents, where they are and their severity. All this information to be accessible not only to aid staff, but to advise Board and the national team going forward. The Organisation is currently liaising with other Health Boards across Wales, demonstrating the system's obvious benefits.<br>• With regards to the impact of training, a trajectory was requested that shows the relationship between training, delivery and performance. | **AW** |
| **QS24/92.4** Members raised concerns regarding the increase in child to parent violence. They also emphasised the need to reduce the backlog with regards to the Deprivation of Liberty (DoLs) Assessments. The EDoN confirmed that a deep dive into these was currently being undertaken and that the Organisation had reduced the delays significantly in the last two years and that work was being carried out to realign safeguarding support. It was noted that there had been an improvement in the quality of DoLs applications going through the system, but some delays were still reliant upon local partners support to undertake assessments; however once the UK officially moves to the Liberty Protection Safeguards system, it will be much more within the Health Board's control, with the Organisation's own teams undertaking assessments rather than relying on partners for this information. | |
| **QS24/92.5** A discussion took place around the need for better customer/patient approach, in particular regarding recent dealings with some of the deaf community and problems concerning the availability, or lack of, interpreters not being communicated appropriately to patients. The EDoN agreed to investigate the situation to ensure it was being appropriately addressed. She confirmed that Civility training was starting to be rolled out across the Health Board, to both those services identified as requiring it and those who had shown an interest; it had also been promoted at leadership conferences and workshops. The Deputy Director of Quality confirmed that through funding made available by Awyr Las, Chris Turner, an Emergency Medical Doctor who was the founder of a well-respected piece of work on Civility training, shared his experiences. Following on from this, 50 Civility champions have been trained across the Organisation – these include a mix of all professional groups – medics, allied health professionals, nursing, pharmacy and some support staff – with the aim that this becomes a self-sustaining network, once they have been provided with suitable resources. Members were very pleased to hear this positive news and felt it would have a beneficial impact in reducing the number of complaints. | **AW** |
| **QS24/92.6** The Deputy Executive Medical Director noted that, having taken | |

on feedback from the Committee and also Board, this and future reports would include more evidence of learning and challenges in specific areas, and where findings from Audit have led directly to improvements in patient care.

**QS24/92.7** The Deputy Executive Medical Director noted that his department had improved their ability to articulate its problems in delivering Audit, adding that the asks of the National audits are increasing in complexity – the effect of this is particularly heightened due to the infrastructure element (the three main sites being far from each other geographically) and the effect this has on the collection of data (paper records). He noted that the Audit Management and Tracking Database (AMaT) was proving to be very helpful, and this is starting to be filtered through into local Clinical Effectiveness groups, giving them more accountability for ensuring that any barriers would not prevent them from progressing as they were able to get involved earlier and address the problem.

**QS24/92.8** It was noted that work was being done regarding the implementation of Health Board-wide policies, which had not hitherto been collected and dealt with centrally. The EDoN confirmed that with the Deputy Executive Medical Director, a piece of work was underway to ensure oversight of, and compliance to, NICE Guidelines and what the risks are if these are not adhered to.

**QS24/92.9** When questioned regarding the status of compliance across the 3 IHCs, The Deputy Executive Medical Director explained that the report was a reflection of the number of vacant clinical leadership posts – as was the case with the Central IHC. This has caused problems in identifying those responsible for delivery of compliance and placed more responsibility and work on the site Directors. It was noted that this had been a major contributory factor for the lack of compliance in certain sites and was being addressed.

**QS24/92.10** With regards to the Mortality Review, The Deputy Executive Medical Director was pleased to note that two new colleagues had recently been taken on as Associate Medical Directors for Mortality. The lack of such personnel over the previous 6-8 months had led to capacity issues. The two new Associate Medical Directors will be responsible for leading the way the Health Board deals with mortality, providing necessary levels of assurance. The Deputy Executive Medical Director was also pleased to note that BCUHB's mortality rates, along with other benchmarks for mortality indicators compared with all Wales, are consistent with its peers and that the Team had worked hard to succeed in reducing the backlog on the Corporate side of Mortality.

**QS24/92.11** With regards to Quality Assurance, The Deputy Director of Quality wished to highlight the following:

- A report was expected towards the end of the year, following the recent inspection into the management of ionising radiation regulation compliance; preliminary feedback had been very positive, with no significant issues raised.
- it was expected that the HIW report into the Emergency Department at Ysbyty Glan Clwyd would be published w/c 19th August, which it was anticipated would show some sustained improvements, with recognition of system pressures, as seen across the whole of Wales.
- as had been requested by QSE, a process of quality peer reviewing had started, with the intention being to expand this across the Health Board, which should provide some internal assurance, resulting in the updating of action plans.
- A recent meeting with the Public Ombudsman had raised no issues.
- Work continued regarding the learning portal - the repository of learning which will support the cascading of information. Members hoped that when this portal goes live, it will be well-publicised to staff in bulletins and newsletters, to which the Deputy Director of Quality confirmed that one of the key features of the system is that it will automatically generate and cascade learning out to predetermined mailing lists.

**QS24/92.12** Members were pleased to note that each contributor to the Incident Learning System was being recognised and would receive a personal certificate from the Chief Executive, which was noted as being important for staff morale.

**QS24/92.13** The Deputy Director for Quality was pleased to note that since the EDoN had taken over chairing the bi-weekly meetings which address the challenges submitting reports on deadline to the Coroner, the number of late submissions had reduced significantly.

**QS24/92.14**. With regards to Litigation, it was noted that there continued to be challenges with overdue learning from events reports and that a piece of work was to commence in the coming weeks to look at these processes. The EDoN confirmed that the Learning from Events Reports was the next item to be focussed on, once the Complaints and Inquests focussed work was complete.

**QS24/92.15** Chair thanked everyone for the quality of the information contained within the report.

**It was resolved that** the Committee:

- **Noted** the Integrated Quality Report

**QS24/93 Integrated Performance Report**

**QS24/93.1** The Director of Performance presented the report, noting that a great deal of commentary of the report had already been discussed earlier in the meeting. He wished to note that following on from previous requests,

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| local metrics had been added into the report, however he felt that work needed to be done with the EDoN and her team to refine these metrics, as he did not feel that they were helpful in their present form. | **EW / AW** |
| **QS24/93.2** It was noted that there was information missing from Pg. 4 of the report and the Director of Performance agreed to share this outside the meeting. | **EW** |
| **QS24/93.3** The Executive Director of Public Health explained why the Human Papillomavirus (HPV) vaccinations show as red on Pg. 14 of the report. This related to certain vaccinations which are carried out by school nurses; in the first two quarters the school nurses had been concentrating on Mumps, Measles and Rubella (MMR) vaccinations, with HPV vaccinations being scheduled for the third quarter and therefore by the end of quarter 3 this would be back in the green. The Director of Performance agreed to review and include more context into the next report, including how to engage staff and teams with performance reporting. | **EW** |
| **QS24/93.4** The Executive Director of Public Health showed concern regarding vaccine reluctance. COVID and Respiratory virus vaccinations' statistics showed that there seemed to be a steady decline in take-up as some members of the public wrongly assume that Covid is no longer a big health issue. It was noted that there was a concerted effort to encourage the take up of the pertussis (whooping cough) vaccinations, as figures showed a significant increase in the number of deaths caused by pertussis, compared to the expected mortality rate. For young babies, the best prevention is the vaccination of expectant mothers. She noted that these concerns were recognised across the four nations and that work was being done around the narrative with vaccinations for mothers-to-be and the elderly – particularly as the Respiratory Synctialvirus (RSV) vaccination programme was about to be introduced and this is a major cause of morbidity and mortality in both very young children and the elderly. | |
| **QS24/93.5** Chair noted the low percentage of patients being offered an index colonoscopy procedure within 4 weeks of booking their Specialist Screening Practitioners assessment appointment (Pg. 14). The EDoN confirmed that Executives were aware and already working to address this as part of the current Planned Care piece of work. | |
| **QS24/93.6** The EDoN addressed concerns regarding the number of confirmed COVID-19 cases (Pg. 17). It was noted that there had been an increase in the number of COVID cases coming through the organisation, but Members were assured that staff were especially vigilant around hospital-acquired COVID. However certain sites had a limited numbers of side rooms and patients with COVID were having to be treated in open-bay areas. In these situations, the use of pods was being investigated. | |
| **QS24/93.7** Regarding Clinical Coding, it was noted that two Coders and a Clinical Coding Assurance Lead had been appointed. Members were | |

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| appreciative that training would need to take place and noted that agency staff were being brought in to mitigate the risk in the meantime; however there was a backlog and all these measures would take time to start having a positive effect on the figures.<br><br>**QS24/93.8** A discussion took place regarding the need to work with managers, staff and teams to motivate them in order to ensure that they appreciate that the information they provide for these reports does get taken seriously at all levels - Board, Committee and Government levels. The vast amount of information provided needs to be simplified and creatively shown to staff in a way that assists clinical teams to critically review themselves and take ownership; and for staff, divisions and IHCs to be able to compare themselves to learn.<br><br>**QS24/93.9** The Director of Performance asked the Committee to look at Liverpool's Women's Hospital's Facebook page, which on one single page of infographics shares each month's Early Pregnancy Assessment Unit and Midwifery birth facts. The Committee felt it should consider this as a form of communication to be adopted by the Communications Department. Fiona Lewis to pass this information onto the Communications Team.<br><br>**It was resolved that** the Committee:<br>• **Received assurance** from the Integrated Performance Report.<br><br>*[Ed Williams, Director of Performance, left the meeting]* | **FL** |
| **QS24/94 Infection Prevention and Control Annual Report**<br><br>**QS24/94.1** The EdoN presented the report which was received as a well-balanced, comprehensive report, showing the work carried out across the organisation not only by the Infection Prevention team but also by the IHCs and divisions in order to keep our patients safe.<br><br>**QS24/94.2** Regarding the recruitment of extra Facilities staff, The EDoN's team described the problems that had been encountered, however her team were working to support Facilities to work with local communities in order to help local people back into the workforce; they would also offer support and wrap-around care, if needed.<br><br>**It was resolved that** the Committee:<br>• **received assurance** from the Infection Prevention and Control Annual Report<br><br>*[A break was taken]* | |
| **QS24/95 Challenged Services Report – Cancer and Oncology**<br><br>**QS24/95.1** In the absence of the author of the report, The Deputy Executive Medical Director (DEMD) presented the Annual Report. | |

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| **QS24/95.2** A discussion took place around ongoing recruitment problems and Members were advised that the Oncology team had identified existing staff who were being trained up to address some of the recruitment issues.<br><br>**QS24/95.3** The Committee noted the considerable challenges facing the service, notably:<br><br>• that the complexity of treatment was increasing dramatically<br>• now that there are more treatments becoming available, the ability to deliver was becoming more difficult. It was noted that this is an All-Wales concern and that solutions are being sought to this challenge.<br><br>**QS24/95.4** It was suggested that the *Roadmap for Cancer Services in North Wales*, as referred to in item 4.3 of the report, be shared with the Committee.<br><br>**It was resolved that** the Committee:<br>• **received assurance** from the Challenged Services Report – Cancer and Oncology. | **JR** |
| **QS24/96 Challenged Services Report - Urology**<br><br>**QS24/96.1** The DEMD presented the report. He noted that there had been a failure to recruit replacements to the two vacant clinical leads positions – West and Centre. Despite extensive attempts to recruit, there had been no expressions of interest in the position. This situation has meant that both Deputy Executive Directors were providing clinical leadership and guidance to move the Service forward.<br><br>**QS24/96.2** The DEMD assured Members that a final decision had yet to be reached as to the ongoing Service redesign. Executives had appraised the options and with support from both the Transformation and Improvement team and Quality Management will help determine what the workforce model should look like, which will then determine whether they go for a two or three-site service reconfiguration. He wished to note that there had been patient involvement throughout the process, via the Strategic Improvement Group.<br><br>**It was resolved that** the Committee:<br>• **Noted and received assurance** from the Challenged Services Report – Urology.<br><br>[*Nesta Collingridge, Head of Risk Management, joined the meeting]* | |
| **QS24/97 Health Board Response to the Royal College of Psychiatrists Invited Review Services Report**<br><br>**QS24/97.1** The Executive Director of Allied Health Professionals and Health Science (AHPHS) thanked the Interim Director for Mental Health and Learning Disabilities (MHLD) and the Associate Director of Governance for | |

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| their help preparing the report which outlined and clarified the new governance approach being taken by establishing the Expert Advisory Group, a sub-committee of the QSE, to oversee the creation of and trajectory against recommendations of the Royal College of Psychiatrists Invited Review Services Report (RCPsych Report).<br><br>**QS24/97.2** It was noted that The Board had considered and endorsed the establishment of the Group, which will be independently chaired, with both family and user representatives, and Llais included as members.<br><br>**QS24/97.3** The Interim Director of MHLD was pleased to note that recent meetings involving the Chair, the Chief Executive, The Executive Director of AHP&HS, The Interim Director of MHLD and both Llais representatives and some Tawel Fan families' members, although challenging, had also been very productive and felt that it is now considered fundamental that people who had experienced poor care in the past are able to influence the Health Board's future direction. The Interim Director of MHLD informed the Committee that the Board had considered and endorsed the outline approach and governance arrangements, which included the establishment of a governance framework that enables transparent and accountable progress and the report highlights some of the key aims for this Group to consider<br><br>**QS24/97.4** Members thanked all responsible for the important developments outlined in the report, acknowledging that there needed to be a proper space for people's experiences to be reflected.<br><br>**It was resolved that** the Committee:<br><br>• **Considered** and **endorsed** the proposed governance arrangements to oversee/monitor the response plan in order to assure the Board that progress and trajectory address the recommendations within the RCPsych Report.<br>• **Agreed** to establish the Expert Advisory Group as a sub committee of the Quality Safety and Experience Committee which will have the responsibility for the oversight of the Action Plan.<br>• **Noted** the Draft Terms of Reference for the Health Board RCPsych Action Delivery Group that will be received and considered at Executive Team Meetings. | |
| **QS24/98 Corporate Risk Register**<br><br>**QS24/98.1** The Head of Risk Management presented the report, bringing the Committee's attention to two risks that were over the tolerance set by Board – (1) Failure to Embed Learning, and (2) The Primary Care Risk.<br><br>**QS24/98.2** The Committee was asked to note that within the reports it referred to the CRR24-03 'Safeguarding' risk, which was to be noted for de- | |

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| escalation, however this was **incorrect** as the de-escalation had yet to be formally approved by the Executive Committee.<br><br>**QS24/98.3** Members were concerned that the report noted that despite several actions having been progressed, no risk scores had been reduced. The EDoN noted that with regards to the 'Failure to Embed Learning', there was a great deal of evidence across the Health Board that actions were being progressed, however it had been felt that until there was undisputed evidence that reduction in incidents was due to the learning, the risk score should not be reduced. The Deputy Director of Quality wished to note that he was ready to move a significant number of items to close, which would help demonstrate that progress was being made. Deputy Director of Quality agreed to update and circulate. The EDoN noted that some of the slippages of timescales were necessary because although the work towards the actions was complete, they still required sign-off by committees and Board.<br><br>**QS24/98.4** The EDoN assured the Committee that the need to identify how learning was being shared and embedded was extremely important to the organisation, however it was a very complex issue to provide evidence of success. She noted that the NHS Executive wished both the Learning Repository (which once completed will be a first of its kind for Wales) and the Terms of Reference for the Learning Forum, will be cascaded across Wales as they have both been identified as 'best practice'.<br><br>**It was resolved that** the Committee:<br>• **Noted and took assurance** on the Corporate risks within the report.<br><br>*[Nesta Collingridge, Head of Risk Management left the meeting]* | **MJ** |
| **QS24/99 NHS Wales – Joint Commissioning Committee Quality Committee Chairs Report.**<br><br>The report was **noted.** | |
| **QS24/100 Quality Delivery Chair's Assurance Report**<br><br>**QS24/100.1** The EDoN noted that since the last meeting, a new template had been put in place to facilitate a consistent approach to capturing information, anticipating that this report will provide an escalation to Executives and Independent Members.<br><br>The report was **noted.** | |
| **QS24/101 Summary of Business to be Reported from Private**<br><br>The report was **noted.** | |
| **QS24/102 Committee Cycle of Business and Committee Workplan** | |

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| **QS24/102.1** As Chair of the Risk Scrutiny Group, The EDoN agreed to keep Committee informed of support for East IHC's in relation to increased demand for Children's Neurodevelopment services which far outweighs its capacity.<br><br>**QS24/102.2** In relation to Mental Health & Learning Disabilities, these need to be added as two separate items (1) Mental Health and (2) Learning Disabilities. Primary Care to be added onto the Cycle of Business.<br><br>The report was **noted.** | **AW**<br><br>**AW / PPJ / FL** |
| **QS24/103 Organ and Tissue Donation Committee Annual Report**<br><br>**QS24/103.1** The Executive Director of Allied Health Professionals and Health Science (AHPHS) asked the Committee to note the important work carried out by the committee and urged Board to support where possible, with suggested attendance at the annual service held at St Asaph Cathedral. It was acknowledged that the Committee's work was often not discussed, however, to note that it was extremely important to families that it be recognised.<br><br>The report was **noted.** | |
| **QS24/104 Meeting effectiveness**<br><br>**QS24/104.1** It was noted that although the meeting had overrun slightly, there had been some extremely important information within the reports and presentations, which focussed on the good work taking place, as well as on-going challenges.<br><br>**QS24/104.2** A discussion took place regarding the balance, quality and length of the meeting. It was agreed to extend the length of meeting to four hours in future, to provide more time for in-depth discussion.<br><br>**QS24/104.3** It was noted that more time should be allocated to Primary Care on a regular basis. | **AW / PPJ / FL**<br><br>**AW / PPJ / FL** |
| **QS24/105 Date of Next Meeting**<br><br>24th October 2024 | |
| **QS24/106 Resolution to Exclude the Press and Public** | |

# QSE Committee PUBLIC Action Log

| Open Actions | | | | | | |
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| **Action No.** | **Minute Ref.** | **Date** | **Agreed Action** | **Lead** | **Timescale** | **Status** |
| 1 | QS24/69.2 | 6.6.24 | Vascular Action plans via an escalation report/template to be received at QSE | Nick Lyons / James Risley | August 2024 | Suggest close<br>16.8.24 Vascular Update circulated to Members |
| 2 | QS24/69.4 | 6.6.24 | Take outside the meeting the issue of Vascular referral to the wrong place and how often this is happening | Nick Lyons / James Risley | August 2024 | Suggest close.<br>Unsure as to what this relates. |
| 3 | QS24/69.5 | 6.6.24 | Review the Progress update narrative on P1. 07 of the Vascular Action Plan | Nick Lyons / James Risley | August 2024 | Suggest close.<br>The wording on the P1 . 07 changed to: "work not yet started" – Lessons learnt from the AAA improvement work, which is equally acute, will be applied to this area. |
| 4 | QS24/89 | 15.8.24 | **QS24/89 Matters Arising and Action Log**<br>Add title of agenda item on action log. Requested by Committee members | Fiona Lewis | September 2024 | Suggest close.<br>16.8.24 Actioned. |
| 5 | QS24/91.1 | 15.8.24 | **QS24.91 Service Presentation from Women's Services.**<br>To ensure 'The Health Board' is placed at the top of both 'Women's Services Operating Governance Structure' and 'Leadership – Women's | Fiona Giraud | September 2024 | Suggest close.<br>21.8.24 Actioned. |

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| | | | Services Management & Leadership Structure' diagrams. | | | |
| 6 | QS24.91.2 | 15.8.24 | **QS24.91 Service Presentation from Women's Services.** The Committee asked for more evidence to be included to show if learning was being embedded successfully, leading to improvements. (This should include consideration of pan Health Board learning and how Services can influence the annual planning process.) | Fiona Giraud / Philippa Peake-Jones | October 2024 | Suggest close. Paper provided by Fiona Giraud and added to October agenda, for information. |
| 7 | QS24/91.6 | 15.8.24 | **QS24.91 Service Presentation from Women's Services.** The Director of Midwifery and Women's Services was asked for her assistance in shaping the organisation's strategies in its 3/5/10 year plans. | Pam Wenger / Philippa Peake-Jones | December 2024 | Suggest close This will be taken forwards in the planning work which has now commenced. |
| 8 | QS24/91.7 | 15.8.24 | **QS24.91 Service Presentation from Women's Services** To connect with women who have gone through the service and create links with existing women's community groups to aid improvements. | Fiona Giraud | December 2024 | Suggest close. **15.10.24** Paper provided by Fiona Giraud and added to October agenda for information. |
| 9. | QS24/92.1 | 15.8.24 | **QS24.92 Integrated Quality** | Fiona Lewis | Sept 2024 | Suggest close. |

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| | | | **Report.**<br>It was agreed to hold a Committee Development Session in October. Chair and Committee Secretary to confirm date. | | | Development Session arranged for 4.10.24 |
| 10. | QS24/92.3 | 15.8.24 | **QS24.92 Integrated Quality Report.**<br>With regards to the impact of training, a trajectory was requested that shows the relationship between training, delivery and performance**.** | Angela Wood | October 2024 | Suggest close.<br>Full response added to October agenda - item |
| 11. | QS24/92.5 | 15.8.24 | **QS24.92 Integrated Quality Report.**<br>Regarding a question concerning problems some of the Deaf Community were having making appointments, AW agreed to investigate the situation to ensure it is being appropriately addressed. | Angela Wood | October 2024 | Suggest close.<br>**13.9.24**. Update received from AW:<br>The Patient and Carer Experience Group has a monthly standard agenda item 'accessible health care' with the particular focus now on the launch of Sign Live. IHC Patient & Carer Experience Group meetings receive WITS/Accessible Health Care updates from the Patient & Carer Experience Team.<br>Below are examples of work being undertaken to meet the needs of the deaf and BSL using community:<br>• Introduction of Sign Live in November 2024 – 24/7 access to BSL video interpretation and the ability to telephone the Health Board through a video relay service.<br>• Quarterly feedback reports from Centre of |

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| | | | | | | Sign Sight and Sound on behalf of the deaf and BSL using community to be reported to the Patient and Carer Experience Group.<br>• In partnership with Centre of Sign Sight and Sound, working with the deaf and BSL using community to capturing a series of patient stories to raise awareness and learn from experiences.<br>• Deaf awareness and Welsh Interpretation Translation Service training for staff.<br>In November, it's national Sensory loss awareness month. The Patient & Carer Experience Team will be working with the Equality & Human Rights Team to promote sensory loss awareness to staff. This includes:<br>• Holding a series of bite-sized sessions online and face to face to for staff<br>• Promotion of equipment available in hospitals to use for translation e.g. translator on wheels, iPad for 'Insight' app<br>• PALS staff engagement across wards/service areas. |
| 12. | QS24/93.1 | 15.8.24 | **QS24/93 Integrated Performance Report**<br>EW to discuss with AW how to improve the use of metrics within the report. | Ed Williams / Angela Wood | October 2024 | **Suggest close.**<br>**15.10.24** Update received. Presentation made at Development Session on 4.10.24. As a result, changes to the report were agreed. Some immediate small changes and some that will take time to develop. The minor changes have been made for October's report |
| 13. | QS24/93.2 | 15.8.24 | **QS24.93 Integrated** | Ed Williams | October | Suggest close. |

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| | | | **Performance Report.**<br>EW agreed to provide information missing on Pg 4 of report. | | 2024 | This information is now included in the October Report. |
| 14. | QS24/93.3 | 15.8.24 | **QS24.93 Integrated Performance Report**<br>EW agreed to review and include more context into the next report, including how to engage staff and teams with the performance reporting. | Ed Willaims / Jane Moore | October 2024 | Suggest close.<br>**15.10.24** Update received. Presentation made at Development Session on 4.10.24. As a result, changes to the report were agreed. Some immediate small changes and some that will take time to develop. The minor changes have been made for October's report |
| 15. | QS24/93.9 | 15.8.24 | **QS24.93 Integrated Performance Report.**<br>Asked Members to look at Liverpool's Women's Hospital's Facebook page, which on one page of infographics shares each month's Early Pregnancy Assessment Unit and Midwifery birth facts. The Committee felt it should consider this as a form of communication to be adopted by the Communications Department. | Fiona Lewis / Helen Stevens-Jones | October 2024 | Suggest close<br>20.8.24 HS-J advised that Comms already have infographics on Maternity. The team is looking at the Liverpool website to make comparison and improve where necessary. |
| 16. | QS24/95.4 | 15.8.24 | **QS24/95 Challenged Services Report – Cancer & Oncology.**<br>To share the ' Roadmap for Cancer Services in North Wales', as referred to in Item | James Risley / Caroline Williams | Sept 2024 | Suggest close.<br>20.8.24 Item shared. |

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| | | | 4.3 of report, with both QSE and The Board. | | | |
| 17. | QS24/98.3 | 15.8.24 | **QS24/98 Corporate Risk Register**<br>Regarding Pg 6 of report (Pg 326 of bundle), item Ref CRR24-04. MJ to update and circulate. | Angela Wood / Matt Joyes / Phil Meakin | September 2024 | Suggest close<br>17.10.24 MJ confirmed complete following work with the Risk Team. Discussed within the October Development Session |
| 18. | QS24/102.1 | 15.8.24 | **QS24/102 Committee Cycle of Business & Committee Workplan**<br>As Chair of the Risk Scrutiny Group, AW to keep Committee informed of support for East IHC's in relation to increased demand for Children's Neurodevelopment services which far outweighs its capacity. | Angela Wood | September 2024 | Suggest close<br>This has been transferred to the Risk Scrutiny Group's forward work plan. |
| 19. | QS24/102.2 | 15.8.24 | **QS24/102 Committee Cycle of Business & Committee Workplan**<br>In relation to Mental Health & Learning Disabilities, these need to be added as two separate items (1) Mental Health and (2) Learning Disabilities. Primary Care to be added onto the Cycle of Business. Revised Cycle of Business to be presented at December meeting. | Angela Wood / Philippa Peake-Jones / | December 2024 | Suggest close<br>These have been added to the cycle of business and will be received in due course |

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| 20. | QS24/104.2 | | **QS24/104 Meeting Effectiveness** It was agreed to extend the length of future meetings to 4 hours, allowing more time for in-depth discussion. | Philippa Peake-Jones / Fiona Lewis | October 2024 | Suggest close It was agreed at agenda setting to leave the timing of the meeting as 3.5 hours |
| 21. | QS24/104.3 | | **QS24/104 Meeting Effectiveness** Ensure more time allocated to Primary Care on CoB, on a regular basis. | Angela Wood / Philippa Peake-Jones | | **16.10.24** CoB will be updated once further conversations have taken place with Executives. |

**Closed Actions**

| Action No. | Minute Ref. | Date | Agreed Action | Lead | Timescale | Status |
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| 1 | QS24/68.3 | 6.6.24 | To circulate, when available, the national report on HAPU that is currently being populated | Angela Wood | July 2024 | 15.8.24 Item incorrect. To be removed. |
| 2 | QS24/68.8 | 6.6.24 | To include a reference date on the data table | Angela Wood / Matt Joyes | July 2024 | Suggest close<br>Actioned.<br>15.8.24 Closed. |
| 3 | QS24/68.8 | 6.6.24 | The Ombudsman Letter to be a separate item not included in the Quality Report at both QSE and Board | Angela Wood / Philippa Peake-Jones | August 2024 | Suggest close<br>Now on COB for both QSE and Board<br>15.8.24 Closed |
| 4 | QS24/68.8 | 6.6.24 | Include historic/comparison data on the tables that are broken down by themes and re-align tables | Angela Wood / Matt Joyes | August 2024 | Suggest close<br>Actioned.<br>15.8.24 Closed |
| 5 | QS24/70.2 | 6.6.24 | Move the Quality Delivery Group Chair's Report to after | Angela Wood / Philippa Peake- | August 2024 | Suggest close<br>Amended on Agenda/COB |

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| | | | the Quality Report at forthcoming meetings | Jones | | |
| 6 | QS24/72.2 | 6.6.24 | Schedule a visit to Electronic Records visits | Angela Wood / Philippa Peake-Jones | August 2024 | Suggest Close<br>Now on Forward Work Plan for QSE. Will be scheduled after summer given holiday period. |

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| **Teitl adroddiad:**<br>***Report title:*** | **Patient Story: Milly's Story – My Beautiful Home Birth**<br><br>**Stori Claf: Stori Milly – Geni Gartref Gwych** |
| **Adrodd i:**<br>***Report to:*** | Quality, Safety and Experience Committee |
| **Dyddiad y Cyfarfod:**<br>***Date of Meeting:*** | 24th October 2024 |
| **Crynodeb Gweithredol:**<br>***Executive Summary:*** | A patient or carer story is presented to QSE to bring the voice of the people we serve directly into the meeting. The digital story will be played at the meeting. A short summary is included in the attached paper. |
| **Argymhellion:**<br>***Recommendations:*** | QSE is asked to note this report. |
| **Arweinydd Gweithredol:**<br>***Executive Lead:*** | Angela Wood, Executive Director of Nursing and Midwifery |
| **Awdur yr Adroddiad:**<br>***Report Author:*** | Mandy Jones, Deputy Executive Director of Nursing<br>Leon Marsh, Head of Patient Experience<br>Rachel Wright, Patient and Carer Experience Lead Manager |

| **Pwrpas yr adroddiad:**<br>***Purpose of report:*** | I'w Nodi<br>*For Noting*<br>☐ | I Benderfynu arno<br>*For Decision*<br>☐ | Am sicrwydd<br>*For Assurance*<br>☒ |
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| **Lefel sicrwydd:**<br>***Assurance level:*** | Arwyddocaol<br>*Significant*<br>☐<br>Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol<br><br>*High level of confidence/evidence in delivery of existing mechanisms/objectives* | Derbyniol<br>*Acceptable*<br>☒<br>Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol<br><br>*General confidence / evidence in delivery of existing mechanisms / objectives* | Rhannol<br>*Partial*<br>☐<br>Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol<br><br>*Some confidence / evidence in delivery of existing mechanisms / objectives* | Dim Sicrwydd<br>*No Assurance*<br>☐<br>Dim hyder/tystiolaeth o ran y ddarpariaeth<br><br>*No confidence / evidence in delivery* |
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**Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:**
***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***

In line with best practice, a patient or carer story is presented to QSE to bring the voice of the people we serve directly into the meeting, but it is not presented as an assurance item. However, the accompanying paper describes some of the learning and actions undertaken in response to the story.

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| **Cyswllt ag Amcan/Amcanion Strategol:**<br>***Link to Strategic Objective(s):*** | Quality |
| **Goblygiadau rheoleiddio a lleol:**<br>***Regulatory and legal implications:*** | N/A |
| **Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal?**<br>***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?** | N/A |

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| ***In accordance with WP68, has an SEIA identified as necessary been undertaken?*** | |
| **Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR)**<br>***Details of risks associated with the subject and scope of this paper, including new risks( cross reference to the BAF and CRR)*** | BAF21-10 - Listening and Learning |
| **Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith***<br>***Financial implications as a result of implementing the recommendations*** | N/A |
| **Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith**<br>***Workforce implications as a result of implementing the recommendations*** | N/A |
| **Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori**<br>***Feedback, response, and follow up summary following consultation*** | N/A |
| **Cysylltiadau â risgiau BAF:**<br>(neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)<br>***Links to BAF risks:***<br>*(or links to the Corporate Risk Register)* | BAF21-10 - Listening and Learning |
| **Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)**<br>***Reason for submission of report to confidential board (where relevant)*** | N/A |
| **Camau Nesaf: Gweithredu argymhellion**<br>***Next Steps: Implementation of recommendations***<br>N/A | |
| **Rhestr o Atodiadau:**<br><br>WELSH SUBTITLES FINAL - My Beautiful Home Birth Patient Story.mov<br><br>ENGLISH SUBTITLES FINAL - My Beautiful Home Birth Patient Story.mov<br><br>I am willing for my story to be shared with:<br>[√ ] Level 1 – Any Health and Social Care Professionals within BCUHB<br>[√ ] Level 2 – Researchers for Service Evaluation and improvement beyond BCUHB<br>[√ ] Level 3 – Meetings and Conferences with anyone present including public and journalists<br>[√ ] Level 4 – Anyone including Online, Internet, Social Media and CIVICA<br><br>***List of Appendices:***<br>Appendix A- Patient Story Summary | |

**Betsi Cadwaladr University Health Board**

**Milly's Story – My Beautiful Home Birth**
**Stori Milly – Geni Gartref Gwych**

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

## Overview of Patient Story

The storyteller describes her experience of her most recent 'fourth and final' pregnancy and birth.

The storyteller describes being consultant-led, but how she also received outstanding care from Llandudno Community Midwives, who also attended her 'beautiful home birth'.

The storyteller describes how she felt her individual birth preferences were explored and supported, felt involved and confident in the decision making process and felt empowered by the Community Midwives who 'set her up for success'. The storyteller also describes the positive impact of the Community Midwives on her labour and birth knowing she was in the very best hands, showing professionalism and genuine care.

The storyteller describes her positive experience of homebirth, where she felt safe and relaxed surrounded by family and friends as beautiful and one that she and her family will treasure forever.

## Key Messages

- The storyteller's standard of care was 'outstanding' from start to end and felt that she and her baby were at the centre of the care throughout.
- The storyteller felt that the Llandudno Community Midwives were 'truly magic' and provided genuine interest, care and support.
- The storyteller said that she 'felt heard' by her Midwives and that her thoughts and preferences were important.
- The storyteller said that she 'felt empowered' by her Midwives, involved in her own care and supported to make confident and informed decisions.
- The storyteller felt that she was nurtured in the right environment at home and 'set up for success'.
- The storyteller felt that she was 'in the very best hands' on 'the big day', which supported her to relax into labour.
- The storyteller felt safe and relaxed giving birth in her own home surrounded by supportive midwives, family and friends. She felt loved and this 'beautiful home birth' is a memory that she will treasure forever.

## Summary of Learning and Improvement

The patient story has been shared widely across the Health Board Maternity and Women's Services, including the Maternity / Women's QSE and Board and Team Meetings within the midwifery-led unit and Community Midwives Teams.

This is to highlight this positive patient experience following the recent Health Board decision to re-introduce the active offer for homebirths in February 2024.

During the Covid pandemic, there was a concern at a national level regarding the potential impact on ambulance resources and maternity services have experienced ongoing issues and concerns with regards response times due to WAST (Welsh Ambulance Services) pressures, staff shortages and more recently industrial action. This potentially threatened the ability to transfer women and / or babies in an emergency situation for appropriate medical review and care when required. In July 2022, the decision was taken by the Health Board to temporarily suspend the active offer / promotion of homebirths. A thorough review of the Health Board homebirth service provision and WAST's ability to respond appropriately to maternity transfer requests, was undertaken by the BCUHB Consultant Midwife. During this time, women planning a homebirth were informed of the potential risks and were advised to give birth in a hospital setting, but in instances where women continued with plans to give birth at home, they were fully supported to do so via thorough care planning.

To provide assurances to stand down the temporary suspension of the Homebirth Service, and to resume the active re-offer of homebirths, WAST have developed a number of service improvements and support mechanisms. These include the development of an 'All Wales Guideline for Maternity Transfer for Community and Freestanding Midwifery Units', an all Wales training package, communication scripts to ensure a standardised language and approach to requesting maternity transfers as well as consideration of a Midwife role within WAST to support the triage of calls. In addition, the Health Board has developed a 'Community Midwife Support Plan' with the aim of upskilling Community Midwives to confidently offer homebirth as a birth place for women experiencing low risk pregnancies and to support women who choose to give birth outside of local / national guidance. Due to historical low levels of homebirth activity and the suspension of the active offer of homebirth, this has reduced the exposure of Community Midwives to intrapartum care and reduced levels of confidence. Community Midwives have been provided with Community PROMPT (Practical Obstetric Multi-professional Training) to maintain skills in managing obstetric emergencies, as well as additional training around cannulation and suturing skills and place of birth risk assessments. The patient story will support the training for staff as part of the re-introduction of home birth, in particular student Midwives to boost both positivity and confidence within the maternity service.

**The patient story has been shared via the Health Board 'Maternity and Neonatal Voices' Group.**

The Maternity and Neonatal Voices Group brings together women, partners and families who have had a recent experience of maternity services and those with an interest in improving maternity services with Midwives, Doctors and other health professionals who work in Maternity Services as well as other stakeholders to plan, review, develop and improve maternity and neonatal care. Maternity and Neonatal Voices listens to its members

and contributes to the development and provision of quality services to meet the needs of the Health Board community by ensuring that service users voices are at the heart of decision making. This influences improvements in the safety, quality and experience of maternity and neonatal care. Maternity and Neonatal Voices meets quarterly and always welcomes new members. The Patient and Carer Experience Teams are currently supporting the Maternity and Neonatal Voices Group to further strengthen this vital patient-led group through increased patient membership, feedback and involvement.

**The patient story has been shared to support the new Health Board 'Best Start Hub' for parents and families.**

In line with the Women's Board 'Best Start in Partnership' priority, the Health Advice section of the Health Board public-facing website has been systematically revamped with support from the BCUHB Public Health Team. Annually, approximately 6,300 people visit the Betsi Cadwaladr University Health Board website for information before, during, after and between pregnancies.

Working in collaboration with over fifty partner groups and organisations, including Gynae Voices, Maternity and Neonatal Voices and the North Wales Perinatal Mental Health Steering Group, the new 'Best Start Hub' includes seventy new webpages, ensuring current, evidence-based information. The 'Best Start Hub' includes useful information, advice and support across the life course, including preconception, pregnancy, early years and family.

The 'Best Start Hub' was officially launched during National Parenting Week in October 2023 and the engagement analytics exhibit a consistently elevated number of views since launch. The new look pages simplify and streamline the process for individuals, couples and families to find the information that they need as well as serving as a comprehensive resource for Health Board staff and external stakeholders to support meaningful conversations with patients, families, carers and other service users. This patient story will be embedded within the 'Home Birth' patient stories section for the public to access.

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

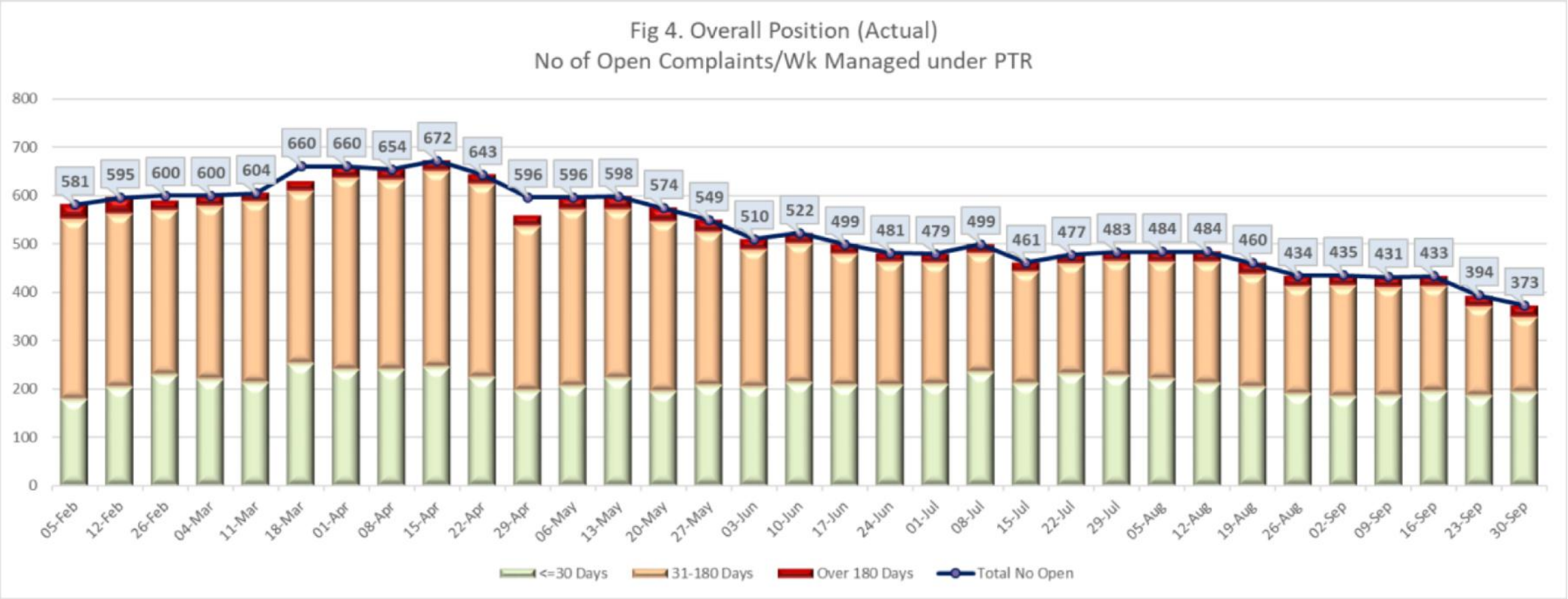
# Complaints Improvement Deep Dive

## QSE Committee

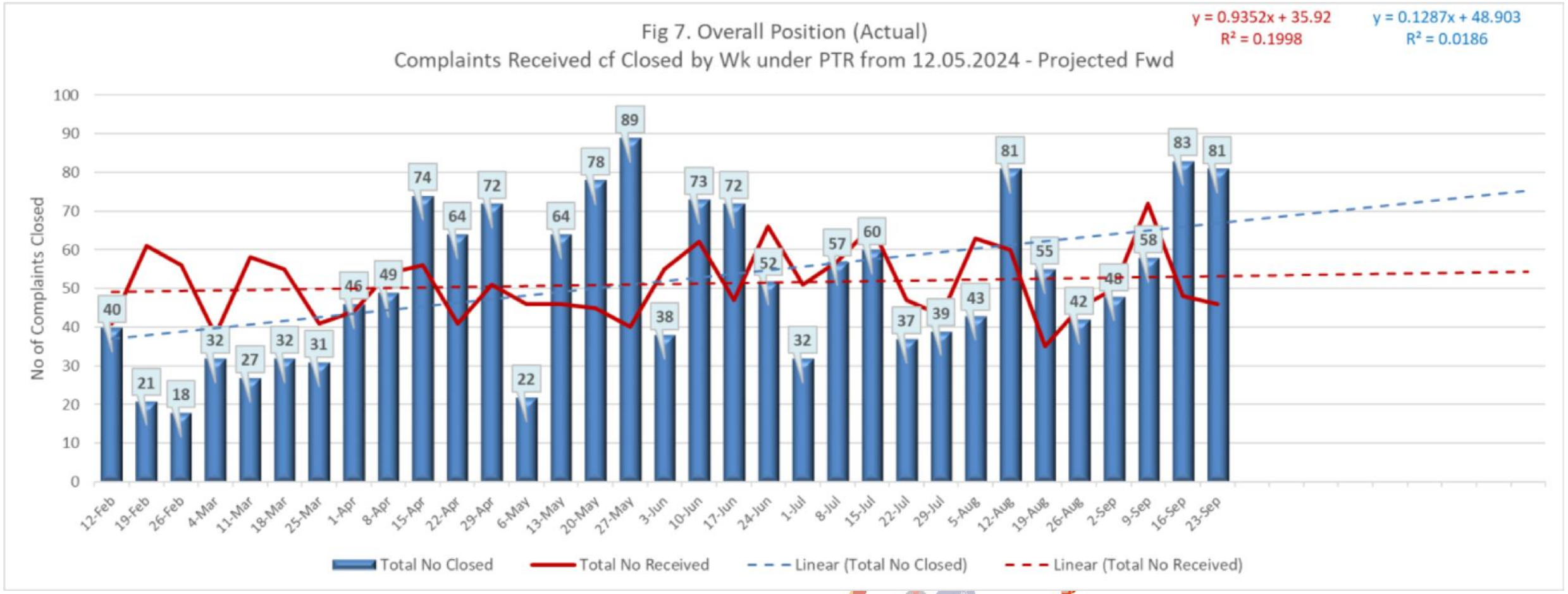
### October 2024

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

# BCUHB OVERALL COMPLAINTS POSITION (as of 30th September )




# BCUHB OVERALL COMPLAINTS CLOSED / RECIEVED




(as of 30th September )

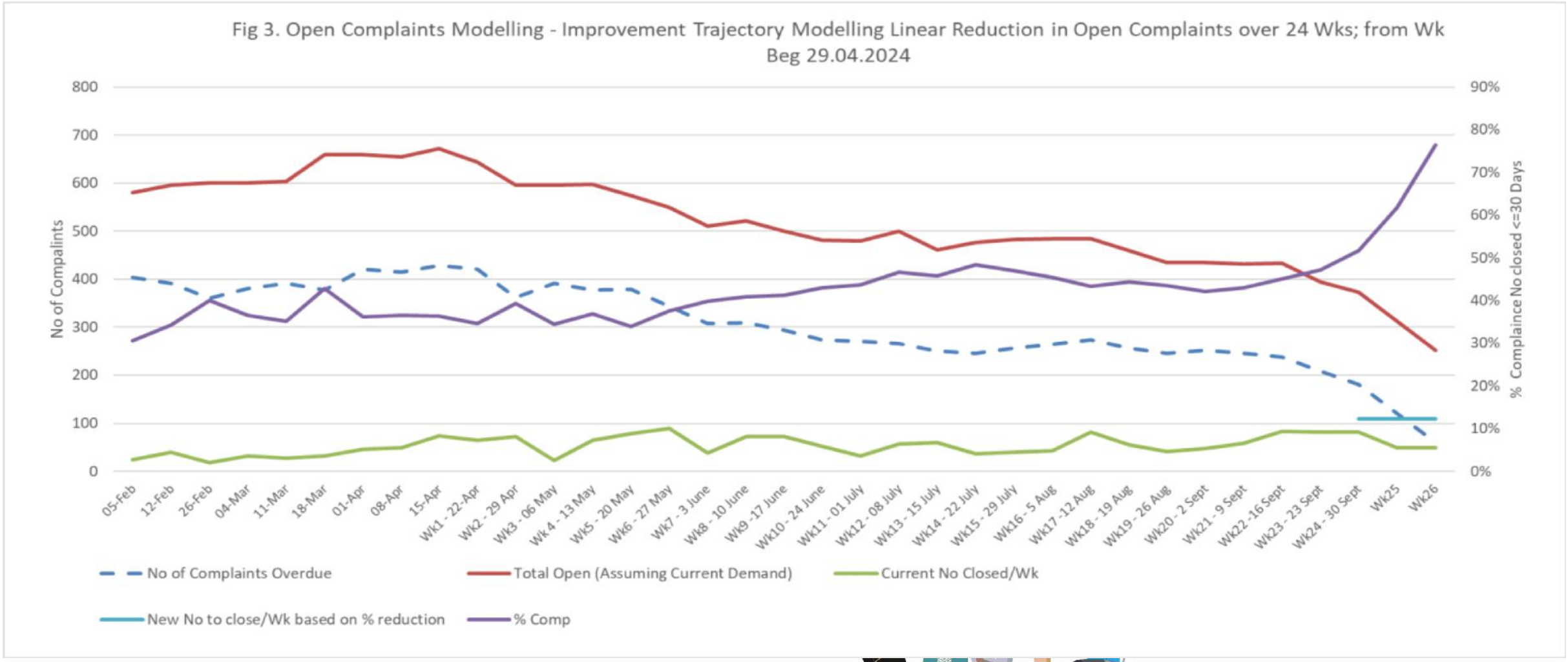
# BCUHB OVERALL COMPLAINTS POSITION (as of 30th September )

| Time Open | 02-Sep | 09-Sep | 16-Sep | 23-Sep | 29- Sep |
|---|---|---|---|---|---|
| Less than 30 days | 183 | 185 | 195 | 185 | 193 |
| Between 31 and 180 days | 231 | 226 | 217 | 186 | 156 |
| Over 180 days | 21 | 20 | 21 | 22 | 24 |
| Total | 435 | 431 | 433 | 394 | 373 |

| Complaint Stage | 02-Sep | 09-Sep | 16-Sep | 23-Sep |
|---|---|---|---|---|
| Overdue | 252 | 246 | 238 | 208 |
| Closed | 48 | 57 | 83 | 81 |
| Received | 50 | 71 | 35 | 46 |

This table shows in the last 4 weeks we have received 202 complaints and closed 269, creating a **positive** variance of 67.

# BCUHB OVERALL COMPLAINTS TRAJECTORY




# BCUHB Overall Complaints Trajectory In Numbers

| Date Wk Beginning | No of Complaints Overdue | Total Open (Assuming Current Demand) | Current No Closed/Wk | % Comp |
|---|---|---|---|---|
| 05-Feb | 404 | 582 | 24 | 30.58% |
| 12-Feb | 392 | 598 | 40 | 34.45% |
| 26-Feb | 360 | 600 | 18 | 40.00% |
| 04-Mar | 381 | 600 | 32 | 36.50% |
| 11-Mar | 392 | 604 | 27 | 35.10% |
| 18-Mar | 378 | 660 | 32 | 42.73% |
| 01-Apr | 421 | 660 | 46 | 36.21% |
| 08-Apr | 415 | 654 | 49 | 36.54% |
| 15-Apr | 428 | 672 | 74 | 36.31% |
| 22-Apr | 420 | 643 | 64 | 34.68% |
| 29-Apr | 362 | 596 | 72 | 39.26% |
| 06-May | 391 | 596 | 22 | 34.40% |
| 13-May | 377 | 598 | 64 | 36.96% |
| 20-May | 379 | 574 | 78 | 33.97% |
| 27-May | 343 | 549 | 89 | 37.52% |
| 03-Jun | 307 | 510 | 38 | 39.80% |
| 10-Jun | 309 | 522 | 73 | 40.80% |
| 17-Jun | 293 | 499 | 72 | 41.28% |
| 24-Jun | 274 | 481 | 52 | 43.04% |
| 01-Jul | 270 | 479 | 32 | 43.63% |
| 08-Jul | 266 | 499 | 57 | 46.69% |
| 15-Jul | 250 | 461 | 60 | 45.77% |
| 22-Jul | 246 | 477 | 37 | 48.43% |
| 29-Jul | 256 | 483 | 39 | 47.00% |
| 05-Aug | 264 | 484 | 44 | 45.45% |
| 12-Aug | 274 | 484 | 81 | 43.39% |
| 19-Aug | 256 | 460 | 55 | 44.35% |
| 26-Aug | 245 | 434 | 42 | 43.55% |
| 02-Sep | 252 | 435 | 48 | 42.07% |
| 09-Sep | 246 | 431 | 48 | 42.92% |
| 16-Sep | 238 | 433 | 57 | 45.03% |
| 23-Sep | 208 | 394 | 83 | 47.21% |
| 29-Sep | 180 | 373 | 81 | 51.74% |
| 14-Oct | 65.00 | 264.00 | 49.00 | 75.38% |

## Progress against Target

We must close a minimum of 110 complaints per week for the next 2 weeks to achieve a 76.49 % trajectory, including complaints received

At the current rate a trajectory of 63.64% will be achieved by 14th October, 2024,

# BCUHB Overall Complaints By Grade / Time Open

| No of Open Complaints under PTR | Column Labels |
|---|---|
| | Managed through |
| Service/IHC | PTR |
| IHC Central | 134 |
| IHC East | 84 |
| IHC West | 69 |
| Mental Health and Learning Disabilities | 26 |
| Midwifery and Women's Services | 17 |
| Diagnostics and Specialist Clinical Suppo | 16 |
| Cancer Services | 9 |
| Dentistry | 9 |
| Corporate Services | 8 |
| Support Services (Old hierarchy) | 1 |
| **Grand Total** | **373** |

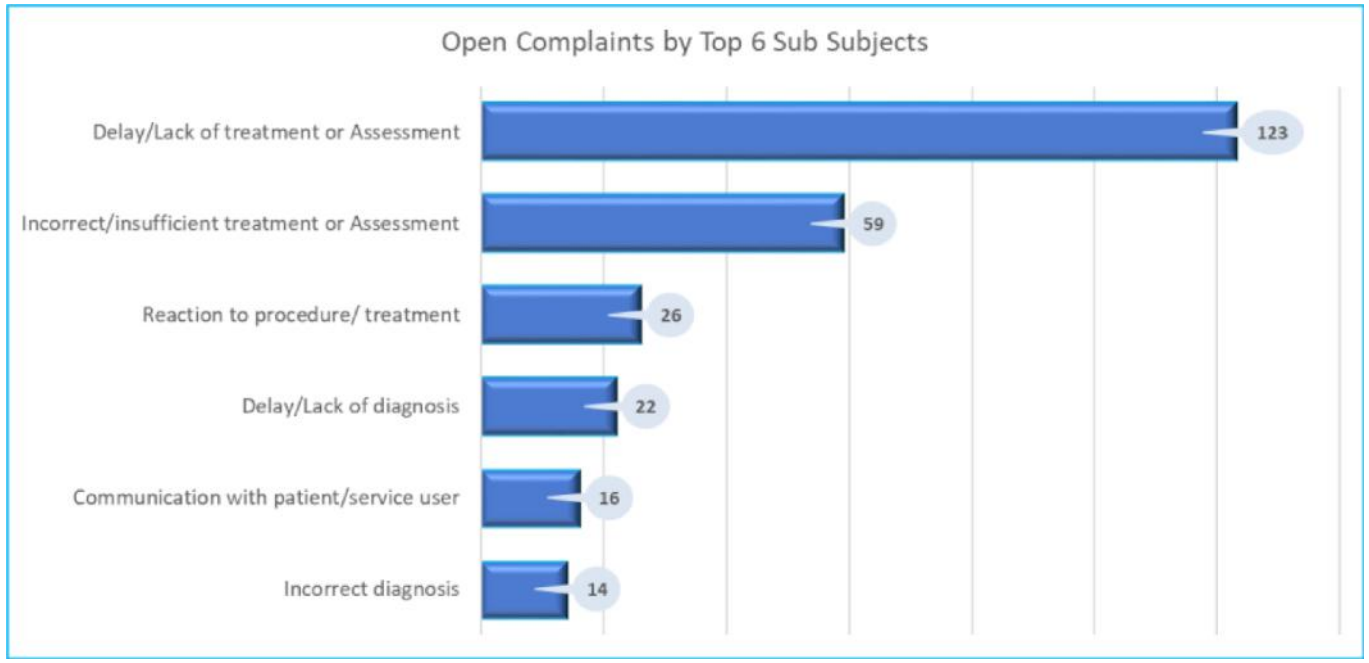
(as of 30th September )

# BCUHB Overall Complaints By Service / Time open

| Calendar Months | IHC Central | IHC East | IHC West | Mental Health and Learning Disabilities | Midwifery and Women's Services | Diagnostics and Specialist Clinical Support Services | Dentistry | Cancer Services | Corporate Services | Support Services (Old hierarchy) | Grand Total |
|---|---|---|---|---|---|---|---|---|---|---|---|
| <= 1 Mnth | 40 | 35 | 36 | 17 | 10 | 6 | 7 | 3 | | | 154 |
| Over 1 Mnth | 21 | 10 | 18 | 7 | 3 | 2 | 2 | 4 | 2 | | 69 |
| Over 2 Mnths | 20 | 15 | 5 | | 3 | 2 | | | 1 | | 46 |
| Over 3 Mnths | 13 | 10 | 2 | | | | | 1 | 2 | | 28 |
| Over 4 Mnths | 6 | 4 | | 1 | | 1 | | 1 | | | 13 |
| Over 5 Mnths | 6 | 3 | 3 | | 1 | 2 | | | | | 15 |
| Over 6 Mnths | 8 | 1 | 2 | | | 2 | | | | | 13 |
| Over 7 Mnths | 5 | 2 | 2 | | | | | | | | 9 |
| Over 8 Mnths | 4 | 1 | 1 | 1 | | 1 | | | 2 | | 10 |
| Over 9 Mnths | 4 | 1 | | | | | | | | | 5 |
| Over 10 Mnths | 1 | | | | | | | | 1 | | 2 |
| Over 11 Mnths | 1 | | | | | | | | | | 1 |
| Over 12 Mnths | 5 | 2 | | | | | | | | | 7 |
| Over 18 Mnths | | | | | | | | | | 1 | 1 |
| **Grand Total** | **134** | **84** | **69** | **26** | **17** | **16** | **9** | **9** | **8** | **1** | **373** |

(as of 30th September )

# BCUHB Overall Complaints open by top 6 themes




| | |
|---|---|
| Incorrect diagnosis | 14 |
| Communication with patient/service user | 16 |
| Delay/Lack of diagnosis | 22 |
| Reaction to procedure/ treatment | 26 |
| Incorrect/insufficient treatment or Assessment | 59 |
| Delay/Lack of treatment or Assessment | 123 |
| **Grand Total** | **260** |

(as of 30th September )

# BCUHB Overall Complaints open by top 6 themes broken down IHC (as of 30th September )

| IHC East | 60 |
|---|---|
| Delay/Lack of treatment or Assessm | 21 |
| Incorrect/insufficient treatment or / | 17 |
| Delay/Lack of diagnosis | 5 |
| Delay in appointment/waiting time, | 4 |
| Reaction to procedure/ treatment | 4 |
| Medication not prescribed | 3 |
| Attitude/Behaviour of Clinical Staff | 3 |
| General care and respect | 3 |

| IHC Central | 111 |
|---|---|
| Delay/Lack of treatment or Assessm | 68 |
| Reaction to procedure/ treatment | 15 |
| Incorrect/insufficient treatment or / | 8 |
| Communication with patient/servic | 7 |
| Inappropriate/unsafe discharge | 7 |
| Delay/Lack of diagnosis | 6 |

| IHC West | 60 |
|---|---|
| Incorrect/insufficient treatment or / | 17 |
| Delay/Lack of treatment or Assessm | 16 |
| Incorrect diagnosis | 6 |
| Delay in appointment/waiting time, | 6 |
| Delay/Lack of diagnosis | 6 |
| Reaction to procedure/ treatment | 3 |
| Communication with family | 3 |
| Inappropriate/unsafe discharge | 3 |

IHC Central have 68 complaints relating to delay / lack of treatment or assessment (50.74%) of the total overall number of complaints (134)

# BCUHB Overall Complaints open by top 6 themes broken down by Division (as of 30th September )

| Midwifery and Women's Services | 17 |
|---|---|
| Incorrect/insufficient treatment or / | 7 |
| Delay/Lack of treatment or Assessm | 4 |
| Communication with patient/servic | 2 |
| Unsafe transfer | 1 |
| Appointment cancelled | 1 |
| Patient lost to follow-up | 1 |
| Incorrect/missing information in rec | 1 |

| Mental Health and Learning Disabilitie | 26 |
|---|---|
| Delay/Lack of treatment or Assessm | 11 |
| Incorrect/insufficient treatment or / | 4 |
| Communication with patient/servic | 3 |
| Delay/Lack of diagnosis | 2 |
| Attitude/Behaviour of Clinical Staff | 2 |
| Inappropriate/unsafe discharge | 1 |
| Referral Delayed | 1 |
| Side effects not explained | 1 |
| Alleged Physical Assault | 1 |

| Corporate Services | 8 |
|---|---|
| Incorrect/missing information in rec | 2 |
| Attitude/Behaviour of Non-Clinical : | 2 |
| Response to Patient needs | 1 |
| Breach in confidentiality | 1 |
| Inappropriate restraint issues | 1 |
| Communication with family | 1 |

| Diagnostics and Specialist Clinical Sup | 16 |
|---|---|
| Incorrect diagnosis | 3 |
| Delay/Lack of diagnosis | 3 |
| Test results not acted upon | 2 |
| Delay/Lack of treatment or Assessm | 2 |
| Incorrect/insufficient treatment or / | 1 |
| Test not performed/ incorrectly per | 1 |
| Communication with patient/servic | 1 |
| Communication between Services/I | 1 |
| Attitude/Behaviour of Clinical Staff | 1 |
| Attitude/Behaviour of Non-Clinical : | 1 |

| Dentistry | 9 |
|---|---|
| Reaction to procedure/ treatment | 3 |
| Attitude/Behaviour of Clinical Staff | 2 |
| Incorrect/insufficient treatment or / | 2 |
| Delay in appointment/waiting time, | 1 |
| Eligibility/criteria of patient not me | 1 |

| Cancer Services | 9 |
|---|---|
| Incorrect/insufficient treatment or / | 3 |
| Reaction to procedure/ treatment | 1 |
| Communication with patient/servic | 1 |
| Delay in appointment/waiting time, | 1 |
| Test results not acted upon | 1 |
| Delay/Frequency in providing medi | 1 |
| Delay/Lack of treatment or Assessm | 1 |

# Improvement Initiatives

***Business Intelligence***

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

***Improvement Collaborative***

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

# Improvement Collaborative

***Corporate Complaints***

To provide a consistent approach aligned to all Wales Health Boards regarding complaint consent timescales aligned to the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011.(Consent is referred to as written consent if a concern is received by an individual/responsible body other than the patient with the additional element of requiring the patients consent if a concern is received in relation to a primary care service which is an independent contractor).

*Recommendation and Implementation* **–** Reduce consent timeframe to 10 working days

***Central Integrated Health Community***

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

# Improvement Collaborative

***Womens Services***

To implement a telephone conversation which is timely, robust and succinct to establish the outcome the complainant is seeking, and the specific questions asked.

***West Integrated Health Community***

To introduce a multi-disciplinary review and tracking of the top 20 overdue complaints and complaints remaining open between 30 – 20 days

***Cancer Services***

To reduce the length of time to respond to multi divisional complaints by facilitating an early multi-disciplinary meeting to discuss allocation and lead investigating officer.

# Improvement Collaborative

***Scrutiny Meetings***

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

***Integrated Complaints / Mortality / Incidents policy***

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

***Grade 1 and 2 complaints***

Increasing the ownership of IHC's to close Grade 1 and 2 complaints once they have reached conclusion, reducing the administrative burden of corporate QA and Approval.

# Improvement Collaborative

***Effective Communication***

The Public Service Ombudsman Wales (PSOW) has recently requested re-assurance that complainants are communicated with once a complaint is submitted. This has been identified as an area for improvement. This restricts opportunities to build a therapeutic alliance with the complainant throughout the complaints process and limits opportunities for quick and timely resolutions. A new telephony system has been implemented which has supported a single point of access for patients, carers and families, In August 2024, 651 Calls were handled by the complaints team.

***Planned Care – The 3P's***

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

# Future Priorities

- Pro-active engagement with the 3 P's team to ensure a consistent approach to the experience of patients awaiting planned care treatment to support an improved experience and a reduction in the Planned Care Complaints.

- Further enhance the IRIS Dashboard to support a qualitative model for data for the IHC's and Specialist Services.

- To undertake quarterly triangulation of quality data identifying themes and trends

- Implementation of an agreed training plan for the Corporate and Operational teams in relation to Complaints Management and PALS

- Commence a formal campaign to promote how to raise concerns

# Thank you for Listening

# Questions?

# Presentation of the Nurse Staffing Levels

## Reporting Period: Autumn 2024

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

# Introduction / Background

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

The Act has two key requirements:

1. **A duty to calculate and take steps to maintain nurse staffing levels**
2. **Apply triangulated methodology to nurse staffing level calculations i.e. Professional Judgement / Patient Acuity / Quality Indicators**

In line with the Act, nurse staffing calculations are to be approved by a ***designated person*** who is authorised to undertake this calculation on behalf of the Chief Executive Officer. The designated person should be registered with the Nursing and Midwifery Council and have an understanding of the complexities of setting a nurse staffing level in the clinical environment. Within Welsh Health Boards the designated person is the Executive Director of Nursing.

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

# Section 25C: Nurse staffing levels: method of calculation

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

- **Professional Judgement** - applying knowledge, skills and experience in a way that is informed by professional standards, law and ethical principles to develop a decision on the factors that influence clinical decision making

- **Patient Acuity** - an estimate of the amount of care a patient requires based on the intensity, complexity and unpredictability of their holistic needs. In Wales the Welsh Levels of Care is the tool used to assist nurses in measuring the acuity and dependency of their patients.

- **Quality Indicators** – a measure of factors that relate to the delivery of nursing care and are used to demonstrate whether the department delivers good outcomes for patients and staff.


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

# Nurse Staffing Levels Calculations Process

## Ward Level Data Collection & Review

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

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

## Health Board Wide Multi-site, Service Specific Reviews

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

Autumn 2024 reviews were undertaken during the week commencing 16th September.

## Review & Approval by Designated Person

Formal presentations will be made to the Executive Director of Nursing and Midwifery on 17/10/2023. In attendance will be the Executive Directors of People Services; & Finance or their nominated deputies.

Agreed Nurse Staffing Level calculations will be formally presented to the Board on 28/11/2024.

# All Wales Acuity Audit

## Acuity Audit data

During the months of January and June each year a national acuity audit is held as directed by the Chief Nursing Officer. The acuity audit is used to collect data relating to patient acuity, patient flow and nurse staffing levels.

Patient acuity is assessed using the Welsh Levels of Care evidence-based workforce planning tool. This measure of patients levels of acuity indicates how much care is required in order to determine the nurse staffing level that is required to meet reasonable requirements of care.

This information when used as part of a triangulated approach alongside the use of quality indicators and professional judgement will determine the nurse staffing level for the ward.

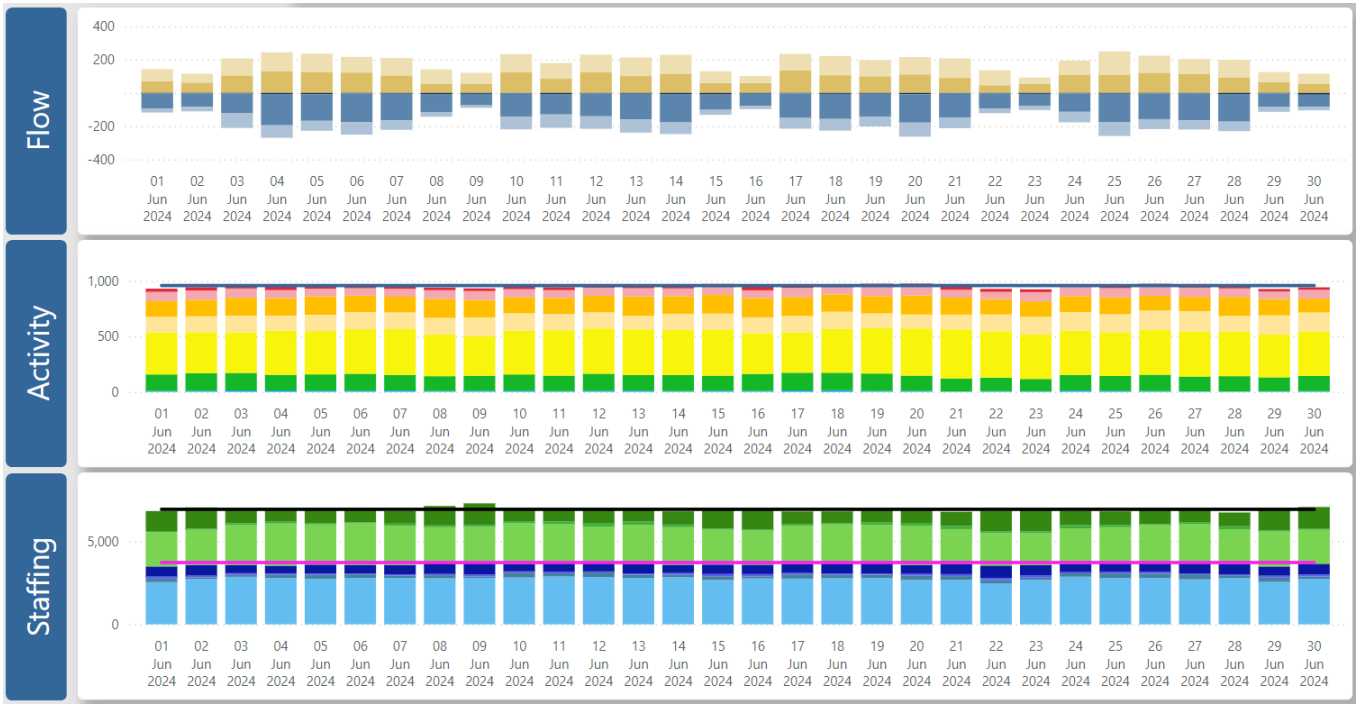
Individual BCU ward acuity details can be viewed **here**

## Welsh Levels of Care

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

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


## BCUHB Section 25B Wards June 2024 Acuity Audit data



# Quality Indicators

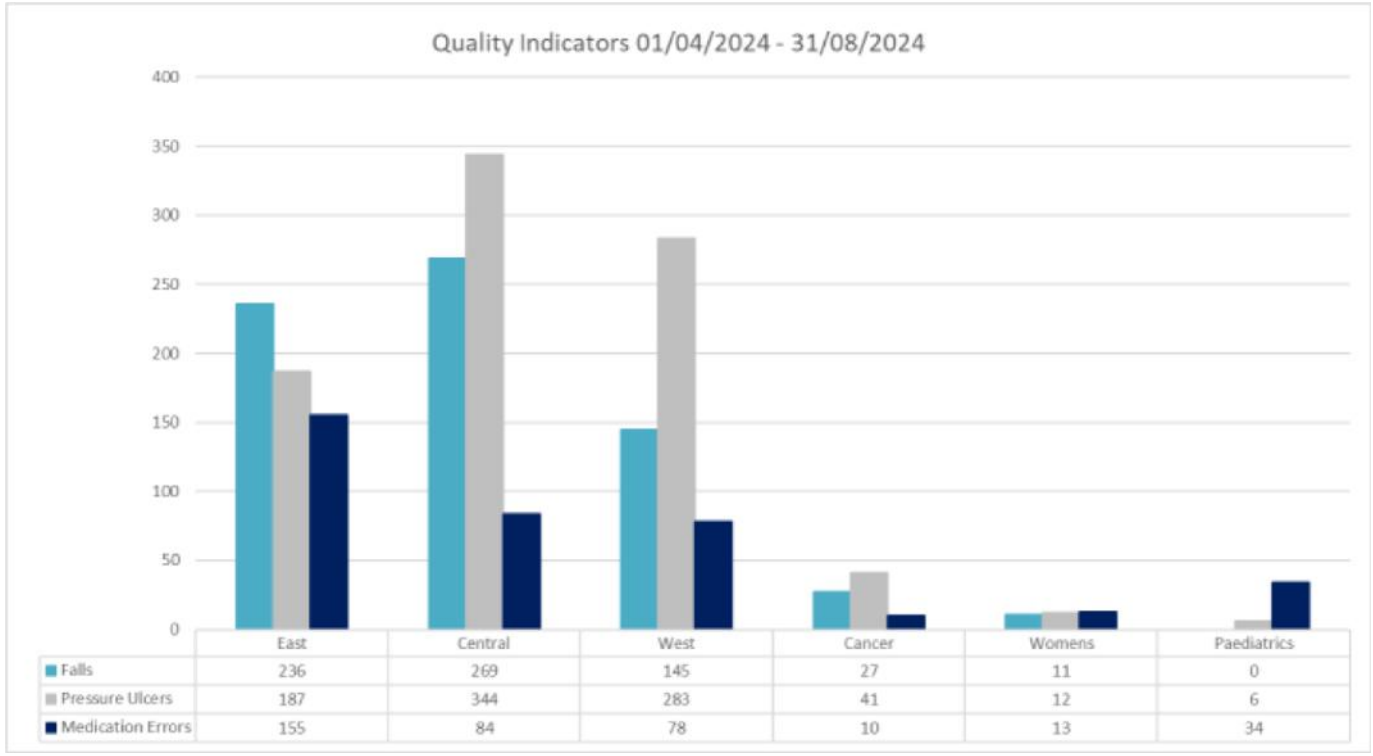
**When calculating the nurse staffing level the quality indicators that are particularly sensitive to care provided by a nurse must be considered. These include patient falls, pressure ulcers and medication errors.**

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

- patient falls
- pressure ulcers
- medication errors

which have been recorded within the DATIX system for the period 01/04/2024 – 31/08/2024.

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




| | East | Central | West | Cancer | Womens | Paediatrics |
|---|---|---|---|---|---|---|
| Falls | 236 | 269 | 145 | 27 | 11 | 0 |
| Pressure Ulcers | 187 | 344 | 283 | 41 | 12 | 6 |
| Medication Errors | 155 | 84 | 78 | 10 | 13 | 34 |

Date Source: DATIX system as at 06.09.2024

# Approved Nurse Staffing Levels – Autumn 2024 (summary)

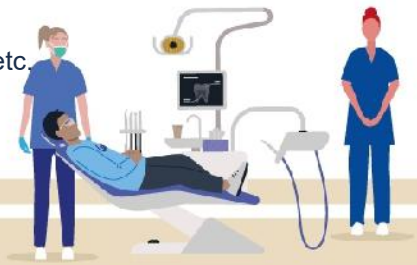
The nurse staffing level calculations undertaken during this reporting period (October 2023 – September 2024) identified a number of wards that require a change to their establishments with the overall proposed FTE changes summarised in the table below:

| Integrated Health Community | Number of Act Wards | Funded Bed Numbers | Required Establishment at the start of the reporting period (October 23) | | Required Establishment at the end of the reporting period (September 2024)* | | Staffing FTE changes during reporting period 2023 - 2024* | | Funded** Establishment (as at September 2024) | | FTE Variance between current funded and required (September 2024) | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | RN | HCA | RN | HCA | RN | HCA | RN | HCA | RN | HCA |
| YMW | 14 | 305 | 279.17 | 229.45 | 280.6 | 233.72 | 1.43 | 4.27 | 277.14 | 219.9 | 3.46 | 13.82 |
| YGC | 13 | 311 | 264.23 | 258.88 | 263.46 | 257.71 | -0.77 | -1.17 | 261.51 | 253.56 | 1.95 | 4.15 |
| YG | 10 | 239 | 228.83 | 218.01 | 217.45 | 217.02 | -11.38 | 13.77 | 211.87 | 199.55 | 5.58 | 17.47 |
| Womens Gynaecological | 2 | 32 | 33.87 | 21.9 | 34.11 | 21.94 | 0.24 | 0.04 | 36.11 | 18.66 | -2 | 3.28 |
| Oncology & Haematology | 3 | 38 | 33.3 | 31.27 | 38.38 | 34.11 | 5.08 | 2.84 | 33.3 | 31.27 | 5.08 | 2.84 |
| Paediatric Inpatient Wards | 3 | 64 | 83.46 | 31.27 | 85.29 | 28.43 | 1.83 | -2.84 | 80.63 | 28.95 | 4.66 | -0.52 |
| **BCUHB Total** | **45** | **989** | **922.86** | **790.78** | **919.29** | **792.93** | **-3.57** | **16.91** | **900.56** | **751.89** | **18.73** | **41.04** |

* Required establishment at the start of the reporting period and staffing FTE changes during the reporting period both include the stepping down of Tryfan ward which following a reconfiguration within the Ysbyty Gwynedd site no longer met the definition of a Section 25B ward

** Funded establishment sourced from Finance Ledger

Note: The required and funded establishment figures exclude supernumerary ward manager and ward support staff i.e. housekeepers, dementia support workers etc.



# Section 25B wards requiring a change to nurse staffing levels

During this reporting period (October 2023 – September 2024) two statutory calculations of nurse staffing levels have taken place, these being Spring 2024 (reported to Board in May 2024) and Autumn 2024 (to be reported to Board in November 2024).

12 wards requested changes to their establishments during this reporting period. The changes approved following review by the Executive Director of Nursing are summarised in the table below:

| Integrated Health Community | Number of Act Wards | Number of Wards Requesting Adjustments | Adjustments Approved by Exec DoN | Comments |
|---|---|---|---|---|
| YWM | 14 | 1 | | Pending review - Pantomime |
| YGC | 13 | 3 | 2 | Abergele Ward 6 - Staffing reconsidered in Spring 2024 as part of the orthopaedic surgical services review. |
| | | | | Ward 6 YGC - HCSW staffing reconsidered during spring 24 due to increased patient care acuity and harms profile |
| | | | | Pending review - Ward 2 |
| YG | 10 | 5 | 1 | Dulas - HCSW staffing reconsidered in spring 24 due to patient care acuity |
| | | | | Pending review - Tegid, Prysor, Moelwyn, Hebog |
| Oncology & Haematology | 2 | 2 | 2 | Enfys - RN & HCSW staffing reconsidered in Spring 24 review due to increased patient care acuity, harms profile and out of hours triage requirements. |
| | | | | Alaw - RN staffing reconsidered in Spring 24 and Autumn 24 reviews due to increased patient care acuity and out of hours triage requirements. Pending autumn review also |
| Womens Gynaecological | 3 | 0 | - | - |
| Paediatric Inpatients Wards | 3 | 1 | 1 | Childrens Ward YG - RN & HCSW staffing adjusted during Spring 24 review due to patient care acuity |
| **BCUHB Total** | **45** | **12** | **6** | - |

# Recommendations

## Office of the Executive Nurse Director:

- Continue to review the impact of nurse staffing within the clinical areas and quality metrics.
- Continued focus on recruitment and retention and innovation to support workforce utilisation and reporting.
- Corporate finance teams will work with operational finance teams to adjust budgets as part of the annual planning cycle to reflect the revised approved rosters.
- The E-Rostering team will adjust roster demand templates to reflect the agreed ‘planned rosters’
- Ward Managers will process the recruitment of staff, based on the revised nursing establishment (where applicable)
- Ward Managers will display any changes to the planned roster on the ward boards displayed at the ward entrance

# Diolch / Thank you

# Any questions?

| | |
|---|---|
| **Teitl adroddiad:**<br>***Report title:*** | QSE Committee – Quality Report |
| **Adrodd i:**<br>***Report to:*** | QSE Committee |
| **Dyddiad y Cyfarfod:**<br>***Date of Meeting:*** | 24th October 2024 |
| **Crynodeb Gweithredol:**<br>***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:**<br>***Recommendations:*** | The Committee is asked to note this report |
| **Arweinydd Gweithredol:**<br>***Executive Lead:*** | • Angela Wood, Executive Director of Nursing and Midwifery (Lead Executive)<br>• Dr Nick Lyons, Executive Medical Director<br>• Teresa Owen, Executive Director of AHPs and Healthcare Science |
| **Awdur yr Adroddiad:**<br>***Report Author:*** | • **Patient Safety:** Chris Lynes, Deputy Director of Nursing (Patient Safety) and Tracey Radcliffe, Head of Patient Safety<br>• **Safeguarding:** Michelle Denwood, Director of Safeguarding<br>• **IPC:** Andrea Ledgerton, Assistant Director of Infection Prevention and Decontamination<br>• **Patient and Carer Experience:** Mandy Jones, Deputy Director of Nursing (Patient Experience) and Leon Marsh, Head of Patient Experience<br>• **Clinical Effectiveness:** Dr James Risley, Deputy Medical Director (Clinical Effectiveness), and Joanne Shillingford, Head of Clinical Effectiveness<br>• **Quality Assurance:** Matthew Joyes, Deputy Director of Quality and Erika Dennis, Quality Lead Manager<br>• **Healthcare Law:** Matthew Joyes, Deputy Director of Quality and Debbie Kumwenda, Healthcare Law Lead Manager |

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

| **Lefel sicrwydd:**<br>***Assurance level:*** | Arwyddocaol<br>*Significant*<br>☐ | Derbyniol<br>*Acceptable*<br>☐ | Rhannol<br>*Partial*<br>☒ | Dim Sicrwydd<br>*No Assurance*<br>☐ |
|---|---|---|---|---|
| | Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol<br><br>*High level of confidence/evidence in delivery of existing mechanisms/objectives* | Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol<br><br>*General confidence / evidence in delivery of existing mechanisms / objectives* | Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol<br><br>*Some confidence / evidence in delivery of existing mechanisms / objectives* | Dim hyder/tystiolaeth o ran y ddarpariaeth<br><br>*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 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:**<br>***Link to Strategic Objective(s):*** | • Objective 4 - Improving quality, outcomes and experience |
|---|---|

| | |
|---|---|
| | • Objective 5 - Establishing an effective environment for learning |
| **Goblygiadau rheoleiddio a lleol:**<br>***Regulatory and legal implications:*** | The Duty of Quality is a statutory requirement under the Health and Social Care (Quality and Engagement) (Wales) Act 2020.<br><br>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.<br><br>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?**<br>***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?**<br>***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)**<br>***Details of risks associated with the subject and scope of this paper, including new risks( cross reference to the BAF and CRR)*** | BAF-SP18 and CRR-24-04 – Quality, Innovation and Improvement |
| **Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith***<br>***Financial implications as a result of implementing the recommendations*** | N/A |
| **Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith**<br>***Workforce implications as a result of implementing the recommendations*** | N/A |
| **Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori**<br>***Feedback, response, and follow up summary following consultation*** | N/A |
| **Cysylltiadau â risgiau BAF:**<br>(neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)<br>***Links to BAF risks:***<br>*(or links to the Corporate Risk Register)* | BAF-SP18 and CRR-24-04 – Quality, Innovation and Improvement |
| **Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)**<br>***Reason for submission of report to confidential board (where relevant)*** | N/A |
| **Camau Nesaf: Gweithredu argymhellion**<br>***Next Steps: Implementation of recommendations***<br>N/A | |
| **Rhestr o Atodiadau:**<br>***List of Appendices:***<br>Appendix 1 - PSOW Annual Letter 2023 -2024<br>Appendix 2 – Health Board Response 2023 – 2024 | |

# QSE Committee – Quality Report – October 2024

## INTRODUCTION

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


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

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

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

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

## CONTENTS

## PATIENT SAFETY

### PATIENT SAFETY INCIDENTS

**Integrated Concerns Policy**

Following approval at Board, the integrated concerns policy was launched on 1st September 2024. Work is in progress with the first 3 months being a bedding in period and one of tests of change. The language we use to describe our processes will change moving forward and comments and feedback on the implementation are being sought.

A daily integrated concerns hub has commenced, led by the Patient Safety and Patient Experience teams with attendance from IHCs/Divisions to review Incidents/Complaints (Grade 4 & 5) and medical examiner scrutiny letters. The concerns hub undertake the triangulation to determine the pathway of incident management of either a learning review or a learning investigation.

A number of meetings are being reviewed, e.g. Harm free care and rapid learning panels, to ensure streamlining of the process complimenting the IHC/Divisional meetings.

Information is available on the Concerns portal on BetsiNet and there is a Learning Investigations Tracker on the Quality Dashboard for all investigations, regardless of whether an incident or a complaint.

Several Policy awareness sessions have taken place which have now been replaced with drop-in sessions with the patient safety team for any queries or support.

**Oxygen 'no flow' incidents**

Welsh Health Circular -

Following an inquest into the death of a patient in BCUHB where an Oxygen CD cylinder was not prepared correctly (although this did not cause the patient's death), His Majesty's Coroner issued a Regulation 28 'Prevention of future deaths' report to BOC (the cylinder manufacturers).

Due to the number of incidents occurring, further assurance is required by Welsh Government and they have re-issued the 2018 patient safety notice (PSN 041 which related to the operation of Oxygen CD cylinders), to ensure that all actions in the PSN are in place and effectively monitored and audited across Wales. BCUHB compliance with this notice has been monitored with the improvement work that has been progressed but formal compliance will be submitted.

Labelling of Cylinders with Warning 'Feel the flow' Tags

The aim of introducing these labels was to have a reminder of the two controls at the point of use. They were being attached with elastic bands which BOC have advised that whilst the risk is small there is a potential fire risk with using elastic bands to attach the labels, especially as they will be near high-pressure outlets.

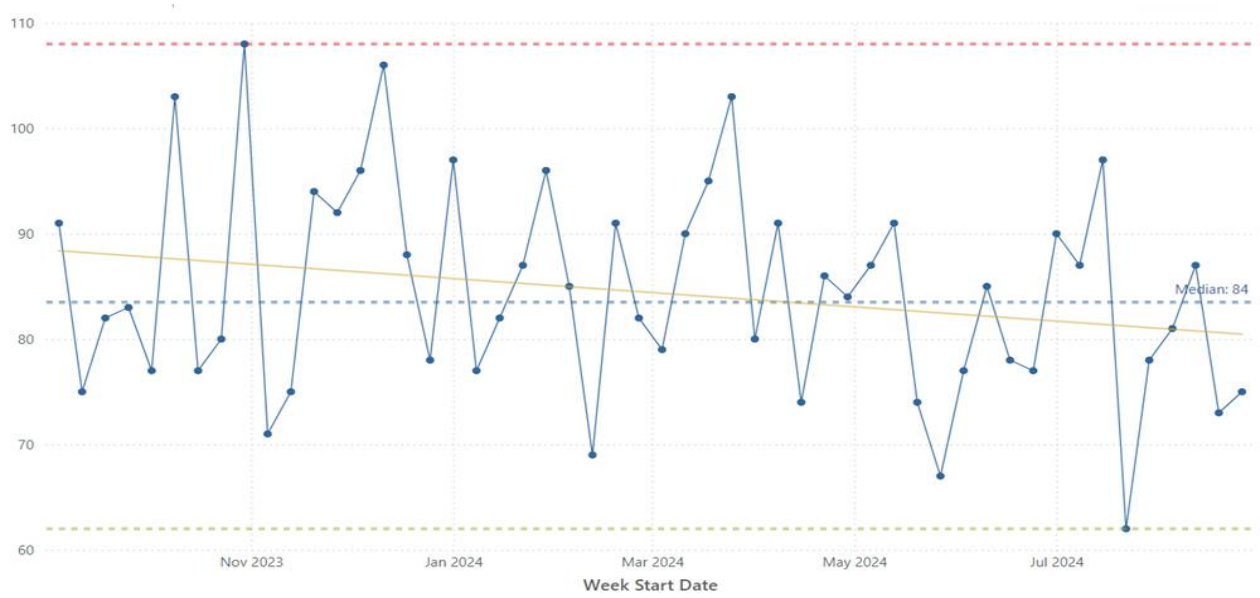
Further discussion with BOC has concluded that string can be used. There was a previous concern about infection prevention risk and ability to decontaminate but the infection prevention team have agreed that the risk is negligible and the benefits outweigh the risks. A risk (benefit) assessment will be formally completed.

BOC visited BCUHB on 18th July 2024 to demonstrate a prototype of a single control CD cylinder. We were the first organisation they have demonstrated it to and is testament to the engagement we have had with them over the years in relation to the design issues of the

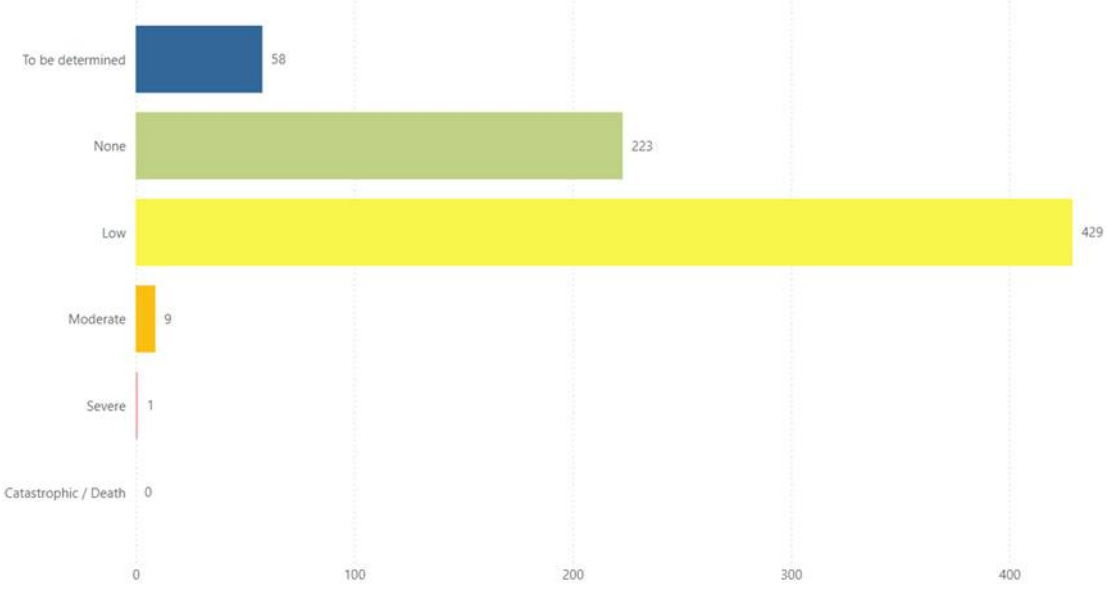
CD cylinder. The prototype was welcomed that would reduce the risk of no flow incidents but it will be about 12 months before they will be available.

**Patient Falls**

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




In July and August 2024, the below patient falls occurred with a post investigation level of harm as shown, (to be determined means the investigation/review is ongoing)




At the time of writing the Health Board is awaiting a formal notification of prosecution from the Health and Safety Executive (HSE) in respect of the Health Board response letter (dated September 2023) regarding the notice of contravention. The Chief Executive and members of the Health Board Health and Safety team have recently met with the Health and Safety Executive officer for North Wales. Following this meeting a request has been made from the HSE for the Health Board to offer support and advice in terms of Falls Prevention to a neighbouring organisation.

The 4th Health Board Executive team falls review was held on Thursday 5th September 2024. The Chair noted improvements had taken place and that the Health Board was in a better

position to provide assurance for our patients, and against the actions within the HSE notice of contravention.

E learning Health Board Training:
August 2024 compliance for part 1a and 1b falls training has seen improvement with the inpatient wards in most cases exceeding the Health Board standard of 85%. Work is still ongoing with ESR colleagues undertaking a data cleanse to ensure accuracy.

The Patient Handling team are currently working on a planned trajectory and target date for the Health Board Patient Handling compliance that would include temporary staffing (bank).

Agency Worker induction:
A Health Board task and finish group has been established to review the process of induction and on boarding of Agency Workers into the Health Board. The TOR includes the Agency Workers training regarding Falls Prevention as the first priority.

Risk assessments:
The consistency of the detail and quality of interventions of the Falls and Bone Health Multifactorial Assessment (FBHMA) remains a challenge, as identified by the IHC feedback as part of the monthly Strategic Falls meeting and Accreditation team supportive visits. However, all IHC Falls Leads reported this was an area of notable improvement as part of the Executive review on 5th September 2024 and as part of the monthly strategic falls meeting. Risk assessments are being scrutinised in the local weekly learning and improvement meetings and within local accountability meetings.
All IHC/Divisional leads reported the challenge of sustaining the peer review process currently in place and whether the process has added value to the quality of the FBHMA. All leads are keen to explore options to make the reviewing of the FBHMA as routine business within the IHCs as opposed to an additional task. This included Matron's audits and encouragement of therapy colleague's reviews. It was agreed the peer review would be evaluated against recommendations alongside the options for business as usual.

Falls Champion network:
The Accreditation team are leading on the formal development of a Falls Champion support network for the Health Board as a mechanism to support clinical based champions with tailored support and training as a continuation of the Wrexham University Falls Champion module. A draft framework is being reviewed by the Strategic Falls group membership.

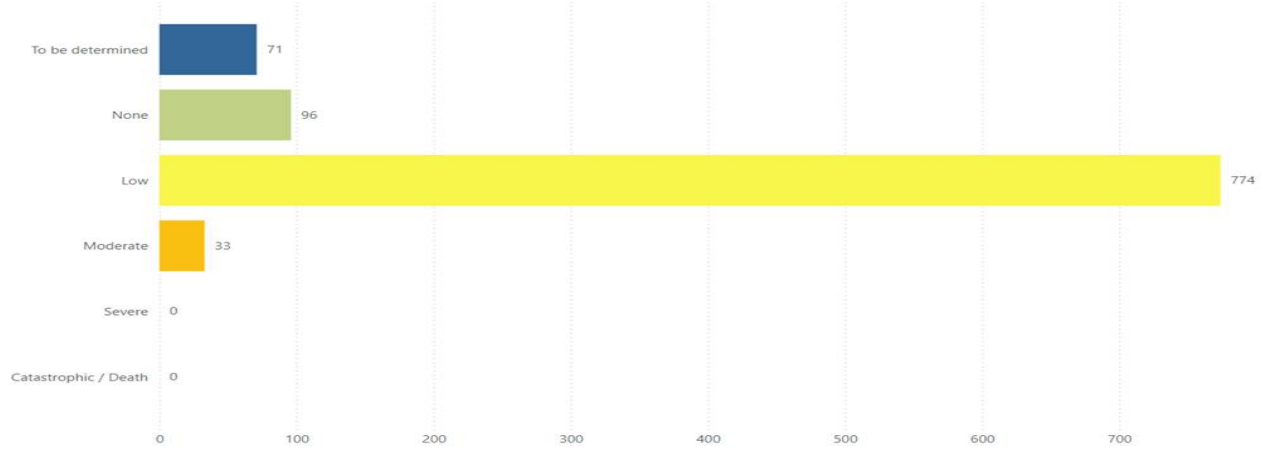
Improvement work:
Community hospitals in West are trialling placement mats with key messages about using the call bell, PJ paralysis etc. Feedback and potential for rollout will be shared.
A postural hypotension information leaflet has been approved by the Strategic Falls group and sent to the Readers panel before review at PSG.

Manual Handling Training:
Challenges remain with staff not attending manual handling training that they have booked on to. The Assistant Director of Occupational Health, Safety and Security confirmed they have been working on a reminder to staff and are actively considering phoning people the day before the training as a reminder, so if they are unable to attend then those places can be offered to others. However, they are unable to implement this with current resource. A meeting with the Manual Handling Team and Health and Safety leads is going to take place to explore options and develop an action plan.

**Pressure Ulcers**

The following shows patient healthcare acquired pressure ulcers (HAPU) reported across BCUHB in the previous 12 months; the yellow line shows an upward trend (although the last 2 months shows a downward trend).


In July and August 2024, the below patient healthcare acquired pressure ulcers occurred with a post investigation level of harm as shown, (to be determined means the investigation/review is ongoing)




An Executive review meeting was held on 29th July 2024 where the IHC West Director of Nursing was commissioned to lead improvement in the prevention of pressure ulcers. Progression of this has led to a review of the BCUHB improvement plan and policy. The Tissue Viability Intranet page is now being updated incorporating ASSKING as a tool for assessment which has been implemented across NHS England and being incorporated into the review of BCUHB pressure ulcer prevention policy.

The Health Board Mandatory Training Group has approved an updated SBAR for Pressure Ulcer Prevention Training. Discussions have commenced with workforce and staff positions on ESR have been agreed for patient facing clinical staff to have this training. A Health Board Training Needs Analysis for Pressure Ulcer Prevention Training has been completed; and was shared with the HAPU Strategic Group in August 2024.

The Standard Operating Procedure for Wound Management Photography has been completed. Although the preferred method would be to use the ward IPads to capture the photograph, discussion with WNCR Lead Nurse have confirmed this is not an option at present. The HAPU Lead and Central Tissue Viability Lead Nurse have discussed with CITO system that the software can allow for clinical areas to store medical wound photographs

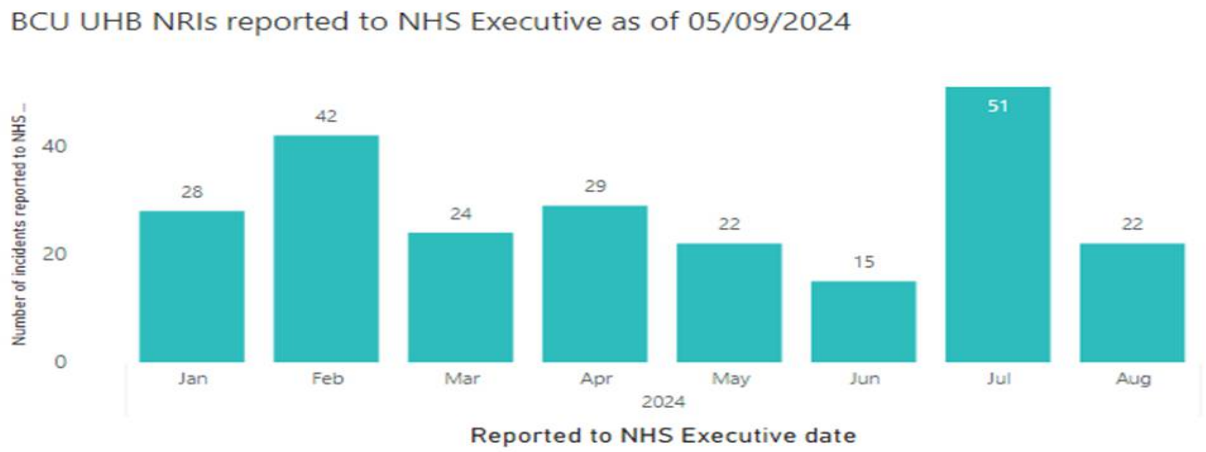
through uploading from hand held cameras. Guidance and Links to training have been included in the SOP.

Improvements have been noticed in correct reporting of incident severity with pressure ulcers which was supported by dissemination of the traffic light system of reporting, and feedback via Datix from the HAPU lead to notify of incident severity categories.

An updated All Wales Pressure Ulcer Prevention / Management Care Plan and All Wales Pressure Ulcer Reporting and Guidance were due for launch in July 2024, but these are still awaited.

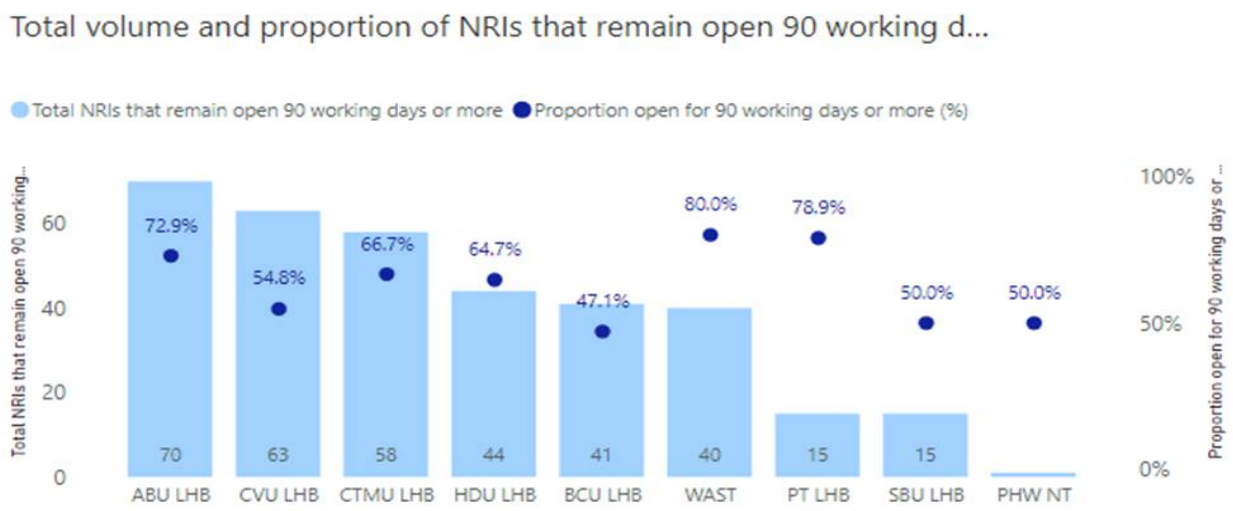
**Nationally Reportable Incidents**

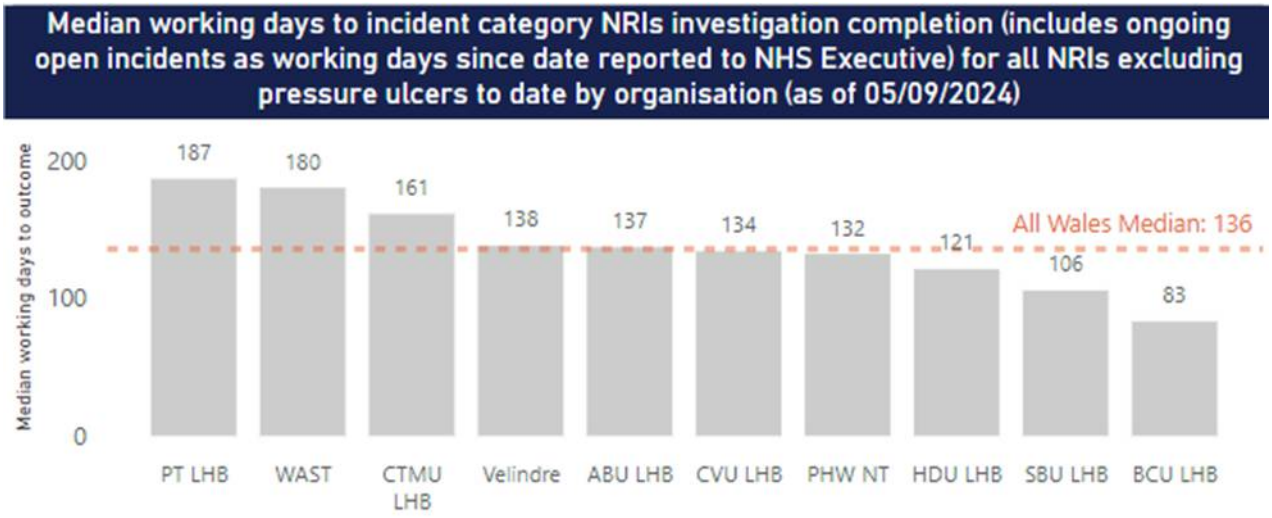
From 01st July – 31st August 2024, 25 National Reportable Incidents (NRIs) occurred, and 73 notifications were submitted. The increase in notifications compared to incidents occurring is due to retrospective reporting of patient falls and pressure damage. These are only notified when the review has been completed and deemed to be avoidable at local harms meetings. In July there was a drive by the HAPU improvement Lead Nurse (now Patient Safety Matron to work with IHCs to get these completed.




