Bundle Quality, Safety and Experience Committee 20 February 2025

1 PRELIMINARY MATTERS

1.1 13:00 - QS25/01 Welcome and apologies
Caroline Turner, Chair
Apologies received from:
Imran Devji, Interim Chief Operating Officer
_Teresa Owen, Executive Director of Allied Health Professionals & Health Science (_Sue Brierley-Hobson, Assistant Director of Allied Health Professionals & Health Science to deputise)

1.2 QS25/02 Declarations of Interest
Caroline Turner, Chair

1.3 13:00 - QS25/03 Unconfirmed minutes of meeting held on 17th December 2024
Caroline Turner, Chair
QS25 03.1 Draft QSE minutes PUBLIC 17.12.24 v0.3 approved by CT

1.4 13:05 - QS25/04 Matters Arising and Action Log
Caroline Turner, Chair
QS25 04.1 QSE Action Log PUBLIC

1.5 13:10 - QS25/05 Patient's Story
Angela Wood, Executive Director of Nursing and Midwifery
QS25 05.1 Patient Story - My 22 hours in the Emergency Department

2 QUALITY PLANNING

2.1 QS25/06 Children's Services - Item deferred
Imran Devji, Interim Chief Operating Officer

3 QUALITY CONTROL

3.1 13:30 - QS25/07 Integrated Quality Report
Angela Wood, Executive Director of Nursing and Midwifery
Sreeman Andole, Interim Executive Medical Director
QS25 07.1 Integrated Quality Report - February 2025
QS25 07.2 IQR Appendix 1 BCUHB Q3 24-25 V3
QS25 07.3 IQR Appendix 2 Quarterly Data Jan 2025 Medical Examiner Service

3.2 14:10 - QS25/08 Integrated Performance Report
Stephen Powell, Director of Performance and Commissioning
QS25 08.1 Coversheet for IQPR for QSE 20022025 DRAFT v0.2
QS25 08.2 IQPR for QSE 20022025 DRAFT v0.2

3.3 14:30 - COMFORT BREAK

4 QUALITY IMPROVEMENT

4.1 14:35 - QS25/09 Quality Management System Update
Angela Wood, Executive Director of Nursing and Midwifery
QS25 09.1 QMS update January 2025 AW

4.2 14:50 - QS25/10 Ophthalmology - verbal update
Sreeman Andole, Interim Executive Medical Director

4.3 15:05 - QS25/11 Colonoscopy Performance Update - Item deferred
Imran Devji, Interim Chief Operating Officer

5 QUALITY ASSURANCE

5.1 15:05 - QS25/12 Health Board Response to the Royal College of Psychiatry Invited Services Review
Iain Wilkie, Director of Mental Health & Learning Disabilities
QS25 12.1 Health Board Response to the RCPsych Invited Services Review - Final

6 ROUTINE REPORTING

6.1 15:25 - QS25/13 Corporate Risk Register
Nesta Collingridge, Head of Risk Management
QS25 13.1 Corporate Risk Register Report QSE Committee February 2025 v2

7 ANNUAL REPORTING

7.1 15:40 - QS25/14 Designated Educational Clinical Lead Officer (DECLO) Annual Report
Sue Brierley-Hobson, Assistant Director of Allied Health Professionals & Health Science
QS25 14.1 DECLO Annual Report Sept 2024 Coversheet
QS25 14.2 DECLO Annual Report Sept 2024

8 FOR INFORMATION

8.1 QS25/15 Summary of Business to be Reported from Private
QS25 15.1 Summary of Business to be reported from Private 17.12.24

8.2 QS25/16 Review Committee Forward Workplan
QS25 16.1 QSE Forward Work Plan - live document

8.3 QS25/17 Review Committee Cycle of Business
QS25 17.1 QSE CoB V0.01 (Live Version as at 06.01.25)

8.4 QS25/18 Llais Annual Report and Accounts 2023-24
QS25 18.1 Llais Annual Report & Accounts 2023-2024

9 CLOSING BUSINESS

9.1 15:55 - QS25/19 Agree items for Referral to Board
Caroline Turner, Chair

9.2 15:57 - QS25/20 Meeting Effectiveness
Caroline Turner, Chair

9.3 QS25/21 Date of Next Meeting
13.00hrs, Thursday, 17th April 2025

9.4 15:59 - Resolution to Exclude the Press and Public Chair
Caroline Turner, Chair
'Those representatives of the press and other members of the public be excluded from the remainder of this meeting, having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest, in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960'.

Betsi Cadwaladr University Health Board (BCUHB)
Minutes of the Quality, Safety and Experience Committee meeting held in public
on 17th December 2024, The Boardroom, Carlton Court, St Asaph

Board Members present	
Name	**Title**
Dr Caroline Turner	Committee Chair
Urtha Felda	Independent Member
Chris Lothian-Field	Committee Vice Chair
Prof Mike Larvin	Independent Member
In Attendance	
Carol Shillabeer	Chief Executive Officer (part meeting)
Angela Wood	Executive Director of Nursing & Midwifery
Dave Harris	Head of Internal Audit
Sreeman Andole	Interim Executive Medical Director (part meeting)
Imran Devji	Interim Chief Operating Officer (part meeting)
Matt Joyes	Deputy Director for Legal Services
Lois Lloyd	Chief Pharmacist
David Maslen-Jones	Assistant Director of Occupational Health, Safety and Security
Jane Moore	Acting Executive Director of Public Health
Teresa Owen	Executive Director of Allied Health Professionals and Health Science
Philippa Peake Jones	Head of Corporate Affairs
Pam Wenger	Director of Corporate Governance
Brace Griffiths	Llais, North Wales
Iain Wilkie	Interim Director MHLD
Stephen Powell	Director of Performance and Commissioning
Nichala Jones	Interim Head of Operations and Service Delivery, Mental Health and Learning Disability, West (part meeting)
Phil Meakin	Associate Director of Governance (part meeting)
Saffie Roberts	Specialist Nurse in Organ Donation (part meeting)
Nesta Collingridge	Head of Risk Management
Chris Stockport	Executive Director of Transformation and Strategic Planning (part meeting)
Fiona Lewis	Minute Taker

Agenda Item
PRELIMINARY MATTERS
QS24/139 Welcome and apologies **QS24/139.1** Apologies were received from Jason Brannan (Deputy Director of People) noting that David Maslen-Jones (Assistant Director of Occupational Health, Safety and

Security) would be in attendance in his behalf. The Chair welcomed Dr. Sreeman Andole (Interim Executive Medical Director) and Imran Devji (Interim Chief Operating Officer) to their first meeting.

The Chair welcomed Brace Griffiths attending on behalf of Llais North Wales.

QS24/140 Declarations of Interest

None were received.

QS24/141 Unconfirmed minutes of meeting held on 24th October 2024

It was resolved that the Committee
Agreed the minutes were a true and correct record of the meetings held 24th October 2024 subject to the minor amendments.

[Carol Shillabeer joined the meeting]

QS24/142 Matters Arising and Action Logs

There were no comments on the action log.

The Chair welcomed the two updates received – the Flow Chart G4 G5 Complaints Process and the Complaints Improvement Deep Dive – and welcomed the progress made in reducing the backlog.

It was resolved that the Committee

- **Agreed** the updated log.

QS24/143 Patient Story – Gareth's Journey

The Executive Director of Nursing and Midwifery introduced a video presented by both the mother and partner of Gareth, a young gentleman, who presented at both the Emergency and Intensive Care Departments in Wrexham Maelor Hospital, in June 2023. Gareth sadly passed away, however through organ donation was able to save and transform four lives. Gareth's family had approached the Patient Care Experience team to ask if they would be able to share their story. Their story and the feedback contained within, resulted in improvements being made.

In discussing the report, the Committee were told:

- Gareth experienced delays in care and treatment in the Emergency Department, and this was discussed in detail.
- Gareth received exemplary care in Intensive Care department where the nurses showed great kindness, compassion and sensitivity.
- Despite the challenges, Gareth's organ donation after his passing saved four lives, transforming the lives of the recipients.

In discussing the report, the committee discussed:

- The importance of organ donation, and the impact of Gareth's selfless act were emphasized.
- The Committee, on behalf of the Health Board, expressed sincere condolences to Gareth's family and gratitude for sharing Gareth's story.
- The circumstances surrounding Gareth's journey through the Emergency Department, analysing where improvements could be made and implemented appropriate actions.
- The Specialist Nurse in Organ Donation described how proud she was to be part of the Organ Donation Team but noted that despite being world leaders in transplants by bringing in the 'opt-out system', consent rates in North Wales were reducing and felt that a new approach was required to raise awareness with both staff and the public.
- The Executive Director of Nursing and Midwifery was pleased to note that both she and the Executive Director of Allied Health Professionals and Health Science had attended the Annual Organ Donation Remembrance Service, which continues to be very well attended, to celebrate both the lives of those who have donated their organs and also the lives of the recipients, who along with their families, wished to give thanks.
- The Chief Executive Officer was very pleased to note that the Health Board was using people's experiences to help shape and steer the organisation.
- The Chair asked that raising awareness of Organ Donation should be included in the AAA report, and therefore be referred to Board.

Actions:

- **QS24/143.1** The Minute Taker to ensure this subject is included in the AAA report to be referred to Board to raise awareness with people who might engage.

It was resolved that the Committee

- **Noted** the report.

[The Interim Chief Operating Officer and Interim Head of Operations and Service Delivery, West, joined the meeting. The Specialist Nurse in Organ Donation left the meeting]

SERVICE PRESENTATION

QS24/144 Learning and Disabilities Deep Dive

The Executive Director of Allied Health Professionals and Health Science introduced The Interim Head of Operations and Service Delivery Mental Health and Learning Disability (West), who presented the report which highlighted the following:

- **Overview of Services provided:**
- A bed-based provision with two assessment and treatment units, with an additional Continuing Healthcare provision in Bryn-y-Neuadd Hospital.
- Six Learning Disability community teams across North Wales, which continue to be co-located with local authority partners
- Specialist behaviour support services

- Health Liaison services, instrumental in supporting annual health checks with their preventative agenda to avoid the deterioration of physical health, noted as having a knock-on effect with mental health.
- Enhanced Community residential services for people with learning disabilities.
- The service helps more than 13,000 people
- **Achievements:**
- Mapping nursing processes and developing standard operating procedures.
- Implementing the Health Equality Framework to measure outcomes.
- North Wales is the first area in Wales to have developed a pooled budget – a formal Section 33 partnership agreement, which has been running for one year, focussed on a key group of people in supported living. Preliminary findings are that this has had a very positive effect, however will be formal reviewed in January 2025.
- Works very closely with the North Wales Learning and Disability Strategy Group, the vice-chair of which is a service user.
- **Challenges:**
- Workforce vacancies: 55 vacancies pan BCU, which is around 15% of required staffing, with active review of existing job descriptions for roles that have not been filled for over 6 months.
- To attain an enhanced community service, they will have to deal with the significant demand capacity for locally sourced accommodation; however they have secured funding from the Housing Care Fund through the transformation strategy, which will progress the enhanced community intermediate care model.
- The complexity of cases had increased over the years.
- Estates issues: Matching the development of clinical responses to the provision of fit for purpose environments. Old prefab buildings requiring investment.
- The Health Liaison Team, by working in partnership alongside IHCs, to enhance patient journeys in acute sites.
- Reviewing measurable services to ensure they can demonstrate to both the Health Board and Welsh Government, how they have achieved those positive outcomes for individuals with learning disabilities.
- **Plans:**
- Improving quality outcomes and experiences for service users, by using all the strategic drives coming from Welsh Government and local intelligence.
- To continue to review the current disability inpatients pathway and the existing processes to ensure there is a single service for people.
- Continuing to work towards the Learning Disabilities Strategic Action Plan 2022-26, which is in alignment to strategy.
- Enhancing community residential services.
- Addressing restrictive practices and ensuring safe and effective care.

Following the presentation, the Committee discussed the following:

- The Committee was pleased to note the focus on physical as well as mental health.
- To address the problems around staff recruitment, recruitment challenges and the workforce pathway design were discussed, to ensure that the organisation is using the new Band 4 associate roles coming in, to give an opportunity to radicalise the delivery of care. It was noted that work is currently underway to develop a new workforce retention strategy.

- The need to provide an update to provide clarity around the strategic direction across North Wales
- The Executive Director of Nursing & Midwifery to introduce Nichaela Jones to her colleagues in England, with regards to digitising the HEF

Actions:

- **QS24/144.1** The Executive Director of Allied Health Professional and Health Science to circulate an update to provide clarity around Learning Disabilities' strategic direction across North Wales
- **QS24/144.2** The Executive Director of Nursing & Midwifery to introduce Nichaela Jones to her colleagues in England, with regards to digitising the HEF

It was resolved that the Committee

- **Noted** the report.

[*The Interim Chief Operating Officer and Interim Head of Operations and Service Delivery, West, left the meeting. The Executive Director of Transformation and Strategic Planning joined the meeting]*

QUALITY PLANNING

QS24145 Clinical Services Plan

Members received the Clinical Services Plan (CSP) presented by the Executive Director of Transformation and Strategic Planning, who highlighted the following:

- The purpose of the CSP was to configure and deliver clinical services aligned with the health board's strategy and quality management system (QMS).
- Prioritization was based on risk and benefit profiles, focusing on services experiencing significant difficulties.
- Enabling Work
    - understanding risk appetite and prioritization.
    - Implementing QMS to identify and demonstrate improvements.
    - Emphasizing well-being, prevention, and de-medicalization.
- Collaboration: Learning from Hywel Dda University Health Board's experiences in clinical service configuration.
- Initial Focus: Urology, with plans to test and scale up the methodology.
- Next Steps: Testing the methodology in Urology, engaging more medical voices, and planning for the next tranche of services.

In discussing the report, the Committee:

- Discussed identifying evidence of best practice
- discussed the advantages of QMS for the CSP moving forward
- managing the Workforce's expectations

It was resolved that the Committee

- **Noted** the report.

QUALITY IMPROVEMENT

QS24/149 Urgent and Emergency Care (UEC) Deep Dive

Members received the Urgent and Emergency care Deep Dive, presented by the Interim Chief Operating Officer, who highlighted the following:

- It was noted that UEC had been identified as one of the four major change programs.
- To avoid having separate programmes, the work of both the National Six Goals Programme and the Major Change Programme and brought under the leadership of one Board, chaired by the Chief Operating Officer.
- The UEC Design and Delivery Group meets weekly – this meeting brings together operational leads, workstream leads and wider stakeholders.
- The 12-week UEC focus period has helped galvanise the new approach.
- An interim Programme Director had been brought in on secondment from Hywel Dda, to help strengthen the UEC programme team.
- A further fixed-term appointment had been made to lead the System Resilience team, which brings all three IHCs and pan-BCU services – Diagnostics and Women's Services - together. This approach enables the organisation to have oversight for system resilience on a day-to-day basis; improving ambulance handovers; ensuring out of hours plans in place to ensure co-ordination. Improving ambulance handovers, therefore reducing 12-hour breaches in ED.
- Funding: £4.5 million allocated to both the Health Board and local authority colleagues for system improvements, focusing on high-risk patient groups in Primary and Community care, to reduce pathway care delays.
- Strengthened governance structure and work stream delivery plans.
- Improved patient experience feedback mechanisms.
- Achievements noted:
    - Establishing a system resilience hub for proactive oversight.
    - Implementing a comprehensive patient experience feedback system.
    - Positive feedback from HIW on recent inspections.

In discussing the report, the Committee:

- observed that the report was both comprehensive and positive.
- noted that the Patient Experience text messaging service had been implemented in September 2024. This service was providing data to analyse, to help understanding the issues felt by patients and families.
- asked when the Committee should expect feedback to indicate system improvements, the Interim Chief Operating Officer confirmed that a reset would take place in January 2025, prior to a further 12-week UEC focus period. Data from the previous focus period would be analysed and fed back to the committee.
- noted that the Health Board must once again advise Welsh Government that their metrics for recording Hospital Acquired Pressure Ulcers was not fit for purpose.
- The Executive Director of Nursing and Midwifery referred to an unannounced 3-day Healthcare Inspectorate Wales (HIW) visit to Wrexham Maelor Hospital. The preliminary overall feedback from this visit was very positive, with four issues in one area being noted, to which assurance was provided, with action plans submitted to HIW, and implemented.

- Independent Member, Urtha Felda, to discuss outside of meeting concern raised to her recent experience in an ED department.

Action:

- **QS24/149.1** Independent Member, Urtha Felda, to discuss outside of meeting, with Executive Director of Nursing and Midwifery, concern raised to her recent experience in an ED department.

It was resolved that the Committee
- **Noted** the report.

[The Interim Chief Operating Officer left the meeting]
[The Head of Risk Management joined the meeting]

QUALITY CONTROL

QS24/146 Integrated Quality Report

Members received the Integrated Quality Report, presented by the Executive Director for Nursing and Midwifery, who highlighted the following:

- Integrated Concerns Policy, which had been operating for almost 12 weeks was working well, with daily hub meetings and weekly Executive oversight.
- Noted the reduction in the number of falls and percentage by severity post investigation, with positive feedback from coroners.
- Noted the reduction in the numbers of pressure ulcers and their severity.
- The improvements in quality of care with Nationally Reported Incidents: 54 currently open, with 10 overdue. Efforts to manage incidents in real-time.
- Never Events: No new Never Events since September.
- Patient Safety Alerts were being successfully monitored and managed.
- Implementation of the Single Unified Safeguarding Review and other safeguarding measures.
- Ongoing oversight of infection prevention action plans, following learning reviews.
- Oxygen Administration: Improvement plans and training in place.
- Enhanced protocols and collaboration with police following the Missing Patient review.
- Patient Experience: Significant increase in feedback responses through SMS text messaging.
- Chaplain and Spiritual Care Services noted as being active during the Christmas period.
- Clinical Audits and Mortality Reviews: Need for improved compliance and reporting. Structured judgment reviews and learning from deaths emphasized.
- More work required across the Board to ensure NICE compliance.

In discussing the report:

- The Chair asked for the Complaints Update to be circulated to Board Members.
- Were advised that the Chief Executive Officer, the Executive Medical Director and the Executive Director of Nursing and Midwifery were in discussions to instigate a review to identify the cause of the backlog of cases awaiting corporate mortality administrative sieve and sort process, to identify what can be done to remedy the situation.

- Agreed that the Director of Governance and the Executive Medical Director discuss outside the meeting when a paper could be brought to the Committee regarding the Clinical Audit Plan.
- The Director of Performance and Commissioning to work with the Executive Medical Director to focus on the Mortality Review data to improve quality of reporting.
- The Chair requested a development session during Q4 to help the Committee understand reporting challenges.
- Positive verbal feedback received following Healthcare Inspectorate Wales' (HIW) unannounced 3-day visit to Heddfan Unit in Wrexham, 21-23 October 2024. HIW issued four recommendations requiring immediate attention. Action plans were submitted by 1st November and put in place and being monitored. Formal Inspection report awaited.

Actions:

- **QS24/146.1** The Head of Corporate Office to circulate the Complaints Update to Board Members.
- **QS24/146.2** Director of Governance and the Executive Medical Director to discuss outside the meeting when a Clinical Audit Plan paper could be brought to the Committee and added to the Forward Workplan.
- **QS24/146.3** Work with Executive colleagues on the Mortality Data and bring back to QSE Development Session in March

It was resolved that the Committee

- **Noted** the report.

QS24/147 Integrated Performance Report

Members received Integrated Performance Report, presented by the Director of Performance and Commissioning, who noted:

- To improve the quality of reporting, The Director of Performance and Commissioning and the Executive Director of Nursing and Midwifery met with Welsh Government (WG) Quality colleagues, where a commitment was given to WG develop a set of quality indicators, with a timetable.
- Mitigations being put in place to address the need to reduce backlog caused by the 2 years required to train new clinical coders.
- Areas of improvements identified – an increase in the number of complaints closed within 30 days; consistent reduction in the number of new patient safety incidents; no new Never Events in September and October; the number of open NRIs is improving and a reduction plan had been developed. In areas currently under scrutiny, where continued improvements had been identified, recommendations will be made to Executives to de-escalate.
- Areas of Concern identified - highest ever number of Ombudsman contacts; Issues across services relating to access, particularly in planned care, drug and alcohol services, and index colonoscopy patients. The need for improvements in reporting identified.
- Need for detailed actions to return indicators to compliance identified. Development of a more detailed PowerPoint report with mitigations and actions being developed.

In discussing the report, the Committee noted:

- The need to identify areas of concern, develop action plans with timescales to return to compliance.
- The Executive Director of Allied Health Professionals and Health Science agreed to meet outside meeting with Director of Performance & Commissioning and the Executive Medical Director, to address the challenges causing delays relating to index colonoscopy patients and to provide a briefing. To add to Forward Workplan for early January 2025. To be highlighted in the AAA report to Board.

Actions:

- **QS24/147.1** Head of Corporate Office to circulate the coding paper to all QSE Members via the AAA report to be presented to January Board.
- **QS24/147.2** The Executive Director of Allied Health Professionals and Health Science agreed to meet outside meeting with Director of Performance & Commissioning and the Executive Medical Director, to address the challenges causing delays relating to index colonoscopy patients and to provide a briefing to QSE. To add to Forward Workplan for early January 2025.

It was resolved that the Committee:

Reviewed the contents of the report.

(The Associate Director of Governance joined the meeting]

QUALITY ASSURANCE

QS24/148 Health Board Response to the Royal College of Psychiatrists (RCPsych) Invited Review Services Report.

The Executive Director of Allied Health Professionals and Health Sciences advised the Committee that Expert Advisory Group (EAG) was still maturing. Ros Alstead, Special Advisor, continued to work with past and present Services users and their families, to ensure that everyone understands and agrees with the approach being taken. The Committee wished to offer its sincerest thanks to Geoff Ryall-Harvey and Llais for their continued support in this endeavour.

The Associate Director of Governance confirmed that he had met with members of the EAG, and that they were highly engaged, and good progress was being made.

Amendments had been made to the Terms of Reference (ToR) as requested, with further adjustments to be made for clarity. It was agreed that Urtha Felda, Independent Member, would remain independent of the EAG, but act as a 'sounding board' for the EAG and provide a link to QSE, therefore providing assurance to the Board.

It was resolved that the Committee

1. **Noted and received assurance** on updates related to governance arrangements for the Health Board Response to the RCPsych Invited Review Services Report.
2. **Noted** progress against the ten themes identified in the Invited Review Services Report.

3. **Approved** the amended ToR V2 for the EAG.

Noted the Draft Terms of Reference for the EAG.

ROUTINE REPORTING

QS24/150 Corporate Risk Register

The Head of Risk Management presented the report, noting:

- Six corporate risks reviewed, with updates on patient safety, primary care, community care, and clinically challenged services.
- No amendments to risk scores, but actions prioritised for clarity and progress.
- No overdue actions within the six new risks.
- All 6 clinical challenged service risks were reviewed at the Risk Scrutiny Group and approved, except for some minor caveats. The Head of Risk Management assured Members that all six services would be sent to Clinical Executives for review and then onto the Executive Team for approval
- With regards to timely Diagnostics and Medical Devices, deep dives had been conducted, with feedback incorporated for further development.

In discussing the Report, the Chair thanked both the Head of Risk Management and the Executive Director of Nursing and Midwifery for their work in setting up the Risk Scrutiny Group (RSG). At the RSG monthly meetings, risks are regularly checked and challenged, thus resulting in QSE being better placed to focus its attention and seek assurance.

It was resolved that the Committee

- **Received assurance** for the six corporate risks to which the Committee has overall accountability.

FOR INFORMATION

QS24/151 Quality Delivery Group Chair's Assurance Report

It was resolved that the Committee
- **Noted** the Quality Delivery Group Chair's Assurance Report

QS24/152 Summary of Business to be Reported in Private part of Last Meeting

It was resolved that the Committee
- **Noted** the Summary of Business reported from the Private part of Last Meeting

QS24/153 Committee Forward Work Plan

It was resolved that the Committee
- **Noted** the Committee Forward Work Plan

QS24/154 NHS Wales - Joint Commissioning Committee Quality Committee Chair's Report

It was resolved that the Committee
- **Noted** the Joint Commissioning Committee Quality Committee Chair's Report

CLOSING BUSINESS

QS24/155 Agree Items for Referral to Board / Other Committees

- Following the powerful presentation shared, relating to Organ Donation, the Committee would like to raise its profile.
- Concerns raised about the performance indicators presented on colonoscopy, asking that an agenda item and briefing return to QSE at the February meeting.
- Assure Board that the process of creating a CSP is ongoing and that all services will be assessed as part of that process in terms of prioritisation.
- Following detailed update on UEC, QSE assured actions being taken to address the risks to patient safety, experience and outcomes across UEC pathways, particularly during Winter 2024/25, however Q4 was noted as a concern.
- Advise Board that the Integrated Quality Report was received, and the Clinical audits were reviewed and discussed, noting that further work will take place to understand where best to focus.
- Advise Board that it takes two years for clinical coders to be fully trained and that a report previously circulated would be attached to the AAA Report.
-

QS24/156 Meeting Effectiveness

It was reported that despite the size of the agenda, there had been some good discussions.

It was noted that over the past 7 months, the quality of reports and presentations to QSE had improved greatly, and were far more fit for purpose.

QS24/156 Date of Next Meeting

20th February 2025

Resolution to Exclude the Press and Public

It was resolved that 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.

QSE Committee PUBLIC Action Log

Open Actions						
Action No.	**Minute Ref.**	**Date**	**Agreed Action**	**Lead**	**Timescale**	**Status**
1	QS24/147.2	17.12.24	**QS24/147.2 Integrated Performance Report** Provide members with a briefing on the issues around colonoscopies at the next QSE meeting. To add to Forward Workplan for January 2025.	Executive Director for Allied Health Professionals & Health Science (Teresa Owen) / Interim Chief Operations Offices (**Imran Devji**)	Jan 2025	**Suggest close.** **17.12.24** Added to Forward Workplan. **8.1.25** Update requested for Feb meeting.
2	QS24/147.1	17.12.24	**QS24/147.1 Integrated Performance Report** Circulate a briefing on the Clinical Coding training via the AAA report to Board.	Head of Corporate Affairs (**Philippa Peake-Jones)**	Jan 2025	**Suggest close** **30.1.25** Added to AAA report.
3	QS24/146.1	17.12.24	**QS24/146.3 Integrated Quality Report** Work with Executive colleagues on the Mortality Data and bring back to QSE Development Session in March.	Exec. Medical Director (**Sreeman Andole)** / (Director of Performance & Commissioning (**Stephen Powell)**	May 2025	

4	QS24/146.2	17.12.24	**QS24/146.2 Integrated Quality Report** Look at bringing Clinical Audit back to a future Committee as a separate item. Pam and Sreeman to confirm timing	Exec. Medical Director (**Sreeman Andole)** / Director of Corporate Governance (**Pam Wenger**)	May 2025	**Suggest close** **12.2.25** Transferred to Forward Work Plan.
5	QS24/146.3	17.12.24	**QS24/146.1 Integrated Quality Report** Circulate the Complaint update as received as part of the Action Log to all IM's in the Corporate Governance Weekly meeting.	Head of Corporate Affairs (**Philippa Peake Jones**)	20.12.24	**Suggest close** **12.2.25** PPJ has added this to the IM's Teams channel
6	QS24/149.1	17.12.24	**QS24/149.1 Urgent and Emergency Care Deep Dive** Urtha take off line the concern raised in relation to her recent experience in an ED department.	Executive Director of Nursing & Midwifery (**Angela Wood**)		**Suggest close.** No contact from Urtha regarding this issue
7	QS24/144.2	17.12.24	**QS24/144.1 Learning & Disabilities Deep Dive** Circulate the strategy outside of the meeting	Executive Director for Allied Health Professionals & Health Science (**Teresa Owen**) / Director of Mental Health (**Iain Wilkie**)		**Suggest close.** **12.02.25** Strategy circulated.

8	QS24/144.1	17.12.24	**QS24/144.2 Learning & Disabilities Deep Dive** Angela to introduce Nichaela Jones to her colleagues in England with regards to digitising the HEF	Executive Director of Nursing & Midwifery (**Angela Wood**)		**Suggest close.** **1.2.25** Email sent to NHSE as way of introduction.
9	QS24/143.1	17.12.24	**QS24/143.1 Patient Story** Refer Organ Donation to the Board as part of the AAA report	QSE Chair **Caroline Turner** Head of Corporate Affairs (**Philippa Peake-Jones)**	30.1.25	**Suggest close.** Included in the AAA report to be referred to Board **17.12.24 Actioned.**
10	QS24/104.3		**QS24/104 Meeting Effectiveness** Ensure more time allocated to Primary Care on CoB, on a regular basis.	Exec. Dir. of Nursing & Midwifery (**Angela Wood**) Head of Corporate Affairs (**Philippa Peake-Jones**)	17.12.24	**16.10.24** CoB will be updated once further conversations have taken place with Executives. **12.2.25** This will take place as part of the annual review of CoBs. Added to Forward Work Plan.
11	QS24/116		**QS24/104.3 Matters Arising** To add outcomes for women from deprived and ethnically vulnerable communities to the forward work plan and to check that the DOLs deep dive has been included.	Head of Corporate Affairs (**Philippa Peake-Jones**)	17.12.24	**Suggest close.** **10.12.24** Both items have been added to Forward Workplan and timings for these will be updated in due course.
12	QS24/121		**QS24/121 Integrated Performance Report**	Executive Director for	17.12.24	**9.12.24** TO spoke with Deputy Executive Medical Director. Data/information is being

			to speak to the Deputy Executive Medical Director to check the veracity of colonoscopy data provided in report, and to escalate concerns if required.	Allied Health Professionals & Health Science (**Teresa Owen**)		checked by the team. **12.2.25** Jim McGuigan advised that Imran Devji was aware of this query and was looking into it.
13	QS24/123		**QS24/123 Corporate Risk Register** to discuss at next Chairs' Advisory Group whether certain risks sat is Performance or Quality, or whether they straddled both.	Director of Corporate Governance (**Pam Wenger**)	17.12.24	**Suggest close** **4.12.24** Following a discussion with both Chair's of PFIG and QSE, the Director of Corporate Governance advised that both risks Diagnostics and Medical devices should remain with QSE as the gaps in controls relate to the service model and regulatory and accreditation requirements and should the risks materialise they both would impact on the quality and safety domain. However, the Executive lead for both risks need to be clarified and confirmed, and this may alter the risks meaning they sit more appropriately with PFIG. This will be discussed and worked through by the Risk Scrutiny Group and Executive Team. **12.2.25** On CAG agenda for 26.2.25.
Closed Actions						
Action No.	**Minute Ref.**	**Date**	**Agreed Action**	**Lead**	**Timescale**	**Status**
1	QS24/118		QS24/118 Deep Dive on Complaints – Duty of Care to share an updated	Executive Director of Nursing &	17.12.24	4.12.24 Information shared post meeting.

			presentation with the most recent figures.	Midwifery (Angela Wood)		
2	QS24/118		QS24/118 Deep Dive on Complaints – Duty of Care In relation to the request for a communications training strategy, share the tool kit which includes the communication plan being developed as part of the implementation of Integrated Concerns Framework.	Executive Director of Nursing & Midwifery (Angela Wood)	17.12.24	4.12.25 It was confirmed that an integrated training programme for staff across the organisation has commenced initially with overview training of the policy and processes contained within it. This will support them to implement the integrated concerns policy. After the launch of the policy, this has been replaced by weekly drop-in sessions with the Patient Safety Team, to discuss any issues or to seek support with regards the processes. Level 2 training has commenced and takes place every Thursday. This is targeted at those responsible for undertaking Learning Reviews and covers the approach, methodology, process and tools to conduct a Learning Review. Level 3 training will be targeted at those responsible for undertaking Learning Investigations. Finalisation of the training pack and tools will be completed December 2024 and training dates are planned for January 2025. Information for the above is available on Betsinet
3	QS24/118		QS24/118 Deep Dive on Complaints – Duty of Care to discuss with the Chair having a Putting Things Right	Executive Director of Nursing & Midwifery	17.12.24	4.12.24 Welsh Government Response to Consultation feedback on Draft National Putting Things Right (PTR) Guidance released, which indicates likely changes to the guidance.

			(PTR) on a future Development session.	(Angela Wood)		Consequently, action put on hold and added to Forward Workplan.
4	QS24/119		QS24/119 Presentation of the Nurse Staffing Levels - Autumn 2024 to share an updated presentation with the most recent figures.	Deputy Executive Director of Nursing & Midwifery (Chris Lynes)	17.12.24	9.12.24 Information circulated to IMs
5	QS24/120		QS24/120 Integrated Quality Report to refer the monitoring of Manual HandlingTraining to the People and Culture Committee.	Head of Corporate Affairs (Philippa Peake Jones)	17.12.24	18.11.24 Laura Jones has included this on the Forward Workplan for P&C.
6	QS24/120		QS24/120 Integrated Quality Report to ensure that there is consistency when reporting National Reportable Incidents (NRI) as the Integrated performance Report is showing different data to the Integrated Quality Report.	Deputy Executive Director of Nursing & Midwifery (Chris Lynes)	17.12.24	Head of Patient Safety linking in with Performance team to confirm source of information and align. NHS Executive also have a number of NRI's to close which have been completed by the Health board which gives a different number open on the national beacon dashboard .
7	QS24/120		QS24/120 Integrated Quality Report to seek an update on Health Protection for future reports from the Assistant Director of	Executive Director for Public Health (Jane Moore)	17.12.24	4.12.24 JM confirmed that action complete and that an update has been provided for the December Integrated Quality Report.

			Health Protection. The Deputy Director of Legal Services to report back regarding the expected Medical Examiner Service.			
8	QS24/120		QS24/120 Integrated Quality Report to report back regarding the expected Medical Examiner Service.	Deputy Director for Legal Services (Matt Joyes) / Executive Medical Director (Sreeman Andole)	17.12.24	20.11.24 MJ confirmed that the impact on an independent medical examiner certifying all deaths will be monitored and an update given at the April meeting. FL added to the Forward Work Plan noting it is the OMD's responsibility to respond.
9	QS24/120		QS24/120 Integrated Quality Report to provide figures showing the number of current complaints and claims, and their status for the December meeting	Deputy Director of Legal Services (Matt Joyes) / Deputy Executive Director of Nursing & Midwifery (Chris Lynes)	17.12.24	4.12.24 MJ confirmed that a claims paper was planned for December, but this has been deferred while a review of the process and approach to litigation is underway, due to the transition of legal services to the Director of Corporate Governance in October 2024. This has allowed a full review of the process to commence, and will be discussed with the CEO in the New Year. A paper will be brought back to QSE after this has been completed. To address the Complaints element, see Complaints Improvement Deep Dive attached to agenda.
10	QS24/121		QS24/121 Integrated Performance Report	Interim Director of Performance	17.12.24	Kathryn Lang and Dafydd Ap Gwyn providing the clinical coding report.

			to provide a standalone report on the backlog of clinical coders' work to the December meeting.	(Ed Williams)		
11	QS24/121		QS24/121 Integrated Performance Report to provide updated performance data regarding vaccinations.	Interim Director of Performance (Ed Williams)	17.12.24	Updated performance data regarding vaccinations provided in December's Integrated Performance Report.
12	QS24/121		QS24/121 Integrated Performance Report To provide an update on Diabetes figures to the Committee as holding position had been provided to PFIG but that her team was looking at this as part of the transformation work.	Executive Director for Public Health (Jane Moore)	17.12.24	10.12.24 The outputs of the work on diabetes will be available March 2025. Added to Forward Workplan.
13	QS24/121		QS24/121 Integrated Performance Report to look at why WAST figures were in the report.	Interim Director of Performance (Ed Williams)	17.12.24	WAST figures are part of our National Performance Framework of measures. although they are WAST measures, BCU has a responsibility in ensuring ambulances are freed up to be able to respond to other calls, hence the measures are important for our understanding in the 'partnership' with WAST.
14	QS24/122		QS24/122 Update on the Royal College of Psychiatrists ology (RCPsych) Response Plan to ensure that a timeframe be	Associate Director of Governance (Phil Meakin)	17.12.24	4.12.24 Draft ToR for the Expert Advisory Group have been updated and are available in the appendix to the HB Response to RCPsych Invited Services Review report.

			included into the ToR. Draft ToR and forward work plan to be brought back to the Committee in December			
15	QS24/122		QS24/122 Update on the Royal College of Psychiatry (RCPsych) Response Plan to ensure that the families meet with the Dementia Nurse, when she joins the Health Board in the New Year	Associate Director of Governance (Phil Meakin)	Feb 2025	4.12.24 Dementia Nurse has now been appointed and the arrangements for this meeting will be concluded when she joins in the new year.
16	QS24/122		QS24/122 Update on the Royal College of Psychiatry (RCPsych) Response Plan to report back to the Committee in December, with how she envisages moving forward and how she envisions this improving patient care.	Welsh Government Independent Advisor (Ros Alstead)	17.12.24	4.12.24 RCPsych Invited Services Review Report includes update on how the Special Advisor envisages moving forward and how this will improve patient care.
17	QS24/123		QS24/123 Corporate Risk Register to investigate whether there was a corporate risk on Mental Health.	Executive Director for Allied Health Professionals & Health Science (Teresa Owen)	17.12.24	4.12.24 The Head of risk Management confirmed that there is no corporate risk on Mental Health and that she has raised this for discussion at the next Mental Health Risk Meeting for further discussion and also at The Head of Risk Management meeting with key service leads, ahead of the Mental Health Risk Meeting to discuss a gap analysis and review of the risk register to discuss a corporate risk for mental health.

						A Royal College Psych response plan risk has been developed and included within the December paper for Risk Scrutiny Group review and decision to escalate to the corporate risk register.
18	QS24/123		QS24/123 Corporate Risk Register to provide an update on clinical services, following discussions with the COO.	Director of Corporate Governance (Pam Wenger)	17.12.24	4.12.24 The Head of Risk Management has provided an update, confirming that five risks from clinically challenged services have been included within the December paper for Risk Scrutiny Group review and decision to escalate to the corporate risk register: Oncology Services Ophthalmology Service Vascular Services Renal Services Orthodontics Services Risks drafted, but remain to be finalised and are with the services for further development and approval: • Urology services • Dermatology & Plastics
19	QS24/118		QS24/118 Deep Dive on Complaints – Duty of Care To consider whether it would be of use to for the Committee to track a complaint from the moment of receipt to completion, to understand the pinch points.	Executive Director of Nursing & Midwifery (Angela Wood)	17.12.24	9.12.24 Delays relating to PTR, redress independent investigation, police involvement, legal services to be built in. First draft complaint flowchart attached to December agenda.

20	QS24/119		QS24/119 Presentation of the Nurse Staffing Levels - Autumn 2024 to report back to the Chair of PFIG that a review of nurse staffing levels for those wards that did not fall under the Act had taken place, to share the staffing levels for those areas not covered in the Act to all Independent Members.	Executive Director of Nursing & Midwifery (Angela Wood)	17.12.24	The information has been shared with the Chair of PFIG
21	QS24/118		QS24/118 Deep Dive on Complaints – Duty of Care To discuss the GDPR issue raised at the Flintshire event outside of the meeting with Independent Member, Urtha Felda.	Executive Director of Nursing & Midwifery (Angela Wood)	17.12.24	CS has been in contact with Urtha and the matter will be resolved outside of the meeting

Teitl adroddiad: ***Report title:***	**Patient Story – My 22 hours in the Emergency Department.**			
Adrodd i: ***Report to:***	QSE Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	20th February 2025			
Crynodeb Gweithredol: ***Executive Summary:***	A patient or carer story is presented to QSE Committee 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 Committee 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 Hannah Hughes, Patient & Carer Experience Project 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 Committee 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 gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	BAF21-10 - Listening and Learning
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	N/A
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	N/A
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	N/A
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	BAF21-10 - Listening and Learning
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	N/A
Camau Nesaf: Gweithredu argymhellion ***Next Steps: Implementation of recommendations*** N/A	
Rhestr o Atodiadau: Cancer and ED Patient Story - ENGLISH SUBTITLES.mov Cancer and ED Patient Story - WELSH SUBTITLES.mov I am willing for my story to be shared with: [√] Level 1 – Any Health and Social Care Professionals within BCUHB [√] Level 2 – Researchers for Service Evaluation and improvement beyond BCUHB [√] Level 3 – Meetings and Conferences with anyone present including public and journalists [√] Level 4 – Anyone including Online, Internet, Social Media and CIVICA ***List of Appendices:*** Appendix A- Patient Story Summary	

Betsi Cadwaladr University Health Board

Patient Story – My 22 hours in the Emergency Department as a cancer patient.
Stori Claf – Fy 22 awr yn yr Adran Achosion Brys fel claf canser.

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

Overview of Patient Story

The storyteller describes her 22 hours spent in the Emergency Department, outlining several concerns regarding her care as an oncology patient within the Emergency Department.

The storyteller describes the distress and trauma she felt by this experience and the support that she has accessed through Tenovus and the Macmillan Information Centre as a result.

The storyteller describes how she was undergoing radiotherapy treatment for breast cancer at the North Wales Cancer Treatment Centre and was experiencing pain in her back. She describes how the Breast Care Team were concerned that her pain could be Spinal Compression and as such, provided the storyteller with a spinal compression leaflet and took her to the Emergency Department (ED) of Ysbyty Glan Clwyd for further investigation and treatment.

Following a formal complaint, the storyteller requested to share her experience in the form of a patient story to support further organisational learning.

Key Messages

- Storyteller describes her patient journey through the Emergency Department, lasting 22 hours.
- Storyteller describes the traumatic impact of the experience on her mental health and accessing counselling sessions delivered by Tenovus and support from the Macmillan Information Centre as a result.
- Storyteller describes the kindness of nursing staff – examples provided of supporting with a quiet waiting area and providing a drink and toast.

Summary of Learning and Improvement

This patient story has been shared widely across Cancer Services, the Emergency Department at Ysbyty Glan Clwyd, Radiology and Pharmacy for feedback and learning.

The concerns raised within this patient story were initially investigated as part of a formal complaint by the Head of Nursing for Emergency Care. The investigation was undertaken by reviewing Symphony Documentation, WPAS, the storytellers' clinical notes and discussions with Nursing and other colleagues to provide supplementary information.

The complaint investigation addressed all concerns the storyteller has shared in their story. At the time of the storytellers visit, Ysbyty Glan Clwyd site was escalated to a level 4 (highest level), contributing to a busy department, and crowding due to a lack of patient flow throughout the hospital.

The Storyteller describes the frustration of the Doctor writing down medical history, which was already available on her medical record. In the future to reduce patients having to repeat their medical history to each practitioner they see, the Health Board is planning to move to electronic patient systems across the emergency quadrant and Same Day Emergency Care. The purpose of this would be to reduce risk and improve continuity of care.

The Emergency Department are working towards meeting National Key Performance Indicators to improve pathways and patient flow within the department to continue to improve standards, reduce harm, improve safety and patient experiences.

As part of the 6 Goals Urgent and Emergency Care Programme, an Optimal Hospital Patient Flow Framework has been implemented across the Health Board, which involves targeting wards with the highest flow impact potential to improve patient flow in the Emergency Department, to help reduce length of stay and to prevent de-conditioning.

The Storyteller describes a situation where she was not able to collect her prescribed medication as the hospital pharmacy was closed at that time on the weekend. Acute site Pharmacies are open across the weekend but with a limited service at times. In order to improve patient experience, and reduce overall waiting times in the Emergency Department some patients will be given a prescription that will allow them to attend their local pharmacy to receive their medication. This initiative will also help improve patient flow within the Emergency Department.

The storyteller described her concerns with being an immune-compromised oncology patient and feeling vulnerable to infection in a crowded Emergency Department. Patients currently receiving oncology and haematological cancer treatments under the care of Cancer Services are provided with the triage helpline number to ensure there is access to advice 24/7.

Within hours, patients' queries are addressed by the triage teams based on the Ysbyty Glan Clwyd and Ysbyty Gwynedd Sites. Within hours, most patients are seen in Nurse-led Triage Units and appropriate treatments are instigated, but there are clinical situations that indicate a medical emergency in which the front door services are appropriate to enable timely assessment and treatment. These are patients who present with sepsis and metastatic spinal cord compression, which was the case for the storyteller.

There is a dedicated team of Acute Oncology Nurse Practitioners from Monday to Friday on each main hospital site providing review and treatment to patients admitted with acute oncological problems and who work closely with the Cancer Treatment Units to facilitate the transfer of patients as soon as they are clinically safe to do so.

Cancer Services are currently working with colleagues across the Integrated Health Communities to develop pathways for direct admission to Medicine and/or Same Day Emergency Care (SDEC) to avoid Emergency Department attendance for clinically appropriate patients with the recognition that Emergency Departments are not always the appropriate environment for oncology patients.

There is currently no out of hours MRI to provide an overnight service for Cauda Equina due to the lack of resources and Radiographers to provide the 24/7 service. Other Radiology imaging is available 24/7, including CT scan and X-ray, which they are working on stabilising long-term. The Radiology Service are currently working through a workforce remodelling plan, which requires appropriate financial resource, additional staff and Organisational Change Process to provide this extended Cauda Equina MRI service.

The storyteller describes the British Red Cross service that was actively supporting patients within the Emergency Department at Ysbyty Glan Clwyd. Red Cross staff can offer reassurance and emotional support for patients who are anxious, overwhelmed or alone and families and relatives that need a listening ear as well as sitting with upset or bereaved relatives. Being in hospital can be daunting for some people and the Red Cross teams are able to give time to the little things that make a big difference to how patients and visitors feel about their experience in hospital.

The storyteller describes the impact of her experience within the Emergency Department on her mental health and wellbeing. The storyteller describes how she was able to access help and support via the Macmillan Cancer Information Centre in Ysbyty Glan Clwyd. Macmillan Centres are also located at Wrexham Maelor Hospital and Ysbyty Gwynedd to support those affected by cancer across the Health Board. Macmillan Centres are free to use and people are welcome to 'pop in' as many times as they need. Appointments can also be booked for those making a special trip or wanting to use a particular service.

Macmillan Centre staff provide a warm welcome for anyone at any point in their cancer experience, as well as their family and friends. They provide a listening ear and signposting advice. Taking the time to get to know people affected by cancer and what really matters, staff can help people to find the right cancer support for them. They can also signpost to other local services. Macmillan Centres provide a comfortable space to ask questions, to talk openly, to find information and support or to simply pop in for a chat.

The storyteller describes how she was able to access mental health advice and support from Tenovus Cancer Care / Gofal Canser. Tenovus are a Wales-based charity providing treatment, expert advice, support, and a voice to those affected by cancer. Tenovus provide a number of services, including a support line, virtual support groups, benefits advice, 'sing with us' choirs, an all-Wales cancer community, mobile support unit and a counselling service, which was accessed by the storyteller.

Available in both English and Welsh, the Tenovus specialist counselling service provides a safe and confidential space for individuals to talk about the impact of their cancer diagnosis and whatever matters most to them. The trained counsellors are BACP registered and are highly experienced in helping people with cancer to explore their feelings and to talk through confusing or upsetting emotions. Tenovus accept referrals from identified Health Care professionals and provide support for anyone living in Wales, aged over 18 and experiencing emotional and psychological distress in relation to their own cancer diagnosis. After a 30-minute session to gather information, counsellors can offer up to six consecutive weekly one-hour virtual counselling sessions. A cancer diagnosis can trigger a wide range of feelings and emotions that people may need support with. Tenovus counselling can help people adjust to what it means to live with cancer during a difficult and confusing time.

Signposting people with urgent care needs to the right place, first time is an ambition of Welsh Government's Six Goals for Urgent and Emergency Care Programme. In particular, the aim of Goal 2 was to establish a pathway (NHS 111 Press 2) to support people with emotional health, mental illness and /or wellbeing issues to directly access a Mental Health Worker 24/7.

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

Teitl adroddiad: ***Report title:***	QSE Committee – Quality Report			
Adrodd i: ***Report to:***	QSE Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	20th February 2025			
Crynodeb Gweithredol: ***Executive Summary:***	This report provides the Committee with assurance, underpinned by analysis, on significant quality issues alongside longer-term data and information on the improvements underway			
Argymhellion: ***Recommendations:***	The Committee is asked to note this report			
Arweinydd Gweithredol: ***Executive Lead:***	• Angela Wood, Executive Director of Nursing and Midwifery (Lead Executive) • Dr Sreeman Andole, Interim Executive Medical Director • Teresa Owen, Executive Director of AHPs and Health Science • Dr Jane Moore, Acting Executive Director of Public Health			
Awdur yr Adroddiad: ***Report Author:***	• **Patient Safety:** Chris Lynes, Deputy Director of Nursing (Patient Safety) and Tracey Radcliffe, Head of Patient Safety • **Safeguarding:** Michelle Denwood, Director of Safeguarding & Public Protection • **IPC:** Andrea Ledgerton, Assistant Director of Infection Prevention and Decontamination • **Patient and Carer Experience,** Mandy Jones, Deputy Director of Nursing (Patient Experience) and Leon Marsh, Head of Patient Experience • **Clinical Effectiveness:** Dr James Risley, Deputy Medical Director (Clinical Effectiveness), and Joanne Shillingford, Head of Clinical Effectiveness • **Quality Assurance:** Jo Kendrick, Head of Quality and Erika Dennis, Quality Lead Manager • **Healthcare Law:** Matthew Joyes, Deputy Director for Legal Services and Debbie Kumwenda, Healthcare Law 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:***				

There is confidence in the data provided in the report however, the pace of learning and improvement remains a key focus of work. This is being addressed through a range of measures including the actions aligned to Special Measures and the Board Assurance Framework.	
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	• Objective 4 - Improving quality, outcomes and experience • Objective 5 - Establishing an effective environment for learning
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	The Duty of Quality is a statutory requirement under the Health and Social Care (Quality and Engagement) (Wales) Act 2020. The statutory duty of quality requires the decision-making processes by the Health Board take into account the improvement of health services and outcomes for the people of Wales – the duty also includes new Health and Care Quality Standards. Instances of harm to patients may indicate failures to comply with the NHS Wales standards or safety legislation.
Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqlA been identified as necessary and undertaken?***	N/A
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	N/A
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR)***	BAF-SP18 and CRR-24-04 – Quality, Innovation and Improvement
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	N/A
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	N/A
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	N/A
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	BAF-SP18 and CRR-24-04 – Quality, Innovation and Improvement
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	N/A
Camau Nesaf: Gweithredu argymhellion ***Next Steps: Implementation of recommendations*** N/A	
Rhestr o Atodiadau: ***List of Appendices:*** QSE Committee Quality Report: Clinical Effectiveness – Mortality: Appendix 1 BCUHB Quarter 3 24-25 Appendix 2 Quarterly Data Jan 2025 Medical Examiner Service	

QSE Committee – Quality Report – February 2025
Reporting period – November – December 2024

INTRODUCTION

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

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

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

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

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

CONTENTS

PATIENT SAFETY

PATIENT SAFETY INCIDENTS

Datix Incidents

There are currently 5313 open incidents (down from 5817), of which 2966 are overdue as per process review timescales. The total overdue is now lower by 21%.

The patient safety team are currently running the below, drop-in sessions and training sessions to provide support as well as PST representative attending local ICOG or relevant meetings.

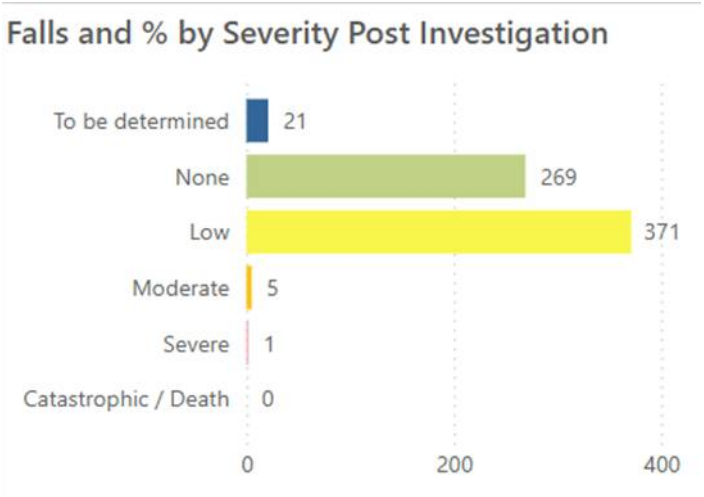
- Weekly Q&A Drop in Session
- Weekly Awareness Session
- Weekly Incident Management Training
- Weekly NRI drop in sessions

Incident review workshops held across the Health Board with the IHC's and Divisions are reviewing incidents and themes and have been instrumental in the improvement of the backlog. There is ongoing work with the Central IHC to complete the backlog review and learning. This should lead to a significant improvement in the Central IHC overdue incidents position.

Patient Falls

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

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



Improvement Plan:

- E learning Health Board Training:
  December 2024 compliance for part 1a and 1b training has seen continued improvement with the compliance exceeding the Health Board standard of 85% for Health Board staff.

  Compliance with E learning 1a and 1b for bank worker remains below Health Board standard but has seen an improvement month on month. Please note work is still ongoing with ESR colleagues undertaking a data cleanse to ensure accuracy; it is anticipated the bank worker compliance will improve as the bank worker compliance shows all individuals who are registered on the bank of which a large number are inactive but still show as being on the nurse bank. Agency worker compliance with Falls prevention training remains a key priority and will be included as part of the HSE evidence bundle.

  Therapies staff compliance for both E learning modules are above Health Board Standard.

  Manual Handling training compliance for level 2 remains a challenge due to Patient Handling resource capacity and the requirement to provide training for large volumes of Pre-registration nursing students. Communications have taken place between Patient Handling Team and IHC Directors to improve the position.

- Risk assessments:
  The consistency of the detail and quality of interventions of the Falls and Bone Health Assessment (FBHMA) remains a theme however all the IHC Falls leads report continued improvements as noted as part of the weekly review and learning meetings.

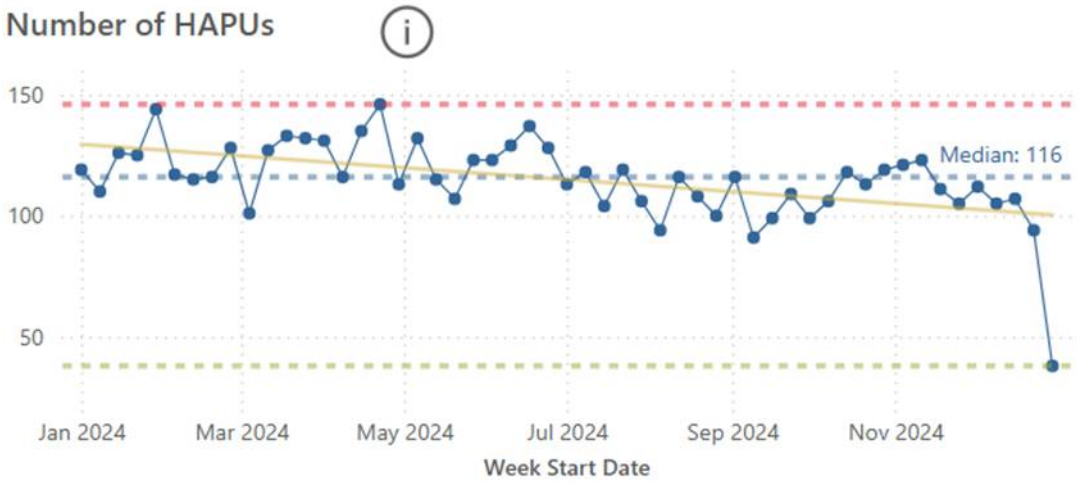
  Following December 2024 Executive Falls review chaired by Executive Director of Nursing and Midwifery, Angela Wood, the membership agreed to introduce an additional one-off senior peer review process (reviews will be undertaken by Matron,

Head of Nursing and Directors of Nursing) due to commence this month that will be an addition to the existing review processes by Ward Managers and Matrons.

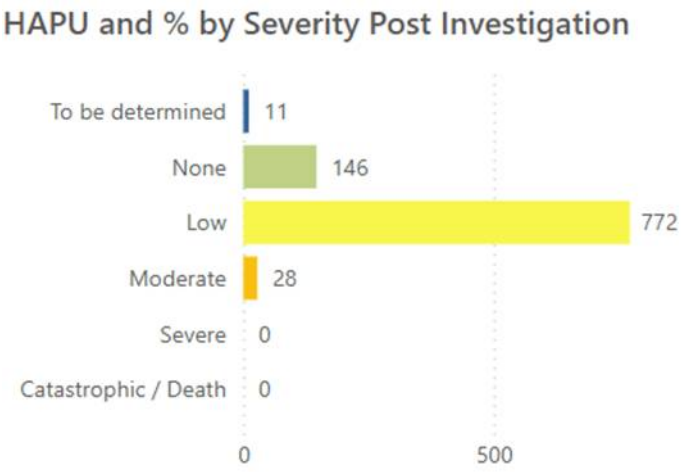
There is evidence to demonstrate the positive impact of BCUHB NU06 and the aligned performance and quality forums. The IHC leads have reported some challenges of sustaining the initial ward level peer review process and although this was felt to be beneficial whilst the BCUHB NU06 policy was being embedded and training was being provided it is now felt this has reached a saturation point for any further improvement and assurance and therefore no longer required alongside the standard processes in place.

Pressure Ulcers

The following shows patient healthcare acquired pressure ulcers (HAPU) reported across the Health Board in the previous 12 months (each week); the yellow line shows a downward trend.



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



NU38 SOP to promote patient cooperation and self-management to reduce the risk and treat/manage pressure ulcers has now been removed from the Health Board Policy Library. Steering away from the term non concordance and all staff adopting a patient centred approach (aSSKINg) assess risk; skin assessment and skin care; surface; keep moving; incontinence or increased moisture; nutrition and hydration assessment / support; and give information approach to Pressure Ulcer Prevention and Management (PUPM).

All weekly reviews across each IHC have adopted the title Pressure Ulcer Learning Forum and will follow the aSSKINg framework, an agreed Terms of Reference across each IHC is now in place. Data will be extracted from themes and trends to inform improvement focus across the Health Board.

Weekly learning Forums are supporting timely reviews utilising the All-Wales Focused review tool prior to presentation. Further analysis of themes of learning will be discussed by each IHC in the PUPM strategic Group meeting.

Core level mandatory training is now in the final stages with a h launch planned for the end of January 2025.The focus will then move swiftly to the development of

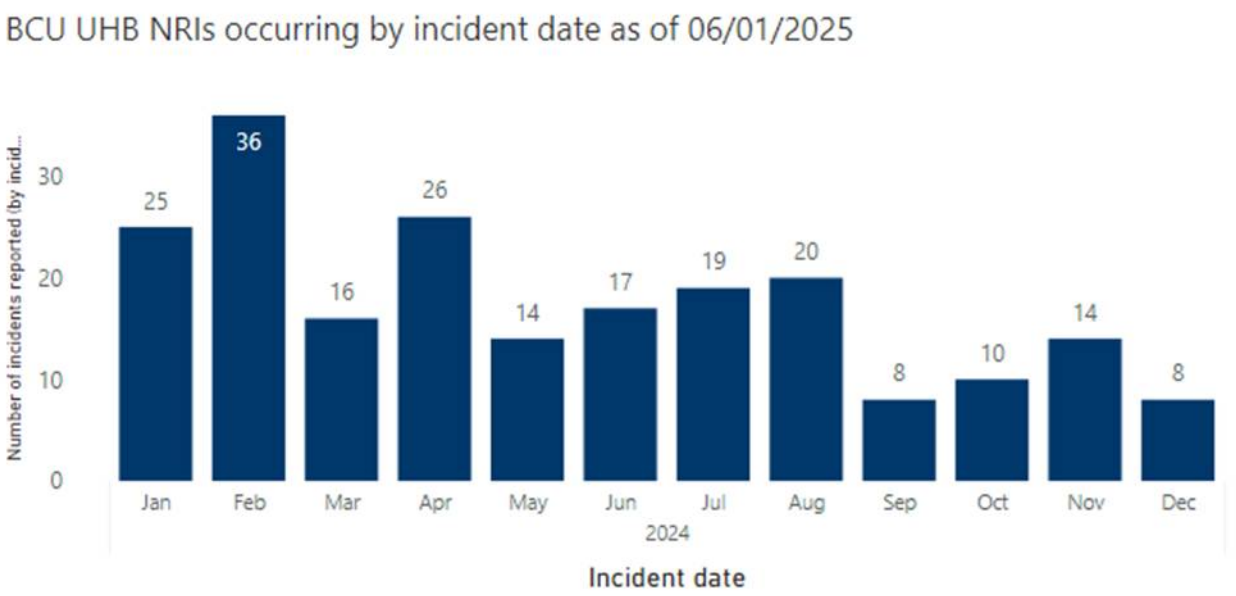
- Level 1 – Heath care Professionals with responsibility of undertaking risk assessments and planning care for PUPM.
- Level 2 – Registered Healthcare Professionals holding caseload of patients with pressure ulceration.

All areas have now adopted the new referral process for Tissue Viability Nurses (TVN), and the referral process is accessible on the TVN Betsi Net page. All Grade 4 pressure ulcers will be automatically be seen by TVN through submission of Datix with no referral required. Datix reporting of Grade 3 and unstageable pressure ulcers are reviewed daily by TVN's.

Digital, Data and Technology (DDAT) reviewed the request for support to create an electronic referral to TVN, CITO is the system that has been approved to support the requirements of the referrals. Meetings are in progress with an assigned member of the CITO team as a programme lead.

