Bundle Quality, Safety and Experience Committee 18 April 2024

1 OPENING ADMINISTRATION

1.1 09:30 - QS24/30 Welcome, introductions and apologies for absence - Verbal - Chair

1.2 09:35 - QS24/31 Declarations of interest relating to agenda

1.3 09:36 - QS24/32 Minutes of Meeting - Attached - Chair
- QS24.32 - Draft Minutes of Meeting

1.4 09:41 - QS24/33 Matters Arising & Table of Actions- Attached - Chair
- QS24.33 - Matters Arising & Table of Actions

1.5 09:46 - QS24/34 Report of the Chair - Verbal - Chair

1.6 09:51 - QS24/35 Notification of Matters referred from other Board Committees on this or future agendas - Verbal - Chair

1.7 09:52 - QS24/36 Committee Terms of Reference - Attached - Director of Governance
- QS24.36 - Committee Terms of Reference
- QS24.36a - Appendix 1 - QSE Committee ToR V10.0

1.8 09:54 - QS24/37 Committee Cycle of Business 2024/25 - Attached - Director of Governance
- QS24.37 - Committee Cycle of Business 202425
- QS24.37a - Appendix 1 QSE Committee CoB 2024-25 Live Document

1.9 09:56 - QS24/38 Patient Story - Attached - Executive Director of Nursing and Midwifery / Deputy Director of Quality Governance
- QS24.38 - Patient Story

2 QUALITY CONTROL

2.1 10:16 - QS24/39 Quality Report - Attached - Executive Director of Nursing and Midwifery /Deputy Director Quality
- QS24.39 - Quality Report

2.2 10:36 - QS24/40 Integrated Performance Report - Attached - Director of Performance
- QS24.40 - Integrated Performance Report
- QS24.40a - Integrated Performance Report

2.3 10:56 - QS24/41 Quality Delivery Group Chair's Report -Attached - Executive Director of Nursing and Midwifery / Deputy Director Quality
- QS24.41 - Quality Delivery Group Chair's Report

3 QUALITY ASSURANCE

3.1 11:01 - QS24/42 Regulatory and Legal Report - Attached - Executive Director of Nursing and Midwifery / Deputy Director of Quality
- QS24.42 - Regulatory and Legal Report
- QS24.42a - Appendix 1 Letter from Ombudsman
- QS24.42b - Appendix 2 Response from HB

3.2 11:11 - QS24/43 Deep Dive report - East IHC - Attached - Director of East IHC
- QS24.43 - Deep Dive report
- QS24.43a Deep Dive report

3.3 11:26 - QS24/44 Clinical Policy Report - Attached - Associate Director of Governance
- QS24.44 - Clinical Policy Report

3.4 11:36 - QS24/45 Nurse Staffing Act - Attached - Executive Director of Nursing and Midwifery
- QS24.45 - Nurse Staffing Act

3.5 11:46 - QS24/46 Commissioned Services Quality report - Verbal - Executive Director of Nursing and Midwifery

3.6 11:56 - QS24/47 Urology Review - Attached - Executive Medical Director
Please note, appendix 3 - Urology Improvement Plan will be circulated via email.
- QS24.47 - Urology Review
- QS24.47a - Appendix 1 - Invite Service Review Final Report
- QS24.47b - Appendix 2 - Getting It Right First Time Urology Review - January 2023 Betsi Cadwaladr University Health Board
- QS24.47d - Appendix 4 - Urology Risk 5050

3.7 12:16 - QS24/48 Corporate Risk Register & Board Assurance Framework - Attached - Associate Director of Governance

QS24.48 - Board Assurance Framework
QS24.48a - Corporate Risk Register

4 CLOSING ITEMS

4.1 12:31 - QS24/49 Agree Items for referral to Board / Other committees - Verbal - Chair

4.2 12:32 - QS24/50 Review of Risks highlighted in the meeting for referral to Risk Management Group - Verbal - Chair

4.3 12:33 - QS24/51 Agree items for Chairs Assurance Report - Verbal - Chair

4.4 12:34 - QS24/52 Review of Meeting Effectiveness - Verbal - Chair

4.5 12:36 - QS24/53 Report items discussed in previous meeting private session - Verbal - Head of Corporate Affairs

4.6 12:38 - QS24/54 Date of next meeting

4.7 12:39 - QS24/55 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."

4.8 12:40 - Comfort Break

Betsi Cadwaladr University Health Board (BCUHB)
DRAFT Minutes of the Quality, Safety and Experience Committee meeting held in public
on 20 February 2024 09:30 – 13:00
at The Board Room, Carlton Court, St Asaph

Committee Members Present	
Name	**Title**
Rhian Watcyn Jones	Independent Member/Chair of Quality, Safety and Experience Committee
Urtha Felda	Independent Member
Prof Mike Larvin	Independent Member
In Attendance	
Dyfed Edwards	BCUHB Chair (For part of the meeting)
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
Other Executive Directors as required by the Chair	
Dr Jane Moore	Acting Executive Director of Public Health
Phil Meakin	Acting Board Secretary
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
Simon Newman	Integrated Health Community Director of Nursing (Central) (Part of the meeting)
Geraint Parry	Quality Improvement Fellow (Part of the meeting)
Philippa Peake-Jones	Head of Corporate Affairs
Libby Ryan-Davies	Integrated Health Community Director (Central) (Part of the meeting)
Organisations / Individuals observing the meeting	
Internal Audit Wales	Dave Harries

Agenda Item	**Action**
OPENING BUSINESS	
QS24/1 Welcome, introductions and apologies for absence **QS24/1.1** The Chair welcomed everyone present. Apologies were noted from Jason Brannan, Deputy Director of People for whom Nick Gray would be present for the Strategic Occupational Health and Safety Group Chair's Assurance Report. Apologies were also noted from Chris Stockport, Executive Director of	

Strategy and Transformation for whom Geraint Parry would present the Special Measures Report. Adele Gittoes, Interim Executive Director of Operations, also gave her apologies. The Chair explained that she was unwell and apologised in advance for any shortcomings in her chairing of the meeting. **QS24/1.2** The Chair noted that two items scheduled to be on the agenda had been withdrawn. The Executive Medical Director clarified that the expected Urology item would be considered at the Executive Team Meeting in the next fortnight and would be an item at the next Quality, Safety and Experience Committee (QSE) meeting in April. The Vascular item would be scheduled for QSE Committee once the second review had reported. **QS24/1.3** The Executive Medical Director advised that he may need to leave the meeting periodically due to the ongoing industrial action	**PPJ**
QS24/2 Declarations of Interest on current agenda There were no declarations of interest made in respect of items on the agenda.	
QS24/3 Draft minutes of the previous meeting held on 30.11.23 **QS24/3.1** The draft minutes of meeting held on 19.12.23 were **approved** subject to the following amendments: • Tom Davies not being an Interim appointment • Gareth Evans title changing to "Acting Executive Director of Therapies and Health Sciences" • Removing the word "Strategy" from Steve Grayston's title • QS23.131.3.2 SP5. Cancer. – Change "Neurology" to "Urology" • QS23.72. Include link "to" quality	
QS24/4 Matters Arising and Table of Actions **QS24/4.1** Following a detailed discussion, the updates provided within the action log were **agreed**. The Chair wished for it to be noted that she had not been invited to the meeting with the Executive Director of Finance and the Chair of PFIG but that she was content to close down action QS23.108.2. **QS24/4.2** The Committee had a detailed discussion relating to Primary Care including a consistent approach, definition and managed practices. The Acting Board Secretary **agreed** to follow up with the Primary Care team and feed back to attendees prior to the next meeting.	**PM**

QS24/5 Report of the Chair **QS24/5.1** The Chair noted that she had met informally with the three IHC Directors and the Director of Mental Health with an invitation being given for them to attend future QSE meetings.	
QS24/6 Notification of Matters referred from other Board Committees on this or future agendas There was nothing to note.	
QS24/7 Development of Patient Stories **QS24/7.1** It was noted that Patient Stories would be linked into the cycle of business of the committee as far as possible. **QS24/7.2** The Executive Director of Nursing and Midwifery advised that the learning from patient stories would be included in an annual report, scheduled on the Cycle of Business. Her team was working with NHSE with regards to a Learning Framework which would be a pioneering tool in Wales. The Deputy Director of Quality advised that the Quality Team had created a Great-ix system, a platform on Betsi net for sharing learning and the system was now being showcased across the UK.	
QS24/8 Committee Terms of Reference **QS24/8.1** The Acting Board Secretary thanked both the QSE Chair and the Health Board's Vice Chair for their detailed review of the Terms of Reference. **It was resolved that** the Committee **Noted** the Terms of Reference	
QS24/9 Cycles of Business 2024/25 **QS24/9.1** The Cycle of Business was received noting that it was a live document. The Head of Internal Audit raised concern in relation to Health and Safety. This would be the responsibility of the People Committee going forward but Quality Safety would continue to report through the QSE Committee. The Head of Internal Audit raised concerns that items may slip between Committees. The Board had made the decision to split the work this way and concerns would be mitigated by Workshops and the new Chairs' Management Business Group when it was established. **QS24/9.2** An Independent Member reflected that the business scheduled at the June meeting was very heavy due to the number of Annual Reports to be received. It was **agreed** that annual reports would be shared when they were drafted so that colleagues would have the opportunity to scrutinise rather than	All

having to do so in a short period of time. **QS24/9.3** The Executive Medical Director requested that the item "Clinical Service of Concern" report be changed to "Fragile Services/Services that the Committee is concerned about". Acting Board Secretary **agreed** to amend the Cycle of Business to reflect this change. **It was resolved that** the Committee **Noted** the Cycle of Business	PM
QUALITY CONTROL	
QS24/10 Patient Safety, Effectiveness and Experience Report **QS24/10.1** The Executive Director of Nursing and Midwifery presented the report highlighting a number of areas, the first being Oxygen Administration. The paper had not gone into detail in order to protect patient confidentiality. The Committee was advised that training had been reinforced and that discussions were ongoing with the supplier. The Chair declared an interest in the item, and the Executive Director of Nursing and Midwifery **agreed** to follow up outside the meeting. It was acknowledged that around 75% of patients in hospitals were on oxygen and that the numbers highlighted were extremely low in comparison to usage. The Head of Internal Audit queried what assurance the committee could have in regards to competence. The Executive Director of Nursing and Midwifery advised that the issue was a live one, that training was ongoing, spot checks were taking place by Matrons and Ward Managers and that further details would be shared outside the meeting. **QS24/10.2** The Chair highlighted that in the statutory Duty of Quality, quality was defined as "health services are safe, timely, effective, efficient, equitable and person-centred" and queried if it would be possible to say that, or if there was currently a gap. The Executive Medical Director advised that Duty of Quality was a statutory requirement, but one that he could not give complete assurance on. Independent Members acknowledged that it was not possible to give everything to everyone but that there was a mix of trying prevent patient harm whilst accepting that this would not always be successful. Learning from experience to prevent future harm was key and true to all health organisations. **QS24/10.2** The Executive Director of Nursing and Midwifery highlighted the Urology Administrative backlog and what was being done to address the situation including looking into an electronic record system. She advised that she had formally written to all the Areas to ensure this would not happen again, noting that all patients had been contacted. She formally apologised to the patients. The Executive Medical Director advised that he had spoken to consultant colleagues to ask them to support. *[Geraint Parry joined the meeting]* **QS24/10.3** The Executive Director of Nursing and Midwifery updated that the	AW AW

Deprivation of Liberty funding from Welsh Government was now in place and that training had reached 75% compliance, with colleagues from the Safeguarding Team engaged and integrating well with the Local Authorities. **QS24/10.3** With regards to Infection Control, the Committee noted that that the Health Board was in the middle of the pack across Wales. There had been a positive reduction in the community in BCUHB however, one of only two Health Boards to achieve this in Wales. **QS24/10.4** The Committee focussed on Patent Experience and Complaints looking at detail into the numbers, noting an increase in complaints around Planned Care but a 14% reduction in overdue complaints. The process of complaint sign off was discussed noting that IHCs were aware of the final response and that the quality of responses was much improved in the past year. The PALS team was key in communicating with patients to help ensure that formal complaints did not ensue and that a new telephony system was being installed for the PALS team to enable more effective communication. Members asked if data was being collected from Primary Care and noted that it was but only on a limited basis with Managed Practices. **QS24/10.5** Finally, the Executive Director of Nursing and Midwifery wanted to formally thank the Chaplains for their time over the Christmas Period. **QS24/10.6** The Executive Medical Director presented the Clinical Effectiveness part of the paper. He noted that the Audit results were being reviewed and reflected upon and that NICE Guidelines was an area that required more focus to ensure compliance with the parts of the guidance most applicable to the Health Board. With regard to mortality, he explained that this would be the first year for Medical Examiners to give feedback in secondary care. Concern was raised about the lack of data for COPD with the Executive Medical Director clarifying that it was extremely difficult to pull out of the notes and that significant investment was required in order to do so. The Health Board was not alone with this problem but it would be kept under review. *[Libby Ryan-Davies joined the meeting]* *[Simon Newman joined the meeting]* **It was resolved that** the Committee **noted** the report	
QS24/11 Quality Delivery Group Chair's Report **QS24/11.1** The Executive Director of Nursing and Midwifery explained that a peer review had taken place at the Maternity Unit on the Ysbyty Gwynedd sites to assist with identifying any learning and improvement required to support preparations for a future Health Inspectorate Wales (HIW) Inspection, expected in the near future. The initial feedback was very positive. Also, an investigation had taken place with regards to the referral of babies to Ty Gobaith following concerns raised by the Director of Care at Ty Gobaith. The investigation	

concluded that there was nothing to be concerned about. **QS24/11.2 In response to** the Chair query about what had happened with the letters for gastroenterology services in the East, the Executive Director of Nursing and Midwifery advised that an investigation was ongoing alongside a review on governance. **It was resolved that** the Committee **noted** the report	
QUALITY ASSURANCE	
QS24/12 Special Measures Report **QS24/12.1** The Quality Improvement Fellow presented the report noting that seven milestones had been achieved, 14 were on track and seven were unlikely to be delivered, with the details of these being identified within the paper. The Chair asked what feedback had been received from Welsh Government and noted that two thirds of the milestones set had been delivered which was positive but that nationally it is understood the strides that the Health Board has taken over the past 12 months. The 90-day cycles had been very challenging and did not align well to the planning cycle. As the Interim Executive Director of Operations would be reverting to her substantive post her responsibilities regarding milestones would be distributed amongst the Executives rather than engaging another interim. *[Dyfed Edwards joined the meeting]* **QS24/12.2** The Quality Improvement Fellow advised that the review of reviews was due to be received that week and would be aligned to the Internal Audit. It was noted that a wide range of work had taken place around quality and a dashboard had been tested and good progress been made. The Chair concluded that she was looking forward to seeing what the different approach ie aligned to the planning cycle rather than 90day chunks, would look like over the next 12 months. **It was resolved that** the Committee **Received Assurance** on the progress to date, acknowledging the challenges highlighted and risks to delivery	
QS24/13 Regulatory and Legal Report including HSE update/ Ombudsman **QS24/13.1** The Deputy Director of Quality presented the item noting that there had only been one inspection report published, an unannounced inspection of Morris Ward, Wrexham Maelor Hospital on 12 and 13 September 2023, the outcoming being that HIW were satisfied with the assurance given on the two concerns raised verbally at the time of inspection. The Chair declared an interest in this item and that the discussion would take place on her observations outside the meeting.	MJ

QS24/13.2 HIW made an announced visit to Nant-y-Glynn Community Mental Health Team on 23 and 24 January 2024. The verbal feedback from this visit was positive with no surprises. The HSE Prosecution from December 2023 was referred to along with two regulation 28 notices received from the coroner. It was noted that this item would be discussed in the private session to protect patient confidentiality. **QS24/13.3** Attendees were advised that there were no significant issues to note in relation to the Welsh Risk Pool, however, there was a slight delay to setting up learning forums and this was being supported. The Head of Internal Audit raised concerns about forms not being submitted and this had led to the Risk Pool not paying out in previous years. It was noted that this matter was being reviewed as part of the Executive Accountability Review. **QS24/13.4** While noting that there were no public interest reports from the Ombudsman it was **agreed** that Members should have been given more of an opportunity to scrutinise the Annual Letter from the Ombudsman prior to it being received at the Board in March. The reason for the delays were acknowledged and it was **agreed** that it would be reviewed in detail at the April Committee Meeting. **It was resolved that** the Committee **noted** the report but would explore the detail in April.	MJ
QS24/14 Deep Dive report – Central **QS24/14.1** The Chair welcomed Simon Newman, Integrated Health Community Director of Nursing (Central) and Libby Ryan-Davies, Integrated Health Community Director (Central) to the meeting to share their deep dive presentation on the Central Integrated Health Community. **QS24/14.2** The presentation was received with thanks; discussion took place around governance clarifying the approach across all of the Integrated health Communities, it was noted that joint meetings were attended to share learning and ensure governance was consistent. Achievements and areas of concern were discussed in detail. The Executive Medical Director noted the significant change that had taken place in the past year with regards to the Integrated Health Communities, suggesting that it would not have been possible to receive such a report previously and wished to recognise the hard work that had been undertaken.	
QS24/15 Healthcare Acquired Pressure Ulcers (HAPU) deep dive report **QS24/15.1** QSE had asked for a HAPU deep dive following a similar deep dive into falls. The Executive Director of Nursing and Midwifery advised that there was much more resource with an increase in no and low HAPUs. In the future HAPUs would be reported differently and a new assessment tool would help to cleanse data and this would make identification of assessments in a timely manner possible. Attendees discussed mandatory training and best practice	

being shared across the organisation. It was **agreed** that the Improvement Plan could be monitored and fed back to QSE as appropriate and would include the points raised. **It was resolved that** the Committee **noted** the report and would receive future information of incidence and progress against plans.	AW
QS24/16 Corporate Risk Register & Board Assurance Framework **QS24/16.1** The Head of Risk Management presented the report highlighting that there had been some good discussion on risks throughout the meeting and that she would pick up the risk around Managed Practices outside the meeting. Attendees noted that the risks would be aligned to objectives in the new iteration of the BAF but currently were aligned to priorities, that ongoing work had been taking place with planning leads and that there had been some movement in risk scores. **It was resolved that** the Committee **noted** and **received assurance** on the management of the four BAF risks of which it had oversight. **QS24/16.2** In relation to the Corporate Risk Register it was noted that further work had taken place with Executives and the risks that the Committee was responsible for were in a good place. The falls risk had been updated and a deep dive on the safeguarding risk would take place with the likely outcome being a lowered score. The risk about failure to embed learning had been discussed throughout the meeting. The Acting Executive Director of Public Health updated the Committee on the population health risk highlighting the need to embed prevention, early intervention and partnership working. Concern was raised at inconsistency with risk scoring and it was noted that the workshops taking place on risk and the training documentation would enable standardisation. The Chair of the Health Board noted that the role of the Committee was to gain assurance that action identified and mapped was indeed taking place and suggested that the Committee may wish to sample in detail one or two risks at each meeting. The Chair of QSE agreed that this should be considered for future meetings. **It was resolved that** the Committee **received assurance** for the four corporate risks which the Committee has overall accountability.	NC
FOR INFORMATION	
QS24/17 Strategic Operational Health and Safety Group Chairs Report The Chair raised concerns with regards to the content of the report asking what the main issue was that the Group was facing. The Assistant Director of	

Workforce Optimisation clarified that the main issue had been that there was no substantive Executive Director but it had been agreed at the Executive Team Meeting the previous week that the Chief Executive Officer would take on the remit. With this in mind it was **agreed** that the policy name should change to be delegated to the Chief Executive Officer, then the policy could be approved. The Head of Internal Audit agreed that in the absence of an Executive Director of Workforce, the Chief Executive Officer had responsibility for Health and Safety. It was noted that Internal Audit had just completed a Health and Safety audit report.	NG
CLOSING ITEMS	
QS24/18 Agree Items for referral to Board / Other committees There were no items identified for referral.	
QS24/19 Review of Risks highlighted in the meeting for referral to Risk Management Group There were no risks identified for referral.	
QS24/20 Agree items for Chairs Assurance Report It was **agreed** that the Chair would work with the Head of Corporate Affairs outside the meeting to draft this report and circulate it to Committee Members.	RWJ/ PPJ
QS24/21 Review of meeting effectiveness The Chair invited all attendees to give feedback. It was felt that the meeting had been good, that the IHC presentation had been useful although possibly too detailed for the time available and that there had been robust challenge throughout.	
QS24/22 Report items discussed in previous meeting private session The Chair noted that the only item received at the confidential meeting held on 19 December 2023 was the Confidential Quality Report which was always taken in private to ensure patient confidentiality.	
QS24/23 Date of next meeting - Verbal – Chair 18 April 2024, The Board Room, Carlton Court, St Asaph	
Resolution to Exclude the Press and Public "Those representatives of the press and other members of the public be excluded from the remainder of the meeting which would take place after the Trustee 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."	

BCUHB QUALITY, SAFETY& EXPERIENCE COMMITTEE - Summary Action Log Public Version				
Officer/s	**Minute Reference and summary of action agreed**	**Original Timescale**	**Latest Update Position**	**Revised Timescale**
ACTIONS FROM MEETING HELD ON 27.10.23				
Phil Meakin	**QS23.101.5** A discussion took place about the quality of papers brought to QSE and Board; there did not appear to be consistency, in particular with regards to levels of assurance noted on covers. It was suggested that report writing might be a very useful topic for a Board Workshop. Phil Meakin, Interim Board Secretary, to look into .	December	A new cover paper is being drafted to ensure the Board/Committee Cover Paper is fit for purpose and has all the statutory reporting requirements included. Further work is ongoing with regards to Board Workshops and Report Writing is highlighted in the OBS review and will be included in the Work Plan. It is intended to hold this work until the new Director of Governance is in post	May
Rhian Watcyn Jones	**QS23.115.1** Internal Audit to be approached to gain assurance regarding Clinical Audit Strategy and the quality of commissioned services.	December	PPJ and DH to meet w/c 15/04/24	May
ACTIONS FROM MEETING HELD ON 19.12.23				
Adele Gittoes	**QS23.135.2** AG to keep Members updated as to creation of formal Primary Care structure		Updates were received at the meeting on 20/02/24 with regards to the ongoing discussions around Primary Care. This action to be kept on the action log until a position is able to return to Committee	
Karen Higgins	**QS23.102.8** To update Members as to Diabetic Programme Board which has recently had its inaugural meeting.	April	KH is linking in with the Assistant Medical Director who is Chairing the Diabetic Programme Board.	
Angela Wood	**QS23.126.5** AW agreed to do a deep dive evaluation of the Patient's Story and report back.	April	Evaluation not complete, once this has been received a deep dive will be scheduled. Awaiting feedback on the timescales. To be	

			added to the COB	
Angela Wood	**QS23.129.5.** AW agreed to update the committee as to the date for rolling out the Call 4 Concern initiative to Central and East.	February	It has yet to be identified when the roll out will take place, most likely after the organisational pressures have reduced The roll out at YG has been completed. 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.	
Angela Wood	**QS23.129.8.** AW to provide update to the Committee regarding key recommendations from the Older Persons Commissioner review into Care homes across North Wales and the newly developed Quality Assurance Framework (QAF) and how this develops over the next 12 months.	June	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 Recommendations and actions for next 12 months are • 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 The Quality and Safety Committee support the continuation and further development of the QAF and associated processes	
Phil Meakin / Nesta Collingridge	**QS23.131.2** PM & NC to organise a bespoke Board Development session aimed to specifically clarify what a BAF is and details of each BAF related to each IM's Committee.	February	Draft Strategic risk management training with CEO for comment and for discussion on arranging a date.	April
Phil Meakin / Nesta Collingridge	**QS23.131.2** To arrange Strategic Risk Management training for the Board.	February	Draft Strategic risk management training with CEO for comment and for discussion on arranging a date.	April
Rhian Watcyn Jones	**QS23.131.3.1** RWJ to ensure Board advised that there needed to be more early intervention to avoid health inequalities.	February	Agreed to take this forward once the CBMG was convened	May
Phil Meakin	**QS23.134.4** PM to contact the two new Associate Directors of Primary Care to define which services are included in Primary Care.	February	A requested has been made, awaiting an update	
ACTIONS FROM MEETING HELD ON 20.02.24				
Philippa Peake-Jones	**QS24/1.2** Ensure that both the Urology and Vascular items are scheduled on the appropriate forthcoming agendas	April	Urology on Agenda, timing for Vascular to be confirmed.	

Phil Meakin	**QS24/4.2** To follow up with the Primary Care Team with regards to consistent approach, definition and managed practices and share outside of the meeting.	April	This links to the Risk action below. Suggest Close	
All responsible Executives	**QS24/9.2** Ensure that when Annual Reports were received they were circulated in a timely manor rather than waiting until the QSE meeting in June 2024	June		June
Phil Meakin	**QS24/9.3** Amend the COB to reflect the change in wording from "Clinical Service of Concern" to Fragile Services/Services that the Committee is concerned about	April	Action completed. Changes amended as per the attached COB	
Angela Wood	**QS24/10.1** follow up with the Ward highlighted by the Chair regarding Oxygen Administration.	April	Action completed. Feedback received and followed up. Learning has been identified and shared.	
Angela Wood	**QS24/10.1.2** Share details on oxygen administration numbers and training outside of the meeting	April	Complete – details shared.	
Matt Joyes	**QS24/13.1** To discuss with the Chair her experience of the Morris ward outside of the meeting and follow up	April	Discussion taken place with RWJ and AW	
Matt Joyes	**QS24/13.4** Ensure that the Annual Report of the Ombudsman is on the April Agenda for discussion.	April	This item is on the agenda and went to Board	
Angela Wood	**QS24/15.1** Bring the HAPU Improvement Plan to the most appropriate QSE Committee	TBC	To be submitted to June QSE Meeting	
Nesta Collingridge	**QS24/16.1** Follow up on the risk around Managed Practices	April	Michelle Greene gave assurances to the corporate risk team that there is a risk around	

			managed practices and action plan in place	
Nick Graham	**QS24/17** Change the policy to reflect the change from the Executive Director of Workforce to the Chief Executive Officer.	TBC	Response requested	

RAG Status	
	Completed/for closure
	Ongoing
	Outstanding

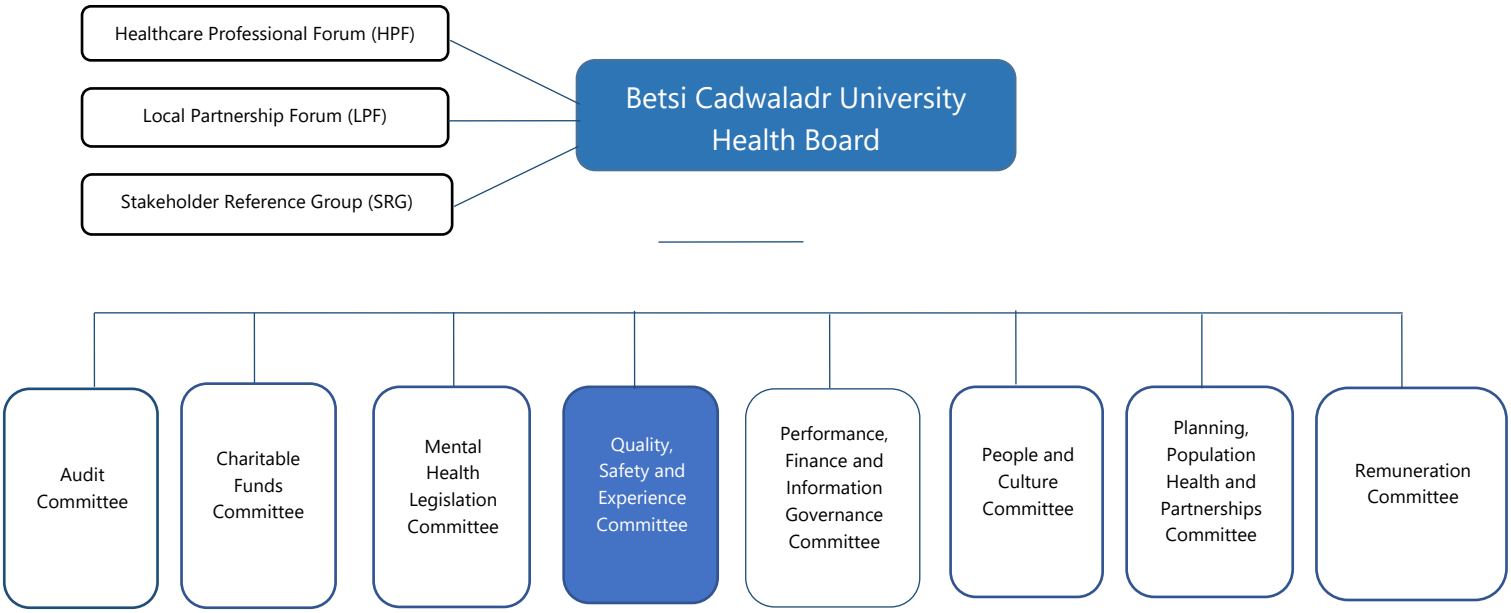
Teitl adroddiad: ***Report title:***	Terms of Reference			
Adrodd i: ***Report to:***	Quality Safety and Experience (QSE) Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 18 April 2024			
Crynodeb Gweithredol: ***Executive Summary:***	The Corporate Governance Directorate has worked with Chairs and Committee Executive Leads through December 2023 and January 2024 to ensure that the Health Board has appropriate Terms of Reference and a cycle of business for all of the Committees and Advisory Groups of the Health Board. The Health Board approved the Terms of Reference for all Committees at its meeting on 25 January 2024. The QSE Terms of Reference are attached as Appendix 1. It is proposed that the Terms of Reference will be reviewed on an annual basis and this is included in the Cycle of Business.			
Argymhellion: ***Recommendations:***	The Committee is asked to **note** the Terms of Reference.			
Arweinydd Gweithredol: ***Executive Lead:***	Pam Wenger, Director of Corporate Governance			
Awdur yr Adroddiad: ***Report Author:***	Philippa Peake-Jones, Head of Corporate Affairs			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☒	I Benderfynu arno *For Decison* ☐	Am sicrwydd *For Assurance* ☐	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:N/A ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this: N/A***				

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

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

QUALITY, SAFETY AND EXPERIENCE COMMITTEE

TERMS OF REFERENCE



Version	Issued to	Date	Comments
V0.01 Draft	Audit Committee	16/11/23	Developed as a first draft for review by Audit Committee on 16/11/23
V0.02 Draft	ToR Meeting with Committee Chair and Executive Lead	15/12/23	Developed as a draft for review with Committee Chair and Executive Lead. The ToR were also reviewed at QSE Committee held on 19/12/23
V0.03 Draft	Health Board	18/01/24	Approved by Health Board 25 January 2024

1) Introduction

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

2) Purpose

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4) Membership

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

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

4.2 The following should attend Committee meetings:

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

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

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

5) Quorum and Attendance

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

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

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

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

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

6) Agenda and Papers

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

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

6.3 All papers must be approved by the Executive Lead.

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

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

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

7) In Committee

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

8) Meetings

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

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

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

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

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

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

9) Reporting

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

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

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

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

10) Accountability, Responsibility and Authority

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

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

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

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

11) Review Date

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

Teitl adroddiad: ***Report title:***	Cycle of Business			
Adrodd i: ***Report to:***	Quality Safety and Experience (QSE) Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 18 April 2024			
Crynodeb Gweithredol: ***Executive Summary:***	The Corporate Governance Directorate has worked with Chairs and Committee Executive Leads through December 2023 and January 2024 to ensure that the Health Board has appropriate Terms of Reference and a cycle of business for all of the Committees and Advisory Groups of the Health Board. The Health Board approved the Cycles of Business for all Committees at its meeting on 25 January 2024. The QSE Cycle of Business is attached as Appendix 1. These are being mapped to ensure that governance flows through from the Executive Team Meetings, through the Committees to Board. It is proposed that the Cycle of Business is included on each agenda and kept as a live document. During Committee Meetings agenda items may be requested as one-off items at a future meeting. A record of these will be kept by the Committee Support. At the last QSE meeting it was agreed that there should be a change in wording from "Clinical Service of Concern" to "Fragile Services/Services that the Committee is concerned about" this is a highlighted change in red in the attached Cycle of Business.			
Argymhellion: ***Recommendations:***	The Committee is asked to **note** the Cycles of Business.			
Arweinydd Gweithredol: ***Executive Lead:***	Pam Wenger, Director of Corporate Governance			
Awdur yr Adroddiad: ***Report Author:***	Philippa Peake-Jones, Head of Corporate Affairs			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☒	I Benderfynu arno *For Decison* ☐	Am sicrwydd *For Assurance* ☐	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in*	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*

	delivery of existing mechanisms/objectives	*existing mechanisms / objectives*	*existing mechanisms / objectives*	

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

Links to BAF risks: *(or links to the Corporate Risk Register)*	
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	N/A
Camau Nesaf: ***Next Steps:*** Cycles of business will be included on each agenda and will be a live document.	

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

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

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

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

Quality, Safety & Experience Committee Cycle of Business (April 2024 – March 2025)									
Item of Business	**Purpose**	**Lead**	**April 2024**	**June 2024**	**August 2024**	**Oct 2024**	**Dec 2024**	**Feb 2025**	**Notes**
Placeholder for any agenda items deriving from the BAF & CRR		Director of Corporate Governance	#	#	#	#	#	#	
For Assurance									
Special Measures Report		Executive Director of Strategy & Transformation *Director of Transformation and Improvement*	✓	✓	✓	✓	✓	✓	
Regulatory Report (including Human Tissue Authority – October)	Providing information on regulatory compliance including new HIW, CIW and PSOW reports (including Public Interest Reports) and action plan progress	Executive Director of Nursing & Midwifery *Deputy Director of Quality Governance*	✓	✓	✓	✓	✓	✓	
Healthcare Law Report	Providing information on healthcare legal compliance including inquest activity, new Regulation 28 Notices and action progress and WRP compliance	Executive Medical Director *Deputy Director of Quality Governance*	✓		✓		✓		
Clinical Policy Report		Executive Director of Nursing & Midwifery *Deputy Director of Quality Governance*	✓			✓			

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

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

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

Quality, Safety & Experience Committee Cycle of Business (April 2024 – March 2025)									
Item of Business	**Purpose**	**Lead**	**April 2024**	**June 2024**	**August 2024**	**Oct 2024**	**Dec 2024**	**Feb 2025**	**Notes**
safety of services provided to the Health Board)									
Update on Progress Monitoring of Case Notes Review	Action plans & progress reported to Board via Chair Assurance Report	Executive Medical Director	✓	✓	✓	✓	✓	✓	
Part B Rolling Programme of Ad-hoc Items (Timing of agenda items to be agreed by the Chair & Executive Lead)									
Radiation Safety									
Covid 19 Inquiry Preparedness									
Ombudsman's Annual Letter and Annual Report									
Primary Care Report (to include a cycle of areas to report on as per themes identified)									
Clinical Audit Plan									
Monitoring compliance - Professional registration and revalidation updates NMC/GMC/HPC/GPhC (Pharmacy)									

Quality, Safety & Experience Committee Cycle of Business (April 2024 – March 2025)									
Item of Business	**Purpose**	**Lead**	**April 2024**	**June 2024**	**August 2024**	**Oct 2024**	**Dec 2024**	**Feb 2025**	**Notes**
Historical Inquest Review	To receive assurance on the Review	Executive Medical Director							
IHC Community Pilots relating to MFD		Executive Director of Nursing and Midwifery							
# = As Required									

Teitl adroddiad: ***Report title:***	Patient Story – My journey through orthopaedic surgery Fy nhaith drwy lawdriniaeth orthopaedig			
Adrodd i: ***Report to:***	QSE Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	18th April 2024			
Crynodeb Gweithredol: ***Executive Summary:***	A patient or carer story is presented to QSE to bring the voice of the people we serve directly into the meeting. The digital story will be played at the meeting. A short summary is included in the attached paper.			
Argymhellion: ***Recommendations:***	QSE is asked to note this report.			
Arweinydd Gweithredol: ***Executive Lead:***	Angela Wood, Executive Director of Nursing and Midwifery			
Awdur yr Adroddiad: ***Report Author:***	Mandy Jones, Deputy Executive Director of Nursing Leon Marsh, Head of Patient Experience Rachel Wright, Patient and Carer Experience Lead Manager			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				
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: ***Link to Strategic Objective(s):***	Quality			
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	N/A			
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)***	BAF21-10 - Listening and Learning
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	N/A
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	N/A
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	N/A
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	BAF21-10 - Listening and Learning
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	N/A
Camau Nesaf: Gweithredu argymhellion ***Next Steps: Implementation of recommendations*** N/A	
Rhestr o Atodiadau: APPROVED - My Journey Through Orthopaedic Surgery.mov ***List of Appendices:*** Appendix A- Patient Story Summary	

Betsi Cadwaladr University Health Board

My journey through Orthopaedic Surgery
A video story will be played at the meeting.

Overview of Patient Story

This patient story describes the journey of a patient in his eighties who has recently had hip replacement surgery at Wrexham Maelor Hospital, following increased pain and inflexibility.

This was the storyteller's first experience as an inpatient and describes it 'like a trip to Disney'.

The storyteller is complimentary of the care and treatment he received throughout his patient journey, from start to finish. He describes it as an 'amazing piece of teamwork' and a 'great experience', with everyone doing what they said they would do, almost on time.

The storyteller outlines a request for increased post-operative patient support, both physical and mental through peer support and proposes the concept of an anonymous patient App through which connections and shared experiences could be made.

The storyteller is now recovering well following surgery and would like to thank everyone involved by sharing his patient story.

Key Messages

- The storyteller highlights that he has never previously been an inpatient in hospital. His hip replacement was his first stay in hospital and describes his journey 'like a trip to Disney'.
- The storyteller highlights that he found all services to work collaboratively across the trust and praised all staff involved in his care to make his experience as positive as it could be, from the start of his journey with the General Practitioner (GP), to coming home.
- The storyteller describes his care as an 'amazing piece of teamwork' and a 'great experience', encompassing porters, cleaners, surgeons and anaesthetists.
- The storyteller highlights that he would read his notes more thoroughly next time and prepare by doing more research.
- The storyteller states how communication with other patients that have been through similar procedures would be beneficial for all parties via peer support.
- The storyteller felt that guidance was provided with what patients could expect, but also felt that they could not really prepare themselves for the mental impact recovery would take. The storyteller feels a way of connecting patients who have been through similar would bridge that gap, for example via an App.
- The storyteller has found surgery to be life changing and is so impressed by the hospital, the surgery and care he received as a whole that he wouldn't hesitate to come in for future procedures.

Summary of Learning and Improvement

The patient story has been shared widely across the Health Board Trauma and Orthopaedics staff and teams to showcase an example of great teamwork and positive patient feedback for the service.

Although the storyteller highlights a positive patient experience, they storyteller first contacted the Patient and Carer Experience Team via a Patient Advise and Liaison Service (PALS) enquiry for information on waiting times for his procedure. Orthopaedics is one of the busiest departments, before the Covid-19 pandemic, there was a two-year waiting list for orthopaedic surgery. Due to the disruption caused by the pandemic, the waiting list for some procedures has grown to as much as five years with patients experiencing pain and distress while waiting for much-needed treatment. Continued pressures from unscheduled and emergency care continues to impact on surgical inpatient bed capacity, in particular for patients requiring Orthopaedic intervention. The waiting times for patients continues to be a challenge and the Health Board is working on several projects / proposals to improve orthopaedic care for the future.

To support the Orthopaedic Recovery Plan, in June 2023 the East Integrated Health Community (IHC) supported the Surgical Directorate at Wrexham Maelor Hospital to operate an 'Orthopaedics Perfect Month', a unique project to reduce the length of time patients wait for elective surgery. The objectives of the 'perfect month' were to: increase bed base to support additional activity, improve patient experience, improve staff morale and experience, demonstrate value in doing things differently through innovation and aligning to Getting it Right First Time (GIRFT) recommendations to drive improvements in planned care recovery. During this period, the directorate worked with a multitude of stakeholders to ensure the safety of patients, both those with emergency attendance and those having planned procedures. Multi Disciplinary Team (MDT) meetings were set up to ensure engagement of all parties involved through the patient pathway. Data showed significant improvements and showcased what could be achieved by the team. The work has been evaluated, lessons learnt and shared across the Health Board. In addition, two new Trauma & Orthopaedics Consultants have been recruited to the team at Wrexham Maelor Hospital. Bringing new outlooks and ways of working, the team are adapting new and innovative working practices within the team.

In an effort to further reduce the current patient waiting lists / times, the team are utilising a protected surgical hub at Abergele Hospital for patients waiting for elective orthopaedic surgery. Extra operating lists are taking place at the community hospital with a ring-fenced short stay orthopaedic ward and a dedicated physiotherapy facility to increase the capacity for surgery. There are 16 Consultant Orthopaedic Surgeons now operating at Abergele Hospital. Patients who are given the option to undergo their operation in Abergele Hospital must meet specific clinical criteria, with more complex high-risk patients continuing to receive their surgery at one of the District General Hospitals. The reported advantages of having a standalone orthopaedic unit in Abergele is the specialised care it provides. Having a dedicated unit fosters collaboration amongst surgeons, nurses, physiotherapists and other specialists and ensures that patients receive focused, expert care tailored to their musculoskeletal needs.

The Welsh Government has agreed the funding of up to £29.4m for a new Orthopaedic Hub at Llandudno General Hospital to help further reduce orthopaedic waiting times. The new hub will transform elective orthopaedic services by delivering a planned 1,900 procedures a year. The funding will be used to refurbish a vacant ward to create 19 bed spaces, two new

theatres and an 8-bed enhanced recovery / post-anaesthetic care unit. Specialising in high volume, low complexity care, the dedicated hub will increase annual surgical activity by providing orthopaedic services away from hospitals, reducing the effects that unscheduled care and emergency pressures can have on elective treatment and reduce the chance of surgeries being postponed. Elective orthopaedic services will continue at Abergele Hospital until the new hub is built. The proof of concept work at Abergele will be replicated at Llandudno Hospital to expand surgical capacity and enable patients across North Wales to access expert care faster. Work will start in February 2024, with the aim that the hub will be operating at full capacity by 2025.

The storyteller highlights how communication with other patients that are going through similar procedures would be beneficial for all parties via peer support.

Wrexham Maelor hospital provides an Enhanced Recovery Programme for its Joint Replacement Patients. The aim of this programme is to support patients back to full health as soon as possible following their operation. The Enhanced Recovery Programme provides patients with information and guidance on how to prepare for surgery, information about their inpatient stay, enhanced recovery goals, information about going home and continued recovery as well as contacts for support.

Patients are also provided with an appointment to attend a pre-operative Joint School, a face-to-face group patient education session. Joint Schools are an important part of patient preparation for surgery and ensure that patients receive the required information and clear expectations regarding their operation. They provide an opportunity to meet many of the staff that will be involved in the patients care as well as other patients going through the same experience for ongoing peer support. Patients are encouraged to bring a ‘coach’ with them to Joint School, where possible. A coach is often a partner, family member or carer who plays an important role in supporting the patient through treatment as well as the recovery and rehabilitation process. Ysbyty Gwynedd have launched virtual interactive Joint School sessions to complement the face-to-face sessions, which was accelerated by the Covid-19 pandemic social distancing regulations. Patients are able to view a number of online videos in advance on topics which include preparation for surgery, anaesthesia, pain management and postoperative physiotherapy and they are able to discuss any issues with a multi-disciplinary team. They are joined by previous patients who are able to share their experiences and provide peer support. There are plans to roll this service out across the East and Centre Health Board areas in the future.

The Health Board Self Care Team are supporting a 3P’s (Promote, Prevent, Prepare) programme, a Welsh Government initiative that was formulated to empower people waiting for treatment to optimise their health and wellbeing, initially due to the volume of patients waiting excessive periods of time to be seen or treated. The aim of this programme is to empower people through improving communication channels and keeping them informed. The goal is to challenge the ‘traditional’ relationships people have with their health through empowering them to take responsibility and sharing decisions about their health. The key principles underpinning the 3P’s programme include: keeping people informed throughout their healthcare pathway, informing and empowering people to share the decision making regarding their health, ensuring care that is individualised based on their needs and that data is utilised to learn and improve services that people use for their health. The 3P’s programme would be able to support the patient pre-treatment by easing the information process through signposting to a robust directory of community and NHS resources.

The Health Board currently has no dedicated Single Point of Contact (SPOC) for patients to access and 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 being 'passed around the system'. A Task and Finish Group has been set up within the Health Board with the Self Care Team as the basis to implement a plan to establish a single point of contact for people to access information and support following a referral to specialist secondary care.

The Self Care Team provide EPP Cymru (Education Programmes for Patients) health and wellbeing courses that are free and aimed at adults who are living with or caring for someone with a long term health condition. Provided online or face-to-face, there are a number of courses available to suit a variety of patients and needs. Although there is no specific orthopaedics support, there is for example a living with persistent pain course available that may have been useful for the storyteller. The Self Care Team are also developing ongoing peer support, with the view to provide a 'drop in' where patients can chat to others in similar situations.

The storyteller feels a way of connecting patients who have been through similar would bridge that gap, for example via an App.

An exciting new recovery-based App for North Wales is currently being implemented into Trauma and Orthopaedic care. The App will support patients undergoing knee, hip and shoulder replacements. The App will be used to facilitate care, outcomes and satisfaction in both patient's surgical preparation and recovery. The App is intended to support patients by increasing their engagement and compliance, keeping patients engaged in their surgical journey, allowing patients to better understand their condition and take an active role in optimising their surgical experience. It will deliver patient-friendly education for pre-operative and post-operative care, answers to commonly asked questions and exercises. The App is intended to support clinicians by collecting and monitoring data that leads to clinical and operational insights by tracking patient's progress through remote monitoring and engagement. The App will be accessible by using a smart phone or device and is aiming to be launched before the end of the 2023-24 financial year in the West area team initially before being rolled out across the Health Board.

The Patient and Carer Experience Team will share this feedback and seek assurance from all departments by way of evidence that learning has been embedded. The Patient and Carer Experience Team will continue to work with the Orthopaedic service to promote all of the patient experience initiatives outlined above. The Patient and Carer Experience Team extend their gratitude and appreciation to the storyteller for sharing his experience. The Patient and Carer Experience Group will seek regular feedback regarding progress on the above actions for reporting to the Quality Delivery Group.

Teitl adroddiad: ***Report title:***	QSE Committee – Quality Report			
Adrodd i: ***Report to:***	QSE Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	18th April 2024			
Crynodeb Gweithredol: ***Executive Summary:***	This report provides the Committee with assurance, underpinned by analysis, on significant quality issues alongside longer-term data and information on the improvements underway			
Argymhellion: ***Recommendations:***	The Committee is asked to note this report			
Arweinydd Gweithredol: ***Executive Lead:***	• Angela Wood, Executive Director of Nursing and Midwifery • Dr Nick Lyons, Executive Medical Director • Gareth Evans, Executive Director of Therapies and Health Sciences			
Awdur yr Adroddiad: ***Report Author:***	• **Patient and Carer Experience, Safeguarding and IPC Sections:** Mandy Jones, Deputy Director of Nursing (Patient Experience) and Leon Marsh, Head of Patient Experience • **Patient Safety Sections:** Chris Lynes, Deputy Director of Nursing (Patient Safety) and Tracey Radcliffe, Head of Patient Safety • **Clinical Effectiveness Sections:** Dr James Risley, Deputy Medical Director (Clinical Effectiveness), and Joanne Shillingford, Head of Clinical Effectiveness			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☐ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☒ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				
There is confidence in the data provided in the report however, the pace of learning and improvement remains an area of concern and is a key focus of work. This is being addressed through a range of measures including the actions aligned to Special Measures and the Board Assurance Framework.				

Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	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. 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 – April 2023

INTRODUCTION

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

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

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

An Integrated Quality Dashboard is in development as outlined in the last report. Technical development, testing and data validation is underway.

A separate Regulatory Assurance Report provides the Committee with assurances and analysis on regulatory and healthcare law compliance matters.

Organisational Learning

The Organisational Learning Forum continues to receive regular presentations identifying opportunities for organisational learning and reflection. These presentations have included more recently learning from inquests, learning from medication errors and a recent presentation highlighted the learning from investigation report writing standards. The learning from medication errors has in particular included the importance of learning from human factors and its importance to integrate into patient safety reviews.

Further organisational learning has been disseminated across the organisation with regards to the safe administration of transdermal patches utilising the 7 minute briefing. This framework for staff briefing has been endorsed by the OLF as its evidence base suggests that seven minutes is an ideal time span in which to concentrate and learn.

Standards of practice for patient transplants and learning has also been disseminated across the organisation utilising 7 Principles endorsed by the OLF and supported with audit for evaluation.

The meeting has supported the ongoing development of an Organisational Learning Framework receiving reflections from the staff engagement event and supporting its plans to engage with service users in its further development.

The Health Board has received more than 1000 submissions through GREAT-ix – the new Learning from Excellence platform - showcasing the wealth of innovation, improvement, kindness and empathy our whole workforce has in abundance.

Any member of staff is welcome to submit a GREAT-ix to capture excellent things that happen within the NHS.

Every month the Health Board shines a light on recent submissions which showcase learning and innovation in practice.

The new Learning Portal continues in development with the aim of launching in April 2024 as a pilot. This portal will provide a single, digital organisation-wide repository for learning to be captured, analysed and cascaded.

The new Quality Informatics Portal/Quality Dashboard also continues in development. This suite of dashboards will provide a single, organisation-wide resource for accessing quality information.

Quality Improvement

The Health Board is currently working on producing a Quality Improvement Register that will provide a record of all service improvement, service change and service implementation projects currently taking place.

The purpose of the register will be a point of access for staff to use the information when looking to start any improvement project to check if it is already underway or has taken place to reduce crossover, promote cross team working, aid in sharing best practice, lessons learnt and reduce waste from repeating previously attempted changes.

Quality Management

Work continues to develop the Quality Management System (QMS) Framework ahead of Board in May 2024, building on the workshops at the Board, Executive Team and Senior Leadership Team. Research into best practice is underway by contacting and visiting NHS organisations across the UK, alongside support from Improvement Cymru, the IHI and the NHS Wales Executive Quality Team.

A QMS Working Group is in place with representatives from all key specialist functions and a rapid design workshop is planned for April 2024 to support the development – the workshop will be virtual to encourage as many services as possible to engage.

PATIENT SAFETY

PATIENT SAFETY INCIDENTS

Key issues relating to patient safety incidents:

Nationally Reportable Incidents (NRI) themes/learning

The main themes of the learning from closed incidents during January and February 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.

Incident management process

A proposal of the initial improvements based on the co-production work with services has been shared with the Patient Safety Group at the end of January 2024. The proposal progressed through to the Quality Delivery Group for approval in March 2024.

Oxygen Incidents:

There have been 6 further incidents relating to the preparation of the portable CD oxygen cylinder this year, one with a catastrophic outcome.

A number of actions were requested for assurance:

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

Additional actions were undertaken after the most recent incident:

- The internal alert has been re-issued with an additional action of when connecting patients to CD (portable) oxygen cylinders, the preparation of the cylinder and the flow of oxygen must be checked by two members of staff, one of whom must be a Registered Healthcare Professional who has completed their medicines management and oxygen competencies. HCSWs can be the 2nd checker if they have completed their oxygen competencies.
- An SBAR has been presented to the Mandatory Training Group for approval of oxygen administration to be a mandatory requirement for those staff preparing the cylinders, currently responding to queries from the group before decision.
- An SBAR for executives has been prepared for consideration of digital cylinders which would highly mitigate this risk.
- A label at the point of use that can be tied to the shoulder of the cylinder is currently being developed for use and evaluation. Confirmation of infection control issue and responsibility for application are underway.

Urology administrative backlog update

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

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

The overarching report for these incidents is awaiting director approval. Further learning following immediate actions will be shared across the Health Board by the Urology Network Manager. Of the individual cases identified as potential harm, all have been confirmed as no harm following investigation however there were lessons to be learnt around administration processes. A Standard Operating Procedure (SOP) has been developed for the administration team to support their adherence to the tasks required.
As part of the initial review there have been a further 2 cases reported of individual harm. These incidents are currently under investigation

Safe Care Collaborative

One project underway as part of this work is a standardised approach to the support of staff working within Women's Services following untoward incidents within the clinical areas.

A team collected initial data to support feedback from staff in the form of a questionnaire. 104 responses were received. 58.65% of responders who were involved in an incident felt that this had an impact on how they felt about work or on their ability to come to work. 62.50% of responders said they were not offered a group debrief following an incident.

A Task and Finish Group was developed to devise a process that ensures psychological safety. They introduced a communication tool for use following an event. This provided a consistent streamlined approach that anyone can instigate and ensures equal support for all.

The communication tool enables staff to engage in open and supportive conversation. Audit of the completion of the tool is going to be undertaken monthly and a Likert scale to measure psychological safety has been introduced for capturing of data monthly.

The tool has been implemented in East with plans to roll out to West in the next few months with recommendation for roll out further than the Women's and Midwifery Directorate with the learning to be shared across the organisation.

PATIENT SAFETY ALERTS

Outstanding Alerts:

There continues to be ongoing issues with a delay in the Health Board receiving Patient Safety and Nationally Reportable Alerts for action and distribution. This concern has been raised at the monthly All Wales Patient Safety Solutions Group (AWSSG) on multiple occasions. The Patient Safety Team were advised at the last AWSSG that compliance would not be required for those not issued by the NHS Wales Executive and therefore compliance date does not need to be on these alerts. However, the Health Board will still collate compliance even though this is not required for submission.

There are no outstanding All Wales patient safety alerts.

BCUHB compliant and now closed alerts:

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

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

- NatPSA/2023/013/MHRA Valproate: organisations to prepare for new regulatory measures for oversight of prescribing to new patients and existing female patients

- NatPSA/2023/015/UKHSA: Potential contamination of some carbomer-containing lubricating eye products with Burkholderia cenocepacia – measures to reduce patient risk

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

In progress alerts and within timescale:

- 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. Actions Plan underway. Submission of compliance is not required as not circulated via the NHS Wales Executive office. As good safety practice BCUHB will continue to comply with the alert and complete evidence.

- NatPSA_2024_001_DHSC Shortage of GLP-1 receptor agonists (GLP-1 RA) update. Pending compliance. Submission of compliance is not required as not circulated via the NHS Wales Executive office. As good safety practice BCUHB will continue to comply with the alert and complete evidence.

SAFEGUARDING

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

Serious Violence Duty (SVD) Update

The SVD was introduced as part of the Police Crime Sentencing and Courts Act 2022, the SVD requires specified authorities to work together to prevent and reduce serious violence in their local area. This SVD is supported by national guidance, finalised in December 2022. The guidance includes a chapter specifically on delivery in Wales due to its unique Partnership and delivery context. In this strategy, partners in North Wales have set out how we intend to meet the SVD.

The Health Board are one of the specified Authorities "with a duty to identify, reduce and prevent serious violence in our communities". Other specified Authorities include, North Wales Police, Local Authorities, Fire and Rescue, Probation, Youth Services and Education.

The Safeguarding and Public Protection team have been fully engaged with this agenda, attending all meetings, workshops and providing data as requested. The aim of this work is not to create additional services, but to establish what is already in place, to work collaboratively and coproduce when development opportunities occur. There has already been significant progress made towards meeting the Duty requirements in North Wales.

Specific Actions for the Health Board were to ensure that data was provided to inform the strategic needs assessment in relation to serious violence within our Emergency Departments which has resulted in a Datix development request which was presented and accepted by the Quality Systems Group for progression to the National Development Team. This will mean that when violence has

occurred, we will be able to select the weapon involved, using a drop-down list. This will enable us to monitor themes and provide accurate data.

Safeguarding Data

Health Board Safeguarding Data, specifically Adult at Risk and Child at Risk information is reported weekly into Divisional Putting Things Right meetings and monthly into respective Safeguarding Forums. Data is also shared externally within the North Wales Safeguarding Board Sub-Groups for multi-agency oversight, scrutiny and governance.

For assurance, there have been no reported concerns or issues highlighted with regard to the data between December and February 2023-24. All data is received and reviewed by the Safeguarding and Public Protection Team daily with any areas requiring additional support prioritised internally. An audit of the data is due to take place in Q1 2024-25.

Single Unified Safeguarding Assessment (SUSR) Update

Led by the Welsh Government (WG) the SUSR is an example of how, through collaboration and co-production across political, organisational, and geographical boundaries, we will tackle a complex problem and deliver a shared response. Almost 200 stakeholders were engaged in the design and delivery of the SUSR, all of whom have put the person who has been harmed, their families and communities first. This transformation supports our one public service ethos, creates a stronger culture of accountability, and dispersed leadership empowering people to share learning.

The SUSR lays out a framework for how Regional Safeguarding Boards should work with Community Safety Partnerships and other partnerships in the area such as Public Service Boards and Regional Partnership Boards to protect people from harm - sharing lessons and ensuring we work together to secure the wellbeing of every person in Wales.

This process will simplify the review landscape in Wales by combining Adult Practice Review, Child Practice Review, Mental Health Homicide Review, Domestic Homicide Review and Offensive Weapon Homicide Review processes. The SUSR will be launched in April 2024. Health Board staff have been part of the national training pilot with a full training programme due to be delivered locally from April.

INFECTION PREVENTION AND CONTROL

Lowering the burden of infection

The Health Board is currently above trajectory for all key performance organisms, however when compared to the other acute hospital provider health boards performance it has the lowest rate for MRSA bloodstream infections and the 2nd lowest for MSSA. The Health Board are slightly above average for *C. difficile* and 4th highest in Wales but are reporting less cases than for the same time period last year.

For our gram-negative bloodstream infections, BCUHB are above average for all Wales, being 3rd for *Klebsiella* and 4th highest for *E. coli* and *Pseudomonas; with the Pseudomonas* infection rate being lower than the previous year. Gram negative infections are commonly associated with the urinary tract, so Integrated Health Communities (IHC) have established working groups to specifically look at reducing catheter associated urinary tract infections (CAUTI). A full audit of urinary catheter practice was carried out in January highlighting some improvements since the last audit in April but further work is required to reduce the CAUTI rate.

Cases of Norovirus have reduced in West and Central but remain a challenge in East.

Cases of acute respiratory infection (ARI) reduced in February; in the 7 days up to 03/03/24, among all hospital admissions, hospital admissions with acute respiratory infection (ARI) reduced to 1.7%;

0.4 % were with COVID-19; 0.2 % were RSV; 1.1 % were Influenza. The majority of recent Influenza cases have been in the East.

The Infection Prevention Team and IHC's continue to liaise to:

- Ensure learning from post infection reviews is cascaded and improvement monitored through local infection prevention groups reporting up to the strategic infection prevention group.
- Deliver a robust audit programme of practices associated with the key infections and feedback performance data to enable improvement.
- Increase awareness through the new campaign "HABITS" launched in February to further engage our staff, patients and public. March will focus on 'H': Hand hygiene.

Isolating all patients with an infection into a side room remains an ongoing challenge particularly in Wrexham Maelor where the number of side rooms is very low and very few are ensuite. The Infection Prevention team support clinical staff to prioritise those who are greatest risk and there is a detailed 'Isolation Risk Matrix' to support this.

Due to ongoing pressure from patient flow, all three acute sites still have no formal decant facilities to enable a pro-active programme of Deep clean / High level disinfection. However, this is being done post infections and where there have been outbreaks. Disinfection is being done using Ultra-Violet light as the Metis hypochlorous machines have been out of use for several months now due to electrical failures and ongoing maintenance issues. BCUHB are liaising with the manufacturer to try to resolve this as soon as possible.

Optimising the use of antimicrobials

Due to an internal promotion, the Consultant Antimicrobial Pharmacist post is currently vacant but will be advertised as soon as approvals are received. Some of the key tasks of this role have meanwhile been allocated to the regional Antimicrobial Pharmacists to support.

Decontamination of reusable medical devices

The redevelopment of an area close to theatres in Wrexham Maelor for the decontamination of endoscopes is progressing well with plans to open in May. Following concerns raised by Bowel Screening Wales an options appraisal to address decontamination issues for endoscopy at YGC has been submitted to the hospital management team for consideration.

Due to increasing demand for their time and expertise, the 2 Decontamination nurse advisors are having to prioritise their workload and are to carry out a review of the service they can provide.

All operational decontamination areas are being asked to ensure they have Business Continuity Plans in place that are fully documented and signed off at Executive level.

OTHER PATIENT SAFETY CONCERNS AND IMPROVEMENTS

Falls

Attendance and requested updates by each IHC/Division against the monthly Health Board Inpatient Falls Group reporting template is sporadic. This was escalated at Patient Safety Group to support and facilitate the IHC's attendance and reporting to the Falls Group to support the sharing of learning, good practice and innovation, and in addition as an opportunity for peer support.

The Health Board desktop review for the HSE Notice of Contravention improvement plan with each IHC took place as scheduled on 29th January 2024 with the aim to review progress and support against the actions within the overarching improvement plan. Not all IHC's were in attendance for this first review and a further Executive led desktop review is scheduled for March 2024.

Access to accurate falls data by Occupied Bed Days remains a challenge for the Health Board. It is anticipated this will be resolved once the Health Board Quality Dashboard is approved and launched.

The Health Board Health and Safety Team are currently reviewing the Health Board position for access to correct manual handling equipment (flat lifting equipment) across the Health Board. Access to equipment remains variable across Health Board sites and that this is one of the four Key Performance Indicators reported nationally as part of the National Audit Inpatient Falls.

Nosocomial COVID-19 Programme

Funding for the project ceases at end of March 2024 and the Health Board is on track to complete all investigations of cases by the end of February 2024. March will then be used as a focus period for transferring all remaining investigations and Scrutiny Panel outcomes onto Datix.

