Bundle Quality, Safety & Experience Committee 19 December 2023

1 OPENING ADMINISTRATION

Draft QSE Agenda 19.12.23 0.7

1.1 09:30 - QS23.122 Welcome, Introductions and apologies for absence - Verbal
Chair

1.2 09:32 - QS23.123 Declarations of interest relating to agenda - Verbal
Chair

1.3 09:33 - QS23.124 Report of the Chair - Verbal
Chair's Action
Feedback from Board

1.4 09:38 - QS23.125 Notification of Matters referred from other Board Committees on this or future agendas - Verbal
Chair

1.5 09:43 - QS23.126 Patient Story - Presentation
Executive Director of Nursing and Midwifery
Deputy Director of Quality Governance

QS23.126 - Patient Story

2 CONSENT AGENDA

2.1 10:03 - QS23.127 The Chair will ask if there are any items from the Consent Agenda (item 6) that Committee Members wish to bring forward to the main agenda for discussion.

3 MAIN AGENDA

3.1 10:08 - QS23.128 Matters Arising not contained within the Action Log - verbal
Chair

4 QUALITY CONTROL

4.1 10:18 - QS23.129 Patient Safety, Effectiveness and Experience Report
Executive Director of Nursing and Midwifery
Deputy Director of Nursing

QS23.129 - QSE Patient Safety Effectiveness and Experience Report
QS23.129a - Appendix 2 Patient Safety Effectiveness and Experience Report - Safeguarding Summary Dec 23
QS23.129b - Appendix 3 Patient Safety Effectiveness and Experience Report
QS23.129c - Appendix 4 Patient Safety Effectiveness and Experience Report

4.2 10:38 - QS23.130 Quality Delivery Group Chair's Report
Executive Director of Nursing and Midwifery / Deputy Director of Quality Governance

QS23.130 - QDG Chair Report

5 QUALITY ASSURANCE

5.1 10:53 - QS23.131 Corporate Risk Register & Board Assurance Framework
Interim Board Secretary
Head of Risk Management

QS23.131a - QSE Committee Coversheet - Corporate Risk Register Dec 23 v3
QS23.131b - QSE Board Assurance Framework Report Dec 23 v3

5.2 11:08 - QS23.132 Special Measures Report
Executive Director of Strategy and Transformation
Director of Transformation and Improvement

QS23.132 - QSE Special Measures
QS23.132a - QSE Special Measures

5.3 11:23 - QS23.133 Regulatory Report
Executive Director of Nursing and Midwifery
Deputy Director of Quality Governance
(To include HSE, NOC, HIW Activity, R28's and the Regulatory Assurance Group's Chairs Report)

QS23.133 - Regulatory Assurance Report

5.4 11:38 - QS23.134 Primary Care Report
Chief Operating Officer
(To focus on diabetes)

6 CONSENT AGENDA

6.1 QS23.135 Minutes of Meeting
Chair

QS23.135 Draft QSE Public Minutes 27.10.23 v0.6

6.2 QS23.136 Matters Arising and Table of Actions
Chair

QS23.136 - Summary Action Log QSE Public

6.3 11:53 - QS23.137 WHSSC Quality Committee Chair's Report
Executive Director of Nursing and Midwifery
Deputy Director of Quality Governance

QS23.137 - Quality Patient Safety Committee Chairs Report

6.4 11:53 - QS23.138 Falls Audit
Executive Director of Nursing and Midwifery
Deputy Director of Quality Governance

QS23.138 - Falls Audit Cover Paper
QS23.138a Final Internal Audit Report - Falls Management

6.5 11:53 - QS23.139 Committee Terms of Reference and Cycle of Business
Interim Board Secretary

QS23.139 Committee Terms of Reference and Cycle of Business
QS23.139a - Appendix 1 - QSE ToR v0.02 Draft (reviewed 11.12.23)
QS23.139b - Appendix 2 QSE - Cycle of Business - CoB- draft for round table

6.6 11:53 - QS23.140 Committee Forward Work Programme
Interim Board Secretary
This will be populated as the Committee matures, it will consist of items that are highlighted within Committee not formally on the Cycle of Business

7 CLOSING ITEMS

7.1 QS23.141 Agree items for referral to Board / Other Committees - verbal
Chair

7.2 11:53 - QS23.142 Review of Risks highlighted in the meeting for referral to Risk Management Group - verbal
Chair

7.3 12:13 - QS23.143 Agree items for Chair's Assurance Report - verbal
Chair

7.4 12:18 - QS23.144 Review of Meeting Effectiveness - verbal
Chair

7.5 12:23 - QS23.145 Report of items discussed in previous meeting private session - verbal
Chair

7.6 QS23.146 Date of Next Meeting - verbal
Chair

7.7 QS23.147 Resolution to Exclude the Press and Public
Chair
"Those representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960."

BETSI CADWALADR UNIVERSITY HEALTH BOARD

QUALITY SAFETY EXPERIENCE COMMITTEE
TUESDAY 9 DECEMBER 2023
9.30 – 12:30
BOARDROOM, CARLTON COURT, ST ASAPH

AGENDA QSE				
1. OPENING ADMINISTRATION				
	1.1	QS23.122 Welcome, introductions and apologies for absence	Verbal	Chair
	1.2	QS23.123 Declarations of interest relating to agenda	Verbal	Chair
	1.3	QS23.124 Report of the Chair • Chair's Action • Feedback from Board	Verbal	Chair
	1.4	QS23.125 Notification of Matters referred from other Board Committees on this or future agendas	Verbal	Chair
	1.5	QS23.126 Patient Story *(Requested that this one be from Primary Care)*	Presentation	Executive Director of Nursing and Midwifery *Deputy Director of Quality Governance*
2. CONSENT AGENDA				
	2.1	QS23.127 The Chair will ask if there are any items from the Consent Agenda (item 7) that Committee Members wish to bring forward to the main agenda for discussion.	Verbal	Chair
3. MAIN AGENDA				
	3.1	QS23.128 Matters Arising not contained within the Action Log	Verbal	Chair
4. QUALITY CONTROL				
	4.1	QS23.129 Patient Safety, Effectiveness and Experience Report *(Report to be built around the quality dashboard)*	Attached	Executive Director of Nursing and Midwifery *Deputy Director of Nursing*
	4.2	QS23.130 Quality Delivery Group Chair's Report *(Please include RAG and OLF)*	Attached	Executive Director of Nursing and Midwifery *Deputy Director of Quality Governance*
5. QUALITY ASSURANCE				

	5.1	QS23.131 Corporate Risk Register & Board Assurance Framework	Attached	Interim Board Secretary Head of Risk Management
	5.2	QS23.132 Special Measures Report	Attached	Executive Director of Strategy and Transformation *Director of Transformation and Improvement*
	5.3	QS23.133 Regulatory Report	Attached	Executive Director of Nursing and Midwifery *Deputy Director of Quality Governance*
	5.4	QS23.134 Primary Care Report	Verbal	Chief Operating Officer
6. CONSENT AGENDA				
	6.1	QS23.135 Minutes of Meeting	Attached	Chair
	6.2	QS23.136 Matters Arising & Table of Actions	Attached	Chair
	6.3	QS23.137 WHSSC Quality Committee Chair's Report	Attached	Executive Director of Nursing and Midwifery *Deputy Director of Quality Governance*
	6.4	QS23.138 Falls Audit	Attached	Executive Director of Nursing and Midwifery *Deputy Director of Quality Governance*
	6.5	QS23.139 Committee Terms of Reference and Cycle of Business	Attached	Interim Board Secretary
	6.6	QS23.140 Committee Forward Work Programme	Attached	Interim Board Secretary
7. CLOSING ITEMS				
	7.1	QS23.141 Agree Items for referral to Board / Other committees	Verbal	Chair
	7.2	QS23.142 Review of Risks highlighted in the meeting for referral to Risk Management Group	Verbal	Chair
	7.3	QS23.143 Agree items for Chairs Assurance Report	Verbal	Chair
	7.4	QS23.144 Review of Meeting Effectiveness	Verbal	Chair
	7.5	QS23.145	Verbal	Chair

		Report items discussed in previous meeting private session		
	7.6	QS23.146 Date of next meeting	Verbal	Chair
	7.7	QS23.147 Resolution to Exclude the Press and Public - "Those representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960."	Verbal	Chair

BOARD MEMBERS	**POSITION**
Rhian Watcyn Jones	Independent Member, Chair
Prof Mike Larvin	Independent Member
Urtha Felda	Independent Member
IN ATTENDANCE	**POSITION**
Jason Brannon	Deputy Director of Workforce
Dyfed Edwards	Independent Member/Health Board Chair
Gareth Evans	Acting Executive Director Therapies & Health Science
David Jenkins	Independent Advisor (observing)
Matt Joyes	Associate Director of Quality
Dr Nick Lyons	Executive Medical Director
Phil Meakin	Interim Board Secretary
Teresa Owen	Executive Director of Public Health
Chris Stockport	Executive Director of Transformation & Strategic Planning
Angela Wood	Executive Director of Nursing & Midwifery (Lead Executive)

Teitl adroddiad: ***Report title:***	Patient Story Cardiac Care – Rysseldene G.P. Surgery Story			
Adrodd i: ***Report to:***	QSE			
Dyddiad y Cyfarfod: ***Date of Meeting:***	9 December 2023			
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 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	BAF21-10 - Listening and Learning

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)***	
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: https://nhswales365-my.sharepoint.com/:v:/g/personal/zoe_gamble_wales_nhs_uk/EdFNOslkLSlHhJqLpviS8WwBs1yOmVSdrVDjLPoSGs5MfA?e=YPrQkD ***List of Appendices:*** Appendix A- Patient Story Summary	

Betsi Cadwaladr University Health Board
Cardiac Care – Rysseldene G.P. Surgery Story

A video story told by Cheryl Williams Advance Nurse Practitioner and patients attending Rysseldene G.P. Surgery be will be played at the meeting.

Overview of Patient Story

A collection of experiences from patients accessing the specialist Primary Care, Cardiac Care Clinic at Rysseldene Surgery, Colwyn Bay.

Cheryl Williams, Advance Nurse Practitioner has been in position for 12 months specialising in Cardiology at the G.P. surgery. The Cardiac Clinic helps reduce hospital admission by providing local support, care and treatment to patients. The Cardiac Clinic helps bridge the gap between Primary and Secondary Care Cardiology Services.

Recent feedback has shown this service is of great benefit to both patients and their unpaid carers.

Summary of Learning and Improvement

The collection of positive patient stories from the Cardiac Clinic has been shared with Rysseldene Surgery management team, Cheryl Williams, Advance Nurse Practitioner and will be used for training purposes.

Key learning points shared:

- Overall excellent experience of the Cardiac Care service from the perspective of both patient and carer.
- Improved communication and easier access to specialist Cardiology advice and signposting.
- Access to localised care reducing the need for patients to access Secondary Care services.
- Supportive staff understanding the needs of the patients and what matters to them.
- A good practise model that can be replicated across the Health Board.

This story highlights positive experiences and as part of our commitment to build a learning culture from patient experience, the learning from positive experience is equally important to ensure all people who use of services receive a consistently positive experience of their care.

The Patient and Carer Experience Team will share this feedback and seek assurance from departments by way of evidence that learning has been embedded. The Patient and Carer Experience Team extend their gratitude and appreciation to all of the patients who shared their experiences.

Teitl adroddiad: ***Report title:***	QSE Committee – Patient Safety, Effectiveness and Experience Report		
Adrodd i: ***Report to:***	QSE Committee		
Dyddiad y Cyfarfod: ***Date of Meeting:***	19th December 2023		
Crynodeb Gweithredol: ***Executive Summary:***	This report provides the Committee with assurance information and analysis on quality matters (a separate report covers quality related regulatory matters). The key points of note are: • The main themes of Nationally Reportable Incidents (NRIs) remain falls, healthcare acquired pressure ulcers, and the recognition and action on deteriorating patients. Improvement work for all these areas is progressing under the leadership of senior clinical staff. During the last period of data, the main theme was escalation and communication (verbal and nonverbal) relating to handovers of care and referrals. • One Never Event has occurred during this period. • The Coroners continue to raise serious concerns relating to the quality of investigations and evidence of action plan delivery – this has been raised with the Chief Executive directly and work is underway to explore a way to address this, which will be detailed in future reports. • The number of overdue patient safety incident investigations, and consequently closure within the target timeframe, remains a challenge. • The number of overdue complaints remains unacceptably high, with an unacceptable impact on patients and has an impact on the closure target compliance. • The Call 4 Concern initiative at YG has now been fully rolled out across the site.		
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:***	The various sections have been drafted by the respective leads: • Matthew Joyes, Deputy Director of Quality Governance and Dr Kath Clarke, Head of Quality Governance • Mandy Jones, Deputy Director of Nursing (Patient Experience) and Leon Marsh, Head of Patient Experience • Chris Lynes, Deputy Director of Nursing (Patient Safety) and Tracey Radcliffe, Head of Patient Safety • 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:***	
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. Deep dives are being undertaken to identify improvements and resource allocation reviewed.	
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Quality
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	The Duty of Quality is a statutory requirement under the Health and Social Care (Quality and Engagement) (Wales) Act 2020. The statutory duty of quality requires the decision-making processes by the Health Board take into account the improvement of health services and outcomes for the people of Wales – the duty also includes new Health and Care Quality Standards. Instances of harm to patients may indicate failures to comply with the NHS Wales standards or safety legislation.
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	N/A
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	N/A
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	BAF1.2

Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	N/A
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	N/A
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	N/A
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	BAF1.2
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	N/A
Camau Nesaf: Gweithredu argymhellion ***Next Steps: Implementation of recommendations*** N/A	
Rhestr o Atodiadau: ***List of Appendices:*** 1. QSE Committee Patient Safety, Effectiveness and Experience Report 2. Safeguarding Summary 3. Clinical Audit Activity Quarter 1 4. Clinical Audit Activity Quarter 2	

QSE Committee – Patient Safety, Effectiveness and Experience Report – December 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 Patient Safety, Effectiveness and Experience Report has been reformatted and is presented to the Committee as an emerging draft of a new report format. Feedback from the Committee is welcomed. The report is structured, for ease, around three domains of quality: patient safety, patient experience and clinical effectiveness.

1. PATIENT SAFETY

PATIENT SAFETY INCIDENTS

Key issues relating to patient safety incidents raised by IHCs/Divisions:

Never Event – wrong site surgery

Learning has been identified following a wrong scar tissue removal that was categorised as a Never Event. The learning has been identified as a requirement for improved medical staff documentation and the correct anatomical description of surgery site required, including the use of photography to identify the correct site. The pre – surgical checklists and safety huddle needs to be more robust and there is a need to review of the OPD minor operating theatre booking templates/schedules.
This feedback has been shared with the team involved and actions are being progressed. Further sharing of the learning will be via the Organisation Learning Forum and Theatre business Meetings.

Medication errors

Work is being undertaken in East IHC in relation to medication errors.

- Development of a focused medicines audit, reviewing access and storage, is in progress with support from the corporate nursing team.
- Support to improve Clinician's attendance at HARM's panel to progress with reductions in prescribing errors.
- Development of a database to enable identification of specific clinical locations where medication incidents occur. This will support progressive theme and trend analysis going forward. Developments in the East will then be shared across BCU to ensure consistency and standardisation.

Mental Health

A thematic review of the Substance Misuse Service is underway, with a Harm Reduction Service Manager having commenced in post on 16th of October 2023.
Patient abuse of staff incidents have been noted to have risen slightly in the last quarter and these remain the top reported incident for the Division. The majority of incidents remain low in severity and the data is being reviewed to ensure triggers and de-escalation actions are identified.
There has been a significant decrease in the number of reported ligature incidents in the period and is the lowest since April 2021. Early indication that the implementation of policies and procedures aligned to restrictive items, searching, clinical risk management and the aligned training is having an impact.

NRI themes/learning

The main themes of the learning from closed nationally reportable incidents during October 2023 were related to escalation and communication (verbal and non verbal) relating to handovers of care and referrals. A more detailed review of these cases is included in the private section of QSE papers.

Incident management process

A review of the current incident management process was held on 23rd October 2023, in conjunction with the BCUHB Quality Team and key stakeholders. The aim of the meeting was to identify how the function and incident management processes are currently supporting and how they need to be refined to provide increased assurance on effectiveness and a greater focus on learning. Engagement with IHCs to gain understanding of how the process and activities impact, and are implemented in the service areas, is due to take place in November.
Feedback from these events and further benchmarking and exploration of delivery models will be fed into the Quality System work that is being supported by the NHS Executive as part of Special Measures.

PATIENT SAFETY ALERTS

Outstanding Alerts

Nil

Submitted

NatPSA/2023/009/OHID - Potent synthetic opioids implicated in heroin overdoses and deaths compliance

PSN066 - Safer Temporary Identification Criteria for Unknown or Unidentified Patients compliance

In progress and within timescale:

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

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.

SAFEGUARDING

Safeguarding Summary Q1 and Q2 – please see appendix 2 for tables of detailed data.

Adult at Risk

- Increase in reporting is seen as a positive approach to Safeguarding

- Adult Safeguarding compliance has improved during 2023-24
- Over 70% of all concerns are raised by BCUHB for non-BCUHB sites or services
- Less than 5% of all concerns progress to a Strategy Meeting under the Adult at Risk Process. This demonstrates positive actions taken by BCUHB to both safeguard and subsequently reduce the risk of further harm, abuse or neglect.
- Increased reporting across all three BCUHB areas
- Significant increases in Central and West as a result of raised concerns in relation to Care Home/Home Care provision
- An increase in Modern Slavery concerns has led to more concerns about Care Home patients being submitted
- For assurance all concerns are reviewed by the Multi Agency Adult at Risk process managed by the respective Local Authorities

Child at Risk

- Increase of Child at Risk Reports within the Central IHC attributed towards the significantly improved mandatory safeguarding training compliance
- East & West have had slight decreases.
- In the East there has been a relaunch of their 'Team Around the Family' early intervention and prevention service which is a contribution factor to the decrease in reporting.
- The highest proportion of reports are for unborn babies and children under 5 years old.
- Health Visitors and Midwifery combined are the highest reporters (34% of all reports).
- Regular face-to-face contact with children and families and the increased ability to identify safeguarding concerns, including domestic abuse have contributed to the upward trend in reporting.

DoLS

- DoLS applications have increased steadily year on year as a result of mandatory and bespoke MCA training and awareness as well as staff understanding of the legislative framework
- There is a significant difference in the number of applications from each area.
- Work undertaken and ongoing suggests that this is due to demographics of the population in each respective area
- Numbers are increasing in the West and the appointment of an MCA Training Lead (on secondment) will strengthen link between services and further promote the MCA and DoLS agenda
- DoLS compliance is recorded as a Tier 1 Risk on the Corporate Risk Register
- Welsh Government currently providing non-recurring funding to support activity and reduce waiting lists

Multi-Agency Risk Assessment Conference (MARAC)

- Evidence that Domestic Abuse starts and/or increases during pregnancy has been identified.
- Actions are in place to support victims and explore further preventative measures.
- The number of MARAC cases has a significant impact upon Safeguarding resources and wider health practitioners who complete the research forms within a very short timescale.
- The Safeguarding Team continue to liaise with North Wales Police resulting in the distribution of the agenda for the Weekly MARAC Meetings improving significantly.

Procedural Response to Unexpected Deaths in Childhood (PRUDiC)

- There is continued evidence of multi-agency engagement and support when PRUDiCS are identified in the community and individuals are conveyed to hospital
- Compliance with the new PRUDiC guidance (2023) is monitored with good practice having been identified across respective BCUHB engaged services
- YGC ED & Paediatrics have managed four out of the five PRUDiCS in 2023-24
- Additional support has been provided to staff engaged within these emotive circumstances.

- Support has included safeguarding supervisions, attendance within debriefs, increased referrals to TRiM, and face-to-face discussions
- No specific safeguarding or criminal concerns have contributed towards the unexpected death of children during Q1 & Q2
- Themes have included adolescent mental health and the rapid deterioration of a child's physical health indicating infection or illness

INFECTION CONTROL

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

For our gram-negative bloodstream infections, we are below average and achieving the lowest rate for Klebsiella, we are on average and third highest for E.coli yet above average and second highest for Pseudomonas aeruginosa. There is a working group and a detailed action plan in place in East to manage and reduce the anti-microbial resistant gram negatives with any new cases being rapidly isolated into side rooms.

We are only slightly above average for Clostridioides difficile and third highest in Wales, however reporting less cases than for the same time period last year.

Having seen an increase on COVID-19 cases during September and October, the number of cases fell in November. Influenza and Norovirus is not currently causing concern across the Health Board.

The Infection Prevention Team and the Integrated Health Communities are working closely together to:

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

OTHER PATIENT SAFETY CONCERNS AND IMPROVEMENTS

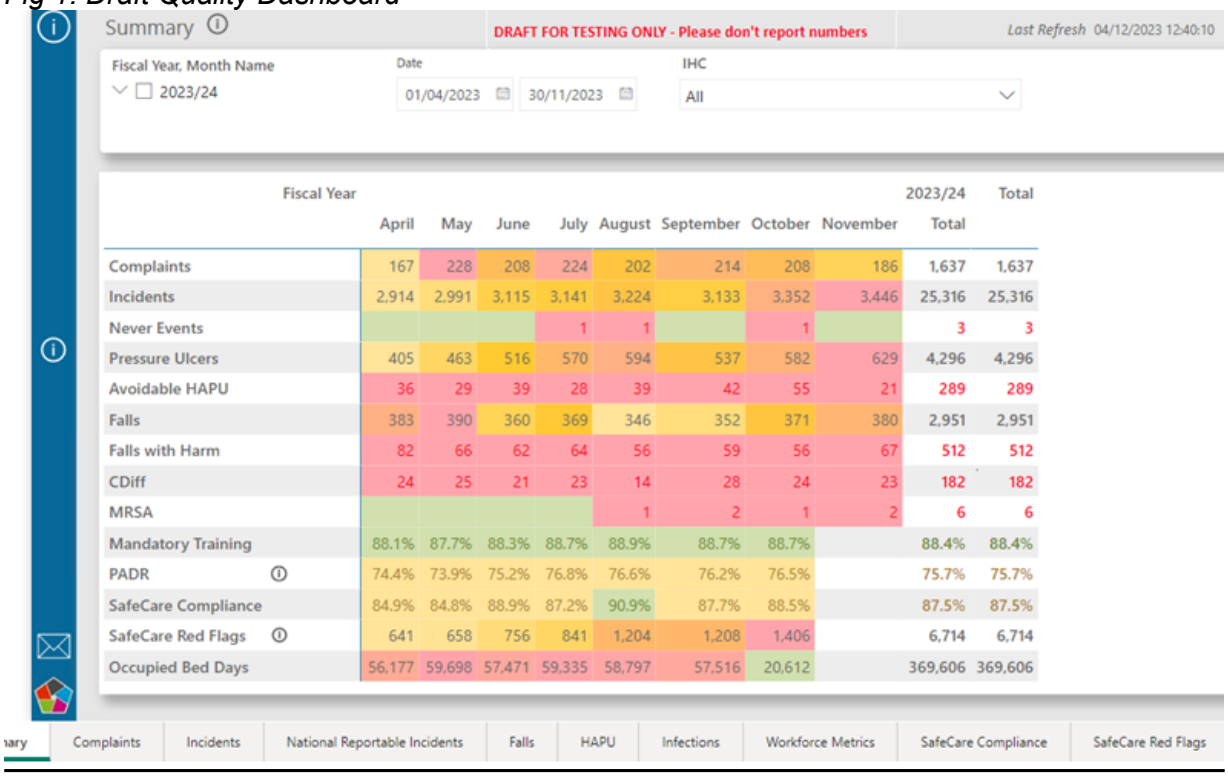
Quality Dashboard

The quality dashboard has been in development for some time, which will allow a more transparent quality position in the organisation and to allow consistent scrutiny. The plan is for the dashboard to be able to be interrogated and provided at a ward, department, site and IHC level, as well as an overarching Health Board level.

The screen shot below gives a first look at a limited, but populated dashboard, with a caveat that data validation still needs to be undertaken on the numbers presented.

Future meetings will see the quality dashboard presented with a narrative provided and areas escalated and mitigating actions identified. This may then inform areas for deep dives for the committee to undertake going forward.

Fig 1. Draft Quality Dashboard



Quality Strategy

The Quality Strategy continues to be a requirement for the organisation in line with the Duty of Quality introduced in April 2023. Work is continuing to engage with colleagues in the organisation, and to identify what priorities the board needs to focus on.
A decision is awaited where the Quality Strategy will be situated, and whether it will be a stand-alone Strategy or that it will be integrated as a golden thread through the organisations overarching Strategy. Updates will be brought through QSE and oversight of the development will come through the committee.

Nosocomial Covid-19 Project

Government funding allocated to BCU for the Covid 19 project ceases at end of March 2024. If trajectory is not met, then this will pose a reputational and potential financial risk to the organisation.

Current Position

- 1,483 cases remain to be investigated.
- 58.94% cases have been completed.
- 221 cases have been completed since last month.
- Based on August 2022 trajectories, BCUHB was 559 cases behind where we need to be in order to complete all investigations by March 2024.

(*Information provided 20.10.2023 by NHS Executive Business Analyst).*

The August position identified that the completion of all reviews would not be achieved by March 2024, so a review of activities and allocation of resources was undertaken by the internal team with support from NHS Executive.

Improvements in process and increased resource would suggest that the current trajectory will allow BCU to meet all the reviews required, as long as the current resource remains in place, and the pace of the reviews undertaken is maintained. The risk of losing resource and activity is being mitigated, with weekly oversight by the Executive Director of Nursing.

Operational Progress

- SBAR approach implemented for cases of low harm in outbreaks, which is proving to positively assist with overall efficiency of case completion.
- Scrutiny panels re-implemented and working well. Single case to be referred to legal and risk for omission in care.
- Acquisition of live case notes continues to be challenging since such records must be prioritised into clinical teams where patients are receiving current inpatient treatment.
- 3 weekly strategy meetings in place to provide support to the programme.

Communication / Letters update:

- All Wave 1 - 4 letters have been sent to patients
- Wave 1 and Wave 2 outcome letter distribution has commenced.

Staff Survey

The Learning from Staff Experience of Covid 19 Survey has now been now completed and themes are being reviewed and a report will be presented to the Executive Team before being shared with the wider organisation via the Organisational Learning Forum, and presented to QSE.

Medical Gases

Training arrangements for oxygen management and delivery is a continued risk (4649) for the Health Board. A task and finish group has been established, to include representation from IHCs/divisions with a remit to review the most appropriate options for training. Part of this review will be to consider an e-learning package from the National Association of Medical Device Educators and Trainers (NAMDET) which has just been made available.

To further support patient safety, a digital version of the CD oxygen cylinder is expected to be available once the licensing process is complete. This would reduce the risk of 'no flow' oxygen incidents - if the flow-rate is less than selected, or if the cylinder runs empty. Consideration of the options and costs of introducing digital cylinders needs to be given, and ensuring training reflects the changes if made.

Falls Improvement Group

The HSE and Internal Audit recommendations relating to falls have been combined in one overarching improvement plan for the Health Board that will be reviewed, monitored for progress and opportunities for sharing good practice by the monthly Health Board Inpatient Falls group. The group will escalate issues of significance to the Health Board Patient Safety Group. Work outside of the group will be undertaken to make sure that the evidence required from the IHCs is clear and provides assurance of the improvements.

The development of the Health Board Quality dashboard continues and will include data relating to all falls occurring and falls that have been with harm and will be presented the number per 1000 occupied bed days in line with the nationally recognised measures for Adult Inpatient Falls. This will allow oversight by QSE and updates regarding action plan progress will be provided at appropriate intervals.

Clinical Quality Support Tools for Care Homes across North Wales

In response to lessons learnt from Operation Jasmine – a review into serious neglect within Care homes in South Wales and key recommendations from the Older Persons Commissioner review into Care homes across North Wales the Care home corporate quality team have developed a Quality Assurance Framework (QAF). The HB previously had to submit action plans and update reports to the Older Person Commissioner on the implementation of key learning.

A key element to the QAF has been the development of a suite of clinical quality support tools (CQSTs), led by the Care Provider Quality Team in conjunction with specialist clinical teams, IHCs and providers. The CQSTs provide a mechanism for proactive quality monitoring, early detection, prevention and support within our Nursing Homes across North Wales. This also includes latest evidence, action plans, education materials for the care homes as part of a resource pack and also highlights area of training required. These tools have been in place for the last 18 months following a request by IHCs Practice development Teams to review the previous quality monitoring tool which was deemed no longer fit for purpose. The CQSTs have been recognised nationally as 'best practice', and with the recommendation from the CNOs office that theses should be adopted by other LHBs.

As the Operational delivery sits within the IHC's the tools should be undertaken by the Nursing Home Practice Development resource. When undertaken proactively they have been shown to improve quality and safety, reduction in escalating concerns and the need to place embargos on care home admissions and provide assurance to the HB on the standard of care delivery in our nursing homes.

Currently due to capacity and demand within the Practice development teams in some IHC's they are not able to implement any proactive monitoring and have paused using the CQSTS. There is a significant concern that this is leading to an increase in escalating concerns, clinical issues such as Tissue Viability and pressure sores. In addition, variation and limited assurance for the HB on the standard of care in our nursing homes, and lack of equity in the support to some homes and residents. This increases the risk of increased escalating concerns and safeguards leading to possible embargos on admissions to Care Homes impacting on optimal patient flow from hospital for this cohort of patients and wider impact on unscheduled and planned care.

Safe Care Collaborative – Call 4 Concern

Call 4 Concern has been implemented by the Acute Intervention Team in Ysbyty Gwynedd.

Call 4 Concern allows patients and families to activate a direct referral to the Acute Intervention Team if they have concerns that themselves or the patient/relative is deteriorating, and their concerns have not been recognised or acknowledged. The patient themselves and relatives will often pick up on deterioration before it is identified by staff. Having a Call 4 Concern service provides patients and families with a voice, and adds a safety net for our patients. Having patients involved in their health care treatment decisions improves patient safety, reduces harm and rebalances the relationship between individuals and health professionals. Having the Call 4 Concern service available within BCUHB has the potential to prevent patient deterioration, and will positively influence the quality of the patient and family experience.

The service was initially piloted with patients discharged from critical care to the general wards at Ysbyty Gwynedd. This allowed them to test the calling/referral system for a very small group of patients. From May 2022 – March 2023 the second phase of the pilot study included one surgical ward. During the pilot phase a total of 8 calls were received. From these calls 1 patient was escalated to critical care with another patient being treated on the ward which prevented a critical care admission from the Acute Intervention Team interventions. The Call 4 Concern initiative enrolled on the Safe Care collaborative programme in November 2022, which has provided the Acute Intervention Team with the support and guidance to implement the service to all adult in patients at Ysbyty Gwynedd in April 2023. Since April 2023, a total of 50 calls have been received.

The recommendation is to continue with the ongoing work of Call 4 Concern at Ysbyty Gwynedd, with the aim of having the service available at Central and East in the near future.

Massive Obstetric Haemorrhage Report

In August 2022 an Independent External Expert Review was commissioned to investigate 11 cases of Massive Obstetric Haemorrhage which occurred in the Ysbyty Glan Clwyd Maternity Unit, between

January 2022 and July 2022. Following receipt of the report, concerns were raised by a Consultant Anaesthetist as to the External Expert Reviewer's working knowledge of the All Wales Protocol (2017 and 2021), as some of the recommendations where contrary to the current national practice. Therefore, a second review was commissioned.

Two of the eleven individual cases reviewed in each report, identified that a Breach of Duty has been identified. These breaches are being progressed through the Putting Things Right (PTR) process.

The findings and recommendations of both reviews have been collated into one overall improvement plan which will be monitored by the Women's Service Senior Leadership Team and assurance updates will be provided to the Women's Service Board on a quarterly basis or until actions are completed and full assurances received. QSE will receive updates and escalations as required.

The report will be attached to the private quality report, for context and understanding of further presented updates.

2. PATIENT EXPERIENCE

COMPLAINTS

During September 2023 to October 2023 the Health Board received 445 complaints, 354 of these were managed under Putting Things Right, an additional 68 were resolved as Early Resolutions and 26 complaints re-opened (re-opened concerns refer to complaints which have been re-opened due additional questions raised or dissatisfaction with the initial response).

The majority of the complaints related to Secondary Care Services. The top themes relate to: clinical treatment and assessment, poor communication, appointments and medication. Pro-active work is ongoing with the Patient Advice and Liaison Service (PALS) to coordinate with services, addressing recurring themes. The PALS team are providing patient and carer experience training which includes empowering staff to resolve low level concerns. Attitude and behaviour issues are common themes across all services which is consistent with the communication issues.

To support the achievement of the key performance indicators, each Integrated Health Community (IHC) has adopted weekly Putting Thing Right Meetings to manage the progress of complaints received. In addition, a weekly scrutiny meeting to manage the overdue complaints backlog is well established and chaired by the Deputy Executive Director of Nursing, this includes monitoring of complaints which are potentially becoming overdue during the next 7 days, this supports early intervention.

There were 296 overdue complaints at the end of October 2023. This is a reduction of 14% of overdue complaints since January 2023, the position in January 2023 was 344 overdue complaints. However, the overdue numbers have remained consistent over the past quarter due to the volume received and the impact of a significant number of planned care enquiries that have yet to have an outcome identified.

The Complaints Team are currently working to trajectories to reduce the overdue complaint number by 20 complaints per month from the overall overdue numbers. It has been identified that the numbers are not reducing to the volume expected due to a high number 'tipping over' and becoming overdue over the week. The Complaints Team have adopted a targeted approach to ensure that new complaints are closed within the 30 working day timeframe, streamlining the approvals process, ensuring that those due to becoming overdue are prioritised to ensure that deadlines are met.

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

The number of complaints closed from the 1st of September 2023 to the 30th of October was 410 complaints, of those 319 were managed under Putting Things Right, 65 Early Resolution, and 26 re-opened.

It has been highlighted during the teams Putting Things Right Compliance / Quality Assurance review of complaints, that 40% are being returned to the service due to poor quality and lack of local quality assurance, reports aren't addressing all the questions raised which is often due to the lack of communication from the investigating officer once the concern is received to ensure all issues are addressed. This intelligence is being utilised by the team and the team will be providing additional training and support to complaint authors to ensure improved quality and consistency of responses.

There are several complaints currently awaiting input from the Redress team including the Legal and Risk Services, as there has been an impact on staffing within the redress team, it is becoming difficult to provide timely advice to support the complaint resolution.

The Complaints Team are currently managing several complex complaint cases where the Unreasonable Behaviour Policy may have been adopted to support the management of these complaints, this ensures that a designated point of contact is implemented to ensure that the Health Board captures and investigates all concerns raised.

PATIENT FEEDBACK

Patient Advice Liaison Service (PALS)

Within this reporting period the Patient Advice Liaison Service (PALS) facilitated the resolution of 1237 enquiries of which, 77 were escalated to formal complaints in line with the PALS operating model. This means enquirers were dissatisfied with the resolution provided by PALS or allegations of harm were identified. Targeted work is being undertaken with each IHC to identify and support areas where PALS enquiries are being escalated to formal complaints due to dissatisfaction. The aim is to reduce the number of PALS cases that escalate to a formal complaint.

The key themes identified from PALS enquiries:

- Delays in appointments
- Delay in treatment
- Attitude and behaviour of clinical staff
- Communication with patient/service user
- Communication with family
- Patient stories

Patient Surveys

From September 2023 to October 2023 the Patient & Carer Experience Team received 7745 patient experience feedback responses via the Civica feedback system. The newly launched SMS service offers the survey via a text to all patients attending an Outpatient appointment, 5388 responses collected in this reporting period were received through SMS relating to outpatient services. This demonstrates the importance and value of SMS feedback and the team seek support to role this out to each Emergency Department.

Key findings from the survey feedback include:

- 80.92% of staff always introduced themselves
- 83.33% of respondents always felt listened to
- 80.8% of respondents felt that staff took the time to understand what mattered to them as a person and took this into account when planning and delivering their care.

There are now nine Civica feedback kiosks installed pan BCUHB. The kiosks are located in outpatient areas, Emergency Department waiting areas, Cancer Services and community hospitals.

The feedback kiosks provide patients, relatives and carers with the opportunity to record their experience using our Civica feedback survey.

A BCUHB Civica task and finish group has been established to review the system functionality and to look to see how BCUHB can increase feedback responses, reporting and demonstrate learning from patient feedback.

Emergency Care Feedback

In August 2023 an All Wales Emergency Department national patient feedback survey was launched. Unfortunately, there has been a lower response than anticipated with only 46 responses collected within the reporting period.

The Patient and Carer Experience Team are encouraging responses from patients, relatives and carers who visit our emergency sites pan BCUHB through promotional initiatives and providing training to staff. Ways in which to improve uptake and to ensure the feedback is representative across BCU will be explored at the next Patient Experience Group meeting.

OTHER PATIENT EXPERIENCE CONCERNS AND IMPROVEMENTS

PALS Officers delivered patient and carer experience training and PALS awareness training to 161 staff across North Wales, for the following service areas:

- Health Board Led Practice Education Training Session for non -managed and managed practices
- Newly qualified surgical directorate Nurses
- Physician Associates pan BCUHB
- Emergency Department staff at Ysbyty Glan Clwyd
- Cancer Services – CNS Forum meeting, Assistant practitioner forum meeting centre AP forum West, AP Forum East.

Welsh Interpretation and Translation Service (WITS)

From September 2023 - October 2023, the Welsh Interpretation and Translation Service (WITS) received 804 bookings to support BCUHB patients. A ‘Digital First’ initiative is promoted whereby staff are advised to book remote digital support, in the first instance. This is not available for BSL interpretation, although an online BSL service will be promoted as part of staff communication. There has been an increase in the number of face to face interpreter bookings which has resulted in increased spend.

Due to BCUHB demographics and geographical location BCUHB are spending a significant amount of money on paying for travel costs and expenses for interpreters to travel into Wales to attend an appointment. Prior to the launch of digital first initiative BCUHB interpretation costs were approximately £47,000, per month. In February 2023, the impact of digital first reduced monthly invoicing to £26,000, however we have noted a gradual increase in these costs to pre digital levels due to an increase in face to face bookings. The Patient and Carer Experience Team continue to engage with services, staff and departments to promote and remind them of the accessibility of the digital service available to support translation and interpretation.

