

Bundle Quality, Safety and Experience Committee 6 June 2024

- 1 OPENING BUSINESS
 - 1.1 13:00 – QS24/63 – Welcome, introductions and apologies for absence – Verbal – Chair
 - 1.2 13:02 – QS24/64 – Declarations of interest relating to agenda – Verbal – Chair
 - 1.3 13:03 – QS24/65 – Draft Minutes of Last Meeting – Attached – Chair
QS24.65.1 Draft Minutes of Meeting 18.04.24 V0.3 – Chair Approved
 - 1.4 13:05 – QS24/66 – Matters Arising & Table of Actions – Attached – Chair
QS24.66.1 QSE Matters Arising & Table of Actions – Public 22.05.24
 - 1.5 13:10 – QS24/67 – Patient Story – Attached – Executive Director of Nursing and Midwifery / Deputy Director of Quality Governance
QS24.67.1 Patient Story – June 2024
- 2 QUALITY CONTROL
 - 2.1 13:20 – QS24/68 – Quality Report – Attached – Executive Director of Nursing and Midwifery / Deputy Director Quality
QS24.68.1 Quality Report – June 2024
 - 2.2 13:35 – QS24/69 – Clinical Service of Concern Report – Vascular – Executive Medical Director
QS24.69 – Clinical Service of Concern Report – Vascular
 - 2.3 14:10 – QS24/70 – Quality Delivery Group Chair’s Report – Attached – Executive Director of Nursing and Midwifery / Deputy Director Quality
QS24.70.1 Quality Delivery Group Chair's Report – June 2024
 - 2.4 14:15 – QS24/71 – IHC/Regional Service Quality Deep Dive – East IHC – Integrated Health Community Director of Nursing (East)
QS24.71.1 IHC Regional Service Quality Deep Dive East IHC – Cover Sheet – PPJ checked
QS24.71.2 IHC Regional Service Quality Deep Dive East IHC
 - 2.5 14:50 – QS24/72 – Integrated Performance Report – Attached – Director of Performance
QS24.72.1 Coversheet for Integrated Performance Report to 31.03.24
QS24.72.2 Integrated Performance Report to 31.03.24
- 3 15:00 – COMFORT BREAK – 10 mins
- 4 ISSUES RELATED TO KEY RISKS
 - 4.1 15:10 – QS24/73 – Corporate Risk Register – Attached – Director of Corporate Governance
QS24.74.1 QSE Corporate Risk Register June 24 Draft v1 (003) v3 OM
- 5 CLOSING BUSINESS
 - 5.1 15:20 – QS24/74 – Date of Next Meeting – 15 August 2024
 - 5.2 15:22 – QS24/75 – 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)

**DRAFT Minutes of the Quality, Safety and Experience Committee meeting held
in public**

on 18 April 2024 09:30 – 13:00

at The Board Room, Carlton Court, St Asaph

Committee Members Present	
Name	Title
Caroline Turner	Independent Member/Chair of Quality, Safety and Experience Committee
Urtha Felda	Independent Member
In Attendance	
Angela Wood	Executive Director of Nursing and Midwifery (Executive Lead)
Dr Nick Lyons	Executive Medical Director
Gareth Evans	Acting Executive Director of Therapies and Health Sciences
Pam Wenger	Director of Corporate Governance
Other Executive Directors as required by the Chair	
Dr Jane Moore	Acting Executive Director of Public Health
Other BCUHB Senior Managers as required by the Chair	
Nesta Collingridge	Head of Risk Management
Nick Graham	Assistant Director of Workforce Optimisation (Part of the meeting)
Matthew Joyes	Deputy Director of Quality
Phil Meakin	Associate Director of Governance (Part of the meeting)
Geraint Parry	Quality Improvement Fellow (Part of the meeting)
Philippa Peake-Jones	Head of Corporate Affairs
Iain Wilkie	Acting Director of Mental Health
Ed Williams	Director of Performance

Agenda Item	Action
OPENING BUSINESS	
QS24/30 Welcome, introductions and apologies for absence	
QS24/30.1 The Chair welcomed everyone present and thanked the outgoing Chair Rhian Watcyn Jones. Apologies were noted from Dave Harries, Internal Audit, Mike Larvin, Independent Member, Chris Field, Independent Member, Jane Wild, Associate Member, Dyfed Edwards, Chair who often observes the meeting.	
QS24/31 Declarations of Interest on current agenda	
There were no declarations of interest made in respect of items on the agenda.	

<p>QS24/32 Draft minutes of the previous meeting held on</p> <p>QS24/32.1 The draft minutes of meeting held on 20 February 2024 were approved.</p>	
<p>QS24/33 Matters Arising and Table of Actions</p> <p>QS24/33.1 Following a detailed discussion, the updates provided within the action log were agreed.</p>	
<p>QS24/34 Report of the Chair</p> <p>QS24/34.1 The Chair advised that since she had been appointed as Chair of the Committee, she had met with the outgoing Chair to have a handover, the Lead Executive, the Deputy Director of Quality, the Director of Governance and Head of Corporate Affairs and that with regards to her fellow Independent Members of the Committee she had met with one, spoken to another and had one meeting scheduled.</p> <p>QS24/34.2 Further background research had enabled her to meet with Olivia Shorrocks, Welsh Government and Cathy Dowling, NHS Executive, as well as with Independent Advisors Graham Shortland and Susan Aitkenhead. The Committee noted that Graham Shortland would support Independent Members of the Committee for a few months.</p> <p>QS24/34.3 The Chair advised that at the next meeting there would be a focus on Vascular and that the areas identified in Special Measures would be reviewed throughout the year. A future QSE Development session would be scheduled and would review the Cycle of Business alongside the Annual Plan to ensure alignment to the Plan. Attendees would also discuss Risk, Services of Concern and Performance Indicators.</p>	
<p>QS24/35 Notification of Matters referred from other Board Committees on this or future agendas - Verbal - Chair</p> <p>There was nothing to note.</p>	
<p>QS24/36 Committee Terms of Reference - Attached - Director of Governance</p> <p>QS24/36.1 The Committee Terms of Reference were noted, it was agreed that the Deputy Director of Quality would circulate a structure chart outlining the groups that reported into the Quality Delivery Group</p> <p>It was resolved that the Committee:</p> <ul style="list-style-type: none"> • Noted the Terms of Reference 	<p>MJ</p>

<p>QS24/37 Committee Cycle of Business 2024/25</p> <p>QS24/37.1 The Cycle of Business was noted and would be looked at during the Committee Development Session.</p> <p>It was resolved that the Committee:</p> <ul style="list-style-type: none"> • Noted the Cycle of Business 	
<p>QS24/38 Patient Story</p> <p>QS24/38.1 The Committee listened to a story from a patient describing the journey he had experienced while recently undergoing hip replacement surgery at Wrexham Maelor Hospital, following increased pain and inflexibility. The learning identified from the patient sharing his experience was received.</p> <p>QS24/38.2 The Committee were concerned that the waiting lists for Planned Care had increased since Covid and noted that the figures on the wait times were reported to Welsh Government. Plans were in place and movement on the longest waits had taken place with plans to try and make as much progress as soon as possible.</p> <p>QS24/38.3 The Chair felt that it was good to make reference to the Multi-Disciplinary Teams and queried whether it worked well across all areas. The Acting Executive Director of Therapies and Health Sciences advised that Orthopaedics was shining a light on Multi-Disciplinary Team working and that there was a philosophy throughout the organisation to work in this way but that there was more to do.</p> <p>QS24/38.4 Clarification was sought around how the Orthopaedic Hub being created in Llandudno would work with the Abergele site. Initially there would be some double running of both sites with the ambition to see more services across the whole of North Wales coming together, making the Health Board a more attractive place to work.</p> <p>It was resolved that the Committee:</p> <ul style="list-style-type: none"> • Noted the Patient Story 	
<p>QS24/39 Quality Report</p> <p>QS24/39.1 The Executive Director of Nursing and Midwifery presented the report advising that it gave the Committee the narrative on organisational learning, quality improvement, the forthcoming Quality Management System, Patient Safety and information on Safeguarding and Infection Control. The report identified organisational learning, that this had not been an area where the organisation had historically been very good. The Learning Forum was highlighted as way colleagues were able to come together to share learning, the forum had been in place for a year. A learning depository was being established and that would be a way for all those through the organisation to have access to</p>	

<p>historical learning. The Committee noted that a Quality Improvement register was in development and would be another way to share leaning.</p> <p>QS24/39.2 The Quality Management System had been discussed at Senior and Executive level and the Board would be taken through that at Development session scheduled for the following week.</p> <p>QS24/39.3 The Executive Director of Nursing and Midwifery shared information on Patient Safety Incidents, Infection control, falls and complaints. An Independent Member thanked her for the report and asked what had happened with the Urology letters and was advised that it had been an internal administration error around referrals which had been identified internally and rectified. The Executive Medical Director advised that he had met with the Clinicians on the matter and that further investigations were ongoing with regards to an insourcing matter.</p> <p>QS24/39.4 The process of Patient Safety Alerts was clarified and the Committee understood that there were some outstanding from Welsh Government. Further discussion took place on Safeguarding, Infection Control, flow and manual handling. It was agreed that there should be a separate development session on the Quality Report and Integrated Performance Report.</p> <p>[The Director of Corporate Governance joined the meeting]</p> <p>It was resolved that the Committee:</p> <ul style="list-style-type: none"> • Noted the Quality Report 	<p>PPJ</p>
<p>QS24/40 Integrated Performance Report</p> <p>QS24/40.1 The Director of Performance presented the report highlighting two specific points, one in relation to Never Events and one in relation to Clinical Coding compliance. It was noted that there had been a business case received at the previous Board around Clinical Coding and that the matter was being managed by the Chief Digital and Information Officer.</p> <p>QS24/40.2 A discussion took place around whether delays in responding to complaints were due to having independent Primary Care contracts. It was noted that any complaints would follow the individual Independent Primary Care governance process before addressing the Health Boards process. Concern was raised that the Health Board had a Duty of Quality but that there were few contractual leavers to ensure that the Independent Organisations followed the timescale set by the Health Board, or that they were consistent in their processes; however, that was being worked on through relationship meetings.</p> <p>It was resolved that the Committee:</p> <ul style="list-style-type: none"> • Reviewed the contents of the report and agreed that a separate development session would be held on the subject. 	
<p>QS24/41 Quality Delivery Group Chair's Report</p>	

<p>QS24/41.1 The Executive Director of Nursing and Midwifery presented the report, clarified reporting lines and advised that the report shared a summary of what had been discussed at the Quality Deliver Group meeting. The Committee noted that the Maternity Service had an active offer for home births and that a number of service pressures and concerns from Integrated Health Communities had been escalated.</p> <p>QS24/41.2 It was noted that there was positive support from Workforce, Finance and Data at the Quality Delivery Group and the Director of Governance suggested that the Group would be a future place for External Reviews to be shared. The Acting Director of Mental Health advised that the Quality Delivery Group was a very good real-life example of integration and Multi-Disciplinary approach, whereby corporate and clinical services come together to learn. The Executive Director of Nursing and Midwifery advised that she had asked for a review of attendance.</p> <p>It was resolved that the Committee:</p> <ul style="list-style-type: none"> • Noted the Quality Delivery Group Chair's Report 	
<p>QS24/42 Regulatory and Legal Report</p> <p>QS24/42.1 The Deputy Director of Quality presented the report and an Independent Member asked if there had been a response to the fourth case on the Concerns / Requests for Assurance from HIW, and were advised that there had been. Details on the Coronial cases and Regulation 28 Notices would be discussed in the private session.</p> <p>QS24/42.2 The Deputy Director of Quality advised of the normal process around the Ombudsman Letter, noting that this would normally be received by Committee much earlier in the cycle but there had been an administrative error that had delayed that this year.</p> <p>It was resolved that the Committee:</p> <ul style="list-style-type: none"> • Noted the Regulatory and Legal Report • Considered the Ombudsman Annual Letter and Health Board response and noted that it would inform the Committee's work on seeking assurance of the complaint handling process. 	
<p>QS24/43 Deep Dive report – East IHC</p> <p>This item was deferred until the June meeting.</p>	
<p>QS24/44 Clinical Policy Report</p> <p>QS24/44.1 The Associate Director of Governance advised that the Policy on Policy had been approved at the Audit Committee; it was agreed that Committees would note policies.</p>	

<p>It was resolved that the Committee:</p> <ul style="list-style-type: none"> • Noted that the “Policy for the Management of Health Board Wide Policies, Procedures and other Written Control Documents” were received at the Audit Committee in March. • Noted the progress that was being made on updating policies 	
<p>QS24/45 Nurse Staffing Act</p> <p>QS24/45.1 The Committee received a presentation on the Nurse Staffing Act, noting that the Non-Act wards had not been reviewed for some time and that the Community Hospitals were currently going through a review. It was noted that systems were in place but that recruitment was difficult; despite that, permanent recruitment had improved and many Integrated Health Communities had stopped using Agency Staff. Each ward was being looked at independently alongside acuity data. The detail around the not funded 179 beds was shared and the Act explained in detail.</p>	
<p>QS24/46 Commissioned Services Quality report</p> <p>QS24/46.1 The Committee received a verbal update on the Commissioned Services Quality report; it was highlighted that a no assurance report from Internal Audit had been received and that they would be following up. Ongoing conversations were taking place with the Executive Team to move this forward.</p> <p>[Acting Executive Director of Public Health left the meeting]</p>	
<p>QS24/47 Urology Review</p> <p>QS24/47.1 The Executive Medical Director presented the Urology Review Paper, highlighting that the action plan had been shared by email in Excel format as the Board and Committee software did not support the upload of Excel documents, and the Action Plan could not be converted into a readable PDF version. He highlighted the background to the service review and explained that it had not been possible to appoint a Clinical Lead. It was also difficult to recruit to this speciality as most surgeons who were robotically trained use a DaVinci robot and the one the Health Board had procured was not DaVinci.</p> <p>QS24/47.2 It was noted that a review had taken place and there had been no evidence of harm; however, improvements had been slow and the key to change was service reconfiguration but that would require consultation. Two surgeons had resigned and recruitment was very difficult as the Royal College were unable to approve the Job Descriptions as drafted due to the need for a reconfiguration, as well as the robotic issue.</p> <p>QS24/47.3 The Committee noted that despite a lack of clinical lead, the Network Lead was very good, with the Deputy Medical Director leading on the development and overseeing the implementation of the Action Plan. A discussion took place around how to resolve the issues and it was noted that the service reconfiguration would be key and as part of that reconfiguration the</p>	<p>NL</p>

<p>robotic issue would be included. The Chair emphasised the importance of pace in responding to the recommendations of the reports by the Royal College and the GIRFT report, particularly those recommendations that had been identified as being urgent; she also expressed concern at the lack of detail in the Action Plan, and asked for a fuller version to be shared with the Committee.</p> <p>QS24/47.4 It was agreed that the Committee would be updated on progress at the August meeting.</p> <p>It was resolved that the Committee:</p> <ul style="list-style-type: none"> • Noted the Royal College of Surgeons England report and the Getting it Right First-Time reports. • Noted the approach to respond to the recommendations received and noted the actions made which had already been to the Executive Team for approval and support. • Supported the approached outlined to identify a sustainable service model and the development of a robotic resource for urology. • Receive a further update on progress at it's meeting in August. 	
<p>QS24/48 Corporate Risk Register & Board Assurance Framework</p> <p>QS24/48.1 The Committee discussed the Corporate Risk Register and Board Assurance Framework, noting that this subject would be reviewed in detail at the forthcoming Development Session. The changes in risk scores in the BAF were discussed and the rational understood but asked that the narrative be updated to explain why changes had been made. Concern was raised in relation to the cancer risk and nursing and noted that this had been escalated to the CEO and a roundtable discussion was being scheduled.</p> <p>QS24/48.2 In relation to the Corporate Risk Register, it was noted that there was a proposal from both the Risk Management Group and Executive Team to close a risk on Falls and open one on Risk of Harm which would compass falls and broader issues relating to patient deterioration. With regards to Primary and Community Care, it was agreed that the risk should be reviewed with risk owners to look at disaggregating community from primary. The Committee understood the reduction to the Safeguarding risk but asked that it be kept on the risk register.</p> <p>It was resolved that the Committee:</p> <ul style="list-style-type: none"> • Noted and received assurance on the management of two BAF risks to which it had oversight • received assurance on the six corporate risks to which the Committee had oversight of. 	<p>PM</p> <p>PM</p>
<p>QS24/49 Agree Items for referral to Board / Other Committees</p> <p>There were no items identified as requiring referral</p>	

<p>QS24/50 Review of Risks highlighted in the meeting for referral to Risk Management Group</p> <p>There were no items identified as requiring referral</p>	
<p>QS24/51 Agree items for Chairs Assurance Report</p> <p>It was agreed that this would be done outside of the meeting</p>	
<p>QS24/52 Review of Meeting Effectiveness</p> <p>A brief discussion took place, where observations were made that the meeting had been effective and had focused on appropriate issues.</p>	
<p>QS24/53 Report items discussed in previous meeting private session</p> <p>It was noted that the following items were received at the meeting held in private on 20 February 2024:</p> <ul style="list-style-type: none"> • Confidential Quality Report November • Update on progress and developments with the UK Covid-19 Inquiry and Thirlwall Inquiry 	
<p>QS24/54 Date of next meeting</p> <p>The meeting date was to be agreed</p>	
<p>QS24/55 Resolution to Exclude the Press and Public</p>	

QSE Committee Action Log

Open Actions

Action No.	Minute Ref.	Date	Agreed Action	Lead	Timescale	Status
1	QS24.15.1	20.02.24	Bring the HAPU Improvement Plan to the most appropriate QSE Committee	Angela Wood	June 2024	This will be circulate to the Committee as soon as it is available.
2	QS24.47.4	18.04.24	To update the Committee at August meeting to understand progress with regards to the Urology Review.	Nick Lyons	August 2024	This will be scheduled on the August QSE Agenda

Closed Actions

Action No.	Minute Ref.	Date	Agreed Action	Lead	Timescale	Status
1	QS23.115.1	27.10.23	Internal Audit to be approached to gain assurance regarding Clinical Audit Strategy and the quality of commissioned services.	Rhian Watcyn Jones	December 2023	PPJ and DH met on 16 April to discuss the action, a follow up of the Quality Commissioning review is scheduled in the first part of the Internal Audit reviews taking place and that the Clinical Strategy may fall into the second half of the year, however, it was noted that this is being linked in with the Quality Management System currently being developed. This will form part of normal reporting. Action closed on 18.04.24
2	QS23.135.2	19.12.23	To keep Members updated as to creation of formal Primary Care	Adele Gittoes		Updates were received at the meeting on 20/02/24 with regards to

			structure			<p>the ongoing discussions around Primary Care. This action to be kept on the action log until a position is able to return to Committee</p> <p>Update in Meeting - Primary care is still ongoing – a Board for Primary Care has been established and QSE will receive updates through normal reporting</p> <p>Action closed on 18.04.24</p>
3	QS23.102.8	19.12.23	To update Members as to Diabetic Programme Board which has recently had its inaugural meeting.	Karen Higgins	April 2024	<p>KH is linking in with the Deputy Medical Director who is Chairing the Diabetic Programme Board.</p> <p>Update in Meeting – the Steering Group is being chaired by Julie Lewis and the Clinical group by the Deputy Medical Director. QSE will receive updates through normal reporting</p> <p>Action closed on 18.04.24</p>
4	QS23.126.5	19.12.23	Agreed to do a deep dive evaluation of the Patient's Story and report back.	Angela Wood	April 2024	<p>Evaluation not complete, once this has been received a deep dive will be scheduled. Awaiting feedback on the timescales.</p> <p>Update in Meeting – This item related to a story that came on Primary Care and as above QSE will now receive updates on this through normal reporting.</p>

						An annual report on Patient Stories and learning is now in the COB. Action closed on 18.04.24
5	QS23.129.5	19.12.23	AW agreed to update the committee as to the date for rolling out the Call 4 Concern initiative to Central and East	Angela Wood	February 2024	<p>It has yet to be identified when the roll out will take place, most likely after the organisational pressures have reduced</p> <p>The roll out at YG has been completed.</p> <p>The roll out at YWM is due to commence imminently with a pilot on critical care discharges and the surgical admission wards. The roll out at YGC is in the planning stages.</p> <p>Update in Meeting - Just keep monitoring and the Committee will be updated in due course Action closed on 18.04.24</p>
6	QS23.129.8	19.12.23	AW to provide update to the Committee regarding key recommendations from the Older Persons Commissioner review into Care homes across North Wales and the newly developed Quality Assurance Framework (QAF) and how	Angela Wood	June 2024	The development and implementation of the Quality Assurance Framework for Care Homes has given the HB greater assurance in relation to the 12 key actions from Operation Jasmine and the Older Persons Commissioner reviews. The key

			<p>this develops over the next 12 months.</p>			<p>Recommendations and actions for next 12 months are</p> <ul style="list-style-type: none"> • A formal launch of the QAF and CQSTs • Continue to work with the development groups, improving services for our residents. • Continue to ensure an equitable approach to training is delivered for all • Annual review of CQSTs to ensure evidenced based and fit for purpose • Provide assurance report monthly to the Patient Safety Group. • Ensure the QAF is fully implemented and adhered to across the IHC's • Improve on Dementia services and support to Care homes • Develop a quality service specification for Care homes • Develop and improve discharges to Care homes by improving trust between our Care home providers and HB services. • Work towards developing a career framework for Care homes • Support the development of a live quality monitoring/alert IT system <p>The Quality and Safety Committee support the continuation and further development of the QAF and</p>
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						<p>associated processes</p> <p>Update in Meeting – this now forms part of business as usual</p> <p>Action closed on 18.04.24</p>
7	QS24.4.2	20.02.24	To follow up with the Primary Care Team with regards to consistent approach, definition and managed practices and share outside of the meeting.	Phil Meakin	April 2024	<p>Update in meeting – this links with previous discussions around Primary care and will be taken forward in normal reporting</p> <p>Action closed on 18.04.24</p>
8	QS24.9.3	20.04.24	Amend the COB to reflect the change in wording from “Clinical Service of Concern” to Fragile Services/Services that the Committee is concerned about	Phil Meakin	April 2024	Action completed. Changes amended as per the attached COB
9	QS24.10.1	20.04.24	Follow up with the Ward highlighted by the Chair, regarding Oxygen Administration.	Angela Wood	April 2024	<p>Action completed.</p> <p>Feedback received and followed up. Learning has been identified and shared.</p> <p>Action closed on 18.04.24</p>
10	QS24.10.1.2	20.04.24	Share details on oxygen administration numbers and training outside of the meeting	Angela Wood	April 2024	<p>Complete – details shared</p> <p>Action closed on 18.04.24</p>
11	QS24.13.1	20.04.24	To discuss with the Chair her experience of the Morris ward outside of the meeting and follow up	Matt Joyes	April 2024	<p>Discussion taken place with RWJ and AW. Assurance has been received on the matter</p> <p>Action closed on 18.04.24</p>
12	QS24.13.4	20.04.24	Ensure that the Annual Report of the	Matt Joyes	April 2024	This item is on the agenda and went to Board

			Ombudsman is on the April Agenda for discussion			Action closed on 18.04.24
13	QS24.16.1	20.04.24	Follow up on the risk around Managed Practices	Nesta Collingridge	April 2024	Michelle Greene gave assurances to the corporate risk team that there is a risk around managed practices and action plan in place Action closed on 18.04.24
14	QS24.36.1	18.04.24	To circulate a structure chart of what reported into the Quality Delivery Group	Matt Joyes	June 2024	Structure Chart circulated. Action Completed 18.04.24
15	QS24.39.4	18.04.24	To organise a separate development session on the Quality Report and Integrated Performance Report.	Philippa Peake-Jones	June 2024	This meeting took place on 29 May 2024 Action Closed 29.05.24
16	QS24.17	20.02.24	Change the policy to reflect the change from the Executive Director of Workforce to the Chief Executive Officer.	Nick Graham		The Policy has been changed to "Director of Environment". Closed 22.05.24
17	QS23.131.4.4	19.12.23	PM to contact the two new Associate Directors of Primary Care to define which services are included in Primary Care.	Phil Meakin	June 2024	PM has received an update from Director of Primary Care Contracting. Whilst there appears to be no formally agreed national definition of Primary Care it can be pure Primary Care or encompass a wider group to include Community Services etc. The national Strategic Programme for Primary Care covers a wide spectrum of services and this document has

						<p>been shared with QSE Chair and members on 30 May 24.</p> <p>The Director for Primary Care Contracting has offered to discuss the point raised at the Primary Care Board will work the 2 Associate Directors (who work nationally for NHS Wales)</p>
18	QS24.48.1	18.04.24	Update the narrative with the rational as to why risk scores had changed in the BAF.	Phil Meakin	June 2024	<p>It was agreed by Audit Committee that the 23/24 BAF would be closed and a Board workshop will take place in June to identify the new BAF risks and unresolved BAF risks will also be taken into account.</p> <p>(Since the April Committee the lead for Cancer Services presented to the Integrated Performance Delivery Group on where risks related to Cancer Services (Chief Executive was present) and key areas of concern and focus identified. This can be added to the final narrative when the closure of the BAF is considered)</p>
19	QS24.48.2	18.04.24	Review the Primary and Community Care risk with Risk owners to look at disaggregating community from primary.	Phil Meakin	June 2024	<p>A lead has been identified for a Community corporate risk and the draft has been reviewed, this remains in development and will be presented to Risk Management Group and</p>

						approval by the Executive Team. An update is provided in the Risk Management paper for June 2024.
20	QS23.101.5	27.10.23	Further work to be undertaken on report writing and a Board Cover and potentially taken to a Board Workshop.	Pam Wenger	July 2024	Now on the Board Development and included in the Corporate Governance Improvement work
21	QS23.131.2	19.12.23	PM & NC to organise a bespoke Board Development session aimed to specifically clarify what a BAF is and details of each BAF related to each IM's Committee and understand risk Management	Pam Wenger	June 2024	Will be done at the Board Development session in July
22	QS23.131.3.1	19.12.23	RWJ to ensure Board advised that there needed to be more early intervention to avoid health inequalities.	Rhian Watcyn Jones	June 2024	The Integrated Governance Committee has been scheduled for 06.06.24 where this will be raised.
23	QS24.9.2	20.02.24	Ensure that when Annual Reports are received are circulated in a timely manner rather than waiting until the next QSE meeting.	All responsible Executives	June 2024	Where Annual Plans were ready, they have been shared.

Teitl adroddiad: <i>Report title:</i>	Patient Story – Access & Admission			
Adrodd i: <i>Report to:</i>	QSE Committee			
Dyddiad y Cyfarfod: <i>Date of Meeting:</i>	6 th June 2024			
Crynodeb Gweithredol: <i>Executive Summary:</i>	A patient or carer story is presented to QSE to bring the voice of the people we serve directly into the meeting. A short summary is included in the attached paper.			
Argymhellion: <i>Recommendations:</i>	QSE is asked to note this report.			
Arweinydd Gweithredol: <i>Executive Lead:</i>	Angela Wood, Executive Director of Nursing and Midwifery			
Awdur yr Adroddiad: <i>Report Author:</i>	Mandy Jones, Deputy Executive Director of Nursing Leon Marsh, Head of Patient Experience Rachel Wright, Patient and Carer Experience Lead Manager			
Pwrpas yr adroddiad: <i>Purpose of report:</i>	I'w Nodi <i>For Noting</i> <input type="checkbox"/>	I Benderfynu arno <i>For Decision</i> <input type="checkbox"/>	Am sicrwydd <i>For Assurance</i> <input checked="" type="checkbox"/>	
Lefel sicrwydd: <i>Assurance level:</i>	Arwyddocaol <i>Significant</i> <input type="checkbox"/> <small>Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol <i>High level of confidence/evidence in delivery of existing mechanisms/objectives</i></small>	Derbyniol <i>Acceptable</i> <input checked="" type="checkbox"/> <small>Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol <i>General confidence / evidence in delivery of existing mechanisms / objectives</i></small>	Rhannol <i>Partial</i> <input type="checkbox"/> <small>Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol <i>Some confidence / evidence in delivery of existing mechanisms / objectives</i></small>	Dim Sicrwydd <i>No Assurance</i> <input type="checkbox"/> <small>Dim hyder/tystiolaeth o ran y ddarpariaeth <i>No confidence / evidence in delivery</i></small>
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: <i>Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:</i>				
In line with best practice, a patient or carer story is presented to QSE to bring the voice of the people we serve directly into the meeting, but it is not presented as an assurance item. However, the accompanying paper describes some of the learning and actions undertaken in response to the story.				
Cyswllt ag Amcan/Amcanion Strategol: <i>Link to Strategic Objective(s):</i>	Quality			
Goblygiadau rheoleiddio a lleol: <i>Regulatory and legal implications:</i>	N/A			
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? <i>In accordance with WP7 has an EqIA been identified as necessary and undertaken?</i>	N/A			
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal?	N/A			

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

Betsi Cadwaladr University Health Board

Access & Admission

Patient Story

I have a problem with my ankle and I've been suffering with it for a while now. The tendon keeps slipping across the bone causing it to pop out. The more I put weight on my foot the more it pops out. I am really worried the tendon is going to snap and then I will need an operation.

I was referred to Orthopaedics clinic in February 2023. I then received a letter for an appointment at Ysbyty Glan Clwyd on the 26th March 2023, which I attended. The outcome of the assessment was to have further investigations and possibly have cortisone injections.

I was told I would receive my next appointment in about three months. I then waited a further seven months and still did not hear anything. I felt like I was left in the dark waiting for an appointment. I hadn't heard anything so I thought I best phone up the department to enquire. I was told that they were working on clearing the back log of patients and that I was on a list, but they did not know what to do with me as they don't offer that treatment in that department.

I was told to go back to my Doctor to be referred again, and be at the bottom of another waiting list not knowing when I would be seen. I was really annoyed by this response as by now I had been suffering for 12 months and in daily pain. I am very distressed and disappointed with this and feel this is very unfair as this should have been explained to me seven months ago. I had to ring the service to get this update.

I am really struggling on a daily basis and do need further treatment. I like to walk with my wife and my dogs, but at times I do struggle with this. I can no longer walk long distances. I have been given insole shoe support which helped however it does restrict what types of shoes I can wear.

I contacted the Patient Advice Liaison Service (PALS) asking for help and advice on what to do next, as I didn't know who to go to for help. Throughout my time waiting to be seen I was not given any information on waiting times or what would happen now I am on a waiting list. I did not receive any information on how to look after myself and my condition whilst waiting to be seen. I am a self-employed window cleaner and this is affecting my ability to work.

I just want to know where I am on the waiting list and for it to get it sorted quickly so it doesn't snap.

Key Messages

- The storyteller highlights the lengthy wait he is experiencing.
- The storyteller highlights the impact waiting for treatment is having on his physical health.
- The storyteller poor communication whilst he has been on the waiting list to be seen.
- The storyteller describes not knowing who to go to for help whilst on the waiting list.
- The storyteller describes not being offered any support to manage his condition whilst waiting to be seen.

Summary of Learning and Improvement

The storyteller shares his experiences of being on a waiting list to receive treatment, and the impact this has had on his health and ability to work. The storyteller describes not knowing who to go to for help whilst on the waiting list and not being offered any support to manage his condition whilst waiting to be seen.

From April 2024 the Health Board is introducing the 3P's programme (Promote, Prevent, Prepare) introduced by Welsh Government Policy to empower people waiting for treatment to optimise their health and well-being. Initially the focus for the Health Board will be on the volume of patients waiting excessive periods of time to either be seen or treated.

The aim of this programme is to empower patients through improving communication channels and keeping them informed whilst waiting for treatment. In addition to this, the goal is to challenge the 'traditional' relationship patients have with their health through empowering them to take responsibility and sharing decisions about their health.

The principles underpinning the 3P's programme include;

- Keeping people informed throughout their health care pathway
- Informing and empowering people to share the decision making regarding their health
- Ensuring that care that is individualised based on their needs
- Ensuring that people's needs are seen as a whole, in a holistic manner
- Data is utilised to learn and improve services that people use for their health

The Health Board has no dedicated Single Point of Contact (SPOC) for patients to access, they currently tend to call the consultants' secretary or booking team, who may then direct them onto other departments. Patients are often left feeling frustrated at having being passed around the system. This is often highlighted within the complaints patients make. From April 2024, the Health Board will be implementing a single point of contact for people to access information and support following referral to specialist secondary care.

The 3P's programme will be able to support the patient pre-treatment by easing the information process through signposting to a robust directory of community and NHS resources. A Task and Finish Group has been established to help set up the single point of contact service for patient to access information and support following a referral to specialist secondary care. The task and finish group is led by the Self Care Team, ensuring it is robustly connected to existing services including PALS. The aim of the single point of contact is to improve patient and carer experience by putting patients at the centre of their care and decision making.

Welsh Government has developed a Patient Charter called 'Promote, Prevent and Prepare Services Charter' outlining what patients can expect from Promote, Prevent and Prepare services. The Health Board is engaging with patients who have contacted PALS with enquiries around waiting times for planned care. Patients will be asked to review the charter and to add promises to this.

A Task and Finish Group has been established to looking at Patient Experience Reported Measures (PREMS) and Patient Reported Outcome Measures (PROMS). A programme of feedback mechanisms has been agreed including the capturing of patient feedback through the All Wales Real Time Feedback Survey through the Civica Feedback System, and the

collection of data via the all Wales agreed combined PREMS and PROMS once it becomes available linked to WPAS. A programme of involvement activity has been agreed with PALS, including a series of Care 2 Share Discovery Interviews with patients at week 4, week 8 and week 12 into the project where learning and opportunity for improvements will be identified and implemented.

In implementing this programme, it is split into two phases;

1. Phase 1 – To standardise the 3P's offer across Wales and ensure equity of access to services for the people of Wales. From April 2024, the service will go live supporting Orthopaedic patients who are on or entre waiting lists.
2. Phase 2 – Embed the model as business as usual and extend the scope of the model supporting all patients on waiting lists to maximise integrated approaches across the health and care system to deliver seamless support to the people of Wales.