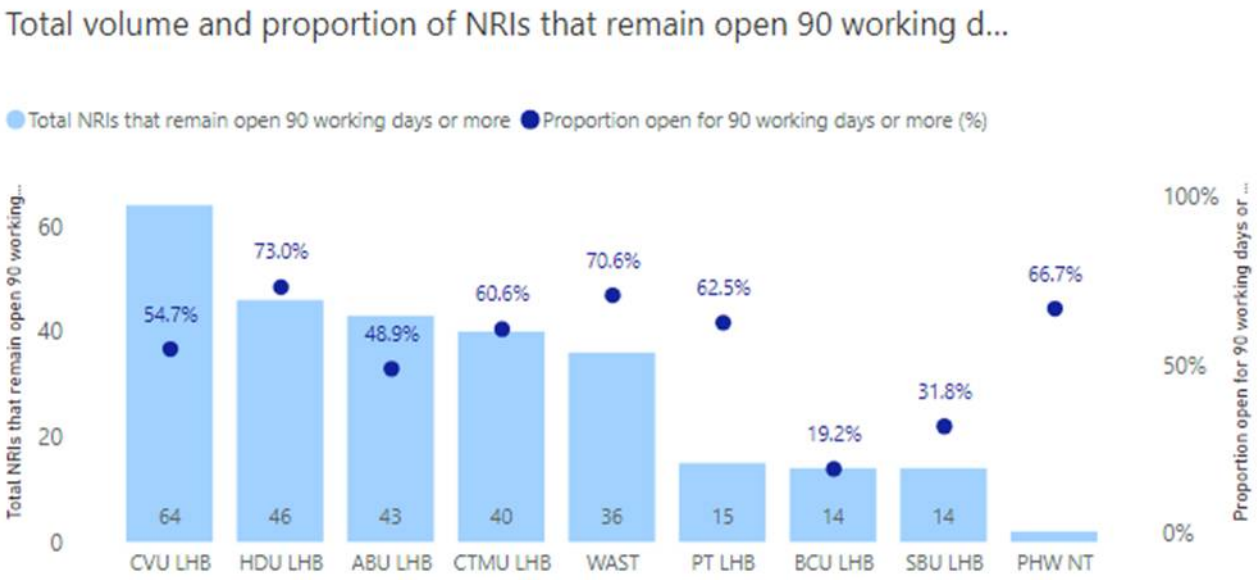
Nationally Reportable Incidents

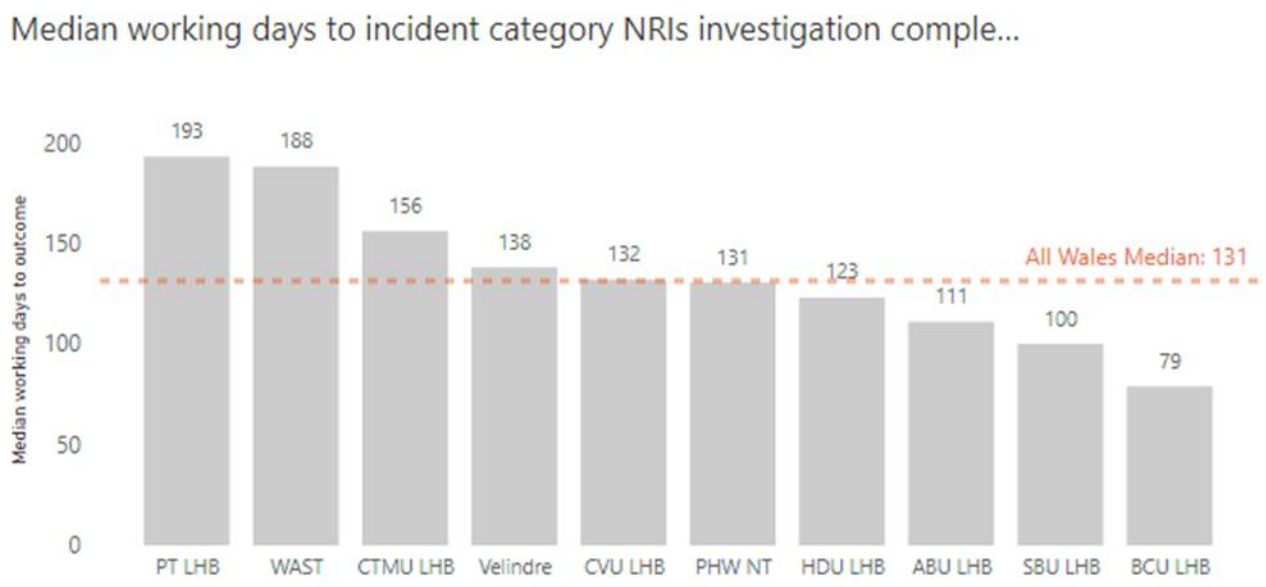
From 01st November – 31st December 2024, 22 National Reportable Incidents (NRIs) occurred, and 60 notifications were submitted. The increase in notifications compared to incidents occurring is due to retrospective reporting of patient falls and pressure damage. These are only notified when the review has been completed and deemed to be avoidable at local harms meetings.



The total number of NRI investigations that were open as at the end of December 2024 was 61 (up from last report), of which 10 (down from 12) were overdue closure with NHS Wales Executive.

The proportion of NRIs that remain open 90 working days or more is 19.2% (reduction from 28.4%) which is the lowest across Wales. The median working days that NRIs are completed is 79 which is the lowest across Wales compared to the median of 131 days.





Closures – Outcome forms submitted to NHS Wales Executive
56 NRI Outcome forms were sent during November and December 2024 of which 27 were for combined forms relating to HAPUs/ falls, and the remaining 29 were outcome forms for all other incident categories.

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

Never Events
Zero Never Events were reported in November or December 2024 (none since July 2024).

Oxygen Administration Improvement
Due to the change in policy following recent incidents i.e. registered staff only can transfer patients on oxygen, the training package needed to be changed to reflect this. It is now with the ESR team and awaiting ‘go-live’.

Labels attached to the CD oxygen cylinders at the point of use has now been fully actioned. There were some initial problems with the materials used to attach the warning tags and portering staff raised some concerns re the time it is taking to attach the tags. This will continue to be monitored.

BOC are still progressing with the development of the Single Valve cylinder. No recent update has been received but it is anticipated it will be available in the summer this year. There will likely be a cost implication.

The Medical Gases group briefly revisited the previous decision of not advocating activating cylinders in advance. The group agreed that this position had not changed.

A sub group of the medical gases group has been set up – No Flow Oxygen Improvement Group to lead on the Improvement Plan in the elimination of no flow incidents resulting in harms across the Health Board.

PATIENT SAFETY ALERTS

- PSA018 Risk of oxytocin overdose during labour and childbirth
  Women's services are leading, deadline 31/03/2025

SAFEGUARDING & PUBLIC PROTECTION

Publication of North Wales Safeguarding Children's Board Extended Child Practice Review 2/2022

The review found that the child, whose name was placed on the child protection register on 20/10/20 under the category of physical abuse, sexual abuse and neglect, was made subject of Care Proceedings in September 2021 and as a result, was placed in the care of the Local Authority.

A multi-agency action plan is being developed in response to the recommendations with monitoring arrangements via the North Wales Safeguarding Board [NWSB] Single Unified Safeguarding Review [SUSR] Case Review Group. The Safeguarding and Public Protection Team have an established quality assurance and governance process in place to ensure identified learning become lessons learnt.

The report is available via this link NWSCB-ECPR-2022-2-Report.pdf

All Wales Anti Sexual Harassment Policy

In response to the new protections from sexual harassment introduced in October 2024, the People Network, Deputy Directors WOD All Wales Group are developing an All-Wales Policy. Employers now have a legal duty to take reasonable steps to prevent sexual harassment and create a safe working environment.

- New duty under the Equality Act 2010 will require employers to take "reasonable steps" to prevent sexual harassment of their employees.
- New guidance for employers on how they can protect their staff

Employers must anticipate when sexual harassment may occur and take reasonable steps to prevent it. If sexual harassment has taken place, an employer should take action to stop it from happening again. This sends a clear signal to all employers that they must take reasonable preventative steps against sexual harassment, encourage cultural change where necessary, and reduce the likelihood of sexual harassment occurring.

The work will progress to implement the policy, with engagement from the Wales Safeguarding Network, Violence Against Women, Domestic Abuse and Sexual Violence [VAWDASV] Board with progress reported into the Vulnerability & Exploitation Board.

Implementation of the Once for Wales Safeguarding Report Form

Update Position
Following notification from Public Health Wales (PHW) on the 1st of October 2024 to confirm the implementation of the Datix Once for Wales Safeguarding Report Form which was due

to be launched on the 1st November 2024, will now not progress, the Health Board have engaged in the National Multi-Agency work to develop and produce an 'All Wales Agencies Report Form' that will support the Datix Module.

The 'Form' will ensure a standardised approach to safeguarding adults and children across Wales. We remain fully engaged in this work and provide updates as required through agreed governance channels.

Single Unified Safeguarding Review (SUSR)

Update Position

As previously reported the Minister for Children and Social Care issued a statement on the 1st of October 2024 announcing the launch of the SUSR in Wales. The purpose of the SUSR is to create a single review process where a multi-agency approach is required, incorporating the following review processes; Adult Practice Review; Child Practice Review; Domestic Homicide Review; Mental Health Homicide Review; and the Offensive Weapon Homicide Review.

The Safeguarding and Public Protection Team have been working with the North Wales Safeguarding Board and partner agencies to ensure this process was implemented within agreed timescales. The North Wales Safeguarding Board are delivering recurring training to support staff in the application of the new review process.

During Q3 and Q4, the team has engaged with Health Board colleagues to ensure that Governance, Reporting, Training and Policy & Procedures are updated. The Team have also been working with the Safeguarding Board and the Community Safety Partnerships (5 in North Wales) to support the transition from the old 'review' process into the SUSR.

Although is expected that Agencies will provide skilled staff to undertake the SUSR, it has been acknowledged that this will result in an increase in workload and costs. The Safeguarding Team are reviewing what this looks like and what this means for the Health Board, this will take time to assess as it will be based upon the number of SUSR requests that requested and subsequently completed. A 6-month review that will include Q4 2024-25 and Q1 2025-26 is planned.

INFECTION PREVENTION AND CONTROL

At the end of December, when considering the HCAI Improvement Goals outlined in the Welsh Health Circular (WHC) 2024/5 HCAI (Healthcare Acquired Infection) and AMR (Antimicrobial Resistance) set against the 2023/24 outturn, BCUHB are below trajectory for MSSA, E. coli, Klebsiella and Pseudomonas, and above for MRSA and C.diff.

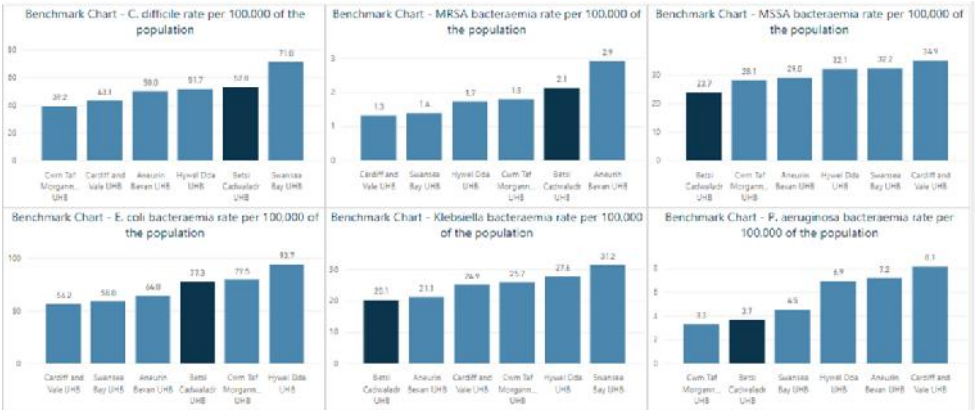
When considering the improvement goals to have fewer Staphylococcus aureus BSI than in 2024/2025 and to reduce hospital onset (HO) cases of Pseudomonas, E. coli and C. diff by 10% and 20% for Klebsiella against 2023/24 BCUHB are:

- Above trajectory for C. diff by 39 cases
- Below trajectory for E. coli by 3 cases
- Below trajectory for Klebsiella by one case
- Below trajectory for MSSA by 6 cases
- Below trajectory for Pseudomonas by 3 cases

It is no longer possible for the Health Board to achieve the 2024/2025 improvement goal for MRSA.

Row Labels	HO Specimens 24/25	HO Specimens 23/24	24/25 Trajectory	Yr on Yr	Trajectory Comparison
C. difficile	117	98	78	19	39
E. coli bacteraemia	88	101	91	-13	-3
Klebsiella sp bacteraemia	25	32	26	-7	-1
MRSA bacteraemia	3	3	3	0	0
MSSA bacteraemia	24	30	30	-6	-6
P. aeruginosa bacteraemia	6	10	9	-4	-3
Grand Total	**263**	**274**	**237**	**-11**	**26**

When compared to other Health Boards, at the end of December 2024, BCUHB remained in 1st position for MSSA and Klebsiella, 2nd for Pseudomonas, 4th For E. coli and 5th for MRSA, dropping to 5th for C. diff.



Actions to address the WHC 2024/25 HCAI Improvement Goals

- A Learning Review has been conducted across the IHCs, resulting in the development of a definitive improvement plan with measurable outcomes for each IHC. These are being reported and monitored through the Local Infection Prevention (IP)Groups and escalated to the Strategic Group.
- High level actions within these plans include a) Environmental cleaning and disinfection (to include with decant facility) b) Increasing isolation and cohorting capacity, c) Improving the estate, d) Improving invasive device management and Aseptic Non-Touch Technique ANTT, e) Improved antimicrobial prescribing/stewardship.
- The Local Infection Prevention Groups have been requested to review the recommendations within the National C. diff Framework (2025 – 2027) for Wales to ensure that these have been considered within their IHC improvement plans.
- Healthcare Associated infection Antimicrobial Resistance and Prescribing (HARP) and Public Health Wales (PHW) conducted a supportive external visit during the week of 9th December 2024, meeting with key stakeholders to discuss the IP agenda/strategy for BCUHB, whilst also visiting several wards/departments across the three IHCs. Whilst a formal report has not yet been provided, the preliminary verbal feedback was reassuring, however did stress the importance for improved medical engagement within the IPC agenda. Subsequent discussions have taken place amongst the Clinical Executives in relation to this.
- The staff HABITS campaign has continued with a repeated focus on Hand Hygiene during in January and February. An additional element to the campaign is to be launched which is to be more patient and public focused this time around.
- The Hand Hygiene escalation process has been refreshed and relaunched.
- A programme of Microteaching sessions relating to the six key performance indicators are being formally scheduled with attendance recorded across each IHC.
- Through a weekly Integrated Concerns meeting with Executive Oversight, all significant and catastrophic infection related incidents will be presented. A selected Post infection Review is now being presented at each Local Infection Prevention Group and learning is also being presented at the Strategic Infection Prevention Group and there is a plan to present also at the Organisational Learning Forum.
- High Level Disinfection (HLD) in the form of Hydrogen Peroxide Vaporisation or Hypochlorous Acid has now been re-established within all IHC.
- A work plan is being compiled in preparation for the imminent publication of revised National Cleaning Standards.
- Each IHC now has a named ANTT Lead. The IPT ANTT Lead is planning to meet with the leads to discuss responsibilities and priorities to ensure ANTT training compliance is robust across all IHCs.

OTHER PATIENT SAFETY CONCERNS AND IMPROVEMENTS

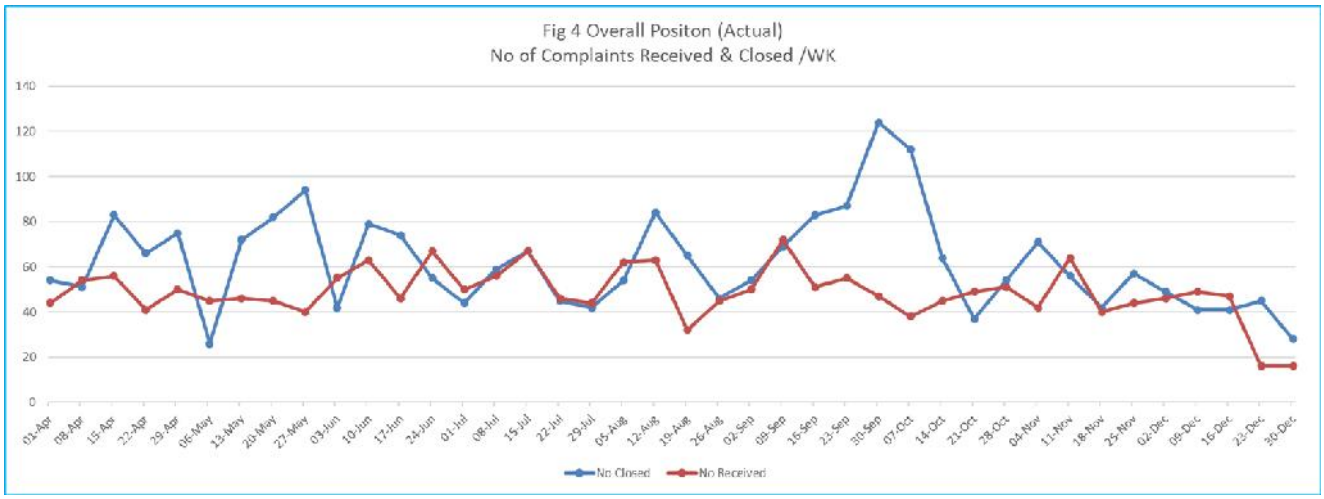
There are no significant issues to report.

PATIENT EXPERIENCE

COMPLAINTS

Between the 1st December and 31st December 2024, the BCUHB received 174 complaints and closed 204 complaints, a positive variance of 30

The chart below provides further detail:



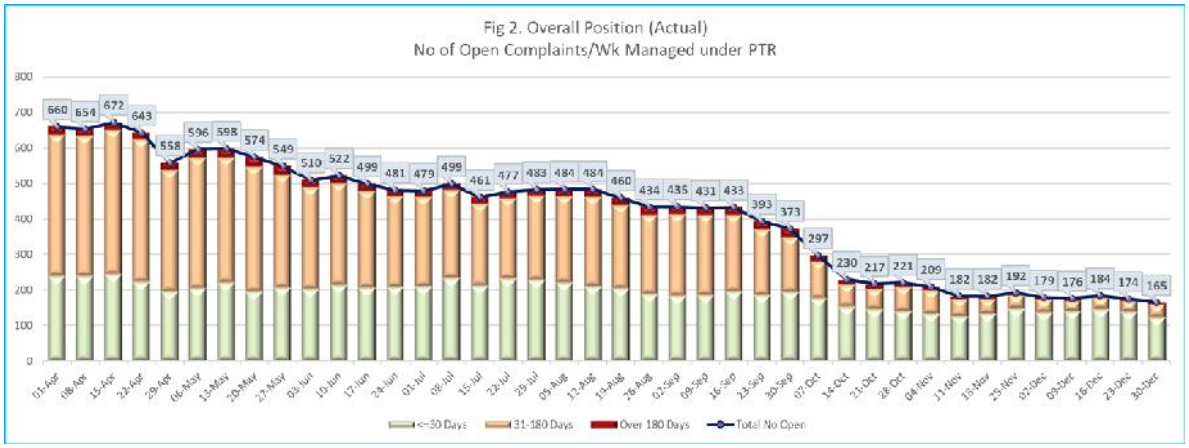
Complaint's position as of 31st December 2024

Total Number of open complaints – 165 (a reduction from 179 in the previous reporting period)

Number of Complaints Less than 30 working days – 122
Number of Complaints overdue = 43 (the same as the previous reporting period)
Compliance with 75% target of overdue complaints – 73.94% (a reduction from 75.98% in the previous reporting period, and below 75% target)

The complaints trajectory work commenced on 1st April 2024, and between 15th April 2024 and 31st December 2024;

The total number of BCUHB complaints have fallen 672 to 165 = 75.45% improvement of which Overdue complaints have fallen from 428 to 43 = 89.95% improvement.



Compliance Breakdown by IHC / Service as of w/c 30th December 2024

IHC/Service	<=30 Days	>30 Days	Total	(%)
Cancer Services	3	0	3	100.00%
Corporate Services	3	1	4	75.00%
Dentistry	2	0	2	100.00%
Diagnostics and Specialist Clinical Support Services	4	0	4	100.00%
HCAI Nosocomial COVID-19 Reviews	1	0	1	100.00%
IHC Central	22	17	39	56.41%
IHC East	44	12	56	78.57%
IHC West	24	6	30	80.00%
Mental Health and Learning Disabilities	11	0	11	100.00%
Midwifery and Women's Services	8	7	15	53.33%
Total	**122**	**43**	**165**	73.94%

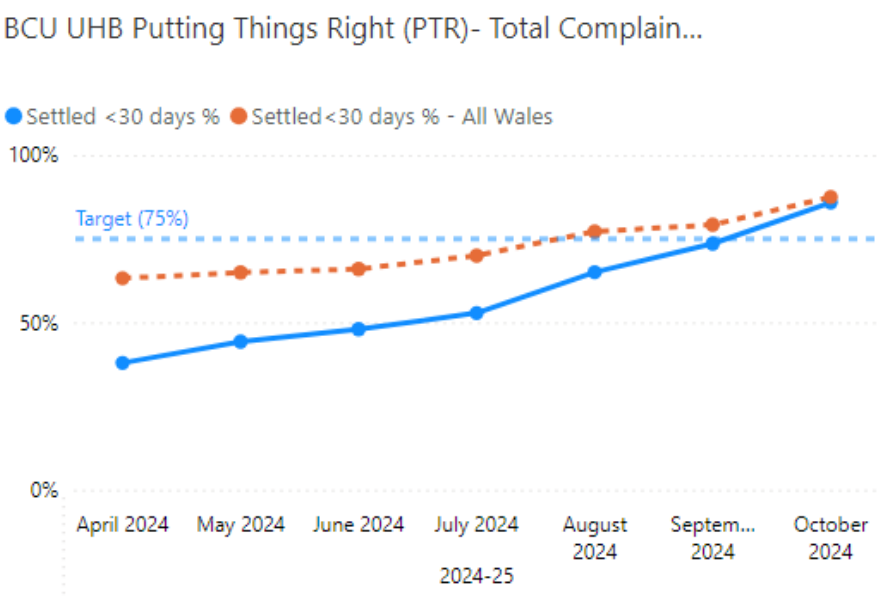
Average complaint closure time

As of 31st December 2024, the average number of working days / months a complaint is open is as follows, with the average time 32.09 working days including historical and backlog complaints (a small improvement from 32.29 working days in the previous reporting period, and remains above the 30-day target)

Note: the average length of time for complaint responses includes longest wait (over 16 months) which directly impacts the average

Real Time performance complaint closure performance (National Beacon Dashboard)

The chart below outlines or performance improvement in real time. i.e. how many complaints that we receive in any given month, are we closing within 30 days of receipt. The latest update is up to October 2024, with the National Beacon (Dashboard refreshing on 31st January 2025)



The data shows a continual improvement in efficiency of closure rates, where patients are receiving responses to their concerns in a timelier manner as follows. Percentage of complaints closed within 30 working days (Target 75%)

April 2025 = 37.91%
May 2025 = 44.24%
June 2025 = 47.98%
July 2025 = 52.82%
August 2025 = 65.00%
September 2025 = 73.56%
October 2025 = 85.82%

Complaint themes

Clinical Treatment and assessment and communication remain our biggest two themes, equating for 125 complaints of the 165 total open complaints (75.5%)

Within these main themes the 3 most significant sub themes are

- Delay / lack of diagnosis – 60 complaints
- Incorrect / Insufficient treatment or assessment – 21 complaints
- Incorrect / Insufficient treatment or assessment – 15 complaints

96 complaints received within the month of December 2024 out of the total 174 relate to these three sub themes (55.17% - over 1 in every 2 complaints)

Themes and sub-themes

Clinical treatment/Assessment	**72**	**35**	**107**
Compliment regarding clinical treatment/assessment	1	0	1
Delay/Lack of diagnosis	9	6	15
Delay/Lack of treatment or Assessment	41	19	60
Incorrect diagnosis	3	2	5
Incorrect/insufficient treatment or Assessment	13	8	21
Reaction to procedure/ treatment	5	0	5
Communication Issues (including Language)	**16**	**2**	**18**
Communication with family	5	0	5
Communication with patient/service user	10	2	12
Insufficient/Incorrect information	1	0	1

Once for Wales Assessment (Welsh Risk Pool)

An assessment was undertaken by Welsh Risk pool in the month of May, June 2024, and the initial scoring states they have reasonable assurance, an increase from limited assurance received last time, and one grade down from the top grading of substantial assurance. Since the assessment has been undertaken, there have been further improvements made with complaints and concerns management, including the introduction of the new integrated complaints, concerns, incidents, and mortality hub and associated, noting the positive comments as follows
"Overall, the quality and compassion of complaint responses seen across a number of files, were considered to be of very high quality, and there was evidence of high-level oversight of responses. This is recognised as excellent practice.

In summary, the Assessors considered that there had been considerable improvement in processes and quality of the complaints function. Further action is needed to achieve consistency and high-quality data. The assessors felt that if the current trajectory of improvement is sustained, it is likely that Substantial Assurance could be attained"

PATIENT FEEDBACK

Patient Advice and Liaison Service (PALS)

From 1 November 2024 – 31 December 2024, the Patient Advice and Liaison Service (PALS) facilitated the resolution of 950 enquiries, received 80 compliments in writing and 63 suggestions for improvement.

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

- Appointments
- Clinical treatment or assessment
- Access to services

Patient Feedback

From 1 November 2024 – 31 December 2024, 8246 All Wales Real-Time Patient and Carer Feedback Survey responses were received via Civica feedback system.

The Health Board continues to make positive progress to achieve the All-Wales satisfaction benchmark of 85%. Overall satisfaction levels have remained high with 82.16% of respondents 'very satisfied' with their overall experience of accessing Health Board services.

Below are key findings from the All-Wales Real-Time Patient and Carer Feedback Survey:

1. 82.55% were always given all the information needed
2. 83.23% were always involved in decisions about care
3. 84.96% always felt listened to
4. 82.56% felt staff always took the time to understand what mattered to them

From 1 November 2024 – 31 December 2024, 2870 Emergency Department feedback survey responses were collected via Civica feedback system.

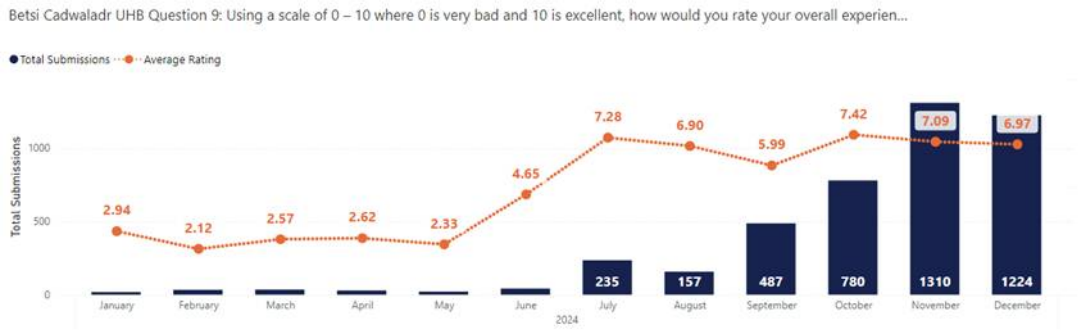
Although the Health Board was late to implement SMS Feedback surveys, it is now ranked the 3rd highest Health Board in Wales to capture Emergency Department feedback returns. The Health Board has the 4th highest average satisfaction score across All Wales Emergency Departments (Beacon Dashboard 29/1/25).

Average experience rating and number of returns in Wales:

Average experience rating (for completed surve...

Organisation	Total Submissions (excluding Did not answer)	Average Rating (0-10)
CTMU UHB	11,291	7.69
CVU UHB	5,775	7.45
BCU UHB	4,371	7.02
HDU UHB	2,632	7.69
SBU UHB	1,124	6.30
ABU UHB	221	6.17
All Wales	**25,414**	**7.44**

In December 2024 respondents rated their overall experience as 6.79 out of 10, with 10 being excellent (Beacon Dashboard 29/1/2024).



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

1. 60.30% of respondents always felt well cared for
2. 34.54% of respondents felt they waited 'shorter than expected' to be seen
3. 65.41% of respondents always felt listened to
4. 65.94% always felt things were explained in a way that they understood

The Patient and Carer experience Team are working with the Emergency Departments to review their feedback data, to identify opportunities and learning through 'you said, we did' methodology.

OTHER PATIENT EXPERIENCE CONCERNS AND IMPROVEMENTS

NHS Wales People's Experience Framework

In preparation for the launch of NHS Wales People's Experience Framework in April 2025, IHC and Specialist Services have reviewed the Civica Hierarchy to identify missing services to be added to the feedback system to ensure all services are open to receive patient feedback.

To promote the importance of capturing patient feedback PALS have been targeting service areas that receive low numbers of monthly feedback returns. Training and support mechanisms have been put in place to increase feedback returns. Priority areas identified include Vascular Service, Urology Service, National Children's Survey, and inpatient wards.

The Patient and Carer Experience Team are working with the Communication Team to support the 'always on' reporting approach to ensure we are promoting all methods available for patients/carers to provide feedback, and the Health Board is sharing learning from patient feedback to the public.

The Patient and Carer Experience Lead is the Chair of the All-Wales Compliment Working Group to support the implementation of the People's Experience Framework. The working group is exploring the introduction of standard coding/theming on Datix Cymru to support compliment feedback analysis. A standard All Wales approach to compliments will be developed to ensure the collection of compliments are within easy reach for all people, process in place to support learning from compliments, good practice is shared, and staff and service areas are recognised.

Patient Communication and Information

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

The Patient Information Readers Panel continues to meet monthly to review patient information leaflets. Within the reporting period 32 patient information leaflets were reviewed by the Readers Panel.

Below are examples of leaflets approved at Readers Panel:

- Information for patients having a Vascular Embolisation
- Information for patients having a Fistulogram, Fistuloplasty and Venogram
- Patient Guidance for MRI Examinations with MR Conditional Cochlear Implants

- Information for patients having a Hysterosalpingogram (HSG)

Ongoing work continues to support the production of high-quality patient information. The Patient and Carer Experience Team are developing a Patient Information Library on SharePoint, to ensure all patient information leaflets reviewed by the Readers Panel are accessible to staff.

Accessible Health Care

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

To promote National Sensory Loss Awareness Month in November 2024, the Patient Advice and Liaison Service led a campaign to promote digital access to interpretation through the Wales Interpretation and Translation Service (WITS), and to raise awareness of British Sign Language (BSL) support available. As part of the campaign PALS delivered training to over 300 front line staff, engaged with wards and service areas and organised events across North Wales.

Chaplain & Spiritual Care Service

From 1 November 2024 – 31 December 2024, the Chaplain and Spiritual Care Service responded to 155 requests for support pan North Wales. These requests for support are in addition to daily pastoral work undertaken on wards/units.

Twenty-one multi-faith events were organised across North Wales fostering inclusivity and support for individuals from diverse religious backgrounds. The aim of the events was to create a supportive environment that honours and respects the traditions of faith groups of individuals under our care.

Examples of events organised:

- Baby memorial service in Bangor Cathedral
- Remembrance Services in Ysbyty Glan Clwyd, Wrexham Maelor Hospital and Ysbyty Gwynedd
- Transgender Day of Remembrance Vigil in Ysbyty Gwynedd Chapel
- Music sessions with patients and staff in Denbigh Community Hospital
- Christmas events in Ysbyty Glan Clwyd, Ysbyty Wrexham Maelor, Ysbyty Gwynedd and community hospitals across the Health Board

CLINICAL EFFECTIVENESS

CLINICAL AUDIT

National Clinical Audits (Tier 1) are mandated audits that provide benchmarking reports to help Health Boards clinically monitor performance against national standards and identify areas of improvement. These audits are crucial for maintaining high standards of care and ensuring continuous improvement in the NHS.

Within BCUHB Tier 1 audits are monitored quarterly, a report is collated and shared within the Strategic Clinical Effectiveness Group and then within the Chair's Report in Executive Quality Delivery Group. There were 16 Tier 1 nationally published reports within Quarter 3 (the information in the report is relating to the care received by patients for the relevant audit topic) 4 are noted below, and the remaining 12 will be captured in Quarter 4, when the response is due.

Service Assessments of Compliance (SAoCs) are requested following the publication by the Clinical Effectiveness Facilitators (Audit) to note key achievements. Please refer to the table below which captures improvements made, impact shown and lessons learnt.

				West	Central	East	
Title of National Audit	Name of report	Date of publication	Date Service Assessment response due	Service Assessment Completed	Service Assessment Completed	Service Assessment Completed	Key Achievements Summary
National Emergency Laparotomy Audit (NELA)	NELA Year 9 Report	10-Oct-24	05-Dec-24	Yes - Draft	Yes - Draft	No - Overdue	Service Assessment of Compliance (SAoC) received from IHC West & Central undergoing Clinical Effectiveness (CE) Team Review SAoC not received from IHC East, escalated to IHC Management Structure in line with CE Team process.
MBRRACE - Maternal, Newborn and Infant Clinical Outcome Review Programme: Perinatal surveillance (UK wide, 2022)	Saving lives, improving mothers care report	10-Oct-24	12-Dec-24	Yes - Draft	Yes - Draft	Yes - Draft	SAoC undergoing CE Team Review
FFFAP: National Audit of In-patient Falls (NAIF)	2024 Audit report	10-Oct-24	26-Dec-24	Yes - Draft	Yes - Draft	No - Overdue	SAoC received from IHC West & Central undergoing CE Team Review SAoC not received from IHC East, escalated to IHC Management Structure in line with CE Team process
National Early Inflammatory Arthritis Audit (NEIAA)	State of the Nation Summary Report 2024	10-Oct-24	26-Dec-24	No - Overdue	No - Overdue	No - Overdue	SAoC not received from all areas, escalated to IHC Management Structure in line with CE Team process

The Clinical Effectiveness Team have made significant changes in the way that Tier 1 audits and NICE guidelines compliance are now monitored on the software Audit Management and Tracking (AMaT). This has meant a more structured approach in our reporting across BCUHB. All information is uploaded monthly to our website BCU.ClinicalEffectivenessTeam@wales.nhs.uk

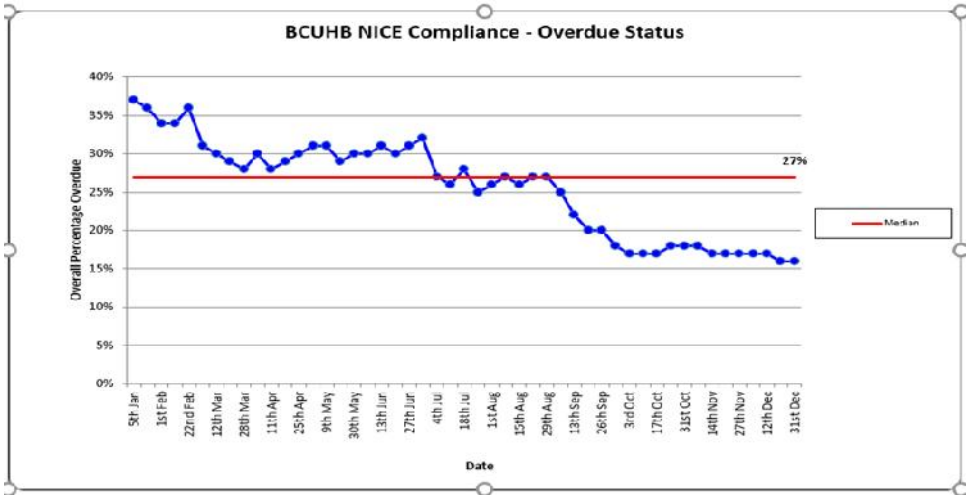
We are currently reviewing the **Tier 2 audit list** for 2025-2026, which are Health Board's local priority audits, which support the delivery of the Quality Improvement Strategy goals and priorities, or those related to identified clinical risks. The review will take place in Strategic Clinical Effectiveness (SCEG) meeting in February to discuss which current continuous Tier 2 audits are to be carried over and which will be new Tier 2 audits identified for approval. With the current Tier 2 audits, we will be contacting the audit leads to provide an update on lessons learnt, where this information has been shared and any action plan that has been developed and this will be fed back through relevant meetings and within the Quarterly and Annual Clinical Effectiveness reports.

NICE GUIDELINES

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

The overall Health Board compliance status is improving with only 16% (up to end of December 2024) outstanding as overdue (non-responses).

BCUHB NICE (Overdue) run chart for 2024



Overall BCUHB Compliance Status

Period from: 03 October 2024 to: 31 December 2024		N value	Percentage
Fully Achieved	↑	up from 111 to 127	up 2.8%
Partially Achieved - Acceptable	→	no change	down 0.00039
Partially Achieved - Improvement Needed	↑	up from 15 to 16	down 0.1%
Not Achieved	↑	up from 7 to 9	up 0.6%
Not Applicable (N/A)	→	no change	down 1.2%
In Progress	↓	down from 5 to 4	down 0.6%
Overdue	→	no change	down 1.4%
Total	↑	up from 206 to 224	

Current position - as of 31 December 2024		
127	57%	Fully Achieved
1	0%	Partially Achieved - Acceptable
16	7%	Partially Achieved - Improvement Needed
9	4%	Not Achieved
31	14%	Not Applicable (N/A)
4	2%	In Progress
36	16%	Overdue
224		

The recently reviewed **NICE Protocol** has been approved in January SCEG and will be available on Betsi net shortly.

MORTALITY REVIEW

Corporate Mortality Update:

- Monthly Learning from Mortality Panel and Reducing Avoidable Mortality Steering Group (LFMP & RAMSG) meetings will formally re-instate in January 2025 with review of the agenda format, terms of reference and cycle of business. Accountability in terms of reporting back to LFMP will be a key priority as well as wider clinical engagement. An extraordinary LFMP was held in January discussing learning cases from July 2024 – October 2024.
- Following appointment of AMDs for mortality, clinical engagement with the Once for Wales (OfW) group to hone the themes (both in terms of options but also descriptions) is seen as a key opportunity with the aim to glean accurate data extraction from the

mortality Datix. This will allow the Health Board to draw upon themes via the Mortality Datix in the future.

- A report of cases that have been reviewed by Corporate Mortality Clinical Reviewers is being provided to the Integrated Concerns Hub (ICH) daily to ensure triangulation of the incidents, concerns and mortality process is taking place in a timely manner. The ICH are no longer reporting cases from 'New' which means that all mortality cases discussed will have gone through Clinical Effectiveness Mortality Admin and Clinical Sieve and Sort processes. The mortality process is running alongside this in line with The All-Wales Mortality Framework, where the focus will be learning from cases.
- There is currently **no backlog of cases** awaiting Clinical Effectiveness team mortality processing. Risk mitigation was put in place by a temporary increase in staffing resource, but additional funding is only short term. Workload will continue to be closely monitored. There remains a high number of cases outstanding IHC/service reviews, which has been highlighted to the IHC's and services.
- A consolidated improvement plan for the Health Board has been compiled following on from the results of the 2023-24 cycle of the BCUHB audit of compliance of completed Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms with the All-Wales DNACPR policy and publication of the Health Inspectorate Wales (HIW) Review of DNACPR decision-making in Wales.

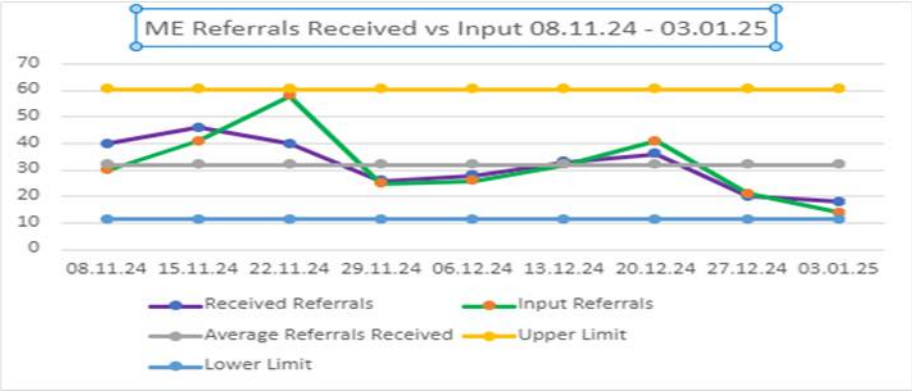
	Input/output			Inputting Backlog				Datix Status										
Date	Total received per week*	Total input per week	Output Differential	Total w/e Backlog inc compliments	Backlog of cases requiring inputting within 1 month from date received by MES	Backlog of cases requiring inputting within 2 months from date received by MES	Backlog of cases requiring inputting within 3 months from date received by MES	Total New cases (awaiting mortality admin s&s)	New Under 1 month DOD (awaiting mortality admin s&s)	New Within 2 months DOD (awaiting mortality admin s&s)	New Within 3 months & over DOD (awaiting mortality admin s&s)	Total Pending Cases awaiting Mortality Clinician Review S&S	Pending Cases Under 1 month awaiting Mortality Clinician Review S&S	Pending Cases Within 2 months awaiting Mortality Clinician Review S&S	Pending Cases Within 3 months awaiting Mortality Clinician Review S&S	Pending scrutiny panel (with IHC's, for IHC's to RAG rate)	Under investigation / action required (with IHC's, for IHC's to RAG rate)	Process completed
08.11.24	40	30	-30	21	21	0	0	37	33	4	0	9	2	7	0	1009	215	2867
15.11.24	46	41	-5	26	26	0	0	10	8	2	0	29	22	7	0	1025	214	2894
22.11.24	40	58	18	10	10	0	0	38	38	0	0	18	12	6	0	1052	200	2915
29.11.24	26	25	-1	11	11	0	0	21	21	0	0	18	12	6	0	1049	205	2958
06.12.24	28	26	-2	11	11	0	0	2	2	0	0	15	15	0	0	1065	205	2989
13.12.24	33	32	-1	11	11	0	0	11	11	0	0	11	9	2	0	1054	200	3032
20.12.24	36	41	5	6	6	0	0	5	5	0	0	12	12	0	0	1064	209	3059
27.12.24	20	21	1	5	5	0	0	12	12	0	0	2	2	0	0	1078	211	3062
03.01.25	18	14	-4	4	4	0	0	4	4	0	0	1	1	0	0	1078	214	3090

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

MES = Medical Examiner Service. DOD = Date of Death. IHC = Integrated Health Community.

S&S= Sieve and Sort process recognising if the case needs to be sent to relevant departments or whether the issues/learning is included in another Putting Things Right (PTR) process, in which case the mortality review can be closed.

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



OTHER CLINICAL EFFECTIVENESS CONCERNS AND IMPROVEMENTS

Below is an update on areas of data collection issues reported for review raised through Quarter 3. Local Clinical Effectiveness meetings are updated each month on any areas of concerns and if no improvement is made then this will be escalated to IHC/Divisions, who will be asked to submit to Strategic Clinical Effectiveness group an SBAR or through Chair's report as a risk and upload to the risk register. Strategic Clinical Effectiveness Group will raise with Quality Development Group, and this would be monitored through an action tracker.

	West	Central	East
Title of National Audit/ Clinical Outcome Review	Participation/Data collection issues reported	Participation/Data collection issues reported	Participation/Data collection issues reported
NELA - National Emergeancy Laparotomy Audit	The Anaesthetic department has recently recruited a specialist who will spend some SPA time working with the NELA audit. The department is also in the process of trying to secure admin support for NELA.		
National Major Trauma Registry (NMTR) (formerly Trauma Audit & Research Network - TARN)	The data sharing agreement was signed off in November 2024 and data entry to the new platform is now legal. Data from the point of the TARN database shut down 16.06.2023 to the 31.03.2024 has been lost. BCU acute sites are now working to address the backlog of data entry for the current audit year April 2024 to March 2025. East has recently appointed a new Trauma lead.		

QUALITY ASSURANCE

HEALTHCARE INSPECTORATE WALES

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

Healthcare Inspectorate Wales Activity December 2024 to January 2025

Published Reports (1)

HIW have published the inspection report pertaining to Gwanwyn and Hydref Wards on the 23rd January 2025.

Announced/Unannounced Inspections (3)

Unannounced inspection at Ysbyty Maelor, Emergency Department

HIW undertook an inspection at Ysbyty Maelor, Emergency Department from the 12th to the 14th December 2024. HIW issued an immediate assurance, as the inspection team identified areas posing immediate risk to patient safety. As such, HIW made the following recommendations to the Health Board which require immediate action:

- HIW requires details on how the health board will ensure that measures are in place to ensure that medication and intravenous infusions expiry dates are checked on a regular basis, and to remove any items past their expiry dates.
- HIW requires details on how the health board will ensure that medication is always stored in its original dispensing boxes, along with the relevant information sheets.

The Health Board submitted an Immediate Improvement Plan to HIW on 19th December 2024 confirming the action it will take to make the required improvements and mitigate any further risks.

Unannounced Inspection at Kestrel Ward, North Wales Adolescent Service (NWAS)

HIW undertook an inspection of Kestrel Ward, NWAS, Abergele Hospital from the 14th January to 15th January 2025. HIW issued an immediate assurance, as the inspection team identified areas posing immediate risk to patient safety. As such, HIW made the following recommendations to the Health Board which require immediate action:

- Dispose of and replace all expired medication at the setting, including emergency and patient medication
- Implement a reliable audit system to ensure emergency and patient medications remain in date and available for use
- Provide additional training and guidance to ensure all staff are aware of their role and responsibilities in relation to medicines management

- Strengthen leadership and management systems to ensure robust governance oversight of medicines management systems and audit processes
- Review the outdated Medicines Policy to provide clear and current guidance to staff.

The Health Board submitted the immediate plan to HIW on the 24th January 2025, confirming the action it will take to make the required improvements and mitigate any further risks.

Unannounced Inspection at Carreg Fawr, Bryn Y Neuadd, Mental Health and Learning Disabilities (MHLD)

HIW undertook an unannounced inspection of Carreg Fawr Rehabilitation Unit, at Bryn y Neuadd, from the 21st January to the 23rd January 2025.

There were no immediate assurances required, praise for all staff and their positive engagement with the patients was noted. HIW also highlighted that robust leadership was noticeable, and mandatory training was of a high compliance rate. One of the main recommendations for improvement pertained to the escalation process within the unit.

The inspection report and improvement plan will be provided by HIW to the Health Board for action, within 8 weeks post inspection.

Concerns / Requests for Assurance (4)

Upon receipt of a concern, or where their intelligence suggests that there is a risk to patient safety, HIW write to the Health Board to determine whether any action is required. Where the Health Board provides sufficient information to confirm that it has reviewed the matter, acted in the best interests of its patients, and is managing / mitigating risk accordingly. If the Health Board's response does not provide sufficient assurance, HIW will request further information / action.

All responses from the Health Board receive approval from Responsible Directors and the appropriate Executive Director, prior to submission to HIW.

Case 1: IHC West – Conduct of Member of Staff, Subject to Legal Action

The Health Board received a letter of concern from HIW regarding the following: -

- Conduct and capability of staff member
- Potential use of NHS equipment for private practice and reimbursement of fees

This concern has been responded to and accepted by HIW as providing sufficient assurance.

Case 2: IHC East – Referral system from Health Board to The Walton Centre

The Health Board received a letter of concern from HIW regarding the referral process of patients to the Walton Centre. Assurances relating to what fail safes are in place for follow up of referrals.

A response has been provided and accepted by HIW as providing sufficient assurance.

Case 3: IHC West – Same Day Emergency Care (SDEC)

The Health Board received a letter of concern from HIW regarding staffing issues and patient dignity.

A response has been provided and accepted by HIW as providing sufficient assurance.

Case 4: IHC East, Gladstone Ward, Deeside Hospital

The Health Board received a letter of concern from HIW regarding the following: -

- Staffing levels
- Staff retention
- Dignity of patients
- Staff reluctant to raise concerns

The Health Board has responded to HIW and HIW has accepted what has been provided as sufficient assurance.

Healthcare Inspectorate Wales – Progress with Improvement Plans December 2024 to January 2025

Month on month progress rates, as reported to the Regulatory Assurance Group (RAG)

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

Performance markers are based on 'Complete' and 'Fully Complete' actions only
Overall RAG status is based on the overall completion status of the action/improvement plan

Service / Area	Date	Responsible Lead	Position overview
Local Review of Discharge Arrangements for Adult Patients from Inpatient Mental Health Services (Action Plan)	Mar 2023	Interim Director, Mental Health and Learning Disabilities	Fully Complete (Approved)
Nant Y Glyn Community Health (Improvement Plan)	Jan 2024	Interim Director, Mental Health and Learning Disabilities	Fully Complete (Approved)
Emergency Department, Ysbyty Glan Clwyd (Immediate Improvement Plan)	Apr 2024	Integrated Health Community Director, Central	Fully Complete (Approved)
Emergency Department, Ysbyty Glan Clwyd (Improvement Plan)	Apr 2024	Integrated Health Community Director, Central	⇧ 19%
IR(ME)R, Ysbyty Gwynedd (Improvement Plan)	June 2024	Professional Service Manager, Radiography	⇧ 5%
Gwanwyn and Hydref Wards, Heddfan Unit (Immediate Improvement Plan)	Oct 2024	Interim Director of Operations, MHLD Services	Reported to RAG from Feb 2025

- **Local Review of Discharge Arrangements for Adult Patients from Inpatient Mental Health Services (Action Plan):** This was reported as 'Fully Complete (Approved)' at the RAG meeting in February 2025. This status means that the evidence provided by the service has provided sufficient assurance that

improvements have been made as per the recommendations made by HIW. A review date for the plan has been agreed with the service to ensure improvements are sustained.

- **Nant Y Glyn Community Health (Improvement Plan):** This was reported as 'Fully Complete (Approved)' at the RAG meeting in February 2025. This status means that the evidence provided by the service has provided sufficient assurance that improvements have been made as per the recommendations made by HIW. A review date for the plan has been agreed with the service to ensure improvements are sustained.
- **Emergency Department, Ysbyty Glan Clwyd (Immediate Improvement Plan):** This was reported as 'Fully Complete (Approved)' at the RAG meeting in February 2025. This status means that the evidence provided by the service has provided sufficient assurance that improvements have been made as per the recommendations made by HIW. A review date for the plan has been agreed with the service to ensure improvements are sustained.
- **Emergency Department, Ysbyty Glan Clwyd (Improvement Plan):** 49 out of the total 70 service improvement actions are 'Fully Complete (Approved)', and 6 actions are 'Complete (Awaiting Approval)'. A progress rate of 19% has been made since the RAG meeting in December 2024. 5 actions are 'Partially Complete (Overdue)', and 8 actions are 'Overdue', which means that of those actions remaining, they are overdue and so the improvement plan has passed the timescale agreed for completion. This has been escalated accordingly as the Health Board received the improvement plan back in July 2024, following the inspection in April 2024. Most recently, the IHC Director for Centre (Nursing), has reviewed the overdue actions in detail with the Quality Assurance and Regulation Team and has arranged a 'Rapid Response' meeting with the service to address the overdue actions in a timely manner.
- **IR(ME)R, Ysbyty Gwynedd (Improvement Plan):** 17 out of the total 21 service improvement actions are 'Fully Complete (Approved)'. A progress rate of 5% has been made since the RAG meeting in December 2024. 3 actions are 'Partially Complete (Overdue)' and 1 action is 'Overdue' which means that of those actions remaining, they are overdue and so the improvement plan has passed the timescale agreed for completion. This was escalated at the RAG meeting in December, and the service have made timely progress.
- **Gwanwyn and Hydref Wards, Heddfan Unit (Immediate Improvement Plan):** 0 out of the 76 service improvement actions are Complete. 25 actions are 'In Progress' and 50 actions are 'Overdue'. As the improvement plan was receive in October, the service has not made sufficient progress. This has been escalated to RAG in February 2025.

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

CARE INSPECTORATE WALES

CIW regulate adult services such as care homes for adults, domiciliary support services, adult placement services and residential family centre services. As the Health Board is one legal entity, it is a registered provider for multiple services which includes Enhanced

Community Residential Service (MHLD) and Tuag Adref (across all three Integrated Health Communities).

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

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

Quality of Care Review visits

The Health Board aims to undertake six-monthly Quality of Care Review visits. Ahead of a visit, services are asked to complete a Quality-of-Care Review Report which gives the service an opportunity to demonstrate that they are meeting the four key well-being areas in line with legal requirements. The purpose is for them to assess their performance and look at any opportunities to improve and develop. No immediate issues were raised during the visits undertaken by the Health Boards Responsible Individual during 2024.

The visit schedule for 2025 is underway to ensure that the Health Board meets its legal requirements for undertaking Quality of Care Reviews.

Amendment to CIW Registration

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

The request has been made in line with the considerations outlined in the Regulation and Inspection of Social Care (Wales) Act 2016, confirming that the services are no longer providing the ‘care’ and ‘support’ as set out in the Regulation and Inspection of Social Care (Wales) Act 2016.

The Health Boards Responsible Individual approved the requests, and the Health Board is liaising with CIW in terms of the next steps required as it still has two services (IHC East and Enhanced Community Residential Care ECRS) which are providing domiciliary care.

QUALITY PEER REVIEWS

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

The review involves an internal process of self-assessment and mock inspections against core criteria, which has been developed based on the approach of Healthcare Inspectorate Wales (HIW). Reviews have taken place as follows:

- Maternity Services at Ysbyty Gwynedd, West on 18 December 2023.
- Maternity Services at Glan Clwyd Hospital, Central on 17 July 2024.
- Maternity Services at Wrexham Maelor Hospital, East on 26 November 2024.

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

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

HEALTH AND SAFETY EXECUTIVE / LOCAL AUTHORITY

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

Detail can be found in the confidential quality report.

PUBLIC SERVICES OMBUDSMAN FOR WALES

PSOW has legal powers to investigate complaints about public services and independent care providers in Wales. PSOW investigates complaints from members of the public about alleged maladministration and service failure.

When the Ombudsman investigates a complaint and thinks that something has gone wrong, they prepare a report to summarise their findings. Sometimes, where there is a need for

wider learning, or what went wrong was significant, or in the interest of the public, a Public Interest Report (PIR) is issued.

Public Interest Reports (PIRs)

In 2023-24, a total of three Public Interest Reports have been issued to the Health Board. An action plan was developed for all three cases. The recommendations made by the Ombudsman have all been actioned and evidence of compliance has been submitted to the Ombudsman's office.

PIR received June 2024 (Case Ref ID1962 / 202300527)
The Ombudsman has confirmed compliance has been met on 23 October 2024 and closed the case. The committee has been sighted on this case previously.

PIR received July 2024 (Case Ref ID5663 / 202207270)
The Ombudsman has confirmed compliance has been met on 1 October 2024 and closed the case. The committee has been sighted on this case previously.

PIR August 2024 (Case Ref ID 753/202206250)
The investigation considered the care and treatment provided by the Health Board between January 2021 and the patient's death on 31 January 2022 from biliary sepsis, and following discharge in January 2021 (after admission with abdominal pain), whether monthly blood tests were an appropriate way to monitor the patient's condition. The Ombudsman upheld these complaints. The Ombudsman did not uphold the complaint that there was a lack of follow-up care following a biliary stent being fitted in November 2021. The Health Board has written to the family and has issued a fulsome apology in line with the recommendations made by the Ombudsman, along with a financial redress payment of £4,000, reflecting the serious failings and the resulting and lasting significant impact upon the patient and their family.

The recommendations due before 15 September 2024 and before 13 December 2024 have all been completed with evidence of compliance submitted to the Ombudsman on 10 December 2024. The Health Board is awaiting confirmation from the Ombudsman's office that compliance has been met. The report and action plan were provided to the Committee back in December 2024.

Average Variance to Target (AVT)

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

The Health Board's AVT for November 2024 is currently -1. This means that the Health Board is responding to the Ombudsman one day ahead of the target date. For context, the NHS average for November is 0.10 compared with 1.69 in October 2024. On average, compliance evidence is reaching the Ombudsman's office on time against the target dates.

The Quality Assurance and Regulation Team continue to network with other Local Health Boards and Trusts to identify ways which the Health Board can improve how it captures, tracks and monitors Ombudsman recommendations and compliance. The Health Board

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

ORGANISATIONAL LEARNING

The Organisational Learning Forum (OLF) brings together colleagues with a shared interest in and vision for working in new ways to improve safety, practice and processes across our healthcare system. The following is a sample of learning from the last two meetings of the OLF:

- The OLF forum will be supporting the organisations continued journey to promote a continual Learning Culture. The OLF will inform the cycle of business, suggestions for external and internal speakers and themes.

- Suzanne Kenyon Specialist Nurse, Medicine management, IHC West, gave a presentation on reducing omissions and delays of critical medication within community hospitals.

Incidents involving omissions and delays of critical medication were among the top themes for medication error reporting in our community hospital. Upon review, it was found that many errors could have been prevented with a robust medication chart handover process during shift changes.

It was decided to use a PDSA (Plan-Do-Study-Act) cycle for implementation and involved creating packs for staff to facilitate the process. The first area to trial this was Dolgellau Hospital. Essential checks included ensuring all medications due for the shift were given and signed for, critical medications were administered, and any omissions or delays were documented with reasons and actions taken.

The response to the change has been very successful and it is believed that the reason for this may be that we involved the staff in the process from the beginning. By informing them, and including them in the process, seeking their opinions, thoughts, and feelings. Overall, this benefitted the change process and staff appeared far more positive about the change to practice. Although there were Initial challenges which included staff arriving late for handover, handover taking longer, and the need for reminders. Adjustments were made, including creating a handover sheet to streamline the process.

Continue to review handover process every 2 weeks and ensure it is embedded into practice and review in 3months.

There is now a new medication handover form in place.

The project led to a 50% reduction in medication omissions and delays and a 30% reduction in errors overall. Staff engagement and flexibility in implementing changes were key to the project's success.

The project will continue until the implementation of electronic prescribing in 2025, with ongoing evaluation and adjustments as needed.

Discussion was held on the success of the project and the importance of staff engagement and flexibility in implementing changes.

Transformation and Improvement will progress working with Suzanne in creating an improvement poster and supporting to put on Betsi net so it can be shared more widely across the organisation.

HEALTHCARE LAW

CORONER AND INQUESTS

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

The Health Board received zero Regulation 28 Prevention of Future Death (PFD) Reports since the last report.

A bi-weekly Inquest Oversight Panel provides Executive support to ensuring deadlines are achieved.

Since the last meeting, the coroner returned one conclusion with a neglect rider. In this case, the coroner returned a conclusion of natural causes contributed to by neglect, related to a portable oxygen cylinder not being correctly turned on depriving the patient of oxygen. The coroner noted the significant work undertake by the Health Board to raise this issue, where the root cause relates to human factors based design issues.

Legal Services continue to work with the local Senior Coroners to offer training for staff. A session was held in November 2024, led by the Senior Coroner for North Wales (East and Central) covering the inquest process and giving evidence. Over 300 staff attended from across the Health Board. Several "Meet the Coroner" sessions are planned for the forthcoming year, as is a "Mock Inquest." A session was held in January 2025 with the Senior Coroner for North Wales (West). Over 50 staff attended from across the Health Board.

LIABILITY CLAIMS

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

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

The Health Board was successful in a clinical negligence trial in December 2024. The trial related to an incident in 2017 and was listed for 5 days, however the claimant withdrew their claim on day 2 after the Health Board presented its evidence demonstrating the correct standard of care was provided. The outcome resulted in savings of around £450,000.

Legal Services estimate that £272,235 was saved during November and December 2024 as a result of effective personal injury claims management. This included three claims withdrawn/discontinued by the claimant and two claims settled for a value less than the estimate. In the financial year to date, it is estimated personal injury claim savings of £2,948,314 have been achieved.

The Health Board has a significant number of overdue Learning from Events Reports (LFERs) which are due to be submitted to the Welsh Risk Pool (WRP). At the time of writing, this number was 87. As with other areas of overdue documents (such as incidents and complaints) support is being provided to divisions to facilitate completion and regular reporting and escalation is in place. A briefing has been submitted to the Audit Committee.

OTHER HEALTHCARE LITIGATION ISSUES

The Health Board, along with all other health boards in Wales, have been subject to a Judicial Review regarding the decision to support changes in the Emergency Medical Retrieval and Transfer Service (EMRTS) being delivered in partnership with the Welsh Air Ambulance Charity. The decision was taken by the Joint Commissioning Committee, which is legally a joint committee of the health boards in Wales hence each organisation being a defendant in the Judicial Review. A court hearing was heard in January 2025 and a further hearing listed for February 2025.

A Judicial Review has been lodged against the Health Board and Gwynedd Council, relating to a patient's care and educational provision. This relates to a long-term complex care package. Further detail is included in the private report due to patient confidentiality.

In December 2024, the Welsh Government released its response to the public consultation concerning changes to the Putting Things Right (PTR) Regulations. The Health Board will engage with national workshops to understand the possible impact; however, we continue to await specific details on the new Regulations and standards. The changes will result in a concerns process intended to be more patient/family and learning focussed, while increasing the scope of financial redress.

On 6 November 2024, a new Mental Health Bill (the Bill) was presented in Parliament by the UK Government. As health is a devolved matter, the Bill is subject to the legislative consent process. This is when the consent of the Welsh Parliament is sought by the UK Government to legislate on an issue which falls within the competence of the Senedd. The Bill has already passed its second reading in the House of Lords, and is now in Committee stage. The government has said that the primary aims of the Bill are to strengthen the voice of patients subject to the Act, to add statutory weight to patients' rights to be involved in planning for their care and to inform choices regarding their treatment. The reforms are designed to ensure that detention under the Act it is only used when, and for as long, as necessary. Additionally, the reforms aim to limit the use of the Act to detain people with learning disabilities and autism. A briefing has been submitted to the Mental Health Legislation Committee.