Patient and Carer Champions

The Patient & Carer Experience Team continue to train and support 124 Patient and Carer Champions across the Health Board. Staff who are Patient & Carer Champions are passionate about improving health and delivering excellent patient care. Within the reporting period guest speakers have attended monthly sessions to talk to the champions about areas such as the lost property process and the Intravenous Access Service. The Digital Delivery Strategic Engagement Team also

attended to update Champions on the development of the new BCUHB Digital Strategy and the impact for staff and patients.

Emergency Department Ysbyty Gwynedd

PALS Officers have been supporting and engaging with staff at the Emergency Department, Ysbyty Glan Clwyd. PALS Officers provide a daily presence speaking to patients, relatives and carers who are waiting to be seen. It has been agreed with site management that when the Emergency Department escalates to a level 4, meaning a considerable amount of patients are within the department, PALS will attend to provide support. The feedback kiosk situated in ED is being re-located to a more central point with bi-lingual information and guidance on how to provide feedback. All Health Care Support Workers have now received patient and carer experience training. Bite size training based on issues raised via the weekly PALS report to acknowledge feedback, trends and themes is due to commence with ED staff and a PALS Officer present.

SBRI Patient Communication

A SBRI Patient Communication pilot project in Ysbyty Glan Clwyd is now live. Ward 9 are now sending daily updates to relatives through a digital system. Ward 1 and 5 are due to go live over the next two weeks. The pilot will run for 3 months. The aim of the project is to improve communication between the family/relative whilst their loved one is in hospital.

Chaplaincy and Spiritual Care

As of the 1st September 2023, the Chaplaincy and Spiritual Care Service pan North Wales joined the Patient and Carer Experience Department, working together to support patient, family and carer experiences. The chaplaincy continues to develop outreach events on wards and in community hospitals, including music, art, group chats and 1-1 pastoral work. Within the reporting period the service has been involved in a number of public celebrations and memorials, including Organ Donation Week, Remembrance Services and Dedication to Veterans. In October 2023, the Chaplain Service made Qur'an Cubes available for staff and patients to support members of the Muslim community with an audible version of their holy book.

Chaplain and Spiritual Care Service recently received charitable funding from Awyr Las to purchase a new Christian Altar and Credence Table for Glan Clwyd Chaplaincy worship area and a new multi-faith information trolley for staff to access for Ty Llywelyn Medium Secure Unit.

3. CLINICAL EFFECTIVENESS

CLINICAL AUDIT

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

Tier 1 audits are required annually, prioritised by Welsh Government, and are mandatory. They are focused on the areas that NHS Wales have identified as key to ensure that we continue to drive forward improvements in the quality and safety of healthcare services in Wales.

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

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

during Quarter 1 and Quarter 2 and an update on key achievements, for more detailed information the reports are attached for reference. (Appendix 3 and 4).

				West	Central	East	
Tier 1 Mandatory Audits Title of National Audit	**Name of report**	**Date of publication**	**Date Service Assessment response due**	**Service Assessment Completed**	**Service Assessment Completed**	**Service Assessment Completed**	**Key Achievements Summary/General update**
National Paediatric Diabetes Audit (NPDA)	Annual report 2021-22: Care processes and outcomes	05-Apr-23	31-May-23	Yes	Yes	No	Service assessment response, due May 2023, not received from IHC East (received for IHC Central & West). Lack of engagement to requests for a response to the publication escalated to IHC through local Clinical Effectiveness (CEG) Meeting in June. Chair of CEG meeting agreed to contact lead to progress this response.
National Lung Cancer Audit	State of the Nation Report 2023	13-Apr-23	08-Jun-23	Yes	Yes	Yes	Proportion of patients with Non-Small Cell Lung Cancer (NSCLC) undergoing resection surgery has increased from 11.1% to 20.3% which is now above the national benchmark of 17%
National Heart Failure Audit (NHFA)	2023 Summary Report	09-Jun-23	26-Sep-23	Yes	Yes	Yes	• East-Cardiac rehab referrals have increased to 25% which is up from the previous year, however ongoing work continues with cardiac rehab. • BNP blood test has gone live for acute care across BCU – recommended by NICE• East - Beta Blocker 91% which exceeds the previous year and exceeds NICE target• Centre- Have good discharge planning and lessons to be learned for North Wales• 81% of patients received an ECHO which exceeds the previous year and with NTproBNP available, this will allow for the appropriate triage of ECHO and facilitate early diagnoses.
National Audit of Cardiac Rhythm Management Devices and Ablation (NACRM)	2023 Summary Report (2021/22 data)	09-Jun-23	26-Sep-23	Yes	Yes	Yes	Draft Service Assessment response received however details still under review, will be included in Quarter 3 report.
National Audit of Percutaneous Coronary Intervention (NAPCI) Audit	2023 Summary Report	09-Jun-23	26-Sep-23	N/A	Yes	N/A	Best performing 60-minute Door to Balloon (DTB) in Wales with 72.16% of patients meeting the target.
Myocardial Ischaemia National Audit Project (MINAP)	2023 Summary Report	09-Jun-23	26-Sep-23	Yes	Yes	Yes	Draft Service Assessment response received however details still under review, will be included in Quarter 3 report.
National Audit of Care at the End of Life (NACEL)	2022/23 Annual Report (Round 4)	13-Jul-23	07-Sep-23	Yes	Yes	Yes	BCUHB hospitals have access to face to face specialist palliative care, 8 hours a day, 7 days a week through clinical nurse specialist support. The UK national average for this service was 60% of health-boards/trusts. BCUHB also has access to a telephone specialist palliative care service (doctor led) available 24 hours a day, 7 days a week.

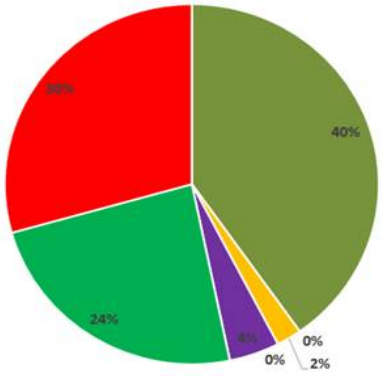
The National Clinical Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)	Epilepsy12 2023 combined organisational and clinical audits 2020-22	13-Jul-23	07-Sep-23	Yes	Yes	Yes	BCUHB is compliant with the Welsh standards for the organisational element of the audit. Wales scored 73%. Data completeness was 100% for this cohort. This improves assurance for patient care. The overall case ascertainment for Betsi Cadwaladr University LHB is the same as the national standard. 10 out of 12 KPIs were comparable with the mean for Wales overall.
National Dementia Audit	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 Joint Registry	20th Annual Report 2023 - Surgical data to 31 December 2022	28-Sep-23	06-Dec-23	In progress	In progress	In progress	Draft Service Assessment response received however details still under review, will be included in Quarter 3 report.
National Hip Fracture database (Falls & Fragility Fractures Audit Programme)	15 Years of Quality Improvement. The 2023 National Hip Fracture Database Report on 2022. 1st Jan 2022-31 Dec 2022	14-Sep-23	14-Nov-23	In progress	In progress	In progress	Draft Service Assessment response received however details still under review, will be included in Quarter 3 report.

NICE GUIDELINES

All NICE guidance is now being managed on the database Audit Management and Tracking (AMaT), from April 2023 and the graphs below show our current percentage for guidance published since that date.

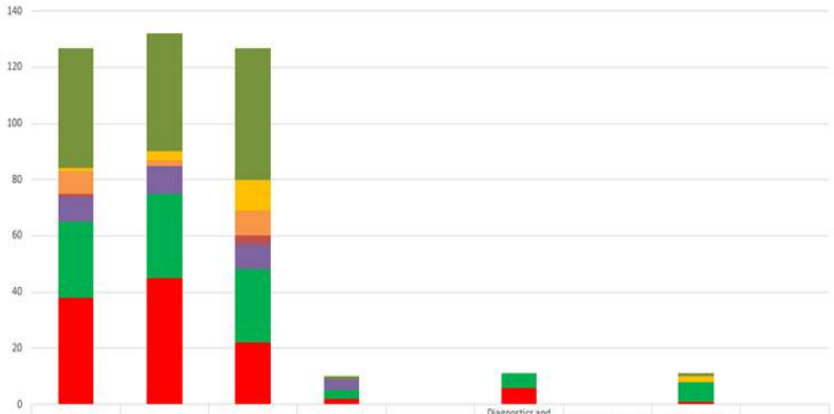
Initially, a pilot was completed within Women's to monitor the database and reports produced and as it was working well, as we finalised the hierarchy on the database, training has started to be rolled out to IHCs and Divisions designated leads. This has allowed us to get a clear picture of compliance and there will continue to be a considerable amount of support from all IHCs/Divisions to increase the overall percentage. Below is detail of our current percentage.

Overall BCUHB Compliance Status



	Count	%
Fully Achieved	37	40%
Partially Achieved - Acceptable	0	0%
Partially Achieved - Improvement Needed	2	2%
Not Achieved	0	0%
Not Applicable (N/A)	4	4%
In Progress	22	24%
Overdue	27	29%
	92	

Status of compliance responses by IHC/Pan BCUHB divisions*

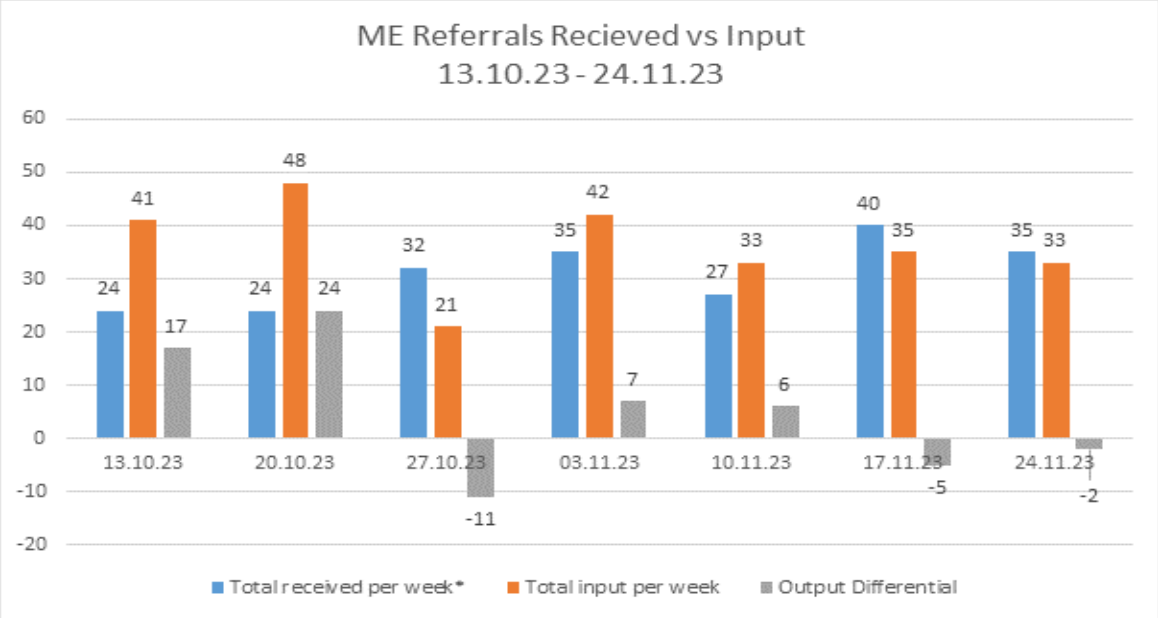


	IHC West	IHC Central	IHC East	Cancer	Dentistry	Diagnostics and Specialist Clinical Support Services	Mental Health and Learning Disabilities	Midwifery and Women's Services	Corporate Services
Fully Achieved	43	42	47	1	0	0	0	1	0
Partially Achieved - Acceptable	1	3	11	0	0	0	0	2	0
Partially Achieved - Improvement Needed	8	2	9	0	0	0	0	0	0
Not Achieved	1	0	3	0	0	0	0	0	0
Not Applicable (N/A)	9	10	9	4	0	0	0	0	0
In Progress	27	30	26	3	0	5	0	7	0
Overdue	38	45	22	2	0	6	0	1	0

** guidance is circulated to each relevant speciality for them to respond, compliance responses could be requested from more than one speciality within each IHC/Pan BCU divisions per guidance*

MORTALITY REVIEWS

Date	Input/output			Inputting Backlog				Datix Status										
	Total received per week*	Total input per week	Output Differential	Total w/e Backlog inc compliments	Backlog of cases requiring inputting within 1 month from date received by MES	Backlog of cases requiring inputting within 2 months from date received by MES	Backlog of cases requiring inputting within 3 months from date received by MES	Total New cases (awaiting mortality admin s&s)	New Under 1 month DOD (awaiting mortality admin s&s)	New Within 2 months DOD (awaiting mortality admin s&s)	New Within 3 months & over DOD (awaiting mortality admin s&s)	Total Pending Cases awaiting Mortality Clinician Review S&S	Pending Cases Under 1 month awaiting Mortality Clinician Review 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)	Under investigation / action required (with IHC's, for IHC's to RAG)	Process completed
13.10.23	24	41	17	32	32	0	0	234	62	118	54	27	3	1	23	347	193	1633
20.10.23	24	48	24	7	6	1	0	244	83	101	60	15	1	10	4	364	192	1660
27.10.23	32	21	-11	17	17	0	0	256	77	99	80	17	1	12	4	361	194	1668
03.11.23	35	42	7	10	10	0	0	283	79	102	102	0	0	0	0	363	196	1688
10.11.23	27	33	6	10	10	0	0	304	86	98	120	0	0	0	0	364	197	1696
17.11.23	40	35	-5	15	15	0	0	336	101	86	149	0	0	0	0	364	197	1696
24.11.23	35	33	-2	17	17	0	0	351	93	95	163	0	0	0	0	261	197	1698



OTHER CLINICAL EFFECTIVENESS CONCERNS AND IMPROVEMENTS

All services participating in National Clinical Audits and Outcome Reviews are now being asked to complete the Service Assessment form that is sent out to the recommendations made in the published report for the mandatory National Audit/Review. Within the review information noted below is captured:

- Key achievements for the Service
- Where and when the SMART Action Plan was agreed?
- Where has learning from this audit been disseminated?
- Please outline how the National Audit findings and recommendations are used to inform local continuous quality improvement and local audits for the Service?
- Data collection issues
- Improvements achieved (noted in Clinical Audit section above)

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

Title of National Audit/ Clinical Outcome Review	East Participation/Data collection issues reported	Central Participation/Data collection issues reported	West Participation/Data collection issues reported
NELA - National Emergency Laparotomy Audit			BCU lead raised 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 SCEG September 2023.
Trauma Audit & Research Network (TARN)			UK Trauma Registry shut down due to cyber-attack on host. No data collection since June 2023 (UK wide). Contingency tool promised but never provided. New Registry in development - no release date as yet - and the backlog will be huge.
National Diabetes Inpatient Safety Audit (NDISA)	HARMS element - data submission to this element of the audit not established since the re-launch in Nov 2022	HARMS element - data submission to this element of the audit not established since the re-launch in Nov 2022	HARMS element - data submission to this element of the audit not established since the re-launch in Nov 2022
NRAP: Adult Asthma	Never submitted data to this audit	No data submitted since Nov 2019	Data submitted up to Feb 2023 (issue raised Oct 23)
NRAP: Children and Young People Asthma	Data submitted up to Jul 2023 but struggling to meet the Nov 2023 deadline	Data submitted up to Feb 2023 (issue raised Oct 23)	No data submitted since Nov 2019
National Early Inflammatory Arthritis Audit (NEIAA)	New elements added to this audit which are not being captured due to resources		New elements added to this audit which are not being captured due to resources
National Dementia Audit	Not participating in Round 6, HB decision to pool resources and submit for 1 site only	Not participating in Round 6, HB decision to pool resources and submit for 1 site only	
NRAP: COPD	Never submitted data to this audit		

Patient Safety, Effectiveness and Experience Report

Appendix 2

Safeguarding Summary Data Q1 and Q2

Adult at Risk

Table 1: *Adult at Risk Reports by year*

Year	Reports
2017-18	1034
2018-19	1113
2019-20	1219
2020-21	1282
2021-22	1406
2022-23	1716
2023-24 (Q1-Q2)	1033 (trajectory 2066)

Table 2: *Adult at Risk reports by Area Q1 – Q2*

	2022-23 (Q1-Q2)	2023-24 (Q1-Q2)	Trend
West	299	342	↑ 14.4%
Central	260	360	↑ 38.5%
East	309	316	↑ 2.3%
Out of Area	18	15	↓16.7%
Total	886	1033	↑ 16.6%

Child at Risk

Table 3: *Child at Risk Reports by year*

Year	Reports
2019-20	2867
2020-21	3116
2021-22	3642
2022-23	4130
2023-24 (Q1-Q2)	2327 (trajectory 4654)

DoLS

Table 4: *DoLS Applications by Area per and year*

Year	West	Central	East	England	Applications
2018-19	89	257	343	55	743
2019-20	177	282	483	72	1014
2020-21	208	322	550	82	1162
2021-22	251	333	925	120	1629
2022-23	267	352	824	134	1577

2023-24 (Q1 & Q2)	138	243	467	87	935 (trajectory 1870)	

Multi-Agency Risk Assessment Conference (MARAC)

Table 5: *MARAC by health*

Year	West	Central	East	Out of Area	Total
2018-19	46	57	68	0	171
2019-20	66	53	61	0	180
2020-21	46	68	63	0	177
2021-22	54	83	64	0	201
2023-24	60	86	84	2	232
2023-24 (Q1 & Q2)	22	42	43	0	107 Trajectory (214)

Procedural Response to Unexpected Deaths in Childhood (PRUDiC)

Table 6: *PRUDiC by year and area*

Year	West	Central	East	Other	Total
2018-19	2	4	8	0	14
2019-20	3	7	4	0	14
2020-21	2	4	3	0	9
2021-22	5	5	8	0	18
2022-23	0	6	4	1	11
2023-24 (Q1 & Q2)	0	2	3	0	5 (trajectory 10)

Quarter 1 April 1st – June 30th 2023

Clinical Audit Activity

1.0 The National Audit Programme and Clinical Effectiveness Overview

The Health Board receives an annual notification of the National Clinical Audit and Outcome Review Plan (NCAORP) from Welsh Government (WG), which describes priority areas for completion by all Health Boards regarding mandatory audits; these form our Tier 1 activity. Relevant Tier 1 (National audits) is incorporated within relevant Divisional/Directorate annual clinical plans, progress on which is then reported by the Clinical Effectiveness Department on a quarterly basis.

2.0 Risks reported to the Clinical Effectiveness Team

No new risks reported to Clinical Effectiveness during Quarter 1.

3.0 Tier 1 Overview of Quarter 1 - Clinical Audit Activity 2023-2024

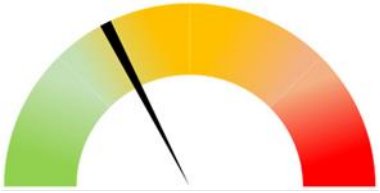
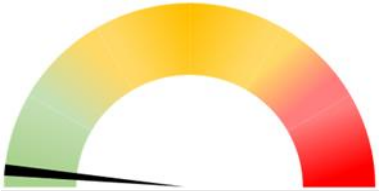
The tables below show the position on 30/06/2023 (end of Quarter 1).

	Q1 Apr-Jun	**Q2 Jul-Sep**	**Q3 Oct-Dec**	**Q4 Jan-Mar**	**Expected publication/activity 2024-2025**
Estimated publications due	6	11	10	6	7
Actual publications	6	0	0	0	-
Service assessments due	2	8	9	12	9
Service assessments received	1	0	0	0	-
Service assessments overdue	1	0	0	0	-

3.1 BCUHB Assurance returns

3.1.1 List of completed Service Assessment returns

One of the **2** service assessment returns due were received during Quarter 1– please see table below.

National Audit publication	**Lessons/Actions**	
National Lung Cancer Audit (NLCA) - State of the Nation Report 2023	**Assurance level:** Significant  The service is above the national benchmark in over 75% of measures and has shown significant improvement in the surgical resection measure, which had previously been an area of concern.	**Clinical risk level:** None  There is no deficit in compliance against the audit standards
	BCUHB Action plan received outlining the following actions: • **Proportion of patients with pathological diagnosis** – results (84.7%) just below the national benchmark (90%), data to be re-audited to establish whether this is a data accuracy issue; if not, the reasons will be reviewed, and an action plan agreed at the Lung Cancer Clinical Advisory Group meeting (Quarter 3) • **Proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy** – results (67.3%) slightly below the national benchmark (70%). Local data will be re-audited to establish whether this is a data accuracy issue; if not, the reasons will be reviewed, and an action plan agreed at the Lung Cancer Clinical Advisory Group meeting (Quarter 3)	

In addition to the service assessments above, action plans were received during Quarter 1 for projects that were delayed from previous Quarters (this includes publications from Quarter 4 with responses expected and received in Quarter 1)

<table>
<tr><th>National Audit publication</th><th colspan="2">Lessons/Actions</th></tr>
<tr><td rowspan="2">National Oesophago-Gastric Cancer Audit (NOgCA) – 2022 Annual Report (2019/21 audit period)</td><td>Assurance level: Significant
 
Points of variance are under review particularly with respect to point of diagnosis of Oesophago-Gastric (OG) cancers presenting to the service</td><td>Clinical risk level: None
 
There is no deficit in compliance against the audit standards</td></tr>
<tr><td colspan="2">BCUHB Action plan received outlining the following:
Robust Data collection of Point of diagnosis - Review to ensure data capture is robust outlining point of diagnosis of OG cancers to the service to be undertaken by the Lead clinicians on each site. (Quarter 2 2023/24)</td></tr>
</table>

3.1.2 List of outstanding Service Assessment returns expected during Quarter 1

National Audit publication	Reason for non-response & escalation
National Paediatric Diabetes Audit (NPDA) - Annual report 2021/22: Care processes and outcomes	**Service assessment response, due May 2023, not received from IHC East (received for IHC Central & West)**. Lack of engagement to requests for a response to the publication escalated to IHC through local Clinical Effectiveness (CEG) Meeting in June. Chair of CEG meeting agreed to contact lead to progress this response.
National Emergency Laparotomy Audit (NELA) Year 8	**Service assessment response –** will now report in Quarter 2.

3.1.3 Escalation of outstanding Service Assessments expected in previous quarters

National Audit publication	Assurance response due in Quarter Report	Escalation during quarter 1
National Paediatric Diabetes Audit (NPDA) - Parent and Patient Reported Experience Measure (PREMs) 2021	Quarter 4	**Service assessment response not received from East (received for Central & West area)**. Lack of engagement to requests for a response to the publication escalated to area through local Clinical Effectiveness Meetings (April, May & June) and discussed with BCUHB Diabetic lead in follow up meeting in April 2023, who will support progress with outstanding diabetic responses.
In-patient Falls Audit (Falls & Fragility Fractures Audit Programme) - Working together to improve inpatient falls prevention (2021 clinical & 2022 facilities audit data)	Quarter 4	**Service assessment response not received for all three areas**. Lack of engagement to requests for a response to the publication escalated to area through local Clinical Effectiveness Meetings (April, May & June). At the June East IHC CEG meeting Chair has asked if we could send the Audit Lead names for East area as he will email them direct

National Early Inflammatory Arthritis Audit (NEIAA) - Year 4 Annual Report (2021/22)	Quarter 4	**Final Action plan not received for all three areas**. Project Lead has drafted an action plan during Quarter 4, awaiting details of SMART actions. Lack of engagement to requests for a response to the publication escalated to area through local Clinical Effectiveness Meetings (April & May)
Renal Registry - 24th Annual Report	Quarter 4	This audit reports as a BCU wide service. Clinical Lead finalising detail of SMART Action Plan in Quarter 4.
National Diabetes Audit - - 2017-21 Adolescent and Young Adult (AYA) Type 1 Diabetes Report	Quarter 3	**Service assessments response not received from all areas**. Lack of engagement to requests for a response to the publication escalated to area through local Clinical Effectiveness Meetings (April, May & June) and discussed with BCUHB Diabetic lead in follow up meeting in April 2023, who will support progress with outstanding diabetic responses.
NACAP: Adult Asthma & COPD (Chronic Obstructive Pulmonary Disease) - 2021 Organisational Report	Quarter 3	**Service assessments response not received from all areas.** Respiratory team currently feel they are not able to submit an action plan as the lack of progress against many of the requirements is stark. Our services are so far behind post covid and due to loss of staff that any response to the organisational audit is far off the (Key Performance Indicators) KPIs. Ongoing issues with participation with **East** and **West**, **Central** have employed admin for 0.5 WTE from November 2022 to help with data submission who is doing an excellent job at collecting & entering this data. All issues have been escalated to the local Clinical Effectiveness Groups. At the June East IHC CEG meeting Chair has asked if we could send the Audit Lead names for East area as he will email them direct
National Diabetes Audit: Type 1 Diabetes 2020-21 Report	Quarter 3	**Service assessments response not received from all areas**. Lack of engagement to requests for a response to the publication escalated to area through local Clinical Effectiveness Meetings (April, May & June) and discussed with BCUHB Diabetic lead in follow up meeting in April 2023, who will support progress with outstanding diabetic responses.
National Diabetes Inpatient Safety Audit (NDISA) – 2018-21 Report	Quarter 3	**Service assessments response not received from all areas**. Lack of engagement to requests for a response to the publication escalated to area through local Clinical Effectiveness Meetings (April, May & June) and discussed with

		BCUHB Diabetic lead in follow up meeting in April 2023, who will support progress with outstanding diabetic responses.
National Hip Fracture database – 2021 Report	Quarter 3	**Service assessments response not received for East**. Received draft response from West and Central but returned as not SMART actions, both areas now working towards finalising on the new service assurance proforma. At the June East IHC CEG meeting Chair has asked if we could send the Audit Lead names for East area as he will email them direct

3.2 Benchmarking

When a National Audit report includes Health Board specific data, we benchmark BCU against the National outcomes and against BCU data in previous reports.

Six National Audit reports have been published in Quarter 1, all included BCU identifiable data.

The table below outlines the benchmarking information:

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

Tier 1 **Project reference**	**Title**	***Performance against***		***Progress / Completed Actions***	***Outstanding issues - by whom by when***
		National Benchmark	***Last BCU report***		
Long Term Conditions					
NCAORP/2023-24/09	National Paediatric Diabetes Audit (NPDA)	G	G	• Maintained compliance when compared to the last report and national benchmark	• Service assessment response due to be completed in Quarter 1 (Referenced in 3.1.2)
Cancer					
NCAORP/2023-24/29	National Lung Cancer Audit	G	G	• Maintained compliance when compared to the last report and national benchmark	• Service assessment response completed in Quarter 1

Tier 1 Project reference	Title	*Performance against*		*Progress / Completed Actions*	*Outstanding issues - by whom by when*
		National Benchmark	*Last BCU report*		
Heart					
NCAORP/2023-24/23	National Heart Failure Audit	A	A	• Maintained the previous standard overall although some KPIs improved and some deteriorated	• Service assessment response due to be completed in Quarter 2
NCAORP/2023-24/24	National Audit of Cardiac Rhythm Management	A	A	• Maintained the previous standard overall although some KPIs improved and some deteriorated	• Service assessment response due to be completed in Quarter 2
NCAORP/2023-24/25	National Audit for Percutaneous Coronary Intervention (PCI)	A	A	• Maintained the previous standard overall although some KPIs improved and some deteriorated	• Service assessment response due to be completed in Quarter 2
NCAORP/2023-24/26	Myocardial Ischaemia National Audit Project (MINAP)	A	A	• Maintained the previous standard overall although some KPIs improved and some deteriorated	• Service assessment response due to be completed in Quarter 2

3.3 Assurance response timetable for reports published in Quarter 4 - as of 31st March 2023

Project Reference	Title of National Audit	Name of report	Date of publication	Service assessment response due in Quarter Report
NCAORP/2023-24/09	National Paediatric Diabetes Audit (NPDA)	Annual report 2021/22: Care processes and outcomes	5th April 2023	Quarter 1
NCAORP/2023-24/29	National Lung Cancer Audit	State of the Nation Report 2023	13th April 2023	Quarter 1
NCAORP/2023-24/23	National Heart Failure Audit	2023 Summary Report	9th June 2023	Quarter 2
NCAORP/2023-24/24	National Audit of Cardiac Rhythm Management	2023 Summary Report (2021/22 data)	9th June 2023	Quarter 2
NCAORP/2023-24/25	National Audit for Percutaneous Coronary Intervention (PCI)	2023 Summary Report	9th June 2023	Quarter 2
NCAORP/2023-24/26	Myocardial Ischaemia National Audit Project (MINAP)	2023 Summary Report	9th June 2023	Quarter 2

Key	**Red**	Response overdue
	Amber	Response not received but within deadline
	Green	Response received

4.0 Tier 2 Audit Program

The Tier 2 program is a suite of audits mandated across the Health Board (which are not reported nationally) related to high-risk activity and corporately agreed service improvement priorities. It is likely that the number of these audits will increase in line with evidence from Harms Reviews, Concerns Recommendations, Prevention of Future Death Notices, and Ombudsman Reports. The Clinical Effectiveness team is working closely with the Quality Department to ensure that the correct Tier 2 audit program is in place to provide assurance across the risks that the Health Board holds.

Tier 2 reports/updates below have been submitted in Quarter 1 (as per the reporting schedule).

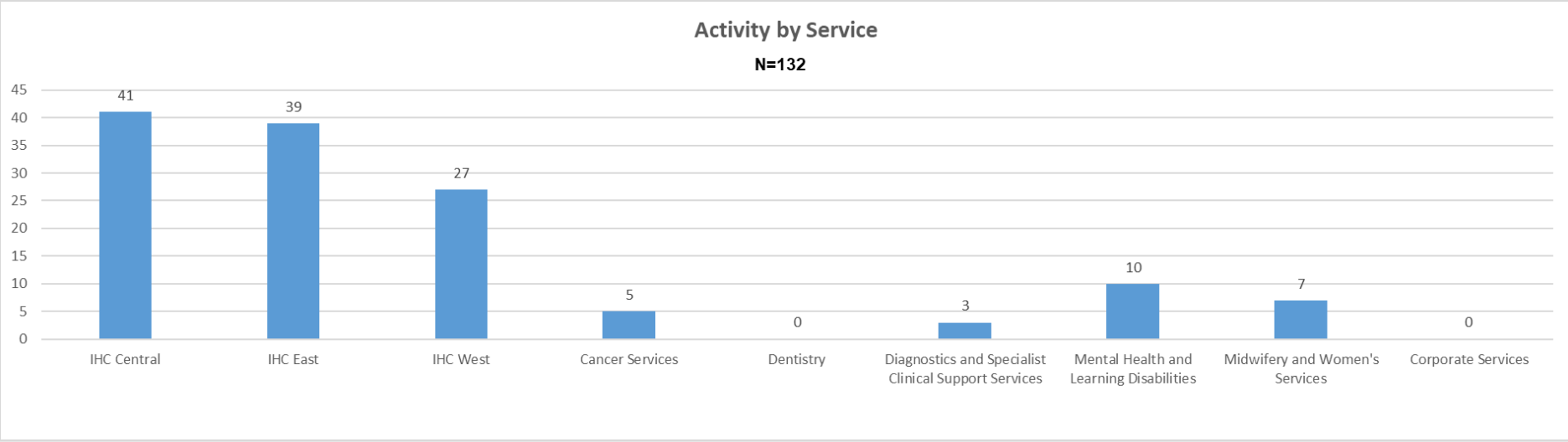
Project title	Report due	Objectives
Peer Review of Consent to Examination and Treatment Processes	Q1	Data collection started in June 2022; extension of the data collection period due to challenges with participation at speciality level has impacted on the expected date of reporting. Data collection completed in quarter 4 and now expected to report during Quarter 2 2023/24 (previously report was expected end of Quarter 1).
Point Prevalence Antimicrobial Prescribing *(Antimicrobial Resistance & Prescribing Programme Point Prevalence Survey of Antimicrobial Prescribing in Hospitals in Wales 2022 Report published 20/03/23)*	Q1	Antimicrobial Prescribing rate There is a fall in the Wales prescribing rate from 32.2% in 2021 to 31.0% in 2022. BCUHB is below the Wales average at 30.7% in 2022. Hospital rates within BCUHB vary with Ysbyty Glan Clwyd being the highest and Ysbyty Gwynedd now the lowest. Systemic prescribing rates: BCUHB is again below the Wales average of 27.1%, and BCU has decreased from the 2021 rate of 26.7% to 26.0%. Ysbyty Gwynedd showed a non-significant decrease from 41.2% in 2021 to 32.6% in 2022 Respiratory Tract Infection (RTI) prescribing: RTI prescribing rate decreased in YG (14.2% in 2021, 12.5% in 2022) and YGC (18.7% in 2021, 11.5% in 2022) but increased slightly in WMH (9.4% in 2022 from 6.6% in 2021). Urinary Tract Infection (UTI) prescribing: The focus on this Point Prevalence Survey (PPS) was UTI prescribing. The audit was carried out on all wards, with further quality data being submitted on MS forms around Antimicrobial Stewardship (AMS) risks and factors such as catheterisation. This aspect of the PPS should be repeated targeting areas with issues. Suggest repeating this aspect with the Infection Prevention & Control (IP&C) team to gain more meaningful data on UTIs and interventions.

Project title	Report due	Objectives
2222 Audit	Q4* (*reporting adjusted to 2023-24)	Continuous data collection initiated 2022 on two acute sites (YGC and YG), however progress with this audit has been hampered by low staffing levels, training capacity, training facilities and insufficient IT capacity to fully support its completion (70% to date). Reporting is now anticipated during 2023-24 – subject to required resources.

5.0 Tier 3 Audit Activity

This activity relates to those audits that should be agreed by the service/specialty and included within their local annual clinical audit forward plan. Activity is captured through our self-registration database; project leads self-register their audits and upload completed audit reports. The audit is considered closed when the audit report has been uploaded.

During Quarter 1, 132 projects were registered across the Health Board. The largest proportion of tier 3 audit topics were linked to against NICE Guidelines (17.4%). Of the remainder: 15.2% were re-audits, 15.2% in response to National guidelines and 9.8% were Service evaluations. There was a total of 59 projects completed during the quarter 1.



Quarter 2

July 1st – September 30th 2023

Clinical Audit Activity

1.0 The National Audit Programme and Clinical Effectiveness Overview

The Health Board receives an annual notification of the National Clinical Audit and Outcome Review Plan (NCAORP) from Welsh Government (WG), which describes priority areas for completion by all Health Boards regarding mandatory audits; these form our Tier 1 activity. Relevant Tier 1 (National audits) is incorporated within relevant Divisional/Directorate annual clinical plans, progress on which is then reported by the Clinical Effectiveness Department on a quarterly basis.

2.0 Risks reported to the Clinical Effectiveness Team

Risks reported to Clinical Effectiveness in Quarter 2 are as follows:

Audit	Audit level	Risk ID	Risk Tier	Risk level	Nature of Risk
National Clinical Audit of Seizures and Epilepsies for Children and Young People	1	4722	3	Moderate	This relates to the current pause in tertiary neurology support. Welsh Health Specialised Services Committee (WHSSC) / BCUHB and Alder Hey Children's Hospital are in discussion to agree a new model for Specialist outreach service and referral process going forward. To mitigate the risk any urgent referrals are sent to Liverpool and urgent case discussions occur as required.
National Audit of Heart Failure	1	4431	1	Extreme	Potential increase in mortality rates due to insufficient staff to provide the acute Heart Failure pathway for patients.

3.0 Tier 1 Overview of Quarter 2 - Clinical Audit Activity 2023-2024

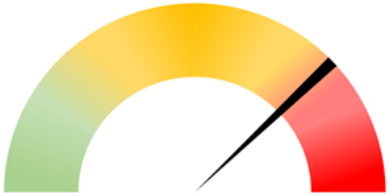
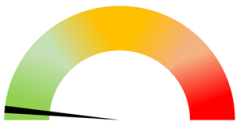
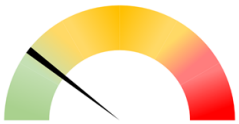
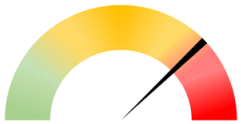
The tables below show the position on 30/09/2023 (end of Quarter 2).

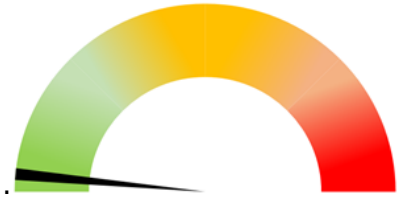
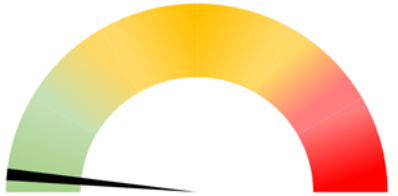
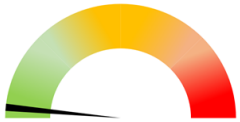
	Q1 Apr-Jun	Q2 Jul-Sep	Q3 Oct-Dec	Q4 Jan-Mar	Expected publication/activity 2024-2025
Estimated publications due	6	5	13	4	10
Actual publications	6	5	0	0	-
Service assessments due	2	6	10	10	10
Service assessments received	1	6	0	0	-
Service assessments overdue	1	0	0	0	-

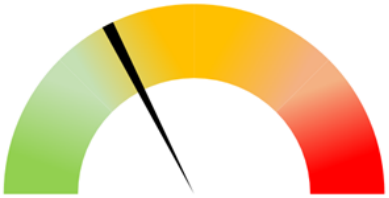
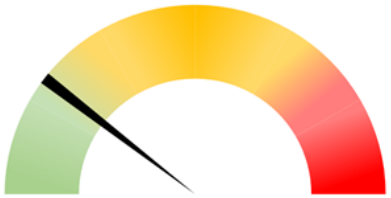
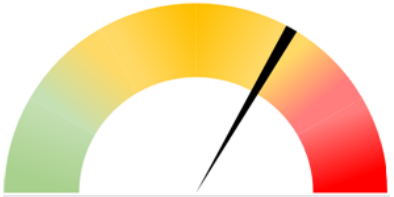
3.1 BCUHB Assurance returns

3.1.1 List of completed Service Assessment returns

Six of the six service assessment returns due were received during Quarter 2 however two of them are still under review and details will be included in Q3 report.