Patients on waiting lists will have access to Education Programmes for Patients (EPP Cymru) health and wellbeing courses led by the Self Care Team that are free and aimed at adults who are living with or caring for someone with a long term health condition. There are a number of courses available to suit a variety of patients and needs such as a living with persistent pain course available that may be of benefit for the storyteller.

Two patients who are on current Health Board waiting lists for treatment have taken part in a pilot of the 3 P's Programme. Please see below is feedback of their experience accessing the 3 P's Programme:

- 'I am doing this as a pre-op request to find details and time scales of an operation that I am waiting for. I am disappointed in the long delay, and the risk that I carry until then'.
- 'Having this option and service when first being diagnosed instead of being left to look for answers and info myself and this would have prevented the denial of the diagnosis and would have helped me cope better'.
- 'I felt listened to and encouraged to move at my own pace. She was aware of my feelings of overwhelm and acknowledged this. She made small suggestions that helped me to be in control of the decisions. I wished I had had this counselling when first diagnosed as I was just left to deal with the emotions of the diagnosis'.

The Patient and Carer Experience Team extend their gratitude and appreciation to the storyteller for sharing their experience.

Teitl adroddiad: Report title:	QSE Committee – Quality Report			
Adrodd i: Report to:	QSE Committee			
Dyddiad y Cyfarfod: Date of Meeting:	June 2024			
Crynodeb Gweithredol: Executive Summary:	This report provides the Committee with assurance, underpinned by analysis, on significant quality issues alongside longer-term data and information on the improvements underway			
Argymhellion: Recommendations:	The Committee is asked to note this report			
Arweinydd Gweithredol: Executive Lead:	<ul style="list-style-type: none"> Angela Wood, Executive Director of Nursing and Midwifery Dr Nick Lyons, Executive Medical Director Gareth Evans, Executive Director of Therapies and Health Sciences 			
Awdur yr Adroddiad: Report Author:	<ul style="list-style-type: none"> Patient and Carer Experience, Safeguarding and IPC Section: Mandy Jones, Deputy Director of Nursing (Patient Experience), Leon Marsh, Head of Patient Experience and Chris Walker, Head of Safeguarding, Rebecca Gerrard, Director of Infection Prevention and Decontamination Patient Safety Section: Chris Lynes, Deputy Director of Nursing (Patient Safety) and Tracey Radcliffe, Head of Patient Safety Clinical Effectiveness Section: Dr James Risley, Deputy Medical Director (Clinical Effectiveness), and Joanne Shillingford, Head of Clinical Effectiveness Healthcare Law and Regulation Sections: Matthew Joyes, Deputy Director of Quality, Erika Dennis, Quality Assurance and Regulation Lead Manager and Debbie Kumwenda, Healthcare law Lead Manager 			
Pwrpas yr adroddiad: Purpose of report:	I'w Nodi <i>For Noting</i> <input type="checkbox"/>	I Benderfynu arno <i>For Decision</i> <input type="checkbox"/>	Am sicrwydd <i>For Assurance</i> <input checked="" type="checkbox"/>	
Lefel sicrwydd: Assurance level:	Arwyddocaol <i>Significant</i> <input type="checkbox"/> Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol <i>High level of confidence/evidence in delivery of existing mechanisms/objectives</i>	Derbyniol <i>Acceptable</i> <input type="checkbox"/> Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol <i>General confidence / evidence in delivery of existing mechanisms / objectives</i>	Rhannol <i>Partial</i> <input checked="" type="checkbox"/> Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol <i>Some confidence / evidence in delivery of existing mechanisms / objectives</i>	Dim Sicrwydd <i>No Assurance</i> <input type="checkbox"/> Dim hyder/tystiolaeth o ran y ddarpariaeth <i>No confidence / evidence in delivery</i>
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: <i>Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:</i>				
There is confidence in the data provided in the report however, the pace of learning and improvement remains an area of concern and is a key focus of work. This is being addressed through a range of measures including the actions aligned to Special Measures and the Board Assurance Framework.				

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

QSE Committee – Quality Report – June 2024

INTRODUCTION

For the NHS in Wales, quality is considered to be defined as continuously, reliably, and sustainably meeting the needs of the population that we serve. In achieving this, under the statutory Duty of Quality, Welsh Ministers and NHS bodies will need to ensure that health services are **safe, timely, effective, efficient, equitable** and **person-centred**. Underpinning these domains are six enablers, which are **leadership, workforce, culture, information, learning and research** and **whole-systems approach**. These domains and enablers form the Health and Care Quality Standards for Wales introduced in April 2023 through statutory guidance.

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

The report is structured around three components of quality: Patient Safety, Patient and Carer Experience and Clinical Effectiveness. This reflects the organisational management arrangements for quality leadership in the Health Board.

The Healthcare Law and Regulation Report has now been included in this report (which was previously a separate report).

An Integrated Quality Dashboard is in development as outlined in the last report. Technical development, testing and data validation is underway. The Dashboard will be made available in May as this work is now complete.

PATIENT SAFETY

PATIENT SAFETY INCIDENTS

Oxygen 'no flow' incidents continue to occur in the Health Board when using CD cylinders. A further incident has occurred in Ysbyty Gwynedd in mid-April. Further actions taken to support mitigation are:

- 'Feel the flow' - Point-of-use reminders - Tie-on labels produced by the Patient Safety Team for O2 cylinders – reminding staff to 'feel the flow' i.e., to confirm oxygen is flowing.
- Further internal alerts disseminated regarding the CD oxygen cylinders confirming the role limitations of Health Care Support Workers, the requirement of a Registered Healthcare Professional to administer oxygen and the need for a second checker.
- E-learning package under development.
- Transfer policy which incorporates the transfer checklist progressing with an aim for completion next month.

The Executives considered a paper in March regarding new 'Digital cylinders' and the Health Board is reviewing the national position.

BOC (manufacturer) are developing a new 'single control' cylinder which would address most risk issues and a prototype demonstration is expected in May 2024 with an expected launch date of Q2 2025.

Following an inquest that concluded on 10th May 2024, the Coroner has issued a Prevention of Future Deaths (Regulation 28) to BOC expressing concerns that the CD Oxygen cylinders manufactured by them which, it is understood, supply most if not all Health Boards in Wales (under procurement processes) are unsafe for use in heightened / pressurised situations in that it is not overtly clear how the cylinders are to be operated with the confusion of the two valves.

Patient Falls

The following falls were reported in March/April 2024:

Fall's	Total
Low	511
None	130
Moderate	115
Severe	4
Total	760

The Improvement Plan following the Health and Safety Executive (HSE) Notification of Contravention (NOC) is being progressed and monitored through the Strategic Falls Group. The HSE have intimated that the Health Board response to the NOC is with their legal team, and we expect to hear back on the decision in June 2024.

The second Health Board desktop review for the improvement plan was undertaken on 18th March 2024 Led by the Executive Director of Nursing and Midwifery with the aim to review progress and support against the actions within the overarching improvement plan which includes actions following HSE notice, Internal Audit review and KPI's for the National Audit of Inpatient Falls. The next meeting is scheduled at the end of May 2024 to include the wider Multi-Disciplinary Team.

Selected actions identified and also discussed in the strategic inpatient falls group are specifically around agency induction, training, risk assessments and post falls management.

There has been a dip in compliance for part 1a and 1b training due to a number of staff requiring renewal at the same time. There has been an improvement in terms of overall compliance for moving and handling, but it remains below expectation, this has been escalated to IHC/Divisional directors to improve compliance.

Peer reviews have been monitoring quality of risk assessments and the patient safety team are conducting spot checks of the Risk Assessments on the acute wards. Some areas are also conducting spot checks via the Weekly Harms Meetings.

Pressure Ulcers

The following pressure ulcers were reported in March/April 2024:

HAPU	None	Low	Moderate	Severe	Total
Pressure ulcer category 2	30	474	54	0	558
Suspected deep tissue injury	10	172	24	0	206
Pressure ulcer category 3	7	50	118	0	175
Unstageable pressure ulcer	2	28	81	1	112
Pressure ulcer category 1	11	44	6	0	61
Device-related pressure ulcer category 1 (d)	0	6	1	0	7
Pressure ulcer category 4	0	0	4	3	7
Device-related pressure ulcer category 2 (d)	0	6	0	0	6
Device-related suspected deep tissue injury (d)	0	2	0	0	2
Total	60	782	288	4	1134

As part of the Improvement Plan, there will be an implementation of a change to the Datix system Health Acquired Pressure Ulcers (HAPU) report to incorporate Tissue Viability Nurse (TVN) referrals as this has been identified as a theme within incidents. The HAPU Lead and Patient Safety Team are in the process of implementing a trial of a prompt for TVN referral/review on Datix. Thus, when an incident is reported as moderate and above, it will notify the TVN and administration team. This was progressed through the Development Request Process at the Quality Systems Group meeting in February 2024. The Once for Wales team have confirmed that it requires initial approval with All Wales Tissue Viability Nurses Forum; a request has been made for discussion at the AWTVN March meeting and the Health Board is awaiting the outcome.

Mandatory Training for pressure ulcer prevention has been approved by the Executive Director of Nursing and Midwifery and is going through the approvals process, to be rolled out across BCUHB in 2024.

Analysis of the reported data across all IHCs demonstrates increased incident reporting of HAPU – common themes still include:

- Delays in moving patients into the Emergency Departments in times of increased demand.
- Sourcing of pressure relieving mattresses.
- Correct classification of pressure Ulcers – wound photographs required as part of the TVN referral.
- Purpose T completion including inconsistencies of regular skin inspection and documentation.

The HAPU lead nurse is supporting action from learning from the National Reportable Incidents outcome forms in addition to in the capture and management of themes arising through engagement

and 1:1 meeting with individual leads and clinical Teams (via local Harm Meetings) to highlight, review and focus actions in line with Health Board Improvement Plan.

Incident Management

Following the escalation letter sent on 2nd February 2024 from Executives to IHCs/Divisions regarding the focused intervention on the Management of Concerns and Incidents, an update report on their current position on all open incidents to include Nationally Reportable Incidents and Never Events has been provided.

The report included:

- The numbers of all open incidents within their area by working day and severity.
- The handlers with the highest number of open incidents.
- Overdue NRI position against trajectories.

A request has been made for an improvement plan to address the open incidents and overdue NRI's. This will be monitored during the Weekly Concerns Improvement Meeting and in the Patient Safety Group. An executive escalation has been undertaken to support the complaints recovery with fortnightly meeting being held with the Executive Director of Nursing and the Chief Executive, attended by IHC and Divisional Directors.

In addition, all handlers who have open incidents will receive automatic reminders every 2 weeks from the Datix system for their attention, which will be one email with the detail in and not an email per incident. This should act as an aid to review, action and close incidents in a timely way.

NRI themes/learning

In the months from 1st March to 30th April 2024, 30 National Reportable Incidents (NRIs) occurred, and 55 notifications were submitted, including combined notification / outcome forms. The difference relates to incidents occurring in prior months e.g. Health Care Acquired Pressure Ulcers or fall with harm that have been awaiting outcomes from harms meetings. The total number of NRI investigations that were open as of end April 2024 is 94, of which 32 were overdue closure with NHS Wales Executive. This is down from the last report on 5th March where there were 109 open. 70 NRI Outcomes forms were sent during March and April, of which 25 were for combined forms relating to HAPUs/ falls, and the remaining 45 were outcomes forms for all other incident categories.



The main themes of the learning from closed incidents during March and April 2024 were related to infection prevention, the need to follow correct checking processes to prevent never events and appropriate monitoring of follow up and/or investigations for patients care and treatment. A more detailed review of these cases is included in the private section of the Committee papers due to potentially identifiable information.

The main themes from the learning from incidents (those not falls and Healthcare Acquired Pressure Ulcers) relate to a lack of following agreed procedures and the need for robust patient pathways.

Examples of learning actions from submitted reviews:

- Development of a Standard Operating Procedure for the Management of Dermatology Urgent Suspected Cancer.
- Actions aimed at improved communication between teams and services.
- Peer review by outsourcing company on published reports to establish data accuracy and to identify any issues for learning. The report is now shared with Radiology Services on a quarterly basis.
- Timely treatment of sepsis.
- Review of Ophthalmology waiting list process and change introduced regarding use of Do Not Defer (DND).

BCUHB/WAST Incidents and learning

The Health Board currently has 92 open incidents in relation to WAST/BCUHB varying from intra hospital transfers, Ischaemic limb to appendix B's owing to inability to send an ambulance to a 999 call in a timely fashion.

Learning from Regulation 28's, an element that has been highlighted on multiple occasions is the inability to present a joint approach when reviewing harm. Terms of Reference have been developed to support reviews with clear governance going forwards to support both internal and external concerns. The reviews will run parallel with the Mortality Group to ensure shared learning.

The number of declined immediate releases continues to raise concern in comparison to the all-Wales position, whilst the Health Board maintains a 100% compliance for red requests, Amber 1 requests remain <50%. A full review of the immediate release process is being undertaken with requests from IHCs for feedback to support an all-Wales review.

PATIENT SAFETY ALERTS

There are no outstanding All Wales patient safety alerts.

There are two alerts not issued by the NHS Wales Executive and therefore compliance is not required for submission. However, the Health Board are still collating compliance as good practice.

- MDA/2023/03 / NatPSA/ 2023/010/MHRA - Medical beds, trolleys, bed rails, bed grab handles and lateral turning devices: risk of death from entrapment or falls.
- NatPSA_2024_001_DHSC - Shortage of GLP-1 receptor agonists (GLP-1 RA).

SAFEGUARDING

The Safeguarding and Public Protection Team provides oversight and organisational assurance in relation to the Health Boards statutory duty under the Social Service and Wellbeing (Wales) Act 2014 and Wales Safeguarding Procedures 2019, the Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act (MCA) 2005. The activity includes key actions and activities to ensure that the Safeguarding and Public Protection agenda remains paramount to service delivery across BCUHB. Safeguarding reports throughout the organisation in accordance with the Safeguarding Reporting

Framework. This framework reinforces organisational engagement, reporting and escalation by the Safeguarding Governance and Performance Group (SGPG), and key Forums and Committees.

Safeguarding Governance Update

A review of the SGPG membership is underway to ensure safeguarding reporting and governance is in-line with the Health Boards organisational framework. The last SGPG was cancelled at short notice due to the high number of apologies and this was reported into QDG. However, Health Board Safeguarding documents were distributed amongst the members for approval and information:

- SA05 TRAUMA Risk Management SOP, 7 Minute Briefing & EqIA
- RAD34 SOP Undertaking Imaging of Suspected Inflicted Injury (formally NAI)

Safeguarding Quality Assurance for Reviews

The Health Board Safeguarding and Public Protection Team has developed a Quality Assurance Group covering Child Practice Reviews (CPR), Adult Practice Reviews (APR) and Domestic Homicide Reviews (DHR). The group monitors review activity across North Wales to ensure that BBCUHB are able to offer assurances in terms of identified learning.

The Quality Assurance Group meets monthly to:-

- Identify early learning for the health board and agree any necessary actions
- Identify any challenges/drift within the process
- Identify and share good practice to support learning
- Capture key themes and trends to support future actions
- Capture agreed data
- Respond to any triggers for internal escalation to the Director of Safeguarding and Public Protection
- Group members are responsible for disseminating information to the Safeguarding and Public Protection Team, and the wider organisation as appropriate as well as auditing the group function.

Key functions include:-

- Incorporating identified learning into relevant training packages
- Developing relevant 7 Minute Briefings
- Influencing internal and local policy, procedures and guidance
- Ensuring timely escalation and sharing of information
- Communication of learning and information across the Health Board
- Developing expertise in the engagement with and function of CPR/APR/DHR's
- Working in collaboration with the Safeguarding Policies and Procedures Task Group to ensure learning is included in Health Board policies and procedures
- Ensuring the Health Board Safeguarding webpage accurately reflects CPR/APR/DHR learning

Through the above activity the Quality Assurance Group acts as an exemplar of multi-agency learning and embeds an effective foundation for learning.

Safeguarding Activity

Safeguarding activity is shared weekly and monthly with respective Health Board services. Activity is then scrutinised at monthly Integrated Health Communities (IHC's) and Mental Health and Learning Disability (MHL) Safeguarding Forums to allow for assurance and governance in relation to concerns raised and actions taken. The Safeguarding Forum is held monthly across IHC's and MHL services. The Forum is accountable to the in full SGPG Group and ultimately to the QDG and the QSE. IHC and MHL Nurse Directors and Medical Directors are accountable for the

Safeguarding function and reporting arrangements within their areas of delegated accountability and responsibility. The purpose of the Safeguarding Forum is to ensure Safeguarding practices within the geographical area of responsibility are not only implementing the strategic safeguarding agenda set by the group and ultimately the Board, but are also actively engaged in the wider safeguarding agenda including reporting, auditing and evaluating practice.

Safeguarding Training Data

Safeguarding training has improved across the organisation during 2023-24 in all areas. The latest information highlights the majority of IHC's and other services are compliant with the training. Some areas require further support and input. This was highlighted at QDG in May with an agreed action to be taken to engage in further activity to support training compliance.

Health Economy	Staff	MCA Level 1	MCA Level 2	Safeguarding Adults Level 1	Safeguarding Adults Level 2	Safeguarding Children Level 1	Safeguarding Children Level 2	VAWD ASV
Corporate Services	12975	72.6%	69.6%	76.4%	73.3%	76.0%	73.0%	65.5%
Health Community Centre (HCCX)	5525	85.3%	87.1%	88.5%	89.7%	88.7%	89.9%	79.0%
Health Community East (HCEX)	5541	86.1%	86.0%	90.6%	89.3%	90.7%	89.5%	82.8%
Health Community West (HCWX)	4449	86.4%	87.3%	90.3%	90.8%	90.7%	91.4%	78.9%
Integrated Clinical Delivery - Primary Care (ICDP)	754	83.0%	84.2%	83.8%	84.9%	85.0%	87.0%	80.0%
Integrated Clinical Delivery - Regional Care (ICDR)	1609	84.3%	84.9%	88.1%	87.9%	86.6%	86.9%	79.6%
Mental Health & LDS (MX00)	2179	91.9%	92.0%	94.1%	93.9%	94.1%	93.7%	87.3%
Midwifery and Womens Services (WXXX)	827	87.9%	88.0%	90.1%	90.3%	94.0%	94.3%	77.8%
Total	33859	81.1%	80.2%	84.7%	83.5%	84.7%	83.6%	75.0%

INFECTON PREVENTION AND CONTROL

- In comparison with other Welsh Health Boards, BCU finished 2023/24 1st for MRSA, 2nd for Klebsiella and MSSA, 3rd for Pseudomonas and 4th for E.coli and C. diff.
- CPE – an outbreak of 2 patients has been declared on a Ward at YGC: 2 patients linked, one transferred to a bay on Holywell Community Hospital before result known. All contacts screened and negative to date.
- A measles case has been diagnosed from a patient visiting ED in WM. IP are working with Public Health and Health Protection to trace and risk assess contacts.
- Other infections: COVID-19 overall numbers remain low. Norovirus numbers and outbreaks have reduced, Influenza case numbers have reduced. Cases of B pertussis continue to increase: there were 40 cases 2023/24 compared to 1 the year before.
- SBAR on Gram negative blood stream infections: discussed with Angela Wood and agreed to obtain further information from IHCs on their progress with the recommendations to be able to present a more detailed assessment to the Executives and be more specific with what is required.
- SBAR presented on Standards for the Identification, Management and Treatment of Clinically Significant Antimicrobial Resistant Organisms (CSARO): there are 3 main areas rated red above that require additional resource for BCU to comply. These are:
 - Additional side rooms (preferably ensuite) are required in YG and WM.

- Additional Facilities staff are required to meet all of the requests for enhanced cleaning and high level disinfection (HLD) related to patients, incidents and outbreaks associated with CSARO and decant facilities need to be identified and ring-fenced in each acute site, to enable HLD to occur.
- Increased medical support for the Antimicrobial Stewardship Group and the Antibiotic Resistance Group along with further education and training for staff in antimicrobial stewardship.
- Metis machines: these high level disinfection machines are still not in use due to further electrical concerns and there are no proactive HLD programmes taking place due to site pressures and escalation of all available beds / decant areas. A meeting is to take place this week with the manufacturers to try and resolve the outstanding issues.
- Capital programme budget reduction: only £100k allocated to Estates this year for 'Safe Clean Care' so there will be minimal improvements seen this year.
- Only one NRI relating to infection prevention was reported for the period. This related to a COVID-19 outbreak in a ward in Mold Community Hospital in August 2023. Five patients and one member of staff were involved (who was thought to be the index case; she had felt unwell but not had any respiratory symptoms while at work). Patients with symptoms were separated from others and reviewed by the doctor. The infection prevention team supported and advised the staff, and the outbreak was quickly brought under control. Infection prevention practices in hand hygiene, the use of PPE and commode cleaning were found to be good.

OTHER PATIENT SAFETY CONCERNS AND IMPROVEMENTS

Nosocomial Covid-19 Project (NNCP)

The project ended on 31st March 2024, with disbandment of the team. Original caseload of 3539 cases were reviewed including 671 deaths.

- All investigations have been uploaded to Datix and closed.
- Learning report finalised by the Quality Analyst and submitted to the National Programme Team.
- End of Programme Report and checklist completed and sent to the National Programme Team.

There are currently 4 cases referred to Legal and Risk to determine the extent of any qualifying liability. All 4 cases are aligned to an outbreak in Morris Ward (Wrexham Maelor Hospital) which was closed to admission on 17th July 2020 following a cluster of cases of Covid-19. A contributory factor to the outbreak was due to wandering patients making social distancing difficult and potentially resulting in environmental contamination. Unfortunately, it has not proved possible to determine the index case for this outbreak.

An improvement programme based on the learning from the reviews will be carried forward via the Patient Safety Team.

PATIENT EXPERIENCE

COMPLAINTS

Between February, and April, 2024 the Health Board **received** 446 complaints.

Nov,23	Dec,23	Jan,24	Feb,24	Mar,24	Apr,24
50	51	79	103	148	195

The majority of the complaints related to Secondary Care Services. The top three complaints areas remain the same from the last report relating to:

- Surgery, Anaesthetics and Critical Care (255)
- Emergency Care (87)
- Medicine (74)

Broken down by themes as follows

Surgery, Anaesthetics and Critical Care	255
Delay/Lack of treatment or Assessment	163
Delay in appointment/waiting time/transport	41
Reaction to procedure/ treatment	16
Incorrect/insufficient treatment or Assessment	11
Communication with patient/service user	10
Attitude/Behaviour of Clinical Staff	7
Delay/Lack of diagnosis	7

Emergency Care	87
Delay/Lack of treatment or Assessment	53
Incorrect/insufficient treatment or Assessment	14
Inappropriate/unsafe discharge	8
Incorrect diagnosis	4
Delay/Lack of diagnosis	2
Lack of assistance with patients personal hygiene - bath, teeth, toilet	2
Attitude/Behaviour of Clinical Staff	2
General care and respect	2

Medicine	74
Delay/Lack of treatment or Assessment	45
Incorrect/insufficient treatment or Assessment	16
Delay/Lack of diagnosis	5
General care and respect	4
Attitude/Behaviour of Clinical Staff	2
Communication with family	2

At the end of April, there were 643 total open complaints.

361 of the 643 total open complaints (56%) related to Delay/Lack of treatment/Assessment/Diagnoses/Appointments.

Of the 643 Open complaints, 312 complaints were Grade 1 and 2 (48.5% of the total number of open complaints) highlighting opportunities for improved performance.

At the end of April, there were 420 overdue complaints in total of which 224 complaints were Grade 1 and 2 (53.3% of the total number of overdue complaints – 420)

The contributing factors to an increased number of complaints is due to the number of planned care complaints received, staffing pressures within the Integrated Health Communities and within the Patient and Carer Experience Department.

Breaking this down further by the 3 main IHC'S, to which as of the end of April, owned 548 of the 643 total open complaints

Length of Time	IHC Central	IHC West	IHC East
<= 1 Month	51	49	48
Over 1 Month	54	31	33
Over 2 Months	26	29	21
Over 3 Months	22	25	7
Over 4 Months	20	14	11
Over 5 Months	18	14	15
Over 6 Months	6	1	23
Over 7 Months	6	2	4
Over 8 Months	11	1	
Over 9 Months	2		1
Over 10 Months	1		
Over 11 Months			1
Over 12 Months	1		
Grand Total	218	166	164

Each Integrated Health Community (IHC) has adopted a weekly Putting Thing Right Meeting to manage the progress of complaints received. The Complaints Team have developed a suite of data, to inform performance against trajectories to reduce the number of overdue complaints. Additional scrutiny is provided by a weekly performance meeting, and a bi weekly meeting with the CEO.

The IHC'S / Divisions supported by the complaints team have adopted a targeted approach to complaint management to ensure that new complaints are closed within the 30-working day timeframe, streamlining the approvals process, ensuring that those due to "trip over" to overdue are prioritised to ensure that deadlines are met.

The number of complaints **closed** between February, 24 and April, 24 was 577 complaints.

5	12	19	26	4	11	18	25	1	8	15	22	29
Feb	Feb	Feb	Feb	Mar	Mar	Mar	Mar	Apr	Apr	Apr	April	April
27	45	24	23	33	29	37	32	55	51	78	68	75

Overall: Complaints received – 446, with Complaints closed 577 resulting in a positive variance of 131.

PATIENT FEEDBACK

Within the reporting period 1st February 2024 to 30th April 2024, the Patient Advice and Liaison Service (PALS), logged 1564 cases. 1334 of those were enquiries, 198 were compliments and 32 were suggestions. The key themes identified from PALS enquiries within this reporting period, which are consistent with the top three areas of complaints, include:

- Delays in appointments/ waiting times
- Delay/lack of treatment or assessment
- Communication with family

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

From 1st February 2024 to 30th April 2024, 13,077 All Wales Real Time Feedback survey responses were received via the Civica feedback system.

Key findings from the real-time survey feedback include:

- 81.13% of respondents were satisfied with their overall experience
- 80.53% of respondents were always given all of the information needed
- 83.62% of respondents always felt listened to
- 80.27% of respondents felt that staff always took the time to understand what mattered to them as a person and took this into account when planning and delivering their care.

Please find some positive comments regarding patient and carer experience from the reporting period;

- “I would like to say a big thank you to the Betsi Cadwaladr NHS service. A week ago, one of my grandchildren had a fall in our garden, I drove him straight to ED and he went straight through as the 999 operator had already let them know. He was x-rayed and assessed for emergency surgery which took place only 2 and a half hours after we arrived. Every member of staff that helped were fantastic. I can’t thank you enough. You really have wonderful people working in your teams”
- “Since my referral, I have been so impressed with the pre-hab team at Wrexham. I received friendly and welcoming phone call arranging my appointments which put me at ease during this stressful time. I received a thorough assessment that tailored my exercise programme, expert diet advice and supportive psychological training and help which have prepared more than what I could achieve myself for my operation. The team have gone the extra mile to support me and I can’t thank them enough”

Between 1st February 2024 – 30th April 2024, 106 All Wales Real Time Emergency Department (ED) Feedback survey responses were received via the Civica feedback system. Response rates remain low and the Patient and Carer Experience Team are working with Heads of Nursing and Emergency Quadrant staff to improve the feedback response rate, so that patterns and trends and associated learning can be identified, and a sufficient improvement plan put in place. The Patient and Carer Experience Team are progressing the implementation of SMS feedback surveys to patients who

have attended the Emergency Department this will offer patients the opportunity to provide feedback on their recent experience following their visit to ED.

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

- 91.53% of respondents felt from the time they needed to use this service they waited much too long
- 46.23% of respondents felt they were sometimes well cared for
- 21.90% of respondents always felt listened to
- 15.09% of respondents always got assistance when needed
- 20.75% of respondents always felt things were explained in a way that they could understand.

The Patient and Carer Experience Team have been supporting Cancer Services embed Civica All Wales Feedback System. All 'tumour sites' are now mapped to CIVICA feedback system to provide the opportunity for patients and carers to give feedback. All tumour sites now receive monthly data reports which allow staff to demonstrate direct listening and learning from patient feedback. Further collaborative work is being undertaken with Cancer Services and the Patient and Carer Experience Team to understand their feedback data and to drill down on data identifying areas of improvement.

The Mental Health and Learning Disability Service (MHL) are working with the Patient and Carer Experience Team to undertake a piece of work to increase patient feedback across all services. To ensure the patient feedback received reflects all service areas across North Wales, all MHL services are being mapped to the Civica Feedback system and will receive monthly data reports. MHL Services will be the first Specialist Service/IHC to have all service areas receiving real-time patient feedback on a monthly basis. Staff at the Hergest Unit run a fortnightly 'Feedback Friday' with PALS Officers to allow patients the opportunity to share their experiences and feedback with staff. An example of patient feedback received from the Feedback Friday event acknowledges how lovely staff were with them and that they "couldn't be faulted" with the care provided.

Patient Stories

Within the reporting period 7 patient stories were captured and shared with relevant services to identify learning and share good practice.

- Collection of Vascular experiences
- Internationally Educated Nurses
- Orthopaedics – access and admission
- Orthopaedics – waiting times
- Dermatology – delays in treatment
- Access to the canteen by a patient with Cannula
- Community Stroke Prevention Team.

The Patient and Carer Experience Team supported the Vascular Service by contacting 40 patients to capture their experience of the service. The patient experience information shared helped inform the Vascular Service review.

OTHER PATIENT EXPERIENCE CONCERNS AND IMPROVEMENTS

Small Business Research Initiative (SBRI) Patient Communication Project

The SBRI Patient Communication pilot funded by Welsh Government is live in Ysbyty Glan Clwyd on wards 1 and 9 and Glaslyn, Prysor and Ogwen Ward within Ysbyty Gwynedd. The aim of the project is to improve communication between the families and key contacts whilst their loved one is in hospital. Staff provide written and verbal daily updates using a digital portal that supports text messaging and voice notes. The uptake of the pilot has been slightly slower than anticipated due to

lack of patient/relative uptake and ward acuity impacting and staffing on the ability to provide daily messages e.g. Ward 9 had a flu outbreak so had to pause.

The pilot will continue until 14 June 2024. The Patient Advice and Liaison Service are engaging with relatives to capture their experience of using this system to understand if this has helped improve communication between the wards and relatives. To date, feedback from relatives has been positive. Examples of feedback provided by relatives who have used the system in Ysbyty Glan Clwyd have been submitted as follows;

- *'Excellent. Service was beneficial, it worked well. Would absolutely use the service again' (Ward 9).*
- *'It was easy to use and I would recommend it to a friend. I received good quality messages and I found it useful. It reduced the amount of times I had to phone the ward and it gave me the information I needed' (relative Ward 9).*
- *'Really good way of communication. We live far away. Good quality of messages and it reduced the amount of times I called the ward. I would recommend service. Worked really well and simple' (Ward 1).*
- *'I liked it and I felt positive about it. I sent messages and received responses sometimes. I think there is room for improvement. Didn't get everything I wanted to know at times. I think the idea is excellent. Good quality messages. I was happy with it and was well educated well on the system. Very user friendly. I would use it again and I would want it if I was a patient (Ward 1).'*

Patient Communication and Information

The Health Board has a duty to provide quality information, whilst adhering to statutory legislation when producing any form of patient information whether it be verbal or written. Within the reporting period 19 patient information leaflets were reviewed by the Readers Panel. Examples of patient information leaflets reviewed include:

- IBD – Managing Breathlessness
- IBD – Managing your energy
- Cancer Services – Blue Folder information

Ongoing work continues to support the Radiology Service who are reviewing all their patient information documents, including patient letters and patient information leaflets to ensure consistent information is being given to patients across North Wales. Cancer Services have reviewed all of their patient information contained in a 'blue folder' that is given to all patients who receive a cancer diagnosis. The aim of the review was to improve the quality of information given to newly diagnosed patients and to produce information in an accessible format for all patients to access.

The Patient and Carer Experience Department is improving the way it communicates with customers by improving access to its services and the quality of information available online. To support the website improvement work 22 patients who had recently contacted PALS via the internet for support were interviewed. Patient feedback and suggested improvements made by patients will help inform website changes so access to PALS/Complaints services is more accessible and easier for the public to share compliments, provide feedback, make an enquiry and raise a formal complaint.

In May 2024, the Patient and Carer Experience Department will be implementing a new single point of contact telephony system for the PALS and Complaints Team. The new telephony system will improve call handling and call waiting experiences for customers and will enable the department to monitor quality control. The telephone line will also have a survey at the end, allowing callers to provide us with feedback on their call experience. In line with the improvement made to the PALS website and telephony the PALS service opening hours from 1st April 2024 will change to Monday, Tuesday, Thursday and Friday 10 am – 4pm and on Wednesday 9 am – 12.30pm. The change in operating hours will enable PALS Officer to increase face to face patient experience and engagement activities, being more visible on wards and across community hospitals capturing and learning from patient and carer experiences.

PALS Activity

As well as completing 1334 PALS enquiries, the team have also supported with significant areas of development including presentations to the Student Nurses Forums pan BCUHB allowing the PALS team to run through the process and functionality of the service as well as the importance of patient and carer experience. Further work is being undertaken with internationally educated nurses to ensure they are given patient and carer experience training as part of their induction.

Emergency Department engagement work pan BCU has begun with replicated actions and topics being covered to ensure a standardised approach. Support has been given to Wrexham Maelor ED to help identify re-occurring themes. An example of improvement is the introduction of a waiting time announcement on a loop allowing patients, relatives and carers to understand how long it may be until they are seen. In Wrexham Maelor ED, a scheme called streaming is available Monday - Friday where patients arriving in ED are triaged to see if they can be signposted to a more suitable service elsewhere for example out of hours or their GP.

In Ysbyty Glan Clwyd ED, a PALS Officer has worked with staff to revise and update the Patient and Carer Experience board, which includes the most recent patient feedback reports, signposting information for relatives and carers and PALS contact details as well as QR codes for links to surveys.

