Bundle Quality, Safety and Experience Committee 3 July 2025

1 PRELIMINARY MATTERS

1.1 13:00 - QS25.52 Welcome and apologies
Chair

1.2 13:02 - QS25.53 Declarations of Interest
Chair

1.3 13:03 - QS25.54 Unconfirmed Minutes of meeting held on 1st May 2025
Chair
- QS25.54.1 UNCONFIRMED QSE minutes PUBLIC 1.5.25 V0.3 CT approved

1.4 13:05 - QS25.55 Matters Arising and Action Log
Chair
- QS25 55.1 QSE Action Log PUBLIC - 26.6.25

1.5 13:10 - QS25/56 Patient's Story - Carer Aware
Executive Director of Nursing & Midwifery
- QS25 56.1 QSE July 2025 - Patient Story - Carer Aware

2 SERVICE PRESENTATION

2.1 13:25 - QS25.57 Integrated Health Community - Central
Integrated Health Community Director, Central
- QS25 57.1 Central IHC Deep Dive Cover Sheet
- QS25 57.2 Central IHC Deep Dive Presentation 03 July 2025

3 QUALITY PLANNING

3.1 13:55 - QS25.58 Executive Summary of the Key Strategies Relating to Women's Health and Perinatal Services
Director of Midwifery & Women's Services
- QS25 58.1 Exec Summary of the Key Strategies Relating to Women's Health & Perinatal Srvcs- Cover sheet
- QS25 58.2 Executive Summary of the Key Strategies Relating to Women's Health and Perinatal Services

3.2 14:15 - QS25.59 Corporate Governance Review
Director of Corporate Governance
- QS25 59.1 Corporate Governance Report (Cover sheet)
- QS25 59.3 Appendix 2 DRAFT QSE Committee Annual Report - 2024-2025 V0.1
- QS25 59.4 Appendix 3 QSE Committee Self Assessment Presentation 03.07.25
- QS25 59.4 Appendix 4 DRAFT Cycle of Business for the QSE Committee 2025-26 V0.1

4 QUALITY CONTROL

4.1 14:20 - QS25.60 Integrated Quality Report
Executive Director of Nursing and Midwifery
Interim Executive Medical Director
- QS25 60.1 Integrated Quality Report June 2025
- QS25 60.2 Integrated Quality Performance Report July 2025

4.2 14:35 - QS25.61 Integrated Performance Report
Director of Performance
- QS25 62.1 Integrated Quality Performance Report Coversheet 3 July 2025
- QS25 60.2 Integrated Quality Performance Report 3 July 2025

4.3 14:45 - COMFORT BREAK

5 QUALITY ASSURANCE

5.1 14:50 - QS25.62 Update on the Royal College of Psychiatrists Action Plan

Special Advisor
Associate Director of Governance

QS25 62 Update on the Royal College of Psychiatrists Action Plan

6 ROUTINE REPORTING

6.1 15:05 - QS25.63 Corporate Risk Register
Head of Risk Management

QS25 63.1 Corporate Risk Register Report July 2025

7 FOR INFORMATION

7.1 QS25.64 JCC Quality Safety Outcomes Highlight Report 20.5.25

QS25 64.1 JCC Quality, Safety & Outcomes Sub-Committee Highlight Report March 2025

7.2 QS25.65 Summary of Business to be Reported from Private

QS25.65.1 Summary of Business to be reported from Private 01.05.25

7.3 QS25.66 Committee Forward Workplan

QS25 66.1 Forward Work Plan

7.4 QS25.67 Llais NW Monthly Report

QS25 67.1 Llais - NW Monthly Report 05 2025

8 CLOSING BUSINESS

8.1 15:15 - QS25.68 Agree Items to be Referred to Board / Other Committees
Caroline Turner, Chair

8.2 15:17 - QS25.69 Meeting Effectiveness
Caroline Turner, Chair

8.3 QS25.70 Date of Next Meeting
1pm, Thursday 4th September 2025.

8.4 15:19 - Resolution to Exclude the Press and Public
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)
DRAFT Minutes of the Quality, Safety and Experience Committee meeting held in PUBLIC
on 1st May 2025, The Boardroom, Clwyd Alyn, St Asaph

Board Members present	
Name	**Title**
Dr Caroline Turner	Committee Chair, Independent Member
Chris Lothian-Field	Committee Vice Chair, Independent Member
Prof Mike Larvin	Independent Member
In Attendance	
Tehmeena Ajmal	Chief Operating Officer
Sreeman Andole	Interim Executive Medical Director (part meeting)
Becky Baker	Head Of Mental Health Operations And Service Delivery (East)
Nesta Collingridge	Head of Risk Management (part meeting)
Alison Cowell	Asst. Area Director, Child & Adolescent Health (Central) (part meeting)
Dyfed Edwards	Chair, BCUHB
Liz Fletcher	Asst. Area Director, Child & Adolescent Health (West) (part meeting)
Dave Harries	Head of Internal Audit
Matt Joyes	Deputy Director for Legal Services
Stuart Keen	Director of Environment and Estates
Jo Kendrick	Head of Quality
David Maslen-Jones	Associate Director of Occupational Health, Safety and Security
Phil Meakin	Associate Director of Governance, RCP Action Plan Lead
Jane Moore	Executive Director of Public Health
Teresa Owen	Executive Director of Allied Health Professionals and Health Science
Philippa Peake Jones	Head of Corporate Affairs
Maeve Puleston-Jones	Audit Wales (Observing)
Geoff Ryall-Harvey	Llais, North Wales
Pam Wenger	Director of Corporate Governance
Iain Wilkie	Director MH&LD
Ed Williams	Director of Performance (part meeting)
Gareth Williams	Vice-Chair, BCUHB (part meeting)
Angela Wood	Executive Director of Nursing & Midwifery
Fiona Lewis	Minute Taker

Agenda Item
PRELIMINARY MATTERS
QS25/26 Welcome and apologies The Chair welcomed Geoff Ryall-Harvey (Llais North Wales) and Maeve Pulesta-Jones (Audit Wales). The Chair also welcomed Tehmeena Ajmal, Chief Operations Officer, to her first meeting. Apologies were received from Urtha Felda; Stephen Powell (Director of Performance and Commissioning) – Ed Williams deputised; Andrew Gralton (Associate Director Of Childrens Services); Jason Brannan (Deputy Director People Services) – David Maslen Jones deputised; Ros Alstead (Independent Advisor, RCPsych Review) and Lois Lloyd (Chief Pharmacist).
QS25/27 Declarations of Interest None were received.
QS25/28 Unconfirmed minutes of meeting held on 20th February 2025 **It was resolved that** the Committee: • **Agreed** the Minutes were a true and accurate record of the meeting held 20th February 2024, subject to a minor amendment to apologies received.
QS25/29 Matters Arising and Action Logs Updates to the Action Log were noted. **It was resolved that** the Committee • **Agreed** the updated log.
QS25/30 Patient Story – My Diabetic Journey The Executive Director of Nursing and Midwifery shared a patient's positive experiences following her diagnosis of Type 2 Diabetes. Despite feeling initially overwhelmed by her diagnosis, the information and support she received from both her GP, her Diabetic nurse and Diabetes UK encouraged her to change her diet and exercise routine, which proved to greatly improve both her physical and mental health. Within six months, the patient was allowed to come off medication - she believed that peer support received on the Diabetes UK website was hugely beneficial. Following the presentation, Members noted: • a lack of advice and support would lead to patients finding it very difficult to get the diabetes under control. • Good management in Primary Care, with early interventions by GPs and Diabetic Nurses, was key to a positive outcome. • Links with Diabetes UK, who provide leaflets which contain information regarding their forum for peer support, helped.

- Concern was raised that the forecasted number of cases of Type 2 Diabetes in the future was high; Members received assurance that the Health Board was aware and was gearing up to dealing with the increase.
- Personalised care becoming more the norm and very important
- Assurance was given that information received from private consultations is added to patients' records
- Members were advised that the Health Board was focussed on prevention and delivery of interventions close to home, and that for more than 50% of people diagnosed with Type 2 Diabetes, this is reversible with good care – both personal and professional
- Evidence was available that showed a holistic approach was best; however it needed to be applied consistently in a way that made changes happen.

It was resolved that the Committee

- **Noted** the report.

[Becky Baker, Head of Mental Health Operations, joined the meeting]

SERVICE PRESENTATIONS

QS25/31 Overview of Mental Health Structure - focussing on Community Mental Health

The Head of Mental Health Operations, East, shared her presentation, highlighting the following:

- The Community Pathway Group focussed on streamlining the patient's journey, making sure to link with the whole acute care pathway, where appropriate.
- The Community Mental Health Team (CMHT), being accessible 24/7, provides support and assessments and acts as a one-stop-shop for all types of care.
- The large geographical area covered by the CMHT service had an impact on resources and for patient attendance. In Wrexham, the Adults and Older Persons Mental Health Teams have moved and linked in with the IHC, resulting in better provision of support, as well as economies of scale.
- There's a robust focus on service development and transformation.
- 111+2 service proving very successful
- Work continued to ensure the provision of Electronic Health Records, with 2025 being the expected date for phased implementation.
- the assessment and intervention target was 80%; however at the time of the meeting was 69.3%. Members were assured that the Senior Leadership Team was focussed on improving this.
- Work continued to link GPs to other referring bodies to improve patient waiting times
- The quality indicator showed the Division's CMHT target was 90%, however at the time of the meeting stood at 82.1%. Further work being undertaken to review people on the waiting list.
- Mitigation taking place to fight challenges brought about by the impact of the withdrawal of Social Workers by the Local Authorities. Ongoing Health Board and Local Authority engagement workshops will review the CMHT model.
- CMHT multi-disciplinary team work hugely beneficial for patients
- As a whole-system approach, feedback assessed on a weekly basis by local and divisional teams to continually assess service delivery,

Following the presentation, discussions took place regarding:

- The withdrawal of Local Authorities. It was felt that there was better communication between services since the separation, and the 'No wrong door' approach appeared beneficial.
- Ongoing Community Staffing Review should identify appropriate caseloads.
- As the new strategy is expected to change from the approach of the first strategy, service demands have changed since COVID-19, therefore the approach needs to be more agile. Teresa Owen to share the link to the new strategy with Members.
- There is the possibility of the CMHT moving to a 24/7 model
- The risks associated with dealing with long waiting lists and the lack of accessibility to psychologists. Head of Corporate Affairs to arrange an informal Board session with Vicky Jones, Head of Mental Health Strategic Programme.
- The challenges regarding being mindful of the need for Welsh-speakers to be available at front line services.

ACTIONS:

QS25/31.1 The Executive Director of Allied Health Professionals and Health Science to share link to new strategy with Members.
QS25/31.2 The Head of Corporate Affairs to invite Board to session regarding CMHT and accessibility to psychologists, with Vicky Jones, Head of Mental Health Strategic Programme.

It was resolved that the Committee**:**

- **Recognised** the work undertaken to date through the community pathway group to align and sustainably transform community mental health services.

[*Dyfed Edwards, Chair, BCUHB, Alison Cowell, Asst. Area Director, Child & Adolescent Health, Central and Liz Fletcher, Asst. Area Director, Child & Adolescent Health, West, joined the meeting. Becky Baker, Head of Mental Health Operations, East, left the meeting]*

QS25/32 CHILDREN'S SERVICES, FOCUSSING ON CAMHS

The West and East Area Directors for Children's and Adolescent Health jointly presented the Deep Dive on Children's Services, highlighting the following:

- Governance assurance and how it was achieved by taking the best parts from the CPG and area structures, thus creating a service fit for young people
- Children's Services sits within the IHC structure
- Nationally, Children's Services report to several national networks and quality assurance bodies, e.g. Maternity/Neonatal network, JCC, CAMHS network, Child Health Network.
- All services participate in several national audits/standards
- Over recent years, work had taken place in order to raise the voice of the child, to ensure it was heard across the organisation
- Improvements in Children's Services included:
    - achieving getting the Regional Partnership Board to put Neuro Diversity as a priority
    - Following substantial targeted work, significant improvements in MMR uptake
    - Crisis model redesign work

  - A reduction in CAMHS waiting times
  - The Alternative to Admission Resource, now available in Rhyl, prevents distressed children having to be admitted into hospital in order to be assessed.
  - Following the 27% national increase in Type 1 diabetes, Children's Services provides insulin pumps and continuous glucose monitoring and care via specialist Diabetes nurses. This had transformed children and young people's quality of life
  - The development of the All-Age Mental Health digital information system
  - Awarded the Stage 2 accreditation of the UNICEF Neonatal Baby-Friendly Initiative. Now working towards Stage 3.
  - There had been two recent S4C 'Ysbyty' television programmes. The first was filmed in the Children's unit in Ysbyty Glan Clwyd (YGC) and the second in the SuRNICC.(Neonatal unit). Both films celebrated the quality of care being provided by the teams and celebrated the Welsh language. S4C - Ysbyty
- Areas of concern included:
  - Vacancies in Health Visiting practitioners impacting on safeguarding – a vacant caseload policy is being implemented, with locums used if required.
  - Increased demand for Neuro-diversity assessments and diagnoses since COVID-19. Targeted waiting list management for long waiters in operation.
  - Tertiary provision capacity for Neurology. Urgent advice pathways put in place
  - Sustainability of Retinopathy of Prematurity provision., due to lack of ophthalmologists across the region. Links in place with surgical teams and support sought regionally, as well as from Alder Hey.
  - Lack of digital records. Some patients have been known to have various separate sets of notes, which led to several Child Practice Reviews recommending that a digital record be developed to ensure good communication, which in turn would support safeguarding. It was noted that the new digital record for mental health being developed will include children and young people.
  - Determining a health or social care need as per Welsh Government's Children's Continuing Care Guidance is often challenged and will likely lead to increased pressures to agree joint funded placements.
  - The challenges associated with trying to provide a provision in unsuitable or inadequate accommodation – both office and clinical.

- Childrens Service complaints – 54% attributed to clinical assessment/treatment, however this could be due to when the child is accessing other services, eg surgery.
- Children's Services Incidents – the most prevalent being behaviour (including violence and aggression). It was noted that behaviour/ violence and aggression was usually caused by service users either self-harming or causing harm to staff or property, and that there were very few serious incidents.
- Performance against standards. It was noted that Children's Services were very successful in relation to Welsh Government initiatives and that the Neonatal service in North Wales is nationally regarded as an exemplar. It was noted that the Maternity and Neonatal Safety Programme have champions who work closely with Maternity colleagues, developing leadership skills with the culture of learning.

- Since the Donor Breast Milk (DBM) Hub, located in YGC, had collaborated with the Chester DBM bank, this had helped reduce carbon footprint and promote the DBM Hub in North Wales.
- The success of the newly launched shared Transitional Care Maternity and Neonatal Care bundle in March.

The Executive Director of Public Health noted that the recent Neurodiversity workshop provided a great deal of positive feedback from various stakeholders, including parents.

It was resolved that the Committee
- **Noted** the presentation and had discussed any areas where further assurance was required.

10 minutes Comfort Break

QUALITY PLANNING

QS25/33 Nursing Staffing Presentation

The Executive Director of Nursing and Midwifery presented her six-monthly report, highlighting the following:

- All wards were categorised, and each category had a legal requirement to be reviewed on a set regular basis. Wards and departments were assessed as to whether staffing met requirements, and based on the patient acuity and quality indicators, identified whether staffing levels were appropriate.
- A programme of work was underway reviewing Mental Health Services. Reviews also scheduled for the Emergency quadrant, Community services, District Nurses and Health Visitors, taking care to compare across all three sites, to ensure a consistent approach.
- Every three years, once all recommendations had received Board approval, the previous 6-monthly reports are collated and formally presented to Welsh Government.
- Available outside each Ward is a list of what expected staffing levels should be for that specific ward.

Following the presentation, Committee Members discussed how best to capture the problems concerning nurses moving frequently between Wards. Members were advised that this had been a major problem when the Executive Director of Nursing and Midwifery took up her post (August 2022), however better recruitment and processes had led to there being no 25b vacancies for September 2025 and the staffing level was the best it has been for many years. It was also noted that the daily monitoring had resulted in a reduction in incidents.

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

QS25/34 Integrated Quality Report

Members received the Integrated Quality Report, presented by the Executive Director for Nursing and Midwifery, who wished to bring attention to the following:

- The reduction in both harm from falls and the number of pressure ulcers

- As of the date of the meeting, there had been four overdue Nationally Reported Incidents (NRI) investigations, which was a significant improvement from the last report. The Health Board had reduced the percentage of cases taking longer than 90 days to 16.4% – the best position for any Welsh Health Board. It was felt that the improvements reflected the hard work from the team and support received from IHCs and Divisions.
- There were no Never Events recorded in January and February, however one regarding insulin administration had been reported in March (the Integrated Performance Report required amending to reflect this).
- Work continued to improve Safeguarding Level 3 reporting
- The Deprivation of Liberty Safeguards (DoLS) paperwork had improved, brought about by additional Welsh Government resources. This had enabled enhanced training capacity and greater on-site visibility, leading to fewer incidents – from 65% in April 2024 to 25.3% by the end of the year.
- A national review of Infection Prevention and Control had provided positive feedback. Work continued with the Executive Medical Director's team to ensure that the input from a medical perspective was being received.
- Complaints: 82% compliance within 30 working days, against a target of 75%.
- It was noted that within the Integrated Performance Report, the compliance data was inaccurate and would be amended.
- Work continued around the launch of the Patient Experience Framework, noting that the launch delay was due to Welsh Government translation issues.
- The Chaplain and Spiritual Care Service continue to offer support to patients and families by recruiting a further four on-call Chaplains to help cover North Wales out of hours.
- Feedback from the recent Clinical Audit had been included in the report
- The Clinical Effectiveness Facilitator for NICE continued to work with the Health Board to support departments with guidance and training, where needed.
- Healthcare Inspectorate Wales (HIW) inspection had taken place at Ysbyty Gwynedd Maternity. Fewer concerns due to much improved HIW process.
- Health and Safety Executive (HSE) concerning the falls case that went to court in April. The Health Board pleaded guilty and was able to provide assurance around improvements that had taken place. The Public Services Ombudsman for Wales' (PSOW) report, the organisational learning for improvements and the Coroner's inquest into the improvement work undertaken all provided assurance to Members.

The Deputy Director for Legal Services advised that:

- an additional Reg. 28 notice (not included within the report) had been issued regarding discharge information from Community Hospitals into care homes. It was noted that this was primarily aimed at care homes; however as the Health Board was part of the process, it therefore had been included.
- Recent interactions with the Coroner's office were proving very positive.
- Work which had taken place since January, to implement new processes regarding Learning from Events Reports (LFER), was proving effective.
- Increased scrutiny through the Escalation meetings, had enabled the Health Board to apply for several extensions which will allow services some more breathing space

to get on top of the overdue forms. Welsh Risk Pool had acknowledged that the Health Board had got a tighter grip around the LFERs; however there was more work to be done in this regard.

The Interim Executive Medical Director noted:

- that until the clinical coders were fully trained, not all deaths were being coded and therefore Mortality data would be unreliable.
- In future, NICE compliance will be reported by the Health Board as a whole, and not by each site individually.

Following the presentation, Members discussed the following:

- The Llais representative was pleased to note the work which had taken place to reduce the backlog of complaints and advised not to be concerned if there was not an immediate reduction of actual complaints, because it was felt that the easier it was to complain, more complaints would come.
- The continued improvement in the quality of information contained within the report was noted.

ACTION:

- **QS25/34.1 AW** to ensure Integrated Performance Report be rectified to reflect 1) a Never Event had taken place in March 2025 and 2) the Complaints compliance figures were updated.

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

[Ed Williams, Head of Performance, joined the meeting]

QS25/35 Integrated Quality Performance Report (IQPR)

The Director of Performance presented his report, noting:

- Most of the Quality performance indicators had significantly improved over the last 12 months
- Narrative and context for information included in this IQPR was not of the quality expected and will be improved for the next report.
- The number of complaints was unlikely to reduce until issues around Urgent and Emergency Care and Planned care had been addressed.
- DDaT should be asked to provide trajectories for improvements in clinical coding, to facilitate closer monitoring.
- Work ongoing with the Interim Executive Medical Director to improve Mortality reporting.
- The Director for Commissioning and Performance was working to create a multi-disciplinary team to scrutinise externally commissioned services and this to be reported in future IQPRs.

Following the presentation:

- The Director of Corporate Governance confirmed that following on from an internal audit of commissioned services held in 2024, which had offered limited assurance, a follow-up from that review had taken place and a report on its findings was being taken to Audit Committee on 8th May.
- The Chair was pleased to note the improved level of data included within the report which provided the Committee with assurance.

It was resolved that The Committee:

- **Reviewed** the contents of the report and
- **Proposed** actions noted above arising from the report,
- **identified** any additional assurance work or actions it would recommend Executive colleagues to undertake, as noted above.
-

[Ed Williams, Performance Director, left the meeting]

QUALITY IMPROVEMENT

QS25/36 Challenged Service – Orthodontics.

This item was deferred.

QS25/37 Update on the Royal College of Psychiatry (RCP) Action Plan

The Executive Director of Allied Health Professionals and Health Science:

- thanked Ros Alstead, Independent Special Advisor and Chair of the Expert Advisory Group (EAG), Phil Meakin, the RCP lead, and Geoff Ryall-Harvey from Llais for their continued support in this process;
- confirmed that a consultant Dementia nurse had been appointed to start in June 2025, with planning in place awaiting their arrival.
- Wished to note the work which was taking place regarding staff recruitment and retention

The RCP lead presented his report and noted the following:

- The EAG Chair was now in receipt of the seventeen RCPsych evidence submissions that have been endorsed for approval by the Health Board Action Delivery Group.
- Having now clarified and matched the requirements of each individual Expert by Experience, a detailed work programme had been developed which enabled the EAG to provide a much more personal, tailored approach for each of the five members of the EAG, recognising their different interests.
- The dates of each EAG meeting have been blocked out for people to review to help people to triangulate and support the assessment of progress.
- The development of the 'Ways of Working' document, which had been co-produced by the EAG and Leon Marsh, Head of Patient Experience.

Following the presentation, the Committee noted:

- The Chair was pleased with the content and structure of this report, which included actions and mitigations.
- The difficulties overcome, and the time taken to ensure that each of EAG members is supported, and were assured of the improvements.

- Llais confirmed that their support would continue by way of them accompanying EAG members on their visits.
- this process was taking longer than anticipated, and that Ros Alstead's contract with the Health Board was due to expire in August 2025. Dyfed Edwards, BCUHB Chair, was due to meet with Ros Alstead to discuss arrangements regarding her contract.

It was resolved that the Committee**:**

- **Noted and Considered** the update from the Health Board RCPsych Action Delivery Group with an emphasis of demonstrating that there is evidence of actions being carried out which improve current services.
- **Noted and Considered** the update from the Chair of the Health Board RCPsych Expert Advisory Group
- **Noted and Considered** the approach to the development of the Expert Advisory Group Work Programme and Outcome Performance Framework
- **Received assurance** on the Health Board response to the RCPsych Invited Review Services Report

[Phil Meakin left and Nesta Collingridge joined the meeting]

QS25/38 Board Assurance Framework and Corporate Risk Register

The Head of Risk Management provided an update firstly on the Corporate Risk Register, noting:

- The newly escalated Neurodevelopmental Waiting List Risk. The Executive Director of Nursing and Midwifery had met with the Neurodevelopmental team, who were appreciative of the level of support they were receiving and she confirmed that the Risk was being progressed, with further updates being provided to the Risk Scrutiny Group.
- As Primary Care, Ophthalmology, Community Care and Diagnostics risks all sat above accepted tolerance levels, deep dives have been prioritised and were being conducted in these areas. Both Oncology and Ophthalmology had expressed their thanks for the support given.
- Despite Oncology extending their Risk date, it was felt that this was a positive move as this was brought about by the level of scrutiny on the Action Plan.
- The lack of an update to Dermatology's corporate Risk was due to their not being an appropriate Risk lead, following the departure of the original Risk lead. This had been escalated to the Risk Scrutiny Group (RSG), who provided assurance that they are aware and seeking a replacement. The RSG confirmed that they had instigated a deep dive into Dermatology for their next meeting.
- A meeting to take place with the Chief Operating Officer to handover the Primary and Community Care Risk and to provide her with progress on that risk.

Following the presentation:

- The Executive Director of Nursing and Midwifery wish to offer assurance to the Committee that the Health Board's Risk Register was in a much better position than 12 months previously and wished to express her gratitude to the Head of Risk Management and her team for their efforts in making the process 'seamless'.

- It was noted that the Risk Management Team had been successful in being shortlisted for a Risk Management Award.
- The Chair thanked the Head of Risk Management and agreed that the reporting was much improved over the last 12 months, with challenges at both operational and executive level taking place. She requested that the next step would be to provide more external validations and mitigations, with particular focus on Challenged Services' Risks.

The Head of Risk Management presented the Board Assurance Framework (BAF) and

- confirmed that she, along with the Director of Corporate Governance and the Executive Director of Nursing and Midwifery, were continuing to work hard to shape the BAF to ensure it will be aligned and available on the portal, where it will be seamlessly updated and track the Annual Plan.
- Discussed good Board assurance and the level of external validation still required to provide this.
- Recognised that there was a lot of progress in the BAF and that the RSG will be carrying out a deep dive.

The Committee reviewed the risks including those on the Board Assurance Framework that the Committee had oversight of. The focus will now be on bringing the risk scores down by external sources specifically around the Board Assurance Framework.

ACTION:

- **QS25/38.1** Head of Risk Management to provide more external validations and mitigations, focussing on challenged services' risks

The Committee;

- **Noted** the contents of both reports.

ANNUAL REPORTING

QS25/39 Committee Annual Report 2024-2025

The Director of Corporate Governance provided a brief verbal update, confirming that it had been agreed to do a self-assessment, with planned surveys due to be circulated imminently. Once responses to these surveys have been collated, the Director of Corporate Governance agreed to bring results back to the Committee.

The Committee:

- **Noted** the verbal update

QS25/40 Review Committee's Terms of Reference (ToR)

The Director of Corporate Governance provided a brief verbal update, advising Members that once a few minor amendments had been made, these ToR would be updated and presented to Board, along with all other committee ToRs.

The Committee:

- **Noted** the verbal update

FOR INFORMATION

QS25/41 Executive Quality Delivery Group Chair's Assurance Report

It was resolved that the Committee

- **Noted** the Quality Delivery Group Chair's Assurance Report.

QS25/42 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

QS25/43 Review Committee Forward Work Plan (FWP)

Head of Corporate Affairs advised Members that she was carrying out a piece of work to ensure no duplication of items on the Forward Work Plan

ACTION:

- **QS25/43.1** Head of Corporate Affairs to work on FWP.

It was resolved that the Committee

- **Noted** the Committee Forward Work Plan

CLOSING BUSINESS

QS25/44 Agree Items for Referral to Board / Other Committees

- Assurance provided with regards to quality of the Deprivation of Liberty (DoLs) assessments
- Much improved RCPsych Action Plan, which was of the right level, with positive actions and improvements noted in the paper.
- Advise Board of presentations received, and risks identified around the services – as evidenced on the BAF and CRR.
- Legal Team had implemented a new process which has led to improved performance LFER's and established strong relationships

QS25/45 Meeting Effectiveness

- It was noted that despite some agenda items taking longer than expected, all other items had been afforded enough time.
- Balanced discussions took place where progress made was discussed and when challenges were identified, mitigations put in place were either noted or discussed.
- A very helpful overview of the Mental Health structure was provided by Becky Baker, Head of Operations and Service Delivery (East).
- The Committee received a very detailed overview of Children's Services, focussing on CAMHS.
- Members were pleased to receive contributions from managers and not purely the responsible Executive, along with important feedback and level of detail provided within the deep dives.

QS25/46 Date of Next Meeting

13.00hrs, Thursday, 3rd July 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	**QS25/31**	01.05.25	**QS25/31.1 Overview of Mental Health** Circulate the Link to the New Strategy	Exec. Dir. Allied Health Professionals & Health Science (**Teresa Owen**)	May 2025	**Suggest close** Mental health and wellbeing strategy 2025 to 2035 | GOV.WALES **26.6.25** Circulated to members
2	**QS25/31**	01.05.25	**QS25/31.2 Overview of Mental Health** Invite Board to a session regarding CMHT accessibility – with Vicky Jones, Head Mental Health Strategic Programme	Head of Corporate Affairs **(Philippa Peake-Jones)**	May 2025	**Remain Open** Included in the Board Development Programme agreed in May 2025.
3	**QS25/34**	01.05.25	**QS25/34.1 Integrated Quality Report** Ensure Integrated Performance Report be rectified to reflect 1) a Never Event had taken place in March 2025 and 2) the Complaints Compliance figures were updated	Exec. Dir. of Nursing and Midwifery **(Angela Wood)**	May 2025	**Suggest close.** **17.6.25** J Kendrick, Head of Quality, has linked with the Performance Team. Going forwards reports will be shared between both teams, Quality and Performance to ensure alignment. In addition, the data set will be accessed via the Quality Dashboard and signed off by Head of Quality prior to publication.

4	QS25/38	01.05.25	**QS25/38.1 Board Assurance Framework and Corporate Risk Register** BAF to include more external validations and also to include mitigations, focussing on challenged services' risks.	Head of Risk Management (**Nesta Collingridge**)	July 2025	
5	QS25/43	01.05.25	**QS25/43.1 Review Committee Forward Work Plan**	Head of Corporate Affairs **(Philippa Peake-Jones)**	July 2025	
6	QS25/11	20.02.25	**QS25/11.1 Colonoscopy Performance Update Clarify when the Colonoscopy data/paper can be reported back into QSE.**	Exec. Dir. of Nursing & Midwifery **(Angela Wood)** to link in with Interim Chief Operation Officer) **(~~Imran Devji~~) Tehmeena Ajmal**	May 2025	**24.02.25** From AW - Email sent to Imran, awaiting clarification **12-6-25** Meeting arranged 3rd July, AW and Tehmeena Ajmal, COO. A further update will be provided in the meeting.
7	QS25/43	20.02.25	**QS25/43.1 Review Committee Forward Work Plan (FWP)**	Director of Corporate Governance **(Pam Wenger)** Head of Corporate Affairs **(Philippa**	June 2025	

				Peake-Jones)		
8	QS25/10	20.02.25	**QS25/10.1 Ophthalmology** Circulate a paper on challenged services, to include Ophthalmology, before 1st May QSE mtg.	Interim Executive Medical Director **(Sreeman Andole)**	~~April 2025~~ July 2025	**22.4.25** Advised that Deep Dive into Opthalmology will be provided at July meeting.
9	QS25/05	20.02.25	**QS25/05.1 Patient's Story** Chief Pharmacist to review options and mitigation strategies to ensure access to the most frequently used medicines seven days a week in high-demand areas.	Chief Pharmacist **(Lois Lloyd)**	July 2025	**Suggest close.** **30.4.25** A review of current arrangements across the Health Board's emergency quadrants has been undertaken to better understand existing processes. It has identified that frequently used, ready-labelled take-home medicines, such as pain relief and antibiotics are often prepared in advance and stored in automated medicine cabinets for ease of access at any time. These are positioned to support timely discharge within key priority pathways. In parallel, a pharmacy workforce review is in progress as part of a national programme led by the NHS Wales Directors of Pharmacy Peer Group. This includes mapping current staff deployment against demand, and assessing skills and contributions in relation to NHS Wales priorities - particularly within the

						Emergency Department and Same Day Emergency Care (SDEC). This work is being informed by the recommendations from the Independent Review of Clinical Pharmacy Services in NHS Wales Hospitals. While a 24/7 on-site pharmacy presence may not be required, the emerging strategy is exploring options to ensure timely access to pharmaceutical expertise and medicines every day of the week. This could include enhanced use of automation or appropriate signposting to community pharmacy services."
10	QS24/121	24.10.24	**QS24/121 Integrated Performance Report** to speak to the Deputy Executive Medical Director to check the veracity of colonoscopy data provided in report, and to escalate concerns if required.	~~Exec. Dir. Allied Health Professionals & Health Science (**Teresa Owen**) Interim COO **(Imran Devji)**~~ Chief Operating Officer **– Tehmeena Ajmal**	~~17.12.24~~ May 2025	**9.12.24** TO spoke with Deputy Executive Medical Director. Data/information is being checked by the team. **12.2.25** Jim McGuigan advised that Imran Devji was aware of this query and investigating. **9.4.25** Update requested.

Closed Actions

Action No.	Minute Ref.	Date	Agreed Action	Lead	Timescale	Status
1	QS25/14	20.02.25	**QS25/14.1** DECLO Annual Report	Head of Corporate Office	May 2025	Suggest close. 20.2.25 Liz McKinney confirmed report will be

			Ensure that DECLO Annual Report is on the Cycle of Business for November meetings.	(Philippa Peake-Jones) /		available for January QSEs.
2	QS25/12	20.2.25	**QS25/12.1** RCPsych Invited Review Services Report to provide evidence of actions being carried out, which improve current services.	Associate Director of Governance (Phil Meakin)	May 2025	Suggest close. May's report includes this.
5	QS25/07	20.02.25	**QS25/07.3** Integrated Quality Report The Committee to review the Clinical Audit as a substantive item – to be included in the forward work plan	Director of Corporate Office (Pam Wenger)/ Interim Executive Medical Director (Sreeman Andole)	Feb 2025	Suggest close. 20.2.25 Added to Forward Work Plan.
6	QS25/07	20.2.25	**QS25/07.2** Integrated Quality Report The Interim Executive Medical Director working with the Executive Director of Nursing to provide a deep dive into Mortality data, to be presented at the March development Session.	Interim Executive Medical Director (Sreeman Andole) Exec. Dir. of Nursing & Midwifery (Angela Wood)	17.3.25	Suggest close. Deep Dive into Mortality Data provided at March Development Session.
7	QS25/07	20.2.25	**QS25/07.1** Integrated Quality Report	Head of Corporate	Feb 2025	Suggest close. 20.2.25 Added to Forward Work Plan

			The Committee to receive a Deep Dive on PALS at a future Development Session – place on Forward Work Plan.	Affairs (Philippa Peake-Jones)		
9	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	Suggest close. 19.2.25 Sree is working with Ben Thomas & Gemma on the mortality data, update will be provided at the QSE development session in March.
10	QS24/104.3	15.8.24	**QS24/104**.1 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	Suggest close. 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.

Teitl adroddiad: ***Report title:***	Patient Story: Carer Aware Approach to Hospital Discharge			
Adrodd i: ***Report to:***	Quality and Safety Experience (QSE)			
Dyddiad y Cyfarfod: ***Date of Meeting:***	3rd July 2025			
Crynodeb Gweithredol: ***Executive Summary:***	A patient or carer story is presented to QSE to bring the voice of the people we serve directly into the meeting. The digital story will be played at the meeting. A short summary is included in the attached paper.			
Argymhellion: ***Recommendations:***	QSE is asked to note this report.			
Arweinydd Gweithredol: ***Executive Lead:***	Angela Wood, Executive Director of Nursing and Midwifery			
Awdur yr Adroddiad: ***Report Author:***	Chris Lynes, Deputy Executive Director of Nursing Rachel Wright, Patient and Carer Experience Lead Manager			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				
In line with best practice, a patient or carer story is presented to QSE to bring the voice of the people we serve directly into the meeting, but it is not presented as an assurance item. However, the accompanying paper describes some of the learning and actions undertaken in response to the story.				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Quality			
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	N/A			
Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqlA been identified as necessary and undertaken?***	N/A			
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	N/A			

Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan 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: Ymwybodol o ofalwyr wrth ryddhau o'r ysbyty Carer aware approach to hospital discharge 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

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

Overview of Story

In January 2025, Carers Trust Wales commissioned a short film to showcase the positive partnerships between NEWCIS and staff at Wrexham Maelor Hospital supporting unpaid carers. The film was shown at Carers Trust's Network celebration event at the Senedd on 4 February 2025, which was attended by Dawn Bowden MS, Minister for Children and Social Care.

The film will be used to support Welsh Government training as part of the Carer Aware programme and was shared across Wales throughout National Carers Week 9 – 15 June 2025.

The film shares a collection of experiences from carers, staff from BCUHB, NEWCIS and Swansea Carers Centre.

Key Messages

- Unpaid carers play a vital role in the health and social care system, providing most care for individuals with long-term conditions, disabilities, or those recovering from illness.
- It can be a stressful and uncertain time for unpaid carers caring for someone who's being discharged from hospital.
- Health and social care professionals play a key role in identifying and signposting unpaid carers for support at this key pressure point in their caring role.
- Staff from BCUHB share the importance of involving carers.
- Storytellers share their experiences as carers, including the support they have received from NEWCIS.
- NEWCIS describe the support they offer carers as part of the Welsh Government £213,000 Carers Hospital Discharge contract managed by the Patient and Carer Experience Team at BCUHB.

Summary of Learning and Improvement

The story has been shared across Patient and Carer Experience Group and Health Board services for awareness.

On an annual basis the Health Board (BCUHB) receives £213,000 Welsh Government funding to support un-paid carers through the Hospital Discharge Facilitation Service. This funding is ringfenced for third sector organisations, and is part of North Wales Regional Integrated Funding (RIF).

NEWCIS and Carers Outreach were awarded the Un-paid Carer Hospital Discharge Facilitation Service contract for BCUHB to work across Acute and Community Hospitals across North Wales. NEWCIS and Carers Outreach staff attend acute hospitals and community hospital on a daily basis. Their role is to actively identify professionals to provide training and information around the needs of unpaid carers. It is important for staff to identify carers as part of admittance/discharge process so they can be appropriately referred to support services. This ensures carers are well supported whilst their cared for is in hospital, whilst also the benefit of providing ongoing support when the cared for is discharged back to their own home. This holistic support means NEWCIS and Carers Outreach can support carers to care for their dependants safely in the community, helping to reduce rates of re-admittance to hospital.

The outcomes of the service to be achieved include:

1. Unpaid Carers are supported by all professions within Community & Secondary Care.

2. Unpaid Carers are pro-actively signposted to third sector support or local authority social services for further information, support, or to obtain a Carers Needs Assessment (as appropriate), as part of the patient's discharge process recognising the holistic needs of the unpaid carer.

3. Community & Secondary Care settings (all professions) are supported to become carer aware (understanding the needs of young and adult carers).

4. Unpaid Carers voices are heard and are proactively involved in the discharge plans for the patient.

5. Unpaid Carers are supported to become more digitally aware.

6. Support Community & Secondary settings to become more unpaid carer friendly workplaces.

Contract performance for this Welsh Government funding is reported quarterly to BCUHB Patient and Carer Experience Group and the North Wales Regional Carers Group who report to the North Wales Regional Partnership Board.

NEWCIS and Carers Outreach are represented as part of the Health Board's Reaffirming Our Commitment to the 3rd Sector Steering Group. NEWCIS and Carers Outreach attend local IHC Patient and Carer Experience Groups to provide updates on service provision and direct referrals.

NEWCIS and Carers Outreach have developed a strong relationship with the PALS team so they can raise issues quickly to avoid concerns escalating to formal complaints, achieving a better result and outcome for carers.

For National Carers Week from 9 – 15 June 2025 the focus on the campaign was on 'caring about equality'. A series of information events were organised by NEWCIS and Carers Outreach were held across Health Board sites and community venues to promote their

services. Across West IHC, Carers Outreach are working in partnership with Local Authorities to promote a Carers Identification Card to be used in a crisis. Carers Outreach have set up stalls within the foyer of Ysbyty Gwynedd to promote this initiative.

The Patient and Carer Experience Team will continue to work with all services to promote the Carers Hospital Discharge Facilitation Service programme as outlined above. The Patient and Carer Experience Team extend their gratitude and appreciation to the storytellers for sharing their experiences.

Teitl adroddiad: ***Report title:***	Central Integrated Health Community - Deep Dive			
Adrodd i: ***Report to:***	Quality and Safety Executive Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 03 July 2025			
Crynodeb Gweithredol: ***Executive Summary:***	This deep dive presentation is to provide the committee with a key oversight of quality and safety matters in the Central IHC.			
Argymhellion: ***Recommendations:***	The committee is asked to note the Information provided, there are no key recommendations			
Arweinydd Gweithredol: ***Executive Lead:***	Angela Wood, Executive Director of Nursing and Midwifery			
Awdur yr Adroddiad: ***Report Author:***	Naomi Holder, Interim Director of Nursing, Central IHC Aderemi Adalade, Interim Medical Director, Central IHC Rhys Davies, Interim Director of Pharmacy and Medicines Management, Central IHC Steven Grayston, Director of Therapies, Central IHC			
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):***	Building an effective organisation Creating compassionate culture, leadership and engagement Improving quality, outcomes and experience Establishing an effective environment for learning			
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	Health and Safety Executive Health Inspectorate Wales Professional regulation			

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?***	No Not required
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?***	No Not required
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)***	Risk register detail included
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	NA
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	NA
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	NA
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	BAF not available
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:*** ***NA***	
Rhestr o Atodiadau: Dim ***List of Appendices:*** Presentation – Appendix 1	

Central IHC
QSE Deep Dive
July 2025

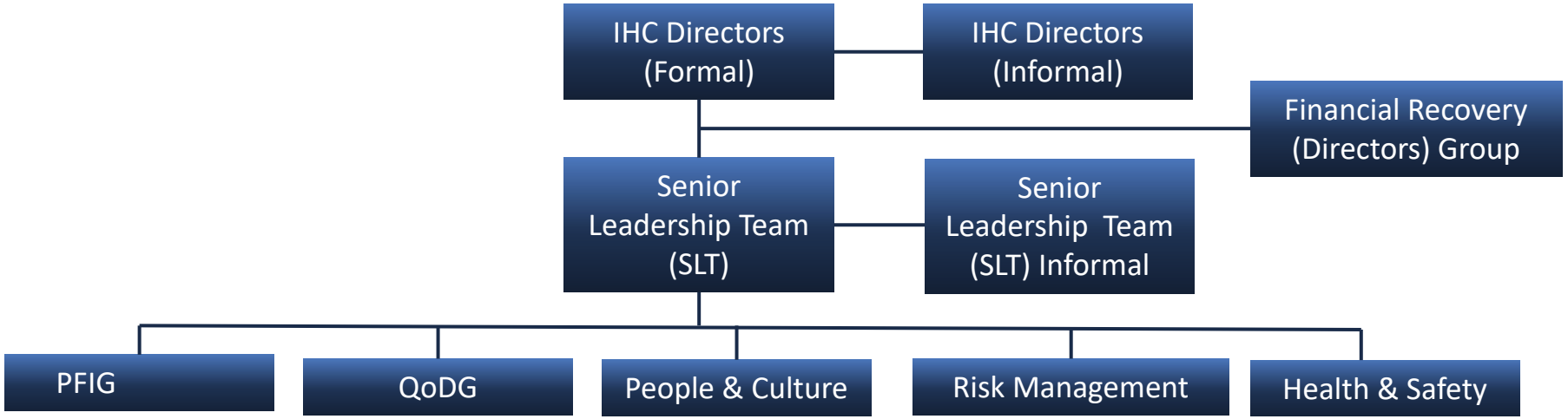
20.02.24

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

GOVERNANCE

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

Central IHC Governance Structure



Governance & Risk - Progress against internal audit recommendations

Internal Audit ID	PROGRESS TO DATE	BARRIERS TO IMPLEMENTATION/DELIVERY	MITIGATION IN PLACE TO ENSURE IMPLEMENTATION/ DELIVERY	PLAN AND TIMELINE FOR DELIVERY
ID 1283	**Effective Governance – Integrated Health Community (IHC) Central** Working with the Corporate Governance Directorate, review the governance arrangements within the IHC, ensuring all Terms of Reference are reviewed and updated and consider the dates of meetings to always enable quorum **Management Response:** Central IHC will complete the review of the governance arrangements including frequency of meetings, Terms of Reference (ToR) and Cycle of Business. Suitable Chairs and Vice-Chair will be reviewed within this process. **Update 17.04.2025 for Audit Tracker:** continues to be ongoing, the ToRs have been reviewed and moved over to the new template for the Central IHC and are at the stage of being reviewed at the individual delivery groups. They will then be presented at a Directors Formal meeting (May) to be approved.	None	Central IHC Business Manager is working with the Chairs of the Delivery Group to review the ToRs and to have them signed off at Directors Formal Meeting before 31 May 2025.	All terms of reference submitted and awaiting audit committee date, recommendation to close
ID 1287	***Effective Governance – Integrated Health Community (IHC) Central*** *The IHC have since developed trajectories to address the backlog of Open and overdue complaints, which will support completion of complaints against the reporting timelines.* *The QODG will receive assurance through the Patient, Safety Group (PSG).* *All Services will review their respective open incidents, and performance will be monitored at PSG and assurance provided to QODG* ***Update 03.02.2025:*** *An update on progress provided to Audit Committee on 16/01/2025, with an improvement in the position since September 2024. Action recommended to be closed by February 2025.*	*None*	Regularly reported at QODG and continue with the supportive implementation of the process to manage and respond to formal concerns in line with the specified timeframes, enabling the IHC to achieve compliance.	*R*ecommended to Audit Committee for this action to be closed 28/02/2025

ACHIEVEMENTS

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

Stabilised the senior IHC team

Improved the IHC Governance

Improved Staff Engagement

Nurse Vacancies Improvement

Reduction in concerns over 30 days

10 Key pieces of progress and achievements made over the last 12 months

Improved financial grip & control

Reduced Planned care extreme waits

ED de-escalated by HIW

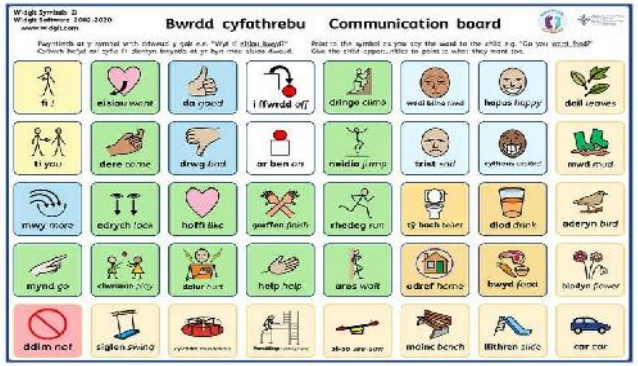
Vascular Stability and Cohesion

Introduction/ Enhancement of T&T Service

Central CAMHS Alternative to Admissions (A2A) Hub

North Denbighshire and Central & South Denbighshire Clusters have been working closely with the third sector.

North Wales Communication Park Project



Celebrating with patients and families

Every member of the ward team was so kind and caring. They showed compassion and humanity throughout but especially when Dad showed signs that his health was declining and he approached his end of life.

IVAS project

Conwy East Cluster DSN service

QUALITY INDICATORS

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

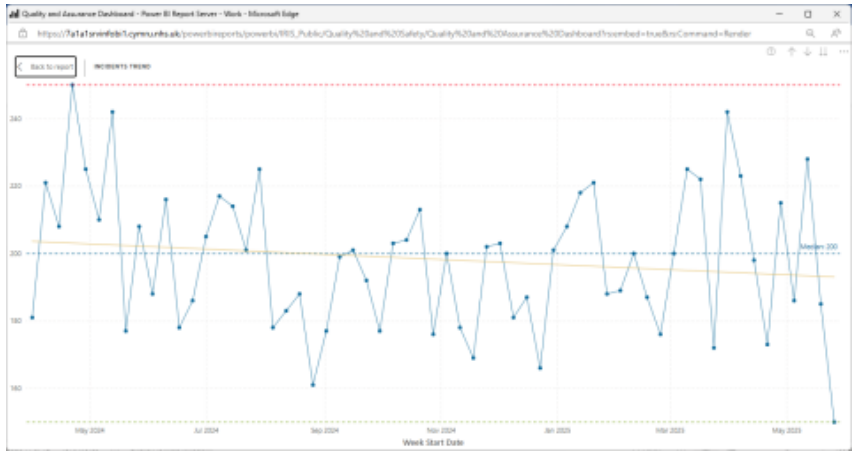
Quality and Assurance Dashboard - Power BI Report Server - Work - Microsoft Edge

https://7a1a1srvinfobi1.cymru.nhs.uk/powerbireports/powerbi/IRIS_Public/Quality%20and%20Safety/Quality%20and%20Assurance%20Dashboard?rs:embed=true&rs:Command=Render

Back to report

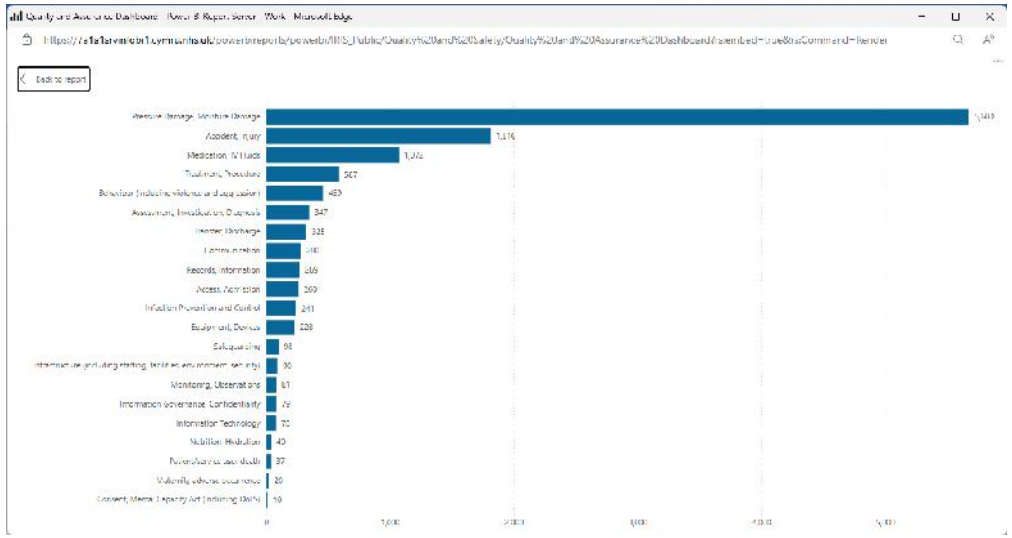
Fiscal Year	2024/25													2025/26			Total
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total	Apr	May	Total	
Incidents	932	941	817	936	823	810	886	790	817	938	759	879	10,328	897	872	1,769	12,097
Incidents with Harm (Low and above)	791	801	694	768	680	669	734	638	694	772	595	709	8,545	738	707	1,445	9,990
Never Events	0	0	0	1	0	0	0	0	0	0	0	0	1	0	1	1	2
HAPU	239	233	217	190	198	183	221	222	201	267	176	225	2,572	227	216	443	3,015
Avoidable HAPU	11	11	13	7	8	8	15	10	19	27	16	27	172	11	11	22	194
Falls	122	115	104	126	104	84	110	91	107	106	89	109	1,267	93	106	199	1,466
Falls with Harm (Moderate and above)	20	11	12	19	10	9	11	14	11	16	8	14	155	8	11	19	174

Central IHC – incident profile

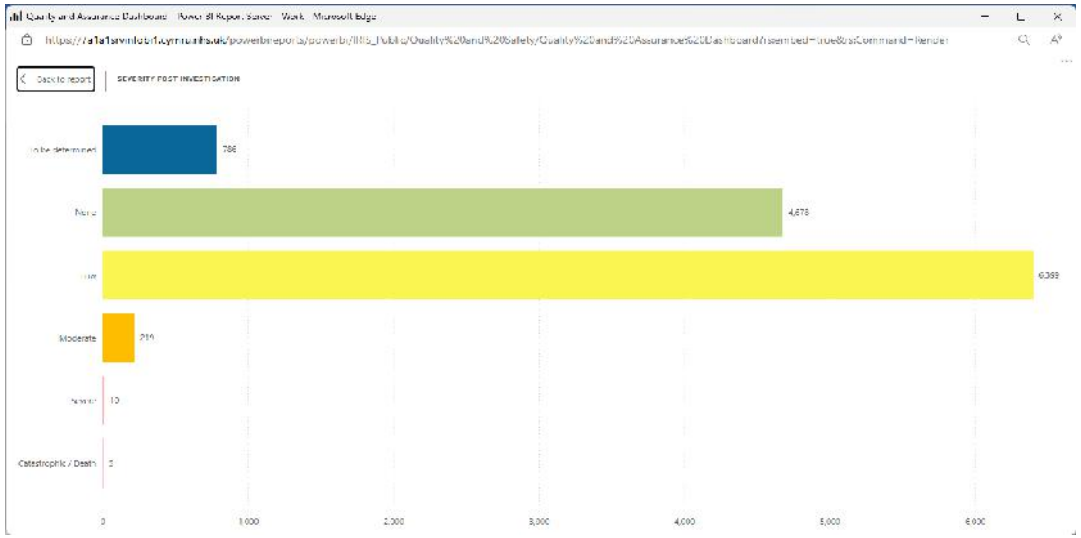


Incident reporting reduced in quarter 2 of 2024 and is now on a recovery trajectory.
There have been a number of nationally reportable incidents relating to access to planned care services and harm suffered by patients due to long waits or patients being lost to follow up.