Medical Examiner Service

Quarterly Mortality Statistics

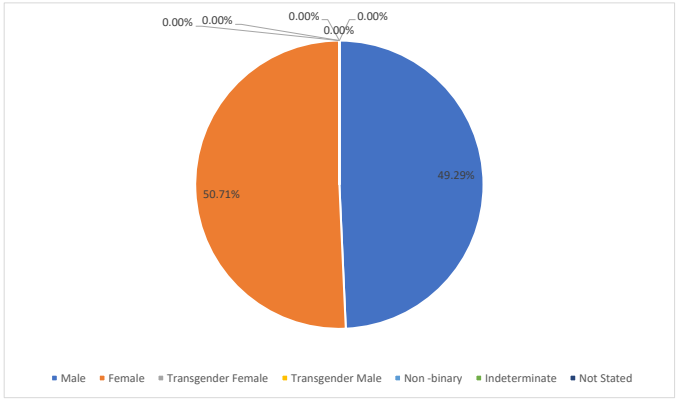
2024/25 Quarter 3
01/10/2024 to 31/12/2024

Data for:

Betsi Cadwaladwr UHB

Number of Deaths Reported	1824
Number of Paediatric Deaths	2

Breakdown of deaths reported by Age Group		**Gender**						
		Male	Female	Transgender Female	Transgender Male	Non -binary	Indeterminate	Not Stated
0 to 4	2	2	0	0	0	0	0	0
5 to 17	0	0	0	0	0	0	0	0
18 to 24	0	0	0	0	0	0	0	0
25 to 29	1	0	1	0	0	0	0	0
30 to 34	5	4	1	0	0	0	0	0
35 to 39	8	5	3	0	0	0	0	0
40 to 44	7	5	2	0	0	0	0	0
45 to 49	19	10	9	0	0	0	0	0
50 to 54	19	9	10	0	0	0	0	0
55 to 59	47	25	22	0	0	0	0	0
60 to 64	65	36	29	0	0	0	0	0
65 to 69	101	54	47	0	0	0	0	0
70 to 74	162	84	78	0	0	0	0	0
75 to 79	277	154	123	0	0	0	0	0
80 to 84	312	163	149	0	0	0	0	0
85 and over	772	332	440	0	0	0	0	0
Unknown	27	16	11	0	0	0	0	0
	1824	899	925	0	0	0	0	0
	% of deaths by gende	49.29%	50.71%	0.00%	0.00%	0.00%	0.00%	0.00%

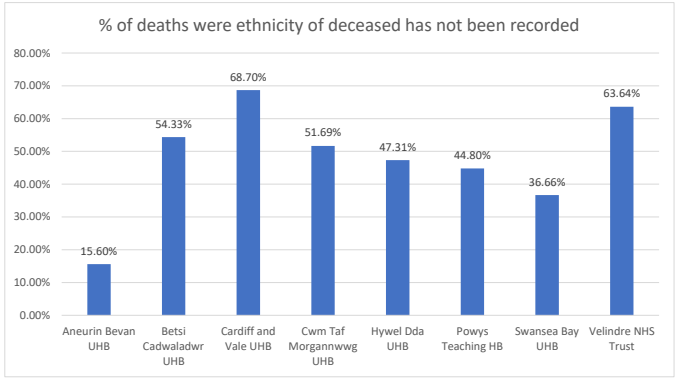


Medical Examiner Service

Quarterly Mortality Statistics

Breakdown of deaths reported by Ethnicity

Asian or Asian British - Bangladeshi	0
Asian or Asian British - Indian	0
Any other Asian background	0
Asian or Asian British - Pakistani	2
Black or Black British - African	0
Black or Black British - Caribbean	0
Any other Black Background	0
Mixed - White and Black Caribbean	0
Mixed - White and Black African	0
Mixed - White and Asian	0
Any other mixed background	0
Chinese	0
Any other ethnic group 65	0
Any White Background	783
Gypsy \ Irish Traveller	0
Any other white background	0
Arab	0
Not stated	48
Not Recorded	991



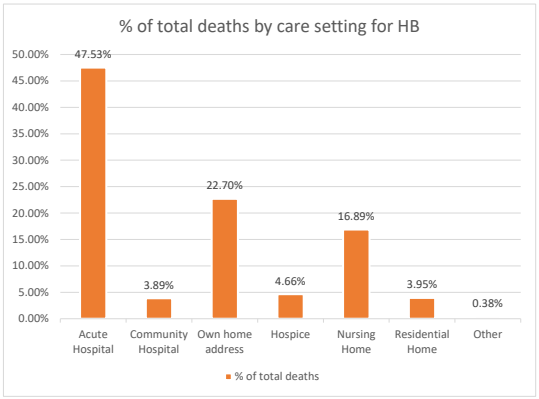
Location at time of death

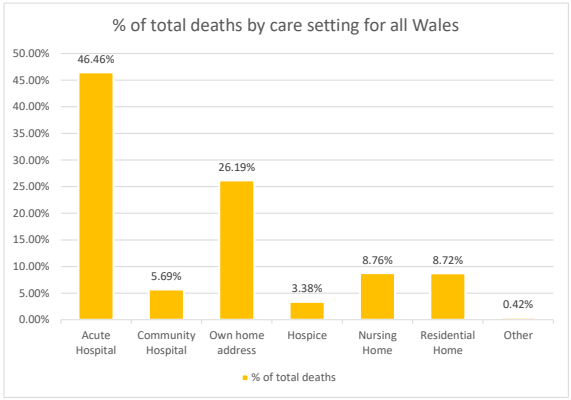
Location	
Glan Clwyd Hospital	321
Wrexham Maelor Hospital	276
Ysbyty Gwynedd	257
Abergele Hospital	0
Bryn Beryl Hospital	9
Bryn Y Neuadd Hospital	1
Chirk Hospital	6
Colwyn Bay Hospital	0
Deeside Community Hospital	4
Denbigh Hospital	0
Dolgellau and Barmouth Hospital	0
Holywell Community Hospital	11
Llandudno General Hospital	0
Mold Community Hospital	9
Penley Hospital	1
Royal Alexandra Hospital	0
Ruthin Hospital	0
Tywyn Hospital	0
Ysbyty Alltwen	2
Ysbyty Cefni Hospital	1
Ysbyty Eryri	1
Ysbyty Penrhos Stanley	4
HMP Berwyn	0
Other Location	921
Other Health Board Site	1

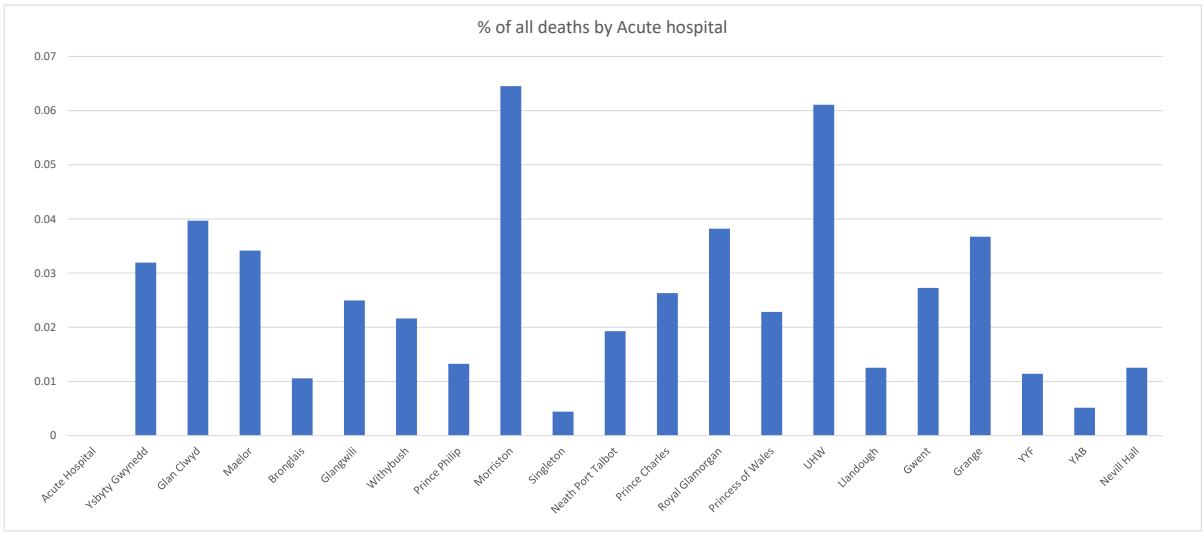
Care Setting		% of total deaths	All Wales % of total deaths
Acute Hospital	867	47.53%	46.46%
Community Hospital	71	3.89%	5.69%
Own home address	414	22.70%	26.19%
Hospice	85	4.66%	3.38%
Nursing Home	308	16.89%	8.76%
Residential Home	72	3.95%	8.72%
Other	7	0.38%	0.42%

Medical Examiner Service

Quarterly Mortality Statistics







Medical Examiner Service

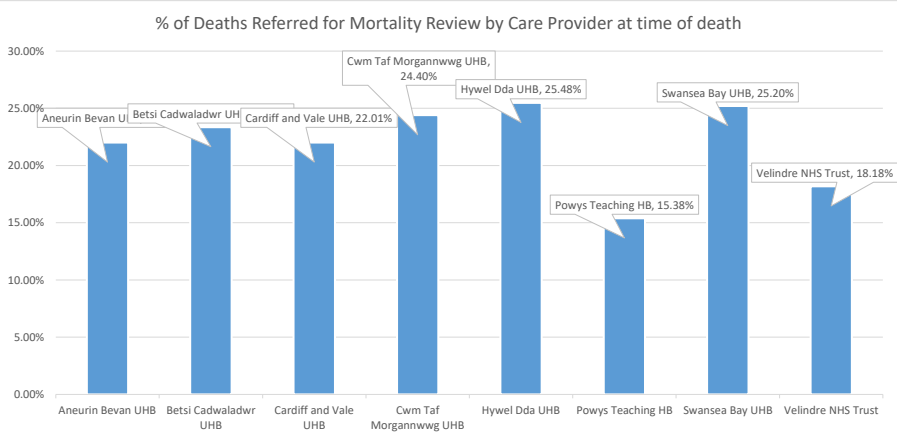
Quarterly Mortality Statistics

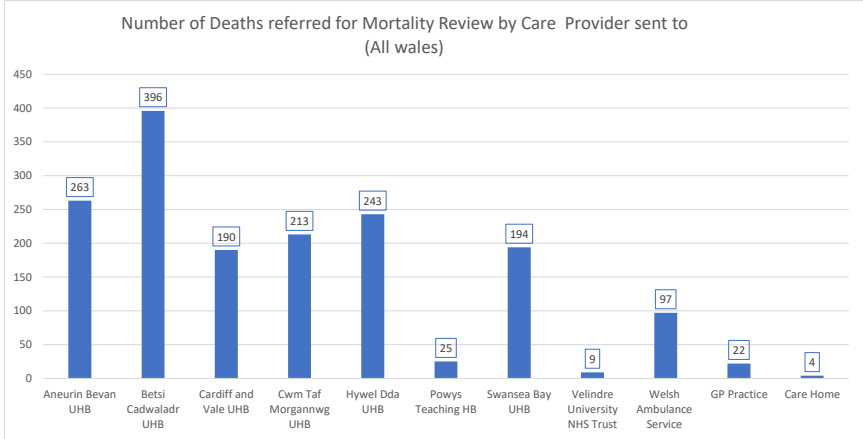
Referral to Coroner		No attending medical practitioner within a reasonable time frame	Death in custody or otherwise in state detention	Death due to an injury or disease attributable to any employment held by the person during the person's lifetime	Death due to the use of a medicinal product, controlled drug or psychoactive substance	Death due to neglect, including self-neglect	No referral required	Death due to poisoning, including by an otherwise benign substance	Death due to self-harm	Death due to exposure to or contact with a toxic substance;	Death due to trauma or injury	Death due to the person undergoing a treatment or procedure of a medical or similar nature	Unknown identity of the deceased	Death due to unnatural causes but does not fall within any of the circumstances listed in sub-paragraph (a)	Cause of death unknown	Death due to violence	Category not stated
Glan Clwyd Hospital	69	0	0	2	10	1	2	0	0	0	20	21	0	0	9	0	4
Wrexham Maelor Hospital	52	1	0	2	11	1	1	0	0	0	12	15	0	0	7	0	2
Ysbyty Gwynedd	59	1	0	1	9	7	0	0	0	0	15	14	0	0	6	0	6
Abergele Hospital	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Bryn Beryl Hospital	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Bryn Y Neuadd Hospital	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Chirk Hospital	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Colwyn Bay Hospital	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Deeside Community Hospital	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Denbigh Hospital	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Dolgellau and Barmouth Hospital	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Holywell Community Hospital	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Llandudno General Hospital	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Mold Community Hospital	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Penley Hospital	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Royal Alexandra Hospital	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Ruthin Hospital	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Tywyn Hospital	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Ysbyty Alltwen	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Ysbyty Cefni Hospital	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Ysbyty Eryri	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0
Ysbyty Penrhos Stanley	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
HMP Berwyn	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other Location	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other Health Board Site	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	183	2	0	5	30	9	3	0	0	0	48	50	0	0	22	0	14

Medical Examiner Service

Quarterly Mortality Statistics

Referred for Moratality Review by Health Board





		Care Provider that review was sent to										
Care Provider at Time of Death	**Number Referred**	**Aneurin Bevan UHB**	**Betsi Cadwaladr UHB**	**Cardiff and Vale UHB**	**Cwm Taf Morgannwg UHB**	**Hywel Dda UHB**	**Powys Teaching HB**	**Swansea Bay UHB**	**Velindre University NHS Trust**	**Welsh Ambulance Service**	**GP Practice**	**Care Home**
Aneurin Bevan UHB	309	259	0	4	1	0	0	0	3	19	0	0
Betsi Cadwaladwr UHB	426	0	393	0	0	0	0	0	0	23	0	0
Cardiff and Vale UHB	256	0	0	182	4	0	0	0	3	8	0	0
Cwm Taf Morgannwwg UHB	304	0	0	3	206	0	0	0	2	12	1	0
Hywel Dda UHB	308	0	0	0	0	241	0	5	0	18	14	3
Powys Teaching HB	34	3	0	0	0	0	25	0	0	1	0	0
Swansea Bay UHB	255	0	0	0	2	2	0	189	0	16	7	1
Velindre NHS Trust	2	0	0	1	0	0	0	0	1	0	0	0

Medical Examiner Service

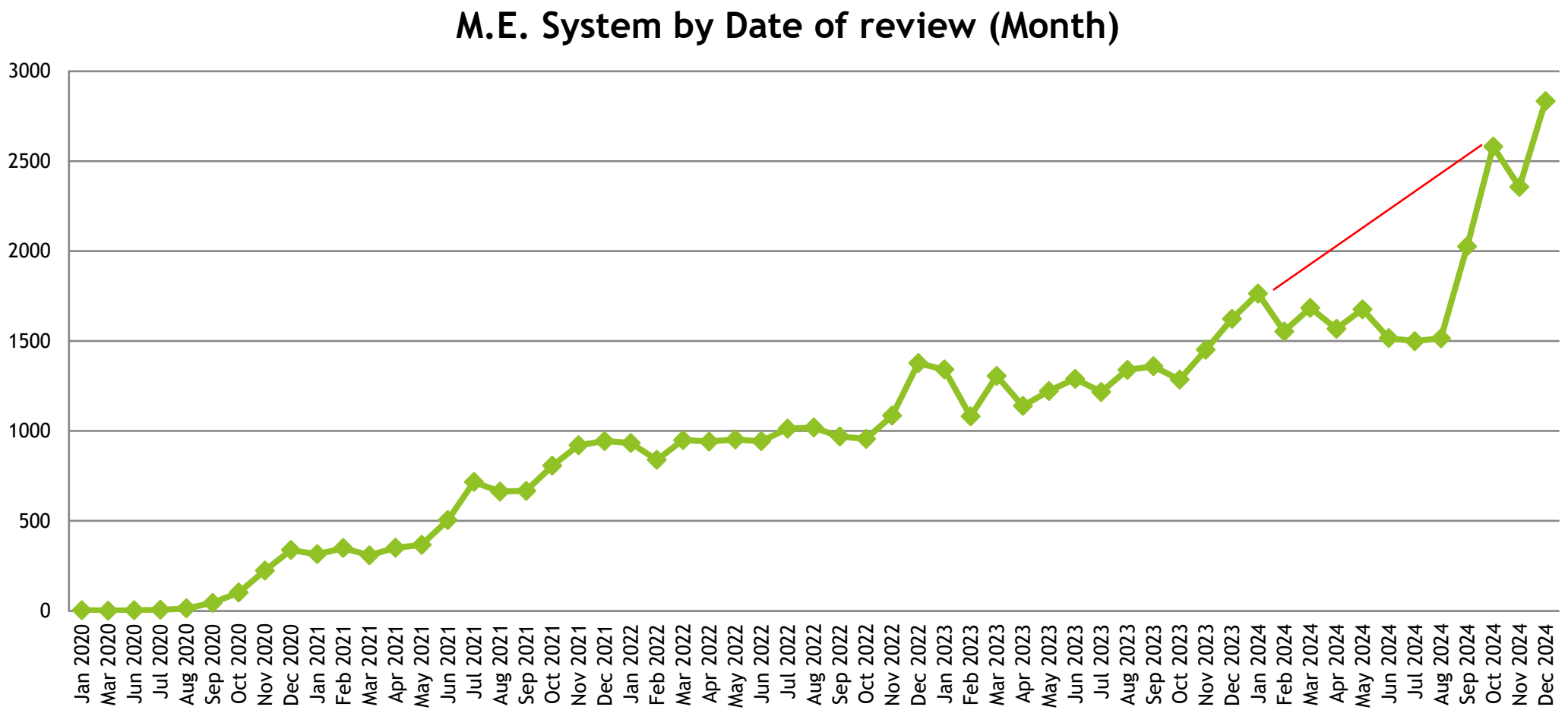
Quarterly Mortality Statistics

HCQS Category	Sub Category	HCQS Category of reason for review by Care provider review was sent to										
		Aneurin Bevan UHB	Betsi Cadwaladr UHB	Cardiff and Vale UHB	Cwm Taf Morgannwg UHB	Hywel Dda UHB	Powys Teaching HB	Swansea Bay UHB	Velindre University NHS Trust	Welsh Ambulance Service	GP Practice	Care Home
Safe Care	Pressure areas	3	10	6	4	6	1	1	0	0	0	0
	Hospital acquired thrombosis without appropriate VTE management	0	0	0	0	0	0	0	0	0	0	0
	IR(ME)R / radiation incidents 'significant' or 'clinically significant' accidental or unintended exposure	0	0	0	0	0	0	0	0	0	0	0
	Inappropriate identification and management of a patient with sepsis	0	2	0	0	0	0	0	0	0	0	0
	Inappropriate management of hyperkalaemia and hypokalaemia	0	1	0	0	0	0	0	0	1	0	0
	Inappropriate management of a patient with diabetes	0	0	0	0	0	0	0	0	0	0	0
	Clinical documentation / records	25	58	14	31	24	4	20	0	5	1	0
	Falls – with or without Injuries sustained due to fall	0	0	0	0	0	0	0	0	0	0	0
	Iatrogenic injuries	9	12	12	9	5	0	11	0	3	3	0
	Safeguarding	2	2	2	1	1	0	3	0	0	1	1
	Omissions of care and treatment	16	29	6	15	9	0	10	1	4	0	0
	Nosocomial Covid	17	21	20	28	8	1	11	0	2	0	0
	Health care associated infections	3	5	3	2	2	2	4	0	0	0	0
	Transfusion incidents	0	0	1	0	0	0	0	0	0	0	0
	Medication/prescribing errors	15	13	5	14	9	0	4	0	0	0	0
	Category Total	90	153	69	104	64	8	64	1	15	5	1
Timely Care	Delays in diagnosis	20	26	15	17	13	1	13	1	3	3	0
	Delays in treatment	14	19	14	15	14	0	13	0	10	5	0
	Delays in escalation	5	5	5	8	4	0	4	0	4	2	1
	Delays in referral to appropriate service/s	8	9	8	4	13	0	4	0	5	2	0
	Delays in assessment or triage	4	12	3	8	7	0	8	0	10	1	0
	Delays in transfer or admission	12	25	10	10	10	0	12	0	63	2	0
	Timely intervention for provision of care	14	28	13	12	15	3	19	0	10	6	0
	Category Total	77	124	68	74	76	4	73	1	105	21	1
Effective Care	Precipitous readmission	14	15	4	6	11	0	5	0	3	1	0
	Delayed discharge	0	1	1	1	3	0	0	0	0	0	0
	Apparent insufficient senior management of the patient	1	3	0	1	1	0	1	0	0	0	0
	Care at the end of life care	12	11	6	5	19	0	5	0	0	0	0
	Right ward/speciality for the patient's care	0	0	0	0	0	0	0	0	0	0	0
	Category Total	27	30	11	13	34	0	11	0	3	1	0
Efficient Care	Bloods and observations where the patient is near the end of life	0	1	1	0	1	0	0	0	0	1	0
	Cardiopulmonary resuscitation (CPR)	23	45	15	38	25	3	21	0	9	0	0
	Appropriate and efficient use of antibiotics and fluids	3	2	1	1	1	0	0	0	0	0	0
	Inappropriate investigations or procedures	0	3	1	1	3	0	1	0	0	1	0
	Inappropriate cardiopulmonary resuscitation	0	5	0	0	0	0	3	0	1	0	0
	Absence of treatment escalation plan	0	1	0	2	1	0	2	0	0	0	1
	Avoidable admissions or unsuitable place of treatment	1	3	0	2	4	0	2	0	0	0	1
	Category Total	27	60	18	44	35	3	29	0	10	2	2
Equitable Care	Provision of appropriate mental health care	0	0	0	0	0	0	1	0	0	1	0
	Appropriate language for the service user	0	0	0	0	0	0	0	0	0	0	0
	Age	0	0	0	0	0	0	0	0	0	0	0
	Religious wishes	0	0	0	0	0	0	0	0	0	0	0
	Learning difficulties - Diagnostic over shadowing	0	0	0	0	0	0	0	0	0	0	0
	Inappropriate consideration of mental health assessment	0	0	0	0	0	0	1	0	0	0	0
	Category Total	0	0	0	0	0	0	2	0	0	1	0
Person-centred Care	Empathetic	3	14	12	8	15	0	9	1	1	3	2
	Compassionate care	24	30	23	23	22	1	12	1	2	6	2
	Advanced care planning and individual wishes	13	24	4	14	8	2	12	0	2	4	1
	Family wishes	11	27	5	6	23	1	17	0	1	4	3
	Communication	64	81	44	42	75	7	63	7	14	11	3
	Individualised treatment and care (patient first)	51	44	20	21	34	6	18	2	5	2	1
	Care after death	13	8	4	5	20	1	11	0	3	5	1
	Category Total	179	228	112	119	197	18	142	11	28	35	13

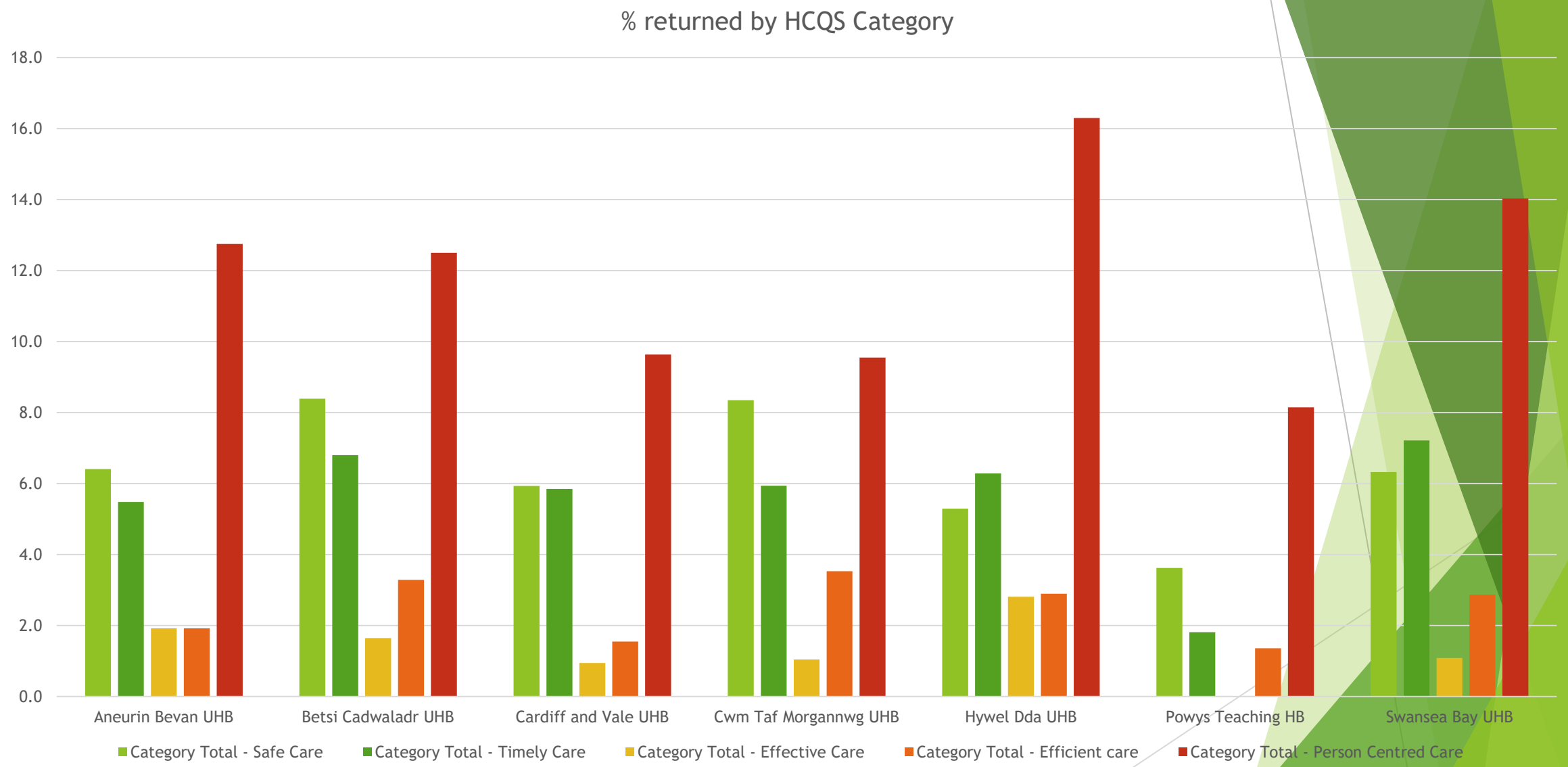
Quarterly Data – Medical Examiner Service

Dr Jason Shannon

Lead Medical Examiner for Wales


M.E. System by Date of review (Month)
3000
2500
2000
1500
1000
500
0
Jan 2020
Mar 2020
Jun 2020
Jul 2020
Aug 2020
Sep 2020
Oct 2020
Nov 2020
Dec 2020
Jan 2021
Feb 2021
Mar 2021
Apr 2021
May 2021
Jun 2021
Jul 2021
Aug 2021
Sep 2021
Oct 2021
Nov 2021
Dec 2021
Jan 2022
Feb 2022
Mar 2022
Apr 2022
May 2022
Jun 2022
Jul 2022
Aug 2022
Sep 2022
Oct 2022
Nov 2022
Dec 2022
Jan 2023
Feb 2023
Mar 2023
Apr 2023
May 2023
Jun 2023
Jul 2023
Aug 2023
Sep 2023
Oct 2023
Nov 2023
Dec 2023
Jan 2024
Feb 2024
Mar 2024
Apr 2024
May 2024
Jun 2024
Jul 2024
Aug 2024
Sep 2024
Oct 2024
Nov 2024
Dec 2024


% deaths returned to HB for consideration for further review
30.0
25.0
20.0
15.0
10.0
5.0
0.0
Aneurin Bevan UHB
Betsi Cadwaladwr UHB
Cardiff and Vale UHB
Cwm Taf Morgannwwg UHB
Hywel Dda UHB
Powys Teaching HB
Swansea Bay UHB
Average


% returned by HCQS Category
18.0
16.0
14.0
12.0
10.0
8.0
6.0
4.0
2.0
0.0
Aneurin Bevan UHB
Betsi Cadwaladr UHB
Cardiff and Vale UHB
Cwm Taf Morgannwg UHB
Hywel Dda UHB
Powys Teaching HB
Swansea Bay UHB
Category Total - Safe Care
Category Total - Timely Care
Category Total - Effective Care
Category Total - Efficient care
Category Total - Person Centred Care

Teitl adroddiad: ***Report title:***	Our Integrated Performance Report – Month 9, 2024/25
Adrodd i: ***Report to:***	Quality, Safety & Experience Committee
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 20 February 2025
Crynodeb Gweithredol: ***Executive Summary:***	This Report relates to the Month 9, 2024/25. Please note the title of the report has now been amended to IQPR to illustrate that the report has a significant section on quality. The structure of our IPR is based upon the Quadruple Aims as per the Welsh Government's 'A Healthier Wales's paper and the NHS Wales Performance Framework 2024-25. It identifies where metrics fall within the Special Measures Framework for BCUHB. Where appropriate, we have linked performance metrics to items on the Corporate risk Register (CRR). Performance is RAG (Red, Amber Green) rated against the targets set within the NHS Wales Performance Framework 2024-25, or as set by Welsh Government in the Special Measures Framework for BCUHB. However, where appropriate, BCUHB's internal improvement trajectories as submitted and agreed by Welsh Government have also been included. Key areas of escalation are identified within the 'Performance Escalations Report' section at the beginning of the report. (We will continue to strengthen this section to include more information about the plans to mitigate or improve performance). The responsible executive has reviewed the elements of the report that are within their portfolio. Statistical Process Control (SPC) charts have been included where appropriate.
Argymhellion: ***Recommendations:***	The Quality, Safety, & Experience Committee is asked to: Review the contents of the report and to propose any actions arising from the report, or identify any additional assurance work or actions it would recommend Executive colleagues to undertake.
Arweinydd Gweithredol: ***Executive Lead:***	Stephen Powell, Director of Performance & Commissioning

Awdur yr Adroddiad: ***Report Author:***	Ed Williams, Deputy Director of Performance			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☒	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☐ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☒ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	The performance measures included in this report are from the NHS Wales Performance Framework 2024-25.			
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	This report will be available to the public once published for Quality, Safety & Experience Committee			
Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqlA been identified as necessary and undertaken?***	N The Report has not been Equality Impact Assessed as it is reporting on actual performance.			
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal?	N The Report has not been assessed for its			

In accordance with WP68, has an SEIA identified as necessary been undertaken?	Socio-economic Impact as it is reporting on actual performance
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)***	References to Corporate Risks have been made in the body of the report, where applicable. 24-04 Failure to Embed Learning 24-10 Urgent and Emergency Care 24-11 Planned Care 24-12 Areas of Clinical Concern (encompasses ophthalmology and dermatology) 24-13 Timely Diagnostics
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	The delivery of the performance indicators within our IPR will directly/ indirectly impact upon the financial recovery plan of the Health Board.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	The delivery of the performance indicators within our IQPR will directly/ indirectly impact on our current and future workforce.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	The full report has been reviewed by the Director of Performance and Commissioning.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	Where appropriate, performance metrics have been annotated with the Corporate Risk Register (CRR) reference number as a link to the Board Assurance Framework (BAF).
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Amherthnasol Not applicable
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** ***Implementation of recommendations:*** Continued focus on any areas of under-performance where assurance is not of sufficient quality to believe performance is or will improve as described.	

The Integrated Quality & Performance Report will undergo continuous development and utilise the Performance and Commissioning Directorate's internal Change Advisory Board (CAB) process to modify any reporting metrics and formatting.
Rhestr o Atodiadau: ***List of Appendices: 2*** *1: Summary of Report* *2: Integrated Performance Report in PDF* *3: Escalations from Integrated Performance Report in PowerPoint*

Appendix 1 – Summary of Report

Committee: **Quality, Safety & Experience**

Report title: **Summary of Integrated Performance Report (Month 9)**

Report Author: **Deputy Director of Performance** on behalf of

Director of Performance and Commissioning

1. Introduction

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

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

This structure enables an 'at a glance' view of the main concerns or message of the report through review of the initial one-page summary that is split into four quadrants, with the further slides contained within this escalation section articulating in more detail the current performance and actions being taken to support improvements. Following the summary quadrant page, there is a page on each section providing more detail about the measures escalated. This should be the area of most focus in the report.

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

Work is being undertaken to improve the report, for example, re-introducing Mortality Rates, Surgical Site Infection (SSI) rates and developing metrics by rate of per 100,000 population

or bed occupancy etc. to improve the intelligence, triangulation and assurance in the report as we go into 2025-26.

2. Overall Summary

Please note that the data for several metrics are published in arrears and/ or on a quarterly basis.

3.1 Quality (Safety, Effectiveness & Experience) Performance

(Corporate Risk 24-04 Failure to Embed Learning)

The key areas highlighted centre upon:-

No new never events have been reported in the period between 31.07.2024 and 31.01.2025.

On 22.01.2025, the Integrated Performance Executive Delivery Group (IPEDG) enacted the **de-escalation** process within the Integrated Performance Framework 2023-2027 to remove performance against National Reportable Incidents & Complaints measures out of escalation as performance is now consistently sustained above national target rates.

On 22.01.2025, the Integrated Performance Executive Delivery Group (IPEDG) has **formally escalated** the measure '**Timely Submission of Learning From Event Reports (LFERs)'** due to an increasing number of submissions overdue which a) has a possible impact on timely ability to embed lessons learned and organisational learning and b) incur financial penalties at a rate of £2,500 per overdue report. Currently it is estimated that BCUHB will incur a £195.5k penalty, however there is a risk, although small, that this could reach ten times that, at £1.925m by the end of March 2025. IPEDG is supporting and

monitoring the urgent action now being taken to address the timely completion of LFERs and recovery of the overdue position to both avoid potential harm and further financial penalties.

The percentage rate of people **completing treatment for Drug and/or Alcohol Misuse** has been falling for the last couple of months, from a high of 96.7% in August 2024, to 82.7% in October 2024. A **recommendation to escalate** performance against this measure will be made at Integrated Performance Executive Delivery Group on 26.02.2025

The percentage of **patients offered an index colonoscopy within 4 weeks of booking their Specialist Screening Practitioner assessment** appointment has fallen to 3.2% against a 90% target. A **recommendation to escalate** performance against this measure will be made at Integrated Performance Executive Delivery Group on 26.02.2025.

Clinical Coding compliance will remain a significant risk as compliance will remain low into the latter part of 2025-26. Although considerably below the 95% national target rate, the position has stabilised and has started to improve from 13.6% to **15.1%** in the last 3 month reporting period.

See appendix below.

Appendix 1 – IQPR for QSE 22.02.2025

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Integrated Quality & Performance Report

Reporting Period: to 31.12.2024

Presented to

Quality, Safety & Experience Committee

Thursday, 20th February 2025

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

Table of Contents

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

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

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

Performance Escalations Report

Key Messages

Quality, Safety, Effectiveness & Experience Performance

Newly Escalated **Learning from Events Reports:** Significant level of penalties levied on organisation in November 2024 for 58 overdue LFERs (financial risk of c £193k). December, there were **64 outstanding LFERs** indicating a further and higher financial risk.

- No **New Never Events** reported since 31.07.2024.
- **Complaints**: Consistent compliance over 75% of complaints resolved within 30 days. Measure formally **de-escalated** at Integrated Performance Executive Delivery Group (IPEDG) 22.01.2025. **(Corporate Risk 24-04 Failure to Embed Learning)**
- **Clinical Coding Compliance** will remain a significant risk through 2024-25 and will recover towards the end of 2025-26. Position stabilised and showing signs of improvement. Measure will be kept in escalation for assurance.
- **National Reportable Incidents** open for 90 days or more position has significantly and consistently improved. Recommendation for formal **de-escalation** will be made at IPEDG on 26.02.2025.

Our Access and Activity

- **Referral to Treatment (RTT):** Planned Care remains in heightened escalation and intense executive support. Additional WG funding is being utilised to eradicate 156-week breaches and to halve the number of 104-week breaches by 31.03.2025. (Currently, **1,356** and **10,210** respectively). **(Corporate Risk 24-11 Planned Care)**
- **Cancer:** Performance maintained in November at **52%**, however this remains below plan, use of Planned Care funds is expected to attain the Welsh Government ask of a 70% delivery by March 2025. Trajectory re-profiled. **(Corporate Risk 24-11 Planned Care)**
- **Diagnostics waits over 8 weeks:** The number of patients continues to increase at **10,185** waiting over 8 week – significant step change increase from prior month **(Corporate Risk 24-13 Timely Diagnostics)**
- **Therapy waits over 14 weeks:** Continued though slowed reduction in overall number of breaches at **1,893**. Nearly all breaches are within Physiotherapy in Central and East.
- **Pathways of Care Delays:** The 12 week Reset and Refocus programme in Urgent and Emergency Care is demonstrating some positive outcomes and whilst delays did increase in December 2024, at **298** compared to prior month the level was lower than same period prior year (362). **(Corporate Risk 24-10 Urgent and Emergency Care)**
- **Ambulance handover waits over 4 Hours:** Although lower than the same period in 2023, the number of handover breaches remains a concern with **854** reported in December 2024. **(Corporate Risk 24-10 Urgent and Emergency Care)**
- **Child Neurodevelopment** performance remains poor and in escalation under focus.

People & Organisational Development Performance

(Corporate Risk 24-01 People, Culture and Wellbeing)
(Corporate Risk 24-1 Leadership/Special Measures)

- At **78.5%**, **PADR** rate has improved in year but remains below the 85% target.
- **At 6.8%, Sickness absence rate** has seen an overall increasing trend over recent months, in line with seasonal change.
- At **0.6%**,**Turnover rate** for nursing staff leaving BCUHB, aligned with the national and local retention work put in place
- At **3.6%**, focus continues on reduction of off-contract **agency spend.** Ongoing work taking place around the Welsh Health Circular for agency spend reduction and the Value and Sustainability workforce programme.

Our Finance (Corporate Risk 24-05 Financial Sustainability)

The Health Board is currently reporting an adverse year to date position of **£8.3m over** plan, and forecasting a **£24.6m deficit** for the financial year with an impact of **the £82m received non-recurrently in 2024/25 being withdrawn in 2025/26.** There is no central resource to support a deficit that exceeds plan. Whilst some forecast reduction in expenditure has come through, additional reductions are required to reduced the forecasts by **£16m** to deliver the overall plan of **£8.6m**. If unable to improve forecasts, central controls and enhanced oversight will be needed so as to secure the £82m for next and future years.
(Losing the £82m would be catastrophic for the financial sustainability of BCUHB).

Quality: Escalated Performance Measures

Corporate Risk 24-04 Failure to Embed Learning

Learning form Events Reports

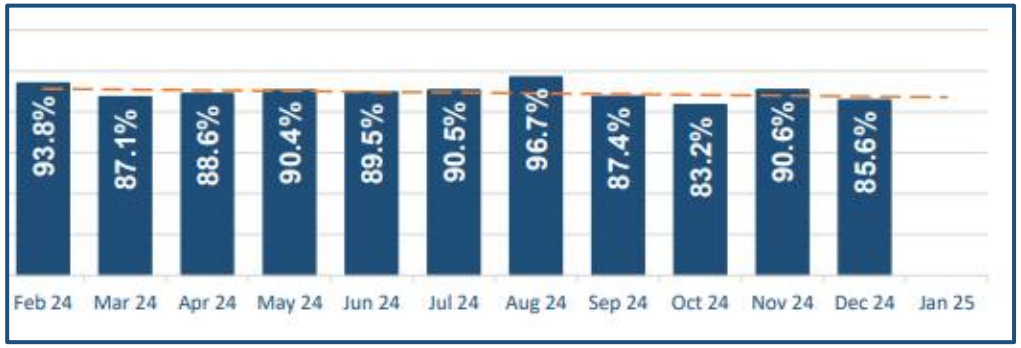
Learning From Events Reports (LFERs):
There are 64 outstanding LFERs at the end of December. This poses a Quality and Safety risk from the perspective that if we haven't completed the reports in a timely manner, how can we embed the learning to prevent future events? There is a significant risk of further financial penalties which would exacerbate the challenged financial position of the Health Board. The likely scenario is c£192.5k in financial penalties, however it is a possibility, albeit small, to incur ten times that amount at £1.925m. Urgent action is now being taken to address the timely completion of LFERs and recovery of the overdue position. Therefore this measure has been escalated for increased scrutiny and support via the Integrated Performance Executive Delivery Group (IPEDG) on 22.01.2025.

Index Colonoscopy

Index colonoscopy within 4 weeks of booking their Specialist Screening Practitioner assessment

The percentage of **patients offered an index colonoscopy within 4 weeks of booking their Specialist Screening Practitioner assessment** appointment has fallen to 3.2% against a 90% target. A recommendation to escalate performance against this measure will be made at Integrated Performance Executive Delivery Group on 26.02.2025.

Completing treatment for Drug and/or Alcohol Misuse



The percentage rate of people completing treatment for Drug and/or Alcohol Misuse

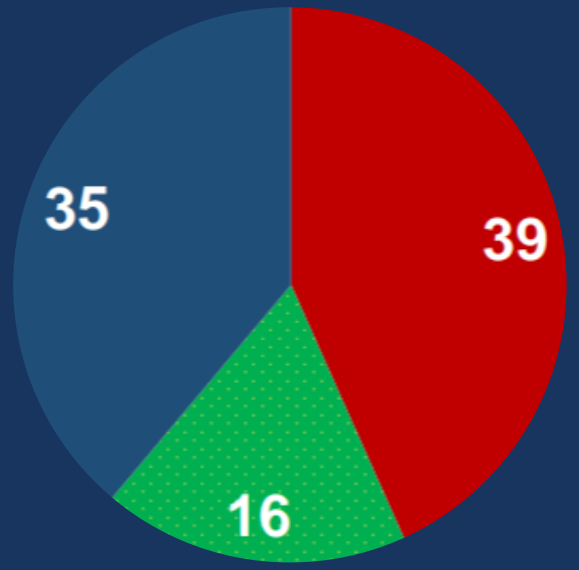
The percentage rate of people **completing treatment for Drug and/or Alcohol Misuse** has been falling for the last couple of months, from a high of 96.7% in August 2024, to 82.7% in October 2024. A recommendation to escalate performance against this measure will be made at Integrated Performance Executive Delivery Group on 26.02.2025

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

Presented on 20.02.2025

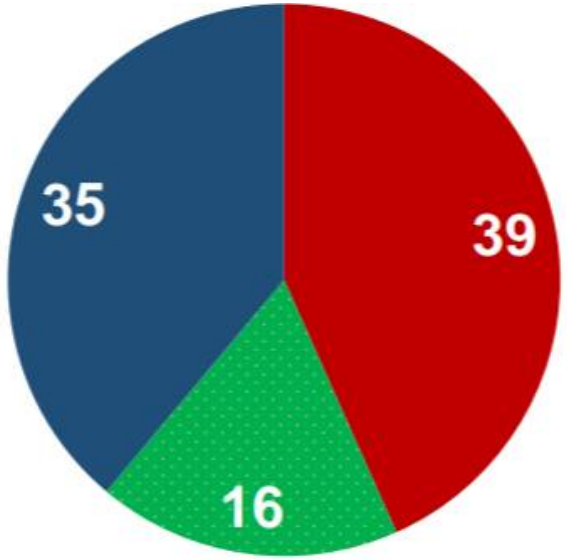
GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Integrated Performance Report

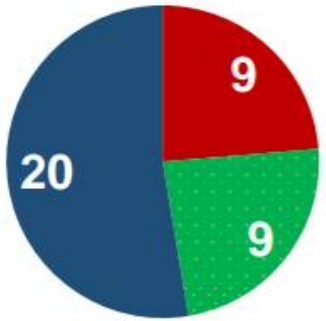


Produced on behalf of the **Quality, Safety and Experience Committee** by the
Performance and Commissioning Directorate in partnership with our **Health Board Directors**

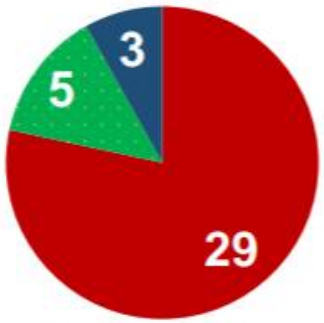
Summary of Performance to Month 9



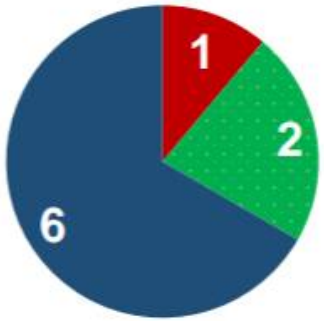
All Sections



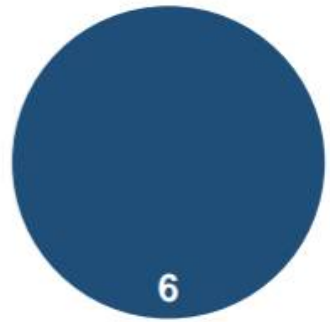
Quality, Safety, Effectiveness & Experience Performance



Access & Activity Performance



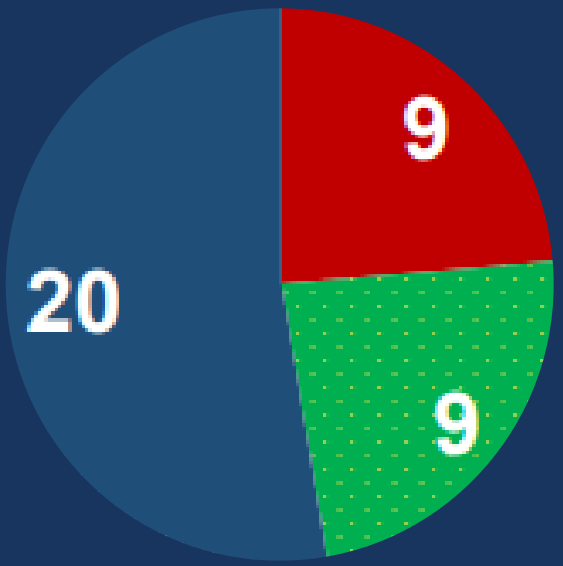
People & Organisational Development Performance



Financial Performance

Section 1

Quality, Safety, Effectiveness and Experience Performance



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

Quality: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	QSE	Percentage of adult smokers who make a quit attempt via smoking cessation services	5% annual	TBC	2.47%	2nd of 7 (at Sep 24)
-	QSE	Percentage of adult smokers who made a quit attempt via smoking cessation services who are CO-validated as quit at 4 weeks	40% annual target	TBC	21.2%	3rd of 8 (at Sep 24)
-	QSE	Percentage of children receiving the Human Papillomavirus (HPV) vaccination by the age of 15	90%	TBC	78.2%	4th of 7 (at Sep 24)

* Wales Ranking may differ as may refer to previous month

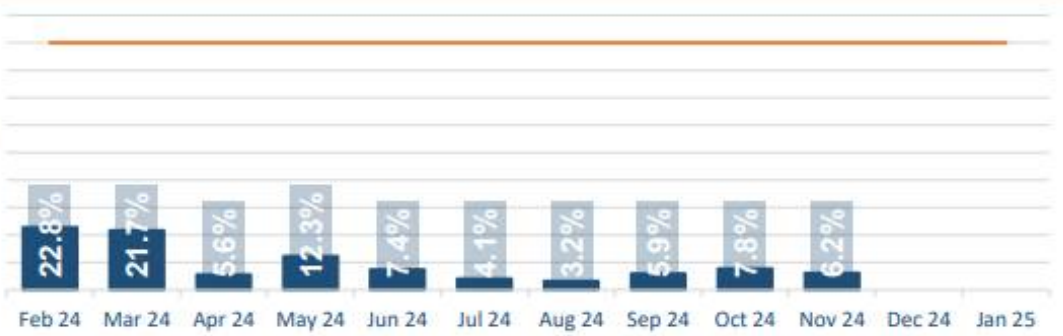
Quality: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	QSE	Percentage of children who are up to date with the scheduled vaccinations by age 5 ('4 in 1' preschool booster, the Hib/MenC booster and the second MMR dose)	95%	TBC	87.3%	2nd of 7 (at Sep 24)
-	QSE	Percentage uptake of the influenza vaccination amongst adults aged 65 years and over	75%	TBC	72.3%	2nd of 7 (at Dec 24)
-	QSE	Percentage uptake of the COVID-19 vaccination for those eligible Spring Booster 2023: Aged 75 years & over; residents in care home for older adults and; immunosuppressed aged 5 years & over Autumn Booster 2023: Age range to be confirmed	75%	TBC	44.1%	3rd of 7 (at Dec 24)

* Wales Ranking may differ as may refer to previous month

Quality: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	QSE	Percentage of patients offered an index colonoscopy procedure within 4 weeks of booking their Specialist Screening Practitioner assessment appointment	90%	TBC	6.2%	6th of 7 (at Oct 24)
-	QSE	Percentage of well babies entering the new-born hearing screening programme who complete screening within 4 weeks	90%	TBC	99.1%	5th of 7 (at Oct 24)
-	QSE	Percentage of eligible newborn babies who have a conclusive bloodspot screening result by day 17 of life	95%	TBC	96.3%	2nd of 7 (at Nov 24)



* Wales Ranking may differ as may refer to previous month

Quality: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	QSE	Percentage of people who have been referred to health board services who have completed treatment for substance misuse (drugs or alcohol)	4 qtr imp. trend	TBC	85.6%	4th of 7 (at Sep 24)
-	QSE	Percentage of patients (aged 12 years and over) with diabetes who received all eight NICE recommended care processes	Equival-ent month increase (2024/25 to 2023/24) to 100%	TBC	37.8%	7th of 7 (at Dec 24)

* Wales Ranking may differ as may refer to previous month

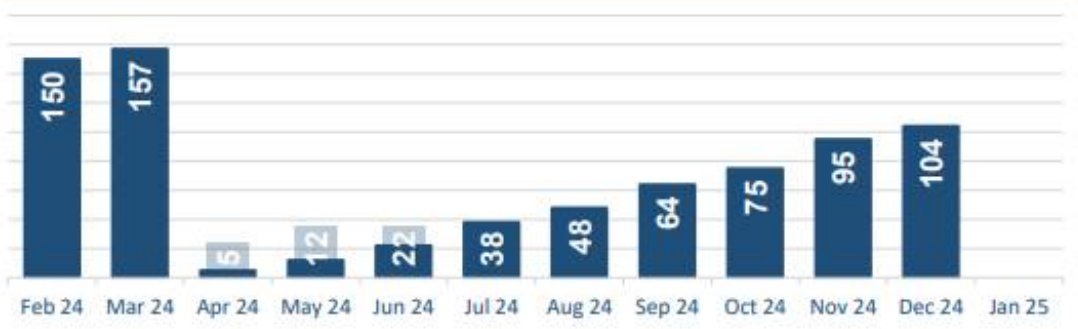
Quality: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	QSE	Percentage of confirmed COVID-19 cases within hospital which had a definite hospital onset of COVID-19	Equivalent month reduction (2024/25 to 2023/24)	TBC	34.0%	1st of 6 (at Dec 24)
-	QSE	Number of service user feedback experience responses completed and recorded on CIVICA	Increasing trend	TBC	5513	2nd of 10 (at Dec 24)

* Wales Ranking may differ as may refer to previous month

Quality: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
CRR: 24-04	QSE	The cumulative number of laboratory confirmed Klebsiella in reporting month	Not available	TBC	104	6th of 6 (at Dec 24)
CRR: 24-04	QSE	The cumulative number of laboratory confirmed Pseudomonas Aeruginosa in reporting month	Not available	TBC	19	3rd of 6 (at Dec 24)
CRR: 24-04	QSE	The cumulative rate of laboratory confirmed E.coli bacteraemias cases per 100,000 population	Not available	TBC	75.5	4th of 6 (at Dec 24)



* Wales Ranking may differ as may refer to previous month

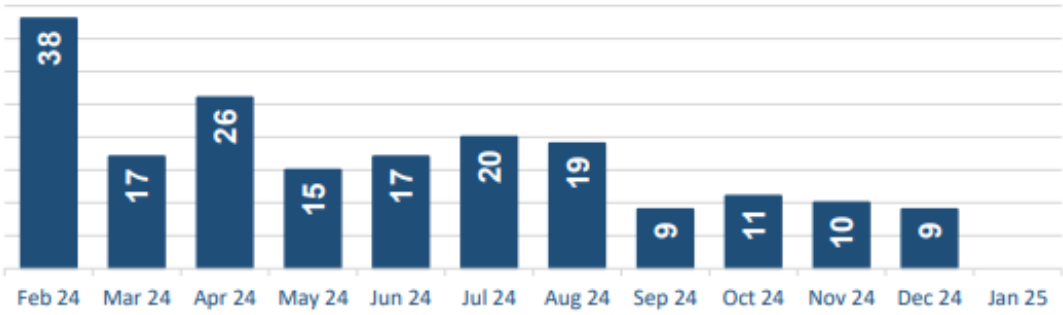
Quality: Performance

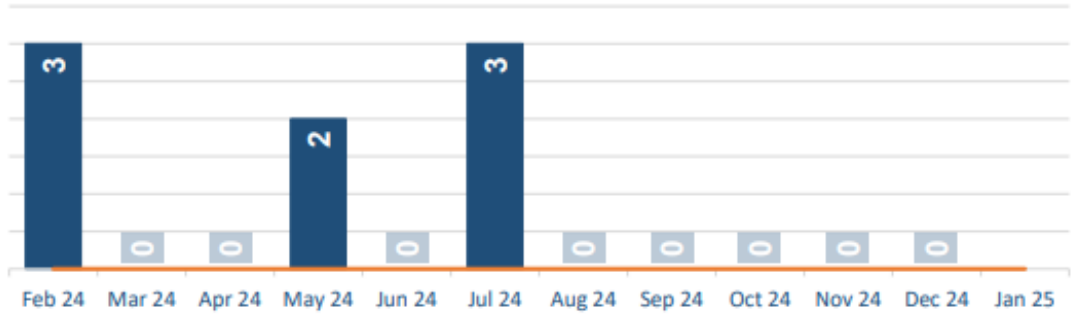
Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
CRR: 24-04	QSE	The cumulative rate of laboratory confirmed S. Aureus Bacteraemia (MRSA and MSSA) cases per 100,000 of the population	Not available	TBC	25.3	1st of 6 (at Dec 24)
CRR: 24-04	QSE	The cumulative rate of laboratory confirmed C.difficile cases per 100,000 of the population	Not available	TBC	51.5	5th of 6 (at Dec 24)
CRR: 24-04	QSE	Number of National reportable incidents that remain open 90 days or more	Decreasing trend	TBC	15	6th of 10 (at Dec 24)

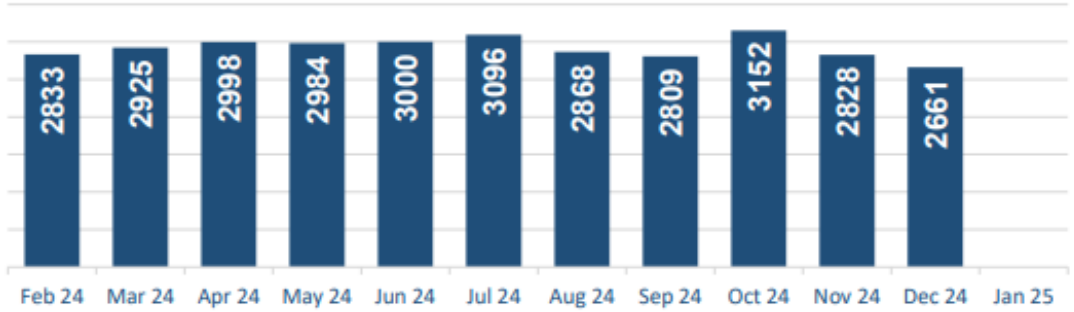
* Wales Ranking may differ as may refer to previous month

Quality: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	QSE	Number of National reportable incidents (NRIs)	N/A	TBC	9	
-	QSE	Number of new never events	0	TBC	0	
-	QSE	Number of patient safety incidents	N/A	TBC	2661	







* Wales Ranking may differ as may refer to previous month

Quality: Performance

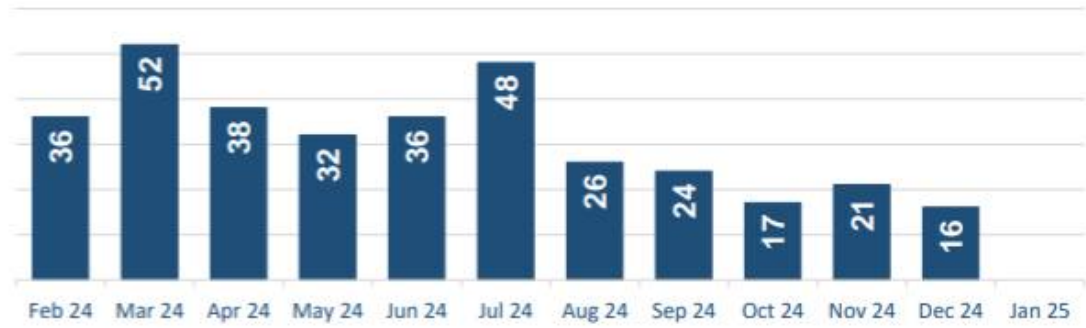
Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	QSE	Number of reported falls	N/A	TBC	340	
-	QSE	Number of reported hospital acquired pressure ulcers (HAPU) (excluding new to caseload)	N/A	TBC	462	
-	QSE	Number of reported medication incidents	N/A	TBC	240	

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

Presented on 20.02.2025

Quality: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	QSE	Number of 'Putting Things Right' (PTR) complaints [No Title]	N/A	TBC	152	
-	QSE	Of the complaints closed, the percentage that were closed within 30 days	75.0%	TBC	79.6%	
-	QSE	Number of complaints closed as early resolutions	N/A	TBC	16	

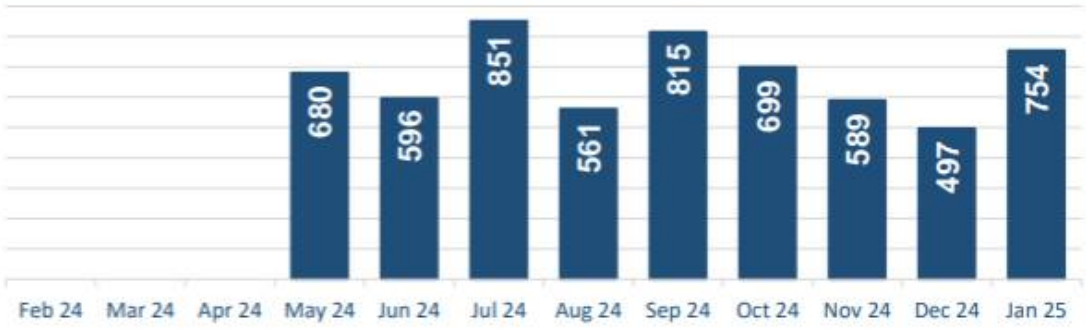


Produced on behalf of the **Quality, Safety & Experience Committee**
by the **Performance and Commissioning Directorate** in partnership with the **Quality Directorate**

Presented on 20.02.2025

Quality: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	QSE	Number of PALS (Patient Advice and Liason Service) contacts	N/A	TBC	754	
-	QSE	Number of new Ombudsman contacts	N/A	TBC	23	
-	QSE	Number of regulation 28 notices	N/A	TBC	0	



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

Presented on 20.02.2025

Quality: Performance

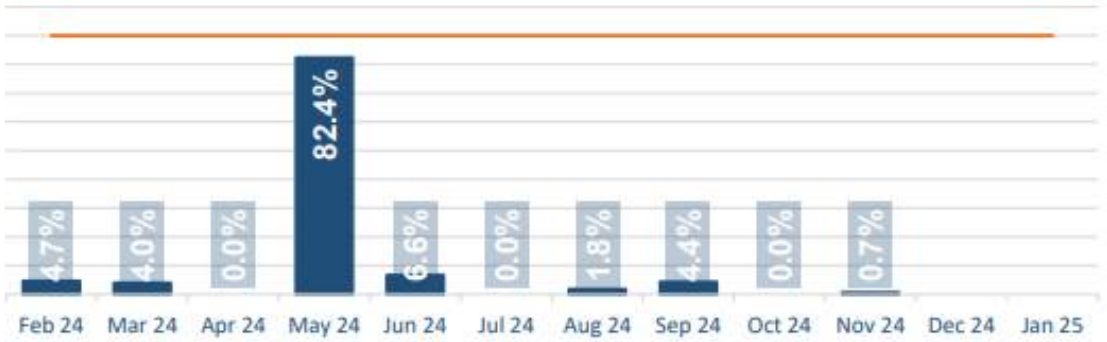
Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	QSE	Number of overdue 'Learning from Event Reports' (LFERs)	N/A	TBC	54	
-	QSE	Number of Great-ix submissions	N/A	TBC	146	
-	QSE	Percentage of episodes clinically coded within one reporting month post episode discharge end date	Increas-ing trend (to 95%)	TBC	16.1%	8st of 8 (at Oct 24)

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

Presented on 20.02.2025

Quality: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	QSE	Percentage of all classifications' coding errors corrected by the next monthly reporting submission following identification	90%	TBC	0.7%	8st of 8 (at Nov 24)
-	QSE	Percentage of calls ended following WAST telephone assessment (Hear and Treat)	>17%	TBC	13.9%	5th of 7 (at Apr 24)



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

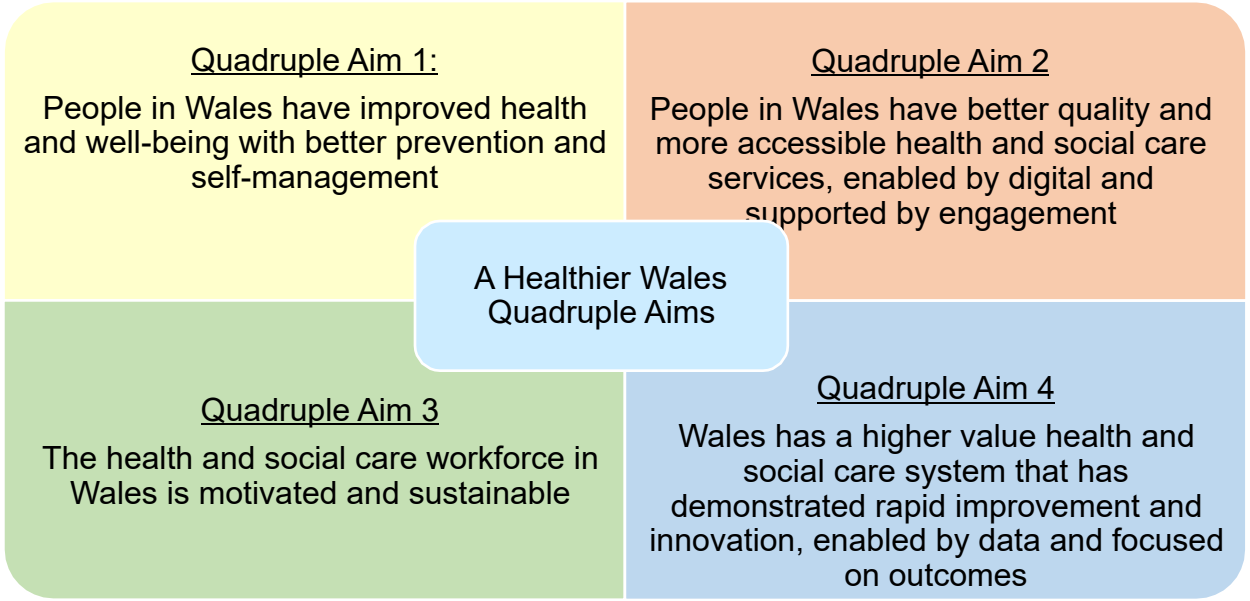
Presented on 20.02.2025

Additional Information

NHS Wales Performance Framework 2024-25

The NHS Performance Framework is a key measurement tool for “A Healthier Wales” outcomes, the 2024/25 revision now consists of 53 quantitative measures of which 9 are Ministerial Priorities and require Health Board submitted improvement trajectories. A further 11 qualitative measures are also currently included of which assurance is sought bi-annually by Welsh Government

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



Our Integrated Quality & Performance Report

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

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

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

Red, Amber & Green (RAG) Rating System

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

Green

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

Amber

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

Red

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

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

Interpreting Results of Statistical Process Control (SPC) Charts

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

How to interpret variance results

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

How to interpret assurance results

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

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

Introduction to Integrated Quality & Performance Report (IQPR)

What is an Integrated Quality & Performance Report (IQPR)?