The total number of NRI investigations that were open as at the end of August 2024 was 54 (down from 63), of which 22 (down from 32) were overdue closure with NHS Wales Executive. Discussion with NHS Executive is in progress as there are discrepancies with numbers open on the beacon dashboard data and datix data, possibly due to time lags between submission and acknowledgement of closure.

The proportion of NRIs that remain open 90 working days or more is 47.1% which is the lowest across Wales. The median working days that NRIs are completed is 83 compared to 136 for all Wales.




**Closures**

62 NRI Outcome forms were sent during July and August of which 34 were for combined forms relating to HAPUs/ falls, and the remaining 28 were outcomes forms for all other incident categories.

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

**Never Events**

Two never events have been reported broken down as below

| Never Event reported | Total |
|---|---|
| Wrong site surgery (block) | 1 |
| Retained foreign object post procedure | 1 |
| Total | 2 |

Immediate learning and actions:

- Stop, prep, block process must be part of the WHO surgical safety checklist – a pause immediately before the block is inserted

- Scrub practitioner needs to ensure counts are completed at the correct time – prior to any cavity closure

- Theatre Staff need to ensure they are completing their own role – i.e. was asked by the surgeon to hold a retractor (a first assistant role rather than a scrub role) which delayed the final count

## PATIENT SAFETY ALERTS

PSN041 reminder WHC2024/036 Oxygen cylinders: regulation 28 report and patient safety notice 041 reminder (WHC/2024/036) Sep 2024 (as detailed above)

- Compliance originally submitted Oct 2018, being reviewed, and updated for submission.
- Continued compliance to be monitored via the medical gasses group

DSI/2024/007 MHRA - CPT Hip System Femoral Stem 12/14 Neck Taper: Increased Risk of Postoperative Periprosthetic Femoral Fracture

- Relevant to IHC West only - Compliance complete and submitted.

## SAFEGUARDING

**The Joint Inspectorate Review of Child Protection Arrangements (JICPA) 2023 and Joint Inspection of Child Protection Arrangements- Overview Report 2019-2024 (Sept 2024)**

### Introduction

In February 2023, Care Inspectorate Wales (CIW), His Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS), Healthcare Inspectorate Wales (HIW) and Estyn carried out a joint inspection of the multi-agency response to abuse and neglect of children in Denbighshire. Across Wales, Local Authorities and partners exercise their functions under the Social Services and Well-being (Wales) Act 2014 and endeavour to ensure they make a positive contribution to the well-being and safety of children who need care and support.

### Scope of the inspection

The Joint Inspectorate Review of Child Protection Arrangements (JICPA) reviewed:

- the response to allegations of abuse and neglect at the point of identification
- the quality and impact of assessment, planning and decision-making in response to notifications and referrals
- protecting children aged 11 and under at risk of abuse and neglect
- the leadership and management of this work
- the effectiveness of the multi-agency safeguarding partner arrangements in relation to this work.

**Findings**

The findings were positive for BCUHB and found that Safeguarding professionals employed within Betsi Cadwaladr University Health Board (BCUHB) are approachable and proactive. There is a clear Safeguarding & Public Protection Team structure in place ensuring all areas of the Health Board have Safeguarding Leads, with a number of specialist Safeguarding roles. The Safeguarding & Public Protection Team are fully engaged in all areas of multi-agency working, both at strategic and operational level. Senior Safeguarding Managers currently hold positions as Vice Chair of the North Wales Safeguarding Board and Chair of the Local Delivery Group. The Health Board completed the National, peer reviewed, Safeguarding Self-assessment for 2021/22, scoring 25 out of 25.

Multi-agency training is readily available, well received and well publicised. Learning from reviews, such as Child Practice and Domestic Homicide Reviews are delivered through training events, 7-Minute Briefings and Learning Bulletins. A programme of audits reflects areas of concern and determines whether lessons have been embedded in practice.

There are examples of good engagement between GPs and statutory safeguarding processes. In hospital safeguarding practice there are examples of exemplary and innovative practice across departments including Safeguarding Ambassadors across the Health Board, Independent Domestic Violence Advisers (IDVAs) and weekly Cardiff and Vale meetings to review injuries in children under the age of 2. A new initiative to provide Student Nurses with a one-week placement in the Health Board's Safeguarding & Public Protection Team means students graduate with an improved practical understanding of staff safeguarding responsibilities and partnership working to protect children, young people and adults at risk.

The findings also included areas of front-line practice that required improvement and/or strengthening. For assurance, the Multi - agency Action Plan is monitored by the Multi-agency Delivery Group and 80% of the recommendations for BCUHB are complete, the remaining 20% (2) relate to the implementation of electronic records or the required collaboration of Multi-Agency Partners.

The National Report was published in September 2024 and the Report outlines their main thematic findings across these inspections as well as the effectiveness of both partnership working and the work of individual Agencies across Wales. It was reported, Health Boards have a mostly positive approach to learning and development in relation to Safeguarding. In BCUHB, learning from reviews, such as Child Practice and Domestic Homicide Reviews are delivered through training events, 7-Minute Briefings and Learning Bulletins. A programme of audit also reflects areas of concern and determines whether lessons have been learned and improvements are embedded in practice.

Inspectorates reported it is important the momentum for change in such an important practice area and the protection and safety of children, is maintained and led by Regional Safeguarding Boards. All activities are implemented on a BCUHB footprint and monitored by the North Wales Safeguarding Board to ensure compliance and assurance.

**RLDatix Safeguarding Module Review.**

The National Safeguarding Module was reported in July 2024 for implementation on the 1st of October 2024.

Due to challenges within the system, encryption function, inability to send child at Risk and Adult at Risk Reports directly to the Local Authority, and concerns raised regarding the DIPA which was dated 2019 the date of implementation has been amended to 1st November 2024.

The Interim Chair of the National Safeguarding Network presented the proposal to the North Wales Safeguarding Board Joint Meeting on 18th September 2024. The six Local Authorities expressed concern and were unhappy regarding the lack of consultation and engagement as these changes will have a significant impact upon their IT platforms and Safeguarding duties.

The Safeguarding and Public Protection Team have engaged in an attempt to help resolve the National NHS challenges to improve the system, and to share the challenges relating to BCUHB. Information Governance is a significant concern, the inability to report directly to the Local Authority, the additional administration and a varied reporting approach required out of hours and weekends, is of concern.

BCUHB proposed a realistic time scale for implementation of the system is the 1st April 2025. BCUHB has a current safeguarding data and performance system that is advanced and is directing and triangulating activity to support improvements. Also, the JICPA reinforces IT platforms for Safeguarding Reporting, should be on a National and Multi-agency basis, of which the Local Authorities are advocating.

BCUHB will continue to engage and facilitate change, however service user safety and compliance with legislation and accountability is vitally important and must be at the forefront of any improvements to collect data as required.

## INFECTION PREVENTION AND CONTROL

When compared to other Health Boards, up until the end of August, BCUHB were 1st for MSSA, Klebsiella spp. and Pseudomonas aeruginosa bacteraemia (i.e. lowest infection rates), this an improvement for P. aeruginosa, dropping to 4th for C. difficile and 4th for MRSA; this an improvement and remaining in 5th place for E. coli.

A catheter associated urinary tract infection (CAUTI) audit was performed in July identifying a 5% CAUTI rate compared to 10% in January 2002.

IP Learning Reviews are to be completed across the Integrated Health Communities with data led insight to allow for triangulation, definitive action, and measurable milestones. Outcomes will be presented at Local and Strategic Infection Prevention Groups.

High Level Disinfection programmes have recommenced in East and West using Hypochlorous solution or Hydrogen Peroxide Vaporisation, whilst Central have yet to confirm start date.

The Associate Director of Nursing for IP has met with the HARP Lead who has agreed to conduct an external supportive review to gain an understanding in relation to the increasing number of cases of C. diff. The HABITS campaign has continued with a focus on Treatment.

The End of Programme Learning Report from the National Nosocomial COVID-19 Programme was published with the following key IP&C learning identified:

**Publication and Distribution of guidance**

NHS Wales organisations are encouraged to continue exploring and implementing digital communication methods that support timely and engaging communication with colleagues on updates to guidance.

**Outbreak Management**

Policies and processes should reflect mechanisms that result in limiting the number of patient moves, ensuring patients are in the right place at the right time. Where patients are moved, families should receive proactive and timely communication on the location and rationale for the move.

**Discharge Planning**

Patients who experienced delayed discharge were at an increased risk of deterioration and infection. It should be acknowledged that delayed discharges were arguably a symptom of unprecedented wider system pressures (secondary, primary and community care) including different ways of working, high levels of seriously ill patients, staffing pressures and limited patient movement due to IP&C precautions and national guidance regarding discharge arrangements and community support.

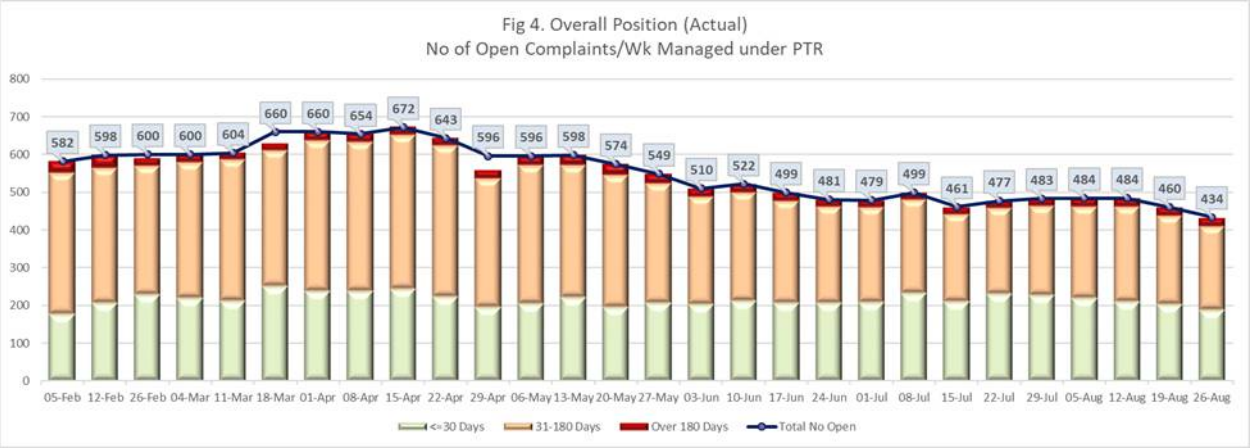
**Hospital environments**

An aging healthcare estate in Wales presents a number of challenges, especially around IP&C in a pandemic scenario. Where possible, health boards and trusts should continue make improvements that enhance IP&C measures and use learning from the pandemic to inform future hospital design.

## PATIENT EXPERIENCE

### COMPLAINTS

During 1st July 2024 to 31st August 2024, the Health Board **received** 540 complaints, 437 of those were managed under Putting Things Right, an additional 73 were resolved as Early Resolutions and 30 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.




**Complaints Performance**

There were 245 overdue complaints in total at the end of August 2024.

The complaints performance improvement Trajectory (Linear Model) to support the achievement of the performance target for complaints closures by the 14th of October 24 for compliance of 75% of complaints responded to within less than 30 working days at the end of August 2024 was as follows:

**Trajectories**

BCUHB Overall Compliance with 75% target of overdue complaints – 43.55% - On track to achieve 75.10% if the Health Board close 74 complaints per week each week until the 14th October 2024. (This figure will change based on weekly performance).

**IHC East** - 38.61% Not on Track projected 69.22%

**IHC West** - 58.02% On track to achieve above 75%

**IHC Central** - 35.59% Not on Track projected 57.33%

**MHLD** - 69.57 % On Track predicted to achieve 98.54%

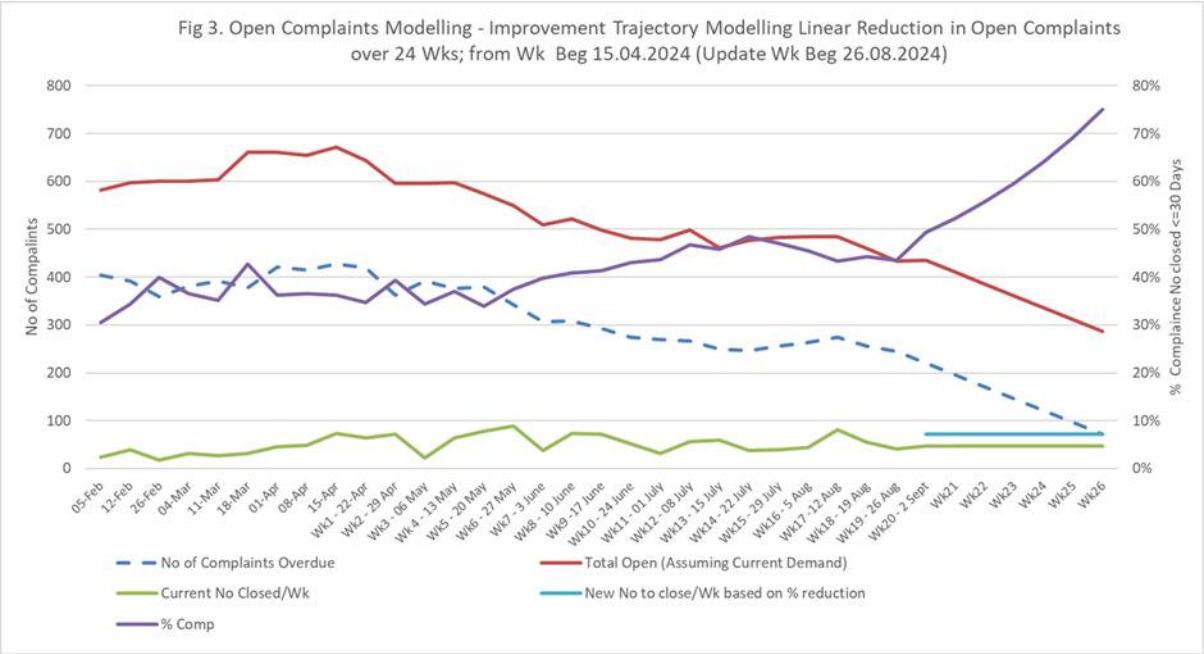
**Womens & Midwifery** - 62.4% On Track to achieve 88.98%

**Cancer Services** - 77.78% On Track to achieve over 75%

**Diagnostics and Clinical Support Services -** 25% Not on Track projected to achieve 35.87%

**Dentistry -** 100% On Track to achieve over 75%

The Trajectories above are based on the complaint's performance up to the 2nd September 2024.




**Complaints Compliance**

External Review - Welsh Risk Pool Assessment undertaken on the 13th June 2024 to consider compliance of BCUHB in relation to the regulatory and Putting Things Right (PTR)procedural requirements. A final report remains awaited.

## PATIENT FEEDBACK

From the 1 July 2024 to 31st August 2024 the Patient Advice and Liaison Service (PALS) facilitated the resolution of 1196 enquiries, received 296 compliments in writing and 58 suggestions for improvement. In July 2024, the Health Board received 198 compliments from patients/relatives sharing positive experiences of accessing Health Board Services; this is the highest number of compliments the Health Board has received in one month.

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

- Appointments
- Clinical treatment or assessment
- Access to services.

PALS Officers have visited wards across Secondary and Community Hospitals across North Wales to capture real time feedback from patients through Care2share discovery interviews. PALS Officers revisit the service within 10 weeks to test if the improvements identified have been embedded. Below are examples of 'you said, we did' learning formulated by services:

**Erddig Ward, Wrexham Maelor Hospital**

**You said:** *'The food isn't very good, the temperature, choice and quality are all poor.'*

**We did:** We will ensure that our patient's nutritional needs are monitored, and we will pass your feedback on to our catering department.

**Enfys Ward, Ysbyty Glan Clwyd**

**You said:** *'The staff have been very attentive and kind, a credit to the Hospital.'*

**We did:** We will share your feedback with the staff.

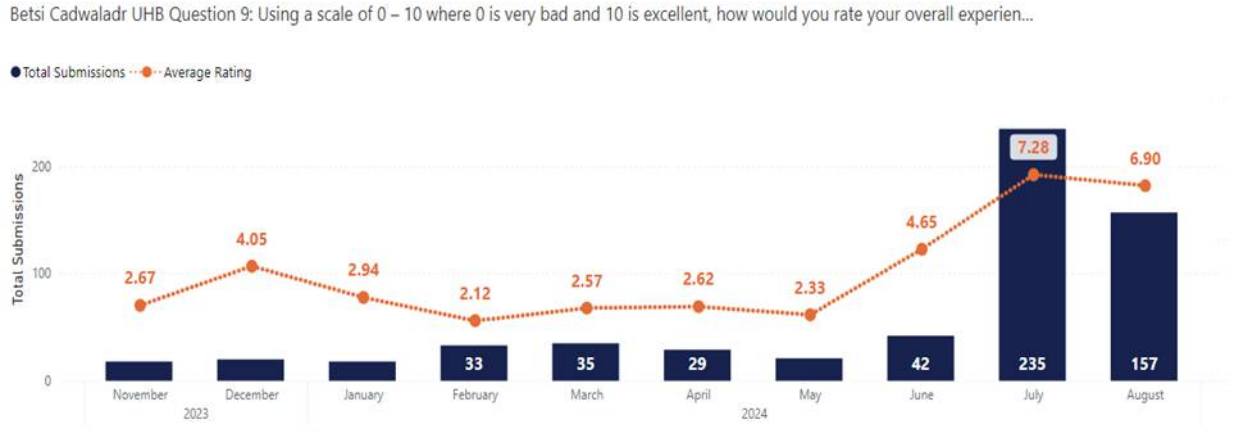
## Patient Feedback

From the 1 July 2024 to 31 August 2024, 8793 All Wales Real-Time Patient and Carer Feedback Survey responses were received via Civica feedback system. Overall satisfaction levels have increased by 1.73% from the last reporting period (April 2024 - June 2024) with 82.76% of respondents very satisfied with their overall experience of accessing Health Board services. This is the highest satisfaction level recorded in the last 12 months.

There has been a significant increase in patient satisfaction levels reported in the real-time patient survey. Below are key findings from the All Wales Real-Time Patient and Carer Feedback Survey:

- 82.44% were always given all of the information needed (1,27% increase)
- 83.23% were always involved in decisions about care (2.06% increase)
- 86.12% always felt listened to (1.84% increase)
- 82.47% felt staff always took the time to understand what mattered to them (1.43% increase)

From the 1 July 2024 to 31 August 2024, 381 All Wales Emergency Department (ED) survey responses were received via Civica Feedback System, this is an increase of 289 surveys from April 2024 – June 2024. Overall the ED average satisfaction rating has increased by 4.23% from April 2024, with respondents rating their overall experience in August 2024 as 6.90 out of 10 being excellent.




(Data source Beacon Dashboard, 23/9/2024)

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

- 63.81% of respondents always felt well cared for (35.97% increase)
- 30.77% felt they waited much too long to be seen (47.8% improvement)
- 64.53% always felt listened to (37.73% increase)
- 51.88% always got assistance when needed (28.17% increase)

- 64.71% always felt things were explained in a way that they understood (31.38% increase)

A Task & Finish Group has been established with Heads of Nursing for ED to improve feedback responses. The initial priority is to capture 3% of attendee's feedback by 30 September 2024. Each ED has agreed a test of change, looking at different ways to capture patient feedback surveys under the 'Plan Do Study Act' (PDSA) cycle. The ED feedback data is monitored at monthly local Integrated Health Community, Patient and Carer Experience meetings and is reported monthly into Patient & Carer Experience Group.

Below are two examples of improvements based on patient/relative feedback:

- Vending machine installed in Ysbyty Gwynedd ED following feedback relating to lack of access to food out of hours.
- Wrexham Maelor Hospital have implemented streaming on the front door of ED, to support in streaming patients to the right area to help reduce waiting times.

**Small Business Research Initiative (SBRI) Patient Communication Project**

The SBRI pilot funded by Welsh Government to improve communication between staff and relatives when their loved one is an inpatient has now ended. In total 1121 messages were sent to relatives through a digital portal within this period. The benefits realisation of the project is currently being analysed including an independent staff evaluation. The project has been shortlisted as a finalist for the Patient Experience National Network UK Awards ceremony on 3 October 2024 at Birmingham University for the award category 'Communicating effectively with patients and families.'

**Patient Communication and Information**

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

The Patient Information Readers Panel continues to meet monthly to review patient information leaflets. Within the reporting period 9 patient information leaflets were reviewed by the Readers Panel. Below are examples of leaflets approved at Readers Panel:

- Rib Fracture Information – Ysbyty Glan Clwyd
- Dietary advice for use of Wegovy - Specialist Weight Management Services
- Antenatal Screening Team information
- Information for patients having an Ultrasound scan

Ongoing work continues to support the Radiology Service who are near completion of reviewing all their patient information leaflets to ensure consistent information is being given to patients across North Wales.

**Accessible Health Care**

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

Improvement work is being undertake in partnership with the deaf and BSL using community to improve deaf and BSL using community access to Health Board services. This includes the introduction of Sign Live giving 24/7 access to BSL video interpretation and the ability to telephone the Health Board through a video relay service.

Quarterly patients experience reports from Centre of Sign Sight and Sound will now be reported to the Patient and Carer Experience meeting and a series of staff deaf awareness/ Welsh Interpretation Translation Service training sessions will be delivered pan North Wales.

**Chaplain & Spiritual Care Service**

From 1st July 2024 – 31st August 2024, the Chaplain and Spiritual Care Service responded to 179 requests for support pan North Wales. Nine multi-faith events were organised across North Wales; including music sessions to dementia patients across Secondary and Community Hospitals in partnership with PALS and an annual baby memorial event at St Asaph Cathedral for baby loss.

## OTHER PATIENT EXPERIENCE CONCERNS AND IMPROVEMENTS

Over the last twelve months there has been a significant focus on ensuring more mental health and learning disability staff are trained in Restrictive Practices and Interventions. The Positive Intervention Clinical Support Service (PICSS) team make themselves available to all inpatient areas to advise and assist on how to care for complex patients with challenging behaviour. They have also been providing assistance with patients in the District General Hospitals. All incidents are reported and reviewed through locality and Divisional 'putting things right (PTR)' meetings, and the PICSS team provide a monthly report to the Service Quality Delivery Group. All incidents relating to use of Restrictive Practices and Interventions are robustly reviewed by the PICSS team.

Mental Health and Learning Disability Division have been working to reduce the number of inpatient ligature incidents, this is being tracked and monitored through Divisional PTR on a weekly basis. The highest risks were identified in inpatient bathrooms and from use of clothing. All ligature incidents are reviewed appropriately and considered according to the level of risk and harm, and these are discussed in detail at the monthly Ligature Risk Reduction Group.

**Improving Nutrition Catering Hydration Standards Group (INCHS)**

The e-learning module for Food Safety (000 NHS Wales – Food Safety) was loaded onto ESR in January 2024 and a compliance check in April/May 2024 detailed 298 staff having undertaken this, which is a disappointingly low level of staff. There are some potential data issues that are being followed up on and a re-run of the report is being requested.

The training has still not been uploaded to appear on staffs compliance list and really needs to happen to ensure that access and uptake improves. Further communications will be going out to encourage staff to undertake this with screenshots to guide staff to where they can find the training.

Notification of the use of red wrist bands for patients with food allergy/intolerance was launched on BetsiNet on the 22nd December 2023. Anecdotally there are areas not using these. Ward accreditation is due to re-start and this will be picked up as part of that process.

Swallow screening

An all-Wales approach to swallow screening for stroke patients is being recommended using the Yale tool (validated tool). This involves an 85ml bolus of water, which is very different to BCUHB's current swallow screening tool. No other Health Boards in Wales use screening tools for other health conditions, so this is under review in BCUHB. Further work is being undertaken to fully implement this and there will be an update in the September INCHS meeting. Training will be rolled out on the back of this, including ESR training.

In addition, a review is being undertaken on the use of thickened fluids based on updates to evidence. Working groups are in place across Wales and a task and finish group will be developing some guidance. This will also go back to INCHS in September and subsequently PSG.

## CLINICAL EFFECTIVENESS

### CLINICAL AUDIT

National clinical audits (Tier 1) are mandated audits that provide benchmarking reports to help Health Boards compare their performance against national standards and identify areas of improvement. These audits are crucial for maintaining high standards of care and ensuring continuous improvement in the NHS. This year there have been an additional 8 audits added BCUHB's list for 2024-2025.

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

| | | | | West | Central | East | |
|---|---|---|---|---|---|---|---|
| Title of National Audit | Name of report | Date of publication | Date Service Assessment response due | Service Assessment Completed | Service Assessment Completed | Service Assessment Completed | Key Achievements Summary |
| National Lung Cancer Audit | State of the Nation Report 2024 | 10-Apr-24 | 07-Jul-24 | Yes | Yes | Yes | High levels of compliance with national standards |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| National Paediatric Diabetes Audit (NPDA) | Report on Care and outcomes 2022/23 | 10-Apr-24 | 07-Jul-24 | Yes | Yes | Yes | **West:** Data reported is at or above the Wales and National average<br>• We have been introducing more proformas for patients on admission to check that they have the correct blood tests done and to make sure that data is being collected at each clinic and at a longer annual review clinic<br>**Central:** Sustained higher proportion of patients having their HbA1c checked 4 or more times per year (65.5%), This is despite us scaling back our drive through HbA1c clinics<br>**East:** Continue to maintain our clinical outcome data (especially HbA1c data) well above national averages. Our unit has the lowest proportion (3.9%) of high HbA1c of >80 mmol/mol among all other paediatric units (PDU) in Wales and the second best PDU in Wales for lower HbA1c of <58 mmol/mol (42.8%)<br>• 94.5% of our children with diabetes over 12 years had all six key health checks when compared to 63.4% in England & Wales |
| Myocardial Ischaemia National Audit Project (MINAP) | Summary report 2024 | 10-Apr-24 | 11-Aug-24 | Yes | Yes | Yes | **West** - Referral to cardiac rehab 96.56 % - excellent<br>**East** - Proportion of patients discharged on all eligible secondary medication- highest across BCU<br>**Central** – proportion of S T Elevation Myocardial Infarction (STEMI)/NSTEMI undergoing echo during admission exceeds the national target |
| National Audit of Cardiac Rhythm Management (NACRM) | Summary Report 2024 | 10-Apr-24 | 15-Aug-24 | Yes | Yes | Yes | **West** -93% DDD implant for sick sinus syndrome (target >90%)<br>Complex device numbers now back up to pre-Covid levels.<br>**East** -100% and 95% targets achieved respectively for DDD implants for SSS and AV block (NICE Technology appraisal guidance TA324 and TA88)<br>Complex device numbers have fully recovered post covid. Better data capture and validation seen in comparison to previous years.<br>**Central** -Compliance dual pacing for sick sinus syndrome & AV block (TA88)<br>100% achieved on ICD use for secondary prevention. (TA314) |
| National Audit of Percutaneous Coronary Intervention (NAPCI) | Summary Report 2024 | 10-Apr-24 | 15-Aug-24 | N/A | Yes | N/A | Best performing 60-minute Door to balloon performance in Wales with 71.70% achieving the target. |
| National Heart Failure Audit (NHFA) | Summary Report 2024 | 10-Apr-24 | 15-Aug-24 | Yes | Yes | Yes | **Central**: 99% of patients received an echocardiogram and 100% received input from a specialist. |
| National Perinatal Mortality Review Tool | 5th Annual Report | 26-Apr-24 | 15-Aug-24 | Yes | Yes | Yes | In January 2023, the Clinical Governance Lead introduced a full Perinatal Mortality review process using the MBRRACE Perinatal Mortality Review Tool for all Stillbirths and Neonatal deaths who meet the criteria. Prior to this the service had used the Serious Incident Process. The introduction and use of the PMRT tool will ensure that all case reviews are completed to a standardised level with structured consistency in the information being reviewed and the process for grading of care. The use of the tool also supports the service in providing accurate information into the national MBRRACE system which publishes national reports on an annual basis. |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| National Diabetes Foot Care Audit (NDFA) | 2023 State of the Nation Report | 09-May-24 | 16-Aug-24 | Yes - Draft | Yes - Draft | Yes - Draft | Service Assessment of Compliance undergoing Clinical Effectiveness Team review, Service highlighted: East area now has a weekly fully functional vascular, podiatry, endocrinology, and orthopaedic MDT session. |
| National Diabetes Audit: Adolescent and Young Adult (NDA: AYA) | 2017/2023 Report | 13-Jun-24 | 05-Sep-24 | No - Overdue | No - Overdue | No - Overdue | Service assessments of compliance not received from all areas, escalated to IHC management structure in line with Clinical Effective Team Process. |

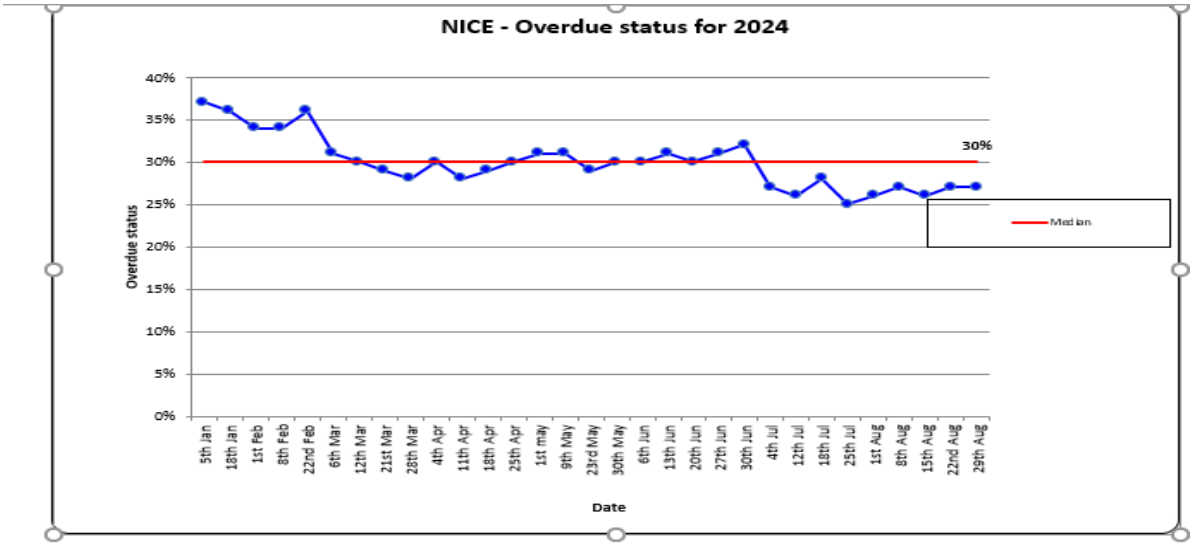
## NICE GUIDELINES

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

**IHCs updates:**

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

**Overdue run chart for 2024: January – end August 2024**




There is a positive shift in overdue responses since January 2024.

## MORTALITY REVIEW

It will now be statutory for **all** deaths to be independently reviewed across the country by either a Medical Examiner (ME) or a Coroner, this came into effect on 9th September and will include all BCUHB Primary Care, Secondary Care and Private health care deaths. This will and is expected to have an increase on workload and impact the Corporate Mortality Team, IHC's, Mortuary Teams and Record Scanning Teams.

The new death certification process will also be coming into force; changes within the process are being triangulated among services such as MES, Coroners, and the Health Board (HB).

Corporate Mortality have participated and continue to support the development of the new Integrated Concerns Policy, Dashboard and Hub project that is being managed by the Quality Directorate.

A report of Medical Examiner cases that have been received, inputted, gone through the admin sieve and sort process, and sent on for clinical review or IHC scrutiny review from 01/09/24 has been shared with the Integrated Concerns Hub, to ensure oversight and triangulation of services. The cases have also been inputted into the Mortality Datix module with an outcome of investigation or HMC referral continue to be shared at the weekly Harms Free Care meeting to ensure oversight and triangulation with the complaints team and Patient Safety Team.

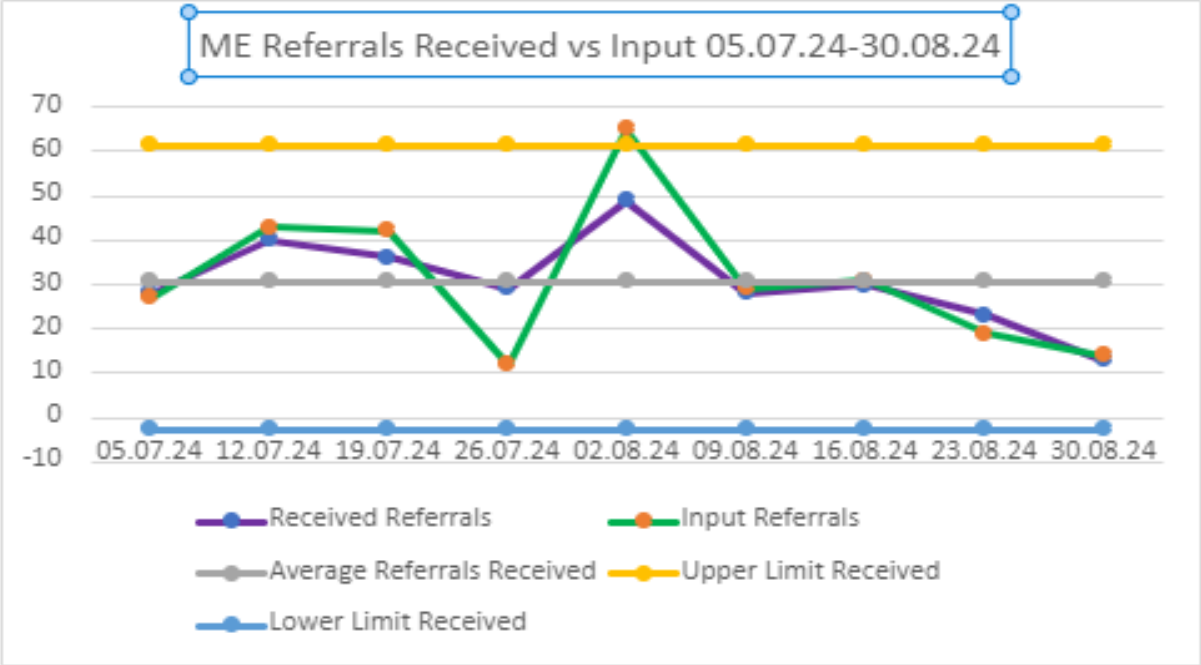
The Corporate Mortality Associate Medical Director position has been recruited to as of 1st September and the team would like to welcome Dr Gemma Lewis-Williams and Dr Ben Thomas to the team.

The Corporate Mortality front door inputting and administrative sieve and sorting process of ME scrutiny letters backlog has been cleared and cases requiring to be input, and admin sieved and sorted are within a 1–2-week time limit.

| | Input/output | | | Inputting Backlog | | | | Datix Status | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Date | Total received per week* | Total input per week | Output Differential | Total w/e Backlog inc compliments | Backlog of cases requiring inputting within 1 month from date received by MES | Backlog of cases requiring inputting within 2 months from date received by MES | Backlog of cases requiring inputting within 3 months from date received by MES | Total New cases (awaiting mortality admin s&s) | New Under 1 month DOD (awaiting mortality admin s&s) | New Within 2 months DOD (awaiting mortality admin s&s) | New Within 3 months & over DOD (awaiting mortality admin s&s) | Total Pending Cases awaiting Mortality Clinician Review S&S | Pending Cases Under 1 month awaiting Mortality Clinician Review | Pending Cases Within 2 months awaiting Mortality Clinician Review | Pending Cases Within 3 months awaiting Mortality Clinician Review | Pending scrutiny panel (with IHC's, for IHC's to RAG rate) | Under investigation / action required (with IHC's, for IHC's to RAG rate) | Process completed |
| 05.07.24 | 28 | 27 | -1 | 11 | 10 | 1 | 0 | 28 | 27 | 1 | 0 | 282 | 42 | 52 | 188 | 648 | 224 | 2440 |
| 12.07.24 | 40 | 43 | 3 | 8 | 8 | 0 | 0 | 20 | 20 | 0 | 0 | 291 | 42 | 55 | 194 | 665 | 224 | 2462 |
| 19.07.24 | 36 | 42 | 6 | 2 | 2 | 0 | 0 | 33 | 32 | 0 | 1 | 284 | 34 | 64 | 186 | 691 | 224 | 2469 |
| 26.07.24 | 29 | 12 | -17 | 19 | 19 | 0 | 0 | 18 | 18 | 0 | 0 | 277 | 34 | 62 | 181 | 705 | 224 | 2489 |
| 02.08.24 | 49 | 65 | 16 | 3 | 3 | 0 | 0 | 22 | 22 | 0 | 0 | 302 | 56 | 59 | 187 | 693 | 226 | 2528 |
| 09.08.24 | 28 | 29 | 1 | 2 | 2 | 0 | 0 | 14 | 14 | 0 | 0 | 313 | 57 | 64 | 192 | 701 | 226 | 2543 |
| 16.08.24 | 30 | 31 | 1 | 1 | 1 | 0 | 0 | 42 | 42 | 0 | 0 | 273 | 32 | 58 | 183 | 722 | 217 | 2572 |
| 23.08.24 | 23 | 19 | -4 | 4 | 4 | 0 | 0 | 23 | 23 | 0 | 0 | 224 | 39 | 55 | 130 | 723 | 220 | 2611 |
| 30.08.24 | 13 | 14 | 1 | 3 | 3 | 0 | 0 | 0 | 0 | 0 | 0 | 218 | 42 | 56 | 122 | 762 | 233 | 2644 |

**For info: *New Within 3 months & over DOD (awaiting mortality admin s&s) refers to inputted cases being sent to the relevant services/departments and then being closed or sent for Corporate Mortality clinical review. These are included on the risk register and are due to lack of staffing resource.**
MES = Medical Examiner Service. DOD = Date of Death. IHC = Integrated Health Community.
S&S= Sieve and Sort process recognising if the case needs to be sent to relevant departments or whether the issues/learning is included in another PTR process, in which case the mortality review can be closed.

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




## OTHER CLINICAL EFFECTIVENESS CONCERNS AND IMPROVEMENTS

Below is an update on areas of data collection issues reported for review raised through Quarter 1.

Updates on NELA and TARN were submitted within previous quarterly reports to QSE, and there are no further updates. Any concerns are escalated initially to local Clinical Effectiveness meetings, if no improvement is made the IHC/Divisions would note to Strategic Clinical Effectiveness group in form of SBAR or through Chair's report as a risk and put on risk register. Strategic Clinical Effectiveness Group will raise with Quality Development Group.

| | West | Central | East |
|---|---|---|---|
| **Title of National Audit/ Clinical Outcome Review** | **Participation/Data collection issues reported** | **Participation/Data collection issues reported** | **Participation/Data collection issues reported** |
| Fracture Liaison Service (Falls & Fragility Fractures Audit Programme) | **This was included last report however an update has been noted.**<br>Fracture Liaison Service not functioned since March 2020 due to ongoing issue of support to run the National database. This service is only provided at present in Llandudno/YGC.<br>It was noted in recent Strategic Clinical Effectiveness Group September meeting that Welsh Government have agreed funding till March 2025 for Band 4 FLS database administrator on the understanding that the Health Board will continue funding after that. Funding needs to be identified from Central (50%) & West (50%) however currently only been agreed 50% between two sites. This has been escalated to IHCs for guidance as without this the Health Board will lose the Welsh Government funding.<br>This has also been noted in the recent Chair's report that will be submitted to Quality Delivery Group in October. | | |
| National Heart Failure Audit | Data entry not progressing in West as the audit administrator post is vacant. ***(Reported previously, no change)*** | | |
| Myocardial Ischaemia National Audit Project (MINAP) | Data entry not progressing in West as the audit administrator post is vacant. ***(Reported previously, no change)*** | | |
| National Clinical Audit of Psychosis | | Only undertaken in West due to service roll out | Only undertaken in West due to service roll out |

## QUALITY ASSURANCE

### HEALTHCARE INSPECTORATE WALES

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

**Healthcare Inspectorate Wales Activity August to September 2024**

**Published Reports (2)**

**Unannounced follow-up inspection of the Emergency Department**

In May 2022, the department was designated as a **Service Requiring Significant Improvement (SRSI)** which is forms part of the HIW service of concern process which is separate to the NHS Escalation and Intervention arrangements. This process is undertaken where HIW decide that action is required because standards are not met. It enables HIW to take focused and rapid action to ensure that safe and effective care is being provided and supports improvement and learning.

HIW undertook an unannounced follow-up inspection on 29, 30 April and 01 May 2024. During the inspection which took place over three consecutive days, HIW found a marked improvement within the areas of significant concern which were identified back in 2022. Specifically:

- Timely escalation of patients with critical and high-risk conditions
- Strengthened oversight of the waiting area, compared to previous inspections
- An improved culture
- Increase in staffing levels
- Stronger leadership

Despite the de-scalation, several issues do remain for the service which continues to operate in highly demanding and challenging conditions.

The Health Board Three Year Plan 2024-27 confirms plans to make improvements to demand and capacity, which includes improving the timeliness of ambulance handover times and working with partner organisations to improve the timeliness of discharge for people awaiting community care services and who no longer require medical care in hospital.

**Announced follow-up inspection of the Diagnostic Imaging Department, Ysbyty Gwynedd, Bangor**

HIW undertook an announced follow-up inspection on 25 and 26 June 2024. There were no immediate concerns identified and the inspection was overall positive with some areas for improvement identified.

- **Quality of Patient Experience** There were a couple of areas requiring attention such as the displaying of information posters and for some of the less positive comments to be addressed.
- **Delivery of Safe and Effective Care:** There were some areas of improvement with minor issues for addressing. These related to audits, written protocols and quality assurance testing.
- **Quality of Management and Leadership:** Feedback from staff was generally positive, with staff speaking well about their immediate and senior managers. Staff were friendly, welcoming, and positive and answered questions professionally.

The Health Board received the HIW Improvement Plan and Embargoed Inspection Report for consideration and action. The Health Board subsequently submitted a completed improvement plan to HIW who confirmed that it provided them with sufficient assurance on 02 September 2024.

The embargoed HIW Inspection Report can be found in the appendix of the Confidential Quality Report and is due for publication by HIW on 26 September 2024.

**Concerns / Requests for Assurance (5)**

**Case 1: IHC East, Mental Health and Learning Disabilities (HMP Berwyn)**

The Health Board received a letter of concern from HIW regarding staffing levels within the Mental Health and Substance Misuse Team.

**Case 2: IHC Central, Ablett Unit, Mental Health and Learning Disabilities**

The Health Board received a letter of concern from HIW regarding issues concerning the 136 Suite, situated on the Ablett Unit.

**Case 3: IHC Central, Nant y Glyn Community Mental Health Team (CMHT), Mental Health and Learning Disabilities**

The Health Board received a letter of concern from HIW regarding lack of assurance pertaining to telephone communication issues.

**Case 4: IHC Central, Hafod Community Mental Health Team (CMHT), Mental Health and Learning Disabilities**

The Health Board received a letter of concern from HIW regarding lack of staff within the service at Hafod Community Mental Health Team.

**Case 5: IHC Central, Phlebotomy Service, Llandudno General Hospital**

The Health Board received a letter of concern from HIW regarding the lack of arm support for patients when blood is being taken, no phlebotomy chairs and an old cushion is being continually used which is considered unhygienic. We received a further assurance request for phlebotomy audits and query pertaining to governance reporting.

All the above have been responded to by the Health Board.

**Healthcare Inspectorate Wales – Progress with Improvement Plans August to September**

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

| Service / Area | Date | Responsible Lead | Position overview |
|---|---|---|---|
| Local Review of Discharge Arrangements for Adult Patients from Inpatient Mental Health Services (Action Plan) | Mar 2023 | Interim Director, Mental Health and Learning Disabilities | 3% ⇧ |
| Nant Y Glyn Community Health (Improvement Plan) | Jan 2024 | Interim Director, Mental Health and Learning Disabilities | ⇨ |

| | | | |
|---|---|---|---|
| Emergency Department, Ysbyty Gwynedd (Improvement Plan) | Aug 2023 | Integrated Health Community Director, West |  |
| Emergency Department, Ysbyty Glan Clwyd (Immediate Improvement Plan) | Apr 2024 | Integrated Health Community Director, Central | 2%  |
| Emergency Department, Ysbyty Glan Clwyd (Improvement Plan) | Apr 2024 | Integrated Health Community Director, Central | New to RAG |

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

The main improvement plan for the Emergency Department at Glan Clwyd was recently introduced to RAG, following a period of focused review on the immediate improvement plan which has seen sufficient progress.

## CARE INSPECTORATE WALES

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

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

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

Quality of Care Review visits

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

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

Amendment to CIW Registration

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

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

## QUALITY PEER REVIEWS

In Quality Peer Reviews were introduced at the end of last summer with the purpose of supporting services to understand how compliant they are against the Health and Care Quality Standards which were introduced in April 2023 in line with the Duty of Quality in Wales.

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

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


The focus on Maternity Services comes from the HIW National Review of Maternity Services which was launched across Wales in 2019. Whilst HIW completed phase one of the review, phase two was paused due to the Covid-19 pandemic. In 2021, HIW took the decision not to progress with phase two of the review after careful consideration of their risk-based inspection and reviews programme for 2021-22 and their resources. However, HIW have since begun to inspect maternity services in Wales including Swansea Bay University Health Board and Cwm Taf Morgannwg University Health Board. The intelligence had led to the above reviews, together with the direct support of the Director of Maternity and Women's Services.

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

## HEALTH AND SAFETY EXECUTIVE / LOCAL AUTHORITY

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

There are no issues to highlight in the public report.

## PUBLIC SERVICES OMBUDSMAN FOR WALES

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

### Annual Letter

On an annual basis, the Public Services Ombudsman for Wales writes to Local Authorities, Local Health Boards and NHS Trusts concerning the complaints the Ombudsman has considered during the year. The aim is to provide bodies with information to help them improve both their complaint handling and the services that they provide.

The Health Board received the Ombudsman's Annual Letter 2023-24 on 09 September 2024 (Appendix1).

Following a response to the previous annual letter 2022-23, the Chair of the Health Board requested that arrangements were put in place ahead of responding to the annual letter 2023-24, in order to ensure that the Health Board could consider and respond to the contents of the annual letter, in full, through its Committee and Board.

As such, the Executive Director of Nursing and Midwifery and the Director of Corporate Governance have agreed the approach to this year's response and have initially responded to the Ombudsman with a letter of acknowledgement from the Chair and Chief Executive of the Health Board outlining the approach it will take to respond to the 2023-24 annual letter which is as follows;

- The Executive Director of Nursing and Midwifery has commenced a response to the annual letter with key colleagues such as Patient Experience.
- The Executive Director of Nursing and Midwifery will present both the annual letter and the Health Board's intended response to the Quality, Safety and Experience Committee on 24 October 2024 and then the Board on 28 November 2024. (Appendix 2)
- The Executive Director of Nursing and Midwifery will include the Committee and Board's considerations within the final response to the letter, **by 20 December 2024**.

The Health Boards response to the Ombudsman's Annual Letter 2023-24, aims to specifically address the above requests and to provide the Ombudsman with assurance in relation to how the Health Board is working to improve its complaints handling, whilst providing transparency in terms of the areas which continue to prove challenging as well as those areas where there is recognised improvement.

The response also clarifies how the data received from the Ombudsman enables the Health Board to understand how it is performing and how it is using the data and information provided to drive forward change in key areas such as improving compliance with Ombudsman recommendations, learning from complaints and how it can use the data to target certain of challenge such as complaints handling and learning.

Public Interest Reports (PIRs)

The Health Board currently has three public interest reports which are available in the public domain. Two public interest reports remain ongoing, whilst one is awaiting closure with the Ombudsman:

1. **Public Interest Report ID1962: IHC East (Medicine) (Ongoing)**: The Health Board received the draft public interest report on 29 April 2024 and has commented on the proposed conclusions and recommendations. The report was published on 10 July 2024, and a copy of the final report can be found here. The Health Board are proceeding with progressing actions to meet the recommendations made by the Ombudsman and reporting to the Regulatory Assurance Group (RAG). The wider issues contained within the report will form part of a wider Health Board action plan. The Executive Director of Nursing and Midwifery has requested the formation of a task group to develop this and take forward to ensure the wider work required, compliments the local service action plan.

2. **Public Interest Report ID5663, IHC East (Urology) (Awaiting closure):** The Health Board received the draft public interest report on 06 March 2024 and has commented on the proposed conclusions and recommendations. The report was published on 18 July 2024, and a copy of the final report can be found here. The Health Board has finalised the action plan to meet the recommendations made by the Ombudsman and all evidence of compliance has been submitted to the Ombudsman for closure. Progress reports continue to the Regulatory Assurance Group (RAG).

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

Average Variance to Target (AVT)

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

to provide evidence to comply with a target date to provide evidence to comply with a recommendation.

As shown below, the Health Board's AVT is currently 1, which means that it is responding 1 day later than the Ombudsman's target date. For context, The NHS average for August 2024 was 3.35 compared with 3.56 in July 2024. On average compliance evidence is reaching the Ombudsman's office over 3 days later than the target dates.

| | 23/24 | 24/25 |
|---|---|---|
| Aneurin Bevan University Health Board | -1 | -3 |
| Betsi Cadwaladr University Health Board | -2 | 1 |
| Cardiff and Vale University Health Board | -1 | -1 |
| Cwm Taf Morgannwg University Health Board | 3 | 70 |
| Hywel Dda University Health Board | -2 | -10 |
| Powys Teaching Health Board | -13 | -27 |
| Swansea Bay University Health Board | 3 | -2 |
| Velindre University NHS Trust | 13 | -1 |
| Welsh Ambulance Services NHS Trust | - | - |
| NHS Average AVT | 0.14 | 3.35 |

Routinely, the Health Board has achieved compliance with submissions ahead of the Ombudsman's deadlines and there are various factors contributing to this change in performance which includes delays in receiving evidence from services due to service pressures, or insufficient evidence received from services, indicating education and further support is required for staff.

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

## ORGANISATIONAL LEARNING

The Organisational Learning Forum (OLF) brings together colleagues with a shared interest in and vision for working in new ways to improve safety, practice and processes across our healthcare system.

The following is a sample of learning from the last 2 meetings of the OLF:

- Chris Shirley, Professional Development Lead Resus Services, and Ffion Pursglove, Specialist Nurse Medicines Management, gave a brief introduction to Human Factors and how this can be instrumental in improving culture, reducing errors & harm and improving patient and staff safety and experience. The principles and practices of Human Factors focus on optimising human performance through better understanding the behaviour of individuals, their interactions with each other and with their environment. The pair will be presenting in full about developing a health board wide approach in embedding human factors in practice at October's OLF.

- Lou Rodrigues shared an update on the development of the #BetterByBetsi community. The community, which has been running now for around 18 months, is open to all Betsi staff to join to share ideas and examples of improvement work. Evidence demonstrates that more connected organisations perform better, and that relationships are not only a priority but a prerequisite for improvement. This enables organisations to transfer knowledge and learning more quickly and effectively. The #BetterByBetsi community presents opportunities and possibilities for an improved network approach to delivering services across BCU. Lou shared the opportunity for new and existing networks within BCU to collaborate together to improve knowledge and information sharing, and the chance to design a “network of networks" to improve things for the wider organisation.

- Sam Watson, shared an update on work to learn and improve on our approach to missing patients. Sam shared how a weekly review of cases now takes place, using data provided by North Wales Police from its control room incident logs. The data is cross referenced with Datix to gain a better understanding of the circumstances and details around incidents where patients go missing. Colleagues from ED, Mental Health and Learning Disabilities, Children’s Services and IHC teams collaborate with partners from North Wales Police in carrying out the weekly reviews. The Welsh Ambulance Service are joining the work soon. The group meets to review instances where a patient has gone missing, assess the management of each case, learn from each other’s expertise, and reach an agreement on actions to improve on management in future. The reviews provide an opportunity for operational colleagues to talk openly about the challenges of supporting patients who go missing while under Health Board care, and devise practical solutions to keep patients as safe as possible in future. One of the early pieces of learning is a trend in missing patients being reported to North Wales Police by health staff in the absence of any vulnerability or risk, the emerging picture is one of reports that are primarily driven by practitioner and organisational anxiety. The team are now focussing early resources on practical measures to help staff dealing with a live situation reach a conclusion quicker without needing to refer to the Police.

- Sharon Eyre, medicine management nurse Central IHC, presented information on lessons learned for methotrexate incidents. She shared the implementation of a reviewed version of the methotrexate prescription chart that has been updated following the lessons shared from incidents.

- Debbie Kumwenda, Healthcare Law Lead Manager, shared an update on progress being made to address concerns from the North Wales Coroner about the quality, effectiveness and timeliness of Health Board’s investigations. Debbie shared details of two recent Regulation 28 reports issued in July 2024, both of which highlighted concerns from the Coroner around the quality of investigations produced by the Health Board. The instances shared illustrated how communication issues between teams with responsibility for drafting the reports had impacted their quality. As a result, the coroner issued a Regulation 28 report over concerns that weaknesses in our investigating processes meant that opportunities to improve safety and prevent deaths were being hampered. Learning from the concerns raised by the coroner has helped shape a revamped approach to how we respond to complaints, incidents and mortality reviews, detailed within the introduction of our new Integrated Concerns Policy.

- Tracey Williamson, Consultant Nurse for Dementia, shared feedback from a two-week pilot scheme to see if intercepting dementia-related complaints could lead to

better outcomes for our population. The pilot saw one dementia-related complaint received by the Health Board referred directly to Tracey, rather than going through the normal complaints process. A second complaint already being investigated was also referred to Tracey. This allowed Tracey to respond directly to the complainants, and through her position as a senior figure focussed on dementia care, build rapport and share experience and expertise with them. By demonstrating common ground and a shared objective of improving care for a specific cohort of our population, the approach helped to work to resolve aspects of their complaints quickly, constructively and in a patient-focussed and empathetic way. Both cases offered to withdraw their complaints, and expressed satisfaction at the involvement of an expert in resolving their specific queries. Tracey was especially able to demonstrate actions she had already taken in light of their concerns and future actions, which both families found very reassuring. Work is now underway to consider extending the pilot, but learning can already be pulled out from the findings so far. Tracey's findings illustrated the opportunity to develop more timely and effective approaches to systems through the power of taking an empathetic, patient-focussed approach. It also showcased an opportunity to gain rich, in-depth insight from complaints, which can lead to opportunities to make improvements, due to the shared interest between the complainant and our subject matter expert. Tracey also shared insights about working in collaboration with the complaints team, and how working with subject matter experts can supplement and support the existing process.

- Catherine Sutton shared a medicines management update on the careful use of Ondansetron, an anti-emetic (anti-sickness), drug. The learning stems from two recent cases where patients were admitted to ITU with hyperkalaemia, with a query upper GI bleed, both of which went into cardiac arrest after receiving doses of Ondansetron. Both patients made a full recovery. Guidance from our pharmacists details that Ondansetron should be avoided in patients with congenital prolonged QT syndrome, a heart rhythm disorder, and caution should be taken if administering Ondansetron to patients with risk factors including electrolyte disturbances, existing medication which can prolong the QT interval, such as antipsychotics, antidepressants, and antihistamines. Following investigation, learning include the dissemination of a medication safety memo, and caution around its use is part of induction for all FY1 students. Members of the forum discussed the fine balance between taking caution when using Ondansetron and understanding risk factors, while also acknowledging its routine and essential use without side effects day in, day out across North Wales.

## HEALTHCARE LAW

### CORONER AND INQUESTS

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

During July and August 2024, the Health Board received two Regulation 28 Prevention of Future Death Reports. A summary of the issues raised by the Coroner are listed as follows:

2. **IHC Central and MHLD** – issues raised relate to the investigation process and accountability of staff members. An investigation by the Health Board identified that there were failings in relation to the care afforded to the patient both following a mental health referral and at ED, however the evidence at inquest indicated that the persons with responsibility for these issues had not been spoken to, nor played a part in the investigation process. Furthermore, an action plan provided by the Health Board advised that a leaflet would be available by the end of May 2024. This would be given to patients attending ED with mental health issues at the time of triage to provide advice, support and an indication of likely waiting times before any psychiatric assessment took place. The Coroner was concerned that there does not appear to be any consequences for staff members whose actions or omissions result in a failure to adhere to the policies and procedures, which the Health Board imposes for the safe care and treatment of patients. The Coroner stated that the failure to act in a timely manner when learning and actions had been identified (especially when the timetable had been set by the Health Board) was incomprehensible.

3. **IHC Central** – issues raised relate to the quality, effectiveness and timeliness of the Health Board's investigation. The Health Board conducted an investigation to include a review of the patient's previous mental health care and treatment as well as ED care and treatment. This did not identify any concerns from an ED perspective. Following a request for an ED statement, a second review of the ED care and treatment was undertaken however this was completed only 8 days prior to the already listed Inquest. This identified omissions in the care and treatment.

The Health Board has 56 days to respond to all Regulation 28 Notices. Notices are allocated to a lead within the relevant Service, with responses scrutinised and approved by the relevant Executive Director. In both of the cases above, responses were submitted to the Coroner on time and within the relevant time period: the responses made reference to the new Integrated Concerns Policy.

A bi-weekly Inquest Oversight Panel was established in autumn last year to provide Executive support to ensuring deadlines were achieved. A number of inquests continue to be listed which are several years following a death however; these are beyond the control of the Health Board and reflect various external factors such as the long-term impact of the pandemic.

Escalation of investigation reports by the Coroner.

The Coroner had previously raised concerns with the Chief Executive and Executive Medical Director in relation to the length of time it takes for investigation reports to be concluded and made available to the Coroner. Noted, was the inevitable impact this has not only on the progress of inquests but also how these delays can exacerbate grief for bereaved families.

The Health Board shares the concerns raised by HM Senior Coroners regarding investigation timeliness, quality and evidence of learning. In response, a review of the investigation process commenced. A project was also undertaken to provide assurance of investigation quality, learning and supporting evidence for previously completed investigations. This work commenced in January 2024 and concluded at the end of June 2024 with a dedicated review team established and an oversight panel of senior leaders reporting to an executive steering group. The findings from this project led to a clear understanding of where the problems were occurring in the Health Boards processes.

A further programme of work was therefore commissioned to develop a new Integrated Policy covering Incidents, Complaints and Mortality Reviews. This is known as the Integrated Concerns Policy. The new policy was approved at the Board meeting in July 2024 and became operational on 1 September 2024. Deputy Directors of Nursing are leading implementation of this new policy through a working group consisting of the Patient Safety Team, Patient and Carer Experience Team, Complaints Team, Clinical Effectiveness Team and Legal Team. As with any major new policy, the Health Board expects full implementation to occur over the next three months.

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

## LIABILITY CLAIMS

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

*Claims are restricted by time limits. Typically, a claim must be brought within 3 years of the alleged negligence taking place or from the point of knowledge. A minor will generally have until their 21st birthday to submit a claim. In order to bring a claim a claimant would need to show there was a 'breach of duty of care' and that 'causation' had taken place. All claims are brought against the Health Board and not against any individual clinicians. Clinical Negligence and Personal Injury Claims are managed by the Healthcare Law Team who work closely with Legal & Risk Services.*

Where claims are justified, we aim for early settlement to provide support for those affected and to reduce costs. All claims are managed to ensure a fair and equitable settlement. However, where unjustified claims are made, these are robustly defended and are taken to trial if necessary.

One trial took place during the period of July/August 2024. Details are as follows:

1. **Personal Injury Claim, East – Trial Win**
   Allegations relate to injury caused as a result of a slip/fall on a wet floor surface. The Court found that the Health Board did have reasonable systems in place in the form of its reactive cleaning procedure and that the accident had not been caused by any form of negligence on behalf of the Health Board. The Claim was therefore dismissed.

During the two months of July and August 2024, 74 new claims were opened. This consisted of 63 clinical negligence claims and 11 personal injury claims. This is a 47% increase in new claims received compared to the previous two monthly period.

At the end of August 2024, the Health Board had 428 confirmed clinical negligence claims, 378 potential clinical negligence claims and 92 personal injury claims open. The overall number of outstanding claims has decreased by just over 7%. The Healthcare Law Team carried out a data cleansing exercise during August 24, which enabled some dormant claims to be closed, hence the reduction in the number of claims.

Learning from Events Reports (LFERs)

The Health Board has a number of overdue Learning from Events Reports (LFERs) which are due to be submitted to the Welsh Risk Pool (WRP). At the end of August 2024, this number was 49 (all bar four are out with services for 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.

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Ask for: Communications
01656 641150
Caseinfo@ombudsman.wales

Date: 9 September 2024

Dyfed Edwards
Betsi Cadwaladr University Health Board

**By email only**
dyfed.edwards@wales.nhs.uk
carol.shillabeer3@wales.nhs.uk

**Annual Letter 2023/24**

Dear Dyfed

**Role of PSOW**

As you know, the role of the Public Services Ombudsman for Wales is to consider complaints about public services, to investigate alleged breaches of the councillor Code of Conduct, to set standards for complaints handling by public bodies and to drive improvement in complaints handling and learning from complaints. I also undertake investigations into public services on my own initiative.

**Purpose of letter**

This letter is intended to provide an update on the work of my office, to share key issues for health boards in Wales and to highlight any particular issues for your organisation, together with actions I would like your organisation to take.

**Overview of 2023/24**

This letter, as always, coincides with my Annual Report – "A New Chapter Unfolds" – and comes at a time when public services continue to be in the spotlight, and under considerable pressures. My office has seen another increase in the number of people asking for our help – a 17% increase in overall contacts compared to the previous year, with nearly 10,000 enquiries and complaints received. Our caseload has increased substantially - by 37% - since 2019.



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.

During 2023/24 we considered and closed more enquiries and complaints than we ever have done before, and we reduced the average cost for each case and investigation. We started the year with a focus on reducing our aging cases, those over 12 months old, by 50% by the end of the year. These cases are often the most complex and distressing for the people making the complaint. I am extremely pleased to say we exceeded this target, reducing our aged investigations by over 70%. We are now well on track to meeting our objective to complete investigation of complaints within 12 months.

**Public Service Complaints and compliance with recommendations**

We received 939 complaints about health boards last year – roughly the same number as the previous year. During this period, we intervened in (upheld, settled or resolved at an early stage) 31% of health board complaints - a similar proportion to previous years.

Last year, we received 214 complaints about Betsi Cadwaladr University Health Board, we closed 256 (some complaints were carried over from the previous year) and intervened in 32% of cases. Further information on the complaints we dealt with last year can be found in the appendices.

We published 3 public reports in the public interest relating to care and treatment delivered by the Health Board, one of which was issued following an investigation undertaken on our own initiative. I am pleased that the Health Board has complied with the recommendations in these reports.

In total, we made 253 recommendations to your health board during the year. To ensure that our investigations and reports drive improvement, we follow up compliance with the recommendations agreed with your organisation. In 2023/24, 246 recommendations were due and 58% were complied with in the timescale agreed. The remainder were complied with, but outside the timescales agreed, or remained outstanding as at 9 April 2024.

Recommendations and timescales for complying with recommendations are always agreed with the public body concerned before being finalised, and we therefore expect organisations to comply within the timescales agreed.

Further to the report my office issued in June 2023, Groundhog Day 2: An opportunity for cultural change in complaint handling? I wish to thank the Health Board for its consideration of the report and recommendations. I trust that it has ensured that lessons learned from the PSOW's findings and recommendations on cases we considered last year are included in your Health Board's Annual Report on the Duty of Candour and Quality.

## Supporting improvement of public services

We continued our work on supporting improvement in public services last year and worked on our second wider Own Initiative investigation. The investigation considers carers' needs assessments undertaken by local authorities in Wales. My report on this work will be finalised and published in the near future.

We have continued our work on complaints handling standards for public bodies in Wales and now have 56 public bodies following our model complaints handling policy. These public bodies account for around 85% of the complaints we receive.

We continued our work to publish complaints statistics into a third year with data, gathered from public bodies, now published twice a year. This data allows us to see information with greater context – for example, last year 10% of complaints made to Betsi Cadwaladr University Health Board's complaints went on to be referred to PSOW - the highest proportion of any Health Board. I would encourage all health boards to use this data to better understand their performance on complaints and ensure that all complaints are appropriately logged.

I have written recently to your Chief Executive about the significant reduction in the number of complaints recorded by Betsi Cadwaladr University Health Board over the past 3 years – 4,854 in 2021/22 down to 2,469 in 2023/24. At the same time, the number of complaints referred to my office about Betsi Cadwaladr University Health Board has, as indicated above, remained high. I am sure that you will wish to receive assurances that all complaints received are correctly recorded, that all who wish to complain are able to do so and that learning from complaints is used to improve outcomes for all service users

Colleagues from my Improvement Team continue to meet regularly with Betsi Cadwaladr University Health Board to discuss compliance with our recommendations and our complaints standards work. We have seen real benefit come from these conversations, as well as improved working relationships, and we would like to pass on our thanks to Denise Williams and their team for their work with our officers.

## Action we would like your organisation to take

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.

- Consider the data in this letter, alongside your own data, to understand more about your performance on complaints, including any patterns or trends and your organisation's compliance with recommendations made by my office.

- Provide assurance that all complaints received are correctly recorded, that all who wish to complain are able to do so and that learning from complaints is used to improve outcomes for all service users.

- Provide my office with a copy of the Health Board's Annual Report for 2023/24 on the Duty of Candour and Quality.

- Inform me of the outcome of the Board's considerations and proposed actions on the above matters at your earliest opportunity.

Finally, I would like to thank you, and your teams, for your work with my officers in the last year. Their work is important in ensuring that patients and families receive timely and thorough responses to complaints, and in improving outcomes for all service users – not just those who complain.

Yours sincerely,

**Michelle Morris**
Public Services Ombudsman

Cc. Carol Shillabeer, Chief Executive, Betsi Cadwaladr University Health Board

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**Factsheet**

Appendix A - Complaints Received

| Health Board | Complaints Received | Received per 1,000 residents |
|---|---|---|
| Aneurin Bevan University Health Board | 175 | 0.30 |
| Betsi Cadwaladr University Health Board | 214 | 0.31 |
| Cardiff and Vale University Health Board | 150 | 0.30 |
| Cwm Taf Morgannwg University Health Board | 109 | 0.25 |
| Hywel Dda University Health Board | 138 | 0.36 |
| Powys Teaching Health Board | 21 | 0.16 |
| Swansea Bay University Health Board | 132 | 0.35 |
| **Total** | 939 | 0.30 |

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Appendix B - Received by Subject

| Betsi Cadwaladr University Health Board | Complaints Received | % share |
|---|---|---|
| **Admissions/discharge and transfer procedures** | 4 | 2% |
| **Adult Mental Health** | 16 | 9% |
| **Ambulance Services** | 0 | 0% |
| **Appointment procedures (including outpatients)** | 6 | 3% |
| **Child and Adolescent Mental Health** | 2 | 1% |
| **Clinical treatment in hospital** | 107 | 50% |
| **Clinical treatment outside hospital*** | 14 | 7% |
| **Complaints Handling** | 36 | 17% |
| **Covid-19** | 1 | 0% |
| **Continuing care** | 2 | 1% |
| **De-Registration** | 0 | 0% |
| **Disclosure of personal information / data loss** | 0 | 0% |
| **Funding** | 1 | 0% |
| **Independent Health Care providers** | 0 | 0% |
| **Medical records/standards of record-keeping** | 4 | 2% |
| **Medication > Prescription dispensing** | 0 | 0% |
| **Non-medical services** | 0 | 0% |
| **Nosocomial*** | 0 | 0% |
| **Other*** | 2 | 1% |
| **Out of Hours GP care** | 0 | 0% |
| **Parking (including enforcement and bailiffs)** | 0 | 0% |
| **Patient list issues** | 5 | 2% |
| **Poor/No communication or failure to provide information** | 2 | 1% |
| **Prisoner Care** | 3 | 1% |
| **Recruitment and appointment procedures** | 0 | 0% |
| **Referral to Treatment Times** | 2 | 1% |
| **Regulation and Inspection (including private sector provision)** | 1 | 0% |
| **Rudeness/inconsiderate behaviour/staff attitude** | 2 | 1% |
| **Services for people with a disability inc DFGs** | 0 | 0% |
| **Service for vulnerable Adults (eg with learning difficulties or mental health issues)** | 0 | 0% |
| Total | **214** | |

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Appendix C - Complaint Outcomes
(* denotes intervention)

| Betsi Cadwaladr University Health Board | | % Share |
|---|---|---|
| Out of Jurisdiction | 47 | 18% |
| Premature | 30 | 12% |
| Other cases closed after initial consideration | 83 | 32% |
| Early Resolution/ voluntary settlement* | 40 | 16% |
| Discontinued | 3 | 1% |
| Other Reports - Not Upheld | 12 | 5% |
| Other Reports Upheld* | 37 | 14% |
| Public Interest Reports* | 4 | 2% |
| Special Interest Reports* | 0 | 0% |
| **Total** | **256** | |

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Appendix D - Cases with PSOW Intervention

| | No. of Interventions | No. of Closures | % of Interventions |
|---|---|---|---|
| Aneurin Bevan University Health Board | 73 | 195 | 37% |
| Betsi Cadwaladr University Health Board | 81 | 256 | 32% |
| Cardiff and Vale University Health Board | 34 | 158 | 22% |
| Cwm Taf Morgannwg University Health Board | 39 | 129 | 30% |
| Hywel Dda University Health Board | 55 | 154 | 36% |
| Powys Teaching Health Board | 3 | 21 | 14% |
| Swansea Bay University Health Board | 41 | 141 | 29% |
| **Total** | **326** | **1054** | **31%** |

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Appendix E – Compliance performance comparison

| Health Board | Number of recommendations made in 2023-24 | Number of Recommendations falling due in 2023-24 | % of recommendations, complied with on time |
|---|---|---|---|
| Aneurin Bevan University Health Board | 209 | 208 | 75% |
| Cardiff and Vale University Health Board | 104 | 95 | 81% |
| Cwm Taf Morgannwg University Health Board | 123 | 121 | 60% |
| Swansea Bay University Health Board | 119 | 127 | 62% |
| Hywel Dda University Health Board | 160 | 151 | 81% |
| Betsi Cadwaladr University Health Board | 253 | 246 | 58% |
| Powys Teaching Health Board | 10 | 12 | 67% |

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**Information Sheet**

**Appendix A** shows the number of complaints received by PSOW for all Health Boards in 2023/24. 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 2023/24. This table shows both the volume, and the proportion that each outcome represents for the Health Board.

**Appendix D** shows Intervention Rates for all Health Boards in 2023/24. An intervention is categorised by either an upheld complaint (either public interest or non-public interest), an early resolution, or a voluntary settlement.

**Appendix E** shows compliance performance for all Health Boards.

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

Bloc 5, Llys Carlton, Parc Busnes Llanelwy, Llanelwy, LL17 0JG
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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:**
Caseinfo@ombudsman.wales

**Ein cyf / Our ref:** CE24/0999
☎: 03000 852633
**Gofynnwch am / Ask for:** Denise Williams
**E-bost / Email:**
BCU.Ombudsman@wales.nhs.uk
**Dyddiad / Date:** **(By 20 December 2024)**

This is a draft response and is subject to the approval of QSE Committee and Board.

Dear Michelle,

**Re: Ombudsman Annual Letter 2023/24**

Further to my letter dated 26 September 2024, I am pleased to confirm that the Health Board's Committee and Board have considered the contents of your Annual Letter 2023-24.

This comes at an important point in time for the Health Board with the Integrated Three-Year Plan 2024-27 developed under the leadership of myself as new Chair and Carol Shillabeer as new Chief Executive Officer, supported by a substantial change in Board membership. The plan outlines the actions required in order to achieve our ambition to provide high quality and sustainable services for our citizens of North Wales.

To enable the Health Board to address its current challenges, it requires a strong understanding of the needs of its citizens. The information and data you have shared within your Annual Letter provides insight to this and is a key driver to our organisational learning and I would like to thank you again for the opportunity for the Board and I to consider and respond to your Annual Letter.

**Present my Annual Letter to the Board at the next available opportunity and notify me of when these meetings will take place.**

As outlined in my previous letter, I can confirm that Angela Wood, Executive Director of Nursing and Midwifery co-ordinated an initial response to your letter with input from key colleagues which was then presented to the Quality, Safety and Experience Committee on 24 October 2024 and then the Board on 28 November 2024.

As such, this response from the Health Board includes the Committee and Board's considerations who have had the opportunity to discuss your letter in detail, and have welcomed the opportunity to review the data and information you have shared.

**Consider the data in this letter, alongside your own data, to understand more about your performance on complaints, including any patterns or trends and your organisation's compliance with recommendations made by my office.**

The Health Board has considered the data within your Annual Letter 2023-24 which has provided the opportunity for the Board to review the organisation's journey, in particular in relation to quality and learning, along with any areas which remain particularly challenging.

The Board and I note that whilst there has been a significant reduction in the number of complaints recorded by the Health Board over the past three years, the number of complaints referred to your office has remained high. This indicates further improvement is required for the Health Board, particular in relation to how it manages its complaints process and how it learns from complaints.

As confirmed within the data you have provided, complaints handling continues to be an area of challenge for the Health Board, together with concerns expressed by service users in relation to the clinical treatment they receive whilst in hospital which is reflected within the Health Board's top six complaints themes;

1. Delay/Lack of Treatment or Assessment
2. Incorrect/Insufficient Treatment or Assessment
3. Reaction to Procedure/Treatment
4. Delay/Lack of Diagnosis
5. Communication with Patient/Service User
6. Incorrect Diagnosis

The Health Board is undertaking focused work in relation to complaint handling, including introducing a new concerns management process, along with focused Complaints Performance Trajectory Work and better engagement with service users. Through this work, the aim is to reduce the number of complaints the Health Board receives and improve compliance with Putting Things Right timescales, which should subsequently improve the experience for service users when raising a complaint, and reduce the level of intervention required by your office. To achieve this, the Health Board must ultimately provide better outcomes for its citizens by ensuring it becomes a learning organisation.

The Health Board is on a journey to improve how it collates and interprets data in order to focus improvement in the areas that require it the most, this includes learning from complaints. As you will see in the Health Board's Three-Year Plan, one of the organisations ambitions is to 'Establish an Effective Environment for Learning'. It aims to improve the consistency in learning from complaints and significant events. This includes improving how we investigate complaints, taking a more integrated approach to future investigations and I am pleased to inform you of the progress made to so far.

Integrated Concerns Policy

In September this year, the Health Board implemented a new approach to concerns management, launching the new Integrated Concerns Policy. This aims to provide a more coordinated approach to how the organisation manage responses to incidents, complaints and mortality reviews.

The policy introduces a daily virtual Concerns Hub, where services meet to discuss and triangulate all complaints, incidents and Medical Examiners' scrutiny letters that have been received/ occurred in the previous 24 hours. This ensures all complaints are triaged, allocated and acted upon in a timely manner. The hub also allows early identification of cross /cutting organisational themes, reduces silo working and improves efficiency in the complaint handling process. Furthermore, it enables staff to share learning, insights and information on investigations which are live. This encourages learning initiatives at the outset as opposed to the final stages of investigations.

In order to support an intelligence led approach to the new process, a Learning Investigations' Tracker has also been introduced which enables staff to monitor service performance for investigations so the Health Board knows what investigations are open across the organisation, when they are due, and what is overdue, with further development underway to include trends analysis and themes.

Whilst the Health Board is an organisation that is rich in data, it is not always able to translate that data into rich information and intelligence. This, of course, impacts the organisation's ability to understand the areas requiring the most focus, limiting its ability to maximise learning and improvement to achieve the outcomes required for all service users.

Quality Dashboard

This has led to the development of a Quality Dashboard which is a portal that triangulates key quality data from a range of systems in the Health Board. It includes patient feedback and complaints data, in real time, allowing organisational leaders to improve complaint management performance, and to inform workplans on emerging themes and trends. This supports services to embed learning, and evaluate its impact.

Through further development of the dashboard over the coming months, it will also capture local measures for Ombudsman cases, helping to strengthen Board oversight and assurance in this area, along with supporting services to monitor their performance and take forward learning. The organisation's Quality Assurance and Regulation Team will ensure your Improvement Team continue to be updated on the developments through the quarterly compliance meetings.

Complaints Performance Improvement Trajectory

As reflected in your data, complaint handling is an area requiring improvement for the Health Board and has posed a challenge for some time. In recent months, the organisation has undertaken a thematic analysis of complaints and introduced a Complaints Performance Improvement Trajectory, whereby a weekly analysis of complaints, themes and trends is undertaken and scrutinised at weekly executive led performance meetings.

This data is then triangulated against patient feedback, to inform the Health Board of any specific areas of concern. The Health Board, proactively identifies areas of underperformance, and weekly targets are set to improve the complaints handling process. This analysis, feeds into a number of key strategic groups including the Organisational Learning Forum and patient and carer experience group, to support learning initiatives, across the organisation.

The Complaints Performance Improvement Trajectory to support the achievement of the performance target for complaints closures by the 14 October 2024, for compliance of 75% of complaints responded to within less than 30 working days, has achieved a 70% compliance.

Organisational Learning Forum and Learning Repository

Learning, which includes learning from the recommendations you make to the Health Board, is another key area for improvement. The Health Board has introduced an Organisational Learning Forum which brings together staff with a shared interest in and vision for working in new ways to improve safety, practice and processes across our healthcare system. Each month, the forum enables staff to bring any learning which is transferrable or relevant to other areas of the Health Board they would be otherwise unable to reach.

The Health Board is also developing a Learning Repository which is a knowledge management system that enables healthcare professionals to access, share, and learn from data and insights related to patient safety incidents. The system integrates data from various sources and supports collaborative learning.

The main objective of the Organisational Learning Forum and Learning Repository is to improve patient safety by facilitating organisational learning from past incidents and best practices.

Compliance with recommendations

The Board and I are pleased to see that the Health Board have complied with the recommendations pertaining to the three published Public Interest Reports, relating to

care and treatment delivered by the Health Board. The recommendations made to the Health Board within the reports, will continue to be taken forward to improve the experience for citizens, staff and the services it provides.

How the organisation captures, tracks and monitors Ombudsman recommendations, is a key area of performance which the Health Board aims to improve over the coming months, acknowledging the current compliance rate of 58% complied with in the timescales agreed. As the number of complaints referred to your office about the Health Board have remained high, this will have contributed to the reduction in compliance, along with the areas we continue to improve such as complaint handling and learning.

It is also recognised that further support and education is required for Health Board staff in relation to the management of Ombudsman recommendations. The Health Boards Quality Assurance and Regulation Team have discussed this with your Improvement Team and will jointly facilitate a session for Health Board staff.

At present, the Health Board captures the recommendations on the Datix Cymru system and performance is monitored via the organisations Regulatory Assurance Group which is chaired by the Deputy Director of Quality and reports up to the Executive Delivery Group. There are limitations to how Ombudsman recommendations are currently captured on the system. Therefore, the Health Board is networking with colleagues in other Welsh NHS Local Health Boards and Trusts in order to develop this area through the All-Wales network groups.

In the meantime, the Health Boards Quality Assurance and Regulation Team will continue to meet with your Improvement Team to review compliance on a quarterly basis and continues to review the Average Variance Target via the Regulatory Assurance Group.

I am pleased to hear you have seen a benefit to the conversations which have taken place as part of these meetings and I have indeed passed on your thanks to the team who appreciate the continued support and guidance from your team.

**Provide assurance that all complaints received are correctly recorded, that all who wish to complain are able to do so and that learning from complaints is used to improve outcomes for all service users.**

In addition to the initiatives mentioned above, improvements have taken place over the past year, particularly in terms of how complaints are managed corporately and in relation to focusing on how the Health Board can improve the experience for service users when raising a complaint and how feedback from service users can drive the wider agenda for the Health Board.

All complaints are correctly recorded, triaged, allocated and investigated in accordance with policies and procedures and aligned to the Putting Things Right (PTR) regulations, through a specialist team in a dedicated complaints department. The staff attend weekly

operational meetings to ensure each complaint is being addressed and where breaches of duty and qualifying liability have been identified, attend a weekly PTR clinic which is hosted by the organisation's Healthcare Law Team.

The Health Board have redesigned the complaint response template and issued guidance to staff on its completion, to ensure responses are robust and written in a way that is understandable, and empathetic, improving the experience for the complainant. All complaints have an action plan of learning, which is embedded not only in the area identified by the complainant, but key learning disseminated across the organisation in the key strategic groups which includes the Patient and Carer Experience Group and the Organisational Learning Forum.

All complaints are quality assured corporately, to ensure learning has been identified and action plans delivered upon, as part of a continual cycle of improvement.

The Health Board have increased the ability for citizens to make a complaint, including the introduction of a new telephone system, new web pages for complaints, and will be introducing a new digital interface whereby citizens can raise concerns digitally through social media and other platforms such as WhatsApp. In addition to this, the organisation proactively attends community engagement events, capture patient stories, and have improved the uptake of patient feedback via the CIVICA system, which is a part of a proactive and preventative approach to complaint management. There is a significant focus on patient engagement to capture qualitative feedback on experience, which supports delivery plans of the organisation.

**Provide my office with a copy of the Health Board's Annual Report for 2023/24 on the Duty of Candour and Quality.**

The Health Board's Annual Quality Report 2023024 which includes the annual reporting requirements on Duty of Quality, Duty of Candour and Putting Things Right, is due to be received by the Board for approval on 26 September 2024. The report is on track for publication by October, and a copy will be shared with you.

The duties collectively bring together an opportunity for the Health Board to strengthen its partnership working, be more transparent with its population and to review its approach to quality, ensuring a quality-focused approach to decision making that is informed by the experiences and voices of its people along with its learning and data insights.

The report focuses on the steps the organisation has taken to secure improvement in the quality of health services, looking back at the Special Measures journey, and looking forward to the Three-Year Plan 2024-27 with a 'whole system' approach, working with the Health Board and its partners to achieve better outcomes.

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**Inform me of the outcome of the Board's considerations and proposed actions on the above matters at your earliest opportunity.**

Having considered your Annual Letter 2023-24, the Board will continue to review the following areas through the organisation's governance arrangements:

- Complaints Performance Improvement Trajectory and any improvement on compliance with the 30 working days target, including any reduction on the level of intervention by your office.
- Performance on Compliance with Ombudsman Recommendations
- Integrated Concerns Policy, and how the new approach contributes to an improved experience for citizens and any further reduction in the complaints received by the Health Board.

Thank you for continuing to highlight the experiences of our patients and their families as this is a key contribution to our learning and improvement journey. I look forward to updating you further on the progress made, and look forward to continuing to work with you and your team.

Yours sincerely

_____

**Dyfed Edwards**
**Cadeirydd / Chair**

c.c Carol Shillabeer, Chief Executive
Angela Wood, Executive Director of Nursing and Midwifery and executive lead for PSOW
Pam Wenger, Executive Director of Corporate Governance
Matthew Joyes, Deputy Director of Quality

| | |
|---|---|
| **Teitl adroddiad:**<br><br>***Report title:*** | Our Integrated Performance Report – Month 6, 2024/25 |
| **Adrodd i:**<br><br>***Report to:*** | Quality, Safety & Experience Committee |
| **Dyddiad y Cyfarfod:**<br><br>***Date of Meeting:*** | Thursday, 24 October 2024 |
| **Crynodeb Gweithredol:**<br><br>***Executive Summary:*** | This Report relates to the Month 6, 2024/25.<br><br>The structure of our IPR is based upon the Quadruple Aims as per the Welsh Government's 'A Healthier Wales' paper and the NHS Wales Performance Framework 2024-25. It identifies where metrics fall within the Special Measures Framework for BCUHB.<br><br>Where appropriate, we have linked performance metrics to items on the Corporate risk Register (CRR).<br><br>Performance is RAG rated against the targets set within the NHS Wales Performance Framework 2024-25, or as set by Welsh Government in the Special Measures Framework for BCUHB. However, where appropriate, BCUHB's internal improvement trajectories as submitted and agreed by Welsh Government have also been included.<br><br>Key areas of escalation are identified within the 'Performance Escalations Report' section at the beginning of the report. (We will strengthen this section as the report matures, to include more information about the plans to mitigate or improve performance). The responsible executive has reviewed the elements of the report that are within their portfolio.<br><br>Statistical Process Control (SPC) charts have been included where appropriate. |
| **Argymhellion:**<br><br>***Recommendations:*** | The Quality, Safety & Experience Committee is asked to:<br><br>Review the structure, components and contents of the report and confirm agreement to continue with this format, propose any actions arising from the report, or identify any additional assurance work or actions it would recommend Executive colleagues to undertake. |
| **Arweinydd Gweithredol:**<br><br>***Executive Lead:*** | Russell Caldicott, Interim Executive Director of Finance and Performance |
| **Awdur yr Adroddiad:** | Ed Williams, Acting Director of Performance |

| | | | | |
|---|---|---|---|---|
| ***Report Author:*** | | | | |
| **Pwrpas yr adroddiad:** ***Purpose of report:*** | I'w Nodi<br>*For Noting*<br>☐ | I Benderfynu arno<br>*For Decision*<br>☒ | Am sicrwydd<br>*For Assurance*<br>☒ | |
| **Lefel sicrwydd:**<br><br>***Assurance level:*** | Arwyddocaol<br>*Significant*<br>☐<br>Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol<br><br>*High level of confidence/evidence in delivery of existing mechanisms/objectives* | Derbyniol<br>*Acceptable*<br>☐<br>Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol<br><br>*General confidence / evidence in delivery of existing mechanisms / objectives* | Rhannol<br>*Partial*<br>☒<br>Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol<br><br>*Some confidence / evidence in delivery of existing mechanisms / objectives* | Dim Sicrwydd<br>*No Assurance*<br>☐<br>Dim hyder/tystiolaeth o ran y ddarpariaeth<br><br>*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:**<br><br>***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:**<br><br>***Link to Strategic Objective(s):*** | The performance measures included in this report are from the NHS Wales Performance Framework 2024-25. | | | |
| **Goblygiadau rheoleiddio a lleol:**<br><br>***Regulatory and legal implications:*** | This report will be available to the public once published for Quality, Safety & Experience Committee | | | |
| **Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal?**<br><br>***In accordance with WP7 has an EqlA been identified as necessary and undertaken?*** | N<br><br>The Report has not been Equality Impact Assessed as it is reporting on actual performance. | | | |
| **Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal?** | N<br>The Report has not been assessed for its Socio-economic Impact as it is reporting on actual performance | | | |

| | |
|---|---|
| ***In accordance with WP68, has an SEIA identified as necessary been undertaken?*** | |
| **Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR)**<br><br>***Details of risks associated with the subject and scope of this paper, including new risks( cross reference to the BAF and CRR)*** | There remians a number of risks to the delivery of care across the healthcare system due to the legacy impact the COVID-19 Pandemic had upon planned care delivery between 2020 and 2022. |
| **Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith***<br><br>***Financial implications as a result of implementing the recommendations*** | The delivery of the performance indicators within our IPR will directly/ indirectly impact upon the financial recovery plan of the Health Board. |
| **Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith**<br><br>***Workforce implications as a result of implementing the recommendations*** | The delivery of the performance indicators within our IPR will directly/ indirectly impact on our current and future workforce. |
| **Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori**<br><br>***Feedback, response, and follow up summary following consultation*** | The full report has been reviewed by the Director of Performance, and the Executive Director of Finance & Performance. |
| **Cysylltiadau â risgiau BAF:**<br>(neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)<br><br>***Links to BAF risks:***<br>*(or links to the Corporate Risk Register)* | Where appropriate, performance metrics have been annotated with the Corporate Risk Register (CRR) reference number as a link to the Board Assurance Framework (BAF). |
| **Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)**<br><br>***Reason for submission of report to confidential board (where relevant)*** | Amherthnasol<br><br>Not applicable |
| **Camau Nesaf:**<br>**Gweithredu argymhellion**<br><br>***Next Steps:***<br>***Implementation of recommendations:*** Continued focus on any areas of under-performance where assurance is not of sufficient quality to believe performance is or will improve as described.<br><br>The Integrated Performance Report will undergo continuous development through the remainder of 2024-25 and utilise the Performance Directorate's CAB process to modify any reporting metrics and formatting. | |
| **Rhestr o Atodiadau:** | |

***List of Appendices: 2***
*1: Summary of Report*
*2: Integrated Performance Report in PDF*
*3: Escalations from Integrated Performance Report in PowerPoint*

**Appendix 1 – Summary of Report**

**Committee:** **Quality, Safety & Experience**

**Report title:** **Summary of Integrated Performance Report (Month 6)**

**Report Author:** **Acting Director of Performance**

## 1. Introduction

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

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

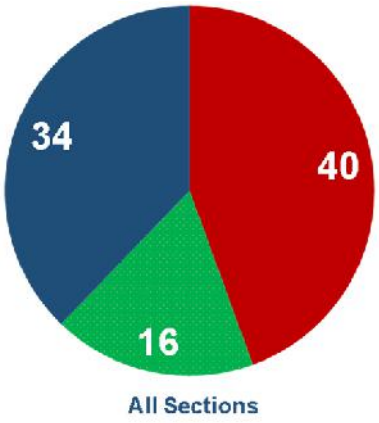
This structure enables an 'at a glance' view of the main concerns or message of the report through review of the initial one-page summary that is split into four quadrants, with the further slides contained within this escalation section articulating in more detail the current performance and actions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

This structure enables an 'at a glance' view of the main concerns or message of the report. Following the summary quadrant page, there is a page on each section providing more detail about the measures escalated. This should be the area of most focus in the report.

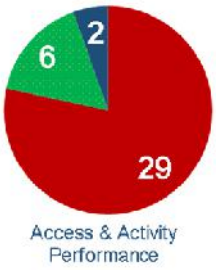
Only escalations in the Quality quadrant of the IPR has been included as these are what is in the remit of the Quality, Safety & Experience Committee.

On the 4th October 2024, the Acting Director of Performance presented a background on the Integrated Performance Framework to the QSE Committee Development Session. Some changes to the report were agreed, and where possible these have been included in this iteration of the Report. Further work will be undertaken to improve the intelligence, triangulation and assurance in the report into 2025-26.

## 2. Overall Summary










### 3.1 Quality (Safety, Effectiveness & Experience) Performance

The key areas highlighted centre upon:-

The Chief Executive Officer, together with support from the Executive Director of Nursing and Midwifery and colleagues throughout the organisation have had intense focus on the reduction of the number of **overdue investigations**, setting a target of 75% of all complaints resolved within 30 days by the 14th October 2024. Whilst the target hasn't been reached, the Health Board has achieved a position of over 70% (70.2%) of complaints being closed within 30 days. Of the 228 complaints currently open, 68 are overdue. The intense effort has resulted in a 66% (two-thirds) reduction from 672 open complaints in April 2024 to 228, and an 88% reduction in overdue complaints from 408 to 68.

A third (33%) of all complaints relate to delayed or lack of treatment or assessment (100). Continued focus on the extreme waits within our system together with this significant reduction in complaints should enable a sustainable performance against the 30 day measure going forward.

**Clinical coding compliance** will remain a significant risk directly attributed to staffing issues. A Clinical Coding Assurance Lead together with 6 new Clinical Coders have commenced in post. Compliance will remain low into the latter part of 2025-26 whilst the backlog is recovered and new staff are trained and working to full potential.

**Forty National Reportable incidents (NRIs) that remain open 90 days of more** at the end of September 2024. The Patent Safety Team (PST) are supporting the progression of all NRIs. Drop in clinics for staff are held weekly to help focus the outcome from the incident

review with any learning which can be shared. The IHCs and Divisions have submitted their reduction plans to the Executive Director of Nursing and Midwifery for onward monitoring of trajectory.

See appendices below.

Appendix 1 – IPR for QSE 24.10.2024

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

# Integrated Performance Report

Reporting Period:  to 30.09.2024

Presented to

# Quality, Safety & Experience Committee

# Thursday, 24th October 2024

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

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# Performance Escalations Report

# Key Messages

## Quality, Safety, Effectiveness & Experience Performance

- **Complaints**: 58.9% closed within 30 days at the end of September. However, at 14.10.2024 it was **70.2%** against the 75% target set.
- Since April 2024, there has been a **88.3% reduction** in number of overdue complaints. **(Corporate Risk 24-04 Failure to Embed Learning)**
- **Clinical Coding Compliance** will remain a significant risk through 2024-25 and will recover in 2025-26. New coding staff have commenced in post.
- **National Reportable Incidents** open for 90 days or more has remained static between 39 and 40 each month since June 2024.

## People & Organisational Development Performance

- **PADR Rates** - Falling steadily since April 2024, down from 79.4% to 77.1%
- **Sickness Absence Rates** - Continues to fall, from a high of 6.3% in July 2024, to 5.7% in September 2024.
- **Turnover Rates for Nursing & Midwifery Staff** - Increased to 2.3% in September 2024, compared to 1.5% in August.
- **Agency Spend as a Percentage of Staff Pay Bill** - Decreased to 3.8% in September 2024, down from 4.6% in August and July.
- **Roster Compliance** – Significantly improved from 26.5% in August 2024 to 69.2% in September.

For Information Only. Reported via the Performance, Finance & Information Governance Committee

## Access & Activity Performance

**Extreme Waits**

- 208 Weeks – Single figures in General Surgery being booked as priority
- 156 weeks – Reduction of nearly 500 breaches since July 2024, 1,573 September 2024.
- 104 weeks – Position stabilised and reducing for the first time since April 2024.
- 52 weeks (Stage 1) – Continues to increase, though slightly lower than predicted.

**Cancer Performance**

- **62 Days** – Compliance at 52.5% driven mainly by dermatology, Urology and Colorectal. Should be noted that performance for all tumour sites has deteriorated in August 2024.

**Diagnostic 8 Weeks Wait Breaches Total 8,467 (2,760 over plan)**

- Endoscopy – 3,536 Recommencing of insourcing from September 2024
- Radiology – 2,360 Working through additional staffing options
- Cardiology – 1,592 Identifying possible insourcing opportunities

**Physiotherapy 14 Weeks Wait Breaches 2,236**

Breaches are in East and Centre with no breaches reported in West. Main breach reasons regard lack of accommodation in East and lack of staff in Centre.

**Mental Health**

- **Out of Area Placements –** Reduced from 61 to 50, but still incurring over £1m per month in costs.
- Psychological Therapy Waits within 26 weeks – At 65.9% is the lowest ever compliance. This is due to vacancies.

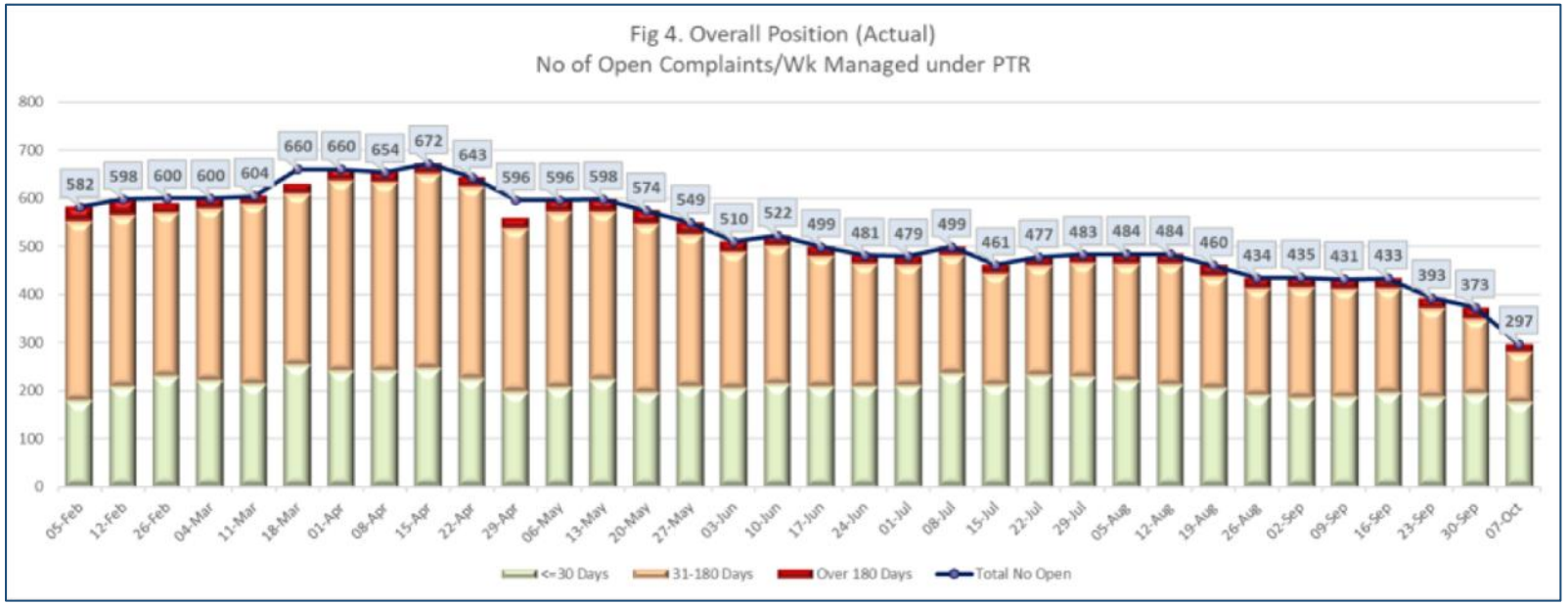
For information Only. Reported via the Performance, Finance & Information Governance Committee

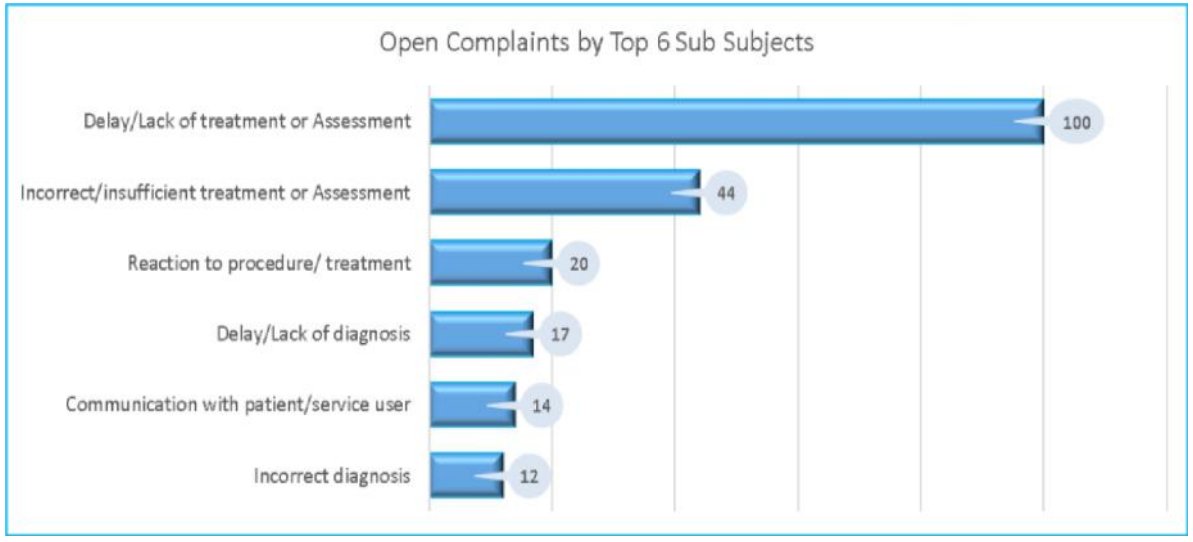
## Financial Performance

**£48m Savings Target** – At month 6, £48.7m worth of savings schemes identified.
**£19.8m Deficit Target** – On Track

For Information Only. Reported via the Performance, Finance & Information Governance Committee

# Quality: Escalated Performance Measures – Complaints Overdue 30 Days




Over **33% (a third)** of the total of open complaints – (100 / 297) relate to a delay or lack of treatment or assessment, demonstrating the impact of the number of extreme waits upon the concerns and complaints function.