Central IHC – incident themes



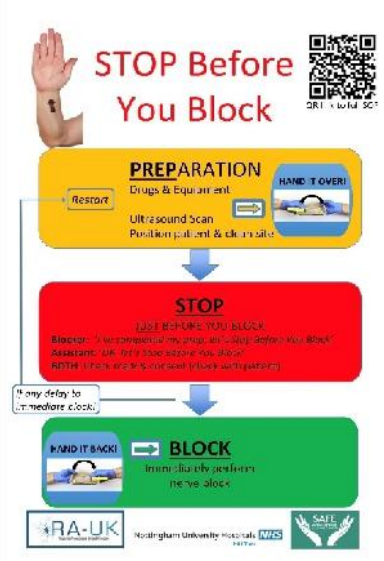
Central IHC – incident severity



Never Events

July 2024, INCIDENT 100585:
Wrong side block, ophthalmology

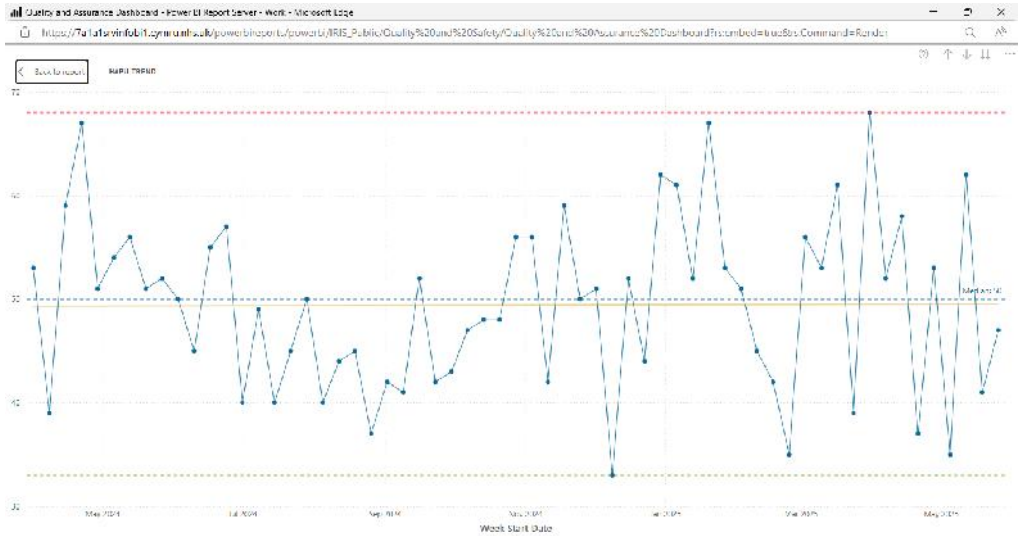
- No harm/injury to patient
- Multiple human factors were contributory factors
- Full investigation resulting in lessons learnt and changes to practices in theatre with a focus on Prep/Stop/Block



May 2025, INCIDENT 137487
Wrong route medication, Acute Medicine

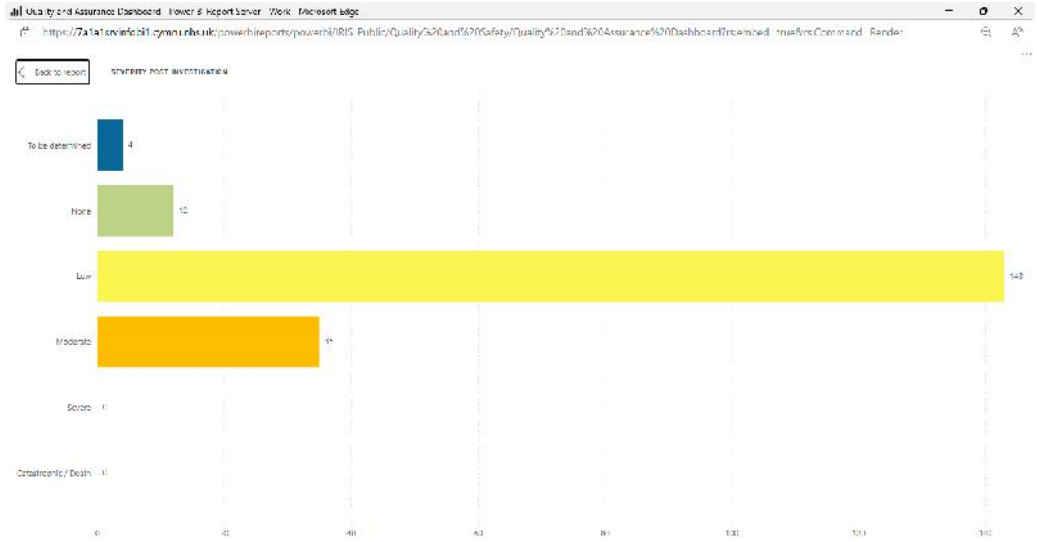
- Rapid review completed and immediate safety actions in place
- Thematic wrong route presentation at Patient Safety
- Investigation ongoing

Central IHC health acquired pressure injury

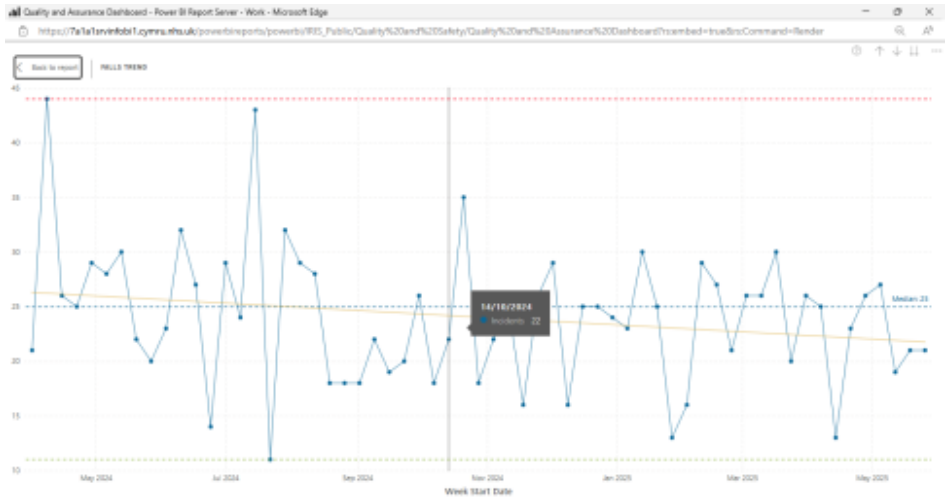


The Central IHC has re-established it pressure injury governance to support improvements in practice and education.

Central IHC health acquired pressure injury - avoidable Severity post investigation



Central IHC inpatient falls

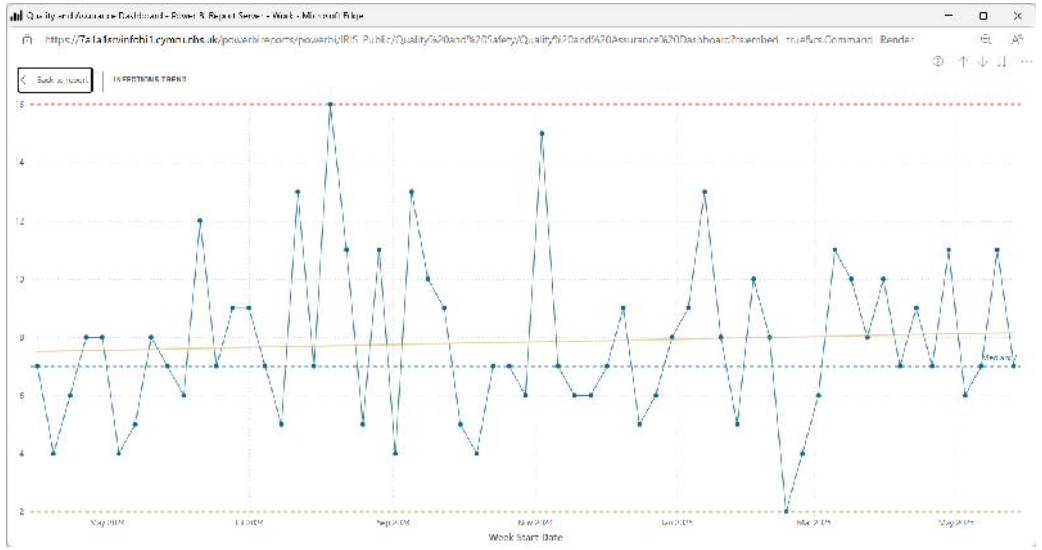


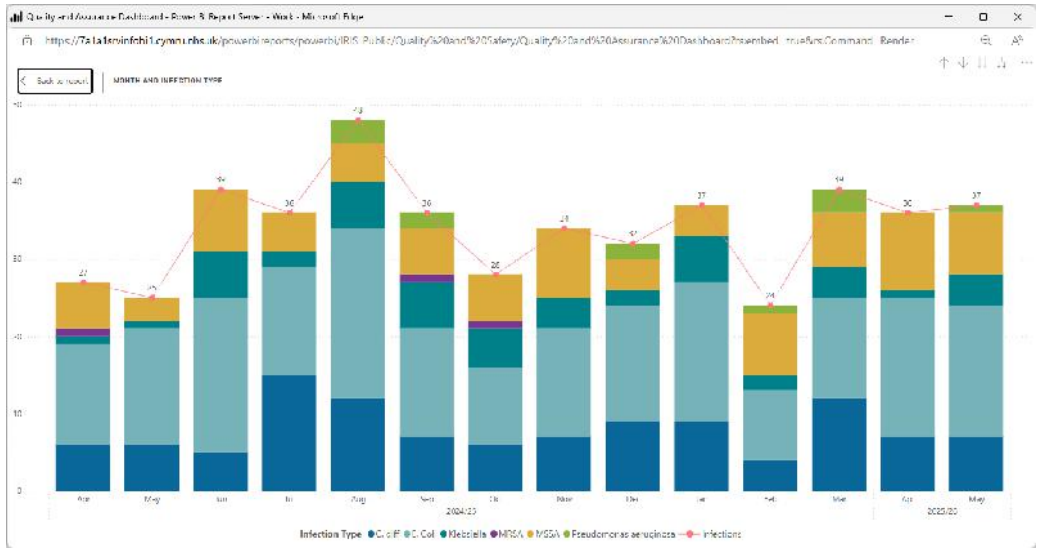
The Central IHC falls group is now established and supporting the ongoing improvement work relating to inpatient falls. This has focused on delivering training, undertaking robust risk assessments and developing initiatives to reduce falls risks.

Central IHC inpatient falls – with harm

Severity post investigation

Infection Trends

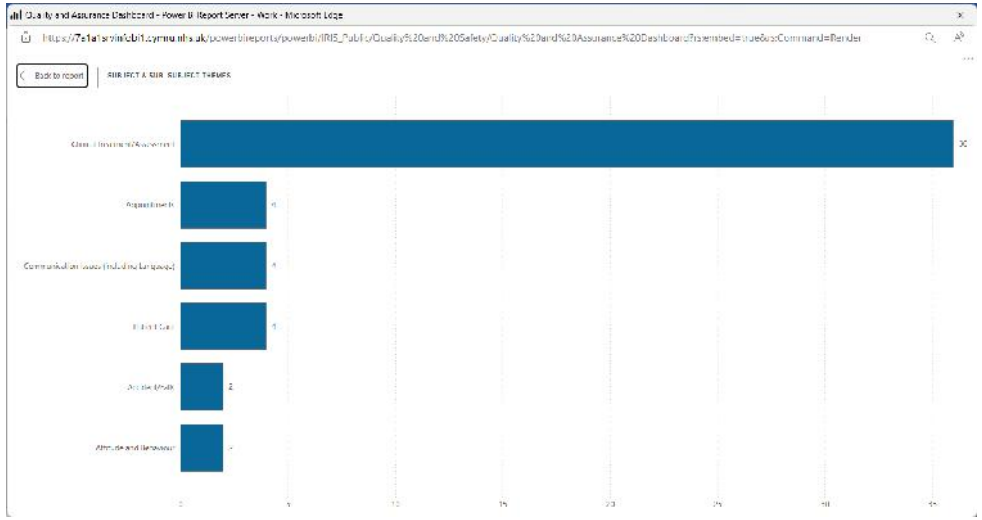




Issues of Significance	Mitigation
Ability to maintain required levels of domestic cover due to vacancy, absence and unfunded pressures	Clinical teams escalate to facilities. Weekly meetings IPC/Domestic services catch up meetings.
Delayed isolation due to increased capacity April 2025. Impacting resulting in bay closures and delayed isolation and further transmission of infections	Staff on wards – Clinical teams continue to risk assess side rooms in accordance with isolation risk matrix. If unable to isolate within 2 hrs Datix is completed. IPT supporting decision making.
Absence of proactive deep cleaning programme (space, kit)	Prioritisation with IPC, weekend decant area in place
Lack of assurance in HCID training	One trainer trained, kit supplied, area for training identified however capacity to deliver is limited.

Formal Concerns

Themes



Ombudsman Enquiries

	Central
Enquiries from PSOW	2
Early Resolution Proposals	1
New Cases (Health Board gathering information for PSOW)	4
Further Information Requests	0
Waiting for PSOW Draft Report	1
Draft Report Received	1
Waiting receipt of Final Report	0
Final Report received and working on Action Plans	2
Further compliance info requested for sign off	0
TOTAL	11

Central IHC has made significant improvements in concerns management. There is assurance that we are investigating and managing concern well and this is reflected in the reduction of ombudsman enquires, which are now at a level with or below the other IHCs.

The IHC patient experience group focuses on the improvements required in relation to the thematic trends.

Childrens Services - MMR

APPENDIX 2 - BETSI CADWALADR UNIVERSITY HEALTH BOARD

TABLE A2. Coverage of one, or two doses of MMR (MMR1/ MMR2) in children reaching birthdays between 01/09/2023 and 31/08/2024, including coverage as it was at the start of the school year and the proportion of children immunised after 01/09/2023, Betsi Cadwaladr UHB

Betsi Cadwaladr UHB							
Birthday reached during 2023-24 academic year	Children	Total MMR1 coverage		Received MMR1			
				Before 01/09/2023		On or after 01/09/2023	
	(n)	(n)	(%)	(n)	(%)	(n)	(%)
5	6,710	6,463	96.3	6,407	95.5	56	0.8
6	7,155	6,891	96.3	6,857	95.8	34	0.5
7	7,320	6,994	95.6	6,968	95.2	26	0.4
8	7,505	7,221	96.2	7,200	95.9	21	0.3
9	7,631	7,331	96.1	7,304	95.7	27	0.3
10	7,781	7,488	96.2	7,469	96.0	19	0.2
11	8,115	7,773	95.8	7,743	95.4	30	0.4
12	8,284	7,993	96.5	7,955	96.0	38	0.5
13	8,294	8,004	96.5	7,984	96.3	20	0.2
14	8,255	7,984	96.7	7,947	96.3	37	0.4
15	8,040	7,764	96.6	7,741	96.3	23	0.3
16	8,163	7,873	96.4	7,846	96.1	27	0.3
Total	93,253	89,779	96.3	89,421	95.9	358	0.4

Betsi Cadwaladr UHB							
Birthday reached during 2023-24 academic year	Children	Total MMR2 coverage		Received MMR2			
				Before 01/09/2023		On or after 01/09/2023	
	(n)	(n)	(%)	(n)	(%)	(n)	(%)
5	6,710	6,196	92.3	6,006	89.5	190	2.8
6	7,155	6,661	93.1	6,604	92.3	57	0.8
7	7,320	6,807	93.0	6,765	92.4	42	0.6
8	7,505	7,070	94.2	7,025	93.6	45	0.6
9	7,631	7,175	94.0	7,144	93.6	31	0.4
10	7,781	7,328	94.2	7,305	93.9	23	0.3
11	8,115	7,601	93.7	7,577	93.4	24	0.3
12	8,284	7,866	95.0	7,818	94.4	48	0.6
13	8,294	7,870	94.9	7,843	94.6	27	0.3
14	8,255	7,843	95.0	7,792	94.4	51	0.6
15	8,040	7,635	95.0	7,600	94.5	35	0.4
16	8,163	7,733	94.7	7,710	94.4	23	0.3
Total	93,253	87,785	94.1	87,189	93.5	596	0.6

Childrens Services – Neonatal

Performance against standards – National Neonatal Audit Programme (NNAP)

	Above National Average	Below National Average	Missing Measure Data	Total
SURNICC	16	4	0	20
East	13	6	1	20
West	8	11	1	20

Key Headlines

- Several measures included in PERIPrem Cymru perinatal optimisation bundle have shown and improvement
- Action plan in place with a view to reducing mortality and serious brain injury

Challenges / Risks / Focus Areas

- Antenatal steroid use in YGC and YG
- Temperature at admission in YGC and YG
- ROP compliance in all three areas
- Small case numbers in SCBU's can be misleading

• Success

- Delayed cord clamping improvements in YGC and WMH
- Breast milk use (day 2, day 14 and discharge)
- Parent inclusiveness at ward rounds
- Neonatal nursing staff above national target in all three units
- Bloodstream infections below national target in all three units

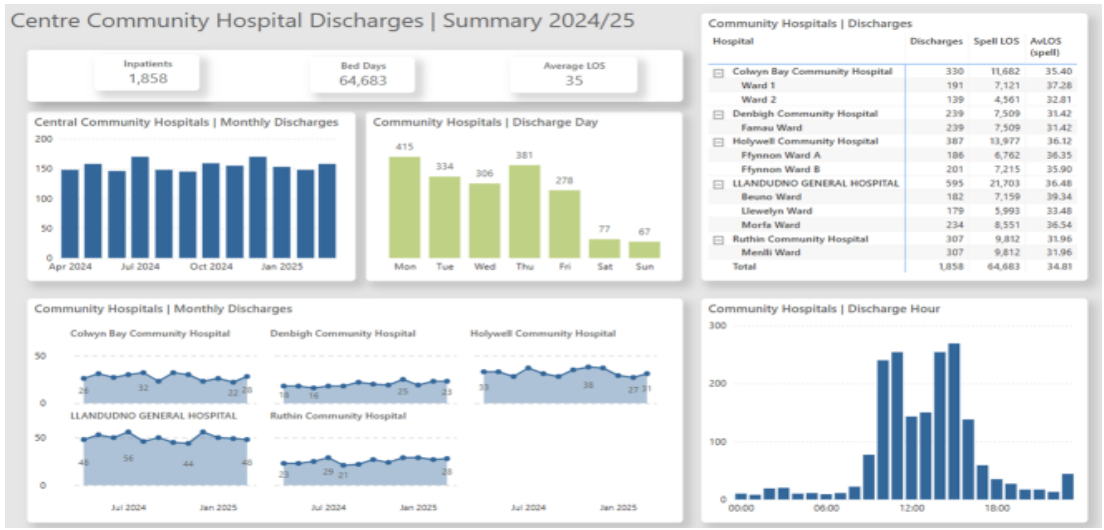
ICMS - Discharge to Recover and Assess (D2RA)

Increasing appropriate flow to and through Community Hospitals

	PW1			PW2			PW3		
	2023	2024	2025	2023	2024	2025	2023	2024	2025
Jan	21	16	19	106	106	113	5	22	35
Feb	10	23	35	75	87	132	0	26	51
Mar	16	16	38	88	80	126	4	22	44
Apr	20	19	0	77	85	0	6	30	0
May	31	17	0	99	94	0	1	30	0
June	11	33	0	46	106	0	0	29	0
July	13	31	0	70	89	0	27	29	0
August	18	21	0	87	86	0	34	30	0
September	17	15	0	98	118	0	25	40	0
October	23	29	0	85	153	0	36	52	0
November	11	33	0	108	115	0	26	42	0
December	16	17	0	103	94	0	29	27	0
Total	207	270	92	1042	1213	371	193	379	130

Increasing numbers of pathway 2 patients are accessing community hospital capacity.

Focus on ensuring that new pathway 3 patients are transferred to community hospitals, where appropriate to reduce acute admission length of stay but importantly to explore decision making in a more therapeutic environment.



Patients being discharged in time for tea

Out of hours discharges are, in the main, escalations to the acute hospital site.

Regulation 28:

The Coroner served a Regulation 28 notice on the Health Board on 14th February 2024. This arose following the death of a patient who was registered with a Health Board managed GP Practice in Holyhead. The Health Board responded on 10th April proposing a timeline to achieve the requirements by 31st May 2025.

Both CIHC Managed Practices continue to work on Regulation 28 medication reviews. Currently HPI are at 65% and WEMC are 80% completion of reviews.

Focus has been made on high-risk medications. Focus has been on identifying dedicated clinics with all clinicians competent to undertake reviews.

It is anticipated that both practices will be compliant by July 2025.

There is further work to be undertaken to ensure that this quality and safety standard is embedded into routine practice.

Ysbyty Glan Clwyd – HIW inspection, ED.
De-escalated as a service of significant concern

Emergency Department at Glan Clwyd, Improvement Plan:

Inspection Date: 29/04/2024 – 01/05/2024

Responsible Lead: IHC Director, Central

Overall Status: Overdue

Outstanding Actions:

Plan to Close Outstanding Actions:

The IHC Director conducted a 'Rapid Review' of the improvement plan with the Senior Leadership Team on 3rd February 2025. The evidence for the overdue action has been reviewed by the Hospital Management Team (HMT) Oversight Group and reviewed by the Quality Team. This is approved for closure, subject to further supporting evidence which is the minutes of the latest ED Governance Meeting where the outcome of the audit was discussed.

The plan is under scrutiny by the Regulatory Assurance Group (RAG), which reports to the Executive Delivery Group (EDG).

The Quality Team provided an update to the inspector on 19th March 2025.

Improvement Focus:

•Ensuring timely review and closure of overdue actions by the HMT Oversight Group.

•Maintaining rigorous scrutiny through the RAG and EDG to ensure accountability and progress.

•Providing regular updates to inspectors and stakeholders to demonstrate ongoing commitment to

Position Overview / Summary:

27 Recommendations

70 Service Improvement actions

0 actions in progress

0 actions partially complete

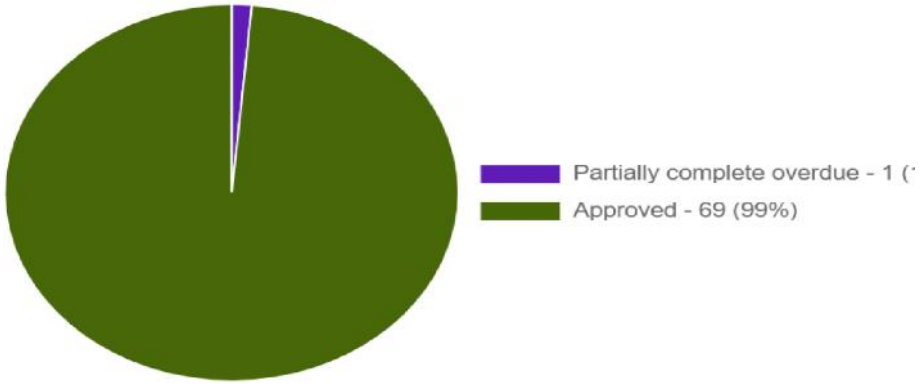
1 actions partially complete (overdue)

0 actions overdue

0 rejected

0 actions complete (awaiting approval)

69 actions completed (99% of plan is complete)



Therapies

The D2RA team support patients back to their place of residence where appropriate from the front door and wards at YGC
The total number of referrals over the 12-month period stands at 773, while follow-up activities totalled 1881, indicating a significant level of continued patient engagement post-referral.

88% of these referrals received a same-day assessment. For the 12% where same-day assessments were not achieved;

- 27% due to transport issues.
- 27% due to late referrals.
- 45% categorized as “other” (this category will be refined in future data collection to better understand the underlying causes).

Achievement

- **Avoided Admission:** 34% of cases resulted in avoiding hospital admission.
- **Earlier Discharge Facilitated:** 26% of cases supported earlier discharge.
- **Safer Discharge Facilitated:** 37% of cases contributed to a safer discharge

Plan

Further establish and embed role of the team more broadly within the acute setting and in particular in the community.
ADT and D2RA becoming one larger therapy team
Explore opportunities to work more closely with social care/reablement

Pharmacy

Technical Services

- MHRA working capacity target for aseptic services is 70-80%.

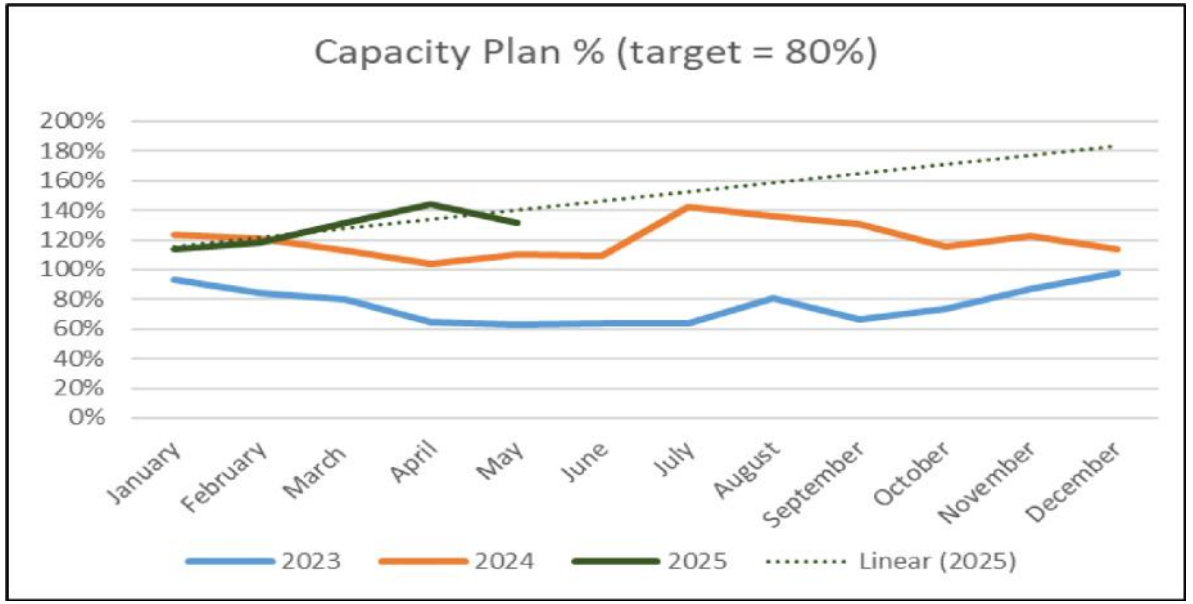
Regulatory standards and scrutiny are constantly increasing.

- WHC/2024/004 (Sterile Preparation of Medicines) audit March 2025 – amber rating.

•Capacity breaches have a significant impact on regulatory compliance and loss of assurance around safety.

- Pharmaceutical Quality Management System
- GMP compliance.
- Training
- Validation processes and environmental monitoring.
- Errors and complaints investigation and reporting

- April 2025 – escalation of continual capacity breaches and equipment failure exposed fragility of aseptic services.
- IMT actions and lessons learnt captured.



CONTINUING AREAS OF CONCERN

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University Health Board

FRAGILE SERVICES

In addition with of the formal list of specialities recognised as challenged there are a number of other specialities which we are concerned about and would welcome progress towards a clinical strategy.

In the immediacy we need support to address the current position in our Gastroenterology service to bring the potential for a North Wales solution to a decision-making point. As an IHC we are managing a number of formal patient complaints and serious incidents relating to gastroenterology services.

ENHANCED ORGANISATIONAL CONTROLS/NONE RECURRENT FUNDING

Enhanced Organisational controls (contracts, oracle, RIGA)
A lived example of the impact can be evidence through the Speech and Language provision in the ESD service. There is currently no provision in service due to staff movement and there has been a challenge to have backfill approved as these posts are none recurrent and held in RIGA 2. 5 incidents have been reported since 30th April 2025, the detail of one is highlighted below;

139382	03/06/2025	26/05/2025	Patient discharged home with early supported discharge team on 26/5/2025 requiring ongoing speech therapy following a diagnoses of left LACS stroke on 29/4/25. Pt was having speech therapy at SSIR and required ongoing input in ESD however no SLT in post to assess or review plan. Pt has not been receiving any SALT intervention as required. Patient has been referred to community SALT from SSIR and awaiting appointment

RISKS

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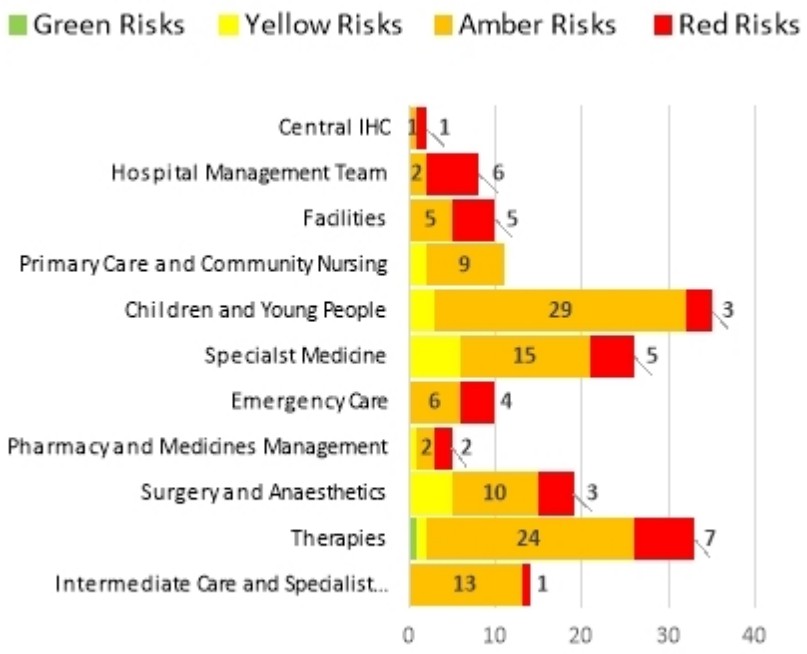
Betsi Cadwalar
University Health Board

Governance & Risk - Top 5 risks and plans to mitigate

The Central Integrated Health Community (IHC) Risk Register currently has 34 Red Risks, (Risk rating of 15 and above) in June 25 and 114 Amber Risks, (risk rating between 8 and 12).

June 2025



All risks are actively reviewed and updated with regular dynamic assessments of risk score

The IHC Service review their Risk Registers through the Governance Structure and they are brought to the monthly Central IHC Risk Management Group for scrutiny and potential escalation to the SLT.

Central IHC Tier 1 Risk Register - June 2025

Risk Rating	ID	Title	Opened
25	2664	Risk of delay in receiving emergency treatment following a GI Bleed due to lack of an emergency rota/staff to support it	04/04/19
25*	2304	Risk of patient harm and delayed diagnosis/treatment due to insufficient new and review outpatient capacity in gastroenterology	24/08/18
20*	5136	Critical Staffing Capacity in Pharmacy Production Unit and Clinical Cancer Pharmacy Team	12/02/24
16	3949	Delays to be seen in the Emergency Department	27/05/21

*Risk scores expected to be updated during next review period

Emerging and Escalating Risks to note:

- Car Parking & Access – YGC Site – Risks 5497, 5022, 5232, 5498
- Security – YGC Site Risk 5099

Presenter: Rhys Davies

Source: Central IHC Risk Management Report June 2025

<table>
<tr><td>Quality, Safety and Experience CommitteeTeitl adroddiad:

Report title:</td><td colspan="4">Executive Summary of the Key Strategies and Policies Relating to Women’s Health and Perinatal Services in Wales</td></tr>
<tr><td>Adrodd i:

Report to:</td><td colspan="4">Quality, Safety and Experience Committee</td></tr>
<tr><td>Dyddiad y Cyfarfod:

Date of Meeting:</td><td colspan="4">Thursday, 03 July 2025</td></tr>
<tr><td>Crynodeb Gweithredol:

Executive Summary:</td><td colspan="4">This Report provides the Board with an overview of the newly published Strategeis and Policies relating to Women’s Health and Perinatal Services in Wales. The report outlines what is expected of the Health Board and provides a local update on progress against each of the key documents.</td></tr>
<tr><td>Argymhellion:
Recommendations:</td><td colspan="4">The Committee is asked to:

Note the national requirements/recommendations and expectation of the Health Board.

And

Support the local implementation and monitoring of these requirements as detailed in the Health Board’s Three-Year Plan submitted to Government.</td></tr>
<tr><td>Arweinydd Gweithredol:

Executive Lead:</td><td colspan="4">Mrs Angela Wood, Executive Director of Nursing and Midwifery</td></tr>
<tr><td>Awdur yr Adroddiad:

Report Author:</td><td colspan="4">Women’s Senior Leadership Team</td></tr>
<tr><td>Pwrpas yr adroddiad:
Purpose of report:</td><td>I’w Nodi
For Noting
☐</td><td colspan="2">I Benderfynu arno
For Decision
☒</td><td>Am sicrwydd
For Assurance
☒</td></tr>
<tr><td>Lefel sicrwydd:

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

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

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

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

No confidence / evidence in delivery</td></tr>
<tr><td colspan="5">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:</td></tr>
</table>

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):***	Welsh Government Planning and Legislation Framework. The NHS (Wales) Act 2006: Engagement Consultation. The Equality Act (2010) The Social Services and Wellbeing Act (Wales) 2014. The Wellbeing of Future Generation Act 2015. Health and Social Care (Quality and Engagement (Wales) Act 2020.
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)***	N/A
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	The outlined expectations of Health Boards have been included in the Health Board's Three-Year Plan (2025-28) for 25/26 onwards. Any available National funding, resourcing, allocation has not been confirmed.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	This is to be quantified in relation to each of the documents included in the Executive Summary
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	NO
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***	

Rhestr o Atodiadau:
Dim
List of Appendices: *one*

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

Executive Summary of the Key Strategies and Policies Relating to Women's Health and Perinatal Services in Wales

CONTENT PAGE NO

1. Introduction

This report has been drafted to provide the Committee with an overview of the newly published strategies and policies relating to Women's Health and Perinatal Services in Wales. They are a as follows:

- The NHS Wales Women's Health 10 Year Plan – (NHS Executive, 2024).
- Quality Statement for Maternity and Neonatal Services – (WG, 2025)
- The All-Wales Perinatal Engagement Framework – (WG, 2025)
- Strategic Perinatal Workforce Plan (HEIW, 2025-2028)

These key documents will be individually presented within the report, noting what is expected of the Health Board and Local progress to date.

2. The NHS Wales Women's Health Plan (2025-2035) – 10 Year Vision for Women's Health in Wales – https://executive.nhs.wales/functions/networks-and-planning/womens-health/the-womens-health-plan-for-wales

The Plan outlines an NHS Wales approach to improving health outcomes and healthcare services for women in Wales. It has been co-ordinated and led by the National Strategic Clinical Network for Women's Health with involvement from NHS staff, experts in the field and third sector organisations. It builds upon the work of the 'Discovery Report' which captures the voices of 4,000 women and girls in Wales.

The Plan outlines the key health inequalities experienced by women in Wales and notes the disparities in health that are emerging. It also highlights opportunities for closing the gender gap, improving health across NHS Services, and in taking a preventative approach to Women's Health aligned to the Welsh Governments 'A Healthier Wales our Plan for Health and Social Care'.

The Plan will be delivered over ten years, through short (up to 2yrs) medium (3-5yrs) and long term (6-10yrs) actions. It will follow a life course approach, with a focus on delivery of services from 16 years of age, which mean that 'women's health' is broader than Gynaecology and Maternal Health related conditions.

The vision is that in 10 years

The Plan includes sixty-eight actions across eight key priority areas which underpins the 10 Year Vision for the Plan. They are;

- Menstrual Health
- Endometriosis and Adenomyosis
- Contraception, Post-Natal Contraception and Abortion Care
- Preconception Health
- Pelvic Health and Incontinence
- Menopause
- Violence against Women and Girls
- Ageing Well and Long-Term Conditions Across the Life Course (incudes; Diabetes, ME/CFS, Cardiovascular Disease, Cancer, Musculoskeletal conditions, end of life care).

The health system in Wales has adopted a collaborative approach to integrated planning, delivery and monitoring of healthcare services. The Plan embraces collaboration to ensure all aspects of Women's Health are co-ordinated and robust to meet the need of women in Wales. The overall aim is to bringing together Health Boards, Special Health Authorities and Trusts alongside Welsh Government, third sector partners and women themselves. The plan will help drive better services and population outcomes.

Welsh Government has added Women's Health to its Ministerial Priorities for 2025/26. The specific Key Delivery Expectation is: *'Establishment of one Women's Health Hub in each Health Board area by March 2026,'* aligned to the Women's Health Plan.

The local response to the successful launch of the Plan to date is as follows;

- **A Ministerial Priority Template for Women's Health –** has been submitted to reflect the expectation of establishing a Women's Hub (Appendix 1) locally in North Wales by March 2026. This will be informed by a National Service Specification focused on three Priority Areas in 2025/26;
  Menstrual Health, Contraception, Menopause care and the development of an all-Wales Web-based Service-User Resource.

- **An Executive Sponsor has been appointed** - Mrs Angela Wood (Executive Director for Nursing and Midwifery) will be responsible for the oversight of the delivery of the Women's Health Plan for the Organisation and represent the Health Board on the Women's Health Network Leadership Group.

- **The Health Board Clinical Lead for Women's Health** – Consultant Nurse Nia Boughton has been appointed and will be responsible for delivery of the Women's Health Hub locally in partnership with the Women's Health Network and represent the Health Board at the Women's Health National Clinical Reference Group.

- **A Local Executive Lead Programme Management Group –** with clear terms of reference has been established as requested for all Health Boards in Q1 25/26 and as noted in the related Ministerial Template

- **The Women's Directorate** has led on a local benchmarking exercise against the relevant 8 Priorities in the Plan and included the short-term actions in its Service's Planning Priorities for 2025/26 which features in the Women's Section of the Health Board's Three-Year Plan.

- **A Local Stakeholder Analysis –** has been completed.

- **A Stakeholder Workshop –** informed by the Stakeholder Analysis, has been scheduled in Q1 25/26.

- **Indicative Funding for the Establishment of the Women's Heath Hubs** – confirmed on 30/4/25. A maximum allocation of £300,00 is anticipated for each Health Board outlining a two-phased approach to submitting proposals for funding

The following updates and information from the National Women's Network are awaited;

- The Local Population Health Benchmarking Template – to be completed in Q1 of 25/26.

The governance and implementation of the Plan will be overseen by the NHS Wales Executive with annual reports on behalf of NHS Wales to Welsh Government.

Local Progress on the Plan is reported and monitored at IQPD and JET sessions led by the NHS Executive.

3. Quality Statement for Maternity and Neonatal Services - https://www.gov.wales/quality-statement-maternity-and-neonatal-services

The National Clinical Framework (WG, 2021) written in response to A Healthier Wales (2018) sets out the purpose of quality statements in prioritising the vision for specific clinical services enabling a consistent approach to improving outcomes and should be considered alongside 'Working Together for a Healthier Wales' (2023-2035).

This Quality Statement builds on the Maternity Care in Wales - A Five Year Vision for the Future (WG, 2019) which focused on achieving high quality Maternity Services in Wales. The essence of the vision remains unchanged with an ambition to continue to drive forward the five key principles of maternity care,

- Family Centred
- Safe and Effective
- Continuing of Carer
- Skilled Multi-Professional Teams
- Sustainable Quality Services

The quality attributes for perinatal care in Wales are shaped around the 12 Health and Care Quality Standards which seek to support delivery of the right care, in the right place the first time, leading to better outcomes and experiences for women, babies and their families during pregnancy, childbirth and the postnatal period. This Quality Statement should not be viewed in isolation, recognising that pregnancy and childbirth are small timeframes in a life course and as such the 'Quality Statement for Women and Girls' Health' (2022) and the subsequent 'Women's Health Plan for Wales' (2024) as well as the 'Healthy Child Wales Programme' are important adjuncts to this document.

It is expected that Health Boards undertake a review of their current status against each of the 34 quality attributes described in the Quality Statement, aligned to their local action plan for the MatNeo Safety Support Programme (MatNeoSPP). This will act as a baseline and contribute to the development of, or alignment to, existing improvement plans. Locally, this requirement will be undertaken jointly with the Neonatal Service in Quarter One of 25/26 and resulting actions included in the Women's and Neonatal Services Planning Prioritise.

Health Boards will be supported by the NHS Executive to deliver the expectations set out in the document. This will be discharged through the Implementation Network for MatNeo SSP and

where appropriate the Maternity and Neonatal Strategic Network, who will be responsible for developing a robust service specification for maternity and neonatal services in Wales.

All Health Board are required to identify an Executive Sponsor to adopt this Quality Statement locally. Mrs Angela Wood, Executive Director of Nursing and Midwifery has been appointed for the Health Board.

Health Boards are also required to commence the following work during 2025 to 2026, prioritising the **seven key actions** as follows;

Seven key actions	
1	All health boards are required to deploy the national digital maternity system by the end of March 2026 *(quality attribute 29; MatneoSSP report p.64)*.
2	Work in partnership with the NHS Executive to devise an implementation plan to deliver on the Perinatal Engagement Framework commitments. Health boards must ensure they engage with women from Black, Asian, minority ethnic and other under-represented groups majority to improve outcomes by identifying barriers in access to services *(quality attribute 18; MatneoSSP action 5.2)*.
3	Ensure a baseline assessment and an associated action plan for neonatal services is developed, seeking support where appropriate to enable care to be delivered in line with the Bliss Baby Charter Principles; and commence the journey to accreditation *(quality attribute 17; MatneoSSP action 7.4 5)*.
4	Collaborate with HEIW to prioritise year one actions to ensure the Perinatal Strategic Workforce Plan is delivered, noting that this will be a phased approach *(quality attribute 23, MatneoSSP action 2.1)*.
5	All health boards are required to develop a perinatal quality surveillance dashboard with key standardised metrics that inform both network level and national oversight which in turn inform policy direction *(quality attribute 28, MatneoSSP action 11.7)*.
6	All health boards should ensure that choice of place of birth is offered to encompass all birth settings, noting that this may be in an alternative health board *(quality attribute 14, MatneoSSP action 10.2)*.
7	Ensure that four of the five bereavement pathways are ratified within year one, with an implementation plan, to ensure a co-ordinated roll out *(quality attribute 20, MatneoSSP action 13.1)*.

Six of the seven key actions have been included in the Women's Services Priorities which feature in Section 4k of the Health Board's 2025-28 Three Year Plan, with milestones identified.

Local Progress against the seven key actions will be monitored at the Health Board's Strategic Perinatal MatNeo SSP and Quality Implementation Oversight Group, chaired by Mrs Angela Wood with quarterly updates being provided to IQPD and bi-monthly to the MatNeoSSP Network Oversight Group.

4. The All-Wales Perinatal Engagement Framework (WG, 2025) - https://www.gov.wales/perinatal-engagement-framework-guidance-health-boards

Active collaboration and engagement with women, parents and families is essential and is encompassed with the Wellbeing of Future Generations (Wales) Act (2015)

The Perinatal Engagements Framework, as referred to in the Maternity and Neonatal Quality Statement sets out the minimum standards for high quality service user engagement across Wales. It provides details of the 10 commitments Health Boards are expected to implement, the requirements to meet these commitments and what good looks like.

The Ten commitments are as detailed below;
Commitment 1: ***Organisations will promote an active listening culture which recognises the importance of compassion, empathy and kindness. These values and behaviours are actively embraced by the entire perinatal workforce (floor to board) and reflected in all language and terminology used to communicate with women, parents, families and staff.***
Commitment 2*: Organisations will promote a culture of partnership with the women, parents and families who access their perinatal services.*
Commitment 3*: Perinatal services are provided in a way that meets the unique needs and requirements of all women, parents, babies and their families, which in turn will help to optimise the experiences and outcomes of care.*
Commitment 4*: Develop, maintain and use a national stakeholder mailing list as a means of all-Wales perinatal service communication and engagement, including those representing or advocating for protected characteristics groups.*
Commitment 5: ***Organisations will ensure appropriate processes are in place to collect, collate and analyse all forms of feedback, with an overview available to staff and the public through consistent reporting arrangements***
Commitment 6: ***Organisations will develop and maintain local MNVPs forums which are embedded within their governance structures and feed into the national MNVPC forum.***
Commitment 7: ***Llais will develop, maintain and support national Maternity and Neonatal Voice Partnership Cymru (MNVPC) forum arrangements.***
Commitment 8: ***All forms of feedback and experience data will be triangulated with other quality, outcome and experience measures when considering service performance. It will be included within quality and assurance reports across the service and organisation, as well as in other public-facing reports.***
Commitment 9*: Organisations will embed a culture of learning from experiences, on which a continuous programme of QI and service improvement is built.*
Commitment 10: ***Organisations will have processes in place to ensure that services are listening and responding to feedback, and that the public is informed about how their experiences have influenced change in line with the Duty of Quality.***

The application of these commitments will ensure an equitable, inclusive approach so all women, parents and families are engaged at every stage of their journey, to enable improvements in service provision and to inform policy.

It is expected that Health Boards will work in partnership with the NHS Executive to devise an implementation plan to deliver on the Perinatal Engagement Framework commitments. Health

Boards will be expected to engage with Women from Black, Asian, ethnic minority and other under – represented group majorities to improve outcomes by identifying barriers in access to services.

The Health Board awaits an invite from the NHS Executive to progress the outlined plan. A local plan is being progressed to implement the All-Wales Maternity and Neonatal Experience Measure Questionnaire in Q1 of 2025/26, aligned to the CIVICA system and a local benchmarking exercise against the 10 commitments has been completed and will inform the Services' Priorities for 2025/26.

5. The Strategic Perinatal Workforce Plan 2025-26 (HEIW, 2025)

This Perinatal Workforce Plan sets out how, over the next 3 years NHS Wales will continue to develop and grow the perinatal workforce to provide personalised, equitable, safe care to women, babies and families.

This multi-professional plan, guided by Health Education and Improvement Wales' – 'A Healthier Wales Our Workforce Strategy for Health and Social Care', prioritises workforce, training and education recommendations from multiple UK reports into Maternity and Neonatal Services.

The healthcare landscape faces significant challenges. While birth rates in Wales are declining, care complexity continues to increase, accompanied by growing health outcome inequalities and workforce supply and demand, HEIW is committed to building a sustainable, engaged and motivated workforce.

The HEIW Vision and 4 key actions are; **A**ttract, **R**etain, **T**rain and **T**ransfer.

As noted in the Maternity and Neonatal Quality Statement, Health Boards are expected to collaborate with HEIW to prioritise year one actions to ensure the Perinatal Strategic Workforce Plan is delivered, noting that this will be a phased approach.

The Plan is to be presented to their Executive Board on 27/3/25 and if approved will be published and launched in Quarter One of 2025/26.

6. Conclusion

The report intends to provide an overview of the newly released strategic documents and requirements relating to Women's Health and Perinatal Services in Wales that have been included as key prioritise in the Health Board's Three-Year Plan for implementation in 2025/25 and as part of its Integrated Medium-Term Plan (IMTP) to Welsh Government.

7. Recommendations

The Committee is asked to:

- Note the National requirements/recommendations and expectation of the Health Board.

And

- Support the local implementation and monitoring of the requirements as detailed in the Health Board's Three-Year Plan submitted to Government.

8) References

A Healthier Wales: https://www.gov.wales/healthier-wales-long-term-plan-health-and-social-care

Women's Health Plan for Wales – Discovery Report: https://executive.nhs.wales/functions/networks-and-planning/womens-health.womens-health-in-wales-a-discovery-report/

Health and Social Care Quality & Engagement Wales Act: https://www.gov.wales/health-and-social-care-quality-and-engagement-walesact-summary

Maternity Care in Wales – A Five Year Vision for the Future (2019-2024) WG, 2019

The Quality Statement for Women's and Girls Health https://www.gov.wales/quality-statement-women-and-girls-health-html

Wellbeing of Future Generations Act 2015 https://www.gov.wales/well-being-of-future-generations-wales

Women's Health Wales: A Quality Statement for the Health of Women, Girls, and those Assigned Female at Birth 2022: https://www.ftww.org.uk/2021/wp-Content/uploads/2022/05/WomensHealth-Wales-Quality-Statement-English-FINAL.pdf

APPENDIX 1

NHS WALES PLANNING FRAMEWORK 25-28- TEMPLATES

The Ministerial templates support the development of organisational IMTPs/ plans along with the Minimum Data Set (MDS).

A template will be required to detail milestones, actions and risks etc for the delivery expectations against each of the following strategic priorities:

- **Timely Access to Care**
- **Population Health and Prevention**
- **Building Community Capacity**
- **Mental Health Access**
- **Women's Health**

Progress on these expectations, including specific delivery metrics, have been referenced in the planning framework. The set of 3-year strategic priorities and year 1 delivery expectations must be delivered by all health boards, and other NHS organisations where relevant, and will be a focus of the planning process for 2025-26.

Completing the template will provide detailed delivery points including baseline, milestone and actions to demonstrate how the priority will be implemented. The detail contained in the template should align to the narrative plan.

All priorities need to be underpinned by a focus on quality, safety and prevention as a part of the planned activity, with good medical outcomes at the heart of NHS services.

APPENDIX 1

MINISTERIAL TEMPLATE BLANK

All organisations are expected to complete the templates proportionate to their direct or supporting roles and functions.

The completed templates must be collated and submitted alongside the organisation's plan and the completed Minimum Data Set by 31 March 2025. Please send to: HSS-planningteam@gov.wales

The blank template below needs to be replicated as required for each priority / delivery expectation identified. Additional rows can be expanded as necessary.

Priority area(s) to deliver 25/26:	
Key focus should be on delivering	• Timely Access to Care • Population Health and Prevention • Building Community Capacity • Mental Health Access • Women's Health

Priority area(s) to deliver 25/26: Womens Health

Key focus should be on delivering	**Establishment of one Women's Heath Hub in each health board area by March 2026 (aligned to the Women's Health Plan) – New Priority**
Ref:	**(Indicate if new priority or continued from 24/25)**

Resume of planning Milestones 24/25: Not applicable as a new Ministerial Priority for 25/26				
	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
Ref:	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Progress synopsis	Not Applicable	Not Applicable	Not Applicable	Not Applicable

Outcomes of delivering Ministerial Priorities: Not Applicable – New Ministerial Priority for 25/26	
Ref:	**Ministerial Priority 5**

Planned milestones for Priority area to deliver 2025/26

	Quarter 1 – Discovery Phase	**Quarter 2 – Design Phase**	**Quarter 3 – Design & Approval Phase**	**Quarter 4 – Delivery Phase**
Ref:	**1)Scoping and baseline review of current women's health offer and access to services. This will include:** • **Regional and national benchmarking** • **Capacity and demand modelling** • **Workforce review (including key roles)** • **Skills and capacity review** • **Review of patient pathways- in line with national optimised pathways including SoS, PiFU and GIRFT recommendations** **2) Local Executive lead Programme Management Group to be established to include PPIE and stakeholder engagement**	**1) Utilise scoping and baseline review from Q1 (to include workforce analysis) and national metrics (due WHN Q2), complete gap analysis** **2) Identify and agree funding sources** **3) Develop a local model options appraisal with support from WHN** **4) On approval of the preferred option commence development of a local business case and implementation plan with support from WHN**	**1) Completion of local Business Case and implementation plan with support from WHN** **2) Business Case to be progressed via the Health Board's internal governance requirements for consideration and approval** **3) Development of local Communication Strategy**	**1) On approval of the Business Case commence implementation of the delivery of the local hub model against the National Service Specification to include recruitment, education and training** **2) Work with WHN to define the scope of evaluation criteria To enable early reporting of data on KPIs and gathering of patient feedback via PREMs and PROMs** **3) Alongside the WHN co-create a comprehensive long term sustainable plan that includes strategics, including funding, staffing and**

		5) Support the national development of specific KPIs, data sets and a monitoring and evaluation framework (to include the development of a national dashboard)		**resource allocation (roll over to 26/27)**

Overarching outcome measures/ metrics:

- **Delivery of a Local Women's Health Hub model in line with the Welsh Government NHS Wales Women's Health Plan 2025-2035**
- **Specific metrics to be determined with Women's Health Network (WHN) at national level (Q2)**

Baseline position 24/25			
Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
Not Applicable			

Performance Trajectories 25/26			
Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
N/A	N/A	N/A	N/A

	Risks of Non-Delivery	**Mitigations**
Risks	**National timeline not aligned to local plan which potentially brings a multitude of high risks**	**Work collaboratively with WHN**
	Patient Satisfaction and Quality of Care: Non-delivery could lead to reduced local community access to quality services (Care closer to home) which would directly impact on acute capacity and demand management and the opportunity to increase screening and public health opportunities in localities. ***(impacting on our ability to improve access to planed care and reduced waiting times in line with national requirement and implement an agreed outpatient transformation plan, and implement agreed plans in response to the Gynae GIRFT review – special measure de-escalation requirement)***	**Work collaboratively with WHN and all identified regional stakeholders including Primary Care, IHCs etc. on robust planning mitigation strategies, monitoring and escalation pathways.** ***(Please see Other (Specify Section for full list of stakeholders)*** **Establish clear lines of accountability to ensure alignment, progress and effective risk management by all Stakeholders across the region.**
	Widening Inequalities: Delayed or incomplete implementation may exacerbate disparities in access to care, particularly for vulnerable populations.	**Work collaboratively with WHN and all identified regional stakeholders including Primary Care, IHCs etc. on robust planning mitigation strategies, monitoring and escalation pathways.**

		Establish clear lines of accountability to ensure alignment, progress and effective risk management by all Stakeholders across the region.
	Financial Implications: Non-delivery could result in inefficiencies, unplanned expenditures, and missed opportunities for cost savings, further straining budgets.	**Robust Business Case and Implementation Plan with support from WHN to be supported by Welsh Government allocation to Health Board's for 25/26 or other funding source to be confirmed by WG**
	Reputation Damage: Failure to deliver on priorities undermines trust in the NHS and the government, damaging credibility with the public and stakeholders.	**Work collaboratively with WHN and all identified regional stakeholders including Primary Care, IHCs etc. on robust planning mitigation strategies, monitoring and escalation pathways.** **Establish clear lines of accountability to ensure alignment, progress and effective risk management by all Stakeholders across the region.**
	Risks to Delivery	**Mitigations**
	Staffing Capacity and Resource Constraints: Limited funding may stop implementation, impact on staffing requirements (including training and identified skill mix) and the required infrastructure.	**Robust Business Case and Implementation Plan with support from WHN to be supported by Welsh Government allocation to Health Board's for 25/26 or other funding source to be confirmed by WG**
	Operational Effectiveness	**Work collaboratively with WHN and all identified regional stakeholders including Primary Care, IHCs etc. on robust planning mitigation strategies, monitoring and escalation pathways.** **Establish clear lines of accountability to ensure alignment, progress and effective risk management by all Stakeholders across the region.**
	Stakeholder Resistance: Resistance from staff, unions, or public stakeholders can delay or derail initiatives.	**Work collaboratively with WHN and all identified regional stakeholders including Primary Care, IHCs etc. on robust planning mitigation strategies, monitoring and escalation pathways.** **Establish clear lines of accountability to ensure alignment, progress and effective risk management by all Stakeholders across the region.**
	Technological Barriers: Accessibility of data across multiple systems, services and	**Work collaboratively with Digital colleagues including DHCW, WHN and all identified regional stakeholders including Primary Care,**

	organisations may create progress limiting factors.	**IHCs etc. on robust planning mitigation strategies, monitoring and escalation pathways.** **Establish clear lines of accountability to ensure alignment, progress and effective risk management by all Stakeholders across the region.**

Critical Enablers

Finance

Overall costs to be determined as part of the scoping exercise and preferred model outcome in accordance with WHN and Welsh Government specification.

