Bundle BCU Quality, Safety and Experience Committee 7 May 2026

1 PRELIMINARY MATTERS

1.1 13:00 - QS26.58 Welcome & Apologies
Caroline Turner, Chair

1.2 13:01 - QS26.59 Declarations of Interest
Caroline Turner, Chair

1.3 13:02 - QS26.60 Minutes of the Previous Meeting - 5 March 2026
Caroline Turner, Chair
1.3 QSE 05.03.26 unconfirmed public minutes V1

1.4 13:04 - QS26.61 Action Log & Matters Arising
Caroline Turner, Chair
1.4 QSE Action Log PUBLIC

1.5 13:09 - QS26.62 Patient Story
Angela Wood, Executive Director of Nursing & Midwifery
1.5 Patient Story

1.6 13:24 - QS26.63 Service Presentation - Urgent & Emergency Care
Tehmeena Ajmal, Chief Operating Officer
Presentation to follow

2 GOVERANCE, RISK AND ASSURANCE

2.1 13:39 - QS26.64 Integrated Quality Report
Angela Wood, Executive Director of Nursing & Midwifery
2.1 QSE Integrated Quality Report

2.2 13:54 - QS26.65 Integrated Performance Report
Ed Williams, Director of Performance & Commissioning
2.2.1 IQPR Coversheet
2.2.2 IQPR
2.2.3 NHSWPF Coversheet
2.2.4 NHSWPF Briefing Paper

2.3 14:04 - QS26.66 Regulatory Paper
Joanne Kendrick, Head of Quality
2.3 QSE Regulation and Governance Report

2.4 14:19 - QS26.67 Nurse Staffing Act
Angela Wood, Executive Director of Nursing & Midwifery
2.4 Nurse Staffing Act
2.4 Nurse Staffing QSE Presentation

2.5 14:34 - QS26.68 Board Assurance Framework
Pam Wenger, Director of Corporate Governance
2.5 QSE BAF Report
2.5 QSE BAF Risks

3 IMPLEMENTING QUALITY MANAGEMENT SYSTEM

3.1 14:44 - QS26.69 Clinical Services Plan
Dr Clara Day, Executive Medical Director
3.1 QSE Paper CSP

4 14:59 - BREAK

5 IMPROVING QUALITY, OUTCOMES AND EXPERIENCE

5.1 15:09 - QS26.70 Challenged Services Update
Dr Clara Day - Executive Medical Director
Paolo Tardivel - Executive Director of Transformation & Strategic Planning
Tehmeena Ajmal - Chief Operating Officer
5.1 QSE Challenged Services Report

5.2 15:24 - QS26.71 Adult Mental Health & Learning Disabilities
Teresa Owen, Executive Director of Allied Health Professions & Health Science
5.2 QSE Mental Health Strategic Update

5.3 15:39 - QS26.72 Mortality - Paper Update
Dr Clara Day, Executive Medical Director & Teresa Owen, Executive Director of Allied Health Professionals & Health Sciences
5.3.1 QSE mortality paper
5.3.2 appendix 1
5.3.3 appendix 2

6 15:54 - FOR INFORMATION

6.1 QS26.73 Corporate Governance Report
Pam Wenger, Director of Corporate Governance
6.1 Corporate Governance Report

6.2 QS26.74 AAA Report - Mental Health Oversight and Development Group
Teresa Owen, Executive Director of Allied Health Professionals & Health Sciences
6.2 AAA Report MHODG

7 15:59 - CLOSING BUSINESS

7.1 QS26.75 Agree Items for Referral to Board / Other Committees
Caroline Turner, Chair

7.2 QS26.76 Review of Meeting Effectiveness
Caroline Turner, Chair

7.3 QS26.77 Date of the Next Meeting - 2 July 2026
Caroline Turner, Chair

7.4 QS26.78 Resolution to exclude the Press and Public
'Those representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960'

Betsi Cadwaladr University Health Board (BCUHB)
Unconfirmed Minutes of the Quality, Safety & Experience Committee
held in Public on 5 March 2026
held in the Boardroom, Carlton Court, St Asaph and via Microsoft Teams

In Attendance	
Name	**Title**
Caroline Turner	Chair
Dr Clara Day	Executive Medical Director
Jody Evans	Assistant Head of Risk Management
Debbie Eyitayo	Executive Director of Workforce & Organisational Development (via teams)
Urtha Felda	Independent Member
Sean Gallagher	Interim Head of Nursing RSS LD /SMS (part meeting)
Dr Faye Graver	Interim Deputy Medical Director MHLD (part meeting)
Matthew Joyes	Deputy Director of Legal Services
Stuart Keen	Executive Director of Environment & Estates (via teams)
Mike Larvin	Independent Member
Liz McKinney	Designated Education Clinical Lead Officer (DECLO)
Jane Moore	Executive Director of Public Health
Jodie Morgan	Clinical Operational Manager MHLD (part meeting)
Teresa Owen	Executive Director of Allied Health Professionals & Health Sciences (via teams)
Zoe Prince	Director of Nursing for Adult Mental Health (part meeting)
Geoff Ryall-Harvey	Llais
Pam Wenger	Director of Corporate Governance (via teams)
Angela Wood	Executive Director of Nursing & Midwifery
Observing	
Glesni Driver	Head of Statutory Compliance and Inquiries
Fflur Jones	Audit Wales
Committee Support	
Philippa Peake-Jones	Head of Corporate Governance
Harriet Abbott	Corporate Governance Officer

PRELIMINARY MATTERS
QS26.27 Welcome and Apologies Apologies were received from Tehmeena Ajmal, Dyfed Edwards, Dave Harris, Chris Lothian-Field, Joanne Kendrick, Carol Shillabeer and Paolo Tardivel.
QS26.28 Declarations of Interest No declaration of interest were received.
QS26.29 Unconfirmed Minutes of the Meeting held on 15 January 2026 The following amendment to the minutes was noted:

- missing “he” on third bullet point under QS26.05 Patient Story.

It was agreed that subject to the amendments, the minutes of the meeting held on **15 January 2026** were a true and accurate record.

QS26.30 Matters Arising & Action Log

Members reviewed the action log and noted the following progress against actions:

- Action QS25/11.1: this action is awaiting update from the Chief Operating Officer.
- Action QS24/121.1: this action is awaiting update from the Chief Operating Officer.
- Action QS26.5.1: the report has not yet been received.
- Action QS26.8.2: work on the updated report is ongoing. Owner of the action to be updated to the Executive Director of Finance & Performance.

It was resolved that the Committee:

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

QS26.31 Patient Story

The Executive Director of Nursing & Midwifery presented the item, which focused on the All-Wales Diabetes Prevention Programme. It was advised that the item has also been shared across BCU, as well as from an All-Wales Diabetes perspective.

In discussing the item, the Committee:

- Referenced care coordination and links with social prescribing, and how the programme links with the longer-term prevention offer within Primary Care Services.
- Were advised that training regarding the programme is funded through a national budget, however this budget will decrease over the next 2 years due to implementation as a national pilot. It was advised that GP cluster work is ongoing to continue the support, however once national funding ceases, BCU will need to support GP practices to continue the work.

It was resolved that the Committee:

- **NOTED** the report.

[Jodie Morgan, Faye Graver, Sean Gallagher and Zoe Prince joined the meeting].

QS26.32 Service Presentation
Teresa Owen, Executive Director of Allied Health Professionals & Health Sciences

The Committee received the presentation on the Substance Misuse, Harm Reduction, Enhancing Lives and Helpline Services. The following points were highlighted through the presentation:

- The BCUHB SMS is the only remaining NHS treatment provider for SMS in North Wales.
- Referrals to the Substance Misuse Service (SMS) have doubled over the past 10 years, with an average of 1,100 referrals received by the service each quarter, and over 4,000 patients open to the service currently.

- The service notes a low number of staff vacancies, with emphasis on skill mix thought to lead to good retention rates. The vacancies that are listed are on the whole new vacancies as they are related to a new service being taken on.

[Teresa Owen left the meeting].

In discussing the item, the Committee:

- Queried the rate of unexpected deaths and how this is reported, referencing a previous query raised through the Expert Advisory Group (EAG). It was clarified that BCU is the only Health Board that includes substance misuse related deaths in the Mental Health deaths figure; other Health Boards do not as SMS services are provided separately from NHS MH services.
- Noted that within the National Dataset (currently available up until the end of 2024), BCU had lower rates of drug related deaths compared to other Welsh Health Boards. It was also clarified that as advised through HM Coroner, any death that occurs, where the individual is using drugs or alcohol is considered an unexpected death, and so is included in this figure.
- Agreed for a further briefing on unexpected deaths to be presented at a future meeting.
- Acknowledged the number of deaths, and potential impact of staff within the teams. It was advised that the team are well supported, with a MDT focus and occupational health support as required, with a strong emphasis on psychology.
- Noted the shift in referral reason. Approximately 10 years ago, majority of referrals related to opiate use, whereas currently the two main reasons for referral are regarding alcohol and ketamine.
- Emphasised the need to ensure best use of spaces and appropriate location of services.
- Thanked the team for their ongoing work, support and clarity given.

The following actions were agreed:

- **Action QS26.32.1**: a further briefing on unexpected deaths data to be presented at a future meeting.

[Jodie Morgan, Faye Graver, Sean Gallagher, Zoe Prince left the meeting].

It was resolved that the Committee:

- **NOTED** the update.

GOVERNANCE, RISK & ASSURANCE

QS26.33 Integrated Quality Report

The Executive Director of Nursing & Midwifery presented the item. The following points were highlighted:

- A recent wrong site surgery, in ED (Emergency Department) triggered a review of non-theatre procedures. Work is underway to strengthen governance, led by the Executive Medical Director.

- Recovery plans are in place regarding Infection Control, ensuring appropriate implementation of the new cleaning standards. This may require additional investment to implement.
- A prevention of future deaths (regulation 28) notice was received regarding Endoscopy and Gastroenterology. The Executive Medical Director is supporting the quality review, with actions underway.
- An increase in complaints is noted, many linked to insourcing pathways.
- Work is underway to reconfigure the PALs and complaints service to meet new national timescales through the new "Listening to People" framework. This will be explored further at the upcoming QSE development session.
- A report will come to the next meeting regarding mortality. It was agreed for this to be linked with action QS26.32.1 requested in the previous item.

[Teresa Owen rejoined the meeting].

In discussing the item, the Committee:

- Noted the "go live date" of 1 April 2026 for the Listening to People Framework, and noted requested delay to this start date from Llais.
- Noted additional demand that will be created through changes to the redress process.
- Queried the ongoing issue highlighted through national audit data regarding oxygen cylinders. The Executive Director of Nursing & Midwifery advised that this is a national issue and a piece of work is being coordinated by the Welsh Government to ensure consistent reporting.

The following actions were agreed:

- **Action QS26.33.1**: A report to come to the next Committee meeting regarding mortality with appropriate time allocated for discussion.

It was resolved that the Committee:

- **NOTED** the current position.

QS26.34 Integrated Performance Report

The report was presented by the Executive Director of Nursing & Midwifery. The following points were highlighted:

- No further escalations to note in addition to those highlighted in the previous item report (QS26.33).

In discussing the item, the Committee:

- Noted persistent concerns around access and activity, and the risk of harm that sits with those on waiting lists.
- Were advised of ongoing work to assess harm, and the most effective use of time and resource in manging waiting lists and reducing potential harm caused by long waits, and identifying high risk areas. Any incidents that are reported are reviewed by the medical executives.
- Noted the key role of the GP in supporting patients.

- Noted outsourcing of services regarding cataracts and the positive effects of this, as well as the upcoming opening of the Llandudno Orthopaedic Centre and the impact service should have on reducing waits.
- Noted some reduction in prevention and screening, but how further improvement was still required. It was advised that once Action QS25/11.1 and Action QS24/121.1 were complete, further work regarding this can be undertaken.
- Noted large, sustained improvement in clinical coding accuracy, being at 95%, queried the correction of errors figures, and emphasised the need for identifying the reason for errors to enable learning for future.

It was resolved that the Committee:

- **NOTED** the current position.

QS26.35 Corporate Risk Register

The Director of Corporate Governance presented the item. The following points were highlighted:

- There are two main risk areas: Timely Access to Care, and Regulatory Compliance.
  i) Timely Access to Care: multiple controls are in place, with additional reframing required following a recent deep dive to reduce the risk over the next 3 months. The deep dive also highlighted other areas of potential risk.
  ii) Regulatory Compliance: work is underway to map accountability and reporting lines across all compliance domains.

In discussing the item, the Committee:

- Queried the impact of Foundations for the Future on manging risk. It was advised that working is underway to map all areas of compliance, along with the relevant lead and compliance area to help reduce risk. A compliance report has been introduced to the Audit Committee to collate these areas.

It was resolved that the Committee:

- **NOTED** the report.

QS26.36 Challenged Services Update

The Executive Medical Director presented the report. The following points were highlighted:

- Plastics and Oncology remain stable and may be ready for de-escalation soon.
- Gastroenterology is recognised as requiring inclusion in fragile services.
- Orthodontics considered to be the most challenging, due to ongoing national issues around staffing and limited resource.
- Insourcing and outsourcing are used in several specialities to reduce waiting lists, however there are issues noted in some areas.

In discussing the item, the Committee:

- Noted good progress being made against a number of challenged services, and that BCU is now in a position to take ownership over these areas following guidance from the Welsh Government.

- Referenced some duplication of reporting to multiple Committees and emphasised that discussion remains relevant to the Committee receiving the update.
- Noted increased fragility within Urgent and Emergency Care, and the associated risk , with concerns escalated regarding ED pressures, delays, and safety risks associated with workforce fragility and reliance on temporary staffing.
- Noted the importance of ensuring the IMTP reflects service fragility and regional plans.

It was resolved that the Committee:

- **NOTED** the report.

[Liz Mckinney joined the meeting].

QS26.37 DECLO ALNET Act - Annual Report

The Item was presented by the DECLO regarding the Additional Learning Needs (ALN) Act Annual Report. The following key points were highlighted:

- BCUHB has achieved 95% compliance with statutory duties during this reporting period, covering Sept 24 – Aug 25.
- A legislative review is underway due to ambiguities in ALN interpretation across Wales. DECLO's across Welsh Health Boards are feeding into a national group to ensure consistency. A policy statement is expected from the Welsh Government.

[Stuart Keen joined the meeting].

- National KPIs are due to be implemented in 2026/27. Data areas that will feed into this are already captured through monitoring.
- There are challenges around funding, with the team supporting the compliance being funded through temporary monies. This has created difficulty with retention due to fixed term positions.

In discussing the item, the Committee:

- Noted the need for improved cross-sector alignment.
- Noted the requirement for legislative review of the Act, and it was advised that with changes approximately 20% of cases are no longer within remit, creating a large patient impact. It was hoped this would be kept under review following the legislative review.
- Noted feedback received from Welsh Government, but supported the welcomed request of a thematic report to pull together key themes.

It was resolved that the Committee:

- **NOTED** the report.

[Liz McKinney left the meeting].

IMPLEMENTING THE QUALITY MANAGEMENT SYSTEM (QMS)

QS26.38 Learning Repository

The report was presented by the Executive Director of Nursing & Midwifery. The following points were highlighted:

- The learning repository was identified as a requirement approx. 2 years ago, with the aim of a mechanism of sharing learning across the organisation consistently and reliably.
- A pilot is currently underway in Pharmacy which is nearing completion. Organisational roll out is planned from April 2026
- The system will be open for use by all staff, with a dashboard and search function, which will include anonymised information, using data from incidents, complaints, audits, greatix and patient/staff feedback.

In discussing the item, the Committee:

- Supported the implementation, noting the importance of sharing learning across the organisation.
- Requested a demonstration of the learning repository in a future development session following full organisational roll out.
- Highlighted the need for ensuring ease of access to all staff, noting that depending on their role, not all staff with have regular access to an electronic system, so to look at ways of disseminating to offline/ward-based roles.
- Were advised that work is ongoing to explore ability of information being pulled from different sources electronically rather than relying on individual input to ensure accuracy and regular inputs.
- Suggested update be received through Audit Committee on the item whilst in implementation stage for assurance.

The following actions were agreed:

- **Action QS26.38.1**: A demonstration of the learning repository to be given in a future development session.
- **Action QS26.38.2**: Update to be received at Audit Committee on implementation of the Learning Repository for assurance.

It was resolved that the Committee:

- **NOTED** the update.

IMPROVING QUALITY, OUTCOMES & EXPERIENCE

QS26.39 Adult Mental Health & Learning Disabilities

[Zoe Prince re-joined the meeting].

The item was presented by the Director of Nursing for Adult Mental Health. The following points were highlighted:

- Performance against the Mental Health Measure is strong. It was advised that due to special measure status the target is reduced. It was noted that performance was met for Part 1b during the period, and just under target for Part 1a and Part 2. It was noted however, that there is regional variance in relation to Part 2.
- West Area is an outlier regarding target waiting times, with short-medium term recovery plans and oversight plans in place.
- There is investment of £300K to further increase the crisis model.

- The position regarding Out of Area placements has significantly improved over the past 12 months, with BCU having the strongest position in Wales. Work is ongoing to further reduce these numbers.
- Introduction of the new Electronic Health Record is expected to significantly improve data quality and governance.

In discussing the item, the Committee:

- Noted the workforce remodelling taking place in relation to the crisis model, which is led by the Executive Director of Nursing & Midwifery.
- Were advised that whilst the Care Coordinator role cannot be fulfilled by a psychiatrist, this person can be someone who is already involved in a patient's care; it will not necessarily be an additional individual involved in the patient's care. It was requested for this also to be clarified through a future briefing for information.
- Noted the improvement seen in staffing levels across the division.
- Referenced earlier discussion regarding SMS figures, and noted the paper regarding mortality that will be received at the next meeting. It was requested that part 3 and 4 of the measure are also referenced within a future paper
- Noted the variation of collaborative working across BCU with partner agencies, with further progress required in some areas.
- Requested numerative figures referenced in the paper to also include percentages for future for reports.

The following actions were agreed:

- **Action QS26.39.1**: future briefing to clarifying regarding care coordinator role for inclusion for information at the next committee.
- **Action QS26.39.2**: future paper of MH to contain further information on Part 3 and 4 of MH measure.
- **Action QS26.39.3**: percentages for figures to be included in future reports.

It was resolved that the Committee:

- **NOTED** the report.

[Zoe Prince left the meeting].

EFFECTIVE ENVIRONMENT FOR LEARNING & SKILLS DEVELOPMENT

QS26.40 Medical Education

The item was presented by the Executive Medical Director. The following points were highlighted:

- It was clarified the information received is generated from the GMC survey completed by trainees, which enables the Health Board to judge quality, training and environment. Previously concerns regarding acute medicine in central and west area were received, triggering visit from HEIW.
- Following a visit in West Area in November 2025 metrics were put in place to improve. A further visit is expected in Central area imminently.
- Significant improvement has been seen in East area following previous visits.

In discussing the item, the Committee:

- Welcomed the link between data received and patient safety and experience signals.

It was resolved that the Committee:

- **NOTED** the report.

QS26.41 Research and Development Annual Report

The item was presented by the Executive Medical Director. The following points were highlighted:

- The importance of research and development was highlighted, as well as the impact this area can have on patient care, in how it can enable access to commercial trials that are otherwise inaccessible.
- The Chief Medical Officer (CMO) is interested in this work, with a review of Research and Development (R&D) models taking place.

In discussing the item, the Committee:

- Noted concerns over some risk areas, which reflect service pressures.
- Noted the impact of job planning on R&D.
- Referenced the wider research area, noting work ongoing with both Wrexham University and Bangor University regarding this.

It was resolved that the Committee:

- **NOTED** the report.

FOR INFORMATION

QS26.42 Corporate Governance Report

It was resolved that the Committee:

- **NOTED** the report.

QS26.43 Llais Monthly Report

In discussing the item, the Committee:

- Noted reference to concerns from patients regard treatment not received and advised that this specific issue had now been resolved.
- Noted issues raised regarding travel and timescales of waits for PET scan previously. It was advised that regarding this specific issue, an update was received by the Audit Committee, referencing new procurement regulations that had resulted in the delay. Lessons learnt have been identified from this, and the issue is now resolved. It was noted the support is given by other hospitals in Wales and West England to enable patients to be seen as close to home as possible in the circumstances.

It was resolved that the Committee:

- **NOTED** the report.

CLOSING BUSINESS

QS26.44 Agree Items for Referral to Board / Other Committees

It was agreed that the following should be referred to the Audit Committee:

- The Learning Repository.

QS26.45 Review of Meeting Effectiveness

It was agreed that the meeting ran well with good discussion.

QS26.46 Date of next meeting

7 May 2026

QS26.47 Resolution to Exclude the Press and Public

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

Quality, Safety and Experience Committee PUBLIC Action Log

Updated 29.04.26

Open Actions						
Action No.	**Minute Ref.**	**Date**	**Agreed Action**	**Lead**	**Time scale**	**Status**
Actions to remain open						
1	QS25/11.1	20.02.25	**QS25/11 Colonoscopy Performance Update** Clarify when the Colonoscopy data/paper can be reported back into QSE.	~~Exec. Dir. of Nursing & Midwifery **(Angela Wood)** to link in with Interim Chief Operation Officer)~~ **(~~Imran Devji~~)** **Tehmeena Ajmal – Chief Operating Officer**	~~May 2025~~ May 2026	**Remain Open** 24.02.25 From AW - Email sent to Imran, awaiting clarification 03.07.25 AW confirmed that she had met with Tehmeena Ajmal, COO. A further update will be provided at the November meeting. 07.01.26 – awaiting update 05.03.26 – AW advised with Chief Operating Officer. Awaiting update, and action lead updated. 13.04.26 – update requested 29.04.26 – to be merged with action QS24/121.1, with update to be provided in the meeting for context under matters arising.

2	QS26.5.1	15.01.26	**Patient Story:** National Carers Report to be reviewed by PPHP and QSE Committees when received.	Exec. Director of Nursing & Midwifery.	TBC	**Remain Open** Awaiting receipt of report. 05.03.26 – report not yet received. 26.03.26 – final version of report still outstanding. AW chasing. 29.04.26 – update from Rachel Wright - been no further update on the draft un-paid carer strategy. Formal consultation ended on 13 April 2026. Approval expected after May 2026
3	QS26.10.1	15.01.26	**Challenged Services** Utilisation of risk registers and risk flagging to be an item for QSE development session	Executive Medical Director	Sept 2026	**Remain Open** To be included at future development session.
4	QS26.38.1	05.03.26	**Learning Repository** A demonstration of the system to be given in a future development session	Exec Director of Nursing & Midwifery	Sept 2026	**Remain Open** To be included at future development session.
			Suggest Close			
1	QS26.39.3	05.03.26	**Adult Mental Health & Learning Disabilities** percentages for figures to be included in future reports	Exec Director of Allied Health Professions & Health Sciences	May 2026	Suggest Closure 12.03.26 – to be included in reports going forward
2	QS26.07.03	15.01.26	**Integrated Quality Report** Redress change process to be item on the QSE development	Exec Director of Nursing & Midwifery	March 2026	Suggest Closure 12.02.26 – Development Day scheduled

			day			for 16.03.26 with topic included
3	QS25.106.1	06.11.25	Cycle of Business to be reviewed ahead of the end of financial year	Director of Corporate Governance	May 2026	Suggest Closure 06.11.25 – referenced in 06.11.25 meeting as further action QS25.106.1 07.01.26 – action ongoing 25.02.26 – COB reviewed and further amendment needed to aligned with IMTP as agreed at Chairs Advisory Group 12.03.26 – added to draft agenda for agenda setting for May meeting.
4	QS26.32.1	05.03.26	**Service Presentation (SMS)** a further briefing on unexpected deaths data to be presented at a future meeting.	Exec Director of Allied Health Professions & Health Sciences	May 2026	Suggest closure 12.03.26 – to be included in MH update at next meeting.
5	QS26.33.1	05.03.26	**Integrated Quality Report** A report to come to the next Committee meeting regarding mortality with appropriate time allocated for discussion	Executive Medical Director	May 2026	Suggest closure 12.03.26 – added to agenda for May 26.03.26 – advised action complete.
6	QS26.38.2	05.03.26	**Learning Repository** Update to be received at Audit Committee on implementation of the Learning Repository for assurance.	Head of Corporate Governance	May 2026	Suggest Closure 20.03.26 - Transferred to audit committee for action.

7	QS26.39.2	05.03.26	**Adult Mental Health & Learning Disabilities** future paper of MH to contain further information on Part 3 and 4 of MH measure.	Exec Director of Allied Health Professions & Health Sciences	May 2026	Suggest closure 12.03.26 – referenced under item on agenda for May agenda 13.04.26 – agreed close. Information to be included in future reports.
8	QS26.39.1	05.03.26	**Adult Mental Health & Learning Disabilities** future briefing to clarifying regarding care coordinator role for inclusion for information at the next committee	Exec Director of Allied Health Professions & Health Sciences	May 2026	Suggest Closure 12.03.26 – for inclusion in future report. 13.04.26 – agreed close. Information to be included in future reports.
9	QS26.08.02	15.01.26	**Integrated Performance Report** Update on screening services to be given at a future meeting	Exec Director of Finance & Performance	May 2026	Suggest Closure Awaiting update. 05.03.26 – work is ongoing regarding updating the report. Action owner to be changed to the Executive Director of Finance & Performance. 12.03.26 – query added to draft agenda for May 29.04.26 – update to be given in May meeting by Deputy Director of Performance
10	QS24/121.1	24.10.24	**QS24/121 Integrated**	~~Exec. Dir. Allied Health~~	~~17.12.~~	Proposed closure

			Performance Report to speak to the Deputy Executive Medical Director to check the veracity of colonoscopy data provided in report, and to escalate concerns if required.	~~Professionals & Health Science~~ (**~~Teresa Owen~~**) ~~Interim COO~~ **(~~Imran Devji~~)** Chief Operating Officer **– Tehmeena Ajmal**	~~24~~ May 2025	**9.12.24** TO spoke with Deputy Executive Medical Director. Data/information is being checked by the team. **12.2.25** Jim McGuigan advised that Imran Devji was aware of this query and investigating. Update to be received at meeting 07.01.26 – awaiting update 05.03.26 – AW advised with Chief Operating Officer. Awaiting update. 13.04.26 – update requested. 29.04.26 – merged with action QS25/11.1.
Closed Actions (Closed at 05.03.26 meeting)						
Action No.	**Minute Ref.**	**Date**	**Agreed Action**	**Lead**	**Timescale**	**Status**
1	Board Meeting 30.01.25	Chair	**25/09.03 Citizens Engagement Report** A briefing on the new legislation due to be issued, to be discussed at a future QSE Committee.	Director of Partnerships, Engagement & Communication	January 2025	Closed 15.01.26 – "Listening to People Framework" to return as part of the quality Update Report at the next 20.01.26 – noted on draft agenda for Mar 26

2	QS26.06.1	15.01.26	**Rapid Quality Review – Emergency Department** Update of ED Rapid Quality Review to be included in the next Integrated Quality Performance report	Exec Director of Nursing & Midwifery / Exec Medical Director	March 2026	Closed 20.01.26 – to be covered on March agenda.
3	QS26.07.01	15.01.26	**Integrated Quality Report** Check action for march and demonstration regarding QMS system in relation to Mental Health	Exec Director of Nursing & Midwifery	March 2026	Closed 20.01.26 - to be covered on March agenda.
	QS26.08.01	15.01.26	**Integrated Performance Report** Update required regarding no.100% overdue follow up. Discussion between EW and AW outside of meeting to agree format	Exec Director of Nursing & Midwifery / Director of Performance	March 2026	Closed 20.01.26 - to be covered on March agenda.
	QS26.08.03	15.01.26	**Integrated Performance Report** Update to be requested from Kathryn Lang for assurance of accuracy of coding data.		March 2026	Closed 20.01.26 - to be covered on March agenda.
	QS26.11.01	15.01.26	**Womens Services Update** Update on progress to be brought to future meeting following submission to the Cabinet Secretary	Exec Director of Nursing & Midwifery	March 2026?	Closed 20.01.26 - to be covered on March agenda.
	QS26.08.04	15.01.26	**Integrated Performance Report** Diabetes to be added as topic for development session	Exec Director of Public Health	TBC	Closed 12.02.26 – agreed that topic no longer required for discussion at development

						centre.
	QS26.17.1	15.01.26	Development Session to be scheduled.	Head of Corporate Governance	March 2026	Closed 12.02.26 – arranged for March.
	QS26.07.02	15.01.26	**Integrated Quality Report** Date of the last PFD to be added to the Integrated Performance report for clarity.	Exec Director of Nursing & Midwifery	Januar y 2026	Closed Complete. To close

Quality Safety & Experience Committee

This Too Will Pass, My Bipolar Life - Patient Story

Date of Meeting	07 May 2026
Publication Status	Open/ Public
	Not Applicable
Report Author name and title	Rachel Wright – Patient & Carer Experience Lead Manager
Lead Executive Team Member name and title	Angela Wood, Executive Director of Nursing and Midwifery

Report Purpose	For Noting

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 of the experience and actions undertaken in response to the story is included in the paper.

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

Committee / Group / Individuals	Date	Outcome, Evidence and Data
N/A		

Acronyms / Glossary of Terms

https://youtu.be/uliVWOgd-7o

Subtitles available in Welsh and English via the settings menu.

1. Overview of patient Story

This patient story shares the experience of Chris, an individual who has lived experience with bipolar disorder for decades. His story offers a grounded perspective on the realities of navigating the condition day to day, including the hurdles, the hard-won coping strategies, and the impact it has had on his relationships, work and sense of self.

The storyteller has previously been the Vice Chair of Hafal a mental health charity, which is now known as Adferiad Recovery, and the Chair of Bipolar Disorder UK.

The story was created in partnership with the Patient Experience and MHLD team in collaboration with LLAIS, and produced Wild Kindness Films CIC to help shine a light on the realities of living with bipolar disorder.

The project was jointly supported by Awyr Las and LLAIS, in line with BCUHB's values of Compassion, Openness and Respect and the organisation's commitment to embedding lived experience in service design, training, and recovery-focused practice.

2. Summary of the story

The story aims to give mental health professionals a clearer sense of what the clinical picture looks like of living with bipolar disorder over a lifetime, helping teams engage with patients in a more human, less textbook-driven way.

The production includes a sit-down interview led by Hannah Mart, Peer Lead (MHLD), where Chris, speaks openly about the impact the condition has had on his life, from early experiences of depression, to periods of mania, to the relationships and employment challenges that followed. The film also explores stigma, coping strategies, and Chris' interactions with mental health services over many years.

"The video builds on the Health Boards existing commitment to co-production and patient experience. Behind Chris's mental health challenges illness is a man with so much to give, a gentleness, and an unwavering commitment to helping others. I am incredibly proud that Chris has had the opportunity to discuss in detail the impacts of mental health, and how his thoughts and views can be used to shape our services with lived experience front and centre, honouring our collective ambition to deliver outstanding patient experience" Leon Marsh, Head of Patient Experience.

Many people still carry outdated or unhelpful ideas about bipolar disorder, and hearing directly from someone who has spent years figuring out how to live with it is a powerful way to cut through misconceptions. For people who are themselves at an early point in their diagnosis, Chris's reflections offer the reassurance of shared experience and a sense of community. His insight, earned through years of trial, error, and adjustment,

may help others feel less alone and give them something practical to hold on to as they begin making sense of their own path.

The NHS has a duty to utilise the voice of Lived Experience as an integral part of improving the quality of care and service delivery. The NHS must make a commitment to improving outcomes for individuals with lived experience of mental distress and/or long-term physical health conditions. To create services shaped by the people who use them and to ensure that the voices of service users, carers, and families drive the design and development of improvement.

This includes:

- **Supporting and educating NHS staff:** Individuals with Lived Experience use their own recovery stories to support and educate others, ensuring that the voice of those with lived experience is embedded in service design and delivery.
- **Promoting recovery-oriented environments:** Individuals with lived experience can support the development and delivery of training and foster a culture of hope within MHLD.
- **Advocating for recovery principles:** Individuals with lived experience can shine a light and advocate for recovery principles through regular communication with colleagues and external partners.
- **Collaborating with external agencies**: Individuals with lived experience can support wider engagement with external agencies and voluntary care sector partners to promote a collaborative approach to partnership working, embedding the principals of true co-production.

The story will be used in the following ways:

- As an educational / training aid for MHLD and wider staff.
- During Mental Health Awareness week (May 2026).
- At the LLAIS national conference (February 2026) highlighting the importance of co-production.
- At a national level on key strategic groups.
- On social media, to break down barriers for those seeking to access services.

The Patient and Carer Experience Team extend their gratitude and appreciation to the storyteller for sharing their experience and to LLAIS and Awyr Las Charity for funding the production of the film.

3. Recommendations

3.1 The Committee is asked to note this report.

ASSESSMENT	
Link to Strategic Priorities	
	4. Improving quality, outocmes and experience
	If more than one applies, please list below: • Creating compassionate culture, leadership, and engagement. • Establishing an effective environment for learning.
Design Principles	People First If more than one applies, please list below: • Consistency with organisational values.
Corporate Risks and Board Assurance Framework	Not Applicable
Wellbeing of Future Generations Act – Wellbeing Goals	A Healthier Wales
	If more than one applies, please list below: • A more equal Wales. • A resilient Wales.

IMPACT ASSESSMENTS		
Equality *Have you undertaken an Equality Impact Assessment Screening (which includes the requirements of the Welsh Language Standards)*	Yes: ☐	No: ☒
	Outcome:	
	If no, please include rationale:	Not applicable
Socio-Economic Impact Assessment *Have you undertaken a Socio-Economic Impact Assessment*	Yes: ☐	No: ☒
	Outcome:	
	If no, please include rationale:	Not applicable.
Quality *Have you undertaken a Quality Impact Assessment Screening?*	**Enablers of Quality** All Apply	**Domains of Quality** All Apply
	If more than one applies, please list below:	If more than one applies, please list below:

Wellbeing of Future Generations Act – Wellbeing Goals	A Healthier Wales	
Environmental /Sustainability Impact (5Rs)	If more than one applies, please list below:	
	No - Not Applicable	
	If more than one applies, please list:	
Armed Forces Covenant Due Regard Duty Have you considered the Armed Forces Covenant Due Regard Duty?	Yes: ☐	No: ☒
	Outcome:	
	If no, please include rationale:	
Data Protection Impact Assessment *Have you undertaken a Data Protection Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	
	If no, please include rationale:	
Counter Fraud Impact Assessment *Have you considered the counter fraud impacts*	Yes: ☐	No: ☒
	Outcome:	
	If no, please include rationale:	
Legal	There are no specific legal implications related to the activity outlined in this report.	
Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Resource Impact *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

Quality Safety & Experience Committee

INTEGRATED QUALITY REPORT

Dyddiad y Cyfarfod **Date of Meeting**	07 May 2026
Statws Cyhoeddi **Publication Status**	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad **Report Author name and title**	• **Patient Safety:** Chris Lynes, Deputy Director of Nursing (Patient Safety) and Tracey Radcliffe, Head of Patient Safety • **Safeguarding:** Michelle Denwood, Director of Safeguarding and Public Protection • **IPC:** Deputy Director of Nursing Infection Prevention and Decontamination • **Patient and Carer Experience:** Chris Lynes, Deputy Director of Nursing (Patient Experience) and Leon Marsh, Head of Patient Experience • **Clinical Effectiveness:** Joanne Shillingford, Head of Clinical Effectiveness • **Quality Assurance:** Jo Kendrick, Head of Quality, Erika Dennis, Quality Lead Manager, Sarah Musgrave Quality Learning Business Manager • **Healthcare Law:** Matthew Joyes, Deputy Director for Legal Services and Debbie Kumwenda, Healthcare Law Lead Manager
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol **Lead Executive Team Member name and title**	• Angela Wood, Executive Director of Nursing and Midwifery (Lead Executive) • Dr Clara Day, Executive Medical Director • Teresa Owen, Executive Director of AHPs and Healthcare Science • Dr Jane Moore, Executive Director of Public Health

Pwrpas yr Adroddiad **Report Purpose**	For Noting

Crynodeb Gweithredol **Executive Summary**
This report provides the Committee with assurance, underpinned by analysis, on significant quality issues alongside longer-term data and information on the improvements underway.

Ymgysylltu (mewnol/allanol) yr ymgymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp) **Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)**		
Pwyllgor / Grŵp / Unigolion **Committee / Group / Individuals**	**Dyddiad** **Date**	**Canlyniad, Tystiolaeth a Data** **Outcome, Evidence and Data**
n/a		

Acronymau / Rhestr Termau **Acronyms / Glossary of Terms**	
AMaT	Audit Management and Tracking
BAT	Baseline Assessment Tool
CIW	Care Inspectorate Wales
EDON	Executive Director of Nursing
EICOP	Executive Integrated Concerns Oversight Panel
EMD	Executive Medical Director
HIW	Healthcare Inspectorate Wales
LFERs	Learning from Events Reports
LocSSIPs	Local Safety Standards for Invasive Procedures
LTP	Listening to People
NICU	Neonatal Intensive Care Unit
NRI	National reportable Incident
PES	People's Experience Survey
PET	Protected Education Time
PFD	Prevention of Future Deaths
PSOW	Public Services Ombudsman for Wales
PST	Patient Safety Team
NICE	National Institute for Health and Care Excellence
QMS	Quality Management System
SAoC	Service assessment of compliance
SCEG	Strategic Clinical Effectiveness Group
UEC	Urgent and Emergency Care
WRP	Welsh Risk Pool

INTEGRATED QUALITY REPORT

1.0 Y SEFYLLFA / SITUATION

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

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

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

2.0 Y CEFNDIR / BACKGROUND

2.1 The Health Board remains committed to delivering high-quality services across all areas of care. To provide assurance and drive continuous improvement, the Health Board routinely monitors a range of quality metrics. These measures enable informed decision-making, support organisational learning, and underpin growth and development.

2.2 This report summarises the Health Board's current position regarding quality performance and identifies key actions required to strengthen outcomes and achieve sustained improvement.

3.0 MATERION PENODOL I'W HYSTYRIED / SPECIFIC MATTERS FOR CONSIDERATION

3.1 **Never Events:** Two Never Events were reported this period; nine recorded in the last 12 months. Recurring themes identified (LocSSIP non-compliance and human factors). Full investigations underway with system learning review planned.

3.2 **Increase in NRIs** this period (20 vs 14). Median completion time remains best in Wales (75 days), though proportion open >90 days has increased. Ongoing focus on investigation timeliness and quality.

3.3 **Patient Safety Incidents:**
Incident backlog remains high (4,976 open; 58.9% overdue). Reduction target not achieved; refreshed recovery trajectories being agreed with IHCs and Divisions. Enhanced PST training and early-stage investigation improvements planned.

3.4 **Patient Safety Alerts & Medical Device Recall:**
Progress noted against national alerts; some compliance timelines extended. Significant Profemur hip recall affecting 821 patients with management plan and executive sponsorship in place.

3.5 **Patient Experience & Complaints:**
Complaints volume and overdue cases have increased, though overall performance remains among the best in Wales. Legislative transition to *Listening to People* successfully implemented.

3.6 **Quality Assurance:**
Progress continues against HIW action plans, though several remain overdue. Multiple new HIW assurance requests noted across acute and mental health services.

4.0 RISGIAU ALLWEDDOL / MATERION I'W HUWCHGYFEIRIO
KEY RISKS / MATTERS FOR ESCALATION

4.1 **Sustained incident investigation backlog** risks regulatory scrutiny, delayed learning and patient harm if improvement trajectories are not delivered.

4.2 **Rising Never Events**, including repeat events at the same site, indicate system control and compliance failures requiring urgent executive oversight. EMD has instigated a programme to identify and implement relevant learning.

4.3 **HIW overdue actions and rising assurance requests** signal continued regulatory pressure, particularly in emergency, vascular and mental health services.

4.4 **DXA scan delays (≈15 months)** pose a direct risk of avoidable harm from fractures within the Fracture Liaison Service as highlighted by national fractures audit.

4.5 **Complaints growth and behavioural themes**, particularly within insourced services, risk reputational impact and workforce relationships if not addressed.

5.0 ARGYMHELLION / RECOMMENDATIONS

5.1 The Committee is asked to take the report as assurance. All exceptions noted in this paper are being monitored and have management plans to track completion. These action plans are tracked through core quality forums.

ASESIAD / ASSESSMENT		
Cyswllt â'r Blaenoriaethau Strategol **Link to Strategic Priorities**	     4. Improving quality, outcomes and experience	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below: 4. Improving quality, outcomes and experience Simplify, Standardise, and Adopt Best PracticesSimplify, Standardise, and Adopt Best Practices	
Yr Egwyddorion Dylunio **Design Principles**	Simplify, Standardise, and Adopt Best Practices Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd **Corporate Risks and Board Assurance Framework**	Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR) BAF-SP18 and CRR-24-04 – Quality, Innovation and Improvement	
Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant Wellbeing of Future Generations Act – Wellbeing Goals	A Healthier Wales	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
ASESIADAU O EFFAITH / IMPACT ASSESSMENTS		
Cydraddoldeb *A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o'r Effaith ar Gydraddoldeb (sy'n cynnwys gofynion Safonau'r Gymraeg)* **Equality** *Have you undertaken an Equality Impact Assessment Screening (which includes the requirements of the Welsh Language Standards)*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	*n/a*

Asesiad o'r Effaith Economaidd-gymdeithasol *A ydych chi wedi cynnal Asesiad o'r Effaith Economaidd-Gymdeithasol?* **Socio-Economic Impact Assessment** *Have you undertaken a Socio-Economic Impact Assessment*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	*n/a*
Ansawdd *A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	**Galluogwyr Ansawdd** **Enablers of Quality** All Apply	**Meysydd Ansawdd** **Domains of Quality** All Apply
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant **Wellbeing of Future Generations Act – Wellbeing Goals**	A Healthier Wales	
Effaith Amgylcheddol / Cynaliadwyedd (5Rs) **Environmental /Sustainability Impact (5Rs)**	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
	No - Not Applicable	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:	
Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog A ydych chi wedi ystyried Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog: **Armed Forces Covenant Due Regard Duty** Have you considered the Armed Forces Covenant Due Regard Duty?	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	n/a

Asesiad o Effaith ar Ddiogelu Data *A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?* **Data Protection Impact Assessment** *Have you undertaken a Data Protection Impact Assessment Screening?*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	n/a
Asesiad o Effaith ar Atal Twyll *A ydych chi wedi ystyried yr effeithiau ar atal twyll?* **Counter Fraud Impact Assessment** *Have you considered the counter fraud impacts*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	n/a
Cyfreithiol **Legal**	Yes (Include further detail below)	
Enw Da **Reputational**	Yes (Include further detail below)	
Effaith ar Adnoddau *(Pobl / Ariannol)* **Resource Impact** *(People / Financial)*	Yes (Include further detail below)	
	Implementation of LTP framework April 2026	

6.0 PATIENT SAFETY

6.1 PATIENT SAFETY INCIDENTS

6.1.1 **Incidents**

There are currently 4976 open incidents of these, 58.94% are overdue, which is a consistent position to the previous reporting period. The number of closed incidents versus the number of opened incidents is a similar number each week. A target to achieve a 40% reduction by March 2026 has not been achieved, and the Patient Safety Team (PST) are in the process of meeting with IHCs and Divisions to refresh and agree trajectories

6.1.2 The Patient Safety Team continues to provide a comprehensive programme of training, support, and targeted interventions to strengthen incident management processes and reduce the backlog.

6.1.3 Continued efforts are ongoing to build upon existing improvements of incident performance, along with efforts focussed on the earlier part of the process (namely investigation initiation and ongoing investigation management). Arrangements are also in progress to provide more training sessions for services. This training will focus on investigation types and the level of detail and format required. The training is scheduled to commence from April 2026 and provided by the Patient Safety Team.

6.1.4 **Nationally Reportable Incidents**

From 01st February 2026 to 31st March 2026, there were 20 Nationally Reportable Incidents (NRIs) submitted (by incident date) compared with 14 for the previous reporting period. These can be categorised as follows: -

BCU UHB top 10 NRI categories occurring by volume (incident dates between Feb-26 and Mar-26) as of 07/04/2026

NRI category	Total
Infection outbreak / period of increased incidence	4
Neonate	3
Clinical assessment, clinical diagnosis	2
Healthcare Acquired Infection (community, primary care or hospital)	2
Treatment or procedure issues	2
Unexpected death	2
Access to services or admission delayed	1
Bed availability (general)	1
Discharge	1
Patient injury	1
Self-harm / self-injurious behaviour	1

The total number of NRI investigations that were open as at the end of January 2026 was 47 with 7 overdue closures.

6.1.5 The proportion of NRIs that remain open for more than 90 days has increased from 21.5% to 33%. The median working days to completion is the lowest in Wales at 75 compared to the All-Wales median of 125 days.

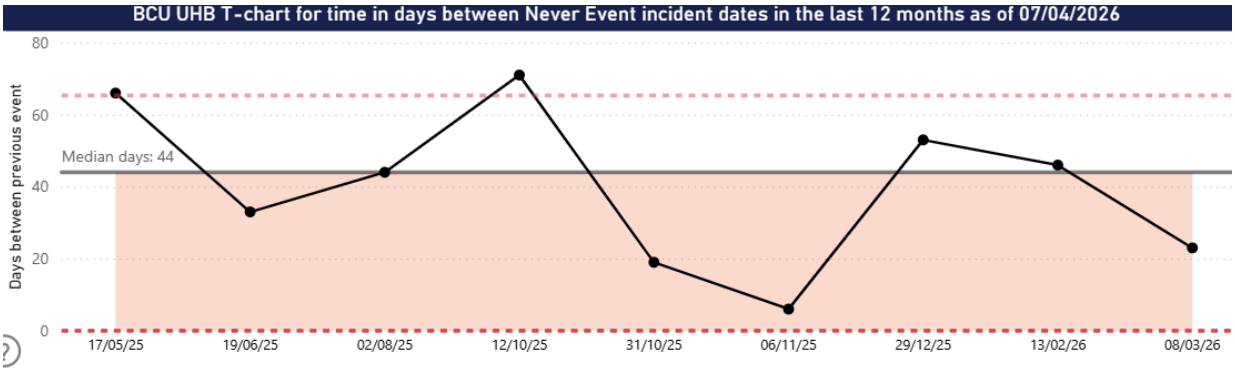
6.1.6 A total of 21 NRI outcome forms were submitted to NHS Wales Performance and Improvement for closure during February 2026 and March 2026. Further detail and learning from a sample of these closures can be found in the confidential quality report.

6.1.7 **Never Events**

The Health Board reported two Never Events occurring in the reporting period. One relates to a wrong implant/prosthesis, noting that an almost identical Never Event was reported in October 2025, both occurring at the same hospital site. The second Never Event was wrong site surgery (Dermatology in-sourcing).

Year	2025									2026		
Never Event	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Administration of medication by the wrong route	0	1	0	0	0	0	0	0	0	0	0	0
Retained foreign object post procedure	0	0	0	0	1	0	0	1	0	0	0	0
Wrong implant/prosthesis	0	0	0	0	0	0	1	0	0	0	1	0
Wrong site surgery	0	0	1	0	0	0	1	0	1	0	0	1
Total Never Events	**0**	**1**	**1**	**0**	**1**	**0**	**2**	**1**	**1**	**0**	**1**	**1**

6.1.8 Never Events occurring within BCUHB continues to rise, with 9 Never Events reported in a rolling period, April 2025 to March 2026, with limited time between events, 44 median days.



6.1.9 Both Never Events are currently going through the full investigation process, along with review of the previous incident in October 2025. Initial findings indicate a common and recurring theme of process error (absence of LocSIPPs, LocSIPPs missing some elements or failure to follow LocSSIPs), along with human error. Following the review and comparison of both events, a report will be provided.

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

6.2 PATIENT SAFETY ALERTS

Patient Safety Team have circulated 2 national alerts, 4 Field Safety Notices, 1 MHRA alert, and 2 pharmacy updates.

6.2.1 **PSA019 Delayed administration of Rasbricase:** Meeting held with Cancer Leads (13.03.26). Amended adult flowcharts now progressing through local site governance. PST has contacted Alder Hey for paediatric guidance. Compliance was due 28/02/2026 but delayed due to further information required from Cancer Services.

6.2.2 **PSA020 – Incorrect Recording of Penicillin vs Penicillamine Allergy:** Deadline for compliance is 30/11/2026. ePMA rollout progressing well. System warnings and reporting options being explored. Follow-up meeting planned post-rollout.

6.2.3 **PSA021 – Risk Associated with Adult Breathing Circuits Lacking a Patent Exhalation Route:** Deadline for compliance is 28/08/2026.
A working group is planned, with confirmed clinical lead. Nominations have been received from IHC West and East. IHC Central have advised that these circuits are no longer in use within their area.

6.2.4 **Profemur Hip Replacements (DSI/2025/005):** Profemur Cobalt Chrome Modular Neck Hip Replacements: Higher than anticipated risk of revision surgery, metal-wear effects and component fracture. Field Safety Notice Recall.

- Total of 821 patients in this cohort
    - IHC West x 105
    - IHC Central x 716
    - IHC East x 0

A management plan including resource requirements has now been developed and is in the implementation phase.

6.3 SAFEGUARDING

6.3.1 **Safeguarding and Public Protection Training compliance**

Primary Care Protected Education Time (PET) Safeguarding and Public Protection Training
A strong partnership between the Primary Care Academy and Safeguarding & Public Protection has enabled successful planning and the delivery of safeguarding training across Primary Care, including clusters. During 2025-2026 Safeguarding was identified

as a high-priority PET topic through the Academy's training needs analysis, which supported the delivery of two Safeguarding training sessions.

The positive feedback and responses have supported future engagement and an annual safeguarding education programme for Primary Care, is in place for 2026-2027.

6.3.2 Attendance and Evaluation

- A total attendance of 1,520 was recorded during the identified period.
- Evaluation feedback was highly positive, with over 80% 'strongly agree' ratings for content, clarity, engagement, and confidence in applying learning. Free-text comments were also positive, highlighting strong presentation quality and valuable case studies.
- Safeguarding Level 2 was delivered to administrative staff and Level 3 children & Adult at Risk Module A to GP's, included Nursing staff and allied professionals.