In Ysbyty Gwynedd ED, a PALS Officer has been working with staff to promote the use of WITS and equipment available for staff to use such as the translator on wheels and language line.

A significant piece of work has been undertaken to ensure information, videos and resources are available to staff through SharePoint to support their usage of WITS. An analysis of WITS usage has been undertaken to determine staff training requirements to promote digital first access of service. PALS staff are engaging with service to provide training and information on how to access the service.

Within Cancer Services a User Involvement Facilitator has been appointed into the Service. Their role is to work with staff and patients to improve person centred care and patient experience.

The User Involvement Facilitator's role is to:

- Support the North Wales Cancer Forum - to ensure the voice of patients is representative of the population of North Wales.
- Develop mechanisms to engage with Cancer Services patients across North Wales to ensure they have a voice in service design.

- Capture experiences of Cancer Services patients through a variety of methods, demonstrating learning and improvement.
- Improve communication with patients and families.
- Work closely with BCUHB PALS and Engagement Team.

The Patient and Carer Experience Team have been providing support to Central integrated Health Community (IHC) Patient and Carer Experience Group to strengthen their group's membership to reflect IHC services, developing reporting mechanisms and to demonstrate learning from patient feedback/experiences.

Chaplain and Spiritual Care Service

Between 1st February 2024 - 30th April 2024 the Chaplaincy and Spiritual Care Service have organised and delivered the following events across the Health Board:

- Gong Bath – In partnership with Wellbeing Team, the Chaplain and Spiritual Care Service organised a Gong Bath session for staff at Ysbyty Gwynedd to help aid relaxation and meditation. The event was very well attended by staff and further events will be planned for the other sites across the Health Board. Such events promote a wider holistic view of what spirituality and chaplaincy.
- Following the success of the Christmas events, a series of music and spiritual care sessions were delivered across community hospitals. An afternoon of music and pastoral care took place in Mold, Eryri and Holywell Community Hospitals. In February 2024, the Chaplain Manager launched evening staff Ukulele lessons with 8 members of staff attending. Once staff members are feeling confident the ambition is that they will create a staff band and visit wards playing the Ukulele to patients and relatives.
- The Chaplain and Spiritual Care Service has developed strong working relationships with external partner organisations. In February 2024, the Chaplain Manager attended an event in Llandudno, organised by Conwy Connect Project to provide information and support to people with a learning disability.

In partnership with the Equality and Human Rights Team three events were organised across the Health Board to celebrate the breaking of the Ramadan fast event (Iftar) for staff in the Chaplaincy at Ysbyty Gwynedd, Ysbyty Glan Clwyd and Wrexham Maelor Hospital. There was a great attendance across all three sites The ceremony started with all staff eating a date (something sweet) to signify breaking of the fast for the day, this was then followed with prayers of which we were allowed to observe. Once the prayers were finished staff then shared food together.

During this period the Chaplaincy & Spiritual Care Service has delivered pastoral care to patients across the Health Board including a number of baby and adult funeral, end of life blessings, and pastoral counselling of patients and staff. All out of hours calls were responded to within the target of delivering care within 1 hour of the initial request for all end of life or urgent care

CLINICAL EFFECTIVENESS

CLINICAL AUDIT

National clinical audits (Tier 1) are mandated and aimed at measuring and benchmarking the improvement of healthcare services in Wales; this year an additional 8 audits have been added. Tier 2 audits are determined by the Health Board's priorities, high-level risks or concerns, and the focus is on the main Health Board's governance priorities of risk, incidents, and complaints. Each year the Tier 2 list is reviewed and submitted to Strategic Clinical Effectiveness Group, and subsequently the Quality Delivery Group, for discussion and agreement.

Progression of both Tier 1 and Tier 2 audits is monitored quarterly to provide accountability and to identify any assistance that may be necessary to ensure completion against agreed timelines.

These reports are submitted to Strategic Clinical Effectiveness Group for discussion and review and then the Quality Delivery Group. Below is a summary of Tier 1 nationally published reports (the information in the report is relating to the care received by patients for the relevant audit topic) during Quarter 4 with an update on key achievements.

Title of National Audit	Name of report	Date of publication	Date Service Assessment response due	West	Central	East	Key Achievements Summary
				Service Assessment Completed	Service Assessment Completed	Service Assessment Completed	
National Vascular Registry	State of the Nation 2023 Report	09-Nov-23	11-Jan-24	Yes	Yes	Yes	<ul style="list-style-type: none"> The establishment of dual consultant operating for elective abdominal aortic aneurysm repair; regular participation in a supra-regional aortic multidisciplinary meeting with the University Hospital of the North Midlands, and improved pre-operative assessment, investigation and case selection for abdominal aortic aneurysm repair
Sentinel Stroke National Audit Programme (SSNAP)	State of the Nation 2023 Report	09-Nov-23	11-Jan-24	Yes	Yes	Yes	<p>West:</p> <ul style="list-style-type: none"> Specialist rehab unit established in Eryri Hospital, led by Consultant Therapist in Stroke. ESD (Early Supported Discharge) established. Stroke Specialist Nurses completed clerking training facilitating early transfer of stroke patients to ASU Established a weekly deep dive meeting including stakeholders from Therapies, ED (Emergency Department) and Stroke services Re-established monthly Stroke service meeting including stakeholders from Therapies, ED, Pharmacy and finance, across acute and community settings. <p>Central:</p> <ul style="list-style-type: none"> The Computed Tomography (CT) scanning time has improved with Stroke Clinical Nurse Specialist (CNS) on duty scan requestors. Improvement with swallow screen assessments with on-going ED staff trained <p>East:</p> <ul style="list-style-type: none"> The CT scanning time has improved with extended Stroke Coordinator cover, with Stroke Coordinators able to request scans Time to Specialist Nurse Assessment has improved with four coordinators post and extended hours cover. Time to swallow screen test has improved with 100% of ED staff trained in addition to

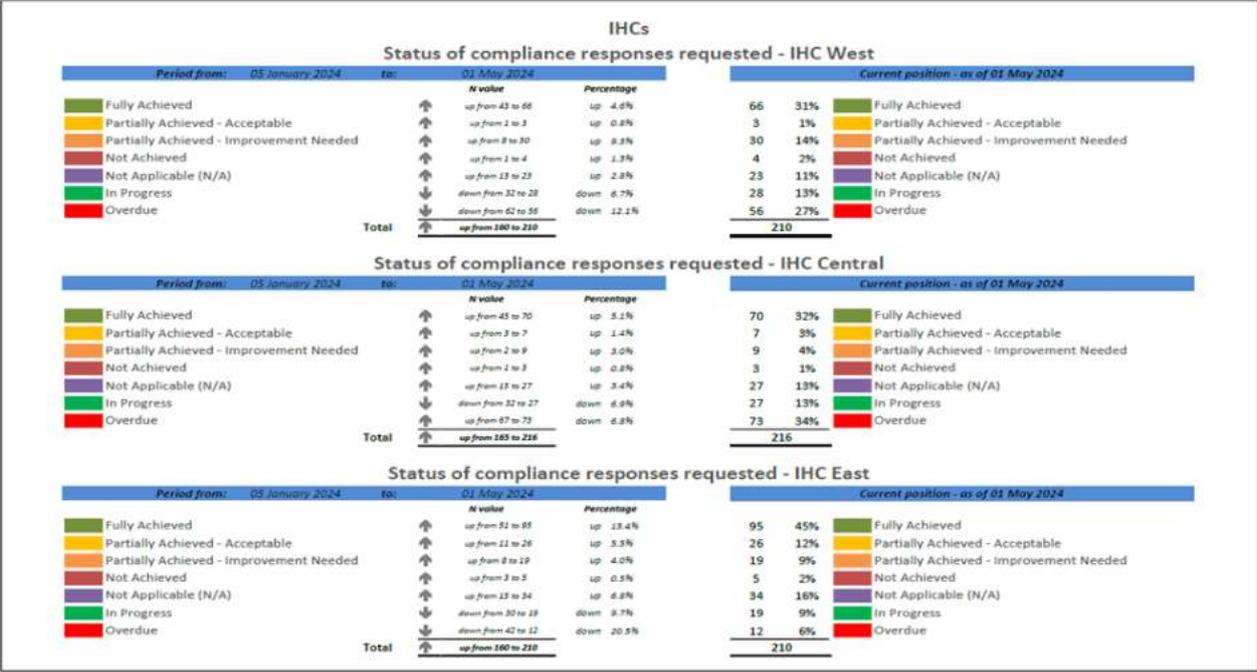
							the extended hour's cover of the Stroke Coordinator and the awareness training.
National Audit of Inpatient Falls (NAIF) (Falls & Fragility Fractures Audit Programme)	Inpatient falls and Fractures - One chance to get it right. The 2023 National audit of Inpatient Falls (NAIF) report on 2022 Clinical data 1st Jan - 31st Dec 22	09-Nov-23	16-Jan-24	Yes	Yes - Draft	Yes	<p>WEST: There has been an improvement in the quality of the completion of the MFRA (Multi Factorial Risk Assessment) but still needs work. Positive feedback provided from the Coroner for North Wales on the ongoing Falls Prevention work. Improvement engagement in the fall's scrutiny meeting.</p> <p>EAST: East IHC hold a quarterly 'Harms Prevention Conference', which is well attended by staff – there is a Falls Presentation included at this, which is well received with good feedback regarding Falls prevention, and shared learning.</p> <p>CENTRAL: Draft Service Assessment response received however details still under review, will be included in Quarter 1 (2024/25) Report</p>
National Diabetes Audit: Young People with Type 2 Diabetes	2021-22 Report	14-Dec-23	*	-	-	-	Publication not shared for a response as provided without the provision of Local LHB data from the Host (NHS Digital) This level of data is not provided due to the size of Cohort for Welsh HB
National Audit of Cardiac Rehabilitation (NACR)	Quality and Outcomes Report 2023	14-Dec-23	22-Feb-24	Yes - Draft	Yes - Draft	Yes - Draft	<p>West: Service meets all seven Key performance Indicators</p> <ul style="list-style-type: none"> · All recruitment plans are now complete. · Improved process of patient recruitment to rehab. · Added an additional exercise assessment to enable lower functioning patients to have a validated exercise assessment <p>Central: Service meets all seven Key performance Indicators</p> <ul style="list-style-type: none"> · Increased use of online tools · Nursing staff fully recruited <p>East: Service meets all seven Key performance Indicators</p> <ul style="list-style-type: none"> · Virtual group education commencing <p>Service delivery alteration aiming to increase uptake and quality of CR interventions provided – offering education and exercise sessions at separate venues and times</p>
National Oesophago-Gastric Cancer Audit	State of the Nation 2023 Report	11-Jan-24	19-Mar-24	Yes	Yes	Yes	None highlighted by the service / Audit standards being met
National Prostate Cancer Audit	State of the Nation 2023 Report	11-Jan-24	13-Mar-24	Yes	Yes	Yes	None highlighted by the service / Audit standards being met
Renal Registry	UK RR 25th Annual Report	21-Dec-23	15-Feb-24	Yes - Draft	Yes - Draft	Yes - Draft	None highlighted by the service / Audit standards being met. Action plan awaited.

NICE GUIDELINES

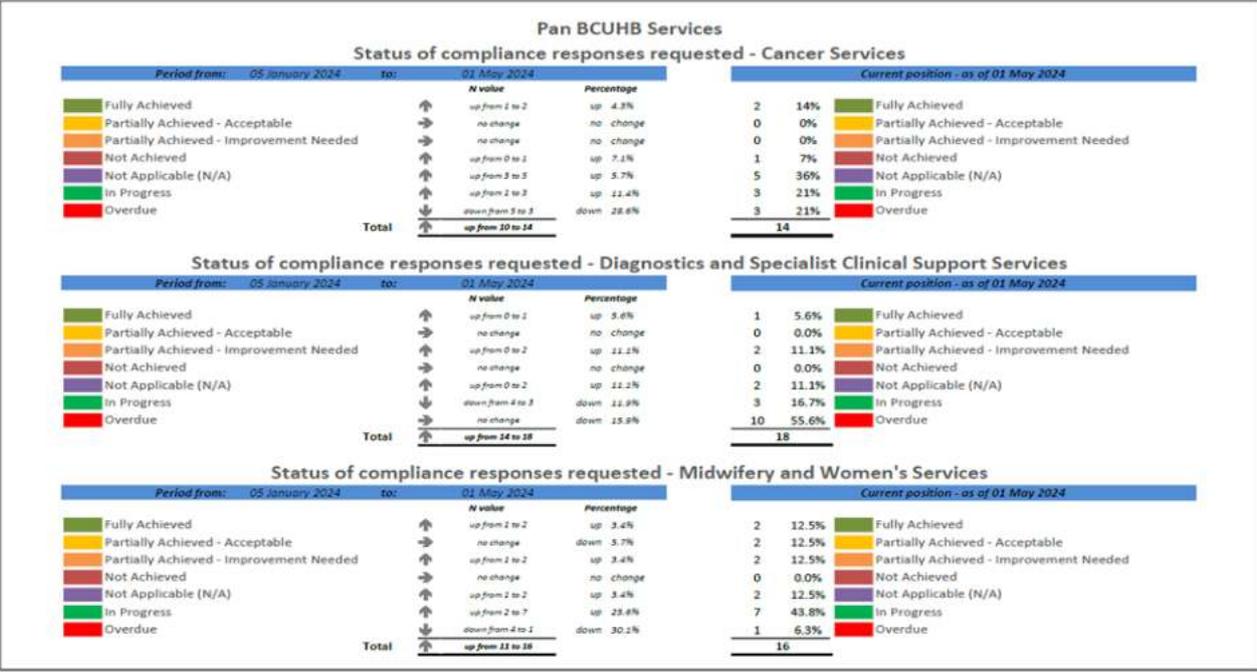
There has been improvement in all aspects of NICE guidance compliance since the introduction of the Audit Management and Tracking (AMaT) tool, as demonstrated below.

The Clinical Effectiveness Facilitator for NICE is continuously working to support departments with guidance and training where needed, and any overdue guidance is escalated via the Strategic Clinical Effectiveness Group (SCEG) when necessary.

NICE Guidelines - Summary of activity Guidelines published between: - 1st April 2023 & 1st May 2024



NICE Guidelines - Summary of activity Guidelines published between: - 1st April 2023 & 1st May 2024



MORTALITY REVIEW

The All-Wales Learning from Mortality Reviews Model Framework (second edition) and Single Process for Mortality Reviews in General Practice (second edition) have been finalised by NHS Wales Executive and Welsh Government and have been distributed to BCU Mortality Lead contacts for sharing and dissemination.

Legislation changes are now being processed; as previously reported this will encompass primary care and community deaths, and also now extends to all private care incidents being sent directly to the Health Board for consideration of mortality review.

Changes to the Mortality Datix module have been made and changes will continue to be made by way of improvement that are agreed at an All-Wales level.

The Mortality Associate Medical Director position is currently vacant, which is impacting the review of backlogs. There has however been improvement in processing front door reports from the ME service in a timely manner as they are now being uploaded in real time onto Datix. Therefore, they are accessible to colleagues at any time if required.

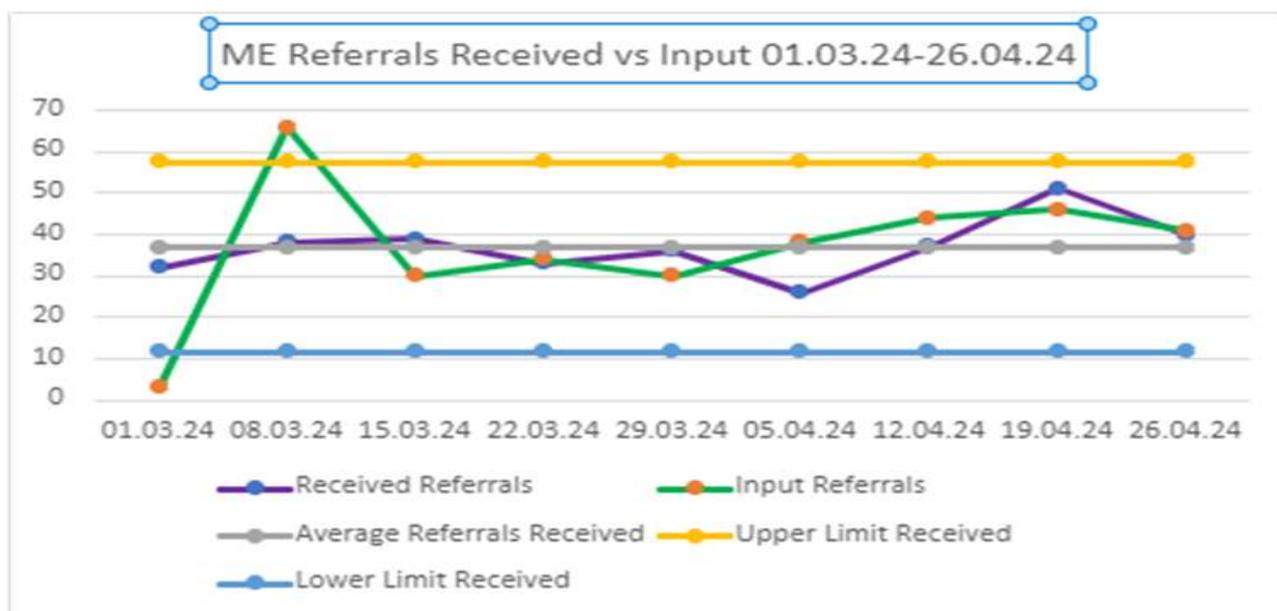
A report of Medical Examiner cases that have been received and inputted into the Mortality Datix module with an outcome of investigation or HMC referral are being shared at the weekly Harms Free Care meeting to ensure oversight and triangulation with the Complaints Team and Patient Safety Team.

Date	Input/output			Inputting Backlog				Datix Status										
	Total received per week*	Total input per week	Output Differential	Total w/e Backlog inc compliments	Backlog of cases requiring inputting within 1 month from date received by MES	Backlog of cases requiring inputting within 2 months from date received by MES	Backlog of cases requiring inputting within 3 months from date received by MES	Total New cases (awaiting mortality admin s&s)	New Under 1 month DOD (awaiting mortality admin s&s)	New Within 2 months DOD (awaiting mortality admin s&s)	New Within 3 months & over DOD (awaiting mortality admin s&s)	Total Pending Cases awaiting Mortality Clinician Review S&S	Pending Cases Under 1 month awaiting Mortality Clinician Review	Pending Cases Within 2 months awaiting Mortality Clinician Review	Pending Cases Within 3 months awaiting Mortality Clinician Review	Pending scrutiny panel (with IHC's, for IHC's to RAG rate)	Under investigation / action required (with IHC's, for IHC's to RAG rate)	Process completed
26.04.24	32	3	29	32	32	0	0	209	57	132	20	164	12	8	144	501	218	1956
19.04.24	38	66	28	4	4	0	0	212	93	118	1	180	13	16	151	515	217	1995
12.04.24	39	30	9	13	13	0	0	207	85	118	4	197	7	18	172	496	230	2013
04.24	33	34	1	13	13	0	0	199	89	99	11	214	14	27	173	506	230	2026
24.03.24	36	30	6	20	20	0	0	227	104	104	19	179	9	28	142	530	233	2034
24.03.24	26	38	12	8	8	0	0	218	75	99	44	208	31	25	152	530	238	2041
04.24	37	44	7	1	1	0	0	224	83	104	37	203	27	29	147	552	239	2059
04.24	51	46	5	6	6	0	0	231	85	104	42	193	22	30	141	560	241	2092
26.04.24	40	41	1	5	5	0	0	211	78	112	21	214	27	26	161	556	237	2127

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

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

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



OTHER CLINICAL EFFECTIVENESS CONCERNS AND IMPROVEMENTS

Below is an update on areas of data collection issues reported for review raised through Quarter 4.

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

	West	Central	East
Title of National Audit/ Clinical Outcome Review	Participation/Data collection issues reported	Participation/Data collection issues reported	Participation/Data collection issues reported
National Emergency Laparotomy Audit (NELA)	The Audit lead raised an issue of data entry by Consultants before stepping away from the role in 2021. West has consistently raised the issue of data entry by Consultants and in 2023 the West Anaesthetic Lead stepped down as a result. SBAR submitted to Strategic Clinical Effectiveness Group in September 2023. Following consideration of the SBAR, the Deputy Executive Medical Director advised that the issue regarding data input by Consultants should be progressed within the service by means of a business case. Should that prove unsuccessful, the matter should be escalated by the service through the appropriate reporting line.	No issues reported.	No issues reported.
Trauma Audit (previously Trauma & Research Network (TARN) to be replaced by National Major Trauma Registry	Participation suspended for all Health Boards UK-wide in June 2023 due to cyber-attack on host organisation (University of Manchester). NHS England have developed a new registry which is now live for major trauma centres. Training is ongoing for the data co-ordinators in other trauma units (23 rd April for BCU) however, for legal reasons data cannot be uploaded to the new registry as yet. Information Governance will confirm when data upload may commence.	Participation suspended for all Health Boards UK-wide in June 2023 due to cyber-attack on host organisation (University of Manchester). NHS England have developed a new registry which is now live for major trauma centres. Training is ongoing for the data co-ordinators in other trauma units (23 rd April for BCU) however, for legal reasons data cannot be uploaded to the new registry as yet. Information Governance will confirm when data upload may commence.	Participation suspended for all Health Boards UK-wide in June 2023 due to cyber-attack on host organisation (University of Manchester). NHS England have developed a new registry which is now live for major trauma centres. Training is ongoing for the data co-ordinators in other trauma units (23 rd April for BCU) however, for legal reasons data cannot be uploaded to the new registry as yet. Information Governance will confirm when data upload may commence.
National Diabetes Inpatient Safety Audit (NDISA)	HARMS element - data submission to this element of the audit not established since the re-launch in Nov 2022	HARMS element - data submission to this element of the audit not established since the re-launch in Nov 2022	HARMS element - data submission to this element of the audit not established since the re-launch in Nov 2022
National Heart Failure Audit	-Data entry not progressing in West as the audit administrator post is vacant.	-Data entry not progressing in West as the audit administrator post is vacant.	
Myocardial Ischaemia National Audit Project (MINAP)	-Data entry not progressing in West as the audit administrator post is vacant.		
The National Clinical Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)			-Data collection did not progress for Cohort 3. Clinical teams agreed in 2021 to allocate time to collect data for Cohort 4 and 5 but East have reported a lack of time resources again. However, the team write an action plan for improvement based on the National recommendations.
NRAP: Children and Young People Asthma	No data submitted since Nov 2019	Data submitted up to Feb 2023 (issue raised Oct 23)	
NRAP: Adult Asthma			Never submitted data to this audit

NRAP: COPD		25.03.24 Issues with Coding 5 months behind will have an impact on the data submission for Jan to end of March	Never submitted data to this audit
National Early Inflammatory Arthritis Audit (NEIAA)	New elements added to this audit which are not being captured due to resources		New elements added to this audit which are not being captured due to resources
National Dementia Audit		Not participating in Round 6, HB decision to pool resources and submit for 1 site only	Not participating in Round 6, HB decision to pool resources and submit for 1 site only
Fracture Liaison Service (Falls & Fragility Fractures Audit Programme)	Never submitted data to this audit. 13.12.23 Response letter sent to Dr Inder Singh, National Clinical Lead for Falls and Frailty on behalf of the Welsh Government. As a Health Board we can confirm recognition of the Health Ministers ambition for everyone in Wales to have access to an FLS by September 2024. For further information please see letter is saved in NCAORP (National Clinical Audit & Outcome Review Programme) Fracture Liaison folder		

HEALTHCARE LAW AND REGULATION

This report provides the Committee with a summary of quality related regulatory and legal assurances.

The report covers the period of March and April 2024.

The Health Board's Regulatory Assurance Group provides central oversight and coordination of quality related regulatory matters to strengthen the approach to quality governance.

The group, and the work of the Quality Assurance and Regulation Team and Healthcare Law Team, has focused over the last year on significantly on improving process and evidence.

HEALTHCARE INSPECTORATE WALES

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

The Quality Assurance and Regulation Team manage the internal process for HIW regulatory activity and play a key role in providing oversight and assurance.

Healthcare Inspectorate Wales Activity March to April 2024

Inspection Reports (1)

An inspection took place in the Emergency Department, Ysbyty Glan Clwyd from the 29th April to the 1st May 2024.

Whilst the overall inspection was positive and HIW could see evidence that the Health Board has taken further steps to improve certain areas of concern, the below immediate concerns were identified. The Health Board awaits clarification as to whether HIW will accept the Health Boards response as providing sufficient assurance in relation to the steps it is taking to ensure patient safety is protected :-

- Ensure that there are measures in place to ensure that risks to patient health and safety are assessed and mitigated in a timely way.
- Ensure that staff administer medication in line with prescriptions
- Ensure staff accurately record patient fluid intake and output
- Ensure that staff complete a care plan when a patient has a cannula
- Ensure that checks of resuscitation equipment are undertaken and recorded on a regular basis
- Ensure consistent monitoring and recording of visual and physiological observations

Concerns / Requests for Assurance (4)

Case 1: IHC Central

The Health Board received a letter of concern from HIW regarding a patient who was transferred from the Emergency Department to the Surgical Assessment Unit. The concerns related to staff attitude, lack of observations, infection control, dietary issues and overall lack of care.

Case 2:, IHC West

The Health Board received a letter of concern from HIW following a query regarding safeguarding of an inpatient. The patient had pressure sores and blistering and there was query around neglect and whether a safeguarding referral had been made.

Case 3: IHC East

The Health Board received a letter of concern from HIW in relation to the care of a patient. The family of the patient reported a lack of dietary care, specifically, that the patient did not receive meals for a period of two days upon admission.

Case 4: IHC East

The Health Board received a letter of concern from HIW in relation to patient who had sustained a fall.

Case 5: MHL D

The Health Board received a telephone call from HIW in relation to a patient who had expressed concerns around their quality of care.

The Health Board responded to the assurance requests from HIW to timescales required, and was able to give information and assurance in each case. No further action was taken by HIW.

Healthcare Inspectorate Wales – Progress with Improvement Plans March to April 2024

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

Service / Area	Date	Responsible Lead	Position overview
Local Review of Discharge Arrangements for Adult Patients from Inpatient Mental Health Services (adapted from the CTMUHB Mental Health Discharge Review).	Mar 2023	Iain Wilkie, Interim Director, MHL D	
Nant Y Glyn Community Health	Jan 2024	Iain Wilkie, Interim Director, MHL D	
Emergency Department, Ysbyty Gwynedd	Aug 2023	Ffion Johnstone, Integrated Health Community Director, West	

Quality Checks (to be known as Quality Peer Reviews) were introduced at the end of last summer (with a visit to YGC ED) and most recently a review was undertaken of Maternity Services at Ysbyty Gwynedd, West. A similar methodology approach to that of HIW is used for consistency. The report and improvement plan have now been finalised. Further reviews are planned for other parts of the Maternity Service and across the Health Board.

CARE INSPECTORATE WALES

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

To help strengthen governance and assurance, a standard six month service quality review template has been developed for all registered services to complete (aimed at encouraging a culture of quality improvement), alongside a quarterly assurance declaration. These two formal processes support the overall annual declaration made by the Health Board.

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

Quality of Care Review visits

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

The services have completed a Quality of Care Review Report ahead of the visit which helps to demonstrate that they are meeting the four key well-being areas in line with legal requirements. The purpose is for them to assess their performance and look at any opportunities to improve and develop.

IHC Centre have made a formal request to amend their service registration with CIW which will initially be reviewed by the Regulatory Assurance Group on 23 May 2024. The request has been made in line with the considerations outlined in the Regulation and Inspection of Social Care (Wales) Act 2016. If approved, the Health Boards Responsible Individual will inform CIW and clarify the next steps.

Annual Return

The Health Board is in the processing of collating information from services to submit an Annual Return to CIW by 26 May 2024. This is required under section 10 of the Regulation and Inspection of Social Care (Wales) Act 2016. The return includes questions about regulated services operated by the Health Board (the service provider) and reflects the position as at the 31 March 2024.

HEALTH AND SAFETY EXECUTIVE / LOCAL AUTHORITY

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

The Health Board awaits further contact from the HSE following its response to the Notice of Contravention regarding falls in 2023 in September 2023.

HIS MAJESTY'S CORONER

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

During March and April 2024, the Health Board has received 2 Regulation 28 Prevention of Future Death Reports. A summary of the issues raised by the Coroner are listed as follows:

1. East – issues raised in relation to miscommunication or misunderstanding when a ward nurse bleeped a junior doctor with a view to action being taken in relation to the administration of the beriplex infusion. This resulted in a delay in the doctor attending as they did not prioritise a task which was time critical and the subsequent delays resulted in an unrecoverable deterioration in the patient's condition. Evidence was received in the course of the inquest that the current bleep system did not enable information to be conveyed electronically and that this in turn created a risk of misunderstanding as to work requirements and hence impacted upon prioritisation of tasks and therefore potential delays, the effects of which (as in this case) could be catastrophic in terms of patient safety.
2. Central - issues raised relate to inter-hospital transfer. An investigation by the Health Board indicated that the transport request for urgent transfer for vascular surgery should have been booked by the ward with the Adult Critical Care Service Cymru (ACCTS) and not WAST and evidence was received in the course of the inquest which suggests that there is inadequate knowledge of the use of ACCTS and its operation across the whole of the Health Board, including clinical site managers as well as clinicians and nursing staff.

These Notices are being reviewed and responses drafted – the Health Board has 56 days to respond and is therefore within time for all Notices. All Notices are allocated to a lead within the relevant service, with responses scrutinised and approved by the Executive Medical Director.

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

The Coroner raised concerns with the Chief Executive and Executive Medical Director in relation to the length of time it takes for investigation reports to be concluded and made available to the Coroner. Noted was the inevitable impact this has not only on the progress of inquests but also how these delays can exacerbate grief for bereaved families. In April, the Coroner highlighted 11 cases that were of particular concern. The cases were escalated to all services, and every overdue report was individually reviewed and services committed to dates to address them.

The Health Board shares the concerns raised by HM Senior Coroners regarding investigation timeliness, quality and evidence of learning. In response, a review of the investigation process is underway. A project is also underway to provide assurance of investigation quality, learning and supporting evidence for previously completed investigations.

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

PUBLIC SERVICES OMBUDSMAN FOR WALES

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

The Health Board has received 2 draft public interest reports;

- 1. Public Interest Report ID1962: IHC East (Medicine):** The Health Board received the draft public interest report on 29 April 2024 and have been asked to review and comment on the conclusions and recommendations by 21 May 2024. The draft remains under embargo and will be shared in this report when finalised and published.
- 2. Public Interest Report ID5663, IHC East (Urology):** The Health Board received the draft public interest report on 06 March 2024 and has commented on the proposed conclusions and recommendations. The draft remains under embargo and will be shared in this report when finalised and published.

The Ombudsman measures responsiveness using a measure called Average Variance to Target (AVT). This is regularly shared with all health boards. The Health Board AVT is currently -5 (i.e. submissions are on average 5 days ahead of a deadline).

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

The Annual Letter from the Ombudsman was received, and responded to. A copy of both letters were provided at the last board meeting. A further letter from the chairman is due to be sent to the Ombudsman to confirm the steps the Health Board is taking to comply with the recommendations made within the Ombudsman's report, Groundhog Day 2: an opportunity for cultural change.

LITIGATION (WELSH RISK POOL)

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

Where claims are justified, the Health Board works for early settlement to provide support for those affected by harm and to reduce costs. All claims are managed to ensure a fair and equitable settlement. However, where unjustified claims are made, these are robustly defended, and are taken to trial if necessary. No trials took place during the period of March or April 2024.

The Health Board has a number of overdue Learning from Events Reports (LFERs) which are due to be submitted to the Welsh Risk Pool (WRP). At the time of writing, this number was 27 (all of which were with services for providing evidence of learning). There is a risk of financial penalty for delayed forms. As with other areas of overdue documents (such as incidents and complaints which both remain unacceptably high) support is being provided to divisions to facilitate completion and regularly reporting and escalation is in place.