Critical Enablers:

- WHN and Welsh Government specification – Q4 24/25
- Secure available funding sources – Q1 25/26
- Development of robust Business Case and implementation plan – Q3 25/26

Workforce

Analysis and cost to be determined as part of the scoping and preferred model outcome.

Critical Enablers:

- Appointment of Executive Lead - Q4 24/25
- Dedicated SRO to manage the 10 Year Plan – Q4 24/25
- Appointment of Clinical Lead - Q4 24/25
- Establish a Programme Management Group - Q1 25/26
- Consider new ways of working and transformation of services – Q1 25/26
- Appropriately trained and skilled workforce identification – Q1/2 25/26
- Full workforce analysis/ requirement to inform the Business Case – Q1/2 25/26

Digital

Requirement to be determined in line with the development of Women's National Dashboard and data set in Q2.

Critical Enabler:

- Identification of Digital Lead for the development – Q4 24/25
- Digital analysis to support the development as part of scoping – Q1 25/26
- Consideration of the IT integration and required digital developments (e.g. Virtual Appointments, Tele Medicine systems) as part of the Business Case - Q3 25/26
- Consideration of other digital solutions to support remote working/ access - Q3 25/26

Other (Specify)

- Collaborative working with WHN, HEIW, DHCW, National Pathway Team, local Planning, Estates, IHCs, Divisions, Primary Care, Accelerated Cluster Development Programme, Corporate Services and Communication Team, PHW
- Public Health Assessment of and engagement with the local population to understand needs
- Review referral management processes to ensure effective delivery

	• Full implementation of national optimised pathways including delivery of effective outpatient services through SoS and PiFU by default • Estate – consider utilisation of current estate in primary care, community areas (including cluster development) to support this development
Prevention & Population Health	**Opportunities identified**
	Health Boards will prioritise women's health services across the life course and listen to and act upon the voices of women in the development of these services Better access to services, including preventative healthcare and early intervention, and reduced unmet need for healthcare Improved patient experience, with care being delivered in one appointment where possible Improved health outcomes and reduced health inequalities Improved access to health information, in a range of formats, and supported patient self-management where appropriate

Teitl adroddiad: ***Report title:***	**CORPORATE GOVERNANCE REPORT**			
Adrodd i: ***Report to:***	Quality, Safety and Experience Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 03 July 2025			
Crynodeb Gweithredol: ***Executive Summary:***	The objective of this report is to provide the Committee with an update on key Corporate Governance matters and to provide an update to the Committee on a range of corporate governance matters as well as assurance.			
Argymhellion: ***Recommendations:***	Members are asked to: • **APPROVE** the Quality, Safety & Experience Committee Cycle of Business 2025-2026; • **APPROVE** the Committee Annual Report • **NOTE** and **DISCUSS** the Committee Self-Assessment			
Arweinydd Gweithredol: ***Executive Lead:***	Pam Wenger – Director of Corporate Governance			
Awdur yr Adroddiad: ***Report Authors:***	Philippa Peake-Jones – Head of Corporate Governance			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☒	Am sicrwydd *For Assurance* ☐	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing*	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*

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

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***	
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	This work links to all strategic objectives of the Health Board as Corporate Governance is a key enabler for them.
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	The Health Board is required to act according to its Standing Orders. This report contains information to allow the Health Board to conform to this. It is essential that the Board has robust arrangements in place for Corporate Governance and failure to do so could have legal implications for the Health Board.
Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqlA been identified as necessary and undertaken?***	This is not applicable for this report.
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	This is not applicable for this report.
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	The effective management of Governance has the potential to leverage a positive financial dividend for the Health Board through better integration of risk management into business planning, decision-making and in shaping how care is delivered to our patients thus leading to enhanced quality and less waste

Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	Failure to have effective Corporate Governance can impact adversely on the workforce.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	Not applicable
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	BAF24-01 Building an Effective and Accountable Organisation CRR-16 – Leadership/Special Measures
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Not applicable
Next Steps: • To continue to improve and report on Corporate Governance	
List of Appendices: **Appendix 1** The Committee Cycle of Business 2025-2026 **Appendix 2** The Committee Annual Report **Appendix 3** The Committee Self-Assessment	

CORPORATE GOVERNANCE REPORT

1. INTRODUCTION

The purpose of this report is to provide the Committee with an update on key corporate governance matters.

2. ANNUAL BUSINESS CYCLE 2025-26 (Formal, Informal and Board Development)

The Business Cycle for the Quality, Safety and Experience Committee for 2025-26 is attached at **Appendix 1**

3. DRAFT COMMIITTEE ANNUAL REPORT

Under Standing Order 10.2.3, each Committee of the Board is required to submit an annual report "setting out its activities during the year and detailing the results of a review of its performance". This first annual report from the Quality, Safety and Experience Committee details the activities and performance for the Committee for the reporting period 2024-2025.

4. COMMITTEE SELF ASSESSMENT

The results of the Committee Self-Assessment are available in Appendix 3 of the report.

5. RECOMMENDATIONS

Members are asked to:

- **APPROVE** the Quality, Safety and Experience Committee Cycle of Business 2025-2026;
- **APPROVE** the Committee Annual Report
- **NOTE** and **DISCUSS** the Committee Self-Assessment

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

DRAFT QUALITY, SAFETY AND EXPERIENCE COMMITTEE

Annual Report 2024-25

FOREWORD

I am pleased to present the 2024-25 Annual Report of the BCUHB Quality Safety and Experience Committee which outlines the activity for the period 1 April 2024 – 31 March 2025.

Dr Caroline Turner
Chair of the Quality, Safety and Experience Committee

QUALITY, SAFETY AND EXPERIENCE COMMITTEE Annual Report 2024 - 2025

1. Introduction

1.1 This report summarises the key areas of business activity undertaken by the Committee between 1 April 2024 and 31 March 2025 and highlights some of the key issues which the Committee intend to give further consideration to over the next 12 months.

1.2 The Committee's Annual 'Business Cycle' was reviewed in 11 April 2024 and was a key component in ensuring that the Committee effectively carried out its role during 2024 - 25

1.3 This report reflects the Committee's key role in the development and monitoring of the Governance and Assurance framework with respect to the (activity/function).

2. Role and Responsibilities

2.1 The primary purpose of the Committee is to act on behalf of the Board to:

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

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

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

2.1.4 provide assurance that the organisation, at all levels, has the right governance arrangements and strategy in place to ensure that the care planned or provided is of a high standard.

3. Agenda Planning Process

3.1 The Chair of the Committee, in conjunction with the Executive Lead and Meeting Secretary develops the final agenda for the Committee meetings.

3.2 The venue, location and other administrative arrangements are organised a year in advance where possible.

3.3 The secretariat for the meeting is provided by Fiona Lewis.

3.4 The agenda and papers are disseminated to Committee members prior to the date of the meeting. Where appropriate all papers are accompanied by a cover sheet which provides an executive summary and guidance to the Committee on the action required.

4. Operating Arrangements

4.1 Only very minor amendments were considered necessary in respect of the Terms of Reference and Operating arrangements for the Quality, Safety and Experience Committee.

4.2 The new Committee Cycle of Business for Quality, Safety and Experience Committee is being presented for approval on 3 July 2025, however the agenda for each meeting is sufficiently flexible to allow the committee to consider any emerging issues.

5. Membership, Frequency and Attendance

5.1 The Terms of reference of the Committee state that the Committee should consist of a minimum of three members of the Board.

5.2 During the year the Committee met on six occasions with member attendance as follows:

Name	6 Committee Meetings
Dr. Caroline Turner	Six out of six meetings
Christopher Lothian-Field	Four out of six meetings
Urtha Felda	Six out of six meetings
Prof. Michael Larvin	Five out of six meetings

5.3 The Committee requires the attendance of other Health Board Officers for advice, support and information routinely at meetings. It may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.

6. Committee Activity

6.1 The Committee fulfilled its work plan for 2024-2025 covering a wide range of activity. This work can be summarised under the following headings;

a) Patient Story
b) Clinical Services Plan
c) Currently Challenged Services –
   - Urology
   - Vascular
   - Dermatology
   - Plastics
   - Oncology
   - Ophthalmology
d) Complaints
e) East Integrated Health Community
f) Children's Services
g) Urgent and Emergency Care
h) Colonoscopy Performance
i) Commissioned Services
j) Women's, Maternity and Gynaecology Services
k) Learning and Disabilities
l) Response to the Royal College of Psychiatrists Invited Assessment
m) Nurse Staffing Levels
n) Quality Management System
o) Annual Reports for
   - Quality,
   - Llais
   - Putting Things Right
   - Safeguarding and Public Protection
   - Designated Educational Clinical Lead Officer
p) Corporate Risks and BAF Risks associated with the Committee

7. Key Achievements/Benefits:

7.1 As a reader you will see from this report what a successful and varied year the Quality, Safety and Experience Committee has had during 2024-25. Although detailed more fully above and within the Committee papers, some of the key highlights were:

- Hearing from patients as part of a "Patient's Story"
- The formation of the Committee
- Deep Dives into all Challenged Services concerns
- Oversight of the development of the new Quality Management System
- Oversight of each Integrated Health Community

8. Key Challenges

8.1 As indicated earlier in the report a focus for the committee in 2025 forward into 2026, will be the work which is underway to give assurance at a strategic level.

8.2 Finally, although these challenges remain the Committee will continue to monitor activity and develop innovative ways to support new developments and opportunities.

9. Committee Effectiveness & Performance

9.1 The Committee regularly reviews its own performance by completing this report on an annual basis, reviewing the cycle of business which provides the Committee with the basis on which it will monitor its progress during the year and also provide clarity for all of those who contribute to the agenda as to the expectations of them.

9.2 A committee effectiveness questionnaire will be issued again circa February 2026, the outcome of which will be reported to the Committee in respect of recommendations and subsequent actions in response to areas identified for improvement.

9. Reporting the Committee's Work

9.1 The Committee Chair reports the key issues discussed at each of its meetings by way of a 'AAA Report' to the Board.

9.2 These reports are supported by the relevant and more detailed Committee minutes. Committee papers, including minutes are routinely published on the Health Board's website.

10. Conclusion and way forward

10.1 The Committee is very grateful to all those involved in the work of the Committee for their support over the past 12 months, and for the constructive and positive way in which they have contributed to the activity.

10.2 The Committee will continue to ensure that it conducts its business in accordance with legislation and best practice.

10.3 It will provide the assurance that the Committee has in place the appropriate governance arrangements and resources to ensure success in achieving its objectives.

11. Further Information

Please visit the Health Board's websites for further information as outlined below:
Committees and Advisory Groups - Betsi Cadwaladr University Health Board

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

Quality, Safety and Experience Committee
Self-Assessment Results
Corporate Governance
July 2025

Purpose

- Present results of the 2024–25 Quality, Safety and Experience Committee self-assessment.
- Provide insights into strengths gaps, and opportunities.
- Recommend next steps for continuous improvement.

Following Special Measures: "***BCUHB is committed to strengthening governance, accountability, and decision-making***"

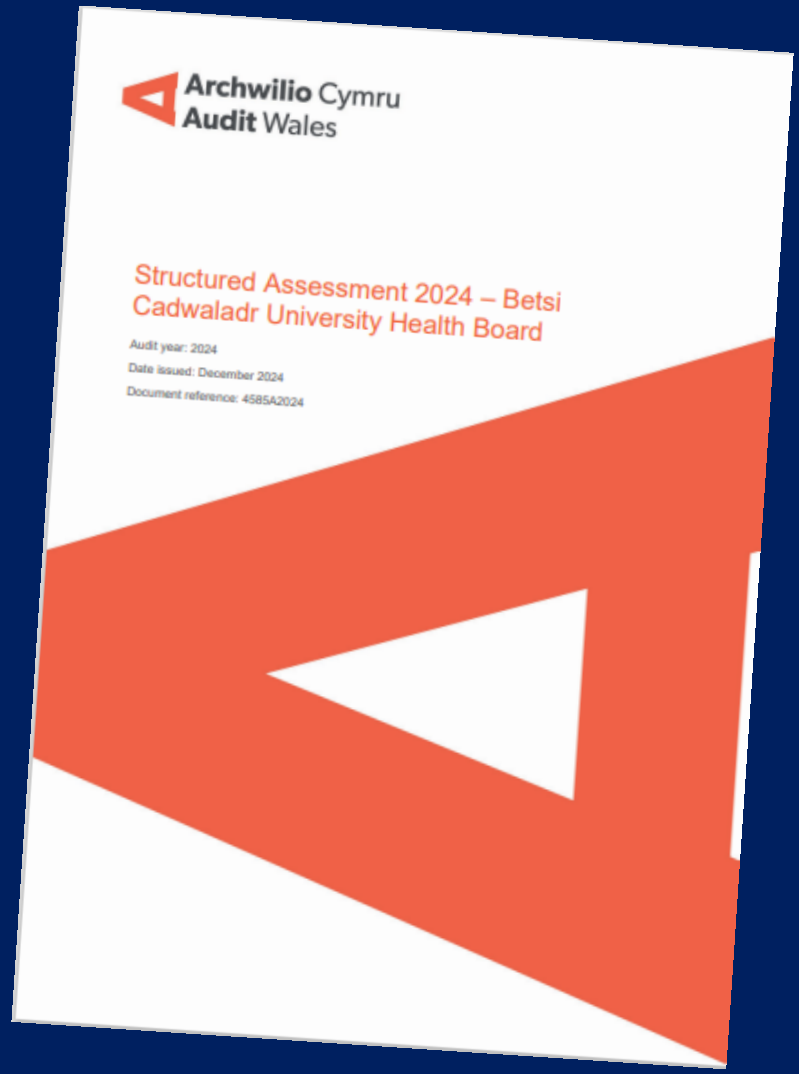
➢ This self-assessment ensures the Committee function effectively, driving continuous improvement and delivering better outcomes.

Why It Matters

- Accountability & Assurance: Strong governance builds trust and oversight.
- Strategic Focus: Ensures alignment with key priorities for improvement.
- Continuous Learning: Identifies strengths and areas needing development.
- Sustained Progress: Supports long-term transformation and cultural change.
- By embedding effective governance, BCUHB can move forward with confidence, clarity, and impact.

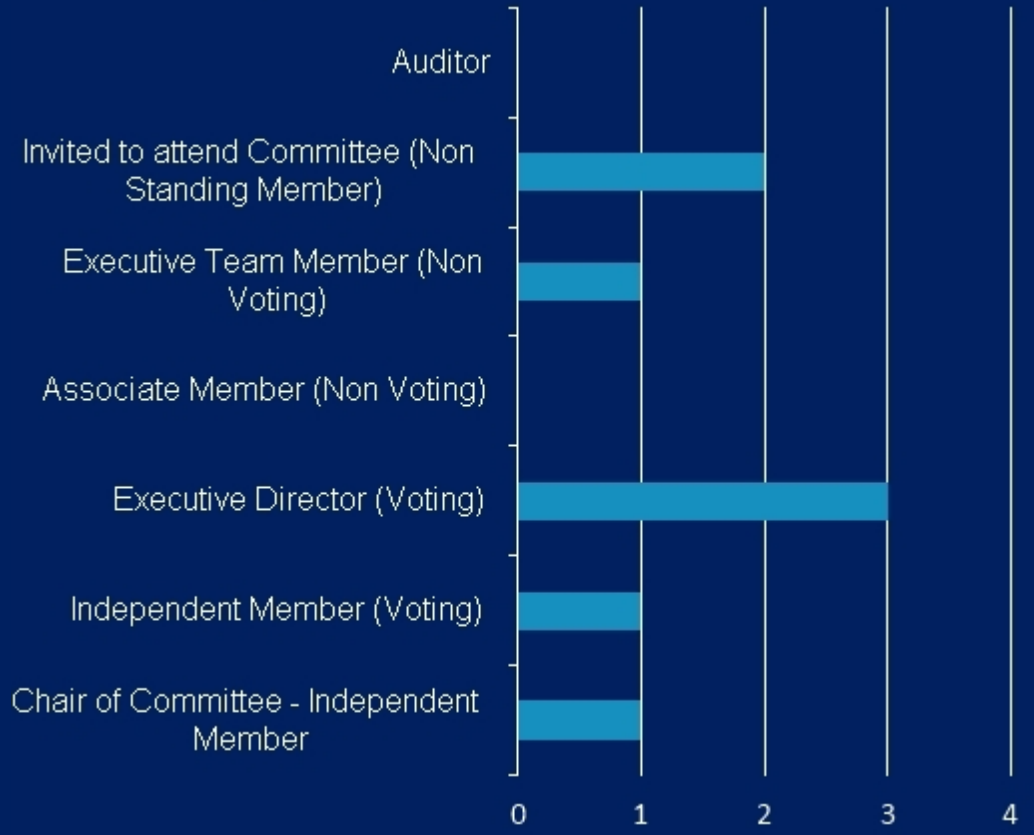
Ensuring 'Sound Governance'

- "We found that Board and Committee meetings are conducted appropriately and effectively, but there is scope to further improve…"
- "Length & quality of papers"
- "…focus on more strategic issues"
- "Remuneration Committee… effectiveness"
- "Transparency of Board and Committee business, 2023 ongoing"

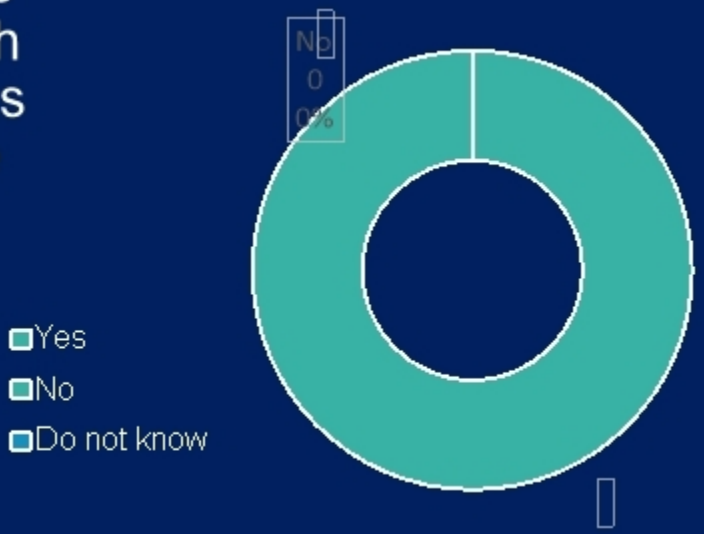


Role Response

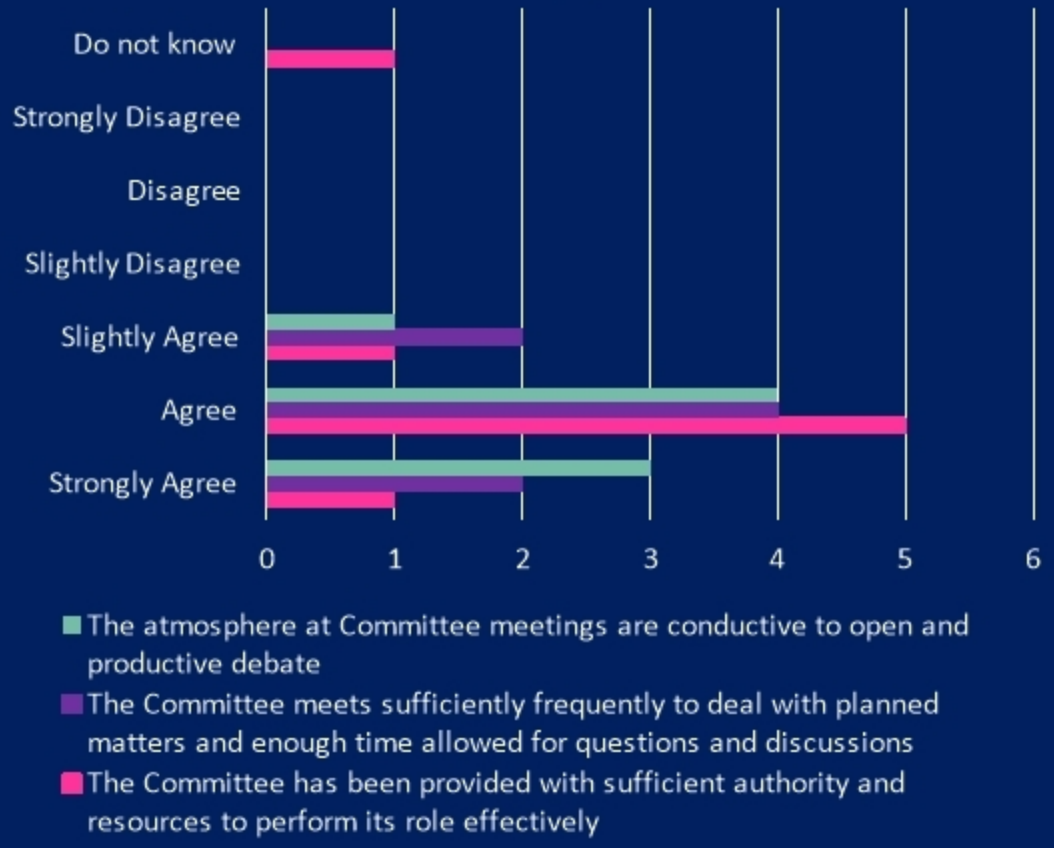
Role Response Breakdown



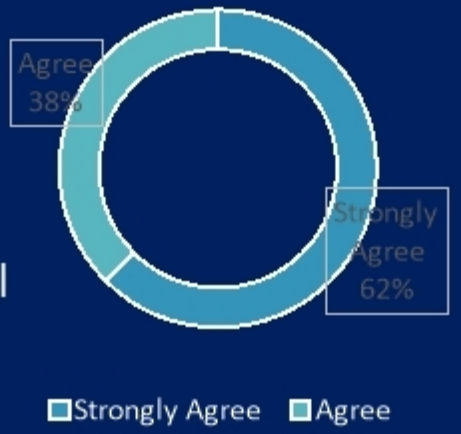
Does the Committee have written Terms of Reference, which adequately define its role in accordance with Welsh Government guidance?



Role Response



The behaviour of all members and attendees is courteous and professional



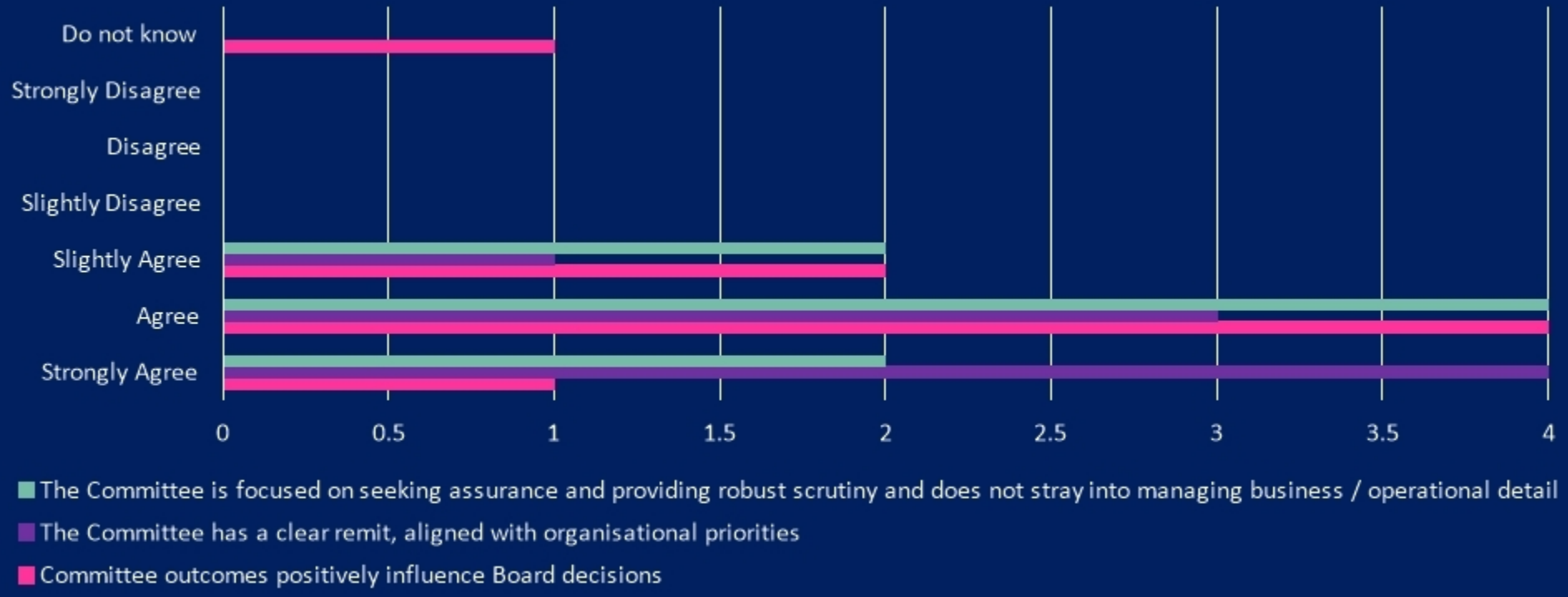
Response	Percentage
Yes	63%
No	13%
Do not know	25%

Does the Committee prepare an Annual Report on its work and performance in preceding year, for consideration by the Health Board?

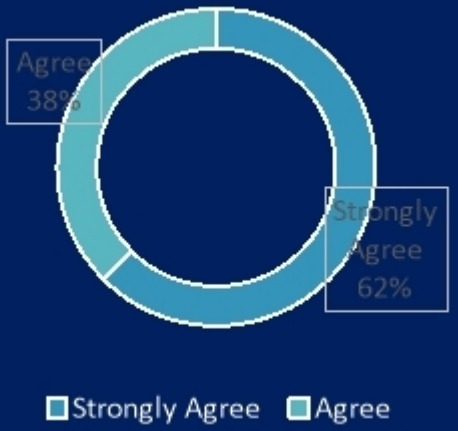
Has the Committee established a cycle of business to be dealt with across the year?

88%

Committee Response



Committee meetings are chaired effectively and with clarity of purpose and outcome?



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

Key Findings – Governance & Function

- 88% confirmed written Terms of Reference are reviewed annually taking into account governance developments and the remit of other Committees, 13% were unsure.
- There was slight agreement relating to private meetings being used appropriately.
- It was agreed that meetings are chaired effectively, the Committee Chair provides clear information to the Board on the activities of the Committee and the Committee is adequately supported.
- The assessment highlighted that the Committee is adequately supported by the Executive Directors in terms of attendance, quality and length of papers and response to challenges and questions.

Key Findings – Information & Risk

- There was agreement in terms of oversight of the risks for which the Committee is responsible for as well as reports received in a timely manner and have the right format and content in relation to internal controls and risk management.
- The assessment highlighted agreement in relation to reviewing the robustness of the organisation's internal assurance system.
- There was uncertainty that the Committee effectively monitors the implementation of management actions from Audit Reports.

Key Findings - Training & Development

- The majority felt confident in fulfilling their role and do not require additional training however a small percentage were unsure if additional training is required.

Improvements

Of 28 questions, there were…

Response	Number of responses
Do not know	5
Slightly Disagree	0
Disagree	1

Disagree *The Committee effectively monitors the implementation of management actions from Audit Reports.*

Comments:

In relation to Internal Controls and Risk Management –

"The Committee should receive more detail in terms of assurances on external reports such as Health Inspectorate Wales"

"QSE has a significant number of Corporate Risks to manage, and most have been red for quite some time. This makes it difficult to look at each of them at every meeting. However, we prioritise and do consider them in some depth at each meeting"

In relation to Composition, Establishment and Duties –

"The narrowness of QSE now needs to move into the next phase"

"I've found attending the Committee to be a positive experience, where I've been welcomed and listened to. I've felt the Committee were interested in my professional judgement in relation to questions they may have and that they were scrutinising issues effectively and joining the dots between different items they'd heard across their agenda"

"The arrangements have improved over the past year and continue to evolve"





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

Comments:

In relation to Committee Leadership and Support –

"Always open to doing things better - so if new training that could help us all - I'd be willing to give it a go"

"I think the Committee is well led and supported. From what I've observed not all the papers are of suitable length or clarity for the purpose of the meeting"

"I am always happy to take up development when offered"

"It has been difficult to engage meaningfully with Challenged Services over the past 12 months. We considered Vascular in some detail, but have not had updates on Urology, and there are many others that we have yet to consider. This has been a source of frustration for some time"

In relation to Committee Effectiveness –

"The Committee has developed well over the last year, there needs to be a balance of oversight from other elements in terms of quality so it is not just focused on incidents, complaints etc. A more strategic holistic approach would be beneficial to consider in the next 12 months"

"I think the Committee has evolved over the last 2 years and is able to fully discharge its function with governance and support provided. It has the appropriate range of agenda items and a much more robust cycle of business"

"Definitely improving and having the Interim Medical Director attending regularly is very helpful so that focus is more general quality and not just some areas of Health Board work. I think maturing constructively under the Chair's leadership and with Corporate Governance Director support"

I feel the Committee works well as a group. there are serious challenges with fragile services with which it is hard to gain traction due to a number of barriers"





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

Quality, Safety and Experience Committee Self-Assessment

Corporate Governance

July 2025

Diolch yn Fawr

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

Betsi Cadwaladr University Health Board
Quality, Safety and Experience Committee

DRAFT Cycle of Business

(1 April 2025 – 31 March 2026)

Betsi Cadwaladr University Health Board should, on an annual basis, receive a cycle of business that identifies the items which will be regularly presented for consideration. The annual cycle is one of the key components in ensuring that the Health Board is effectively carrying out its role.

The Committee Cycle of Business cover the period 1 April 2025 to 31 March 2026.

The Committee Cycle of Business has been developed to help plan the management of Health Board matters and facilitate the management of agendas and Health Board business. The Annual Cycle of Business will be complemented by a "Non-Routine Board Business (Forward Work Plan)" for 'one-off' Ad-hoc items raised during the course of meetings.

The role of the Quality, Safety and Experience Committee is set out in the Terms of Reference which is available here: [Insert here]

Committee Chair Caroline Turner **Committee Vice Chair** Christopher Lothian-Field	**Independent Members** Urtha Felda Mike Larvin	**Executive Members** Angela Wood (Executive Director of Nursing & Midwifery) – Exec Lead Jane Moore (Executive Director of Public Health) Teresa Owen (Executive Director of Allied Health Professions & Health Science) Sreeman Andole (Interim Executive Medical Director)	**In Attendance** Tehmeena Ajmal (Chief Operations Officer) Stephen Powell (Director of Performance & Commissioning) Stuart Keen (Director of Environment & Estates) Executive Director of Workforce and Organisation **Other BCUHB Senior Managers as required by the Chair** Chair of Healthcare Professionals Forum (Associate Board Member) Llais Representative

QUALITY, SAFETY AND EXPERIENCE COMMITTEE CYCLE OF BUSINESS 2025-26

Item of Business	Executive Lead	Reporting period	Q1			Q2			Q3			Q4			2026-27	
			April 2025	May 2025	June 2025	July 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	April 2026	May 2026
Preliminary Matters																
Minutes of the previous Board Meeting	Executive Director of Nursing & Midwifery	All Regular Meetings		⚑		⚑		⚑		⚑		⚑		⚑		⚑
Action Log	Executive Director of Nursing & Midwifery	All Regular Meetings		⚑		⚑		⚑		⚑		⚑		⚑		⚑
Patient Story	Executive Director of Nursing & Midwifery	All Regular Meetings		⚑		⚑		⚑		⚑		⚑		⚑		⚑
Service Presentation	Varied	All Regular Meetings		⚑		⚑		⚑		⚑		⚑		⚑		⚑
Governance, Risk & Assurance																
Corporate Governance Report: • Committee Cycle of Business • Committee Terms of Reference • Committee Annual Report • Committee Self-Assessment *(Going forward these documents will go to the Committee in March)*	Director of Corporate Governance	Annually		⚑		⚑								⚑		
Corporate Risk Register Report	Director of Corporate Governance			⚑		⚑				⚑				⚑		⚑
Board Assurance Framework	Director of Corporate Governance			⚑				⚑				⚑				
Integrated Quality Report	Executive Director of Nursing & Midwifery / Executive Medical Director	All Regular Meetings		⚑		⚑		⚑		⚑		⚑		⚑		⚑
Integrated Performance Report	Director of Performance & Commissioning	All Regular Meetings		⚑		⚑		⚑		⚑		⚑		⚑		⚑
Nurse Staffing Act	Executive Director of Nursing & Midwifery	Bi-Annually		⚑						⚑						
Annual Quality Report	Executive Director of Nursing & Midwifery	Annually				⚑										
Research & Development Annual Report	Executive Medical Director	Annually				⚑										

Item of Business	Executive Lead	Reporting period	Q1			Q2			Q3			Q4			2026-27	
			April 2025	May 2025	June 2025	July 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	April 2026	May 2026
Duty of Candour Annual Report	Executive Director of Nursing & Midwifery	Annually						⚑								
Putting Things Right Annual Report	Executive Director of Nursing & Midwifery	Annually				⚑										
Ombudsman Annual Letter	Executive Director of Nursing & Midwifery	Annually						⚑								
Controlled Drugs Accountable Officer Report	Executive Medical Director	Bi-Annually				⚑						⚑				
Adoption of Clinical Policies (TBC)	Director of Corporate Governance	As Required														
Strategic Item 1D – Implementing the Quality Management System (QMS)																
Quality Management System • Maternity and Neonatal	Executive Director of Nursing & Midwifery	Bi-Annually						⚑						⚑		
Clinical Services Plan	Executive Director of Nursing & Midwifery	To be confirmed														
Strategic Item 4 – Improving Quality, Outcomes and Experience																
Adult Mental Health & Learning Disability (4F) • Mental Health Crisis • Perinatal and Eating Disorder Services	Executive Director of Allied Health Professions & Health Science			⚑								⚑				
Royal College of Psychiatry (RCPsych) Review	Associate Director of Governance	Alternate Meetings				⚑				⚑				⚑		
CAMHS (4G) • Alternative to Admissions • Schools in Reach	Chief Operating Officer	To be agreed														
Neurodevelopment (4H)	Chief Operating Officer															
Dementia Services (4I)	Executive Director of Allied Health Professions & Health Science															
Currently ‘Challenged Services’ (4J) • Urology • Vascular • Dermatology • Plastics • Oncology	Chief Operating Officer	To be agreed														

Item of Business	Executive Lead	Reporting period	Q1			Q2			Q3			Q4			2026-27	
			April 2025	May 2025	June 2025	July 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	April 2026	May 2026
• Ophthalmology • Orthodontics																
Women's Services (4K) • Women's Health Hub • Preconception Strategy • Perinatatal • Specialist Infant Feeding	Chief Operating Officer	Bi-Annually														
Children & Young People (4L) • Childrens Charter • Youth Board	Chief Operating Officer															
Pharmaceutical Services (4M) • Independent Review of Hospital Clinical Pharmacy Services • Radiopharmacy Services	Chief Operating Officer															
Palliative, End of Life and Bereavement Care (4N) • Strategic Delivery Plan • Quality Improvement Strategy (End of Life Care)	Executive Director of Nursing & Midwifery															
Strategic Item 5 - Effective Environment for Learning and Skills Development																
Research, Development & Innovation (5B)	Executive Medical Director															
Learning Organisation (5E)	Executive Director of Nursing & Midwifery															
For Information																
NHS Wales JCCQC Chairs	Director of Corporate Governance															
Quality Delivery Chairs Report	Executive Director of Nursing & Midwifery															
Closing Business																
Agree Items for Referral to Board / Other Committees	Chair	All Regular Meetings														

Item of Business	Executive Lead	Reporting period	Q1			Q2			Q3			Q4			2026-27	
			April 2025	May 2025	June 2025	July 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	April 2026	May 2026
Review of meeting effectiveness	Chair	All Regular Meetings														
Date of the next meeting	Chair	All Regular Meetings														
Resolution to exclude the Press and Public	Chair	All Regular Meetings														

Teitl adroddiad: ***Report title:***	QSE Committee – Quality Report
Adrodd i: ***Report to:***	QSE Committee
Dyddiad y Cyfarfod: ***Date of Meeting:***	3rd July 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 Allied Health Professionals 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 Sreeman Andole, 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* ☐	Derbyniol *Acceptable* ☐	Rhannol *Partial* ☒	Dim Sicrwydd *No Assurance* ☐
	Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	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 EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	N/A
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	N/A
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR)***	BAF-SP18 and CRR-24-04 – Quality, Innovation and Improvement
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	N/A
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	N/A
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	N/A
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	BAF-SP18 and CRR-24-04 – Quality, Innovation and Improvement
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	N/A
Camau Nesaf: Gweithredu argymhellion ***Next Steps: Implementation of recommendations*** N/A	
Rhestr o Atodiadau: ***List of Appendices:*** QSE Committee Quality Report Appendix 1 Clinical Audit Report Quarter 4	

QSE Committee – Quality Report – July 2025
Reporting period – April - May 2025

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

Incident Management:
There are currently 5,226 open incidents, of which 3,312 (63%) are overdue based on the agreed process review timescales.

Previous workshops held across the Health Board, incorporating SBAR methodology and risk assessment, have contributed to a reduction in the overall backlog. Central Integrated Health Communities (IHC) has now finalised and approved the agreed narrative, and their current priority is to focus on reviewing and closing overdue incidents, as 41% of all open incidents are attributed to Central IHC.

Position reports detailing performance and progress of open incidents are now being sent to the IHC's and Divisions on a weekly basis.

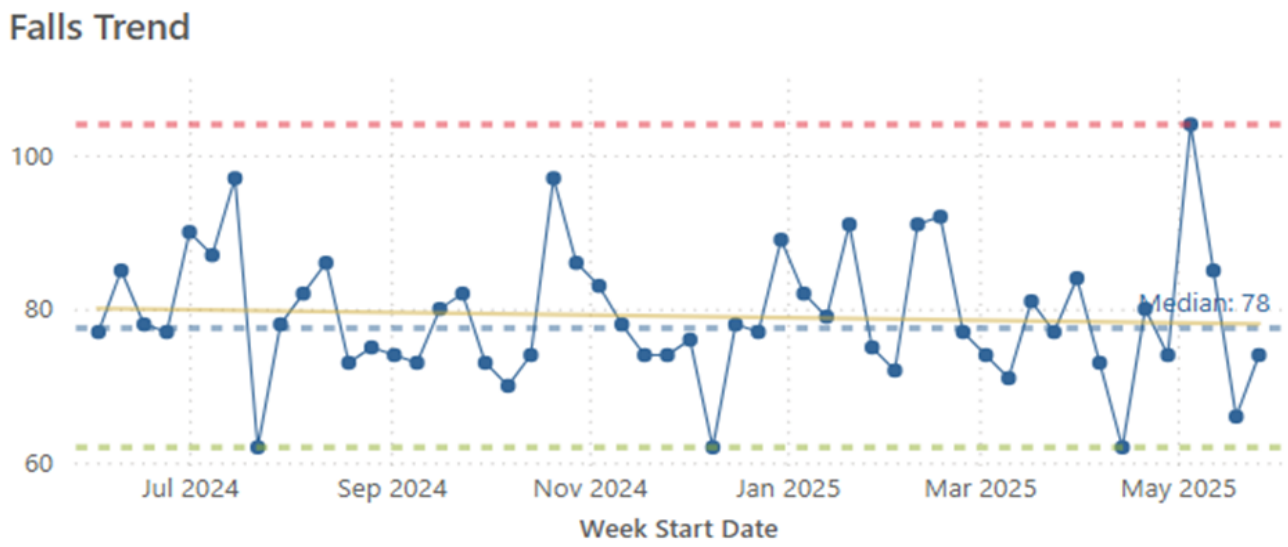
Since the introduction of the Duty of Candour in April 2023, there has been a continued focus on strengthening compliance with incident management standards. Currently, 816 incidents involving moderate harm or above remain without a completed Manager's Interim Harm Assessment, which is required within three working days of the incident being reported.

This figure represents a notable improvement, having been reduced from 1,198 following a targeted interim review by the Patient Safety Team. This reduction demonstrates the positive impact of recent interventions and the commitment to improving timeliness and accountability in incident review processes.

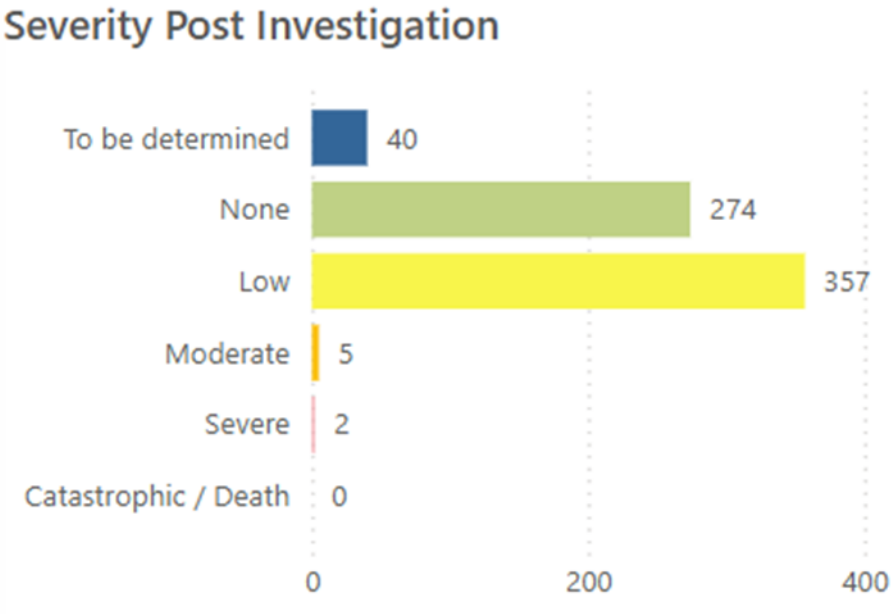
The Patient Safety Team remain actively engaged in supporting Divisions and IHCs to ensure sustained progress. Ongoing monitoring, regular reporting, and accessible support mechanisms are in place to provide assurance that this area continues to receive focused attention and that further improvements will be achieved.

It is important to note that without timely review, these incidents may require redress or escalation under the Duty of Candour process. The Patient Safety Team are currently reviewing closed incidents to ensure compliance with the Duty of Candour.

Patient Falls and Prevention:
The graph below demonstrates the weekly patient falls reported across BCUHB over the past 12 months. The yellow line illustrates a clear downward trend, indicating positive progress in reducing the number of falls:



In April and May 2025, patient falls occurred with a post investigation level of harm as shown below (to be determined means the investigation/review is ongoing).



The Health Board Strategic Falls Group continues to meet on a monthly basis, chaired by the Head of Patient Safety, with representation invited from all Integrated Health Communities (IHCs) and Divisions. This forum provides strategic oversight and coordination of falls prevention efforts across the organisation.

The Health Board remains committed to delivering the Falls Improvement Plan, developed in response to the Health and Safety Executive (HSE) notice. Notably, the Health Board has

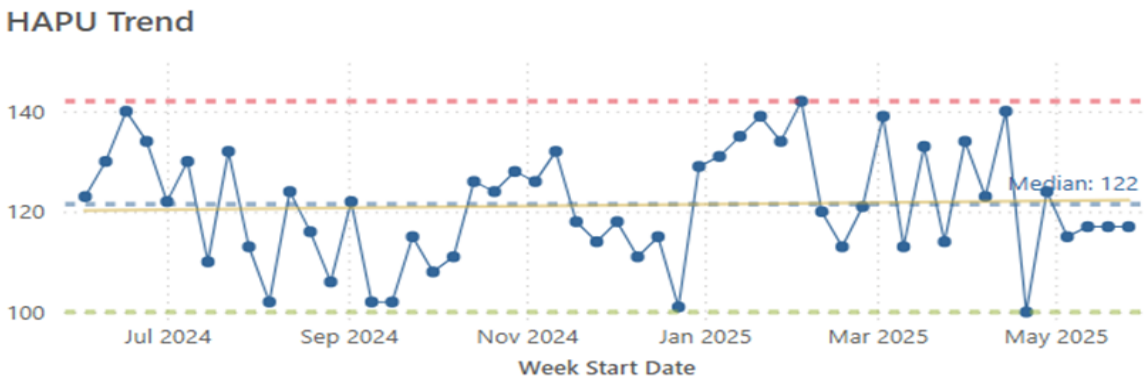
been invited to showcase its learning and achievements, with a particular emphasis on the improvements and outcomes resulting from the implementation of system-wide changes.

The Director of Quality, Safety and Improvement at the NHS Executive has offered support in sharing and communicating this journey more broadly, recognising the value of the work undertaken.

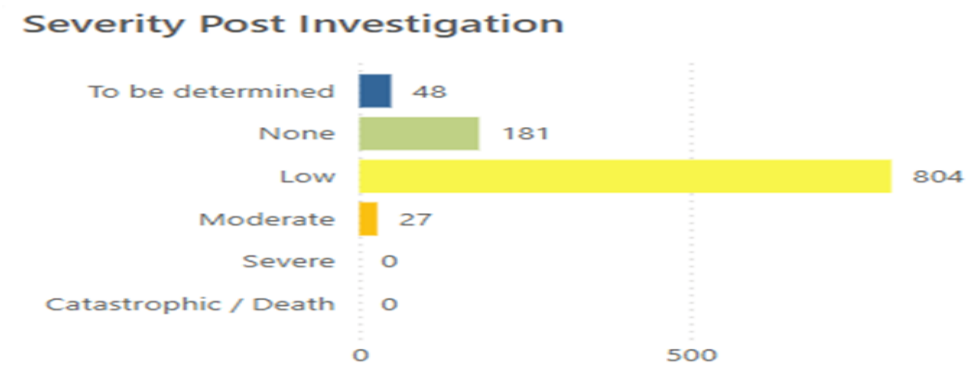
In parallel, the Principal Auditor for Internal Audit has completed the fieldwork phase of the Falls Review. This included visits to two wards on an acute site and one ward on a community site within each IHC, ensuring a representative and comprehensive assessment. The desktop review is now underway, focusing on the evaluation of evidence from both local and strategic meetings.

The Health Board will be provided with an opportunity to review and comment on the draft report prior to its final publication, ensuring transparency and the opportunity to reflect on findings and further strengthen improvement and assurance.

Pressure Ulcers:
The chart below shows the weekly healthcare-acquired pressure ulcers (HAPUs) reported across the Health Board over the past 12 months. The yellow line represents an upward trend, indicating an increase in reported cases over time:



The chart below shows the healthcare-acquired pressure ulcers (HAPUs) reported across the Health Board in April and May 2025, categorised by post-investigation level of harm. (The category "To be determined" reflects cases where investigations are still ongoing):



As of the end of May 2025, there are 146 open incidents of avoidable pressure ulcers across the Health Board, all of which are currently progressing through the redress process. A recent review has identified that several incidents dating back to 2023 remain unresolved, despite investigations having been completed. In response, the Patient Safety Team (PST) has re-circulated the standardised process for managing HAPUs to ensure consistent application and understanding across all IHCs and Divisions.

In a positive development, following participation in the All-Wales Subgroup for Education, the All-Wales Tissue Viability Nurses (AWTVN) Forum has expressed interest in collaborating with the BCUHB Tissue Viability Nurse (TVN) team to lead the development of e-learning mandatory training on pressure ulcer prevention and management (PUPM) at a national level. Notably, no other Health Board in Wales currently has an e-learning platform or mandatory training requirement for PUPM. The BCUHB TVN's presentation on the planned e-learning programme has been well received, and AWTVN has indicated a desire to progress this initiative nationally.

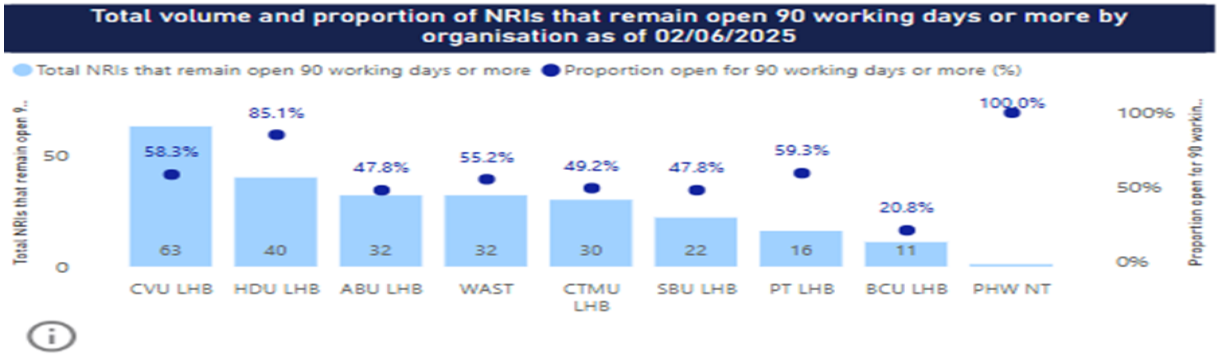
Additionally, the All-Wales Guidance on Pressure Ulcer Reporting has now been formally approved and will be re-circulated following feedback from the initial consultation phase.

Operationally, a backlog of mattresses awaiting decontamination at the YGC laundry—reported in April 2025—has now been resolved. The service has confirmed capacity to decontaminate up to eight mattresses per day, and assurance has been provided that the backlog has been cleared. There are currently over 20 pressure-relieving mattresses across various sites awaiting inspection and repair by EBME following decontamination. This matter is being escalated to the Medical Devices Governance Group for further consideration.

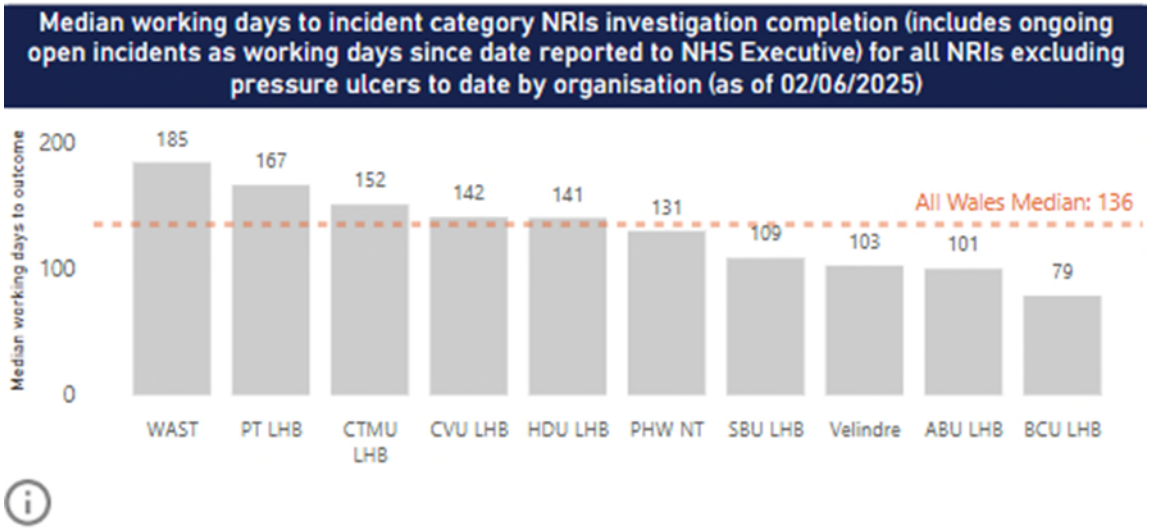
Nationally Reportable Incidents:
Between 1st April and 31st May 2025, a total of 10 National Reportable Incidents (NRIs) were recorded by incident date, representing a notable reduction compared to 23 incidents in the previous reporting period. In particular, April 2025 saw a significant decrease in NRIs reported by the Health Board.