<table>
<tr><th>National Audit publication</th><th colspan="6"></th></tr>
<tr><td>National Heart Failure Audit (NHFA)</td><td colspan="3">Assurance level: Limited
 
Limited resources to meet best practice guidelines.</td><td colspan="3">Clinical risk level: Major
 
Potential increase in mortality rates due to insufficient staff to provide the acute Heart Failure pathway for patients</td></tr>
<tr><td></td><td colspan="6">Draft Service Assessment response received however details still under review, will be included in Quarter 3 report.</td></tr>
<tr><td>National Audit of Cardiac Rhythm Management (NACRM)</td><td colspan="3">Assurance level:</td><td colspan="3">Clinical risk level:</td></tr>
<tr><td></td><td>West:
Significant
  </td><td>Central:
Full
  </td><td>East:
Limited
  </td><td>West:
Low
  </td><td>Central:
Minor
  </td><td>East:
Major
  </td></tr>
<tr><td></td><td colspan="6">Draft Service Assessment response received however details still under review, will be included in Quarter 3 report.</td></tr>
</table>

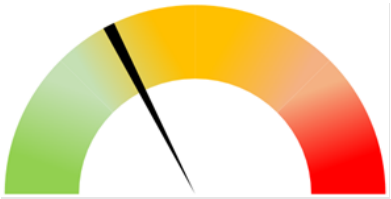
<table>
<tr><td rowspan="2">National Audit of Percutaneous Coronary Intervention (NAPCI)</td><td>Assurance level: Full
  </td><td>Clinical risk level: None
  </td></tr>
<tr><td colspan="2">Draft Service Assessment response received however details still under review, will be included in Quarter 3 report.</td></tr>
<tr><td rowspan="2">Myocardial Ischaemia National Audit Project (MINAP)</td><td colspan="3">Assurance level:</td><td colspan="3">Clinical risk level:</td></tr>
<tr><td>West:
Limited
  </td><td>Central:
Full
  </td><td>East:
Limited
  </td><td>West:
Moderate
  </td><td>Central:
Minor
  </td><td>East:
Moderate
  </td></tr>
<tr><td colspan="6">Draft Service Assessment response received however details still under review, will be included in Quarter 3 report.</td></tr>
</table>

<table>
<tr><td rowspan="2">The National Clinical Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)</td><td>Assurance level: Significant
 
We have made progress on previous recommendations.</td><td>Clinical risk level: Low
 
There has been a pause in tertiary neurology support. Discussions are being held to agree a new model for Specialist outreach service and referral process going forward. To mitigate the risk any urgent referrals are sent to Liverpool and urgent case discussions occur as required.</td></tr>
<tr><td colspan="2">Draft Service Assessment response received however details still under review, will be included in Quarter 3 report.</td></tr>
<tr><td>National Audit of Care at the End of Life (NACEL)</td><td>Assurance level: Limited
 
The report gives us limited assurance regarding the quality of end of life care being delivered in acute and community hospital settings within the organisation and demonstrates clear areas for improvement</td><td>Clinical risk level: Moderate to Major
 
Although BCUHB has shown some improvement when compared to the last NACEL round, it must be noted that when compared to national benchmarking, BCUHB is delivering on less than 50% of all measured KPIs</td></tr>
</table>

	Key Achievements highlighted by the service • BCUHB hospitals have access to face-to-face specialist palliative care, 8 hours a day, 7 days a week through clinical nurse specialist support. The UK national average for this service was 60% of health-boards/trusts. • BCUHB also has access to a telephone specialist palliative care service (doctor led) available 24 hours a day, 7 days a week. **BCUHB Action plan received outlining the following actions:** • **Share audit results** – Co-Clinical Director for Specialist Palliative Care to take to Quality and Safety IHC meetings (Quarter 3) & Consider presenting NACEL findings at a BCU wide grand round (Quarter 4) • **Educate and promote the use of Care decisions Guidance for care in the Last Days of Life** - consider use of online resource for Health Care Professionals (Quarter 2 2024/25) • **Strategic planning for palliative and end of life care** - Secure consistent executive chairmanship to steer and champion across all care settings in BCUHB (Quarter 1 2024/25) • **Bereaved relative experience** - Look to explore capturing regular family feedback in addition to CIVICA reports (bereaved relatives experience within acute settings not captured currently). (Quarter 2 2024/25) • Present the findings of the End of Life Decision Making Project to BCU executives as a significant supplementary project alongside NACEL findings (Quarter 3)

In addition to the service assessments above, action plans were received during Quarter 2 for projects that were delayed from previous Quarters

<table>
<tr><th>National Audit publication</th><th colspan="2">Lessons/Actions</th></tr>
<tr><td rowspan="2">National Audit of Inpatient Falls – “Working together to improve inpatient falls prevention” Report

Response from West only - Originally expected Q4 (2022/23)</td><td>Assurance level: Significant
 
Following any fall – this includes fall with HARM and no HARM, they are discussed in the weekly fall's scrutiny meeting, the stakeholders within this group include members of the Health and Safety Team. All cases are discussed, this includes all falls that have occurred in YG. Prior to this new process the scrutiny meetings would only discuss falls with HARM. This new process ensures that lessons learnt are identified and put in place to prevent falls with HARM. These meetings have been established since October 2022.</td><td>Clinical risk level: Moderate
 
Flat lifting equipment remains an area of concern however there is mitigation in place. Currently there is a clear process for patients when they require flat lifting following fall, a call will be made and a member of the team in ED will support with this exercise. We acknowledge that this is an onerous task for the team in ED however, it is safe mitigation for the site and to date there has been no evidence of concern in relation to flat lifting. A business case has been submitted to support the equipment, which will be accessible for all staff in the future once funding, approved</td></tr>
<tr><td colspan="2">BCUHB Action plan received outlining the following:
Purchase of flat lifting equipment: Business case submitted in November 2022. This will support a consistent approach to lifting patients who may have an unstable fracture without impacting on staff within the ED
Falls mandatory training remains under the target of 85%: Electronic Staff Record will demonstrate the improved performance. Training will also support improved completion of risk assessments overall
Reviews during the fall's scrutiny meetings have highlighted that there has been a significant improvement in the time that a patient is reviewed post fall: This needs to be evidenced clearly within</td></tr>
</table>

	the medical and nursing records in order to demonstrate improvement / compliance. **Lessons learnt will demonstrate improvement where they can be shared across the health board** • **MFRA – bedside learning has demonstrated the quality of the standard expected:** This will support an improvement in the quality of the documentation, which in turn will support a reduction in the number of overall falls**.** • **Engagement from the medical teams in relation to falls prevention requires further work:** Named lead to be identified	
National Emergency Laparotomy Audit (NELA) - Year 8 Report **Response from West & Central only –** Originally expected Q1 (2023/24)	**Assurance level: Awaiting confirmation** For most of the measured parameters, YGC is confident of its compliance against standards, with the following exceptions: • peri-operative COTE Specialist Assessment • post-operative length of stay (partly due to long delays in post-op transfer) • performance in '*Theatre Arrival appropriate to surgery'* • *'CT reported by Consultant Radiologist before Surgery'* is close to the national average, but the lowest in BCU. • *'Antibiotics administered within 1 hour to patients with suspected sepsis'* appears low For YG, performance against the measured parameters is good with the following exceptions: • no peri-operative COTE assessment as the focus is on Orthopaedic patients • '*Timeliness of Theatre Arrival'* • *'Pre-operative CT'* prior to laparotomy	**Clinical risk level: Awaiting confirmation** - this is in part due to long delays in transfer of post op patients to community hospitals - (better than national average, but worst in BCU, most likely due to competition for theatre space with the centralised services (vascular & maxillo-facial surgery) - there is confidence that the use of CT is compliant with standards and further investigation will be made as to why the site falls so low in this standard - possibly this is due to a recording error - identified as resulting from a documented failure to record the suspicion of sepsis which is being addressed - there is confidence that the management of sepsis, with antibiotics, is appropriate - no peri-operative COTE assessment as the focus is on Orthopaedic patients - could be further improved with a dedicated Anaesthetist for CEPOD theatre instead of being shared with covering arrest elsewhere - also, it can be affected by long delay in ED during periods of high pressure

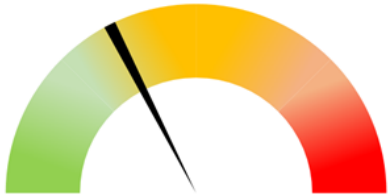
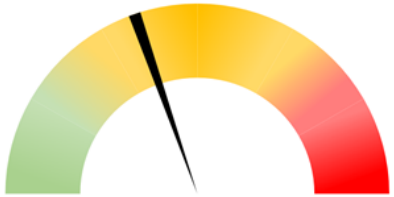
<table>
<tr><td></td><td></td><td>- most patients received pre-operative CT scan prior to laparotomy however, a significant proportion are reported by the outsourced Radiologist</td></tr>
<tr><td></td><td colspan="2">BCUHB Action plan received outlining the following:
Resource/capacity issues for data entry already escalated to BCU CEG – SBAR presented to September meeting by Deputy Medical Director.

Identified for immediate action by the Hospital Management Team

• Greater capacity in the emergency theatre is required (Central)
• Faster transfer of post-op patients to the community hospitals (Central)
• Dedicated anaesthetists for CEPOD (West)
• NELA lead in Radiology (West)

Identified short term for action within twelve months by the Hospital Management Team

• Greater input from COTE team required (Central)
• Input from COTE1 Year (West)</td></tr>
<tr><td>Renal Registry - 24th Annual Report

Originally expected Q4 (2022/23)</td><td>Assurance level: Significant
 
All three BCU Renal sites are compliant with data collection and keeping well within National standards. Multi-disciplinary setting of work pattern fully embedded at all 3 BCU acute sites. A mechanism in place for review of clinical parameters and timely action at all 3 BCU acute</td><td>Clinical risk level: Low
 
Once published, National Audit data disseminated to all involved units (National level). Data is individually reviewed by the 3 sites of BCUHB (multidisciplinary level). QIPs and Audits planned as per the National Audit findings.</td></tr>
</table>

	sites. QIPs and review of the Service Quality indicators are identified and systems are in place for monthly audit meetings to share best practices across 3 BCU acute sites. Specific time slots are allocated for annual review of service parameters.Audit measures are reviewed and actions identified in a 'SMART' way. Key leaders are identified which works well across the 3 sites.	Findings discussed at MDT settings for local quality indicator points and amended at the Clinical Governance meetings for local policy changes. Learning is incorporated into local guideline/protocol matrices.
	BCUHB Action plan received outlining the following: All measures taken by BCU Renal units based on up-to-date/recent data and regular review and actions on all parameters are for the current year 2023. • **Review of Serum Calcium of Haemodialysis patients (YGC** a) Regular review (monthly) of all parameters to be conducted by a multidisciplinary team – this includes monthly MDT, regular review of patients on dialysis unit, dietetic review as per Renal association guidance, adjusting Vitamin D supplementation, adjusting dialyser Calcium concentration and education of patients and staff. (b) Re-audit of these parameters took place at all 3 BCU acute sites in March 2023 and findings presented at the North Wales Regional meeting on 22nd of March 2023. This audit demonstrated an **improvement at all levels and full compliance with national standards**. • **Review of Urea reduction Ratio of Haemodialysis patients in YGC** This is reviewed every month at MDT meetings and parameters adjusted (duration of dialysis, patency of arteriovenous fistula discussed at vascular MDT, prompt correction of vascular insufficiency by interventional radiologists/ Vascular surgeons, CKD education programme and pre-emptive arteriovenous fistula formation, regular review of patients on ward rounds in renal unit and dialyser capacity adjusted). • **Low number of transplant listing for the year 2020 (Possibly due to Covid reasons)** Review of transplant pathways and review of all patients (above the age of 65 years across 3 sites) regarding suitability for transplant listing. All patients were reviewed by an MDT team including clinicians from 3 sites, transplant nurses from 3 sites and CKD team from 3 sites.	

3.1.2 List of outstanding Service Assessment returns expected during Quarter 2

National Audit publication	Reason for non-response & escalation
National Emergency Laparotomy Audit (NELA) – Year 8 Report	**Service assessment response not received from IHC East.** West and Central have provided site responses to the national findings however none has been received from East. One lead from East has left BCU.

3.1.3 Escalation of outstanding Service Assessments expected in previous quarters

National Audit publication	Assurance response due in Quarter Report	Escalation during quarter 2
National Paediatric Diabetes Audit (NPDA) - Annual report 2021/22: Care processes and outcomes	Quarter 1 (2023/2024)	**Service assessment response, due May 2023, not received from IHC East (received for IHC Central & IHC West)**. Lack of engagement to requests for a response to the publication escalated to IHC through local Clinical Effectiveness (CEG) meetings during Quarter 2. Chair of East IHC CEG meeting agreed to contact lead to progress this response.
National Paediatric Diabetes Audit (NPDA) - Parent and Patient Reported Experience Measure (PREMs) 2021	Quarter 4 (2022/2023)	**Service assessment response, due Jan 2023, not received from IHC East (received for IHC Central & IHC West)**. Lack of engagement to requests for a response to the publication escalated to IHC through local Clinical Effectiveness (CEG) meetings during Quarter 2. Chair of East IHC CEG meeting agreed to contact lead to progress this response.
In-patient Falls Audit (Falls & Fragility Fractures Audit Programme) - Working together to improve inpatient falls prevention (2021 clinical & 2022 facilities audit data)	Quarter 4 (2022/2023)	**Service assessment response not received for East & Central areas**. Lack of engagement to requests for a response to the publication escalated to area through local Clinical Effectiveness Meetings (each month since April 23) June 23 East IHC CEG meeting Chair has emailed the leads directly. Received West but nothing from East & Central

National Early Inflammatory Arthritis Audit (NEIAA) - Year 4 Annual Report (2021/22)	Quarter 4 (2022/2023)	**Final Action plan not received for all three areas**. Project Lead has drafted an action plan during Quarter 4, awaiting details of SMART actions. Lack of engagement to requests for a response to the publication escalated to area through local Clinical Effectiveness Meetings (every month since April 2023)
National Diabetes Audit - - 2017-21 Adolescent and Young Adult (AYA) Type 1 Diabetes Report	Quarter 3 (2022/2023)	**Service assessments response, due Oct 2022, not received from all areas**. Lack of engagement to requests for a response to the publication escalated to IHC's through local Clinical Effectiveness (CEG) meetings in during Quarter 2
NACAP: Adult Asthma & COPD (Chronic Obstructive Pulmonary Disease) - 2021 Organisational Report	Quarter 3 (2022/2023)	**Service assessments response not received from all areas.** **Central:** Respiratory team currently feel they are not able to submit an action plan as the lack of progress against many of the requirements is stark. Service is so far behind post covid and due to loss of staff that any response to the organisational audit is far off the (Key Performance Indicators) KPIs. Ongoing issues with participation with **East** and **West.** All issues have been escalated to the local Clinical Effectiveness Groups. From the June 23 IHC ECEG meeting Chair requested the project lead names to email directly.
National Diabetes Audit: Type 1 Diabetes 2020-21 Report	Quarter 3 (2022/2023)	**Service assessments response, due Oct 2022, not received from IHC East & IHC West (received for IHC Central)**. Lack of engagement to requests for a response to the publication escalated to IHC's through local Clinical Effectiveness (CEG) meetings in during Quarter 2.
National Diabetes Inpatient Safety Audit (NDISA) – 2018-21 Report	Quarter 3 (2022/2023)	**Service assessments response not received from all areas**. Lack of engagement to requests for a response to the publication escalated to IHC's through local Clinical Effectiveness (CEG) meetings in during Quarter 2.
National Hip Fracture database – 2021 Report	Quarter 3 (2022/2023)	**Service assessments response not received for East**. At the June 23 IHC ECEG meeting Chair requested the project lead name to email directly. Received draft response from West and Central but returned as not SMART actions, lack of engagement to requests for further response to the publication escalated to area through local Clinical Effectiveness Meetings (every month since April 2023)

3.2 Benchmarking

When a National Audit report includes Health Board specific data, we benchmark BCU against the National outcomes and against BCU data in previous reports.

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

Five National Audit reports have been published in Quarter 2, four included BCU identifiable data.

The table below outlines the benchmarking information:

Tier 1 **Project reference**	**Title**	***Performance against***		***Progress / Completed Actions***	***Outstanding issues - by whom by when***
		National Benchmark	***Last BCU report***		
Acute					
NCAORP/2023-24/01	National Joint Registry	N/A	N/A	• This report does not provide the level of data or recommendation which health services can measure against	• Service assessment response due to be completed in Quarter 3

Tier 1 **Project reference**	**Title**	***Performance against***		***Progress / Completed Actions***	***Outstanding issues - by whom by when***
		National Benchmark	***Last BCU report***		
Older People					
NCAORP/2023-24/19	National Hip Fracture database (Falls & Fragility Fractures Audit Programme)	A	G	• Maintained compliance in line with national average and improved performance compared to last reported period	• Service assessment response due to be completed in Quarter 3
NCAORP/2023-24/21	National Dementia Audit	G	A	• Maintained compliance in line with national average, however performance compared to last report period has dropped	• Service assessment response due to be completed in Quarter 3
End of Life					
NCAORP/2023-24/22	National Audit of Care at the End of Life (NACEL) - 2022/23 Annual Report (round 4)	R	G	• Maintained compliance in line with previously reported period although dropped when compared to national average.	• Service assessment response completed in Quarter 2. (Referenced in 3.1.1)
Other					
NCAORP/2023-24/37	The National Clinical Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)	G	A		• Service assessment response completed in Quarter 2 (Referenced in 3.1.1)

3.3 Assurance response timetable for reports published in Quarter 2 - as of 30th September 2023

Project Reference	Title of National Audit	Name of report	Date of publication	Service assessment response due in Quarter Report
NCAORP/2023-24/01	National Joint Registry	20th Annual Report 2023 - Surgical data to 31 December 2022	30th September 2023	Quarter 3
NCAORP/2023-24/19	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	14th September 2023	Quarter 3
NCAORP/2023-24/21	National Dementia Audit	Care in General Hospitals 2022-2023 Round 5 Audit Report	10th August 2023	Quarter 3
NCAORP/2023-24/22	National Audit of Care at the End of Life (NACEL)	2022/2023 Annual Report (round 4)	13th July 2023	Quarter 2
NCAORP/2023-24/37	The National Clinical Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)	Epilepsy 12 - 2023 combined organisational and clinical audits 2020-2022	13th July 2023	Quarter 2

Key	**Red**	Response overdue
	Amber	Response not received but within deadline
	Green	Response received

4.0 Tier 2 Audit Program

The Tier 2 program is a suite of audits mandated across the Health Board (which are not reported nationally) related to high-risk activity and corporately agreed service improvement priorities. It is likely that the number of these audits will increase in line with evidence from Harms Reviews, Concerns Recommendations, Prevention of Future Death Notices, and Ombudsman Reports. The Clinical Effectiveness team is working closely with the Quality Department to ensure that the correct Tier 2 audit program is in place to provide assurance across the risks that the Health Board holds.

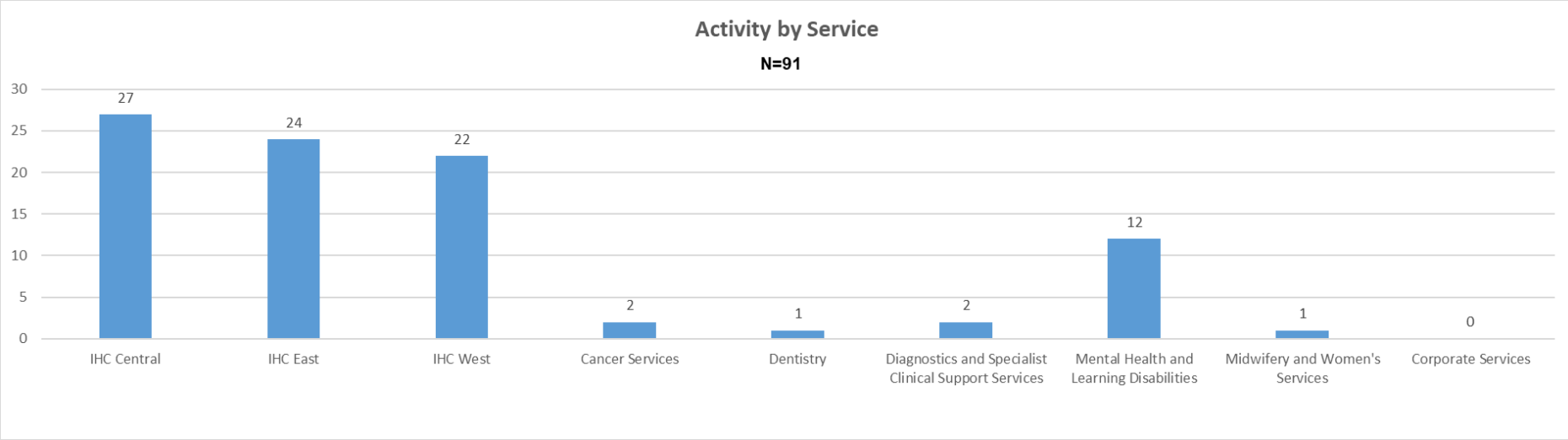
Tier 2 reports/updates below have been submitted in Quarter 2 (as per the reporting schedule).

Project title	Report due	Objectives
Audit of upper GI bleeding (*from 2022/23 Tier 2 Audit Plan*)	Quarter 3	A UK wide audit on all patients presenting with a UGIB to hospital. Data collection closed (Aug 2022) and awaiting analysis and report from British Society of Gastroenterology, originally due Spring 2023 but now further delayed until end of October 2023 (Quarter 3)
Annual Accessible Healthcare Audit	Quarter 3	An audit of the All-Wales Standard for Accessible Communication and Information for People with Sensory Loss Audit undertaken between April & June 2023 and currently in the process of reviewing the findings. Findings to be shared at the Strategic Patient and Carer Experience Group

5.0 Tier 3 Audit Activity

This activity relates to those audits that should be agreed by the service/specialty and included within their local annual clinical audit forward plan. Activity is captured through our self-registration database; project leads self-register their audits and upload completed audit reports. The audit is considered closed when the audit report has been uploaded.

During Quarter 2, 91 projects were registered across the Health Board. The largest proportion of tier 3 audit topics were linked to against National Guidelines (16.5%). Of the remainder: 15.4% were linked to NICE Guidelines, 13.2% were service evaluation and 12.1% were Re-audits. There was a total of 20 projects completed during the quarter 2.


Activity by Service
N=91
30
25
20
15
10
5
0
27
24
22
2
1
2
12
1
0
IHC Central
IHC East
IHC West
Cancer Services
Dentistry
Diagnostics and Specialist Clinical Support Services
Mental Health and Learning Disabilities
Midwifery and Women's Services
Corporate Services

Teitl adroddiad: ***Report title:***	Quality Delivery Group – Chair's Report			
Adrodd i: ***Report to:***	QSE Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	19 December 2023			
Crynodeb Gweithredol: ***Executive Summary:***	This report provides the Committee with the Chair's Report from the Quality Delivery Group (QDG). The QDG is the clinical executive led quality group in the Health Board through which all other quality-related groups report.			
Argymhellion: ***Recommendations:***	The Committee is asked to note this report			
Arweinydd Gweithredol: ***Executive Lead:***	Angela Wood, Executive Director of Nursing and Midwifery Dr Nick Lyons, Executive Medical Director Gareth Evans, Executive Director of Therapies and Health Sciences			
Awdur yr Adroddiad: ***Report Author:***	Matthew Joyes, Deputy Director of Quality Governance			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☐ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☒ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				
There is confidence in the data provided in the report however, the strength of learning and improvement remains an area of concern and is a key focus of work. This is being addressed through a range of measures including the actions aligned to the Board Assurance Framework.				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Quality			
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	The Duty of Quality is a statutory requirement under the Health and Social Care (Quality and Engagement) (Wales) Act 2020. The statutory duty of quality requires the decision-making processes by the Health Board take into account the improvement of health services and outcomes for the people of			

	Wales – the duty also includes new Health and Care Quality Standards. Instances of harm to patients may indicate failures to comply with the NHS Wales standards or safety legislation.
Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqlA been identified as necessary and undertaken?***	N/A
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	N/A
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	BAF1.2
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	N/A
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	N/A
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	N/A
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	BAF1.2
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	N/A
Camau Nesaf: Gweithredu argymhellion ***Next Steps: Implementation of recommendations*** N/A	
Rhestr o Atodiadau: ***List of Appendices:*** QDG Chair's Report	

Chair's Report

Report to:	Quality, Safety and Experience Committee
Report from:	Executive Quality Delivery Group
Report date:	November 2022
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	Escalation of concerns regarding ECR process and delays in agreeing posts, from IHCs. AW agreed to speak to DOF and DD Workforce about reviewing current process.

Issues for escalation – for information	None. Please note this is the first report in the new reporting/governance framework to QSE and the format and content will evolve over time.
Summary of business conducted – for assurance	• Quality highlight and escalation reports were received from all IHC/Divisions. The format and content of these reports are under review to improve assurances, as part of the wider Special Measures Quality Governance Review. A number of core themes were noted including overdue incidents and complaints across services. • East IHC advised that a deep dive took place last month into CAHMS services, which helped with understanding where their specific areas of challenge are and how they are trying to resolve those issues. • Central IHC advised there is a new risk around magnetic doors at NWAS which sustained some damage following a period of time where two challenging patients worked together to breach the doors. Once slippage funds have been approved, the work will be carried out. • West IHC advised their main risks are around the shortfall in medical staffing with one being Rheumatology and a second Dermatology with has affected patient care. • MHLD Division advised for information and assurance, a fortnightly HSE NoC meeting remains in progress, which is aligned to the fortnightly nationally collaborative action plan meetings as well as the weekly HIW discharge action plan. They also referenced clinical risk training where the division have reached a point where majority of staff have been trained in the two-day training and we have just commenced refresher training, which will be on a three-year basis. • Women's and Midwifery Division provided an update on the maternity information systems for Wales, which supports the reporting, data and collection of information. There is currently a slight delay with funding for a digital midwife. A business plan is in process and will go back to Welsh Government before the procurement starts.

	• Cancer Division highlighted that all the three systemic anti-cancer treatments, the day units and the current waiting times for new treatments are now between four and five weeks. This is due to the number of NICE approved treatment regimens and the lack of chair space. The lack of Pharmacy capacity to meet the demand to prepare treatments is also a factor. Escalation meetings are taking place to make sure we are moving in the right direction. With regards to Radiotherapy they advised that unfortunately we are now sitting at a five to six week wait due to lack of staffing capacity. • Diagnostics and Clinical Support Division highlighted there are two major IT implementations underway, one in Pathology and one in Radiology. These are both looking at being implemented in 2025. • Dental Division advised that in relation to recruitment, they have now recruited two Assistant Clinical Directors who are both now in post. • The Strategic Infection Prevention and Control Group advised that there are three key issues to highlight this month. The first being not having the ability to do amikacin and therapeutic levels on site, which has gone through several escalation pathways to date. The second is the struggle around medical engagement at many IPC forums. The third is in relation to the ongoing delays with the Enhanced ECR process for physical facilities staff and estates, which is having an impact on the cleaning programs. • The Strategic Clinical Effectiveness Group advised there are two points to raise, one around blood transfusion, which has been noted in the past. There are a number of incidents relating to blood transfusion products and it has been noted that there is no mandatory training in place within the Health Board, although there is some online training, there is no mechanism by which we can ensure that those that are using blood products are actually up to date with their training. The Chair and Deputy Medical Director agreed to discuss outside the meeting. The second point was around the Executive Lead for Palliative Care / End of Life Care. This ask has been brought to this group as it has been noted that the Palliative Care / End of Life Group have not been able to meet for some time due to no chair in attendance as well as the route it would take for escalations. The Chair advised that this would also be noted as an action for herself, and the other two Clinical Executive Directors to have a discussion around this. • The Urology Clinical Improvement Group confirmed that there is nothing to escalate at this time. • The Strategic Patient Safety Group highlighted two issues. We are coming to the end of the first cycle in spring of 2024 of the Safe Care Collaborative and there are discussions nationally around planning for the second, which we need to look at differently and try to become more business as usual and have more engagement and visibility at executive level. The group advised that the second point for escalation is around nosocomial reviews, is due to be completed in March 2024. The national team felt that we were on trajectories to compete in August 2024 as there has been a significant

	improvement and increase in numbers during the last month. If we maintain that we should then complete by March 2024. The risk with this is if we do any reviews all over it will pick up that we do not have any funding to support the reviewers past March 2024. • The Strategic Safeguarding Group offered assurance around Iris that there is a meeting planned with Powys Health Board and we will see if there is any learning aspects we can pick up from them. The second issues was around terrorism training. The Home Office have mandated national training and it would appear that the Health Board are the only board in Wales that have progressed with this. • The Deputy Director of Quality Governance provided the Welsh Risk Pool Concerns Assessment and action plan which was noted. The Deputy Director advised on the risk of penalties now in place by WRP through an updated national procedure for late submissions of learning. • The MHLD Director provided a report on incidents at EDs involving patients presenting with mental health conditions. There has been three catastrophic incidents and one very serious incident that took place between June and September 2023 in relation to patients who presented themselves to different Emergency Departments. All incidents have been discussed at Rapid Learning Panels. The report provided a summary of actions taken collaboratively across MHLD and all IHCs, and advised of a further workshop planned for January.

Teitl adroddiad: ***Report title:***	Corporate Risk Register Report			
Adrodd i: ***Report to:***	Quality Safety and Experience (QSE) Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Tuesday, 19 December 2023			
Crynodeb Gweithredol: ***Executive Summary:***	The purpose of this standing agenda item is to provide an update from the Risk Management Group (RMG) meeting on the 5th of December 2023 and present the Corporate Risk Register (CRR). The Committee provided with corporate risks to which QSE has overall accountability for as well as an overview of outstanding corporate risks.			
Argymhellion: ***Recommendations:***	The Committee is asked to: 1. receive assurance from the Chair's report of the Risk Management Group The Committee is asked to consider: 2. the corporate risks to which the Committee has overall accountability. 3. consider which corporate risks should be included in papers to the Board.			
Arweinydd Gweithredol: ***Executive Lead:***	Phil Meakin, Acting Board Secretary			
Awdur yr Adroddiad: ***Report Author:***	Nesta Collingridge Head of Risk Management			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☒	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: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 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 in respective CRR reports
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	The effective and efficient mitigation and management of risks has the potential to leverage a positive financial dividend for the Health Board through better integration of risk management into business planning, decision-making and in shaping how care is delivered to our patients thus leading to enhanced quality, less waste and no claims.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	Failure to capture, assess and mitigate risks can impact adversely on the workforce.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	Individual Executive Sign off of CRR reports
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	See the individual risks for details of the related links to the Board Assurance Framework.

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

1. Introduction

The purpose of this standing agenda item is to provide an update from the Risk Management Group (RMG) meeting on the 5th of December 2023 and present the Corporate Risk Register (CRR).

The Committee is provided with corporate risks to which QSE has overall accountability for as well as an overview of outstanding corporate risks.

The Committee is asked to:

1. receive assurance from the Chair's report of the Risk Management Group

The Committee is asked to consider:

2. the corporate risks to which the Committee has overall accountability.
3. consider which corporate risks should be included in papers to the Board.

2. Risk Management Group Meeting Assurance Report Summary

RMG was held on the 5th of December 2023. The group heard from the Head of Risk Management on key changes that were received and approved at Audit Committee on the 16 November 2023 in relation to the revised Corporate Risk Register (CRR) and Board Assurance Framework (BAF).

The Group received the Risk Management Procedures which had been updated following the approval of the Risk Management Framework. The procedures have been cascaded out for consultation for two weeks (ending 15th of December, 2023) and feedback is being collated. The procedures were agreed in principle and changes will be highlighted to the Group following consultation outside of the meeting. This is due to the need to agree the procedures prior to the February meeting and have a guide for those which need to progress with the new changes in relation to the CRR and BAF.

An update was provided on the Risk Management Training Plan which is being developed to provide more comprehensive training over three levels according to staff's requirements. The Group heard this will encompass: risk management awareness (mandatory for all), operational risk management (for those key leads who manage risk registers) and strategic risk training (for the Board and senior staff who manage corporate and BAF risks).

Risk Register Reports were received from the: Office of CEO and Deputy CEO; Office of the Board Secretary; Office of the Nurse Director; Therapies & Health Sciences; Finance and Counter Fraud. All risk registers were relevant and had been recently reviewed.

Updates were received on the Risk Management Annual Work Programme. Five out of six actions on the 23/24 risk management annual workplan have been completed. There remain to be outstanding actions from 22/23 due to dependency on the Once for Wales

Risk Management Datix system, this is due to the system being delayed for roll out and actions dependent on the new system being adopted.

The second iteration of the Risk Management Performance Report Q2 was received at RMG. The report provided an overview of the Health Board's risk management performance, showing trends and practices across functions/services and regions. The purpose of this report is to communicate recommendations on how areas of improvement would be addressed.

The key elements highlighted in the report were:

- Improvement of the Health Board's risk maturity from novice to normalised.
- Potential under-reporting of risks in key functions within the Health Board such as Primary Care, Finance, Workforce and Organisational Development etc.
- The continuous improvement required to ensure risk titles and descriptions are suitable and action plans are functional (SMART) in risk mitigation.
- The report also highlighted the importance of utilising risk descriptors to support risk scoring and to ensure the risk had the proportionate level of management.
- All high risks (Tier 1) are being prioritised for quality assurance.

The report demonstrated positive momentum in many areas such as closure rates of medium risks and the RMG acknowledge progress compared to a couple of years ago. However, there are still areas that require additional improvement, most of which can be mitigated by further training, controls, and support from corporate risk team, champions and leads.

3. **Corporate Risk Register Report Related to QSE Committee**

Four corporate risks are detailed in full in the report below and the Committee is asked to consider the reports for approval as the overall accountable Committee for the risks.

1. **Patient Safety-Falls**
2. **Safeguarding**
3. **Failure to Embed Learning**
4. **Population Health**

The Committee is to note there are three outstanding corporate risks yet to be received at Committee. This is because the updates have not at the time of writing the report been received from the risk owners.

5. Timely Diagnostics
6. Harm from the Medical Devices/Equipment
7. Community & Primary Care Provision

Furthermore, QSE also have share accountability of three risks with the Performance, Finance and Information Governance Committee (PFIG) due to the impact of patient harm which are also outstanding.

8. Unscheduled Care
9. Planned Care

10. Areas of Clinical Concern/Special Measures

As per the last QSE Committee meeting, a discussion was had that the Committees would take a view as to which Corporate Risks would be presented in the quarterly Board paper. This suggestion was well received at PFIG and Audit Committee. This aims to facilitate a more focused discussion the corporate risks (17 in total). **Therefore, the Committee is asked to review the corporate risks presented consider for approval and indicate which reports should be presented to the Board.**

The following detail is provided:

- CRR Heat Map
- CRR Overview
- CRR Overview Outstanding Risks

Out of the 17 newly revised corporate risks, 10 risks remain outstanding to be fully developed and scores yet to be determined and full reports to be completed. The Heat Map illustrated below will be updated once all scores have been completed.