Teitl adroddiad: Report title:	Independent Review Management Response (Vascular Assurance Assessment)
Adrodd i: Report to:	Quality and Safety Executive (QSE)
Dyddiad y Cyfarfod: Date of Meeting:	6 th June 2024
Crynodeb Gweithredol: Executive Summary:	<p>As part of the Special Measures intervention, Welsh Government requested a further external assessment of the vascular service at BCUHB (Vascular Assurance Assessment – Part 1). The review was undertaken during May 2023 by the Vascular Clinical Network. It was agreed with the Health Board that this Assurance Assessment would be a supportive piece of work, undertaken in collaboration with the Health Board. The purpose of Part 1 of the Assurance Assessment was to review the quality of the vascular service and other related services that are involved in the pathways of care, and to assess the extent to which recommendations from various reviews and reports, had been implemented sustainably. Part 1 of the Assurance Assessment was published in October 2023 and highlighted an overall improvement in the quality and safety of the vascular service.</p> <p>Welsh Government then commissioned a review of 40 case notes from vascular patients between August 2022 and August 2023 (Vascular Assurance Assessment – Part 2). The purpose of this case note review was to support the Part 1 assessment by analysing the extent to which recommendations from various previous reviews and reports has been implemented and are operationally in place. This report was shared with the Health Board in March 2024. The findings of the panel are that 38 out of 40 of a number of vascular procedures undertaken during the time period have been graded as overall acceptable. Taking into account the timeline of this assessment work, it is considered by the Panel that this demonstrates an ongoing positive trajectory of improvement within BCUHB vascular practice.</p> <p>It is important to recognise that this progress forward is underpinned by many examples of good work happening across the Health Board. Several patients and their families highlighted that they were pleased and most appreciative of the care that they had received. The Panel also noted that it was clear from the local vascular team representation, that there is a strong desire to deliver optimal care to patients and their families.</p> <p>There were also several areas where it was considered that improvements could be further addressed or strengthened. It should be recognised that these areas are not solely associated with the direct practice of the vascular service and include other related services and</p>

	<p>practice involved in the delivery of multi-professional pathways of care. Some of these areas had also been identified within previous reviews. It is important then, that the Health Board and the Vascular Network make every effort to ensure all outstanding improvement recommendations are acted upon in a timely manner.</p> <p>This report outlines the management response to Parts 1 and 2 of the Assurance Assessment, and has been developed in partnership with our clinicians. A summary of the key findings of the Assurance Assessments are outlined, as are the actions that will be taken forward in order to deliver the suggested service improvements.</p>			
Argymhellion: Recommendations:	QSE are asked to note this report			
Arweinydd Gweithredol: Executive Lead:	Dr Nick Lyons, Executive Medical Director			
Awdur yr Adroddiad: Report Author:	Dr Jo Flannery, Vascular Network Manager			
Pwrpas yr adroddiad: Purpose of report:	I'w Nodi <i>For Noting</i> <input checked="" type="checkbox"/>	I Benderfynu arno <i>For Decision</i> <input type="checkbox"/>	Am sicrwydd <i>For Assurance</i> <input checked="" type="checkbox"/>	
Lefel sicrwydd: Assurance level:	Arwyddocaol Significant <input type="checkbox"/> Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol <i>High level of confidence/evidence in delivery of existing mechanisms/objectives</i>	Derbyniol Acceptable <input checked="" type="checkbox"/> Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol <i>General confidence / evidence in delivery of existing mechanisms / objectives</i>	Rhannol Partial <input type="checkbox"/> Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol <i>Some confidence / evidence in delivery of existing mechanisms / objectives</i>	Dim Sicrwydd No Assurance <input type="checkbox"/> Dim hyder/tystiolaeth o ran y ddarpariaeth <i>No confidence / evidence in delivery</i>
<p>Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:</p> <p><i>Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:</i></p>				
Cyswllt ag Amcan/Amcanion Strategol: Link to Strategic Objective(s):	To support Special Measures			
Goblygiadau rheoleiddio a lleol: Regulatory and legal implications:	Incidents of harm to patients may indicate failures to comply with the NHS Wales Health and Care Standards or safety legislation			
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? In accordance with WP7 has an EqIA been identified as necessary and undertaken?	N/A for this paper. However, an EqIA will be completed as part of the overall improvement work			

<p>Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? <i>In accordance with WP68, has an SEIA identified as necessary been undertaken?</i></p>	<p>Not applicable</p>
<p>Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR)</p> <p><i>Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR)</i></p>	<p>CRR22-25: Risk of failure to provide full vascular service due to lack of available consultant workforce</p> <p>CRR22-26: Risk of significant patient harm as a consequence of sustainability of the acute vascular service</p> <p>CRR22-30: Risk that a lack of robust and consistent leadership can contribute to the safety and quality concerns</p>
<p>Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith</p> <p><i>Financial implications as a result of implementing the recommendations</i></p>	<p>Health Board delivery against the following improvement recommendations is dependent upon the development of Business Case:</p> <p>VAA_P1_R4: Further recruitment of Foot & Ankle surgeons, Diabetologists and Therapists to support the MDFs, especially in the spoke sites</p> <p>VAA_P1_R5: Ensure sustainable funding for the MDFs which is currently pump primed</p>
<p>Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith</p> <p><i>Workforce implications as a result of implementing the recommendations</i></p>	<p>Health Board delivery against the following improvement recommendations is dependent upon the development of Business Case:</p> <p>VAA_P1_R4: Further recruitment of Foot & Ankle surgeons, Diabetologists and Therapists to support the MDFs, especially in the spoke sites</p> <p>VAA_P1_R5: Ensure sustainable funding for the MDFs which is currently pump primed</p>
<p>Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori <i>Feedback, response, and follow up summary following consultation</i></p>	<p>This report has been shared with the C-IHC Director and Deputy Executive Medical Director, who have approved the report</p>
<p>Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) Links to BAF risks: (Or links to the Corporate Risk Register)</p>	<p>BAF21-02: Recovering access to timely care pathways</p>
<p>Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) <i>Reason for submission of report to confidential board (where relevant)</i></p>	<p>Not applicable</p>
<ul style="list-style-type: none"> ▪ To commence implementation of the improvement recommendations outlined in Parts 1 and 2 of the Assurance Assessment ▪ To commence implementation of the improvement recommendations outlined in Parts 1 and 2 of the Assurance Assessment 	

Quality and Safety Executive Committee – 6th June 2024

Special Measures Independent Reviews - Management Response

Vascular Assurance Assessment

1) Background and context

The Betsi Cadwaladr University Health Board (BCUHB) vascular service had been in Targeted Intervention since May 2022 following the publication of the second Royal College of Surgeons (RCS) Report into the service. Healthcare Inspectorate Wales (HIW) designated vascular services in the health board as a service requiring significant improvement in March 2022.

On the 27 February 2023, the Minister for Health and Social Services announced that she was escalating the intervention status of BCUHB to special measures with immediate effect. This significant decision followed the tripartite group of Healthcare Inspectorate Wales, Audit Wales and Welsh Government officials' meetings in November 2022 and January 2023 to specifically discuss concerns about the service delivery, quality and safety of care and organisational effectiveness at Betsi Cadwaladr University Health Board. This decision reflects serious and outstanding concerns about board effectiveness, organisational culture, service quality and reconfiguration, governance, patient safety, operational delivery, leadership and financial management.

The first Royal College of Surgeons (RCS) report on the BCUHB Vascular Surgery Service Review visit was issued 15 March 2021. The second Royal College of Surgeons' Report on 44 clinical records relating to vascular surgery on behalf of BCUHB was issued 20 January 2022 (annex A).

Vascular services had been in Targeted Intervention since May 2022 following the publication of the second RCS report with Healthcare Inspectorate Wales (HIW) designating vascular services as a service requiring significant improvement in March 2022. HIW undertook an inspection of the service in November 2022 and the report was published in June 2023 which resulted in the HIW designation being deescalated. However, the Vascular Quality review panel report published in January 2023 highlighted further gaps in the service.

On 27 February 2023, the Minister for Health and Social Services announced that she was escalating the Health Board to Special Measures with immediate effect. Various components of improvement and assurance work are taking place via the Special Measures programme in line with the agreed special measures framework for year one.

2) Overview from Development Session

Vascular consultants were content with the findings of both reports, and welcomed the positive feedback contained within them. The following key points were noted:

- The development of clinical pathways remains a key priority for the Health Board, with resources having been secured from within the Transformation and Improvement Team to ensure their continued development. Once finalised, pathways and SOPs are submitted to the Strategic Clinical Effectiveness

Group. This ensures that all pathways meet clear criteria for quality and effectiveness. The Network recognises the challenges in ensuring full cascade across all teams, and intends to develop the Vascular intranet site as a site where pathways can be easily accessed by staff.

- Progress with the development and implementation of Multi-disciplinary Foot Services, with clear, pathways and SOPs is a key priority for the Health Board, and work is underway to co-design the emergency diabetic foot pathway, which is agreeable across the Health Board footprint.
- The Network recognises the need to continue to strengthen integrated working across hub and spoke sites, especially in relation to communications and the wider MDT workforce. Work is needed to standardise culture and practice across the Network in order to ensure equity of access and provision. Operational management teams have worked hard to strengthen working relationships across hub and spoke sites, with the Central IHC team taking a lead role in pan-BCU matters, whilst ensuring full involvement of other IHC teams. However, we are cognisant of the fact that such practices can always be strengthened in order to improve service efficiency and efficacy. The network recognises the crucial role played by administrative staff in enabling the successful and smooth working of the vascular network, and is committed to ensuring equity of provision across hub and spoke sites
- The Network is keen to ensure that Vascular services in North Wales are driven by robust activity and performance data, and that this data is used to inform both operational and strategic planning. A range of data sources are already used to enable this, including an operational dashboard. However, we acknowledge that much work can be done to enhance our use of data and different levels and with different audiences. The ongoing development of integrated operational and outcome dashboard to be key area of focus for Network in 2024/25
- The importance of providing vascular patients with information, advice and support to enable them to manage their health, well-being and vascular condition, both pre- and post-operatively, is something which the Network recognises, and is keen to develop. Long-term, this strategy aligns with an ambition to provide prehabilitation support to people with a vascular condition in order to improve post-operative outcomes.
- The Network welcomes those recommendations which call for greater collaborative working with and dedicated input from a range of services, including micro-biology, psychology. Such additions can only be seen as a positive step for the service moving forward

3) Key Themes from the Review

Themes from reviews received to date	Applicable to this review <i>Check box if applicable</i>
1. Data, Intelligence & Insight Ensuring that there is an organisation wide approach with prioritised interventions into improving our data, intelligence and insight tools and capabilities. This will be a key enabler for sustainable improvement as well as supporting identification of future potential services of concern.	<input checked="" type="checkbox"/>
2. Culture Defining, engaging and committing to the long-term work necessary to improve the culture of the organisation. Integrated into our broader organisational development plan across Culture, Leadership and Engagement.	<input type="checkbox"/>
3. Risk Management	<input checked="" type="checkbox"/>

Reviewing and refining our approach and appetite to risk, including how risks are identified, managed, mitigated, reported and monitored.	
4. Patient, Family, Carer Involvement A single coordinated approach to maximise involvement and engagement with our patients and their families and carers, using their experiences to guide our ongoing service improvement.	<input type="checkbox"/>
5. Operating model Ensuring our operating model is designed to best deliver our strategic priorities, with clarity for everyone across all levels of the organisation on the roles and responsibilities, systems and processes within divisions and Pan BCU services.	<input checked="" type="checkbox"/>
6. Organisation Governance and compliance Ensuring organisation wide visibility and understanding of governance best practice and ensuring adherence to it.	<input checked="" type="checkbox"/>
7. Integrated Planning A well understood integrated approach to planning as a discipline, as well as contributions to our annual planning process.	<input type="checkbox"/>

4) Recommendations

The committee is asked to **APPROVE** the management response in readiness for onward publication into the public domain.

Table 1: Management Response Action Plan

Data, Intelligence and Insight					
Ref	Action	Lead	Deadline	RAG status ¹	Progress Update
P1.09	Develop a local vascular dashboard to monitor compliance.	Jo Flannery	December 2024		<ul style="list-style-type: none"> Operational teams and clinicians have confirmed KPIs which support operational management of the service. These have been incorporated into a first re-draft of the Vascular Dashboard. Work currently underway to develop a vascular performance framework. Which will be agreed with senior managers across hub and spoke sites Agreement that agreed KPIs to be routinely presented to individual IHC vascular delivery group meetings, as well as to Vascular Steering Group to provide assurances re: service performance. Scorecards being developed for inclusion of forthcoming meeting agendas

¹ RAG status definitions: **Green**: On track, **Amber**: Off track with mitigations in place to bring back on track, **Red**: Off track without mitigations in place to bring back on track

Risk Management					
Ref	Action	Lead	Deadline	RAG status ¹	Progress Update
P2.10	Ensure a focus on mitigation of the risk that vascular patients, and in particular amputees, may specifically face regarding falls, with an updated plan of management	Jo Flannery	March 2025		<ul style="list-style-type: none"> Audit of uptake of mandatory falls training amongst vascular staff undertaken. Work will commence over the next 1-2 months, with the support of the Ward Manager and Clinical Lead to ensure all outstanding members of staff complete mandatory falls training asap

P2.12	Review the Did Not Attend (DNA) policy and guidance on when DNA might potentially become a safeguarding issue to ensure that all staff are aware of this and the actions to take	Jo Flannery	March 2025		<ul style="list-style-type: none"> Initial contact made with BCUHB safeguarding team to determine whether DNA policy exists. DNA policy is not standard within adult services; however, work will commence with safeguarding and nursing colleagues to develop vascular specific policy
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Operating Model					
Ref	Action	Lead	Deadline	RAG status¹	Progress Update
P1.01	Review of MDFS service looking at the appropriateness of the referrals to the vascular service, which will aid SOP and pathways development	Jo Flannery	September 2024		<ul style="list-style-type: none"> Initial engagement with T&I team to secure additional support to deliver this action, as a bespoke programme of work. Initial scoping work being designed
P1.02	Better integration of the three IHC operational teams from a vascular perspective to create a more effective network.	Jo Flannery	October 2024		<ul style="list-style-type: none"> Initial engagement with operational teams and DGMs to understand current challenges and priorities. Intention is to hold 2 x ½ day sessions to further develop and refine clinical and operational model, with view to development of a MOU to strengthen hub and spoke working. This action will be delivered in conjunction with P1.05
P1.03	BCUHB Q&S Panel to assess the quality of the new vascular pathways, flowcharts, SOPs and ensure the team achieve the proposed timeline for writing. The Q&S panel and operational teams must also ensure these pathways are distributed to the clinical, nursing and therapy teams.	Gareth Griffiths	March 2025		<ul style="list-style-type: none"> Local and pan-BCU processes agreed to support sign-off and approval of vascular pathways as they are developed. The Health Board's Strategic Clinical Effectiveness Group (S-CEG) will receive all pathways for final sign-off IHC Medical Directors will be responsible for cascading the pathways across the relevant teams/ service areas. Pathways will also be uploaded onto the vascular intranet pages, to support ease of access. KPIs are developed for each pathway, and will enable the network to monitor uptake and compliance

P1.04	Audit of vascular cases referred to the Medical Examiners Service and those escalated to stage two and three Mortality Reviews.	Laszlo Papp	July 2024		<ul style="list-style-type: none"> Consultants prepare presentations on vascular deaths, for discussion at monthly M&M meetings (Clinical Governance) in order to support continuous learning and improvement Forward work programme for Clinical Governance meeting to include audit of deaths
P1.05	All three IHC operational teams to have input into the authorisation of annual and study leave which impacts on the cancellation of activity on their site.	Jo Flannery	October 2024		<ul style="list-style-type: none"> Initial engagement with operational teams and DGMs to understand current challenges and priorities. Intention is to hold 2 x ½ day sessions to further develop and refine clinical and operational model, with view to development of a MOU to strengthen hub and spoke working. This action will be delivered in conjunction with P1.02
P1.06	Monitoring of out-patient waiting times across the network to avoid disparities	Jo Flannery	July 2024		<ul style="list-style-type: none"> Baseline data collected IMS ensuring waiting time data included within vascular dashboard Plan to include waiting time data on scorecards reported to IHC vascular meetings and pan-BCU vascular steering group
P1.07	To align chronic limb threatening ischaemia (CLTI) pathway with NHS England Commissioning for Quality and Innovation (CQUIN) framework i.e., aim for greater than 60% of patients to be re-vascularised within 5 days of admission.	Laszlo Papp/ Gareth Griffiths	September 2024		<ul style="list-style-type: none"> WORK NOT YET STARTED – Current focus is upon AAA work. Once this has stabilised, the network will work with clinicians to undertake deep dive of CLTI data
P1.08	Review patients not treated within targets to conduct a deep dive to ascertain trends.	Jo Flannery	July 2024		<ul style="list-style-type: none"> Baseline data collected IMS ensuring treatment target time data included on vascular dashboard Plan to include treatment targets data on scorecards reported to IHC vascular meetings and pan-BCU vascular steering group
P1.10	Develop a discharge pathway in the MAC between therapy and nurse teams to successfully plan discharges	Jo Flannery	September 2024		<ul style="list-style-type: none"> Initial discussions with C-IHC Director of Nursing to agree approach. Task & Finish group to be established to develop pathway, aligned to BCUHB discharge pathway. Approach to include information and support needs of vascular patients upon discharge

					<ul style="list-style-type: none"> ▪ We will engage with patients and carers to understand what 'good looks like' and co-design local pathway and approach that is aligned to BCUHB discharge policy ▪ This action shall be delivered in conjunction with P2.11
P2.01	Agree what constitutes a contemporary and evidence-based diabetic foot pathway, with the same approach and pathway implemented immediately across all the BCUHB sites	Jo Flannery	August 2024		<ul style="list-style-type: none"> ▪ Achieving pan-BCU agreement over the emergency diabetic foot pathway continues to be challenging. The pathway is agreed in 2/3 sites, with further work underway to confirm agreement in remaining site. Matter has been escalated to OMD for support to push forward if resolution not achieved within next 3-4 weeks
P2.02	Identify opportunities to work across the Health Board as an integrated service model strengthening links between primary care and secondary care within areas such as the management of diabetes; and implement to avoid patients having to see 'duplicate' health professionals experience delay	Jo Flannery	August 2024		<ul style="list-style-type: none"> ▪ Work has yet to commence and is likely to be delayed, depending on outcome of AAA work. • Once AAA work stabilised, the intention is to hold a vision setting workshop in order to: <ul style="list-style-type: none"> ○ Review what elements of vascular care currently happen 'out of hospital' ○ Identify what additional interventions could take place 'out of hospital' ○ Understand what need to be put in place to allow 'shift-left' to happen ▪ The workshop will help inform the 3–5-year Vascular Business Strategy
P2.03	Confirm what constitutes the palliative care pathway, and disseminate what that structure consists of, including over weekends and public holidays	Jo Flannery	September 2024		<ul style="list-style-type: none"> ▪ Initial meeting with palliative care team arranged for mid-June
P2.04	Ensure robust links between the palliative care team and the vascular service	Jo Flannery	September 2024		<ul style="list-style-type: none"> ▪ Initial exploration indicates that whilst palliative care team do not contribute to individual patient care within the current format of the MDT the relationship between palliative care and vascular is strong

P2.05	Formally set up a pain management pathway, particularly in the management of neuropathic pain	Jo Flannery	February 2025		<ul style="list-style-type: none"> Initial pain management pathway developed – this is to be reviewed to ensure it covers management of neuropathic pain. Any required changes will be co-designed with clinical colleagues and formally signed-off at S-CEG
P2.06	Evaluate the stroke referral pathway and implement subsequent findings across all the relevant multi-professional teams	Jo Flannery	September 2024		<ul style="list-style-type: none"> Monthly review of NVR data at clinical governance meetings indicate timeliness of treatment is positive Meeting to be arranged with Stoke Lead to agree further review
P2.07	Agree psychology input as a standard component of vascular care with dedicated, protected sessions of psychological support available for those vascular patients who require it	Jo Flannery/ Laszlo Papp	December 2024		<ul style="list-style-type: none"> Work to agree psychological input has yet to commence and will be picked up by the Network and/ Clinical Lead in the next 1-2 months
P2.08	Provide dedicated protected sessions of micro-biological support for the relevant vascular patients who require it	Jo Flannery/ Laszlo Papp	December 2024		<ul style="list-style-type: none"> Work to review current working practice has yet to commence, and will be picked up by the Network and/ Clinical Lead in the next 1-2 months
P2.09	Ensure availability of a Care of the Elderly (COTE) consultant and their clinical team for daily input as required for vascular patients	Laszlo Papp	March 2025		<ul style="list-style-type: none"> Discussions are ongoing and have highlighted the value in considering other models including experienced COTE ANP/ Physician Associate with support from COTE consultants, due to challenges in COTE capacity and/ or recruitment.
P2.11	Review what constitutes good and safe discharge planning in relation to the BCUHB guidance being provided regarding 'out of hours' discharge timing and	Jo Flannery	March 2025		<p>This action shall be delivered in conjunction with P1.10</p> <ul style="list-style-type: none"> BCUHB Discharge policy has been identified – work will commence to map local vascular pathway against health board wide policy.

	associated risk assessments. This should be part of a general review of the Discharge policy which the Panel understands was due for review in 2018, but could not identify evidence of it being updated			
P2.13	It is recommended that clinicians email patients and/or their nominated family member, information leaflets to ensure that they are always provided. Although this would require to be undertaken by means of the relevant information governance processes	Jo Flannery	March 2025	<ul style="list-style-type: none"> ▪ Range of information currently available to patients and their family/ carers. The suitability of this information will be reviewed, and the network will work closely with PALS to better understand information needs of vascular patients ▪ Vascular webpages to be developed, which will include information leaflets and sources of support
P2.16	It is recommended that letters to patients are more individualised in relation to the following: <ul style="list-style-type: none"> ▪ Invitation to surgery letters for “fistula” patients who plan to have a local anaesthetic. ▪ Invitation to surgery letters for a vascular procedure to be reviewed to reflect individual medication regimens and timescales 	Laszlo Papp	September 2024	<ul style="list-style-type: none"> ▪ Work with clinicians and patients to understand the types of information that should be included within patient letters has yet to commence and will be picked within the next 1-2 months
P2.18	It is recommended that there is consideration of whether the practice of completing	Laszlo Papp	June 2024	<ul style="list-style-type: none"> ▪ Discussions with clinicians indicates that this practice no longer continues

	Individual Funding Requests (IFRs) for Direct Oral Anticoagulants (DOACs) when they are widely available, remains reasonable and whether this should be continued				
P2.19	It is important to note that some recent improvements were recognised as having been made and that there was acknowledgement of the professionalism and work of the current administrative team. However, it is recommended that capacity is evaluated again	Jo Flannery	March 2024		<ul style="list-style-type: none"> Mapping work commenced across the network to help outline resources currently available and identify and gaps – information will support development of a Phase 2 Business Case, where additional resources are required

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Organisation Governance and Compliance					
Ref	Action	Lead	Deadline	RAG status¹	Progress Update
P2.14	It is recommended that consent training should be mandatory, for junior doctors as part of their induction into BCUHB and ongoing training	Jo Flannery	June 2024		<ul style="list-style-type: none"> Refresher consent training session organised for vascular surgeons to ensure all are up-to-date. Pending discussions with training department to include consent training as mandatory training module for all trainee, junior doctors and new starters. Booking people on will be managed via network

P2.15	It is recommended that unless the healthcare professional is fluent in the patient's preferred language, an interpreter should always be used for seeking consent from the patient	Laszlo Papp	July 2024		<ul style="list-style-type: none"> Item included within agenda for July vascular away day meeting
P2.17	<p>It is recommended that all staff should be reminded and supported in their professional accountability to maintain high standards of records and record keeping. This includes:</p> <ul style="list-style-type: none"> The need for documentation to explain decision-making and demonstrate the delivery of safe and effective care The use of Datix as a professional responsibility to report on any issue which may compromise patient safety 	Jo Flannery	September 2024		<ul style="list-style-type: none"> Deep dive audit tool being developed to enable quality focused review of case notes. The intention is for this to be undertaken on a quarterly basis, and will ensure that vascular clinicians are proactive in identifying areas for improvement

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Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Teitl adroddiad: Report title:	Quality Delivery Group – Chair’s Report			
Adrodd i: Report to:	QSE Committee			
Dyddiad y Cyfarfod: Date of Meeting:	6 th June 2024			
Crynodeb Gweithredol: Executive Summary:	This report provides the Committee with the Chair’s Report from the Quality Delivery Group (QDG). The QDG is the clinical executive led quality group in the Health Board through which all other quality-related groups report.			
Argymhellion: Recommendations:	The Committee is asked to note this report			
Arweinydd Gweithredol: Executive Lead:	Angela Wood, Executive Director of Nursing and Midwifery Dr Nick Lyons, Executive Medical Director Gareth Evans, Executive Director of Therapies and Health Sciences			
Awdur yr Adroddiad: Report Author:	Matthew Joyes, Deputy Director of Quality			
Pwrpas yr adroddiad: Purpose of report:	I’w Nodi <i>For Noting</i> <input type="checkbox"/>	I Benderfynu arno <i>For Decision</i> <input type="checkbox"/>	Am sicrwydd <i>For Assurance</i> <input checked="" type="checkbox"/>	
Lefel sicrwydd: Assurance level:	Arwyddocaol <i>Significant</i> <input type="checkbox"/> Lefel uchel o hyder/tystiolaeth o ran darparu’r mecanweithiau / amcanion presennol <i>High level of confidence/evidence in delivery of existing mechanisms/objectives</i>	Derbyniol <i>Acceptable</i> <input type="checkbox"/> Lefel gyffredinol o hyder/tystiolaeth o ran darparu’r mecanweithiau / amcanion presennol <i>General confidence / evidence in delivery of existing mechanisms / objectives</i>	Rhannol <i>Partial</i> <input checked="" type="checkbox"/> Rhywfaint o hyder/tystiolaeth o ran darparu’r mecanweithiau / amcanion presennol <i>Some confidence / evidence in delivery of existing mechanisms / objectives</i>	Dim Sicrwydd <i>No Assurance</i> <input type="checkbox"/> Dim hyder/tystiolaeth o ran y ddarpariaeth <i>No confidence / evidence in delivery</i>
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: Justification for the above assurance rating. Where ‘Partial’ or ‘No’ assurance has been indicated above, please indicate steps to achieve ‘Acceptable’ assurance or above, and the timeframe for achieving this:				
There is confidence in the data provided in the report however, the strength of learning and improvement remains an area of concern and is a key focus of work. This is being addressed through a range of measures including the actions aligned to the Board Assurance Framework.				
Cyswllt ag Amcan/Amcanion Strategol: Link to Strategic Objective(s):	Outcome 4 - Improved access, outcomes and experience for citizens Outcome 5 - Recognition of BCU as a learning and self-improving organisation			
Goblygiadau rheoleiddio a lleol: Regulatory and legal implications:	The Duty of Quality is a statutory requirement under the Health and Social Care (Quality and Engagement) (Wales) Act 2020.			

	<p>The statutory duty of quality requires the decision-making processes by the Health Board take into account the improvement of health services and outcomes for the people of Wales – the duty also includes new Health and Care Quality Standards.</p> <p>Instances of harm to patients may indicate failures to comply with the NHS Wales standards or safety legislation.</p>
<p>Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal? <i>In accordance with WP7 has an EqlA been identified as necessary and undertaken?</i></p>	N/A
<p>Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? <i>In accordance with WP68, has an SEIA identified as necessary been undertaken?</i></p>	N/A
<p>Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) <i>Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)</i></p>	BAF-SP18 and CRR-24-04 – Quality, Innovation and Improvement
<p>Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith <i>Financial implications as a result of implementing the recommendations</i></p>	N/A
<p>Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith <i>Workforce implications as a result of implementing the recommendations</i></p>	N/A
<p>Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori <i>Feedback, response, and follow up summary following consultation</i></p>	N/A
<p>Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) Links to BAF risks: <i>(or links to the Corporate Risk Register)</i></p>	BAF-SP18 and CRR-24-04 – Quality, Innovation and Improvement
<p>Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) <i>Reason for submission of report to confidential board (where relevant)</i></p>	N/A
<p>Camau Nesaf: Gweithredu argymhellion Next Steps: Implementation of recommendations N/A</p>	
<p>Rhestr o Atodiadau: List of Appendices: QDG Chair's Report</p>	



Chair's Report

Report to:	Quality, Safety and Experience Committee
Report from:	Executive Quality Delivery Group
Report date:	May 2024
Presented by:	Angela Wood, Executive Director of Nursing & Midwifery

Quality highlights and escalations:

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

Issues for escalation – requiring action/decision	None.
Issues for escalation – for information	<ul style="list-style-type: none">• A number of service pressures and concerns are noted in the reports from IHCs detailed below.• The Executive Director of Nursing and Midwifery will now chair the group permanently, rather than rotate, to ensure consistency.
Summary of business conducted – for assurance	<p>Quality highlight and escalation reports were received from IHC/Divisions.</p> <ul style="list-style-type: none">• Central IHC advised the April Patient Safety and Quality Group was stood down due to poor attendance. All areas were subsequently asked for any escalations by exception, of which there were none and the PSQ report was tabled at the Quality ODG meeting of 18.04.24. There is slow progress completing estates works identified on C4C audits (Estates only responding to emergency calls – impacting scores). Estates teams estimated an 18% daily reduction in operational workforce. They noted that they are closing more complaints than ever but pressures within the system are linking to patient satisfaction. Additional measures are required to support services.• East IHC advised that the discontinuation of Overnight Service for Adult Critical Care Transfer Service which poses a risk to the prompt transfer of critically ill patients between North Wales sites and outside of our Health Board. For Restorative Dentistry there is no definitive timeline as to when the service is expected to recommence. The number of electronic referrals are currently unmanaged and will continue to increase, this has been added to the Risk Register. This has been escalated to Nick Lyons as Executive Lead for Planned Care.

- **West IHC** advised following issue of Prevention of Future Deaths (WINQ1683) progress is on track with the actions. Five inquests are listed for May 2024 (1 postponed awaiting further date). Review reports on track via approval process or completed in readiness. The Putting Thing Right (PTR) meeting has been reviewed by IHC Nurse Director. Collective measures are underway to improve the processes for closure in accordance with policy. West IHC IPC risk has been reviewed and remains at a score of 16 and continues to be monitored at LIPG. Due to the level of bed occupancy and the number of escalated areas in use the inability to decant patients to provide proactive high-level disinfectant remains a risk. West IHC CAUTI Improvement Group has been established. The improvement plan and achievements will be monitored through LIPG.
- **MHLD Division** did not submit a report. A verbal update was provided
- **Women's and Midwifery** Division advised that there is a risk Women's Services may continue to fail to comply with the Single Cancer Pathway Performance targets (10 days to first appointment and 62 days to commence treatment. This is caused by increasing demand, insufficient capacity, theatre availability and diagnostics. An Internal Audit was carried out by Internal Audit colleagues to review the effectiveness of the governance arrangements within the service and Internal Audit issued reasonable assurance on Womens Services.
- **Cancer Division** highlighted there is a review being undertaken of all open incidents and a Datix programme of training is being commenced by the Governance Facilitator for the nursing team and the clinicians. The post of User Involvement Facilitator has been filled and the staff member started on the 1st April 2024. The Neuro Oncology ANP vacancy has now been filled and the staff member will be starting in post in due course.
- **Diagnostics and Clinical Support** did not submit a report. A verbal update was provided
- **Dental Division** did not submit a report. A verbal update was provided.
- **The Infection Prevention and Control Group** reported that the Metis machines (high level disinfection machines) are still not in use due to further electrical concerns and there are no proactive HLD programmes taking place due to site pressures and escalation of all available beds / decant areas. An SBAR on GNBSIs was discussed with Angela Wood and it was agreed to obtain further information from IHCs on their progress with the recommendations to be able to present a more detailed assessment to the Executives and be more specific with what is required. In comparison with other Welsh Health Boards, BCU finished 2023/24 1st for MRSA, 2nd for Klebsiella and MSSA, 3rd for Pseudomonas and 4th for E.coli and C. diff. *Other infections:* COVID-19 overall numbers remain low. Norovirus numbers and outbreaks have reduced, Influenza case numbers have reduced.

- The **Regulatory Assurance Group** advised the Mental Health Inpatient Discharge into Community Review was being worked through and support being provided by Clare Jones, Quality Assurance Manager.
- The **Patient Safety Group** reported that Oxygen 'no flow' incidents continue to occur with CD cylinders. The Health and Safety team have provided a Health Board position in respect of National Audit Inpatient Falls (NAIF) Key Performance Indicator as staff being able to access Manual Handling equipment (Flat Lifting equipment) following a fall. It was identified that there is limited access across the Health Board to this equipment and funding options being sought e.g. through Awyr Las. Following the escalation letter sent on 2nd February 2024 from Executives to IHCs/Divisions regarding the focused intervention on the Management of Concerns and Incidents, an update report on their current position on all open incidents to include Nationally Reportable Incidents and Never Events has been provided. There are no outstanding All Wales patient safety alerts. Timely progression of incidents to ILP remains an issue, some improvement identified. The Patient Safety Team provide feedback to IHC and Division to communicate which incidents are pending ILP with escalation for those currently overdue which may also be linked to an inquest and Nationally Reportable Incident. A Quality Assurance report presented to show a monthly snapshot of the Health Board's performance in a number of key areas that relate to the Quality Assurance of commissioned care within our care homes across North Wales.
- The **Patient and Carer Experience Group** reported on a presentation by Ceri Harris, Head of Equality & Human Rights provided an overview of a proposal to trial Sign Live for 3 years to support BSL patients in out of hours and emergency situations accessing Health Board Services. The patient story presented at the meeting shared a patient's experience in Ysbyty Glan Clywd of not being able to access the canteen area due to having a cannula in his arm. The storyteller highlights the importance of accessing canteen services and having a 'change of scenery' away from the ward with improved patient experience. A Task & Finish group was set up with Catering Managers across the Health Board, Infection Prevention Team and Patient and Carer Experience team to develop one consistent set of guidance to ensure all patients can access the canteen areas across all Health Board sites in a safe and consistent way ensuring there is inclusive access of services for our patients. Consideration on future projects to include the design of outdoor space with new builds or hospital upgrades to support inpatient experience and well-being.
- The **Clinical Effectiveness Group** reported that Jason Walker, Consultant Anaesthetist and CCIO presented the report to the group and current engagement with projects that are being led by Digital Health and Care in Wales, including local updates. In relation to the fragmented care record concern, agreement from the Board has been given to pursue with the strategic outline case for a full electronic digital record, and that the discussions have become a national topic. Steering groups have been set up and colleagues are now involved with putting

together the outline for the business case. The business case for electronic prescribing is complete, a supplier has been chosen, and the Finance Director has signed off the contract agreement. Roll out should be later this year across secondary care.

- The **Safeguarding Group** reported the governance arrangements within Safeguarding are under review in line with BCUHB reporting frameworks.
- The group approved MHL0002 Seclusion and Long Term Segregation Policy.