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

The Integrated Performance Framework (IPF)

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

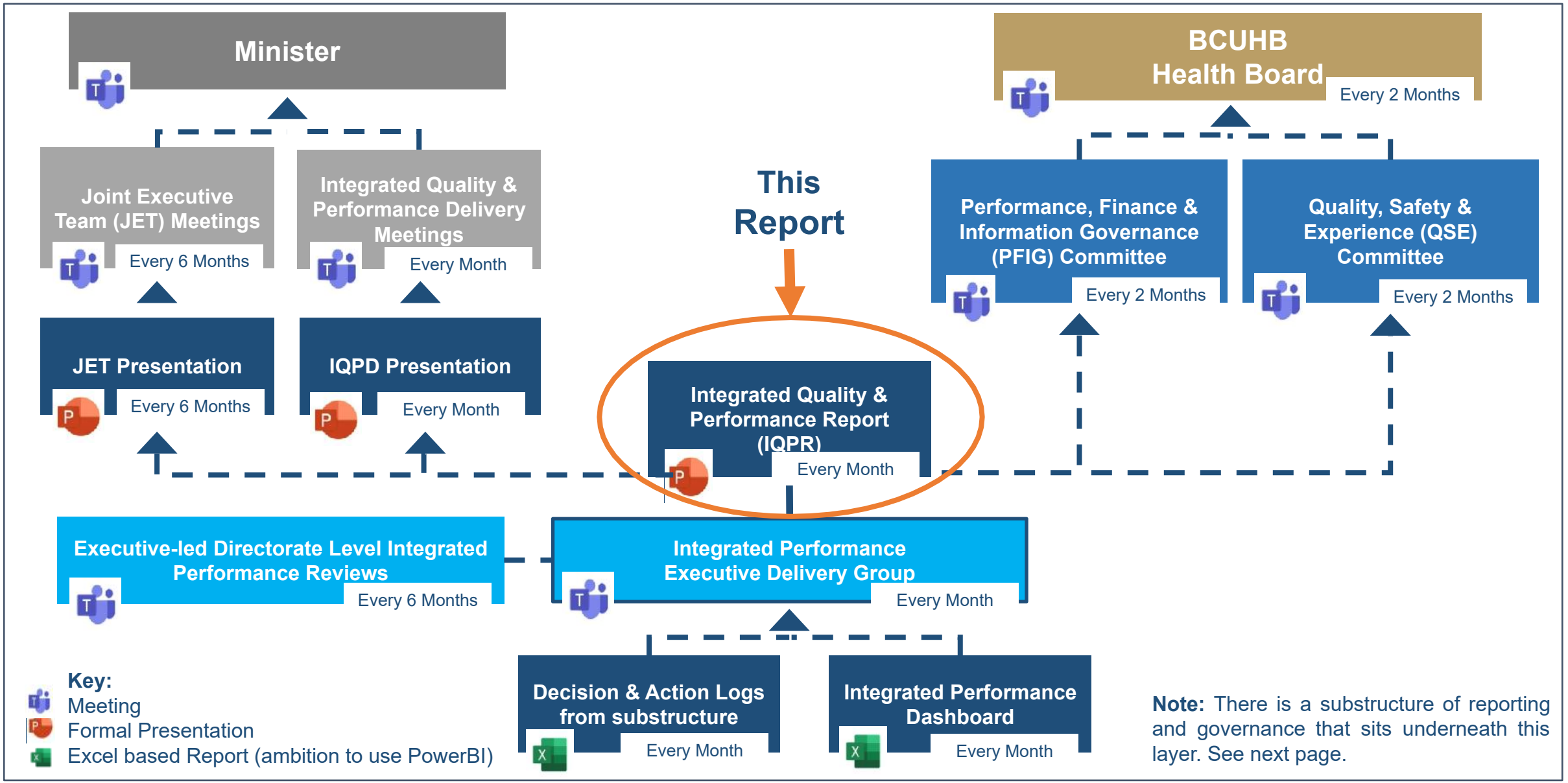
The Integrated Performance Framework sits within a "triumvirate" together with the Integrated Planning Framework and the Risk Management Framework (also ratified at Health Board on the 28th September 2023). This triumvirate of frameworks will encompass the planning, safe delivery and monitoring of the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

Where does the IQPR feature within the Performance Governance Structure

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

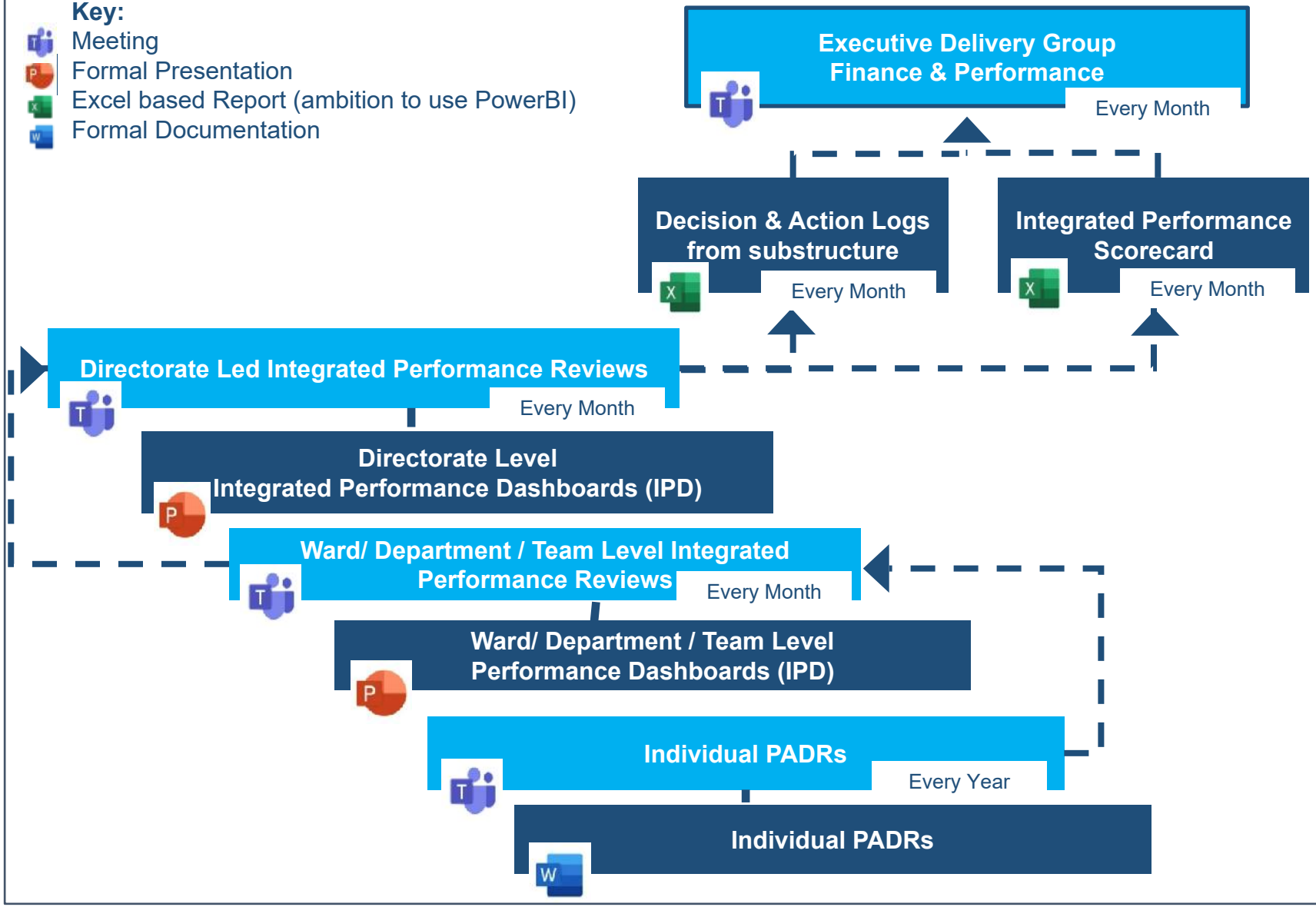
The IQPR will be embedded as the 'single version of the truth' and used to report on performance to the Health Board, it's scrutinising committees namely Performance, Finance & Information Governance (PFIG) Committee and Quality, Safety & Experience (QSE) Committee and externally to Welsh Government.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

The Integrated Performance Reporting & Governance Superstructure



The Integrated Performance Reporting & Governance Substructure

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



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

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

Performance Directorate Outputs

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

Further Information

Our Integrated Performance Report
Betsi Cadwaladr University Health Board

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

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

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


follow @bcuhb


http://www.facebook.com/bcuhealthboard

Appendix

Our Partners

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

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

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

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

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

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

QUALITY MANAGEMENT SYSTEM UPDATE

QMS Maturity Assessment tool:

- Trialled as excel workbook
- Moved to digital product now in late stages of development
- Tested in 4 services areas – Vascular, Urology, Women's and T&I with key learning and outputs that will shape the development of digitised product

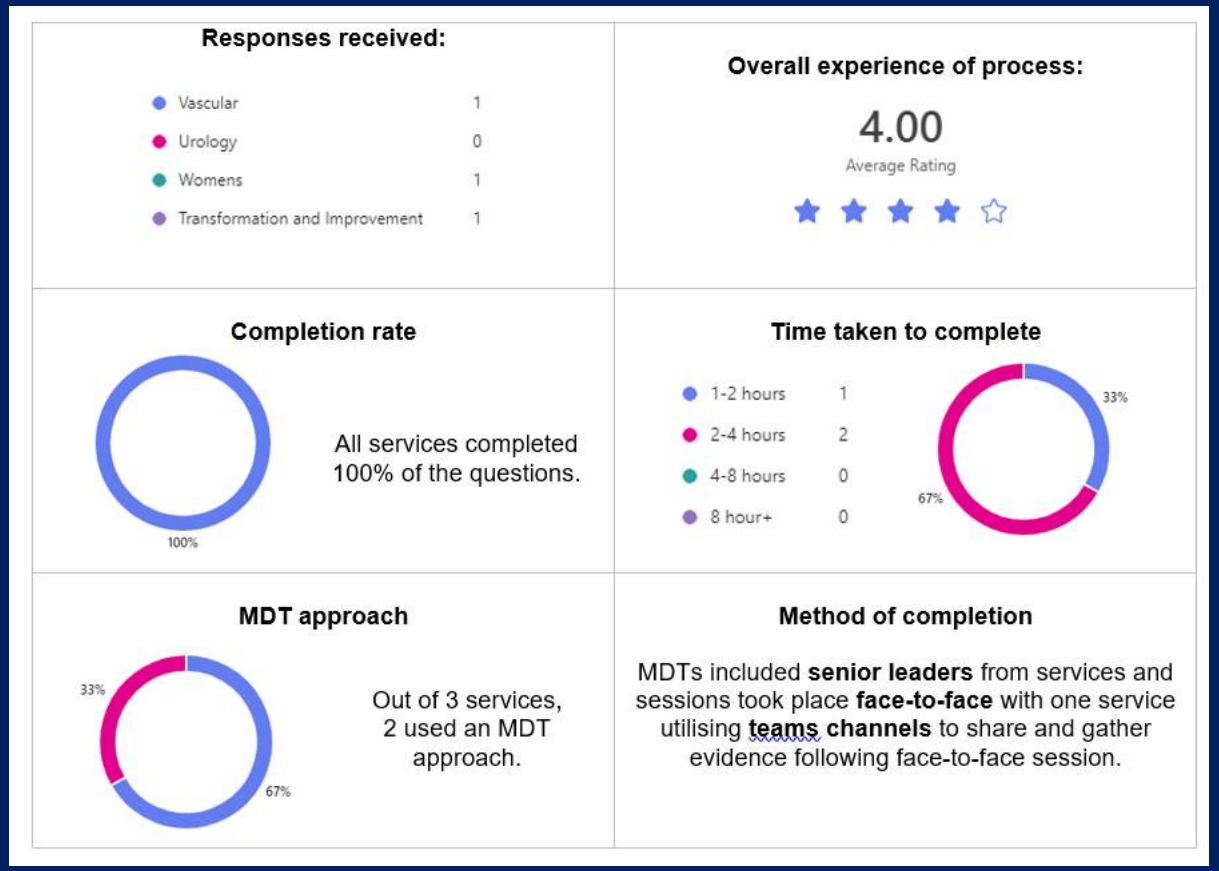
Communications and engagement:

- Approach developed with three key phases.
- Single signpost hub developed and made available to all on BetsiNet.
- Launch article published here: A quality-led Betsi: Quality Management System in development
- Included and circulated in internal Betsi channels on 16th December 2024.
- Maternity agreed to provide first early implementer case study for sharing and awareness raising.
- Stakeholder mapping and engagement plan being formulated

Project Steering Group:

- Being refocussed to support with governance, deployment and implementation.
- Membership of the group has grown and widened in its membership as a result of communications via Betsi channels.

PDSA Cycle 2



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

PDSA Cycle 2

Statement	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
We had the right people involved from the service to complete the assessment to the best of our ability			33.3%	66.7%	
As a team, we were engaged with the process of completing the assessment			33.3%		66.7%
We had enough information to be able to complete the assessment with confidence				100%	
The assessment was intuitive and easy to use		33.3%		66.7%	
The language used in the assessment was clear and understandable				100%	
We feel we can use the outputs from the assessment process to improve our service approach to a QMS				66.7%	33.3%

Summary of Key Themes

Overall response to the QMS maturity assessment was positive with services indicating that this was a worthwhile exercise for their service

Services expressed that the process of completion allowed them to consider their approach to managing quality.

All services stated that following completion they felt they understood where the gaps are in their service relating to a functioning QMS.

Completing as an MDT allowed rich conversations to take place and allowed senior leaders of the service to understand the requirements of a functioning QMS

Services that completed as an MDT emphasised how essential it is to the process to have the right people in the room and engaged with the process.

Services would like more information around the organisational expectations of completing the assessment and best practice on completing assessment

It was expressed that more information regarding the organisational expectation of services following completion would be useful as part of this process.





Next steps

Continue to develop and bolster the QMS ‘hub’ on BetsiNet to include further information around QMS as a concept, each quadrant and the importance and benefits of a functioning QMS. It was suggested the need for a particular focus on QC to ensure that it is clearly understood as concept as they felt QC language was less familiar to services.

Agree and document organisational expectations and governance requirements for QMS maturity assessment and manual including approach to evidence bases.

Move to a maturity score for each question or option of ‘partial’ in addition to ‘yes’ and ‘no’.

Review all questions in the assessment to ensure language is applicable to non-clinical and clinical services.

Next steps

Improve any navigation issues with the development of a digitised solution that will automatically populate the QMS plan and evidence with outcomes of the questions.

System governance and architecture being described to support rollout to specified follow on services from April 25

Digital product will allow for identified gaps to be connected to improvement plans and provision of evidence where quality is embedded within the service / system.

Digital evidence base will form the basis of the quality manual for the individual area.

Demonstration

Questions ?

Teitl adroddiad: ***Report title:***	**Health Board Response to the Royal College of Psychiatrists Invited Review Services Report**
Adrodd i: ***Report to:***	**Quality, Safety and Experience Committee**
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 20 February 2025
Crynodeb Gweithredol: ***Executive Summary:***	**Background** The Health Board received the Royal College of Psychiatry (RCPsych) Invited Services Review Report in March 2024. The Health Board is required to progress the improvements recommended in the report and demonstrate that the improvements are meeting the objectives of the recommendations and able to improve the outcome and experience for patients and staff. The last report to this Committee was on the 17 December 2024. The Board very recently received a report on the RCPsych Invited Services Review at its meeting of the 30 January 2025. At that meeting the requirements of the next report to the Quality Safety and Experience Committee were outlined and are reflected in this report. More specifically this included; • An update on the work underway to develop the Expert Advisory Group Work Programme • An update on the work underway to support the Expert Advisory Group Work Programme by the development of an Outcome and Performance Framework • An update in response to any escalated matters related to improvement actions in the Invited Services review • An opportunity for more in-depth understanding of the progress that has been made up to January 2025 in the Committee on the 20 February 2025. Including an update from the January RCPsych Invited Services Review. • An update on the work of the Health Board Evidence of Outcome Group is provided as the Committee has requested an update on this work. These matters are contained in this report from the Health Board RCPsych Action Delivery Group and from the Chair of the Expert Advisory Group. This report highlights that the Health Board Action Delivery Group notes good progress against these actions but it is clearly understood that the ability to assess whether the actions taken are meeting the objectives of

	the Service Review will not be clear until the Expert Advisory Group is in full operation. It continues to be important that the Health Board takes the appropriate amount of time to make sure that the role of the Expert Advisory Group is clear, operates effectively and has the full engagement of service users, families and experts so that it can independently validate that the response to the actions is meeting the objectives of the recommendations and can demonstrate improvements for service users.			
Argymhellion: ***Recommendations:***	The Committee is asked to: • **Note and Consider** the update from the Health Board RCPsych Action Delivery Group • **Note and Consider** the update from the Chair of the Health Board RCPsych Expert Advisory Group • **Note and Consider** the approach to the development of the Expert Advisory Group Work Programme and Outcome Performance Framework • **Receive assurance** on the Health Board response to the RCPsych Invited Review Services Report			
Arweinydd Gweithredol: ***Executive Lead:***	Teresa Owen, Executive Director of Allied Health Professionals and Health Science			
Awdur yr Adroddiad: ***Report Authors:***	Phil Meakin, Associate Director of Governance Ros Alstead, Special Advisor Carole Evanson, MHLD Director of Operations			
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	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithia	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 /*

	High level of confidence/evidence in delivery of existing mechanisms/objectives	u / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	*Some confidence / evidence in delivery of existing mechanisms / objectives*	*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):***	1. Building an Effective Organisation 2. Compassionate Culture, leadership and engagement 4. Improving quality, outcomes and experience 5. Effective environment for learning
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	None
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,***	Strategic Priority P18 Quality, Innovation and Improvement

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***	None to note at this stage
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	None to note at this stage
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	This paper has been prepared following the recommendations agreed at the Health Board, 25 July 2024 and the previous reports to QSE Committee, most recently the 24 October 2024.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	• CRR 24-04 (Learning) • BAF24-06 Ineffectively Delivering the Required Improvements to Transform Care and Enhance Outcomes • BAF24-05 Ineffectively Engaging with Citizens, Partners and Communities
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Not applicable
List of Appendices: • Appendix 1 – Extract from Board Report from 30 January 2025 showing key progress of the RCPsych Invited Services Review • Appendix 2 – Summary of Progress against the Invited Services Review – as at 17 January 2025	

HEALTH BOARD RESPONSE TO THE

ROYAL COLLAGE OF PSYCHIATRISTS INVITED SERVICES REVIEW REPORT

1. INTRODUCTION

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

The last report to this Committee was on the 17 December 2024 and the Board recently received a full report at its meeting on the 30 January 2025 (and which can be accessed on this link).

2. PURPOSE OF THIS REPORT

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

- **Note and Consider** the update from the Health Board RCPsych Action Delivery Group
- **Note and Consider** the update from the Chair of the Health Board RCPsych Expert Advisory Group
- **Note and Consider** the approach to the development of the Expert Advisory Group Work Programme and Outcome Performance Framework
- **Receive assurance** on the Health Board response to the RCPsych Invited Review Services Report.

3. BACKGROUND

The Board recently received a comprehensive report on the Health Board response to the RCPsych Invited Services Review at its meeting of the 30 January 2025. At that meeting the requirements of the next report to this Committee were outlined and are reflected in this report to the Quality Safety and Experience Committee. More specifically this included;

- An update on the work underway to develop the Expert Advisory Group Work Programme
- An update on the work underway to support the Expert Advisory Group Work Programme by the development of an Outcome and Performance Framework
- An update in response to any escalated matters related to improvement actions in the Invited Services review

- An opportunity for more in-depth understanding of the progress that has been made up to January 2025 in the Committee on the 20 February 2025. Including an update from the January RCPsych Invited Services Review.
- An update on the work of the Health Board Evidence of Outcome Group is provided as the Committee has requested an update on this work.

These matters are contained in a report from the Health Board RCPsych Action Delivery Group and from the Chair of the Expert Advisory Group.

This report highlights that the Health Board Action Delivery Group notes good progress against these actions but it is clearly understood that the ability to assess whether the actions taken are meeting the objectives of the Service Review will not be clear until the Expert Advisory Group is in full operation. It continues to be important that the Health Board takes the appropriate amount of time to make sure that the role of the Expert Advisory Group is clear, operates effectively and has the full engagement of service users and experts so that it can independently validate that the response to the actions is meeting the objectives of the recommendations and can demonstrate improvements for service users.

4. ADDITIONAL BACKGROUND

As a reminder, the ten themes (Table 1 below) are outlined below.

Table 1: The ten themes

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

5. UPDATE FROM HEALTH BOARD ACTION DELIVERY GROUP

5.1. Progress Against The Improvements of The RCPsych Invited Services Review

The Health Board Action Delivery Group received a report at its meeting of the 27 January 2025 that contained progress against the improvement action in the Invited Services Review. It should be noted, that whilst the Expert Advisory Group is developing their Work Programme (reported in section 6.2 below) for how it will consider progress against the actions of the Invited Services Review, the work to evidence progress against the actions should continue. A Chairs Report from the Health Board RCPsych Action Delivery Group will be received at the Executive Committee.

The Quality Safety and Experience Committee members will be aware that the Board recently received a report on the 30 January 2025 on the progress against the improvements of the RCPsych Invited Services Review and there was a section from the Board Report that provided an update on progress against the improvements set out in the Invited Services Review as at 17 December 2024. This section is extracted and provided in Appendix 1.

Appendix 2 contains a Progress Update Report that the Health Board Action Delivery Group received on 27 January 2025 that summarises progress against the Invited Services Review as at the 17 January 2025.

Since the report to the Board on 30 January 2025 there has been progression of six additional Improvement Actions that have been progressed with evidence submitted for review by the Evidence of Outcomes Group.

Following review at the Mental Health and Learning Disabilities (MHLD) Programme Improvement Delivery Group and Health Board Regulatory Assurance Group the following improvement actions were endorsed for approval with evidence of progress provided by the improvement action owners. These include:

Action 3.2 - Audit on call medical staff to ensure that they have their own personal login for Paragon.

Action 1.8 – Develop and improve Dementia care data to provide consistent Welsh Government reporting from reliable and accurate data.

Action 1.10 – Continue engagement with Tawel Fan families and current service users via the Expert Advisory Group

Action 1.11 - Continue engagement activities from Llais Wales, Patient Advice and Liaison Service, Canaid, wider stakeholders and stakeholders aligned to patients and carer co-working.

Action 1.6 – Further develop the model of patient and carer engagement to ensure people with lived and living experience of BCUHB services are at the heart of planning, delivery and evaluation of services as equal partners in the care they receive, building on current good practice that exists across Wales and further afield.

Colleagues will be present at the Committee meeting on the 20 February 2025 to provide further insight if required.

5.2. Escalated Matters to the Health Board RCPsych Action Delivery Group

The Health Board Action Delivery Group received an update on two improvement actions that have been escalated.

Improvement Action 1.1 "Progress the recruitment of the MH&LD Nurse Consultant Dementia.

The Health Board RCPsych Action Delivery Group risk log higlights that there is a risk to the ability to confirm the final appointment of a successful candidate to this post that may detract from progress against the Invited Services Review. This is in relation to action 1.1 and actions that rely on this appointment. The Delivery Group confirmed this as a Programme risk and will be reported via the Delivery Group Chairs Report to the Executive Team.

The key action being taken to mitigate this risk include the assessment of the suitability of alternative appointable candidates for the role and progress on this will be reported back to the Executive Team in due course. As at 6 February 2025 an alternative appointable candidate has confirmed their agreement to join the Health Board and workforce checks are being progressed at pace.

Improvement Action 9.3 "Therapies Provision in Inpatient Settings".

The Delivery Group risk log highlights that mitigations against this risk have included close working between Therapies and MHLD senior managers resulting in an outline approach to realise earlier improvements as soon as possible. The Delivery Group approved a proposal to a change to amend the Delivery Date of this improvement action from 31 October 2024 to 31 October 2025 to recognise that business cases for the allocation of Health Board resources will need to be further developed, considered and approved in order to achieve an effective response to this improvement action.

The Delivery Group endorsed this approach and will seek formal confirmation from the Executive Team when the Delivery Group Chairs Report is received at the Executive Team.

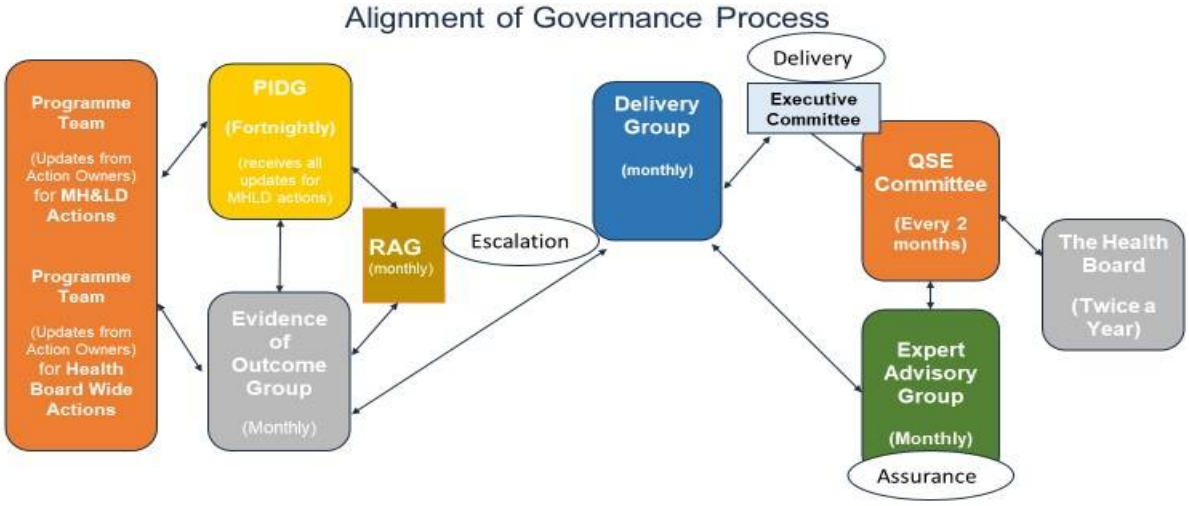
5.3. Report from the Evidence of Outcomes Group

The Health Board RCPsych Action Delivery Group received a report from the Evidence of Outcomes Group. This Group reports directly to the Health Board RCPsych Action Delivery Group.

Both the MHLD Programme Improvement Delivery Group (PIDG) and the Regulatory Assurance Group (RAG) continue to be supported by the Evidence of Outcomes Group which reviews, checks and challenges evidence of progress from action owners.

During the Evidence of Outcomes meeting held in January 2025 the Alignment of Governance Process was presented to show the route of the improvement actions. This is provided visually below in Figure 1 and highlights the position of the Group in the Governance process.

Figure 1 – Alignment of the RCPsych Governance Process



The following Health Board colleagues are members of the Evidence of Outcomes Group:

- Associate Director of Governance - Chair
- Deputy Executive Director of Nursing
- Associate Director for People
- Assistant Director of AHP and Health Science
- Mental Health and Learning Disabilities - Head of Integrated Strategy and Development
- Lead for Patient Experience and Carers
- Mental Health and Learning Disabilities – Operational Business Lead
- Standing Invite to Executive Director of AHP and Health Science

The members of the Group receive information from the improvement action owners and peer review the submission. In the meeting the Group recommends which improvement actions evidence requires strengthening and which improvement actions can be endorsed and progress to the Delivery Group and Expert Advisory Group. There are four questions that are posed to enable the Group to make this recommendation and they are included in Figure 2 below

Figure 2. Questions that Evidence of Outcome Group Uses to Review Information

Does the information provided give you assurance that the action has been taken as set out in the RCPsych Invited Services Review Response?

Is there evidence of an improved outcome for patients/service users OR progress made towards improving outcomes?

Is there evidence that it is embedded into the work of the Health Board to demonstrate 2 above?

What, if anything, would you find useful to better meet the three questions above?

Table 2 below highlights the status as at 24 January 2025 of each of the improvement actions that has been received by the Evidence of Outcomes Group. The table below illustrates that seven of the 25 improvement actions were reviewed and more information provided by the improvement action owner. Eight improvement actions are currently being reviewed.

Nos of improvement actions endorsed for approval and awaiting Evidence of Outcome Group peer review	Nos of improvement actions peer reviewed by Evidence of Outcome Group and awaiting strengthening	Nos of improvement actions approved by Evidence of Outcomes Group after peer review and strengthening awaiting Expert Advisory Group review.
8	10	7

The current Terms of Reference for the Evidence of Outcome Group were considered by the Health Board RCPsych Action Delivery Group on the 27 January 2025. The Health Board RCPsych Action Delivery Group agreed that the Terms of Reference be amended to reflect the strengthening of peer group review arrangements in the Evidence of Outcomes Group. A version 2 of the Terms of Reference will therefore be considered for approval at the Health Board Action Delivery Group on 24 February 2025 and will be provided to the Quality Safety and Experience Committee at its next meeting for information.

A Chairs Report from the Evidence of Outcomes Group will be received by the Health Board Action Delivery Group on 24 February 2025.

6. REPORT FROM THE CHAIR OF THE EXPERT ADVISORY GROUP

6.1. The Expert Advisory Group

The Board, including members of the Quality Safety and Experience Committee received a presented report from the Chair of the Expert Advisory Group on the 30 January 2025. The fourth round of meetings will be planned for later in the month of February 2025.

Significant work has been undertaken in January and February 2025 towards a Work Programme for the Expert Advisory Group and the development of an Outcome Performance Dashboard that members of the Expert Advisory Group will be asked to consider so that information on the action improvements undertaken from the Invited Services Review can be assessed from the March 2025 round of meetings with the Expert Advisory Group.

This builds on the work that was tabled with Expert Advisory Group following the second round of meetings (December 2024) where members of the Group were presented with an approach by which they can review the progress against their particular areas of focus by alignment with the actions of the RCPsych Invited Services Review. This included the receipt of a proposal cross referencing their areas of interest against the relevant actions in the Invited Services Review and support from the Special Advisor to the Health Board in defining what the sustainable improvement in outcomes could be. The Group members were asked to review this proposal ahead of a third round of meetings in January 2025.

6.2 Development of an Expert Advisory Group Work Programme

The report to Board and feedback from Board members on 30 January 2025 clarified that a clear next step is the development of a Work Programme for the Expert Advisory Group so that members of the Group can assess progress against the improvement actions set out in the Invited Services Review.

The Special Advisor to the Health Board reported to the last Quality Safety and Experience Committee that the Expert Advisory Group members have articulated clear areas of interest. Specifically the patient and carer experience in:

1. Older Peoples Mental Health
2. Adult Mental Health and
3. A cross cutting theme of Governance and Leadership.

The Board (on the 30 January 2025) requested that the Expert Advisory Group Work Programme should align with the Groups areas of interest (as outlined above). In addition the Board proposed that Group members should be able to influence the nature of the Work Programme and agree a monthly by month programme from up to October 2025. Finally, that the Group should have the opportunity to review progress against other areas of the response to the Invited Services Review that are reported to the Delivery Group.

The Delivery Group has recommended that the first review of information be available from the end of March 2025 and that it should focus on the assessment of progress made against **Theme 1 "Patient and User Centred Care".** The information to be received needs to reflect an outcomes focus with real time measures so that the reality of the impact of improvement actions taken is apparent.

It is important that the Group receives both quantitative and qualitative information to support their assessment. An outline of the Work Programme is reflected in Table 1 below. These proposals will be considered by the Expert Advisory Group during the February 2025 and March 2025 round of meetings.

Table 1 – Outline of Expert Advisory Group Work Programme

Month	Focus of Expert Advisory Group Review	Additional Agenda Item	Content and Method
March 2025	Improvements related to Theme 1 "Patient and User Centred Care"	Discuss and agree a work programme for April to October 2025	Information Pack and Team Presentations
April 2025	To be agreed by Group	Delivery Group Progress Report	Information pack, team presentations/site visits
May 2025	To be agreed by Group	Delivery Group Progress Report	Information pack, team presentations/site visits
June 2025	To be agreed by Group	Delivery Group Progress Report	Information pack, team presentations/site visits
July 2025	To be agreed by Group	Delivery Group Progress Report	Information pack, team presentations/site visits
August 2025	To be agreed by Group	Delivery Group Progress Report	Information pack, team presentations/site visits
September 2025	To be agreed by Group	Delivery Group Progress Report	Information pack, team presentations/site visits
October 2025	To be agreed by Group	Delivery Group Progress Report	Information pack, team presentations/site visits

6.3 Development of an Expert Advisory Group Outcome and Performance Framework

The families previous experience of having papers to review and given reassurance on improvement actions has not always led to demonstrable improvement in Mental Health and wider Health Board services. Families and current service users, supported by the Special Advisor wish to take the time to design a different approach to test and challenge whether the improvements that are described on paper are evident in practice and there is a plan for them to be sustained. This was outlined at the Board Meeting on 30 January 2025.

As outlined in section 6.2 above, following the dialogue with Expert Advisory Group members the Outcome and Performance framework approach will reflect the three distinct work programmes, as well as the RCPsych Invited Services Review report and themes. These will be addressed through the Work Programme, through involvement and engagement with day-to-day activities within services.

In order for the work programme outlined above to be enacted, consideration of an Outcome and Performance Framework has been progressed ready for review by a meeting of the Special Advisor and the Executive Director of Allied Health Professionals and Health Science on 13 February 2025. Once reviewed, feedback will be used to clarify a proposal for the Health Board Action Delivery Group on the 24 February 2025 and then ready for reporting to the Expert Advisory Group.

This proposal will build on work undertaken and developed during January and February 2025 that identifies:

- Aims of the Invited Services Review themes and associated improvement actions
- Primary drivers (factors directly contributing to achieving these aims) linked to measurement of outcomes
- Secondary drivers (actions or interventions necessary to achieving the primary drivers)
- Assessment of outcomes (by areas of focus) by the Expert Advisory Group

A key development since the last Committee report has been the Health Board RCPsych Action Delivery Group endorsement of 21 Outcome Measures to enable real time demonstration of progress against the actions in the Invited Services Review.

The final outcomes and performance framework will support the evidence of progress that has been submitted by improvement action owners and that has been scrutinised by the Evidence of Outcomes Group. As outlined above, this will be complimented with interaction with Health Board teams, including presentations from Health Board teams, speaking to staff members and visits, where appropriate. This interactive approach will allow Expert Advisory Group members the opportunity to discuss and validate the information that is being provided “on paper”.

7.SUMMARY

This is an important juncture in the Health Board’s drive to make sustainable improvements in care. The last six months focus has been on meaninful engagement and the deployment of a Governance Framework. The current and next six month focus is to assess, through a Work Programme and Outcome and Performance framework where progress has been made and where further attention is required to deliver the sustaibale and embedded improvements in care for the population of North Wales.

The continued focus of Health Board members, colleagues and the stakeholders in the Expert Advisory Group continues to be important as we focus on demonstrating improvement and learning from feedback in the next six months. Supporting colleagues and stakeholders has been highlighted to the Committee and the Board as a key enabler to progress. Since the last report to the Quality Safety and Experience Committee, the Associate Director of Governance has confirmed additional programme support from the Health Board Transformation and Improvement Team. Emotional and practical support has also been confirmed for the Expert Advisory Group members through the BCUHB Psychological Therapies team and Patient Experience Team respectively.

8.NEXT STEPS

- Complete work on the Expert Advisory Group Work Programme and present at the Health Board RCPsych Action Delivery Group on 24 February 2025
- Complete proposal for the Outcome and Performance Framework and present at the Health Board RCPsych Action Delivery Group on 24 February 2025
- Present proposals for consideration by the Expert Advisory Group Work Programme and Outcome and Performance Framework to the Expert Advisory Group members through February and March 2024.
- Make arrangements for the review of progress against Theme 1 related improvement actions to the Expert Advisory Group by 1 April 2025.

9.RECOMMENDATIONS

This report asks the Committee to;

- **Note and Consider** the update from the Health Board RCPsych Action Delivery Group
- **Note and Consider** the update from the Chair of the Health Board RCPsych Expert Advisory Group
- **Note and Consider** the approach to the development of the Expert Advisory Group Work Programme and Outcome Performance Framework
- **Receive assurance** on the Health Board response to the RCPsych Invited Review Services Report

10.APPENDICES

Appendix 1 – Extract from Board Report from 30 January 2025 showing key progress of the RCPsych Invited Services Review (Follows this report below)

Appendix 2 – Summary of Progress against the Invited Services Review – as at 17 January 2025 (Follows this report below

APPENDIX 1 – Extract from Board Report from 30 January 2025 showing key progress of the RCPsych Invited Services Review (Follows this report below)

1. PROGRESSING THE ACTIONS IN THE INVITED SERVICES REVIEW REPORT

This report highlights that over the last six months the focus has been on meaningful engagement with stakeholders, including clarity on how an assessment of progress of improvements will made and the Quality, Safety and Experience Committee has been clear that there will not be validation of progress made until the Expert Advisory Group has reported this assurance to the Committee. As reported in Section 5, it is important that the Health Board continues to progress improvements and the following section gives a brief summary of matters reported to the Quality, Safety and Experience Committee on 17 December 2024. Noted below are some examples of progress that has been accomplished aligned to improvement activity;

- The Electronic Patient records business case has been approved by Welsh Government and pre-procurement processes are underway to enable a digital patient solution.

- The Patient and Carer Experience Team's introduced a new telephony system in July 2024 to give customers an improved caller experience. The successful relaunch of the Health Board's Patient Advice and Liaison Service (PALS) online platforms in October 2024, through the new "Report it" page, has led to the number of visitors to the new PALS and Complaints webpage increasing to 1559 (an average of 390 page visits per week). In October 2024, 5095 All Wales Real-Time Patient and Carer Feedback Survey responses were received via CIVICA, with 80.94% of respondents 'very satisfied' with their overall experience of accessing Health Board services.

- Health Board wide Implementation of the five step approach to the management of Complaints, Incidents and Mortality Reviews, has led to the total number of open complaints across the Health Board falling from 672 to 195 (70.98% decrease) and the total overdue complaints have fallen from 428 to 42 (90.18% decrease). As a Health Board, we are addressing complaints quicker and as at 15th January 2025, the Health Board compliance for addressing complaints was 80.23%, with Mental Health & Learning Disabilities achieving 100% compliance during this period.

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

- A Peer Review Environmental Ligature Risk Assessment Audit has been completed across all inpatient units across the MH&LD Division. The Audit demonstrates that ward areas have ligature assessments in place with a compliance of annual assessment at 93.1%. A re-audit will be completed on a six-monthly basis with a focus on bedrooms and bathrooms. In addition, the Health Board has trained 457

staff in ligature awareness training which has led to increased awareness by staff of ligature risks.

- The MH&LD Anti-psychotic Audit Task and Finish group, (established to ensure Audits are received and completed by the Multidisciplinary Teams), produced their first update in November 2024. A monthly update is reported into the group, to ensure implementation and embedded process for these Audits.

- A MH&LD Falls Audit was completed during August 2024 which has led to improvements in the quality of record-keeping and staff awareness and the development of Falls Champions, Falls workshop and a Falls Bulletin developed and progress shared with all staff across the Division.

- The Divisional Recruitment & Retention Group have focused their activity on 'grow your own' nursing, with a number of Health Care Support Workers (HCSW's) supported to enter into a Registered Nurse training programme. This activity supports HCSW retention, career progression and skill development which will have a positive impact on our workforce.

- The development and implementation of a clear and comprehensive framework for senior leadership connectedness to the wards has progressed with the development a MH&LD Senior Leadership Walkabout Schedule. The Walkabouts commenced in April 2024, which includes "Ask DSLT (Divisional Senior Leadership Team) virtual staff engagement sessions and "Drop in Sessions" for patients, families and carers to improve engagement with external partners and stakeholders.

- The "iCAN" Dashboard has been strengthened to give an overview of community support activity and performance with outcomes measures achieved during the reporting period. Several Workshops were held during September 2024 with Primary Care, Mental Health, Local Authority, Allied Health Professionals and Third Sector Partners to help inform the approach to Tier 0/1 service strategy and development and the approach to commissioning services going forward. This has led to an increase in external partner and stakeholder engagement.

The governance arrangements that have been established allow early identification of actions where additional support or focus is needed. The Health Board Action Delivery Group received an escalation in regards to Action 9.3 which relates to. "Development of Business Cases related to Therapeutic provision in inpatient settings." This escalation was reported to Quality, Safety and Experience Committee on 24 October 2024. The matter was also escalated to Executive Team and work has commenced by the Therapies Senior Managers and MH&LD Senior Managers working together to establish proposals to address the action. An update on this position will be reported to Quality, Safety and Experience Committee in February 2024.

The last report to Board identified the requirement to identify best practice in Mental Health and Learning Disabilities. Since the last report the Health Board has joined the Mental Health Network which is an NHS Confederation members network. The Network

seeks to champion good practice and innovation in the mental health sector, influence policy and legislation and interpret the broader political and policy environment.

The Quality, Safety and Experience Committee received the report on progress against the actions from the Delivery Group (of 25 November 2024). At this reporting point the Committee noted good progress has been made overall and that there was an acceptable level of assurance of progress against the actions that have been taken up to 15 November 2024, as set out in the detailed response plan. The work of the Evidence of Outcome Group (Pilot phase) is supporting the provision of information that evidences actions taken and sustained improvement.

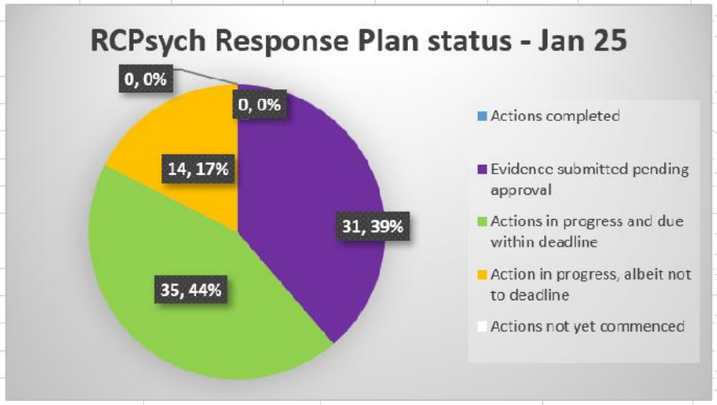
Royal College of Psychiatrists' Invited Review Services Report
Mental Health and Learning Disability services in Betsi Cadwaladr University Health Board
Progress Update Report - as at 17 January 2025

Date	17/01/2025	Period	Month / Jan 2025	Author	Adrianne Jones, MH&LD Operational Business Lead	MH&LD Lead	Carole Evanson, Director of Operations	Senior Responsible Owner	Teresa Owen, Executive Lead.	RAG	Current month: Green	RAG Last Month: Green

CURRENT STATUS SUMMARY

80 action in total - 31 actions pending approval, 35 actions in progress and due within deadline, and 14 action in progress, albeit not to deadline.

Action Status	Completed	Evidence submitted, pending approval	In progress and due within deadline	In progress, but not to deadline	Overdue and no recent progress
Theme 1	0	10	3	2	0
Theme 2	0	3	4	2	0
Theme 3	0	7	5	2	0
Theme 4	0	2	3	3	0
Theme 5	0	0	3	0	0
Theme 6	0	0	6	1	0
Theme 7	0	1	1	2	0
Theme 8	0	4	3	0	0
Theme 9	0	1	2	2	0
Theme 10	0	3	5	0	0
Total	0	31	35	14	0
Change from previous month	No Change	Increased by 6 from previous month	Decreased by 10 from previous month	Increased by 4 from previous month	No change



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

ACTION RECOVERY & MITIGATION

Progress on 80 (↑5) of the 80 actions underway, 10 albeit not within deadline. Outcomes to be independently reviewed

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

KEY MILESTONES/DELIVERABLES - IMPLEMENTATION & OVERSIGHT

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

PROGRESS SINCE LAST MONTH

Evidence submitted to PIDG and RAG reviewed in meetings held in January 2025 - 10 in total.
Two actions endorsed for approval at PIDG and 4 actions reviewed at RAG - 12 Actions remain in progress not to deadline.

Following review at PIDG/RAG, the following actions were endorsed for approval -

- 3.2 - Audit on call medical staff to ensure they have their own personal login for Paragon.
- 1.8 - Develop and improve Dementia care data to provide consistent Welsh Government reporting from reliable and accurate data
- 1.10 - Continue engagement with Tawel Fan families via the Expert Advisory Group monthly meetings.
- 1.11 - Continue engagement activities from Llais Wales, Patient Advice & Liaison Service, Canaid, wider partners and stakeholders aligned to patients and carer co-working.
- 1.6 - Further develop the model of patient and carer engagement to ensure people with lived and living experience of our services are at the heart of the planning, delivery and evaluation of services as equal partners in the care that they receive, building on current good practice that exists across Wales and further afield.

NEXT MONTHS ACTIVITIES

1. Progress completion of 12 actions in progress, albeit not to deadline
2. Progress March 2025 MH&LD and Health Board actions
3. Continue peer reviews undertaken by Evidence of Outcomes Group, to ensure transparency, honesty and assurance from the evidence approval process.
4. Continue to progress the development of performance metrics to measure the impact of outcomes, outputs and benefits to patients, workforce and service
5. Continue establishment of the Expert Advisory Group.

CHALLENGES, RISKS & ESCALATIONS

Resource Planning paper considered at HBADG meeting to be implemented.

Updated Risks and Issues Log to be reviewed and considered.

LESSONS LEARNED AND IMPACT THIS MONTH

- Development of new pathway to support any medical access to the Medium Secure Unit Paragon Patient Administration System, improving information governance processes and data capture.

- Service User and Carer Engagement strategy is being developed productively. Divisional Patient and Carer Engagement Group have commissioned the establishment of Service User and Engagement Task and Finish Group. The involvement and engagement of people with lived experience of Mental Health services, carers and our workforce has been central throughout the development and delivery of a range of Lived Experience Engagement Events with the support of 'Caniad'.

- Co-Production Lab Wales as the leading 'co-production' think tank' in Wales was commissioned by 'Caniad' to support the facilitation of the engagement events. Co-Pro Lab will continue to work with the Task and Finish Group and people with lived and living experience to co-design and draft the emerging strategy

- Six Service User Engagement Events held during November 2024 to aid coproduction of a Service User and Carer Engagement Strategy

Teitl adroddiad: ***Report title:***	Corporate Risk Register Report
Adrodd i: ***Report to:***	Quality, Safety and Experience Committee (QSE)
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 20 February 2025
Crynodeb Gweithredol: ***Executive Summary:***	The purpose of this standing agenda item is to provide an update position of the Corporate Risk Register to which the Committee has oversight. Three risks reported to committee score above the tolerance range set in the appetite (scores of 20): • **CRR24-09** 'Primary Care', • **CRR24-13** 'Timely Diagnostics', • **CRR24-19** 'Community Care Provision', • **CRR24-21** – Ophthalmology Service All risks have been reviewed and updated by the relevant service, with no proposed changes in risk scoring. • **CRR24-02 '**Patient Safety' – Target risk due date, approved changed from the 31/03/2025 to 30/09/2025. • **CRR24-04 '**Failure to embed learning' – Target risk due date approved changed from the from the 31/03/2025 to 30/09/2025. • **CRR24-12** 'Areas of Clinical Concern' – Risk has been closed and 7 new clinical Corporate Risks have been developed and approved by the relevant Executive: • CRR24-20 – Oncology Service • CRR24-21 – Ophthalmology Service • CRR24-22 – Orthodontics Service • CRR24-23 – Vascular Service • CRR24-24 – Renal Service • CRR24-25 – Dermatology & Plastic Surgery Service • CRR24-26 – Urology Service
Argymhellion: ***Recommendations:***	The Committee is asked to **receive assurance** for the progression of the corporate risks to which the Committee has overall accountability.
Arweinydd Gweithredol: ***Executive Lead:***	Pam Wenger, Director of Corporate Governance
Awdur yr Adroddiad: ***Report Author:***	Nesta Collingridge Head of Risk Management

Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐		I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***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):***	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?***	Not applicable for this report			
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary ben undertaken?***	Not applicable for this report			
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***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	Failure to capture, assess and mitigate risks can impact adversely on the workforce.			

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***	Individual Executive Sign off of CRR reports, Review at next Risk Scrutiny Group and subsequent Executive Team Meeting.
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)***	Not applicable for this report
Camau Nesaf: ***Next Steps:*** 1. Further scrutiny of all corporate risks by Executive Team as per normal reporting cycle. 2. Submission of Corporate Risks to Board.	
Rhestr o Atodiadau: ***List of Appendices:*** Appendix 1 – Corporate Risk Dashboard – Quality, Safety and Experience Committee (QSE) Appendix 2 – Corporate Risk Register Report - Quality, Safety and Experience Committee (QSE)	

Corporate Risk Register

Corporate Risk Register Report

1.0 Purpose

1.1 The purpose of this report is to provide an update to the Committee on the most significant risks to which the committee has overall accountability and oversight of.

There are 13 Corporate Risks for Quality, Safety and Experience Committee oversight and assurance. The full details of those risks are highlighted in Appendix 2 and include evidence of controls in place, additional controls required and actions with due dates:

- CRR24-02 – Patient Safety
- CRR24-04 – Failure to Embed Learning
- CRR24-09 – Primary Care
- CRR24-13 – Timely Diagnostics
- CRR24-14 – Harm from Medical Devices/Equipment
- CRR24-19 – Community Care Provision
- CRR24-20 – Oncology Service
- CRR24-21 – Ophthalmology Service
- CRR24-22 – Orthodontics Service
- CRR24-23 – Vascular Service
- CRR24-24 – Renal Service
- CRR24-25 – Dermatology & Plastic Surgery Service
- CRR24-26 – Urology Service

2.0 Key Highlights

- **CRR24-02 '**Patient Safety' – Extend the target risk due date approved by the Executive Team from the 31/03/2025 to 30/09/2025.
- **CRR24-04 '**Failure to embed learning' – Extend the target risk due date approved by the Executive Team from the 31/03/2025 to 30/09/2025.
- **CRR24-12** 'Areas of Clinical Concern' – Risk has been closed and 7 new clinical Corporate Risks have been developed and approved by the relevant Executive, that will supersede CRR24-12:
    - CRR24-20 – Oncology Service
    - CRR24-21 – Ophthalmology Service
    - CRR24-22 – Orthodontics Service
    - CRR24-23 – Vascular Service
    - CRR24-24 – Renal Service
    - CRR24-25 – Dermatology & Plastic Surgery Service
    - CRR24-26 – Urology Service
- **CRR24-13** – Timely Diagnosis – Executive Lead for the risk updated and amended from the Executive Director of Allied Health Professions & Health Science to the Chief Operating Officer.

The following risks were subject to a deep dive at the January 2025 Risk Scrutiny Group where the group discussed and reviewed, the risks and were presented to the group by the relevant risk lead and service:

- **CRR24-02 –** Patient Safety
- **CRR24-04** – Failure to embed learning

2.1 Changes in Score

None

2.2 New Risks

The risk(s) added to the Corporate Risk Register since the last update are:

Risk Ref	New Risks	Lead Exec Director	Current Risk Score (and IxL)
CRR24-20	Oncology Service	Executive Medical Director	**15 (3x5)**
CRR24-21	Ophthalmology Service	Chief Operating Officer	**20 (4x5)**
CRR24-22	Orthodontic Service	Chief Operating Officer	**16 (4x4)**
CRR24-23	Vascular Service	Chief Operating Officer	**16 (4x4)**
CRR24-24	Renal Service	Chief Operating Officer	**16 (4x4)**
CRR24-25	Dermatology & Plastic Surgery Service	Executive Medical Director	**15 (3x5)**
CRR24-26	Urology Service	Executive Medical Director	**16 (4x4)**

2.3 Overdue/Delayed Actions

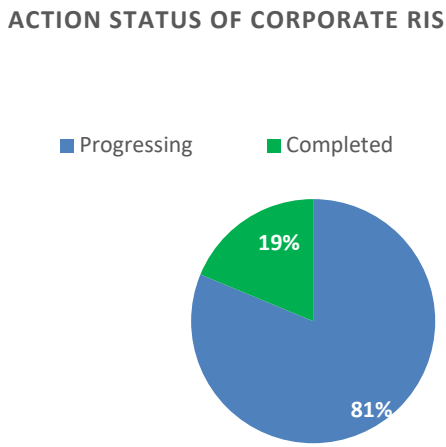
None

2.1 Risks above Health Board 24/25 appetite

Four risks reported to committee score above the tolerance range set in the appetite.

Risk Ref	Risks	Lead Exec Director	Current Risk Score	Risk Tolerance Range in Appetite Score
CRR24-09	Primary Care	Executive Director of Operations	**20**	**Quality 15-19**
CRR24-13	Timely Diagnostics	Chief Operating Officer	**20**	**Quality 15-19**
CRR24-19	Community Care Provision	Executive Director of Transformation and Strategic Planning	**20**	**Quality 15-19**
CRR24-21	Ophthalmology Service	Chief Operating Officer	**20**	**Quality 15-19**

2.2 Action Plan status of Corporate Risks



Out of the 13 corporate risks, 81 actions have been developed to mitigate the risks. 16 actions have been completed, 55 actions are progressing and on track (with 2 actions yet to commence), and 10 new actions identified. No actions are currently overdue.

Next steps

1. Further scrutiny of all corporate risks by Executive Team as per normal reporting cycle.
2. Submission of Corporate Risks to Board

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

Lead	Ref	Risk Title	Current Score (Impact x Likelihood)	Risk Target Score	Appetite Main Risk Type / Appetite Level	Lead Board Committee	Risk Management Commentary
EDoN	CRR24-02	Patient Safety	4 x 4 = 16 ⟷	12	Quality / Open 15-19	Quality, Safety and Experience Committee	Opened Dec 23. Risk revised to become broader patient safety risk, 4 actions identified, 1 completed, and 3 actions progressing (1 with revised due dates). **Proposal to extend target risk due date from 31/03/2025 to 30/09/2025.**
EDoN	CRR24-04	Failure to Embed Learning	5 x 3 = 15 ⟷	5	Quality / Open 15-19	Quality, Safety and Experience Committee	Opened Dec 23, 5 actions identified, 1 completed, 1 progressing with revised due date and 3 new action identified. Reduction in current risk score from 20 to 15 – September 2024. **Proposal to extend target risk due date from 31/03/2025 to 30/09/2025.**
EDoO	CRR24-09	Primary Care	4 x 5 = 20 ⟷	12	Quality / Open 15-19	Quality, Safety and Experience Committee	Opened Feb 24, 7 actions identified, all 7 progressing, with 3 revised due dates. The **inherent and current risk scores are both 20**, indicating the controls are not yet reducing the risk. **Risk Score above tolerance set in risk appetite.**
COO	CRR24-13	Timely Diagnostics	5 x 4 = 20 ⟷	5	Quality / Open 15-19	Quality, Safety and Experience Committee	Opened Feb 24, 6 actions progressing, with 1 revised date. **Risk Score above tolerance set in risk appetite. Inherent impact score of 5 revised from 4 to 5 and likelihood of 5 to 4. Overall score remains the same.** **Executive Lead for the risk updated and amended from the Executive Director of Allied Health Professions & Health Science to the Chief Operating Officer.**

EDoTH	CRR24-14	Harm from the Medical Devices/ Equipment	4 x 4 = 16 ⟷	8	Quality Open 15-19	Quality, Safety and Experience Committee	Opened Feb 24, 4 actions identified, all 4 progressing with revised due dates.
EDTSP	CRR24-19	Community Care Provision	4 x 5 = 20 ⟷	12	Quality 15-19	Quality, Safety and Experience Committee	Risk reviewed Jan 2025, 12 actions identified, 2 actions completed, with 3 actions progressing and 7 new actions identified. New risk developed by the services and approved by the Executive Director of Transformation and Strategic Planning.
EMD	CRR24-20	Oncology Services	3 x 5 = 15 ⟷	9	Quality Open 15-19	Quality, Safety and Experience Committee	Risk approved Nov 24, 7 actions in total, 3 completed actions, 4 progressing.
COO	CRR24-21	Ophthalmology Services	4 x 5 = 20 ⟷	9	Quality Open 15-19	Quality, Safety and Experience Committee	Risk approved Nov 24, 4 actions in total, 4 progressing. **Risk Score above tolerance set in risk appetite.**
COO	CRR24-22	Orthodontic Services	4 x 4 = 16 ⟷	4	Quality Open 15-19	Quality, Safety and Experience Committee	Risk approved Nov 24, 11 actions in total, 3 completed actions, 8 progressing.
COO	CRR24-23	Vascular Services	4 x 4 = 16 ⟷	12	Quality Open 15-19	Quality, Safety and Experience Committee	Risk approved Nov 24, 9 actions in total, 9 progressing.
COO	CRR24-24	Renal Services	4 x 4 = 16 ⟷	12	Quality Open 15-19	Quality, Safety and Experience Committee	Risk approved Nov 24, 3 actions in total, 3 progressing.
EMD	CRR23-25	Dermatology & Plastic Surgery Services	3 x 5 = 15 ⟷	9	Quality Open 5-19	Quality, Safety and Experience Committee	Risk approved Nov 24, 5 actions in total, 5 progressing.

EMD	CRR24-26	Urology Services	4 x 4 = 16 ⟷	6	Quality Open 15-19	Quality, Safety and Experience Committee	Risk approved Nov 24, 4 actions in total, 1 completed actions, 3 progressing.