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Corporate Risk Register

Last updated 08 Dec 23

CRR Risk Heat Map

Impact			1	2	3	4	5
	Catastrophic	5				Extreme **Financial Sustainability (PFIGC)** **ICT Failure and Cyber (PFIGC)** **Patient Safety-Falls (QSE)**	Extreme **Failure to Embed Learning (QSE)**
	Major	4				**Safeguarding (QSE)**	Extreme **Availability and Integrity of Patient Information (PFIGC)** **Population Health (QSE)**
	Moderate	3					
	Minor	2					
	Negligible	1					
			Rare	Unlikely	Possible	Likely	Almost Certain
			Possibility				

Corporate Risk Register Overview

Possibility: Almost Certain				
Reference	**Title**	**Committee Oversight & Date Last Reviewed**	**Current Risk Score**	**Progress**
Executive Director of Nursing and Midwifery				
CRR24-04	Failure to Embed Learning	QSE	25	Six out of seven actions to support controls in relation to this risk are due in March 2024. Gaps in controls have been well identified and have further mitigations noted.
Executive Director of Public Health				
CRR 24-09	Population Health	PPPH (QSE) 19/12/2023	20	As per the previous population health corporate risks, action plans are progressing well within the control of the Health Board considering the funding constraints being the most notable gap in control. Due dates for some of the actions will be added but note the overall more long-term target date of 2026 to reduce the score to a target of 12.
Chief Digital and Information Officer				
CRR 24-07	Availability and Integrity of Patient Information	PPPH (PFIG) 18/01/203	20	

Impact: Catastrophic				
Reference	**Title**	**Committee Oversight**	**Current Risk Score**	**Progress**
Executive Director of Nursing and Midwifery				
CRR 24-02	Patient Safety-Falls	QSE 19/12/2023	20	1 out of 6 actions have been completed, 2 to be progressed in Dec and remaining actions to be completed by February 2024 in order to reduce this score down to the target of 12.
CRR 24-03	Safeguarding		16	Five out of six actions to support controls in relation to this risk are due in March 2024 but this will not

Possibility: Almost Certain				
Reference	**Title**	**Committee Oversight & Date Last Reviewed**	**Current Risk Score**	**Progress**
				necessarily resolve the main gap in control around staffing resources. Gaps in controls have been well identified and have further mitigations noted.
Chief Digital and Information Officer				
CRR 24-17	ICT Failure and Cyber	PPPH (PFIG) 18/01/203	20	
CRR 24-04	Financial Sustainability	PFIG	20	

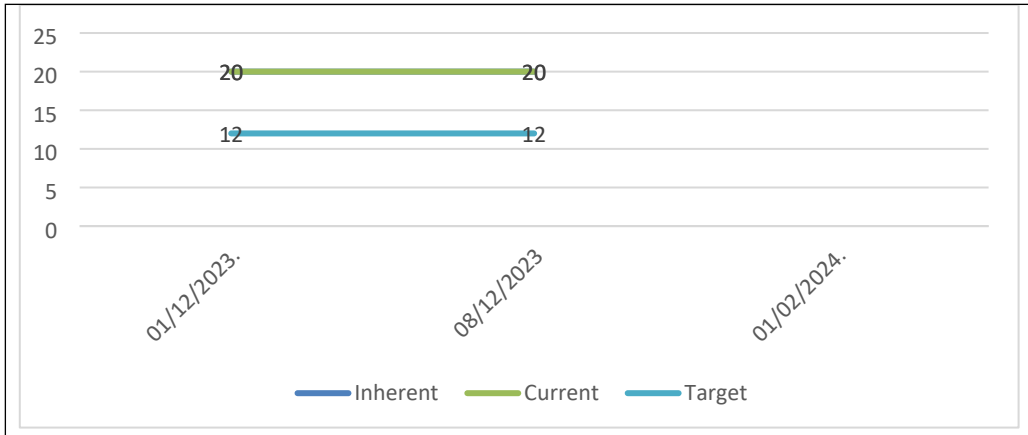
Corporate Risk Register Outstanding Risks

Risks Yet to Be Scored		
Executive Director Therapies & Health Science		
CRR 24-13	**Timely Diagnostics**	**QSE**
CRR 24-14	**Harm from the Medical Devices/Equipment**	**QSE**
Executive Director of Operations		
CRR 24-09	**Community & Primary Care Provision**	**QSE**
CRR 24-10	**Unscheduled Care**	**QSE & PFIG**
CRR 24-11	**Planned Care**	**QSE & PFIG**
CRR 24-12	**Areas of Clinical Concern/Special Measures**	**QSE & PFIG**
Deputy Director of People		
CRR 24-01	People, Culture and Wellbeing	People Committee (PFIG)
CRR 24-15	Health and Safety	People Committee (PFIG)
CRR 24-16	Leadership	People Committee (AC)
Executive Director of Finance		
CRR 24-06	Suitability and Safety of Sites	PFIG

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

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

Controls in place	Assurances	Additional Controls required	Actions and Due Date
1.Mandatory E learning modules (1a and 1b) for Falls Prevention launched and monitoring in place for completion via the Strategic Inpatient Falls Group. Health Board compliance currently 1a 93.83%, 1b 94.55%. 2. Manual Handling training data cascaded monthly to respective IHC's/Division Director of Operations to include compliance, Did Not Attend rates and available capacity for upcoming 2 months. 3. Welsh Nursing Care Record (WNCR) has been implemented which has an electronic version of the Falls and Bone Health Multifactorial Assessment (FBHMA) that is identified on the dashboard if not completed and monitored for compliance by the Ward Manager. 4. How to /good practice guide developed and implemented to support with completion and quality of FBHMA across all Adult Inpatient wards: 5. Peer review process in place for 3 months to improve quality of the FBHMA across adult inpatient wards. 6. Falls review groups in place across the Health Board with exception reporting, updating of improvements to Strategic Inpatient Falls Group. 6. Temporary staffing team have ensured Nurse Agencies have access to BCUHB e-learning packages and are encouraged to complete.	1. Strategic Inpatient Falls Group - Integrated Health Community (IHC) and Divisional falls review groups report to the falls leads who report to the strategic group. 2. Ward accreditation metrics 3. Ward accreditation review process 4. Peer reviews	1. Falls prevention and management policy to be ratified and relaunched - has been updated to include a clear step by step approach to completion of the Falls and Bone Health Multifactorial Assessment (FBHMA) and post falls management and currently under review with Patient Safety Group. 2. Assurance and training of agency workers. 3. Improved compliance with manual handling training. 4.Sustained improvement in the quality of completion of FBHMA.	1.New updated and revised Falls Prevention and Management Policy NU06 reviewed in BCUHB Patient Safety Group to be ratified and re-launched 30/12/2023. 2.Audit of Ward Managers induction checklist for agency staff to ensure falls training has been completed 13/12/2023. 3.Capacity within the Manual Handling training team to be optimised with focused recruitment drive for Band 6 posts (x3) supported by workforce 01/01/2024. 4. Manual Handling corporate team to progress contract arrangements for external training facilities to support capacity by December 2023. 30/12/2023. 5. Outcome of peer review pilot to be evaluated and recommendation presented to the Strategic Inpatient Falls Group for sustainable model 01/02/2024. 6. The Welsh Nursing Care Record currently does not auto populate with Patient details such as mobility status from the admission assessment section into the FBHMA. This will be a future enhancement to the Welsh Nursing Care Record on an all-Wales basis. 01/02/2024.



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

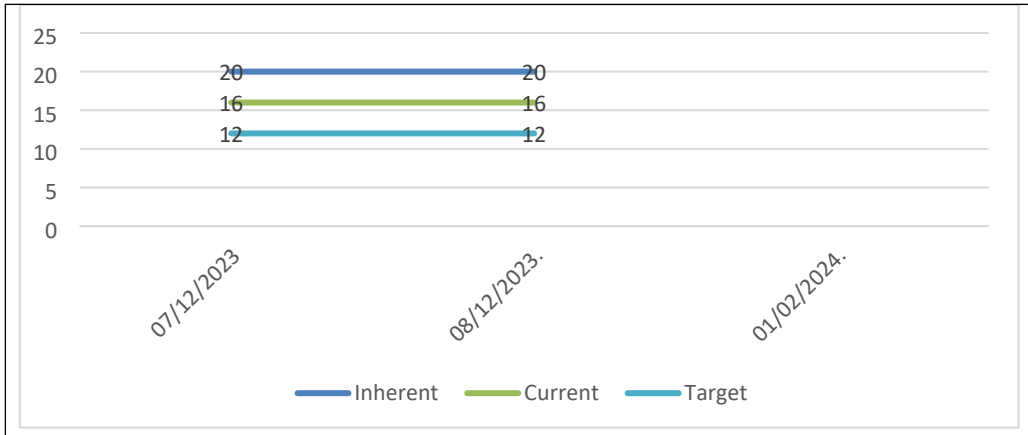
Overall Assessment

1 out of 6 actions have been completed, 2 to be progressed in Dec and remaining actions to be completed by February 2024 in order to reduce this score down to the target of 12. This is in line with the Falls Internal Audit limited assurance report. The Falls Group also have oversight of the gaps in controls and is working to mitigate these.

CRR 24-03	**Safeguarding**			**Date Opened:** 07/12/2023
	Assuring Committee: Quality, Safety and Experience Committee			**Date Last Reviewed:** 08/12/2023
	Director Lead: Executive Director of Nursing and Midwifery	**Link to Datix IDs**	**3766/2548**	**Date Last Committee Review:** 19/12/2023
		Link to BAF	**N/A**	**Target Risk Date:** 31/03/2025

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

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



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

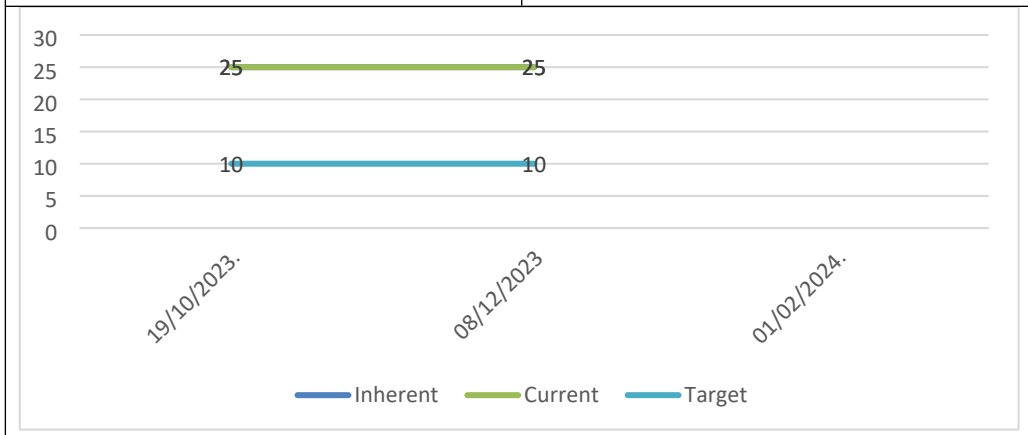
Overall Assessment

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

CRR 24-04	**Failure to Embed Learning**		**Date Opened:** 19/10/2023
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Reviewed:** 08/12/2023
	Director Lead: Executive Director of Nursing and Midwifery	**Link to Datix IDs: 3025/4519/4520/3795/ 3759**	**Date Last Committee Review:** 19/12/2023
		Link to BAF: **SP18 -** Quality, Innovation and Improvement	**Target Risk Date:** March 2024

There is a risk that the Health Board could fail to meet requirements for **timely review and learning** from mortality cases, claims, inspections, incidents and complaints. This could be caused by insufficient resources, lack of unified processes, outdated IT systems, duplication of effort, and overreliance on single personnel. The impacts may include missed opportunities for improvement, lack of family/carer engagement, potential patient harm events going undetected, non-compliance with national frameworks or legislation, and reputational damage.

Controls in place	Assurances	Additional Controls required	Actions and Due Date
1. Putting Things Right processes and monitoring 2. Clinical audit programme & monitoring arrangements 3. Senior sign-off process for National Reportable Incidents (NRIs) and Complaints 4. Clinical policies, procedures, guidelines, pathways, supporting documentation & IT systems 5. Clinical staff recruitment, induction, mandatory training, registration & re-validation 6. Defined nurse staffing levels for all wards & departments as per Nurse Staffing Act 7. Ward accreditation schemes and ward manager/matron checks/audits. 8. Tracking of regulatory action plans 9. Internal Reviews against External National Reports 10. Getting it Right First Time (GIRFT), localised deep dives, reports and action plans 11. HIW, Ombudsman NHS Wales Exec and WG Engagement Meetings 12. Operational oversight on workforce gaps reporting into the system oversight arrangement,	1. Service and IHC Quality Groups 2. Quality Delivery Group, its sub-groups and the Quality, Safety and Experience Committee oversight of quality issues 3. Quality reporting to Board 4. Executive performance reviews with IHCs 5. Clinical audit and Internal audit 6. Regulatory Assurance Group and oversight/assurance reporting 7. Annual Quality Report and Annual Putting Things Right Report 8. Internal audit 9. HSE inspections 10. HIW/CIW inspections 11. PSOW investigations 12. WG performance monitoring and assurance 13. Welsh Government Reviews 14. Royal College Reviews	1. Lack of a Quality Strategy 2. Lack of peer review structure 3. Duty of Quality to be reflected through TORs for all groups alongside requirement to provide assurance against for example Special Measure reporting, HIW action plans etc. 4. Continued similar issues being raised through NRI investigations and complaints, which are then reflected at Coroners Inquests. 5. Staffing pressures compounding on adhering to good quality governance and embedding learning.	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.

	Impact	Likelihood	Score
Inherent Risk Rating	5	5	25
Current Risk Rating	5	5	25
Target Risk Score	5	2	10
Risk Appetite	low level		1-8

Overall Assessment

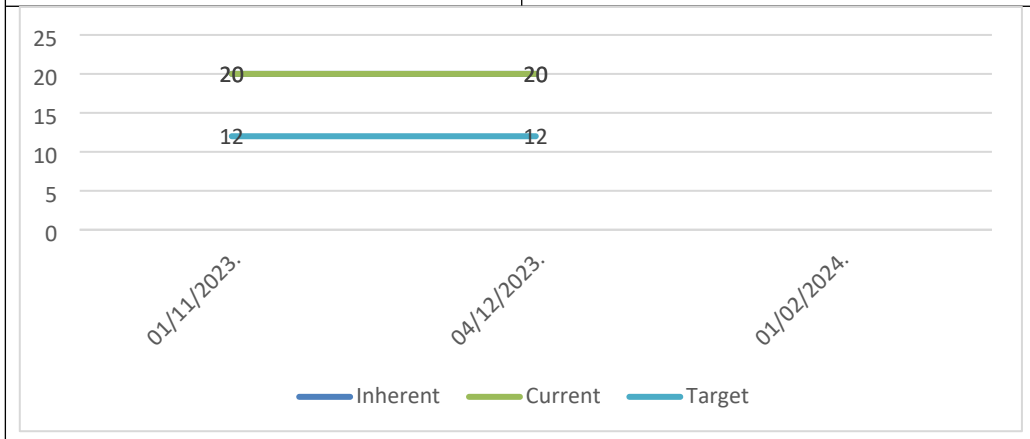
Six out of seven actions to support controls in relation to this risk are due in March 2024. Gaps in controls have been well identified and have further mitigations noted.

CRR 24-09	**Population Health**			**Date Opened:** 01/11/2023
	Assuring Committee: PPPH (PFIG) (QSE)			**Date Last Reviewed:** 04/12/2023
	Director Lead: Executive Director of Public Health	**Link to Datix IDs**	**4200/4201/1642**	**Last Committee Review:** 19/12/2023
		Link to BAF	**SP1 –** Prevention and Health Protection	**Target Risk Date:** March 2026

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

Controls in place	Assurances	Gaps in Controls	Actions and Due Date
1. Population Health Executive Delivery Group (meets monthly) provides strategic direction. 2. PPPH Committed has oversight and received regular reports. 3. Welsh Government provides oversight of grant funded activity supporting prevention and early years. 4. The Executive Director of Public Health provides consistency to the regional strategic approach for North Wales in the form of expertise and prioritisation and through leadership of the Public Health Team. 5. Consultants in Public Health are linked to delivery of key programmes of work, Public Health Wales and with IHC areas, providing expertise. 6. Public Health Team provide review and feedback on planning applications. 7. Health Protection Team work in partnership with Local Authorities to provide expertise and management of cases.	1. Risks linked to CRR24-09 are reviewed and monitored via the Population Health Executive Delivery Group and the Public Health Senior Leadership Team. 2. Health Board progress is reported to Regional Partnership Board and PPPH Committee. 3. The Public Health Team provide the Health Board, its partners and the public with evidence informed information and approaches to improve health and wellbeing. 4. The Public Health Team support population needs analysis and provide professional expertise to support the development of Health Board and partner plans. 5. Prevention is embedded in the Living Healthier, Staying Well Strategy and a 'life-course' approach is promoted. 6. Representation by senior Public Health team members at Public Service Boards, Partner Boards, Regional Partnership Board and National forums. 7. A 'Whole System Approach' is being implemented across a number of key priority areas. 8. A number of national programmes of work are underway including	1. In order to implement a system wide approach it is necessary for commitment from partners wider than the Health Board to prioritise the implementation of evidence informed practices and proposals. 2. The North Wales region is not operating at the pace or scale required to meet the current and forecast needs of the population. Resources and current pressures for all partners and the Health Board presents significant challenge to increasing the activities required. 3. It is acknowledged that this is a long term risk which cannot be mitigated and fully evidenced within 1-3 years as is well documented through evidence and research. As a Health Board we will work with partners to implement the approaches (many of which are long term approaches) which support the strongest evidence base for success. 4. A recognition of the importance of investing in prevention within the health board. 5. Commitment from partners within the health board to population health and prevention.	Actions supporting mitigation of this risk are via delivery of a range of specific strategies, plans and frameworks (some of which are continuous by nature of the work) which include: 1. Tobacco Control Legislation (including Smoke Free Sites) / Welsh Government Tobacco Control Plan 2. All Wales Weight Management Pathway 2021 3. Infant Feeding Strategy 2019 (current refresh underway to 2025) 4. Health Care Public Health Programme (also linked to Special Measures Plans and chronic disease pathways) 5. Together for Mental Health Strategy (local / national) 6. Well North Wales targeted partner programmes 7. Health Board Annual Plan / IMTP milestones and associated activity 8. Working in partnership across BCUHB, PHW and LA to reduce the risk associated with infectious diseases 9. Immunisation Strategy 2023-2026 10. Actions as per detailed within specific risks linked to this CRR.

	implementing the Weight Management Pathway and Smoke Free Sites regulations. 9. Annual development of Public Health work plan to reflect current and emerging need. 10. National Performance Framework measures.	6. The failure to recognise the risk associated with the demographic profile and current prevalence of chronic conditions and how further demand due to a lack of prevention could risk overwhelming the system in the future. 7. There is no secured long-term funding to support implementation and growth of the whole system approach across North Wales at scale. 8. The current cost of living crisis will adversely affect those most at risk. 9. The current financial position of the Health Board and its partners will impact on investment into key business cases which support this work. 10. The current position of the Health Board within escalatory measures and short term focus of meeting ministerial and special measures priority actions may reduce focus on longer term priority work. 11. The availability of data to support strategic focus at the local level and planning is not available. 12. The Health Protection service is not confirmed past 23/24.	



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

Overall Assessment

As per the previous population health corporate risks, action plans are progressing well within the control of the Health Board considering the funding constraints being the most notable gap in control. Due dates for some of the actions will be added but note the overall more long-term target date of 2026 to reduce the score to a target of 12.

Teitl adroddiad: ***Report title:***	Board Assurance Framework			
Adrodd i: ***Report to:***	QSE			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Tuesday, 19 December 2023			
Crynodeb Gweithredol: ***Executive Summary:***	As per the 23/24 Annual Plan Organisational Deliverables proposed risk descriptions have been provided and also the relationship with the proposed corporate risk register and Tier 1 risks.			
Argymhellion: ***Recommendations:***	The Committee is asked to **consider and approve** the BAF risks to which it has accountability for.			
Arweinydd Gweithredol: ***Executive Lead:***	Phil Meakin, Acting Board Secretary			
Awdur yr Adroddiad: ***Report Author:***	Nesta Collingridge, Head of Risk Management			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☒	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: 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:	Appendix BAF report highlights the link between CRR.			

Link to Strategic Objective(s):	
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 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)***	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:*** *(or links to the Corporate Risk Register)*	BAF paper which further links Tier 1 and CRR.

Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	
Camau Nesaf: ***Next Steps:*** 1. Submission to the Board. 2. Hold 1-1s for outstanding BAF risks and further develop controls, action plans etc. 3. Corporate Team to monitor and escalate any new BAF risks to Executives for review.	
Rhestr o Atodiadau: ***List of Appendices:*** Appendix 1- BAF Heat Map & Risk Overview Appendix 2 - QSE BAF Risk Reports 1. Cancer 2. Women's 3. Quality, Innovation and Improvement	

Introduction/Background

1. The purpose of the Board Assurance Framework (BAF) is to inform and assure the Board with controls and action plans for identified high-extreme risks that relate to any possibilities of not delivering on the Annual Strategic Priorities of the Health Board. This will be aligned to Objectives once these have been reviewed.

   Where high risks emerge, Executives have provided Committees and the Board with a risk report which outlines controls and action plans in relation to achieving the deliverables on the Strategic Priorities. An overview is provided to the Committee in relation to the all the high risks identified, progress and score. Where the Committee have oversight, a BAF report has been completed.

   Executives have signed off their individual BAF risk reports prior to submission to Committee and the Board. **Committees are asked to review the report prior to approval at the Board.**

   QSE has the overall accountability of five BAF risk reports, four attached.
   1. Prevention and Health Protection
   2. Cancer
   3. Women's
   4. Quality, Innovation and Improvement

   Children's has been identified as a high risk and report has been developed but not yet reviewed and signed off by the Executive.

Summary

It is anticipated that out of the 19 Strategic Priorities, 10 are likely to be anticipated in the full BAF report and potentially high risk of failing to deliver on the strategic priority. However, controls and action plans detail the work ongoing to mitigate and overall reduce this risk. The Board will be updated on progression of action plans and movement in score.

Five leads are outstanding in providing a score/report for their risk in relation to non-delivery.

Next steps

1. Ongoing monitoring of risks in relation to the Annual Plan Strategic Deliverables.
2. Risk scores for all to be monitored and Board to be provided with full BAF risk report.

Appendix 1-

BAF Heat Map & Risk Overview

Appendix 2 -

QSE BAF Risk Reports

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Board Assurance Framework

Last updated 08 Dec 23

Appendix 1

BAF Risk Heat Map

Impact			1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
	Catastrophic	5			• SP1 – Population Health and Health Inequalities		• SP3 – Planned Care • SP18 – Quality, Innovation and Improvement
	Major	4				• SP9 – Women's Services • SP16 – Board Leadership & Governance	• SP5 – Cancer • SP13 – Digital, Data & Technology • SP10 – Children
	Moderate	3		• SP6 – Mental Health • SP8 – Learning Disabilities • SP19 – Social & Civic Leadership & Responsibility	• SP15 – Partnerships • SP2 Primary Care		
	Minor	2		• SP7 – Substance Misuse			
	Negligible	1					

Possibility

Board Assurance Framework Risks Overview

Title	Score	Committee	Executive	Progress
Strategic Priority P1 Prevention and Health Protection	**15**	Quality, Safety and Experience Committee	Executive Director of Public Health	Approved by the Executive Director of Public Health
Strategic Priority P2 Primary Care	**9**	Performance, Finance and Information Governance Committee	Director of Primary Care	Confirmation of moderate risk score from the service
Strategic Priority P3 Planned Care	**25**	Performance, Finance and Information Governance Committee	Executive Director of Integrated Clinical Services	Draft risk being developed by the service to be reviewed.
Strategic Priority P4 Urgent and Emergency Care	**TBC**	Performance, Finance and Information Governance Committee	Executive Director of Integrated Clinical Services	Draft risk being developed by the service to be reviewed.
Strategic Priority P5 Cancer	**20**	Quality, Safety and Experience Committee	Executive Director of Integrated Clinical Services	Approved by the Executive Director of Integrated Clinical Services. Confirmation of funding required to reduce the score.
Strategic Priority P6 Mental Health	**6**	Quality, Safety and Experience Committee	Executive Director of Public Health	Confirmation of low risk score from the service
Strategic Priority P7 Substance Misuse	**4**	Quality, Safety and Experience Committee	Executive Director of Public Health	Confirmation of low risk score from the service
Strategic Priority P8 Learning Disability	**6**	Quality, Safety and Experience Committee	Executive Director of Public Health	Confirmation of low risk score from the service
Strategic Priority P9 Women's Services	**16**	Quality, Safety and Experience Committee	Executive Director of Integrated Clinical Services	Approved by the Executive. Score will be reduced once clarity on funding and steer from NHS Executive is received.

Strategic Priority P10 Children	**20**	Quality, Safety and Experience Committee	Executive Director of Integrated Clinical Services	Draft risk developed by the service, approval confirmation required from Executive Lead
Strategic Priority P11 Wider Delivery	**TBC**	Audit Committee	Executive Director Transformation And Strategic Planning	Score being reviewed.
Strategic Priority P12 Workforce	**TBC**	Quality, Safety and Experience Committee	Executive Director of Workforce	Score being reviewed.
Strategic Priority P13 Digital, Data and Technology	**20**	Performance, Finance and Information Governance Committee	Director of Digital (Chief Digital Information Officer (CDIO)	Approved by Executive Director and reviewed at Committee
Strategic Priority P14 Estates and Capital	**TBC**	Performance, Finance and Information Governance Committee	Executive Director of Finance	Score being reviewed.
Strategic Priority P15 Partnerships	**9**	Quality, Safety and Experience Committee	Executive Director Transformation And Strategic Planning	Confirmation of low risk score from the service
Strategic Priority P16 Board leadership and governance	**16**	Audit Committee	Board Secretary	Reviewed by AC. Score will be reduced once IMs are onboarded
Strategic Priority P17 Organisational development	**TBC**	Quality, Safety and Experience Committee	Executive Director of Workforce	Score being reviewed.
Strategic Priority P18 Quality, Innovation and Improvement	**25**	Executive Director of Nursing and Midwifery	Executive Director of Nursing and Midwifery	Approved by the Executive Director of Nursing and Midwifery
Strategic Priority P19 Social and Civic leadership and responsibility	**6**	Quality, Safety and Experience Committee		Confirmation of low risk score from the service

Appendix 2

<table>
<tr><td rowspan="4">BAF SP1</td><td colspan="2">Executive: Executive Director of Public Health</td><td>Date Opened: March 2023 (Annual Operating Plan 23/24)</td></tr>
<tr><td colspan="2">Committee: PPPH (Quality, Safety and Experience Committee)</td><td>Date Last Reviewed: November 2023</td></tr>
<tr><td>Strategic Priority: P1
Population Health and health inequalities</td><td>Link to CRR: Population Health
Link to Tier 1's: 4200/4201/1642</td><td>Committee Review Date: 19/12/2023</td></tr>
<tr><td></td><td></td><td>Target Risk Date: 31 March 2024</td></tr>
<tr><td colspan="4">There is a risk that the Health Board fails to adequately plan for and deliver improvement of population health and reduce health inequalities. This may be caused by a lack of provision for sustainable services and targetted programmes of activity, and capacity, financial and resource constraints within the Health Board. This may contribute to poorer health outcomes and widening inequalities alongside increasing demand on services across North Wales.</td></tr>
<tr><td colspan="2">Mitigations/Controls in place</td><td>Gaps in Controls</td><td>Current Risk Score</td></tr>
<tr><td colspan="2">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. Population Health Exec Delivery Group (PHEDG) provides strategic direction and monitors delivery of the Population Health Services.
2. There are a number of key strategy documents specific to local needs developed with partners e.g. including weight, smoking, infant feeding, mental health and wellbeing, immunisations and reducing alcohol intake.
4. Integrated Health Community plans reflect local priorities based on data and evidence.
5. Population Needs assessment informs local planning.
6. Progress reports to Public Health Wales (PHW) in regard to activity funded by PHW and links to national programmes of work.
7. Progress reports to Arts Council of Wales in regard to activity funded by Arts Council.
8. Building a Healthier North Wales Partner Network meets three times per year to share learning and develop network.
9. Engagement and contribution to Regional Partnership Group.
10. Engagement and contribution to Public Services Boards.</td><td>1. In order to implement a system wide approach, it is necessary for commitment from partners wider than the Health Board to prioritise the implementation of evidence informed practices and proposals.
2. Inadequate resources and multiple constraints including finance.
3. System wide change cannot be implemented within 1-3 years as is well documented through evidence and research.

4. Prevention, health inequalities, improving</td><td>Impact 5 | Likelihood 3 | Score 15

Movement since last Qtr:

1. Provision of planning packs to Integrated Health Community Management and planning teams which outlines priorities 'on the patch'.
2. Funding secured for 24/25 for continuation of Arts in Health project.
3. Healthcare Public Health paper outlining potential opportunities submitted as part of special measures framework.
4. Whole System Approach to Weight Strategic Delivery Plan</td></tr>
</table>

11. Strategic partnership with Actif North Wales. 12. Regular meetings with Welsh Government in relation to Prevention and Early Years funded activity.	health and wellbeing should be strengthened through integration into all planning and decision making frameworks, with sufficient weighting. 5. Robust intelligence and data availability at local level to support planning and decision making	approved and launched with partners. 5. First iteration of Food and Drink policy for the Health Board drafted 6. Meeting quarterly targets for % of adult smokers who make a quit attempt via smoking cessation services 7. Qualitative reports have been submitted to Welsh Government outlining the progress for Help Me Quit Services (pregnancy and hospital) and Weight Services in line with National Performance Framework requirements. 8. National guidance has recently been received in relation to vaping which is informing the development of resources for schools. 9. Appointment of (secondment) Strategic Partnership Development Manager working to develop the Social Prescribing offer from 24/25. 10. Incentivisation scheme aimed at reducing smoking during pregnancy has been established. 11. Inverse Care Law programme has been established with workshops taking place across each area. 12. Continued engagement with partner organisations (eg third sector, health board, local authority, community organisations)

		13. Maintained strong connections with the strategic programme for primary care and accelerated cluster development programme. 14. Gypsy, Roma, Traveller needs analysis undertaken.

Actions and Due Date	
Continue to deliver programmes which support the All Wales Tobacco Control plan including smoke free regulations	Q3/Q4
Continue to deliver programmes supporting the All Wales Weight Management Pathway	Q3/Q4
Finalise Arts in Health Strategic Plan	Q3
Continue to implement the Infant Feeding Strategic plan	Q3/Q4
Share report and recommendations following Gypsy Roma Traveller needs analysis	Q3
Together with partners and as part of the work of the Area Planning Board, implement the Alcohol Strategy for North Wales	Q3/Q4

Lines of Defence			**Overall Assessment**
1	**2**	**3**	
1. Local Public Health Team 2. Public Health Performance and Risk Management Group 3. Population Health Executive Delivery Group 4. Public Health Consultants attend Integrated Health Community Senior Meetings	1. QSE Board 2. PPPH Committee	1. Embed Public Health Outcomes approach into local planning through local partners and Health Board.	**Score of 15,** multiple constraints including finance, impacting on risk of the annual plan and failure of delivery in relation to prevention.

<table>
<tr><td rowspan="4">BAF
SP5</td><td colspan="2">Executive: Executive Director Integrated Clinical Services</td><td>Date Opened: October 2023</td></tr>
<tr><td colspan="2">Committee: Quality, Safety and Experience Committee</td><td>Date Last Reviewed: October 2023</td></tr>
<tr><td>Strategic Priority:
Cancer</td><td>Link to CRR: Special Measures
Link to Tier 1's: None</td><td>Last Date Reviewed at Committee: 19/12/2023</td></tr>
<tr><td colspan="2"></td><td>Target Risk Date: TBC</td></tr>
<tr><td colspan="4">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>Gaps in Controls</td><td>Current Risk Score</td></tr>
<tr><td colspan="2">These are measures/interventions implemented by the Health Board to reduce either the likelihood of a risk and/or the magnitude/severity of its potential impact were it to be realised.

1. Draft Cancer Strategy for North Wales developed by North Wales Cancer Partnership Board highlighting key challenges and resulting strategic aims for cancer for the next 5 years
2. Workstreams underway as part of Special Measures programme to support vulnerable services, including dermatology & plastics, urology and oncology
3. New services to improve cancer pathways in place via investment from the Performance Fund Suspected Cancer Pathway (SCP) allocation, including straight to test lung and neck lump pathways, rapid diagnosis clinics, additional breast cancer capacity and increase in tracking teams
4. Pathway reviews commenced to assess compliance with national optimal pathways for cancer and identify areas of improvement; prostate and colorectal reviews completed with breast and gynaecology underway
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>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</td><td><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: N/A</td></tr>
</table>

	4. Service improvements funded via Performance Fund allocation vulnerable due to RIGA process 5. Lack of new funding to implement service expansion in line with demand, and further service improvements identified via pathway review work	

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

Lines of Defence			**Overall Assessment**
1	**2**	**3**	Confirmation of funding required.
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.	

<table>
<tr><td rowspan="4">BAF SP9</td><td colspan="2">Executive: Executive Director Integrated Clinical Services</td><td colspan="2">Date Opened: October 2023</td></tr>
<tr><td colspan="2">Committee: Quality, Safety and Experience Committee</td><td colspan="2">Date Last Reviewed: October 2023</td></tr>
<tr><td>Strategic Priority: Women's</td><td>Link to CRR: Staffing/Financial Sustainability
Link to Tier 1's: 4490/ 4773</td><td colspan="2">Last Date Reviewed at Committee: 19/12/2023</td></tr>
<tr><td colspan="2"></td><td colspan="2">Target Risk Date: April 2024</td></tr>
<tr><td colspan="5">There is a risk of failing to effectively implement critical actions to improve maternity, neonatal, and women's health services and outcomes.</td></tr>
<tr><td colspan="2">Mitigations / Controls in place</td><td>Gaps in Controls</td><td colspan="2">Current Risk Score</td></tr>
<tr><td colspan="2">1. Local Maternity and Neonatal Strategic Plan mapping exercise of the National programme and recommendations has been undertaken to identify actions and resource requirements against 31 'short-term' maternity actions and 6 'short-term' neonatal actions.
2. On-going engagement with Welsh Government (WG). NHS Executive commissioned to undertake Phase 2 (implementation) of the Maternity and Neonatal Safety Support Programme. The network will be providing the clinical and management leadership on the design and delivery of the Programme.
3. Maternity and Neonatal Safety Support Programme actions have been included in the Women's Service Delivery Plan 23/24 under Transforming Maternity Services (Priority 1). Progress is monitored quarterly and reported to the Women's Transformation Group and Women's Service Delivery Board and upwardly via lines of defence.
4. Digital Maternity Cymru National Programme Board established with appropriate BCUHB representation.
5. Local Digital Maternity Cymru working group established ahead of the required governance structure for the implementation of the Maternity Information System.
6. Service is planning for pre-implementation phase ahead of the national Digital Maternity Cymru full Business Case in Dec 23 which will inform national procurement.
7. In relation to the Quality Statement Women's service continue to develop the WG funded projects e.g. pelvic health and endometriosis services.</td><td>1. Delays in prioritisation of the recommendations made in the Maternity and Neonatal Safety Support Programme Discovery Report will impact on local implementation.
2. No confirmed funding for Maternity and Neonatal Safety Support Programme implementation phase and recommendations.
3. Funding for the local Informatics capital and resource requirements for Digital Maternity Cymru Programme not confirmed.
4. Quality Statement for Women and Girls' Health - Confirmation of Corporate Executive Lead required. Also awaiting further National steer which will inform funding available for the 10-year Women's Plan.</td><td colspan="2"><table><tr><td>Impact</td><td>Likelihood</td><td>Score</td></tr><tr><td>4</td><td>4</td><td>16</td></tr></table>Movement since last Qtr: N/A</td></tr>
</table>

Actions and Due Date	
Action Detail	**Due Date**
Digital Midwife appointed to interface with the Digital Health Care Wales National team and local support for the pre-implementation planning.	March 2024 and ongoing
Of the outstanding short-term Maternity and Neonatal Strategic Plan actions 3/8 of the amber actions and 2/11 of the red actions will be achievable by the end of Q4 with minimum resource required	March 2024
Remaining Maternity and Neonatal Strategic Plan outstanding actions will be rolled over into 24/25 Women's Service Delivery Plan – implementation resource impact has been considered as part of the planning for 24/25.	March 2024
Clarification from WG as to how the NHS Executive will manage Phase 2 Implementation and prioritisation of the recommendations – update received see above.	March 2024
Local Capital and Resource requirements for Digital Maternity Cymru to be included in 24/25 planning. Band 7 Project Manager funding to be confirmed by WG.	March 2024
Quality Statement for Women and Girls' Health (issued by WG). NHS Executive commissioned to lead on the development of a National Women's Health Network and 10-year Women's service plan. An Executive lead will need to be identified to locally lead on the Plan.	March 2024

Lines of Defence			Overall Assessment
1	2	3	
. Women's QSE 2. Women's Risk Management Group 3. Women's Integrated Performance Group 4. Women's Senior Leadership Team meeting 5. Women's Service Delivery Board 6. Women's Transformation Delivery Group	1. BCUHB Quality Executive Delivery Group 2. QSE Committee 3. Executive Accountability Meetings	1. Welsh Government Digital Cymru Programme Board 2. National Maternity and Neonatal Safety Support Programme Board 3. IQPD	Further steer is required from NHS Executive (delegated by WG) in relation to the Maternity and Neonatal Safety Support Programme on prioritisation of recommendations made in the Discovery Phase. Local funding to deliver the priorities is to be confirmed. Short-term actions as detailed in the Maternity and Neonatal Safety Support Programme are progressing well within target and 14 green, 13 amber, 17 red and 11 further to progress. Progression with all short-term actions would reduce the score.

<table>
<tr><td rowspan="4">BAF
SP18</td><td colspan="2">Executive: Executive Director of Nursing and Midwifery</td><td>Date Opened: 19/10/2023</td></tr>
<tr><td colspan="2">Committee: QSE</td><td>Date Last Reviewed: October 2023</td></tr>
<tr><td>Strategic Priority: SP18
Quality, Innovation and Improvement</td><td>Link to CRR: Failure to Embed Learning
Link to Tier 1's: 3025/4519/ 4520/3795/3759</td><td>Last Date Reviewed at Committee: 19/12/2023</td></tr>
<tr><td colspan="2"></td><td>Target Risk Date: March 2024</td></tr>
<tr><td colspan="4">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.</td></tr>
<tr><td colspan="2">Mitigations/Controls in place</td><td>Gaps in Controls</td><td>Current Risk Score</td></tr>
<tr><td colspan="2">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.

Governance is in place to ensure IHC/Division meetings report effectively through to the EDG for Quality, the QSE Committee and then to Board. Duty of Quality awareness has been focussed on within the organisation. Six Goals improvement Group in place to oversee the USC improvement programme of work and monitor performance which provides regular reports to PFIG. Clinical service structures, accountability & quality governance arrangements at Health Board, IHC & service levels including:
▪ Quality meetings structures and reporting
▪Clinical policies, procedures, guidelines, pathways, supporting documentation & IT systems
▪ Putting Things Right procedures and processes in place such as incidents, complaints, claims, mortality reviews and inquests
▪ Clinical audit programme & monitoring arrangements
▪ Clinical staff recruitment, induction, mandatory training, registration & re-validation
▪ Defined nurse staffing levels for all wards & departments as per Nurse Staffing Act
▪ Ward assurance accreditation programme
▪ Revised sign-off process for incidents and NRIs
▪ Tracking of regulatory action plans
▪ Internal Reviews against External National Reports</td><td>• Lack of a Quality Strategy
• Lack of peer review structure
• Lack of consistent embedding of learning from incidents, mortality reviews and complaints
• Duty of Quality to be reflected through TORs for all groups alongside requirement to provide assurance against for example Special Measure reporting, HIW action plans etc.
• Lack of timely completion of NRI reports and complaints and robust process to follow up actions;
• Continued similar issues being raised through NRI investigations and complaints, which are then</td><td><table><tr><td>Impact</td><td>Likelihood</td><td>Score</td></tr><tr><td>5</td><td>5</td><td>25</td></tr></table>Movement since last Qtr: N/A</td></tr>
</table>

▪ Getting it Right First Time (GIRFT) localised deep dives, reports and action plans ▪ HIW, Ombudsman NHS Wales Exec and WG Engagement Meetings ▪ Operational oversight on workforce gaps reporting into the system oversight arrangement	reflected at Coroners Inquests. • Staffing pressures compounding on adhering to good quality governance and embedding learning.	