- We have achieved a **66.07% reduction in the total of overall complaints from 672 to 228**
- We have achieved a **88.33% reduction in the total number of overdue complaints from 408 to 68**
- We have achieved all IHC / Services having less than 100 complaints open
- We have achieved all IHC/ Services having less than 50 overdue complaints
- We are closing more complaints per week in 2024/2025-Qtrs 1&2 than was the case in 2023/2024-Qtrs 3&4
- We are closing more complaints per week in 2024/2025-Qtrs 1&2 within the target of 30 working days than was the case in 2023/2024-Qtrs 3&4
- In July, 2024, we closed 86.3% of all complaints at all grades within 30 days.
- We are addressing complaints quicker, with average time to close complaints in 2024/2025-Qtrs 1&2 is less than in 2023/2024-Qtrs 3&4
- We have sustained a reduction in complaints remaining open, which has decreased on a weekly basis in 2024/2025-Qtrs 1&2 compared to 2023/2024-Qtrs 3&4

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

Presented on 24.10.2024

# Quality: Escalated Performance Measures

**New Never Events – No new Never events were reported in August or September 2024.** However, five new never events have been reported so far in 2024-25 (2 in May and 3 in July). Rapid Learning Panels were arranged and full investigations are underway. Learning will be reported via the Improving Quality Report to Board.

| Measure | WG Target | Internal Target | Position | Wales Rank |
|---|---|---|---|---|
| Percentage of episodes clinically coded within one reporting month post episode discharge end date | Increasing trend (to 95%) | TBC | 13.6% | 8st of 8 (at Jun 24) |

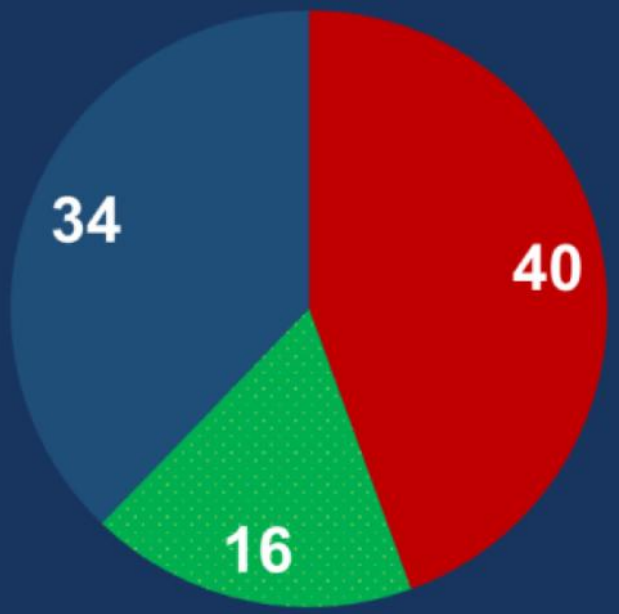

**Clinical coding** compliance will remain a significant risk directly attributed to staffing issues. A Clinical Coding Assurance Lead together with 6 new Clinical Coders have commenced in post. Compliance will remain low into the latter part of 2025-26 whilst the backlog is recovered and new staff are trained and working to full potential.

| Measure | WG Target | Internal Target | Position | Wales Rank |
|---|---|---|---|---|
| Number of National reportable incidents that remain open 90 days or more | Decreasing trend | TBC | 40 | 6th of 10 (at Aug 24) |


**National Reportable incidents (NRIs) that remain open 90 days of more** 40 remain open 90 days or more at the end of September 2024. The Patent Safety Team (PST) are supporting the progression of all NRIs. Drop in clinics for staff are held weekly to help focus the outcome from the incident review with any learning which can be shared. The IHCs and Divisions have submitted their reduction plans to the Executive Director of Nursing and Midwifery for onward monitoring of trajectory.

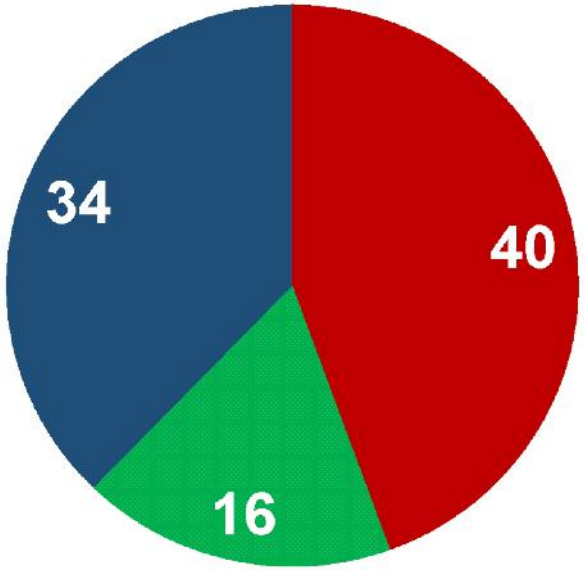
GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

# Integrated Performance Report

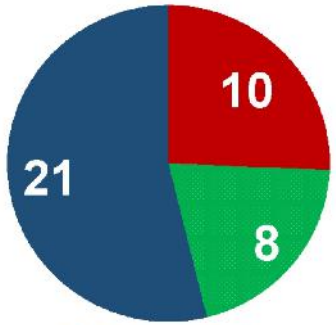



Produced on behalf of the **Quality, Safety and Experience Committee** by the **Performance Directorate in** partnership with our **Health Board Directors**

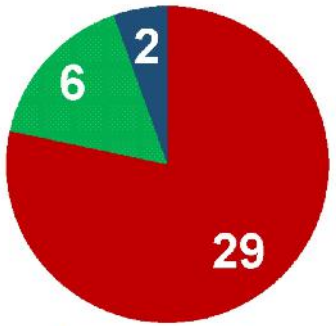
# Summary of Performance to Month 11



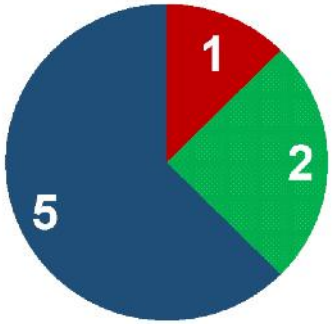

All Sections



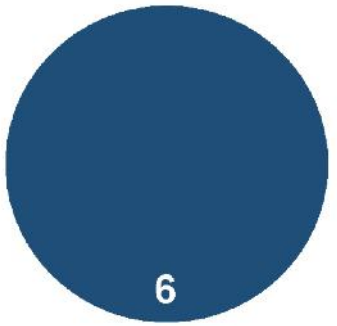

Quality, Safety, Effectiveness & Experience Performance




Access & Activity Performance



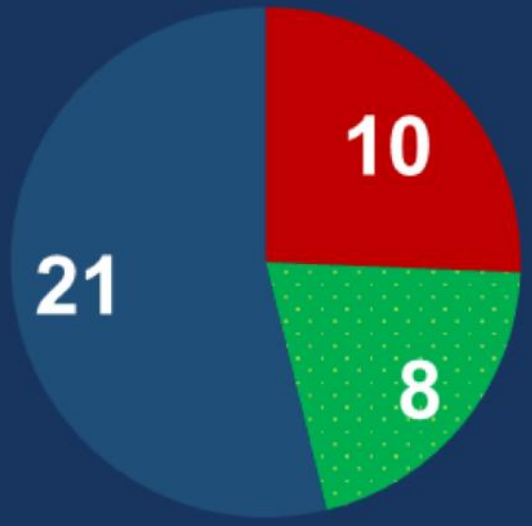

People & Organisational Development Performance




Financial Performance

# Section 1

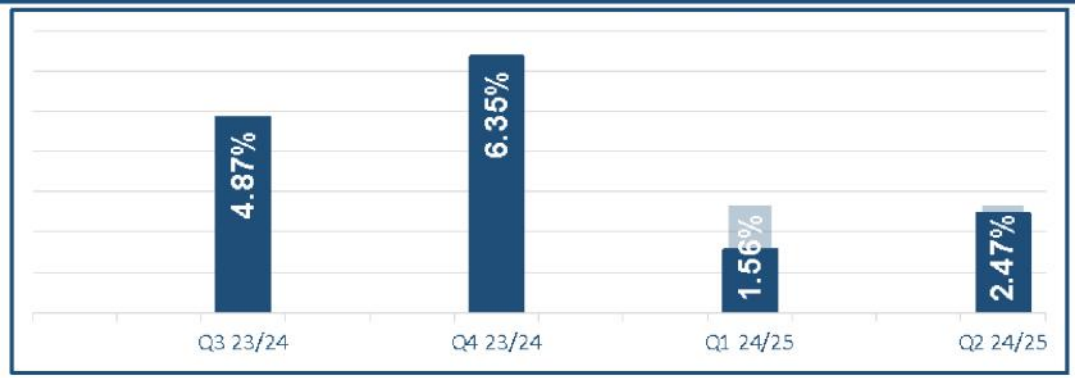
# Quality, Safety, Effectiveness and Experience Performance

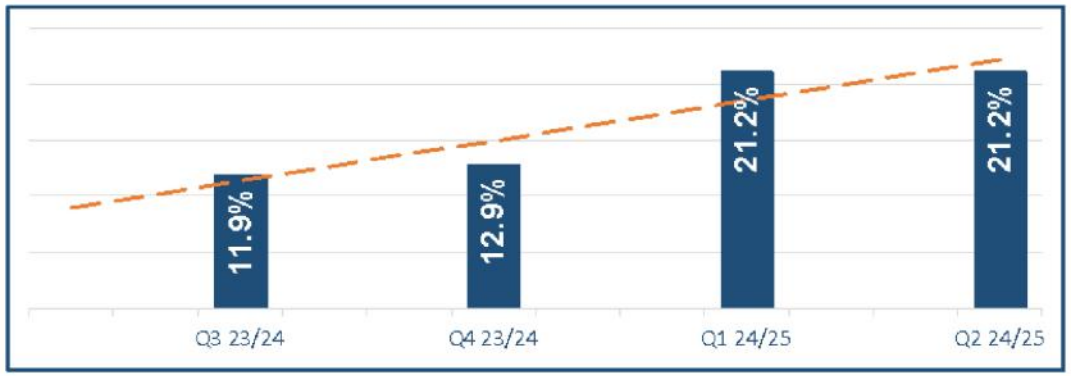


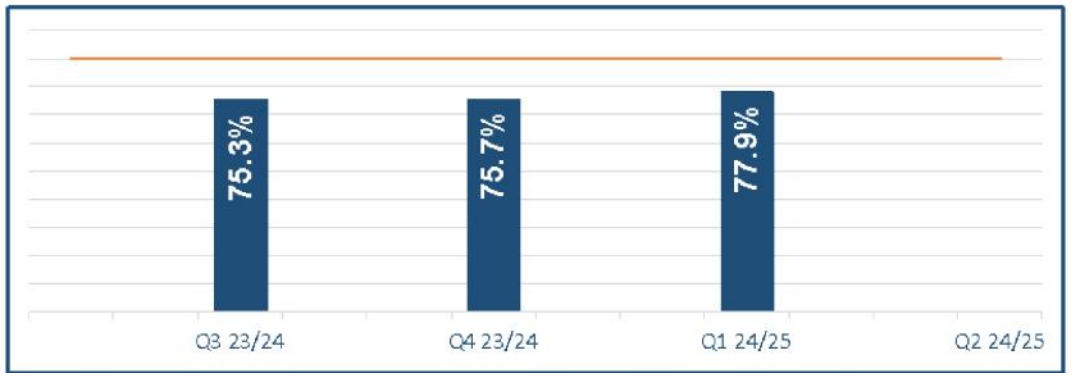

Produced on behalf of the **Health Board** by the
**Performance Directorate in** partnership with our **Health Board Directors**

# Quality: Performance

| Cmt | Measure | WG Target | Internal Target | Position | Wales Rank |
|---|---|---|---|---|---|
| QSE | Percentage of adult smokers who make a quit attempt via smoking cessation services | 5% annual | TBC | 2.47% | 2nd of 7 (at Jun 24) |
| QSE | Percentage of adult smokers who made a quit attempt via smoking cessation services who are CO-validated as quit at 4 weeks | 40% annual target | TBC | 21.2% | 4th of 8 (at Jun 24) |
| QSE | Percentage of children receiving the Human Papillomavirus (HPV) vaccination by the age of 15 | 90% | TBC | 77.9% | |



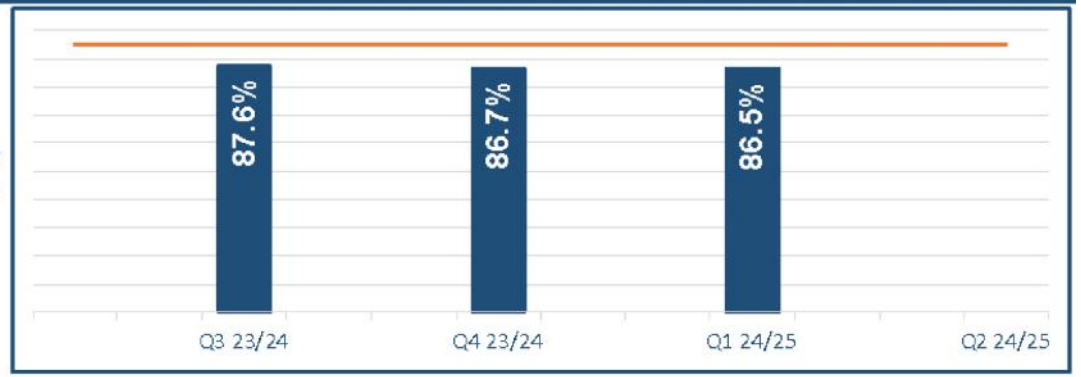



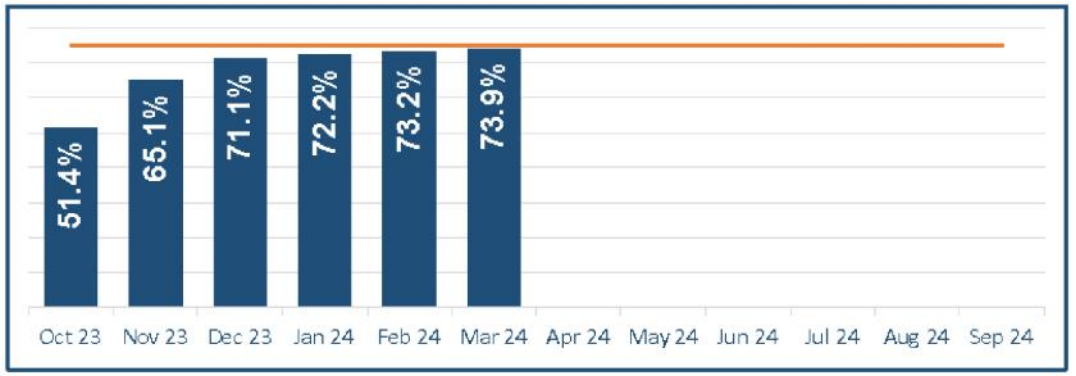



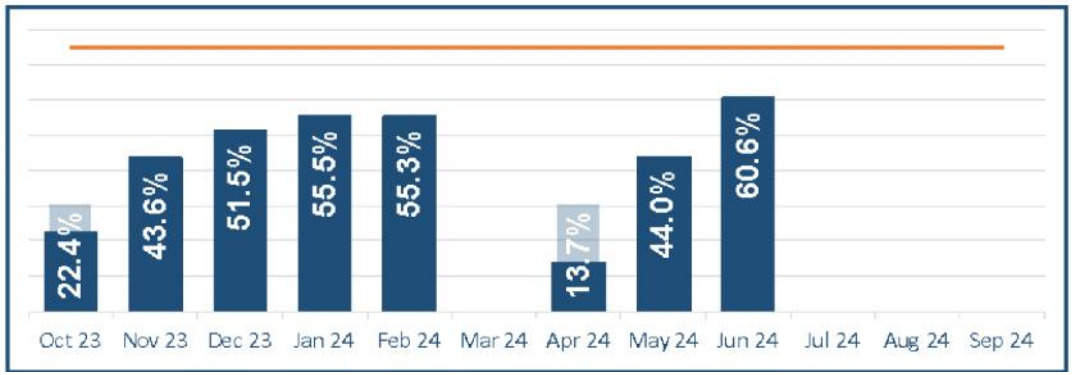

* Wales Ranking may differ as may refer to previous month

# Quality: Performance

| Cmt | Measure | WG Target | Internal Target | Position | Wales Rank |
|---|---|---|---|---|---|
| QSE | Percentage of children who are up to date with the scheduled vaccinations by age 5 ('4 in 1' preschool booster, the Hib/MenC booster and the second MMR dose) | 95% | TBC | 86.5% | 3rd of 7 (at Jun 24) |
| QSE | Percentage uptake of the influenza vaccination amongst adults aged 65 years and over | 75% | TBC | 73.9% | 2nd of 7 (at Mar 24) |
| QSE | Percentage uptake of the COVID-19 vaccination for those eligible<br>Spring Booster 2023: Aged 75 years & over; residents in care home for older adults and; immunosuppressed aged 5 years & over<br>Autumn Booster 2023: Age range to be confirmed | 75% | TBC | 60.6% | 4th of 7 (at Jun 24) |

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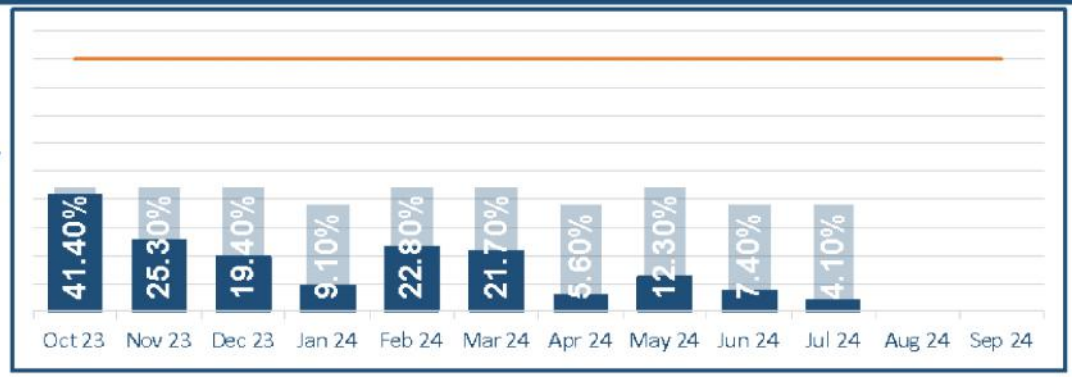
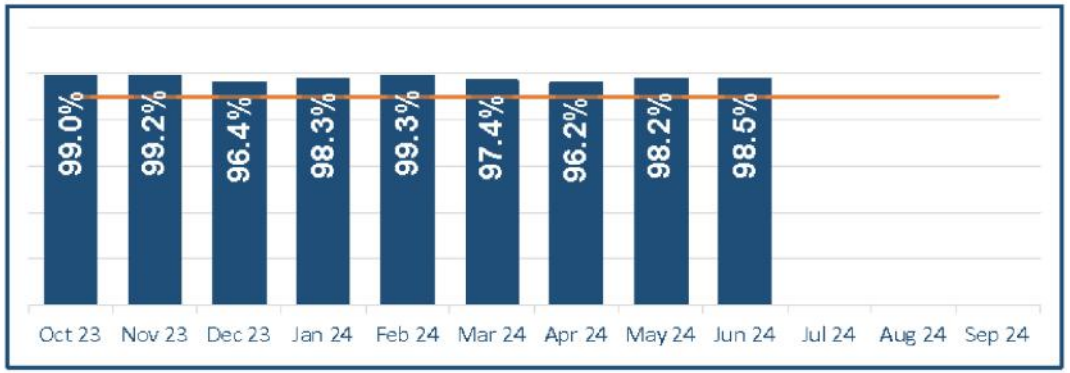
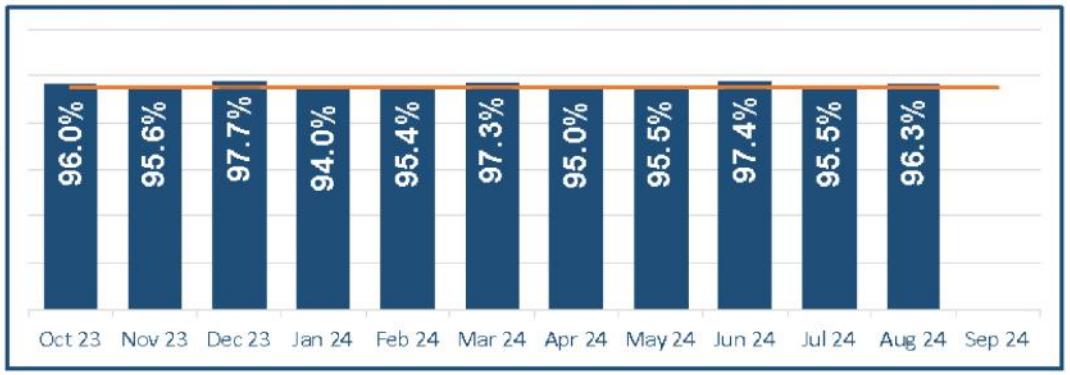
# Quality: Performance

| Cmt | Measure | WG Target | Internal Target | Position | Wales Rank |
|---|---|---|---|---|---|
| QSE | Percentage of patients offered an index colonoscopy procedure within 4 weeks of booking their Specialist Screening Practitioner assessment appointment | 90% | TBC | 4.1% | 4th of 7 (at Jun 24) |
| QSE | Percentage of well babies entering the new-born hearing screening programme who complete screening within 4 weeks | 90% | TBC | 98.5% | 3rd of 7 (at Jun 24) |
| QSE | Percentage of eligible newborn babies who have a conclusive bloodspot screening result by day 17 of life | 95% | TBC | 96.3% | 5th of 7 (at Jul 24) |

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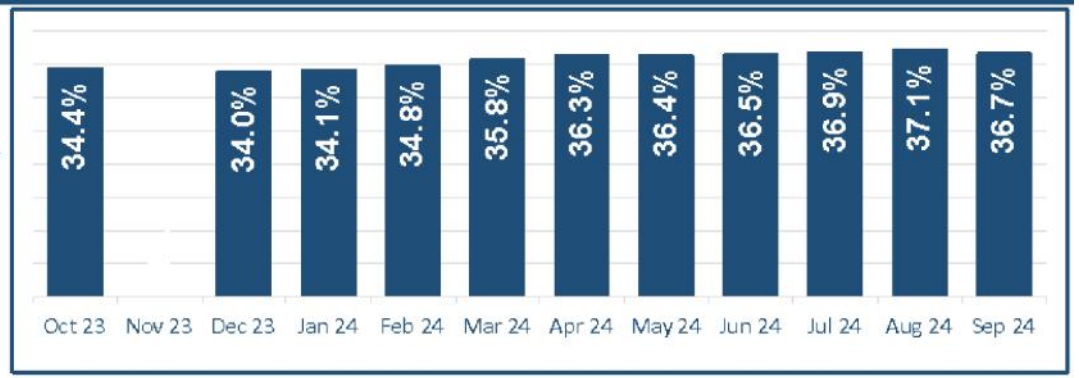
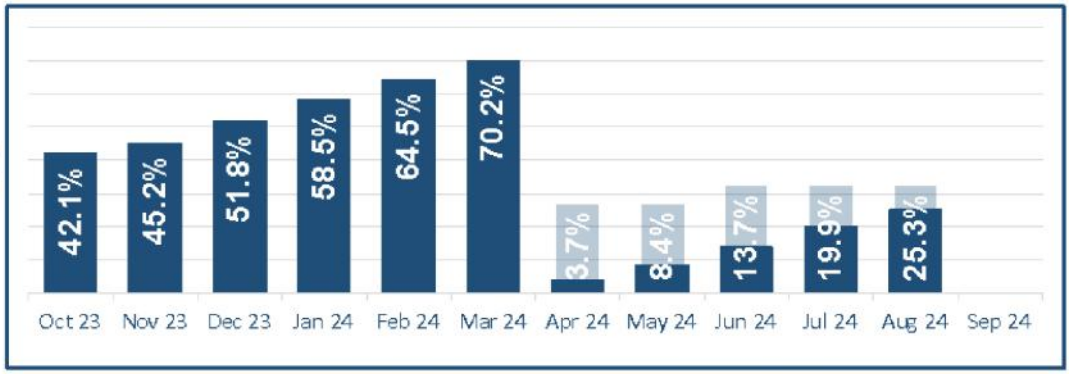
# Quality: Performance

| Cmt | Measure | WG Target | Internal Target | Position | Wales Rank |
|---|---|---|---|---|---|
| QSE | Percentage of patients (aged 12 years and over) with diabetes who received all eight NICE recommended care processes | Equival-ent month increase (2024/25 to 2023/24) to 100% | TBC | 36.7% | 7th of 7 (at Jul 24) |
| PFIG | Percentage of the primary care dental services (GDS) contract value delivered (for courses of treatment for new, new urgent and historic patients) | Increas-ing trend (to 30% (end Sept), then 100% (end Mar)) | TBC | 25.3% | 6th of 7 (at Aug 24) |
| PFIG | Number of consultations delivered through the Pharmacist Independent Prescribing Service (PIPS) | Equival-ent month increase (2024/25 to 2023/24) | TBC | 2090 | 1st of 7 (at Jul 24) |





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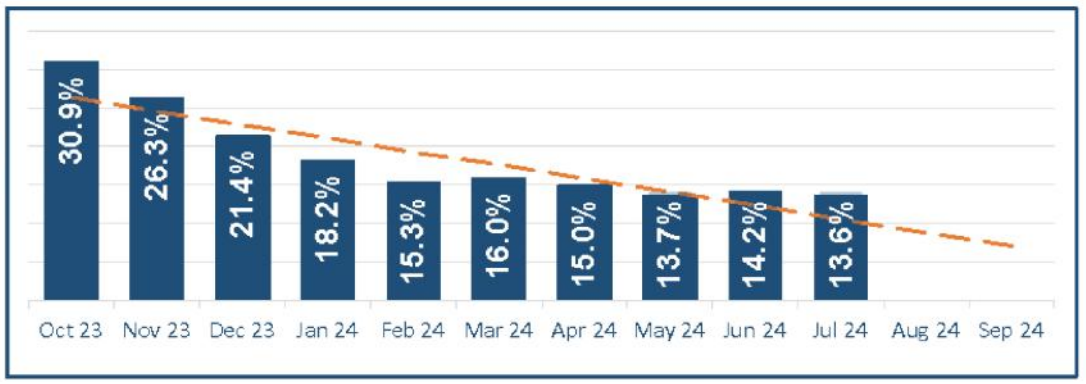
# Quality: Performance

| Cmt | Measure | WG Target | Internal Target | Position | Wales Rank |
|---|---|---|---|---|---|
| QSE | Percentage of people who have been referred to health board services who have completed treatment for substance misuse (drugs or alcohol) | 4 qtr imp. trend | TBC | 98.0% | 4th of 7 (at Jun 24) |
| QSE | Percentage of calls ended following WAST telephone assessment (Hear and Treat) | >17% | TBC | 13.9% | 5th of 7 (at Apr 24) |
| QSE | Percentage of episodes clinically coded within one reporting month post episode discharge end date | Increas-ing trend (to 95%) | TBC | 13.6% | 8st of 8 (at Jun 24) |



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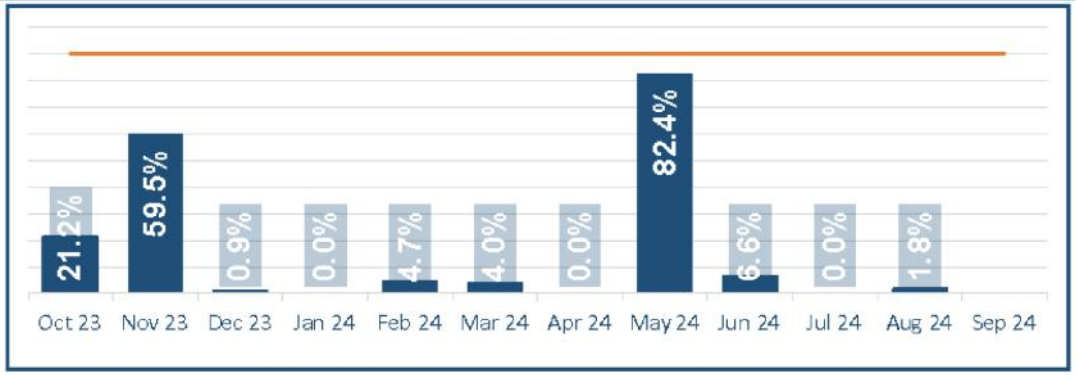
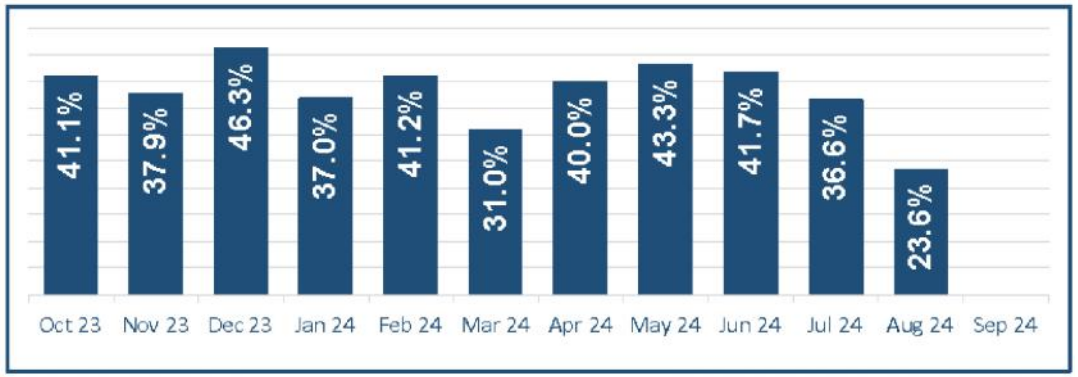
# Quality: Performance

| Cmt | Measure | WG Target | Internal Target | Position | Wales Rank |
|---|---|---|---|---|---|
| QSE | Percentage of all classifications' coding errors corrected by the next monthly reporting submission following identification | 90% | TBC | 1.8% | 8st of 8 (at Jul 24) |
| QSE | Percentage of confirmed COVID-19 cases within hospital which had a definite hospital onset of COVID-19 | Equival-ent month reduct-ion (2024/25 to 2023/24) | TBC | 23.6% | 2nd of 6 (at Aug 24) |
| QSE | Number of service user feedback experience responses completed and recorded on CIVICA | Increas-ing trend | TBC | 4229 | 2nd of 10 (at Jun 24) |





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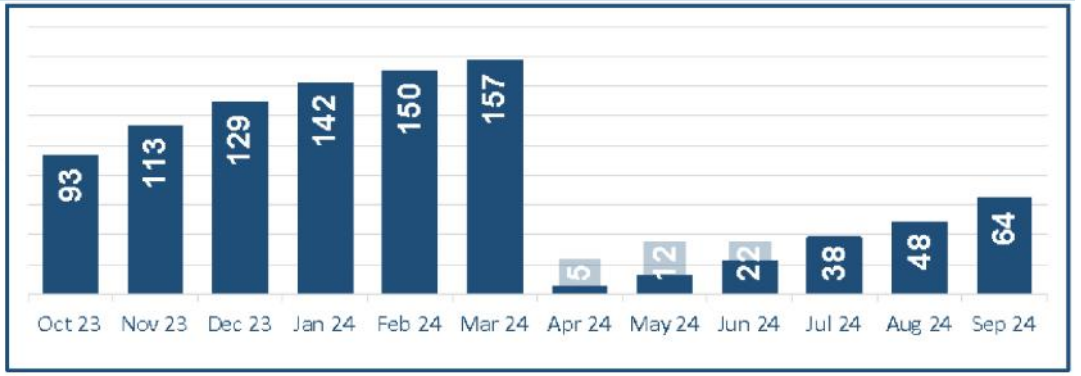
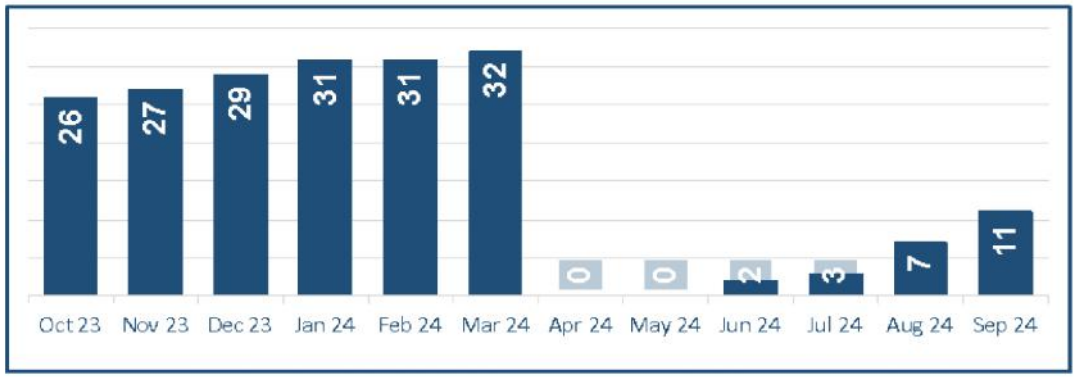
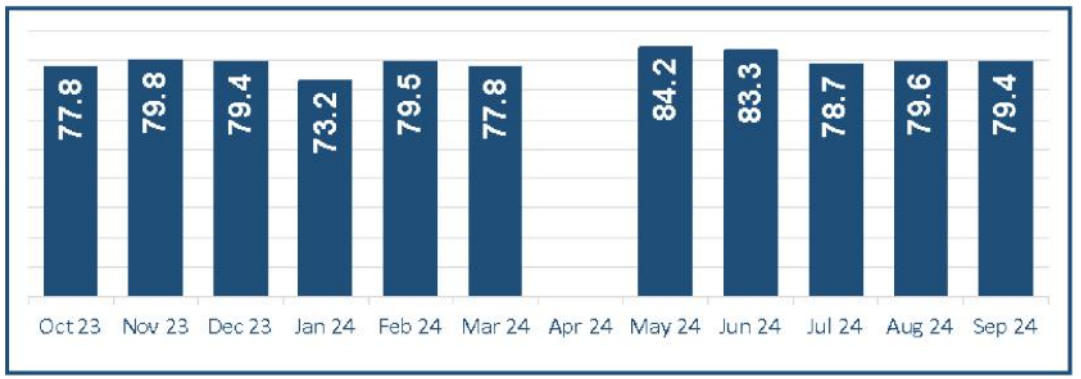
# Quality: Performance

| Ref | Cmt | Measure | WG Target | Internal Target | Position | Wales Rank |
|---|---|---|---|---|---|---|
| CRR: 24-04 | QSE | The cumulative number of laboratory confirmed Klebsiella in reporting month | Not available | TBC | 64 | 3rd of 6 (at Aug 24) |
| CRR: 24-04 | QSE | The cumulative number of laboratory confirmed Pseudomonas Aeruginosa in reporting month | Not available | TBC | 11 | 3rd of 6 (at Aug 24) |
| CRR: 24-04 | QSE | The cumulative rate of laboratory confirmed E.coli bacteraemias cases per 100,000 population | Not available | TBC | 79.4 | 5th of 6 (at Aug 24) |

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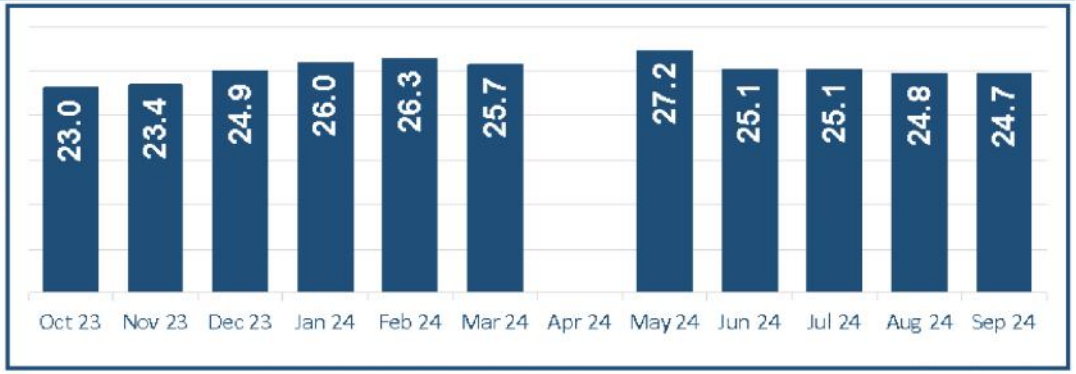
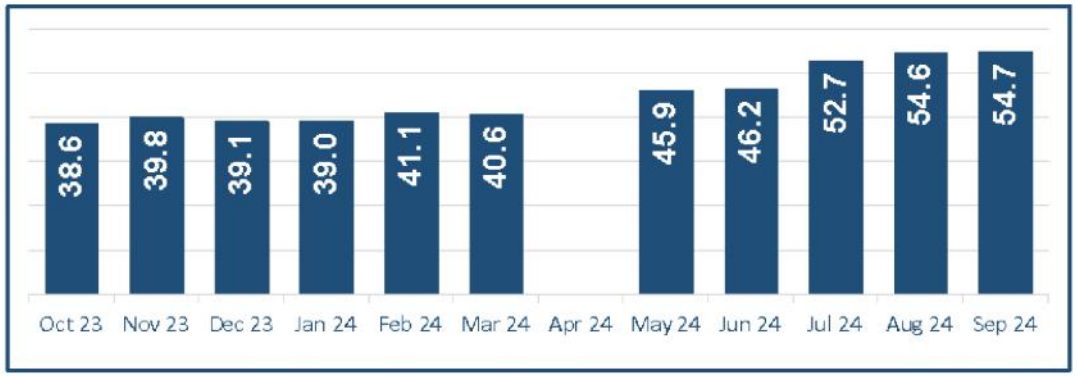
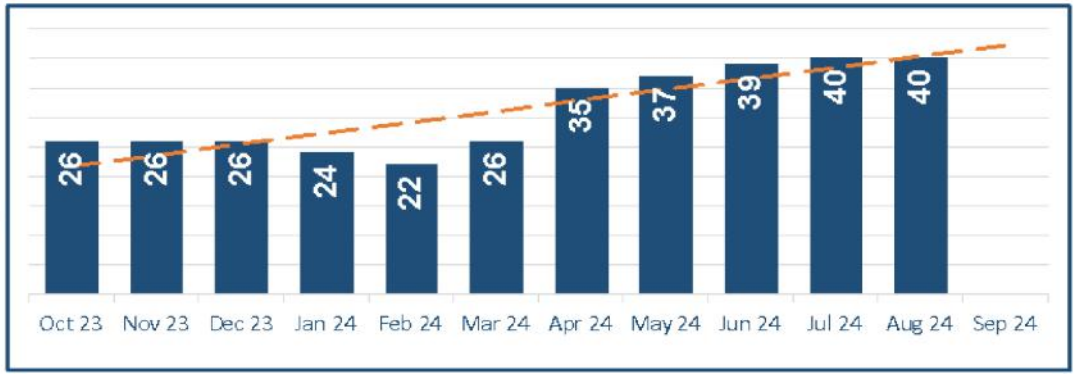
# Quality: Performance

| Ref | Cmt | Measure | WG Target | Internal Target | Position | Wales Rank |
|---|---|---|---|---|---|---|
| CRR: 24-04 | QSE | The cumulative rate of laboratory confirmed S. Aureus Bacteraemia (MRSA and MSSA) cases per 100,000 of the population | Not available | TBC | 24.7 | 1st of 6 (at Aug 24) |
| CRR: 24-04 | QSE | The cumulative rate of laboratory confirmed C.difficile cases per 100,000 of the population | Not available | TBC | 54.7 | 4th of 6 (at Aug 24) |
| CRR: 24-04 | QSE | Number of National reportable incidents that remain open 90 days or more | Decreasing trend | TBC | 40 | 6th of 10 (at Aug 24) |

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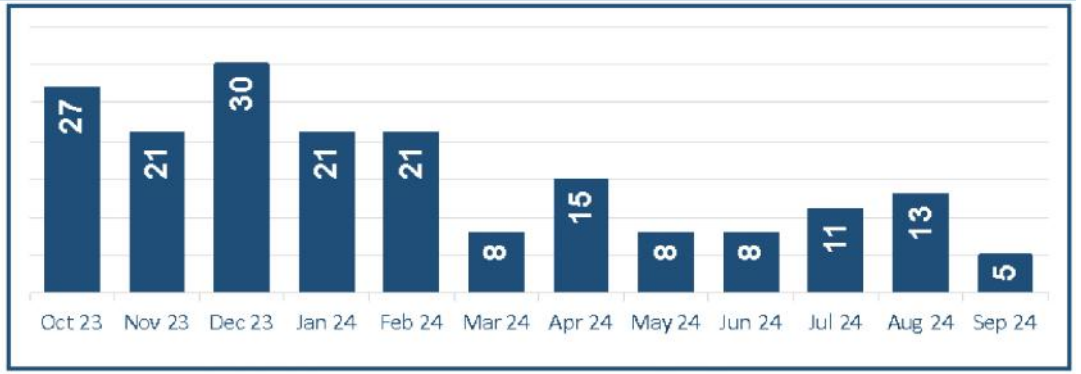
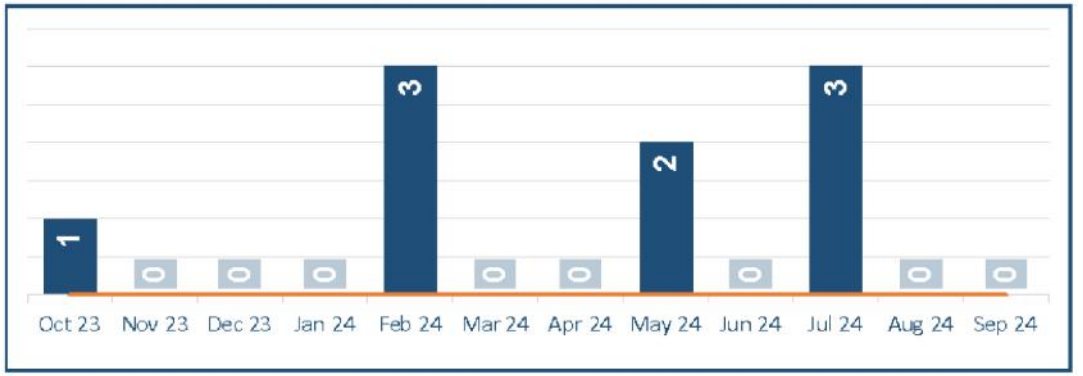
# Quality: Performance

| Cmt | Measure | WG Target | Internal Target | Position | Wales Rank |
|---|---|---|---|---|---|
| QSE | Number of new National reportable incidents (NRIs) | N/A | TBC | 5 | |
| QSE | Number of new never events | 0 | TBC | 0 | |
| QSE | Number of new patient safety incidents | N/A | TBC | 3205 | |



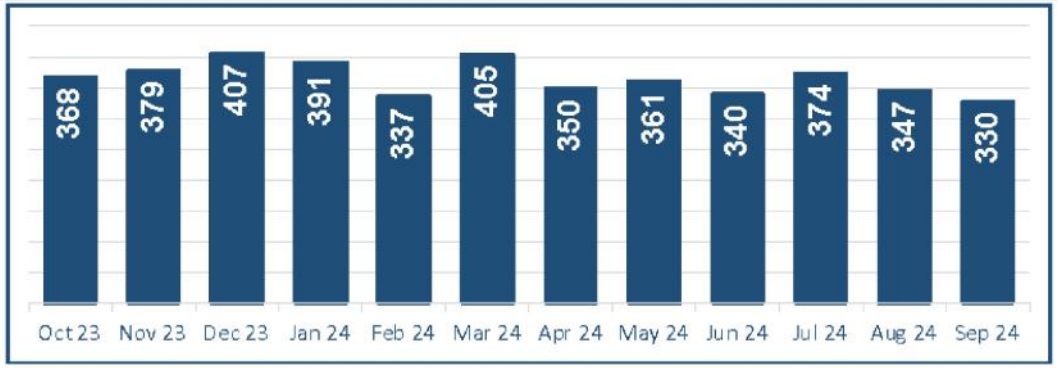


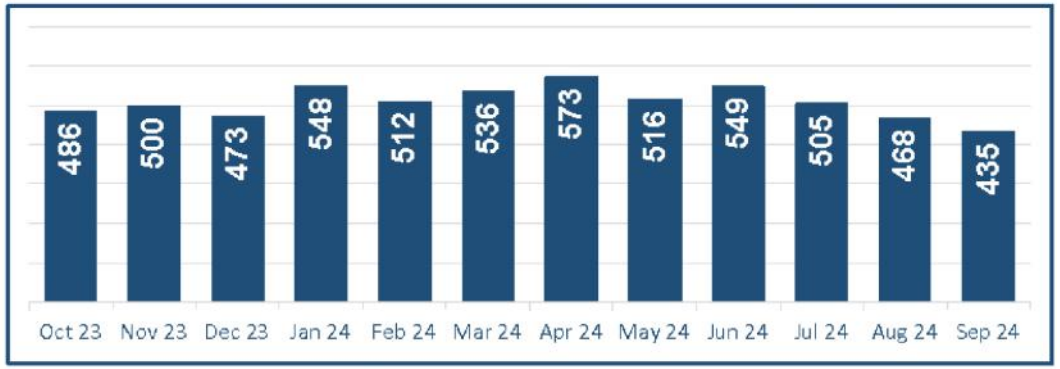
Produced on behalf of the **Quality, Safety & Experience Committee**
by the **Performance Directorate** in partnership with the **Quality Directorate**

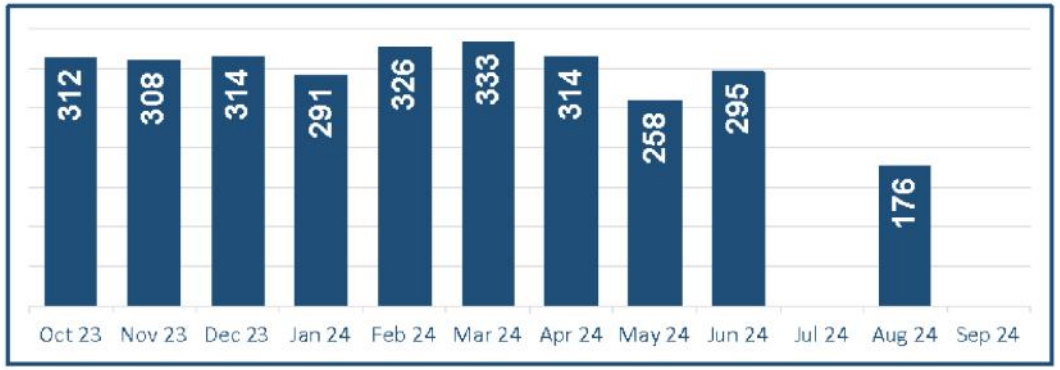
Presented on 24.10.2024

# Quality: Performance

| Cmt | Measure | WG Target | Internal Target | Position | Wales Rank |
|---|---|---|---|---|---|
| QSE | Number of new reported falls | N/A | TBC | 330 | |
| QSE | Number of new reported hospital acquired pressure ulcers (HAPU) (excluding new to caseload) | N/A | TBC | 435 | |
| QSE | Number of new reported medication incidents | N/A | TBC | 176 | |



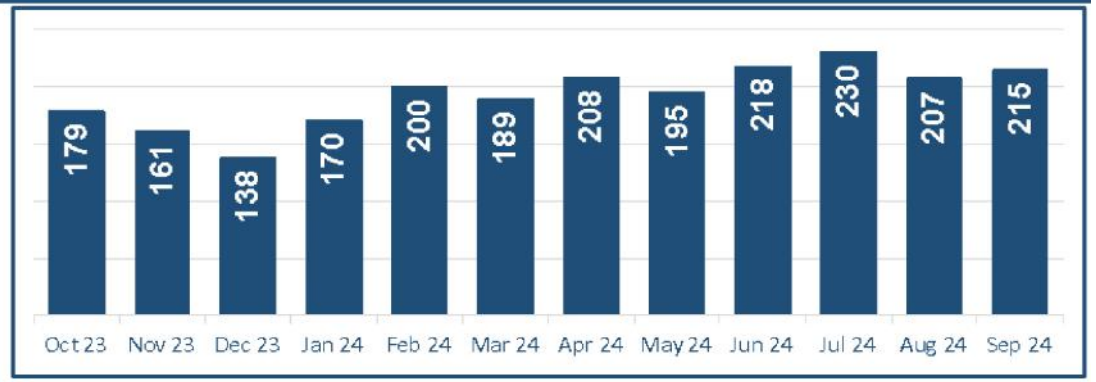



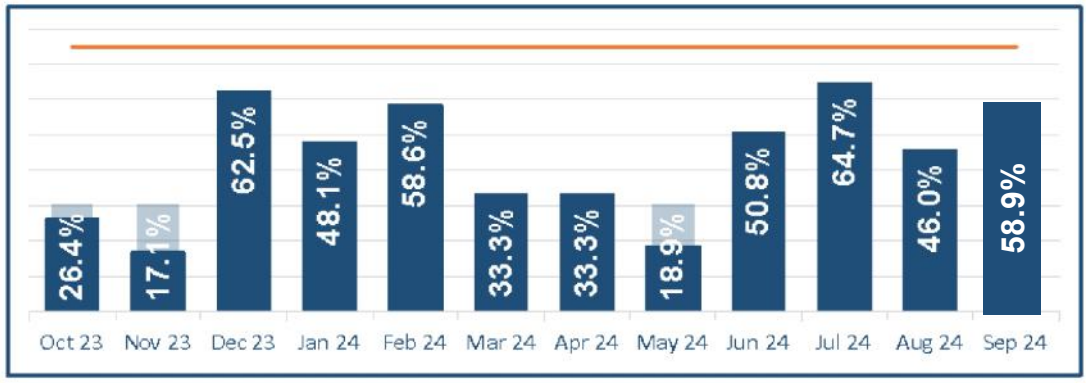

Produced on behalf of the **Quality, Safety & Experience Committee**
by the **Performance Directorate** in partnership with the **Quality Directorate**

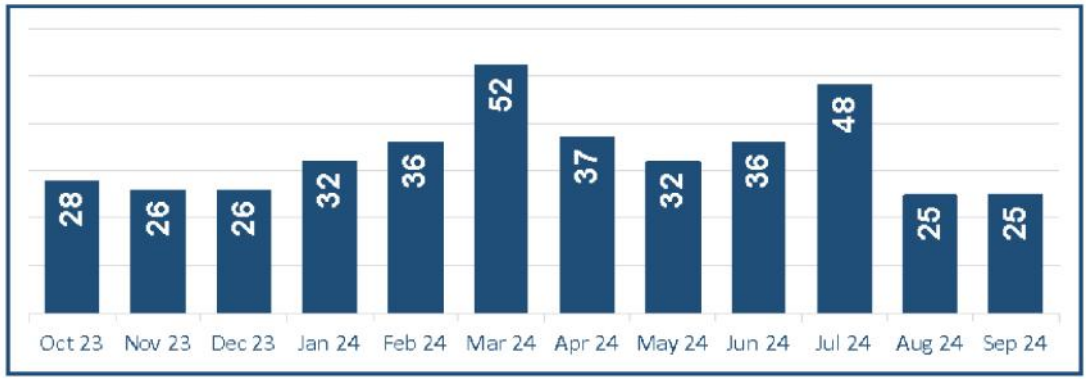
Presented on 24.10.2024

# Quality: Performance

| Cmt | Measure | WG Target | Internal Target | Position | Wales Rank |
|---|---|---|---|---|---|
| QSE | Number of new 'Putting Things Right' (PTR) complaints | N/A | TBC | 215 | |
| QSE | Of the complaints closed, the percentage that were closed within 30 days | 75.0% | TBC | 58.9% | |
| QSE | Number of new early resolutions | N/A | TBC | 25 | |

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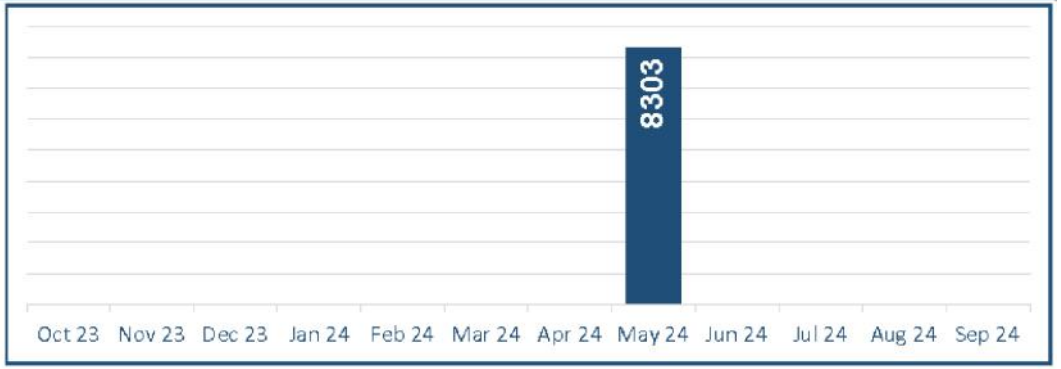
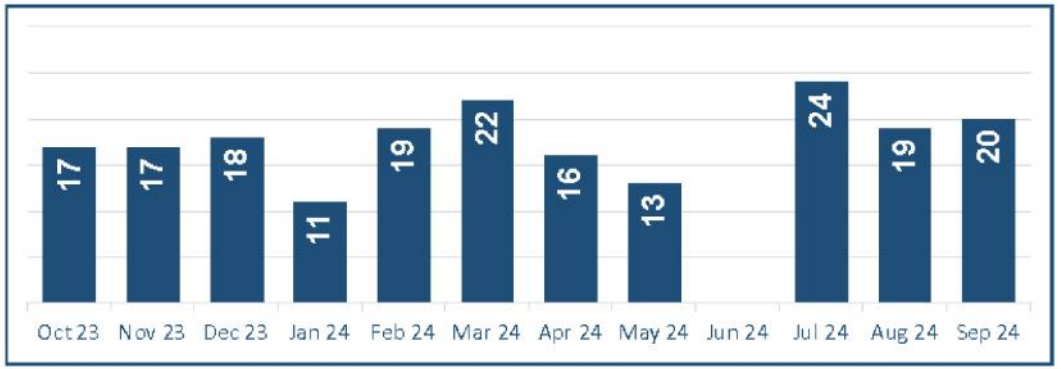
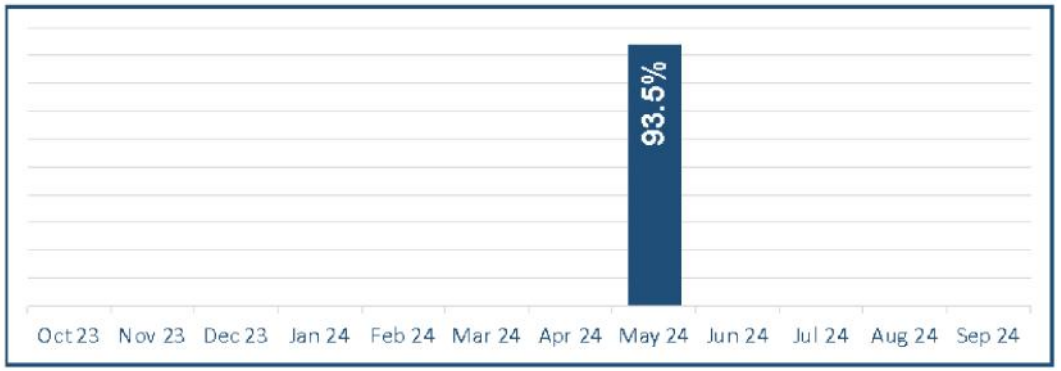
Presented on 24.10.2024

# Quality: Performance

| Cmt | Measure | WG Target | Internal Target | Position | Wales Rank |
|---|---|---|---|---|---|
| QSE | Number of new PALS (Patient Advice and Liason Service) contacts | N/A | TBC | 8303 | |
| QSE | Number of new Ombudsman contacts | N/A | TBC | 20 | |
| QSE | Percentage of survey responses rating care as good or very good | N/A | TBC | 93.5% | |



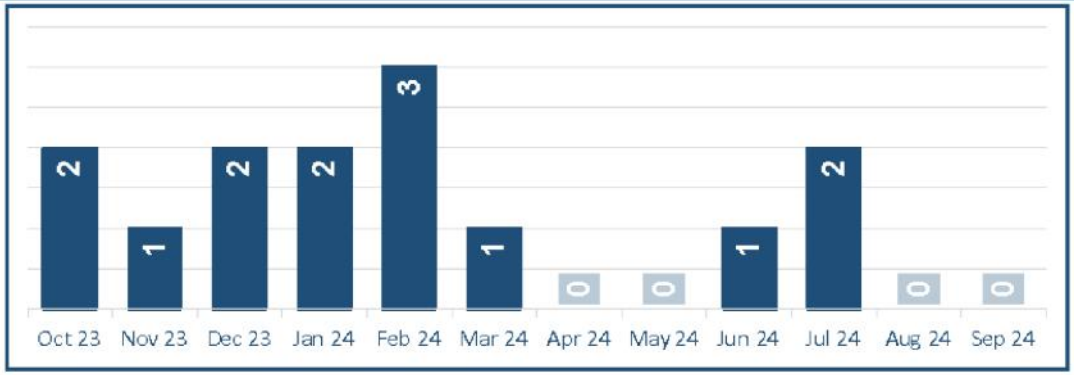



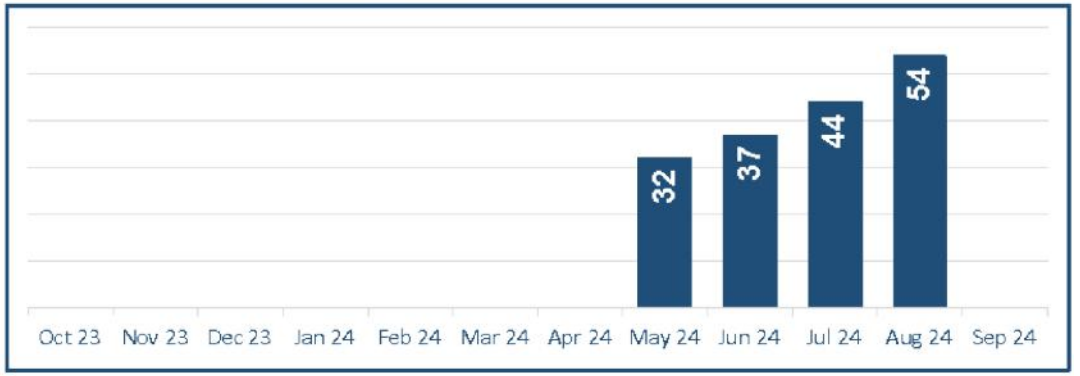

Produced on behalf of the **Quality, Safety & Experience Committee**
by the **Performance Directorate** in partnership with the **Quality Directorate**

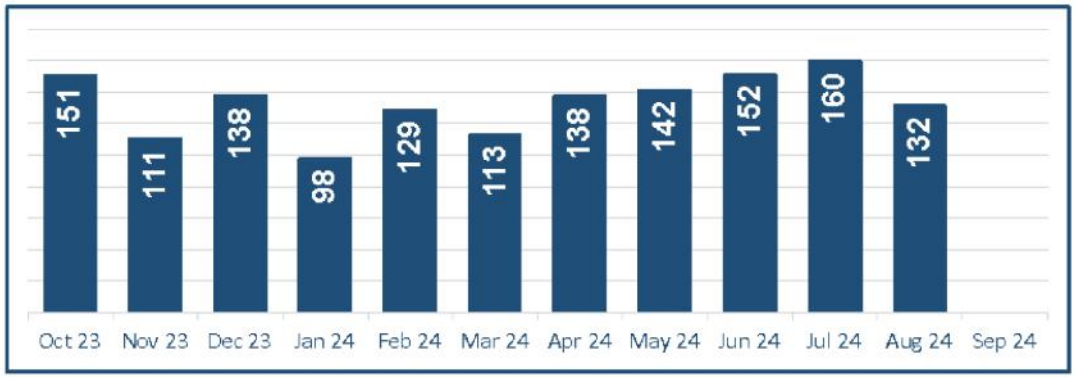
Presented on 24.10.2024

# Quality: Performance

| Cmt | Measure | WG Target | Internal Target | Position | Wales Rank |
|---|---|---|---|---|---|
| QSE | Number of regulation 28 notices | N/A | TBC | 0 | |
| QSE | Number of overdue 'Learning from Event Reports' (LFERs) | N/A | TBC | 54 | |
| QSE | Number of Great-ix submissions | N/A | TBC | 132 | |




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

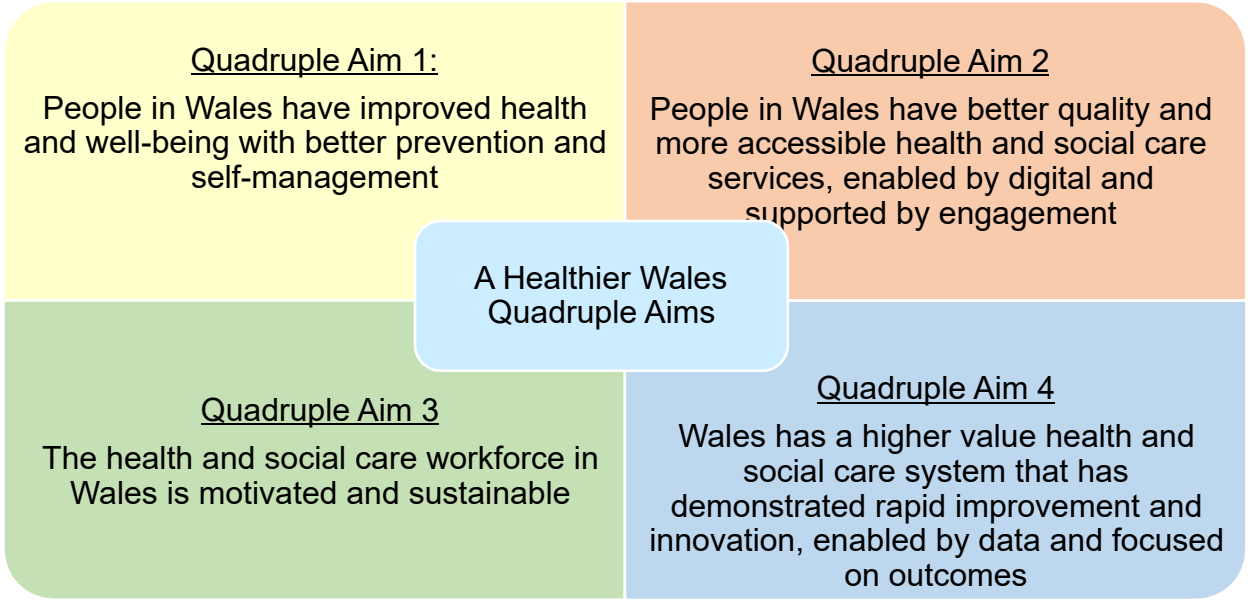
Presented on 24.10.2024

# Additional Information

# NHS Wales Performance Framework 2023-24

The NHS Performance Framework is a key measurement tool for "A Healthier Wales" outcomes, the 2023/24 revision now consists of 53 quantitative measures of which 9 are Ministerial Priorities and require Health Board submitted improvement trajectories. A further 11 qualitative measures are also currently included of which assurance is sought bi-annually by Welsh Government

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




## Our Integrated Performance Report

- **Our Quality, Safety, Effectiveness & Experience Performance**
- **Our Access & Activity Performance**
- **Our People & Organisational Development Performance**
- **Our Financial Performance**

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

The IPF is undergoing phased implementation across the Health Board with core integration by Q4 2023/24 and to run as business as usual from 1st April 2024.

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

# Red, Amber & Green (RAG) Rating System

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

**Green**

**Green = On track**
A stable, sustained or improving position that is consistently on or above the **Welsh Government Target** for at least 3 or more consecutive months

**Amber**

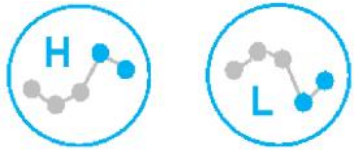
**Amber = Early Warning or Off Track and in Exception – Short summary provided**
On or above **Welsh Government Target,** but a deteriorating position of 3 or more consecutive months or inconsistently above/on/below the **Welsh Government Target**

**Red**

**Red = Off Track and in Escalation**
Consistently below **Welsh Government Target** and below **BCU submitted improvement trajectories – Detailed Exception report provided**

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

# Interpreting Results of Statistical Process Control (SPC) Charts

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

## How to interpret variance results

- Variance results show the trends in performance over time
- Trends either show **special cause** variance or **common cause variance**
- **Blue Icons** indicate **positive** special cause variance
- **Orange Icons** indicate **negative** special cause variance **requiring action**
- **Grey Icons** indicate **no significant change**

## How to interpret assurance results

- Assurance results demonstrate the likelihood of achieving a target and is based upon the trends over time
- **Blue Icons** indicate an expectation **to** consistently achieve the target
- **Orange Icons** indicate an expectation **not to** consistently achieve the target
- **Grey Icons** indicate an expectation for **inconsistent** performance, sometimes the target will be achieved and sometimes it will not be achieved.

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

# Introduction to Integrated Performance Report (IPR)

## What is an Integrated Performance Report (IPR)?

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

## The Integrated Performance Framework (IPF)

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

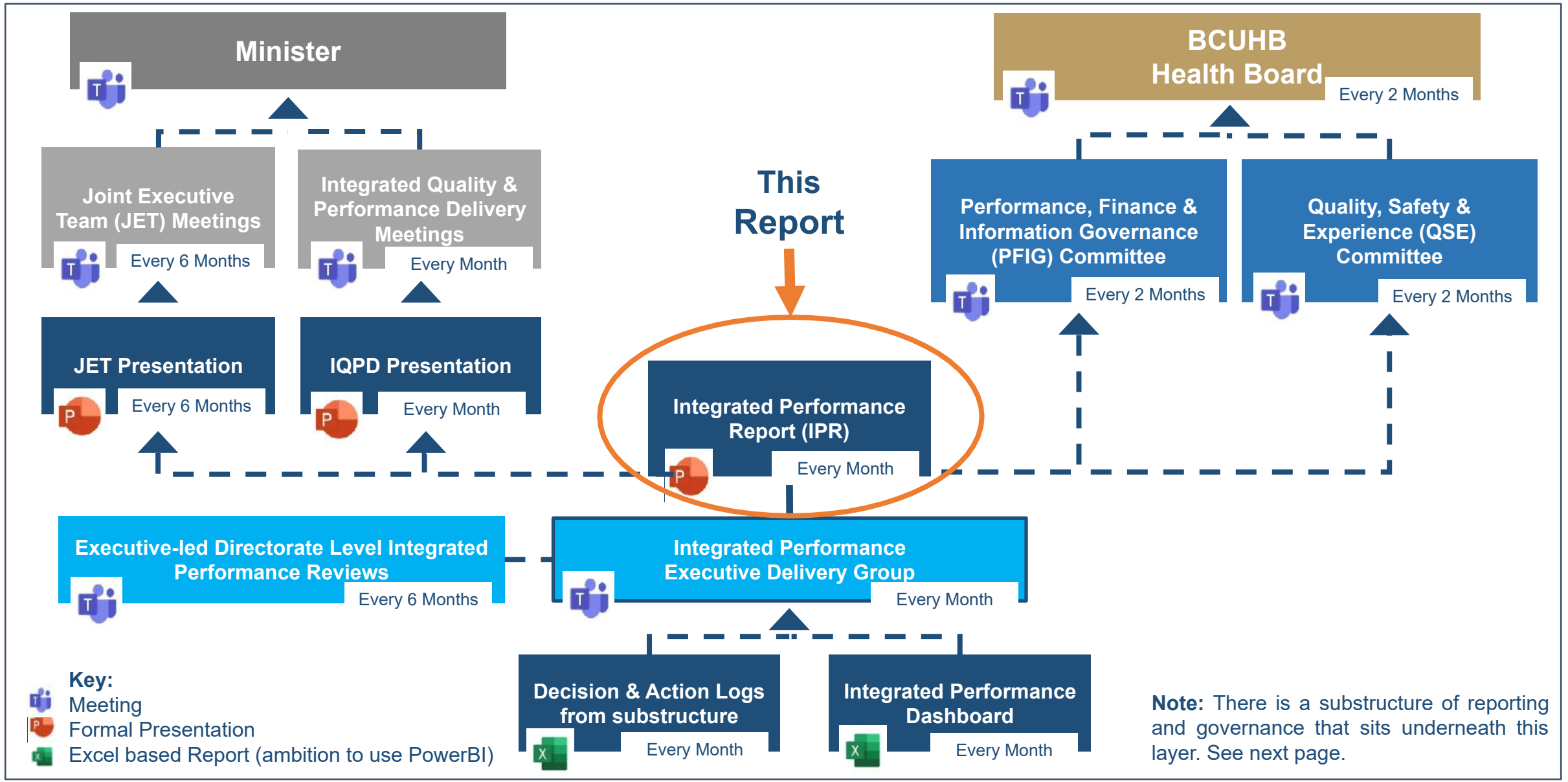
The Integrated Performance Framework sits within a "triumvirate" together with the Integrated Planning Framework and the Risk Management Framework (also ratified at Health Board on the 28th September 2023). This triumvirate of frameworks will encompass the planning, safe delivery and monitoring of the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

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

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

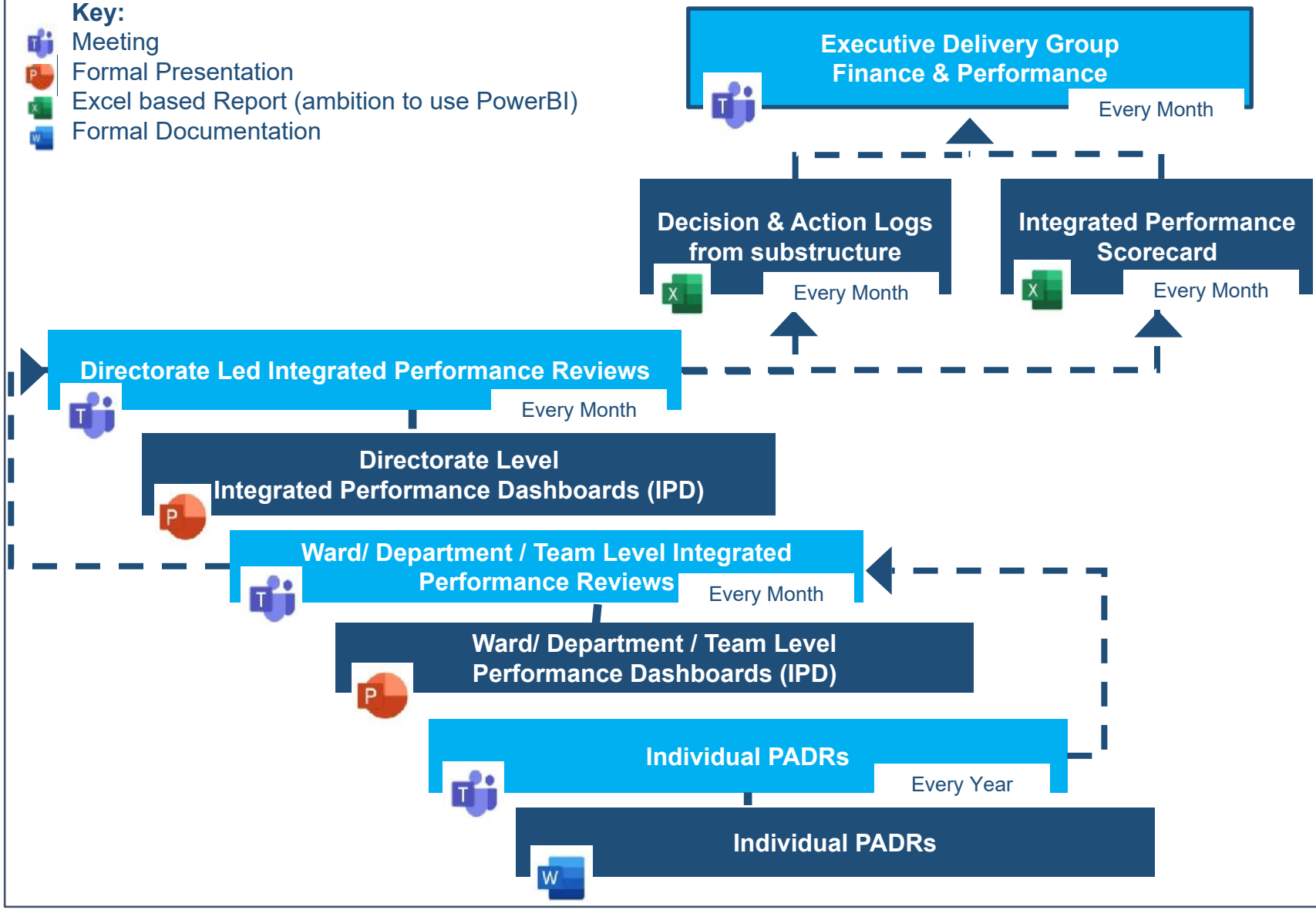
The IPR will be embedded as the 'single version of the truth' and used to report on performance to the Health Board, it's scrutinising committees namely Performance, Finance & Information Governance (PFIG) Committee and Quality, Safety & Experience (QSE) Committee and externally to Welsh Government.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

# The Integrated Performance Reporting & Governance Superstructure



# The Integrated Performance Reporting & Governance Substructure

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




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

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

# Performance Directorate Outputs

| | |
|---|---|
| **Integrated Performance Reports** | Formal and comprehensive reports to the Health Board and its scrutinising committees, Integrated Quality & Performance Delivery Group (IQPD)(Welsh Government) and Joint Executive Team (JET). |
| **Integrated Performance Scorecards** | Summary scorecards for– Integrated Performance Executive Delivery Group et al |
| **Integrated Performance Dashboards** | Operational level performance dashboards with drill through capabilities. For end of month's submitted position. Ambition for production in PowerBI. – Produced by Digital, Data & Technology (DDAT) in partnership with the Performance Directorate(PI&AD) |
| **Deep Dive Reports** | Detailed Deep Dive reports used in accompaniment to Formal Reports, Scorecards and Dashboards to complement data, provide context, add intelligence and provide assurances as appropriate. Used at all levels as necessary, I.e. to support escalation, de-escalation. |
| **Ad-hoc Reports** | Ad-hoc reports used outside of the formal channels and for specific queries to complement data, provide context, add intelligence and provide assurances as appropriate. Used at all levels as necessary to provide additional intelligence and assurances as required. |

# Our Integrated Performance Report
# Betsi Cadwaladr University Health Board

Further information is available from the office of the Director of Performance for further details regarding this report. And further information on our performance can be found online at:

- Our website www.bcu.wales.nhs.uk
- Stats Wales https://statswales.gov.wales/Catalogue/Health-and-Social-Care

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

follow @bcuhb

http://www.facebook.com/bcuhealthboard

# Appendix

# Our Partners

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

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

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

- Executive Director of Operations
- Executive Director of Finance
- Executive Director for Public Health
- Executive Director for People & Organisational Development
- Executive Director of Therapies and Health Sciences
- Executive Director of Strategic Planning & Transformation
- Executive Director of Nursing & Midwifery
- Executive Medical Director

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

| | |
|---|---|
| **Teitl adroddiad:**<br><br>***Report title:*** | **Health Board Response to the Royal College of Psychiatrists Invited Review Services Report** |
| **Adrodd i:**<br><br>***Report to:*** | **Quality Safety and Experience Committee** |
| **Dyddiad y Cyfarfod:**<br><br>***Date of Meeting:*** | Thursday, 24 October 2024 |
| **Crynodeb Gweithredol:**<br><br>***Executive Summary:*** | **The purpose of this report is for QSE Committee to:**<br><br>1. **Note and receive assurance** on updates related to governance and programme arrangements for the Health Board Response to the RCPsych Invited Review Services Report.<br>2. **Note** progress against the ten themes identified in the Invited Review Services Report.<br>3. **Note** a Draft Terms of Reference for the Expert Advisory Group.<br><br>**Background**<br><br>The Board, at its meeting on 25 July 2024, received and considered the Health Board response to the Royal College of Psychiatrists Invited Review Service Report. The full report can be found on the BCU website.<br><br>It included a high level description of proposed governance arrangements to oversee the response plan delivery. The Board has now agreed that oversight of the response to the RCPsych Report will be through the Quality Safety and Experience (QSE) Committee with six-monthly progress reports, provided to the Board. The next report to Board is scheduled for January 2025.<br><br>The QSE Committee on the 15 August 2024 considered and endorsed the proposed governance arrangements to oversee/monitor the response plan in order to assure the Board that progress addresses the recommendations within the RCPsych Invited Review Services Report (the RCPsych Report).<br><br>The QSE Committee agreed on the 15 August 2024 that the following next steps should be progressed. This report provides an update in relation to these next steps.<br><br>1. To commence the implementation of the governance framework |

| | | | |
|---|---|---|---|
| | 2. Confirm the appointment of the Independent Chair of the Advisory Group<br>3. To report every two months on progress against the report<br>4. To report every six months on progress to the Board<br><br>In particular the report provides an update on:<br>• The establishment of a Health Board RCPsych Action Delivery Group (an internal group) that reports into the Executive Team.<br>• A regular monitoring and oversight of response plan progress/delivery via the Quality Safety and Experience Committee.<br>• The establishment of an Expert Advisory Group, independently chaired with family and user representatives, and Llais included as group members. Initial membership to be agreed in advance of the QSE Committee in August 2024<br>• Progress on the Terms of Reference that have been collaboratively developed and agreed for groups, supported by the Directorate of Corporate Governance.<br>• A procedure for providing progressive and sustained evidence of actions is required. | | |
| **Argymhellion:**<br><br>***Recommendations:*** | The Committee is asked to:<br><br>1. **Note and receive assurance** on updates related to governance and programme arrangements for the Health Board Response to the RCPsych Invited Review Services Report.<br>2. **Note** progress against the ten themes identified in the Invited Review Services Report.<br>3. **Note** a Draft Terms of Reference for the Expert Advisory Group. | | |
| **Arweinydd Gweithredol:**<br><br>***Executive Lead:*** | Teresa Owen, Executive Director of Allied Health Professionals and Health Science | | |
| **Awdur yr Adroddiad:**<br><br>***Report Authors:*** | Phil Meakin, Associate Director of Governance<br>Carole Evanson, MHLD Director of Operations | | |
| **Pwrpas yr adroddiad:**<br><br>***Purpose of report:*** | I'w Nodi<br>*For Noting*<br>☒ | I Benderfynu arno<br>*For Decision*<br>☐ | Am sicrwydd<br>*For Assurance*<br>☒ |

| | | | | |
|---|---|---|---|---|
| **Lefel sicrwydd:** ***Assurance level:*** | Arwyddocaol *Significant* ☐<br><br>Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol<br><br>*High level of confidence/evidence in delivery of existing mechanisms/objectives* | Derbyniol *Acceptable* ☒<br><br>Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol<br><br>*General confidence / evidence in delivery of existing mechanisms / objectives* | Rhannol *Partial* ☐<br><br>Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol<br><br>*Some confidence / evidence in delivery of existing mechanisms / objectives* | Dim Sicrwydd *No Assurance* ☐<br><br>Dim hyder/tystiolaeth o ran y ddarpariaeth<br><br>*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:**<br><br>***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:**<br><br>***Link to Strategic Objective(s):*** | 1. Building an Effective Organisation<br>2. Compassionate Culture, leadership and engagement<br>4. Improving quality, outcomes and experience<br>5. Effective environment for learning | | | |
| **Goblygiadau rheoleiddio a lleol:**<br><br>***Regulatory and legal implications:*** | None | | | |
| **Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal?**<br><br>***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?**<br><br>***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)**<br><br>***Details of risks associated with the subject and scope of this paper, including new risks( cross reference to the BAF and CRR)*** | Strategic Priority P18 Quality, Innovation and Improvement |
| **Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith***<br><br>***Financial implications as a result of implementing the recommendations*** | None to note at this stage |
| **Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith**<br><br>***Workforce implications as a result of implementing the recommendations*** | None to note at this stage |
| **Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori**<br><br>***Feedback, response, and follow up summary following consultation*** | This paper has been prepared following the recommendations agreed at the Health Board, 25 July 2024 and the report to QSE Committee on the 15 August 2024. |
| **Cysylltiadau â risgiau BAF:**<br>(neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)<br><br>***Links to BAF risks:***<br>*(or links to the Corporate Risk Register)* | CRR 24-04 (Learning) |
| **Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)**<br><br>***Reason for submission of report to confidential board (where relevant)*** | Not applicable |
| ***List of Appendices:*** | |

**Appendix 1 – Summary of Progress against the Invited Services Review – September 2024**

**Appendix 2 – Chairs Report – Health Board Action Delivery Group**

**Appendix 3 – Draft Terms of Reference for the Expert Advisory Group**

**HEALTH BOARD RESPONSE TO THE**

**ROYAL COLLAGE OF PSYCHIATRISTS INVITED SERVICES REVIEW REPORT**

## 1. INTRODUCTION

The Health Board received the Royal College of Psychiatry (RCPsych) Invited Services Review Report in March 2024. The report noted out of the 84 recommendations identified from the reports, strong evidence was received to show 44% of the recommendations were implemented, 49% had some evidence to show implementation and 7% showed little or no evidence of the report recommendations being implemented. The Health Board is required to progress the improvements recommended in the report and demonstrate that the improvements are meeting the objectives of the recommendations and able to improve the outcome and experience for patients and staff.

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

- **Note and receive** assurance on updates related to governance and programme arrangements for the Health Board Response to the RCPsych Report.
- **Note** progress against the ten themes identified in the Report.
- **Note and consider** a development on the development of an Expert Advisory Group, including a Draft Terms of Reference.

In order for the Response Plan to progress there are a number of detailed actions to be completed to show progress against the outstanding recommendations in the Invited Services Review. The work is system-wide, with Health Board system-wide actions and specific Mental Health and Learning Disabilities (MH&LD) actions. The delivery actions have been aligned to the ten themes as outlined by the Royal College of Psychiatry. This report highlights that the Health Board Action Delivery Groups notes progress against these actions but it is clearly understood that the ability to assess whether the actions taken are meeting the objectives of the Service Review will not be clear until the Expert Advisory Group is in full operation.

The report outlines the governance that has been established, including the establishment of a Health Board RCPsych Action Delivery Group and more detail on this is reported below. In order to prepare information on progress against the Invited Services Review to this Group specific MH&LD actions are monitored and reported at the MHLD Programme Improvement Delivery Group (PIDG). Health Board system-wide actions are received at the Regulation, Assurance and Oversight Group (RAG).

It is important that the Health Board takes the appropriate amount of time to make sure that the role of the Expert Advisory Group that is currently being established is clear, operates effectively and has the full engagement of service users and experts so that it can independently validate that the response to the actions is meeting the objectives of the recommendations and can demonstrate improvements for service

users. This report contains a draft Terms of Reference for information that the Expert Advisory Group will be asked to consider. This is attached in Appendix 3.

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

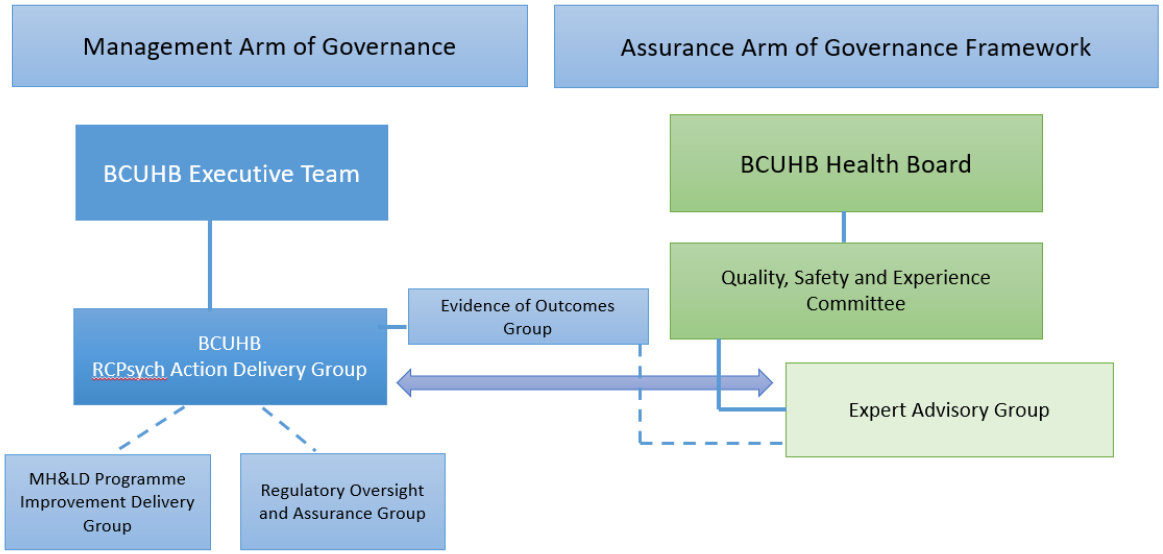
## 2. ADDITIONAL BACKGROUND

As a reminder, the ten themes (Table 1 below) and the governance arrangements that were approved at the previous QSE Committee are outlined below. (Figure 1 below)

**Table 1: The ten themes**

| The Ten Themes | Key Focus of Reports to the Expert Advisory Group |
|---|---|
| ○ Theme 1 – Patient and user centred care<br>○ Theme 2 – Legislation and clinical guidance<br>○ Theme 3 – Governance<br>○ Theme 4 – Staffing<br>○ Theme 5 – Management Structure<br>○ Theme 6 - Clinical services organisation.<br>○ Theme 7 - Training and development<br>○ Theme 8 – Leadership and staff engagement<br>○ Theme 9 – Resources<br>○ Theme 10 – Physical environment | What is progressing effectively?<br><br>What is the evidence of progress and improved outcomes?<br><br>What is progressing but needs additional support/focus to demonstrate evidence of improved outcomes?<br><br>What is not progressing effectively and what action is needed to progress |

**Figure 1 – Summary of the Governance Framework**




It is also important to note that the both Mental Health and Learning Disabilities (MH&LD) and system-wide actions across the Health Board have been brought into a consolidated Programme Plan that captures progress against the ten key system-wide actions and will be reported consistently through the agreed governance framework, including at QSE Committee. The diagram also shows the relationship to the groups that are referenced in section 3.2,3.3 and 3.4 below.

## 3. PROGRESS ON GOVERNANCE AND PROGRAMME ARRANGEMENTS

Since the last report to QSE Committee on 15 August 2024 progress has been made on a number of governance and programme matters and are summarised below.

### 3.1. Establishment of the Health Board RCPsych Action Delivery Group (HBADG)

The Terms of Reference for the HBADG have been developed and approved at the Executive Team Meeting on the 14 August 2024. The first meeting of the HBADG was held on 30 September 2024. The Group received and adopted a Terms of Reference, with some minor proposed amendments. It also received a full update on the status of the Invited Services Review actions. Importantly, it was able to receive evidence of satisfactory progress of actions that were due to be progressed by the end of August 2024. It was also able to identify actions that required more support and this has resulted in a report to the Executive Team.

Appendix 2 contains a Chairs Report from the Health Board RCPsych Action Delivery Group Meeting on the 30 September 2024.

### 3.2. Establishment of a MH&LD Programme Improvement Delivery Group (PIDG)

For recommendations in the Invited Services Review that are actionable by the MH&LD Division, a bespoke group has been established called the Programme Improvement Delivery Group (PIDG). This group has been established so that progress against the recommendations of the Invited Services Review that are being actioned within the MH&LD Division can be monitored, including a review of evidence that has been submitted by action owners. It also allows for "portfolio oversight" of all MH&LD Improvements so that the response to the Invited Services Review are not considered in isolation of other Divisional Improvement Programmes.

The Terms of Reference for this Group were approved at the MH&LD Divisional Service Leadership Team (DSLT) in September 2024 and PIDG has met on the 11th and 25th September 2024.

### 3.3. Utilising the Health Board Regulation Advisory and Oversight Group (RAG)

For recommendations in the Invited Services Review that are actionable by the wider Health Board (rather than solely by the MH&LD Division) the existing Health Board Regulation Advisory and Oversight Group (RAG) is being used. This ensures that progress against the recommendations of the Invited Services Review that are being actioned can be monitored, including a review of evidence that has been submitted by action owners. It also allows for the cross referencing of other regulatory information so that the response to the Invited Services Review are not considered in isolation of other Improvement Programmes. This group was established in September 2024 and has now reviewed updates on progress in September and October 2024.

### 3.4 Development of an "Evidence of Outcomes" Group (EoOG)

Both the PIDG and the RAG role in reviewing progress will be supported by the development of a newly established "Evidence of Outcomes Group" (EoOG) that will review, check and challenge evidence of progress from action owners. The first meeting will aim to commence during October 2024. This will support and validate actions the Health Board is taking to meet the objective of the recommendations that were made and able to improve outcomes for Patients, workforce and services.

This work will be supported by the Special Advisor and there will be a proposal developed that clarifies the roles of service-user representatives and "experts" in this group. The report to QSE Committee in December 2024 will confirm these arrangements.

### 3.5 Appointment of a Health Board Special Advisor

As mentioned above, the Health Board is pleased to confirm Ros Alstead has been appointed by the Health Board as a Special Advisor (2 days a month for an initial 12

months). The focus of this role is to offer additional independent expertise and specialist knowledge in supporting the Health Board's response to the Royal College of Psychiatrists Invited Services Review. The approach and aim will be to support the Health Board to move beyond achieving the recommendations from the review, and towards continuously improving and sustaining improvements in services across North Wales which local people including patients, families and staff value are proud of.

This support is especially welcomed by the Health Board as the Special Advisor will be able to build on her knowledge and experience working as the Welsh Government Independent Advisor for Mental Health from July 2023-March 2024. Ros worked with the Board, Divisions and Corporate teams to improve mental health leadership and services during the early phases of Special Measures.

**3.6 Development of an Expert Advisory Group Terms of Reference**

Related to the point above, draft Terms of Reference have been established for the Expert Advisory Group and the Chair (Ros Alstead) has been working with the Directorate of Corporate Governance to establish Terms of Reference for service user representatives to consider. (Attached in Appendix 3) As colleagues will be aware the membership of this group will include current and previous service user representation. The Special Advisor has arranged initial discussion meetings with stakeholders, experts and Health Board staff and these meetings will take place (with Llais present) on 24th October 2024. The outcome of these discussions will help shape and clarify the nature of information that will be provided both to this Committee (and the Health Board Action Delivery Group and Expert Advisory Group).

The Committee is asked to note these Terms of Reference with the Special Advisor in attendance at the meeting for this item. Engagement with experts and service user members will take place before the Terms of Reference are formally received for approval at the next QSE Committee.

The Special Advisor has noted that initial responses to the review and the governance arrangements have progressed and is keen that the Health Board takes the appropriate amount of time to make sure that the role of the Expert Advisory Group is clear and operates effectively so that it can demonstrate the response to the actions is meeting the objectives of the recommendations and can demonstrate improvements for service users.

**3.7. Senior Programme and Governance Support Collaboration with Governance, MH&LD and Transformation and Improvement**

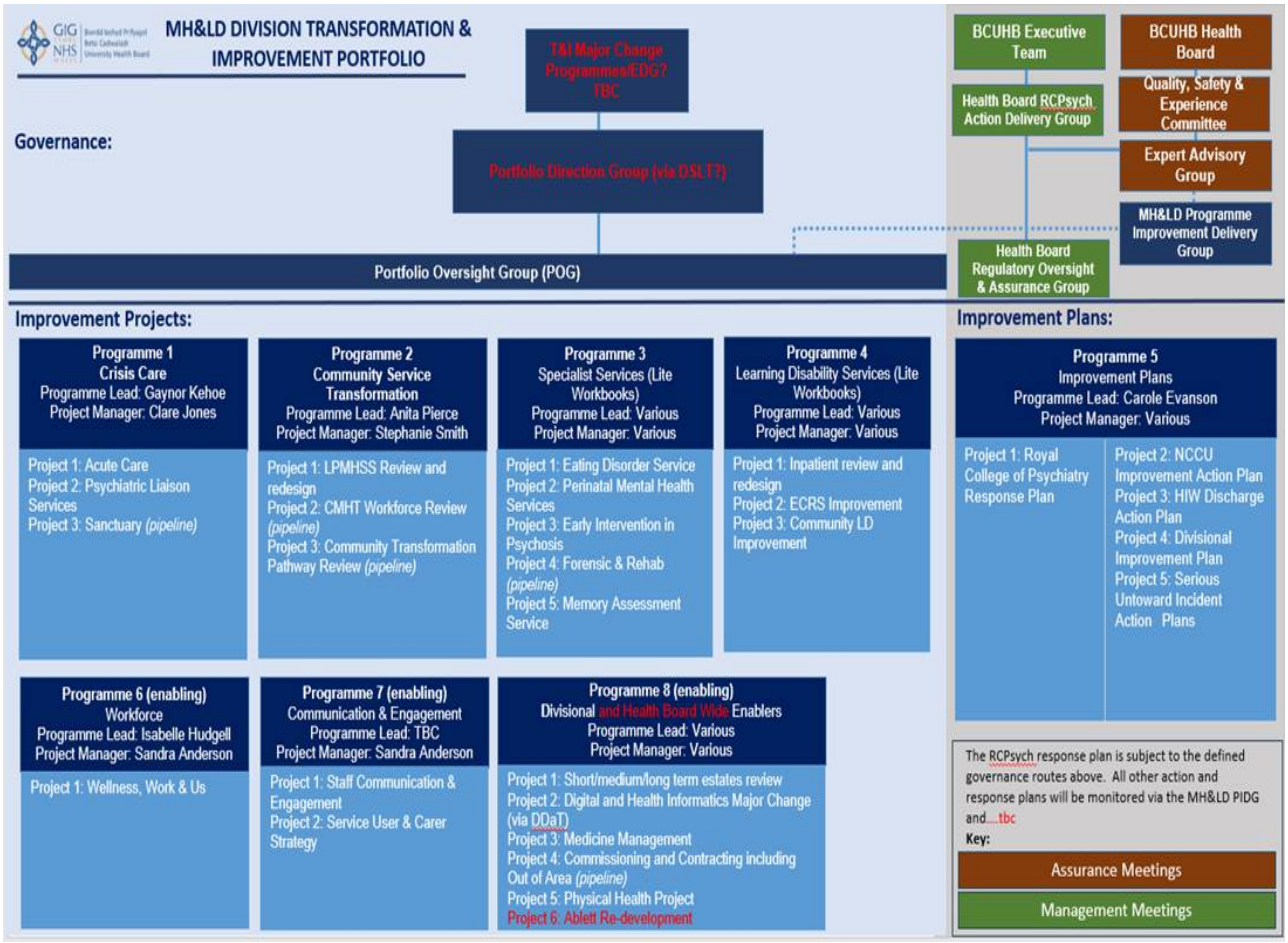
The Associate Director of Governance is working 1.5 days per week with the MH&LD Team from the start of September 2024 to provide support to the Programme and Governance arrangements. A Risk and Issues Log has been developed for this work that will be received at the next Health Board Action Delivery Group in October 2024.

In addition, as this is a Tier 2 Major Change Programme there is support provided from the BCUHB Transformation and Improvement Team into the MH&LD Division.

Linked to the point above the Transformation & Improvement Team and MH&LD Teams have further developed the actions that were received at the Board in July 2024 to be more SMART (**S**pecific, **M**easurable, **A**chievable, **R**ealistic and **T**imely). This has provided greater clarity on the actions required to be taken. This has been approved and is now in place. There is also a requirement to provide regular updates on progress made with both MH&LD actions and Health Board wide actions to Welsh Government. The Transformation and Improvement Team support this ongoing commitment.

On the 10 September 2024 the MH&LD Divisional Senior Leadership Team (DSLT) approved the proposal to commence the consolidation of all improvement activity aligned to external reviews and projects into one Transformation and Improvement Portfolio. This has given the opportunity to connect with and report through all the newly established governance arrangements. Figure 2 below shows this below:

This will provide divisional and organisational assurance that the Division and Board have clear oversight at a high and more granular level. **Figure 2 below – MH&LD Transformation and Improvement Portfolio**



## 4. SUMMARY OF PROGRESS AGAINST THE INVITED SERVICES REVIEW AS AT 20 SEPTEMBER 2024

Future reports to the QSE Committee will contain the responses from the Health Board RCPsych Action Delivery Group **and** the Expert Advisory Group. At this stage, as reported above it is only possible to report the updates from the Health Board RCPsych Action Delivery Group.

The Health Board Action Delivery Group noted the following updates against the Invited Services Review Action Plan.

### 4.1. What is Progressing Effectively?

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

Incorporated in the Response Plan are 16 actions with a completion date of either June, July, August or September 2024. Evidence has been submitted from action leads to illustrate progress against 15 of these actions, and an update has been submitted to explain the delays with the remaining one due action.

A summary of improvements made aligned to all the actions that have progressed to date include the following;

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

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

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

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

the Health Board continues to focus on embedding the five steps to illustrate continued and sustained improvement.

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

Appendix 1 of this report gives a high level summary of the progress that has been underway to the end of September 2024.

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

At this initial reporting point it is proposed that there is an acceptable level of assurance of early progress against the **actions** that have been taken up to the end of September 2024, as set out in the detailed response plan and as reported above. This can be examined in Appendix 1 (summary of progress) and Appendix 2. (Chairs Report from the HBADG).

The key matter is being able to demonstrate that the work being undertaken is leading to an improvement in **outcomes** for service users and workforce. In relation to this, advice and support from the Performance team is being sought to development metrics to clearly demonstrate improvements on outcomes, outputs and benefits – both quantative and qualitative. This is one of the key milestones for aligned to the Response Plan.

The next report to QSE Committee in December 2024 will be able to report on progress in this regard, which will then inform the scheduled update to Board in January 2024.

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

The governance arrangements that have been established allow early identification of actions where additional support or focus is needed. The HBADG received an escalation in regards to Action 9.3 which relates to. “Development of Business Cases related to Therapeutic provision in inpatient settings.”

A gap analysis has been provided aligned to therapeutic provisions across MH&LD Inpatient units. It was noted in the Health Board Action Delivery Group that the documentation has been explored by the Programme Team and action owners to understand the current position. This has illustrated that the information required to progress this is not fully complete. The gap analysis has been undertaken and this can be evidenced. To progress any Business Case there will be a need for clarity on the funding approach and organisational models to progress them. Discussion on how to move this forward have commenced and it was agreed to report on this matter

through this Group to the Executive Team Meeting on 9 October 2024 setting out the current position and options to address the required objective and clear timescales to address it. The Executive Team noted the gap analysis on 9th October 2024 and the future work required.

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

The ability for the Expert Advisory Group to review information provided from a Service User perspective will determine how effectively progress against the recommendations can be judged by the QSE Committee and the Board by January 2025. The approach to this will be fully considered by the Expert Advisory Group. The purpose of bringing this to the Committee's attention is to make sure there is not an assumption that progress reported today is able to be articulated to the Expert Advisory Group members who have/had a lived experience of the actions that have been taken. Care needs to be taken that actions that are reporting as being progressed can be evidenced in "real time" as being embedded and meeting the original objectives of the recommendations.

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

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

Actions that are being developed and progressed by the MH&LD Division are being effectively progressed in the meantime. Health Board wide actions have required additional support to ensure co-ordinated responses by multi-disciplinary teams. The HBADG has recognised this and taken action to ensure this. The action taken was for the Associate Director of Governance to support a Programme lead role with owners of recommendations that are Health Board wide (rather than MH&LD). This has now commenced (from September 2024).

**5. NEXT STEPS**

- Fully establish the new Expert Advisory Group (EAG) after consideration of the Terms of Reference by service user representatives and experts.

- Fully establish the "Evidence of Outcomes Group" Terms of Reference. (to be approved by the Health Board Action Delivery Group after consultation with service user representatives.