Key:

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

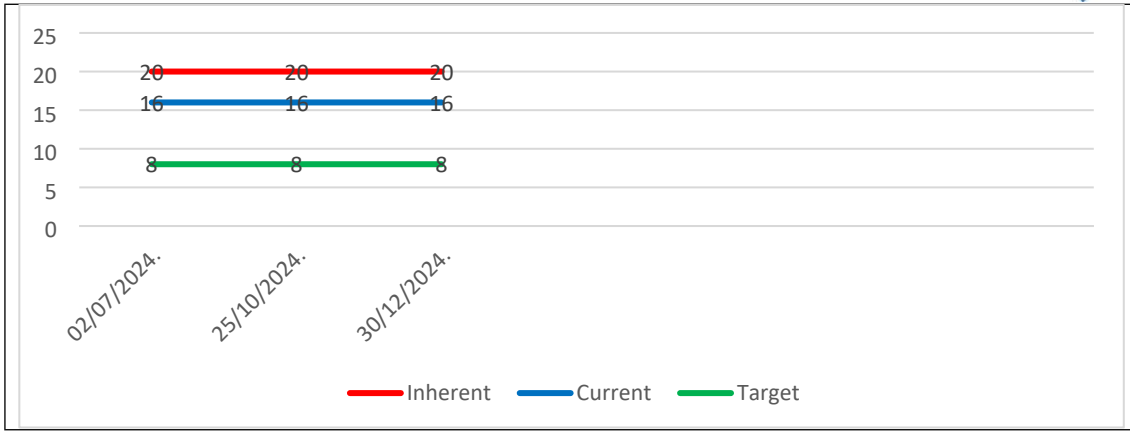
Appendix 2 – Corporate Risk Register Report – Quality, Safety and Experience Committee

<table>
<tr><td rowspan="2">CRR 24-02</td><td colspan="2">Risk Title: Patient Safety</td><td>Date Opened: 02/07/2024</td></tr>
<tr><td colspan="2">Assuring Committee: Quality, Safety and Experience Committee</td><td>Date Last Committee Review: 17/12/2024</td></tr>
<tr><td>Date Last Reviewed: 30/12/2024</td><td>Director Lead: Executive Director of Nursing and Midwifery</td><td>Link to BAF:</td><td>Target Risk Date: 30/09/2025</td></tr>
<tr><td colspan="4">There is a risk that patients may experience preventable harm and a poor experience whilst receiving care due to inadequate preventative measures, not following correct procedures , adhering to best practice and/or learning from concerns . This could lead to poor quality of care resulting in severe complications, prolonged hospital stays, decreased quality of life, psychological distress, reputational damage, increased costs, and potential legal and financial consequences for the organisation.</td></tr>
<tr><th colspan="3">Mitigations/Controls in place</th><th>Additional Controls required</th></tr>
<tr><td colspan="3">1. Policies and Procedures to support risk assessment, guidance and escalation in place e.g.NU06 Prevention and Management of Adult Inpatient Falls, NU03 Pressure Ulcers, MM01 Medicines, National Early Warning Score.
2. Review of patient safety incidents at a local level supported by integrated concerns meetings and harms reviews for learning meetings.
3. Strategic groups that report into the Health Board Patient Safety Group, e.g. Falls Group, Prevention and Management of Pressure Ulcers Group, Medicines Steering Group, Sepsis Triggers Escalation & Antibiotic Stewardship Review for learning and improvement.
4. Escalation to Quality Delivery Group and Quality, Safety and Experience Committee.
5. Cycle of business to PSG that includes IHC/Divisional deep dives of progress and action.
6. BCUHB wide Improvement plans for falls and HAPUs
7. Incident management process including rapid reviews, focused reviews and learning panels.
8. Staff induction, training and competency
9. Organisational Learning Forum for shared learning and improvement
10. Regular patient safety incident alerts issued to staff as and when required
11. Integrated concerns policy and framework implementation.</td><td>a. Sustained compliance of >85% of patient safety related mandatory training
b. Timely update of policies and procedures in line with evidence based practice and as per governance cycle for review.
c. Continue to undertake the bi-annual nurse staffing reviews to ensure we have the levels of staffing required to meet acuity as per NSA and clinical judgment</td></tr>
</table>

12. Bi-annual Nurse Staffing reviews are undertaken in line with the Nurse Staffing Levels (Wales) Act 2016 for all acute adult medical and surgical inpatient wards, and paediatric inpatient wards (Section 25B). Additionally, and in keeping with the principles of the legislation nurse staffing reviews are also undertaken in other areas of the Health Board such as Community Hospitals, Mental Health, and other 24hr services. 13. Roster Policy WP28A in place and monthly roster KPI reports are issued to the Directors of Nursing to enable roster performance to be actively managed. Additionally allocate Safe Care compliance reports are also sent to the Directors of Nursing, to enable maximum utilisation of nursing workforce.	

Actions	Due Date	Progression Analysis
Workshops to be held across BCUHB to reduce backlog of open incidents using approved methodology to improve immediate learning. This includes setting of trajectories for improvement, cluster reviews and drop in clinics. This has been completed apart from within Central IHC, escalated and awaiting dates.	15/01/2025	Progressing (revised date from 30/09/2024)
Implement the Integrated concerns policy and framework to include toolkits for timely review of learning and action. Integrated concerns policy and framework has been implemented	31/08/2024	Complete
Strategy for Increasing compliance with mandatory training	31/01/2025	Progressing
Deliver all the actions from the Internal Audit of falls Combined HSE and Internal Audit action plan in place. Evidence is being compiled for action plan and submitted and reviewed at bi monthly to Falls Steering Group.	31/03/2025	Progressing

	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	2	8
Risk Appetite			



Rationale for Corporate Risk

There are circa 38,000 patient safety incidents reported in the last financial year of which approximately 25% graded as moderate harm or above by the reporter. Feedback has also been received from His Majesty's Coroner in the form of regulation 28 prevention of future deaths around risks from timely investigation and implementation of actions to improve patient safety.

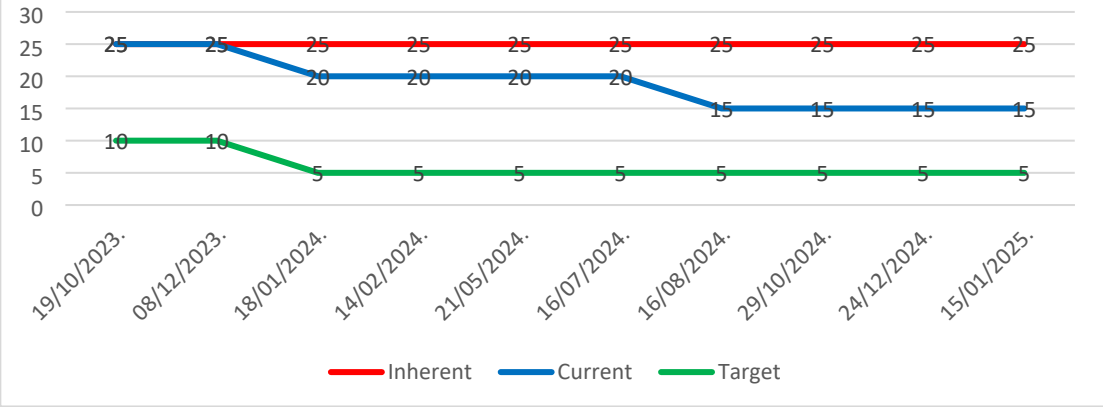
CRR 24-04	**Risk Title:** Failure to Embed Learning		**Date Opened:** 19/10/2023
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** 17/12/2024
Date Last Reviewed: 15/01/2025	**Director Lead:** Executive Director of Nursing and Midwifery	**Link to BAF**:	**Target Risk Date:** 30/09/2025

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

Mitigations/Controls in place	Additional Controls required
1. Clinical policies, procedures, guidelines, pathways, supporting documentation & IT systems. Integrated Concerns Policy 2. Senior sign-off process for National Reportable Incidents (NRIs) and Complaints 3. Clinical staff recruitment, induction, mandatory and professional training, registration & re-validation 4. Putting Things Right and clinical review processes and monitoring 5. Quality governance framework of meetings and reporting structured 6. Quality Dashboard and access to quality data from ward/team to Board 7. Patient and carer feedback and involvement processes 8. Defined nurse staffing levels for all wards & departments as per Nurse Staffing Act 9. Ward accreditation schemes and ward manager/matron checks/audits. 10. Getting it Right First Time (GIRFT), localised deep dives, reports and action plans 11. Organisational Learning Forum (OLF)**:** This forum promotes sharing of learning for continuous improvement and encourages sharing best practices and lessons learned to enhance safety and quality. 12. Exec Oversight Group**:** This group provides strategic direction and high-level oversight for risk management, ensuring alignment with organisational goals and adequate resource allocation. It also monitors and adjusts risk mitigation strategies. 13. Inquest Review Group**:** Focused on cases with significant adverse outcomes, this group conducts thorough investigations to recommend	a. Implementation of a Quality Management System (QMS) setting out an integrated approach to Quality Planning, Control, Assurance and Improvement (dashboard completed). b. Clarity on quality leadership, structures and accountabilities c. Development of a quality learning framework, aligned to the overall learning organisation programme d. Resolution of outstanding overdue positions for incidents, complaints, claims, mortality reviews and inquests e. Launch of a new Learning from Events (LEFR) process to improve divisional ownership and completion of a recovery plan to address the overdue position f. Medical engagement to ensure active participation and commitment from medical staff in learning and improvement. g. Integration of LFER/Claims – To enhance the management and resolution of claims, ensuring they are addressed promptly and effective h. Ensure learning from deaths – Provide the mortality panel with access to a process that ensures thematic learning from deaths is taken forward to facilitate continuous improvement.

changes in policies and practices, ensuring accountability and transparency. 14. Rapid Review Process: Designed for urgent issues, this process uses streamlined methods to quickly identify risks and implement corrective actions, minimizing the impact of emerging risks. 15. New Thematic Review Group: This group conducts in-depth reviews of specific themes or patterns, developing targeted recommendations to address systemic issues and continuously improve the organisation.	

Actions	Due Date	Progression Analysis
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. Development work continues with a revised aim of March 2025. Work continues to develop the new Quality Learning Portal. Due to other work pressures, development on the Solution has slowed and little progress has been made since the previous update. These additional work pressures are being addressed, and the development continues on the admin app that will allow administrators to review learning prior to being published to the organisation. The first of three apps, which will allow users to enter learning into the system, is currently being tested. The second app is due to be completed by the end of December, with the final part of the Solution due to be complete early in the New Year. Whilst this is later than hoped in the original ambitious plan, this work is an entirely new project being developed and the first of its kind in Wales, so an agile development approach is being taken to ensure the solution is reliable, sustainable and delivers a real benefit to BCUHB.	31/03/2025 – delayed due to DDAT priorities	Progressing (Date Revised from April 2024)
Delivery of improvement activity to reduce the overdue complaint, overdue investigation and overdue open incident position. Improvement trajectory for complaints reached with performance currently over 75% - sustainability will be monitored weekly. NRI overdue position improved and all incidents overdue open on a positive downward trajectory - monitored weekly and through patient safety group	31/12/2024	Completed
Implementation of the new/approved QMS Framework within the identified pilot sites. Implementation of the QMS progressing in the test sites with other early adopters identified, this will be ongoing.	31/03/2025	New Action
Implementation of the new Learning from Events Report (LFER) process	31/01/2025	New Action
Delivery of overdue LFER recovery plans by each IHC/Division to eliminate the overdue position	31/06/2025	New Action



	Impact	Likelihood	Score
Inherent Risk Rating	5	5	25
Current Risk Rating	5	3	15
Target Risk Score	5	1	5
Risk Appetite	Open		15-19

Rationale for Corporate Risk

Learning is now being embed through Organisational Learning Forum (OLF) and the Integrated Concerns Forum (ICF), complaints and incidents position on a positive improvement trajectory. The monitoring of the sustained improvement is required prior to de-escalating the risk. Improvement trajectory for complaints reached with performance currently over 75% - sustainability will be monitored weekly. The number of Prevention of Future Death (PFD) / Regulation 28 Notices issued to BCUHB since February 2023 currently stands at 32.The Health Board saw a large number issued in 2023/24 (23) which was a significant outlier compared to previous years and other NHS Wales bodies. However 5 were received in 2024/25 (to date), a significant reduction compared to the number issued in same period of the prior year and more in-line with the average of previous years and other NHS Wales bodies. Coroners have raised a number of common themes through these Regulation 28 reports, the quality of investigations and effectiveness of actions being the most common. The Health Board completed a Learning from Investigations Programme to assess and improve its investigation process and improve the assurances it can take on existing action plans. The programme had direct oversight from the Chief Executive and wider executive team and reported to the Quality, Safety and Experience Committee with a clear escalation process in place. The learning from this programme directly informed the new Integrated Concerns Policy which was approved by the Board in July and launched in September 2024 providing a new, integrated approach to patient safety investigations, complaint investigations and mortality reviews.

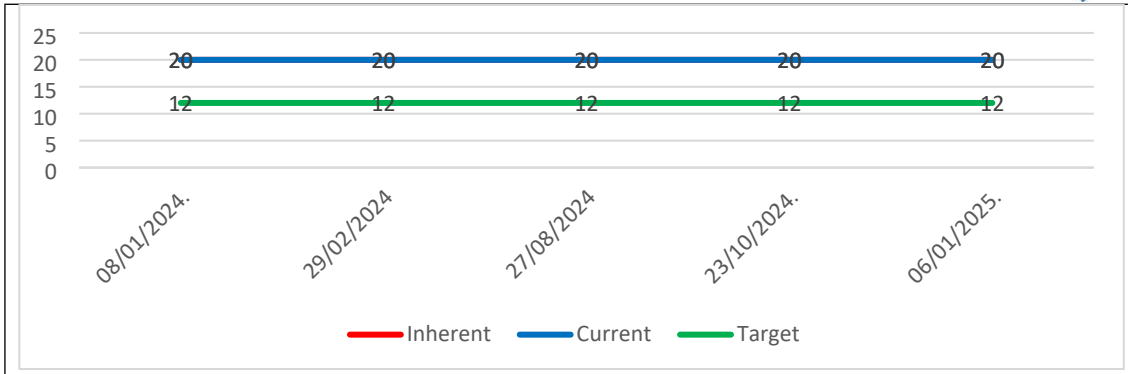
CRR 24-09	**Risk Title:** Primary Care		**Date Opened:** 08/02/2024
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** 17/12/2024
Date Last Reviewed: 06/01/2025	**Director Lead:** Executive Director Transformation and Strategic Planning	**Link to BAF**: N/A	**Target Risk Date:** 31/03/2026

There is a risk that the Health Board's ability to meet its statutory obligation to provide primary care services will be impacted by growing patient demand, workforce and financial pressures. This could be caused by financial pressures due to factors such as rising operational costs and insufficient funding. This could lead to ineffective or failing primary care function would increase the likelihood of declining population health, poor service performance, regulatory non-compliance, poor staff morale and an increase in activity in other parts of the system such as emergency departments.

Mitigations/Controls in place	Additional Controls required
1. Primary Care Board established in 2024 to ensure executive oversight of services. 2. Primary Care sub groups established in 2024 that focus on specific key elements of service overview including governance and quality, workforce and contracting. 3. Primary care team working closely with national team to deliver Strategic Programme for Primary Care (SPPC) in North Wales Focuses on elements including Accelerated Cluster Development, Pan-Cluster Planning Groups, Primary Care Professional collaboratives and the Primary Care Academies. 4. Established Cluster and Collaborative Leads across the 14 cluster areas in BCU. 5. Pan Cluster Planning Groups (PCPGs) are now in place across each IHC in the Health Board, and are supported by the Local Authorities and Public Health.	a. Primary care plan needed to set out long term strategy for services b. Programme management approach needed to monitor and drive strategic and operational priorities. c. Consistent approach to managing primary care services across BCU is needed. Currently most services are managed at an IHC level. d. A clear governance framework is needed for each primary care service that will ultimately feed into the Primary Care Board. This will allow risk and other areas of assurance to be discussed and monitored. e. Developing stronger working relationships with internal and external stakeholders in order to optimise the management of services and patient flow in the wider system

Actions	Due Date	Progression Analysis

Primary Care strategic plan A plan needs to be created that looks at all areas of primary care, and describes what the long term strategy is and how it will be delivered.			31/03/2025	Progressing
Implementation of recommendations from the National Strategic Programme for Primary Care. July workshop planned to review the recommendations and programme of work for 24/25			31/03/2025	Progressing (revised date from 30/06/2024)
Primary Care Academy to utilise SPPC monies to further progress multi-professional working Work on going to develop local health board response to the national strategy and year 1 priorities as set out by HEIW/SPPC. Update expected nationally in November 2024.			31/03/2025	Progressing (revised date from 31/12/2024)
a review of cluster monies spend to allow introduction of new roles, ways of working and models of service delivery			31/03/2025	Progressing (revised date from 31/12/2024)
Primary Care plan/strategy drafted to lay ground work for pathway to true Partnership and integrated working, with joint planning and decision making across Local Authorities/NHS for health, care and prevention.			31/03/2025	Progressing
Place based person centred provision to be at the forefront of planning, transformation and innovation in all health and social care plans.			31/03/2026	Progressing
Deep dive / diagnostic into general dental and community dental services (scope to be defined)			31/03/2025	Progressing
		Impact	Likelihood	Score
	Inherent Risk Rating	4	5	20



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

Current Risk Rating	4	5	20
Target Risk Score	4	3	12
Risk Appetite	Quality		15-19

Rationale for Corporate Risk

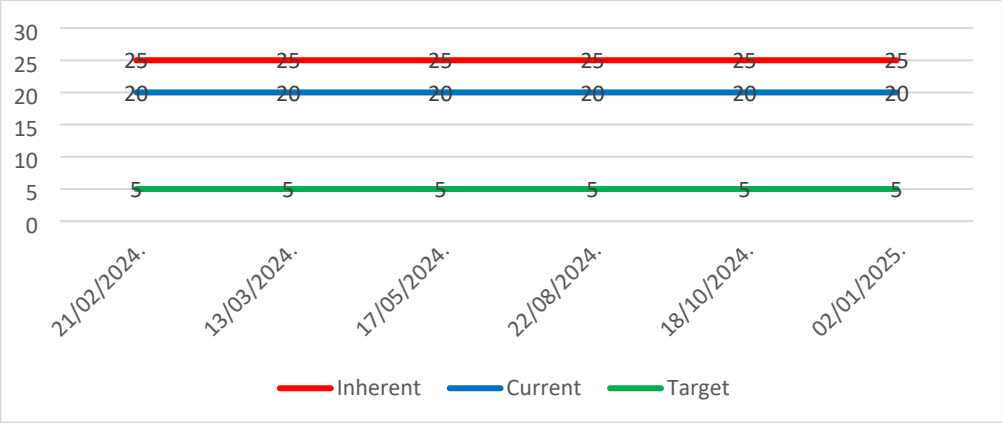
This risk sits across all primary care services within BCU. The risk of having an ineffective or failing primary care function would increase the likelihood of declining population health, poor service performance, regulatory non-compliance, poor staff morale and an increase in activity in other parts of the system such as emergency departments.

CRR 24-13	**Risk Title:** Timely Diagnostics		**Date Opened:** 21/02/2024
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** 17/12/2024
Date Last Reviewed: 02/01/2025	**Director Lead:** Chief Operating Officer	**Link to BAF**:	**Target Risk Date:** 31/12/2025

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

Mitigations/Controls in place	Additional Controls required
1. Insourcing of CT, MRI and ultrasound to deliver required capacity 2. Significant guidance and steer with National Imaging Programme workforce work. 3. Outsourcing of radiology reporting to maintain Welsh government turnaround times 4. Waiting list & capacity and demand management is in place to monitor radiology required resources. 5. New all Wales contract with Everlight from 1st November 2024 to maintain provision of radiology reporting 6. Active participation by pathology in the nation pathology programme	a. Replacement of Radiology Informatics System (RISP) – implementation underway go live planned for 19th May 2025 b. Replacement of LINC (national pathology IT system) - Contract signed with current supplier plans to implement by September 2025 being progressed nationally c. Radiology workforce model not suitable for meeting the current demands being placed on the service from both clinical activity and supporting activity required to deliver service e.g. governance, regulatory and accreditation requirements d. Escalate to BCU Clinical Effectiveness Group – issues around failure to act. Procedure MD (Office of the Medical Director) 23 – 'Mitigation of the risk of failure to act on diagnostic results' needs updating which is being led by the Executive medical director. Discussions held with OMD and a plan is being put in place for a task and finish group to update procedure MD23 e. PHW Collaborative Executive group. f. Diagnostic Strategy for BCU needs to be developed g. Mitigation of the risk of failure to act. h. Work commenced on new radiology staffing model for the identification of significant restructuring of the service with succession planning, career development, staff wellbeing etc.

Actions	Due Date	Progression Analysis
Replacement of Radiology Informatics System (RISP) – implementation with anticipated go live date of the 19/05/2025.	14/04/2025	Progressing
Replacement of LINC (national pathology IT system) - Contract signed with current supplier plans to implement by September 2025 being progressed nationally	30/09/2025	Progressing
Procedure MD23 (Mitigation of the risk of failure to act on diagnostic results) to be updated	31/12/2025	Progressing
Radiology workforce revised model to be developed by June 2025	30/06/2025	Progressing
Diagnostic Strategy to be developed by diagnostic group	30/06/2025	Progressing (Revised date from 30/09/2024)
Escalate failure to act risks to CEG	31/03/2025	Progressing



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

Rationale for Corporate Risk

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

	about the health and wellbeing of the radiology senior team due to the number of competing priorities and the unsustainable amount of TOIL being accrued and unable to be taken by radiology SMT to manage the higher number of major projects and the operational delivery

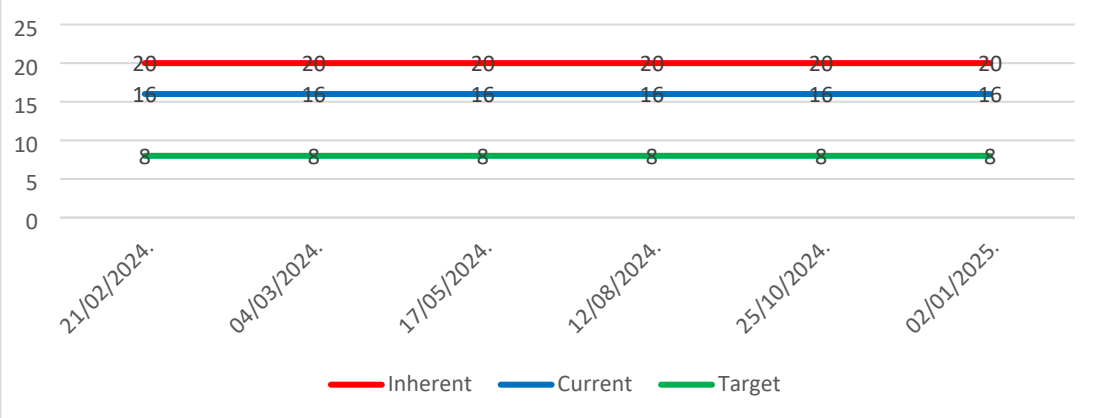
CRR 24-14	**Risk Title:** Harm from the Medical Devices/Equipment		**Date Opened:** 21/02/2024
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** 17/12/2024
Date Last Reviewed: 02/01/2025	**Director Lead:** Executive Director of Allied Health Professions & Health Science	**Link to BAF**: N/A	**Target Risk Date:** 31/03/2025

There is a risk of harm and infection from aging, **unsuitable** or unreliable **medical equipment** and devices. This could be caused by equipment breakdowns, **lack of replacement funding**, ineffective cleaning and **decontamination**, insufficient **staff training**, improper use and poor traceability. The impacts may include inability to deliver essential services, delays in diagnostic and treatment leading to incidents and poor patient outcomes, increased costs and reputational damage.

Mitigations/Controls in place	Additional Controls required
1. Medical Devices Governance and Assurance Group leads on selection and procurement, processes and procedures of significance, learning from incidents, safety communications and risk management of medical devices. 2. Annual capital planning process reflects known priorities taking account of key pieces of equipment due for replacement with a risk assessment that support the overall outcome. 3. Scrutiny and assessment of the capital programme at Capital Programme Management Team (CPMT) and Capital Investment Group (CIG). 4. Welsh Government Capital review meeting to escalate and discuss potential risks and requirements for key medical equipment e.g. Linac. 5. An effective medical devices management system is utilised through EBME. 6. EBME uses the management system to monitor the condition and performance of medical devices including device failures and issues; utilisation, performance, maintenance; repair and calibration history. 7. Audits on affected equipment in line with regulatory compliance completed. 8. Radiology fully engaged with the National Imaging Capital Equipment Group peer review programme.	a. Internal risk assessment and priorities are flagged in the context of fully depreciated equipment (£34.659m) to understand priorities and potential risks. b. Lack of medical device training and good governance of safety of equipment has been lacking and documented as a risk since 2016. c. Robust risk assessments of how often certain equipment breaks down, the scale of difficulty sourcing spare parts to be considered for included in requests for capital replacement. d. The number of capital bids not approved now exceeding circa £30million in capital and resources required. Backlog of equipment beyond end of life, some 10 years+. SBAR submitted to EDAHPHS for escalation to Executive team. e. Medical Device regulations work ongoing – see additional risk ID 5282 ‘Medical Devices Regulations 2002(SI 2002 No 618, as amended) (UK MDR 2002) compliance’. External review completed. Workplan now needs to be considered.

9. External links with National Imaging and Pathology Diagnostic Programmes are documented and appropriately reported through correct channels to ensure transparency and potential benchmarking.	

Actions	Due Date	Progression Analysis
CPMT and CIG to review annual planning process to ensure risk scoring to inform prioritisation	31/03/2025	Progressing (Revised from 31/03/2024)
Medical physics have been tasked with testing all ultrasound equipment to ensure its safety and will consider compliance Medical Physics are working through the ultrasound Quality Assurance and testing.	31/03/2025	Progressing (Revised from 31/09/2024)
Directorate teams to review their medical devices capital replacement plans to ensure all services have a medical device replacement programme in place. Directorate teams are linking with Capital to update their replacement plans.	31/03/2025	Progressing (Revised from 31/09/2024)
Recruitment to Head of Clinical Engineering and associated posts within the medical devices team Recruitment to Head of Clinical Engineering is progressing, currently with Welsh translation and approval by Exec Director of Operations.	31/03/2025	Progressing (Revised from 31/09/2024)



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	2	8
Risk Appetite	Open		15-19

Rationale for Corporate Risk

Significant capital funding required, robust controls and governance required to ensure safety of equipment, £33M represents the value of capital medical equipment which is fully depreciated and at end of life.

CRR 24-19	**Risk Title:** Community Care Provision		**Date Opened:** 01/05/2024
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** New Risk
Date Last Reviewed: 15/01/2025	**Director Lead:** Executive Director Transformation and Strategic Planning	**Link to BAF**:	**Target Risk Date:** 31/03/2026

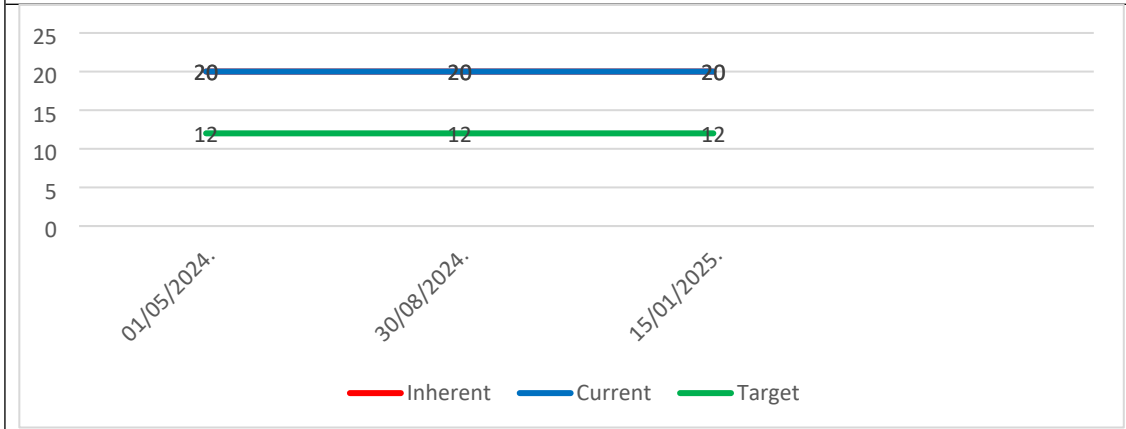
There is a risk that the Health Board may not be able to provide safe, effective and timely care to patients in the community, and the Health Board not fully meeting its obligation to commission and provide accessible and high-quality community care, D2RA, Care Home support services and continuing health care (CHC) services. This may be caused by insufficient care in the community sector fragility, lack of available domiciliary care provision, delays of CHC assessments, staffing shortages and the fragility of care home sector
This may also be caused by a lack of investment in services and skill mix development, restrictions in IT systems and communication between different parts of the integrated team. This may lead to unnecessary admissions, delayed transfers of care, increased length of stay in hospital and poorer outcomes for patients, people not receiving end of life care in their place of choice.

Mitigations/Controls in place	Additional Controls required
1. Daily patient flow meetings including focus on long-stay patients and partnership with Local Authorities 2. Primary Care Board has been established with the first meeting held May 2024, monthly meetings planned moving forwards. Community Care is reporting into the Primary Care Board around this risk. 3. Community Resources Team model bringing together agencies and professionals supporting locality populations. 4. North Wales care homes single action plan overseen by Regional Commissioning Board and Regional Partnership Board. 5. Care home Quality Assurance Framework and tools in place 6. Established Continuing Healthcare (CHC funding) teams and processes including escalation where delays occur 7. Agreed joint escalation processes with Local Authorities for care homes of concern	a. Escalation and sustainability report requires commissioning to address risks associated with workforce and workload pressures allows for early identification and management. b. Programme management to be implemented to monitor and drive strategic priorities. c. Community Care Quality and Delivery Group to be established or investigate feasibility of implementing Community Care reporting to Primary Care Quality and Delivery Group d. Strategy, focus and resources including staff, training and IT to deliver joined up planning, innovation and delivery for place based, integrated prevention, health and care services across NHS/Local Authorities to deliver on place based care and care closer to home. e. Additional Resourcing of CIVICA system (scheduling system for District Nurses), access to EMIS (GP Patient record system)

8. Greater Health Board oversight of Community Care issues and risks via PPHP Committee with first report to committee during April 2024 with further reporting in June 2024.	community for teams. Connecting Care Implementation for community services f. Better arrangements for allocating available resources. g. Financial systems that support transformative systems in line with Primary Care Model for Wales outcome 13 h. Improved joint planning with local Mental Health services i. Improved planning for access to diagnostics in the community setting j. Community Care and CHC services audits of sustainability matrix ongoing periodically – Programmes to be put in place to undertake the audits k. Equity of resource to support community care and CHC transformation, innovation, management and governance. l. As part of the refresh of UEC structures work stream 4 focus's on Discharge m. Pathways of Care Regional Action Plan n. Develop surge plans jointly with Local Authorities for winter pressures – did not happen to be progressed again. o. Complete pre-placement agreements with all providers and implement strengthened contract monitoring

Actions	**Due Date**	**Progression Analysis**
Primary Care Board established	30/05/2024	Completed
Community Care and CHC strategic plan to be drafted to inform the Health Board strategic plans	31/03/2025	Progressing
Escalation process in place for community hospitals, community nursing and CHC	31/12/2024	Complete
Programme management to be implemented to monitor and drive strategic priorities.	31/10/2024	New action
Community Care Quality and Delivery Group to be established or investigate feasibility of implementing Community Care reporting to Primary Care Quality and Delivery Group Get rid	31/10/2024	New action

Community Care and CHC services audits of sustainability matrix ongoing periodically – Programmes to be put in place to undertake the audits	31/03/2025	New action
Strategy and resources to be made available to support introduction of new roles, ways of working and models of service delivery.	31/03/2025	New action
Equity of resource to support community care and CHC transformation, innovation, management and governance.	31/03/2025	New action
Strategy, focus and resources to deliver joined up planning, innovation and delivery for place based, integrated prevention, health and care services across NHS/Local Authorities to deliver on place based care and care closer to home.	31/03/2026	New action
Joint commissioning plan with Local Authorities to increase domiciliary care capacity Following evaluation panels there is now a list of domiciliary care workers that are able to provide the more complex care. All will go on the new framework that is due to go live April 2025.	25/04/2025	Progressing
Review of community services model and development of business case to address gaps in capacity	31/03/2025	New action
Determine required level of Quality Assurance Framework increased frequency of visits, resource requirement and plans to implement. Final version of SOP for Clinical Quality Support Tools under the QAF is awaiting approval at the next Patient Safety Group on January 28th.	28/02/2025	Progressing



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

Rationale for Corporate Risk

The data on reduced care home placement, number of care homes in escalation due to quality concerns, significant numbers of patients delayed in hospital awaiting domiciliary care and reablement packages, and a current inability to meet Welsh Government unscheduled care targets - all of which indicate risk of harm due to insufficient safe provision in the community. –

	Wider impacts resulting in the impacted access to and delivery of Community Care and CHC services is severely impacted and is affecting patient flow through secondary care, Primary care and Emergency/Urgent Service delivery, LA Care provision delivery and exacerbating patients' health conditions. Recognition of inherent score currently further controls needed. Lack of adequate investment and provision in domiciliary care.

CRR 24-20	**Risk Title:** Oncology Services		**Date Opened:** November 2024
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** New Risk
Date Last Reviewed: 19/12/2024	**Director Lead:** Executive Medical Director	**Link to BAF**:	**Target Risk Date:** 30/04/2025
There is a risk that patients may not experience a safe, effective and timely Oncology service provided by the Health Board. This may be caused by reduced substantive medical workforce, demands for oncological care, increasing numbers of NICE approved treatments for cancer, and patients remaining within the service due to developmed chronics condition. This could lead to poor patient outcomes, failure to meet Single Cancer Pathway target of 62 days and detrimental impact on the organisations reputation to the public, government and others.			

Mitigations/Controls in place	**Additional Controls required**
1. Medical locums in place to support gaps in substantive provision 2. Escalated requirement to support recruitment of medical oncology trainees within next 12 months 3. Supporting 2 NHS Locums to complete *Certificate of Eligibility of Specialist Registration* (CESR) and additional competencies to be eligible to become substantive in the future. 4. Development plan in place for 2 Senior Clinical Fellows with aim to train them to become substantive Consultants within 2-3 years. 5. Systemic anti-cancer treatment (SACT) Operational group established to improve processes and systems – collaboration with pharmacy. 6. Radiotherapy Oversight meeting established to monitor progress against plan and maintenance of target. 7. Developed extended non-medical nursing roles to support medical gaps including immunotherapy toxicity, cancer of unknown primary and metastatic breast and colorectal services. 8. Developed an extended non-medical radiotherapy role to support prostate cancer patients who require radiotherapy 9. Clinical Leads (Joint role) appointed.	a. Remaining substantive medical vacancies unfilled despite active recruitment – in line with national picture of vacancies and report by Royal College of Radiologists for Clinical Oncologists, medical locums use 34% - 50%. b. Lack of available high-quality data to provide robust capacity and demand modelling per tumour site, per clinical/medical oncologist c. Recurrent funding needs to be secured for 7 consultants and a number of temporary nursing and administrative roles (and other elements subject to RIGA) d. Inability to respond effectively to increasing demand for oncological treatments and new NICE-approved regimes e. Home care service is saturated meaning no further treatments can be transferred out of the day units to release capacity f. Lack of physical estate to expand services and/or recruit more staff. g. Outsourcing opportunities for the highest risk tumour sites, remains a gap, further exploration required. h. Gap and lack of clinical oncology trainees with multiple gaps limiting ability to ‘grow our own’. i. Collaboration with recruitment agencies to explore overseas consultant opportunities.

	j. There is an aim to implement nursing staff rotational opportunities to improve cover arrangements and skill mix but this is limited due to vacancies and amount of fixed term funded posts

Actions	Due Date	Progression Analysis
Continue to expand Systematic Anti-Cancer Therapy training with the oncology division and extend the operating hours of the day units, providing further capacity Opening hours until 6.30pm on all sites Mon – Fri. Unable to expand further without investment into additional nursing, medics and pharmacy.	Complete	Complete
Establish potential of a joint Consultant Oncologist role with Bangor University A Meeting was held, and the plan is for the university to provide 4 sessions to support a full-time position.	31/01/2025	Progressing
Progress plan to deliver more anti-cancer therapies from Ysbyty Gwynedd for residents living within the West of North Wales All treatments have been transferred, apart from those that can only be produced in the Centre area Pharmacy	30/08/2024	Complete
Complete Planning to repatriate the delivery of Stereotactic Ablative Radiotherapy into the Health Board A letter is being submitted to the JSCC requesting approval to proceed according to the established process commence as per process	30/04/2025	Progressing
Establish potential of undertaking shared recruitment with other cancer centres Discussions need to be initiated to address operational concerns, particularly the high risks associated with specific tumour sites	30/04/2025	Progressing
Work with informatics to support development of quality data Regular meetings are being held, and training plans are being developed to support correct use of the Welsh Patient Administration System. National queries have been raised regarding the duplication of work with SACT on Chemocare and WPAS, however, it is necessary to establish a secure link between the systems to improve quality and efficiency. Process mapping has been undertaken identifying areas to be resolved.	31/03/2025	Progressing
Escalated requirement to support recruitment of medical oncology trainees within next 12 months Funding has been provided following a discussion with ELT. Interviews are taking place 20/12/24 so this is completed	31/12/2024	Completed

To be completed following approval of escalation		Impact	Likelihood	Score
	Inherent Risk Rating	3	5	15
	Current Risk Rating	3	5	15
	Target Risk Score	3	3	9

	Risk Appetite	Quality	15-19

Rationale for Corporate Risk

The combination of multiple factors, *including;*

- the inability to recruit substantially to Senior Medical posts,
- increasing reliability on availability of Locums
- large number of temporary staff, as a result of RIGA
  and increasing demand for oncological treatments, which has resulted in service gaps which have increased waiting times for patients to be seen and treated.

Delays to commencing treatment will result in significant patient harm and potentially premature death**.** NICE approved regimes indicate optimum time frames and that delay will decrease effectiveness of treatment. In general research has shown that every 4 week delay to commence (any cancer) treatment increases the likelihood of death by 10%. Escalation paper to Executive Lead and Chief Operating Officer indicated waiting times in east and centre were now 6 weeks (Dec 24)

11th October 2024 – Extreme risk within Gynae, Breast and Upper GI as a result of sickness and high use of Locums who can leave with one week's notice.

Waiting times to see a Consultant following referral range from 0 to 12 weeks depending on tumour site and clinical priority. The aim is to see patients within 2 weeks, so that treatment can commence quickly. This is not reported externally.

CRR 24-21	**Risk Title:** Ophthalmology Services		**Date Opened:** November 2024
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** New Risk
Date Last Reviewed: 08/01/2025	**Director Lead:** Chief Operating Officer	**Link to BAF**:	**Target Risk Date:** 31/12/25

There is a risk that patients may come to harm casued by the lack of a sustainable service model, unmanaged demands and the current capacity not being able to meet incoming demands. This could lead to, and result in, increased waiting lists and an increased risk of harm including irreversible sight loss, and litigattion due to prolonged wait times.

Mitigations/Controls in place	Additional Controls required
1. Train and Treat initiative in place to increase the number of procedures that can be done in a community/high street optometry setting. 2. Outsourcing solution for cataract procedures in place. 3. Development of High flow lists for cataracts in place.	a. Appoint Health Board clinical lead to secure professional oversight and leadership b. Development of a sustainable service model c. Ensure specialty demand, capacity and planning is delivered along with further mitigations to be developed to close any gaps in delivery. d. Release planned care funding to cover funding cut in RIGA2 process, this will enable significant positive mitigation for loss of high risk follow ups

Actions	Due Date	Progression Analysis
Convene a Health Board wide Ophthalmology summit to identify sub specialty leads to support service redesign, agree priorities and initiate work plan	28/02/2025	Progressing
To Appoint a Health Board Clinical Lead	30/06/2025	Progressing (revised date from 31/12/204)
Develop a work programme for service design and development (output of summit)	28/02/2025	Progressing
Resource activity as previously identified and reinstate eye care performance fund that has been reduced through RIGAII financial prioritisation	01/04/2025	Progressing

To be completed following approval of escalation		Impact	Likelihood	Score
	Inherent Risk Rating	4	5	20

Current Risk Rating	4	5	20
Target Risk Score	3	3	9
Risk Appetite	Quality		15-19

Rationale for Corporate Risk

Significant harm may occur including irreversible sight loss in high risk R1 & R2 patients (Glaucoma and Retinopathy). Large volume of patients on Patient Treatment List currently stands at 23,544 un-booked of which 963 are 2 years+

CRR 24-22	**Risk Title:** Orthodontics Services		**Date Opened:** November 2024
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** New Risk
Date Last Reviewed: 08/01/2025	**Executive Lead:** Chief Operating Officer	**Link to BAF**:	**Target Risk Date:** 31/03/2026

There is a risk that patients under the Orthodontics Service may come to harm, this could be caused by the lack of consultant capacity to provide an effective and timely Orthodontics service care provided by the Health Board, backlog demand outweighs capacity available in both primary and secondary care, driving less favourable patient outcomes (psycho-social vulnerability amongst younger patient groups). Less conservative/preservative treatment options – meeting urgent need. Increased chance of requiring intervention general anaesthetics, intravenous antibiotics. This may lead to reputational damage and increased litigation.

Mitigations/Controls in place	Additional Controls required
1. Appropriate referrals pathway/ triage implementation (as per national pathway) 2. Dentist with Specialist Interest (DESI) and Tier 2 – wider, easily accessible pathways 3. PAN BCUHB approach dating patients according to length of wait into additional Waiting List Initiative (WLI) activity 4. Health prevention/promotion within primary care 5. Reviewing Academy Model to increase attractiveness of North Wales as a place to work to include upskilling/additional training for suitable Health Care Practitioners 6. Supporting hosting of undergrad training in North West Wales, online Continued Professional Development and microcredentials course for local people (including consideration for maternity leave, single parent etc.)	a. Continued shortfall of workforce across BCUHB needs recruitment strategy b. Continued conversations with external providers indicates limited outsourcing opportunity c. No restorative consultant service available d. No proactive comms to patients and stakeholders agreed e. Current service provision indicates ongoing service delivery shortfalls with recovery in excess of 5 years

Actions	Due Date	Progression Analysis
	31/07/2024	Complete

Agreement of BCUHB to advertise Consultant Orthodontists at top of scale following submission of SBAR in September 2023		
Successful appointment of 0.7 WTE Consultant Orthodontist	31/08/2024	Complete
Attempted but unsuccessful recruitment of Agency & NHS Locums Unable to complete	31/12/2025	Progressing
Review of workload of consultants across BCUHB to improve equity of access within BCUHB	28/02/2022	Complete
Temporary allocation of 2 additional sessions from Ysbyty Glan Clwyd to support patients in active treatment in Ysbyty Gwynedd up until Maternity commenced February 2024	28/02/2022	Complete
SBAR & options appraisal submitted for consideration of a primary/secondary care dental review in 2021, 2023, 2024	31/12/2024	Complete
Restorative Consultant re-advertisement	31/12/2025	Progressing
Submission of executive paper requestion stakeholder comms in relation to Orthodontic service provision in March 2024	31/03/2024	Complete
Orthodontic & Oral Surgery 'Getting it Right first time' (GIRFT) review	31/12/2024	Complete
National Benchmarking of service model and approach to service recovery for RTT stage 1 patients	31/12/2024	Complete
SBAR submission recommendation 2024: Continued procurement exercise to determine full treatment plan capacity with external providers-funding noted as available	31/12/2025	Progressing

To be completed following approval of escalation

	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	2	2	4
Risk Appetite	Quality		15-19

Rationale for Corporate Risk

	Waiting lists and waiting times have continued to grow with patients waiting in excess of 156 weeks for initial clinical assessment. Impact of vacant sessions across Health Board on capacity provision with limited opportunity to resolve the backlog position with a current BCUHB active workforce establishment at 2.2 WTE. Poor provision in some geographical areas. Lack of stability from Welsh Government around future Dental contracts. Patients awaiting treatment completion are dating back to referrals first received in 2017 highlighting significant delays in treatment pathways. Patients awaiting Patients referred for Max Fax treatment (waiting up to 156 weeks) are being returned to Orthodontics due to timescale lapsed since orthodontic referral. No current service provision for Restorative Dentistry for new or existing patients across BCUHB. Delays in Orthodontic provision impact surgical cleft optimisation delivered via Alder Hey Cleft outreach service. Clinical risk being held within the waiting lists. National shortage in Orthodontic consultants Infrastructure & estate restrictions on expanding Medical workforce. Current model of care is disjointed and lacking fluidity between primary & secondary care. Delay in sustainable service planning across BCUHB. Patients and parents reports the mental and physical challenges associated with unaddressed orthodontic issues as a result of delays into teenage years. Parents have reported orthodontic related bullying which has resulted in their child's withdrawal from education and social aspects of their childhood; also the inability to meet ministerial targets as required by Welsh Government.

CRR 24-23	**Risk Title:** Vascular Services		**Date Opened:** November 2024
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** New Risk
Date Last Reviewed: 15/01/2025	**Director Lead:** Chief Operating Officer	**Link to BAF**:	**Target Risk Date:** 31/03/2026

There is a risk that individuals may expeirence preventable harm and a poor experience whilst receiving care from the North Wales Vascular Service.This may be caused by current and projected future staffing challenges,a lack of capacity across the network a lack of clarity with regards secondary care and/ or end-to-end, vascular pathways. This could lead to increased morbidity and mortality, poor quality of care, reduced quality of life, psychologcial distress, difficulties recruiting and retaining staff, staff health and well-being, reputational damange, increased costs, increased legal and financial claims.

Mitigations/Controls in place	Additional Controls required
1. Management of bed base through assessment of clinical risk in place. 2. Optimising and streamlining management of inpatients and ensuring clear communication across site to ensure timely transfer and repatriation 3. Additional funding to support delivery of robust vascular services across hub and spoke sites, approved. This will allow capacity to be increased in key areas (i.e., Cardio Pulmonary Exercise Testing and Ward 3 staffing) and a number of agency/ locum appointments to be made permanent 4. Weekly case-note audits in place to monitor standards of record keeping, with results discussed at clinical governance meetings 5. Pathways are co-designed with an extensive group of delivery partners across the 3 sites 6. Local Vascular Delivery Groups in place for 2/3 IHCs (West and Central) in order to proactively identify performance concerns and manage risk 7. Development of Abdominal Aortic Aneurism (AAA) Quality Improvement programme. 8. Consultant vascular surgeon is picking up IR sessions	a. Development of Vascular Intranet pages to help share information, including clinical pathways, with staff, in a way that is simple and accessible b. Local vascular delivery groups to be operational across each IHC. c. Review of AAA surveillance protocol / pathway, to include management of persons turned down for AAA repair d. Implementation of deep-dive audit tool to enable quality audit of case notes e. Workforce and resource review to support development of Phase 2 Business Case f. Development of vascular workforce strategy aimed at improving recruitment. g. Improve the way that information relation to service quality via patient, carer and staff satisfaction and well-being questionnaires is used to inform continuous improvement h. Development of Quality dashboard, to support improved use of service and outcome data

9. Weekly Multi-Disciplinary Team meeting to allocate patients onto the waiting list and ensuring consultants are aware of patients that need Interventional Radiology provision and/or can have an open Abdominal Aortic Aneurism (AAA)repair? 10. Enhanced clinical and programme governance to ensure learning from events and focus on quality	

Actions	**Due Date**	**Progression Analysis**
Finalise vascular intranet page as key place for network and wider Health Board staff to access the full range of information, policies, procedures and pathways relating the vascular network	31/03/2025	Progressing
Work with East IHC Medical Director to establish Local Vascular Delivery Group	31/03/2025	Progressing
Review AAA surveillance protocol / pathway to ensure timely monitoring of persons with an AAA not identified by Welsh Abdominal Aortic Aneurism screening programme.	31/03/2025	Progressing
Strengthen information, advice and support provided to people turned down for AAA repair, and ensure 'register' of persons turn down is maintained	30/05/2025	Progressing
Implement quarterly quality audit tool to enable network to proactively identified areas for improvement	31/03/2025	Progressing
Work with key delivery partners to develop a (Phase 2) vascular and diabetic foot business case	31/03/2026	Progressing
Develop and implement vascular training and workforce strategy to improve recruitment and retention across the network	31/03/2026	Progressing
Revised patient, carer and staff satisfaction and well-being questionnaires to be regularly disseminated, and findings analysed in order to inform continuous improvement	Ongoing	Progressing
Build pan-BCU and local quality dashboard to support improved use of service and outcome data	Ongoing	Progressing

To be completed following approval of escalation

	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	3	12
Risk Appetite	Quality		15-19

Rationale for Corporate Risk

Demand for vascular care in North Wales is increasing, however, recruitment to vascular services is not increasing as at the same rate. Whilst this is a UK-wide issue, the history of vascular services in North Wales, makes recruitment and retention across the network a particular concern. Whilst the network has been successful in embedding a wide-ranging improvement programme, the impact of this unstable workforce risks undermining the quality and safety of care provided, both now, and in the future. Work ongoing to develop a workforce framework for the service to allow monitoring.

CRR 24-24	**Risk Title:** Renal Services		**Date Opened:** November 2024
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** New Risk
Date Last Reviewed: 15/01/2025	**Director Lead:** Chief Operating Officer	**Link to BAF**:	**Target Risk Date:** 31/03/2026
There is a risk that individuals may expereince preventable harm, and have a poor experience whilst waiting for dialysis. This may be caused by extended waiting times for vascular access procedures, a lack of capacity, inequity in resource allocation across the Health Board. This could lead to, increased hospital admissions, longer hospital stays, increased morbidity and mortality, poor quality of care, reduced quality of life, psychologcial distress, reputational damange, increased costs, legal costs and financial claims.			

Mitigations/Controls in place	**Additional Controls required**
1. Close regular scrutiny of waiting lists at a vascular and renal network level. 2. Informal management of waiting lists on a networked basis to support prioritisation of cases, where possible 3. Additional capacity provided by Locum Consultant.	a. Formal agreement to the establishment of a single Pan-BCU list, rather than 3 separate Integrated Health Community (IHC) Clinic and Theatre lists. b. Additional capacity to support reduction of current wating list in the East, to a more manageable position. c. Recruitment to 2x vacant Consultant posts d. Re-allocation of resources across the Network, to enable equitable access to interventions locally.

Actions	**Due Date**	**Progression Analysis**
Submit Waiting List Initiative request to facilitate additional theatre lists, in order to reduce current backlog 2 requests submitted, one declined due to lack of Theatre staff availability, and awaiting confirmation on 2nd request	28/02/2025	Progressing (revised date from 30/12/2024
Undertake Workforce review across entire Service to ensure equity across the Region	30/05/2025	Progressing (revised date from 30/12/2024

Review Theatre provision, particularly in relation to overrunning lists, which result in Renal access patients being cancelled Theatre utilisation group, first meeting 19/02/2025, has been established and will lead on this work.		30/05/2025	Progressing (revised date from 30/12/2024

To be completed following approval of escalation

	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	3	12
Risk Appetite	Quality		15-19

Rationale for Corporate Risk

There is currently a significant backlog of people waiting for Vascular Access Clinics and Theatre Appointments in the East IHC. This situation has arisen for a variety of reasons, but principally, because:

a. Higher **demand** in the East due to its larger population size, together with the fact that it has the largest dialysis unit.
b. An inequity in **capacity** across the three IHCs to support renal access – the East having the fewest number of clinics sessions and theatre lists.

Reducing the current backlog and waiting list is critical to preventing further in-line sepsis. A peer review of Renal Vascular Access (2022) concluded that whilst BCU outcomes from renal vascular procedures were excellent, further work was required in order to:

- Ensure a dedicate group of Vascular Surgeons to complete renal access procedures – with flexibility to move across sites
- Dedicated Clinics for Renal VANS alongside surgeons (on each site)
- Dedicated Theatre lists on each site – reflecting the demand of each site's renal population

Whilst these recommendations have been implemented in Central and West IHCs, it has not been possible to secure such provision in the East.

CRR 24-25	**Risk Title:** Dermatology and Plastic Surgery Services		**Date Opened:** November 2024
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** New Risk
Date Last Reviewed: 08/01/2025	**Director Lead:** Executive Medical Director	**Link to BAF**:	**Target Risk Date:** 010/7/2025

There is a risk that patients for the Dermatology and Plastic Surgery Services will come to harm, this may be caused by lack of a sustainable service model, unmanaged demand and current capacity not able to meet incoming demand, this may lead to increasing waiting list increasing risk of harm caused by length of wait.

Mitigations/Controls in place	Additional Controls required
1. Prioritisation of urgent suspected cancer to mitigate clinical risk 2. Provision of Waiting List Initiative activity to provide short term additionality 3. Development of insourced arrangements to provide interim additional capacity for a 12-18 month period 4. Appointment of clinical leads to support service redesign 5. Introduction of Teledermoscopy with a commensurate increase in treatment capacity (minor operating procedures)	a. Appoint a specialty managerial lead to take forward service redesign. b. Approve and implement increased treatment capacity.

Actions	Due Date	Progression Analysis
Dermatology - Maintain support for the Clinical Leads in Dermatology as part of a single Dermatology Service for North Wales	Ongoing	Progressing
Dermatology – Fund requisite MoPS Minor Operating Procedure capacity to support expansion of Teledermoscopy	01/07/2025	Progressing
Dermatology - Establish the viability of an expanded GP with Special Interest Model for referrals to Secondary Care	30/06/2025	Progressing
Plastic Surgery - Agree and Sign updated SLA between Partner Organisations	30/04/2025	Progressing
Plastic Surgery - Implement additional dressings clinic to address current variation across North Wales	01/07/2025	Progressing

	Impact	Likelihood	Score
Inherent Risk Rating	3	5	15
Current Risk Rating	3	5	15
Target Risk Score	3	3	9
Risk Appetite			

Rationale for Corporate Risk

Significant volumes of patients remain in the list (currently 13,212 unbooked), within these there will be undiagnosed cancers and the obvious risk follows regarding delayed diagnosis and treatment.

CRR 24-26	**Risk Title:** Urology Services		**Date Opened:** November 2024
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** New Risk
Date Last Reviewed: 08/01/2025	**Director Lead:** Executive Medical Director	**Link to BAF**:	**Target Risk Date:** 31/12/2025

There is a risk of increased avoidable harm caused by unsustainable service configuration for Urology in North Wales This could be caused by the inability to recruit to consultant posts driven by unattractive on call rota and lack of recognised best practice equipment (robotic assisted surgery), the lack of specialist knowledge for cancer pathways, issues with access to estates and a lack of clinical leadership. This may lead to the inability of the Health Board to deliver timely and appropriate care to the population of North Wales. As detailed in the RCS and GIRFT reviews, there is a need to develop a provision within a network model to ensure that the service achieves the recommendations from external reviews and complies with national/professional guidance.
If the actions within the Urology Improvement Plan are not achieved, the ability to mitage the known risks will not be possible, which will have an adverse impact on patients access to the service in North Wales, as well as the reputuation of the Health Board.

Mitigations/Controls in place	Additional Controls required
1. High use of locum provision 2. Outsource of service, case by case, whilst commissioning discussions take place. 3. Anuual commissioning of service in place 4. Commission of Robotic Assisted Surgery prostates to UCL 5. Office of the Medical Director currently supporting with Clinical Lead input 6. Monthly meeting with Welsh Government and NHSE to provide assurance and update on the risks currently identified and actions within the Improvement Group.	a. Agree mitigation to move to 2 site model if staff becomes unsafe at 1 site. b. Review purchase of an appropriate Robotic Assisted Surgery platform for prostatectomies c. Clinical facilities and equipment investment identified in the Urology Improvement Plan under the Planned care theme not yet in place

Actions	Due Date	Progression Analysis
Scoping, development and implementation of a revised network model of care for on call.	01/04/2025	Progressing

Review current outsource provision and align Multi-Disciplinary Team meeting for in-reach support in specialist discussion and decision. Review current outsourced/commissioned agreements to provide care closer to home and review opportunities to repatriate cancer procedures at BCU. New arrangements being onboarded with Arrowe Park	01/12/2024	Complete
Cancer services with support from the OMD to advertise for a Urology Cancer lead.	01/11/2025	Progressing
Agreement to fund the MyMR PSA tracking license internally through the Planned Care funds for 24/25 whilst Digital, Data a Technology colleagues look at the integration with AB colleagues and supplier.	01/04/2025	Progressing

To be completed following escalation approval

	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	2	3	6
Risk Appetite			

Rationale for Corporate Risk

Urology service is one of the areas of Clinical Concern and has been subject to an invited review by The Royal college of Surgeons. The identified risk for the services are:

- Increased financial expenditure due to locum provision on the on call rota
- Fragile Out Of Hours on-call rota across BCU
- Delay in patient care with an inability to meet targets for cancer diagnosis and treatment.
- Failure to deliver care closer to home.
- Difficulty in recruiting to provide a sustainable cancer service

Teitl adroddiad: ***Report title:***	**QSE Committee - Designated Educational Clinical Lead Officer (DECLO) Summary of Annual Report (September 2024) and Current Priorities**			
Adrodd i: ***Report to:***	Quality, Safety and Experience Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 20 February 2025			
Crynodeb Gweithredol: ***Executive Summary:***	This report provides the Committee with a summary of the DECLO annual report for the academic year 2023-2024 in addition to current priorities for the Health Board in relation to *statutory* duties under the Additional Learning Needs and Education Tribunal Act (ALNET Act)			
Argymhellion: ***Recommendations:***	The Committee is asked to note this report for assurance purposes.			
Arweinydd Gweithredol: ***Executive Lead:***	Teresa Owen, Executive Director of Allied Health Professionals and Health Science			
Awdur yr Adroddiad: ***Report Author:***	Liz McKinney, Designated Education Clinical Lead Officer			
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:*** Assurance regarding BCUHB's compliance under ALNET Act is 'partial' due to the Additional Learning Needs (ALN) support team contracts being fixed term with imminent end dates. The situation has been escalated via a paper to the Exec Team who acknowledge the Health Board's statutory duties. Decisions regarding permanent funding are pending.				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Workforce Planning (1G); Quality Management System (1H); Compassionate Leadership and Organisational Development (3A); Citizen Engagement (3B); Being a good partner (3C); Children (4L); Intelligence Led Learning (5D).			
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	Statutory duties for health boards are outlined within the legislation of the Additional Learning Needs and Education (Wales) Act, 2018. Breach of statutory duties could lead to legal action (judicial review proceedings) against the health board and/or involvement in Education Tribunals.			
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?***	EqIA assessment 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?***	SEIA assessment 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)***	The ALN Act team support compliance. Fixed term contracts end from 31st March 2025. Risks from 1st April 2025 include: • Breach of statutory duties under the ALNET Act. • Failure to support children and young people with ALN. • Failure to give robust assurances. • Legal challenge via Judicial Review. • Appeals to Education Tribunal. • Complaints under Putting Things Right. • Damage to BCUHB's reputation. • Damage to partnership relationships (with education services). • Failure to comply with the Duty of Quality. • Negative impact on staff wellbeing.
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith Financial implications as a result of implementing the recommendations*	Allocating recurrent funding to the ALN Act support team has financial implications to cover annual staffing costs. However, a dedicated support team mitigates the risk of legal challenge (and costly judicial review processes) due to breach of the legislation.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith. *Workforce implications as a result of implementing the recommendations*	The current ALN Act support team consist of fixed term posts only. A permanent support team would ensure an efficient use of workforce, minimising administrative and procedural tasks for clinical services in line with prudent healthcare.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	• The DECLO annual report (September, 2024) was shared at BCUHB ALNET Act steering group (October 2024) and the Regulatory Advisory Group (December 2024). • Options for managing the risks associated with the temporary nature of the ALN Act staff team were considered via the ALNET Act Steering Group, ALN Champions groups, and meetings with Heads of Service during 2023. Concerns were expressed that without a single point of contact and a dedicated team for BCUHB's ALNET Act activity, services would be at risk of breaching the legislation due to demand in core services already challenging the available capacity. • Engagement outcomes were fed back to the then Acting Executive Director of Therapies and Health Science (August 2023). Permanent funding was indicated in October 2023. This funding was later confirmed as non-recurrent in April 2024 as part of RIGA2 process. • A paper was presented to the Exec Team in October 2024. The Exec team acknowledge the statutory nature of ALNET Act. A decision regarding permanent funding is pending. • An update was presented to BCUHB's ALNET Act Steering Group on 30/1/2025.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	**Tier 1 risk - ID 5248 Risk Grading: 20** The risk created by not having an ALN Act support team indicates an *extreme* risk score of 20 (consequence=4; likelihood=5). The consequence score is *high* due to the risk of ***multiple breaches*** in ***statutory duty*** and the risk of ***low performance*** under the legislation. The risk is mitigated via the work of the ALN Act support team reducing the risk to *moderate* with a score of 6 (consequence=2; likelihood=3).
Reason for submission of report to confidential board (where relevant)	Amherthnasol Not applicable
Camau Nesaf: *Next Steps:* The work of the DECLO and ALN Act support team is ongoing. Requests for extension of contracts have been submitted whilst funding decisions regarding permanent funding are pending.	
Rhestr o Atodiadau: ***List of Appendices:*** QSE Committee - Designated Educational Clinical Lead Officer (DECLO) Summary of Annual Report (September 2024) Summary and Current Priorities	

QSE Committee - Designated Educational Clinical Lead Officer (DECLO) Summary of Annual Report (September 2024) and Current Priorities

1. INTRODUCTION

The Designated Education Clinical Lead officer (DECLO) is a statutory post under the framework of the Additional Learning Needs and Education Tribunal Act[1] (ALNET Act). The post supports BCUHB's compliance with statutory duties under the legislation.

The ALNET Act became lawful in Wales in September 2021. The aim of the Act is to transform education for children and young people with Additional Learning Needs (ALN) by reducing barriers to learning and facilitating *every* child and young person to meet their full potential. The Act places *statutory* duties on health boards. It is being implemented in a phased way.

BCUHB has an ALN Steering Group providing oversight and scrutiny of ALNET Act matters for the Health Board. The Steering Group reports to BCUHB's Regulatory Assurance Group (RAG). A recommendation from RAG was for the DECLO to present a report and update to the Quality, Safety and Experience Committee

This report is the DECLO's first report into QSE committee and provides a summary of the DECLO annual report of September 2024[2] (academic year 2023-2024) followed by an update of current priorities.

2. SUMMARY OF DECLO ANNUAL REPORT, SEPTEMBER 2024 (academic year 2023-2024)

Key background information and headlines from the DECLO annual report (September 2024) are outlined within this section.

2.1 BACKGROUND

2.1.1 Workforce

The DECLO post is a full-time permanent role providing strategic oversight and coordination of the duties for BCUHB under the ALNET Act. The DECLO works with BCUHB services, Local Authorities, schools and colleges in North Wales to support multi-agency working and compliance under the ALNET Act for the benefit of children and young people with ALN.

The ALN Act support team (table 1) provide administrative and operational support to enable the health board to have a single point of access for the 6 local authorities and 390 schools across North Wales in relation to ALN matters. The statutory duties for BCUHB under the ALNET Act are received, processed, and tracked via the support team to enable robust data collection for compliance reporting alongside quality control and assurance measures.