Upcoming activities in this period:

1. Completion of all outstanding cases by the end of February 2024.
2. Remaining investigation outcome letters to be distributed.
3. CIVICA survey responses to be included in the end of programme report.
4. Completion of Datix work i.e. ensuring all investigations are captured on reporting system and closed appropriately

The following is a position against the trajectory:

- Cases not yet started n = 10.
- In progress n = 53.
- For Scrutiny Panel n = 13

The following is a position for Investigation Outcome Letters:

894 response letters sent to date with 100 additional letters remaining, with a breakdown as follows

- Wave 1 - 257
- Wave 2 - 286
- Wave 3 - 173
- Wave 4 – 178

PALS have received 11 phone calls ranging from simple queries to concerns regarding the letters.

10 emails have been received in response to outcome letters.

PALS currently have 3 concerns from service users. All 3 concerns response letters have been drafted and sent to the Complaints Team for review.

894 rveys have been distributed with response rate of 1.68% (n=15).

A staff story has been completed; the transcribed version has been sent to the participant for consent.

Provision of Intravenous Access (IVAS)

A review has been undertaken to consider whether there are robust processes and controls in place within the Health Board to ensure compliance with the provision of Intravenous (IV) Access pan North Wales. It identified that there is not a system wide approach to IV Access provision within the Health Board. Underfunded service provisions are fragmented and collaboration between present providers is limited. Staff and patients are not equipped to deal with complex IV access related issues putting patients at risk. This is evidenced in the IVAS Business case, Quality Impact Assessment and Datix reports.

In December 2023 the IHC Leads were asked to complete a baseline IHC self-assessment Matrix against Quality Standards for Intravenous Access Service (IVAS) following request by the Patient Safety Group for IHC position against Quality Standards. Provision of assurance or mitigation was required. The outcomes combined gives an overall rating for the Health Board. The paper will be presented to the Quality Delivery Group in March with recommendations on future service delivery.

Sharing learning from incidents

A revised lessons learnt template will include a number of prompts in order to help IHCs and Divisions to consider how to generate the evidence of learning and experience within their respective operational areas. The idea is to identify, collate, analyse and implement the learning.

A cycle of business for the Patient Safety Group will be prepared to focus on certain specialities for next year's meetings with IHC's/areas bringing by exception anything requiring escalation. The learning will then be tracked through the action log to understand the impact of the change.

PATIENT EXPERIENCE

COMPLAINTS

During January 2024 to February 2024, the Health Board received 450 complaints, 360 of these were managed under Putting Things Right, an additional 67 were resolved as Early Resolutions and 23 complaints re-opened (re-opened concerns refer to complaints which have been re-opened due to additional questions raised or dissatisfaction with the initial response).

The majority of the complaints related to Secondary Care Services. The top themes remain the same from the last report relating to: clinical treatment and assessment (227), poor communication (44), appointments (25) and medication (25). Attitude and behaviour issues are common themes across all services which is consistent with the communication issues.

There were 364 overdue complaints in total at the end of February 2024. This is an increase of 23% of overdue complaints since December 2023, where the position in December 2023 was 296 overdue complaints. 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.

It should be noted the number complaints relating to planned care is 102 (to the end of February) of which 78 are overdue, a further increase of 36 since the report of December 2023, where planned care had a total of 42 overdue complaints. This gives an overall overdue complaints position of 286 when excluding planned care complaints. This however, would still indicate an increase in the overall percentage of overdue complaints of 12.5% when excluding planned care complaints in comparison to December 2023 (254 Vs 286).

Planned Care Complaints Data

	Received	Still open or overdue
2023		
Sep	2	1
Oct	28	25
Nov	27	24
Dec	17	17
2024		
Jan	14	14
Feb	14	11
Totals	102	92

Each Integrated Health Community (IHC) has adopted weekly Putting Thing Right Meeting to manage the progress of complaints received. The Complaints Team are currently working to trajectories to reduce the number of overdue complaints which are under scrutiny by the Executive Team. This is supported by the submission of complaints / PALS' data sent every Monday commencing from 4th March, 2024.

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 becoming overdue are prioritised to ensure that deadlines are met.

The number of complaints closed from the 01 January 2024 to the 29 February 2024, was 318 complaints, of those 241 were managed under Putting Things Right, 67 Early Resolution, and 10 reopened, broken down as follows:

Total complaints closed = 318
Within 30 working days = 134 (42.93%)
Total closed after 40 working days= 153 (52.1%)

Broken down by

PTR = 241 (75.78%)
Early Resolution = 67 (21.07%)
Re-opened = 10 (3.14%)

The closure rate within 30 working days has improved from 39.5% to 42.93%, this is evident following the increased scrutiny by the Directors of the IHC to promote early resolution and closure to complaints.

PATIENT FEEDBACK

Within the reporting period the Patient Advice Liaison Service (PALS) facilitated the resolution of 1,522 enquiries for January 2024 to February 2024, which is a 16% increase in the number of enquiries in comparison to the previous reporting period. The key themes identified from PALS enquiries within this reporting period include:

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

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

From November January 2024 to February 2024 the Health Board received 8,716 All Wales Real Time Feedback survey responses via the Civica feedback system.

Key findings from the real-time survey feedback include:

- 88% of respondents were satisfied with their overall experience
- 80.77% of respondents were always given all of the information needed
- 83.82% of respondents always felt listened to
- 80.53% 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.

There has been a slight in increase in responses from the All-Wales Emergency Department national patient feedback survey from 19 surveys collected in the last reporting period to 57 surveys collected from January 2024 – February 2024. 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 exploring the implementation of SMS feedback surveys to patients who have attended the Emergency Department.

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

- 89.66% of respondents felt from the time they needed to use this service they waited much too long
- 24.56% of respondents always felt listened to
- 19.64% of respondents always got assistance when needed
- 23.21% of respondents always felt things were explained in a way that they could understand

A patient story was captured describing a patient's experience of being an inpatient on Ward 12 at Ysbyty Glan Clwyd. Whilst receiving intravenous antibiotics during his two-week stay, the storyteller had a cannula fitted in his arm. Being an early riser and wanting a 'change of scenery' away from the ward, the storyteller describes visiting the Ysbyty Glan Clwyd canteen on multiple occasions with no issues, until a staff member noticed his cannula and then refused to serve him food and drink in the canteen area in line with 'policy' and due to infection prevention recommendations.

The storyteller highlights the importance of accessing canteen services on patient wellbeing and improved patient experience. From a learning perspective, the story highlighted the inconsistent messages for patients accessing canteen areas across the Health Board. A Task and Finish Group with Catering Manager representation from all three areas, Infection Prevention Control (IPC) representation and support from the Patient and Carer Experience Team was set up to develop consistent guidance to prevent disparity in experience and to support all patients being able to access the canteen areas across all Health Board sites in a safe and consistent way.

This piece of work will support Health Board's 'HABITS' Infection prevention Campaign.

OTHER PATIENT EXPERIENCE CONCERNS AND IMPROVEMENTS

Small Business Research Initiative (SBRI) Patient Communication Project

The SBRI Patient Communication pilot led by Red Star in Ysbyty Glan Clwyd is now live on Ward 1 and Ward 5. The aim of the project is to improve communication between the family/relative whilst their loved one is in hospital, by providing relatives with written daily updates via a digital portal/SMS. The uptake of the pilot has been slower than expected 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.

To date 30 patients consented to be involved in the pilot whilst they were an inpatient. Of the 30 patients, 41 family members/relatives signed up to receive daily updates. In total 121 updates have been sent out, of which 116 updates provided were general updates (e.g. patient had a good night), 1 update was in relation to discharge information and 4 updates were requesting items from home such as clothing/books. There were also 50 enquiry messages received from relatives, of which 35 required response from staff.

The pilot will continue until June 2024 with Ward 9, re-engaging in the pilot in March 2024. The Patient Advice Liaison Service are engaging with relatives to capture their experience of using this system to understand if this has helped improve communication between the ward and relatives. To date feedback from relatives has been positive '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).

The SBRI Patient Communication pilot project led by Round Safely in Ysbyty Gwynedd is now live on Prysor Ward. Glaslyn and Ogwen Ward will be going live by the end of March 2024. This pilot will involve staff sending daily voice note updates to relatives. In total 27 staff (nursing and therapies) have received training to use the system.

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. In the reporting period 19 patient information leaflets were reviewed by the Readers Panel. Examples of patient information leaflets reviewed include:

- See on Symptoms – information for patients and carers
- Patient Initiative Follow Up (PIFU) - information for patients and carers
- Blood Taking Service – patient information leaflet (East)
- Guide to wrapped bathing for babies

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.

The Patient and Carer Experience Department are improving the way it communicates with patients and families 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 April 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 patients and families 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 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 Officers to increase face to face patient experience activity, being more visible on wards and across community hospitals capturing and learning from patient and carer experiences.

Chaplain and Spiritual Care Service

During the reporting period 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.

- Arts in Health - In January 2024 the chaplaincy worked alongside the Dementia Support Team on an art project as art has been recognised as an important vehicle for the development of spirituality. Working with a local artist, the Dementia Support Team and the Chaplaincy held two morning events in the chaplaincy in Ysbyty Gwynedd. Patients who were supported by the Dementia Support Team, came down to the centre to participate in art projects such as painting and craft work. The art work is now displayed on a wall in the hospital for visitors to see.

- Music – 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.

- Conwy Connect Project – 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.

The Chaplaincy organised and delivered a Holocaust memorial event which was held in Ysbyty Glan Clwyd Chaplaincy Centre. It is important that the Health Board continues to recognise and celebrate national/world awareness days.

For World Faith Day on the 15th January 2024 the Chaplain Manager produced a video to celebrate World Faith Day. The video included a tour of the Chaplaincy Centre in Ysbyty Gwynedd showing the significance of all the faith areas within the centre and the meaning of the different symbols within our centre. The video was shared across the Health Boards social media sites.

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 hr of the initial request for all end of life or urgent care.

CLINICAL EFFECTIVENESS

CLINICAL AUDIT

Clinical audit is a quality improvement cycle that involves measurement of the effectiveness of healthcare against agreed and proven standards for quality, and taking action to bring practice in line with these standards to improve the quality of care and health outcomes.

National clinical audits (Tier 1) are aimed at measuring and benchmarking the improvement of healthcare services in Wales. Tier 2 audits, which 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.

Within the Clinical Effectiveness department in order to capture relevant information, Service Assessment of Compliance forms are sent to all services participating in Tier 1 National Clinical Audits and Outcome Reviews, to complete with regard to the recommendations made in the published reports for the mandatory National Audit/Review.

Over the last year, these forms have been reviewed, monitored and adjusted to make sure the correct information is requested to enable a detailed response to be provided. Where national findings reveal common issues identified from the audits, and where national healthcare is generally falling below the required audit standards, there is a requirement to provide an action plan to address how these will be managed and a realistic timeframe provided. Guidance provided to services for completion of the form is below:

Response questions:	**Guidance Note:**
How was the data validated within BCU for the period covered by this national report publication?	Please outline the process of validation of data, how is it checked for accuracy before it is submitted to the national host
Is the Service confident of its compliance against the audit/review standards? **(Yes/No)**	Does the Service exceed/meet/fail the required standards? This is a clinical judgement of the Service's overall compliance against the national audit standards.
Assurance Level: **Full / Significant / Limited / Very limited**	Please indicate appropriate level of assurance identified for the Service by the National findings by clicking on the box. **(**i.e., Full / Significant / Limited / Very limited) and outline a brief rationale for this judgement. **If service is fully compliant, evidence should be kept in case of future requests from external auditors.**
Clinical Risk level: **None / Low / Minor / Moderate / Major / Catastrophic**	This is a clinical assessment of the risk identified for the Service by the National findings. There should be clear distinction between operational service issues and organisational risks. If the Service has judged that it carries no clinical risk (**None)** in terms of the standards then the following section relating to risk register is therefore not applicable (N/A). **If service carries no clinical risk then evidence should be kept in case of future requests from external auditors.**
Is this currently captured on the Health Board Risk Register?	If yes – please give the Risk number If no, please outline briefly why it is not on the Risk Register.

Please provide below an indication of what is needed to mitigate or achieve compliance via **S**MA**R**T Actions / Improvement Plan.

Issue or National Recommendation	**Details of proposed Action(s)** (including how improvement will be measured and demonstrated)	**Responsible for completing action** (name and job title)	**Timescale** (Inc. milestones & expected end date). If completed, add completion dates & embed evidence	**RAG STATUS** (Red/Amber/Green) Impact on people who use services, visitors or staff - *see guidance*
Issues identified and Actions	A **S**MA**R**T action should fully capture the work ongoing within the Service. It may be helpful to identify: • To which national recommendation does the audit link? • Which issue will the proposed action address? • What will the action achieve? • How will the outcome of the action be measured/evidenced? • If actions are delayed/on hold for an extended period (>six months) what mitigations are in place?			

Progression of both Tier 1 and Tier 2 audits are monitored quarterly to provide accountability and any assistance that may be necessary to ensure completion against agreed timelines. These reports are submitted to Strategic Clinical Effectiveness Group for discussion and review and then the Quality Delivery Group. Below is a summary Tier 1 nationally published reports (the information in the report is relating to the care received by patients for the relevant audit topic) during **Quarter 3** with an update on key achievements.

				West	Central	East	
Title of National Audit	**Name of report**	**Date of publication**	**Date Service Assessment response due**	**Service Assessment Completed**	**Service Assessment Completed**	**Service Assessment Completed**	**Key Achievements Summary**
National Audit of Dementia	National Audit of Dementia Care in General Hospitals 2022-2023 Round 5 Audit Report	10-Aug-23	11-Oct-23	**Yes**	**Yes**	**Yes**	**East & West:** Robust dementia governance arrangements in place since January 2023. NAD will be part of BCU's Dementia Improvement Plan so is fully integrated into core business. **Central:** Significant increase in use the 'Single Question in Delirium' (SQUID) question on admission for delirium screening compared to Round 4 across all 3 sites. Significant rise in use of the 4AT tool in diagnosing delirium across all 3 sites. Excellent compliance with pain assessment & re-assessment in patients with dementia within 24 hours of admission across all 3 sites.
National Hip Fracture database (Falls & Fragility Fractures Audit Programme)	15 Years of Quality Improvement. The 2023 National Hip Fracture Database Report on 2022. 1st Jan 2022-31 Dec 2022	14-Sep-23	14-Nov-23	Yes - Draft	Yes - Draft	Yes - Draft	*Draft responses received from IHC West & Central to be finalised and reported in Quarter 4 report. Outstanding response have been escalated to IHC East; Draft response now received (March) to be reported in Quarter 4*
National Pregnancy in Diabetes Audit (NPID)	2021-2022 report	12-Oct-23	07-Dec-23	Yes - Draft	Yes - Draft	Yes - Draft	*Challenges in providing a comprehensive assessment due to size of cohort for each individual IHC. Draft responses received from all three IHCs and exploring if collating into a BCUHB-wide assessment would be suitable, to be reported in Quarter 4 report.*
National Diabetes Audit	Report 1 Care Processes and Treatment Targets 2021/2022	12-Oct-23	07-Dec-23	Yes - Draft	Yes - Draft	Yes - Draft	*Response delayed (due Dec 2023) and now expected for inclusion in Quarter 4 report following a meeting scheduled for Jan 2024 between the BCUHB Diabetic Lead and the IHC Assistant Medical Directors to discuss and finalise*
National Diabetes Audit: Type 1 Diabetes	2021-2022 Report	12-Oct-23	07-Dec-23	Yes - Draft	Yes - Draft	No	*Draft responses received from IHC West to be finalised and reported in Quarter 4 report. Outstanding responses have been escalated to IHC's. IHC Central response drafted and will be reported in Quarter 4 report.*
National Early Inflammatory Arthritis Audit (NEIAA)	State of the Nation report 2023- summary report data collection period 1st April 2022-31st March 2023	12-Oct-23	11-Dec-23	**Yes**	**Yes**	**Yes**	**Central:** Established weekly Early Arthritis Clinic (including ultrasound assessment which will allow to confirm / rule out diagnosis same day of assessment without any further delay). **East:** Audit results from the 4th annual report – Wrexham have now committed to EIA clinics: EIA service commenced in Wrexham Maelor for the first time – one doctor and one nurse followed by additional doctor and nurse led clinics. 2 clinics for review / education and treatment giving room to cover for any sickness/annual leave in the department, without having any impact on time scales of review /treatment/education for our patients.

National Neonatal Audit Programme (NNAP)	Summary report on 2022 data	12-Oct-23	12-Dec-23	Yes	Yes	Yes - Draft	**West:** Maintained 100% compliance for use of Magnesium Sulphate. Above the national average for cord clamping, recording the first skin temperature within one hour, parents being seen by a consultant within the first 24 hrs and the first retinopathy of prematurity (ROP) screening of eligible babies. The proportion of nursing shifts staffed in accordance with guidance sits at 98.6%. **Central**: YGC has made significant progress in improving breast-feeding rates, thanks to the work in relation the BFI accreditation project. We have also made significant reduction of significant Bronchopulmonary Dysplasia (BPD) or death from 38.5% in 2019 to 29.4% in the 2022. This is due to multiple measures being taken in response to the national NNAP reports. **East:** We are pleased to note the improvements that are showing in the NNAP data for the first three quarters of 2023, which indicate significant achievement for the team across a range of measures.

NICE GUIDELINES

The Audit Management and Tracking (AMaT) system is now being used to monitor compliance with NICE guidance. The Clinical Effectiveness Team are working to support departments with guidance and training, where needed and any overdue guidance is escalated back through the Strategic Clinical Effectiveness Group (SCEG) when necessary.

NICE Guidelines - Summary of activity
Guidelines published between: - 1st April 2023 & 29th February 2024

BCUHB

Guidance published by NICE

Period from: 05 January 2024 to: 29 February 2024	N value	Percentage
Compliance statement required	up from 121 to 137	down 0.0%
For information only	up from 33 to 36	down 0.8%
Not applicable to HB	up from 2 to 3	up 0.4%
Blanks	up from 2 to 3	up 0.4%
Total	up from 158 to 179	

Current position - as of 29 February 2024		
Compliance statement required	137	76.5%
For information only	36	20.1%
Not applicable to HB	3	1.7%
Blanks	3	2%
	179	

Overall BCUHB Compliance Status

Period from: 05 January 2024 to: 29 February 2024	N value	Percentage
Fully Achieved	up from 38 to 52	up 6.6%
Partially Achieved - Acceptable	no change	no change
Partially Achieved - Improvement Needed	no change	down 0.3%
Not Achieved	down from 1 to 0	down 0.8%
Not Applicable (N/A)	up from 14 to 19	up 2.3%
In Progress	down from 20 to 17	down 4.1%
Overdue	up from 45 to 46	down 3.6%
Total	up from 121 to 137	

Current position - as of 29 February 2024		
Fully Achieved	52	38%
Partially Achieved - Acceptable	0	0%
Partially Achieved - Improvement Needed	3	2%
Not Achieved	0	0%
Not Applicable (N/A)	19	14%
In Progress	17	12%
Overdue	46	34%
	137	

Status of compliance responses requested - Overall

Period from: 05 January 2024 to: 29 February 2024	N value	Percentage
Fully Achieved	up from 141 to 203	up 6.9%
Partially Achieved - Acceptable	up from 17 to 22	up 0.4%
Partially Achieved - Improvement Needed	up from 19 to 47	up 4.2%
Not Achieved	no change	down 0.1%
Not Applicable (N/A)	up from 47 to 71	up 2.9%
In Progress	down from 101 to 80	down 6.0%
Overdue	down from 190 to 168	down 8.4%
Total	up from 520 to 596	

Current position - as of 29 February 2024		
Fully Achieved	203	34%
Partially Achieved - Acceptable	22	4%
Partially Achieved - Improvement Needed	47	8%
Not Achieved	5	1%
Not Applicable (N/A)	71	12%
In Progress	80	13%
Overdue	168	28%
	596	

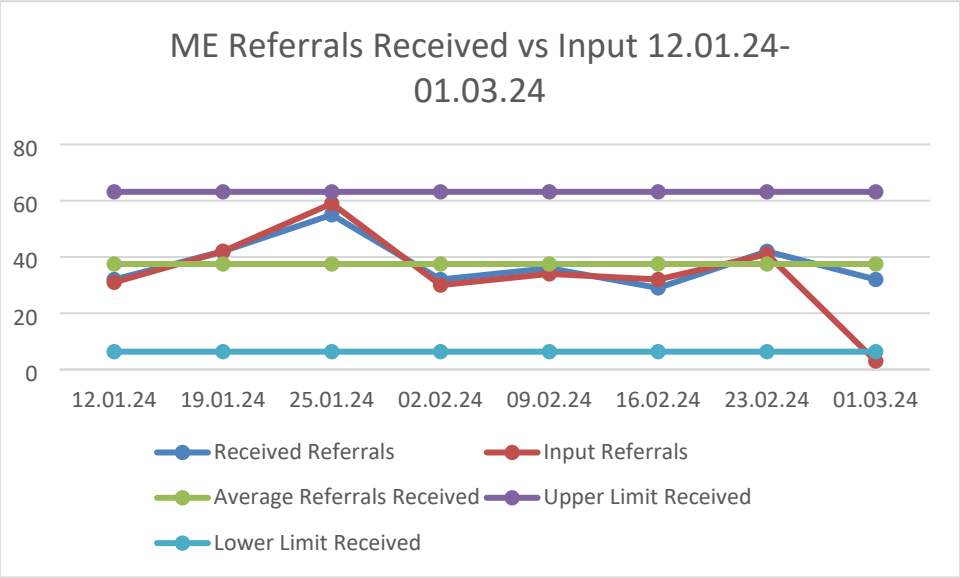
MORTALITY REVIEWS

	Input/output			Inputting Backlog				Datix Status										
Date	Total received per week*	Total input per week	Output Differential	Total w/e Backlog inc compliments	Backlog of cases requiring inputting within 1 month from date received by MES	Backlog of cases requiring inputting within 2 months from date received by MES	Backlog of cases requiring inputting within 3 months from date received by MES	Total New cases (awaiting mortality admin s&s)	New Under 1 month DOD (awaiting mortality admin s&s)	New Within 2 months DOD (awaiting mortality admin s&s)	***New Within 3 months & over DOD (awaiting mortality admin s&s)**	Total Pending Cases awaiting Mortality Clinician Review S&S	Pending Cases Under 1 month awaiting Mortality Clinician Review s&s	Pending Cases Within 2 months awaiting Mortality Clinician Review s&s	Pending Cases Within 3 months awaiting Mortality Clinician Review s&s	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
12.01.24	32	31	-1	11	11	0	0	328	105	99	124	76	11	6	59	411	205	1806
19.01.24	42	42	0	10	10	0	0	279	108	103	68	133	15	5	113	407	210	1839
25.01.24	55	59	4	1	1	0	0	296	118	111	67	141	22	9	110	424	214	1852
02.02.24	32	30	-2	3	3	0	0	263	107	126	30	159	17	12	130	444	215	1876
09.02.24	36	34	-2	5	5	0	0	274	-	-	-	158	-	-	-	461	215	1881
16.02.24	29	32	3	2	2	0	0	284	105	129	50	153	14	3	136	476	216	1892
23.02.24	42	41	-1	3	3	0	0	266	99	127	40	168	23	2	143	488	217	1919
01.03.24	32	3	-29	32	32	0	0	209	57	132	20	164	12	8	144	501	218	1956

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



The mortality review process will be extended further from April. New legislation commencing then mandates that all of community/primary care deaths, along with secondary care deaths, will now be reviewed through the Medical Examiner Service.

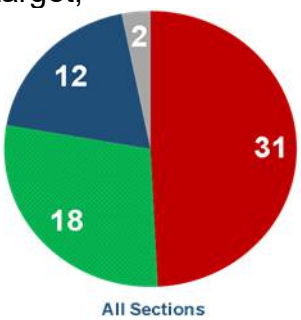
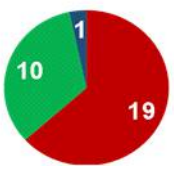
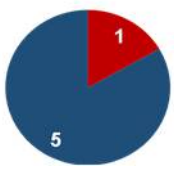
As a result of concerns identified through inquests, the Deputy Executive Medical Director reviewing and revising the inquest process in March 2024 to improve the links to, and triangulation with, the incident process.

OTHER CLINICAL EFFECTIVENESS CONCERNS AND IMPROVEMENTS

Below is an update on areas of data collection issues reported for review raised through Quarter 3. NELA and TARN, which were submitted within Quarter 1 and Quarter 2, have been highlighted where updates have been provided; the remainder are new for this report.

Title of National Audit/ Clinical Outcome Review	East Participation/Data collection issues reported	Central Participation/Data collection issues reported	West Participation/Data collection issues reported
National Emergency Laparotomy Audit (NELA)			The Audit lead raised an issue of data entry by Consultants before stepping away from the role in 2021. West has consistently raised the issue of data entry by Consultants and in 2023 the West Anaesthetic Lead stepped down as a result. SBAR submitted to Strategic Clinical Effectiveness Group in September 2023. ***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.***
Trauma Audit & Research Network (TARN)			UK Trauma Registry shut down due to cyber-attack on host. No data collection since June 2023 (UK wide). NHS England has developed an improved replacement to TARN - the National Major Trauma Registry (NMTR). ***In February 2024, NHS England disseminated an update to the Trauma Networks for the Trauma leads,***

			Information Governance and the Emergency Care DGMs. ***Summary:*** ***1) Request Medical Directors to cascade and communicate – Re: Resumption of data collection to Service Leads for Trauma activity*** ***2) By April 2024, all trauma centres to re-establish a routine submission of data to the new service.*** ***3) The annual invoice cycle will resume for the new NMTR from April 2024. The Finance department will be contacted shortly to details.*** 4) ***Detailed plans for on boarding and training on the new platform will be provided shortly.***
National Heart Failure Audit		National Heart Failure Audit (NHFA): -Data entry not progressing in West as the audit administrator post is vacant.	National Heart Failure Audit (NHFA): -Data entry not progressing in West as the audit administrator post is vacant.
Myocardial Ischaemia National Audit Project (MINAP)			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)	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.		

Teitl adroddiad: ***Report title:***	Our Integrated Performance Report – Month 11, 2023/24
Adrodd i: ***Report to:***	Quality, Safety & Experience Committee
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 18 April 2024
Crynodeb Gweithredol: ***Executive Summary:***	This Report relates to the Month 11, 2023/24 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. The purpose of the Framework is to integrate key performance indicators (KPIs) from: - 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. 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;  All Sections  Quality, Safety, Effectiveness & Experience Performance  Access & Activity Performance  Financial Performance  People & Organisational Development Performance

	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. 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: - • 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 Executive Delivery - Integrated Performance Group (IPG). The implementation requiring production of an Integrated Performance Report (IPR), with an initial report presented through the Performance, Finance & Information Governance Committee. The structure of our IPR is based upon the 'Quadruple Aims' as per the Welsh Government's A Healthier Wales paper, the NHS Wales Performance Framework 2023-24 and identifies where metrics fall within the Special Measures Framework for BCUHB or within the Ministerial Priorities. This Report relates to the Month 10, 2023/24 (Month 11 for Financial performance) 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. The purpose of the Framework is to integrate key performance indicators (KPIs) from: - 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. 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; 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. 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: - • 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 Executive Delivery - Integrated Performance Group (IPG). The implementation requiring production of an Integrated Performance Report (IPR), with an initial report presented through the Performance, Finance & Information Governance Committee. The structure of our IPR is based upon the 'Quadruple Aims' as per the Welsh Government's A Healthier Wales paper, the NHS Wales Performance Framework 2023-24 and identifies where metrics fall within the Special Measures Framework for BCUHB or within the Ministerial Priorities. 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. The intention of the report structure is to enable members to identify key escalations from sub-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; • Development of local metrics that give greater insight into understanding current performance (through Executive forums & sub-Committees). • Greater ownership by sub-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. 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.
Argymhellion: ***Recommendations:***	The Quality, Safety & Experience Committee is asked to: 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.
Arweinydd Gweithredol: ***Executive Lead:***	Russell Caldicott, Interim Executive Director of Finance and Performance
Awdur yr Adroddiad: ***Report Author:***	Ed Williams, Acting Director of Performance

Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐		I Benderfynu arno *For Decision* ☒	Am sicrwydd *For Assurance* ☒
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☐ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☒ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	The performance measures included in this report are from the NHS Wales Performance Framework 2023-24.			
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	This report will be available to the public once published for Quality, Safety & Experience Committee			
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	N The Report has not been Equality Impact Assessed as it is reporting on actual performance.			
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	N The Report has not been assessed for its Socio-economic Impact as it is reporting on actual performance			
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan	There remians a number of risks to the delivery of care across the			

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)***	healthcare system due to the legacy impact the COVID-19 Pandemic had upon planned care delivery between 2020 and 2022. 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. References to Corporate Risks have been made the body of the report, where applicable.
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	The delivery of the performance indicators within our IPR will directly/ indirectly impact upon the financial recovery plan of the Health Board.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	The delivery of the performance indicators within our IPR will directly/ indirectly impact on our current and future workforce.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	The full report has been reviewed by the Director of Performance, and the Executive Director of Finance & Performance.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	24-04 Failure to Embed Learning
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Amherthnasol Not applicable
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** ***Implementation of recommendations:*** Continued focus on any areas of under-performance where assurance is not of sufficient quality to believe performance is or will improve as described.	

The Integrated 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. 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.
Rhestr o Atodiadau: ***List of Appendices: 2*** *1: Summary of Report* *2: Integrated Performance Report in PDF* *3: Escalations from Integrated Performance Report in PowerPoint*

Appendix 1 – Summary of Report

Committee: **Quality, Safety & Experience**

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

Report Author: **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

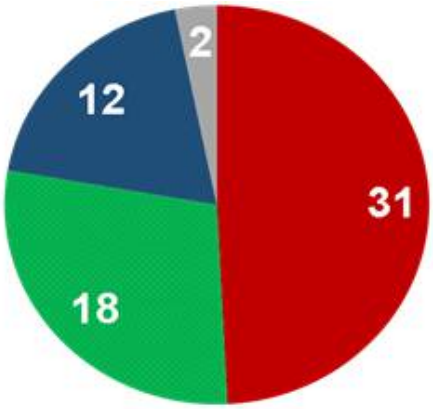
This structure enables an 'at a glance' view of the main concerns or message of the report through review of the initial one-page summary that is split into four quadrants, with the further slides contained within this escalation section articulating in more detail the current performance and actions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

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

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

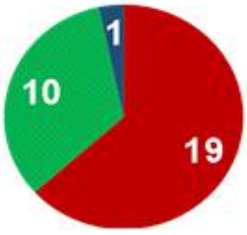
In response to the request from the Health Board on 25.01.2024, where appropriate, the Corporate Risk Register (CRR) reference number has been included in the report. This is to facilitate triangulation between the performance and risk contexts.

2. Overall Summary



All Sections

Quality, Safety, Effectiveness & Experience Performance



Access & Activity Performance

Financial Performance

People & Organisational Development Performance

3.1 Quality (Safety, Effectiveness & Experience) Performance

The key areas highlighted centre upon:-

Three new never events were reported in February 2024.

- **Wrong Site Surgery:** Patient undergoing amputation of 2nd and 3rd toes had an incision into the 4th toe instead of the 3rd, however stopped and proceeded to amputate the correct toe.
- **Wrong Procedure:** Patient had mirena coil inserted after a category 2 caesarean section that was planned for a different patient. There was a change in the list order due to the increase in category for this patient.
- **Wrong Route (Medication):** Patient was unable to swallow oral medication. The medication was crushed and mixed with water in a syringe and inadvertently given intravenously (IV).

Overdue investigations remain a challenge. From a total of 594 open complaints, 365 investigations remain overdue at the end of February 2024. Of the number of overall complaints made, the sub category of Delay / Lack of treatment has risen significantly due to complaints about the situation with insourcing.

Cause of delays:

- Operational team capacity
- Legal and redress turnaround times
- Delay with independent primary care providers' responses
- Corporate team capacity
- Workforce capability leading to significant support required
- Increase in planned care insourcing enquiries

Actions:

- Weekly PTR clinic with legal team; weekly scrutiny by Integrated Health Communities (IHCs) and Corporate team to expedite
- Executive Directo4r of Nursing (EDoN) focus on grade 1 and 2 for early resolution
- Development sessions, review of complaints process to be presented to Patient & Carer Executive Group (P&CEG) in March 2024
- EDoN / Executive Medical Director (EMD) / Executive Director of Therapies & Health Sciences (EDT&HS) requested feedback by 5th February 2024 from each IHC / specialist service regarding trajectory and plans
- weekly corporate meeting to track

Clinical coding compliance has and will continue to see a significant reduction as it is a result of the loss of staff to other organisations who pay more money and offer home working as they have Electronic Healthcare Record systems. There were 8.63 WTE (17.8%) fewer Qualified Clinical Coders in the department pan BCU in January 2024 as there was in January 2023. During the same period, the department has seen an increase of 2 WTE trainee clinical coders in the department (this number will increase as we move through recruiting the vacancies). The issue affects all sites although it has affected West and Centre more than East to date.

See appendix below

Appendix 1 – IPR for QSE 18.04.2024

IPR for QSE 12.12.2023 DRAFT v0.3

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

Integrated Performance Report

Presented **on 18th April 2024**

Quality, Safety & Experience Committee

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

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Performance Escalations Report

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

Key Messages

Quality, Safety, Effectiveness & Experience Performance

Three Never Events have occurred. At the time of writing, Rapid Learning Panels were being arranged and full investigations are underway. Learning will be reported in the Improving Quality Report to Board.

Clinical coding compliance has and will continue to see a significant reduction which is directly attributed to a loss of staff to other organisations who pay more money and offer home working as they have Electronic Healthcare Record systems. A paper for additional financial superior is being prepared for Health Board to review at the end of March 2024.

Overdue investigations remain a challenge across incidents and complaints leading to delays in patient responses, learning and submissions to the Coroners. The Corporate teams continue to provide support and scrutiny of IHC performance.

Planned care/insourcing **complaints** remain an issue: the number complaints relating to planned care is 102, which equates to 17% of the overall number of open complaints, of which 78 are overdue.

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 & Safety – Complaints, Concerns and Incidents

Nationally Reportable Incidents (NRIs)

There were 21 incidents that occurred in January 2024 that were reported to NHS Wales Executive as NRIs under the following themes :

- 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

Early Warning Notifications

There were 5 early warning notifications to WG (some also NRIs) relating to death of patients under mental health services, death of patients in community whilst waiting for an ambulance and contents of a package received reported to the police.

Never Events

In February 2024, there were 3 Never Events

- Wrong Site Surgery: Patient undergoing amputation of 2nd and 3rd toes had an incision into the 4th toe instead of the 3rd, however stopped and proceeded to amputate the correct toe.
- Wrong Procedure: Patient had mirena coil inserted after category 2 caesarean section which had been planned for a different patient. The list order was changed due to the increase in category for this patient.
- Wrong Route (Medication): Patient was unable to swallow oral medication, medication was crushed and mixed with water in a syringe and inadvertently given Intravenously.

At the end of January 2024 there were 87 open NRIs of which 24 were overdue outcome forms to NHS Wales Executive. The Patent Safety Team (PST) are supporting the progression of all NRIS. Drop in clinics for staff are held weekly to help focus the outcome from the incident review with any learning which can be shared.

The Integrated Health Communities (IHCs) and Divisions have submitted their reduction plans to the Executive Director of Nursing and Midwifery for onward monitoring of trajectories.

Quality – Clinical Coding Timeliness

Clinical coding compliance has and will continue to see a significant reduction which is directly attributed to a loss of staff to other organisations who pay more money and offer home working as they have Electronic Healthcare Record systems. There were 8.63 WTE (17.8%) fewer Qualified Clinical Coders in the department pan BCU in January 2024 as there was in January 2023. During the same time period the department has seen an increase of 2 WTE trainee clinical coders in the department (this number will increase as we move through recruiting the vacancies). All sites have been effected due to the decrease in the retention of staff, West and Centre have been effected more than East to date.

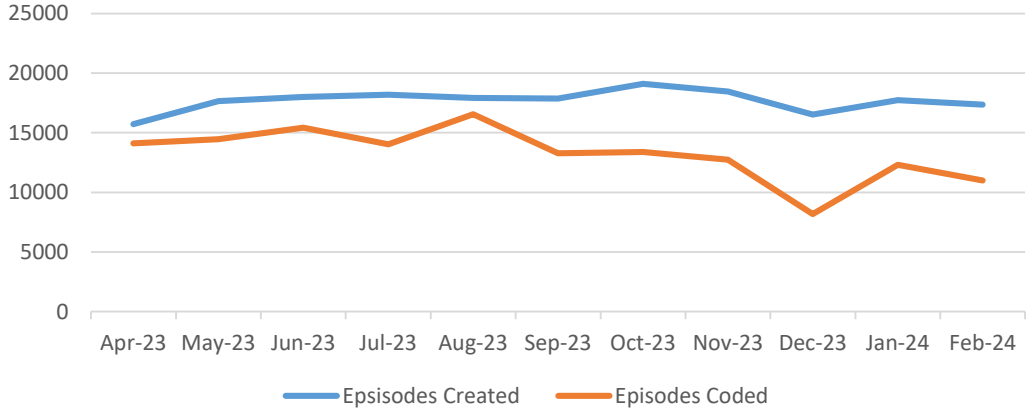
The trainee clinical coder rates across Wales have risen from 11% to 40% over the past 3 years showing a national retention issue of qualified experienced coding staff.

A paper has been submitted to the Board requesting additional financial support, additional information has been requested and new draft of paper is being prepared to be escalated to Board at the end of March 2024.

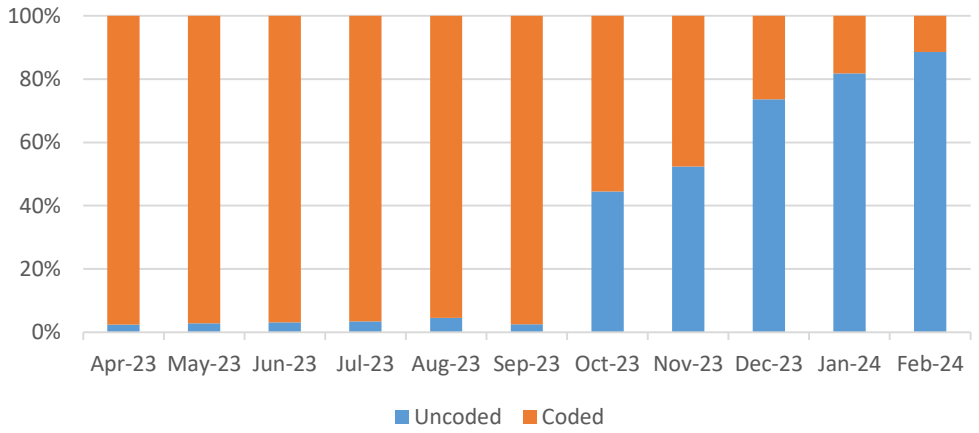
Trainee coder pay has been changed from Annex 21 of a Band 4 to a Band 3, this will help with R&R issue of trainees.

All vacant posts are being submitted to the Establishment Control panel requesting permission to recruit replacement staffing.

Coding Capacity vs Demand



Coding Completeness for 23/24



Quality & Safety – External Assessment

- No HIW or CIW inspection reports were published in January 2024.

- The Health Board awaits the draft report following the inspection of Nant Y Glynn CMHT – no immediate concerns were raised at the time.

- Two immediate assurance letters were received and responded to:
  i. a paediatric case relating to child protection concerns.
  ii. a surgical case where the family of the patient approached HIW to express concerns in relation to care and treatment after the patient was admitted to ITU.

- No Ombudsman Pubic Interest Reports were published.

- Regulation 28 Notices: 3 in February, 1 in March, detailed as follows:

i. East - issues in relation to no Datix or subsequent investigation into a patient lost to follow-up.
ii. MHLD - issues raised in relation to communication between the Health Board and an out of area acute psychiatric facility.
iii. West - issues raised in relation to communication between the Health Board and an out of area acute psychiatric facility.
iv. West - issues raised in relation to the patient being seen by a number of orthopaedic doctors of varying grades including consultants.

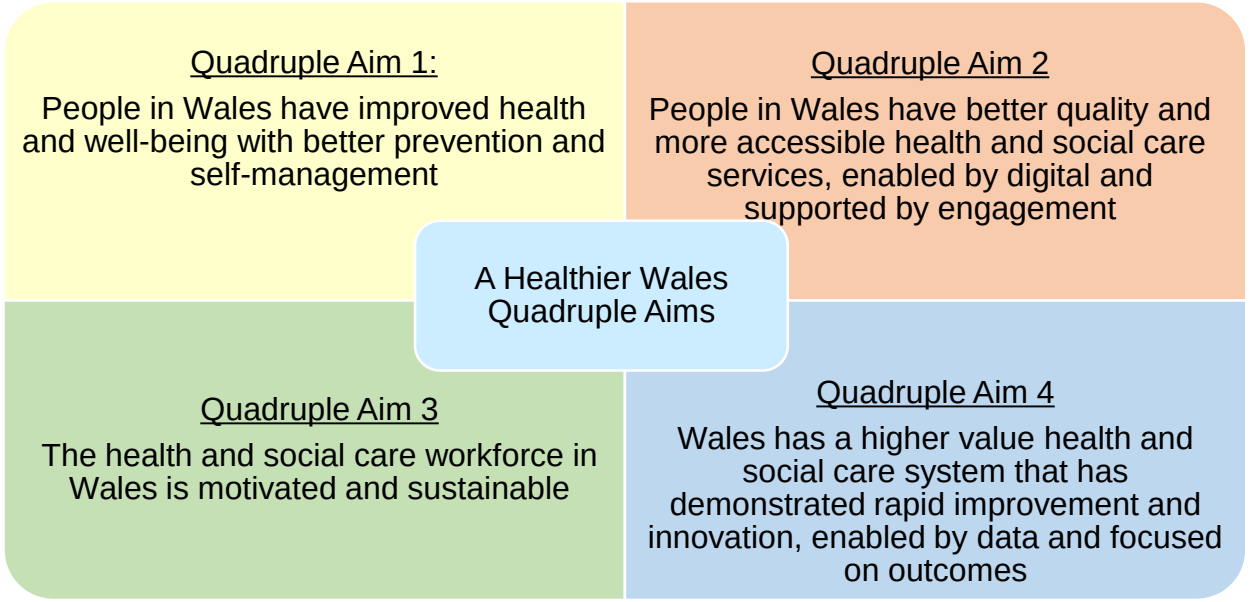
About the Integrated Performance Report

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

NHS Wales Performance Framework 2023-24

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

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



Our Integrated Performance Report

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

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

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

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

Red, Amber & Green (RAG) Rating System

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

Green

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

Amber

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

Red

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

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

Interpreting Results of Statistical Process Control (SPC) Charts

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

How to interpret variance results

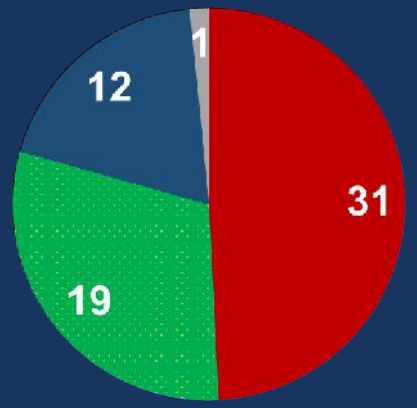
- Variance results show the trends in performance over time
- Trends either show **special cause** variance or **common cause variance**
- **Blue Icons** indicate **positive** special cause variance
- **Orange Icons** indicate **negative** special cause variance **requiring action**
- **Grey Icons**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

How to interpret assurance results

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

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

Integrated Performance Report



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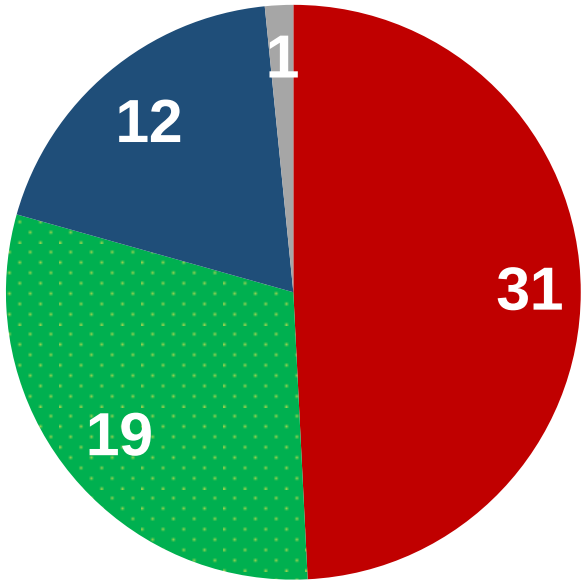
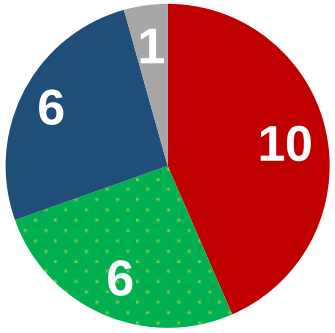
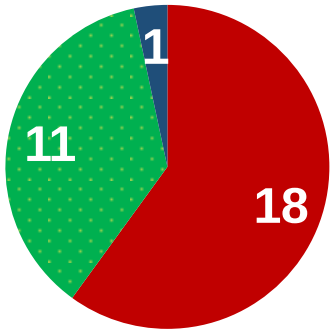
Summary of Performance to Month 11



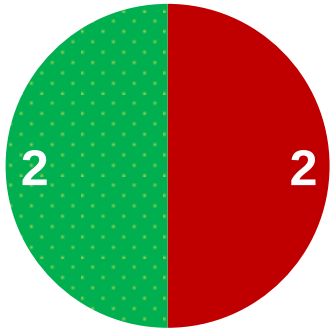
All Sections



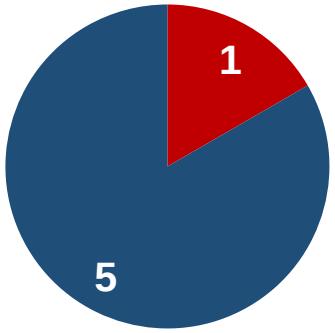
Quality, Safety, Effectiveness & Experience Performance



Access & Activity Performance



People & Organisational Development Performance

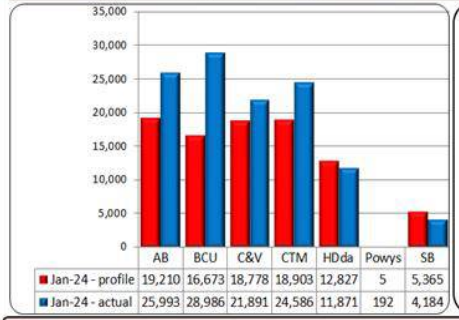


Financial Performance

NHS Wales Performance Dashboard- part 1

PERFORMANCE DASHBOARD

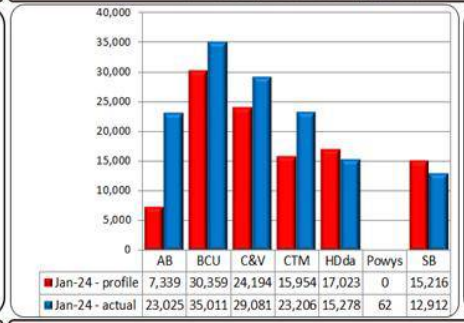
Number of patients waiting more than 36 weeks for a new outpatient appointment



	AB	BCU	C&V	CTM	HDda	Powys	SB
Jan-24 - profile	19,210	16,673	18,778	18,903	12,827	5	5,365
Jan-24 - actual	25,993	28,986	21,891	24,586	11,871	192	4,184

- In Jan-24, HDda and SB achieved their trajectories for the number of patients waiting over 36 weeks for a new outpatient appointment.
- HDda, Powys and SB all saw a reduction in Jan-24 when compared to the previous month.
- At an all Wales level, the number of patients waiting over 36 weeks for a new outpatient appointment has increased in Jan-24 when compared to the previous month by 2,707 to 117,703, a 2.4% increase.
- Powys had the lowest number of patients waiting over 36 weeks for a new outpatient appointment in Jan-24 at 192, BCU had the highest number of waits at 28,986 (24.6% of the total).

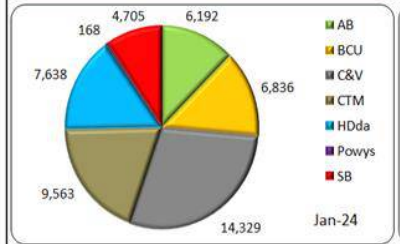
Number of patients waiting more than 52 weeks for referral to treatment



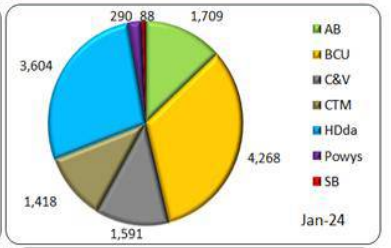
	AB	BCU	C&V	CTM	HDda	Powys	SB
Jan-24 - profile	7,339	30,359	24,194	15,954	17,023	0	15,216
Jan-24 - actual	23,025	35,011	29,081	23,206	15,278	62	12,912

- In Jan-24, HDda and SB achieved their trajectories for the number of patients waiting over 52 weeks for referral to treatment.
- BCU, CTM, HDda and SB have seen a reduction in Jan-24 when compared to the previous month.
- At an all Wales level, the number of over 52 week referral to treatment waits has reduced in Jan-24 when compared to the previous month by 1,747 to 138,575, a 1.3% reduction.
- Powys had the lowest number of patients waiting over 52 weeks for referral to treatment in Jan-24 at 62, BCU had the highest number of waits at 35,011 (25.3% of the total).

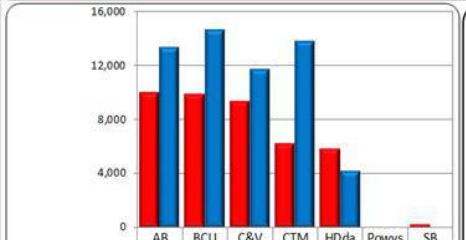
Number of patients waiting more than 8 weeks for a specified diagnostic



Number of patients waiting more than 14 weeks for a specified therapy (including audiology)



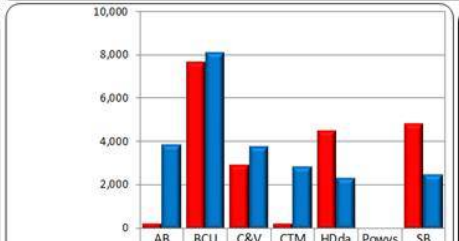
Number of patients waiting more than 52 weeks for a new outpatient appointment



	AB	BCU	C&V	CTM	HDda	Powys	SB
Jan-24 - profile	9,951	9,856	9,303	6,247	5,813	0	281
Jan-24 - actual	13,339	14,664	11,752	13,780	4,197	22	0

- In Jan-24, HDda and SB achieved their trajectory for the number of patients waiting over 52 weeks for a new outpatient appointment.
- All HBs, except CTM and HDda, saw an increase in Jan-24 compared to the previous month.
- At an all Wales level, the number of over 52 week new outpatient waits has increased in Jan-24 when compared to the previous month by 818 to 57,754, a 1.4% increase.
- SB have had no over 52 week new outpatient waits for the last 4 months, BCU had the highest number of waits at 14,664 (25.4% of the total).

Number of patients waiting more than 104 weeks for referral to treatment



	AB	BCU	C&V	CTM	HDda	Powys	SB
Jan-24 - profile	246	7,634	2,946	231	4,504	0	4,833
Jan-24 - actual	3,873	8,093	3,786	2,854	2,339	0	2,503

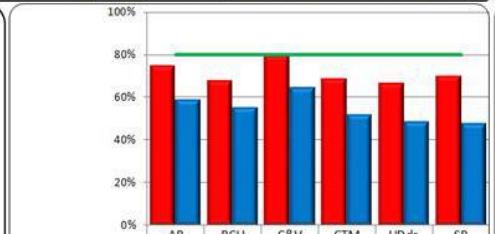
- In Jan-24, HDda, Powys and SB all achieved their trajectories for the number of patients waiting over 104 weeks for referral to treatment.
- All HBs, except AB and C&V, have seen a reduction in Jan-24 when compared to the previous month.
- At an all Wales level, the number of over 104 week referral to treatment waits has reduced in Jan-24 when compared to the previous month by 800 to 23,448, a 3.4% reduction.
- Powys have had no over 104 week referral to treatment waits since Feb-22, BCU had the highest number of waits at 8,093 (34.5% of the total).

- In Jan-24 no HB achieved the target of an improvement trajectory towards a national target of zero by 31 March 2024 for the number of patients waiting over 8 weeks for a specified diagnostic.
- AB has not provided an 8 week diagnostic trajectory.
- Only BCU and HDda saw an increase in Jan-24 when compared to the previous month.
- At an all Wales level, the number of over 8 week waits for specific diagnostics has reduced in Jan-24 when compared to the previous month by 1,102 to 49,431, a 2.2% reduction.
- Powys had the lowest number of over 8 week waits for specific diagnostics in Jan-24 at 168, C&V had the highest at 14,329 (29.0% of the total).

- In Jan-24 no HB achieved the target of an improvement trajectory towards a national target of zero by 31 March 2024 for the number of patients waiting over 14 weeks for a specified therapy.
- CTM has not provided a 14 week therapy trajectory.
- AB, C&V and Powys saw a reduction in Jan-24 when compared to the previous month.
- At an all Wales level, the number of over 14 week waits for specific therapies increased in Jan-24 when compared to the previous month by 390 to 12,968, a 3.1% increase.
- SB had the lowest number of over 14 week waits for specific therapies in Jan-24 at 88, BCU had the highest at 4,268 (32.9% of the total).

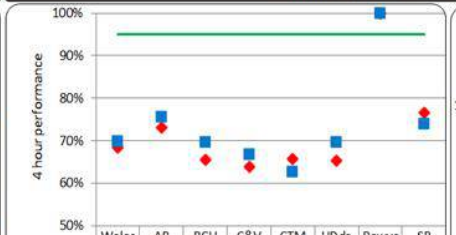
% of patients starting their first definitive cancer treatment within 62 days from point of suspicion (regardless of referral route)

- In Jan-24, none of the HBs achieved their trajectory for the percentage of patients starting 1st definitive cancer treatment within 62 days.
- All HBs saw a deterioration in performance in Jan-24 when compared to the previous month.
- At all Wales level, the percentage of patients starting 1st definitive treatment within 62 days has seen a deterioration in performance in Jan-24 when compared to the previous month of 3.3 percentage points to 54.7%.
- The best performing HB in Jan-24 was C&V with performance at 64.4%, SB had the lowest performance at 47.5%.

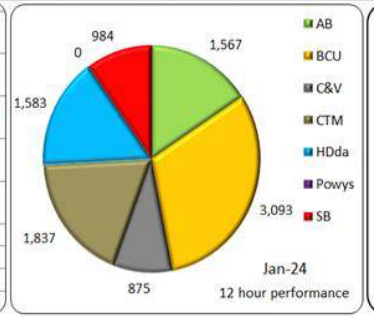


	AB	BCU	C&V	CTM	HDda	SB
Jan-24 - profile	75%	68%	80%	69%	67%	70%
Jan-24 - actual	59%	55%	64%	52%	49%	48%
2026 Target	80%	80%	80%	80%	80%	80%

4 hour and 12 hour A&E waiting times in all major and minor emergency care facilities - from arrival until admission, transfer or discharge



	Wales	AB	BCU	C&V	CTM	HDda	Powys	SB
Jan-24	68%	73%	66%	64%	66%	65%	100%	77%
Jan-23	70%	75%	70%	67%	63%	70%	100%	74%
Target	95%	95%	95%	95%	95%	95%	95%	95%

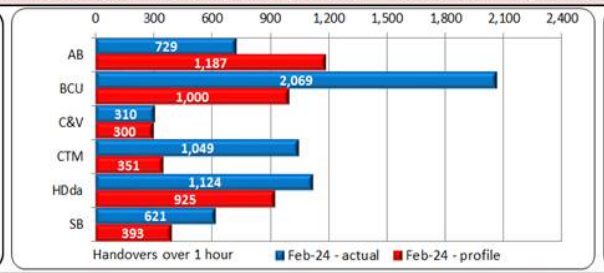


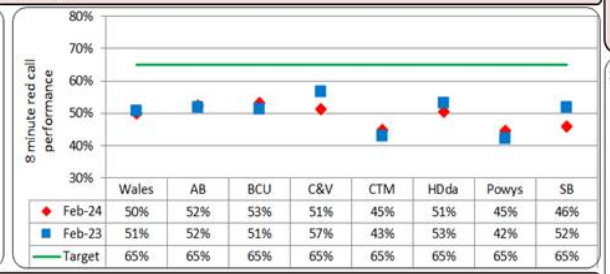
- In Jan-24 CTM, Powys and SB achieved the target of an improvement compared to the same month in 2022-23, towards the national target of 95%, for the percentage of patients who spent less than 4 hours in A&E.
- All HBs, except C&V and HDda, saw an improvement in performance in Jan-24 when compared to the previous month. Powys remained the same at 100%.
- At all Wales level, the percentage of patients who spent less than 4 hours in A&E has seen a improvement in performance in Jan-24 when compared to the previous month of 1.6 percentage points to 68.4%.
- The best performing HB in Jan-24 (exc. Powys) was SB at 76.6%, C&V had the lowest performance at 63.9%.
- In Jan-24 AB and Powys achieved the target of an improvement trajectory towards a national target of 0 by 31 March 2024 for the number of patients who spent more than 12 hours in A&E.
- C&V had the lowest number of patients who spent more than 12 hours in A&E (exc. Powys) at 875, BCU had the highest at 3,093 (31.1% of the total).

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

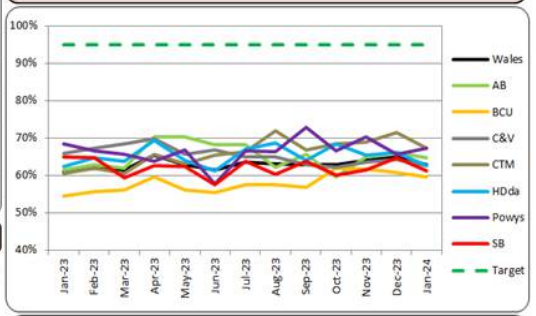
- In Feb-24, only AB achieved their trajectory for the number of ambulance patient handovers over 1 hour.
- C&V had the lowest number of over 1 hour handovers in Feb-24 with 310 over 1 hour handovers, BCU had the highest at 2,069 (35.1% of the total).
- Over the last 12 months, only AB and C&V saw an improvement trend in performance.
- In Feb-24, no HB achieved the 65% target for the percentage of emergency responses to red calls within 8 minutes.
- BCU were the best performing HB in Feb-24 with performance at 53.1%, Powys were the lowest with performance at 44.7%.
- Over the last 12 months only Powys saw an improvement trend in performance. All HBs, except SB, saw an improvement in performance in Feb-24 when compared to the previous month.





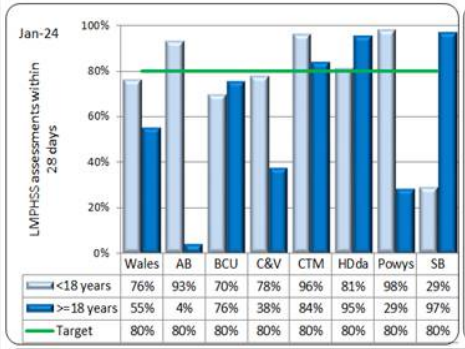
	Wales	AB	BCU	C&V	CTM	HDda	Powys	SB
Feb-24	50%	52%	53%	51%	45%	51%	45%	46%
Feb-23	51%	52%	51%	57%	43%	53%	42%	52%
Target	65%	65%	65%	65%	65%	65%	65%	65%

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

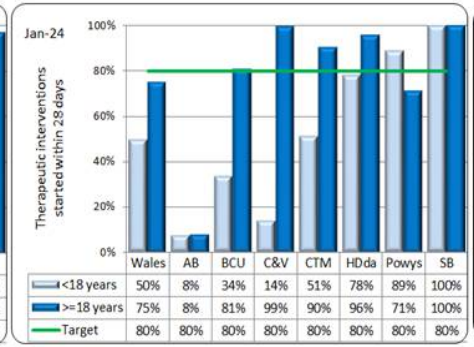


- In Jan-24 no HB achieved the 95% target for the percentage of ophthalmology R1 appointments attended which were within their clinical target date or within 25% beyond their clinical target date.
- The best performing HB in Jan-24 was CTM with performance at 67.3%, BCU were the lowest performing HB with performance at 59.6%.
- In Jan-24, only Powys saw an improvement in performance compared to the previous month.
- Over the last 12 months, all HBs, except AB and C&V, saw an improvement trend in performance.

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



	Wales	AB	BCU	C&V	CTM	HDda	Powys	SB
<18 years	76%	93%	70%	78%	96%	81%	98%	29%
>=18 years	55%	4%	76%	38%	84%	95%	29%	97%
Target	80%	80%	80%	80%	80%	80%	80%	80%



	Wales	AB	BCU	C&V	CTM	HDda	Powys	SB
<18 years	50%	8%	34%	14%	51%	78%	89%	100%
>=18 years	75%	8%	81%	99%	90%	96%	71%	100%
Target	80%	80%	80%	80%	80%	80%	80%	80%

<18 years

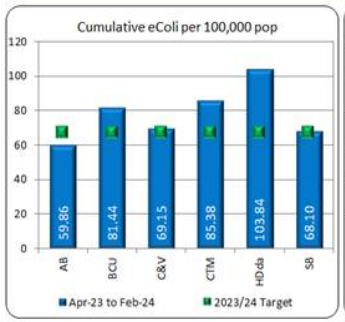
- In Jan-24 AB, CTM, HDda and Powys all achieved the 80% target for % of LMPHSS assessments undertaken within 28 days of a referral. The best performing HB was Powys at 98.0%, SB had the lowest performance at 29.2%. Over the last 12 months, only C&V and Powys saw a deterioration trend in performance.
- In Jan-24 only Powys and SB achieved the 80% target for % of therapeutic interventions started within 28 days of an LPMHSS assessment. The best performing HB was SB at 100%, AB had the lowest performance at 7.5%. Over the last 12 months, CTM, HDda, Powys and SB all saw an improvement trend in performance.