As of the end of May 2025, there were 49 open NRI investigations, with 6 cases overdue for closure. Despite this, the Health Board continues to perform better than other Health Boards in terms of investigation timeliness. The proportion of NRIs remaining open for more than 90 days stands at 20.8%, which, although slightly increased from the previous period, remains the lowest across Wales. For comparison, the next best-performing Health Board reported 47.8% of cases exceeding the 90-day threshold.

This performance reflects the Health Board's continued commitment to timely and effective incident management, while also identifying areas for further improvement in early threshold confirmation and reporting compliance.



The median working days to completion continues to be the lowest at 79 days compared to the All-Wales median of 136 days.



Closures – Outcome forms submitted to NHS Wales Executive
A total of 24 NRI outcome forms were submitted to NHS Wales Executive during April and May 2025. *(Further detail and learning can be found in the confidential quality report).*

Never Events:
Since the last reporting period, the Health Board has recorded two Never Events. The first occurred in March 2025 and involved the incorrect administration of insulin. The second took place in May 2025, when oral morphine was inadvertently administered via a subcutaneous line instead of the prescribed injectable formulation.

It is important to note that neither incident resulted in significant harm to the patients involved. Both events have been subject to thorough investigation, and appropriate measures are being implemented to strengthen clinical safety protocols and prevent recurrence. These incidents are being shared through Local and Health Board learning forums.

Oxygen Cylinder Safety Review and Ongoing Improvements:
In response to the concerns raised by the North Wales Coroner in a letter to Welsh Government regarding the incorrect use of BOC oxygen CD cylinders, the Chief Nursing Officer (CNO) and Deputy Chief Medical Officer (DCMO) for Wales have requested that all

NHS organisations undertake a summary review. This review is to assess the number and severity of patient safety incidents, including near misses, related to oxygen cylinder use across NHS Wales since 2021. The Patient Safety Team has completed this review for our organisation.

BOC continues to progress the development of a single-valve oxygen cylinder, which is expected to become available during the summer of this year. It is anticipated that there will be associated cost implications with the introduction of this new design.

The 'No Flow Oxygen Improvement Group' continues to meet on a monthly basis to address key safety concerns and to identify further opportunities for improvement. This ongoing work aims to reduce the risks associated with oxygen delivery and enhance Quality and patient safety across the Health Board.

PATIENT SAFETY ALERTS

Patient Safety Alerts and System Issues:
No new Patient Safety Alerts (PSAs), Patient Safety Notices (PSNs), or internal alerts were received during this reporting period.

Since 1st April 2025, the Health Board has been utilising the new Once for Wales (OFW) alerts system, integrated within the Datix (Once for Wales, Incident Reporting System). However, several operational issues have been identified, including:

- Inability to amend entries once a handler has been assigned
- Document upload functionality not working
- Distribution list failures
- Notification system not functioning
- Reporting function currently unavailable

These challenges are contributing to duplication of effort across teams, as users are required to implement additional processes to maintain assurance. All identified issues have been formally raised at the next Once for Wales (OFW) workstream meeting. It is recognised that these concerns are shared across multiple organisations, and a coordinated approach going forward will be essential to ensure the system meets operational and safety assurance needs.

OTHER PATIENT SAFETY CONCERNS AND IMPROVEMENTS

Training for Designated Nursing and Medical Officers (DNOs/DMOs):
A training gap has been identified in relation to Designated Nursing Officers (DNOs) and Designated Medical Officers (DMOs), specifically regarding the safe use and management of medical gas pipeline systems.

There is an urgent need to address this gap through the provision of appropriate training. In the longer term, a sustainable plan will be required to ensure ongoing competency and compliance.

This has been escalated to the Health Board Medical Gases Group and subsequently to the Health Board Patient Safety Group.

BOC Health Care Services offers face-to-face training packages, with a maximum of 15 participants per half-day session. The cost is approximately £2,000 per day. Given the significant number of staff requiring this training, options for delivery are currently being explored by Andrew Merriman (BCUHB Lead Pharmacist) and options will be discussed for agreement at the next Patient Safety Group meeting.

SAFEGUARDING & PUBLIC PROTECTION

BCUHB Safeguarding and Public Protection Assurance Report:
During Q3 and Q4 of 2024–2025, Betsi Cadwaladr University Health Board's (BCUHB) Safeguarding and Public Protection arrangements were reviewed by Welsh Government and the NHS Executive. This review was informed by evidence submitted by the Health Board and aligned with the findings of the commissioned Patient Safety Report on Quality.

On 17 April 2025, the Health Board received the formal findings. The review assessed performance across several key domains:

Governance and Oversight
Legislative and Policy Compliance
Training and Education
Risk Management
Reporting Trends
Annual Priorities
Independent Mental Capacity Advocate (IMCA) Services

The report concluded that the Health Board has established robust safeguarding systems to protect children, young people, and adults at risk of abuse, harm, or neglect. A structured governance framework with multiple layers of oversight was recognised, ensuring effective implementation and cross-organisational collaboration through safeguarding forums and multi-agency partnerships.

The review also acknowledged the increasing demand and complexity of safeguarding work. It recommended sustained engagement with inspectorates such as Healthcare Inspectorate Wales, Care Inspectorate Wales, the Health and Safety Executive, and coronial services. Continued focus on risk management and "Make It Safe" initiatives were also advised.

An action plan has been developed to demonstrate ongoing progress and provide assurance in areas requiring continued support. This is actively monitored by the Safeguarding Governance and Performance Group in accordance with the Safeguarding Reporting Framework, Strengthening Safeguarding in Health: National Review and Implementation

On 30 April 2025, the inaugural meeting of the NHS Safeguarding Delivery Group was held, chaired by the Deputy Director of Quality, Safety and Improvement, NHS Executive.

This group was established following the Strengthening Safeguarding in Health review, commissioned by Welsh Government and the Chief Nursing Officer's Office. The review,

which ran from April to Autumn 2024, examined safeguarding arrangements across NHS Wales and the mechanisms through which Welsh Government and Ministers receive assurance.

The final report outlined 28 recommendations for improvement, including structural and systemic changes. These have been widely shared across NHS Wales, with a phased implementation approach. The five Year 1 priorities have informed the creation of Task and Finish Groups focused on:

Establishing the Safeguarding Oversight Group (now referred to as the Delivery Group)
Developing a Safeguarding Quality & Safety/Learning Framework
Creating a Safeguarding Quality, Assurance & Accountability Framework
Defining a Quality Statement and Safeguarding Metrics
Exploring the development and implementation of a digital tracking system
Next steps include agreeing Terms of Reference for each group and identifying representatives from NHS organisations to support delivery.

Safeguarding and Public Protection Training Compliance:
The Health Board continues to adopt a targeted approach to safeguarding and public protection training, aiming to meet the compliance KPI of 85%.

Training is delivered through a range of platforms and materials to support accessibility and practical application across all service areas. Reporting and escalation of training activity are managed through the Safeguarding Reporting Framework and BCUHB governance structures.

Quality assurance of training compliance is a key focus. In addition to monitoring uptake, audit activities and findings from Single Unified Safeguarding Reviews (SUSRs) are used to assess the effectiveness of training in practice, recognising that completion data alone does not confirm understanding or application.

Safeguarding Module	**Apr-25**	May-25	Trajectory
MCA – Level 1	85.6%	86.0%	↑
MCA – Level 2	84.6%	85.0%	↑
Safeguarding Adults – Level 1	87.7%	88.3%	↑
Safeguarding Adults – Level 2	86.7%	87.3%	↑
Safeguarding Children – Level 1	88.4%	88.9%	↑
Safeguarding Children – Level 2	87.3%	87.7%	↑
Safeguarding Children – Level 3	53.0%	54.5%	↑
VAWDASV	77.6%	78.3%	↑

From August 2024, Level 3 Safeguarding Children Training compliance has been incorporated into staff profiles within the Electronic Staff Record (ESR). This enhancement has enabled the separate reporting of Level 2 and Level 3 training compliance, providing a more accurate and detailed picture of training uptake.

As of May 2025, Level 3 compliance stands at 54.5%, reflecting a steady month-on-month improvement. While the target compliance rate of 85% has not yet been reached, this represents a significant achievement and supports the implementation of more targeted interventions based on accurate data.

Targeted areas of focus are, Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV) training remains an area of focused intervention. However, it is encouraging to note that several clinical services have now achieved the required 85% compliance threshold.

There has been a notable improvement in overall safeguarding training compliance across the Health Board: Five of the seven Safeguarding Modules now exceed the 85% KPI, compared to three modules in March 2025. Mental Health & Learning Disabilities continues to lead with the highest overall compliance across the Health Board.

BCUHB Corporate Services, while currently below the KPI in all modules, has demonstrated the most significant improvement, increasing average compliance from 75.5% to 77.9% compared to the previous quarter. Areas requiring additional performance monitoring have been clearly identified by area, department, and professional group. These are included in regular reports to the Integrated Health Communities (IHC) Safeguarding Forums and are monitored in line with the Safeguarding Reporting Framework.

National ten-year strategy for Preventing and Responding to Child Sexual Abuse 2025 – 2035:

The forthcoming national strategy will replace the anticipated second iteration of the Welsh Government's Child Sexual Abuse (CSA), Child Sexual Exploitation (CSE), and Harmful Sexual Behaviour (HSB) Action Plan. It adopts a broader and more inclusive scope, encompassing all forms of sexual abuse, including harmful sexual behaviour, sibling sexual abuse, and sexual exploitation.

The strategy also recognises the diverse contexts in which sexual abuse can occur—within families, institutions, gangs, social groups, communities, and online—ensuring safeguarding is appropriately contextualised across all settings.

Following extensive stakeholder engagement, including with adult victim-survivors, the strategy was scheduled for public consultation at the end of April 2025. However, this has been delayed. An update has been requested from Welsh Government via the Children's Commissioner for Wales Roundtable Group.

Welsh Government continues to implement the recommendations from the final report of the Independent Inquiry into Child Sexual Abuse (IICSA), with BCUHB fully engaged in both the consultation and implementation processes.

Artificially generated CSA material refers to images that are partially or entirely computer-generated. Raising awareness of this emerging threat is a strategic priority for the Safeguarding and Public Protection Team. The aim is to ensure the workforce is informed and equipped to respond appropriately to these concerns.

The Online Safety Act 2023, which applies in Wales, places legal duties on online platforms to address illegal and harmful content, particularly content involving children. The Act is being implemented in phases by Ofcom, with full enforcement expected by 2026.

BCUHB's commitment to this agenda was recognised at the Children's Commissioner for Wales CSA Roundtable Meeting on 31 March 2025, where the Health Board received special recognition for its engagement.

To support workforce awareness and preparedness the Health Board has launched a comprehensive awareness-raising programme, including:

Learn and Inspire Webinars
Special Edition Learning Bulletins
7-Minute Briefings
Refreshed bespoke training package (launching June 2025)

These initiatives are designed to ensure that safeguarding remains a core component of professional practice and that the Health Board workforce are equipped to respond to evolving risks.

INFECTION PREVENTION AND CONTROL

Actions to Address the WHC 2024/25 HCAI Improvement Goals:
As the Welsh Health Circular (WHC) Improvement Goals for 2025/2026 have not yet been issued, the actions aligned with the 2024/2025 goals remain in effect. A comprehensive action plan has been developed following the peer review conducted by the Healthcare Associated Infection, Antimicrobial Resistance and Prescribing (HARP) Programme Team. This plan has been shared with members of the Strategic Infection Prevention Group (SIPG) to support progress through Integrated Health Care (IHC) improvement plans.

The Infection Prevention Team (IPT) has outlined its Programme of Work for 2025/2026, which includes the following key initiatives:

- Implementation of a proactive audit programme
- Development of an Infection Prevention (IP) Acuity Matrix to support decision-making triggers
- Continued development of the nurse-led service to optimise delivery of the Faecal Microbiota Treatment service
- Enhancement of the IP quality dashboard within the IRIS system to improve triangulation of audit compliance data with infection incidents (e.g., Clostridioides difficile with hand hygiene and antimicrobial prescribing compliance; bloodstream infections with Aseptic Non-Touch Technique (ANTT) training compliance)
- Development of Phase 2 of the HABITS programme, with a focus on visitors and the general public

Integrated Health Care (IHC) Reviews and Progress:

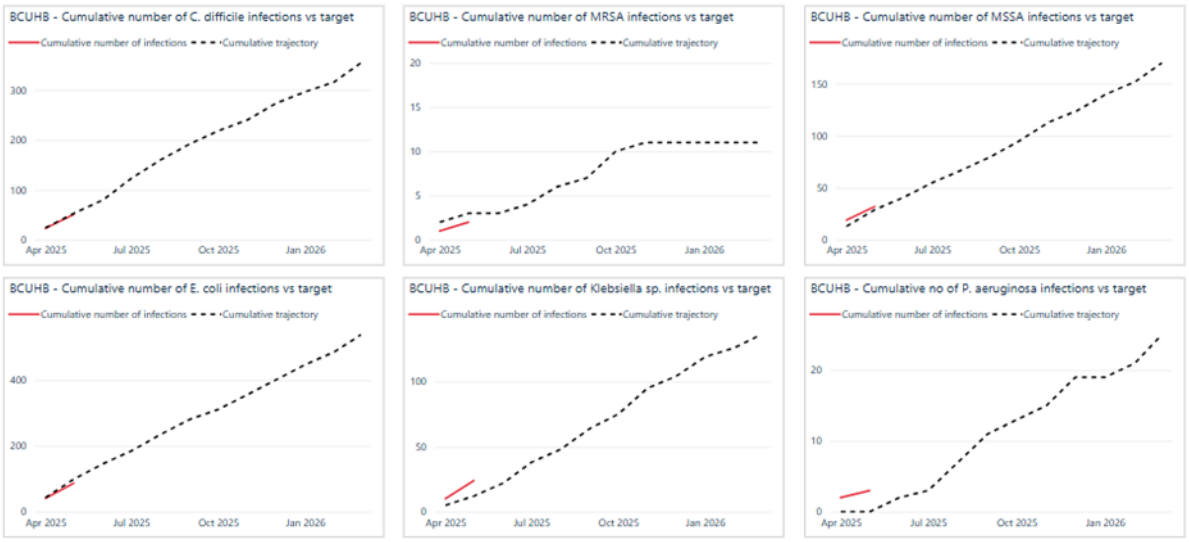
- East IHC has completed its six-month IPC Learning Review, demonstrating improvements across several indicators and identifying areas requiring targeted attention.

- Central IHC has received its six-month review, with noted improvements in MRSA, Klebsiella, and clinical practice audits. Sustained engagement is necessary to maintain progress and address remaining challenges.
- West IHC is scheduled for its six-month review in July.
- Reviews for Cancer Services and Mental Health and Learning Disabilities are planned for later in the year.
- Women's Services have completed their initial learning review and are currently developing an improvement plan for presentation to SIPG in June 2025.

High-level improvement plans across all IHCs continue to focus on addressing the following challenges:

- Availability of decant space for both reactive and proactive high-level disinfection
- Capacity and patient flow constraints impacting timely isolation
- Cohorting options when isolation is not feasible
- Estates and Facilities-related improvements

To support the standardisation of high-level disinfection practices across the Health Board, East IHC is currently piloting enhanced UVC technology. Plans are in place to extend this pilot to Central and West IHCs, pending confirmation of implementation dates from the supplier.



Infection Reduction Performance Update – May 2025:
In the absence of defined Welsh Government Improvement Goals for 2025/2026, Betsi Cadwaladr University Health Board (BCUHB) has established local targets aligned with the reduction goals set for 2024/2025.

When comparing performance to the same period in 2024/2025, BCUHB has made progress in several key areas, aiming to reduce the overall number of healthcare-associated infections across both community and hospital settings. As of the end of May 2025, the following changes have been reported:

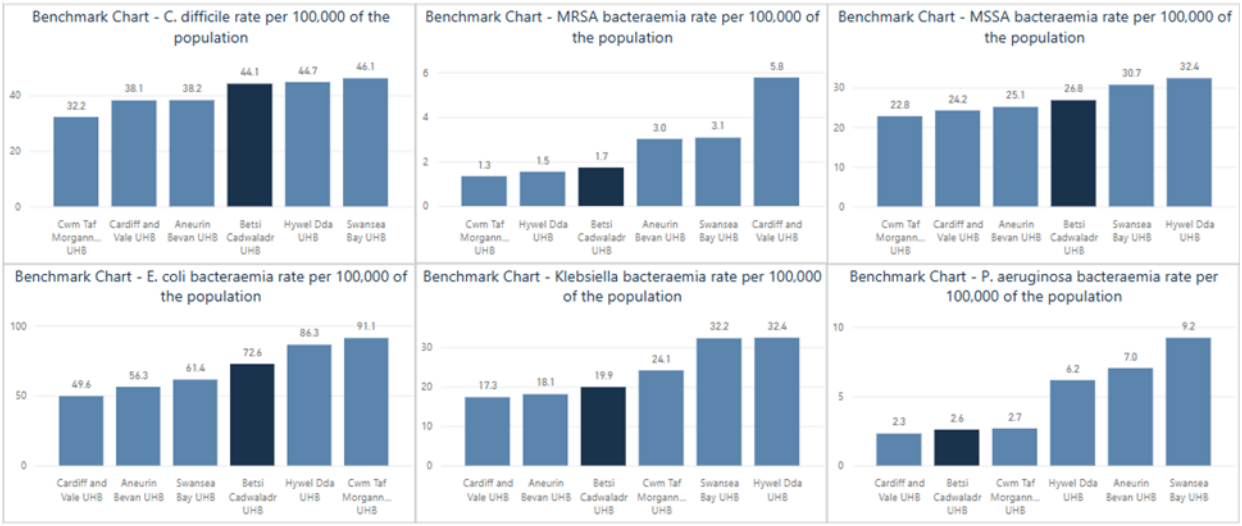
Clostridioides difficile (C. diff): 2 fewer cases (no specific goal set for overall numbers)
Meticillin-sensitive Staphylococcus aureus (MSSA): 1 fewer case (no specific goal set for overall numbers)
Meticillin-resistant Staphylococcus aureus (MRSA): 3 additional cases (no specific goal set for overall numbers)
Escherichia coli (E. coli): 12 fewer cases (aligned with Goal 1)

Klebsiella spp.: 12 additional cases (aligned with Goal 2)
Pseudomonas aeruginosa: 3 additional cases (aligned with Goal 3).

When benchmarked against other Health Boards in Wales as of May 2025, BCUHB ranked:
2nd for Pseudomonas
3rd for MRSA and Klebsiella
4th for MSSA, E. coli, and C. diff

This represents a downward trend in ranking for MRSA, MSSA, and Klebsiella. However, there has been an improvement in the position for C. diff, while rankings for E. coli and Pseudomonas have remained stable.

The Health Board remains committed to continuous improvement and is actively reviewing targeted interventions to address MRSA, MSSA and Klebsiella, while sustaining progress in areas showing positive trends.



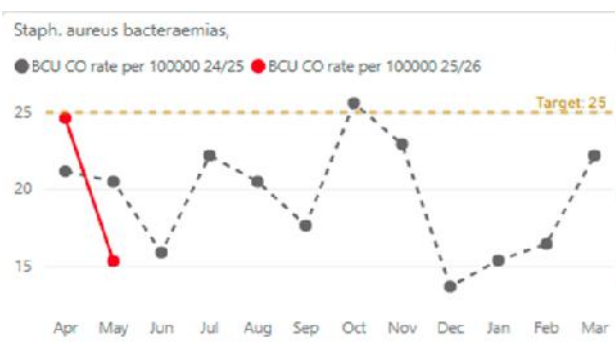
Hospital Onset (HO) Infections:
Compared to the same period for 2024/2025, at the end of May 2025 BCUHB reported:
26 HO cases of C. diff –11 cases over the 20% reduction (goal 7)
22 HO cases of E. coli – 5 cases over the 10% reduction (goal 2)
7 HO cases of Klebsiella – 3 cases over the 20% reduction (goal 6)
1 HO case of MRSA – 1 case over fewer infections (goal 9)
8 HO cases of MSSA - 1 case over fewer infections (goal 9)
1 HO case of Pseudomonas – 1 case over the 10% reduction (goal 4)

Organism Type	BCU HO Numbers 25/26	BCU HO Numbers 24/25	BCU Year on Year 25/26	BCU HO Trajectory 25/26	BCU Comparison to Trajectory 25/26
C.diff	26	19	7 ↑	15	11 ↑
E.Coli	22	19	3 ↑	17	5 ↑
Klebsiella	7	5	2 ↑	4	3 ↑
MRSA	2	1	1 ↑	1	1 ↑
MSSA	8	7	1 ↑	7	1 ↑
Pseudomonas aeruginosa	1	0	1 ↑	0	1 ↑
Total	**66**	**51**	**15 ↑**	**44**	**22 ↑**

Community Onset Infections – May 2025 Update:
As of the end of May 2025, Betsi Cadwaladr University Health Board (BCUHB) has demonstrated positive progress in reducing community onset infections when compared to the same period in 2024/2025.

The following outcomes have been achieved:
Staphylococcus aureus (combined MRSA/MSSA): Reported at fewer than 25 cases per 100,000 population, meeting the target set under Goal 10.
Clostridioides difficile (C. diff): Reported at fewer than 25 cases per 100,000 population, achieving compliance with Goal 8.

These results reflect a continued commitment to infection prevention and control across community settings. BCUHB will maintain its focus on sustaining these improvements through targeted interventions and collaborative working with primary care and public health partners.



Month	CO rate per 100000 24/25	BCU CO rate per 100000 25/26	Yr on Yr
Apr	21.16	24.61	3.46 ↑
May	20.47	15.31	-5.16 ↓
Total	**20.81**	**19.89**	**-0.92** ↓

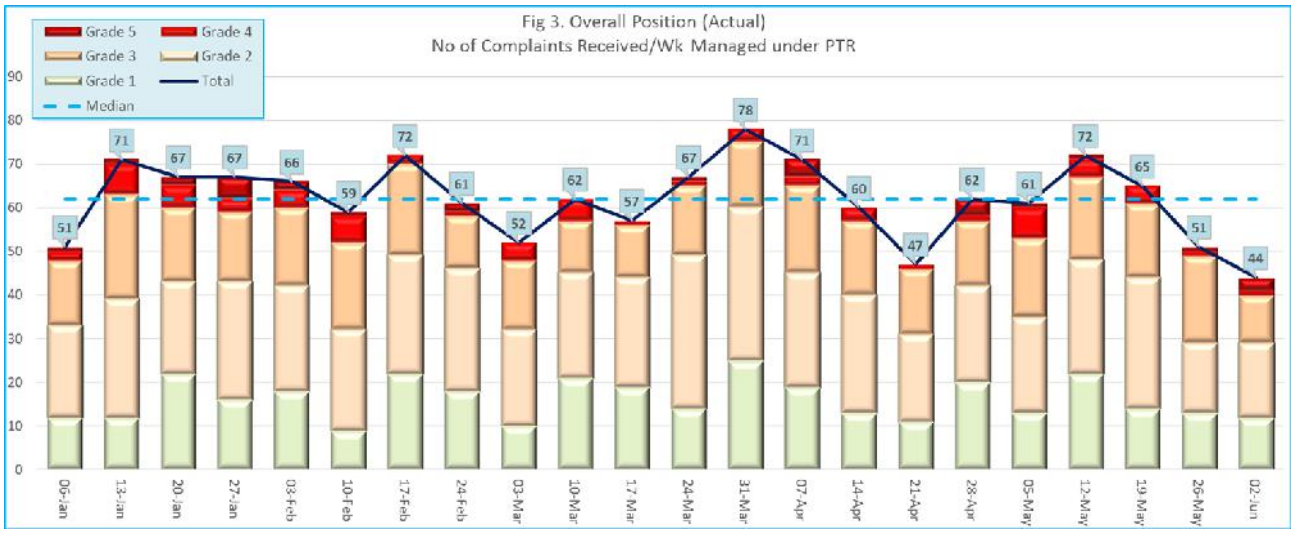
Month	CO rate per 100000 24/25	CO rate per 100000 25/26	Yr on Yr
Apr	24.68	17.58	-7.10 ↓
May	35.83	25.52	-10.31 ↓
Total	**30.35**	**21.62**	**-8.73** ↓

PATIENT EXPERIENCE

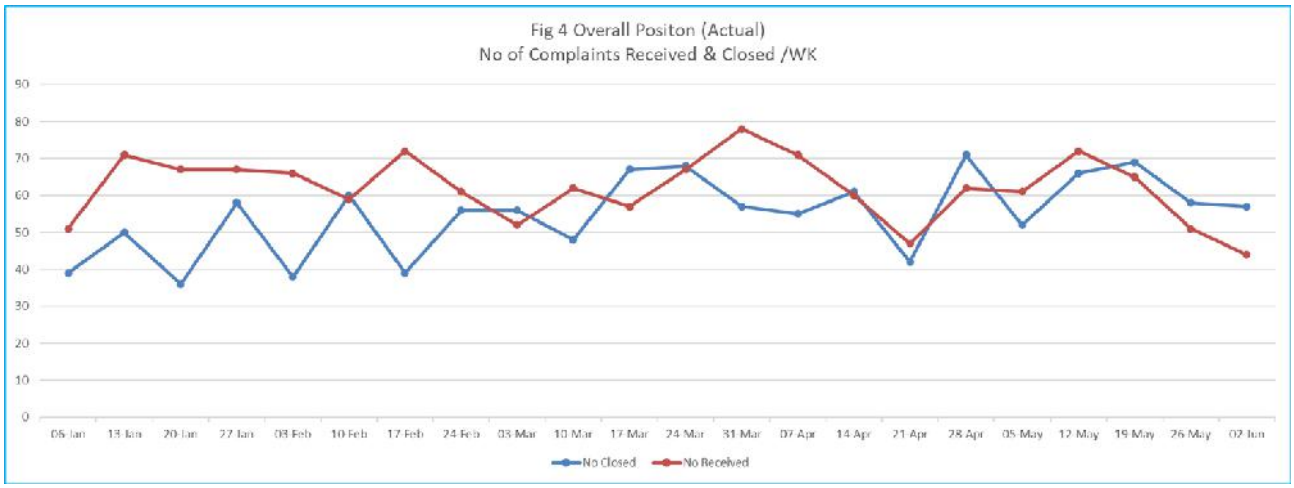
COMPLAINTS

Between 1st April and 2nd June 2025, the BCUHB received 533 complaints and closed 531 complaints, a negative variance of 2.

Number of complaints received per week by grade



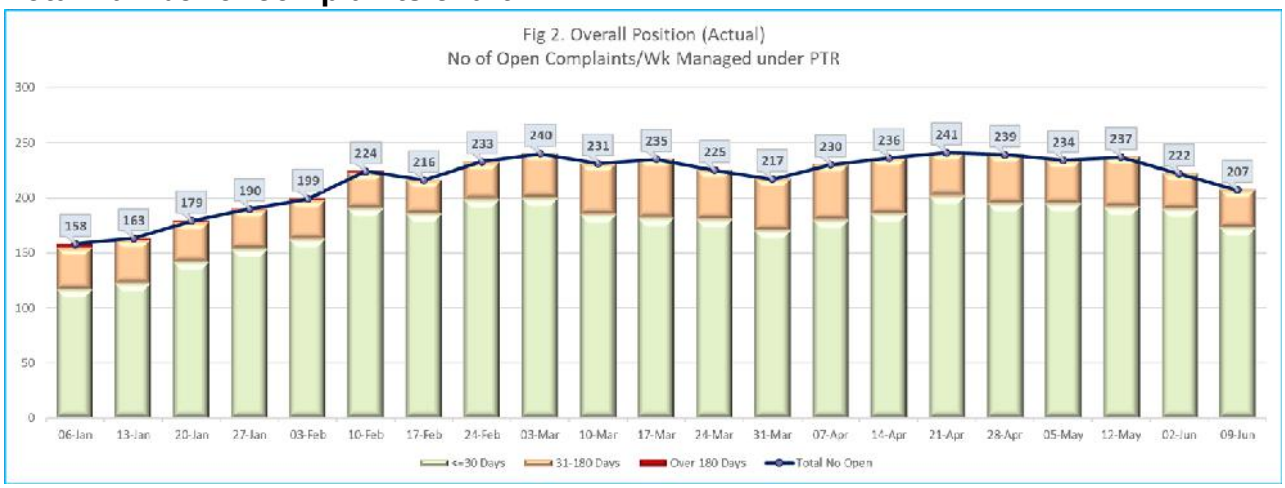
Number of complaints received Vs Closed



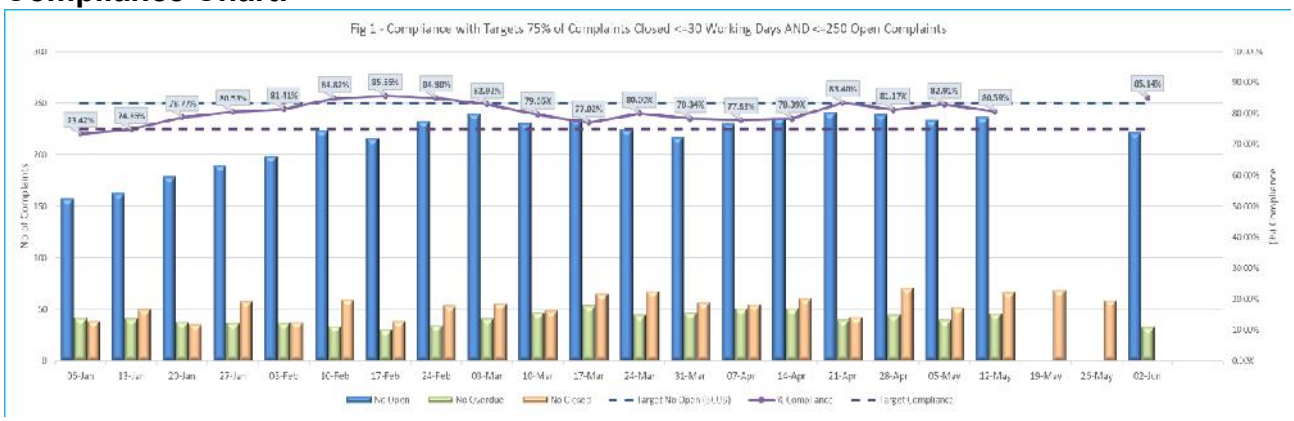
Complaint's position as of 2nd June 2025:

Total Number of open complaints – **222** (an increase from 165 in the previous reporting period)
Number of Complaints Less than 30 working days = **189**
Number of Complaints overdue = 33 (a reduction from 43 in previous reporting period)
Compliance with 75% target of overdue complaints – **85.14%** (an increase from 73.94% in the previous reporting period, and above 75% target)

Total number of complaints chart:



Compliance Chart:



Compliance Breakdown by IHC / Service as of w/c 2nd June, 2025:

IHC/Service	<=30 Days	>30 Days	Total	(%)
Cancer Services	7	1	8	87.50%
Corporate Services	6	1	7	85.71%
Diagnostics and Specialist Clinical Support Services	6	1	7	85.71%
IHC Central	70	8	78	89.74%
IHC East	36	7	43	83.72%
IHC West	33	9	42	78.57%
Mental Health and Learning Disabilities	15	0	15	100.00%
Midwifery and Women's Services	16	6	22	72.73%
Total	**189**	**33**	**222**	85.14%

Average complaint closure time:

Here is a visual comparison of the average number of working days complaints remained open:

No Open	222.00
Average of No of Working Days Open	18.44
Max. of No of Working Days Open	85.00
Min. of No of Working Days Open	2.00
Average of Months	0.88
Max. of Months	4.10
Min. of Months	0.07

Previous reporting period: 32.09 days
As of 2nd June 2025: 18.44 days
Target: 30 working days

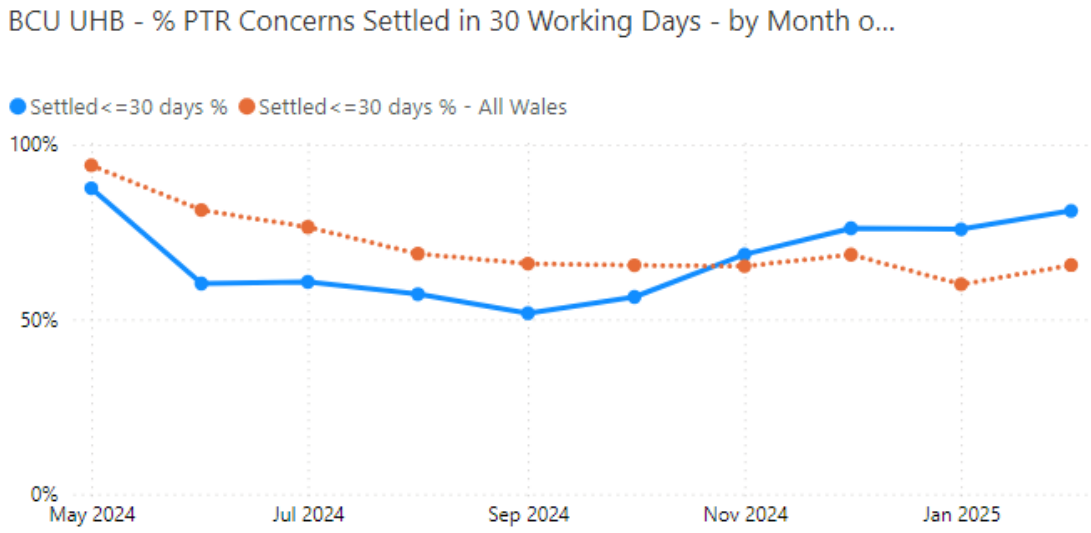
Note: As of the 2nd June 2025 the longest open complaint across BCUHB is 85 Working days. This demonstrates a significant improvement, with current performance well below the 30-day target.

Real-Time Complaint Closure Performance (National Beacon Dashboard):
Between June 2024 and February 2025, BCUHB has demonstrated a consistent improvement in the timeliness of complaint closures. This data, drawn from the National Beacon Dashboard (latest update: February 2025), reflects how many complaints received in a given month were closed within 30 working days, measured by the month of response.

The performance against the 75% target is as follows:

June 2024	60.24%
July 2024	60.69%
August 2024	57.21%
September 2024	51.74%
October 2024	65.47%
November 2024	68.56%
December 2024	76.02%
January 2025	75.76%
February 2025	81.03%

This trend reflects a marked improvement in the efficiency of complaint handling, with performance exceeding the national target from December 2024 onwards. It demonstrates a positive shift towards more timely responses and improved service user experience.



Complaint themes:
As of the latest reporting period, Clinical Treatment and Assessment remains the most prominent theme in complaints received by BCUHB. Of the 222 total complaints, 127 (57.21%) relate to this category.

This trend highlights the continued need for focused quality improvement efforts in clinical care delivery and patient assessment processes. The data will inform targeted actions and learning to address recurring concerns and enhance patient experience.

Themes and sub-themes:
The Health Board top 5 themes and elated sub themes are detailed below

Row Labels	Compliant <=30 Days	>30 Days	Grand Total
Clinical treatment/Assessment	**106**	**21**	**127**
Delay/Lack of diagnosis	5	1	6
Delay/Lack of treatment or Assessment	58	8	66
Incorrect diagnosis	4	1	5
Incorrect/insufficient treatment or Assessment	30	8	38
Reaction to procedure/ treatment	9	3	12
Patient Care	**19**	**3**	**22**
General care and respect	6	2	8
Response to Patient needs	8	0	8
Handling of patients	2	1	3
Lack of assistance with Patients personal hygiene - bath, teeth, toilet	2	0	2
Failure to follow end of life pathway	1	0	1
Communication Issues (including Language)	**13**	**5**	**18**
Communication with family	2	2	4
Communication with patient/service user	10	3	13
Communication between Services/Departments	1	0	1
Attitude and Behaviour	**11**	**0**	**11**
Attitude/Behaviour of Clinical Staff	11	0	11
Medication	**10**	**0**	**10**
Delay/Frequency in providing medication	3	0	3
Incorrect medication given	1	0	1
Lack of/No funding of medication	1	0	1
Access to own medication	1	0	1
Incorrect dosage given	2	0	2
Availability of medication	1	0	1
Allergies not considered	1	0	1

PATIENT FEEDBACK

Patient Advice and Liaison Service (PALS) Activity: 1 April – 31 May 2025:

During the reporting period, the Patient Advice and Liaison Service (PALS) supported the resolution of 1,170 enquiries, received 202 written compliments, and recorded 23 suggestions for improvement. On average, PALS resolved enquiries within 5.83 working days, reflecting a responsive and patient-focused approach.

Key themes emerging from PALS enquiries included:

Appointment-related concerns
Clinical treatment or assessment
Communication issues
These themes continue to inform service improvement priorities and targeted interventions.

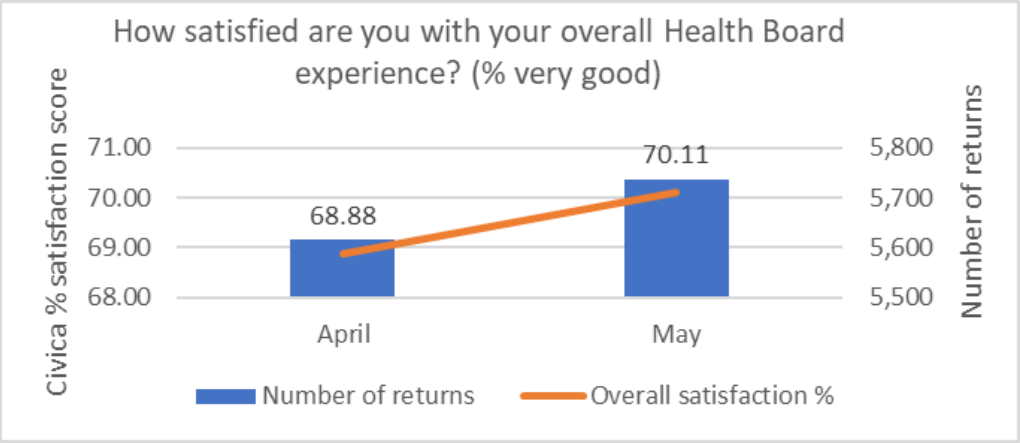
Patient Feedback – People's Experience Survey:

On 1 April 2025, NHS Wales launched the new People's Experience Survey, replacing the All-Wales Real-Time Feedback Survey and the Emergency Department Survey. This updated survey includes new questions designed to capture more nuanced insights into patient experience, such as:

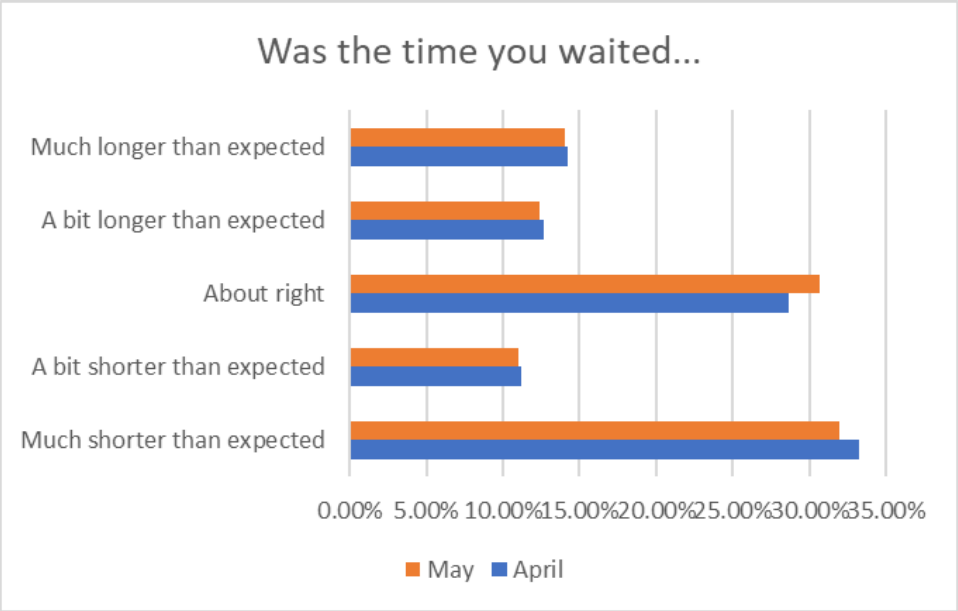
Recency of the experience
Perception of waiting times
Communication in preferred language
Language preferences
Treatment with dignity and respect
Due to the revised question set and scoring methodology, direct comparisons with previous years' Civica feedback data are not possible. Additionally, Emergency Department feedback is now integrated into the overall dataset.

Between 1 April and 31 May 2025, a total of 11,879 responses were received via the Civica feedback system. Of these, 70.11% of respondents rated their overall experience as 'very good', showing a slight improvement from 68.88% in April 2025.

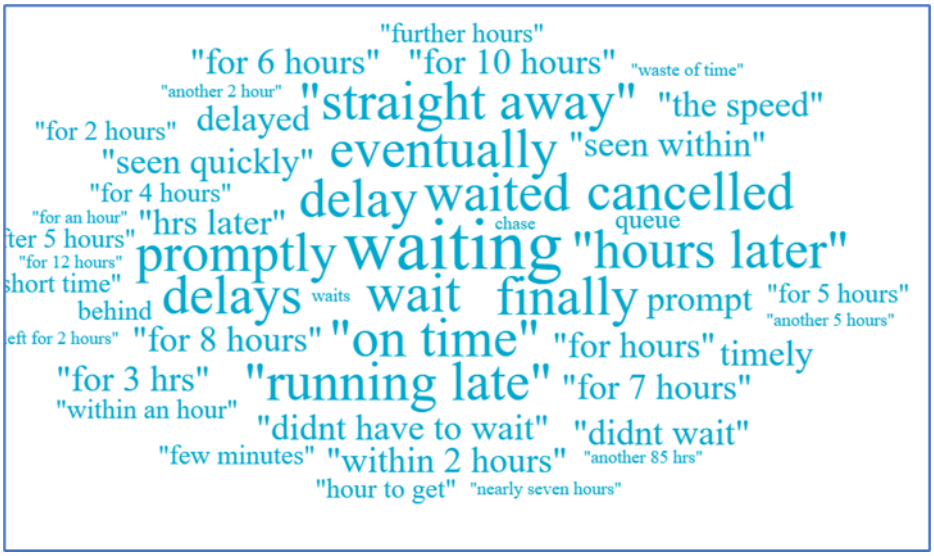
While the overall satisfaction score has decreased compared to historical data due to changes in methodology, the new survey provides a more accurate and inclusive reflection of patient experience across services.



There was a reported increase in satisfaction levels around the time people have waited, feeling listened to, feeling well cared for and always involved in decision making.



Here is a word cloud visualising the key feedback words related to waiting times identified from the qualitative responses in the People's Experience Survey using the Akumen tool:



Using the Akumen analysis tool on Civica, several recurring terms and concerns were identified in relation to waiting times. These include:

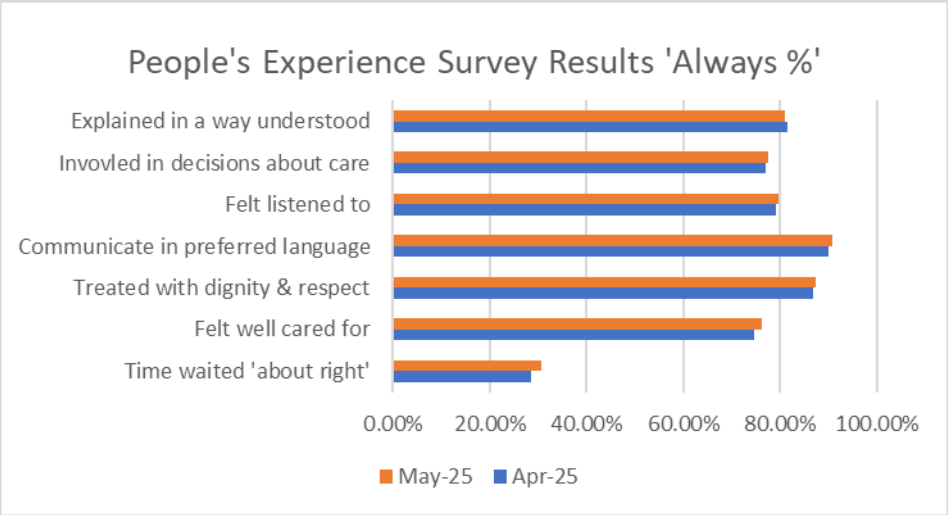
Delays in appointments and procedures
Long queues in waiting areas
Rescheduling and cancellations
Limited availability of appointment slots
Extended referral and follow-up times
Frustration with lack of communication about delays
These themes reflect a consistent concern among service users about the timeliness and predictability of care access.

People's Experience Survey – Dignity, Respect, and Language Accessibility:
As part of the newly launched People's Experience Survey, two key questions have provided encouraging insights into patient experience across BCUHB:

87.51% of respondents reported that they were always treated with dignity and respect. 90.80% of respondents indicated they were always able to communicate in their preferred language, which included Welsh, English, British Sign Language (BSL), Romanian, Urdu, and Portuguese.

Both results exceed the NHS Wales satisfaction benchmark of 85%, reflecting strong performance in two critical areas of patient-centred care: respectful treatment and inclusive communication.

These findings reinforce the Health Board's commitment to equity, dignity, and culturally sensitive care.



What people said was good about their experience:

> 'I left my appointment happy and reassured. I dropped off my prescription letter at my GP Surgery and was very impressed by the whole experience. Thank you!' (Ysbyty Glan Clwyd Outpatients).
>
> 'I was impressed by the sensitivity of staff by the fact that I am vulnerable to infection and my partner is immune deficient. They went out of their way to ensure I was well cared for, and they explained everything very carefully' (Ysbyty Gwynedd, Radiology Service).
>
> 'I was amazed how much the Doctor went through the process of my treatment; she was amazing' (Adult CMHT Wrexham).
>
> 'Nurses, Doctors, Consultants, theatre staff and everyone I met were amazing. They all ensured I was aware of what was going on and they thought of me first' (Abergele Hospital, Eye Outpatient Unit).
>
> 'The whole system of care at Bangor Hospital was exemplary. From A&E, to the ward, to the food, to the operation, aftercare, and consequent discharge - superb! Thank you, we are so lucky to have you' (Cancer Services, Ysbyty Gwynedd).

Preparatory work is being progressed by the Health Board to launch the All-Wales Maternity and Neonatal surveys.

OTHER PATIENT EXPERIENCE CONCERNS AND IMPROVEMENTS

PALS Engagement and Training:
Between April and May 2025, PALS Officers delivered Patient and Carer Experience Training to newly qualified nurses, reinforcing the importance of compassionate care and effective communication. In addition, PALS staff conducted 'Care to Share' discovery interviews across four wards in Ysbyty Gwynedd, Ysbyty Glan Clwyd, and Wrexham Maelor Hospital. Patients consistently praised staff for their kindness and caring approach.

Wards visited included:

- Ysbyty Gwynedd: Medical Day Unit and Gogarth Ward
- Wrexham Maelor Hospital: Arrivals Ward
- Ysbyty Glan Clwyd: Ward 3
- Staff Engagement and Support

At the May 2025 Health Board Nursing Conference, the Patient Experience Department facilitated two breakout sessions to explore how staff can be better supported in resolving low-level concerns locally.

People's Experience Survey and Framework:
The NHS Wales People's Experience Survey (PES) launched on 1 April 2025, replacing previous feedback mechanisms. PALS staff actively promoted the survey across services, and the Health Board was commended by NHS Executives for its outstanding implementation and high volume of responses.

To mark National Patient Experience Week in May 2025, the Patient and Carer Experience Team:

- Recognised staff and teams who received compliments
- Launched the NHS Wales People's Experience Framework
- Supported the All-Wales Compliment Workstream with a staff campaign, resulting in 61 compliments submitted by staff

The Quality Dashboard on Iris is now live, providing staff with access to Civica feedback, PALS enquiry themes, and complaints data to support real-time analysis and service improvement.

Patient Communication and Information:
The Health Board continues to uphold its duty to provide high-quality, accessible patient information. The Patient Information Readers Panel meets monthly to review materials for clarity and compliance. During the reporting period, 25 patient information leaflets were reviewed, including:

- Welcome to Enfys Ward booklet
- Skin and Scar Care
- Vitamin D and Sun Protection
- Cardiac CT Preparation
- CT Water Preparation

The Panel continues to support the Radiology Service in reviewing oral preparation materials.

End of Life and Bereavement Care – SWAN Model:
In alignment with the Welsh Government's ministerial priorities (2025–2028), the Health Board launched the SWAN Model for End of Life and Bereavement Care during National Dying Matters Week in May 2025. Events were led by the Specialist Palliative Care Team, Chaplaincy, and Macmillan colleagues to raise awareness and promote compassionate care.

Chaplaincy and Spiritual Care Service:
Between 1 April and 31 May 2025, the Chaplaincy and Spiritual Care Service responded to 187 support requests, including out-of-hours referrals across North Wales. This is in addition to daily pastoral care provided on the inpatient wards.

Seven multi-faith events were held to promote inclusivity and respect for diverse spiritual needs. Highlights included:

- Easter Gospel Concert at Ysbyty Gwynedd
- Kerala staff event celebrating cultural diversity
- National Dying Matters Week awareness activities
- Dementia Action Week music sessions
- Weekly music sessions on the Dementia Care Ward at Ysbyty Gwynedd
- Spiritual and cultural care training for midwives across North Wales

The service has also introduced an online referral system, accessible via the Chaplaincy & Spiritual Care SharePoint page, to streamline access for the Health Board workforce.

CLINICAL EFFECTIVENESS

CLINICAL AUDIT

National Clinical Audits (Tier 1) – Quarter 4 Update

Overview:

National Clinical Audits (Tier 1) are mandated by NHS Wales and play a vital role in benchmarking clinical performance against national standards. These audits are essential for identifying areas of good practice, highlighting opportunities for improvement, and ensuring the delivery of safe, effective, and high-quality care.

Governance and Reporting:

Within Betsi Cadwaladr University Health Board (BCUHB), Tier 1 audits are monitored on a quarterly basis. A consolidated report is produced and shared with the Strategic Clinical Effectiveness Group, and key findings are subsequently escalated through the Chair's Report to the Executive Quality Delivery Group.

Quarter 4 Activity:

During Quarter 4, 10 nationally published Tier 1 audit reports were received. These reports reflect the quality of care delivered to patients in relation to specific clinical topics. Of these, 2 audits have been reviewed and summarised in this reporting cycle. The remaining 8 audits will be included in the Quarter 1 report, once the Health Board's formal responses are due.

Service Assessments of Compliance (SAoCs):

Following the publication of each audit report, Clinical Effectiveness Facilitators (Audit) request Service Assessments of Compliance (SAoCs). These assessments are used to:

Highlight key achievements
Demonstrate improvements made
Capture impact and outcomes
Share lessons learnt

A summary table (Appendix 1 – Quarter 4 Audit Report) provides a detailed overview of these findings and actions taken.

				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 Prostate Cancer Audit (NPCA)	State of the Nation Report 2024	09-Jan-25	13-Mar-25	No - Overdue	No - Overdue	No - Overdue	Service assessment response, due March 2025, not received from all areas. Lack of engagement to requests for a response to the publication escalated to IHC management structures in line with CE Team process.
National Oesophago-Gastric Cancer Audit (NOgCA)	State of the Nation Report 2024	09-Jan-25	13-Mar-25	Yes	Yes	Yes	All outcomes are within National data points. All practice parameters are within guidance. No new learning identified from the results of this audit as we were already meeting all the requirements.

NICE GUIDELINES

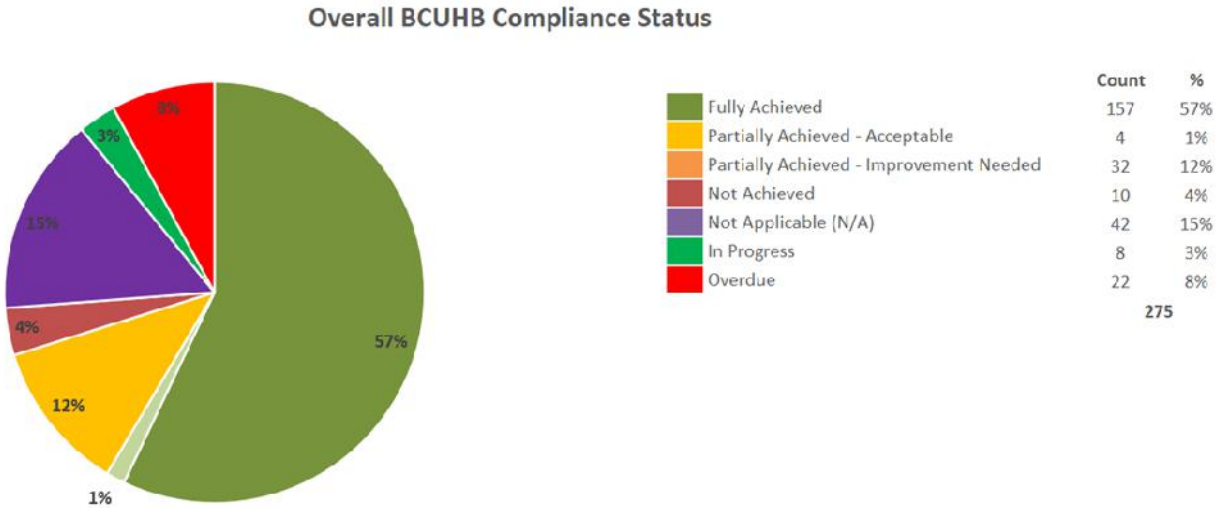
NICE Guidance Compliance and Support:

The Clinical Effectiveness Facilitator for NICE (CEF for NICE) continues to provide proactive support to departments across the Health Board, offering guidance and training where required. Where responses to NICE guidance are overdue, these are escalated through the Strategic Clinical Effectiveness Group (SCEG) to ensure appropriate oversight and accountability.