Teitl adroddiad: <i>Report title:</i>	East IHC – QSE Deep Dive			
Adrodd i: <i>Report to:</i>	Quality Safety and Experience Committee			
Dyddiad y Cyfarfod: <i>Date of Meeting:</i>	Thursday, 06 June 2024			
Crynodeb Gweithredol: <i>Executive Summary:</i>	Overview of current position in relation to Quality and Safety – East IHC			
Argymhellion: <i>Recommendations:</i>	The Committee are asked to Note the presentation.			
Arweinydd Gweithredol: <i>Executive Lead:</i>	Angela Wood, Executive Director of Nursing and Midwifery			
Awdur yr Adroddiad: <i>Report Author:</i>	Andrea Hughes, IHC East Director of Nursing Michelle Greene, IHC East Director			
Pwrpas yr adroddiad: <i>Purpose of report:</i>	I'w Nodi <i>For Noting</i> <input type="checkbox"/>	I Benderfynu arno <i>For Decision</i> <input type="checkbox"/>	Am sicrwydd <i>For Assurance</i> <input checked="" type="checkbox"/>	
Lefel sicrwydd: <i>Assurance level:</i>	Arwyddocaol <i>Significant</i> <input type="checkbox"/> <small>Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol</small> <i>High level of confidence/evidence in delivery of existing mechanisms/objectives</i>	Derbyniol <i>Acceptable</i> <input type="checkbox"/> <small>Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol</small> <i>General confidence / evidence in delivery of existing mechanisms / objectives</i>	Rhannol <i>Partial</i> <input type="checkbox"/> <small>Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol</small> <i>Some confidence / evidence in delivery of existing mechanisms / objectives</i>	Dim Sicrwydd <i>No Assurance</i> <input type="checkbox"/> <small>Dim hyder/tystiolaeth o ran y ddarpariaeth</small> <i>No confidence / evidence in delivery</i>
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:				
<i>Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:</i>				
Cyswllt ag Amcan/Amcanion Strategol: <i>Link to Strategic Objective(s):</i>	4. Improving Quality, Outcomes and Experience			
Goblygiadau rheoleiddio a lleol: <i>Regulatory and legal implications:</i>	N/A			

<p>Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal?</p> <p><i>In accordance with WP7 has an EqIA been identified as necessary and undertaken?</i></p>	N/A
<p>Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal?</p> <p><i>In accordance with WP68, has an SEIA identified as necessary been undertaken?</i></p>	N/A
<p>Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR)</p> <p><i>Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)</i></p>	
<p>Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith</p> <p><i>Financial implications as a result of implementing the recommendations</i></p>	N/A
<p>Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith</p> <p><i>Workforce implications as a result of implementing the recommendations</i></p>	N/A
<p>Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori</p> <p><i>Feedback, response, and follow up summary following consultation</i></p>	Approved by the Executive Director of Nursing and Midwifery
<p>Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)</p> <p><i>Links to BAF risks:</i> (or links to the Corporate Risk Register)</p>	N/A
<p>Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)</p> <p><i>Reason for submission of report to confidential board (where relevant)</i></p>	N/A
<p>Camau Nesaf: Gweithredu argymhellion</p> <p>Next Steps: Implementation of recommendations</p>	
<p>Rhestr o Atodiadau: Dim</p> <p>List of Appendices: Presentation – Appendix 1</p>	

East IHC QSE Deep Dive



20.02.24



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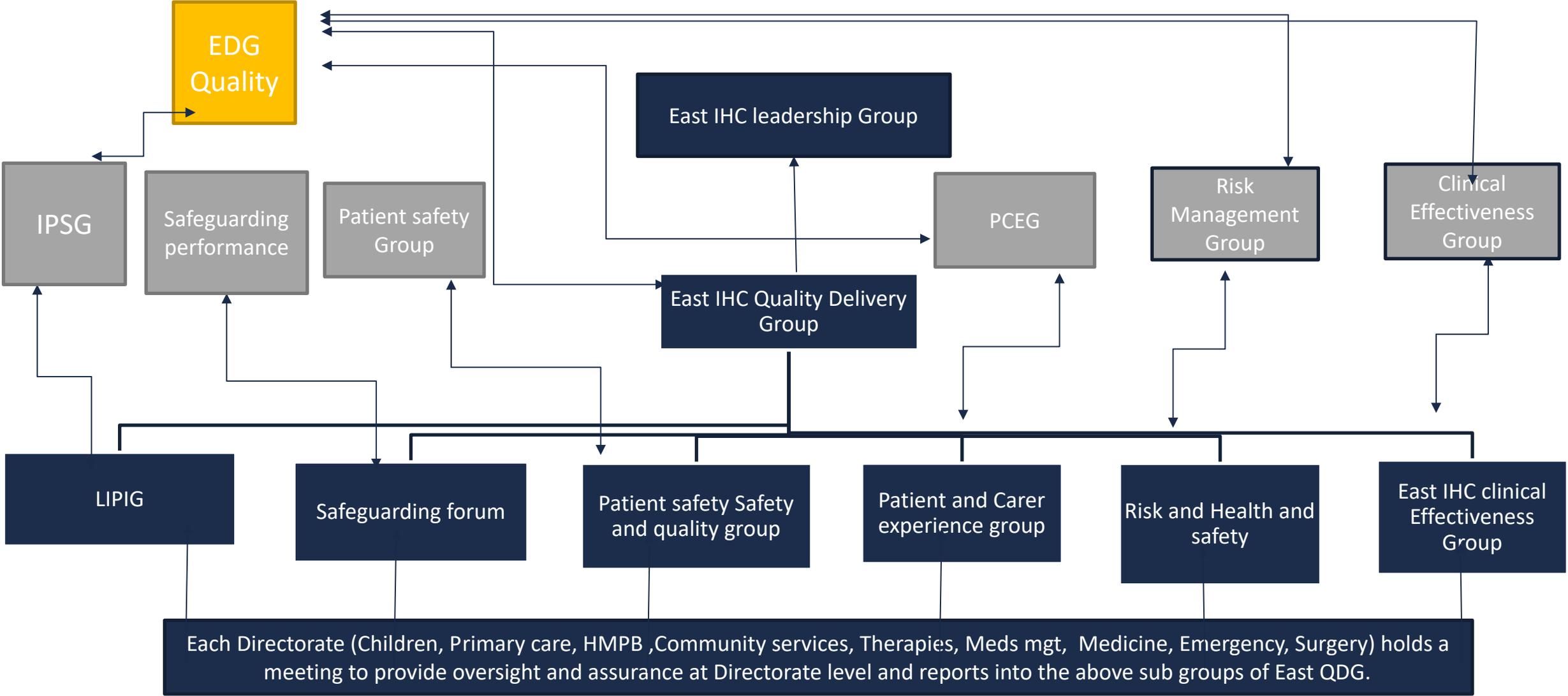
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Key relationship and reporting structure

- Executive quality Delivery Group
- BCU Wide sub group
- East IHC governance group

Achievements

Managed practices pharmacy Hub we have established a Pharmacy Hub to support Managed GP Practices with medicines reconciliation from hospital discharges with the aim of making the service more sustainable, ensuring delivery in a safe, efficient and supportive environment

Reduction in overdue complaints and LFERs

Progressive development of the Community Falls Team

Ward manager development programme continues to excel

Duty of Candour educational programme continues to deliver

Hepatitis C service at HMP Berwyn – the service has recently won awards following the development of an accelerated care pathway to test and treat Hepatitis C.

HMP Berwyn Tuberculosis pilot – Following the publication of NICE guidance on TB that advised prisons with x-ray facilities should xray all new prisoners and detainees (if not had a chest xray in past 6 mths) for active TB

Implementation of East IHC weekly SITREP governance report

Extension of the Wrexham Health Campus The relocation of non-acute services into Plas Gororau – the first phase of services moved in at the end of March. Services included as part of the move include mental health outpatients, vaccination centre and phlebotomy services.



March 2024



**Overdue
complaints (61)**

Falls (128, 2 with harm)

Medication Incidents (109)

**Infection Prevention
(82)**

HAPU (230)

**NRIs (7
open, Nil
overdue)**

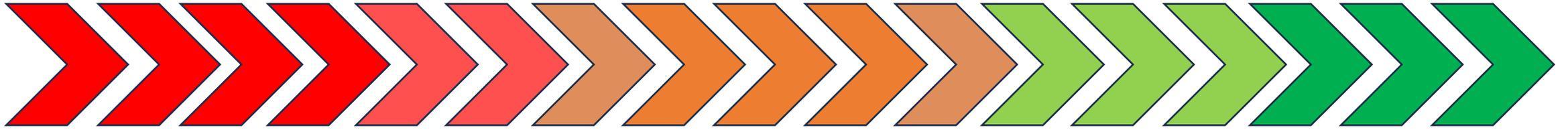
**Inquests
88**

LFERs (11)

**Ombudsman
cases 22
(nil overdue)**



April 2024



Overdue complaints (58) of which 23 sitting with Insourcing



NRIs 12 (4 overdue - 2 in QA process)

LFERs (8)



Medication Incidents (107)



Falls (97, 1 with harm)



Inquests (77)

Infection Prevention (34)



Ombudsman cases (12, nil overdue)

HAPU (245)



So, what are we doing to continually improve?

- Patient and family engagement via Duty of Candour process
- Focus on learning and improvement (MiS, ILP, RLP, Qtrly Harms forum)
- Deep dive methodologies – incident themes and trends
- Review and update risk registers
- Transformational review with IHC engagement
- Continual review of safe staffing
- Proactive engagement with LA



Continuing areas of Concern

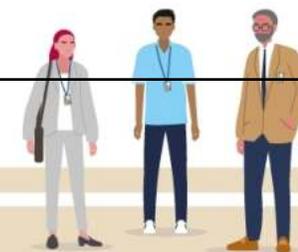
- No service for restorative dentistry
- Lack of clinical pathways – insourcing/outourcing
- Delays with critical transfers in ED
- Inability to deliver safe care – acute medicine
- Inability to facilitate timely ambulance off-loads
- Lost acute beds due to discharge profile
- Cancellation of elective cases due to site pressures



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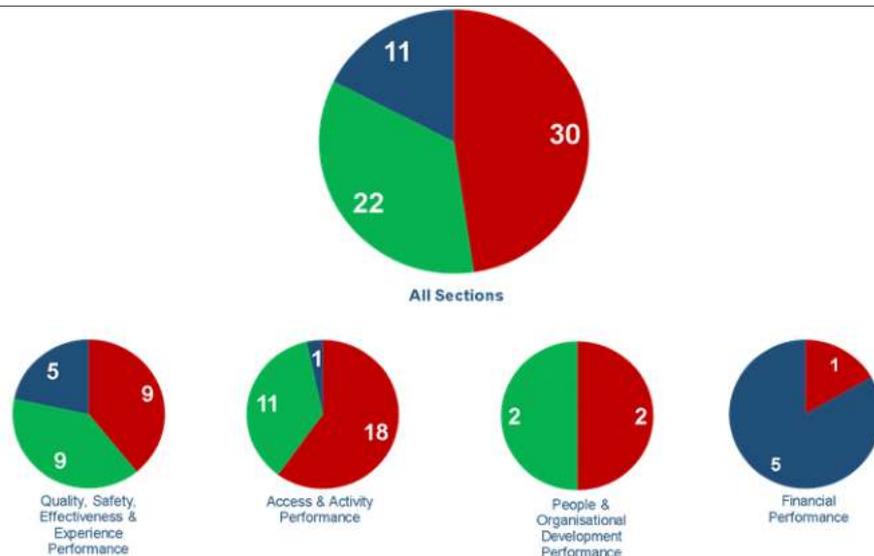
Risk	Summary	Mitigation
<ul style="list-style-type: none"> • Wrexham Maelor Infrastructure <ul style="list-style-type: none"> ○ Sustainability ○ Future redevelopment 	<p>The Wrexham hospital is in a poor state of repair and does not comply with the standards required of a model health care acute setting. This is split into 2 parts, sustainability and future hospital</p>	<ul style="list-style-type: none"> • Sustainability, FBC submitted to Welsh Gov in June 2023, review being completed with additional questions, a meeting arranged 29 April With national team to discuss options • Redevelopment, completion of All Wales Capital Funding Programme Prioritisation Form in January 2024, with the initial proposed OBC on hold.
<ul style="list-style-type: none"> • Finance 	<p>The East IHC is forecasting a year end deficit of £11.2m, which is an improved picture, with a shortfall against CRES of £2.327m in month. The current challenges in maintaining core services and delivering within a financial envelop will continue into the new financial year, we wait the outcome of Riga 2 The projected shortfall of £6.5m against the control target, even if all high risk schemes are delivered</p>	<ul style="list-style-type: none"> • ECR process and recruitment scrutiny • Additional measures to reduce cost implemented • Monthly directorate and team meeting to confirm and challenge CRES and spend to reduce run rates • RIGA 1 submitted and outcomes being supported • RIGA 2 submitted waiting for outcomes
<ul style="list-style-type: none"> • Access / Capacity and Flow <ul style="list-style-type: none"> ○ ED ○ RTT 	<ul style="list-style-type: none"> • Currently the ED is experiencing significant delays in moving patient through the system, this is impacting on patient waiting times by clinicians as the department is full of patients waiting for a bed, we know as evidenced by the Society of Emergency Medicine that holding patients for long periods on the ED can lead to harm and an increase in mortality. Lack of system flow is being compounded by the number of patients waiting for external providers, we are aware of the financial challenges within the LAs that may impact further through 2024/25 • Due to the loss of the insourcing for planned care patients and the insourcing for Diagnostics with Endoscopy we have an increase waiting list with these areas, the projected outturn for 2024 financial indicates that our 52ww stage 1 will increase from 7224 patients to an outturn of 12607 patients and our 104ww all stages will increase from 3241 to an outturn 7354 patients. We will not achieve the mistrial ask of no patients over 156ww, currently we have 645 patients, this will increase to 2899 	<ul style="list-style-type: none"> • ED <ul style="list-style-type: none"> ○ Continue with the 6 Goals programme ○ Daily check and challenge ○ Point prevalence ○ Escalation of delays ○ HFC enacted • RTT • Review of all capacity to deliver all cancer targets • Seek agreement of planned care transformation monies for WLIS • Seek agreement of insourcing procurement for Endoscopy



<ul style="list-style-type: none"> • Childrens Neurodiversity 	<p>We are failing to achieve WG targets for assessment, for our ND WG target is 80% with 26 weeks current position is 29% with over 1800 on the East WL. Our internal capacity is 300-400 assessments per annum, the monthly levels of referral approx. 200 which is double pre pandemic levels and quadruple historical activity capacity.</p> <p>Retention and Recruitment of Professionals, remains challenging, the current model requires Professionals from the various specialities whom are highly sought both within other Health (CAMHS) and Educational services. External contract not currently progressing: A request for a value for money assessment has been requested, halting the contract being commenced.</p>	<ul style="list-style-type: none"> • Regional transformation programme team, being recruited too to look at transformation from medical model to needs led model. • We have established working groups with LA and Education to support Awareness and Actions to support C&YP in the community. • We have been successful in allocation of WG monies (via RPB) for some trials of alternative diagnostic pathways. • DU D&C Review undertaken and improvement plan being drafted. • BCU part of WG Neurodevelopmental improvement Programme – which are the trials of new ways of working, to help inform a new model of delivering the service in the future. • Establishing with schools alternatives to diagnostic support for C&YP whom require assistance • Working with Executive Team to progress on the value for monies exercise. (this is a Red Flag as our external contract has been the source of the majority of assessments in the last couple of years)
<ul style="list-style-type: none"> • Primary Care Managed Practices 	<p>We have a number of on going issues across primary care and managed practices the fragility of some of these services within GPS could lead to more request being handed back to the Heath Board. In addition we have significant challenges across the GP estate, through lease rental, repair and capacity and further challenges through sustainability of the GP workforce</p>	<ul style="list-style-type: none"> • Work continues through the contract team, specifically the current biggest risk Strathmore • Work with Managed Practices and estates for priorities • Continue to drive recruitment, we have a high number of new starts over the next few months, we will continue to recruit to vacancies and reduce the locum use



<p>Teitl adroddiad:</p> <p>Report title:</p>	<p>Our Integrated Performance Report – Month 12, 2023/24</p>
<p>Adrodd i:</p> <p>Report to:</p>	<p>Quality, Safety & Experience Committee</p>
<p>Dyddiad y Cyfarfod:</p> <p>Date of Meeting:</p>	<p>Thursday, 06 June 2024</p>
<p>Crynodeb Gweithredol:</p> <p>Executive Summary:</p>	<p>This Report relates to the Month 12, 2023/24</p> <p>The Health Board signed off the Integrated Performance Framework (IPF) 2023-2027 on the 28th September 2023. It is one of a trilogy of new frameworks intended to drive the strategic objectives of the Health Board for the next four years. The IPF will be used in conjunction with the new Integrated Planning Framework (IPlanF) and the Risk Management Framework (RMF). The three Frameworks support the Board Assurance Framework (BAF). The Framework will align with the Quality Surveillance Strategy as it is developed.</p> <p>The purpose of the Framework is to integrate key performance indicators (KPIs) from: -</p> <ol style="list-style-type: none"> 1. Key deliverables from the Annual Plan (IMTP) 2. NHS Wales Performance Framework (Quadruple Aims) 3. Key deliverables in response to WG, HIEW and other formal recommendations including Special Measures. <p>The Health Board has a number of measures rated monthly and included within this report, the below graphic indicating a number of these measures are off target;</p> <p>The Framework will support the delivery of better outcomes for our patients and our staff, and ensure that all stakeholders understand their roles, responsibilities, and accountabilities. The management requirements of the Integrated Performance Framework (IPF) aligns to the Health Board's corporate governance structure.</p> <p>Performance improvement is achieved through an approach of partnership and openness about our current performance and opportunities for innovation, and engenders a commitment at all levels of the organisation to improve, firmly based on our values: -</p>



- Put patients first
- Work together
- Value and respect each other
- Learn and innovate
- Communicate open and honestly

We also reflect the Health Board's current level of performance escalation with Welsh Government within the framework; the approach will be subject to review should escalation levels change.

The Performance Directorate has been working with our partners across the organisation, developing the report with the Integrated Performance Executive Delivery Group (IPEDG).

Performance is RAG rated against the targets set within the NHS Wales Performance Framework 2023-24, set by Welsh Government in the Special Measures Framework for BCUHB or outlined in the Ministerial Priorities. However, where appropriate, BCUHB's internal improvement trajectories as submitted and agreed by Welsh Government have also been included.

Key areas of escalation are identified within the 'Escalated Performance Measures' section at the beginning of the report. This section will be strengthened as the report matures, to include more information about the plans to mitigate or improve performance, the report composition articulates the following;

- Within the escalation, section a high-level one-page summary that highlights key performance across the four quadrants, followed by escalation pages to further articulate performance within the escalated metrics.
- A brief introduction to the Performance report to include a key for RAG rating and Statistical Process Control (SPC) charts.
- The further reporting contains all of the metrics by domain, so members can review performance against all metrics reported.

	<p>The intention of the report structure is to enable members to identify key escalations from Committees of the Health Board, whilst enabling oversight of the current reported metrics. The key performance indicators utilised are the nationally required metrics, a key enhancement to the reporting moving forwards will be for the following;</p> <ul style="list-style-type: none"> • Development of local metrics that give greater insight into understanding current performance (through Executive forums & Committees). • Greater ownership by Committees of the measures then included within the escalation section of the report for Health Board, with areas of good practice also to be included within this section. <p>The Performance team continue to work with the Health Board to further embed the endorsed Integrated Performance Framework. These arrangements include putting in place formal and informal accountability review structures and escalation / de-escalation mechanisms.</p>			
<p>Argymhellion:</p> <p>Recommendations:</p>	<p>The Quality, Safety & Experience Committee is asked to:</p> <p>Review the contents of the report and propose any actions arising from the report, or identify any additional assurance work or actions it would recommend Executive colleagues to undertake.</p>			
<p>Arweinydd Gweithredol:</p> <p>Executive Lead:</p>	<p>Russell Caldicott, Interim Executive Director of Finance</p>			
<p>Awdur yr Adroddiad:</p> <p>Report Author:</p>	<p>Ed Williams, Acting Director of Performance</p>			
<p>Pwrpas yr adroddiad:</p> <p>Purpose of report:</p>	<p>I'w Nodi <i>For Noting</i></p> <input type="checkbox"/>	<p>I Benderfynu arno <i>For Decision</i></p> <input checked="" type="checkbox"/>	<p>Am sicrwydd <i>For Assurance</i></p> <input checked="" type="checkbox"/>	
<p>Lefel sicrwydd:</p> <p>Assurance level:</p>	<p>Arwyddocaol <i>Significant</i></p> <input type="checkbox"/> <p>Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol</p>	<p>Derbyniol <i>Acceptable</i></p> <input type="checkbox"/> <p>Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol</p>	<p>Rhannol <i>Partial</i></p> <input checked="" type="checkbox"/> <p>Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol</p>	<p>Dim Sicrwydd <i>No Assurance</i></p> <input type="checkbox"/> <p>Dim hyder/tystiolaeth o ran y ddarpariaeth</p> <p><i>No confidence /</i></p>

	High level of confidence/evidence in delivery of existing mechanisms/objectives	General confidence / evidence in delivery of existing mechanisms / objectives	Some confidence / evidence in delivery of existing mechanisms / objectives	evidence in delivery
<p>Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:</p> <p><i>Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:</i></p>				
<p>Cyswllt ag Amcan/Amcanion Strategol:</p> <p><i>Link to Strategic Objective(s):</i></p>	<p>The performance measures included in this report are from the NHS Wales Performance Framework 2023-24.</p>			
<p>Goblygiadau rheoleiddio a lleol:</p> <p><i>Regulatory and legal implications:</i></p>	<p>This report will be available to the public once published for Quality, Safety & Experience Committee</p>			
<p>Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal?</p> <p><i>In accordance with WP7 has an EqlA been identified as necessary and undertaken?</i></p>	<p>N</p> <p>The Report has not been Equality Impact Assessed as it is reporting on actual performance.</p>			
<p>Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal?</p> <p><i>In accordance with WP68, has an SEIA identified as necessary been undertaken?</i></p>	<p>N</p> <p>The Report has not been assessed for its Socio-economic Impact as it is reporting on actual performance</p>			
<p>Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR)</p> <p><i>Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)</i></p>	<p>There remains a number of risks to the delivery of care across the healthcare system due to the legacy impact the COVID-19 Pandemic had upon planned care delivery between 2020 and 2022.</p> <p>Several corporate risks remained to be approved this month however the draft risks have included the rationale and evidence from the Acting Director of Performance.</p> <p>References to Corporate Risks have been made the body of the report, where applicable.</p> <p>24-04 Failure to Embed Learning</p>			

<p>Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith</p> <p><i>Financial implications as a result of implementing the recommendations</i></p>	<p>The delivery of the performance indicators within our IPR will directly/ indirectly impact upon the financial recovery plan of the Health Board.</p>
<p>Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith</p> <p><i>Workforce implications as a result of implementing the recommendations</i></p>	<p>The delivery of the performance indicators within our IPR will directly/ indirectly impact on our current and future workforce.</p>
<p>Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori</p> <p><i>Feedback, response, and follow up summary following consultation</i></p>	<p>The full report has been reviewed by the Director of Performance, and the Executive Director of Finance & Performance.</p>
<p>Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)</p> <p><i>Links to BAF risks:</i> (or links to the Corporate Risk Register)</p>	<p>24-04 Failure to Embed Learning</p>
<p>Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)</p> <p><i>Reason for submission of report to confidential board (where relevant)</i></p>	<p>Amherthnasol</p> <p>Not applicable</p>
<p>Camau Nesaf: Gweithredu argymhellion</p> <p>Next Steps: Implementation of recommendations: Continued focus on any areas of under-performance where assurance is not of sufficient quality to believe performance is or will improve as described.</p> <p>The Integrated Performance Report will undergo continuous development through the remainder of 2023-24 with a view to have the 'end product' embedded as business as usual from 1st April 2024.</p> <p>In addition, the Performance Directorate is working with executive colleagues via the Executive Delivery Integrated Performance Group, on the development of a suite of locally defined measures that once ratified, will be include in the Integrated Performance Reports from May 2024.</p>	
<p>Rhestr o Atodiadau:</p> <p>List of Appendices: 2</p>	

<p>1: <i>Summary of Report</i> 2: <i>Integrated Performance Report in PDF</i> 3: <i>Escalations from Integrated Performance Report in PowerPoint</i></p>
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Appendix 1 – Summary of Report

Committee: **Quality, Safety & Experience**

Report title: **Summary of Integrated Performance Report (month 11)**

Report Author: **Acting Director of Performance**

1. Introduction

The Performance Directorate has been developing a revised performance report for the Health Board, the key aim being to enable focus to be placed upon areas of high performance or those metrics requiring improvement, with the 'Integrated Performance Report' now including a section summarising the areas requiring escalation for Board members, divided into the following four quadrants;

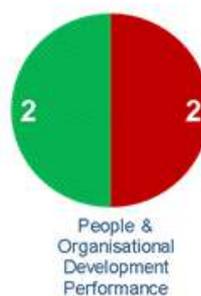
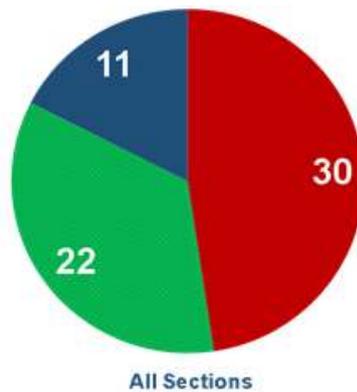
- Quality (Safety, Effectiveness & Experience) Performance
- Access & Activity Performance
- People & Organisational Development Performance
- Financial Performance

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

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

In response to the request from the Health Board on 25.01.2024, where appropriate, the Corporate Risk Register (CRR) reference number has been included in the report. This is to facilitate triangulation between the performance and risk contexts.

2. Overall Summary



3.1 Quality (Safety, Effectiveness & Experience) Performance

The key areas highlighted centre upon:-

National Reportable Incidents & Complaints have been targeted to improvement in performance against compliance with National Reportable Incidents (NRIs) and Complaints backlogs via the Integrated Performance Executive Delivery Group (IPEDG). The Integrated Healthcare Communities (IHCs) and Divisions have submitted their plans to reduce the backlog and improve response times to the Executive Director of Nursing and Midwifery for onward monitoring of trajectories.

Infection rates remain above predicted trajectories. The Infection Prevention Team are ensuring learning from post infection reviews is cascaded and improvement monitored through local infection prevention groups and delivering a robust audit programme, alongside increasing awareness through promotional campaigns with a new campaign ("HABITS") being established to further engage staff, patients and public.

Clinical coding compliance remains a risk. This is attributed to staff vacancies and absence experienced across the Health Boards. Working with People & Organisational Development (P&OD) Directorate to address recruitment and retention issues. Coding Assurance Lead role will support development of new trainees as they progress. Working with Welsh Patient Administration System (WPAS) Operational Steering Group to improve availability of electronic records to enable some remote working opportunities starting with theatre operation sheets. Five trainee coders will commence in post mid July 2024.

See appendix below

Appendix 1 – IPR for QSE 18.04.2024



IPR for QSE
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Integrated Performance Report

Reporting Period: to 31.03.2024

Presented to

Quality, Safety & Experience Committee

Thursday, 6th June 2024

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Performance Escalations Report

Quality, Safety, Effectiveness & Experience Performance

- There were 6 **never events** reported in 2023/24 with no new never events reported in March or April 2024.
- **Clinical coding compliance** remains a significant risk that is likely attributed to staff absence: work is underway to review this and a paper pertaining to solutions is being presented to the Health Board in due course.
- **NRIs**: During 2023/24 there were 321 NRIs. 26 remain open 90 days or more at the end of March 2024. (**Corporate Risk 24-04 Failure to Embed Learning**)
- **Complaints**: There were 2,502 complaints during 2023/24. 50% of the overall complaints are from Clinical treatment/Assessment. The sub category of Delay / Lack of treatment has risen significantly due to insourcing based complaints.

Access & Activity Performance

Reported via the Performance, Finance & Information Governance Committee

People & Organisational Development Performance

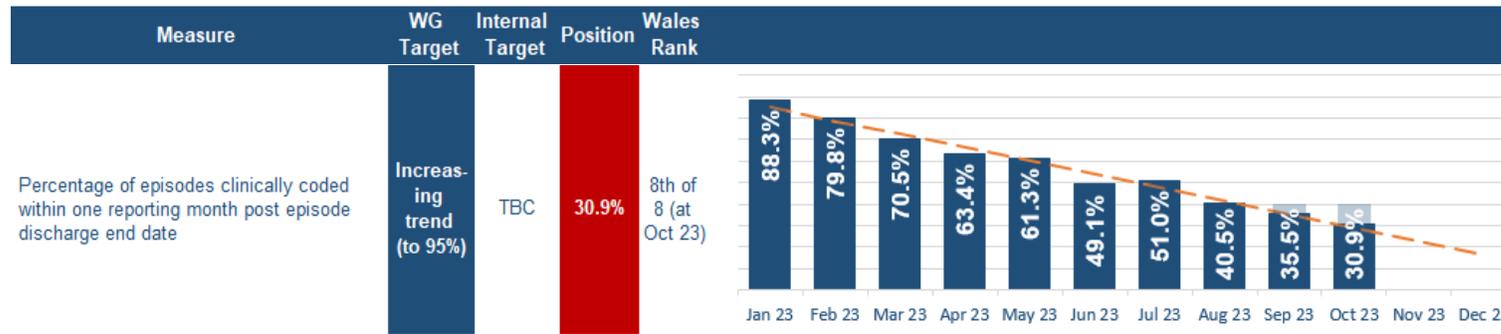
Reported via the Performance, Finance & Information Governance Committee

Financial Performance

Reported via the Performance, Finance & Information Governance Committee

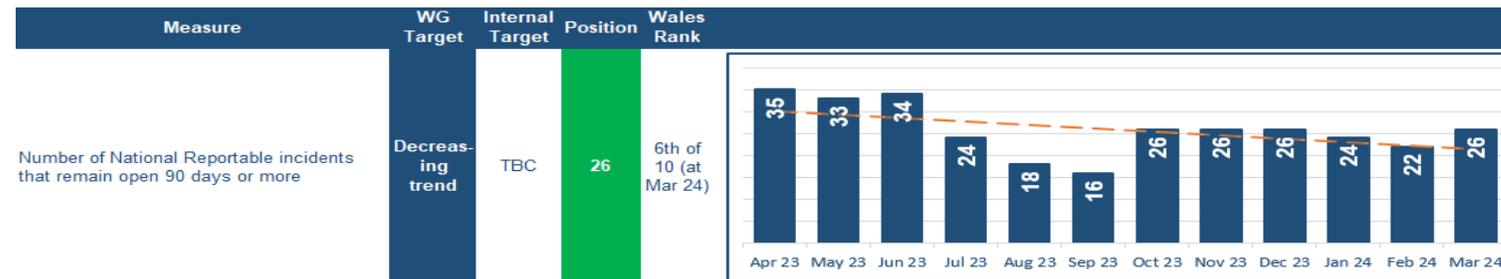
Quality: Escalated Performance Measures

New Never Events – No new Never events were reported in March of 2024. However, there were 6 never events reported in 2023/24. Rapid Learning Panels were being arranged and full investigations are underway. Learning will be reported via the Improving Quality Report to Board.



Clinical coding compliance will remain a significant risk directly attributed to staffing issues. Currently working on a delivery plan that is likely to include a proposal to work to a lower target level of coding completeness for the latter part of 2023/24 and in to 2024/25. Working with People & Organisational Development to address recruitment and retention issues. Exploring potential of a Coding Assurance Lead to oversee a training programme and reduce the training burden on qualified coders.

National Reportable incidents (NRIs) that remain open 90 days of more



Clinical treatment/Assessment
Communication Issues (including Language)
Attitude and Behaviour
Medication
Appointments
Patient Care
Discharge Issues
Access (to Services)
Confidentiality
Referral

50% of the overall complaints are from clinical treatment / Assessment. The sub category of Delay / Lack of treatment has risen significantly due to insourcing based complaints.

During 2023/24 there were 321 NRIs. 26 remain open 90 days or more at the end of March 2024. The Patient Safety Team (PST) are supporting the progression of all NRIs. Drop in clinics for staff are held weekly to help focus the outcome from the incident review with any learning which can be shared. The IHCs and Divisions have submitted their reduction plans to the Executive Director of Nursing and Midwifery for onward monitoring of trajectory. Themes included: Delay in referral, admission or treatment. Investigation reporting error. Unexpected death or self harm of patient under or recently under mental health services. Correct preparation of portable oxygen cylinder. Maternity adverse occurrence. Healthcare acquired Grade 3 pressure ulcer. Patient fall with harm. Healthcare acquired infection. PRUDIC – child brought to ED.