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.	**December 2023**
2. Best practice guidance will be issued to IHCs and Regional Divisions to support effective local quality governance arrangements.	**January 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.	**January 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**	Movement in scoring to be reviewed in March 24 and reflect on progression of action plan.
1. Service and IHC Quality Groups 2. PTR 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 has oversight of quality issues 2. Quality reporting to Board 3. Executive performance reviews with IHCs 4. Clinical audit 5. Learning from Deaths (Mortality) Group and oversight/assurance reporting 6. Patient and Carer Experience Group and oversight/assurance reporting 7. Patient Safety Group 8. Clinical Effectiveness Group and oversight/assurance reporting 9. Regulatory Assurance Group and oversight/assurance reporting 10. Annual Quality Report and Annual PTR Report 11. Patient stories to Board	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	

Teitl adroddiad: ***Report title:***	Special Measures Update			
Adrodd i: ***Report to:***	Quality, Safety and Experience Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	19th December 2023			
Crynodeb Gweithredol: ***Executive Summary:***	The purpose of this paper is to provide an update on Special Measures, outlining the progress to date on the deliverables associated to this Committee.			
Argymhellion: ***Recommendations:***	The Committee is asked to **RECEIVE ASSURANCE** on the progress to date, acknowledging the recent Board update and the impending formal closure assessment.			
Arweinydd Gweithredol: ***Executive Lead:***	Carol Shillabeer, Chief Executive (Accountable Officer) Dr Chris Stockport, Executive Director of Transformation & Strategic Planning (Lead Executive)			
Awdur yr Adroddiad: ***Report Author:***	Geraint Parry, Special Measures Programme			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	To support Special Measures			
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	Not applicable			

Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqlA been identified as necessary and undertaken?***	Not applicable
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	Not applicable
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	Not applicable
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	Not applicable
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	Not applicable
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	Not applicable
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	Not applicable
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Not applicable
Camau Nesaf: Gweithredu argymhellion ***Next Steps:*** Implementation of recommendations	

Quality, Safety and Experience Committee

Special Measures Update

1) Introduction

This report presents a brief update on Special Measures at the end of Cycle 2 (September to November 2023).

The report provides a high level overview of key business relating to this committee, including progress regarding the Independent Reviews. The November Board has just received a full report across all deliverables and milestones within Cycle 2, with an assessment undertaken towards the end of the cycle, and the formal closure assessment will occur in the first 2 weeks of December. This assessment will conclude after the writing of this report, therefore an abbreviated version of this report has been prepared, and the full closure assessment will be submitted to Board, once available.

The third and final 90-day cycle (December 2023 to February 2024) within the Stabilisation phase is now underway, with teams looking to build upon the foundations laid within the first 2 cycles and ensure the preparedness for the important Standardisation phase, due to commence in April 2024. Readiness activities for this phase are underway, with criteria being developed in collaboration with Welsh Government and these will continue alongside this final 90-day cycle. The agreed milestones for this third cycle within the QSE remit are included at Appendix 1 and once the Cycle 2 closure is complete an assessment of activity required to roll forward will also take place and be appended.

2) Background

The background to the Health Board escalation into Special Measures and the resultant organisational response has been covered in previous committees. The full Board meeting also receives a detailed update across all deliverables and milestones to enable scrutiny.

3) Progress to date

Independent Reviews

A process is in place for the development and then delivery of recommendations associated to reviews received. The first 2 reviews under the remit of this committee (Patient Safety Review and Mental Health Inpatient Safety Review) have been presented to a development session of the committee and management responses have been presented to a formal committee.

These reports have now been published for the public on our website as part of the November Board papers and form an important part of our transparent approach to respond to identified issues and demonstrating how we are changing the organisational culture.

The following table provides the summary position against each of the reviews within the QSE remit.

Review	Update
Patient Safety Review	Presented to committee, along with management response which is now being enacted. The review has been published on the BCUHB website.
Mental Health Inpatient Safety Review	Presented to committee, along with management response which is now being enacted. The review has been published on the BCUHB website.
Vascular Review	The report has been received and a development session has been arranged for the 18th December to formally receive the report.
Stocktake Review of Progress Against Previous Mental Health Reviews	Due to be received in December in line with initial expectations.
Clinical Governance Review	The first meeting to commence this work, referred to as the Quality Round Table, took place on the 16th November and the work will progress during cycle 3.

The Health Board is taking a thematic approach to the reviews to ensure we address the root causes of our issues, which are common across many of our areas. Thus far, the following 7 themes have been identified and these are being mapped to the most appropriate Executive Led Delivery Group to oversee delivery of the actions.

Themes from reviews received to date
1. Data, Intelligence & Insight Ensuring that there is an organisation wide approach with prioritised interventions into improving our data, intelligence and insight tools and capabilities. This will be a key enabler for sustainable improvement as well as supporting identification of future potential services of concern.
2. Culture Defining, engaging and committing to the long-term work necessary to improve the culture of the organisation. Integrated into our broader organisational development plan across Culture, Leadership and Engagement.
3. Risk Management Reviewing and refining our approach and appetite to risk, including how risks are identified, managed, mitigated, reported and monitored.
4. Patient, Family, Carer Involvement A single coordinated approach to maximise involvement and engagement with our patients and their families and carers, using their experiences to guide our ongoing service improvement.
5. Operating model Ensuring our operating model is designed to best deliver our strategic priorities, with clarity for everyone across all levels of the organisation on the roles and responsibilities, systems and processes within divisions and Pan BCU services.
6. Organisation Governance and compliance Ensuring organisation wide visibility and understanding of governance best practice and ensuring adherence to it.
7. Integrated Planning A well understood integrated approach to planning as a discipline, as well as contributions to our annual planning process.

Cycle 3 and Standardisation Phase Preparation

The plan for Cycle 3 (December 2023 to February 2024) has now been agreed by the Board. As the Health Board reaches a greater position of stability a growing focus will be placed upon the 'Standardisation' phase that will follow. This phase, which is due to commence in April 2024, will be crucial in developing consistent standards across each of our geographical areas, reducing variation, and delivering continual improvement in our services.

Ensuring that Special Measures is incorporated into business-as-usual planning cycles is critical. Planning for 2024/25 is currently underway as part of the Integrated Medium-Term Plan (IMTP) for 2024 to 2027 and as such the Special Measures 'Standardisation' thinking is being incorporated into that process.

4) Portfolio Management Office (PMO) Assessment

Overall good progress has been made during Cycle 2 across a number of areas, such as with the Board approval of the Risk Management Framework and subsequent progression to implementation. Following review at committee, the Health Board responses to the Patient Safety Review, and the Mental Health Inpatient Safety Review are being implemented, and we have seen continual strengthening of our Oncology Services. A number of challenges do still exist however, most importantly ensuring that the clinical areas of concern identified in cycle 2 and 3 move as quickly as possible from 'discovery and design' into delivery and realisation of improved outcomes for the population of North Wales.

5) Change Control

As part of Special Measures governance arrangements any proposed changes require approval through a change control process. This is approved through the Special Measures Senior Responsible Officer (SRO) before being submitted to the Board for final approval.

There are no new change requests to report during December 2023 for deliverables mapped to this committee.

6) Recommendations

The Committee is asked to **RECEIVE ASSURANCE** on the progress to date, acknowledging the recent Board update and the impending formal closure assessment.

Appendix 1

Cycle 3 Milestones relating to QSE

1. A well-functioning Board

No Cycle 3 deliverables from Outcome 1 fall under the remit of this committee

2. A clear, deliverable plan for 2023/24

No Cycle 3 deliverables from Outcome 2 fall under the remit of this committee

3. Stronger leadership and engagement

Exec Lead	Milestone	Due Date	Why it's important to track
C1-3.10: Implement plans for integrated electronic healthcare record			
Dylan Roberts	3.10.7 - Finalise, review and agree prioritised service and digital tactical interventions for ED, quantify benefits and develop costed plan for delivery.	31/12/2023	Identifying the full list of problems and prioritised list of actions will ensure systems and processes work as consistently and effectively as possible across all BCU EDs, which is a core enabler for delivery of high quality, timely and safe urgent and emergency care.
Dylan Roberts	3.10.8 - Draft Strategic Outline Case for Electronic Healthcare Record Systems (EHR) presented to Exec Team, including plan to take forward with wider stakeholders	31/01/2024	A single integrated electronic patient record system will improve the coordination of care, enhance patient experience and safety through improved clinical outcomes, enable faster access to care, improve communications between clinicians and provide the foundations for remote monitoring and telehealth in the future. Having the same data accessible to clinicians across all care settings is core to the transformation and improvement of practice over what will be a 5 – 10 year programme of work.
Dylan Roberts	3.10.9 Case developed for best of breed Mental Health system in conjunction with DHCW and WG to help address the lack of electronic health care records.	29/02/2024	There are significant record keeping issues in Mental Health which have repeatedly featured in Regulation 28 notices from the Coroner.

4. Improved access, outcomes and experience for citizens

Exec Lead	Milestone	Due Date	Why it's important to track
C1-4.5a: Vascular improvement plan			
Nick Lyons	4.5a.10 Welsh Government Phase 2 audit of anonymised case files completed	29/02/2024	The Network, Clinical Lead and Office of the Medical Director will have an understanding of any ongoing areas of concerns, or areas of significant progress. This will support the ongoing development of the Vascular Network Improvement Plan/ and improvement programme
Nick Lyons	4.5a.11 Updated Vascular Integrated Improvement Plan, which incorporates all outstanding, and new improvement recommendations, and service level priorities developed and approved by Vascular Steering Group	29/02/2024	It is important that the Network is able to articulate a clear vision for the ongoing improvement of Vascular services across North Wales, and the steps necessary to get there, including any actions that need to be carried forward from the existing Improvement Plan, as well as new and emergent priorities
Nick Lyons	4.5a.12 17 vascular related pathways approved by Strategic Clinical Effectiveness Group for implementation including audit and evaluation cycles	29/02/2024	To ensure the implementation of key programmes of work, and that Health Board governance protocols have been adhered to throughout
Nick Lyons	4.5a.13 Emergency Diabetic Foot Pathway implemented and clinical audit cycle in place to monitor improvements in access, outcomes and experience	29/02/2024	To ensure this key strategic pathway is implemented and embedded within everyday practice across the Network, thereby assuring the Health Board that positive outcomes are being achieved for citizens
Nick Lyons	4.5a.9 Integrated Vascular hub and spoke: North Wales Vascular Service Specification, outlining roles and responsibilities of Hub and Spoke sites, to be revised in light of other improvements made and presented to Vascular Steering Group	31/01/2024	Agreeing the model across North Wales is a key step in the ongoing improvements of vascular services.
C1-4.5b: Urology improvement plan			
Nick Lyons	4.5b.10 Plan agreed with the national robotic programme to ensure effective and sustainable use of the north Wales robot, to enable improved access for our population	31/01/2024	Realising the benefits of cutting edge, modern tools will improve the quality of care we provide for our patients.
Nick Lyons	4.5b.8 Recruitment completed of dedicated expert clinical support to advise, support and implement the Urology Improvement Plan	31/12/2023	Having the right clinical expertise is important to ensure evidence based improvements in line with best practice.
Nick Lyons	4.5b.9 Delivery commenced of the Urology Improvement Plan and improvements in consistency of delivery in quality standards and access to urgent and elective pathways across North Wales starting to be realised	19/01/2024	Delivery of standardised care and reducing variation in the quality of services is important in ensuring equity for our population.

C1-4.5c: Ophthalmology improvement plan			
Adele Gittoes	4.5c.10 Development commenced of an outline 5-year eye care plan based on an integrated sustainable model.	29/02/2024	As we move towards standardisation it is important that we outline a longer term vision to transform our services.
C1-4.5d: Oncology improvement plan			
Nick Lyons	4.5d.7 Review of Oncology completed at Exec Team with respect to readiness for transitioning towards standardisation	29/02/2024	This is an important step in preparing for the potential de-escalation of a service of concern and how we track on an ongoing basis.
C1-4.5e: Dermatology improvement plan			
Adele Gittoes	4.5e.8 Delivery commenced of an immediate plan to reduce the backlog with a maximum scope of an additional c.2000 patient appointments, dependent on WLIs.	29/02/2024	There is a significant backlog of patients with skin cancer not being treated in a timely manner.
C1-4.6: Mental Health review of previous reviews – phase 2			
Teresa Owen	4.6.7 Copy of Royal College of Psychiatry MH&LD report received.	31/01/2024	Receiving this overarching report will be a key point in summarising historic concerns and providing a clear path for future improvements.
Teresa Owen	4.6.8 MH&LD/RCPsych Action Plan developed and scheduled for sign off via appropriate governance routes.	29/02/2024	Ensuring a timely response to issues raised in the reports will key to building confidence in our future plans.
C1-4.7: Mental Health Inpatients Safety review - phase 2			
Teresa Owen	4.7.5 NCCU Action Plan Delivery Group fortnightly meetings held.	31/12/2023	Regular review of the plan and progress against patient outcomes will ensure improvements are made and any challenges can be resolved in a timely manner.
Teresa Owen	4.7.6 MH&LD evidence log and repository developed.	31/12/2023	Having a central repository will ensure good governance and oversight and ensure actions committed to are delivered upon.
Teresa Owen	4.7.7 MH&LD NCCU update report submitted through appropriate governance routes to provide an overview of progress made with implementation of action plan.	29/02/2024	Having strong governance and sign off ensures that appropriate challenge can be made and that progress is tested by senior stakeholders.
C1-4.8a: CAMHS improvement plan			
Adele Gittoes	4.8a.7 Delivery of the agreed BCU performance trajectories for the Mental Health Measure for December, January, February.	29/02/2024	It is important children get access to timely treatment before their condition worsens.
Adele Gittoes	4.8a.8 Focused review of CAMHS service model across BCU undertaken	29/02/2024	It is important that we are able to provide equitable care across each of our geographical areas.

5. A learning and self-improving organisation

Exec Lead	Milestone	Due Date	Why it's important to track
C1-5.2: Effective procedures for learning from incidents and preparing for inquests and HSE			
Angela Wood	5.2.10 As part of the integrated performance framework, the first part of the Quality Dashboard will be live	29/02/2024	To ensure dashboard is fit for purpose and that quality performance is visible in key meetings, with a single version of the data, and is visible to both the Executives and Board members
Angela Wood	5.2.8 A central and digital learning repository and cascade system prototype developed, based on Office 365	29/02/2024	To ensure actions are delivered within agreed timescales and that consistent datasets are in use across operational areas to facilitate shared learning, benchmarking and measurement of progress.
Angela Wood	5.2.9 Comprehensive review completed of current PTR processes including incidents, claims, inquests (to include PFDs), complaints and subsequent learning. The process will support the implementation of the Duty of Quality utilising the Health and Care Quality Standards to drive continual improvement to meet the needs of the population	29/02/2024	To ensure all stakeholders are engaged and that the review is comprehensive and represents a system wide position
C1-5.3: Clinical Governance review			
Angela Wood	5.3.2 To have fully supported and engaged with the review process as directed by the reviewing team, ensuring all key staff are available as required once ToRs agreed and review commenced. It is unknown at this time what format the review will take. Ensure the learning and actions from the Patient Safety Review are covered by this work	29/02/2024	To ensure that the format of the review is fully supported and facilitated to ensure a comprehensive approach and delivery of actions and / or recommendations.

Teitl adroddiad: ***Report title:***	Special Measures Update			
Adrodd i: ***Report to:***	Quality, Safety and Experience Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	19th December 2023			
Crynodeb Gweithredol: ***Executive Summary:***	The purpose of this paper is to provide an update on Special Measures, outlining the progress to date on the deliverables associated to this Committee.			
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Arweinydd Gweithredol: ***Executive Lead:***	Carol Shillabeer, Chief Executive (Accountable Officer) Dr Chris Stockport, Executive Director of Transformation & Strategic Planning (Lead Executive)			
Awdur yr Adroddiad: ***Report Author:***	Geraint Parry, Special Measures Programme			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	To support Special Measures			
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	Not applicable			

Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	Not applicable
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	Not applicable
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	Not applicable
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	Not applicable
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	Not applicable
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	Not applicable
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	Not applicable
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Not applicable
Camau Nesaf: Gweithredu argymhellion ***Next Steps:*** Implementation of recommendations	

Quality, Safety and Experience Committee

Special Measures Update

1) Introduction

This report presents a brief update on Special Measures at the end of Cycle 2 (September to November 2023).

The report provides a high level overview of key business relating to this committee, including progress regarding the Independent Reviews. The November Board has just received a full report across all deliverables and milestones within Cycle 2, with an assessment undertaken towards the end of the cycle, and the formal closure assessment will occur in the first 2 weeks of December. This assessment will conclude after the writing of this report, therefore an abbreviated version of this report has been prepared, and the full closure assessment will be submitted to Board, once available.

The third and final 90-day cycle (December 2023 to February 2024) within the Stabilisation phase is now underway, with teams looking to build upon the foundations laid within the first 2 cycles and ensure the preparedness for the important Standardisation phase, due to commence in April 2024. Readiness activities for this phase are underway, with criteria being developed in collaboration with Welsh Government and these will continue alongside this final 90-day cycle. The agreed milestones for this third cycle within the QSE remit are included at Appendix 1 and once the Cycle 2 closure is complete an assessment of activity required to roll forward will also take place and be appended.

2) Background

The background to the Health Board escalation into Special Measures and the resultant organisational response has been covered in previous committees. The full Board meeting also receives a detailed update across all deliverables and milestones to enable scrutiny.

3) Progress to date

Independent Reviews
A process is in place for the development and then delivery of recommendations associated to reviews received. The first 2 reviews under the remit of this committee (Patient Safety Review and Mental Health Inpatient Safety Review) have been presented to a development session of the committee and management responses have been presented to a formal committee.

These reports have now been published for the public on our website as part of the November Board papers and form an important part of our transparent approach to respond to identified issues and demonstrating how we are changing the organisational culture.

The following table provides the summary position against each of the reviews within the QSE remit.

Review	Update
Patient Safety Review	Presented to committee, along with management response which is now being enacted. The review has been published on the BCUHB website.
Mental Health Inpatient Safety Review	Presented to committee, along with management response which is now being enacted. The review has been published on the BCUHB website.
Vascular Review	The report has been received and a development session has been arranged for the 18th December to formally receive the report.
Stocktake Review of Progress Against Previous Mental Health Reviews	Due to be received in December in line with initial expectations.
Clinical Governance Review	The first meeting to commence this work, referred to as the Quality Round Table, took place on the 16th November and the work will progress during cycle 3.

The Health Board is taking a thematic approach to the reviews to ensure we address the root causes of our issues, which are common across many of our areas. Thus far, the following 7 themes have been identified and these are being mapped to the most appropriate Executive Led Delivery Group to oversee delivery of the actions.

Themes from reviews received to date
1. Data, Intelligence & Insight Ensuring that there is an organisation wide approach with prioritised interventions into improving our data, intelligence and insight tools and capabilities. This will be a key enabler for sustainable improvement as well as supporting identification of future potential services of concern.
2. Culture Defining, engaging and committing to the long-term work necessary to improve the culture of the organisation. Integrated into our broader organisational development plan across Culture, Leadership and Engagement.
3. Risk Management Reviewing and refining our approach and appetite to risk, including how risks are identified, managed, mitigated, reported and monitored.
4. Patient, Family, Carer Involvement A single coordinated approach to maximise involvement and engagement with our patients and their families and carers, using their experiences to guide our ongoing service improvement.
5. Operating model Ensuring our operating model is designed to best deliver our strategic priorities, with clarity for everyone across all levels of the organisation on the roles and responsibilities, systems and processes within divisions and Pan BCU services.
6. Organisation Governance and compliance Ensuring organisation wide visibility and understanding of governance best practice and ensuring adherence to it.
7. Integrated Planning A well understood integrated approach to planning as a discipline, as well as contributions to our annual planning process.

Cycle 3 and Standardisation Phase Preparation

The plan for Cycle 3 (December 2023 to February 2024) has now been agreed by the Board. As the Health Board reaches a greater position of stability a growing focus will be placed upon the 'Standardisation' phase that will follow. This phase, which is due to commence in April 2024, will be crucial in developing consistent standards across each of our geographical areas, reducing variation, and delivering continual improvement in our services.

Ensuring that Special Measures is incorporated into business-as-usual planning cycles is critical. Planning for 2024/25 is currently underway as part of the Integrated Medium-Term Plan (IMTP) for 2024 to 2027 and as such the Special Measures 'Standardisation' thinking is being incorporated into that process.

4) Portfolio Management Office (PMO) Assessment

Overall good progress has been made during Cycle 2 across a number of areas, such as with the Board approval of the Risk Management Framework and subsequent progression to implementation. Following review at committee, the Health Board responses to the Patient Safety Review, and the Mental Health Inpatient Safety Review are being implemented, and we have seen continual strengthening of our Oncology Services. A number of challenges do still exist however, most importantly ensuring that the clinical areas of concern identified in cycle 2 and 3 move as quickly as possible from 'discovery and design' into delivery and realisation of improved outcomes for the population of North Wales.

5) Change Control

As part of Special Measures governance arrangements any proposed changes require approval through a change control process. This is approved through the Special Measures Senior Responsible Officer (SRO) before being submitted to the Board for final approval.

There are no new change requests to report during December 2023 for deliverables mapped to this committee.

6) Recommendations

The Committee is asked to **RECEIVE ASSURANCE** on the progress to date, acknowledging the recent Board update and the impending formal closure assessment.

Appendix 1

Cycle 3 Milestones relating to QSE

1. A well-functioning Board

No Cycle 3 deliverables from Outcome 1 fall under the remit of this committee

2. A clear, deliverable plan for 2023/24

No Cycle 3 deliverables from Outcome 2 fall under the remit of this committee

3. Stronger leadership and engagement

Exec Lead	Milestone	Due Date	Why it's important to track
C1-3.10: Implement plans for integrated electronic healthcare record			
Dylan Roberts	3.10.7 - Finalise, review and agree prioritised service and digital tactical interventions for ED, quantify benefits and develop costed plan for delivery.	31/12/2023	Identifying the full list of problems and prioritised list of actions will ensure systems and processes work as consistently and effectively as possible across all BCU EDs, which is a core enabler for delivery of high quality, timely and safe urgent and emergency care.
Dylan Roberts	3.10.8 - Draft Strategic Outline Case for Electronic Healthcare Record Systems (EHR) presented to Exec Team, including plan to take forward with wider stakeholders	31/01/2024	A single integrated electronic patient record system will improve the coordination of care, enhance patient experience and safety through improved clinical outcomes, enable faster access to care, improve communications between clinicians and provide the foundations for remote monitoring and telehealth in the future. Having the same data accessible to clinicians across all care settings is core to the transformation and improvement of practice over what will be a 5 – 10 year programme of work.
Dylan Roberts	3.10.9 Case developed for best of breed Mental Health system in conjunction with DHCW and WG to help address the lack of electronic health care records.	29/02/2024	There are significant record keeping issues in Mental Health which have repeatedly featured in Regulation 28 notices from the Coroner.

4. Improved access, outcomes and experience for citizens

Exec Lead	Milestone	Due Date	Why it's important to track
C1-4.5a: Vascular improvement plan			
Nick Lyons	4.5a.10 Welsh Government Phase 2 audit of anonymised case files completed	29/02/2024	The Network, Clinical Lead and Office of the Medical Director will have an understanding of any ongoing areas of concerns, or areas of significant progress. This will support the ongoing development of the Vascular Network Improvement Plan/ and improvement programme
Nick Lyons	4.5a.11 Updated Vascular Integrated Improvement Plan, which incorporates all outstanding, and new improvement recommendations, and service level priorities developed and approved by Vascular Steering Group	29/02/2024	It is important that the Network is able to articulate a clear vision for the ongoing improvement of Vascular services across North Wales, and the steps necessary to get there, including any actions that need to be carried forward from the existing Improvement Plan, as well as new and emergent priorities
Nick Lyons	4.5a.12 17 vascular related pathways approved by Strategic Clinical Effectiveness Group for implementation including audit and evaluation cycles	29/02/2024	To ensure the implementation of key programmes of work, and that Health Board governance protocols have been adhered to throughout
Nick Lyons	4.5a.13 Emergency Diabetic Foot Pathway implemented and clinical audit cycle in place to monitor improvements in access, outcomes and experience	29/02/2024	To ensure this key strategic pathway is implemented and embedded within everyday practice across the Network, thereby assuring the Health Board that positive outcomes are being achieved for citizens
Nick Lyons	4.5a.9 Integrated Vascular hub and spoke: North Wales Vascular Service Specification, outlining roles and responsibilities of Hub and Spoke sites, to be revised in light of other improvements made and presented to Vascular Steering Group	31/01/2024	Agreeing the model across North Wales is a key step in the ongoing improvements of vascular services.
C1-4.5b: Urology improvement plan			
Nick Lyons	4.5b.10 Plan agreed with the national robotic programme to ensure effective and sustainable use of the north Wales robot, to enable improved access for our population	31/01/2024	Realising the benefits of cutting edge, modern tools will improve the quality of care we provide for our patients.
Nick Lyons	4.5b.8 Recruitment completed of dedicated expert clinical support to advise, support and implement the Urology Improvement Plan	31/12/2023	Having the right clinical expertise is important to ensure evidence based improvements in line with best practice.
Nick Lyons	4.5b.9 Delivery commenced of the Urology Improvement Plan and improvements in consistency of delivery in quality standards and access to urgent and elective pathways across North Wales starting to be realised	19/01/2024	Delivery of standardised care and reducing variation in the quality of services is important in ensuring equity for our population.

C1-4.5c: Ophthalmology improvement plan			
Adele Gittoes	4.5c.10 Development commenced of an outline 5-year eye care plan based on an integrated sustainable model.	29/02/2024	As we move towards standardisation it is important that we outline a longer term vision to transform our services.
C1-4.5d: Oncology improvement plan			
Nick Lyons	4.5d.7 Review of Oncology completed at Exec Team with respect to readiness for transitioning towards standardisation	29/02/2024	This is an important step in preparing for the potential de-escalation of a service of concern and how we track on an ongoing basis.
C1-4.5e: Dermatology improvement plan			
Adele Gittoes	4.5e.8 Delivery commenced of an immediate plan to reduce the backlog with a maximum scope of an additional c.2000 patient appointments, dependent on WLIs.	29/02/2024	There is a significant backlog of patients with skin cancer not being treated in a timely manner.
C1-4.6: Mental Health review of previous reviews – phase 2			
Teresa Owen	4.6.7 Copy of Royal College of Psychiatry MH&LD report received.	31/01/2024	Receiving this overarching report will be a key point in summarising historic concerns and providing a clear path for future improvements.
Teresa Owen	4.6.8 MH&LD/RCPsych Action Plan developed and scheduled for sign off via appropriate governance routes.	29/02/2024	Ensuring a timely response to issues raised in the reports will key to building confidence in our future plans.
C1-4.7: Mental Health Inpatients Safety review - phase 2			
Teresa Owen	4.7.5 NCCU Action Plan Delivery Group fortnightly meetings held.	31/12/2023	Regular review of the plan and progress against patient outcomes will ensure improvements are made and any challenges can be resolved in a timely manner.
Teresa Owen	4.7.6 MH&LD evidence log and repository developed.	31/12/2023	Having a central repository will ensure good governance and oversight and ensure actions committed to are delivered upon.
Teresa Owen	4.7.7 MH&LD NCCU update report submitted through appropriate governance routes to provide an overview of progress made with implementation of action plan.	29/02/2024	Having strong governance and sign off ensures that appropriate challenge can be made and that progress is tested by senior stakeholders.
C1-4.8a: CAMHS improvement plan			
Adele Gittoes	4.8a.7 Delivery of the agreed BCU performance trajectories for the Mental Health Measure for December, January, February.	29/02/2024	It is important children get access to timely treatment before their condition worsens.
Adele Gittoes	4.8a.8 Focused review of CAMHS service model across BCU undertaken	29/02/2024	It is important that we are able to provide equitable care across each of our geographical areas.

5. A learning and self-improving organisation

Exec Lead	Milestone	Due Date	Why it's important to track
C1-5.2: Effective procedures for learning from incidents and preparing for inquests and HSE			
Angela Wood	5.2.10 As part of the integrated performance framework, the first part of the Quality Dashboard will be live	29/02/2024	To ensure dashboard is fit for purpose and that quality performance is visible in key meetings, with a single version of the data, and is visible to both the Executives and Board members
Angela Wood	5.2.8 A central and digital learning repository and cascade system prototype developed, based on Office 365	29/02/2024	To ensure actions are delivered within agreed timescales and that consistent datasets are in use across operational areas to facilitate shared learning, benchmarking and measurement of progress.
Angela Wood	5.2.9 Comprehensive review completed of current PTR processes including incidents, claims, inquests (to include PFDs), complaints and subsequent learning. The process will support the implementation of the Duty of Quality utilising the Health and Care Quality Standards to drive continual improvement to meet the needs of the population	29/02/2024	To ensure all stakeholders are engaged and that the review is comprehensive and represents a system wide position
C1-5.3: Clinical Governance review			
Angela Wood	5.3.2 To have fully supported and engaged with the review process as directed by the reviewing team, ensuring all key staff are available as required once ToRs agreed and review commenced. It is unknown at this time what format the review will take. Ensure the learning and actions from the Patient Safety Review are covered by this work	29/02/2024	To ensure that the format of the review is fully supported and facilitated to ensure a comprehensive approach and delivery of actions and / or recommendations.

Teitl adroddiad: ***Report title:***	QSE Committee – Regulatory Assurance Report			
Adrodd i: ***Report to:***	QSE Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	December 2023			
Crynodeb Gweithredol: ***Executive Summary:***	This report provides the Committee with assurance and analysis on significant regulatory matters and issues.			
Argymhellion: ***Recommendations:***	The Committee is asked to **note** this report.			
Arweinydd Gweithredol: ***Executive Lead:***	Angela Wood, Executive Director of Nursing and Midwifery Dr Nick Lyons, Executive Medical Director			
Awdur yr Adroddiad: ***Report Author:***	Matthew Joyes, Deputy Director of Quality Governance			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☐ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☒ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/ tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				
There is confidence in the data provided in the report however, the pace of learning and improvement remains an area of concern and is a key focus of work. This is being addressed through a range of measures including the actions aligned to Special Measures and the Board Assurance Framework.				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Quality			
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	The Duty of Quality is a statutory requirement under the Health and Social Care (Quality and Engagement) (Wales) Act 2020. The statutory duty of quality requires the decision-			

	making processes by the Health Board take into account the improvement of health services and outcomes for the people of Wales – the duty also includes new Health and Care Quality Standards. Instances of harm to patients may indicate failures to comply with the NHS Wales standards or safety legislation.
Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqlA been identified as necessary and undertaken?***	N/A
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	N/A
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	BAF1.2
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	N/A
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	N/A
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	N/A
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	BAF1.2
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	N/A
Camau Nesaf: Gweithredu argymhellion ***Next Steps: Implementation of recommendations*** N/A	
Rhestr o Atodiadau: ***List of Appendices:*** 1. QSE Committee Regulatory Assurance Report	

QSE Committee – Regulatory Assurance Report – December 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 a summary of quality related regulatory assurances. This is a refresh of the report and feedback is welcomed on its style and content to inform ongoing improvement. As this report has not been to the Committee for some time, the report covers information dating back to April 2023 to November 2023 inclusive.

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

HEALTHCARE INSPECTORATE WALES

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

Healthcare Inspectorate Wales (HIW) published their inspection reports into the three Emergency Departments at Ysbgyty Gwynedd (YG), Ysbyty Glan Clwyd (YGC) and Wrexham Maelor Hospital (WMH) during the year. HIW confirmed that YGC ED would remain a Service Requiring Significant Improvement. A mock inspection, or Quality Check, was undertaken over the summer to provide a baseline position of improvement and the service continues to make improvements in key areas; the service is reporting progress against the findings of the Quality Check into the Regulatory Assurance Group.

(HIW) published their Review into the Health Board's Vascular Services in June 2023. HIW confirmed, following the review, that the service would be deescalated as a Service Requiring Significant Improvement (SRSI).

In July 2023, HIW published findings from their inspection of the Ty Llewelyn Unit. We found a dedicated staff team that were committed to providing a high standard of care to patients. We saw staff interacting with patients respectfully throughout the inspection. The inspection team considered the hospital environment during a tour of the hospital on the first night of the inspection and the remaining days of the inspection. Overall, the ward appeared clean and tidy, however they identified

several decorative and environmental issues that required attention. Other issues included therapy provision, food choice and lack of a cleaning schedule.

An inspection of the Nuclear medicine Department at YGC found there was good compliance overall with the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R. HIW found arrangements were in place to provide patients visiting the department with safe and effective care.

In November 2023, HIW published their report following an inspection of Morfa Ward at Llandudno General Hospital. They found the quality of patient experience to be good. Patients and their relatives spoken with during the inspection expressed satisfaction with the care and treatment received. Patients told HIW that staff were kind and caring. HIW observed good interactions between staff and patients, with staff supporting patients in a dignified and respectful manner. HIW also saw staff attending to patients in a calm and reassuring manner. However, some patients and their relatives told inspectors that they were not always involved in discussions around care planning and discharge arrangements.

During autumn, Healthcare Inspectorate Wales (HIW) issued their inspection reports into the Hergest Unit and Ablett Unit. At the Hergest Unit, HIW found staff were committed to providing safe and effective care and there were suitable protocols in place to manage risk, health and safety and infection control. However, improvements were required to prevent patients from bringing items that posed a safety risk onto the wards. Other areas for improvement included the provision of therapeutic activities for patients and overall staff mandatory training compliance. Patient care plans reflected individual needs and risks and were being maintained to a good standard. The statutory documentation we saw verified that the patients were appropriately legally detained. At the Ablett Unit, HIW observed staff treating patients with respect and supporting patients on Tegid Ward with personal care needs in a dignified and sensitive way. The patients they spoke with were complimentary about the care provided and about their interactions with staff. The patient records reviewed during the inspection were comprehensive and of good quality. There was appropriate governance and oversight processes in terms of activities and meetings to discuss issues related to patient care and identify improvements. However, HIW identified issues in relation to the physical layout, location and staffing requirements of the Section 136 suite. HIW found similar issues during their previous inspection of the Ablett Unit in January 2019. HIW have asked the Health Board to undertake a review of the use of the Section 136 suite to identify resolutions to the environmental issues and to the staffing requirements to provide safe cover to staff in the Section 136 suite as well as maintaining safe staffing levels on the wards.

HIW have raised concerns regarding access to the Community Mental Health Team based at Nant y Glynn. A number of written assurances have been provided and HIW intend to undertake an announced visit in the New Year.

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

CARE INSPECTORATE WALES

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

The expansion of CIW regulation to more Health Board services is new this year. To help strengthen governance and assurance, a standard six month service quality review template is being developed for all registered services to complete, alongside a quarterly 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.

CIW undertook an inspection of the Enhanced Community Residential Service in June 2023. No improvement actions were identified.

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 received a Notice of Contravention from the HSE in July 2023. A response was issued within the deadline during September 2023. This Notice related to inpatient falls prevention and management – the Committee received a deep dive into this issue at its last meeting, alongside summary findings of an Internal Audit. The Health Board awaits the HSE's decision on any future steps which could include further enforcement action.

The Health Board is due to attend court in December 2023 facing charges under the Health and Safety at Work Act following a serious incident in mental health services in April 2021. This is a revised date due to availability of the court.

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.

Since April 2023, the Health Board has received 16 Regulation 28 Prevention of Future Death Notices. Both Senior Coroners in the region have raised a number of serious concerns. These concerns can be groups into three clear themes:

- Ambulance handover delays, and Emergency Department pressures.
- Absence of electronic patient records and referral systems.
- The quality of incident investigations and quality of evidence against action plans.

All Notices have been responded to outlining:

- The work of the Unscheduled and Emergency Care Programme, aligned to the Welsh Government Six Goals Programme, to reduce and manage demand on emergency care (a number of the Notices were jointly issued to WAST and the six local authorities, and a joint cover letter was provided setting out the commitment of all organisations to work together).
- The work underway to raise issues nationally regarding electronic record systems.
- The full review of the incident investigation process underway at the moment, due to deliver a new process and procedure for April 2024.

Additionally, the Executive Team approved a new Inquest Procedure in October 2023.

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. At the time of writing, there are no overdue exceptions to report. 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 full review of the investigation process is underway by the Patient Safety Team. Consideration is also underway at present regarding how assurance of learning and supporting evidence can be strengthened, and a proposal will be developed during December 2023 which will be reported to a future Committee.

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 Public Services Ombudsman for Wales (PSOW) issued two Pubic Interest Reports

The first was issued on 14 September 2023. The Ombudsman launched an investigation after a complaint that the Health Board failed to provide appropriate and timely treatment to a patient after she was admitted to hospital with suspected appendicitis. The Ombudsman upheld most parts of the complaint and was concerned that these events took a considerable toll on the patient's physical and mental wellbeing. The patient has been left with health and mobility problems. The Ombudsman made a number of recommendations and all are in the process of being delivered.

A further Pubic Interest Report was issued on 02 November 2023. In this case the patient was seen at Ysbyty Glan Clwyd in January 2018, however it took 11 months before they had urgent surgery resulting in permanent sight loss in one eye and a need for lifelong treatment to manage pain and condition caused by the damage. The Ombudsman also criticised the delay in the complaint response. The Ombudsman made a number of recommendations which are now being delivered.

At the time of writing, one response to the Ombudman is overdue which is being progressed with the service. There has been a reduction in overdue matters.

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 -3 (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.

WELSH RISK POOL

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

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

The WRP team host the national Once for Wales Concerns System Team and have been providing enhanced support to the Health Board to strengthen its management of Datix Cymru and Civica Experience Cymru, two key systems for managing quality.