6.3.3 Safeguarding Training for Primary Care 2026 -2027

- Three sessions for Level 3 Safeguarding Adults Level 3 Exploitation Module B.
- Three sessions for Violence Against Women Domestic Abuse and Sexual Violence (VAWDASV) Group 2: Ask and Act Training.

6.3.4 Safeguarding Training for GP Out of Hours Teams (OOH) 2026-2027

- Level 3 Safeguarding (Children and Adults).
- Violence Against Women Domestic Abuse and Sexual Violence (VAWDASV) Group 2: Ask & Act training.

To support improved compliance and ensure Out of Hours GP teams have equitable access to essential safeguarding learning with these sessions, training will be delivered outside of core hours.
Training compliance remains a key agenda item within the Safeguarding Governance and Reporting Framework, with targeted intervention as required.

6.3.5 Assurance and Reassurance

At the North Wales Safeguarding Board earlier this year, we shared the positive Health Inspectorate Wales (HIW) Report findings from the Hergest; Mental Health Unit, which demonstrated good knowledge and understanding of safeguarding processes. The information was well received.
One Board member was concerned that some recommendations from the report were similar in context to recommendations previously actioned by the MHLD Division from the Tawel Fan report completed by HASCAS in 2018.
As a result, the North Wales Safeguarding Board have asked for assurance specific to the ongoing work undertaken by the MHLD Division in relation to these recommendations across all MHLD services.

6.3.7 Action to provide assurance

- BCUHB Director of Nursing MHLD, will consider the independent work undertaken by the Royal College of Psychiatry in relation to the actions and recommendations from HASCAS.
- Any areas requiring additional assurance will be discussed in collaboration with the Safeguarding and Public Protection Team and cross referenced against Datix and / or other incidents to provide assurance and reassurance of full implementation and progress.
- The findings will be reported within the Mental Health governance and reporting activities with an update provided to the North Wales Safeguarding Board.

6.4 INFECTION PREVENTION AND CONTROL

6.4.1 Strategic Improvement Goals (2025-2027)

Performance against the six key HCAI improvement goals is mixed, with four organisms currently exceeding their target trajectories:

Goal Area	Target	Current Status vs. Trajectory
E. coli (Hospital-onset)	10% Reduction	Below trajectory (-3 cases)
MRSA	< Previous Year	Below trajectory (-3 cases)
C. difficile	25% Reduction	Above trajectory (+17 cases)
Klebsiella (Hospital-onset)	10% Reduction	Above trajectory (+7 cases)
Pseudomonas (Hospital-onset)	10% Reduction	Above trajectory (+6 cases)
MSSA	20% Reduction	Above trajectory (+37 cases)

Additional expectations:

Goal Area	Target	Current Status vs. Trajectory
Klebsiella (community onset)	< Previous Year	Below trajectory (-8 cases)
Pseudomonas (community onset)	< Previous Year	Above trajectory (+8 cases)
Staphylococcus aureus	< Previous Year	Above trajectory (+34 cases)

Additionally, a clinician-led audit on hospital-acquired pneumonia is currently in the planning stages.

6.4.2 Outbreak Management

Outbreak activity peaked in February and March, there were 20 reported outbreaks primarily driven by Norovirus. Others were COVID (2), C. diff (5) and CPE (1)

Impact:

- 13 full ward closures

376 total bed days were lost, with Norovirus accounting for 91% (342 days)

7.0 PATIENT EXPERIENCE

7.1 COMPLAINTS

7.1.1 The following table displays key complaints metrics as of 30th March 2026

Metric	Current Status	Trend (vs. previous period)
Total Open Complaints	311	Increase from 291
Number Overdue	69	Increase from 49
Compliance with 75% Target	77.81%	Decrease from 83.16% (but remains above target)

Between 1st February 2026 and 31st March 2026, the Health Board received 553 complaints, and closed 547 complaints a negative variance of 6.

7.1.2 The top three themes of current open complaints are as follows

Delay/Lack of diagnosis	17
Incorrect/insufficient treatment or Assessment	66
Delay/Lack of treatment or Assessment	85

There has also been a rise in complaints relating to attitude and behaviour and communication, both of which can be directly attributed to increased activity within insourcing.

The Health Board's national performance provides significant assurance:

7.1.3 **Average Closure Time:** The Health Board is the best performing health board in Wales, resolving complaints in an average of 21 working days.

7.1.4 **Real-Time Performance:** The Health Board has consistently performed better than the Welsh national average for closing complaints within 30 days of receipt since September 2024.

7.1.5 **Overdue Complaints:** The Health Board's performance on overdue complaints remains as the third best in Wales, and significantly better than other health boards of a comparable size. We contribute just 49 complaints of the 1192 that are overdue nationally.

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

The core aims of this new framework are to:

7.1.7
- Enhance safer care delivery through listening and acting on feedback.
- Promote an open and just culture.
- Increase transparency and trust.
- Mitigate future harm and support staff learning.
- Meet legal and ethical standards.

During February and March 2026 all key milestones were met on time and to schedule, with the Health Board meeting the deadline for implementation.

7.1.8

7.2. PATIENT FEEDBACK

7.2 Feedback

7.2.1 The Patient Advice and Liaison Service (PALS) resolved 1561 enquiries between 1st February 2026 and 30th March 2026.

7.2.2 The Top 3 enquiry themes included appointments, communication issues and clinical treatment and assessment. During this period, the service also received 83 written compliments praising general care and respect and 17 suggestions for improvement.

7.2.3 Findings from the All-Wales People's Experience Survey (PES) remain highly positive. Based on 12,168 responses, 86.2% of patients rated their overall experience as 'Good (18.06%)' or 'Very Good (68.14%)'. Satisfaction levels were high with people reporting they were 'Always' treated with dignity and respect (86.18%) and being able to communicate in a preferred language (90.28%) which exceeded the national benchmark of 85% satisfaction.

7.2.4 Furthermore, to ensure the Health Board is open and accessible to receive feedback the NHS Wales People's Experience Survey is now available in 9 top languages spoken in Wales, including a BSL video survey.

The following quote identifies one of the positive experiences reported:

"Everyone who cared for mum did so with full care and respect. The care also extended to myself and my family. I can't thank the full team enough for their care and devotion to my mum and myself during our time on AMU." (Wrexham Maelor Hospital, AMU Assessment Ward).

7.2.5 The Easy Read version of the PES also yielded positive results, with 87.04% of respondents sharing a positive experience (good and very good). The Health Board was involved in the implementation of new All Wales Listening to People Survey focused on the concerns process that went live from 1 April 2026.

7.2.3 **Advocacy and Support**

7.2.3.1 The Chaplain and Spiritual Care Service responded to 140 requests for support from staff, patients, relatives, and community faith leaders in the reporting period.

This focus on the patient's experience of care is matched by an equal focus on the effectiveness of the clinical care provided.

7.3 OTHER PATIENT EXPERIENCE UPDATES

7.3.1 Nothing further to note.

8.0 CLINICAL EFFECTIVENESS

8.1 CLINICAL AUDIT

8.1.1 During February and March (Quarter 4), there were three Tier 1 national clinical audits published, all are scheduled for reporting during April and May 2026. **Four National Audit reports have been published in Quarter 4, all included BCU identifiable data.** The table below outlines the benchmarking information:

Tier 1 Project reference	Title	*Performance against*	
		National Benchmark	***Last BCU report***
NCAORP/ 2025-26-05	Fracture Liaison Service (FLS) Database Steps to fracture liaison service effectiveness: importance of treatment recommendations **Update noted end of table*	R	No comparable data as first report BCUHB YGC participated in
NCAORP/ 2025-26-14	National Lung Cancer Audit (NLCA) State of the Nation Report 2026	G	G
NCAORP/ 2025-26-42	National Clinical Audit of Psychosis (NCAP): State of the Data Report 2025 (2025 period)	G	G

	Exploring the quality and completeness of routine data for EIP		
NCAORP/ 2025-26-22	National Paediatric Diabetes Audit (NPDA) 2026 Report on Care & Outcomes (2024/25)	G	G

Key	***Comparison with National Benchmark*:**	***Comparison with Last BCUHB Report*:**
R	Where BCUHB reported performance is at or above the benchmark in fewer than 50% of KPIs	Where the previously reported BCUHB performance has deteriorated in more than 50% of Key performance indicators (KPIs) according to the latest National audit report
A	Where BCUHB reported performance is at or above the benchmark in 50% to 74% of KPIs.	Where the previously reported BCUHB performance has been maintained or improved in 50% to 74% of KPIs in the latest reporting period.
G	Where BCUHB reported performance is at or above the benchmark in 75% or more of KPIs.	Where BCUHB has maintained or improved in 75% or more of KPIs since the previous reporting period

**Update on Fracture Liaison Service (FLS)*

This service operates exclusively from the YGC site; therefore, the data reflects this site only. The action plan will be overseen via SCEG.

Notable Strengths – above All Wales average	**Indicators falling below national benchmarks**	**Main Concerns/Risk identified**	**Improvement Actions Planned**
• Bone health assessments completed within 90 days (KPI 4). • Strength and balance programmes delivered (KPI 8). • Bone-strengthening	• Not enough fractures identified and recorded (KPI 2–3). • Significant delays for DXA scans (KPI 5). • Incomplete falls assessments (KPI 6).	• DXA waiting time around 15 months, delaying diagnosis and increasing risk of further fractures.	• Standardise data entry. • Improve coding accuracy, increase follow-up capacity. • Share findings with

treatment initiated by first follow-up (KPI 10).	• Inconsistent treatment recommendations (KPI 7). • Monitoring and follow-up data incomplete (KPI 9 & 11).		Bone Unit team. • Monitor progress via audits and reporting.

8.2 NICE GUIDELINES

8.2.1 The Health Board continues to make steady progress in improving the recording and monitoring of compliance with NICE guidance. This improvement reflects the ongoing support provided to clinical departments and the successful embedding of the Audit Management and Tracking (AMaT) system across services.

8.2.2 To enhance oversight, instances of '**Not Achieved'** compliance (where the service **has not met the standards** that the National Institute for Health and Care Excellence (NICE) recommends) are now being escalated to Strategic Clinical Effectiveness Group (SCEG) to provide targeted support and drive improvements in compliance. The responsible service must put together an action plan or Baseline Assessment Tool (BAT) in place to show how they are planning to meet the national standard in the near future and the timescale for this to be achieved.

8.2.3 A recent internal audit has been completed and the Health Board response has been submitted. The audit highlighted that some clinical leads were able to bypass the full compliance review process by overriding their responses within AMaT. In response, AMaT is working on removing this functionality, and the Clinical Effectiveness NICE team will contact the clinical leads who have used the override to ensure the required compliance reviews are completed in full.

8.3 MORTALITY REVIEW

8.3.1 A corporate mortality update is presented separately within the meeting, alongside an analysis of mortality metrics in the CHKS Annual Report for BCUHB (2024-25) and a review of deaths in patients known to mental health and learning disability services including deaths from suspected suicide.

8.3.2 Corporate mortality papers highlight the continued improvement in RAMI since August which has corresponded with attainment of 95% target for clinical coding completion. The East and Central IHC mortality panels have reviewed a historical backlog of cases and learning has been shared within relevant organisational forums. Thematic concerns raised by the Medical Examiner Service continue to be monitored and are currently a deeper dive into concerns relating to DNACPR

decision-making and wider aspects of treatment-escalation planning is being completed.

9.0 QUALITY ASSURANCE

9.1 HEALTHCARE INSPECTORATE WALES

9.1.1 HIW inspection action plans remain in progress, with some overdue actions requiring continued monitoring. Recent assurance requests relate to staffing, safety, person-centred care and environmental issues.

The Quality Assurance Team continue to work with clinical areas to progress action plans, the below are all open HIW improvement plans, with targeted plans to progress completion.

9.1.2 **Inspections**

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

- **Status:** Overdue
- **Recommendations:** 28
- **Actions:** 66 total; 65 completed (98%)
- **Outstanding:** 1 action remains (Progress the ED nurse staffing Business Case with Executives to determine long term staffing levels in order to meet the recommended standards.)
- **Closure Date:** TBC
- **Governance:** Continuous monitoring via Local HIW Review Meeting, Regulatory Assurance Group (RAG), and Executive Quality Delivery Group (EQDG).

Inspection – Hergest Ward, Ysbyty Gwynedd (6th to 8th September 2025)

- **Status: Complete**
- **Recommendations:** 26
- **Actions:** 47 total; 47 completed (100%)
- **Closure Date:** 31st May 2026 (Closed on 31st March 2026)
- **Governance:** Progress monitored through Local HIW Review Meeting, T4 Programme Group, Regulatory Assurance Group (RAG), and Executive Quality Delivery Group (EQDG)

Inspection – Pantomime Ward, Ysbyty Maelor (14th to 16th October 2025)

- **Status:** Overdue
- **Recommendations: 18**
- **Actions:** 42 total; 32 completed (76%)
- **Closure Date:** 31st July 2026
- **Governance:** Progress monitored through the Local HIW Review Meeting, East Patient Safety Quality Delivery Group, Regulatory Assurance Group (RAG), which reports directly to the Executive Quality Delivery Group (EQDG).

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

- **Hafod Community Mental Health Unit (Feb 26)**
  Assurance request following concerns received via email from the father of an individual raising concerns about his daughter's safety and the current management of her mental health care. This was relating to Out of Area Placement and previous patient experience.
- **Nant Y Glyn Community Mental Health Unit (March 2026)**
  Assurance request from HIW highlighted concerns regarding an individual who has been struck off by Nant y Glyn CMHT after missing an appointment. This now places him in a difficult situation as he is unable to access repeat prescriptions.
- **Emergency Department Ysbyty Glan Clwyd, IHC Central (March 2026)**
  Assurance request from HIW in relation to an early warning notification they had received regarding a patient who sadly died in a corridor area.
- **Ogwen Ward, Ysbyty Gwynedd (March 2026)**
  Assurance request from HIW in relation to patient handover, lack of leadership, patient dignity, pain assessment, palliative care and bereavement support issues.
- **Vascular Services, Pan BCU (March 2026)**
  Assurance request from HIW for the Health Board to provide a comprehensive summary of the trends and themes identified from Datix incidents recorded over the past two years, together with the actions taken in response. The Health Board must also detail any demonstrable improvements arising from these themes since work commenced within the Vascular Service following HIW's review.

9.2 CARE INSPECTORATE WALES

9.2.1 Care Inspectorate Wales (CIW) inspections found no immediate concerns and improvement plans remain on track.

9.3 URGENT AND EMERGENCY CARE (UEC) QUALITY OVERSIGHT

9.3.1 As described previously, a Rapid Quality Review addressing concerns in UEC was held in November 2025 to ensure clear identification of quality concerns, with defined governance routes for oversight and pathways for improvement.

9.3.2 Oversight of defined quality metrics is held fortnightly as part of Executive Integrated Concerns Oversight Panel (EICOP). Each IHC reports in a structured manner outlining performance, incidents (including defined 'must report' incidents) and complaints. In addition, IHCs report daily forward waiting data, episodes of boarding *in extremis,* numbers receiving care in undesignated areas, and a now standardised audit of intentional rounding for those in undesignated areas.

9.3.3 Following an incident at YGC, a review of corridor care placement has been undertaken with a cap of 12 patients introduced. Areas defined as appropriate have been identified by local staff and agreed by the EMD and EDON.

9.3.4 Incidents within the UEC pathways meeting the criteria for review in EICOP continue to be reviewed at rapid review stage. Learning has included:

- the need for review of falls assessments and management in emergency care
- the need for prompt review and clarity of ownership by specialist teams
- the need for provision of access to digital systems for all non-substantive staff
- the need for learning around chest drain placement and care
- the need for clear communication with forward waiting patients

9.3.5 Work is also in place via the CEO chaired weekly UEC oversight meeting to ensure review of all documentation associated with dynamic risk assessment within UEC pathways and learning from the first three months of implementation of the Forward Waiting SOP.

9.4 PUBLIC SERVICES OMBUDSMAN FOR WALES

9.4.1 PSOW has legal powers to investigate complaints about public services and independent care providers in Wales. PSOW investigates complaints from members of the public about alleged maladministration and service failure.
When the Ombudsman investigates a complaint and thinks that something has gone wrong, they prepare a report to summarise their findings. Sometimes, where there is a need for wider learning, or what went wrong was significant, or in the interest of the public, a Public Interest Report (PIR) is issued.

There are **52 active Ombudsman cases** across the Health Board.

9.4.2 **Final Public Interest Report (Escalated):** One Public Interest Report remains open due to an outstanding action on the Commissioning Assurance Framework (CAF). Although a revised deadline of 31 January 2026 was agreed with the Ombudsman, this was not met. A further extension has been granted by PSOW until 15 May 2026.
CAF is being presented at the Confidential BCU Performance, Finance & Information Governance (PFIG) Committee on 28 April 2026 for endorsement.

9.4.3 **New Public Interest Report:** A further Final Public Interest Report was received March 2026 with 6 recommendations for implementation. All actions are progressing in line with agreed timescales.

9.4.4 **Performance Metrics (March 2026):**

	March 2026	Feb 2026	Jan 2026	Dec 2025	Nov 2025	Strategies in place for improvement
Total Contacts Received	45	35	41	28	41	**Strengthening Complaint Handling & Early Resolution** • Focus on resolving issues quickly and compassionately, reducing escalation to the Ombudsman. • Embed the Listening to People Framework (2026) to ensure responsiveness and empathy in complaint handling. • Build a culture of continuous learning, using patient feedback, incident reviews, and Ombudsman recommendations to drive improvement across all services. **Integration with Governance & Quality Systems** • Ensure timely compliance with Ombudsman recommendations through stronger tracking and a unified Quality Dashboard. • Enhance Board oversight by embedding Ombudsman reporting into the Quality, Safety & Experience Committee from 2026. • Introduce clear escalation routes so missed deadlines are addressed promptly at Executive level. **Collaboration & External Engagement** • Benchmark performance with other Welsh Health Boards to set realistic improvement targets. • Maintain open, proactive engagement with the Ombudsman's Office to clarify expectations and strengthen relationships. • Align internal reporting with Ombudsman data to ensure accuracy, consistency, and transparency.
New Full Investigations Received by PSOW	3	3	3	4	4	
Complaints Upheld / Partially Upheld	7	5	2	2	0	
Average Response Time *						
PSOW Recommendations Issued in month	31	28	5	20	6	
Compliance with all Open PSOW Recommendations *	91%	97%	79%	80%	33%	
Number of Final Public Interest Reports Received	1	0	0	0	0	

Performance monitoring continues to show high levels of Ombudsman activity, with 45 contacts received in March 2026, an increase from 35 in February. The number of new full investigations remained steady at 3, while complaints upheld or partially upheld rose to 7, indicating a need for continued focus on early resolution and complaint quality.

Recommendations continue to rise, with 31 issued in March, up from 28 in February and 5 in January. Despite this, compliance remains high at 91%, reflecting strengthened internal tracking and governance oversight.

One new public interest report was issued in March 2026.

Average response time remains unreported due to Datix limitations, but system improvements are underway on an All-Wales level, to enable more accurate tracking. The Ombudsman page on Datix has been updated from 01/04/2026.

9.5 QUALITY SCORECARD

9.5.1 The Quality Score Card has now been approved by the Health Boards Dashboard Group. This means we can promote and launch the score card. Subject Matter Experts have previously tested the score card. There will be a launch for the scorecard on Betsinet followed by Quality Score Card workshops.

9.6 Quality Management System (QMS) Implementation

9.6.1 Over the past 12 months, BCUHB has progressed the development of a Quality Management System (QMS) framework**,** moving from early evaluation to structured deployment planning. Key infrastructure has been established, including **a** digital QMS Maturity Assessment tool**,** governance structures, and supporting digital architecture using Dataverse, Power BI and SharePoint to enable monitoring, reporting and resource sharing. Early implementation has begun across a range of

clinical services, with engagement from Corporate Teams and subject matter experts to populate tools, document templates and best practice resources.

9.6.2 Governance and oversight have been strengthened through the establishment of a Strategic Group with clinical and non-clinical representation, alongside regular engagement with executive leadership, national partners and organisational service leads. The development of a QMS Policy, benefits framework, and communications plan is underway to support formal adoption and long-term sustainability.

9.6.3 Engagement and communication activity has increased through service-level presentations, national forums, conferences and refreshed “Journey to Date” materials for Board development sessions. A six-month evaluation and learning review have been completed to inform future priorities and align the programme with organisational transformation initiatives, including the organisational restructure - Foundations of the Future programme.

9.6.4 While progress remains strong and delivery is broadly on track**,** long-term sustainability remains constrained by the absence of dedicated funding and permanent resource**.** The next phase will focus on embedding QMS practices into core business as usual, finalising policy and governance arrangements, expanding organisational rollout, strengthening communications and training needs as well as also developing data reporting to inform learning and improvement.

9.7 ORGANISATIONAL LEARNING

9.7.1 The BCUHB Digital Learning Repository continues to progress as planned following the successful completion of Phase 1. Medicines Management remains the Health Board’s early adopter service, with the repository supporting a growing programme of validated learning briefings. A second Health Board-wide learning output has recently been shared via Medicines Management, focused on methotrexate safety, demonstrating the repository’s effectiveness in enabling consistent, high-quality learning to be shared at scale across the organisation.

9.7.2 Further learning outputs are in active development, including a forthcoming briefing on chest drain safety, with delirium identified as the next priority area for organisational learning shared via the repository. This reflects increasing confidence and capability in using the repository to support thematic learning across key patient safety risks.

9.7.3 The Mental Health Division has formally expressed interest in becoming an early adopter, and engagement is progressing to support their involvement as part of the wider phased rollout. Early adopter work is on schedule and aligned with the agreed implementation plan for 2026.

9.7.4 System development continues, with the developer progressing work to centralise and automate the pulling of data into the repository. This will enable improved cross-referencing and triangulation of information from multiple sources, supporting stronger thematic analysis and insight. This development work will continue over the coming months as the repository matures.

9.7.5 Governance and strategic oversight remain in place providing assurance that delivery remains on track and aligned with the Health Board's quality, safety and learning priorities.

10.00 HEALTHCARE LAW

10.1 CORONER AND INQUESTS

10.1.2 Newly issued Regulation 28 Prevention of Future Deaths (PFD)
During the reporting period, a Regulation 28 Prevention of Future Deaths (PFD) Report was issued by HM Coroner for South Wales Central following the conclusion of an inquest into the death of a child in September 2024 after a prolonged inpatient stay and subsequent multi-organ failure.

10.1.3 The Coroner's concerns relate to delays in the availability of emergency medication during paediatric resuscitation, arising from the lack of standardisation of paediatric crash trolleys across hospital sites, particularly in out-of-hours settings involving rotating junior medical staff. The Coroner concluded that this presented a risk of future deaths unless action is taken.

10.1.4 The PFD was issued on an all-Wales basis to all Health Boards, NHS Trusts and the Cabinet Secretary for Health and Social Care. While this was not an inquest involving Betsi Cadwaladr University Health Board services, the Health Board is a named recipient. Legal Services is supporting consideration of the report alongside medical and resuscitation colleagues. A response is required by 27 June 2026.

10.1.5 Response to previously issued Regulation 28 Prevention of Future Deaths (PFD
As reported previously, the Health Board received a PFD highlighting wider risks within gastroenterology and endoscopy services (notwithstanding the Coroner's conclusion that in this case death was due to natural causes and that the issues identified did not affect the outcome).

10.1.6 In response to the PFD, the Health Board set out a programme of immediate and longer-term actions to mitigate patient safety risks, including strengthened Executive oversight, workforce recruitment and redesign, enhanced diagnostic capacity (including a temporary endoscopy unit), validation and rationalisation of waiting lists, and standardisation of referral and triage pathways. A Rapid Quality Review of gastroenterology services was convened in February 2026, with risks being reviewed and escalated through corporate governance arrangements.

10.1.7 The Health Board also confirmed work is underway to develop an Integrated Digestive Disease Service to improve resilience, governance and consistency of care across North Wales. The response provides assurance to the Coroner that the risks identified are being actively managed through clear governance, mitigation, and sustained service improvement.

10.1.8 Response to other Coroner Concerns
In addition to formal Prevention of Future Deaths reports, the Health Board has responded to a number of Coroner observations which did not meet the statutory threshold for a PFD but raised issues of assurance, governance or service resilience. These responses have focused on providing clear explanations of the actions taken and the mitigations in place.

10.1.9 The Coroner sought assurance regarding delays in reaching a definitive position on permanent Emergency Department nursing establishments at Ysbyty Gwynedd. The Health Board confirmed that interim staffing arrangements had been maintained to manage patient safety risk while formal business cases progressed with final Executive approval being progressed.

10.1.10 Concerns were raised about the absence of a modern electronic clinical record system within mental health services. The Health Board confirmed that procurement of a new all-age mental health and learning disabilities electronic health record system is in its final stages, supported by Welsh Government, with defined timescales for contract award, mobilisation and go-live.

10.1.11 The Coroner also highlighted issues relating to consent documentation, access to intravenous therapy, and overnight medical workload pressures. The Health Board outlined mandatory consent training aligned with national guidance, the introduction of a dedicated intravenous access service, and additional clinical support measures to mitigate workload pressures while longer-term workforce solutions are progressed.

10.1.12 Observations were made regarding sustained pressure across urgent and emergency care pathways, including ambulance handover delays and care delivered in highly pressurised environments. The Health Board provided assurance that these risks are subject to strengthened Executive oversight following clinically led Rapid Quality Reviews, with enhanced escalation, monitoring and system-wide action undertaken in partnership with other organisations.

10.2 LIABILITY CLAIMS

10.2.1 The Health Board continues to maintain focused oversight of Learning from Events Reports (LFERs) required by the Welsh Risk Pool. Based on the position at the end of the reporting period, there were 10 overdue LFERs, demonstrating continued improvement compared with earlier in-year performance.

10.2.2 A further 15 LFERs are due within the next month and are under active monitoring to mitigate the risk of slippage. Overdue LFERs remain concentrated within a small number of Divisions and Integrated Health Communities.

10.2.3 Overall performance has improved year-on-year, with a sustained reduction in both the number of overdue submissions and the proportion of cases attracting penalties. Many delays relate to WRP deferrals for further evidence or clarification, rather than non-submission.

10.2.4 Process improvements remain in place, including an earlier internal assurance deadline ahead of WRP submission, designed to strengthen quality and reduce avoidable deferrals.

10.3 OTHER HEALTHCARE LITIGATION ISSUES

10.3.1 During the reporting period, Legal Services issued a legal update following a Court of Appeal judgment concerning decision-making about medical treatment options for patients who lack capacity. The update emphasises the importance of clear best-interests reasoning, consultation, documentation and early escalation in cases of disagreement, while reaffirming that clinicians are not required to provide treatment, they consider clinically inappropriate.

10.3.2 The reporting period has also seen a Supreme Court judgment in CCC v Sheffield Teaching Hospitals NHS Foundation Trust, which reverses a long-standing decision on loss of earnings in the "lost years" significantly increasing potential compensation for paediatric catastrophic injury cases.

10.3.3 Key provisions of the Health and Social Care (Wales) Act 2025 came into force from 1 April 2026. The Act delivers major system reforms, including removal of profit from children's social care, strengthened rights for disabled people and those with long-term conditions, and enhanced regulatory oversight, with implications for NHS commissioning and partnership working.

10.3.4 The NHS (Direct Payments) (Wales) Regulations 2026 came into force on 1 April 2026. They enable adults eligible for NHS Continuing Healthcare to request direct payments instead of NHS-arranged services, creating new legal and governance responsibilities for Health Boards around assessment, commissioning and oversight.

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Quality Safety & Experience Committee

INTEGRATED QUALITY AND PERFORMANCE REPORT (IQPR)

Dyddiad y Cyfarfod **Date of Meeting**	07 May 2026
Statws Cyhoeddi **Publication Status**	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad **Report Author name and title**	Ed Williams Dirprwy Cyfarwyddwr Perfformiad Deputy Director for Performance
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol **Lead Executive Team Member name and title**	Angela Wood Cyfarwyddwr Gweithredol Nyrsio Executive Director of Nursing

Pwrpas yr Adroddiad **Report Purpose**	For Noting

Crynodeb Gweithredol
Executive Summary

This paper provides an update on quality performance for information and assurance, with the full report included as an appendix and the key messages being;

There are no performance indicators requiring escalated scrutiny in this reporting period. Where measures were in escalation previously, these have now achieved the levels of performance required and have been stood down from escalated status.

Members are asked to note the above and further information that contained within appendix to the report (appendix A – The Integrated Quality & Performance Report) identifying further the wider performance metrics.

Ymgysylltu (mewnol/allanol) yr ymgymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp)
Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)

Pwyllgor / Grŵp / Unigolion Committee / Group / Individuals	Dyddiad Date	Canlyniad, Tystiolaeth a Data Outcome, Evidence and Data
Not applicable for this report		

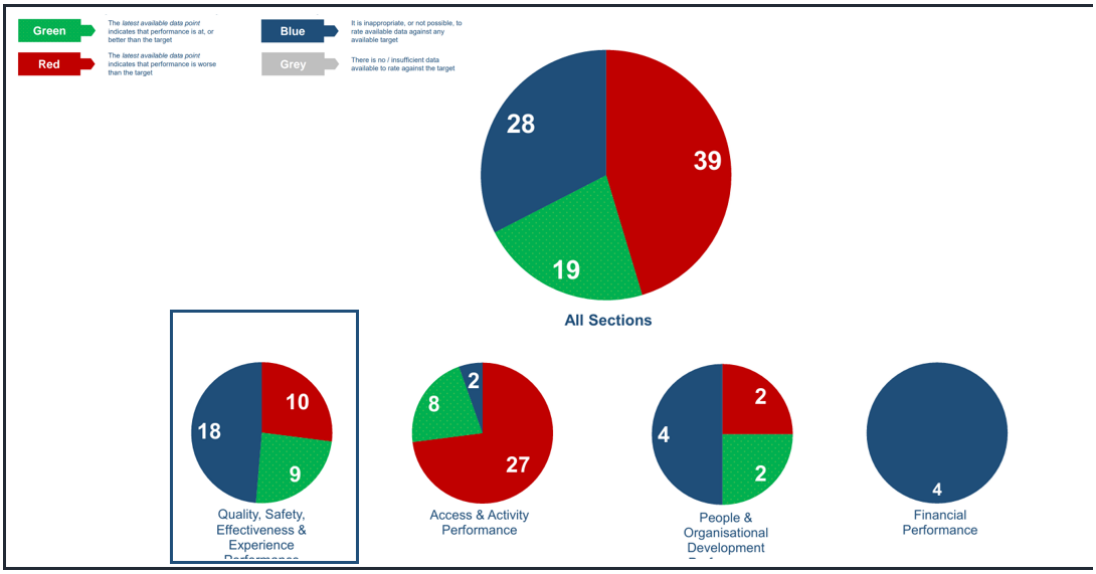
Acronymau / Rhestr Termau Acronyms / Glossary of Terms	
A&E	Accident and Emergency
AB	Aneurin Bevan Health Board
ADHD	Attention Deficit Hyperactivity Disorder
ASD	Autistic Spectrum Disorder
BCU/BCUHB	Betsi Cadwaladr University Health Board
C&V	Cardiff and Vale University Health Board
CRR	Corporate Risk Register Reference
CTM	Cwm Taf Morgannwg University Health Board
ENT	Ear, Nose, and Throat
GDS	General Dental Services
GP	General Practitioner
HDda	Hywel Dda University Health Board
HEIW	Health Education and Improvement Wales
IHC	Integrated Health Community
LPMHSS	Local Primary Mental Health Support Services
MH&LD	Mental Health and Learning Disabilities
MMR	Measles, Mumps and Rubella
NHS	National Health Service
NR	non-recurrent

PADR	Performance Appraisal and Development Review
PFIG	Performance, Finance, and Information Governance Committee
QSE	Quality, Safety, and Experience Committee
SB	Swansea Bay University Health Board
SM	Special Measures
WAST	Welsh Ambulance Services NHS Trust
WG	Welsh Government
YTD	year to date

INTERGRATED QUALITY & PERFORMANCE REPORT

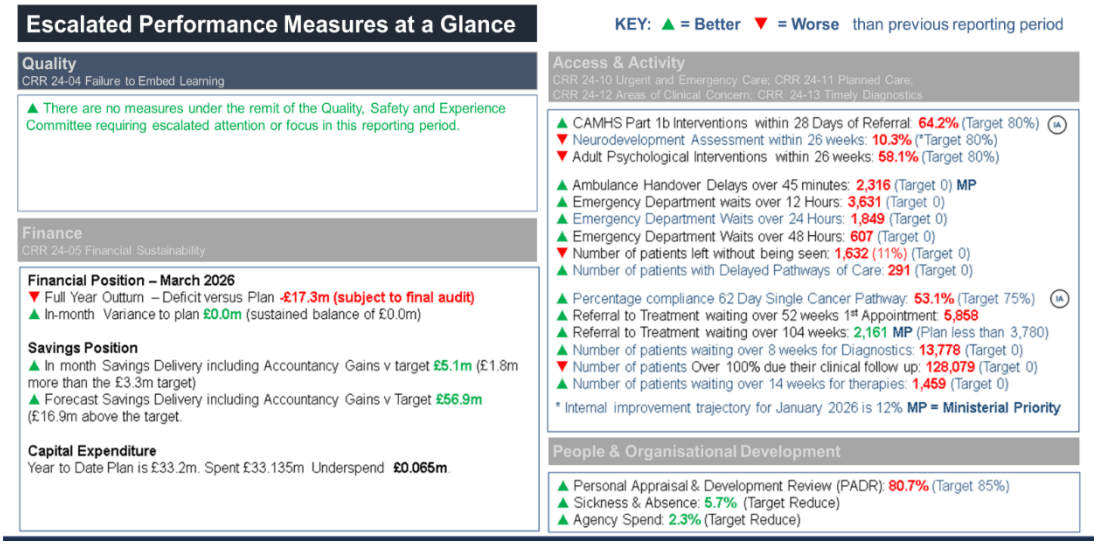
1. Y SEFYLLFA / SITUATION

1.1



1.2 Of the measures from the NHS Wales Performance Framework included in the report, 9 are on target, 10 are off target. Whilst the organisation has significantly improved within the Patients Safety, Experience and Quality spaces, it remains clear that there continues to be significant risks to delivery on a number of key metrics within the wider organisation, specifically within Urgent and Emergency Care (details included within the 'Performance at a Glance' page of the report and shown below. Full details can be seen in the IQPR for Performance, Finance and Information Governance Committee (PFIG).

1.3



Escalated Performance Measures at a Glance

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

Quality
CRR 24-04 Failure to Embed Learning

▲ There are no measures under the remit of the Quality, Safety and Experience Committee requiring escalated attention or focus in this reporting period.

Finance
CRR 24-05 Financial Sustainability

Financial Position – March 2026
▼ Full Year Outturn – Deficit versus Plan **-£17.3m (subject to final audit)**
▲ In-month Variance to plan **£0.0m** (sustained balance of £0.0m)

Savings Position
▲ In month Savings Delivery including Accountancy Gains v target **£5.1m** (£1.8m more than the £3.3m target)
▲ Forecast Savings Delivery including Accountancy Gains v Target **£56.9m** (£16.9m above the target.

Capital Expenditure
Year to Date Plan is £33.2m. Spent £33.135m Underspend **£0.065m**.

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

▲ CAMHS Part 1b Interventions within 28 Days of Referral: **64.2%** (Target 80%) IA
▼ Neurodevelopment Assessment within 26 weeks: **10.3%** (*Target 80%)
▼ Adult Psychological Interventions within 26 weeks: **58.1%** (Target 80%)

▲ Ambulance Handover Delays over 45 minutes: **2,316** (Target 0) **MP**
▲ Emergency Department waits over 12 Hours: **3,631** (Target 0)
▲ Emergency Department Waits over 24 Hours: **1,849** (Target 0)
▲ Emergency Department Waits over 48 Hours: **607** (Target 0)
▼ Number of patients left without being seen: **1,632** (11%) (Target 0)
▲ Number of patients with Delayed Pathways of Care: **291** (Target 0)

▲ Percentage compliance 62 Day Single Cancer Pathway: **53.1%** (Target 75%) IA
▲ Referral to Treatment waiting over 52 weeks 1st Appointment: **5,858**
▲ Referral to Treatment waiting over 104 weeks: **2,161 MP** (Plan less than 3,780)
▲ Number of patients waiting over 8 weeks for Diagnostics: **13,778** (Target 0)
▼ Number of patients Over 100% due their clinical follow up: **128,079** (Target 0)
▲ Number of patients waiting over 14 weeks for therapies: **1,459** (Target 0)

* Internal improvement trajectory for January 2026 is 12% **MP = Ministerial Priority**

People & Organisational Development

▲ Personal Appraisal & Development Review (PADR): **80.7%** (Target 85%)
▲ Sickness & Absence: **5.7%** (Target Reduce)
▲ Agency Spend: **2.3%** (Target Reduce)

1.4 The Health Board continues to face significant challenges in attainment of the performance targeted within the national and local plans and escalation continues in these areas as a consequence. However, it is of note that in a number of areas performance continues to improve (based on historic delivery and in year comparison) and in some instances attains national targeted levels.

1.5 Throughout 2026-27, plans are being implemented to support delivery priorities to substantially improve elective wait times, outpatients (new & follow up) cancer and 8-week diagnostic performance.

1.6 Members are invited to review the detail contained within the performance report to assess areas of key challenge and improvement opportunity, debating delivery on a balanced scorecard.

2 Y CEFNDIR
BACKGROUND

2.1 The Performance Directorate now reports through to the Executive Director of Finance's portfolio, with development of the Integrated Quality and Performance Report (IQPR) a key objective to ensure the needs of Operational forums, Executive, Committees and the Health Board are met. The development of the report will build on the launch of the Foundations for the Future model for services, which is essential to ensure clarity on roles, responsibilities and accountability.

2.2 Statistical Process Control Charts (SPC) will be the main vehicle to report performance (historical, current and future trends) ensuring movements in performance are understood. In January 2026, Welsh Government have indicated the use of 'Making Data Count' methodology within all formal reports which has already been adopted by BCUHB and will be strengthened further in coming months. It is essential the users of the reports can ascertain the impact of key actions expected for future performance, and importantly how this compares to that contained within our Integrated Medium-Term Plans (IMTP) and national expectations.

2.3 Initial meetings with the Executive, Senior Leadership and the teams have occurred, with further debate to occur with Health Board colleagues to shape the future report model, the anticipation being this would be supported by;

- **2.3.1** Hierarchical reporting (the information tailored for the audience)
- **2.3.2** Review of metrics used for assessment, ensuring relevance
- **2.3.3** Engagement with Operational and Clinical teams, to ensure actions planned to improve performance are quantifiable and thus can be used to forecast delivery

2.3.4 A refreshed 'Performance and Accountability Framework' that will enable areas and directorates that require additional support to be identified and escalated

2.4 The implementation of 'Foundations for the Future' in providing clarity on roles and responsibilities will support identification of lines of accountability, it is important that the accountability framework recognises high performing areas and differentiates with those requiring support to deliver improvement. Reporting future performance requiring Operational & Clinical colleagues to determine action to be taken and expected impact.

2.5 Whilst these developments are progressed, the report will continue to be presented within the current format, each section will endeavour to enhance reporting with inclusion of;

2.5.1 A one-page high level summary of matters to be highlighted to members.
2.5.2 Then a page per quadrant, supporting a more focused view of the performance.
2.5.3 Finally, each performance metric is then articulated within the report to provide the detail should officers seek to understand more in regards to a particular metric.

3 MATERION PENODOL I'W HYSTYRIED
SPECIFIC MATTERS FOR CONSIDERATION

3.1 It remains clear that there continues to be significant risks to delivery on a number of key metrics described within this report. In particular within the Urgent and Emergency Care space.

3.2 The Health Board continues to face significant challenges in attainment of the performance targeted within the national and local plans and escalation continues in these areas as a consequence. However, it is of note that in a number of areas performance continues to improve, with members invited to review the detail contained within the summary and full performance report to assess areas of key challenge and improvement opportunity.

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

4.1

4.2

5 ARGYMHELLION RECOMMENDATIONS

5.1 Gofynnir i'r Pwyllgor/Cyfarfod/Grŵp:
The Committee/Meeting/Group is asked to:

Review and comment upon the information presented.

ASESIAD / ASSESSMENT	
Cyswllt â'r Blaenoriaethau Strategol **Link to Strategic Priorities**	     4. Improving quality, outcomes and experience
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Yr Egwyddorion Dylunio **Design Principles**	Equity and Accessibility Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd **Corporate Risks and Board Assurance Framework**	CRR 25-08 Non-Compliance with Regulatory and Legislative Requirements

ASESIADAU O EFFAITH / IMPACT ASSESSMENTS		
Cydraddoldeb *A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o'r Effaith ar Gydraddoldeb (sy'n cynnwys gofynion Safonau'r Gymraeg)* **Equality** *Have you undertaken an Equality Impact Assessment Screening (which includes the requirements of the Welsh Language Standards)*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Asesiad o'r Effaith Economaidd-gymdeithasol *A ydych chi wedi cynnal Asesiad o'r Effaith Economaidd-Gymdeithasol?* **Socio-Economic Impact Assessment** *Have you undertaken a Socio-Economic Impact Assessment*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Ansawdd *A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?*	**Galluogwyr Ansawdd** **Enablers of Quality** All Apply	**Meysydd Ansawdd** **Domains of Quality** All Apply

Quality *Have you undertaken a Quality Impact Assessment Screening?*		
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant **Wellbeing of Future Generations Act – Wellbeing Goals**	A Healthier Wales	

Effaith Amgylcheddol / Cynaliadwyedd (5Rs) **Environmental /Sustainability Impact (5Rs)**	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
	No - Not Applicable	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:	
Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog A ydych chi wedi ystyried Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog: **Armed Forces Covenant Due Regard Duty** Have you considered the Armed Forces Covenant Due Regard Duty?	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Asesiad o Effaith ar Ddiogelu Data *A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?* **Data Protection Impact Assessment** *Have you undertaken a Data Protection Impact Assessment Screening?*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	

Asesiad o Effaith ar Atal Twyll *A ydych chi wedi ystyried yr effeithiau ar atal twyll?* **Counter Fraud Impact Assessment** *Have you considered the counter fraud impacts*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Cyfreithiol **Legal**	Yes (Include further detail below)	
Enw Da **Reputational**	Yes (Include further detail below)	
Effaith ar Adnoddau *(Pobl / Ariannol)* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

Thursday, 7th May 2026

Integrated Quality & Performance Report

Quality, Safety and Experience Committee

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

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

Table of Contents

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

Escalated Performance Measures at a Glance

KEY: ☐ = Better ☐ = Worse than previous reporting period

Quality
CRR 24-04 Failure to Embed Learning

☐ There are no measures under the remit of the Quality, Safety and Experience Committee requiring escalated attention or focus in this reporting period.

Finance
CRR 24-05 Financial Sustainability

Financial Position – March 2026

▼ Full Year Outturn – Deficit versus Plan **-£17.3m (subject to final audit)**
▲ In-month Variance to plan **£0.0m** (sustained balance of £0.0m)

Savings Position

▲ In month Savings Delivery including Accountancy Gains v target **£5.1m** (£1.8m more than the £3.3m target)
▲ Forecast Savings Delivery including Accountancy Gains v Target **£56.9m** (£16.9m above the target.

Capital Expenditure

Year to Date Plan is £33.2m. Spent £33.135m Underspend **£0.065m**.