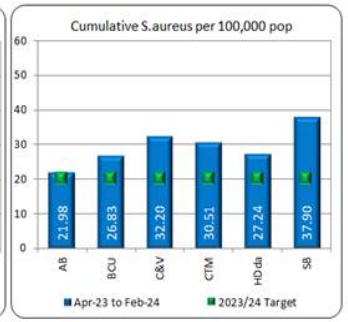
>=18 years

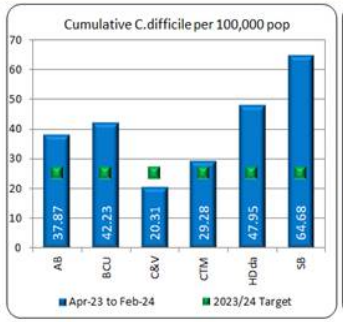
- In Jan-24, CTM, HDda and SB all achieved the 80% target for % of LMPHSS assessments undertaken within 28 days of a referral. The best performing HB was SB at 96.8%, AB had the lowest performance at 4.5%. Over the last 12 months, BCU, HDda and SB all saw an improvement trend in performance.
- In Jan-24, only AB and Powys failed to achieve the 80% target for % of therapeutic interventions started within 28 days of an LPMHSS assessment. The best performing HB was SB at 100%, AB had the lowest performance at 7.9%. Over the last 12 months, BCU, C&V, CTM and SB all saw an improvement trend in performance.

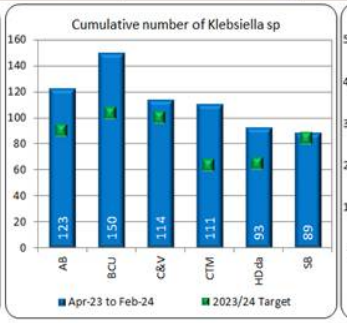
- Note: AB are still validating their data from Apr-23 due to moving to a new IT system so data may be revised in future months.

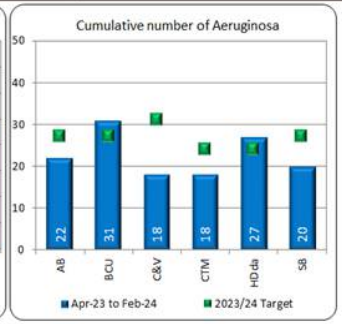
Health Care Acquired Infections - HCAIs (provisional data)





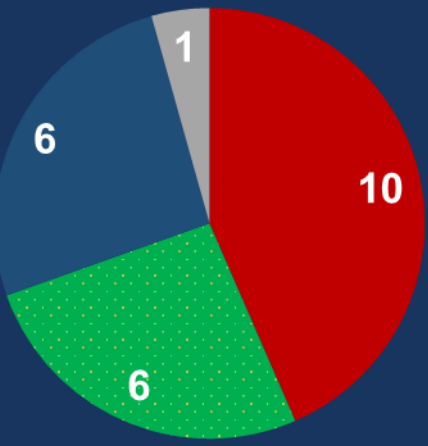






- For eColi, only AB are currently achieving the 2023/24 cumulative target. In the Apr-23 to Feb-24 period, HDda had the highest rate of eColi at 103.84 per 100,000 population compared to AB who had the lowest rate at 59.86 per 100,000 population.
- For S.aureus, no HB is currently achieving the 2023/24 cumulative target. In the Apr-23 to Feb-24 period, SB had the highest rate of S.aureus at 37.90 per 100,000 population compared to AB who had the lowest rate at 21.98 per 100,000 population.
- For C.difficile, only C&V are currently achieving the 2023/24 cumulative target. In the Apr-23 to Feb-24 period, SB had the highest rate of C.difficile at 64.68 per 100,000 population compared to C&V who had the lowest rate at 20.31 per 100,000 population.
- For Klebsiella, no HB is currently achieving the 2023/24 cumulative target. In the Apr-23 to Feb-24 period, BCU had the highest number of cases of Klebsiella at 150 compared to SB who had the lowest number at 89.
- For Aeruginosa, all HBs, except BCU and HDda, are currently achieving the 2023/24 cumulative target. In the Apr-23 to Feb-24 period, BCU had the highest number of cases of Aeruginosa at 31 compared to C&V and CTM who had the lowest number at 18.

Section 1



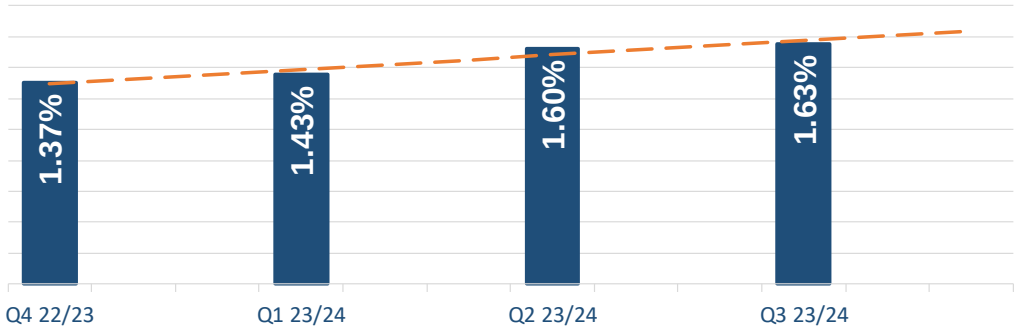
Quality, Safety, Effectiveness and Experience Performance

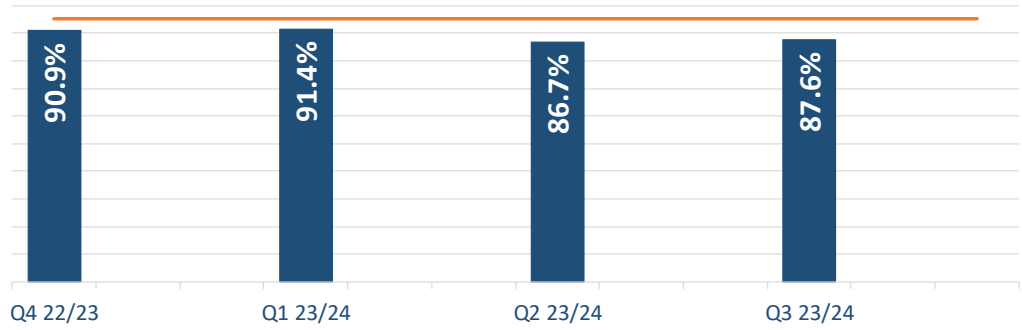
GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Betsi Cadwalar
University Health Board

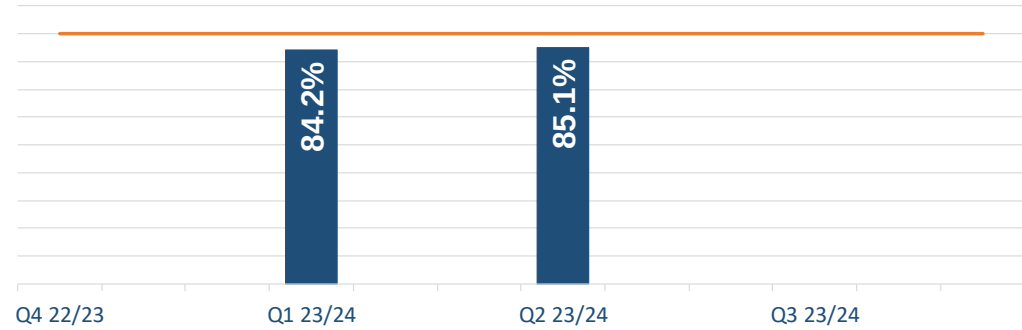
Produced on behalf of the **Health Board** by the
Performance Directorate in partnership with our **Health Board Directors**

Quality: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
QA1-001	QSE	Percentage of adult smokers who make a quit attempt via smoking cessation services	5% annual	TBC	1.63%	2nd of 7 (at Sep 23)
QA1-003	QSE	Percentage of children who are up to date with the scheduled vaccinations by age 5 ('4 in 1' preschool booster, the Hib/MenC booster and the second MMR dose)	95%	TBC	87.6%	1st of 7 (at Sep 23)
QA1-004	QSE	Percentage of girls receiving the Human Papillomavirus (HPV) vaccination by the age of 15	90%	TBC	85.1%	5th of 7 (at Jun 23)





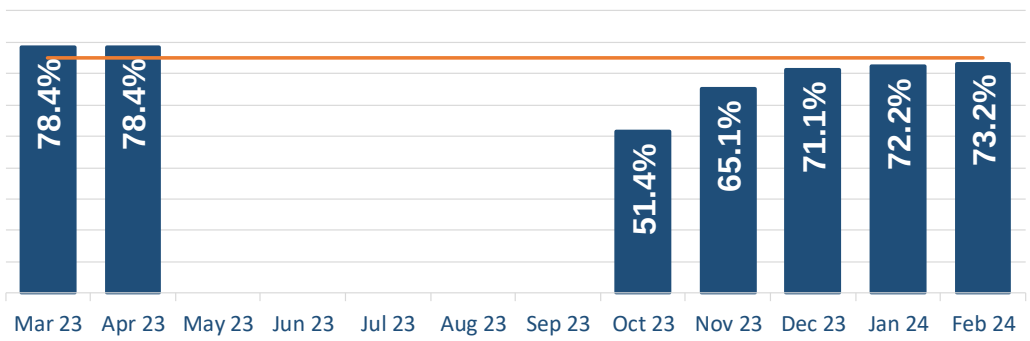


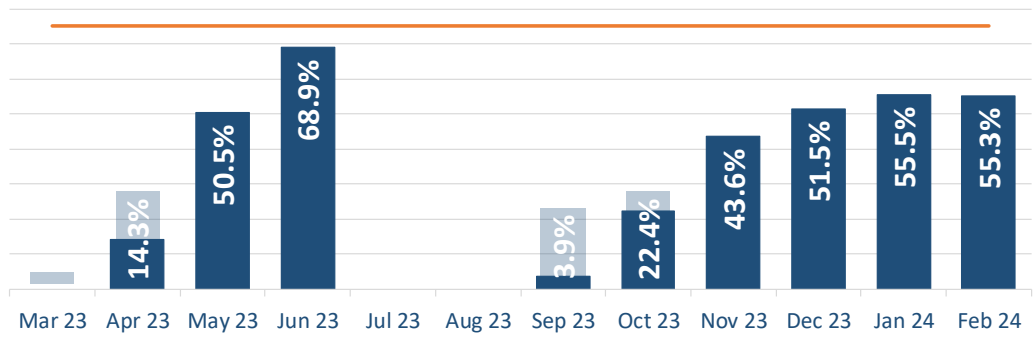
Produced on behalf of the **Quality, Safety & Experience Committee** by the **Performance Directorate**

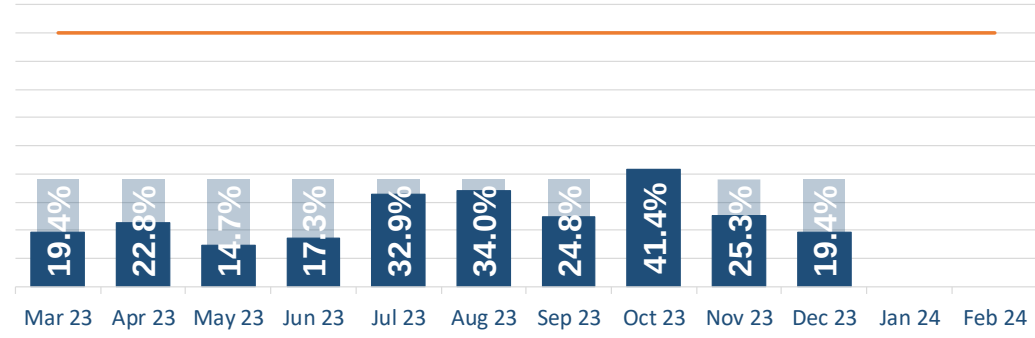
* Wales Ranking may differ as may refer to previous month

Quality: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
QA1-005	QSE	Percentage uptake of the influenza vaccination amongst adults aged 65 years and over	75%	TBC	73.2%	2nd of 7 (at Feb 24)
QA1-006	QSE	Percentage uptake of the COVID-19 vaccination for those eligible Spring Booster 2023: Aged 75 years & over; residents in care home for older adults and; immunosuppressed aged 5 years & over Autumn Booster 2023: Age range to be confirmed	75%	TBC	55.3%	3rd of 7 (at Feb 24)
QA1-007	QSE	Percentage of patients offered an index colonoscopy procedure within 4 weeks of booking their Specialist Screening Practitioner assessment appointment	90%	TBC	19.4%	3rd of 7 (at Dec 23)



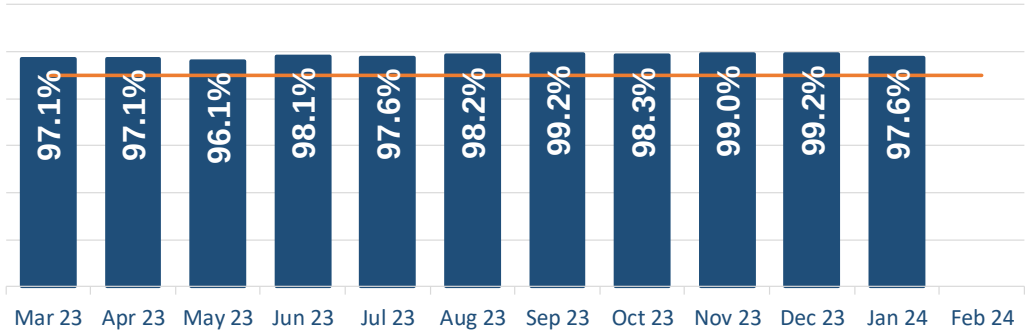


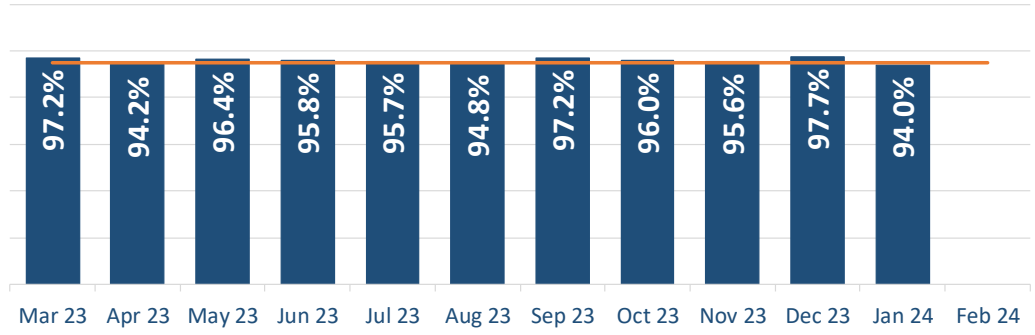


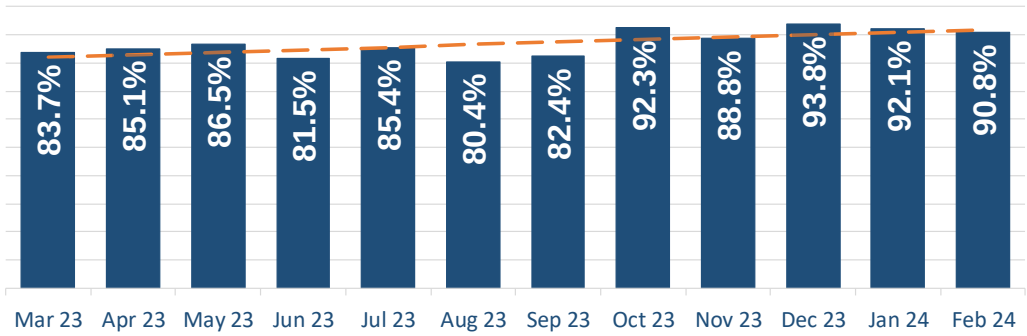
* Wales Ranking may differ as may refer to previous month

Quality: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
QA1-008	QSE	Percentage of well babies entering the new-born hearing screening programme who complete screening within 4 weeks	90%	TBC	97.6%	1st of 7 (at Dec 23)
QA1-009	QSE	Percentage of eligible newborn babies who have a conclusive bloodspot screening result by day 17 of life	95%	TBC	94.0%	6th of 7 (at Jan 24)
QA1-002	QSE	Percentage of people who have been referred to health board services who have completed treatment for substance misuse (drugs or alcohol)	4 qtr imp. trend	TBC	90.8%	3rd of 7 (at Dec 23)





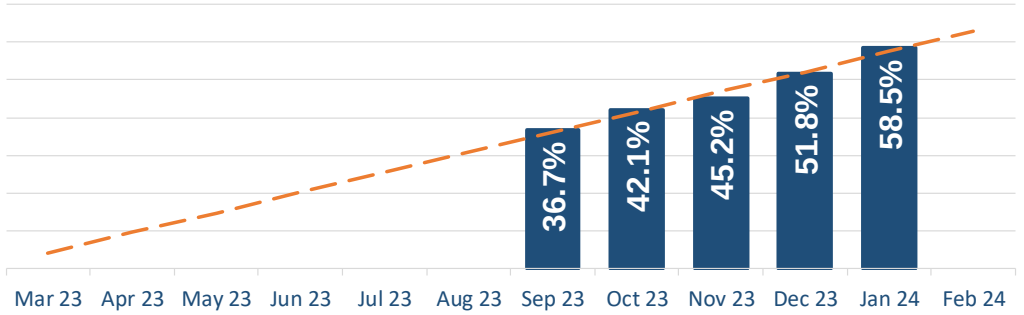


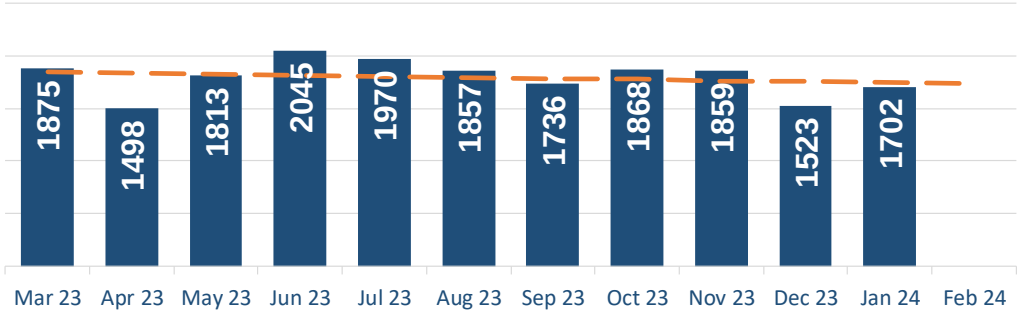
Produced on behalf of the **Quality, Safety & Experience Committee** by the **Performance Directorate**

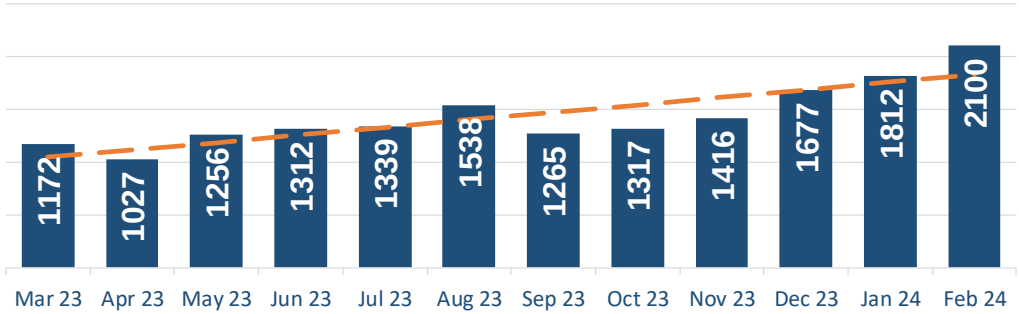
* Wales Ranking may differ as may refer to previous month

Quality: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
QA2-011	PFIG	Percentage of the primary care dental services (GDS) contract value delivered (for courses of treatment for new, new urgent and historic patients)	Increas-ing trend (to 100%)	TBC	58.5%	6th of 7 (at Jan 24)
QA2-012	PFIG	Number of patients referred from primary care (optometry and General Medical Practitioners) into secondary care Ophthalmology services	Decreas-ing trend	TBC	1702	7th of 7 (at Jan 24)
QA2-013	PFIG	Number of consultations delivered through the Pharmacist Independent Prescribing Service (PIPS)	Mth to mth increase (2022/23 to 2023/24)	TBC	2100	3rd of 7 (at Jan 24)

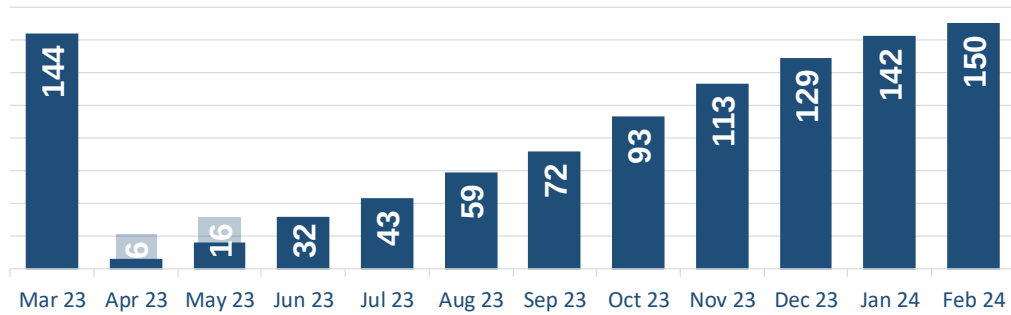


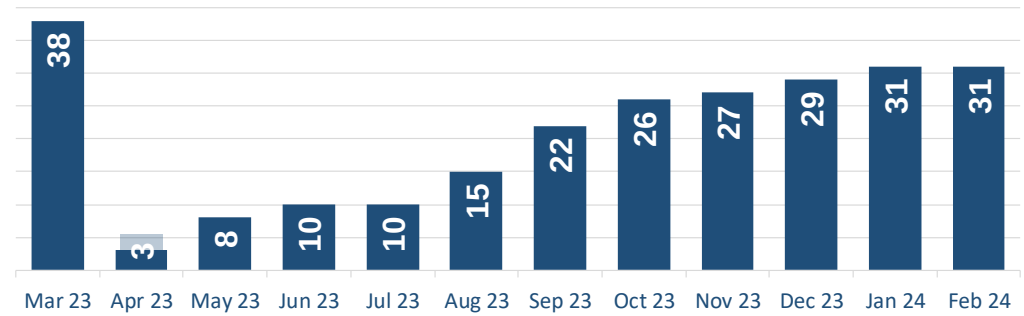




Quality: Performance

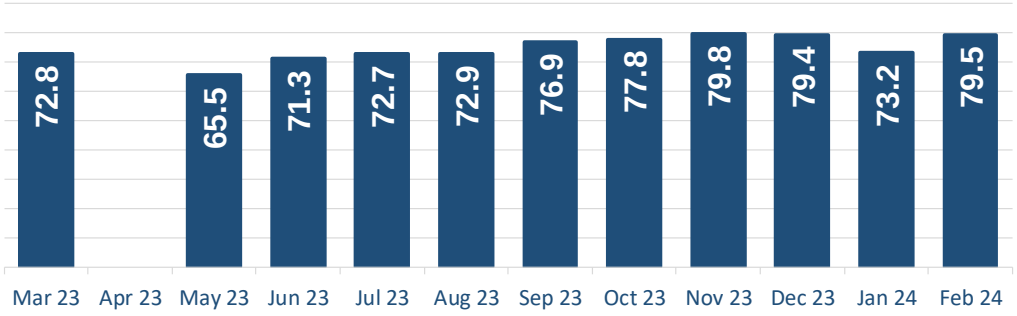
Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
QA4-046	QSE	Number of patient experience surveys completed and recorded on CIVICA	Increas-ing trend	TBC	Data not currentl y available	N/A
QA4-047	QSE	The cumulative number of laboratory confirmed Klebsiella in reporting month	Not avail-able	TBC	150	6th of 6 (at Feb 24)
QA4-048	QSE	The cumulative number of laboratory confirmed Pseudomonas Aeruginosa in reporting month	Not avail-able	TBC	31	6th of 6 (at Feb 24)

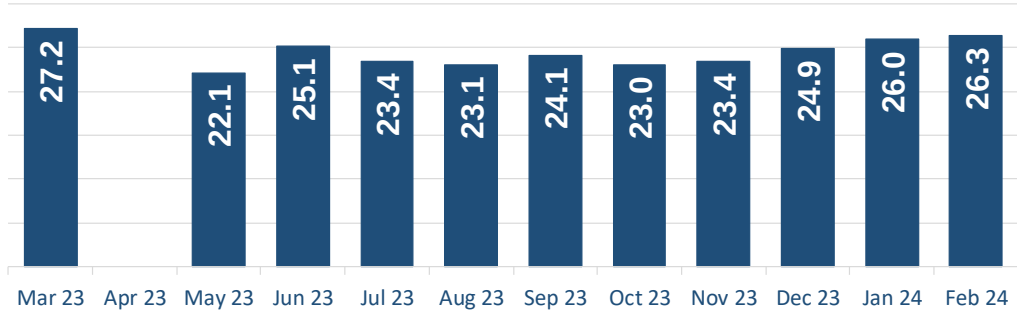


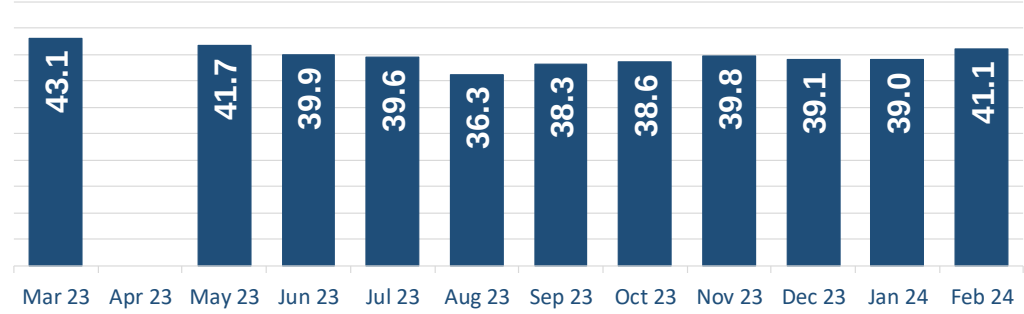


Quality: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
QA4-049	QSE	The cumulative rate of laboratory confirmed E.coli bacteraemias cases per 100,000 population	Not available	TBC	79.5	4th of 6 (at Feb 24)
QA4-050	QSE	The cumulative rate of laboratory confirmed S. Aureus Bacteraemia (MRSA and MSSA) cases per 100,000 of the population	Not available	TBC	26.3	2nd of 6 (at Feb 24)
QA4-051	QSE	The cumulative rate of laboratory confirmed C.difficile cases per 100,000 of the population	Not available	TBC	41.1	4th of 6 (at Feb 24)

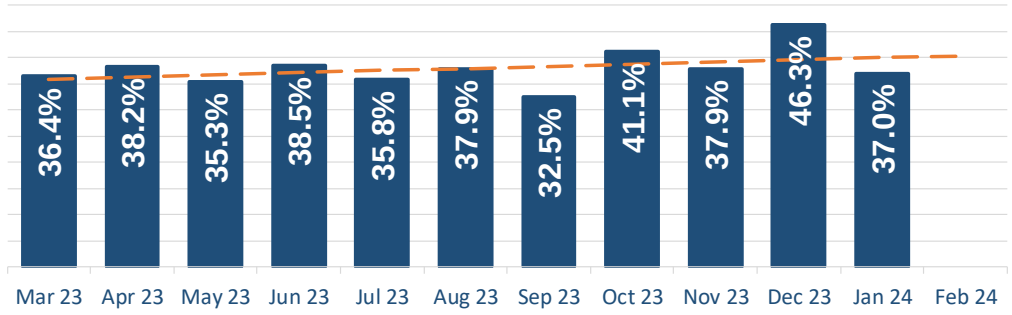


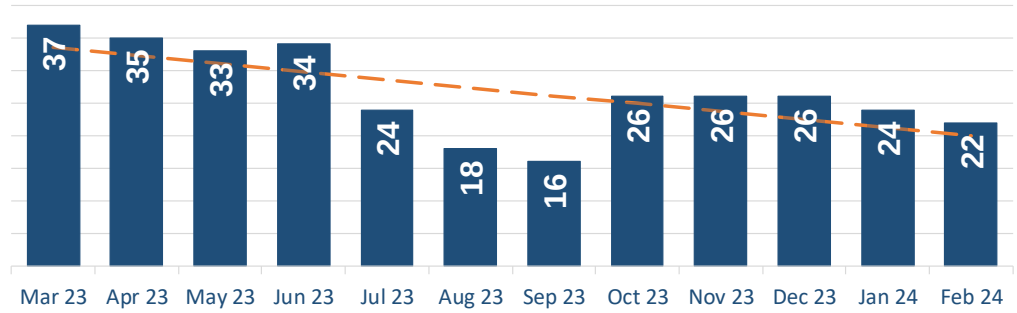


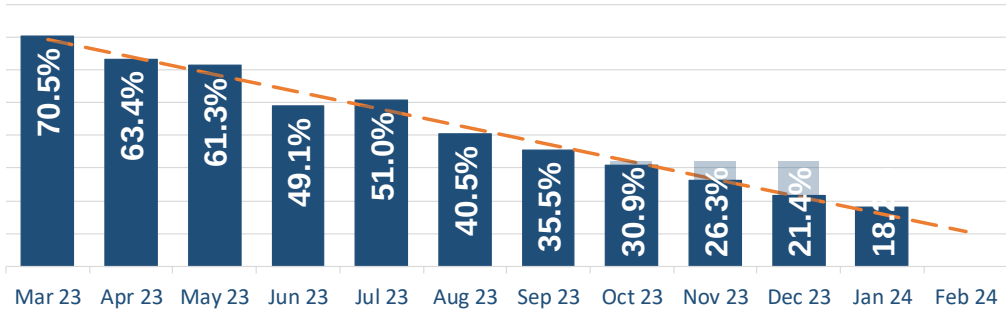


Quality: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
QA4-052	QSE	Percentage of confirmed COVID-19 cases within hospital which had a definite hospital onset of COVID-19	Mth to mth reduction (2022/23 to 2023/24)	TBC	37.0%	2nd of 6 (at Feb 24)
QA4-055	QSE	Number of National Reportable incidents that remain open 90 days or more	Decreasing trend	TBC	22	6th of 10 (at Feb 24)
QA4-040	QSE	Percentage of episodes clinically coded within one reporting month post episode discharge end date	Increasing trend (to 95%)	TBC	18.2%	8th of 8 (at Dec 23)

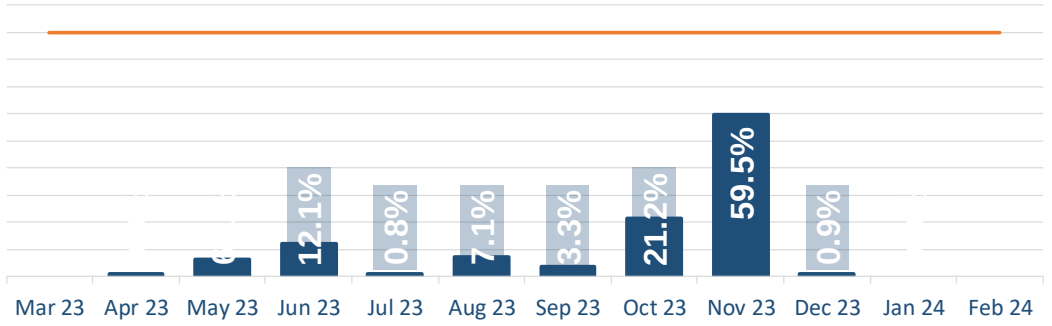


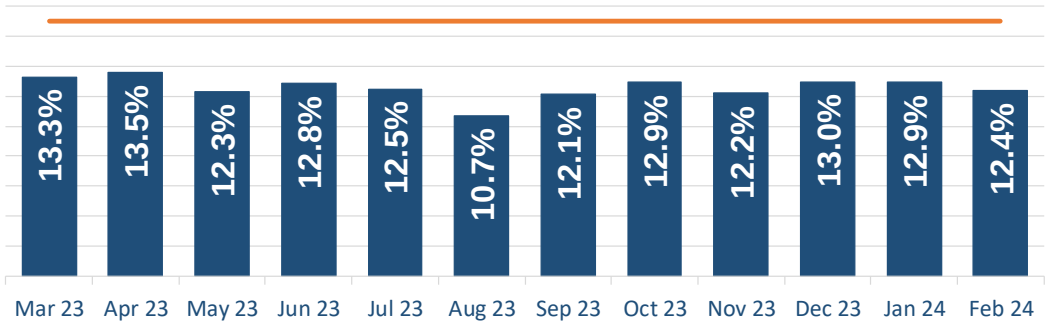




Quality: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
QA4-041	QSE	Percentage of all classifications' coding errors corrected by the next monthly reporting submission following identification	90%	TBC	0.0%	8th of 8 (at Jan 24)
QA4-042	QSE	Percentage of calls ended following WAST telephone assessment (Hear and Treat)	>17%	TBC	12.4%	5th of 7 (at Jan 24)





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Board Integrated Quality Report - Patient Safety

Indicator	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Total	Average	Sparkline
Patient safety incidents with harm	1,742	1,730	1,552	2,103	2,117	2,259	2,354	2,454	2,545	2,362	2,545	2,592	2,391	2,514	2,337	33,597	2,240	
Nationally Reportable Incidents (NRI)	21	22	22	20	22	26	19	14	24	31	32	26	31	22	24	356	24	
Overdue NRIs	39	39	37	43	37	30	29	16	18	28	27	24	23	24	30	N/A	30	
NRIs - Patient Falls	5	5	3	5	5	2	2	0	3	1	1	1	1	2	2	38	3	
NRIs - Healthcare Acquired Pressure Ulcers	4	10	12	6	9	11	11	8	8	14	14	5	4	2	1	119	8	
NRIs - Patient Deterioration	1	1	1	2	1	0	1	0	3	0	0	2	0	0	2	14	1	
NRIs - Never Events	0	0	0	0	0	0	0	1	1	0	1	0	0	0	4	7	0	

Supporting notes: Data is provided from the Health Board's Datix system and is accurate at the time of reporting (21/03/2024). Incident data shows the date of the incident (which is different from the date reported).

Board Integrated Quality Report - Patient and Carer Experience

Indicator	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Total	Average	Sparkline
Complaints under PTR	138	133	149	168	133	169	179	183	182	168	177	160	139	168	200	2,446	163	
Early resolutions	49	51	48	23	26	44	28	43	27	42	26	27	25	32	38	529	35	
Overdue complaints under PTR	335	359	307	295	271	254	266	260	284	260	287	280	269	344	364	N/A	296	
Ombudsman contacts	10	18	10	6	11	8	18	10	5	15	6	8	9	6	8	148	10	
Ombudsman full investigations	4	5	5	1	1	1	6	2	0	3	0	1	1	1	0	31	2	
PALS contacts	432	479	518	694	563	520	595	556	566	583	654	593	456	666	649	8,524	568	

Supporting notes: Data is provided from the Health Board's Datix system and is accurate at the time of reporting (21/03/2024). Experience data shows the date of the complaint or contact.

Cause of delays: operational team capacity, legal and redress turnaround times, delay with independent primary care providers responses, corporate team capacity, workforce capability leading to significant support required , increase in planned care insourcing enquiries

Actions being taken to reduce time to resolve complaints: weekly PTR clinic with legal team; weekly scrutiny by Integrated Health Care (IHC) and Corporate team to expedite, Executive Director of Nursing (EDoN)focus on grade 1 and 2 for early resolution, development sessions, review of complaints process to be presented to Patient & Carer Executive Group (PCEG) March, EDoN/ Executive Medical Director (EMD)/ Executive Director of Therapies & Health Sciences (EDTHS) requested feedback by 5th February from each IHC/specialist service regarding trajectory and plans, weekly corporate meeting to track.

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.

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

Additional Information

Introduction to Integrated Performance Report (IPR)

What is an Integrated Performance Report (IPR)?

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

The Integrated Performance Framework (IPF)

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

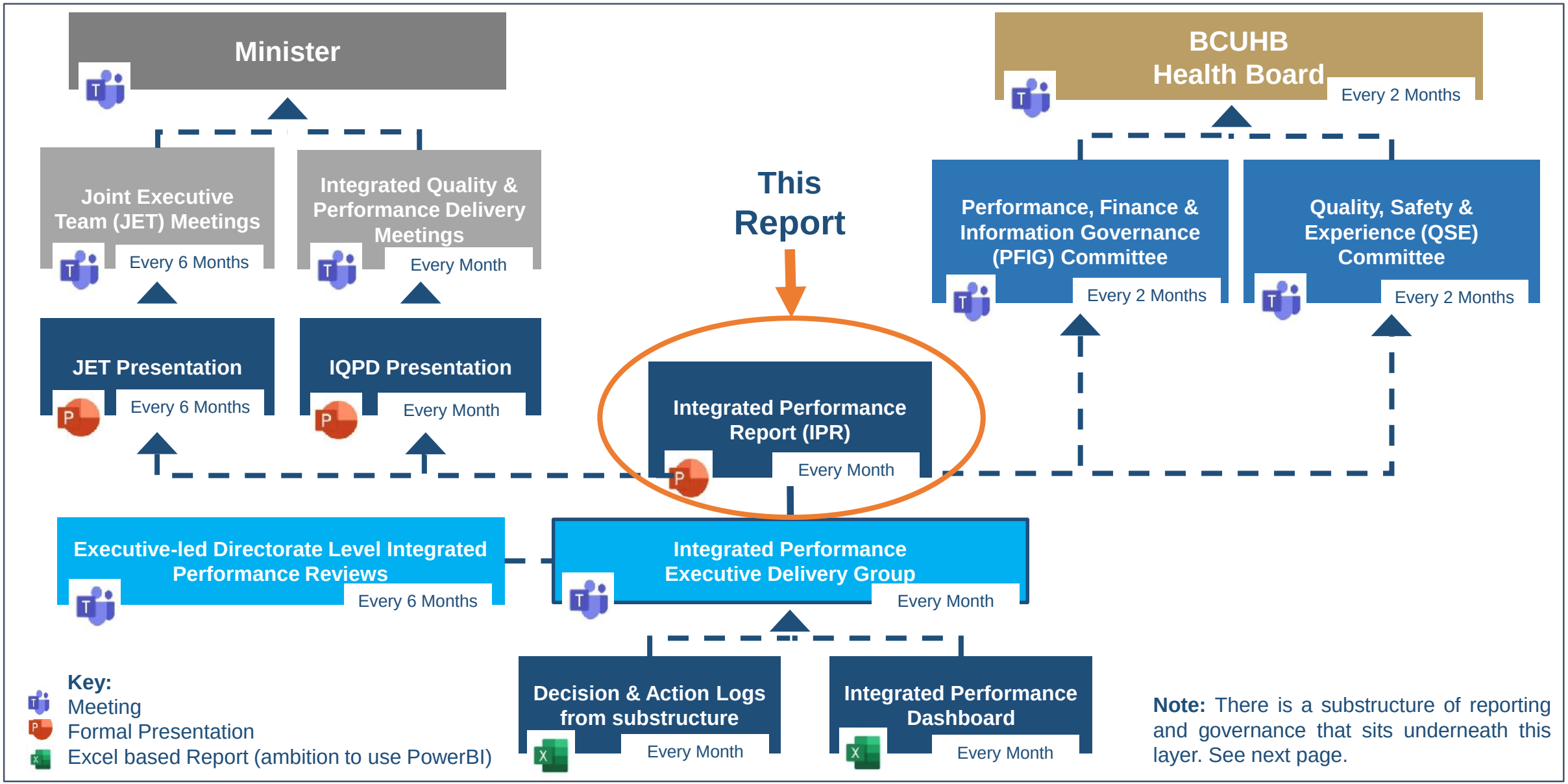
The Integrated Performance Framework sits within a "triumvirate" together with the Integrated Planning Framework and the Risk Management Framework (also ratified at Health Board on the 28th September 2023). This triumvirate of frameworks will encompass the planning, safe delivery and monitoring of the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

Where does the IPR feature within the Performance Governance Structure

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

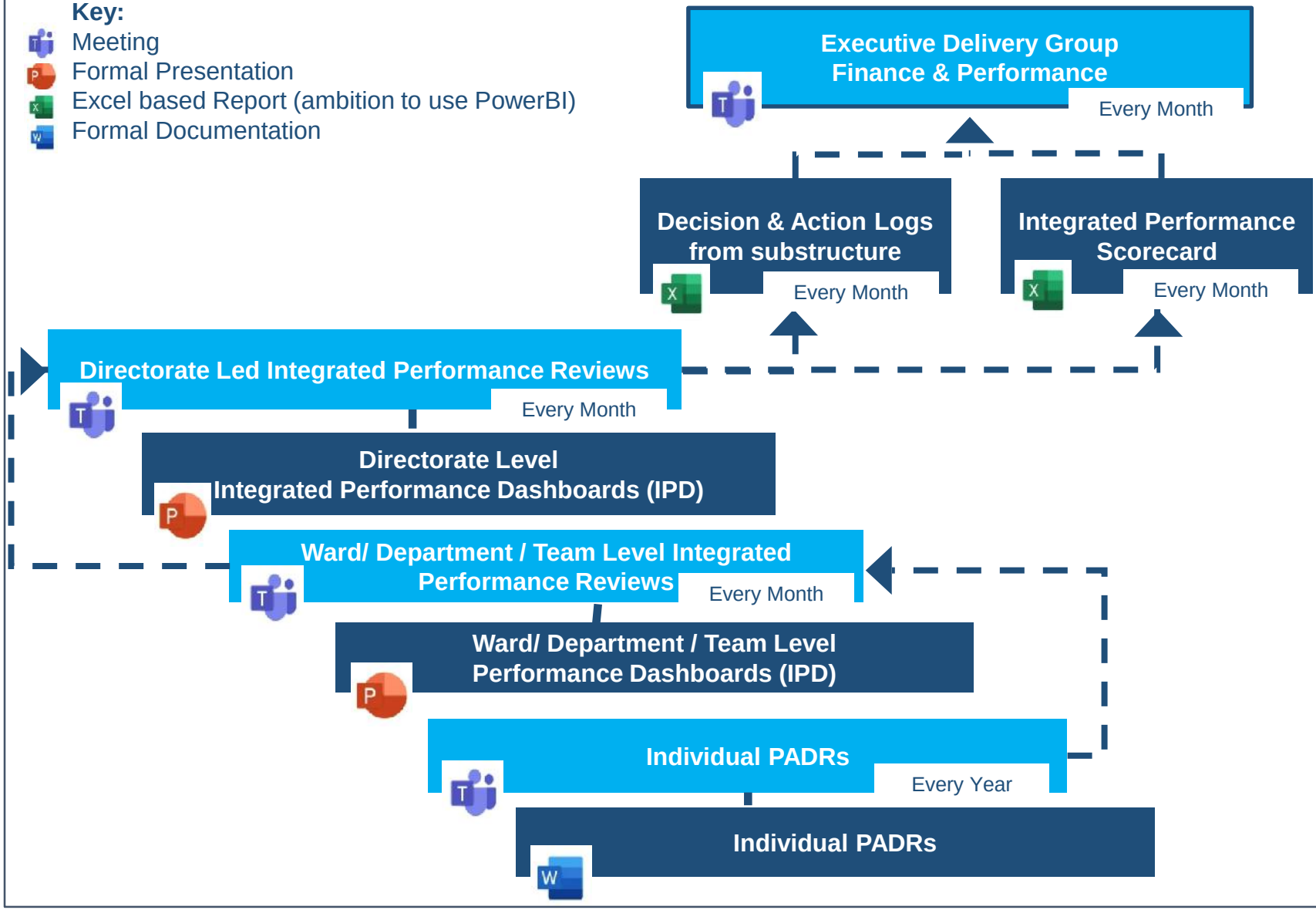
The IPR will be embedded as the 'single version of the truth' and used to report on performance to the Health Board, it's scrutinising committees namely Performance, Finance & Information Governance (PFIG) Committee and Quality, Safety & Experience (QSE) Committee and externally to Welsh Government.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

The Integrated Performance Reporting & Governance Superstructure



The Integrated Performance Reporting & Governance Substructure

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



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

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

Performance Directorate Outputs

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

Our Integrated Performance Report
Betsi Cadwaladr University Health Board

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

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

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

follow @bcuhb

http://www.facebook.com/bcuhealthboard

Appendix

Our Partners

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

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

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

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

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

Teitl adroddiad: ***Report title:***	Quality Delivery Group – Chair's Report			
Adrodd i: ***Report to:***	QSE Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	18th April 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 *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☐ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☒ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				
There is confidence in the data provided in the report however, the strength of learning and improvement remains an area of concern and is a key focus of work. This is being addressed through a range of measures including the actions aligned to the Board Assurance Framework.				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	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.			

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

Chair's Report

Report to:	Quality, Safety and Experience Committee
Report from:	Executive Quality Delivery Group
Report date:	April 2024, from meeting held on 11th March 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	• A number of service pressures and concerns are noted in the reports from IHCs detailed below.
Summary of business conducted – for assurance	Quality highlight and escalation reports were received from IHC/Divisions. • **Central IHC** advised investigation delays are partly due to demand on clinical staff diverting priority and resources away from completion of complaint investigation reports. New daily and weekly PTR meetings have been established to review all new Grade 4 and 5 complaints received and ensure that they have a prompt initial review and any immediate learning is identified. A number of inquests cases have arisen over the past 3 weeks, with a total of 61 open cases as at time of writing. The Head of Nursing for CHC and Clinical Quality continues to attend the weekly Inquests Board Round and any escalations are raised thereafter. Overdue LFER cases continue to reduce and the

number is much reduced compared with November 2023. Work is ongoing to address the remaining 5 overdue cases.

- **East IHC** advised that the new sepsis screening tools was accepted across all the IHC's – it has shown increased compliance in Wrexham following the pilot. The IHC advised on the risk of a sustained increase in incidents with harm as a consequence of increased overcrowding in the ED and subsequently inadequate staffing levels. The IHC advised on the discontinuation of the Overnight Service for Adult Critical Care Transfer Service. An options appraisal has been completed by clinical lead for critical care in East IHC.

- **West IHC** advised they continue to hold 'round table' meetings for complex concerns to support triangulation between inquests, concerns, patient safety and mortality working closely with the Healthcare Legal Team. Reviews have been prioritised in accordance with urgency and likely Inquest dates. We are experiencing some difficulty with this as currently multiple avenues for notification in place which risk duplication of effort and inability to prioritise. The IHC have developed a robust risk and improvement plan for HAPUs. They are in the process of finalising the falls risk and improvement plan in the same format for ease of review and collation. The dermatology service remains extremely fragile. Discussions with affected staff ongoing including sessions with CEO. There is a dermatology progress review meeting chaired by Deputy EMD ongoing with representation from the IHC. The performance for emergency care remains challenging however the IHC have seen a significant reduction in the number of outliers flowing establishment of a Step Down Ward. Daily Safety Huddle refresh now includes interpretation and challenge of live data using WAST, Right patient – Right place dashboards and continues to be medically led. Plans to revise the Escalation and Hospital Full Policy to reflect intention to protect planned care as much as is reasonably practicable.

- **MHLD** Division highlighted their work on safeguarding. This includes an improvement in the application of DoLS within the division. Improving the understanding and application of the Mental Capacity Act is a key priority. To support this the service have created a secondment position for an MCA trainer.

- **Women's and Midwifery** Division advised that following an 18 month suspension of an active offer of homebirth as a choice for women, due to WAST pressures and the potential impact on intrapartum transfers from community, it has been agreed by the Executive Team on 31 January 2024 that the service can be reinstated. Gynae Cancer performance remains a concern for the Service. An SBAR was presented to the Executive Team on 31 January 2024 requesting agreement to commission Gynaecology Cancer Services. The Service has recovered its overdue NRI position and has open 6 NRIs none of which are overdue. In response to an accumulation of performance concerns, potential red flags and system issues highlighted by the wider staff team on Site, relating to the Women's Local Leadership Team in YG (current and recent), the West Local Improvement Plan remains in place. The national induction of labour (IOL) rate is 34% (NMPA, 2022),

	locally BCUHB has seen a steady increase in this rate. Whilst the majority of inductions are appropriate as per local policy and national guidelines, there is an opportunity, via an improved communication strategy, to ensure that women are supported to make informed decisions regarding IOL. A working group has been established and its first meeting was held in December 2023. Currently data collected in relation to women presenting to services with existing mental health conditions is not categorised according to severity. Work has commenced with the Women's Service Information Officer to be able to record this as either mild or moderate to severe, as the latter only would meet criteria for referral to the Specialist Perinatal Mental Health Service. Of those women that meet criteria for and accept referral to the Specialist Perinatal Mental Health Service, there would be an expectation that they would all have mental health care plan in place. • **Cancer Division** highlighted the secondment for the Metastatic Clinical Nurse Specialist Post (East) post ends 31 March 2024. An establishment control request has been submitted and is currently in RIGA 2 stage. The current caseload is 130 metastatic breast patients and 73 Metastatic colorectal patients and the CNS is key worker for these patient groups. Patients are aware that this post may not be supported due to the financial constraints and have voiced their concerns. The post is currently being considered by the Executive RIGA and an outcome awaited. This has been logged on the risk register. There is fragility of the neuro-oncology service due to having two locum consultants and the Band 7 nurse retiring in April 2024. A Neuro-oncology Service Group has been established within the division to table concerns and find solutions. Funding for the Band 7 post has now been agreed. A further review of the service is required. Cancer Services are experiencing extreme and unprecedented pressure on the Systemic Anti-Cancer Treatment (SACT) service. There has been a surge of new patient referrals with a simultaneous increase in SACT deferrals. Cancer Services staff are working hard to find solutions, both immediate and medium term, and there are work streams currently underway to take this forward. • **Diagnostics and Clinical Support** Division advised a HIW inspection of nuclear medicine / radio nucleotide services identified estates issues within the Medical Physics Department at YGC. The improvement plan was accepted by HIW. The United Kingdom Accreditation Service assessed compliance with ISO 15189 during 2023 with the final onsite visit during December 2023. The report was received and highlights the effectiveness of the Pathology Quality Management System. The use of artificial intelligence in Cellular Pathology provides additional assurance and efficiencies for Reporting. The division have also seen a reduction in the use of additional testing for prostate pathology. • Dental Division did not submit a report. • **The Infection Prevention and Control Group** reported concerns raised that there is limited resource in Occupational Health if a staff member was to acquire an infection in hospital that needed swabbing and/or treatment e.g. Measles and Group A Strep; they would probably

	be sent to their GP. The Health Board is the only board in Wales not adhering to WHTM01-06 in relation to the decontamination of choledochoscopes. Further concerns were raised this month re out of hours training for decontaminating choledochoscopes - assurance has not been given and processes must be strengthened. • **The Regulatory Assurance Group** advised an announced inspection took place in Nant Y Glyn on 23-24 January 2024. The group received an update on HIW, CIW, PSOW and WRP activity alongside a discussion around inquests. • **The Patient Safety Group** reported on presentations they had received on insourcing and the provision of intravenous access. The Nosocomial Covid-19 Project (NNCP) is on track to complete all investigations of cases by the end of February 2024. March will be used as a focus period for transferring all remaining investigations and Scrutiny Panel outcomes onto Datix. The group advised attendance and requested update's by each IHC's against the monthly Health Board Inpatient Falls Group reporting template is sporadic and they were asked to support/facilitate the IHC's attendance and reporting to the Falls group to support the sharing of learning, good practice and innovation, and in addition as an opportunity for peer support. The desktop review for the HSE improvement plan with each IHC took place as scheduled for 29th January 2024 with the aim to review progress and support against the actions within the overarching improvement plan. Not all IHC's were in attendance for this first review and a further Executive led desktop review is scheduled for March 2024. There continues to be ongoing issues with a delay in the health board receiving Patient Safety and Nationally Reportable Alerts for action and distribution. This concern has been raised at the monthly All Wales Patient Safety Solutions Group on multiple occasions. The Health Board was advised at the last AWSSG that compliance would not be required for those not issued by the NHS Wales Executive and therefore compliance date does not need to be on these alerts. However the Health Board will still collate compliance even though this is not required for submission. • **The Safeguarding Group** reported on the Serious Violence Duty. The Health Board are one of the specified Authorities "with a duty to identify, reduce and prevent serious violence in our communities". Other specified Authorities include, North Wales Police, Local Authorities, Fire and Rescue, Probation, Youth Services and Education. The strategy will be launched on the 27 March 2024. The Health Board has a duty to "identify, reduce and prevent serious violence in our communities". • The group received and noted the HIW Annual Report. • The group received a proposal for improvements to the Incident Procedure. The chair invited comments within two weeks and advised all Clinical Executives needed to have opportunity to review and discuss.

Teitl adroddiad: ***Report title:***	QSE Committee – Regulatory Assurance Report			
Adrodd i: ***Report to:***	QSE Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	18th April 2024			
Crynodeb Gweithredol: ***Executive Summary:***	This report provides the Committee with assurance and analysis on significant regulatory matters and issues.			
Argymhellion: ***Recommendations:***	The Committee is asked to note this report. The Committee is asked to consider the Ombudsman Annual Letter and Health Board response which will inform the Committee's work on seeking assurance of the complaint handling process.			
Arweinydd Gweithredol: ***Executive Lead:***	Angela Wood, Executive Director of Nursing and Midwifery			
Awdur yr Adroddiad: ***Report Author:***	Matthew Joyes, Deputy Director of Quality Governance Erika Dennis, Lead Quality Assurance and Regulation Manager			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☐ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☒ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/ tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				
There is confidence in the data provided in the report however, the pace of learning and improvement remains an area of concern and is a key focus of work. This is being addressed through a range of measures including the actions aligned to Special Measures and the Board Assurance Framework.				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	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. 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 Regulatory Assurance Report 2. Ombudsman Annual Letter 3. BCUHB Response to Ombudsman Annual Letter	

QSE Committee – Regulatory Assurance Report – March 2024

INTRODUCTION

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

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

The report covers the period of January and February 2024.

The Health Board's Regulatory Assurance 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 Governance Department, 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 Governance Department manage the internal process for HIW regulatory activity and play a key role in providing oversight and assurance.

Healthcare Inspectorate Wales Activity January to February 2024
Inspection Reports (1) An inspection report was published on 07 February 2024 in relation to the announced inspection of Coach House Dental Care which took place on 07 November 2023. It is an independent practice which provides both Private and NHS dental care. Overall it was a positive inspection with no immediate concerns issued. The improvement plan includes a specific request for the practice to seek advice from the Health Board in relation to implementing an 'Active Officer' for offering services through the medium of Welsh. The Health Boards Primary Care Clinical Governance Team have taken this forward with the Independent Dental Advisor. This report can be accessed here.

Concerns / Requests for Assurance (4)

Case 1: Fleming Ward, Respiratory Medicine, IHC East (Wrexham Maelor)

On 25 January 2024, the Health Board received a letter of concern from HIW following an individual wishing to raise concerns in relation to patient care. The individual was advised by HIW to raise their concerns directly with the Health Board, however, due to the nature of the concerns raised, HIW required assurances. The concerns pertained to pressure damage, discharge planning meetings lacking sufficient information to family regarding proposed plans, patients not being assisted with personal care needs and their food. The Health Board responded to the concerns on 31 January 2024.

Case 2: Acute Stroke Ward, IHC East (Wrexham Maelor)

On 24 January 2024, the Health Board received a letter of concern from HIW in relation to staffing on the acute stroke wards following allegations made in relation to staffing levels not meeting legal requirements which is putting staff at risk, the moving of staff to make it appear that the wards are adequately staffed and staff scared to speak out. The Health Board responded to the concerns on 31 January 2024.

Case 3: Heddfan Unit, Mental Health and Learning Disabilities, Wrexham Maelor

On 22 February 2024, the Health Board received a letter of concern from HIW in relation to staffing on the unit following allegations that senior leadership are not actioning submitted requests for additional staff. The Health Board responded to the concerns on 28 February 2024.

Case 4: Dermatology Services, IHC West

On 27 February 2024, the Health Board received a request for assurances from HIW in relation to allegations made regarding issues with clinical lead absences subsequently impacting on clinics and cancelled clinics impacting on patient safety. The Complainant feels unsafe and feels an investigation is required.

Healthcare Inspectorate Wales – Progress with Improvement Plans January to February 2024

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

Service / Area	Date	Responsible Lead	Position overview
Foelas Assessment and Treatment Unit, Bryn y Neuadd, MHLD, West	Mar 2023	Iain Wilkie, Interim Director, MHLD	
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, MHLD	⇧ 6%
Hergest Unit (Acute Mental Health), MHLD Ysbyty Gwynedd, West	May 2023	Iain Wilkie, Interim Director, MHLD	

Ty Llewelyn Unit (Rehabilitation), Bryn y Neuadd, MHLD, West	Jul 2023	Iain Wilkie, Interim Director, MHLD	
Ablett Unit (Acute Mental Health), MHLD, Glan Clwyd Hospital, Centre	Jul 2023	Iain Wilkie, Interim Director, MHLD	
Morris Ward, Respiratory Medicine, Wrexham Maelor, East	Sep 23	Michelle Greene, IHC Director, East	⇧ 31%
Emergency Department, Ysbyty Gwynedd, West	Sep 23	Ffion Johnstone, IHC Director, West	⇧ 15%

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 draft report and improvement plan are in the final stages and will be available once final approval is received from RAG. Further reviews are planned for other parts of the Maternity Service.

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.

The first of the six monthly Quality of Care Review visits took place at Tuag Adref / Home First, IHC East on 29 February 2024. The service completed a Quality of Care Review Report ahead of the visit which helped 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.

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 January and February 2024, the Health Board has received 4 Regulation 28 Prevention of Future Death Reports. A summary of the issues raised by the Coroner are listed as follows:

1. East – issues in relation to no Datix or subsequent investigation into a patient lost to follow-up. No assurances as to what changes and learning have been identified other than a tracking system for PSA monitoring. Evidence heard that Datix was not completed and that the system was not user-friendly.

2. MHLD – issues raised in relation to communication between the Health Board and an out of area acute psychiatric facility. Relevant information did not appear to be shared between the two organisations e.g. deceased's progress, medication, treatment etc. No joined up planning or joint meeting between the Health Board and private facility prior to the deceased's discharge.

3. West – issues raised in relation to compliance with the target of 12-15 monthly medication reviews in Health Board managed GP practices. No standard practice for medication reviews leading to a lack assurance that all pertinent matters will be covered and the approach varying between clinicians and practices. The risk of inadvertent overdose in individuals who are receiving strong opiates and other drugs that have the ability to depress the central nervous system without regular reviews nor specific advice to patients in respect of the associated risks issued.

4. West – Issues raised in relation to the patient being seen by a number of orthopaedic doctors of varying grades including consultants. Junior doctors may reach a different opinion to their consultant colleagues and the Coroner felt there was a risk (missed diagnosis) if doctors are not encouraged to challenge or discuss their findings (which may be different) to their consultant colleagues or have professional discussions. Further issues were raised in relation to responses to families when a complaint is raised and the limitations of the Health Board's investigation (due to an ongoing police investigation). This meant that there were no formal considerations as to immediate actions or learning required to reduce harm and the risk of death.

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 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 Health Board shares the concerns raised by HM Senior Coroners regarding investigation 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.

A presentation on the learning from Regulation of 28 Prevention of Future Deaths was shared at the Organisational Learning Forum in December 2023. The emphasis is on improving the way learning

is shared across the organisation, especially to front line clinicians and to ensure we reduce the risk of further Regulation 28 reports being issued by focussing on the main themes.

Training sessions have been arranged in May 2024, facilitated by one of our leading Barristers, on the best approach to formulating a 'Lessons Learned Statement'. The objective of the lessons learned statement is to provide a chronological summary of actions taken, referencing key policies, improvements and learning in a witness statement to be signed off at senior leadership level. This can be used successfully to provide assurance to the Coroner and family that lessons have been learned and implemented in order to reduce future deaths.

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 until 27 March 2024 to comment on the proposed conclusions and recommendations of a draft Public Interest Report. 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 -2 (i.e. submissions are on average 3 days ahead of a deadline).

The Health Board continues to meet with the Ombudsman's Complaints Standards Authority to ensure good working practices and to facilitate awareness training for staff working within the Health Board. The Chief Executive also held their regular meeting with the Ombudsman.

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

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

WELSH RISK POOL

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

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 January or February 2024.

In January 2024, there has been a Supreme Court judgement in respect of secondary victim claims which impacts claims and concerns. A secondary victim is someone who has suffered psychiatric

injury not by being directly involved in the incident but by witnessing it. Secondary victims tend to be family members who witness negligent medical treatment. The judgement has made it far more difficult for secondary victim claims to succeed. In summary, it was held that claims by secondary victims for psychiatric injury are only valid where the claimant witnesses ‘an accident’ or its immediate aftermath, which is different from a medical crisis, and that a clinician does not owe a duty of care to a secondary victim. This is likely to have an impact on reducing secondary victim claims brought against the Health Board.

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 38 (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.