Since the implementation of the Audit Management and Tracking (AMaT) tool, there has been a measurable improvement in all aspects of NICE guidance compliance. The tool has enhanced visibility, tracking, and reporting, enabling more timely responses and improved assurance.

As of the end of May 2025, only 8% of NICE guidance remains overdue (non-responses), reflecting a continued upward trend in compliance.

To reinforce the importance of timely responses, the Medical Director issued a communication to departments with outstanding guidelines. The message emphasised that maintaining compliance with NICE guidance is a fundamental component of the Health Board's clinical governance framework and is essential to delivering safe, evidence-based, and high-quality care. This intervention has contributed to an increase in departmental engagement and response rates.



The recently reviewed **NICE Protocol** is available on Betsinet via the link: NICE Guidance Implementation and Assurance.

AMaT held a Conference in May 25, attended by some of the Clinical Effectiveness Team. There was a competition under the heading 'improving through AMaT' for which poster was designed and submitted and the team who were awarded commended for that category. AMaT Conference 25 Poster V1 16.4.25 FINAL SENT

Health Technology Wales Adoption Audits 2025:

HTW published 9 adoption audits in March 25. These have been circulated to identified leads within relevant services with the expectation to be completed and submitted via AMaT by 20th June 2025. Only one submission is expected per guideline for the Health Board. To date there are only 4 outstanding returns and are on target for the deadline.

MORTALITY REVIEW

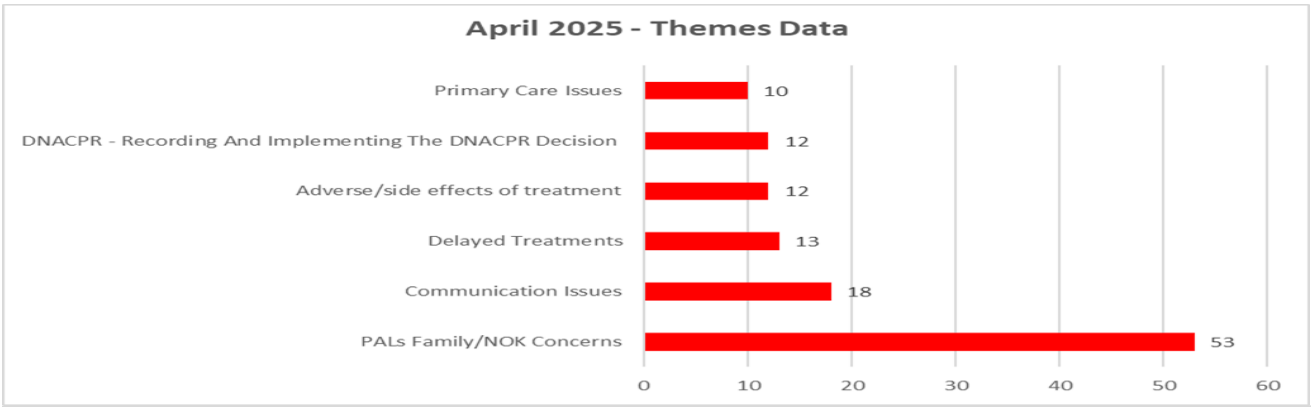
Medical Certification of Cause of Death (MCCD) – Update:
Pending National Guidance: Final papers for the All-Wales MCCD process are still pending publication by Welsh Government. However, the Corporate Mortality Team is already engaged with key outcomes through the Associate Medical Directors (AMDs) for Mortality, who participate in the national strategic group.

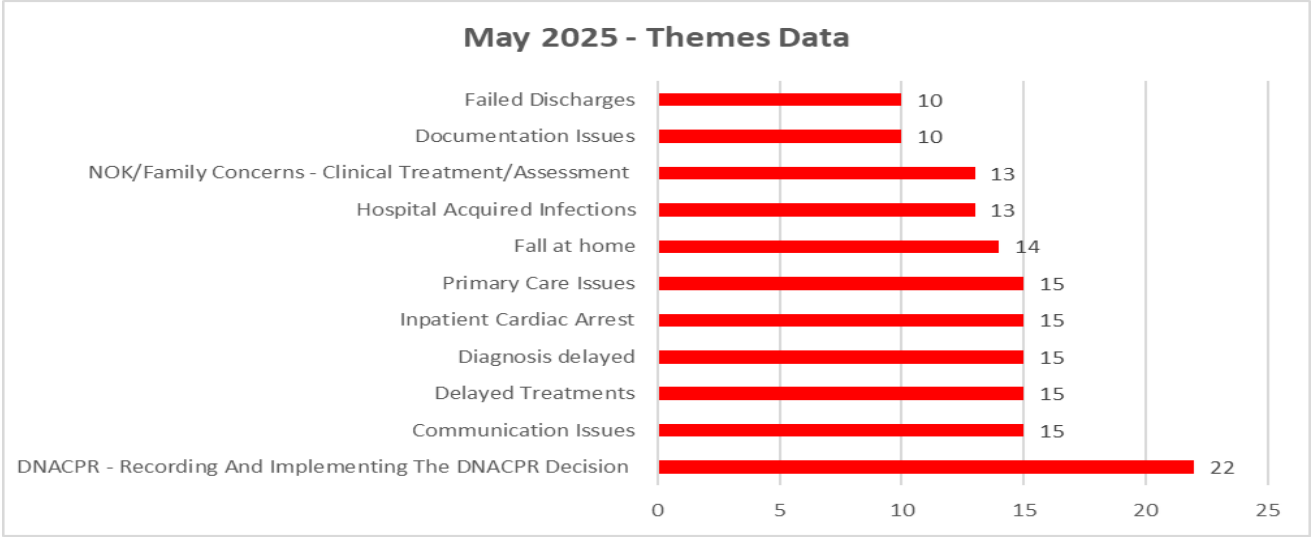
Proactive Implementation: In anticipation of the formal guidance, the Corporate Mortality Group has been proactively implementing preparatory changes behind the scenes to ensure readiness and alignment with expected national standards.

Educational Engagement: A Grand Round session focusing on the Medical Certification of Cause of Death will be held on Wednesday, 19 June 2025, from 1:00pm to 2:00pm via Microsoft Teams. The session will be recorded to maximise accessibility and engagement among clinicians.

Feedback and Learning: The Health Board is now providing the Medical Examiner Service with a monthly feedback report for cases reviewed through the Clinical Effectiveness Corporate Mortality process, supporting continuous learning and quality improvement.

Top 5 MES Identified Potential Themes Monthly Data (by date cases have been clinically reviewed by CE mortality):





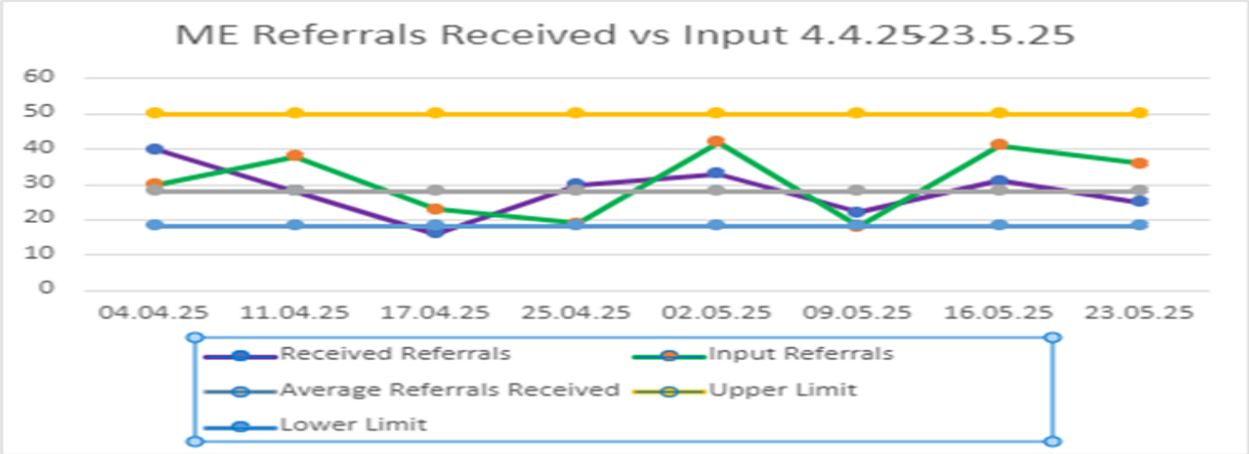
	Input/output			Inputting Backlog				Datix Status										
Date	Total received per week*	Total input per week	Output Differential	Total w/e Backlog inc compliments	Backlog of cases requiring inputting within 2w from date received by MES	Backlog of cases requiring inputting within 3w from date received by MES	Backlog of cases requiring inputting within 4w+ from date received by MES	Total New cases (awaiting mortality admin s&s)	New Under 2w from date received (awaiting mortality admin s&s)	New Within 3w from date received (awaiting mortality admin s&s)	New Within 4w+ from date received (awaiting mortality admin s&s)	Total Pending Cases awaiting Mortality Clinician Review S&S	Pending Cases Under 2w awaiting Mortality Clinician Review S&S	Pending Cases Within 3w awaiting Mortality Clinician Review S&S	Pending Cases Within 4w+ 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
04.04.25	40	30	-10	10	10	0	0	8	8	0	0	11	11	0	0	1180	184	3390
11.04.25	28	38	10	8	8	0	0	10	10	0	0	26	24	2	0	1178	168	3422
17.04.25	16	23	7	3	3	0	0	2	2	0	0	17	14	3	0	1194	174	3440
25.04.25	30	19	-11	14	14	0	0	0	0	0	0	6	6	0	0	1206	176	3458
02.05.25	33	42	9	8	8	0	0	1	1	0	0	17	17	0	0	1210	170	3487
09.05.25	22	18	-4	11	11	0	0	2	2	0	0	4	4	0	0	1220	176	3501
16.05.25	31	41	10	15	15	0	0	7	7	0	0	12	6	6	0	1217	178	3527
23.05.25	25	36	11	4	4	0	0	1	1	0	0	17	17	0	0	1228	177	3555

For info: *New Within 2 weeks & over date received into the HB from the MES. Refers to inputted cases being sent to the relevant services/departments and then being closed or sent for Corporate Mortality clinical review.

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

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

NEW REVISED 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
Inputting Backlog	Red = cases within 4 weeks and over from date received by MES that require inputting
	Amber = cases within 3 weeks from date received by MES that require inputting
	Green = cases under 2 weeks and over from date received by MES that require inputting
Datix Status	Red = cases within 4 weeks and over from date received by MES that require corporate mortality/IHC/service review
	Amber = cases within 3 weeks from date received by MES that require corporate mortality/IHC/service review
	Green = cases within 2 weeks from date received by MES that require corporate mortality/IHC/service review



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 Inspection Activity April to May 2025

Published Reports (2)

Kestrel Ward, North Wales Adolescent Service (NWAS)

HIW have published an inspection report pertaining to the Unannounced Inspection Kestrel Ward, North Wales Adolescent Service on the 17th of April 2025. The inspection took place from the 14th to 15th January 2025.

Due to an immediate risk to patient safety, HIW issued the following Immediate Assurances to the Health Board:

- Emergency medication was being stored in a sealed case within the medication room. We found that the emergency medication contained inside had expired in September 2024
- There was no documentary evidence to indicate that regular checks of the emergency medication were being carried out to ensure the items were present and in date. The staff we spoke with during the inspection confirmed that checks were not being undertaken of the emergency medication
- No additional seals were being stored on the ward for the purpose of routinely checking and resealing the emergency medication case
- In addition, we found expired patient Fortisip medication was being stored within the fridge in the medication room
- The Health Board's Medicines Policy was out of date, according to its review date of February 2023

As outlined within the inspection report, the Health Board has taken steps to address the immediate issues raised by HIW. Both the Immediate Improvement Plan and Main Improvement Plan are being monitored via the Health Boards Regulatory Assurance Group (RAG) which reports to the Executive Delivery Group (EDG), and up to the Quality Safety and Experience (QSE) Committee.

The report can be viewed via this link - 20250417KestrelWardAbergeleHospitalEN.pdf

Carreg Fawr, Mental Health and Learning Disabilities

HIW have published an inspection report pertaining to the Unannounced Inspection of Carreg Fawr, Bryn Y Neuadd on the 25th of April 2025. The inspection took place from the 21st to 23rd January 2025.

No immediate assurances were issued by HIW.

The report can be viewed via this link - 21012025 - BrynYNeuadd, EN.pdf

Announced/Unannounced Inspections (1)

HIW undertook an inspection at Ysbyty Gwynedd, Emergency Department from the 14th to the 16th of April 2025. HIW issued an immediate assurance, as the inspection team identified areas posing immediate risks to patient safety. As such, HIW made the following recommendations to the Health Board which require immediate action:

- The medication storage temperature records identified that the room temperature had exceeded the maximum threshold of 25 degrees Centigrade on several occasions. HIW requires details on how the health board will ensure that measures are in place to maintain the medication room temperature within accepted parameters of between 8 and 25 degrees Centigrade.
- HIW checked the resuscitation trolley and found a supraglottic airway and tubing that were past their expiry date and an endotracheal tube guide, in opened packaging, which had been placed back in the trolley. HIW requires details on how the Health Board will ensure that the resuscitation trolley is checked regularly and that all items past their expiry date, and items in opened packaging, are removed and replaced.
- HIW was not assured that the oversight of the paediatric area is sufficiently robust and safe. On several occasions during the inspection, the paediatric area was left with no staff in attendance whilst children were accommodated. They are not assured that the risks of harm to paediatric patients was appropriately managed. HIW requires details on how the Health Board will ensure that the paediatric area is adequately staffed at all times when children are accommodated.

The Health Board submitted an Immediate Improvement Plan to HIW on 25th April 2025 confirming the action it will take to make the required improvements and mitigate any further risks.

Concerns / Requests for Assurance (5)

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 East – Tan Y Coed Ward

The Health Board received an assurance request pertaining to a patient on Tan Y Coed ward, Bryn Y Neuadd as follows: -

- Misuse of restrictive practices; patients are being restrained as a first resort
- Discriminatory and Retaliatory Practices
- Lack of appropriate training regarding de-escalation.

Case 2: IHC East - Ysbyty Maelor, Prince of Wales Ward

The Health Board received an assurance request pertaining to Prince of Wales Ward, Ysbyty Maelor as follows: -

- Dirty corridors in hospital and Infection control issues
- Patients unkept and unclean
- Hand sanitisers empty

Case 3: IHC East – Clywedog Ward, Heddfan Unit

The Health Board received an assurance request pertaining to a patient on Clywedog Ward, Heddfan Unit as follows: -

- Patient asked for an advocate, but has not been able to speak to one
- Felt staff had lied and misled him with regards to his housing arrangements
- Incorrect medication administered to patient
- Patient was physically threatened by another patient without staff intervention

Case 4: IHC East – Heddfan Unit

The Health Board received an assurance request pertaining to

- The suitability of fixtures on the Heddfan Unit.

Case 5: IHC West – Carreg Fawr

Healthcare Inspectorate Wales (HIW) has received concerns from the Mental Health Review Tribunal Wales in relation to a recent hearing that was carried out for a patient

at Carreg Fawr, Bryn Y Neuadd Hospital.

The concerns are as follows: -

- Discharge planning for patients.
- Availability of MDT Staff
- Impact on MHRT decision making

The concerns identified in this period have been responded to and accepted by HIW as providing sufficient assurance.

Analysis of HIW Improvements Plans (9)

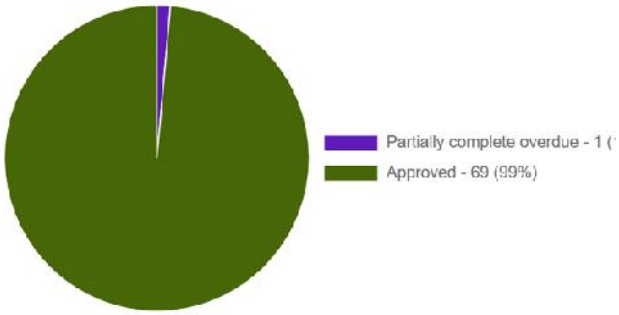
Emergency Department at Glan Clwyd, Improvement Plan

Inspection Date: 29/04/2024 – 01/05/2024
Responsible Lead: IHC Director, Centre
Overall Status: Overdue

Monitoring and Oversight:
The evidence for the overdue action has been reviewed by the Hospital Management Team (HMT) Oversight Group and reviewed by the Quality Team. This is approved for closure, subject to further supporting evidence which is the minutes of the latest ED Governance Meeting where the outcome of the audit was discussed.

The plan is receiving scrutiny via the Regulatory Assurance Group (RAG), reporting up to the Executive Delivery Group (EDG).

Position Overview / Summary:
27 Recommendations
70 Service Improvement actions
99% of plan is complete



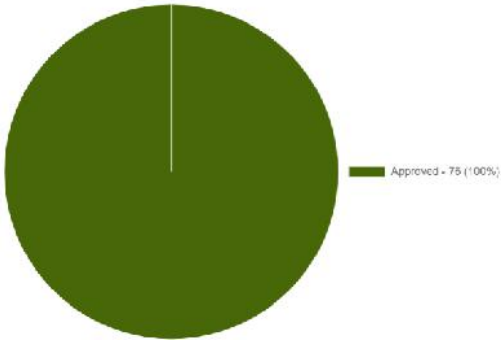
Gwanwyn and Hydref Ward, Heddfan Unit, Improvement Plan

Inspection Date: 21/10/2024 - 23/10/2024
Responsible Lead: Responsible Director, MHLD
Overall Status: Fully Complete

Monitoring and Oversight:
The plan is being monitored via the Fortnightly Divisional Programme Improvement Delivery Group (PIDG), reporting up to the Local Quality Delivery Group (LQDG).

The plan is receiving scrutiny via the Regulatory Assurance Group (RAG), reporting up to the Executive Delivery Group (EDG).

Position Overview / Summary:
31 HIW Recommendations
76 Service Improvement actions agreed
100% of plan is complete



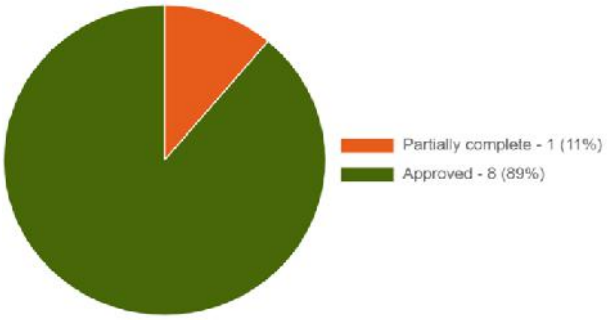
Emergency Department at Wrexham Maelor Hospital, Immediate Improvement Plan

Inspection Date: 09/12/2024 – 11/12/2024
Responsible Lead: Responsible Director, IHC East
Overall Status: In Progress

Monitoring and Oversight:
The plan is receiving scrutiny via the Regulatory Assurance Group (RAG), reporting up to the Executive Delivery Group (EDG).

Please note that the remaining action is being progressed by Pharmacy, with an anticipated closure date of 30th September 2025.

Position Overview / Summary:
2 HIW Recommendations
9 Service Improvement actions agreed
89% of plan is complete



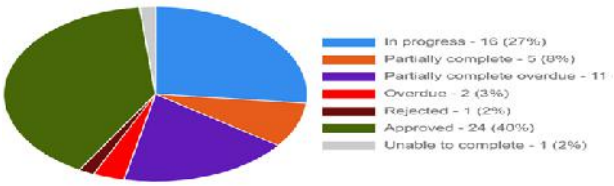
Emergency Department at Wrexham Maelor Hospital Improvement Plan

Inspection Date: 09/12/2024 – 11/12/2024
Responsible Lead: Responsible Director, IHC East
Overall Status: In Progress

Monitoring and Oversight:
The plan is receiving scrutiny via the Regulatory Assurance Group (RAG), reporting up to the Executive Delivery Group (EDG).

Please note that the overdue and rejected actions are currently being progressed by the IHC Director. A meeting took place on 04/06/2025 to discuss the evidence rejected by the Quality Team and the service are being supported to collate further evidence for submission.

Position Overview / Summary:
15 HIW Recommendations
60 Service Improvement actions agreed
40% of plan is complete



Kestrel Ward, North Wales Adolescent Service) at Abergele Hospital, Improvement Plan

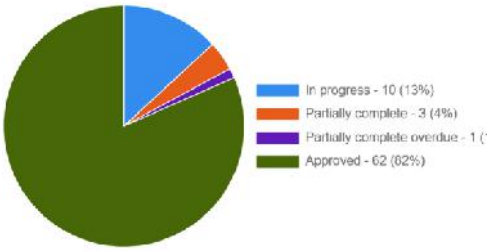
Inspection Date: 13/01/2025 – 15/01/2025
Responsible Lead: Chief Operating Officer and Responsible Director, IHC Centre
Overall Status: In Progress

Monitoring and Oversight:
The plan is being taken forward via the T4 Programme Group meeting.

The plan is receiving scrutiny via the Regulatory Assurance Group (RAG), reporting up to the Executive Delivery Group (EDG).

There is one partially complete overdue action related to the Medicines Policy. The subsection on medicines storage is currently under review and is progressing well through policy review process.

Position Overview / Summary:
28 HIW Recommendations
75 Service Improvement actions agreed
82% of plan is complete



Carreg Fawr, Impatient Rehabilitation Unit, Bryn y Neuadd Hospital, Improvement Plan

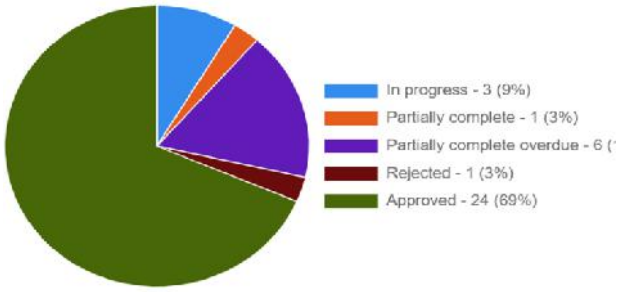
Inspection Date: 21/01/2025 – 23/01/2025
Responsible Lead: Responsible Director, MHLD
Overall Status: In Progress

Monitoring and Oversight:
The plan is being monitored via the Programme Improvement Delivery Group.

The plan is receiving scrutiny via the Regulatory Assurance Group (RAG), reporting up to the Executive Delivery Group (EDG).

A meeting took place on 05/06/2025 with the service to review the partially complete overdue actions and support was provided in terms of the evidence which needs to be submitted. The Quality Team aim to support the service to close the remaining actions by the 30/06/2025.

Position Overview / Summary:
13 HIW Recommendations
35 Service Improvement actions agreed
69% of plan is complete



Radiotherapy Department, North Wales Cancer Treatment Centre, Improvement Plan

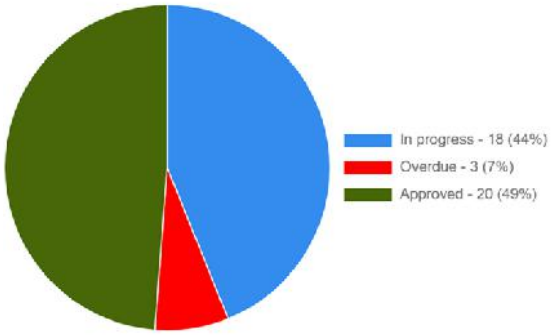
Inspection Date: 28/01/25 to 29/01/25
Responsible Lead: Responsible Manager, Radiotherapy
Overall Status: In Progress

Monitoring and Oversight:
The plan is being monitored via the Radiotherapy Quality Assurance Group.

The plan is receiving scrutiny via the Regulatory Assurance Group (RAG), reporting up to the Executive Delivery Group (EDG).

The evidence to support the closure of the overdue actions will be reviewed at the next Radiotherapy Quality Assurance Group in June.

Position Overview / Summary:
23 HIW Recommendations
41 Service Improvement actions agreed
49% of the plan is complete



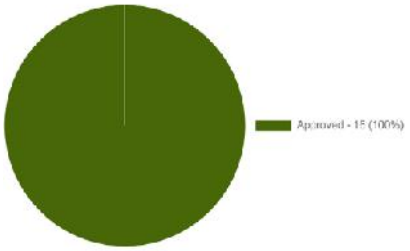
Ysbyty Gwynedd Maternity Services, Immediate Improvement Plan

Inspection Date: 18/02/25 to 20/02/25
Responsible Lead: Director of Midwifery and Women's Services
Overall Status: Fully Complete

Monitoring and Oversight:
The plan is under continuous monitoring by the Local Service Monitoring meeting (SLT).

The plan is receiving scrutiny via the Regulatory Assurance Group (RAG), reporting up to the Executive Delivery Group (EDG).

Position Overview / Summary:
3 HIW Recommendations
12 Service Improvement actions agreed
100% of the plan is complete



Ysbyty Gwynedd, Emergency Department, Immediate Improvement Plan

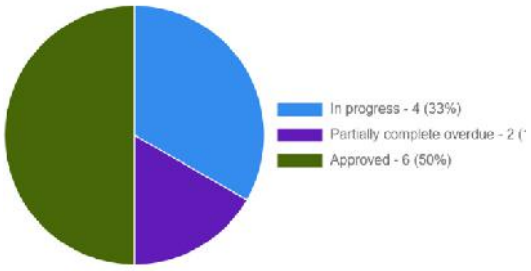
Inspection Date: 14/04/25 to 16/04/25
Responsible Lead: Responsible Director IHC, West
Overall Status: In Progress

Monitoring and Oversight:
The plan is under continuous monitoring by the Senior Leadership Team meeting (SLT).

The plan is receiving scrutiny via the Regulatory Assurance Group (RAG), reporting up to the Executive Delivery Group (EDG).

Both partially complete overdue actions are overdue as at 31/05/2025. The Service are reviewing the further evidence required at the next HIW Review Meeting to support closure of those actions.

Position Overview / Summary:
3 HIW Recommendations
12 Service Improvement actions agreed
50% of the plan is complete



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.

Annual return and Amendment to Registration:
The Regulation and Inspection of Social Care (Wales) Act 2016 requires registered service providers to submit an Annual Return following the end of each financial year. This includes those services operating as ‘Domiciliary’ services. The Annual Return was successfully completed by the Health Board ahead of 26 May 2025.

As part of the Annual Return, the Health Board submitted a notification of the following changes:

1.Change of Responsible Individual
2.Change to legal Statement of Purpose

The changes have been made in line with the considerations outlined in the Regulation and Inspection of Social Care (Wales) Act 2016, as Local Health Boards must have a designated Responsible Individual (RI) who holds a position of sufficient seniority within the organisation. The new designated RI, Head of Quality, was appointed by the Health Boards Executive Nurse Director and approved via the Regulatory Assurance Group. The RI is now progressing via CIW's 'Fit and proper person' assessment. This process ensures that CIW are satisfied that the individual is fit and proper.

The Statement of Purpose has been updated to ensure compliance with regulations are there have been changes to some of the Health Board service provisions, namely Tuag Adref / Home First in IHC Centre and IHC West who have been internally assessed as no longer providing 'domiciliary care, to which CIW have been notified accordingly.

Quality of Care Review visits:
The Health Board aims to undertake six-monthly Quality of Care Review visits. The regulations require the review to take place as often as required, or at least every month. 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 in progress and a visit to Enhanced Community Residential Services (ECRS) is scheduled for 19 June 2025. The previous visit took place on 10 July 2024, whereby no immediate risks to patient safety were identified. As such, this will be a routine visit to the service.

QUALITY PEER REVIEWS

In 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.

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. The Quality Team are planning to undertake feedback sessions with colleagues who have taken part in the peer reviews to date, in order to develop the process further.

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):

There have been no Public Interest Reports received during this reporting period.

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.

Due to a change in staffing within the Ombudsman's office, the Health Boards have not received monthly performance data in 2025. The Health Board is liaising with the new Head of Complaints Standards to establish whether the data can be provided on a month-by-month basis again, to monitor compliance. The Health Board have also requested that data is published with context to enhance the Health Board's and external stakeholders understanding.

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

The 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.

ORGANISATIONAL LEARNING

Quality Learning Portal:

The BCU Learning Repository App is a new knowledge management platform being developed to capture, organise, and share learning across Betsi Cadwaladr University Health Board (BCUHB). It is a response to the Health Board's commitment under Special Measures to improve how we learn from experience - particularly incidents, feedback, and best practices - and to ensure that learning leads to real, measurable improvements in patient safety, staff wellbeing, and service quality.

The system will serve as a centralised, searchable repository that integrates data from multiple sources such as Datix, Greatix, audits, complaints, and mortality reviews. It will allow staff to access relevant learning content, receive targeted updates, and contribute feedback. The platform is designed to be intuitive and secure, with features such as natural language search, automated notifications, and dashboards for trend analysis.

Project Timeline: Key Milestones

Milestone	Timeline
Internal Testing with Pharmacy	Now - July 2025
Go-live Testing Phase with Pharmacy	End of July 2025

Milestone	Timeline
Evaluation and Adjustments	August - September 2025
Phased Rollout to Other Departments	Autumn 2025
Live Feeds Rolled Out Organisation-wide	November 2025

Engagement Session continue with next session planned for July 2025.

Quality Dashboard:

Launched in June 2024, the Quality Dashboard is now embedded within the Health Board and is pivotal to understanding the quality of care provided to our population through key quality metrics. This suite of dashboards offers a single, organisation-wide resource for accessing real-time quality information from ward/team to Board.

The dashboard is essential for the Health Board to meet its quality reporting obligations, including 'Always on' reporting, in line with the Duty of Quality for Wales. It routinely collects, analyses, monitors, and makes information about the quality of services readily available. This promotes openness and transparency with the Health Board's population and stakeholders, driving learning and continuous improvement by identifying areas requiring significant change.

The Quality Dashboard was relaunched across the organisation in April 2025 and the Quality Directorate continue to work with areas of the organisation to support and strengthen the link between data driven quality improvement, which is presented through learning forums within the Health Board.

The Quality Dashboard is linked to the BCUHB Quality Management System (QMS) Digital App to ensure that as the systems are linked.

Quality Management System:

Development of the BCUHB Quality Management System continues to progress at pace. In August 2025 the QMS Group are planning to move into the implementation, wider socialisation and embedding stage, with key stakeholder engagement sessions and presentations in core forums throughout the organisation. The QMS group are linked with national forums to align with work across Wales.

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 one Regulation 28 Prevention of Future Death (PFD) Notice since the last report.

In this case, the coroner also determined death (which occurred in July 2023) was contributed to by Neglect. The coroner found there were missed opportunities to identify concerns on the midwifery led unit including properly conducting holistic assessments, properly completing portogram and manual palpation of maternal pulse, which would also likely have resulted in earlier detection of distress and successful delivery. In the PFD the Coroner raised concerns that:

a) The neonatal investigation was not thorough. The investigator did not obtain or request statements from doctors directly involved in the resuscitation, nor did they meet with them to understand what had occurred. The investigation was based on records alone. The records themselves, identified as part of the investigation, were often incomplete or included retrospective entries. Despite this, the investigator nor the panel involved considered speaking to or obtaining statements from crucial individuals.
b) There was no sufficiently full contextual sharing of the investigation or its findings from a neonatal or maternity perspective. Some witnesses had only received and read the report as part of the inquest process, which occurs many months after the incident.
c) The memoranda sent to staff highlighting the learning did not include context or narrative around the circumstances of investigation. Therefore, those not directly involved would not have been fully aware of the context of what had occurred.

At the time of writing this report, responses to the above Notices were still being drafted. The response will include changes already made in 2024 with the new Integrated Concerns Policy and process as well as other learning from this inquest.

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 WRP procedures require a Learning from Events Report (LFER). These are used by the Health Board to report the issues that have been identified from a claim or redress case and to demonstrate with evidence how these have been addressed in order to reduce the risk of reoccurrence and reduce the impact of a future event.

The Health Board, like several other boards, has recurring issues with the timeliness of Learning from Events Report (LFER) submissions, with these often delayed within services who struggle to provide evidence of learning and sustained improvement (it is important to note, the period between an adverse event and a claim being settled can be several years).

However, at the time of writing, 9 LFERs are overdue (down from 86 at the start of the year). This reflects the significant effort put in to eliminate the backlog, and the benefits of the new process introduced by Legal Services in January 2025. Legal Services have presented at national meetings on the work that has been done to improve, to share learning across Wales.

OTHER HEALTHCARE LEGAL MATTERS

There are no other matters to note.

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Integrated Quality & Performance Report

Reporting Period: to 31.05.2025

Presented to

Quality, Safety & Experience Committee

Thursday, 3rd July 2025

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

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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

- **2 New Never Events reported** 1 on March and 1 in May.
- **Learning from Events Reports:** Progress made during Q4 in reducing number of overdue LFERs reducing from 64 at end of Q4 to 43 at end of Q1. Continued focus is required to address the timely completion and recovery of the overdue position.
- **Clinical Coding Compliance** will remain a significant risk during 2025-26, however trajectories indicate improvement towards the end of 2025-26. Position stabilised and showing improvement, now at 40%. Measure will be kept in escalation for assurance.
- Percentage of **patients offered an index colonoscopy within 4 weeks of booking their Specialist Screening Practitioner assessment** appointment has fallen to 4.3% against a 90% target. All Wales performance at latest benchmark point (of Mar 25) is 8.4%

Access and Activity For Information Only (Corporate Risk 24-11 Planned Care)

Performance within the planned care space remains poor when compared to Access Standards

- **Referral to Treatment (RTT):** After the improvements seen in the numbers of extreme waits during 2024/25, it may be concerning to see the number of 104 weeks waits rising again in Q1 2025/26.However, solutions are in place which will see a significant reduction in these by the end of June 2025 as detailed on slide 7.
- **Cancer -** Performance against single cancer pathway target remains fragile with a rate of **53.8%** at end of April 2025 as forecast previously. However, the focus on dermatology backlog has seen a significant decrease in the backlog although the rate of reduction has slowed in Q1 of 2025/26.
- **Diagnostics waits over 8 weeks**: At the end of May 2025, there were just under **14,000** patients experiencing waits of over 8 weeks for diagnostic tests. The delays are mainly in radiology and endoscopy. The delays in endoscopies are impacting on our ability to improve our cancer 62 day position. **(Corporate Risk 24-13 Timely Diagnostics)**
- **Percentage of Ophthalmology R1 patients seen within 25% of their clinical due date** remains significantly adverse to target and due to the potential irreversible nature of conditions that some patients in this cohort have, is of concern. Urgent harm reviews for assurance is recommended.
- **The number of patients that are 100% overdue their clinical review date** is of increasing concern and continues to increase with latest position over 95,700. This will be a key area of focus during 2025/26.

Urgent & Emergency Care (Corporate Risk 24-10 Urgent and Emergency Care)

Performance within the urgent & emergency care space continues to deteriorate and shows no significant signs of improvement. With **3,749** waiting over 12 hours and **1,741** waiting over 24 hours. Further, ambulance handover delays of 4 hours or more remains over **640** per month on average, however significant improvements are evident at Ysbyty Glan Clwyd. There has been no statistically significant change in the number of delayed pathways of care at **337**.

People & Organisational Development Performance

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

- At 80.7%, **PADR** rate continues within normal variation but remains below the 85% target.
- **At 5**.4%, **Sickness absence rate** has seen a continuous decrease in trend over recent months, in line with seasonal change.
- At **0.5%**,**Turnover rate** for nursing staff leaving BCUHB increased in month. Focus continues on national and local retention work.
- At 3.5%, **agency spend** has shown an increasing trend during the first 2 months. Ongoing work taking place around the Welsh Health Circular for agency spend reduction and the Value and Sustainability workforce programme.

Finance For Information Only

(Corporate Risk 24-05 Financial Sustainability)

The in-month position is reporting a deficit of £2.4m and the year to date position is £6.2m deficit, largely driven by £4.5m shortfall in undelivered savings and pressures associated with escalated beds and Healthcare Services provided by other NHS Bodies Contracts.

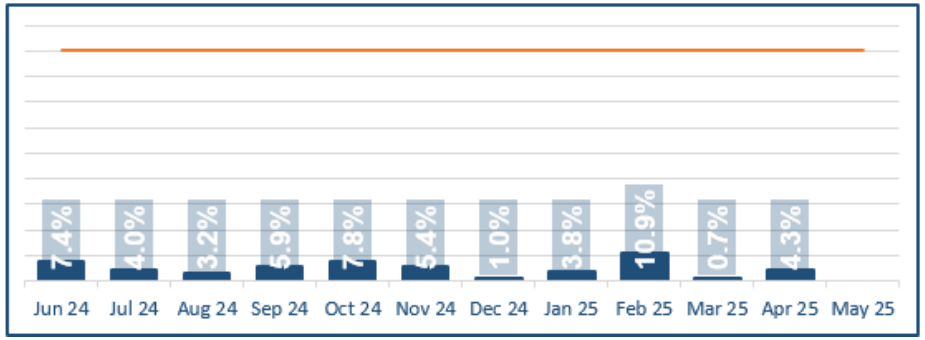
The Health Board's financial plan has set a savings target of £40.0m to be delivered in 2025/26, profiled on an equal twelfth's basis. Full year forecast values of Deliverable Schemes total £12.8m (including £12.7m Savings and £0.1m Income Generation). Of these, £9.3m have been identified as recurring, with a full year effect of £13.0m and £3.5m are non-recurring savings. In-month delivery includes Savings of £1.6m against a £3.3m Target.

Quality: Escalated Performance Measures

Corporate Risk 24-04 Failure to Embed Learning

Learning form Events Reports

Index Colonoscopy



Learning From Events Reports (LFERs):

There are 14 outstanding LFERs at the end of May. There has been a month on month decrease in number of overdue reports since December 2024.

Overdue reports pose 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 also the financial risk given that the Health Board can incur a penalty of £2,500 per overdue report. Continued focus is required to address the timely completion of LFERs and recovery of the overdue position.

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 is 4.3% against a 90% target. All Wales performance at latest benchmark point (of Mar 25) is 8.4% with five of the seven Health Boards seeing rate of less than 7%. Further review is required to understand drivers for current performance and plans moving into 2025/26.

GIG CYMRU NHS WALES
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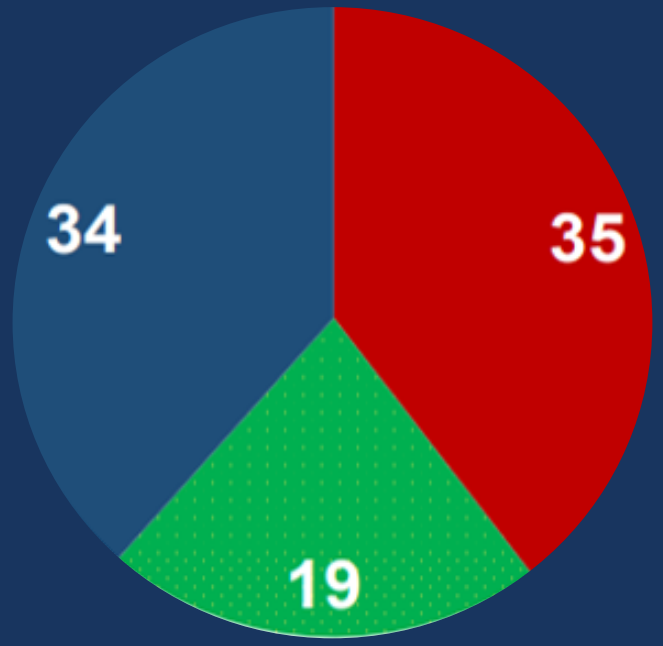
University Health Board

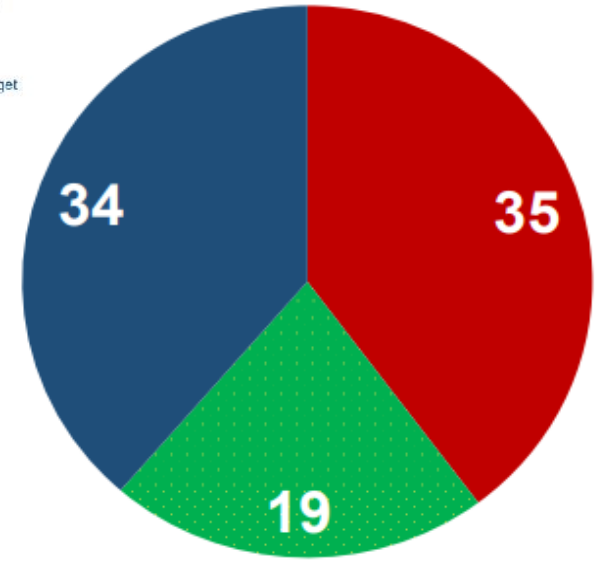
Integrated Performance Report



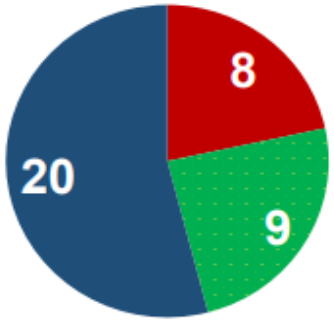
Produced on behalf of the **Quality, Safety and Experience Committee** by the
Performance and Commissioning Directorate in partnership with **Health Board Directors**

Summary of Performance to Month 12

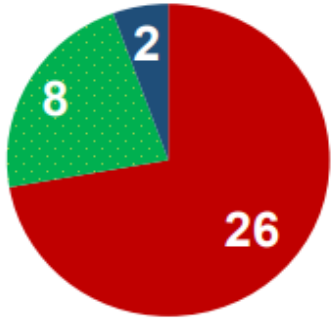
Green	The *latest available data point* indicates that performance is at, or better than the target
Red	The *latest available data point* indicates that performance is worse than the target
Blue	It is inappropriate, or not possible, to rate available data against any available target
Grey	There is no / insufficient data available to rate against the target



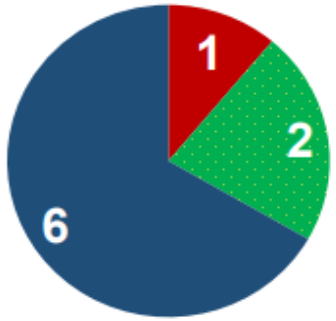
All Sections



Quality, Safety, Effectiveness & Experience Performance



Access & Activity Performance

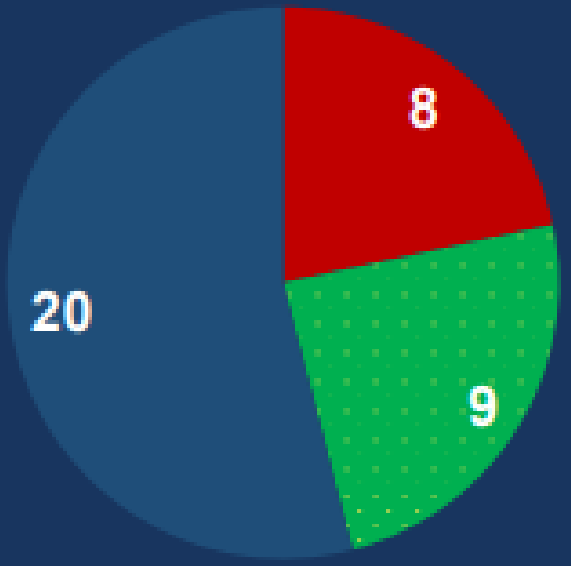


People & Organisational Development Performance

Financial Performance

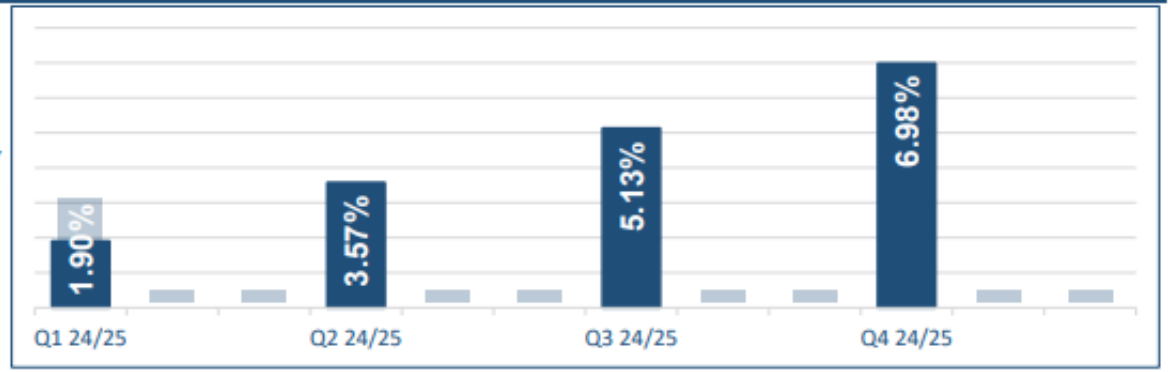
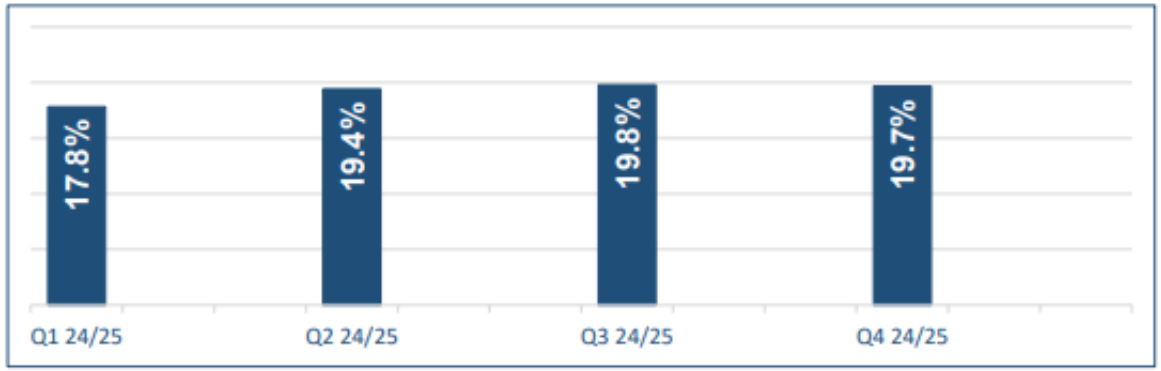
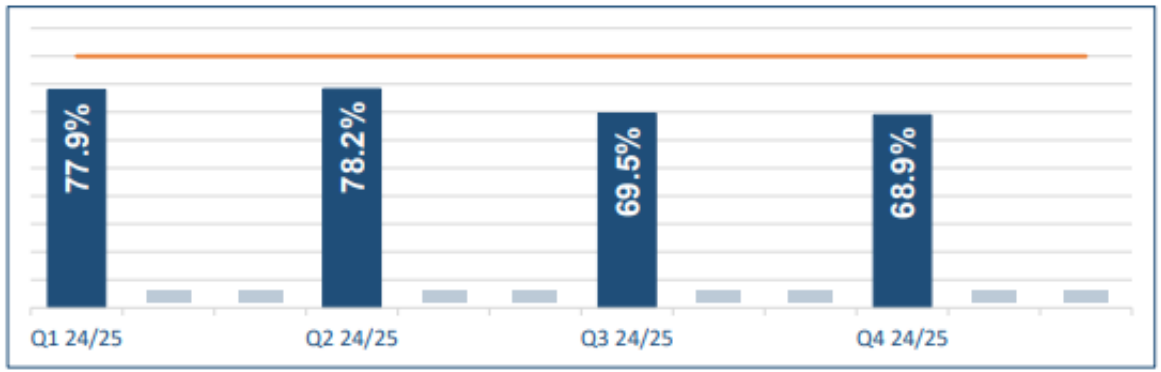
Section 1

Quality, Safety, Effectiveness and Experience Performance



Produced on behalf of the **Quality and Safety Committee** by the **Performance and Commissioning Directorate i**

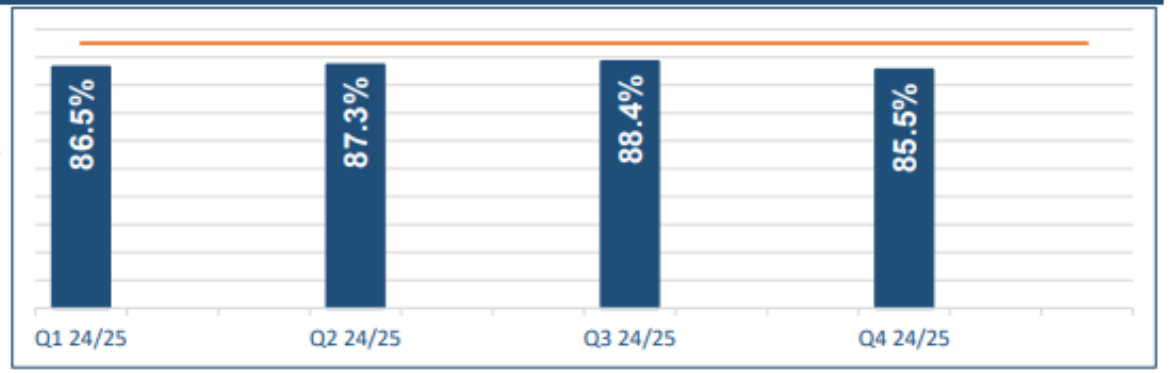
Quality: Performance

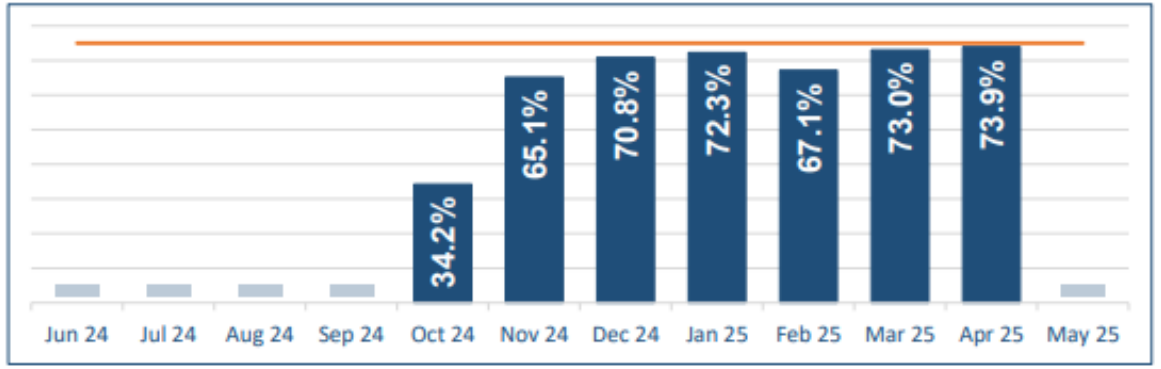
Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank	
-	QSE	Percentage of adult smokers who make a quit attempt via smoking cessation services	5% annual	TBC	6.98%	2nd of 7 (at Dec 24)	
-	QSE	Percentage of adult smokers who made a quit attempt via smoking cessation services who are CO-validated as quit at 4 weeks	40% annual target	TBC	19.7%	3rd of 7 (at Dec 24)	
-	QSE	Percentage of children receiving the Human Papillomavirus (HPV) vaccination by the age of 15	90%	TBC	68.9%	5th of 7 (at Mar 25)	

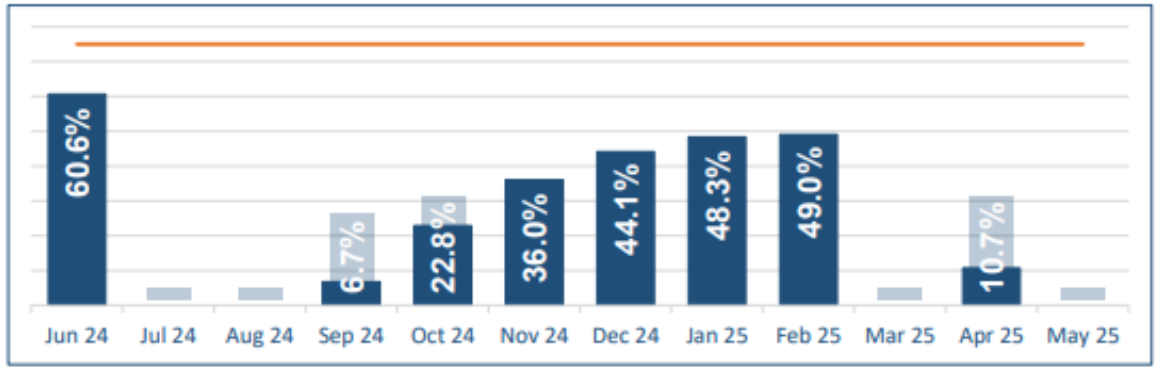
* Wales Ranking may differ as may refer to previous month