Betsi Cadwaladr University Health Board (BCUHB)

Minutes of the Quality, Safety & Experience Committee meeting held on 27 October 2023, Boardroom, Carlton Court, St Asaph

Present	
Name	**Title**
Rhian Watcyn Jones	Independent Member, Chair
Clare Budden	Independent Member
Prof Mike Larvin	Independent Member
In attendance	
Jason Brannan	Deputy Director of People
Nesta Collingridge	Head of Risk Management
Adele Gittoes	Interim Executive Director of Operations
Karen Higgins	Director of Primary Care
Matt Joyes	Deputy Director of Quality
Fiona Lewis	Corporate Business Officer (Minutes)
Dr Nick Lyons	Executive Medical Director
Teresa Owen	Executive Director of Public Health
Heledd Thomas	Audit Wales (to observe)
Jane Wild	Associate Member
Angela Wood	Executive Director of Nursing & Midwifery

Agenda item	**Action**
OPENING BUSINESS	
QS23.97 Welcome introductions and apologies **QS23.97.1** Rhian Watcyn Jones, Independent Member and Chair (Chair) of the Quality, Safety & Experience (QSE) Committee welcomed everyone. **QS23.97.2** Apologies were received from Gareth Evans, Acting Executive Director Therapies & Health Science **QS23.97.3** The Chair welcomed Karen Higgins, Director of Primary Care to the meeting.	
QS23.98 Declarations of interest on current agenda **QS23.98.1** There were no declarations of interest noted.	
QS23.99 Minutes of the last meeting and action log **QS23.99.1** The minutes of the meeting held on the 22 August 2023 were approved as an accurate record of the meeting. **QS23.99.2** The Committee reviewed the action log and agreed the closure of those which had been completed.	

• Re Action **QS23.67**. Angela Wood (AW) Executive Director of Nursing & Midwifery, explained that the approved internal Audit Report was not available when the Deep Dive report on falls was drafted, however a summary of its findings had been attached. • Re Action **QS23.72**. The Chair asked that when the Cycle of Business is reviewed, it be made clear that the Quality Strategy must be scrutinised by QSE	**RWJ / OBS**
QS92.2.2 Subsequent to Chair's meeting with Head of Internal Audit, Chair requested that he be invited to all meetings.	**OBS**
QS92.2.3 The Chair requested that a meeting be arranged with herself, all three IHCs, the Head of Womens Services and the Head of Mental Health together. The timing of this to be clarified in due course.	**OBS / RWJ**
QS23.100 QUALITY SAFETY AND IMPROVEMENT	
QS23.101 Outline on Reporting Cycles for QSE Report **QS23.101.1** Matt Joyes presented his report and a discussion ensued around the classification of why specific items were on the agenda. It was agreed that items noted as being 'for information' should be forwarded to Members as soon as they became available and not held back to a meeting; then noted on the agenda as an item circulated, rather than being presented. It was agreed that items should only be put onto the agenda if assurance is required.	**MJ**
QS23.101.2 Reporting cycles were discussed as it was felt that more work was required around the scheduling of reporting to QSE. It seemed that at certain meetings there were too many reports when at other meetings there were not enough. It was questioned whether some items needed to be on every agenda. More clarification was required as to the purpose of certain papers being added to every agenda, when other important subjects such as Public Health, were very seldom discussed. Teresa Owen (TO). Executive Director of Public Health, explained that Public Health historically reported to what was the PPPH Committee, but felt that QSE would benefit from receiving Public Health service information, where there was a quality aspect – such as Obesity Services, Smoking Cessation Services, etc. TO confirmed that pre-Covid, the immunisation services used to appear on the QSE cycle of business (COB) but no longer does.	**MJ**
QS23.101.3 Nick Lyons (NL), Executive Medical Director, was concerned that the Human Tissue Authority, as a statutory report, needed to be reinstated onto the QSE COB, or if QSE were not the appropriate committee, asked Matt Joyes (MJ), Deputy Director of Quality, to ensure that the relevant committee reinstated it onto its agenda. Concern was expressed that there was a danger that only services placed in Special	**MJ**

Measures (SM) received focus rather than other, equally important services. **QS23.101.4** It was felt that a great deal of information was being provided that served little purpose unless the background was also provided and then followed by what was to be done with this information. MJ agreed that reports should be about assurance on compliance and learning; MJ agreed that the cycle of business needed to be right, with all the correct headings and the proper sequencing; and that the authors needed to be clear as to what the committee expected in the reports, by way of templates and support. MJ agreed to take the report away, engage with Executives, and bring back to the next meeting. **QS23.101.5** A discussion took place regarding the quality of papers brought to QSE and Board as it was felt that 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. **QS23.101.6** The Committee approved the principle of the report and was appreciative of the work to date, but noted that further development was required.	**MJ** **PM**
QS23.102 Primary Care Report **QS23.102.1** The Chair warmly welcomed Karen Higgins (KH), Director of Primary Care, noting that the structure laid out in the report was extremely complex. **QS23.102.2** KH highlighted the fact that it is currently very difficult to get a view of what is happening across the organisation, which she noted was a risk. The report highlighted the four main areas of primary care – general practice, pharmacy, optometry and dental services along with Audiology and the voluntary sector. Responsibility for primary care is shared across the Executive team and that this complexity makes the task of seeing the whole picture extremely difficult. To tackle this, in June 2023, a newly created Primary Care Senior Leadership (PCSL) was created; the aim is to bring together all who work in primary care to discuss the current structure and how best to all work together; KH noted that there are plans to make this more formal, with a primary care board, chaired by the Interim Executive for Operations and felt that whilst the current structure remained, the situation would not improve. **QS23.102.3** KH noted that one of the biggest barriers had been access to reliable and clear data, as data in isolation does not provide the full picture. An example she provided was GP practice access, a subject regularly talked about by the media and politicians. However it receives fewer complaints than medication, behaviour of staff and clinical treatment and more people are now being seen by their GP than were	

seen pre-pandemic. This media narrative fuels fears and compounds the problem - people believe it will be hard to get appointments and therefore develop a low threshold for self-care and book an appointment just in case; which translates to 80,000 missed GP appointments every month. Data showed that managed practices scored 100% for access standards but she felt that this did not translate into better patient care. **QS23.102.4** To improve quality monitoring, a single quality delivery group for primary care has been created, to be chaired by Jim McGuigan, Deputy Medical Director. A decision has not been reached as to where the group should report to for assurance – a primary care board or QSE. KH wished to note that her team had received tremendous support from the Deputy Director of Quality and his team. **QS23.102.5** KH was concerned that the single biggest issue in primary care is chronic disease management and recovery post-pandemic, and that most post-pandemic effort was being put into secondary care. KH felt that more work was needed to understand the cause of the increased acuity of disease in emergency departments (ED) and the huge increase of people going to GPs. For GPs, whilst dealing with the crisis, one of the the knock-on effect is that they are unable to deal with the management of chronic illnesses, such as COPD, diabetes and heart disease and therefore as their patients' health deteriorates, their symptoms become more severe and consequently these patients appear in ED. KH felt that the management of chronic diseased should be a key performance indicator (KPI) and the development of clusters would support that. **QS23.102.6** A discussion took place around the problems surrounding referrals. It was felt that there was a large number of patients who were not seen during the pandemic and now entering the system. To help combat this, it was suggested that whilst creating dashboards for the QSE, it might be good to focus efforts on a certain pathway, where data is readily available from blood tests markers taken in primary care, people treated as an emergency in ED and also diabetic outcomes from within secondary care. This approach would enable the team to look at not only one part of the pathway but also how everything fits together. Should the patient experience in one region not be as good as another, then the team could start to identify the reasons behind that. The Digital and Information team would need to be approached to ensure that Datix would be able to capture the relevant information and some work would need to be carried out regarding the reporting of incidents and escalations of concerns. **QS23.102.8** The Chair thanked KH for her reporting approach and it was agreed that KH would focus on a Diabetes pathway and how it might look, returning with an update to QSE when ready.	**KH / OBS**
QS23.103 Patient Story Annual Report	

QS23.103.1 The Chair welcomed the report but as the report was to be noted 'for partial assurance' she asked for an explanation in future as to why this situation persists and what effort was being made to overcome the situation. **QS103.2** Angela Wood (AW), The Executive Director for Nursing and Midwifery had been asked to provide this report following a request to identify the patients' stories that were known, and explain the methodology from not only the patients' but from the relatives' and carers' perspectives. The report described the benefits for the story teller, their families and carers, staff and the organisation. Acknowledging the need for sustained learning across the organisation, AW's team is looking at a learning portal being developed, which will capture learning across the organisation and put mechanisms in place to cascade this information and receive feedback. **QS103.3** AW confirmed that her colleagues had developed a toolkit for teams to provide support in identifying their own stories and how to capture them. The Executive Director for Public Health was able to confirm that she was aware that feedback from patients and users was already being captured and intended to direct her colleagues to AW's toolkit **QS103.4** The Chair asked if there was a specific example of where cascading patient stories had changed policies and asked if, where possible, more of the stories could be made accessible to the public. MJ confirmed that via the CIVICA portal, over the previous three months, more than 4,500 patient responses per month were being captured – thus providing the opportunity to look at experiences and ask what was being learned. With this in mind, over the coming months a task group had been set up with both Chris Stockport, The Executive Director for Transformation And Strategic Planning and AW to maximise potential and ensure consistency across the organisation. **QS23.103.5** The Chair thanked AW for the report and the way in which it brought all the information together and asked if it were possible to find a specific change that had taken place in direct response to one of the Patient's stories.	**AW**
QS23.104a Corporate Risk Register **QS23.104a.1** The Chair wished to acknowledge the progress that had been made and the huge amount of work that had obviously gone into creating the new style of report. **QS23.104a.2** Nesta Collingridge (NC), The Head of Risk Management, presented her report, the contents of which followed on from approval of the RM01 – Risk Management Framework – at Board, where it was agreed that the Corporate Risk Register (CRR) was to be separated from	

Tier 1 Risks. NC noted that in order to make this report more manageable, work needed to be done to look at the 123 Tier 1 risks, details of which would normally be individually itemised in this report and to look at the ongoing themes, with a view to possibly refining and consolidating them. **QS23.104a.3** NC aimed to bring both the Corporate Risk Register and Board Assurance Framework to the November Board. It was felt that a Board Workshop regarding strategic risks training might be very useful and the Chair would suggest this. **QS23.104a.4** It was agreed that the new format appeared much more strategic and it was felt that reporting should be by exception only, with QSE only being informed when there is something fundamentally wrong in a specific risk and what is being done to tackle the problem. It was felt that Falls was an operational and not strategic risk and therefore did not warrant its own risk and despite being a significant issue, it should be listed under Patient Safety; with the Committee only receiving more regular reports if targets were not being met. **QS23.104a.5** It was suggested that to reduce the report from 300 pages to a much more manageable, (ideally 6 page) report, the Committee could still receive an overall summary and remain aware of the overall risks but that the report would focus on one theme in detail; in addition to that, the report could list anything that had changed since the last meeting. **QS23.104a.6** The Chair thanked The Head of Risk Management for the obvious hard work put into providing the new format whilst noting that more work needed to be done.	**RWJ** **NC**
QS23.104b Board Assurance Framework **QS23.104b.**1 No comments received regarding this item.	
QS23.105 Patient Safety Report **QS23.105.1** Angela Wood (AW), Executive Director for Nursing and Midwifery, presented her report, acknowledging the need to refine it and that discussions were ongoing as to how best to present this to get a consistent approach. AW noted that it remained difficult to pull all the information together due to the Datix system not currently working - work was ongoing with the Digital and Information team to rectify this. **QS23.105.2** AW noted that there were 44 nationally reported incidents, 0.4% of the total incidents occurring. These incidents all required full investigations, with 'Make it Safes' taking place, as is normal with all serious incidents and each of these incidents to be reviewed and closed on Datix, with Management oversight. In addition, weekly meetings take place where the previous week's serious and catastrophic incidents	

involving nurses, allied health professional and medics, are reviewed. **QS23.105.3** AW highlighted the additional Slip, Trip or Falls data, which included some comparison information. The two Never Events which occurred during the reporting period both involved wrong site surgery. AW noted that the targeted work that took place in 2021 on wrong site surgery and patient safety in theatres resulted in a dramatic reduction in Never Events. **QS23.105.4** Within the section Learning from Nosocomial Covid-19 Reviews, AW noted that the significant amounts of learning had come from those areas and been shared nationally as well as pan-BCU. Following completion of the individual case reviews, patients or families will be informed via letter of any lapses in care. **QS23.105.5** AW agreed that future reports would go further to identify what was being done to rectify situations and would not be not just data-driven but would look at outcomes. The Chair requested that the next report identifies areas of concern that the Committee and Board should be made aware of, including comparative data and to only include incidents that involve quality of patients' care and experience. **QS105.6** AW confirmed that her team was currently exploring the reason behind the 22% increase in Pressure and Moisture Damage, to identify if there were any wards or departments where there is increased damage. It was felt that there needed to be a breakdown to identify which of these were hospital-acquired or not, noting that there is evidence that an increasing number of patients have been presenting at ED with pressure damage. **QS105.7** Matt Joyes (MJ) The Deputy Director for Quality, assured the Committee that work was ongoing by the National Quality Team to produce a national quality dashboard, which would provide welcome benchmarking. MJ also noted that data regarding Primary Care Incidents was provided mostly by managed practices due to the fact that independent contractors tend not to use Datix system, despite being offered the opportunity; national work is being carried out to encourage its use.	**AW / MJ**
QS23.106 Nursing and Midwifery Council (NMC) Fitness to Practise (FtP) Annual Report April 2022 – March 2023 **QS23.106.1** Angela Wood (AW), Executive Director of Nursing and Midwifery, presented the report, highlighting the fact that between April 2022 and March 2023 there were fewer referrals than the previous 12 months. **QS23.106.2** AW confirmed that the temporary register remains in place until September 2024. The Temporary register was created during the	

pandemic to allow retirees and international recruits to come onto the register to provide extra support. There are currently 7 employees on the temporary register; 3 no longer work for the organisation and the others are being encouraged to go through their assessment to join the register permanently. **QS23.106.3** A discussion took place regarding other referrals – optical dental and medical - and about where these reports are taken, the reporting cycles and the need to ensure that all people are treated consistently. The Executive Medical Director, AW and The Director of Primary Care to meet outside of the meeting to discuss the frequency and consistency of reporting and the level of detail required and to report back with an update. **QS23.106.4** AW assured the Committee that her team is in regular contact with the NMC and that during their visit the previous week were really complimentary about the engagement BCU has with them and felt assured that any concerns would be discussed with them before they proceed. **QS23.106.5** In answer to a query regarding the monitoring of FtP incidents involving student nurses, AW assured the Committee that her team form part of the universities' FtP panels and have direct contact, reviewing any concerns raised by either the universities or by BCU. *[Emma Adamson, Consultant Midwife, joined the meeting]*	**NL / AW / KH / OBS**
QS23.107 Maternity and Neonatal Services **QS23.107.1** Emma Adamson (EA), Consultant Midwife, presented her report, which Welsh Government had requested as a regular report to be placed on the Cycle of Business. **QS23.107.2** It was noted that the NHS Wales Executive intends to take the lead for this program of work from 2024. **QS23.107.3** A discussion took place around reintroduction of home births, which had been discouraged during the pandemic – not for financial reasons but because of the lack of availability of ambulances, should they be required. **QS23.107.4**. Angela Wood (AW), The Executive Director of Nursing and Midwifery, explained that part of the review was to make recommendations and to identify some of the specialist roles required in the report with a view to making them statutory. The team had been asked to do a deep dive into the report, in order to provide benchmarks and AW advised the Committee that they had pushed back against Welsh Government, to identify what their requests were from a resource perspective, bearing in mind the current financial situation. They are awaiting a response which once received will be incorporated into the	

Patient Safety Review and only brought to the Committee should anything require escalation. *[Emma Adamson, Consultant Midwife, left the meeting]*	
QS23.108 Performance Report Month 5 **QS23.108.1** Chair was disappointed with the report and felt that it did not provide the information required by the Committee. Whilst understanding there were certain constraints which necessitated only sharing validated figures with the Committee, this means they were sometimes 2 – 3 months out of date so not particularly useful. Also, she found the format made the data very difficult to read. The Chair agreed to wait for the new format, which she hoped would also include an 'Outcomes' section. **QS23.108.2** It was suggested that for future meetings it might be appropriate to discuss the un-validated figures within the private session – possibly by exception? Adele Gittoes (AG), Interim Executive Director of Operations, agreed to pick these suggestion up with the Interim Executive Director of Finance outside the meeting. She advised against using un-validated data as this could be part-month, meaning that trends would not be comparable. She suggested reporting by exception only could be the way forward. AG proposed that once the first draft of the new Integrated Performance Framework becomes available and she is due to meet with both the Interim Executive Director of Finance and the Chair of PFIG to discuss, she would ask for QSE Chair to be able to join that meeting. **QS23.108.3** A question arose regarding the excessive costs relating to the insourcing of nurse endoscopies, to which AG explained that there was a wider issue around colorectal endoscopy and that she was meeting with the operational senior management team the following week with a view to asking the IHCs to do a deep dive review on Endoscopy services, to discover their service models and risk and to enable them to see what a productive and efficient service model should look like going forward. **QS23.108.4** The report was accepted but the Committee would be interested to see what the next iteration would look like. *[Alison Griffiths, Director of Nursing, joined the meeting]*	**AG** **AG / RWJ**
QS23.109 Nurse Staffing Act Presentation **QS23.109.1** Alison Griffiths (AG), Director of Nursing, highlighted slide 8 of the presentation, which demonstrated the variance between what is currently funded and what is being asked. Slide 9 detailed what was asked but through the Check and Challenge meeting was not supported on this occasion, but would be revisited when the reviews take place in 6 months' time. **QS23.109.2** Angela Wood, (AW), The Executive Director of Nursing, felt that the process was where it should be as following on the previous	

Board presentation in November, work had taken place with Finance to allocate resources to enable changes to rosters to ensure they were reflective of the Nurse staffing Act. However AW remained concerned about the staffing of the wards not covered by the Nurse Staffing Act - such as those within Community hospitals. The team had been systematically looking at these wards, applying the same methodology, using professional judgement and harm profiles, as if these areas were covered by an Act, to ensure staffing levels were appropriate. **QS23.109.3** AW noted that there were a significant number of unfunded beds across the organisation and these are being managed, on a daily basis, using both temporary and permanent staff, whilst always ensuring that there is a permanent staff presence on all wards. **QS23.109.4** AW informed the Committee that she was in talks with The Interim Executive Director of Finance regarding the organisation's ongoing efforts to avoid filling vacant shifts with agency nurses. The need to ensure the use of on-contract, less expensive agency staff rather than off-contract agencies was proving difficult, due to a considerable number of on-contract staff leaving to work in Chester, Liverpool and Manchester. **QS23.109.5** To explain why some adjustments to staffing level requests were 'not approved', AW explained that this was due to the teams providing insufficient harm data, background or professional judgement justification into the Check and Challenge meetings. These requests will be revisited if such evidence is provided. **QS23.109.6** Chair noted that the new style of report was far easier to understand and thanked the author. *[Alison Griffiths, Director of Nursing, left the meeting and Chris Stockport, Executive Director Transformation And Strategic Planning joined the meeting]*	
QS23.110 SPECIAL MEASURES	
QS23.111 Special Measures Report (cycle 2) including Output from the Development Sessions on Independent Reviews **QS23.111.1** Chair was pleased to note that the authors of the National Collaborative Commissioning Unit (NCCU) and the NHS Executive Performance and Assurance Division Mental Health Inpatient Safety Review Report intended to return, free of charge, to follow up in the new year. **QS23.111.2** Teresa Owen (TO), Executive Director for Public Health, reflected on the NCCU report, which she had very much welcomed. The purpose of the report was to do a root and branch scrutiny of all Mental Health and Learning Disability (MHLD) in-patient areas over a two week period. The NCCU report contained 8 recommendations, as listed in the	

Independent Review Management Response; for each of these recommendations, the MHLD team produced a response plan, in line with similar Special Measures (SM) templates. Care had been taken to ensure all relevant areas were covered and all response plans were tracked, in alignment to the themes of the SM work. **QS23.111.3** TO welcomed the revisit early in the new year and felt that would give the team time to move forward with the actions. The MHLD team was making an effort to theme them across the division, linking regularly with the SM team. **QS23.111.4** A discussion took place around the time limitations placed around actions being tied to the 90 day cycles, and it was felt that there should be recognition of available resources and all areas being worked on to ensure that time frames are realistic, noting that unattainable targets will always be missed, making it even harder to build staff and patient morale and to encourage buy-in to ideas. The Committee felt that there might be a need to conversation with Welsh Government, to explain that in order to get things right, be transformative and embed into the organisation's culture, will need a long-term approach. **QS23.111.5** It was felt that there should be some push-back against some of the reviews and resulting recommendations. The Chair felt strongly that Welsh Government and Board would support being pragmatic and sensible about what is achievable and that it would be unacceptable to have yet more recommendations and requirements added to Special Measures work. **QS23.111.6** Chris Stockport (CS), Executive Director Transformation And Strategic Planning, confirmed that his team was taking a very firm line in all conversations with Welsh Government on how the organisation cannot keep receiving more reviews and recommendations. **QS23.111.7** The Committee requested that in the next report it starts to receive more detail on outcomes. *Chris Stockport, Executive Director Transformation And Strategic Planning left the meeting]*	**CS**
QS23.112 FOR NOTING	
QS23.113 Research Governance Policy. **QS23.113.1** The report was removed for further scrutiny.	
QS23.114 CLOSING BUSINESS	
QS23.115 Reflections on meeting **QS23.115.1** The Chair reminded OBS that QSE needed to approve the Clinical Audit strategy.. Also she was keen to gain assurance regarding	

quality of commissioned services. Internal Audit had looked at it and intends to revisit in January 2024. . Angela Wood (AW),The Executive Director for Nursing and Midwifery, confirmed that in response to the Internal Audit Report, and the obvious need for better oversight of quality services, a Commissioning Assurance Framework had been set up. The Interim Chief Executive Officer was very keen to bring in the framework, which is based on the system at Powys, and had been discussing with colleagues how to take this forward. AW and the Interim Director of Operations are in discussions to improve the quality oversight as part of contract monitoring. The Chair said that QSE wished to be kept informed at the appropriate time. **QS23.115.3** It was generally agreed to be a good meeting and that reports presented were improving and the detail much more useful. There was still work to be done but definitely going in the right direction.	**RWJ** **OBS** **OBS**
QS23.116 Date of Next Meeting **QS23.116.1** 19 December 2023.	

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**
AW	**QS23.67** AW to bring a deep dive on falls to the meeting next month explaining how making change and challenge of embedding into practice.	August	Deferred to meeting on the 27.10.23 when audit report will also be included. On agenda.	**proposed for closure**
AW	**QS23.72** Special Measures Report: AW to discuss Quality Strategy with CEO regarding timings	August	The CEO has confirmed that this will take place in the third 90-day Special Measures Cycle. Included in Patient Safety, Effectiveness and Experience Report.	Proposed for closure
ACTIONS FROM MEETING HELD ON 27.10.23				
OBS	**QS92.2.2** FL to ensure Head of Internal Audit be invited to meetings going forward.	December	30.10.23 FL actioned.	Proposed for closure
OBS	**QS92.2.3** FL to arrange a meeting for Chair to meet with all 3 IHCs, and the Heads of Womens Services and Mental Health.	November	Meeting being arranged	
RWJ / OBS	**QS23.72** The Chair asked that when the Cycle of Business is reviewed, it be made clear that the Quality Strategy must be scrutinised by QSE	December	This process will be included in the forthcoming roundtable work but has been reflected in the COB circulated at the meeting	Proposed for closure
OBS	**QS23.92.2.2** Head of Internal Audit, Chair requested that he be invited to all meetings.	October	30.10.23 FL actioned.	Proposed for closure
OBS / RWJ	**QS23.92.3** Chair requested that a meeting be arranged with herself, all three IHCs and the Heads of Womens Services and Mental Health together.	November	A meeting is being arranged – Duplicate action QS92.2.3	Proposed for closure

MJ	**QS23.101.1** To ensure items only to be put onto agenda if assurance is required.	December	A consent agenda has been included on the agenda	Proposed for closure
MJ	**QS23.101.2** To reinstate Immunisation Services onto CoB.	December	This process will be included in the forthcoming roundtable work but has been reflected in the COB circulated at the meeting	Proposed for closure
MJ	**QS23.101.3** To reinstate Human Tissue Authority onto CoB	December	This process will be included in the forthcoming roundtable work but has been reflected in the COB circulated at the meeting	Proposed for closure
MJ	**QS23.101.4** MJ agreed to engage with Executives regarding reporting cycles, and bring back to the next meeting.	December	This meeting is being taken forward as part of the wider TOR/COB round table discussion	Proposed for closure
PM	**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.	Proposed for closure
KH / OBS	**QS23.102.8** KH to focus on a Diabetes pathway, how it might look and returning with an update to QSE when ready.	December	There is a Primary Care item on the agenda which will be an opportunity to discuss how all Primary Care items can be focussed on. There is a Diabetic Programme Board which has recently had their inaugural meeting, their work will feed in through the EDG.	Proposed for closure
AW	**QS23.103.5** AW to identify a specific change that had taken place in direct response to one of the Patient's stories.	December	This will form part of the Patient Story but feedback from the last story has been shared by email	Proposed for closure

RWJ / PM	**QS23.104a.3** Chair to discover possibility of making strategic risks training a Board Workshop topic would suggest this.	December	A Board development programme is being produced and this will be considered by the Chair	Proposed for closure
NC	**QS23.104a.6** NC to reduce CRR report from 300+ pages to ideally a 6 page report which would focus on one theme in detail and note anything that had changed since previous report.	December	This work has been undertaken and further work is ongoing to ensure the CRR is a live document which feeds into the BAF and Committees	Proposed for closure
AW / MJ	**QS23.105.5** Chair requested that the future reports identify areas of concern that the Committee and Board should be made aware of, including comparative data and to only include incidents that involve quality of patients' care and experience.	December	Following the meeting, the Chair and Executive Lead agreed a new integrated report replacing this existing report, the first of which is being presented at this meeting. Therefore feedback on this new report will be requested to ensure it developed as the Committee wishes. The report will make use of the new Quality Dashboard as it becomes available.	Proposed for closure
NL / AW / KH / OBS	**QS23.106.3** To meet outside of meeting to discuss the frequency and consistency of reporting, the level of detail required and to report back with an update.	December	Undertaken as part of agenda setting meeting.	Proposed for closure
AG / RC	**QS23.108.2** AG agreed to speak to Russell Caldicott outside of meeting, to discuss options regarding provision of un-validated figures.	November	Ongoing	Proposed for closure
AG	**QS23.108.2** AG agreed to ensure Chair invited to her meeting with Russell Caldicott and PFIG Chair, once first draft of new IPF becomes available.	November	Meeting has been held with the PFIG Chair who has an open invitation to meet with AG and RC to work through performance	Proposed for closure

CS	**QS23.111.7** CS agreed to include more details of outcomes in future Special Measures Reports	December	Report on Agenda	Proposed for closure
RWJ	**QS23.115.1** Internal Audit to be approached to gain assurance regarding Clinical Audit Strategy and the quality of commissioned services.	December	PPJ will take this action forward on behalf of the Chair	
AW / AG	**QS23.115.3** Chair to be kept updated regarding implementation of a Commissioning Assurance framework, when appropriate.	December	This is ongoing. No updates at present.	Propose to close as ongoing
AW	**QS23.120.6** The Committee requested Management Response to Internal Audit be shared with Members, once it becomes available.	December	On agenda	Propose to close
AW / MJ	**QS23.121.4** AW & MJ to investigate ways of sharing specific instances of where procedures have changed as a result of the feedback and learning from investigations into incidents.	December	The NRI Report, provided to the Committee in private, summarises the learning from completed national reportable incident investigations (these would be the most serious harm incidents). The learning would indicate where a policy or procedure has been changed as part of the action plan.	

RAG Status	
	Completed/for closure
	Ongoing
	Outstanding

Reporting Committee	**Quality Patient Safety Committee (QPSC)**
Chaired by	**Carolyn Donoghue**
Lead Executive Director	**Director of Nursing & Quality**
Date of Meeting	**23rd October 2023**

Summary of key matters considered by the Committee and any related decisions made

As the morning had been taken up with the Quality Patient Safety Development Day there was no presentation or Patient Story at this meeting. The Chair welcomed two new members to the committee representing Cardiff & Vale University Health Board and the Deputy Regional Director for Llais.

1.0 COMMISSIONING TEAM AND NETWORK UPDATES

Members received a report outlining the current Quality and Patient Safety issues within the services that are commissioned by the Welsh Kidney Network (WKN) across Wales.

Reports from each of the Commissioning Teams were received and taken by exception. Members noted the information presented in the reports and a summary of the services in escalation is attached to this report. The key points for each service are summarised below and updates regarding services in escalation are attached in the tables at the end of the report.

- **Cancer & Blood**

It was noted that no new risks for the portfolio had been added to the Risk Register since the last report.

- Members noted the improved traction on the performance issues within the All Wales Lymphoma Panel (AWLP) service and following the submission of a final report by the service, it is likely a recommendation will be made to reduce the level of escalation level by the next meeting.
- The Harm Review being undertaken on the North Wales (NW) plastics service remains outstanding. No timescales for completion were presented to the committee and members asked for further clarity.
- Whilst the Burns South Wales (SW) remains in Escalation Level 3 the capital case has been approved by Welsh Government and it is anticipated that the interim staffing arrangements can be sustained until the new build is complete.
- A Neuro Endocrine Tumour Stakeholder meeting was organised by Cardiff & Vale University health Board on the 17th October 2023.

- **Neurosciences**

Members noted that one new risk scoring above 15, relating to staffing levels within Neuro-rehabilitation at CVUHB, had been added since the last report was received. The committee was informed that due to quality issues with current provider commencement of Designated Provider process for the South Wales Deep Brain Simulation (DBS) service has been initiated. A letter has been sent to Llais informing them of the position.

- **Cardiac**

No new risks for the Cardiac portfolio had been added to the Risk Register since the last report. Members noted the updates against the two services, which currently remained in escalation at level 2.

- **Women & Children**

Members were concerned that there were five service areas with risks scoring 15 and above and that two new risks scoring above 15, both relating to Neonatal at CVUHB, had been added since the last report was received.

There are five service areas with high risks and in Escalation Level 3 are noted as follows and further detail and actions can be found in the summary of services in escalation, which is attached to the report.

  - Paediatric Intensive Care (CVUHB)
  - Paediatric Surgery (CVUHB)
  - Neonatal Intensive Care (CVUHB)
  - Paediatric Cardiac Surgery (UHBNHSFT)
  - Wales Fertility Institute (WFI) (SBUHB)

The committee were informed that an extraordinary Exec to Exec meeting with CVUHB was due to take place later that day to consider the areas of concern and agree a way forward. It has been proposed that all three will be brought into a single Escalation process with joint Exec Leads to provide additional support. It was also noted that Paediatric Surgery is not meeting contract volumes but ministerial measures are being met. A recommendation will be considered at the November Joint Committee for the escalation objectives to remain that Paediatric Surgery achieves contract volumes.

It was noted that the SBUHB assurance report was not submitted to HFEA on time. A further WHSSC escalation meeting is scheduled for the 27th October 2023, and the worst case scenario will be to source a new provider.

- **Mental Health & Vulnerable Groups**

One new risk has been added to the risk register regarding the magna security locks in the North Wales CAMHS unit. Assurance was received that this was being closely monitored and a meeting with the provider had identified the need for a capital bid to fund the necessary remedial works. A number of incidents had

been reported to WHSSC following that meeting and it was agreed that these would be further escalated to the BCUHB DoN for urgent consideration.

Members received an update regarding progress on the development of a Children and Young People's Gender Identity Service led through the NHS England transformation programme.

Members noted that there are a number of safeguarding concerns at an NHSE Eating Disorder provider and these have been escalated to NHSE for discussion and investigation. The relevant safeguarding teams are aware and the care coordinators from the Health Boards have been asked to review the individual patients. A more detailed report was to be received at the next meeting.

The new Eating Disorder unit in Tŷ Glyn Ebwy Hospital, Hillside, Ebbw Vale is due to be opened by the Deputy Minister for Health on the 9th November 2023. This will allow for repatriation of out of area placements and reduce the risk identified with one of the current independent providers.

- **Intestinal Failure (IF) – Home Parenteral Nutrition**

Members received an update of the quality issues for services relating to the Intestinal Failure Commissioning Team Portfolio and noted that no new risks for the portfolio had been added to the Risk Register since the last report.

2.0 OTHER REPORTS RECEIVED

Members received reports on the following:

- **Services in Escalation Summary**

A copy of each of the services in escalation is attached to the report at ***Appendix 1***

- **CRAF Risk Assurance Framework**
- **Care Quality Commission (CQC)/ Health Inspectorate Wales (HIW) Summary Update**
- **Incident and Concerns Report**
- **Report from the WHSSC Policy Group**.

3.0 ITEMS FOR INFORMATION:

Members received a number of documents for information only:

- Chair's Report and Escalation Summary to Joint Committee September 2023
- Welsh Health Circular: Speaking up Safely Framework
- QPSC Distribution List; and
- QPSC Forward Work Plan.

4.0 ANY OTHER BUSINESS

It was noted that there had been a Development Day for QPS members and Quality Leads from the Health Boards that morning. The theme of the session

was to consider the impact of the Duty of Quality Act in terms of future reporting and monitoring of commissioned services. It had been well attended and a report will be presented at the next meeting.	
Key risks and issues/matters of concern and any mitigating actions Key risks are highlighted in the narrative above. Members expressed concerns regarding the number of services that were in escalation in the Women & Childrens portfolio and asked that these were escalated for the attention of the Joint Committee.	
Summary of services in Escalation • Attached (***Appendix 1***)	
Matters requiring Committee level consideration and/or approval • None	
Matters referred to other Committees As above.	
Confirmed minutes for the meeting are available upon request	
Date of Next Scheduled Meeting	5 December 2023

Appendix 1

Executive Director Lead: Nicola Johnson
Commissioning Lead: Luke Archard
Commissioning Team: Cancer and Blood

Date of Escalation Meetings: 27/09/22, 01/12/2022, 03/03/2023, 03/05/2023
Date Last Reviewed by Quality & Patient Safety Committee: 16/08/23

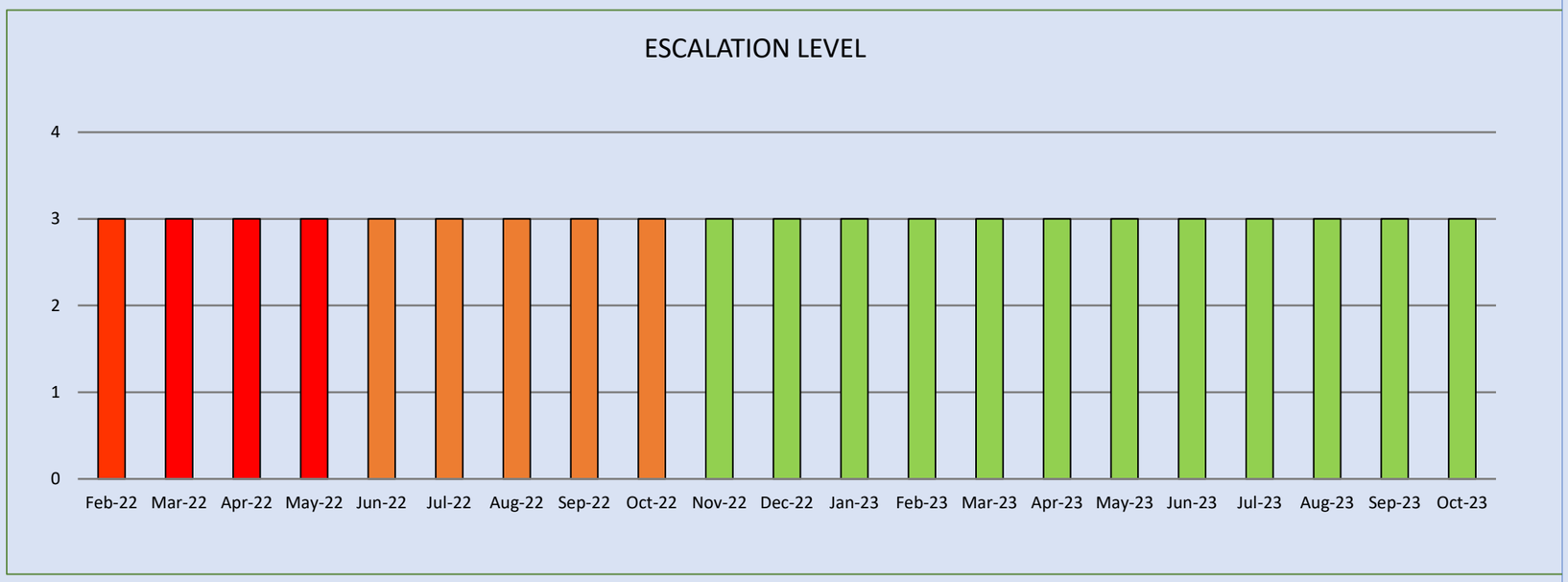
Service in Escalation: Burns

Current Escalation Level 3

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↔ October 2023
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level
November 2021 – South West Burns Network escalation	**4**
February 2022 – WHSSC escalation	**3**
August 2022 – WHSSC escalation	**3**
September 2022 – WHSSC escalation	**3**
December 2022 – WHSSC escalation	**3**

Rationale for Escalation Status :
Remains at level 3.
The current timeline for completion of the capital works to enable relocation of burns ITU to general ITU at Morriston Hospital is the end of 2023.
The capital case may be delayed to the initial intended timeline as the case goes through the scrutiny process.

Background Information:

At the time of initial escalation, the burns service at SBUHB was unable to provide major burns level care due to staffing issues in burns ITU. An interim model was put in place allowing the service to reopen in February 2022. The current escalation concerns the progress of the capital case for the long term solution and sustainability of the interim model.