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

▲ CAMHS Part 1b Interventions within 28 Days of Referral: **64.2%** (Target 80%) IA
▼ Neurodevelopment Assessment within 26 weeks: **10.3%** (*Target 80%)
▼ Adult Psychological Interventions within 26 weeks: **58.1%** (Target 80%)

▲ Ambulance Handover Delays over 45 minutes: **2,316** (Target 0) **MP**
▲ Emergency Department waits over 12 Hours: **3,631** (Target 0)
▲ Emergency Department Waits over 24 Hours: **1,849** (Target 0)
▲ Emergency Department Waits over 48 Hours: **607** (Target 0)
▼ Number of patients left without being seen: **1,632** (11%) (Target 0)
▲ Number of patients with Delayed Pathways of Care: **291** (Target 0)

▲ Percentage compliance 62 Day Single Cancer Pathway: **53.1%** (Target 75%) IA
▲ Referral to Treatment waiting over 52 weeks 1st Appointment: **5,858**
▲ Referral to Treatment waiting over 104 weeks: **2,161** **MP** (Plan less than 3,780)
▲ Number of patients waiting over 8 weeks for Diagnostics: **13,778** (Target 0)
▼ Number of patients Over 100% due their clinical follow up: **128,079** (Target 0)
▲ Number of patients waiting over 14 weeks for therapies: **1,459** (Target 0)

* Internal improvement trajectory for January 2026 is 12% **MP = Ministerial Priority**

People & Organisational Development

▲ Personal Appraisal & Development Review (PADR): **80.7%** (Target 85%)
▲ Sickness & Absence: **5.7%** (Target Reduce)
▲ Agency Spend: **2.3%** (Target Reduce)

Integrated Quality & Performance Report

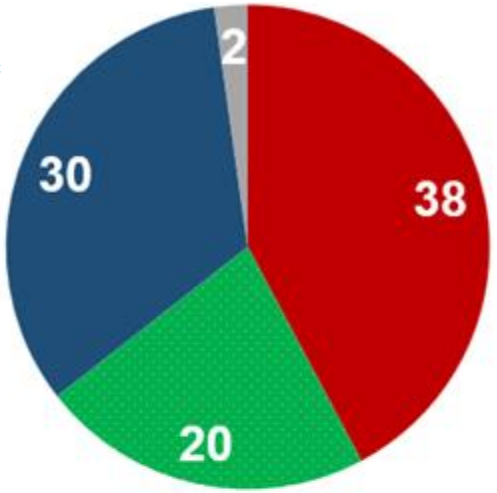
Summary of Performance to Month 9 (December 2025)

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

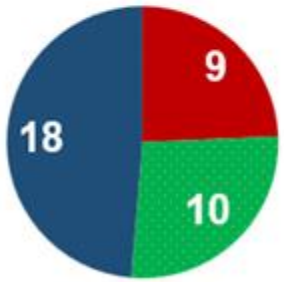
Red The *latest available data point* indicates that performance is worse than the target

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

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

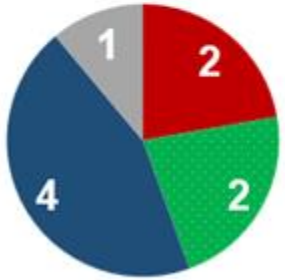


All Sections



Quality, Safety, Effectiveness & Experience Performance

Access & Activity Performance



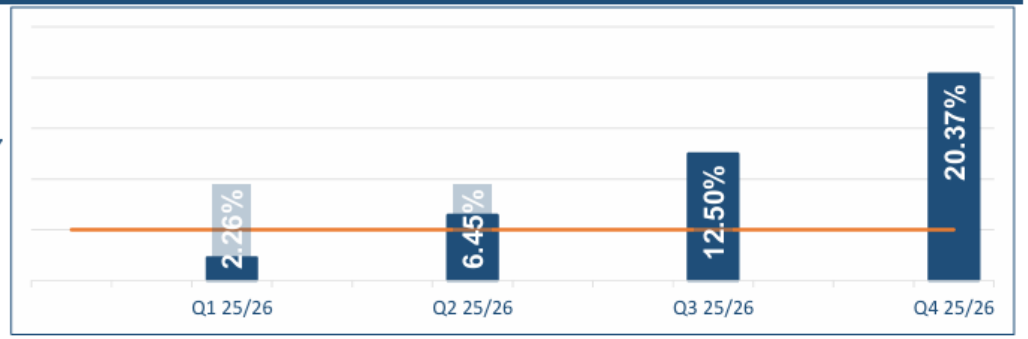
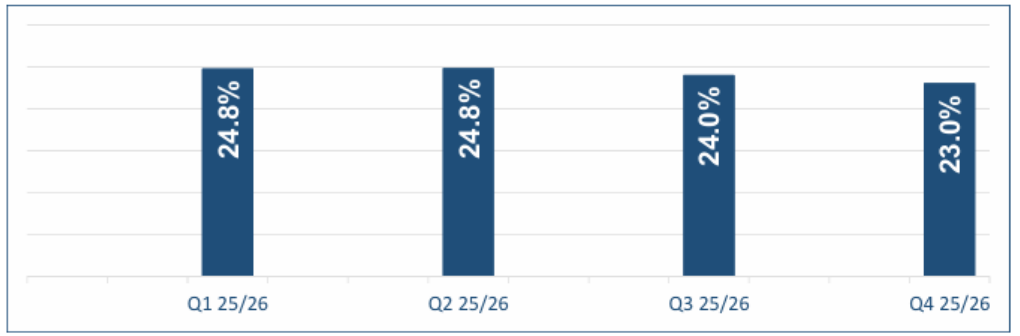
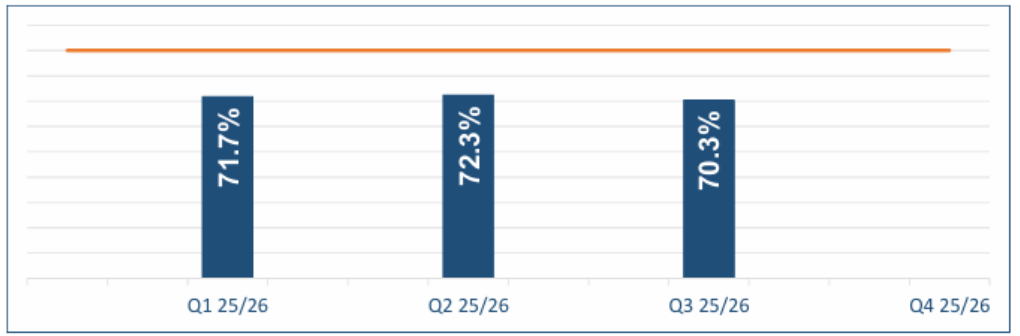
People & Organisational Development Performance

Financial Performance

Section 1

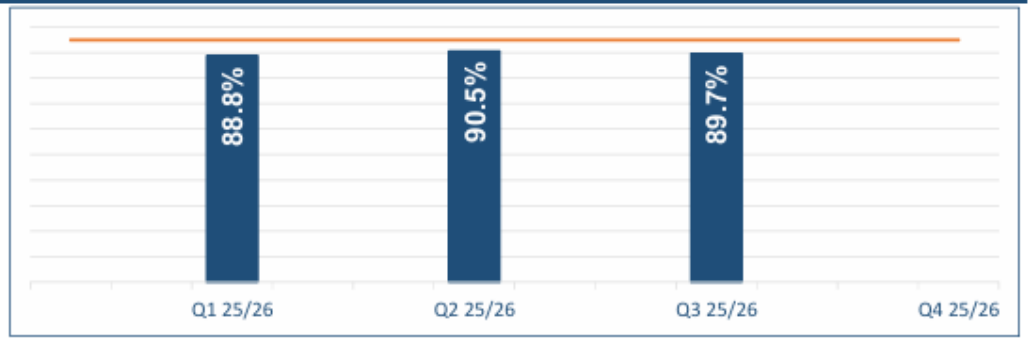
Quality, Safety, Effectiveness and Experience Performance

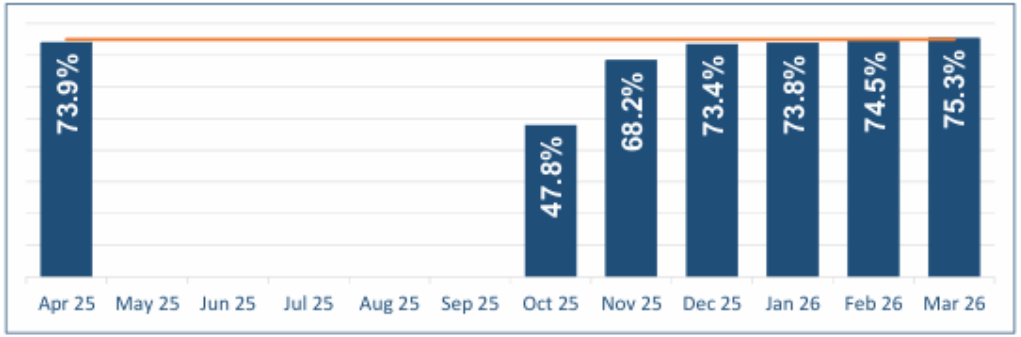
Prevention and Vaccinations

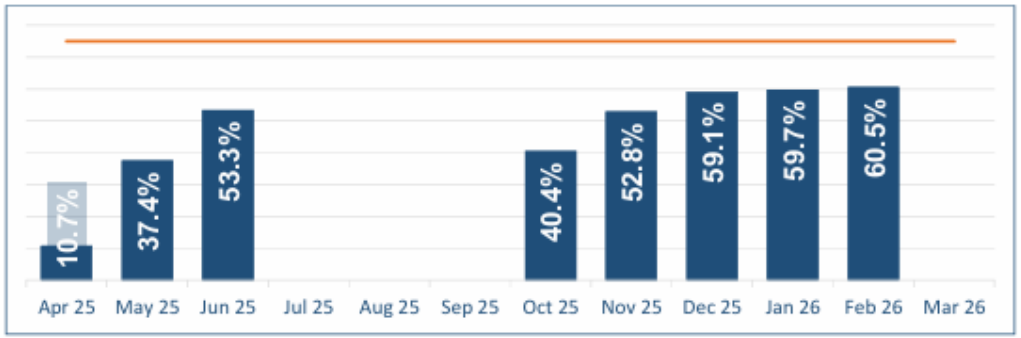
Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank	
-	QSE	Percentage of adult smokers who make a quit attempt via smoking cessation services	5% annual	TBC	20.37%	2nd of 7 (at Dec 25)	
-	QSE	Percentage of adult smokers who made a quit attempt via smoking cessation services who are CO-validated as quit at 4 weeks	40% annual target	TBC	23.0%	4th of 8 (at Dec 25)	
-	QSE	Percentage of children receiving the Human Papillomavirus (HPV) vaccination by the age of 15	90%	TBC	70.3%	7th of 7 (at Dec 25)	

Prevention and Vaccinations

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	QSE	Percentage of children who are up to date with the scheduled vaccinations by age 5 ('4 in 1' preschool booster, the Hib/MenC booster and the second MMR dose)	95%	TBC	89.7%	3rd of 7 (at Dec 25)
-	QSE	Percentage uptake of the influenza vaccination amongst adults aged 65 years and over	75%	TBC	75.3%	1st of 7 (at Mar 26)
-	QSE	Percentage uptake of the COVID-19 vaccination for those eligible Spring and Autumn Booster: All eligible people	75%	TBC	60.5%	2nd of 7 (at Feb 26)

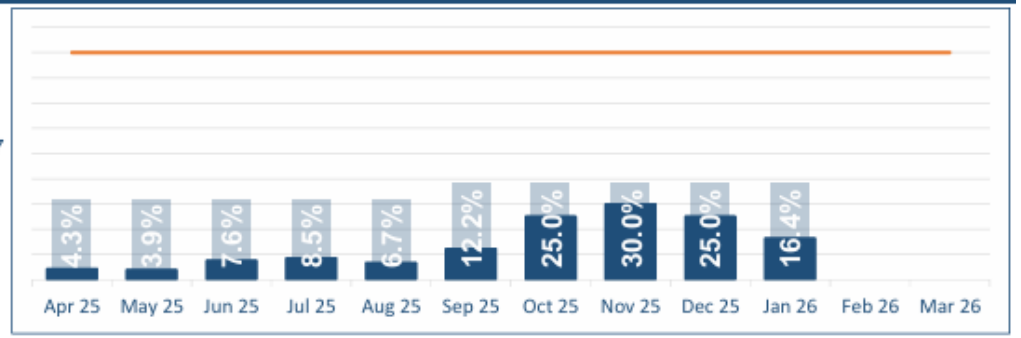


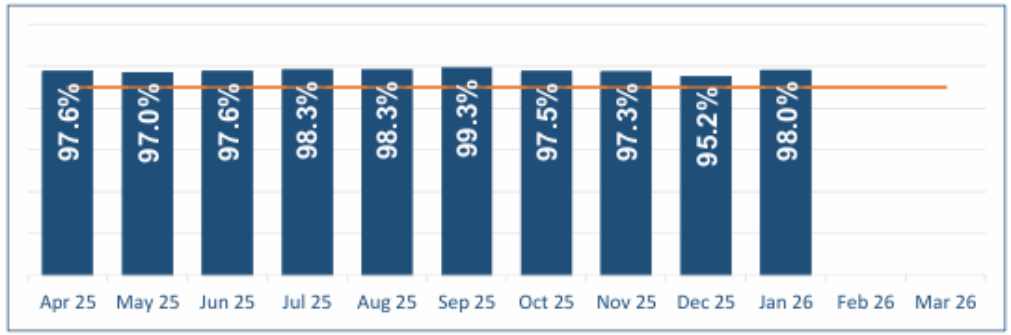


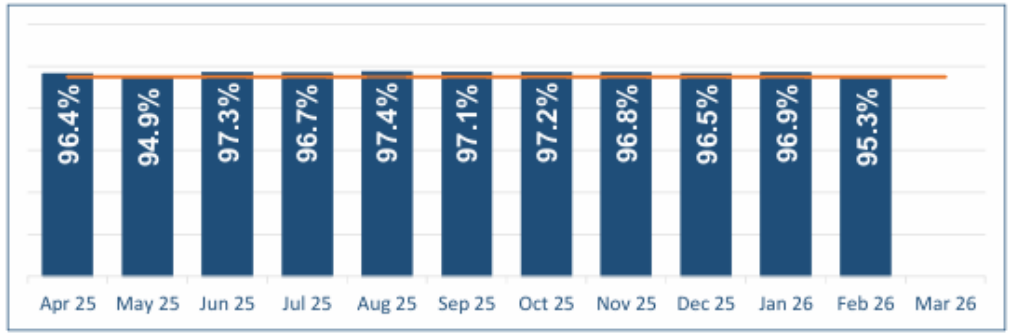


Prevention and Screening

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	QSE	Percentage of patients offered an index colonoscopy procedure within 4 weeks of booking their Specialist Screening Practitioner assessment appointment	90%	TBC	16.4%	2nd of 7 (at Jan 26)
-	QSE	Percentage of well babies entering the new-born hearing screening programme who complete screening within 4 weeks	90%	TBC	98.0%	3rd of 7 (at Dec 25)
-	QSE	Percentage of eligible newborn babies who have a conclusive bloodspot screening result by day 17 of life	95%	TBC	95.3%	6th of 7 (at Feb 26)

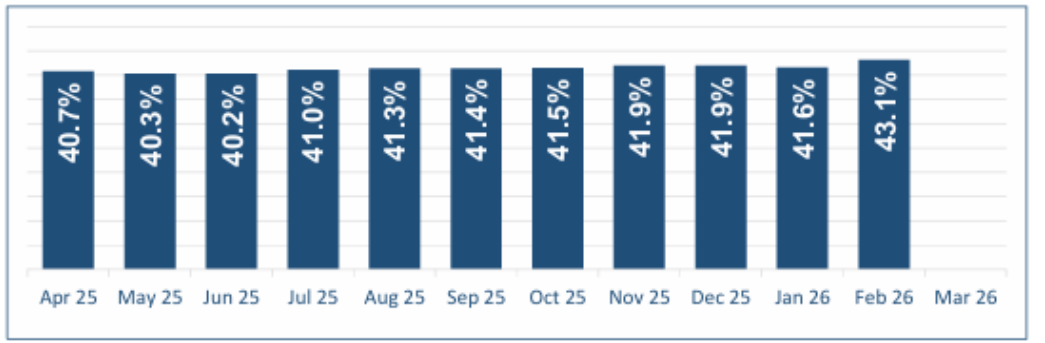


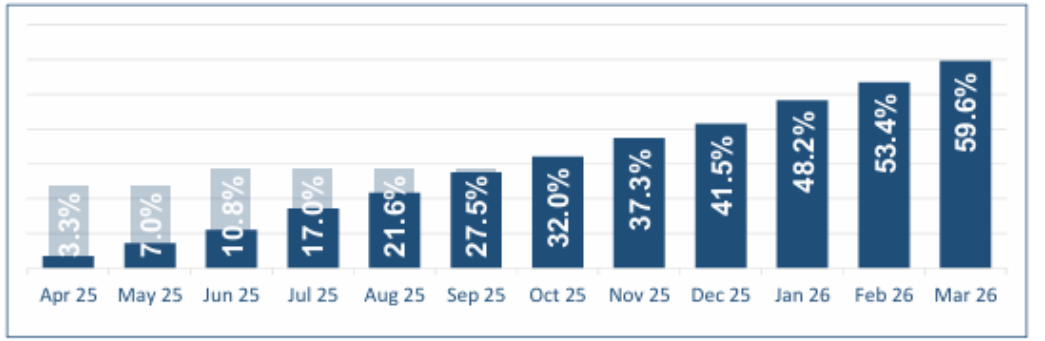




Prevention

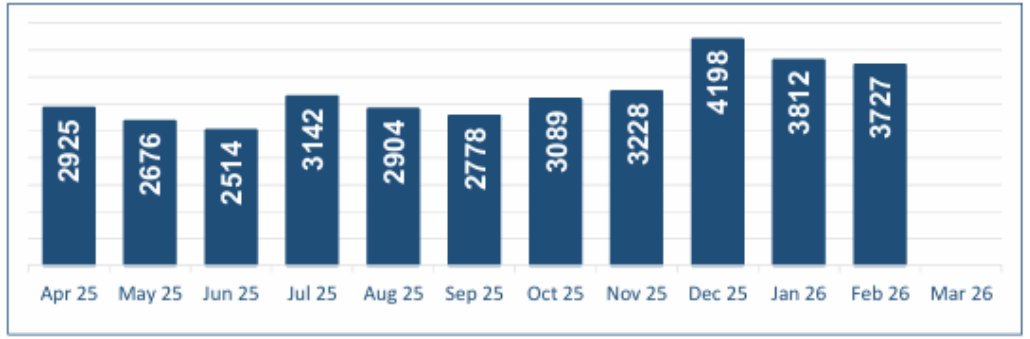
Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	QSE	Percentage of people who have been referred to health board services who have completed treatment for substance misuse (drugs or alcohol)	4 qtr imp. trend	TBC	97.2%	1st of 7 (at Dec 25)
-	QSE	Percentage of patients (aged 12 years and over) with diabetes who received all eight NICE recommended care processes	Equival-ent month increase (2025/26 to 2024/25) to 100%	TBC	43.1%	7th of 7 (at Feb 26)
-	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	59.6%	6th of 7 (at Mar 26)

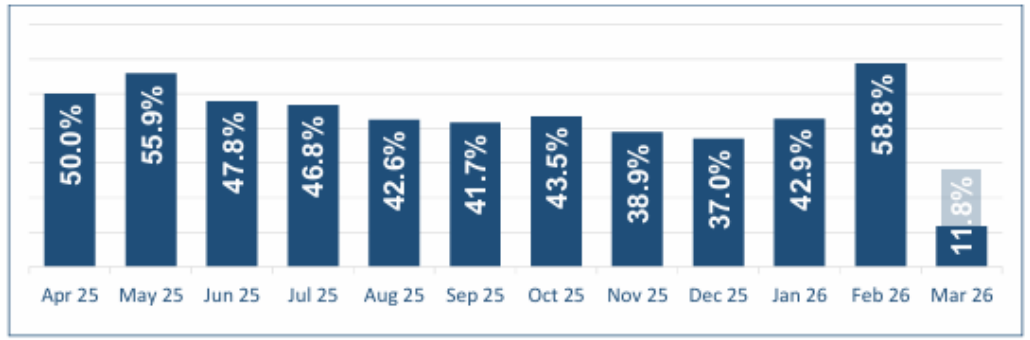


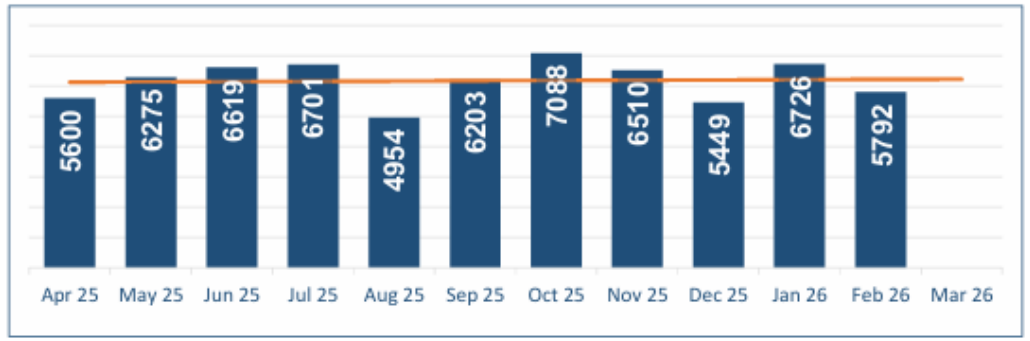


Patient Access and Experience

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	PFIG	Number of consultations delivered through the Pharmacist Independent Prescribing Service (PIPS)	Equival-ent month increase (2025/26 to 2024/25)	TBC	3727	1st of 7 (at Feb 26)
-	QSE	Percentage of confirmed COVID-19 cases within hospital which had a definite hospital onset of COVID-19 (>14 days after admission)	Equival-ent month reduct-ion (2024/25 to 2023/24)	TBC	11.8%	1st of 6 (at Mar 26)
-	QSE	Number of service user feedback experience responses completed and recorded on CIVICA	Increas-ing trend	TBC	5792	2nd of 10 (at Feb 26)

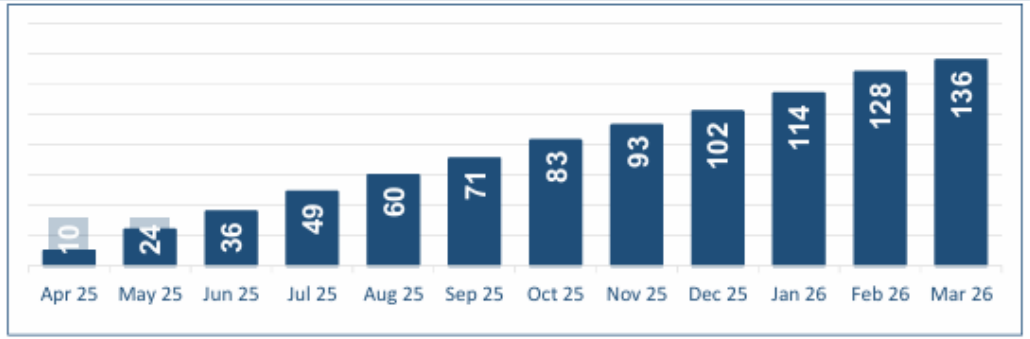


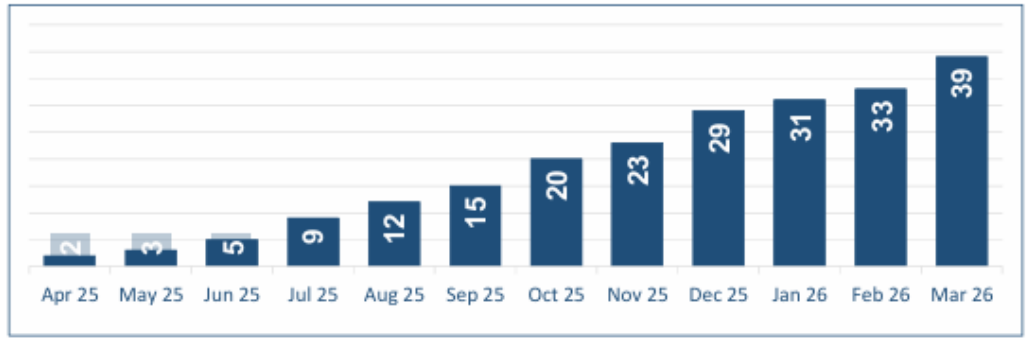


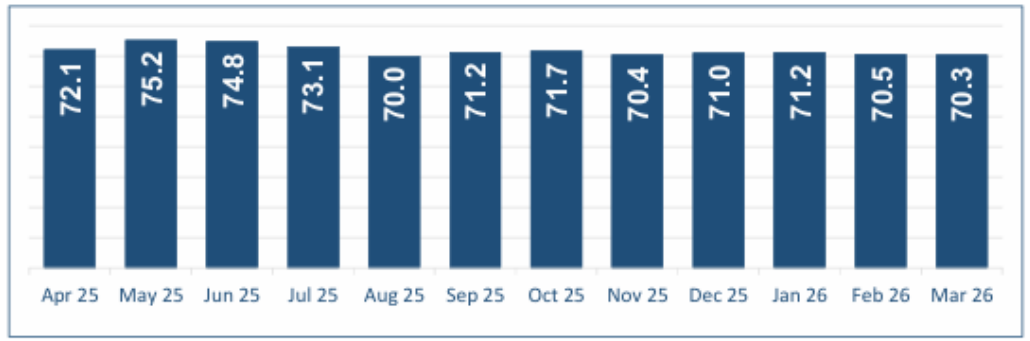


Infection Prevention and Control 1

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
CRR: 24-04	QSE	The cumulative number of laboratory confirmed Klebsiella in reporting month	TBC	TBC	136	5th of 6 (at Mar 26)
CRR: 24-04	QSE	The cumulative number of laboratory confirmed Pseudomonas Aeruginosa in reporting month	27	TBC	39	6th of 6 (at Mar 26)
CRR: 24-04	QSE	The cumulative rate of laboratory confirmed E.coli bacteraemias cases per 100,000 population	67	TBC	70.3	4th of 6 (at Mar 26)

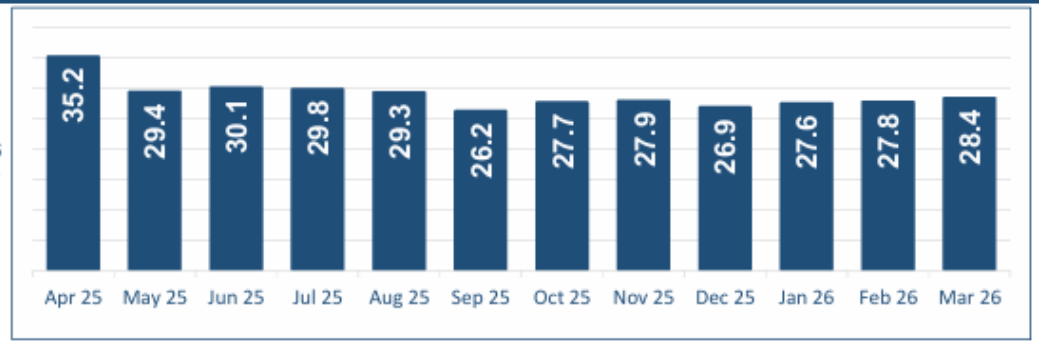


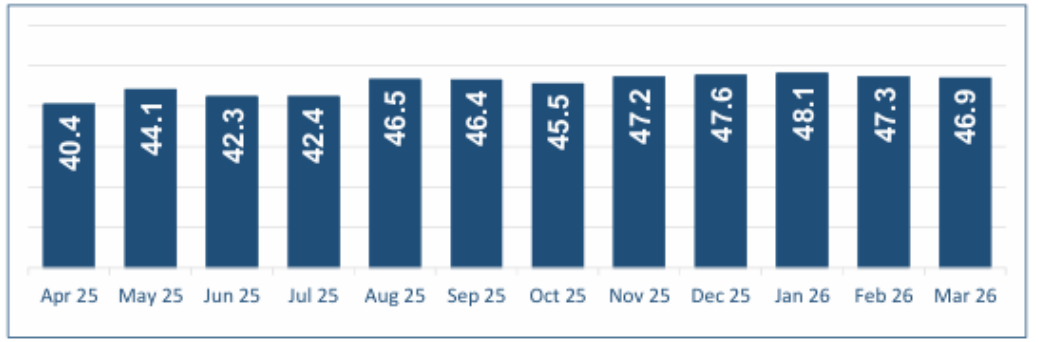


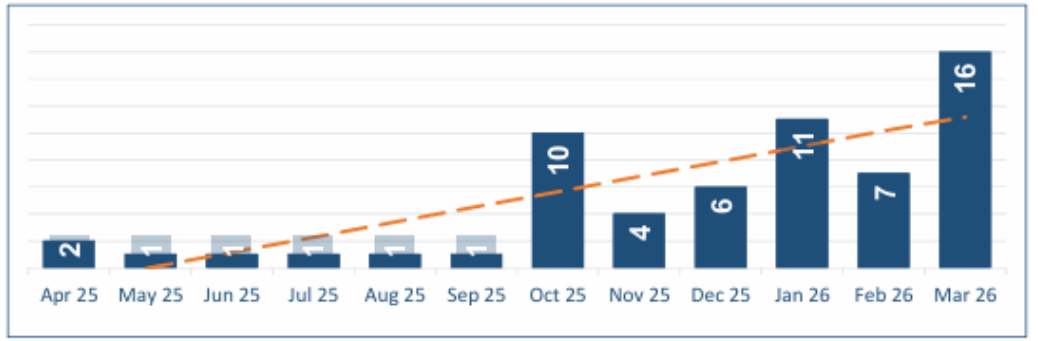


Infection Prevention and Control 2

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
CRR: 24-04	QSE	The cumulative rate of laboratory confirmed S. Aureus Bacteraemia (MRSA and MSSA) cases per 100,000 of the population	20	TBC	28.4	3rd of 6 (at Mar 26)
CRR: 24-04	QSE	The cumulative rate of laboratory confirmed C.difficile cases per 100,000 of the population	25	TBC	46.9	5th of 6 (at Mar 26)
CRR: 24-04	QSE	Number of National reportable incidents that remain open 90 days or more	Decreas-ing trend	TBC	16	8th of 10 (at Nov 25)

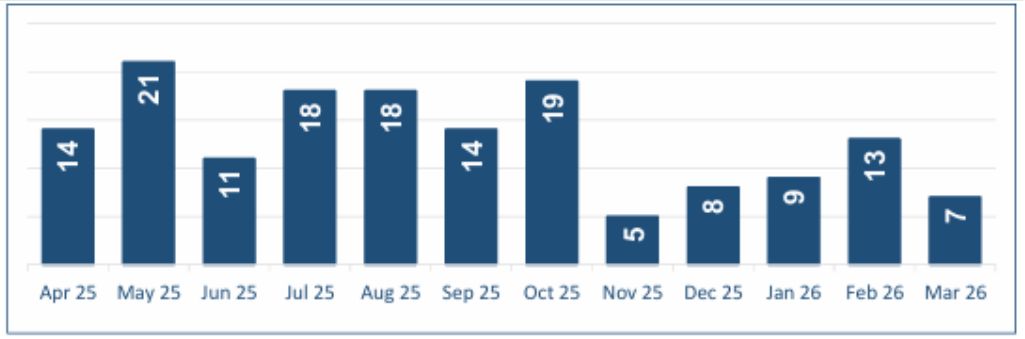


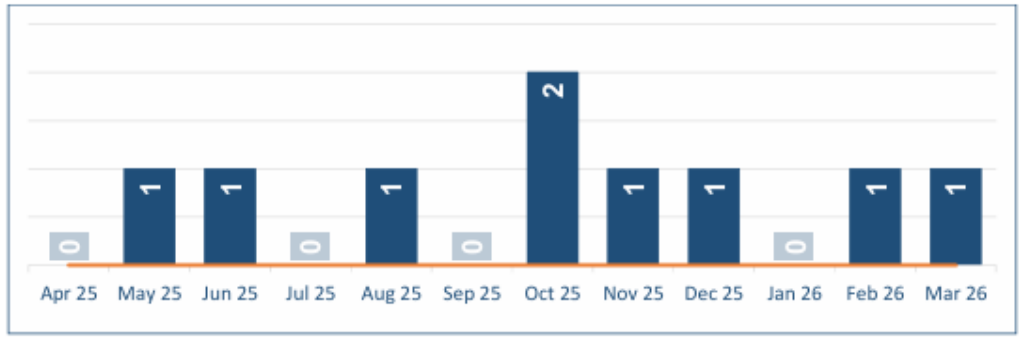


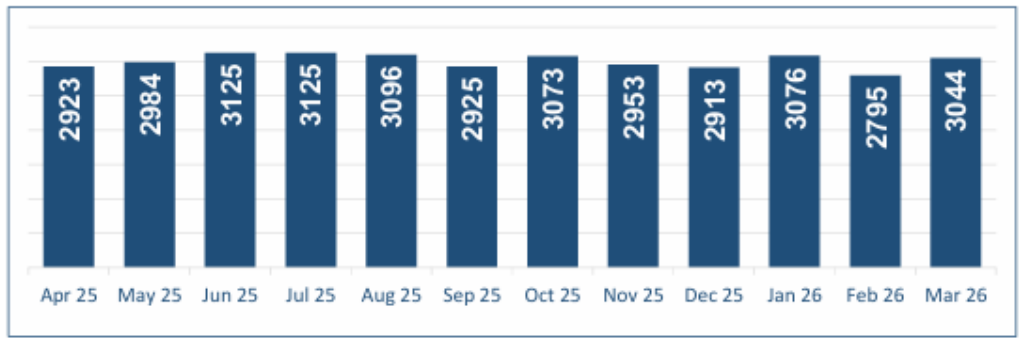


Patient Safety 1

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	QSE	Number of National reportable incidents (NRIs)	N/A	TBC	7	
-	QSE	Number of new never events	0	TBC	1	
-	QSE	Number of patient safety incidents	N/A	TBC	3044	

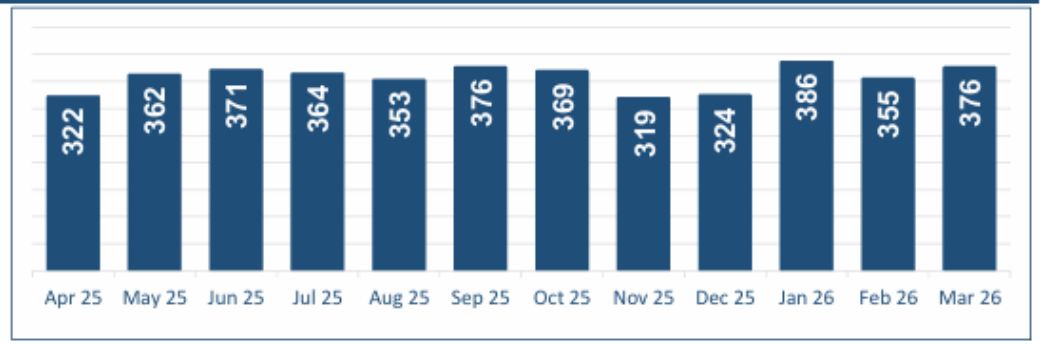


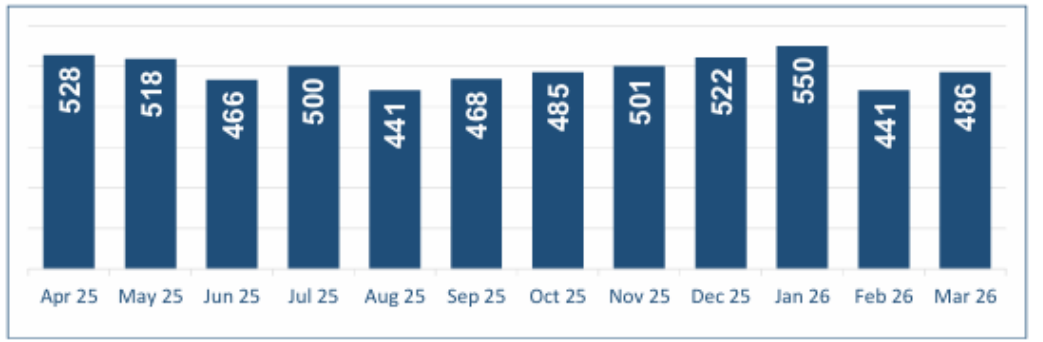


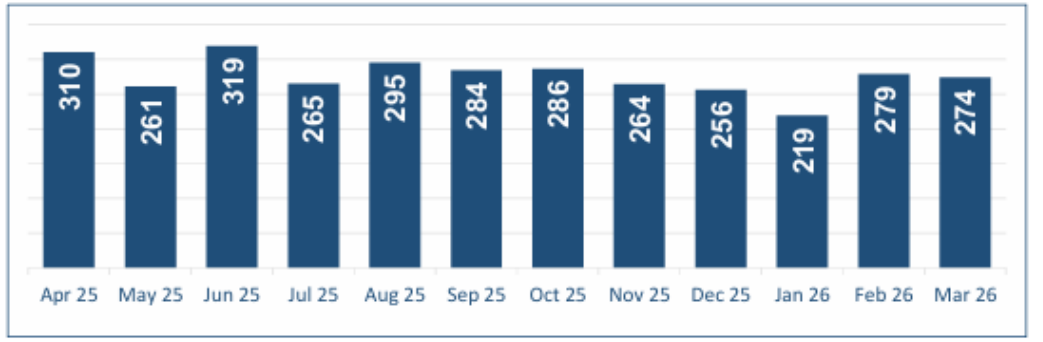


Patient Safety 2

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	QSE	Number of reported falls	N/A	TBC	376	
-	QSE	Number of reported healthcare acquired pressure ulcers (HAPU) (excluding new to caseload)	N/A	TBC	486	
-	QSE	Number of reported medication incidents	N/A	TBC	274	

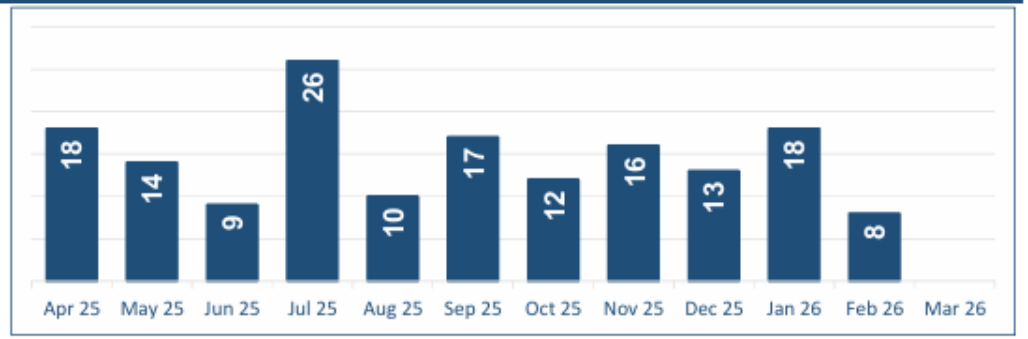


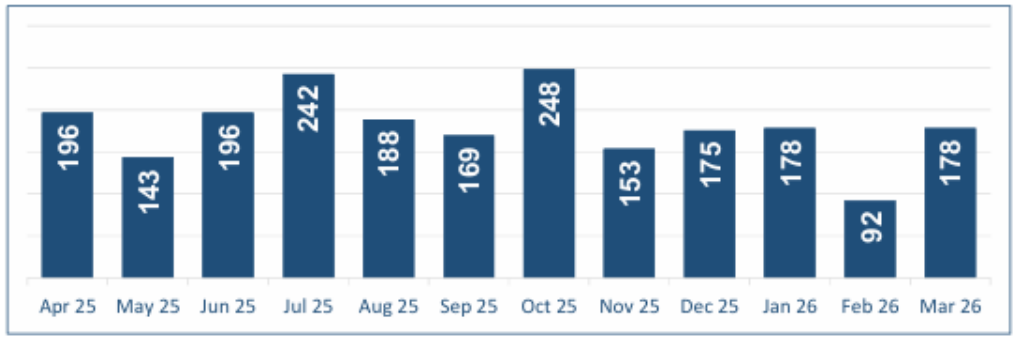




Patient Safety 3 and Staff Recognition

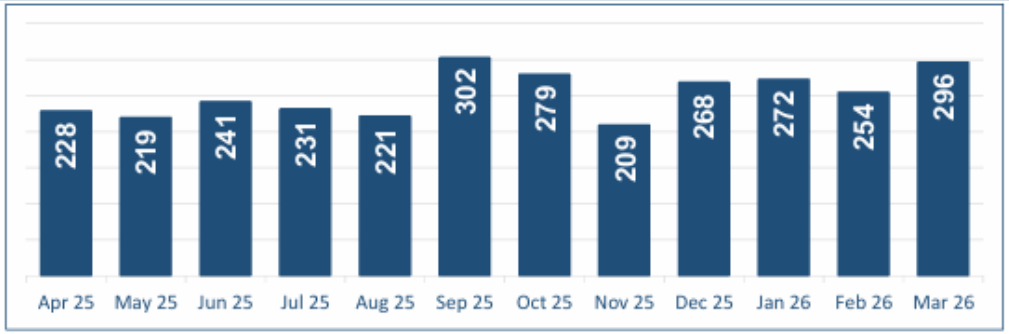
Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	QSE	Number of overdue 'Learning from Event Reports' (LFERs)	N/A	TBC	8	
-	QSE	Number of Great-ix submissions	N/A	TBC	178	

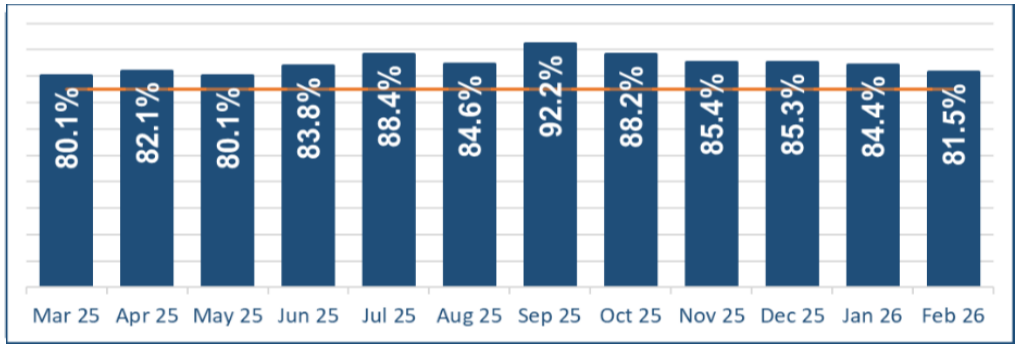


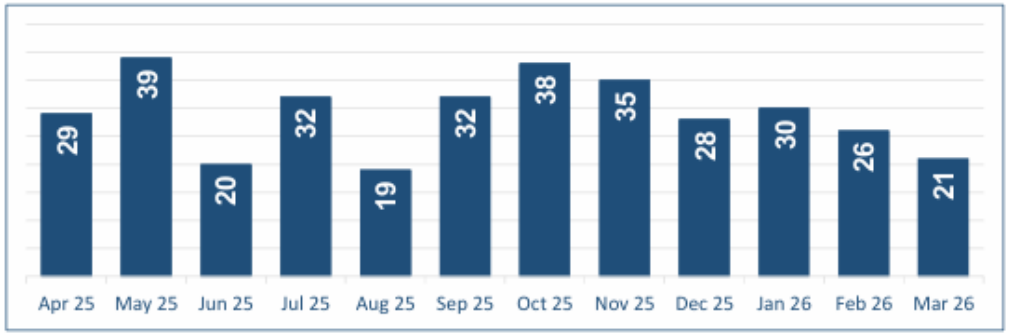


Patient Experience

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	QSE	Number of 'Putting Things Right' (PTR) complaints	N/A	TBC	296	
-	QSE	Of the complaints closed, the percentage that were closed within 30 days	75%	TBC	81.5%	
-	QSE	Number of complaints closed as early resolutions	N/A	TBC	21	

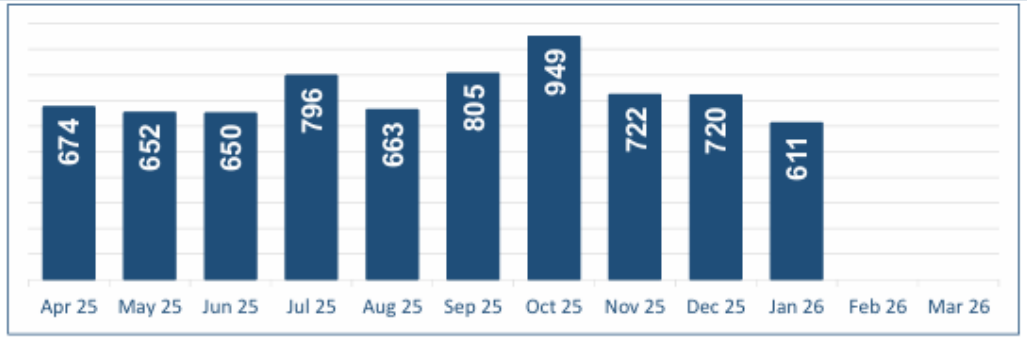


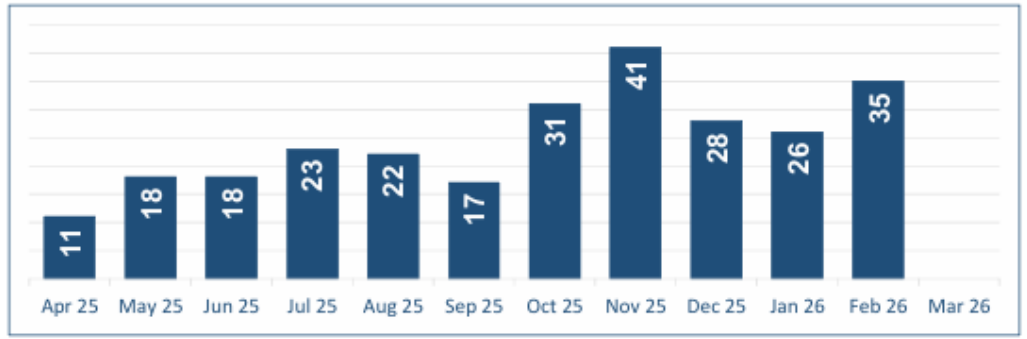


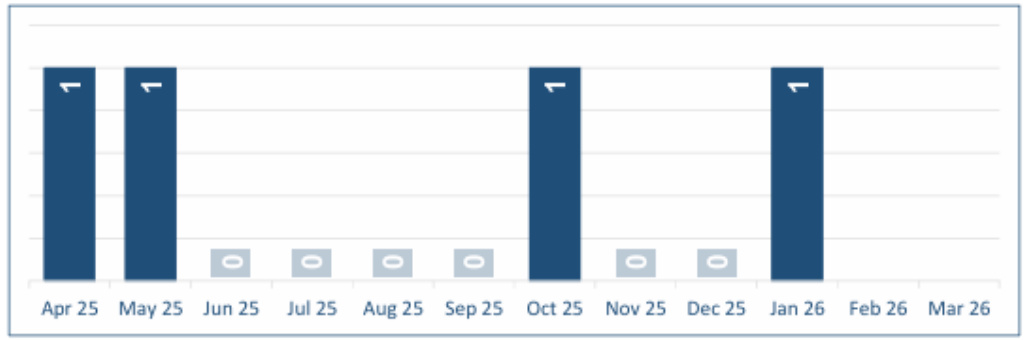


Patient Experience and Regulation Compliance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	QSE	Number of PALS (Patient Advice and Liason Service) contacts	N/A	TBC	611	
-	QSE	Number of new Ombudsman contacts	N/A	TBC	35	
-	QSE	Number of regulation 28 notices	N/A	TBC	1	

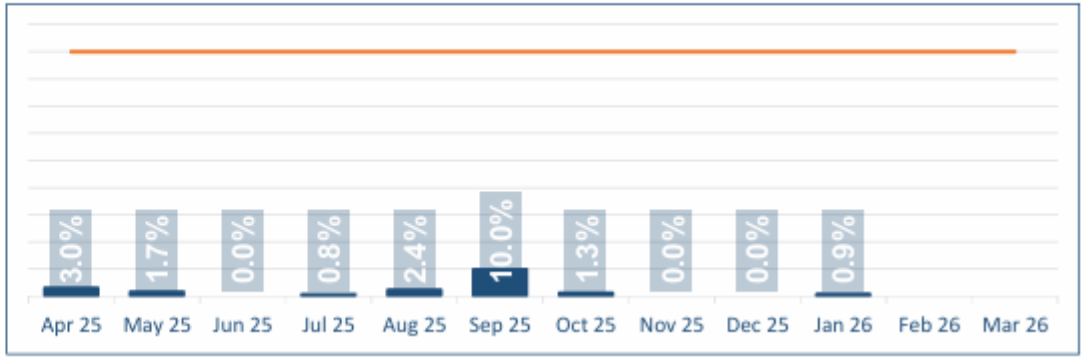


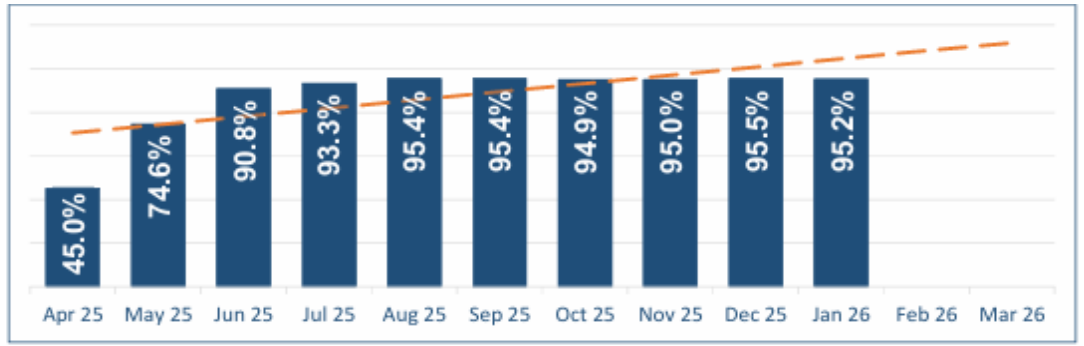




Clinical Coding Compliance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	QSE	Percentage of all classifications' coding errors corrected by the next monthly reporting submission following identification	90%	TBC	0.9%	8st of 8 (at Jan 26)
-	QSE	Percentage of episodes clinically coded within one reporting month post episode discharge end date	Increas-ing trend (to 95%)	TBC	95.2%	4th of 8 (at Jan 26)





Additional Information

Integrated Quality & Performance Report
Betsi Cadwaladr University Health Board

Further information is available from the Performance Directorate.
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

Abbreviations

Please see below a list of abbreviations commonly found within the report:

A&E	Accident and Emergency
AB	Aneurin Bevan Health Board
ADHD	Attention Deficit Hyperactivity Disorder
ASD	Autistic Spectrum Disorder
BCU/BCUHB	Betsi Cadwaladr University Health Board
C&V	Cardiff and Vale University Health Board
Cmt	committee
CRR Ref	Corporate Risk Register Reference
CTM	Cwm Taf Morgannwg University Health Board
ENT	Ear, Nose, and Throat
GDS	General Dental Services
GP	General Practitioner
HDda	Hywel Dda University Health Board
HEIW	Health Education and Improvement Wales
IHC	Integrated Health Community
LPMHSS	Local Primary Mental Health Support Services
MH&LD	Mental Health and Learning Disabilities
MMR	Measles, Mumps and Rubella
NHS	National Health Service
NR	non-recurrent
PADR	Performance Appraisal and Development Review
PFIG	Performance, Finance, and Information Governance Committee
QSE	Quality, Safety, and Experience Committee
R	recurrent
SB	Swansea Bay University Health Board
WAST	Welsh Ambulance Services NHS Trust
WG	Welsh Government
YTD	year to date

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Quality Safety & Experience Committee

NHS WALES PERFORMANCE FRAMEWORK 2026-2027: A BRIEFING PAPER

Dyddiad y Cyfarfod Date of Meeting	07 May 2026
Statws Cyhoeddi Publication Status	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad Report Author name and title	Ed Williams Dirprwy Cyfarwyddwr Perfformiad Deputy Director for Performance
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol Lead Executive Team Member name and title	Russell Caldicott Cyfarwyddwr Gweithredol Cyllid Executive Director of Finance

Pwrpas yr Adroddiad Report Purpose	For Noting

**Crynodeb Gweithredol
Executive Summary**

This paper provides an update on the NHS Wales Performance Framework for 2026-2027 outlining:

- What has changed compared to the 2025-2026 Framework,
- where the risks lie for BCUHB, and
- what assurance the Committees and the Board should focus upon.

The 2026–27 NHS Wales Performance Framework represents a tightening and rebalancing of the national performance regime. It moves away from improvement trends and process compliance towards fixed national targets, patient risk, safety, sustainability, and system flow. The framework is more explicitly aligned to the Oversight and Escalation Framework, reinforcing its role in escalation and intervention decisions. In particular:

- Introduction of key new measures that focus on prevention, safety, workforce sustainability, system flow and environmental sustainability.

- A significant number of measures now move from improvement trends to fixed national expectations.

- The framework removes a large number of legacy or low-impact indicators.

The 2026–27 framework has particular significance for the health board given ongoing challenges in unscheduled care flow, planned care backlogs, workforce sustainability and infection prevention.

The 2026–27 NHS Wales Performance Framework increases performance, safety and escalation risk for Betsi Cadwaladr University Health Board. The introduction of fixed national targets and zero-tolerance thresholds significantly reduces delivery headroom and increases the likelihood of regulatory escalation without sustained whole-system control.

Members are asked to note the above and review the full paper attached as appendix A, as this highlights through a risk based model, the areas of performance the Committee should focus upon for substantial assurances.

Ymgysylltu (mewnol/allanol) yr ymgymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp) **Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)**		
Pwyllgor / Grŵp / Unigolion **Committee / Group / Individuals**	**Dyddiad** **Date**	**Canlyniad, Tystiolaeth a Data** **Outcome, Evidence and Data**
Not applicable for this report		

Acronymau / Rhestr Termau **Acronyms / Glossary of Terms**	
A&E	Accident and Emergency
AB	Aneurin Bevan Health Board
ADHD	Attention Deficit Hyperactivity Disorder
ASD	Autistic Spectrum Disorder
BCU/BCUHB	Betsi Cadwaladr University Health Board
C&V	Cardiff and Vale University Health Board
CRR	Corporate Risk Register Reference

CTM	Cwm Taf Morgannwg University Health Board
ENT	Ear, Nose, and Throat
GDS	General Dental Services
GP	General Practitioner
HDda	Hywel Dda University Health Board
HEIW	Health Education and Improvement Wales
IHC	Integrated Health Community
LPMHSS	Local Primary Mental Health Support Services
MH&LD	Mental Health and Learning Disabilities
MMR	Measles, Mumps and Rubella
NHS	National Health Service
NR	non-recurrent
PADR	Performance Appraisal and Development Review
PFIG	Performance, Finance, and Information Governance Committee
QSE	Quality, Safety, and Experience Committee
SB	Swansea Bay University Health Board
SM	Special Measures
WAST	Welsh Ambulance Services NHS Trust
WG	Welsh Government
YTD	year to date

ASESIAD / ASSESSMENT	
Cyswllt â'r Blaenoriaethau Strategol **Link to Strategic Priorities**	     4. Improving quality, outcomes and experience Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Yr Egwyddorion Dylunio **Design Principles**	Equity and Accessibility Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd **Corporate Risks and Board Assurance Framework**	CRR 25-01 Timely Access to Safe and Effective Care CRR 25-06 Value Delivery and Financial Sustainability CRR 25-08 Non-Compliance with Regulatory and Legislative Requirements

ASESIADAU O EFFAITH / IMPACT ASSESSMENTS		
Cydraddoldeb *A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o'r Effaith ar Gydraddoldeb (sy'n cynnwys gofynion Safonau'r Gymraeg)* **Equality** *Have you undertaken an Equality Impact Assessment Screening (which includes the requirements of the Welsh Language Standards)*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Asesiad o'r Effaith Economaidd-gymdeithasol *A ydych chi wedi cynnal Asesiad o'r Effaith Economaidd-Gymdeithasol?* **Socio-Economic Impact Assessment** *Have you undertaken a Socio-Economic Impact Assessment*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Ansawdd	**Galluogwyr Ansawdd**	**Meysydd Ansawdd**

A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd? **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	**Enablers of Quality** All Apply	**Domains of Quality** All Apply
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant Wellbeing of Future Generations Act – Wellbeing Goals	A Healthier Wales	

Effaith Amgylcheddol / Cynaliadwyedd (5Rs) Environmental /Sustainability Impact (5Rs)	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
	No - Not Applicable	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:	
Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog A ydych chi wedi ystyried Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog: **Armed Forces Covenant Due Regard Duty** Have you considered the Armed Forces Covenant Due Regard Duty?	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Asesiad o Effaith ar Ddiogelu Data *A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?* **Data Protection Impact Assessment**	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	

Have you undertaken a Data Protection Impact Assessment Screening?		
Asesiad o Effaith ar Atal Twyll *A ydych chi wedi ystyried yr effeithiau ar atal twyll?* **Counter Fraud Impact Assessment** *Have you considered the counter fraud impacts*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Cyfreithiol **Legal**	Yes (Include further detail below)	
Enw Da **Reputational**	Yes (Include further detail below)	
Effaith ar Adnoddau *(Pobl / Ariannol)* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

NHS Wales Performance Framework 2026 -2027

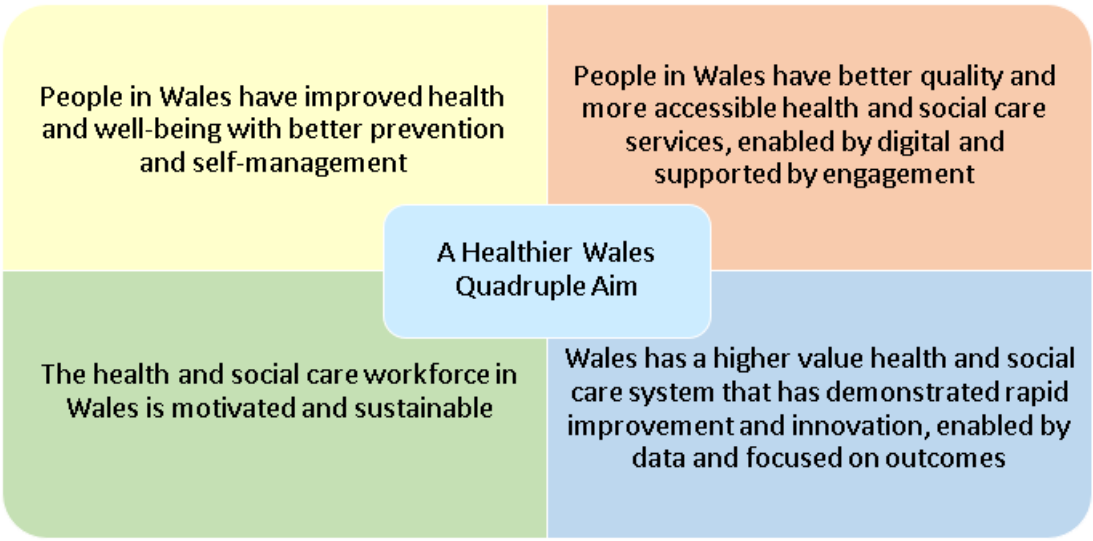
Summary for BCUHB Health Board and its scrutinising committees outlining:

- What has changed,
- where the real risks lie for the health board, and
- what assurance the Health Board and its Committees should focus upon.