Table 1: ALN Act support team (academic year 2023-2024)

Post title	Band	WTE	Tenure	Funding	Additional Information
Clinical Transformational Lead (vacant)	8a	0.8	Fixed term	Partial RIGA funded/partial cost pressure	Postholder retired 20/6/2024. No plans to re-recruit. 0.11 WTE reprofiled to increase band 3 admin time on a temporary basis.
Project Manager	7	0.67	Fixed term	RIGA funded (non-recurrent)	This post functions as an operational manager
Team Secretary	3	1.0	Fixed term	RIGA funded (non-recurrent)	Post holder has employment rights (>4 years in BCUHB temporary posts)
Team Secretary	3	0.56 (0.8 temp)	Fixed term	RIGA funded (non-recurrent)	Current hours temporarily increased to 0.8 WTE due to partial reprofile of band 8a

2.1.2 Statutory Duties

The statutory duties of particular note for the Health Board relate to four sections of the legislation:

- **Section 20:** The Health Board has a duty to ensure timely responses (i.e., within 6 weeks) to referrals from the Local Authority or Colleges to consider whether there is a treatment or service that may be of benefit in addressing the child or young person's ALN. When such a treatment or service is identified, there is a duty to provide the service (taking all reasonable measures to provide it in Welsh if this is indicated) and to contribute to review meetings where the provision is discussed.

- **Section 64:** The Health Board has a duty to notify the Local Authority of children under compulsory school age who have (or probably have) ALN.

- **Section 65:** The Health Board has a duty to ensure timely responses (i.e., within 6 weeks) to requests for information, advice, or other help from Local Authorities in relation to children and young people, or more general matters, where the advice can assist the Local Authority in the carrying out of their functions under the Act.

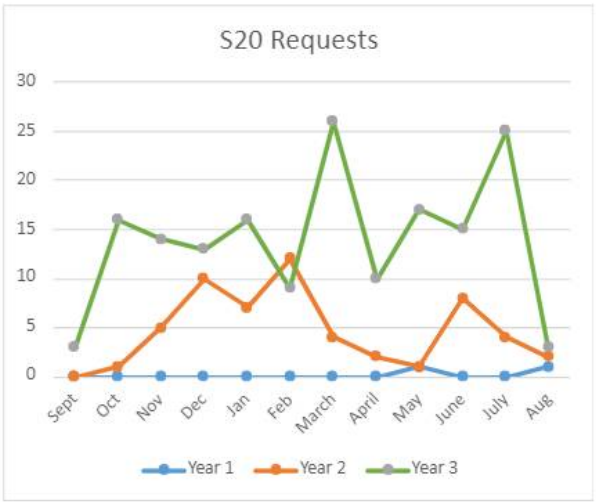
- **Section 76:** The Education Tribunal for Wales may require the Health Board to give evidence in relation to the exercise of Health Board functions under the ALNET Act and may recommendations to a Health Board. In such cases, a response must be provided within 6 weeks of receipt.

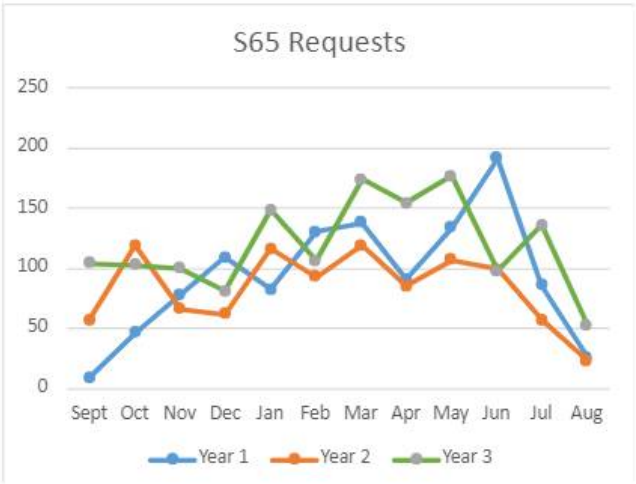
2.1.3 Demand

Demand for BCUHB to fulfil its statutory duties under the ALNET Act has steadily increased since the implementation of the legislation in September 2021. A 42% increase in demand was noted from year 1 (2021-2022) to year 3 (2023-2024) – see figure 1.

Based on the Pupil Level Annual School Census (PLASC) 2023-2024[3], there are over **11,510** children and young people across North Wales with Additional Learning Needs.

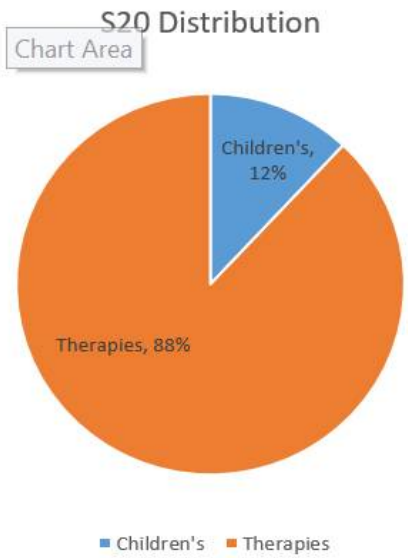
Figure 1: Demand in relation to section 20 referrals and section 65 requests for BCUHB. Year 1 (2021-2022) - year 3 (2023-2024)

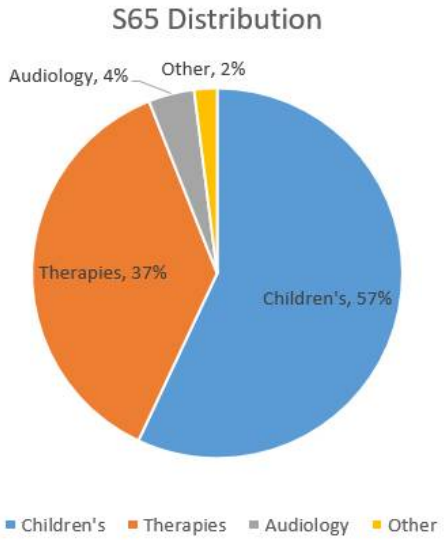




During 2023-2024 the distribution of demand under section 65 (s65) and section 20 (s20) was recorded as follows (see figure 2).

Figure 2: Distribution of demand under section 20 and section 65 in year 3 (2023-2024)





It is forecast that there will be an increase in demand of over 100% for health services by the end of year 4 of implementation (2024-2025), largely due to this year being the final phase of the implementation plan and all children with learning needs being transferred over to the ALNET Act.

2.2 COMPLIANCE AND PERFORMANCE

Current compliance monitoring is in relation to timely responses to section 65 requests and section 20 referrals. The minimum test of compliance is that the health board responds no later than 6 weeks to the request/referral made. A nil or late response is a breach of the legislation.

TABLE 2 – COMPLIANCE REPONSE RATES 2023-2024

Time Period	Section 65 requests	Section 20 referrals
Year 3 (2023-2024)	94%	100%

Processes have been established to enable robust data collection alongside quality control of the information that flows in and out of the Health Board under the ALNET Act. This enables assurances of compliance to be underpinned by robust data and evidence of quality.

Good collaboration and multi-agency working are central to supporting children and young people with ALN. BCUHB compliance and performance is dependent on close collaboration between health board staff, schools, colleges, and the 6 Local Authorities in North Wales at all levels, as supported by the DECLO and ALN Act support team.

Table 3 outlines the training sessions provided by the DECLO and ALN Act team during 2023-2024.

TABLE 3 – TRAINING SESSIONS DELIVERED BY DECLO & ALN ACT TEAM 2023-2024

	ALN Champions	BCUHB admin staff	BCUHB clinical staff
No of sessions	14	7	27

2.3 GOVERNANCE

2.3.1 Standards

The ALNET Act legislates the standards to be met by Health Boards under section 20, section 64 and section 65 of the Act.

National key performance indicators are being developed by DECLOs in association with Welsh Government. Work with the Welsh Informatics Standards Board is underway with a view to a Data Standards Change Notice regarding compliance being issued to Health Boards in the future.

2.3.2 Reporting arrangements

The DECLO reports directly to the Executive Director of Allied Health Professionals and Health Science. Strategic oversight, advice, assurance and scrutiny is provided by the BCUHB ALNET Act Steering Group. The ALNET Act steering group reports in to BCUHB's Regulatory Assurance Group.

The DECLO sits on the North Wales Regional ALN/Inclusion Steering group alongside Local Authority ALN leads and GwE (regional school improvement service). This group reports to the Regional Partnership Board (providing a link from DECLO to RPB).

2.3.3 Quality Management System (QMS)

BCUHB's ALNET Act activity is built around the Duty of Quality via a Quality Management System[5]:

- **Quality Planning**
  Planning is carried out via an annual team engagement day focusing on 5 work streams: Workforce, Governance, Operationalisation, Multi-agency working, and Engagement.
- **Quality Control**
  Quality control is carried out via combined methodology on a regular (weekly or monthly) basis.
- **Quality Assurance**
  Quality assurance is carried out via analysis of key areas to support changes and improvement.
- **Quality Improvement**
  Quality improvement projects are informed via the planning, control, and assurance process.

The QMS outlines current and future activity for the ALN Act team linked to five workstreams: Multi-agency working; Workforce development; Governance; Operationalisation; Communication and Engagement.

2.3.4 Engagement

Engagement with relevant parties is central to ALNET Act compliance. DECLO and ALN support team have regular contact and engagement with Local Authorities, schools, colleges, BCUHB clinical staff, BCUHB service leads, third sector organisations, cross border partners (Local Authorities and Health Trust staff in England), and children, young people and their families.

2.3.5 Learning and Improvement

The ALNET Act team is committed to supporting ongoing learning of Health Board staff in relation to ALNET Act matters to facilitate compliance with the Act and to guide continual improvements.

The team regularly update BetsiNet to ensure contemporaneous information is available to support BCUHB staff in carrying out their duties under ALNET Act. A playlist of bitesize videos was updated in 2023-2024 to support understanding of each element of the Act relevant to Health. Decision tools and guidance were also updated to support staff through the process. All resources are available via ALN Act - Home (sharepoint.com)[4]

During 2023-2024, the DECLO fed back ALN Act team learning to the Organisation Learning Forum.

During 2023-2024, the DECLO team pledged a commitment to working within a Compassionate Leadership framework. Information is available here: *Compassionate Leadership ALN Team*

2.4 RISK

Due to the ALNET Act support teams' contracts ending from March 2025, there is a significant risk that BCUHB will not maintain compliance with the ALNET Act from April 2025. This risk is documented on the risk register (ID 5248).

From 1st April 2025, risks include:

- Failure to support children and young people with ALN.
- Non-compliance with statutory duties under ALNET Act.
- Failure to provide assurance and provide robust data as part of National Reporting.
- Legal challenge via Judicial Review.
- Appeals to Education Tribunal.
- Complaints under Putting Things Right.
- Damage to BCUHB's reputation.
- Damage to partnership relationships (with education services).
- Failure to comply with the Duty of Quality.
- Negative impact on staff wellbeing.

2.5 FINANCE

The DECLO is a substantive post, however it is currently a cost pressure for the office of the Executive Director of Allied Health Professionals and Health Science.

Costs for the planned future configuration of the ALN Act support team are outlined below:

TABLE 4: ALNET ACT SUPPORT TEAM COSTS

Post title	Band	WTE	Annual costs *
Admin support	3	1.56	£49,597
Project Manager	7	0.67	£41,044
Non-pay			£500
Total			£91,141

**Based on mid-point pay scales 2024-2025 including oncosts*

3. CURRENT PRIOIRITIES

The current work of the ALNET Act team will be reported in the annual report of September 2025. The priorities for the remainder of year four (academic year 2024-2025) are outlined below:

3.1 QUALITY MANAGEMENT SYSTEM (QMS)

The achievements and learning from year three (academic year 2023-2024) have been taken forward and included within a Quality Management System (QMS) for the ALNET Act team for year four of delivery[5].

The QMS for the team for 2024-2025 is based on annual planning and engagement. Quality control, quality assurance and quality improvement mechanisms and are built in to the QMS and provide a focus for all of the work carried out by the DECLO and ALNET Act team.

Plans for year four of delivery (2024-2025) outline a range of activity including maintaining stable compliance rates and quality control of responses under section 65 and 20; providing quality assurance via case study reviews in partnership with Local Authorities; developing BCUHB's public facing webpage following a period of patient engagement; supporting quality improvement via patient-centred approaches.

3.2 DEMAND

As part of the QMS, the demand for BCUHB involvement in ALNET Act activity and statutory duties is being monitored.

A full academic term is now complete within year four of LANET Act implementation and the data indicates an increase in demand of 46% compared to the same period last year. It is anticipated that this will further increase during the Spring and Summer Terms of 2025 due to all children with learning needs moving over to the ALNET Act system by the end of August 2025 under the phased implementation plan.

The DECLO and ALNET Act team are working with systems and services to explore and support the demand increase.

3.3 WORKFORCE

A paper was presented to the Exec team in October 2024 to escalate the risks associated with the fixed term nature of contracts of the ALNET Act team. The exec team understand the statutory nature of the ALNET Act and decisions regarding permanent funding are pending.

Securing a permanent solution in order to support and maintain BCUHB's compliance with the ALNET Act remains an urgent priority to be able to maintain compliance. A request to extend contracts has been made via Establishment Control processes whilst decisions regarding permanent funding are pending.

3.4 REPORTING ARRANGEMENTS

The DECLO and the work of the ALNET Act Team will continue to report to the QSE Committee as deemed appropriate by the QSE Committee.

LINKS & REFERENCES

1. *Welsh Government (2018), Additional Learning Needs and Educational Tribunal (Wales) Act 2018*
2. *DECLO Annual Report September 2024 (copy available)*
3. *Stats Wales (2024), Pupil Level Annual School Census.*
4. *BCUHB ALNET Act BetsiNet pages, ALN Act - Home (sharepoint.com)*
5. *BCUHB DECLO-ALNET Act, Quality Management System ALN Team*
6. *BCUHB DECLO-ALNET Act, Compassionate Leadership ALN Team*

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

Additional Learning Needs and Education Tribunal Act, 2018

Annual Report

Date: September 2024
Author: Liz McKinney, Designated Education Clinical Lead Officer (DECLO)
Version: 1.0

CONTENTS

1. INTRODUCTION

1.1 Purpose of report

The purpose of this report is to provide an update in relation to BCUHB's implementation of the Additional Learning Needs and Education Tribunal Act for Wales (2018) following year 3 of implementation (academic year 2023-2024).

1.2 The Additional Learning Needs and Education Tribunal Act, 2018

The Additional Learning Needs and Education Tribunal Act[1] became lawful in Wales from 1st September 2021. The aim of the ALNET Act is to transform education for children and young people with Additional Learning Needs (ALN) by reducing barriers to learning and facilitating *every* child and young person to meet their full potential. The Additional Learning Needs and Education Tribunal Code[2] provides guidance in relation to delivery of the Act. The Act is being implemented in a phased way with completion of the implementation phase scheduled by the end of August 2025.

1.3 Implications for the Health Board

The Act places statutory duties on health boards to:

- Appoint a Designated Clinical Lead Officer (DECLO) to oversee and coordinate Health Board functions under ALNET Act.
- Notify the Local Authority of children under compulsory school age who have (or probably have) ALN.

- Ensure timely responses (i.e., within 6 weeks) to requests for information, advice, or other help from Local Authorities in relation to children and young people, or more general matters where the advice can assist the Local Authority in the carrying out of their functions under the Act.

- Ensure timely responses (i.e., within 6 weeks) to requests from the Local Authority or Colleges to consider whether there is a treatment or service that may be of benefit in addressing the child or young person's ALN. When such a treatment or service is identified, there is a duty to provide the service (taking all reasonable measures to provide it in Welsh if this is indicated) and to contribute to review meetings where the provision is discussed.

- Support early dispute resolution and provide evidence, information, and support in relation to appeals to Education Tribunals in addition to considering recommendations made by Tribunal Panels.

2 BACKGROUND

2.1 Workforce

Liz McKinney is the Designated Education Clinical Lead Officer within BCUHB. This is a full-time permanent role. However, the post is currently a cost pressure within the office of the Executive Director of AHPs and Health Science.

An ALN Act support team is in place on fixed term contracts to ensure BCUHB's compliance with the Act

TABLE 1 – ALNET ACT SUPPORT TEAM

Post title	Band	WTE	Tenure	Funding	Additional Information
Clinical Transformational Lead	8a	0.8	Fixed term to 7.3.2025	Partial RIGA funded/partial cost pressure	Postholder retired 20/6/2024. No plans to re-recruit. 0.11 WTE reprofiled to increase band 3 admin time temporarily.
Project Manager	7	0.67	Fixed term to 31.3.2025	RIGA funded (non-recurrent)	This post functions as an operational manager
Admin support	3	1.0	Fixed term to 17.4.2025	RIGA funded (non-recurrent)	Post holder has employment rights (>4 years in BCUHB temporary posts)
Admin support	3	0.8 (temp increase from 0.56 1/7/24)	Fixed term to 11.6.2025	RIGA funded (non-recurrent)	Hours increased from 0.56 WTE to 0.8 WTE until March 2025 due to partial reprofile of band 8a

These posts are a cost pressure for the Health Board due to no budget allocation currently. This matter is being escalated to BCUHB's Executive Team to explore options.

2.2 Demand

Based on information from the Pupil Level Annual School Census (PLASC) 2023-2024, there are over 11,510 children and young people across North Wales with Additional Learning Needs. This figure is for the age range 5-18 years due to the data captured by PLASC and, therefore, is an underestimate of actual need due to the ALNET Act covering 0-25 years. Table 2 shows the demand during year 3 of ALNET Act

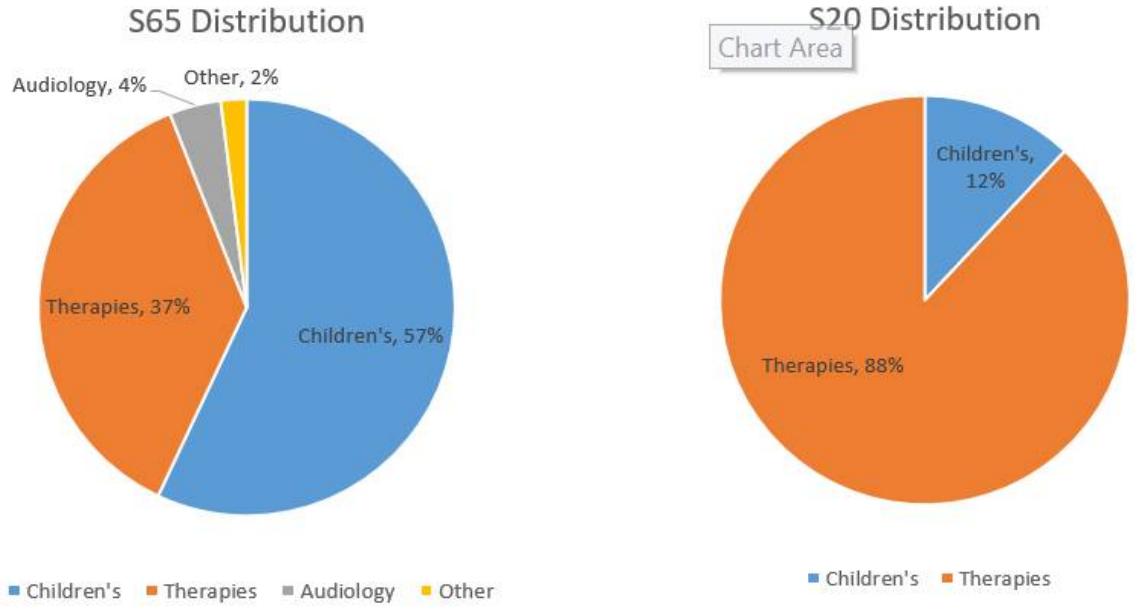
TABLE 2 - STATUTORY REQUESTS & REFERRALS RECEIVED

Time Period	Section 65 requests to health departments	Section 20 referrals to health departments
1/9/2021-31/8/2022	1121	2

1/9/2022-31/8/2023	1003	56
1/9/2023–31/8/2024	1435	167

During 2023-2024 the demand under statutory ALNET Act activity was distributed as follows:

- Section 65 requests: Childrens 57%; Therapies 37%; Audiology 4%; other 2%.
- Section 20 referrals: Therapies 88%; Childrens 12%.



3 COMPLIANCE & PERFORMANCE DATA

3.1 Compliance

Compliance with ALNET Act means that:

- BCUHB will employee a DECLO to oversee Health Board functions under the Act.
- Health professionals will notify the Local Authority when a child under compulsory school age has or probably has ALN.
- Requests from Local Authorities to Health for information or other help (section 65 in the Act) will be responded to within six weeks of receipt. The information will be included in the child/young person's Individual Development Plan (a statutory document).
- Requests from Local Authorities to Health for consideration of treatments or services that may be of benefit in addressing the child/young person's ALN (section 20 in the Act) will be responded to within six weeks of receipt.
- Any such treatments will be written in to the child's Individual Development Plan as NHS additional learning provision and must be secured, delivered, and reviewed by health staff as a statutory requirement. All reasonable steps will be made to provide the treatments in Welsh where this is indicated.
- To achieve the above, Health teams will have a good understanding of the ALNET Act, work in a collaborative way and use person centred principles during assessment and intervention as informed and supported by the DECLO office.

The table below shows data collected over the 3 years of ALNET Act implementation

TABLE 3 – COMPLIANCE RATE WITH STATUTORY REQUESTS

Time Period	Section 65 requests to health departments	Section 20 referrals to health departments
Year 1 (2021-2022)	89%	100%
Year 2 (2022-2023)	93%	100%
Year 3 (2023-2024)	94%	100%

3.2 Performance Data breakdown

3.2.1 Section 65 requests

In Year 3, 94% of requests for information made under section 65 of the Act were responded to within 6 weeks. Of those responses:

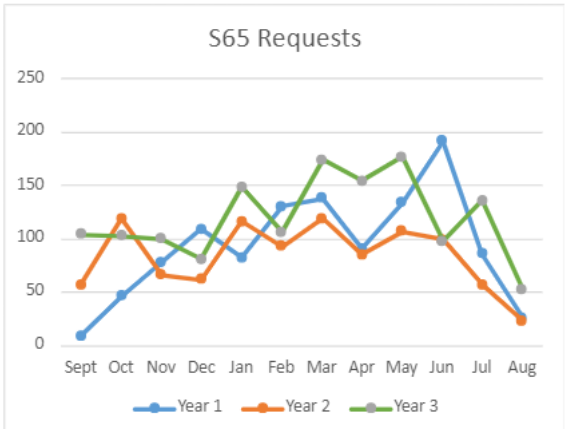
- 58% were provided with the information requested.
- 21% were to notify the requester that no information was available either because the Child or young person was not known to the service or had previously been discharged and the information held was out of date or no longer relevant.
- 11% were to notify the requester that information would be provided outside of the statutory 6 weeks most commonly because the child/young person had very recently been referred to the service and had not been seen for initial assessment and no information was yet available.
- 6% missed the 6-week statutory deadline to respond.

TABLE 3: Breakdown of response type in relation to section 65 requests

S65	Year 1		Year 2		Year 3	
Information requested	1121		1003		1390	
Info Recvd on time	656	**48%**	627	**63%**	810	**58%**
8U Info Unavailable	108	**10%**	160	**16%**	295	**21%**
8D Notified of delay	236	**21%**	141	**14%**	146	**11%**
Missed deadline	121	**11%**	75	**7%**	78	**6%**
Compliance		**89%**		**93%**		**94%**

The number of requests received in Year 3 has increased. During Year 3, the average response time for a request for information was 24 calendar days.

TABLE 4: Total Section 65 Requests Received

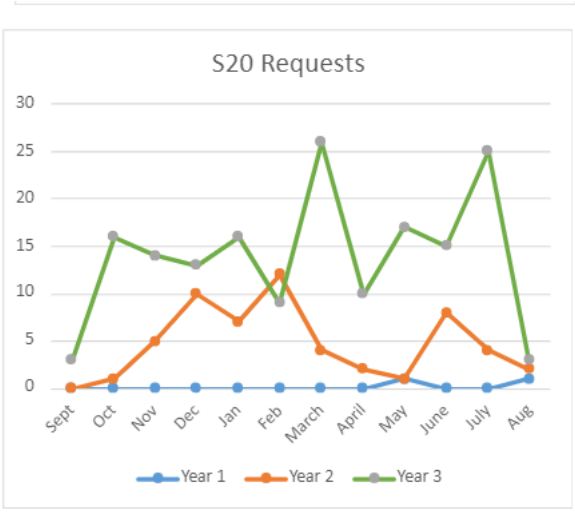


	Yr 1	Yr 2	Yr 3
Sept	9	57	104
Oct	46	119	103
Nov	78	66	100
Dec	109	62	81
Jan	82	116	149
Feb	130	93	106
Mar	138	119	174
Apr	91	85	154
May	134	107	177
Jun	192	99	98
Jul	86	57	136
Aug	26	23	53
Total	1121	1003	1435

3.2.2 Section 20 referrals

As the phased implementation of the ALN Act progressed during year 3, considerations for NHS Additional Learning Provision via section 20 referrals increased. Processes for managing section 20 referrals is under continual joint review with the 6 Local Authorities.

TABLE 5: Total Section 20 Referrals Received



S20 received in month

S20 Requests	Yr 1	Yr 2	Yr 3
Sept	0	0	3
Oct	0	1	16
Nov	0	5	14
Dec	0	10	13
Jan	0	7	16
Feb	0	12	9
March	0	4	26
April	0	2	10
May	1	1	17
June	0	8	15
July	0	4	25
Aug	1	2	3
Year TOT	2	56	167

In Year 3 100% of section 20 referrals (asking health staff to consider whether there is NHS Additional Learning provision (ALP) were responded to within 6 weeks.

BCUHB currently has 166 active episodes of NHS ALP described on IDPs, 17 of which are being provided in Welsh.

The responses to section 20 referrals during year 3 can be broken down as follows (see also Table 6):

- 80% - NHS ALP identified and described
- 8% - not able to consider NHS ALP as the child/young person is not open to the service.
- 3% - response will be delayed due to either ongoing assessments or to being newly referred to the service.

TABLE 6: Breakdown of response type in relation to section 20 referrals

S20	Year 1		Year 2		Year 3	
Consideration requested	2		56		173	
NO ALP Identified	1	**50%**	17	**30%**	14	**8%**
ALP Identified	1	**50%**	29	**52%**	139	**80%**
8U Unable to consider	0	**0%**	9	**16%**	13	**8%**
8D Notified of delay	0	**0%**	1	**2%**	5	**3%**
Missed deadline	0	**0%**	0	**0%**	0	**0%**
Compliance		100%		100%		100%

3.3 Processes and roles to support compliance

Compliance rates are high as a direct result of the ALNET Act support team roles which collectively involve:

- Providing a single point of access (via DECLO email inbox) for the 6 Local Authorities, 2 colleges, and 390 schools in North Wales as part of partnership working and to deliver against ALNET Act duties.
- Logging, sending on requests, and interacting with a range of BCUHB departments including therapies, ND, CAMHS, Childrens Learning Disability Teams, Adult Learning Disability Teams, Psychology, Orthoptics, Audiology, Health Visiting, School Nursing, Specialist Nursing, Community Paediatrics, Acute Paediatrics, and more across regional teams and within the three IHCs.
- Monitoring, tracking, and sending reminders to services to ensure statutory timescales are met
- Providing support, training, and resources to complete responses to meet statutory duties
- Collating responses, quality checking, and sending on to the requester
- Collaboratively implementing lessons learnt when breaches occur
- Being a first point of contact for concerns and queries requiring early resolution
- Engaging with patients, families, partners, education services, and third sector organisations
- Tracking involvement in legal challenge and education tribunals to ensure compliance
- Recording and collating robust performance data
- Supporting delivery of the Quality Management System for ALNET Act

The DECLO team roles are summarised as below:

- DECLO: Provides strategic oversight and coordination of Health Board's duties under the ALNET Act.
- Clinical Transformational Lead: Ensures clinical readiness of BCUHB services during the implementation phase of ALNET Act. This post is vacant and recruitment is not being explored as this was a transformation post and the transformation period is near completion.
- Project Manager: Ensures operational delivery and implementation of ALNET systems, data collection, performance monitoring, and support structures.
- Secretary: Ensures timely processing of statutory requests, dealing with enquiries and processing responses via the DECLO email inbox.

The absence of a clinical digital system to support the management of requests places further demands on administration support.

3.4 Training and activity to support compliance

Good collaboration and multi-agency working are central to supporting children and young people with ALN. BCUHB compliance is dependent upon close collaboration between health board staff, schools, colleges, and the 6 Local Authorities in North Wales at all levels, as supported by the DECLO and ALN Act support team.

Table 7 outlines the training sessions provided by DECLO and ALNET Act team during 2023-2024.

TABLE 7 – TRAINING SESSIONS PROVIDED

Time Period	ALN Champions sessions delivered	Training sessions to BCUHB admin staff	Training sessions to BCUHB clinical staff
Year 3 (2023-2024)	14	7	27

The DECLO and ALN Act support team is committed to supporting ongoing learning of Health Board staff in relation to ALNET Act matters to facilitate compliance with the Act and to guide continual improvements. In addition to training sessions, the ALNET Act support team regularly update BetsiNet to ensure contemporaneous information is available to support BCUHB staff in carrying out their duties under ALNET Act.

During 2023-2024, a playlist of bitesize videos was updated to support understanding of each element of the Act relevant to Health. Decision tools and guidance are also available and have been updated this year. Newsletters have been created for staff to ensure updates are readily available. BCUHB resources are all available via ALN Act - Home (sharepoint.com)[4]

3 GOVERNANCE

4.1 Standards

Standards under the ALN Act and Code relate to statutory requirements as outlined in section 3 ‘compliance’.

National key performance indicators and compliance targets are being developed by DECLOs and in association with Welsh Government. Work with the Welsh Informatics Standards Board is currently underway with a view to a Data Standards Change Notice being issued in relation to ALNET Act KPIs.

Clinical standards for each health department working with children and young people with Additional Learning Needs apply as per standard practice (in line with clinical evidence base, clinical guidelines, and professional body guidance).

4.2 Reporting arrangements

- The DECLO oversees the work and line management of the temporary staff within the DECLO support team.
- The DECLO support team operate within the ALNET Act Operational Group for BCUHB.
- BCUHB ALNET Act Operational Group reports in to the ALNET Act Steering Group for BCUHB.
- The DECLO reports directly to the Executive Director of Therapies and Health Science
- The ALNET Act steering group reports in to BCUHB’s Regulatory Assurance Group.

- The DECLO sits on the North Wales Regional ALN/Inclusion Steering group alongside Local Authority ALN leads and GwE (regional school improvement service).

- The Regional ALN leads group reports to the Regional Partnership Board (providing a link from DECLO to RPB).

4.3 Quality Management System

The DECLO and ALN Act team activity is built around the Duty of Quality via a Quality Management System

- **Quality Planning**
  Planning is carried out via an annual team engagement day focusing on 5 work streams: Workforce, Governance, Operationalisation, Multi-agency working, and Engagement.
- **Quality Control**
  Quality control is carried out via combined methodology on a regular (weekly or monthly) basis.
- **Quality Assurance**
  Quality assurance is carried out via detailed analysis of key areas to support changes and improvement.
- **Quality Improvement**
  Quality improvement is informed via the planning, control, and assurance process.

Performance and compliance are reported to BCUHB's ALNET Steering group on a bi-monthly basis for assurance and scrutiny.

The DECLO and ALN Act team's Quality Management System is available here DECLO QMS 2024-2025.xlsx (sharepoint.com)[5]

4.4 Engagement

Engagement with relevant parties is central to ALNET Act compliance. Engagement activity for year 3 (2023-2024) is outlined below:

- **Local Authorities across North Wales**: Regular meetings between DECLO and Local Authority colleagues on a regional and local basis.
- **Schools**: DECLO attendance at school ALNCO forums took place at least annually; DECLO attended the North Wales Association of Special School Heads forum twice during year 3.
- **Colleges**: The DECLO met with ALN leads in Further Education Institutions on a monthly basis.
- **BCUHB clinical staff**: Engagement with teams internally to BCUHB took place via ALN champions meetings (with clinical staff) on a six-weekly basis.
- **BCUHB service leads**: During year 3, the DECLO attended the Childrens Community CAG (bi-monthly); the Regional Childrens Services Group (monthly); West IHC's CYP Programme Group (monthly).
- **Cross border working:** The DECLO met with colleagues in Local Authorities and Health services in England on three occasions during year 3 to support effective problem solving in relation to cross-border matters due to different legislation enacted in England.
- **Third sector organisations:** The DECLO met with 3rd Sector organisations to establish links during year 3.
- **Families:** DECLO had contact with families who had escalated queries and concerns in relation to health matters under ALNET Act during year 3.

4.5 Learning and Improvement

The DECLO and ALN Act support team is committed to supporting ongoing learning of Health Board staff in relation to ALNET Act matters to facilitate compliance with the Act and to guide continual improvements.

The DECLO office regularly update BetsiNet to ensure contemporaneous information is available to support BCUHB staff in carrying out their duties under ALNET Act.

A playlist of bitesize videos has been updated to support understanding of each element of the Act that are relevant to Health. Decision tools and guidance are available and are continually updated to support staff through the process. Resources are all available via ALN Act - Home (sharepoint.com)[4]

During year 3, the DECLO fed back ALN Act team learning to the Organisation Learning Forum (June 2024).

During year 3, the DECLO team pledged a commitment to working within a Compassionate Leadership framework. Information is available here: *Compassionate Leadership ALN Team*

5.0 RISK

5.1 ALNET ACT Support team & impact on compliance

During the final quarter of year 3, it became apparent that the funding underpinning the ALN Act support team was not re-current. Due to the support teams' contracts ending from March-June 2025, there is a significant risk that BCUHB will not maintain compliance with the ALNET Act beyond March 2025 if recurrent funding is not identified. This risk is documented on the risk register (ID 5248).

In the event of BCUHB not continuing with a dedicated ALNET Act support team, all ALNET Act activity would need to be channelled directly to the relevant individual clinical services. Processing ALNET Act activity in this way would present significant demands on already stretched services and would lead to:

-a risk to effective partnership working due to the loss of a single point of access for education colleagues;

-a risk of BCUHB not being able to assure accurate and robust performance data;

-a risk of BCUHB breaching statutory duties under the ALNET Act legislation (impacting on outcomes for children and young people with ALN);

-a risk to compliance with the Duty of Quality (quality control, assurance, and improvement) in relation to the ALNET Act for BCUHB.

The risk imposed by not having a dedicated ALNET Act support team would place BCUHB in a particularly precarious position once national KPI reporting becomes mandated (work with the Welsh Informatics Standards Board is currently underway with a view to a Data Standards Change Notice being issued in relation to ALNET Act KPIs).

Risks are compounded by the fact that BCUHB does not have a single digital clinical system in place that could be used to support the tracking, monitoring, and reporting of ALNET activity in a robust and consistent manner.

Non-compliance with ALNET Act statutory duties as a result of no dedicated team could lead to:

- Failure to support children and young people with ALN to reach their full potential
- Legal challenge via Judicial Review process (and significant time and resource to address such challenges)

- Appeals to Education Tribunals (and significant time and resource for health board staff to prepare reports and/or attend as witnesses)
- Complaints under Putting Things Right
- Damage to BCUHB's reputation and partnership relationships (with Local Authorities/schools/colleges)
- Impact on staff wellbeing and satisfaction due to all points raised above

6.0 FINANCE

6.1 DECLO support team

The DECLO is a substantive post, however it is currently a cost pressure for the office of the Executive Director of Allied Health Professionals and Health Science.

Costs of the current configuration of the ALN Act support team are outlined below:

TABLE 8: ALNET ACT SUPPORT TEAM COSTS

Post title	Band	WTE	Annual costs *
Admin support	3	1.56	£49,597
Project Manager	7	0.67	£41,044
Non-pay			£500
Total			£91,141

**Based on mid-point pay scales 2024-2025 including oncosts*

7.0 FUTURE CONSIDERATIONS

7.1 Predicted increase in demand

It is forecast that there will be an increase in demand for health services in year 4 of implementation (2024-2025) due the following factors:

- The ALNET Act is being implemented in a phased way with completion due by the end of August 2025. Based on ALN census information[3], it is predicted that demand for health board activity under ALNET Act will rise by **115%** by the end of August 2025 (as over half of the children and young people in North Wales with ALN are yet to transfer to the ALNET Act system).

- Section 20 referrals can currently only be made by Local Authorities and Colleges. There are planned changes for schools to also make section 20 referrals. Based on ALN census information[3], it is predicted that section 20 referrals for BCUHB will increase to over 1000 per year once schools can make such referrals.

- There is a need for BCUHB to log, record, and report on health staff involvement in each child's education review meeting (held at least annually) under ALNET Act to align to the performance data reported by other health boards in Wales (as reported to the Cabinet Secretary for Education in June 2024). Based on ALN census information[3], it is predicted that over 1000 invitations will be received annually by end August 2025.

The increase in demand has been included in the risk assessment of the ALN Act team and will be factored in to the planning (as part of a Quality Management System) during year 4.

7.2 Quality Management System (QMS)

- ***Quality Control*** measures have been established and refined for implementation during year 4 and include (but are not limited to): weekly monitoring of compliance; reminder systems; quality checking of information

against the legislation; planned meeting schedules to check and update (within ALN Act team, across wider BCUHB clinical teams, and across agencies) at both an operational and strategic level; monthly performance reports.

- ***Quality Assurance*** activities planned for year 4 include (but are not limited to): Clinical case studies to explore the impact of health involvement in IDP planning/reviews; surveys with staff and LA colleagues; Feedback via the CIVICA system.
- ***Quality Improvements*** for year 4 include (but are not limited to) ongoing use of a QMS tool; Co-production of a single form for the statutory notification of pre-schoolers with ALN (section 64 of ALNET Act); further development of section 65 processes to align with proposed updated national Key Performance Indicators; Person Centred Planning training for health staff; development of ALN Act web page for BCUHB following engagement with families.

8 REFERENCES

1. **Welsh Government (2018),** ***Additional Learning Needs and Educational Tribunal (Wales) Act 2018***
2. **Welsh Government (2021),** ***Additional Learning Needs Code for Wales 2021.***
3. **Stats Wales (2024),** ***Pupil Level Annual School Census.***
4. **BCUHB ALNET Act BetsiNet pages,** ***ALN Act - Home (sharepoint.com)***
5. **BCUHB DECLO-ALNET Act,** ***Quality Management System ALN Team***
6. **BCUHB DECLO-ALNET Act,** ***Compassionate Leadership ALN Team***

Cyfarfod a dyddiad: **Meeting and date:**	Quality, Safety & Assurance Committee
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Summary of business considered in private session to be reported in public
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Pam Wenger, Director of Corporate Governance
Awdur yr Adroddiad **Report Author:**	Philippa Peake-Jones, Head of Corporate Affairs
Craffu blaenorol: **Prior Scrutiny:**	None
Atodiadau **Appendices:**	None

Y/N to indicate whether the Equality/SED duty is applicable **N**

Argymhelliad / Recommendation:

The Committee is asked to note the report.

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		**Ar gyfer Trafodaeth For Discussion**		**Ar gyfer sicrwydd For Assurance**		**Er gwybodaeth For Information**	✓

Sefyllfa / Situation:

To report in public session on matters previously considered in private session.

Cefndir / Background:

Standing Order 6.5.3 requires the Board to formally report any decisions taken in private session to the next meeting of the Board in public session. This principle is also applied to Committee meetings.

Asesiad / Assessment

The Committee considered the following matters in private session:

17 December 2024

- Confidential Quality Report
- Board Assurance Framework

Quality Safety and Experience Committee – Non-Routine Committee Business Forward Plan

(1 April 2024 – 31 April 2025)

This forward plan is only to be used for one-off Adhoc items that do not require inclusion as routine business on the Annual Committee Cycle of Business.

Date of Request	Origin of Request	Requestor	Item Summary / Title	Nature of Request	Lead Officer	Executive Lead	Intended Meeting Date	Status
13.2.25	QSE Action Log	Chair	**QS24/104** Meeting Effectiveness	To ensure that more time allocated to Primary Care on CoB, on a regular basis.	Head of Corporate Affairs **(Philippa Peake-Jones)**	Exec. Dir. of Nursing & Midwifery (**Angela Wood)**	May 2025	
13.2.25	QSE Agenda 20.2.25	Interim COO	**QS25/06** Deep Dive into Childrens Services (CAMHS)	Item deferred due to sickness.	COO	COO	May 2025	
7.2.25	TRANSFER LOG MH24/32.2	MHLC	**MH24/32.2** Translation Services	To ensure that patients are provided with the opportunity to communicate in their preferred language. The action was deemed complete and was moved to the QSE transfer log.	Executive Director for Allied Health Professionals & Health Science (**Teresa Owen**)	Executive Director for Allied Health Professionals & Health Science (**Teresa Owen**)	May 2025	
07.05.24	TRANSFER LOG AC24.60.1.8	Audit Committee		Quality, safety and commissioned services. The Committee agreed to a 6-month deferral requesting that the review take place before the end of the current financial year - it was agreed to inform the QSE of this decision and for the QSE committee to drive progress on recommendations from the May 23 report.	Director of Governance **(Pam Wenger)** / Head of Corporate Affairs **(Philippa Peake-Jones)**	Director of Governance **(Pam Wenger)**	May 2025	**10.12.24** Now the new Director of Performance and Commissioning has started with the Health Board, this will be taken forward within his remit.
22.10.24	PPHP 22.10.24	PPHP	Developing our Partnerships	Ensure that a Llais Experience paper is included on the QSE / PPHP CoB annually.	Head of Corporate Affairs **(Philippa Peake-Jones)**	Director of Governance **(Pam Wenger)**	May 2025	
11.06.24	QSE Agenda Setting	Chair	Primary Care	Update on ongoing work	Head of Primary Care	Executive Director of Nursing & Midwifery (**Angela Wood)**	~~December 2024~~ February 2024	It was suggested at QSE Development Session that this item should come to a joint PFIG & QSE Development Session. Due to timing issues, this has not been managed to be scheduled before Christmas.
26.09.24	Board	Director of Corporate Governance /	Monitoring of Patient safety & experience	Arrange for QSE Committee workplan to include monitoring	Director of Corporate Governance	Director of Corporate Governance **(Pam Wenger)**	February 2025	

		Executive Director of Nursing & Midwifery		of patient safety and experience across EDs reporting	(**Pam Wenger**) / Exec. Dir. of Nursing & Midwifery (**Angela Wood**)			
15.10.24	Email between Teresa Owen and Pam Wenger	Director of Corporate Governance	Governance of DECLO role	To provide an update and ensure appropriate governance of DECLO role, regulation and plans	Designated Education Clinical Lead Officer **(Liz McKinney)**	Exec. Dir of Allied Health Professions & Health Science **(Teresa Owen)**	~~December 2024~~ May 2025	~~Added to draft Dec agenda~~
16.10.24	Email from Chief Operating Officer	Chief Operating Officer	Challenged Services – Dermatology (Plastics)	Update on service.	Head of Planned Care	Executive Medical Director	~~February 2025~~ May 2025	**Jan 2025** Not to be provided until a clinical lead is in place.
16.10.24	Call for Papers inadvertently omitted request for Deep Dive to Children's Services for October 2024 meeting	COB	Service presentation from Children's Services – with particular emphasis on CAMHS.	Update on service with particular emphasis on CAMHS	Assistant Area Directors - Children (Pan-BCU)	Assistant Area Directors - Children (Pan-BCU)	~~February 2025~~ May 2025	**10.2.25** Received request to defer item to May 2025.
24.10.24	Deputy Director for Legal Service's action from October meeting – QS24/120.	Chair	Update on Impact of Independent Medical Examiner certifying deaths.	To provide an update once the impact of an independent medical examiner certifying all deaths has been assessed.	~~Deputy Director of Legal Services~~ Executive Medical Director	~~Director of Corporate Governance~~ Executive Medical Director	May 2025	
29.11.24	Email from Deputy Director for Legal Services	Deputy Director for Legal Services & Director of Corporate Governance	Clinical Negligence Claims	Update. Item removed from Dec 24 agenda by Deputy Director for Legal Services following discussions with Director of Corporate Governance. Further work is required. Meeting with CEO in the new year around wider claims work and the paper would be written after this.	Deputy Director for Legal Services	Director of Corporate Governance	May 2025	
10.12.24	Email from Executive Director of Nursing & Midwifery re Action from Oct – Deep Dive on Complaints – Duty of Care.	Executive Director of Nursing & Midwifery	PTR guidance update for Development Session	Once Welsh Government releases new PTR guidance, this to be a topic at the next Development session.	Executive Director of Nursing & Midwifery	Executive Director of Nursing & Midwifery	March/April 2025	
17.12.24	QSE Meeting	The Executive Director of Allied Health Professionals and Health Science	The Executive Director of Allied Health Professionals and Health Science, Director of Performance & Commissioning and the	To meet outside meeting to address the challenges causing delays relating to index colonoscopy patients and to provide a briefing to next Development session	The Executive Director of Allied Health Professionals and Health Science	The Executive Director of Allied Health Professionals and Health Science	March/April 2025	

			Executive Medical Director					
8.1.25	Email between Chief Pharmacist and Director of Corporate Governance	Director of Corporate Governance	Pharmacy & Medicines Management Deep Dive	Pharmaceuticals item removed from Feb's agenda. To split in two - Pharmacy & Medicines Management Deep Dive	Chief Pharmacist	Executive Medical Director	June 2025	
8.1.25	Emails between Chief Pharmacist and Director of Corporate Governance	Director of Corporate Governance	Controlled Drugs Accountable Officer report must be an item in Private session	Pharmaceuticals item removed from Feb's agenda. To split in two – (see above) with Controlled Drug Accountable Officer report.	Chief Pharmacist	Executive Medical Director	May 2025 must be an item in Private session	

Quality Safety and Experience – Annual Cycle of Committee Business

(1st April 2024 to the 31st March 2025)

The Annual Cycle of Committee Business has been developed to help plan the management of Committee matters and facilitate the management of agendas and committee business. The Annual Cycle of Committee Business will be complemented by a "Non-Routine Committee Business (Forward Work Plan)" for 'one-off' Ad-hoc items raised during meetings.

The role of the Committee is set out in the Health Board's standing orders and the Terms of Reference, both of which are available here:

The **Quality Safety and Experience Committee** meets bi-monthly

Committee Chair:	**Members**	**In Attendance**	**Preliminary matters to be included on agenda:**
• Caroline Turner **Committee Vice Chair** • Christopher Lothian-Field	• Mike Larvin • Urtha Felda	• Angela Wood (Executive Director of Nursing and Midwifery) – Exec Lead • Sreeman Andole (Interim Executive Medical Director) • Teresa Owen (Executive Director of Allied Health Professionals and Health Science) • Jane Moore (Interim Executive Director of Public Health)	Welcome & Apologies Declarations of Interest Unconfirmed minutes of meeting held on xxxx Matters Arising & Action Log

AGENDA ITEM	APRIL (Q1)	JUNE (Q1)	AUGUST (Q2)	OCTOBER (Q3)	DECEMBER (Q3)	FEBRUARY (Q4)
PRELIMINARY MATTERS						
PATIENT STORY						
Patient Story						
SERVICE PRESENTATIONS – 30 mins						
IHC East						
Womens, Maternity and Gynaecology						
Children's						
IHC West						
Pharmaceutical Services						
Mental Health						
IHC Central		2025				
Learning Disabilities			2025			
QUALITY PLANNING						
Clinical Services Plan *Executive Medical Director*						
Nursing Staffing (April & October)						
QUALITY CONTROL						
Integrated Quality Report • Patient Safety • Patient Experience • Clinical Effectiveness (Audit work) • Safeguarding • IPC • Regulatory • Legal *Executive Director of Nursing and Midwifery*						
Integrated Performance Report *Director of Performance*						
QUALITY IMPROVEMENT						
Quality Management System *Executive Director of Nursing & Midwifery*						
Challenged Services *Relevant Executive Director*	Orthodontics	Vascular Stroke (2025)	Cancer Oncology	Dermatology (Plastics)	Urgent and Emergency Care	Ophthalmology

Note 1

AGENDA ITEM	APRIL (Q1)	JUNE (Q1)	AUGUST (Q2)	OCTOBER (Q3)	DECEMBER (Q3)	FEBRUARY (Q4)
QUALITY ASSURANCE						
Update on the Royal College of Psychiatry Action Plan *Lead for Mental Health*						
ROUTINE REPORTING						
Corporate Risk Register						
Internal Audit Reports (as and when required)						
ANNUAL REPORTING						
Committee Annual Report to Board						
Review Committee Terms of Reference						
Annual Quality Report • Duty of Candour • Putting Things Right (PTR)		Draft	Final			
Ombudsman Annual Letter						
Organ Donation						
Infection Prevention Control (IPC)						
Safeguarding			Possibly October			
Medicine Management (Controlled Drugs)						
Research and Development		2025				
Designated Educational Clinical Lead Officer (DECLO) *Executive Director of Allied Health Professionals & Health Science*						
FOR INFORMATION						
Any Clinical Policy (to be identified)						
NHS Wales – Joint Commissioning Committee Quality Committee Chairs Report						
Quality Delivery Chairs Assurance Report						
Summary of Business to be Reported from Private						
Review Committee Workplan						
Review Committee Cycle of Business						
CLOSING BUSINESS						
Agree Items for Referral to Board / Other Committees						
Meeting Effectiveness						
Date of the Next Meeting						
Resolution to Exclude the Press and Public						
PRIVATE AGENDA						
Confidential Quality Report						
BAF Appendix – for noting						

NB

Developing our Partnerships Ensure that a Llais experience paper is included on the QSE / PPHP CoB annually.	PPHP Committee 22.10.24	QSE Committee	PP24/74.1	LJ checked with Geoff Ryall-Harvey, GR-H confirmed the Llais Annual Report / Experience Paper will go to QSE & PPHP in April / May 2025 – LJ & FL to include on CoB / forward plans.

						12.2.25 added to FWP.
10	QS24/104.3		**QS24/104 Meeting Effectiveness** Ensure more time allocated to Primary Care on CoB, on a regular basis.	Exec. Dir. of Nursing & Midwifery (**Angela Wood**) Head of Corporate Affairs (**Philippa Peake-Jones**)	17.12.24	**16.10.24** CoB will be updated once further conversations have taken place with Executives. **12.2.25** This will take place as part of the annual review of CoBs.

LLAIS

Eich llais chi mewn iechyd a gofal | Your voice in health and social care

ANNUAL REPORT AND ACCOUNTS 2023-2024

Accessible formats

This document is also available in Welsh.

If you would like this publication in an alternative format and/or language, please contact us at enquiries@llaiscymru.org

You can download it from our website or ask for a copy by contacting our office.

CONTENTS

Overview

Performance report

Accountability

Finance

Prof. Medwin Hughes
Chair

Message from the Chair

Thank you for taking the time to read our Annual Report for 2023/2024.

The past year has been a period of significant transformation and growth for Llais as we established ourselves as the new independent body dedicated to reflecting the views and representing the interests of the people of Wales in their health and social care services.

The Board and I are immensely proud of the progress we have made as a new organisation. We are grateful for the unwavering commitment of our staff, volunteers, and partners.

Since our inception on April 1, 2023, we have focused on laying a strong foundation. Our initial efforts were directed towards listening – to the public, our stakeholders, and our own team. This foundational period allowed us to understand the needs and aspirations of the communities we serve.

Despite the complexities of setting up new systems and integrating new staff and volunteers, we have made significant strides in building a robust framework that supports our mission.

Throughout the year, we have engaged in numerous initiatives to amplify the voices of the Welsh people. From attending local and national events to launching a comprehensive multimedia marketing campaign, our efforts have been aimed at raising awareness about our independent role in improving health and social care services.

We have successfully established strong partnerships with NHS bodies, local authorities, and third-sector organisations, which have been instrumental in supporting our efforts.

We are dedicated to making Llais a well-run, trusted, and ambitious organisation. Our vision for the next 3 to 5 years will set ambitious goals to help make sure that health and social care services in Wales work best for everyone. We will continue to learn, adapt, and grow, always prioritising the needs and voices of the communities we serve.

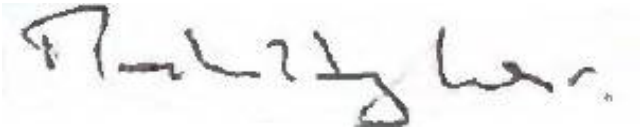
Looking ahead, our strategic plan for 2024–2027 will guide our efforts to drive a national conversation about the future of health and social care in Wales.

> *I extend my deepest gratitude to the people and communities across Wales for taking the time to share their views with us so their voices help shape health and social care services. My thanks also to our dedicated staff, volunteers, and partners for their unwavering commitment and support. Your contributions are vital to our success, and I look forward to continuing our collaborative efforts to improve health and social care services in Wales.*

This conversation will be inclusive and honest, addressing the challenges we face and building consensus around sustainable solutions.

As we move forward, I invite all of us who may need or use services, community representatives and groups and everyone involved in health and social care to join us in this transformative journey. Together, we can build a health and social care system that is not only fit for today but also equipped for tomorrow, truly belonging to the people of Wales.

Thank you for your commitment to the health and well-being of Wales. Let us move forward with resolve and optimism, ready to make a difference in the lives of everyone living in Wales.



Performance overview

This section provides an overview of our performance throughout the year in relation to our engagement activities, representations made to health and social care providers, including about changes in the way health and social care services are provided, service changes and our complaints advocacy service.

We knew that our plans for our first year were ambitious, and that we might not get everything done. We are really pleased to tell you that, thanks to the hard work and commitment of our staff and volunteers, the goals we set for Llais in **Our first 100 days report** and **Our Plan & Priorities: October 2023 – March 2024** have largely been achieved.

We are Llais (it means "voice" in Welsh)

LLAIS
Eich llais mewn iechyd a gofal cymdeithasol | Your voice in health and social care

We are a Welsh Government sponsored public body. This means we get our funding from the Welsh Government, but we are operationally independent, so we get to choose what we work on, how we work, and who we work with.

We were set up in April 2023 and we have about 102 staff, operating in every corner of Wales.

The way we work

We're aiming to set the standard, listen carefully, and team up with others to make sure we get the job done well. Our values, what's important to us, helps us to do this. Our values are:

People–driven

We put the needs and experiences of people at the centre of decision–making.

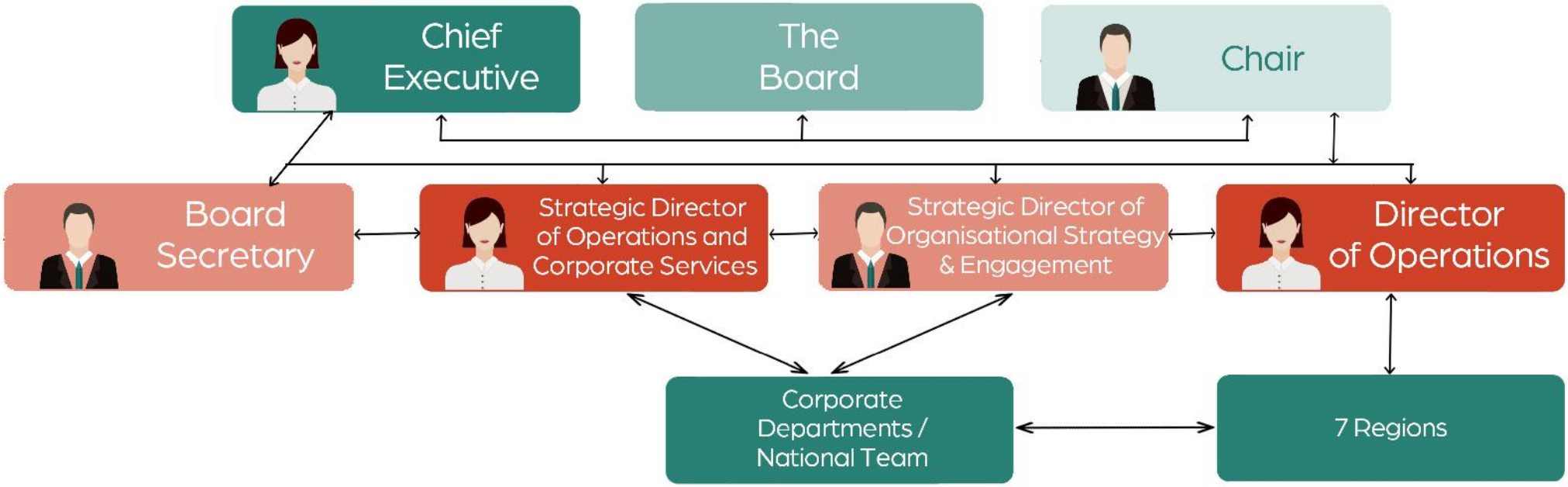
Working together

We are inclusive and accessible. We work as one team with shared goals, both within our organisation and externally.

Integrity

We are independent, honest, accountable and transparent about our work.

We organise ourselves into 7 regions across Wales, and our organisational structure can be seen below:



Our corporate services teams and strategy, communication and insights teams support our regional teams to deliver our work.

Our Board sets our strategic direction. It makes sure we are on track to do what we said we would do – in ways that best meet people's needs.

Tîm Arwain is our senior leadership team. All Directors are part of this leadership team and they support our Accounting Officer, who is our Chief Executive, to run Llais in a way that meets our obligations in the legislation and guidance set out for public bodies.

Our first year has been about listening, learning and working with others to understand what you want and need from your health and social care services. We set out our plans for our first year in our **100-day plan** and Our Plans and Priorities (Oct 2023 -March 2024). The outcomes we were aiming for were:

01. Listen and represent your views and experiences to decision makers to make a difference.

02. Build awareness and understanding of who we are, what we do and how we make a difference.

03. Make it easy to connect with you and our partners, by being accessible and inclusive.

04. Speak up to help keep people safe when things aren't right.

05. Build a strong voice in social care.

06. Develop our people, attract new people and support their involvement in our work.

07. Be a well-run, trusted and ambitious organisation.

We had a lot to do to make sure we got the basics right to help us support you, form new partnerships, and to be an independently run organisation.

Our Vision

We believe in a healthier Wales. A health and social care system where people get the services they need in a way that works best for them and is ready for whatever the future holds.

Our Mission

We make it our mission to listen carefully, locally, regionally and nationally, and to increase the impact of people's voices in shaping services.

We work together with the people of Wales to give you a stronger voice, and represent your interests, when it comes to health and social care. **We do this by:**

These are our core activities, and we base our key performance indicators on these four areas as well as how we are doing in meeting our strategic priorities and objectives.

Alyson Thomas,
Chief Executive

Statement from the Chief Executive on our performance

This first year has been all about growth and change as we set up Llais to be the independent voice for the people of Wales in health and social care.

Starting on April 1, 2023, we faced the big task of building a new standalone organisation at a really challenging time for everyone. Our first job was to listen carefully – to you the people and communities of Wales, our partners, and our teams. This listening phase helped us understand what people really need and want from health and social care services, and from us.

We focused on getting everything set up. We put new systems in place, brought in a fantastic team of new staff and volunteers, and found new ways of working. This work was crucial to setting a strong foundation for making a real impact on health and social care services in Wales.

We've made great progress in lots of important areas:

Engagement

We tried new ways of engaging with people. Working locally to understand your needs, building regional understanding and using this to help shape national policies.

Representations

We have used our new legal powers of representation responsibly so that decision makers listen and act upon what we have heard. This has led to some small and some big changes.

Complaints advocacy

We've worked hard to develop our service and make sure your experiences and needs are front and centre in health and social care. Our efforts have led to positive changes in individuals lives and have tackled important issues affecting our communities.

Raising awareness and understanding of our services

We have spread the word about what we do with lots of different communities so that when people want to speak to us, they know where to go.

Building relationships

We formed strong partnerships with NHS bodies, local authorities, third-sector organisations and community groups. These partnerships have been vital in making sure we hear and act on what you need in your communities.

Developing our values and standards of behaviour

We used what we had heard from members of the public, our partners and our people to develop our organisational values, and to start work on developing a new behaviour framework.

We haven't performed as well as we would have liked in a couple of areas and will focus on getting better in these areas next year. We know for example that there is more work to be done in social care. The economic situation means our Local Authorities are working to do more when things cost more and this will have an impact on services. We need more people to talk to us about their social care services and we need to be better connected to the 'system'. We also need to be better at making sure people know who we are and what services we provide so we will get better at spreading this message.

We still have a way to go in setting up our organisation. We will continue to update our policies, procedures and governance arrangements, such as our Board Assurance and committee arrangements, so they support us to do things in the best way possible.

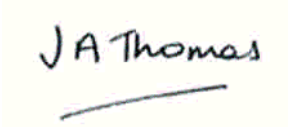
I want to thank our dedicated staff, volunteers, and partners. It's because of you that Llais has started to become a trusted organisation.

We will also continue to work on our organisational culture, our people's development and our recruitment and induction processes, all with the intention of making Llais a great place to work. Setting up Llais has been a learning experience. We've faced and overcome many challenges, from building new systems to understanding the complex world of health and social care. These challenges have taught us valuable lessons and helped us shape how we work. We are committed to continually learning and adapting to better serve the people of Wales.

While this report is about looking back at what we've achieved, it's also about looking forward. We will build on the strong foundation we've created, and our annual plan for 2024/2025 sets out the steps we need to take to achieve the aims we have set out in our new 3 year strategic plan, A National Conversation. Our plans for the next 3 years will be to:

1. **Drive a national conversation about the future of health and social care services.**
2. **Push for services that meet everyone's needs.**
3. **Work together better.**
4. **Help people and services to use technology in ways that work for them.**
5. **Grow and improve as an organisation.**

Thank you for your support and commitment to the health and well-being of Wales. Together, we will keep working hard to make a positive difference in the lives of everyone in our country.



Performance analysis

We have made a good start in building awareness and understanding of who we are, what we do and how we make a difference. Our first 100 days listening to people, communities and partner bodies informed our priorities for the rest of the year.

We set ourselves an ambitious amount to do in our first year. We were happy with our performance, we did a lot of things as planned, but we also needed to roll some things over into our 2024/2025 annual plan.

Overall, we believe our performance was good in most areas. We have identified that we are under recording our representations and this is an area we want to get better at next year.

In our first year, 26,726 people have engaged with Llais.

Our **518 engagement activities** and **71 on-site health and social care premises visits** have successfully led to us building relationships and gaining valuable insights into people's experiences of health and social care in Wales.

We have shared what we've heard in the **159 representations** made to decision makers, including health boards and local authorities, and we will keep a close eye on how this makes a difference for people as services respond.