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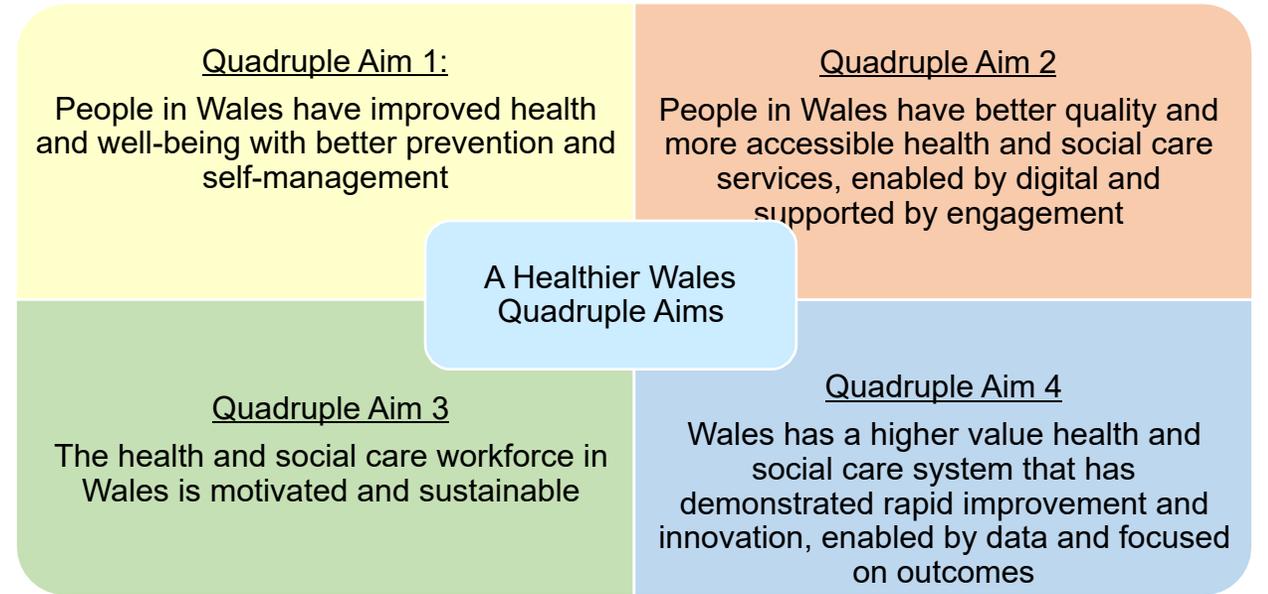
About the Integrated Performance Report



NHS Wales Performance Framework 2023-24

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

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



Our Integrated Performance Report

Our Quality, Safety, Effectiveness & Experience Performance

Our Access & Activity Performance

Our People & Organisational Development Performance

Our Financial Performance

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

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

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



Red, Amber & Green (RAG) Rating System

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

Green	<p>Green = On track A stable, sustained or improving position that is consistently on or above the Welsh Government Target for at least 3 or more consecutive months</p>
Amber	<p>Amber = Early Warning or Off Track and in Exception – Short summary provided On or above Welsh Government Target, but a deteriorating position of 3 or more consecutive months or inconsistently above/on/below the Welsh Government Target</p>
Red	<p>Red = Off Track and in Escalation Consistently below Welsh Government Target and below BCU submitted improvement trajectories – Detailed Exception report provided</p>

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



Interpreting Results of Statistical Process Control (SPC) Charts

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

How to interpret variance results	How to interpret assurance results
<ul style="list-style-type: none"> Variance results show the trends in performance over time Trends either show special cause variance or common cause variance Blue Icons indicate positive special cause variance Orange Icons indicate negative special cause variance requiring action Grey Icons indicate no significant change 	<ul style="list-style-type: none"> Assurance results demonstrate the likelihood of achieving a target and is based upon the trends over time Blue Icons indicate an expectation to consistently achieve the target Orange Icons indicate an expectation not to consistently achieve the target Grey Icons indicate an expectation for inconsistent performance, sometimes the target will be achieved and sometimes it will not be achieved.

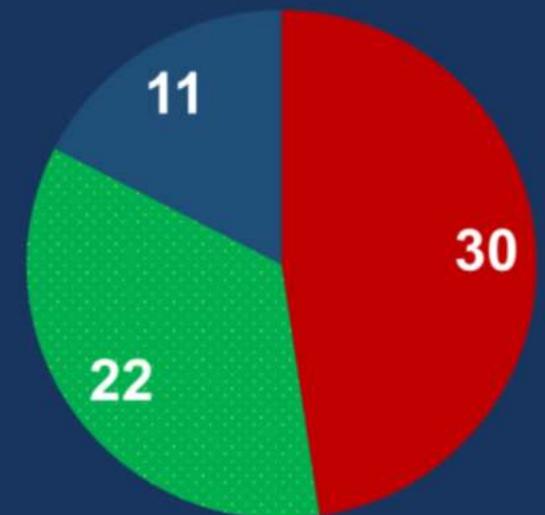
* Assurance based upon observations of the data as presented in the SPC charts only.



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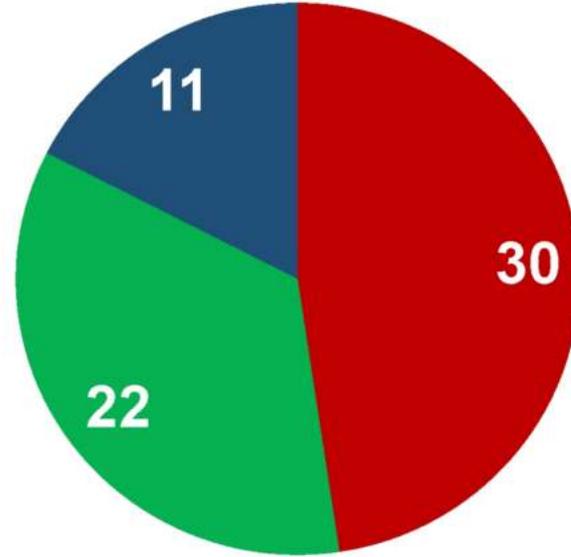
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University Health Board

Integrated Performance Report





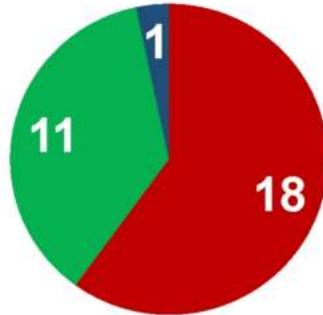
Summary of Performance to Month 11



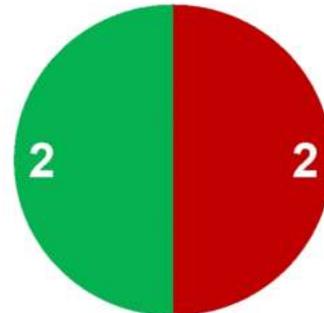
All Sections



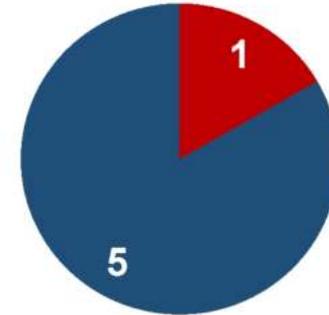
Quality, Safety, Effectiveness & Experience Performance



Access & Activity Performance



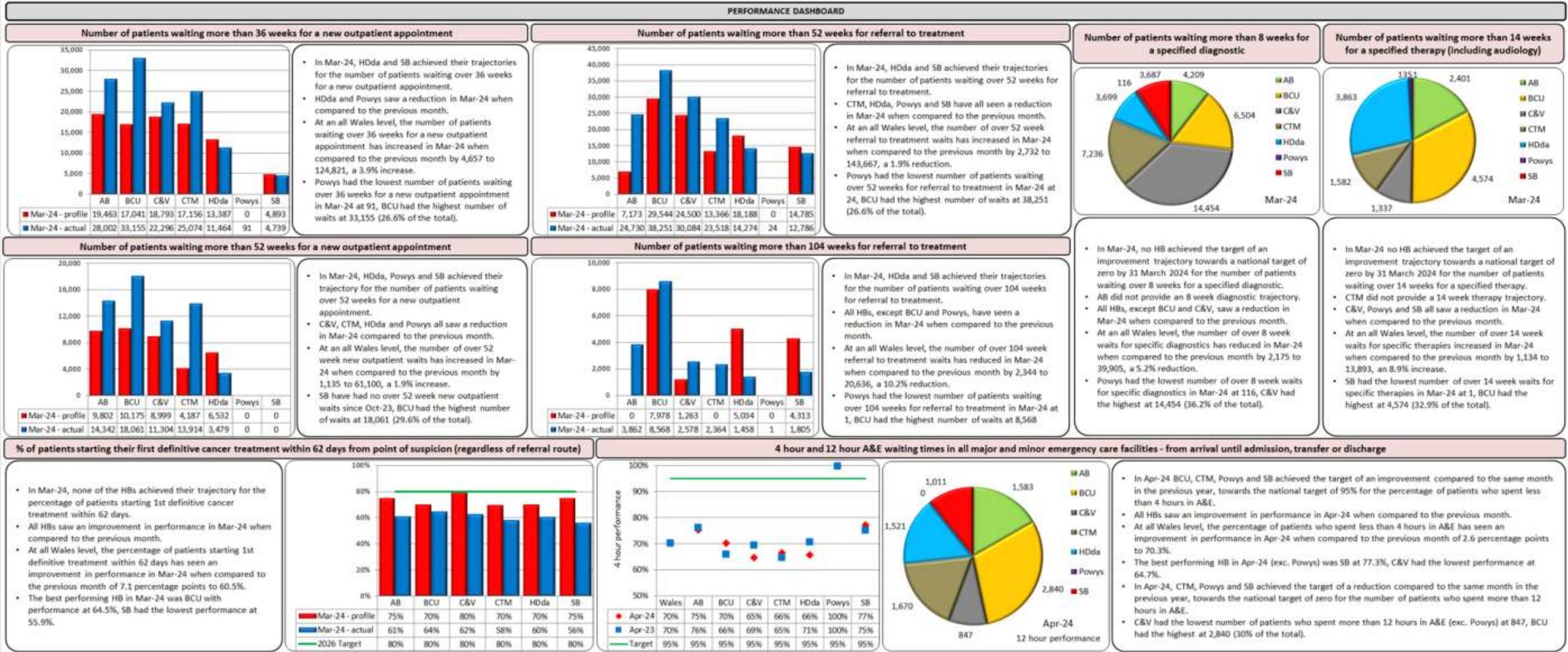
People & Organisational Development Performance



Financial Performance



NHS Wales Performance Dashboard- part 1

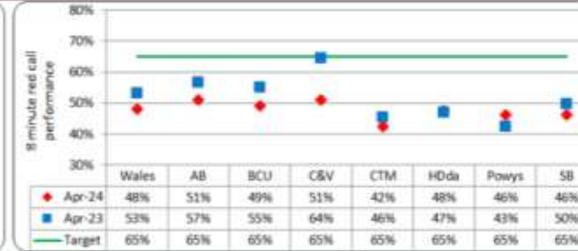
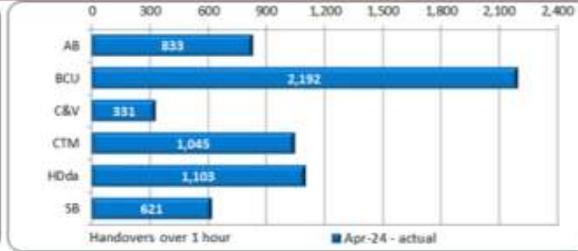




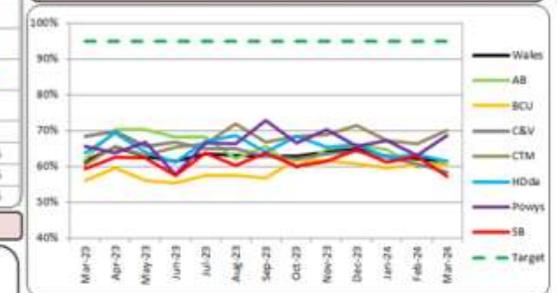
NHS Wales Performance Dashboard – part 2

Number of ambulance patient handovers over 1 hour and % of emergency responses to red calls arriving within 8 minutes

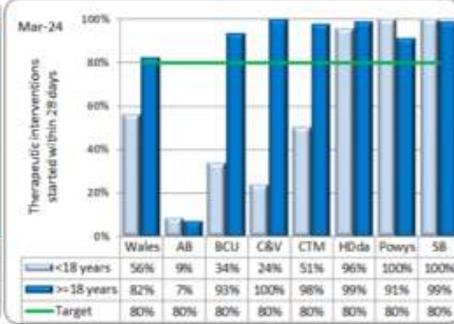
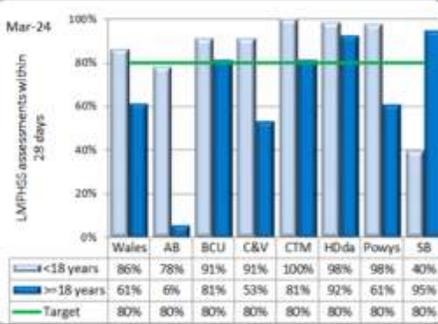
- C&V had the lowest number of over 1 hour handovers in Apr-24 with 331 over 1 hour handovers, BCU had the highest at 2,192 (35.8% of the total).
- Over the last 12 months, AB, C&V and SB saw an improvement trend in performance.
- In Apr-24, no HB achieved the 65% target for the percentage of emergency responses to red calls within 8 minutes.
- C&V were the best performing HB in Apr-24 with performance at 51%, CTM were the lowest with performance at 42.4%.
- Over the last 12 months all HBs saw a deterioration trend in performance. HDda and Powys saw an improvement in performance in Apr-24 when compared to the previous month.



% of ophthalmology R1 appointments attended which were within their clinical target date or within 25% beyond their clinical target date



Mental Health Part 1 - % of LPMHSS assessments and therapeutic interventions within 28 days



<18 years

- In Mar-24, all HBs, except AB and SB, achieved the 80% target for % of LPMHSS assessments undertaken within 28 days of a referral. The best performing HB was CTM at 100%, SB had the lowest performance at 40%. Over the last 12 months, all HBs, except Powys, saw an improvement trend in performance.
- In Mar-24, HDda, Powys and SB achieved the 80% target for % of therapeutic interventions started within 28 days of an LPMHSS assessment. The best performing HBs were Powys and SB at 100%, AB had the lowest performance at 8.6%. Over the last 12 months, all HBs, except BCU, saw an improvement trend in performance.

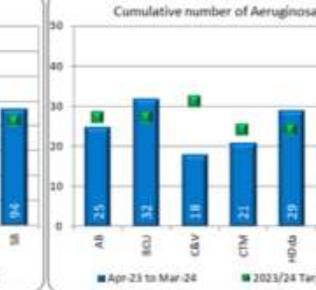
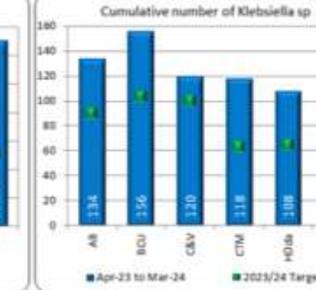
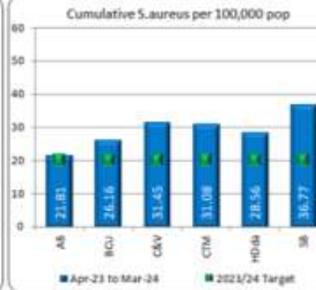
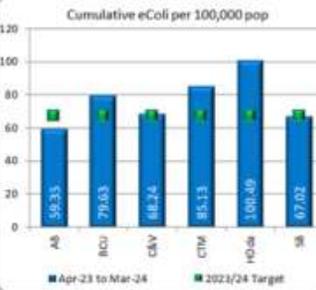
>18 years

- In Mar-24, BCU, CTM, HDda and SB all achieved the 80% target for % of LPMHSS assessments undertaken within 28 days of a referral. The best performing HB was SB at 94.5%, AB had the lowest performance at 5.8%. Over the last 12 months, all HBs, except AB and C&V, saw an improvement trend in performance.
- In Mar-24, all HBs, except AB, achieved the 80% target for % of therapeutic interventions started within 28 days of an LPMHSS assessment. The best performing HB was C&V at 100%, AB had the lowest performance at 7%. Over the last 12 months, BCU, C&V, CTM and SB all saw improvement trend in performance.

- Note: AB are still validating their data from Apr-23 due to moving to a new IT system so data may be revised in future months.

- In Mar-24 no HB achieved the 95% target for the percentage of ophthalmology R1 appointments attended which were within their clinical target date or within 25% beyond their clinical target date.
- The best performing HB in Mar-24 was CTM with performance at 70%, SB were the lowest performing HB with performance at 57.3%.
- In Mar-24, AB, CTM and Powys saw an improvement in performance compared to the previous month.
- Over the last 12 months, BCU, CTM and Powys saw an improvement trend in performance.

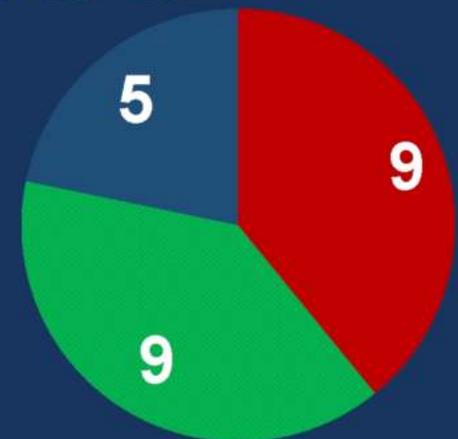
Health Care Acquired Infections - HCAs (provisional data)



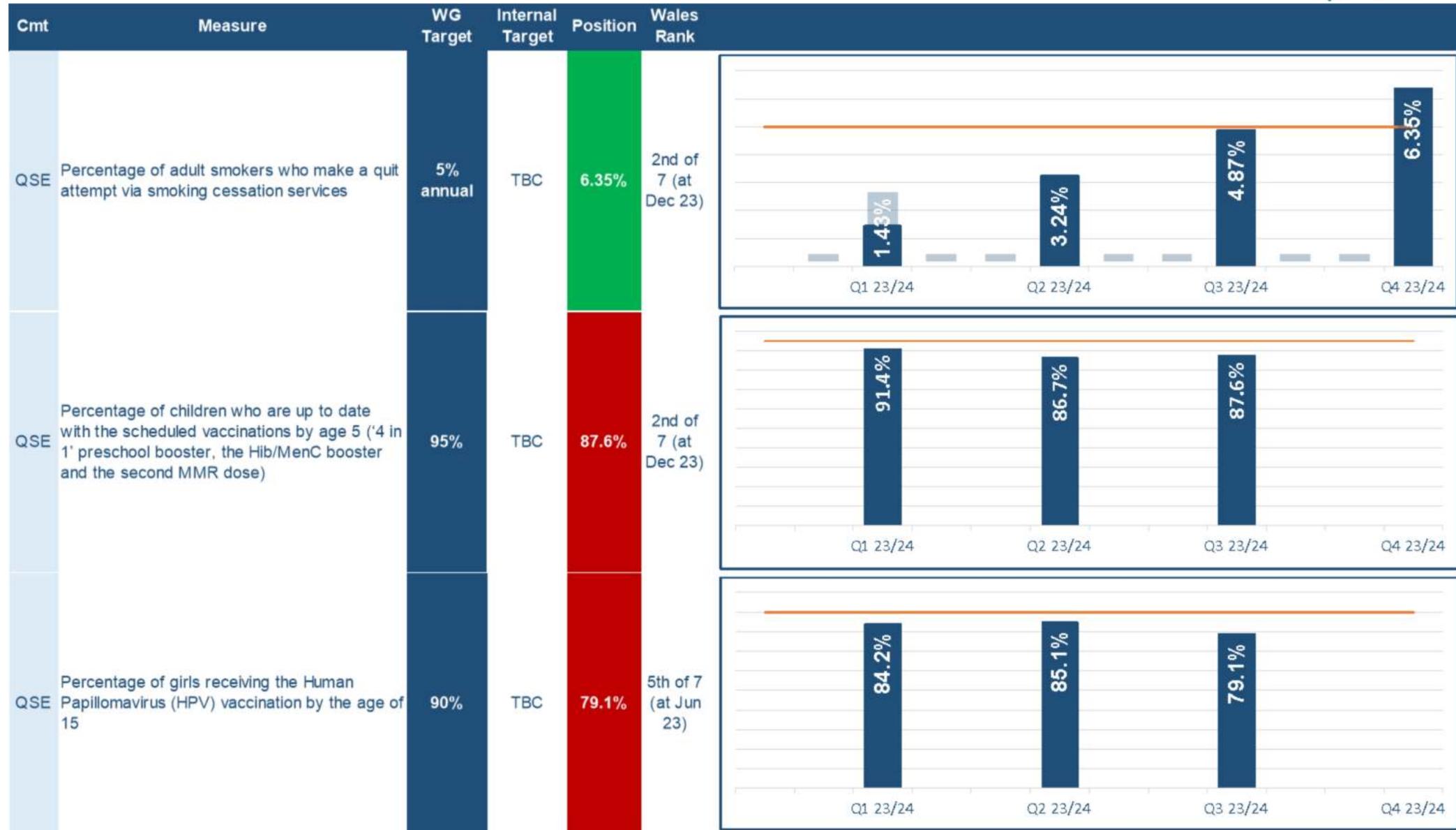
- For eColi, only AB have provisionally achieved the 2023/24 cumulative target. In the Apr-23 to Mar-24 period, HDda had the highest rate of eColi at 100.09 per 100,000 population compared to AB who had the lowest rate at 59.35 per 100,000 population.
- For S.aureus, none of the HBs have provisionally achieved the 2023/24 cumulative target. In the Apr-23 to Mar-24 period, SB had the highest rate of S.aureus at 36.77 per 100,000 population compared to AB who had the lowest rate at 21.81 per 100,000 population.
- For C.difficile, only C&V have provisionally achieved the 2023/24 cumulative target. In the Apr-23 to Mar-24 period, SB had the highest rate of C.difficile at 65.20 per 100,000 population compared to C&V who had the lowest rate at 22.35 per 100,000 population.
- For Klebsiella, none of the HBs have provisionally achieved the 2023/24 cumulative target. In the Apr-23 to Mar-24 period, BCU had the highest number of cases of Klebsiella at 156 compared to SB who had the lowest number at 94.
- For Aeruginosa, all HBs, except BCU and HDda, have provisionally achieved the 2023/24 cumulative target. In the Apr-23 to Mar-24 period, BCU had the highest number of cases of Aeruginosa at 32 compared to C&V who had the lowest number at 18.

Section 1

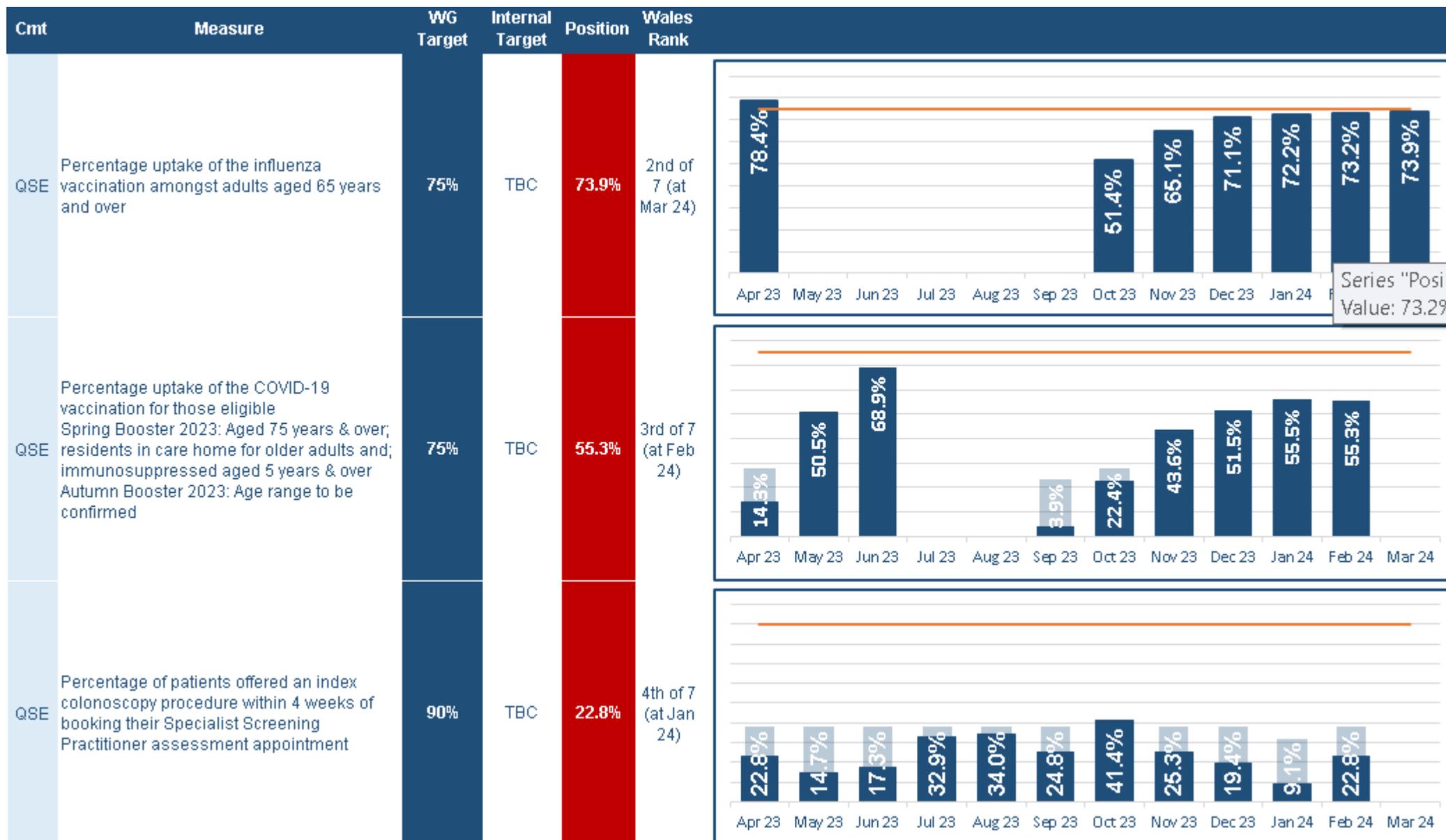
Quality, Safety, Effectiveness and Experience Performance



Quality: Performance



Quality: Performance



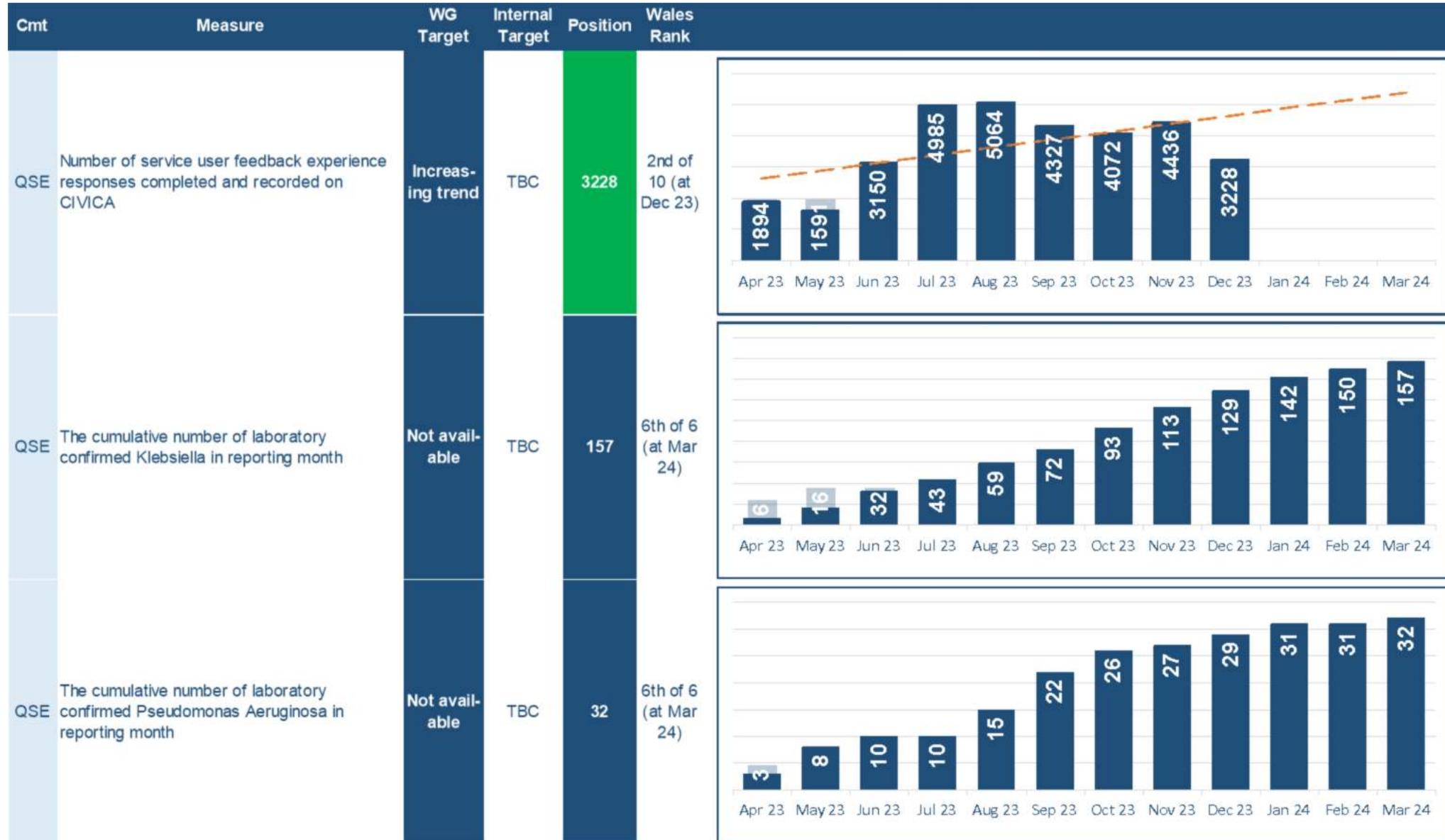
Quality: Performance



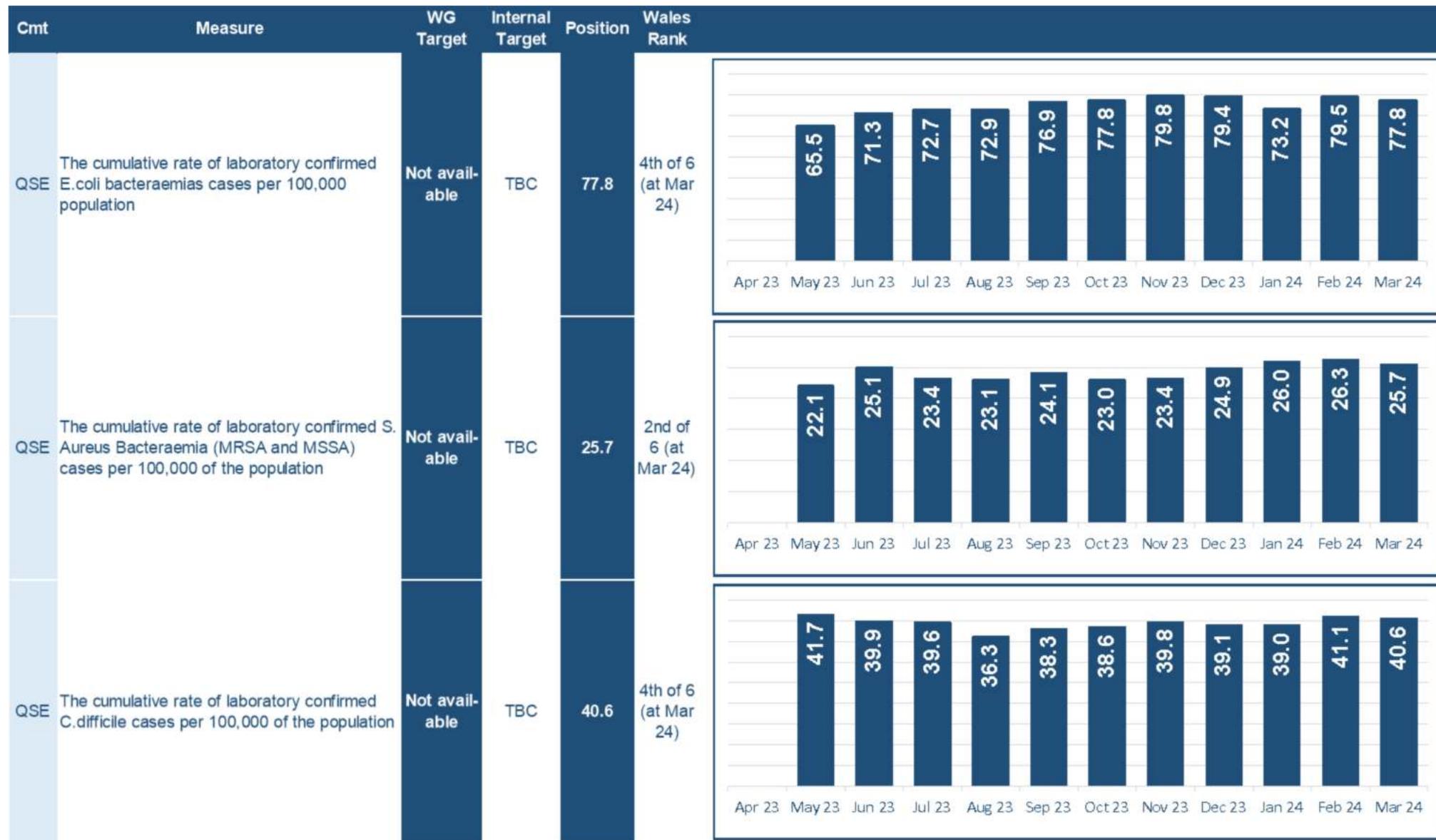
Quality: Performance



Quality: Performance



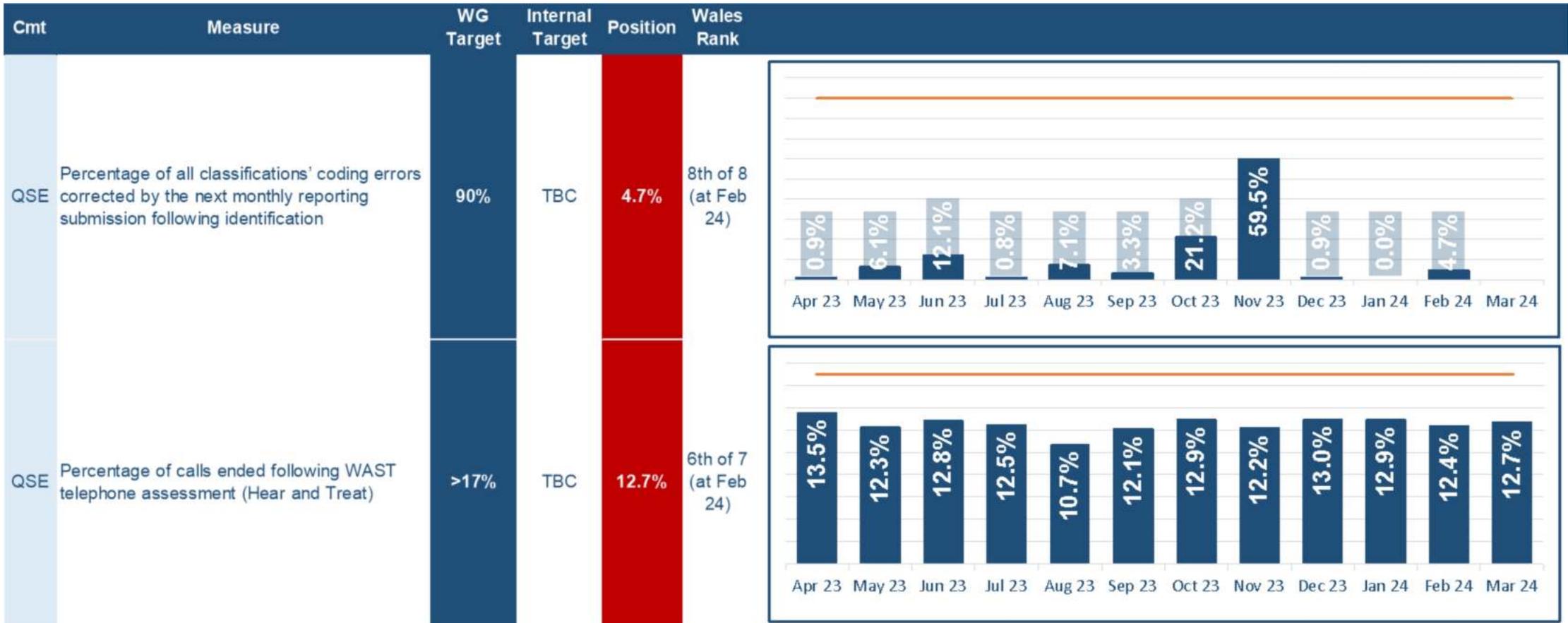
Quality: Performance



Quality: Performance



Quality: Performance



Note: The Executive Director of Nursing and Midwifery is leading work to review the quality metrics provided to the Board through the new format IPR, expected in May 2024. This expanded and enhanced suite of metrics will complement the new format improving Quality Report to the Board.