Actions:

Action	Lead	Action Due Date	Completion Date
To escalate and liaise with SBUHB at CEO and MD level with regard to the immediate actions needed to provide continued access to burns care for patients in Wales and the Network.	MD/ CEO		Completed
To work with NHS England south west commissioners and the SWW Burns Network to support clear pathways and ensure continued access to burns care for patients in Wales and the Network.	MD/Exec Lead WHSSC		Completed
To monitor the SBUHB action plan through formal escalation meetings.	MD/ Exec Lead WHSSC		Ongoing
The peer review report was received by WHSSC and discussed at the Burns Network meeting on the 16th December 21. The interim mitigations are still in place at present.	Senior Planner		Completed

Appendix 1

SBUHB are to provide a plan based on the recent peer review by the end of January 22.	Senior Planner		Completed
A series of monitoring meetings are being put in place and LA to ask SBUHB if they are confident as to whether 2 beds meets their requirements. The unit has reopened with reduced capacity, i.e. 2 ITU beds instead of 3. Full capacity will return in the longer term. WHSSC has responsibility for monitoring implementation rather than the burns network. It was agreed that the risk score could be reduced to 9 (3 x 3) and considered for further reduction when assurance as to whether the service considered the reduced capacity to be sufficient for their needs.	Senior Planner WHSSC/ Service Manager SBUHB		Completed
Interim arrangements to sustain burns service are in place while the business case is developed to collocate burns intensive care with the general intensive care unit. Interim arrangements appear to have taken effect. Risk may be reduced once escalation meetings can be confirmed.	Senior Manager/ Senior Planner WHSSC	Ongoing	Completed
WHSSC to look at the business continuity plan in the event of potential loss of staff.	Senior Planner WHSSC	Ongoing	Completed
Since the last escalation meeting, there has been a degree of delay relating to the process of Welsh Government scrutiny of the case which went to their Investment in Infrastructure Board on 22nd June; it had been hoped that the works would commence in May. There may, therefore, be a 2 month or so departure from original timelines. At the SLA with Swansea on 5th June, it was confirmed that this message had been conveyed to the staff supporting the interim rota arrangements (one of the concerns has been to ensure the resilience of this rota which in turn is felt to depend in part on there being demonstrable progress with the business case so they can see the finish line).	Senior Team SBUHB/WHSSC Med Director/ Senior Planner WHSSC	Ongoing	Completed
The capital case has now been approved by Welsh Government. The level of escalation will therefore be reviewed further to the next escalation meeting which is scheduled for November. It is anticipated that the interim staffing arrangements can be sustained until the new build is complete.	Senior Team SBUHB/WHSSC Med Director/ Senior Planner WHSSC	Ongoing	

Issues/Risks:

- **July 2023 The Welsh Government Infrastructure Investment Board considered the burns case on June 22nd the outcome is not confirmed as yet.**
- **October 2023: the capital case has been approved by Welsh Government. Timeline tbc.**

Appendix 1

Executive Director Lead: Nicola Johnson
Commissioning Lead: Kimberley Meringolo
Commissioning Team: Women and Children

Date of Escalation Meetings: 26/04/23, 23/05/23, 20/06/2023, 26/07/23, 12/09/23 & 10/10/23
Date Last Reviewed by Quality & Patient Safety Committee: 16/08/23

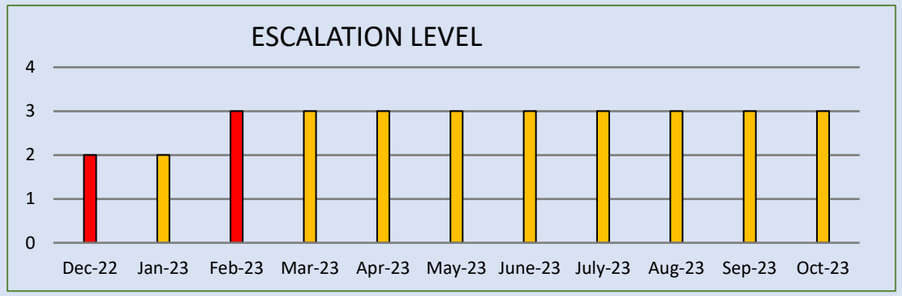
Service in Escalation: Paediatric Surgery

Current Escalation Level 3

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↔ October 2023
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level
March 2023 – WHSSC escalation	**3**

Rationale for Escalation Status :
As a result of the service failing to engage fully with WHSSC regarding the weekly submission of contract delivery and waiting time profiles, it was agreed that the C&VUHB Paediatric Surgery service should be further escalated from Level 1 to Level 3 of the WHSSC Escalation Framework.

Background Information:

There is a risk that Paediatric patients waiting for surgery in the Children's Hospital of Wales are waiting in excess of 36 weeks due to COVID-19. The consequence is the condition of the patient could worsen and that the current infrastructure is insufficient to meet the backlog.
• Original recovery plan trajectories have reflected a nominal improvement on the waiting list position, and clarity is required on zero waits > 104 weeks,
• The original plan did not deliver contracted volume,
• Timely assurance on delivery against the baseline for future recovery, via weekly reports, as opposed to monthly reporting suggested by the UHB.

WHSSC assurance and confidence level in developments:

Medium – Action plan developed and positive progress made in designing a number of new pilot schemes and securing additional capacity, some delays in implementation. The current financial pressures and savings plans requested by WG have resulted in the Health Board re-profiling the trajectories and unlikely to meet contract volumes for the remainder of the financial year.

Actions:

Action	WHSSC Lead	Action Due Date	Completion Date
Monthly escalation meetings with CVUHB to review progress against the improvement plan.	Senior Planning Manager	Monthly	
Action plan to be monitored through the monthly escalation meetings and when data shows improvement consideration will be given to de-escalation.	Senior Planning Manager	Monthly	
Requested revised trajectories to be issued to WHSSC by the end of June 2023.	Senior Planning Manager	30 June 2023	Completed 20/06/23
Further reprofiling of waiting times being undertaken by the HB in line with meeting contract volumes by December 2023.	Senior Planning Manager	August 2023	Completed 06/10/23
Special Executive to Executive meeting scheduled with provider.	Director of Planning & Performance	23 October 2023	

Issues/Risks:
April 2023 – Action plan presented by HB and actions agreed to progress in time for next meeting.
May 2023 – a number of actions within the action plan are in progress, action at meeting to update trajectories in time for the July meeting in order to allow measurement of improvement.

Appendix 1

Executive Director Lead: Nicola Johnson
Commissioning Lead: Kimberley Meringolo
Commissioning Team: Women and Children

Date of Escalation Meetings:
Date Last Reviewed by Quality & Patient Safety Committee:
New Service in Escalation

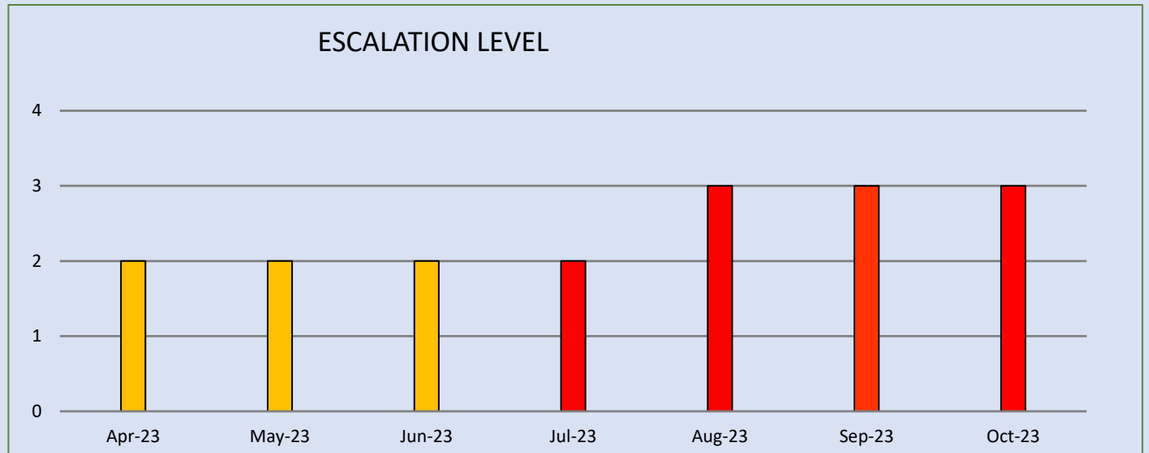
Service in Escalation: Paediatric Intensive Care

Current Escalation Level 3

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↑ October 2023
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level

Rationale for Escalation Status :
Following concerns regarding bed availability due to workforce shortages, refusal rates and pressure sore incidents the service was escalated to level 2. There was limited progress over a 3 month period against the objectives therefore the decision was taken to further escalate to level 3.

Background Information:

There is a risk that a Paediatric intensive care bed, in the Children's Hospital for Wales, will not be available when required due to constraints within the service. There is a consequence that Paediatric patients requiring intensive care will be cared for in, inappropriate areas where the necessary skills or equipment is not available or the patient being transferred out of Wales. The availability of a bed and staffing constraints have been brought to the attention of WHSSC through various routes including HiW and the daily SITREP.

WHSSC assurance and confidence level in developments:

Low – HB have submitted draft action plan, a final version has been requested. The escalation is predominantly linked to workforce and the lead in time for mitigations is medium term, in particular the recruitment of International Nurses. New streamliners have begun in the HB and although supernumerary at present and will not directly fill PIC vacancies it will support the wider workforce challenges across the Children's Hospital.

Actions:

Action	WHSSC Lead	Action Due Date	Completion Date
Requested demand and capacity plan from HB to develop sustainable contracting framework for PIC and HD	Senior Planning Manager	31 October 2023	
Requested action plan to be developed against the escalation objectives.	Senior Planning Manager	31 October 2023	
Requested sight of the Pressure Sore report presented to the HB Quality and Patients Safety Committee.	Senior Planning Manager	31 October 2023	
Special Executive to Executive meeting scheduled with provider	Director of Planning	23 October 2023	

Issues/Risks:

Appendix 1

Executive Director Lead: Nicola Johnson
Commissioning Lead: Kimberley Meringolo
Commissioning Team: Women and Children

Date of Escalation Meetings:
Date Last Reviewed by Quality & Patient Safety Committee:
New Service in Escalation

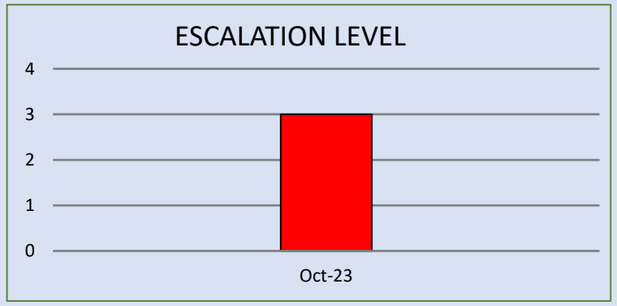
Service in Escalation: Neonatal Intensive Care Unit

Current Escalation Level 3

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↑ October 2023
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level
September 2023	3

Rationale for Escalation Status :

High levels of cot closures reported across all three levels of care, blood stream infection rates and progress implementing the new cot configuration.

Background Information:

There are currently two risks on the CRAF relating to Neonatal services at Cardiff and Vale UHB, lack of cot availability due to workforce and the service being a negative outlier status for blood stream infections, on the National Neonatal Audit Programme (NNAP). Limited progress has also been made against implementing the workforce required to support the cot configuration.

WHSSC assurance and confidence level in developments:

The service were only notified of escalation in late September therefore at the time of writing the report the objectives have not yet been set.

Actions:

Action	WHSSC Lead	Action Due Date	Completion Date
Develop agreed objectives for escalation	Planning Manager	31 October 2023	
Health Board to develop detailed action plan against the agreed objectives	Planning Manager	14 November 2023	
Special Executive to Executive meeting scheduled with provider	Director of Planning	23 October 2023	

Issues/Risks:

Appendix 1

Executive Director Lead: Iolo Doull
Commissioning Lead: Dominique Gray-Williams
Commissioning Team: Women and Children

Date of Escalation Meetings: 07/08/23
Date Last Reviewed by Quality & Patient Safety Committee: 16/08/23

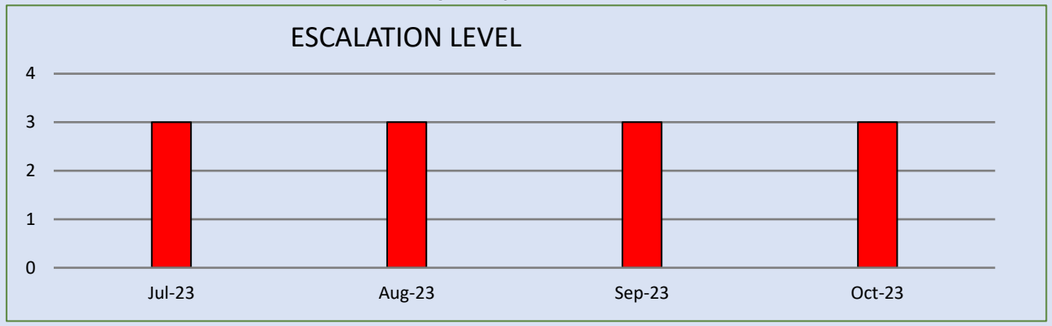
Service in Escalation: Wales Fertility Institute

Current Escalation Level 3

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↔ October 2023
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level
July 2023 – WHSSC escalation	**3**

Rationale for Escalation Status :
Concerns from a number of routes with regards to the service including the WHSSC contract monitoring data submission; adherence to WHSSC policies and HFEA performance outcomes below National average.

Background Information:
A number of concerns regarding the safety and quality of service had been raised through different routes, including HFEA re-inspection report January 2023, WHSSC quality and assurance meetings and WFI IPFR requests regarding Wales Fertility Institute leading to the escalation of the service.
There is a risk the Wales Fertility Institute (WFI) in Neath & Port Talbot Hospital is not providing a safe and effective service due to 7 major concerns identified during a relicensing inspection by HFEA in January 2023. There is a consequence that families who have treatment at this centre are not receiving the quality of care expected from the service and in turn impacting outcomes.

WHSSC assurance and confidence level in developments:

Medium – The Health Board have instigated regular Gold Command and operational service improvement meeting with positive progress made in addressing HFEA concerns. The Action plan has been agreed and progress has been made with regards to WHSSC data submissions, however, the service need to ensure time is given both internally and to WHSSC to allow for review and consideration of documentation.
The service are due to submit a progress report to the HFEA by the 18th October. HFEA re-inspection is due to take place in January 2024.

Actions:

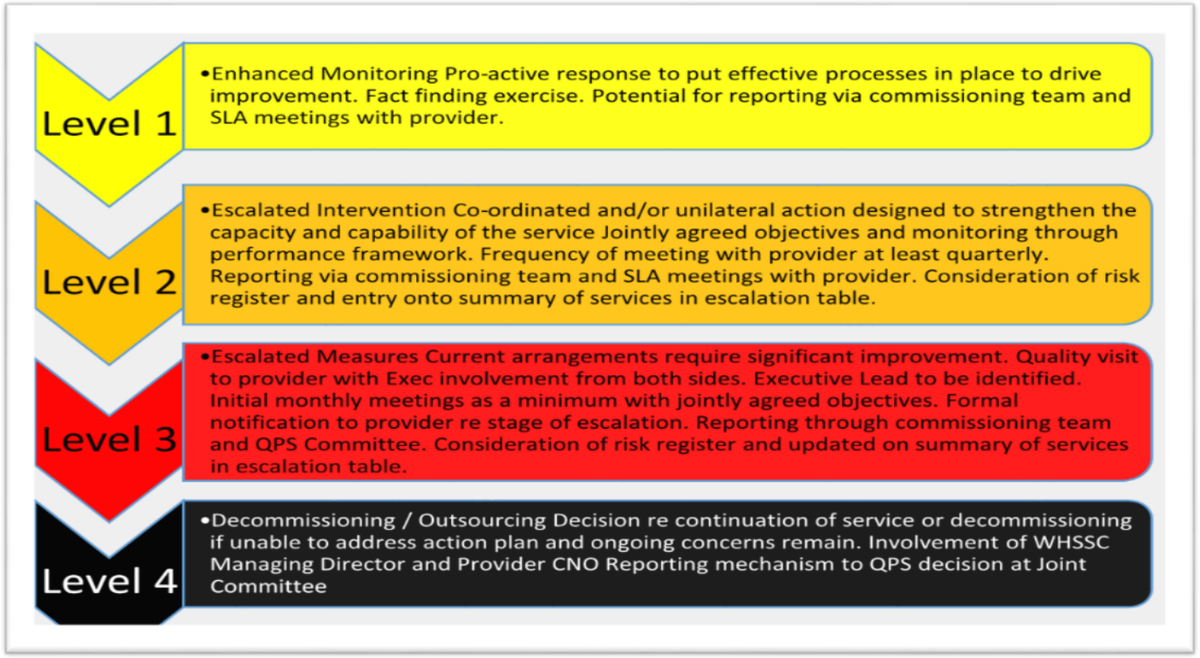
Action	Lead	Action Due Date	Completion Date
Initial escalation planning meeting Exec to Exec	Assistant Specialised Planner	7th August 2023	7th August 2023
Monthly escalation meeting to review progress against Action Plan Escalation meeting 19th September 2023	Assistant Specialised Planner	Monthly	Ongoing
Quality visit	Assistant Specialised Planner	14th November 2023	
SMART Action plan from WFI, action plan has been requested in order that it can be agreed with WHSSC colleagues	Assistant Specialised Planner/ Service Manager	7th August 2023	7th August 2023
SMART Action plan reviewed and agreed	Service Manager	19th September 2023	19th September 2023

Issues/Risks: There is a risk the Wales Fertility Institute (WFI) in Neath & Port Talbot Hospital is not providing a safe and effective service due to 7 major concerns identified during a relicensing inspection by HFEA in January 2023. There is a consequence that families who have treatment at this centre are not receiving the quality of care expected from the service and in turn impacting outcomes.

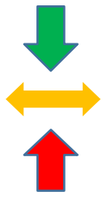
Appendix 1

Level 1 ENHANCED MONITORING	Any quality or performance concern will be reviewed by the Commissioning Team. Enhanced monitoring is a pro-active response to put effective processes in place to drive improvement. It is an initial fact finding exercise which should ideally be led by the provider and closely monitored and reviewed by the commissioning team. The enquiry will lead to one of the following possible outcomes: • No further action is required routine monitoring will continue. The concern which raised the indication for inquiry will be logged and referred to during the routine monitoring process to ensure this has not developed any further. • Continued intervention is required at level 1 and a review date agreed. • Escalation to Level 2 if further intervention is required There is the potential for reporting via commissioning team report to Quality Patient Safety Committee and through SLA meetings with provider
Level 2 ESCALATED INTERVENTION	Escalated intervention will be initiated if Level I Enhanced Monitoring identifies the need for further investigation/intervention. There should be a Co-ordinated and/or unilateral action designed to strengthen the capacity and capability of the service. At this stage there should be jointly agreed objectives between the provider and commissioner and monitored through the relevant commissioning team. Frequency of meeting with provider should be at least quarterly and possible interventions will include • Provider performance meetings • Triangulation of data with other quality indicators • Advice from external advisors • Monitoring of any action plans A risk assessment should be undertaken, and logged on the Commissioning Team Risk Register. Where appropriate the risk will be included on the WHSSC Risk Management Framework. Reporting is via commissioning team report to Quality Patient Safety Committee report and SLA meetings with provider. The investigation will lead to on to the following possible outcomes: • Action plan and monitoring are completed within the allocated timeframe, evidence of progress and assurance the concern has been addressed. De-escalation to Level 1 for ongoing monitoring. • If the action plan is not adhered to and further concerns are raised by the Commissioning team or by the provider team or further concerns are identified it may be necessary to move to Level 3 Escalated Measures
Level 3 ESCALATED MEASURES	Where there is evidence that the Action Plan developed following Level 2 has failed to meet the required outcomes or a serious concern is identified a service will be placed in escalated Level 3. At this stage the quality of the service requires significant action/improvement and will require Executive input. In addition to routine reporting through QPS a formal paper will be considered by the WHSSC Corporate Directors Group (CDG) and an Executive Lead nominated. Formal notification will be sent to the provider re the Level of escalation and a request made for an Executive lead from the provider to be identified. An initial meeting will be set up as soon as possible dependant on the severity of the concern. Meetings should take place at least monthly thereafter or more frequently if determined necessary with jointly agreed objectives. Provider representation will depend on the nature of the issue but the meetings should ideally comprise of the following personnel as a minimum: • Chair (WHSSC Executive Lead) • Associate Medical Director - Commissioning Team • Senior Planning Lead – Commissioning Team • WHSSC Head of Quality • Executive Lead from provider Health Board/Trust • Clinical representative from provider Health Board/Trust • Management representative from provider Health Board/Trust An agreed agenda should be shared prior to the meeting with a request for evidence as necessary. At the conclusion of the meeting a clear timeline for agreed actions will be identified for future monitoring and confirmed in writing if appropriate. Reporting will be through commissioning team to QPS Committee. Consideration of entry on the risk register and summary of services in escalation table for Chairs report to Joint Committee. Consideration to involve and have a discussion with Welsh Government may be considered appropriate at this stage. If there is ongoing concern relating patient care and safety with no clear progress then further escalation will be required to Level 4. On the other hand if progress is made through the escalation Level 3 evidence of this should be presented to CDG/QPS and a formal decision made with the provider to de-escalate to Level 2.
Level 4 DECOMISSIONING/OUTSOURCING	Where services have been unable to meet specific targets or demonstrate evidence of improvement a number of actions need to be considered at this stage. This stage will require notification and involvement of the WHSSC Managing Director and CEO from the provider organisation. Both Quality Patient Safety Committee and Joint Committee should be cited on the level of escalation. The following areas will need to be considered and the most appropriate sanction applied to help resolve the issue: 1. De-commissioning of the service 2. Outsourcing from an alternative provider. This may be permanent or temporary 3. Contractual realignment to take into account the potential need to maintain and agree an alternative provider. Involvement with Welsh Government and the Community Health Council is critical at this stage as often there are political drivers and levers that need to be considered and articulated as part of the decision making. Moving in and out of escalation and between Levels In addition to the Levels described above the process has introduced a traffic light guide within each level. The purpose of this is to help demonstrate the direction of travel within the level. It sets out an approach to help identify progress within the level and lays out the steps required for movement either upwards (escalation) or downwards (de-escalation) through the level. At every stage a red, amber or green colour will be applied to the level to illustrate whether more or less intervention is in place. Red being a higher level of intervention moving down to green. It will also help determine the easing of the escalated measures described and inform movement within the stages of escalation. As the evidence and understanding of the risks from a provider and commissioner become evident decisions can be made to reduce the level of intervention or there may be a need to reintroduce intervention should conditions worsen and trigger the re-introduction of measures if progress is unacceptable. In this way organisations will be able to understand what is being asked of them, progress will be easily identified and it will help avoid any confusion. It will also help in the reporting to provide assurance that action is being taken to meet the agreed timescales.

Appendix 1



SERVICES IN ESCALATION



Level of escalation reducing / improving position

Level of escalation unchanged from previous report/month

Teitl adroddiad: ***Report title:***	**Falls Management Final Internal Audit Report** **October 2023**
Adrodd i: ***Report to:***	Quality Safety and Experience Committee
Dyddiad y Cyfarfod: ***Date of Meeting:***	Tuesday, 19 December 2023
Crynodeb Gweithredol: ***Executive Summary:***	Internal audit conducted a review of compliance with the BCUHB Policy NU06 – The Prevention and Management of Inpatient Falls as well as reporting and management arrangements in place. They issued limited assurance on this area. The significant matters which require management attention include: • The Falls policy is overdue for review. • Testing demonstrates a lack of detail included on completion of the Falls and Bone Health Multifactorial Assessment (FBHMA) and documentation pertaining to patient falls. Further detail is necessary to fully understand the patient's needs. • To decrease the inconsistent information amongst documentation, standardising of patient fall documentation should be taken into consideration. • There is high non-compliance of Patient Handling training. This requires urgent improvement to ensure staff are appropriately trained. • There are a high number of agency staff on wards, with part of the responsibilities including completing falls documentation. There is no oversight of what training agency staff have received on falls to ensure effective completion of required documentation. • There is no evidence to demonstrate appropriate reporting from the Health Board Patient Safety Group to the Executive Delivery Group – Quality (EDQG). • We are unable to determine if there is a standardised process in place for identifying themes, patterns, and lessons learned from falls.
Argymhellion: ***Recommendations:***	The Committee are asked to endorse the following recommendations: • The Policy requires review to ensure staff are provided with up to date requirements and guidance relating to falls. • Staff should be reminded, through training, of the requirement to ensure the FBHMA and documentation pertaining to patient falls, provides sufficient information to fully understand the patients' needs and requirements to minimise the risk of a potential fall. Compliance with this should be reviewed through existing audit mechanisms. • To reduce the inconsistent information amongst documentation, standardising of patient fall documentation should be considered. • Reminder to staff that all FBHMAs are to be completed upon patient transfer between wards. Compliance with this should be reviewed through existing audit mechanisms. • To review training compliance for all areas relating to Patient Handling training and ensure staff who require training undertake this as soon as possible. • Review Safeguarding training to include post falls management.

<table>
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- Consider a more formal training method for the bedside learning programme, and consider resources required to provide this to staff. Ensure records of training are kept.
- Determine what training agency staff receive relating to patient falls and whether it is in line with training that the Health Board staff undertake and sufficient to ensure effective completion of falls documentation.
- The development of a standardised strategy that routinely identifies themes, trends, and lessons learned could enhance health boards' response to patient falls.
- Lessons learned information included in Datix should be reviewed regularly to ensure learning is communicated / reported as appropriate, and to deter staff entering a full stop or a dash in the section.
- Review the ward accreditation audits on the FBHMA to establish if the audits can include specific questions on detail that give a true reflection of the patient requirements.

The recommendations from the internal audit have been integrated into a falls management improvement plan that incorporates the recommendations from the HSE notice of contravention and the National Audit of Inpatient Falls.</td></tr>
<tr><td>Arweinydd Gweithredol:
Executive Lead:</td><td colspan="4">Angela Wood, Executive Director of Nursing and Midwifery</td></tr>
<tr><td>Awdur yr Adroddiad:
Report Author:</td><td colspan="4">NWSSP Audit and Assurance Services</td></tr>
<tr><td>Pwrpas yr adroddiad:
Purpose of report:</td><td>I’w Nodi
For Noting
☒</td><td>I Benderfynu arno
For Decision
☐</td><td colspan="2">Am sicrwydd
For Assurance
☐</td></tr>
<tr><td>Lefel sicrwydd:

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

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

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

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

No confidence / evidence in delivery</td></tr>
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Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***	
Further assurance required with regards to training of temporary staff	
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Improve the Safety and Quality of all Services
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	Further action from HSE
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?***	
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?***	
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)***	There is risk of harm to patients and the Health Board reputation if recommendations are not supported and implemented.
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	There will be additional resources required across the Health Board to accelerate improvements in line with HSE notice and reduce harm from falls.
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***	
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	Risk 4562 on Tier 1 of risk register
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:***	

The BCUHB Strategic Falls Group will lead to the implementation of the recommendations and report through to the BCUHB Patient Safety group.
Rhestr o Atodiadau: ***List of Appendices:*** 1. Internal Audit Report 2. Falls Management improvement plan

Falls Management
Final Internal Audit Report
October 2023

Betsi Cadwaladr University Health Board

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

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

Contents

Review reference:	BCUHB-2324-05
Report status:	Final
Fieldwork commencement:	21 July 2023
Fieldwork completion:	12 September 2023
Debrief meeting:	25 September 2023
Draft report issued:	22 September 2023
Management response received:	19 November 2023
Final report issued:	20 November 2023
Auditors:	Patrick Williams, Principal Auditor Nicola Jones, Deputy Head of Internal Audit Dave Harries, Head of Internal Audit
Executive sign-off:	Angela Wood, Executive Director of Nursing and Midwifery
Distribution:	Diane Read, Ward Accreditation Team Lead, Mandy Jones, Deputy Executive Director of Nursing Tracey Radcliffe, Head of Patient Safety Russell Caldicott, Interim Executive Director Of Finance Phil Meakin, Associate Director of Governance Bathen Wassel, Statutory Compliance, Governance and Policy Manager Andrea Hughes, Interim Director of Finance Joanne Garrington, Finance Director - Commissioning & Strategy Karen Balmer, Independent Member
Committee:	Audit Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Acknowledgement:
NHS Wales Audit and Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

use of the Betsi Cadwaladr University Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with Betsi Cadwaladr University Health Board. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Executive Summary

Purpose

We reviewed compliance with Policy NU06 - The Prevention and Management of Adult In-Patient falls as well as reporting and management arrangements in place.

Overview

We have issued limited assurance on this area. The significant matters which require management attention include:

- The Falls policy is overdue for review.
- Testing demonstrates a lack of detail included on completion of the Falls and Bone Health Multifactorial Assessment (FBHMA) and documentation pertaining to patient falls. Further detail is necessary to fully understand the patient's needs.
- To decrease the inconsistent information amongst documentation, standardising of patient fall documentation should be taken into consideration.
- There is high non-compliance of Patient Handling training. This requires urgent improvement to ensure staff are appropriately trained.
- There are a high number of agency staff on wards, with part of the responsibilities including completing falls documentation. There is no oversight of what training agency staff have received on falls to ensure effective completion of required documentation.
- There is no evidence to demonstrate appropriate reporting from the Health Board Patient Safety Group to the Executive Delivery Group – Quality (EDQG).
- We are unable to determine if there is a standardised process in place for identifying themes, patterns, and lessons learned from falls.

Further matters arising concerning the areas for refinement and further development have also been noted (see Appendix A).

Report Opinion

		Trend
Limited 	More significant matters require management attention. Moderate impact on residual risk exposure until resolved.	 2018/19

Assurance summary[1]

	Objectives	Assurance
1	Appropriate policies and procedures in place to support falls prevention processes.	Limited
2	All Wales Falls and Bone Health Multifactorial Assessment (FBHMA) have been completed for inpatients.	Limited
3	Staff are appropriately trained in patient handling and the completion of the Falls and Bone Health Multifactorial Assessment (FBHMA).	Limited
4	There is regular reporting and scrutiny of falls data at an appropriate forum.	Limited

[1]The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

Key Matters Arising		Objective	Control Design or Operation	Recommendation Priority
1	The Falls Policy is out of date and requires review.	1	Design	Medium
2	Lack of detail in the FBHMA and inconsistent information between the FBHMA and patient details in the nursing record.	2	Operation	High
3	Compliance with falls training requires improvement, and there is no oversight of the training agency staff receive in terms of patient falls.	3	Operation / Design	High
4	Unable to view chairs assurance reports from the Health Board Patient Safety Group being submitted to the EDQG. There is no consistent method for identifying themes, patterns and lessons learned.	4	Design	High

1. Introduction

1.1 The National Institute of Health and Care Excellence (NICE) identifies that falls and fall-related injuries are a common and serious problem for older people and falls in hospital are the most common patient safety incidents reported. The human cost of falling includes distress, pain, injury, loss of confidence, loss of independence and mortality, not only affecting patients but also affecting the relatives, carers and hospital staff.

Falling has an impact on quality of life, health and healthcare costs and the Health Board recognises that the prevention of falls, and effective management of patients following a fall, is an important patient safety challenge, in common with all Health Boards.

1.2 The risks considered in the review were:

- Patient Safety is compromised through lack of formal risk assessment.
- Staff are not compliant with Health Board mandatory training requirements; and
- Reputational risk through increased publicity of patients falling and associated litigation.

2. Detailed Audit Findings

This report is based upon the information provided by officers supporting our review. We have relied solely on the documents, information and explanations provided and, except where otherwise stated, we have not contacted or undertaken work directly to verify the authenticity of the information provided.

We would like to thank the Ward Accreditation Team Lead and Transforming Quality Care Nurse who accompanied and supported us with this review.

Objective 1: There are appropriate policies and procedures in place to support falls prevention processes, including escalation of avoidable falls.

2.1 There is a Health Board Policy in place, NU06 401 'The Prevention and Management of Adult In-Patient Falls' (Falls Policy), which was due for review in April 2023. We are advised that the Policy is in the process of being updated and circulated for comments prior to being submitted for approval. We are advised the Policy has been developed by reviewing the National Institute of Health & Care Excellence (NICE) clinical guidance Falls in Older People: Assessing Risk & Prevention (CG161) and 'State of the Nation – Wales report Royal College of Physicians' to reduce falls and their effects on patients and staff.

The advice and recommendations are intended for use by healthcare experts, other professionals, and personnel who provide care for elderly individuals who are at danger of falling.

2.2 The Falls Policy is consistent with the principles of the NICE guidance, Section 6 depicts the roles and responsibilities of persons within the falls management process whilst Section 7 of the policy outlines the falls assessment process.

Section 7 includes guidance on the actions to be taken on patient admission, stipulating timescales for completion, review, updating of the Falls and Bone Health Multifactorial Assessment (FBHMA), falls prevention, post falls management and monitoring and compliance.

Conclusion:

2.3 There is a Falls Policy in place that also outlines the process for falls management. This is available on the intranet, however at the time of undertaking this review the policy was out of date and is currently under review.

We have concluded **limited assurance** for this objective.

Objective 2: The All Wales Falls and Bone Health Multifactorial Assessment (FBHMA) have been completed for inpatients, and where necessary appropriate action taken to reduce the risk of a fall.

2.4 The digitised Falls & Bone Health Multifactorial Risk Assessment tool has been implemented across the Health Board, and it focuses on manageable risk factors and identifies actions to reduce the risk of falling. It incorporates NICE clinical guidance CG161 current best practice.

2.5 We sought to establish that the FBHMA assessments are being fully completed for all inpatients prior to a fall, and where necessary appropriate action taken to reduce the risk of a fall.

We reviewed 42 completed FBHMA assessments across three acute hospitals and three community sites one in each area.

- Wrexham Maelor, Ysbyty Gwynedd, Ysbyty Glan Clwyd, and
- Penrhos Stanley Hospital, Llandudno Hospital, Deeside Hospital.

We were accompanied by either the Ward Accreditation Team Lead or the Transforming Quality Care Nurse to advise on clinical issues.

Our key findings are:

2.6 <u>FBHMA</u>

- All wards we reviewed were using the digital Welsh Nursing Care Records (WNCR) containing the FBHMA.
- There was a lack of detail included in the FBHMA in identifying the patients individual risk factors for falling e.g. parts of the forms had limited to no detail for visual and hearing issues.
- There is contradicting detail between the information contained in the communication, mobility, patient handling and patient notes sections of the Nursing Care record compared to the FBHMA i.e.

- There were no visual issues noted in the communication domain, however the patient was noted as 'requires glasses' in the FBHMA.
- The patient was noted as Mobility category A (mobile) in patient handling form, however, was noted as needing a zimmer frame in the FBHMA.
- There were no issues noted relating to a patients hearing in the FBHMA, however the patient was noted as requiring hearing aids in the communication domain.

- Nurse perception of risk in relation to patient falls varies. For example, patients identified as a high risk of falls, and upon review a week later identified as no risk of falls, with no change to the documentation.
- There is inconsistent review of FBHMA upon transfer from one ward to another.
- Communication and Mobility domains were not being reviewed following the patient being admitted. This can cause inconsistencies of the patients profile as the FBHMA is reviewed.
- In accordance with the policy, the FBHMA should be completed within a six-hour timeframe; from the sample reviewed, 27 (64%) were completed within this time frame, with 15 (36%) completed outside of it.
- The post fall management section of the FBHMA was completed with all patients who had fallen within our sample.
- Business Continuity – at times when the digital system drops out the wards revert to a paper version. This information is then added to the Nursing Care record once the system is available.
- FBHMA's tended to provide information on what's wrong with the patient rather than what is required to give staff a view of what is needed for the patient.
- Abbreviation of terminology within two of the FBHMA was not recognised by a qualified nurse who accompanied us for the testing.

<u>Other findings in relation to patient falls: -</u>

- Eleven of the thirteen wards we visited were using STREAM, a digital service situated at the nurse's station, containing the details of all patients on the ward.
- Within the West community, the RAMBLEGUARD system is being used which identifies which patients are at high risk of falls and are using pressure mats when seated. The system includes an alarm and identifies which patient has fallen/slipped from the chair.
- The West community hospital is trialling pagers which identify which patient has fallen/slipped.

- Not all wards are using the 'Hot de-brief' short document, which was intended to be utilised across the Health Board immediately following a patient fall. This includes a review of how the fall occurred.
- All wards we sampled had a nominated nurse situated within a bay where there are patients at a high risk of falls.
- Areas of good practice include a QR code being available on one ward which when used directs the staff to all the latest falls documentation; signage above beds to indicate a patient at risk of a fall; and in one ward a 'I must' board is being used by the beds of patients at risk of a fall, which highlights to staff what the patient must do to reduce the risk of a fall.

Conclusion:

2.7 Having reviewed the FBHMA's, it would be challenging for staff reviewing the material to acquire a clear picture of the patients' needs due to the FBHMA's lack of clarity.

Although digitised on tablets, the FBHMA forms, communication, mobility domains, and patient handling assessment forms are still distinct and not in a single common document, making it challenging to obtain consistent up to date data regarding patient falls.

The Health Board may benefit from good practice on some wards employing QR codes and 'I must' boards over the beds.

Having spoken to several staff members whilst undertaking the testing, the perception of the documentation seems to be one of, falls documentation often seen as something we need to complete rather than a recipe for care.

We have concluded **limited assurance** for this objective.

Objective 3: Staff are appropriately trained in patient handling and the completion of the Falls and Bone Health Multifactorial Assessment (FBHMA).

We note that the observations below are based on the training of Health Board staff and do not include agency staff. We have been unable to determine what training agency staff receive on patient falls, and whether this is of the same standard and consistency as the training provided to Health Board staff.

2.8 The Falls Policy requires that staff must undertake relevant training to ensure that they have the required competencies to comply with their responsibility in implementing the policy and associated procedures.

All Health Board staff must complete the Mandatory Level 1a Adult Falls Prevention Awareness training on ESR. This training is to be completed every 2 Years.