This paper outlines the key changes from the 2025-2026 NHS Wales Performance Framework together with a risk based impact assessment.

Background

The performance measures in the NHS Wales Performance Framework for 2026-2027 reflect the priorities as set out in the NHS Wales Planning Framework 2026-2029. All the performance measures in the NHS Performance Framework have been mapped to the quadruple aims as outlined in 'A Healthier Wales'.



Oversight and Escalation Framework – NHS Wales Organisations

The Oversight and Escalation Framework, sets out how Welsh Government has oversight of and gains assurance about NHS Wales organisations, as well as describing in more detail what intervention approach will be taken.

There are five levels within the framework: routine arrangements; areas of concern; enhanced monitoring; targeted intervention and the highest rate of escalation - special measures.

1. Summary of key changes

The 2026–27 NHS Wales Performance Framework represents a tightening and rebalancing of the national performance regime. It moves away from improvement trends and process compliance towards fixed national targets, patient risk, safety, sustainability, and system flow. The framework is more explicitly aligned to the Oversight and Escalation Framework, reinforcing its role in escalation and intervention decisions.

1.1 Structural and Governance Changes

- Framework now supersedes all previous NHS Performance, Delivery, and Outcomes frameworks.
- Clearer link between performance metrics and escalation / de-escalation decisions.
- Emphasis on nationally assured datasets and reduced data burden.
- Stronger expectation of Board-level oversight and assurance.

1.2 Key New Measures Introduced for 2026–27

New measures that focus on prevention, safety, workforce sustainability, system flow and environmental sustainability. Key areas include:

- RSV vaccination uptake for people aged 75
- Diabetes care processes (foot surveillance and kidney screening)
- Dental access measured by population coverage
- New ambulance metrics (Purple/Red categories, ROSC)
- Strengthened ambulance handover standards
- Outpatient access measures (new OP waits >26 weeks, ophthalmology R1 risk)
- Workforce turnover and absolute agency spend reduction
- Never events and long-open nationally reportable incidents
- Expanded infection prevention measures
- Prescribing prudence and environmental sustainability indicators
- Overall patient experience score

1.3 Revised Targets (Harder, More Explicit)

A significant number of measures now move from improvement trends to fixed national expectations, including smoking cessation, substance misuse treatment, unscheduled care performance, long waits, cancer pathways, audiology waiting times, follow-up backlogs, sickness absence and clinical coding timeliness.

1.4 Measures Removed from the Framework

The framework removes a large number of legacy or low-impact indicators, including COVID-related measures, some access process measures, GP access standards, appraisal metrics, and superseded safety indicators. This rationalisation supports a stronger focus on outcomes, risk and assurance.

2. BCUHB-Specific Impact Assessment

The 2026–27 framework has particular significance for the health board given ongoing challenges in unscheduled care flow, planned care backlogs, workforce sustainability and infection prevention. Key impacts are set out below.

2.1 Highest Risk / Focus Areas for BCUHB

- **Unscheduled care:** Zero tolerance for 12-hour waits and >45-minute ambulance handovers will require sustained grip on whole-system flow, particularly at peak pressure sites.
- **Ambulance performance:** New Purple/Red categories and ROSC outcome measures increase scrutiny on both response and handover performance.
- **Planned care access:** Introduction of zero tolerance for new outpatient waits >26 weeks tightens expectations beyond current recovery trajectories.
- Workforce sustainability: New turnover measure and 30% agency spend reduction sharpen expectations on retention and workforce transformation.
- **Infection prevention:** Expanded BSI and C. difficile measures increase scrutiny on hospital-onset harm, particularly given historic challenges.

- **Follow-up care:** A mandated 25% reduction in follow-up delays requires acceleration of PIFU/SOS models and pathway redesign.

2.2 Governance and Assurance Implications for BCUHB

- Greater need for early internal escalation and de-escalation discipline.
- Stronger integration of quality, safety, workforce and performance reporting through the Integrated Quality & Performance Report.
- Increased Board visibility of trajectory risk, sustainability and delivery confidence.
- Clear alignment required between improvement plans, workforce plans and financial recovery plans.

3. Risk Based RAG Impact Summary

3.1 Overall Risk Assessment: RAG Status: RED / AMBER

The 2026–27 NHS Wales Performance Framework increases performance, safety and escalation risk for Betsi Cadwaladr University Health Board. The introduction of fixed national targets and zero-tolerance thresholds significantly reduces delivery headroom and increases the likelihood of regulatory escalation without sustained whole-system control.

Performance Domain	RAG Status	Key Risks	Board Assurance Message
Unscheduled Care & Patient Flow	RED	• Zero tolerance for 12-hour emergency waits • Zero tolerance for ambulance handovers over 45 minutes • Increased scrutiny via Purple/Red response categories and ROSC outcomes	Sustained whole-system grip on flow and discharge is required, particularly during periods of peak demand.
Planned Care & Outpatient Access	RED	• Zero tolerance for new outpatient waits over 26 weeks	Recovery trajectories must be credible and based on sustainable pathway redesign rather

		• Mandatory 25% reduction in follow-up delays from March 2026 baseline • Increased scrutiny of high-risk ophthalmology (R1) pathways	than short-term backlog clearance.
Workforce Sustainability & Agency Spend	RED	• New registered staff turnover metric • 30% reduction in absolute agency spend • Reduced tolerance for agency-dependent service models	Workforce, finance and performance recovery plans must be aligned to ensure sustainability and avoid risk displacement.
Infection Prevention & Patient Safety	AMBER / RED	• Expanded hospital-onset infection measures by organism • Fixed reduction expectations for C. difficile and bloodstream infections • Zero tolerance for never events and incidents open over 12 months	Greater granularity requires stronger prevention, timely investigation, and clear evidence of organisational learning.
Prevention, Primary & Community Measures	AMBER	• New RSV vaccination, diabetes process and dental access measures • Reliance on system partners and primary care capacity	Risks must be managed at system level to prevent inappropriate transfer into secondary care.
Data Quality, Experience & Prescribing Sustainability	AMBER / GREEN	• Patient experience score threshold • Prescribing sustainability and decarbonisation measures • Clinical coding timeliness standards	These areas are comparatively controllable and should be used to support improvement, assurance, and learning.

3.2 Summary Risk Statement

The tightened national performance framework for 2026–27 materially increases escalation risk for the health board, particularly across unscheduled care flow, planned care access and workforce sustainability. Early internal escalation, robust assurance and sustained system leadership will be critical to maintaining organisational control.

Quality Safety & Experience Committee

Quality Regulatory Oversight and Compliance

Dyddiad y Cyfarfod **Date of Meeting**	07 May 2026
Statws Cyhoeddi **Publication Status**	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad **Report Author name and title**	• **Quality Assurance:** Jo Kendrick, Head of Quality, Erika Dennis, Quality Lead Manager, Sarah Musgrave Quality Learning Business Manager
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol **Lead Executive Team Member name and title**	• Angela Wood, Executive Director of Nursing and Midwifery (Lead Executive) • Dr Clara Day, Executive Medical Director • Teresa Owen, Executive Director of AHPs and Healthcare Science • Dr Jane Moore, Executive Director of Public Health

Pwrpas yr Adroddiad **Report Purpose**	For Noting

Crynodeb Gweithredol
Executive Summary

This report provides the Quality, Safety and Experience (QSE) Committee with assurance regarding regulatory compliance, statutory reporting, improvement activity and performance for services subject to external regulation and oversight through the Health Board's Regulation and Governance (RAG) Meeting.

The report demonstrates that the Health Board continues to strengthen its response to regulatory requirements, supported by increasingly robust governance arrangements and improved oversight.

Whilst overall regulatory performance remains positive, recognised risks persist. These risks are actively managed through defined mitigation plans, clear accountability, and escalation through established governance routes.

The purpose of this report is to:

- Summarise key themes and issues arising from the RAG Meeting;
- Highlight areas requiring ongoing oversight, action or escalation; and

- Provide assurance on compliance with statutory and regulatory requirements, including HIW, CIW, the Public Services Ombudsman for Wales (PSOW), and the Health and Safety Executive (HSE).

This report supports the QSE Committee in fulfilling its assurance, scrutiny and governance responsibilities.

Ymgysylltu (mewnol/allanol) yr ymgymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp) **Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)**		
Pwyllgor / Grŵp / Unigolion **Committee / Group / Individuals**	**Dyddiad** **Date**	**Canlyniad, Tystiolaeth a Data** **Outcome, Evidence and Data**
n/a		

Acronymau / Rhestr Termau **Acronyms / Glossary of Terms**	
AMaT	Audit Management and Tracking
CIW	Care Inspectorate Wales
ECRS	Enhanced Care Residential Services
HIW	Health Inspectorate Wates
IRMER	Ionising Radiation (Medical Exposure) Regulations
MHRA	Medicines and Healthcare products Regulatory Agency
PSOW	Public Services Ombudsman for Wales
WRP	Welsh Risk Pool

QUALITY REGULATORY OVERSIGHT AND COMPLIANCE

1. Y SEFYLLFA / SITUATION

1.1 The Health Board is required to maintain effective oversight of external regulatory activity and compliance with statutory duties. This report provides the Quality, Safety and Experience (QSE) Committee with assurance regarding regulatory compliance, statutory reporting, improvement activity and performance for services subject to external regulation and oversight based on intelligence and assurance drawn from the Health Board's Regulation and Governance (RAG) Meeting.

1.2 The report supports the Committee in discharging its responsibilities for assurance, scrutiny and governance in relation to quality, safety and experience.

2. Y CEFNDIR / BACKGROUND

2.1 The Regulation and Governance (RAG) Meeting provides a structured, corporate forum for the oversight of regulatory and statutory activity pertaining to quality regulation across the organisation.

2.2 The meeting identifies emerging risks and challenges to compliance and ensures these are escalated appropriately to the Executive Quality Delivery Group (EQDG) to enable timely intervention, strengthened oversight and informed decision-making.

2.3 In addition to providing regulatory assurance, the RAG Meeting promotes accountability, transparency and organisational learning by ensuring that findings from inspections, audits, incidents and reviews are captured, shared and translated into sustainable improvement. This approach supports the delivery of safe, high-quality care and improved patient experience.

3. MATERION PENODOL I'W HYSTYRIED / SPECIFIC MATTERS FOR CONSIDERATION

3.1 The report demonstrates that the Health Board continues to strengthen its response to regulatory requirements, supported by increasingly robust governance arrangements and improved oversight. Sustained progress is evident across key areas, including the completion of Healthcare Inspectorate Wales (HIW) improvement plans, Care Inspectorate Wales (CIW) compliance, Ombudsman performance, Medicines, Additional Learning Needs (ALN) compliance, and regulatory engagement.

3.2 While overall regulatory performance remains positive, recognised risks persist. These risks are actively managed through defined mitigation plans, clear accountability, and escalation through established governance routes.

3.3 **Healthcare Inspectorate Wales (HIW):**

- Continued progress against HIW improvement plans, with actions tracked through the AMaT system. Further detail is within the Integrated Quality Report.
- Multiple HIW inspections undertaken or scheduled between April 2025 and April 2026.
- Ongoing engagement with Inspectors through quarterly progress updates coordinated by the Quality Team.

3.4 There is no single defined end-point for HIW improvement plans. Services submit completed actions and supporting evidence through the Audit, Management and Tracking (AMaT) system. Evidence is reviewed and either approved where assurance is sufficient or returned for further submission where gaps remain.

3.5 Healthcare Inspectorate Wales (HIW) requests a three-month update from the date the acceptance letter is issued to the Health Board. This update is provided by the Quality Team in the form of an action plan extracted from the AMaT system. The action plan details each recommendation, the associated actions, and the evidence submitted by the service, alongside the current progress status.

3.6 The allocated Inspector reviews the action plan and will liaise with the Quality Team should additional assurance or further evidence be required.

3.7 **Care Inspectorate Wales (CIW):**

- Sustained compliance with CIW requirements.
- Successful implementation of updated internal processes in response to new CIW guidance for 2026.
- Positive feedback from a recent joint CIW/HIW assurance visit to Learning Disabilities ECRS.

3.8 The Health Board continues to demonstrate compliance with CIW requirements, with forthcoming national changes identified and addressed. New CIW guidance for 2026 required updated internal processes, which have been implemented by the Quality Directorate. The Health Board has a registered Responsible Individual and a recent joint CIW/HIW assurance visit to Learning Disabilities Enhanced Care Residential Services (ECRS) received positive feedback.

3.9 **Public Services Ombudsman for Wales (PSOW):**

- Sustained high levels of compliance with Ombudsman recommendations (97%).
- Active management of a live caseload, with continued oversight of complaint-handling quality.
- Two further Public Interest Reports at varying stages, with governance oversight in place.

3.10 The current Ombudsman position is provided to QSE Committee through the Integrated Quality Report as a standing item.

3.11 The Health Board maintains sustained compliance with Ombudsman requirements, with overall compliance against recommendations at 97%. Engagement with the Ombudsman's office has strengthened, supporting timely resolution and improved assurance.

3.12 Complaint-handling issues remain an identified quality and patient experience risk and are subject to focused oversight and escalation.

3.13 **Overview of ombudsman caseload**

Case Type	Central	East	West	Totals
Enquiries from PSOW	2	0	2	**4**
Early Resolution Proposals	4	5	1	**10**
New Cases (Health Board gathering information for PSOW)	1	2	0	**3**
New Hybrid * Investigation	0	0	0	**0**
Further Information Requests	2	0	0	**2**
Waiting for PSOW Draft Report	6	5	4	**15**
Draft Report Received	0	0	0	**0**
Waiting receipt of Final Report	2	2	2	**6**
Final Report received and working on Action Plans	5	4	4	**13**
Further compliance info requested for sign off	0	0	0	**0**
TOTALS	**22**	**18**	**13**	**53**

3.14 **Cases with Complaint Handling issues**

		Findings
New Investigations	1	1. ID30329 East (Respiratory Medicine) Complaint cover letter referred to incorrect patient forename.
Enquiries	1	1. ID39394 Central (Emergency Medicine) Complainant feels response has not addressed all the issues raised.
Early Resolution Proposal	4	1. ID37053 Central (Cardiology) HB failed to address all of the concerns when initially raised. 2. ID26939 Central (Vascular) Failure to address all of the concerns in the initial complaint response. 3. ID35777 West (Trauma & Orthopaedics) Concerns in relation to the clinical issues have not been adequately addressed in each response provided by the Health Board. 4. ID38627 Central (ENT) HB Complaint response did not adequately address the concerns.
Wating for Draft Investigation Report	2	1. ID13586 Central (ED) Complaint submitted to the Health Board on 15 February 2023 and PTR response was delayed. 2. ID33174 West (General Surgery) Complainant felt complaint was incomplete.
Draft Investigation Report Received	0	
Waiting for Final Report	2	1. ID22118 West (Cardiology) Whether the handling of the complaint was in line with Putting Things Right guidance.

		2. ID30491 East (General Practice) Complaint not addressed impartially and elements ignore.
Final Investigation Report Received	3	1. ID2087 Central (General Surgery/Womens/Cross Border) Lack of co-operation between first Trust and HB when addressing the complaint. 2. ID24148 East (MHLDS) HB has not responded to all concerns raised. 3. ID27698 Central (Clinical Site Management) HB response not sufficiently robust and omitted details.

3.15 **Final Public Interest Report - ID2087 / 202301141 - Received March 2025**
The investigation related to the care a patient received from the Health Board and Liverpool University Hospitals NHS Foundation Trust. Her concerns included her management and care following surgery for her inflammatory bowel disease in 2019, whether she was properly consented for surgery to address her fluid collections and pelvic infection in March 2022, as well as the post-operative care and treatment and the handling of her complaint.

3.16 PSOW issued 10 recommendation, 9 actions are complete, 1 action remains overdue with a new deadline granted - 15th May 2026. Corporate oversight and Board-level governance arrangements are in place to secure a resolution.

3.17 **Further Public Interest Reports**
There are two further Public Interest Reports at varying stages. Governance oversight is in place. Action plans are being developed and will be monitored to ensure timely implementation.

3.18 **Health & Safety Executive (HSE):**

- A 32% reduction in RIDDOR incidents demonstrating improved safety performance.
- Escalation and active management of ligature-related HSE actions within mental health services.

3.19 A 32% reduction in RIDDOR incidents has been achieved, demonstrating measurable progress in improving safety performance. Robust oversight and targeted follow-up actions are now in place to ensure timely resolution, providing assurance that the identified risks are being actively managed and mitigated. This is reviewed within the CEO chaired MHLD Oversight Group.

3.20 **Welsh Language Commissioner:**

- One complaint escalated to formal investigation; all other matters addressed appropriately.
- Ongoing engagement to clarify expectations for services delivered outside Wales.

3.21 In relation to Welsh Language Commissioner compliance, one complaint concerning telephone access has been escalated to a full investigation. All other complaints have

been appropriately addressed, with evidence provided and shared learning implemented to support service improvement. Discussions are ongoing regarding Welsh language expectations for services delivered outside Wales, with engagement focused on achieving clarity and consistency. Appropriate oversight and governance arrangements are in place, providing assurance that compliance requirements are being actively managed and continuously strengthened.

3.22 **Medicines and Healthcare products Regulatory Agency (MHRA)**
The Medicines and Healthcare products Regulatory Agency (MHRA) undertook a Wholesale Dealers Authorisation (Human) [WDA(H)] inspection at Wrexham Maelor Hospital in November 2025. The inspection concluded with no critical or major findings and the site was assessed as low regulatory risk. All identified non-conformances have been addressed through an agreed action plan, and a wider Quality Management System recovery programme is in place to provide sustained assurance and ongoing compliance with Good Distribution Practice requirements.

3.23 **Home Office**
All outstanding actions relating to Home Office controlled drug possession and supply licensing have been completed. Licences have now been secured for all relevant sites, including hospital pharmacies and associated services, with self-declaration exemptions completed where applicable. A centralised licensing register and annual review process are now established, providing assurance of sustained compliance and strengthening ongoing governance and oversight arrangements.

3.24 **IRMER (Ionising Radiation (Medical Exposure) Regulations)**
HIW supported by the exposures division of the UK Health and Security Agency (UKHSA) held an announced regulatory inspection under the Ionising Radiation (Medical Exposures) Regulations 2017 including the 2024 amendments. This is a regulatory inspection of the employer i.e. the Chief Executive which this time focused around the Nuclear Medicine department at Ysbyty Gwynedd. It was held on the 26th and 27th March 2026.

There were no immediate improvement or enforcement actions and the report is expected in about 4 weeks' time.

The feedback for Nuclear Medicine and Radio pharmacy was very positive but highlighted potential concerns around staff wellbeing.

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

4.1 **Ligature Safety in Mental Health Settings:**
Historical delays in completing ligature-related HSE actions are now subject to strengthened oversight and mitigation.

4.2 **Complaint Handling and Patient Experience:**
Complaint handling continues to be an identified risk, reflected in Ombudsman case themes. This remains under focused oversight through corporate quality and governance structures.

4.3 **Ombudsman Public Interest Report Actions:**
One overdue action (ID2087) has required escalation and revised timelines. Corporate oversight and Board-level governance arrangements are in place to secure resolution.

5. ARGYMHELLION / RECOMMENDATIONS

5.1 The Committee is asked to take the report as assurance. All exceptions noted in this paper are being monitored and have management plans to track completion. These action plans are tracked through core quality forums.

ASESIAD / ASSESSMENT	
Cyswllt â'r Blaenoriaethau Strategol **Link to Strategic Priorities**	 4. Improving quality, outcomes and experience
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below: 4. Improving quality, outcomes and experience Simplify, Standardise, and Adopt Best PracticesSimplify, Standardise, and Adopt Best Practices
Yr Egwyddorion Dylunio **Design Principles**	Simplify, Standardise, and Adopt Best Practices Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd **Corporate Risks and Board Assurance Framework**	Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR) BAF-SP18 and CRR-24-04 – Quality, Innovation and Improvement
Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant Wellbeing of Future Generations Act – Wellbeing Goals	A Healthier Wales
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:

ASESIADAU O EFFAITH / IMPACT ASSESSMENTS		
Cydraddoldeb *A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o'r Effaith ar Gydraddoldeb (sy'n cynnwys gofynion Safonau'r Gymraeg)* **Equality** *Have you undertaken an Equality Impact Assessment Screening*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	*n/a*

(which includes the requirements of the Welsh Language Standards)		
Asesiad o'r Effaith Economaidd-gymdeithasol *A ydych chi wedi cynnal Asesiad o'r Effaith Economaidd-Gymdeithasol?* **Socio-Economic Impact Assessment** *Have you undertaken a Socio-Economic Impact Assessment*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	*n/a*
Ansawdd *A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	**Galluogwyr Ansawdd** **Enablers of Quality** All Apply	**Meysydd Ansawdd** **Domains of Quality** All Apply
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant **Wellbeing of Future Generations Act – Wellbeing Goals**	A Healthier Wales	
Effaith Amgylcheddol / Cynaliadwyedd (5Rs) **Environmental /Sustainability Impact (5Rs)**	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
	No - Not Applicable	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:	
Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog A ydych chi wedi ystyried Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog: **Armed Forces Covenant Due Regard Duty** Have you considered the Armed Forces Covenant Due Regard Duty?	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	n/a
Asesiad o Effaith ar Ddiogelu Data *A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?* **Data Protection Impact Assessment**	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	n/a

Have you undertaken a Data Protection Impact Assessment Screening?		
Asesiad o Effaith ar Atal Twyll *A ydych chi wedi ystyried yr effeithiau ar atal twyll?* **Counter Fraud Impact Assessment** *Have you considered the counter fraud impacts*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	n/a
Cyfreithiol **Legal**	Yes (Include further detail below)	
	Adherence to regulatory requirements.	
Enw Da **Reputational**	Yes (Include further detail below)	
	Adherence to regulatory requirements.	
Effaith ar Adnoddau *(Pobl / Ariannol)* **Resource Impact** *(People / Financial)*	Yes (Include further detail below)	
	Adherence to regulatory requirements.	

Quality Safety & Experience Committee

PRESENTATION OF THE NURSE STAFFING LEVELS – SPRING 2026

Dyddiad y Cyfarfod **Date of Meeting**	07 May 2026
Statws Cyhoeddi **Publication Status**	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad **Report Author name and title**	Alison Griffiths Director of Nursing Workforce, Staffing & Professional Standards Joanna Brown Nurse Staffing Programme Lead
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol **Lead Executive Team Member name and title**	Angela Wood Executive Director of Nursing & Midwifery

Pwrpas yr Adroddiad **Report Purpose**	Endorse for Board Approval

Crynodeb Gweithredol
Executive Summary

This paper provides assurance to the Quality Safety and Experience Committee on compliance with the Nurse Staffing Levels (Wales) Act 2016, following completion of the spring 2026 bi-annual nurse staffing calculations for all wards covered by Section 25B of the Act.

The calculations have been undertaken in accordance with statutory guidance and approved by the designated person, the Executive Director of Nursing, acting on behalf of the Chief Executive Officer. The accompanying Nurse Staffing QSE Presentation demonstrates that Betsi Cadwaladr University Health Board (BCUHB) is meeting its statutory duty to calculate and take steps to maintain nurse staffing levels across all applicable wards.

The paper also highlights material risks that limit full and unqualified assurance, including unfunded approved establishments, sustained reliance on unfunded escalation capacity, and delays in confirming revised Emergency Department nursing establishments. These issues present ongoing operational, workforce, financial, and regulatory risk, requiring continued Board oversight and timely decision-making.

The full Annual Assurance Report on compliance with the Nurse Staffing Levels (Wales) Act, covering the period 6 April 2025 to 5 April 2026, will be presented to the Board in May 2026.

Ymgysylltu (mewnol/allanol) yr ymgymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp) **Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)**		
Pwyllgor / Grŵp / Unigolion **Committee / Group / Individuals**	**Dyddiad** **Date**	**Canlyniad, Tystiolaeth a Data** **Outcome, Evidence and Data**
Not applicable for this report		

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

MEWNOSODWCH DEITL YR ADRODDIAD
INSERT REPORT TITLE

1. Y SEFYLLFA
SITUATION

1.1 The statutory guidance supporting the Nurse Staffing Levels (Wales) Act 2016, requires Health Boards to provide annual assurance to the Board on nurse staffing levels in all wards covered by Section 25B of the Act.

1.2 This assurance is provided through:

- An annual presentation by the designated person setting out the calculated nurse staffing levels for each Section 25B ward; and
- An annual assurance report, structured to support the statutory triennial submission to Welsh Government.

1.3 In line with these requirements, bi-annual nurse staffing calculations are undertaken in spring and autumn using the nationally mandated triangulated methodology. The spring 2026 calculations underpin the assurance presented in this paper.

1.4 Due to national reporting timelines, the full annual assurance report is not yet available. This paper therefore presents a summary position, supported by the Nurse Staffing QSE Presentation (Appendix 1), to enable the Executive Committee to take assurance on statutory compliance and note the risks that currently constrain full assurance.

2 Y CEFNDIR
BACKGROUND

2.1 Under the Nurse Staffing Levels (Wales) Act 2016, nurse staffing calculations must be approved by a designated person authorised to act on behalf of the Chief Executive Officer. In Welsh Health Boards, this role is undertaken by the Executive Director of Nursing.

2.2 The approved calculation establishes the nurse staffing level for each ward, expressed as the required establishment to support a planned roster that enables nurses to meet all reasonable patient care requirements. These staffing levels are expected to be maintained through the Health Board's revenue allocation, taking account of the substantive pay costs of employed staff.

3 MATERION PENODOL I'W HYSTYRIED
SPECIFIC MATTERS FOR CONSIDERATION

3.1 The HCSW Skill Set Assessment process, undertaken in accordance with the NHS Wales Collective Agreement Framework, is currently in progress. Upon completion, the findings will require detailed analysis to determine the implications for future workforce configuration, including the optimal Band 2 / Band 3 skill mix. This will inform subsequent recruitment planning and any associated changes required to ensure a safe and sustainable staffing model.

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

4.1 The risks outlined below each impact the organisation's ability to provide full assurance on statutory compliance, workforce sustainability, and safe care delivery and therefore require continued Board oversight.

4.2 Outstanding Funding Requirements:
Under the Act, Health Boards and Trusts must take all reasonable steps to maintain nurse staffing levels, funded through their revenue allocations. Three 25B wards across BCUHB have approved nurse staffing establishments, however, the corresponding budget uplifts required to deliver these establishments have not yet been implemented. This misalignment between agreed staffing levels and allocated financial resources presents a material and ongoing risk to compliance with the Act.

From a governance perspective, this issue limits the organisation's ability to provide full assurance to the Board regarding statutory compliance, workforce sustainability, and the delivery of safe and effective care. Until the required budget uplifts are secured, the Board will continue to carry heightened operational, financial, and regulatory risk, and this will need to be reflected in the organisation's risk management and assurance processes.

4.3 Unfunded and Escalation Beds:
Sustained pressures across the system continue to necessitate the routine use of escalation capacity, with an average of 157 unfunded beds or trolleys in operation at any given time. While a proportion of this activity can be absorbed within existing establishments, a significant proportion require additional staffing to maintain safe care delivery.

From a governance perspective, the persistent reliance on unfunded and variably staffed escalation areas presents a material risk to organisational compliance with statutory nurse staffing requirements, quality standards, and financial control. The inability to consistently staff these beds within approved establishments increases exposure to patient safety incidents,

undermines the organisation's ability to provide robust assurance to the Board, and contributes to recurrent financial pressures.

Until a sustainable approach to managing escalation capacity is established, including clarity on funding, workforce availability, and operational triggers, the Board will continue to carry elevated operational, quality, and regulatory risk.

4.4 Emergency Department (ED) Staffing Requirements:
A decision is pending on the September 2025 ED business case, which outlines revised nursing establishments for the three Emergency Departments. The proposed changes directly reflect current and sustained operational pressures, with the recommended FTE increases essential to stabilise ED staffing, support safe patient flow, and mitigate clinical risk.

From a governance perspective, the delay in confirming the proposed establishments limits the organisation's ability to provide assurance against statutory and regulatory requirements, including safe staffing, timely access to care, and quality standards. Prolonged misalignment between operational need and funded establishment heightens the risk of patient safety incidents, extended waiting times, and workforce deterioration through continued reliance on temporary staffing.

Failure to progress this business case in a timely manner also presents a material risk to financial planning, as ongoing mitigation measures such as high levels of agency utilisation, continue to generate unplanned expenditure. Until a clear decision is reached and implementation commenced, the Board will carry elevated operational, quality, and financial risk.

5 ARGYMHELLION
RECOMMENDATIONS

5.1 Gofynnir i'r Pwyllgor/Cyfarfod/Grŵp:
The Committee/Meeting/Group is asked to:

- Note the collective risks outlined in the report, including those relating to 25B wards, escalation capacity and Emergency Departments, and support timely decisions on the associated staffing and budget requirements. These risks should remain visible on the corporate risk register and under strengthened oversight until mitigations are fully implemented.
- Receive the presentation and take assurance that Betsi Cadwaladr University Health Board (BCUHB) is meeting its statutory duty to "calculate and take steps to maintain nurse staffing levels" in all wards that fall under Section 25B of the Nurse Staffing Levels (Wales) Act 2016, while noting the risks and limitations to full assurance as outlined in the report.

- Support the recommendations contained within the presentation including those necessary to address identified staffing, operational, and financial risks.
- Note that the Annual Assurance Report on Compliance with the Nurse Staffing Levels (Wales) Act for the period 6 April 2025 - 5 April 2026 will be presented to the Board in May 2026.

ASESIAD / ASSESSMENT	
Cyswllt â'r Blaenoriaethau Strategol **Link to Strategic Priorities**	3. Improve Access, Outcomes and Experience Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Yr Egwyddorion Dylunio **Design Principles**	Consistency with Organisational Values Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below: Wise Spending
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd **Corporate Risks and Board Assurance Framework**	There are several risks associated with the subject and scope of this paper, including workforce, financial and operational risks related to staffing deficits, unfunded escalation capacity, and the need for timely decisions on nurse staffing establishments.

ASESIADAU O EFFAITH / IMPACT ASSESSMENTS		
Equality Act 2010 **Public Sector Equality Duty:** **Has BCUHB provided evidence of 'Due Regard' to compliance with the three parts of the Public Sector Equality Duty (General Duty):** Public Sector Equality Duty [HTML] | GOV.WALES	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	N/A
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	The report concerns internal workforce establishment decisions. There is no impact on protected groups identified within the report, and the associated public sector equality duties are not engaged (there are no associated impacts on any of the protected groups).
Equality Act 2010 - Socio-economic Duty *Has BCUHB provided evidence of 'Due Regard' to compliance of ther Socio-*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	N/A
	Os naddo, dylech gynnwys y rheswm:	The report does not introduce decisions that would

economic Duty when making strategic decisions?	If no, please include rationale:	disproportionately affect individuals or communities experiencing socio-economic disadvantage.
Have you completed an Integrated Equality Impact Assessment WP8a? *WP8a Template*	Canlyniad/Outcome: Do/Yes:	Naddo/No: ☒
	Canlyniad/Outcome:	N/A
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	The report concerns internal workforce establishment decisions. There is no impact in terms of equality.
Human Rights Act *Have Human Right based concerns been addressed within WP8a*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	The proposal does not alter patient rights, service entitlements, privacy, liberty, or care pathways. It is an internal workforce establishment decision rather than one affecting individual rights.
Compliance to the Welsh Language requirements? *Have you undertaken an Impact Assessment*	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Naddo/No: ☒
	Canlyniad/Outcome:	N/A
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	The changes proposed do not affect the delivery of bilingual clinical services, communication with the public, or access to information in Welsh.
Compliance to giving 'Due Regard' to the principles of the Armed Forces Covenant *Have the principles of the Armed Forces Covenant*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	N/A
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	There is no evidence that the proposed workforce establishment impacts

been addressed within WP8a		members of the Armed Forces community differently from other staff or service users. The proposal does not create or remove access to services that specifically affect veterans, serving personnel, or their families.
Ansawdd *A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	N/A
	Galluogwyr Ansawdd Enablers of Quality Choose an item. Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	The report concerns internal workforce establishment decisions. There is no impact in terms of quality.
Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant Wellbeing of Future Generations Act – Wellbeing Goals	Not Applicable	
Effaith Amgylcheddol / Cynaliadwyedd (5Rs) Environmental /Sustainability Impact (5Rs)	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
	No - Not Applicable	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:	
Asesiad o Effaith ar Ddiogelu Data *A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?* **Data Protection Impact Assessment**	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	Not Applicable
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	The report concerns internal workforce establishment decisions.

Have you undertaken a Data Protection Impact Assessment Screening?		There is no impact in terms of data protection.
Asesiad o Effaith ar Atal Twyll *A ydych chi wedi ystyried yr effeithiau ar atal twyll?* **Counter Fraud Impact** *Have you considered the counter fraud impacts*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	N/A
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	The report concerns internal workforce establishment decisions. There is no impact in terms of counter fraud.
Cyfreithiol **Legal**	Yes (Include further detail below)	
	The Nurse Staffing Levels (Wales) Act 2016 places a statutory duty on Health Boards to have *"regard to the importance of providing sufficient nurses to allow the nurses time to care for patients sensitively*" and within 25B areas to "*calculate and take all reasonable steps to maintain nurse staffing levels".*	
Enw Da **Reputational**	Yes (Include further detail below)	
	There is potential reputational impact should quality, financial performance, or operational delivery deteriorate as a result of unresolved staffing and budgetary risks outlined in this report. Failure to maintain safe staffing levels, particularly within 25B areas and Emergency Departments, may attract scrutiny from regulators, the public, and Welsh Government.	
Effaith ar Adnoddau *(Pobl / Ariannol)* **Resource Impact** *(People / Financial)*	Yes (Include further detail below)	
	Premium agency costs will remain unless staffing gaps are addressed, including those associated with unfunded escalated beds. Failure to reduce agency spend will attract ongoing scrutiny.	

Trugaredd
Compassion

Agored
Openness

Parch
Respect

Presentation of the Nurse Staffing Levels Reporting Period: Spring 2026

Trugaredd
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Openness

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Introduction / Background

- The **Nurse Staffing Levels (Wales) Act** became law in Wales in March 2016 and places a duty on Welsh health boards and trusts to ensure that nurses have enough time to care for patients.
- The Act consists of 5 sections:
- 25A refers to the health boards'/trusts' overarching responsibility to have regard to providing sufficient nurses in all settings;
- 25B requires health boards/trusts to calculate and take all reasonable steps to maintain the nurse staffing level in all adult acute medical inpatients wards; adult acute surgical inpatient wards; and paediatric inpatient wards. Health boards/trusts are required to inform patients of the nurse staffing level on those wards;
- 25C requires health boards/trusts to use a specific method to calculate the nurse staffing level in all adult acute medical and surgical wards;
- 25D relates to the statutory guidance released by Welsh Government;
- 25E requires health boards/trusts to report their compliance in maintaining the nurse staffing level for each adult acute medical inpatient ward; adult acute surgical inpatient ward; and paediatric inpatient ward.

Key Issues & Risks

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There are four critical areas requiring urgent financial and operational decisions to ensure compliance with the Nurse Staffing Levels (Wales) Act and to maintain safe, high-quality patient care across BCUHB.

1. Outstanding Funding Requirements

Under the Act, Health Boards and Trusts must take all reasonable steps to maintain nurse staffing levels, funded through their revenue allocations. Three 25B wards across BCUHB have approved nurse staffing establishments, however, the corresponding budget uplifts required to deliver these establishments have not yet been implemented. This misalignment between agreed staffing levels and allocated financial resources presents a material and ongoing risk to compliance with the Act.

2. Unfunded and Escalation Beds

Sustained pressures across the system continue to necessitate the routine use of escalation capacity, with an average of 157 unfunded beds or trolleys in operation at any given time. While a proportion of this activity can be absorbed within existing establishments, a significant proportion require additional staffing to maintain safe care delivery. The FTE uplift required to safely staff these areas is detailed in slide 5.

3. Emergency Department (ED) Staffing Requirements

A decision is pending on the September 2025 ED business case, which outlines revised nursing establishments for the three Emergency Departments. The proposed changes directly reflect current and sustained operational pressures, with the recommended FTE increases essential to stabilise ED staffing, support safe patient flow, and mitigate clinical risk. Summary FTE requirements are provided on slide 6.

4. HCSW Skill Set Assessment

The HCSW Skill Set Assessment process, undertaken in accordance with the NHS Wales Collective Agreement – Framework, is currently in progress. Upon completion, the findings will require detailed analysis to determine the implications for future workforce configuration, including the optimal Band 2 / Band 3 skill mix.

Unfunded / Escalated Beds

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IHC	Area	Ward	NSA Ward	Funded Bed Numbers	Unfunded Bed Numbers	Funded Trolley Numbers	Unfunded Trolley Numbers	Additional Establishment Required RN	Additional Establishment Required HCA	Early RN	Early HCA	Late RN	Late HCA	Twilight RN	Twilight HCA	Night RN	Night HCA
Central	YGC	EDOU	No	0	10	0	0	5.45	5.45	1	1	1	1	0	0	1	1
Central	YGC	Ward 14 - Discharge Hub	No	0	24	0	0	19.07	16.34	4	3	4	3	0	0	3	3
East	YMW	Fleming	Yes	8	21	0	0	8.53	14.21	2	3	2	3	0	0	1	2
East	YMW	Samaritan	No	0	13	0	0	11.37	11.37	2	2	2	2	0	0	2	2
East	YMW	SDEC	No	0	0	20	0	2.84	0	1	0	1	0	0	0	0	0
East	Community	Deeside Branwen	No	18	3	0	0	0	5.69	0	1	0	1	0	0	0	1
East	Community	Deeside Gladstone	No	20	8	0	0	2.84	2.84	1	0	1	0	0	0	0	1
East	Community	Evington Rehab	No	22	5	0	0	2.84	2.84	1	0	1	0	0	0	0	1
West	YG	Glaslyn Ward	Yes	26	4	0	0	5.69	0	1	0	1	0	0	0	1	0
West	YG	Ogwen Ward	Yes	24	6	0	0	2.84	2.84	1	0	1	0	0	0	0	1
West	YG	Prysor (Sat & Sun)	Yes	12	3	1	0	0	0.41	0	0	0	1	0	0	0	0
West	YG	Conwy SAU	No	24	6	5	0	2.84	5.69	1	1	1	1	0	0	0	1
West	YG	Gogarth AMAU (Mon - Fri)	No	28	4	5	3	3.86	3.86	0	1	0	1	0	0	2	1
		Gogarth AMAU (Sat & Sun)								0	0	0	0	0	0	1	1
West	YG	SDEC (Mon - Fri)	No	0	10	20	0	6.5	9.34	1	1	1	1	0	0	1	2
		SDEC (Sat & Sun)								2	2	2	2	0	0	1	2
West	YG	Tudno DOSA (Mon - Fri)	No	0	0	18	22	14.62	14.62	0	0	0	0	0	0	2	2
		Tudno DOSA (Sat & Sun)								2	2	2	2	0	0	2	2
West	Community	Dolgellau	No	14	4	0	0	0	2.84	0	1	0	1	0	0	0	0
West	Community	Morfa Alltwen	No	20	2	0	0	0	5.69	0	1	0	1	0	0	0	1
West	Community	Tryfan Step Down	No	24	4	0	0	2.84	2.84	1	0	1	0	0	0	0	1
Womens	YG	Ffrancon	Yes	12	5	0	0	2.84	5.69	1	1	1	1	0	0	0	1
TOTAL				**252**	**132**	**69**	**25**	**94.97**	**112.56**								

The additional establishment and staffing figures above demonstrate the requirements to permanently establish and recruit to the current unfunded bed base inclusive of a 26.9% headroom.

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ED Staffing Requirements

The September 2025 Emergency Departments (ED) business case presented the requirement to revise the current nursing establishment within the 3 ED departments, with the overall FTE requirements summarised in the table below:

IHC	Current Estabished Staffing Ratio (RN: HCA)	Proposed Established Staffing Ratio (RN: HCA)	Current Establishment (FTE)		Recommended Establishment (FTE)		Variance (FTE)	
			RN	HCA	RN	HCA	RN	HCA
West - Ysbyty Gwynedd	10 RN:3 HCA (24/7)	12 RN: 6 HCA (24/7)	54.74	19.03	68.22	34.11	13.48	15.08
Centre - Ysbyty Glan Clwyd	15 RN:5 HCA (Mon - Fri) 15 RN:4 HCA (Sat & Sun)	16 RN: 6 HCA (24/7)	81.66	24.4	87.17	32.69	5.51	8.29
East - Wrexham Maelor Hospital	13 RN:5 HCA (Early) 15 RN: 5 HCA (Late) 12 RN :5 HCA (Night)	15 RN: 7 HCA (Early) 16 RN: 8 HCA (Late) 1 RN: 1 HCA (Twilight) 14 RN: 8 HCA (Night)	77.73	31.49	86.22	45.6	8.49	14.11
Totals			**214.13**	**74.92**	**241.61**	**112.4**	**27.48**	**37.48**

The additional establishment and staffing figures above are inclusive of a 26.9% headroom.

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

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- Section 25B of the Nurse Staffing Levels (Wales) Act 2016 applies to adult acute medical inpatient wards; adult acute surgical inpatient wards; and paediatric inpatient wards.
- In line with the Act, nurse staffing calculations must be undertaken bi-annually (as a minimum) and are to be approved by a designated person who is authorised to undertake this calculation on behalf of the Chief Executive Officer.
- The designated person should be registered with the Nursing and Midwifery Council and have an understanding of the complexities of setting a nurse staffing level in the clinical environment. Within Welsh Health Boards the designated person is the Executive Director of Nursing.
- The calculation undertaken by the designated person must result in the nurse staffing level for the ward area. In practice, the nurse staffing level will be the required establishment and the planned roster. The nurse staffing level should be funded from the health boards revenue allocation.

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

Section 25C: Nurse staffing levels: method of calculation

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

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

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

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

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

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

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

Whilst national guidance is in development the **NU53 - Calculating and Maintaining Nurse Staffing Levels SOP** details the process to follow within BCU.

Nurse Staffing Levels Calculations Process

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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.

Spring 2026 reviews were undertaken during the week commencing 9th March 2026.

Review & Approval by Designated Person

Formal presentations were made to the Executive Director of Nursing and Midwifery on 23/03/2026. In attendance were the nominated deputies for the Executive Director of Finance.

Agreed Nurse Staffing Level calculations will be formally presented to the Board on 28/05/2026.

Extent to which the Nurse Staffing Levels are maintained

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

The table below details the extent to which the planned roster was met across the adult medical & surgical wards and paediatric wards pertaining to Section 25B of the Act 2016 and the appropriateness of the staff on duty to meet patient care needs.

Month	Total number of shifts	Shifts where planned roster met and appropriate		Shifts where planned roster met but not appropriate		Shifts where planned roster not met but appropriate		Shifts where planned roster not met and not appropriate		Data completeness	Shifts where planned roster met but no appropriateness		Shifts where planned roster not met and no appropriateness	
Apr-25	3558	45.98%	1636	13.07%	465	20.63%	734	14.64%	521	94.32%	3.49%	124	2.19%	78
May-25	4396	47.59%	2092	12.53%	551	20.59%	905	15.22%	669	95.93%	2.37%	104	1.71%	75
Jun-25	4244	46.75%	1984	13.41%	569	22.22%	943	14.75%	626	97.13%	1.79%	76	1.08%	46
Jul-25	4399	44.76%	1969	14.53%	639	19.96%	878	17.00%	748	96.25%	2.61%	115	1.14%	50
Aug-25	4403	46.38%	2042	13.63%	600	19.78%	871	16.97%	747	96.75%	2.18%	96	1.07%	47
Sep-25	4260	47.02%	2003	13.54%	577	18.54%	790	15.94%	679	95.05%	2.30%	98	2.65%	113
Oct-25	4395	44.62%	1961	14.58%	641	17.32%	761	19.25%	846	95.77%	2.41%	106	1.82%	80
Nov-25	4234	41.07%	1739	14.69%	622	18.42%	780	20.31%	860	94.50%	2.60%	110	2.91%	123
Dec-25	4377	41.31%	1808	12.34%	540	18.60%	814	22.02%	964	94.27%	2.63%	115	3.11%	136
Jan-26	4390	43.62%	1915	12.62%	554	19.07%	837	20.11%	883	95.42%	2.07%	91	2.51%	110
Feb-26	3953	43.49%	1719	13.91%	550	17.91%	708	21.02%	831	96.33%	1.95%	77	1.72%	68
YTD Running Total	46609	44.77%	20868	13.53%	6308	19.35%	9021	17.97%	8374	95.63%	2.39%	1112	1.99%	926

Please note data presented is between 06/04/2025 – 28/02/2026 in line with national reporting guidelines.

Acuity Audit Data

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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.

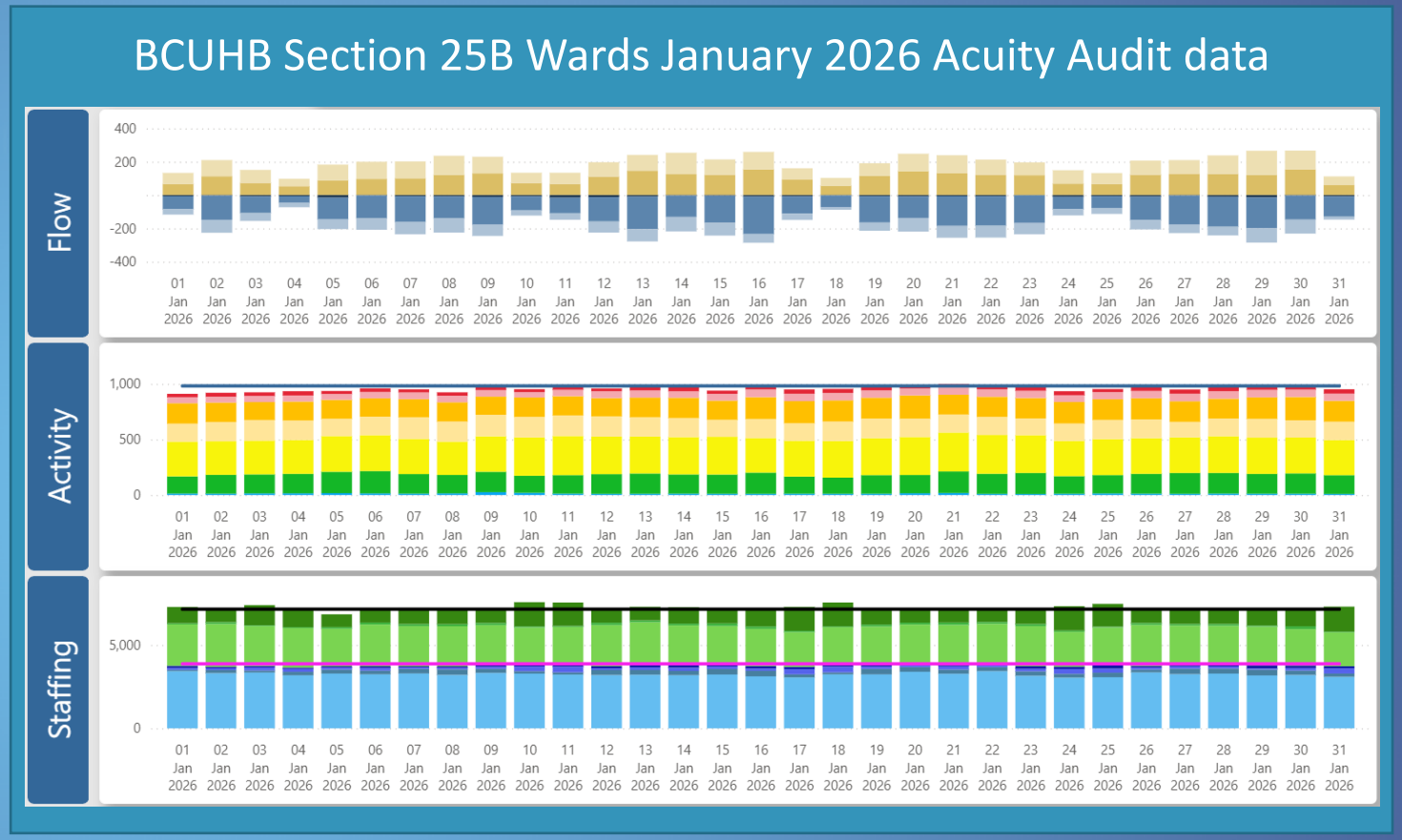
Patient acuity is assessed using the Welsh Levels of Care evidence-based workforce planning tool. This measure of patients levels of acuity indicates how much care is required in order to determine the nurse staffing level that is required to meet reasonable requirements of care.