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	85.5%	3rd of 7 (at Mar 25)
-	QSE	Percentage uptake of the influenza vaccination amongst adults aged 65 years and over	75%	TBC	73.9%	1st of 7 (at Mar 25)
-	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	10.7%	5th of 7 (at May 25)







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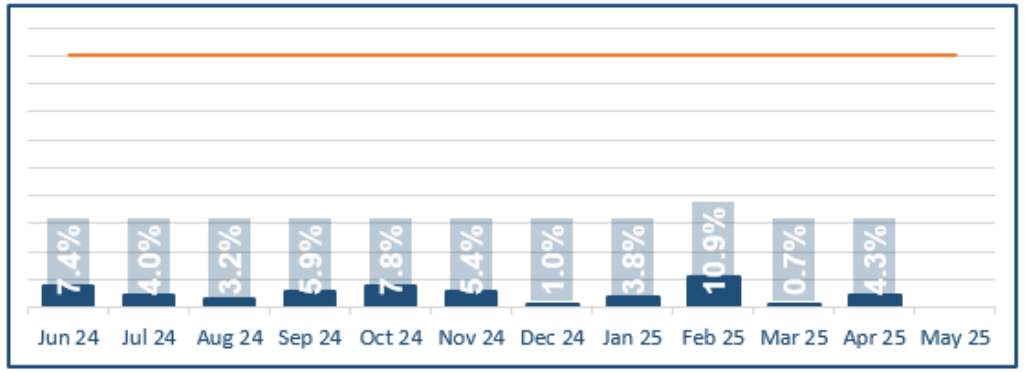
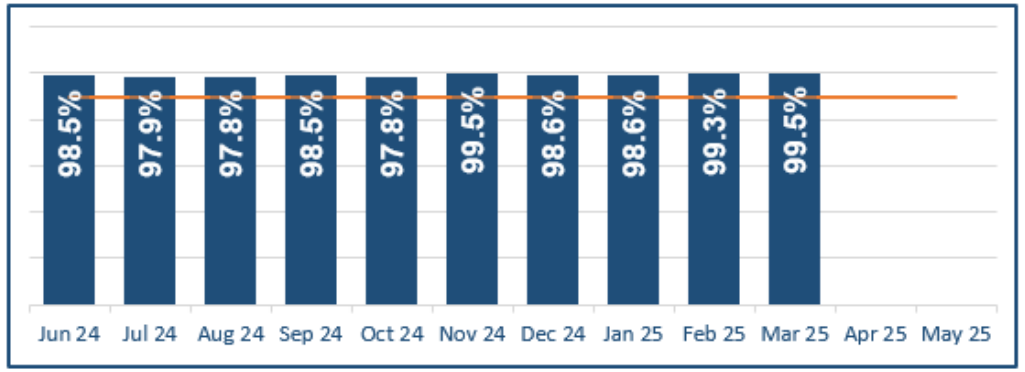
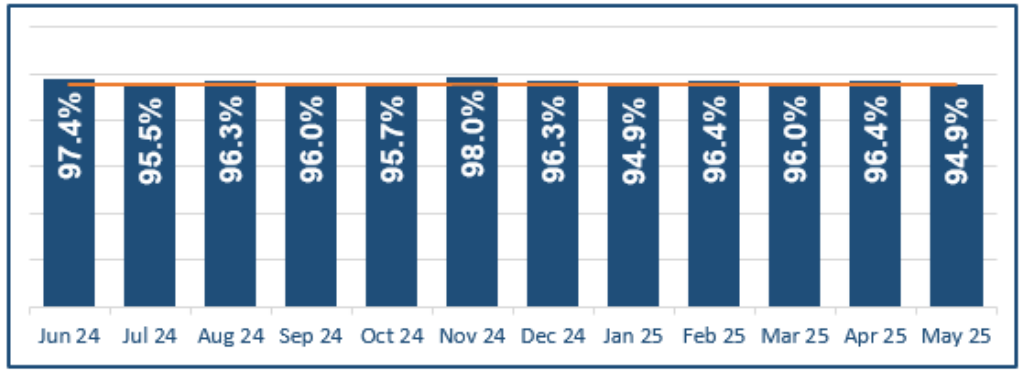
Quality: Performance

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	4.3%	6th of 7 (at Mar 25)
-	QSE	Percentage of well babies entering the new-born hearing screening programme who complete screening within 4 weeks	90%	TBC	99.5%	2nd of 7 (at Mar 25)
-	QSE	Percentage of eligible newborn babies who have a conclusive bloodspot screening result by day 17 of life	95%	TBC	94.9%	5th of 7 (at Apr 25)







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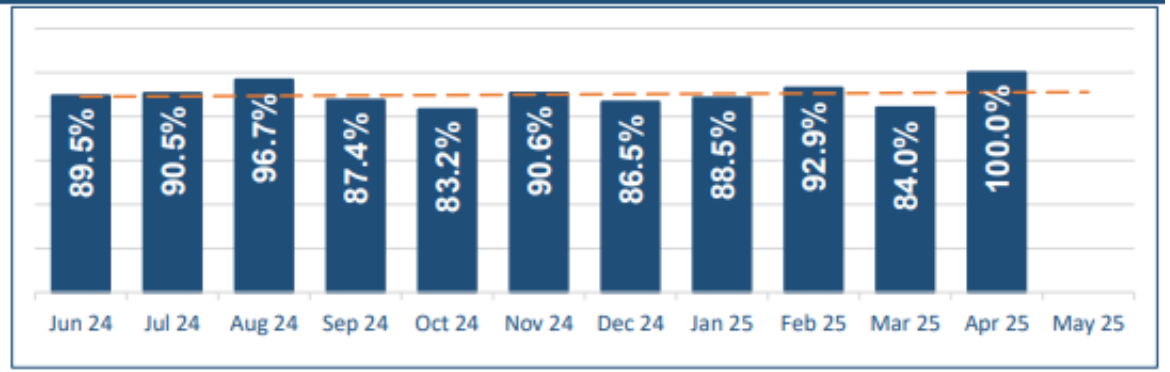
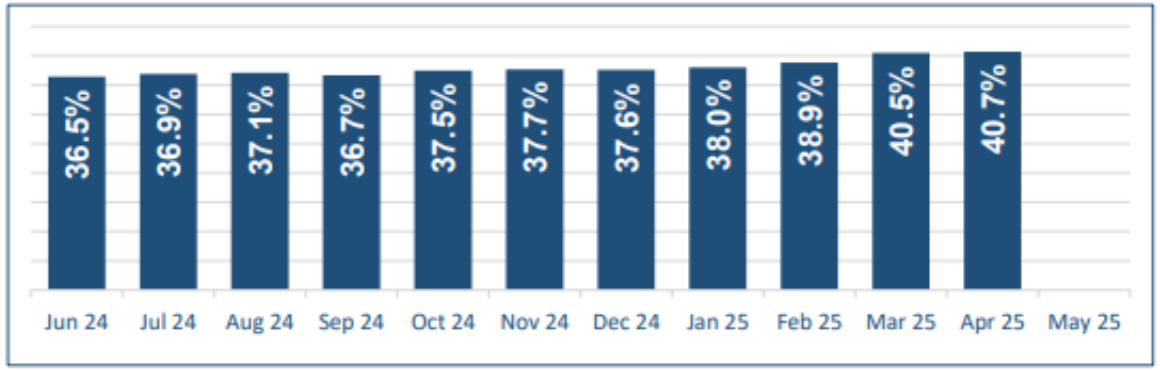
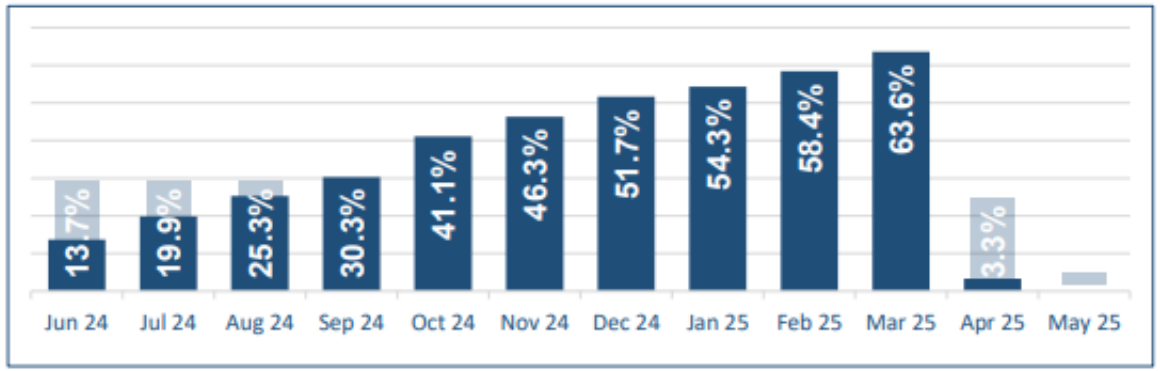
Quality: Performance

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	100.0%	5th of 7 (at Mar 25)
-	QSE	Percentage of patients (aged 12 years and over) with diabetes who received all eight NICE recommended care processes	Equival-ent month increase (2025/26 to 2024/25) to 100%	TBC	40.7%	7th of 7 (at May 25)
-	PFIG	Percentage of the primary care dental services (GDS) contract value delivered (for courses of treatment for new, new urgent and historic patients)	Increas-ing trend (to 30% (end Sept), then 100% (end Mar))	TBC	3.3%	6th of 7 (at May 25)







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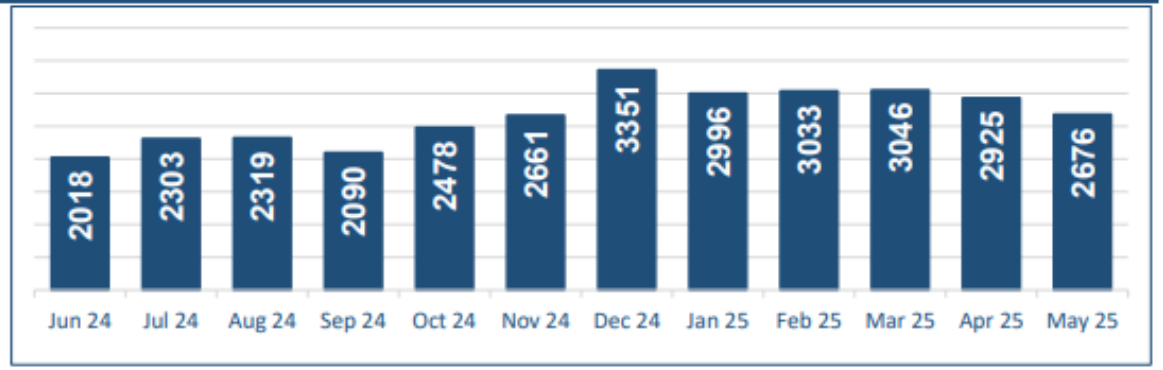
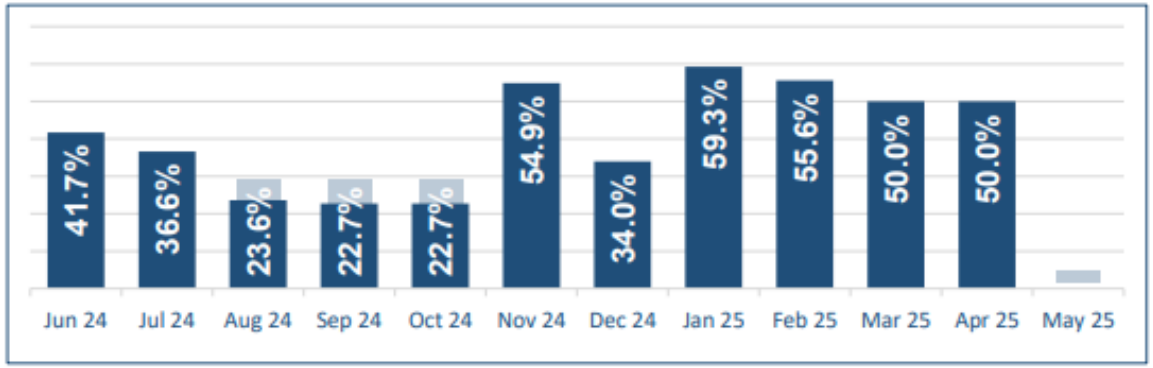
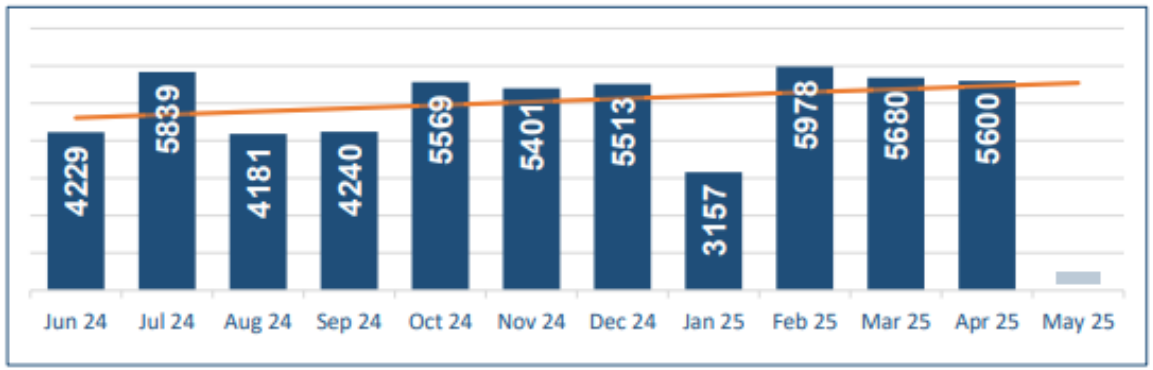
Quality: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	PFIG	Number of consultations delivered through the Pharmacist Independent Prescribing Service (PIPS)	Equival-ent month increase (2025/26 to 2024/25)	TBC	2676	1st of 7 (at Apr 25)
-	QSE	Percentage of confirmed COVID-19 cases within hospital which had a definite hospital onset of COVID-19 (>14 days after admission)	Equival-ent month reduct-ion (2024/25 to 2023/24)	TBC	50.0%	3rd of 6 (at May 25)
-	QSE	Number of service user feedback experience responses completed and recorded on CIVICA	Increas-ing trend	TBC	5600	2nd of 10 (at Apr 25)







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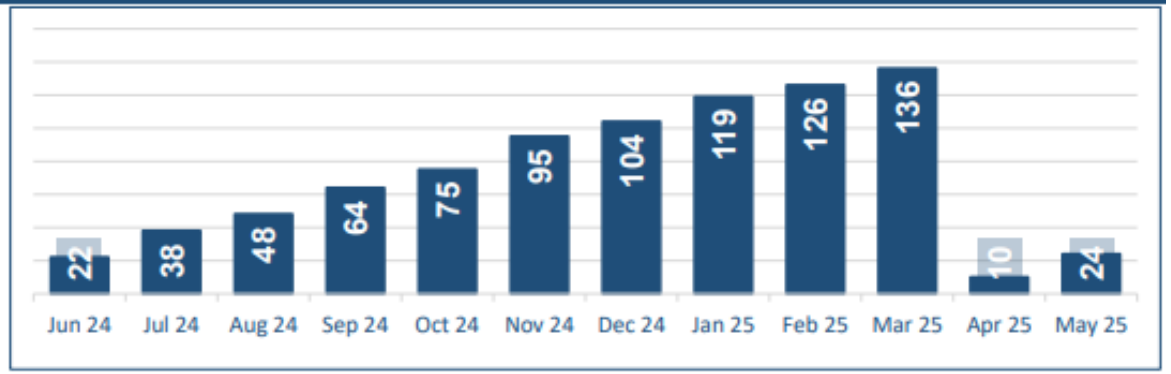
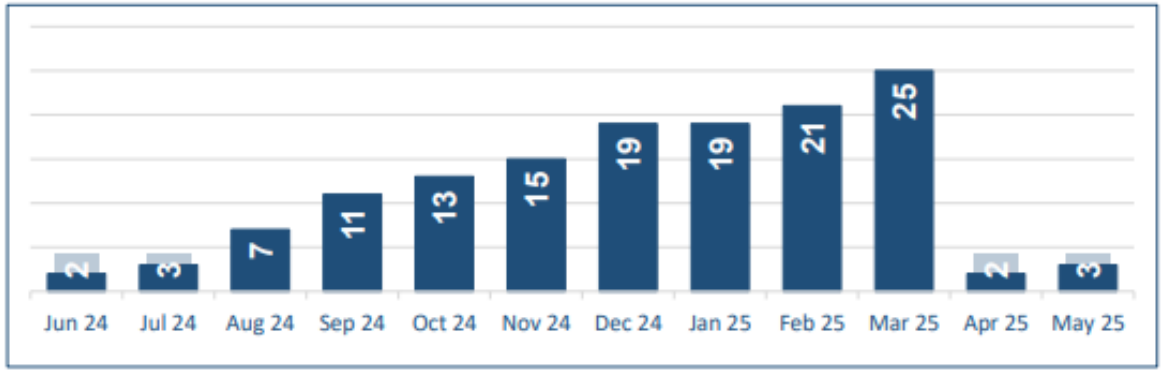
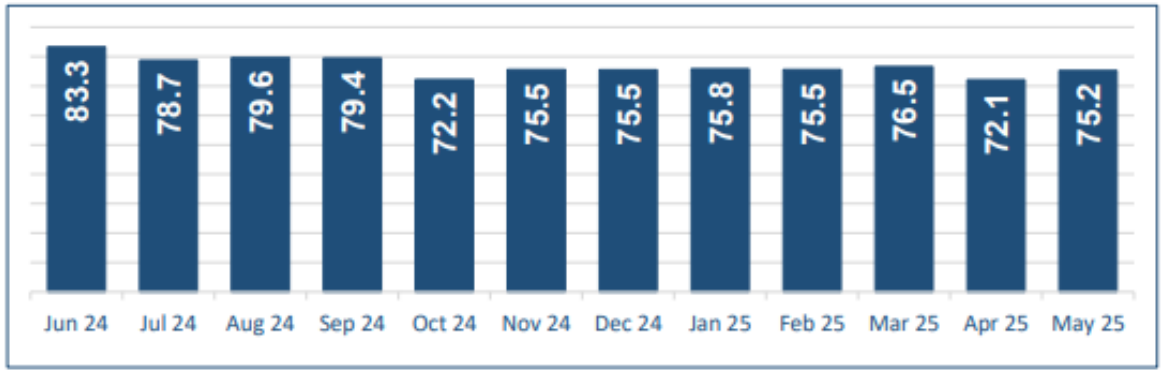
Quality: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
CRR: 24-04	QSE	The cumulative number of laboratory confirmed Klebsiella in reporting month	106	TBC	24	4th of 6 (at May 25)
CRR: 24-04	QSE	The cumulative number of laboratory confirmed Pseudomonas Aeruginosa in reporting month	27	TBC	3	3rd of 6 (at May 25)
CRR: 24-04	QSE	The cumulative rate of laboratory confirmed E.coli bacteraemias cases per 100,000 population	67	TBC	75.2	4th of 6 (at May 25)







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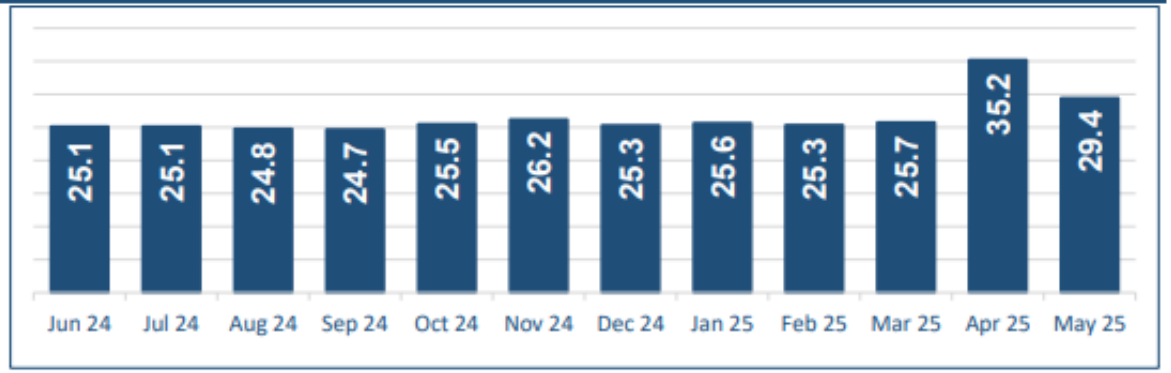
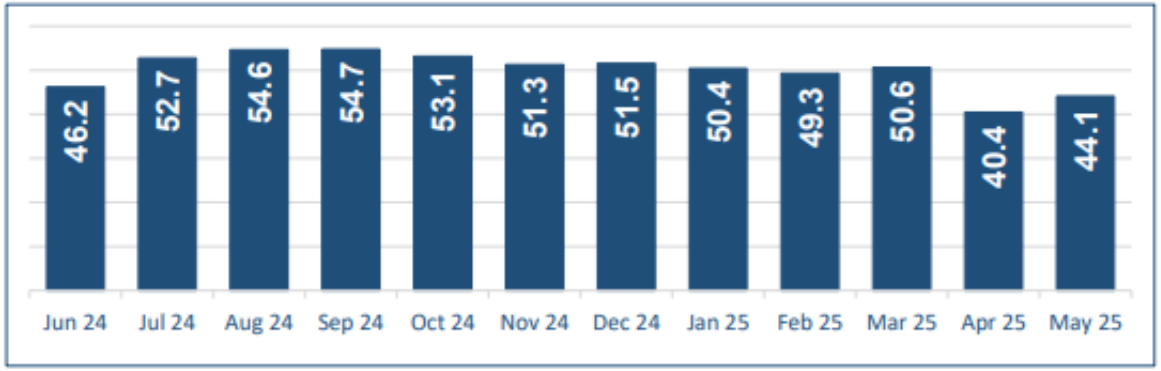
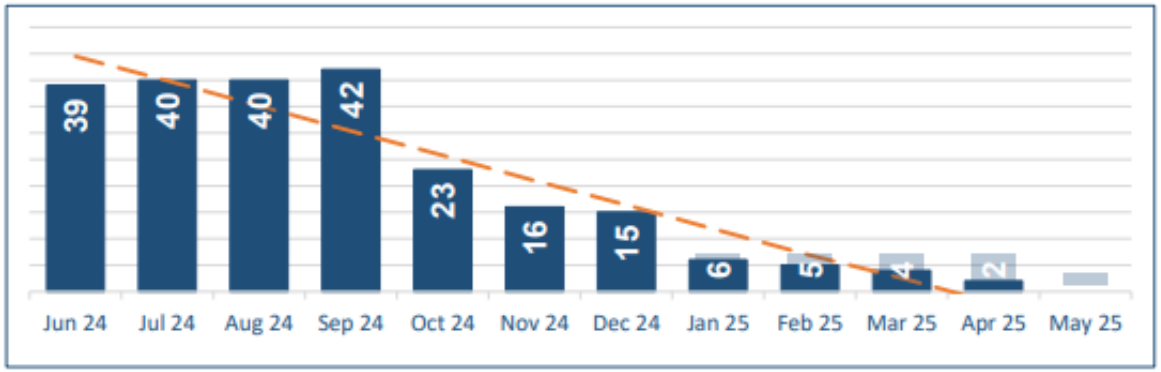
Quality: Performance

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	20	TBC	29.4	6th of 6 (at May 25)
CRR: 24-04	QSE	The cumulative rate of laboratory confirmed C.difficile cases per 100,000 of the population	25	TBC	44.1	3rd of 6 (at May 25)
CRR: 24-04	QSE	Number of National reportable incidents that remain open 90 days or more	Decreas-ing trend	TBC	2	8th of 12 (at May 25)







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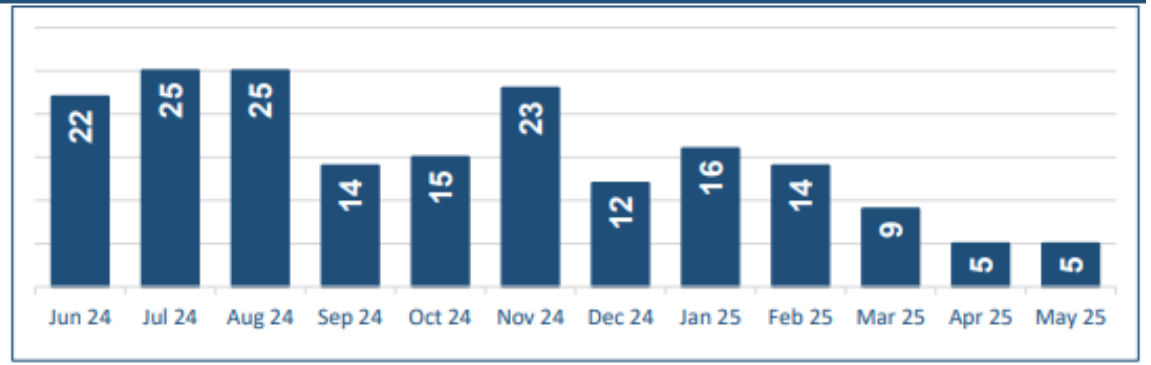
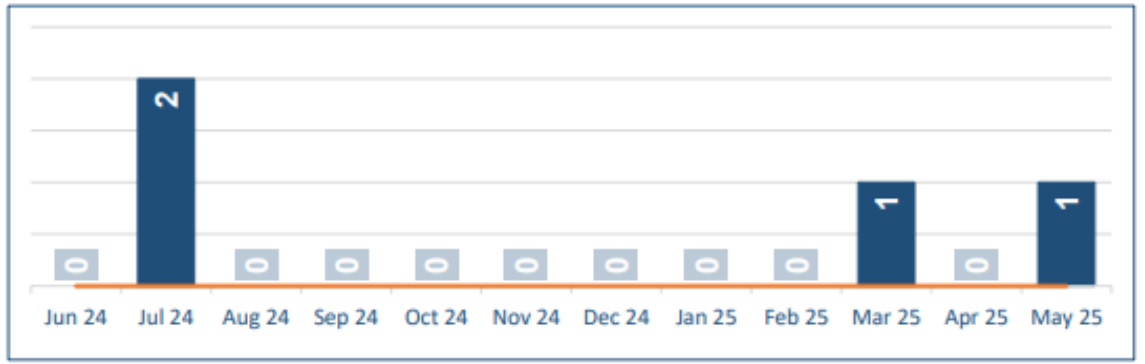
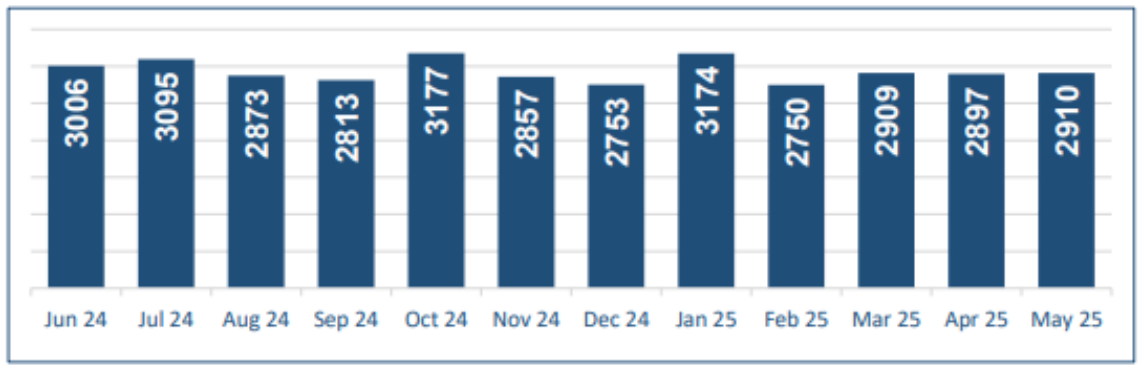
Quality: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	QSE	Number of National reportable incidents (NRIs)	N/A	TBC	5	
-	QSE	Number of new never events	0	TBC	1	
-	QSE	Number of patient safety incidents	N/A	TBC	2910	







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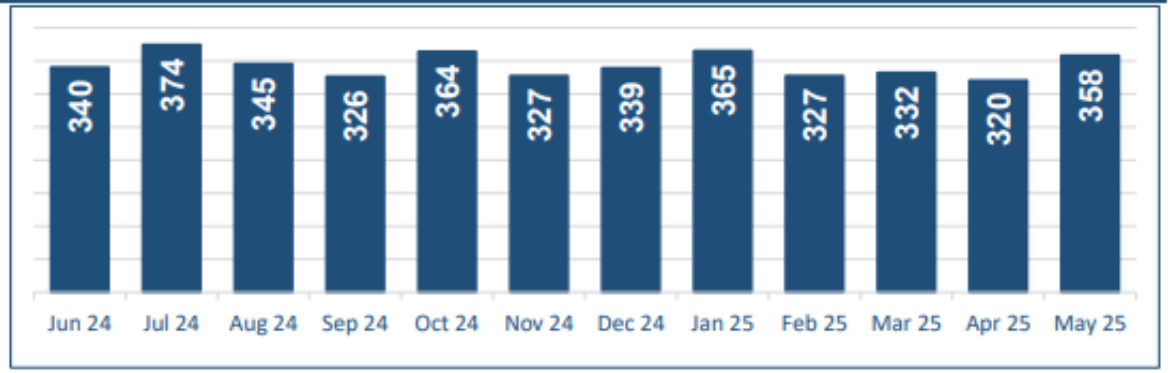
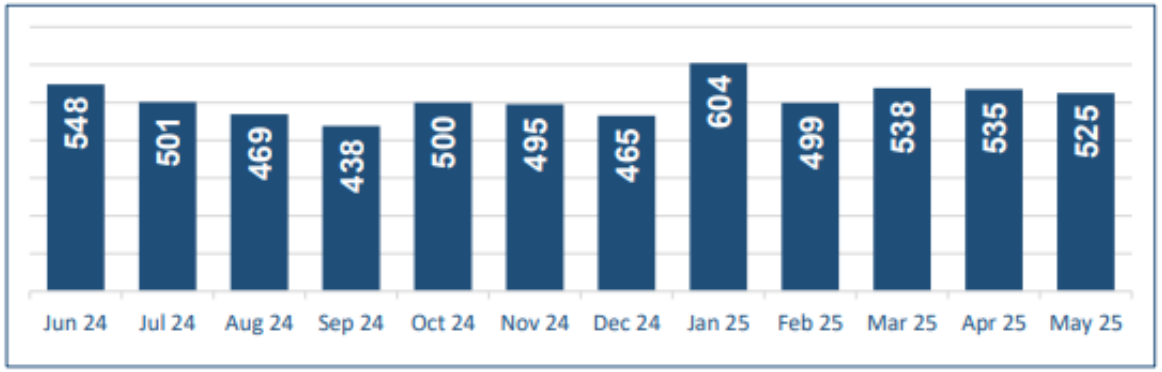
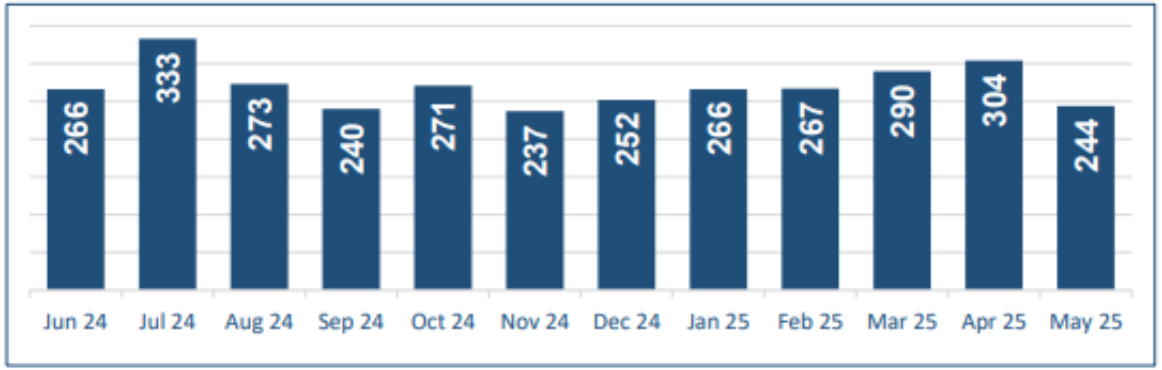
Quality: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	QSE	Number of reported falls	N/A	TBC	358	
-	QSE	Number of reported hospital acquired pressure ulcers (HAPU) (excluding new to caseload)	N/A	TBC	525	
-	QSE	Number of reported medication incidents	N/A	TBC	244	





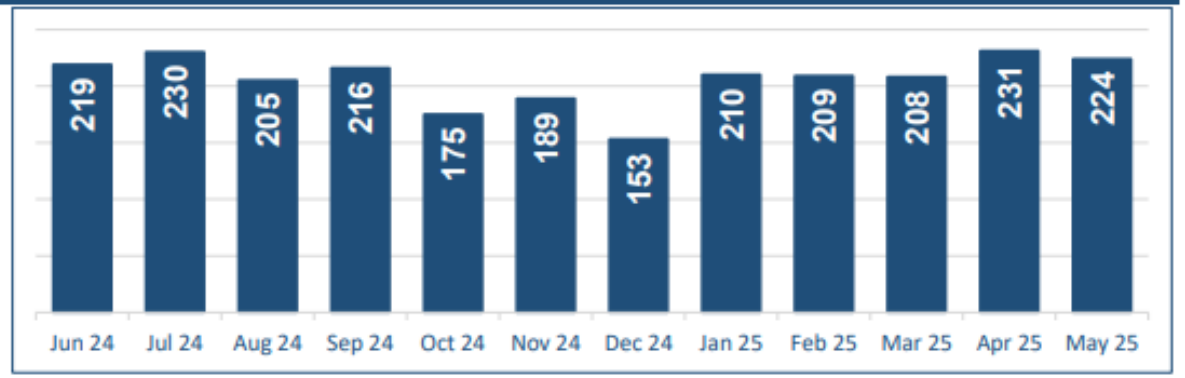


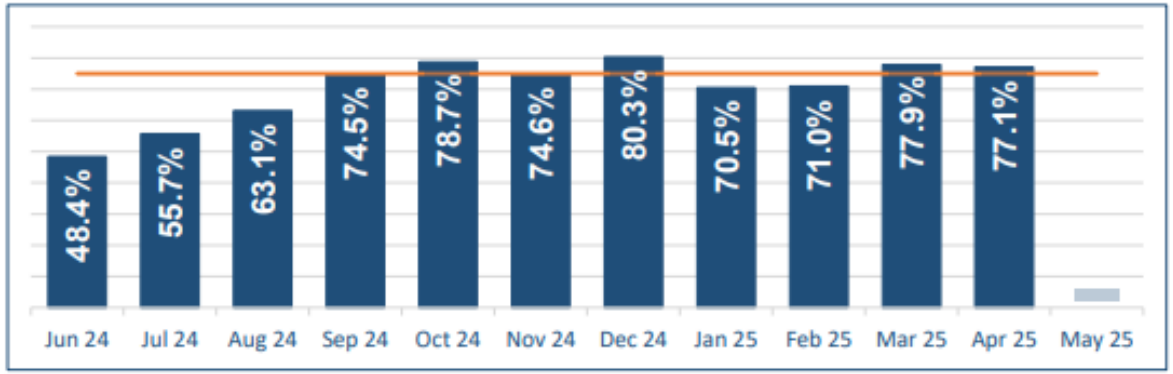
Produced on behalf of the **Quality, Safety & Experience Committee**
by the **Performance and Commissioning Directorate** in partnership with the **Quality Directorate**

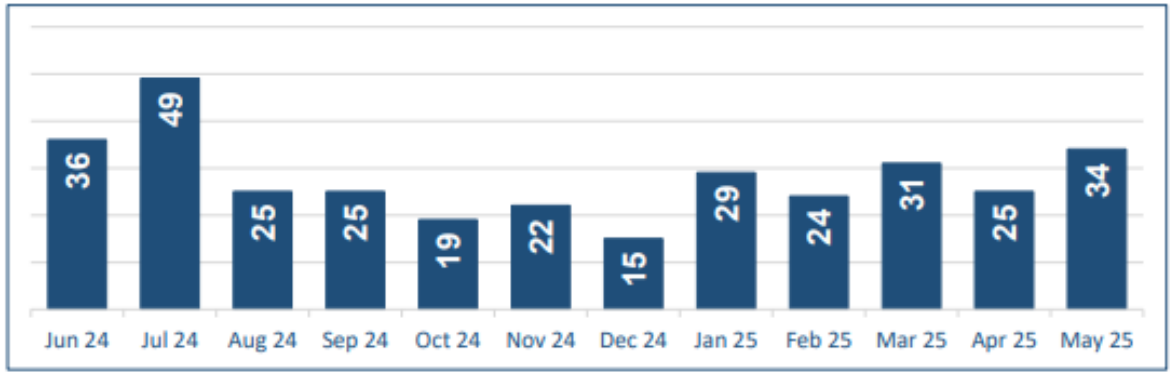
Presented on 03.07.2025

Quality: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	QSE	Number of 'Putting Things Right' (PTR) complaints	N/A	TBC	224	
-	QSE	Of the complaints closed, the percentage that were closed within 30 days	75.0%	TBC	77.1%	
-	QSE	Number of complaints closed as early resolutions	N/A	TBC	34	







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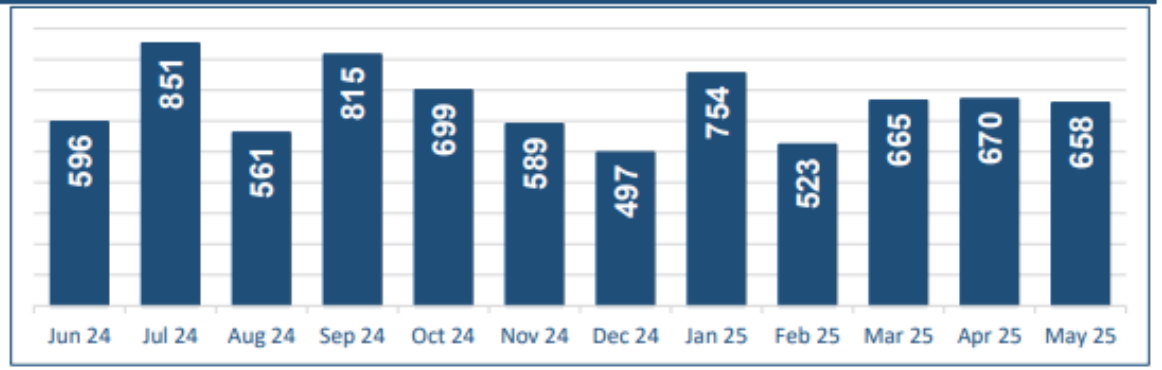
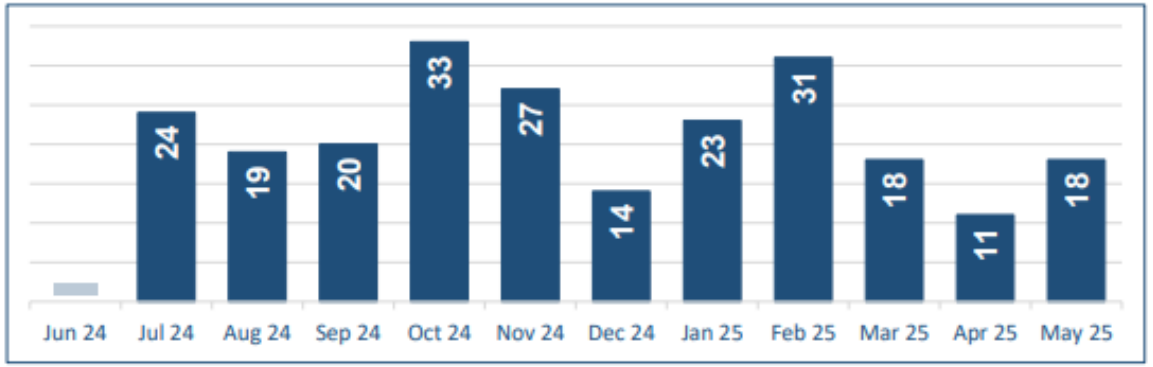
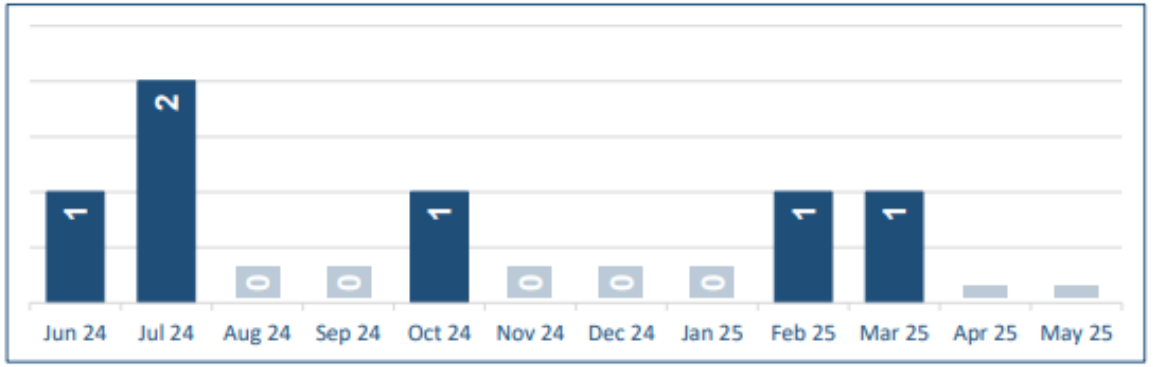
Presented on 03.07.2025

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	658	
-	QSE	Number of new Ombudsman contacts	N/A	TBC	18	
-	QSE	Number of regulation 28 notices	N/A	TBC	1	







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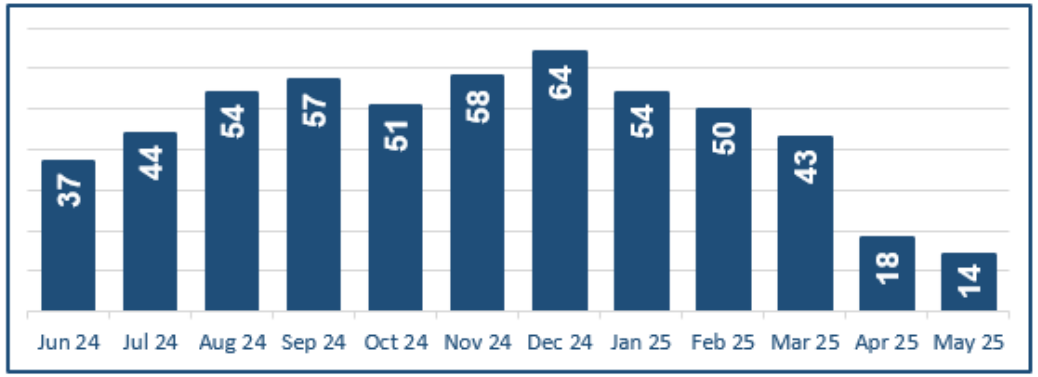
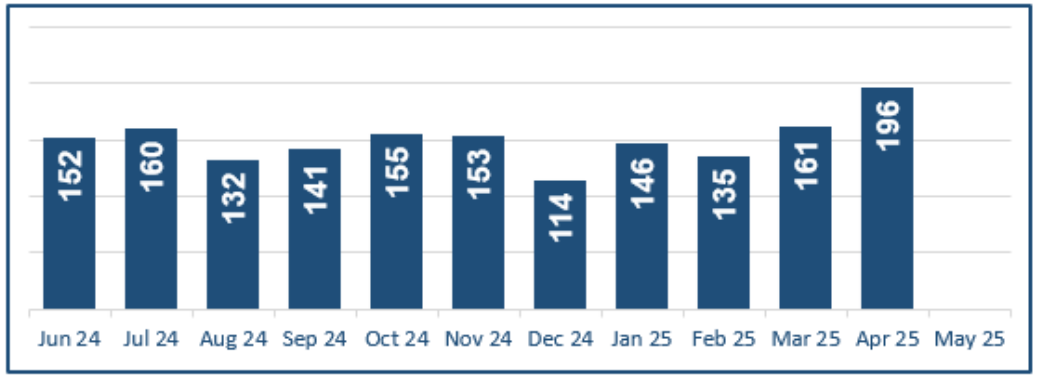
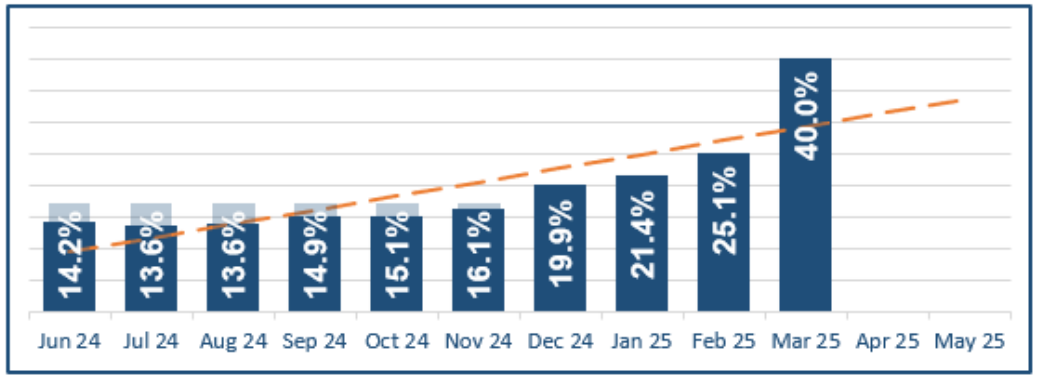
Presented on 03.07.2025

Quality: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	QSE	Number of overdue 'Learning from Event Reports' (LFERs)	N/A	TBC	14	
-	QSE	Number of Great-ix submissions	N/A	TBC	196	
-	QSE	Percentage of episodes clinically coded within one reporting month post episode discharge end date	Increas-ing trend (to 95%)	TBC	40.0%	8st of 8 (at Mar 25)







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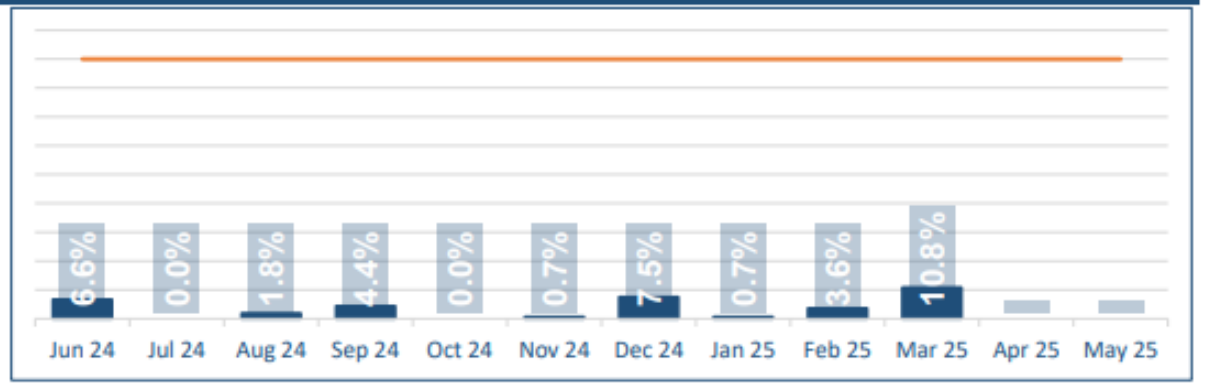
Presented on 03.07.2025

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	10.8%	8th of 8 (at Mar 25)



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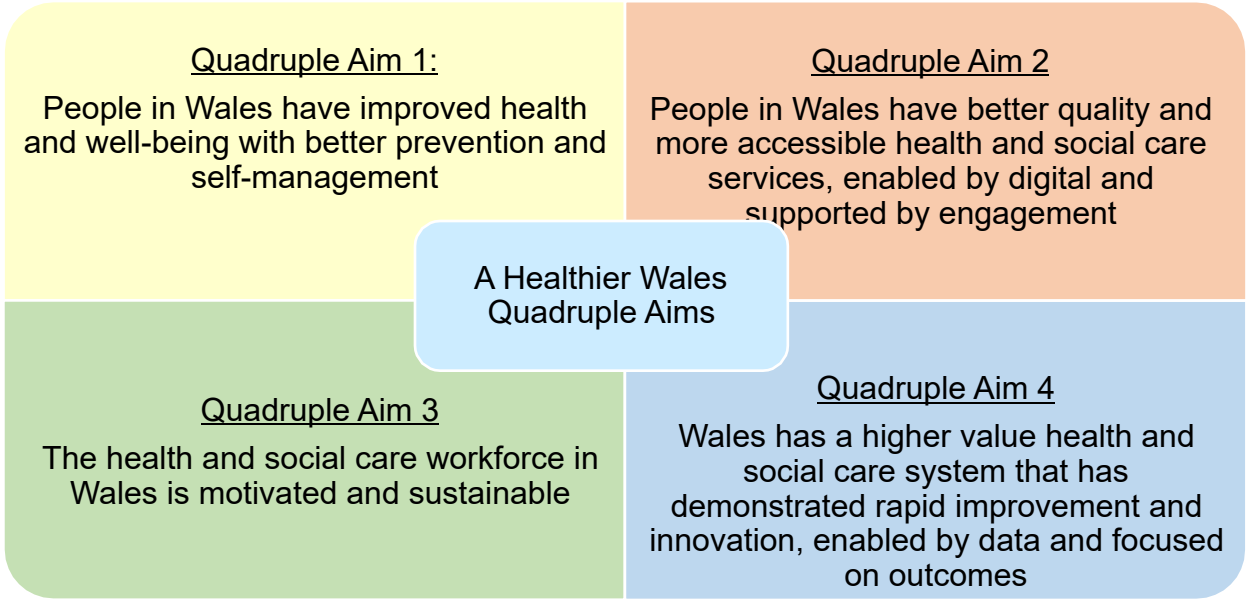
Presented on 03.07.2025

Additional Information

NHS Wales Performance Framework 2024-25

The NHS Performance Framework is a key measurement tool for “A Healthier Wales” outcomes, the 2025/26 revision now consists of 53 quantitative measures of which 9 are Ministerial Priorities and require Health Board submitted improvement trajectories.

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.

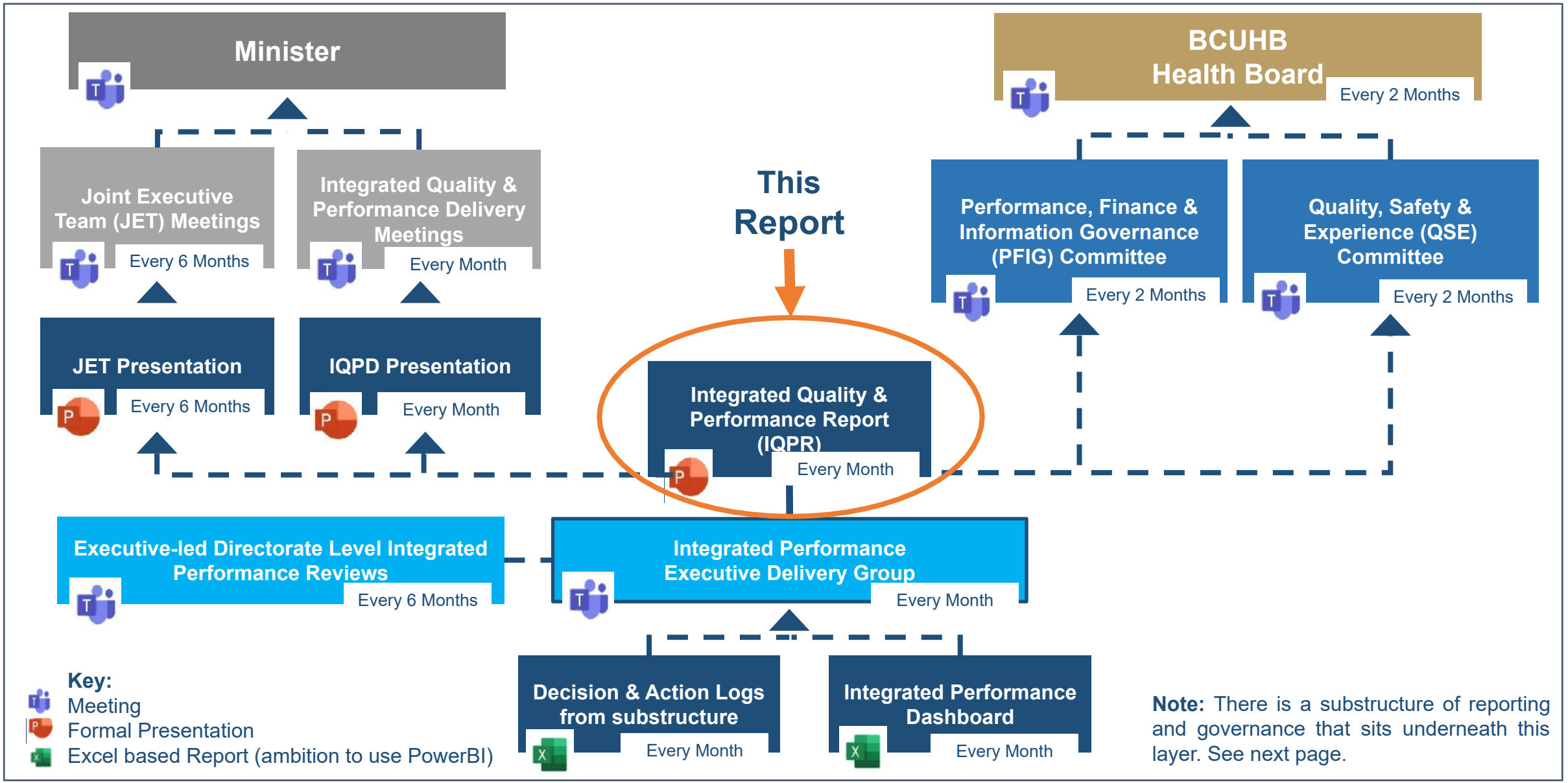
The Integrated Performance Framework sits within a "triumvirate" together with the Integrated Planning Framework and the Risk Management Framework (also ratified at Health Board on the 28th September 2023). This triumvirate of frameworks will encompass the planning, safe delivery and monitoring of the 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.