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Ask for: Communications
01656 641150
Communications
@ombudsman.wales

Date: 17 August 2023

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

Annual Letter 2022/23

Dear Dyfed

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

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

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

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

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

Supporting improvement of public services

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

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

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

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

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

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

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

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

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

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

Yours sincerely,

Michelle Morris
Public Services Ombudsman

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

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Factsheet

Appendix A - Complaints Received

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

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Appendix B - Received by Subject

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

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Appendix C - Complaint Outcomes
(* denotes intervention)

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

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Appendix D - Cases with PSOW Intervention

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

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Information Sheet

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

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

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

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

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

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

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

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

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

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

Dear Michelle,

Re: Ombudsman Annual Letter 2022/23

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

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

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

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

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

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

I can confirm our updated position is as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

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

Yours sincerely

Dyfed Edwards
Cadeirydd / Chair

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

Teitl adroddiad: ***Report title:***	East IHC – QSE Deep Dive			
Adrodd i: ***Report to:***	QSE			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 18 April 2024			
Crynodeb Gweithredol: ***Executive Summary:***	Overview of current position in relation to Quality and Safety – East IHC			
Argymhellion: ***Recommendations:***	N/A			
Arweinydd Gweithredol: ***Executive Lead:***	Angela Wood, Executive Director of Nursing and Midwifery			
Awdur yr Adroddiad: ***Report Author:***	Andrea Hughes, IHC East Director of Nursing Michelle Greene, IHC East Director			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☐ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***				
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	e.e. Yr Awdurdod Gweithredol Iechyd a Diogelwch			

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

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

East IHC
QSE Deep Dive

April 2024

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University Health Board

Governance

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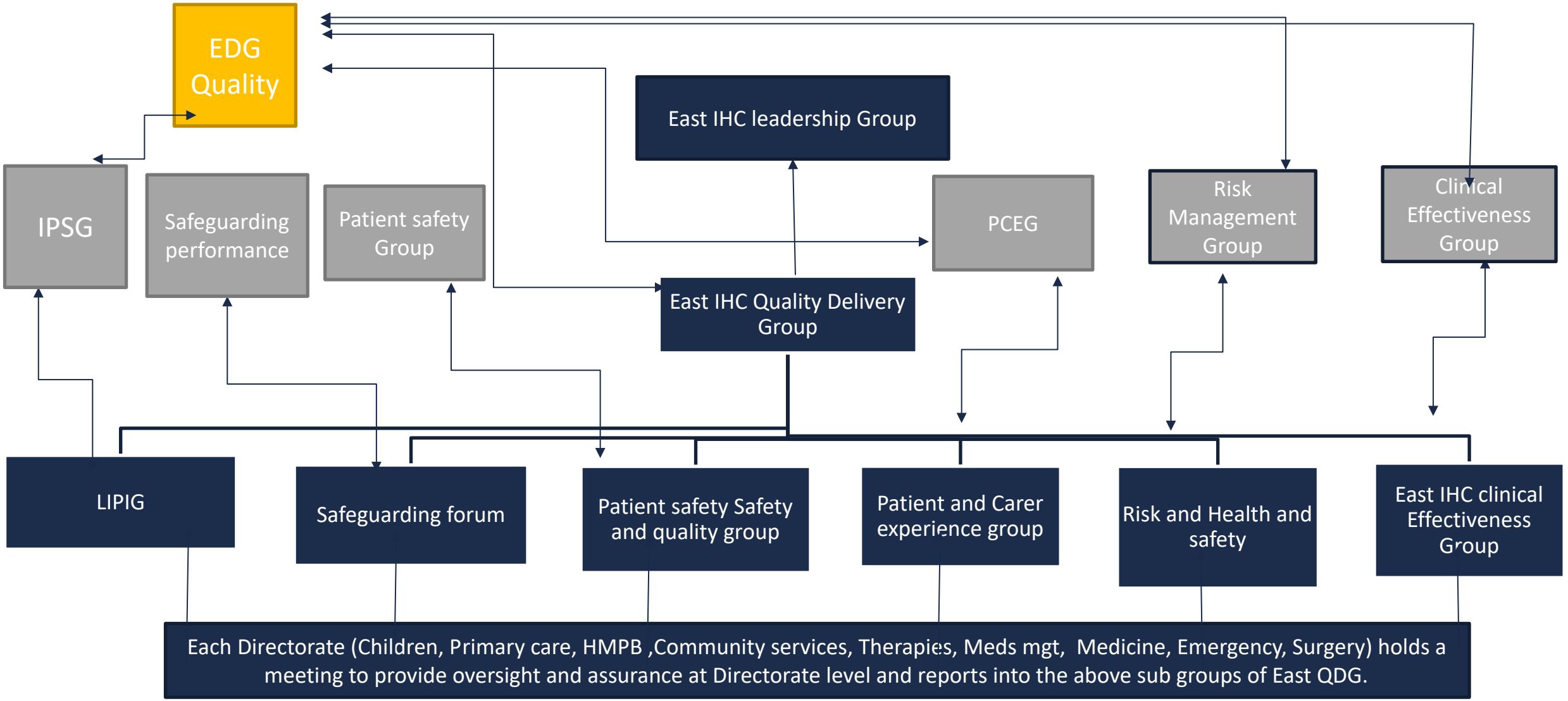
University Health Board



Key relationship and reporting structure

Executive quality Delivery Group

BCU Wide sub group

East IHC governance group

Achievements

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Bwrdd Iechyd Prifysgol
Betsi Cadwalar
University Health Board

- **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
- **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.
- **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. The service has won awards, including the Wales Advancing Healthcare Aware for improving public health outcomes.
- **HMP Berwyn Tuberculosis pilot** – HMP Berwyn was selected as a pilot site to evaluate the process of implementing and offering a chest x-ray to new admissions at HMP Berwyn. The reason for the pilot was following the publication of NICE guidance on Tuberculosis that advised prisons with static digital x-ray facilities should x-ray all new prisoners and detainees if they had not had a chest x-ray in the past 6 months for active TB.

Quality Indicators

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

JANUARY 2023

Overdue complaints (51)

Falls (129, 6 with harm)

Medication Incidents (75)

Infection Prevention (82)

HAPU (221)

Ombudsman cases 22 (nil overdue)

NRIs (7 open, Nil overdue)

Inquests

LFERs (11)

FEBRUARY 2024

Overdue complaints (59)

LFERs (14)

NRIs 11 (7 overdue - 5 in QA process)

Infection Prevention (37)

Medication Incidents (104)

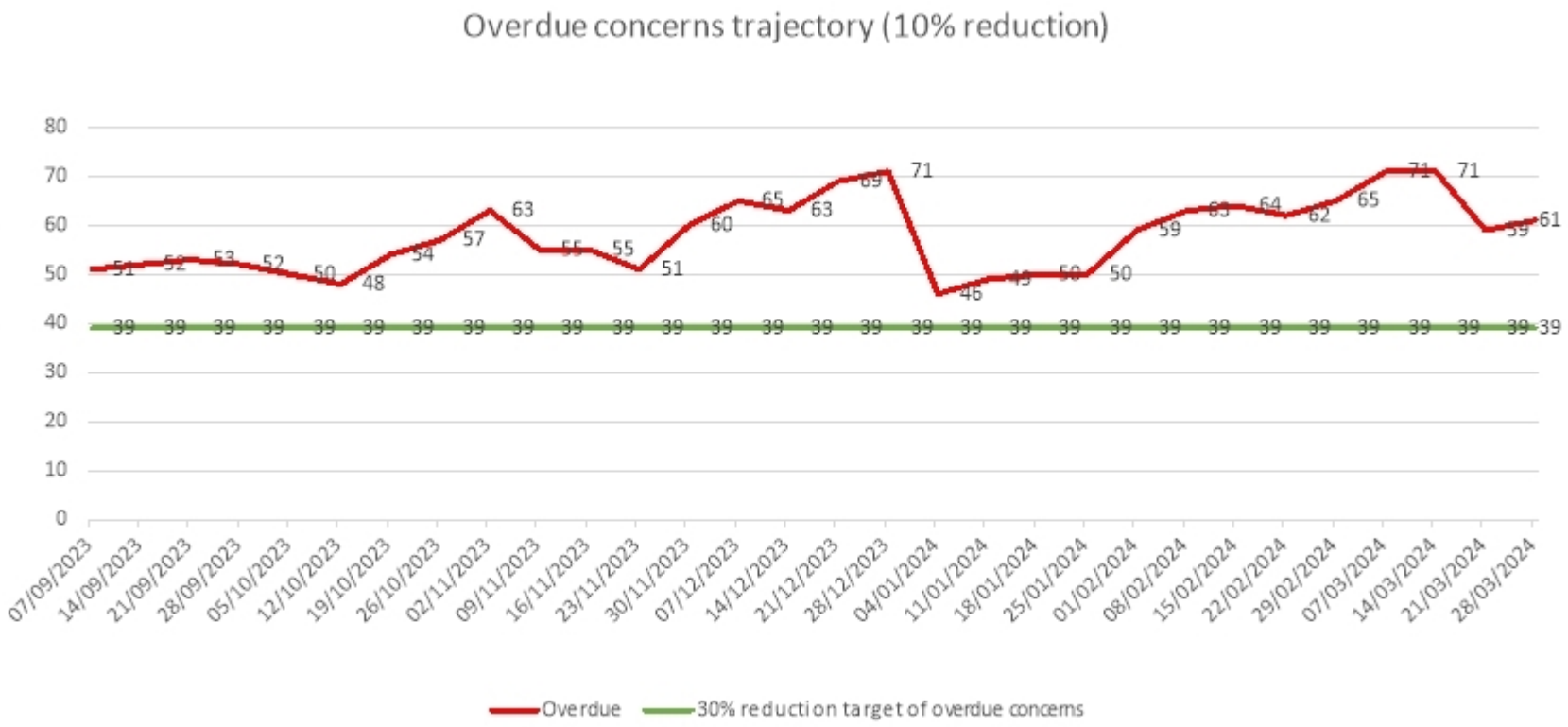
Falls (101, 1 with harm)

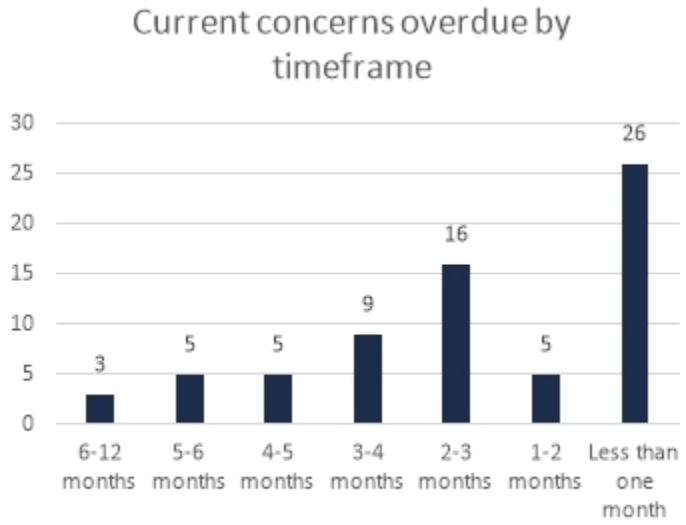
HAPU (271)

Inquests (71)

Ombudsman cases (17, Nil overdue)

Overdue complaints Trajectory





NB: This data does not include insourcing, outsourcing complaints
As of concerns submitted for approval to
Quality Assurance
Legal and Risk

Continuing areas of Concern

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Betsi Cadwalar
University Health Board

Risk	Summary	Mitigation

• Wrexham Maelor Infrastructure
  ○ Sustainability
  ○ Future redevelopment
	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	• 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.

• Finance	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	• 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

• Access / Capacity and Flow
  ○ ED
  ○ RTT
	• 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
		• ED
		  ○ 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

• Childrens Neurodiversity	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. 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.	• 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)
• Primary Care Managed Practices	We have a number of on going issues across primary care and manged 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	• 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

Teitl adroddiad: ***Report title:***	**Update on Policies**			
Adrodd i: ***Report to:***	QSE Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Tuesday, 16 April 2024			
Crynodeb Gweithredol: ***Executive Summary:***	The purpose of this report is to provide QSE Committee with an update on the development of Policies, their approval route and the planning taking place to review policies that are due for review during 2024. This has an impact on QSE Committee as under a new process it will be required to note the approval of Health Board wide Clinical Policies rather than approve them. The report sets out the current progress in approving a "Policy on Policies" document and sets out how the Health Board Teams are programme planning the review of policies during 2024/25.			
Argymhellion: ***Recommendations:***	*The Committee is asked to:* • **Note that** the "Policy for the Management of Health Board Wide Policies, Procedures and other Written Control Documents" is being received at Audit Committee on the 15 May 2024 • **Note** the progress that is being made on updating policies			
Arweinydd Gweithredol: ***Executive Lead:***	Phil Meakin - Acting Board Secretary Angela Wood – Executive Director of Nursing and Midwifery			
Awdur yr Adroddiad: ***Report Authors:***	Phil Meakin – Acting Board Secretary Matt Joyes – Deputy Director of Quality			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☒	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence*	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*

	in delivery of existing mechanisms/objectives	*General confidence / evidence in delivery of existing mechanisms / objectives*	*Some confidence / evidence in delivery of existing mechanisms / objectives*	

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***	
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	This work links to all strategic objectives of the Health Board as effective Governance is a key enabler for them.
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	It is essential that the Board has robust arrangements in place for Corporate Governance and failure to do so could have legal implications for the Health Board.
Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqlA been identified as necessary and undertaken?***	This is not applicable for this report.
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?***	This is not applicable for this report.
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	Internal controls such as the Policy on Policies are fundamental to compliance. A failure to implement a robust policy for the development and review of written control documents may leave the organisation exposed to the following risks: • Failure to provide employees/workers with comprehensive, up to date guidance may result in the application of inappropriate care or care that is not in line with current best practice. This in turn could lead to harm being incurred by patients and subsequently, financial detriment via the redress process. • Failure to provide employees/workers with comprehensive, up to date guidance may result in non-compliance with non-clinical legislative obligations / public sector duties, which could incur financial penalty via fines.

	• Failure to provide an authoritative repository may result in employees/workers having limited confidence that the document they require is extant or fit for purpose. Employees/workers should be able to efficiently access a single, authoritative source where they can easily navigate to the appropriate guidance and have confidence that the document that they are applying is correct, without fear of legal or professional repercussions. • Failure to provide adequate guidance may result in complications during disciplinary proceedings. Written control documents enable BCUHB to set out the standards required. If employees/workers do not comply with the relevant written control document, then this may be justification for invoking the relevant disciplinary and/or capability procedure. • Failure to provide an authoritative Policy on Policies may result in written control documents being developed without the appropriate oversight, consultation or approval which may lead to variances in care across the BCUHB sites. • When incidents/concerns do occur or arise, professional regulators or members of the public may request the document in force at the time. BCUHB risk further reputational damage or regulatory enforcement action wherein the document cannot be found, is out of date or not fit for purpose
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	The effective and management of Governance 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 and less waste
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	Failure to have effective Corporate Governance can impact adversely on the workforce. The development of robust Policies and Declarations of Interest as outlined in this report will strengthen arrangements for workforce related matters
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	This report now reflects the additional consultation that has been received and has been shared with the Executive Team for further comments in relation to Policies
Cysylltiadau â risgiau BAF:	BAF Risk Board Leadership and Governance

(neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Not applicable

Next Steps:

If approved by the Audit Committee on the 15 May 2024 the Policy for the Management of Health Board Wide Policies, Procedures and other Written Control Documents

- will be communicated to the organisation and information provided to Services and Corporate Functions setting out requirements.
- To schedule an update at the next Audit Committee (May 2024) on the programme to update policies.
- QSE Committee will receive regular policies to note as approved as part of this process
- The QSE Committee forward plan will be updated accordingly.

List of Appendices

Appendix 1 – Summary of Policies approval route

Policies Update

1. Introduction and Background

1.1. Corporate and Clinical Policies are a crucial part in any organisation's approach to Quality. They enable the workforce to have clarity and direction in the way that the duties and responsibilities of Health Board are implemented and this in turn has an impact on the way the workforce treat and care for Patients.

1.2. The objective of this report is to give the QSE Committee an update on the process for policy approvals and the review of policies where QSE has a role. There are two key areas to provide an update on. They are:

- Policy for the Management of Health Board Wide Policies, Procedures and other Written Control Documents
- Work underway to update Clinical Policies

2. Update on the Process to Approve Policies

2.1 The Audit Committee on the 15 May 2024 has been asked to approve what is in effect "*A Policy for Policies"* and also note next steps on the development of policies that are past a review date with a proposal to bring an update on this to the May Audit Committee. An update on the status of that approval can be provided at the QSE Committee as this report was written before that meeting took place.

2.2 The Health Board has a duty to ensure that appropriate policies and supporting procedures, protocols or guidelines (referred to collectively as written control documents) are in place to comply with legislation, enabling all employees/workers to fulfil their roles safely and competently. The Health Board's "*Policy on Policies*" sets out the various roles, responsibilities and the route to be followed when developing or updating written control documents. *There is a Special Measures Milestone 1.9.4 "The final Policy on Policies document approved at Audit Committee in January 2024"*

2.3 If approved by Audit Committee on the 15 May 2023 the key change that is being reported to QSE Committee is the proposed new approvals route. Previously, any pan BCUHB policy required final approval at the relevant Board level Committee. The revised approval route delegates this responsibility to the relevant Executive (noting that some Policies as per the Health Board Standing Orders are reserved for Board approval. Appendix 1 provides an overview of this.)

2.4 The key point for QSE Committee to note is the change from Board Committees approving some policies to noting them. For the record, this change does reflect a request from QSE Committee in 2023 that this be put in place so this change puts the governance of that in place.

2.5 Once this programme has been agreed (a target date has been set as the 15 April 2024) then a programme of when relevant policies will be brought to the QSE Committee can be factored into the Committee forward plan. This includes the following categories:

- Clinical Policy BCU Wide (all to be noted at QSE Committee
- Non-Clinical Policy BCU Wide (If related to the remit of QSE Committee)
- Any BCU Wide Policy which includes Medicines Management (all to be noted at QSE Committee)

3. Update on Review of Policies

3.1 The policy outlined above only deals with the **process** for policies. In line with another Special Measures milestone *1.9.3 "A stock take of all policies will be undertaken and Exec Team members asked to prioritise the review of policies that they are responsible for".* The Governance Directorate is leading work to review all policies are due to be reviewed with their Executive owners. This work is now underway to address the number of documents past their review date. This includes:

- A summary of overdue documents has been produced by the Governance Directorate and meetings arranged with all Executive Policy owners to progress a 12 month programme. Effectively this means agreeing with Executives a prioritisation of which policies will be reviewed and the method by which to review them.
- This will result in a programmed plan to review policies over the 4 quarters of 2024/25.
- Short term plans to review extant documents.
- Agree criteria to prioritise – (number of out of date documents and impact assessments by relevant Executives and Leads).

3.2 Progress on this work will be reported to the Audit Committee at the May 2024 meeting so that the process deployed and progress made can be scrutinised by the Audit Committee.

3.3 Once this programme has been agreed (a target date has been set as the 15 April 2024) then a programme of when relevant policies will be brought to the QSE Committee can be factored into the forward plan. This includes the following categories:

  - Clinical Policy BCU Wide
  - Non-Clinical Policy BCU Wide (If related to the remit of QSE)
  - Any BCU Wide Policy which includes Medicines Management

3.4 At the time of writing this report (13 March 2024) the Executive Director of Nursing and Midwifery and Deputy Director of Quality had met with the Governance Teams and agreed an initial programme plan for the majority of policies that relate to QSE Committee. A further update can be provided at the Committee .

4. Next Steps

4.1 If approved by the Audit Committee on the 15 May 2024 the Policy for the Management of Health Board Wide Policies, Procedures and other Written Control Documents:

- Will be communicated to the wider organisation and information provided to Services and Corporate Functions setting out requirements.
- To schedule an update at the next Audit Committee (May 2024) on the programme to update policies to receive a progress update.
- QSE Committee will receive regular policies to note as approved as part of this process.
- The QSE Committee forward plan will be amended to reflect this.

Appendix 1

Table 1: Simplified Approval Route Planner

Document Type/Scope	Approval route in sequence order		
	1	2	3
Policies reserved as a matter for the board	Please refer to the Health Board Standing Orders, Scheme of Reservation & Delegation and the Office of the Board Secretary to confirm approval route. The above documents reference the Health & Safety Policy, Standards of Business Conduct Policy, Counter Fraud Policy as reserved for the Board		
Clinical Policy BCU Wide	Relevant Specialist Governance Groups	Relevant Strategic Quality Group (i.e. patient safety, clinical effectiveness)	Executive Quality Delivery Group (to include approval of the Clinical Executives) and noted at QSE Committee.
Clinical Other written control document BCU wide	Relevant Local Specialist Governance Groups	Relevant Strategic Quality Group (i.e. patient safety, clinical effectiveness) and note at Executive Quality Group	
Non-Clinical Policy BCU Wide	Relevant Local Governance Groups	HBLT/Exec Team and noted at relevant Committee	
Non-Clinical other written control document BCU wide	Relevant Local Governance Groups	Relevant BCUHB Corporate Group or Senior Management Team	
Clinical - Local Written Control document (i.e. below policy level) [see section 5.3]	Local Clinical Governance Group	IHC/Division Quality Group	
Non-Clinical – Local Written Control	Relevant Senior		

document (i.e. below policy level)	Management Team		

Table 2: Documents that include Medicines Management

Document Type/Scope	Approval route in sequence order			
	1	2	3	4
Any BCU Wide Policy which includes Medicines Management	Medicines Policy, Procedures and Patient Group Direction Sub Group	Drug and Therapeutics Group	Relevant Strategic Quality Group (i.e. patient safety, clinical effectiveness)	Executive Quality Group (to include approval of the Clinical Executives) and noted at QSE Committee
Any BCU Wide written control document (below policy level) which includes Medicines Management	Medicines Policy, Procedures and Patient Group Direction Sub Group	Drug and Therapeutics Group	Relevant Strategic Quality Group (i.e., patient safety, clinical effectiveness) and noted at Executive Quality Group.	
Patient Group Directives (PGDs) and BCU wide prescription charts	Medicines Policy, Procedures and Patient Group Direction Sub Group	Drug and Therapeutics Group		
Shared Care Agreements Prescribing Guidelines, Standard Operating Procedures for switching treatments for General Practice	BRAG Sub group	Drug and Therapeutics Group		

Presentation of the Nurse Staffing Levels

Reporting Period: Spring 2024

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Introduction / Background

The Nursing Staffing Levels (Wales) Act became law in Wales in March 2016 and places a duty on Welsh health boards and trusts to ensure that nurses have enough time to care for patients.

The Act consists of 5 sections:

- 25A refers to the health boards'/trusts' overarching responsibility to have regard to providing sufficient nurses in all settings;
- 25B requires health boards/trusts to calculate and take all reasonable steps to maintain the nurse staffing level in all adult acute medical inpatients wards; adult acute surgical inpatient wards; and paediatric inpatient wards. Health boards/trusts are required to inform patients of the nurse staffing level on those wards;
- 25C requires health boards/trusts to use a specific method to calculate the nurse staffing level in all adult acute medical and surgical wards;
- 25D relates to the statutory guidance released by Welsh Government;
- 25E requires health boards/trusts to report their compliance in maintaining the nurse staffing level for each adult acute medical inpatient ward; adult acute surgical inpatient ward; and paediatric inpatient ward.

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

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

The Act has two key requirements:

1. **A duty to calculate and take steps to maintain nurse staffing levels**
2. **Apply triangulated methodology to nurse staffing level calculations**

In line with the Act, nurse staffing calculations are to be approved by a ***designated person*** who is authorised to undertake this calculation on behalf of the Chief Executive Officer.

The designated person should be registered with the Nursing and Midwifery Council and have an understanding of the complexities of setting a nurse staffing level in the clinical environment. Within Welsh Health Boards the designated person is the Executive Director of Nursing.

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

Section 25C: Nurse staffing levels: method of calculation

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

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

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

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

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

Section 25A: Duty to have regard to providing sufficient nurses

Whilst the statutory requirement to undertake nurse staffing level reviews following the triangulated approach, described in Section 25C, may only apply to those wards which pertain to Section 25B, the Executive Director of Nursing & Midwifery has endorsed this as the approach to be used for all nurse staffing level reviews*.

BCUHB nursing services pertaining to Section 25A who have commenced reviews of their nurse staffing levels using the triangulated approach over the 2023/24 reporting period are:

- Community hospital wards
- Emergency quadrant wards and departments
- 24/7 medical & surgical wards who do not pertain to Section 25B of the Act
- Mental Health and Learning Disability wards

Upon the conclusion of all 24/7 wards and departments nurse staffing level reviews, a paper will be formally presented to Board detailing the outcome and associated recommendations of these.

*To support this a Calculating Nurse Staffing Levels SOP is currently in development and will inform the process which all nurse staffing level reviews, undertaken in any nursing service within BCUHB, should follow.

Nurse Staffing Levels Calculations Process

Ward Level Data Collection & Review

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

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

Health Board Wide Multi-site, Service Specific Reviews

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

Spring 2024 reviews were undertaken during the week commencing 11th March 2024.

Review & Approval by Designated Person

Formal presentations will be made to the Executive Director of Nursing and Midwifery on 12/04/2024. In attendance will be the Executive Directors of People Services; & Finance or their nominated deputies.

Agreed Nurse Staffing Level calculations will be formally presented to the Board on 30/05/2024.

Extent to which the Nurse Staffing Levels are maintained

A real time view of staffing is provided by the RL Datix (formally Allocate) E-Rostering SafeCare system. This provides the ward manager/shift lead with the opportunity to record whether or not staffing was appropriate to meet the needs of the patients on a shift by shift basis. Any concerns relating to nurse staffing levels are to be escalated in line with the NU28 Nurse Staffing Levels and CW01 Paediatric Escalation policies.

The table below details the extent to which the planned roster was met across the adult medical & surgical wards and paediatric wards pertaining to Section 25B of the Act 2016 and the appropriateness of the staff on duty to meet patient care needs. The table is based on the Early, Late and Night shifts and is inclusive of both substantive and temporary staffing as recorded on the rosters.

Month	Total number of shifts	Shifts where planned roster met and appropriate		Shifts where planned roster met but not appropriate		Shifts where planned roster not met but appropriate		Shifts where planned roster not met and not appropriate		Data completeness	Shifts where planned roster met but no appropriateness		Shifts where planned roster not met and no appropriateness	
Apr-23	3345	27.29%	913	7.44%	249	27.41%	917	23.89%	799	86.04%	5.32%	178	8.64%	289
May-23	4123	30.05%	1239	9.22%	380	23.09%	952	22.46%	926	84.82%	6.43%	265	8.76%	361
Jun-23	3990	29.02%	1158	6.02%	240	28.55%	1139	26.29%	1049	89.87%	3.81%	152	6.32%	252
Jul-23	4185	32.31%	1352	6.67%	279	29.87%	1250	20.26%	848	89.10%	4.83%	202	6.07%	254
Aug-23	4185	31.88%	1334	8.39%	351	28.48%	1192	20.79%	870	89.53%	4.28%	179	6.19%	259
Sep-23	4140	32.00%	1325	8.67%	359	25.92%	1073	22.34%	925	88.94%	4.88%	202	6.18%	256
Oct-23	4278	34.06%	1457	9.72%	416	22.88%	979	24.43%	1045	91.09%	3.97%	170	4.93%	211
Nov-23	4140	34.71%	1437	10.53%	436	24.01%	994	21.18%	877	90.43%	4.81%	199	4.76%	197
Dec-23	4278	30.58%	1308	9.02%	386	25.81%	1104	23.63%	1011	89.04%	4.70%	201	6.26%	268
Jan-24	4278	37.73%	1614	9.33%	399	24.92%	1066	20.62%	882	92.59%	3.16%	135	4.25%	182
Feb-24	3915	38.01%	1488	10.04%	393	23.30%	912	21.28%	833	92.62%	3.17%	124	4.21%	165
YTD Running Total	44857	32.60%	14625	8.67%	3888	25.81%	11578	22.44%	10065	89.52%	4.47%	2007	6.01%	2694

Please note data presented is between 06/04/2023 – 29/02/2024 in line with national reporting guidelines.

06/04/23 – 30/06/23 figures for Central & West Paediatric wards reported from HCMS system, with East Paediatric ward reported via the SafeCare system.
01/07/23 onwards all Paediatric ward data reported via the SafeCare system.

Aran Ward YG had been stepped up as an Act ward between September 2023 – December 2023. Data applicable to this ward has therefore only been included during this timeframe.

All Wales Acuity Audit

Acuity Audit data

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

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

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

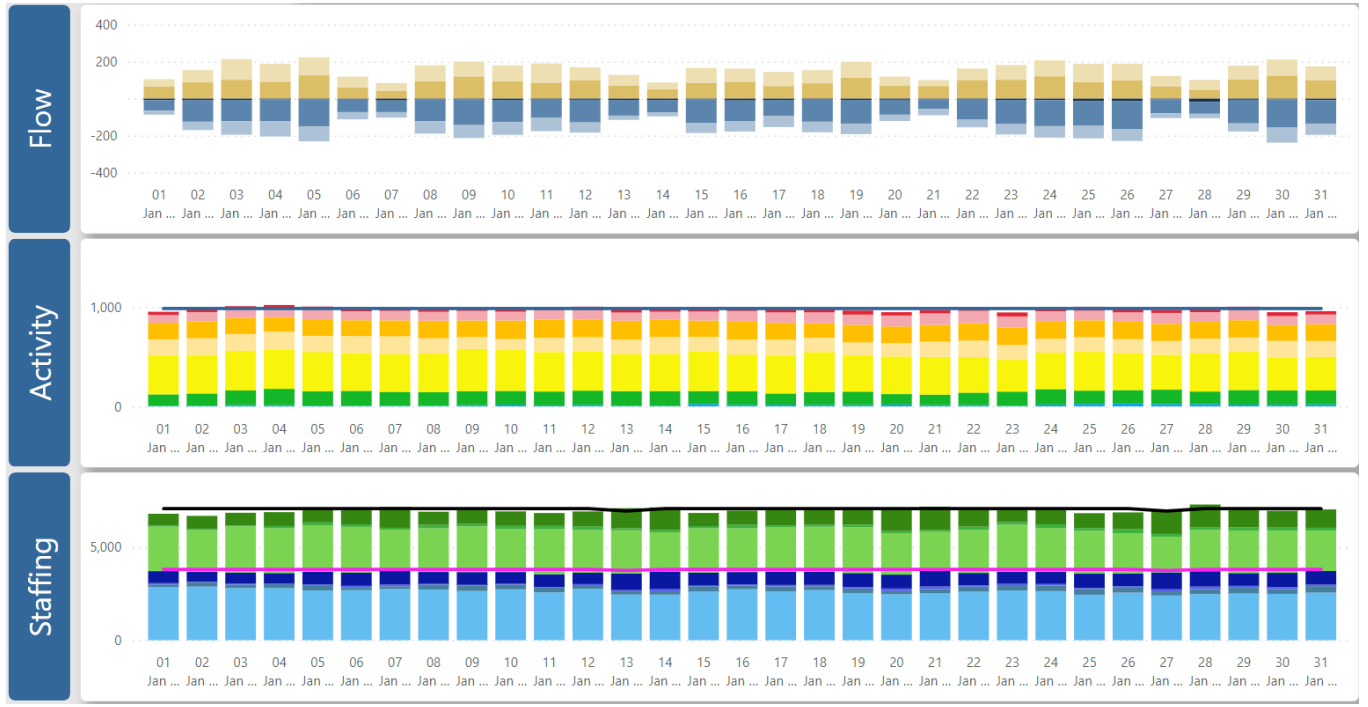
Individual BCU ward acuity details can be viewed **here**

Welsh Levels of Care

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

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

BCUHB Section 25B Wards January 2024 Acuity Audit data



Quality Indicators

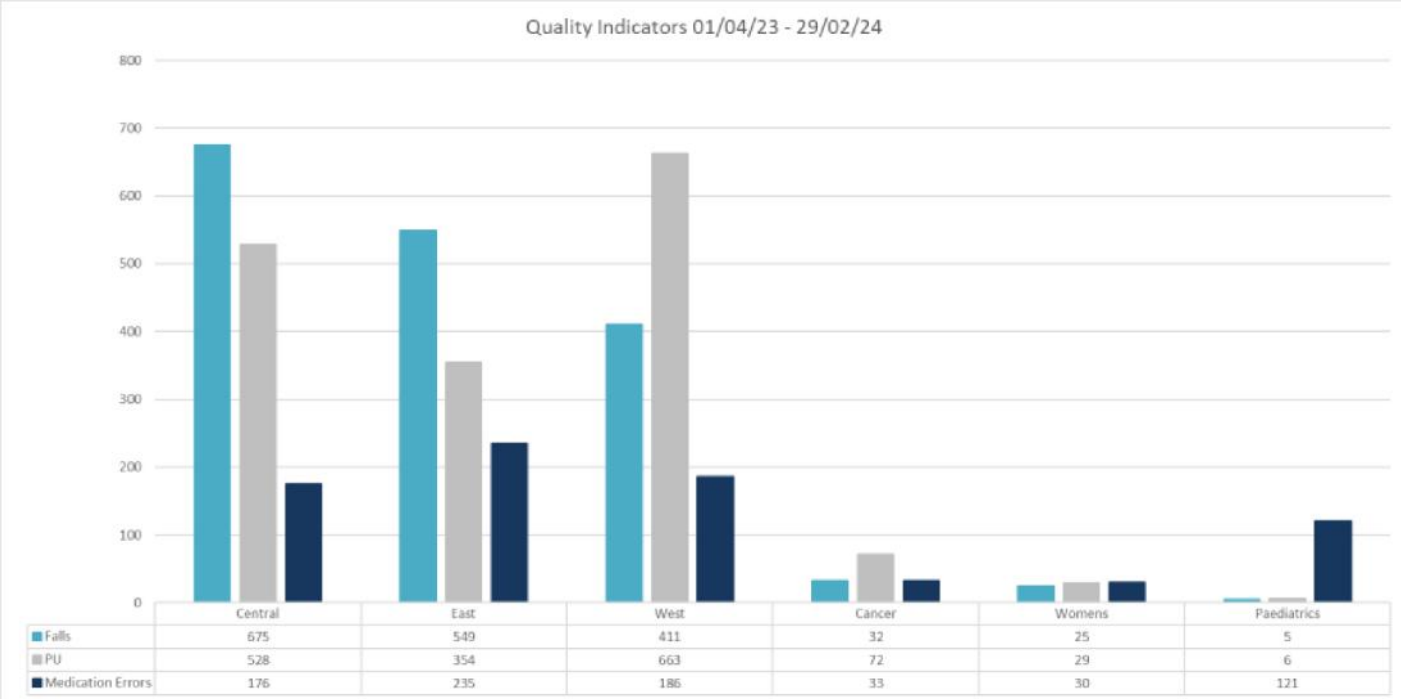
When calculating the nurse staffing level the quality indicators that are particularly sensitive to care provided by a nurse must be considered. These include patient falls, pressure ulcers and medication errors.

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

- patient falls
- pressure ulcers*
- medication errors

which have been recorded within the DATIX system for the period 01/04/2023 – 29/02/2024.

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



	Central	East	West	Cancer	Womens	Paediatrics
Falls	675	549	411	32	25	5
PU	528	354	663	72	29	6
Medication Errors	176	235	186	33	30	121

*pressure ulcers include those which were present prior to admission to the clinical area

Date Source: DATIX system as at 16.03.2024
Aran Ward YG had had been stepped up as an Act ward between September 2023 – December 2023. Data applicable to this ward has therefore only been included during this timeframe.

Approved Nurse Staffing Levels – Spring 2024 (summary)

The nurse staffing level calculations undertaken during the Spring 2024 reporting period (October 2023 – April 2024) proposed FTE changes are summarised in the table below:

Integrated Health Community	Number of Act Wards	Funded Bed Numbers	Required Establishment at the start of the reporting period (October 23)		Required Establishment at the end of the reporting period (April 2024)*		Staffing FTE changes during reporting period 2023 - 2024*		Funded** Establishment (as at September 2023)		FTE Variance between current funded and required	
			RN	HCA	RN	HCA	RN	HCA	RN	HCA	RN	HCA
YMW	14	303	279.17	229.45	TBC	TBC	TBC	TBC	277.14	219.9	TBC	TBC
YGC	13	308	264.23	258.88	TBC	TBC	TBC	TBC	261.51	253.56	TBC	TBC
YG	10	239	228.83	218.01	TBC	TBC	TBC	TBC	228.92	217.91	TBC	TBC
Womens Gynaecological	2	32	33.87	21.9	TBC	TBC	TBC	TBC	36.11	18.66	TBC	TBC
Oncology & Haematology	3	38	33.3	31.27	TBC	TBC	TBC	TBC	33.3	31.27	TBC	TBC
Paediatric Inpatient Wards	3	64	83.46	31.27	TBC	TBC	TBC	TBC	80.98	28.95	TBC	TBC
BCUHB Total	**45**	**984**	**922.86**	**790.78**	**0**	**0**	**0**	**0**	**917.96**	**770.25**	**0**	**0**

* Required establishment at the end of the reporting period and staffing FTE changes during the reporting period.
** Funded establishment sourced from Finance Ledger
Note: The required and funded establishment figures exclude supernumerary ward sister/charge nurse and ward support staff i.e. housekeepers, dementia support workers etc.

Section 25B wards requiring a change to nurse staffing levels

During the spring 2024 reporting period (October 2023 – April 2024) two statutory calculations of nurse staffing levels have taken place, these being autumn 2023 (reported to Board in November 2023) and spring 2024 (to be reported to Board in May 2024).

The autumn 2023 review saw 2 wards requesting changes to their establishments, with the spring 2024 reviews due to be undertaken on 12th April 2024. The changes approved following review by the Executive Director of Nursing are summarised in the table below:

Integrated Health Community	Number of Act Wards	Number of Wards Requesting Adjustments	Adjustments Approved by Exec DoN	Comments
YWM	14	1 autumn 2023	1 autumn 2023	Cunliffe - HCA staffing was reconsidered in Autumn 23 due to harm profile.
YG	10	5 autumn 2023	0	-
YGC	13	1 autumn 2023	1 autumn 2023	ABH Ward 6 - staffing reconsidered during Autumn 23 as part of the ongoing orthopaedic surgical services review
Oncology & Haematology	2	0 autumn 2023	TBC	-
Womens Gynaecological	3	0 autumn 2023	TBC	-
Paediatric Inpatients Wards	3	0 autumn 2023	TBC	-
BCUHB Total	**45**	**7**	**2**	-

Recommendations

Office of the Executive Nurse Director:

- Continue to review the impact of nurse staffing within the clinical areas and quality metrics.
- Ensure the Calculating Nurse Staffing Levels SOP is implemented across all nursing services.
- Continue with the work underway to link the Quality and Workforce metrics to enable review of the data (Exec. Nurse Dashboard)
- Continued focus on recruitment and retention and innovation to support workforce utilisation and reporting. The BCUHB People Strategy & Plan is an essential enabler, which is further supported by the All Wales National Workforce Implementation Plan and the subsequent Nurse Retention Plan, which place.
- Corporate finance teams continue to work with operational finance teams to adjust budgets as part of the annual planning cycle to reflect the revised approved rosters.
- The E-Rostering team will adjust roster demand templates to reflect the agreed ‘planned rosters’
- Ward Managers will process the recruitment of staff, based on the revised nursing establishment (where applicable)
- Ward Managers will display any changes to the planned roster on the ward boards displayed at the ward entrance

Diolch / Thank you

Any questions?

Teitl adroddiad: ***Report title:***	Urology Services in Betsi Cadwaladr University Health Board
Adrodd i: ***Report to:***	Quality, Safety and Experience Committee
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 18 April 2024
Crynodeb Gweithredol: ***Executive Summary:***	In 2021 the Health Board commissioned an Invited Service Review from the Royal College of Surgeons (RCS) of England following concerns identified by the Public Services Ombudsman Wales, a number of incidents within the service, as well as the identification of the need to consider what was needed to ensure a sustainable model for delivery of urology services in the longer term. This review reported in 2023 and did not identify any immediate safety concerns but did make a series of recommendations. These focus on improvements in the delivery of care, the need for a Robotic Assisted Surgery resource and on the longer-term options for service delivery in North Wales. Actions in response to those recommendations began immediately, with the initial focus on providing assurance that no actions were needed in response to the College's review of clinical notes. A Urology Improvement Plan that responds to the College report, as well as to improvements identified within a Getting it Right First Time review that also reported in 2023, is now being developed and is overseen by a Urology Improvement Group, that includes patient representatives and Llais. Work is now underway, collaborating with colleagues across Wales to address the needed improvements in the service, including the culture and the leadership model. The longer-term options for service delivery will be developed as a key component of the Health Board's wider planning priorities.
Argymhellion:	The Quality, Safety and Experience Committee is asked to:

Recommendations:	Note the Royal College of Surgeons England report and the Getting it Right First Time reports Note the approach to respond to the recommendations received and to note the actions already made, which has already had Executive Team approval and support. Support the approach outlined to identify a sustainable service model and to the development of a robotic resource for urology			
Arweinydd Gweithredol: ***Executive Lead:***	Dr Nick Lyons, Executive Medical Director			
Awdur yr Adroddiad: ***Report Author:***	Dr James Risley, Deputy Executive Medical Director Dino Tedaldi, Urology Network Manager			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☒	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
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:				
Link to Strategic Objective(s):	Strategic Priority 4 – Urgent and Emergency Care			
Regulatory and legal implications:	Welsh Government Quality Standards 2023			
In accordance with WP7 has an EqIA been identified as necessary and undertaken?	N/A			
In accordance with WP68, has an SEIA identified as necessary been undertaken?	N/A			
Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)	ID5050 – Network Urology Risks, see Appendix 4			
Financial implications as a result of implementing the recommendations	Detail to be worked through by project plans on each theme			
	Detail to be worked through by project plans on each theme			

Workforce implications as a result of implementing the recommendations	
Feedback, response, and follow up summary following consultation	The recommendations as outlined by the RCS and GIRFT have been shared with the Urology Improvement Group, which accept and support their implementation.
Links to BAF risks: *(or links to the Corporate Risk Register)*	In relation to sustainability of clinical services
Reason for submission of report to confidential board (where relevant)	Not applicable
Next Steps: Implementation of recommendations, aligned to the approach and prioritisation of themes through the Urology Improvement Plan, monitored by the Urology Improvement Group.	

Quality, Safety and Effectiveness Committee
18th April 2024
Urology Services in Betsi Cadwaladr University Health Board: Timeline of Service Development

The establishment and development of Departments of Urology has been underway for many years in all 3 acute sites, the speciality having until the early 1990s been a part of wider General Surgical provision.

During that time a Same Day Urology Unit was developed in Ysbyty Glan Clwyd, but similar units were not developed on the other sites, where a more traditional inpatient/outpatient model remains, restricting the development of more innovative clinical pathways.

Further, a well-developed case for a Urology Investigations Unit in Wrecsam Maelor offering innovative one-stop day case care was not implemented, and a Urology Improvement Plan owned and developed by the clinical body was also not fully delivered.

Concerns were identified by the Public Services Ombudsman Wales in 2018, and a number of incidents within the services then ensued, perhaps contributing to difficulties in recruitment, particularly of the consultant workforce.

In 2021 the Health Board commissioned an Invited Service Review from the Royal College of Surgeons of England (RCS) to consider these issues, but also to support the identification of a sustainable model for delivery of urology services in the longer term.

This report was received by the Health Board in 2023. The Health Board also received a Getting It Right First Time (GIRFT) report in the same year, both identifying very similar areas for improvement.

No immediate safety concerns were identified in these reports (indeed much excellent practice was identified), but on receipt of the report actions were immediately taken in response to the review of notes to ensure that no treatment for individual patients was required. No such need was identified.

In June 2022 a CMR Versius “robot” platform was established at Ysbyty Gwynedd following a national procurement process, and in August 2022 a Urology Network Manager was recruited and started in post.

A deep-dive workshop into the urology service was held by the Transformation and Improvement team, also in 2022, and oversight group was established in the form of a Urology Improvement Group in 2023 that includes patient involvement and representation from Llais.

The Urology services were identified in 2023 as being a Clinical Area of Concern within the Special Measures (SM) escalation for the Health Board in March 2023.

In February 2024 the improvement plan, approach and priority themes were shared at the Executive Team meeting, which was approved by the Executive.

Royal College of Surgeons England Review

Following a decision by BCUHB in September 2021 a review was requested and the visit commenced in November 2022, with a further visit held in March 2023.

The RCS issued the final report to the Health Board on 31st August 2023, which highlighted a number of urgent recommendations. The full report is included in Appendix 1

The recommendations may be broken down into 4 main areas:

- In relation to the case notes review of 52 patients’ care a further “deep dive” review of 8 cases was recommended:

All 8 cases, including the individual case for consideration of Duty of Candour, were rapidly reviewed by local clinical teams. No patient harm was identified.

A second review to provide additional assurance is now taking place by teams not involved in the original care and this work, although delayed by Industrial Action leading to cancellation of learning events, will be finalised by end of April 2024.

- In relation to improvements in the quality of clinical decision making, quality of decision making and quality assurance of outcomes:

This work has commenced as a part of wider review (for example in relation to adoption of the new national Multidisciplinary Team (MDT) guidance and improvements in mortality reviews) and will now be monitored through the Urology Improvement Group (UIG).

- In relation to the recommendations for service reconfiguration:

These have been considered in detail at a number of meetings with the clinical workforce. Whilst the general principles identified are recognised the final model will be developed as part of a wider review of clinical services and will be implemented only after working closely with our partners and with the population we serve.

- In relation to the provision of Robotic Assisted Surgery:

The significant investment (capital and revenue) to adopt a second robot is considerable and it is intended to take this work forward as part of a wider review of the robotic programme in Wales.

Further recommendations will be key and include the need for:

- Transparent commissioning arrangements for contracts with NHS England, including regular review of access and outcomes
- Regular outcome comparison between the three sites with joint meetings on a regular basis
- More effective communication and engagement with patients
- Recruitment of urological patients into national trials (research)

Getting it right First Time (GIRFT)

The visit to Betsi Cadwaladr University Hospital (BCUHB) took place on Thursday 3rd November 2022. The review team visited all three acute hospital sites and held multiple sessions to review and discuss the data provided by the Health Board. The review is included as Appendix 2.

The final report was issued to the Health Board in January 2023. A meeting was subsequently held with the urology services across BCUH in April 2023 which was facilitated by the Office of the Medical Director, GIRFT and an author of the report, in which there was agreement on the findings and that they should form the core of the Improvement Plan moving forwards.

This process has been slow to develop due to leadership capacity within the clinical teams but is now proceeding at a faster pace as individual actions are being identified, as is the responsibility of individual consultants.

Summary of GIRFT recommendations

The GIRFT recommendations focus on a number of key project objectives, taking out unwarranted variation, a drive for ‘top decile’, standardised procedure-level clinical pathways, the potential establishment of surgical hubs, and agree principles which will leave a legacy of sustainable quality improvement.

As with the RCS report, the GIRFT recommendations are grouped as themes under specific areas of focus:

- Workforce modernisation with development of more specialised roles
- Outpatient and diagnostic access and development, building on the successful work in using Artificial Intelligence (AI) in histopathology
- Planned care recovery
- Unscheduled and emergency care
- Oncology, building on the successful “one stop” model of care

- Management of stones

- Intelligence, using data to inform performance and service development

Urology Improvement Plan

The Urology Improvement Plan is predicated on the outcomes of the RCS and GIRFT reviews, which have a number of cross-cutting themes.

There are a total of 69 recommendations from both reviews (RCS 51, GIRFT 18) which are to be managed through a single improvement plan, supported by the Transformation and Improvement team. Following input from the Transformation and Improvement team, the recommendations have been combined and aligned to six themes:

1. Planned Care
   - Pathways (Cancer/Benign)
   - Network provision (Location of specialist services)
   - Nurse Led pathways

2. Unscheduled Care
   - Inpatient beds
   - On call and Out of Hours provision- Network
   - On call rota – Model

3. Workforce
   - Clinical leadership
   - Job Planning
   - Skill Mix

4. Infrastructure
   - Urological Investigation Unit
   - RAS (Robotic Assisted Surgery) provision for Urology in North Wales

5. Governance and Risk
   - Concern and Investigation – Process, shared learning, audits
   - MDT structures
   - Communication and transparency
   - Patient documentation

6. Data
   - Coding of activity
   - Business intelligence

With the support from the Transformation and Improvement team, a project workbook for each of the themes has been developed, which replaces the previous approach to the improvement plan.

This ensures that we have a structured approach to plan and monitor improvement, with the ability to measure outcomes against objectives aligned with Health Board improvement methodology.

The Urology Improvement Plan is included as Appendix 3, noting that this is a working document and which will continue to evolve.

Improvement Plan Oversight and Assurance

Consistent with the other Clinical Areas of Concern, there is a Strategic Group and a Progress Review Group, which alternate and meet monthly. Both are minuted with Action Trackers and are Chaired by a Deputy Executive Medical Director with multi-professional membership.

The Strategic Group includes a wider group of members, as well as patient representatives, and reports into the Executive Chaired Quality Delivery Group. The Progress Review Group has a smaller membership and focuses more on overcoming barriers to progress with the Improvement Plan.

Barriers for Consideration

The recommendations and opportunities detailed within the Urology Improvement Plan illustrate the need to implement service change at a network level. This will allow the service to ensure any developments are robust, sustainable and provides the best value for the population of North Wales. To support this approach, it is essential that there is a Network Clinical Lead in post to provide leadership and essential clinical input into network discussions and decisions. Although there has been a number of attempts to recruit internally, there is no North Wales Urology Clinical Lead currently in post. This presents a significant risk to the pace and success of achieving the recommendations within the Improvement Plan.

There are clear themes set out to manage the improvements within the plan, although many of the actions will be crosscutting and have interdependencies. The priority of actions will need consideration and agreement, as the interdependencies structure how the actions are prioritised within the plan.

It should also be noted that at the time that the RCS conducted their review, the urology service had a cancer surgeon based in Ysbyty Gwynedd who received referrals across North Wales for cystectomy and nephrectomy procedures. Unfortunately, since the visit, this consultant has left the Health Board, which has put significant pressure on the urology cancer service as the Health Board has been unable to recruit a replacement surgeon. This is in the context of a lack of urological surgeons across the United Kingdom.

Currently all cancer procedures, except a small number of laparoscopic prostatectomy procedures, are now managed and commissioned to external providers in Wales and England.

Finance Considerations

Each theme within the Improvement Plan will have individual funding needs and as such, will require business cases for any identified opportunities or development to be progressed.

Progress

Whilst the RCS visit was undertaken in November 2022, the report was not received by the Health Board until August 2023. This led to a delay in the formation of a unified Improvement Plan, as it was important to ensure that both the GIRFT and RCS recommendations were incorporated and actions aligned; as a result, the service was not able to move forward at the pace that it would have liked.

This notwithstanding, there has been progress across the service:

- A Network Clinical Lead was appointed, however they later resigned
- Integration with the National Robotic Programme
- Development and implementation of Straight To Test on the prostate cancer pathway, which reduced waiting times from GP referral to mpMRI test by over 10 days
- Introduction of the Trans Urethral Laser Ablation service, as recommended in the GIRFT report
- Engagement with the National Clinical Lead for Urology, as well as colleagues in South Wales Health Boards who will help support service development at BCU
- Renewal of prostatectomy contract with London provider, whilst working with ABUHB on a case-by-case basis to support BCU cystectomy procedures in South Wales
- Recommencement of the Urology Clinical Advisory Group meeting which had been stood down previously due to there being no North Wales Clinical Lead; these meetings have been reinstated, with the first meeting on the 28th February, supported by the Office of the Medical Director in the absence of a Urology Clinical Lead.
- The Executive Medical Director has met with the urology consultants individually to ensure that all are engaged with service development and the Improvement Plan
- Work has taken place through the Patient Safety Team, led by the Executive Director of Nursing and Midwifery, to investigate and address concerns around the management of results and the processes in place to ensure patient follow-up.
- An assurance framework for ensuring that review of investigation results and follow up of patients is in place is being finalised and expected to be in place in May 24.

Risks

There is a risk that urology services in North Wales are unsustainable within the current operational model resulting in the inability for the Health Board to deliver timely and appropriate care to the population of North Wales . As detailed in the RCS and GIRFT reviews, there is a need to develop provision within a network model to ensure that the service achieves recommendations from the external reviews and comply with national and professional guidance.

Root causes underpinning this risk is the inability to recruit to consultant posts, the lack of specialist knowledge for cancer pathways, issues with access to estates and lack of clinical leadership.

If the actions within the Urology Improvement Plan are not achieved, the ability to mitigage these risks will be more difficult , which will have an adverse impact to patients access the service in North Wales and the reputation of the Health Board.

These risks are attached as Appendix 4.

Summary

The recommended option is to develop the Improvement Plan in line with the recommendations of the external reviews. This approach was supported by the Executive Team on the 28th February, approving the next steps and recommendations, approach and prioritisation of actions as advised in this paper.

Invited Service Review Report

Royal College of Surgeons of England
ADVANCING SURGICAL CARE

Report on the urology surgical service at

Betsi Cadwaladr University Health Board

Review visits carried out on: 14-17 November 2022 and 27 March 2023

Report issued: 31 August 2023

A service review on behalf of:

The Royal College of Surgeons of England
The British Association of Urological Surgeons
Lay Reviewer

Review team:

Mr Mark Speakman FRCS
Mr Ian Eardley FRCS
Ms Susan Hynes

PRIVATE AND CONFIDENTIAL

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Contents

1. Introduction and background

On 28 March 2022 Dr Nick Lyons, Executive Medical Director for Betsi Cadwaladr University Health Board (the 'Health Board'), wrote to the Chair of the Invited Review Mechanism (IRM) to request an invited service review of the Health Board's urology surgical service. In particular, the request highlighted a high number of complaints and Ombudsman[1] enquiries, variable performance across three sites and issues regarding medical staffing, leadership and succession planning. This request was considered by the Chair of the RCS England IRM and a representative of the British Association of Urological Surgeons (BAUS), and it was agreed that an invited service review would take place.

A review team was appointed and an invited review visit was held between 14 and 17 November 2022 and a supplementary visit was held in the Ysbyty Gwynedd (YG) Bangor site on 27 March 2023[2]. The appendices to this report list the members of the review team, the individuals interviewed, the service overview information, the documents provided to the review team and the clinical records reviewed.

Overview of Health Board and Department[3]

Betsi Cadwaladr University Health Board (BCUHB) has three hospitals that provide urology services across North Wales: Ysbyty Glan Clwyd (Centre), Ysbyty Gwynedd (West) and Ysbyty Wrexham Maelor (East). Each hospital has its own urology department.

The Health Board commissioned a review to provide an objective and impartial assessment of quality, to support their improvement agenda for this specialty. The urology service, which operates across three district general hospitals (DGH) has been an internal service of concern for some time. This has arisen from:

- A high number of complaints and Ombudsman enquiries, a number of which related to access issues and their impact on patients. The Ombudsman also raised concerns about the lack of a clinically or managerially led consensus for the delivery model of urological cancer services in North Wales, the effectiveness of the multi-disciplinary team (MDT) working and succession planning;
- A mismatch in demand and capacity across the three sites;
- Variable performance across the three sites leading to variation in outcomes;
- A Never Event in late 2019 resulting in the removal of the wrong organ and the lack of assurance that learning was embedded and remaining concerns regarding the medical culture and leadership arising from this event;
- A lack of assurance that the deployment of a new surgical robot will lead to sustained improvement in outcomes for patients;
- A recognised issue regarding medical staffing, leadership and succession planning;
- An overall lack of assurance from the service, which operates as three distinct units at each DGH, on the quality of care.

A Urology Improvement Group has been formed to provide strategic leadership to the development of an improvement plan. Clinical and operational leadership arrangements were being considered at the time that the review was commissioned.

[1] The Ombudsman have legal powers to look into complaints about public services and independent care providers in Wales. Public Services Ombudsman for Wales

[2] The visit to the YG Bangor site planned for January 2023 was postponed as a result of a nursing strike.

[3] Information provided by the Health Board in the review request form.

2. Terms of reference for the review

The following terms of reference for this review were agreed prior to the RCS England review visit between the RCS England and the healthcare organisation commissioning the review.

Review of the urology surgery service at Betsi Cadwaladr University Health Board under the Invited Review Mechanism.

Background

The Health Board is seeking this review to provide an objective and impartial assessment of quality, to support their improvement agenda for the urology surgery service.

The review team will consider the standard of care provided by the urology surgery service, following a high number of complaints, correspondence and Ombudsman enquiries, which relate to access issues and its impact on patients. The Ombudsman has also raised concerns about the lack of a clinically or managerially led consensus for the delivery model of urological cancer services in North Wales, the effectiveness of MDT working and succession planning.

The concerns within the urology service includes:

- A mismatch in demand and capacity across the three sites;
- Variable performance across the three sites leading to variation in outcomes;
- A Never Event in late 2019 and the lack of assurance that learning has been embedded and there are remaining concerns regarding medical culture and leadership arising from this event;
- A lack of assurance that the deployment of a new surgical robot will lead to sustained outcomes for patients;
- Issue with medical staffing, leadership and succession planning
- An overall lack of assurance from the service, which operates as three distinct units at each district general hospital, on the quality of care being provided.

The review team is to address the challenges identified associated with the current service configuration and provision, which have contributed to the concerns raised. This will include considering the standard, safety and quality of care provided by the urology surgery service, including specific reference to a number of key areas.

Review

The review will involve:

- Consideration of background documentation regarding the urology surgery service.

- A clinical records review of 51 randomly selected cases put forward by the Health Board.

- Interviews with members of the urology surgery service, those working with them to provide the service and other relevant members of Betsi Cadwaladr University Health Board staff.

Terms of Reference

In conducting the review, the review team will consider the standard, safety and quality of care provided by the urology surgery service, including with specific reference to:

1) Clinical Pathways – both established and developing clinical pathways in providing clinical care, including consideration of:

   a) The effectiveness of the management of the urology Suspected Cancer Pathways (SCPs) in-line with national standards, for all key urology cancer sites.
   b) The effectiveness of referral pathways across the healthcare system in enabling timely access for patients to effective interventions.
   c) Clinical decision-making and MDT effectiveness.
   d) Access and waiting times for cancer and non-cancer pathways.
   e) Frequency and adequacy of follow-up arrangements for patients on these pathways.
   f) Arrangements for Health Board contracted outsourced pathways including governance and quality assurance.

2) Clinical Governance – including sustainable improvement in the effectiveness of:
   a) Mortality and Morbidity (M&M) meetings – identifying and applying learning across the service.
   b) The processes in place for concerns and incidents (Health Board and service specific), to be reported and lessons learnt.

   This will include:
   - The robustness of recommendations made following Serious Incident Reviews.
   - The reliability of follow-up of outcomes from Serious Incident Reviews and external reviews.
   - The response to concerns raised in reports of the Public Services Ombudsman for Wales, Regulation 28s and/or other external reports relating to the service and Health Board process.
   - The commitment of the MDTs to implement consistent practice across teams and sites.

3) Clinical Outcomes - use of current clinical outcomes and patient experience for both the service and individual surgeons in the context of accepted national and international standards/norms, including specific reference to:
   a) Changes the Health Board will need to make to ensure this continues within a revised service model.
   b) Identify areas of good and exceptional practice.
   c) Identify areas of practice that have utilised innovative and/or transformational methodologies.
   d) Identify areas of practice, which could benefit from innovation and or transformation.

4) Robotic Surgery - review the impact of the implementation plan for robotic surgery in terms of positive and negative impacts, risks and learning points for future implementation programmes.

5) Service Model – review the service model opportunities with the current workforce provision, as a ‘Once for North Wales’ networked service.

6) Infrastructure Support - the adequacy and the future requirements of the infrastructure supporting delivery of clinical services, which should include, but not be exclusive to Information Technology and Informatics.

7) Culture - identify ways to strengthen the team approach through a culture of openness, honesty, trust and shared values within and across:

   - The urology clinical team;
   - The wider urology service;
   - The multi-disciplinary team (MDT);
   - Other hospital services, primary care, tertiary referral services, external stakeholders, patients and partners.

8) Communication with patients and other health professionals, with specific reference to:

   a) The effectiveness of providing information to patients in supporting and enabling shared decision-making.
   b) The adequacy and timeliness of the provision of patient clinical information to the appropriate primary and community health care teams.
   c) The interaction between primary and secondary care and the views of the primary care clusters.

9) Leadership within the urology service, in particular:

   a) Leading a urology service across all three sites and primary care
   b) Encouraging the use of data to improve services;
   c) Managing waiting times;
   d) Strategic workforce and succession planning;
   e) Governance processes;
   f) Robust accountability.

Conclusions and recommendations

The review team will, where appropriate:

- Form conclusions as to the standard of care provided by the urology surgery service including whether there is a basis for concern in light of the findings of the review.

- Make recommendations for the consideration of the Executive Team and Board as to courses of action, which may be taken to address any specific areas of concern, which have been identified or otherwise improve patient care.

- Provide advice on ways that the Health Board could improve and sustain a resilient, high quality urology service in North Wales.

- The final report provided by the RCS review team will be in a format capable of being made available in the public domain. The report will be presented with naming codes or convention adopted to the findings to ensure that the report is not impacted by significant redaction or references to individual staff or patients.

- The Health Board will review the final report for approval, prior to any publication.

The above terms of reference were agreed by the College, the Health Board and the review team on 1st November 2022.

3. Conclusions

The following conclusions are based on the information provided to the review team from the interviews held, the documentation submitted and the clinical records reviewed. They are largely organised according to the Terms of Reference (ToR) agreed prior to the review but also take account of the themes that emerged whilst reviewing this information.

It should be noted that this section also highlights a number of conclusions and comments on the clinical records reviewed and provides a summary of these. Further and more specific details in respect of the review team's comments and conclusions on the clinical records reviewed are included in Appendix B under each case.

It should also be noted that while this section (and the wider report that follows) sets out the expert perspectives of the review team about the Health Board's current access to specific robotic platforms to address the Terms of Reference set in the specific circumstances of the invited review, the College is device and platform neutral and these perspectives should not be seen as a wider endorsement of any particular platform.

3.1. Clinical Pathways

The Terms of Reference requested that the review team consider the established and developing clinical pathways in providing clinical care.

3.1.1. The effectiveness of the management of the urology Suspected Cancer Pathways (SCPs) in-line with national standards, for all key urology cancer sites

Cancer pathways

The review team considered that although diagnostic cancer pathways were set up in each of the three sites, in their opinion, the quality of management varied between sites. The review team's overall view was that the management of the urology SCPs in the East (Wrexham) and West (Bangor) was adequate, but was insufficient in the Centre (Glan Clwyd) due to lack of clinical leadership and consultant workforce.