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 opposite, 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.

Quality Indicators

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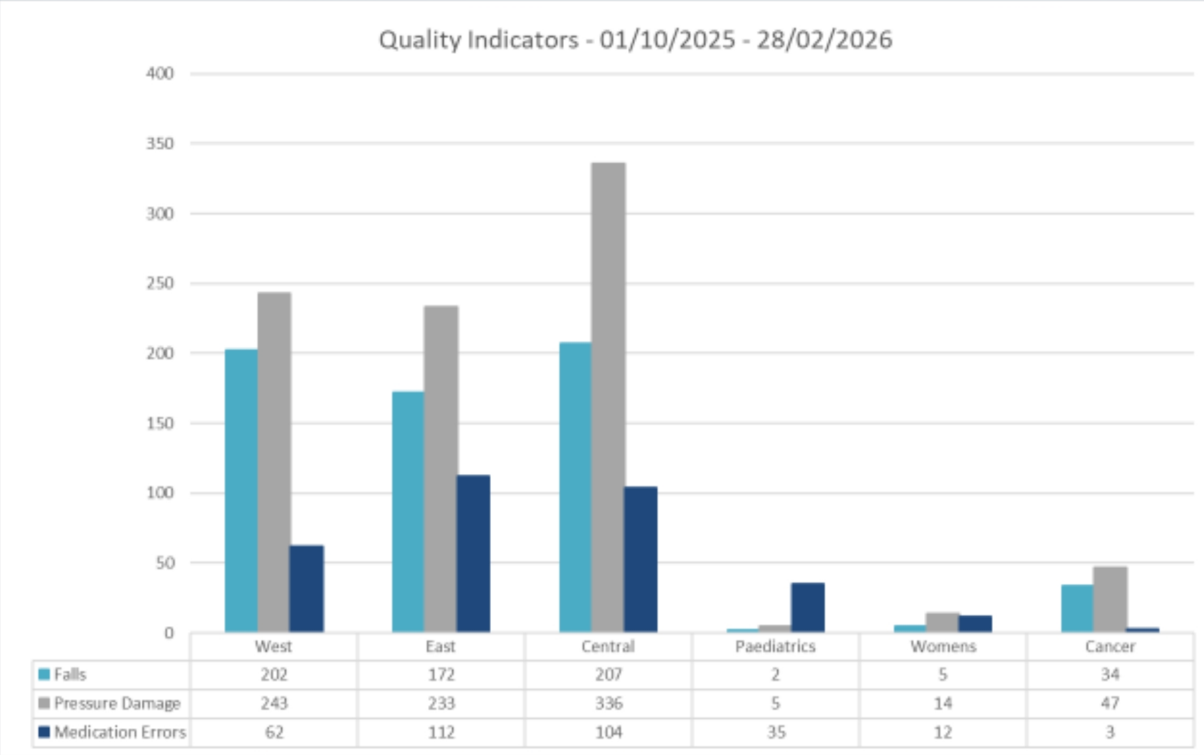
When calculating the nurse staffing level the quality indicators that are particularly sensitive to care provided by a nurse must be considered. These include patient falls, pressure damage, medication errors and complaints.

The below chart details by IHC / Division the total number of patient falls; pressure damage and medication errors, which have been recorded within the DATIX system for the period 01/10/2025 – 28/02/2026. Data is based on only those wards to which Section 25B of the 2016 Act pertains.



	West	East	Central	Paediatrics	Womens	Cancer
Falls	202	172	207	2	5	34
Pressure Damage	243	233	336	5	14	47
Medication Errors	62	112	104	35	12	3

Data Source: DATIX system as at 13.03.26

Nurse Staffing Levels Summary

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The nurse staffing level calculations undertaken during the spring 2026 reporting period (October 2025 – March 2026) FTE changes are summarised in the table below:

Integrated Health Community	Funded Bed Numbers	Unfunded Bed Numbers	Required Establishment at the start of the reporting period (October 25)		Required Establishment at the end of the reporting period (March 26)		Staffing FTE changes during reporting period (October 25 - March 26)		Funded* Establishment (as at March 26)		FTE Variance between current funded and required (March 26)	
			RN	HCA	RN	HCA	RN	HCA	RN	HCA	RN	HCA
YMW	334	22	279.17	229.45	301.92	255.04	22.75	25.59	302.49	252.2	-0.57	2.84
YGC	311	10	263.46	254.99	263.46	254.99	0	0	263.46	254.99	0	0
YG	239	19	214.61	206.65	211.77	206.65	-2.84	0	211.87	202.39	-0.1	4.26
Womens Gynaecological	32	5	34.11	21.94	34.11	21.94	0	0	34.11	21.94	0	0
Oncology & Haematology	38	1	37.56	34.11	37.56	34.11	0	0	37.57	34.11	-0.01	0
Paediatric Inpatient Wards	64	0	85.29	28.43	85.29	28.43	0	0	85.29	28.43	0	0
BCUHB Total	**1018**	**57**	**914.2**	**775.57**	**934.11**	**801.16**	**19.91**	**25.59**	**934.79**	**794.06**	**-0.68**	**7.1**

Funding changes between February and July 2025 resulted in the funded bed base fluctuating across 4 wards within YMW (Arrivals, Pantomime, Prince of Wales & Morris), with their escalated beds moving in and out of funded status. In January 2026, funding was permanently restored from central HB reserves, establishing a fully funded bed base across these 4 wards.

The regular (and in some areas sustained) use of “escalation beds” in response to patient demand have meant that on average an additional 157 unfunded beds can be in use of which 57 are across the Section 25B wards. The additional staffing requirements for these 57 unfunded beds equates to 25.58 WTE RN and 23.15 WTE HCA**.

*Funded establishment sourced from Finance Ledger

**The additional establishment and staffing figures above demonstrate the requirements to permanently establish and recruit to the current unfunded bed base inclusive of a 26.9% headroom.

Note: The required and funded establishment figures exclude any additional staffing requirements needed to support the unfunded bed base, and also exclude the supernumerary ward manager and ward support staff i.e. housekeepers, dementia support workers etc.

Section 25B wards requesting a change to nurse staffing levels

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During the spring 2026 reporting period (April 2025 – March 2026) two statutory calculations of nurse staffing levels have taken place, these being autumn 2025 (reported to Board in November 2025) and spring 2026 (to be reported to Board in May 2026).

Across both calculation periods 7 wards have requested changes to their establishments.

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

Review Period	IHC	Ward	Roster Period	Bed Numbers (actual excluding unfunded)	Current staffing (at time of review)								Proposed staffing (submitted by IHCs for EDoN Consideration)								Supported staffing (following review by EDoN)							
					Early		Late		Twilight		Night		Early		Late		Twilight		Night		Early		Late		Twilight		Night	
					RN	HCA	RN	HCA	RN	HCA	RN	HCA	RN	HCA	RN	HCA	RN	HCA	RN	HCA	RN	HCA	RN	HCA	RN	HCA	RN	HCA
Autumn 2025	East	Arrivals	7 Days	16	5	3	5	3	0	0	3	3	3	2	3	2	0	0	2	2	3	2	3	2	0	0	2	2
Autumn 2025	East	Morris	7 Days	21	4	5	4	4	0	0	3	4	4	4	4	3	0	0	2	4	4	4	4	3	0	0	2	4
Autumn 2025	East	Pantomime	7 Days	21	5	4	4	4	0	0	3	3	4	3	4	3	0	0	2	2	4	3	3	3	0	0	2	2
Autumn 2025	East	Prince of Wales	7 Days	21	4	4	4	4	0	0	3	3	3	3	3	3	0	0	2	2	3	3	3	3	0	0	2	2
Autumn 2025	East	Mason	7 Days	26	4	6	4	5	0	0	3	3	4	6	4	5	0	0	3	4	4	6	4	5	0	0	3	3
Autumn 2025	West	Hebog	7 Days	27	5	5	5	5	0	0	3	4	5	5	5	5	0	0	4	4	5	5	5	5	0	0	3	4
Autumn 2025	Cancer	Alaw	Mon - Fri	18	4	3	4	3	1	0	2	2	4	3	4	3	1	0	2	2	4	3	4	3	1	0	2	2
			Sat & Sun		3	3	3	3	1	0	2	2	4	3	3	3	0	0	2	2	4	3	3	3	0	0	2	2
Spring 2026	East	Arrivals	7 Days	26	3	2	3	2	0	0	2	2	5	3	5	3	0	0	3	3	5	3	5	3	0	0	3	3
Spring 2026	East	Morris	7 Days	27	4	4	4	3	0	0	2	4	4	5	4	4	0	0	3	5	4	5	4	4	0	0	3	4
Spring 2026	East	Pantomime	7 Days	27	4	3	3	3	0	1	2	2	5	4	4	4	0	0	3	3	5	4	4	4	0	0	3	3
Spring 2026	East	Prince of Wales	7 Days	27	3	3	3	3	0	0	2	2	4	4	4	4	0	0	3	3	4	4	4	4	0	0	3	3
Spring 2026	West	Moelwyn	7 Days	28	6	4	6	4	0	0	5	4	6	4	6	4	0	0	4	4	6	4	6	4	0	0	4	4

Section 25B wards requesting a change to nurse staffing levels

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During the spring 2026 reporting period (April 2025 – March 2026) two statutory calculations of nurse staffing levels have taken place, these being autumn 2025 (reported to Board in November 2025) and spring 2026 (to be reported to Board in May 2026).

Across both calculation periods 7 wards have requested changes to their establishments. The changes approved following review by the Executive Director of Nursing, and the rationale for these, are summarised in the table below.

Integrated Health Community	Number of Act Wards	Number of Wards Requesting Adjustments	Adjustments Approved by Exec DoN	Comments	Funding Received
YWM	14	5	4	Arrivals - funding changes between February and July 2025 resulted in the funded bed base fluctuating between 16 and 26 beds, with 10 escalated beds moving in and out of funded status. In January 2026, funding was permanently restored from central HB reserves, establishing a funded bed base of 26.	Yes
				Morris - funding changes between February and July 2025 resulted in the funded bed base fluctuating between 21 and 27 beds, with 6 escalated beds moving in and out of funded status. In January 2026, funding was permanently restored from central HB reserves, establishing a funded bed base of 26. - Whilst the funding for 27 beds was reinstated in January 2026, the associated night shift staffing requirement—specifically the 5th HCA—remains unfunded. IHC requests funding for this post, supported by the ward staffing data and patient harm profile.	Partially - requirement of 2.84 HCSW remains outstanding
				Pantomime - funding changes between February and July 2025 resulted in the funded bed base fluctuating between 21 and 27 beds, with 6 escalated beds moving in and out of funded status. In January 2026, funding was permanently restored from central HB reserves, establishing a funded bed base of 26.	Yes
				Prince of Wales - funding changes between February and July 2025 resulted in the funded bed base fluctuating between 21 and 27 beds, with 6 escalated beds moving in and out of funded status. In January 2026, funding was permanently restored from central HB reserves, establishing a funded bed base of 26.	Yes
YGC	13	0	-	-	-
YG	10	2	1	Moelwyn - RN staffing adjusted at night following a review of the utilisation of NIV beds.	Yes - no change in funded requirements. RN night staffing had previously been unfunded.
Oncology & Haematology	2	1	1	Alaw - RN staffing adjusted at weekends to support out of hours triage requirements. No change to staffing FTE requirements.	Yes - no change in funded requirements.
Womens Gynaecological	3	0	-	-	-
Paediatric Inpatients Wards	3	0	-	-	-
BCUHB Total	**45**	**8**	**5**	**-**	**-**

Recommendations

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- Continue to review the impact of nurse staffing levels within the clinical areas, observing workforce and quality metrics.
- Continued focus on recruitment and retention and innovation to support workforce utilisation and reporting, supported by the **All Wales National Workforce Implementation Plan**; the subsequent **Nurse Retention Plan** and the **Strategic Nursing Workforce Plan**.
- Approve the September 2025 ED business case, which is essential to stabilise ED staffing, improve patient flow, and reduce risk.
- Undertake a review of the unfunded and escalation beds to determine if these are able to be de-escalated and closed; where this is not a viable option the appropriate re-occurring funding must be provided.
- In line with the **Act** and the **Statutory Guidance**, on approval by the Executive Director of Nursing & Midwifery as the nominated Designated Person:
  - Amend budgets to reflect the approved rosters. Nurse staffing levels presented to Board in November 2024; May 2025 and November 2025 remain unfunded at present.
  - Amend planned roster templates within E-Rostering to reflect the approved nurse staffing levels.
  - Ward Managers to recruit nursing staff in line with approved nurse staffing numbers
  - Ward Managers to ensure public facing boards at ward entrances display the agreed nurse staffing levels

Trugaredd
Compassion

Agored
Openness

Parch
Respect

Diolch / Thank you

Any questions?

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Quality Safety & Experience Committee (QSE)

BOARD ASSURANCE FRAMEWORK

Dyddiad y Cyfarfod **Date of Meeting**	07 May 2026
Statws Cyhoeddi **Publication Status**	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad **Report Author name and title**	Jody Evans, Assistant Head of Risk Management
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol **Lead Executive Team Member name and title**	Pam Wenger, Director of Corporate Governance

Pwrpas yr Adroddiad **Report Purpose**	Endorse for Board Approval

Crynodeb Gweithredol
Executive Summary

This report provides the QSE Committee with an updated position on the Board Assurance Framework (BAF) actions within the Committee's remit, drawing on the most recent BAF update presented through governance routes.

A total of 24 actions are currently recorded across the relevant principal risks, of which 12 actions are complete, 1 is progressing, 7 are overdue and 4 are delayed.

While a significant proportion of actions have been delivered, the number of overdue and delayed actions continues to limit the level of assurance available, particularly where delivery is dependent on workforce capacity, system-wide dependencies, digital enablement and nationally-led programmes.

Executive oversight remains in place for all outstanding actions, with continued focus on prioritisation, recovery planning and alignment to the four Strategic Intents approved in March 2026. Further updates will be provided through established governance forums as part of the ongoing BAF refresh.

Ymgysylltu (mewnol/allanol) yr ymgymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp)

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Pwyllgor / Grŵp / Unigolion Committee / Group / Individuals	**Dyddiad Date**	**Canlyniad, Tystiolaeth a Data Outcome, Evidence and Data**
Executive Committee (EC)	22nd April	Full BAF Report
Risk Scrutiny Group (RSG)	16th April 2026	Full BAF Report

Acronymau / Rhestr Termau Acronyms / Glossary of Terms	
BAF	Board Assurance Framework
RSG	Risk Scrutiny Group

BOARD ASSURANCE FRAMEWORK – BAF 06

1. Y SEFYLLFA
SITUATION

1.1 The Health Board's Board Assurance Framework (BAF) has undergone its latest cycle of updates, and while progress continues across several areas, a significant proportion of mitigating actions remain outstanding, including a concentration of actions that are now overdue

The Board has recently also approved four new Strategic Intents. Work is currently underway to map all existing BAF actions, with particular focus on outstanding actions within this report, to the new Strategic Intent Deliverables. This will ensure continuity and alignment as part of the forthcoming 2026 BAF refresh. The output of this mapping exercise will be submitted to the Risk Scrutiny Group for review.

2. Y CEFNDIR
BACKGROUND

2.1 The Board Assurance Framework (BAF) is the Health Board's primary mechanism for providing assurance that strategic risks to the delivery of organisational objectives are being effectively identified, managed and mitigated. It aligns principal risks, controls, assurances and mitigating actions and supports the Board, its Committees and the Executive Team in monitoring progress and identifying gaps requiring escalation or intervention.

The extant BAF was approved by the Board in January 2025 and continues to be updated routinely by Executive Leads and action owners and remains the basis for oversight of strategic risks across quality, workforce, finance, digital transformation, and timely access to care.

3. MATERION PENODOL I'W HYSTYRIED
SPECIFIC MATTERS FOR CONSIDERATION

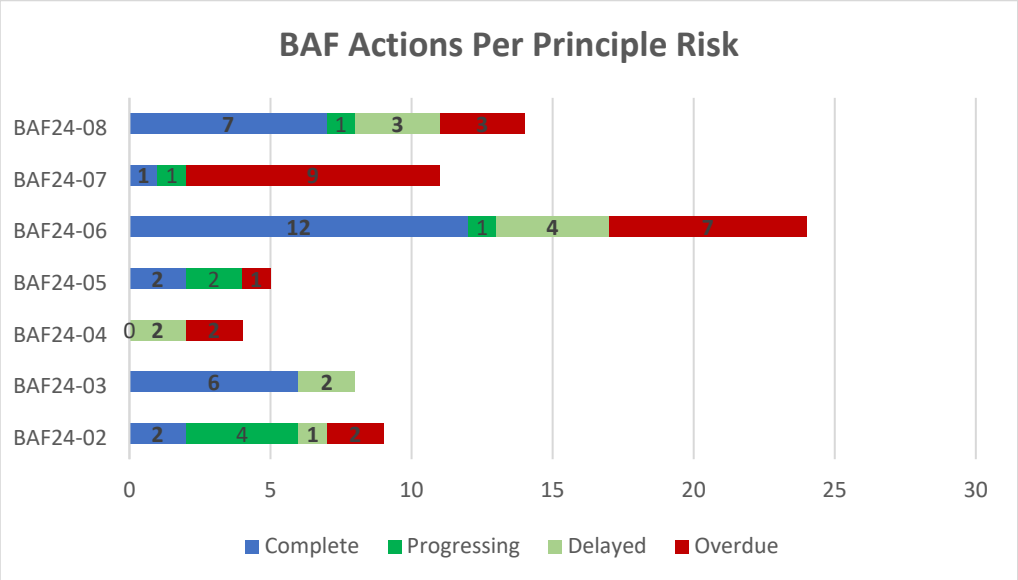
3.1 Overall Action Progress Position

Based on the most recent Board Assurance Framework update, there are 24 actions associated with risks relevant to this Committee. Of these:

- 12 actions are complete,
- 1 action is progressing,
- 7 actions are overdue, and
- 4 actions are delayed.

Completed actions largely reflect improvements in governance arrangements, assurance processes and service-level controls. Overdue and delayed actions are primarily associated with complex programmes of work, including workforce capacity, digital and data dependencies, capital and estates constraints, and reliance on national decision-making, or external approvals.

Across the full BAF, 75 actions are currently recorded, with 24 aligned to the Principle Risk at this Committee. An overview for comparison across the full BAF is noted below:



3.2 Impact on Assurance Levels

The current position of actions aligned to BAF Risk 06 continues to impact the level of assurance available for this risk. While progress is evidenced through completed actions, the persistence of overdue and delayed actions limits confidence that risk exposure is reducing as quickly as intended.

As a result, the assurance rating for BAF Risk 06 remains constrained, reflecting delivery challenges. Assurance is expected to improve as outstanding actions progress and are realigned through the 2026 BAF refresh.

3.3 Outstanding actions aligned to the following Strategic Intents:

Work is underway to align all outstanding and overdue actions associated with BAF Risk 06 to the four Strategic Intents approved in March 2026. This alignment will support clearer prioritisation, improved coherence between actions and strategic objectives, and more focused assurance reporting.

The outcome of this work will inform the development of the 2026–2029 Board Assurance Framework, with updates reported through established governance routes, including the Risk Scrutiny Group.

3.4 Key Constraints

Delivery of outstanding actions within this Committee's remit continues to be constrained by a number of inter-related factors.

Additional constraints include digital and data limitations, capital and estates dependencies, and competing operational pressures, all of which impact the pace at which actions can be progressed and assurance strengthened. These constraints are recognised through governance routes and are being considered as part of recovery planning and the 2026–2029 Board Assurance Framework refresh.

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

- BAF Risk 06 continues to present a constraint to assurance due to a number of overdue and delayed actions, limiting confidence that risk exposure is reducing at the required pace.
- Progress remains dependent on system-wide capacity, digital enablement and cross-directorate delivery, contributing to slippage against original timescales.
- Without sustained Executive oversight and prioritisation, there is a risk that outstanding actions will continue to impact the overall assurance position for this risk.

5. ARGYMHELLION
RECOMMENDATIONS

a. Gofynnir i'r Pwyllgor/Cyfarfod/Grŵp:

The Committee is asked to:

- **Note** the current position of BAF Risk 06, including the impact of overdue and delayed actions on the level of assurance available.
- **Note** the key constraints affecting delivery, including system-wide dependencies, capacity pressures and digital enablement requirements.
- **Support** the continued oversight and prioritisation of outstanding actions to improve assurance and support risk reduction.
- **Note** that outstanding actions will be realigned to the four Strategic Intents as part of the 2026–2029 Board Assurance Framework refresh, with progress reported through established governance routes.

ASESIAD / ASSESSMENT	

Cyswllt â'r Blaenoriaethau Strategol **Link to Strategic Priorities**	1. Building an effective organisation
	Effective Risk Management
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Yr Egwyddorion Dylunio **Design Principles**	Consistency with Organisational Values Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd **Corporate Risks and Board Assurance Framework**	Board Assurance Framework risks linked to corporate risks
Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant Wellbeing of Future Generations Act – Wellbeing Goals	Not Applicable
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:

ASESIADAU O EFFAITH / IMPACT ASSESSMENTS		
Cydraddoldeb *A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o'r Effaith ar Gydraddoldeb (sy'n cynnwys gofynion Safonau'r Gymraeg)* **Equality** *Have you undertaken an Equality Impact Assessment Screening (which includes the requirements of the Welsh Language Standards)*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	Not applicable
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not applicable
Asesiad o'r Effaith Economaidd-gymdeithasol *A ydych chi wedi cynnal Asesiad o'r Effaith Economaidd-Gymdeithasol?* **Socio-Economic Impact Assessment**	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	Not applicable
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not applicable

Have you undertaken a Socio-Economic Impact Assessment		
Ansawdd *A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	**Galluogwyr Ansawdd** **Enablers of Quality** All Apply	**Meysydd Ansawdd** **Domains of Quality** All Apply
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
	Not Applicable	
Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant **Wellbeing of Future Generations Act – Wellbeing Goals**	Not Applicable	

Effaith Amgylcheddol / Cynaliadwyedd (5Rs) **Environmental /Sustainability Impact (5Rs)**	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
	No - Not Applicable	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:	
Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog A ydych chi wedi ystyried Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog: **Armed Forces Covenant Due Regard Duty** Have you considered the Armed Forces Covenant Due Regard Duty?	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	Not applicable
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not applicable
	Do/Yes: ☐	Naddo/No: ☒

Asesiad o Effaith ar Ddiogelu Data *A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?* **Data Protection Impact Assessment** *Have you undertaken a Data Protection Impact Assessment Screening?*	Canlyniad/Outcome:	Not applicable
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not applicable
Asesiad o Effaith ar Atal Twyll *A ydych chi wedi ystyried yr effeithiau ar atal twyll?* **Counter Fraud Impact Assessment** *Have you considered the counter fraud impacts*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	Not applicable
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not applicable
Cyfreithiol **Legal**	There are no specific legal implications related to the activity outlined in this report.	
Enw Da **Reputational**	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith ar Adnoddau *(Pobl / Ariannol)* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

Board Assurance Framework

Quality, Safety and Experience Committee – 7th May 2026

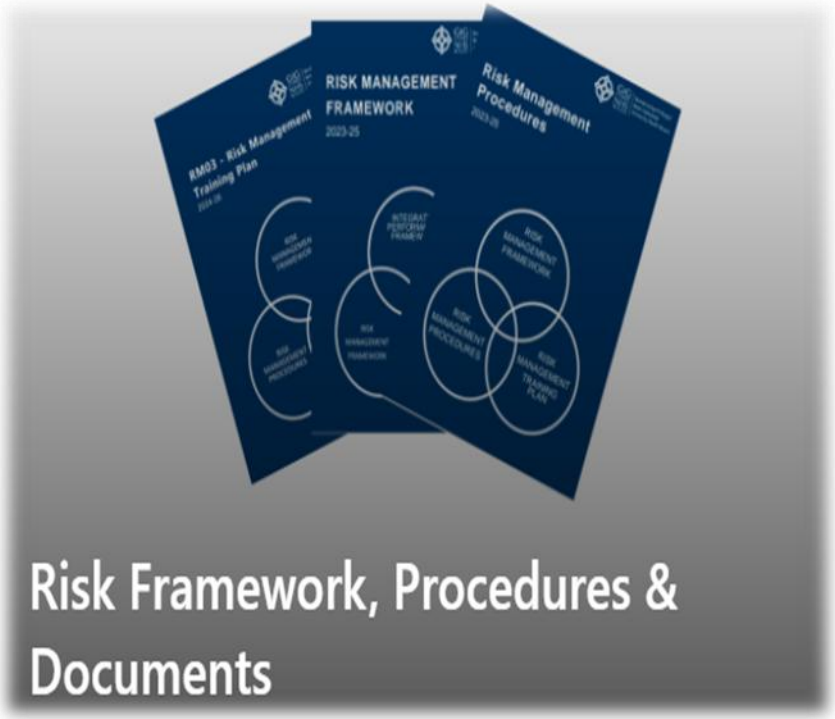
GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Board Assurance Framework

This report provides the Quality, Safety and Experience Committee with an update on the Board Assurance Framework (BAF) risk within its remit, specifically BAF24-06: Not Delivering the Required Improvements to Transform Care and Enhance Outcomes.

The report summarises the current position in respect of this risk, including progress against associated mitigating actions.

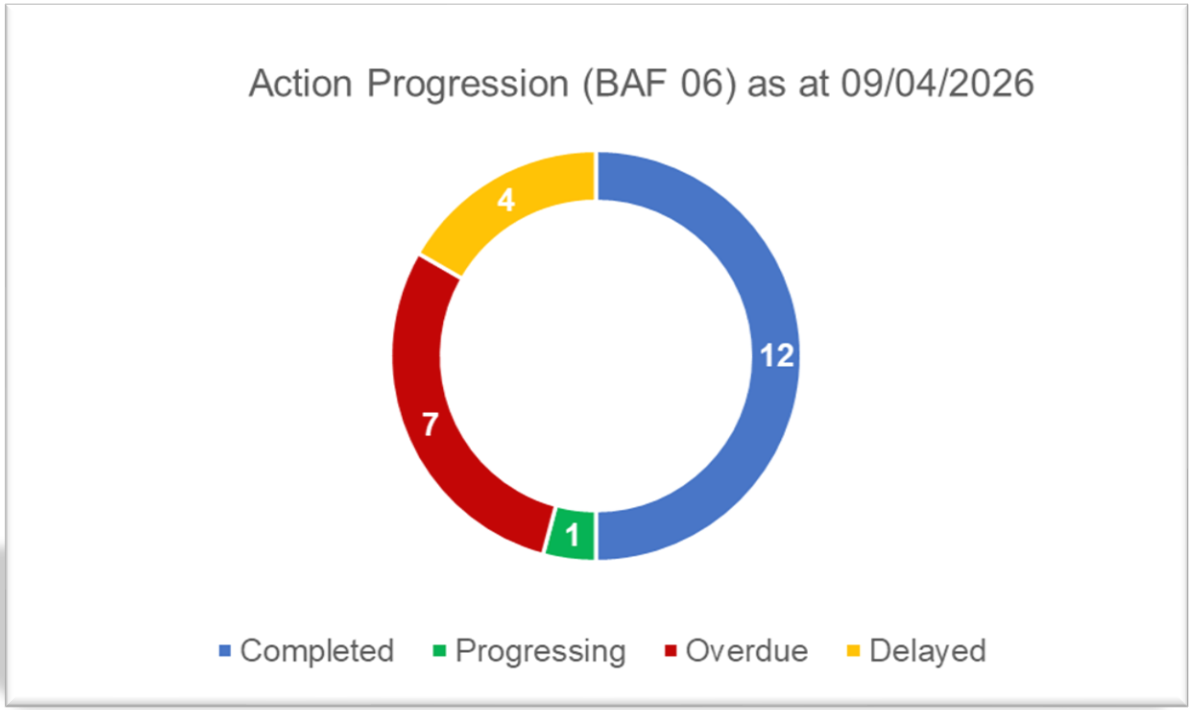


BAF24-06 – Not Delivering the Required Improvements to Transform Care and Enhance Outcomes

BAF24-06 – This risk continues to carry a limited *assurance* rating. The risk score remains unchanged at a score of 20 despite many actions which are progressing and have been completed.

The Risk has also undergone recent deep-dive review at the Risk Scrutiny Group where further scrutiny of actions and controls had been undertaken.

The majority of actions have been completed (50%), with a small number progressing. Overdue and delayed actions are primarily linked to complex, system-wide programmes and capacity or dependency challenges, which are clearly documented and under active oversight.



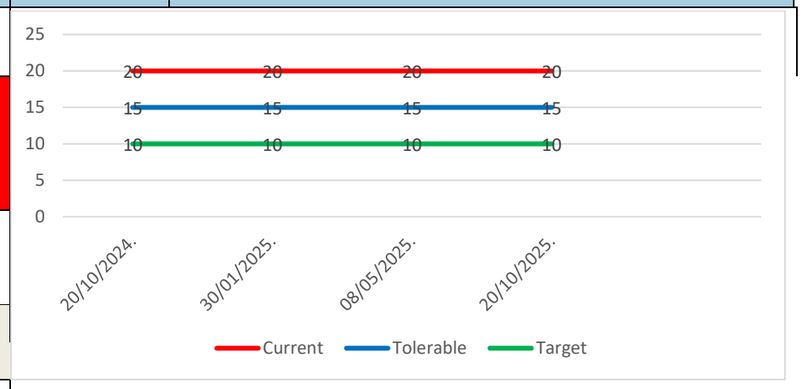
Board Assurance Framework (BAF): 9th April 2026

Appendix 1 – Board Assurance Framework

4: Improving quality, outcomes and experience

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

Principal risk (what could prevent us achieving this strategic objective)	**BAF24-06: Not Delivering the Required Improvements to Transform Care and Enhance Outcomes** Risk of ineffectively delivering consistent high quality of patient care across the HB resulting in incidents of avoidable harm and poor clinical unmet patient needs, regulatory non-compliance, and reputational harm.			**Strategic objective**	4. To Improve Quality, Outcomes and Experience (4A Patient Experience; 4B Prevention; 4I Adult Mental Health, Learning Disability)
Lead Committee	Quality, Safety and Experience Committee / Planning, Population Health & Partnership Committee	**Risk type**	Quality		
Risk Lead	Executive Director of Nursing Executive Director of Public Health Executive Medical Director Executive Director of Allied Health Professionals and Health Science	**Risk appetite**	Open <15 Above Tolerance		
Related Corporate Risks:	CRR25-01, Timely Patient Access to Safe and Effective Care; CRR25-03, Population Needs				



Risk rating			**Review Dates**		
	Current exposure	**Target**			
Consequence	5	5	**Initial date of assessment**	20/10/2024	
Likelihood	3	2	**Last reviewed by Committee:**	21/08/2025	
Risk rating	20	10	**Last updated by Executive:**	20/10/2025	Executive Committee Review – April 2026

Board Assurance Framework (BAF): 9th April 2026

Appendix 1 – Board Assurance Framework

Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps and issues** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
Responsible: Deputy Executive Director of Nursing		Accountable: Executive Director of Nursing	Responsible Committee	Quality, Safety and Experience Committee	

Threat: A loss of organisational focus on patient safety and quality of care leading to increased incidence of avoidable harm, exposure to 'Never Events', higher than expected mortality, and significant reduction in patient satisfaction	• Integrated Concerns Policy and daily Hub meetings in place to review all concerns of moderate, grade4/5 and above
	• Patient incident/feedback systems and policies
	• Data analysis and learning at service level
	• Datix Reporting
	• Patient safety Staff training - Quality governance arrangements at Health Board, IHC/division & service levels including:
	  ○ Local ICOG and Exec EICOG Groups
	  ○ BCUHB patient safety, infection prevention, safeguarding and patient experience groups
	  ○ BCUHB SCEG, meetings
	  ○ Local and Exec Quality Delivery Groups
	  ○ Clinical audit programme & monitoring arrangements
	  ○ Ward accreditation/ metrics
	
	• Integrated Concerns Policy and Toolkit
	• Concerns Hub
	• Rapid review Sign-off process for incidents and Nationally Reported Incidents
	• Executive Led Oversight Group
	• Quality assurance visits
	• Internal Reviews against External National Reports
	• Getting it Right First Time (GIRFT)
	• Localised deep dives, reports and action plans
	• Operational grip on workforce gaps
	• Patient Advice and Liaison Service Activity
	• Comprehensive Cultural Competence training and awareness
		• Operational oversight of sustainable change, evidence of learning and improvement measures
		• Harm review process to be approved for the planned care major change programme
			Management:
			• Learning from deaths Report to QC and Board
			• Quarterly Strategic Priority Report to Board.
			• Divisional risk reports to SRG bi-annually.
			• Guardian of Safe Working report to Board
			• Quality and Governance Reporting Pathway.
			Quality Safety and Experience Committee reports include:
			  ○ Safeguarding Annual Report to QSE
			  ○ Infection Control Annual Report
			  ○ Health and Safety Annual Report
			  ○ Bimonthly Quality Report
			  ○ Deep dive Reports
			  ○ Risk Management Report
			  ○ Integrated Performance Report
			  ○ Duty of Quality annual report
			
			Risk and compliance:
			• Quality Dashboard
			• Duty of Candour
			• Corporate Risks
			• Ombudsman Annual Letter
			
			Independent assurance:
			• Health Inspectorate Wales Reports
			• Care Inspectorate Wales Reports
			• Coroners' reports:
			• Internal Audit reports. Patient Experience –Reasonable
			• Quality Directorate – Reasonable
				Limited Assurance Internal Audit report for Limited Assurance: Lessons Learnt, Falls, Deprivation of Liberty
				
				All actions on track or closed
				
				• Nursing & Midwifery Vision Embedding (launched May 2025)
				• Allied Health Professional Strategy
				• Clinical services plan
				• Harms review process to be approved for planned care
					Limited Assurance

Appendix 1 – Board Assurance Framework

			• Complaints management – reasonable • Royal College Reports • Llais Reports • Ombudsman Screening Quality Assurance Services assessments and reports of: • Antenatal and New-born screening • Breast Cancer Screening Services • Bowel Cancer Screening Services • Cervical Screening Services External Accreditation/Regulation annual assessments and reports of; • Pathology (UKAS) • Endoscopy Services (JAG) • Medical Equipment and Medical Devices (BSI) • Blood Transfusion Annual Compliance Report (MHRA) • Ionising Radiation (Medical Exposure) Regulations		

	Plans to improve control (are further controls possible in order to reduce risk exposure within tolerable range?)	**Action Handler**	**Status of Actions**	**Date when action will be completed**
	Civica mapping of services to improve consistency of levels of feedback.	Deputy Executive Director of Nursing	Complete	31/03/2025
	Expand real-time feedback systems across all services (SMS texting for priority areas e.g. ED).	Deputy Executive Director of Nursing	Complete	31/12/2024
	Quality Management System in development. – pilots in urology and vascular.	Deputy Executive Director of Nursing	Complete	31/03/2025
	Reduced response times for addressing patient complaints.	Deputy Executive Director of Nursing	Complete	31/03/2025
	Learning Repository Development – **A Project Group oversees governance, strategic alignment, and accountability for the wider rollout by 31st April 2026.** ***(Delayed from 31/11/2025)***	Deputy Executive Director of Nursing	**Delayed**	**31/04/2026**
	Harms review process to be approved for planned care activity.	Programme Director Planned Care	Overdue	30/11/2025

Board Assurance Framework (BAF): 9th April 2026

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Appendix 1 – Board Assurance Framework

Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps and issues** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
Responsible: Head of Public Health Assurance & Development	Accountable: Executive Director of Public Health	Responsible Committee: Population Health & Partnership Committee			
Threat: A widespread loss of organisational focus on investment and support to improve integrated prevention to better population health and wellbeing	• Public Health team and other teams across the HB, working on evidenced based programmes of work which link to National and local priorities • Integrated prevention strategies focused on population health and wellbeing to reduce health inequalities • Continuation of Grant funding confirmed 25/26 • Ministerial Priorities include Prevention and Population Health • Prevention, Population Health and Early Intervention Exec Delivery Group established July 25 will review Corporate and emerging risks.	• Limited access to timely integrated data supporting prevention activity. • Insufficient integration between prevention and clinical services • Services fail to prioritise prevention as part of the delivery of effective services and outcomes. • Large proportion of budget is non-recurrent grant funding • Diabetes Pathway Programme delivery plans (service level) - dependent on options for change agreement	**Management:** • Regular reports against a range of outcomes from the public health outcomes framework to Planning, Population Health & Partnership Committee (PPHP). The format for delivery reports is under review for 26/27 to explore more concise approach with all ministerial, local and national performance targets presented alongside the development of a set of core indicators (with associated metrics) under development. • The Prevention, Population Health and Early Intervention Delivery Group has been established over the last 6 months, chaired by the Exec Director of Public Health. This group reports to the Exec Committee and the PPHP Committee in relation to delivery. **Risk and compliance:** • CRR24-08 Delivering a population health approach to health and wellbeing and CRR24-18 Outbreak Management reported to Planning, Population Health & Partnership Committee. Corporate Risk Review has resulted in refresh and consolidation of these two risks into one. • Operational Risk Register maintained.	• Limited assurance of effective models - based on availability of data, intelligence, evidence and evaluation of impact of current prevention approaches within the Health Board and wider partner networks.	**Limited Assurance**

Appendix 1 – Board Assurance Framework

			Independent assurance: • Regular reports against a range of outcomes from the public health outcomes framework to Regional Partnership Board Public Service Boards & Welsh Government • Review held with Welsh Government October 25 –focus on shift to prevention, Health Improvement activity and health inequalities programmes.		

	Plans to improve control (are further controls possible in order to reduce risk exposure within tolerable range?)	**Action Handler**	**Status of Actions**	**Date when action will be completed**
	Increase collaboration with community partners.	Strategic Partnership Manager	Complete	31/03/2025
	Strengthen the integration of prevention into service and Health Board planning.	Head of Public Health Assurance & Development	Complete	31/03/2025
	DDAT/Public Health Integrated approach to population health and clinical data and intelligence embedded in Health Board plans.	Assistant Director - Data, Intelligence & Insight / Consultant in Public Health Medicine	Complete	30/09/2025
	Diabetes Pathway Programme – completion of case for change and next steps agreed - delay in appointing Clinical Lead however this has now gone out for expressions of interest. There have been some revisions to the plan as a result and also in keeping with wider priority programmes including Primary Care. **Completion of the Diabetes Pathway Programme case for change has been completed however the overall implementation of the programme has been delayed in 25.26 due to dependencies, including the appointment of a Clinical Lead. The plan has been revised to align with wider priorities, and the completion date has moved from July 2025 to December 2026.**	Executive Director of Public Health	**Delayed**	**31/12/2026**
	Deliver Primary Care based approaches to improving the compliance with NICE guidance. **Awaiting update and revised date from Primary Care leads.**	Service Leads	Overdue	30/10/2025
	Grant funded Programme plans approved by Welsh Government and Public Health Wales.	Head of Public Health Assurance & Development	Complete	30/04/2025
	Prevention embedded in Board Major Programmes.	Programme Leads / SRO	Overdue	31/03/2026
	Development of Clinical Services Plan and Health Board Strategy recognises prevention as component part. **Development of the Clinical Services Plan and Health Board Strategy, which incorporates prevention as a key component, has been delayed due to dependencies on preceding work. The completion date has moved from March 2025 to December 2026.**	Consultant in Public Health	**Delayed**	**31/12/2026**

Board Assurance Framework (BAF): 9th April 2026

Appendix 1 – Board Assurance Framework

Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps and issues** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
Responsible:	Director of Mental Health & Learning Disabilities	Accountable:	Executive Director of Allied Health Professionals and Health Science	Responsible Committee	Quality, Safety and Experience Committee
Threat: Risk of insufficient focus on Mental Health, wellbeing and Learning Disabilities in the Health Board strategy, planning and operations leading to sub optimal patient outcomes, lack of an holistic approach, regulatory non-compliance and reputational harm.	• Alignment with Welsh Government National strategies for Mental Health and wellbeing, Learning Disabilities and Substance Misuse • Adherence to Royal College and Clinical standards • National NHS Executive Mental Health and Learning Disabilities (MHLD) Strategic Improvement Programme • Established Royal College Psychiatry Improvement programme with Health Board wide reporting and governance • Established reporting through existing HB Governance Frameworks, Oversight committees and routine audits to ensure compliance and monitor progress. • Inclusion in Health Board Annual Plan and monitoring mechanisms • Inclusion in organisational Major change programme, oversight and reporting • Clinically led Physical health work stream in MHLD • Primary care pathways • Crisis Care Concordat in place • **Out of Area bed utilisation biweekly escalation meetings**	• Recruitment and Retention challenges impacting on workforce including interim posts • Engagement and collaboration with physical health services • 'Foundations for the Future' programme maturity • Insufficient focus on health inequalities • Lack of integrated Electronic Health Record and other digital systems • Limited visibility of Mental health and Learning disabilities data at Board level • Current risk to balanced financial position • Waiting lists for care coordination • Greater focus on community and earlier intervention services	**Management:** • External reviews in 2023-24, undertaken as part of Special Measures all recommendations completed and managed. • Performance Management and reporting e.g. IQPD • Civica and patient reporting metrics **Risk and compliance:** • Compliance with Royal College Standards • Audit Reports **Independent assurance:** • Development of co-produced Patient Carer engagement work • Expert advisory group • External reviews • National and Local performance reporting • Together 4 Mental Health Partnership Board in place	• Lack of integrated patient care records impacting on care, planning and reporting • Increasing the scope of performance reviews focusing on patient pathways. • Improving our real time patient data • Visibility of community mental health activity	**Limited Assurance**

Appendix 1 – Board Assurance Framework

	• **MHODG - developing ToRs taking an ambidextrous organisational approach to MH across the organisation led by the Chief Executive.**				

Plans to improve control (are further controls possible in order to reduce risk exposure within tolerable range?)	**Action Handler**	**Status of Actions**	**Date when action will be completed**
Recruitment plans for substantive workforce. Director of Nursing successfully recruited with anticipated start date 17th November 25. Recruitment activity remains business as usual, but progress made across the division and plan now in place. **All substantive SLT appointments in place with no interims. Vacancy rate improved - medic recruitment remains a challenge**	Director of Operations MHLD	Complete	31/09/2025
Increased pathways with Primary care. **Primary Care Service Transformation Delivery group has progressed with work completed outlining system challenges to inform next steps. On track but will be ongoing.**	Consultant Psychiatrist/medical Director	**Delayed**	31/12/2025 **(Ongoing)**
Active engagement with the Foundations for the future programme now completed as MHLD formally engage with aspects of the programme and with be Business as usual until FftF is rolled out.	Director of Operations MHLD	Complete	31/10/2025
Electronic Health Record programme with MHLD as early adopter. **Procurement concluded - assurance activity underway for award of contract. Implementation will be impacted by contract award timescales; this may impact the control completion date, but measures are being into place to mitigate this.**	Interim Director MHLD	Overdue	31/03/2026
Enhanced Savings plans. **OOA/ CHC remain the well documented risks here for delivery, but plans are progressing well.**	Chief Finance Officer	Overdue	31/03/2026
Responsive annual plan.	Head of Integrated Strategy and Development	Complete	31/03/2025
Capping OOA bed utilisation	**Divisional Directors**	**Overdue**	**31/03/2026**
Continued implementation of waiting list protocol to ensure patients are supported whilst waiting.	**Director of Operations**	**Progressing**	**Ongoing**
Implementation of Communication strategy, will remain dynamic and developmental. **Phase 2 plan progressed and group within division to provide leadership to ensure BAU.**	Head of Integrated Strategy and Development	Complete	31/12/2025
Alignment with Learning Disabilities national programme- Improving Care Improving lives review. **The LD transformation programme covers ECRS, Inpatient and Community Services and is fully aligned to the NHS P&I National improvement works. Improvements are project managed through service and divisional governance as well as the national programme. Progress to date includes successful roll out and uptake of Paul Ridd disability awareness training across BCU (not just LD services), introduction of the Health Equalities Framework (HEF) outcomes measure to support identifying health inequalities for people with a learning disability.**	Director Of Operations MHLD	Overdue	31/03/2026

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Quality Safety & Experience Committee

DEVELOPMENT OF THE BCUHB CLINICAL SERVICES PLAN (CSP) - PROGRESS REPORT

Date of Meeting	07 May 2026
Publication Status	Open/ Public
	Not Applicable
Report Author(s) name and title	*Kamala Williams, Interim Assistant Director of Strategy*
Lead Executive Team Member name and title	*Clara Day, Executive Medical Director*

Report Purpose	For Noting

Executive Summary

The Clinical Services Plan (CSP) is being established as a clinically led Major Change Programme within the 2026–29 IMTP. This paper provides an early update on mobilisation activity and the establishment of programme foundations. No service change proposals or decisions are being sought at this stage.

The CSP is intended to address known system risks linked to fragile services, unwarranted variation and inconsistent clinical leadership. While the programme is at an early stage and measurable quality or safety impacts are not yet available, it has been designed to support safer, more sustainable models of care as the work progresses.

The Committee is asked to:

- **NOTE** progress to date
- **CONSIDER** the approach to future oversight, including the information and assurance it will require as the programme develops.

Engagement (internal/external) undertaken to date (including receipt/ consideration at Committee/Group) *Detail in here the engagement that has already been undertaken, for example discussed at QSE on [date], where the proposal was approved in principle*		
Committee / Group / Individuals	**Date**	**Outcome, Evidence and Data**
Progress report paper to the Strategic Planning and Service Change Group (SPSCG)	23rd March 2026	Progress was noted

Acronyms / Glossary of Terms *Include in here all the acronyms included in the paper to aid the reader. Do not assume that everyone will be aware of the terminology used.*	
Clinical Service Plan (CSP)	Sets out how clinical services will be organised, staffed, and supported to deliver safe, effective, and sustainable care for the population, in line with national and local strategic priorities.
National Clinical Framework (NCF)	Sets the overarching national direction for how clinical services in NHS Wales should be designed and organised, providing the strategic principles and quality expectations that guide service planning and improvement.
National Clinical Plan (NCP)	Translates the (NCF) into practical action, setting out the programmes, priorities, and implementation steps needed to develop and improve clinical services across NHS Wales.

DEVELOPMENT OF THE CLINCIAL SERVICES PLAN (CSP) - PROGRESS REPORT

1. SITUATION

1.1 The Health Board is progressing the development of a comprehensive Clinical Services Plan (CSP) to support sustainable, high-quality care across North Wales. Previous large-scale service change has been hindered by fragmented clinical leadership, inconsistent engagement and weak planning structures, contributing to variation in service quality and difficulties sustaining fragile services. The CSP has been designed to directly address these issues through strengthened multi-professional leadership, clearer governance and more robust, evidence-based planning.

1.2 A coherent, system-wide CSP is also a core requirement of the Health Board's Special Measures improvement journey, providing a mechanism to strengthen strategic planning, tackle long-standing service fragilities and demonstrate organisational grip. Reflecting its strategic importance, the CSP has been designated a Major Change Programme within the 2026–29 IMTP, ensuring dedicated resources, enhanced oversight and alignment of service change activity across the organisation.

1.3 The programme will formally launch at the 'Shaping the Future: Clinical Services Plan Co-Design Day' on the 5th of May, with 129 senior clinical leaders invited to participate. At this early stage, the CSP does not propose service changes or create direct quality or safety impacts. However, it has been intentionally designed to address known systemic risks linked to fragile services, unwarranted variation and inconsistent leadership. As the programme progresses, assurance will increasingly focus on how emerging service models strengthen safety, improve outcomes and enhance equity of access.

2. BACKGROUND

2.1 Delivering modern, resilient and high-quality healthcare for the population of North Wales requires a decisive shift from reactive service management to a proactive, strategic and clinically led approach. The CSP will provide the framework for this shift, setting out how services will evolve to deliver person-centred, preventative and evidence-based care aligned with the Health Board's Strategic Intent, emerging 10-year strategy as well as the principles outlined in Community by Design (CbD), the National Clinical Framework (NCF) and developing National Clinical Plan (NCP).

2.2 Delivering this change requires empowered, well-supported and clearly defined clinical leadership across primary, community and secondary care. Effective service redesign depends on leaders who can balance quality, performance and sustainability, use data to inform decisions, work across boundaries and lead change. This will be supported through strengthened leadership development, clearer roles, and improved job planning and remuneration, as set out in the Board-approved 2026–29 IMTP (see extract, section 4C Appendix 1).

2.3 Successful delivery will support coherent clinical service planning, stronger leadership and inter-professional working, enabling clearer decisions, more resilient services and sustainable, high-value care. This is central to delivering the ambitions of the CSP and the Health Board's long-term strategy

3. SPECIFIC MATTERS FOR CONSIDERATION

3.1 As the CSP will formally commence following the 5th of May launch, the Committee may wish to reflect on several early-stage factors that will shape programme delivery. The programme is currently in mobilisation and diagnostic mode, and expectations should remain proportionate while baseline assessments, scope confirmation and engagement activity are completed. Early outputs will not include service redesign proposals, and assumptions about future solutions should be avoided until the evidence base is fully developed.