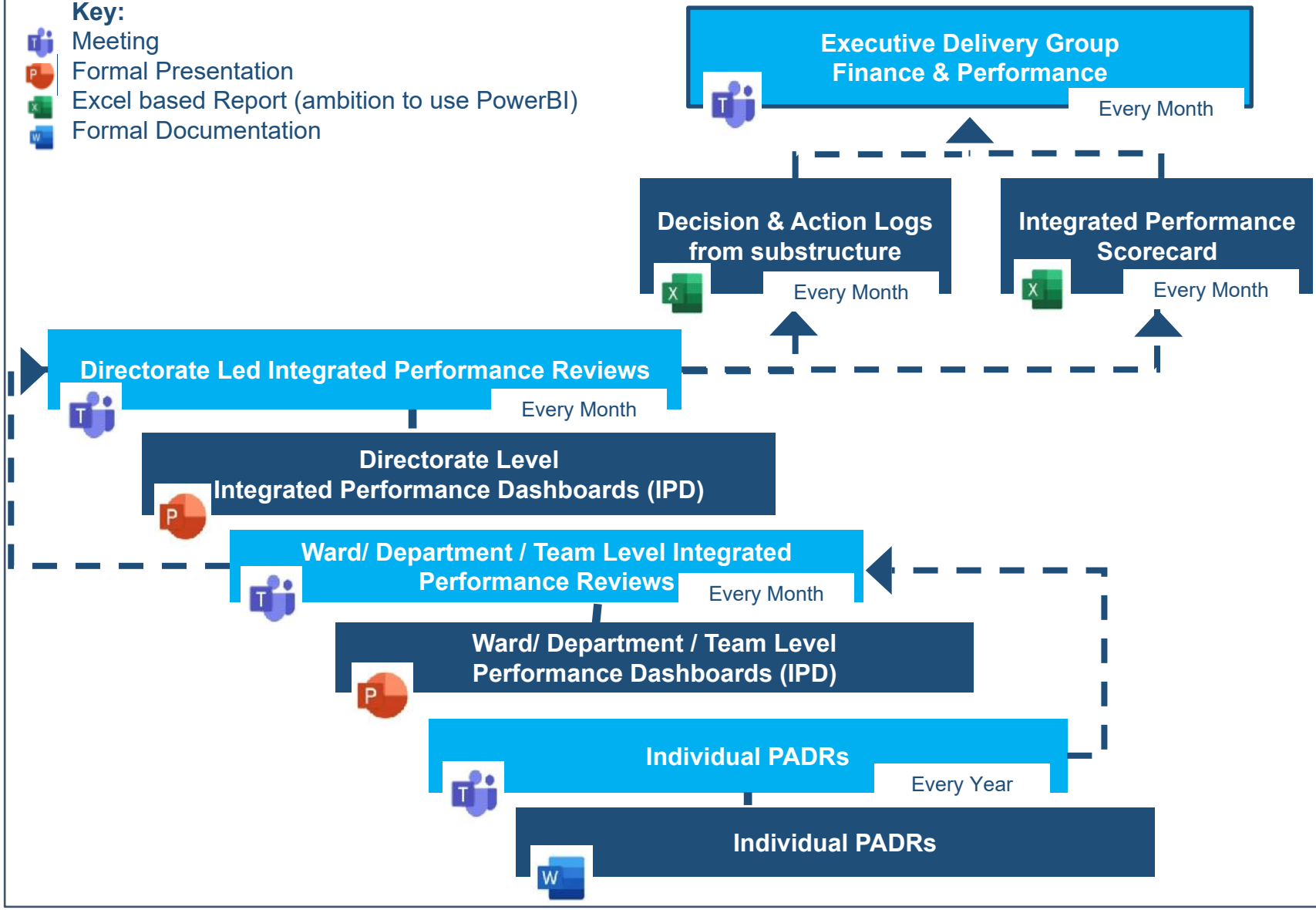
The IQPR will be embedded as the 'single version of the truth' and used to report on performance to the Health Board, it's scrutinising committees namely Performance, Finance & Information Governance (PFIG) Committee and Quality, Safety & Experience (QSE) Committee and externally to Welsh Government. 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.

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

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

Teitl adroddiad: ***Report title:***	Integrated Quality & Performance Report (IQPR) – Month 2, 2025/26
Adrodd i: ***Report to:***	Quality, Safety & Experience Committee
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 03 July 2025
Crynodeb Gweithredol: ***Executive Summary:***	This Report relates to Month 2, 2025/26. 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 the IQPR is based upon the Quadruple Aims as per the Welsh Government's 'A Healthier Wales's paper and the NHS Wales Performance Framework 2025-26. It identifies where metrics fall within the Special Measures Framework for BCUHB. Where appropriate, performance metrics are linked 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 2025-26, 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 & Commissioning			
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 2025-26.			
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 2)**

Report Author: **Deputy 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

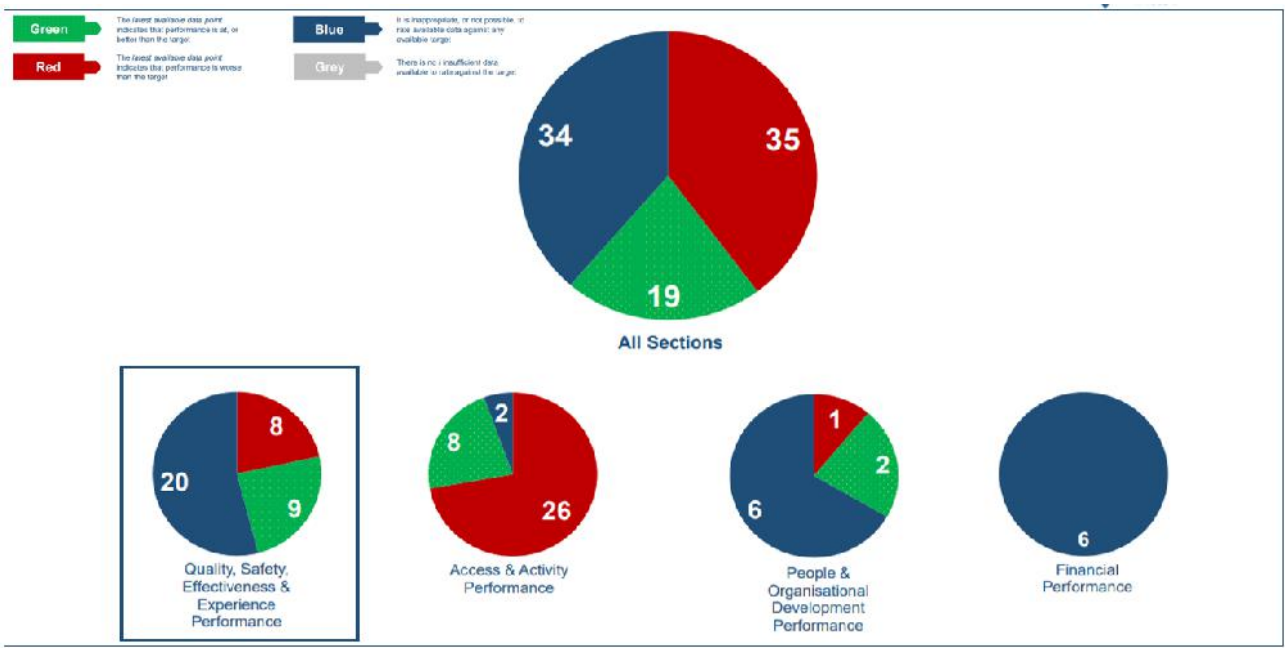
This structure enables an 'at a glance' view of the main concerns or message of the report through review of the initial one-page summary that is split into four quadrants, with the further slides contained within this escalation section articulating in more detail the current performance and actions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

Two new never events have been reported in the period between 01.03.2025 and 31.05.2025.

- One incident in March 2025 related to administration of insulin above prescribed dose. This resulted in moderate harm and patient has made complete recovery.
- Incident in May was administration of medication by wrong route. The patient experienced no lasting physical harm.

The number of **national reportable incidents** that remain open 90 days or more continues to demonstrate a decreasing trend. The latest figure from May 2025 of 2 incidents open demonstrates continued improvement in year. It is recommended that this measure now be de-escalated according to the protocols of the Integrated Performance Framework (IPF).

The number of overdue **'Learning from Event Reports' (LFERs)** have decreased month on month since end of December with 14 overdue at the end of May 2024. Overdue returns can .

- have a possible impact on timely ability to embed lessons learned and organisational learning and
- incur financial penalties at a rate of £2,500 per overdue report

The percentage of **patients offered an index colonoscopy within 4 weeks of booking their Specialist Screening Practitioner assessment** is 4.3% against a 90% target at the latest reporting period. The rate has been between 0.7% and 12.3% during the last 12 months. No Health board is currently achieving the target with the best performance being 26% at latest available benchmarked month (March 2025). Further review is required to understand drivers for current performance and delivery plans moving into 2025/26.

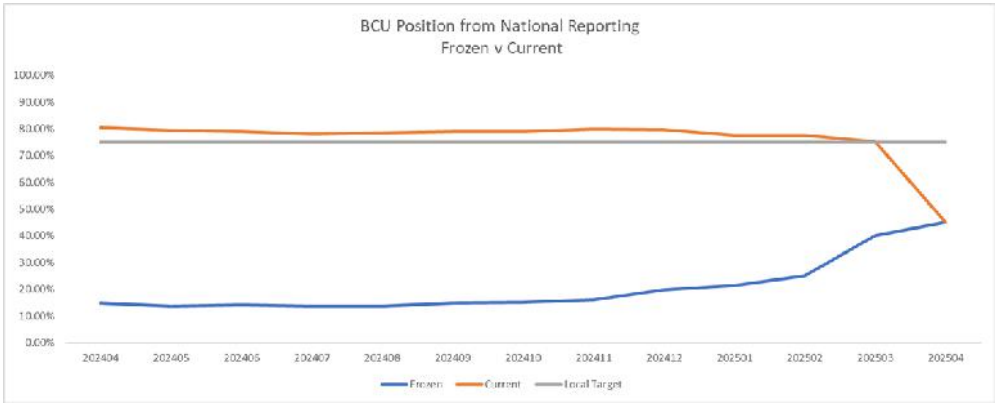
Clinical Coding compliance will remain a significant risk as compliance will remain low into the latter part of 2025-26 against the 95% national target. The position continues to improve from a low of 13.6% to latest position of 40% as at March 2025.

The frozen position which is included within the report looks at coding completeness for a given month, this is not refreshed to demonstrate progress and our retrospective approach to coding the oldest episodes first.

Table 1 shows the difference between frozen and current position. The blue line is the external frozen position to check whether we achieve the monthly target. There is no look back to check how coding compliance has increased after the target date. The gap between the lines is closing as we clear the backlog and we'll see a much smaller difference in the coming weeks as we get closer to achieving target.

We have now coded 75% of the 2024/25 activity and working to get to coding within one month of activity and to increase completeness to 95% during quarter 2.

Table 1 – BCU Position Clinical Coding – Frozen v Current



3.2 Access & Activity Performance

Whilst the overall oversight of the metrics within the Access & Activity quadrant fall outside remit of the Quality and Safety Committee, given the extended waiting times both within planned care and urgency and emergency care it is prudent to highlight performance within this area as part of this forum given the potential impact of continued delay on patient pathways.

Key areas of risk include: -

- **Percentage of Ophthalmology R1 patients seen within 25% of their clinical due date** is significantly adverse to target and due to the potential irreversible nature of

conditions that some patients in this cohort have, is of concern. Harm reviews for assurance is recommended.

- **Percentage of children and young people waiting less than 26 weeks to start and ADHD or ASD neurodevelopment assessment**
- **Cancer pathways starting definitive treatment within 62 days** metric deteriorating over the last 12 months to a latest performance of 53.7% against a target of 80%
- Continued increase in the number of patients waiting over 8 weeks for a **Diagnostic appointment** and lack of capacity resulting in higher level of **surveillance delays**

Appendix 1 – IQPR for QSE 03.07.2025

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Integrated Quality & Performance Report

Reporting Period: to 31.05.2025

Presented to

Quality, Safety & Experience Committee

Thursday, 3rd July 2025

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

- **2 New Never Events reported** 1 on March and 1 in May.
- **Learning from Events Reports:** Progress made during Q4 in reducing number of overdue LFERs reducing from 64 at end of Q4 to 43 at end of Q1. Continued focus is required to address the timely completion and recovery of the overdue position.
- **Clinical Coding Compliance** will remain a significant risk during 2025-26, however trajectories indicate improvement towards the end of 2025-26. Position stabilised and showing improvement, now at 40%. Measure will be kept in escalation for assurance.
- Percentage of **patients offered an index colonoscopy within 4 weeks of booking their Specialist Screening Practitioner assessment** appointment has fallen to 4.3% against a 90% target. All Wales performance at latest benchmark point (of Mar 25) is 8.4%

Access and Activity For Information Only (Corporate Risk 24-11 Planned Care)

Performance within the planned care space remains poor when compared to Access Standards

- **Referral to Treatment (RTT):** After the improvements seen in the numbers of extreme waits during 2024/25, it may be concerning to see the number of 104 weeks waits rising again in Q1 2025/26.However, solutions are in place which will see a significant reduction in these by the end of June 2025 as detailed on slide 7.
- **Cancer -** Performance against single cancer pathway target remains fragile with a rate of **53.8%** at end of April 2025 as forecast previously. However, the focus on dermatology backlog has seen a significant decrease in the backlog although the rate of reduction has slowed in Q1 of 2025/26.
- **Diagnostics waits over 8 weeks**: At the end of May 2025, there were just under **14,000** patients experiencing waits of over 8 weeks for diagnostic tests. The delays are mainly in radiology and endoscopy. The delays in endoscopies are impacting on our ability to improve our cancer 62 day position. **(Corporate Risk 24-13 Timely Diagnostics)**
- **Percentage of Ophthalmology R1 patients seen within 25% of their clinical due date** remains significantly adverse to target and due to the potential irreversible nature of conditions that some patients in this cohort have, is of concern. Urgent harm reviews for assurance is recommended.
- **The number of patients that are 100% overdue their clinical review date** is of increasing concern and continues to increase with latest position over 95,700. This will be a key area of focus during 2025/26.

Urgent & Emergency Care (Corporate Risk 24-10 Urgent and Emergency Care)

Performance within the urgent & emergency care space continues to deteriorate and shows no significant signs of improvement. With **3,749** waiting over 12 hours and **1,741** waiting over 24 hours. Further, ambulance handover delays of 4 hours or more remains over **640** per month on average, however significant improvements are evident at Ysbyty Glan Clwyd. There has been no statistically significant change in the number of delayed pathways of care at **337**.

People & Organisational Development Performance

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

- At 80.7%, **PADR** rate continues within normal variation but remains below the 85% target.
- **At 5**.4%, **Sickness absence rate** has seen a continuous decrease in trend over recent months, in line with seasonal change.
- At **0.5%**,**Turnover rate** for nursing staff leaving BCUHB increased in month. Focus continues on national and local retention work.
- At 3.5%, **agency spend** has shown an increasing trend during the first 2 months. Ongoing work taking place around the Welsh Health Circular for agency spend reduction and the Value and Sustainability workforce programme.

Finance For Information Only

(Corporate Risk 24-05 Financial Sustainability)

The in-month position is reporting a deficit of £2.4m and the year to date position is £6.2m deficit, largely driven by £4.5m shortfall in undelivered savings and pressures associated with escalated beds and Healthcare Services provided by other NHS Bodies Contracts.

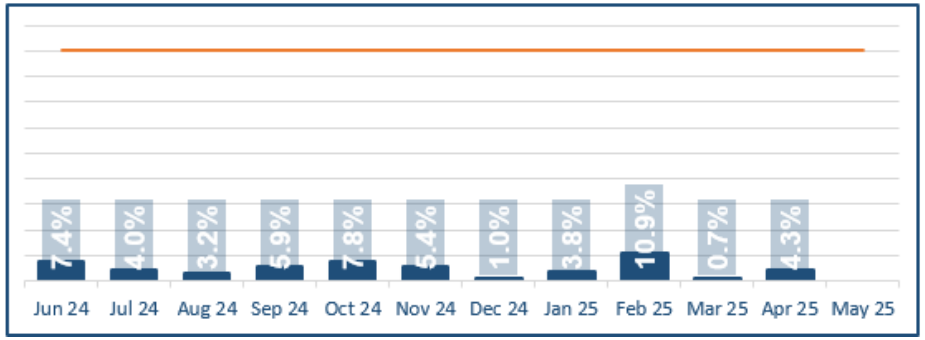
The Health Board's financial plan has set a savings target of £40.0m to be delivered in 2025/26, profiled on an equal twelfth's basis. Full year forecast values of Deliverable Schemes total £12.8m (including £12.7m Savings and £0.1m Income Generation). Of these, £9.3m have been identified as recurring, with a full year effect of £13.0m and £3.5m are non-recurring savings. In-month delivery includes Savings of £1.6m against a £3.3m Target.

Quality: Escalated Performance Measures

Corporate Risk 24-04 Failure to Embed Learning

Learning form Events Reports

Index Colonoscopy



Learning From Events Reports (LFERs):

There are 14 outstanding LFERs at the end of May. There has been a month on month decrease in number of overdue reports since December 2024.

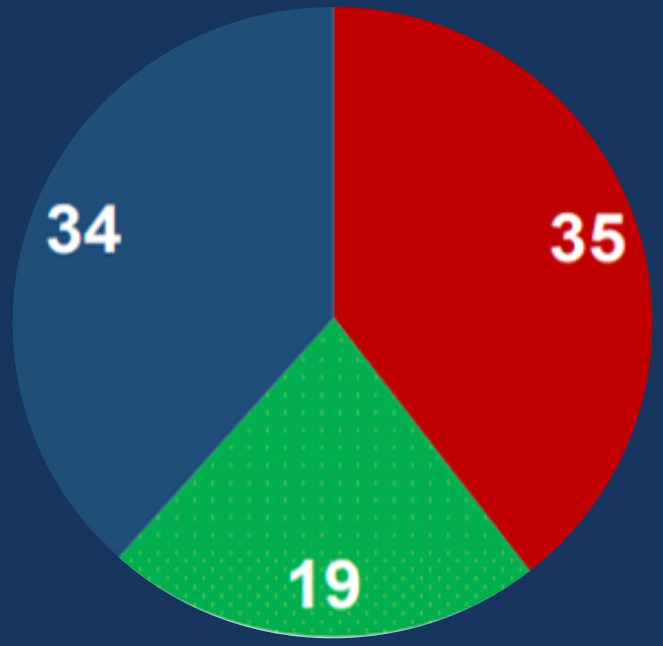
Overdue reports pose a Quality and Safety risk from the perspective that if we haven't completed the reports in a timely manner, how can we embed the learning to prevent future events. There is also the financial risk given that the Health Board can incur a penalty of £2,500 per overdue report. Continued focus is required to address the timely completion of LFERs and recovery of the overdue position.

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 is 4.3% against a 90% target. All Wales performance at latest benchmark point (of Mar 25) is 8.4% with five of the seven Health Boards seeing rate of less than 7%. Further review is required to understand drivers for current performance and plans moving into 2025/26.

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

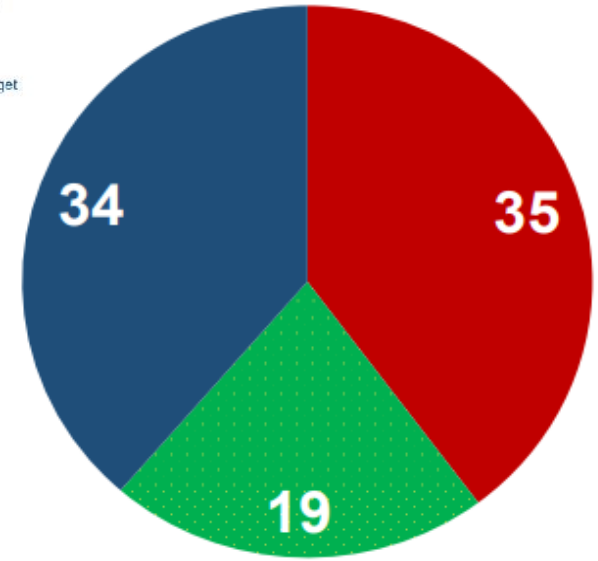
Integrated Performance Report



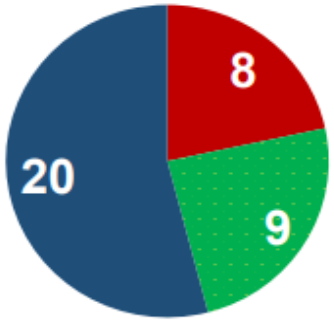
Produced on behalf of the **Quality, Safety and Experience Committee** by the
Performance and Commissioning Directorate in partnership with **Health Board Directors**

Summary of Performance to Month 12

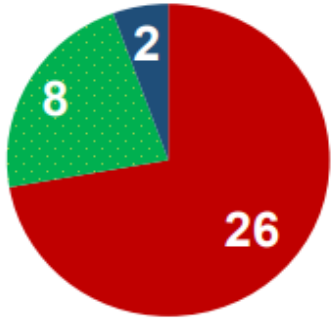
Green	The *latest available data point* indicates that performance is at, or better than the target
Red	The *latest available data point* indicates that performance is worse than the target
Blue	It is inappropriate, or not possible, to rate available data against any available target
Grey	There is no / insufficient data available to rate against the target



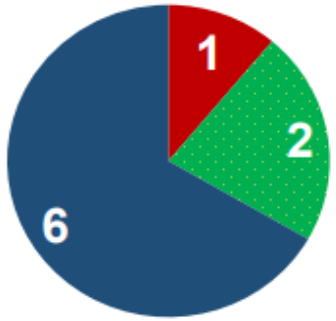
All Sections



Quality, Safety, Effectiveness & Experience Performance



Access & Activity Performance

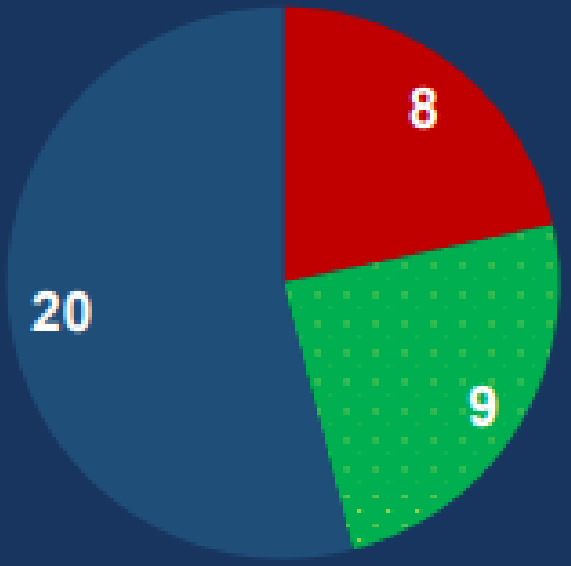


People & Organisational Development Performance

Financial Performance

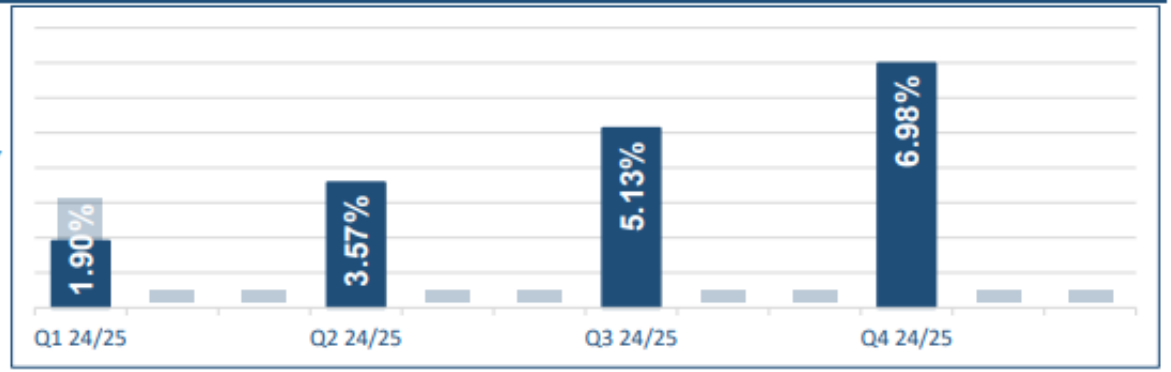
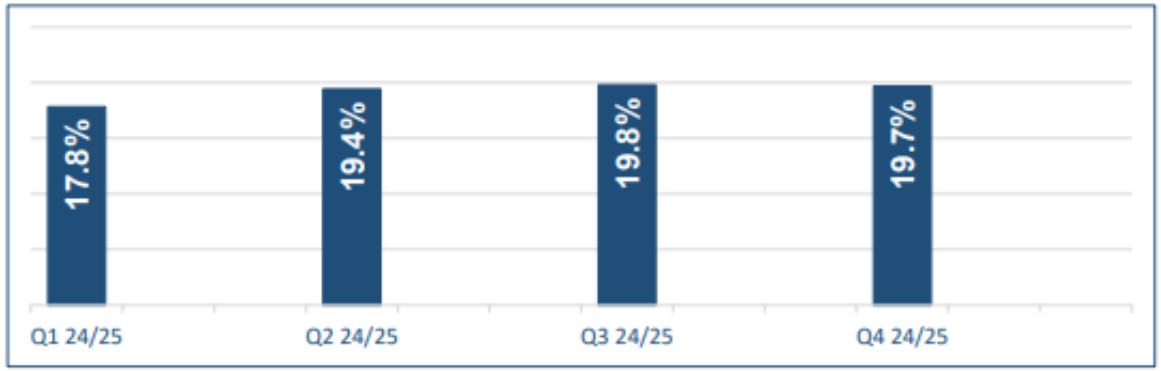
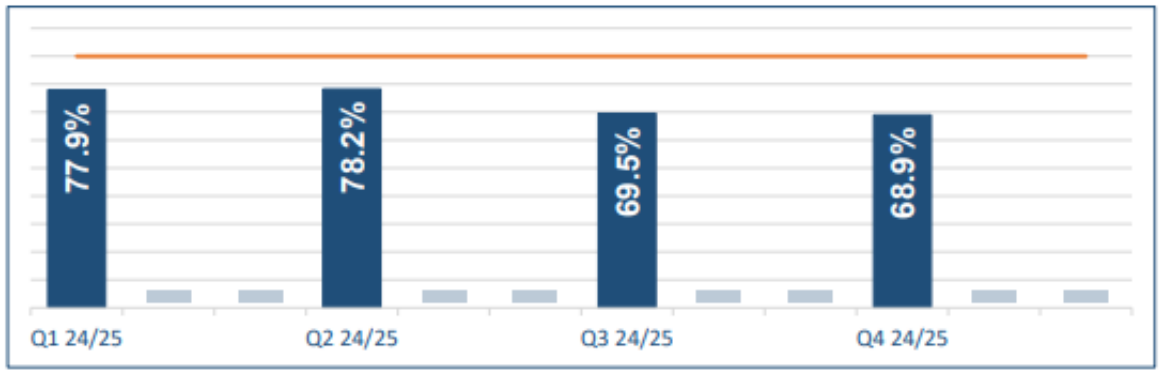
Section 1

Quality, Safety, Effectiveness and Experience Performance



Produced on behalf of the **Quality and Safety Committee** by the **Performance and Commissioning Directorate i**

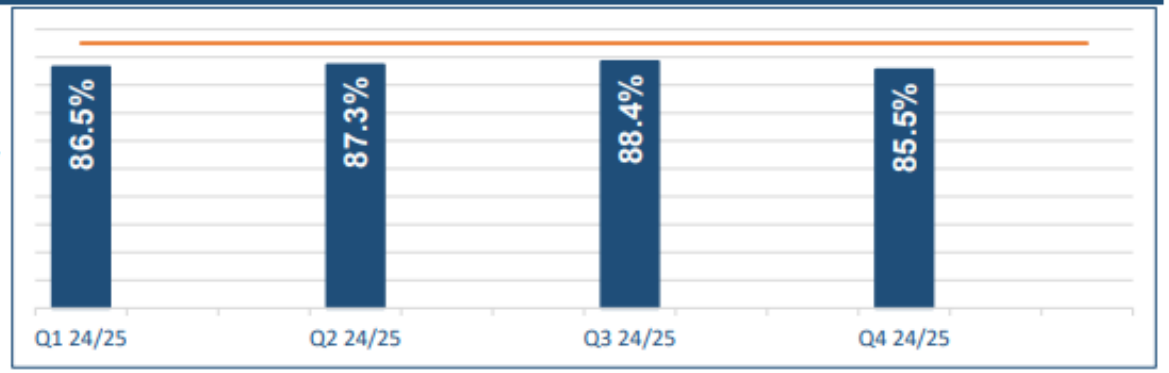
Quality: Performance

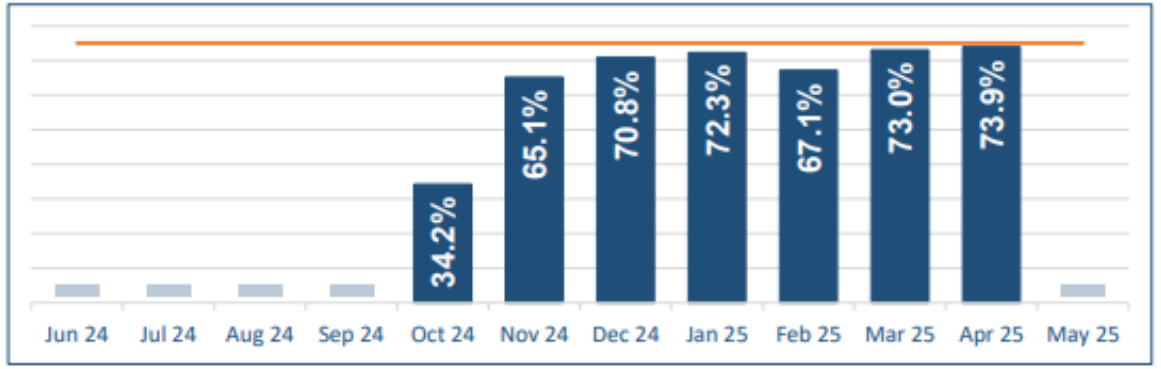
Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank	
-	QSE	Percentage of adult smokers who make a quit attempt via smoking cessation services	5% annual	TBC	6.98%	2nd of 7 (at Dec 24)	
-	QSE	Percentage of adult smokers who made a quit attempt via smoking cessation services who are CO-validated as quit at 4 weeks	40% annual target	TBC	19.7%	3rd of 7 (at Dec 24)	
-	QSE	Percentage of children receiving the Human Papillomavirus (HPV) vaccination by the age of 15	90%	TBC	68.9%	5th of 7 (at Mar 25)	

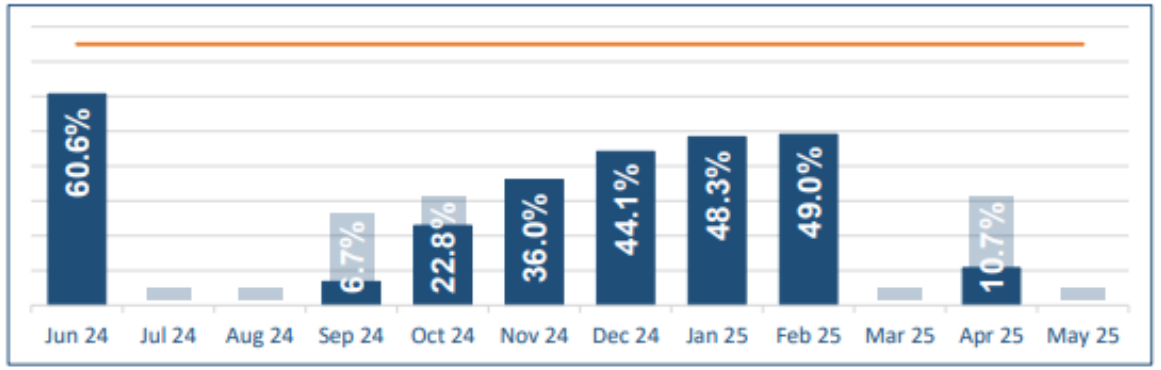
* Wales Ranking may differ as may refer to previous month

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	85.5%	3rd of 7 (at Mar 25)
-	QSE	Percentage uptake of the influenza vaccination amongst adults aged 65 years and over	75%	TBC	73.9%	1st of 7 (at Mar 25)
-	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	10.7%	5th of 7 (at May 25)







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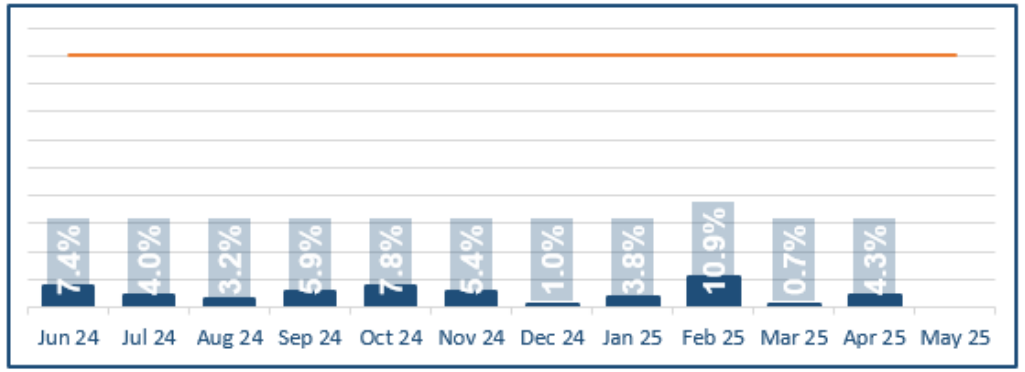
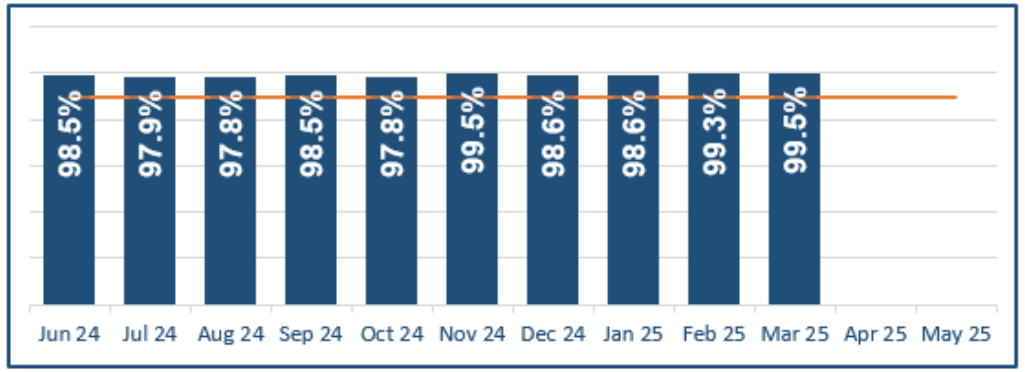
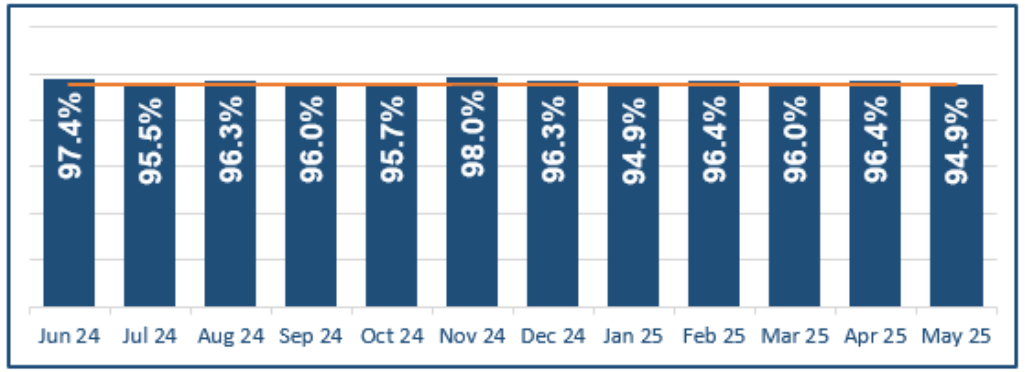
Quality: Performance

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	4.3%	6th of 7 (at Mar 25)
-	QSE	Percentage of well babies entering the new-born hearing screening programme who complete screening within 4 weeks	90%	TBC	99.5%	2nd of 7 (at Mar 25)
-	QSE	Percentage of eligible newborn babies who have a conclusive bloodspot screening result by day 17 of life	95%	TBC	94.9%	5th of 7 (at Apr 25)







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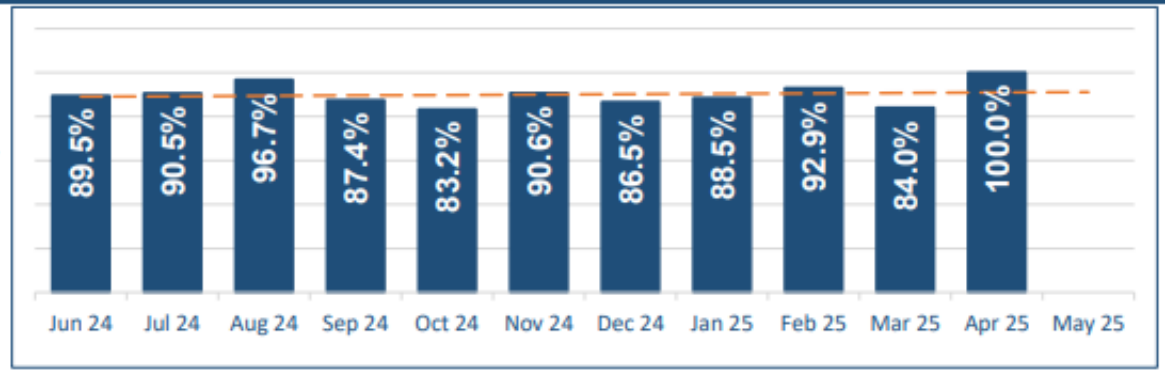
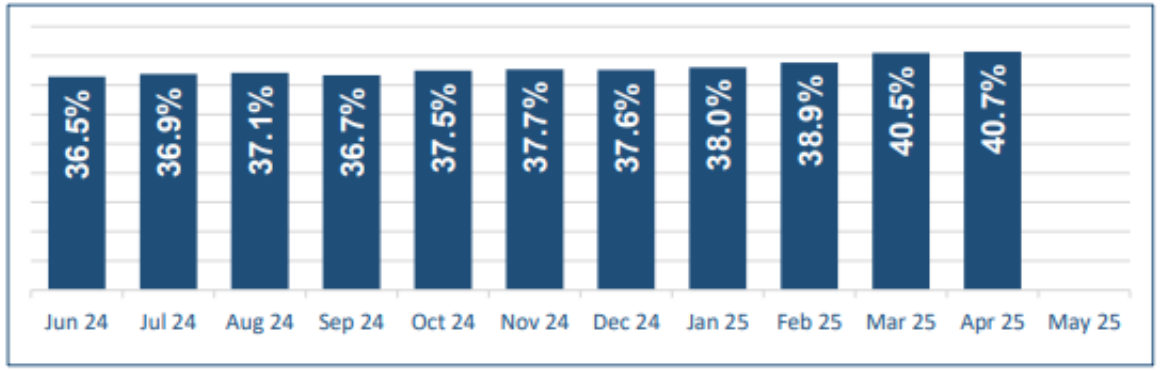
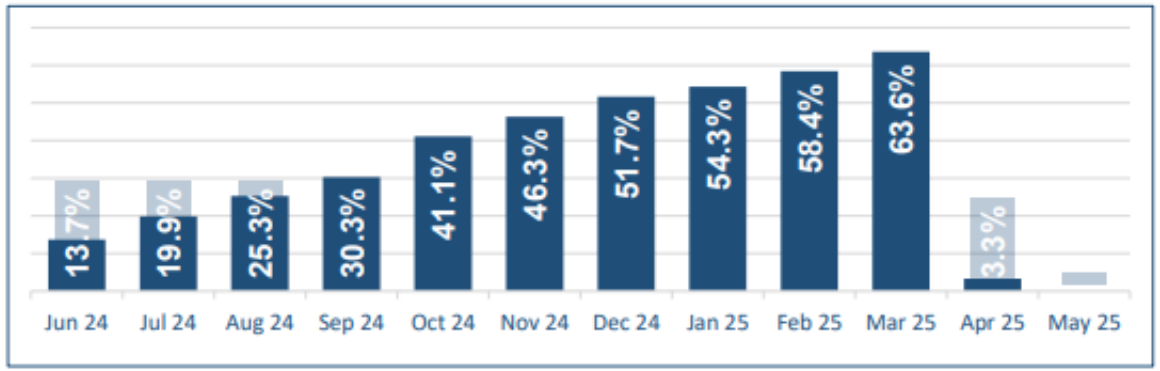
Quality: Performance

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	100.0%	5th of 7 (at Mar 25)
-	QSE	Percentage of patients (aged 12 years and over) with diabetes who received all eight NICE recommended care processes	Equival-ent month increase (2025/26 to 2024/25) to 100%	TBC	40.7%	7th of 7 (at May 25)
-	PFIG	Percentage of the primary care dental services (GDS) contract value delivered (for courses of treatment for new, new urgent and historic patients)	Increas-ing trend (to 30% (end Sept), then 100% (end Mar))	TBC	3.3%	6th of 7 (at May 25)







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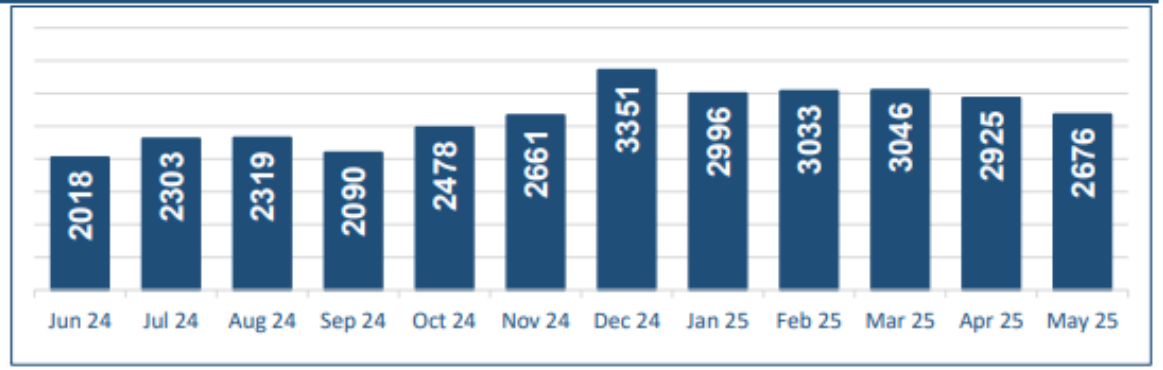
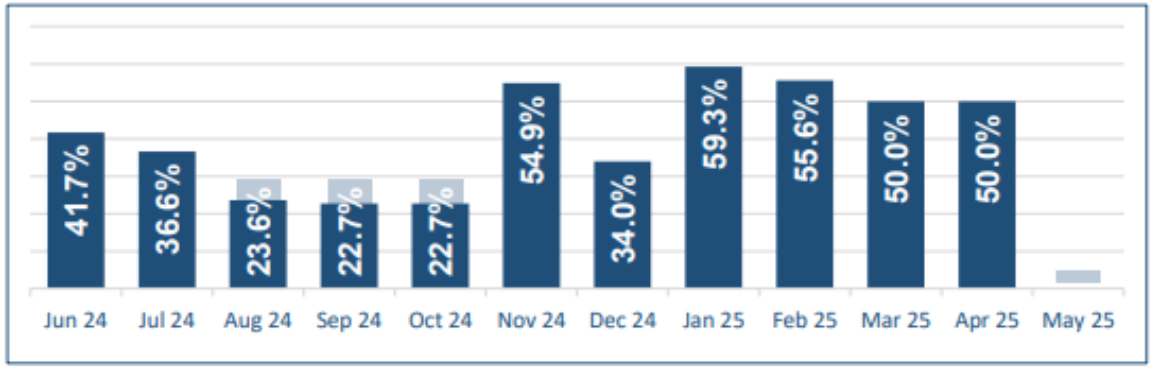
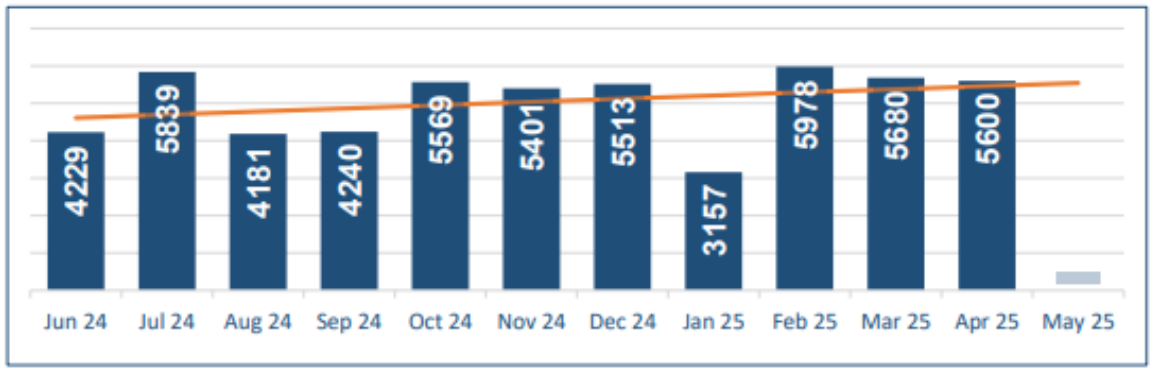
Quality: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	PFIG	Number of consultations delivered through the Pharmacist Independent Prescribing Service (PIPS)	Equival-ent month increase (2025/26 to 2024/25)	TBC	2676	1st of 7 (at Apr 25)
-	QSE	Percentage of confirmed COVID-19 cases within hospital which had a definite hospital onset of COVID-19 (>14 days after admission)	Equival-ent month reduct-ion (2024/25 to 2023/24)	TBC	50.0%	3rd of 6 (at May 25)
-	QSE	Number of service user feedback experience responses completed and recorded on CIVICA	Increas-ing trend	TBC	5600	2nd of 10 (at Apr 25)







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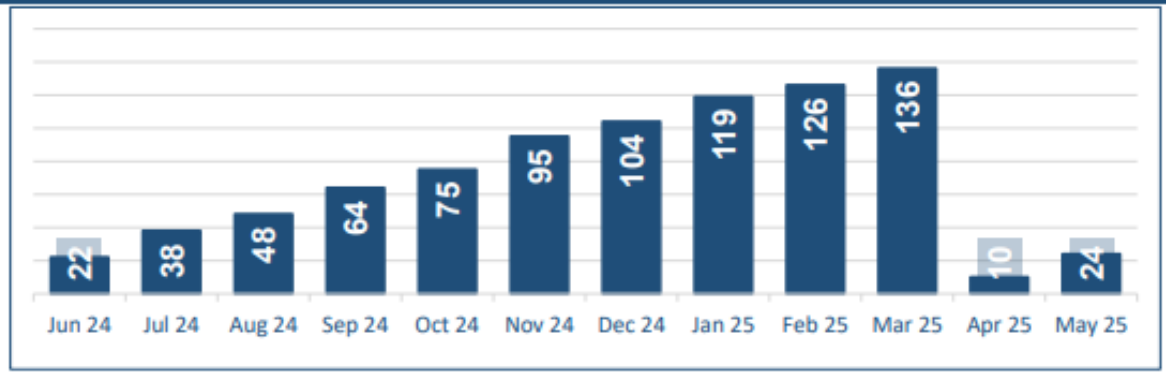
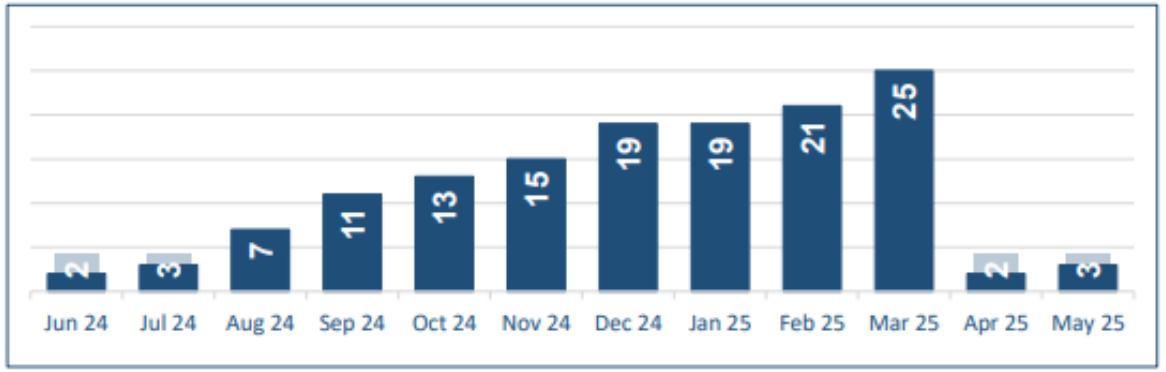
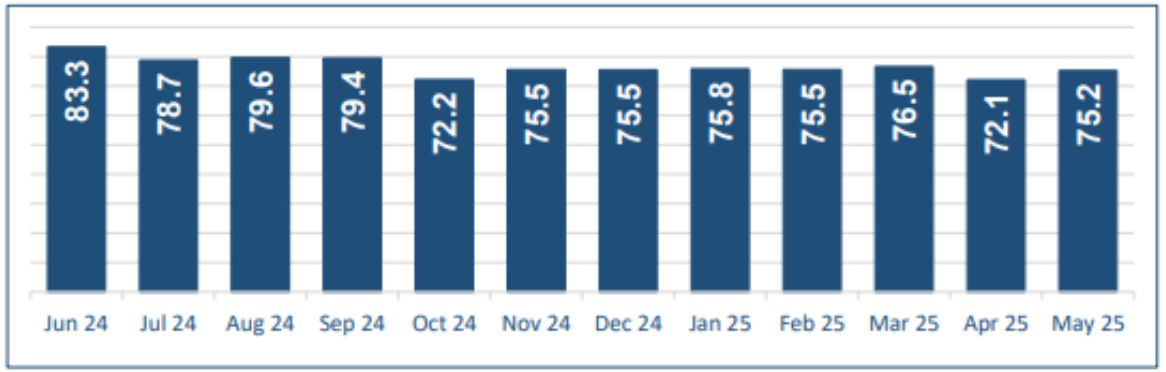
Quality: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
CRR: 24-04	QSE	The cumulative number of laboratory confirmed Klebsiella in reporting month	106	TBC	24	4th of 6 (at May 25)
CRR: 24-04	QSE	The cumulative number of laboratory confirmed Pseudomonas Aeruginosa in reporting month	27	TBC	3	3rd of 6 (at May 25)
CRR: 24-04	QSE	The cumulative rate of laboratory confirmed E.coli bacteraemias cases per 100,000 population	67	TBC	75.2	4th of 6 (at May 25)