The review team considered that the pathways for surgical intervention were largely acceptable, with indication of the appropriate referral of pelvic oncology cases from Wrexham to Bangor.

However, for some time, many cases have been referred out of the North Wales region for their surgery (including radical prostatectomy and partial nephrectomy) with the review team noting that some referrals were delayed when referred to London.

It was recognised that there were capacity issues with regards to the service overall, as well as issues relating to the Health Board's purchase of a Versius robotic platform (which the review team considered is currently unproven in urology) rather than an alternative robotic platform (such as the Da Vinci robotic platform which has an evidence base of use within urology). It was reported that the Versius robotic platform had been purchased with the intention of providing robotic pelvic oncology services in Bangor, but the review team considered that at the time of the review, this robot has little evidential track record in this area. This situation has also been further hampered by the fact that most urological robotic surgeons, available for recruitment, have been trained on the Da Vinci robotic system, which has significant technical differences for the operating surgeon.

Other urological pathways

The review team found a number of examples of good urological clinical practice with excellent delivery of both stone services and andrology services in Wrexham.

There was indication of excellent co-operation between the Bangor and Wrexham sites, with a steady flow of complex stone, andrology and reconstructive patients from the West to the East, and also appropriate referrals of cancer cases from the East to the West.

In the opinion of the review team, all consultant urological surgeons should have provision for complex care on one of the two 'major' sites (West or East) and programmed time to provide outpatient and diagnostic services in the Centre. The review team considered that this would require a change to consultant contracts to allow this to happen. This would provide adequate consultant cover for two safe night-time on call services in Bangor and Wrexham with these two sites alternatively providing consultant night-time cover to the Centre for urological emergencies arising in Glan Clwyd. Alternatively, when safe to do so, these patients could be transferred to Wrexham or Bangor.

Infrastructure

It was concerning to hear that the lack of a dedicated outpatient urology unit in Wrexham was a major issue in delivering one-stop urological assessment.

3.1.2. The effectiveness of referral pathways across the healthcare system in enabling timely access for patients to effective interventions

The review team considered that the pathways for surgical intervention were largely acceptable, with indication of appropriate referrals of pelvic oncology cases from Wrexham to Bangor.

However, for some time, many patients have been referred out of region for their surgery (including radical prostatectomy and partial nephrectomy) with the review team noting that some referrals which were sent out of North Wales were delayed when referred to London.

The review team found that there was an absence of oversight of the quality of the service provided under these contracted outsourced pathways and no effective contract monitoring or audit work was being undertaken. The review team were concerned to hear that, although the number of cases was monitored, no audit of the service quality was in place.

Having reviewed the clinical records provided, the review team considered that, in the majority of cases reviewed, it appeared that the overall patient care had been acceptable. However, the review team identified cases where there were areas for improvement within the patients' pathway and as a consequence, the patients' standard of care was of concern. The review team made specific comments regarding several cases, including:

In **Case A8**, there appeared to be no CT[4] scan undertaken during the patient's investigation.

In **Case A17**, there was little information of any subsequent investigations undertaken. In the review team's view, obtaining antegrade nephrostograms during the investigation may have confirmed ongoing obstruction.

In **Case A20**, the review team were unsure whether it was possible to undertake a laparoscopic partial nephrectomy at Glan Clwyd. If this was not possible, the review team considered whether a referral outside of North Wales should have been considered, discussed at MDT and discussed with the patient.

[4] Also known as: CAT scan, computerized tomography

In **Case A21**, the review team noted that the referral process from the ultrasound scan being obtained to the patient undergoing a nephrectomy was unduly slow.

In

Case A24, it was the review team's view that the investigations undertaken had room for improvement due to some delay in waiting for the OGD[5] to be arranged.

In **Case A28**, the review team found the assessment, investigations and treatment were gradual and delayed which required room for improvement. In addition, it was noted that record keeping was inadequate as some records were missing, such as clinical letters, following the assessments undertaken between September 2019 and January 2020. It was also concerning that the patient pathway was poorly documented.

In **Case A33**, the review team considered that this case should have been discussed with the team in Wrexham if there were staffing problems in Bangor. In the review team's opinion, the patient should have been referred to Wrexham for earlier surgery.

In **Case A49**, it was of concern to the review team that there was an 8-month delay from presentation to having the prostate biopsy and MRI[6] undertaken on what should be a 2-week wait pathway.

In **Case A51**, the review team considered that the assessment and investigations were unacceptable as an ultrasound scan was not undertaken during the patient's first admission, which resulted in a three-week delay. In addition, the patient was incorrectly diagnosed with orchitis with no local investigation undertaken during the previous A&E visit in October 2021.

3.1.3. Clinical decision-making and MDT effectiveness

In the review team's opinion, MDT meetings were of variable quality. From the interviews conducted during the visit, it appeared that there was a lack of clarity on who was, or was not, required to attend. In addition, there was little evidence of good chairing of these meetings. There were reports of some attendees switching off their computer camera during the meeting while making few proactive contributions to the meetings. It was noted by the review team that there were reasonable recorded minutes of MDT meetings, however it was considered that the documentation could be improved.

The review team considered that while most clinical decisions made at MDT appeared appropriate, there was a suggestion that some decisions for treatment have been based on what was available locally rather than what might be best for the patient. For example the choice between laparoscopic radical nephrectomy, which is available within the region, was preferred to laparoscopic partial nephrectomy, which currently is only available outside the region.

Furthermore, the review team highlighted that there were no robust mechanisms for checking that decisions that were agreed at meetings were progressed, e.g. booking scans or referral to other sites.

The review team considered that in some cases the clinical decision making (and, therefore, the treatment pathway), either had room for improvement or had not been appropriate and provided the following comments in this respect:

In **Case A16**, the review team questioned the need for the stent to remain, and in their view, this decision should have been reconsidered.

In **Case A17**, there was no indication of any MDT review to consider alternatives to repeat antegrades. The review team expected other strategies to be discussed at an MDT meeting and the options discussed with the patient.

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[5] Oesophago-Gastro Duodenoscopy (OGD) is known more simply as a gastroscopy or endoscopy. This is an examination of the oesophagus (gullet), stomach and the first part of the small bowel called the duodenum.

[6] Magnetic Resonance Imaging

In

Case A20, in the review team's view, partial nephrectomy rather than total radical nephrectomy should have been considered and undertaken, with this discussion documented in the patient's clinical record. The review team considered that there is still considerable debate about the pros and cons of partial nephrectomy versus radical (total) nephrectomy. In the review team's opinion, these alternatives should have been debated at a regional MDT by considering the tumour size, its position within the kidney, the patient's age and any co-morbidities. The review team do not consider there was severe harm, however, this is an example of an inadequate cancer pathway.

In **Case A21**, the review team were of the opinion that the decision regarding partial versus total nephrectomy was debatable, given the radiological report. In the review team's view, many centres would have undertaken partial nephrectomy in such a case. However, the review team considered that the treatment provided was acceptable as it could be justified following an MDT discussion regarding the merits of partial, versus total nephrectomy.

In **Case A25**, it was of significant concern to the review team that the investigations and treatment undertaken were unacceptable due to the excessive delay and very poor care provided to this patient. The review team found that there was a lack of MDT decision-making and effectiveness in this case which resulted in multiple readmissions for a potentially soluble problem.

In **Case A33**, the review team did not agree with the decision to insert a stent initially rather than providing definitive laser treatment on 14 September 2019. The failed attempt at ureteroscopy (URS) to reach the stone on 17 February 2020 was due to the mid ureteric oedema preventing either the semi rigid or flexible URS getting to the stone which was compounded by the long delay between the two procedures (5 months).

In **Case A37**, it was of concern to the review team that there was a long delay in undertaking the second operation although the patient's fitness (high BMI[7]) prevented a planned earlier operation in the private sector. It was noted by the review team that for six months, the patient had their stent in situ which was encrusted when the second operation finally took place.

In **Case A38**, in the review team's view, the failure of lithotripsy took too long to identify before there was a change in the management plan. The review team noted that failure of lithotripsy took six treatments over 12-18 months to identify. It was the review team's opinion that earlier recognition of the failure of lithotripsy may possibly have reduced the duration of treatment and the number of interventions undertaken in this case.

3.1.4. Access and waiting times for cancer and non-cancer pathways

The review team were concerned to hear that, at the time of the review, there were no nurses undertaking prostate biopsies and there was no benign urology nurse doing urodynamics in Glan Clwyd, and that in Wrexham, patients were often scattered all over the hospital due to pressure on beds, often resulting in a number of theatre cancellations.

3.1.5. Frequency and adequacy of follow-up arrangements for patients on these pathways

The review team considered that, from the clinical records seen, the frequency and adequacy of follow up arrangements appeared to be appropriate and were conducted satisfactorily in the majority of the cases reviewed.

However, the review team highlighted that there were several cases in the sample reviewed where there was need for the patients to receive clinical follow-up to ensure their safety:

[7] Body Mass Index (BMI) is a person's weight in kilograms (or pounds) divided by the square of height in meters (or feet). A high BMI can indicate high body fatness.

In
In **Case A6**, the patient appeared to be lost to follow up.

Case A8, the patient appeared to have no follow up plan in place.

In **Case A10**, it was not clear to the review team why the stone was left untreated and the patient appeared to be lost to follow-up.

In **Case A25**, in the review team's opinion, this patient had inadequate follow up and insufficient arrangements for definitive treatment. It was of significant concern that the patient had been awaiting surgery for at least three years and has had several nephrostomy related emergency admissions since October 2019. The review team highlighted that this patient needs urgent review and treatment to ensure her safety and well-being.

In **Case A30**, it was of significant concern to the review team that the patient was lost to follow up with a retained JJ[8] stent. The review team noted that the patient was re-referred after 12 months and that the patient fortunately had come to no harm.

In **Case A36**, it was concerning to the review team that the patient appeared to still be waiting for follow up for the referral on 04 December 2020.

In **Case A37**, it was of significant concern to the review team that the patient is potentially still waiting for follow up from the referral made on 04 December 2020.

3.1.6. Arrangements for Health Board contracted outsourced pathways including governance and quality assurance

It was of concern to the review team that, for some time, many cases had been referred out of region for their surgery (including radical prostatectomy and partial nephrectomy) and worryingly, some referrals which were sent out of North Wales were delayed when referred to London.

In the review team's opinion, there was no clarity on how the external contracts were negotiated with, for example, Royal Free Hospital (RFH) and University College London Hospitals (UCLH) rather than the more local Liverpool University Hospitals NHS Foundation Trust or The Christie Hospital in Manchester.

The review team considered that there was also an absence of oversight of the quality of the service provided under these contracted outsourced pathways and no effective contract monitoring or audit work.

It was the opinion of the review team that there is a need for an effective system for contract monitoring and audit in relation to services provided as part of the outsourced pathways.

3.2. Clinical Governance

The terms of reference requested that the review team draw conclusions on the clinical governance of the urology service, including sustainable improvement.

The review team found that the clinical governance systems and processes were lacking in maturity and effectiveness. The absence of clear leadership at service level and above (including at Board level) meant that there was an absence of assurance in relation to the safety and quality of the urology service. It was the review team's understanding that this was recognised by the Health Board.

3.2.1. Mortality and Morbidity (M&M) meetings

[8] A double-J stent is a ureteral stent with curving ends that prevent the stent slipping into the bladder or the kidney.

The review team found an absence of clinical leadership across the region and this was particularly apparent in relation to the poor functioning of M&M processes. In the review team's view, this will not be rectified without appropriate clinical leadership in place.

It was concerning that there was no apparent overall plan for consistency of practice across the three sites, nor sharing of lessons learned and action plans/evaluation of actions taken, in order to improve. In the review team's view, without any clear clinical leadership in place there was no clarity with regard to the M&M process and therefore its ability to be effective.

The review team considered that there should be clear agreement about who should attend M&M meetings and clarify the roles for urologists, Clinical Nurse Specialists (CNS), oncologists, pathologists and radiologists. In the review team's view, the structure of the M&M meetings needs to be further developed. The M&M meetings need to be redesigned with clear roles for all members of the team, administrative support for M&M meetings and follow-up processes including mechanisms to check that agreed actions are promptly carried out and clinicians held to account for the actions they are required to take as the outcomes of these meetings.

3.2.2. The processes in place for concerns and incidents (Health Board and service specific), to be reported and lessons learnt

The review team were concerned to hear that engagement in local audit was poor with little audit work being undertaken, although, reportedly, it had improved in the last year. The review team were provided with limited information regarding audit on all three sites during the review and therefore cannot comment further regarding this matter.

It was the review team's opinion that the system for responding to Serious Incidents (SI), implementing change and evaluating the effectiveness of changes made, needs to be better embedded within the service. In the review team's view, there needs to be effective reporting up to, and oversight at, Board level as part of the overall Health Board governance process.

3.3. Clinical Outcomes

The terms of reference requested that the review team draw conclusions on the use of current clinical outcomes and patient experience for both the service and individual surgeons in the context of accepted national and international standards/norms.

3.3.1. Changes the Health Board will need to make to ensure this continues within a revised service model

The review team noted that there was a lack of a dedicated physical urology department in Wrexham.

In the review team's opinion, there was inadequate provision for interventional radiology at all three sites. The provision of consultant supervision on the wards should be reviewed by the Health Board.

The review team found good integration of Clinical Nurse Specialists at all three sites, however, there was room for further development with the need for nurse led urodynamics, flexible cystoscopy with provision for stent removal and Botox bladder injections and local anaesthetic trans-perineal prostate biopsies. In the review team's view, this currently needs to be provided at all three sites but if development proceeds to enhance cancer services in the West and complex stones and female urology services in the East, then the Centre (Glan Clwyd) may be able to become the principle centre for these nurse-led facilities which are largely outpatient and day case activities.

3.3.2. Identify areas of good and exceptional practice

The review team considered that there was excellent delivery of urological stone investigation and surgery in the East in Wrexham. The review team found a cohesive consultant body with a wellintegrated urology department working well, albeit with very poor infrastructure provided at Wrexham. It was the review team's view that, with the appropriate investment, it is likely that Wrexham can be further developed to become a centre of excellence for complex stone disease, reconstruction and andrology and the investigation and management of benign prostate disease.

The review team identified high quality facilities for outpatient and nurse led services on the Glan Clwyd site with the potential for delivery of a urological investigation unit.

The review team were pleased to see clear indication of excellent cooperation between Bangor and Wrexham with a steady flow of complex stone, andrology and reconstructive patients from the West to the East and also appropriate referrals of cancer cases from the East to the West.

3.3.3. Identify areas of practice that have utilised innovative and/or transformational methodologies

During their visit to Bangor, the review team considered that the Urological Unit appeared to offer some excellent facilities and was in the process of developing an infrastructure that it was hoped would enable it to support the delivery of an excellent urology cancer centre.

The review team highlighted the good integration of urological research projects in patient care in the East with indications of good basic science studies. In addition, there was also an indication of good patient enrolment in research studies in Wrexham.

3.3.4. Identify areas of practice, which could benefit from innovation and or transformation

The review team identified the difficulties that need to be overcome in relation to getting the three units to work together, due to lack of leadership at a clinical and managerial level and the apparently competing agendas of those involved. The issues identified were:

1. Varied quality of management and leadership between sites.
2. Absence of oversight of the quality of the service provided under the contracted outsourced pathways.
3. Varied quality of MDT meetings.
4. Inadequate provision for interventional radiology at all three sites.
5. The need for nurse led urodynamics, flexible cystoscopy with provision for stent removal and Botox bladder injections and local anaesthetic trans-perineal prostate biopsies to be provided at all three sites.
6. Lack of provision of consultant supervision on the wards.
7. Poor engagement in local audit.

The review team considered that there was provision of some good urological cancer work in Bangor. In the review team's view, enhanced cancer services in the West would greatly increase the probability of consultant recruitment and retention in Bangor.

During the review visit, the review team identified concerns relating to the urological service at the central Glan Clwyd site. These related to the following matters, which may have consequences for the provision of a safe, high-quality service at this site:

- Poor consultant ward supervision, leading to the recent loss of the site's only formal trainee.
- Poor engagement in formal MDTs.

- Poor team-working on a wider basis as part of a Pan-North Wales[9] urology service, with e-mails often unanswered and other examples of a lack of engagement given.

3.4. Robotic Surgery

The Terms of Reference requested that the review team review the impact of the implementation plan for robotic surgery in terms of positive and negative impacts, risks and learning points for future implementation programmes.

The review team explored the work that had been done by the Health Board regarding the procurement of a robotic platform for the Bangor site. They understood the Versius platform was purchased with the intention of assisting surgical practice across a number of specialties, including urological surgery.

With regard to robotic prostatectomy, it was the review team's view that the current clinical consensus both within the UK and worldwide is that the evidence base supports the use of the Da Vinci platform and that there is no evidence base for the use of the Versius platform for urological robotic surgery, which is as yet unproven and few urological surgeons within the UK are trained in its use. Nevertheless, its use in urological surgery is continuing to be evaluated within the UK and internationally.

It was the review team's view that this choice of the Versius robotic platform has had, and continues to have, serious consequences for both the current service delivery of urology services and for future recruitment and retention of urological surgeons.

The review team considered that the All-Wales plan for robotic surgery centred on the Versius robotic platform may be appropriate for general surgery and gynaecology. However, the review team noted that urological robotic surgery using the Da Vinci robot is far more developed throughout the UK and around the world, and this presents major challenges for the Health Board in urology.

Specifically, the review team noted that urological trainees and consultants in the UK are well trained in the use of the Da Vinci robotic platform. There are currently no urological surgeons within the Health Board who are trained and competent to use the Versius robotic platform. The review team heard that the plans for international training of teams to be able to use the Versius were not successful for a variety of reasons. Further, it was reported that there is no capacity for the very small number of urological surgeons within the UK who have any experience with the Versius to provide training to the Health Board's urological surgeons. As a consequence, the review team's view is that it is most unlikely that urological trainees will apply for posts to work on a Versius platform on which they have not had, and cannot access, training.

Conversely, there are a number of urology trainees within the UK who are now well trained in the use of the Da Vinci platform and so there are a good number of potential candidates coming to the end of their training who could be candidates for consultant positions if the Da Vinci was available at the Bangor site.

The review team found that the purchase of the robotic platform has also had a significant impact on the morale of the current urological workforce and is also having a major impact on the ability of the Board to recruit and retain urological surgeons. The review team heard that North Wales had already had experience of a high-quality candidate coming to the Bangor site in the expectation that the Da Vinci system was to be procured, but then leaving, once it was clear that the Versius platform was being purchased.

In conclusion, whilst a department that already has extensive experience with a Da Vinci platform on site and considerable expertise in robotic surgery (such as Guy's Hospital in London, or perhaps

[9] Across the whole Health Board

Cardiff), could potentially introduce a project using a Versius robotic platform in parallel with a Da Vinci platform, and train urological surgeons in its use, in the review team's view, this is completely impractical in a centre with no existing expertise on site and without a first-rate track regard of consultant recruitment and retention.

For a North Wales urological cancer service to be set up within the next five years, the review team considered that this will require access to a Da Vinci robotic platform. A dedicated complex pelvic cancer service in the West in Bangor requires access to such a platform as soon as possible if the Health Board hopes to deliver cancer services in North Wales within the next five years. The ability of the Health Board to deliver a major urological cancer centre in Bangor without access to a Da Vinci robotic platform will be adversely affected by this.

The review team considered that the Bangor site currently has an excellent urological surgeon who has the advantage of a world class mentor in Liverpool. In the review team's view if there was a Da Vinci robotic platform sited in Bangor, it is likely that two or more urological surgical oncologists could be appointed quickly, allowing for the service to be developed into a centre of excellence.

The learning point is the need for transparency and accountability during procurement processes. The review team found that staff were extremely unclear as to the decision-making process that had resulted in the purchase of the Versius robotic platform rather than the Da Vinci robotic platform, which they had expected.

Suspicions were reported to the review team as to how the process had worked and the reasons for the procurement of the Versius robotic platform. From the interviews conducted, it was not clear to staff who was ultimately responsible for the procurement decision and this had led to a worsening of relationships both between clinicians, in particular with regard to those clinicians who had been actively involved with the procurement process, and more widely in terms of trust and confidence in the Health Board.

The review team understands that the ability of the Health Board to pursue their preferred option of purchasing the Da Vinci robotic platform is not possible without the help of the Welsh Government which holds the capital for such investment, as part of a national procurement programme.

3.5. Service Model

The Terms of Reference requested that the review team draw conclusions on the service model opportunities with the current workforce provision, as a 'Once for North Wales' networked service.

Workforce

Workforce issues are a major problem for the health board at all levels. The review team made the following observations:

- Limitations in the consultant and mid-grade workforce in place at the time of the review teams' visits in November 2022 and March 2023 was having a significant impact on the ability of the service to deliver emergency services.
- There was a significant problem identified in of recruiting and retaining middle grade doctors with a reliance on locums. Furthermore, there was also an absence of career development for both surgical and nursing staff.
- It was found that, in November 2022, the only formal trainee working in the team at Glan Clwyd had left reportedly due to lack of ward supervision being provided by a consultant.
- The review team were of the opinion that without the presence of a Da Vinci robotic platform for urology, it will not be possible to recruit and retain consultant grade staff.

- The review team regarded that it was not possible to deliver urology services efficiently and effectively as there was a need for viable rotas which required the appointment of high-quality urological staff, including consultants, middle tier urologists and clinical nurse practitioners, and other members of the extended surgical team. The review team had been informed of certain short-term placements that had been made since the review visit in November 2022 in order to ensure safe and effective on-call rotas. The review team's overall view was that this needs a clear, effective and sustainable strategy in order for patient safety concerns to be addressed in the long term.
- The review team observed that the Health Board was not currently able to provide the capacity needed for local anaesthetic trans-perineal prostate biopsy (LATP[10]) with the staffing currently in place. The review team heard that there was a strong appetite on the part of nursing staff to develop a nurse-led LATP service as part of a pathway to professional advancement, in line with the practice in many healthcare organisations, for the benefit of patients and staff. The review team were informed that if there was more capacity in place, LATPs could be carried out every week. During the interviews held, there was support from some surgeons for this development and some willingness to provide the training for nurse-led LATPs.
- With regard to the service, it was expressed by a number of staff that it had been a difficult workplace for a number of years; although ideas were put forward to combine and rationalise the work of the three hospital sites in order to provide an effective service there had been no clear support at Board level to implement these ideas.
- The review team heard from a number of staff that there was a sense of stress and dissatisfaction as well as frustration, at the lack of career development and being restricted in their roles. In the review team's opinion, if this is not addressed, recruitment and retention issues will worsen.

In the review team's opinion, it is likely that the quality of the consultant team in the East will continue to attract high quality candidates to this site. It will only be possible to attract and retain high quality consultant staff to apply for a post in Bangor with an established, and well recognised, robotic platform in place (with at least two trained robotic surgeons). The answer for the Glan Clwyd site is likely to be to appoint high quality staff to the other two sites and programme sessions in the Centre on a regular basis.

Infrastructure

The review team noted that there also appeared to be a lack of both inpatient and day case theatre capacity for the number of urologists. In addition, at the time of the review there were substantial workforce issues and the review team considered that it will not be possible to optimise the service without addressing these matters.

The review team found that the nursing workforce demonstrated a commitment to developing and improving the service. At the Bangor site, work was being done to maximise the service offered to patients and reduce the backlog. It was the review team's view there was a need for more clinical space as a high priority. A particular room that was currently used as an office for clinicians from another specialty had been identified by the review team as a potential clinical space.

It was concerning for the review team to hear that the lack of a urology unit in Wrexham was a major issue, and that there was no dedicated ward for urology patients.

Immediate and subsequent actions

At the time of the visit to the Bangor site, there were significant concerns at the Bangor site as there was not an appropriate consultant workforce available to deliver the cancer service.

[10] Local anaesthetic transperineal prostate biopsy (**LATP**) is the standard procedure for prostate cancer diagnosis.

The consultant leading on the Health Board's cancer practice was no longer on the on-call rota and that had resulted in de-stabilisation of the emergency rota such that immediate concerns were raised by the review team regarding the safety of the service with regard to on-call provision.

The review team were informed in a letter dated 12th April 2023 that two locum consultants had been recruited to work at the Bangor site on a three-month contractual basis to ensure a 1:6 on-call rota with a plan to review this on an ongoing basis.

In the review team's view, this addressed the immediate patient safety issues. However, it did not present a sustainable solution to building a stable workforce where there are strong learning and development opportunities.

Implications for the future

In the review team's opinion, there were insufficient number of consultant urological surgeons currently working in North Wales to run three relatively independent urological services covering both elective care and emergency care.

The most acute problem related to the delivery of emergency care. Working on the assumption that a 1 in 6 on-call system is the minimum acceptable rota, then it appeared inevitable the number of acute on-call rotas must be reduced.

3.6. Infrastructure Support

The Terms of Reference requested that the review team draw conclusions on the adequacy and the future requirements of the infrastructure supporting delivery of clinical services, which should include, but not be exclusive to Information Technology and Informatics.

The review team considered that the secretarial and nursing support, recruitment and retention appeared adequate across all three sites.

In the review team's opinion, junior doctors and middle grade support was less than ideal and could improve with enhanced consultant working practice at ward level.

The review team highlighted that the urological unit at Bangor had a number of excellent facilities and the infrastructure continues to be developed. It was the review team's view that if that commitment continued then this site has the capacity to support the delivery of an effective and well-performing urology cancer centre. There was a need for further clinical space in order to support these service developments. The review team were made aware of a space that was currently being used as an office and was well positioned to be repurposed as a clinical space for the urological service.

The review team noted that there was poor physical infrastructure at the Wrexham site which would require investment in order for Wrexham to be further developed to become a centre of excellence for complex stone disease, reconstruction and andrology and the investigation and management of benign prostate disease.

3.7. Culture

The Terms of Reference requested that the review team draw conclusions on the culture within the urology service and identify ways to strengthen the team approach through a culture of openness, honesty, trust and shared values.

From the interviews conducted, the review team observed that there were some perceptions of management at Health Board level favouring certain individuals and certain services over others, which also contributed to an absence of a positive working culture.

The review team also noted that there was a perception that there was a lack of senior management support for the urology service and that previous suggestions for reconfiguration of the three sites had not moved forward over the last three years.

Comments provided by interviewees indicated that there was a sense of frustration, disappointment and a sense of a lack of transparency in relation to the Health Board's purchase of the Versius robotic platform rather than the expected and planned purchase of a Da Vinci robotic platform. Furthermore, the review team found that urology staff were not clear as to how the Versius robotic platform had come to be purchased and there was a sense that there was an absence of anyone being accountable for its acquisition with concern regarding the lack of transparency around the recruitment process. There was some discussion about how staff felt that they had not been listened to and that it was not clear why things had happened the way they had. The review team considered that this had contributed to a sense of the urology service being 'let down' after the stated expectation of the Da Vinci robotic system being purchased and that this had led to a loss of faith in the systems in place and in the Health Board's leadership.

It was clear that the 2019 Never Event[11] had resulted in significant and adverse consequences for the clinicians involved, which at present have not fully been resolved.

In a letter dated 12 April 2023 provided by the Medical Director after the review visit, the Health Board confirmed that the issues relating to team working across the three units were recognised and that a urology summit was scheduled for 27 April 2023 facilitated by GIRFT[12], to identify clinical and operational ownership of the key issues faced.

3.7.1. The urology clinical team

In the review team's opinion, the urology clinical team was strong in the East, appeared satisfactory in the West and was considered poor in the Centre due to lack of effective clinical leadership.

The review team heard of breakdowns in relationships between urology doctors both across the Bangor and Glan Clwyd sites. In the review team's view, significant difficulties at Bangor had contributed to staff feeling alienated from one another and contributed to staff sickness.

3.7.2. The wider urology service

The review team considered that there was good nursing support on all sites, with better recruitment and retention of staff noted during the review.

In addition, the review team noted that there was good use of clinical nurse specialists, however it was of concern that there was no evidence of use of clinical nurse practitioners (CNPs) to support ward care.

The review team observed that the relationships between the sites were somewhat fragmented and there was an absence of a shared goal and purpose. Rather, the review team heard that there was sense of apparently competing agendas which contributed to an inability for effective multidisciplinary team working and a clear goal for the service. Furthermore, the review team found that there was a lack of leadership at both a clinical and managerial level and little information relating to clear lines of accountability.

The review team noted that there was not a shared vision for a future configuration of the service and some perception of resentments between the different teams. The review team found that the geographical footprint of the urology service across three sites in North Wales was complex and

[11] A never event is the "kind of mistake (medical error) that should never happen" in the field of medical treatment. Never events are defined as "adverse events that are serious, largely preventable, and of concern to both the public and health care providers for the purpose of public accountability".

[12] Getting It Right First Time (GIRFT) is a national programme designed to improve the treatment and care of patients through in-depth review of services, benchmarking, and presenting a data-driven evidence base to support change.

challenging. The review team heard that North Wales was never in effect a single urology team and that the need for effective team working had never been imposed across the three sites.

3.7.3. The multi-disciplinary team (MDT)

In the review team's opinion, it is likely that the quality of staff in the East at Wrexham will continue to encourage high quality candidates to apply for posts at this site. It will only be possible to attract and retain high quality consultant staff to apply for a post in the West in Bangor when a Da Vinci robotic platform is in place. The solution for the Centre at Glan Clwyd could be to appoint high quality staff to the other two sites and programme sessions in the Centre on a regular basis.

3.7.4. Other hospital services, primary care, tertiary referral services, external stakeholders, patients and partners

It was concerning to the review team that there was little indication of dialogue with primary care services across the three sites in relation to planning and delivery of care.

3.8. Communication with patients and other health professionals

The Terms of Reference requested that the review team draw conclusions on communication with patients and other health professionals.

3.8.1. The effectiveness of providing information to patients in supporting and enabling shared decision-making

The clinical record review revealed a number of cases where consent forms had not been given to patients and copies of letters had not been sent to patients.

In the review team's opinion, the overall quality of the patient clinical notes was generally poor. Furthermore, the review team found many examples of poor filing in the notes.

The review team noted, that at a time when most Trusts are moving to paperless record systems, all three hospital sites had paper records with limited digital and IT support.

The review team highlighted the importance of documenting discussions with patients and the patients' families, including adequate detail. In this respect, they noted the following:

In **Cases A16, A32, A36 and A50**, the review team noted that multiple consent forms were completed satisfactorily, however, it was of concern that copies often were not provided to the patients.

In **Case A20**, it was the review team's view that a referral outside of North Wales should have been discussed with the patient. In addition, alternative treatments (partial nephrectomy) were not mentioned as an option on the consent form which was misfiled in the patient's clinical record.

In **Case A35**, it was of concern to the review team that there was no documentation that the MDT advice had been discussed with the patient. The review team noted that it was only mentioned in the letter to the GP (which had not been copied to the patient) that stated the patient did not want surgery. The review team were uncertain if the patient was provided with supporting information to enable shared decision-making, as the patient's preference appeared to be radical radiotherapy instead.

In Case A37, the review team were significantly concerned that a copy of the consent form was not provided to the patient for either of the two operations.

In **Case A39**, the review team noted that the consent forms did not include other options for treatment. Furthermore, the consent forms were not consistently copied to the patient, for all multiple procedures that occurred between 2018 and 2022.

In **Case A51**, a copy of the consent form was not provided to the patient and his parents. Furthermore, the review team questioned if there was a duty of candour to inform the patient's family about the earlier mistaken diagnosis when the patient was re-admitted in November 2021.

The review team highlighted that it was not acceptable to just write in the notes that the patient and parent understood the risk of a missed torsion.

3.8.2. The adequacy and timeliness of the provision of patient clinical information to the appropriate primary and community health care teams

The review team considered that secretarial services appeared to be drafting letters in a timely manner, however that not all correspondence were being sent to patients.

3.8.3. The interaction between primary and secondary care and the views of the primary care clusters

The review team were significantly concerned that there was little indication of discussions between the urologists and primary care about the planning or delivery of care of patients.

In the review team's view, there was an urgent need to start a dialogue with primary care and especially patient groups, before any changes to the provision of emergency urological provision take place, otherwise there is a danger that patients will see this as a reduction in care rather than the delivery of a safer and more efficient service for patients.

3.9. Leadership within the urology service

The Terms of Reference requested that the review team draw conclusions on the leadership within the urology service.

3.9.1. Leading a urology service across all three sites and primary care

The review team found that there were significant differences in approaches to leadership at site level and the effectiveness of that leadership within the urology service.

- The review team heard that there was limited co-operation between surgeons across the three sites.
- The review team found that in the East (Wrexham) there was a cohesive consultant body with a well-integrated urology group of clinicians who worked well together as a multidisciplinary team.
- There were significant concerns regarding an absence of effective local leadership in the Centre (Glan Clwyd). Reportedly, relationships between urology doctors were not working and there had been an absence of effective consultant ward supervision leading to the loss of the only formal trainee on the team. The review team raised immediate concerns regarding the effectiveness of the clinical leadership at the Centre in November 2022 and understood in March 2023 that those leadership concerns persisted.
- In addition, the review team did not find any effective strategic workforce and succession plan in place. It was the review team's view that it was not possible to achieve this in the absence of effective clinical leadership and absence of a plan for the overall service, both at the service level and, equally importantly, at Board level.
- The review team considered that this crisis was significantly exacerbated by the absence of an effective robotic platform.

In the opinion of the review team, there was an urgent need for a clinical lead for urology for North Wales to cover all three sites. Ideally, this should be a consultant urologist but, if necessary, this could be a consultant from another specialty. In addition, the review team

highlighted that there was a need for clear leadership at service level, with support at Board level, to be able to effect real change and rebuild trust and confidence across the teams.

The review team were concerned to hear during interviews that the Health Board was struggling to maintain core capacity due to lack of workforce and in their opinion, there was an urgent need for a more consistent leadership and better planning for the development of middle grades (especially in research and education) which would result in more exposure and development for them.

3.9.2. Encouraging the use of data to improve services

The review team were concerned that there appeared to be little use of data in audit cycles.

The review team found a lack of effective use of data to monitor and improve services. Furthermore, the review team noted there was no joined-up approach across the sites and found it difficult to ascertain where accountability lay for monitoring and audit work.

Furthermore, in the review team's opinion, the Health Board should encourage increased recruitment of urological patients into research through national clinical trials which is good practice and improves patient care.

3.9.3. Managing waiting times

The review team did not identify any major issues in respect of managing waiting times based on the limited information gathered during the review. However, the review team were aware that most complaints were from patients who experience prolonged waiting times.

It was of concern to the review team that the lack of nurses performing biopsies and the lack of benign urology nurses doing urodynamics had substantially affected waiting times for surgery.

From the clinical record review, the review team identified the following cases where the waiting times were considered unacceptable and as a consequence the patients' standard of care was of concern:

In **Case A24**, there was some delay in waiting for the OGD to be arranged.

In **Case A25**, it was of significant concern that the patient had been waiting for surgery for at least three years.

In **Case A37**, the review team highlighted that the patient was potentially still waiting for follow up from the referral made on 04 December 2020.

3.9.4. Strategic workforce and succession planning

The review team considered that there were few signs that succession planning had been seriously considered.

The review team noted that there was a major problem in North Wales with consultant recruitment and retention and, as a result, there was also an issue with locum consultant working. This was particularly the case with the Glan Clwyd and Bangor sites.

In the opinion of the review team, there is need to create a clear role for a clinical lead for the whole of urology for North Wales. Ideally this should be an external appointment of a senior clinician whose leadership and clinical qualities will incentivise urologists to apply to work in North Wales. For this to be able to happen, clear leadership at Board level and a commitment to financial and management investment in the urology service is required. If an external appointee is going to be able to provide effective leadership and make the service attractive to urologists, access to a Da Vinci robotic platform that will work for the urology service is required.

3.9.5. Governance processes

The review team considered that whilst there was effective leadership and governance within individual units, most notably in Wrexham, the absence of clinical leadership across the region was having a draining effect. This was particularly apparent in relation to the poorly functioning MDT and M&M processes and, in the review team's opinion, will not be rectified without appropriate leadership with the development of a future vision for the service.

3.9.6. Robust accountability

The review team were concerned to learn that accountability varied across the three sites. From information provided during the interviews, the clinical leads for the East and West appeared to be more engaged and took responsibility whilst accountability was considered unstable in the Centre.

The review team noted that the Executive Medical Director plainly set out the significant issues relating to the urology service and responded in a timely manner, on each occasion, to the feedback provided to the Board by the RCS review team.

3.10. Other

The documentation and record-keeping in the clinical records reviewed was below the standard expected by the review team. From the clinical records reviewed, it was of concern to the review team that discharge summaries often lacked detail. In the review team's opinion, greater care needed to be taken with paper notes.

The review team had specific concerns regarding several cases, including:

In **Case A15**, the review team noted that some entries in the clinical record were illegible and unclear. Furthermore, some paperwork was not filed in any form of order as the urological notes were included in the cardiology section.

In **Case A18**, although the review team considered that the individual records were of adequate standard, the overall condition of the clinical notes were very poor.

In **Case A19**, the radiology reports were included in the haematology section.

In **Case A20**, the review team noted that the patient's clinical notes were of poor quality. The review team found no documentation filed in the consent or anaesthetic sections of the notes, as they were included in the general sections of the patient's record.

In **Case A32**, the review team found that the patient's clinical notes were poorly organised. The review team acknowledged that most of the information was included within the clinical record, however, they were filed in disarray.

In **Case A33**, the review team considered that the standard of record-keeping in the Bangor notes was poor and had room for improvement as there was no clarity of the filing.

In **Case A35**, it was the review team's view that record keeping had room for improvement as the filing of the notes was confusing.

In **Case A37**, the review team did not find the operation note for the initial operation to insert the stent.

In **Case A52**, the review team found that the clinical record notes were poorly presented and difficult to navigate. In particular, the notes were poorly filed, making assessment of consent challenging to review.

4. Recommendations

4.1 Urgent recommendations to address patient safety risks

The recommendations below are considered to be highly important actions for the Health Board to take to ensure patient safety is protected.

1. The Health Board, at every level, must focus on resolving the issues that have been highlighted by the review team in this report and ensure that they have accessible and committed operational and strategic management in place, dedicated to fulfilling the recommendations made by the review team and able to influence transformational change.

2. The Health Board should consider the conclusions of this report, as well as the other information it holds, and on this basis provide further follow-up of patients for which it considers this to be required. In particular, the review team highlighted that it was important that the Health Board confirm that cases A6, A8, A10, A25, A30, A36 and A37 had received appropriate clinical follow-up and in case A51, that Duty of Candour has been considered in respect of the misdiagnosis of the patient. This should protect patient safety and ensure that patients and/or their families have received communication in line with the responsibilities set out in the Duty of Candour Procedure (Wales) Regulations 2023[13].

3. The Health Board should review the urology pathway arrangements for patients across all three sites to ensure that there are appropriate decision-making processes and clearly defined standardised pathways in place. In particular, there is a need for improvements in the cancer pathways across the service and for the work to be facilitated and supported at the most senior level to be able to implement effective change.

4. That the Bangor site provide complex cancer care for the whole of North Wales with timely referrals from Glan Clwyd and Wrexham. In addition, all three sites should provide diagnostic management for all cancer groups locally before onward referral.

5. The review team considered that the Health Board needs two major inpatient services, one concentrating on complex benign disease and one majoring on complex cancer surgery, with a third unit at the Glan Clwyd site providing extensive diagnostic and day-case services but without night-time emergency admissions and without urology inpatients overnight. Therefore, all consultant urological surgeons should have provision for complex care on one of the two 'major' sites (West or East) and programmed time to provide outpatient and diagnostic services in the Centre. This would require a change to consultant contracts to allow this to happen.

6. To develop and deliver an effective robotic urological cancer service in North Wales within the next five years, the Health Board needs access to a robotic platform that has an evidence base of use within urology, and which current UK urological surgery trainees are trained to use. In the review team's opinion, this[14] is the only possible option, failing which there will need to be an effective plan for all such cases to go to England. This would require a significantly more effective governance system than is in place at present.

7. In order to address issues relating to the current delivery of the service that pose safety risks, the Health Board should immediately consider the following:

[13] The Duty of Candour Procedure (Wales) Regulations 2023 (legislation.gov.uk) which came in to force across NHS Wales in April 2023.

[14] I.e. access to a Da Vinci robotic platform.

a) Implementing 3-session days and Saturday morning elective work to increase theatre capacity.
b) Appointing a 'consultant of the week' who sees all urological patients each day, either a week at a time or split into Mon-Thurs and Fri-Sun basis.
c) Reviewing the provision of consultant supervision on the wards.
d) Effective performance management of all clinicians, particularly with regard to MDT involvement, is required to ensure accountability and transparency.
e) Urology cancer leads are needed at site and overall service level, with support at Board level. It is recommended that there should be clear leadership at Board level and accountability for oversight of the service.
f) In addition to the above, the Health Board should urgently identify a Clinical Leader who can lead the whole team in the development of a Pan-Betsi[15] urological service.
g) It is recommended that strong links and channels of communication between primary care and patient groups need to be enhanced.
h) The Health Board should review the consent-taking practices within the urology surgical service to ensure that copies of consent forms are given to patients (and/or their parents/guardians/carers).
i) The Health Board should ensure that all GP correspondence is copied to patients (or written to patients and copied to GPs) after consultations. The Health Board should ensure there are systems in place in which letters are written and sent out to patients and their GPs after each clinic visit in a timely manner.

8. The current structure of the MDT should be reviewed immediately to ensure that it is fit for purpose. As part of this, the Health Board should consider the following:
    a) Having a designated lead and chair for all MDT meetings.
    b) Adequately resourcing MDT co-ordinators and secretarial support for these meetings, with minutes going out and actions taken within 24 hours of the meeting;
    c) Reintroducing some face to face MDT meetings in order to rebuild team relations and trust, and ensure greater accountability.
    d) Setting clear expectations for all clinicians attending.
    e) The complex MDT needs to accept a supervisory role over the local MDTs. The review team considered that this is only possible with a North Wales Clinical Lead in place.
    f) The Health Board should agree defined criteria by which cases are identified for discussion at MDT meetings. The Health Board should also ensure that there is a system of identifying which cases should be prioritised. Ideally, a local MDT meeting should discuss all new cases managed locally (eg TURBT[16] for superficial bladder cancers and advanced prostate cancer in the very elderly) and cases for consideration of radical cancer therapies need to be referred to 'regional' MDT.
    g) Early review is required at Regional MDT and rapid referral to external centres is needed with regular audit of this process until complex cancer care are provided in Bangor and appropriate additional consultant appointments have been made.

9. The review team recommend that the M&M meetings should be improved and redesigned. The Health Board should consider implementing the following:
    a. Having clear roles for all members of the team.
    b. Providing administrative support for M&M meetings and follow-up processes.
    c. The Health Board should support the process of accountability for acting on decisions made at M&M meetings by establishing a formal monitoring process, overseen by an identified clinical audit lead.

[15] Across the whole Health Board

[16] transurethral resection of bladder tumour

10. The Health Board should have a system for reporting, investigating, sharing learning and regular audit of critical incidents such as SIs. The policy should identify underlying relevant factors to inform learning and development of safe systems, as well as enabling thematic analysis, continuous monitoring and evaluation. There should be multi-professional involvement in the review of critical incidents and near misses, and wider staff participation when reviewing the lessons learned from these situations.

11. The Health Board should audit the standard of clinical documentation to ensure there are contemporaneous and comprehensive notes of patient care at each stage of the surgical pathway.

4.4. Recommendations for service improvement

The following recommendations are considered important actions to be taken by the Health Board to improve the service.

12. Improved outpatient departmental facilities are required in the East at Wrexham to provide a dedicated urology department with space for outpatient visits and nurse led facilities such as urodynamics, flexible cystoscopy and local anaesthetic biopsies etc.

13. In addition to Recommendation 12, the Health Board should further develop the need for nurse led urodynamics, flexible cystoscopy with provision for stent removal and Botox bladder injections and local anaesthetic trans-perineal prostate biopsies. This needs to be provided at all three sites but if development proceeds to enhance cancer in the West and complex stones and female urology in the East, then the Centre (Glan Clwyd) may be able to be the major centre for these nurse-led facilities which are largely outpatient and day case activities.

14. There will be a need for enhanced diagnostic and day-case facilities at Glan Clwyd to allow all visiting urologists from the West and the East to provide services there.

15. There needs to be a plan for delivering interventional radiology, for example, for cases needing antegrade nephrostomies for obstructed infected kidneys, either delivered in North Wales or in adjacent areas of the North West of England.

16. Increased use of nurse practitioners to work at ward level supporting the junior and middle grade staff. This will be particularly important for the Glan Clwyd site.

17. Increased use of Physicians Associates, Advanced Clinical Practitioners and Surgical Care Practitioners should be explored to support both inpatient and outpatient services.

18. The Health Board should consider appointing additional high quality (i.e. those who hold the Certificate of Completion of Training (CCT) or the Certificate of Eligibility for Specialist Registration (CESR)) urological staff, including consultants, middle tier urologists and clinical nurse practitioners, once there is a clear and viable plan in place. The Health Board should make development of such a plan, within the context of service configuration, a priority.

19. The review team considered that over 90% of urological care is delivered either in an outpatient or day-case environment. The recommendations below should not affect the location of access to care for the vast majority of patients in the Health Board.

    It was the view of the review team that the most effective and sustainable service model might have the following components:

a) Delivery of two emergency rotas in Wrexham and Bangor with alternating and limited (perhaps 8am – 8pm) out of hours care on the Glan Clwyd site being offered from Bangor and Wrexham and with patients presenting outside of these hours being transported to the accepting site for that evening.
b) Delivery of complex stone surgery, female urology and andrology in Wrexham.
c) Delivery of pelvic oncology in Bangor.
d) Delivery of diagnostic and day case urology on all three sites with a particular focus in Glan Clwyd, where the infrastructure is most developed at present.
e) Rotate all consultant staff to deliver outpatient and day case care on the Glan Clwyd site on an equitable basis.

20. The review team considered that this would require a number of facilitating actions including, but not limited to the following:

a) Changes in consultant contracts to work safely and effectively.
b) Appropriate investment in infrastructure on all three sites.
c) Purchase of an alternative robotic system for the Bangor site.

4.5. Additional recommendations for consideration

The following recommendations are for the Health Board to consider as part of its future development of the service.

21. Transparent contracts with external sites, whether in London or the North West, need to be presented. The Health Board should ensure regular audit for their timeliness and results.

22. The Health Board should encourage increased recruitment of urological patients into national trials (research).

23. The Health Board should encourage audit comparison between the three sites with joint meetings on a regular basis.

24. The Health Board should ensure that future procurement processes are carried out in an open and transparent manner and that the process itself is clearly understood by clinicians. Each stage of the process needs to be fed back to them.

4.6. Responsibilities in relation to this report

This report has been prepared by the Royal College of Surgeons of England and the British Association of Urological Surgeons (BAUS) under the IRM for submission to the healthcare organisation which commissioned the invited review. It is an advisory document and it is for the healthcare organisation concerned to consider any conclusions and recommendations reached and to determine subsequent action.

It is also the responsibility of the healthcare organisation to review the content of this report and in light of these contents take any action that is considered appropriate to protect patient safety and ensure that patients have received communication in line with the responsibilities set out in the Duty of Candour Procedure (Wales) Regulations 2023[17].

[17] The Duty of Candour Procedure (Wales) Regulations 2023 (legislation.gov.uk) which came in to force across NHS Wales in April 2023.

4.7. Further contact with the Royal College of Surgeons of England

Where recommendations have been made that relate to patient safety issues the Royal College of Surgeons of England will follow up with the healthcare organisation that commissioned the invited review to ask it to confirm that it has taken action to address these recommendations.

If further support is required by the healthcare organisation, the College may be able to facilitate this. If the healthcare organisation considers that a further review would help to assess what improvements have been made the College's Invited Review service may also be able to provide this assistance.

Appendix A - Information provided to the review team

The following section represents a summary of the information provided to the review team during the interviews held, in the documentation submitted and in the clinical records reviewed.

This section is largely organised according to the Terms of Reference agreed prior to the review but also takes account of the themes that emerged whilst reviewing this information. Information provided by interviewees during their interviews is presented as it was reported to the review team at the time of their review and circumstances may have changed subsequently. It is summarised in an amalgamated and anonymised format.

The information presented will sometimes reflect the viewpoints of individual staff members and some viewpoints described may be contradictory or may have been expressed in the absence of further, substantiating information. Noting these viewpoints is not intended to imply their factual accuracy. The information in this section does not necessarily represent the review team's opinions, which are provided in the Conclusions Section of this report.

Clinical Pathways

The effectiveness of the management of the urology Suspected Cancer Pathways (SCPs) in-line with national standards, for all key urology cancer sites

The review team were informed that the population for North Wales is 750,000.

The review team noted that cancer pathways were set up in each of the three sites, where superficial bladder cancer was managed within the sites whilst muscle invasive bladder was referred to the Bangor site if cystectomy was required. The review team were further informed that flexible cystoscopies were done in the outpatient departments. It was the review team's understanding that radiotherapy was undertaken in the Glan Clwyd site.

During the review visit to Bangor in March 2023, the review team were informed that work was underway looking at cancer improvement pathways across all cancers including urology. The review team were informed that the Urology network meets every Wednesday morning to discuss urology and other areas.

The review team were made aware that funding had been obtained for co-ordinators for the prostate cancer pathway. They were due to start work shortly after the Invited Review team's visit and were tasked with looking at streamlining the system fundamentally regarding the capacity to carry out biopsies across all three sites. During interviews, the review team heard that there were two biopsy clinics per month, although there was need to do six biopsies per week. Furthermore, 70 laparotomies were referred to UCLH per year which was part of the contract agreed with UCLH three years previously, with the renewal being made each year.

The review team were informed that there were capacity issues with regard to the service overall, as well as issues relating to the purchase of the current robotic device rather than an alternative robotic platform and the impact that has had.

The review team heard during the interviews that the lack of having a urology unit in Wrexham was a major issue, as there was no dedicated ward for urology patients. Reportedly, the volume backlog in capacity and demand was due to not having a dedicated urology room for treatment, therefore, the services in Wrexham were spread out within the hospital. From the interviews, it appeared that, for emergency services, patients were moved where the consultants in charge of their care were doing their normal on-call.

It was reported that there was a 1 in 5 rota in place for acute cases where consultants spent a whole morning undertaking ward rounds which ended around 11:30am. The review team were made aware during the interview that consultant-led ward rounds were spread across more than six wards (including some gynaecology wards). Furthermore, in the afternoons there were two hot clinics in the week, which were booked with patients who attended their on-call, and consultants covered each other during leave. Reportedly, this was arranged six weeks in advance for any changes and they swap a whole week, Friday to Thursday.

From the interviews, it appeared that consultants who were on-call in Bangor also worked cross site in Wrexham. Reportedly, consultants in Bangor were running a 1 in 6 rota for five consultants, therefore on the 6th week they were doing 1 on-call. It was noted that the 6th week was shared with a locum consultant. In addition, consultants did elective work whilst being on-call which became difficult for consultants to manage.

Descriptions of job plans were given by interviewees which stated that consultants started their weekend lists at Bangor to deal with the backlog as there was capacity issue across all specialties. In addition, consultants had urology theatre five days a week which included two sessions a day. Reportedly, cancellations on the day could be an issue. The review team heard that the consultants' job plans in Glan Clwyd only included one session of operating a week.

Interviewees were asked if they had concerns in urology theatre provision within their sites. Some interviewees stated that they had no concerns with patient safety, however, they considered that utilisation of theatres could be expanded.

The review team were concerned to hear that there were two cases in Wrexham which raised concerns due to delays in reviewing the patients by the urology team, resulting in them going back to theatre. The review team heard that lists on Fridays often get cancelled due to staff shortages.

Interviewees reported that lists were full and theatre list utilisation was estimated at 80%. Feedback from interviewees suggested that a possible solution was to request for additional cases to be added to lists, to resolve utilisation as lists were often under booked. From the interviews, the review team understood that staff agreed on scheduling lists three weeks in advance and sometimes the lists were changed after they have been agreed, when additional cases were added to the list.

The review team heard that, in Wrexham, every list started with a safety briefing. Reportedly, staff had comprehensive briefings in the morning prior to starting a list. While in Bangor, the review team were informed that the morning team briefing was considered very good and time outs were "excellent". It was reported that there were time outs for major cases and staff observed a "pause" to allow for refocus and reflection. The review team were informed that in Glan Clwyd, a meeting was held every Thursday to check lists that had been booked.

Interviewees provided different perspectives about the effectiveness of the management of the urology Suspected Cancer Pathways. The range of comments provided by interviewees included:

a. The review team heard from a number of staff in the West that there was provision of good urological cancer work and a sense that the urology team was one of the "best surgical teams in Bangor".
b. A divergent view was that the urology cancer service (both ends of the prostate cancer pathways) had been poorly performing for many years, which has had a big impact on the overall performance of the service.
c. For urology and robotic assisted surgery to move forward, there needs to be better networking between sites, to function as a single team but also within their primary sites.
d. It was a struggle for consultant surgeons to integrate and buy into the concept of three urology departments working within a single pool of patients, therefore providing care across North Wales irrespective of the patients' postcode.

e. Reportedly, the challenge was to get the workforce to agree on "*what needs to be done*" to improve the urology service as staff already know what was required.
f. The urology department in Wrexham was progressing, it was considered that there was adequate cover for staff leave if needed and they "*just get on with things*" for the benefit of the patients.
g. There were views that the Bangor site was not as busy as the other two sites, staff appeared more relaxed in their practice, albeit they were "getting quite progressive".
h. Communication with Bangor was considered good, when contacted by other sites, as they respond quickly when needed.
i. Patients were reportedly happy to go to Bangor for treatment.
j. The Glan Clwyd site was initially progressive and optimistic in their approach but over time had not developed. It appeared to be "one problem after another" and communication was considered non-existent, either written or verbal.
k. It was considered that the lack of response from the clinical lead in Glan Clwyd, when being contacted, indicated poor management.
l. The constant movement of cases to Bangor was driven "politically".

The effectiveness of referral pathways across the healthcare system in enabling timely access for patients to effective interventions

From information gathered, the review team understood that the initial diagnostic management of prostate cancer was dealt with on all sites and was referred to MDT before onward referral for radiotherapy to the Centre (GC) and for referral to UCLH, London, for radical prostatectomy. Reportedly, there was not enough provision for cancer prostate cases locally, resulting in patients being referred to Royal Free Hospital (RFH), London, and operated on there.

In addition, the review team heard that renal cancer was managed by radical nephrectomy when required in the Centre and the West sites, with referral to RFH in London for partial nephrectomy.

The review team were also made aware that kidney cancer patients were centralised. These cases were either picked up by a Glan Clwyd or Bangor consultant or, if there was no capacity, the cases would go to UCLH. Furthermore, testicular cancer was managed centrally at The Christie Hospital in Manchester, usually after diagnosis by orchidectomy.

The review team learned that at present a large number of patients were referred each year to UCLH for radical prostatectomies at a reported cost of £750,000 per annum with patients also being referred to the RFH (for partial nephrectomies). The review team understood that these were managed through a Pan-Wales[18] specialised commissioning arrangement. Reportedly, the cost sits with the Health Board and a significant amount of financial resource from the Health Board budget was spent annually on these outsourced pathways.

The review team further learned that there was an apparent absence of oversight of the quality of the service provided under these contracted outsourced pathways and no effective contract monitoring or audit work. The review team heard that there was audit work regarding the number of cases but no quality audit work was in place.

The review team heard during interviews that there was good understanding between the Bangor and Wrexham sites and 60-70% of cases referred to Bangor were from Wrexham. Reportedly, all stones cases were referred to Wrexham. Furthermore, from the interviews it appeared that treatment depended either on local availability or what was best for the patient.

There were divergent views between interviewees across the three sites on the effectiveness of referral pathways. The range of comments from interviewees included:

[18] Across NHS Wales

i. Theatre utilisation across the three sites were varied. It was reported that lists were full in the East, with 80% capacity. While in the West, it was apparently under-booked as the lists were sometimes changed after they have been agreed, with staff occasionally asking for cases to be added. There were no safety concerns reported within the theatre in the Centre.
ii. Historically, the delivery of urology under the Health Board was unsustainable as the service was stretched.
iii. There was a view that when things were done locally, it was more efficient. Each hospital worked differently and has different philosophies.
iv. Reportedly, there was no continuity with the patients' pathways. Although consultants in Wrexham were supportive of nursing staff, there were concerns raised on the limited space available. Despite having availability to practice, there was no facility to be able to provide the treatment that was required.
v. Concerns were reported about not having nursing management support and no time to do flexible cystoscopy lists. The review team were informed during interviews that there were discussions about having funding for an Advance Nursing Practitioner (ANP) in the Bangor site.
vi. Reportedly, clinicians in Wrexham did not want to undertake any more nephrectomies as they did not feel it was safe.

Clinical decision-making and MDT effectiveness

The review team heard that MDTs were held online and were described by interviewees as 'dysfunctional' with some members of the team logged into the meeting but not speaking and, when complaints have been made against certain attendees, no actions have been taken by senior management regarding behaviours.

The review team learned that MDTs were supposed to be a single meeting of clinicians from all three sites. Reportedly, this was the model when it was set up eight years ago. At that time, a single MDT took place on a face-to-face basis at the Centre (GC) once a week. This system continued for a couple of years. The review team heard that those urologists who were not involved in cancer work reportedly considered that it was an excessive commitment to listen to those cases that did not involve them. The meetings then moved online with each site effectively holding its own meeting on a consecutive basis, allocating one hour to each site. It was reported that some clinicians would only dial in for part of the meetings that was relevant to their work and their site, while some clinicians would stay for the whole duration of the meetings. With regard to the consultant at the Centre (GC), there was a perception from interviewees that questions were asked of them with no reply forthcoming.

Furthermore, concerns were reported about not having a dedicated chair for the MDT meeting, just as there was no overall clinical lead for urology. Each of the three sites led their own section of the MDT meeting. In addition, there was no longer any urology cancer lead in place. The review team were informed that the clinical oncologist was able to chair the MDT and was based in Glan Clwyd.

The review team were made aware during interviews that there was a set MDT every lunch time at Glan Clwyd where complex stone cases, including any X-rays were discussed. Furthermore, it was the review team's understanding that kidney cases were discussed at cancer MDT (PanBetsi) with three slots allocated to each hospital, 8am-9am for Glan Clwyd, 9am-10am for Bangor and 10am-11am for Wrexham. It was noted that surgeons were present during the allocated time based on their site. For bladder cases, it was reported that the same surgeon in Bangor always attended the MDT.

For the regional stone MDTs, consultants were invited and representatives from Wrexham and Bangor attended these meetings. However, reportedly there was no consultant from Wrexham who attended as the previous stone surgeon had retired.

A number of interviewees reported positive aspects of MDT working and effectiveness. These included the following:

a. There was good attendance of local urologists and oncologists from Glan Clwyd.

b. Interviewees from Wrexham reported that they did not have any issues when attending MDTs and that they were on "good terms" with staff in Bangor.
c. It was reported that consultants appeared to have an "equal voice" across the MDT.
d. There was a discussion on whether there were effective debates at MDTs and interviewees stated that this occurred when deciding whether local treatment would be adequate (i.e. total or partial nephrectomy) and who was able to do it at that time.

A number of interviewees reported that there had been some difficulties amongst the MDT affecting clinical decision-making. These included the following:

a. Concerns were reported that staff at Glan Clwyd were isolated and they "do not get much involvement from there".
b. Reportedly, turnover of staff in Glan Clwyd was very high, affecting continuity.
c. There was an expectation that only cancer surgeons would join the meeting for the three sites.
d. In addition, the review team heard that some cancer surgeons were sometimes not available for the whole MDT meeting and that this situation had only changed recently (six months prior to the review visit).

Access and waiting times for cancer and non-cancer pathways

The review team heard that, in Wrexham, patients were "scattered" all over the hospital due to a lack of beds, reportedly resulting in a number of cancellations which frustrated the consultants.

Reportedly, the current[19] waiting time was 18 weeks from appointment. The review team were informed that 40% of patients were treated within 62 days for the whole of urology. The Welsh target is within 60 days from referral to treatment.

In Glan Clwyd, it was reported that psychological support was provided to patients and staff were able to support them from diagnosis to care, which patients appreciated. From the interviews, it was the review team's understanding that no nurses were doing biopsies and there was no benign urology nurse doing urodynamics. Reportedly, this had substantially affected waiting times for surgery which was considered "*atrocious*".

Frequency and adequacy of follow-up arrangements for patients on these pathways

The review team heard during interviews that in Glan Clwyd, registrars ran the wards and the oncall consultants were not visible which made on-call at night unpredictable. However, interviewees stated that consultants were helpful and were always available when needed.

Arrangements for Health Board contracted outsourced pathways including governance and quality assurance

[19] At the time of the review visit in November 2022

The review team were informed that many cases had been referred out of region for their surgery (including radical prostatectomy and partial nephrectomy) with the review team hearing that some referrals which were sent out of North Wales were delayed when referred to London.

Clinical Governance

Mortality and Morbidity (M&M) meetings

The review team explored the M&M set up with interviewees and were informed that online meetings occurred for half a day every month, with one full day three or four times a year.

Reportedly, there was administration support, with the clinical governance lead providing meeting notes. An issue with the consultant report was mentioned during interviews, which had been reportedly raised on several occasions. It was cited that the recording of mortality highlighted in the report was not accurate.

The review team were provided with incomplete data regarding the attendance at M&M meetings. There was no indication on who chairs the meetings and there were no information on how the number of cases that can be seen at individual meetings, and what type of follow-up cases should be brought back to the meetings, were agreed.

For morbidity outcomes, the review team heard during interviews that consultants made their own records and prepared their own report to share during the M&M meetings.

The review team heard during interviews that the guidance from the Health Board stated that all concerns, (including all Ombudsman investigations and recommendations) should be shared and discussed in Pan-Wales[20].

Reportedly, there was a specific individual M&M meetings for each site which the clinical governance lead for Betsi did not attend. The review team were informed that Ward sisters and Ward nursing staff were not invited to M&M meetings.

The processes in place for concerns and incidents (Health Board and service specific), to be reported and lessons learnt

The review team were made aware of cases referred to the Ombudsman due to delays in getting cases done in UCLH.