3.2 The matters outlined in 3.2.1 – 3.2.5 below are intended to shape the Committee's assurance expectations for future reporting, rather than to seek immediate action or decision.

3.2.1 Alignment between the CSP and the Health Board's new operating model is a key dependency. Clarity is required on how emerging clinical leadership structures will interface with CSP workstreams, how responsibilities for future actions will sit within new service groups, and whether transitional governance is needed while both programmes mature.

3.2.2 Given that the CSP will act as the overarching strategic framework for other Major Change Programmes, early and robust interfaces with UEC, Planned Care, Community by Design and enabling strategies are essential to avoid duplication and ensure coherent system-wide planning.

3.2.3 Workforce capacity and capability remain important considerations. The CSP requires significant clinical leadership and planning input at a time of system pressure, and progress on leadership development, job planning and capability-building will be necessary to support delivery.

3.2.4 Finally, the early risk profile is evolving. Initial risks relating to operating model alignment and political uncertainty may shift rapidly, and the Committee may

wish to consider whether the current assessment is sufficiently comprehensive, whether an early review of risk appetite is required, and whether it would value early visibility of planned versus actual programme maturity milestones.

4. KEY RISKS / MATTERS FOR ESCALATION

4.1 Two strategic risks have been identified at this stage, both of which relate to external dependencies and programme timing.

4.2 R01 – Alignment with Operating Model Structures

There is a risk that the sequencing and timing of work to implement the Health Board's new operating model may affect the ability of teams to fully engage with, and action, the CSP requirements. If the CSP work is not integrated effectively with operational restructuring, this could reduce engagement, delay implementation activity, and limit early adoption of new ways of working.

Mitigation: Early and sustained engagement will be undertaken with operational teams to build confidence and ensure they understand how the CSP will complement—and form part of the benefits of—the new operating model. This includes proactive communication, structured engagement sessions, and clear alignment of programme outputs with operational responsibilities.

4.3 R02– Political Uncertainty Affecting Appetite for Change

The wider political environment remains variable, introducing potential uncertainty regarding the scale and ambition of change that can be pursued through the CSP. Shifts in national priorities or ministerial direction could influence the pace, scope, or acceptability of proposed service models.

Mitigation: The programme will continue to adopt an evidence-based approach, drawing on benchmarking, data analysis, and learning from other Health Boards. This ensures proposals are robust, transparent, and defensible regardless of political variability. This approach will be maintained throughout all programme phases

5. RECOMMENDATIONS

5.1 The Group is asked to:

- **NOTE** the progress detailed in this report.
- **CONSIDER** the approach to future oversight, including the information and assurance it will require as the programme develops.

ASSESSMENT	
Link to Strategic Priorities	
	2. Developing strategy and long-lasting change
	If more than one applies, please list below:
Design Principles	Choose an item. All apply
Corporate Risks and Board Assurance Framework	*N/A*
Wellbeing of Future Generations Act – Wellbeing Goals	A Healthier Wales
	If more than one applies, please list below:

IMPACT ASSESSMENTS		
Equality Act 2010 **Public Sector Equality Duty: Has BCUHB provided evidence of 'Due Regard' to compliance with the three parts of the Public Sector Equality Duty (General Duty):** Public Sector Equality Duty [HTML] | GOV.WALES	Yes: ☐	No: ☒
	Outcome:	Provide details of the findings following the review
	If no, please include rationale:	An impact assessment has not been undertaken as this report is purely administrative in nature and submitted for information only.
Equality Act 2010 - Socio-economic Duty *Has BCUHB provided evidence of 'Due Regard' to compliance of ther Socio-economic Duty when making strategic decisions?*	Yes: ☐	No: ☒
	Outcome:	Provide details of the findings following the review
	If no, please include rationale:	An impact assessment has not been undertaken as this report is purely administrative in nature and submitted for information only.

Have you completed an Integrated Equality Impact Assessment WP8a? *WP8a Template*	Canlyniad/Outcome: Do/Yes:	Naddo/No:
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale: Canlynaid/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	An impact assessment has not been undertaken as this report is purely administrative in nature and submitted for information only.
Human Rights Act *Have Human Right based concerns been addressed within WP8a*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
Compliance to the Welsh Language requirements? *Have you undertaken an Impact Assessment*	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Naddo/No: ☒
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	An impact assessment has not been undertaken as this report is purely administrative in nature and submitted for information only.
Compliance to giving 'Due Regard' to the principles of the Armed Forces Covenant *Have the principles of the Armed Forces Covenant been addressed within WP8a*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	An impact assessment has not been undertaken as this report is purely administrative in nature and submitted for information only.
Quality *Have you undertaken a Quality Impact Assessment Screening?*	**Enablers of Quality** All Apply	**Domains of Quality** All Apply

	If more than one applies, please list below:	If more than one applies, please list below:
	Please list other Enablers of Quality in here	*Please list other Domains of Quality in here*
Wellbeing of Future Generations Act – Wellbeing Goals	A Healthier Wales	
	All apply	
Environmental /Sustainability Impact (5Rs)	No - Not Applicable	
	If more than one applies, please list:	
	If no, please include rationale:	An impact assessment has not been undertaken as this report is purely administrative in nature and submitted for information only.
Data Protection Impact Assessment *Have you undertaken a Data Protection Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	Provide details of the findings following the review
	If no, please include rationale:	The paper is administrative and informational in nature and does not involve the processing of personal data, nor does it introduce any new data flows, systems, or changes that would trigger DPIA requirements.
Counter Fraud Impact Assessment *Have you considered the counter fraud impacts*	Yes: ☐	No: ☒
	Outcome:	Provide details of the findings following the review
	If no, please include rationale:	The paper is administrative and informational in nature and does not propose any changes to financial processes, resource flows or operational arrangements that would

		warrant consideration of counter fraud implications
Legal	There are no specific legal implications related to the activity outlined in this report.	
	If yes, include further details in here	
Reputational	Yes (Include further detail below)	
	The absence of a CSP represents a reputational risk for the Health Board, reinforcing perceptions of weak strategic grip, limited progress on long-term service improvement and a lack of clarity on how safe and sustainable services will be delivered. This may undermine confidence among partners, regulators and stakeholders, increase external scrutiny and weaken assurance at a time when visible progress is critical.	
Resource Impact *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	
	If yes, include further details in here	

APPENDIX 1

Extract from BCUHB 2026_2029 IMTP (pages 89-92)

4C – Clinical Services Planning, Leadership and Interprofessional Working

Why this is a priority

Delivering sustainable, high-quality services for the people of North Wales requires a clear, forward-looking Clinical Services Plan (CSP) supported by strong, skilled and collaborative clinical leadership. Together, these elements provide the foundations for moving from reactive service management to a proactive, coherent approach that aligns strategic ambition with the realities of clinical practice, workforce capability and population need. The CSP sets out how services will evolve to provide person-centred, preventative and evidence-based care, reducing unwarranted variation and ensuring that models of care reflect the principles of Community by Design and the priorities of the Health Board's long-term strategy.

Central to achieving this vision is empowered, multi-professional clinical leadership. Modern healthcare demands leaders who can balance quality, performance and sustainability, work across traditional boundaries, use data intelligently and make value-driven decisions. These skills are essential for guiding the redesign work underway through the first phase of the CSP work, where clinically led assessments of challenged or fragile services are informing options for consolidation, redesign or new models of care. This is being built upon in the 'Fragile Services' section of the IMTP, which will identify and address clinical services that meet the principles for fragility in the National Clinical Framework (AR-13). As the CSP progresses, effective leaders will be needed across all sectors; primary, community and secondary care, to drive change at pace, support colleagues through transition and ensure that service improvements translate into better outcomes for patients.

To enable this, clearer role definitions, strengthened leadership development offers and more robust job planning and remuneration models will be required. Creating attractive, well-supported clinical leadership roles is essential to engaging clinicians in shaping the future of services and ensuring that redesign is grounded in practical experience and professional insight.

By integrating structured clinical service planning with strong inter-professional leadership, the Health Board will be better equipped to make consistent, transparent decisions, strengthen regional working, improve workforce resilience and deliver sustainable, high-value care. This combined approach is critical to realising the ambitions of the 10-year strategy and creating a modern, resilient and equitable healthcare system for North Wales.

What we will deliver

2026/27 Deliverables

Workstream	Deliverable	Lead Executive – Committee	Quarter	Ref	Impacts
CSP methodology and initial engagement	4C.1 - Agree the CSP methodology and first tranche of areas to be prioritised and establish the CSP Programme by developing the programme structure, governance, and delivery approach, supported by targeted internal engagement and awareness raising activities to build understanding and organisational buy in. Success will be demonstrated through formal approval of the methodology, confirmation of programme governance, and evidence of staff awareness and engagement across key teams including the first major engagement event held.	Executive Medical Director - PPHP	Q1	SM-07 AR-13	P01
CSP preparatory work for first tranche of areas	4C.2 - Operationalise the CSP Programme by finalising detailed delivery plans for the process (pertaining to the first tranche of areas), establishing programme reporting and risk management processes, and initiating structured engagement with leads to prepare for CSP assessments. Success will be demonstrated through approved delivery plans, active reporting cycles, and evidence of areas' readiness to enter the CSP process in Q3.	Executive Medical Director - PPHP	Q2	SM-07	P01
CSP first tranche areas assessments	4C.3 - Deliver the full CSP assessment process for the first tranche of priority services, including evidence gathering (including use of key population level intelligence, assessment workshops, option development and prioritisation. This will be supported by structured engagement with leads and clinical and operational teams from the full set of professional groups to ensure clarity, collaboration and high-quality outputs. Success will be demonstrated through completed CSP assessment documentation and agreed prioritisation outcomes for all first tranche areas that demonstrates Community by Design principles, maximise pathway redesign and strengthened joint working between primary and secondary care and partners.	Executive Medical Director - PPHP	Q3	SM-07 SM-31 TPG-09 TPG-66 TPG-150	P01
CSP first tranche areas service change proposals	4C.4 - Finalise and submit the first tranche of CSP service change proposals for formal approval by the CSP Programme Board. This will include refining proposals based on feedback, completing required documentation, and ensuring alignment with strategic, operational and financial considerations. Success will be demonstrated through Programme Board approval of all first tranche service change proposals and confirmation of readiness for wider Health Board governance approvals and implementation planning.	Executive Medical Director - PPHP	Q4	SM-07 SM-37	P01

Clinical Leadership	4C.5 - Job descriptions with roles with responsibilities and appropriate remuneration in place for all clinical leadership posts with Foundations for the Future organisation structure, across primary, community and secondary care. (Links to 4A – Foundations for the Future)	Executive Medical Director - PPHP	Q1	SM-60	P02
	4C.6 - Commence implementation of a menu of formal training programmes informed by training and development needs analysis for all within clinical leadership positions, across primary, community and secondary care. (Links with 4J – Workforce)	Executive Medical Director - PPHP	Q3	SM-34 SM-60	P04
	4C.7 - Generalised upskilling related to modern NHS needs via Clinical Services Plan programme to include strategic planning, value-based health care, population health management etc, across primary, community and secondary care. (Links with 4J – Workforce)	Executive Medical Director - PPHP	Q4	SM-34 SM-60 IPT-07	
	4C.8 - Develop a clear and attractive career path and development package for those in or aspiring to Clinical Leadership position, drawing on internal and external expertise and support including NHS P&I and CMO. Across primary, community and secondary care.	Executive Medical Director - PPHP	Q4	SM-60	
Interprofessional Working	4C.9 - Provide clarity over best practice clinical and operational multi-professional working, in line with the new operating model structures roll out, both roles and responsibilities and effective team working. Across primary, community and secondary care. (Links to 4A – Foundations for the Future)	Executive Medical Director - PPHP	Q1	SM-60	
	4C.10 - Provide organisation development support to ensure newly formed teams are working effectively together across clinical and operational inter-professional disciplines. Across primary, community and secondary care. (Links to 4A – Foundations for the Future)	Executive Medical Director - PPHP	Q2-Q3	SM-60 IPT-07	
Related deliverables covered in other sections	▪ 1B – Proactive strategies for disease prevention, falls & frailty ▪ 3B – Planned Care, Cancer & Diagnostics ▪ 3C – Fragile Services ▪ 3G – Women's Health ▪ 4A – Foundations for the Future ▪ 4J – Workforce ▪ 4K – Finance & Commissioning				

2027/28 Deliverables	2028/29 Deliverables
▪ Start preparatory work on the next tranches of areas to be taken through the CSP process, building on learning from the first year and ensuring a more efficient, consistent and evidence-based approach. ▪ Embed and mature the CSP methodology across the organisation by strengthening governance, capability and alignment with enabling strategies and wider planning activity, while supporting operational teams to begin implementation planning for the first tranche service change proposals approved at the end of 2026/27. ▪ Support teams with the implementation of service change ensuring they follow the BCUHB Organisational Approach to Change. ▪ Assessing the success in relation to increased interest and Clinical leadership roles filled.	▪ Continue to work through the next set of tranches, applying the process and approach tested and refined through 2026-28. ▪ Continue to support existing service change implementations, ensuring they are operating as expected, fully embedded and any learning from this stage factored into future changes. ▪ Embed CSP learning into wider organisational planning processes and training.

What difference it will make

ID	Performance Expectations	Ref	Level 5 De-escalation criteria	Planning / Performance Framework	Baseline	Q1	Q2	Q3	Q4
P01	Develop the measures of success in relation to both population and patient outcomes as well as the CSP process for those areas selected in the first tranche of the CSP.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
P02	Number of clinical lead vacancies.	N/A	N/A	N/A	To be defined as part of FFTF work				
P03	Training and development feedback scores.	N/A	N/A	N/A	Measure to be developed				

Risks to delivery and how we'll mitigate them

ID	Delivery Risk Description	Risk Score (Baseline)	Mitigating Action	Quarter	Risk Score (Target)
R01	Timing of operating model structures work could impact adequate team engagement and implementation of actions relating to the CSP.	4 x 4 = 16	▪ Invest in early and continual engagement and involvement with teams, securing belief that the CSP work will be part of the benefit of the new operating model structures.	Q1	4 x 2 = 8
R02	Unstable political environment leading to uncertainty around appetite for scale of change.	4 x 3 = 12	▪ Proceed on an evidence-based approach and take learning from other Health Boards.	Q1 - 4	4 x 2 = 8
R03	Sufficient resources (funding and time) are not prioritised both corporately and locally.	3 x 3 = 9	▪ Agreement of key success criteria and demonstrating progress towards it. ▪ Engagement and co-production of this work with a range of professional groups.	Q1 Q1	3 x 2 = 6
R04	Insufficient number of clinicians will want to progress into leadership position.	4 x 3 = 12	▪ Engagement and co-production of this work with a range of professional groups. ▪ Progress of Clinical Services Plan work for people to see the potential for service transformation.	Q1 Q1	4 x 2 = 8

Quality Safety & Experience Committee

CHALLENGED SERVICES REPORT

Date of Meeting	07 May 2026
Publication Status	Open/ Public
	Not Applicable
Report Author(s) name and title	Geraint Parry, Interim Assistant Director Transformation & Improvement Julie Ward-Jones, Head of Improvement
Lead Executive Team Member name and title	Paolo Tardivel, Interim Executive Director of Transformation & Strategic Planning Tehmeena Ajmal, Chief Operating Officer Clara Day, Executive Medical Director

Report Purpose	For Assurance

Executive Summary

The purpose of this paper is to provide the committee with an overview of current progress and assurance regarding scrutiny that has already taken place at the Strategic Planning and Service Change Group.

The paper provides an update on the eight Welsh Government identified challenged services under enhanced monitoring and provides assurance to the Group on progress, remaining risks, and the effectiveness of actions underway to improve safety, quality and sustainability across these specialties.

As previously reported, 2 specialties – Plastics and Oncology – have made sufficient progress to be considered for transition to Business as Usual arrangements and discussions with Welsh Government are ongoing regarding this. The remaining specialties - Vascular, Ophthalmology, Dermatology, Urology, Orthodontics and Orthopaedics - continue to experience significant operational pressures driven by rising demand, workforce shortages, estate limitations and inconsistent pathway models. Gastroenterology (included Endoscopy) will also be formally recognised as a Challenged Service from April 2026 with reporting mechanisms being set up for inclusion in future reports.

The Committee is asked to **note** the progress made across all eight challenged services and **receive assurance** that risks are being appropriately managed. Whilst progress is noted across all specialties the Strategic Planning and Service Change Group did receive escalations at its April meeting regarding challenges in addressing the issues with the Urology on-call set-up and the need to progress an interim model for Dermatology at increased pace.

Engagement (internal/external) undertaken to date (including receipt/ consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome, Evidence and Data**
Strategic Planning and Service Change	23/04/2026	Approved for onward submission.

Acronyms / Glossary of Terms	
WG	Welsh Government
IMTP	Integrated Medium Term Plan
CSP	Clinical Services Plan
MDT	Multidisciplinary Team
CLTI	Chronic Limb-Threatening Ischaemia
AAA	Abdominal Aortic Aneurysm
SAS	Specialty Associate Specialist and Specialist
SOP	Standard Operating Procedures
MDT	multidisciplinary team
POAC	pre-operative assessment clinic
HVLC	high volume low complexity
WGOS	Welsh General Ophthalmic Services
HCQ	Hydroxychloroquine
IVT	intravitreal therapy
EPR	Electronic Patient Record
JCC	NHS Wales Joint Commissioning Committee

Urology – Challenged Service Update	RAG
Executive Summary There remains sustained pressure on urology services across Betsi Cadwaladr UHB but material progress has been made in stabilising performance and improving sustainability. Significant reductions in long waits have been achieved through targeted insourcing, LATP diagnostic capacity and flexible cystoscopy delivery. Access to cancer diagnostics has improved, with some patients now being seen within days of decision to investigate, while reliance on distant outsourcing has reduced through local capacity and closer regional partnerships.	

Issue	Progress	Impact (actual and potential)
1. Unsustainable use of locum consultants due to recruitment and retention issues related to unattractive on-call rota and lack of robotic surgery provision	• Work is underway to redesign the urology on-call model through formal emergency activity data collection; analysis of data to be presented to Urology Steering Group in May 2026 • Progress has been made in developing access to robotic prostate surgery (RAS) through partnership arrangements and commissioning proposals.	Better understanding of workload enabling smarter rota design Supporting recruitment and retention of substantive consultants
2. Lack of recruited clinical leadership pan BCU and vacancy within West IHC	• The vacancy within West IHC has now been filled provided a full set of IHC leads • Pan BCU leadership roles will be addressed via Foundations for the Future; in the meantime leads across BCU are working together with the support of IHC Medical Directors.	Lack of pan BCU clinical leadership impacts on service redesign and decision making
3. No contracted vasectomy provision in primary care	• Full tender programme for commissioned Vasectomy service agreed with procurement. The service specification is now being drafted ahead of the procurement process commencing in May 2026, a slight delay from mid-March due to focus on 104-week position and other commissioning priorities. Aim to have services commissioned by September 2026.	Potential to increase capacity and improve local access for patients.

Issue	Progress	Impact (actual and potential)

4. Performance – waiting time delays in urgent suspected cancer, first appointments and diagnostics caused by rising demand, inefficiencies and inconsistent and out dated practices	• Improvement in waits for first appointments and diagnostics:
	  ○ 104+ week waits (un-booked patients) reduced from: 1,272 (March 2025) to 192 (March 2026)
	  ○ 52+ week waits for first appointment (un-booked patients) reduced from: 1,855 (March 2025) to 68 (March 2026)
	  ○ 128 LATP diagnostic slots delivered during the reporting period, with some patients now receiving prostate biopsy within 7–10 days of decision to investigate
	• Flexible cystectomies:
	  ○ 512 flexible cystoscopy slots delivered
	  ○ Removed all 104+ week pathways requiring flexible cystoscopy
	  ○ LATP funding agreed through Q2 2026/27; and Flexible cystoscopy funding (£150k**)** approved to support: 480 additional slots, reduction in 8-week waits in line with IMTP trajectory
		Reduction in waiting times for patients

5. Poor patient experience due to significant travel to existing outsourcing providers	• Progress has been made with a strategic move away from long-distance outsourcing (e.g. London-based providers):
	  ○ Agreement with the Wirral to support 20 robotic-assisted prostatectomies across the course of 2026/27
	  ○ A standard operating procedure has been developed to outline how the arrangement will work in practice and preparatory work underway
	• A private provider in Chester (Spire) has indicated capacity for up to 50 RAS prostatectomies per year, which will be progressed with procurement
		Reduction in travel burdens and enabling timelier treatment. Treatment nearer to home

Issue	Progress	Impact (actual and potential)
6. Lack of interventional radiology out of hours and inequity of service provision across North Wales due to differing provision across IHCs	• The Diagnostic Management Team is developing a paper for Executives outlining out-of-hours interventional radiology requirements for urology and proposed next steps.	Current mitigation through escalation via silver and gold on call
7. Lack of estates to increase capacity	• Future service resilience is being prepared for through a business case for a Urology Investigation Unit. Business case to be prepared and submitted for consideration in 2026/27, however due to financial constraints potential funding streams are being considered before submission.	Increase diagnostic capacity

Ophthalmology - Challenged Service Update		RAG
Executive Summary Ophthalmology remains a service with significant challenges; these include long waits, workforce and leadership gaps, ageing infrastructure and data-quality issues. Recent progress in Teach & Treat capacity (allowing optometrists to improve skills while providing faster patient care), cataract efficiency and data improvement is beginning to strengthen demand management; however, sustained focus is still required to stabilise the workforce, strengthen leadership and deliver estates and digital upgrades to ensure a safe, consistent and sustainable service across the Health Board.		
Issue	**Progress**	**Impact (actual & potential)**
1. Delayed access to patient care resulting in patient harm and/or poor patient experience	• Delivered patient wait time reduction through Glaucoma Teach & Treat. Four graduates delivered 700 long waiting patient reduction. Graduates to collectively offer >4000 community-based capacity per annum. • Outsourced/insourced 5,288 patients during 2025-2026 financial year to further reduce waiting times for those waiting the longest. • Delivery of One Stop (pre-operative assessment clinic) POAC and HVLC (high volume low complexity) surgery models pan BCU achieved: - Central IHC BAU delivery of four One Stop POAC and four HVLC (8 patients/session)/month. Remaining IHCs to deliver Q1, 2026-27, increasing throughput and shortening key pathway delays.	Reduction in patient waiting time. Improving the access to patient care and timely treatment, helping to reduce patient harm, improve patient outcomes and enhancing patient experience.
2. Data quality & completeness with an impact on sub-speciality cohort identification and ability to report regionally	• Developed a multi-professional case-note review proposal and completed data quality scope to address clinical coding anomalies. Improved Cataract data quality and established standard regional coding. Funding confirmed Q4, 2025-26, with working group onboarding: to deliver standard Ophthalmology subspeciality coding to enable regional care and maximise identification of which patients are suitable for WGOS	Enables accurate referral management and treatment listing; more accurate performance reporting, demand and capacity leading to better quality planning

Issue	Progress	Impact (actual & potential)
	community-based monitoring. Oversight by newly formed Steering Group, Q1 2026-27 onward.	
3. Ageing estates, equipment and areas of non-compliance with disability access	• Lead adopter of national e-referral. • Implementation of the 'Open Eyes' Electronic Patient Record in progress • Successful West IVT (intravitreal therapy) clean room business case: with project team onboarded to deliver implementation	Improved waiting list management and increased treatment capacity
4. Lack of recruited pan- BCU clinical lead (Ophthalmology & secondary care Optometrist)	• As we move into the Foundations for the Future consultation and 2026/27 implementation phase, appointing a short-term clinical lead is challenging. Therefore, a proactive approach is taken by working closely with clinicians to drive ongoing Eye Care improvement.	Clinical ownership and broader engagement with pathway development.
5. Unsustainable workforce plan: with retire & return and locum reliance for core delivery	• Workforce planning project lead onboarded Q3, 2025-26. • Primary care extended workforce delivering WGOS (Welsh General Ophthalmic Services) pathways, with sustainability supported by Teach & Treat training courses: expanded to 4 in Q3, 2025-26 (Glaucoma/Medical Retina/Independent Prescribing/Hydroxychloroquine screening	Workforce can be aligned to service needs through identification of gaps, pressures and opportunities for redesign
6. Lack of a single service model across North Wales	• Sustainable models of Care progression led by Pan BCU clinically-led networks. Enabled by delivery of standard regional coding-establishment, the Pan BCU Cataract Network progressed One Stop POAC and HVLC PDSA tests of change in Q2, 2025-2026, delivering staged progression of standard One Stop/HVLC regional model	Improved patient safety and flow by directing patients for the right care and treatment

Vascular - Challenged Service Update		RAG
Executive Summary The Vascular Service continues to demonstrate positive progress in addressing key challenges identified through external and internal review. There has been a sustained reduction in long waits, supported by alternative access routes such as nurse-led clinics and the development of Hot Clinics for higher-acuity patients. Work to strengthen the clinical strategy and integrated service framework is progressing, underpinned by an established improvement plan, service model redesign, enhanced demand and capacity work, and improved performance oversight. Further work continues in challenged areas to build a stronger culture to enable a safe learning environment and improve Multidisciplinary working relationships.		
Issue	**Progress**	**Impact (actual and potential)**
1. Unsustainable workforce due to consultant age profile and UK-wide vascular shortage, and lack of surgical speciality trainees	• Development of the operational work force plan has commenced, focusing on identifying and addressing key workforce challenges across the service. Initial actions have been identified including the requirement to review specific staff groups. Further work will continue to finalise plan and commence implementations of actions. **also see Issue/progress 6*	Improved job satisfaction and morale leading to retention of SAS grade doctors.
2. Large number of people waiting for appointments leading to delays in assessments and/or treatment	• Nurse-led clinics provide timely access to vascular review, offering an alternative to ED, SDEC and traditional outpatient clinics • Development of 'Hot Clinics' is now underway, with planned implementation at YGC, particularly for patients with Chronic Limb-Threatening Ischaemia (CLTI) • A review of varicose vein referrals following a change in policy has been completed. Targeted work is commencing with GP practices to improve	Continued reduction in 104+week waiters, with numbers falling from 27 (January 2026) to 3 (March 2026) Stage 1 waits have also reduced month-on-month from 1834

Issue	Progress	Impact (actual and potential)
	pathway adherence and reduce avoidable delays and appropriate demand.	(January 2026) to 1354 (March 2026)
3. Challenges impacting working relationships across the Multidisciplinary Team	• Two SOPs have been formally agreed and signed off by the Consultant body, providing clarity, consistency and shared expectations across professional groups; a further four SOPs have been shared with Consultants and are ready for sign off. • An established Improvement group is leading the programme of work, providing a formal, multidisciplinary forum for joint problem-solving and decision-making.	Strengthened leadership and the ability to affect change; reduction in concerns in relation to professional conduct; clearer pathways, processes and role expectations.
4. Further work required to strengthen clinical strategy and service framework to ensure seamless integrated working	• External assurance received from Health Inspectorate Wales (HIW) • Clinical direction is being strengthened in a number of ways incrementally, including the development of a consistent model for diabetic foot services, addressing variation in practice and MDT functioning, supported by leadership charters. A Vascular Clinical Audit group has also been established and is working through an agreed list of clinical audits, including an audit of any new pathways. • A preliminary redesign of the vascular integrated performance dashboard has been completed and shared with the vascular data analyst for rebuild; this will strengthen oversight of access, performance and flow across the whole network, supporting more proactive and integrated decision making.	Consistent model across network; improved shared decision-making leading to better patient outcomes
5. Lack of estates to increase capacity	• Discussions have taken place regarding the use of community spaces to support service delivery with work due to commence to identify appropriate clinics that can be delivered from these community settings.	Increased clinic capacity delivering care closer to home

Issue	Progress	Impact (actual and potential)
6. Suspension of new FY1s rotating into the service	• A 'Safe Learning Charter' has been soft-launched with supporting maturity matrix tools developed to build a stronger learning culture – full launch is due in April 2026. • Funding secured for a SAS grade doctor to undertake a PG Certificate in Medical Education, supporting workforce development, retention and future capacity building.	Fostering of a positive safety and continuous learning culture to support the return of FY1s.

Dermatology - Challenged Service Update		RAG
Executive Summary Dermatology remains a service under sustained pressure from workforce shortages, demand exceeding capacity, and infrastructure constraints, particularly in the West locality; however, it evidences meaningful mitigating progress this period, including significant reductions in cancer and long-waiting patients. While performance and access have improved and patient harm risk has reduced, delivery remains reliant on interim solutions.		
Issue	**Progress**	**Impact (actual and potential)**
1. Inability to recruit Consultant staff (in the West IHC)	• Whilst there has been no substantive resolution to the inability to recruit permanent Consultant staff in West IHC, short-term service stability has been achieved through insourcing, locum Consultants, and executive-backed interim models – with the EquIA due to be presented to OLT in April 2026	Address short-term fragility and provide a clearer understanding of patient and workforce impacts whilst long-term plans develop.

2. Increased demands which outstrip the capacity of the current model has led to longer waits	• Continued insourced provider support in the West has increased available clinical capacity over the reporting period, reduction of >52 and >104 week waits with a additional cancer activity happening in Central and East IHCs.
	• Work is underway to reduce pressure on outpatient capacity by changing how demand is managed:
	  ○ Optimisation of referral processes
	  ○ Continued development of Teledermoscopy services across North Wales to avoid unnecessary outpatient appointments and enable quicker clinical decisions and treatment
		Reduction in long waits for patients

Issue	Progress	Impact (actual and potential)
	○ Consideration of **PIFU / SOS models** for low-risk cancers to release follow-up capacity for higher-need patients	
3. Inability to deliver key performance targets	• RTT 104-week performance is reported as on track to deliver within Q1. • Suspected Cancer Pathway (>62 days) breaches have reduced significantly: 1,261 patients down to 392. • Continued reduction in USC first OPD waits noted during the reporting period: From 1,539 to 1,195	Continued delivery against key performance targets
4. Delays with access to patient care resulting harm and poor patient experience	• Reductions in Single Cancer Pathway (SCP) and Referral to Treatment (RTT) long waits supports the decrease in clinical risk and poor patient experience (*as per progress in 2 &3*) • Clerical and clinical validation of follow-up waiting lists underway to improve the 100% overdue position	Risk reduction of patients being delayed beyond clinically appropriate review points.
5. Insufficient current facilities across North Wales to deliver Minor Operative Procedures and increase outpatient capacity and enable 'one stop' approach.	• Continuation of funding is confirmed to support ongoing Minor Op (MOPs) activity at Connah's Quay Health Centre • Authorisation of a scrub sink at Connah's Quay Health Centre has been approved, enabling the introduction of Plastic Surgery MOP activity.	Reducing reliance on acute site facilities whilst developing conditions to optimise a 'one-stop' approach

Plastics - Challenged Service Update		RAG
Executive Summary Plastic Surgery services in North Wales are becoming more stable, with all issues related to the 2025/26 contract now resolved and no patients waiting longer than 104 weeks to be seen. While the waiting list has been maintained rather than reduced, overall progress is positive, and work continues to expand clinic capacity and finalise long term plans to support sustainable, high quality care for patients across the region.		
Issue	**Progress**	**Impact (actual and potential)**
1. Lack of timely access – high volume of new and follow up patients waiting over target time	• Waiting list position maintained with zero patients waiting > 104 weeks. • Plastics clinical team have raised some concerns in relation to national decision to move some skin cancer patients to a PIFU (patient initiated follow-up) pathway; further clinical discussions will take place at the BCUHB Skin Cancer Clinical Advisory Group.	Reduction in waiting times for new and follow up patients
2. Inequity – no theatre provision in Central IHC with patients having to travel to England for treatment.	• Connah's Quay facility successfully tested single plastics outpatient clinic in February 2026. • Work underway to review costs of Connah's Quay activity and potential funding stream to address financial impact of costs incurred via JCC contract.	Increased capacity, reduction in waiting times
3. Poor infrastructure and operational support in north Wales	• All outstanding issues relating to 2025/26 contract now resolved. • Travel funding issues for visiting surgeons have been resolved	Secured continuity of care for local patients

Oncology - Challenged Service Update		RAG
Executive Summary Oncology services remain challenged primarily due to workforce shortages, with reliance on locum consultants driving financial overspend and creating delivery risks, although there has been encouraging interest from potential Medical and Clinical Oncology consultant applicants, supported by planned site visits. Progress continued on the development of a comprehensive Clinical Strategy, which completed end of March 2026 and is currently out for consultation with key stakeholders. This will support recruitment, service planning and future sustainability.		
Issue	**Progress**	**Impact (actual and potential)**
1. Fragile senior medical staffing due to high volume of locums and low number of substantive due to inability to recruit	• Progressing discussions to backfill activity for consultant commencing career break from April 2026, ensuring continuity of care for lung and urology patients, and redistributing workload safely across the existing consultant body where appropriate • Exploring funding options with finance to support a trainee's request to take time out of their training programme to gain further experience (Out of Programme (OOP) Experience) recognising the potential long-term benefit to service development and consultant retention.	Stable workforce contributing to improved performance, patient safety and patient experience
2. Increasing demand for oncology treatments with increasing numbers of NICE/AWMSG (All Wales Medicines Strategy Group) approvals of regimens	• Performance against SACT and radiotherapy targets declined during the month, largely due to rising demand, increasing treatment complexity, toxicity-related deferrals - all patients have been booked in line with clinical priority to maximise safety and outcome - and limited radiotherapy planning capacity, despite treatment machine availability.	Improved access to treatments and reduction in delays for patients
3. Increasing complexity of treatments including toxicity	• The clinical strategy group concluded strategy development at the end of March 2026. The strategy is currently out for consultation with staff and key stakeholders with consultation due to conclude by the end of April	To guide future service improvements and support recruitment by clearly setting

Issue	Progress	Impact (actual and potential)
	2026. Feedback will be reviewed and strategy updated prior to submission to the Clinical Effectiveness Group for approval.	out the vision for oncology care in North Wales.
4. Increasing number of patients remaining under oncology review – cancer has become a chronic condition	• The clinical strategy will play a key role in supporting future business cases for additional medical and non-medical support. The timeline for associated proposals is likely to extend into the longer term.	Increased capacity to see patients across a diverse workforce.

Orthodontics - Challenged Service Update		RAG
Executive Summary Orthodontics remains a highly challenged service, with workforce shortages, limited clinical capacity and infrastructure issues now creating a significant and growing treatment backlog that poses ongoing patient safety risk. Overall progress remains limited, with the corporate risk rated at 16 and sustained concern about the services ability to deliver timely, safe orthodontic treatment without more fundamental workforce, capacity and service model solutions.		
Issue	**Progress**	**Impact (actual and potential)**
1. National and local workforce shortages including senior medical staff	• Working with the strategic recruitment team to redesign the consultant recruitment package to improve attractiveness • Continued workforce review to fully understand current establishment, demand and supervision gaps across all sites • Exploration of external capacity options, including strategic partnerships with providers in North West England	Increased capacity to deliver care and treatment and reduce waiting times and improve patient safety and experience
2. Backlog demand outstripping capacity across both primary and secondary care	• Stage 1 waiting times have improved substantially through insourcing achieving an 85% decrease - reducing from 1142 (Oct 2025) to 169 (April 2026). • Approximately 472 patients have been converted from assessment into follow-up or treatment placing significant pressure on the service to progress them due to current capacity. • Exploring options for further capacity with external agencies and consideration of strategic partnerships with other stakeholders in the North West of England	Timely access to first appointment **and** follow-up treatment

Issue	Progress	Impact (actual and potential)
3. Managing patient harm as a result of delays within Orthodontic services	• Agreement (via the North Wales Orthodontic Group) that **all** waiting lists (both 1st appointment and treatment) will be reported formally to understand full demand of patients waiting to be seen. • Development of a simple monthly reporting template to capture demand and to include complaints and risk indicators • Aim to introduce a communication plan for patients waiting for treatment to manage expectations post in-sourcing	Eliminating 'unknown' risks by identifying urgent needs and clarifying future treatment demand.
4. Infrastructure, especially digital and estate restrictions on expanding consultant work force	• Linking workforce planning to estates, digital and equipment baselines to ensure new or redesigned roles are deliverable in practice and supported by appropriate infrastructure	Identification of current space constraints and gaps to better understand opportunities for improvement in room utilisation
5. Lack of a sustainable service model to address current disjointed care across primary and secondary care	• Governance has improved through formal recognition of treatment waits, completion of risk assessments and agreement of a three-year improvement plan. • Corporate risk updated to reflect current issues – rated 16.	A sustainable service model to reduce clinical variation and inconsistencies across the service

Orthopaedics - Challenged Service Update		RAG
Executive Summary The Orthopaedics Network continues to make progress in reducing follow-up backlogs, standardising clinical pathways, and improving patient experience across BCUHB. Key actions this period include capacity and demand modelling undertaken and embedded within the IMTP, clinically led pathway redesign is advancing across multiple sub-specialties, aligning local pathways with national standards to reduce unwarranted variation and improve equity and outcomes. Work to maximise high-value follow-up models (SOS/PIFU) and optimise surgical delivery, including supplier rationalisation and the phased implementation of the Llandudno Surgical Hub, is progressing, with further impact expected as national guidance and protocols are finalised.		
Issue	**Progress**	**Impact (actual and potential)**
1. Delayed cold site optimisation due to estates, service configuration and long waiting acute site need	• Reduction in >104 week waiting list continues (365 December 2025, 260 March 2026) • Trauma and Orthopaedic capacity and demand undertaken with a trajectory output confirmed within IMTP. Pan BCUHB meeting held to review trajectories and re-establish a Pan BCUHB approach to KPI delivery	Reduction in unwarranted variation, supporting standardised pathways. Securing better value without compromising quality
2. Slow progression of efficiency measures (HVLC, day case arthroplasty, HSQ and MOPs)	• Conversations regarding Knee Implant Supplier rationalisation for Llandudno General Hospital (LLGH) are in progress with support from the Welsh Orthopaedic Network - Awaiting National Terms of Reference & Standard Operating Procedure to be agreed and circulated to support with the options appraisal process – target of Sept/Oct 2026 for completion. • BCUHB Knee Osteoarthritis Pathway has been tailored to suit the National Pathway led by consultant – The plan will be presented at next	Improved data quality to support demand and capacity analysis and improved efficient planning

Issue	Progress	Impact (actual and potential)
	month's Clinical Reference Group ahead of wider consultation and subsequent adoption. • Clinically led pathway re-design is ongoing locally in the Shoulder, Hip and Hand sub-speciality with the aim of reducing unwarranted variation, improving equity of access and outcomes for our North Wales population.	
3. Significant volume of overdue follow-up patients	• Implementation of SOS pathways, including application to follow up objective has been partially met with good progress. Recognising there is more work to do to ensure consistent application of the pathways. All Health Boards in Wales are awaiting the release of the refreshed protocols which will trigger further work to maximise the use of SOS and PIFU within high-value pathways.	Reduction in waiting times for follow-up patients
4. Network clinical leadership sessions currently assigned to Llandudno orthopaedic project	• Operational and clinical deployment of Llandudno Surgical Hub in progress ahead of LLGH Surgical Hub opening, including job planning and service planning	Clinical ownership and broader engagement with pathway development.

ASSESSMENT	
Link to Strategic Priorities	
	4. Improving quality, outocmes and experience
	If more than one applies, please list below:
Design Principles	Choose an item. *All design principles apply*
Corporate Risks and Board Assurance Framework	*CR25-5 Strategic Change – impacting care and staff delivery*
Wellbeing of Future Generations Act – Wellbeing Goals	Not Applicable

IMPACT ASSESSMENTS		
Equality *Have you undertaken an Equality Impact Assessment Screening (which includes the requirements of the Welsh Language Standards)*	Yes: ☐	No: ☒
	Outcome:	
	If no, please include rationale:	*Not applicable*
Socio-Economic Impact Assessment *Have you undertaken a Socio-Economic Impact Assessment*	Yes: ☐	No: ☒
	Outcome:	
	If no, please include rationale:	*Not applicable*
Quality *Have you undertaken a Quality Impact Assessment Screening?*	**Enablers of Quality** Whole-systems Perspective	**Domains of Quality** All Apply
Wellbeing of Future Generations Act – Wellbeing Goals	Not Applicable	
Environmental /Sustainability Impact (5Rs)	No - Not Applicable	
Armed Forces Covenant Due Regard Duty Have you considered the Armed Forces Covenant Due Regard Duty?	Yes: ☐	No: ☒
	Outcome:	
	If no, please include rationale:	*Not applicable*
Data Protection Impact Assessment *Have you undertaken a Data Protection Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	
	If no, please include rationale:	Not applicable
Counter Fraud Impact Assessment *Have you considered the counter fraud impacts*	Yes: ☐	No: ☒
	Outcome:	

	If no, please include rationale:	*Not applicable*
Legal	There are no specific legal implications related to the activity outlined in this report.	
Reputational	Yes (Include further detail below)	
	If the challenges outlined in this report are not adequately addressed then the organisation is likely to remain in Special Measures status, and thus contributing to the ongoing negative perception of healthcare delivery in North Wales	
Resource Impact *(People / Financial)*	Yes (Include further detail below)	
	Current workforce levels are insufficient in a number of the Challenged Services to meet demand and provide an effective and efficient service pan BCU	

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Quality, Safety and Experience Committee

MENTAL HEALTH STRATEGIC UPDATE

Dyddiad y Cyfarfod **Date of Meeting**	7 May 2026
Statws Cyhoeddi **Publication Status**	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad **Report Author name and title**	Zoe Prince, Director of Nursing, Mental Health and Learning Disability Division
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol **Lead Executive Team Member name and title**	Teresa Owen Executive Director of Allied Health Professions & Health Science.

Pwrpas yr Adroddiad **Report Purpose**	For Approval

Crynodeb Gweithredol
Executive Summary

This paper has been prepared to provide the Quality, Safety and Experience Committee with an update on the strategic direction in Mental Health and to provide assurance that our mental health services are aligned with both national and organisational priorities supporting the improvement journey for patients and carers.

The paper is written in two parts and responds to the two information requests from the QSE committee.

Part one sets out the strategic direction and intentions for mental health services, demonstrating alignment with national policy requirements and the organisation's priorities as outlined in the Integrated Medium Term Plan (IMTP). This also links with the Mental Health Oversight and Delivery Group activity.

Part two provides a follow-up to the paper previously considered by the Quality, Safety and Experience Committee on 5th March 2026. The paper provides a further update on delivery against Parts 3 and 4 of the Mental Health Measure and offers a more detailed overview of the purpose, function, and configuration of

Community Mental Health Teams, including how these teams are organised to meet population needs.

Ymgysylltu (mewnol/allanol) yr ymgymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp) **Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)**		
Pwyllgor / Grŵp / Unigolion **Committee / Group / Individuals**	**Dyddiad** **Date**	**Canlyniad, Tystiolaeth a Data** **Outcome, Evidence and Data**
Not applicable for this report		

Acronymau / Rhestr Termau **Acronyms / Glossary of Terms**	
Integrated Medium Term Plan	IMTP
Mental Health Oversight and Delivery Group	MHODG
Expert Advisory Group	EAG
Mental Health and Learning Disability	MHLD
Strategic Programme for Mental Health	SPMH
Community Mental Health Team	CMHT
Single Point of Access and Assessment	SPoAA
Mental Health Measure	MHM
Independent Mental Health Advocate	IMHA
Did Not Attend	DNA
Community Advice and Development in Mental Health Services	CADMHS
Out of Area	OOA
Clinical Decision Unit	CDU
Welsh Ambulance Service Trust	WAST

MEWNOSODWCH DEITL YR ADRODDIAD
PART 1 - MENTAL HEALTH STRATEGIC UPDATE

Y SEFYLLFA
SITUATION

Mental health services continue to operate within a challenging national and local context, characterised by increasing demand, performance expectations, and a strong emphasis on quality, safety, and experience. Within this environment, Betsi Cadwaladr University Health Board is required to evidence a clear strategic intent aligned with national policy and the Integrated MediumTerm Plan (IMTP), and demonstrate progress in delivering statutory requirements, including the Mental Health Measure. This section of the paper sets out the current position and articulates the strategic direction for mental health services.

1 Y CEFNDIR
BACKGROUND

The previous cross-government strategy, “Together for Mental Health”, was published in 2012. This was the first mental health strategy that covered all ages, promoted the mental wellbeing of all people in Wales, and aimed to ensure that people with mental health conditions got the support they need.

The successor Mental Health and Wellbeing strategy 2025-2035 was launched in May 2025 with an ambitious mission statement stating that “People in Wales will live in a country which promotes, supports and empowers them to improve their mental health and wellbeing, and will be free from stigma and discrimination”. The strategy is a system wide strategy which outlines four vision statements:

- There is action to make sure the building blocks are in place to support good mental health and wellbeing, this sets out to explain how Government departments and agencies can support those areas that we know impact on mental health, such as housing, employment and education.
- Everyone has the knowledge, opportunities and confidence to protect and promote good mental health and wellbeing, this relates to how we can collectively support the provision of information and resources to protect and promote good mental wellbeing that are available and accessible for all.
- There is a connected system where all people receive the appropriate level of support wherever they reach out for, this section sets out how we all have a part to play in protecting good mental health and how we can create an environment which supports it, by ensuring organisations work together to support a person’s mental health.

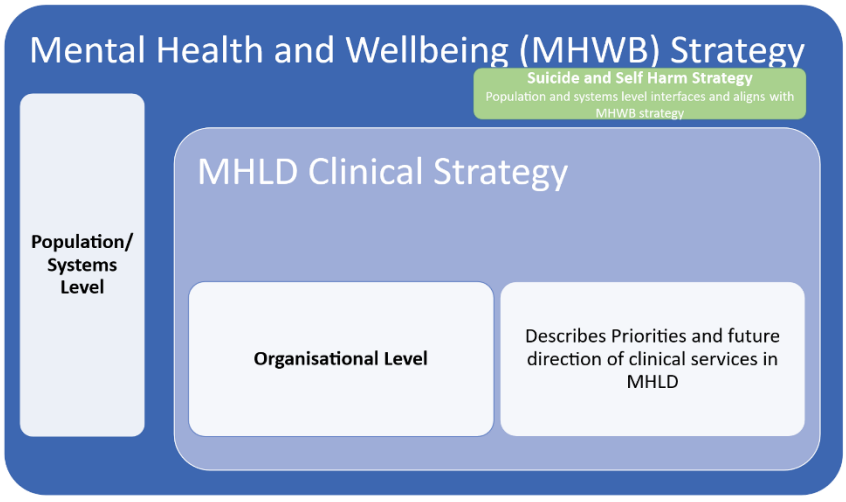
- There are seamless mental health services – person-centred, needs led and guided to the right support first time, without delay, this explains how we will support the delivery of quality and accessible mental health services, creating a clear plan for services to work together

The Mental Health and wellbeing strategy is also considered alongside a separate but related (new) Suicide and Self Harm Prevention Strategy.

During the hiatus between national strategies the North Wales Together for Mental Health Partnership Board coproduced a renewed version of the current North Wales Strategy. The purpose was to provide strategic direction for the interim period until the national strategy was published to ensure that the strategic direction and intentions reflected the needs of local people, especially in light of the impact of Covid-19 and the changing landscape.

The Ministerial priorities set for delivery through the national NHS planning framework and the local Integrated Medium Term Plan (IMTP) are underpinned by the Strategic Programme for Mental Health (SPMH), specifically Vision Statement 4. This establishes a clear framework of priorities and actions for the Health Board to deliver through the IMTP, ensuring alignment with national policy direction and expectations for mental health services.

On a more granular level the Mental Health and Learning Disability (MHLD) clinical services strategy describes priorities and future direction of clinical services in MHLD. All of these plans are linked and are illustrated in the figure below::



The clinical strategy for the MHLD division complements (rather than replaces) national and Health Board strategies, including *Together for Mental Health*, *A Healthier Wales*, the *National Clinical Framework*, and *Living Healthier, Staying Well*.

The strategy is explicitly clinical, with workforce and estates strategies referenced but addressed separately. It reflects post-pandemic learning, increased demand, and the need to reduce fragmentation and dependency on inpatient care.

Key priorities and timescales of the clinical strategy include

- Reduce Out of Area (OOA) bed usage- By April 2026, reduce OOA placements to 10 or fewer with overall goal of achieving zero OOA by Q4

- Expansion of crisis services- By June 2026, new crisis service posts to be recruited and in place, enabling enhanced community based crisis response and reduced reliance on inpatient admission

- Standardisation of Older People's Mental Health (OPMH) Community Model- By end of 2026, achieve standardisation of the OPMH community service model across North Wales to reduce variation, improve equity of access, and strengthen continuity of care

- ADHD Pathways Cluster Model- Development of a cluster-based model for ADHD pathways to improve access and consistency across primary and secondary care. Timescale to be confirmed, subject to pathway design, workforce capacity and system dependencies

To provide effective oversight and drive delivery, the Mental Health Oversight and Delivery Group (MHODG), chaired by the Chief Executive, has been established to develop and oversee a coherent, Health Board wide strategic plan and service model for mental health. The MHODG ensures alignment with national legislation, policy requirements, and best practice, and represents a progression from previous governance arrangements established to support delivery of the Royal College of Psychiatrists' recommendations arising from the invited service review, including the work of the Expert Advisory Group (EAG).

The inaugural meeting of the MHODG was in November 25, with two further meetings held in January and March 26, in addition to the objectives outlined above MHODG has considered the next stages of a co-designed and created 'Outcomes Framework' that reflects the strategy and objectives of the whole Health Board. It has also initiated establishment of an effective estates and physical environment plan that encompasses a focus on preventing and monitoring ligature risks and reflects key Health Board programmes. Work has progressed to achieve another key aim relating to ensuring the effective interplay of Mental Health services with other Health Board services, including Psychological Therapies and Children's services with recent presentations from Psychology and Allied Health

Professions. MHODG reports through Executive Committee via the standard AAA reporting process.

A key priority within the MHODG's remit is to strengthen and embed a meaningful approach to patient, carer, and citizen involvement, ensuring that lived experience informs service design, transformation, and continuous improvement. This builds on the foundations established through the EAG and reinforces the organisation's commitment to co-production as a core principle of mental health service development. The Strategic Programme for Mental Health (SPMH) workplan has a number of strategic outcomes one of which is to improve access, experience and outcomes across all mental health services by starting to implement the Flexible Open Access Model. This is categorised by a person access to service being based upon their level of readiness, preferred autonomy and investment.