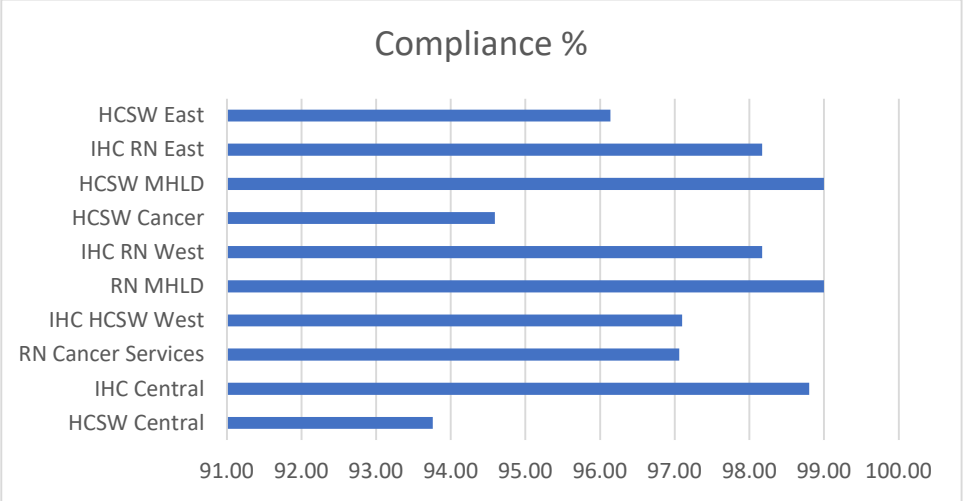
We reviewed the training required before an employee commences in a post where they may be moving / handling a patient or completing the FBHMA:

Level 1b Adult Falls Prevention Awareness training

Additional training for Clinical staff which includes instruction on how to complete the FBHMA and additionally the care and management of an adult patient following

an in-patient fall.

Table 1: Breakdown of compliance for 1b training up to August 31st, 2023.

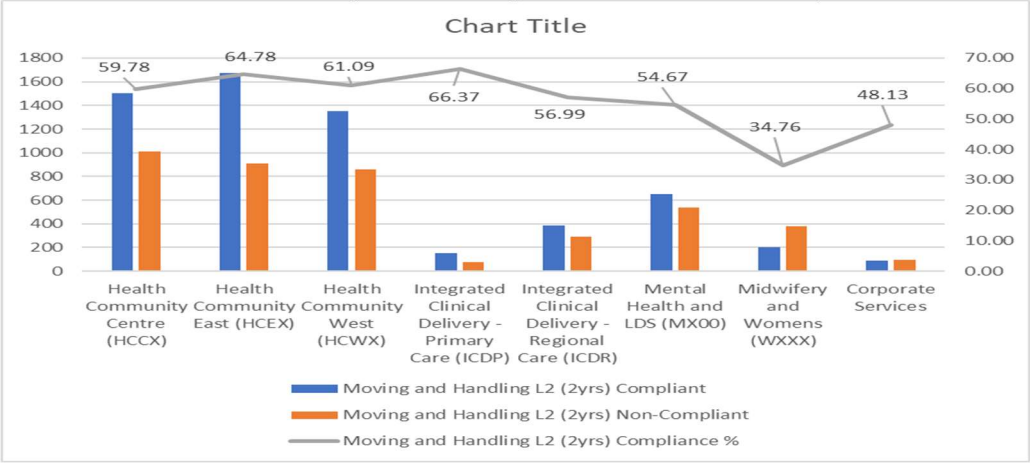


2.9 Patient Handling Training

Clinical staff must complete face to face training every two years which includes an overview of the FBHMA completion as well as care of the patient who may be falling / fallen / collapsed in line with the All Wales NHS Manual Handling Training Passport and Information Scheme.

Figures obtained from the Manual Handling Department show that as of the end of June 2023, from a total of 10,160 staff who require patient handling training 5,999 staff had been trained, with 4,161 non-compliant (59% trained).

Table 2 - Breakdown of compliance throughout the Health Board up to June 30th 2023



2.10 Level 2 Adult Safeguarding training

Clinical staff must complete the training, an element of the training includes post Falls management as per Falls Policy.

Following email correspondence with the Safeguarding Department it was determined that there was no reference to post falls management from a safeguarding perspective within the package.

2.11 Bedside Learning

Bedside learning has been introduced throughout the Health Board in Autumn 2022. A member of the Ward Accreditation Team will go through a live FBHMA while collaborating with a member of the ward's staff to identify good and bad practice. The learning is in real time with the real challenges the patients and environments pose.

At present the roll out of bedside learning is limited due to resources; it is currently delivered on an ad hoc basis by the Ward Accreditation Team or when it is requested by the wards.

2.12 Falls Champions on the Ward

A draft version of the Generic (Falls) Champion Framework was provided to us. The framework is generic and is used for other key Champion roles. It is envisaged that this framework will provide mentoring and coaching for the Champions as well as ensuring the right person for the role. The time allocated to perform the champions duties is seen as a challenge as training will be needed for the role to carry out bedside learning and monitoring of the FBHMA document.

Conclusion:

2.13 Training is in place for staff for both the FBHMA and patient handling. The Health Board currently has a 97% completion rate for the Adult Falls Prevention Awareness training. Compliance with the Patient Handling training requires improvement, as shown by the low completion in Table 2 of the report.

Clarification is required relating to safeguarding training and the inclusion of post falls management.

Due to resource constraints, bedside learning is currently undertaken on an ad hoc basis. The implementation of falls champions on the wards would facilitate this learning process.

We were unable to establish the quality and consistency of the patient falls training that agency staff had undertaken. It is noted that there is a high number of agency staff on wards at present, so this is a high-risk area for the Health Board which needs to be addressed, ensuring agency staff are able to effectively complete the FBHMA.

We have concluded **limited assurance** for this objective.

Objective 4: There is regular reporting and scrutiny of falls data at an appropriate forum. Falls incidents are investigated and monitored to identify themes, trends and lessons learned, with assurance provided to the Health Board.

2.14 We reviewed the following meetings (section 6 of the policy) to establish the reporting and assurance to the Health Board.

Quality Safety and Experience (QSE & Executive Delivery Group - Quality (EDGQ)

Health Board Patient Safety Group Terms of Reference

The PSG shall:

- *provide a Chair's Assurance Report that will be shared with the QDG (additionally, a Patient Safety Report is provided to the QSE Committee which will include details of the work of the PSG).*

Patient safety reports which included falls key actions were presented to the QSE meetings on the following dates 20th January 2023, 19th May 2023 and 25th July 2023. We note that the QSE did not take place from 20th January 2023 – 19th May 2023.

We were provided with the following minutes: 12 June, 14 August 2023; and agendas: 14 August & 11 September 2023 from the Executive Delivery Group for Quality (EDGQ). The EDGQ agendas for August and September each include the chairs' reports from the Patient Safety Group. It should be noted that the EDGQ meeting in July 2023 was a workshop and the meeting in September 2023 was stood down.

Health Board Patient Safety Group

Three sets of minutes were provided to us for meetings which took place on the following dates 21 April; 24 May and 22 June 2023.

We noted:

- Chairs report from the strategic Patient Safety Group can be seen being presented at all the of the minutes provided which includes: -
    - Issues for escalation requiring action and for information.
    - Summary of business conducted including training and establishment of weekly IHC harms meeting.
    - Data on inpatient falls (total number of falls).
    - Resources.

Strategic Inpatient Falls Steering Group

Three sets of minutes were provided to us for meetings which took place on the following dates 24 November 2022; 6 April and 25 May 2023.

We noted:

- Feedback from the Strategic Community Prevention of Falls Group, All Wales Falls Group and Strategic Occupational Health and Safety Group.
- Updates on training compliance for 1a, 1b, and Patient Handling.
- Performance data including level of harm per division, area, and how to accurately record falls on Datix to ensure assisted falls are recorded as falls.
- PowerPoint presentation on types of falls, and number of falls, broken down into areas, RIDDORs and severity of falls.
- Due to the high number of RIDDORs, a decision has been made to continue with the current position i.e. all staff regardless of work area need to complete 1a training in order to have an increased awareness of falls.

2.15 The table below highlights the number of inpatient falls between 1 June and 31 August 2023 and the number of RIDDORs reported to the Health and Safety Executive (HSE).

Incident Service - BCU Division	No of Incidents	RIDDORs
Cancer Services	7	
Dentistry	1	
IHC Central	350	
IHC East	308	
IHC West	230	2
Integrated Health Community (IHC) - (Old hierarchy)	3	
Mental Health and Learning Disabilities	136	
Midwifery and Women's Services	10	
(blank) no Division Highlighted	30	
Total	1075	2

2.16 Within the minutes of the Group on 24 November 2022 it states that the frequency of meetings is changing:

"The Strategic Falls Group has moved to bi-monthly meetings but attendance has not been as expected".

We did not receive any minutes for December 2022 to March 2023 with the January 2023 meeting being stood down. April and May meetings were convened on a monthly basis. The Terms of Reference (TOR) does state monthly however we are advised that the TR will be reviewed at the next meeting.

2.17 As evidence of regular investigating and monitoring of falls, details from harms meetings that take place in all three areas were provided to us.

Every week, harms meetings are held where all recent falls are discussed. The details of the falls are reviewed to determine if the falls were avoidable or unavoidable.

We note that we were provided with evidence to demonstrate discussions concerning falls, including the updating of DATIX as cases were addressed, the review of fall documentation, and what had been done to reduce the risk of the patient falling in the future.

2.18 Along with the harms meetings, evidence of learning lessons was provided, which included:

- Falls presentation at quarterly 'safety days' on sites.

- Alerts regrading falls.
- Emails highlighting incidental findings from a fall.
- Discussions on post falls i.e. issues around lying and standing blood pressure.

We note that while evidence of lessons learned has been provided, there does not appear to be a standard procedure in place for identifying themes, patterns, and lessons learned.

2.19 When completing a DATIX incident form, a lessons learned section needs completing when closing the incident. A total of 851 had been closed from our sample of 1,075. All 851 had completed the lessons learned section. Of the 851 incidents, 317 had input comments such as "N/A," "As above," "NIL," and "Non Identified." Seven events had a full stop or a dash recorded within the section of lessons learned.

2.20 Weekly and monthly matrons audits are conducted as part of ward accreditation, these look at the FBHMA as well as other areas that need to be reviewed.

We received evidence of the audits from the wards we sampled, whilst confirming that the necessary audits are being conducted on schedule. We note the majority of the audits are achieving 100% when answering the question below.

"Have all sections of the falls pathway been completed accurately?"

Concerning the lack of detail, this does not correspond to the results of the testing we undertook on the FBHMA.

Conclusion:

Lessons learned are being shared, but the Health Board's approach to patient falls can be improved with a robust process that regularly identifies themes, patterns, and lessons learned.

Consideration needs to be given to a drop-down box within the lessons learned section in Datix order to prevent staff inputting a full stop or a dash – This undermines the ability of the Health Board to demonstrate it is a learning organisation.

Our sample findings do not correspond to the high percentage scores that the weekly and monthly matrons audits are achieving in regard to the FBHMA completion accuracy. The FBHMA are complete, however the lack of detail has the ability to obscure the patient's actual needs.

A review of incident data from Datix relating to falls highlights over 1,000 falls in a three month period, with two classed as RIDDOR reportable falls. We are advised the two incidents were within the West IHC, with no RIDDORs reported for Central or East. Whilst we have not reviewed the details of these falls and made no recommendations, the RIDDOR figures appear low and require urgent review.

We have concluded **limited assurance** for this objective.

Appendix A: Management Action Plan

Matter Arising 1: Policy (Design)			**Impact**
The Prevention and Management of Adult In-Patient Falls NU06 situated on the intranet is currently outdated and requires review.			Potential risk of: • Staff are not provided with up to date policies and procedures, increasing the likelihood of non-compliance with requirements.
Recommendations			**Priority**
1.1a	The Policy requires review to ensure staff are provided with up to date requirements and guidance relating to falls. We understand this process is currently underway.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
1.1a	Policy NU06 The Prevention and Management of Adult Inpatient Falls will be: • Review/consultation by Health Board Inpatient Falls Steering group; • Approval required by the Health Board Patient Safety Group; • Health Board Clinical and Written Documents policy process for uploading, communication and replacing of the current version on Betsinet	30th November 23 30th November 23 31st December 23	Ward Accreditation Team Lead / Deputy Executive Director of Nursing

Matter Arising 2: All Wales Falls and Bone Health Multifactorial Assessment (FBHMA) (Operation)	**Impact**
A number of issues were identified through our testing of completion of the FBHMA: • Lack of detail in the FBHMA when identifying each patient's unique risk factors for falling, such as sensory and communication components of the forms. • FBHMA forms, communication, mobility domains, and patient handling assessment forms although digitised are separate. • Contradicting detail within the relevant documentation. • Inconsistency in FBHMA not being reviewed when patients are transferred between wards. • FBHMAs tended to focus on the patients issues rather than what is necessary to help other staff members understand requirements to mitigate the risks of a potential fall. • Nurse perception of risk in relation to patient falls varied. • Abbreviation of terminology within two of the FBHMA. • Fifteen of the 42 forms were not completed within a six-hour timeframe in accordance with the Policy.	Potential risk of: • FBHMA assessments are not completed appropriately and do not identify requirements to mitigate the risk of patient falls.

Recommendations		**Priority**
2.1a	Staff should be reminded, through training, of the requirement to ensure the FBHMA and documentation pertaining to patient falls, provides sufficient information to fully understand the patients needs and requirements to minimise the risk of a potential fall. Compliance with this should be reviewed through existing audit mechanisms.	**High**
2.1b	To reduce the inconsistent information amongst documentation, standardising of patient fall documentation should be considered.	
2.3c	Reminder to staff that all FBHMAs are to be completed upon patient transfer between wards. Compliance with this should be reviewed through existing audit mechanisms.	

Agreed Management Action		**Target Date**	**Responsible Officer**
2.1a	• Health Board mandatory training Falls Prevention E learning module 1b relating to the FBHMA has been updated;	Completed	Deputy Executive Director of Nursing

2.1b	• How to guide/good practice guide to support Adult Inpatient with completion and quality of FBHMA to be developed and implemented across all Adult Inpatient wards; • In addition to the established Health Board monitoring mechanisms, an additional level of monitoring/coaching to improve the quality of the risk assessments will be implemented across the Adult Inpatient wards, this will be a peer review process completed by suitably trained registrant. This will be a pilot of 3 months, evaluate outcomes and present recommendation to the Strategic inpatient falls Group for sustainable model. • The Welsh Nursing Care Record currently does not auto populate with patient detail such as mobility status form the admission assessment section into the FBHMA. This will be future enhancement to the Welsh Nursing Care Record on an all-Wales basis. To mitigate this risk: o the Health Board Training resources stress the requirement for using this detail to promote accurate and consistent patient profile.	30th November 23 1st February 24 1st February 24 then ongoing	Deputy Executive Director of Nursing
2.1c	• Training resources outlined 2.1a will include the re enforcement of when the FBHMA requires review and updating in line with national standard. • The B6 Clinical MH Advisors now lead the patient risk assessment bedside learning programme (for falls and patient handling risk assessments) for the H&S team.	30th October 23	

Matter Arising 3: Training (Operation and Design)			**Impact**
At the time of writing this report only 59% of staff had completed the Health Boards patient handling training. Other issues relating to training include: • Safeguarding training does not reference post falls management. • Bedside learning is presently done on ad hoc basis due to resource constraints. • There is no overview of the training undertaken by agency staff relating to patient falls, to ensure they are aware of the requirements when completing falls documentation.			Potential risk of: • Staff are not trained appropriately in falls management, resulting in increased risk of patient falls.
Recommendations			**Priority**
3.1a	To review training compliance for all areas relating to Patient Handling training and ensure staff who require training undertake this as soon as possible.		**High**
3.1b	Review Safeguarding training to include post falls management.		
3.1c	Consider a more formal training method for the bedside learning programme, and consider resources required to provide this to staff. Ensure records of training are kept.		
3.1d	Determine what training agency staff receive relating to patient falls and whether it is in line with training that the Health Board staff undertake and sufficient to ensure effective completion of falls documentation.		
Agreed Management Action		**Target Date**	**Responsible Officer**

3.1a	Manual Handling (MH) is a Tier One risk on the BCUHB risk register scoring 16 requiring regular review of actions being completed. MH training compliance 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. Capacity within the MH training team to be optimised with focused recruitment drive for Band 6 posts (x3) supported by workforce Internal training facilities to be identified by each IHC by December 2023.	January 2024	Head of Health, Safety and Security
3.1b	MH corporate team to progress contract arrangements for external training facilities to support capacity by December 2023. Text messaging reminders for booked training session to be implemented to reallocate capacity from Did Not Attend (DNA) individuals.	30th December 23	Head of Health, Safety and Security
3.1c	Health Board Falls Lead to make a formal request to the Safeguarding all Wales programme regarding consideration of safeguarding following recurrent falls. Falls lead to include Safeguarding matrix within the revised Falls Policy NU06 to support staff as to when to refer/engage Safeguarding following recurrent falls.	1st April 24	Deputy Executive Director of Nursing
3.1d	Bedside learning programme to be recommended as a formal programme of training that will be implemented collaboratively with IHC Practice Development Nurses, Corporate Patient Safety team and Health & Safety team.	1st December 23	Head of Digital Workforce and Resourcing

	Scope of what training agency staff (58 external agencies part of the All Wales Framework) receive relating to patient falls and whether it is in line with training that the Health Board staff undertake and sufficient to ensure effective completion of falls documentation. • Temporary Staffing team for the Health Board to ensure the agencies have access to the Health Board e learning packages and are encouraged to complete; • the Health Board are amending and implementing the agency worker ward induction documentation to include familiarisation with risk assessments.	Complete Completed	Head of Digital Workforce and Resourcing

Matter Arising 4: Governance (Operation)			**Impact**
Although there has been evidence of lessons learned, it is not clear if there is a standardised process in place for identifying themes, patterns, and lessons learned. Staff are completing the lessons learned section of DATIX however not all information inputted relates to lessons learned. Our sample findings do not correspond to the high percentage scores that the weekly and monthly matrons audits are achieving in regard to the FBHMA completion of accuracy.			Potential risk of: • Repeated falls incidents taking place due to lack of learning and sharing of information.
Recommendations			**Priority**
4.1a	The development of a standardised strategy that routinely identifies themes, trends, and lessons learned could enhance health boards' response to patient falls.		**High**
4.1c	Lessons learned information included in Datix should be reviewed regularly to ensure learning is communicated / reported as appropriate, and to deter staff entering a full stop or a dash in the section.		
4.1d	Review the ward accreditation audits on the FBHMA to establish if the audits can include specific questions on detail that give a true reflection of the patient requirements.		
Agreed Management Action		**Target Date**	**Responsible Officer**
4.1a	The revised Health Board policy NU06 outlines the following process for Inpatient falls to support identification of themes, trends and learning as follows: • Hot debrief on the ward following the fall for immediate learning and mitigation; • All falls are reviewed daily by local quality teams; • All falls are subject to focused review contained within Datix system;	1st December 23	Deputy Executive Director of Nursing

	• All falls identified as harm being Moderate or above will have a Make it safe review within 72 hrs; • All falls identified as serious harm will have an executive led Rapid Learning Panel (RLP) which may then lead to an external investigation to identify potential additional learning opportunities. • The Health Board will communicate the revised policy NU06 via Health Board communication channels in addition core Health Board meetings. • Ongoing Monitoring will be via Patient Safety team.		
4.1b	• Each Integrated Health Community (IHC) Health Board has established weekly harms review meeting that includes Inpatient Falls, to improve the sharing of lessons learned the Health Board will develop a SOP to ensure standardised practice across the IHC's.	30th December 23	Deputy Executive Director of Nursing
	• The Health Board Patient Safety team will provide a weekly report from Datix of the previous weeks closed incidents to monitor quality of completion to be sent to IHC Directors of Nursing and IHC Governance leads to action locally this will be an ongoing process;	Completed	Deputy Executive Director of Nursing
	• The Health Board Patient Safety team will provide training and support to clinical teams to include best practice, lessons learned etc due to commence November 23 and will be an ongoing programme of training and support across the Health Board.	20th November 23 then ongoing	Deputy Executive Director of Nursing
4.1c	The ward accreditation metrics are currently under review as part of the Health Board Ward Accreditation review. The revised metrics will be tested across the Health Board Inpatient wards to confirm the appropriateness and level of detail within the metric.	1st April 24	Deputy Executive Director of Nursing

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**Unsatisfactory assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

* Unless a more appropriate timescale is identified/agreed at the assignment.

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4-5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ

Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

Teitl adroddiad: ***Report title:***	Draft Terms of Reference and Cycle of Business			
Adrodd i: ***Report to:***	Quality Safety and Experience (QSE) Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Tuesday, 19 December 2023			
Crynodeb Gweithredol: ***Executive Summary:***	The Office of the Board Secretary is working 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. This will consist of a workshop style meeting with the Chairs of the Committee, the Executive Leads and Committee Leads. This is to be transacted outside of the Committee. An outline remit of each Committee was approved by the Board on 28 September 2023. Then a draft Version 1 Terms of Reference and Cycle of Business was developed and reviewed at the Audit Committee on 16 November 2023 and then received at the Health Board meeting on 30 November 2023. These versions will now be reviewed by the and any feedback received and updates provided on a Draft Version 2 that will be shared by email with the Independent Members of the Committee for any final reflections. This report gives the whole of the QSE Committee an additional opportunity to provide feedback either at the meeting or after the meeting			
Argymhellion: ***Recommendations:***	The Committee is asked to **note** and **consider** the Draft Terms of Reference and to provide feedback on them to the Office of the Board Secretary			
Arweinydd Gweithredol: ***Executive Lead:***	Phil Meakin, Acting Board Secretary			
Awdur yr Adroddiad: ***Report Author:***	Philippa Peake-Jones, Head of Corporate Affairs			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☒	I Benderfynu arno *For Decison* ☐	Am sicrwydd *For Assurance* ☐	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol	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*

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

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:

- ✓ Each Committee Chair, Exec Lead and Committee Lead to Review the Terms of Reference and Cycle of Business for their Committee ahead of the meeting with the Office of the Board Secretary if possible – **Chair and Exec Leads for Committee**
- ✓ If assurance and reassurance is required on the information provided then please review the information provided in the final slide or speak to Phil Meakin, Philippa Peake-Jones or Laura Jones **– Chair and Exec Leads for Committee**
- ✓ To provide feedback at the meeting being arranged by the Office of the Board Secretaries on any content matter of the Terms of Reference or insights into the Cycle of Business **- All**
- ✓ If a Committee is planned during December or early January then this gives an additional opportunity for Terms of Reference review "twice". The Chair of the Committee will need to agree to this of course – **Chair and Board Secretary**
- ✓ For all feedback to be collated and provided to the Audit Committee for review on 12 January 2024 **– Philippa Peake-Jones**
- ✓ Feedback from Audit Committee and these sessions to be collated for a Version 3 to be received by the Board for approval in January 2024. **Philippa Peake-Jones and Laura Jones**
- ✓ Corporate Calendars to be updated to support the implementation of the Committees **- Catrin Rhys-Williams and Laura Jones**
- ✓ Committee Leads to examine Cycles of Business informed by this meeting **–Philippa Peake-Jones and Committee Leads**
- ✓ **Philippa Peake-Jones** to draft Board Report with **Phil Meakin** oversight and support

Draft Terms of Reference for QSE Committee – Appendix 1

Draft Version 2 Cycle of Business – Appendix 2

1. Introduction

The Office of the Board Secretary is working 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.

This will consist of a workshop style meeting with the Chairs of the Committee, the Executive Leads and Committee Leads.

A draft Terms of Reference and Cycle of Business was reviewed at the Audit Committee in November 2023 and then received at the Health Board meeting in November 2023.

These versions will now be reviewed and any feedback received and updates provided on a Draft Version 2 that will be shared by email with the Independent Members of the Committee for any final reflections.

This report gives the whole of the QSE Committee an additional opportunity to provide feedback either at the meeting or after the meeting. **The Committee is asked to note and consider the Draft Terms of Reference/Cycle of Business and to provide feedback on them to the Office of the Board Secretary by the 29th December 2023.**

2. Terms of Reference

A Draft Terms of Reference version 2 is attached below.

3. Cycle of Business

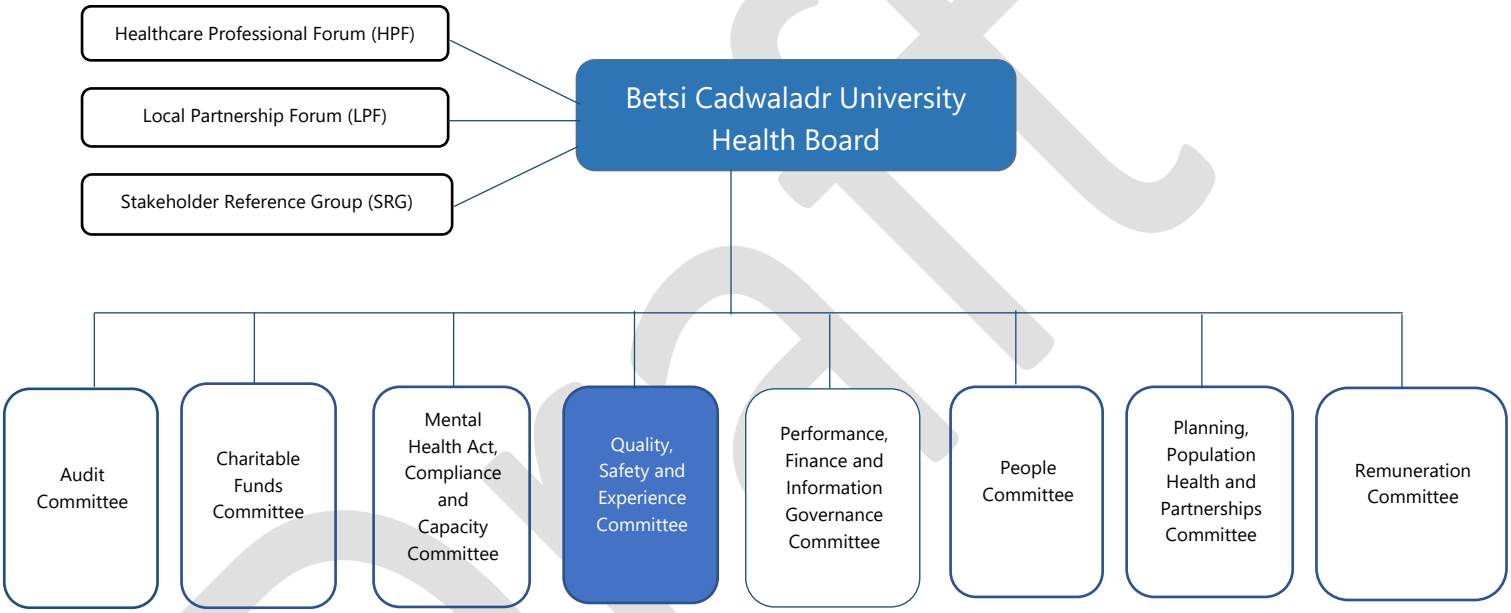
A Draft Cycle of Business is attached below

4. Next Steps

- Each Committee Chair, Exec Lead and Committee Lead to Review the Terms of Reference and Cycle of Business for their Committee ahead of the meeting with the Office of the Board Secretary if possible – **Chair and Exec Leads for Committee**
- If assurance and reassurance is required on the information provided then please review the information provided in the final slide or speak to Phil Meakin, Philippa Peake-Jones or Laura Jones **– Chair and Exec Leads for Committee**
- To provide feedback at the meeting being arranged by the Office of the Board Secretaries on any content matter of the Terms of Reference or insights into the Cycle of Business **- All**
- If a Committee is planned during December or early January then this gives an additional opportunity for Terms of Reference review “twice”. The Chair of the Committee will need to agree to this of course – **Chair and Board Secretary**
- For all feedback to be collated and provided to the Audit Committee for review on 12 January 2024 **– Philippa Peake-Jones**
- Feedback from Audit Committee and these sessions to be collated for a Version 3 to be received by the Board for approval in January 2024. **Philippa Peake-Jones and Laura Jones**
- Corporate Calendars to be updated to support the implementation of the Committees **- Catrin Rhys-Williams and Laura Jones**
- Committee Leads to examine Cycles of Business informed by this meeting **–Philippa Peake-Jones and Committee Leads**
- **Philippa Peake-Jones** to draft Board Report with **Phil Meakin** oversight and support.

QUALITY, SAFETY AND EXPERIENCE COMMITTEE

TERMS OF REFERENCE



Version	Issued to	Date	Comments
V0.01~~Draft Version~~	Audit Committee	16/11/23	Developed as a first draft for review with Committee Chairs and Lead Executives
V0.02	Meeting of Chair and Lead Execs of the Quality, Safety and Experience Committee	11/12/23	Updated after a desktop review of all ToR against the requirements of the OBS Review

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:

2.1 Scrutinise, assess and seek assurance in relation to the patient 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 to the Board 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.

2.4 Assure the development and delivery of the enabling strategies within the scope of the Committee, aligned to organisational objectives and the Annual Plan/Integrated Medium-Term Plan for sign off by the Board.

2.5 To receive an assurance on delivery against relevant Planning Objectives aligned to the Committee, in accordance with Board approved timescales, as set out in the Annual Plan.

2.6 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.

3) Objectives of the 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. ~~e.g. where risk tolerance is exceeded, lack of timely action.~~

3.3 Recommend acceptance of risks that cannot be brought within the Health Boards risk appetite/tolerance to the Board through the Committee Update Report.

3.4 Receive assurance through Sub-Committee Update Reports that risks relating to their areas are being effectively managed across the whole of the Health Board's activities (including for hosted services and through partnerships and Joint Committees as appropriate).

3.5 Ensure the right enablers are in place to promote a positive culture of quality improvement based on best evidence.

3.6 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.

3.7 Oversee the development and implementation of strengthened and more holistic approaches to triangulating intelligence to identify emerging issues and themes that require improvement or further investigation.

3.8 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 the capacity and capability to deliver, and lessons are learned from patient safety incidents, complaints and claims.

3.9 Provide assurance to the Board that current and emerging clinical risks are identified and robust management plans are in place and any learning from concerns is applied to these risks as part of this management.

3.10 Provide assurance to the Board in relation to improving the experience of patients, including for those services provided by other organisations or in a partnership arrangement. Patient Stories and Board to Floor Walkabouts will feature as a key area for patient experience and lessons learnt.

3.11 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.

3.12 Ensure that the organisation is meeting the requirements of the NHS Concerns, Complaints and Redress Arrangements (Wales) Regulations.

3.13 Approve the required action plans in respect of any concerns investigated by the Ombudsman.

3.14 Agree actions, as required, to improve performance against compliance with incident reporting.

3.15 Provide assurance that the Central Alert Systems process is being effectively managed with timely action where necessary.

3.16 Provide assurance on the delivery of action plans arising from investigation reports and the work of external regulators.

3.17 Approve the annual clinical audit plan, ensuring that internally commissioned audits are aligned with strategic priorities.

3.18 Provide assurance that a review process to receive and act upon clinical outcome indicators suggesting harm or unwarranted variation is in place and operating effectively at operational level, with concerns escalated to the Board.

3.19 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 who will collectively agree recommendations for consideration through relevant Committee structures.

3.20 Provide assurance in relation to the organisation's arrangements for safeguarding vulnerable people, children and young people.

3.22 Approve policies and plans within the scope of the Committee, having taken an assurance that the quality and safety of patient care has been considered within these policies and plans.

3.23 Assure the Board in relation to its compliance with relevant healthcare standards and duties, national practice, and mandatory guidance.

3.24 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.

3.254 Refer quality & safety matters which impact on other Board Committees and vice versa.

3.267 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)
~~Independent Member (Vice Chair)~~ A Vice Chair will be sought through due process in the Committee
2 x Independent Members (to be developed and agreed with Chair of the Health Board)

4.2 The following should attend Committee meetings:

IN ATTENDANCE
Executive Director of Nursing and Midwifery (Lead Executive) **~~Other Executive Directors as required by the Chair including:~~**
Executive Medical Director
Executive Director of Therapies and Health Sciences **Other Executive Directors as required by the Chair including:**
Executive Director of ~~Primary Care & Community Services~~Operations
Executive Director of Workforce & Organisational Development
Executive Director of Public Health
Other Senior Managers as required by the Chair including
Director of Performance
Associate Director of Quality Assurance
Director of Mental Health & Learning Disabilities
Senior Associate Medical Director
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 less 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. To include 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 either 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, they may nominate a deputy to attend in their 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 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 Lead Director the Executive Director of Nursing and Midwifery at least six weeks before the meeting date.

6.2 The agenda will be based around 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 Lead Director.

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 days of the meeting. The minutes and table of actions will be circulated to the Lead Director within seven days to check the accuracy, prior to sending to Members (including the Committee Chair) 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 approval.

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 Lead Director.

8.4 The Committee may, subject to the approval of the Health Board, establish ~~sub-committees or task and finish~~ 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 Board Secretary.

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 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 Committees activities.
- Bring to the Boards specific attention any significant matter under consideration by the Committee.
- Ensure appropriate escalation arrangements are in place to alert the Health Boards 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 Office of the Board Secretary will lead this review.

10) Accountability, Responsbility 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 Boards 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 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.

QUALITY, SAFETY & EXPERIENCE COMMITTEE (QSE)

Item of Business	Purpose	Lead	April	June	August	October	December	February
Opening items								
Apologies		Chair	✓	✓	✓	✓	✓	✓
Declarations of Interest		Chair	✓	✓	✓	✓	✓	✓
Minutes from previous Meeting		Chair	✓	✓	✓	✓	✓	✓
Matters Arising & Table of Actions		Chair	✓	✓	✓	✓	✓	✓
Report of the Chair • Chair's Action • Feedback from Board		Chair	✓	✓	✓	✓	✓	✓
Notification of Matters referred from other Board Committees on this or future agendas		Chair	✓	✓	✓	✓	✓	✓
Annual review of ToR		Board Secretary *Head of Corporate Affairs*	✓					
Annual review of CoB		Board Secretary *Head of Corporate Affairs*	✓					
Committee Annual Report		Board Secretary *Head of Corporate Affairs*	✓					
Patient Story		Executive Director of Nursing and Midwifery *Deputy Director of Quality Governance*	✓	✓	✓	✓	✓	✓
Quality Planning								
Quality Strategy Annual Priorities	Agree annual priorities for quality, underpinning delivery of the overall Quality Strategy	Executive Director of Nursing and Midwifery *Deputy Director of Quality Governance*	✓					
Quality Control								
Patient Safety Report	Providing information on key patient safety issues and mitigations including nationally reportable incidents, safety alerts, maternity and neonatal safety and mortality, safeguarding and infection prevention and control	Executive Director of Nursing and Midwifery *Deputy Director of Nursing*	✓		✓		✓	
Patient and Carer Experience Report	Providing information on key patient and carer experience issues and mitigations including complaints, accessible healthcare and patient feedback	Executive Director of Nursing and Midwifery *Deputy Director of Nursing*		✓		✓		✓
Clinical Effectiveness Update Report	Providing information on key clinical effectiveness issues and mitigations including clinical audit, NICE guidelines and external peer reviews. The April report will include the proposal annual clinical audit plan.	Executive Medical Director *Deputy Medical Director*	✓		✓		✓	
Clinical Service of Concern Report	Providing information on issues, risks, mitigations and improvements for clinical services of concern (to be decided by the Committee)	Executive Medical Director *Deputy Medical Director*	✓	✓	✓	✓	✓	✓
Quality Delivery Group Chair's Report		Executive Director of Nursing and Midwifery *Deputy Director of Quality Governance*	✓	✓	✓	✓	✓	✓

QUALITY, SAFETY & EXPERIENCE COMMITTEE (QSE)

Item of Business	Purpose	Lead	April	June	August	October	December	February
WHSSC Quality Committee Chair's Report		Executive Director of Nursing and 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	✓ Central IHC	✓ West IHC	✓ Primary Care Dental	✓ MHLD	✓ Cancer Diagnostics Womens
Quality Assurance								
Corporate Risk Register & Board Assurance Framework		Board Secretary *Head of Risk Management*	✓	✓	✓	✓	✓	✓
Special Measures Report		Executive Director of Strategy and Transformation *Director of Transformation and Improvement*	✓	✓	✓	✓	✓	✓
Regulatory Report	Providing information on regulatory compliance including new HIW, CIW and PSOW reports (including Public Interest Reports) and action plan progress	Executive Director of Nursing and 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 and Midwifery *Deputy Director of Quality Governance*	✓			✓		
Nurse Staffing Act Report	Statutory bi-annual report	Executive Director of Nursing and Midwifery *Deputy Director of Nursing*	✓			✓		
Annual Quality Report	Statutory annual report	Executive Director of Nursing and 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 and Midwifery *Deputy Director of Quality Governance*		✓				
Safeguarding Annual Report	Statutory annual report	Executive Director of Nursing and Midwifery *Director of Nursing (Safeguarding)*		✓				

QUALITY, SAFETY & EXPERIENCE COMMITTEE (QSE)

Item of Business	Purpose	Lead	April	June	August	October	December	February
IPC Annual Report	Statutory annual report	Executive Director of Nursing and Midwifery *Director of Nursing (IPC)*		✓				
Research Annual Report		Executive Medical Director *Associate Medical Director (Research)*		✓				
Organ Donation Annual Report	Statutory annual report	Executive Director of Therapies and Health Sciences		✓				
Quality Improvement								
Quality Strategy Monitoring Report		Executive Director of Nursing and Midwifery *Deputy Director of Quality Governance*	✓			✓		
Closing items								
Agree Items for referral to Board / Other committees		Chair	✓	✓	✓	✓	✓	✓
Review of Risks highlighted in the meeting for referral to Risk Management Group		Board Secretary *Head of Risk Management*	✓	✓	✓	✓	✓	✓
Agree items for Chairs Assurance Report		Chair	✓	✓	✓	✓	✓	✓
Review of Meeting Effectiveness		Chair	✓	✓	✓	✓	✓	✓
Report items discussed in previous meeting private session		Chair	✓	✓	✓	✓	✓	✓
Date of next meeting		Chair	✓	✓	✓	✓	✓	✓
Private Business								
Apologies		Chair	✓	✓	✓	✓	✓	✓
Declaration of Interests		Chair	✓	✓	✓	✓	✓	✓
Minutes from previous meeting		Chair	✓	✓	✓	✓	✓	✓
Matters arising & Table of Actions		Chair	✓	✓	✓	✓	✓	✓
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 and Midwifery *Deputy Director of Quality Governance*	✓	✓	✓	✓	✓	✓

Items to be discussed at round table discussions:

Immunisation Services								
Human Tissue Authority		Executive Medical Director						
Controlled Drugs Local Intelligence Network Annual Report		Executive Medical Director						
Cancer Services Annual Report		Executive Medical Director						
Strategic Operational Health & Safety Report								

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								