Through **Llais representation at 234 formal meetings/networks** we have helped make sure that people's voices were considered by a broad range of organisations across the country. This is the area of representations we need to be better at recording.

We have been involved in **143 service changes and 17 national consultations**, feeding in what the communities of Wales are saying to help shape their services.

We have helped people to raise **1,510 formal complaints**, helping to put things right for them and, in some cases, influencing changes to services in the future.

Key organisational risks

Risks to our performance have been closely monitored through new arrangements.

We have identified several key risk themes and have sought to reduce those risks in the following ways:

Setting up a new organisation

means doing things in new and different ways. This takes time and resources to support our people to be equipped with the right tools and to understand, adapt and be confident to start using those new ways of doing things.

This poses several performance risks such as an initial drop in productivity due to learning, resistance to change, significant resource allocation for training and support and impact on our people in adopting new ways of working.

We have mitigated this through a change programme that is balanced and proportionate. Regular communication and engagement of our people in the changes, and new opportunities for learning and development are also important elements of our approach.

With our remit now covering social care as well as health

we have also needed to build new relationships and learn new areas of work. We took a careful and considered approach, avoiding potential delays and inefficiencies which could have been caused by stretching our resources and diverting some focus from existing responsibilities.

This is especially important for our complaints advocacy service that has needed to build a collective understanding of where and when we can support people to raise concerns and the types of involvement we can have.

Failure to mitigate risks in the complaints advocacy service could have led to inconsistencies in support, miscommunication, uneven service quality, and slower response times, all of which could have undermined effectiveness and credibility during the transition.

To avoid this, we introduced a new role of Head of Advocacy Profession to lead and co-ordinate the continued development of our complaints advocacy service and bring together our teams across Wales to share ideas and experiences.

Potential demand for Llais service and support

via our complaints advocacy service. As we made efforts to promote our services across health and social care in a more impactful and sustainable way there was a risk that the demand for complaints advocacy support would increase beyond our capacity.

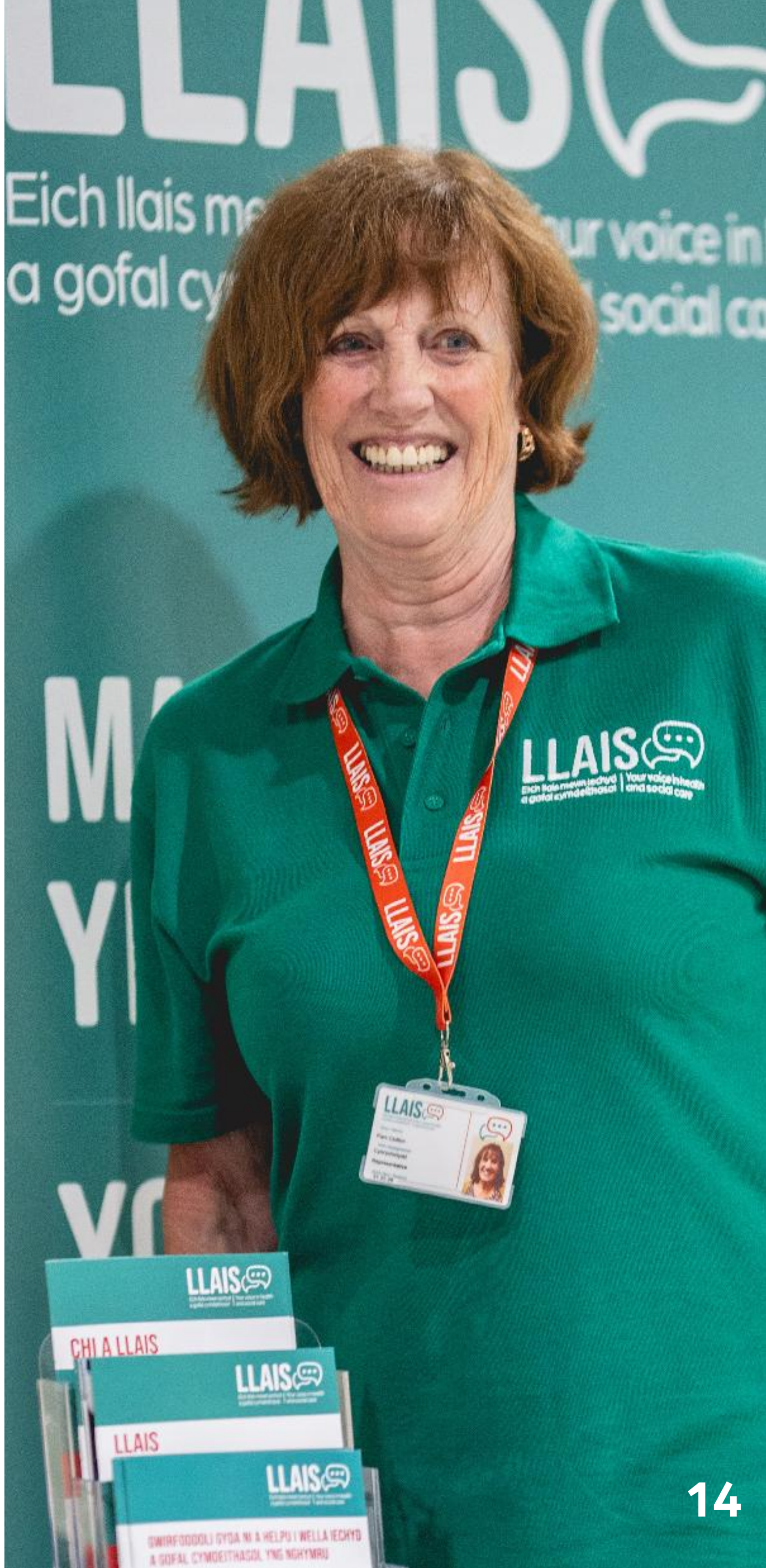
This was mitigated by working in a cross regional way, balancing all-Wales demand and capacity.

Securing volunteers to increase our capacity to engage

We have 151 volunteers signed up and are actively seeking to recruit more. If not enough volunteers were recruited and retained, or if the ones recruited weren't adequately trained or engaged, we might have struggled to meet our engagement goals.

This was a particular risk in our first year as previous Community Health Council members transferred to become Llais volunteers and may not have felt able to continue due to new ways of working, new remit, or personal reasons.

This was mitigated through a series of actions including supporting existing volunteers in understanding our new ways of working, including them in the future direction of Llais, and efforts to recruit new volunteers.



People and skills

Potential impacts on our ability to engage with communities due to inconsistencies, misalignments and knowledge gaps around engagement.

Towards the end of the year, in late February 2024 we recruited a Head of Insights and Engagement whose focus has been on developing an Insights and Engagement framework and accompanying engagement toolkit to support our teams to engage with communities in ways that work for them.

A learning and development programme is currently being created to provide our teams with the necessary skills to ensure that our engagement activities are appropriate, effective, outcome-focused and culturally sensitive.

The risk that people and communities do not understand our role and how we can support them may result in complaints and reputational damage as we may be seen to be unhelpful or refusing to act on people's behalf, even though to do so would be acting outside our remit.

These risks were mitigated by lots of communication of our role and remit, and the impact we are having for people. We did this by producing information in a range of ways and languages, and supporting our stakeholders to promote our services themselves.

There is a lot to cover across health and social care. People have highlighted lots of good things and lots of areas that need to be improved. We have had to manage expectations and communicate the types of work we can get involved with. We have looked to prioritise our work based on where we can have the most impact.

As this is our first year of operation, we have been developing and adapting processes for tracking and communicating our impact because we know this is important to people.

With oversight from the Strategic Director of Organisational Strategy and Engagement, the insights and engagement team have been refining the ways we capture and use what we are hearing and tracking the difference we are making to the health and social care system.

Overview of our performance against our strategic priorities and objectives 2023/2024

The following is a summary of how we did against our objectives for October 2023 to March 2024:

RAG stands for Red, Amber, Green. It is a traffic light system we use to show how well things went. Green is everything went well according to plan, Amber means things were okay but could have gone better, Red means there was a problem.

Achieved means we did what we set out to do during the year. It doesn't mean that there isn't further work to do. Partially achieved means that we didn't make as much progress during the year as we set out to do.

Priority 01	Objective	RAG	Status
Listen and represent your views and experiences to decision makers to make a difference.	Continue to represent your voices through our involvement with local, regional and national meetings, boards, committees and projects.		Achieved.
	Listen to your views on an ongoing and open basis at a local, regional and national basis by delivering a rolling programme of open engagement to find out what matters most about your health and social care.		Achieved.
	Respond on your behalf to new and emerging issues that we hear about.		Achieved.
	Create a new communications, insights and engagement team.		Partially achieved. All but 2 of the team were recruited by April 2024. 2 posts were going through the job evaluation process and were due to be advertised in 2024/2025.

Priority 02	Objective	RAG	Status
Build awareness and understanding of who we are, what we do and how we make a difference.	Design and run communications campaigns, locally, regionally and nationally to reach different groups on relevant issues and to promote our work more generally.		Achieved.
	Agree standards for our communication, engagement and digital media that reflect our people-centred approach and let people know how they have helped make a difference.		Partially achieved. National principles for engagement were adopted, communication and digital media standards were rolled over into 2024/2025 workplan.
	Develop new ways of engagement, communication and information sharing with our people and the people we work with.		Achieved.
	Create our communication and engagement strategy so everyone is clear where we want to get to and how we want to work.		Partially achieved. Engagement on the strategy took place throughout the year but completion of the strategy ran over into 2024/2025.
	Develop a network of engagement, communications and insights and learn and improve what we do by sharing good practice.		Achieved.

Priority 03	Objective	RAG	Status
Make it easy to connect with you and our partners, by being accessible and inclusive.	Create new approaches, tools and ways of engaging and communicating to learn as much as we can about how services work for you.		Achieved.
	Develop our strategic equality plan in a way that makes equity, diversity and inclusion run through everything we do.		Achieved.
	Get ready to work with a common set of standards so that people in all parts of Wales can work for and with us easily and consistently in the Welsh language.		Achieved.
	Improve our people's knowledge, understanding and confidence working with underrepresented communities.		Achieved.
	Make sure equity, diversity and inclusion is everyone's business. Provide support in each region and bring people together to share ideas and learning so that we think about, identify and act wherever we find barriers to equity, diversity and inclusion in all that we do.		Achieved.

Priority 03	Objective	RAG	Status
Make it easy to connect with you and our partners, by being accessible and inclusive.	Take steps to understand and increase the diversity of our people so we better reflect our diverse communities across Wales.		Partially achieved. System access to data has prevented a clear picture so this work will be completed in 2024/2025.
	Get better information and use it to understand the diversity and representation within local communities as a starting point for building and increasing our on-going connections with underrepresented groups – so we can help to make sure everyone's voice is heard by decision makers.		Partially achieved. Improvements have been made in this area but more work is required in 2024/2025 to link understanding with engagement and complaints advocacy in regional areas.
	Build an understanding of what we need to do more of, or differently, so that we build trust as an organisation that is anti-racist and where disabled people, LGBTQIA+, and people with different communication needs feel welcomed, comfortable and valued through their involvement in our work.		Achieved.

Priority 04	Objective	RAG	Status
Speak up to help keep people safe when things aren't right.	Use what we hear through our activities to understand how the new Duties of Candour and Quality are working to improve the care and experience of those needing health care.		Achieved.
	Develop how we use data and information to work together and with our partners in Wales and across the UK to identify, share and act on concerns about the safety of individuals and services.		Achieved.
	Develop the links between our complaints advocacy service, our other activities, our plans and reports and wider developments like the Duties of Candour and Quality.		Achieved.
	Agree new ways of working and partnership arrangements between our Complaints Advocacy Service and the Public Services Ombudsman Wales.		Partially achieved. New arrangements were developed. Final agreement completed in 2024/2025.
	Review and develop our complaints advocacy service and support our people to develop their practice.		Achieved.

Priority 05	Objective	RAG	Status
Build a strong voice in social care in Wales.	Improve our knowledge and understanding about social care in Wales.		Achieved.
	Build good relationships in social care: with service providers, service users, charities and other people and organisations who support people in social care such as carers and families.		Achieved.
	Create a series of engagement events designed to hear what matters most to you about your social services.		Partially achieved. More focused engagement needed in 2024/2025 as we mostly hear feedback about health.
	Promote our services, particularly our complaints advocacy service, with Local Authorities and service providers and support them to fulfil their duty to promote our services.		Partially achieved. More work is planned in 2024/2025 to support this objective such as including providing a wider range of resources to support the promotion of our services.

Priority 06	Objective	RAG	Status
Develop our people, attract new people and support their involvement in our work.	Create ways that help attract a more diverse range of people to work with us, learning and development that is right for the role they do for us, and we are clear about how they should go about their work.		Partially achieved. More work is planned in 2024/2025 to support this objective such as our learning and development strategy, our Workforce Strategy, our Strategic Equality Plan and our Welsh Language Plan.
	Develop our communications and ways of working with our people so they feel more connected, more informed, and they know what difference their contributions make to achieving our strategic aims.		Achieved.
Priority 07 **Be a well–run, trusted and ambitious organisation.**	Developing our people's knowledge, skills and understanding in good governance, managing public money and records management.		Achieved.
	Reviewing our governance arrangements against the highest standards and working on a plan to do things better where we need to.		Achieved.

Priority 07	Objective	RAG	Status
Be a well-run, trusted and ambitious organisation.	Looking at how we are carrying out our tasks and making changes to make it better for everyone where we need to.		Achieved.
	We will agree what values we believe in and use this to work on our: • organisational culture • behaviours framework • skills and capability framework • revised performance assessment approach • our national learning and development plan.		Partially achieved. Engagement had begun on: • behaviours framework • skills and capability framework • revised performance assessment approach • our national learning and development plan. The items will be completed in 2024/2025.
	Co-produce our strategic vision for the next 3 to 5 years.		Achieved.
	Develop more ways for our people to play an active role in the future of the organisation.		Achieved.
	We'll provide better opportunities for development and learning, more chances to suggest and be a part of new ways of working, and bring people together with similar interests to share ideas and experiences across Wales.		Complete and ongoing.

Engagement activities

During our first year we tested, learned, and developed different ways of doing things to find out what works best. We have listened to your views on an ongoing and open basis at a local, regional and national level by delivering a rolling programme of open engagement to find out what matters most about your health and social care.

We have undertaken **518 community engagement activities** across all regions in the past year, including hosting events and workshops, attending partner events, networks and forums, profile raising activities, information sharing and general promotion of Llais.

186 relating to health

36 relating to social care

269 relating to health and social care

We have had a presence at several national and regional events, including the Royal Welsh Show, Pride Cymru, National Eisteddfod and the Big Welsh Bite, giving us the opportunity to engage with up to 380,000 visitors.

Engagement impact #1

LGBTQIA+ Open door event

We co-hosted an open-door event with Swansea Bay University Health Board to launch their LGBTQIA+ strategy plan, sharing information on the strategy, information on Llais and getting to know the LGBTQIA+ community in the Neath Port Talbot and Swansea region.

The event gave those who came a chance to ask questions about the work both Llais and the Health Board are doing and we made some great new connections with representative organisations for future engagement.

Engagement impact #2

Vascular Services

Our team in North Wales have worked with Betsi Cadwaladr University Health Board to provide independent advice and support to the families affected by the identified failings of vascular services in North Wales.

At the launch event of the Vascular Harm Report, we took a facilitative approach to ensure that all voices were heard, offering advice and assistance for those who needed it in relation to the NHS Redress process. We advised on the next steps, offered the support of our complaints advocacy service and signposted to other relevant services.

The work of our North Wales team has been cited by Betsi Cadwaladr University Health Board as key drivers for improvements in vascular services in the region.

Llais Local

We piloted a new Llais Local approach to engagement in Powys. This involves spending concentrated periods of time in a range of local towns and neighbourhoods to hear what's important to the people who live there.

We worked with local clubs, charities, and health and social care services to make it easy for people to share their experiences.

One of the outcomes of the Llais Local pilot was that we saw a notable increase in referrals to our complaints advocacy service in those areas through the awareness-raising activities.

The pilot has been so successful we are replicating the approach across Wales going forward.

On–site health and social care engagement (visits)

Our staff and volunteers have been out and about visiting you wherever you're receiving your health or social care service to listen to your experiences.

This year we have made **71 on–site visits;**

56 to **healthcare premises**, **5** to **social care premises** and **10** to premises that cover **both health and social care.**

Representations

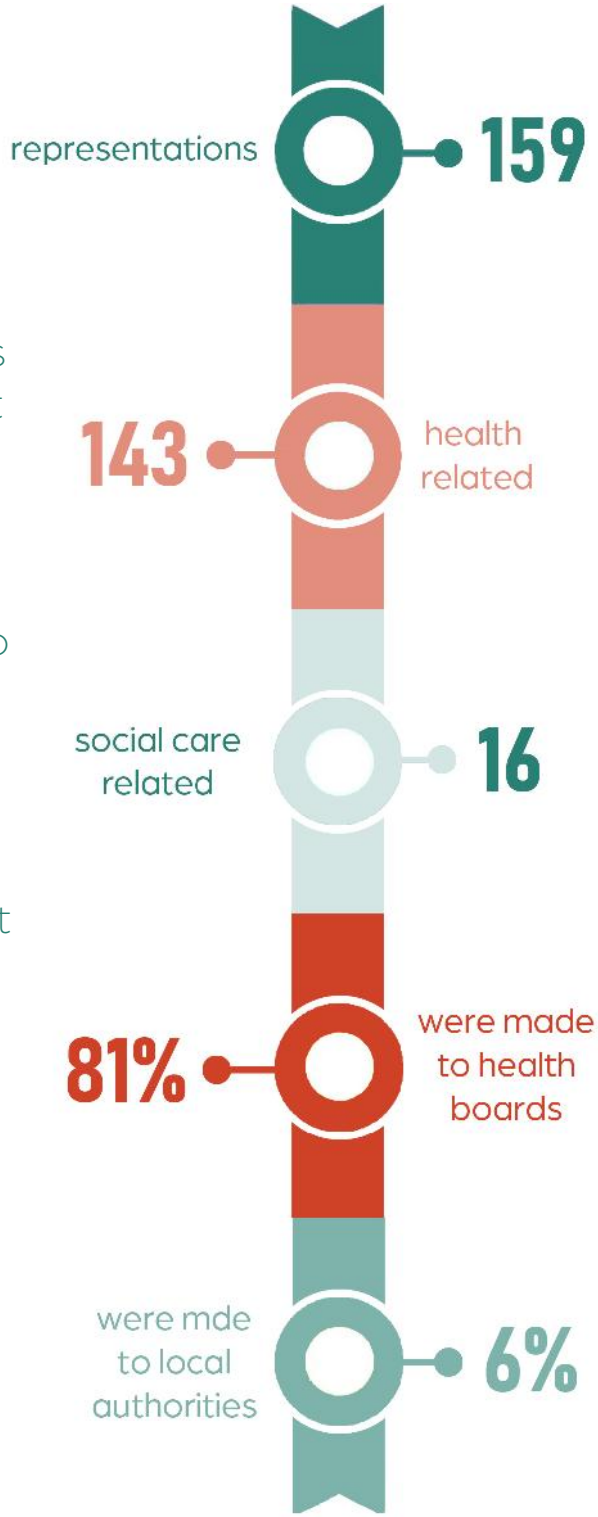
Across Wales we have attended 234 activities.

181 relating to Health, 22 relating to Social Care and 31 relating to both Health and Social Care.

Throughout the year we have listened and represented your views and experiences to decision makers to make a difference.

The overall purpose of these representations is to support the process of co-development of health and social care services by amplifying and reinforcing your voice to decision makers.

We have kept track of 159 representations to NHS bodies and local authorities, and those acting on their behalf or working jointly e.g. regional partnership boards regarding the provision of health or social care services.



Half of the representations were made by email, with letters being the second most frequent method of communication. Less than a quarter of representations were made in formal meetings. 143 were relating to health and 16 were relating to social care.

Most of our representations were made to health boards (81%) with only 6% made to local authorities and the remainder made to a mix of private practices and health-related organisations.

We know we need to do more to make sure we keep a full record of the representations we make to health and social care bodies so we can keep track and let people know the difference it makes.

Representation Impact #1

BSL interpretation service

We were contacted by a British Sign Language (BSL) interpretation service with concerns that a hospital was not booking interpretation services for patients on weekends. The hospital had advised the BSL interpretation service that "no therapies take place over the weekend" so they did not provide cover.

The BSL interpretation service was concerned not only for the person they were supporting, but for other patients who may need to access BSL services at weekends.

We got in touch with the local health board about the person who needed support at their weekend appointment and the concerns around the hospital not providing BSL interpretation services more broadly at weekends.

As a result, the person was given the BSL interpretation they needed. All nursing staff were reminded that they must act on the requests of any person who has raised language needs as part of their requirements to access and attend appointments and receive the healthcare they need.

Representation Impact #2

Digital exclusion

We made a representation to a health board about their surveys for people registered in 2 GP surgeries. We asked the health board to provide paper copies of the surveys so that people who aren't on-line could get involved.

The health board changed their approach so that people registered with the GP surgeries could get the information in paper form as well as digitally. It also offered support to anyone who needed further help to get involved and share their views.

Representation Impact #3

Outpatient appointments

We were told about a person who had difficulties attending outpatient appointments. Their appointments had been redirected from their closest hospital to a different hospital further away. The 2 hospitals were run by different local health boards.

We made a representation to the health board who talked things through with their neighbouring health board so that the patient could continue to receive their appointments closer to home.

We are continuing to work with the health board to make sure this kind of problem isn't more widespread.

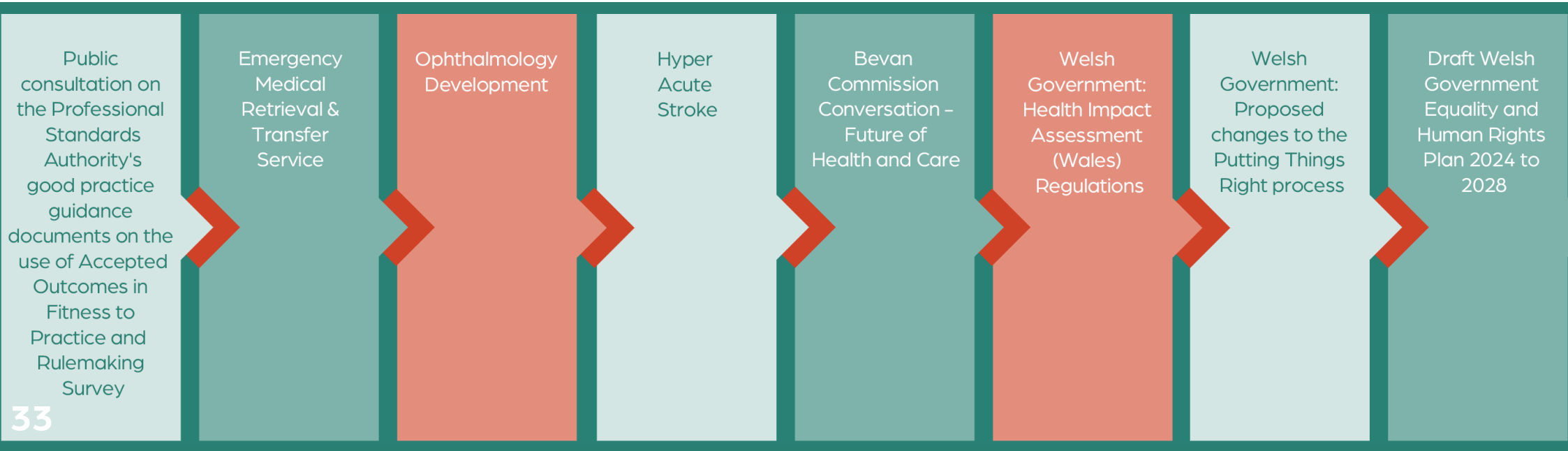
Consultations and service change

Open consultations include Llais' involvement when health and social care bodies want to make changes in the way services are provided. This may be called a service reorganisation, reconfiguration, redesign, variation, improvement, or expansion.

When changes to services are proposed, the NHS and local authorities must involve people when they plan, develop, and design services from the start so that they can understand peoples' existing and future needs. Our role is to help make sure they gather the views of people who may be affected and then think about and respond to what they say.

We also share what we hear with policy makers and others when they want to get feedback or views on the things they are thinking about or proposing to do about health and social care services in Wales. This may be by responding to public consultations or providing evidence to inquiries that cover aspects of health and social care services.

Across Wales we were involved in **143 open consultations** this year. We also made **17 responses to national consultations,** or calls for evidence. These included:



Service Change Impact #1

Emergency Medical Retrieval and Transfer Service (EMRTS) Review

We know how much the changes to the Emergency Medical Retrieval and Transfer Service (EMRTS) mean to many of us, especially those in rural areas of Wales. We have heard how deeply people care about the emergency services they and their loved ones can get when they need it and that for a lot of people making sure that any changes to the ways the service is provided does not mess with the quality or speed of help in their area is important to them.

That's why we've been meeting with those responsible for organising the service, sharing public feedback and encouraging them to not only engage with the public, but to listen and respond to what people say. Whenever we've seen room for improvement, we've spoken up, pushing for changes to be made.

Our involvement in the plans for this service are continuing into 2024/2025.

You can also **watch this video** about the impact of our involvement in a proposed service change in West Wales.

How we have used what we heard

Our work is driven by what we hear about what matters most to people living in Wales about their health and social care services, and what is expected of us. We do this by working with and listening to individuals and community representatives and groups.

We used what we heard to develop:

- our vision, mission and purpose
- our values, behaviours and ways of working
- our organisational strategy, which sets out our longer term aims – A National Conversation: Llais Strategic Plan 2024–2027

Things we still need to work on...

We still have work to do to improve our knowledge and understanding about social care in Wales, and to build good relationships with service providers, service users, charities and other people and organisations who support people in social care such as carers and families.

We are in the final stages of agreeing standards for our communication, engagement and digital media that reflect our people-centred approach and let people know how they have helped make a difference.

Our complaints advocacy service

In the past year our complaints advocacy teams have provided free, independent and confidential advocacy services to people across Wales to help them raise concerns or make a complaint about the health or social services they or someone they care for has received.

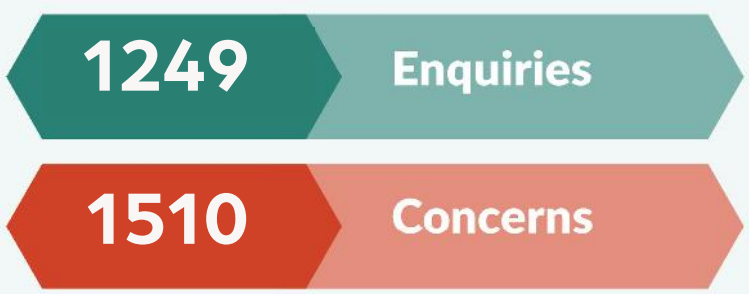
We have also signposted people to other organisations if we think that someone else can also help answer questions about health and/or social services.

People often wanted guidance on administrative processes, such as how to make formal complaints, access medical records, or navigate health and care systems. Providing information and guidance like this was a key part of the support we offered through our enquiries service.

Some people we supported experienced difficulties with communication, such as getting through to the right department or making appointments. We advised them on the next steps to take, like contacting specific departments or using online resources. In many cases we were able to help people without the need for them to go through a formal complaint process, by providing information or by picking up the concern directly with the people involved, e.g. contacting a GP, making an appointment, or resolving administrative issues.

In total our complaints advocacy service has been contacted by 2,759 people. We have supported 1,249 people with their enquiries and helped people to take forward 1,510 concerns or complaints.

This was the first year our complaints advocates have supported people with social services complaints.



Around 15% of the complaints we supported related to social services. Whilst we know that the level of social services complaints is much lower than in health, we think more needs to be done to promote the ways in which people can make a complaint and to promote our services. We will work with local authorities and regulators to improve this next year.

Complaints advocacy

Region	Enquiry	Support Provided	Total
Cardiff & Vale	276	105	381
Cwm Taf Morgannwg	233	108	341
Gwent	97	322	419
Neath Port Talbot & Swansea	86	248	334
North Wales	332	293	625
Powys	52	100	152
West Wales	173	334	507
Total	**1249**	**1510**	**2759**

Most of the complaints we supported were about GPs, dental services and waiting for treatment. We have also supported people with complaints about mental health services and services supporting or assessing learning disabilities.

Some of the most common things people wanted support to raise concerns about were long delays in getting seen, poor communication or not feeling the care people received was good enough.

You can find out more about our complaints advocacy service in this guide: **Llais Advocacy Guide** or by **watching this video.**

Advocacy Case Study

An incident occurred in local authority protected accommodation involving a young person who was taken to hospital following an overdose of medication.

The parents of the young person initially complained to the care establishment about the supervision and management of their child in that care environment. They weren't satisfied with the response they received.

They contacted our service for further advice and support.

We provided support to raise the continued concerns to the local authority responsible for placing the young person with that care provider.

We supported the parents through the Independent Stage 2 Investigation under the social services complaints process. Most of the concerns the parents were unhappy about were upheld by the independent investigation.

Our service supported the parents to meet with the local authority and the care provider to talk about the way forward. As a result, an action plan has been put in place for the future care of the young person, and this is being monitored to make sure it is working well.

Communication and promotion of our services

As a new organisation in our first year we needed to create a new communication, insights and engagement team. Most of our newly recruited team joined us towards the end of the financial year in 2024.

During our first year we have focused on promoting public awareness of our functions and objectives so people know who we are, what we do and how to reach us. Our efforts were focused on achieving these goals through a series of targeted promotional activities. These included advertising campaigns along key transport routes such as motorways and railway routes, and a multi-media campaign aimed at increasing brand awareness.

Special focus was placed on reaching underrepresented groups to promote Llais' volunteer opportunities, in line with the communication needs identified in Our Plans and Priorities October 2023–March 2024.

We also produced a range of bilingual promotional videos, posters, infographics, animations, information booklets, radio adverts, newspaper articles (online and print) and social media toolkits to help people and organisations understand and engage with our service.

These have been shared locally and regionally with other health and social care organisations and nationally through our website and YouTube Channel.

Developing our website

In our first year, our focus has been on improving awareness and understanding of what we do and ensuring that our website serves as an effective communication tool to support this.

Our new website (www.llaiswales.org) is central to our strategy, providing essential information and a primary means for people to engage with us. Recognising its importance, we have prioritised the development of its design, content, and accessibility to ensure it meets the needs of our diverse audience. We did this in a range of ways including 2 accessibility audits and improvement plans.

Since 14 February 2024, we have been analysing website traffic to gain insights into how people use the site. With around 3,900 visitors between 14 February and 31 March 2024, this data has provided an important way for us to understand how people use the website so we can improve our online presence. Our goal is to keep improving the website, making it more engaging and easier to use.

The website also plays a key role in interacting with people, as shown by the 299 inquiries made through the site during this short period (14 February to 31 March 2024). Moving forward, we will continue to develop our website and monitor its use, so it remains a valuable resource for the public and a strong tool for engagement.

Using social media to reach and engage with communities

Starting from zero followers, we have focused efforts on increasing our social media presence as it plays such an important role in making more people aware of Llais and helping them understand what we do.

Social media is a powerful tool for us because it lets us reach a wide audience, engage directly with people and communities, and quickly share important information.

We now have 2,265 followers on our social media platforms, with an average engagement rate (the percentage of people who interact with our content) of 5.35%. This is a good engagement rate for a public body.

In our first year, our reach (how many people see our posts) and engagement (how many people can see our posts) achieved 1,978,294 users, increasing the chances of more people becoming aware of Llais.

LinkedIn has the highest engagement rate, making it a good platform for connecting with professionals and organisations. By engaging with stakeholders on LinkedIn, we've been able to spread our message further through their networks, making it an important channel for promoting our services.

Facebook is our most effective platform in terms of reach and followers, partly because our 7 regional offices each have their own Facebook pages. This allows them to share local updates and events that matter most to people in their area. This local focus keeps us connected with communities across Wales and makes sure our messages are relevant to each region.

Instagram is especially good for us in reaching younger audiences with visual content. It has the second-highest reach and engagement levels, and we plan to build on this to create more dynamic content on Instagram in the coming year to boost interaction and visibility and complement our children and young people's programme.

As we continue to grow our social media presence in line with our communication strategy, our focus will be on using these platforms to connect with communities, share valuable information, and encourage people to take part in our work. This approach will help make sure we stay visible, relevant, and responsive to the needs of our communities.

We have an average engagement rate across all platforms of 5.35%.

Media Activity

There were 26 pieces of media coverage

8 **Online**

Broadcast **4**

14 **In print**

Media activity

In April 2023, we launched Llais with a targeted awareness campaign, managed by an external agency. This campaign resulted in 26 media mentions across online, broadcast, and print channels, helping us introduce Llais to a broad audience.

Since then, we've taken an active role in media discussions about important health and social care issues, like the challenges facing Betsi Cadwaladr University Health Board and proposals to change the way the Emergency Medical Retrieval and Transfer Service operates. We've also provided commentary on the junior doctor strikes for BBC Radio Wales and BBC Radio Cymru, establishing Llais as a trusted voice in these areas.

From April 2023 to March 2024, Llais was mentioned in 192 news stories, with a potential reach of over 1 billion (the number of times a story could have been viewed by someone). This coverage included 113 online articles, 78 in print, and one magazine feature.

Being proactive in public relations has been key to increasing awareness of Llais and what we do. By consistently providing timely and relevant information, and making sure our messaging is clear and coordinated, we're steadily building our presence and influence in the public conversation.

192 items of news coverage that mentioned Llais with a potential post reach of 1,095,526,905

Our commitment to the Welsh language

We are dedicated to promoting and supporting the Welsh language in everything we do. As we prepared to meet the requirements set out in our Welsh Language Standards from April 2024, (as set out in our **compliance notice**), we've made sure that our communications are fully bilingual and accessible to Welsh speakers across Wales. Over the past year, we've worked hard to integrate the Welsh language into our communication efforts. This means that all our website content is available in both Welsh and English, with equal care given to both languages in all our promotional materials.

To further support our commitment to the Welsh language, we created and started to implement a Welsh Language Standards Action Plan. This plan outlines how we will meet the requirements of our compliance notice and shows our commitment to encouraging and supporting an environment where our people can feel comfortable and confident to use Welsh internally and when working in our communities and with our partners.

We've done some specific things like:

- Providing all external communications, both digital and printed, in both Welsh and English and providing more information internally in both Welsh and English.
- Holding bilingual public board meetings, and publishing all our Board papers in Welsh and English.
- Actively promoting the use of Welsh in our services and internal communications.
- Recruiting more Welsh speaking staff.
- Sharing good practices across our team to emphasise a "Welsh first" approach in developing our communications.

Our preparations for the introduction of the Welsh Language Standards are part of a larger commitment to the Welsh language and its use in health and social care services and we will be looking to develop more projects that explore this next year.

Digital initiatives and improvements

To better serve people and communities across Wales, we developed a new Customer Relationship Management (CRM) system in collaboration with a third-party developer. This system brings all our functions together, making it easier for us to manage data, track our impact, and identify trends in health and social care.

By doing so, we can work more efficiently and effectively, especially in areas like complaints advocacy. We can make quicker and better connections across the different areas of our activity, so that we can be more effectively addressing broader systemic issues and influence national policies.

Our move to SharePoint has been another important step forward. This digital tool has helped us to streamline how we manage documents and work effectively together across our teams. By standardising the way we work and share information, we can make sure that no matter where people engage with us, they receive a consistent and high-quality service.

This not only makes our work easier and better governed, but also directly benefits the people we serve by improving our responsiveness and efficiency.

Additionally, SharePoint will be our internal intranet, which will improve our communication within our teams across all areas of Wales. We have been working on making it a tool that provides a central hub where all our people can access important updates, resources, and tools, helping us to have more connected and informed teams across all regions.

This helps us to make sure that everyone at Llais is aligned and able to work together effectively, no matter where they are located. We will be launching the intranet in 2024.

Sustainability

We've designed our organisation to be easily accessible to people. This helps us reach more people in their communities, making our services more convenient and reducing our environmental impact.

We are committed to reducing the environmental, financial, and social impacts of our work. To support this, we're aligning with broader public sector efforts, like the NHS Shared Services Partnership Sustainable Procurement policies.

Even though we're not required to join the Welsh Government Net Zero Scheme, we've decided to participate starting in 2024/2025. We plan to start reporting our progress on Net Zero by September 2025.

This year, we've updated or reinforced the principles set out in several key policies, such as our travel and subsistence and agile working policies. These encourage using the most economical and sustainable travel options and finding ways to do business that have less impact on the environment.

By focusing on sustainability in our daily operations and joining these larger initiatives, we're helping to create a more sustainable future while ensuring our services remain accessible and effective for everyone in Wales.

Our future plans and strategic priorities

Strategic goals for 2024/2025

We will build on the foundations and learning from our first year, while continuing to focus on key strategic goals designed to enhance the health and social care landscape across Wales at a local, regional and national level. Our overarching priorities and objectives include:

1. Driving a national conversation about the future of health and social care services: We will involve people from all over Wales in discussions about the future of health and social care. By making sure policymakers and service providers listen to public feedback, we can help shape a system that better serves everyone.
2. Push for services that meet everyone's needs: We are committed to ensuring that health and social care services are not only effective but also inclusive and accessible. We will focus on making sure these services are designed with the needs of all groups in mind.
3. Working together better: We will work to build stronger partnerships across different sectors, making sure health and social care services try to work together more smoothly and effectively to improve how services are delivered.
4. Help people and services to use technology in ways that work for them: We want to help people and services talk to each other so everyone feels okay about new tools and technologies, everyone can use them if they want to, and no one feels left behind.
5. Growing and improving as an organisation: This includes adopting new IT systems, improving our communication strategies, and fostering a workplace that values continuous learning and development.

Upcoming projects and initiatives

Here's a preview of some of our important projects and initiatives that are planned under each strategic priority:

1. Drive a national conversation about the future of health and social care services:

- Llais local expansion: We will bring Llais Local to more towns across Wales, engaging with local communities to hear their views on health and social care.
- Collaboration with the Bevan Commission: Partnering with the Bevan Commission to explore innovative solutions to the challenges facing health and social care services.
- Review of the Duties of Candour and Quality: Assessing the implementation of these new standards in Wales and providing feedback to NHS Wales.

2. Push for services that meet everyone's needs:

- Community-focused research: Conducting detailed studies on the top health and social care concerns identified in different regions, such as access to doctors and dentists, or support for carers.
- Strategic Equality Plan implementation: Advancing our commitment to equity, diversity, and inclusion by embedding these principles into all areas of our work.
- Expansion of our complaints advocacy service: Streamlining our complaints advocacy service to better support individuals across Wales.

3. Working together better:

- Launch of a Rural Programme: Addressing the unique health and social care challenges in rural areas through targeted initiatives.
- Hosting a complaints summit: Bringing together key stakeholders to discuss and learn from public complaints, driving improvements in service delivery.
- Increasing stakeholder engagement: Strengthening our partnerships with organisations like Social Care Wales and Health Education Improvement Wales.

4. Help people and services to use technology in ways that work for them:

- Representation on the NHS Wales App development: Ensuring that user needs are central to the design and functionality of the new NHS Wales App.
- Promoting Digital Inclusion: Advocating for developments that help everyone, regardless of their digital literacy, to use health and social care technologies confidently.
- Collaboration on Digital Strategies: Working with partners like Digital Health and Care Wales to shape digital strategies that benefit all users.

5. Grow and improve as an organisation:

- Further developing the use of our Customer Relationship Management (CRM) System: Working on how we have introduced and used our new IT systems to improve our efficiency and impact.
- Development of a Volunteer Strategy: Creating more opportunities for volunteering within Llais, enhancing our community outreach and impact.
- Refinement of Communication and PR Strategies: Launching new campaigns to better communicate our work and engage with the public.

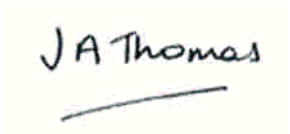
Finance review

Our 2023/2024 financial plan was based on both the ongoing and the additional responsibilities and resources we needed in our first year of operation. This included Welsh Government additional investment, including significantly increasing the funded staff establishment over transfer baseline.

Regular finance reporting to our Board highlighted any important in-year financial issues. These included delays in hiring new staff, using unspent money to temporarily cover 2023/2024 Agenda For Change staff pay rises, and funding one-off projects.

Our outturn financial performance for 2023/2024 equated to a revenue underspend of £156k.

	Revenue	**Notional 6.3% Pension Contribution**	**Total Revenue**
	£m	£m	£m
Revenue Resource Allocation	7.131	0.195	7.326
Revenue Expenditure	6.974	0.195	7.170
Surplus/ (Deficit)	**0.156**	**–**	**0.156**



Alyson Thomas
18 December 2024

03. Corporate governance report

Statement of Accounting Officer's responsibilities

As required by the Health and Social Care (Quality and Engagement) (Wales) Act 2020, I, as Accounting Officer, have prepared, for each financial year, an annual report and statement of accounts in the form and on the basis set out in the Accounts Directions issued by HM Treasury and Welsh Ministers. These documents are fair, balanced and understandable.

The accounts are prepared so as to give a true and fair view of the state of affairs as at the year-end and of the net expenditure, financial position, cash flows and changes in taxpayers' equity for the financial year then ended. The annual report is fair, balanced and understandable.

In preparing the accounts, I am required to comply with the requirements of the Government Financial Reporting Manual and in particular:

01. Observe the Accounts Directions, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis.

02. Make judgements and estimates on a reasonable basis.

03. State whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed, and disclose and explain any material departures in the accounts.

04. Prepare the accounts on a going concern basis.

05. Confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

I have been appointed by the Director General, Health and Social Services Group, Welsh Government, as Accounting Officer of Llais with effect from 1 April 2023.

The responsibilities of an Accounting Officer include responsibility for the propriety and regularity of the public finances for which the Accounting Officer is answerable, for keeping proper records, and for Llais' assets as set out in the memorandum – 'Managing Public Money' – published by HM Treasury, and 'Managing Welsh Public Money', published by the Welsh Government.

As the Accounting Officer, I have taken all steps that I should to make myself aware of any relevant audit information and to establish that Audit Wales' auditors are aware of this information. So far as I am aware, there is no relevant audit information of which the auditors are unaware.

J A Thomas

Alyson Thomas,
Chief Executive,
Accounting Officer, Llais
18 December 2024

Directors' report History and statutory background:

The Citizen Voice Body for Health and Social Care, Wales, known by its operating name **Llais** is a national, independent body set up by the Welsh Government to give the people of Wales a stronger voice in their health and social care services. Llais became fully operational on the 1 April 2023 and replaced former Community Health Councils across Wales, which ended when Llais was established under the Health and Social Care (Quality and Engagement) (Wales) Act 2020.

Chief Executive and Accounting Officer

The Chief Executive and Accounting Officer for the financial year 2023/2024 was Alyson Thomas.

Chair of Llais

The Chair of Llais for the financial year 2023/2024 was Professor Medwin Hughes CBE DL.

Members serving during 1 April 2023 to 31 March 2024 are outlined in the Board membership and attendance table on page 59.

Our Board and Committees

Our Chair and 9 Board members are responsible for providing us with leadership and direction. Our Board comprises a Chair, Deputy Chair, 6 other non-executive members and the Chief Executive. All these positions can vote on Board decisions. Our Board has 1 associate non-executive member, who can not vote.

Our Board works closely with the Chief Executive and our senior leadership team, known as Tîm Arwain, to set our strategic direction through the approval of a 3 year strategic plan and annual plan, allocates our resources, and monitors our performance. Our work is scrutinised, guided, and approved by the Board and its committees.

Declarations of interest of Board members:

Members' interests:

Details of company directorships and other significant interests held by members of the Board or close relatives which may conflict with their responsibilities are maintained and updated on a regular basis. The document, which can be accessed in the link below, shows details of directorships of other organisations or other interests that have been declared by the members of the Board of Llais in line with our Standards of Business Conduct and Declarations of Interest Policy.

Declarations of Interest 2023/2024

Committees of the Board

The Board has established 2 committees, which are the Audit and Risk Assurance Committee, and the Remuneration and Terms of Service Committee.

These committees provide detailed scrutiny, insight, information, and advice to the Board. The committees comprise non-executive members of the Board and are supported and advised by officers and other internal and external advisers.

The Board has also appointed to the Audit and Risk Assurance Committee two additional independent members to provide further input from the perspectives of particularly finance, cyber and information technology (IT).

Llais Board – roles and responsibilities include:

01 Makes decisions on those matters reserved for the Board and agrees the overall governance arrangements for the organisation.

02 Demonstrates high standards of organisational governance – agreeing Standing Orders and other required governance documentation and committee terms of reference.

03 Provides leadership and direction by setting our strategic direction, agreeing a three-year strategic plan and associated annual plans.

04 Scrutinises resources and performance – through finance and performance reports.

05 Considers information regarding the role of Llais in representing the interests of the citizens of Wales in health and social care and receives reports on our activities locally, regionally and nationally in discharging these responsibilities.

06 Considers human resources (HR), governance, policy, and employee engagement information.

Audit and Risk Assurance Committee roles and responsibilities include:

Advises the Board on:

01 the effectiveness and adequacy of the financial position and performance, risk management, internal control and governance.

02 the appropriateness, adequacy and integrity of the Annual Report and Accounts.

03 the adequacy of management and organisational responses to issues that have been identified by internal audit, Audit Wales and the Counter Fraud Service relating to the corporate governance requirements for the Board and the organisation.

Remuneration and Terms of Service Committee roles and responsibilities include:

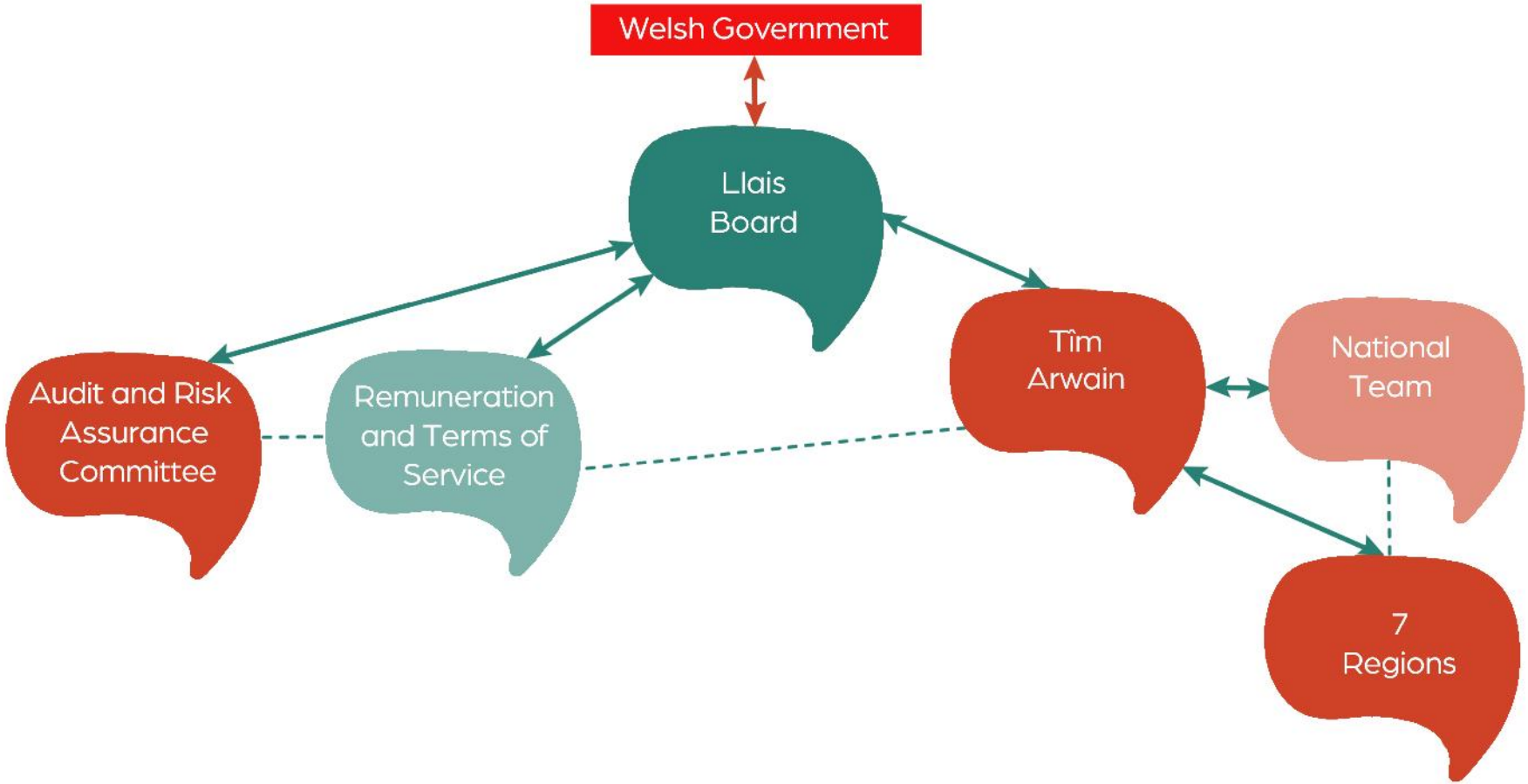
Advises the Board on matters relating to the setting and review of the pay of the Chief Executive and, consideration and endorsement of any required recommendation for staff annual payments/uplifts in line with Agenda for Change, Llais policies and any additional national agreements.

Governance statement

This statement sets out our control structure and provides an account of corporate governance and risk management, alongside a description of the strategic risks. This governance statement sets out the ways in which we are governed and managed and how the Accounting Officer is accountable for how the organisation discharges its responsibilities.

Our accountability, governance and assurance framework and structure

We have a governance framework which guides and supports how we work. This is illustrated in the diagram below:



Governance framework and processes

2023/2024 has been our first full operational year. It is recognised that we are still an organisation in development. However, we have ensured that we have the fundamental governance structure, documentation, and processes in place. Nevertheless, as an organisation we want to continuously improve and strengthen our governance arrangements.

As a result, in February 2024 our Board undertook a detailed Board and governance effectiveness review and the Audit and Risk Assurance Committee undertook a committee review in March 2024. The Chair and Chief Executive also engaged external advice to undertake an independent review of the governance arrangements established in the first year. This review confirmed that all the fundamentals are in place, but that further refinement and embedding was required.

As a result of these reviews our Board agreed to a governance review and development programme, which is currently underway to further strengthen governance and assurance arrangements during 2024. This includes a full review of Standing Orders, Standing Financial Instructions, the development of a Board Assurance Framework and a review of Llais's risk management approach. A review is also underway of the committee framework and the terms of reference for each committee. This will include the expanding of the scope of the Remuneration and Terms of Service committee to take on wider responsibilities for workforce and general performance matters.

In addition to our public board meetings that took place in 2023/2024, the Board has also undertaken a programme of development and briefing sessions. These have covered engagement with partner bodies, discussions with staff of the organisations on key strategic and business developments, preparedness for required organisational developments and requirements from Welsh Government, new legislation, and national consultations.

Members' attendance at Board and Committees

Our Board members are public appointments and are appointed in accordance with national requirements. They have also been appointed to reflect Welsh society – people from all walks of life – to help them understand people's needs and make better decisions.

In addition to our publicly appointed members, we have several people who are co-opted onto our Board and our Committees:

We have an associate non-executive member of the Board, in line with legislative requirements who is a staff member from one of our recognised trades unions.

We have also appointed, in line with our Standing Orders, 2 independent members to our Audit and Risk Assurance Committee for their additional expertise and experience in financial, cyber and IT matters.

Board and Committee membership and attendance 2023/2024

Name	Committee Membership	Attendance at Board Meetings	Attendance at Committee(s)	Terms of Appointment
Medwin Hughes, Chair	None. However, can attend all meetings	5 out of 5	Not applicable	1 April 2022 to 31 March 2026
Alyson Thomas, Chief Executive	None. However, is invited to attend committees	5 out of 5	Attendance, as required	Not applicable
Grace Quantock (Deputy Chair)	Remuneration and Terms of Service Committee (Chair)	5 out of 5	1 of 1	6 June 2022 to 5 June 2025
Bami Adenipekun (Non Executive Member)	Remuneration and Terms of Service Committee	5 out of 5	1 of 1	1 July 2022 to 30 June 2026
Jack Evershed (Non Executive Member)	Audit and Risk Assurance Committee	5 out of 5	4 of 4	1 July 2022 to 30 June 2024
Barbara Harrington (Non Executive Member)	Audit and Risk Assurance Committee	3 out of 5	4 of 4	1 July 2022 to 30 June 2024
Karen Lewis (Non Executive Member)	Audit and Risk Assurance Committee	5 out of 5	4 of 4	1 July 2022 to 30 June 2026
Dr Rajan Madhok (Non Executive Member)	Remuneration and Terms of Service Committee	4 out of 5	1 of 1	1 July 2022 to 30 June 2026
Jason Smith (Non Executive Member)	Audit and Risk Assurance Committee	4 out of 5	4 of 4	1 July 2022 to 30 June 2024
Mwoyo Makuto (Associate Member of the Board)	None	3 out of 3	Not applicable	1 November 2023 to 1 November 2026

Independent members for Audit and Risk Assurance Committee

Name	Committee Membership	Attendance at Board Meetings	Attendance at Committee(s)	Terms of Appointment
John Baker (Independent Member of the Audit and Risk Assurance Committee)	Audit and Risk Assurance Committee	Not applicable	1 of 1 (one committee meeting since appointment)	1 February 2024 to 31 January 2026
Anthony Pritchard (Independent Member of the Audit and Risk Assurance Committee)	Audit and Risk Assurance Committee	Not applicable	1 of 1 (one committee meeting since appointment)	1 February 2024 to 31 January 2026

System of internal control, risk management framework and processes

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risks; it can therefore only provide reasonable and not absolute assurances of effectiveness.

The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place for the year ended 31 March 2024 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

As Chief Executive and Accounting Officer, I have overall responsibility for risk management and report to the Board on the effectiveness of risk management across Llais. My advice to the Board has been informed by officers and feedback received from the Board's committees, in particular the Audit and Risk Assurance Committee. Tîm Arwain meetings present an opportunity for the senior leadership team to consider, evaluate and address risk, and actively engage with and report to the Board and its committees on our risk profile.

Our Strategic Director of Operations and Corporate Services is the lead for risk and is responsible for establishing the policy framework and systems and processes that are needed for the management of risks within the organisation. Depending on the nature of risk, other senior officers take ownership for management and mitigation, especially at a regional level. **The Board has agreed a risk management policy and has also agreed a risk appetite statement, which is provided below:**

Finance /VfM	**RA 1**	We have an **averse** risk appetite to any financial loss or impact. Value for money is a key objective.
	RA 2	We have an **eager** risk appetite to invest where there is benefit to the establishment of Llais systems, functions and services.
Governance	**RA3**	We have an **averse** risk appetite for decisions that may compromise compliance with statutory, regulatory or policy requirements particularly during our establishment phase.
	RA 4	We have an **eager** risk appetite to our internal governance controls. We want our internal controls to reflect our culture. We want our people to feel empowered to make decisions and not feel like they are restricted by red tape.
Operational and policy delivery	**RA 5**	We have an **eager** risk appetite to innovation. We are a new ambitious organisation wanting to make real change for the people of Wales.
Reputational	**RA 6**	We have a **cautious** risk appetite for decisions that could adversly affect how our partners and the public see us. Our priority is to build trust and establish positive relationships.
Our people	**RA 7**	We have an **eager** risk appetite for decisions that could have a negative impact on the welfare of our people. Our priority is to build trust with our staff and volunteers.
	RA 8	We have an **eager** risk appetite to help our people develop and to do things differently and for the better. We want to provide our people with opportunities ot share ideas and suggest new ways of working.
	RA 9	We have an **averse** risk appetite when it comes to the safety of the information and data we hold about our people and the public and the damage that could be caused by the disclosure of that information.
Information and data	**RA10**	We have an **eager** risk appetite when it comes to sharing information that will improve joint working with our strategic partners, but only where the aim is to improve services for the people of Wales.

The risk management framework

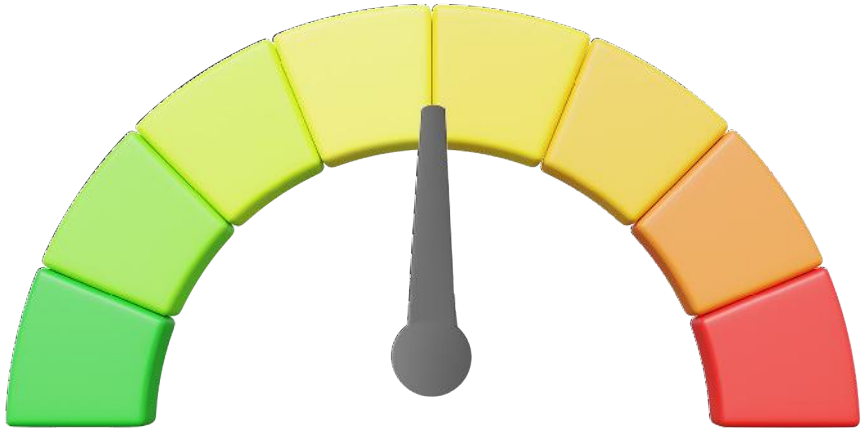
We have continued to implement and refine our approach to risk management during 2023/2024. A complete review of the risk approach is underway during 2024, and it is intended that this will result in a substantial revision of our Risk Management Strategy and approach. The Audit and Risk Assurance Committee will remain responsible for monitoring effectiveness of the implementation of the risk approach to ensure we reach our full potential.

In monitoring the ongoing implementation, any risks to the non-delivery or gaps in the achievement of our goals and objectives will be identified and acted upon with remedial actions agreed and implemented to mitigate and ensure the plan continues to progress. This will be further developed in the coming year through the finalisation and adoption of a Board Assurance Framework.

At each Llais Board meeting, the Board receives a strategic risk report, which provides a high-level account of all risks included on the corporate risk register. This report is published in the public domain, ensuring transparency and openness around the strategic risks that Llais has identified as potential impacts to achievement of the Board's strategic priorities.

Members of the public and any other stakeholders can comment or raise queries about these risk reports, in-line with Llais's Board Standing Orders.

In addition to this, the strategic directors hold assurance meetings with their respective regions and teams to discuss management of ongoing risks that are held at regional and team levels. Reports are discussed at Tîm Arwain to ensure a balanced and consistent approach and cross referral of risks and agreed joint working, as required.



Risk profile

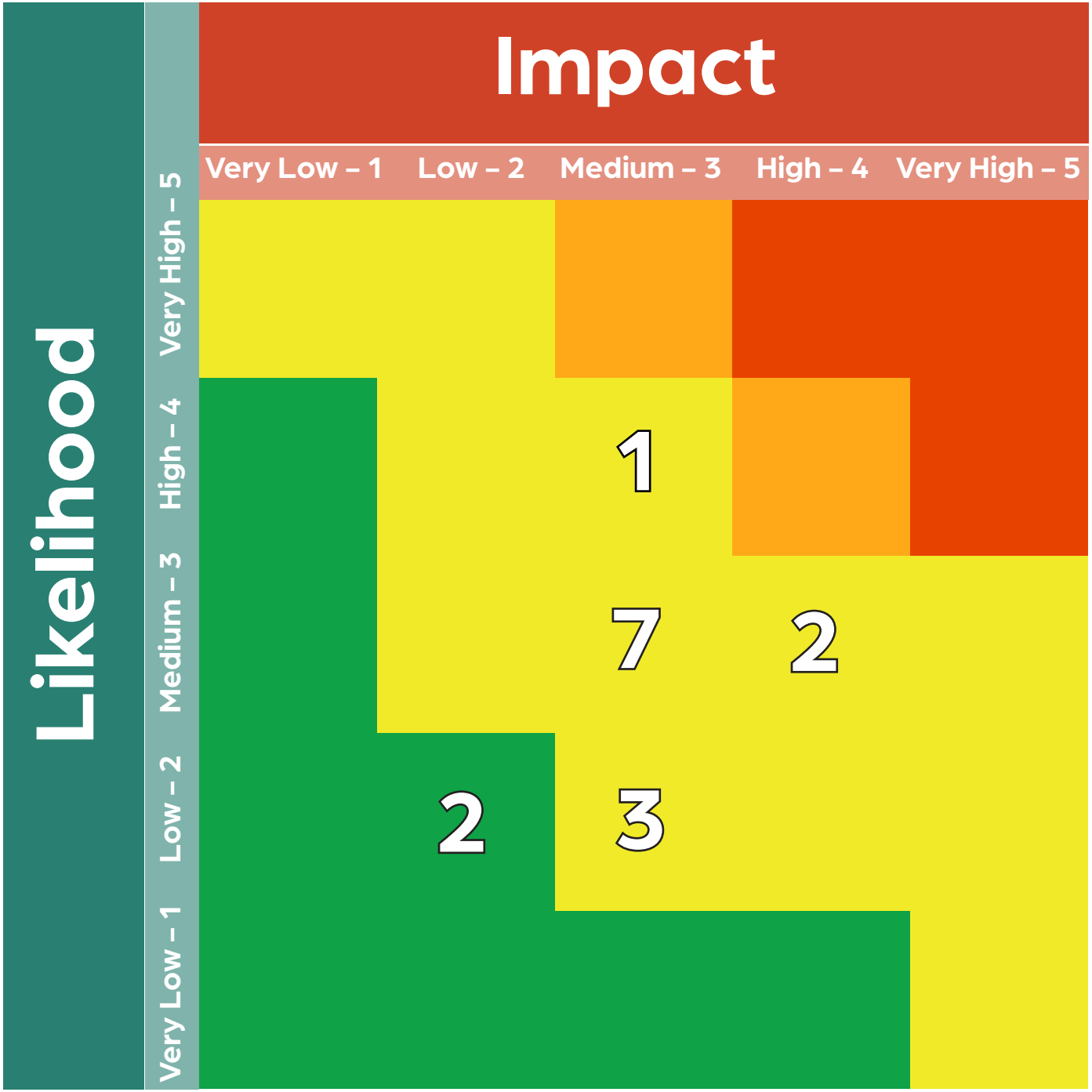
As at end of March 2024, there were 15 strategic risks described within the Corporate Risk Register which represents the most significant risks to the organisation which could potentially impact on the delivery of the Board's strategic priorities.