- A further (scheduled) QSE Committee on 17 December 2025 will receive an updated position on progress against a single agenda item with two reports

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

- QSE Committee will also be asked to consider and approve a final Draft Terms of Reference for the Expert Advisory Group in December 2024

## 6. RECOMMENDATIONS

This report asks the Committee to;

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

## APPENDIX 1

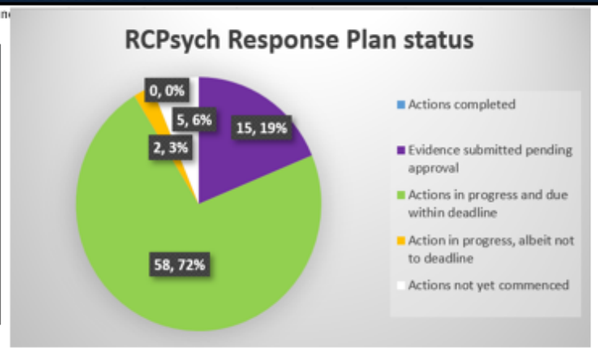
**Royal College of Psychiatrists' Invited Review Services Report**
**Mental Health and Learning Disability services in Betsi Cadwaladr University Health Board**
**Progress Update Report - September 2024**

| Date | 30/09/2024 | Period | Month / Sept 2024 | Author | Adrianne Jones, MH&LD Operational Business Lead | MH&LD Lead | Carole Evanson, Director of Operations | Senior Responsible Owner | Teresa Owen, Executive Lead. | RAG | Current month: Green | RAG Last Month: Green |
|---|---|---|---|---|---|---|---|---|---|---|---|---|

### CURRENT STATUS SUMMARY

15 actions evidence submitted, 58 actions in progress and due within deadline, 2 action in progress, albeit not to deadline and 5 actions n
yet commenced.

| Action State | Completed | Evidence submitted, pending | In progress and due within deadline | In progress, but not to deadline | Overdue and no recent progress | Total number of actions |
|---|---|---|---|---|---|---|
| Theme 1 | 0 | 2 | 14 | 0 | 0 | 16 |
| Theme 2 | 0 | 2 | 7 | 0 | 0 | 9 |
| Theme 3 | 0 | 5 | 9 | 1 | 0 | 15 |
| Theme 4 | 0 | 2 | 6 | 0 | 0 | 8 |
| Theme 5 | 0 | 0 | 3 | 0 | 0 | 3 |
| Theme 6 | 0 | 0 | 6 | 0 | 0 | 6 |
| Theme 7 | 0 | 0 | 3 | 0 | 0 | 3 |
| Theme 8 | 0 | 0 | 3 | 0 | 0 | 3 |
| Theme 9 | 0 | 1 | 2 | 1 | 0 | 4 |
| Theme 10 | 0 | 3 | 5 | 0 | 0 | 8 |
| Total | 0 | 15 | 58 | 2 | 0 | 75 |
| Change from previous month | No Change | Increased | Increased | Increased | No change | Decreased |




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

### ACTION RECOVERY & MITIGATION

Progress on 73 of the 80 actions underway and due within deadline. Outcomes to be independently

**Themes**

| | |
|---|---|
| 1.Patient and user centred care | Evidence submitted to close 2 |
| 2.Legislation and clinical guidelines | Evidence submitted to close 2 |
| 3.Governance | Evidence submitted to close 5 |
| 4.Staffing | Evidence submitted to close 2 |
| 5.Management structure | |
| 6.Clinical services organisation | |
| 7.Training and development | |
| 8.Leadership and Staff Engagement | |
| 9.Resources | Evidence submitted to close 1 |
| 10.Physical Environment | Evidence submitted to close 3 |

### KEY MILESTONES/DELIVERABLES - IMPLEMENTATION & OVERSIGHT

| | | |
|---|---|---|
| 1. RCPsych Response Plan Approved by Health Board | 30/05/24 | Complete |
| 2. The Board received the Health Board Response, Governance Framework agreed by Board and Exec | 25/07/24 | Complete |
| 3. Board appoints Ros Alstead as Independent Chair of Expert Advisory Group and Adviser to the Board | 02/09/24 | Complete |
| 4. Governance Framework meetings established and all ToR's agreed and reporting cycle agreed and | 30/09/24 | Draft Developed |
| 5. Inaugural Expert Advisory Group will meet (Chaired by an Independent Advisor with family and stakeholder | 08/10/24 | Date agreed 8/10/24 |
| 5. Develop performance metrics to measure the impact of improvements | 31/12/24 | Meetings held |
| 6. Report into QSE 26/10/25 | 26/10/24 | Draft Developed |
| 7. Report into QSE 17/12/25 | 17/12/24 | |
| 8. Report into QSE 19/2/26 | 19/02/25 | |
| 9. Report into Health Board meeting 6 monthly 30/1/25 | 30/01/25 | |
| 10. Completion of all actions | 31/12/25 | |
| 11. Evaluation, summary report | 31/01/26 | |
| 12. Future developments/next Steps | 31/01/26 | |

### PROGRESS SINCE LAST MONTH

Actions completed, awaiting approval through due governance - June, July and August = 8, September = 9
September -
- 1.13 - Undertake a Quality, Compliance and Outcomes Audit of the DoLS
- 2.6 - Continue to complete annual audits of antipsychotic medication prescribing
- 3.2 - Audit on call medical staff to ensure they have their own personal login for Paragon
- 3.4 - Deliver engagement and socialisation activities aligned to the MH&LD Operating Model review
- 3.8 - Support with engagement events aligned to the MH&LD Operating Model
- 4.3 - Continue to progress the recruitment and retention activities aligned to the MH&LD Recruitment and Retention plan
- 4.5 - Implement a review process of cover arrangement when Dementia Support workers
- 6.1 - Desk top audit of Multi-disciplinary (MDT)ward round
- 10.2 - Progress Environmental Ligature Risk Assessment Audit

### NEXT MONTHS ACTIVITIES

1. Progress completion of 2 actions in progress, albeit not to deadline
2. Establish an Evidence of Outcomes Group to check, challenge and review evidence of action completion. This includes confirmation of service user representation.
3. Agree Expert Advisory Group ToR
4. Progress the development of performance metrics to measure the impact of improvements, meeting with Performance and T & I colleagues.

### CHALLENGES, RISKS & ESCALATIONS

Governance route to check, challenge and approve evidence submission to close actions will be introduced in October with the establishment of an Evidence of Outcomes Group.

Additional support required for Action 9.3, aligned to developing a business case for identified gaps in therapeutic provision across MH&LD inpatient units. Several business cases have been undertaken; however, the status of funding remains unclear. Discussions have commenced to move this forward and a paper will be provided to the Executive Team on 9 October 2024 to address the required objective and clear timescales to address it.

### LESSONS LEARNED AND IMPACT THIS MONTH

- Improved MCA Training compliance has led to an increase in DoLS applications. This has demonstrated an improvement in MCA/DoLS awareness by the Division thus ensuring that patients are better protected by respective legislative frameworks.

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

- A consistent five step approach to the management of Complaints, Incidents and Mortality Reviews has been developed aligned to streamlining the process for staff and patients. Implementation of this approach commenced during September 2024.

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

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

# Chair's Report

| | |
|---|---|
| **Report to:** | Executive Committee, 9 October 2024 |
| **Report from:** | Health Board Royal College of Psychiatry (RCPsych) Action Delivery Group |
| **Report date:** | 30 September 2024 |
| **Presented by:** | Teresa Owen, Executive Director of Allied Health Professionals and Health Science |

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

| ID | Title | Date Opened | Current Score | Last Reviewed |
|---|---|---|---|---|
| | | | | |

**Quality highlights and escalations:**
*Please include matters of escalation (for action/decision and for information) and a short summary of all business conducted by the group, organised by the domains set out below.*

| | |
|---|---|
| **Issues for escalation – requiring action/decision** | 1. Further consideration to be given aligned to establishing a focussed session to review evidence submitted to check, challenge and endorse the closure of Royal College of Psychiatry Response Plan actions. There is a need to ensure established groups are not "marking their own homework". Recommend the establishment of an Evidence Sub-Group.<br><br>2. Request for additional support for Action 9.3, aligned to developing a business case for identified gaps in therapeutic provision across MH&LD inpatient units. Several business cases have been undertaken; however, the status of funding remains unclear. Discussions have commenced to move this forward and a paper will be provided to the Executive Team on 9 October 2024 to address the required objective and clear timescales to address it. |
| **Summary of business conducted** | **Purpose of the Health Board Royal College of Psychiatry (RCPsych) Action Delivery Group**<br><br>The purpose of this Delivery Group is to ensure the Health Board can deliver transparent and accountable progress against the ten themes identified in the Royal College of Psychiatrists (RCPsych) Invited Services Review. This includes overseeing progress against the delivery of recommendations that derive from the Mental Health and Learning Difficulties (MH&LD) Services and the wider Health Board. This reflects that the responses to the Review need to take a system-wide approach and the need to take key strategic actions to improve services.<br><br>**Terms of Reference**<br><br>The Health Board RCPsych Action Delivery Group Terms of Reference, previously approved by the Executive Team on the 14 August 2024, were |

| | |
|---|---|
| | received by the group. Proposal made for some amendments to the membership of the group. Amended Terms of Reference embedded below –<br><br>RCPsych Terms of Reference v2 after Del<br><br>**Governance and Programme Management**<br><br>The Board has agreed that oversight of the response to the RCPsych Report will be through the Quality Safety and Experience (QSE) Committee. An Expert Advisory Group will act as a sub group of the QSE Committee to support the provision of this assurance.<br><br>Specific MH&LD actions are monitored and reported at the MH&LD Programme Improvement Delivery Group (PIDG) and Health Board system-wide actions are received at the Regulation, Assurance and Oversight Group (RAG). A monthly progress report will be brought to this Health Board Royal College of Psychiatry (RCPsych) Action Delivery Group to reflect the previous month's progress plus a forward look of what is being progressed in the following two months.<br><br>**Progress against ten themes**<br><br>Summary of progress up to the end of August 2024 - Update and evidence to close four out of five Health Board Wide Actions was submitted for review at the RAG meeting held on 10/9/24. One action remains outstanding aligned to "Establish a Health Board Oversight Group" This action will not be closed until the Terms of Reference for this Group has been agreed by the Expert Advisory Group at the inaugural meeting planned for 8/10/24. At the MHLD PIDG meeting held on 11/9/24 updates and evidence to close three MH&LD Actions was submitted for review.<br><br>Two Health Board Wide Actions are due for completion for September and updates will be expected to be submitted for review at the RAG meeting due to be held on 8/10/24. There are seven MH&LD Actions due for completion for September 2024, updates/evidence to close actions will be expected to be submitted for review at the MH&LD PIDG meeting due to be held on 9/10/24.<br><br>There are seven MH&LD Actions due for completion for October 2024, updates/evidence to close actions will be expected to be submitted for review at the MHLD PIDG meeting due to be held on 11/11/24. Four Health Board wide Actions are due for completion for October.<br><br>**Appointment of a Health Board Special Advisor**<br><br>The Health Board has appointed a Specialist Adviser, Ros Alstead (2 days a month for 12 months) to offer additional independent expertise and specialist knowledge in supporting the Health Board's response to the Royal College of Psychiatrists Invited Services Review. Ros Alstead will chair the Expert Advisory Group.<br><br>**Next Steps agreed at the meeting**<br><br>• Establish the new Expert Advisory Group (EAG) on 8 October 2024<br>• Clarify how the EAG will assess satisfactory progress against the Invited Services Review recommendations. |

| | |
|---|---|
| | • Report to the Executive Team on 9 October 2024<br>• Report on progress to the QSE Committee on 24 October 2024.<br>• Finalise the Programme Risk and Issues Log and report to the next HB Action Delivery Group |

# Health Board Royal College of Psychiatrists Invited Services Review Expert Advisory Group

## Draft Terms of Reference

### 1.0 INTRODUCTION

1.1 The Quality Safety and Experience (QSE) Committee can establish sub groups and associated governance arrangements, including in this case a time limited Group which is a sub group of the QSE Committee. The detailed terms of reference and operating arrangements in respect of the meetings and business of the Group are set out below in these Terms of Reference document. The Expert Advisory Group has a direct line of accountability to the QSE Committee with its reports being received at the QSE Committee.

1.2 In May 2023, as part of Special Measures, the Welsh Government commissioned the Royal College of Psychiatry (RCPsych) to review the extent to which recommendations from previous Mental Health reports have been implemented and the extent to which these have maintained and consistently integrated into "business as usual" practices.

1.3 The Board has agreed that an Expert Advisory Group be established that will be Chaired by an Independent Adviser and with and its membership reflecting current and previous family and service user representatives so that actions responding to the recommendations are influenced by and reflect the lived experience of service users and their families.

1.4 For the purpose of clarity, it is noted in these Terms of Reference that there is a Health Board Invited Services Review Action Delivery Group that formally reports into the Executive Team (and is accountable to the Executive Team).

### 2.0 PURPOSE

2.1. The purpose of this Group is to provide independent assurance, that is informed by service user and expert experience to the QSE Committee (on behalf of the Board) so that the Health Board response to the Invited Service Review is delivering sustainable change with transparent and accountable progress against the ten themes identified in the Royal College of Psychiatrists (RCPsych) Invited Services Review. This will include consideration of the experience of care as a result of the actions taken and of the likely medium term, longer term and future impact.

2.2 The Expert Advisory Group will enable people with lived experience and their families to express what safe and reliable care looks like to them and will also enable input from external experts on best practice nationally and internationally. This will enable the Group to take a view on the sustainability and effectiveness of the Health Board's proposed responses to the agenda set by the Invited Services Review and also of the Health Board's strategic objectives and plans.

2.3 This will include providing a view as to whether the specific actions taken address the relevant recommendations appropriately and whether they resonate with the experience of service users and their families. It will also include identifying what is progressing effectively (in terms both of action and of improved outcomes), , what is progressing but needs additional support/focus to demonstrate evidence of improved outcomes and what is not progressing effectively as well as providing a view as to the action needed where progress is inadequate..

2.4 Specifically the group will:

- Approve and keep under review these Terms of Reference.
- Test and challenge whether the reported progress against the recommendations evidence meets the objectives of the recommendations and is evidenced by real time information and the experience of service users.
- Bring together representatives of service users and their families, professional experts and Health Board staff to establish the above points.
- Ensure that changes and actions to meet the Invited Review recommendations are equitable, sustainable and embedded in every day practice across the whole Health Board through the implementation of a programme of reviewing information and audit.
- Review progress on the development of an evidence bank to store actions and accomplishments for each of the recommendations across the ten themes with access to Health Board staff to provide oversight and further assurance.
- Ensure inter-dependencies and commonalities with other pieces of work are considered i.e. Health and Safety Executive Notice of Contravention, Special Measures/Annual Delivery Plan and the Menta Health and Learning Disabilities Improvement Plan.
- Assess whether governance arrangements provide robust assurance that recommendations are being implemented.

Additionally, this group will:

- Promote improvement skills and knowledge based on service users experience that can be enacted at every level, from the top tiers through to front line staff.
- Recognise the importance of creating a workplace culture that is conducive to improvement.
- Ensure that all members of the Group have the time, space, permission, encouragement and skills to collaborate on planning and delivering improvement.
- Seek expert guidance and support from within BCUHB where it seems appropriate to the group.

## 3.0 DELEGATED POWERS

3.1 The Expert Advisory Group is established by the QSE Committee to:

- Assess whether there is sustainable and effective improvement in Services resulting from the recommendations and actions arising the RCPsych Invited Services Review maintaining the trust of patients and public throughout its delivery against these recommendations.
- Recommend where it deems it appropriate the stopping, starting or extending of work on key matters.
- Investigate and act upon any activity within its Terms of Reference with particular reference to the recommendations cited within the RCPsych Invited Services Review, and the ongoing Improvement and development agenda.
- Seek evidenced based assurance from clinical and corporate services in relation to the delivery against the recommendations of the RCPsych Invited Services Review.
- Seek evidenced based assurance that there is compliance with all appropriate legislation and regulatory requirements related to delivery against the recommendations of the RCPsych Invited Services Review.
- Provide constructive feedback to clinical and corporate services in relation to delivery against the recommendations of the RCPsych Invited Services Review.
- Support the effective operational management of the Health Board, enabling issues related to delivery against the recommendations of the RCPsych Invited Services Review to be anticipated, discussed and actions agreed.
- Support individual BCUHB members of staff to deliver their delegated responsibilities by providing a forum for briefing, exchange of information, mutual support, resolution of issues and achievement of agreement;
- Act as the forum in which representatives of service users and their families, professional experts and BCUHB members of staff attending the Group can formally raise concerns and issues for discussion relating to the response to the recommendations of the review;

## 4.0 AUTHORITY

4.1. The Group derives its authority from the QSE Committee and is therefore accountable to the Chair of the QSE Committee.

4.2. The Group has responsibility for co-ordinating and providing the QSE Committee with evidence based assurance regarding the Health Board response to the RCPsych Invited Services Review.

4.3. The Group will engage with employees, committees or groups as set up by the Board or by the Accountable Officer to assist in expediting its role.

4.4. The Group may obtain outside legal or other independent professional advice via the Directorate of Corporate Governance if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements.

4.5. The Group will, where appropriate, recommend courses of action to the QSE Committee within the remit of the Group's 'business.

4.6 The Group will make recommendations and assessments on issues within the remit of the Group, in-line with the Board's Scheme of Delegation.

## 5.0 WAY OF WORKING

5.1 The Group may, subject to the approval of the Chair of the Group and the Executive Director of Allied Health Professionals and Heath Science, establish the ability for individual members of the group to carry out tasks (in line with these Terms of Refence) on its behalf.

5.2 These arrangements may result in establishing time limited or task limited activity to support the purpose of the group. The intention being to support the effective understanding of whether there is sustainable improvement in place arising from the actions taken in response to the recommendations of the Invited Service Review.

## 6.0 MEMBERSHIP

6.1 The core members of the Expert Advisory Group (Health Board RCPsych)

| |
|---|
| Independent Special Adviser to the Board - Chair |
| Llais Senior Director – Vice Chair |
| An Independent Clinical Adviser (Psychiatrist) |
| An Independent Clinical Adviser (Dementia) |
| 2 x Representatives (including families) of previous service users |
| 2 x Representatives of current service users |
| Associate Director of Governance - BCUHB |
| |
| **Standing Invitees** |
| Executive Director of Allied Health Professionals and Health Science |
| Executive Director of Nursing and Midwifery (or representative) |
| Director of Partnerships and Engagement |
| Director of Operations MH&LD |
| Director of Nursing for MH&LD |
| MH&LD Operational and Business Lead |
| A Senior Nurse specialist on Learning and Development |
| |

6.2 Other directors/officers will attend as required by the Chair of the Group, as well any others from within or outside the organisation whom the Chair of Group considers should attend, taking into account the matters under consideration at each meeting.

6.3 The membership of the Group shall be determined by the Chair of the Group taking account of the balance of skills and expertise necessary to deliver its remit and subject to any specific directions made by the QSE Committee.

6.4 Subject to approval by the Chair of the Group, nominated deputies are permitted and will have the full voting rights and accountability of the member for whom they are deputising.

6.5 The Directorate of Corporate Governance shall act and provide secretariat for the meeting.

## 7.0 MEETINGS (Including Attendance)

7.1 At least one third of core members must be present to ensure the quorum of the Delivery Group, one of whom must be the Chair or Vice-Chair.

7.2 Where members are unable to attend a meeting, a nominated deputy should be asked to attend, at the discretion of the meeting Chair. The Chair will initiate action in the event that a members fails to attend, or sends a representative to three consecutive meetings.

7.3 Decisions shall be made by consensus.

7.4 Where the Group is unable to make a decision, the meeting Chair may refer the matter to the QSE Committee.

7.5 Where there is a matter for concern derived from a decision, the meeting Chair will escalate to the Executive Director for Therapies and Allied Health Professionals

7.6 There may, occasionally, be circumstances where assessments or decisions, which would normally be made by the Group, need to be taken between scheduled meetings. In these circumstances, the Chair of the Group, supported by the secretariat, may deal with the matter on behalf of the group. The secretariat must ensure that any such action is formally recorded and reported to the next meeting for consideration and ratification. Chair's Action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

7.7 The Directorate of Corporate Governance, as secretariat, will develop and maintain a Cycle of Business for the Delivery Group which shall be approved by the Chair of the Group. The Directorate will also ensure standard templates are used throughout the Delivery Group and its supporting structure and will take action to ensure the good governance and effectiveness of the supporting structure including the cross-referral and escalation of issues between meetings.

7.8 This is a time limited Group. The Group will be scheduled to meet 12 times a year (monthly) with a minimum of 6 meetings at appropriate times in the reporting cycle for the QSE Committee. The Chair is able to schedule additional meetings if in their opinion that is required.

## 8.0 RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES

8.1 The Expert Advisory Group is a time limited Group and it will provide a Chair's Report that will be reported to the QSE Committee and other fora as required and agreed by the Chair of the Group.

8.2 The Group will engage with the Health Board RCPsych Action Delivery Group to ensure the connection and consideration of programmes of work.

8.3 Group members are directly accountable to the Chair (an Independent Advisor) for delivering the functions set out in the Terms of Reference.

8.4 The Group shall embed the Health Board's values, standards, priorities and requirements across all aspects of its work.

## 9.0 REPORTING AND ASSURANCE ARRANGEMENTS

9.1 The Group shall:

- Report on progress against the Invited Services Report to QSE Committee on a bi-monthly basis.
- Provide a Chair's Report that will be shared with other fora, including community partners and other stakeholders as determined by the Chair of the Group to support common understanding of delivery against the recommendations of the Invited Services Review.
- Bring to the Health Board RCPSych Action Delivery Group specific attention to any significant matters under consideration by the Group;.
- Ensure appropriate escalation arrangements are in place to alert the Chair of the QSE Committee to any urgent or critical matters that may affect the purpose of this Group and/or reputation of the Health Board.

9.2 For the purpose of clarity, it is noted in these Terms of Reference that there is a Health Board Invited Services Review Action Delivery Group that formally reports into the Executive Team. This Delivery Group will also provide a report under the same agenda item (Health Board Response to the Invited Services Review) to the QSE Committee.

9.3 Members are expected to communicate any development, decisions and or recommendations arising from the work delivered that may affect their area of responsibility.

9.4 The Directorate of Corporate Governance, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Group performance and operation.

## 10.0 REVIEW ARRANGEMENTS

10.1 These terms of reference and operating arrangements shall be reviewed after 6 months by the Group and any changes recommended to the QSE Committee for approval. This Group is established on a time limited basis and the end point of the Group will be reviewed and considered by the Chair as and when required.

10.2 The minutes, Risk Log and associated action plans of the meeting and issues of significance shall be formally reported to the Delivery Group subject to the Health Board's Information Governance Policies.

Version 0.3

**Drafted:** 15 October 2024

**Draft approved by the QSE Committee:**

**Received for review by the Expert Advisory Group:**

| | | | | |
|---|---|---|---|---|
| **Teitl adroddiad:**<br><br>***Report title:*** | Corporate Risk Register Report | | | |
| **Adrodd i:**<br><br>***Report to:*** | Quality Safety and Experience (QSE) Committee | | | |
| **Dyddiad y Cyfarfod:**<br><br>***Date of Meeting:*** | Thursday, 24 October 2024 | | | |
| **Crynodeb Gweithredol:**<br><br>***Executive Summary:*** | The purpose of this standing agenda item is to provide an update position of the Corporate Risk Register to which QSE has oversight.<br><br>The Committee is asked to note and discuss the following risk which sits above the risk appetite of the Health Board;<br><br>• CRR24-09 'Primary Care'<br>• CRR24-13 'Timely Diagnostics<br><br>CRR24-02 – Risk revised to become broader patient safety risk. New risk current score identified as 16.<br><br>CRR24-04 Reduction in the current risk score from 20 to a score of 15 due to the delivery of a number of system and process improvements. The risk score is currently within risk tolerance set in the risk appetite.<br><br>Appendix 1 - Risk Dashboard, Quality, Safety and Experience Committee<br>Appendix 2 - Corporate Risk Register Report (Risk score above tolerance set within the risk appetite) | | | |
| **Argymhellion:**<br><br>***Recommendations:*** | The Committee is asked to **receive assurance** for the six corporate risks to which the Committee has overall accountability. | | | |
| **Arweinydd Gweithredol:**<br><br>***Executive Lead:*** | Pam Wenger, Director of Corporate Governance | | | |
| **Awdur yr Adroddiad:**<br><br>***Report Author:*** | Nesta Collingridge Head of Risk Management | | | |
| **Pwrpas yr adroddiad:**<br><br>***Purpose of report:*** | I'w Nodi<br>*For Noting*<br>☒ | I Benderfynu arno<br>*For Decision*<br>☐ | Am sicrwydd<br>*For Assurance*<br>☒ | |
| **Lefel sicrwydd:** | Arwyddocaol<br>*Significant* | Derbyniol<br>*Acceptable* | Rhannol<br>*Partial* | Dim Sicrwydd<br>*No Assurance* |

| | | | | |
|---|---|---|---|---|
| ***Assurance level:*** | ☐<br>Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol<br><br>*High level of confidence/evidence in delivery of existing mechanisms/objectives* | ☒<br>Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol<br><br>*General confidence / evidence in delivery of existing mechanisms / objectives* | ☐<br>Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol<br><br>*Some confidence / evidence in delivery of existing mechanisms / objectives* | ☐<br>Dim hyder/tystiolaeth o ran y ddarpariaeth<br><br>*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**<br><br>***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:**<br><br>***Link to Strategic Objective(s):*** | Links to the BAF detailed in respective CRR reports |
| **Goblygiadau rheoleiddio a lleol:**<br><br>***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 EqlA yn angenrheidiol ac a gafodd ei gynnal?**<br><br>***In accordance with WP7 has an EqlA been identified as necessary and undertaken?*** | Not applicable for this report |
| **Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal?**<br><br>***In accordance with WP68, has an SEIA identified as necessary ben undertaken?*** | Not applicable for this report |
| **Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR)**<br><br>***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***<br><br>***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** | Failure to capture, assess and mitigate risks can impact adversely on our workforce. |

| | |
|---|---|
| ***Workforce implications as a result of implementing the recommendations*** | |
| **Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori**<br><br>***Feedback, response, and follow up summary following consultation*** | Individual Executive sign off of CRR reports, Review at Risk Scrutiny Group 10/09/2024. |
| **Cysylltiadau â risgiau BAF:**<br>(neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)<br><br>***Links to BAF risks:***<br>*(or links to the Corporate Risk Register)* | See the individual risks for details of the related links to the Board Assurance Framework. |
| **Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)**<br><br>***Reason for submission of report to confidential board (where relevant)*** | Not applicable for this report |
| **Camau Nesaf:**<br><br>***Next Steps:***<br>• Community Care and Six Separate Areas of Clinical Concern Corporate Risks all to be further developed and to be reviewed at Risk Scrutiny Group. | |
| **Rhestr o Atodiadau:**<br><br>***List of Appendices:***<br>Appendix 1 – Risk Dashboard, Quality, Safety and Experience Committee<br><br>Appendix 2 – Corporate Risk Register Report (Risk score above tolerance set within the risk appetite):<br><br>1. Primary Care<br>2. Timely Diagnostics | |

## Corporate Risk Register Report

### 1) Introduction and Background

What Is a Corporate Risk?

A corporate risk register is a repository used by services and corporate functions to record significant risks that could impact the strategic objectives and operations of the Health Board. The register provides a comprehensive overview of the key risks facing the organisation. It is a pivotal tool to help proactively strengthen risk oversight and management.

1.1 There are 6 Corporate Risks for Quality, Safety and Experience Committee oversight and assurance. The full details of those risks where the risk score is above tolerance set within the risk appetite are highlighted in Appendix 2 and include evidence of controls in place, additional controls required and actions with due dates.

- CRR24-02 - Patient Safety
- CRR24-04 - Failure to Embed Learning
- CRR24-09 - Community Care and Primary Provision
- CRR24-12 - Areas of Clinical Concern
- CRR24-13 - Timely Diagnostics
- CRR24-14 - Harm from Medical Devices/Equipment

## 1) Key Highlights

The corporate risk dashboard (Appendix 1) below provides a list of the 6 corporate risks to which the Quality Safety and Experience (QSE) Committee has within its remit.

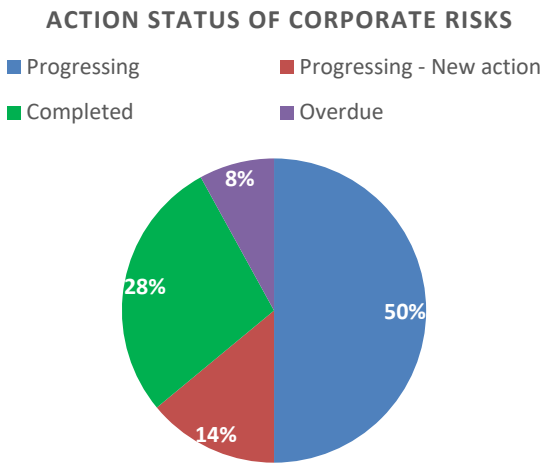
The Committee is asked to discuss the risks which are above tolerance of the risk appetite of the Health Board (Appendix 2)

- CRR24-09 'Primary Care' (risk score 20, above tolerance 15-19) - work remains ongoing for the development of 'Community Care' as a standalone Corporate risk.
- CRR24-13 'Timely Diagnostics' – Following review the risk appetite for the risk has been amended from Reputational (Appetite level 20-25) to Quality (Appetite Level 15-19) resulting in the current risk score (20) falling above the tolerance set in risk appetite.

The committee is asked to note the following development;

- CRR24-02 'Patient Safety' – Risk revised to become broader patient safety risk from the former 'Patient Safety – Falls' Corporate Risk.
- CRR24-04 'Failure to embed learning' – Reduction in the current risk score from 20 (Impact -5 x Likelihood -4) to a score of 15 (Impact -5 x Likelihood -3) due to the delivery of a number of system and process improvements but recognising there are still remaining actions to mitigate the risk further. The reduction in score results in the risk being within the risk appetite tolerance score of 15-19.
- CRR24-12 'Areas of Clinical Concern' - the risk is currently being split into 6 separate risks that will focus on specific services, work is scheduled with the newly appointed Chief Operating Officer to review and fully develop the risks:
    - Urology services
    - Oncology services
    - Ophthalmology
    - Vascular services
    - Orthodontics
    - Dermatology & Plastics

The committee is asked to receive assurance of the 6 corporate risks, noting 50 actions have been developed to mitigate the risks. 14 actions have been completed, 25 actions are progressing and on track with 7 new actions identified. 4 actions are overdue, and all relate to CRR24-12 'Areas of Clinical Concern', which is currently under review with a view to split the risk into 6 separate clinical risks.




**Next steps**

1. Continued scrutiny of the actions, controls and progress of all corporate risks by Executives, Risk Scrutiny Group and Executive Team.
2. Development of 'Community Care' as a standalone Corporate risk.
3. Further development of the 'Areas of Clinical Concern' risk.

## Appendix 1 - Corporate Risk Register Dashboard – Quality, Safety and Experience Committee

| Lead | Ref | Risk Title | Current Score (Impact x Likelihood) | Risk Target Score | Appetite Main Risk Type<br>Appetite Level | Lead Board Committee | Risk Management Commentary |
|---|---|---|---|---|---|---|---|
| EDoN | CRR24-02 | Patient Safety | 4 x 4 = 16 ⬇ | 12 | Quality<br>Open 15-19 | Quality, Safety and Experience Committee | Opened Dec 23. Risk revised to become broader patient safety risk, 10 actions identified, 1 completed, and 9 actions progressing. New risk current score identified as 16. |
| EDoN | CRR24-04 | Failure to Embed Learning | 5 x 3 = 15 ⬇ | 5 | Quality<br>Open 15-19 | Quality, Safety and Experience Committee | Opened Dec 23, 14 actions identified, 9 completed (rolled into QMS action), 5 progressing.<br><br>Reduction in the current risk score from 20 to a score of 15 due to the delivery of a number of system and process improvements. |
| EDoO | CRR24-09 | Primary Care | 4 x 5 = 20 ⟷ | 12 | Quality<br>Open 15-19 | Quality, Safety and Experience Committee | Opened Feb 24, 6 actions identified, 3 completed, 3 progressing. The **inherent and current risk scores are both 20**, indicating the controls are not yet reducing the risk.<br><br>This risk has been revised and now only reflects primary care and not community. A separate community risk is being drafted.<br><br>**Risk Score above tolerance set in risk appetite.** |
| EDoO | CRR24-12 | Areas of Clinical Concern (encompasses ophthalmology and dermatology) | 5 x 3 = 15 ⟷ | 12 | Quality<br>Open 15-19 | Quality, Safety and Experience Committee | Opened Feb 24, 6 actions identified, 2 progressing with 4 actions currently overdue in relation to the action due date.<br><br>Further work will be done to separate this risk to the key areas of clinical concern.<br><br>No update for the risk from the service. |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| EDoTH | CRR24-13 | Timely Diagnostics | 5 x 4 = 20 ⟷ | 5 | Quality<br>Open 15-19 | Quality, Safety and Experience Committee | Opened Feb 24, 7 actions identified, 0 completed, 5 progressing, 2 new actions<br><br>**Risk Score above tolerance set in risk appetite.** |
| EDoTH | CRR24-14 | Harm from the Medical Devices/Equipment | 4 x 4 = 16 ⟷ | 8 | Quality<br>Open 15-19 | Quality, Safety and Experience Committee | Opened Feb 24, 5 actions identified, 1 completed, 4 progressing. Previous overdue actions escalated to Chair of Medical Devices, reviewed and revised dates allocated to the actions. |

**Key:**

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

## Appendix 2 – Corporate Risk Register Report (Risk score above tolerance set within the risk appetite)

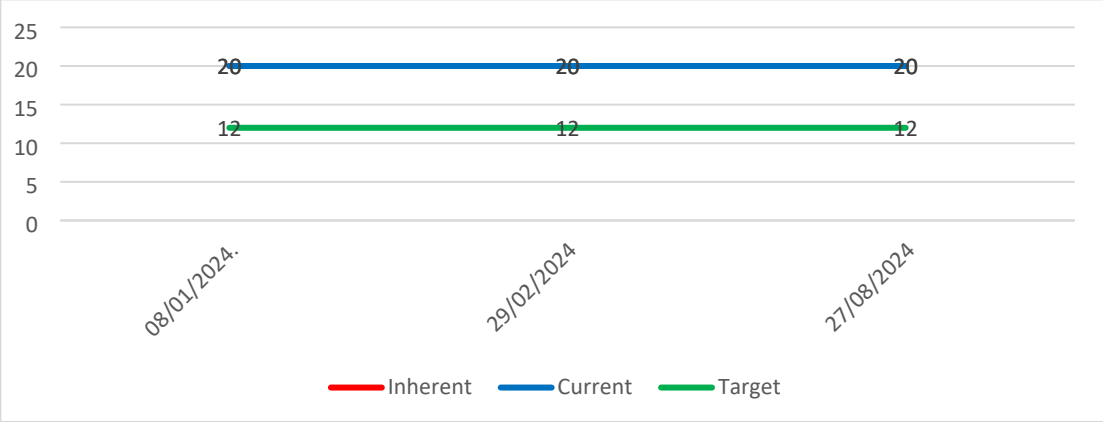
| | | | |
|---|---|---|---|
| CRR 24-09 | **Risk Title: Primary Care** | | **Date Opened:** 08/02/2024 |
| | **Assuring Committee:** Quality, Safety and Experience Committee | | **Date Last Committee Review:** 15/08/2024 |
| **Date Last Reviewed:** 27/08/2024 | **Director Lead:** Executive Director Transformation And Strategic Planning | **Link to BAF**: N/A | **Target Risk Date:** 31/03/2025 |

There is a risk of the Health Board not fully meeting its legal obligation to provide accessible and high-quality primary care. This may be due the sustainability of primary care professions, patient access, timely diagnosis, and appropriate healthcare utilisation. This may result in a demoralised primary care workforce, increased strain on emergency services, prolonged hospital stays, preventable admissions, lapses in care, regulatory non-compliance, and declining population health indicators. Consequently, there is a cascading effect on patient flow, service performance, care quality, collaborative partnerships, cost-effectiveness, and the viability of primary care and community care models. The ultimate consequence is a rise in mortality rates, treatment delays, and extended hospitalisations, exacerbating patients' health conditions.

| Mitigations/Controls in place | Additional Controls required |
|---|---|
| 1. Escalation and sustainability report to address risks associated with workforce and workload pressures allows for early identification and management.<br>2. Risk management training completed Q3 2023 for all primary care leaders for better identification and management.<br>3. Programme management implemented to monitor and drive strategic priorities.<br>4. Primary Care Quality and Delivery Group established Q3 23/24<br>5. Primary Care Board has now been established with the first meeting held May 2024, monthly meetings planned moving forwards. Sub group reporting into the Primary Care Board.<br>6. Primary Care contractor services audits of sustainability matrix ongoing periodically – Programmes in place to undertake the audits<br>7. Greater Health Board oversight of Primary Care issues and risks via PPHP Committee with first report to committee during April 2024 with further reporting in June 2024. | 1. Strategy and resources to support introduction of new roles, ways of working and models of service delivery.<br>2. Equity of resource to support primary care transformation, management and governance.<br>3. Strategy, focus and resources to deliver joined up planning, innovation and delivery for place based, integrated prevention, health and care services across NHS/Local Authorities to deliver on place based care and care closer to home. |

| Actions | Due Date | Progression Analysis |
|---|---|---|
| Primary Care Board established<br>Primary Care Board has now been established with the first meeting held May 2024, monthly meetings planned moving forwards. Sub group reporting into the Primary Care Board. | 30/05/2024 | Completed |
| Primary Care strategic plan<br><br>National Primary Care model being reviewed with HB input which will inform the Betsi Strategic plan. | 31/03/2025 | Progressing |

| | | |
|---|---|---|
| Escalation and sustainability implementation<br><br>Primary Care contractor services audits of sustainability matrix ongoing periodically – Programmes in place to undertake the audits which were included in the annual delivery plan. | 30/06/2024 | Completed |
| Health Board Managed Practices – recommendations for improved governance report<br><br>Managed practices governance and assurance sub group reporting into Primary Care Board | 31/01/2024 | Completed |
| Focused on implementation of recommendations from the National Strategic Programme for Primary Care.<br><br>July workshop planned to review the recommendations and programme of work for 24/25 | 31/03/2025 | Progressing (revised date from 30/06/2024) |
| Primary Care academy to utilise SPPC monies to further progress multi-professional working with a review of cluster monies spend to allow introduction of new roles, ways of working and models of service delivery. | 31/12/2024 | Progressing |
| Primary Care plan/strategy drafted to lay ground work for pathway to true Partnership and integrated working, with joint planning and decision making across Local Authorities/NHS for health, care and prevention. | 31/03/2025 | New action |
| Place based person centred provision to be at the forefront of planning, transformation and innovation in all health and social care plans. | 31/03/2026 | New action |




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

| | Impact | Likelihood | Score |
|---|---|---|---|
| Inherent Risk Rating | 4 | 5 | 20 |
| Current Risk Rating | 4 | 5 | 20 |
| Target Risk Score | 4 | 3 | 12 |
| Risk Appetite | Open | | 15-19 |

**Rationale for Corporate Risk**

Optometry reform delivery compromised, continue to have further managed practices and financial implications to the Health Board.
Dental access compromised.
Recognition of inherent score currently further controls needed.

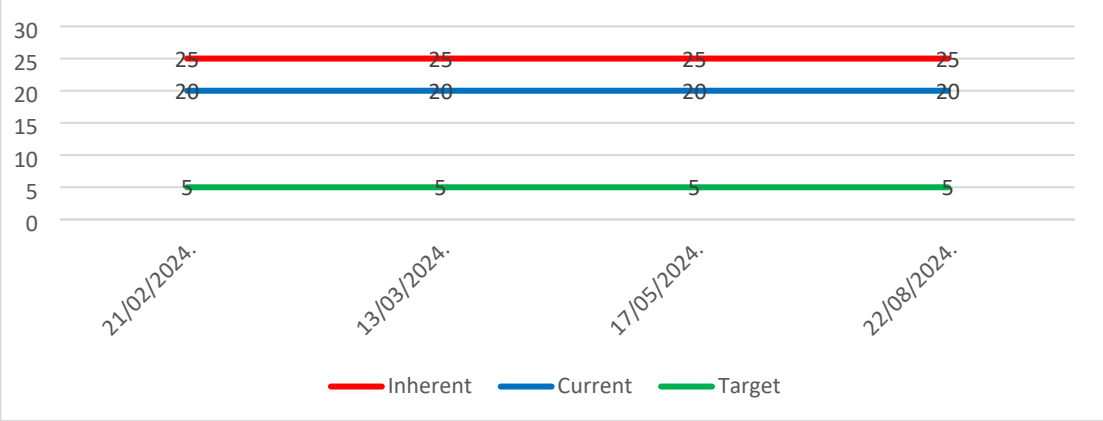
| CRR 24-13 | **Risk Title:** Timely Diagnostics | | **Date Opened:** 21/02/2024 |
|---|---|---|---|
| | **Assuring Committee:** Quality, Safety and Experience Committee | | **Date Last Committee Review:** 15/08/2024 |
| **Date Last Reviewed:** 22/08/2024 | **Director Lead:** Executive Director of Therapies & Healthcare Sciences | **Link to BAF**: N/A | **Target Risk Date:** 31/12/2025 |

There is a risk of delay in diagnostics, service failure, poor performance or disruption to **radiology** and **pathology** services across. This could be caused by shortages of specialist staff, aging or inadequate IT systems and infrastructure, and insufficient governance structures. The impacts may include delays in diagnosis, treatment and discharge, increased outsourcing costs, patient harm events, preventable deaths, regulatory non-compliance, and significant reputational damage. There is also additional risk related to clinicians failing to act on results of diagnostic tests.

| Mitigations/Controls in place | Additional Controls required |
|---|---|
| 1. Insourcing of CT, MRI and ultrasound to deliver required capacity<br>2. Work commenced on new radiology staffing model for the identification of significant restructuring of the service with succession planning, career development, staff wellbeing etc.<br>3. Significant guidance and steer with National Imaging Programme workforce work.<br>4. Outsourcing of radiology reporting to maintain Welsh government turnaround times<br>5. Waiting list & capacity and demand management is in place to monitor radiology required resources. | 1. Replacement of Radiology Informatics System (RISP) – implementation underway go live planned for April 2025<br>2. Replacement of LINC (national pathology IT system) - Contract signed with current supplier plans to implement by September 2025 being progressed nationally<br>3. Radiology workforce model not suitable for meeting the current demands being placed on the service from both clinical activity and supporting activity required to deliver service e.g. governance, regulatory and accreditation requirements<br>4. Escalate to BCU Clinical Effectiveness Group – issues around failure to act. Procedure MD (Office of the Medical Director) 23 – 'Mitigation of the risk of failure to act on diagnostic results' needs updating which is being led by the Executive medical director.<br>5. PHW Collaborative Executive group.<br>6. Diagnostic Strategy for BCU needs to be developed<br>7. Radiology Information System Programme to go live 28.4.2025 |

| **Actions** | **Due Date** | **Progression Analysis** |
|---|---|---|
| Replacement of Radiology Informatics System (RISP) – implementation with anticipated go live date of the 14/04/2024. | 14/04/2025 | Progressing |
| Replacement of LINC (national pathology IT system) - Contract signed with current supplier plans to implement by September 2025 being progressed nationally | 30/09/2025 | Progressing |

| | | |
|---|---|---|
| Procedure MD23 (Mitigation of the risk of failure to act on diagnostic results) to be updated | 31/12/2025 | Progressing |
| Radiology workforce revised model to be developed by June 2025 | 30/06/2025 | Progressing |
| Diagnostic Strategy to be developed by diagnostic group | 30/09/2024 | Progressing |
| Review of Radiology Risks<br>Risk management team to do an external review of radiology risks with the radiology Senior Management Team | 18/09/2024 | New Action |
| Escalate failure to act risks to CEG | 31/03/2025 | New Action |




| | Impact | Likelihood | Score |
|---|---|---|---|
| Inherent Risk Rating | 5 | 5 | 25 |
| Current Risk Rating | 5 | 4 | 20 |
| Target Risk Score | 5 | 1 | 5 |
| Risk Appetite | Open | | 15-19 |

**Rationale for Corporate Risk**

Increasing demand for both radiology and pathology
Outdated IT infrastructure in both Radiology and Pathology that carry significant clinical and operational risks. – National programmes in place to resolve these issues
Additional work required to mitigate the risks from failure to act and update procedure MD23
Waiting lists longer than the national targets which results in delay in diagnosis which results in harm to patients. In addition, staffing stress related to demand in the service leading to burn out. 31st January 6,801 diagnostic waits over 8 weeks with Endoscopy (2,163) and Cardiology (1,552) being the largest. Endoscopy capacity at most risk as the insourcing into Wrexham stopped as of 1st April 2024.
Demand in radiology continues to increase.
MDT demand in terms of numbers of patients on an MDT is at unsafe levels.

| | |
|---|---|
| **Teitl adroddiad:**<br>***Report title:*** | Annual Quality Report 2023-24<br>*Incorporating the Annual PTR Report and Annual Duty of Candour Report* |
| **Adrodd i:**<br>***Report to:*** | QSE Committee |
| **Dyddiad y Cyfarfod:**<br>***Date of Meeting:*** | 24 October 2024 |
| **Crynodeb Gweithredol:**<br>***Executive Summary:*** | From April 2023, The Health and Social Care (Quality and Engagement) (Wales) Act 2020, requires NHS bodies to publish an annual report on the steps they have taken to comply with the duty of quality – **Annual Quality Report**.<br><br>The report must include an assessment of the extent of any improvement outcomes in the steps the Health Board have taken to improve the quality of the health services we provide.<br><br>Most importantly, the report must be meaningful to the Health Board, stakeholders and our population if we are to optimise learning, sharing and improvement opportunities.<br><br>The Health Board is also required under the same act, to report annually on compliance with the **Duty of Candour,** from April 2023. The Duty of Candour guidance recommends that this is included in the **Putting Things Right** Report which is published each year.<br><br>The NHS Wales Executive have provided support to the Health Board and other NHS bodies by providing some fundamental principles to be considered when developing the Annual Quality Report under the Duty of Quality.<br><br>In terms of what needs to be included within the report, the duty outlines the following:<br><br>• A look back at what has been achieved, including where things may not have gone well.<br>• A look forward about the organisations quality priorities and ambitions for the upcoming year, alongside how progress will be monitored.<br>• Describe what key strategic decisions have been taken, and how the duty of quality has informed these decisions.<br>• Describe the progress and challenges on our quality journey to our population and stakeholders, in a meaningful way<br>• Reflect the breadth of the domains of quality, quality enablers and quality management system.<br>• Develop a so-called ‘always on’ reporting mechanism (how we collate, monitor and make information about the quality of our services readily available to our population.<br>• Demonstrate the duty of quality decision-making, action taken following learning, quality improvement and ultimately, improved outcomes for the population.<br><br>**Discussion at Board on September 2024**<br><br>Following approval via the QSE Committee in August 2024, the report was received and discussed at Board in September 2024. The Board agreed that for the most, the report was complete, however required some amendments and agreed delegated authority to the QSE Committee for final approval ahead of publication on 31 October 2024.<br><br>The following are some of the points discussed at Board:<br><br>• Future Annual Quality Report to better align with the Health Boards Annual Report and Accounts and other key quality governance reports. This includes formatting. This will avoid duplication and ensure consistency across all reports. |

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

- Future Annual Quality Report to be approached using the Whole System Approach as the organisation matures and works within a Quality Management System.
- Future Annual Quality Report incorporate organisational culture, in particular in relation to candour.
- Future Annual Quality Report to include more context in terms of the volume of patient interactions.
- Reporting timeframes to be fed back to Welsh Government.
- Engagement required for sharing the report internally with staff.

Key changes made to the report, following Board:

- **Part 2, Foreword:** the revised foreword gives examples of specific challenges and improvements made over the past year, making reference to those key elements within the report for ease, whilst integrating the content of other key reports such as the Annual Report and Accounts 2023/24 and Three-Year Plan 2024-27.
- **Part 3, Looking Back:** very minor amendments to narrative from a Communications and Public Affairs perspective.
- **Part 4, Looking Forward:** very minor amendments to narrative from a Communications and Public Affairs perspective.

Key points for the QSE Committee to note:

- The Director of Corporate Governance and Executive Director of Nursing and Midwifery have supported and approved the above changes to the report.
- The Chair and Chief Executive have approved the above changes to the report.
- The Director of Corporate Governance has made arrangements for future annual quality reporting to be included within the Health Boards annual reporting planning process, ensuring future alignment to other key reports such as the Annual Report and Accounts which is a specific request within the Duty of Quality guidance.
- Publication date for the Annual Quality Report is 31 October 2024, and the report has been sent for external translation.

</td></tr>
<tr><td>Argymhellion:<br>Recommendations:</td><td colspan="4">The Committee is asked to approve this report and its contents in order to approve the Annual Quality Report 2023-24.</td></tr>
<tr><td>Arweinydd Gweithredol:<br>Executive Lead:</td><td colspan="4">Angela Wood, Executive Director of Nursing and Midwifery<br>Dr Nick Lyons, Executive Medical Director<br>Teresa Owen, Executive Director of AHPs and Health Science</td></tr>
<tr><td>Awdur yr Adroddiad:<br>Report Author:</td><td colspan="4">Matthew Joyes, Deputy Director of Quality<br>Erika Dennis, Lead Quality Manager<br>With contributions from across the Health Board</td></tr>
<tr><td>Pwrpas yr adroddiad:<br>Purpose of report:</td><td>I'w Nodi<br>For Noting<br>☐</td><td colspan="2">I Benderfynu arno<br>For Decision<br>☒</td><td>Am sicrwydd<br>For Assurance<br>☒</td></tr>
<tr><td>Lefel sicrwydd:<br>Assurance level:</td><td>Arwyddocaol<br>Significant<br>☐<br>Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol<br><br>High level of confidence/evidence in delivery of existing mechanisms/objectives</td><td>Derbyniol<br>Acceptable<br>☐<br>Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol<br><br>General confidence / evidence in delivery of existing mechanisms / objectives</td><td>Rhannol<br>Partial<br>☒<br>Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol<br><br>Some confidence / evidence in delivery of existing mechanisms / objectives</td><td>Dim Sicrwydd<br>No Assurance<br>☐<br>Dim hyder/ tystiolaeth o ran y ddarpariaeth<br><br>No confidence / evidence in delivery</td></tr>
</table>

| | |
|---|---|
| **Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:**<br>***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:**<br>***Link to Strategic Objective(s):*** | Outcome 4 - Improved access, outcomes and experience for citizens<br><br>Outcome 5 - Recognition of BCU as a learning and self-improving organisation |
| **Goblygiadau rheoleiddio a lleol:**<br>***Regulatory and legal implications:*** | The Duty of Quality is a statutory requirement under the Health and Social Care (Quality and Engagement) (Wales) Act 2020.<br><br>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.<br><br>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?**<br>***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?**<br>***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)**<br>***Details of risks associated with the subject and scope of this paper, including new risks( cross reference to the BAF and CRR)*** | BAF-SP18 and CRR-24-04 – Quality, Innovation and Improvement |
| **Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith***<br>***Financial implications as a result of implementing the recommendations*** | N/A |
| **Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith**<br>***Workforce implications as a result of implementing the recommendations*** | N/A |
| **Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori**<br>***Feedback, response, and follow up summary following consultation*** | N/A |
| **Cysylltiadau â risgiau BAF:**<br>(neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)<br>***Links to BAF risks:***<br>*(or links to the Corporate Risk Register)* | BAF-SP18 and CRR-24-04 – Quality, Innovation and Improvement |

| | |
|---|---|
| **Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)**<br>***Reason for submission of report to confidential board (where relevant)*** | Information intended for future publication |
| **Camau Nesaf: Gweithredu argymhellion**<br>***Next Steps: Implementation of recommendations***<br>N/A | |
| **Rhestr o Atodiadau:**<br>***List of Appendices:***<br>1. Annual Quality Report including the Annual PTR Report and Annual Duty of Candour Report | |

# ANNUAL QUALITY REPORT

2023 - 2024

**Final Draft – Version 0.7**

## Table of Contents

# PART 1 – INTRODUCTION TO BETSI CADWALADR UNIVERSITY HEALTH BOARD

## Introduction

Betsi Cadwaladr University Health Board (BCUHB), are committed to consistently deliver in line with its organisational values. It is the largest Health Board in Wales, with a budget of £1.87 billion and a workforce of over 19,000.

The organisation is responsible for the delivery of health care services to more than **700,000 people** across the six counties of north Wales (Anglesey, Gwynedd, Conwy, Denbighshire, Flintshire and Wrexham). The Health Board coordinates the work of **96 GP practices**, and NHS services provided by **78 dental and orthodontic practices**, **70 optometry practices** and opticians and **145 pharmacies** in North Wales.

This makes the Health Board a significant employer, healthcare provider, and a key player in many areas of partnership working.

In February 2023 the Health Board was escalated into **Special Measures** due to a number of concerns relating to delivery, organisational performance and governance. It has established a framework for delivery against the areas of concern and areas that are particularly relevant to Special Measures

In its **Annual Plan 2023/24**, the Health Board confirmed its approach to delivering its strategic priorities in respect of both Ministerial and local priorities along with our response to Special Measures, through seeking to stabilise and recover our delivery and performance. In March 2024, the Health Board published our 'One Year On' report which confirms the progress it has made so far and the organisations strategic objectives for 2024/25.

The Health Board will now bring the areas identified for improvement as part of Special Measures into its overall planning approach. This way of working ensures the organisation are embedding its learning and making best use of resources.

To achieve this, they have embedded the Special Measures response into the Health Boards **2024-27, 3 Year Plan**. This will ensure an integrated approach through a quality lens, helping to ensure it is quality driven in its decision making.

# PART 2 – FOREWORD FROM THE CHAIR AND CHIEF EXECUTIVE

We are pleased to present the Health Board's Annual Quality Report, the first time it has been published independently of our Annual Report.

The **quality and safety** of the services we provide to the people of North Wales is paramount. This report sets out the progress we have made over the last year in many different areas, including implementing plans to reduce long waiting lists, starting work on a new multi-million-pound orthopaedic centre in Llandudno and improved mental health services for our young people.

As detailed within **Part 4** of this report, over the last year we have reduced the number of people waiting 52 weeks for a first appointment by 45%; **vascular services** have received a positive external review by Health Inspectorate Wales leading it to be de-escalated; and we have introduced new ways of treating and diagnosing some cancers, including using artificial intelligence for breast and prostate cancers.

The Board approved our **Quality Management System (QMS)** earlier this year, which will guide our staff across the organisation to develop their quality management assessments and improvements. This tool will be used across the Health Board, with the initial focus to further improve our vascular and urology services. Further details can be found within **Part 3**.

QMS is not an additional layer of governance or bureaucracy, but is a set of principles through which we will look at our approach to quality at both an organisational and local level. It enhances, complements and strengthen our existing processes.

But we know that we still need to ensure that people get **timely access to health and well-being services**, particularly in some of those areas that currently have very long waits. We are determined to continue on our improvement journey in order to create the best outcomes for the people we serve. While we are making good progress in developing our **quality governance** process and systems, we are also dealing with serious legacy issues that must be addressed at pace. This includes cases highlighted by **HM Coroners** and the **Public Services Ombudsman for Wales** such as failure to act promptly with the complaints process, insufficient or ineffective strategic planning and support, the timeliness of investigations and the continued reliance on paper patient records.

We have completed the first phase of our **learning from investigations** programme which has informed the implementation of a new integrated policy for investigating incidents, complaints and mortality. It now incorporates patient or family involvement from the start and includes staff contributions throughout the process. Further detail is available within **Part 5** of this report.

Significant work has also been carried out to develop a business case for an electronic healthcare record for North Wales, enabling systems of care to be transformed and supporting staff to provide even more effective care. Resources have been aligned to key clinical services at the front line, providing extra support for those areas most in need.

**Board awareness** and consideration of the quality, safety and experience of services across the organisation has been improved with a report on quality at each meeting. A **citizen experience** report has also been introduced and is presented to board meetings on a quarterly basis, together with a patient experience story,

to give members a better insight into current issues and provides an opportunity for learning and development of patient centred services.

We have demonstrated **areas of improvement** during the year, with activity levels across nearly every aspect of our services building on improvements from last year and continuing to increase, and we have successfully delivered a number of key strategic projects, as outlined within **Part 3**.

We would not be able to do this without the **resilience, commitment and enthusiasm** of all our staff, which gives us encouragement and hope for the future.

Looking ahead, we will continue to **work alongside partners** including NHS colleagues such as the Welsh Ambulance Service, Welsh Government, local authorities and the third sector, to build on what we have achieved so far. We will build an effective organisation with a robust plan for long-lasting improvement, with quality at its heart, to ensure the **best possible outcomes and experience** for the people of North Wales.

You can find out more about our vision and how we will do this in our Three-Year Plan 2024-27. If you would like to know more about what we do as a Health Board, the care we provide, how we plan, deliver and improve your local healthcare services, along with our achievements and challenges, you can read about this in our Annual Report and Accounts 2023/24.

**DYFED EDWARDS**
Chair,
BCUHB

**CAROL SHILLABEER**
Chief Executive,
BCUHB

# PART 3 – A COMMITMENT TO IMPROVING QUALITY

The Health Board is making progress, working with staff to explore the best way of implementing a robust Quality Management System with which to support and assure quality-focused decision making. This approach to quality will lead to improved reliability, improvements in sustainability, better experience and improvement in clinical outcomes.

With quality becoming the strategy as opposed to being a component within the Health Board's strategy, this will drive how the organisation manages quality and delivers the needs of our people. It will also shape the future annual quality reporting through a more systematic and standardised way of working.

A key driver in the Health Boards commitment to becoming a quality-focused organisation is the implementation of the Duty of Quality across Wales. The Duty of Quality was introduced through the **Health and Social Care (Quality and Engagement) (Wales) Act 2020**.

The Duty of Quality came into force in April 2023 and places a responsibility on Welsh Ministers and NHS Wales bodies to ensure that when setting strategic plans, the Health Board do so through a quality lens. The duty of quality sets out the next steps in the organisations journey of quality improvement to achieve more open, transparent and learning services.

The Duty of Quality duty defines quality as '**Continuously, reliably, and sustainably meeting the needs of the population that we serve'**.

The overarching **aims** of the Duty of Quality are:

- Improved quality of health services
- Better outcomes for the population in Wales

There are **four key components** to the Duty of Quality;

1. Health and Care Quality Standards
2. Quality-driven decision making
3. Quality Management Systems
4. Quality reporting

By embedding and putting in place these components, it will enable the Health Board to plan, deliver, and monitor its services, whilst assessing the impact its decisions will have on the quality of the services the Health Board provide and optimise means of learning and improvement, enabling the organisation to deliver the best outcome and experience for patients, their families and carers.

## The Health Boards approach to the Duty of Quality

The NHS Wales Executive have supported and collaborated with NHS bodies across Wales since before the Duty of Quality came into force in April 2023, leading on a national approach to embed the Duty of Quality. The Duty of Quality Reference Group chaired by the Programme Director for the National Quality and Safety Programme, set out to inform the duty of quality workplan for 2023/2024 in collaboration with representatives from NHS bodies, Trusts, Special Health Authorities, and national partners.

Representatives from the Health Board attended the group up until its conclusion in March 2024 and continue to work in collaboration with quality and patient safety representatives of the NHS Wales Executive to drive forward implementation of the duty and approach to quality governance and quality management.

### What has been achieved so far?

- Duty of Quality awareness training is taking place across all levels the Health Board with an e-learning programme available on Electronic Staff Record (ESR) and Learning@Wales so that all NHS staff can access the learning.
- A Quality Impact Assessment (QIA) Toolkit has been developed to enable quality driven decision making. This includes the Health and Care Quality standards.
- An integrated approach to Planning is underway which will enable the Health Board to identify improvement areas, with specific focus on strategic planning based on the needs of its staff and population.
- The Health Board are taking a quality management approach to how it works. This work is running parallel to the review into Quality Governance Systems as part of special measures. The Quality Management System (QMS) for BCUHB was approved by the Board in May 2024. This will ensure that the Health Board takes a consistent and coordinated approach to quality, bringing together all information surrounding quality in the Health Board into one place.
- A Quality Dashboard has been developed which will provide a consistent way of reporting to the Board and to the public. This is key to the Health Board becoming a data intelligence led organisation.
- The Health Board's Quality Board Report has been refined to ensure a focus on quality when reporting, in line with the Duty of Quality.
- Board and committee templates include a section on regulatory and legal implications the Duty of Quality can be considered and help drive quality driven decision making by ensuring the committee and board are aware of any impact on the quality of our health services caused by any changes the Health Board make.
- The Quality Learning Framework is in development and will provide a systematic learning approach to quality governance and assurance. This will be integrated with the Quality Management Framework.

### What has challenged the Health Board?

The Health Board's special measures status has provided an opportunity to strengthen its infrastructure for quality, namely in relation to having an integrated approach, supported by compassionate leadership and culture, and informed by its staff and population as this provides clear direction for staff and stakeholders and allows the organisation to focus improvement on the areas which require it the most.

Special measures have also provided the Health Board with an opportunity to review its approach and refine its ways of working to improve the quality of care it provides and the experiences of patients, their families and carers.

Together with a change in leadership, the Health Boards revised approach as an organisation is laying the foundations of the organisation it wants to be and needs to be.

## Health and Care Quality Standards

The Duty of Quality requires NHS organisations in Wales to ensure that strategic decisions are made through a quality lens, ensuring that they, **"continuously, reliably, and sustainably meeting the needs of the population that we serve"**, by providing health services that are **safe**, **timely**, **effective**, **efficient**, **equitable** and **person-centred**.

To drive this, Welsh Ministers have withdrawn the Health and Care Standards (April 2015) and in 2023, introduced the new Health and Care Quality Standards which consist of the six quality domains above, and five enablers (**leadership**, **workforce**, **culture**, **information**, **learning improvement and research** and **whole systems approach**).


*Figure 1: The 12 Health and Care Quality Standards*

- The quality domains and enablers set the high level of standards that people in Wales can expect when they access health services.
- They will drive quality driven decision making and help to plan, deliver and monitor its health care services.
- They also provide a framework for quality management as it connects the duty, the standards, and the wider quality management process.

## Quality-driven decision making

Moving forward, the Health Board will be taking the Health and Care Quality Standards into account when making decisions about healthcare services. It will do this by ensuring that they are embedded into the Health Boards integrated planning process to help it plan using these standards to guide. They will also be used by services when setting out their local delivery plans as part of the Health Boards annual planning process.

Furthermore, through the work of the Quality Management System, the Health Board will embed the standards into our ways of working across all levels of the organisation, supporting it to assess quality and safety, enabling it to identify areas for improvement.

### Quality Impact Assessment (QIA)

To drive quality driven decision making at a corporate and operational level, the Health Board will use a QIA as a mechanism through which it can consider and record the impact of its decisions on the quality of healthcare services. This approach will:

- Inform strategic quality-driven decision-making.
- Identify and assess the effect or influence of a proposal on the quality and safety of the healthcare system, in line with the Health and Care Quality Standards.
- Identify any actions needed to reduce risks where quality or safety could be negatively affected, and to ensure these risks and mitigations feed into existing corporate monitoring processes.
- Provide assurance of quality-driven decision-making, together with audit trail.

## Quality Management System (QMS)

Delivery of high quality care requires the Health Board to have a consistent and coordinated approach to managing quality that is applied from team through to Board level. This is known as a **Quality Management System (QMS)**.

The Board is working with the Institute of Healthcare Improvement and Improvement Cymru in developing a strong understanding of quality systems in healthcare. The Board approved the Quality Management System (Framework) in May 2024, testing, building and refining the system thereafter. Learning from other organisations in the UK and internationally is supporting this work.

The QMS model being developed in the Health Board **(Figure 1),** adopts the four domains of quality management, as equal and aligned priorities.

Central to the QMS model is the commitment to being **a learning, self-improving, data led organisation that serves the people of North Wales.**

The QMS model is not an additional layer of governance or reporting, but rather a set of principles through which the Health Board will look at its approach to quality at an organisational and local level. It enhances, compliments and helps strengthen further existing governance.


*Figure 2:* Diagram to demonstrate the connectivity between the four components of a Quality Management System

Effective quality management systems used iteratively, should lead to a variety of benefits for those who access services as well as those who deliver services.

**It will help the Health Board to:**

- develop processes to help services understand their priorities for improvement;
- design appropriate interventions to make those improvements;
- develop processes to help maintain acceptable levels of quality and early warning to highlight when quality slips; and
- build knowledge and accelerate improvement in outcomes.

**This will support every member of staff, from service to board level, to feel confident:**

- that they understand what is important to those who use their services;
- that they are supported and connected to deliver high-quality services;
- that they have access to relevant data to enable them to know when they are doing well and to know quickly if quality slips; and
- that they are supported to deliver high quality services and improve those services every day.

## Quality Reporting

Sharing information about the quality of services with our population is important to the Health Board, and it is also an expectation within the duty of quality.

The concept of **'Always on' quality reporting** has been developed to help achieve the organisations quality reporting obligations. 'Always on' means routinely collecting, analysing, monitoring and making information about the quality of services readily available.


*Figure 3: 'Always On' Quality Reporting*

It promotes openness and transparency with our population and stakeholders.

It is important that staff routinely make use of quality-related information and measures too. This ensures Health Board staff are data-driven in their activities to improve service quality.

**How the Health Board will monitor the quality of its services**

- Existing performance, outcome and delivery indicators and measures
- Patient Reported Outcome Measures and Patient Experience Measures (PROMS and PREMS)
- Mortality measures
- Incidents, compliments and concerns
- Patient and staff stories
- Reports following external reviews or inspections by inspectorate and licensing bodies

**How the Health Board will know improvements have been made**

- Self-Assessment
- Peer Review and feedback
- National Clinical Audit
- Internal Audit
- External reviews, for example, Wales Audit Office Inspections, for example, Healthcare Inspectorate Wales

### Quality Dashboard

The development of the Quality Dashboard is key to 'Always on' reporting and informing the population of the organisations performance in terms of how well we are doing and the areas we need to improve. The dashboard on how we are performing on key quality areas such as;

- Patient Feedback
- Complaints
- Patient Safety Incidents
- Health Acquired Pressure Ulcers (HAPUs)
- Infection rates
- Safe Care Compliance
- Staffing

The dashboard will at a glance provide data relating to key metrics aligned with the Integrated Performance Framework, and will support staff with analysing workforce metrics, safe care compliance, and safe care red flags. The Integrated Performance Framework will provide core quality data for regular reporting across the Health Board, ensuring consistency and triangulation, helping to increase assurance levels for future.

Angela Wood, Executive Director of Nursing and Midwifery, is the senior responsible officer for the programme. Angela said: *"The dashboard will help all our staff across North Wales be able to quickly and efficiently access a range of data relating to quality issues.*

*"By bringing together data in one place, staff will be able to see at a glance their performance, and also be able to drill-down into data where needed as well. A lot of work is going into helping make it easier to access this information and act on it, with a real focus on supporting colleagues to make the changes and improvements they want to make."*

*Figure 4: Angela Wood, Executive Director of Nursing and Midwifery, BCUHB*

# PART 4 – LOOKING BACK AT 2023-24

## Special Measures

It is never good for any public body to be placed in Special Measures, but it has helped focus our efforts on elements of our service that need improvement.

The Health Board has already seen improvements and patients are being treated sooner in a number of areas. For example, the number of people waiting more than 52 weeks for a first appointment has been reduced by 45% and those waiting over 104 weeks has been reduced by 37%.

Vascular services have been de-escalated by Health Inspectorate Wales and received a positive external review. Welsh Government has approved our plans for a multi-million-pound orthopaedic centre in Llandudno that will treat an additional 1,900 patients a year when it's operational in 2025.

The Health Board now have a full complement of Independent Board Members who can ensure scrutiny of our services through our sub committees. The Health Board is investing in our staff and are encouraging a positive working culture that is open and transparent so that everyone can share their thoughts and ideas to improve the patient experience.

We have made progress over the last year but we still have some way to go. Improving our services so that we exit special measures is important, but even more important is ensuring that all the services we provide are the best for the people of North Wales.

## Outcome 1 - A well-functioning Board

In the Structured Assessment 2023 report, Audit Wales point to the improvements made in governance and outline the need to further strengthen board transparency and effectiveness, corporate systems of assurance, approach to planning and managing financial resources. The findings of the Structured Assessment are also informed by the *Audit Wales Board Effectiveness Follow Up Review 2023.* The Health Board agrees fully with the Board Effectiveness report's key findings that the Board is more stable, with stronger leadership and engagement evident and as such that there has been significant improvement during 2023/24. However, there is much more to do to improve the Health Board's governance. These reports indicate that significant improvements need to be made before an assessment of reasonable assurance on the effectiveness of internal controls can be made.

A Board Development Programme has been developed and is being implemented, including focus on areas such as:

- Compassionate Leadership
- Mental Health
- Planning

- Performance management
- Risk management
- Digital
- Quality
- Winter Resilience Planning

**Achievements so far:**

- Substantive, experienced Chief Executive appointed, with experience in NHS Wales.
- Recruitment of Chair, Vice Chair and permanent Independent Members following a public appointments process.
- New Risk Management Framework agreed at the September Board, with implementation underway and reporting to the Audit Committee.
- The independent reviews received to date have been considered in Board Committee Development Sessions, prior to management responses being developed. These have been highlighted in the regular Special Measures reports to full Board.
- Good progress made within corporate governance arrangements including Board Committee structures and cycle of business, with appointment made to the revised role of Director of Corporate Governance.

The Health Board welcomed Audit Wales latest report (15 February 2024) which states that, compared with a year ago, the Board is in a more stable position and working relationships amongst senior leaders are more positive.

*Figure 5: Dyfed Edwards, Chair, BCUHB*

Dyfed Edwards, Chair, said: "I welcome this report which acknowledges the progress the health board has made over the past year. I fully understand that there is much more to be done as we continue on our improvement journey in order to ensure excellent healthcare services for the people of north Wales."

"I see the Audit Wales report as a milestone to show we are moving in the right direction. We now have a firm foundation to build on, with a new Chief Executive and new Board members in place who are committed to improving our governance, our financial management and ultimately improving our focus on quality and the experience of the patient and their families.

"I am grateful for the support of our partners and Government in all our efforts."

**Areas to stay focused on in 2024/25:**

- Implementation of the Executive Portfolio plan has commenced, but will necessarily continue in FY24/25.
- Now that the Health Board have a full complement of Independent Members, it will start the new financial year in a more stable position to progress work on corporate governance, establish the Corporate Business Management Group and fully implement any new policies and improvements.
- A "Policy on Policies" will then be taken through the necessary governance to outline best practice standards for the development of and adherence to policies across the Health Board.

## Outcome 2 – A clear deliverable plan for 2023/24

The requirements within this outcome seek to improve the ability of the organisation to develop capability in planning, recognising the Health Board has been unable to develop an approvable 3 Year Integrated Medium-Term Plan since the requirement was established. Furthermore, this outcome is focused on improving financial governance and performance.

**Achievements so far:**

- Annual Plan (2023/24) developed and submitted to Welsh Government at the end of June 2023. Positive feedback received on this and it provides the platform for moving toward a 3-year plan approach for 2024/27.
- A new Integrated Planning Framework developed, approved by Board and implementation commenced.
- Integrated Performance Framework developed, approved at the September Board, with implementation commenced.
- The Independent Planning Review approved with progress reported through the Health Board Committee structure
- The Independent Contract and Procurement Management Review was received and good progress against the recommendations has been reported through the Audit Committee.
- Financial Control Actions have progressed well, with the Standing Financial Instructions (SFIs), Scheme of Reservation and Delegation (SORDs) and Standing Orders (SOs) revised and endorsed by Board.
- Targeted Procurement training delivered to over 500 BCU staff at different levels, including the Executive Team.

**Areas to stay focused on in 2024/25:**

- More work to fully underpin financial challenges and opportunities for the year ahead as well as delivery of the Financial Plan, taking Special Measures and 3 Year Plan priorities into account.
- Responding to the Planning Review and fully implementing the associated action plan.
- Recurrent finance staffing requirements and ongoing permanent recruitment processes.

## Outcome 3 – stronger leadership and engagement

This outcome focuses on improving the stability of leadership in the organisation as well as enabling more effective engagement and involvement with staff internally and stakeholders and communities externally.

The organisation must focus on improving the culture and the way leaders are attracted, identified, developed and retained. Improvements must also be made to the way the Health Board engages and involves communities, staff and stakeholders. The Health Board is committed to strong, visible leadership internally and externally, including with the media and public, to re-build trust in the services BCUHB provides.

**Achievements so far:**

- The Board approved in September 2023 its Strategic Intent in relation to developing Culture, Leadership and Engagement, agreeing nine key areas of initial focus.
- A new Organisational Development Steering Group has been established to lead the work, chaired by the Chief Executive. A new People and Culture (Board) Committee has been formed, chaired by the Chair of the Health Board.
- Developing transparent, strong, and visible leadership specifically on key issues, e.g., Health and Social Care Committee and media interviews.
- A new approach to the Annual General Meeting has been developed and implemented, including Health Fayres held in local community centres, enabling conversations between the Health Board and local communities.
- Three community engagement events held during quarter four in 2023/24, testing and refining the approach for further events across the region during 2024.
- New Integrated Leadership Development Framework in its final stages of development for implementation from March 2024 onward.
- Draft 'Listening to Patients, Families and Communities' Report received from the Independent Advisor, with findings and recommendations currently being considered. A new engagement approach taken with those affected by vascular service issues.
- Clinical Engagement Rapid Review completed, considered by the Executive Team and Organisational Development Steering Group ahead of consideration by the People and Culture Committee.
- A series of Leadership Conferences is being implemented. Following a whole day, whole Board session on Compassionate Leadership, a health board-wide conference has been held focusing on compassionate leadership and culture, with sessions from experts Michael West and Henry Engelhardt.
- There is significant reduction in the usage of high-cost agency interim staff from 41 in December 2022 to 2 by the end of February 2023.

**Areas to stay focused on in 2024/25:**

- There is a need to complete a full stocktake of the Operating Model, utilising the work of Internal Audit, feedback from external colleagues/stakeholders and feedback from colleagues internally to understand the benefits and issues.
- An Integrated Leadership Development Framework: This is still in development and having executive ownership of the framework will be key to ensuring any culture change is truly embedded.
- Revisiting and revising where necessary, the values of the organisation: Having clear, defined values that are known and practised by all staff is a well-recognised feature of successful organisations.

- A behaviours framework: Having an agreed and co-designed behaviours framework, owned by the Board, outlining what kind of organisation it wants and needs to be.
- A full Organisational Development plan: Work has begun via an Organisational Development Steering Group, which has been established and has begun to discuss the approach and way forward. It will be accelerated for 2024/25 with a focus also on Clinical Engagement and Leadership.
- Expand the use of patient experience feedback as a vital insight into services and way of identifying opportunities for improvements.
- Culture Change Programme: Putting the right foundations in place for a positive, supportive culture, taking NHS Wales Staff Survey feedback into account.

## Outcome 4 – Improved access, outcomes and experience for citizens

This outcome is the area that is likely to impact patients and clients most directly, and not dissimilar to other NHS organisations is where significant service pressure exists. There are however specific issues relating to North Wales services that require both short and longer-term action.

People are frustrated about the amount of time they have to wait for appointments. There are too many people experiencing difficulty accessing a GP or an NHS dentist and too many are waiting long periods for hospital appointments and important diagnostic tests.

### Achievements so far:

- **Planned care**: A new Planned Care Programme has been established to take forward systematic improvements. These include streamlining and standardising the approach to booking and scheduling, implementing the Getting It Right First Time (GIRFT) findings and recommendations across several clinical service areas, and implementing developments such as 'See On Symptoms', 'Patient Initiated Follow-up' and the 3Ps 'Promote, Prevent and Prepare' assisting people awaiting their planned care intervention.
- Progress has been made across a range of indicators in relation to planned care waiting times, including a 19% reduction in people waiting 208 weeks to begin treatment, a 63% reduction in people waiting over 156 weeks to have their first appointment or to have started treatment and a 21% reduction in people waiting 104 weeks in comparison with the position last year.
- **Vascular**: Following their review in June 2023, Healthcare Inspectorate Wales de-escalated the service from a 'Service of Concern'. Two further elements of review are currently in process. The first of these is a review by the National network which is reported positive results; the second is in the process of being finalised.
- **Dermatology**: This is a significantly challenged service as a result of workforce gaps. However, a plan to resolve immediate issues is being implemented with service modelling for a sustainable solution commenced. A new teledermoscopy service approach has been approved and funded by the Welsh Government.
- **Urology:** This service is under pressure due to workforce challenges and service configuration issues. A GIRFT review and Royal College Review has been received and a plan for the short term is in place. Longer-term service planning will be required for this specialty.
- **Mental Health:** Several key elements of work have been undertaken including:
    - **Inpatient Quality and Safety Review**: An initial review of Mental Health inpatient safety took place in spring 2023 and an action plan implemented as a result. A follow-up review has been carried out to observe and evidence where improvements have been made and sustained.

In addition, the views and experience of those not represented in the first review, e.g., ward staff, service users and carers, as well as those who previously participated, have been asked their perceptions of progress or areas of concern.

- **'Review of Reviews'**: The Royal College of Psychiatrists has undertaken a look-back across several reviews dating back some 10 years to understand where progress has been made.
- Performance in relation to access to Mental Health services continues to show an overall positive position. The new '111 press 2' service is now provided over a 24-hour period, providing immediate access to mental health support. This service is being well-utilised and has now formed a core element of provision across the region.

- **Urgent and Emergency care:** Improvement work at Emergency Departments as well as further into the hospitals is taking place, with the continuing development of Same Day Emergency Care for example. In relation to four-hour ambulance handover delays, some improvement had been achieved. However, it was impacted by winter pressures and further improvement is still required. The Board dedicated a session in its development programme to urgent and emergency care and did a 'walk-through' of the hospital patient pathway at Ysbyty Gwynedd in October, prior to considering the Winter Resilience Plan at the Board meeting in November.
- **Oncology**: Key Oncology staffing appointments have been made to be able to treat more people within BCUHB and joint opportunities are being explored with Bangor University.
- **Plastics**: An initial review of dermatology patients completed with a contract in place with St Helens & Knowsley Teaching Hospital NHS Trust and a consistent partnership clinical model and data sharing model operating across BCUHB

**Areas to stay focused on in 2024/25:**

- Detailed Demand and Capacity modelling which is key to establishing and ensuring robust service models and making sustainable improvements. Delayed as dependent on external support.
- Further stabilising the Health Boards "challenged" services, particularly in Dermatology where waiting times are reducing but there is further work required to strengthen the service and manage the timely treatment of skin cancer.
- There is a need to further stabilise and reduce delays in urgent and emergency care, much of which requires working with partners on whole system solutions.
- Adoption of actions as outlined in the Urgent Primary Care Review which assessed the effectiveness of Urgent Primary Care Centres, taking into account learning from across BCUHB and Wales.
- Implementation of the Integrated Urgent and Emergency Care (6 Goals) Plan: Continuing to work with the support of the national programme on local implementations to make a long-term sustainable difference.

## Outcome 5 – Recognition of BCU as a learning and self-improving organisation

It is essential in building an effective organisation that can implement long lasting change, that a focus on learning and mechanisms that support improvement are embedded. This outcome therefore draws in elements that will enable the organisation to identify issues and areas for improvement earlier and build capacity and capability to itself make changes without a heavy reliance on external support.

The Health Board is determined to learn from its experiences and are developing better ways to use all feedback, information (data) and insight available to continually improve - both now and in the future.

**Achievements so far:**

- Significant work has been undertaken to develop a business case to invest in an Electronic Healthcare Record for North Wales. This would enable systems of care to be transformed, supporting staff to provide safer, more effective care. Discussions are underway with Welsh Government and Digital Health and Care Wales in relation to progressing this case to the next stage.
- Transformation and Improvement resource has been aligned to key areas of focus at the front line, providing extra support to those areas most in need.
- A Learning Organisation Framework is being developed to support the culture, system and process of learning.
- An Investigations and Learning Programme has been established to review retrospectively the standards and effectiveness of investigations relating to clinical care within the organisation. The Programme focuses on the quality of action planning and the evidence that embedded learning has taken place.
- Training and guidance provided in the use of Information products through a series of sessions to support capability in becoming an intelligence led organisation.
- The Public Health Directorate started a project on transforming diabetes services across North Wales using healthcare public health principles.

**Areas to stay focused on 2024/25:**

- A central and digital learning repository and cascade system prototype developed, based on Office 365: It was agreed that this would be developed as a method of learning from incidents, using consistent datasets that facilitate shared learning, benchmarking and measurement of progress.

# PART 5 - LOOKING FORWARD AT 2024-25

## Future plans for 2024/25

**Over the next 12 months** the Health Board will continue to work alongside partners and the Welsh Government to focus on how it can ensure its approach continues. The Board wants to build **an effective organisation**, with a robust plan for long-lasting change which is quality driven so that as an organisation, it can truly improve the outcomes and experience for the population of North Wales.

Preparation for the financial year 2024/25 is close to completion with the **Special Measures plan** being incorporated within the Health Board's Three Year Plan 2024-27. Given that there will be considerable overlap between the requirements for improvement outlined within Special Measures and the priorities included in the 2024-27 plan, this allows a more **streamlined and efficient planning and oversight approach** going forward.

The Health Board's approach to Special Measures gave significant focus and pace and will be built upon to enable longer term planning. Ensuring that the specific focus areas are fully embedded into the Three-Year Plan and reflecting the more stable position the Board is now in, the main focus will be on 'business as usual' planning processes, incorporating all learning to provide integrated monitoring, assurance and reporting against plans.

The focus over the last nine months has been on **'stabilisation'**, making the most significant and immediate changes necessary after the escalation into Special Measures to continue to provide services to the residents of North Wales.

During 2024-2027 the Health Board will build upon this to implement an approach that both ensures an approach to service delivery in North Wales that is more **'standardised'**, making the changes needed to place the Health Board on a 'sustainable' footing for the future.

During the last year the Health Board has started to progress in a number of areas and although there are still many challenges, there is a commitment to taking the learning from the processes introduced to ensure that BCUHB is an organisation that can proactively plan, identify risks and challenges, and put in place necessary actions to address them.

Embedding the Special Measures response into the **Three-Year Plan** will enable the organisation to move through each of the phases outlined above and to make real and lasting improvements to services. Working with the Health Board's partners across the whole system, along with continued Welsh Government support, will ensure the organisation is sustainably set up for success in the future.

## 5 Strategic Objectives

During 2023-24 the Health Board has continued to progress through its objectives against the Special Measures Framework. As the year has progressed this has coalesced around five main areas where improvement was most necessary. Recognising the need to **prioritise improvements** in the areas that led to Special Measures, the core of the Health Board 2024-27 Plan builds further upon those **five objective areas**:


*Figure 6: Betsi Cadwaladr University Health Board Three Year Plan 2023-27, 5 Strategic Objectives, 2023.*

Many of the priorities will be delivered substantially or in full during year one, whilst other priorities will take longer to implement over the three year period building upon the priorities implemented earlier. This sequencing is important to successfully deliver the necessary change in a coordinated way that recognises the co-dependencies of priorities.

### Design Principles

Organisational Design Principles will be used to inform the **designing** and **aligning** of the strategic vision, goals, capabilities, processes of the organisation. The use of design principles will provide simple clarity to improve effectiveness, efficiency, quality, and innovation. This approach will also incrementally move the

Health Board towards a **common direction**, as well as provide assurance in terms of best use of public finances. The Health Board has commenced the drafting of Design Principles but there is further work to do to engage, discuss and refine those before finalising them. The principles will contribute as a route map to help focus and inform improvement activity.

## Driving a quality-focused approach

Every day across North Wales people receive high quality care. However, there are occasions when this care does not meet the standard patients expect or deserve. A key part of the Health Board's plans to deliver sustainable improvement throughout its services will be the development of a new **Quality Management System (QMS)**. This system will support the organisation's **commitment to being a learning, self-improving, data-led organisation**. Work has already taken place with experts nationally and internationally, as well as with healthcare professionals in North Wales, to start developing this. By effectively developing services and continually monitoring performance at the point where care is delivered, as well as outcomes, the system will provide real-time quality control and assurance. The QMS will anticipate where a service needs improvement so support can be provided before significant issues arise rather than reactively when harm may already have been caused.

The QMS tool will initially be used to support Clinical Areas of Concern within the special measures framework. The first two services to adopt this approach will be vascular and urology, two services that have quality issues that are well recognised and are on different stages of the development journey.

## A Learning and Improving Organisation


Robustly investigating significant events, and then ensuring widespread learning will reduce the number of future significant events that arise. Key to the Health Board achieving this is the recent launch of an **Integrated Concerns** Policy. This new integrated approach to concerns management which was launched on 01 September 2024, provides a more coordinated approach to how the organisation manages responses to incidents, complaints and mortality reviews.

The policy introduces a daily virtual Concerns Hub, where services will meet to share learning, insights and information on investigations along with new resources to support staff engaged in the investigations process which brings together all resources needed to help staff work through the steps outlined in the Integrated Concerns Policy.

The Health Board have also developed a **Learning Repository** which is a knowledge management system that enables healthcare professionals to access, share, and learn from data and insights related to patient safety incidents. The system integrates data from various sources and supports collaborative learning.

The main objective of the Learning Repository is to **improve patient safety** by facilitating **organisational learning** from past incidents and best practices. The system aims to reduce the recurrence of adverse events,

enhance the quality of care, and foster a culture of safety and innovation. The system is designed to meet the needs and expectations of various stakeholders, such as clinicians, managers, educators, researchers, and regulators, who have different roles and responsibilities in relation to patient safety.

The Health Board continues to drive improvement on clinical outcomes through its Clinical Effectiveness activities. Clinical Audit is a good example of this. Clinical audit enables the Health Board to determine if the care provided is being delivered in line with standards and best practice. During 2023-24, the Health Board engaged with 27 out of 38 projects from the **National Clinical Audit and Patient Outcomes Programme (NCAPOP)** which is key to the Health Board benchmarking its compliance and performance, using the findings to identify necessary improvements for patients. The outcome of the programme reported that the Health Boards performance was 48% at or above the benchmark in 75% or more of Key Performance Indicators (KPIs).

The Health Boards **Clinical Audit Annual Report 2023-24** provides an overview of clinical audit activity across the organisation and confirms the recommendations and key priorities for 2024-25. The Clinical Effectiveness Group (CEG) which is the clinical governance oversight for clinical effectiveness, has the role of providing assurance in relation to clinical audit arrangements, mortality reviews and NICE guidance and will have oversight of the priorities within the report.

## Research, Development and Innovation

The Health Board has an established **Research, Development and Innovation programme** that continues to grow. This provides opportunities for academic development of current staff, retention of research-focused new staff, and offers opportunities for residents of North Wales to access research and innovative treatments options within their care.

Significant activities are underway, working with academic, commercial and third sector partners to **lead and deliver high quality research** including the North Wales Clinical Research Facility (CRF), providing a space where early phase clinical trials can be conducted in a safe and regulated way that to date with over 700 citations in high impact journals. The Health Board has 316 research studies open to recruitment; or in follow up. Of these, 208 are portfolio studies, and 108 are non-portfolio studies. Each study has a named Principal Investigator (PI) from the Health Board; with the Health Board's Chief Investigator (CI) leading 41 of these.

# PART 6 - COMMUNICATION, ENGAGEMENT AND PATIENT EXPERIENCE

**Listening** to and understanding the **experiences** of the citizens of North Wales is essential to improving how the Health Board design and deliver care and services. Gathering **insight** enables the organisation to understand the issues that matter to our population. The Health Board are determined to make sustained improvements and its staff and the citizens of North Wales are increasingly coming together to solve ongoing issues.

Improving public confidence is another area the Health Board are working hard to achieve. It is working hard to increase visibility and to strengthen its connections with our population and stakeholders to restore confidence that the Health Board listens to communities when setting out its priorities and making key decisions is vital in helping to create an environment for mature discussion and involvement. This includes explaining why it makes certain decisions and being open with people who want to question or disagree with those decisions.

By doing this the Health Board will go some way to promoting trust, accountability and equality, leading to increased public engagement and enhancing its reputation.

## The Health Boards approach to communication, engagement and patient experience

### Engagement Exercise's

Starting in January 2024, the Health Board has been rolling out an **engagement programme,** holding events across counties with the aim of:

- **Increasing the visibility** of Board Members, Executives and senior leaders to listen and connect with the public,
- **Provide opportunities** to hear from communities about what they feel works well in health care, what could be better and what the Health Board should prioritise in the coming months and years.
- **Discuss and promote** good practice and examples of how the Health Board is responding to local health concerns and;
- **Be creative and innovative** in the Health Board's approach to engaging and involving the public.

The format of the events has been to create an inclusive session, focusing on local, regional or national topics of interest. These events are an opportunity for the public to meet and engage with Board Members and Health Board leaders through informal conversations. The engagement events aim to be interactive and enjoyable.

### Bite Sized Health Events

The Bite Sized Health Events are part of the Welsh Governments *A Healthier Wales* agenda to bring care closer to home, where the Health Board can team up with businesses and organisations to bring health advice and guidance direct to North Wales residents in their place of work and also out in the Community.
Bite Sized Health is a collaboration between the Health Board's Public Engagement Team, its services, and partner organisations, working together to improve access to information and promote preventative Health and Wellbeing.

Bite Sized Health sessions provide support and information including:

- Blood pressure checks
- Mental health and wellbeing
- Health screening
- Smoking cessation
- Alcohol and substance misuse
- Carers information
- Active lifestyle
- Liver Health
- Healthy eating


*Figure 7: Bite Sized Health, BCUHB, 2023.*

### BCUHB Engagement Group

On 27th February 2023, the Minister for Health and Social Services announced that she was escalating the intervention status of the Health Board to special measures with immediate effect. The Special Measures 2023 Operating Framework identifies eight areas of concern one of which specifically mentions patient experience in its links with clinical governance and safety.

In the current situation for the Health Board, meaningful engagement, strong relationships, partnerships and communication are at the heart of building trust and confidence in the quality of care and services, and intrinsic to their journey of improvement and developing care to meet the needs of its population. In order to deliver a **sustainable**, **responsive, learning and improving** organisation, effective and meaningful engagement and communication must be embedded throughout its practice, the strategic approach, the way it delivers improvement and transformation and how it plans service design.

In order to improve and develop engagement, communication and patient experience, the Health Board have formulated the BCUHB Engagement Group who will specifically undertake the work required to meet the objectives of the special measures work. This will be done through two phases:

### Phase 1 - Internal engagement review

The purpose of the review is to learn more about the range of engagement undertaken by Health Board services, the impact their engagement has made and what help is needed to deliver effective and meaningful engagement in the future.

### Phase 2 - External engagement

Delivery of a comprehensive engagement programme with partners, public and patients to help inform and shape the Health Board's improved approach to engagement. The scope of engagement phase will be on understanding how:

- The Health Board listens to and provides opportunities for people to influence and get involved in shaping services, priorities and plans
- Engagement and insight supports learning and best practice
- Engagement and patient experience is embedded widely across the Health Board to inform service improvement, safety and quality

- Intelligence & insight from engagement is systematic collected, triangulated & analysed
- Themes and issues are identified and support the shaping of Health Board priorities plans and improvements.

Whilst it is important the Health Board adopts meaningful and inclusive approaches when it engages, such as that it follows the National Principles for Public Engagement in Wales, the key focus of this engagement programme is on improving how it listens and learns from engagement, embed the importance of engagement across the organisation and analyse feedback and insight more effectively.

### Partnerships, Engagement and Communications (PEC)


*Figure 8: Partnership, Engagement and Communications Team, BCUHB, 2023.*

The PEC function was created in late 2021. It **brings together engagement**, **communications**, and has established a new **public affairs and partnership function**. The Health Board has been exploring opportunities for strengthening some activities and partnerships so that the function is better placed to achieve meaningful engagement by:

- Re-setting the PEC senior leadership team and becoming more focused on building stronger connections across the functions
- Re-casting its approach so that the Health Board are working together in a planned and co-ordinated way
- Re-focused to become more of a listening function
- Re-claimed its organisational narrative

The function's core activities are split into four areas;

- Strategic Engagement
- Digital Engagement
- Stakeholder Relationships
- Strategic Communications

Together, the function listens to patients, carers, families, citizens, communities and partners. It triangulates themes and enables the organisation to act on their feedback and have an ongoing dialogue and relationship with the people of North Wales.

### Independent Review: Listening to citizens, patients, staff and partners.

During 2023, Cath Broderick who is an independent consultant in Patient and Public engagement, communication, consultation and facilitation, undertook a review as part of the Health Board's Special Measures Framework which recognises the importance of meaningful engagement, strong relationships, partnerships & communication.

The review specifically focused on **the role and effectiveness of engagement and involvement at the Health Board,** and following the review, a range of recommendations have been made to the Health Board for which updates on progress are regularly provided to the Board. Some of the outcomes of the review include:

- The need to build a joined up, sustainable system to listen to patients, carers, families, citizens, communities, staff and partners.
- Build better strategic partnerships & conversations with our communities.
- Develop a central resource & database of all engagement, experience and insight activity and methodology.
- Assess the efficacy and impact of patient experience, engagement and coproduction, on quality and safety of care, including pan organisational and specialist services.
- Have one operational framework for coordinated cohesive experience, engagement and insight.
- Build on the strengths of the PEC team with opportunities of joint working across teams.
- Review and develop the role of the Patient Advice and Liaison Service (PALS).
- Ensure the Board have knowledge of emerging themes, risk factors and patient safety issues.
- Review the infrastructure for the lay voice in the Health Board's scrutiny approach.

The **BCUHB Engagement Group** are leading on this work in **co-production with Llais Wales** who are the national independent body set up by Welsh Government to give the people of Wales a stronger voice in their health and social care services. The BCUHB Engagement Group report on the progress against the recommendations made by Cath Broderick, to the Planning, Population Health and Partnerships Committee.

### NHS Wales People's Experience Framework (2024)

In addition to the above, the Health Board is preparing for the introduction of the NHS Wales People's Experience Framework (2024), to replace the current Framework for Assuring Service User Experience (2018).

**'People's experience'** can be described as how people feel when utilising any services and programmes offered by NHS in Wales. Whether it be in a hospital ward, outpatient appointment, participation in national screening programs, engagement with primary care services (such as GP, Optometrist, Pharmacist, Dentist), interaction with health promotion practitioners, or attendance at any event hosted by an NHS Wales organisation.

The People's Experience Framework aligns with the Health and Social Care (Quality and Engagement) (Wales) Act 2020 (Duty of Quality and the Duty of Candour), the National Health Service (Concerns, Complaints, and Redress Arrangements) (Wales) Regulations 2011, the Public Services Ombudsman (Wales) Act 2019, the Well-being of Future Generations (Wales) Act 2015, the Equality Act 2010, and the Socio-economic Duty. **Listening and learning from people's experiences is an integral element of these regulations.**

The People's Experience Framework will introduce a self-assessment maturity matrix, empowering Health Boards to evaluate their current position and to develop an ambitious improvement plan to improve patient experience, covering the following areas:

- Complaints
- Compliments
- Patient stories
- Incidents
- National and Local Peoples experience surveys

- Peoples Experiences (Patient Reported Experience Measures/People's Experience Surveys)
- Staff experiences.

The **triangulation of experience feedback data** alongside other metrics is indicative of an organisation committed to **quality**. The framework will encompass all services provided by NHS Wales's organisations, including commissioned services. As part of the new framework, quality and experience indicators must be integrated into all commissioned services arrangements and the data gathered used as part of contractual monitoring and compliance.

In addition, a revised set of nationally Patient Reported Experience Measure questions and national surveys will be launched. As a Health Board it will have a duty to ensure:

- All people accessing the organisations services have the ability to provide anonymous feedback quickly and easily when they want to.
- People's feedback should be used to celebrate and build on what is working well, and to identify areas where improvements could be made.
- People's experience feedback should be made readily available to the public in an accessible format.
- Information should demonstrate that feedback is being listened to and acted upon, e.g. 'You said, We did'.

Patient stories help the Health Board to understand what works well and how we can improve patient care and experience. Listening to patient stories, whether good or bad, enables the Health Board to identify ways that it can continue to improve services for patients, families and carers. The following are a snapshot of patient stories shared for learning during 2023-24:

| Patient Story Title | Overview of story | Key Messages | Learning |
|---|---|---|---|
| **The importance of communication in 'Fast Track' surgery** | The storyteller describes a ten and half month journey at Wrexham Maelor Hospital, including three pre-operative assessments, two cancelled operations and the overall impact of the lack of communication between specialties where patients have more than one condition and the impact of this on patients needing to access 'fast track' surgery. | The storyteller highlights the impact of the lack of communication and co-ordination between specialties where patients have multiple underlying conditions from accessing surgery. | Pharmacy have improved communication by developing the use of a health screening process to identify patients with complex medication needs much earlier in the process by developing a Health Screening Questionnaire. This will ensure the Pre-Operative Assessment Clinic (POAC) appointment is booked sufficiently in advance of the operation date.<br><br>Pharmacy created a standardised communication checklist of actions required by POAC Pharmacists that can be shared with all appropriate teams involved with the patient to help |

| | | | |
|---|---|---|---|
| | | | prevent inappropriate pre-op and surgical dates being given to patients and then subsequently being cancelled. |
| **Cauda Equina Syndrome and Spinal Education** | The storyteller describes her experience of Cauda Equina Syndrome, describing the physical and emotional impact of Cauda Equina Syndrome. | The storyteller describes a lack of knowledge of Cauda Equina Syndrome amongst staff, and the lack of support available | Development of the new BCUHB Cauda Equina Syndrome Pathway.<br><br>A dedicated Spinal Education Day for East IHC held on Tuesday 21st November 2023 with Cauda Equina Syndrome as a key topic. The patient story was played to open the day to provide a 'patient centred' approach to learning. |
| **Cannula in the Canteen** | The storyteller shares his experience of staff in the canteen refusing to serve him food and drink in the canteen area in line with 'policy' and due to infection prevention recommendations. | The storyteller highlights the importance of accessing canteen services and having a 'change of scenery' away from the ward. | A pan BCUHB guidance was developed in accessing canteen facilities pan BCU, to ensure all patients can access canteen facilities in a safe and consistent way. |
| **A Patient's Journey through Cancer Services** | This story follows the storyteller's five-year treatment journey through Cancer Services from a primary diagnosis of breast cancer, secondary cancer diagnosis and ongoing palliative care. | The storyteller describes her frustrations at not feeling listened to throughout her journey.<br><br>The storyteller describes the frustrations around the co-ordination of her care. | The Cancer Services Patient Centred Care Sub-Group developed a Person Centred Care Action Plan to improve patient experience of cancer care and treatment.<br><br>This patient story reinforces the need for the newly developed Metastatic Breast / Colorectal Cancer Service. Patients with incurable breast cancer are now benefitting from the support of Metastatic Clinical Nurse Specialists (CNS).<br><br>A User Involvement Facilitator post within Cancer Services has now been recruited to work with the North Wales Cancer Patient Forum and to listen and understand what matters most to patients. |

**Improving the Health Boards approach to Real-Time Feedback**

**From 1st April 2023 to 31st March 2024,** the Health Board received **45,152** All Wales Real-Time Feedback survey responses via the Civica feedback system..

Overall, **79.78%** of respondents were **satisfied with their experience of accessing Health Board services.** Key findings from the real-time patient survey feedback include:

- 80% of respondents were always given all of the information needed
- 83.30% of respondents always felt listened to
- 69.83% of respondents always got assistance when needed
- 80.91% of respondents were always involved in decisions about care
- 80.56% of respondents felt that staff always took the time to understand what mattered to them as a person and took this into account when planning and delivering their care.

In preparation for the launch of the NHS Wales People's Experience Framework, and the implementation of a new national set of **Patient-Reported Experience Measures (PREMS)** which are questionnaires which measure a patients perceptions of their experience whilst receiving care, work is being undertaken with across the Health Board to ensure all wards, services and departments are mapped to Civica Feedback System.

The Patient and Carer Experience Team will review its accessibility requirements to allow people and communities to leave their experience feedback on an **'Always on'** basis, ensuring there are opportunities to people to provide feedback and in their first language of choice e.g., British Sign Language (BSL) and through other methods such as QR code posters in waiting areas, Kiosks, SMS, and social media.

# Annex A – Annual Duty of Candour and Putting Things Right Report

2023 - 2024

# ANNEX A – ANNUAL DUTY OF CANDOUR AND PUTTING THINGS RIGHT REPORT 2023-2024

## Duty of Candour

The Duty of Candour, as with the Duty of Quality, has been introduced through **the Health and Social Care (Quality and Engagement) (Wales) Act 2020** and came into force in April 2023. The duty requires NHS organisations in Wales to be **open and honest** about the care and treatment patients receive.

**What does it mean?**

Even when the Health Board does its very best to prevent harm, people may experience harm. This is why the duty of candour is in place. If the care provided has caused moderate harm, severe harm or death to a patient, this means that the organisations health and care professionals must tell its patients or someone acting on their behalf that harm has been caused.

By being open and honest, it will give people confidence and trust in the care and treatment they received from the Health Board.

**What is meant by moderate or severe harm?**

- **Moderate harm** is when the NHS treatment the patient has received has caused or contributed to causing them harm, leading to further treatment. At this stage, harm can be serious, but not permanent. For example, *a patient is given medicine that they are allergic to, even though it is written in their notes as an allergy. The patient gets a reaction because of the medicine. They need to stay in hospital for 4 or more days before they recover*.