The review team heard that coding was a ‘nightmare’ and that there was little audit work being undertaken.

It was the review team’s understanding that the Wrexham site relied on paper, using Microsoft Excel and staff experience for data collection. Reportedly, there was no electronic system available. It was reported that complaints were also site-specific. The review team were informed during interviews that most complaints were from patients who experience prolonged waiting times.

From the interviews, it was the review team’s understanding that during site quality meetings, all concerns and complaints were discussed and lessons learned were identified for remedial action.

However, the review team heard that learning from incidents was varied. Reportedly, the Health Board had identified this issue and discussions took place to improve how feedback was given to

[20] Across NHS Wales

staff. Reportedly, the outcomes were not necessarily shared. Furthermore, there was no information provided of co-ordination between the local MDTs to share lessons learned.

The review team explored with interviewees the mechanism for sharing learning. The review team were informed that there used to be weekly meetings to share information, however this had stalled in the weeks preceding the review visit. The review team heard that staff did keep in touch with colleagues from other sites and flagged issues when necessary.

Clinical Outcomes

The review team heard that there was a lack of a dedicated physical urology department in the East in Wrexham.

There was also minimal provision for interventional radiology at all three sites and the consultant provision on the wards were lacking. The review team were informed that interventional radiology was only available on each site during the standard working hours and there was no cover for out of hours arranged in each hospital.

Identify areas of good and exceptional practice

The review team were informed that there was good integration of clinical nurse specialists at all three sites.

The review team learned of some good urological cancer work in the West and heard from a number of the ward staff during the interview process that they considered the urology team was one of the best surgical teams in Bangor.

Identify areas of practice that have utilised innovative and/or transformational methodologies

The review team explored the facilities within the urology service during their visit to Wrexham in November 2022 and during the visit to the Bangor site in March 2023. The site tours were facilitated by staff who efficiently guided the review team across their units and showed them the relevant areas used within the service.

Identify areas of practice, which could benefit from innovation and or transformation

From the interviews, the review team were made aware of concerns relating to the urological service at the central Glan Clwyd site. Interviewees considered that these may have consequences for the provision of a safe, high-quality service at this site:

- It was reported that there was poor consultant ward supervision, leading to the recent loss of the site's only formal trainee;
- There was poor engagement in formal MDTs;
- Reportedly, there was poor team-working on a wider basis as part of a Pan-North Wales urology service, with e-mails unanswered and other examples of a lack of engagement given.

Robotic Surgery

The review team were informed during interviews that the Versius robot platform procured for BCUHB was not being used for urology and that the robot was being used in Gynaecology instead. The review team heard that there was a delay in implementation within that specialty, but not in theatre.

During the interviews, the review team noted that the Colorectal team were being trained on the Versius robotic platform as they were due to start using it in April 2023. Interviewees stated that there were no plans to roll out the Versius robotic platform within the urology service.

The review team heard during interviews that the Welsh committee panel decided on which robot to procure for the Health Board. Reportedly, at a government meeting attended by representatives from all urologists in Wales, the purchase of the Versius robotic platform was signed off and the Health Board was told that "*if they reject the robot, they will not get the robot they want*".

The review team were informed that the clinical staff were under the impression it was the Da Vinci robotic platform that was being procured. Most interviewees were unsure how the decision to procure the Versius robotic platform was made and most of them reported that they were not involved in the decision-making to place the robot at the Bangor site. A number of interviewees indicated that they were not able to transfer the Versius robotic platform between the other two sites due to "politics". The interviewees attributed this to the changes within senior management with the coming and going of the CEO and Medical Director during the process, resulting in a lack of overall leadership.

It was reported that urology prostate cancer cases were sent to UCLH in London as the current robotic platform was only used in Obstetrics and Gynaecology. Furthermore, the review team were informed that the Health Board may need to consider purchasing the Da Vinci robotic platform if the Versius robotic platform cannot be used for robotic prostate surgery. However, the review team heard that the Health Board cannot independently purchase another robotic platform as they do not have the power to do so.

Service Model

During the interviews, there was a significant problem highlighted by all parties in terms of recruiting and retaining middle grade doctors and a current reliance on locums. Furthermore, there was also an absence of career development highlighted for both surgical and nursing staff. The review team heard from a number of staff there was a sense of stress and dissatisfaction as well as frustration, at not being able to have any career development and being restricted in their roles.

During the review visit in November 2022, the review team heard that the only formal trainee working in the team at Glan Clwyd had left, reportedly due to lack of ward supervision being provided by the consultant.

With regard to the service, it was expressed by a number of staff that it had been a difficult workplace for a number of years with ideas being put forward regarding how to combine the work of the three hospital sites in order to provide an effective service and there had been no support at Board level to implement these ideas.

The review team heard that there was a strong appetite on the part of nursing staff to develop a nurse-led LATP service as part of a pathway to professional advancement, for the benefit of patients and staff. The review team were informed that, if there was more capacity in place, LATPs could be carried out every week. During the interviews, there was support from some surgeons for this development and some willingness to provide the training for nurse-led LATPs.

Infrastructure Support

The review team were informed that there appeared to be a lack of both inpatient and day case theatre capacity for the number of urologists. In addition, it was reported that there were currently substantial workforce issues that needs urgent attention.

Reportedly, work was underway in Bangor to maximise the services provided and reduce the significant backlog. During their visit, the review team noted that the Urological Unit in Bangor appeared to offer some excellent facilities and was in the process of developing an infrastructure that it was hoped would enable it to support the delivery of an excellent urology cancer centre.

The review team heard that the lack of having a urology unit in Wrexham was a major issue, as there was no dedicated ward for urology patients.

Culture

The geographical footprint of the urology service across three sites in North Wales is complex and challenging and the review team heard during interviews that North Wales was never in effect a single urology team and that the need for effective team working across the three sites had never been imposed.

The urology clinical team

Interviewees provided different perspectives about the wider urology service. It was reported that the urology unit in the West was good, with some interviewees stating they had not had any issues in the last 13 years and they considered that they had the “best surgeons” across all the three sites.

Feedback from interviewees regarding the urology clinical team included:

a. There was always a lack of continuous consultants working in the service. Reportedly, the service had lost two consultants in the last six years.
b. There was a good relationship within the urologists in the West.
c. Urologists were considered approachable and if staff were unable to contact them, their secretaries “chased” them.
d. If concerns were escalated by staff, the urologists took responsibility by supporting staff in escalating issues together.
e. There was professional understanding and good rapport amongst the clinical team.
f. One interviewee considered that they were proud to be a part of the service.
g. Reportedly, there was constant “firefighting” within the urology teams as no one wanted to change, with the preference to stay in their comfort zone.

The wider urology service

The review team were informed during interviews that at present, all consultants have a Health Board contract but are employed to work at a single site. The review team heard that new consultant posts being appointed under the Health Board were contracted to work on more than one site, with one specific site as their base.

Reportedly, most urology cases were conducted at the Bangor site due to issues with staff recruitment and retention, resulting in a lack of available surgical staffing. Furthermore, review team heard that there was no plan to replace the consultant who was due to retire.

The review team heard that middle grade doctors were fully trained and independently running. Reportedly, trainees at Wrexham were impressed with the training and support they received. Some urologists were considered to be excellent trainers and great at being “hands on” at teaching. The review team also heard that trainees had protected time off for exams. In addition, the review team were made aware during interviews that training opportunities in Wrexham were considered better than in Aintree as there were more opportunities available. However, the review

team heard that trainees from Glan Clwyd reportedly lacked support and apparently, there were no consultant cover in the wards to support them.

The multi-disciplinary team (MDT)

Interviewees provided different perspectives about the MDT. Interviewees stated that the MDT were well organised, however, there were mixed experiences between them. Some noted that the MDT team were approachable and had excellent relationships with them, while others stated that the relationship between surgeons across all sites was poor as they "never saw eye to eye" from when Betsi Cadwaladr became a Health Board and was centralised. This was attributed to "jealousy" between the surgeons and having their "egos" involved.

It was reported that since the COVID-19 pandemic, the Health Board had increased medical staffing, although an issue with lack of nursing staff due to long term sickness remained.

The review team heard that consultants had good relationship with junior and middle grade doctors and that their schedules were aligned with consultants.

There was a discussion about consultants' job plans and the review team were informed that an appointed job planner organises the job plans by December (3SPAs[21]).

During the review visit in Bangor, the review team heard that there was only one main cancer surgeon who had come off the on-call rota resulting in the rest of the consultant team doing a 1 in 4 rotation. In addition, one of the consultants was currently signed off on leave due to health issues. The review team heard that most nights only a locum middle grade was doing on-call. Reportedly, the consultant team had lost faith in the system due to disconnect between senior management and site staff.

Other hospital services, primary care, tertiary referral services, external stakeholders, patients and partners

The review team were informed that there was a site specialty manager and an assistant service manager who supported staff. Furthermore, specialty managers meetings, which were site specific, were conducted to discuss training, appraisals, issues, audits and day to day operational concerns.

Communication with patients and other health professionals

The effectiveness of providing information to patients in supporting and enabling shared decisionmaking

There was some discussion about consent forms not being provided to patients as the review team noted they were still in the patients' files when they were reviewing the sample of records provided by the Health Board. The review team heard from interviewees that the forms were shared with patients and were handed out. However, apparently some patients leave them behind so the consent forms were put back in the file, although the review team highlighted that the forms were not pulled apart, indicating that they were not initially given to patients.

The adequacy and timeliness of the provision of patient clinical information to the appropriate primary and community health care teams

[21] Supporting Professional Activities

The review team explored with interviewees how clinical records were managed in ward level and were informed that in Wrexham, records were filed electronically since mid-2022 whilst in Bangor, clinical records were managed by ward clerks.

The interaction between primary and secondary care and the views of the primary care clusters

The review team were not provided with sufficient information regarding communication between urologists, primary care and secondary care about the planning or delivery of care to patients to form a view on this matter.

Leadership within the urology service

The review team were informed that the incumbent Medical Director had been at the Health Board for a year and that the departmental structure had been under development in the last year. During interviews, there were some discussion about accountability and the review team heard that the Health Board report through the integrated health care teams, in a similar way that English Trusts do. Although there was no direct equivalent to the Care Quality Commission (CQC) in Wales, they are held accountable to Health Inspectorate Wales (HIW).

In addition, the minimum standards requirement, which was in line with the Health Board's clinical strategy, stated that there should be three emergency departments, one in each site with 24/7 service. Reportedly, there has been a long-standing lack of investment of the Health Board in developing the service, notably, in not addressing staffing issues and poor leadership.

The review team heard that at the time of the review visit there was no North Wales overall urological lead and no clinical lead in the Centre. Furthermore, there was uncertainty about the clinical lead in the West in Bangor when the visit was conducted in March 2023, as the clinical lead had to step down prior to being on long term leave due to health issues. Reportedly, the Clinical Director post was vacant due to the "history" and "characters" in the urology service.

Leading a urology service across all three sites and primary care

From the interviews it appeared that the three acute teams were not working together, whereas other services had identified leads for their service. Descriptions of lack of clear clinical leadership and consensus were given by interviewees. In particular, it was reported that certain individuals were not keen on working together and accepting leadership from others. There was consensus amongst interviewees that it would be ideal to have an individual overseeing clinical leadership within the three sites and taking ownership.

Encouraging the use of data to improve services

Feedback from interviewees about the use of data indicated that they were not assured of the system currently in place. It was the review team's understanding that audit of systems and safety process were held eight days a year.

Managing waiting times

The table below shows the patient timeline, by stage, by site against the time bands as provided by the Health Board. To note, this is all un-booked pathways, those who do not have a first outpatient appointment or procedure booked.

Count of Patient Name	Column Labels

Row Labels	0-25 Weeks	26-35 Weeks	36-51 Weeks	52-103 Weeks	104-155 Weeks	156 Weeks and Over	Grand Total
1	**2166**	**532**	**742**	**1869**	**511**	**31**	**5851**
Cent	605	80	134	476	266	13	1574
East	845	223	298	822	226		2414
West	716	229	310	571	19	18	1863
2	**333**	**132**	**174**	**275**	**124**	**30**	**1068**
Cent	138	77	135	162	46	24	582
East	124	21	31	77	55	6	314
West	71	34	8	36	23		172
3	**473**	**219**	**196**	**412**	**203**	**54**	**1556**
Cent	208	65	100	199	40	33	645
East	97	19	29	144	101	20	410
West	168	135	67	69	61	1	501
4	**770**	**141**	**138**	**369**	**205**	**61**	**1684**
Cent	244	55	55	162	93	53	662
East	196	58	66	141	93	5	559
West	330	28	17	66	19	3	
Grand Total	**3742**	**1024**	**1250**	**2925**	**1043**	**176**	463 **10159**

Strategic workforce and succession planning

From the interviews held, the review team heard that there were no issues with recruiting junior doctors. Reportedly, there were currently six middle grades, two placements and two Trust doctors (sitting for FRCS). In addition, the Wrexham site hosted North West of England teaching twice a year.

The review team were made aware that the Wrexham site has capacity to have two trainees and enough work for a junior and senior trainee.

The view amongst interviewees was that the Health Board needs to move to a network service (with a common pathway, shared access and the same quality of care), as at present there were three acute sites with a number of consultants for each site. Feedback from interviewees suggested that there was not enough demand to support full consultant rotas in each site. It was suggested that strategically, the Health Board should move to an RTC (regional treatment centres) model (for which a business case was being built) as the future five-year plan.

The review team heard that Service Managers had weekly planned meetings with the clinical leads for each site to discuss strategic and operational matters.

Governance processes

From the interviews held, the review team were made aware that there were planned BCUHB governance meetings at each site, where individual sites present at the Pan-Betsi meeting. Reportedly, there were eight or nine meetings per year.

Robust accountability

Interviewees provided different perspectives about the accountability of the clinical leads within their sites. In Glan Clwyd, it appeared "*hit and miss*" and interviewees were unsure if clinical leads were too busy to engage and take responsibility and were described as "quite all over the place" whilst in the East and West, the clinical leads were considered to take more responsibility for their actions.

Appendix B – Clinical record review notes

The following notes were made by the clinical reviewers with regard to the cases under review. These represent their initial views on each case while looking at them individually and do not necessarily reflect their final conclusions. The Conclusions Section of this report contains the review team's definitive view on the cases reviewed.

Case A1

Description

This 86-year-old male patient was recorded as having transitional cell carcinoma (TCC[22]) bladder cancer with a PtaG2[23] grade in 2016, which was considered low grade.

The patient has had regular flexible cystoscopy checks since then.

Comments

The review team considered that the patient was adequately assessed, their diagnosis was considered acceptable, and investigations undertaken were suitable to the patients' needs and were considered satisfactory.

In the opinion of the review team, the patient was provided with prompt and sufficient treatment, which was considered to have been appropriate, and received satisfactory post-operative care. The review team noted the positive outcome for the patient.

The review team considered that team working including communication and MDT discussions was acceptable as the appropriate colleagues were consulted and a second opinion was obtained.

The review team found communication with the patient /their family and or carers appeared to be appropriate in this case.

The review team found that the clinical record entries were clear, accurate and legible to an acceptable standard.

The review team concluded that the overall care provided to this patient was satisfactory.

Case A2

Description

[22] Urothelial carcinoma, also known as transitional cell carcinoma (TCC), is by far the most common type of bladder cancer. In fact, if you have bladder cancer it's almost always a urothelial carcinoma. These cancers start in the urothelial cells that line the inside of the bladder.

[23] pTaG2 (high grade) is low-risk non-muscle-invasive bladder cancer recurring within 12 months of last tumour occurrence.

This 81-year-old male patient was admitted in June 2017 with lower urinary tract symptoms (LUTS) and following investigation was prescribed Tamsulosin[24] for treatment.

The clinical record documented that the patient was prescribed Finasteride[25] in June 2018.

In January 2019, the patient was recorded as having retention following nasal surgery. It would appear that the patient had a successful trial without catheter (TWOC) however, it was noted that the patient had large residual.

It was recorded that the patient had transurethral resection of the prostate (TURP) in January 2020, with a good post-operative recovery noted.

In June 2022, it was documented that the patient had persistent LUTS and was prescribed Solifenacin as treatment.

Comments

The review team considered that the patient was adequately assessed, and their diagnosis was considered acceptable.

In the review team's view, the investigations undertaken were suitable to the patients' needs and were considered satisfactory.

In the opinion of the review team, the patient was provided with prompt and sufficient treatment, which was considered to have been appropriate, and received satisfactory post-operative care. The review team noted the positive outcome for the patient.

The review team considered that team working including communication and MDT discussions was acceptable as the appropriate colleagues were consulted and a second opinion was obtained.

The review team found communication with the patient /their family and/or carers appeared to be appropriate in this case.

The review team found that the clinical record entries were clear, accurate and legible to an acceptable standard.

It was the review team's conclusion that this patient received satisfactory care and no further follow up was necessary.

Case A3

The review team were not provided with the clinical records for this case.

Case A4

Description

[24] Tamsulosin belongs to a class of medications called alpha blockers. It works by relaxing the muscles in the prostate and bladder so that urine can flow easily. Tamsulosin capsules are used in men to treat the symptoms of an enlarged prostate which include difficulty urinating, painful urination, and urinary frequency and urgency.

[25] Finasteride (Proscar) is used alone or with other medication to treat symptoms of benign prostatic hyperplasia (BPH) in men with enlarged prostate.

This 52-year-old female patient, who was recorded to have morbid obesity and mid ureteric stones, was an emergency admission in May 2021 due to left loin pain. The patient subsequently underwent insertion of a JJ stent[26] with pus obtained during the procedure.

In July 2021, the patient had ureteroscopy and laser treatment.

The stent was removed in September 2021.

Comments

The review team considered that the patient was adequately assessed, and their diagnosis was considered acceptable, and investigations undertaken were suitable to the patients' needs and were considered satisfactory.

In the opinion of the review team, the patient was provided with prompt and sufficient treatment and received satisfactory post-operative care.

The review team considered that team working, including communication and MDT discussions, was acceptable.

The review team found communication with the patient appeared to be appropriate in this case.

The review team found that the clinical record entries were clear, accurate and legible to an acceptable standard.

Overall, the review team concluded that this patient received satisfactory care.

Case A5

Description

The patient was a 52-year-old male. No further information was made available.

Comments

The review team were not able to draw any further conclusions on the care of this patient based on the limited information and lack of imaging provided. Therefore, inadequate records made it not possible to assess this case.

Case A6

Description

This 66-year-old female patient was referred by their GP due to non-visible haematuria.

In January 2021, the patient had flexible cystoscopy and a CTU[27] was requested following the procedure. There was no evidence that the scan was obtained.

The patient appeared to be lost to follow up.

Comments

[26] JJ stent is a thin, flexible tube that helps urine flow from the kidney to the bladder.

[27] CT urography (CTU or CT IVU), also known as CT intravenous pyelography (CT IVP), has now largely replaced traditional IVU in imaging the genitourinary tract. It gives both anatomical and functional information, albeit with a relatively higher dose of radiation.

The review team considered that the patient was adequately assessed, and the diagnosis was considered acceptable and investigations undertaken were suitable to the patient's needs and were considered satisfactory.

In the opinion of the review team, the patient was provided with prompt and sufficient treatment.

The review team considered that team working, including communication and MDT discussions, was acceptable.

However, the review team found communication with the patient had room for improvement as there was limited communication following the flexible cystoscopy and the patient appeared lost to follow up.

The review team found that there was room for improvement with record keeping as limited records made it difficult to assess this case.

Case A7

Description

This 70-year-old female patient had a small renal mass and was referred to The Christie Hospital in Manchester where she was treated.

The patient had their follow up in North Wales.

Comments

The review team did not review this case further as there was no relevant procedure performed that was appropriate for this review.

Case A8

Description

This 75-year-old female patient with haematuria had a two-week wait for their referral in August 2021.

The patient had an ultrasound scan (normal results were recorded) and a flexible cystoscopy in September 2021. A computerised tomography (CT) scan was booked.

No follow up or CT scan result were documented.

Comments

The review team considered that the patient was adequately assessed, and their diagnosis was considered acceptable.

In the review team's view, the investigations undertaken had room for improvement as the CT scan result was not included in the clinical record.

The review team considered that the patient was provided with prompt and sufficient treatment which was appropriate and noted the positive outcome for the patient.

The review team considered that team working, including communication and MDT discussions was acceptable.

The review team found communication with the patient appeared to be appropriate in this case. However, it was of concern that this patient has not had follow up since their procedure was undertaken.

The review team found that record keeping had room for improvement as no follow up was documented. **Case A9**

Description

This 47-year-old male patient was referred by their GP with loin pain in November 2020.

In December 2020, during an outpatient appointment (OPA), the patient was diagnosed with renal stones and was listed for Extracorporeal Shock Wave Lithotripsy (ESWL[28]). Shortly after, the surgery was performed and there were no documented complications.

Comments

The review team considered that the patient was adequately assessed, and their diagnosis was considered acceptable, and investigations undertaken were suitable to the patients' needs and were considered satisfactory.

The review team considered that the treatment undertaken had been appropriate and noted the positive outcome for the patient.

The review team considered that team working including communication and MDT discussions was acceptable.

The review team found communication with the patient appeared to be appropriate in this case.

The review team found that the clinical record entries were clear, accurate and legible to an acceptable standard.

Overall, the review team concluded that the patient received satisfactory care and further follow up was not required.

Case A10

Description

This 71-year-old female patient was referred by their GP.

In January 2020, the patient was seen during an OPA and was listed for ureteroscopy and laser treatment for small renal stone.

Ureteroscopy and stent insertion were undertaken in February 2021.

In March 2021, the patient had flexible stent removal while the stone was left untreated.

Comments

The review team considered that the patient was adequately assessed, and their diagnosis was considered acceptable, and investigations undertaken were suitable to the patients' needs and were considered satisfactory.

[28] Extracorporeal Shock Wave Lithotripsy (ESWL) is a modern, non-surgical way of treating kidney stones, without General Anaesthetic.

In the opinion of the review team, the treatment provided had room for improvement as it was not clear why the stone was left untreated, and the patient now appeared lost to follow-up.

The review team considered that team working including communication and MDT discussions was acceptable.

The review team found that record keeping had room for improvement as there was no recorded follow up arranged for this patient.

Case A11

Description

This 31-year-old female patient had an index operation appendicectomy on 07 April 2021.

There was no urological involvement throughout the patient's clinical journey. Comments

The review team did not review this case further as it involved general surgery only.

Case A12

Description

This 71-year-old male patient with haematuria was found to have transitional cell carcinoma (TCC[29]) on their left renal pelvis.

Scans showed mass in the left renal pelvis and further CT and MRI scans were carried out before the left URS and tumour biopsy was performed on 06 May 2021.

The patient underwent definitive treatment with nephroureterectomy on 23 June 2021.

The patient was also found to have high pressure chronic urinary retention (HPCR) which was treated by catheterisation and subsequent TURP on 30 September 2021.

Comments

The review team noted that this patient with haematuria went into retention and was found to have poor renal function and HPCR.

The review team considered that the patient was adequately assessed at initial presentation and their diagnosis was considered acceptable.

In the review team's view, the investigations undertaken were suitable to the patient's needs and were considered satisfactory. It was noted that ultrasound, CT and MRI scans were obtained as necessary.

In the opinion of the review team, the patient was provided with prompt and sufficient treatment with the initial URS and tumour biopsy in May 2021, followed by a nephroureterectomy in June 2021 and finally, a TURP in September 2021. The review team considered that the procedures undertaken were appropriate and were managed well by the clinicians involved.

[29] Transitional cell carcinoma, also called urothelial carcinoma, is a type of cancer that typically occurs in the urinary system. It is the most common type of bladder cancer and cancer of the ureter, urethra, and urachus. It accounts for 95% of bladder cancer cases.

The review team considered that team working, including communication and MDT discussions in April, May and June 2021 were acceptable as the appropriate colleagues from nephrology were consulted and a second opinion was obtained.

The review team highlighted that communication with the patient, including obtaining consent for all three operations, was adequate.

The review team found that the clinical record entries were clear, accurate and legible to an acceptable standard and considered that record keeping was acceptable.

The review team noted that the planned and ongoing follow up for this patient was satisfactory.

Case A13

Description

This 70-year-old female patient initially had haematuria in 2019 and was treated for urinary tract infection (UTI) that year.

In 2020, the patient was referred to urology with haematuria. A CT scan on 24 September 2020 showed a defect on their left mid/proximal ureter. The patient had a left URS and biopsy on 19 November 2020 and histology indicated a G1pTa transitional cell carcinoma (TCC) tumour.

It was documented that the patient was reviewed at MDT meetings on 02 December 2020, 24 February 2021, 17 March 2021 (at Royal Free Hospital in London) and 24 March 2021.

Subsequently, the patient was diagnosed with ureteric tumour.

Comments

The review team considered that the patient was adequately assessed, during the initial assessment of haematuria, and their diagnosis was considered acceptable.

In the review team's view, the investigations undertaken, following the initial assessment and at the follow up stage, were suitable to the patient's needs and were considered satisfactory.

The review team noted that this patient received appropriate local treatment, initially with a URS and biopsy performed on 19 November 2020, and subsequently with definitive treatment of URS and laser ablation undertaken on 04 May 2021. In the opinion of the review team, the patient was provided with prompt and sufficient treatment and received satisfactory post-operative care.

The review team found that team working, including communication and MDT discussions, was excellent as there was good use of MDT reviews and adequate advice was obtained from Royal Free Hospital.

It was the review team's opinion that consent was carried out well, with comprehensive outpatient letters and patient discussion and adequately completed consent forms. The review team considered that communication with the patient, including obtaining consent, was exceptional.

The review team found that the clinical record entries were clear, accurate and legible, including detailed operation notes and considered that record keeping was satisfactory.

The review team noted that the patient had an ongoing six-monthly follow up and considered this to be acceptable.

The review team concluded that this was a well-managed case of left ureteric superficial TCC and there were no concerns identified in the quality of care provided to the patient.

Case A14

Description

This 69-year-old female patient was first diagnosed with TCC bladder in South Africa in 1993. The patient's superficial bladder cancer was relatively aggressive and was treated with intravesical BCG[30] and Mitomycin[31] overseas.

The patient was treated within the Bangor site between 2018 and 2021, undertaking multiple procedures and finally having TURBT in June 2021.

The clinical record documented that, during an MDT on 29 August 2018, repeat URS and nephroureterectomy were considered.

From the documentation provided, the patient was also discussed at MDT on 07 November 2018 and 27 March 2019.

On 10 June 2021, it was recorded that the patient had lung metastases by 2021. Comments

The review team noted that the patient had a long-standing bladder cancer over the last 20 years. This was initially found to be superficial, becoming more aggressive with muscle infiltration over time, until the patient was finally diagnosed with metastatic disease.

In the opinion of the review team, the patient was assessed adequately, and appropriate local investigations were undertaken after their previous treatment in South Africa.

The review team considered that the patient was provided with prompt and sufficient treatment as appropriate surgeries were carried out, despite the patient refusing nephroureterectomy in July 2021.

The review team found that team-working, including communication and MDT discussions, was acceptable as repeat URS was undertaken, after consideration at MDT, and nephroureterectomy was also considered.

The review team found communication with the patient was excellent in this case. There were records of detailed explanations to the patient and a comprehensive letter from the consultant surgeon was provided to the patient.

The review team found that the clinical record entries were clear, accurate and legible to an acceptable standard.

It was acknowledged by the review team that this was a difficult case to manage, however, in the review team's view, patient management was carried out adequately.

Case A15

Description

This 74-year-old male patient had an early presentation and investigation on 26 May 2017 with haematuria. The first test results were all clear, however, subsequent testing revealed a Gleason[32] Score 4+4 prostate cancer which was treated by radiotherapy.

[30] Bacillus Calmette-Guerin (BCG) treatment is a type of intravesical (in the bladder) immunotherapy.

[31] Mitomycin is a chemotherapy drug used to treat different cancers including breast, bladder, stomach, pancreatic, anal and lung cancers.

[32] Gleason scoring system is the most commonly used grading system for prostate cancer.

On 07 September 2020, the patient presented with urosepsis at the Medical Admissions Unit (MAU), complaining of left loin to groin pain. The patient was found to have an impacted ureteric stone on CT scanning. Urgent stenting was carried out in the early hours of 08 September 2020. The patient was sent home when fit and was re-admitted for planned surgery on 04 November 2020.

The patient had a left ureteroscopy and laser treatment of stone on 04 November 2020.

Comments

The review team found that the early assessment and investigations were excellently conducted.

The review team considered that this patient was very ill, presenting with an obstructed infected kidney which was treated promptly and appropriately. In the review team's view, acceptable urgent treatment and subsequent planned elective treatment were undertaken.

The review team had no concerns regarding team working and MDT communication, therefore this was considered acceptable.

The review team found communication with the patient appeared to be appropriate in this case. In addition, clear explanations to the patient were documented in the clinical record.

The review team noted that some entries in the clinical record were illegible and unclear. Furthermore, some paperwork was not filed in any form of order as the urological notes were included in the cardiology section. Therefore, the review team considered that record keeping had room for improvement.

In conclusion, the review team highlighted that this was a well-managed case and that there was no cause for concern with regard to the clinical outcome.

Case A16

Description

This 60-year-old female patient with haematuria, had a complex past history with severe peripheral vascular disease in a heavy smoker having had chemo radiotherapy for ano-rectal cancer in 2006 and aorto-bifemoral bypass on 24 February 2016.

In February 2017, it was documented that there was an incidental finding of a hydronephrotic left kidney.

The patient underwent left URS on 18 May 2017 and the clinical record stated that the operating surgeon was unable to pass the 'level of obstruction', although contrast passed up into the kidney. Therefore, interventional radiology insertion of antegrade stent was conducted on 09 June 2017 and subsequent changes of stents occurred for a further six times, the last being undertaken on 20 August 2020.

A letter dated 10 December 2020 to the patient's GP noted that the patient turned down a request for an urgent haematuria clinic visit as the patient already had a stent in place and was on a waiting list for change of stent. It was recorded that the patient had a CT scan in August 2020.

The patient sadly died on 07 January 2021 with the cause of death unknown and undocumented in the clinical record.

Comments

In the review team's view, although the underlying definitive cause of the hydronephrosis was never discovered, the overall assessment of the patient was adequate.

The review team found that the investigations undertaken were limited, however they were considered satisfactory. It was noted by the review team that a few retrograde studies, to assess 'obstruction', were conducted during stent changes; this may be possibly related to the patient's previous vascular surgery.

In the opinion of the review team, the patient was provided with prompt and sufficient treatment and received satisfactory post-operative care. The review team considered that all the stent changes were managed appropriately, and the failed URS was adequately dealt with, where plans for radiology antegrade stent was documented.

The review team noted that there was no malignancy found in the patient, therefore no MDT discussion was necessary in this case.

The review team found communication with the patient had room for improvement. Although multiple consent forms were completed satisfactorily, copies were often not provided to the patient.

The review team were provided with three large volumes of clinical records relating to this patient and they appeared to be of an acceptable standard.

The review team concluded that the review of this case was challenging, although they acknowledged that it was adequately managed.

Case A17

Description

This 81-year-old male patient had been having repeated antegrade interventional radiology, undertaking changes of stents since their radical cystectomy in 2017, which had been complicated by narrowing of the ileo-ureteric anastomosis. This was treated by antegrade stenting and repeated stents over a number of years.

The patient had intermittent urology clinic visits and repeated admissions as a result of experiencing pain when the antegrade stents became blocked.

Comments

The review team considered that the patient was adequately assessed.

Following initial satisfactory investigations, there was little information of any subsequent investigation undertaken. In the review team's view, obtaining antegrade nephrostograms may have confirmed ongoing obstruction. The review team considered that the investigations undertaken had room for improvement.

In the opinion of the review team, the patient was provided with prompt and sufficient treatment as the interventional radiology was suitably managed and appeared acceptable.

In addition, the review team considered that the consent process was in place for each stent change; this were mainly done by radiologists. However, it was the review team's view that patient communication had room for improvement as alternatives to repeated stent changes were not discussed with the patient.

The review team highlighted that there was good integration between urology and interventional radiology teams. The review team considered team working to be acceptable in this case.

However, it was of concern to the review team that there was no indication of any MDT review to consider alternatives to repeat antegrades. The review team expected other strategies, such as revision of the uretero-ilea anastomosis, to be discussed within the urology team and the options

discussed with the patient. The review team concluded that clinical decision-making and MDT communication had room for improvement.

It was the review team's opinion that the clinical records provided for this case was disordered and therefore difficult to review. The review team found that record keeping had room for improvement.

The review team noted that the patient had ongoing follow up and considered this to be appropriate.

Case A18

Description

This 76-year-old male patient had an ongoing management of renal TCC tumour at the YG Bangor site after previous treatment in Thailand in which the patient underwent radical right nephrectomy on 25 April 2018. The patient was subsequently found to have a second tumour in the left renal pelvis on follow up in Thailand and returned to the UK.

The patient was discussed at MDT on 13 January 2021.

The patient declined a second nephrectomy which would require dialysis afterwards and opted for treatment with ureteroscopy (URS) and laser treatment. Palliative treatment was carried out on 18 February 2021. Consent was obtained and a copy of the consent form was provided to the patient on 18 February 2021.

Subsequent surgery was performed on 09 August 2021 and a follow up CT scan showed considerable improvement.

The patient was discussed at MDT on 13 October 2021. It was decided that the patient would have ongoing surveillance and would undertake URS and laser treatment as required.

Comments

The review team considered that there was appropriate assessment of the management of the patient's recurrent left renal disease and there was appropriate use of CT scanning and retrograde ureteroscopy during the investigation period. In the review team's opinion, the assessments and investigations undertaken were acceptable.

The review team noted that there was appropriate use of URS and laser treatment on 18 February 2021. However, the review team considered whether ongoing stent was necessary.

The review team found that consent was obtained satisfactorily, and a copy of the consent form was provided to the patient on the same day.

In the review team's view, individual records were of adequate standards. However, the overall condition of the clinical notes was very poor. The review team found record keeping had room for improvement.

The review team noted that the patient had ongoing follow up and considered this to be appropriate.

The review team concluded that this was a generally well-managed but difficult case.

Case A19

Description

This 67-year-old male patient was being investigated for a moderately elevated PSA[33] and was found to have a 11 x 9.8cm tumour in upper pole of the right kidney.

The patient was discussed at MDT on 03 November 2021 and the decision was made to perform open surgery to remove the kidney.

Open nephrectomy was performed on the patient on 26 November 2021. The procedure and complications were explained to the patient and his daughter.

The patient was discussed at MDT post-operatively on 19 January 2022.

Comments

The review team considered that the patient history was excellently taken and appropriate explanation was provided to the patient and his daughter.

In the review team's view, appropriate CT investigations were undertaken and were suitable to the patients' needs.

It was the review team's opinion that it was a reasonable decision for the patient to have radical open nephrectomy rather than laparoscopic nephrectomy because of the size of the tumour.

The review team noted that consent was carried out satisfactorily and a copy of the consent form was provided to the patient. Patient communication was considered acceptable by the review team.

The review team found record keeping had room for improvement as the filing of the notes was poor. The radiology reports were included in the haematology section.

The review team noted that the patient had planned and ongoing follow up and considered this to be appropriate.

The review team concluded that this was a well-managed case of renal carcinoma.

Case A20

Description

This 58-year-old male patient had been followed up at the Bangor site for more than a year with a very small tumour which subsequently doubled in size from 2.3 to 4.6cm. Biopsies obtained had shown it to be a relatively benign chromophobe tumour.

The patient was transferred to Glan Clwyd with a 4.6cm left renal tumour. The patient was discussed at MDT and was referred for radical laparoscopic nephrectomy.

Patient consent was carried out and copied to the patient. There were no alternative treatments recorded on the consent form.

The radical laparoscopic nephrectomy was carried out on 06 February 2020.

The post-operative complications were documented as ileus with fluid collection and abscess, which were conservatively managed. The complications after surgery were recorded on the consent form.

Comments

[33] PSA stands for prostate-specific antigen, a protein made by the prostate gland.

The review team considered that the patient was appropriately managed at the Bangor site and the size of the tumour was satisfactorily monitored after the biopsies were taken.

It was noted by the review team that there was appropriate use of ultrasound and CT scans and biopsy. In the review team's view, the investigations undertaken were suitable to the patient's needs and were considered satisfactory.

The review team were of the opinion that the referral from the Bangor site to the Glan Clwyd site was appropriate. However, the review team were unsure whether it was possible to undertake a laparoscopic partial nephrectomy at Glan Clwyd. If this was not possible, the review team questioned whether a referral outside of North Wales should have been considered, discussed at MDT and discussed with the patient.

The review team considered that, in their view, partial nephrectomy rather than total radical nephrectomy should have been considered and this discussion should have been documented in the patient's clinical record. The review team considered that the clinical decision making had room for improvement.

The review team acknowledged that consent was carried out and a copy was provided to the patient. The review team noted that the complications after surgery were documented on the consent form, however, it was misfiled in the patient's clinical record.

It was of concern to the review team that the patient's clinical notes were of poor quality. The review team found no documentation filed in the consent or anaesthetic sections of the notes, as they were included in the general sections of the patient's record. The review team considered that record keeping had room for improvement.

The review team concluded that overall, the case was reasonably well-managed. It was noted by the review team that the patient recovered well and was referred back to the Bangor site for follow up. The review team considered that the patient's ongoing follow up at Bangor was appropriate.

Case A21

Description

This 42-year-old female patient was diagnosed with a left renal mass on their exophytic upper pole following an ultrasound scan in September 2020.

In November 2020, an MRI was obtained and an MDT discussion took place.

A renal biopsy taken in January 2021 indicated that renal cell carcinoma (RCC[34]) was proven. An MDT discussion considered that the case was not suitable for partial nephrectomy.

In March 2021, the patient had laparoscopic radical nephrectomy and the subsequent follow up was recorded as unremarkable.

Comments

The review team considered that the patient was adequately assessed, and their diagnosis was considered acceptable. However, the review team noted that the process from the ultrasound scan being obtained to the patient undertaking a nephrectomy was unduly slow. The review team found the investigation had room for improvement.

[34] Renal cell carcinoma (RCC) is also called hypernephroma, renal adenocarcinoma, or renal or kidney cancer. It's the most common kind of kidney cancer found in adults.

The review team were of the opinion that the decision regarding partial versus total nephrectomy was debatable given the radiological description. In the review team's view, many centres would undertake partial nephrectomy. However, the review team considered that the treatment provided was acceptable as it could be justified following an MDT discussion regarding the merits of partial, versus total nephrectomy.

The review team considered that team working including communication and MDT discussions was acceptable as the appropriate colleagues were consulted and a second opinion was obtained.

The review team found communication with the patient /their family and or carers appeared to be appropriate in this case.

The review team found that the clinical record entries were clear, accurate and legible to an acceptable standard.

The review team concluded that, notwithstanding the decision regarding partial versus total nephrectomy which could be questionable, the overall care appeared satisfactory.

Case A22

Description

This 59-year-old female patient had comorbidities that included obesity, diabetes and hypertension.

From the clinical records, it was stated that the patient was an emergency admission in January 2021 with cellulitis and acute kidney injury (AKI[35]). It was documented that the incidental finding was left renal mass. An MDT discussion took place and RCC was confirmed with renal vein involvement.

The patient was listed for surgery in February 2021.

In March 2021, the patient had left open nephrectomy and was discharged home after 14 days.

The patient was readmitted in April 2021 with septic shock, no cause was identified and the patient sadly died one day after admission.

Comments

The review team considered that the patient was adequately assessed and their diagnosis for the incidental mass in kidney was timely and appropriate.

In the review team's view, the investigations undertaken were suitable to the patients' needs and were considered satisfactory.

In the opinion of the review team, the decision for open surgery was reasonable and the perioperative care provided appeared satisfactory.

The review team considered that team working including communication and MDT discussions was acceptable as the appropriate colleagues were consulted.

The review team found communication with the patient /their family and or carers appeared to be appropriate in this case.

[35] AKI is a condition when an abrupt reduction in the kidneys' ability to filter waste products occurs within a few hours or a few days. Symptoms include legs swelling and fatigue.

The review team found that the clinical record entries were clear, accurate and legible to an acceptable standard.

The review team noted that the patient's post-operative death was unexpected and the cause was not identified. However, the review team did not identify concerns with the quality and safety of care provided to this patient.

Case A23

Description

This 48-year-old female patient had an incidental diagnosis of left renal tumour following a CT scan in March 2020.

In April 2020, the patient attended an out-patient appointment (OPA) and was listed for surgery.

The patient had left laparoscopic radical nephrectomy in June 2020, with an early discharge. No complications were recorded following the procedure.

The subsequent follow up was recorded to be satisfactory.

Comments

The review team considered that the patient was adequately assessed and their diagnosis was considered acceptable and investigations undertaken were suitable to the patients' needs and were considered satisfactory.

In the opinion of the review team, the patient was provided with prompt and sufficient treatment and received satisfactory post-operative care.

The review team considered that team working including communication and MDT discussions was acceptable as the appropriate colleagues were consulted.

The review team found communication with the patient appeared to be appropriate in this case.

The review team found that the clinical record entries were clear, accurate and legible to an acceptable standard.

The review team were of the opinion that the post-operative reviews were adequately conducted and documented.

The review team concluded that this patient received satisfactory care.

Case A24

Description

This 73-year-old male patient was first seen as an OPA in September 2020. The patient was diagnosed with incidental renal tumour and was considered possibly having a GIST[36] tumour at an MDT.

The patient had Oesophago-Gastro Duodenoscopy (OGD) in November 2020.

[36] Gastrointestinal stromal tumours (GISTs) are rare cancers that develop in the digestive system. They are a type of soft tissue sarcoma. Most GISTs start in the stomach or small bowel.

In January 2021, following a repeat CT scan, the patient undertook an open radical nephrectomy where it was documented that his subsequent recovery was satisfactory.

Comments

The review team considered that the patient was adequately assessed, and their diagnosis was considered acceptable.

In the review team's view, the investigations undertaken had room for improvement due to some delay in waiting for the OGD to be arranged. However, the review team found timely care was provided following the procedure and the patient had sufficient treatment and received satisfactory post-operative care.

The review team considered that team working including communication and MDT discussions was acceptable as the appropriate colleagues were consulted.

The review team found communication with the patient appeared to be appropriate in this case.

The review team found that the clinical record entries were clear, accurate and legible to an acceptable standard.

Overall, the review team concluded that satisfactory care was provided to this patient and no further follow up was required.

Case A25

Description

This 80-year-old female patient was an emergency admission with loin pain due to a ureteric stone in October 2019. A JJ stent was inserted and the patient was listed for ureteroscopy and laser for fragmentation of the stone.

In July 2020, the patient was re-listed for surgery. It was documented that the JJ stent was still in situ.

In September 2020, the patient was an emergency admission due to a blocked stent. The patient subsequently had a bilateral nephrostomy insertion.

From the clinical records, it was documented that between November 2020 and September 2021, the patient had around nine emergency attendances due to nephrostomy related complications.

As of September 2022, the patient still has nephrostomy in situ and was still awaiting surgery.

Comments

The review team found that the patient was adequately assessed, and their diagnosis was considered acceptable. However, the review team considered that the investigations and treatment undertaken were unacceptable due to the excessive delay and very poor care provided to this patient.

In the review team's opinion, this patient had inadequate follow up and insufficient arrangements for definitive treatment. It was of significant concern to the review team that the patient had been awaiting surgery for at least three years and has had several nephrostomy related emergency admissions since October 2019. The review team highlighted that there was a lack of MDT decision-making and effectiveness in this case which resulted in multiple readmissions for a potentially soluble problem.

The review team concluded that this patient needs urgent review and treatment to ensure her safety and well-being.

Case A26

Description

This 56-year-old male patient had a cystectomy and ileal conduit in 2015.

In 2017, the patient had JJ stents inserted for bilateral hydronephrosis and renal impairment.

The patient's stents were changed in 2018.

In 2019, the patient underwent bilateral nephrostomy and stent change. Bilateral nephrostomies were again replaced in 2020.

The patient began dialysis in 2022.

Comments

The review team considered that the patient was adequately assessed, and their diagnosis was considered acceptable and the investigations undertaken were suitable to the patients' needs and were considered satisfactory.

The review team considered that the treatment undertaken had been appropriate and noted the positive outcome for the patient. However, in the review team's view, consideration may have been given to revision of the ileal conduit rather than treatment with JJ stents in 2017. Furthermore, the review team noted that the patient received satisfactory care for the postoperative complication of cystectomy.

The review team considered that team working including communication and MDT discussions was acceptable as the appropriate colleagues were consulted.

The review team found communication with the patient appeared to be appropriate in this case.

The review team found that the clinical record entries were clear, accurate and legible to an acceptable standard.

The review team considered that this patient does not require follow up beyond the care that has already been given.

Case A27

Description

This 36-year-old female patient had cervical cancer treated in Preston by radiotherapy in January 2020. This was complicated by vesicovaginal fistula, hydronephrosis and nephrostomy insertion in Preston.

The patient subsequently moved to North Wales and had bilateral nephrostomy change in March 2021.

Comments

The review team considered that the patient was adequately assessed, and their diagnosis was considered acceptable, and investigations undertaken were suitable to the patients' needs and were considered satisfactory.

In the opinion of the review team, the patient was provided with prompt and sufficient treatment and received satisfactory post-operative care.

The review team considered that team working including communication and MDT discussions was acceptable.

The review team found communication with the patient appeared to be appropriate in this case.

The review team found that the clinical record entries were clear, accurate and legible to an acceptable standard.

Overall, the review team considered that the patient received satisfactory care.

Case A28

Description

This 53-year-old male patient was referred with LUTS and left scrotal swelling in January 2018.

In August 2018, the patient was seen and investigated.

The patient was listed for left epididymal cyst excision in October 2018.

In September 2019 and January 2020, further assessments were undertaken. No clinic letters were included in the clinical record.

The patient was listed for left varicocele embolization in November 2020. It was documented that in December 2020, the attempted left varicocele embolization had failed.

In September 2022, the patient was listed for left open varicocele ligation.

Comments

The review team considered that the pathway followed was reasonable and appropriate. However, in the review team's view, it progressed very slowly. The assessment and treatment provided were gradual and delayed. Therefore, in the review team's opinion the assessment, investigations and treatment had room for improvement.

The review team considered that team working including communication and MDT discussions was acceptable.

The review team found communication with the patient /their family and or carers appeared to be appropriate in this case.

It was noted by the review team that some records were missing such as clinical letters following the assessments undertaken between September 2019 and January 2020. It was also concerning to the review team that the patient pathway was poorly documented. The review team considered that record keeping had room for improvement.

Case A29

Description

This 45-year-old female patient had undertaken Abdomino Perineal Excision of Rectum (APER[37]) in 2015 with consequent acontractile bladder (AcB[38]) and the need for clean intermittent selfcatheterisation (CISC[39]).

In 2019, the patient was diagnosed with bilateral hydronephrosis secondary to recurrent cancer and was treated with an antegrade JJ stent placement.

There were a number of missing documents in the clinical record provided, with most recent history and findings unavailable. However, it was documented that in January 2022, the patient had their JJ stent changed.

Comments

The review team considered that the patient was adequately assessed, and their diagnosis was considered acceptable and investigations undertaken were suitable to the patients' needs and were considered satisfactory.

The review team considered that the treatment undertaken had been appropriate and noted the positive outcome for the patient.

The review team considered that team working including communication and MDT discussions was acceptable as the appropriate colleagues were consulted.

The review team found communication with the patient appeared to be appropriate in this case.

The review team noted that the clinical record was incomplete. However, based on the available information, the review team concluded that the care provided appeared satisfactory.

Case A30

Description

This 83-year-old female patient was an emergency admission on 26 December 2019 with sepsis and was transferred to ICU for ventilation.

In 27 December 2019, the patient had a CT scan and was reviewed by the Urology team the next day, where it was documented that the patient was advised to undertake a nephrostomy.

The patient had nephrostomy on 28 December 2019.

In January 2020, an antegrade JJ stent was inserted and the patient was subsequently discharged. It appeared that the patient was lost to follow up.

The patient was referred to urology in February 2021 and had an OPA in April 2021.

In June 2021, the patient had the JJ stent changed.

Comments

[37] Abdomino Perineal Excision of Rectum (APER) is an operation to remove all of the rectum and anus. It is most usually performed for patients with rectal cancer.

[38] The acontractile bladder (AcB) is a urodynamic-based diagnosis wherein the bladder is unable to demonstrate any contraction during a pressure flow study.

[39] Clean intermittent self-catheterisation (CISC) is the procedure of inserting a catheter to drain the urine from your bladder, when it is unable to do this naturally

The review team considered that the patient was adequately assessed, and their diagnosis was considered acceptable, and investigations undertaken were suitable to the patients' needs and were considered satisfactory.

The review team considered that the treatment undertaken had been appropriate. However, it was of significant concern to the review team that the patient was lost to follow up with a retained JJ stent. The review team noted that the patient was re-referred at 12 months and the patient had come to no harm. It was the opinion of the review team that if this patient was not referred back, this would have resulted in serious harm with a likelihood of an indefensible litigation due to a possible Serious Untoward Incident (SUI).

The review team considered that team working including communication and MDT discussions was acceptable and communication with the patient appeared to be appropriate in this case.

The review team found that the clinical record entries were clear, accurate and legible to an acceptable standard.

Case A31

Description

This 89-year-old male patient had a colonic operation to examine and biopsy the colon on 23 January 2020, after a previous major bowel cancer surgery (anterior resection) in 2015.

There was no urological involvement throughout the patient's clinical journey. Comments

The review team did not review this case further and no other comments were provided.

Case A32

Description

This 74-year-old male patient was referred by their GP on 20 March 2019 with a raised PSA of 8.6. Biopsies showed a Gleason Score of 4+3 prostate cancer and staging showed T3bNoMo prostate cancer (locally advanced without metastases).

The patient was discussed at MDT on 19 June 2019 with the involvement of clinical nurse specialists (CNSs). The patient's prostate cancer was treated with hormone blockade and radical radiotherapy in 2019. He was treated with curative intent with radiotherapy with a dose of 60Gy over 4 weeks.

The patient subsequently had LUTS and retention in 2020 which led to the patient having TURP on 21 September 2020.

Comments

The review team noted that the patient was adequately assessed, and their diagnosis was considered acceptable, and investigations undertaken were suitable to the patients' needs and were considered satisfactory.

The review team considered that the treatments undertaken were acceptable. It was the review team's opinion that the management of the patient's raised PSA in 2019 and the management of the subsequent LUTS and retention in 2020, were carried out appropriately. In addition, the review team highlighted the appropriate use of hormone blockade and radiotherapy.

The review team acknowledged that the patient was discussed at MDT in June 2019. The review team considered that there was positive involvement of clinical nurse specialists (CNSs) when the

case was discussed. The review team found team working and MDT communication to be acceptable.

It was of concern to the review team that, although the consent forms were written well and included detailed information, copies of the consent forms were not provided to the patient. The review team found patient consent had room for improvement.

It was of concern that the patient's clinical notes were poorly organised. The review team acknowledged that most of the information was included within the clinical record, however, they were filed in disarray. The review team considered that record keeping had room for improvement.

The review team considered that the patient's ongoing follow up was appropriate.

The review team concluded that this was a case with the TURP being the index operation, preceded by treatment for prostate cancer with radiotherapy and in their opinion, the overall quality of care provided to the patient was adequate.

Case A33

Description

This 51-year-old male patient was diagnosed with renal stone disease following a CT scan on 13 September 2019 which showed a 7mm left pelvi-ureteric junction (PUJ) stone in the kidney.

A stent was inserted on 14 September 2019.

The patient had an emergency admission 02 October 2019 with abdominal pain and haematuria.

On 17 February 2020, it was documented that there was a failed attempt to treat the stone by uteroscopy.

The patient was subsequently successfully treated by three sessions of ESWL between 25 February 2020 and 24 March 2020.

Comments

The review team considered that the patient's initial assessment at presentation with loin pain and stone at the left PUJ was acceptable.

In the review team's view, there was appropriate use of CT scans during the investigations, which was acceptable.

The review team were strongly of the opinion that the treatment provided to the patient was unacceptable. The review team did not concur with the decision to insert the initial stent rather than providing definitive laser treatment on 14 September 2019. In the review team's view, the failed attempt at URS to reach the stone on 17 February 2020 was due to the mid ureteric oedema preventing either the semi rigid or flexible URS getting to the stone which was compounded by the long delay between the two procedures. The review team considered that this was a difficult case made more challenging by the time between the initial and definitive attempts at treatment.

Furthermore, the review team highlighted that the GIRFT target is 6 weeks and the two procedures were undertaken five months apart. The review team considered that the case should have been discussed with the team in Wrexham if there were staffing problems in Bangor, and if this was viable, in the review team's view, the patient should have been referred to Wrexham for earlier surgery.

The review team noted that appropriate consent was carried out on 17 February 2020. In addition, the review team found communication with the patient to be acceptable.

The review team considered that the standard of record-keeping in the Bangor notes was poor and had room for improvement as there was no clarity of the filing processes which made the case difficult to review.

The review team were of the opinion that the patient's ongoing follow up was appropriate and that there was appropriate use of kidney, ureter and bladder (KUB) x-rays at follow up.

Case A34

Description

The review team were not provided with the clinical records for this case.

Case A35

Description

This 73-year-old male patient was seen in Bangor in 2008 with haematuria. The bladder biopsies undertaken indicated that the tumour was thought to be benign.

The patient was referred to Glan Clwyd in October 2017 and was seen in May 2018. The flexible cystoscopy investigations showed normal results.

The patient presented at the Glan Clwyd A&E with haematuria in April 2021. The patient underwent cystoscopy with biopsy under general anaesthetic, which indicated that the patient had stage G1pT1 bladder cancer. The patient had a resection and as the cancer progressed, the patient was discussed at MDT and was treated radically.

On 03 August 2021, it was recorded that that patient had stage T1G2 bladder cancer on pathology.

At an MDT review on 13 October 2021, it was decided that the patient needed to undergo TURBT urgently.

On 18 October 2021, the patient's haematuria had worsened and he was admitted at Glan Clwyd for the TURBT to treat their stage T1G3 transitional cell carcinomas (TCC).

A further MDT review suggested that the patient was referred back to Bangor for a possible cystectomy. However, the patient declined surgery at their KCE appointment on 17 November 2021.

In December 2021, the patient started chemotherapy and completed chemoradiation treatment in May 2022.

Comments

The review team noted that appropriate assessments were conducted in earlier visits to Bangor in 2008 and later in 2021 and during the visits to Glan Clwyd in 2017, 2018 and 2021.

In the review team's view, the investigations undertaken were suitable to the patients' needs and were considered satisfactory.

In the opinion of the review team, the patient was provided with prompt and sufficient treatment between 2021 and 2022.

The review team considered that team working, including communication and MDT discussions, was acceptable as the patient's detailed past history were documented in the MDT notes and there was good involvement of CNSs.

The review team noted that the decision from the second MDT review was to refer the patient back to Bangor for consideration of cystectomy. It was of concern to the review team that there was no documentation that the MDT advice had been discussed with the patient. It was only mentioned in the letter to the GP (which had not been copied to the patient) which stated that the patient did not want surgery. The review team were uncertain if the patient was provided with supporting information to enable shared decision-making, as the patient's preference appeared to be radical radiotherapy instead. Although the review team found that the consent forms were adequately completed, in the review team's opinion, patient communication had room for improvement.

It was the review team's view that record keeping had room for improvement as the filing of the notes was confusing. The review team found the notes were not correct filed and were placed in different sections.

The review team concluded that this was a difficult case that was managed adequately and no further follow up was required.

Case A36

Description

This 66-year-old male patient had complex comorbidities that included Type II Diabetes Mellitus, atrial fibrillation (AF[40]), coronary artery disease, chronic obstructive pulmonary disease (COPD[41]) and asthma. The patient also had a past history of urological treatment for BPH with a TURP undertaken in 2007.

The patient was diagnosed with bilateral renal stone disease and had left ESWL performed on 07 February 2020.

Comments

The review team considered that there was limited but adequate patient assessment for ESWL renal stone treatment.

In the review team's view, the investigations undertaken were suitable to the patients' needs and within the limitations of COVID-19 and its potential impact on a patient with comorbidities in early 2020. The investigations were considered satisfactory.

In the opinion of the review team, the patient was provided with prompt and sufficient treatment, which was managed well. The review team acknowledged that admission with urosepsis after a cystoscopy is a recognised complication.

The review team considered that team working including communication and MDT discussions was acceptable as the appropriate colleagues were consulted and a second opinion was obtained. The review team found good liaison between medical, A&E and urology doctors.

It was noted by the review team that the consent form was adequately completed, however a copy of the form was not provided to the patient, therefore, in the review team's view, patient consent had room for improvement.

The review team considered that record keeping was adequate within the limitations of old paper records.

[40] Atrial fibrillation is a heart condition that causes an irregular and often abnormally fast heart rate.

[41] Chronic obstructive pulmonary disease (COPD) is the name for a group of lung conditions that cause breathing difficulties.

It was concern to the review team that the patient is potentially still waiting for follow up from the referral on 04 December 2020. The review team considered that this patient requires follow up.

The review team concluded that this was a well-managed case, particularly in a patient with complex comorbidities and considering the impact of the COVID-19 pandemic in 2020. **Case A37**

Description

This 63-year-old male patient presented to the emergency department (ED) with 24-hour right loin to groin pain with ureteric colic on 19 March 2020.

A CT scan obtained in ED showed a 4.6mm stone. The patient was subsequently admitted to urology.

The patient's pain continued the following day, therefore, he was consented for stent insertion. On 20 March 2020, insertion of the right stent was undertaken.

The patient was listed for URS and stent change.

On 01 September 2020, it was documented that the patient had an encrusted stent and an oedematous ureter. URS was performed only to mid ureter.

The post-operation CT scan was clear with no stone seen.

The removal of the stent was undertaken on 25 September 2020.

The patient had follow up by telephone on 09 October 2020 where it was recorded that the patient was well and was subsequently discharged.

Comments

In the review team's opinion, the patient was adequately managed by the ED Team. It was noted by the review team that the patient was seen by a urology speciality registrar.

In the review team's view, the investigations undertaken were suitable to the patient's needs and were considered satisfactory. The review team acknowledged that the patient had a CT scan and a blood test and was reviewed twice, early on 20 March 2020.

The review team considered that there was excellent ward decision-making and the assessment for theatre was efficient. Furthermore, the patient had good anaesthetic assessment during the operation. However, it was of concern to the review team that there was a long delay in undertaking the second operation although patient fitness (high BMI) prevented a planned earlier operation in the private sector. It was noted by the review team that for 6 months the patient had their stent in situ and the stent was encrusted when the second operation finally took place. The review team highlighted that GIRFT recommends a 6-week target for second stone procedures where a stent is in situ. For this reason, it was the review team's opinion that the treatment provided to the patient was unacceptable.

The review team considered that team working, including communication and MDT discussions, was acceptable as the appropriate colleagues were consulted and a second opinion was obtained. The review team found there was good communication between the ED, the on-call registrar and the ward. In addition, the review team noted that the patient review on the ward and the documented plans for theatre were efficient. Furthermore, the review team considered that there was good involvement of the clinical biochemist, by giving the patient information on dietary advice to avoid further stones.

It was acknowledged by the review team that appropriate consent was obtained for the two operations, with the consent forms completed adequately. However, the review team were significantly concerned that a copy of the consent form was not provided to the patient on both occasions. The review team considered that there was good provision of information to the patient, regarding dietary advice to avoid stones in the future. Overall, the review team found patient consent and communication had room for improvement.

The review team found that the clinical record entries were of an acceptable standard, within the limitations of old paper notes. However, there was no operation note for the initial operation to insert the stent. The review team considered that record keeping had room for improvement.

The review team concluded that, with the exception of the delays highlighted, this was a wellmanaged case with sensible decision making and management. In the review team's view, no further follow up is required.

Case A38

Description

This 46-year-old female patient initially presented with loin pain in June 2017. The patient was diagnosed in August 2017 with left renal stone which was treated with ESWL that continued until early 2019, undertaking six treatments in total.

In September 2019, it was documented that lithotripsy failed and the patient had repeat imaging and was reviewed as an outpatient.

The patient was listed for URS and laser treatment in November 2019.

In March 2021, a URS obtained indicated that there were no significant stones seen.

The patient was subsequently discharged in August 2021.

Comments

The review team considered that the patient was adequately assessed, and their diagnosis was considered acceptable, and investigations undertaken were suitable to the patients' needs and were considered satisfactory.

The review team were of the opinion that the treatment of the left renal stone was adequate, initially by ESWL. However, in the review team's view, the failure of lithotripsy took too long to identify before there was a change in management plan. It was noted that failure of lithotripsy took 6 treatments over 12-18 months to identify. Earlier recognition of the failure of lithotripsy may possibly have reduced the duration of treatment and the number of interventions undertaken in this case. The review team therefore considered that the treatment provided to this patient had room for improvement. Nevertheless, the review team concluded that the management of the patient was satisfactory and ultimately resulted in a good outcome.

The review team considered that team working including communication and MDT discussions was acceptable and that patient communication was adequate.

The review team found that the clinical record entries were clear, accurate and legible to an acceptable standard.

Case A39

Description

This 67-year-old male patient had metastatic prostate cancer with an obstructed left kidney. The patient was treated with conventional stent in 2018 and subsequently with metallic stent, on an annual basis, between 2019 and 2022.

Comments

The review team considered that there was good pre-assessment undertaken on multiple occasions and the patient was adequately assessed.

The review team found limited information regarding pre-operative discussions with the patient about the use of the metallic stents. However, in the review team's opinion, the overall management appeared acceptable.

It was the review team's view that appropriate cancer treatment and treatment of ureteric obstruction were provided to the patient. The advanced metastatic prostate cancer was predominantly treated by medical oncology with hormone blockade, chemotherapy and radiotherapy. The review team considered that the treatments undertaken were acceptable.

The review team noted that appropriate MDT discussion took place on 28 March 2018. The review team considered that team working, including communication and MDT discussions, was acceptable.