Additional Information



What is an Integrated Performance Report (IPR)?

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

The Integrated Performance Framework (IPF)

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

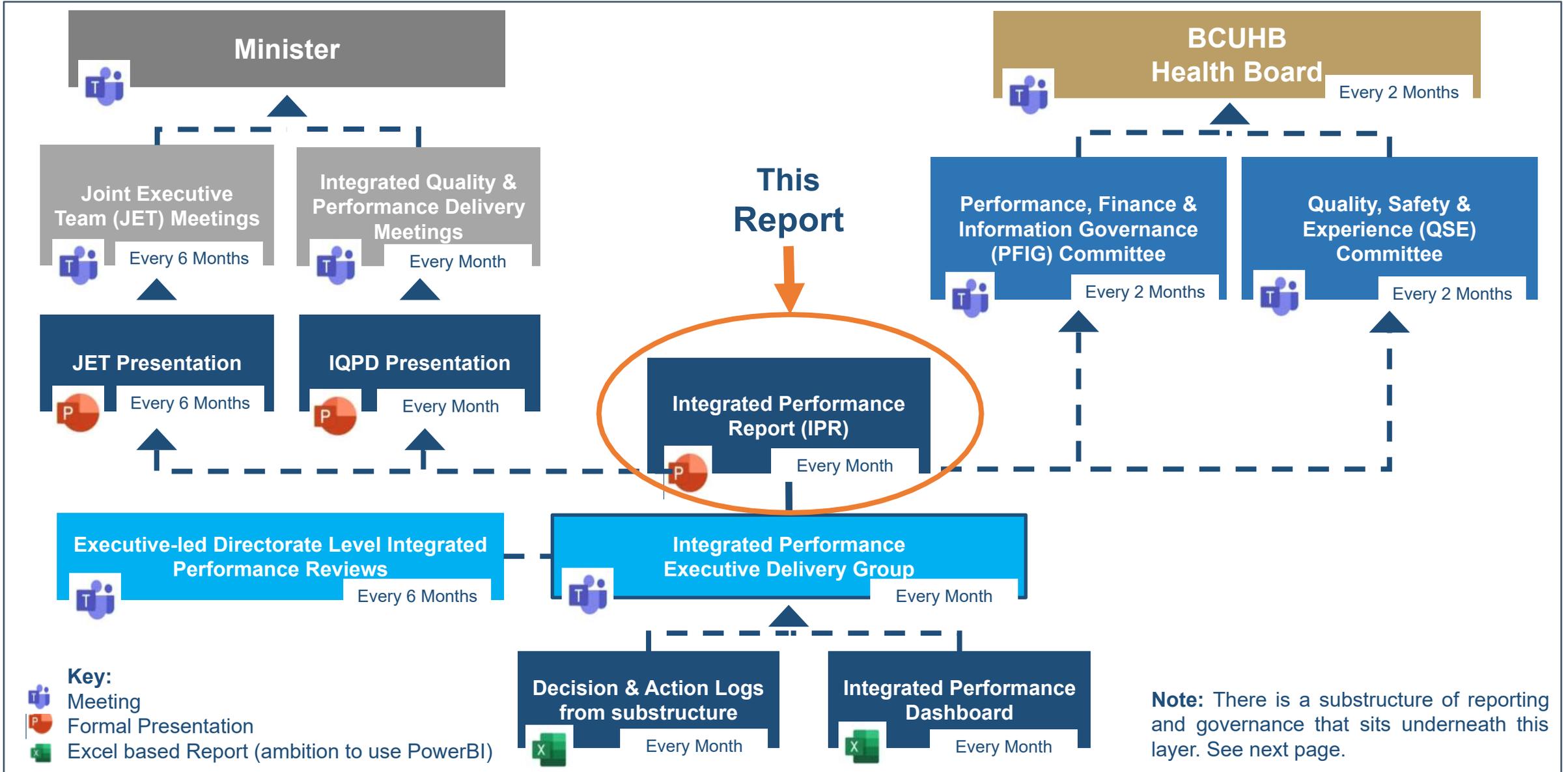
The Integrated Performance Framework sits within a “triumvirate” together with the Integrated Planning Framework and the Risk Management Framework (also ratified at Health Board on the 28th September 2023). This triumvirate of frameworks will encompass the planning, safe delivery and monitoring of the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

Where does the IPR feature within the Performance Governance Structure

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

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

The Integrated Performance Reporting & Governance Superstructure



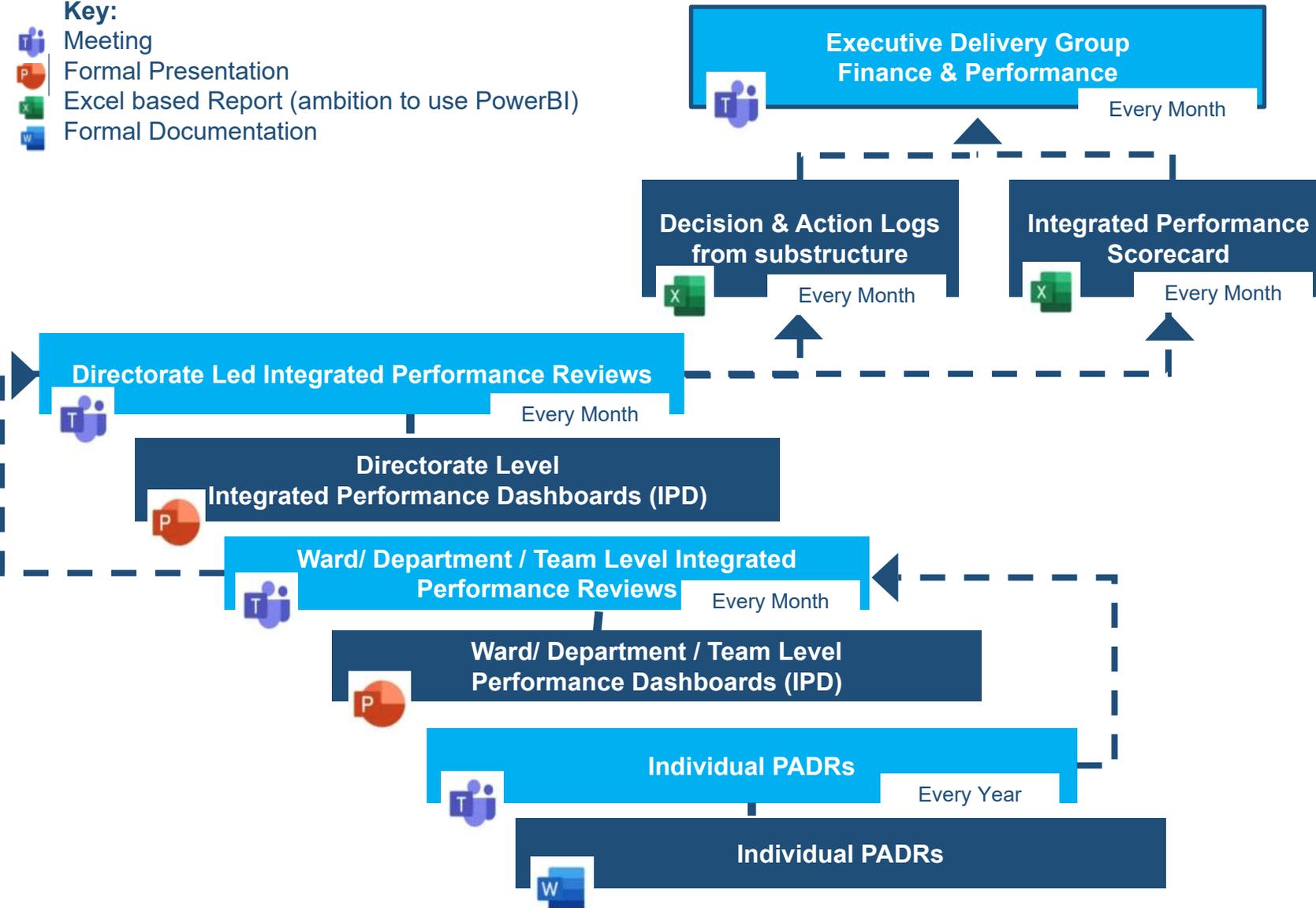


The Integrated Performance Reporting & Governance Substructure

Key:

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

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



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



Integrated Performance Reports



Formal and comprehensive reports to the Health Board and its scrutinising committees, Integrated Quality & Performance Delivery Group (IQPD)(Welsh Government) and Joint Executive Team (JET).

Integrated Performance Scorecards



Summary scorecards for– Integrated Performance Executive Delivery Group et al

Integrated Performance Dashboards



Operational level performance dashboards with drill through capabilities. For end of month's submitted position. Ambition for production in PowerBI. – Produced by Digital, Data & Technology (DDAT) in partnership with the Performance Directorate(PI&AD)

Deep Dive Reports



Detailed Deep Dive reports used in accompaniment to Formal Reports, Scorecards and Dashboards to complement data, provide context, add intelligence and provide assurances as appropriate. Used at all levels as necessary, i.e. to support escalation, de-escalation.

Ad-hoc Reports



Ad-hoc reports used outside of the formal channels and for specific queries to complement data, provide context, add intelligence and provide assurances as appropriate. Used at all levels as necessary to provide additional intelligence and assurances as required.

Our Integrated Performance Report Betsi Cadwaladr University Health Board

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

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

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



follow @bcuhb



<http://www.facebook.com/bcuhealthboard>



Appendix

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

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

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

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

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



Teitl adroddiad: <i>Report title:</i>	Corporate Risk Register Report			
Adrodd i: <i>Report to:</i>	Quality Safety and Experience (QSE) Committee			
Dyddiad y Cyfarfod: <i>Date of Meeting:</i>	Thursday, 06 June 2024			
Crynodeb Gweithredol: <i>Executive Summary:</i>	<p>The purpose of this standing agenda item is to provide an update position of the Corporate Risk Register to which QSE has oversight.</p> <p>The Committee is asked to note the following;</p> <ul style="list-style-type: none"> • CRR24-02 'Patient Falls' – development of the risk to include a wider range of Patient Safety risks for the inclusion of a 'Patient Harm' risk onto the Corporate Risk register • CRR24-09 'Primary and Community Care' – risk to be split into two separate Corporate risks for 'Primary Care' and 'Community Care'. <p>In addition, work will commence in June to examine the development of the 'Areas of Clinical Concern' and 'Timely Diagnosis' risks to incorporate further risks raised by Cancer services.</p> <p>These amendments/reviewed risks will be presented to the next QSE following Executive approval.</p> <p>Appendix 1 Risk Dashboard Appendix 2 Detailed Risk Reports of seven risks</p>			
Argymhellion: <i>Recommendations:</i>	The Committee is asked to receive assurance for the seven corporate risks to which the Committee has overall accountability.			
Arweinydd Gweithredol: <i>Executive Lead:</i>	Pam Wenger, Director of Corporate Governance			
Awdur yr Adroddiad: <i>Report Author:</i>	Nesta Collingridge Head of Risk Management			
Pwrpas yr adroddiad: <i>Purpose of report:</i>	I'w Nodi <i>For Noting</i> <input checked="" type="checkbox"/>	I Benderfynu arno <i>For Decision</i> <input type="checkbox"/>	Am sicrwydd <i>For Assurance</i> <input checked="" type="checkbox"/>	
Lefel sicrwydd: <i>Assurance level:</i>	Arwyddocaol <i>Significant</i> <input type="checkbox"/> <small>Lefel uchel o hyder/tystiolaeth o ran</small>	Derbyniol <i>Acceptable</i> <input checked="" type="checkbox"/> <small>Lefel gyffredinol o hyder/tystiolaeth o ran</small>	Rhannol <i>Partial</i> <input type="checkbox"/> <small>Rhywfaint o hyder/tystiolaeth o ran</small>	Dim Sicrwydd <i>No Assurance</i> <input type="checkbox"/> <small>Dim hyder/tystiolaeth o ran y ddarpariaeth</small>



	darparu'r mecanweithiau / amcanion presennol <i>High level of confidence/evidence in delivery of existing mechanisms/objectives</i>	darparu'r mecanweithiau / amcanion presennol <i>General confidence / evidence in delivery of existing mechanisms / objectives</i>	darparu'r mecanweithiau / amcanion presennol <i>Some confidence / evidence in delivery of existing mechanisms / objectives</i>	<i>No confidence / evidence in delivery</i>
<p>Cyfiawnhad dros y gyfradd sicrwydd uchod. Lie bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: N/A</p> <p><i>Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this: N/A</i></p>				
<p>Cyswllt ag Amcan/Amcanion Strategol:</p> <p><i>Link to Strategic Objective(s):</i></p>	<p>Links to the BAF detailed in respective CRR reports</p>			
<p>Goblygiadau rheoleiddio a lleol:</p> <p><i>Regulatory and legal implications:</i></p>	<p>It is essential that the Health Board has robust arrangements in place to assess, capture and mitigate risks, as failure to do so could have legal implications for the Health Board.</p>			
<p>Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal?</p> <p><i>In accordance with WP7 has an EqIA been identified as necessary and undertaken?</i></p>	<p>Not applicable for this report</p>			
<p>Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal?</p> <p><i>In accordance with WP68, has an SEIA identified as necessary ben undertaken?</i></p>	<p>Not applicable for this report</p>			
<p>Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR)</p> <p><i>Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)</i></p>	<p>Links to the BAF detailed in respective CRR reports</p>			
<p>Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith</p> <p><i>Financial implications as a result of implementing the recommendations</i></p>	<p>The effective and efficient mitigation and management of risks has the potential to leverage a positive financial dividend for the Health Board through better integration of risk management into business planning, decision-making and in shaping how care is delivered to our patients thus leading to enhanced quality, less waste and no claims.</p>			
<p>Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith</p> <p><i>Workforce implications as a result of implementing the recommendations</i></p>	<p>Failure to capture, assess and mitigate risks can impact adversely on our workforce.</p>			

<p>Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori</p> <p><i>Feedback, response, and follow up summary following consultation</i></p>	<p>Individual Executive sign off of CRR reports, Review at Risk Management Group 09/04/2024 and Executive Team 10/04/2024.</p>
<p>Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)</p> <p><i>Links to BAF risks:</i> (<i>or links to the Corporate Risk Register</i>)</p>	<p>See the individual risks for details of the related links to the Board Assurance Framework.</p>
<p>Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)</p> <p><i>Reason for submission of report to confidential board (where relevant)</i></p>	<p>Not applicable for this report</p>
<p>Camau Nesaf:</p> <p><i>Next Steps:</i> Submission of Corporate Risks to the July Board meeting Further strengthening of Patient Safety Corporate Risk Development of 'Community Care' as a stand-alone Corporate Risk</p>	
<p>Rhestr o Atodiadau:</p> <p><i>List of Appendices:</i> Appendix 1 –Dashboard</p> <p>Appendix 2 – Corporate Risk Register Report:</p> <ol style="list-style-type: none"> 1. Patient Safety-Falls 2. Safeguarding 3. Failure to Embed Learning 4. Community Care and Primary Provision 5. Areas of Clinical Concern 6. Timely Diagnostics 7. Harm from Medical Devices/Equipment 	

Corporate Risk Register Report

The corporate risk dashboard (Appendix 1) below provides a list of the 7 corporate risks to which the Quality Safety and Experience (QSE) Committee has within its remit.

The Committee is asked to note changes in relation to:

- CRR24-02 'Patient Safety – Falls' (risk score 20) – to further develop the risk to include a wider range of Patient Safety risks i.e. avoidable patient deterioration and healthcare acquired pressure ulcers to provide a more strategic narrative on patient safety risks to the Executive Team and Committees. The Patient Safety team are in the process of reviewing their entire risk register, conducting a gap analysis and updating this accordingly prior to further developing a more strategic risk. A Draft has been requested by the Corporate Risk Management Team.
- CRR24-09 'Primary and Community Care' (risk score 20) - to separate Primary and Community Care into two standalone risks on the Corporate Risk Register, work is underway to develop the Community Care risk and will be presented following full development and Executive approval.
- The Committee will note that there has been an update on the actions related to CRR24-12 'Areas of Clinical Concern' (risk score 15). In addition to this, work will commence in June to examine the further development of 'Areas of Clinical Concern' risk and CRR24-13 'Timely Diagnosis' to incorporate risks raised by Cancer services. Any amendments/reviewed risks will be presented to the next QSE following Executive approval.

FUTURE DEVELOPMENT OF THE RISKS ALIGNED TO THE COMMITTEE

The Board will be considering at a future session the alignment of the risks to the Three Year Plan and in doing so, the risks currently aligned to the Quality, Safety and Experience Committee will need to be reviewed. For example, the risk covering the areas of clinical concern is too generic and will need to be separated into the specific services that are of risk with clear action to manage the risks. The focus going forward must be on clarity on the risk and actions to mitigate the risk, with an expectation of movements in risks as actions are implemented.

Next steps

1. Submission of Corporate Risks to the July Board meeting
2. Further strengthening of Patient Safety Corporate risk
3. Development of 'Community Care' as a standalone Corporate risk
4. Review of 'Areas of Clinical Concern' and 'Timely Diagnostics' risks

Appendix 1 - Corporate Risk Register Dashboard

Lead	Ref	Risk Title	Current Score (Impact x Likelihood)	Risk Target Score	Appetite Main Risk Type	Lead Board Committee	Risk Management Commentary
					Appetite Level		
EDoN	CRR24-02	Patient Safety-Falls	4 x 5 = 20 ↔	12	Quality 3 - Open	Quality, Safety and Experience Committee	Opened Dec 23. 7 actions identified, 2 completed, 4 overdue, 1 new action. Some action dates amended from the 31/03/2024 to the 30/04/2024. However, work ongoing by the service to further develop a broader patient safety risk.
EDoN	CRR24-03	Safeguarding	4 x 3 = 12 ↓	8	Quality 3 - Open	Quality, Safety and Experience Committee	Opened Dec 23. 8 actions identified, 1 completed, 7 progressing, highlighted, some, action deadlines have all been extended to July 2024. Scored reduced 18/04/24 from 16 to 12. Minor Quality Assurance comments sent to the service lead around gaps in controls which will need to be further refined into controls as opposed to statements.
EDoN	CRR24-04	Failure to Embed Learning	5 x 4 = 20 ↔	5	Reputational 4 - Seek	Quality, Safety and Experience Committee	Opened Dec 23, 10 actions identified, 2 completed (rolled into QMS action), 5 progressing. March 2024 highlighted action deadlines have all been extended to April-June 2024. The current risk score remains at 20. Some actions delayed due to reliance on NHS Executive National team.
EDoO	CRR24-09	Primary Provision	4 x 5 = 20 ↔	12	Quality 3 - Open	Quality, Safety and Experience Committee	Opened Feb 24, 5 actions identified, 1 completed, 4 progressing. Actions are on track for the 2025 target date. However, the inherent and current risk scores are both 20 , indicating the controls are not yet reducing the risk. Timely development of a Primary Care strategy and governance model is key to reducing this risk, along with resourcing plans to address workforce and capacity gaps to reduce the likelihood of 5 . Work is ongoing to split the risk into a separate community risk.
EDoO	CRR24-12	Areas of Clinical Concern	5 x 3 = 15 ↔	12	Quality	Quality, Safety and	Opened Feb 24, 6 actions identified, 0 completed, 6 progressing. The lack of substantive medical leads and reliance on locum staffing for several fragile services is impeding progress. Focused leadership and clinical pathway work is

		(encompasses ophthalmology and dermatology)			3 – Open	Experience Committee	needed to mitigate this risk. Work is ongoing to further develop the risk and consider adding further actions to reflect Cancer services risks. The Risk Management Team have received updates to the original current “actions” during May 2024. Further work in early June needs to take place to reflect the Cancer services risk in time for review by the next Executive Team report on risk.
EDoTH	CRR24-13	Timely Diagnostics	5 x 4 = 20 ↔	5	Reputational 4 – Seek	Quality, Safety and Experience Committee	Opened Feb 24, 5 actions identified, 0 completed, 5 progressing. All actions are on track against the 2025 target date. Challenges remain around radiology staffing, ageing IT infrastructure and acting on test results and development of a Diagnostic Strategy and workforce plan required to reduce risk impact of 5.
EDoTH	CRR24-14	Harm from the Medical Devices/Equipment	4 x 4 = 16 ↔	8	Quality 3 – Open	Quality, Safety and Experience Committee	Opened Feb 24, 6 actions identified, 0 completed, 4 progressing, 2 overdue . The overdue action around internal communication requires focus. More progress is needed on risk-based prioritisation and securing capital funding to address the £33m of outdated equipment and ensure compliance with regulations.

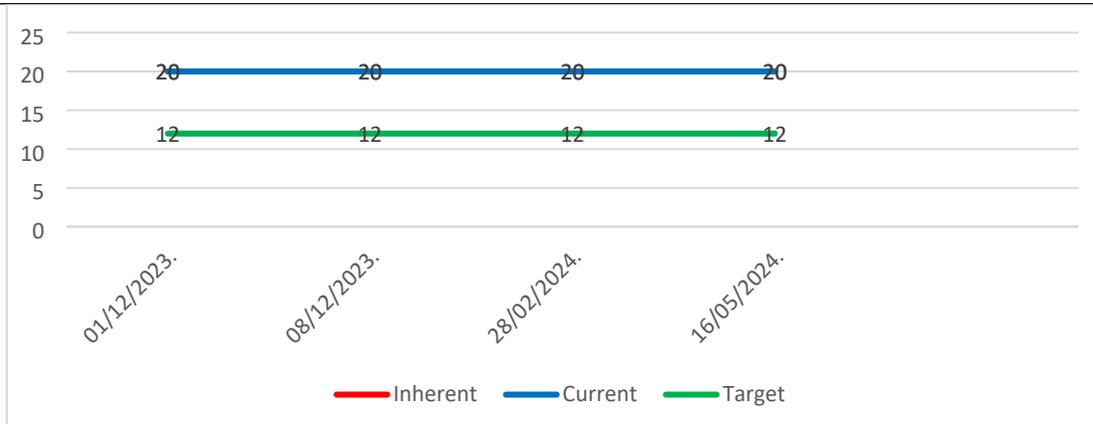
Key:

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

Appendix 2 – Corporate Risk Register Report

CRR 24-02	Risk Title: Patient Safety - Falls		Date Opened: 01/12/2023		
	Assuring Committee: Quality, Safety and Experience Committee		Date Last Committee Review: 18/04/2024		
Date Last Reviewed: 16/05/2024	Director Lead: Executive Director of Nursing and Midwifery	Link to BAF: N/A		Target Risk Date: 30/04/2024	
<p>There is a risk to patient safety, in particular harm, as a result of slips, trips and falls within Secondary Care acute sites. This may be caused by patients acuity/clinical condition/frailty alongside contributory factors such as reduced staffing, segregated areas and premises which do not allow for ease of oversight, compliance with manual handling training, compliance of falls risk assessment and subsequent implementation of mitigating actions. This could result in poorer patient health outcomes, extended hospital stay, regulatory non-compliance and litigation and associated financial impact.</p>					
Mitigations/Controls in place		Lines of Assurances		Additional Controls required	
<p>1. Mandatory E learning modules (1a and 1b) for Falls Prevention launched and monitoring in place for completion via the Strategic Inpatient Falls Group. Health Board compliance currently 1a 93.83%, 1b 94.55%.</p> <p>2. Manual Handling training data cascaded monthly to respective IHC's/Division Director of Operations to include compliance, Did Not Attend rates and available capacity for upcoming 2 months.</p> <p>3. Welsh Nursing Care Record (WNCR) has been implemented which has an electronic version of the Falls and Bone Health Multifactorial Assessment (FBHMA) that is identified on the dashboard if not completed and monitored for compliance by the Ward Manager.</p> <p>4. How to /good practice guide developed and implemented to support with completion and quality of FBHMA across all Adult Inpatient wards:</p> <p>5. Peer review process in place for 3 months to improve quality of the FBHMA across adult inpatient wards.</p> <p>6. Falls review groups in place across the Health Board with exception reporting, updating of improvements to Strategic Inpatient Falls Group.</p>		<p>1st – eg. Operational:</p> <ol style="list-style-type: none"> Strategic Inpatient Falls Group - Integrated Health Community (IHC) and Divisional falls review groups report to the falls leads who report to the strategic group. Ward accreditation metrics Ward accreditation review process Peer reviews Patient Safety Group <p>2nd – eg. Risk and Compliance:</p> <ol style="list-style-type: none"> Risk Management Group Executive Team Meeting <p>3rd – eg. Independent:</p> <ol style="list-style-type: none"> Internal Audit HSE Regulatory inspections and investigations – HSE, HIW, CIW, PSOW WG performance monitoring and assurance Welsh Government Reviews 		<ol style="list-style-type: none"> Falls prevention and management policy to be ratified and relaunched - has been updated to include a clear step by step approach to completion of the Falls and Bone Health Multifactorial Assessment (FBHMA) and post falls management and currently under review with Patient Safety Group. Assurance and training of agency workers. Improved compliance with manual handling training. Sustained improvement in the quality of completion of FBHMA. 	
Actions				Due Date	Progression Analysis

New updated and revised Falls Prevention and Management Policy NU06 reviewed in BCUHB Patient Safety Group to be ratified and re-launched. Policy approved at Patient Safety Group, disseminated and uploaded to Betsinet	30/12/2023	Completed
Audit of Ward Managers induction for agency/temporary staff to ensure falls training has been completed.	30/04/2024	Overdue
Continues to be raised with Temporary Staffing, waiting for update. Falls training has been prioritised on onboarding checklist		
Capacity within the Manual Handling training team to be optimised with focused recruitment drive for Band 6 posts (x3) supported by workforce	30/04/2024	Overdue
Manual Handling corporate team to progress contract arrangements for external training facilities to support capacity	30/04/2024	Overdue
Outcome of peer review pilot to be evaluated	30/04/2024	Completed
Peer reviews discussed at strategic falls group and quality of risk assessments have shown some improvement. Review of quality of risk assessments need to form part of business as usual and this is part of the ward metrics. The patient safety team are conducting spot checks of the Risk Assessments on the acute wards. Some areas are also conducting spot checks via the Weekly Harms Meetings and chairs of the groups know 'what good looks like'. Plans to embed as part of Board Round process to be discussed with Senior Nurses – New action created		
Future enhancement to the Welsh Nursing Care Record on an all-Wales basis.	30/04/2024	Overdue (Revised date)
still no progress from All Wales group	31/05/2024	
Embed sample review of Falls Risk Assessment at Board Rounds	31/07/2024	New action



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

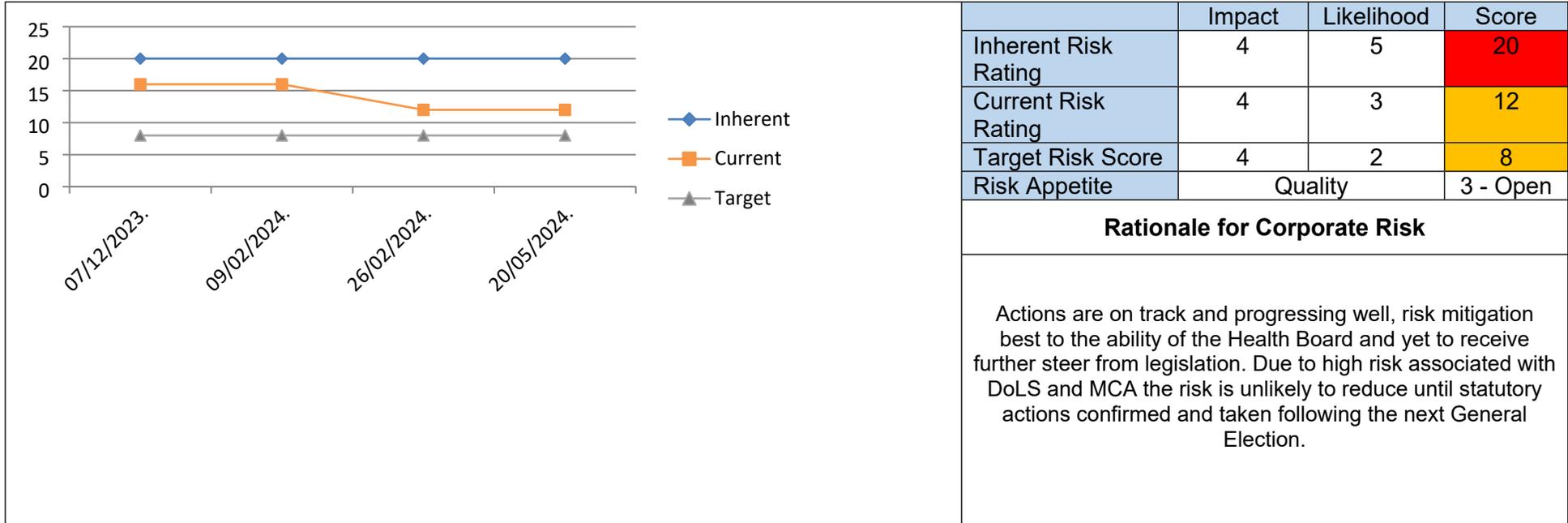
	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	5	20
Target Risk Score	4	3	12
Risk Appetite	Quality		3 - Open

Rationale for Corporate Risk

This is in line with the Falls Internal Audit limited assurance report. Disproportionate high number of avoidable falls across the Health Board compared to other NHS providers.

CRR 24-03	Risk Title: Safeguarding		Date Opened: 07/12/2023
	Assuring Committee: Quality, Safety and Experience Committee		Date Last Committee Review: 18/04/2024
Date Last Reviewed: 20/05/2024	Director Lead: Executive Director of Nursing and Midwifery	Link to BAF: N/A	Target Risk Date: 31/03/2025
<p>There is a risk that BCU may fail in its statutory duties to protect vulnerable groups from harm. This could be caused by gaps in safeguarding governance, insufficient workforce training and engagement, complexity of legal frameworks, and lack of resources to manage growing demand. The impact may result in harm to at-risk adults, children or young persons, victims of violence/abuse, patients unlawfully detained, financial penalties, reputational damage and non-compliance with Safeguarding legislation which includes but is not exclusive to the Social Services and Wellbeing (Wales) Act 2014, the Deprivation of Liberty Safeguards, and the Mental Capacity Act.</p>			
Mitigations/Controls in place	Lines of Assurances		Additional Controls required
<p>1. Standardised formal reporting and escalation of activity, mandatory compliance and exception reports are presented in line with Health Board Governance and Reporting Frameworks.</p> <p>2. Audit findings and data are monitored and escalated. Risk Management has been embedded into the processes of the reporting framework.</p> <p>3. BCUHB mandatory safeguarding training is in place for all staff.</p> <p>4. Welsh Government interim monies has supported temporary the implementation of additional Mental Capacity Act (MCA) training, the completion of Deprivation for Liberty (DoLS) applications, and strengthened the implementation of Court of Protection DoL for 16/17-year-olds.</p> <p>5. BCUHB local work programmes are in place and aligned to the National Strategies which are regularly reported to Welsh Government.</p> <p>6. Safeguarding support the Sexual Abuse Referral Centre (SARC) implementation, compliance and accreditation but the accountability remains with the Central Integrated Health Community (IHC).</p> <p>7. Fully engaged and supporting the Single Unified Safeguarding Review led by Welsh Government and the Home Office/Central Government for the re-write of Safeguarding and Homicide Reviews.</p>	1st – eg. Operational:		<p>1. New legislation and statutory guidance driven by case law, UK and Welsh Government impacts upon the organisation and the date of implementation is not within BCUHB control.</p> <p>2. The increase in safeguarding activity with enhanced complexity has resulted in the delay of the implementation of strategic and operational interventions.</p> <p>3. Local Authorities frequently develop independent local guidance which requires duplication of implementation across BCUHB. This is time consuming and can result in reduced compliance.</p> <p>4. The rise in the number of DoLS assessments has resulted in a backlog. Current post holders work additional hours, weekends and evenings. There are local and national staffing challenges with regard to the recruitment of Safeguarding, MCA and DoLS specialist staff. This is recognised by Public Health Wales and WG. We support flexible working arrangements within the team to ensure staff retention. Reduced</p>
	1. The risks is monitored monthly and reviewed at the Safeguarding Governance and Performance Group		
	2nd – eg. Risk and Compliance:		
	1. Risk Management Group 2. Executive Team		
	3rd – eg. Independent:		
	1. Mental Capacity Act training compliance and the DoLS backlog is monitored and reported into Welsh Government. 2. This risks are regularly monitored and reviewed by the statutory engagement with the North Wales Safeguarding Board. 3. BCUHB are fully engaged in National and Regional Forums to provide assurance of the implementation of legislation.		