*Figure 9: Duty of Candour, HEIW, 2023.*

- **Severe harm** is serious harm which has caused or contributed to the patient suffering a permanent disability or loss of function. For example, *a patient is given medicine they are allergic to, even though it is written in their notes as an allergy. This may lead to brain damage or other permanent organ damage.*
- **Death** is where a patient has died which was caused or contributed to, by their NHS care and treatment. For example, *a patient is given medicine they are allergic to, even though it is written in their notes as an allergy. This leads to their death.*

## The Health Boards approach to the Duty of Candour

**What has been achieved so far?**

The Health Board has a dedicated duty of candour SharePoint page on our intranet which provides a host of training material which has been both locally and nationally produced, together with access to templates and help guides and videos to assist services to operationalise the duty of candour. Additional support was offered from local governance teams within the Health Board and members of the Corporate Quality Team to assist with queries and stumbling blocks. Workshops and presentations have taken place with services throughout the year.

### What has challenged the Health Board?

Through the early months of implementation, issues that arose included validation of severity of incidents that triggered the duty of candour and establishing robust systems and processes to ensure that roles and responsibilities were embedded. The reporting system Datix Cymru, which is the system where duty of candour is recorded, has undergone some upgrade work following areas for improvement being identified.

# HOW THE HEALTH BOARD PERFORMED ON DUTY OF CANDOUR DURING 2023-24

## Where Duty of Candour has been triggered during 2023-24

During the reporting year 2023-24, the Duty of Candour (DoC) has come into effect in respect of **the provision of health care** by the Health Board. The duty was triggered on 761 occasions (excluding primary care which are reported further on in this section).

**Table 1** below demonstrates number of times per month duty of candour was triggered. Average number of times duty of candour triggered per month =63.41.

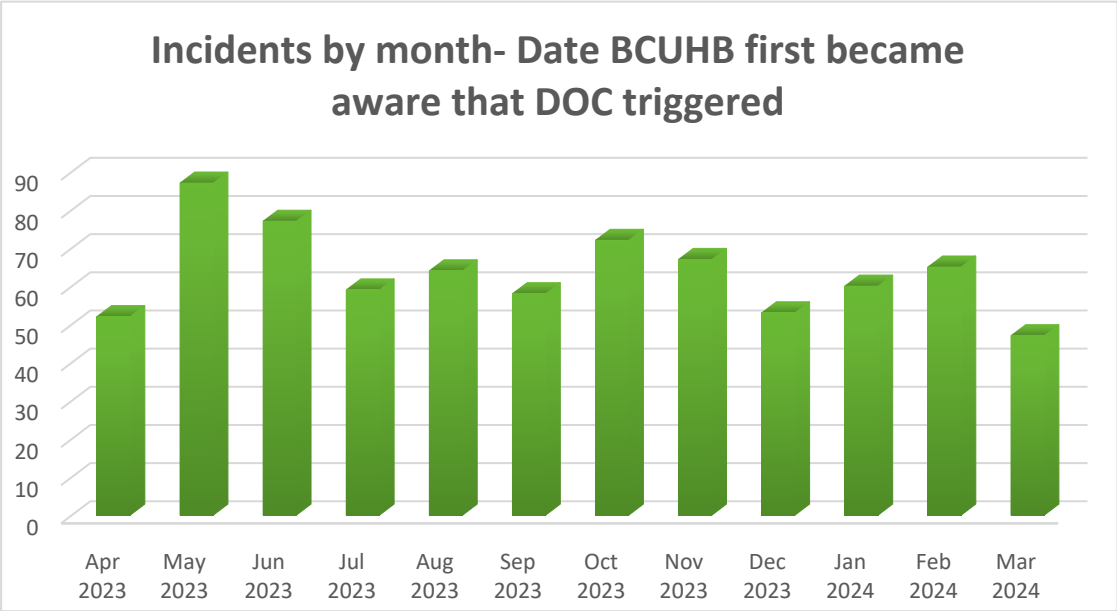



*Table 1: Incidents by month duty of candour triggered, BCUHB.*

**Table 2** below indicates proportion of incidents by level of harm considered after initial review

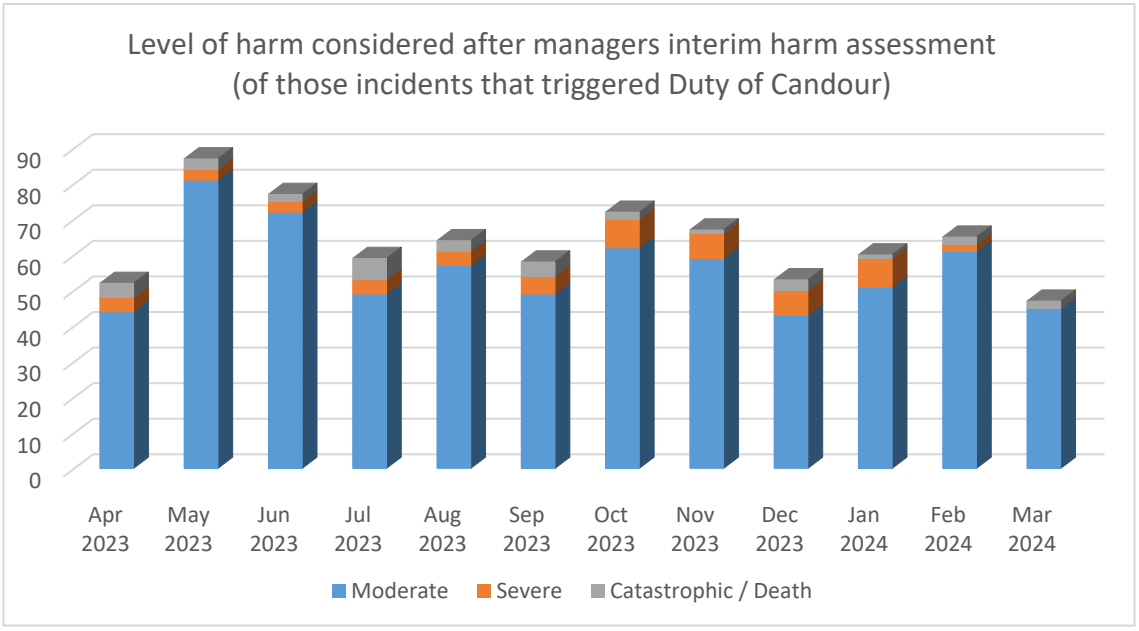



*Table 2: Level of harm considered after managers interim harm assessment (of those that triggered DoC), BCUHB.*

Noticeably, the largest proportion of incidents that have triggered duty of candour **following managers interim harm assessment**, fall into the moderate category.

Historically, a severity of moderate would have been selected when the reviewer was unsure about severity, or, felt that the incident was significant enough to warrant a severity of moderate despite a patient not actually coming to any harm. This is not Health Board policy. It is a misunderstanding of the implications with regards to Duty of Candour and a clear indication of requirement for training in aligning allocating severity of harm according to national guidance on definitions.

It is therefore thought that the number of incidents that are categorised as moderate after initial review is inflated, and support is required for services to understand the importance of accurately assessing the harm according to the definition of moderate as detailed in the policy.

The Duty of Candour legislation mandates that once triggered, the Health Board must inform patient/relative that harm may have been caused via "in person" notification and followed up with a written notification. The patient/relative should also be informed of the outcome of any investigation unless they stipulate that they do not wish to be informed.

Datix Cymru concerns management system is used by the Health Board to record when the "in-person" and written notifications are completed and when any final response of an investigation is shared with patient/relative.

Of the **761** occasions where Duty of Candour was triggered, **643 records have been closed** and **of the closed incident records:**

- 424 "in person" notifications are recorded as completed **(66%)**
- 167 written notifications are recorded as completed **(26%)**
- 63 final responses sent **(9%)**

(It is possible that the actions required by the duty have been completed in additional cases but not recorded on the Datix Cymru system). This position is recognised by the Health Board as being far below acceptable and there is ongoing work to improve the process and provide training.

In addition, ongoing validation work by the Patient Safety Team has identified that for the 2023/24 financial year a number of incidents reported as moderate of above (n=623), have not as yet undergone an initial management review. Had the management review been completed, and assessment of harm remained at moderate or above, a proportion of this number would also have triggered duty of candour. This matter has been escalated through the Quality and Safety Group meeting.

There is some evidence that users of the system had discovered ways in which to by-pass certain sections of the investigation form within Datix Cymru and proper process not being followed. This is most likely due to conflicting priorities of staff having to use the system and the increasing mandatory fields that need to be completed in order to close an incident and the time taken to complete those fields. Since updating Datix to Form 4A at the start of April, this workaround by staff is no longer possible and staff are unable to close incidents without the management review being completed. A recent survey of the users of the Datix Cymru system, two years after it being introduced will be shared with the OFWCMS team in due course. The Health Board would be grateful of a full review of the Yorkshire contributory factors section of Datix to ensure an

easier/quicker process for identifying learning and subsequent closure of incidents. The Health Board understands that there may have been some preliminary discussions about this nationally.

## The circumstance in which the duty came into effect.

The **top 3 classification of incidents** where duty of candour was triggered are:

- **Pressure damage/moisture damage** (n=264)
- **Accident/Injury such as falls** (n=129)
- **Treatment, procedure** (n=58)

The numbers of **pressure ulcers** where duty has been triggered accounts for **35% of the total**. It is worth noting that Duty of Candour is triggered where harm ***may*** have been caused and further investigation in these cases could lead to a conclusion that harm was unavoidable.

## Steps the Health Board are taking to prevent similar circumstances from arising in the future.

There are various improvement initiatives taking place across the Health Board in relation to the main themes for incidents listed above with focused improvement work is in place, reporting to key strategic groups such as the Health Board's **Strategic Falls Group** and the **Strategic Health Care Acquired Pressure Ulcer (HAPU) Group** where sharing of good practice and patient safety alerts takes place to help triangulate patient safety information to inform key learning and improvements.

The Putting Things Right section of this report details improvement work that is being undertaken across the Health Board in order to reduce harm to patients particularly in respect to pressure damage and falls which account for the largest proportion of incidents that cause moderate or above harm to patients and service users.

# HOW PRIMARY CARE CONTRACTORS PERFORMED ON DUTY OF CANDOUR DURING 2023-24

## Preparing the Primary Care Provider Duty of Candour Reports

With effect from April 2023, primary care providers must prepare a report in respect of the health care they provide under a contractual or any other arrangement, with the Health Board. The report confirms whether during the reporting year, the duty of candour has been triggered in respect of the provision of health care by the primary care provider.

Across Betsi Cadwaladr University Health Board there is a good reporting culture amongst primary care contractors who use the Datix Cymru reporting system for the reporting of incidents. It must, however, be noted that the use of the system is not mandatory for primary care contractors. Therefore, it was necessary to contact all contractors to collate the necessary data for this report, providing other means for the collection of data as opposed to solely relying on the Datix Cymru system.

In the Betsi Cadwaladr University Health Board area there are approximately **390 primary care providers**:

- 96 General Practices (GPs)
- 141 Community Pharmacies
- 77 Optometrists (including domiciliary providers)
- 76 Dental Practices

At the time of production of this report there was an **87% response rate across all contractor groups** to the request for information. The following information provides a summary of the reports provided by Primary Care providers which sit within the Health Boards area.

## Where Duty of Candour has been triggered during 2023-24

During the reporting year 2023-24, the Duty of Candour has come into effect in respect of **the provision of independent primary care**. The duty was triggered on **36** occasions.

## The circumstance in which the duty came into effect.

On review of the 36 incidents reported that are believed to have triggered duty of candour, themes and trends were identified as follows:

- **Medication related incidents** 14
  Types of medication related incidents vary and include dispensing errors, side effects from drug interactions, dispensing errors, and prescribing errors
- **Information governance issues** 3
- **Access issues** 2
- **Clinical issues/issues related to diagnosis** 3
- **Referral/follow up/administrative issues** 5
- **Wrong tooth extraction** 2
- **Other miscellaneous issues** 6

## Steps the Health Board are taking to prevent similar circumstances from arising in the future.

All incidents reported via the Datix Cymru system are handled by the Health Board's Primary Care Clinical Governance Team and learning is requested from the independent primary care contractors prior to the closure of any incidents.

Alongside individual learning, any learning that may be beneficial to the wider contractor group is shared, when appropriate, across all contractor groups via **a Stories for Sharing** Newsletter.

In conjunction with the Primary Care Academy, a programme of **Lunchtime Learning sessions** is due to commence in September 2024. This will provide another method of sharing learning with primary care contractors.

Considering potential confidentiality issues highlighted above, it is not possible to provide detailed summaries of learning as these may make cases identifiable, however some **broad learning themes** have been summarised below:

- Contractors have indicated that investigations have been completed using the Significant Event Analysis approach (SEA) and that learning is shared at practice meetings, practice education and training sessions, and with individual staff members/staff groups as appropriate.
- Reminders provided to staff in relation to the importance of effective and accurate communication and checking patient identifiers.
- Use of the in-surgery checklist for tooth extractions.
- Appropriate audits undertaken to mitigate risk of recurrence and identify any patients requiring further follow up.
- Review of protocols and procedures to ensure that they are fit for purpose.

It is unclear from some of the information provided by primary care providers whether those incidents notified via the data collection process actually met the requirements for duty of candour in line with the regulations. This has identified **a need for further education** and a programme will be developed and implemented by the primary care clinical governance team in Quarters 3 and 4 of 2024/25 and onward into 2025/26.

## Putting Things Right Wales

**The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011** requires NHS bodies to make arrangements for the handling and investigation of complaints. These arrangements are known as Putting Things Right (PTR).

*Figure 10: Putting Things Right Wales, Welsh Government, 2018.*

Whilst the Health Board aim to provide the best treatment to its patients, sometimes things mat not go as well as expected. Where there is cause for concern about care and treatment, a complaint can be raised by a patient or their carer, friend, relative or representative. The best place to start is by talking to the staff involved with their care or treatment in order that they can look at what may have gone wrong and try to make it better.
If this does not help, or it is preferred to speak not to speak to the staff involved, the Health Boards complaints team are there to support and listen. They also manage the Putting Things Right arrangements for the organisation.

### How does PTR work?

Where a complaint includes an allegation of harm, or a patient safety incident has resulted in **moderate or severe harm or death**, financial redress will be awarded if **qualifying liability** is established. This is where a two stage legal test is applied to establish if there has been;

1. **Breach of Duty;** some care or treatment a patient has received has fallen below a reasonable and accepted standard.
2. **Causation;** some harm has probably been caused to a patient as a result of the breach of duty.

If the Health Board determines that there is or may be qualifying liability, the **Redress** process commences to discharge the Health Board's duty to make an offer of Redress.

Redress can include one or more of the following;

- a full explanation of what happened; an apology;
- an offer to provide care or treatment (where appropriate);
- a report on action which has been, or will be taken to prevent similar cases arising; and/or financial compensation.

## HOW THE HEALTH BOARD PERFORMED ON PUTTING THINGS RIGHT DURING 2023-24

## Redress

During **2023-24:**

- **27** Regulation 33 responses with offers of redress were accepted
- **18** Regulation 33 responses were sent with offers and are waiting to be accepted
- **1** ex-gratia payment was made to a complainant to cover private medical costs as a result of Health Board failings.
- **3** Apologies as redress were issued
- **2** final responses were sent denying liability following expert reports being obtained

**17** Independent clinical experts were instructed

### Red Flags

Some complaints and incidents are not suitable to be dealt with under redress, as the amount of damages payable (financial compensation) if a qualifying liability was found, would likely exceed the PTR limit of £25,000.

Examples include any complaint or incident about any birth injuries; babies who have been cooled; any life changing events such as amputation; stroke; significant brain or spinal injury; loss of sight or hearing; patients requiring multiple surgeries as a result of alleged negligence; significant pressure sores; death of patient with dependents; psychological harm following stillbirth; missed cancer cases.

The investigation report into these cases should only be a factual account of what happened; not consider breach of duty or harm, and should be issued with a response letter advising that legal advice be sought with regards to pursuing a clinical negligence claim.

- **70** complaints and incidents were reviewed by the Redress Team and deemed not suitable for PTR due to likely value
- **4** cases were removed from Redress and became claims during the process

### Potential Redress

- **190** other complaints and incidents, were received during the year to be reviewed and advised upon by the Redress Team
- **104** were reviewed and deemed not to trigger Part 6 of the Regulations (Redress)
- **25** complaints are pending final review, in addition to
- **61** incidents

### Learning and the Welsh Risk Pool

A Learning from Events Report must be submitted to the Welsh Risk Pool within four calendar months of a qualifying liability being confirmed following an investigation, to provide assurance that the identified issues have been addressed to reduce the risk of reoccurrence or reduce the impact of a future event.

- **28** Redress Learning from Events Reports were submitted during the year
- Learning has been approved for **20** cases to date

Once the learning is approved by the Welsh Risk Pool, the cost of the case will be reimbursed to the Health Board on receipt of a Case Management Report.

- **31** Redress Case Management Reports were submitted.
- **31** cases were approved for reimbursement

## Complaints

The Health Board aims to provide a resolution to complaints as soon as possible and where appropriate, these cases are managed as an 'early resolution,' meaning that they are resolved within two working days of receipt and to the satisfaction of the complainant. Those that have not been resolved within this timescale or that are more complex, or reference that harm has been or may have been caused, are managed under PTR.

Complaints are treated as learning opportunities and bring a wide variety of issues to attention, all of which are responded to with a person-centred approach. The detail of the concerns is categorised in relation to the principal subject, in accordance with Welsh Government reporting requirements, to support the identification of emerging themes and specific areas of concern which result in focussed improvement work.

### Complaint themes / trends

Most of the complaints received this year to date relate to secondary care services with the majority of formal complaints pertaining to clinical treatment and assessments (**1,209**), poor communication (**274**) and staff attitude and behaviour (**190**). Other recurring themes were access to medication (**145**), waiting times for appointments (**136**), and patient nursing care (**118**). The total number of complaints broken down by subtype as shown below in **Table 3.**

| Complaint Subtypes | Total |
|---|---|
| Clinical treatment/Assessment | **1209** |
| Compliment regarding clinical treatment/assessment | 5 |
| Delay/Lack of diagnosis | 87 |
| Delay/Lack of treatment or Assessment | 654 |
| Incorrect diagnosis | 57 |
| Incorrect/insufficient treatment or Assessment | 338 |
| Reaction to procedure/ treatment | 62 |
| Unintended retention of a foreign object after surgery/procedure | 6 |
| Communication Issues (including Language) | **274** |
| Communication with patient/service user | 161 |
| Communication with family | 75 |
| Insufficient/Incorrect information | 18 |
| Communication with External Agencies or Other NHS Organisations | 7 |
| Communication between Services/Departments | 5 |
| Welsh language issues | 4 |

| | |
|---|---|
| Guidance, Policies & Procedures - issues raised | 2 |
| Availability of brail, sign, texting service, language line | 2 |
| **Attitude and Behaviour** | **190** |
| Attitude/Behaviour of Clinical Staff | 173 |
| Attitude/Behaviour of Non-Clinical Staff | 17 |
| **Medication** | **145** |
| Access to own medication | 30 |
| Delay/Frequency in providing medication | 26 |
| Incorrect medication given | 20 |
| Incorrect dosage given | 17 |
| Medication not prescribed | 15 |
| Availability of medication | 14 |
| Poor pain control | 9 |
| Prescription incorrect | 5 |
| Lack of/No funding of medication | 3 |
| Allergies not considered | 3 |
| Patients being given medication but not being observed taking it | 2 |
| Side effects not explained | 1 |
| **Appointments** | **136** |
| Delay in appointment/waiting time/transport | 86 |
| Appointment cancelled | 21 |
| Cancelled appointment/transport | 14 |
| Patient lost to follow-up | 6 |
| Capacity of clinics | 3 |
| Continuity of staff | 3 |
| Location of appointment unsuitable | 2 |
| Patient booked into wrong outpatient clinic | 1 |
| **Patient Care** | **118** |
| General care and respect | 88 |
| Response to Patient needs | 13 |
| Handling of patients | 9 |
| Lack of assistance with Patients personal hygiene - bath, teeth, toilet | 3 |
| Lack of assistance with Patients feeding/hydration | 3 |
| Visiting arrangements | 1 |
| **Discharge Issues** | **86** |
| Inappropriate/unsafe discharge | 71 |
| Discharge - no follow-up arrangements | 6 |
| Inappropriate time of discharge | 5 |
| Incorrect/insufficient information in Discharge Summary | 2 |
| Delay in appointment/waiting time/transport | 2 |
| **Access (to Services)** | **73** |
| Delay in appointment/waiting time/transport | 53 |
| Eligibility/criteria of patient not met for Service | 7 |
| Call handling/Automated call issues | 4 |
| Lack of/No funding for patient within the organisation | 3 |

| | |
|---|---|
| Lack of/No funding available under the NHS | 3 |
| Lack of/No funding for patient outside of organisation | 2 |
| Address/Location issues | 1 |
| **Confidentiality** | **45** |
| Breach in confidentiality | 31 |
| Incorrect disclosure of Patient Information | 7 |
| Correspondence sent to wrong address | 7 |
| **Test and Investigation Results** | **31** |
| Delay in receiving/missing test results | 19 |
| Test results not acted upon | 7 |
| Tests not undertaken/not repeated | 3 |
| Test not performed/ incorrectly performed | 2 |
| **Referral** | **31** |
| Referral Delayed | 17 |
| Concerns regarding grading/decision of referral | 14 |
| **Record Keeping** | **26** |
| Incorrect/missing information in records | 16 |
| Missing records | 6 |
| Inappropriate information in the records | 4 |
| **Accident/Falls** | **16** |
| Slip, trip or fall | 10 |
| Fall from height eg trolley, chair, bed | 4 |
| Lack of assistance | 1 |
| Ice (snow) | 1 |
| Inappropriate Manual Handling of Patient/Service User | 1 |
| **Equipment** | **12** |
| Patient/Service User provided with incorrect/faulty equipment | 6 |
| Lack/Availability of Equipment | 5 |
| Lack of training on use of equipment/devices | 1 |
| **Monitoring/Observation Issues** | **10** |
| Failure to appropriately monitor/undertaken observations | 7 |
| Inappropriate support for Mental Health issues | 2 |
| Failure to notice patient deteriorating | 1 |
| **Admissions** | **9** |
| No admission date | 6 |
| Unsafe transfer | 1 |
| Delay in Admission to Ward from Emergency Department | 1 |
| **Privacy and Dignity** | **7** |
| Failure to maintain Patient/Service User dignity | 4 |
| Failure to maintain Patient/Service User privacy | 3 |
| **Environment/Facilities** | **6** |
| Lack of/availability of car parking | 2 |
| Smoking on NHS premises | 1 |
| Noise/Disturbance to Patients | 1 |
| Lack of Toilet facilities | 1 |
| **Other** | **7** |

| | |
|---|---|
| Other | 7 |
| **Complaints Handling** | **4** |
| Lack of engagement with complainant | 2 |
| Quality of response | 1 |
| Application of consent process | 1 |
| **Consent** | **5** |
| No consent obtained (consent form not signed for treatment/investigation) | 4 |
| Consent form not completed for treatment/investigation | 1 |
| **Nutrition/Hydration Issues** | **2** |
| Appropriateness of food/Dietary options | 2 |
| **Equality** | **2** |
| Discrimination relating to Disability | 3 |
| Discrimination relating to Gender | 3 |
| **Skin Damage** | **2** |
| Failure to appropriately manage skin damage | 2 |
| **Assault** | **3** |
| Alleged Physical Assault | 2 |
| Inappropriate restraint issues | 1 |
| **Infection Control** | **1** |
| Lack of Isolation Facilities | 1 |
| **Resources** | **2** |
| Lack of staff in clinical area | 2 |
| **Cleanliness** | **1** |
| Cleanliness of clinical area | 1 |
| **Catering** | **1** |
| Standard of food/drinks | 1 |
| **Grand Total** | **2457** |

*Table 3: The total number of complaints received, broken down by sub-type, BCUHB.*

### Management of complaints

Every complaint received by the BCUHB is fully acknowledged, robustly investigated and subsequently the complainant is provided with a comprehensive response that addresses the matters raised. There are a small number of these complaints where the failing is considered to be a breach of the Health Boards duty of care. Any such case that has, or may have, caused harm is investigated with complete transparency to identify root causes, failures in process or potential risks so that the Health Board can eliminate or mitigate the opportunity for any similar breach of care in the future.

Complaints managed under PTR are graded against nationally set levels of severity and this is then reviewed as part of the investigation. **Table 4**, below, provides a breakdown of severity grading for complaints, following investigation and closure.

| Grading | Number of complaints managed under PTR |
|---|---|
| Grade 5 (catastrophic harm) | 57 |
| Grade 4 (severe harm) | 143 |
| Grade 3 (moderate harm) | 629 |
| Grade 2 (low harm) | 819 |
| Grade 1 (no harm) | 809 |
| **Total** | **2457** |

*Table 4: The total number of complaints managed under PTR, by grading, BCUHB.*

Of the total **2,457** complaints received **2,048** were managed under PTR and **409** were Subject to Early Resolution.

### Improvement work

The complaints policy and procedure are robust and under continual review to ensure compliance with national legislation and that the designated service understand their responsibility and accountability in investigating their complaints whilst exploring harm and breach of duty.

Following a detailed investigation an action plan is documented and actions implemented to ensure positive changes are made to improve patient safety and experience, as part of a collective commitment for continuous improvement and to meet the Health Boards ambition to be a learning organisation, built on transparency and openness.

The complaints team are proactively supporting the IHC/ Divisions to reduce the overdue complaint numbers, a new complaints trajectory model, has been developed to improve complaints management performance.

To support resolution of complaints weekly meetings are taking place with the Executive Director of Nursing and divisional leads to review grade 1's and 2 complaints received for the previous week, this supports early closure of low-level concerns.

A thematic analysis is conducted on a weekly basis to identify areas of concern and any regular recurrences are shared systematically with the BCUHB Executive Team and senior management teams within those services to investigate and identify opportunities for improvement. The themes of learning are captured and reported at the Patient and Carer Experience Group (PCEG) and Organisational Learning Forum (OLF) with key initiatives discussed with a focus on sharing good practice to improve patient experience.

Pro-active work is being undertaken by the Patient Advice and Liaison Service (PALS) to address recurring themes of complaints. The PALS team are providing patient and carer experience training which includes empowering staff to resolve low level concerns.

To support the achievement of the key performance indicators of complaints, each Integrated Health Community (IHC) / Division has adopted weekly Putting Thing Right Meetings to manage the progress of complaints received. In addition, a weekly improvement meeting chaired by the Deputy Executive Director of Nursing supports early intervention to ensure complainants receive a timely resolution.

Attitude and behaviour issues and communication issues remain as prevalent theme across all services. The Health Boardhave been proactive in addressing these areas, and have seen a marked improvement in

complaints pertaining to communication; with 246 complaints received in 2023/24, down from 496 on the previous year. The Health Board continue to strive to improve all aspects of communication. The following actions have been continued throughout 2023/24, with a reduction of complaints relating to communication being reduced by 253:

- The Complaints Team conduct 'complaints clinics' three times per week via Microsoft Teams to support staff. This is an opportunity for services to liaise with the complaints team and obtain expert advice to support a timely resolution to their complaints.
- To assist improving communication and staff supporting service users, the Patient and Carer Experience Team continue to deliver a series of face-to-face Patient and Carer Experience Training sessions across Integrated Health Communities and Specialist Services. The training includes effective communication, empowering staff to resolve issues locally to encourage early resolution of complaints and raising awareness of the role of the Patient Advice and Liaison Service (PALS).
- The Health Board is working with Small Business Research Initiative (SBRI) funded by Welsh Government to explore innovative digital solutions to improve communication between staff and relatives when their loved one is in hospital. Staff, patients and carers have been involved in focus groups to share their experiences as to what may work well. This feedback will shape the future digital solution to support families' communication with their loved when in the Health Boards care as an inpatient.
- Staff who are Patient and Carer Champions have been working closely with the Patient and Carer Experience Team by sharing information and engaging in patient feedback collection. Patient and Carer Champions are a point of contact to improve engagement between the team, clinical services and patients, by asking, monitoring and acting on patient feedback.
- To ensure effective communication between patients, families and staff the Health Board launched the digital roll out of the Welsh Interpretation and Translation Service (WITS) providing 24-hour access to interpreters. The video interpretation offers support to patients who have unplanned admissions of care as video BSL and other language interpretation does not need to be booked in advance. Since the digital roll out of WITS there has been a reported 50% increase in use of digital translation as a method to communication with patients and their families about their care.
- Complaints staff attend weekly meetings with the services in addition to the complaint clinics, notifying and highlighting any emerging trends in new complaints received, as well providing advice and guidance on complaints management to the service leads. This includes concerns pertaining to communication with staff which result in a negative experience for the patient or their loved ones.

## The Public Services Ombudsman for Wales (PSOW)

The Public Services Ombudsman for Wales (PSOW) has legal powers to look into complaints about care providers in Wales. During **2023/2024** the Health Board has received at total of **214** cases. This figure has been obtained from the Ombudsman and cross checked to internal data and is correct at the time of writing.

### Public Interest Reports

Occasionally, the Ombudsman may produce a public interest report (Regulation 23), making the public aware of a particular type of case. During this period the Health Board received **3 public interest reports**.
The first and second public interest reports are linked to the same case, received in August 2023, and considered the following:

a) The operation to remove the patient's appendix was unduly delayed
b) That there was a failure to investigate the cause of her breathing difficulties in a timely manner.
c) In view of the above the Ombudsman also investigate the additional concern that the Health Board failed to arrange appropriate follow up and treatment for the patient in response to the incidental finding of mucocele of the appendix following a CT Colonoscopy in September 2017.

The third public interest report, received in October 2023, considered whether:

a) the Health Board, between January and September 2018, promptly and appropriately identified, investigated and treated a carotid artery stenosis (blockage of blood vessels in the neck of a patient, restricting the blood flow to the middle of the brain, face and head.
b) Also whether the Health Board had provided timely care once the stenosis had been identified in September, up to his surgery in November 2018

## Incidents

Most incidents that are recorded are classed as 'none' or 'low' in that no significant harm was caused by the event that occurred.

A total of **41,690 incidents** were recorded in **2023/24**, a similar number from the previous year of 41,724. Of these, **34807** incidents were reported as affecting patients/service users. (N.B. retrospective reporting of Nosocomial Covid-19 as part of the National Programme have been excluded).

### Incident themes / trends

The classification of the patient/service user incidents reported along with reporters view on level of harm are shown below in **Table 5.**

| | None | Low | Moderate | Severe | Catastrophic | Total |
|---|---|---|---|---|---|---|
| **Pressure Damage, Moisture Damage** | 665 | 7540 | 2895 | 89 | 0 | 11189 |
| **Accident, Injury** | 915 | 3650 | 947 | 76 | 9 | 5597 |
| **Behaviour (including violence and aggression)** | 577 | 2087 | 794 | 63 | 5 | 3526 |
| **Medication, IV Fluids** | 1016 | 1488 | 526 | 60 | 6 | 3096 |
| **Assessment, Investigation, Diagnosis** | 294 | 618 | 385 | 121 | 21 | 1439 |
| **Treatment, Procedure** | 248 | 669 | 406 | 77 | 11 | 1411 |
| **Maternity adverse occurrence** | 383 | 738 | 160 | 14 | 10 | 1305 |
| **Access, Admission** | 325 | 562 | 169 | 43 | 8 | 1107 |
| **Infection Prevention and Control** | 86 | 607 | 250 | 8 | 4 | 955 |
| **Communication** | 241 | 472 | 185 | 25 | 6 | 929 |
| **Transfer, Discharge** | 161 | 391 | 244 | 42 | 10 | 848 |
| **Records, Information** | 315 | 348 | 76 | 12 | 0 | 751 |
| **Equipment, Devices** | 170 | 287 | 98 | 17 | 0 | 572 |
| **Safeguarding** | 72 | 213 | 182 | 27 | 7 | 501 |
| **Patient/service user death** | 79 | 29 | 6 | 1 | 323 | 438 |
| **Infrastructure (including staffing, facilities, environment)** | 111 | 162 | 64 | 16 | 1 | 354 |
| **Information Governance, Confidentiality** | 83 | 164 | 36 | 2 | 0 | 285 |
| **Monitoring, Observations** | 35 | 105 | 84 | 18 | 12 | 254 |
| **Nutrition, Hydration** | 17 | 68 | 39 | 4 | 1 | 129 |
| **Consent, Mental Capacity Act (including DoLS)** | 8 | 49 | 11 | 1 | 0 | 69 |
| **Information Technology** | 17 | 22 | 10 | 3 | 0 | 52 |

*Table 5: The total number of incidents, by classification, BCUHB.*

The Patient Safety Team monitor incidents to identify themes and where these need to inform organisational priorities. The most reported incidents relate to pressure damage and patient falls. It should also be noted that the significant number of patient deaths reported are of patients under mental health services that are subsequently downgraded following investigation and review of contribution and omission.

### Improvement work

Pressure ulcer prevention, care and treatment training is not currently mandatory in the Health Board. In addressing this in the short term, the HAPU (healthcare acquired pressure ulcer) Improvement Lead Nurse in conjunction with the Tissue Viability Nurses, are re-developing the Tissue Viability Betsinet page on the Health Board's internal intranet site. This will be a repository for validated training videos, education packages etc. which will be accessible and enable all staff to access.

In demonstrating the Health Board's commitment to quality and patient safety in reducing the incidence of healthcare acquired pressure ulcers, the HAPU Strategic Group has been established to supervise local improvement programs in line with the strategic improvement plan with the trajectory of elimination of avoidable HAPU and 50% reduction in all HAPUs.

The aim is to 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 while noting areas for learning and best practice to improve underpinning knowledge and initiate remedial actions.

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.

The Health Board's Strategic Falls Group continues to lead on the multidisciplinary implementation of reduction of inpatient falls with a focus on risk assessment, ensuring the appropriateness of the environment and use of resources to improve patient safety. This approach enables the group to identify any emerging themes and trends or hotspots and to make recommendations for improvements.

A falls collaborative group introduced mandatory falls e-learning modules which are constantly under review to ensure the modules are up to date with the current evidence/practice. The Health Board are the only board in Wales that has taken a mandatory approach to this training for all staff. The Health Board has been commended by the all-Wales Inpatient Falls Network who are recommending the Health Board developed e-learning modules are implemented by all Health Boards in Wales as the standard for e-learning. The requirement for temporary staff to have been trained in patient falls prevention has also been added to formal contracts with Nurse Agencies.

The Health Board has made significant progress with Adult Inpatient Falls Prevention and Management over the past four years, with considerable acceleration of progress following the first Health and Safety Executive (HSE) Improvement Notice issued on 16th June 2021. However, despite the progress the Health Board has remained in a vulnerable position in terms of quality, accuracy and documentation of interventions implemented as part of the all-Wales mandatory completion of the Adult Inpatient Falls and Bone Health Multifactorial Assessment (FBHMA) completion.

Improvement work relating to the compliance with, and quality of completion of the FBHMA has been strengthened with a peer review process whereby nursing staff are critiquing each other's quality and accuracy of the FBHMA.

All falls with harm as a minimum are discussed within the Integrated Health Community (IHC) weekly Harms meetings with representatives of Health and Safety in attendance. These weekly meetings include risk assessment and interventions review, as well as post falls practice. Trends or patterns are recommended to be shared with IHC/Division Patient Safety group, Strategic Inpatient Falls group, and to Health Board Patient Safety group.

The development of a quality dashboard, which includes the *Purpose T* and FBHMA risk assessments 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 not quality of completion and interventions. This qualitative data is being captured via audit.

## Never Events

In **2023/24**, **6 'never events'** were reported.

| | IHC Central | IHC East | IHC West | Women's | Overall Total |
|---|---|---|---|---|---|
| Administration of medication by wrong route | 2 | | | | 2 |
| Wrong site surgery | | 2 | 1 | 1 | 4 |
| Total | 2 | 2 | 1 | 1 | 6 |

*Table 6: The total number of Never Events reported, by area, BCUHB.*

Never Events are adverse incidents that Health Board systems and processes should ensure are never able to happen. The common theme continues to be failure to use a LocSSIP (Local Safety Standard for Invasive Procedures), and failure to use the World Health Organisation surgical safety checklist in its entirety including in areas outside of theatres.

A Clinical Quality Improvement Fellow has worked consistently to review the organisations approach to surgical safety checklists and has worked closely with theatre and surgical staff across the Health Board.

### Never Event themes / trends

The main themes within the learning from these incidents relate to lapses in agreed procedures including the requirement for robust patient pathways. This has been found to be underpinned by incorrect/lack of information at handover, communication and documentation as the contributor with human factors forming part of the root cause. Learning captures which systems and processes can assist in the clear process for completion of tasks, or if they already exist, why they were not followed.

The system sharing and embedding of learning remains a risk for the Health Board and it acknowledges more work is needed to become a learning organisation. Plans are in place to strengthen the extracting, sharing, and embedding of learning to include:

- Monthly Organisational Learning Forum (commenced in February 2023)
- Weekly Harm Free Care Forum (commenced January 2023)
- A revised "lessons learned" on a page template
- A new digital Quality Learning Library;

## Claims

During this financial year **2023-24**, **353** cases have been opened which is an increase on those opened compared to last year's figure (281). The total this year includes **307 Clinical Negligence claims** and **46 Personal Injury claims**.

The Health Board had **945 clinical negligence and personal injury claims open** at the end of the financial year.

In addition to the management of Claims, the Healthcare Law Team also manage all Inquests that have been brought by HM Coroner, supports the wider clinical staff with Court of Protection matters, and supports general legal advice queries that includes reviewing statements for police matters and family law proceedings.

The Health Board is expecting to see claims continue to rise as result of the Covid-19 pandemic, although the full extent of this is not yet known. Such claims will likely relate not only to the direct effects of Covid 19 (i.e. potential nosocomial infections), but also the indirect effects (i.e. patients with longer wait times for surgery as a result of the stepping down of services through 2020-22). It is thought that the majority of Claimants may be waiting for the Covid-19 Public Inquiry to conclude. Openness, transparency, improving patient safety and learning lessons remain key for the Health Board.

Some Claimant Solicitors are representing multiple Personal Injury Claimants in Covid claims against Health bodies in England and Wales. As such they have made an application for a 'group litigation style order'. They

are seeking an order from the court to identify 6 lead claims and for all other claims to be stayed pending further order. The Claimant Solicitors suggest that the lead claims shall determine all issues arising in those claims as well as the following issues:

a. The suitability and/or adequacy of the personal protective equipment provided to the Claimants for their work, particularly the provision of surgical face masks as PPE;

b. The Defendants' liability for the supply of any personal protective equipment found not to be suitable or adequate;

c. The law and/or tests to be applied on causation of Covid-19.

The Court hearing took place in March 2024 and it was not successful. The Judge said it was inappropriate and premature at this stage for any such order. In accordance with the Health Boards position, it was agreed that common case management would be sensible and he has set directions and relisted the matter for a two day case management conference in October 2024.

In January 2024 the Supreme Court handed down a judgement in respect of secondary victim claims which impacts claims and concerns**.** A secondary victim is someone who has suffered psychiatric injury not by being directly involved in the incident but by witnessing it. Secondary victims tend to be family members who witness negligent medical treatment. The judgement has made it far more difficult for secondary victim claims to succeed. In summary, it was held that claims by secondary victims for psychiatric injury are only valid where the claimant witnesses 'an accident' or its immediate aftermath, which is different from a medical crisis and, that a clinician does not owe a duty of care to a secondary victim. Due to this ruling, the Health Board have already seen a number secondary victim claims being withdrawn. The remaining claims are being reviewed on a case by case basis with advice from Legal & Risk.

### Claims themes / trends

Throughout **2023-24**, the Health Board has noticed **trends in claims** in the following areas:

- Claims brought in relation to alleged failed 'Treatment/Procedures' and failures in relation to 'Assessment/Investigation/Diagnosis' continues to be the highest category types received for clinical negligence claims.
- For personal injury claims, the trend continues to be slips and trips, violence/aggression manual handling matters.
- Although not the highest in number, Birth Injury claims account for the largest settlement amounts paid for Clinical Negligence Claims.

### Improvement work

Some actions and improvements made following investigation of claims include:

- Due to the continued concerns raised in regards to mesh/tape procedures, a new uro-gynaecology pathway is in place which includes referral to Physiotherapy for conservative management treatments as an alternative to proceeding with TVT-O.
- It is recognised there is a continued need for robust processes for consenting patients which highlights not just the recognised risks and complications but allow patients to weigh up all the options for treatment (including none). Women's Services have taken a focus on consent training and provision of detailed information in relation to consent. This information has been provided in a

number of ways including documentation, information sharing and education and ongoing training, along with peer review of the consent process. In addition, from January 2024, consent training has been mandated for all clinical staff within the Service taking consent for invasive procedures.

- Due to a concern of unclear documentation relating to patient/nursing observation in the MHLD service, the Therapeutic Engagement and Observation Policy was reviewed in 2023 and defined the criteria for the increase and decrease of nursing observations. A training package in relation to this policy was implemented and continues to be undertaken as the staffing group changes with new recruits.

## Key Learning

### Health and Safety Executive (HSE) Prosecution

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, which included

- significant additional training for staff in risk assessment and management.
- updating the Therapeutic Engagement and Observation Policy, which provides guidance to staff on how at-risk patients should be supported and observed, and developed and delivered training to staff to ensure they are familiar with the policy.
- revising the Acute Care Framework that sets the standards expected from staff regarding patients' care and treatment plans.
- carrying out quality and safety audits across mental health inpatient wards to review the standards of record keeping and risk management.
- an ongoing programme of ligature risk assessments for each ward is in place, overseen by a new Ligature Risk Reduction Group.
- independent, external ligature risk reviews of the wards carried out.
- updating the Searching Patients and Their Property Policy and delivering training to staff to ensure they are familiar with the policy.
- most significantly, putting an end to the routine mixed cohorting of older adults and working age adults at the Hergest Unit, which means that only reduced ligature beds are used routinely with a clear escalation process for traditional hospital beds to be used only as clinically needed.

An internal audit review of the evidence was also undertaken alongside an assurance process led by the Executive Director of Nursing and Midwifery.

HIW conducted an inspection of the Hergest Unit in May 2023. The report states: *"There were established processes and audits in place to manage risk and health and safety, which enabled staff to continue to provide safe and clinically effective care."*

The Chief Executive issued a statement following the conclusion of the hearing: *"My heart goes out to the family and loved ones of Dawn Owen for their tragic loss. On behalf of the Board I wish to reiterate how sorry I am for the failings in her care. We are determined to keep improving the safety and experience of the service that we provide, and although the vast majority of patients receive safe and effective care, we will ensure that, where we fall short, that this drives long lasting change."*

**Prevention of Future Death Notices:**

The Coroners and Justice Act 2009 requires a coroner to issue a Regulation 28 Prevention of Future Deaths (PFD) Notice to an individual or organisation where the coroner believes that action should be taken to prevent further deaths.

The Executive Team approved a new Inquest Procedure in October 2023. A bi-weekly Inquest Oversight Panel was also established in autumn to provide executive support to ensuring submission deadlines were achieved, as the Senior Coroners in North Wales raised concern in relation to the timely completion of investigations.

During the year, the Health Board has a significantly higher number of Regulation 28 Prevention of Future Deaths (PFD) Notices. Across the notices received, there are three key themes that emerged:

- Ambulance handover delays and ED pressures
- Lack of, or integration of, electronic records
- Timeliness or quality of investigations or learning

The following provides an update in relation to the improvement work underway:

*Ambulance handover delays and ED pressures*

Our Urgent and Emergency Care (UEC) Improvement Programme incorporates the delivery against our Special Measures priorities and the National Six Goals for Urgent and Emergency Care, taking a whole system approach which includes strengthening primary care, collaborating with our partners in local authority and WAST (the Welsh Ambulance Service Trust). Our focus for the coming year (and beyond) is on supporting and bolstering our ability to deliver business as usual services, by reviewing how we deliver those services, and by moving existing resource to either support or work in a different way.
We have reinstated an Urgent and Emergency Care (UEC) Programme. This programme board will review performance against key metrics including a focus on the 4-hour ambulance handover time as well as the progress of the Six Goals improvement programme. UEC Groups for each hospital site will report into this board on actions being taken locally.

*Lack of, or integration of, electronic records*

In relation to electronic records, we developed a strategic outline business case for an Electronic Patient Record (EPR) system in conjunction with Welsh Government and Digital Health and Care Wales (DHCW). Once funds are secured, the timelines for delivering such a significant transformation project, as is required in the case of the Health Board, will be at least three years. This is based on an independent assessment made of our business need in terms of people, practice and technology by Ethical Healthcare Consulting who have been assisting us with this business case. The Welsh Nursing Care Record (WNCR) was created by Digital Health and Care Wales working with nurses and other colleagues across NHS Wales to create a digital system with standardised nursing documentation. The WNCR has been rolled out across all inpatient services in the Health Board. As part of the move to WNCR, national nursing standards were necessary to address the document duplication and inconsistencies in nursing records across Wales. Key to the development of these standards was organisational and multidisciplinary collaboration across NHS Wales. A programme of work has successfully linked up separate versions of the Welsh Patient Administration System (WelshPAS) in North Wales, bringing together all areas of the Health Board into one single version of the WelshPAS. The Health Board is also working at pace on the national Electronic Prescribing and Medicines Administration (ePMA) System programme, and is now entering the implementation phase of the ePMA project.

*Timeliness or quality of investigations or learning*

The Chief Executive commissioned a retrospective review of all investigation reports and associated documentation, up to the end of January 2024, that had been (or would be) submitted to the Coroner. Each review was undertaken to determine if the investigation and action plan was sufficient or if remedial work is needed. In total, 262 cases were reviewed. Significant learning was identified on how the Health Board approached its investigations which aligned with the Coroner's observations. The Chief Executive therefore commissioned a further programme of work to develop a new Integrated Policy covering Incidents, Complaints and Mortality Reviews. The Executive Director of Nursing and Midwifery and Acting Executive Director of Therapies and Health Sciences oversaw this work supported by a working group led by the Deputy Director of Quality and consisting of representatives from the various teams involved in the process, and taking into account the learning from the above issues and engagement activity with internal and external stakeholders over the past several months. A new policy was approved at the Board in July 2024 and will be rolled out from September 2024.

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| **Teitl adroddiad:**<br><br>***Report title:*** | Safeguarding and Public Protection Annual Report 2023-2024 |
| **Adrodd i:**<br><br>***Report to:*** | Quality, Safety & Experience Committee |
| **Dyddiad y Cyfarfod:**<br><br>***Date of Meeting:*** | Thursday, 24 October 2024 |
| **Crynodeb Gweithredol:**<br><br>***Executive Summary:*** | The BCUHB Safeguarding and Public Protection Team, has statutory accountability, on behalf of the Executive Director of Nursing and Midwifery to deliver, engage and drive the agenda on behalf of the Health Board and as a key member of multi-agency partnerships on a Local, Regional and National footprint.<br><br>The Social Services and Wellbeing (Wales) Act 2014 (Part 7) is the legislation governing the safeguarding and public protection agenda. Specific legislation drives the key subject areas and the wider harm agenda, and the public protection agenda has seen a meteoric rise in activity legislated by the Crime and Disorder Act 2015. Violence against Women Domestic Abuse and Sexual Violence (VAWDASV), ModernSlavery, Human Trafficking, County Lines, Child Sexual Exploitation (CSE), Child Sexual Abuse (CSA), and PREVENT (anti - terrorism) has required an increase in operational and multi-agency activities over the last 12 months.<br><br>The Mental Capacity Act (MCA) & Deprivation of Liberty Safeguards (DoLS) Code of Practice is fundamental in the overarching and targeted agenda.<br><br>Over the past year, the healthcare sector has faced significant challenges, with a marked increase in demand for safeguarding interventions. The growing complexity of cases, often exacerbated by social factors such as poverty, mental health issues, and domestic abuse, has placed additional pressure on already stretched services. This has necessitated a more robust and adaptive safeguarding approach to ensure the protection of children, adults at risk, and the wider public.<br><br>Activity is overseen by the Board, and reporting arrangements follow the organisations governance and reporting cycle of business. The publication of the 2024-2027 Three Year Plan provides an overview of the areas of work that the Health Board wishes to prioritise, and safeguarding are integral to these.<br><br>These are:<br>1. Building an Effective Organisation<br>2. Developing Strategy and long-lasting change<br>3. Creating compassionate culture, leadership and engagement<br>4. Improving quality, outcomes and experience<br>5. Establishing an effective environment for learning. |

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| | The report highlights performance and activity data from the period of 01.04.2023 to 31.03.2024 and includes an update position. This includes key achievements and assurance and identifies areas where a targeted approach is required to ensure improveents to safeguard service users and their families. | | | |
| **Argymhellion:**<br><br>***Recommendations:*** | The Committee are asked to note the Annual Report for the period of 2023-2024. | | | |
| **Arweinydd Gweithredol:**<br><br>***Executive Lead:*** | Angela Wood, Executive Director of Nursing and Midwifery | | | |
| **Awdur yr Adroddiad:**<br><br>***Report Author:*** | Michelle Denwood, Director of Safeguarding and Public Protection | | | |
| **Pwrpas yr adroddiad:**<br>***Purpose of report:*** | I'w Nodi<br>*For Noting*<br>☐ | I Benderfynu arno<br>*For Decision*<br>☐ | Am sicrwydd<br>*For Assurance*<br>☒ | |
| **Lefel sicrwydd:**<br><br>***Assurance level:*** | Arwyddocaol<br>*Significant*<br>☒<br>Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol<br><br>*High level of confidence/evidence in delivery of existing mechanisms/objectives* | Derbyniol<br>*Acceptable*<br>☐<br>Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol<br><br>*General confidence / evidence in delivery of existing mechanisms / objectives* | Rhannol<br>*Partial*<br>☐<br>Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol<br><br>*Some confidence / evidence in delivery of existing mechanisms / objectives* | Dim Sicrwydd<br>*No Assurance*<br>☐<br>Dim hyder/tystiolaeth o ran y ddarpariaeth<br><br>*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:**<br><br>***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:**<br><br>***Link to Strategic Objective(s):*** | North Wales Safeguarding Adult Board<br>North Wales Safeguarding Children Board<br>North Wales Vulnerability and Exploitation Board<br>North Wales Contest Board | | | |
| **Goblygiadau rheoleiddio a lleol:**<br><br>***Regulatory and legal implications:*** | Social Services and Wellbeing (Wales) Act 2014; Crime and Disorder Act (2014); The Human Rights Act 1998, Mental Capacity Act 2005; Mental Capacity (Amendment) Act (Wales) Act 2019 and Children Act 1989 and 2004. Domestic Abuse Act (2021) | | | |
| **Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal?**<br><br>***In accordance with WP7 has an EqlA been identified as necessary and undertaken?*** | Do/Naddo *N*<br><br>Os naddo, rhowch esboniad yn ymwneud â'r rheswm pam nad yw'r ddyletswydd yn *berthnasol* | | | |

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| | *If no please provide an explanation as to why the duty does not apply*<br><br>Gweithdrefn ar gyfer Asesu Effaith ar Gydraddoldeb WP7<br><br>*WP7 Procedure for Equality Impact Assessments*<br><br>This Report is provided for Assurance relating to the Boards Safeguarding and Public Protection duties, it is not in relation to a decision |
| **Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal?**<br><br>***In accordance with WP68, has an SEIA identified as necessary been undertaken?*** | Do/Naddo *N*<br><br>Os naddo, rhowch esboniad yn ymwneud â'r rheswm pam nad yw'r ddyletswydd yn *berthnasol*<br><br>*If no please provide an explanation as to why the duty does not apply*<br><br>Gweithdrefn WP68 ar gyfer Asesu Effaith Economaidd-Gymdeithasol.<br><br>*WP68 Procedure for Socio-economic Impact Assessment.*<br><br>This Report it is not in relation to a decision. |
| **Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR)**<br><br>***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***<br><br>***Financial implications as a result of implementing the recommendations*** | None |
| **Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith**<br><br>***Workforce implications as a result of implementing the recommendations*** | None |
| **Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori**<br><br>***Feedback, response, and follow up summary following consultation*** | Clear report, evidences continued intervention, organisational challenges and the increase in activity. |

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| **Cysylltiadau â risgiau BAF:**<br>(neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)<br><br>***Links to BAF risks:***<br>*(or links to the Corporate Risk Register)* | Not applicable |
| **Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)**<br><br>***Reason for submission of report to confidential board (where relevant)*** | Not applicable |
| **Camau Nesaf:**<br>**Gweithredu argymhellion**<br><br>***Next Steps:***<br>**Implementation of recommendations** | |
| **Rhestr o Atodiadau:**<br><br>**List of Appendices*:*** Appendix 1- Safeguarding and Public Protection Annual Report 2023-2024 | |

**QSE Committee**
**24th October 2024**
**Safeguarding and Public Protection Annual Report 2023-2024**

## 1. Introduction/Background

The provision of the BCUHB Safeguarding and Public Protection Team, which includes Mental Capacity and Deprivation of Liberty Safeguards (DoLS) is underpinned by Global, UK and national legislation, policy, and procedures, enabling the Health Board to deliver its statutory responsibilities and functions, and implement best practice guidance in relation to safeguarding and public protection.

The service has statutory accountability to deliver, engage and drive the agenda on behalf of the Health Board and as a key member of multi-agency partnerships on a Local, Regional and National footprint.

The Social Services and Wellbeing (Wales) Act 2014 (Part 7) is the legislation governing the safeguarding and public protection agenda. Specific legislation drives the key subject areas and the wider harm agenda, and the public protection agenda has seen a meteoric rise in activity legislated by the Crime and Disorder Act 2015. Violence against Women Domestic Abuse and Sexual Violence (VAWDASV), Modern Slavery, Human Trafficking, County Lines, Child Sexual Exploitation (CSE), Child Sexual Abuse (CSA), and PREVENT (anti -terrorism) has required an increase in operational and multi-agency activities over the last 12 months.
The Mental Capacity Act 2005 (MCA) & Deprivation of Liberty Safeguards (DoLS) Code of Practice is fundamental in the overarching and targeted agenda.

The publication of the 2024-2027 Three Year Plan provides an overview of the areas of work that the Health Board wishes to prioritise, and safeguarding are integral to these.

These are:

1. Building an Effective Organisation
2. Developing Strategy and long-lasting change
3. Creating compassionate culture, leadership and engagement
4. Improving quality, outcomes and experience
5. Establishing an effective environment for learning

The Chief Executive has ultimate accountability for Safeguarding and Public Protection however, Safeguarding is everybody's responsibility. The Safeguarding governance and reporting arrangements support the delivery of safe patient care and is a service that oversees the needs and vulnerabilities of the whole family and not just the service user, serving a population in excess of 703,000.

The Director of Safeguarding and Public Protection leads the strategic and operational agenda with the full support and engagement of the team, on behalf of the Executive Director for Nursing and Midwifery.

This direct line of management provides and supports strong governance arrangements and ensures the provision of effective safeguarding relating to commissioning and provider activities.

Accountability is a cornerstone of safeguarding practices, requiring clear reporting structures and transparency. The Safeguarding Reporting Framework reinforces this practice.

This report underscores the importance of quality and governance monitoring as a key mechanism for delivering assurance across services. Regular audits, safeguarding reviews, and adherence to

quality standards ensure that safeguarding measures are not only compliant but also effective in practice.

In summary, as Safeguarding and Public Protection continues to grow in scope and complexity, the need for rigorous governance and quality monitoring has never been more critical. This report aims to provide a comprehensive overview of the current safeguarding landscape, recognising the challenges while ensuring a proactive, legally compliant, and accountable approach to safeguarding for the year ahead.

## 2. Evidencing compliance against key Priorities; 2024-2027 Three Year Plan.

### 2.1 Building an Effective Organisation

Safeguarding Quality and Governance arrangements are crucial for ensuring the provision of high-quality, safe, and effective care for patients. These arrangements are foundational to maintaining public trust, ensuring accountability, and driving continuous improvement in healthcare services.

BCUHB Safeguarding and Public Protection Team operates a system leadership approach to support intervention, actions and assurance across the Health Board and has adopted a pan North Wales and an Integrated Health Community (IHC) approach to services. This service remains operational across the organisation and allows flexibility, increased capacity and enhanced intervention depending upon safeguarding demand, and capacity both at an operational and strategic level.

The alignment of speciality, for example Adults, Children, VAWDASV, Midwifery, and Dementia, DoLS/MCA provides a greater and more systemic specialist service. Specialist services work cohesively across the health board ensuring that whatever action, activity or learning occurs in one part of the organisation it is then mirrored across all services. The Safeguarding and Public Protection Team provides a strategic, quality assurance and performance management function, and when required engage in high level complex clinical care situations to resolve, inform and give direction.

Recommendations and findings from National, Local Safeguarding Child and Adult Death Reviews and Domestic Homicide Reviews (APR/CPR/DHR) have informed the safeguarding workforce. For example, the BCUHB Ockenden Quality Review (2023) recognised the importance of the role of a Safeguarding Dementia Lead and reiterated the necessity to have a Safeguarding Team that was independent of operational management and leadership, with direct line management to an Executive Director and access to the Board.

The period of 2023-2024 has been challenging and progress in areas has been delayed due to sickness within the senior team. An SBAR was produced for the attention of the Chief Nursing Officer for Wales, Welsh Government and the new NHS Executive to evidence interim arrangements and provide assurance that BCUHB was compliant with Safeguarding Legislation and NHS responsibilities and duties, as agreed by the Executive Director of Nursing and Midwifery.

An update of the Action Plan was shared for the attention of Welsh Government on the 17th September 2024. We are able to report that BCUHB is in an improved position and 100% of the actions are closed, and progress has been made to stabilise the service delivery and ensure direction, priorities and quality assurance activities are in place, with senior and expert overview.

To support organisational assurance and quality monitoring the Safeguarding and Public Protection Team have a Safeguarding Reporting Framework. This is in line with BCUHBs governance and reporting arrangements and cycle of business.

The Safeguarding Reporting Framework supports frontline -to -board compliance by ensuring critical safeguarding information, risks and incidents are effectively communicated across all levels

of the organisation. It creates a structured process that ensures accountability, oversight, and adherence to statutory responsibilities for safeguarding those deemed vulnerable.
In addition, the framework ensures safeguarding arrangements meet the statutory requirements of true engagement and reporting relating to the National, Regional and Local agenda.

**Joint Inspection Child Protection Arrangements (JICPA) Action Plan 2023/2024**
**Introduction**

To evidence this assurance, in February 2023, Care Inspectorate Wales (CIW), His Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS), Healthcare Inspectorate Wales (HIW) and Estyn carried out a joint inspection of the multi-agency response to abuse and neglect of children in Denbighshire.

Across Wales, Local Authorities and partners exercise their functions under the Social Services and Well-being (Wales) Act 2014 and endeavour to ensure they make a positive contribution to the well-being and safety of children who need care and support.

**Scope of the inspection**

The Joint Inspectorate Review of Child Protection Arrangements (JICPA) reviewed:

- the response to allegations of abuse and neglect at the point of identification
- the quality and impact of assessment, planning and decision-making in response to notifications and referrals
- protecting children aged 11 and under at risk of abuse and neglect
- the leadership and management of this work
- the effectiveness of the multi-agency safeguarding partner arrangements in relation to this work.

**Achievements**

The findings were positive for BCUHB and found that Safeguarding professionals employed within Betsi Cadwaladr University Health Board (BCUHB) are approachable and proactive. It is reported that there is a clear Safeguarding & Public Protection Team structure in place, ensuring all areas of the Health Board have Safeguarding Leads, with a number of specialist safeguarding roles.

Importantly the report identified that the Safeguarding & Public Protection Team are fully engaged in all areas of multi-agency working, both at strategic and operational level. Senior Safeguarding Managers currently hold positions as Vice Chair of the North Wales Safeguarding Board and Chair of the Safeguarding Local Delivery Group. The report also found that the Health Board completed the National, peer reviewed, Safeguarding Self-assessment for 2021/22, scoring 25 out of 25.

It was reiterated that multi-agency training is readily available, well received and well publicised. Learning from reviews, such as Child Practice and Domestic Homicide Reviews are delivered through training events, 7-Minute Briefings and Learning Bulletins. A programme of audits reflect areas of concern and determines whether lessons have been embedded in practice.

The review also found examples of good engagement between General Practitioners and statutory safeguarding processes. In hospital safeguarding practice, there are examples of exemplary and innovative practice across departments including Safeguarding Ambassadors across the Health Board, Independent Domestic Violence Advisers (IDVAs) and weekly Emergency Department Safeguarding Meetings to review injuries in children under the age of two (2).
Succession planning in this specialist arena is crucial and it was reported a new initiative to provide Student Nurses with a one-week placement in the Health Board's Safeguarding & Public Protection Team means students graduate with an improved practical understanding of staff safeguarding responsibilities and partnership working to protect children, young people and adults at risk.

The findings also included areas of front-line practice that required improvement and/or strengthening. For assurance, the Multi - agency Action Plan is monitored by the Multi-agency Delivery Group and 80% of the recommendations for BCUHB are complete, the remaining 20% (2) relate to the implementation of electronic records or the required collaboration of Multi-Agency Partners.

## 2.2 Developing Strategy and Long-Lasting Change

To develop strategies to both influence and achieve long lasting change, the activities relating to Violence against Women and Domestic Abuse and Sexual Violence and the potential reduction in the Independent Domestic Violence Advocate (IDVA) Service, several actions can be identified to mitigate the level of risk and the impact on the Health Board.

**Table 1:** MARAC Referrals by Area

| Year | West | Central | East | Out of Area | Total |
|---|---|---|---|---|---|
| 2022-23 | 60 | 86 | 84 | 2 | 232 |
| 2023-24 | 53 | 101 | 93 | 0 | 247 |
| Change | ↓ 11.7% | ↑ 17.4% | ↑ 10.7% | ↓100% | ↑6.5% |

Table 1 above illustrates an overall increase in MARAC referrals during 2023-24 when compared to last year. Both the Central IHC and East IHC areas have a recognised increase, the West has recorded a decrease of seven (7) referrals.

92.7% of these referrals have been in relation to female victims. This is consistent with the national and usual trend.

When analysing the age of the victims, we find that 61.5% of the referrals were in respect of victims under the age of forty (40).

Health Visitors submitted the most MARAC referrals with 26.3% (n=65). This continues the trend seen in 2022-23. 60.3% (n=149) of the victims had children at the time of the referral, twenty-eight (28) were also pregnant. Seventeen (17) of the women that did not have children were pregnant at the time of the referral. This means that nearly a third of all MARAC referrals were for women that were pregnant, supporting research findings that pregnancy is often when domestic abuse starts or escalates.

The strategic direction of the service is clearly in line with the findings within the report, these are;

### 2.2.1 Strengthening Training and Awareness Programme

- **Action**: We continue to enhance and expand and develop VAWDASV training programmes across all staff levels, ensuring high compliance rates.
- **Impact**: Increased awareness and understanding among staff can lead to better identification and support for victims, even in the absence of IDVAs.
- **Current Status**: Training compliance for VAWDASV is below 85% target in many teams. Targeted intervention and bespoke training are being implemented, reported and escalated.

### 2.2.2 Utilising Safeguarding Ambassadors

- **Action**: Increase the number of Safeguarding Ambassadors and provide them with additional training specific to VAWDASV.
- **Impact**: Ambassadors can act as local champions, providing immediate support and guidance to staff and victims, thus filling some of the gaps left by a potentially reduced IDVA service.

- **Current Status**: The Health Board currently has 147 Safeguarding Ambassadors, with plans to recruit more, prioritising where there are low numbers and services/teams with low training compliance.

### 2.2.3 Leveraging Technology and Data Analysis

- **Action**: Continue to triangulate data to identify trends and high-risk areas, and targeted interventions.
- **Impact**: Data-driven insights can help prioritise resources and interventions, ensuring that the most vulnerable receive timely support. Considering the data, the targeted activity is initially focusing upon Midwives, Health Visitors and Emergency Departments.
- **Current Status**: The Safeguarding Data Analyst provides regular reports to highlight themes and trends within safeguarding data. Additional analysis includes safeguarding Domestic Homicide Review findings, supervision outcomes, training compliance and outcomes.

In addition, to ensure we are prepared for any long-term change and a reduction in the IDVA service, BCUHB continues to fully engage with multi-agency partners to continue the collaboration to advocate for sustained funding. Development of contingency plans and importantly ensure referral pathways are clear to reduce the reliance on the internal IDVA services.

## 2.3 Creating Compassionate Culture, Leadership and Engagement

TRiM was introduced to the Health Board in 2019 by the Safeguarding and Public Protection Team, as a finding and a recommendation from a Child Practice Review following the death of an inpatient baby where staff felt they required more support. The training was commissioned and undertaken in November 2019 and the TRiM process went live within the Health Board in May 2021.

**Table 2:** TRiM Referrals by Year

| Year | Referrals | % change |
|---|---|---|
| 2020-21 | 29 | |
| 2021-22 | 41 | ↑ 41.4% |
| 2022-23 | 58 | ↑ 41.5% |
| 2023-24 | 96 | ↑ 65.5% |

In 2023-2024 BCUHB recorded a 65.5% increase in the number of TRiM referrals submitted from Health Board staff and services. Since the introduction of this supportive process, staff referrals have quadrupled. However, the demand and success of the TRiM has resulted in additional pressure on the Safeguarding Public and Protection Team.

To reduce the burden, the team have trained colleagues from other services, but further investment may be required and to determine what this looks like, a review is taking place. This will incorporate feedback from colleagues who have participated in the process, staff wellbeing and agreed outcomes.

Although not all TRiM referrals meet the threshold the Team always provide staff with other options such as signposting to more appropriate support, services, or the offer of supervision.

The increase is a clear indication that staff across the Health Board are aware of the TRiM process when there has been an incident or staff have been exposed to trauma. BCUHB are one of only two Health Boards in Wales that provide TRiM support for staff. There are currently twenty-nine (29) staff trained as TRiM Practitioners.

The wellbeing of TRiM practitioners is monitored, and this specific activity provides BCUHB employees with a safe space to share their feelings, reflect on the incident and the impact this may have or has on them and others in their team.

## 2.4 Improving Quality, Outcomes and Experience

Since the recruitment of a bespoke safeguarding data analyst the collation of safeguarding data year on year has continued to enhance the availability of safeguarding activity and the analysis has supported the strategic agenda. Here are four key activities that have evidenced an improved position or identified risk through the triangulation of data relating to activity, training, and audit:

**2.4.1 Child at Risk Reporting and Training Enhancements**:

- **Activity**: There was a significant increase in Child at Risk reports, with a 16% rise from the previous year, totalling 4,788 reports in 2023-24.
- **Training**: The Safeguarding & Public Protection Team developed and delivered targeted training packages, including a new Level 3 Mandatory Training Package on Self-Harm and Suicide, informed by the rising mental health concerns among adolescents.
- **Audit**: Regular audits of Child at Risk reports, particularly in high-reporting areas like the Emergency Departments, identified trends and informed further training needs and process improvements. For example; disguised compliance, identification of suspected injuries and abuse, substance misuse in young people.

**2.4.2 Implementation of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS)**:

- **Activity**: The Health Board saw a 27.3% increase in DoLS applications, reflecting improved awareness and reporting.
- **Training**: Enhanced MCA training compliance, with Level 1 and Level 2 training reaching over 80% compliance in many areas.
- **Audit**: An internal audit of DoLS processes identified areas for improvement, leading to the development of an Action Plan to address issues such as training compliance and quality of applications.

**2.4.3 Multi-Agency Risk Assessment Conference (MARAC) Engagement**:

- **Activity**: There was a 6.5% increase in MARAC referrals, with a notable rise in referrals from Health Visitors.
- **Training**: The Safeguarding Team provided bespoke training for MARAC representatives within the Health Board.
- **Audit**: The Regional MARAC Steering Group conducted dip-sampling exercises to review the quality of information sharing and action setting. The key areas of improvement were notably consistent administration processess and the consistent attendance of representatives at MARACs, due to the increase in meetings.

**2.4.4 Safeguarding Supervision and Quality Assurance**:

- **Activity**: The Safeguarding & Public Protection Team provided regular safeguarding supervision across the Health Board, particularly in high-risk areas like; Midwifery; Health Visiting, School Nursing, Mental Health and Learning Disabilities and District Nursing.
- **Training**: Development and dissemination of 7-minute briefings and learning bulletins based on findings from safeguarding reviews and audits.
- **Audit**: The Safeguarding Governance and Performance Group (SGPG) monitored the effectiveness of governance frameworks, conducting deep dives into thematic areas and identifying barriers to improvement. For example the use of body maps, IT platforms, understanding of No Further Action by Local Authorities, and consent.

These activities demonstrate a comprehensive approach to safeguarding, combining increased reporting and activity, targeted training, and rigorous auditing to identify risks and improve safeguarding practices across the Health Board.

## 2.5 Establishing an Effective Environment for Learning

A recognised opportunity for learning is the Adult Practice Review (APR) concerning an adult with multiple comorbidities who rarely engaged with Services.

The review identified significant concerns, particularly around the health staff failing to implement safeguarding guidance, when denied Access to a vulnerable Adult. This was potentially a missed opportunity to safeguard a vulnerable person.

### 2.5.1 Actions Taken

Development of Monitoring Procedures; In response to the APR findings, a Procedure for monitoring adults who were deemed vulnerable, who were “not brought”, “did not attend” appointments, or had, “No Access Visits” was developed. This procedure was created in collaboration with multiple services across the Integrated Health Communities (IHCs) and the Mental Health and Learning Disability (MHLD) Division.

Development of a Flow Chart; A key priority was creating as easy-to-follow flow chart for staff to provide quick direction when faced with similar situations, to support gaining access, or reporting for intervention.

### 2.5.2 Challenges and Future Focus

Low Numbers of Adult Practice Reviews (APRs); The report notes a low number of APRs, a trend that is recognised regionally and nationally. The introduction of the Single Unified Safeguarding Review (SUSR) in 2024-2025 aims to address this by increasing awareness and promoting the process.

Promotion and Awareness; BCUHB has proactively provided APR awareness training sessions within safeguarding supervision, to promote this process and to reiterate it is not to apportion blame but to support practice development.

### 2.5.3 Teaching and Resources

The Development and implementation of the procedures and the flow chart serve as valuable resources for staff. These tools support decision making and enhance knowledge ensuring that similar situations are handled more effectively in the future. The proactive approach to APR awareness and the planned introduction of the Single Unified Safeguarding Review will further embed a culture of continous Learning and Improvement.

This example demonstrates how BCUHB has taken a structured approach to learning from past challenges, using the insights gained to increase the awareness of APR’s, improve processes and support staff in making informed decisions.

## 3 Budgetary / Financial Implications

There are no budgetary implications associated with this paper.

## 4 Rheoli Risg / Risk Management

Risk CRR 24-03 records that the Health Board may fail in its statutory duties to protect vulnerable groups from harm. This Risk was reduced on 9th of August 2024 from a rating of 16, to the current rating of 12, based upon impact and likelihood.
The reduction has been supported by the successful bids to Welsh Government to secure funding to support the implementation of the legal framework of Deprivation of Liberty Safeguards (DoLS) and the implementation of the Mental Capacity Act. The risk is monitored every month with updates provided by the Safeguarding and Public Protection Team. It is managed at Tier 2 within a Quality Report presented at QSE quarterly.

The Team have been commended for the proactive engagement and risk management monitoring arrangements.

## 5 Equality and Diversity Implications

All Policies, Procedures, documentation, and safeguarding activity that impacts upon patients, staff or the organisation are in line with a supporting Equality Impact Assessment (EqIA). Consultation and engagement takes place with both internal and where appropriate, external services.

**Conclusion**

In summary, this year has demonstrated progress in safeguarding practices across the Health Board, marked by a further notable annual increase in safeguarding activity in all statutory activities. This reflects heightened vigilance, awareness, and responsiveness to safeguarding concerns which are driven by the proactive and responsive Safeguarding Training agenda.

Our commitment to maintaining high standards is further evidenced through comprehensive quality monitoring mechanisms, ensuring that all safeguarding interventions are both timely and effective. The Health Board continues to implement mechanisms to evidence assurance and audit activities, enabling a targeted and proactive approach by analysing the triangulation of data and quality metrics.

The Health Board recognises it is on a journey of improvement and the safeguarding activity was clearly evidenced in the findings of the Joint Inspection Child Protection Review (JICPA) which reference dynamic leadership, examples of exemplary and innovative practice. The recognition of the importance of the findings of the review, the identification of positive practice and the areas of improvement will be fully implemented throughout BCUHB.

Consistent and annual subject matter audit activities, which include front line services and multi-agency colleagues are a key initiative to monitor improvement, progress and improved service delivery and reduced risk throughout the safeguarding agenda.

It is recognised BCUHB experienced workforce challenges during this period but continued to evidence the implementation of the strategic agenda, fulfil statutory duties and engagement with partner agencies and maintained the strong governance and reporting activities, which are embedded within this service. This was challenging due to the continued increase in activity and complex cases.

The area where recognised progress has been delayed, is the enhanced programme of planned audit and the implementation of an evidenced based approach of what improvement looks like, and when the timescales for improvement will be evidenced and expected. This work has restarted, and key strategic objectives are benchmarked against performance data, audit activity and the implementation of new and best practice initiatives. This will improve the reporting of evidenced based activity and provide greater assurance.

This progress will be triangulated and reported in line with the Safeguarding Reporting Framework.

BCUHB continues to foster a duty of candour and accountability, ensuring safeguarding remains a shared responsibility.

As we move forward, we will continue to build on this solid foundation, striving to improve outcomes for the most vulnerable members of our community, while ensuring safeguarding remains at the core of our service delivery.

The priorities for 2024-2025 have been referenced throughout the report and compliance and progress are within reported timeframes.

APPENDIX 1


# SAFEGUARDING AND PUBLIC PROTECTION

# ANNUAL REPORT

# 2023-2024

Contents

**Foreword**

As Director of Safeguarding and Public Protection, I am pleased to present this year's BCUHB Safeguarding and Public Protection Report for the period of 1st April 2023 to the 31st March 2024, and includes an update position. This report provides an overview of the essential work undertaken across Betsi Cadwaladr University Health Board to protect some of the most vulnerable individuals in our care. Safeguarding remains a cornerstone of our commitment to delivering safe, compassionate, and person-centred healthcare.

Over the past year, our health and care services have faced unprecedented challenges, including the ongoing recovery from the pandemic, increasing pressures on the workforce, and the rising complexity of safeguarding cases. Despite these pressures, the Safeguarding Team and frontline staff have demonstrated extraordinary resilience, dedication, and professionalism in ensuring that the highest standards of care and protection are upheld.

The 2023-2024 period has seen significant advancements in our safeguarding agenda. We have continued to refine our multi-agency partnerships, enabling more effective collaboration between Health, Social Care, Police, wider partner agencies and the third sector. Our focus on improving data sharing and governance has also strengthened our ability to identify and respond to risks in real-time, ensuring timely interventions and improving outcomes for individuals at risk of abuse, neglect, or exploitation.

Our approach to safeguarding and public protection remains person-centred, trauma-informed, and inclusive. This year, we have made significant strides in embedding a culture of learning and continuous improvement across the NHS, developing staff capabilities through enhanced training, and fostering environments where individuals feel empowered to report concerns without fear. The inclusion of new Safeguarding Policies around emerging threats, such as modern slavery, domestic abuse, and the digital exploitation of children and adults, reflects our proactive stance in addressing evolving risks in our communities.

None of these achievements would have been possible without the hard work and commitment of our Safeguarding and Public Protection Team, partners, and the broader NHS workforce. I am deeply grateful for the unwavering efforts of everyone involved in safeguarding and public protection. Together, we will continue to ensure that the NHS remains a beacon of safety and support for those most in need.

Looking ahead, our priorities remain clear: to strengthen our safeguarding culture, enhance our partnerships, and continue building robust frameworks for public protection, evidencing quality a strong commitment to governance. This report outlines our key areas of focus and strategic goals, and I am confident that by working together, we will continue to meet the challenges ahead and ensure the safety, dignity, and well-being of all individuals in our care.

Thank you for your dedication and commitment.

M. Wenward

Director of Safeguarding and Public Protection

## 1. Introduction

The provision of the BCUHB Safeguarding and Public Protection Team, which includes Mental Capacity and Deprivation of Liberty Safeguards (DoLS) is underpinned by Global, UK and National legislation, Policy, and Procedures, enabling the Health Board to deliver its statutory responsibilities and functions, and implement best practice guidance in relation to safeguarding and public protection.

The service has statutory accountability to deliver, engage and drive the agenda on behalf of the Health Board and as a key member of multi-agency partnerships on a Local, Regional and National footprint.

The Social Services and Wellbeing (Wales) Act 2014 (Part 7) is the legislation governing the safeguarding and public protection agenda. Specific legislation drives the key subject areas and the wider harm agenda, and the public protection agenda has seen a meteoric rise in activity legislated by the Crime and Disorder Act 2015. Violence against Women Domestic Abuse and Sexual Violence (VAWDASV), Modern Day Slavery, Human Trafficking, County Lines, Child Sexual Exploitation (CSE), Child Sexual Abuse (CSA), and PREVENT (antiterrorism) has required an increase in operational and multi-agency activities over the last 12 months.

The Mental Capacity Act 2005 (MCA) & Deprivation of Liberty Safeguards (DoLS) Code of Practice is fundamental in the overarching and targeted agenda.

Over the past year, the healthcare sector has faced significant challenges, with a marked increase in demand for safeguarding interventions. The growing complexity of cases, often exacerbated by social factors such as poverty, mental health issues, and domestic abuse, has placed additional pressure on already stretched services. This has necessitated a more robust and adaptive safeguarding approach to ensure the protection of children, adults at risk, and the wider public.

Activity is overseen by the Board, and reporting arrangements follow the organisations governance and reporting cycle of business. The publication of the 2024-2027 Three Year Plan provides an overview of the areas of work that the Health Board wishes to prioritise, and safeguarding are integral to these.

These are:

1. Building an Effective Organisation
2. Developing Strategy and long-lasting change
3. Creating compassionate culture, leadership and engagement
4. Improving quality, outcomes and experience
5. Establishing an effective environment for learning.

The Chief Executive has ultimate accountability for Safeguarding and Public Protection; however, Safeguarding is everybody’s responsibility. The Safeguarding governance and reporting arrangements support the delivery of safe patient care and is a service that oversees the needs and vulnerabilities of the whole family and not just the service user, serving a population in excess of 703,000.

The Director of Safeguarding and Public Protection leads the strategic and operational agenda with the full support and engagement of the team, on behalf of the Executive Director for Nursing and Midwifery.

This direct line of management provides and supports strong governance arrangements and ensures the provision of effective safeguarding relating to commissioning and provider activities. The Safeguarding Reporting Framework reinforces this practice.

Accountability is a cornerstone of safeguarding practices, requiring clear reporting structures and transparency.

This report underscores the importance of quality and governance monitoring as a key mechanism for delivering assurance across services. Regular audits, safeguarding reviews, and adherence to quality standards ensure that safeguarding measures are not only compliant but also effective in practice.

In summary, as Safeguarding and Public Protection continues to grow in scope and complexity, the need for rigorous governance and quality monitoring has never been more critical. This report aims to provide a comprehensive overview of the current safeguarding landscape, recognising the challenges while ensuring a proactive, legally compliant, and accountable approach to safeguarding for the year ahead.

## 2. Quality, Governance and Monitoring Arrangements

Safeguarding Quality and Governance arrangements are crucial for ensuring the provision of high-quality, safe, and effective care for patients. These arrangements are foundational to maintaining public trust, ensuring accountability, and driving continuous improvement in healthcare services.

Below are key aspects that highlight their importance and how they provide assurance relating to Safeguarding:

- Ensuring Patient Safety
  Quality and governance structures play a vital role in protecting patients from harm.

- Maintaining High-Quality Care
  Governance frameworks help us to maintain high standards of care by ensuring that clinical effectiveness, patient experience, and safety are consistently prioritised.

- Regulatory Compliance
  Our safeguarding governance structures ensure compliance with key regulatory bodies like the Healthcare Inspectorate Wales (HIW) and the National Institute for Health and Care Excellence (NICE).

- Promoting Accountability and Transparency
  Direct line management of the Director of Safeguarding and Public Protection by the Executive Director strengthens our safeguarding governance arrangements and ensures that there is a clear line of accountability from the board to frontline staff.

  This ensures that decisions are made transparently, and staff can be held accountable for the quality of care delivered. Assurance processes, such as external and internal audits, provide an objective assessment of performance, allowing the Health Board to make informed decisions and manage risks effectively.

- Driving Continuous Improvement
  Our quality and governance frameworks encourage continuous learning and improvement. Through clinical audits, patient feedback, and benchmarking against best practices.

- Providing Public Confidence
  Due to our service user engagement, when patients and the general public are assured that there are stringent governance mechanisms in place to monitor and improve care, they are more likely to have confidence in the system.

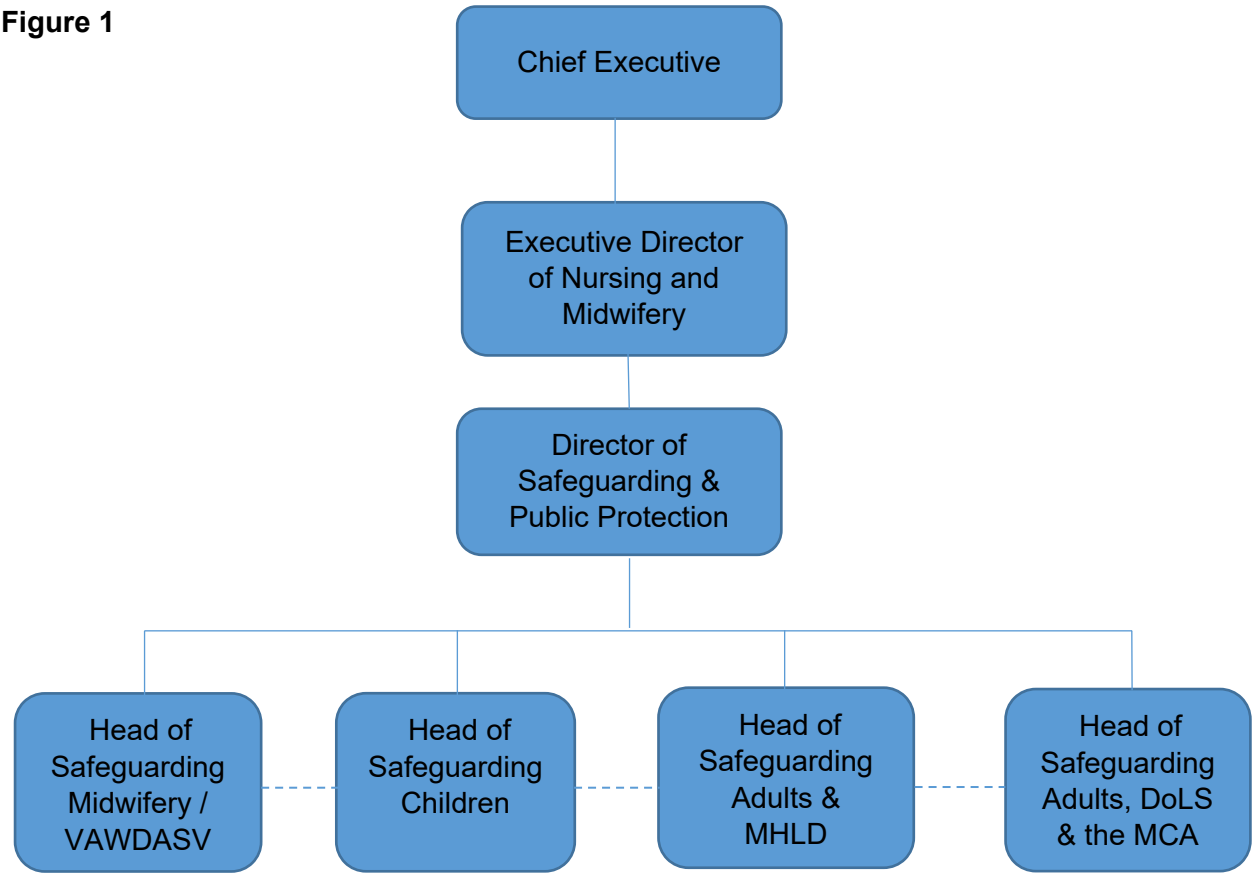
- Risk Management
  Effective governance structures allow for early identification and mitigation of risks. By monitoring clinical outcomes, patient safety incidents, and organisational risks, we can proactively address issues before they escalate. Assurance processes such as risk assessments, performance reviews, and root cause analyses ensure that risks are managed, which ultimately protects patients and staff.

Assurance through Governance Mechanisms:

- Clinical Governance Frameworks: These outline accountability for clinical care, integrating quality improvement into routine practices.
- Audit and Monitoring: Regular internal and external audits assess the quality of care, ensuring compliance with standards and identifying areas for improvement.
- Performance Reporting: Governance Boards receive regular reports on clinical and operational performance, providing transparency and facilitating timely interventions where needed.
- Patient Feedback and Complaints: Patient involvement and feedback are central to governance, especially when triangulated within the safeguarding agenda.

The Safeguarding and Public Protection Structure ensures the promotion of Accountability and Transparency

**Figure 1**



The Safeguarding and Public Protection Team implement National and Regional Strategies and Strategic Plans to identify, reduce risk and safeguard service users, their families and Health Board employees, with a particular emphasis upon high risk and targeted services across the Organisation.

BCUHB Safeguarding and Public Protection Team operates a system leadership approach to support intervention, actions and assurance across the Health Board and has adopted a pan North Wales and an Integrated Health Community (IHC) approach to services. This service remains operational across the Organisation and allows flexibility, increased capacity and enhanced intervention depending upon demand and capacity.

The alignment of speciality, for example Adults, Children, VAWDASV, Midwifery, and Dementia, DoLS/MCA provides a greater and more systemic specialist service. Specialist services work cohesively across the Health Board ensuring whatever action, activity or learning occurs in one part of the Organisation it is then mirrored across all services. The Safeguarding and Public Protection Team provides a strategic, quality assurance and performance management function and when required, engage in high level complex clinical care situations to resolve, inform and give direction.

Recommendations and findings from National and Local Safeguarding Child and Adult Death Reviews, and Domestic Homicide Reviews (APR/CPR/DHR) have informed the safeguarding workforce. For example, the BCUHB Ockenden Quality Review (2023) recognised the importance of the role of a Safeguarding Dementia Lead and reiterated the necessity to have a Safeguarding Team that was independent of operational management and leadership, with direct line management to an Executive Director and access to the Board.

The Team work with and alongside internal and external colleagues, stakeholders, and independent service users who engage and support the Team to implement the safeguarding agenda, which has ensured whole system collaboration, engagement and contribution.

This continues to benefit the service and inform Safeguarding Practice, Policy and Procedures and Training Programmes, resulting in the implementation of real change to evidence service progress throughout the Organisation.

### 2.1 Assurance Against Expert Resource

This period has been challenging and progress in areas has been delayed due to sickness within the senior team. An SBAR was produced for the attention of the Chief Nursing Officer for Wales, Welsh Government and the new NHS Executive to evidence interim arrangements and provide assurance that BCUHB was compliant with Safeguarding Legislation and NHS responsibilities and duties, as agreed by the Executive Director of Nursing and Midwifery. The response report required additional clarification and assurance.

An update of the Action Plan was shared for the attention of Welsh Government on the 17th September 2024. We are now in an improved position and 100% of the actions are closed, and progress has been made to stabilise the service delivery and ensure direction, priorities and quality assurance activities are in place, with senior and expert overview.

### 2.2 Strengthening Safeguarding in Health Review Report May 2024

The Chief Nursing Officer for Wales and Nurse Director of NHS Wales commissioned a review of Safeguarding Teams across the NHS.

This review was in response to a paper presented internally to Welsh Government recommending that Welsh Government (the CNO, Director General/Chief Executive NHS Wales and Ministers) have sufficient and meaningful assurance that the NHS in Wales is delivering against its statutory safeguarding duties.

The review identified seven themes and supporting recommendations. Initial comments have been shared in response to the recommendations and the Health Board awaits an update.

The BCUHB Executive Director of Nursing and Midwifery is a member of the Task Group and is the NHS Executive representative.

### 2.3 Safeguarding Reporting Framework

To support organisational assurance and quality monitoring the Safeguarding and Public Protection Team have a Safeguarding Reporting Framework [Appendix 1]. This is in line with BCUHBs governance and reporting arrangements and cycle of business.

The Safeguarding Reporting Framework supports frontline to board compliance by ensuring critical safeguarding information, risks and incidents are effectively communicated across all levels of the organisation. It creates a structured process that ensures accountability, oversight, and adherence to statutory responsibilities for safeguarding those deemed vulnerable.

In addition, the framework ensures safeguarding arrangements meet the statutory requirements of true engagement and reporting relating to the National, Regional and Local agenda.

In light of the report findings of the; ‘Review of Concerns Raised Around BCUHBs Affiliated Patient Safety’; June 2023, additional engagement and revised reporting throughout the Health Board has taken place. This has supported stronger engagement and participation in additional meetings or those with revised Terms of Reference, which recognise the importance of safeguarding and the importance of embedding safeguarding into practice with an independent safeguarding lens.

**Achievements**

**Safeguarding Governance and Performance Group (SGPG)**

SGPG meet quarterly and leads on the implementation of a transparent and accountable governance and performance framework for safeguarding that uses knowledge and self-evaluation to drive improvement. SGPG is attended by Directors of the Integrated Health Communities (IHC’s), Service Directors, and Heads of Service and Corporate Teams.

The role of SGPG is to also ensure the organisation complies with legislative and statutory duties, recommendations and actions in relation to safeguarding reviews, as well as organisational improvements required within the Safeguarding Maturity Matrix and Safeguarding Annual Report.

The SGPG monitor the effectiveness of the existing governance framework, reviewing the content and ensuring that it is fit for purpose; members provide safeguarding performance data that captures, collates and analyses relevant safeguarding information in a robust, systematic way identifying areas for improvement, areas of risk; triangulation of performance information from different sources to identify synergies and trends, aid collaboration and joined up working; and conduct ‘Deep Dives’ of thematic areas and what the barriers are to improvement.

The Group is responsible for the scrutiny of professional outcomes, activities and trends to inform and support clinical and professional practice; and all ensure the dissemination, consultation and ratification of Training and Development packages, Safeguarding Policy/Procedures, and Multi-agency & National Guidance of Strategies.

SGPG reports into the Health Board Executive Quality Delivery Group (EQDG) on a quarterly basis. However, measures are in place to allow for reporting by exception if and when required. EQDG subsequently reports into the Quality and Safety Executive (QSE) for Board oversight, awareness and approval. Safeguarding can report by exception and provides an Annual Report.

**Priority Activity 1 for 2024-2025**

| | Activity | Timescale |
|---|---|---|
| 1a | Ratify the updated version of the Safeguarding Reporting Framework to ensure compliance with the Boards Governance and Cycle of Business | Q3 2024/25 |
| 1b | Evidence outcomes in line with participation in IC Hubs as guided by the Integrated Concerns Policy (1st September 2024). | Q4 2024/25 |
| 1c | In line with the Independent Review of Concerns Raised Around Patient Safety June 2023 (3.12.12), Ensure membership of the Director of Safeguarding and Public Protection at HLBT Q4 | Q4 2024/25 |

**2.4 Safeguarding Forums**

The Safeguarding Forums are held monthly across all three Integrated Health Communities (IHC's) and Mental Health and Learning Disability (MHLD) services, Midwifery Division hold their Safeguarding Quality Assurance and Performance activity within the Midwifery Board. The Forum is accountable to the SGPG Group and ultimately to the EQDG and the QSE. Corporate Service Directors, IHC and Midwifery/MHLD Directors/Nurse Directors and Medical Directors are accountable for the Safeguarding function and reporting arrangements within their areas of delegated accountability and responsibility. The purpose of the Safeguarding Forum is to ensure Safeguarding practices within the geographical area of responsibility are not only implementing the Boards strategic safeguarding agenda on a BCUHB footprint but are also actively engaged in service specific and targeted activity, reporting, auditing and evaluating practice within their area or service.

In addition, the Reporting Framework enables the triangulation of information and identification of risks, service development which help to provide assurance.

During this period, the provision of the Chair/s, frequency of meetings and changes in workforce, has brought into question the impact, reporting arrangements, identification of risk and ability to obtain assurance that all of the Forums are effective and meeting the scope of the Terms of Reference (ToR).

**Priority Activity 2 for 2024-2025**

| Activity | Timescale |
|---|---|
| For assurance a look-back review of 2023-2024 will inform an updated Terms of Reference and Scope of the Safeguarding Forums | Q4 2024/25 |

### 2.5 Multi-agency Activity and Engagement

The Reporting Framework ensures full engagement, participation and the internal escalation within the Health Board, of safeguarding priorities from multi-agency groups and forums, namely the North Wales Safeguarding Board for both Children and Adults, Vulnerability and Exploitation Board, Multiagency Agency Public Protection Arrangements Strategic Management Board (MAPPA SMB), and associated Sub-Groups and Task Groups on a National, Regional and Local basis.

The alignment with the Local Authority footprint and Safeguarding Board footprint reduces duplication, ensures a 'one voice' approach and strengthens engagement and improves timescales for the implementation of findings from reviews, incidents and strategic actions.

To provide assurance the Director of Safeguarding and Public Protection holds the position of Serious Violence Duty Lead and PREVENT Lead, both of which are required as assurance of engagement and participation.

To ensure a co-ordinated approach is in place to ensure the Health Board has a strong presence and understanding of the PREVENT agenda, the Safeguarding and Public Protection Team, Security Leads Group and Emergency, Preparedness, Planning and Response have established fortnightly meetings to share intelligence and escalate as necessary any key activity, which is related to PREVENT and the anti-terrorism duties for the NHS.

**Priority Activity 3 for 2024-2025**

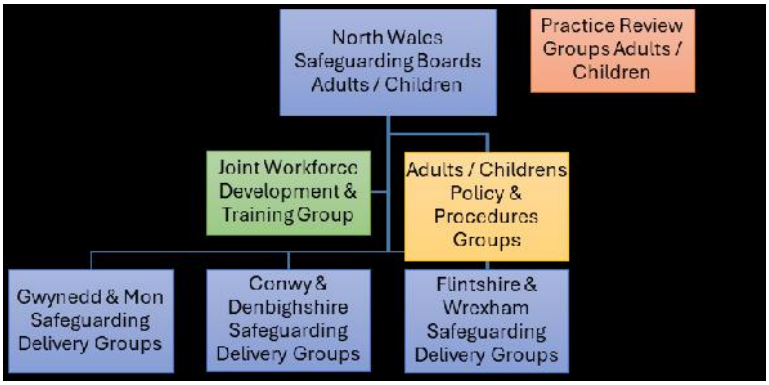
| Activity | Timescale |
|---|---|
| Develop and ratify a health Board PREVENT Standard Operating Procedure [SOP] | Q4 2024/25 |

The BCUHB Director of Safeguarding and Public Protection is the Vice Chair of the North Wales Adult Board.

The North Wales Safeguarding Boards currently meet three times per year and jointly once a year. In addition, there is also a joint Business Development Day held annually to set the priorities for the coming year and self-assess the progress of the Boards.

The Board's Practice Delivery Groups and the Children's Policies and Procedures Group currently meet on a quarterly basis. The Practice Review Groups, the Adults Policies and Procedures Group and the Joint Workforce and Training Group meet bi-monthly. Meetings are held mainly virtually but the Boards are partially returning to face-to-face meetings.

**Figure 2: North Wales Safeguarding Boards Structure**



Safeguarding attendance and reporting and governance is aligned to the organisations Cycle of Business and Statutory Multi-agency Groups and Forums. Reports are submitted to ensure escalation, share information, triangulation of reporting data evidencing good practice and ultimately providing assurance, evidencing 100% attendance at all meetings.

**Challenges**

Due to the revised governance structures within the Health Board the Team are experiencing an additional challenge of being asked to complete reports at short notice for meetings that are outside of the safeguarding governance process. This has been escalated within the Organisation.

**Priority Activity 4 for 2024-2025**

| | Activity | Timescale |
|---|---|---|
| 4a | Collaborate with the Director of Corporate Governance to ensure the request for reports are appropriate, completed on time and follow BCUHBs Cycle of Business. | Q4 2024/25 |
| 4b | To ensure quality and appropriate representation - review the membership and attendance of Safeguarding representatives on BCUHB forums/groups within BCUHB | Q3 2024/25 |
| 4c | Ensure the identified priorities reported within the BCUHB Annual Partner Agency Report to North Wales Safeguarding Board – Children and Adult are triangulated within the 2024-2025 Quality and Governance Safeguarding Objectives | Q4 2024/25 |

**2.6 Quality Assurance**

**Joint Inspection Child Protection Arrangements (JICPA) Action Plan 2023/2024 Introduction**

In February 2023, Care Inspectorate Wales (CIW), His Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS), Healthcare Inspectorate Wales (HIW) and Estyn carried out a joint inspection of the multi-agency response to abuse and neglect of children in Denbighshire.

Across Wales, Local Authorities and partners exercise their functions under the Social Services and Well-being (Wales) Act 2014 and endeavour to ensure they make a positive contribution to the well-being and safety of children who need care and support.

**Scope of the inspection**

The Joint Inspectorate Review of Child Protection Arrangements (JICPA) reviewed:

- the response to allegations of abuse and neglect at the point of identification
- the quality and impact of assessment, planning and decision-making in response to notifications and referrals
- protecting children aged 11 and under at risk of abuse and neglect
- the leadership and management of this work
- the effectiveness of the multi-agency safeguarding partner arrangements in relation to this work.

**Achievements**

The findings were positive for BCUHB and found that Safeguarding professionals employed within Betsi Cadwaladr University Health Board (BCUHB) are approachable and proactive.

There is a clear Safeguarding & Public Protection Team structure in place ensuring all areas of the Health Board have Safeguarding Leads, with a number of specialist Safeguarding roles. The Safeguarding & Public Protection Team are fully engaged in all areas of multi-agency working, both at strategic and operational level. Senior Safeguarding Managers currently hold positions as Vice Chair of the North Wales Safeguarding Board and Chair of the Local Delivery Group. The Health Board completed the National, peer reviewed, Safeguarding Self-assessment for 2021/22, scoring 25 out of 25.

The report reiterated that multi-agency training is readily available, well received and well publicised. Learning from reviews, such as Child Practice and Domestic Homicide Reviews are delivered through training events, 7-Minute Briefings and Learning Bulletins. A programme of audits also reflects areas of concern and determines whether lessons have been embedded in practice.

There are examples of good engagement between GPs and statutory safeguarding processes. In hospital safeguarding practice, there are examples of exemplary and innovative practice across departments including Safeguarding Ambassadors across the Health Board, Independent Domestic Violence Advisers (IDVAs) and weekly Emergency Department (ED) meetings to review injuries in children under the age of 2. The ED meetings were set up in response to a recommendation from a Cardiff & Vale Child Practice Review. A new initiative to provide Student Nurses with a one-week placement in the Health Board's Safeguarding & Public Protection Team means students graduate with an improved practical understanding of staff safeguarding responsibilities and partnership working to protect children, young people and adults at risk.

The findings also included areas of front-line practice that required improvement and/or strengthening. For assurance, the Multi - agency Action Plan is monitored by the Multi-agency Safeguarding Delivery Group and 80% of the recommendations for BCUHB are complete, the remaining 20% (2) relate to the implementation of electronic records or the required collaboration of Multi-Agency Partners.

The National Report was published in September 2024 and the Report outlines their main thematic findings across these inspections as well as the effectiveness of both partnerships working and the work of individual Agencies across Wales. It was reported, Health Boards have a mostly positive approach to learning and development in relation to Safeguarding. In

**Next steps**

This Report provides another opportunity to highlight what works well and the areas of child protection practice that require improvement. Inspectorates reported it is important the momentum for change in such an important practice area and the protection and safety of children, is maintained and led by Regional Safeguarding Boards.

In BCUHB, the reporting activity and progress is driven by the Safeguarding & Public Protection Team Reporting Framework. All activities are implemented on a BCUHB footprint and monitored by the North Wales Safeguarding Board to ensure compliance and assurance.

**Challenges**

The 20% of actions which remain outstanding relate to the implementation of electronic records and the reliance on multi-agency partners in relation to activity which requires a collaborative approach.

Although the JICPA was focused on the County of Denbighshire, the action plan will be firmly embedded across BCUHB. This will form part of our priority activity for 2024/2025.

Some recommendations related to the use of electronic records, and this remains a challenge. BCUHB are however using available electronic and IT systems such as Symphony, to capture safeguarding information; for example, knife crime and the inclusion of mandatory fields to support the identification of harm to non-mobile infants and support safe discharge.