The review team found communication with the patient had room for improvement. Consent forms recorded the benefits and potential complications, however they did not include the alternatives to treatment. It was also of concern to the review team that the consent forms were not consistently copied to the patient, for all multiple procedures that occurred between 2018 and 2022.

The review team considered that the clinical notes were clear, including detailed operation notes and good anaesthetic records. However, there were some missing outpatient notes that were not included in the patient's record, particularly, some urological follow-up notes which the review team acknowledged may be missing because of the patient visits involving both the private and the NHS sectors. In the review team's view, record keeping had room for improvement.

It was noted by the review team that the patient had ongoing follow up which appeared acceptable.

Case A40

Description

This 86-year-old male patient had a colectomy in 2013. Following the surgery, a right-sided hydronephrosis was identified and a JJ stent was inserted in February 2014.

The patient had regular and timely JJ stent changes thereafter every 6-8 months.

A metallic stent was inserted in 2018 and this was changed regularly every 12 months since.

Comments

The review team considered that the patient was adequately assessed, and their diagnosis was considered acceptable, and investigations undertaken were suitable to the patients' needs and were considered satisfactory.

In the opinion of the review team, the patient was provided with prompt and sufficient treatment and received satisfactory post-operative care. The review team were of the opinion that the postoperative reviews were adequately conducted and documented.

The review team considered that team working including communication and MDT discussions was acceptable and found communication with the patient appeared to be appropriate in this case.

The review team found that the clinical record entries were clear, accurate and legible to an acceptable standard.

The review team concluded that the overall quality of care was satisfactory.

Case A41

Description

This 50-year-old female patient had urodynamically proven stress urinary incontinence that had failed to improve with pelvic floor exercises. The patient underwent Bulkamid[42] injections in January 2020.

The patient also failed to benefit from that treatment and following MDT discussion was listed for an autologous fascial sling in July 2020.

Comments

The review team considered that this was a straightforward case of a patient with stress urinary incontinence that appeared to have been managed appropriately, although the first line treatment has failed. The review team acknowledged that the patient was still awaiting an autologous fascial sling, having been listed initially in July 2020.

The review team considered that the patient was adequately assessed, and their diagnosis was considered acceptable, and investigations undertaken were suitable to the patients' needs and were considered satisfactory.

In the opinion of the review team, the patient was provided with prompt and sufficient treatment and received satisfactory post-operative care.

The review team considered that team working including communication and MDT discussions was acceptable as the appropriate colleagues were consulted and an MDT discussion occurred following failure of the first treatment.

The review team found communication with the patient /their family and or carers appeared to be appropriate in this case.

The review team found that the clinical record entries were clear, accurate and legible to an acceptable standard.

The review team concluded that the overall quality of care was satisfactory.

Case A42

Description

This 66-year-old male patient, with an extensive past history of LUTS dating back to 1998, was diagnosed with interstitial cystitis and underwent multiple treatments with intravesical Cystistat.

In January 2020, the patient presented with a PSA of 4.4 and penile lesion.

In September 2020, it was recorded that the patient had circumcision, penile biopsy and prostate biopsy, all of which had negative results for malignancy. In the same month, the patient had

[42] Bulkamid is a minimally-invasive and long-lasting treatment option for bladder leaks caused by stress urinary incontinence (SUI).

testicular pain and undertook an ultrasound. It was documented that the pain settled with conservative treatment.

Comments

The review team considered that the patient was adequately assessed, and their diagnosis was considered acceptable, and investigations undertaken were suitable to the patients' needs and were considered satisfactory.

The review team considered that the treatment undertaken had been appropriate and noted the positive outcome for the patient.

The review team considered that team working including communication and MDT discussions were acceptable and communication with the patient appeared to be appropriate in this case.

The review team found that the clinical record entries were clear, accurate and legible to an acceptable standard and the review team concluded that the overall quality of care was satisfactory.

Case A43

Description

This 46-year-old male patient presented in December 2019 with left scrotal pain and was listed for left epididymectomy.

In January 2020 the patient underwent left epididymectomy with no complications recorded following the procedure.

Comments

The review team considered that the patient was adequately assessed, and their diagnosis was considered acceptable, and investigations undertaken were suitable to the patients' needs and were considered satisfactory.

The review team considered that the treatment undertaken had been appropriate and noted the positive outcome for the patient.

The review team found communication with the patient /their family and or carers appeared to be appropriate in this case.

The review team found that the clinical record entries were clear, accurate and legible to an acceptable standard.

The review team concluded that the overall quality of care was satisfactory.

Case A44

Description

This 55-year-old male patient with Klinefelter[43] syndrome was on testosterone replacement therapy.

[43] Klinefelter syndrome (sometimes called Klinefelter's, KS or XXY) is where boys and men are born with an extra X chromosome. Klinefelter syndrome - NHS (www.nhs.uk)

In October 2015, the patient had a raised PSA but a prostate biopsy showed negative results. The patient continued PSA which was monitored during follow up.

In March 2017, the patient had a template prostate biopsy which recorded negative results.

The patient was admitted in June 2017 with LUTS and testicular pain.

In November 2017, the patient declined having a TURP.

In May 2018, the patient was re-referred with testicular pain and subsequently had right epididymectomy in January 2020.

It was documented that in November 2020, the patient's LUTS was deteriorating and therefore the patient was prescribed medical therapy.

In October 2021, the clinical record stated that medical therapy failed to treat the LUTS and the patient was listed for TURP.

Comments

The review team considered that the patient was adequately assessed, and their diagnosis was considered acceptable, and investigations undertaken were suitable to the patients' needs and were considered satisfactory.

In the opinion of the review team, the patient was provided with prompt and sufficient treatment and received satisfactory post-operative care.

The review team considered that team working including communication and MDT discussions was acceptable and communication with the patient appeared to be appropriate in this case.

The review team found that the clinical record entries were clear, accurate and legible to an acceptable standard.

The review team concluded that this was a multidimensional case and considered that it was managed satisfactorily.

Case A45

Description

This 56-year-old male patient had an abnormal epididymal swelling and underwent a right epididymectomy in March 2020.

The ultrasound imaging was discussed at an MDT and surgery was discussed with the patient.

The histology proved to be a benign adenomatoid tumour.

There were no postoperative complications.

Comments

The review team considered that the patient was adequately assessed and their diagnosis was considered acceptable and investigations undertaken were suitable to the patients' needs and were considered satisfactory.

In the opinion of the review team, the patient was provided with prompt and sufficient treatment and received satisfactory post-operative care.

The review team considered that team working including communication and MDT discussions was acceptable.

It was noted by the review team that the surgery was adequately discussed with the patient.

The review team found that the clinical record entries were clear, accurate and legible to an acceptable standard.

The review team considered that this case appeared to have been managed appropriately with no obvious complications. The review team concluded that the overall quality of care was satisfactory.

Case A46

Description

This 65-year-old male patient was previously seen for lower urinary tract symptoms (LUTS) between 2019 and 2020.

The patient was referred by his GP on 21 July 2020 due to slowly rising PSA.

An MRI was obtained on 15 February 2021.

On 07 April 2021, the patient had template prostate biopsy.

Comments

The review team considered that the patient was adequately assessed, and the investigations undertaken were suitable to the patients' needs and were considered satisfactory. In addition, the review team noted that there was appropriate use of MRI scanning.

The review team considered that this case of slowly rising PSA was managed accordingly, with good discussion with the patient and change in management arranged efficiently as the clinical results changed. In the review team's view, there was appropriate use of template prostate biopsy.

The review team found that team working, including communication and MDT discussions, was acceptable as the appropriate colleagues were consulted.

The review team noted that communication with the patient was acceptable as clear information was provided to the patient. Furthermore, in the review team's opinion, patient consent was obtained appropriately and a copy of the consent form was given to the patient.

The review team considered that record keeping was acceptable. The outpatient notes and GP letter were clear and legible.

The review team concluded that this case was managed well, with appropriate plans for follow up arranged.

Case A47

Description

This 69-year-old male patient had rising PSA and was sent for prostate biopsies following a GP referral on 04 February 2020.

The first set of prostate biopsies were done transrectally on 16 September 2020 and the results were clear with no cancer. However, subsequent transperineal template biopsies undertaken on 20 May 2021 showed prostate cancer.

The patient was discussed at MDT on 09 June 2021.

The patient had ongoing post radiotherapy oncological care.

Comments

The review team considered that the patient was adequately assessed, and the patient was kept informed throughout.

In the review team's view, the investigations undertaken were suitable to the patients' needs and were considered satisfactory. The review team noted there was appropriate use of MRI and prostate diagnostic tests.

In the opinion of the review team, the patient was provided with prompt and sufficient treatment.

The review team considered that team working, including communication and MDT discussions, was acceptable with satisfactory MDT records from 09 June 2021. Furthermore, the review team noted good communication between the urologist and medical oncologists.

The review team found that communication with the patient was excellent as the patient was given treatment options and their decision was appropriately carried out. In addition, the review team highlighted good communication between the GP and the urologist. The review team considered that appropriate consent was obtained, with a copy of the consent form given to the patient.

The review team noted that the clinical record entries were clear, accurate and legible to an acceptable standard. However, the clinic letter was misfiled in the imaging section of the notes.

The review team concluded that this was a well-managed case of prostate biopsies leading to the appropriate management of prostate cancer. The review team acknowledged that follow up is ongoing and appeared appropriate.

Case A48

Description

This 78-year-old male patient had a long history in urology from 2011. The patient had multiple biopsies (in 2011 and 2013) and the transrectal ultrasound scan (TRUS[44]) biopsies results were benign. The patient also had template biopsies in 2015 and 2021, which were also benign.

The patient was referred with haematospermia (blood in the semen) with a moderately elevated PSA after previous prostate biopsies. The patient was found to have LUTS.

It was documented that the patient had several private practice consultations.

Comments

The review team considered that the patient was adequately assessed, and their diagnosis was considered acceptable. The review team noted that histories were taken efficiently and the details were explained to the patient.

In the review team's view, the investigations undertaken were suitable to the patients' needs and were considered satisfactory.

[44] A transrectal ultrasound scan (TRUS) is an examination of the prostate gland using ultrasound.

It was acknowledged by the review team that no specific operations were conducted other than biopsies and use of drug therapies such as Tamsulosin were prescribed for treatment. The review team considered that this was acceptable treatment.

The review team considered that team working, including communication and MDT discussions, was acceptable as the appropriate colleagues were consulted. The review team highlighted good participation by a number of different consultant urologists over the years.

The review team found communication with the patient, including consent, to be appropriate in this case.

The review team found that the clinical record entries were clear, accurate and legible to an acceptable standard.

The review team concluded that overall, the case was managed well and no further follow up was required.

Case A49

Description

This 75-year-old male patient had a raised PSA of 7.5 in February 2020.

In June 2020, it was documented that the patient had an MRI scan which showed a Prostate Imaging Reporting and Data System (PIRADS[45]) score of 5.

A template biopsy obtained in October 2020 showed negative results.

During a subsequent follow up, the patient's PSA fell to 2.1 and the patient was discharged in May 2021.

Comments

The review team considered that this patient had an appropriate but delayed assessment and investigations. It was of concern to the review team that there was an 8-month delay from presentation to having the prostate biopsy and MRI undertaken considering it should be a 2-week wait pathway. The review team were of the opinion that the assessment and investigations undertaken had room for improvement.

The review team considered that the treatment undertaken had been appropriate and noted the positive outcome for the patient.

The review team considered that team working including communication and MDT discussions was acceptable and communication with the patient appeared to be appropriate in this case.

The review team found that the clinical record entries were clear, accurate and legible to an acceptable standard.

Overall, the review team concluded that the management of this patient was appropriate although progress to their subsequent treatment was slow and severely delayed.

Case A50

Description

[45] PI-RADS is a rating scale for the likelihood that clinically significant prostate cancer is present. It is a 5-number system, from least likely to most likely. PI-RADS scores range from 1 (most likely not cancer) to 5 (very suspicious).

This 14-year-old male patient was admitted in A&E on 18 April 2021 at 20:23 hours with severe testicular pain. At 22:18 hours, the patient was seen by a registrar in A&E and was diagnosed with torsion of testis.

Due to rapid progression, the patient had an operation to have his testis removed (orchidectomy) on 18 April 2021 at 23:45 hours.

Comments

The review team considered that the patient was adequately assessed in A&E and their diagnosis was considered acceptable.

In the review team's opinion, the patient was appropriately taken straight to theatre without the need for further investigation, which could have delayed the treatment process.

In the opinion of the review team, the patient was provided with prompt and sufficient treatment and received satisfactory post-operative care. The review team highlighted that there was appropriate management in theatre by the registrar with a consultant scrubbed alongside them.

The review team considered that team working, including communication and MDT discussions, was acceptable as the appropriate colleagues were consulted and a second opinion was obtained. In particular, the review team found good team working during the patient's first admission and then later, when the patient was referred to a colleague for a testicular implant in 2022. In addition, the review team noted good collaboration between the registrar and the consultant during the operation.

The review team found communication with the patient, including consent, had room for improvement. Although the review team acknowledged that consent was obtained appropriately on both occasions, the first consent form was not copied to the patient or their parent. However, the patient and their parent were provided a copy of the second consent form.

The review team found that the clinical record entries were clear, accurate and legible to an acceptable standard. Specifically, the review team found all correspondence to be exceptional.

The review team concluded that this was a very well-managed emergency case and highlighted the appropriate use of theatres and good post-operative care provided to the patient. The review team considered that no further follow up is required.

Case A51

Description

This 15-year-old male patient presented in A&E on 21 October 2021 due to worsening left testicular pain and the patient had difficulty walking. It was documented that the patient was not vomiting and was subsequently prescribed paracetamol and morphine by a consultant.

At 20:47 hours on 21 October 2021, the patient was referred to surgeons. The patient was seen by a surgical SHO at 00:03 who sought advice from a registrar. The registrar reviewed the patient and organised an ultrasound scan with no further local investigation after diagnosis of orchitis was given.

The patient had an ultrasound scan on 06 November 2021 which showed there was no blood flow to the testis. The patient was subsequently diagnosed with testicular torsion and it was written in the notes that the patient and their parent understood the risk of a missed torsion.

The patient and their parent consented to the index operation (orchidectomy) which was performed on 06 November 2021.

Following the operation, it was recorded that the patient had insertion of testicular prosthesis.

Comments

The review team considered that the initial clinical assessment in A&E was inadequate. In the review team's opinion, the ultrasound scan should have been undertaken during the first admission and not delayed for three weeks. In addition, the patient was incorrectly diagnosed with orchitis which the review team found unacceptable. However, the review team acknowledged that the later diagnosis of testicular torsion was managed well by urologists on 06 November 2021.

It was of significant concern to the review team that no local investigation was undertaken during the previous A&E visit in October 2021 and that the patient was misdiagnosed with orchitis with a plan for ultrasound carried out 3 weeks later. In the review team's view the request for an ultrasound was reasonable considering the patient's long history of pain, however, this should have been obtained on the first admission. The review team considered that the lack of investigation was unacceptable.

In the opinion of the review team, the patient was provided with sufficient treatment and received satisfactory post-operative care since their admission in November 2021. The review team noted that the urology management between November 2021 and October 2022 was acceptable, with plans for theatre and subsequent arrangement of a testicular prosthesis appropriate.

The review team considered that team working, including communication and MDT discussions, was acceptable as the appropriate colleagues were consulted. The review team highlighted that the case was managed well by junior doctors and consultants.

The review team found communication with the patient, including consent, was unacceptable. The consent from the earlier visit was unacceptable as it was not copied to the patient and their parents. Although the review team noted that consent was obtained appropriately during the second admission, a copy of the consent form was not provided to the patient and his parents. In addition, the review team questioned if there was a duty of candour to tell the patient's family about the earlier mistaken diagnosis when the patient was re-admitted in November 2021. The review team highlighted that it was not acceptable to just write in the notes that the patient and parent understood the risk of a missed torsion.

It was concerning to the review team that the patient was incorrectly diagnosed with orchitis during their earlier visit to A&E in October 2021. The review team were strongly of the opinion that this should be investigated by the Health Board and the Duty of Candour would require that the patient and their parents were made aware of the initial mis-diagnosis. The review team discussed this case with the Urology Network Manager in Wrexham during the review visit in November 2022 and made him aware of this concern.

In the review team's view, record keeping was acceptable in this case.

The review team did not identify any concerns with the patient's admission in November 2021. The review team considered that the patient received appropriate follow up after their admission in November 2021. Furthermore, in the opinion of the review team, the subsequent outpatient management and insertion of testicular prosthesis was also managed well.

Case A52

Description

This 79-year-old male patient had superficial bladder cancer for more than 15 years resulting in multiple admissions for cystoscopies and cystodiathermy. In addition, the patient had Mitomycin intravesical chemotherapy in 2017 and BCG intravesical treatment in 2021.

On 20 September 2021, there was evidence of more serious disease with squamous differentiation in the biopsies and previous low/intermediate grade cancer becoming high grade (G3) bladder cancer. Furthermore, a CT scan undertaken in September 2021 showed abnormality in the left ureter.

The patient was admitted for ureteroscopy and biopsy on 14 December 2021 which showed high grade cancer in the ureter and recurrent bladder cancer.

An MDT review occurred on 05 January 2022 for symptomatic treatment and consideration of palliative radiotherapy in the future.

The patient sadly died on 11 February 2022.

Comments

The review team considered that the patient was adequately assessed, and their diagnosis was considered acceptable, and investigations undertaken were suitable to the patients' needs and were considered satisfactory.

In the opinion of the review team, the patient was provided with prompt and sufficient treatment, particularly, treatment with cystoscopies, biopsy and resection as required over the years and the subsequent ureteroscopy and biopsy on 14 December 2021. In addition, the review team considered that appropriate intravesical chemotherapy and BCG were also given.

The review team considered that team working including communication and MDT discussions was acceptable. The review team highlighted good team working with clinical nurse specialists.

The review team noted that consent obtained was acceptable.

The review team found that the clinical record notes were poorly presented and difficult to navigate. In particular, the notes were poorly filed, making assessment of consent challenging to review.

The review team concluded that the overall management of this case appeared appropriate. The review team acknowledged that this was a complex case with multiple admissions over more than 15 years with the patient's superficial bladder cancer becoming progressively more severe.

Appendix C – Service overview information

Prior to the review visit, the Health Board was asked to complete the following 'service overview form' for each of the three sites. The information presented below is what was provided.

Information requested	Number	Additional notes
Local information for Ysbyty Gwynedd (YG) – West Site		

Catchment population	186,300	To note, this is ONS data, and doesn't include where some regions access services on different sites. For example, the catchment for some of West will include some Conwy region patients and some Gwynedd patients will be covered by East due to the geography. This is also the case for conveyancing boundaries for emergency care. The ONS data is not available at postcode level, which would have made it slightly easier to calculate.
Sites providing specialty service	On call on all 3 sites	
Personnel numbers		
Consultant Surgeons within specialty service	6	KA – substantive MA – substantive MT – NHS Locum SK – NHS Locum KD – NHS Locum 1 vacant post
Surgeons within wider team	N/A	
Surgical registrar posts		No number trainee posts assigned to YG
Junior doctors supporting the service	1 CT 2 FY's 1 Physician Associate	
Details of on-call		
Consultant surgeon on-call	1:6	weekly on call (internal cover for vacant post)
Surgical registrar oncall	1:5	(appropriate adjustment for daytime activities)

Facilities		
Service dedicated ward beds	4 within surgical ward templates	Number of wards these are spread between Current position not template
ICU beds	2020 – 11 2021 - 12	For all specialties
HDU beds		The above is combined ITU & HDU
Theatres used by the service	1	5 full day sessions per week
Inpatient elective lists per week		Mixed lists
Day case elective lists per week		Mixed lists
Emergency lists per week	7	full day lists shared across all specialties
New patient clinics per week	Approx. 25 per wk	Mixed clinics
Follow up clinics per week	As above	
Activity numbers per year for the past two years		
Outpatients seen	New: 2020 – 1072 2021 – 883 Review: 2020 – 3820	January to December 2020 & 2021
	2021 – 4101	

Acute admissions	2020 – 4078 2021 – 5121	January to December 2020 & 2021
Elective admissions	2020 – 3612 2021 - 4612	January to December 2020 & 2021
Number of patients undergoing surgery – specify total and number of emergency, inpatient and day case procedures	2020: Emergency – 297 Day cases – 3047 2021: Emergency – 296 Day cases – 3716	January to December 2020 & 2021
18 week breaches	2020 – 1110 2021 – 1409	December 2020 & 2021 – Month end snapshots
Patients on elective waiting list	2020 – 109 2021 – 44	December 2020 & 2021 – Month end snapshots; DSU Stage 4 validated data
Clinical governance arrangement for the past two years		
MDT meeting frequency	Weekly	Wednesday AM
Time scheduled for MDTs	10am – 11am	How many cases are typically discussed? Average 17 patients
Average consultant surgeon MDT attendance (%)	4	No quorum

M&M meeting frequency	8 sessions per yr	Clinical Governance
Time scheduled for M&M		How many cases are typically discussed? As per agenda item approx. 3 – 4 cases
Average consultant surgeon M&M attendance (%)		As per Clinical Governance attendance
Number of audit days last year	8 sessions	Are staff free of clinical commitments for these? Yes commitment free
Time scheduled for audit days	4 x full day 4 x half day	
Other regular governance meetings	Fortnightly Business Meetings	
National databases submitted to	BAUS National Prostatectomy Audit	
Complaints, incident reporting and SUIs in the last two years Central		
Number of incidents	291	1 Catastrophic 1 Major 17 Moderate 65 Minor 207 Negligible
Number of SUIs	1	1 investigation ongoing (INC277607)
Number of patient complaints	58	31 on the spot 19 formal • 2 Grade 1 • 9 Grade 2 • 5 Grade 3 • 3 Grade 4 7 MP Enquiries
Number of never events	0	Current investigation status for each

Information requested	Number	Additional notes
Local information for Ysbyty Glan Clwyd (YGC) Centre Site		
Catchment population	210,600	To note, this is ONS data, and doesn't include where some regions access services on different sites. For example, the catchment for some of West will include some Conwy region patients and some Gwynedd patients will be covered by East due to the geography. This is also the case for conveyancing boundaries for emergency care. The ONS data is not available at postcode level, which would have made it slightly easier to calculate.
Sites providing specialty service		Pan-BCU Urology Cancer Pathway is managed by Central, where USC Prostate and Kidney referrals are sent to a Centralised Inbox. The Covid-19 pathway dictates that patients are reviewed at the North Wales MDT and patients are prioritized for surgery in Central initially. If Capacity cannot be provided by Central, patients are outsourced to English Providers UCLH (Prostate pathway) and Royal Free London (Kidney pathway).
Personnel numbers		
Consultant Surgeons within specialty service		KCE – Clinical Lead – Substantive VS - Substantive
Surgeons within wider team		OF – Locum Consultant
Surgical registrar posts		Mr T – ST3 Mr N – Specialty Doctor Mr E – Specialty Doctor Mr O – Specialty Doctor Mr M – Agency Locum covering vacant post

Junior doctors supporting the service		Dr E – FY2 Dr S – FY1
Details of on-call		
Consultant surgeon on-call	1:4	2 vacant posts on the on-call rota, awaiting Locum starting, we do not have consultant of the week and only one consultant on-call per day
Surgical registrar on-call	1:5	Out of hours is non – resident
Facilities		
Service dedicated ward beds		Number of wards these are spread between
ICU beds	2020 – 13 2021 - 13	These figures are combined ITU and HDU
HDU beds	As above	
Theatres used by the service	1	1x Theatre (Theatre B) 4 daily lists per week. Emergency Theatre available on a shared basis daily.
Inpatient elective lists per week	4	Mixture of Inpatient and Day case
Day case elective lists per week	4	Mixture of Inpatient and Day case
Emergency lists per week		Shared lists
New patient clinics per week	10	On average, 69 patients per week.
Follow up clinics per week	7	On average, 59 patients per week
Activity numbers per year for the past two years		
Outpatients seen	New 2020 – 2579 2021 – 3501 Review 2020 – 4774 2021 - 5058	
Acute admissions	2020 – 2404 2021 - 2797	
Elective admissions	2020 – 1616 2021 - 2029	

Number of patients undergoing surgery – specify total and number of emergency, inpatient and day case procedures	Total 2020 – 1865 2021 – 2074 Emergency 2020– 454 2021– 372	
	Day case 2020– 1178 2021- 1431	
18 week breaches	Dec 2020 – 2025 Dec 2021 – 2763	All DSU Stages
Patients on elective waiting list	Dec 2020 – 806 Dec 2021 - 770	
Clinical governance arrangement for the past two years		
MDT meeting frequency	Weekly	Wednesday AM
Time scheduled for MDTs		How many cases are typically discussed? 14-16 patients
Average consultant surgeon MDT attendance (%)	100%	Always a Consultant Urologist on MDT
M&M meeting frequency	6 weekly	Discussion is part of the Monthly Clinical Governance meeting. Clinical Governance dates are set by BCU M&M is a regular standard agenda item
Time scheduled for M&M		How many cases are typically discussed? This varies each month depending on need, M&M is discussed in the 6 weekly governance meetings
Average consultant surgeon M&M attendance (%)		Urology in central budget for 4 substantive consultants currently 2 substantive, 1 NHS Locum and 1 Vacancy. Other than annual leave the expectation is that consultants will attend

Number of audit days last year	4 full days and 4 half days	Are staff free of clinical commitments for these? Yes all grades of clinicians are job planned to attend
Time scheduled for audit days	As above	Are these typically whole or half days?
Other regular governance meetings	Clinical Governance – 6 weekly Urology Business Meeting – Twice Monthly. Consultant Meetings as flexible approach as required	
National databases submitted to	BAUS	
Complaints, incident reporting and SUIs in the last two years		
Number of incidents	229	2 – Catastrophic 3 – Major 12 - Moderate 30 – Minor 182 - Negligible
Number of SUIs	None provided	
Number of patient complaints	208	130 – Early Resolution (On The Spot) 70 – Formal Complaints 8 MP Enquiry
Number of never events	None provided	

Information requested	Number	Additional notes
Local information for Ysbyty Wrexham Maelor - East Site		
Catchment population	290,100	To note, this is ONS data, and doesn't include where some regions access services on different sites. For example, the catchment for some of West will include some Conwy region patients and some Gwynedd patients will be covered by East due to the geography. This is also the case for conveyancing boundaries for emergency care. The ONS data is not available at postcode level, which would have made it slightly easier to calculate.

Sites providing specialty service	Acute/Elective	Acute/Elective
Personnel numbers		
Consultant Surgeons within specialty service	5	All Consultants are substantive IS CS CP BJ MYA
Surgeons within wider team	4	Trust Contacts JI RK HS HA
Surgical registrar posts	1	RJ (Trainee ST7) – Deanery – Mersey
Junior doctors supporting the service	X 1 FY1 Academic X 1 FY2 X 3 SHO	FY1 – Trainee FY2 – Trainee X 3 Clinical Fellows
Consultant surgeon on-call	1-5	6th week covered by internal locums individual days
Surgical registrar on-call	1-4	24 hour on call; at present 5th Registrar shadowing on call
Facilities		
Service dedicated ward beds	16	
ICU beds	12	
HDU beds		The above is combined ITU & HDU
Theatres used by the service	1	Not dedicated majority of procedures are Urology.
Inpatient elective lists per week	10	
Day case elective lists per week	3	
Emergency lists per week	7	NCE POD list shared amongst all specialties.

New patient clinics per week	12	
Follow up clinics per week	10	
Activity numbers per year for the past two years		
Outpatients seen	New 2020 - 3445 2021 – 3634 Review 2020 – 6209 2021 - 6408	January to December 2020 & 2021
Acute admissions	2020 – 1499 2021 - 1775	January to December 2020 & 2021
Elective admissions	2020 – 862 2021 – 1149	January to December 2020 & 2021
Number of patients undergoing surgery – specify total and number	2020 – 1156 2021 – 1462	January to December 2020 & 2021
of emergency, inpatient and day case procedures	Emergency 2020 – 345 2021 - 375 Ordinary Add 2020 – 1953 2021 – 2070 Daycase 2020 – 554 2021 – 775	
18 week breaches	Dec 2020 – 1983 Dec 2021 - 2847	December 2020 & 2021 – Month end snapshots All DSU Stages
Patients on elective waiting list	Dec 2020 – 556 Dec 2021 - 557	December 2020 & 2021 – Month end snapshots DSU Stage 4's – validated data
Clinical governance arrangement for the past tw o years		
MDT meeting frequency	Weekly	Tuesdays

Time scheduled for MDTs	4 hours	5 cases
Average consultant surgeon MDT attendance (%)	80%	Attendance required when not on leave.
M&M meeting frequency	Monthly	On Audit Day
Time scheduled for M&M	1 hour	
Average consultant surgeon M&M attendance (%)	80%	Attendance required when not on leave.
Number of audit days last year	8	All staff are free from clinical commitments
Time scheduled for audit days	5-7 hours	50% of each
Other regular governance meetings	(Business mee	ting arranged on Audit Day)
National databases submitted to	Prostate cance	r database
Complaints, incident reporting and SUIs in the la		**st two years**
Number of incidents	92	Incidents by grading.xlsx
Number of SUIs		
Number of patient complaints	63	Complaints listed by type.xlsx
Number of never events	0	

Appendix D – Documents received during the review

The following items of documentation were provided to the review team before, during or after the review visit. It is requested that the healthcare organisation responsible for commissioning the review retains a copy of all items of documentation for its own records, and to be in a position to make it available on request and to comply with information access requests. Once the RCS England issues the report, it will not keep a copy of this information indefinitely.

- Job Plans – pdf files
  - JobPlan - Dr Mohamed Abdulmajed - 16.02.2021
  - JobPlan - Mr Basharat Jameel - 30.06.2021
  - JobPlan - Mr Chirag Patel - 09.03.2021 (1)
  - JobPlan - Mr Christian Seipp - 22.04.2021
  - JobPlan - Mr Iqbal Singh Shergill - 16.04.2021 (1)
  - JobPlan - Mr Kingsley Chinedu Ekwueme - 12.12.2018 (1)
  - JobPlan - Mr Krassen Donev - 01.06.2020
  - JobPlan - Mr Kyriacos Alexandrou - 25.02.2020
  - JobPlan - Mr Mohamed Yehia Abdallah - 19.04.2021
  - JobPlan - Mr Mohanarangam Thangavelu - 17.12.2018
  - JobPlan - Mr Oladapo Olugbenga Feyisetan - 26.08.2022 (2)
  - JobPlan - Mr Shanmugasig Kannan - 28.12.2018 (1) ➢ JobPlan - Mr Vaikuntam Srinivasan - 01.07.2020 (1)

- Waiting list position
- AUA 2021 J Urol Abstract
- BCU Urol Peer Review Report Jun 2017
- Board committee structure V 0.1
- Clinical services strategy V1.1_post Board
- Prostate pathway bid
- QS21.141a Urology Review
- QS21.141b Urology Appendix 1
- RCS additional questions request – Excel
- RCS Maelor V2
- RCS review data YG Sept 2022
- SIR INC210834
- SIU Abstracts journal - assessment of haematuria and smoking
- SIU abstracts Journal TRUS
- Urology Business Case 17.1.20

Appendix E – List of interviewees

The following individuals were interviewed as part of this invited review. The RCS England provided guidance on who it considered relevant to the Terms of Reference and the individuals listed were selected by the healthcare organisation that commissioned this review.

Mohamed Yehia Abdallah	Urology Consultant – East YWM
Mohamed Abdulmajed	Urology Consultant/Cancer – West YG
Kyriacos Alexandrou	Clinical Lead/Urology Consultant – West YG
Gareth Arndt	Charge Nurse – East YWM
Anwen Castleman	Interim Theatre Manager – West YG
Stephan Clements	Consultant Anaesthetist – West YG
Andrew Davies	Senior Nurse BCUHB Reg Treatment Ctr Prog
Lara Davies	Uro-oncology Clinical Nurse – Centre YGC
Professor Kingsley Ekwueme	Clinical Lead/Urology Consultant – Centre YGC
Elaine Hodgeson	DGM – Centre YGC
Amy Hughes	Theatre Matron – East YWM
Byron Hughes	Deputy Team Leader – West YG
Caroline Hughes	Lead Manager – Centre YGC
Stefan Hugo	Consultant Anaesthetist – Centre YGC
Heather James	Oncology Clinical Nurse Specialist – Centre YGC
Llio Johnson	Lead Manager – West YG
Fran Jones	Interim Theatre Manager – East YWM
Richard Jones	ST7 - East YWM
Michelle Jones	Team Leader – Centre YGC
Ashok Kailasa	Locum Middle Grade – West YG
Shanmugasigamani Kannan	Locum Urology Consultant – West YG
Magdy Khater	Consultant Anaesthetist – Centre YGC
Keri Lavelle	Site Specialty Manager – East YWM
Dr Nick Lyons	Executive Medical Director
Karen Millen	Deputy Ward Manager – West YG
Karen Mottart	Acting Deputy Executive Medical Director Consultant in Anaesthesia & Intensive Care Medicine
Chirag Patel	Urology Consultant/Governance Lead
Martin Pike	Consultant Radiologist
Dafydd Pleming	Acting DGM – West YG

Jennifer Pratt	Sister UDU – Centre YGC
Kelly Price	Nurse Practitioner – East YWM
Joanne Roberts	Surgical First Assistant – Centre YGC
Ben Sasi	Consultant Anaesthetist – East YWM
Professor Iqbal Shergill	Clinical Lead/Urology Consultant – East YWM
Amy Smith	Ward Manager – West YG
Samantha Smyth	Nurse Practitioner – East YWM
Vaikuntam Srinivasan	Urology Consultant – Centre YGC
Dino Tedaldi	Urology Network Manager
Mohanarangam Thangavelu	Locum Urology Consultant – West YG
Keeley Twigg	DGM – East YWM
Caroline Williams	Cancer Network Manager
Linda Williams	Uro-oncology Clinical Nurse Specialist – West YG
Claire Wilson	Unit Manager/Clinical Nurse Specialist – West YG

Appendix F – Royal College Review Team

Mark Speakman FRCS **The Royal College of Surgeons of England**

Mark was appointed consultant urological surgeon at Musgrove Park Hospital, Taunton in 1990 after training in London, Bath, Oxford and Glasgow. He developed a busy practice in benign and malignant (cancerous and non-cancerous) prostate disease, incontinence (urinating involuntarily), children's urology and andrology (men's health), publishing over 140 papers and co-authoring books.

Mark has been a member of British Association Urological Surgeons' Council, was honourable treasurer of the association (2003-2005) and was elected as vice-president of British Association of Urological Surgeons (BAUS), becoming president in June 2014. He was also on the editorial board of the British Journal of Urology. At Musgrove Mark was previously clinical director for surgery (95-00) and was associate medical director from 2004 to 2009. He has also been the director of research and development for the hospital and is a specialist advisor to the National Institute for Health and Care Excellence (NICE).

Ian Eardley FRCS — **The British Association of Urological Surgeons**

Ian has been a Consultant Urological Surgeon in Leeds since 1993, having trained in Cambridge, Portsmouth, St Bartholomew's and Norwich. He specialises in andrology, reconstruction of the urinary tract and genital surgery. He has written over 200 peer review publications and chapters and has edited or written 8 textbooks on various aspects of Urology. He was an Associate Editor of the Journal of Sexual Medicine for 10 years and has been recently appointed as an Associate Editor of the British Journal of Urology International.

He has served as Director of the BAUS Office of Education, Chairman of SAC in Urology, President of the European Society for Sexual Medicine, Chairman of the Joint Committee for Surgical Training and was Vice President of the Royal College of Surgeons of England until July 2018. He is the current Chairman of Council of the Medical Protection Society. In 2014 the British Association of Urological Surgeons awarded him the St Peter's Medal for his contributions to Urology.

Susan Hynes — **RCS Lay Reviewer**

Sue is a healthcare lawyer by background and has worked in both the public and private sectors. She is currently working in a non-practising role as an investigator of healthcare incidents.

GETTING IT RIGHT FIRST TIME

Urology Review

January 2023

Betsi Cadwaladr University Health Board

This report has been produced by the Getting It Right First Time (GIRFT) Project Team at the Royal National Orthopaedic Hospital (RNOH/GIRFT). It aims to reduce unwarranted variation with the adoption of the HVLC/GIRFT principles to ensure best outcomes for patients and maximising the use of existing resources and assets.

Written by:

Kieran O'Flynn: GIRFT Joint National Urology Clinical Lead, Consultant Urological Surgeon, Northern Care Alliance.

John McGrath: GIRFT Joint National Urology Clinical Lead, Consultant Urologist (Royal Devon University Healthcare NHS Foundation Trust), Honorary Senior Lecturer (University of Exeter Medical School).

Table of Contents

1. Executive Summary

The visit to Betsi Cadwaladr University Hospital (BCUHB) took place on Thursday 3rd November 2022. The engagement from senior clinicians was limited by the clinical demands of the service in each of the three hospitals. There was no representation from any of the executive team from BCUHB.

BCUHB is faced with an existential threat to the urology provision including an increased and unmet demand for urology services, long waiting lists for diagnosis and treatment and an understaffed workforce with a shortage of both fully accredited medical and nursing staff. The absence of a clear management plan within BCUHB to support the urology services across the three hospitals has had a demotivating effect on the urology staff who are undoubtedly frustrated by the failure to make any significant progress on a number of issues that have been well signposted over the past few years.

There is now an urgent need for senior management in the Health Board to collaborate with Urologists in producing and enacting a recovery plan for the specialty. Much of the urological practice can now be delivered in outpatients, so there is a pressing need to develop functioning Urological Investigation Units (UIU) to provide a base for developing modern working practices and developing both the nursing and medical workforce. Urgently progressing the UIU model has the potential to deliver more urology services to patients on an outpatient basis and reducing the use of inpatient and day-case beds. The Health Board will need to consider whether this should be delivered on more than two sites to meet the needs of the population and the geographical challenges.

The current provision of oncological surgery (radical prostatectomyand nephrectomy in its various forms) has resulted in a post code lottery of provision, whereby many patients are referred to other units outside Wales, which is not in the best interests of patients who currently have to travel long distances for treatment. This needs to be reviewed again, ensuring that any model which emerges is provided by appropriately trained consultants, with access to suitable facilities (including robotic provision), supported by a dedicated nursing team. Services predicated on a single surgeon lack resilience and are unlikely to be robust.

Service managers at Wrexham Maelor are undoubtedly working hard to address problems with service provision, but until recently we were told that the level of senior executive support has been poor. A failure to rapidly address the problems outlined will inevitably result in the collapse of urological services, the demise of the current (albeit unsatisfactory on-call system) and the loss of staff. This in turn will have a major impact on patient care throughout the hospitals in BCUHB. Unfortunately given the lack of direction and support shown by the Health Board management to date with respect to urology service provision, recruiting new staff will be a formidable challenge.

In the context of the reconstituted service across BCUHB (in effect a Urology Area Network model), consideration should be given to future planning for the provision of acute and elective Extracorporeal Shock Wave Lithotripsy (ESWL) for stone management and the provision of Percutaneous Nephrolithotomy (PCNL) on a single site and surgical management of bladder outflow obstruction. Developing a subspecialty practice in the surgical management of Benign Prostatic Hyperplasia (BPH) may in turn be attractive to new appointees.

Developing a directory of services with other partners and advancing the functionality of the Urology Area Network across the three hospitals will require buy-in from both senior clinicians and management, supported with dedicated Programmed Activity (PA) time and operational support to effect changes in the service.

The current ad hoc arrangements for onward referral for specialised treatment should be

solidified, ensuring that there are clear pathways and processes for patients who need specialist surgical care including andrology and urogynaecology.

RNOH/GIRFT have made several cross cutting and priority recommendations within this report. We believe the implementation of these recommendations is essential if the Health Board is to deliver robust and durable urology services effectively and safely for patients in the short, medium, and long term. We strongly believe that is the best way to make a significant reduction to waiting lists. We request that the Health Board Executive Team provide a response to these recommendations which are all high priority. A table of the recommendations is at **Annex A**. We have also provided a number of useful links to GIRFT Urology good practice documentations in **Annex B.**

To address implementation of all the recommendations we also make the following cross-cutting recommendation.

Recommendation 1: BCUHB to set up a Task and Finish Group to develop an action plan to implement the GIRFT recommendations and allocate responsibilities to relevant people to share the workload. The Task and Finish Group should meet regularly to provide an update on the progress made against each recommendation. RNOH/GIRFT will also continue to provide implementation support for 6 months.

2. Introduction

Getting It Right First Time (GIRFT) is a national programme in England designed to improve patient care, by reducing unwarranted variations in clinical practice. GIRFT helps identify clinical outliers and best practice amongst providers, highlights changes that will improve patient care and outcomes and delivers efficiencies (such as the reduction of unnecessary procedures) and cost savings.

Working to the principle that a patient should expect to receive equally timely and effective investigations, treatment and outcomes wherever care is delivered, irrespective of who delivers that care, GIRFT aims to identify approaches from across the NHS that improve outcomes and patient experience.

3. Background

The GIRFT Projects Directorate at the Royal National Orthopaedic Hospital (RNOH/GIRFT) was approached by BCUHB, to conduct a review of Urology Services using the GIRFT methodology and High Volume Low Complexity (HVLC) principles.

The ambition of the programme is to help BCUHB to urgently restore urology services to the maximum levels possible and identify examples of innovative, high quality and efficient service delivery in the system. The programme looked at areas of unwarranted variation in clinical practice and/or divergence from the best evidence-based care. It aims to assess whether the Health Board is using their existing resources and provisions effectively and is delivering the best outcomes for patients.

4. Programme Objectives

By tackling variations in the way services are delivered across the NHS, and by sharing best practice between trusts, GIRFT identifies changes that:

- focus on system and organisation level to take out **unwarranted variation** in access to care and the outcomes of care
- deliver efficiencies and cost savings
- **drive for 'top decile'** GIRFT performance of outcomes, productivity and equity of access
- **standardise procedure-level clinical pathways** agreed across all providers developed by 'expert advisory panels' supported by professional societies
- inform the **potential establishment of a surgical hub** for high volume elective procedures
- **agree principles** for working across clinical and operational groups e.g. theatre principles
- Leave a **legacy of sustainable quality improvement** by working in partnership with your clinical, operational and analytical teams so that you are able to continue implementation and track progress at the end of our work with you.

5. Urology Programme in BCUHB

The RNOH/GIRFT team conducted a programme of data analysis, followed by a "deep dive" engagement with BCUHB, delivered by the joint urology leads, Kieran O'Flynn and John McGrath. This report details the findings and recommendations arising from the data analysis and deep dive engagement and is a companion document to the GIRFT data pack.

RNOH/GIRFT carried out a webinar in April 2022, which provided BCUHB colleagues with information about the RNOH/GIRFT Urology BCUHB Programme and gave an overview on how Elective Recovery is being delivered across England.

A pre-visit questionnaire, completed by each hospital, requested supplementary data that we were unable to obtain from the BCUHB data extract. The questionnaire asked the hospitals to provide information on the current workforce provision, emergency care provision, on call provision, intervention radiology provision, one-stop clinics, virtual outpatient services, and multidisciplinary team meetings and to describe any strategies in development for the urological service.

6. BCUHB Background

BCUHB provides both acute and elective Urology services at the Ysbyty Gwynedd in Bangor, Glan Clwyd and Wrexham Maelor. The population served by the three hospitals is approximately 750,000. There are three urology departments located at the three hospitals, all of which function largely independently.

This report covers the first GIRFT urology visit to North Wales, which included a short visit to each of the three hospitals' Urology departments and a deep dive with members of the extended Urology team and management on 3rd November 2022. Unfortunately, there was no member of the senior executive team or BCUHB Board members present.

The data provided in the report are based on data extracts directly from BCUHB data analysts to GIRFT analysts, with comparator metrics from England being provided by Model Hospital metrics (NHS England - Model Hospital). The datapack comprises metrics on the hospitals' activity from April 2019 to March 2020 and it is understood that much has changed in the interim, including resignations of consultant staff. In a number of instances, the urology team felt that the data did not accurately reflect their practice.

Recommendation 2: BCUHB consultants to meet regularly with their coding colleagues to ensure that accurate data is being recorded.

7. Workforce

The BCUHB Urology workforce provision is detailed in **Annex C**.

Glan Clwyd currently has two substantive consultants, one consultant is on retire and return and does not do on-call. Each unit remains understaffed with respect to Urology Clinical Nurse Specialist (CNS) support, also detailed in Annex C; this has a major impact on the functioning of the unit. With the exception of Wrexham Maelor, there is limited CNS provision in diagnostics with respect to the provision of flexible cystoscopy, flexi cystoscopy and botox, or flexi cystoscopy and laser ablation as shown in **Annex D**. Such arrangements are standard across the majority of units in England, where these services are provided in a dedicated outpatient setting / UIU.

Each hospital would like to support the development of new consultant appointments in urology. The development of a functioning Urology Area Network (UAN) model was effectively paused at the onset of the Covid pandemic; in the interim little progress has been made and the service remains reliant on locum appointments. Given the current working conditions with a significant on-call burden, the limited subspecialty practice and the failure to develop specialist nursing, it is difficult to see how the hospitals comprising BCUHB will attract high calibre consultant Urologists in the future.

Nationally, it is estimated that there are approximately 120 unfilled consultant posts in urology in England. As only 50 National Training Numbers (NTN) exit training each year with a

Certificate of Completion of Training in urology, there is an undersupply and consultant recruitment for many trusts is challenging. Units with less than eight consultants have particular difficulty attracting new consultants, largely because of onerous on-call arrangements and often a limited subspecialty practice. BCUHB and its associated hospitals are approaching a tipping point with its overreliance on a locum workforce and the anticipated retirement and relocation of consultants in the near future.

Recommendation 3: BCUHB should adopt a more networked model of care if they want to maintain a resilient and viable long-term urology service for BCUHB. The provision of Urgent and Emergency Care (UEC) will need to be one of the priority areas for consideration as it represents a major barrier to recruitment.

8. Outpatients and Diagnostics

The consultants at Wrexham Maelor undertake triage of outpatient referrals and offer a limited advice and guidance service (there is no equivalent online service comparable to the NHSE portal).

The facilities for outpatient assessment in urology are reasonable at each of the three sites but are constrained by the lack of space and suitable consultation and treatment rooms.

In Ysbyty Gwynedd, the lack of space means that it is not possible to provide a contemporary trans-perineal prostate cancer diagnostic service as the allocated room is required for flexible cystoscopy and haematuria / recurrent bladder tumour assessments. As a consequence, there is a long waiting time for prostate cancer diagnostics due to inadequate facilities and understaffing.

In Wrexham Maelor, the consulting, diagnostic and therapeutic facilities are located at different sites around the hospital with no current UIU provision.

At Glan Clwyd, there is a dedicated urology outpatient facility, one of the rooms in the outpatients has a lithotripter which is currently used only once a week; more outpatient work could be delivered if it could be relocated. This issue is explored further in the report below. A second room at Glan Clwyd in the outpatients is being used to disinfect / sterilize flexible equipment including flexible cystoscopes, flexible ureteroscopes (for theatre) and choledochoscopes for use in general surgery. The sterilising unit is old and requires replacing. Taking this element of the service out of the Urology unit could potentially free up more space for outpatients.

Recommendation 4: BCUHB to urgently develop functioning Urological Investigation Units at all three hospitals in order to provide a base for developing modern working practices and developing both the nursing and medical workforce. Urgently progressing the Urology Investigation Unit model has the potential to deliver more urology services to patients on an outpatient basis and reducing the use of in-patient and day-case beds.

The relatively low staffing levels in the urology department are undoubtedly a source of real pressure. The number of Specialist Nurses is particularly low, given the Health Board's size and population (see Annex C). The nurses work exceptionally hard, largely concentrating their work on oncology provision with little dedicated CNS provision for 'benign urology.' The nurses are under-supported by secretarial services and have little support with admin and many have to do their own letters, eroding clinical time.

Recommendation 5: BCUHB should review the role and responsibilities of the specialist nurses and make plans to improve their numbers and their involvement in diagnostic

and therapeutic pathways. **This requires significant expansion in all sites and there is a need to review the administrative burden that currently affects the team. Specialist nursing expertise could be deployed more effectively if this inappropriate workload was addressed.**

There is a definite sense that both the nursing and medical urology team feel under-supported in this setting. The current model does not serve the specialty well as most units nationally have, or are in the process of transitioning to, a UIU type model, where flexible cystoscopy, laser ablation, urodynamics and local anaesthetic prostate biopsy can be provided by the Urology team comprising medics and CNSs with a special interest.

Throughout the country, urology has largely morphed into an outpatient specialty, where with appropriate and modern practices, patient can be rapidly seen and assessed without recourse to day-case or inpatient attendance. If implemented effectively, a functioning UIU can have a dramatic effect on the number of patients requiring day-case procedures or overnight stays. It is estimated that only 1:12-14 patients seen in UIU will then require some form of admission.

There should be a strong focus on one-stop models of consulting, often using a nurse-led or physicians' associate led model. This should be applied to high volume areas such as haematuria and lower urinary tract symptoms. The recommendations are in line with the Richards report on development of diagnostic facilities in England: NHS England » Diagnostics: Recovery and Renewal – Report of the Independent Review of Diagnostic Services for NHS England.

None of the three units offer transurethral ablation of bladder lesions (TULA). Investment in a dedicated handheld laser at each of the three sites would enable access to flexible cystoscopy and laser ablation of small bladder tumours, avoiding the necessity for repeat visits or a day-case procedure. Many units nationally have found this investment to be worthwhile with significant cost savings (for example, a contact diode laser costs approximately £10,000). The development of a TULA service has the potential to significantly reduce the requirement for day case cystoscopy and biopsies and treatment of small bladder lesions. As services nationally transition from day case to outpatient delivery, it is important that mechanisms are in place to record this significant activity.

Recommendation 6: All departments in BCUHB should implement TULA services. It is low cost and offers an outpatient treatment to what are often elderly and co-morbid patients as well as a rapid release of theatre capacity.

There remain significant pressures with the 'Trial without Catheter' (TWOC) service in outpatients. Improving this element of the service, with timely access would enable more patients to be put on day surgery pathways (see below) and avoid long lengths of stay.

Recommendation 7: BCUHB urology team to prioritise a review of the TWOC service, to ensure it is resourced appropriately with a Standard Operating Policy (SOP) across the three hospitals.

The diagnostic pathway for patients suspected of having prostate cancer is not optimal. Patients referred with a high Prostate Specific Antigen (PSA) and suspected prostate cancer are generally first seen in outpatients and then referred for a prostate MRI scan. The pathway is delayed due to limited access to MRI, delays in reporting and frequent delays in accessing transrectal biopsy (TRUS) / transperineal biopsy (LATP) in outpatients and delays in pathology reporting. Whereas both Ysbyty Gwynedd and Wrexham Maelor have largely transitioned to LATP, TRUS remains the default option for cancer diagnosis at Glan Clwyd. The appointment

of a prostate cancer navigator and an agreed pathway has the potential to shorten the pathway and enable an upfront MRI prior to first appointment for those patients who meet the criteria.

Recommendation 8: BCUHB to improve the pre-investigation of patients attending the departments, especially those on suspected cancer pathways. A priority area would be those patients needing mpMRI of the prostate.

9. Elective Care

When compared to Model Hospital data for England, the day case rate for transurethral resection of bladder tumour (TURBT) is a below the England average at 19%. The current English national benchmark performance is 44%. There is no information on Mitomycin treatment at the time of resection, although there were acknowledged difficulties in delivering this effectively. The reasons cited include lack of personnel, training, pharmacy and theatre staff resistance and interference with the day-case pathway. The BCUHB average length of stay for TURBT is 2.2 days; the current England average 1.8 days.

Recommendation 9: BCUHB to review the transurethral resection of bladder tumour pathway. TURBT should be considered a 'day case by default' pathway with exclusions applying to those patients with significant co-morbidities (unstable ASA 3 and above) and those with large tumours.

There is scope for significant improvement with day case rates across the 'sentinel' procedures referred to in the RNOH/GIRFT data pack (exemplars being TURBT and bladder outlet surgery), which should help relieve the pressure on inpatient beds. Ideally, suitable patients should have their intravesical chemotherapy performed by the surgeon at the end of the procedure in theatre with a TWOC later that day, prior to discharge. Further improvement should be possible if the right facilities are provided and the philosophy regarding 'day case as default' is built into the booking rules for these procedures and the pathways are supported by a dedicated nursing team.

The current provision of day case surgery for bladder outflow obstruction is extremely limited across the region with the exception of Wrexham Maelor. The benchmark for England is 26%. For bladder outflow obstruction treatment, Ysbyty Gwynedd and Glan Clwyd currently only has access to bipolar TURP.

Wrexham has considerable experience in Holmium Laser Enucleation of the Prostate (HoLEP) and receives referrals from across the region. In addition, day case Urolift and Rezum are offered but these procedures are generally only performed for local patients at present. While the average length of stay was in the mid- range for England, 14.3 % patients were readmitted within 30 days (highest decile for England).

Men awaiting bladder outlet surgery represent the largest patient cohort nationally on the urology waiting list. There is an emerging consensus that patients should have access to all suitable options.

Within the Urology network comprising the three hospitals of BCUHB, it should be seen as one of the priorities for the Health Board to facilitate the implementation of these technologies to support elective recovery and to future-proof the service, recognising that it may not be practicable for all modalities to be offered by a single hospital and that a network solution may be optimal for patients and thus avoid a postcode lottery for them. This should include the adoption of HOLEP within the network in addition to Urolift and /or Rezum. The department and Health Board should refer to the recently published GIRFT Academy guidance on the bladder outlet pathway: Urology_2021-12-10_Guidance_Outpatient-transformation.pdf (gettingitrightfirsttime.co.uk) and may also find the recently released Medical Technology

Funding Mandate (MTFM) guidance for England of interest (NHS England » MedTech Funding Mandate policy 2022/23: guidance for NHS commissioners and providers of NHS-funded care).

Recommendation 10: BCUHB should agree on a networked provision of services for men needing bladder outlet surgery. The team at Wrexham Maelor have the greatest experience of HoLEP and the novel MIS therapies. Patients should be able to access the most appropriate treatment within the region.

By contrast, the three hospitals in BCUHB have good use of day surgery for ureteroscopy. For those patients who are admitted, lengths of stay are higher than those seen in England at 2.9 days (versus 1.7 days in England).

10. Emergency Care

In common with other urology departments in England, each hospital appears to have seen an increase in the number of patients admitted with urological conditions. The on-call arrangements for each hospital are summarised in **Annex E.**

At Wrexham, the consultants now utilise a consultant of the week model with a daily ward-round, with provision for a hot clinic, triage and some advice and guidance provided to GPs. There is a full tier of middle grade cover. At both Ysbyty Gwynedd and Glan Clwyd, the consultants continue with their normal work while being on-call. Ward rounds are often provided by different consultants each day which can impair continuity of care. There is general acknowledgement that with a properly functioning consultant of the week model that inpatient stays are shorter. Without such an arrangement, there will be fewer consultant led ward-rounds and this is likely to have a detrimental effect on the length of inpatient stay for patients with common urological conditions.

Recommendation 11: BCUHB departments need to consider how they move towards a consultant of the week model in order to optimally deliver urgent and emergency care. The loss of elective activity will need to be mitigated by expansion of the non-medical workforce and the incorporation of activities that improve the efficiency of the service (referral triage, advice and guidance, hot clinics and regular senior review of inpatients).

Overall, emergency theatre access is poor with limited access to a laser enabled theatre across the three hospital sites (allied with a shortage of consultants who can be freed up to do the procedures). For patients admitted as an emergency with a diagnosis of a urinary tract stone, the use of primary ureteroscopy is limited and there is virtually no use of primary ESWL, although this is recommended in current NICE guidance. Where surgical intervention is required, the patient should routinely be offered early definitive treatment with either lithotripsy or ureteroscopy. At present, this aspect of the service is deficient.

Recommendation 12: BCUHB to improve access for patients requiring acute stone treatments. A 'book and return' model with ring-fenced slots at one or more units in the region could facilitate 'hot' ureteroscopy. A fixed-site lithotriptor, with daily access for urgent and elective cases, would likely be cost effective and clinically superior to the current model. It could be argued that this should be at Wrexham Maelor where more complex stone surgery is going to be centralised.

The pathways for patients admitted with urinary retention and then needing bladder outflow surgery do not function well. Although there is provision for TWOC in an outpatient setting, the pathways are not clear, and many patients appear to be having recurrent TWOC before a definitive decision is made regarding surgery. Patients with indwelling catheters are known to

frequently present with catheter blockages, UTIs and occasionally urosepsis. It is important that their surgical care is appropriately expedited.

Recommendation 13: All relevant units in BCUHB should develop a Trial without Catheter (TWOC) pathway for the more expeditious assessment of patients with urinary retention.

Access to interventional radiology is essentially limited on each site to normal working hours. There are no formal arrangements for out-of-hours interventional radiology cover and no service level agreement with neighbouring Trusts in England. The urgent management of acutely unwell patients needing interventional radiology is ad hoc at present and this represents a significant clinical risk.

Recommendation 14: BCUHB to ensure the deficit of the out of hour's interventional radiology provision is featured prominently on the Corporate Risk Register with urgent steps taken to address this issue.

11. Oncology

The current arrangements for major oncological surgery are shown in **Annex F** and are derived from the pre-visit questionnaire.

Radical cystectomy is currently provided at Ysbyty Gwynedd for the three hospitals with the service reliant on a single surgeon. There was no data available from the datapack between April 2019 and March 2020, but it is estimated that 48 procedures were performed between September 2020 and October 2022, following the appointment of a substantive consultant. There were no concerns expressed in relation to the functioning of the regional oncology cancer MDT with respect to cystectomy.

An outreach oncology clinic is provided by the surgeon from Ysbyty Gwynedd. Ideally the service should be supported by two trained surgeons to be resilient.

Recommendation 15: BCUHB to review the cystectomy service. This service requires recruitment of a second surgeon with expertise in Radical Cystectomy (or who could be trained in Radical Cystectomy).

Provision of Laparoscopic Radical Prostatectomy (LRP) is currently predicated on a single surgeon operating at Glan Clwyd. Approximately 33 procedures were performed between April 2019 to March 2020. The England average for a unit delivering Radical Retro-pubic Prostatectomy (RRP) is 150.

Patients requiring RRP from across the Health Board are currently managed on a central register. Due to the numbers involved and constraints on the service, a majority of patients requiring RP are then referred to University College of London Hospital (UCLH) where they undergo Robotically-Assisted Radical Prostatectomy (RARP). Patients seen at Glan Clwyd are more likely to be retained locally, whereas patients originally assessed at either Ysbyty Gwynedd or Wrexham Maelor are more likely to be sent out of the country for treatment (most commonly UCLH and occasionally Royal Liverpool University Hospital or University Hospital North Midlands). We are told that there is a current contract with UCLH costing the Health Board approximately £750,000 for provision of services.

Up to now the provision of RRP is via Laparoscopy (LRP), whereas in England and most other (Organisation for Economic Co-operation and Development) OECD countries, the services has largely transitioned to robotic prostatectomy (RARP).

The Welsh government has recently purchased an operating robot (Versius system, CMR Surgical), which is based at Ysbyty Gwynedd, but to date we are told that it has not been used. The Versius system has largely been used for intra-abdominal rather than pelvic surgery. In England and elsewhere, all RARPs are performed using the DaVinci system. Clinical consensus in the UK is that the Versius system is unlikely to be appropriate for RARP. The overall requirement for RRP for the Health Board is likely to be in the region of 120-150 cases per year and to ensure resilience the operative practice requires at least 2 surgeons specialising in RALP, with back-up support from a properly staffed nursing and administrative team.

Case volume per surgeon is currently recommended to be at least 50 per year in England (https://www.england.nhs.uk/publication/specialised-kidney-bladder-and-prostate-cancer-services-adults/).

Recommendation 16: BCUHB to consider reviewing the radical retro-pubic prostatectomy service. There is potential to re-patriate the radical retro-pubic prostatectomy service into BCUHB given the volume of patients being referred out of region. However, there would be significant challenges in doing so. It would require investment in a DaVinci robotic platform and the appointment of suitably trained individuals. There is existing expertise in LRP and this individual could consider further development of their surgical practice into robotics.

Both open and laparoscopic nephrectomy are provided at both Ysbyty Gwynedd and Glan Clwyd. Approximately 23 nephrectomy procedures were performed largely by one surgeon at Ysbyty Gwynedd in the last year, comprising 15 laparoscopic cases and the remainder open nephroureterectomy or open radical nephrectomy. Patients requiring partial nephrectomy are referred from Ysbyty Gwynedd outside Wales. Patients from Wrexham Maelor are referred to either the Royal Free Hospital, London or The Christie NHS Foundation Trust, Manchester. Across the UK, robotic nephrectomy is becoming established as the standard operative technique with specialised units providing robotic partial nephrectomy and robotic nephroureterectomy. It is likely that nephroureterectomy will be done robotically as standard in the future, further decreasing the requirement for open surgery.

Recommendation 17: BCUHB should initiate a discussion regarding the current viability of the service and future provision of nephrectomy across the area. The minimum requirement in the future should be based on at least two to three trained surgeons providing the range of robotic and open procedures with appropriate governance and oversight. There should ideally be a single centre in terms of the case volumes that are likely to be undertaken. At present, Ysbyty Gwynedd would be the centre with the greatest expertise and experience.

12. Management of Stones

For 2019-20, each of the departments did some percutaneous stone surgery. The numbers were small and the largest unit providing the service is at Wrexham Maelor. As numbers of PCNL procedures in the UK have declined over the past few years, largely due to better quality of flexible ureteroscopies and laser technology. Given the complexity of PCNL, it would seem appropriate to consolidate the service on a single site at Wrexham Maeolor. This arrangement would have broad clinical support and should be introduced alongside a network MDT, with clinicians from all three units so that only appropriate patients have to travel for the service.