The Open Access model is a central enabler of the Health Board's strategic intentions, supporting timely access to assessment and intervention, reducing unnecessary barriers to care, and providing a consistent operating framework for Community Mental Health Teams. The open access model is a service delivery approach where people can self-refer and access support directly, without needing a formal referral or professional gatekeeper. It is intended to reduce waiting times. improve equity of access, and enable earlier intervention based on need rather than referral pathway

Oversight through the MHODG ensures that this approach is aligned with statutory requirements, informed by lived experience, and contributes to continuous service improvement. BCUHB were successful in an application to become a demonstrator site for this work at the end of 2025. In collaboration with the Welsh Ambulance Service Trust (WAST) and system partners, MHLD Divisional leads have developed a proposal to redesign the NHS 111+2 front door, centred on a 24/7 Rapid Remote Clinical Assessment model that directs people to the right care, first time, through Flexible Open Access and integrated community services

Plans are being formulated to implement and evaluate this approach to inform the national evidence base. Colleagues from the Health Board attended a conference in Swansea recently to share the approach with other demonstrator sites and learn more in terms of implementation and evaluation at the end of March. This marks an exciting opportunity to be part of a whole system change nationally.

2 PART 2 – QUALITY SAFETY AND EXPERIENCE UPDATE COMMUNITY MENTAL HEALTH TEAMS AND DETAIL ON THE MENTAL HEALTH MEASURE – PARTS 3 AND 4

At the previous Quality, Safety and Experience Committee on 5th March 2026, committee members requested further detail and assurance in relation to the implementation of Parts 3 and 4 of the Mental Health Measure together with clarification regarding the configuration and operation of Community Mental Health Teams. The following part of the paper sets out the additional information requested, focusing on statutory requirements and current delivery arrangements.

COMMUNITY MENTAL HEALTH TEAMS

Community Mental Health Teams (CMHT's) form the core delivery model for the Division's mental health services. Adult and Older Person CMHTs operate across 17 sites, providing secondary (Tier 2) mental health care for people with moderate to severe mental illness, predominantly under Part 2 of the Mental Health Measure. These multidisciplinary teams comprise of medical, nursing, psychological, allied health professional, pharmacy, administrative and management expertise and operate as part of a whole-system model, working closely with primary care, specialist services, third sector partners and social care.

Under Part 2 of the Mental Health Measure, a Care Coordinator must be a registered health or social care professional with the appropriate skills, experience and competence to coordinate care for an individual with secondary mental health needs. The role is not tied to a single profession, but it cannot be undertaken by non-registered individuals or those undertaking purely administrative roles.

CMHTs are accessed through a Single Point of Access and Assessment (SPoAA), applying a "no wrong door" approach that supports the principles of the Open Access model by enabling timely, equitable access to assessment and care regardless of referral route. The SPoAA provides daily multidisciplinary oversight of referrals, urgent presentations and requests for support, ensuring appropriate triage, risk management and onward pathways. This includes the delivery of unscheduled care through duty officer roles, which, while outside the statutory remit of the Mental Health Measure, are essential to meeting urgent need and supporting system resilience

Mental Health Measure (MHM) Part 3

Part 3 of the Mental Health Measure places a statutory duty on Health Boards to provide timely reassessment for individuals previously known to secondary mental health services who believe their mental health is deteriorating. The intention of Part 3 is to enable direct access back into specialist services, without requiring individuals to first re-present to primary care or repeat the full referral and assessment pathway, thereby supporting early intervention and relapse prevention.

In practice, Part 3 allows eligible former patients to self refer directly to secondary mental health services for treatment and interventions. This model aligns closely with the proposed national open access approach and is designed to reduce delays, minimise duplication, and improve patient experience at a point of increased vulnerability. However, both local and national experience indicates that individuals often default to traditional routes of access, particularly through their GP, rather than exercising their Part 3 right to self-refer. This issue has been discussed at a national level with NHS Performance and Improvement colleagues and other Local Health Boards, who report similar challenges.

In response, the MHLD division has strengthened its discharge processes to improve patient awareness and understanding of their Part 3 rights. Revised discharge information is routinely provided in both Welsh and English and includes personalised clinical and behavioural indicators that may signal deterioration, alongside clear instructions on how to access support. This includes contact details for in-hours and out-of-hours services, the CALL helpline, NHS 111 (press 2), and the online mental health hub, supported by QR code access. This approach is intended to empower individuals to seek timely support and make informed decisions about re-accessing services.

To support continuity of care, GPs are also routinely notified at the point of discharge, reinforcing shared understanding of the patient's care pathway and enabling appropriate collaboration between primary and secondary care should needs reoccur.

The division is required to report formally on compliance with Part 3, including adherence to statutory timescales for reassessment. While compliance is currently monitored through manual reporting systems, this limits the accuracy and timeliness of data. Implementation of the electronic health record will significantly strengthen the division's ability to evidence compliance, improve reporting quality, and provide greater assurance on performance against Part 3 duties. During 2025, MHLD coordinated a total of 90 Mental Health Act Part 3 assessments across the division. Of these, 66 patients were assessed, with the remainder either cancelling or did not attend. Following assessment, 27 patients were accepted back into services.

Delivery of Part 3 is underpinned by effective liaison and joint working across the mental health system. Community Mental Health Teams work closely with Home Treatment Teams, inpatient services, primary care, specialist mental health services, social care, third sector partners, and criminal justice agencies to ensure appropriate pathways back into care, safe transitions, and continuity of oversight. This collaborative approach is critical to managing risk, preventing escalation, and supporting individuals to remain safely in the community wherever possible.

Mental Health Measure (MHM) Part 4

Part 4 of the Mental Health Measure establishes a statutory entitlement for all eligible inpatients in Wales who are receiving assessment or treatment for a mental disorder to request support from an Independent Mental Health Advocate (IMHA). This provision extends the Independent Mental Health Advocacy arrangements set out under the Mental Health Act 1983 and applies to a wider group of patients.

The entitlement covers both:

- individuals subject to compulsory measures under the Mental Health Act 1983; and
- individuals receiving assessment or treatment in hospital on a voluntary basis.

Eligibility applies across a range of inpatient settings, including specialist mental health hospitals, independent hospitals, and general hospitals where treatment for a mental disorder is being provided.

Part 4 places responsibility on Welsh Ministers to ensure that appropriate arrangements are in place to make IMHA services available to eligible patients. Regulations may specify the circumstances under which an individual may act as an IMHA, the conditions attached to the role, and the approval process required. This ensures consistency, quality, and safeguarding within the advocacy service.

A fundamental principle of Part 4 is that Independent Mental Health Advocacy must, as far as practicable, be provided by someone who is independent of those professionally involved in the patient's medical treatment. This independence is central to the purpose of IMHA and ensures that patients can receive impartial support to understand their rights, express their views, and engage in decisions about their care without conflict of interest. The legislation is clear that advocacy undertaken under specific statutory arrangements, such as the Mental Capacity Act 2005, does not compromise this independence.

While IMHA services are delivered independently of clinical teams, Health Boards retain responsibility for ensuring that eligible patients are informed of their right to advocacy and are supported to access it when requested. This includes ensuring that staff understand the entitlement, referral pathways are clear, and access is facilitated promptly across inpatient settings.

Within Betsi Cadwaladr University Health Board, Independent Mental Health Advocacy services are commissioned from Community Advice and Development in Mental Health Services (CADMHS), the North Wales provider of IMHA. This commissioning arrangement provides assurance that Part 4 requirements are met through an independent, regulated advocacy service.

An activity and performance report from CADMHS is due at the end of April 2026 and will provide further assurance on uptake, access, and emerging themes from advocacy provision. This information will support Executive and Committee oversight and contribute to the Health Board's wider focus on patient rights, voice, and experience.

MATERION PENODOL I'W HYSTYRIED
SPECIFIC MATTERS FOR CONSIDERATION

- Note the Health Board's mental health strategic direction aligned to the new Mental Health and Wellbeing Strategy for Wales 2025–2035, the IMTP, and statutory duties (including the Mental Health Measure), with a coherent line of sight from national vision to local delivery through CMHTs and the Open Access model.

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

- CMHT Modernisation- There is a risk to patient safety and patient experience associated with delays in care delivery, variation in access to services, and inconsistent coordination across teams. (Risk Register items 3973, 5515, 5224). Mitigations include active clinical triage and escalation of unallocated patients, flexible use of workforce capacity to maintain safe care, reconfiguration of resources to sustain core CMHT functions, and routine performance oversight through established governance structures

1 **ARGYMHELLION**
RECOMMENDATIONS

a. Gofynnir i'r Pwyllgor/Cyfarfod/Grŵp:
The QSE Committee is asked to:

- **CYTUNO/AGREE –**

- Note the current position in relation to Parts 3 and 4 of the Mental Health Measure and request continued assurance on compliance.

- Consider receiving further updates on the Demonstrator site work and its impact when the work has developed further

ASESIAD / ASSESSMENT	
Cyswllt â'r Blaenoriaethau Strategol **Link to Strategic Priorities**	 4. Improving quality, outcomes and experience
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below Strategic Priorities 3 & 4
Yr Egwyddorion Dylunio **Design Principles**	People First Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below: People First Equity and Accessibility
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd **Corporate Risks and Board Assurance Framework**	Risks relate to CMHT access/variation and delivery of improvement programmes (cross-reference Divisional and Corporate registers).

ASESIADAU O EFFAITH / IMPACT ASSESSMENTS		
Cydraddoldeb *A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o'r Effaith ar Gydraddoldeb (sy'n cynnwys gofynion Safonau'r Gymraeg)* **Equality** *Have you undertaken an Equality Impact Assessment Screening (which includes the requirements of the Welsh Language Standards)*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	EQIA impacts are considered in any of the necessary policy changes and adaptations
Asesiad o'r Effaith Economaidd-gymdeithasol *A ydych chi wedi cynnal Asesiad o'r Effaith Economaidd-Gymdeithasol?* **Socio-Economic Impact Assessment** *Have you undertaken a Socio-Economic Impact Assessment*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	SEIA impacts are considered in any of the necessary policy changes and adaptations.
Ansawdd	**Galluogwyr Ansawdd** **Enablers of Quality**	**Meysydd Ansawdd** **Domains of Quality** Person Centred

A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd? **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Culture and Valuing People	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant **Wellbeing of Future Generations Act – Wellbeing Goals**	Not Applicable	

Effaith Amgylcheddol / Cynaliadwyedd (5Rs) **Environmental /Sustainability Impact (5Rs)**	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
	No - Not Applicable	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:	
Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog A ydych chi wedi ystyried Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog: **Armed Forces Covenant Due Regard Duty** Have you considered the Armed Forces Covenant Due Regard Duty?	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Considered as part of access and communications standard; no specific impacts identified in this update.
Asesiad o Effaith ar Ddiogelu Data *A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?* **Data Protection Impact Assessment**	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Will be addressed for EHR and any data process changes.

Have you undertaken a Data Protection Impact Assessment Screening?		
Asesiad o Effaith ar Atal Twyll *A ydych chi wedi ystyried yr effeithiau ar atal twyll?* **Counter Fraud Impact Assessment** *Have you considered the counter fraud impacts*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	No specific impacts identified
Cyfreithiol **Legal**	There are no specific legal implications related to the activity outlined in this report.	
Enw Da **Reputational**	Yes (Include further detail below)	
Effaith ar Adnoddau *(Pobl / Ariannol)* **Resource Impact** *(People / Financial)*	Yes (Include further detail below)	

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Quality Safety & Experience Committee

MEWNOSODWCH DEITL YR ADRODDIAD
MORTALITY REPORT

Dyddiad y Cyfarfod Date of Meeting	08 May 2025
Statws Cyhoeddi **Publication Status**	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad **Report Author name and title**	Prof Alberto Salmoiraghi, Medical Director MHLD Dr Anita Pierce, Deputy Medical Director MHLD Dr Faye Graver, Deputy Medical Director MHLD Dr Ben Thomas, Associate Medical Director, BCUHB Mortality Co-Lead Dr Gemma Lewis-Williams, Associate Medical Director, BCUHB Mortality Co-Lead Prof Rob Atenstaed, Public Health Wales
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol **Lead Executive Team Member name and title**	Dr Clara Day, Executive Medical Director

Pwrpas yr Adroddiad **Report Purpose**	For Noting

Crynodeb Gweithredol
Executive Summary

This paper provides a summary of mortality-related data in both physical health, mental health and substance misuse. It interrogates nationally available population data, with deep dives where data indicates that concerns may be present.

This data is complemented within current governance structure with processes to investigate individual deaths which allow review of harm and identify learning in individual cases which can have wider implications. Themes for such learning is described in more detail for deaths of patients under the care of the Mental Health and Learning Disability Division. Themes for deaths reviewed by the Medical Examiner (generally those from a physical cause) are reported regularly into SCEG and QSE.

This paper provides assurance to QSE regarding local interpretation of national mortality data.

Ymgysylltu (mewnol/allanol) yr ymgymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp) **Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)**		
Pwyllgor / Grŵp / Unigolion **Committee / Group / Individuals**	**Dyddiad** **Date**	**Canlyniad, Tystiolaeth a Data** **Outcome, Evidence and Data**
Strategic Clinical Effectiveness Group (Secondary Care Mortality)	17/03/26	Discussion of CHKS data
Strategic Clinical Effectiveness Group (Mental Health and SMS data)	21/04/26	Discussion of MHLD and SMS data
Executive Committee	22/04/26	Discussion of both data sets and analysis

Acronymau / Rhestr Termau **Acronyms / Glossary of Terms**	
Appendix 1	Mental Health and Substance Misuse Mortality
Appendix 2	Review of Mortality metrics in BCUHB CHKS Annual Report (2024-25) Report to accompany the Corporate Mortality Quality Safety Executive (QSE) and Board Committee Report May 2026.
BCUHB	Betsi Cadwaladr University Health Board
QSE	Quality and Safety Executive Meeting
LFMP & RAMSG	Learning from Mortality Panel and Reducing Avoidable Mortality Steering Group
RAMI	Risk-Adjusted Mortality Index
IHCs	Integrated Health Communities
MES	Medical Examiner Service
MCCD	Medical Certificate of Cause of Death
AMD	Associate Medical Director
KPI	Key Performance Indicator
SSNAP	Sentinel Stroke National Audit Programme
HM Coroner	His Majesty's Coroner

CE	Clinical Effectiveness
DNACPR	Do Not Attempt Cardiopulmonary Resuscitation
SRC	Senior Responsible Clinician
QR Code Form	Quick Response Code Form
SCEG	Senior Clinical Effectiveness and Governance
YGC	Ysbyty Glan Clwyd
YG	Ysbyty Gwynedd
WMH	Wrexham Maelor Hospital
MS Teams	Microsoft Teams
HEIW	Health Education and Improvement Wales
CCS	Clinical Classification Software
NELA	National Emergency Laparotomy Audit
MI	Myocardial Infarction
PCI	Percutaneous Coronary Intervention

MEWNOSODWCH DEITL YR ADRODDIAD
MORTALITY REPORT

1 Y CEFNDIR
BACKGROUND

1.1 Mortality reporting with appropriate analysis and learning is an essential part of clinical governance. Such processes consist of both review of population level data sets, and review of individual deaths. Triangulation of analysis from this approach, along with that from incidents, complaints and the coronial process can identify areas of concern and areas for learning.

1.2 This paper and its appendices provide both a summary and a deeper dive into mortality analyses in both patients with mental health and substance misuse, and in those admitted to secondary care.

2 MATERION PENODOL I'W HYSTYRIED
SPECIFIC MATTERS FOR CONSIDERATION

Mental Health Deaths (more information in appendix 1)

2.1 Suicide figures are monitored using 5 year rolling European Age-Standardised Rates (EASR) to avoid over-interpretation of annual variation. These are based on outcomes from inquests and can therefore have a delay in reporting.

- BCUHB suicide rates are shown to be historically lower or comparable to Wales, remaining close to the national average in recent periods.
- Local Authority level analysis shows no statistically significant differences from Wales, except Flintshire, which is significantly lower.

2.2 Real Time Suspected Suicide Surveillance System (RTSSS) enables more timely intelligence and prevention activity

- Using RTSSS data, BCUHB suicide rate are amongst the lower rates in Wales, though differences between Health Boards are generally not statistically significant

- Across Wales, deprivation is a major risk factor: suicide rates are more than twice as high in the most deprived communities compared to the least deprived.

MHLD Thematic Learning from Mortality Reviews (2020–2025)

Thematic analysis shows that care is often compassionate and appropriate, but system weaknesses create recurring risk, particularly at transition points. Key themes include as below. The introduction of a digital health record should help communication and continuity which are consistent themes.

2.3 System and Process Issues

- Fragility and inconsistency of care pathways, including referral, escalation, discharge, and follow-up.
- Unclear thresholds and access delays, leading to risk being transferred rather than contained.
- Variable crisis response capacity and limited alternatives to emergency departments.

2.4 Information, Documentation, and Risk Management

- Poor information flow and fragmented records, reducing visibility of decision-making.
- Documentation quality issues, including incomplete or non-contemporaneous records.
- Risk assessments not sufficiently dynamic or consistently linked to care planning

2.5 Continuity, Transitions, and Governance

- Disrupted clinical ownership and ambiguity during service transitions.
- Handover weaknesses between teams and settings.
- Governance structures exist, but do not always translate into real-time control or sustained change.

2.6 Workforce and Patient Experience

- Heavy system reliance on individual staff effort under high pressure.
- Inconsistent patient and carer experience, especially at points of transition.
- Under-utilisation of family and carer insight in care planning.

Substance misuse mortality (more information in appendix 1)

2.7 The population served by Substance Misuse Services has exceptional complexity, with early-onset multimorbidity and significant social exclusion.

Deaths are often due to advanced physical illness, with substances acting as contributing rather than sole causes.

2.8 BCUHB reports higher absolute numbers of deaths than other Health Boards due to:

- Being the sole NHS provider of prescribing and detoxification services across North Wales.
- Retaining responsibility for the entire treatment cohort, unlike areas reliant on third sector or primary care.

2.9 Therefore, absolute mortality figures are not directly comparable with other Health Boards; ONS population-based data are the correct benchmark and do not show excess mortality within the BCUHB cohort.

2.10 Drug-related deaths continue to rise in Wales (2024 highest on record). Key features include:

- High levels of polysubstance use (62%).
- Predominance of opioids, with increasing stimulant involvement (notably cocaine).
- Strong association with deprivation, housing instability, and mental illness.

2.11 BCUHB drug-related death rate increased in 2024, with Denbighshire above the Welsh average and rising trends also seen in Gwynedd and Anglesey. These local findings align with national ONS data, with no evidence of excess mortality beyond expected levels given population risk

<u>Physical Health Mortality (more information in appendix 2)</u>

2.12 Crude mortality in secondary care has:

- Remained broadly in line with Welsh peers
- Reduced year-on-year (6.2% reduction between 2024–25 and 2025)
- No increase in observed deaths has been identified.

2.13 Risk-Adjusted Mortality Index (RAMI)

- As previously discussed in QSE, RAMI has shown a sustained improvement as coding normalised.

2.14 Interpretation of CHKS Data (a national benchmarking process). Detailed reviews of condition-specific mortality metrics (e.g. stroke, myocardial infarction, non-elective surgery, hip fracture) demonstrate that:

- Apparent increases largely reflect methodological limitations, coding variation, and case-mix differences
- Many “low-mortality” CHKS flags relate to diagnostic classification issues rather than care quality

- Triangulation with national audits (SSNAP (stroke), NHFD (cardiac), NELA (emergency laparotomy surgery) provides reassurance:
- Stroke and hip fracture outcomes align with national benchmarks
- Emergency laparotomy mortality at Ysbyty Glan Clwyd compares favourably with the UK average

2.15 Non-Elective Surgery mortality is reported as higher in the West IHC. Deeper analysis identifies:

- Inclusion of ward-based procedures (e.g. ventilation, CPR) within CHKS definitions
- Differences in local coding practice and small denominators
- No signal of unsafe surgical care identified

Mortality Governance and Learning

2.16 There has been significant improvement in BCUHB governance processes associated with mortality reviews in secondary care. This has been recognised in the recent Audit Wales quality review (currently in draft format) recommending that previously identified recommendations for improvement can be considered to have been completed. In particular:

- Multi-professional mortality reviews now completed in near-real time with historical backlogs resolved
- Learning is routinely shared through established governance forums
- BCUHB is now the best-performing Health Board in Wales for timely completion of Medical Certificates of Cause of Death (MCCD)

2.17 Recurring themes identified through the Medical Examiner Service include:

- Late recognition of deterioration
- Late definition of clear ceilings of care including DNACPR

2.18 To address these themes a system-wide quality improvement work has commenced led by the Executive Medical Director to include

- Recognition of deterioration
- Call 4 Concern implementation
- Timely Treatment Escalation Planning

3 RISGIAU ALLWEDDOL / MATERION I'W HUWCHGYFEIRIO
KEY RISKS / MATTERS FOR ESCALATION

3.1 Analysis of death by suicide is as a five year rolling calculation and as such cannot easily identify immediate local variations. it is also done at a population level and includes all including those not under care of the health board. Local processes do however investigate all deaths of patients under

mental health or substance misuse services where classified as unexpected, in that the patient was not identified as being at end of life. these are reviewed within the division and by the executive team where dictated within the integrated concerns process.

3.2 Deep dives into CHKS data in appendix 2 identifies that interpretation of coding by CHKS has a methodology which can cause anomalies in categorisation of deaths which are only obvious on further review. This can make initial interpretation more difficult.

4 ARGYMHELLION RECOMMENDATIONS

4.1 Gofynnir i'r Pwyllgor:
The Committee is asked to:

- **GWNEUD SYLWADAU/COMMENT** on this report and its appendices
- **CEFNOGI/SUPPORT** ongoing review of mortality through BCUHB clinical governance processes
- **CYTUNO/AGREE** to receive a report of such analysis on a yearly basis.

ASESIAD / ASSESSMENT	
Cyswllt â'r Blaenoriaethau Strategol **Link to Strategic Priorities**	 4. Improving quality, outcomes and experience
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Yr Egwyddorion Dylunio **Design Principles**	Simplify, Standardise, and Adopt Best Practices Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd **Corporate Risks and Board Assurance Framework**	CRR25-01 Timely patient access to safe and effective care BAF24-07 Not Delivering Timely Access to Care Resulting In Potential Clinical Harm, Poor Delivery of Performance Targets and Reputational Risk
Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant **Wellbeing of Future Generations Act – Wellbeing Goals**	A Healthier Wales
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:

ASESIADAU O EFFAITH / IMPACT ASSESSMENTS		
Cydraddoldeb *A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o'r Effaith ar Gydraddoldeb (sy'n cynnwys gofynion Safonau'r Gymraeg)* **Equality** *Have you undertaken an Equality Impact Assessment Screening (which includes the requirements of the Welsh Language Standards)*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Narrative report only
Asesiad o'r Effaith Economaidd-gymdeithasol *A ydych chi wedi cynnal Asesiad o'r Effaith Economaidd-Gymdeithasol?*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm:	Narrative report only

Socio-Economic Impact Assessment *Have you undertaken a Socio-Economic Impact Assessment*	If no, please include rationale:	
Ansawdd *A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	**Galluogwyr Ansawdd** **Enablers of Quality** Data to Knowledge	**Meysydd Ansawdd** **Domains of Quality** All Apply
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant **Wellbeing of Future Generations Act – Wellbeing Goals**	A Healthier Wales	

Effaith Amgylcheddol / Cynaliadwyedd (5Rs) **Environmental /Sustainability Impact (5Rs)**	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
	No - Not Applicable	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:	
Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog A ydych chi wedi ystyried Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog: **Armed Forces Covenant Due Regard Duty** Have you considered the Armed Forces Covenant Due Regard Duty?	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Narrative report only
	Do/Yes: ☐	Naddo/No: ☒

Asesiad o Effaith ar Ddiogelu Data *A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?* **Data Protection Impact Assessment** *Have you undertaken a Data Protection Impact Assessment Screening?*	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Narrative report only
Asesiad o Effaith ar Atal Twyll *A ydych chi wedi ystyried yr effeithiau ar atal twyll?* **Counter Fraud Impact Assessment** *Have you considered the counter fraud impacts*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Narrative report only
Cyfreithiol **Legal**	There are no specific legal implications related to the activity outlined in this report.	
Enw Da **Reputational**	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith ar Adnoddau *(Pobl / Ariannol)* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

Appendix 1. Mental Health and Substance Misuse Mortality

1. MHLD Mortality Governance

From a medical point of view, there is substantial evidence of premature mortality for people with a severe mental illness (SMI). Poor physical health is common in people with SMI (De Hert et al., 2011), with many people experiencing at least one physical health condition at the same time as their mental illness (Reilly et al., 2015). When compared to the general population of the same age group, people with SMI aged 15-74 are more likely to have obesity, asthma, diabetes, chronic obstructive pulmonary disease, coronary heart disease, stroke, and heart failure. The World Health Organization has emphasized that preventable physical health conditions account for most premature deaths among people with severe mental disorders, with estimated life expectancy reductions commonly in the 10–20-year range (World Health Organization, 2018. Hence, premature death is sadly expected when people are affected by SMI.

However, from a procedural point of view the situation is remarkably different. If a person dies within 12 months of being open to services, the death is automatically reported as “unexpected”, unless the person is deemed to be in the last year of life care or recognised to be in a palliative phase of the illness. In the latter cases, the death follows the normal mortality review process.
Unexpected deaths are reported via DATIX and according to the policy, each case can follow three different paths: 1) a learning review 2) a rapid review 3) a full investigation.
All registered “unexpected” deaths are reported to the coroner, who decides the level of inquest. Suspected suicides are also reported to the Real Time Suspected Suicide Surveillance System (RTSSS), a Welsh register of suspected suicides.

2. Suicide

It is commonly acknowledged by those working in the field of suicide research that official statistics underestimate the ‘true’ number and rate of suicide. For example, a perceived stigma attached to reporting a death as suicide may lead to under-reporting.

In the UK, part of the solution to under-reporting has been to include ‘deaths of undetermined intent’ within the official statistical category of suicide. This tries to correct for known under-reporting and is thought to produce a more accurate total (and rate) of suicide in a given year. Therefore, suicides reported by the ONS include deaths which are registered following an inquest where a Coroner has determined:

- a suicide conclusion
- a narrative conclusion (where the death may be recorded as intentional self-harm or injury or poisoning of undetermined intent, based on the information provided by the Coroner)
- an open conclusion (where the death may be coded as injury or poisoning of undetermined intent based on the information provided by the Coroner)

Fortunately, the number of people in BCUHB each year who die by suicide is relatively low. Due to the low numbers of suicides, it is important to:

- Include suicide rates per 100,000 people. Using numbers can give a misleading picture when considered alone.
- Not consider increases or decreases for a year at a time in isolation. Five-year rolling averages have been used for monitoring purposes, in preference to single-year rates, in order to avoid drawing undue attention to year-on-year fluctuations instead of the underlying trend.
- Realise that there is a significant lag time for official suicide data due to the complex, sensitive, and legal nature of investigating these deaths, which creates a significant delay between when a death occurs and when it is formally registered.

Figure 1 shows the trend in the 5-year rolling European Age-Standardised Rate (EASR) per 100,000 persons for suicide in BCUHB compared to the Wales average from 2011-15 to 2020-2024. The EASR is used for reporting suicide rates to ensure that comparisons of suicide prevalence are accurate across different populations, geographical areas, and time periods. The EASR is a weighted average of age-specific suicide rates which removes the influence of varying population age structures. The suicide rate in BCUHB was lower than the Wales average in the period between 2011-2015 and 2015-2019, but since then it has remained close to the Wales average except for 2019-2023 when it dipped below the Wales average.

Figure 1:

Figure: Suicides, EASR per 100,000, persons, Wales, Health Board, 2011-2015 to 2020-2024

Produced by Public Health Wales using PHM & MYE (ONS)

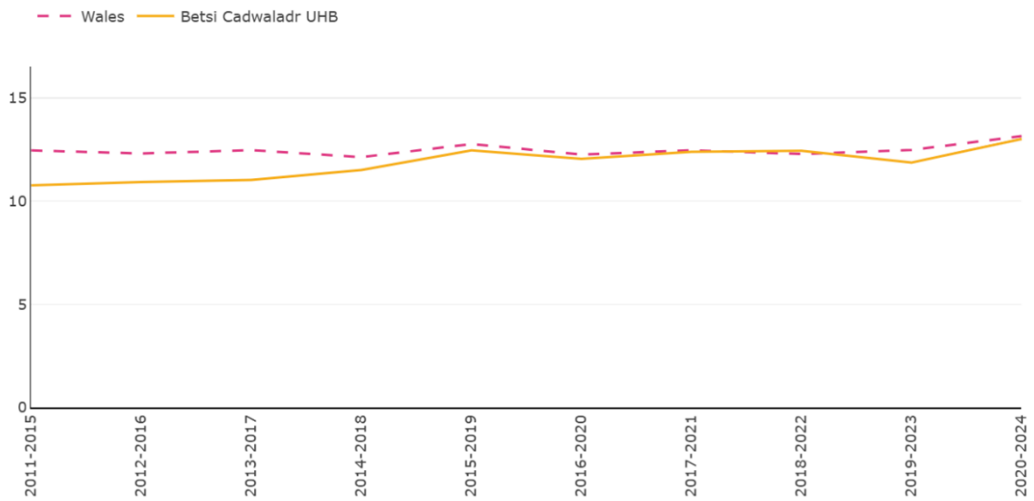


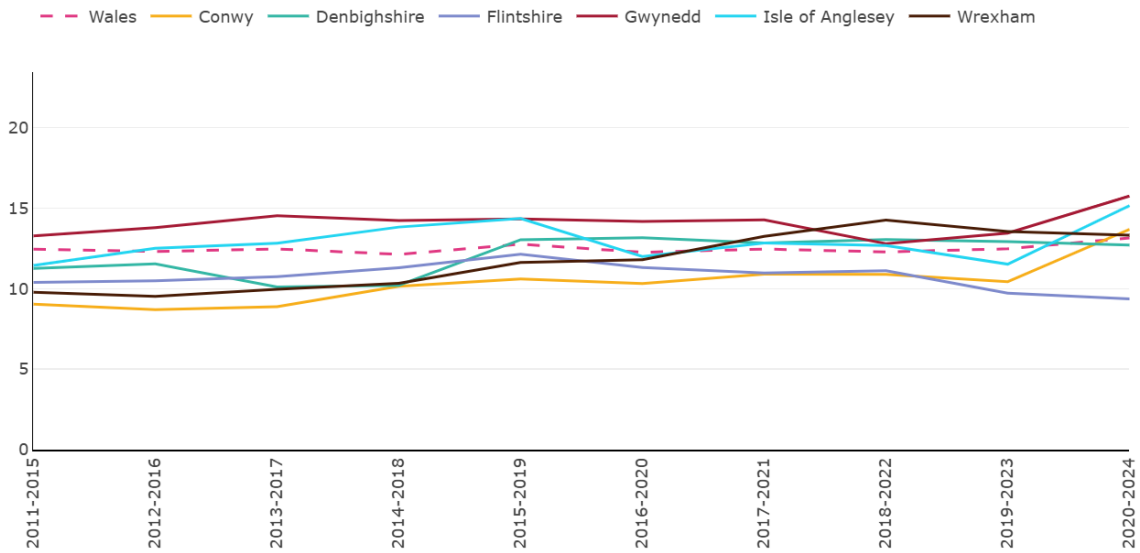
Figure 2 shows the trend in the 5-year rolling EASR per 100,000 persons for suicide in Wales and the North Wales UAs from 2011-2015 to 2020-2024. The number of suicides at Unitary Authority (UA) level is often small; comparisons should therefore be interpreted with caution.

There is variation between the 6 UAs during the time period. Across BCUHB in 2020-2024, the rate of suicide in all the UAs is statistically similar to Wales except for Flintshire which is statistically significantly lower.

Figure 2:

Figure: Suicides, EASR per 100,000, persons, Wales, Local Authority, 2011-2015 to 2020-2024

Produced by Public Health Wales using PHM & MYE (ONS)



Since April 2022, Wales has set up a surveillance system to monitor sudden and unexplained deaths that the police think might be a suicide. The aim of the Real Time Suspected Suicide Surveillance System (RTSSS) is to act as a central national repository for deaths by suspected suicide in Wales and of Welsh residents and to generate intelligence to inform suicide prevention activity across Wales.

Suspected suicides are reported to the RTSSS before a Coroner's inquest. It is anticipated that these may be higher than the number of suicides as determined

by a Coroner, as some may be found to have a different cause following a Coroner's investigation and inquest.

Monthly and quarterly data are provided in confidence to relevant professionals involved in suicide prevention and an annual report is published. This helps Wales to respond more quickly to changes in rates of suicide, and to make sure that the people affected receive the support that they need. This data has a shorter lag time than official suicide information.

Figure 3 shows the suicide (crude) rate per 100,000 persons for BCUHB compared to the other health boards in Wales. Crude rates for suicide are used primarily to understand the actual, raw burden of suicide within a specific population, adjusted for population size to allow for basic comparisons. Crude rates are appropriate in this context because the data is being used as a surveillance tool to inform action.

BCUHB has the third lowest rate (17.6) after Powys (25.3), Hywel Dda (19.3) and Aneurin Bevan (18.2). However, none of the rates are statistically significantly different to the Wales average except for Powys which is statistically significantly higher and Cwm Taff Morgannwg (12.2) which is statistically significantly lower.

Figure 3:

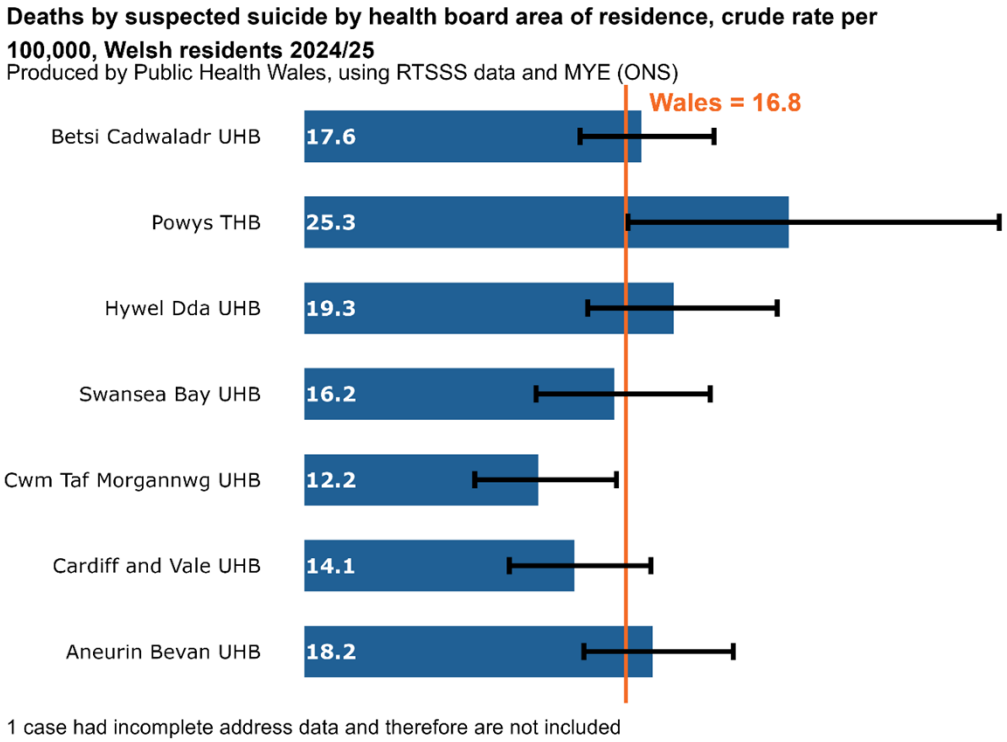
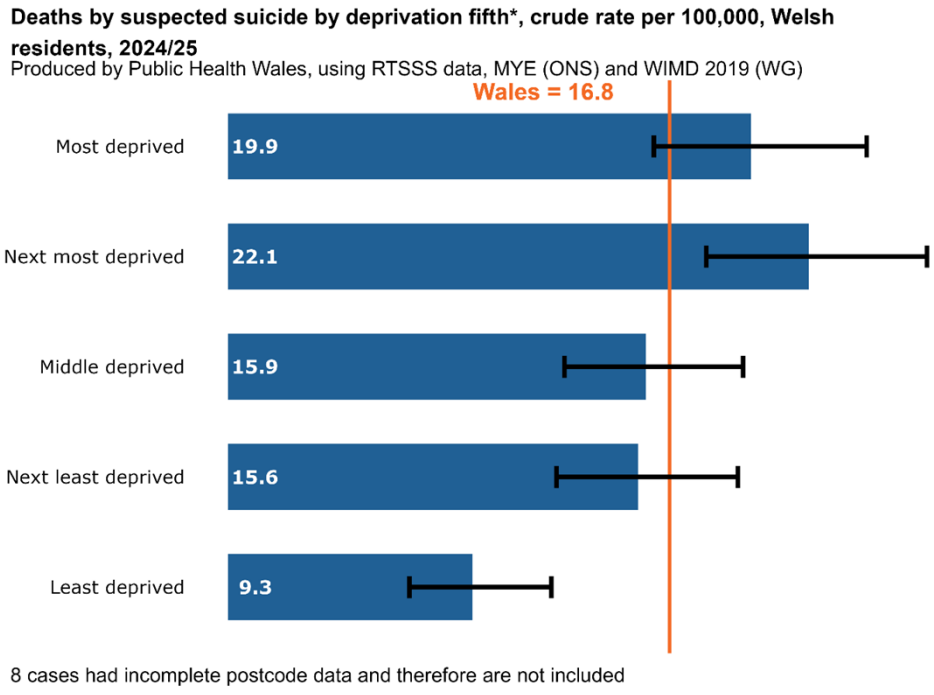


Figure 4 shows that the rate of suspected suicide per 100,000 persons in Wales is statistically significantly higher than the all-Wales rate in residents who lived in the next most deprived areas (22.1 per 100,000) and statistically significantly lower in residents who lived in the least deprived areas (9.3).

The rate of suspected suicides in 2024/25 was over twice as high in residents in the most deprived (19.9), and next most deprived areas (22.1), compared with residents in the least deprived areas (9.3).

Drivers for the higher rate of suicide in the most disadvantaged communities include financial instability, debt, unemployment, poor housing, and reduced access to mental health services.

Figure 4:



3. Thematic review of deaths under care of MHLD division

MHLD Mortality review group has undertaken a thematic review of all deaths occurring within the Division.

This summary brings together the recurring themes identified across mortality reviews in MHLD services over the periods between 2020–2025. The focus is on synthesising system-level learning observed collectively across cases, rather than examining individual incidents in isolation.

Across this timeframe, a consistent pattern emerges: care is often compassionate and aligned with professional standards, yet there are enduring vulnerabilities in how the system functions under real-world conditions. These vulnerabilities relate less to individual practice and more to the reliability, connectivity, and consistency of processes that support care delivery.

The themes presented below therefore reflect where risk tends to accumulate within the system—particularly at points of transition, decision-making, and information exchange—and provide a coherent view of the underlying patterns shaping patient safety across services.

The sources used were the Investigation Reports.

1. System Reliability and Process Fragility

Across these datasets, there is a persistent theme of inconsistent and unreliable processes. Care pathways (referral, triage, escalation, transfer, discharge, follow-up) are not consistently applied, with variation in how decisions are made and executed.

* Escalation processes are not always timely or consistently triggered
* Referral routing and prioritisation vary, including unexplained downgrading
* DNAs and follow-up responses lack standardisation
* Transfer, discharge, and closure processes are inconsistently completed
* Reliance on informal workarounds rather than embedded system processes

2. Access, Flow, and Threshold Ambiguity

A major cross-cutting theme is difficulty accessing the right care at the right time, compounded by unclear thresholds.

* Long waiting times and high demand leading to delayed care
* Movement of patients between services without resolution (boundary disputes, threshold disagreements)
* Risk being shifted between teams rather than contained
* Gaps between primary (LPMHSS) and secondary care
* Limited crisis alternatives and inconsistent access to acute care
* System pressure influencing clinical decision-making

3. Information Flow, Visibility, and Fragmentation

There is a consistent theme of poor information continuity across the system.

* Incomplete sharing of assessments and outcomes between services
* Actions from handovers not clearly tracked or completed
* Lack of visibility of clinical decisions and rationale across teams
* Fragmented records (paper-based, parallel systems)
* Case notes not available at point of care

4. Documentation Quality and Record Integrity

Documentation issues are pervasive and recurrent.

* Incomplete, unclear, or inconsistent clinical records
* Missing timelines, identifiers, or key clinical discussions
* Lack of contemporaneous recording
* Variability in documentation standards across teams
* Administrative and system factors contributing to gaps

5. Risk Assessment and Dynamic Care Planning

A critical theme is the limited effectiveness of risk formulation and care planning.

* Risk assessments present but not sufficiently dynamic or formulation-based
* Lack of clear triggers for review or escalation
* Care plans not updated following significant events
* Weak linkage between assessment, formulation, and action
* Limited use of care plans as active clinical tools

6. Care Coordination and Continuity of Clinical Ownership

There are systemic challenges in who is responsible for the patient at any given time.

* Delays or gaps in allocation of care coordinators
* Disruption in continuity of clinician ownership
* Ambiguity during transfers between teams or consultants
* Competing demands reducing ability to coordinate care effectively
* Fragmented responsibility across services

7. Handover and Transitions of Care

Transitions are consistently identified as points of vulnerability.

* Inconsistent handover quality between services (acute ↔ community, OOH, liaison)
* Lack of clarity on responsibility following transfer
* Poor tracking of agreed actions
* Discharge and transition processes not reliably completed

8. Crisis Response and Service Gaps

A recurring theme is insufficient system capability to respond effectively to crisis.

* Limited crisis resolution capacity and alternatives
* Reliance on emergency departments due to access barriers elsewhere
* Duty systems stretched beyond design
* Gaps between levels of care (Tier 0–2)
* Inability to “hold” risk safely within community services

9. Governance, Oversight, and Assurance Limitations

Governance structures exist but are not consistently effective in practice.

* Escalation routes not reliably used
* Variable senior oversight of high-risk decisions
* Limited assurance that identified issues translate into sustained change
* Reliance on retrospective review rather than real-time control

10. Safeguarding and Vulnerability Recognition

There is variability in how vulnerability and safeguarding risks are recognised and documented.

* Inconsistent application of safeguarding frameworks (e.g., self-neglect, domestic abuse)
* Lack of clarity in threshold decisions
* Variable documentation of concerns even when identified
* Missed opportunities for holistic risk recognition

11. Psychosocial Understanding and Holistic Care

A strong theme is the limited depth of psychosocial assessment and contextual understanding.

* Insufficient exploration of life events, social context, and support systems
* Limited incorporation of psychosocial factors into care planning
* Reduced ability to contextualise crisis presentations

12. Family, Carer, and Community Involvement

There is a recurring theme of underutilisation of family and community insight.

* Family concerns present but not always integrated into care
* Cultural hesitancy around information sharing
* Limited structured involvement of carers

13. Workforce Pressures and System Dependency on Individuals

A key underlying theme is system dependence on individual staff effort under pressure.

* High demand, vacancies, and competing priorities
* Limited capacity for reflective practice and supervision
* Staff compensating for system gaps through workarounds
* Reduced job satisfaction and sense of system strain

14. Variability in Clinical Decision-Making and Practice

There is notable variation in how clinical decisions are made and applied.

* Differences in triage, referral prioritisation, and modality (e.g., telephone vs face-to-face)
* Inconsistent rationale for decisions
* Variation between teams and services

15. Patient Experience at Transitions and Contact Points

The learning highlights inconsistency in what patients experience during key interactions.

* Inconsistent communication of plans and support
* Variable experience at points of discharge or transition

16. High-Frequency Contact and Boundary Strain

A more recent but important theme is system strain from repeated contacts.

* Lack of coordinated approach to frequent callers
* Pressure on staff managing repeated high-risk interactions
* Limited structured support for managing complexity

Most of the themes are consistent with national literature. It is envisaged that the introduction of a digital infrastructure will give more consistency to the processes and communication. BCUHB is leading on Digital Health Record, but of course the support of Welsh Government and the Executive Board is

essential. Equally, the implementation of the new national strategy based on "open access" (open front door, interconnected system offer) and "one at the time" approach (offering one intervention according to needs at that specific time) should improve the situation.

4. Substance Misuse Mortality

Mortality among individuals engaged with Substance Misuse Services (SMS) reflects a population with exceptional clinical complexity, characterised by severe and enduring substance use, high levels of physical and mental health comorbidity, and significant social exclusion due to ongoing stigma even by other areas of healthcare. Many individuals experience longstanding disengagement from wider health services as a result and present late with advanced disease states.

It is common for them to experience complex and significant multisystem disease burden much earlier in life – with individuals in their 40s experiences health conditions of a severity and complexity usually seen in >75s.

Individuals who died typically experienced multiple, overlapping long-term health conditions, including:

- Advanced respiratory disease (e.g. COPD, recurrent infections, TB etc)
- Cardiovascular and cerebrovascular disease
- Chronic liver disease, cirrhosis and cancer
- Severe mental illness and neurological conditions
- Frailty, self-neglect and reduced functional reserve

In many cases, mortality occurs due to physical health deterioration rather than acute overdose alone, although substances frequently contributed as secondary or aggravating factors. Determination of causality is often only clarified following post-mortem and coronial processes, and toxicology results—particularly in relation to opioids—must be interpreted cautiously given issues of tolerance in long-term users.

BCUHB absolute number of deaths is higher than the rest of Wales because we have a distinct service model within Wales, which is critical to interpreting mortality data correctly:

- BCUHB is the sole provider of prescribing and detoxification substance misuse treatment across North Wales, with no third-sector or primary care organisations delivering these functions.
- Local primary care involvement via Locally Enhanced Services (LES) remains limited and requires individuals to remain open to SMS, meaning all deaths are reportable through SMS governance arrangements within 12 months
- This contrasts with all other Welsh Health Boards, where:

- Most substance misuse treatment is delivered by third-sector **o**rganisations or established primary care pathways (primary care is particularly well established in Cardiff and Vale)
- NHS services typically manage only a small cohort of the most complex patients
- In Powys, there is no NHS substance misuse treatment provision

As a result, absolute mortality figures reported by BCUHB are not directly comparable with those from other Health Boards, as they reflect full-cohort reporting rather than a selected subset. For accurate regional and national comparison, ONS population-based mortality data remain the appropriate benchmark as per suicide.

In this respect, BCUHB continues to see a year-on-year increase in the number of individuals open to services, particularly for alcohol use disorders. The population served is ageing, most notably among people using opioids, mirroring trends seen across the UK. In addition, new and emerging patterns of substance use, including ketamine, present evolving clinical and safety challenges.

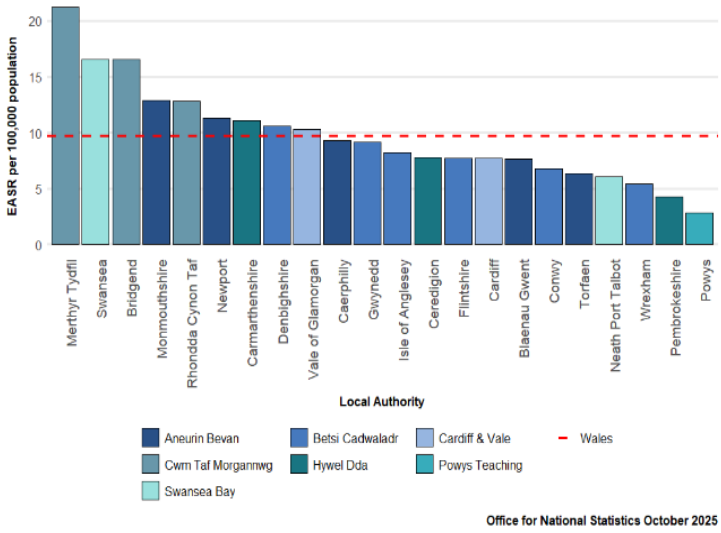
The service operates an open-door, harm-reduction model, which does not require abstinence as a condition of engagement. Individuals are therefore maintained open to services for as long as possible to support harm reduction, risk mitigation, and crisis responsiveness. While this approach is evidence-based and clinically appropriate, it necessarily increases the likelihood that deaths among a highly vulnerable population will occur whilst individuals remain under active care.

In looking at specific situation, the Office for National Statistics (ONS) data demonstrate a continued rise in drug-related deaths in Wales, with 417 drug-poisoning deaths registered in 2024, up from 377 in 2023 (+10.6%). Of these, 288 were classified as drug-misuse deaths (+13.8%) the highest number recorded to date. Wales continues to have a higher drug-related mortality rate than England, with deaths disproportionately affecting men, people aged 40–59, and those living in areas of higher deprivation (5xhigher).