**Priority Activity 5 for 2024-2025**

| | Activity | Timescales |
|---|---|---|
| 5a | Full implementation of the JICPA recommendations across BCUHB | Q3 – Q4 2024/25 |
| 5b | Collaboration with multi-agency partners to implement partnership arrangements | Q3 – Q4 2024/25 |
| 5c | Implementation of the Overarching All Wales JICPA recommendations | Q4 2024/25 |

### 2.7 National Quality Monitoring Safeguarding Maturity Matrix (SMM)

The National Safeguarding Maturity Matrix (SMM) is a quality outcome monitoring tool with the aim of capturing and collating national activity to provide assurance, drive improvements, and share practice towards a 'Once for Wales,' consistent approach to safeguarding across Wales. The SMM is split into 6 Standards. They are, Effective Leadership and Governance; Confident and Competent Workforce; Person Centred; Learning Culture; Multi-Agency Partnerships; and Responsive, Resilient and Purposeful.

Each standard has a number of sub-headings referred to as indicators to support completion and the collation of evidence and activity. The SMM has undergone a change in 2023-24 and has moved away from a number score-based evaluation to focus on progression with the standards as a trend. This is intended to support a fluid approach to good practice, innovation and quality improvement.

**Achievements**

The Health Board has achieved a positive review of the SMM by other Health Board peers and the National Safeguarding Network in 2023-24. Progress on work undertaken has been evidenced within the report to demonstrate areas of improved practice. The National Safeguarding Network Annual Report shared National progress and innovation.

**Challenges**

The SMM tool itself is not an easy document to navigate. The lack of a strong score-based evaluation causes difficulty to evidence progress, or trends and themes. This has been reported to the National Safeguarding Network. It is time consuming to complete and is repetitive.

**Priority Activity 6 for 2024-2025**

| | Activity | Timescale |
|---|---|---|
| 6a | Contribute and engage in the National Safeguarding Network SMM Peer Review | Q2 2024/25 |
| 6b | Progress current SMM Standards and engage with the agreed National priorities. | Q4 2024/25 |

### 2.8 Safeguarding and Public Protection Risk Register

There is a Risk (CRR 24-03) that the Health Board may fail in its statutory duties to protect vulnerable groups from harm. The impact may result in harm to at-risk adults, children or young persons, 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.

**Achievements**

In line with the Health Board Risk Management process the safeguarding Risk was reduced on 9th of August 2024 from a rating of 16, to the current rating of 12, based upon impact and likelihood. The reduction has been supported by the successful bids to Welsh Government to secure funding to support the implementation of the legal framework of Deprivation of Liberty Safeguards (DoLS) and the implementation of the Mental Capacity Act.

The risk is monitored every month with updates provided by the Safeguarding and Public Protection Team. It is managed at Tier 2 with a Quality Report presented at QSE quarterly.

The Team have been commended for the proactive engagement and risk management monitoring arrangements. Safeguarding risk management is reported following the Safeguarding Reporting Framework.

As with all risks it is likely that it will fluctuate over time, however, with monthly reviews and a new Risk Management process to be delivered by the Health Board it is evident the organisations safeguarding risks are managed appropriately.

**Challenges**

The introduction and implementation of a new Risk Management structure will take time to embed within the service. Safeguarding risks can change and are linked to current and new legislation, policy and procedure, as well as learning from major events such as Practice Reviews and Local, Regional and National Reports.

**Priority Activity 7 for 2024-2025**

| | Activity | Timescale |
|---|---|---|
| 7a | The Senior Safeguarding and Public Protection Team to attend new Risk Management Training | Q2 2024/25 |
| 7b | Review current Risks and amend as necessary, in line with the new guidance. | Q1-Q4 2024/25 |

### 2.9 Safeguarding Data Analyst

The Safeguarding and Public Protection Team have the support of a dedicated Data Analyst. The Data analysis plays a crucial role in providing insights to inform decision-making, policy development, and operational improvements across the Health Board. The key responsibilities involve data collection and management, data analysis, reporting, quality assurance and digital innovation.

The Safeguarding Data Analyst provides a suite of regular reports on a weekly and monthly basis to highlight any themes or trends within the Safeguarding Data activity.

**Achievements**

During Q3 of 2023-24, the use of the ‘Making Data Count’ Statistical Process Control charts were implemented within the Teams routine reporting. These charts help to clearly identify when the figures fall outside of the expected range requiring further investigation to establish why this has occurred.

To enhance data triangulation, recording of safeguarding at risk reports include NHS numbers on the adult database. This unique identifier allows data to link with other sources within the health board.

This development provides a more comprehensive understanding of safeguarding concerns and generate new insights to identify risks, enhance decision-making, and enable timely interventions. The next step is to replicate this with the Children’s and Deprivation of Liberty Safeguards (DoLS) databases.

Development has begun on a dashboard to identify patients who are medically fit for discharge but remain in the hospital due to unavailable care packages or placements. The dashboard will aim to highlight any harm experienced by these patients, such as falls, medication errors, and pressure ulcers, as well as any Safeguarding Reports submitted during the period, they remain in the hospital despite being declared medically fit for discharge.

The North Wales Safeguarding Boards Business Unit has also provided positive feedback on the data and quality of reporting on behalf of BCUHB to the Safeguarding Boards Delivery Groups. This supports the triangulation of activity on a multi-agency footprint.

**Challenges**

Discussions have commenced regarding the development of a dashboard to identify children with multiple missed appointments linking a wide range of data sources to allow the early identification of children who may be at risk.

To improve the Safeguarding Supervision provision, the Data Analyst is developing new data collection methods to ensure compliance with Safeguarding Supervision standards.

Additionally, a Supervision Feedback tool is being created to assess the quality and effectiveness of the service, ensuring that staff feel supported and that safeguarding practices are effective.

The look back exercise and the Quality Assurance review of the Safeguarding Forums will evidence if any actions or interventions were the result of the safeguarding data report and evidence an improved position, within that service or IHC.

While it is important to make comparisons, it must be noted that BCUHB is not directly comparable to other Health Boards in Wales due to its unique geographical and demographic characteristics.

**Priority Activity 8 for 2024-2025**

| | Activity | Timescale |
|---|---|---|
| 8a | Implement the recording of NHS numbers on the Childrens database | Q3 2024/25 |
| 8b | Implement the recording of NHS numbers on the DoLS database | Q3 2024/25 |
| 8c | Develop delayed discharge dashboard to highlight any harm experienced | Q4 2024/25 |
| 8d | Develop Was Not Brought/Did Not Attend dashboard | Q4 2024/25 |
| 8e | Develop digital solution for supervision data collection and feedback | Q4 2024/25 |
| 8f | Continue to engage in the Once for Wales Datix Safeguarding Module | Q4 2024/25 |

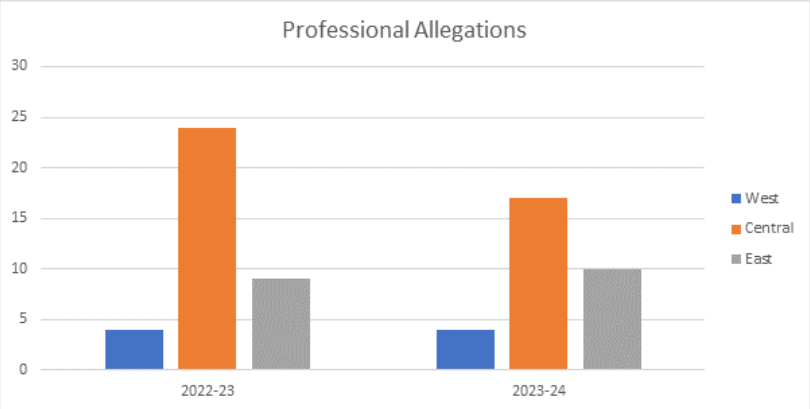
### 2.10 Workforce and Safeguarding

**Section 5: Safeguarding Allegations/Concerns about Practitioners and those in a Position of Trust.**

The Wales Safeguarding Procedures 2019 set out arrangements for responding to safeguarding concerns about those who work with child or adults at risk. It also includes individuals who have caring responsibilities for adults and children in need of care and support.

BCUHB are fully engaged and are guided by the Safeguarding and Public Protection Team in cases where we have been informed, and actively guide and support all parties.

**Figure 3:** Professional Allegations by year and area




In 2023/24 there were a total of thirty-one (31) cases involving BCUHB employees and or Agency staff that were investigated under Section 5. Of those thirty-one (31), five (5) remain open due to on-going criminal investigations.

Seventeen (17) of the cases were from the Central IHC, Ten (10) for the East and four (4) from the West.

Physical & Emotional abuse accounted for the majority of cases, thirteen in total which accounts for thirty two percent (32%) of the referrals.

This process is led by the Local Authorities and as necessary the Police. BCUHB is a partner agency and timelines, and activities are not set by individual agencies.

**Achievements**

When BCUHB are made aware of a professional allegation, a Safeguarding Team member is identified as the lead for the case. This prompts early engagement in multi-agency professional discussions to explore and decide if the safeguarding threshold has been met to instigate a Section 5 investigation.

Key risk management activities are co-ordinated and full engagement from teams within the Health Board are deployed to support and mitigate risk.

Key themes and trends are identified and support learning through the development of 7-Minute briefings and Learning Bulletins.

**Challenges**

Some of the cases are open for a long period of time, often due to a parallel criminal investigation. This can cause distress to the alleged perpetrator and victim. Staff well- being and support is therefore a key consideration within the process.

There have also been some occasions where there has been a delay in informing the Safeguarding Team. This has caused a delay in referring cases for consideration under section 5. Prompt escalation to safeguarding is essential to ensure that safeguards have been considered and mitigation in place.

In cases where the concern is managed as a training or competency concern, the engagement of the Safeguarding Team remains essential. This missed opportunity has been recognised and BCUHBs revised Quality and Governance arrangements will support triangulation and the identification of events which are omitted from this process.

The delay in the publication of the Welsh Government (WG) Guidance on managing Professional Allegations has impacted significantly on the development of a BCUHB Standard Operational Procedure (SOP). A draft SOP has been developed with a suite of associated documents. The document will be presented in SGPG in October 2024, however the WG Guidance is yet to be published, recognising the Health Board been informed it is imminent.

**What we will focus on in 2024/2025**

The completion, ratification and full implementation of the Professional Allegation SOP will be a key focus and will inform phase one (1) of this piece of work. Phase two (2) will explore the requirement for a Professional Allegation Workplace Safety Group to support and enhance the section 5 process as set out in the Wales Safeguarding Procedures 2019.

Consideration will be given to the findings of the NMC Independent Culture Review July 2024. Primarily giving consideration to the wellbeing of all concerned, this will require the full engagement of BCUHB workforce, psychological and well-being services.

**Priority Activity 9 for 2024-2025**

| | Activity | Timescale |
|---|---|---|
| 9a | Completion, Ratification and implementation of the Professional Allegation SOP. **This action is reliant on the publication of the WG Guidance.** | Q4 2024/25 |
| 9b | Agree Terms of Reference for a Working Group to develop the Workplace Safety Group | Q3 2024/25 |

**National Data Collection Initiative**

### 2.11 Once for Wales Concerns Management System (OfWCMS)

The OfWCMS – Safeguarding Datix will change in the way BCUHB report Adults and Children at Risk to the Local Authority and will also, in time, change the way BCUHB report Deprivation of Liberty Safeguard applications. There is continued engagement with the National Team to support ongoing consultation in relation to the potential implementation and impact of the new system.

Communications and engagement with partner agencies to ensure that they are fully aware of any changes is ongoing and a review of all training packages is pending to ensure compliance.

The objective is National NHS data collection for monitoring and informing Quality and Improvement.

**Achievement**

BCUHB have engaged in Local and National meetings and provided comments that were shared with the National Safeguarding Network in relation to the Adult/Child at Risk reporting framework.

Currently the position of BCUHB, is the system would not meet statutory or regional requirements for Data Protection (GDPR) and Wales Safeguarding Procedures 2014.

**Challenges**

Escalation of the proposed new system have been made by the North Wales Safeguarding Board to Welsh Government. Discussions are ongoing

A comprehensive governance programme to ensure safe implementation will be required.

**Priority Activity 10 for 2024-2025**

| | Activity | Timescale |
|---|---|---|
| 10a | Engagement in the OfWCMS implementation. | Q1-Q4 2024/25 |
| 10b | Monitor the identified Governance Programme once the system is complete | Q3 2024/25 |

### 2.12 Safeguarding Activity

On behalf of BCUHB the Safeguarding Team receive, analyse, and action copies of all safeguarding reports to the Local Authority and all Datix Reports that are submitted with the Safeguarding alert having been triggered.

Performance is benchmarked against Local, Regional and National Safeguarding and Public Protection performance indicators. This evidence supports targeted intervention to improve standards and increased safety.

## 3. Child at Risk

### 3.1 Child at Risk Data Reporting

In 2023-24, the Safeguarding & Public Protection Team received four thousand, seven hundred and eighty-eight (4788) Child at Risk Reports. This is a sixteen percent (16%) increase when compared to the, four thousand, one hundred and thirty-two (4132) Child at Risk Reports received during 2022-23. Table 1 shows a fifty four percent (54%) increase in reports since 2020-21.

**Table 1:** Child at risk reports by year

| Year | Reports | % Change |
|---|---|---|
| 2020-21 | 3116 | ↑ 9% |
| 2021-22 | 3642 | ↑ 17% |
| 2022-23 | 4132 | ↑ 14% |
| 2023-24 | 4788 | ↑ 16% |

These figures reflect a combination of reports completed for children and/or unborn babies deemed to be at risk of harm, and reports for children and families where care and support needs have been identified.

During the past Twelve (12) months there have been continued socio-political factors which have significantly contributed towards the increase in reports being received, particularly surrounding poverty and its multi-faceted impact upon childhood neglect and adverse childhood experiences. These include austerity measures, the Ukrainian War, the continued impact of the COVID19 pandemic, high inflation and global instability.

The Welsh Government & Children in Wales (2023) Child & Family Poverty Survey identified that twenty-eight percent (28%) of children live in poverty. The survey outlines the impact of the rising cost of living, food insecurity and debt as three factors having the greatest impact upon families. Significantly, of those surveyed, ninety-five percent (95%) felt circumstances during 2023 were worse than the 12 months prior. The survey also reported an increase in parental and child mental health issues, namely anxiety and depression, due to the impact of poverty.

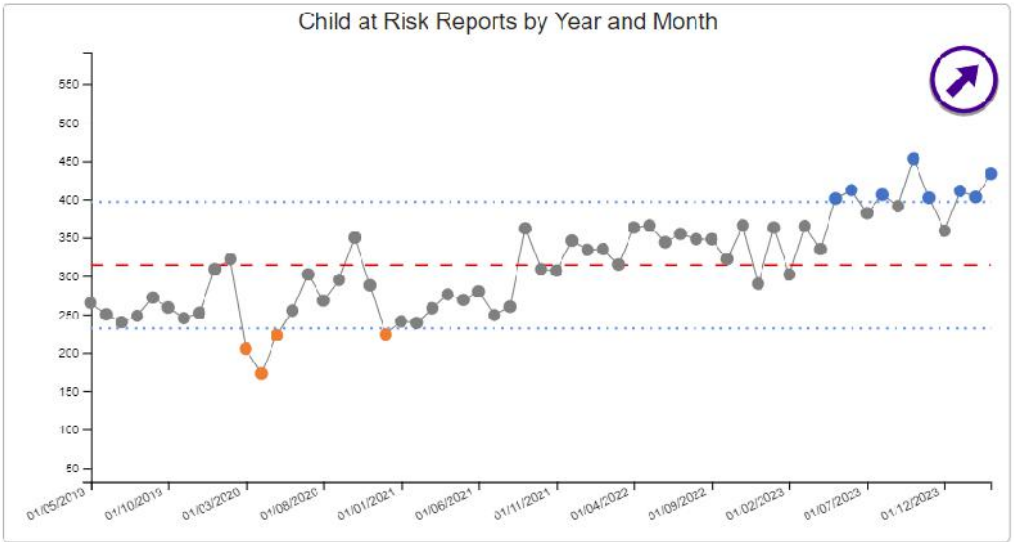
Safeguarding Mandatory Training packages are informed by emerging themes and trends evidenced within the data to support learning. The training packages promote compassionate and strength-based approaches to how we work with children and their families.

Figure 4 below, illustrates a timeline of the total number of Child at Risk reports received from May 2019 to date. The graph includes an average line, an upper and lower control limits to highlight any trends. The graph demonstrates the increasing Child at Risk Report trend since the COVID19 pandemic.

Of concern is the increase of reported abuse across North Wales over the past 4 years. Whilst appreciating there is no universal experience of the pandemic, children and families have been impacted in different ways.

The NSPCC report ‘Impact of COVID19’ identifies trends post-COVID upon adolescent mental health, experiences of abuse, and the decreasing availability of support services.

**Figure 4:** Child at risk reports timeline




Over the past 12 months, there has been a significant increase of Child at Risk Reports within Denbighshire, primarily within Rhyl. When considering the potential reasons for this increase, Rhyl has a geographically large Flying Start provision.

In accordance with the Welsh Index of Multiple Deprivation (2020), the official measure of relative deprivation by the Welsh Government, Rhyl has two separate areas identified as the top two most deprived areas in Wales.

The Safeguarding & Public Protection Team provide enhanced safeguarding supervision for practitioners within Flying Start areas in response to the increased safeguarding activity.

During 2023-24, Child at Risk reports from the community account for 61.7% of all reports received and therefore reports from acute sites account for 38.2%. Central area has generated the highest number of reports per 10,000 children as demonstrated in Table 2.

This is consistent with the trend observed during 2022-23 and is specifically linked to the increasing reports received from Denbighshire, namely Rhyl as demonstrated in Table 2.

**Table 2:** Child at risk reports per 10,000 under 18 population by LA Area

| 2023-24 | Under 18 Population | Reports | Reports per 10,000 Under 18 |
|---|---|---|---|
| Ynys Mon | 13,172 | 315 | 239.1 |
| Gwynedd | 21,819 | 482 | 220.9 |
| Conwy | 20,732 | 642 | 309.7 |
| Denbighshire | 19,182 | 1017 | 530.2 |
| Flintshire | 30,966 | 1041 | 336.2 |
| Wrexham | 27,890 | 1200 | 430.3 |

**Figure 5:** Child at Risk reports by Area and Year

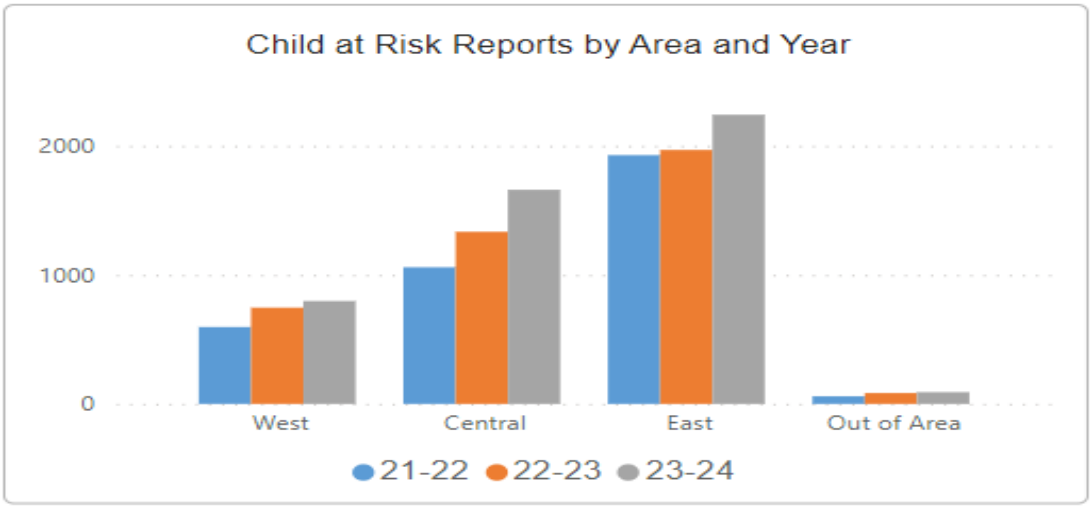



**Table 3**: Child at risk reports by age group

| Age Group | Unborn | <5 | 5-10 | 11-15 | 16-18 | Not Recorded | Total |
|---|---|---|---|---|---|---|---|
| 2022-23 | 459 | 1293 | 601 | 1072 | 544 | 161 | 4130 |
| 2023-24 | 480 | 1629 | 666 | 1262 | 572 | 179 | 4788 |
| Trend | ↑4.6% | ↑26.0% | ↑10.8% | ↑17.7% | ↑5.1% | ↑11.2% | ↑15.9% |

The highest number of reports were generated for children under the age of five, during the reporting timeframe equating to 34% of all reports received. This continues the trend seen in 2022-23. When considering the interface with health practitioners, the under-five population and their parent/carers have a significantly higher contact point with services such as Midwifery, Health Visiting, GPs and attendances at Hospitals. It is reasonable therefore to conclude that the increased number of contacts, offers increased opportunities to identify concerns or needs for care and support. This data supports to inform our key training priorities and activity, neglect is the highest category of abuse for children subject to child protection plans.

**Priority Activity 11 for 2024-2025**

| | Activity | Timescale |
|---|---|---|
| 11a | Review and update the Neglect Level 3 Mandatory Training Package | Q4 2024/25 |
| 11b | Develop a BCUHB Neglect 7-Minute Briefing | Q4 2024/25 |

Increased reporting within the 11-15 age group is mainly attributed to child and adolescent mental health concerns and correlates with increasing referrals into community Child and Adolescent Mental Health (CAMHS) and those requiring CAMHS Unscheduled Care Team services. Research suggests the impact of Covid 19 on the mental health and well-being can be deemed an attributor here. Almost a quarter of secondary school age learners in Wales reported having very high levels of mental health symptoms in the years following Covid 19 (SHRN 2023).

The Safeguarding and Public Protection Team with support and input from CAMHS, have developed a Level 3 Mandatory Training Package: Self Harm and suicide. This package was subject to wide consultation prior to ratification in Q2 2024/2025.

**Priority Activity 12 for 2024-2025**

| Activity | Timescale |
|---|---|
| Fully embed the Suicide & Self Harm Level 3 Training Package into the Level 3 training rolling programme. | Q2 2024/25 |

**Table 4:** Child at risk reports by designation of referrer.

| Designation of Referrer | Reports | Proportion of Reports |
|---|---|---|
| ED | 1234 | 25.8% |
| Health Visitor | 1030 | 21.5% |
| Midwife | 541 | 11.3% |
| CAMHS | 523 | 10.9% |
| Other | 347 | 7.2% |
| MHLD | 326 | 6.8% |
| School Nurse | 230 | 4.8% |
| GP | 181 | 3.8% |
| Children's Ward | 157 | 3.3% |
| Neurodevelopment | 86 | 1.8% |
| SMS | 67 | 1.4% |
| Minor Injury Unit | 34 | 0.7% |
| Neonatal | 18 | 0.4% |

The Emergency Departments submitted the highest number of Child at Risk reports during 2023-24, this replicates the trend we saw in 2022-23. As shown in Table 4, a large number of reports from Ysbyty Maelor (YM) Emergency Department was a significant contributor. Over thirty percent (31.4%) of the Child at Risk reports from the East IHC footprint were submitted by the Emergency Department.

The Safeguarding & Public Protection Team undertook audit activity of Child at Risk Reports within the East IHC to better understand the percentile-difference to Central & West. The outcome of this audit identified that the YM Emergency Department submit significantly higher numbers of Child at Risk Reports in comparison to Ysbyty Gwynedd (YG) & Ysbyty Glan Clwyd (YGC), despite the number of total paediatric attendances within the Emergency Department being similar.

The audit identified a high proportion of child and adolescent mental health attendances at the YM Emergency Department having Care & Support needs, and reports being sent to the relevant local authority with consent of the young people and/or their caregivers. Child at Risk Reporting was used as a mechanism to report all Children Looked After attendances. This mode of reporting is not replicated in the West and Central and there are a number of Child at Risk Reports being submitted acknowledging there were no safeguarding concerns. Safeguarding Hospital Liaison Specialists are leading on a piece of work to standardise the process across the three (3) Emergency Departments. This will allow for a more accurate formulation of acuity and demand which will inform staffing resource allocation moving forward. Further audit activity will be undertaken within 2024-25 to ensure consistency in reporting is maintained.

It is important to acknowledge the continued exceptional practice across all three Emergency Departments between secondary care and the Safeguarding Liaison Specialists. A previous recommendation within a Cardiff & Vale Child Practice Review, was for regular Emergency Department meetings to take place between the two teams to review specified attendances where there are higher risk indicators of potential abuse and harm. BCUHB implemented this activity in 2021-2023 as recognised best practice. These include reviewing attendances of children under 24 months presenting with fractures and burns, and children under 12 months attending with head injuries.

Further work is required to evidence and evaluate this work and the impact.

**Priority Activity 13 for 2024-2025**

| | Activity | Timescale |
|---|---|---|
| 13a | Task & Finish Group to standardised Child at Risk reporting across the three BCUHB Emergency Departments | Q3 2024/25 |
| 13b | Audit activity to capture reporting trends across BCUHB | Q3 2024/25 |
| 13c | Audit the ED Safeguarding Attendance Review Meetings and triangulate safeguarding data. | Q4 2024/25 |

### 3.2 Child at Risk Reporting from Maternity Services

As is consistent with previous years, and demonstrated in Figure 6, the majority of Child at Risk reports are submitted by midwives in the Central IHC area. Figure 6 also demonstrates a decrease in central and a steady rise in East IHC area, overall, the number of At Risk Reports from midwives has decreased over the past 3 years. The out of area At Risk Reports are predominantly related to Shropshire, as there are women who reside in Shropshire but birth in the Wrexham Maelor Hospital, as this maternity unit is geographically closer than Shrewsbury and Telford NHS Trusts.

There has been an overall reduction in the birth rate in North Wales which could be a contributory factor for the reduction in Child at Risk reports, but a benchmarking exercise with the Division is to take place and consider the workforce data.

**Figure 6:** Child at risk reports from midwives by Quarter, Year and Area

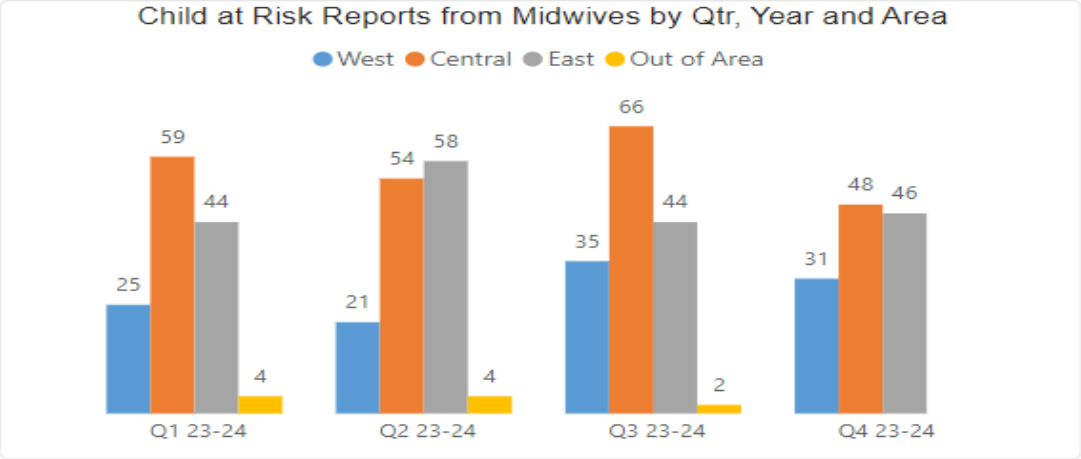


**Figure 7:** Child at risk reports from midwives by Area and Year

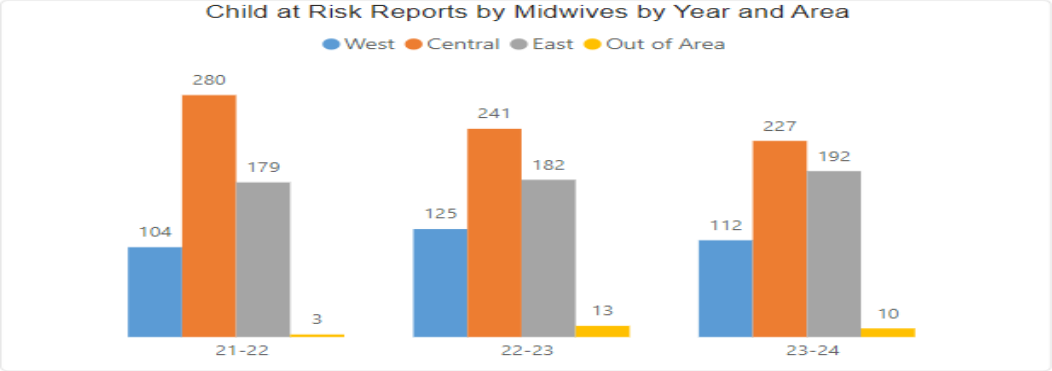



**Table 5:** Child at Risk reports outcomes by reason for referral and Area

| Reason for Referral | West | Central | East | Out of Area | Total | % |
|---|---|---|---|---|---|---|
| Care & Support | 127 | 213 | 503 | 3 | 846 | 17.7% |
| Child Protection | 592 | 1338 | 1544 | 38 | 3512 | 73.4% |
| Early Help | 55 | 65 | 95 | 10 | 225 | 4.7% |
| Not Recorded | 23 | 43 | 99 | 40 | 205 | 4.3% |
| Total | 797 | 1659 | 2241 | 91 | 4788 | |

**Achievements:**

Throughout the reporting year and as evidenced within the data, the Safeguarding & Public Protection Team alongside colleagues across BCUHB have continued to identify, report and engage with risk management plans where abuse, harm and/or neglect has been identified. There has been a significant increase in Child at Risk Reporting over several years. The increased reporting rates could, in part be attributed to the continuous efforts by the BCUHB Safeguarding Team to raise awareness and support and advise the workforce. This is achieved through established and robust quality and governance processes, training and individual and group supervision.

**Challenges**

With increased workload, there comes the challenge of sustaining the level of support internally and externally. Due to increasing safeguarding acuity, all team members have been supported to prioritise engagement aligned to core job description activities. This includes effective use of time within meetings and affording increased individual or group-health based supervisions. Engagement with trained Safeguarding Ambassadors has been enhanced so that they are confidently supporting the safeguarding agenda.

Capturing ‘outcomes’ of reports has been a specific challenge and further work is required to engage with the six (6) North Wales Local Authorities to promote improvement. Capturing outcomes will support the identification of themes and trends informing learning need and targeted intervention.

To ensure a standardised pathway of communication due to informed risk, BCUHB have ratified agreed safeguarding communication pathways for both, The Shropshire and Telford NHS Trust and The Countess of Chester Hospital Foundation Trust.

This has reduced delay and confusion when sharing information. Information sharing is a recognised national risk and is predominantly reported as a contributory factor in child death reviews.

**What we will focus on in 2024/2025**

A further key focus for 2024/2025 is the audit of the quality of the Health Pre-Birth Assessments (HPBA). This is a joint assessment that is undertaken by Health Visitors and Midwives for women that have identified social vulnerabilities during pregnancy. In May 2024 the Royal College of Midwives launched a tool (MatDAT) to assess maternal disadvantage in pregnancy, so scoping to compare the HPBA to the MatDAT will be undertaken to determine if this should be implemented within the Health Board.

**Priority Activity 14 for 2024-2025**

| | Activity | Timescale |
|---|---|---|
| 14a | Audit quality of the HPBA document | Q4 2024/25 |
| 14b | Scope feasibility of the MatDAT for use within the Health Board | Q4 2024/25 |

### 3.3 Female Genital Mutilation (FGM)

**Table 6:** FGM cases by year

| Year | Cases |
|---|---|
| 2016-17 | 6 |
| 2017-18 | 6 |
| 2018-19 | 5 |
| 2019-20 | 5 |
| 2020-21 | 0 |
| 2021-22 | 5 |
| 2022-23 | 9 |
| 2023-24 | 12 |

There has been an increase in FGM reports for 2023-2024. This does correlate with the national picture where there has been an increase of three percent (3%) in FGM disclosures, which was documented by the Violence Prevention Unit (VPU) in their most recent report.

This increase could be directly related to the work that has been undertaken with Public Health Wales around the All-Wales FGM Clinical Pathway.

Three quarters of all disclosures were from maternity services and most disclosures were from Nigerian women, which again was replicated nationally in the VPU report. This demonstrates that the Health Board findings are not dissimilar to what is being reported elsewhere in Wales.

A recognised concern is the period of 2020-2021 and the lack of reporting is a recognised risk as a result of reduced access during the COViD pandemic.

**Achievement**

BCUHBs FGM lead within the Safeguarding and Public Protection Team supported Public Health Wales (PHW) to develop audit tools that have been implemented throughout the Health Boards in Wales, to audit the quality of the All-Wales FGM Clinical Pathway.

**What we will focus on in 2024-2025**

To evidence and Quality Assure the impact of the All-Wales FGM Clinical Pathway.

**Priority Activity 15 for 2024-2025**

| Activity | Timescale |
|---|---|
| Undertake Quality Audit of the FGM clinical pathway | Q3 2024/25 |

### 3.4 Procedural Response to Unexpected Deaths in Childhood (PRUDiC)

**Table 7**: PRUDiC by year and area

| Year | West | Central | East | Other | Total |
|---|---|---|---|---|---|
| 2020-21 | 2 | 4 | 3 | 0 | 9 |
| 2021-22 | 5 | 5 | 8 | 0 | 18 |
| 2022-23 | 0 | 6 | 4 | 1 | 11 |
| 2023-24 | 5 | 4 | 4 | 0 | 13 |

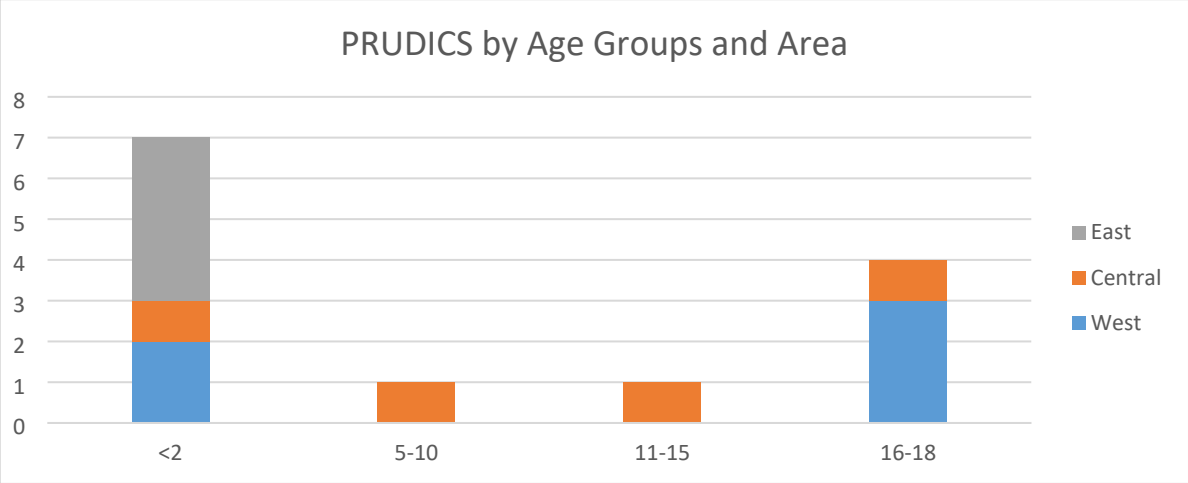
This is a national multi-agency Standard Operating Procedure. BCUHB have no authority on timescales and due to criminal and investigative activities the timescale for closure can be lengthy.

PRUDiCs are reported on Datix and managed on behalf of the IHC by the Safeguarding Team due to the nature of the event and multi-agency intervention. The challenge is the reporting of incidents within the Health Board, and this can cause a challenge regarding the timescale for closure. This has been recently escalated and interim improvements have been made regarding access to Datix management to close the Datix, free from unnecessary delay and further discussions are to take place nationally.

There have been 13 PRUDICs across BCUHB in 2023-24, this is an increase when compared to last year.

The number of unexpected child deaths are within the average annual range, whilst acknowledging the significant increase during 2021-22 (COVID19 pandemic). The Safeguarding & Public Protection Team continue to support the organisation and multi-agency partners to attend meetings under the PRUDiC process to provide a chronology of events, engage in safeguarding investigations, and supporting children / families and anyone else identified as impacted by the bereavement. Not all of the child deaths are a result of deliberate harm or neglect, the findings are a result of suicide, brain injury, road traffic collision, and congenital /medical issues.

**Figure 8:** PRUDICs by Age Groups and Area



### 3.5 Acute Life – Threatening Event (ALTE)

As a result of shared information in a PRUDiC meeting, it was recognised the development of a multi-agency pathway process would be a positive development.

The protocol will provide guidance for professionals from agencies involved in dealing with children who have suffered an acute life-threatening event (ALTE).

**Achievements**

100% attendance at all PRUDiC meetings. This supports the decision making and action planning within the meetings through robust information sharing and scrutiny. Immediate learning is addressed at source and any themes/trends are captured within 7-Minute Briefings and incorporated into training packages.

**Challenges**

Staff welfare is paramount and as part of the PRUDiC process all identified members of BCUHB are offered TRiM as a mechanism of support and wellness at work.

**What we will focus on in 2024/2025**

The introduction of the ALTE Protocol will be a key priority. The Safeguarding Paediatrician - Named Doctor will lead on this multi-agency activity.

**Priority Activity 16 for 2024-2025**

| Activity | Timescale |
|---|---|
| Develop and implement a North Wales ALTE Protocol | Q4 2024/25 |

### 3.6 Child Protection Medical Examinations

Two hundred and twenty-seven (227) Child Protection Medical Examinations have taken place across BCUHB during 2023-24. This is a 16.8% decrease in comparison to the 273 examinations conducted during 2022-23.

The data below also includes children and young people from outside the area who have had an examination within BCUHB.

**Table 8:** Child Protection medical examinations by year

| Year | Examinations |
|---|---|
| 2016-17 | 296 |
| 2017-18 | 273 |
| 2018-19 | 259 |
| 2019-20 | 277 |
| 2020-21 | 227 |
| 2021-22 | 239 |
| 2022-23 | 273 |
| 2023-24 | 227 |

The East IHC area has been the location of the most examinations accounting for 42.7%. All three areas have seen a decrease when compared to last year with the West IHC recording the largest decrease.

**Table 9:** Child Protection medical examinations Trend by Area

| Year | West | Central | East | Out of Area | Total |
|---|---|---|---|---|---|
| 2022-23 | 61 | 94 | 116 | 2 | 273 |
| 2023-24 | 36 | 87 | 97 | 7 | 227 |
| Change | ↓41.0% | ↓7.4% | ↓16.4% | ↑250% | ↓16.8% |

Suspected physical abuse continues to be the most prominent reason for examinations or all cases were referred due to suspected physical abuse.

Suspected Sexual Abuse was the second highest group. With the age range of 5-12 years and 13-15 years the highest.

Table 10 offers the breakdown of examinations by age group and type of abuse for the child.

**Table 10:** Child Protection Medical Examinations

| 2023-24 | < 2 yrs. | 2 - 4 yrs 11 mths | 5 - 12 yrs 11 mths | 13 - 15 yrs 11 mths | > 16 yrs | Total |
|---|---|---|---|---|---|---|
| Physical | 55 | 56 | 50 | 18 | 7 | **186** |
| Neglect | 2 | 0 | 2 | 0 | 0 | **4** |
| Sexual In Hours | 3 | 4 | 11 | 8 | 3 | **29** |
| Sexual Out of Hours | 0 | 0 | 1 | 4 | 1 | **6** |
| Not Recorded | 2 | 0 | 0 | 0 | 0 | **2** |
| Total | **61** | **60** | **64** | **30** | **11** | **227** |

**Achievements**

The quality of Child Protection Medical reports are of a very high standard and now include a statement asking that the author be invited to attend any strategy meetings and or Child Protection Case Conferences. This particular action supports one of the JICPA recommendations.

Desk top reviews have been undertaken to facilitate a ‘Deep Dive’ into two (2) cases which generated recommendations and actions which were fully implemented concerning Inflicted Injuries. This included bespoke training and the development of a number of 7-Minute Briefings, Lunch, Learn and Inspire Webinars and the development of a Level 3 Mandatory Training package.

**Challenges**

**3.7 Inflicted Injury Presentations**

There have been some concerns within the acute and community settings regarding adherence to process and pathways surrounding possible physical harm and inflicted injury presentations.

Missed opportunities are highlighted in the weekly Emergency Department Safeguarding Meetings and or during the daily review of attendances by the Safeguarding Liaison Specialists. Matrons and Heads of Nursing also proactively instigate escalation, review and action in cases where they have identified a concern in relation to process and safeguarding.

A failure to comply with process and miss an inflicted injury presentation can have catastrophic outcomes for children who have been harmed.

In cases where process has not been followed, the Safeguarding Team will engage to address the immediate safeguards, learning and continue to engage with Safeguarding Doctors and other practitioners to identify individual, team and departmental learning.

The Health Board proactively refer cases to the North Wales Safeguarding Children Board Child Practice Review Subgroup for consideration for a review.

This evidences that we are recognising where there are areas for learning and welcome the opportunity for an independent review to ensure improvements are made in practice.

The reduction in activity is an area that has been recognised and for assurance the Safeguarding Paediatricians discuss cases, referrals and outcomes in their peer review sessions with the Safeguarding Paediatrician – Named Doctor.

**Consent**

Obtaining consent to undertake a medical presents a challenge and can result in delays in the child being examined.

Local Authorities and health professionals need to work together to overcome this challenge and when required consent must be obtained via the legal system.

**What we will focus on in 2024/2025**

The development and implementation of a Child Protection Medical Standard Operating Procedure is one of our priorities. Reviewing the process and reporting is planned and is incorporated into Safeguarding and Public Protections Team's audit plan for 2024/25. The audit will explore process, themes, trends and outcomes to help inform learning and best practice.

**Priority Activity 17 for 2024-2025**

| | Activity | Timescales |
|---|---|---|
| 17a | Develop and Launch of the SOP | Q4 2024/25 |
| 17b | Audit of inflicted injury presentations | Q3 2024/25 |
| 17c | Audit Report and identification of findings and any recommendations | Q4 2024/25 |

### 3.8 Under 18's MHA Section 136 Detentions

During 2023-24 there have been 35 section 136 detentions.

Table 11 details the detentions by area and quarter.

**Table 11:** Under 18's Section 136 detentions by area

| 2023-24 | West | Central | East | Total |
|---|---|---|---|---|
| Q1 | 3 | 6 | 10 | 19 |
| Q2 | 1 | 0 | 1 | 2 |
| Q3 | 4 | 3 | 4 | 11 |
| Q4 | 1 | 1 | 1 | 3 |
| Total | 9 | 10 | 16 | 35 |

**Figure.9:** Under 18's Section 136 detentions by month and area

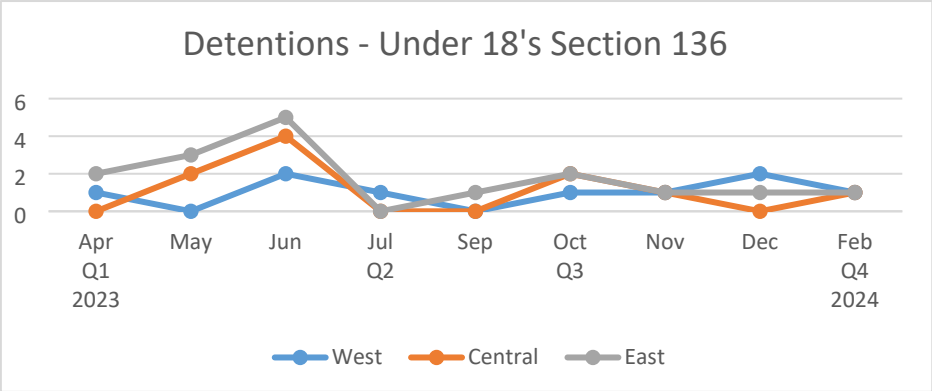



**Table 12:** Under 18's MHA Section 136 detention outcomes by area

| Outcomes | West | Central | East | Total | % |
|---|---|---|---|---|---|
| Discharged | 4 | 7 | 12 | 23 | 65.7% |
| Informal Admission | 0 | 0 | 1 | 1 | 2.9% |
| Section 2 Admission | 5 | 3 | 2 | 10 | 28.6% |
| Section 3 Admission | 0 | 0 | 1 | 1 | 2.9% |
| Total | 9 | 10 | 16 | 35 | |

**Achievements**

The Safeguarding & Public Protection Team continue to review notifications and engage in meetings to ensure all safeguards have been considered.

Any deviation from due process including timescales is escalated and the team engage with the incident reporting via Datix to ensure progress notes are updated. This supports communication and risk management to ensure all safeguarding actions have been undertaken.

**Challenges**

Timescales in terms of section 136 detention can be a challenge. The environment is not conducive for the wellbeing of young people in crisis. In addition, social care and NHS Tier 4 provision is a recognised factor which impacts upon timescales for detention.

**What we will focus on in 2024-2025**

Continued engagement to monitor activity via the three (3) IHC Safeguarding Forums.

Engage, participate and review the report and support the implementation of findings of a case in North Wales Adolescent Service on publication.

**Priority Activity 18 for 2024-2025**

| Activity | Timescale |
|---|---|
| On publication - Fully engage in the review of the findings and recommendations of the North Wales Adolescent Unit Tier 4 Learning Review Report (Oct 2023) | Q4 2024/25 |

## Practice Reviews

### 3.9 Child Practice Reviews (CPR)

Child Practice Reviews are issued under section 139 of the Social Services and Wellbeing (Wales) Act 2014. The aim is to improve practice and identify risks to safeguard children and young people.

There are a significant number of CPR's and Multi Agency Professional Forums (MAPF) commissioned in North Wales, fourteen (14) cases were reviewed during the timeframe of this report, six (6) remain in progress.

Safeguarding Team members are fully engaged and provide all panel members from BCUHB with support and supervision. BCUHB chronologies and agency analyses are quality assured by the Safeguarding Team prior to submission to the Safeguarding Board.

There are a number of key themes and trends which include poor record keeping, communication and information sharing, cannabis use, absence of the voice of the child and lived experience and the lack of trauma informed approaches.

The Safeguarding Team are fully engaged in supporting a high-level landmark CPR where there are multiple cases under review. This engagement has involved the review of thirty-eight (38) sets of notes and the development of five (5) timelines. The Director of Safeguarding and Public Protection is the panel representative for BCUHB as the CPR required a high level of experience and expertise.

BCUHB are engaged in the Thirlwall Inquiry and any findings for improved NHS practice will be implemented.

**BCUHB Quality Assurance Group**
**Child Practice Review, Adult Practice Review and Domestic Homicide Review**

The CPR/APR/DHR Quality Assurance Group is to ensure BCUHB has a strong Quality and Governance Framework for multi-agency reviews.

The group promotes and role models a positive culture of multi-agency learning and sets in place a proactive supportive foundation for learning.

All CPR/APR/DHR's are reviewed on a monthly basis to:

- Identify early learning for the health board and agree any necessary actions
- Identify any challenges/drift within the process
- Identify and share good practice to support learning
- Capture key themes and trends to inform priority activity
- Ensure agreed data is captured and populated on the CPR/APR/DHR Q&A Group template
- Respond to any triggers for internal escalation to the Director of Safeguarding and Public Protection, these include:
    1. Delay, drift of lack of progress in a case
    2. Key learning for the health board
    3. Draft report produced
    4. Final report produced and expected date of publication
    5. Draft Action Plan
    6. Safeguarding Senior Leads Meeting – General update on all cases

- Look back at historical reviews to monitor the impact and if change has been maintained. The findings are also cross referenced with key recommendations from safeguarding reviews and National Inquiries. A recommendation from a recent CPR in relation to handover of cases was also a recommendation within the JICPA report.

  This highlights the importance of the triangulation of findings offering robust governance, reduce duplication and identify themes and trends.

**Achievements**

The Safeguarding Team are fully engaged in all practice reviews in the role of Chair, Reviewer or panel member. Members of the team with the correct level of experience and expertise are attending the Single Unified Safeguarding Review training in preparation for the go live date of October 1st, 2024.

The Quality Assurance Group is very well established and provides a platform for robust scrutiny, learning, escalation and reporting.

**Challenges**

The number of Practice Reviews is challenging for the Health Board and the Safeguarding and Public Protection Team and colleagues across the Health Board, due to the level of demand and volume of work that each review requires.

There are currently six (6) live action plans, three (3) are 100% complete and will be subject to periodic review via the CPR Subgroup.

Two (2) are partially completed with all BCUHB action either completed or on target.

One (1) action plan from a review commissioned in 2021 requires a robust review, this has been tabled to take place at the next NWSCB CPR Sub-Group. BCUHB actions are complete or on track with the exception of two actions which relate to documentation for the purpose of handover between School Nurses and the limitations of information sharing in the absence of electronic records.

There are currently seven (7) commissioned Domestic Homicide Reviews in progress. There are a further 3 that are completed, where the final reports are with the Home Office for sign off, with a further one that was agreed during the reporting period.

During the reporting period there was 1 newly commissioned DHR. Health Board engagement with DHR's is monitored monthly in the CPR/APR/DHR Quality Assurance group.

A concerning theme emerging from these reviews relate to victim suicide, four of the cases have related to death by suicide. Other themes include impact of rurality on disclosing domestic abuse, lack of curiosity around presentations to health services with follow up targeted enquiry.

**What we will focus on in 2024/2025**

Child Practice Review findings are included in the training activity for National Safeguarding Week in November 2024.

A six month and Annual CPR QA Group report will be produced and will follow escalation following the Safeguarding Reporting Framework.

The Safeguarding & Public Protection Team will continue to support the process, with recognition that this will transfer over to the Single Unified Safeguarding Response (SUSR) from October 2024.

Learning from reviews will continue to be disseminated by way of 7-Minute Briefings and accompanying power point presentations, through the IHC and MHLD Safeguarding Forums and Safeguarding Governance & Performance Group.

A review of Quality Monitoring will take place to ensure organisational accountability is in line with the revised BCUHB Governance Framework.

**Priority Activity 19 for 2024-2025**

| | Activity | Timescale |
|---|---|---|
| 19a | Quality Monitoring Review – stage 1 | Q4 2024/25 |
| 19b | Produce a six month and annual position report of practice review activity and action plans status | September 2024<br>April 2025 |

### 3.10 Child Sexual Abuse (CSA), Child Sexual Exploitation (CSE) & Harmful Sexual Behaviour (HSB). National Action Plan for Preventing and Responding to Child Sexual Abuse

The Action Plan is a legal requirement and requires targeted intervention and management. BCUHB CSA Action Plan is aligned to the WG Action Plan (Independent Inquiry into Child Sexual Abuse IICSA 2022) recommendations.

The new National Action Plan is due for publication in early Spring 2025 with a focus on prevention and how we respond to safeguard children from Sexual Abuse, Sexual Exploitation and Harmful Sexual Behaviour. The action plan will also include how we support adult survivors of child sexual abuse.

**Achievements**

The Safeguarding Team have been fully engaged in the Children's Commissioner for Wales Round Table on Preventing Child Sexual Abuse and Exploitation. This engagement has ensured that the Safeguarding Team are informed and able to plan and prepare our response to the action plan once published.

A BCUHB Task & Finish Group has been established with an agreed Terms of Reference. A draft response action plan has been developed and will be finalised prior to wider consultation upon receipt of the published WG Action Plan.

The CSA/CSE Level 3 Training package has been developed and received excellent feedback in terms of content and delivery. A 7-minute briefing has also been developed and cascaded to support awareness raising.

The safeguarding Team is also engaged in an All-Wales Task & Finish Group reviewing the CSERQ15 which is the agreed All Wales Risk Assessment in relation to sexual exploitation.

**Challenges**

The delays in the publication of the Welsh Government second iteration Action Plan have affected the smooth and timely transition between one plan and another.

Through engagement with the Round Table Group we have, however, continued to focus on this activity through training, supervision and the established Task & Finish Group.

**What we will focus on in 2024/2025**

Full engagement with the WG Action Plan when published.

**Priority Activity 20 for 2024-2025**

| | Activity | Timescale |
|---|---|---|
| 20a | Continued engagement with the CSA/CSE/HSB Task & Finish Group in preparation for the second iteration of the WG National Action Plan | Q3 2024/25 |
| 20b | Completion, Consultation and Ratification of BCUHB Action Plan | Q4 2024/25 |
| 20c | Launch of the BCUHB CSA/CSE/HSB Action Plan | Q4 2024/25 |

## 4. Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV)

### 4.1 Independent Domestic Violence Advocates (IDVA)

The Health IDVA Service that is hosted by the Health Board. Information from the Domestic Abuse Safety Unit (DASU) demonstrated that referrals for Quarter 4, for example, had more than doubled since Quarter 3. This in part could be attributed to the IDVA service becoming increasingly established within the Health Board.

This three-year project saw an IDVA placed within each Secondary Care Hospital and provide support to community-based services. The roles are funded by The Office of the Police and Crime Commissioner (OPCC), and they are employed by Gorwel (in the West IHC area) and DASU (in the Central and East IHC areas). Since the 27th of July 2024 all of the IDVAs have been managed by DASU, Gorwel having relinquished the contract.

The IDVAs undertake activities to promote their role and support events such as International Women's Day and National Safeguarding week. They have also hosted stalls in the Mental Health Units to again allow staff and patients to approach the IDVAs for advice and support.

They have supported the delivery of VAWDASV training and attend the Carer and Patient Champion meeting to discuss their role. They actively engage and provide an expert role in all activities within the BCUHB Domestic Abuse agenda.

**Achievements**

An increase in their referrals is demonstrating the need for their service to remain within the Health Board. Their presence within the workplace safety groups has been invaluable and patient stories has evidenced the appreciation of those staff members who are victim/survivors of domestic abuse.

The IDVAs are increasingly capturing Domestic Abuse within the older persons population, this is extremely significant as this population are underrepresented in general Domestic Abuse data.

**Challenges**

The funding to sustain the health IDVA role is due to end at the end of March 2025. BCUHB are engaging with the evaluation of the service to support future funding.

**What we will focus on in 2024-2025**

We will continue to work alongside DASU and the OPCC in relation to the longer-term funding for the health IDVA roles.

### 4.2 Multi-Agency Risk Assessment Conference (MARAC)

**Table 13:** MARAC Referrals by health

| Year | West | Central | East | Out of Area | Total |
|---|---|---|---|---|---|
| 2018-19 | 46 | 57 | 68 | 0 | 171 |
| 2019-20 | 66 | 53 | 61 | 0 | 180 |
| 2020-21 | 46 | 68 | 63 | 0 | 177 |
| 2021-22 | 54 | 83 | 64 | 0 | 201 |
| 2022-23 | 60 | 86 | 84 | 2 | 232 |
| 2023-24 | 53 | 101 | 93 | 0 | 247 |

**Table 14:** MARAC Referrals by Area

| Year | West | Central | East | Out of Area | Total |
|---|---|---|---|---|---|
| 2022-23 | 60 | 86 | 84 | 2 | 232 |
| 2023-24 | 53 | 101 | 93 | 0 | 247 |
| Change | ↓ 11.7% | ↑ 17.4% | ↑ 10.7% | ↓100% | ↑6.5% |

Table 14 illustrates an overall increase in MARAC referrals during 2023-24 when compared to last year. Both the Central IHC and East IHC areas have a recognised increase, the West has recorded a decrease of seven (7) referrals.

92.7% of these referrals have been in relation to female victims. This is consistent with the usual trend.

When analysing the age of the victims, we find that 61.5% of the referrals were in respect of victims under the age of forty (40).

Upon reviewing the relationship of the perpetrator to the victim, 42.5% (n=105) record the perpetrator as the current partner/husband/wife. 32.8% (n=81) of the referrals record the relationship of the perpetrator as the ex-partner/ex-husband/ex-wife.

Health Visitors submitted the most MARAC referrals with 26.3% (n=65). This continues the trend seen in 2022-23.

60.3% (n=149) of the victims had children at the time of the referral, twenty-eight (28) were also pregnant. Seventeen (17) of the women that did not have children were pregnant at the time of the referral. This means that nearly a third of all MARAC referrals were for women that were pregnant, supporting research findings that pregnancy is often when domestic abuse starts or escalates.

**Achievement**

We have had consistent engagement in the regional MARAC steering group and have initiated a key piece of multi-agency work.

The Group now meet quarterly to dip sample the journey of a victim of Domestic Abuse, from the point of referral into MARAC, and then through the MARAC meeting itself, looking at the quality of information sharing, discussion and action setting. The learning and good practice identified will then be shared within the relevant agencies.

The Health Board host 3 Independent Domestic Violence Advocates (IDVA) and during this reporting year they have seen an increase in contacts made to them for advice and guidance. This could account for the increase in MARAC referrals.

Weekly Multi Agency Risk Assessment Conference (MARAC) present a challenge in terms of demand and capacity. The quick turnaround for information sharing and the required need to obtain BCUHB contact intelligence and the amount of time required to engage in this activity imposes pressure on the Safeguarding Team representative, administration support and those completing the research forms. Despite this, there has been 100% engagement and representation at weekly and monthly MARACs from the Safeguarding & Public Protection Team throughout the reporting year.

**Challenges**

The numbers of victims discussed in MARAC across the region continues to rise which poses significant challenge from an administrative perspective for the team and for the practitioners who are working with the victim.

Going forward, this data will be shared within the regional MARAC steering group to inform future practice and business planning. Whilst the Safeguarding and Public Protection Team attend all weekly and monthly MARAC meetings, consistent attendance has been a challenge for colleagues in the MHLD division at times. We are working closely with the division to monitor attendance and support with action setting where needed.

Reduced training compliance in Violence against Women Domestic Abuse Sexual Violence (VAWDASV) is a reported key activity. Most teams within the Health Board are below 85%, in light of the activity and the catastrophic outcome for victims, bespoke and targeted training intervention is taking place.

A further area of concern is the reported possible reduction in government funding for the IDVA service in the future. This may have a detrimental impact upon activity, service delivery and outcome for victims. We remain vigilant to this discussion.

**What we will focus on in 2024-2025**

Audit to ensure the administrative processes within the Health Board for MARAC is consistent across the region. Additionally, the safeguarding practice development leads are in consultation to develop bespoke training for MARAC representatives within the Health Board.

Training is a key priority and is reported within the Training and Learning section of this report.

**Priority Activity 21 for 2024-2025**

| | Activity | Timescale |
|---|---|---|
| 21a | Produce a report in relation to the dip sampling group and present to Safeguarding Senior Leads, IHC Safeguarding Forums and Safeguarding Governance & Performance Group | Q4 2024/25 |
| 22b | Bespoke MARAC representative training for Health Board MARAC representatives will be developed and implemented. | Q4 2024/25 |
| 22c | Review the administration processes within the Safeguarding and Public Protection Team for MARAC to ensure that practice is consistent across the region | Q4 2024/25 |

### 4.3 IRIS

The Ministry of Justice provided £20k to the Office of the Police and Crime Commissioner, to implement the IRIS pilot in North Wales in 2021. BCUHB were engaged in the steering group meetings to discuss the implementation of the pilot.

The project was managed by the Domestic Abuse Safety Unit (DASU) and was piloted in 8 GP practices within South Denbighshire. For context, there are 98 GP surgeries within North Wales. Training commenced with the GP surgeries in April 2022.

In September 2022, the Safeguarding and Public Protection Team in BCUHB, were informed that the current OPCC funding was to cease at the end of March 2023, and ongoing funding was expected from within BCUHB. BCUHB were aware that in other areas, IRIS had been funded by Primary Care.

To support parallel planning, the Safeguarding and Public Protection Team funded the project from April 2023, until the end of September 2023, whilst alternative funds were being explored from within the Primary Care Clusters. BCUHB also requested a formal service evaluation, to demonstrate the impact of the IRIS project to support the funding discussions.

In June 2023, DASU and the regional VAWDASV coordinator were informed that unfortunately, the GP Clusters and BCUHB were not able to commit financially to the continuation of the IRIS project, beyond September 2023. The Welsh Government were sent An Early Warning Notification to notify them of the position.

A detailed evaluation was requested however was not received. It was later confirmed that only 2 GP practices had engaged in the pilot since its inception, resulting only twenty-eight (28) referrals in total.

The IRIS pilot came to an end in North Wales in September 2023.The BCUHB Safeguarding and Public Protection Team offered support with an exit strategy, and continued to provide training, advice and guidance relating to VAWDASV for GP surgeries. This has also included bespoke training sessions to accommodate out of hours GP's.

Further discussions continued to take place with Primary Care to gain assurance that service provision, in relation to practice expectations for VAWDASV were maintained.

**Achievements**

BCUHB continue to deliver Training and support the GP Clusters in VAWDASV.

### Challenges

The absence of a sustainable funding model and formal evaluation to support funding unfortunately resulted in the programme coming to an end.

### What we will focus on in 2024-2025

The Safeguarding and Public Protection Team have engaged, and will continue to engage, with the Welsh Government IRIS Round Table meetings, in relation to the future of IRIS implementation across Wales.

**Priority Activity 22 for 2024-2025**

| Activity | Timescale |
|---|---|
| Engagement with Welsh Government Round Table meetings relating to IRIS | Q4 2024/25 |

### 4.4 Domestic Abuse Screening Tool

During the reporting period, the Safeguarding and Public Protection Team reviewed and updated the national HITS matrix (Hurt, Insulted, Threatened, Screamed) that is used within the Health Board to screen for domestic abuse. This matrix is primarily used as Routine Enquiry into Domestic Abuse in Maternity and in the Emergency Departments. It was felt that HITS was not an appropriate acronym for domestic abuse. This was discussed within the National Safeguarding Service in Public Health Wales, and it was evident that other Health Boards had moved away from this acronym too.

The updated Domestic Abuse Screening Tool had wide consultation throughout the Health Board and with the health IDVA's before the final version of the tool was ratified in April 2024. It was also shared with the national VAWDASV steering group and was well regarded as an excellent initiative. BCUHB Ratification has taken place.

**Priority Activities 23 for 2024-2025**

| Activity | Timescale |
|---|---|
| Commence the implementation of the tool, with the development of an action plan to evidence implementation, audit, evaluation and review in 2025-2026 | Q3 2024/25 |

### 4.5 North Wales without Violence: The North Wales Serious Violence Response Strategy 2024

The North Wales Serious Violence Response Strategy was launched on the 18.06.2024, the objective of the plan is to work with communities to prevent and reduce serious violence across the region.

The key priorities of the North Wales strategy are:

a) Supporting and enhancing prevention and early intervention around violence against women and girls, domestic abuse and sexual violence (VAWDASV).
b) Promoting contextual safeguarding to work with children and young people vulnerable to exploitation and/or modern slavery.
c) Identifying and implementing improvements, best practice and innovation as a partnership to respond to serious violence.
d) Building a preventative approach in North Wales, through and understanding of risk, adverse childhood experiences and trauma.

BCUHBs Safeguarding and Public Protection Team are committed to engage fully with the four (4) key steps of implementing the public health approach, and the nine (9) key violence prevention principles have been identified in collaboration with children and professionals across Wales.

### Achievements

BCUHB Safeguarding & Public Protection Team are fully engaged in the Serious Violence Duty Steering Group which was commissioned by the Safer North Wales Partnership. This has enabled BCUHB to be proactive and prepared. BCUHB membership is agreed and the first meeting is to be convened.

### Challenges

The size of the organisation is always a challenge when we consider how we introduce and embed new legislation, policy and procedures. Through engagement with the Steering Group and a robust multi-agency Implementation Programme, we are confident we can overcome this challenge. The Safeguarding Reporting Framework will support the governance and monitoring arrangements.

### What we will focus on in 2024/2025

The awareness and implementation plan will be the focus moving forward to ensure that BCUHB are informed and engaged, and the strategy is fully embedded and informing practice.

### Priority Activities 24 for 2024-2025

| | Activity | Timescale |
|---|---|---|
| 24a | Full engagement with the implementation steering group | Q3 2024//25 |
| 24b | Host a BCUHB awareness raising event during National Safeguarding week | November 2024 |

### 4.6 Sexual Assault Referral Centre (SARC)

The North Wales Sexual Assault Referral Centre (SARC) was established as a partnership between North Wales Police, Betsi Cadwaladr University Health Board and Third Sector Agencies in 2010.

The Centre is in a North Wales Police building based in Colwyn Bay and provides a service for adults and children or young people for the population of North Wales.

Services offered include:

- Forensic Medical Examination Service (adults and children)
- Non-acute Paediatric clinic
- Sexual health and contraceptive services
- Self-referral service (including by video link) offering advice and support for individuals unsure of reporting to the police

### 4.6.1 SARC International Organisation for Standardisation (ISO) Accreditation

The Forensic Science Regulator has published supporting Guidance and Codes of Practice and Conduct (March 2023) to support the attainment of International Standards for Anticontamination of Sexual Assault Referral Centre's and Assessment, Collection and Recording of Forensic Science related evidence. This accreditation must be implemented across all SARCs by October 2025.

**Achievements**

BCUHB have worked collaboratively with North Wales Police towards an accreditable structure. There is a project management team and a service delivery structure in place which enables the timely escalation and resolution of challenges.

The building work is complete and offers state-of-the-art facilities and required Standard Operating Procedures are complete.

**Challenges**

The SARC ISO Accreditation is currently in exception with the view it will not meet the October 2025 deadline. During the past 6 months there have been some environmental concerns impacting on staff health and well-being, this has resulted in staff not being able to access the building which has impacted upon progress.

There is also a legal issue in terms of the commissioning of forensic medicals which requires resolving. This has resulted in forensic medicals being outsourced to St Mary's in Manchester and Alder Hey Children's Hospital, Liverpool. Whilst this does result in some travelling for children and their families, it does ensure that medicals are undertaken by competent professionals. This outsourcing of medicals also applies for adults.

The ISO Accreditation identifies a required competency framework for skilled forensic practitioners. This includes the number of forensic medicals completed by each practitioner. The demand for sexual assault medicals is low, and discussions are taking place with the Central IHC to agree service delivery with North Wales police.

Executive Director of Nursing and Midwifery is fully engaged, and regular meetings are being held to explore options and agree a sustainable model moving forward. Communication with key partner agencies is taking place.

## 5. Adults at Risk

In 2023-24, the Health Board submitted one thousand nine hundred and sixty-three (1963) Adult at Risk reports from across internal services as well as from commissioned services. Table 15 below demonstrates the continuous increase in the annual number of Adult at Risk reports from 2020-21 to date. The number of reports received during 2023-24 has seen a 14.4% increase when compared to last year's figure. Regular audits have indicated a direct link between the rise in reported concerns and the increase in training across the Health Board.

**Table 15:** Adult at Risk Reports by Year

| Year | Reports | % change |
|---|---|---|
| 2020-21 | 1284 | ↑ 5.3% |
| 2021-22 | 1407 | ↑ 9.6% |
| 2022-23 | 1716 | ↑ 22.0% |
| 2023-24 | 1963 | ↑14.4% |

**Table 16:** Adult at Risk Reports by Area

| Year | West | Central | East | Out of Area | Total |
|---|---|---|---|---|---|
| 2022-23 | 614 | 512 | 558 | 32 | 1716 |
| 2023-24 | 639 | 700 | 589 | 35 | 1963 |
| % Change | 4.1% ↑ | 36.7% ↑ | 5.6% ↑ | 9.4% ↑ | 14.4% ↑ |

Table 16 above provides the breakdown of reports by area. All three areas have seen an increase when compared to last year's statistics, and all three areas are consistent in their reporting of concerns. Every copy of the report submitted to the Local Authority is quality assured by the Safeguarding and Public Protection Team. Engagement at an early stage provides the necessary safeguarding support and guidance as well as offering immediate assurance of actions take to reduce and/or remove any current or further risk of harm to the adult(s).

During 2023-24 due to the triangulation of themes from Adult at Risk Reports, findings from an Adult Practice Review, recognised challenges relating to homelessness and Mental Health, the promotion of the North Wales Protocol on Self-Neglect was a key activity.

It should be noted that although there is an increase in reporting this does not suggest an increase in neglect or abuse. The purpose of the Adult at Risk process is to protect individuals from the risk of harm through early reporting and the identification of the potential risk to the individual. Increase reporting is seen as a proactive and protective measure.

**Achievements**

There is now a regular active offer of Safeguarding Adult Supervision across the Health Board. Findings and outcomes of safeguarding reports have informed the training programme to ensure the Health Board maintains an informed workforce.

In line with HASCAS/Ockenden Recommendations the Team continue to offer additional support to the Mental Health and Learning Disability Division (MHLD) as well as providing specialist support to the Dementia awareness and safeguarding agenda.

The Team attend every MHLD Putting Things Right Meeting (PTR) to engage in discussions relating to all concerns raised by the Division.

The Regional Safeguarding Specialist for Adults with Dementia has been supporting the Health Board alignment with Standard 16 of the Wales Dementia Care Pathway. This has been achieved through the delivery of dementia care mapping and applying specific development in relation to safeguarding practices and the use of the Mental Capacity Act principles in practice.

**Challenges**

The number of Adult at Risk Reports has increased in the 2023- 2024 period compared to that of the 2022-2023. This follows a regional and national in reported concerns. All three areas across the Region are showing an increase in the number of reports submitted. To support with this increase we have ensured attendance at Governance Groups where the Adult at Risk Reports are discussed along with incidents and concerns.

The predominant number of Adult at Risk Reports are generated from commissioned services such as residential placements, nursing homes or independent hospitals.

In 2023-24 in excess of 70% of all Adult at Risk Reports submitted did not relate to Health Board premises or sites. There is engagement within Continuing Health Care (CHC) Services and the Right Care Assurance Programme (RCAP) Team.

An area of particular importance is participation within the quality agenda of commissioned services which included direction and guidance through the Escalating Concerns Improvement Framework and the Modern Slavery process.

The Health Board implementation of the Missing Person Procedure and North Wales Police Multi-Agency Herbert Protocol has offered limited assurance. This can impact on the ability of Agencies to respond in a timely manner to concerns. To mitigate this risk, a relaunch of the Herbert Protocol has been agreed. The Protocol provides a meaningful summary of a person's likes, dislikes, favourite places and known associates which can support finding the individual.

The Wales Dementia Friendly Hospital Charter aims to enhance the experience of a person living with dementia and their carer/loved ones during a hospital admission. This includes measures to safeguard individuals from avoidable harm along with the identification of any pain and discomfort of any kind. The Safeguarding and Public Protection Team are engaged and active in progressing this charter. There is currently an 'All Wales' proposal for more quality care for people living with dementia to highlight the impact on this group within the acute setting.

**Priority Activities 25 for 2024-2025**

| | Activity | Timescale |
|---|---|---|
| 25a | Further development and implementation of the Section 126 Enquiry Form across the Health Board | Q4 2024/25 |
| 25b | Re-launch the Designated Safeguarding Person role – SSWWA 2014 | Q3 2024/25 |
| 25c | Registered Audits of all Adult at Risk Reports | Q4 2024/25 |
| 25d | Re-Launch the Herbert Protocol across the Health Board and audit compliance and awareness. | Q3 2024/25 |
| 25e | Re-Launch the Missing Persons Procedure across the Health Board and audit compliance and awareness | Q3 2024/25 |
| 25f | Ensure the Mental Capacity Act is a standing agenda item at all Health Board Safeguarding Forums | Q12024/25 |
| 25g | Promote the Deprivation of Liberty Safeguards across Care of the Elderly Wards | Q4 2024/25 |

### 5.1 Deprivation of Liberty Safeguards (DoLS)

NHS Health Boards have reported a significant increase in DoLS applications, legal challenges and Court of Protection activity. The increase does not evidence the required resource and commitment to fulfill this legal requirement, which is fundamental to patient safety and experience. Welsh Government have recognised this increase in activity, and they have acknowledged the postponement of the revised guidance (Liberty Protection Safeguards) has been challenging for all Organisations.

The service is split into two key functions; the Supervisory Body, which is the role of the Safeguarding Team/DoLS. This function must be independent of clinical care and holds a governance and oversight remit and includes the function of Best Interest Assessors' (BIAs).

The Managing Authority is the function of the wards/units who hold a clinical role, which includes identification and submission of an application.

The implementation of the Mental Capacity (Amendment) Act 2019 and the Liberty Protection Safeguards (LPS) was placed on hold by UK Government prior to the General Election in July 2024. Welsh Government (WG) continue to ensure additional funding is available to strengthen the current DoLS system and implement elements of the LPS. BCUHB follow WG directives by promoting MCA awareness and delivering MCA training whilst addressing the DoLS backlog (legal term for applications awaiting authorisation).

The MCA/DoLS National Workforce Group continues to focus on the MCA and DoLS enabling stakeholders to jointly consider issues of local concern that may have a wider or national relevance and provide a forum for joint working on national projects. In partnership with other Health Boards, the National Workforce Group continues to meet every quarter. The current action plan looks to address the following:

- DoLS paperwork – Develop National DoLS Forms to update and simplify the forms incorporating the necessary information only to ensure continued working within the Law.
- MCA Training – Explore and develop National Training Standards and training packages.
- DoLS Process – Explore areas for improvement and the implementation of a potential new DoLS work stream.

An internal Audit DoLS review was initiated in Quarter 4 2023-24. The aim was to review the processes in place for the management of DoLS activity in the Health Board, including process and guidance, procedures, staff training, monitoring and escalation of cases. The final report was issued on the 16th April 2024. The outcome was: Limited Assurance.

The Key areas for improvement are

- Mandatory Mental Capacity Act Training- compliance figures for Bank, Locum and Honorary staff are low.
- DoLS Timescales - Urgent DoLS applications should be completed within 7 days, per the Mental Capacity Act; Deprivation of Liberty Safeguards Code of Practice; urgent applications can be extended for an additional 7 days if necessary. The Supervisory Body (Safeguarding Team) continue to address quality issues with relevant areas and continue to review capacity of BIAs and Mental Health Assessor (a S12 (2) Approved Doctor).
- Quality - The overall applications from Managing Authorities have been returned due to either being incomplete and not of appropriate quality, therefore impacting on the timescales of completion.

An Improvement Action Plan is in place with monthly reporting on progress and quarterly reporting to the Executive Director for Nursing and Midwifery and quarterly into the Mental Health Legislative Committee.

**Achievements**

Following the Welsh Government (WG) bidding process, the Health Board was successful in securing additional funding for 2023-2024 to support the activity to strengthen the implementation of the DoLS legal process, reduce what is referred to as the ‘Deprivation of Liberty Safeguards backlog’ and to promote the Mental Capacity Act understanding and compliance across the Health Board. WG has confirmed that additional funding will be made permanent in line with a bidding process.

Prior to WG funding, the Health Board had a Backlog of approximately 144 cases The Health Board has seen the backlog as low as 16 cases during 2023-24.

It is important to note the number of applications received can differ significantly from month to month, therefor the backlog will fluctuate.

With the figure dependant on a number of factors that include good communication, accuracy of reporting, and the increase in reports received. The success of improved training compliance and MCA awareness has resulted in an increase of 27.3% in DoLS applications during 2023-24.

**5.2 Welsh Government Resource**

Our Best Interest Assessors and Section 12(2) Doctors complete additional DoLS Assessments during evenings and weekends to ensure patients are protected by the Legal Framework.

Utilising WG funding the Health Board has been able to offer developmental opportunities for trained staff within the team to support the strategic and operational management of DoLS and the MCA. A number of secondment opportunities have been fulfilled.

A dedicated MCA Trainer within the DoLS/MCA Team is in post to assist the Health Board in achieving compliance with the Mental Capacity Act (MCA). Audit findings have informed the Health Board, the MCA Level 1 and Level 2 Training compliance has increased and there is a greater awareness of the application of the MCA.

The Team have worked with partner agencies to support an increase Independent Mental Capacity Advocate's across North Wales. The previous allocation of 3 advocates was not enough, WG recognised this and provided additional funding. As a result of this funding there are 10 commissioned IMCA's supporting people across North Wales.

**Table 17:** MCA Training Compliance

| All Staff | March 2023 | March 2024 | Trend |
|---|---|---|---|
| MCA Level 1 | 79.0% | 80.4% | ↑ |
| MCA Level 2 | 78.8% | 79.4% | ↑ |

A Court of Protection (CoP) Deprivation of Liberty (DoL) Paediatric Lead was seconded in order to support the continued development of additional assurance with regard to MCA awareness specific to 16-17 year olds and to develop and secure a process to support staff with their engagement in the CoP DoL process.

A Draft Standard Operating Procedure [SOP] has been developed and is currently progressing through the governance process for ratification and approval.

The additional activity undertaken has resulted in improved awareness and knowledge of DoLS and the MCA throughout the Health Board. As a result of this we have seen a significant rise in applications impacting on the DoLS activity, we continue to review this position.

In March 2024 there was a significant increase of new starters within the Health Board, workforce activity impacts upon data and compliance. This is an area we are considering in our audit activity.

**Priority Activity 26 for 2024-2025**

| | Activity | Timescale |
|---|---|---|
| 26a | Additional MCA and DoLS Training to be delivered and audited, with key areas recognised, as required as targeted intervention | Q4 2024/25 |
| 26b | Re-distribute MCA materials across Health Board Services | Q1 2024/25 |
| 26c | Implement Recommendations from the Internal DoLS/MCA Audit | Q4 2024/25 |

### 5.3 Audit the impact of new or temporary workforce in the application activity Q4

### Adult Practice Reviews (APR)

Within this reporting timeframe there was one published Adult Practice Review in North Wales. This was in relation to an adult who had multiple comorbidities and was known to many services although they rarely engaged with services through choice. The review predominantly highlighted concerns that health staff who were denied access to a vulnerable adult failed to implement local 'no access guidance' which may have identified an Adult at Risk thus engaging the statutory framework. However, it was recorded that the Adult themselves would have unlikely engaged in the process.

### Achievements

In collaboration with multiple services across the IHC's and the MHLD Division a procedure for monitoring adults with vulnerabilities 'Who Were Not Brought', 'Did Not Attend' Appointments, and 'No Access Visits' has been developed. It was necessary to have engagement from all services to ensure a unilateral agreement to what should be done in this situation.

A key priority of the process was an easy-to-follow flow chart for staff who need quick and supportive access and direction when faced with similar situations.

### Challenges

The low numbers of Adult Practice Reviews is a recognised trend by both the North Wales Safeguarding Adult Board and the National Safeguarding Network as a national trend. The planned introduction of the Single Unified Safeguarding Review (SUSR) in 2024-25 will support additional awareness of the need to complete Adult Practice Review applications. During 2023-24 the Team have proactively provided APR awareness sessions within safeguarding supervision to promote the process.

**Priority Activity 27 for 2024-2025**

| Activity | Timescale |
|---|---|
| Promote the use of the APR process with consideration given to the; Unexplained Death of an Adult Procedure – North Wales Safeguarding Board | Q1-Q4 2024/25 |

### 5.4 MAPPA (Multi Agency Public Protection Arrangements)

MAPPA is the statutory framework for managing sexual and violent offenders following their release from detention. The Health Board are core members of two levels of MAPPA. These are known as Level 2 and Level 3. The term 'Level' is an indication of the risk associated with each individual. The purpose of MAPPA is to reduce the re-offending behaviour of sexual and violent offenders in order to protect the public, including previous victims, from serious harm. It aims to do this by ensuring that all relevant agencies work together. The Team, along with representation from the MHLD Division attend all meetings and provide proportionate information.

**Achievements**

The Safeguarding and Public Protection Team have secured 100% attendance at the strategic MAPPA Board and at MAPPA Level 2 and 3 both in North Wales and out of the area.

As standing members of the MAPPA process the team have been actively engaged in making disclosures to clinical services where MAPPA nominals (term used for individuals supported under MAPPA) may attend to ensure those services have appropriate risk assessments in place and know how to escalate any concerns or seek the required support. The Team have also undertaken work with the North Wales MAPPA leads to ensure that the invites to the monthly meetings for each of the 6 counties across North Wales are shared with the appropriate people within the team to ensure all meetings are attended.

**Challenges**

Across all six counties in North Wales there have been high numbers of MAPPA nominals reviewed at Level 2. The pressures to ensure these cases are reviewed in line with the statutory MAPPA guidance has resulted in a number of extra MAPPA sessions being undertaken across all areas outside of the regular monthly dates.

The North Wales MAPPA co-ordinator has expressed gratitude for the engagement from the Health Board in ensuring attendance at meetings. The increase has impacted upon team priorities and activity as MAPPA must be prioritised.

Following an incident that involved a MAPPA 2 nominal re-offending, a MAPPA Serious Case Review (SCR) has been commissioned by the Probation Service. This means that the Safeguarding Team are core members of the review and will be tasked with providing necessary information under the statutory framework.

**Priority Activity 28 for 2024-2025**

| | Activity | Timescale |
|---|---|---|
| 28a | Embed any recommendations and learning from the MAPPA SCR | Q4 2024/25 |
| 28b | Complete and share an SBAR in relation to the capacity and ability to engage and attend MAPPA meetings | Q3 2024/25 |

### 5.5 PREVENT

PREVENT is part of the UK's Counter Terrorism Strategy. The early intervention support provided by PREVENT addresses the personal and social factors which make people more receptive to radicalisation, diverting people away from being drawn into violent ideologies and criminal behaviour. PREVENT aims to protect those who are vulnerable to exploitation from those who seek to get people to support or commit acts of violence and Healthcare staff are well placed to recognise individuals, whether service users, patients or staff, who may be vulnerable and therefore more susceptible to radicalisation by violent extremists or terrorists.

Every member of Health Board staff has a role to play in protecting and supporting vulnerable individuals who use our services with the implementation of the PREVENT agenda being fundamental to our duty of care. The Safeguarding and Public Protection Team support services or individuals to consider and make referrals under the PREVENT agenda. The Team also provide the analysis of Heath information held by the Health Board as part of the Channel Panel Meeting statutory framework. The Panel is an initiative to support those at risk of radicalisation and provides intervention as part of the process. There is statutory representation from the Team at the North Wales PREVENT Delivery Group. This group coordinates anti-terrorism activities across North Wales to reduce the risk of radicalisation and the harms of extremism.

#### Achievements

In line with the PREVENT Duty, guidance and the National Intercollegiate Training document, the Health Board have taken the positive step of mandating Home Office PREVENT awareness training. The key principles and objectives of this along with support from the Safeguarding and Public Protection Team are that; staff know how to safeguard and support vulnerable individuals, whether service users, patients or staff, who have been identified as being at risk of being radicalised by extremists. A process is in place for staff to raise concerns if they believe that this form of exploitation is taking place; and the Health Board promotes and operates safe environments.

#### Challenges

The key challenge for the Health Board is to ensure that staff have the skills to interpret potential terrorism/anti-terrorism signs correctly, are aware of the support that is available and are confident in referring any person(s) for further support under the PREVENT process.

#### Priority Activity 29 for 2024-2025

| | Activity | Timescale |
|---|---|---|
| 29a | Adopt the PREVENT training onto the ESR System | Q3 2024/25 |
| 29b | Support the appointment of a CAMHS representative at the PREVENT Delivery Group | Q3 2024/25 |

### 6. Trauma Risk Management (TRiM)

TRiM was introduced to the Health Board in 2019. It was adopted by the Health Board as part of a recommendation from a Child Practice Review following the death of an inpatient baby where staff felt they required more support. The training was commissioned and undertaken in November 2019 and the TRiM process went live within the Health Board in May 2020.

**Table 18:** TRiM Referrals by Year

| Year | Referrals | % change |
|---|---|---|
| 2020-21 | 29 | |
| 2021-22 | 41 | ↑ 41.4% |
| 2022-23 | 58 | ↑ 41.5% |
| 2023-24 | 96 | ↑ 65.5% |

In 2023-2024 we recorded a 65.5% increase in the number of TRiM referrals submitted from Health Board staff and services, see table 18 above. Since the introduction of this supportive process referrals have quadrupled. However, the demand and success of the TRiM has resulted in additional pressure on the Safeguarding Public and Protection Team due to the demand. The Team have trained additional colleagues from other services to support but further investment may be required and an SBAR is being produced to support this activity.

Although not all TRiM referrals meet the threshold the Team always provide staff with other options such as signposting to more appropriate support, services or the offer of supervision.

**Achievement**

The increase is a clear indication that staff across the Health Board are aware of the TRiM process when there has been an incident or staff have been exposed to trauma. BCUHB are one of only two Health Boards in Wales that provide TRiM support for staff. There are currently have twenty-nine staff trained as TRiM Practitioners although more are needed to meet the demand.

The Team are engaged in the National TRiM Network that meet monthly with other Health Boards across England and Wales to look at how they are implementing TRiM within their organisations. This provides an opportunity to benchmark against other services and share learning, challenges and experiences.

The TRiM Standard Operating Procedure has recently been reviewed and updated and is available on the Health Board Safeguarding webpage.

**Challenges**

The increase in demand has been challenging for the Team. TRiM work is undertaken in addition to their day-to-day role and as a result, at times, interventions have been completed outside of the recommended time scales. However, for assurance the Team have not declined a referral due to being unable to provide support.

The Team monitor the wellbeing of our TRiM practitioners and consider their workload and wellbeing when allocating TRiM referrals. This provides them with the opportunity to decide whether they feel able to undertake an assessment or not.

**Priority Activity 30 for 2024-2025**

| | Activity | Timescale |
|---|---|---|
| 30a | Develop an SBAR to highlight the success and challenges associated with TRiM | Q3 2024/25 |
| 30b | Attend REACT process training to support the TRiM process | Q2 2024/25 |

## 7. Single Unified Safeguarding Review (SUSR)

The purpose of the SUSR is to create a single review process where a multi-agency approach is required, incorporating the following review processes Adult Practice Review; Child Practice Review; Domestic Homicide Review; Mental Health Homicide Review; and the Offensive Weapon Homicide Review. The final report is then used to inform professional practice via the National Wales Safeguarding Repository. The Repository can be accessed by all services in Wales to promote ongoing learning from reviews.

Following the Welsh Government (WG) consultation process the final proposal for SUSR has been approved. Regional Safeguarding Boards are currently delivering training to support staff in the application of the review process.

### Achievements

The Health Board have been fully engaged in the development of the SUSR process and the consultation focus groups and sessions that have been delivered across Wales. The initial timeframe dictates that the SUSR process will now go live sometime on October 1st, 2024. It is expected that Agencies will provide skilled staff to undertake the SUSR, however it has been acknowledged that this will result in an increase in workload and costs.

### Challenges

The SUSR process will be managed by Regional Safeguarding Boards. Previously Domestic Homicide Reviews were managed by Community Safety Partnerships who held accountability for the governance, commissioning and completion, to include the actions and recommendations. This change will again have an impact on resources and finances.

### Priority Activity 31 for 2024-2025

| | Activity | Timescale |
|---|---|---|
| 31a | Transition, Engagement and Implementation of the SUSR | Q3 2024/25 |
| 31b | Ensure that the Health Board have suitably trained staff to engage in the SUSR process | Q3 2024/25 |

## 8.Safeguarding Training Summary

The Training Summary presents the Health Board Safeguarding training compliance for 2023-2024. Extensive recording and reporting is disseminated by the Safeguarding Practice Development Leads and reported following the Safeguarding Reporting Framework.

The following safeguarding modules are included:

Safeguarding Adults (Level 1 and Level 2)

Safeguarding Children (Level 1 and Level 2)

Mental Capacity Act (MCA - Level 1 and level 2)

Violence Against Women, Domestic Abuse & Sexual Violence (VAWDASV)

Targeted intervention, mandatory and bespoke training packages are in place to increase awareness to support the prevention and identification of abuse and harm. Information on all of the training programmes is available on the BCUHB Betsinet.

It is positive to report there is a continuing upward trend upwards of the levels of compliance across the organisation in relation to safeguarding training.

There has been a significant emphasis from the team to promote engagement with training across all IHC's and services. BCUHB continues to monitor compliance levels via area and target intervention to support areas to maintain compliance trends with the goal to achieve the key performance indicator of 85% compliance.

Training data, scrutiny and the analysis of compliance is reported and escalated by the Safeguarding Reporting Framework and areas targeted to support improvement, and compliance.

Violence Against Women Domestic Abuse and Sexual Violence is a key target area. Some areas are well below the compliance KPI of 85% and targeted intervention, escalation and reporting is in place. This is a key area for improvement.

Areas and departments of poor compliance were identified and targeted intervention to support and improve the training compliance and the application of learning is evidenced in Table 19 below.

**Table 19**: BCUHB Safeguarding Training Compliance by Module

| Safeguarding Module | Dec-23 | Mar-24 | Trajectory |
|---|---|---|---|
| MCA – Level 1 | 78.9% | 80.4% | ↑ |
| MCA – Level 2 | 78.0% | 79.4% | ↑ |
| Safeguarding Adults – Level 1 | 83.5% | 84.1% | ↑ |
| Safeguarding Adults – Level 2 | 82.3% | 82.8% | ↑ |
| Safeguarding Children – Level 1 | 82.6% | 84.0% | ↑ |
| Safeguarding Children – Level 2 | 81.2% | 82.6% | ↑ |
| VAWDASV | 73.5% | 74.8% | ↑ |

The Team utilise feedback forms to summarise quality, delivery and content from staff attending safeguarding training delivered by the Team.

Positive feedback includes:

*"The trainer was very knowledgeable about the topic and made it relevant to area. There was a lot of information to cover".*

*"A very well delivered presentation and good update of all areas of safeguarding"*

*"Great session"*

*"Good interaction with facilitators and audience"*

Constructive feedback included technical issues associated with online training. Requests for more case study examples, a request for more interactive training.

**Achievements**

The Home Office PREVENT Module has been approved by the Health Board and added to ESR Mandatory Training.

All staff groups who require Level 3 Safeguarding Training in line with the National Intercollegiate Documents (Adult Safeguarding: Roles and Competencies for Health Staff 2018, Safeguarding Children and Young People: Roles and Competencies for Health Care Staff 2019 and Looked After Children: Roles and Competencies of Healthcare Staff 2020) have been identified and shared with the Health Board Workforce and Development & Systems Officer. This is now live on the Electronic Staff Register (ESR) and staff have been notified of their compliance requirements. This will ensure that all staff attend the appropriate level of training for the role that they undertake.

During the reporting period of 2023-2024 the IHC's have reported their safeguarding training compliance within their Safeguarding Reports for the Executive Quality Delivery Group (EQDG). This assurance ensures a positive learning culture, risks are managed and shows the data has been analysed and any rectifying actions taken.

**Challenges**

The Team are committed to producing training packages that are evidence based and capture the wider safeguarding agenda. Our training is delivered by Safeguarding Specialists who bring a wealth of expertise and knowledge to the training sessions, but these are sometimes poorly attended by staff.

The amendments to the recording on ESR for the training packages, level 2 and Level 3 will impact upon the reporting data. Preliminary findings evidence an increased requirement for more Level 3 Training packages across all subject areas.

**Priority Activity 32 for 2024-2025**

| | Activity | Timescale |
|---|---|---|
| 32a | Work with colleagues to ensure all training is linked to ESR | Q4 2024/25 |
| 32b | Adapt new legislation, policy and procedure into current training programmes | Q1-Q4 2024/25 |

**8.1 Safeguarding Ambassadors and the Safeguarding Bulletin**

Engagement with Safeguarding Ambassadors continues and further recruitment and training dates for 2024-2025 are to be arranged. The Ambassadors have proven, and continue to be beneficial in supporting staff in the understanding of the Adult/Child at Risk process with appropriate signposting and escalation to the Designated Safeguarding Practitioner and Safeguarding resources.

BCUHB total number of Safeguarding Ambassadors is currently 147 which is an increase from 2022-23. The current Safeguarding Ambassadors are divided into areas as follows:

- East – 49
- Central – 54
- West – 44

To support education and learning monthly Safeguarding Bulletins are disseminated throughout the organisation. The bulletin has been capturing relevant, topical, and current issues, as well as themes and trends specific to all aspects of the safeguarding agenda. Key 7-Minute messages have been shared to promote the practical and theoretical perspective of safeguarding which can be translated into practice.

**Achievements**

During the distribution of MCA and DoLS materials the Ambassadors were asked to support this activity. Their engagement resulted in the materials reaching clinical and non-clinical areas.

Items within the Safeguarding Bulletin are directly linked to current practices and include live updates and communications to inform staff across the Health Board. The Bulletin also provides 7-Minute Learning updates as well as external learning to support improved safeguarding practices.

**Challenges**

The Team are identifying the clinical areas where there are no Ambassadors for a targeted approach towards further recruitment. Safeguarding reporting has enabled the identification of safeguarding awareness and the impact in areas where Safeguarding Ambassadors are minimal or not in place.

**Priority Activity 33 for 2024-2025**

| Activity | Timescale |
|---|---|
| Recruit additional Ambassadors to support the Safeguarding Agenda | Q4 2024/25 |

**9. Conclusion**

In summary, this year has demonstrated progress in safeguarding practices across the Health Board, marked by a further notable annual increase in safeguarding activity. This reflects heightened vigilance, awareness, and responsiveness to safeguarding concerns which had been driven by the proactive and responsive Safeguarding Training agenda.

Our commitment to maintaining high standards is further evidenced through comprehensive quality monitoring mechanisms, ensuring that all safeguarding interventions are both timely and effective. The Health Board continues to implement mechanisms to evidence assurance and audit activities, enabling a targeted and proactive approach by analysing the triangulation of data and quality metrics.

The Health Board recognises it is on a journey of improvement and the safeguarding activity was clearly evidenced in the findings of the Joint Inspection Child Protection Review (JICPA) which reference dynamic leadership, examples of exemplary and innovative practice.

The recognition of the importance of the findings of the review, the identification of positive practice and the areas of improvement will be fully implemented throughout BCUHB.

Consistent and annual subject matter audit activities, which include front line services, and multi-agency colleagues are a key initiative to monitor improvement, progress and improved service delivery and reduced risk throughout the safeguarding agenda.

BCUHB has also engaged proactively with staff, patients, and communities to foster a culture of candour, openness and accountability, ensuring safeguarding remains a shared responsibility.

Additionally, ongoing and strengthened collaboration with multi-agency partners has been key to delivering coordinated, person-centred care, enhancing both preventive measures and interventions.

National, Regional and Local initiatives impact upon service delivery and new ways of working influence data and reporting. BCUHB will continue to fully engage in the Single Unified Safeguarding Review and the NHS Safeguarding Workforce Review. In addition, the enhanced triangulation of data and performance will inform our governance and assurance activities.

As we move forward, we will continue to build on this solid foundation, striving to improve outcomes for the most vulnerable members of our community, while ensuring safeguarding remains at the core of our service delivery.

The priorities for 2024-2025 have been referenced throughout and compliance and progress are within reported timeframes.