		<p>leadership team capacity due to absences. .</p> <p>A risk assessment and an amendment to the service delivery structure is in place to mobilise staff where required.</p> <p>5. There is a lack of governance and reporting of Court of Protection activity relating to a Community setting. Immediate safeguards are in place and work is taking place to develop a standard procedures.</p>	
Actions		Due Date	Progression Analysis
Review of the safeguarding team and structure A review of the safeguarding team structure has started, a report will be submitted in March 2024		31/07/2024	Date Revised from March 2024
National development and implementation of Single Unified Safeguarding Review SUSR training has been approved by WG. BCUHB attending February 2024		31/03/2025	Progressing
Implementation and monitoring of the 'Workforce Safeguarding Responsibilities SoP', Approved at SGPG being shared at QDG during February2024.		31/03/2024	Completed
North Wales Sexual Assault Referral Centre (SARC) to meet the National Service ISO Specifications, discussions ongoing.		31/07/2024	Date Revised from March 2024
Development of a DoLS/CoP DoL Standard Operating Protocol (SoP)		31/07/2024	Date Revised from March 2024
CNO is undertaking a safeguarding audit of provision which will provide a benchmark for consideration		30/07/2024	Date Revised from March 2024
Whilst awaiting the All Wales Data Module conduct a review of the current data capture processes that inform current service demand and future projections which will identify potential gaps and manual data collection practices		31/07/2024	Date Revised from March 2024
Risks associated with the DoLS & MCA May 2024 Audit		31/03/2025	Progressing



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	3	12
Target Risk Score	4	2	8
Risk Appetite	Quality		3 - Open

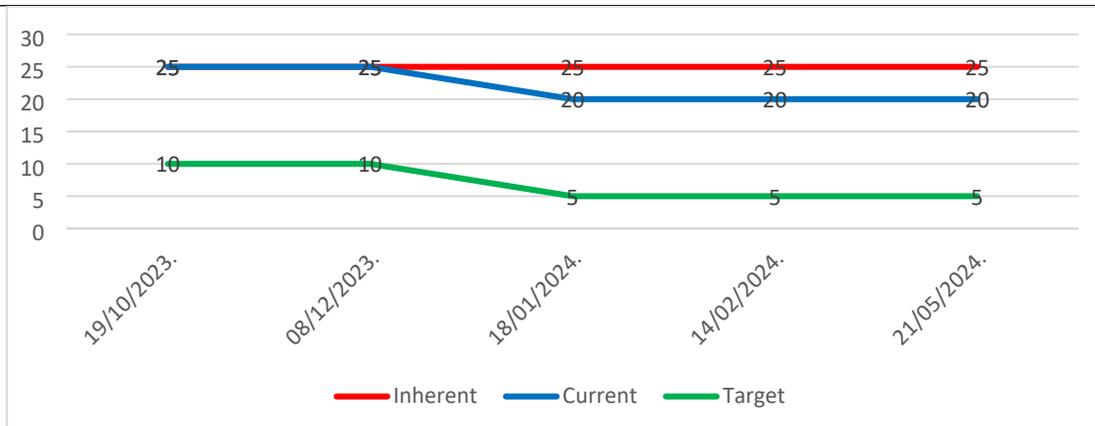
Rationale for Corporate Risk

Actions are on track and progressing well, risk mitigation best to the ability of the Health Board and yet to receive further steer from legislation. Due to high risk associated with DoLS and MCA the risk is unlikely to reduce until statutory actions confirmed and taken following the next General Election.

CRR 24-04	Risk Title: Failure to Embed Learning		Date Opened: 19/10/2023
	Assuring Committee: Quality, Safety and Experience Committee		Date Last Committee Review: 18/04/2024
Date Last Reviewed: 21/05/2024	Director Lead: Executive Director of Nursing and Midwifery	Link to BAF: SP18 - Quality, Innovation and Improvement	Target Risk Date: 30/09/2024
<p>There is a risk that the Health Board could fail to meet requirements for timely review and learning from mortality cases, claims, inspections, incidents and complaints. This could be caused by insufficient resources, lack of unified processes, outdated IT systems, duplication of effort, and overreliance on single personnel. The impacts may include missed opportunities for improvement, lack of family/carer engagement, potential patient harm events going undetected, non-compliance with national frameworks or legislation, and reputational damage.</p>			
Mitigations/Controls in place	Lines of Assurances		Additional Controls required
<ol style="list-style-type: none"> 1. Putting Things Right and clinical review processes and monitoring 2. Risk management processes 3. Audit programmes & monitoring arrangements 4. Patient and carer feedback and involvement processes 5. Senior sign-off process for National Reportable Incidents (NRIs) and Complaints 6. Clinical policies, procedures, guidelines, pathways, supporting documentation & IT systems 7. Clinical staff recruitment, induction, mandatory and professional training, registration & re-validation 8. Defined nurse staffing levels for all wards & departments as per Nurse Staffing Act 9. Ward accreditation schemes and ward manager/matron checks/audits. 10. Tracking of regulatory action plans 11. Internal Reviews against External National Reports 	1st – e.g. Operational:		<ol style="list-style-type: none"> 1. Development of a Quality Management System (QMS) setting out an integrated approach to Quality Planning, Control, Assurance and Improvement 2. Clarity on quality leadership, structures and accountabilities 3. Review of the quality governance framework of meetings and reporting 4. Development of a quality learning framework, aligned to the overall learning organisation programme 5. Review of Putting Things Right and clinical review processes and monitoring 6. Resolution of outstanding overdue positions for incidents, complaints, claims, mortality reviews and inquests
	<ol style="list-style-type: none"> 1. Service and IHC Quality Groups (with reporting) 2. Quality Delivery Group, its sub-groups (with reporting) 3. Executive performance reviews with IHCs 4. Clinical audit 5. Regulatory Assurance Group and oversight/assurance reporting 6. Annual Quality Report, Annual Putting Things Right Report and Annual Duty of Candour Report 		
	2nd – e.g. Risk and Compliance:		
	<ol style="list-style-type: none"> 1. Executive performance reviews with IHCs 2. Risk Management Group 3. Executive Team Meeting 		

<p>12. Getting it Right First Time (GIRFT), localised deep dives, reports and action plans</p> <p>13. HIW, Ombudsman, Coroner NHS Wales Exec and WG engagement Meetings</p>	<p>3rd – e.g. Independent:</p> <ol style="list-style-type: none"> 1. Internal Audit 2. Clinical audit 3. Regulatory inspections and investigations – HSE, HIW, CIW, PSOW 4. WG performance monitoring and assurance 5. Welsh Government Reviews 6. Royal College Reviews 		
Actions		Due Date	Progression Analysis
<p>The Quality Governance Framework will be reviewed and refreshed and will include greater clarity on the roles, responsibilities and authorities of all groups including the reporting expectations, process and templates. This will include mapping meetings into an overall cycle and introducing standard templates and a single document repository This work is being taken forward with the support of the NHS Wales Executive as part of the Quality Governance Intervention, who are currently observing to inform their recommendations, therefore the work will take slightly longer and a revised date of 30 June 24. A QSE Committee workshop is being held on 29/05/2024.</p>		30/06/2024	Date Revised from March 2024
<p>Best practice guidance will be issued to IHCs and Regional Divisions to support effective local quality governance arrangements This work is being taken forward with the support of the NHS Wales Executive</p>		30/06/2024	Date Revised from March 2024
<p>A Quality Dashboard will be developed underpinned by a series of specialist dashboards (i.e. falls, complains, etc). These dashboards will create a single version of the truth using agreed metrics directly connected to the quality systems for real time data Work is progressing on the Dashboard and a test version is live however technical issues remain in extracting and presenting data – these are being resolved and the Dashboard will be soft launched on 01 June 2024.</p>		31/05/2024	Date Revised from April 2024
<p>A central and digital library of learning will be established which will be launched alongside a revised approach to the collation, analysis and dissemination of learning. The system prototype is in place and will be tested with MHLD during Q1 with a view to refinement based on the feedback and roll-out over the summer.</p>		30/09/2024	Date Revised from April 2024
<p>The approach to quality assurance will be reviewed and refreshed and a new regulatory procedure and quality assurance procedure will be developed This work is being taken forward with the support of the NHS Wales Executive as part of the Quality Governance Intervention, who are currently observing to inform their recommendations, therefore the work will take slightly longer and a revised date of 30 June This action is being discontinued with the work rolled into the QMS (see below).</p>		30/06/2024	Completed (action rolled into QMS action)

<p>The new Quality Strategy will be developed through a co-design process A refreshed approach to planning arising from Special Measures - a separate Quality Strategy will not be produced and quality will be part of the overall organisational strategy underpinned by a QMS, see below. A quality section for the ongoing planning process has been written and submitted – May 2024 – Revised date from 03/24 to 05/24 due to external dependencies. This action is being discontinued with the work rolled into the QMS (see below).</p>	31/05/2024	Completed (action rolled into QMS action)
<p>A Quality Management System will be developed in line with the Duty of Quality, which will describe how Quality Planning, Quality Control, Quality Assurance and Quality Improvement will work together as a collective quality system Update - The initial draft of a QMS is due at Board in May 2024. Therefore, the deadline will be extended. A QMS working group is in place, the first meeting was 13 December 2023. There was a workshop at the Executive Team on 24/01/24, at the Senior Leadership Team on 30/01/24, and at the Board on 29/02/24. The Quality Team visited ELFT (an Outstanding rated English Trust) on 26/02/24. The Quality Team are part of the all-Wales working group. Research has been undertaken into work in Wales and Scotland. Support is being provided by Improvement Cymru and the NHS Wales Executive National Quality Team. We plan two further meetings of the working group, and a wider engagement workshop in April May 2024 – Revised date from 03/24 to 05/24 due to external dependencies</p>	31/05/2024	Date Revised from March 2024
<p>The Terms of Reference and Cycle of Business for the Organisational Learning Forum is being refreshed and revised to build on and strengthen the work of the group.</p>	30/06/2024	New action
<p>A project has been commissioned to develop a new, integrated approach to Investigating and Learning from Incidents, Complaints and Mortality Reviews – this new policy is due at Board for approval in July 2024</p>	31/07/2024	New action
<p>A Learning from Investigations Project has been commissioned to review all open cases due at inquest and to ensure the investigations and evidence of learning is robust. Phase 1 of this project is due for completion by the end of June 2024. The learning from this work will inform the new Investigating and Learning from Incidents, Complaints and Mortality Reviews Policy and process.</p>	30/06/2024	New action



	Impact	Likelihood	Score
Inherent Risk Rating	5	5	25
Current Risk Rating	5	4	20
Target Risk Score	5	1	5
Risk Appetite	Reputational		4 - Seek

Rationale for Corporate Risk

Significant backlog of incidents waiting investigation and new cases demonstrating learning has not been embedded

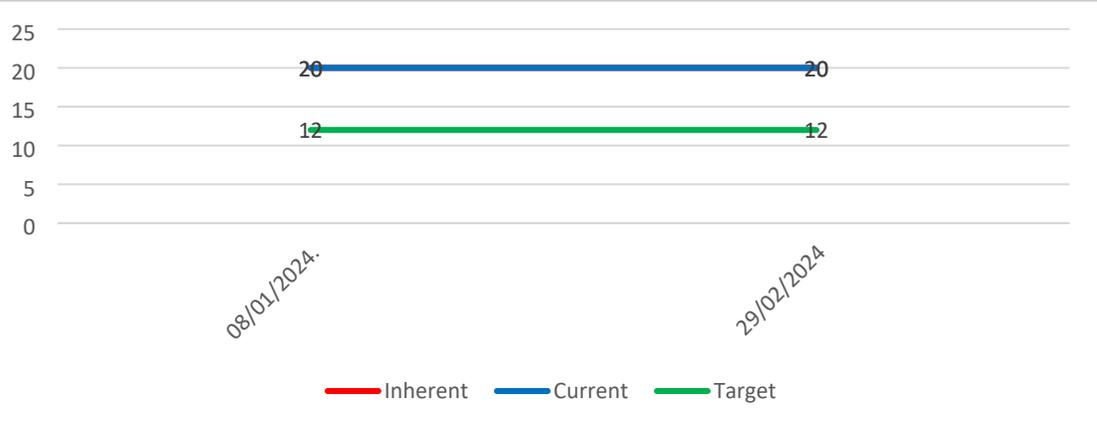
Draft –Work ongoing to split the risk into Primary and Community Care separately

CRR 24-09	Risk Title: Primary and Community Care services		Date Opened: 08/02/2024
	Assuring Committee: Quality, Safety and Experience Committee		Date Last Committee Review: New Risk
Date Last Reviewed: 29/02/2024	Director Lead: Executive Director of Operations (Executive Director Transformation And Strategic Planning)	Link to BAF: N/A	Target Risk Date: 31/03/2025
<p>There is a risk of the Health Board not fully meeting its legal obligation to provide accessible and high-quality primary and community care services. This may be due to challenges stem from various factors including staffing shortages, recruitment and retention issues, inadequate resources, limited prevention services, and funding constraints exacerbated by population growth and transient demographics. Moreover, deficiencies in strategic planning, data management, and information sharing further compound these challenges. The ramifications are wide-ranging, impacting the sustainability of primary care professions, patient access, timely diagnosis, and appropriate healthcare utilisation. This results in a demoralised primary care workforce, increased strain on emergency services, prolonged hospital stays, preventable admissions, lapses in care, regulatory non-compliance, and declining population health indicators. Consequently, there is a cascading effect on patient flow, service performance, care quality, collaborative partnerships, cost-effectiveness, and the viability of primary care and community care models. The ultimate consequence is a rise in mortality rates, treatment delays, and extended hospitalisations, exacerbating patients' health conditions.</p>			
Mitigations/Controls in place	Lines of Assurances		Additional Controls required
<ol style="list-style-type: none"> Escalation and sustainability report to address risks associated with workforce and workload pressures allows for early identification and management. Risk management training completed Q3 2023 for all primary care leaders for better identification and management. Programme management implemented to monitor and drive strategic priorities. Primary Care Quality and Delivery Group established Q3 23/24 	1st – eg. Local Assurances:		<ol style="list-style-type: none"> Greater Health Board oversight of Primary Care issues and risks. Strategy and resources to support introduction of new roles, ways of working and models of service delivery. Improved governance structures, process and procedures. Equity of resource to support primary care transformation, management and governance.
	<ol style="list-style-type: none"> Primary Care Quality and Delivery Group Primary Care Panel 		
	2nd – eg. Risk/Compliance:		
	<ol style="list-style-type: none"> Risk Management Group Executive Team Meeting 		
	3rd – eg. External Assurances:		
	<ol style="list-style-type: none"> Internal Audit Regulatory inspections and investigations – HSE, HIW, CIW, PSOW WG performance monitoring and assurance Welsh Government Reviews 4. Royal College Reviews 		
Actions			Due Date
Primary Care Board established			30/05/2024
Primary Care strategic plan			31/03/2025
			Progression Analysis
			Progressing
			Progressing

Escalation and sustainability implementation	30/06/2024	Progressing
Health Board Managed Practices – recommendations for improved governance report	31/01/2024	Completed
Focused on implementation of recommendations	30/06/2024	Progressing

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

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

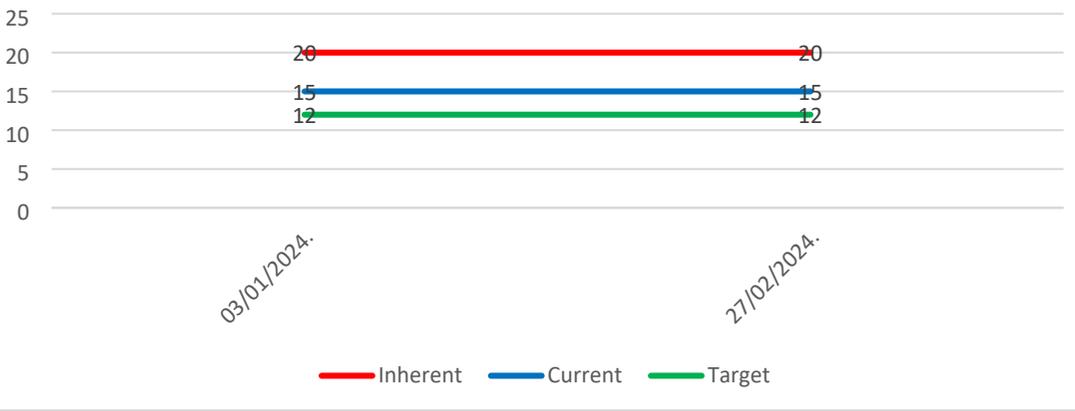


08/01/2024. 29/02/2024.

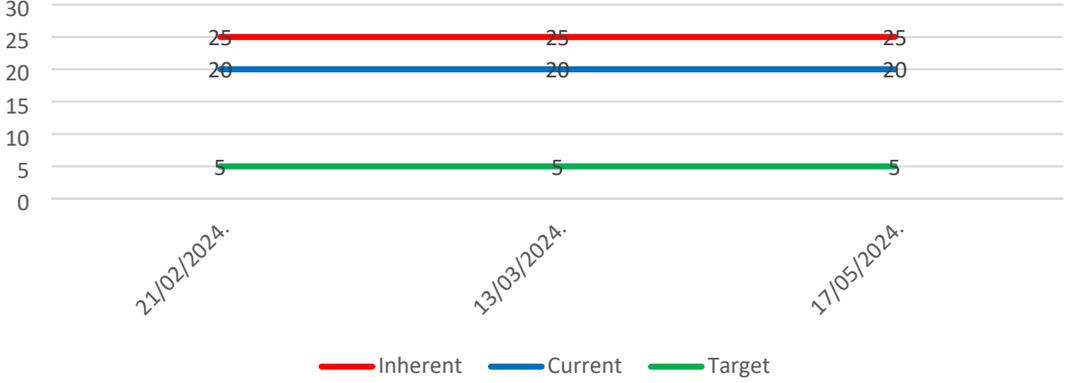
— Inherent — Current — Target

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

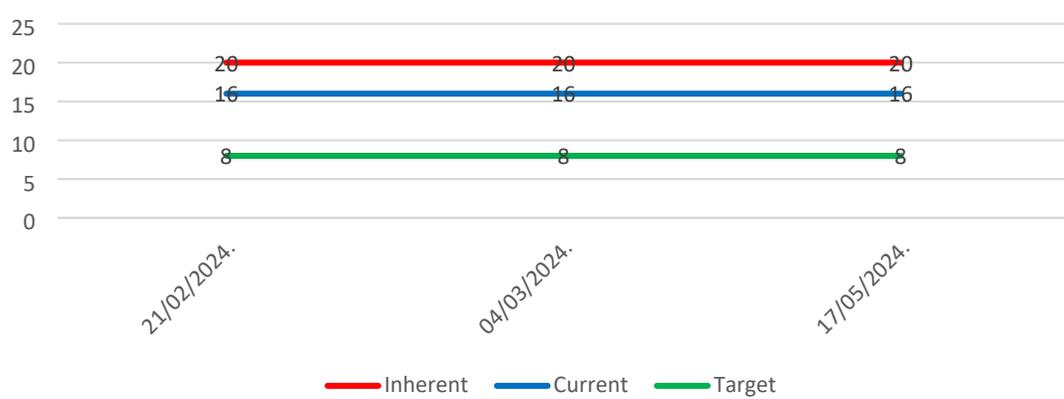
CRR 24-12	Risk Title: Clinical Areas of Concern		Date Opened: 15/12/2023		
	Assuring Committee: Quality, Safety and Experience Committee		Date Last Committee Review: New		
Date Last Reviewed: 29/05/2024	Director Lead: Executive Medical Director/ Executive Director of Operations	Link to BAF: N/A		Target Risk Date: 01/03/2025	
<p>There is a risk of service failure leading to patient harm across a number of fragile clinical specialties. This could be caused by staffing shortages, clinical leadership gaps, lack of productivity, demand backlog, increasing patterns of demand and estates and equipment deficits. The impact may be delayed diagnosis and treatment of significant conditions. This impacts patient safety, healthcare access and public health outcomes.</p>					
Mitigations/Controls in place		Lines of Assurances		Additional Controls required	
<ol style="list-style-type: none"> Strategic Improvement Groups for the fragile clinical specialties. Progress review groups for ophthalmology, dermatology and urology to develop and review progress of improvement plans. Improvement plans for fragile specialties for specialties with clinical leadership. Prioritising/triaging cases in specialties with backlog. 		<p>1st – eg. Local Assurances:</p> <ol style="list-style-type: none"> Special Measures meeting and assurances to committees on 90 day cycle Quality Delivery Group <p>2nd – eg. Risk/Compliance:</p> <ol style="list-style-type: none"> Risk Management Group Executive Team Meeting <p>3rd – eg. External Assurances:</p> <ol style="list-style-type: none"> Internal Audit National touch point meetings with NHS Executive colleagues 		<ol style="list-style-type: none"> Implement plans for integrated electronic patient records Dermatology, ophthalmology, urology continue to have clinical leadership gaps Address lack of consistent medical cover in some specialties. SLA for services provided by non-BCUHB organisations Development of clinical model/pathways for fragile specialties with limited leadership incorporating relevant GIRFT and College recommendations Clinical validation of waiting lists. 	
Actions				Due Date	Progression Analysis
<p>Engagement with National Procurement Processes (i.e. eye record system) and National Programmes (i.e. Robotics) Ongoing engagement with Welsh Government is taking place and is satisfactory.</p>				01/07/2024	Progressing and on track. Monitor this at next risk review
<p>Ongoing recruitment for substantive medical leadership roles. Now recruited into an Ophthalmic Clinical lead role (May 2024). Start date to be confirmed. In addition the team has now had authorisation to appoint a Clinical Lead for Dermatology</p>				01/01/2025	Progressing
<p>Recruitment efforts including substantive, locum and agency staff. Work continues on a cycle of recruitment. Locum dermatological cover in Ysbyty Gwynedd from June 2024 has been confirmed in May 2024.</p>				01/01/2025	Progressing
<p>SLAs to be signed off through governance structures Work has now commenced on the process to implement a Dermatology Outsourcing SLA with national lead input. In relation to governance. Updates and any approvals will be sought through the Executive Team. (for SLA approval)</p>				01/08/2024	Progressing

<p>Clinical pathway events Engagement during May 2024 with NHS Wales Executive on the development of the Community Clinical Pathway system. This will be received at Executive Team for consideration.</p>	30/07/2024	Progressing																																
<p>Non-clinical and clinical validation exercises Andrew Oxberry from BCUHB has commenced work on this and this will be able to reported at the next update to this risk.</p>	30/07/2024	Progressing																																
 <table border="1"> <caption>Risk Score Data</caption> <thead> <tr> <th>Date</th> <th>Inherent</th> <th>Current</th> <th>Target</th> </tr> </thead> <tbody> <tr> <td>03/01/2024</td> <td>20</td> <td>15</td> <td>12</td> </tr> <tr> <td>27/02/2024</td> <td>20</td> <td>15</td> <td>12</td> </tr> </tbody> </table>	Date	Inherent	Current	Target	03/01/2024	20	15	12	27/02/2024	20	15	12	<table border="1"> <thead> <tr> <th></th> <th>Impact</th> <th>Likelihood</th> <th>Score</th> </tr> </thead> <tbody> <tr> <td>Inherent Risk Rating</td> <td>5</td> <td>4</td> <td>20</td> </tr> <tr> <td>Current Risk Rating</td> <td>5</td> <td>3</td> <td>15</td> </tr> <tr> <td>Target Risk Score</td> <td>4</td> <td>3</td> <td>12</td> </tr> <tr> <td>Risk Appetite</td> <td colspan="2">Quality</td> <td>3 - Open</td> </tr> </tbody> </table>		Impact	Likelihood	Score	Inherent Risk Rating	5	4	20	Current Risk Rating	5	3	15	Target Risk Score	4	3	12	Risk Appetite	Quality		3 - Open	<p>Rationale for Corporate Risk</p> <p>The impact of the inherent risk has not been altered by current actions, although its likelihood has been reduced by the identification of the clinical issues and improved governance around the services.</p> <ul style="list-style-type: none"> Ophthalmology R1 seen within 25% over their clinical due date - NHS Wales Performance Framework 2024-25 Target improve to 95% Cancer 62 Days - NHS Wales Performance Framework 2024-25 Target improvement trajectory to 80% by 31.03.2026
Date	Inherent	Current	Target																															
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Risk Appetite	Quality		3 - Open																															

CRR 24-13	Risk Title: Timely Diagnostics		Date Opened: 21/02/2024
	Assuring Committee: Quality, Safety and Experience Committee		Date Last Committee Review: 18/04/2024
Date Last Reviewed: 17/05/2024	Director Lead: Executive Director of Therapies & Healthcare Sciences	Link to BAF: N/A	Target Risk Date: 31/12/2025
<p>There is a risk of delay in diagnostics, service failure, poor performance or disruption to radiology and pathology services across. This could be caused by shortages of specialist staff, aging or inadequate IT systems and infrastructure, and insufficient governance structures. The impacts may include delays in diagnosis, treatment and discharge, increased outsourcing costs, patient harm events, preventable deaths, regulatory non-compliance, and significant reputational damage. There is also additional risk related to clinicians failing to act on results of diagnostic tests.</p>			
Mitigations/Controls in place		Lines of Assurances	Additional Controls required
<ol style="list-style-type: none"> 1. Insourcing of CT, MRI and ultrasound to deliver required capacity 2. Work commenced on new radiology staffing model for the identification of significant restructuring of the service with succession planning, career development, staff wellbeing etc. 3. Significant guidance and steer with National Imaging Programme workforce work. 4. Outsourcing of radiology reporting to maintain Welsh government turnaround times 5. Waiting list & capacity and demand management is in place to monitor radiology required resources. 		1st – eg. Operational:	<ol style="list-style-type: none"> 1. Replacement of Radiology Informatics System (RISP) – implementation underway go live planned for April 2025 2. Replacement of LINC (national pathology IT system) - Contract signed with current supplier plans to implement by September 2025 being progressed nationally 3. Radiology workforce model not suitable for meeting the current demands being placed on the service from both clinical activity and supporting activity required to deliver service e.g. governance, regulatory and accreditation requirements 4. Escalate to BCU Clinical Effectiveness Group – issues around failure to act. Procedure MD (Office of the Medical Director) 23 – ‘Mitigation of the risk of failure to act on diagnostic results’ needs updating which is being led by the Executive medical director. 5. PHW Collaborative Executive group.
		<ol style="list-style-type: none"> 1. Local deployment board and wider programme team stood up with collaborative working with Pathology and DDAT. 2. Radiology RISP project board in place 	
		2nd – eg. Risk and Compliance:	
		<ol style="list-style-type: none"> 1. Risk Management Group 2. Executive Team 	
		3rd – eg. Independent:	
		<ol style="list-style-type: none"> 1. Internal Audit 2. RISP being monitored via National and BCU implementation boards 	

		6. Diagnostic Strategy for BCU needs to be developed																																				
Actions		Due Date	Progression Analysis																																			
Replacement of Radiology Informatics System (RISP) – implementation with anticipated go live date of the 14/04/2024.		14/04/2025	Progressing																																			
Replacement of LINC (national pathology IT system) - Contract signed with current supplier plans to implement by September 2025 being progressed nationally		30/09/2025	Progressing																																			
Procedure MD23 (Mitigation of the risk of failure to act on diagnostic results) to be updated		31/12/2025	Progressing																																			
Radiology workforce revised model to be developed by June 2025		30/06/2025	Progressing																																			
Diagnostic Strategy to be developed by diagnostic group		30/09/2024	Progressing																																			
 <p>The chart displays three data series: Inherent (red), Current (blue), and Target (green) risk scores across three dates: 21/02/2024, 13/03/2024, and 17/05/2024. The Y-axis ranges from 0 to 30. Inherent risk remains constant at 25. Current risk remains constant at 20. Target risk remains constant at 5.</p> <table border="1"> <thead> <tr> <th>Date</th> <th>Inherent</th> <th>Current</th> <th>Target</th> </tr> </thead> <tbody> <tr> <td>21/02/2024</td> <td>25</td> <td>20</td> <td>5</td> </tr> <tr> <td>13/03/2024</td> <td>25</td> <td>20</td> <td>5</td> </tr> <tr> <td>17/05/2024</td> <td>25</td> <td>20</td> <td>5</td> </tr> </tbody> </table>	Date	Inherent	Current	Target	21/02/2024	25	20	5	13/03/2024	25	20	5	17/05/2024	25	20	5	<table border="1"> <thead> <tr> <th></th> <th>Impact</th> <th>Likelihood</th> <th>Score</th> </tr> </thead> <tbody> <tr> <td>Inherent Risk Rating</td> <td>5</td> <td>5</td> <td>25</td> </tr> <tr> <td>Current Risk Rating</td> <td>5</td> <td>4</td> <td>20</td> </tr> <tr> <td>Target Risk Score</td> <td>5</td> <td>1</td> <td>5</td> </tr> <tr> <td>Risk Appetite</td> <td colspan="2">Reputational</td> <td>4 - Seek</td> </tr> </tbody> </table>		Impact	Likelihood	Score	Inherent Risk Rating	5	5	25	Current Risk Rating	5	4	20	Target Risk Score	5	1	5	Risk Appetite	Reputational		4 - Seek	<p style="text-align: center;">Rationale for Corporate Risk</p> <p>Increasing demand for both radiology and pathology Outdated IT infrastructure in both Radiology and Pathology that carry significant clinical and operational risks. – National programmes in place to resolve these issues Additional work required to mitigate the risks from failure to act and update procedure MD23 Waiting lists longer than the national targets which results in delay in diagnosis which results in harm to patients. In addition, staffing stress related to demand in the service leading to burn out. 31st January 6,801 diagnostic waits over 8 weeks with Endoscopy (2,163) and Cardiology (1,552) being the largest. Endoscopy capacity at most risk as the insourcing into Wrexham stopped as of 1st April 2024.</p>
	Date	Inherent	Current	Target																																		
21/02/2024	25	20	5																																			
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Target Risk Score	5	1	5																																			
Risk Appetite	Reputational		4 - Seek																																			

CRR 24-14	Risk Title: Harm from the Medical Devices/Equipment		Date Opened: 21/02/2024
	Assuring Committee: Quality, Safety and Experience Committee		Date Last Committee Review: 18/04/2024
Date Last Reviewed: 17/05/2024	Director Lead: Executive Director of Therapies & Healthcare Sciences	Link to BAF: N/A	Target Risk Date: 31/09/2024
<p>There is a risk of harm and infection from aging, unsuitable or unreliable medical equipment and devices. This could be caused by equipment breakdowns, lack of replacement funding, ineffective cleaning and decontamination, insufficient staff training, improper use and poor traceability. The impacts may include inability to deliver essential services, delays in diagnostic and treatment leading to incidents and poor patient outcomes, increased costs and reputational damage.</p>			
Mitigations/Controls in place	Lines of Assurances		Additional Controls required
<ol style="list-style-type: none"> 1. Medical Devices Oversight Group leads on the capital investment and replacement plan. 2. Annual capital planning process reflects known priorities taking account of key pieces of equipment due for replacement with a risk assessment that support the overall outcome. 3. Scrutiny and assessment of the capital programme at Capital Programme Management Team (CPMT) and Capital Investment Group (CIG). 4. Welsh Government Capital review meeting to escalate and discuss potential risks and requirements for key medical equipment e.g. Linac. 5. An effective medical devices management system is utilised through EBME. 6. EBME uses the management system to monitor the condition and performance of medical devices including device failures and issues; utilisation, performance, maintenance; repair and calibration history. 7. Audits on majority of affected equipment in line with regulatory compliance completed. 	1st – eg. Operational:		<ol style="list-style-type: none"> 1. Internal risk assessment and priorities are flagged in the context of fully depreciated equipment (£34.659m) to understand priorities and potential risks. 2. External links with National Endoscopy and Diagnostic Programmes are documented and appropriately reported through correct channels to ensure transparency and potential benchmarking. 3. Lack of comprehensive governance structure around ensuring equipment all is safe and in line with regulations. 4. Lack of training around equipment and good governance of safety of equipment has been lacking and documented as a risk since 2016. 5. Robust risk assessments of how often certain equipment breaks down, the scale of difficulty sourcing spare parts to be considered for included in requests for capital replacement. 6. The number of bids not approved now reaching over millions in capital and resources required. Backlog of
	<ol style="list-style-type: none"> 1. Medical Devices Oversight Group 2. Capital Programme Management Team 3. Capital Investment Group 		
	2nd – eg. Risk and Compliance:		
	<ol style="list-style-type: none"> 1. Risk Management Group 2. Executive Team Meeting 		
	3rd – eg. Independent:		
	<ol style="list-style-type: none"> 1. Internal Audit 2. National Endoscopy and Diagnostic Programmes 		

		equipment beyond end of life, some 10 years+																				
Actions		Due Date	Progression Analysis																			
CPMT and CIG to review annual planning process to ensure risk scoring to inform prioritisation		31/03/2024	Overdue																			
Review of internal and external group membership and communication to ensure all opportunities and risks are reported and escalated as appropriate.		31/02/2024	Overdue																			
Medical physics have been tasked with testing all ultrasound equipment to ensure its safety and will consider compliance		31/09/2024	Progressing																			
Review medical devices capital replacement to ensure all services have a medical devices replacement programme in place		31/09/2024	Progressing																			
Medical Devices strategy review		31/9/2024	Progressing																			
Recruitment to medical devices team		31/09/2024	Progressing																			
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Current Risk Rating	4	4	16																			
Target Risk Score	2	4	8																			
Risk Appetite	Quality		3 - Open																			
		Rationale for Corporate Risk																				
		Significant funding capital required, lack of robust controls and governance to ensure safety of equipment, £33M represents the value of capital medical equipment which is fully depreciated and at end of life.																				