- 62% of deaths involved multiple substances.
- Opioids are the most common substances reported in Wales (69.4%).
- Heroin/morphine remains the leading substance (55%).
- Next most common opioid was methadone**.**
- Benzodiazepines reported in 29% of drug misuse deaths.
- Cocaine deaths continue to rise:
    - Most common non-opioid substance.
    - 79 (27.4%) deaths involved cocaine; 31 involved cocaine only.
    - Alcohol present in 1 in 5 drug-misuse deaths

BCUHB data:

- 7.8 deaths per 100,000 EASR (49 deaths) in 2024.
- Increase from 5.9 per 100,000 EASR (37 deaths) in 2023.
- Denbighshire above the Welsh national average.
- Rising three-year rolling EASR in:
    - Denbighshire
    - Gwynedd
    - Isle of Anglesey



- **Figure 37: EASR of drug misuse deaths per 100,000 population in Wales by local authority, 2024**

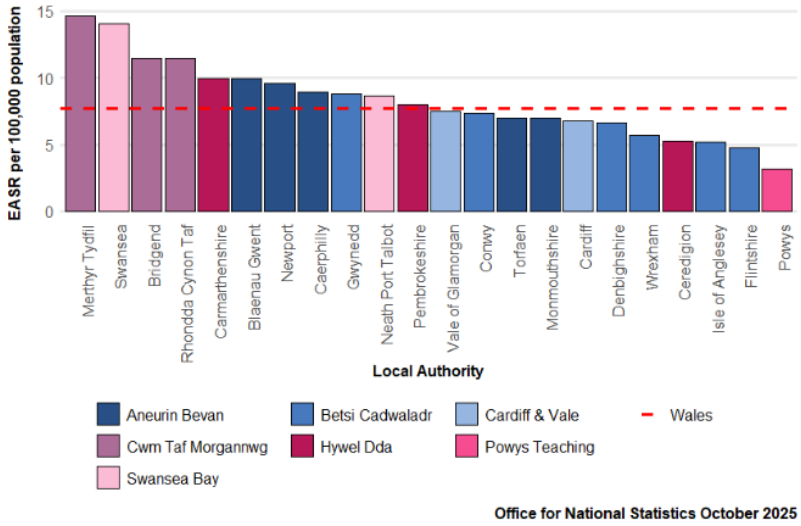


Figure 38: Three-year rolling average EASR per 100,000 drug misuse deaths in Wales, by local authority, 2022-24

Findings from North Wales Area Planning Board (APB) fatal and non-fatal poisoning reviews are consistent with national mortality data. Recurrent themes include:

- Opioid and polysubstance use, frequently involving benzodiazepines and/or cocaine
- Rising involvement of stimulants, increasing unpredictability of overdose
- Strong associations with socio-economic disadvantage, housing instability, and co-existing mental health needs
- Evidence of prior service contact, emergency attendance, or non-fatal overdose before death

These patterns mirror those identified in APB poisoning review reports across Wales, confirming that local learning aligns with national risk trends.

The use of ONS data alongside local mortality reviews provides the most accurate interpretation of risk and performance. Local audit findings are consistent with Wales-wide trends and do not indicate excess mortality beyond what would be expected given population complexity and deprivation.

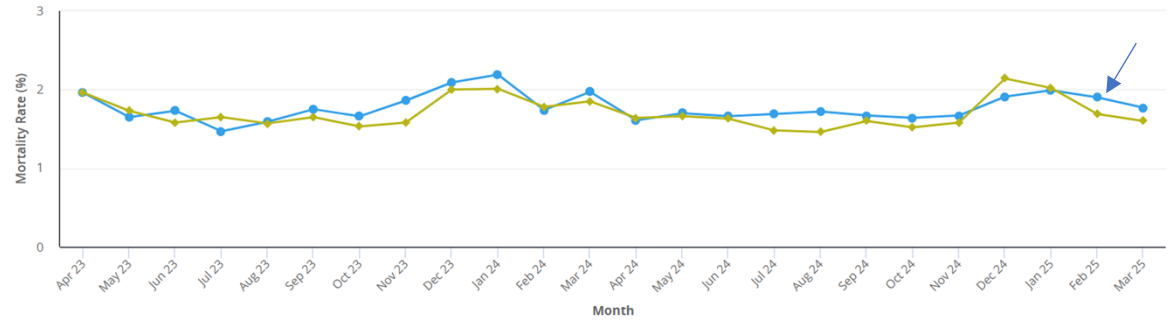
Appendix 2:

Report from:	(Strategic) Clinical Effectiveness Group (SCEG) / Clinical Effectiveness Mortality / Reducing Avoidable Mortality Steering Group and Learning from Mortality Panel
Report date:	April/May 2026
Presented by:	Dr Ben Thomas & Dr Gemma Lewis-Williams, Mortality Associate Medical Directors

Review of Mortality metrics in BCUHB CHKS Annual Report (2024-25) Report to accompany the Corporate Mortality Quality Safety Executive (QSE) and Board Committee Report May 2026.

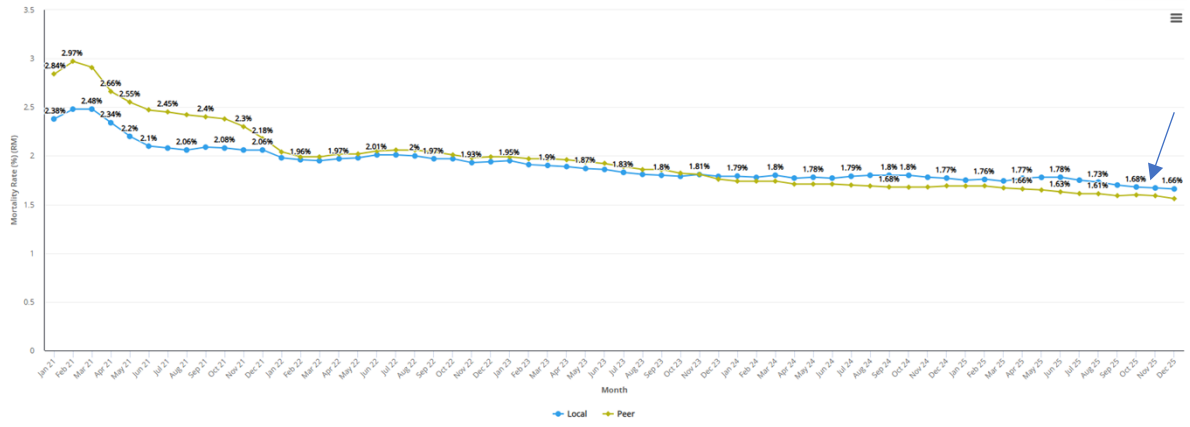
Issues for escalation

Crude Mortality two-year trend monthly values:



This shows the monthly mortality rate for two years up to March 2025. There has been no significant increase in the crude mortality rate in BCUHB over this period.

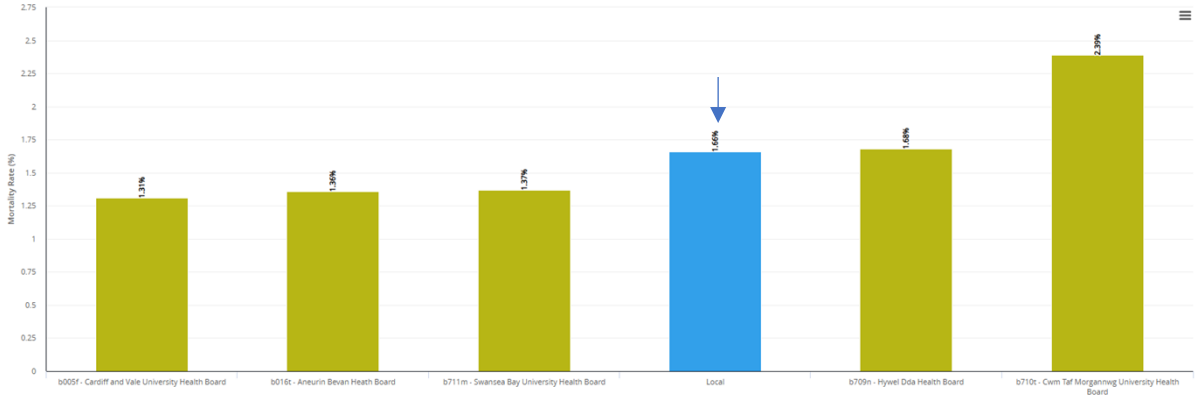
Crude Mortality Rate in Secondary Care - BCUHB vs Peer (All Other Welsh Health Boards excluding Powys):



The above graph shows that crude mortality in BCUHB is running slightly above the national average. Crude mortality is not risk adjusted and will be affected by many factors. Population demographics including age, socio-economic status and rate of chronic disease will all affect the crude mortality rate within a defined area. Comparison of crude mortality between Health Boards should only be interpreted alongside these parameters. We continue to monitor risk adjusted mortality metrics. There has been a downward trend in risk adjusted mortality index (RAMI) in BCUHB during the last quarter.

Crude mortality in secondary care will also be affected by the number of individuals dying outside the acute hospital setting. Capacity in community hospitals, care homes and hospices together with availability of social care packages will affect length of stay and increase mortality in secondary care where a lack of downstream capacity prevents discharge. This will lead to variation between integrated healthcare communities (IHCs) in the Health Board and needs to be considered when making external comparison with other Welsh Health Boards.

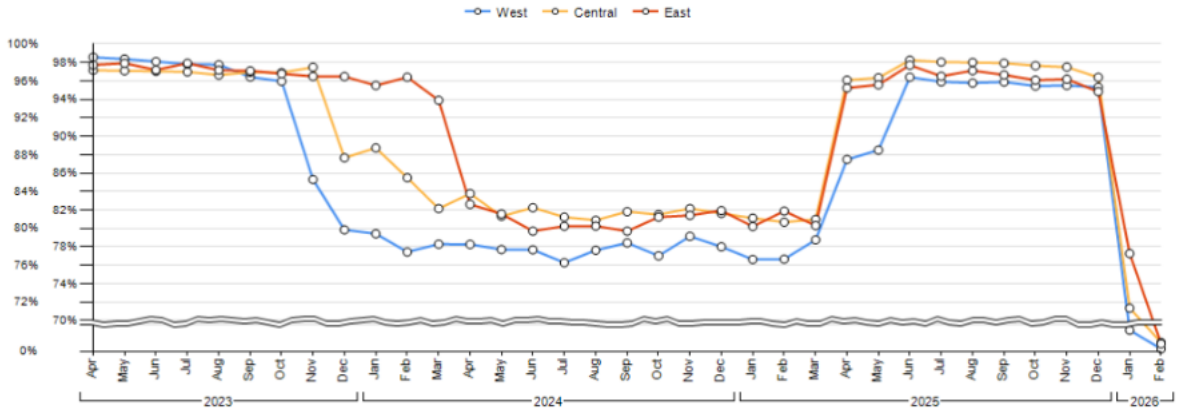
Crude Mortality Rate Overview – January to December 2025:



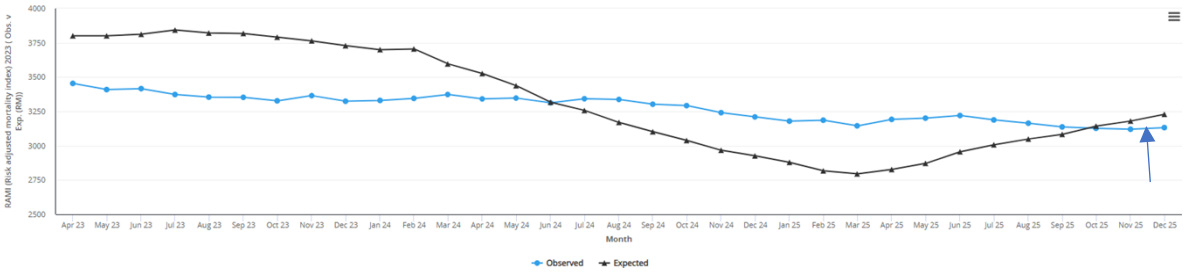
The overall mortality rate for BCU is 1.66% for the 12-month period from January 2025 to December 2025. This is a 6.21% reduction from the previous 12 months when the rate was 1.77%. Peer comparison suggests significant variation in mortality rate across Wales.

Coding Completion Rates – April 2023-March 2026:

A reduction in coding completion from 95% to 79% between March 2024 and June 2025 has led to a predictable increase in RAMI and condition specific metrics attributable to a decrease in the number of expected deaths resulting from the reduced coding completion rate. Furthermore, prioritisation of the coding of deceased patient records will also have increased the mortality rate during this period. BCUHB is now achieving the national target of 95% coding completion. We anticipate an ongoing reduction in RAMI over the next 12 months as this is a rolling 12 month measure. No significant increase in observed deaths or crude mortality rate was seen during this period.



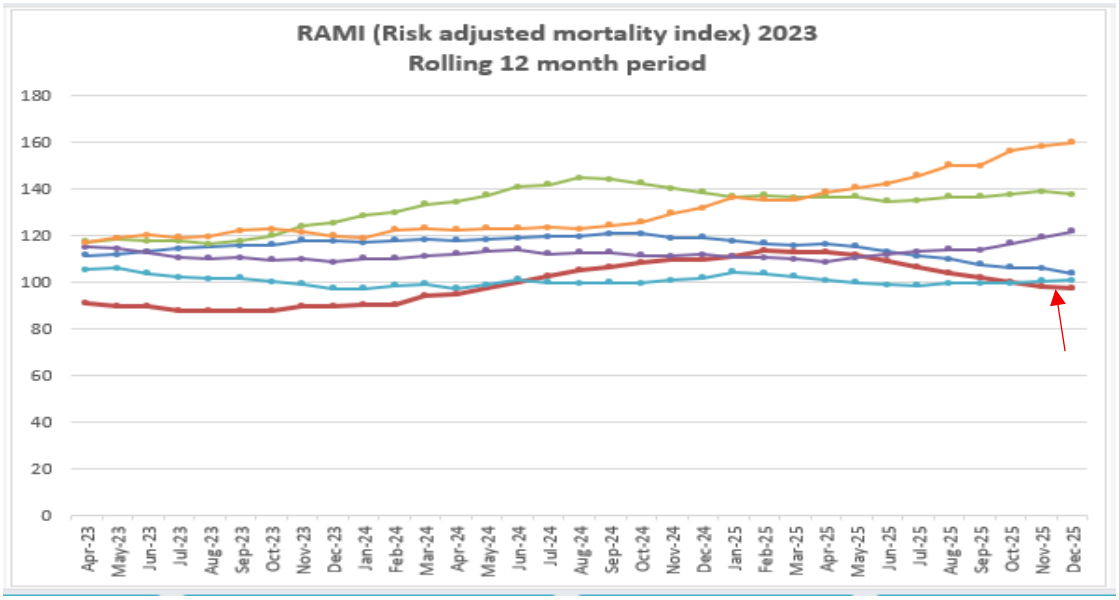
RAMI Observed vs Expected Deaths 12-month Rolling Trend – April 2023-December 2025:



RAMI = Number of deaths observed / Number of deaths expected.

The number of expected deaths has been increasing since April 2025, due increased coding completion rate, with a corresponding reduction (improvement) in our RAMI.

RAMI (Risk adjusted mortality index) 2023 » Rolling 12-month period BCUHB vs Peers:



BCUHB

All other coloured lines are of Welsh Health Board peers

As outlined above, the reduction in coding completion is likely to account for the rise in our RAMI between March 2024 and April 2025. Increased coding completion since August 2025 has correlated with an ongoing reduction in our RAMI The graph above compares BCUHB with other Welsh Health Boards between April 2023 to December 2025.

Deaths in low mortality Clinical Classification Software (CCS) groups:

Low mortality condition specific metrics detailed in the CHKS Report are summarised in the table below. This condition specific summary shows the number of deaths recorded within Low Mortality CCS Groups over the reporting period.

Deaths in Low Mortality CCS Groups			
211 - Other connective tissue disease	12	102 - Nonspecific chest pain	1
143 - Abdominal hernia	7	119 - Varicose veins of lower extremity	1
138 - Esophageal disorders	6	126 - Other upper respiratory infections	1
251 - Abdominal pain	4	142 - Appendicitis and other appendiceal conditions	1
236 - Open wounds of extremities	3	163 - Genitourinary symptoms and ill-defined conditions	1
141 - Other disorders of stomach and duodenum	2	165 - Inflammatory conditions of male genital organs	1
200 - Other skin disorders	2	198 - Other inflammatory condition of skin	1
47 - Other and unspecified benign neoplasm	1	203 - Osteoarthritis	1
66 - Alcohol-related mental disorders	1	242 - Poisoning by other medications and drugs	1
89 - Blindness and vision defects	1	**Total**	**48**

We have undertaken a detailed review of these cases, and no significant concerns have been identified. Review suggests that the assigned diagnostic category did not reliably capture the risk of

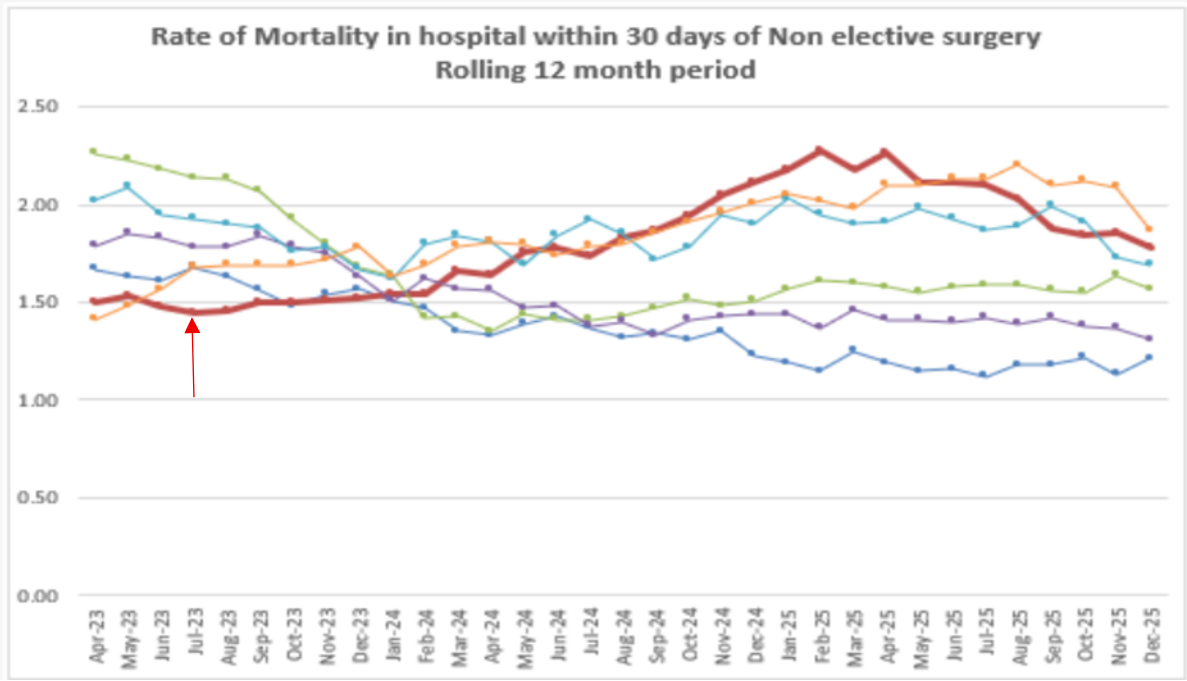
death in these patients. The primary diagnostic/procedural code used to identify these cases does not provide a reliable assessment of the risk of death. In some cases, it is clear that the most appropriate diagnostic category may not have been assigned, but it should also be noted that clinical coding does not assign diagnostic code based on the most likely cause of death.

Following further discussion with the Clinical Coding Team it has also been established that CHKS analysis is based on the primary coding category and will not consider secondary diagnostic categories in which level of associated risk will often be much higher. For example, abdominal hernia may be recorded as the primary diagnosis, which is assigned a low risk of mortality, but bowel obstruction or perforation resulting from the hernia, associated with much higher risk of death would not be considered where they were recorded as secondary diagnoses.

It is likely that we will continue to see anomalies in the CHKS data where methodology is not updated.

30-day mortality following non-elective surgery:

Mortality rate for specific conditions with well-defined clinical pathways such as stroke, myocardial infarction, non-elective surgery and elective surgery are actively monitored. Review of CHKS metrics has shown a significant increase in mortality rate within 30 days of non-elective surgery, stroke and myocardial infarction.



BCUHB

All other coloured lines are of Welsh Health Board peers

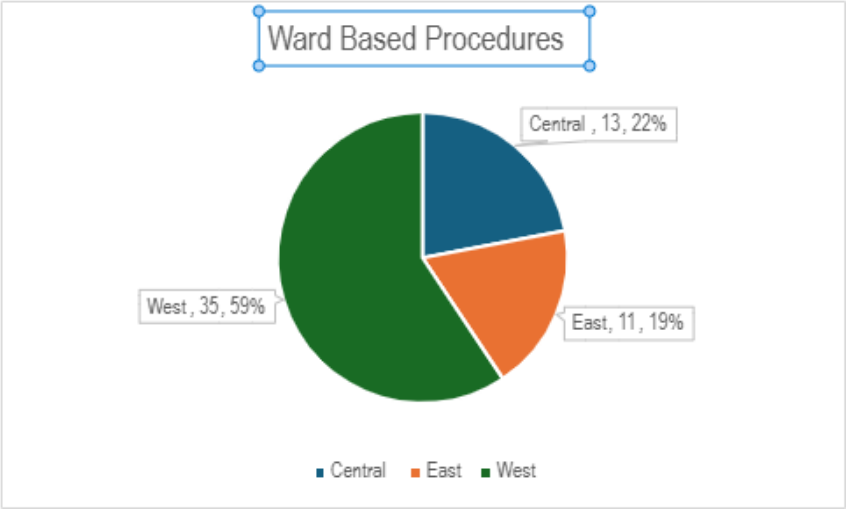
Numerators and denominators by site:

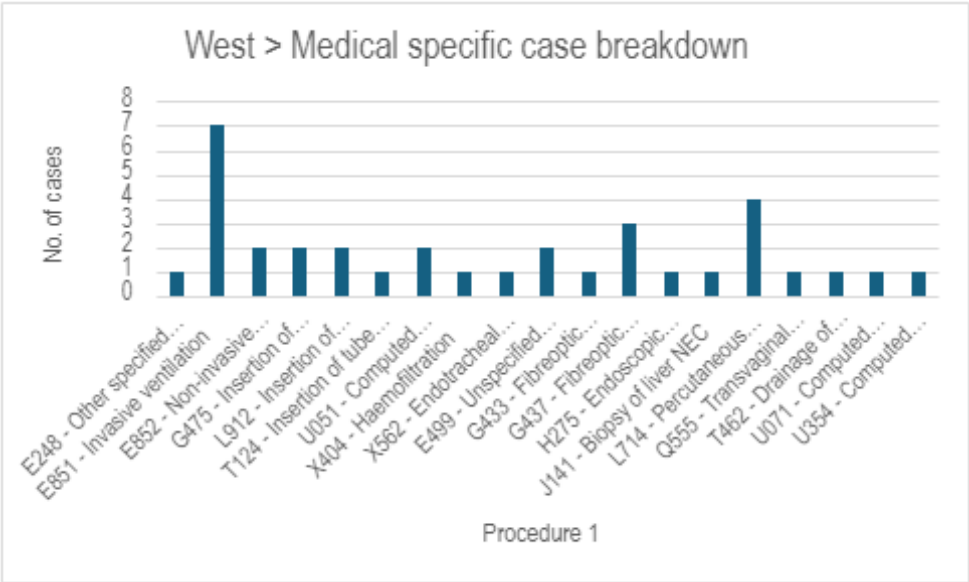
Rate of Mortality in hospital within 30 days of non-elective surgery	177	8105	2.18%
Central	69	3021	2.28%
East	42	3009	1.40%
West	66	2075	3.18%

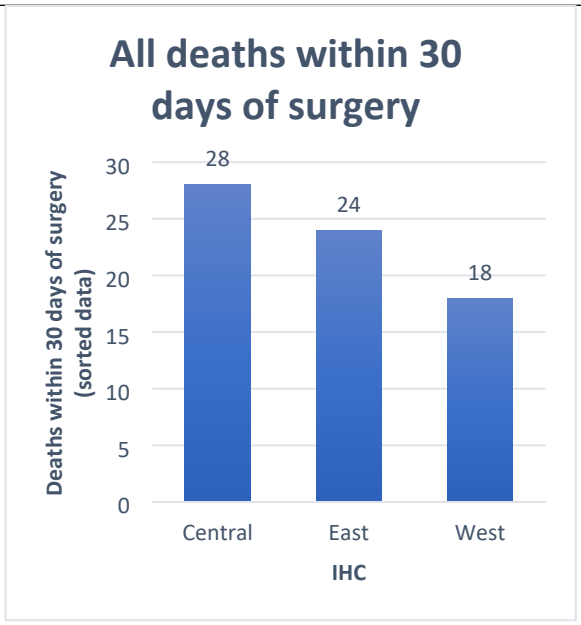
The CHKS definition of non-elective surgery includes radiological, endoscopic, and selected ward-based procedures, in addition to theatre based surgical procedures. Analysis of this cohort has shown that 28 (177) patients had a percutaneous interventional cardiology procedure. Ward based procedures included invasive ventilation, non-invasive ventilation, ascitic drain placement, naso-gastric tube placement, and cardio-pulmonary resuscitation. Intuitively these ward-based procedures will have been undertaken in a much larger number of patients across the Health Board who subsequently died during the relevant admission.

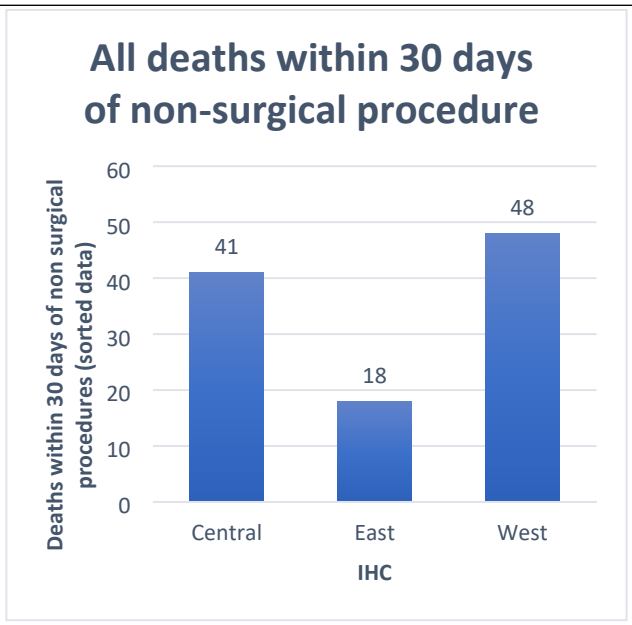
Differences in coding practices between IHCs may also have affected recorded data given the significantly higher number of ward-based procedures attributable to West compared with the other IHCs. This is likely to have contributed to the higher mortality rate seen in West. The total number of coded episodes is also much lower in West, decreasing the denominator and impact of the increased number of deaths on the mortality rate. The reasons for the much lower total number of coded cases in West is not clear and will be considered by the clinical coding team.

Further breakdown of non-operative procedures is shown for West in the chart below. This illustrates the range of non-surgical procedures recorded within the CHKS data and suggests variation in coding practices in West compared with the other IHCs. The increased number of patients dying following ward-based procedures in West compared with the other IHCs is likely to account for the higher mortality rate for non-elective surgery seen in West.


Ward Based Procedures
Central , 13, 22%
East, 11, 19%
West , 35, 59%
Central
East
West


West > Medical specific case breakdown
No. of cases
0
1
2
3
4
5
6
7
8
E248 - Other specified...
E851 - Invasive ventilation
E852 - Non-invasive...
G475 - Insertion of...
L912 - Insertion of...
T124 - Insertion of tube...
U051 - Computed...
X404 - Haemofiltration
X562 - Endotracheal...
E499 - Unspecified...
G433 - Fibreoptic...
G437 - Fibreoptic...
H275 - Endoscopic...
J141 - Biopsy of liver NEC
L714 - Percutaneous...
Q555 - Transvaginal...
T462 - Drainage of...
U071 - Computed...
U354 - Computed...
Procedure 1



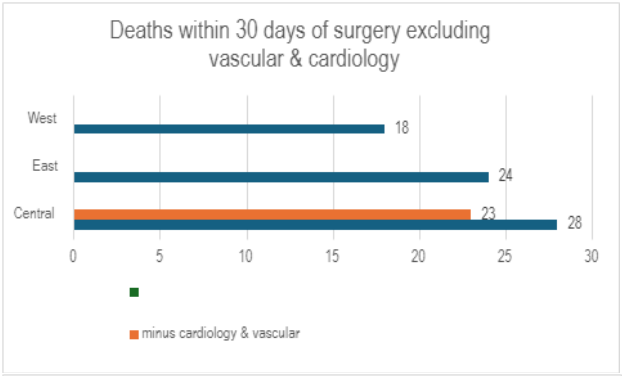


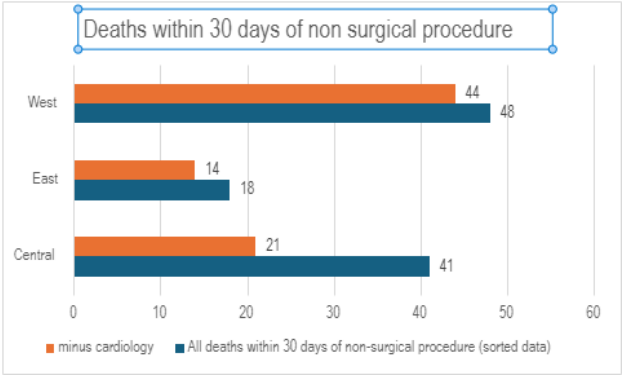
Theatre based Surgical procedures.

70(177) patients had a surgical procedure. Site breakdown is provided above. The largest patient cohort had emergency hip surgery. No significant variation in mortality was noted between the IHCs. Mortality within 30 days of hip fracture is considered separately below. It is not surprising that mortality is high in this patient cohort, as hip fracture is associated with an overall mortality up to 30% at 6 months, reflecting the frailty of this patient group.

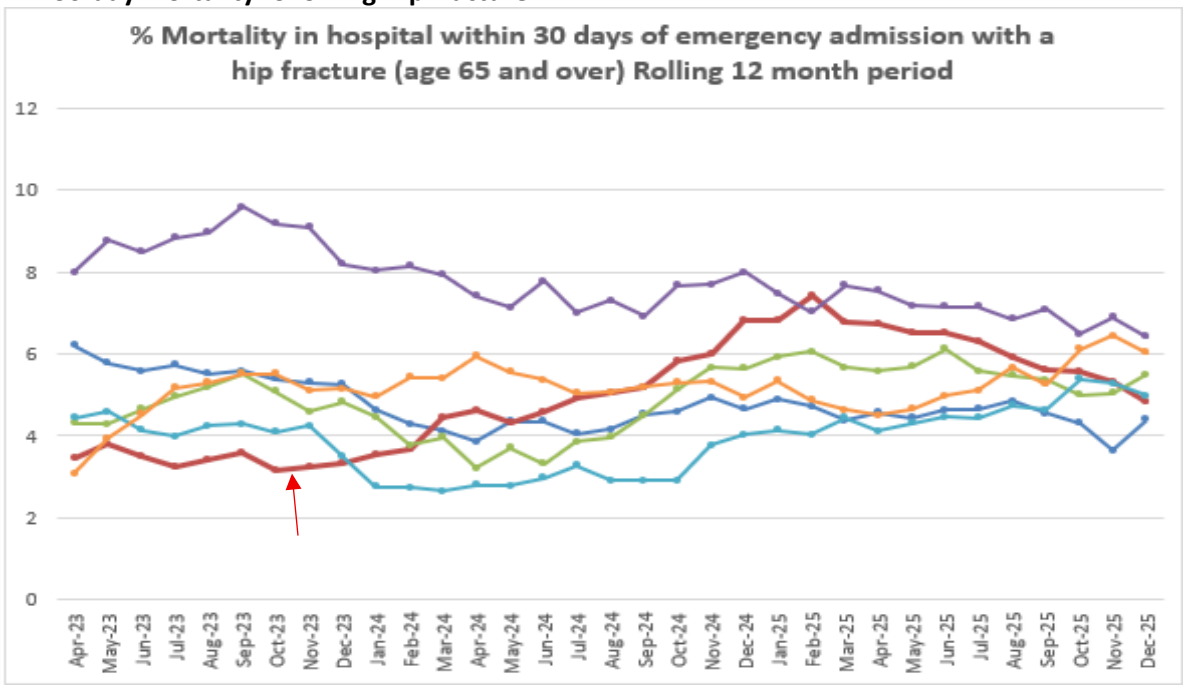
Review of non-elective surgical mortality has highlighted the value of triangulation with national benchmarking audits where available. The National Emergency Laparotomy Audit (NELA) facilitates UK benchmarking. Mortality 30 days post laparotomy in Ysbyty Glan Clwyd (YGC) was 6.9% in the 10th NELA Report covering 04/23-04/24 (UK average 9%), compared with 6.7% for 12/21-03/23 (UK 8.1%). Unfortunately, Ysbyty Gwynedd (YG) and Wrexham Maelor Hospital (WMH) did not participate in these audits. Moving forward it will be important to address issues preventing the submission of local data to the NELA Audit and other national benchmarking audits.

Regionalised services exist for vascular and interventional cardiology, and it would, therefore, be more informative to consider separately, as patients will be admitted from the 3 IHCs:





30-day mortality following Hip fracture:



BCUHB

All other coloured lines are of Welsh Health Board peers

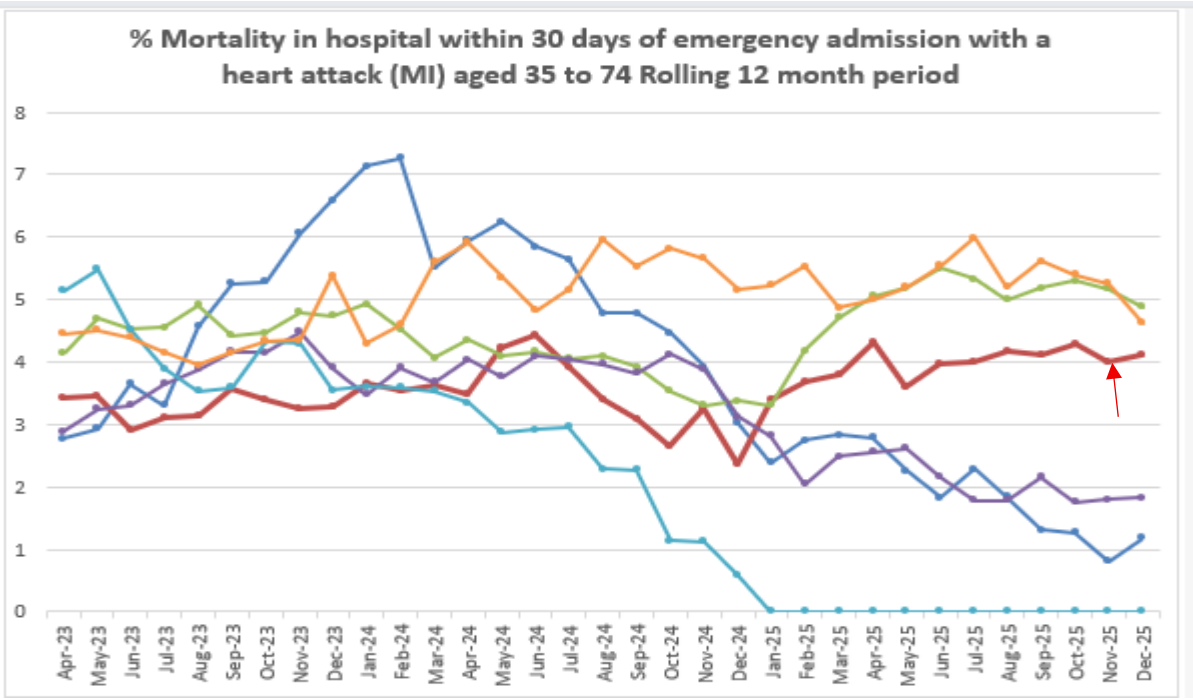
An upward trend in mortality following admission with hip fracture was seen in the last quarter of 2024 and the first quarter of 2025. Reduction in coding completion rate is likely to have impacted upon the accuracy of 12-monthly rolling mortality during this period. In terms of further benchmarking, we actively monitor mortality indicators reported in the national hip fracture registry. In the third quarter of 2025, this data showed that the annualised crude mortality rate was 2.9% in Wrexham Maelor Hospital, 0.7% in Ysbyty Glan Clwyd and 2.6% in Ysbyty Gwynedd compared with a UK average of 5.0%. A small increase in mortality was seen in Wrexham Maelor Hospital in the first 3 quarters in 2021.However, the mortality rate has been below the national average since quarter 4 of 2021.

Link: Mortality (nhfd.co.uk)

The National Hip Fracture Database dashboard facilitates active national benchmarking of mortality rate and other key performance indicators.

Link: NHFD - Charts & Reports

% Mortality in hospital within 30 days of emergency admission with a heart attack (MI) aged 35 to 74 - BCUHB vs Peer:



BCUHB

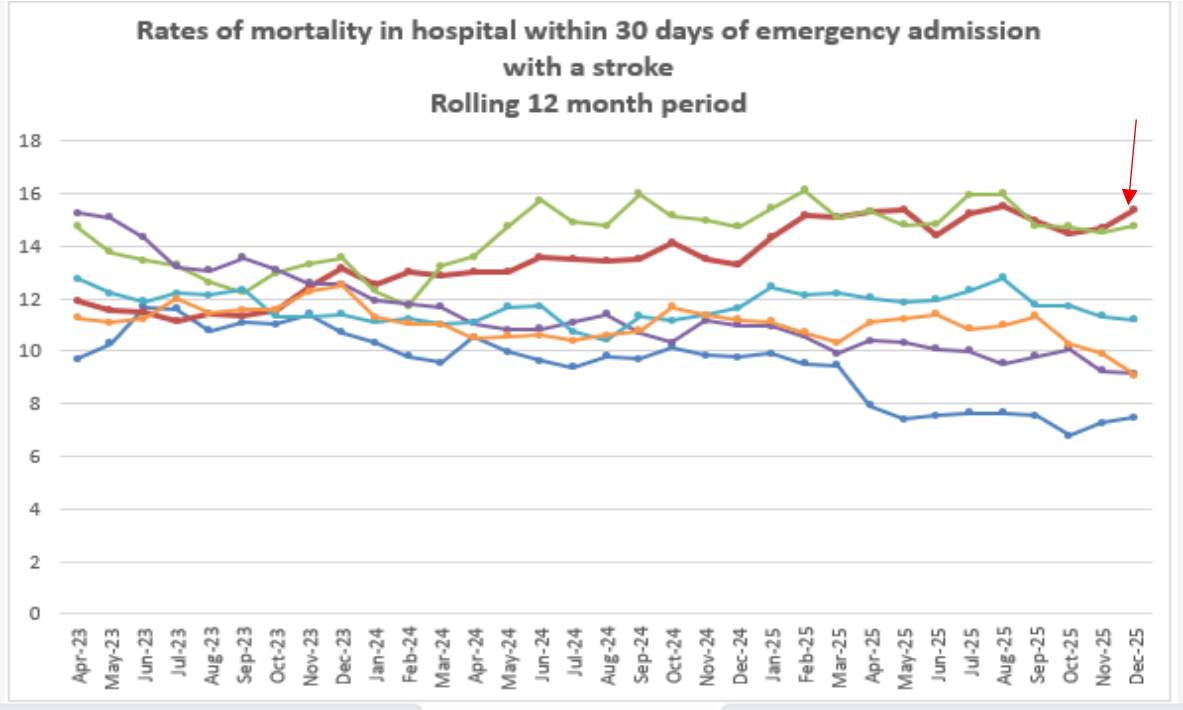
All other coloured lines are of Welsh Health Board peers

There has been a persistent upward trend in mortality rate within 30 days of admission with Myocardial Infarction (MI). Comparison with other Welsh Health Boards provides a further insight. Mortality is highest in CVUHB and SBHB who provide interventional cardiology cover to the whole of South Wales. Mortality is much lower in other Health Boards in South Wales where no primary or rescue percutaneous coronary intervention (PCI) is undertaken. Our mortality rate falls in the middle, which would be consistent with our hybrid model of care and limits the value of direct comparison with performance in other Welsh Health Boards.

The 0% mortality rate in HDUHB will also have impacted upon the peer average reported for comparison within the Welsh Government mortality report.

Preliminary discussions have been held with BCUHB Cardiology Lead, who has confirmed that local data does not suggest a significant increase in mortality, but a retrospective audit is planned, and mortality rate will be monitored alongside other key performance indicators in a Clinical Governance setting.

Mortality 30 Day Post Stroke:



BCUHB

All other coloured lines are of Welsh Health Board peers

A detailed review of stroke mortality during this period has been undertaken, including triangulation of CHKS data with data submitted as part of the Sentinel Stoke Audit (SSNAP). This review concluded that decreased coding completion rate and prioritisation of the coding of deceased patients during this period is likely to account for the increase in mortality observed in the CHKS data.

The table below taken from the closing report compares mortality rates within the CHKS and SSNAP data sets. SSNAP mortality rate for this period tracks the national average within the CHKS data. Exclusion criteria in the SSNAP audit mean that total sample size is smaller than the CHKS data set.

	April 2021 – March 2023		April 2023 – March 2024		April 2024 – March 2025		April 2025 – September 2025	
	CHKS	SSNAP	CHKS	SSNAP	CHKS	SSNAP	CHKS	SSNAP
Total	2435	2096	1272	1237	989	1372	439	652
RIP	297	297	164	204	184	187	64	84
Rate	**12.19%**	**14.2%**	**12.89%**	**16.49%**	**18.60%**	**13.62%**	**14.579%**	**12.88%**

However, there has been a further upward trend in stroke mortality within the CHKS data in the last quarter of 2025, despite increased coding completion rate since August 2025.

	Mortality Associate Medical Director's (AMD's) have met with the Clinical Lead for Stroke, Dr Walee Sayed and Stroke Network Manager, Clare Mcgrath, to discuss the persistent upward trend in mortality within 30 days of Stroke. Outcomes of the meeting included: - Review of cases recorded in the CHKS data for 1st January and 31st December 2025; - Review of CHKS diagnostic categories; - Triangulation of mortality metrics with other Key Performance Indicators (KPIs) included in Sentinel Stroke Audit (SSNAP) dashboard, notably ambulance transfer/handover times; - Terms of reference for a Pan-BCU Clinical Governance Group for Stroke would be developed to facilitate ongoing review of local mortality data and other KPIs; - Formal discussion of Stroke mortality data and related action plan at LFMP & RAMSG meeting in April.

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Quality Safety & Experience Committee

CORPORATE GOVERNANCE REPORT

Dyddiad y Cyfarfod **Date of Meeting**	07 May 2026
Statws Cyhoeddi **Publication Status**	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad **Report Author name and title**	Philippa Peake-Jones, Head of Corporate Governance
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol **Lead Executive Team Member name and title**	Pam Wenger, Director of Corporate Governance

Pwrpas yr Adroddiad **Report Purpose**	For Noting

Crynodeb Gweithredol **Executive Summary**
Members are asked to: • **NOTE** the summary of business considered in private session to be reported in public

Ymgysylltu (mewnol/allanol) yr ymgymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp) **Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)**		
Pwyllgor / Grŵp / Unigolion **Committee / Group / Individuals**	**Dyddiad** **Date**	**Canlyniad, Tystiolaeth a Data** **Outcome, Evidence and Data**
Not applicable for this report		

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

CORPORATE GOVERNANCE REPORT

1. **Y SEFYLLFA**
SITUATION

1 The Health Board is required to act according to its Standing Orders. This report contains information to allow the Health Board to conform to this.

2 It is essential that the Board has robust arrangements in place for Corporate Governance and failure to do so could have legal implications for the Health Board.

3 **Y CEFNDIR**
BACKGROUND

3.1 The purpose of this report is to provide the Committee with an update on key corporate governance matters.

4 **MATERION PENODOL I'W HYSTYRIED**
SPECIFIC MATTERS FOR CONSIDERATION

4.1 **Summary of Business Considered in Private**

4.1.1 Standing Order 6.5.3 requires the Board to formally report any decisions taken in private session to the next meeting of the Board in public session. This principle is also applied to Committee meetings.

4.1.2 The below items were considered in private at the meeting held on 5 March 2026:

- QS26.52 Integrated Quality Performance Report
- QS26.53 Quality Commissioned Services National Outpatient Insourcing Programme
- QS26.54 Communicable Disease Preparedness
- QS26.55 Urgent Emergency Care
- QS26.56 Public Health Wales Sexual Health Testing
- QS26.57 Executive Quality Delivery Group Report

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

5.1 There are no matters for escalation.

6 **ARGYMHELLION**
RECOMMENDATIONS

6.1 Gofynnir i'r Pwyllgor/Cyfarfod/Grŵp:
The Committee/Meeting/Group is asked to:

- **NOTE** the matters considered in Private at the 5 March 2026 Committee.

ASESIAD / ASSESSMENT	
Cyswllt â'r Blaenoriaethau Strategol **Link to Strategic Priorities**	 1. Building an effective organisation
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Yr Egwyddorion Dylunio **Design Principles**	Simplify, Standardise, and Adopt Best Practices Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd **Corporate Risks and Board Assurance Framework**	BAF24-01 Building an Effective and Accountable Organisation CRR-16 – Leadership/Special Measures

ASESIADAU O EFFAITH / IMPACT ASSESSMENTS		
Cydraddoldeb *A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o'r Effaith ar Gydraddoldeb (sy'n cynnwys gofynion Safonau'r Gymraeg)* **Equality** *Have you undertaken an Equality Impact Assessment Screening (which includes the requirements of the Welsh Language Standards)*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not necessary for this report
Asesiad o'r Effaith Economaidd-gymdeithasol *A ydych chi wedi cynnal Asesiad o'r Effaith Economaidd-Gymdeithasol?* **Socio-Economic Impact Assessment**	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not necessary for this report

Have you undertaken a Socio-Economic Impact Assessment		
Ansawdd *A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	**Galluogwyr Ansawdd** **Enablers of Quality** All Apply	**Meysydd Ansawdd** **Domains of Quality** All Apply
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant **Wellbeing of Future Generations Act – Wellbeing Goals**	Not Applicable	

Effaith Amgylcheddol / Cynaliadwyedd (5Rs) **Environmental /Sustainability Impact (5Rs)**	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
	No - Not Applicable	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:	
Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog A ydych chi wedi ystyried Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog: **Armed Forces Covenant Due Regard Duty** Have you considered the Armed Forces Covenant Due Regard Duty?	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not necessary for this report
Asesiad o Effaith ar Ddiogelu Data	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	

A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data? **Data Protection Impact Assessment** *Have you undertaken a Data Protection Impact Assessment Screening?*	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not necessary for this report
Asesiad o Effaith ar Atal Twyll *A ydych chi wedi ystyried yr effeithiau ar atal twyll?* **Counter Fraud Impact Assessment** *Have you considered the counter fraud impacts*	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not necessary for this report
Cyfreithiol **Legal**	There are no specific legal implications related to the activity outlined in this report.	
Enw Da **Reputational**	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith ar Adnoddau *(Pobl / Ariannol)* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

Quality Safety Experience Committee Key Issues Report (this report should be a maximum of 2 sides of A4 paper)				
Committee Date		07/05/2026 Quality Safety Experience Committee		
Date of Committee		13/04/2026	**Report of:**	Mental Health Oversight and Development Group
Quoracy met:		Yes		
1	Agenda	The Mental Health Oversight and Development (MHODG) continue to meet bi monthly following the inaugural meeting in November 25. The Committee considered an agenda which is attached at appendix 1.		
2a	Alert	The MHODG wish to alert members of the Quality Safety Experience (QSE) Committee that: 1. The MHODG will provide strategic oversight **of ligature reduction progress**. Terms of Reference have been drafted for a Ligature Reduction Programme Board. The inaugural meeting is planned for May. All HSE actions will be progressed through the new governance structures led jointly by MHLD and Estates.		
2b	Assurance	The MHODG wish to assure members of QSE Committee that: 1. The approach to **governance and workstream development** is agreed to: • ensure alignment with broader Health Board strategic planning, including clinical service planning and partnership working. • avoid fragmentation of mental health work from wider organisational programmes and ensuring convergence with other executive-led initiatives. • Incorporate patient, carer and citizen experience alongside performance and delivery measures, with a view to reflecting this in future Board-level reporting. • Support consistency of reporting through the agreed governance routes, including Executive Committee, QSE and Board. 2. The **Daily Metrics** requirement for NHS Performance and Improvement (NHSPI) related to inpatient flow were noted.		
2c	Advise	The MHODG wish to advise members of QSE Committee that:		

		1. The Mental Health **Outcomes Framework** will move into a second, broader development phase. An interim framework will be developed and used, recognising it will continue to evolve. Co-production activity will be intensified over the coming weeks. This will act as a foundation for the planned organisational outcome framework. 2. **Developing AHP and Psychological Therapy in MHLD-** Current AHP provision in MHLD is significantly lower than comparator Health Boards. Psychological therapy provision in inpatient settings remains fragile, with ongoing recruitment and retention challenges. There remains strong alignment between AHP, psychological therapy and future service model ambitions (open access, rehabilitation, recovery). MHODG agreed that AHP and psychological therapy provision are core, not optional, components of mental health care and there is a recognition that new service models require new workforce models and long term planning. A strategic MH workforce plan is required, aligned to future models of care this work will be progressed through the agreed MHODG workstreams (MHODG Workstream 5– Workforce).
2d	Review of Risks	Fragility of AHP and Psychological provision in MHLD were noted and discussed.
2e	Sharing of learning	Learning from the Royal College of Psychiatry Invited Services Review developed outcomes frameworks was shared to move to the next stage.
3	Actions to be considered by the Executive Committee	MHODG agreed: • The governance and workstream approach to be communicated to Executive colleagues and MHLD senior leads ahead of Executive Committee (22 April 2026). • Outcomes Framework progress to be reported through MHODG, QSE and Board in July. • To convene a Ligature Reduction Programme Board.

Mental Health Oversight and Development Group

Monday 13 April 2026 at 09.30am–11.30pm

via Teams

AGENDA

Item No/Guide Time	Agenda Item	Lead	Attachments
26.9 09.30 – 09.35	**Welcome, Introduction, Apologies**	Chair	
26.10 09.35	**Declarations of Interest**	Chair	
26.11 09.35 – 09.50	**Minutes of previous meeting and Action log**	Chair	Minutes and Action Log
26.12 09.50 – 10.10	**Development of MH ODG Workstreams and Governance Approach**	PM	Presentation
26.13 10.10 – 10.35	**Development of the Mental Health Outcomes Framework.**	VJ	Presentation
26.14 10.35 – 10.55	**Health and Safety – Focus on mobilising the ligature reduction programme and associated governance**	SK/CE	Presentation

26.15 10.55 – 11.20	**Developing AHP and Psychological Therapy Provision. Understanding current position against the national plans.**	Dr Louise Brookwell/ Nesta McCluskey and Susan Brierley-Hobson	Presentation x 2
26.16 11.20 – 11.25	**Work we are proud of**	All	
	For information		
26.17 11:25	**Reporting to NHS Performance and Improvement** **(data metrics reporting on a daily basis to NHS P and I)**	VJ	
27.17 11.25 – 11.30	**Any Other Business and** **Date & Time of Next Meeting 11 May 2026 - 2pm-4pm**		

Click or tap to enter a date.