## 10. Safeguarding & Public Protection Strategic Plan 2024 - 2025

### Actions Log 2024-2025

| | |
|---|---|
| Red | Incomplete |
| Amber | Partially complete |
| Green | Complete |

| Priority | Action | By Who: | By When: | RAG Status |
|---|---|---|---|---|
| Business and Support Manager | | | | |
| **1a** | Ratify the updated version of the Safeguarding Reporting Framework to ensure compliance with the Boards Governance and Cycle of Business | Business and Support Manager | Q3 | Amber |
| **1b** | Evidence outcomes in line with participation in IHC Hubs as guided by the Integrated Concerns Policy (1st September 2024). | Heads of Safeguarding | Q4 | Amber |
| **1c** | In line with the Independent Review of Concerns Raised Around Patient Safety June 2023 (3.12.12), Ensure membership of the Director of Safeguarding and Public Protection at HLBT Q4 | Safeguarding and Public Protection Team | Q4 | Amber |
| **2** | For assurance a look-back review of 2023-2024 will inform an updated ToR and Scope of the Safeguarding Forums | Business and Support Manager | Q4 | Amber |
| **3** | Develop and ratify a Health Board PREVENT Standard Operating Procedure [SOP] | Director of Safeguarding and Public Protection | Q4 | Amber |
| **4a** | Collaborate with the Director of Corporate Governance to ensure the request for reports are appropriate, completed on time and follow BCUHBs Cycle of Business. | Business and Support Manager | Q4 | Amber |

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| **4b** | To ensure quality and appropriate representation - review the membership and attendance of Safeguarding representatives on BCUHB Forums/Groups within BCUHB | Safeguarding and Public Protection Team | Q3 | Amber |
| **4c** | Ensure the identified priorities reported within the BCUHB Annual Partner Agency Report to North Wales Safeguarding Board – Children and Adult are triangulated within the 2024-2025 Quality and Governance Safeguarding Objectives | Safeguarding and Public Protection Team | Q4 | Amber |
| **5a** | Full implementation of the JICPA recommendations across BCUHB | Head of Safeguarding Children | Q3 - 4 | Amber |
| **5b** | Collaboration with multi-agency partners to implement partnership arrangements | Head of Safeguarding Children | Q3 - 4 | Amber |
| **5c** | Implementation of the Overarching All Wales JICPA recommendations | Head of Safeguarding Children | Q4 | Amber |
| **6a** | Contribute and engage in the National Safeguarding Network SMM Peer Review | Safeguarding and Public Protection Team | Q2 | Green |
| **6b** | Progress current SMM Standards and engage with the agreed National priorities | Safeguarding and Public Protection Team | Q4 | Amber |
| **7a** | The Senior Safeguarding and Public Protection Team to attend new Risk Management Training | Senior Safeguarding and Public Protection Team | Q2 | Green |
| **7b** | Review current Risks and amend as necessary, in line with the new guidance | Safeguarding and Public Protection Team | Q1 – Q4 | Amber |
| **8a** | Implement the recording of NHS numbers on the Childrens database | Safeguarding Data Analyst | Q3 | Amber |
| **8b** | Implement the recording of NHS numbers on the DoLS database | Safeguarding Data Analyst | Q3 | Amber |
| **8c** | Develop delayed discharge dashboard to highlight any harm experienced | Safeguarding Data Analyst | Q4 | Amber |
| **8d** | Develop Was Not Brought/Did Not Attend dashboard | Safeguarding Data Analyst | Q4 | Amber |
| **8e** | Develop digital solution for supervision data collection and feedback | Safeguarding Data Analyst | Q4 | Amber |

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| **8f** | Continue to engage in the Once for Wales Datix Safeguarding Module | Safeguarding Data Analyst | Q4 | Amber |
| **9a** | Completion, Ratification and implementation of the Professional Allegation SOP. **This action is reliant on the publication of the WG Guidance.** | Head of Safeguarding Children | Q4 | Amber |
| **9b** | Agree Terms of Reference for a Working Group to develop the Workplace Safety Group | Safeguarding and Public Protection Team | Q4 | Amber |
| **10a** | Engagement in the OfWCMS implementation. | Safeguarding and Public Protection Team | Q1 – 4 | Amber |
| **10b** | Monitor the identified Governance Programme once the system is complete | Safeguarding and Public Protection Team | Q3 | Amber |
| **Section 3 - Child at Risk** | | | | |
| **11a** | Review and update the Neglect Level 3 Mandatory Training Package | Head of Safeguarding Children | Q4 | Amber |
| **11b** | Develop a BCUHB Neglect 7 Minute Briefing | Head of Safeguarding Children | Q4 | Amber |
| **12** | Fully embed the Suicide & Self Harm Level 3 Training Package into the Level 3 training rolling programme. | Safeguarding Practice Development Lead | Q2 | Green |
| **13a** | Task & Finish Group to standardised Child at Risk reporting across the three BCUHB Emergency Departments | Head of Safeguarding Children | Q3 | Amber |
| **13b** | Audit Activity to capture reporting trends across BCUHB | Business and Support Manager | Q3 | Amber |
| **13c** | Audit the ED Safeguarding Attendance Review Meetings and triangulate safeguarding data | Head of Safeguarding Children | Q4 | Amber |
| **14a** | Audit quality of the HPBA document | Head of Safeguarding Children | Q4 | Amber |
| **14b** | Scope feasibility of the MatDAT for use within the Health Board | Head of Safeguarding Children | Q4 | Amber |
| **15** | Undertake Quality Audit of the FGM clinical pathway | Head of Safeguarding Children | Q3 | Amber |
| **16** | Develop and implement a North Wales ALTE Protocol | Named Doctor Safeguarding Children | Q4 | Amber |

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| **17a** | Develop and launch the Child Protection Medical Standard Operating Procedure | Named Doctor Safeguarding Children | Q4 | Amber |
| **17b** | Audit of inflicted injury presentations | Named Doctor Safeguarding Children | Q3 | Amber |
| **17c** | Audit of inflicted injuries presentations report and identification of findings and any recommendations | Named Doctor Safeguarding Children | Q4 | Amber |
| **18** | On publication - Fully engage in the review of the findings and recommendations of the North Wales Adolescent Unit Tier 4 Learning Review Report (Oct 2023) | Head of Safeguarding Children | Q4 | Red |
| **19a** | BCUHB Quality Assurance Group – quality monitoring review Stage 1 | Head of Safeguarding Children | Q4 | Amber |
| **19b** | BCUHB Quality Assurance Group - Produce a six month and annual position report of practice review activity and action plans status | Head of Safeguarding Children | Q4 | Amber |
| **20a** | Continued engagement with the CSA/CSE/HSB Task & Finish Group in preparation for the second iteration of the WG National Action Plan | Head of Safeguarding Children | Q3 | Amber |
| **20b** | Completion, Consultation and Ratification of BCUHB CSA Action Plan | Head of Safeguarding Children | Q4 | Amber |
| **20c** | Launch of the BCUHB CSA/CSE/HSB Action Plan | Head of Safeguarding Children | Q4 | Amber |
| **Section 4 - Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV)** | | | | |
| **21a** | Produce a report in relation to the dip sampling group and present to Safeguarding Senior Leads, IHC Safeguarding Forums and Safeguarding Governance & Performance Group | Business and Support Manager | Q4 | Amber |
| **21b** | Bespoke MARAC representative training for Health Board MARAC representatives will be developed and implemented. | Safeguarding Practice Development Lead | Q4 | Amber |

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| **21c** | Review the administration processes within the Safeguarding and Public Protection Team for MARAC to ensure that practice is consistent across the region | Head of Safeguarding Children | Q4 | Amber |
| **22** | Engagement with Welsh Government Round Table meetings relating to IRIS | Head of Safeguarding Children | Q4 | Amber |
| **23** | During 2024-2025 we will commence the implementation of Domestic Abuse Screening Tool, with the development of an action plan to evidence implementation, audit, evaluation and review in 2025-2026 | Head of Safeguarding Children | Q3 | Amber |
| **24a** | SARC International Organisation for Standardisation (ISO) Accreditation - Full engagement with the implementation Steering Group and Gold Command | Director of Safeguarding and Public Protection<br>Head of Safeguarding Children | Q3 | Amber |
| **24b** | Host a BCUHB awareness raising event during National Safeguarding week re SARC | Head of Safeguarding Children | November 24 | Amber |
| **Section 5 Adult at Risk** | | | | |
| **25a** | Further development of an implementation of the Section 126 Enquiry Form across the Health Board | Head of Safeguarding Adults | Q4 | Amber |
| **25b** | Re-launch the Designated Safeguarding Person role | Head of Safeguarding Adults | Q3 | Amber |
| **25c** | Registered Audits of all Adult at Risk Reports | Head of Safeguarding Adults | Q4 | Amber |
| **25d** | Re-Launch the Herbert Protocol across the Health Board | Safeguarding Adults – Dementia Lead | Q3 | Amber |
| **25e** | Re-Launch the Missing Persons Procedure across the Health Board | Safeguarding Adults -Dementia Lead | Q3 | Amber |
| **25f** | Ensure the Mental Capacity is a standing agenda item at all Health Board Safeguarding Forums | Business and Support Manager | Q1 | Green |

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| **25g** | Promote the Deprivation of Liberty Safeguards across Care of the Elderly Wards | Head of Safeguarding Adults – DoLS Lead | Q4 | Amber |
| **26a** | Additional MCA and DoLS Training to be delivered | Head of Safeguarding Adults- DoLS Lead | Q4 | Amber |
| **26b** | Re-distribute MCA materials across Health Board Services | Head of Safeguarding Adults- DoLS Lead | Q1 | Green |
| **26c** | Implement Recommendations from the Internal DoLS/MCA Audit | Head of Safeguarding Adults- DoLS Lead | Q4 | Amber |
| **27** | Promote the use of the APR process with consideration given to the; Unexplained Death of an Adult Procedure – North Wales Safeguarding Board | Head of Safeguarding Adults | Q1-Q4 | Amber |
| **28a** | Embed any recommendations and learning from the MAPPA SCR | Head of Safeguarding Adults | Q4 | Amber |
| **28b** | Complete and share an SBAR in relation to the capacity and ability to engage and attend MAPPA meetings | Head of Safeguarding Adults | Q3 | Amber |
| **29a** | Adopt the PREVENT training onto the ESR System | Safeguarding Practice Development Lead | Q3 | Amber |
| **29b** | Support the appointment of a CAMHS representative at the PREVENT Delivery Group | Business and Support Manager | Q3 | Amber |
| **30a** | Develop an SBAR to highlight the success and challenges associated with TRiM | Head of Safeguarding Adults | Q3 | Amber |
| **30b** | Attend REACT process training to support the TRiM process | Head of Safeguarding Adults | Q2 | Green |
| **31a** | Transition, Engagement and Implementation of the SUSR | Director of Safeguarding and Public Protection | Q3 | Amber |
| **31b** | Ensure that the Health Board have suitably trained staff to engage in the SUSR process | Safeguarding Practice Development Lead | Q3 | Amber |

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|---|---|---|---|---|
| **Section 6 - Safeguarding Training Summary** | | | | |
| **32a** | Work with colleagues to ensure all Level 3 Training is linked to ESR | Safeguarding Practice Development Lead | Q4 | Amber |
| **32b** | Adapt new legislation, policy and procedure into current training programmes | Safeguarding Practice Development Lead | Q1-Q4 | Amber |
| **Section 7 - Safeguarding Ambassadors and the Safeguarding Bulletin** | | | | |
| **33** | Recruit additional Ambassadors to support the Safeguarding Agenda | Safeguarding Practice Development Lead | Q4 | Amber |

# [Appendix 1] Safeguarding & Public Protection Reporting Framework

**Health Board Links**
Quality Delivery Groups x 5 and relevant sub groups

**Health Board Reporting**

Triple A Report to EDGQ
Direct reporting to the Board for:
Annual Report / Update
Immediate access for 'Significant Events'
Mental Health Legislation Committee
Primary Care Collaborative
IHC Service Leadership Team
HMP Berwyn
Suicide/Self Harm Forum
Capacity & Consent
Looked After Children Meeting
Organisational Learning Forum
Patient Safety Group
Regulatory Assurance Group
Strategic Falls Group
Integrated Concerns Hub

Health board
Chair: Chief of the Health board

Quality, Safety & Experience Committee (QSE)
Chair: Independent Member

Executive Quality Delivery Group (EQDG)
Chair: Executive Director of Nursing

Executive Policy Oversight Group [EPOG, for Policy approvals]
Chair – Director of Corporate Governance

Strategic Safeguarding Governance & Performance Group
Chair: Director of Safeguarding & Public Protection
Vice Chair: Named Doctor for Safeguarding Children

Escalation as necessary to Executive Team and Health Board

**Multi Agency**

North Wales Safeguarding Adult Board
North Wales Safeguarding Children Board
Community Safety Partnership
Strategic MAPPA Board
National Safeguarding Network
National DoLS/MCA
VAWDASV National Steering Group
Violence & Exploitation Board (e.g. Modern Slavery, CSA, CSE)
Serious Violence Duty Group
Contest Board
Welsh Sexual Assault Services Board
Regional Partnership Board
LAC National Steering Group

MHLD Safeguarding Forum
Chair: Assistant Director of Nursing MHLD / Safeguarding
Vice Chair: Divisional Director (Nursing/Medical)

Sexual Assault Referral Centre Service Delivery Governance Board
Chair: Safeguarding and North Wales Police

Safeguarding Forum: EAST
Chair: IHC Director
Vice Chair: IHC Director (Nursing/Medical)

Health Board: SUSR Group
Chair: Head of Quality Governance and Risk

Safeguarding Forum: CENTRAL
Chair: IHC Director
Vice Chair: IHC Director (Nursing/Medical)

Health Board Safeguarding Policy & Procedure Group
Chair: SG Business Support Manager

Safeguarding Forum: WEST
Chair: IHC Director
Vice Chair: IHC Director (Nursing/Medical)

Health Board Safeguarding Training Group
Chair: Regional Safeguarding Specialist for Adults/Dementia

Safeguarding & Public Protection Quality & Governance Group
Chair: Director of Safeguarding & Public Protection

Safeguarding & Public Protection Quality Business Group
Chair: Heads of Safeguarding

Health Board Adult/Child/Domestic Homicide Practice Reviews Quality Assurance Group

**Multi Agency**

Safeguarding Children Delivery Board (East/Central/West)
Safeguarding Adults Delivery Board (East/Central/West)

**Multi Agency**

**Safeguarding Sub Groups & Forums**

**Key Colour Code**

**Blue = Multi-Agency**
**Orange = BCUHB**
**Green = Internal to Safeguarding**

| | | | | |
|---|---|---|---|---|
| **Teitl adroddiad:** ***Report title:*** | Quality Delivery Group – Chair's Report | | | |
| **Adrodd i:** ***Report to:*** | QSE Committee | | | |
| **Dyddiad y Cyfarfod:** ***Date of Meeting:*** | 24th October 2024 | | | |
| **Crynodeb Gweithredol:** ***Executive Summary:*** | This report provides the Committee with the Chair's Report from the Executive Quality Delivery Group (QDG). The QDG is the clinical executive led quality group in the Health Board through which all other quality-related groups report. | | | |
| **Argymhellion:** ***Recommendations:*** | The Committee is asked to note this report | | | |
| **Arweinydd Gweithredol:** ***Executive Lead:*** | Angela Wood, Executive Director of Nursing and Midwifery<br>Dr Nick Lyons, Executive Medical Director<br>Teresa Owen, Executive Director of AHPs and Healthcare Science | | | |
| **Awdur yr Adroddiad:** ***Report Author:*** | Angela Wood, Executive Director of Nursing and Midwifery (Chair) | | | |
| **Pwrpas yr adroddiad:** ***Purpose of report:*** | I'w Nodi<br>*For Noting*<br>☐ | I Benderfynu arno<br>*For Decision*<br>☐ | Am sicrwydd<br>*For Assurance*<br>☒ | |
| **Lefel sicrwydd:** ***Assurance level:*** | Arwyddocaol<br>*Significant*<br>☐<br>Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol<br>*High level of confidence/evidence in delivery of existing mechanisms/objectives* | Derbyniol<br>*Acceptable*<br>☐<br>Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol<br>*General confidence / evidence in delivery of existing mechanisms / objectives* | Rhannol<br>*Partial*<br>☒<br>Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol<br>*Some confidence / evidence in delivery of existing mechanisms / objectives* | Dim Sicrwydd<br>*No Assurance*<br>☐<br>Dim hyder/tystiolaeth o ran y ddarpariaeth<br>*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:**<br>***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):*** | Outcome 4 - Improved access, outcomes and experience for citizens<br><br>Outcome 5 - Recognition of BCU as a learning and self-improving organisation | | | |
| **Goblygiadau rheoleiddio a lleol:** ***Regulatory and legal implications:*** | The Duty of Quality is a statutory requirement under the Health and Social Care (Quality and Engagement) (Wales) Act 2020. | | | |

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| | 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.<br><br>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?**<br>***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?**<br>***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)**<br>***Details of risks associated with the subject and scope of this paper, including new risks( cross reference to the BAF and CRR)*** | BAF-SP18 and CRR-24-04 – Quality, Innovation and Improvement |
| **Goblygiadau ariannol o ganlyniad i roi'r** ***argymhellion ar waith***<br>***Financial implications as a result of implementing the recommendations*** | N/A |
| **Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith**<br>***Workforce implications as a result of implementing the recommendations*** | N/A |
| **Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori**<br>***Feedback, response, and follow up summary following consultation*** | N/A |
| **Cysylltiadau â risgiau BAF:**<br>(neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)<br>***Links to BAF risks:***<br>*(or links to the Corporate Risk Register)* | BAF-SP18 and CRR-24-04 – Quality, Innovation and Improvement |
| **Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)**<br>***Reason for submission of report to confidential board (where relevant)*** | N/A |
| **Camau Nesaf: Gweithredu argymhellion**<br>***Next Steps: Implementation of recommendations***<br>N/A | |
| **Rhestr o Atodiadau:**<br>***List of Appendices:***<br>QDG Chair's Report | |

# Chair's Report

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| **Report to:** | Quality, Safety and Experience Committee |
| **Report from:** | Executive Quality Delivery Group |
| **Report date:** | September 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.*

| | |
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| **Issues for escalation – requiring action/decision** | None. |
| **Issues for escalation – for information** | • A number of service pressures and concerns are noted in the reports from IHCs detailed below. |
| **Summary of business conducted – for assurance** | Quality highlight and escalation reports were received from IHC/Divisions.<br><br>• **West IHC** advised at time of reporting they had 684 open Patient Safety Incidents, compared with 940 open incidents at the last. This confirms the improved management of patient safety incidents within West IHC through the strengthening of governance processes. Changes to permissions within the Mortality Module are causing some issues with completion – this has been escalated to the Corporate Team who are working to resolve. Management of complaints remains an area of priority. The quality improvement underway takes 2 approaches; management of the backlog and management of the newly reported complaints within 30 days. This is supported by weekly reporting of complaints that require additional enablement from the corporate team when action is required outside of the West IHC.<br><br>• **Central IHC** reported there was 1 never event in July 2024 – ophthalmic block on incorrect eye. MIS+ held and investigation progressing. The Mortality Group have asked the IHC Medical Director for protected mortality sessions, and are awaiting feedback. There is local concern emerging, being explored further, in relation to the overall capability of the Neonatal service to provide the right level of governance assurance, in part is in relation to workforce availability. There has been a successful bid for capital funding to support environmental |

developments which will hopefully be completed in 2025. However, there is ongoing issue with staff and patient safety impacted upon by the ability to respond to escalating behaviours. Mitigation is supported through additional staffing and the learning of the previous investigation will need to be shared and embedded. The SARC continues to not provide a forensic service locally to children and young people This is in relation to appropriate maintenance of competencies in forensic support due to the low number of cases. This cohort of the population are currently receiving care in North West England. Engagement of the medical workforce in the investigation of patient safety incidents was highlighted. This is in part is contributing towards the delay in meeting deadlines and producing finalised and agreed reports. Understanding in relation to this challenge is being further understood through ongoing work with the leadership team.

- **East IHC** reported elective cancellations due to site pressures on Orthopaedic U5, Arrivals & Pasteur- currently action on hold. Planned care work in relation to ministerial priorities ongoing East IHC trajectory showing improvement. All 208 weeks booked, 156 week waits 350 to be booked. Specialist nurse review of Demand and Capacity commenced. In relation to the Restorative Dentistry Service Cessation, there is a service review being undertaken by North Wales Dental Services. Locum cover being explored and where able sending patient via outsourcing. All Specialist Palliative Care Teams (SPCTs) continuing to experience ongoing increasing demand / complexity with no increase in funded capacity

- **MHLD** reported 1 PFD was received relating to patients in ED who leave before being seen by psychiatric liaison.

- **Women's and Midwifery** reported there has been 1 incident which is subject to a Serious Incident review. The case is currently in the process of investigation. The HIW National Review of Maternity Services was published in 2020. The Review found that the quality of care being provided across Wales was generally good and delivered in a safe and effective way. The Report made 32 Recommendation to improve services for women and their families in Wales. BCUHB's response to the HIW Recommendations is as follows; of the 32 Recommendations, 3 are Amber, 1 is N/A and 28 are Completed: Current Compliance is 96.7%. Local Quality Peer Reviews have taken place in West (December 2023) and Centre (July 2024). The West improvement plan is progressing. The Centre report is waited but the 5 immediate actions identified have been completed.

- **Cancer** have currently 310 open incidents with 309 overdue. An incident backlog and improvement plan is now in place following a meeting with the Patient Safety Team. The number of NICE approved regimes is increasing causing delays in getting internal approvals and updates on the Chemocare system – this is resulting in treatment delays. The division were asked to review clinical capacity given current workforce pressures.

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| | • **Diagnostics and Clinical Support** reported increasing demand across all departments limiting forecast plans to eliminate backlogs principally in radiology but also likely to impact others. There is active management to develop urgent recovery plan for 2023-24 and beyond. Operational diagnostics access group to be established in August 2024. HIW reported following their inspection there was good compliance with the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2017. The Health Board had written procedures and protocols in place as required under IR(ME)R.<br><br>• **Dental** did not submit a report.<br><br>• The **Patient and Carer Experience Group** did not submit a report.<br><br>• **The Infection Prevention and Control Group** reported that due to an increase in some infection rates; C. diff and Klebsiella in particular, there is an agreement to undertake a learning review across all IHCs presenting back through Local Infection Prevention Groups in Sept/Oct/Nov, and action is required to review and monitor. Concerns continue to be raised in relation to the delay in the development of the east AMR group and wider group representation with development of actions – awaiting a decision on who will lead this group moving forward. In comparison with other Welsh Health Boards, in July 2024 BCUHB were 1st for MSSA, Klebsiella and Pseudomonas, 3rd for MRSA and 4th for E. coli and C.diff. Having not yet received trajectories for 2024/25, the six mandatory organisms were presented against last year's trajectory placing BCUHB above trajectory for all reportable organisms, except Pseudomonas. BCUHB are reporting increased number of positive C.diff, MRSA and E.coli specimens compared to the same period 2023/2024 Other infections (COVID-19, Flu and Norovirus) decreased. A deep dive on C.diff was presented with a request that a more detailed review of this data resulting in action was had at the Local Infection Prevention Groups. An update around the current Mpox situation was provided, in addition to feedback from a recent suspected case (later reported as negative) to YGC.<br><br>• The **Regulatory Assurance Group** noted the HIW review of IRMER (as referred to above). HIW have closed 5 reportable radiation incidents. Only HIW can close incidents. Discussion to be held on how the assurance can be provided to Executives on radiation protection compliance (a suggestion of a mapping exercise was made and will be taken forward). The National Learning and reporting system for clinical imaging, MRI and nuclear medicine has been released and being implemented across the UK. BCU had 2 members on the national working party and are currently piloting the system as part of Datix prior to the Wales roll out. The taxonomy code and information will be exported from Datix to UKHSA (UK Health & Security Agency exposures division) for analysis and summary reports. This follows the same process as has been in place for radiotherapy for a number of years. |

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| | • **The Patient Safety Group** reported at time of writing this update the Health Board is awaiting a response from Health Safety Executive (HSE) in respect of the Health Board response letter dated September 2023 regarding the notice of contravention. The Chief Executive and members of the Health Board Health and Safety team have recently met with Health and Safety Executive officer for North Wales. Following this meeting a request has been made from the HSE for the Health Board to offer support and advice in terms Falls Prevention to a neighbouring organisation. Two Care Homes issued notice to quit for 53 high acuity, long term, EMI nursing residents. On labelling of Oxygen Cylinders with Warning 'Feel the flow' Tags, this was discussed in detail by the medical gases group. The advice from BOC, health and Safety and the authorised engineer for Wales is that whilst the risk is small there is potential fire risk with using elastic bands to attach the labels especially as they will be near high-pressure outlets. Further discussion with BOC has concluded that string can be used (as they currently use string to attach 'cylinder in use' labels. Previous concern about infection prevention and ability to decontaminate but infection prevention team agreed that risk is negligible and a risk (benefit) assessment will be completed. The purchasing and accessing of Flat Lifting Equipment within the IHC's remain a challenge, the Assistant Director of Occupational Health, Safety and Security has requested the IHC's contact him directly to escalate any concerns in terms of funding. Discussion was held around improving 'did not attend' at manual handling training as a reminder or if unable to attend those places can be offered to others. There are no outstanding All Wales patient safety alerts.<br><br>• The **Clinical Effectiveness Group** reported E-learning and face-to-face consent training is a requirement from Welsh Risk Pool (WRP) that patient facing clinicians complete this training every 3 years. Considering the financial penalties in terms of the risk sharing agreement where compliance is low, many Health Boards in Wales are now mandating this training. The group was asked to escalate for action and decision whether BCUHB should be mandating training on decision making and consent. The All-Wales Consent Group developed an agreed methodology for peer review of consent processes building on the existing tool developed in BCUHB. It was decided that all Health Boards in Wales would undertake a peer review assessment during the period 1st September 2023 to 31st December 2023. BCUHB compliance was lower than previous cycles of consent peer review assessment. Participation was particularly low within IHC East. The results of current Consent Peer Review will be shared with IHC Medical Directors, and they will be asked to seek assurance that formal discussion of the results of the peer review exercise and related action plans are undertaken in their relevant clinical governance meetings. An update on the 2222 Tier 2 audit was provided; challenges of completing the audit remain, since MET call and Arrest Call processes are different across sites. Whilst this in itself is not necessarily an issue, it does however mean that data collection and comparison is difficult. Discussions across the three sites are ongoing.<br><br>• The **Dementia Delivery Group** did not submit a report. |

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| | • The **Safeguarding Group** reported concerns regarding the new national Datix module for reporting. The automatic reporting to local authorities is not ready so OFW are offering to send our reports to Local Authorities. The Safeguarding Department have requested a meeting with the Datix National Team and the chair of the National Safeguarding Network.<br><br>• The **Preventing Hospital Acquired Deconditioning (PHAD) Task and Finish Group** is a 'new' group which was convened on 15th August 2024. The group of interested individuals had previously come together in November 2023 and April 2024 to discuss ongoing projects and workstreams relating to reducing inpatient deconditioning. The PHAD Task and Finish Group will provide a forum for key stakeholders to discuss and commission action relating to developing, implementing and evaluating improvement approaches to hospital acquired deconditioning across BCUHB inpatient settings. The group will ratify new policies, guidelines and / or processes developed relating to the purpose of the group and provide assurance to the Health Board that suitable measures are in place to meet the outlined actions.<br><br>• The group approved:<br><br>o MHLD 0040 Policy – Ty Llewelyn Patient Postal Pockets<br>o MD14 – Private Practice Policy |

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| **Cyfarfod a dyddiad:**<br>**Meeting and date:** | Quality, Safety & Experience Committee<br>24th October 2024 |
| **Cyhoeddus neu Breifat:**<br>**Public or Private:** | Public |
| **Teitl yr Adroddiad**<br>**Report Title:** | Summary of business considered in private session to be reported in public |
| **Cyfarwyddwr Cyfrifol:**<br>**Responsible Director:** | Pam Wenger, Director of Corporate Governance |
| **Awdur yr Adroddiad**<br>**Report Author:** | Philippa Peake-Jones, Head of Corporate Affairs |
| **Craffu blaenorol:**<br>**Prior Scrutiny:** | None |
| **Atodiadau**<br>**Appendices:** | None |

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| **Y/N to indicate whether the Equality/SED duty is applicable** | **N** |

**Argymhelliad / Recommendation:**

The Committee is asked to note the report.

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| **Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval** | | **Ar gyfer Trafodaeth For Discussion** | | **Ar gyfer sicrwydd For Assurance** | | **Er gwybodaeth For Information** | ✓ |

**Sefyllfa / Situation:**

To report in public session on matters previously considered in private session.

**Cefndir / Background:**

Standing Order 6.5.3 requires the Board to formally report any decisions taken in private session to the next meeting of the Board in public session. This principle is also applied to Committee meetings.

**Asesiad / Assessment**

The Committee considered the following matters in private session:

**15th August 2024**

- Quality Report

- Final Draft of Annual Quality Report

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

(1 April 2024 – 31 April 2025)

This forward plan is only to be used for one-off Adhoc items that do not require inclusion as routine business on the Annual Committee Cycle of Business.

| Date of Request | Origin of Request | Requestor | Item Summary / Title | Nature of Request | Lead Officer | Executive Lead | Intended Meeting Date | Status |
|---|---|---|---|---|---|---|---|---|
| 07.05.24 | AC24.60.1.8 | Audit Committee | | Quality, safety and commissioned services. The Committee agreed to a 6-month deferral requesting that the review take place before the end of the current financial year - it was agreed to inform the QSE of this decision and for the QSE committee to drive progress on recommendations from the May 23 report. | Head of Corporate Affairs | | February 2025 | |
| 6.6.24 | | QSE | Do a Deep Dive on complaints – 'Duty of Care' | | | Executive Director of Nursing & Midwifery | October 2024 | Completed. On October agenda |
| 11.06.24 | QSE Agenda Setting | Chair | Primary Care | Update on ongoing work | Head of Primary Care | Executive Director of Nursing & Midwifery | | It was suggested at QSE Development Session that this item should come to a joint PFIG & QSE Development Session before Christmas |
| 11.06.24 | QSE meeting | Chair | Schedule a visit to Electronic Records | | Head of Corporate Affairs | Executive Director of Nursing & Midwifery | September 2024 | Held 04/10/24 |
| 15.08.24 | QSE meeting | Chair | Cycle of Business | To split the MHLD item on CoB to two separate items – MH and LD. | Head of Corporate Affairs | Executive Director of Nursing & Midwifery | September 2024 | Completed and updated on the COB |
| 15.10.24 | Email between Teresa Owen and Pam Wenger | Pam Wenger | Governance of DECLO role | To provide an update and ensure appropriate governance of DECLO role, regulation and plans | Liz McKinney, Designated Education Clinical Lead Officer | Executive Director of Allied Health Professions & Health Science | December 2024 | |
| 16.10.24 | Email from Sandra/Imran | Imran Devji | Challenged Services – Dermatology (Plastics) | Update on service. | Head of Planned Care | Executive Medical Director | February 2025 | |
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# Cancer Services for North Wales

# A Roadmap for 2024-2029

## Final – JANUARY 2024

**Version History:**

| | | |
|---|---|---|
| **Version 1.0** | **January 2023** | |
| **Version 2.0** | **February 2023** | **Comments from Cancer Clinical Lead and BCUHB corporate planning team** |
| **Version 3.0** | **March 2023** | **Comments from tumour site clinical leads, Wales Cancer Network and service user representatives** |
| **Version 4.0** | **June 2023** | **Comments following circulation to all cancer MDT members and Health Board operational managers** |
| **Version 5.0** | **August 2023** | **Comments from BCUHB Public Health Team<br>Updated to reflect pause of Regional Treatment Centre Programme** |
| **Version 5.1** | **January 2024** | **Comments from Cancer Partnership Board members** |
| **Version 5.2** | **January 2024** | **Comments from corporate planning lead; for presentation to BCUHB Executive Team** |
| **Final** | **January 2024** | **Approved at BCUHB Executive Team 31.01.24** |

## CONTENTS

## SECTION 1: INTRODUCTION

### 1.1 Background and Purpose

Cancer is a leading cause of morbidity and mortality worldwide, and is the leading cause of premature death in north Wales.

Cancer incidence and mortality rates in north Wales are comparable to those of the rest of Wales but there are inequalities in cancer outcomes between different areas of north Wales, with some communities experiencing higher rates of cancer and poorer survival rates.

Cancer prevention is a key component of any comprehensive cancer plan. The causes of cancer are complex, and include a combination of genetic, lifestyle, environmental, and socio-economic factors.

Cancer care is also complex and requires multi-disciplinary input, involving a range of healthcare professionals and services. Improving cancer care and outcomes requires a co-ordinated and collaborative approach, with a focus on person-centred care, early diagnosis, effective treatment, and supportive care.

The development of a comprehensive cancer roadmap for north Wales is crucial to improving cancer outcomes in the region. The North Wales Cancer Partnership Board was established in 2022 to improve cancer care in the region. It brings together healthcare professionals, patients, and carers to coordinate and improve cancer services and has overseen the development of this roadmap.

This roadmap is informed by the latest evidence and best practice guidance. It aims to ensure that all patients have access to high-quality, equitable cancer care.

### 1.2 Scope

This document sets out the framework for the future direction of cancer services for the population of north Wales for the next 5 years.

It covers adult cancers only and does not include palliative care services. It should also be read in conjunction with the north Wales strategy for Primary Care services.

### 1.3 Our Vision

Our vision for cancer services in north Wales builds on the overarching clinical vision of the Health Board as set out in its Clinical Services Strategy (2022):

- To reduce cancer incidence, mortality and morbidity in north Wales so that people experience a better quality and length of life
- To commission and provide excellent person centred care in the right place at the right time, taking a whole system approach that focuses on improving outcomes and user experience and, where possible, brings care closer to home
- To empower our staff to transform and innovate and deliver continuous improvement
- To work in partnership with all stakeholders, including service users, other public sector organisations, third sector organisations and the wider community, to maximise value from the resources we have available to improve cancer outcomes in north Wales

### 1.4 Our Guiding Principles

Building on the guiding principles set out in the Health Board's Clinical Services Strategy, we will use the following principles to underpin our plans for cancer services in north Wales.

We believe services should:

- be person centred ie planned around the needs of the individual
- be based on the National Optimal Pathways for cancer and so be designed to achieve the best possible outcomes
- be based on co-design with our service users, their families and carers, our staff and our partners
- be sufficiently resourced to offer compassionate care to our patients and a positive user experience
- be based on population health need and aim to reduce health inequalities
- focus on prevention and keeping people well, as well as diagnosing and treating cancer
- be evidence based and supported by sound data analysis
- take advantage of opportunities offered by digital innovation
- take a whole system approach that encourages and accelerates service transformation and innovation
- be provided as close to home as possible whilst recognising there may be a need to travel to access expert clinical services as appropriate
- be high quality, safe, sustainable and resilient

### 1.5 Key Measures of Success

We will be successful if we improve the health and well-being of our population and ensure the clinical, operational, environmental and financial sustainability of the services we provide and commission.

Specific evidence of success will include:

- Reduction in avoidable cancer incidence
- Improved cancer survival rates
- Reduced cancer mortality and morbidity rates
- A reduction in cancer inequalities across the region
- Service users reporting positive experiences of our clinical services
- Safe, sustainable and high quality clinical services provided in line with national guidance
- Reduced reliance on temporary and agency staff
- Other organisations seeking to learn from our consistent achievements

## SECTION 2: STRATEGIC CONTEXT

### 2.1 Our population

North Wales is the largest geographical region in Wales spanning approximately 2,500 square miles and comprising six counties and local authorities. Approximately half the area is classified as rural; the more densely populated areas are located along an urban strip which broadly follows the northern coast and English border. The diverse geography creates a complex mix of care needs.

The population of north Wales is just under 688,000, with a slightly higher than average elderly population when compared to the rest of Wales:

**Percentage population, by age group, Wales and North Wales, 2021**

| | BCUHB % | Wales % |
|---|---|---|
| 0-15 | 17.2 | 17.6 |
| 16-64 | 59.2 | 60.9 |
| 65-84 | 20.5 | 18.7 |
| 85+ | 3.0 | 2.7 |

Source: StatsWales; ONS MYE 2021

The resident population of north Wales is expected to increase by 2.9% by the year 2043. The population of north Wales aged 65 years and over is predicted to increase by almost 29% by 2043. This is important as older people are more likely to develop cancer, as well as being more likely to be living with other co-morbidities.

There is a clear correlation between deprivation and increased cancer rates and north Wales has some of the most deprived areas in Wales, primarily in Denbighshire, as seen below:

| Area | Local Authority | Welsh Index of Multiple Deprivation Rank (2019) |
|---|---|---|
| Rhyl West 2 | Denbighshire | 1 |
| Rhyl West 1 | Denbighshire | 2 |
| Queensway 1 | Wrexham | 9 |
| Rhyl West 3 | Denbighshire | 11 |
| Rhyl South West 3 | Denbighshire | 19 |
| Glyn (Conwy) 2 | Conwy | 20 |
| Wynnstay | Wrexham | 45 |
| Rhyl South West 1 | Denbighshire | 57 |
| Abergele Pensarn 2 | Conwy | 70 |
| Tudno 2 | Conwy | 78 |

In north Wales, 74.6% of working aged adults (16-64 years) report being in good health, which is similar to the Wales average (75%). Across north Wales, this figure ranges from 69.8% in Flintshire to 83.3% in Gwynedd.

In the older population, 65% of persons aged 65 years and over in north Wales report to be in good health compared to 61.7% across Wales. This figure ranges from 57.7% in Flintshire to 73.1% in Conwy.

Lifestyle plays a key role in the risk of developing cancer. The north Wales population (in line with the whole Wales population) is at risk in a number of key areas:

- only 39.7% of the working aged population of north Wales are a healthy weight (35.4% nationally)
- only 52.6% adults are physically active for at least 150 minutes a week (56.6% nationally)
- Almost 17% of adults said they drink more than the national guidelines in an average week (15.7% nationally)
- 19% of pregnant women smoke (17% nationally).

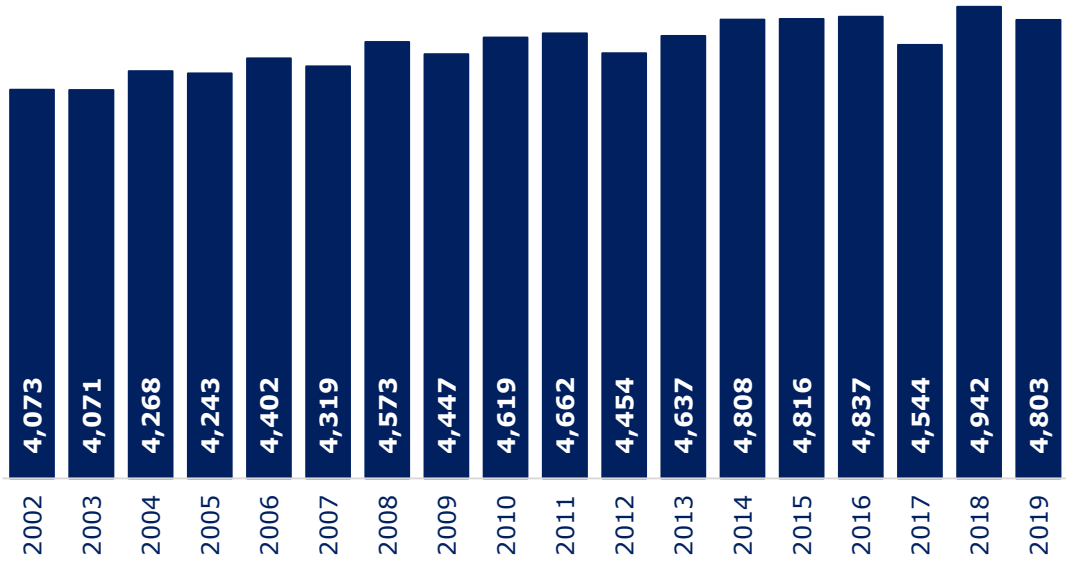
It is also important to note when planning services that more people in north Wales speak Welsh as their first language, when compared with the rest of Wales, with the greatest percentage of Welsh speakers being in the West. We are committed to providing care for individuals in the language of their choice where possible and recognise our duty under the Welsh Language Act of 1993 to treat Welsh and English on an equal basis.

### 2.2 Cancer Incidence

Over 4,500 people in north Wales are diagnosed with cancer each year. This number has increased by 18% over the last 20 years:

**Cancer incidence (number), all malignancies, all persons, Betsi Cadwaladr UHB, 2002-2019**

Source: Public Health Wales Observatory and Cancer Analysis Team, using cancer registration data (WCISU)




Cancer incidence rates, which account for age differences between populations, show that the BCUHB rate (609 per 100,000) is below the all Wales rate (615 per 100,000) but not statistically significantly lower. At unitary authority level, cancer incidence rates on Ynys Môn (Anglesey), Denbighshire and Flintshire are higher than the Wales average but not statistically

significantly higher; the rate in Conwy is statistically significantly lower than the all Wales figure:

**Cancer incidence (rate per 100,000), all malignancies (excluding NMSC), all persons, Wales, Betsi Cadwaladr UHV and unitary authorities, 2019**

| | Rate per 100,000 |
|---|---|
| Wales | 615 |
| Betsi Cadwaladr UHB | 609 |
| Isle of Anglesey | 657 |
| Gwynedd | 606 |
| Conwy | 559 |
| Denbighshire | 634 |
| Flintshire | 627 |
| Wrexham | 602 |

Source: Public Health Wales Observatory and Cancer Analysis Team

The most common cancer sites in north Wales are skin, prostate, breast and lung. The cancer sites that have seen the most significant increases over the period 2002 to 2019 are:

| Cancer site | Change in cancer diagnoses (2002-19) | % increase |
|---|---|---|
| Urology | +269 | 50% |
| Colorectal | +95 | 15% |
| Breast | +91 | 15% |
| Melanoma (skin) | +79 | 64% |
| Head and neck | +59 | 50% |

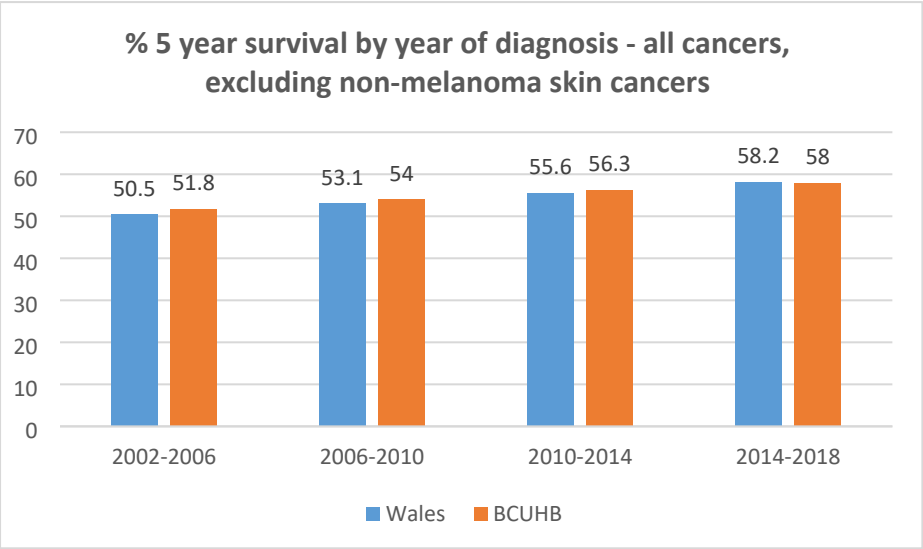
Cancer Research UK published figures in January 2023 indicating that cancer incidence will rise by 30% by 2040, with particular increases in kidney, prostate, skin and pancreatic cancers. The increase will primarily be due to an ageing population and lifestyle factors, principally smoking and obesity.

The pressure on the healthcare system is already increasing. There were 38,328 suspected cancer referrals from primary care in 2022 compared to 23,696 five years before, a 62% increase. Conversion rate to a cancer diagnosis following a suspected cancer referral from primary care has fallen from 8% to 7% over this time. Referrals are expected to continue to rise as national clinical guidance for primary care suspected cancer referrals is based on a 3% positive predictive value of cancer.

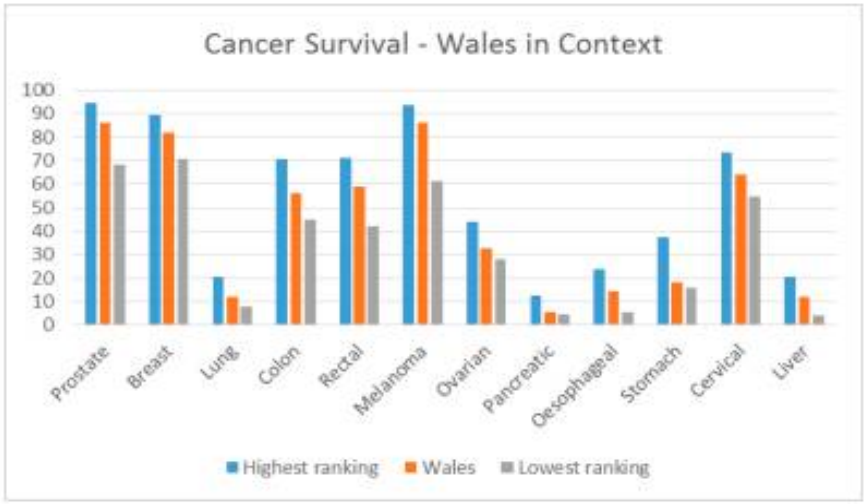
53% of cancers are diagnosed following a primary care suspected cancer referral. The remainder are diagnosed following a non-cancer referral (32%), as part of a screening programme (8%), or following an emergency admission (7%). The percentage of diagnoses following a primary care suspected cancer referral is increasing which is a positive step in increasing early diagnosis rates.

### 2.3 Cancer Survival

Cancer survival in BCUHB and Wales has been improving gradually over time. This means more people are either being cured of cancer or are living longer with cancer.




However, since 2016 cancer has been the main cause of mortality in Wales and cancer survival in Wales remains lower than comparable health systems:




Many factors combine to explain the difference in cancer survival:

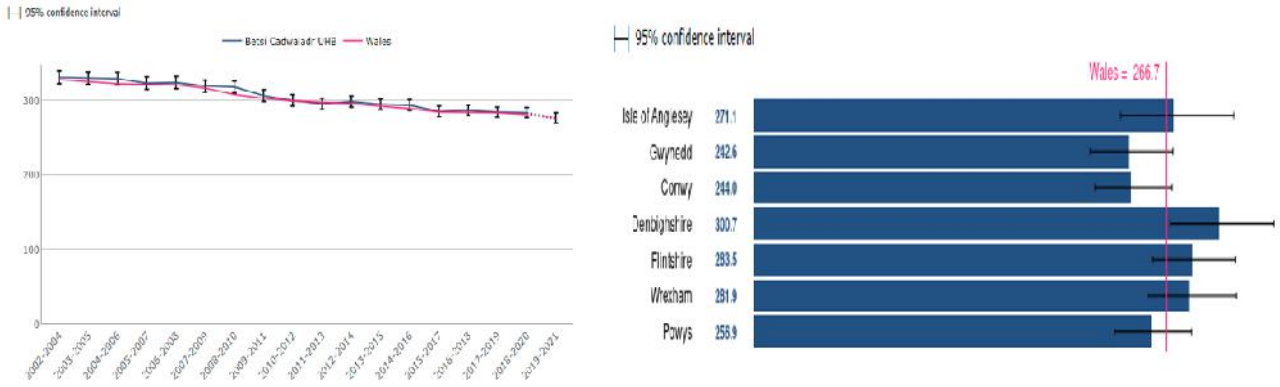
- Different types and grades of cancer
- Ageing population
- Distribution of cancer stage at diagnosis
- Pattern of routes in to the health service at time of diagnosis
- Variation in access to timely and effective treatments
- Presence of co-morbidities and optimisation of their treatment
- Lifestyle after diagnosis – smoking, obesity, physical inactivity

### 2.4 Cancer Mortality

There were just under 2,190 deaths from cancer in BCUHB in 2021. The rate for BCUHB (269.2 per 100,000) is just above the Wales average (266.7 per 100,000) but is not statistically significantly higher. Across the region, rates range from 242.6 per 100,000 in Gwynedd to

300.7 per 100,000 in Denbighshire which is statistically significantly higher than the all Wales figure.

**Mortality (standardised rate/100,000) 2021 – all cancers exc non-melanoma skin cancer**




Cancer is the largest cause of avoidable mortality. In 2020, avoidable mortality rates for cancers were statistically significantly lower than in 2001 across all three constituent countries of Great Britain. In Wales, the avoidable mortality rate for cancer has declined from 96.2 per 100,000 population in 2014 to 86.6 per 100,000 in 2020.

### 2.5 Cancer Inequalities

There are significant inequities with cancer mortality rates higher in the most deprived areas. In 2020, cancer mortality in males and females living in the most deprived areas of Wales were statistically significantly higher than those in the least deprived areas.

**Age-standardised mortality rates with an underlying cause of cancer, males and females and levels of deprivation, Wales, 2001 to 2020**
**Source: Office for National Statistics**

The absolute gap in avoidable mortality between males in the most and least deprived areas of Wales widened between 2019 and 2020, with a gap of 66.2 deaths per 100,000 males in 2019 compared with a gap of 73.8 deaths per 100,000 males in 2020. In females, the absolute gap narrowed from 55.3 deaths to 50.7 deaths per 100,000 females during the same period.

In line with the rest of Wales, screening uptake is lower in the most deprived areas of our region, meaning people with cancer in these areas are less likely to have their cancer detected at an earlier, more treatable stage:

| Screening Programme | Uptake target | Wales uptake 2020/21 | BCUHB uptake 2020/21 | Range – least deprived to most deprived area in BCUHB |
|---|---|---|---|---|
| Bowel | 60% | 67.1% | 66.6% | 71.7% - 56.9% |
| Breast | 70% | 67.1% | 68.2% | 75% - 57.8% |
| Cervical | 70% | 69.5% | 70.5% | 75.5% - 63.2% |

### 2.6 Diagnosis and Treatment of Cancer

Scientific advances have transformed the diagnosis and treatment of cancer over the last decade. More targeted imaging, biopsy and pathology reporting techniques are leading to more accurate diagnoses. Scientific advances eg through genomics (the study of DNA) have led to the development of new targeted treatments, in particular new systemic anti-cancer therapy (SACT) such as immunotherapies. Treatment techniques have advanced, for example robotic assisted surgery (RAS) and targeted radiotherapy which reduce the negative impacts of treatment on patients.

The number of patients living with metastatic cancer and undergoing multiple lines of therapy is increasing which impacts on the clinical capacity required for multidisciplinary team (MDT) discussions, diagnostics and complex management, requiring holistic multi-professional care.

The National Strategic Clinical Network for Cancer (formerly known as the Wales Cancer Network) has worked with clinical teams across Wales to agree National Optimal Pathways (NOPs) for 21 cancer sites covering over 90% of cancers. The NOPs describe what should happen to ensure timely access to evidence based diagnosis and treatment and the support that patients should receive during these pathways. They provide the framework to develop the service capacity to meet demand in timelines consistent with best practice.

### 2.7 Cancer Services in North Wales

BCUHB provides primary, community and acute hospital services to the north Wales population as well as some residents of Powys Teaching Health Board, Hywel Dda University Health Board and some of the English border population.

Cancer services span the whole of the healthcare sector. In north Wales, acute services are provided from three main hospitals – Ysbyty Gwynedd in Bangor, Ysbyty Glan Clwyd in Bodelwyddan and Ysbyty Wrecsam Maelor. Most cancer diagnostic and treatment services are provided on all three sites but some specialist services are centralised to one site. These include radiotherapy which is provided at the North Wales Cancer Treatment Centre at Ysbyty Glan Clwyd, specialist gynaecology cancer surgery at Ysbyty Gwynedd, specialist head and

neck cancer surgery at Ysbyty Glan Clwyd and specialist upper GI cancer surgery at Ysbyty Wrecsam Maelor.

In addition, some specialist aspects of cancer care are provided at hospitals outside of north Wales. These include thoracic surgery at the Liverpool Heart and Chest Hospital NHS Foundation Trust, plastic surgery at Mersey and West Lancashire Teaching Hospitals NHS Trust, specialist oncology and haematology services at The Clatterbridge Cancer Centre NHS Foundation Trust in Liverpool and The Christie NHS Foundation Trust in Manchester and neurosurgery at The Walton Centre NHS Foundation Trust in Liverpool.

### 2.8 Governance

BCUHB is held accountable by Welsh Government for the planning and delivery of cancer services, in line with national cancer policy, for its resident population. Some specialist services are commissioned on the Health Board's behalf by the Welsh Health Specialist Services Committee (WHSSC).

BCUHB is part of the National Strategic Clinical Network for Cancer (formerly known as the Wales Cancer Network), an organisation within the NHS Wales Executive, which works with Health Boards and Trusts in Wales to improve outcomes and care for cancer patients in Wales.

Within BCUHB, the overall strategic direction for cancer services is overseen by the Cancer Partnership Board, which is chaired by the Health Board's Executive Lead for Cancer and reports to the BCUHB Board via the Executive Delivery Group for Transformation. The Cancer Partnership Board comprises all key stakeholders in the planning and delivery of cancer services, including Public Health, primary and secondary care services and third sector partners. Responsibility for the operational delivery of cancer services in north Wales lies with the operational and clinical management teams within the Health Board; these include:

- 3 Integrated Healthcare Communities (East, West and Centre),
- Cancer Division which manages oncology and haematology services across the region
- Women's Division
- Managed Clinical Services Division which manages radiology and pathology services across the region

## SECTION 3: THE CASE FOR CHANGE

### 3.1 Strengths

#### 3.1.1 Quality service provision

The Wales Cancer Peer Review programme has been part of the NHS Wales Quality Assurance Programme since 2013. It has consistently reported evidence of good quality cancer services provision in north Wales. The programme involves submission of data around service provision and outcomes, followed by a peer review of services by clinical and managerial teams from elsewhere in Wales, and more recently by clinicians from England. The most recent peer review reports have highlighted particular areas of good practice including strong clinical leadership, cross-site working, innovation in clinical practice, high quality pathology services and excellent clinical trials recruitment.

The Health Board also submits data to five UK wide cancer audits. These audits benchmark our services against others in the UK and, in the main, our services are demonstrated to have good quality outcomes. These audits cover breast, bowel, lung, oesophago-gastric and prostate cancers.

#### 3.1.2 Innovation

Cancer services in north Wales have delivered innovative new ways of working to improve services and reduce time to diagnosis. These include the reflex CT pathway for patients with suspected lung cancer, the one stop neck lump clinic and the rapid diagnosis clinics for patients with vague but concerning symptoms. The Health Board has led the way in Wales in the use of technology with the use of Artificial Intelligence (AI) in pathology and radiotherapy planning services and the introduction of remote tracking of patients on follow-up pathways for prostate cancer.

#### 3.1.3 Patient experience

The Macmillan Wales Cancer Patient Experience Survey (2023) has demonstrated that cancer patients in north Wales feel they receive a high quality service. 89% of respondents rated their overall care as 7 or more out of 10 and 90% said they were treated with dignity and respect. 88% reported they were supported by a keyworker during their cancer diagnosis and treatment, an increase from 83% in the 2016 survey. The 2023 survey is based upon responses from patients treated in 2020 and we would anticipate the number of patients supported by a keyworker to be higher again in future surveys following a significant joint investment by the Health Board and our partners at Macmillan Cancer Support in additional nursing posts in 2021. The Health Board has also recently trialled a cancer related fatigue service to support patients manage the impact of cancer and cancer treatment, which has received extremely positive patient feedback and won a number of national awards.

We also have a strong Cancer Patient Forum in North Wales whose members actively share their experiences of our services and give their time to work with us to improve and develop services.

### 3.2 Weaknesses

#### 3.2.1 Workforce fragility

A number of our cancer services (in both primary and secondary care) are fragile and lack resilience due to challenges we have experienced in the recruitment and retention of key staff; for example clinical oncology, endoscopy, dermatology, haematology and specialist radiology.

In some specialties we do not have the necessary specialist staff in post and have to refer patients to providers outside north Wales for treatment, for example some major urology cancer surgery.

We need to improve our strategic workforce planning to ensure we can meet the demand for both diagnostic and cancer treatment services in the future.

#### 3.2.2 Infrastructure

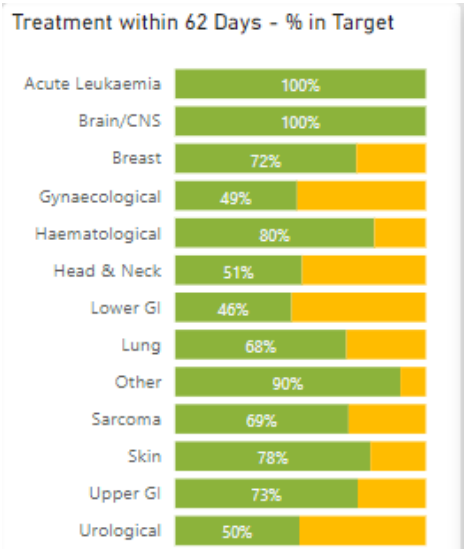
Our real estate is limited with particular concerns in some specialties about inadequate space to provide optimal level of service, for example in breast services in Central and West, urology services in East and endoscopy and rehabilitation services across the Health Board.

In addition, our communication network is limited with differing information systems between primary and secondary care services.

#### 3.2.3 Timely access

We are not meeting the Welsh Government cancer waiting times target – the 'Suspected Cancer Pathway' (SCP) target. This target requires Health Boards to diagnose and treat at least 80% of cancer patients within 62 days of suspicion of cancer by end of March 2026. In 2022 we treated 65% of all new cancer patients within 62 days of suspicion with significant variation between different tumour sites.

Performance against the SCP target has deteriorated in the last year with the most common reasons for delays being insufficient capacity within urology, endoscopy, dermatology and oncology services




#### 3.2.4 Patient experience and support

The Macmillan Wales Cancer Patient Experience Survey (2023) highlighted a number of areas we know we need to improve on. For example only 35% of respondents said their healthcare team completely discussed with them or gave them information about the impact cancer could have on their day-to-day activities (for example, their work life or education) and only 35% of respondents said they had been offered a written care plan.

We need to ensure we continue to develop services, alongside service users, to ensure we adequately prepare our patients for treatment eg through prehabilitation, and adequately support them in returning to healthy living after treatment with appropriate physical and psychological support in place. Since 2017, we have had no dedicated clinical psychology support service for patients in some areas of the Health Board. In addition, we have less Allied Health Professionals (AHPs) to support our cancer patients with recovering functionality than services in the rest of Wales.

### 3.3 Opportunities

#### 3.3.1 Prevention

It is estimated that almost 4 in 10 cancer cases in Wales each year could be prevented. Prevention must be a key area of focus, in particular in areas of deprivation where we see high levels of health inequality. We must seek to reduce the rates of avoidable cancer through raised awareness and uptake of healthy lifestyles eg smoking cessation, obesity reduction, reducing alcohol consumption and increasing physical activity. These lifestyle factors also influence the risk of other diseases eg cardiac disease, stroke and are therefore part of the wider existing public health work programme.

#### 3.3.2 Expanded screening programmes

Expansion of national screening programmes eg the Bowel Screening Wales programme, the All Wales Very High risk MRI Surveillance Programme for breast cancer (due 2024) and the potential introduction of lung cancer screening will enable us to diagnose cancer earlier, thereby reducing the complexity of treatment required and improving survival. We must ensure we have sufficient diagnostic and treatment services in place to fully deliver the potential benefits of this expansion, primarily endoscopy, radiology and surgery.

#### 3.3.3 Regional diagnostic facilities

NHS Wales has established a National Diagnostic Board to take forward the implementation of the national diagnostic programmes, with a particular focus on evaluation of the effectiveness of establishing a network of Regional Diagnostic Hubs. BCUHB covers a wide geographical area which brings complexity but also opportunity to streamline the way diagnostic services are provided. The newly re-established Planned Care Programme in the Health Board will be reviewing opportunities for maximising and increasing access to diagnostic services across the region.

#### 3.3.4 Workforce developments

In September 2024, Bangor University will launch its first Medicine programme to allow students to complete their studies entirely in north Wales. The new Medical School brings together educational and medical experts from across north Wales, and is a collaboration between the university, the Health Board and local GPs. This represents a significant opportunity to align education and training to the Health Board's clinical strategy, support our research strategy and address key challenges in our clinical workforce.

At a national level, Health Education and Improvement Wales is developing a business case to develop an Academy of Clinical Endoscopy to provide a sustainable infrastructure for accelerated high quality training pathways to bring more Joint Advisory Group (JAG) certified endoscopists and endoscopy nurses to independent practice. This will assist in recruitment to our endoscopy services.

The Health Board is also part of the All Wales Robotic Assisted Surgery (RAS) programme and introduced robotic surgery for women with gynaecological cancers in 2022 and for patients with colorectal cancer in 2023. The expansion of this programme to other specialties over the next few years will provide outcome benefits for patients but also assist in the recruitment of surgeons in specialties where we have traditionally struggled to recruit, for example urology.

As a Health Board we will also need to be at the vanguard of the development of new advanced practice roles in order to support clinical services development. This will help address workforce gaps in some specialties eg the development of consultant therapy radiographer posts in oncology and consultant allied health professionals to support prehabilitation and rehabilitation across all cancer sites.

### 3.3.5 Innovation

Our understanding of cancer is increasing all the time and new cancer treatments and diagnostic tools continue to emerge, for example new blood tests to detect cancer at an earlier stage are being trialled UK wide. These innovations will bring exciting opportunities to improve cancer detection and treatment and we need to be ready to maximise their use.

Whilst much of the change required to improve cancer pathways requires an increase in capacity, there are also opportunities to use current capacity more effectively and innovatively. These include further expansion of prehabilitation services to reduce length of stay, one stop clinics, the introduction of teledermoscopy (where patients with skin lesions attend medical photography appointments with images reviewed remotely by dermatologists allowing the clinician to signpost the patient appropriately), video group clinics and expanding the remote tracking of patients on follow-up pathways to more types of cancer. We will continue to seek opportunities to improve through service redesign and will work with the National Strategic Clinical Network for Cancer and third sector organisations to access funding to support innovative tests of change.

Innovations in technology can also help address some of the inequity in current service provision eg virtual appointments to reduce travel time for patients.

### 3.3.6 Research

In October 2021 the North Wales Clinical Research Facility was established in Wrexham. The facility specialises in the delivery of early phase trials using experimental medicines and was involved in COVID-19 vaccination trials. There is an opportunity to branch out into oncology and haematology trials to contribute to new medicines and provide opportunities to attract clinical staff to north Wales.

The Maelor Academic Unit of Medical and Surgical Sciences (MAUMSS) was also established in 2021 on the Wrexham site. It is designed to encourage and support research within the Health Board. It is staffed by an interdisciplinary team of academics, clinicians, scientists and

postgraduate students who are available to lead on and help other healthcare professions develop and run clinical research projects.

### 3.3.7 Better data

We are working with Digital Healthcare Wales (DHCW) to replace the current national cancer database (CaNISC) with an improved integrated cancer data collection system. This system will allow our clinical data about patients diagnosed with cancer to be more readily available to clinical teams and provide more detailed information to help plan and develop services.

In addition, there are five new national audits which will enable us to benchmark our services against others for kidney, ovarian, pancreatic, metastatic breast cancers and Non-Hodgkins Lymphoma. These audits will highlight unwarranted variation and support implementation of best practice.

## 3.4 Threats

### 3.4.1 Increasing demand

The Health Service is under significant pressure throughout the UK. The COVID-19 pandemic severely constrained the ability to provide planned care and waiting times increased. Patients with suspected cancer were prioritised during this time but the Health Board has a backlog of long waiting routine patients to treat as well as facing unprecedented emergency care pressures due to the continued impact of COVID and pressures within the whole care sector.

Suspected cancer referrals continue to increase and we need to ensure cancer patients continue to receive timely diagnosis and treatment despite these significant pressures. It should be noted that suspected cancer referrals are likely to continue to increase; current NICE guidance is based on a 3% risk of cancer whereas our current conversion rate from GP suspected cancer referral to cancer is 7% and therefore it is likely more patients should be being referred on suspected cancer pathways. We will need to work with local services and the National Diagnostic Board to ensure sufficient diagnostic capacity is in place.

### 3.4.2 Workforce pressures

Increasing capacity is not straightforward due to both financial and workforce pressures. The economic picture in the UK means funding for the NHS is constrained and is likely to be so for a number of years. In addition, we have a number of specialties where we struggle to recruit and are likely to continue to do so due to a national shortage within these specialties, see examples below re radiology and clinical oncology from the 2020 Royal College of Radiologists' UK workforce review. We need to ensure our services are attractive to potential applicants to ensure we can continue to provide high quality services, with sufficient numbers of key specialities to support both direct clinical care and multidisciplinary team working.

Figure 7. Clinical oncology consultants (whole-time equivalent), estimated supply and demand – Wales, next five years (2020–2025)

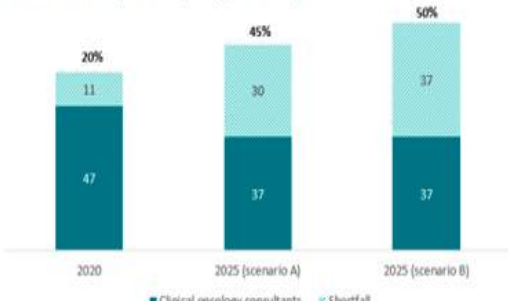
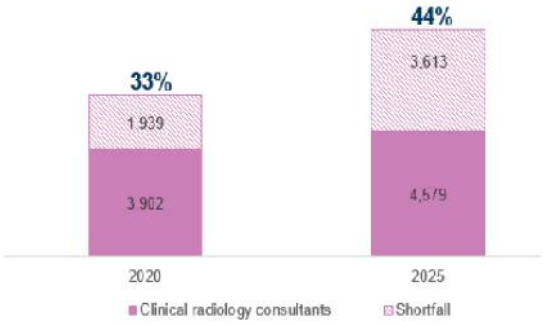



Figure 17. Forecast shortfall of clinical radiology consultants – UK, 2020 and 2025




### 3.4.3 Low volume services

Finally some of our specialist services are vulnerable due to the low patient volume, for example our upper GI specialist surgical service in East. Whilst our outcomes are good, as seen in the national oesophago-gastric cancer audit, we need to ensure we continue to provide services in line with national recommendations re casemix and patient numbers. This may involve working more closely with other centres nearby.

## SECTION 4: DEVELOPING THE ROADMAP

### 4.1 National and local drivers

Existing national and local strategies and plans provide the foundations for the roadmap. These include:

- **Ministerial Priorities for the NHS in Wales (2023)** – highlights cancer as one of the six priorities for the NHS in Wales
- **A Cancer Improvement Plan for NHS Wales 2023-2026 (2023)** – sets out the ambition for Wales to improve cancer patient outcomes and reduce health inequalities with 9 themes for focus and action
- **BCUHB Clinical Services Strategy (2022)** – sets out the future direction and strategic intentions for clinical services in North Wales
- **Welsh Government's Quality Statement for Cancer (2021)** – sets out the 22 attributes of a quality cancer service ie equitable, safe, effective, efficient, person centred and timely
- **A Healthier Wales (2018)** – sets out the Welsh Government's long term plan for health and social care in Wales
- **Diagnostics Recovery and Transformation Strategy for Wales 2023-2025 (2023)** – sets out the Welsh Government's plan to use diagnostics to support the recovery of NHS services and prepare for future need

### 4.2 Our Enablers

Enablers are essential supports which will help us to achieve our vision. These include the following people, strategies and plans:

- Our staff, partners, users and carers
- Public Health Wales: Our Strategic Plan 2022-25
- Welsh Health Specialised Services Committee (WHSSC) Integrated Commissioning Plan 2022-25
- BCUHB Our Digital Future: Digital road map for health in North Wales 2022-24
- BCUHB Quality Improvement Strategy 2019 – currently under review and to be refreshed for the period 2022-25
- BCUHB Estate Strategy 2023

## SECTION 5: OUR STRATEGIC AIMS FOR THE FUTURE

We will meet our cancer vision for north Wales by developing plans to implement the following strategic aims:

### Prevention

1. Reduce cancer incidence by improving the health and well-being of our population with a particular focus on:
    a. smoking cessation – implementing the Wales Tobacco Control Delivery Plan to increase the number of smoke free pregnancies and work towards the Welsh Government target of reducing smoking to 5% of the population by 2030
    b. reducing obesity – implementing the Healthy Weight Healthy Wales Delivery Plan, including pre-diabetes prevention programmes and obesity pathways
    c. reducing alcohol abuse
    d. promoting safer sun exposure
    e. increasing uptake of the HPV vaccination (a vaccine which reduces incidence of a number of cancers including cervical and some head and neck cancers) in schools
2. Ensure a particular focus on these strategies in the most deprived areas of our region in order to reduce health inequalities

### Early detection

3. Increase the percentage of cancers diagnosed at an early stage through maximising opportunities presented by screening programmes with a particular focus on:
    a. increasing uptake of screening for breast, bowel and cervical cancers; aim to exceed the all Wales screening targets in all areas of the Health Board, including the most deprived, by 2028
    b. ensuring timely access to appropriate diagnostic tests following a positive screening outcome eg colonoscopy for participants with positive bowel screening test, colposcopy appointments for participants identified as requiring referral from cervical screening test
    c. implementing new cancer screening programmes in line with national policy decisions and timelines eg lung cancer screening (Public Health Wales expected to produce business case for delivery by end of March 2024), MRI surveillance for women at very high risk of breast cancer in 2024 and liquid biopsy technology as it becomes available
4. Work with Public Health Wales, the BCUHB Public Health Team and our third sector partners to increase awareness of cancer symptoms within the general population to ensure people present to health services in a timely manner
5. Improve the timeliness and quality of suspected cancer referrals from general practice to ensure cancers are referred into specialist services as early as possible; this will include:
    a. access to appropriate diagnostic tests in primary care
    b. clear accessible referral guidance, supported by training and education
    c. introduction of digital software to support enhanced primary-secondary communication

**Early diagnosis**

6. Redesign clinical pathways to provide straight to test and one stop diagnostic models, in line with the National Optimal Pathways for cancer, to ensure cancers are diagnosed as quickly as possible
7. Work with the National Diagnostics Board to ensure sufficient diagnostic capacity is in place to diagnose cancer within the timescales set out in the National Optimal Pathways for cancer with a focus on achieving the 28 day target for diagnostic and staging tests; this will require a particular focus on:
    a. Endoscopy
    b. Radiology
    c. Urology
    d. Dermatology
8. Introduce new diagnostic techniques to improve the quality and efficiency of diagnostic services; this will include:
    a. work with the All Wales Teledermoscopy Programme to establish teledermoscopy services
    b. work with the National Endoscopy Programme to evaluate new diagnostic tests as an alternative to endoscopy eg cystosponge, colon capsule and transnasal endoscopy
    c. build on the success of the use of Artificial Intelligence (AI) within pathology reporting and expand to more cancer types
9. Build on the early success of our Rapid Diagnosis Clinics (RDCs) for patients with vague but concerning symptoms to ensure that patients with an unclear diagnosis are also assessed and diagnosed in a timely manner; this will include implementing the recommendations from the National Strategic Clinical Network for Cancer's evaluation of the RDC programme due end of March 2025

**Timely and effective treatment**

10. Deliver optimum treatment for every patient in line with national clinical guidance
11. Ensure sustainable access to genomics in line with emerging advances in precision medicine to ensure our patients have access to the most appropriate targeted therapies
12. Ensure sufficient capacity is in place to treat cancer within the timescales set out in the National Optimal Pathways for cancer; this will require a particular focus on:
    a. urology
    b. colorectal surgery
    c. dermatology and plastic surgery
    d. oncology, in particular as advances in Systemic Anti-Cancer Therapy (SACT) and radiotherapy treatments lead to more demand on these services.
13. Develop service models that provide the safest clinical service, make the best use of resources and are provided as close to patients' homes as possible. This means some services will be provided in many physical locations across the region but others will need to be provided in a hub and spoke model or on a single site for the whole region. Feedback from user engagement by the Health Board has indicated that people are prepared to travel to access quicker treatment with better outcomes; any plans for change must address the issue of accessibility, particularly in relation to transport and support for users, families and carers. Particular areas of focus will be urology, colorectal and upper GI surgery, and haematology, due to current concerns re the sustainability of the current models

14. Provide specialist services currently provided outside of Wales within north Wales where clinically safe and effective to do so; for example specialist urology surgery, some day case plastics surgery, specialist radiotherapy eg stereotactic ablative body radiotherapy (SABR). This will require joint work with the Welsh Health Specialist Services Committee (WHSCC)
15. Work with the Welsh Health Specialist Services Committee (WHSCC) to commission specialist clinical care outside of north Wales where it is clinically inappropriate to provide within north Wales due to the small volume, specialist nature of the service. Seek to provide as many elements of this care locally and ensure care is timely and seamless
16. Expand the provision of acute oncology services to ensure those patients presenting as emergencies with undiagnosed cancers or complications related to cancer treatment are promptly triaged and effectively treated and supported
17. Develop stratified prehabilitation services, in line with the National Prehabilitation Standards, for all cancer patients to meet individual and population requirements by end of March 2024
18. Provide Enhanced Recovery After Surgery (ERAS) and rehabilitation services to ensure the health benefits of treatment are optimised and patients return to healthy living as soon as possible after treatment
19. Ensure patients are treated within national cancer waiting times targets ie diagnose and treat at least 80% of patients within 62 days of suspicion of cancer by March 2026

**Self-directed aftercare**

20. Where clinically appropriate, support patients in managing their own condition, ensuring fast routes back into services as appropriate; use digital solutions to support this process

**Person centred care**

21. Ensure all cancer patients have access to a cancer key worker by the end of March 2024
22. Ensure all patients who wish to, can actively contribute to and receive a care plan, both at the point of their diagnosis and treatment decision and at the end of their treatment, that provides holistic assessment of their needs, general advice and signposting information for living with and beyond cancer
23. Improve access to psychological support to reduce the impact of psychological morbidity associated with a cancer diagnosis, improve quality of life and clinical outcomes for patients and support all staff in providing psychologically informed care.
24. Collate and act on PROMs and PREMs on an ongoing basis to demonstrate impact on patient care via regular audit
25. Ensure service users are at the heart of service developments by working jointly with the North Wales Cancer Patient Forum to ensure co-production of services and by taking action following patient feedback surveys
26. Offer the option, wherever appropriate, of either a virtual or face to face appointment to suit personal circumstances and avoid additional costs for patients

**Workforce**

27. Ensure our staff have the right values, behaviours, knowledge, skills and confidence to deliver evidence based care

28. Ensure we have sufficient numbers of the right people to be able to deliver healthcare that meets the needs of our population; this will include working with the Wales Cancer Network and Health Education and Improvement Wales (HEIW) to forecast and develop plans to meet gaps in key areas including the diagnostic, nursing, allied health professional, therapeutic radiographer and pharmacy workforce
29. Develop recruitment and retention strategies with a particular focus on hard to recruit specialties eg specialist radiology, clinical oncology. These strategies will need to be supported by education and training opportunities and service redesign to create attractive roles to recruit to
30. Continue to develop the robotic assisted surgery (RAS) programme to ensure we attract surgeons to North Wales
31. Ensure our staff are, and feel, valued with excellent clinical leaders and managers as role models
32. Ensure staff wellbeing and compassionate leadership is embedded and demonstrated through staff wellbeing audits and action plans

**Research**

33. Ensure all eligible patients are offered entry into clinical trials
34. Work collaboratively across Wales to deliver the Wales Cancer Research Strategy (Moving Forward: A Cancer Research Strategy for Wales, 2022) to boost research; this will include ensuring the infrastructure is in place to facilitate full participation in research by our clinical teams

**Digital and data**

35. Ensure our cancer services are supported by appropriate information technology systems eg introduce e-vetting of referrals to improve timeliness of access to our services
36. Ensure data on all our cancer patients is recorded on the new All Wales Cancer Information System; use this data to develop clinically led information dashboards to enable services to benchmark performance and identify areas for improvement
37. Ensure required data is captured for the five new national clinical audits (kidney, ovarian, pancreatic, metastatic breast and Non-Hodgkins Lymphoma) and the new SACT and radiotherapy waiting times national standards to enable services to benchmark performance and learn from best practice

**Estates**

38. Ensure cancer diagnostic, treatment and rehabilitation services are delivered within appropriate physical facilities; this may involve relocation and/or improvement of existing facilities eg urology services in East, breast services in West and Central and endoscopy services
39. Ensure sufficient radiotherapy infrastructure, including timely replacement of equipment, to meet the needs of the north Wales population
40. Work with WHSSC to ensure access to PET (Positron Emission Tomography) imaging in north Wales for the north Wales population

**Governance**

41. Develop the role of the Cancer Partnership Board to ensure a whole system approach to cancer planning and delivery in north Wales
42. Work closely with the National Strategic Clinical Network for Cancer to ensure national initiatives are implemented and where appropriate led by services in north Wales

## SECTION 6: CLINICAL SERVICE PLANS

Following the development of this roadmap we will develop Clinical Service Plans for each area of cancer services delivery. Our Clinical Service Plans will clearly set out **how**, over the period 2024-29, we will use the principles in this document to deliver our Vision for Cancer Services. These will be developed in conjunction with the Health Board's overarching Clinical Service Plan. A plan will be developed for each of the following areas:

- Prevention
- Screening
- Diagnostic services
- Breast cancer
- Colorectal cancer
- Gynaecological cancer
- Haematological cancer
- Head and neck cancer, including thyroid cancer
- Lung cancer
- Skin cancer
- Upper GI cancer
- Urological cancer
- Brain cancer
- Sarcoma
- Cancers of unknown primary
- Oncology
- Primary-secondary care communication including vague symptoms referrals

***Sources***

*Cancer Research UK (CRUK) mortality statistics 2019, CRUK website*

*BCUHB Clinical Services Strategy, 2022*

*North Wales Social Care and Well-being Services Improvement Collaborative, North Wales Population Needs Assessment, 2022*

*Welsh Language Act, 1993*

*Welsh Cancer Intelligence and Surveillance Unit (WCISU) cancer incidence, mortality and survival statistics, WCISU website*

*North West Cancer Research Annual Report, 2022*

*Global surveillance of trends in cancer survival 2000-2014 (CONCORD-3): Lancet (January 2018) Allemani et al*

*Public Health Wales, Screening Division Inequities Report 2020-21 (June 2022)*

*Wales Cancer Network Peer Review reports 2013-2022*

*Wales Cancer Patient Experience Survey, 2023*

*NICE Suspected cancer guidance, NG12, 2015*

*National Clinical Audit reports – National Bowel Cancer Audit, National Oesophago-gastric Audit, National Lung Cancer Audit, National Audit of Breast Cancer in Older Patients, National Prostate Cancer Audit*

*Royal College of Radiologists' UK workforce review, 2020*

*All Things Being Equal? Inquiry into cancer inequalities in Wales caused by socio-economic deprivation, Cross Party Group on Cancer, Welsh Senedd, 2023*

| | |
|---|---|
| **Reporting Committee** | **Quality and Patient Safety Committee (QPSC)** |
| **Chaired by** | **Susan Elsmore** |
| **Lead Executive Director** | **Director of Nursing & Quality** |
| **Date of Meeting** | **2nd September, 2024** |

**Summary of key matters considered by the Committee and any related decisions made**

## 1. PATIENT STORY

Members received an ITV media clip which involved a young woman (HL) who formerly was an in-patient in Ty Llidiard the Children and Adolescent mental Health Unit on the Princess of Wales site with a diagnosis of Anorexia Nervosa. The video interviewed Helen and explained the progress that had been made by the unit whilst in special measures. The importance of patient engagement was seen as a critical element in the success working with young people to improve services. Members acknowledged how difficult it can be to tell your story and applauded the patient who has gone on to undertake her medical training. The story also highlighted the collaborative working between the former WHSSC and NCCU in supporting the Health Board in improving the service.

## 2. FEEDBACK CORONOR'S INQUEST

Members received a presentation containing an update following the Conclusion of the inquest concerning the death of a young woman (aged 29), who was a patient from HDUHB who sadly took her own life whilst an inpatient at a Women's Enhanced Medium Secure (WEMMS) Unit in London. Members noted that the coroner's inquest hearing was held in the West London Coroner's Court and concluded on 23 July 2024. The inquest was held in public with a jury of 8.The recommendations arising from the hearing were shared and it was noted that NHS England have decommissioned the services following a review. The implications of this will be considered as part of the Mental Health Strategy.

The Director of Mental Health and Vulnerable Groups explained that he was currently working with Welsh Government around continuing healthcare, which is a complex area. In response, an independent member stated that little had changed as how continuing health care was managed, it was costly and demand was increasing. It was agreed that these concerns would be escalated to the Joint Commissioning Committee.

## 3. WELSH KIDNEY NETWORK REPORT

Members received a report outlining the current Quality and Patient Safety issues within the services that are commissioned by the Welsh Kidney Network (WKN) across Wales and a summary of the highest scoring risks was provided.

## 4. COMMISSIONING TEAM AND NETWORK UPDATES

Reports from individual Commissioning Teams were received and taken by exception. Members noted the information presented and a summary of the services in escalation as attached. The key points for each service are summarised below and updates regarding services in escalation are attached in the tables at the end of the report.

### 4.1 Cancer & Blood

Quality issues for services relating to the Cancer and Blood Commissioning Team Portfolio.

**South Wales Plastic Surgery**

It was reported that this service provided by SBUHB remained at Level 2 of the Escalation process and was the only NWJCC commissioned service where patients were waiting over 104 weeks. In July 2024, however, the NWJCC agreed to fund some of this additional capacity focusing on higher priority clinical groups who will receive their surgery before the end of December 2024. This was discussed at the July 2024 JCC and MG meetings. Further consideration will be given in August/September 2024 to the remaining funding required to meet the target in full, taking into account the context of the wider JCC financial position.

**Neuroendocrine Tumours**

It was noted that following a patient concern a review of the service provided by CVUHB was to be undertaken. The commissioning team will support the review and consideration given to the findings. The timescales and terms of reference are yet to be agreed.

### 4.2 Cardiac

Members received an update of the quality issues for services relating to the Cardiac Commissioning Team Portfolio.

**Obesity Surgery Waiting Times**

It was noted that there has been no improvement in the waiting list positon for Salford and little or no activity undertaken over the last twelve months. NWJCC are working closely with providers to open up the pathway to South Wales Service as an alternative, and Llais will be updated in relation to this pathway when it becomes available.

### 4.3 Neurosciences

Members received an update of the quality issues for services relating to the Neurosciences Team Portfolio.

**Deep Brain Stimulation**

The service provided by North Bristol NHS Trust (NBNHST) remains temporarily suspended for new referrals. Work is ongoing to secure a temporary alternate pathway into University College Hospitals London (UCL) in partnership with Cardiff and Vale University Health Board (CVUHB) which was agreed by the Senior Leadership Team (SLT) on 19th August 2024. NWJCC are in discussion with NBNHST to gain assurance on the issues raised with a view to reopening the pathway subject to those assurances. NWJCC had reallocated funding to address the Neurosurgery risk and agreed additional money within the ICP for 2024-2025.

### 4.4 Women & Children

Members received an update on the quality issues for services relating to the Women & Children Commissioning Team Portfolio.

**Children's Hospital For Wales**

A reset meeting is due to take place on the 18th September to consider the services in escalation and undertake a collaborative approach to agreeing the way forward. It was noted that the Director of Nursing CVUHB had written providing assurance on the review which had been undertaken relating to pressure damage issues on the Paediatric Intensive Care Unit and the actions that had been taken to address the issues.

**Princess of Wales Hospital (POW)**

Members were informed of the planned closure of the Maternity and Neonatal Unit within Princess of Wales Hospital Bridgend, (POW) and CTMUHB from the 2nd September, 2024 for 12 weeks. This was due to essential maintenance work to be undertaken in both the Neonatal and Maternity Unit. Assurance was given that plans were in place to redirect patient flow.

**Wales Fertility Institute**

Members were informed that a positive HFEA report had been received by the service. No critical or major concerns within the service were highlighted. Four staff members have passed the exam to be the person responsible (PR).The team agreed that the service has met the required standard to be de-escalated from level 4 to level 3. NWJCC continue to work with the provider on service improvements.

### 4.5 Mental Health

Members received an update of the quality issues for services relating to the Mental Health and Vulnerable Groups for the former WHSSC Commissioning Team Portfolio.

**Eating Disorders (ED)**
The new unit in Tŷ Glyn Ebwy Hospital, Hillside and Ebbw Vale was reported at the last meeting to be a 2Q service with an action plan in place with the JCC, via the Framework agreement processes, to improve areas relating to training and supervision arrangements. The service has evidenced improvement in various areas since the last review but quality issues remain, therefore, it is now a 3Q service.

**Mother and Baby Unit / North**
It was noted that provisional works have begun on the new Mother and Baby Unit in Cheshire and Wirral. Recruitment for the required posts has begun with the ward manager in post. The scheme has been delayed considerably due to increased costs from the contractor which Cheshire and Wirral Partnership have formally declined and a new tender process has commenced.

**4.6 Intestinal Failure (IF) – Home Parenteral Nutrition**
Members received an update on the quality issues for services relating to the Intestinal Failure Commissioning Team Portfolio. Members noted that there have been some challenges with regards to robust consultant cover within the Intestinal Failure service. This is an issue which remains closely monitored via the commissioning assurance meetings held with Cardiff and Vale University Health Board

**5.0 OTHER REPORTS RECEIVED**

Members received reports on the following.

**5.1 Services in Escalation Summary**
Members noted the content of the report and a copy of each of the services in escalation is attached to the report at **Appendix 1.**

**5.2 Quality and Safety Report - Ambulance and 111**
A report providing an update on quality and safety matters for the Ambulance and 111 commissioned services was received.

**5.3 Care Quality Commission (CQC)/ Health Inspectorate Wales (HIW) Summary Update**
A briefing on Healthcare Inspectorate Wales (HIW) and Care Quality Commission (CQC) reports published during the period June 2024 to July 2024 was presented to the committee.

**5.4 Incident and Concerns Report**
Members received a report outlining the incidents and concerns reported to WHSSC and the actions taken for assurance.

**5.5 Joint Commissioning Committee Risk Register**

The transitional amalgamated risk register for the JCC was presented to the committee, which encompasses risks scoring 15 and above taken from the commissioning teams and directorate risk registers across the former EASC, NCCU and WHSSC predecessor organisation risk registers. This Risk Register was approved by the JCC in July 2024, and considered by the CTM Hosted Bodies Audit and Risk Committee (ARC) in August 2024. Members noted the significant amount of work done to bring this together, mindful there was still a lot of work to be done with scores and assessing risks to ensure consistency across the range of NWJCC services.

**6. ITEMS FOR INFORMATION**

Members received a number of documents for information only:

- QPSC Distribution List.

**7. ANY OTHER BUSINESS**

None to note.

**Key risks and issues/matters of concern and any mitigating actions**

- Continuing health care and the impact on patients that receive commissioned services, as the concerns continue from the committee.
- Patient story forward to JCC on 17 September 2024.
- An update on the DBS Temporary Service Change was provided and would be relevant for HBs.
- It was important to note that the reset meeting was taking place for Neonatal Cot and PICU and the meeting will be an opportunity to discuss and agree actions/objectives in collaboration with the provider health board.

**Summary of services in Escalation**

- Attached (**Appendix 1**)

**Matters requiring Committee level consideration and/or approval**

None

**Matters referred to other Committees**

As above.

Confirmed minutes for the meeting are available upon request

| | |
|---|---|
| **Date of Next Scheduled Meeting** | TBC |

**Executive Director Lead: Nicola Johnson**
**Commissioning Lead:**
**Commissioning Team: Women and Children**

**Date of Escalation Meetings: 26/04/23, 23/05/23, 20/06/2023, 26/07/23, 12/09/23, 10/10/23, 19/12/23, 16/05/24**
**Date Last Reviewed by Quality & Patient Safety Committee: 24/06/2024**

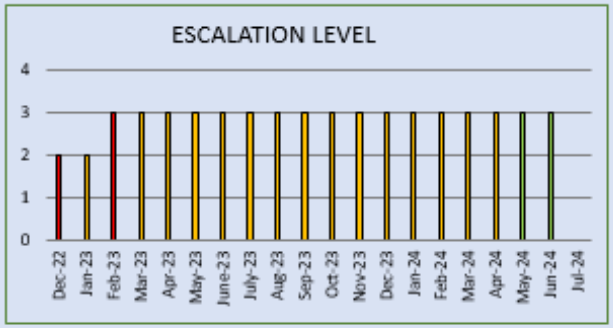
# Service in Escalation: Paediatric Surgery

**Current Escalation Level 0**

**Escalation Trend Level**

| Trend | Rationale | Current Trend Level |
|---|---|---|
| ↓ | Escalation level lowered | ↓ July 2024 |
| ↔ | Escalation remains the same | |
| ↑ | Escalation level escalated | |

Escalation Trajectory:




**Escalation History:**

| Date | Escalation Level |
|---|---|
| **March 2023 – JCC escalation** | **3** |
| **July 2024** | **0** |

**Rationale for Escalation Status :**
As a result of the service failing to engage fully with JCC regarding the weekly submission of contract delivery and waiting time profiles, it was agreed that the C&VUHB Paediatric Surgery service should be further escalated from Level 1 to Level 3 of the JCC Escalation Framework.

**Background Information:**

There is a risk that Paediatric patients waiting for surgery in the Children's Hospital of Wales are waiting in excess of 36 weeks due to COVID-19. The consequence is the condition of the patient could worsen and that the current infrastructure is insufficient to meet the backlog.
- Original recovery plan trajectories have reflected a nominal improvement on the waiting list position, and clarity is required on zero waits > 104 weeks,
- The original plan did not deliver contracted volume,
- Timely assurance on delivery against the baseline for future recovery, via weekly reports, as opposed to monthly reporting suggested by the UHB.

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

**High** – Action plan developed and positive progress made in designing a number of new pilot schemes and securing additional capacity, some delays in

**Actions:**

| Action | JCC Lead | Action Due Date | Completion Date |
|---|---|---|---|
| Monthly escalation meetings with CVUHB to review progress against the improvement plan. | Senior Planning Manager | Monthly | |
| Action plan to be monitored through the monthly escalation meetings and when data shows improvement consideration will be given to de-escalation. | Senior Planning Manager | Monthly | |
| Triple escalation meetings established to monitor progress of all three services in escalation against overarching objectives. | Director of Planning & Performance / Director of | 16 May 2024 | |

| | | | | |
|---|---|---|---|---|
| implementation. The service has committed to deliver a 52-week inpatient waiting list position by year end. The delivery of this is against a robust plan of increasing day case surgery and outsourcing 37 cases to Nuffield. Nuffield contract has concluded. Monitoring progress on a monthly basis and the >52 weeks' position is improving as set out in the trajectories. Escalation status being discussed at executive level within the JCC.<br>Following the assurances received from the Triple Escalation meeting on the 16th May 2024 where the Health Board stated that the 52-week target will be met by the end of June 2024 and with a robust plan to maintain this during 2024/25 in line with the 52-week waiting time agreed by the (previous JCC) Joint Committee in our Integrated Commissioning Plan. In the commissioning team meeting held in July 2024 we agreed to de-escalate the service from Level 3 to Level 0 in line with the previous WHSSC (now NWJCC) Escalation Framework. This escalation has been closed and removed from the women and children's risk register. | | Nursing and Quality | | |

**Issues/Risks:**

May 2024 – Escalation status being discussed at executive level within the JCC.
July 2024 – De-escalation of paediatric surgery agreed in July W&C commissioning team meeting from level 3 to level 0. Closed on risk register.

**Executive Director Lead: Nicola Johnson**
**Commissioning Lead:**
**Commissioning Team: Women and Children**

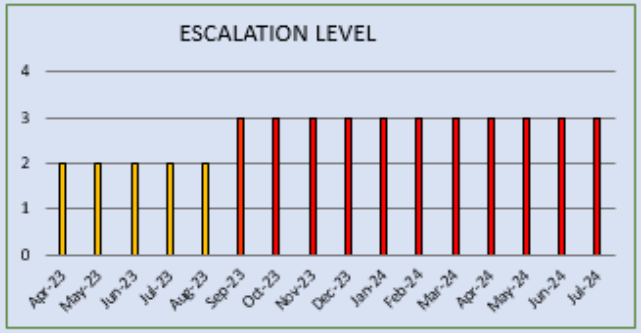
**Date of Escalation Meetings: 10/10/23, 19/12/23, 16/05/24**
**Date Last Reviewed by Quality & Patient Safety Committee: 24/06/2024**

# Service in Escalation: Paediatric Intensive Care

**Current Escalation Level 3**

| Escalation Trend Level | | |
|---|---|---|
| **Trend** | **Rationale** | **Current Trend Level** |
| ↓ | Escalation level lowered | ↔ July 2024 |
| ↔ | Escalation remains the same | |
| ↑ | Escalation level escalated | |

Escalation Trajectory:




**Escalation History:**

| Date | Escalation Level |
|---|---|
| **April 2023** | **2** |
| **September 2023 – Increased level from 2 to 3** | **3** |

**Rationale for Escalation Status :**

Following concerns regarding bed availability due to workforce shortages, refusal rates and pressure sore incidents the service was escalated to level 2. There was limited progress over a 3 month period against the objectives therefore the decision was taken to further escalate to level 3.

**Background Information:**

There is a risk that a Paediatric intensive care bed, in the Children's Hospital for Wales, will not be available when required due to constraints within the service. There is a consequence that Paediatric patients requiring intensive care will be cared for in, inappropriate areas where the necessary skills or equipment is not available or the patient being transferred out of Wales. The availability of a bed and staffing constraints have been brought to the attention of JCC through various routes including HiW and the daily SITREP.

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

Low – HB have submitted draft action plan, a final version has been requested. The escalation is predominantly linked to workforce and the lead in time for mitigations is medium term, in particular the recruitment of International

**Actions:**

| Action | NWJCC Lead | Action Due Date | Completion Date |
|---|---|---|---|
| Requested demand and capacity plan from HB to develop sustainable contracting framework for PIC and HD | Senior Planning Manager | 30 June 2024 | |
| Requested sight of the Pressure Sore report presented to the HB Quality and Patients Safety Committee. | Senior Planning Manager | - | 17th July 2024 |
| Escalation meeting to discuss detail and progress against action plan (monthly) | Senior Planning Manager | - | Next meeting to be arranged post re-set meeting |

| | | | | |
|---|---|---|---|---|
| Nurses. New streamliners have begun in the HB and although supernumerary at present and will not directly fill PIC vacancies it will support the wider workforce challenges across the Children's Hospital. JCC are still awaiting detailed demand and capacity in order to develop a sustainable contracting framework for Paediatric Intensive Care and High Dependency. Escalation status being discussed at executive level within the JCC.<br>The Paediatric and Neonatal Escalation Reset Meeting is to take place on the 18th September where an overview of the service will be discussed to gain an understanding from the health boards perspective of where they feel they are in the process, rather than discussing actions and objectives. The overarching objectives for the service are in the development phase and when agreed within the commissioning team they will be shared with the health board for comments and then presented at the reset meeting, to ensure they are agreed collaboratively. New executive leads for both organisations will be agreed as part of this process to ensure all are in agreement. | Re-set meeting to discuss and agree actions/objectives in collaboration with the health board | Senior Planning Manager | 18th September 2024 | |
| **Issues/Risks:** | | | | |

**Executive Director Lead: Nicola Johnson**
**Commissioning Lead:**
**Commissioning Team: Women and Children**

**Date of Escalation Meetings: 10/10/23, 19/12/23, 16/05/24**
**Date Last Reviewed by Quality & Patient Safety Committee: 24/06/2024**

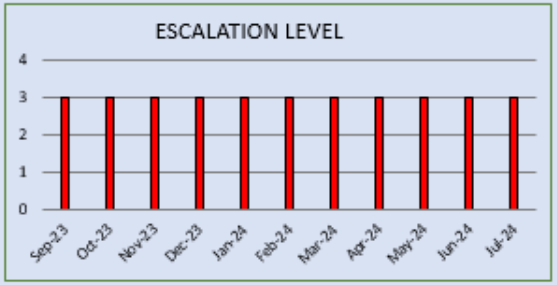
# Service in Escalation: Neonatal Intensive Care Unit

**Current Escalation Level 3**

**Escalation Trend Level**

| Trend | Rationale | Current Trend Level |
|---|---|---|
| ↓ | Escalation level lowered | ↔ July 2024 |
| ↔ | Escalation remains the same | |
| ↑ | Escalation level escalated | |

Escalation Trajectory:




**Escalation History:**

| Date | Escalation Level |
|---|---|
| September 2023 | 3 |

**Rationale for Escalation Status :**

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

**Background Information:**

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

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

Low / Medium – First draft of an action plan has been received however further detail has been requested. The mitigations required to support safe staffing levels and improvements against infection rates requires a robust workforce plan which has a medium to long term lead time for completion. Escalation status being discussed at executive level within the JCC.
The Paediatric and Neonatal Escalation Reset Meeting is to take place on the 18th September where an overview of the service will be discussed to gain an understanding from the health boards perspective of where they feel they are in the process, rather than discussing actions and objectives. The overarching objectives for the service are in the development phase and when agreed within

**Actions:**

| Action | NWJCC Lead | Action Due Date | Completion Date |
|---|---|---|---|
| Working with C&V UHB executive team to develop a plan to implement new baseline as all other HBs are in a position to go live | Director of Planning | 16th August 2024 | |
| Escalation meeting to discuss detail and progress against action plan (monthly) | Senior Planning Manager | - | Next meeting to be arranged post re-set meeting |
| Re-set meeting to discuss and agree actions/objectives in collaboration with the health board | Senior Planning Manager | 18th September 2024 | |

| | |
|---|---|
| the commissioning team they will be shared with the health board for comments and then presented at the reset meeting, to ensure they are agreed collaboratively. New executive leads for both organisations will be agreed as part of this process to ensure all are in agreement. | |

**Issues/Risks:**
March 24 - The service have not submitted an action plan despite being in escalation since Sept 23, they are unable to increase their cot numbers based on the new cot configuration and reported that they cannot safely deliver on the cots that they are currently commissioned, no progress made with exec to exec meeting, possibility that outsourcing from the service may be required, the service remains at escalation level 3 but if there are no improvements increasing the escalation will be considered.
May 24 - Through quarterly assurance meetings with all neonatal units in the South & West of Wales it has been reported that there has been increased pressure across the network for cot availability
July 24 – Temporary closure of Princess of Wales (PoW) Maternity and Neonatal unit for essential maintenance work from September to December. JCC currently commission 4 High Dependency (HD) cots within the PoW and Prince Charles Hospital (PCH) sites within CTMUHB. PCH are able to flex their cot base from 15 cots to 19 to provide HD capacity and Special Care based on clinical need. Consultation and communication with all stakeholders is underway alongside Maternity users who this will impact upon. Swansea Bay University Health Board and Cardiff and Vale have been asked to support the delivery of maternity care based on demand and demographics of the planned maternity users. Work is currently underway within CMTUHB to gain the appropriate data and demographics of the women currently booked to birth during this period. The Welsh Ambulance Service and the Neonatal network are working with CMTUHB to ensure safe delivery and appropriate preparation of pathways to enable safe transfer and clear guidance for the maternity users and clinical teams. Ongoing weekly project meetings have been put in place, NWJCC have been invited to attend these. Updates from these will be shared within the NWJCC to understand the impact this will have on current commissioned cots. An early warning notification has gone to Welsh Government.

**Executive Director Lead: Iolo Doull**
**Commissioning Lead:**

**Commissioning Team: Women and Children**

**Date of Escalation Meetings: 07/08/23, 19/09/23, 10/10/23, 07/12/23, 15/02/24, 14/03/24, 11/04/24, 08/05/24**
**Date Last Reviewed by Quality & Patient Safety Committee: 24/06/2024**

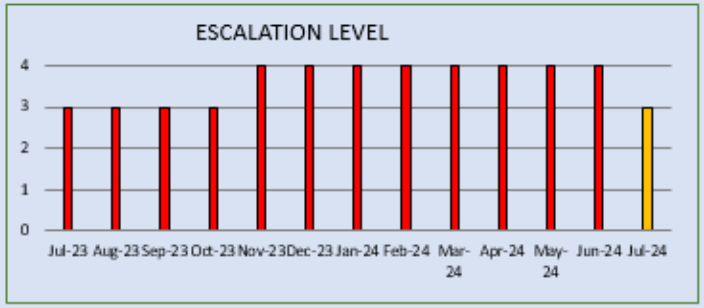
# Service in Escalation: Wales Fertility Institute

**Current Escalation Level 3**

**Escalation Trend Level**

| Trend | Rationale | Current Trend Level |
|---|---|---|
| ↓ | Escalation level lowered | ↓ July 2024 |
| ↔ | Escalation remains the same | |
| ↑ | Escalation level escalated | |

Escalation Trajectory:




**Escalation History:**

| Date | Escalation Level |
|---|---|
| July 2023 – JCC escalation | 3 |
| November 2023 – JCC escalation | 4 |
| July 2024 – JCC escalation | 3 |

**Rationale for Escalation Status :**
Concerns from a number of routes with regards to the service including the JCC contract monitoring data submission; adherence to JCC policies and HFEA performance outcomes below National average.

**Background Information:**
A number of concerns regarding the safety and quality of service had been raised through different routes, including HFEA re-inspection report January 2023, JCC quality and assurance meetings and WFI IPFR requests regarding Wales Fertility Institute leading to the escalation of the service.
There is a risk the Wales Fertility Institute (WFI) in Neath & Port Talbot Hospital is not providing a safe and effective service due to 7 major concerns identified during a relicensing inspection by HFEA in January 2023. There is a consequence that families who have treatment at this centre are not receiving the quality of care expected from the service and in turn impacting outcomes.