Both Wrexham Maelor and Ysbyty Gwynedd have a visiting lithotripter which visits twice a month. Glan Clwyd has a static lithotripter used once a week, based in the urology outpatients. In essence, the Health Board is paying for three separate services, with little evidence of

efficacy or cost effectiveness. There was some concern expressed by the clinicians regarding the efficacy of the fixed site machine at Glan Clwyd and a reluctance to refer suitable patients for lithotripsy there. There is virtually no use of semi acute ESWL (endorsed by NICE guidance) across the three sites.

Recommendation 18: BCUHB should establish a formal stone MDT. There are opportunities for improvement within a Urology Area Network (UAN), with the formal establishment of a stone MDT comprising surgeons from across the three hospitals in the UAN. Auditing the outcomes of the static ESWL service would enable a decision to be made regarding its future use and following consultation a decision could then be reached as to where the machine should be sited. Ideally this should be co-located with a service that has an expressed interest in stone management. There are a number of examples nationally where a fixed site machine provides a rapid and effective service across a wide geographical footprint.

13. Women and children's services

The departments currently provide little in the way of services for women with urinary stress incontinence, the majority if the work being done by the Urogynaecologists or referred onwards. There is some surgery offered by the urology team in Wrexham in the form of mid-urethral bulking and autologous slings. There is no outpatient provision of flexible cystoscopy delivery of botox at either Ysbyty Gwynedd and Glan Clwyd, for reasons related to the availability of suitable outpatient treatment rooms and supporting staff. In many UK units, this service is now undertaken by trained Urology nurse practitioners. Patients who require cystoscopy and botox are currently managed as day cases in both Ysbyty Gwynedd and Glan Clwyd, consuming valuable theatre time and resources. The service is underprovided for the treatment of women with urinary stress incontinence although the RNOH/GIRFT team were interested to hear that the ban on mesh insertion (England and Scotland) for urinary stress incontinence does not apply in Wales. The numbers of urinary stress incontinence procedures being done by a particular urology unit should be sufficient to maintain expertise in this area of practice, supported by audit and appropriate governance arrangements, given the significant litigation emerging across the British Isles. Provision of female and functional urology should be delivered in the context of a joined-up service across the three hospitals, working with the urogynaecologists and a functional MDT.

Paediatric urology is being provided by Wrexham Maelor. This is likely to prove popular in the event that urology trainees rotate through the unit from the deanery as there is a shortage of general urological paediatric training nationally.

14. Andrology and Reconstruction

The provision of andrology (particularly surgery for Peyronnie's disease) is limited across the region and the vast majority is performed at Wrexham Maeolor where there is a subspecialty practice in andrology. This includes the provision of surgery for Peyronnie's disease, penile prosthesis insertion, artificial sphincter insertion and straightforward urethroplasty. The numbers being done by a particular urology unit should be sufficient to maintain expertise in this area of practice and provision of surgical andrology should be addressed in the context of a joined-up service across the three hospitals.

Annex A

Table of BCUHB Recommendations

No.	Recommendations
1	BCUHB to set up a Task and Finish Group to develop an action plan to implement the GIRFT recommendations and allocate responsibilities to relevant people to share the workload. The Task and Finish Group should meet regularly to provide an update on the progress made against each recommendation. RNOH/GIRFT will also continue to provide implementation support for 6 months.
2	BCUHB consultants to meet regularly with their coding colleagues to ensure that accurate data is being recorded.
3	BCUHB should adopt a more networked model of care if they want to maintain a resilient and viable long-term urology service for BCUHB. The provision of Urgent and Emergency Care (UEC) will need to be one of the priority areas for consideration as it represents a major barrier to recruitment.
4	BCUHB to urgently develop functioning Urological Investigation Units at all three hospitals in order to provide a base for developing modern working practices and developing both the nursing and medical workforce. Urgently progressing the Urology Investigation Unit model has the potential to deliver more urology services to patients on an outpatient basis and reducing the use of in-patient and day-case beds.
5	BCUHB should review the role and responsibilities of the specialist nurses and make plans to improve their numbers and their involvement in diagnostic and therapeutic pathways. This requires significant expansion in all sites and there is a need to review the administrative burden that currently affects the team. Specialist nursing expertise could be deployed more effectively if this inappropriate workload was addressed.
6	All departments in BCUHB should implement TULA services. It is low cost and offers an outpatient treatment to what are often elderly and co-morbid patients as well as a rapid release of theatre capacity.
7	BCUHB urology team to prioritise a review of the TWOC service, to ensure it is resourced appropriately with a Standard Operating Policy (SOP) across the three hospitals.
8	BCUHB to improve the pre-investigation of patients attending the departments, especially those on suspected cancer pathways. A priority area would be those patients needing mpMRI of the prostate.
9	BCUHB to review the transurethral resection of bladder tumour pathway. TURBT should be considered a ‘day case by default’ pathway with exclusions applying to those patients with significant co-morbidities (unstable ASA 3 and above) and those with large tumours.
10	BCUHB should agree on a networked provision of services for men needing bladder outlet surgery. The team at Wrexham Maelor have the greatest experience of HoLEP and the novel MIS therapies. Patients should be able to access the most appropriate treatment within the region.
11	BCUHB departments need to consider how they move towards a consultant of the week model in order to optimally deliver urgent and emergency care. The loss of elective activity

	will need to be mitigated by expansion of the non-medical workforce and the incorporation of activities that improve the efficiency of the service (referral triage, advice and guidance, hot clinics and regular senior review of inpatients).
12	BCUHB to improve access for patients requiring acute stone treatments. A 'book and return' model with ring-fenced slots at one or more units in the region could facilitate 'hot' ureteroscopy. A fixed-site lithotripter, with daily access for urgent and elective cases, would likely be cost effective and clinically superior to the current model. It could be argued that this should be at Wrexham Maelor where more complex stone surgery is going to be centralised.
13	All relevant units in BCUHB should develop a Trial without Catheter (TWOC) pathway for the more expeditious assessment of patients with urinary retention.
14	BCUHB to ensure the deficit of the out of hour's interventional radiology provision is featured prominently on the Corporate Risk Register with urgent steps taken to address this issue.
15	BCUHB to review the cystectomy service. This service requires recruitment of a second surgeon with expertise in Radical Cystectomy (or who could be trained in Radical Cystectomy).
16	BCUHB to consider reviewing the radical retro-pubic prostatectomy service. There is potential to re-patriate the radical retro-pubic prostatectomy service into BCUHB given the volume of patients being referred out of region. However, there would be significant challenges in doing so. It would require investment in a DaVinci robotic platform and the appointment of suitably trained individuals. There is existing expertise in LRP and this individual could consider further development of their surgical practice into robotics.
17	BCUHB should initiate a discussion regarding the current viability of the service and future provision of nephrectomy across the area. The minimum requirement in the future should be based on at least two to three trained surgeons providing the range of robotic and open procedures with appropriate governance and oversight. There should ideally be a single centre in terms of the case volumes that are likely to be undertaken. At present, Ysbyty Gwynedd would be the centre with the greatest expertise and experience.
18	BCUHB should establish a formal stone MDT. There are opportunities for improvement within a Urology Area Network (UAN), with the formal establishment of a stone MDT comprising surgeons from across the three hospitals in the UAN. Auditing the outcomes of the static ESWL service would enable a decision to be made regarding its future use and following consultation a decision could then be reached as to where the machine should be sited. Ideally this should be co-located with a service that has an expressed interest in stone management. There are a number of examples nationally where a fixed site machine provides a rapid and effective service across a wide geographical footprint.

Annex B

Links to GIRFT Urology Pathways and Good Practice Guidance

To access the documentation, please click on the links below.

1) NHS England - Model Hospital
2) GIRFT National Urology Report
3) Diagnostics: Recovery and Renewal Report.
4) MedTech Funding Mandate policy 2022/23: guidance for NHS commissioners and providers of NHS-funded care
5) Day case surgery rates
6) GIRFT Good Practice Guide for Urology
7) Clinically-led Specialty Outpatient Guidance
8) Urology Outpatient Transformation
9) Urology: Towards better care for patients with bladder cancer
10) Urology: Towards better care for patients with acute urinary tract stones
11) Urology: towards better care for patients with bladder outlet obstruction
12) Urology: the path to recovery
13) Specialised kidney, bladder and prostate cancer services.
14) Minor peno-scrotal surgery pathway
15) Cystoscopy plus (rigid cystoscopy, endoscopic lower urinary tract procedures)

Annex C

Urology Staffing for BCUHB by Hospital

Profession	Band	Ysbyty Gwynedd	Glan Clwyd	Wrexham Maelor
Consultant		5.00	4.00	5.00
Associate Specialist				-
Staff/Grade		4.00	4.00	-
Registrar				6.00 (mixture of middle grade and registrars)
Nursing	Band > 8c and above			-
	Band 8b			-
	Band 8a	1.00		2.00
	Band 7	1.87	1.00	2.00
	Band 6	2.56	1.00	1.00
	Band 5	2.24	2.60	
Pre-registration	Bands 2-4 e.g. Care navigator, Nurse associate, clinical support worker	4.82	1.8	2.00
Physician Associate		1.00		
Surgical Care Practitioner			0.80	

Annex D

Nursing Independent Practice across BCUHB

	Ysbyty Gwynedd	Glan Clwyd	Wrexham Maelor
Flexible Cystoscopy			Y
Flexible Cystoscopy and laser ablation			
Flexible cystoscopy and botox			Y
Male lower urinary tract symptoms	Y		
TRUS and/or LA transperineal biopsy			Y
Prostate cancer surveillance	Y	Y	Y
Renal cancer surveillance		Y	
Stone clinic			Y
Andrology	Y	Y	Y
Continence, tuition in ISC, TWOC clinics	Y	Y	Y
Provision of intravesical chemotherapy	Y	Y	Y

Annex E

On call and Emergency care arrangements

	Ysbyty Gwynedd	Glan Clwyd	Wrexham
On call consultant arrangements	Full timetable of elective work	Full timetable of elective work	Reduced elective activity to allow review of all patients (4/3 split) HOT clinic one afternoon
Urology middle grade cover	24/7	General surgery SHO first on call, urology middle grade and consultant 24 hours on call 7 days a week	24/7
Interventional Radiology	Office hours only	Does not exist	Office hours only
Access to generic acute theatre (incl laser)	Access to generic acute theatre with **limited** facilities for urological procedures	Access to generic acute theatre with **limited** facilities for urological procedures	Y*
Comments			*Waiting sign-off on theatre nurse training Trauma centre in Stoke

Annex F

Current Provision of Major Oncological Surgery in BCUHB by Hospital

	Ysbyty Gwynedd	Glan Clwyd	Wrexham Maelor
Radical nephrectomy	Y	Y	N Some nephrectomy patients will go to Royal Free and some partial nephrectomy to Manchester
Partial nephrectomy	N	Y	Patients referred to Royal Free or The Christie Manchester
Cystectomy	Y	N	To Ysbyty Gwynnedd at Ysbyty Gwynedd
Radical prostatectomy*	N almost all YG patients referred outside North Wales (UCLH, Arrowe Park)	Y	To Glan Clywd or UCLH

*Majority of patients requiring radical prostatectomy are transferred to other hospitals outside Wales. There is a current SLA with University College Hospital in London

	Director Lead: Executive Medical Director	**Date Opened:** 6 December 2023 **Date Last reviewed:** 10 January 2024
		Urology Improvement Group Urology Review Group National Urology CIN T&I pathways redesign programme Task and Finish groups
	Risk: Urology Special Measures	**Date of Committee Review:**
		Target Risk Date:

There is a risk that Urology services in North Wales are unsustainable within the current operating model, resulting in the inability of the Health Board to deliver timely and appropriate care to the population of North Wales. As detailed in the RCS and GIRFT reviews, there is a need to develop a provision within a network model to ensure that the service achieves the recommendations from external reviews and complies with national/professional guidance.

Root causes include the inability to recruit to consultant posts, the lack of specialist knowledge for cancer pathways, issues with access to estates and a lack of clinical leadership.

If the actions within the Urology Improvement Plan are not achieved, the ability to mitage the known risks will not be possible, which could have an adverse impact on patients access to the service in North Wales, as well as the reputuation of the Health Board.

This may be caused by (reason): -

R1 - OOH on call - YGC fragile, YG and WXH sustaining a 1:5/6 with locum provision (There is currently a risk register entry for each site).
R2 - MDT - Lack of clinical leadership for a Pan BCU Cancer MDT; the current format doesn’t provide a Pan-BCU forum and the lack of specialist knowledge within the meeting (i.e. regards Cystectomy/Nephrectomy/Prostatectomy) does not allow for robust decision making.
R3 - Cystectomy Service - No provision in North Wales, ad-hoc case by case provision supported by ABUHB.
R4 - Nephrectomy Service - No provision in North Wales, all service provision supported with external contracts.
R5 - Prostatectomy Service - Limited Laparoscopic Prostatectomy provision at YGC, no robotic provision in North Wales.
R6 - Robotic Provision – The current robotic platform, procured and commissioned by the All Wales Robotics Network, does not support prostatectomy procedures.
R7 - No Pan-BCU Urology Network Clinical Lead.

R8 - No Pan-BCU Cancer Lead.
R9 – Ability to provide appropriate clinical faciilities and investment in equipment to meet RCS/GIRFT recommendations.
R10 – Mortality & Morbidity – Lack of assurance regarding governance and oversight of clinical practice and learning.
R11 – Deskilling of current workforce due to losing specialist services, which are now delivered outside of BCU.
R12 – Difficulty in recruiting to provide a sustainable cancer service.

This may result in (consequence by score order) : -

C1 - Increased financial expenditure - **Likelihood 5 Consequence 5 = 25**

- Budget level info <5% over agreed budgets – M9 position for Urology PAYE budgets across BCU over spent by £1,654,144 which translated to a 26.1% overspend. M9 position for Urology Consultant PAYE (Consultant Substantive, Locum and Agency Consultants) across BCU over spent by £1,020,901 which translates to a 46.4% overspend.
- Robotic programme – Repatriation of Urological RAS pateints was supposed to fund the CMR RAS contract, WG funding reduces to £157.5k in 24/25 of the annual £525k contract BCU signed up to for 7+1+1+1 years

C2 - Reputational impact - **Likelihood 4 Consequence 5 = 20**

- The service has recently undergone two external reviews, both of which advise that the service, especially the on-call, requires change. This would indicate significant public and government interest if the document and known risks are not addressed.

C3 - OOH on-call - YGC fragile, YG and WXH sustaining a 1:5/6 with locum provision (There is currently a risk register entry for each site) - **Likelihood 4 Consequence 5 = 20**

- There are currently signifant operational challenges to deliver the three on-call rotas, alongside this is the strategic view that a sustainable service is not the current model and change is required as detailed in the RCS and GIRFT reports.

C4 - Delayed patient care (Inability to meet targets for cancer diagnosis and treatment)-**Likelihood 5 Consequence 3 = 15**

- Delays in meeting milestones within the cancer pathway (biopsies, surgery)
- Overdue patients on the follow-up waiting list
- Extreme waits beyond 208w

C5 - Failure to deliver care closer to home - **Likelihood 3 Consequence 4 = 12**

- Due to service changes, cystectomy, RAS prostatectomy and nephrectomy specifically, patients are now receiving treatment in London, the North West of England and South Wales.

C6 - Difficulty in recruiting to provide a sustainable cancer service - **Likelihood 3 Consequence 3 = 9**

- As the service provision has now been commissioned to other providers there is no core team to start to rebuild cancer services in North Wales.

C7 - Poor staff morale and wellbeing - **Likelihood 2 Consequence 3 = 6**

- There is staff dissatisfaction due to the reduction in staff and the inability to recruit. If this situation continues and other staff leave then the consequence will rise as wider service disruption will increase.

C8 - Poor patient experience/Increase in concerns/litigation (Survey) - **Likelihood 2 Consequence 3 = 6**

- At present the number of concerns, incidents and litigation is fairly low.

C9 - Poor patient outcomes including death **Likelihood 1 Consequence 5 = 5**

- The likelihood of a patient death is rare, linked to the risks identified but the consequence is catastophic.

Graph		Impact	Likelihood	Score
	Inherent Risk Rating			
	Current Risk Rating			
	Target Risk Score (Risk Appetite – *select low, moderate or high level)*			
	Movement in Current Risk Rating Since last presented to the Board in	*Increased/Decreased/unchanged (delete)*		

Controls in place	**Assurances**
R1 - High use of locum provision R3 - Outsource of service, case by case, whilst commissioning discussions take place. R4/5 - Anuual commissioning of service in place R6 - Commission of RAS prostates to UCL R7 - OMD currently supporting with CL input	BUSIN CLINIC FINANC GOVERN MEDIC STAFF OPERAT REGCOM REP SAFETY WORKF

Links to	
Strategic Priorities	**Principal Risks**
Quality, Safety and Experience Committee	2004

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score						

Teitl adroddiad: ***Report title:***	Board Assurance Framework			
Adrodd i: ***Report to:***	Quality, Safety and Experience Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 18 April 2024			
Crynodeb Gweithredol: ***Executive Summary:***	The purpose of this report is to provide Committee with information and assurance of the management of two risks identified, as a requirement of a completed Board Assurance Framework (BAF) but in relation to the 23/24 Annual Plan Organisational Deliverables			
Argymhellion: ***Recommendations:***	The Committee is asked to note and **receive assurance** on the management of two BAF risks to which it has accountability for.			
Arweinydd Gweithredol: ***Executive Lead:***	Pam Wenger, Director of Corporate Governance			
Awdur yr Adroddiad: ***Report Author:***	Nesta Collingridge, Head of Risk Management			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: **BAF risks to be reviewed and aligned to Objectives** ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:N/A***				

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

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

Introduction/Background

1. The purpose of this report is to provide the Quality, Safety and Experience Committee with an update on progress against the Board Assurance Framework (BAF) as at end March 2024. This report therefore provides assurance to the Committee of the controls and action plans for identified high-extreme risks that relate to any possibilities of not delivering on the Annual Strategic Priorities of the Health Board.

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

   Since the previous report all deliverable points have been reviewed and progress is being made to reduce the risk.

Two risks have previously been recommended to the Executive Team for being moderated down:

> **SP9- Women's Services**- remains to have an 'Amber' Delivery Confidence with multiple proposed delays from Q2/Q3/Q4 to Q1/Q3/Q4 (23/24). 1 action completed, 2 Amber, 2 Red. Progress is delayed but most operational actions now completed. Score revised now from 16 to 12, as likelihood is now a 3 so no longer a high risk and can be closed from the Board Assurance Framework (scores 15>).
>
> **SP18-Quality Innovation and Improvement** -Score reduced from 25 to 20 as there are still several actions delayed but delivery confidence is now positive.

One strategic deliverable plans where scores remain the same.

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

Summary

QSE is asked to receive assurance on the management of two identified high risks to which the Committee has overall responsibility for.

Next steps

1. BAF risks to be received regularly at Executive Team in line with the Committee cycles.
2. Ongoing monitoring of risks in relation to the Annual Plan Strategic Deliverables in the interim with the view to aligning to Objectives once set.
3. Risk scores for all to be monitored and Board to be provided with full BAF risk report.

Appendix 1- QSE Strategic Priority Risk scoring and progress.

Appendix 2 - QSE BAF Risk Reports

Appendix 1 – QSE Strategic Priority Risk scoring and progress.

Title	Score	Revision	Annual Plan Analysis	Risk Management Commentary
Risks Closed from High-risk reporting				
Strategic Priority P9 Women's Services	12	↓	Overall 'Amber' Delivery Confidence With delays from Q2/Q3/Q4 to Q1/Q3/Q4 (23/24). 1 action completed, 2 Amber, 2 Red.	Likelihood reduced from 4 to 3 as confidence has increased and several operational risks now. completed changing the overall score from a **16 to a 12.** Change approved by Executive Team 14/02/24 and Endorsed at QSE 20/02/24
No changes this reporting cycle				
Strategic Priority P5 Cancer	20	↔	Overall 'Amber' Delivery Confidence With 1 priority delayed from Q3 to Q1 (24/25). 3 actions completed, 2 Amber, 0 Red.	Delivery Confidence to be monitored, risk has been updated remains at 20.
Strategic Priority P18 Quality, Innovation and Improvement	20	↓	Overall 'Green' Delivery Confidence with 1 action delayed from Q3 to Q4 (23/24). 0 actions completed, 0 amber, 0 red. 6 actions remain underway and on track for delivery at the end of Q4 at which time the risk score will be reviewed."	Risk score has subsequently been reduced from **25 to 20**. Reconsider impact of 5 in following iteration of report and provide rationale if remains. Change approved by Executive Team 14/02/24 and Endorsed at QSE 20/02/24

Appendix 2 – QSE BAF risk reports

<table>
<tr><td rowspan="4">BAF
SP5</td><td colspan="2">Executive: Executive Director of Operations</td><td colspan="3">Date Opened: October 2023</td></tr>
<tr><td colspan="2">Committee: Quality, Safety and Experience Committee</td><td colspan="3">Date Last Reviewed: 08/02/2024</td></tr>
<tr><td>Strategic Priority:
Cancer</td><td>Link to CRR: Special Measures
Link to Tier 1's: None</td><td colspan="3">Last Date Reviewed at Committee: 22/02/2024</td></tr>
<tr><td colspan="3">Target Risk Date: April 2024</td></tr>
<tr><td colspan="6">There is a risk of failing to achieve the aims and actions outlined in the cancer strategic priority plan such as maintain access standards, further develop and implement the Cancer Strategic Plan for North Wales and implement immediate targeted actions to improve access in diagnostics and key specialities.</td></tr>
<tr><td colspan="2">Mitigations/Controls in place</td><td colspan="2">Gaps in Controls</td><td colspan="2">Current Risk Score</td></tr>
<tr><td colspan="2">1. Draft Cancer Strategy for North Wales developed by North Wales Cancer Partnership Board highlighting key challenges and resulting strategic aims for cancer for the next 5 years
2. Workstreams underway as part of Special Measures programme to support vulnerable services, including dermatology & plastics, urology and oncology
3. New services to improve cancer pathways in place via investment from the Performance Fund Suspected Cancer Pathway (SCP) allocation, including straight to test lung and neck lump pathways, rapid diagnosis clinics, additional breast cancer capacity and increase in tracking teams
4. Pathway reviews commenced to assess compliance with national optimal pathways for cancer and identify areas of improvement; prostate and colorectal reviews completed with breast and gynaecology underway
5. Service improvement work underway to implement streamlined pathways in dermatology, lung, gynaecology, colorectal and prostate cancer
6. Patients on suspected cancer pathway tracked and delays escalated; suspected cancer patients prioritised within available capacity</td><td colspan="2">1. Cancer Partnership Board funding not secured – proposal to fund via Performance Fund SCP allocation but remains subject to Recurrent Investments Group for Assurance process.
2. Lack of operational plans to implement vision set out in the Cancer Strategy for North Wales; in particular no agreed model for services likely to require reconfiguration across IHCs including potentially colorectal, dermatology, urology, breast
3. Lack of medical workforce in vulnerable services in particular urology, dermatology, oncology, gastroenterology and some specialist radiology posts
4. Service improvements funded via Performance Fund allocation vulnerable due to RIGA process
5. Lack of new funding to implement service expansion in line with demand, and further service improvements identified via pathway review work</td><td colspan="2"><table><tr><td>Impact</td><td>Likelihood</td><td>Score</td></tr><tr><td>4</td><td>5</td><td>20</td></tr></table>Movement since last Qtr:
3 actions completed, 2 Amber, 0 Red. However, 1 action in relation to funding (likelihood of 5) has impact on non-compliance with national suspected cancer pathway.</td></tr>
</table>

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

Lines of Defence			Overall Assessment
1	**2**	**3**	Service improvements funded via Performance Fund allocation vulnerable due to RIGA (recurrent investments group for assurance) process where funding allocated in 2021 is under internal review. Likelihood of 5 remains, impact 4 due to **non-compliance with national** suspected cancer **pathway** due to current pressures within the dermatology service.
Strategy monitored at North Wales Cancer Partnership Board Performance monitored at weekly corporate access meeting and local IHC performance meetings	Reporting line for North Wales Cancer Partnership Board to be confirmed Performance reported to Health Board's PFIG and Board	External scrutiny and support from Welsh Government and Wales Cancer Network.	

Annual Plan for Reference

Strategic Priority P5 **Cancer:** key actions for 23/24					
Ref	Organisational Delivery Objective	Lead	Specific Ministerial or Special Measures Priority	WG Quad. Aim	Completion Timescales (quarters)

P5.1	Maintain access standards in those areas meeting cancer access standards, and to continue improving those areas that do not, aiming to achieve 70% of cancer referrals starting their first definitive treatment within 62 days by the end of the year	EDIC	□ MP	QA2	
	▪ Maximise use of clinic and endoscopy resources in line with capacity and demand modelling				□□□□
	▪ Commence new prostate pathway to facilitate straight to test and pre-booking of biopsies				□□□□
P5.2	Further develop and implement the **Cancer Strategic Plan for North Wales**, aligned to the all Wales Cancer Plan (Cancer network)	EDIC		QA2	
	▪ Refresh and finalise the cancer plan and commence action to implement				□□□□
P5.3	Implement immediate targeted actions **to improve access in diagnostics and key specialities**, including:	EDIC	□ MP	QA2	
	▪ Aim for first appointment within 10 days				□□□□
	▪ Redesign of pathways that enable a 'straight to test' approach				□□□□
P5.4	Implement actions to support local delivery:	EDIC		QA2	
	▪ Finalise four local cancer pathways this year – prostate, colorectal, breast and gynaecology				□□□□
	▪ Continue to work towards filling all Consultant Clinical Oncologist vacancies by the end of the year, recognising the challenge presented by the national shortage of cancer doctors				□□□□
	▪ Continue to support the development and use of new NICE approved cancer treatment regimens				□□□□
	▪ Develop a capital estates plan for the Shooting Star Unit, which will provide additional capacity for treatments and outpatient clinics				□□□□
	▪ Our Haematology service will maintain Referral to Treatment (RTT) time at 26 weeks throughout the year and aims to undertake substantive recruitment of consultants and reduce the number of NHS locums working within the speciality by the end of 2023/24				□□□□

BAF SP18	**Executive:** Executive Director of Nursing and Midwifery		**Date Opened:** 19/10/2023
	Committee: QSE		**Date Last Reviewed:** February 2024
	Strategic Priority: SP18 Quality, Innovation and Improvement	**Link to CRR:** Failure to Embed Learning **Link to Tier 1's:** 3025/4519/ 4520/3795/3759	**Last Date Reviewed at Committee:** 22/02/2024
			Target Risk Date: April 2024

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

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

Actions and Due Date

Action Detail	**Due Date**
1. The Quality Governance Framework will be reviewed and refreshed and will include greater clarity on the roles, responsibilities and authorities of all groups including the reporting expectations, process and templates. This will include mapping meetings into an overall cycle and introducing standard templates and a single document repository.	March 2024
2. Best practice guidance will be issued to IHCs and Regional Divisions to support effective local quality governance arrangements.	March 2024
3. A Quality Dashboard will be developed underpinned by a series of specialist dashboards (i.e. falls, complains, etc). These dashboards will create a single version of the truth using agreed metrics directly connected to the quality systems for real time data.	December 2023
4. A central and digital library of learning will be established which will be launched alongside a revised approach to the collation, analysis and dissemination of learning.	March 2024
5. The approach to quality assurance will be reviewed and refreshed and a new regulatory procedure and quality assurance procedure will be developed.	March 2024
6. The new Quality Strategy will be developed through a co-design process.	March 2024

7. A Quality Management System will be developed in line with the Duty of Quality, which will describe how Quality Planning, Quality Control, Quality Assurance and Quality Improvement will work together as a collective quality system.				March 2024
Lines of Defence				**Overall Assessment**
1	**2**	**3**		Target date revised from March to April 2024. Impact of 5 to be reviewed in following report.
1. Service and IHC Quality Groups 2. Putting Things Right and clinical review processes and monitoring 3. Ward accreditation schemes and ward manager/matron checks/audits 4. Organisational Learning Forum 5. Quality systems – RLDatix, Greatix, Civica Experience and AMAT	1. Quality, Safety and Experience Committee oversight of quality issues 2. Quality reporting to Board 3. Executive performance reviews with IHCs 4. Clinical audit 5. Patient and Carer Experience Group and oversight/assurance reporting 6. Patient Safety Group and oversight/assurance reporting 7. Clinical Effectiveness Group and oversight/assurance reporting 8. Regulatory Assurance Group and oversight/assurance reporting 9. Annual Quality Report, Annual Putting Things Right Report and Annual Duty of Candour Report	1. Internal audit 2. HSE inspections 3. HIW/CIW inspections 4. PSOW investigations 5. WG performance monitoring and assurance 6. Welsh Government Reviews 7. Royal College Reviews		

Annual Plan for Reference

Strategic Priority P18

Quality, Innovation & Improvement: key actions for 23/24

Ref	Organisational Delivery Objective	Lead	Specific Ministerial or Special Measures Priority	WG Quad. Aim	Completion Timescales (quarters)
P18.1	Implement the priorities within the Special Measures Response Plan 90 day cycles, including:	MD	SM	QA4	
	▪ Consider the findings and recommendations of the Patient Safety Review				
	▪ Processes and procedures for learning from incidents				

	▪ Support the Clinical Governance Review				
	▪ Scope an enhanced programme of Healthcare Public Health				
P18.2	Embed the Betsi Way improvement methodology across the organisation	DTSP		QA	
	▪ Develop a sustainable model of service improvement support for IHC/Divisional level and pan-BCUHB programmes of work				
	▪ Ensure service improvement resource is allocated to organisational strategic priorities through a designated forum				
	▪ Develop a Centre of Excellence of Improvement to coordinate the consistent delivery of improvement methodology, and drive forward staff training in improvement methodology, tools and techniques.				

Teitl adroddiad: ***Report title:***	Corporate Risk Register Report			
Adrodd i: ***Report to:***	Quality Safety and Experience (QSE) Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 18 April 2024			
Crynodeb Gweithredol: ***Executive Summary:***	The purpose of this standing agenda item is to provide an update position of the Corporate Risk Register to which QSE has oversight. Key changes to note in report: Reduction in CRR24-03 Safeguarding score Revisions of all CRR24-04 Failure to Embed Learning action plan dates Appendix 1 Risk Dashboard Appendix 2 Detailed Risk Reports of seven risks			
Argymhellion: ***Recommendations:***	The Committee is asked to **receive assurance** for the six corporate risks to which the Committee has overall accountability.			
Arweinydd Gweithredol: ***Executive Lead:***	Pam Wenger, Director of Corporate Governance			
Awdur yr Adroddiad: ***Report Author:***	Nesta Collingridge Head of Risk Management			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☒	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: N/A				

Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this: N/A	
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Links to the BAF detailed in respective CRR reports
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	It is essential that the Health Board has robust arrangements in place to assess, capture and mitigate risks, as failure to do so could have legal implications for the Health Board.
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	N/A
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary ben undertaken?***	N/A
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	Links to the BAF detailed in respective CRR reports
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	The effective and efficient mitigation and management of risks has the potential to leverage a positive financial dividend for the Health Board through better integration of risk management into business planning, decision-making and in shaping how care is delivered to our patients thus leading to enhanced quality, less waste and no claims.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	Failure to capture, assess and mitigate risks can impact adversely on our workforce.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	Individual Executive sign off of CRR reports, Review at Risk Management Group 09/04/2024 and Executive Team 10/04/2024.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)	See the individual risks for details of the related links to the Board Assurance Framework.

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

The Committee is asked to note changes in relation to:

- CRR24-03 Safeguarding – Current score reduced from 16 to 12 which was approved at Risk Management Group and the Executive Team meeting but agreed the risk is to remain on the corporate risk register for continued monitoring. See risk report for full rationale in reduction of likelihood from 4 to 3.
- CRR24-04 Failure to Embed Learning – The initial March 2024 action deadlines have all been extended to April-June 2024.
- CRR24-14 Harm from the Medical Devices/ Equipment – One overdue action reported.

- Recommendations have been made around CRR24-02 - Patient Safety – Falls (risk score 20) – '*Risk of patient falls and harm in secondary care sites due to factors like staffing levels, premises layout, and training compliance. This could lead to poorer outcomes, litigation, and reputational damage*.' to the Patient Safety team 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. The target date for this risk is currently 30/04/24.

Next steps

1. Submission of Corporate Risks to the May Board meeting
2. Further strengthening of Patient Safety Corporate Risk

Appendix 1 - Corporate Risk Register Dashboard

Lead	Ref	Risk Title	Current Score (Likelihood x Impact)	Risk Target Score	Appetite Main Risk Type / Appetite Level	Lead Board Committee	Risk Management Commentary
EDoN	CRR24-02	Patient Safety-Falls	5 x 4 = 20 ⟷	12	Quality / 3 - Open	QSE	Escalated from operational risk as of Dec 23. 6 actions identified, 1 completed, 5 progressing. **Action dates amended** from the 31/03/2024 to the 30/04/2024. Actions are on track for the April 2024 target date. However, the inherent and current risk scores are both 20, so the existing controls have not reduced the risk yet. **Target date likely to change** as this risk is broadened from being operational and around falls; to being strategic and more generally patient safety focused. Work ongoing by the service to further develop the risk with the inclusion of additional patient safety risks i.e. healthcare acquired pressure ulcers, deterioration of patients etc.
EDoN	CRR24-03	Safeguarding	4 x 3 = 12 ↓	8	Quality / 3 - Open	QSE	Presented to the Risk Management Group and Executive Team for a proposed reduction from 16 to 12 in score following Executive review and approval but to remain as a corporate risk. See rationale within corporate risk of reduction in reduced risk due to National dependencies on legislation.
EDoN	CRR24-04	Failure to Embed Learning	4 x 5 = 20 ⟷	5	Reputational / 4 - Seek	QSE	New CR as of Dec 23, 7 actions identified, 0 completed but all progressing. The initial March 2024 **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	Community Care and Primary Provision	4 x 5 = 20 ⟷	12	Quality / 3 - Open	QSE	Newly CR as of 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 noted **likelihood of 5**.

EDoO	CRR24-12	Areas of Clinical Concern (encompasses ophthalmology and dermatology)	5 x 3 = 15 ⟷	12	Quality 3 – Open	QSE	Newly developed strategic risk Feb 24, 6 actions identified, 0 completed, 6 progressing.
EDoTH	CRR24-13	Timely Diagnostics	4 x 5 = 20 ⟷	5	Reputational 4 – Seek	QSE	Newly developed strategic risk Feb 24, 5 actions identified, 0 completed, 5 progressing. All actions are on track against the 2025 target date. Impact of 5.
EDoTH	CRR24-14	Harm from the Medical Devices/ Equipment	4 x 4 = 16 ⟷	8	Quality 3 – Open	QSE	Newly developed strategic risk Feb 24, 6 actions identified, 0 completed, 5 progressing, **1 overdue**.

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

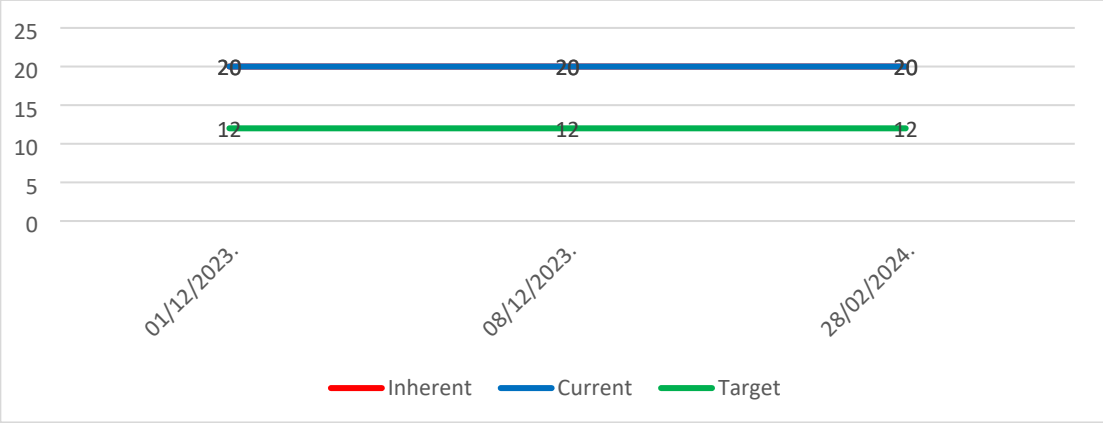
Appendix 2 – Corporate Risk Register Report

CRR 24-02	**Risk Title:** Patient Safety - Falls		**Date Opened:** 01/12/2023
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** 20/02/2024
Date Last Reviewed: 28/02/2024	**Director Lead:** Executive Director of Nursing and Midwifery	**Link to BAF**: N/A	**Target Risk Date:** 30/04/2024

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

Mitigations/Controls in place	Lines of Assurances	Additional Controls required
1.Mandatory E learning modules (1a and 1b) for Falls Prevention launched and monitoring in place for completion via the Strategic Inpatient Falls Group. Health Board compliance currently 1a 93.83%, 1b 94.55%. 2. Manual Handling training data cascaded monthly to respective IHC's/Division Director of Operations to include compliance, Did Not Attend rates and available capacity for upcoming 2 months. 3. Welsh Nursing Care Record (WNCR) has been implemented which has an electronic version of the Falls and Bone Health Multifactorial Assessment (FBHMA) that is identified on the dashboard if not completed and monitored for compliance by the Ward Manager. 4. How to /good practice guide developed and implemented to support with completion and quality of FBHMA across all Adult Inpatient wards: 5. Peer review process in place for 3 months to improve quality of the FBHMA across adult inpatient wards. 6. Falls review groups in place across the Health Board with exception reporting, updating of improvements to Strategic Inpatient Falls Group. 7. Temporary staffing team have ensured Nurse Agencies have access to BCUHB e-learning packages and are encouraged to complete	**1st** – eg. Local Assurances: 1. Strategic Inpatient Falls Group - Integrated Health Community (IHC) and Divisional falls review groups report to the falls leads who report to the strategic group. 2. Ward accreditation metrics 3. Ward accreditation review process 4. Peer reviews 5. Patient Safety Group 6. Risk Management Group 7. Internal Audit 8. Executive Team Meeting **2nd** – eg. Board/Committee Assurances: 1. Quality, Safety and Experience Committee **3rd** – eg.External Assurances: 1. HSE 2. Regulatory inspections and investigations – HSE, HIW, CIW, PSOW 3. WG performance monitoring and assurance 4. Welsh Government Reviews	1. Falls prevention and management policy to be ratified and relaunched - has been updated to include a clear step by step approach to completion of the Falls and Bone Health Multifactorial Assessment (FBHMA) and post falls management and currently under review with Patient Safety Group. 2. Assurance and training of agency workers. 3. Improved compliance with manual handling training. 4. Sustained improvement in the quality of completion of FBHMA.

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	Progressing
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	Progressing
Manual Handling corporate team to progress contract arrangements for external training facilities to support capacity	30/04/2024	Progressing
Outcome of peer review pilot to be evaluated	30/04/2024	Progressing
Future enhancement to the Welsh Nursing Care Record on an all-Wales basis.	30/04/2024	Progressing



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.

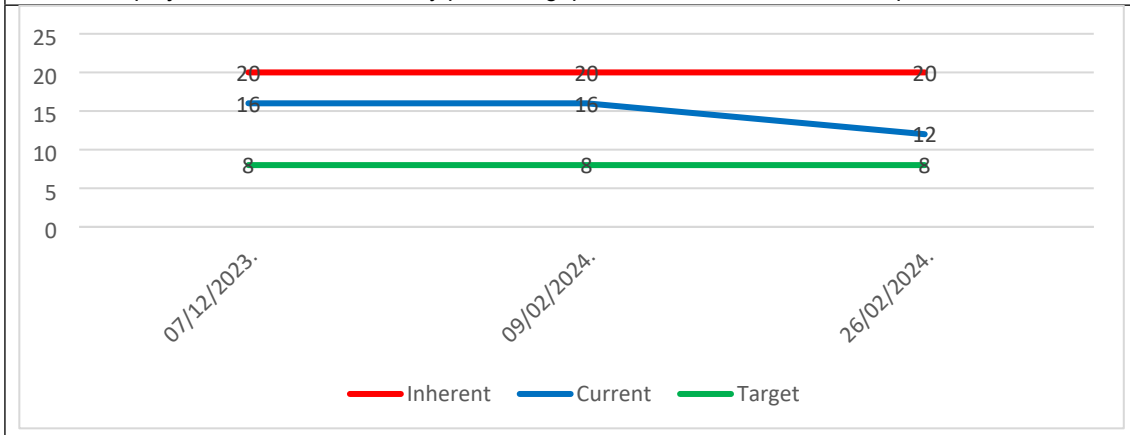
CRR 24-03	**Risk Title: Safeguarding**		**Date Opened:** 07/12/2023
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** 20/02/2024
Date Last Reviewed: 26/02/2024	**Director Lead:** Executive Director of Nursing and Midwifery	**Link to BAF**: N/A	**Target Risk Date:** 31/03/2025

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

Mitigations/Controls in place	Lines of Assurances	Additional Controls required
1. Standardised formal reporting and escalation of activity, mandatory compliance and exception reports are presented in line with Health Board Governance and Reporting Frameworks. 2. Audit findings and data are monitored and escalated. Risk Management has been embedded into the processes of the reporting framework. 3. BCUHB mandatory safeguarding training is in place for all staff. 4. Welsh Government interim monies has supported temporary the implementation of additional Mental Capacity Act (MCA) training, the completion of Deprivation for Liberty (DoLS) applications, and strengthened the implementation of Court of Protection DoL for 16/17-year-olds. 5. BCUHB local work programmes are in place and aligned to the National Strategies which are regularly reported to Welsh Government. 6. Safeguarding support the Sexual Abuse Referral Centre (SARC) implementation, compliance and accreditation but the accountability remains with the Central Integrated Health Community (IHC). 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.	**1st** – eg. Local Assurances: 1. Safeguarding 2. Risk Management Group 3. Internal Audit 4. Executive Team Meeting **2nd** – eg. Board/Committee Assurances: 1. Quality, Safety and Experience Committee **3rd** – eg.External Assurances: 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.	1. New legislation and statutory guidance driven by case law, UK and Welsh Government impacts upon the organisation and the date of implementation is not within BCUHB control. 2. The increase in safeguarding activity with enhanced complexity has resulted in the delay of the implementation of strategic and operational interventions. 3. Local Authorities frequently develop independent local guidance which requires duplication of implementation across BCUHB. This is time consuming and can result in reduced compliance. 4. The rise in the number of DoLS assessments has resulted in a backlog. Current post holders work additional hours, weekends and evenings. There are local and national staffing challenges with regard to the recruitment of Safeguarding, MCA and DoLS specialist staff. This is recognised by Public Heath Wales and WG. We support flexible working arrangements within the team to ensure staff retention. Reduced leadership team capacity due to absences. . A risk assessment and an amendment to the service delivery structure is in place to mobilise staff where required. 5. There is a lack of governance and reporting of Court of Protection activity relating to a Community setting. Immediate safeguards are in place and

		work is taking place to develop a standard procedures.

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 April 2024	30/04/2024	Progressing
National development and implementation of Single Unified Safeguarding Review SUSR training has been approved by WG. BCUHB attending February 2024. Welsh Government delay until Sept 2024.	31/03/2025	Progressing
Implementation and monitoring of the 'Workforce Safeguarding Responsibilities SoP, Approved at SGPG being shared at QDG during February 2024. Progressing through internal governance.	31/03/2024	Completed
North Wales Sexual Assault Referral Centre (SARC) to meet the National Service ISO Specifications, multi-agency discussions ongoing.	30/06/2024	Progressing
Development of a DoLS/CoP DoL Standard Operating Protocol (SoP), almost complete.	31/05/2024	Progressing
CNO is undertaking a safeguarding audit of provision which will provide a benchmark for consideration, dependent on CNO.	30/03/2024	Progressing
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	31/05/2024	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

Safeguarding legislation adherence continues to be progressed and a priority and controls are in place to address risk, in collaboration with national partners. While full compliance is taking longer than desired due to dependencies nationally and outside the control of the Health Board, the team have confidence in robust controls to manage risks in the interim while awaiting further national guidance. Actions to date have

	positioned us well, and the team remain committed to achieving full alignment as soon as the required national guidance and legislation are available. While there remain to be some gaps in controls and full completion of actions this will be continue to be progressed and managed operationally by the team. The likelihood of public scrutiny is reduced to a 3.

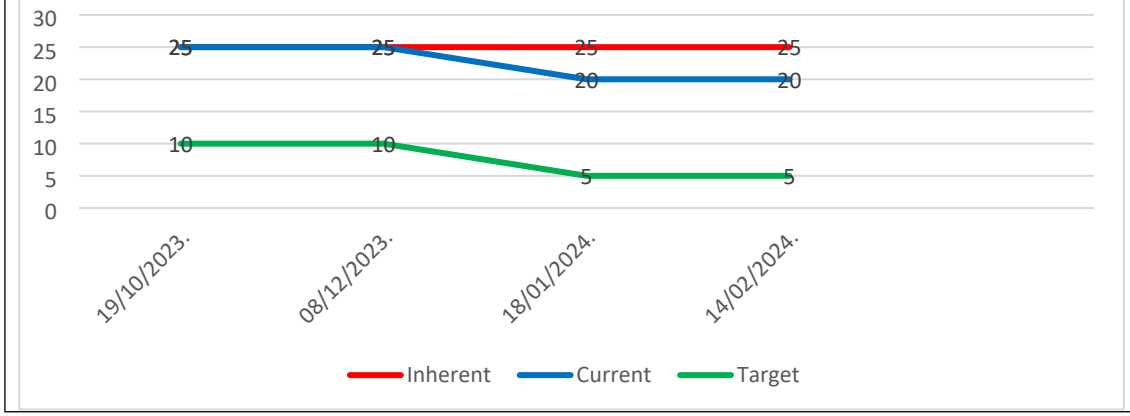
CRR 24-04	**Risk Title:** Failure to Embed Learning		**Date Opened:** 19/10/2023
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** 20/02/2024
Date Last Reviewed: 14/03/2024	**Director Lead:** Executive Director of Nursing and Midwifery	**Link to BAF**: SP18 - Quality, Innovation and Improvement	**Target Risk Date:** 30/06/2024

There is a risk that the Health Board could fail to meet requirements for **timely review and learning** from mortality cases, claims, inspections, incidents and complaints. This could be caused by insufficient resources, lack of unified processes, outdated IT systems, duplication of effort, and overreliance on single personnel. The impacts may include missed opportunities for improvement, lack of family/carer engagement, potential patient harm events going undetected, non-compliance with national frameworks or legislation, and reputational damage.

Mitigations/Controls in place	Lines of Assurances	Additional Controls required
1. Putting Things Right and clinical review processes and monitoring 2. Risk management processes 3. Audit programmes & monitoring arrangements 4. Patient and carer feedback and involvement processes 5. Senior sign-off process for National Reportable Incidents (NRIs) and Complaints 6. Clinical policies, procedures, guidelines, pathways, supporting documentation & IT systems 7. Clinical staff recruitment, induction, mandatory and professional training, registration & re-validation 8. Defined nurse staffing levels for all wards & departments as per Nurse Staffing Act 9. Ward accreditation schemes and ward manager/matron checks/audits. 10. Tracking of regulatory action plans 11. Internal Reviews against External National Reports 12. Getting it Right First Time (GIRFT), localised deep dives, reports and action plans 13. HIW, Ombudsman, Coroner NHS Wales Exec and WG engagement Meetings	**1st** – e.g. Local Assurances: 1. Service and IHC Quality Groups (with reporting) 2. Quality Delivery Group, its sub-groups (with reporting) 3. Executive performance reviews with IHCs 4. Risk Management Group 5. Executive Team Meeting 6. Clinical audit 7. Internal audit 8. Regulatory Assurance Group and oversight/assurance reporting 9. Annual Quality Report, Annual Putting Things Right Report and Annual Duty of Candour Report **2nd** – e.g. Board/Committee Assurances: 1. Executive performance reviews with IHCs 2. Quality, Safety and Experience Committee oversight of quality issues **3rd** – e.g. External Assurances: 1. Regulatory inspections and investigations – HSE, HIW, CIW, PSOW 2. WG performance monitoring and assurance 3. Welsh Government Reviews 4. Royal College Reviews	1. Development of a Quality Management System (QMS) setting out an integrated approach to Quality Planning, Control, Assurance and Improvement 2. Clarity on quality leadership, structures and accountabilities 3. Review of the quality governance framework of meetings and reporting 4. Development of a quality learning framework, aligned to the overall learning organisation programme 5. Review of Putting Things Right and clinical review processes and monitoring 6. Resolution of outstanding overdue positions for incidents, complaints, claims, mortality reviews and inquests

Actions	Due Date	Progression Analysis
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	30/06/2024	Date Revised from March 2024
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	30/06/2024	Date Revised from March 2024
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 – it is hoped to launch the Dashboard in April 2024	30/04/2024	Date Revised from December 2023
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. Update - This was due end of March – the aim is still to have a working test launched for April 2024	30/04/2024	Date Revised from March 2024
The approach to quality assurance will be reviewed and refreshed and a new regulatory procedure and quality assurance procedure will be developed This work is being taken forward with the support of the NHS Wales Executive as part of the Quality Governance Intervention, who are currently observing to inform their recommendations, therefore the work will take slightly longer and a revised date of 30 June	30/06/2024	Date Revised from March 2024
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.	31/05/2024	Date Revised from March 2024
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	31/05/2024	Date Revised from March 2024

	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

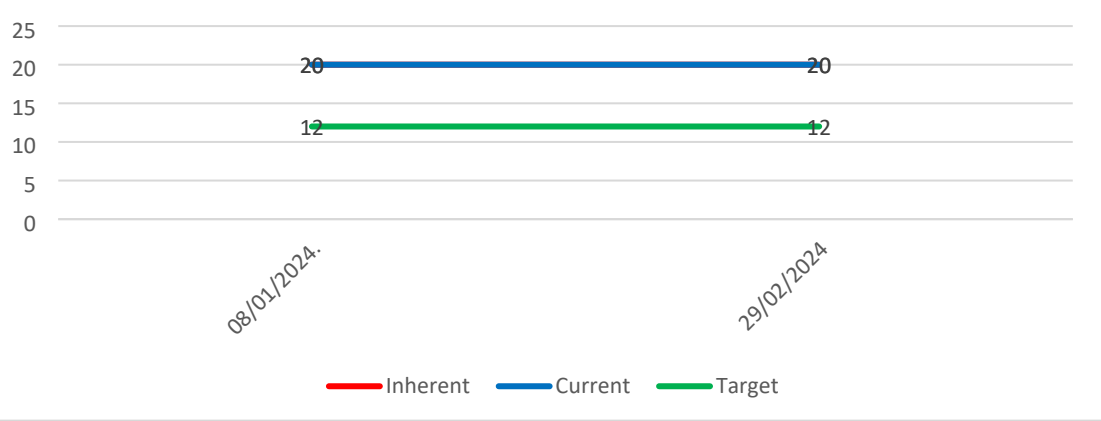
CRR 24-09	**Risk Title: Primary and Community Care services**		**Date Opened:** 08/02/2024
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** New Risk
Date Last Reviewed: 29/02/2024	**Director Lead:** Executive Director of Operations (Executive Director Transformation And Strategic Planning)	**Link to BAF**: N/A	**Target Risk Date:** 31/03/2025

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.

Mitigations/Controls in place	Lines of Assurances	Additional Controls required
1. Escalation and sustainability report to address risks associated with workforce and workload pressures allows for early identification and management. 2. Risk management training completed Q3 2023 for all primary care leaders for better identification and management. 3. Programme management implemented to monitor and drive strategic priorities. 4. Primary Care Quality and Delivery Group established Q3 23/24	**1st** – eg. Local Assurances: 1. Primary Care Quality and Delivery Group 2. Primary Care Panel 3. Risk Management Group 4. Executive Team Meeting 5. Internal Audit **2nd** – eg. Board/Committee Assurances: 1. Quality, Safety and Experience Committee **3rd** – eg. External Assurances: 1. Regulatory inspections and investigations – HSE, HIW, CIW, PSOW 2. WG performance monitoring and assurance 3. Welsh Government Reviews 4. Royal College Reviews	1. Greater Health Board oversight of Primary Care issues and risks. 2. Strategy and resources to support introduction of new roles, ways of working and models of service delivery. 3. Improved governance structures, process and procedures. 4. Equity of resource to support primary care transformation, management and governance.

Actions	**Due Date**	**Progression Analysis**
Primary Care Board established	30/05/2024	Progressing

Primary Care strategic plan	31/03/2025	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



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

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

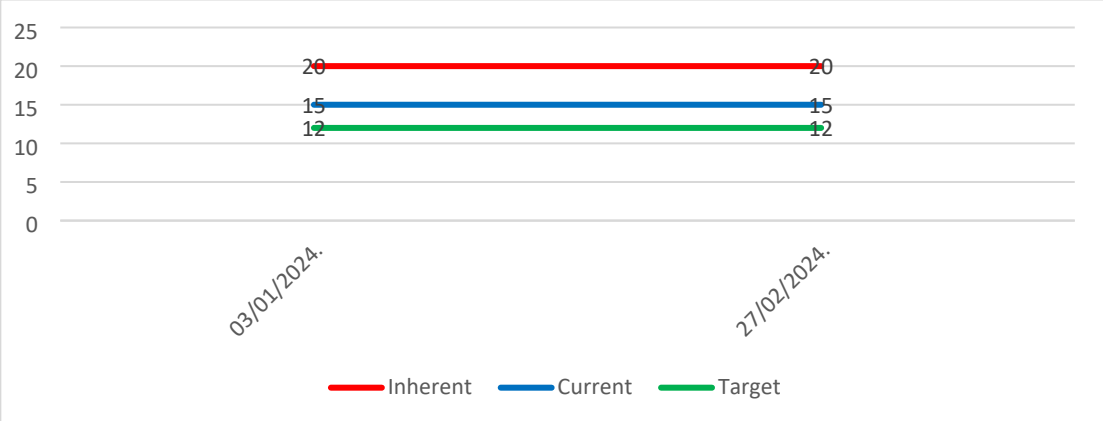
CRR 24-12	**Risk Title:** Clinical Areas of Concern		**Date Opened:** 15/12/2023
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review: New**
Date Last Reviewed: 25/03/2024	**Director Lead:** Executive Medical Director/ Executive Director of Operations	**Link to BAF**: N/A	**Target Risk Date:** 01/03/2025

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.

Mitigations/Controls in place	Lines of Assurances	Additional Controls required
1. Strategic Improvement Groups for the fragile clinical specialities. 2. Progress review groups for ophthalmology, dermatology and urology to develop and review progress of improvement plans. 3. Improvement plans for fragile specialities for specialities with clinical leadership. 4. Prioritising/triaging cases in specialities with backlog.	**1st** – eg. Local Assurances: 1. Special Measures meeting and assurances to committees on 90 day cycle 2. Quality Delivery Group 3. Risk Management Group 4. Internal Audit 5. Executive Team Meeting **2nd** – eg. Board/Committee Assurances: Quality, Safety and Experience Committee / Performance, Finance Committee **3rd** – eg.External Assurances: 1. National touch point meetings with NHS Executive colleagues	1. Implement plans for integrated electronic patient records 2. Dermatology, ophthalmology, urology continue to have clinical leadership gaps 3. Address lack of consistent medical cover in some specialities. 4. SLA for services provided by non-BCUHB organisations 5. Development of clinical model/pathways for fragile specialities with limited leadership incorporating relevant GIRFT and College recommendations 6. Clinical validation of waiting lists

Actions	Due Date	Progression Analysis
Engagement with National Procurement Processes (ie eye record system) and National Programmes (ie Robotics)	01/07/2024	Progressing
Ongoing recruitment for substantive medical leadership roles.	01/01/2025	Progressing
Recruitment efforts including substantive, locum and agency staff.	01/01/2025	Progressing
SLAs to be signed off through governance structures	01/08/2024	Progressing

Clinical pathway events	30/07/2024	Progressing
Non-clinical and clinical validation exercises	30/07/2024	Progressing



	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

Rationale for Corporate Risk

The impact of the inherent risk has not been altered by current actions, although its likelihood has been reduced by the identification of the clinical issues and improved governance around the services.

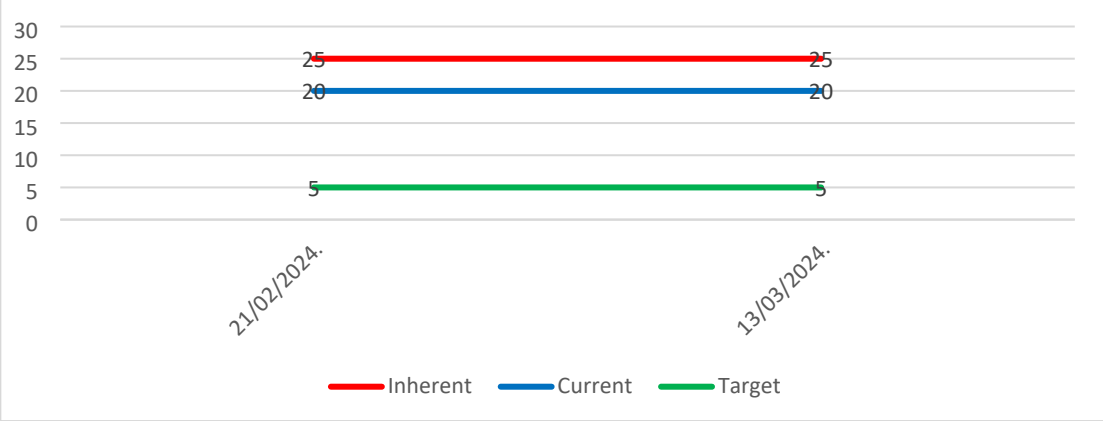
- Ophthalmology R1 seen within 25% over their clinical due date - NHS Wales Performance Framework 2024-25 Target improve to 95%
- Cancer 62 Days - NHS Wales Performance Framework 2024-25 Target improvement trajectory to 80% by 31.03.2026

CRR 24-13	**Risk Title:** Timely Diagnostics		**Date Opened:** 21/02/2024
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** New Risk
Date Last Reviewed: 13/03/2024	**Director Lead:** Executive Director of Therapies & Healthcare Sciences	**Link to BAF**: N/A	**Target Risk Date:** 31/12/2025

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

Mitigations/Controls in place	Lines of Assurances	Additional Controls required
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. Local Assurances: 1. Local deployment board and wider programme team stood up with collaborative working with Pathology and DDAT. 2. Risk Management Group 3. Internal Audit 4. Executive Team **2nd** – eg. Board/Committee Assurances: 5. Quality, Safety and Experience Committee **3rd** – eg.External Assurances: **1.** RISP being monitored via National and BCU implementation boards	1. Replacement of Radiology Informatics System (RISP) – implementation underway 2. Replacement of LINC (national pathology IT system) - Contract signed with current supplier plans to implement by September 2025 being progressed nationally 3. Radiology workforce model not suitable for meeting the current demands being placed on the service from both clinical activity and supporting activity required to deliver service e.g. governance, regulatory and accreditation requirements 4. Escalate to BCU Clinical Effectiveness Group – issues around failure to act. Procedure MD (Office of the Medical Director) 23 – 'Mitigation of the risk of failure to act on diagnostic results' needs updating which is being led by the Executive medical director. 5. PHW Collaborative Executive group. 6. Diagnostic Strategy for BCU needs to be developed

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



	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

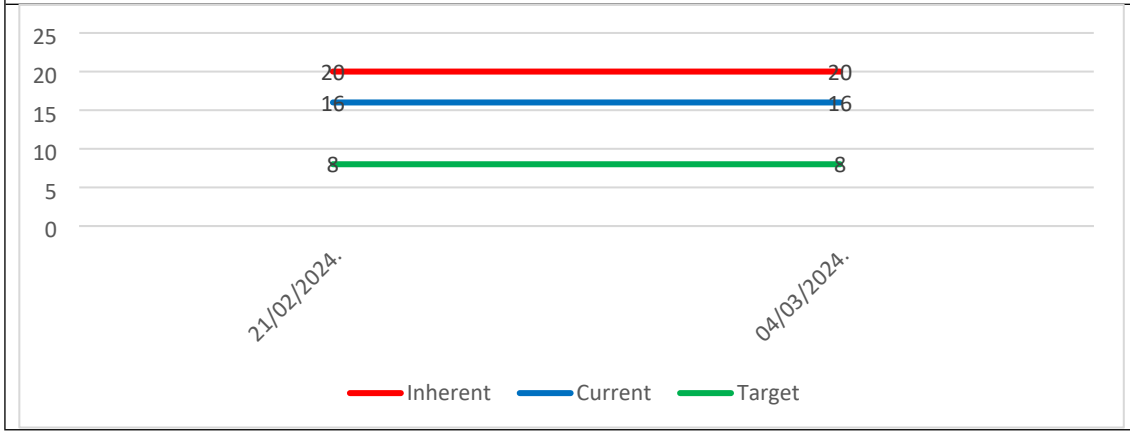
Increasing demand for both radiology and pathology
Outdated IT infrastructure in both Radiology and Pathology that carry significant clinical and operational risks. – National programmes in place to resolve these issues
Additional work required to mitigate the risks from failure to act and update procedure 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.

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:** New Risk
Date Last Reviewed: 04/03/2024	**Director Lead:** Executive Director of Therapies & Healthcare Sciences	**Link to BAF**: N/A	**Target Risk Date:** 31/03/2024 (review point)

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.

Mitigations/Controls in place	Lines of Assurances	Additional Controls required
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. Local Assurances: 1. Medical Devices Oversight Group 2. Capital Programme Management Team 3. Capital Investment Group 4. Risk Management Group 5. Executive Team Meeting **2nd** – eg. Board/Committee Assurances: 6. Quality, Safety and Experience Committee 7. **3rd** – eg.External Assurances: **1.** National Endoscopy and Diagnostic Programmes	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 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	Progressing
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 it's safety and will consider compliance	31/03/2024	Progressing
Review medical devices capital replacement to ensure all services have a medical devises replacement programme in place	31/03/2024	Progressing
Medical Devices strategy	31/03/2024	Progressing
Recruitment to medical devices team	31/03/2024	Progressing



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
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.