The risks are classified as:

Very High 0 **High 0** **Moderate 13** **Low 2**

The key risk themes of the risks on the corporate risk register are:

- **Understanding of Llais's role and remit**
- **Organisational change and cultural change**
- **Securing volunteers**
- **People and skills**
- **Demand for Llais services and support**
- **Public and stakeholder expectations of Llais**
- **Partnerships and service agreements**
- **IT implementation, systems failure, and cyber security**
- **Financial position**



A heat map showing the spread of risks on the corporate risk register as of the 31 March 2024.

A copy of the latest Strategic Risk Report which was presented at the end of March 2024 is available here – **Corporate Risk Report**

The risks contained within this have been subject to risk owner scrutiny, and challenge through management review.

Internal, external audit and counter fraud

Our Internal Audit function is provided by the NHS Wales Shared Services Partnership.

We have developed our internal audit plan using a risk-based approach. The Audit and Risk Assurance Committee and Tîm Arwain advised and agreed on the plan.

Our internal auditors submit regular reports about the adequacy and effectiveness of our systems (financial, corporate and workforce regulation) of internal control, together with recommendations for improvement to management and the Audit and Risk Assurance Committee. The overall assessment of our internal auditors and the Head of Internal Audit opinion is provided below.

We also liaise closely with Audit Wales and actively engage in their programme of work each year. Audit Wales representatives attend our Audit, Risk and Assurance Committee and Board, as required. We receive an Audit of Financial Statements Report and Management letter, which reports on issues that are picked up during the audit of our financial statements.

We have a Counter Fraud Policy and a counter fraud service, which is provided by NHS Wales Shared Services Partnership. Regular updates and an annual report are provided to the Audit and Risk Assurance Committee. Counter fraud training has also been provided to our staff, which is outlined further in the Remuneration Report.

Head of Internal Audit opinion 2023/2024

The purpose of the annual Head of Internal Audit opinion is to contribute to the assurances available to the Chief Executive as Accounting Officer and the Board which underpin the Board's own assessment of the effectiveness of the system of internal control. The approved Internal Audit plan is focused on risk and therefore the Board will need to integrate these results with other sources of assurance when making a rounded assessment of control.

The scope of the Head of Internal Audit Opinion is confined to those areas examined in the risk-based audit plan which has been agreed with senior management and approved by the Audit and Risk Assurance Committee. The Head of Internal Audit assessment should be interpreted in this context when reviewing the effectiveness of the system of internal control and be seen as an internal driver for continuous improvement.

The overall opinion for 2023/2024 is that:

Reasonable Assurance

The Board can take Reasonable Assurance that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to moderate impact on residual risk exposure until resolved.

Overall, the Head of Internal Audit Opinion has provided the following assurances to the Board that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively in the areas in the table below.

Where the audits have identified high priority matters arising, management is aware of the specific issues identified and have agreed action plans to improve control in these areas.

A summary of the audits undertaken in the year and the results are summarised below

Substantial Assurance	Reasonable Assurance
N/A	• Governance and risk management • Performance management and financial systems • Digital arrangements • Workforce arrangements
Limited Assurance	
N/A	
Unsatisfactory	**Advisory/Non-opinion**
N/A	N/A

In reaching this opinion, the Head of Internal Audit has identified that the reviews undertaken during the year concluded positively with robust control arrangements in a number of areas. A summary of the findings is shown below:

Governance and risk management arrangements

The objective of this review was to consider the developing governance and risk management arrangements within the organisation while being mindful that Llais is a new organisation, and its governance and risk arrangements will continue to develop as it begins to establish itself. Internal Audit made three medium priority recommendations and issued a **reasonable assurance** opinion.

Performance management and financial systems

Internal Audit looked at financial planning and reporting arrangements, the standing orders and standing financial instructions and matters relating to performance measuring and reporting. We made three medium priority recommendations. Overall, Internal Audit issued a **reasonable assurance** opinion.

Digital arrangements

The purpose of the review was to establish the processes and mechanisms in place for the management of digital within the organisation. Internal Audit have issued **reasonable assurance** on this area. There is an appropriate governance structure for digital, which ensures reporting to a formal Committee. There are policies and procedures in place that cover some of the significant digital and information governance requirements and gaps will be addressed in 2024/2025. Provision of IT services is via a contract, with a formal monitoring process, and Internal Audit noted good resilience and cyber security practices. In addition to three medium priority recommendations, Internal Audit raised two high priority recommendations relating to information governance and the need to review and update the information asset register.

Workforce arrangements

Internal Audit looked at the developing workforce arrangements. The work included workforce reporting, document retention, training and development, and planning. Internal Audit identified one high priority recommendation in relation to workforce strategy development. Overall, a **reasonable assurance** opinion was issued.

Management response to the internal audits

The management of Llais has put in place an audit recommendations tracker. This tracker logs all the recommendations provided by both internal and external auditors. It identifies the agreed actions, lead officers, timelines within which responses should be made and the outputs/outcomes of completing the actions. This tracker is reported to the Tîm Arwain (senior leadership) meeting to monitor progress against the actions and identify any required remedial actions. The tracker is also reported to each meeting of the Audit and Risk Assurance Committee for assurance purposes.

Information governance

The protection of personal data is important to Llais. Our staff are required to undertake mandatory data protection training to ensure we remain compliant with the Data Protection Act 2018 (GDPR). During the year we worked with our third-party supplier to resolve some issues that were experienced with accessing the learning and development platform. As a result we will run data protection awareness sessions in the first quarter of 2024/2025.

We can confirm that there have been 3 personal data related incidents during the year. Our Corporate Services team has monitored and is reviewing our information governance arrangements across the organisation to ensure they are strengthened moving forward.

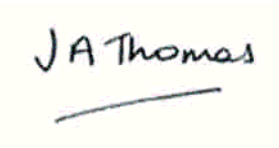
We received 7 requests for information under the Freedom of Information Act 2000. One request was delayed due to IT issues, but all other requests were responded to within the prescribed timescales.

We did not receive any Subject Access Requests during the year.

In recognition of the vital importance of managing security risks relating to data management, our Digital Infrastructure Manager will start working towards gaining Cyber Essentials Plus accreditation in 2024/2025.

Whistleblowing

All staff and board members are encouraged to raise issues of concern about wrongdoing that comes to their attention while at work or undertaking activities on behalf of Llais. We regard internal identification of wrongdoing as an important contribution to managing corporate risk and ensuring good governance. Llais has in place an internal whistleblowing policy and procedures which reflect the provisions of the Public Interest Disclosure Act 1998 and sets out how to raise such matters. In 2023/2024 there were no concerns raised under the policy.



Alyson Thomas
18 December 2024

Remuneration report

Pay policy statement

This is the pay policy statement for the period 1 April 2023 to 31 March 2024. This pay policy statement provides the framework for decision making on pay and decision making on senior pay.

Remuneration (including salary) and pension entitlements (subject to audit)

Name		Salary		Pension Benefits		Total	
		2023/2024 £'000	2022/2023 £'000	2023/2024 £'000	2022/2023 £'000	2023/2024 £'000	2022/2023 £'000
Medwin Hughes	Chair	5–10	0	0	0	5–10	0
Alyson Thomas	Chief Executive	115–120	25–30	0–5	0	115–120	25–30
Grace Quantock	Vice Chair	10–15	10–15	0	0	10–15	10–15
Bami Adenipekun	Non Executive Member	5–10	5–10	0	0	5–10	5–10
Barabra Harrington	Non Executive Member	5–10	5–10	0	0	5–10	5–10
Jack Evershed	Non Executive Member	5–10	5–10	0	0	5–10	5–10
Jason Smith	Non Executive Member	5–10	5–10	0	0	5–10	5–10
Karen Lewis	Non Executive Member	10–15	5–10	0	0	10–15	5–10
Dr Rajan Madhok	Non Executive Member	5–10	5–10	0	0	5–10	5–10
Angela Mutlow	Strategic Director	75–80	0	80–85	0	160–165	0
Ben Eaton	Strategic Director	60–65	0	15–20	0	75–85	0

Ben Eaton commenced in post on the 26 June 2023, the banding for the full year equivalent salary for 2023/2024 was £80–85k. Angela Mutlow commenced in post on the 1 May 2023, the banding for the full year equivalent salary for 2023/2024 was £80–£85k.

For part of 2023/2024 the Chair declined remuneration as he was employed as Vice-Chancellor, University of Wales and University of Wales Trinity Saint David. The full year equivalent salary for 2023/2024 was £15-£20k. No Benefits in Kind or bonuses were paid in 2023/2024.

The Chief Executive and most staff are members of the NHS pension scheme.

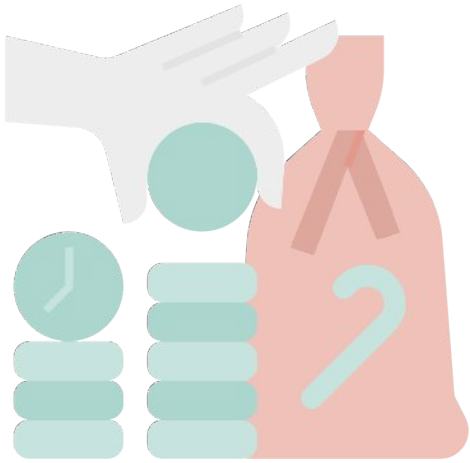
Llais signed up to the NHS pension scheme and staff transferring on 1 April 2023, from the former Board and Community Health Councils in Wales, who were members of the scheme continue to be members of the scheme.

The Chief Executive and directly employed staff are eligible for membership of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS and other employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS and other bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period. The latest NHS Pension Scheme valuation results indicated that an increase in benefit required a 6.3% increase (14.38% to 20.68%) which was implemented from 1 April 2019.

As an organisation within the full funding scope, the joint (in NHS England and NHS Wales) transitional arrangement operated from 2019/2020 where employers in the Scheme would continue to pay 14.38% employer contributions under their normal monthly payment process, and in Wales the additional 6.3% would be funded by Welsh Government directly to the Pension Scheme administrator, the NHS Business Services Authority (BSA, the NHS Pensions Agency).

While Llais budgets and accounts for their staff employer contributions of 14.38% in the financial plan and finance reports, the notional cost of the additional 6.3% is directly funded by Welsh Government.

The amount of pension benefits for the year which contributes to the single total figure is calculated in a similar way to the method used to derive pension values for tax



purposes and is based on information received from actuaries. The value of pension benefits accrued during the year is calculated as (the real increase in pension multiplied by 20) plus (the real increase in any lump sum) less (the contributions made by the individual). The real increases exclude increases due to inflation or any increase or decreases due to a transfer of pension rights.

This is not an amount which has been paid to an individual by Llais during the year; it is a calculation which uses information from the pension benefit table. These figures can be influenced by many factors e.g. changes in a person's salary, whether or not they choose to make additional contributions to the pension scheme from their pay and other valuation factors affecting the pension scheme as a whole.

Pension Entitlements of Directors & Senior Managers	**Total accrued pension** at 31 March 2024 £'000	**Real increase in pension** at 31 March 2024 £'000	**Total accrued lump sum** at 31 March 2024 £'000	**Real increase / (decrease) in lump sum** at 31 March 2024 £'000	**CETV** at 31 March 2024 £'000	**CETV** at 31 March 2023 £'000	**Real increase/ (decrease)** in CETV at 31 March 2024 £'000
Executive Directors							
Alyson Thomas (Chief Executive)	15–20	0–2.5	0	0	281	264	17
Senior Managers							
Ben Eaton (Strategic Director)	0–5	0–2.5	0	0	14	0	14
Angela Mutlow (Strategic Director)	15–20	2.5–5	40–45	7.5–10	351	265	86

The table above is subject to audit. The Chief Executive is an ordinary member of the NHS pension scheme.

The Cash Equivalent Transfer Value (CETV) is the actuarially assessed capitalised value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme.

It is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme, or arrangement when a member leaves a scheme and chooses to transfer the pension benefits they have accrued in their former scheme.

The pension figures shown related to the benefits that the individual has accrued as a consequence of their total membership of the scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures and other pension details include the value of any pension in another scheme or arrangement which the individual has transferred. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

The real increase in the value of the CETV reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee, including the value of any benefits transferred from another pension scheme or arrangement, and uses common market valuation factors from the start and end of the period.

Staff report

During 2023/2024, Llais reported a 19.78% turnover of staff. This figure reflects a year where some staff left via a Voluntary Early Release Scheme, we saw a higher-than-normal number of retirements and, unfortunately, a death in service.

We are committed to recruiting and retaining a high-quality workforce to deliver our services. To do this, we offer fair pay to new starters, which respects existing employees' salary levels and adheres to equal pay legislation.

All staff below the Chief Executive level are employed on NHS Agenda for Change terms and conditions. This decision was taken by the Board as the majority of our staff were

transferred into the new organisation via a Transfer of Undertakings (Protection of Employment) (TUPE) style process.

All new appointees will automatically be placed at the bottom salary point and annual leave entitlement for the role to which they have been appointed. No appointing manager can agree any variation to this, without making an evidenced application where previous reckonable service and transferable skills can be considered, in line with our policy and procedure for determining starting salaries.

All our posts have been subject to Job Evaluation. All roles below the Chief Executive have been banded through the NHS Job Matching, Job Evaluation process to ensure fairness, consistency and equality for all members of staff. The Chief Executive salary was determined via the Job Evaluation for Senior Posts (JESP) scheme.

Changes to existing roles are only accepted when there's a significant and permanent increase in job responsibilities due to progress, innovation, or new technology. Simple changes to tasks or adding more work at the same level does not qualify. These are defined in detail in the evaluating new jobs and re-evaluation of changed jobs policy.

Although all roles are subject to annual appraisals, pay step meetings (to increase a pay increment) no longer occur annually and occur every 2,3 or 5 years depending on pay band.

Annual pay awards for staff on Agenda for Change are determined by Welsh Ministers and actioned in line with Welsh Government pay circulars.

The Chief Executive role does not automatically receive any pay step (increment) but is subject to the pay award as per arrangements for Very Senior Managers (VSM) in NHS organisations, including final decision by the Remuneration and Terms of Service Committee.

Fair pay disclosure (subject to audit)

In 2023/2024 all staff including the highest paid director received a pay award of 5%.

Pay Ratios	**2023/2024**
Highest earner's total remuneration	£115k – £120k
25th percentile pay ratio	4.8:1
Median pay ratio	3.4:1
75th percentile pay ratio	2.8:1
Range of staff remuneration	
Highest paid employee	£115k – £120k
Lowest paid employee	£20k–£25k

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median, 25th percentile (lower end) and 75th percentile (higher end) remuneration of the organisation's workforce.

The banded remuneration of the highest paid director in Llais in the financial year 2023/2024 was £115,000 to £120,000. (2022/2023: £110,000 – £115,000)

The remuneration used for the 25th percentile pay ratio, median and 75th percentile pay ratio were £28,010, £35,922 and £43,257 respectively. As we only became operational on the 1 April 2023, there are no corresponding figures for 2022/2023.

Total remuneration is the salary cost only and does not include employer pension contributions and the cash equivalent transfer of pensions.

Remuneration ranged from £20,000 to £120,000 in 2023/2024.

Staff numbers (subject to audit)

As at 31 March 2024, Llais has 102 employees. 13 Male and 89 Female.

In addition to the 102 employees, through other employers and agencies, an additional 8 full and part time staff worked in Llais.

Percentage of males and females in pay bands (not subject to audit)

	Male	Female
Band 3	1	3
Band 4	1	25
Band 5	0	12
Band 6	4	32
Band 7	1	10
Band 8a	1	0
Band 8b	4	5
Band 8c	0	0
Band 8d	1	1
VSM	0	1

Females make up the largest percentage of the workforce of Llais; 87% are female and 13% are male.

Males working within Llais are mostly at a more senior level (Band 6 and above).

Due to an issue with the electronic staff record reporting system, we are unable to report on more detailed equality data on our people. We have taken action to make sure that we have this information for next year's report.

Recruitment

Between 1 April 2023 and 31 March 2024, Llais advertised 47 positions both internally and externally.

A total of 28 positions were filled, all of which were female.

Gender pay gap (not subject to audit)

This is our first gender pay gap statement since we were established in April 2023.

As a public sector body in Wales, we are required to produce our gender pay statement each year. The report provides data about gender and pay that helps us to identify any differences or gaps that need to be addressed.

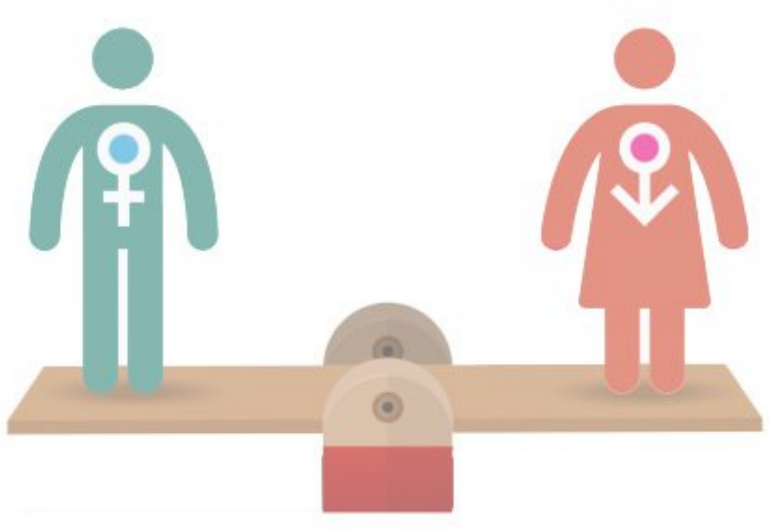
This gender pay statement includes all employees. Our aim is to use the findings in this report to shape and improve our organisation for our people in line with our Strategic Plan 2024–2027 and our Strategic Equality Plan 2024–2028. We have reported our findings based on employee information as of 31 March 2024. For consistency, we will make sure the same date is used each year.

In this statement, gender has been reported in a binary way, that only recognises males and females. This follows UK government guidance on gender pay reporting. We know that there are many people who do not identify in a way that fits into a binary category and having to report in this way does not take them into account.

In this report, we have used the terms 'gender', 'men' and 'women', 'males' and 'females'. We understand that for some people this will be referring only to their biological sex, for some people this may be referring to their gender identity and for some people both.

Median and mean hourly rates and pay gaps (not subject to audit)

Gender	Median Hourly Rate (£ per hour)	Mean Hourly Rate (£ per hour)
Male	26.05	25.83
Female	18.42	19.77
Difference	7.63	6.06
Pay Gap %	29.28%	23.46%



Sickness absence policy

As part of the TUPE style transfer, we have adopted the NHS All Wales Managing Attendance at Work Policy. Reporting of absence is via an Electronic Staff Record system operated on our behalf by NHS Wales Shared Services Partnership.

This year, Llais monitored staff sickness absence against a level set at 3.30%. This is in line with the levels set for our predecessor organisation. This report will consider our performance against this target, and how we might improve absence levels moving forward.

Since April 2023, absence levels have consistently exceeded the 3.30% level. Over the last 12 months, we have seen an average absence rate of 4.13%, reaching a peak of 8.16% in December 2023. A number of long-term absences contributed to these levels, with 10 cases of long term sickness absence occurring between the period September 2023 – January 2024 alone.

Our commitment to our people, diversity, and language

Our people policies are designed to align with current employment law and best practices, with a strong focus on equity, diversity and inclusion. We go beyond the requirements of the Equalities Act, working hard to make sure that our people deliver inclusive services.

We are committed to creating an environment that values diversity and respects the rights of all staff, volunteers, and those we engage with, in line with the Human Rights Act 1998.

Our people also play a key role in promoting language choice and sensitivity within health and social care services. We want to maximise the impact we can have in supporting the delivery of the Welsh Government's "More than Just Words" framework. As a bilingual organisation, we foster an environment that supports and develops our staff's bilingual skills, aiming to embrace a bilingual ethos throughout our work.

More detail on our diversity and inclusion initiatives can be found later on in the report.

Listening to our people

Since we started in April 2023, we've run regular staff update meetings, usually led by our Chief Executive or Strategic Director. All staff are invited to join these virtual sessions, where we share updates on current initiatives, activities, and developments at Llais. These meetings also provide an open forum for staff to ask questions, share ideas, offer feedback, or voice any concerns.

We believe in involving staff in shaping our organisation. This has included gathering input through staff conferences, feedback sessions, and involving staff in the design, development, and review of our vision, mission, values, behaviours framework, our organisational strategies, policies, procedures and ways of working.

Staff have a voice at our Board through an associate member, ensuring their perspectives are considered in decision-making, as well as involving regional teams in each Board meeting to hear more about their work and involve them in Board level activity.

We work closely with our Trade Union colleagues, valuing their insights and feedback on issues that matter to our workforce.

This collaborative approach helps us create a positive and inclusive work environment where everyone's voice is heard and respected.

People assistance programme

We offer our people access to the following range of services:

- Access to fully qualified counsellors and support specialists 24 hours a day, 365 days a year. This offers an opportunity to discuss emotional, personal or work-related issues.
- Face to face and virtual counselling sessions.
- In the moment support – which offers real-time counselling support at the very moment someone needs to talk.
- Self help workbooks available in easy read format and as an audio book on a wide range of subjects ranging from bereavement, anxiety and stress. These allow an insight into the topic, advice and support.
- Podcasts and blogs on over 60 topics relating to health and wellbeing.
- Debt advice offering advice on solutions and support available either in person or virtually and specifically with household utility bills.
- Domestic Abuse support for anyone in an abusive relationship or for anyone who may be concerned about someone they believe to be in one.

In addition to the well-being provisions listed above, we offer our people 'Lifestyle Savings' – this offers the opportunity to save money on everyday essentials to money off cinema tickets, family days out, retail discounts and savings on leisure activities and eating out.

Flexibility

We support staff to work a hybrid pattern of home and office locations and the opportunity to work flexibly subject to the needs of our services. We also support and encourage our people to utilise Wellbeing at Work Breaks.

22% of our workforce worked non standard hours (less than 37.5 hours a week or compressed hours).

We offer our national roles on a pan Wales basis. This means staff can select the nearest Llais office as their base.

Expenditure on consultancy

There was £30k expenditure on consultancy in 2023/2024. This spend relates to an independent advisory review of the governance arrangements for Llais at the end of its first year. The review was commissioned by the Chair and Chief Executive.

The review was completed by the end of March 2024 and confirmed that all the governance fundamentals are in place, but that further refinement and embedding was required, which is being taken forward during the financial year 2024/2025.

Off-payroll engagements

There were no off payroll engagements during 2023/2024.

Compensation for loss of office (subject to audit)

There were no compensation payments made in 2023/2024.

Exit packages (subject to audit)

In 2023/2024, we introduced a Voluntary Early Release Scheme (VERS) to help us adapt quickly to change and reframe how we deliver our services. Information about the scheme was shared with all staff, including those not currently at work. In line with scheme remit and rules, 5 individuals within the organisation were successful in their applications and left our organisation in 2023/2024.

Exit Package cost band	2023/2024	2022/2023
Under £10,000	0	0
£10,000–£25,000	0	0
£25,001–£50,000	5	0
Total	0	0
Resource Cost	**£174,710**	**£0**

Staff learning and development

The main learning and development opportunities offered to staff during the year were:

Course outcomes	Participants
Discrimination and Hate Crime and Cultural Awareness – providing a wider understanding of the difference between certain faiths and cultures. Explores the meaning of cultural awareness and hate crimes.	17
Fraud prevention – training delivered by counter fraud specialist to raise awareness to prevent fraud and how to report any concerns.	75
Risk awareness training – preparing participants to recognize hazards and risks and look at mitigating or reducing them as much as possible.	11

Course outcomes	Participants
Fire marshall – preparing participants how to prevent and respond to workplace fires. Identify hazards, know the different types of extinguishers and how to safely evacuate buildings.	1
Public accountability – Why public funds merit special care, consequences of being classed as a Welsh Government Sponsored Body, Compliance with the guidance contained in Managing Welsh Public Money and the Llais framework document, the concept of "regularity", occasions where highly sensitive spending decisions may need to be referred to Welsh Government and dealing with matters of "financial propriety"	51
Services design	4
Emergency frst aid training – providing protocols for adult casualties in the workplace	10
Cyber security awareness training – educating participants on identifying, preventing and responding to cyber threats. Creating a culture of security awareness to protect the organisation from cyber-attacks.	55
Psychological Safety Training – provide knowledge, skills, tools and confidence to make psychologic safety for everyone in the organisation	9
Advocacy level 2 – covers principles of advocacy, duties of the role, communication and inclusion with respect to advocacy.	2
Team coaching – exploring what 'we do well', 'what we need to improve' and developing as one organisation	75
Social care awareness, and safeguarding for volunteers (also offered to staff)	76 volunteers 16 staff

We also provided tailored training for all our staff to operate new systems like our Customer Relationship Management System.

Volunteer contributions

We have 151 volunteers across all regions of Wales. During the year 32 volunteers stopped volunteering for us and 32 new volunteers started. Volunteers get involved for many reasons. Some want to make a positive difference to the lives of others; some want to develop new skills and some simply want to meet new people and have fun.

Every person who volunteers for us is important to our work.

This year our volunteers have supported Llais activities, including 202 engagement activities and 71 visits to health and social care premises.

Volunteer impact
West Wales hospital wayfaring

Following feedback, the West Wales team wanted to know what it was like to get to each of the 4 main hospitals in the region (including parking) and then use the signs and directions provided for different departments, wards and units that patients need to get to.

With the help of our volunteers, we designed some basic scenarios which aimed to check what kind of information was available and whether it was straight forward to find.

We were also very fortunate to have the help and support of Pembrokeshire People First, (PPF) an independent charity run by and for adults with learning disabilities and autism.

This project gave us an interesting insight into people's experiences as they plan and arrive at hospital. We shared our final report with the Health Board with suggestions for improvements including parking, signage and maps.

You can **watch a video** about volunteering with Llais.

Diversity and inclusion initiatives

We are a new and developing organisation. Over the last 12 months we have been looking at what we need to do to be able to provide further data in terms of how we promote equity, diversity and inclusion in the delivery of services to different groups.

We are still developing our IT and data capture systems so that they can capture the information that we need to inform our work and allow us to identify any potential trends or barriers, both internally and externally.

Alongside that, the way we capture and use our data has been identified as an equality objective in our Strategic Equality Plan 2024–2028.

Over the next 12 months, following the publication of our Strategic Equality Plan, we are looking to review how we capture our workforce data, where that information goes and how we are using it to inform our work.

This review means we will look at any changes we need to make to be able to better understand who our staff are, what communities we are reaching and whether there are any barriers to underrepresented groups inside and outside of our organisation.

Where barriers are identified, any planned actions to address these will be captured alongside our progress against our wider equality objectives in our annual equality monitoring report.

Throughout the year, each of our 7 regions hosted 'Opening Doors' events working with partners and community leaders to encourage those we are less likely to hear from to share their views and experiences of health and social care.

Some of the people we heard from were unpaid Carers, people with different experiences of mental health, people from Gypsy, Roma and Traveller communities, parents and carers of children with learning disabilities, veterans, and LGBTQIA+ groups.

We took this approach as we understand the importance of building trust and continuing to develop relationships to make sure we are hearing from a range of people with different perspectives and experiences. This means we can build a picture of what is happening and what matters to people, so we can work with the NHS, local authorities, and others to address issues.

Regionally, we have been using community spaces to continue establishing a hyper-local approach. This includes drop-in sessions at libraries and warm spaces, attendance at local festivals, freshers' fairs, and various forums.

We have been speaking and engaging with a variety of organisations and community-based groups who advocate for and support underrepresented people. This has included sex workers and minority ethnic groups including Ukrainian, Polish, and African community organisations.

In more rural regions, we have visited farmers' shops, livestock markets and agricultural shows to make sure we hear from people who may have different experiences to those living in urban areas. More statistics can be found under the 'Performance Metrics' section in this report.

We have participated in and raised awareness of a range of important inclusion events over the last 12 months including Social Work Week, Carers Week, International Women's Day, and Diabetes Awareness Week.

In June, many of our regions attended Pride events within their areas to hear about the health and social care experiences of the LGBTQIA+ community and how we may be able to help.

In October, we attended the Race Equality First Minority Ethnic Community Health Fair. We also hosted an event with the African Community Centre Wales that helped us have meaningful discussions about issues that matter within our communities whilst celebrating diversity with live entertainment, dancing, and food.

In February, we celebrated Neurodiversity Inclusion Week for the first time, where our people were invited to attend a range of sessions hosted by Neurodiversity Week and Lexxic to build on their knowledge of how we can work in ways that are more accessible for people who may think, communicate, and process information differently.

In the last year, we have made both big and small changes to how we do things internally to increase equity, diversity and inclusion within our organisation.

An example of a big change was asking for help to guide our equity, diversity, and inclusion work. We recognised we needed focus at a national level to be able to further support our regional teams.

We now have an Equity, Diversity, and Inclusion Programme Lead to help us with this focus. This has led to a scheduled programme of work across the organisation to ensure equity, inclusion, and human rights are at the centre of all we do.

Though it was published in April 2024, our first Strategic Equality Plan has been created based on what our people, our partners and the public told us about what they wanted an inclusive organisation and service to look like.

You can find out more here: **Strategic Equality Plan 2024–2028.**

An example of a small change we have made is actively encouraging our staff to include their pronouns into our email signatures. We know this can help to normalise the use of peoples' chosen pronouns and avoid misgendering someone.

By making this change we hope people both inside and outside our organisation feel safer to share their experiences and views with us knowing we respect people for who they are.

Looking forward – our regional priorities for next year have interwoven equity, diversity, and inclusion as part of their core activities. Some of the themes we will be focusing on are:

- Mental health (including young people)
- Having a baby and maternity services
- Supporting Carers
- Being supported to stay healthy if you have a learning disability
- Ethnic minority communities living with dementia

More information can be found in our **Annual Plan 2024/2025.**

Alongside our national and regional priorities, a set of meaningful actions has been developed to support our objectives in the Strategic Equality Plan.

Working with our newly established Welsh language and equity, diversity and inclusion working groups, we have used what our people have been telling us (through conferences and feedback) to identify the first set of actions we will be working on over the next year.

These actions include recruitment and retention, training, integrated impact assessments, and our inclusion calendar.

A separate Welsh language action plan is being developed to ensure that we are helping the language to thrive beyond our statutory duties.

Updates on how we are delivering the general and specific equality duties and progressing against our actions set out in our **Strategic Equality Plan 2024–2028** will be published in our annual Equality Monitoring Report.

J A Thomas

Alyson Thomas
18 December 2024

05. The Certificate and report of the Auditor General for Wales to the Senedd

Opinion on financial statements

I certify that I have audited the financial statements of the Citizen Voice Body for Health and Social Care, Wales (known as Llais) for the year ended 31 March 2024 under the Health and Social Care (Quality and Engagement) (Wales) Act 2020.

The financial statements comprise the Statement of Comprehensive Net Expenditure, Statement of Financial Position, Statement of Cash Flows and Statement of Changes in Taxpayer's and related notes, including the significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and UK adopted international accounting standards as interpreted and adapted by HM Treasury's Financial Reporting Manual.

In my opinion, in all material respects, the financial statements:

- give a true and fair view of the state of Llais' affairs as at 31 March 2024 and of its net expenditure, for the year then ended;
- have been properly prepared in accordance with UK adopted international accounting standards as interpreted and adapted by HM Treasury's Financial Reporting Manual;
- have been properly prepared in accordance with Welsh Ministers' directions issued under the Health and Social Care (Quality and Engagement) (Wales) Act 2020.

Opinion on financial statements

In my opinion, in all material respects, the income and expenditure recorded in the financial statements have been applied to the purposes intended by the Senedd and the financial transactions recorded in the financial statements conform to the authorities which govern them.

Basis for opinions

I conducted my audit in accordance with applicable law and International Standards on Auditing in the UK (ISAs (UK)) and Practice Note 10 'Audit of Financial Statements of Public Sector Entities in the United Kingdom'. My responsibilities under those standards are further described in the auditor's responsibilities for the audit of the financial statements section of my certificate.

My staff and I are independent of the body in accordance with the ethical requirements that are relevant to my audit of the financial statements in the UK including the Financial Reporting Council's Ethical Standard, and I have fulfilled my other ethical responsibilities in accordance with these requirements. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinions.

Conclusions relating to going concern

In auditing the financial statements, I have concluded that the use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work I have performed, I have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the body's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from when the financial statements are authorised for issue.

My responsibilities and the responsibilities of the Accounting Officer with respect to going concern are described in the relevant sections of this certificate.

The going concern basis of accounting for Llais is adopted in consideration of the requirements set out in HM Treasury's Government Financial Reporting Manual, which require entities to adopt the going concern basis of accounting in the preparation of the financial statements where it anticipated that the services which they provide will continue into the future.

Other information

The other information comprises the information included in the annual report other than the financial statements and parts of the remuneration report that are audited and my auditor's report thereon. The Accounting Officer is responsible for the other information in the annual report. My opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in my report, I do not express any form of assurance conclusion thereon. My responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or knowledge obtained in the course of the audit, or otherwise appears to be materially misstated. If I identify such material inconsistencies or apparent material misstatements, I am required to determine whether this gives rise to a material misstatement in the financial statements themselves. If, based on the work I have performed, I conclude that there is a material misstatement of this other information, I am required to report that fact.

I have nothing to report in this regard.

Opinion on other matters

In my opinion, the part of the Remuneration Report to be audited has been properly prepared in accordance with Welsh Ministers' directions made under the Health and Social Care (Quality and Engagement) (Wales) Act 2020.

In my opinion, based on the work undertaken in the course of my audit:

- the parts of the Accountability Report subject to audit have been properly prepared in accordance with Welsh Minsters' directions made under the Health and Social Care (Quality and Engagement) (Wales) Act 2020; and
- the information given in the Performance Report and Accountability Report for the financial year for which the financial statements are prepared is consistent with the financial statements and is in accordance with the applicable legal requirements.

Matters on which I report by exception

In the light of the knowledge and understanding of the body and its environment obtained in the course of the audit, I have not identified material misstatements in the Performance Report and Accountability Report.

I have nothing to report in respect of the following matters which I report to you if, in my opinion:

- I have not received all of the information and explanations I require for my audit;
- proper accounting records have not been kept or returns adequate for my audit have not been received from branches not visited by my team;
- the financial statements and the audited part of the Remuneration Report are not in agreement with the accounting records and returns;
- information specified by Welsh Ministers regarding remuneration and other transactions is not disclosed;
- certain disclosures of remuneration specified by HM Treasury's Government Financial Reporting Manual are not made or parts of the Remuneration Report to be audited are not in agreement with the accounting records and returns; or
- the Governance Statement does not reflect compliance with HM Treasury's guidance.

Responsibilities of the Accounting Officer for the financial statements

As explained more fully in the Statement of Accounting Officer's Responsibilities, the Accounting Officer is responsible for:

- maintaining proper accounting records;
- the preparation of the financial statements and Annual Report in accordance with the applicable financial reporting framework and for being satisfied that they give a true and fair view;
- ensuring that the Annual Report and financial statements as a whole are fair, balanced and understandable;
- ensuring the regularity of financial transactions;
- internal controls as the Accounting Officer determines is necessary to enable the preparation of financial statements to be free from material misstatement, whether due to fraud or error;
- assessing Llais' ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Accounting Officer anticipates that the services provided by Llais will not continue to be provided in the future.

Auditor's responsibilities for the audit of the financial statements

My responsibility is to audit, certify and report on the financial statements in accordance with the Health and Social Care (Quality and Engagement) (Wales) Act 2020.

My objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes my opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. I design procedures in line with my responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud.

My procedures included the following:

- Enquiring of management, Llais' head of internal audit, and those charged with governance, including obtaining and reviewing supporting documentation relating to Llais' policies and procedures concerned with:
  * identifying, evaluating and complying with laws and regulations and whether they were aware of any instances of non-compliance;
  * detecting and responding to the risks of fraud and whether they have knowledge of any actual, suspected or alleged fraud; and
  * the internal controls established to mitigate risks related to fraud or non-compliance with laws and regulations.

- Considering as an audit team how and where fraud might occur in the financial statements and any potential indicators of fraud. As part of this discussion, I identified potential for fraud in the following areas: posting of unusual journals and management override of controls;
- Obtaining an understanding of Llais' framework of authority as well as other legal and regulatory frameworks that the Llais operates in, focusing on those laws and regulations that had a direct effect on the financial statements or that had a fundamental effect on the operations of Llais; and
- Obtaining an understanding of related party relationships.

In addition to the above, my procedures to respond to identified risks included the following:

- reviewing the financial statement disclosures and testing to supporting documentation to assess compliance with relevant laws and regulations discussed above;
- enquiring of management, the Audit and Risk Assurance Committee about actual and potential litigation and claims;
- reading minutes of meetings of those charged with governance and the Board; and
- in addressing the risk of fraud through management override of controls, testing the appropriateness of journal entries and other adjustments; assessing whether the judgements made in making accounting estimates are indicative of a potential bias; and evaluating the business rationale of any significant transactions that are unusual or outside the normal course of business.

I also communicated relevant identified laws and regulations and potential fraud risks to all audit team members and remained alert to any indications of fraud or non-compliance with laws and regulations throughout the audit.

The extent to which my procedures are capable of detecting irregularities, including fraud, is affected by the inherent difficulty in detecting irregularities, the effectiveness of Llais' controls, and the nature, timing and extent of the audit procedures performed.

A further description of the auditor's responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website www.frc.org.uk/auditorsresponsibilities. This description forms part of my auditor's report.

Other auditor's responsibilities

I am required to obtain evidence sufficient to give reasonable assurance that the expenditure and income recorded in the financial statements have been applied to the purposes intended by the Senedd and the financial transactions recorded in the financial statements conform to the authorities which govern them. I communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that I identify during my audit.

Report

I have no observations to make on these financial statements.

Adrian Crompton
Auditor General for Wales
18 December 2024

1 Capital Quarter
Tyndall Street
Cardiff
CF10 4BZ

06. Finance overview

Llais Financial Statements 2023/2024

Statement of Comprehensive Net Expenditure for the year ended 31 March 2024

	Note	2023/2024 £'000	2022/2023 £'000
Operating Expenditure			
Staff costs	2	5,246	110
Other Operating Expenditure	3	1,590	22
Depreciation/Amortisation	3	196	0
Provision provided in year	3	129	0
		7,162	**132**
Finance Actitvities			
Interest Payable – Right of Use Asset	4	8	0
Comprehensive Net Expenditure for the year		**7,170**	**132**

All income and expenditure is derived from continuing operations.
There are no recognised gains or losses in 2023/2024 or 2022/2023.
Llais receives funding from the Welsh Government.

Statement of Financial Position for the year ended 31 March 2024

	Note	Sunday, 31 March 2024 £'000	£'000	Friday, 31 March 2023 £'000	£'000
Non-current assets:					
Right of use assets	4	353		0	
Property, Plant and Equipment	5	8		0	
Intangible assets	6	622		0	
Total non-current assets			**983**		–
Current Assets:					
Trade and other receivables	7	155		0	
Cash and cash equivalents	8	72		0	
Total current assets			**227**		–
Total assets			**1,210**		
Current liabilities:					
Trade and other payables	9	(731)		(21)	
Right of Use Lease	4	(218)		0	
Provisions	10	(73)		0	
Total current liabilities			**(1,022)**		**(21)**
Total assets less current liabilities			**188**		**(21)**
Non-current liabilities					
Right of Use Lease	4	(136)		0	
Provisions	10	(195)		**0**	
Total non-current liabilities			**(331)**		**0**
Total assets less total liabilities			**(143)**		**(21)**
Taxpayers' equity (SOCTE)			**(143)**		**(21)**
General Reserves			**(143)**		**(21)**

J A Thomas

Alyson Thomas
18 December 2024

Statement of Cash Flows for the year ended 31 March 2024

	Note	Sunday, 31 March 2024 £'000	Friday, 31 March 2023 £'000
Cash flows from operating activities			
Net expenditure		(7,170)	(132)
Adjustments for non-cash transactions	3	325	0
Adjustment for Notional 6.3% Pension Contribution		195	0
(Increase)/decrease in trade and other receivables	7	(155)	0
Increase/(decrease) in trade and other payables	9	583	21
Provision utilised	11	(15)	
Net cash outflow from operating activities		**(6,237)**	**(111)**
Cash flows from investing activities			
Purchase of property, plant and equipment		0	0
Purchase of intangible assets		(622)	0
Proceeds from disposals		0	0
Net cash outflow from investing activities		**(622)**	**0**
Cash flows from financing activities			
Funding from Welsh Government		6,849	111
Cash to match Assets and Liabilities transferring from Powys tHB		269	0
Payments of lease liabilities		(195)	0
Right of Use Assets; interest	10	8	0
Net financing		**6,931**	**111**
Net increase/(decrease) in cash equivalents in the period		**72**	**0**
Cash and cash equivalents at the beginning of the period	8	**0**	**0**
Cash and cash equivalents at the end of the period	8	**72**	**0**

Statement of Changes in Taxpayer's Equity for the year ended 31 March 2024

	General Reserve 1 April 2023 – 31 March 2024	General Reserve 1 April 2022 – 31 March 2023
	£'000	£'000
Balance as at 1 April	(21)	0
Right of Use Lease Adjustment	4	0
Net expenditure	(7,170)	(132)
Total recognised income and expense	**(7,187)**	**(132)**
Funding from Welsh Government	6,849	111
Notional Welsh Government Funding	195	0
Balance as at 31 March	**(143)**	**(21)**

Notes to the Accounts

1. Statement of Accounting Policies

These financial statements have been prepared in accordance with the Welsh Government Accounts Direction and the 2023/2024 Government Financial Reporting Manual (FReM). The accounting policies contained in the FReM apply International Financial Reporting Standards (IFRS) as adapted or interpreted for the public sector context.

Where the FReM permits a choice of accounting policy, the accounting policy which has been judged to be most appropriate to the particular circumstances of Llais for the purpose of giving a true and fair view has been selected. The particular policies adopted by Llais are described below. They have been applied consistently in dealing with items that are considered material to the accounts.

1.1 Accounting Convention

These accounts have been prepared on an accruals basis under the historical cost convention.

1.2 Going Concern

Llais is expected to remain in existence for the foreseeable future and will receive funding from the Welsh Government to meet all of it current liabilities when they mature in 2024/2025 financial year. It has accordingly been considered appropriate to adopt a 'going concern' basis for the preparation of these financial statements.

1.3 Establishment of Llais 1 April 2023

The Non Current and Current Assets and Liabilities transferring to Llais from Powys tHB were transferred in line with Welsh Government issued guidelines and statements. These Assets and Liabilities are recorded in Llais accounts as being transferred on 1 April 2023. These transfers have been reported tracking the changes between the closing position disclosed as at 31 March and the opening position at 1 April in the relevant underlying accounts.

1.4 Income, Funding and Expenditure

The main source of funding for Llais is from Welsh Government via an annual funding allocation.

The accruals basis of accounting means that income and expenditure disclosed in the accounts are accounted for in the year that it takes place, not when cash payments are made or received.

Expenditure is that which relates directly to the activities of Llais.

Llais met its financial obligations by ensuring net expenditure did not exceed the net revenue resource allocation.

1.5 Pensions

Llais Chief Executive and directly employed staff are eligible for membership of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS and other employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS and other bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period. The latest NHS Pension Scheme valuation results indicated that an increase in benefit required a 6.3% increase (14.38% to 20.68%) which was implemented from 1 April 2019.

As an organisation within the full funding scope, the joint (in NHS England and NHS Wales) transitional arrangement operated from 2019/2020 where employers in the Scheme would continue to pay 14.38% employer contributions under their normal monthly payment process, and in Wales the additional 6.3% would be funded by Welsh Government directly to the Pension Scheme administrator, the NHS Business Services Authority (BSA, the NHS Pensions Agency).

While Llais budgets and accounts for their staff employer contributions of 14.38% in the financial plan and finance reports, the notional cost of the additional 6.3% funded by Welsh Government, equating to £195,307 is included in the annual accounts.

1.6 Employee Benefits

Salaries and national insurance contributions for current employees are recognised in the Statement of Comprehensive Net Expenditure as the employees' services are delivered. The Llais accounts for paid annual leave as a liability where the compensation for absence is due to be settled within twelve months after the end of the period in which the employees render the service.

1.7 Property, Plant and Equipment

The minimum level for capitalisation for Property, Plant and Equipment is £5,000 inclusive of irrecovable VAT.

Depreciation is provided at a rate calculated to write off the assets by equal instalments over their estimated useful lives. Depreciation is provided from the date the asset commences its useful life.

Asset lives are normally, as follows:

Leaseholds improvements	Term of the lease or to break clause up to a maximum of 5 years
Office equipment	5 years
I.T related equipment	5 years
Right of use asset	Term of the lease or to break clause up to a maximum of 5 years

Property, Plant and Equipment are included at costs as, in the opinion of Llais, any adjustments arising from revaluation would not be material.

All property occupied by Llais is leased.

1.8 Intangible Assets

The minimum level for capitalisation for an intangible asset is £5,000 inclusive of irrecovable VAT.

Software licences, information technology software and the website have been capitalised as intangible assets and amortised on a straight-line basis over their expected useful lives (normally five years).

1.9 Right of Use Assets

IFRS 16 has replaced the current leases standard IAS 17 and requires that contracts are assessed to confirm if they convey the right to use an asset in exchange for consideration. If they do, they are accounted for in accordance with IFRS16 with a right of use asset and lease liability being recognised at the commencement date. The right of use asset is initially measured at cost, which comprises the initial amount of the lease liability adjusted for initial direct costs, prepayments and incentives.

The right of use asset is depreciated using the straight-line method from the commencement date to the earlier of the end of the useful life of the right of use asset or the end of the lease term. The estimated useful lives of the right of use assets are determined on the same basis as those of property, plant and equipment assets

The lease liability is initially measured at the present value of the lease payments that are not paid at the commencement date, discounted using the interest rate implicit in the lease or, if that rate cannot be readily determined, using the HMT issued incremental borrowing rate. As the Llais leases for the offices do not contain an implicit rate of interest, the HMT discount rate has been used.

1.10 VAT

Llais is not registered for VAT. All expenditure is reported inclusive of VAT where applicable, as VAT is irrecoverable.

1.11 Cash and Cash Equivalents

Cash and cash equivalents include all funds held in accounts to which Llais has instant access. Funds are drawn down into the bank account to pay liabilities as they fall due.

1.12 Accrued Leave

Staff annual leave accrual is accounted for within Note 2 – Staff costs. The accrual is a calculation to reflect the net annual leave owed or owing to staff at the year end. Movement in year is now charged as an accrual within salaries.

1.13 Provisions

Provisions are included in the accounts for liabilities that are likely or certain to arise but uncertain as to the amount or dates on which they will arise. Provisions are created or increased by making a charge to revenue expenditure in the year of creation. When the expenditure is actually incurred, the expenditure is charged directly to the provision. The provision included within these accounts are regarded as short term, within one year and medium term, between two and five years. All provisions are subject to annual review, to ensure they are still relevant and sufficient to fund the specific future liability.

The provision in the accounts includes that for the works required to restore the property back to its original condition prior to tenancy. This is a requirement of lease agreements, and the clause is activated when Llais vacate offices. Also a provision for future reimbursements for an historic Permanent Injury Benefit claim.

1.14 Accounting Standards that have been issued but have not yet been adopted

IAS 8 requires disclosure in respect of new accounting standards, amendments and interpretations that are, or will be, applicable after the accounting period.

In Llais' opinion, no standards that have been issued and have not yet been implemented will impact the organisation.

2. Staff costs

2.1 Employee costs

	Permanent staff	Other staff	2023/2024 Total staff costs	2022/2023 Total staff costs
	£'000	£'000	£'000	£'000
Salaries	3,604	459	4,063	100
Social Security costs	364	0	364	5
Employer contributions to NHS Pension Scheme	446	0	446	5
Other Pension Costs	0	0	0	0
Total net salary costs	**4,414**	**459**	**4,873**	**110**
Voluntary Early Release Scheme	175	0	175	0
Apprentice Levy	3	0	3	0
Notional 6.3% Pension Contribution	195	0	195	0
Total Staff Costs	4,787	459	5,246	110

Further information on staff costs is included within the Remuneration & Staff Report on page 70.

3. Other Operating Expenditure

Other operating expenditure consists of:

	Note	2023/24 £'000	2022/23 £'000
Operating Expenditure			
Rentals under operating leases		254	0
Other accommodation costs		219	0
Information technology		301	0
Professional fees		86	0
Training & development		88	0
Travel & subsistence		41	1
Audit fees – Internal audit		19	0
Audit fees – External audit		30	20
Specific Programmes		252	0
Service Level Agreements		147	0
Other staff related costs		18	0
Other administrative expenses		135	1
		1,590	**22**
Non-cash items			
Depreciation on right of use asset	4	192	0
Depreciation of PPE	5	4	0
Amortisation	6	0	0
Provision	10	129	0
		325	**0**
Total		**1,915**	**22**

4. Rights of Use Assets

	Digital	Buildings	Total
	£'000	£'000	£'000
Cost or valuation			
At 1 April 2023	0	0	0
Additions	454	91	545
Disposals	0	0	0
At 31 March 2024	**454**	**91**	**545**
Depreciation			
At 1 April 2023	0	0	0
Charged in the year	162	30	192
Disposals	0	0	0
At 31 March 2024	**162**	**30**	**192**
Net book value at 31 March 2024	**292**	**61**	**353**
Net book value at 31 March 2023	0	0	0

Maturity Analysis	2024			2023
	Digital	Buildings	Total	Total
	£'000	£'000	£'000	£'000
Contractual undiscounted cash flows relating to lease liabilities				
Within one year	0	0	0	0
Between one and five years	300	66	366	0
After five years	0	0	0	
Sum	**300**	**66**	**366**	**0**
Less future charges allocated to future periods	6	6	12	0
Minimum lease payments	**294**	**60**	**354**	**0**
Included in				
Current trade payables	195	23	218	0
Non current trade paybles	99	37	136	0
	294	**60**	**354**	**0**

Amount recognised in SoCNE	2024			2023
	Digital	Buildings	Total	Total
	£'000	£'000	£'000	£'000
Depreciation	162	30	192	0
Interest on lease liabilities	7	1	8	0
Amount recognised in Statement of Cashflows (net of irrecoverable VAT)				
Interest expense	7	1	8	0
Repayments of principal on leases	(167)	(28)	(195)	0
Total cashflows	**(160)**	**(27)**	**(187)**	**0**

5. Property, Plant and Equipment

	Computer Equipment	Office Equipment	Leasehold Improvements	Total
	£'000	£'000	£'000	£'000
Cost or valuation				
At 1 April 2023	0	20	0	20
Additions	0	0	0	0
Disposals	0	0	0	0
At 31 March 2024	**0**	**20**	**0**	**20**
Depreciation and impairment				
At 1 April 2023	0	8	0	8
Charged in the year	0	4	0	4
Disposals	0	0	0	0
At 31 March 2024	**0**	**12**	**0**	**12**
Net book value at 31 March 2024	**0**	**8**	**0**	**8**
Net book value at 31 March 2023	0	0	0	0

There has been no impairment of any assets and they are shown at cost which is considered to be the 'fair value'

6. Intangible Assets

	Software Licences	Information Technology	Website	Total
	£'000	£'000	£'000	£'000
Cost or valuation				
At 1 April 2023	0	0	0	0
Additions	0	622	0	622
Disposals	0	0	0	0
At 31 March 2024	**0**	**622**	**0**	**622**
Amortisation				
At 1 April 2023	0	0	0	0
Charged in the year	0	0	0	0
Disposals	0	0	0	0
At 31 March 2024	**0**	**0**	**0**	**0**
Net book value at 31 March 2024	**0**	**622**	**0**	**622**
Net book value at 31 March 2023	0	0	0	0

There has been no impairment of any assets and they are shown at cost which is considered to be the 'fair value'

7. Trade and other receivables

	31 March 2024 £'000	31 March 2023 £'000
Current Assets:		
Trade and other receivables	0	0
Prepayments and accrued income	155	0
Total trade and other receivables	**155**	**0**

A prepayment is an amount paid in advance, usually for items such as rates or rent. It is initially recognised as an asset and is expensed in the period when the benefit is received.

There were no receivables falling due after more than one year.

8. Cash and Cash Equivalents

	2023/2024 £'000	2022/2023 £'000
Balance at 1 April	0	0
Net change in cash and cash equivalent balances	72	0
Balance at 31 March	**72**	**0**
The following balances at 31 March were held at:		
Commercial banks and cash in hand	72	0
Balance at 31 March	**72**	**0**

9. Trade payables/accruals

	31 March 2024	31 March 2023
	£'000	£'000
Current liabilities:		
Trade payables	25	0
Other payables & accruals	448	20
Pay accruals	258	1
Total trade and other payables	**731**	**21**

10. Provision for Liabilities and Charges

		31 March 2024		31 March 2023
	£'000	£'000	£'000	£'000
	Permanent Injury	Dilapidations	Total	
Balance at 1 April	101	53	154	0
Provided in year	0	129	129	0
Provision utilised in year	(15)	0	(15)	0
Unwinding of Discount	2	0	2	0
Provision released	(2)	0	(2)	0
Balance at 31 March	**86**	**182**	**268**	**0**
Falling Due:				
Within one year	15	58	73	0
Between two and five years	58	124	182	0
Later than five years	13	0	13	0
Total	**86**	**182**	**268**	**0**

The Permanent Injury provision relates to an injury benefit of a former employee of the Board of Community Health Councils, this liability was transferred from Powys Health Board to Llais on the 1 April 2023.

The dilapidation provision has been established to recognise the condition within Llais' 12 building leases to restore the premises to their original state upon termination of the lease. An approximate 'cost per square foot' has been obtained, from an independent source, on which to base this calculation.

11. Financial Instruments

Llais' cash requirements are met through funding provided by the Welsh Government.
Llais is not therefore exposed to significant liquidity risks.

The majority of financial instruments relate to contracts to buy non-financial items in line with Llais' expected purchase and usage requirements and the Commissioner is therefore exposed to little credit, liquidity, interest rate or foreign currency risk.

There is no material difference between the book values of the organisation's financial assets and liabilites at 31 March 2024 (31 March 2023; £nil).

12. Related-Party Transactions

In 2023/2024, Llais received cash funding of £6.849m from the Welsh Government, against confirmed Grant-in-Aid funding of £7.744m. Confirmed Grant-in-Aid funding split between Revenue of £7.122m and Capital of £0.622m.

In resource accounting terms this equates to confirmed resource allocation of £8.298m, split between revenue resource allocation of £7.131m and Capital allocation £1.167m.

The Welsh Government is regarded as a related party. Material transactions with the Welsh Government during 2023/2024 are:

- funding of £7.744m from Welsh Government (£0.132m 2022/2023)
- notional funding of £0.195m from Welsh Government to cover Notional 6.3% Pension Contribution
- Llais paid Welsh Government £0.104m, mainly for reimbursement of staff salaries and corresponding deductions they pay on our behalf (nil in 2022/2023)
- Llais had £0.017m accruals with the Welsh Government (nil 2022/2023)

During 2023/2024 Llais, in the normal course of its business, entered into the following transactions with the following organisations in which Board and Executive Members or other related parties had an interest.

Name	Relationship with related party
Adenipekun, Bamidele	Associate – Practice Solutions Limited

The above individual has not undertaken any material transactions with us.
Practice Solutions Limited was paid £29,400 – this is included in note 3; no balances were owing to/from this supplier as at 31 March 2024.

13. Events after the reporting period

There were no significant events occurring between the year end and the approval of these accounts.

These financial statements were authorised for issue on the 18 December 2024 by Alyson Thomas.

14. Statement of Assets and Liabilities transferring from Powys tHB at 1 April 2023

	1 April 2023	
	£'000	£'000
Non-current assets:		
Right of use assets	0	
Property, Plant and Equipment	12	
Intangible assets	0	
Total non-current assets		**12**
Current assets:		
Trade and other receivables	0	
Cash and cash equivalents	269	
Total current assets		**269**
Total assets		**281**
Current liabilities:		
Trade and other payables	(126)	
Right of Use Lease	0	
Total current liabilities		**(126)**
Total assets less current liabilities		**155**
Non-current liabilities:		
Provisions	(155)	
Right of Use Lease	0	
Total non-current liabilities		**(155)**
Total assets less total liabilities		**0**
Taxpayers' equity		
General reserves		**0**

Llais became operational on the 1 April 2023 when all staff, assets, liabilities (contracts) were transferred from Powys Teaching Health Board.

The statement above provides a breakdown of the agreed balances transferred to Llais and are included in the calculations for the following notes:

Note 5 – Property, Plant & Equipment
Statement of Cash Flows
Note 10 – Provisions

Glossary of terms

Agenda for Change – These are the pay and conditions framework used in Llais. It provides a fair and transparent system of pay, job evaluation, conditions and pay progression.

Capital – Spending on land and premises and provision, adaptation, renewal, replacement or demolition of buildings, equipment and vehicles.

Community care – A way of providing services to people to help them stay in their own homes as long as they are able, or in other settings in the community such as residential homes.

Complaints advocacy – Complaints advocacy is a specialist service which supports people who are considering, or wishing to make a complaint about the health and social services they receive.

Consultation – The action or process of formally consulting or discussing.

Co-production – Co-production is when professionals work in partnership with people who have lived experience, to develop solutions to challenges in public services and communities.

Corporate governance – A system of accountability to citizens, service users, stakeholders and the wider community within which health and social care organisations work, take decisions and lead their people to achieve their objectives.

Digitally excluded – Not able to use digital devices (such as computers or smart phones and the internet).

Engagement – An active and participative process by which people can influence and shape policy and services that includes a wide range of methods and techniques as explained within the National Principles for Public Engagement Wales.

Equity– Recognising that we do not all start in the same place, and we may have to change to make things more balanced for everyone.

General practice – Refers to the services provided by general practitioners (GPs), also known as family doctors.

Insights – Insights are valuable pieces of information or understanding that are gained from analysing data or observations from our engagement work. They provide a deeper understanding of a situation or issue and can help in making informed decisions.

Mean – Is the average of a set of numbers. To calculate the mean, you add up all the numbers in the set and then divide that sum by the total number of numbers. For example, if you have the numbers 2, 4, and 6, the mean would be (2 + 4 + 6) divided by 3, which equals 4. The mean gives you an idea of the "central" value of the numbers in the set.

Median – The middle value in a set of numbers when they are arranged in order from smallest to largest. If there is an odd number of values, the median is the number right in the middle. If there is an even number of values, the median is the average of the two middle numbers. The median gives you a good sense of the "middle" of the data, especially when there are extreme values that might skew the 'mean'.

Outpatient – Provided on an appointment basis without the need to be admitted to or stay in hospital, e.g. assess need for further treatment, follow up appointment after a period of treatment.

Primary care – Primary care refers to services provided by providers who act as the principal point of consultation e.g. GP practices, dental practices, community pharmacies and high street optometrists.

Representation – Representations made by Llais to NHS bodies and local authorities, and those acting on their behalf or working jointly e.g,. Regional Partnership Boards regarding the provision of health or social services.

Secondary care – Also known as acute care, this refers to specialist medical care or surgery provided in a hospital setting either as an in-patient or outpatient service. Patients seen in hospitals are generally under the care of consultant, not a GP.

Service change – Service change can include service reorganisation, reconfiguration, service redesign, service variation, service improvement, or service expansion.

Stakeholder – An individual or organisation with an interest in health and/or social care initiatives. Stakeholders can be organisations such as local authorities or individuals such as residents.

Terms and conditions – The specific details of a job agreement between an employer and an employee. These terms outline important aspects of the employment relationship, such as salary, benefits, leave entitlements and working hours.

Third sector – The part of an economy or society comprising non-governmental and non-profit-making organisations or associations, including charities, voluntary and community groups, cooperatives, etc.

Under-represented groups – This refers to groups of people who are socially marginalized or under-recognised. This can include people from minority ethnic communities, people with disabilities, people who are neurodivergent, people from a lower socioeconomic background, LGBTQIA+ people and people with different religious backgrounds.

Contact information

Llais
3rd Floor
33 – 35 Cathedral Road
Cardiff
CF11 9HB

02920 235 558
enquiries@llaiscymru.org
www.llaiswales.org

Your local Llais team

Cardiff and Vale of Glamorgan
Covering Cardiff and the Vale of Glamorgan.
Tel: 029 2075 0112
Email: cardiffandvaleenquiries@llaiscymru.org

Cwm Taf Morgannwg
Covering Bridgend, Rhondda Cynon Taf and Merthyr Tydfil.
Tel: 01443 405830
Email: cwmtafmorgannwgenquiries@llaiscymru.org

Gwent
Covering Newport, Caerphilly, Blaenau Gwent, Monmouthshire and Torfaen.
Tel: 01633 838516
Email: gwentenquiries@llaiscymru.org

Neath Port Talbot and Swansea
Covering Neath Port Talbot and Swansea.
Tel: 01639 683490
Email: nptandswansea.enquiries@llaiscymru.org

North Wales
Covering Flintshire, Denbighshire, Wrexham, Conwy, Anglesey and Gwynedd.
Tel: 01978 356178 / 01248 679284
Email: northwalesenquiries@llaiscymru.org

Powys
Covering Montgomeryshire, Brecknockshire and Radnorshire.
Tel: 01874 624206/01686 627632
Email: powysenquiries@llaiscymru.org

West Wales
Covering Pembrokeshire, Carmarthenshire and Ceredigion.
Tel: 01646 697610
Email: westwalesenquiries@llaiscymru.org

If you would like this publication in Braille, Easy Read or in another language, please contact your local Llais team