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

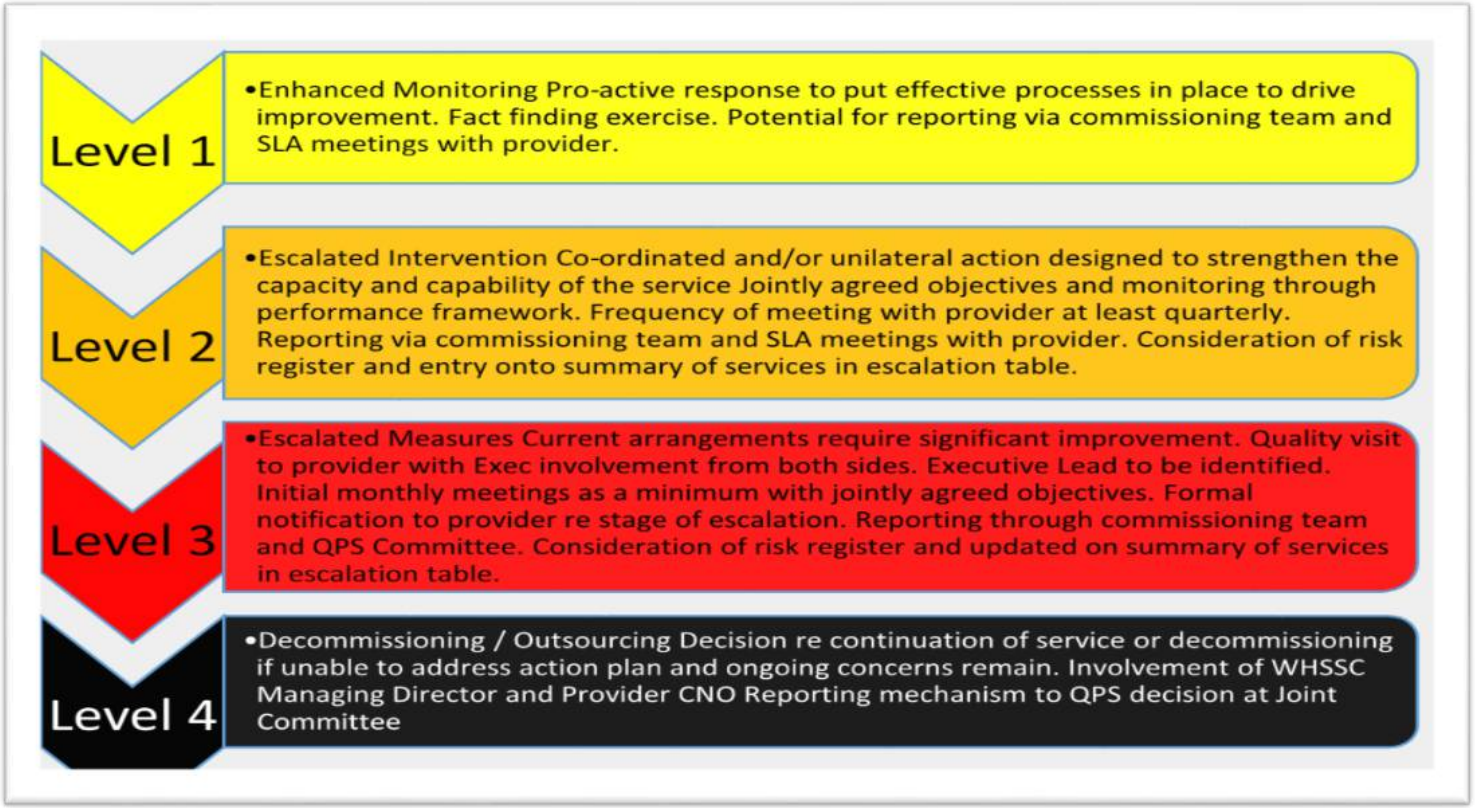
**Actions:**

| Action | Lead | Action Due Date | Completion Date |
|---|---|---|---|
| Monthly escalation meeting to review progress against Action Plan<br>Escalation meeting<br>19th September 2023<br>10th October 2023<br>7th December 2023<br>15th February 2024<br>14th March 2024<br>9th April 2024<br>8th May 2024 | Assistant Specialised Planner | Monthly | 13 June 2024 |

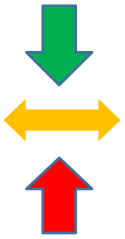
| | | | |
|---|---|---|---|
| Medium – The Health Board have instigated regular Gold Command and operational service improvement meeting with positive progress made in addressing HFEA concerns. The Action plan has been agreed and progress has been made with regards to JCC data submissions, however, the service need to ensure time is given both internally and to JCC to allow for review and consideration of documentation.<br>The service submitted an audit of notes to the HFEA at the end of December, they are awaiting feedback from this submission.<br>The service have identified a number of suitable staff members to prepare and take on the role of PR. The intention is for all suitable staff to sit the exam, to ensure sustainability of the service with a PR over Cardiff and a PR over Neath Port Talbot.<br>Cardiff inspection took place in March 2024, following the inspection being considered by the HFEA licensing panel who agreed to changing the licence to a storage only facility. The Neath Port Talbot Inspection took place in May 2024.<br>A review of the HB escalation process has been undertaken and reconfigured to form a WFI sustainability group which feeds into the WFI Assurance, Recovery and Accountability Board.<br>A new clinical service manager took up post at the start of May 2024.<br>The HB have agreed to undertake a comprehensive service review to include, performance, finance, complaints, incidents and risks. It was originally intended for the review to be completed by the end of January 2024 however this has been delayed with the review report due to be shared with the HB Board at the end of May 2024.<br>The Wales Fertility Institute (WFI) in Neath & Port Talbot Hospital risk score reduced from 25 to 15. A positive report from the HFEA highlights there are no critical or major concerns within the service and the fact that four staff members have taken and passed the exam to be the person responsible (PR), the team agreed that the service has met the required standard to be de-escalated from level 4 to level 3. There remains an issue with receiving contract monitoring information, which is in the process of being resolved. | | | |
| | | | |
| SMART Action plan reviewed and agreed | Service Manager | 19th September 2023 | 19th September 2023 |
| Regular Executive to executive meetings<br>16th November 2023<br>21st November 2023<br>1st December 2023<br>7th December 2023<br>21st December 2023 | Executive lead SBUHB/ Medical Director JCC | 16th November | Ongoing |
| **Issues/Risks:** There is a risk the Wales Fertility Institute (WFI) in Neath & Port Talbot Hospital is not providing a safe and effective service due to 7 major concerns identified during a relicensing inspection by HFEA in January 2023. There is a consequence that families who have treatment at this centre are not receiving the quality of care expected from the service and in turn impacting outcomes. | | | |

| | |
|---|---|
| **Level 1 ENHANCED MONITORING** | Any quality or performance concern will be reviewed by the Commissioning Team. Enhanced monitoring is a pro-active response to put effective processes in place to drive improvement. It is an initial fact finding exercise which should ideally be led by the provider and closely monitored and reviewed by the commissioning team. The enquiry will lead to one of the following possible outcomes:<br>• No further action is required routine monitoring will continue. The concern which raised the indication for inquiry will be logged and referred to during the routine monitoring process to ensure this has not developed any further.<br>• Continued intervention is required at level 1 and a review date agreed.<br>• Escalation to Level 2 if further intervention is required<br>There is the potential for reporting via commissioning team report to Quality Patient Safety Committee and through SLA meetings with provider |

| | |
|---|---|
| **Level 2 ESCALATED INTERVENTION** | Escalated intervention will be initiated if Level I Enhanced Monitoring identifies the need for further investigation/intervention. There should be a Co-ordinated and/or unilateral action designed to strengthen the capacity and capability of the service. At this stage there should be jointly agreed objectives between the provider and commissioner and monitored through the relevant commissioning team. Frequency of meeting with provider should be at least quarterly and possible interventions will include<br>• Provider performance meetings<br>• Triangulation of data with other quality indicators<br>• Advice from external advisors<br>• Monitoring of any action plans<br>A risk assessment should be undertaken, and logged on the Commissioning Team Risk Register. Where appropriate the risk will be included on the JCC Risk Management Framework. Reporting is via commissioning team report to Quality Patient Safety Committee report and SLA meetings with provider. The investigation will lead to on to the following possible outcomes:<br>• Action plan and monitoring are completed within the allocated timeframe, evidence of progress and assurance the concern has been addressed. De-escalation to Level 1 for ongoing monitoring.<br>• If the action plan is not adhered to and further concerns are raised by the Commissioning team or by the provider team or further concerns are identified it may be necessary to move to Level 3 Escalated Measures |
| **Level 3 ESCALATED MEASURES** | Where there is evidence that the Action Plan developed following Level 2 has failed to meet the required outcomes or a serious concern is identified a service will be placed in escalated Level 3. At this stage the quality of the service requires significant action/improvement and will require Executive input. In addition to routine reporting through QPS a formal paper will be considered by the JCC Corporate Directors Group (CDG) and an Executive Lead nominated. Formal notification will be sent to the provider re the Level of escalation and a request made for an Executive lead from the provider to be identified. An initial meeting will be set up as soon as possible dependant on the severity of the concern. Meetings should take place at least monthly thereafter or more frequently if determined necessary with jointly agreed objectives.<br>Provider representation will depend on the nature of the issue but the meetings should ideally comprise of the following personnel as a minimum:<br>• Chair (JCC Executive Lead)<br>• Associate Medical Director - Commissioning Team<br>• Senior Planning Lead – Commissioning Team<br>• JCC Head of Quality<br>• Executive Lead from provider Health Board/Trust<br>• Clinical representative from provider Health Board/Trust<br>• Management representative from provider Health Board/Trust An agreed agenda should be shared prior to the meeting with a request for evidence as necessary.<br>At the conclusion of the meeting a clear timeline for agreed actions will be identified for future monitoring and confirmed in writing if appropriate. Reporting will be through commissioning team to QPS Committee. Consideration of entry on the risk register and summary of services in escalation table for Chairs report to Joint Committee. Consideration to involve and have a discussion with Welsh Government may be considered appropriate at this stage. If there is ongoing concern relating patient care and safety with no clear progress then further escalation will be required to Level 4. On the other hand if progress is made through the escalation Level 3 evidence of this should be presented to CDG/QPS and a formal decision made with the provider to de-escalate to Level 2. |
| **Level 4**<br>**DECOMISSIONING/OUTSOURCING** | Where services have been unable to meet specific targets or demonstrate evidence of improvement a number of actions need to be considered at this stage. This stage will require notification and involvement of the JCC Managing Director and CEO from the provider organisation. Both Quality Patient Safety Committee and Joint Committee should be cited on the level of escalation.<br>The following areas will need to be considered and the most appropriate sanction applied to help resolve the issue:<br>1. De-commissioning of the service<br>2. Outsourcing from an alternative provider. This may be permanent or temporary<br>3. Contractual realignment to take into account the potential need to maintain and agree an alternative provider.<br>Involvement with Welsh Government and the Community Health Council is critical at this stage as often there are political drivers and levers that need to be considered and articulated as part of the decision making. Moving in and out of escalation and between Levels In addition to the Levels described above the process has introduced a traffic light guide within each level. The purpose of this is to help demonstrate the direction of travel within the level. It sets out an approach to help identify progress within the level and lays out the steps required for movement either upwards (escalation) or downwards (de-escalation) through the level.<br>At every stage a red, amber or green colour will be applied to the level to illustrate whether more or less intervention is in place. Red being a higher level of intervention moving down to green. It will also help determine the easing of the escalated measures described and inform movement within the stages of escalation. As the evidence and understanding of the risks from a provider and commissioner become evident decisions can be made to reduce the level of intervention or there may be a need to reintroduce intervention should conditions worsen and trigger the re-introduction of measures if progress is unacceptable. In this way organisations will be able to understand what is being asked of them, progress will be easily identified and it will help avoid any confusion. It will also help in the reporting to provide assurance that action is being taken to meet the agreed timescales. |




**SERVICES IN ESCALATION**



Level of escalation reducing / improving position

Level of escalation unchanged from previous report/month

| | | | | |
|---|---|---|---|---|
| **Teitl adroddiad:**<br><br>***Report title:*** | BCUHB Maternity Services – Learning for Improvement, Examples and Evidence | | | |
| **Adrodd i:**<br><br>***Report to:*** | Quality, Safety and Experience Sub-Committee of the Health Board | | | |
| **Dyddiad y Cyfarfod:**<br><br>***Date of Meeting:*** | Thursday, 24 October 2024 | | | |
| **Crynodeb Gweithredol:**<br><br>***Executive Summary:*** | The purpose of the report is to provide examples and evidence of the Maternity Service quality improvement work, both recent and ongoing, as a result of both local and national data, service user feedback and various reviews. | | | |
| **Argymhellion:**<br><br>***Recommendations:*** | The Committee is requested to note the content of the report and the completed, ongoing, and planned quality improvement activities | | | |
| **Arweinydd Gweithredol:**<br><br>***Executive Lead:*** | Angela Wood, Executive Director of Nursing and Midwifery | | | |
| **Awdur yr Adroddiad:**<br><br>***Report Author:*** | Emma Adamson, Consultant Midwife | | | |
| **Pwrpas yr adroddiad:**<br>***Purpose of report:*** | I'w Nodi<br>*For Noting*<br>☒ | I Benderfynu arno<br>*For Decision*<br>☐ | Am sicrwydd<br>*For Assurance*<br>☒ | |
| **Lefel sicrwydd:**<br><br>***Assurance level:*** | Arwyddocaol<br>*Significant*<br>☐<br>Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol<br><br>*High level of confidence/evidence in delivery of existing mechanisms/objectives* | Derbyniol<br>*Acceptable*<br>☒<br>Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol<br><br>*General confidence / evidence in delivery of existing mechanisms / objectives* | Rhannol<br>*Partial*<br>☐<br>Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol<br><br>*Some confidence / evidence in delivery of existing mechanisms / objectives* | Dim Sicrwydd<br>*No Assurance*<br>☐<br>Dim hyder/tystiolaeth o ran y ddarpariaeth<br><br>*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:**<br><br>***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:**<br><br>***Link to Strategic Objective(s):*** | Quality & Safety Framework – Welsh Government | | | |
| **Goblygiadau rheoleiddio a lleol:**<br><br>***Regulatory and legal implications:*** | | | | |
| **Yn unol â WP7 (sydd bellach yn cynnwys WP68), a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal?** | ~~Do~~/Naddo ~~Y~~/*N* | | | |

| | |
|---|---|
| ***In accordance with WP7 (which now incorporates WP68) has an EqIA been identified as necessary and undertaken ?*** | |
| **Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR)**<br><br>***Details of risks associated with the subject and scope of this paper, including new risks( cross reference to the BAF and CRR)*** | |
| **Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith***<br><br>***Financial implications as a result of implementing the recommendations*** | Several of the planned quality improvements have associated financial implications, specifically MatNeo SSP, (awaiting confirmation from Welsh Government regarding funding sources/streams); Induction of Labour Improvements may have a financial implications, however work is still in the scoping phase |
| **Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith**<br><br>***Workforce implications as a result of implementing the recommendations*** | Several of the priorities for action have associated workforce implications, specifically MatNeo SSP, (awaiting confirmation from Welsh Government regarding funding sources/streams) |
| **Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori**<br><br>***Feedback, response, and follow up summary following consultation*** | |
| **Cysylltiadau â risgiau BAF:**<br>(neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)<br><br>***Links to BAF risks:***<br>*(or links to the Corporate Risk Register)* | |
| **Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)**<br><br>***Reason for submission of report to confidential board (where relevant)*** | Amherthnasol<br><br>Not applicable |
| ***Next Steps:***<br>***Continuation of quality improvement activities*** | |
| **Rhestr o Atodiadau:**<br>***List of Appendices:***<br>Appendix 1: Massive Obstetric Haemorrhage Review: Combined Improvement Plan<br>Appendix 2: Saving Babies Lives Care Bundle 3 BCUHB Action Tracker<br>Appendix 3: Maternity and Neonatal Safety Support Programme (MatNeo SSP) Discovery Phase Report<br>Appendix 4: A Thematic Review of Stillbirths BCUHB 2023<br>Appendix 5: BCUHB Homebirth Service Provision Review<br>Appendix 6: Briefing All-Wales National Maternity & Neonatal Experience Questionnaires | |

*BCUHB Maternity Services –*

*Learning for Improvement: Examples and Evidence*

*To be presented at*

*Quality, Safety and Experience Sub-Committee*

*24th October 2024*

*Prepared by E. Adamson, Consultant Midwife*

## Contents

## 1. Introduction

BCUHB Maternity Services aim to be safe, effective, and responsive at all times. For most women and families who access maternity service in North Wales, their experience is positive, culminating in a healthy outcome for mother and baby. However, there are occasions when the outcome is less positive, resulting in both short and long term physical and psychological harm to mothers, babies, and their families.

Quality improvement aims to reduce unwarranted variation and improve clinical outcomes and experience, via the collection of both quantitative and qualitative data to evaluate care process and outcomes, in order to identify good practice and areas for improvement.

All staff working at all levels are encouraged to engage in quality improvement and there are many examples of excellent small scale, local projects being implemented across the service, however several key national drivers and reports, along with local intelligence, including service user feedback, are directing, and influencing more widespread, strategic quality improvement activities within BCUHB Maternity Services.

They are as follows;

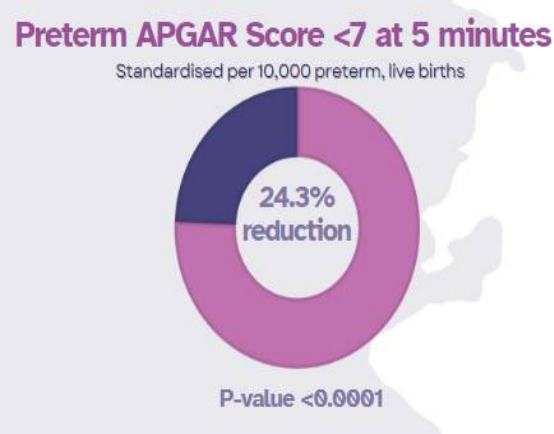
## 2. PRactical Obstetric Multi-Professional Training (PROMPT)

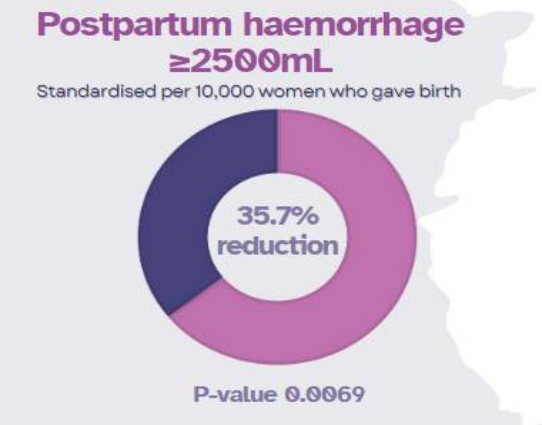
*Background*

PROMPT (PRactical Obstetric Multi-Professional Training) was developed by the PROMPT Maternity Foundation and is an evidence based multi-professional training package designed to prepare all staff who are involved in the care of women and babies to recognise and manage obstetric emergencies, using a structured approach and algorithms. It is associated with direct improvements in clinical outcomes through improvement in knowledge, clinical skills, and human factors. It has been associated with a 50% reduction in term babies born with a 5 min Apgar <7, 50% reduction in neonatal hypoxic-ischaemic encephalopathy (HIE) and a 100% reduction in permanent brachial plexus injuries after shoulder dystocia.

The training package was launched in BCUHB and across Wales in 2018. Local training is delivered to both acute and community maternity teams, to simulate real-life scenarios in care settings and within the team staff are most likely to operate in.

National data was collected pre- and post this intervention, and evaluated by PROMPT Wales. Reduced rates of APGAR scores less than 7 at 5 minutes and PPH of 2500mls and over were noted nationally.




In addition, there was improvement in several staff attitude and cultural elements and scores, including job satisfaction, team working, perception of management, safety climate, stress recognition and working conditions.

## 3. Obs Cymru

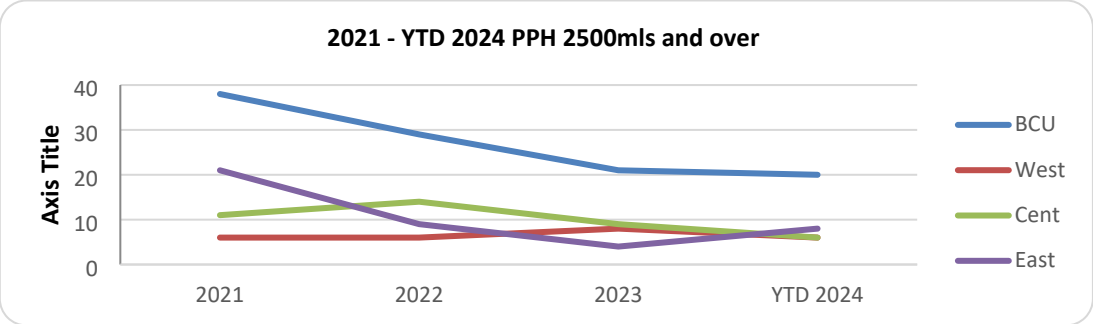
*Background*

OBS Cymru was launched in 2016 and was introduced as a three-year national quality improvement project aimed to standardise care and reduce both morbidity and mortality rates associated with post-partum haemorrhage (PPH) across all Welsh maternity settings. The project was led by a multiprofessional national team who supported local champion teams to effect changes at the twelve Consultant Led Maternity Units across Wales

OBS Cymru standardised PPH care across Wales by embedding the 4 pillars of PPH management.

- Risk assessment
- Early identification by means of measuring blood loss
- Multidisciplinary team working
- ROTEM point of care testing

The work of the project is now embedded into everyday practice and has led to positive changes in the care of mothers experiencing PPH.




Locally all PPHs of more than 1500mls are reportable on Datix and are subject to a rapid review by the multi-disciplinary team, including the Risk and Governance team, with immediate actions and learning appropriately cascaded to all staff. Each case is audited against the Obs Cymru Protocol. Monthly data is also reported via the Maternity Dashboard at unit accountability meetings, the Women's Quality, Safety and Experience meetings, Women's Service Board and a formal Massive Obstetric Haemorrhage (MOH) Review is undertaken annually.

In 2022, it was identified that there was a local increase in the rates of PPH above 2500mls in Ysbyty Glan Clwyd and following local review processes, an external review of 11 cases was arranged. The findings of this review informed the development of a Major Obstetric Haemorrhage Improvement Plan at Ysbyty Glan Clwyd. All the actions contained within the improvement plan have now been completed since August 2024. These include actions and learning for individual staff members and for the service as a whole. The addition of specific elements to PROMPT training locally, including the use of bi-manual compression and Bakri balloon in the management of PPH and training in Impacted Foetal Head intervention technique have also been implemented.

Following the introduction and a period of embedding both Obs Cymru (2016) and PROMPT (2019), there has been an overall reduction in rates of PPH of 2500mls and over. The recently published National review of maternity services in England 2022 to 2024 (Care Quality Commission, 2024) identified a theme of PPH being normalised in some services inspected, particularly when evaluated as well managed. This can mean missed opportunities for learning, potential lack of follow-up care or monitoring and a lack of acknowledgement of the potential psychological harm. The continuance of the above local monitoring and governance process ensures that there is learning from individual cases

and any themes and trends are identified and acted upon in a timely manner. Moving forward this will be supported by the introduction of the national Maternity Beacon dashboard, which includes PPH 2500mls and over as a quality outcome indicator that will be monitored at quarterly maternity focused IQPD meetings with the NHS Executive Team.

## 4. Saving Babies Lives Care Bundle Version 3

*Background*

Saving Babies' Lives Care Bundle (SBLCB) Version 1 was published in 2016 in response to the announcement by the Secretary of State for Health that a national safety ambition was to halve the rates of stillbirths, neonatal and maternal deaths, and intrapartum brain injuries by 2030, with a 20% reduction by 2020.

An independent evaluation of Version 1 showed a decrease in stillbirths in participating Trusts, concluding that whilst the bundle was one of many simultaneous interventions, it was highly likely that it had contributed to the reduction. The evaluation also informed the development of care bundle Version 2, which when launched in 2019 aimed to continue to reduce the stillbirth rate whilst also minimising unnecessary intervention. The care bundle has been included in the NHS England Long Term Plan and the CNST Incentive Scheme, with every English maternity care provided expected to have implemented the bundle.

In 2023 Version 3 was published in response to Office for National Statistics (ONS) and Mothers and Babies Reducing Risk through Audits and Confidential Enquiries (MBRRACE) data demonstrating stagnating rates of stillbirth and neonatal death and the need to continue to reduce preventable mortality in maternity services.

Building on the previous version, bundle 3 includes a refresh of all elements plus an additional element on the management of pre-existing diabetes in pregnancy.

BCUHB Maternity Services first implemented SBLCBv2 in 2020, as an improvement action from the learning following a local stillbirth thematic review in 2019. Version 3 was introduced locally in 2023. Several of the elements and actions contained within the bundle align with other national strategies being progressed locally and echo findings and recommendations of the annual Thematic Review of Stillbirths in Betsi Cadwaladr University Health Board in successive years.

### *The Care Bundle*

There are a total of **71 recommended interventions** and **29 recommended continuous learning actions**, across **six elements**

**Element 1**: *reducing smoking in pregnancy by identifying smokers with the assistance of carbon monoxide (CO) testing and ensuring in-house treatment from a trained tobacco dependence advisor is offered to all pregnant women who smoke, using an opt-out referral process*

*Example improvement*

- *BCUHB Help Me Quit for Baby Service is now well established, with support workers available across all community midwifery teams. In addition to the nicotine replacement therapy and psychological support available, the service was involved in the delivery of a pilot incentivisation scheme to reduce smoking in pregnancy. Recruitment to the scheme has ended and evaluation of its impact expected in quarter three.*

**Element 2:** *Risk assessment and management of babies at risk of or with fetal growth restriction*

*Example improvements*

- *Implementation of GROW 2.0 system in June 2024; the digitalised system will help to reduce errors related to measuring fundal height and plotting estimated fetal weight and support timely identification and referral of women whose babies may be at risk or with fetal growth restriction*
- *Development of Aspirin PGD to enable timely provision of low-dose aspirin to women at risk of hypertensive disorders in pregnancy*

**Element 3**: R*aising awareness of reduced fetal movement*

*Example improvement*

- Implementation of the All Wales Intrapartum Fetal Surveillance Standards, including full day training workshops for all Clincians from January 2024

**Element 4**: *Effective fetal monitoring during labour*

*Example improvement*

- As part of the new PMRT and SI process, where the presentation and/or management of reduced fetal movement is felt to have been a contributory factor to an incident, this is examined as part of the overall outcomes in relation to the interventions, trends, and themes

**Element 5**: *Reducing the number of preterm births and optimising care when a preterm birth cannot be prevented*

*Example improvement*

- *Implementation of the PERIPrem Care Bundle, supported by the local quad team (this work also supports recommendations made by Mat Neo SSP)*

**Element 6**: Management of pre-existing diabetes in pregnancy (new element)

*Example improvement*

- *The Maternity service is currently in the process of identify maternity service users diagnosed with diabetes/gestation diabetes, to provide feedback about their experience, as part of the wider scoping exercise to improve current service provision within antenatal clinic setting (this work also supports recommendations made by Mat Neo SSP*

The annual Thematic Review of Stillbirths in Betsi Cadwaladr University Health Board 2024 (Appendix 4) demonstrates on average that stillbirth rates in BCUHB have been lower than the national rate and lower than the combined England and Wales stillbirth rate. It highlights that there was an improvement in the stillbirth rate in BCUHB in 2020, 2021 with a slight increase in 2022. The data for 2023 shows that the stillbirth rate for this year decreased to 2.25, a reduction of 1.15 per 1000 live births. However, BCUHB Maternity services will continue to progress actions identified by the thematic review and the recommendations made within SBLCBv3, to further reduce the stillbirth rate and to address the inequalities in stillbirth rates.

| The current service compliance with SBLCBv3 June 2024 | | | |
|---|---|---|---|
| | RED | AMBER | GREEN |
| **INTERVENTIONS** | 1 | 19 | 51 |
| **CONTINUOUS LEARNING** | 2 | 7 | 20 |
| **ONGOING / PLANNED ACTIONS** | 1. Ongoing discussions regarding provision of Uterine Artery Doppler assessment<br>2. Implementation of GROW 2.0<br>3. Identify service users with diabetes via community engagement to join focus groups | 1. CO monitoring compliance monitored via monthly audit; targeting continued areas/individuals of low compliance & consider monitoring & follow up of inpatients<br>2. Implementation & embedding of GROW 2.0 to support accurate monitoring of FGR in ethnic minority groups<br>3. Business case submitted for digital BP monitors<br>4. PERIPrem Quad Teams continuing local improvement work | |

## 5. Maternity and Neonatal Safety Support Programme (MatNeo SSP)

*Background*

The introduction of the National MatNeo Safety Support Programme was instigated by Welsh Government (WG) 2022, who commissioned Improvement Cymru to undertake a Discovery Phase Report in response to Action 6 of Welsh Governments Quality & Safety Framework. The aim of leading an All-Wales improvement approach was to maximizing the opportunity for learning from independent reviews of maternity & neonatal services to improve outcomes for women, babies & their families in Wales.

During the Discovery Phase, the team considered:

- Care pathways for women throughout pregnancy and neonatal care journey, where this was needed
- How these care pathways worked within and between maternity and neonatal services
- Evidence of good and innovative practice which could be shared
- Detailed views of work culture, leadership and learning alongside workforce and clinical outcome measures.
- Areas for improvement, both locally and nationally

A total of 134 priorities for action were identified in the Discovery Phase Report across 16 focus areas and health boards were requested to perform a baseline assessment of service provision against these priorities.

Overall local maternity service position against the 124 identified Priorities for Action identified within Discovery Phase Report are divided into short, medium, and long term

| Discovery Phase Report Priorities for Action | Green | Amber | Red |
|---|---|---|---|
| **Short Term** | 18 | 5 | 8 |
| **Medium Term** | 24 | 7 | 4 |
| **Long Term** | 1 | 3 | 0 |

The remaining priorities for action identified in the Discovery Phase Report as requiring actions are to be led by agencies external to health boards, such as NHS Executive, WHSSC, WAST, or are neonatal specific actions

Following this the National Mat Neo SSP team identified three priorities for health boards to progress during phase one of the programme:

1) **Maternal Care Pathway**
2) **Recognition and escalation of the deteriorating patient**
3) **Perinatal optimisation and management of the neonate (PERIPrem Passport)**

| PHASE ONE PRIORITIES | LOCAL ACTIONS | PROGRESS TO DATE | NEXT STEPS | RAG RATING |
|---|---|---|---|---|
| **1) Maternal Care Pathway** | Implement 'Team of the Shift' pilot project in YG | Team of the Shift implemented in YG to support appropriate review & care via improved communication & team working | Evaluation of pilot; implementation in YGC / YM | |
| **2) Recognition and escalation of the deteriorating patient** (Supports findings of local ATAIN case reviews which identified several instances where inappropriate escalation contributed to poor outcomes) | Implement NEWTT2 tool across all maternity units<br><br>BCUHB to provide representation at All Wales MEOWS Standardisation working group | Training package developed by local MatNeo SSP Neonatal Champion & plans agreed to implement however concerns raised at national level, nil further progress<br><br>Members of MDT have supported national work on standardisation of MEOWS tool Team of the Shift supports effective escalation of the deteriorating woman | **Await further national steer on NEWTT2 & MEOWS introduction**<br><br>Continue to collect local term admission data/review cases to identify learning/ actions (weekly review/annual report to Women's Board) | |
| **3) Perinatal optimisation and management of the neonate** (Aligns with PERIPrem Cymru) | Establish PERIPrem Quad Team<br><br>Establish baseline data for all PERIPrem elements<br><br>Early breast milk pilot in YGC<br>Optimal cord management pilot YG | Monthly 'lunch & learn' sessions established to update staff of PERIPrem Care Bundle elements<br><br>Significant improvements noted in compliance with:<br>• Optimal Cord Management<br>• Use of caffeine<br>• Early breast milk<br>• Probiotics<br>• Number of babies fully optimised | Continue to monitor compliance with PERIPrem care bundle | |

## 6. Equality, Diversity, and Inclusion

An increased focus on ensuring that services meet the needs of women and families from diverse backgrounds and/or with protected characteristics, has largely come from the work led by MBRRACE-UK collaboration, co-led by the National Perinatal Epidemiology Unit. The *Saving Lives, Improving Mothers' Care* report on women who died during, or up to a year after, pregnancy between 2019 and 2021 was published in October 2023.

The full report, which is considered a gold standard for identifying improvements needed for maternity services, examines in detail the care received by the women who died showed that persistent disparities in maternal health remains. In 2019 – 2021, women from Black ethnic backgrounds were four times more likely to die during or up to six weeks after pregnancy when compared to White women. There was an almost two-fold difference in the rate of deaths amongst women from Asian ethnic backgrounds compared to White women

The data also showed that 12% of the women who died during or up to a year after pregnancy were at severe and multiple disadvantages, and women living in the most deprived areas of the UK were more than twice as likely to die when compared to women living in the least deprived areas. Deaths from mental health-related causes as a whole accounted for nearly 40% of deaths occurring between six weeks and a year after the end of pregnancy with maternal suicide remaining the leading cause of direct deaths in this period.

The Thematic Review of Stillbirths in Betsi Cadwaladr University Health Board in 2023 (published June 2024), revealed that of the 13 stillbirth cases reviewed, two of the babies were born to mothers of Black ethnicity. Whilst the national findings continue to demonstrate that women from ethnic minorities experience inequalities in care and the local PMRT reviews identified areas for improvement, there were no care issues which impacted on the outcome. However, the service will continue to review adverse outcomes in the context of protected characteristics and ensure continuous improvement to reduce inequalities in care.

BCUHB Maternity Services has commenced work to implement Cultural Competency Training for all staff working in the service and to date this has been delivered to staff working in Community Midwifery Services. This training aims to improve staff confidence when caring for and receiving the feedback of women and families from culturally diverse backgrounds, which will ultimately improve outcomes for women and babies.

There are also planned improvements to service provision for the Gypsy, Roma, and Traveller populations of North Wales, informed by the Health Needs Assessment report produced by the BCUHB Public Health Team. The service is currently in the process of identifying opportunities for engagement with this population.

## 7. Homebirth Service Provision

Between July 2022 and an active offer of the BCUHB homebirth service was suspended due to WAST pressures and potential impact on obstetric emergency transfers from community into the acute maternity setting. During this period women who chose to give birth at home, despite the Health Board's position, were supported to do so however the suspension did result in a significant impact on the choices afforded to women regarding their place of birth, which is in direct opposition to national guidelines and recommendations relating to choice of place of birth. A full review of the homebirth service, including local and national WAST position and service user feedback, provided assurance with regards to transfer request responses but did expose several learning and training needs and areas for improvement. Subsequently a community midwifery support plan was developed and completed to ensure safe and effective reimplementation of the homebirth service, which is monitored to support continual improvement.

Since the reimplementation of the service, the number of women supported to plan and give birth at home has risen across all areas of North Wales and service user feedback has been hugely positive. A recent example of this is Milly's patient story as noted on the link below.

Patient Story - My Beautiful Home Birth - ENGLISH SUBTITLES.mov

### 8. Induction of Labour Improvement Group

In response to service user feedback received via complaints, the Birth Reflections Service, as highlighted by Maternity and Neonatal Voices Partnership (MNVP) and learning from incidents, establishment of an Induction of Labour (IOL) working group was approved by the Women's Service Board to carry out a full scoping exercise to identify and carry out an improvement projects on priority areas.

To date the group, supported by BCUHB's Transformation Team, has completed a mapping exercise of the entire IOL process on each Maternity Unit in North Wales and across community areas and is currently in the process of targeted engagement to obtain feedback via questionnaires and semi-structured interviews, supported by the Patient Experience Team. It is anticipated that several workstreams will be established to tackle the most poignant issues related to IOL to improve clinical outcomes and patient experience.

An application has also been submitted to participate in the 'Green Maternity Challenge' hosted by the Centre for Sustainable Healthcare. If successful, the working group will receive specialist quality improvement support to identify and progress IOL improvement projects which not only improves outcome and experience, but can also have a positive impact on the environment whilst supporting the sustainability agenda.

## 9. Service User and Staff Engagement

*Service User Engagement*

BCUHB Maternity Services have a well-established service user forum. Originally formed in the 1990s as the Maternity Services Liaison Committee, which then developed into Maternity Voices Partnership which was established to bring together the voices of women and their partners with recent experience of maternity services, alongside those with an interest in improving local services, including midwives, obstetricians and other services who support women and their families during the perinatal period. This forum supports the development and provision of quality services which meet the need of the local community, by ensuring that service users are at the centre of everything the service offers.

Following recommendations made by the Maternity and Neonatal Safety Support Programme, the Partnership has been extended to Neonatal Services (MNVP), to ensure that the experiences of families whose babies have been cared for on neonatal units are captured and used to inform and improve services.

This partnership meets formally on a quarterly basis. However, the members are regularly consulted on improvement activities taking place across the services, including all of the detailed programmes of work noted in this report.

BCUHB Women's Service also receives, monitors, and actions feedback via several other routes including Civica, PALS, the Birth Reflection Service, and the formal complaints procedure.

Whilst we acknowledge the considerable amount of good work already undertaken to progress the engagement agenda, the service recognises the importance of ensuring that that views representative of the population of North Wales are proactively sought, listened to, and used to inform improvement activities. In light of this a community engagement approach is currently being implemented which involves the Consultant Midwife attending a variety of local parental social groups across North Wales, to have discussions and obtain feedback on experiences of BCUHB Maternity Services and to promote the work and value of the MNVP.

These sessions, which began in August 2024, will continue as a rolling programme. The aim is to ensure that women and families from a range of backgrounds have the opportunity to be involved in driving improvements in services, to meet the needs of the local population, ensuring that they feel their individual and collective experiences and opinions are valued. This also supports the equality, diversity, and inclusion agenda.

In addition, the Consultant Midwife has been involved in supporting the development of the 'All Wales Perinatal Engagement Framework,' which is currently out for full consultation. The framework, which also address the engagement and communication needs of women and families from culturally diverse background or with other protected characteristics will inform a subsequent engagement implementation plan for use by health boards as per local demographic.

In addition, the NHS Executive Quality and Safety Team have commenced development of a National Maternity & Neonatal quality monitoring and assurance dashboard, which is integrated within its existing Beacon dashboard, one element of which is 'National People's Experience Data,' which will be gathered via a series of All-Wales National Maternity & Neonatal Experience Questionnaires. Nationally agreed experience metrics will be collated within the Civica system and integrated with the Beacon dashboard which will display high level experience data, allowing comparison between health boards, which will support local

oversight and assurance monitoring, in addition to supporting local service improvement and development.

*Staff Engagement*

BCUHB Women's Service provide all staff with a range of opportunities for engagement with the senior leadership team (SLT) in order to provide valuable feedback and quality improvement suggestions. These include; group supervision facilitated by a team of Clinical Supervisors, via numerous meetings, including local Antenatal and Labour Ward Forums, Women's Service's People and Culture, Quality, Safety and Experience and Service Board Meetings, via individual PADRs and the BCUHB Staff Survey.

In addition, following issues escalated to SLT in December 2023 by the midwifery team in Ysbyty Gwynedd, the Women's Service Head of Midwifery and Gynaecology Nursing and Workforce and Organisational Development Head of People Operations have recently facilitated several service-wide engagement workshops. The objectives of these workshops included promotion of engagement from all staff groups, by providing a safe and reflective space in which they could provide feedback on their experience of working within BCUHB Women's Service. This approach was to promote solution-focused discussion when identifying areas for improvement and using feedback obtained informally via the workshops to identify priorities to inform the Women's Service long-term People and Culture Plan, which also supports the Health Board agenda.

Engagement in these informal workshops exceeded expectations and good representation was noted from all staff groups. A Thematic review of the feedback was carried out following this exercise and categorised into four broad themes – organisation of work, supportive relationships, environment and culture and learning, training, and development.

The findings were discussed at the Women's Service Senior Leadership Team Meeting in September 2024 and next steps, which align with the BCUHB Three Year Plan 2024 -2027, agreed, which include facilitation of a community maternity service workshop and using an appreciative inquiry approach to expand on feedback received to date.

## Appendices

**Please note - A number of the reports included for information are considerably large and have therefore been included as a link**

### *Appendix 1: Massive Obstetric Haemorrhage Review: Combined Improvement Plan*

**Massive Obstetric Haemorrhage Review: Combined Improvement Plan – Updated 29/08/2024**

**Two External Reviews of Eleven Cases of Massive Obstetric Haemorrhages at YGC**

| Ref. | Issue identified from First Review in 2022 | Action | Lead for the action | Date of completion | Assurance |
|---|---|---|---|---|---|
| a. | Consideration needs to be given to the issue relating to delay in administering blood products require review by Anaesthetics | External review reports to be shared with senior anaesthetists for review and provision of opinion on findings. | FG | 31/08/2022 **Completed** | All MOH incidents are subject to a review and audited against the Obs Cymru Protocol. As part of the process learning is added as actions and cascaded across all departments.<br><br>Learning is taken forward with individual staff by the relevant senior member and shared more widely by the Clinical Supervisor of Midwives via the Maternity Hub. |
| | | External Review report to be shared with teams who attended the review meeting for the first review by Dr Farkas and Dr Norman. | CL | 31/08/2023 **Completed** | |

| Ref. | Issue identified from First Review in 2022 | Action | Lead for the action | Date of completion | Assurance |
|---|---|---|---|---|---|
| b. | Consideration needs to be given to the | Cases identified by external reviewer to be | CL | 31/08/2022 **Completed** | The 2 breach of duty cases were highlighted to the |

| | | | | | |
|---|---|---|---|---|---|
| | Breach of Duty indicated for delay in providing / administering blood products and the delay in going to theatre | flagged with Legal and Risk. | | | Legal and Risk team at the time of the reports being received and reviewed within BCUHB Women's Service.<br><br>A meeting has been held individually with both Women to feedback from the External Independent Reviews and discuss the findings. |
| c. | Need to share learning | Cases to be used as scenario training for staff | JR | 01/01/2023 **Completed** | Cases were presented at the Women's Service Board – 27th October 2023<br>North Wales Women's Service Audit Day – 8th December 2023<br>Health Board Public Meeting in Q4 2023/24 |
| | | Develop ½ day Symposium across the three unit. Need support to release staff to attend Support needed from MD to cancel activity | CL/NS | 01/01/2023 **Completed** | |

| Ref. | Issue identified from First Review in 2022 | Action | Lead for the action | Date of completion | Assurance |
|---|---|---|---|---|---|
| d. | A review of the case of ET needs to be completed to review where a delay in undertaking a Caesarean Section has been highlighted | Case to be reviewed with specific focus on C/S timings. | NS | 31/08/2023 **Completed** | The Timing of Caesarean Sections are considered as part of any review process. Any delay in decision to sections is reported on Datix. |

| | | | | | |
|---|---|---|---|---|---|
| e. | The Midwife involved in the case of NW need to undertake a reflection as it appears for the review that they M/W left the room (it is unclear from the records if anyone else in room) | LG to review case with M/W and clarify the issues raised. | LG | 31/08/2022 **Completed** | The Matron has confirmed that the Midwife involved has completed a reflection and discussion. |
| f. | A review of the case notes for case NJ and VH needs to be completed as it was identified that there may be an issue of missing notes. | Case notes to be reviewed to identify if concern valid. | LG | 15/09/2022 **Completed** | The Case notes were reviewed by the Matron and no concerns were identified.<br><br>Staff receive regular updates on the requirements of record keeping and as part of a Risk and Governance presentation on PROMPT study days in 2023-24 |

| Ref. | Issue identified from First Review in 2022 | Action | Lead for the action | Date of completion | Assurance |
|---|---|---|---|---|---|
| g. | The case of VH needs to be reviewed with Specialist Registrar on actions taken in relation to the issue raised as to need to extend the | Case to be reviewed with SpR on actions taken | NS | 31/09/2022 **Completed** | The Clinical Lead for Labour Ward has confirmed that the SpR involved has completed a reflection and discussion on the case. |

| | | | | | |
|---|---|---|---|---|---|
| | incision into uterus (33wk, head no engaged) | | | | |
| h. | There is a need to review the concern that has been identified in the review as to the length of time taken from the decision for a C/S to getting to theatre. | Nil Sengupta to share emails with FG | NS | 31/08/2022 **Completed** | The Timing of Caesarean Sections are considered as part of any review process.<br><br>Any delay in decision in relation to timing of sections is reported on Datix. |
| | | Check on current process to be made with Labour Ward coordinators | LG | 31/08/2022 **Completed** | |

| Ref. | Issue identified from First Review in 2022 | Action | Lead for the action | Date of completion | Assurance |
|---|---|---|---|---|---|
| i. | Consideration needs to be given to gaining agreement on the techniques to be used and specific training required when dealing with an impacted fetal head to ensure safe delivery. | Impacted Foetal Head intervention technique to be added to PROMPT training. | National PROMPT team | From September 2022 **Completed** | Impacted Fetal Head has been included on the PROMPT training since September 2023.<br><br>Compliance as of 23-08-2024 is<br>MW – 92%<br>CMW – 94%<br>Obs Drs – 62%<br>Anaesths – 78%<br><br>The compliance has been impacted upon by the Drs Rotation.<br><br>On commencement |

| | | | | | |
|---|---|---|---|---|---|
| | | | | | in post Dr's current compliance status is checked and recorded and their training is prioritised as needed. |

| Ref. | Issue identified from First Review in 2022 | Action | Lead for the action | Date of completion | Assurance |
|---|---|---|---|---|---|
| j. | Share information of incidents and findings | Overarching report to be developed and produced for Sept PSQ with external and internal reviews being included (1st review report | CL | 15/09/2022 **Completed** | The Quality Governance Team commenced presenting on the PROMPT training days in September 2023. The session relates to risks and leaning from specific local case reviews, which includes MOHs and IFH's. |
| | | To be added to Newsletter | CL | 15/09/2022 **Completed** | |
| k. | Challenges / clarification identified from the first external review report | Challenges/Clarifications in the first review to be shared with external reviewer. (Use of latest MOH All Wales Guidance) | FG | 31/08/2022 **Completed** | The local concerns were shared with the External Independent Reviewer who provided feedback, which is included in the overarching combined report |

| Ref. | Issue identified from Second Review in 2023 | Action | Lead for the action | Date of completion | Assurance |
|---|---|---|---|---|---|
| a. | Consideration and education of staff regarding appropriateness of IOL for 'recurrent Reduced Fetal Movements' in presence of all objective, normal fetal and maternal parameters as shown by close monitoring, at gestations earlier than 39/40. | Review of current IOL guidelines to be completed in view of recommendation and any changes identified to be undertaken as per the policy on Policy. | RFM WCD Authors | 31/10/2023 **Completed** 06/12/2023 | Induction of Labour guidelines have been reviewed and updated and approved through the Women's Governance Procedures.<br><br>The RFM policy is being reviewed with the Fetal Medicine Lead and in line with the All-Wales Review of the policy.<br><br>Where Reduced Fetal Movement are identified in a PMRT or SI Review the care provided is audited/assessed against the local and national policies and procedures.<br><br>Any issues are discussed with individual staff involved.<br><br>RFM is part of the Saving Babies Lives Bundle 3.0 which is reviewed monthly and a |

| | | | | | |
|---|---|---|---|---|---|
| | | | | | quarterly update provided the Women's Service Board on progress. |
| **Ref.** | **Issue identified from Second Review in 2023** | **Action** | **Lead for the action** | **Date of completion** | **Assurance** |
| b. | Consideration of further training in management of Impacted Fetal Head at a CS, in terms of anticipation, preparation, calling for help and use of Tocolysis such as Terbutaline 250ugm SC. Re-education in RCOG GTG No 73, Management of Impacted Fetal Head at Caesarean Birth, June 2023 Scientific Impact paper. | A review of the current guidance and for the management of an impacted fetal head to be completed. | Labour Ward Leads | 31/10/2023 **Completed** 30/09/2023 . | PROMPT Algorithms are used on all three sites.<br><br>PROMPT folders containing laminated Algorithms are in all delivery rooms and Obstetric Theatres across all DGH sites |
| | | Case to be reviewed with SpR on actions taken | NS | **Completed** 31/08/2023 | The Clinical Lead for Labour Ward has confirmed that the Dr involved has completed a reflection and discussion of the case.<br>A copy of the Terbutaline PGD was requested from Cardiff and Vale University Health Board on the 19/0//2024 and received on 27th August 2024. The Director of Midwifery and Women's Services has |

| | | | | | |
|---|---|---|---|---|---|
| | | | | | requested that the PGDs and their potential introduction be considered at the next North Wales Intrapartum Forum. |
| | | Any new or additional training identified for staff in relation to the management of the impacted fetal head is to be developed and implemented. | Labour Ward Leads and College Tutors<br><br>Professional Development Midwife | **Completed** 30/09/2023<br><br>. | Impacted Fetal Head intervention technique has been added to PROMPT training in September 2023 and has been covered by the faculty at each session.<br><br>Antepartum Haemorrhage is included in the PROMPT study days for 2024-25. |
| c. | The ownership and maintenance of the overall perspective of a woman on the wards by a Consultant Obstetrician and making an individualised plan. | Issue to be raised with the Consultant body and discussion held as to current and future working practices in relation to the issues raised by the reviewers. | Clinical Directors Women's Services | 31/09/2023 **Completed** | The Clinical Director has confirmed that the action has been completed |

| Practice issues highlighted which were not made as recommendations | | | | | |
|---|---|---|---|---|---|
| 1. | Simple measures such as bimanual uterine compression seems to be sparingly used in most of the cases especially in the earlier stages whilst further investigations are underway and waiting for uterotonics to work, or more senior help to arrive | A review of the current guidance and for the use of bi-manual compression to be completed. | Labour Ward Leads and College Tutors<br><br>Professional Development Midwife | **Completed** 28/08/2024 | The use of Bi-manual compression and Bakri Balloon has been included on the PROMPT training in 2023-24. |
| 2. | There appears to be a theme of somewhat sub-optimal surgical skills amongst some of the Senior Obstetricians. More surgical training of some senior obstetric staff in insertion of Bakri Balloon should be considered. | A review of the current guidance and for the use of a Bakri-Balloon is to be completed. | Labour Ward Leads and College Tutors<br><br>Professional Development Midwife | **Completed** 28/08/2024 | Please see update above and Individual Practices are monitored. |

**Updated 29th August 2024 (post meeting with WG) v3.0**

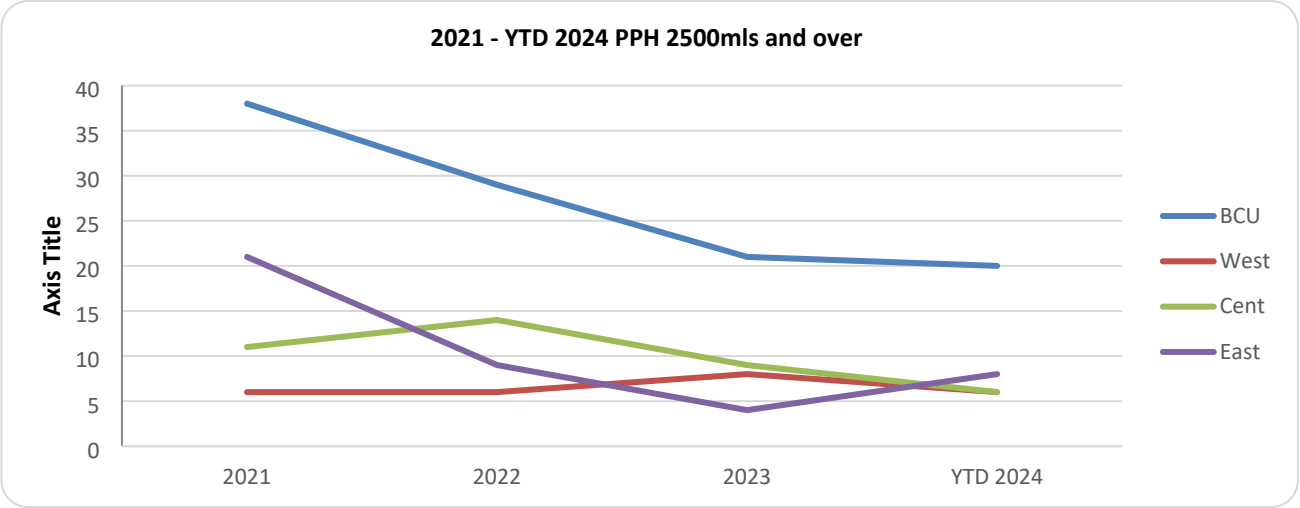
## Massive Obstetric Haemorrhage (2500ml and over)

## 1st January 2021 to 31st July 2024

**The following data has been extracted from the Maternity Outcomes and Performance Indicator Eforms**

**Overall cases 2021 to date**

| SITE | 2021 | 2022 | 2023 | YTD 2024 |
|---|---|---|---|---|
| BCU | 38 | 29 | 21 | 20 |
| West | 6 | 6 | 8 | 6 |
| Cent | 11 | 14 | 9 | 6 |
| East | 21 | 9 | 4 | 8 |



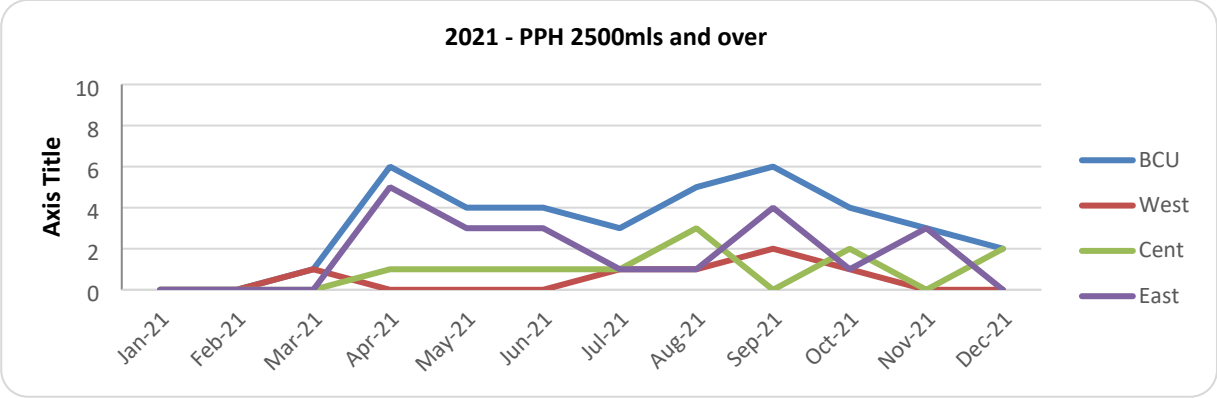

1- As can be seen above the number of MOH cases of 2500ml and over, has overall decreased from 2021. PROMPT training commenced in BCUHB in 2019 amongst the first Health Boards in Wales to introduce the training.

**Data per individual year**

**2021**

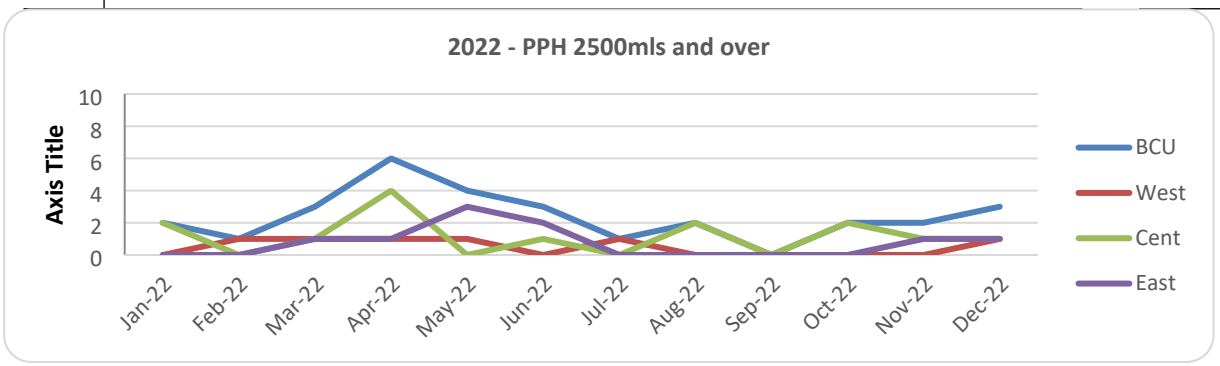
| SITE | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | 2021 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| BCU | 0 | 0 | 1 | 6 | 4 | 4 | 3 | 5 | 6 | 4 | 3 | 2 | 38 |
| West | 0 | 0 | 1 | 0 | 0 | 0 | 1 | 1 | 2 | 1 | 0 | 0 | 6 |
| Cent | 0 | 0 | 0 | 1 | 1 | 1 | 1 | 3 | 0 | 2 | 0 | 2 | 11 |

| | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| East | 0 | 0 | 0 | 5 | 3 | 3 | 1 | 1 | 4 | 1 | 3 | 0 | 21 |



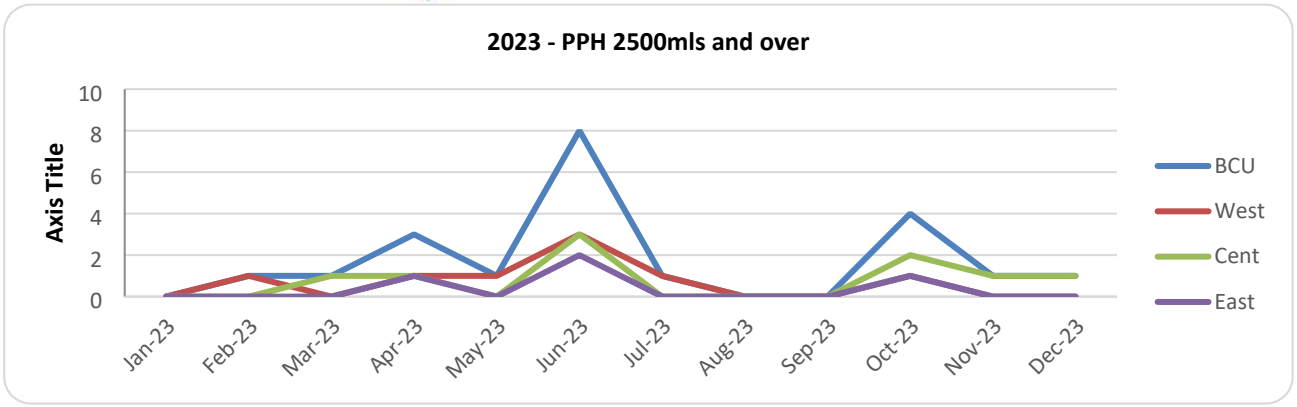

## 2022

| SITE | Jan-22 | Feb-22 | Mar-22 | Apr-22 | May-22 | Jun-22 | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | 2022 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **BCU** | **2** | **1** | **3** | **6** | **4** | **3** | **1** | **2** | **0** | **2** | **2** | **3** | **29** |
| **West** | 0 | 1 | 1 | 1 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | **6** |
| **Cent** | 2 | 0 | 1 | 4 | 0 | 1 | 0 | 2 | 0 | 2 | 1 | 1 | **14** |
| **East** | 0 | 0 | 1 | 1 | 3 | 2 | 0 | 0 | 0 | 0 | 1 | 1 | **9** |



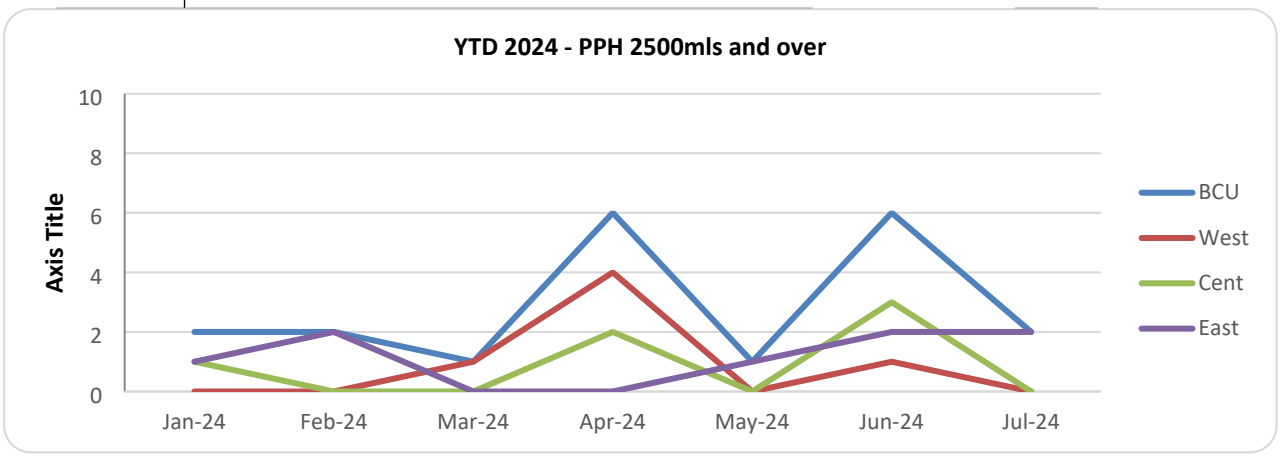

## 2023

| SITE | Jan-23 | Feb-23 | Mar-23 | Apr-23 | May-23 | Jun-23 | Jul-23 | Aug-23 | Sep-23 | Oct-23 | Nov-23 | Dec-23 | 2023 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **BCU** | **0** | **1** | **1** | **3** | **1** | **8** | **1** | **0** | **0** | **4** | **1** | **1** | **21** |
| **West** | 0 | 1 | 0 | 1 | 1 | 3 | 1 | 0 | 0 | 1 | 0 | 0 | **8** |
| **Cent** | 0 | 0 | 1 | 1 | 0 | 3 | 0 | 0 | 0 | 2 | 1 | 1 | **9** |
| **East** | 0 | 0 | 0 | 1 | 0 | 2 | 0 | 0 | 0 | 1 | 0 | 0 | **4** |




## 2024

| SITE | Jan-24 | Feb-24 | Mar-24 | Apr-24 | May-24 | Jun-24 | Jul-24 | YTD 2024 |
|---|---|---|---|---|---|---|---|---|
| **BCU** | **2** | **2** | **1** | **6** | **1** | **6** | **2** | **20** |
| **West** | 0 | 0 | 1 | 4 | 0 | 1 | 0 | **6** |
| **Cent** | 1 | 0 | 0 | 2 | 0 | 3 | 0 | **6** |
| **East** | 1 | 2 | 0 | 0 | 1 | 2 | 2 | **8** |



## *Appendix 2: Saving Babies Lives Care Bundle 3 BCUHB Action Tracker*

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on%20Plan%20BCUH

## *Appendix 3: MatNeo SSP Discovery Phase Report*

MatNeoSSP Cymru
Discovery Phase Repc

[The Maternity and Neonatal Safety Support Programme in Wales - Public Health Wales (nhs.wales)]

## *Appendix 4: A Thematic Review of Stillbirths BCUHB 2023*

Stillbirth report June
24 Final version.pdf

*Appendix 5: Homebirth Service Provision Review*

# BCUHB Maternity Service

## Homebirth Service Provision Review

**Emma Adamson, Consultant Midwife**

**July 2023**

### Background/Introduction

Pre-1948 the majority of births in the United Kingdom (UK) took place at home, however the inception of the National Health Service (NHS) marked a significant turning point in maternity care provision, no longer confined to the realms of midwifery, the care of pregnant women underwent a rapid period of medicalisation and the rate of homebirths began to decrease, in favour of giving birth in hospital; between the late 1940s and 1960s approximately two thirds of births in England and Wales took place at home but by 1975 this had reduced to less than five percent and rates continue to decline. The 2021 figures demonstrate the significant variation across Wales, with five out of seven health boards reporting homebirth rates of between 2.1% (Betsi Cadwaladr University Health Board (BCUHB)) and 3.1% (Swansea Bay University Health Board (SBUHB)). A slightly higher rate of 5.8% was reported by Hywel Dda University Health Board (HDUHB) and a significantly higher rate in Powys Teaching Health Board (PTHB) of 11.6% (Royal College of Midwives, 2023).

These low rates of homebirth exist despite recent evidence which states women who are low risk and plan to give birth at home do not appear to have a different level of risk of fetal or neonatal loss in comparison to those who plant to give birth in hospital (Scarf *et al.* 2018; Hutton *et al.* 2019), and that the reduced chance of maternal morbidity and obstetric intervention support the option of birth centre and homebirth as options for women with low risk pregnancies (Scarf *et al.* 2018).

In 2007 the Department of Health (DoH) (2007) committed to ensuring a choice of place of birth so that, depending upon circumstances, women would be able to choose between a homebirth, birth in a local facility supported by midwives or birth in an obstetric unit, with both former options promoting a philosophy of normal and natural labour and childbirth. The results of the Birth Place Cohort Study (Hollowell *et al*. 2011) supported a policy of offering women with low risk pregnancies a choice of birth setting, whilst simultaneously informing

them of risks associated with each option, specifically the differences in neonatal outcomes of nulliparous versus multiparous women birthing at home. In 2015, the Birth Place Follow on study continued to support a policy of increasing homebirth provision for multiparous women and this is further supported in the National Institute for Health and Care Excellence (NICE) guidelines for the Intrapartum Care for Healthy Women and Babies (2014), which recommends that both low risk nulliparous and multiparous women should be aware that they can choose any available birth setting (home, freestanding midwifery unit (FMU), alongside midwifery unit and obstetric unit) and that they should be supported in that choice. In Wales the Maternity Care in Wales: A Five-Year Vision for the Future (2019 – 2024) (2019), states that as part of the principle of Family Centred Care, women at low risk of complications during labour will be given the choice of all four birth settings and this has been echoed in the recently published All Wales Midwifery Led Care Guidelines 6th ed. (2022). In 2023, the Royal College of Midwives (RCM) issued its position statement regarding reconfigurations in maternity services, stating clearly that 'home birth is an essential part of every maternity service,' recognising the need to ensure safety of mothers and babies, whilst also delivering services that increase and support choice and continuity of care and in its State of Maternity Services Report for Wales (RCM, 2023) declared that the active offer of homebirth is indication of maternity services that are supporting and enabling choice for women over their care.

**National and Local Context**

During the Covid 19 pandemic there was concern at a national level regarding the potential impact of the pandemic on ambulance resources and maternity services have experienced ongoing issues with response times, predominantly due to lost Welsh Ambulance NHS Service Trust (WAST) hours due to delayed handover of non-obstetric patients to hospitals caused by increased demand, staffing shortages and more recently, industrial action. This has potentially threatened the ability to transfer women and/or babies for appropriate medical review and care when required. There is no nationally recognised definition of a 'delay in transfer' for maternity services and therefore the risk potential of an individual delay is unknown. Whilst research suggests that the majority of transfers are initiated for non-urgent reasons, with only 6% being considered a necessity due to life threatening events (Hollowell *et al*. 2011), in rare cases a delay treatment may increase the risk of morbidity and/or mortality.

In July 2022, due to extreme pressures identified by WAST, leading to increased waiting times, the decision to temporarily suspend homebirths and therefore not actively offer the service, was taken by the BCUHB Women's Service Senior Leadership Team, pending consideration at a national level by maternity service leads, the Maternity and Neonatal Network, Welsh Government and WAST. Service users and staff were informed of this decision. Since July 2022, the BCUHB homebirth suspension has been regularly reviewed and due to ongoing WAST pressures, compounded by industrial action, continues to date. During this period women planning a homebirth are informed of the potential risk regarding ambulance response times in an emergency and are advised to give birth in a hospital setting, and whilst many have opted to do so, a number have continued with plans to give birth at home. In these instances, women have been fully supported in their choice via thorough care planning.

Across Wales there has been periodic suspension of homebirth services in all health boards with the exception of PTHB. Similarly, to locally, these suspensions involved women being advised of potential risks and therefore homebirth not being offered as an option for place of birth, whilst community midwifery teams continued to support those individuals who continued to plan for homebirth. Currently however, all health boards across Wales other than BCUHB and SBUHB are actively offering home as an option for place of birth, however conversely this is due to mainly to maternity staffing levels, rather than concerns regarding WAST capacity.

**Welsh Ambulance Services NHS Trust (WAST)**

Receiving care and treatment in times of medical emergencies is vital to ensure optimum health outcomes and to preserve life and since 1998 WAST has been providing emergency treatment to the people of Wales, via a range of services, which operate 24 hours a day, 365 days a year. Pressure to provide a timely response to emergency calls, under financial, resource and capacity demands is extremely challenging and the additional rurality element in many areas of Wales, exacerbates this further (Rural Health and Care Wales, 2020).

Whilst response times are viewed as the benchmark for the provision of quality services, the Clinical Response Model (CRM) developed in 2015, seeks to focus on the provision of appropriate care, which may not necessarily correlate to the fastest response times, except for those categorised as red category calls, which remain subject to specific targets. Since its development, the CRM has been able to ensure the appropriate resource is being used for the appropriate condition and in more recent years, particularly in response to the

increased pressures on services during the Covid 19 pandemic, maternity services, supported by WAST, have been required to review their use of WAST. This resulted in the development of an All-Wales Criteria for Selecting Mode of Transport and, still in development, the All-Wales Guideline for Maternity Transfers from Community and Freestanding Midwifery Units, which aims to support professionals in instances where transfer from a community setting is required, by supporting communication, appropriate assessment of required mode of transport, escalation, pre-labour planning and monitoring.

Options for mode of transport from the community include:

Category A – own transport

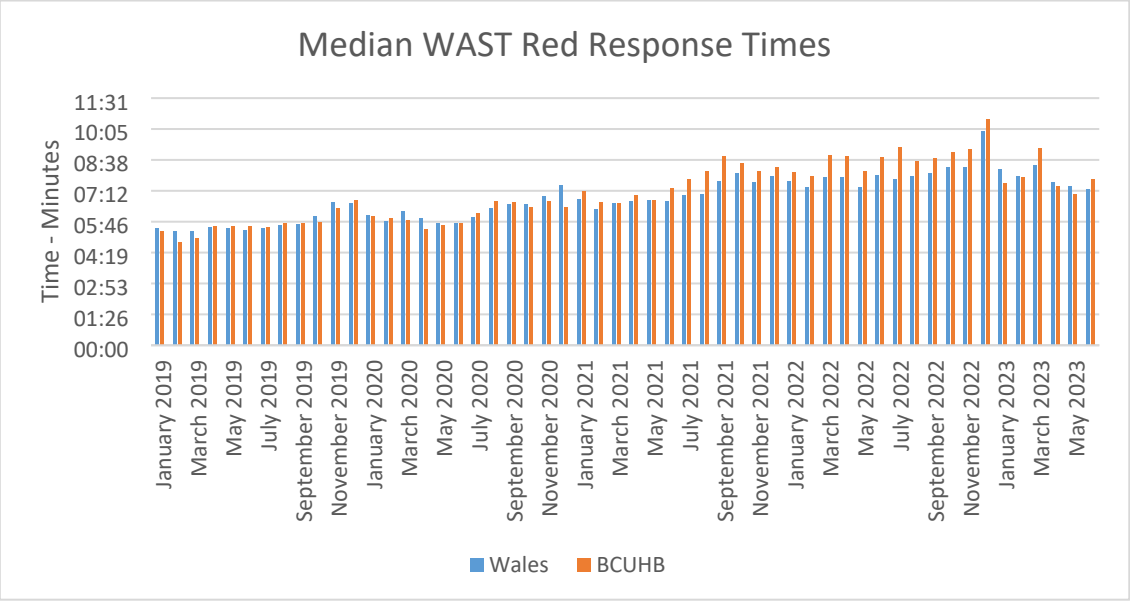
Category B – Taxi; WAST have the ability to arrange a taxi transfer in certain circumstances and have commissioning agreements in place. Further enquiry is required to determine what commissioning/SLA agreements are in place locally

Category C – Urgent Care Services (UCS); where an urgent transfer is required, but paramedic assistance is not necessary, UCS can be requested and will respond in a standards ambulance but will not transfer via blue light/sirens and will not have a paramedic in attendance. UCS carry Entonox, oxygen and AEDs and staff are trained in basic life support, therefore may be a viable option for women in labour requesting additional analgesia or women who are clinically stable and require perineal review and/or suturing

Category D – 999 ambulance; for emergency transfer, where there is threat to life and paramedic support is required.

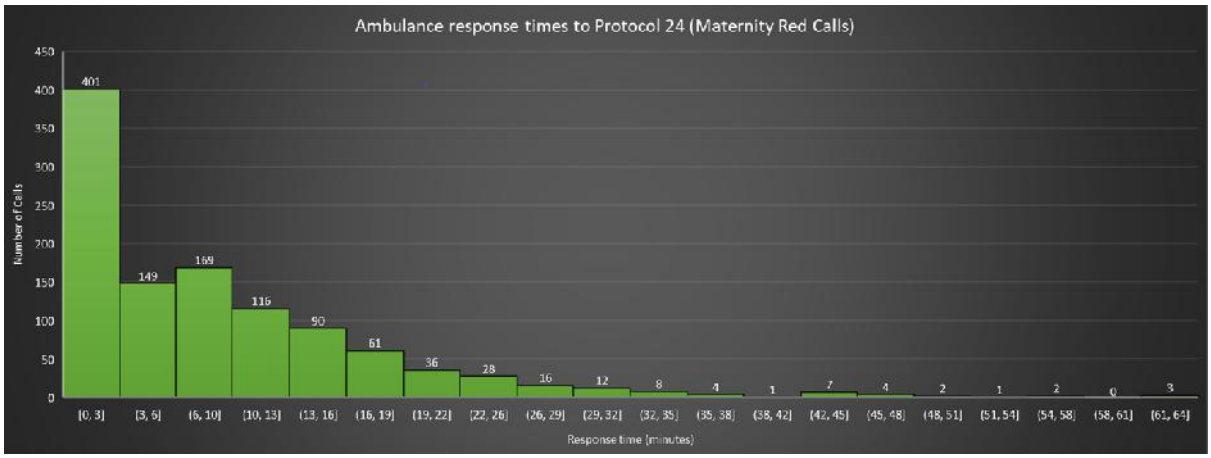
In addition to the above, Cymru High Acuity Response Unit (CHARU) or Emergency Medical Retrieval Transfer Service (EMRTS) may be dispatched by WAST. CHARU is a dedicated resource staff by a paramedic who has completed additional training, including PROMPT, whose purpose is to co-ordinate and provide optimal patient care. CHARU may respond to maternity call to support stabilisation of the patient at the scene prior to transfer, whilst EMERTS provide critical care in the pre-hospital setting.

Figure 1.




Figures obtained from Stats Wales show an increase in the median length of response time for red call across Wales and locally, from 5 minutes 18 seconds in January 2019, to 7 minutes and 44 seconds in June 2023.

Figure 2. WAST Red maternity call response times




The above data relates to maternity calls from both healthcare professionals and patients between March 2022 and February 2023 and clearly demonstrates that the majority of calls were responded to within 10 minutes. Whilst this is reassuring, the WAST data does demonstrate significant variation in terms of both the quality of the information provided by healthcare professionals when requesting a transfer and the documentation by call handlers,

which has prompted the widely accepted view that WAST must strongly consider a dedicated midwife call handler for maternity calls.

Locally data is not routinely collected on response times for 999 requests, however PTHB, who operate a wholly community-based service, have conducted an extensive audit and review of transfers from community maternity services into an obstetric unit, comparing data from 2021 and 2022 and found that the average transfer response time i.e., from call to WAST arrival increased from 32 minutes in 2021 to 35 minutes in 2022. Where delays were identified, it was apparent that this occurred in cases where an alternative, more appropriate mode of transport could have been utilised.

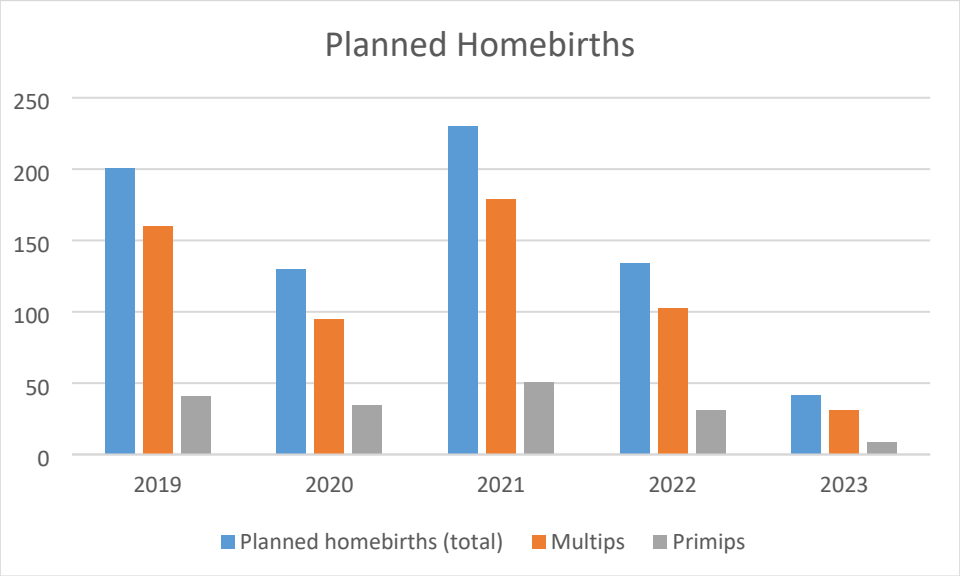
**Local Data Analysis**

Data relating to homebirths is collected on a monthly basis by each of the three community areas and inputted onto a spreadsheet. The spreadsheet includes fields for:

- The number of planned homebirths (multiparous/primiparous)
- The number of actual homebirths (multiparous/primiparous)
- The number of babies born before arrival
- The number of and reason for transfer of care (pre-labour/intrapartum/postnatal)
- The outcome of hospital births where a homebirth was intended

Data from 2019, 2020, 2021, 2022 and 2023 to date was collated for this report, however it must be highlighted that in a significant amount of data is either missing or incomplete and therefore some caution is required in its interpretation. Also note, that data regarding ambulance response times is not collected via the database.

*Figure 3. Planned Homebirths*




The available data demonstrates a variable picture year on year in terms of the number of women planning to give birth at home, with a higher rate of planned homebirths pre- and mid-pandemic, a reduction in 2022 and as expected, significantly reduced number of women planning a homebirth this year, even when considering only partial figures available for the year. Anecdotally, it is reported that a number of women who planned to give birth at home in 2021 did so in response to having a negative experience hospital birth experience in

2020 and for all women giving birth in the acute setting during pandemic, the inability to have partners present for extended visiting hours, has been raised as a contributory factor to women having poor satisfaction with their birth experience and this, coupled with only being able to have one birthing partner at this time, may have led to many multiparous women to plan a homebirth in their subsequent pregnancies, whilst these restrictions remained in place.

Whilst the percentage of homebirths being planned by multiparous women compared to those expecting their first baby has remained fairly stable across BCUHB year on year since 2019, between 73 and 79 percent, with an average of 75 percent, it can be noted that in the West area, the proportion of primiparous women choosing to give birth at home in comparison to multiparous women has increased from 25 percent in 2019 to a high of 39 percent in 2022.

*Figure 4. Achieved Homebirths*

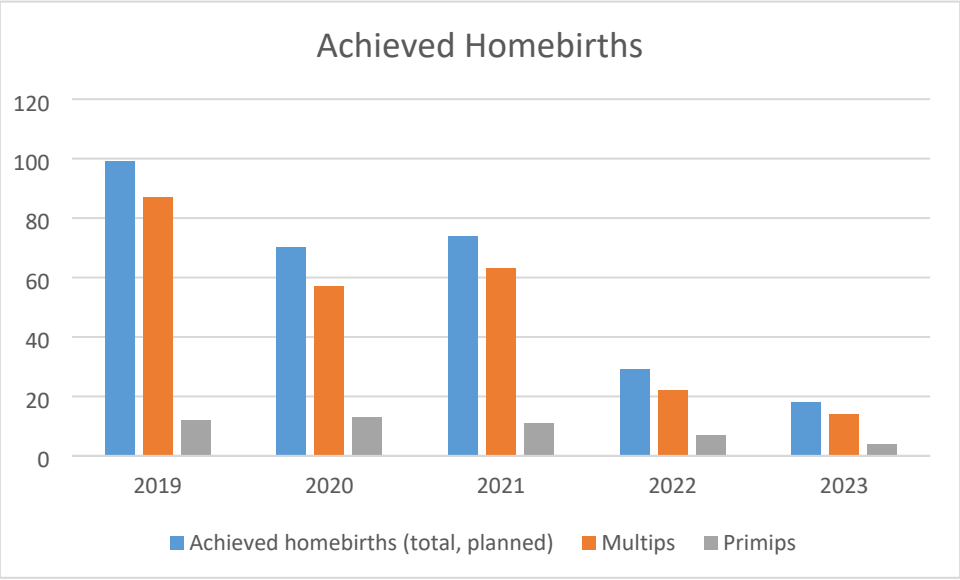
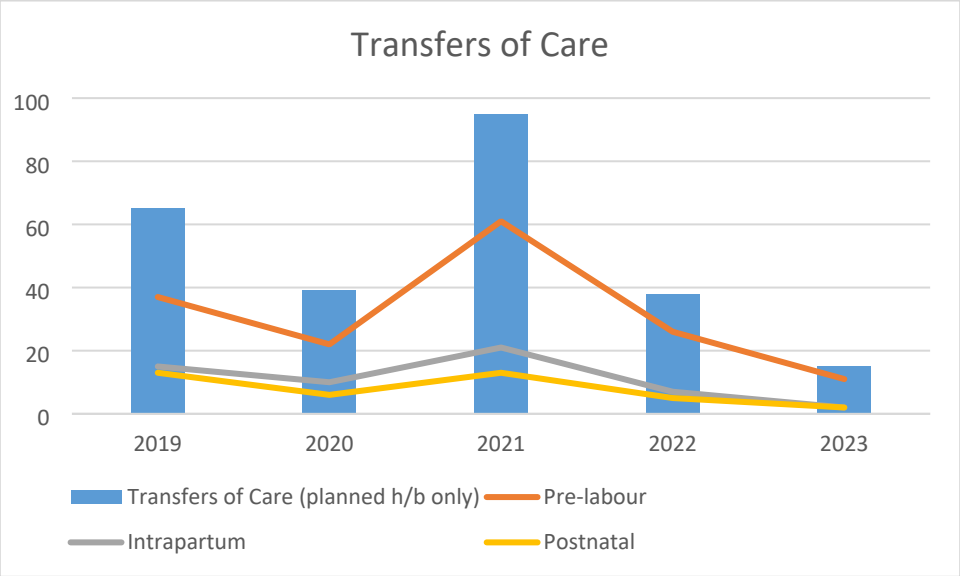
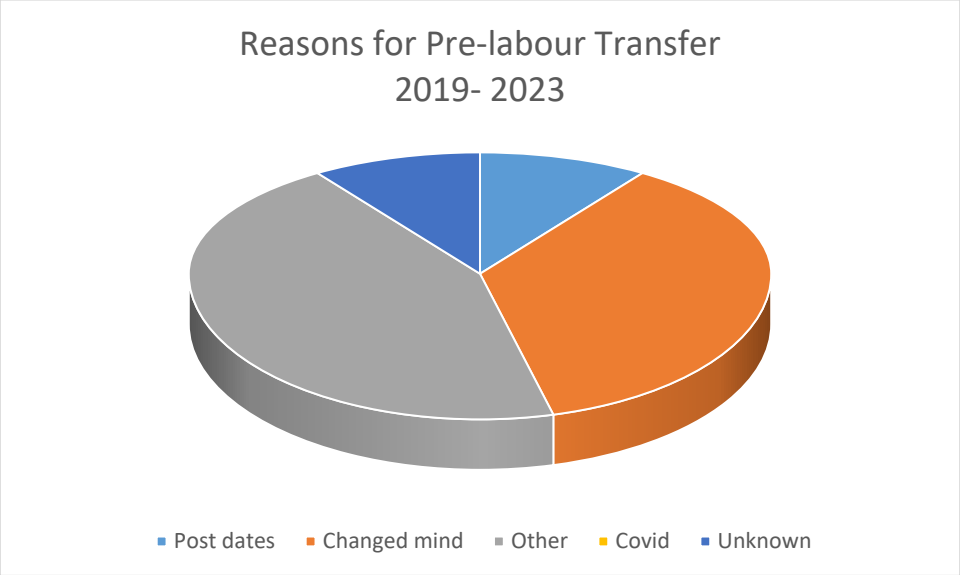


*Figure 5. Transfers of Care*



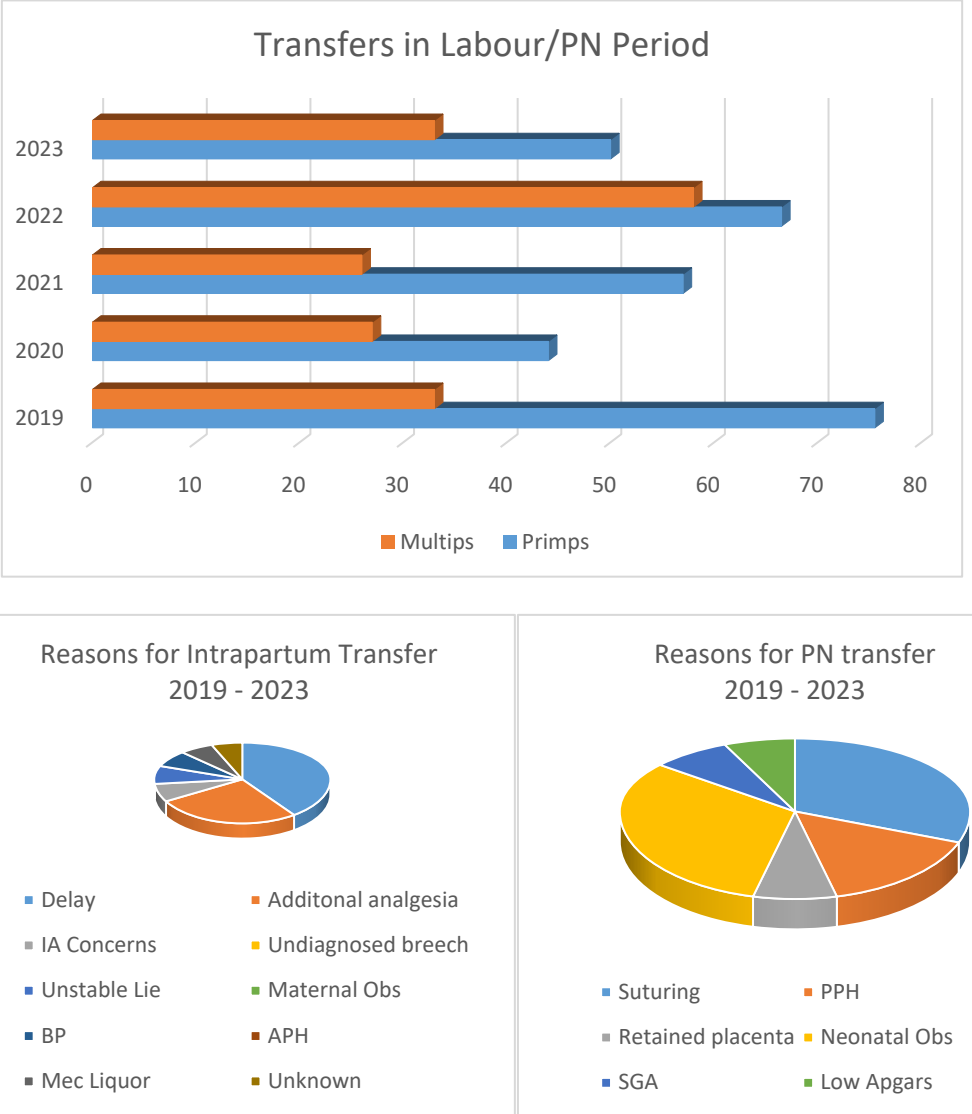

The available local data demonstrates that where a transfer of care has taken place, this occurs most frequently prior to the onset of labour, and this was most likely due to a risk factor being identified which necessitated a hospital birth, such as small for gestational age fetus, premature or pre-labour rupture of membranes, medical issues such as raised blood pressure or the diagnosis of gestational diabetes, or the woman reconsidering her chosen place of birth (Fig. 5). Again, some caution should be applied as there are number of women whose care was transferred in the antenatal period for whom a reason was not recorded.

*Figure 6. Reasons for Pre-Labour Transfer of Care*



National data suggests that the likelihood of an intrapartum transfer is 36-46% for first mothers during labour or the immediate postpartum period, reducing to 9-12% for subsequent births, however this is not demonstrated in the local data, but again caution must be exercised as a significant amount of this data is absent. Locally, the main reasons for intrapartum transfers of care were for delay in either the first or second stage of labour or where women had requested additional analgesia. Where a transfer of care was required following the birth this was predominantly due to the need for suturing or for neonatal observations which does parallel with national data conclusion that a low proportion of transfers are for urgent reasons.

*Figure 7. Reasons for Intrapartum/Postnatal Transfer of Care*



## Conclusions and Recommendations

The Covid 19 pandemic and subsequent service pressures experienced by both maternity services and WAST helped to identify issues within the transfer framework, most notably regarding the use of appropriate modes of transport, and has provided an opportunity to review current service provision and develop more safe and effective ways of working.

As part of the Maternity and Neonatal Safety Support Programme, WAST are currently developing the All-Wales Guideline for Maternity Transfers from Community and Freestanding Midwifery Units, to support safe, effective, and appropriate use of ambulance transfers in maternity services. As an adjunct to this guideline, WAST will also be providing a script type resource, for obstetric emergencies most likely to be experienced in the community, for use by midwives, when requesting a transfer. The service will also be developing training to be included in PROMPT to ensure selection of appropriate mode of transport and further support effective communication between midwives and WAST call handlers.

BCUHB Maternity Services must also take actions, both to mitigate both ongoing risks associated with WAST and those potential issues identified within the community midwifery services, to ensure safe, effective home birth service provision, that is equitably available across North Wales.

***Recommendation 1: Improve Data Collection***

On reviewing the BCUHB homebirth service provision, it was found that the available data is highly insufficient and inconsistent. Not only does this make analysis of the current situation problematic, it prevents maternity staff from being able to provide women and families with the most accurate and up to date local data relating to outcomes of homebirths, which are imperative to informed decision making and an essential action of the Ockenden Report (2022).

Therefore, an immediate action must be to develop a standardised database, which collects appropriate data, including ambulance response times, which can be used to identify themes and trends related to care provision in the home setting and to share with women to aid decision making. It is suggested that the audit and review tool within the draft All Wales Guideline for Maternity Transfers from Community is adopted locally, whilst awaiting a digital solution.

***Recommendation 2: Community Midwifery Inpatient Setting Updates***

As expected, rates of planned homebirths have reduced since the suspension was initiated, which is likely due to a lack of promotion of home as choice for place of birth and public awareness of the potential risks. However, even prior to changes to service provision as a result of the Covid-19 pandemic and WAST pressures, BCUHB were already experiencing relatively low levels of homebirth activity. This in addition to changes to the on-call responsibilities resulted in reduced exposure of community midwives to intrapartum care, since further exacerbated by the suspension and this may have impacted levels of confidence and competence in some instances, which subsequently may affect the quality of discussions between community midwives and women regarding their options for place of birth. The 'Your Birth – We Care' survey, conducted in 2018, found a number of women expressed a lack of meaningful discussion around options for place of birth, particularly homebirth, and recognised that quality discussion were needed in order to be able to make fully informed decision. Whilst an effective multidisciplinary community Practical Obstetric Multi-Professional Training (PROMPT) programme is delivered across the maternity service to maintain the skills of midwives in managing obstetric emergencies, this does not negate the requirement for regular clinical exposure. Real-life and regular experience of caring for women in labour ensures midwives are able to accurately assess, interpret and record the health and wellbeing of the woman and fetus during labour in a community setting, autonomously and without immediate support from the wider multi-disciplinary team, for an increasingly complex childbearing population, where growing numbers of women are requesting to birth outside the recommendations of current guidance, including at home. A homebirth service provided by highly skilled midwives may reduce the need for transfer, particularly when considering for instances such as suturing.

Whilst attending recommended updates, it is also recommended that time is spent on the assessment unit, reviewing updated and new guidance and opportunistic review and discussion of cases, with the midwifery led unit leads and/or fetal surveillance midwife, specifically in relation to the All Wales Normal Labour Care Pathway and intermittent auscultation (as per the Intrapartum Fetal Surveillance Standards) and the booking and 36 week risk assessments within the AWMLCG (2022), which will help ensure women are supported to give birth in the most appropriate place for their circumstances.

A secondary, but vitally important outcome of community midwives attending updates in the inpatient setting, is the improvement in communication and collaborative working between

community and inpatient services, leading to more coordinated and effective care for women and families.

***Recommendation 3: Additional skills sessions***

The unpredictable nature of maternity services may result in community midwives attending updates in the acute setting but due to activity levels and/or characteristics of patients, may not have opportunities for all suggested outcomes, therefore consideration needs to be given to the development and delivery of additional sessions to support suturing skills, booking and place of birth risks assessments, as per the AWMLCG and intermittent auscultation. Where community midwives identify that they would benefit from cannulation refresher training, this can be accessed via ESR. If there have been no opportunities to provide intrapartum care for women following the AWNLCP, consideration should be given to the viability of supporting these women during rostered on-calls (community activity allowing).

Active promotion of homebirth is essential in ensuring true choice for women and in improving outcomes by reducing rates of intervention, which not only enhances women's experiences but supports the maternity service as a whole both in the short and long term. Engaging in the suggested actions would allow the active promotion of homebirth as an option to those women who meet criteria, and ensure effective planning for all women choosing to give birth at home, whereby skilled midwives remain the lead professional for women both at home and during transfer, where appropriate, helping to support appropriate utilisation of resources of both WAST and Maternity Services. Women considering homebirth can be provided with up-to-date data to support their decision making and feel confident in the skills of professionals and pathways in place. Midwives will also be better equipped to identify women who may be suitable to give birth in the midwifery led unit and also be able to engage in more quality and consistent conversations with women during pregnancy regarding their pathways of care and expectations when attending the inpatient unit, ensuring they are better informed and prepared, which will improve satisfaction.

***Recommendation 4: Ascertain commissioning/SLA for local taxi use***

The pending All Wales Guideline for Maternity Transfers from Community & Freestanding Units recommend that there may be instances in which transfer by taxi is appropriate, however this would need further consideration at a local level in terms of availability across the region & any existing BCUHB service level agreement

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**Appendix A (as per All Wales Guideline for Maternity Transfer from Community and Freestanding Midwifery Units)**

## Transfer Audit Form

Date:_____

ADDRESSOGRAPH

Transfer from:_____
Transfer to:_____

Time decision to transfer:_____

Time transport called:_____

Time OU called:_____

Time transport arrived:_____

Time departed location:_____

Time arrived at OU:_____

Time handed over:_____

Time of medical review:_____

Primip Multip Gestation:_____

Reason for transfer:_____

Stage of care:_____

## Please circle responses where applicable:

**Category of transfer required according to framework:**

A-own car B-Taxi C-UCS D-999

**Mode of transport used:** Own car Taxi with midwife UCS 999

**If mode of transport used was different to recommended one as per framework reason why:**_____

**If 999 transfer grading of call:** Red Amber-1 Amber-2 Green

**Escalation required to obtain mode of transport required?** Yes No

**Discussion with Clinical Support Desk:** Yes No

If yes, Time requested:_____Time called back:_____

**Call upgraded:** Yes No

**Escalation required to manager on-call:** Yes No

**Datix Submitted:** Yes No **Incident number:**_____

## OUTCOME:

**Mode of birth:**_____**MBL:**_____**Birth weight centile:**_____

**Adverse primary outcome from list below:** Yes No

Fractured humorous/clavicle HIE Grade: 3 Meconium Aspirate

Still birth (after presentation in labour) NN death (within 7 days) Brachial Plexus injury

**Secondary perinatal or maternal from the list below:** Yes No

**Neonatal outcomes**: • Apgar score <7 at 5 minutes • Neonatal encephalopathy any grade • Fractured skull • Cephalohaematoma • Cerebral haemorrhage • Early onset neonatal sepsis (within 48 hours of birth) • Kernicterus • Seizures • Admissions to neonatal unit within 48 hours of birth for at least 48 hours with evidence of feeding difficulties or respiratory distress.

**Maternal outcome**

• Maternal death (within 42 days of giving birth) • Episiotomy • Third or fourth degree perineal trauma • Blood transfusion • Admission to Intensive Therapy Unit /High Dependency Unit

**Appendix B – Homebirth reimplementation recommendations**

| Recommendation | Activity | Comments |
|---|---|---|
| Data Collection/Sharing | Full review of homebirth database<br>Monthly collation and sharing of local data within service<br>6 monthly sharing of local data with service users | Work in progress |
| Intrapartum Updates Each CM to attend inpatient update over 12 month period via:<br>1 week attendance (min 22.5 hrs) | Provision of care for women on AWNLCP<br>Engage in opportunities to:<br>• Review AWMLCG & associated RAs<br>• Suture<br>• Cannulate<br>• Review management of women on AWNLCP (including escalation of care)<br>• Review/discuss notable cases<br>• Update on current processes and pathways in MOAU | Initiated with community midwifery team leads |
| Additional skills updates | Risk Assessment Training<br>Intermittent Auscultation Training (whilst awaiting WRP training package development)<br>Cannulation Training<br>Suturing Workshops<br>Effective Utilisation the All Wales Guideline for Maternity Transfers from Community | Consultant midwife in initial discussion regarding implementation<br><br>WAST to support initial sessions prior to full roll out in September |

*Appendix 6: Briefing All-Wales National Maternity & Neonatal Experience Questionnaires*

## Briefing

## All-Wales National Maternity & Neonatal Experience Questionnaires

As a priority of the Maternity and Neonatal Safety Support Programme, and as a key deliverable of the All-Wales Perinatal Family Engagement Framework, there is a commitment to ensuring that NHS-Wales perinatal services develop a 'listening system', with the capacity and capability to listen and hear from women, pregnant people, parents, families and communities. This will require mechanisms and processes to receive, collate and analyse experience data and feedback; oversight and monitoring of families' experiences throughout their perinatal care; using this experience data to inform both quality and service improvements, and developments where required.

### Background

The RCOG/RCM external review of maternity services at the former Cwm Taf UHB (2019) made a number of recommendations which centred on improving the quality of women and families' experiences. In response, an extensive maternity and neonatal improvement programme implemented a number of key initiatives and innovations with which to listen to women and families' experience, seeking to continually monitor, measure and improve this.

In 2021, CTMUHB implemented a series of phased/longitudinal maternity experience questionnaires, to enable real-time collation of experience data throughout the perinatal journey. The maternity questionnaires align with the Care Quality Commission maternity survey as a validated tool. Later, a neonatal questionnaire was implemented with which to seek experience data around key elements of families' experience care on a neonatal unit, using principles from British Association of Perinatal Medicine (BAPM), Family Integrated Care (FiCare), and support from Bliss. Questionnaire links are sent out automatically via SMS link and collated within the All-Wales Civica system.

Given its local success, which currently generates around 200 responses per month, an opportunity has been identified to 'spread and scale' this innovation across NHS-Wales perinatal services. This innovation will support the ability to achieve a number of priorities;

- listening to and understanding family's experience,
- develop comparable qualitative experience measures, metrics and key performance indicators
- the use of local and national dashboards to monitor experience

- develop an understanding and focus upon the improvements and developments that are required at both local and national level across NHS-Wales perinatal services.

**The System/Questionnaires**

The NHS Executive quality and safety team have commenced development of a National Maternity & Neonatal quality monitoring and assurance dashboard, which is integrated within its existing Beacon dashboard, one element of which is 'National People's Experience Data'.

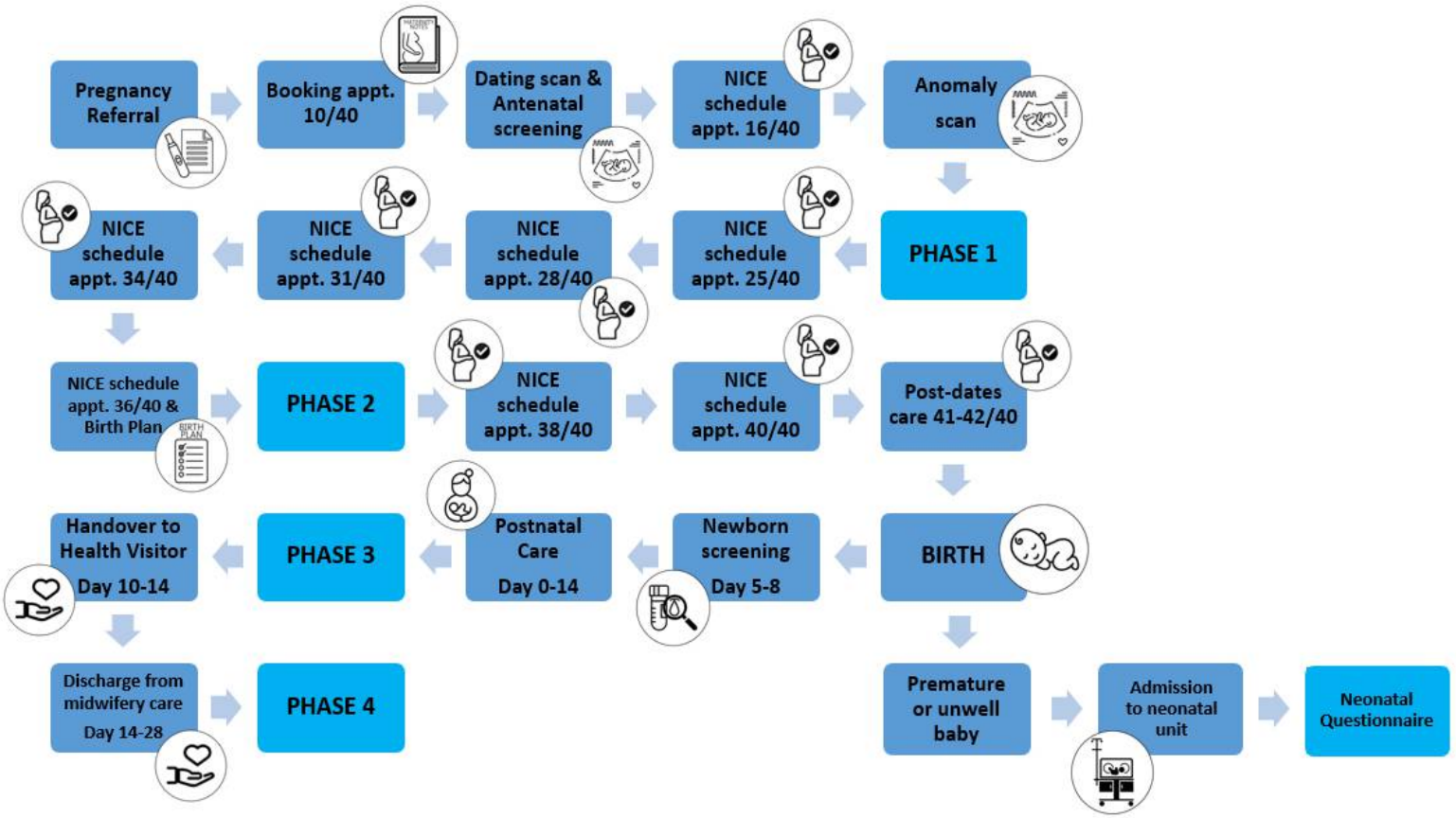
The following maternity and neonatal questionnaires contain both national and local experience questions with the aim that:

- The agreed national experience metrics will be collated within the Civica system and integrated with the Beacon dashboard which will display high level experience data, supporting oversight and assurance monitoring of the experiences of those receiving using perinatal services.

- The agreed local experience metrics will be collated within the Civica system and integrated into localised Health Board processes, supporting local oversight and assurance monitoring of the experiences of those receiving using perinatal services, in addition to supporting local quality and service improvement and development.

Equality monitoring questions are included within all questionnaires, enabling NHS-Wales perinatal services to identify current and future needs, support identification of inequalities, including problems accessing or using services.

A number of data safeguards and exclusions are used within the digitalised system to prevent inappropriate send-out, for example, where women have sadly experience the loss of a baby, or a baby has been placed in to foster care or has been adopted.




- The Phase 1 questionnaire will be automatically triggered by an anomaly ultrasound scan, with normal findings.

- The Phase 2 questionnaire will be automatically triggered at 37 weeks' with a continuing pregnancy. Where a woman has already given birth <37 weeks', the phase 2 questionnaire will be omitted, and defer to the Phase 3 questionnaire, in addition to the neonatal questionnaire if the baby has required admission to a neonatal unit.

- The Phase 3 questionnaire will be automatically triggered at 2 weeks' after registration of a live-birth. If the maternity information system has identified any data safeguards (agreed parameters for exclusion) such as a neonatal death or a baby removed in to foster care within this 2 week period, this will exclude questionnaire send-out.

- Phase 4 questionnaire will be automatically triggered at 8 weeks' after registration of a live-birth (if any poor outcomes have occurred within this 8 week day period, a data safeguard will exclude send-out).

- The neonatal questionnaire will be automatically triggered 2 weeks' after discharge from the neonatal unit.