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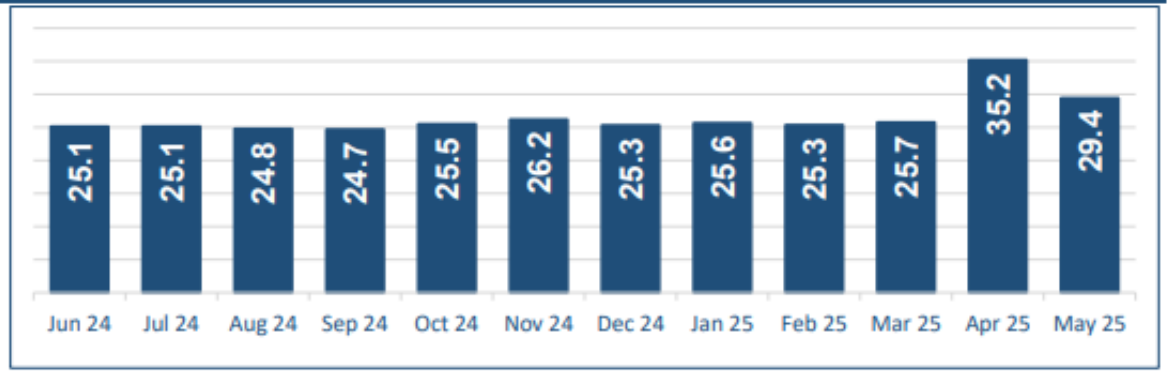
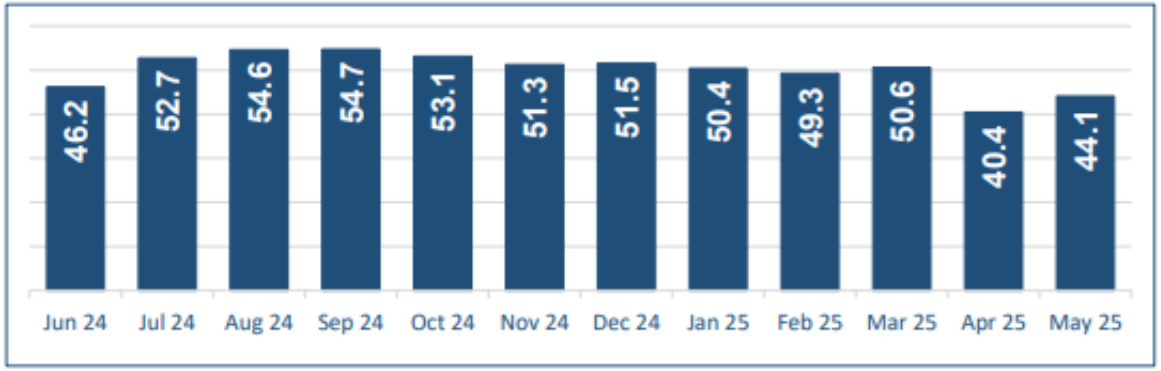
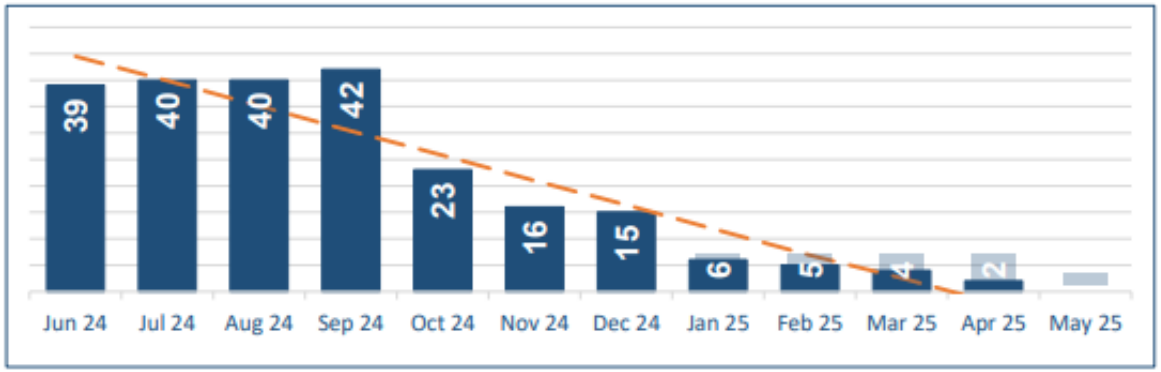
Quality: Performance

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	20	TBC	29.4	6th of 6 (at May 25)
CRR: 24-04	QSE	The cumulative rate of laboratory confirmed C.difficile cases per 100,000 of the population	25	TBC	44.1	3rd of 6 (at May 25)
CRR: 24-04	QSE	Number of National reportable incidents that remain open 90 days or more	Decreas-ing trend	TBC	2	8th of 12 (at May 25)



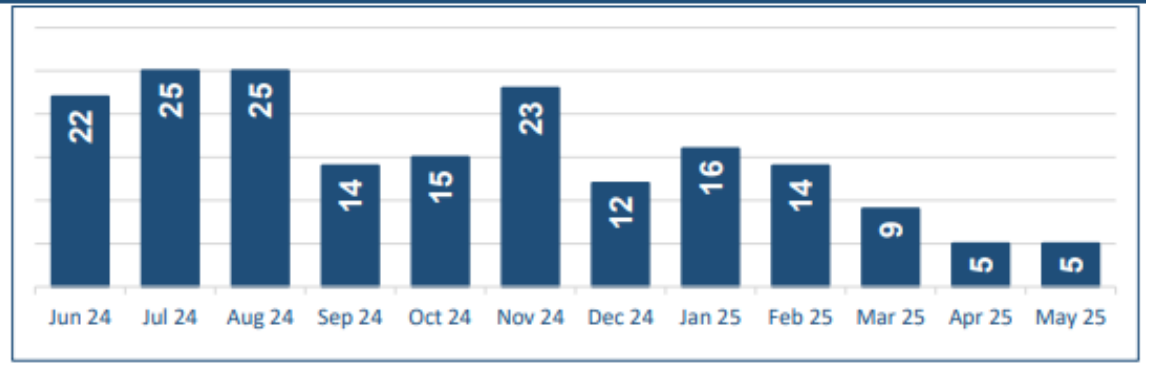


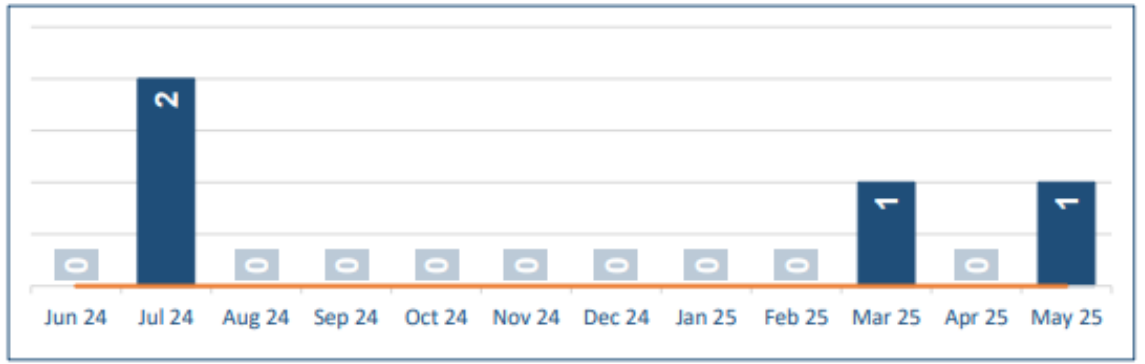


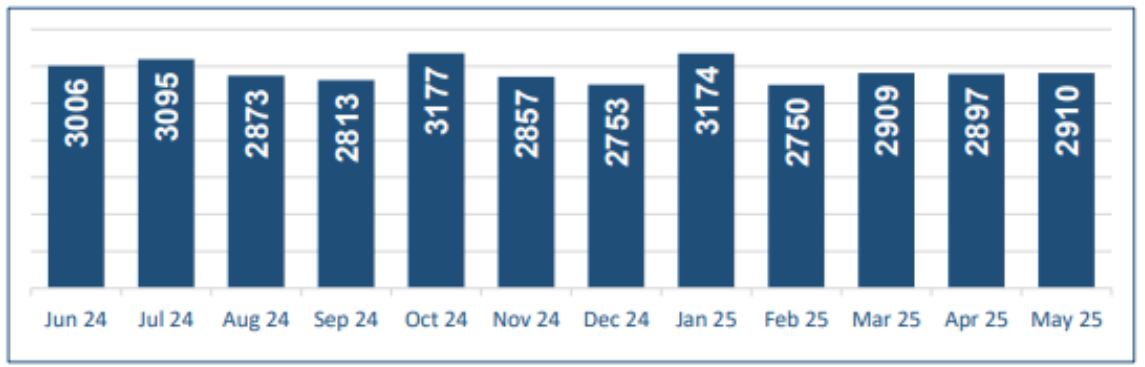
* Wales Ranking may differ as may refer to previous month

Quality: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	QSE	Number of National reportable incidents (NRIs)	N/A	TBC	5	
-	QSE	Number of new never events	0	TBC	1	
-	QSE	Number of patient safety incidents	N/A	TBC	2910	







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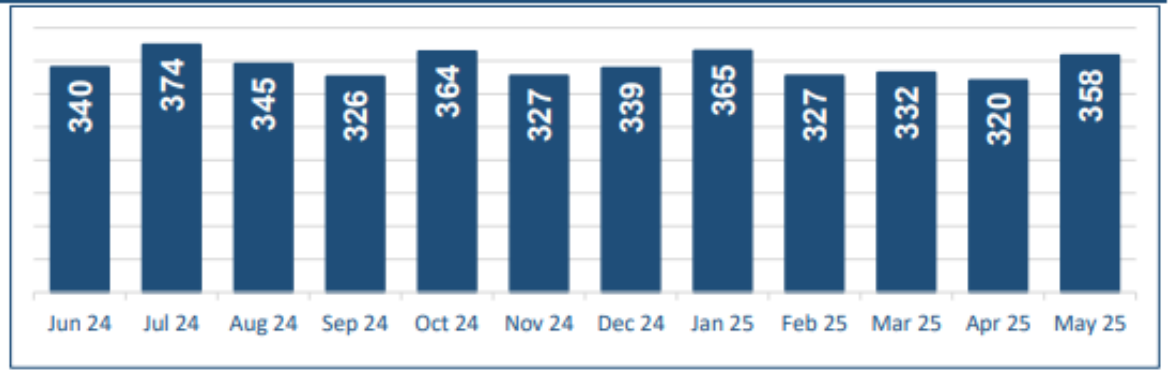
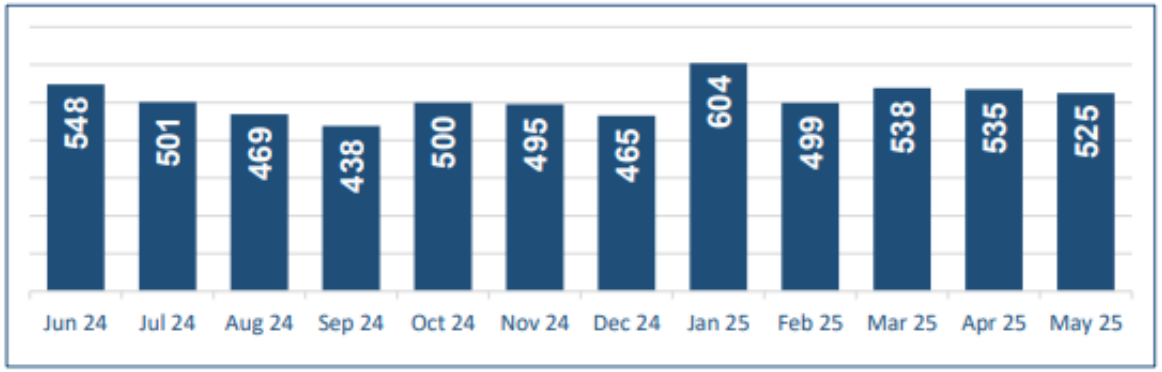
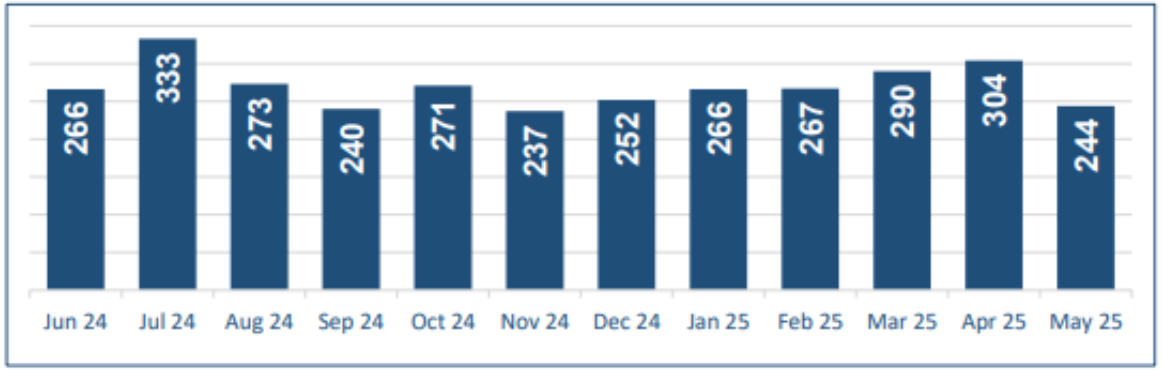
Quality: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	QSE	Number of reported falls	N/A	TBC	358	
-	QSE	Number of reported hospital acquired pressure ulcers (HAPU) (excluding new to caseload)	N/A	TBC	525	
-	QSE	Number of reported medication incidents	N/A	TBC	244	





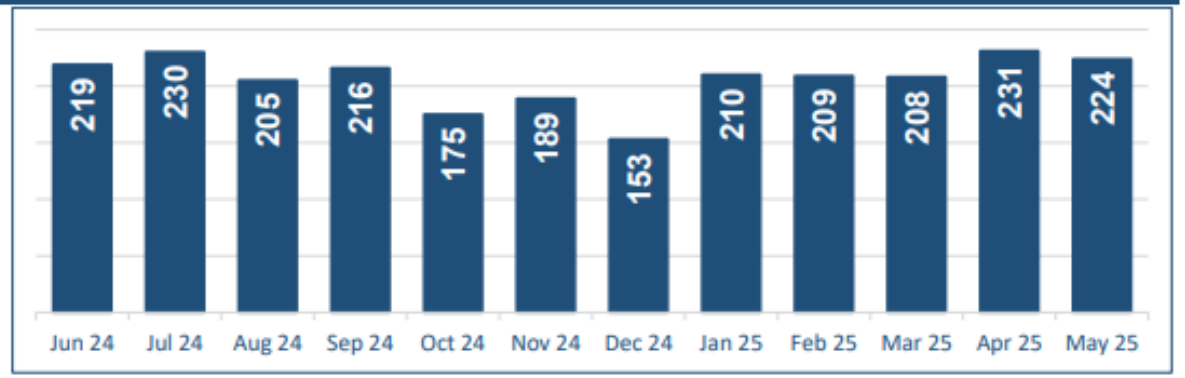


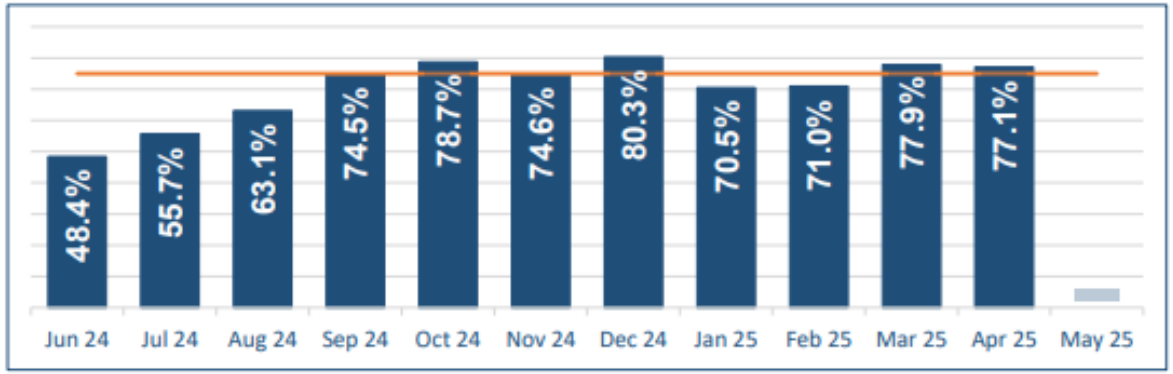
Produced on behalf of the **Quality, Safety & Experience Committee**
by the **Performance and Commissioning Directorate** in partnership with the **Quality Directorate**

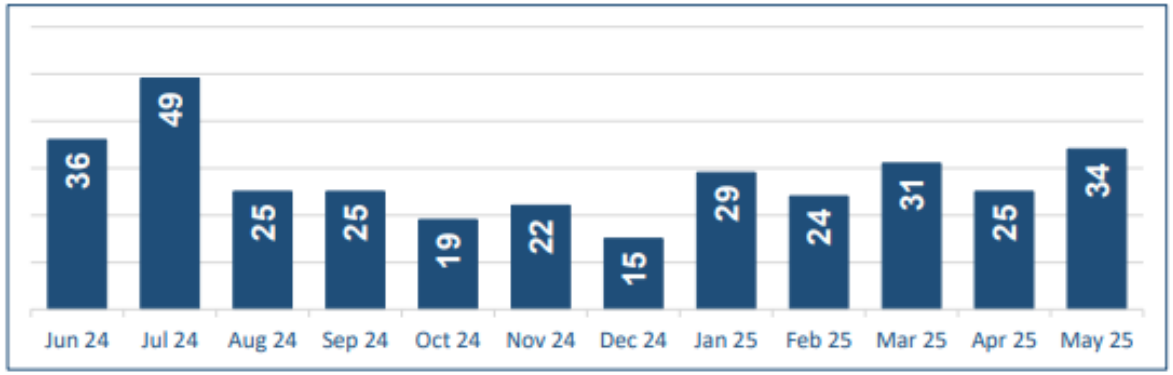
Presented on 03.07.2025

Quality: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	QSE	Number of 'Putting Things Right' (PTR) complaints	N/A	TBC	224	
-	QSE	Of the complaints closed, the percentage that were closed within 30 days	75.0%	TBC	77.1%	
-	QSE	Number of complaints closed as early resolutions	N/A	TBC	34	







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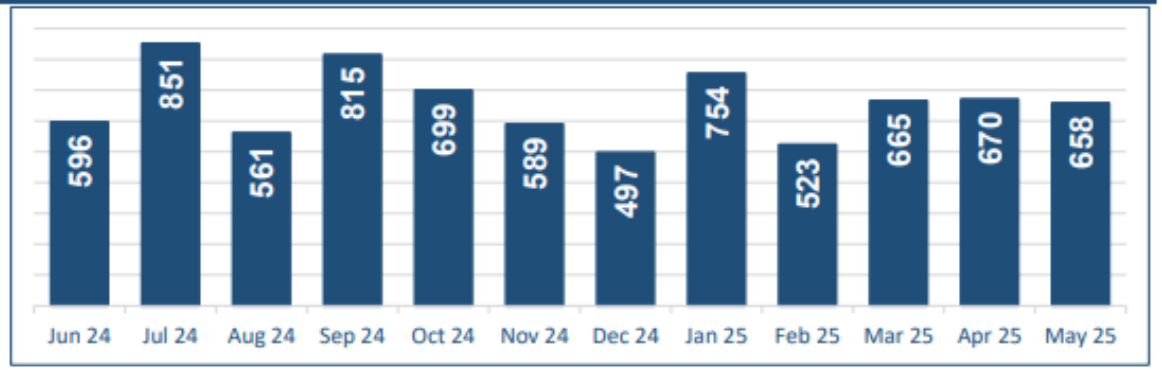
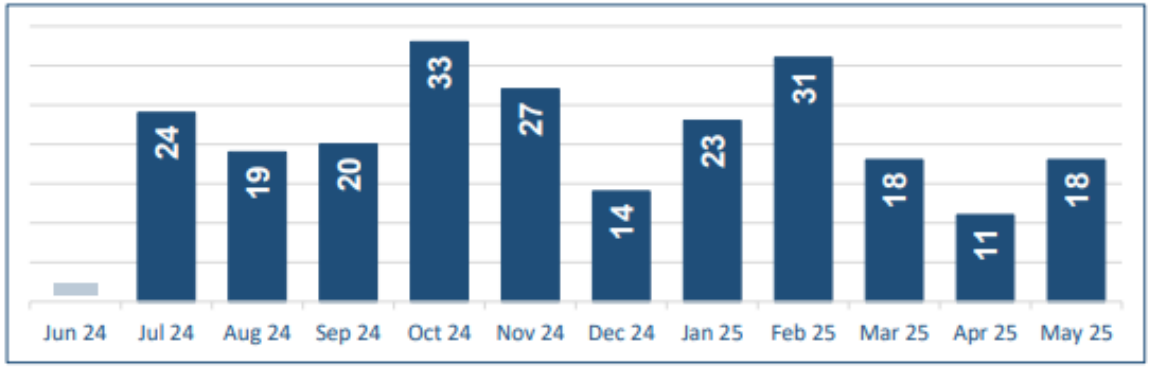
by the **Performance and Commissioning Directorate** in partnership with the **Quality Directorate**

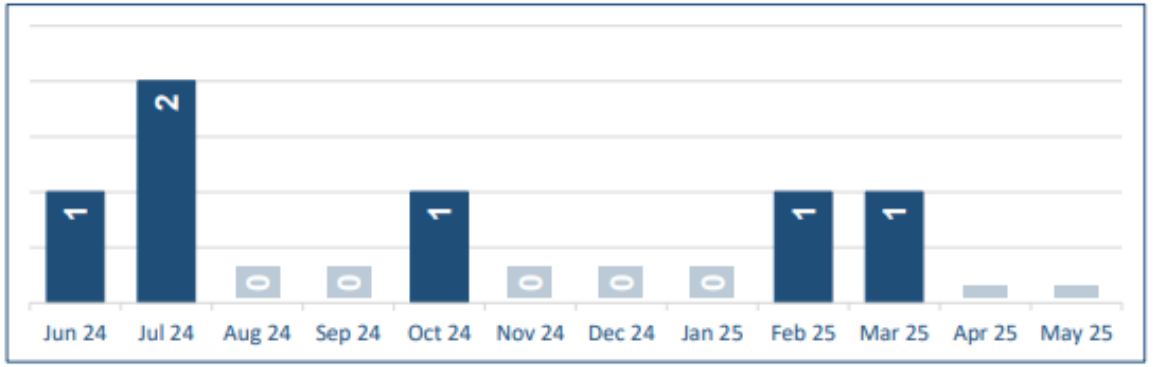
Presented on 03.07.2025

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	658	
-	QSE	Number of new Ombudsman contacts	N/A	TBC	18	
-	QSE	Number of regulation 28 notices	N/A	TBC	1	







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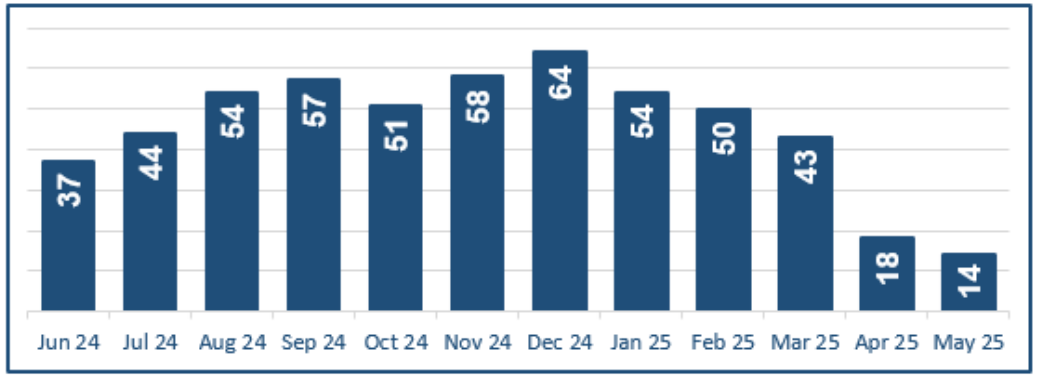
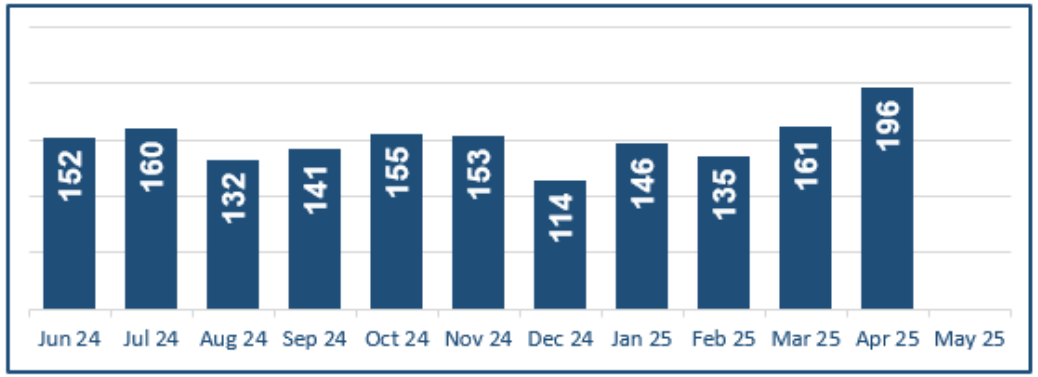
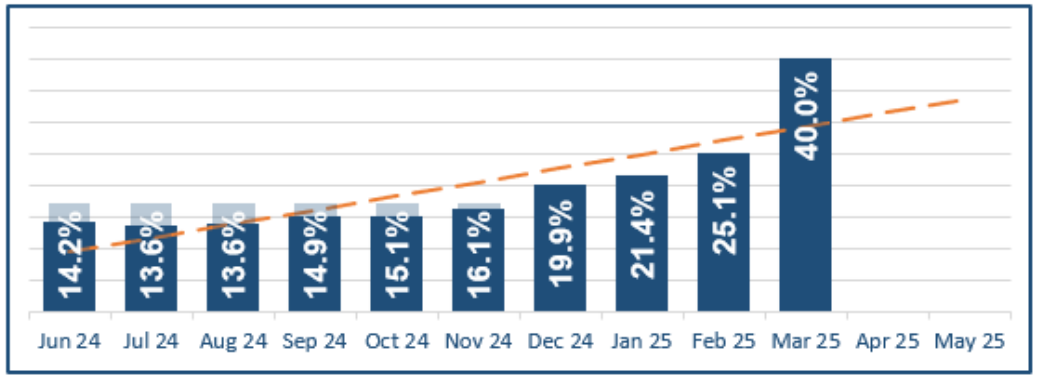
Presented on 03.07.2025

Quality: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	QSE	Number of overdue 'Learning from Event Reports' (LFERs)	N/A	TBC	14	
-	QSE	Number of Great-ix submissions	N/A	TBC	196	
-	QSE	Percentage of episodes clinically coded within one reporting month post episode discharge end date	Increas-ing trend (to 95%)	TBC	40.0%	8st of 8 (at Mar 25)





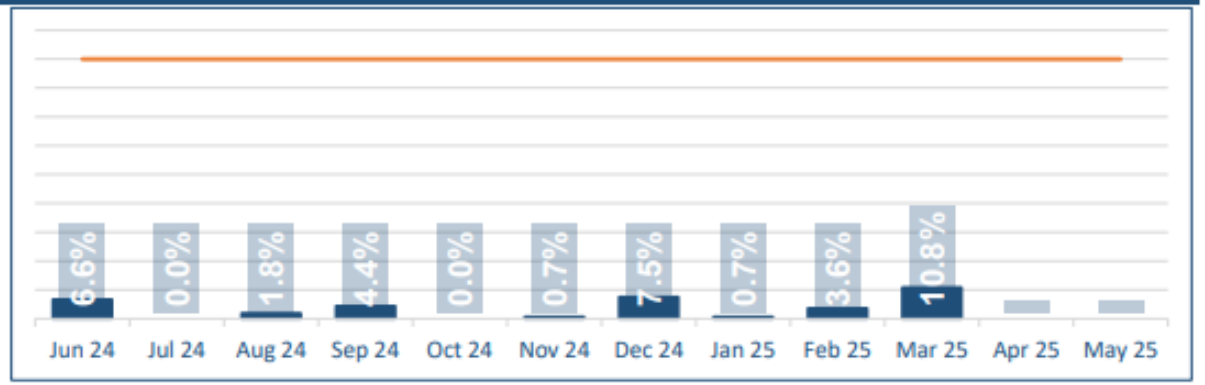


Produced on behalf of the **Quality, Safety & Experience Committee**
by the **Performance and Commissioning Directorate** in partnership with the **Quality Directorate**

Presented on 03.07.2025

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	10.8%	8th of 8 (at Mar 25)



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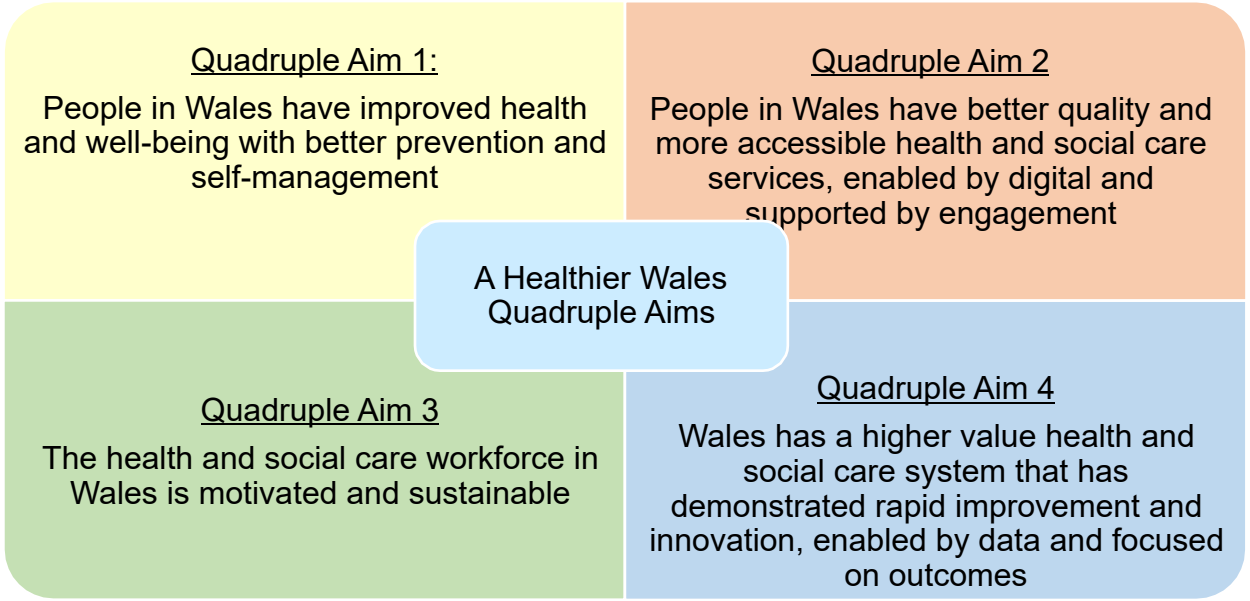
Presented on 03.07.2025

Additional Information

NHS Wales Performance Framework 2024-25

The NHS Performance Framework is a key measurement tool for “A Healthier Wales” outcomes, the 2025/26 revision now consists of 53 quantitative measures of which 9 are Ministerial Priorities and require Health Board submitted improvement trajectories.

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.

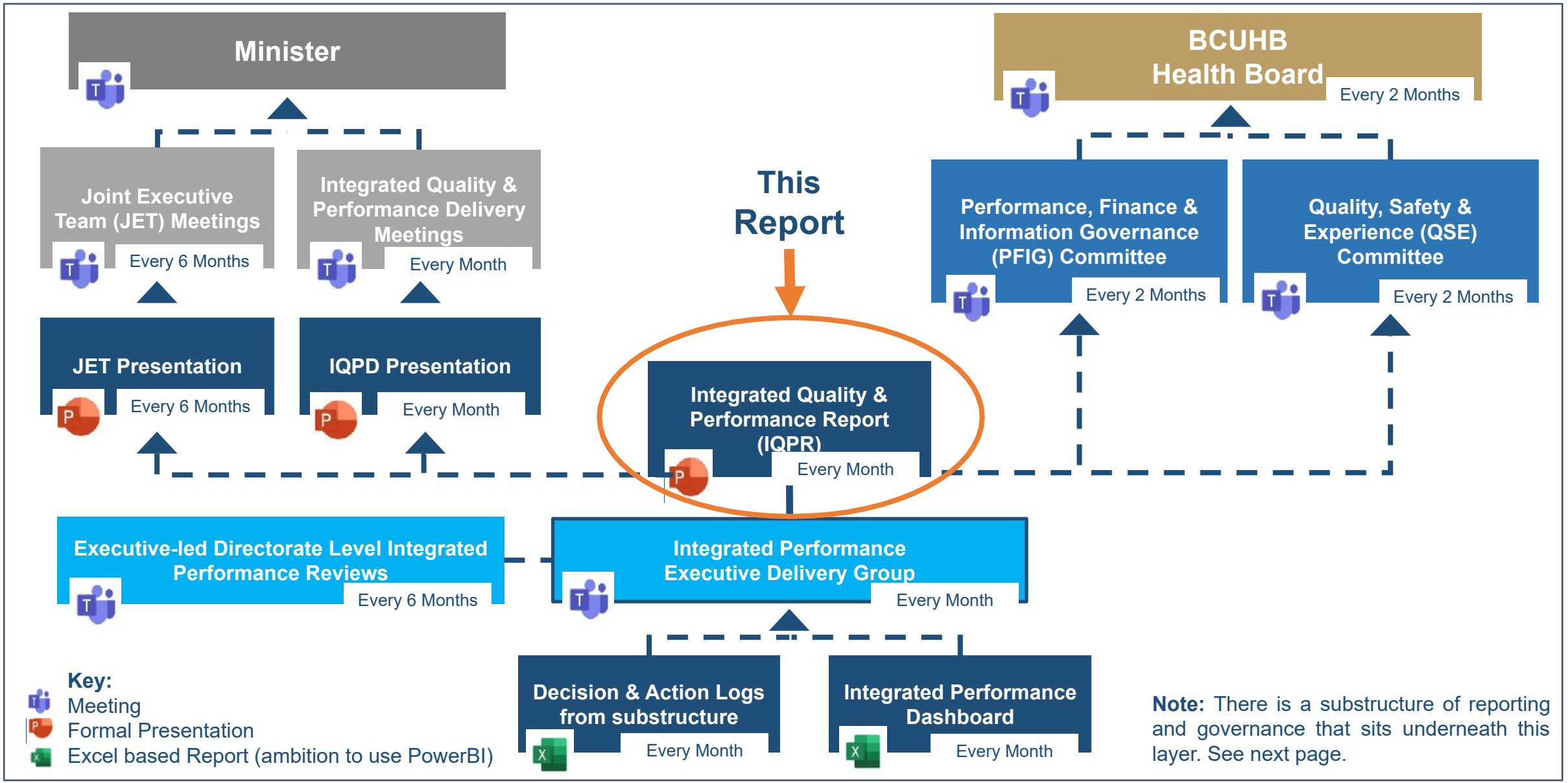
The Integrated Performance Framework sits within a "triumvirate" together with the Integrated Planning Framework and the Risk Management Framework (also ratified at Health Board on the 28th September 2023). This triumvirate of frameworks will encompass the planning, safe delivery and monitoring of the 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.

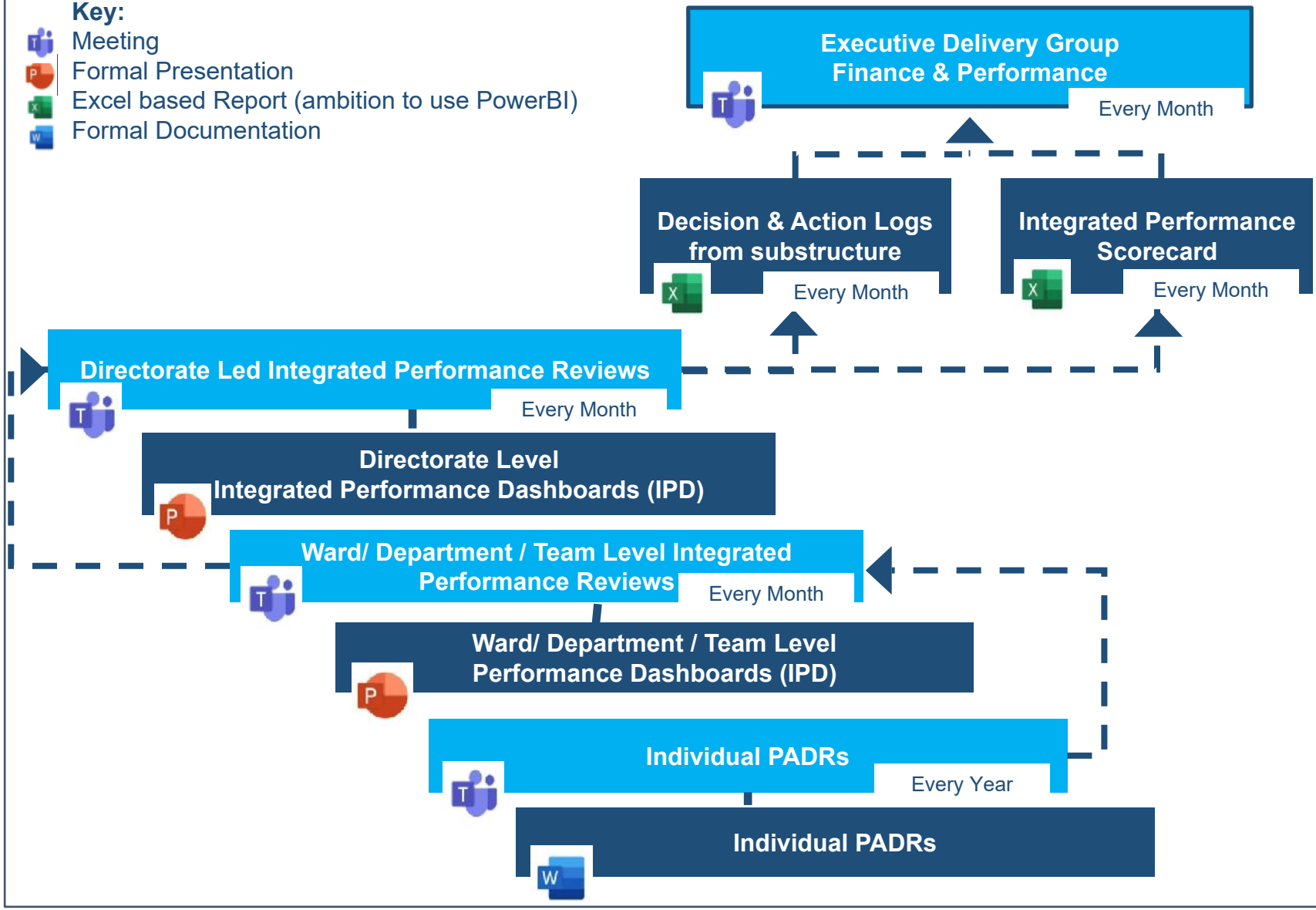
The IQPR will be embedded as the 'single version of the truth' and used to report on performance to the Health Board, it's scrutinising committees namely Performance, Finance & Information Governance (PFIG) Committee and Quality, Safety & Experience (QSE) Committee and externally to Welsh Government. 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.

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

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

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, 03 July 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 1 May 2025. The Committee received an update on the progression of the Improvement Actions in the RCPsych Invited Services Review and received an update on the Expert Advisory Group work programme and approach to outcomes framework. This report highlights a detailed report from the Special Advisor and Chair of the Expert Advisory Group on her key considerations from the work programme during May and June 2025. The report also highlights some practical examples of progress against the RCPsych Invited Services Review since the last Committee meeting. In addition there is a summary of the progress against the improvement actions. An update on the development of a Draft Outcome Framework and Performance Dashboard is also provided ahead of an update that will be provided to the Health Board in July 2025.
Argymhellion: ***Recommendations:***	The Committee is asked to: • **Note and Consider** the update from the Chair of the Expert Advisory Group • **Note and Consider** the update on progress against the Expert Advisory Group Work Programme • **Note and Consider** the development of a Draft Outcome Framework and Performance Dashboard • **Receive assurance** on the Health Board response to the RCPsych Invited Review Services Report reported to the Health Board Action Delivery Group

Arweinydd Gweithredol: ***Executive Lead:***	Teresa Owen, Executive Director of Allied Health Professionals and Health Science			
Awdur yr Adroddiad: ***Report Authors:***	Ros Alstead – Special Advisor Phil Meakin – Associate Director of Governance			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☒	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	1. Building an effective organisation 2. Developing strategy and long lasting change 3. Creating compassionate culture, leadership and engagement 4. Improving quality outcomes and experience			

	5. Establishing an effective environment for learning
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	None
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)***	CRR 24-04 (Learning)
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, January 2025 and the previous reports to Quality Safety and Experience , most recently on 20 February 2025.

Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	• 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 – Update on Improvements by theme since the last Quality Safety and Experience • Appendix 2 – Summary of Progress reported to the Health Board Action Delivery Group on 9 June 2025	

Glossary of Terms Used in This Report

ALN – Alcohol Liaison Nurse
BCUHB – Betsi Cadwaladr University Health Board
CEG – Clinical Effectiveness Group
CTP – Care Treatment Plan
CMHTs – Community Mental Health Teams
DDAT – Digital Data and Technology
DHCW – Digital Health and Care Wales
DSLT – Divisional Senior Leadership Team
DLRRG – Divisional Ligature Risk Reduction Group
HCA – Health Care Assistant
HCSW – Health Care Support Worker
HSE – Health & Safety Executive
HTT – Home Treatment Team
KPI – Key Performance Indicator
LHB – Local Health Board
LOF – Learning Outcomes Framework
MDT – Multi Disciplinary Team
MHLD – Mental Health and Learning Disabilities
NCCU – National Care Commissioning Unit
NHS – National Health Service
NICE – National Institute for Healthcare and Excellence
OD – Organisational Development
PADR – Performance and Development Review

PALS – Patient Advice and Liaison Services
PCE – Patient Care Experience
PST – Patient Safety Team
PTR – Putting Things Right
POMH – Prescribing Observatory for Mental Health
PSOW - Public Services Ombudsman for Wales
R&R – Recruitment and Retention
RMN – Registered Mental Health Nurse
RPharms – Royal Pharmaceutical Society
SLT – Senior Leadership Team MH&LD
SOP – Standard Operating Procedure
SQDG – Service Quality Delivery Group
WARRN – Wales Applied Risk Research Network
WCCIS – Welsh Community Care Information System
WG – Welsh Government

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 the Quality Safety and Experience Committee was on 1 May 2025. The Committee considered the report and clarified that it found it useful to receive a report to evidence that improvement actions are being carried out, which will improve current services.

A report to the Health Board is due in July 2025 and this is the last Quality Safety and Experience Committee before the Board meeting and therefore the focus of this report is to provide an update from the Special Advisor to the Health Board (and Chair of the Expert Advisory Group) on the progress against the Expert Advisory Group work programme and progress towards developing an Outcome Framework and Performance Dashboard.

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

3. ADDITIONAL BACKGROUND

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

Table 1: The ten themes

The Ten Themes
○ 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

4. UPDATE FROM THE CHAIR OF THE EXPERT ADVISORY GROUP

This part of the report provides an update from the Special Advisor on progress towards implementing the recommendations and improvement actions arising from the independent Royal College of Psychiatrists Invited Review, published at the end of 2023. This role provides advice and expertise in mental health. The advisor supports and advises board members, the executive and Health Board teams leading and delivering the RCPysch Invited Service Review improvement actions.

The advisor also chairs the Expert Advisory Group (EAG) which was set up to involve people with lived experience most impacted by this review. This includes a small number of experts by experience including two with current experience, and four family members (who agreed to become re- involved) all whom experienced serious care failings highlighted through the Ockenden, Holden and other external inquiries and reports. The EAG also includes four health board staff with areas of relevant areas of expertise and two staff from Llais, including the North Wales Llais Director who is the Vice Chair of the EAG.

4.1 Expert Advisory Group work and programme so far, our experience and feedback.

The last report highlighted the importance of getting the foundations of engagement and support right.

Since the end of October 2024 six group meetings have taken place, complimented by many individual meetings. Since the last report three group meetings in May and June 2025. The EAG continues to be grateful to Geoff Ryall-Harvey and his team at Llais for their dedicated input and expertise and time, supporting people, and for the use of their meeting room at Llais Office in Bangor.

Each of the recent group meetings focussed on one out of the ten themes outlined in the Royal College Psych report. Each theme had several improvement actions to review. EAG members looked at the information provided and offered views on progress or concerns about the actions, asked questions and added their perspective. Members had previously identified the areas they are most interested in through one- to- one discussions. There is no expectation that members have the desire or time to be involved in everything, or review all the detail. Some family members

feel they have been involved in similar process before, to no avail, and they were disappointed that the RCPsych report identified areas where improvement was not demonstrated, or sustained.

Presenting the information in a format which is accessible and attempting not to overwhelm people with detail has been a challenge. The EAG has listened and changed the format each time to try and improve the approach. The EAG is thankful to everyone for the time, patience and valuable contributions. . Everyone in the EAG wants to see improvement, and moving on from previous adverse experiences.

The EAG has been well supported by Health Board teams including project support through Phil Meakin, Associate Director of Governance, the Mental Health and Learning Disabilities (MHLD) service, the Transformation and Improvement teams and the Corporate Nursing and Quality teams amongst many.

Recent input from the transformation and innovation team helped to make complex data about clinical effectiveness easier to understand.

The EAG reflects that the format that has worked best in recent meetings is when the subject matter expert presents and explains the information we have received. This gives the EAG a better opportunity to have answers to questions in the moment, to provide detail and perspective. This worked well with Tracey Williamson who is the Dementia Nurse Consultant and her colleague presenting on the dementia actions in the meeting in late May, and Leon Marsh, Head of Patient Experience leading the patient experience and involvement theme in early June 2025.

4.2 Update from Expert Advisory Group Meeting on the 16th of May 2025

Commenting briefly on the clinical effectiveness theme which was discussed in May 2025. The EAG could see a number of important audits have been completed in areas where care standards were not met or sustained arising from significant care and service delivery issues arising from recommendations in both external reviews and the independent invited services review..

The audits have already been presented to Health Board Committees, and to the Evidence of Outcomes group looking at the quality of the evidence, making recommendations to an Executive Delivery Group. Once the internal governance has been completed, the relevant information was shared and looked at by the EAG. The information received included audits on falls, mental capacity and administering anti-psychotic medication amongst others. Overall, the EAG saw evidence of audits taking place against best practice standards. In general, where standards had not been met in the wards, improvement plans have been agreed and re- audits checked for improvement. For example, the falls audits in Older Persons Mental Health. However, inconsistency meeting standards was found in mental capacity assessment completion. The EAG members did not find evidence of this being picked up as an issue. EAG members shared personal experiences and perspective a which was valuable to emphasise the impact and importance of completing mental capacity assessments for the individual and their family. This is an area for improvement along with engagement of patients and families in care plans from this audit.

The audit of medical staff log ins took place in 2024. The EAG members fed back to the Director of Mental Health who is on the EAG the need for management action and a re-audit is urgently required due to lack of clear improvement in this important area. The EAG Chair is aware that this work is being prepared for presenting back to the Group for update by the end of July 2025.

Audits with clear actions plans and evidence of improvement provided information that practice meets the required standard at the time of the audit when it took place. To demonstrate that this will be sustained, dates for re- audits of these standards need to be agreed. It is preferable to have some of these areas audited routinely by Matrons / Multi-Disciplinary Teams in “real time” in areas where greater oversight is needed or it is a high priority area of mental health practice.

4.3 Update from Expert Advisory Group Meeting on the 29th May 2025

The meeting looking at the dementia improvement actions benefitted from explanation and presentation by Tracey Williamson and team. The Group could see the significant work been undertaken towards meeting these actions. From the information the EAG looked at it was is not always clear what further evidence of outcomes and outputs is required to decide when the improvement action is met. It is excellent news to hear the Dementia Nurse Consultant has now started in her new role.

4.4 Update from Expert Advisory Group Meeting on the 5th June 2025

The EAG members were very pleased to hear more about the improvement and development in complaints management and how the health board is beginning to collect and use patient experience feedback in real time. Mental health services have no overdue complaints and resolution is timelier. EAG members from experience have been keen to see the balance between satisfactory resolution of complaints and timeliness.

Experiences of the complaints process from friends and family known to members appears mixed, which appears inconsistent with the information received. Patient experience information is most meaningful at team level where individual issues can be addressed and teams receive direct positive and negative feedback which Health Board teams can do something about immediately. With further development and implement the CIVICA (system) is a real opportunity to be able to know about good and poor care experiences at scale, rather than just focus on complaints.

4.5 Key Matters Arising from the Expert Advisory Group Meetings

Overall, it would be helpful if the Evidence of Outcomes group could more clearly set out the requirements and further evidence which must be met for the improvement actions to be approved. It appears that many actions have progressed but lack a clear indication of when the actions have been met and how they will be sustained. This is a key recommendation from this report. At the time of writing this report the matter has been noted by the Chair of the Evidence of Outcomes Group and is placed on the agenda for their next meeting of 1 July 2025 to ensure there is alignment to the Evidence of Outcome Group Terms of Reference.

Where standards have not been met, audits need to have action plans and follow up actions to check that improvements have been made. The annual audit plan needs to detail when re-audits will take place to sustain improvement.

4.6 Expert Advisory Group Visit programme going forward

The Expert Advisory Group have been involved in developing a work programme which includes visits they will participate in if they wish to. This will help with seeing and understanding if changes being reported are having an impact in teams. Some members will be more involved than others. The Llais team and volunteers are trained to visit mental health areas. The EAG Vice Chair, Geoff Ryall -Harvey will lead the visits to adult and older adult inpatient ward in the coming weeks, starting at the end of June 2025. One EAG member has been involved in developing the

questionnaire to be used with Llais and the support documents are in place. The EAG did undertake some work earlier this year on issues that are important to members. The visiting team will also look for information and evidence to support or question the information already received about improvements.

4.7 Expert Advisory Group Work Programme - Next Steps and Areas for Attention

The Group is thinking again how to look at all the information that is being produced to help with the assessment of progress made, aiming not to overwhelm people with a mass of papers that they do not feel comfortable with. The Group aims to use the benefit of people's experiences to guide what it looks at and finds. Although the Group have tried different ways to make this manageable, understandably, some members found the volume of information is too much and the terminology and technical details difficult to understand. It is not the remit of the group to be accountable for what has been done, however being involved in this way has felt uncomfortable. This matter is receiving further attention and a different solution. The Group may consider having extra help form people who feel comfortable looking at detailed technical information who can work with some of us to look through the papers and report back to the group. This maybe a way of reducing the workload and burden for those wishing to be less directly involved.

Something which has been helpful in the Group meeting schedule is topic-based meetings and seminars to inform EAG members about areas being looked at. This is a good opportunity to ask questions and seek clarification and understanding. The seminars in staff wellbeing and staffing have been useful. Several more planned including environmental improvements inclusive of ligature removal, progress on implementation of electronic patient records, learning from deaths and mortality reviews in mental health, ward accreditation and improvements to physical healthcare in inpatient mental health wards and more on staffing including and recruitment retention and staff experience. The Group are also meeting with senior leaders in Older Persons Mental Health and Adult Mental Health.

At times it has been challenging to balance pace, momentum and workload. The need to progress with a timeline of 12 month on the one hand, and needing to be carefully balanced with time, wellbeing and other commitments of the much-valued volunteer members of the group. The EAG are very grateful to them all for their input and ongoing support which makes this work possible. Further attention will be given to this and the EAG may adjust the programme in the next few weeks, seeking a more comfortable balance whilst maintaining a direction of travel with an end point in mind (October.)

It is likely by then there will be a lot of evidence of progress, whilst there may be a few longstanding areas which continue to need attention. Current areas which the EAG detailed have not received information on yet which are known risks include Allied Health Professional and Psychology staffing and leadership in the Health Board. The number of staff in leadership interim positions is another longer-term area which needs continuous attention by leaders and the Health Board to make progress.

Improvement actions are led by Board Directors and action owners from across the Health Board teams and departments. There has been good engagement and input from executives and leaders throughout the organisation which the EAG is grateful for. The Royal College invited review highlighted making sustained improvement is one area that the Health Board has found it difficult to demonstrate. The mental health leaders with corporate teams are developing an outcomes framework accompanied by a performance dashboard which will have dementia and mental health specific sensitive measures. Ensuring this has the right leadership and support to develop and continue to flourish once this programme is stood down is vital to demonstrate that safety

experience and quality improvement continues and improvement can be evidenced in real time and in future. An update on this is provided in Section 6 of this report.

5. EVIDENCE OF PROGRESS AGAINST THE IMPROVEMENTS OF RCPSYCH INVITED SERVICES REVIEW

The previous Quality Safety and Experience Committee welcomed the information in the 1 May 2025 report that gave examples and an update on improvements that have been reported to the Health Board Action Delivery Group and highlight the work that has taken place in response to improvement actions in the Invited Services Review.

Appendix 1 provides an update on this progress since the 1 May 2025. The detailed evidence has progressed through the agreed "management arm" of the governance process and is shared through the "assurance arm" of the governance process (the Expert Advisory Group). Appendix 1 provides a summary of this information.

Appendix 2 provides a summary of progress that was provided to the Health Board Action Delivery Group on the 9 June 2025.

6. DEVELOPMENT OF THE OUTCOME FRAMEWORK AND PERFORMANCE DASHBOARD

At the meeting of the Health Board in January 2025 the Board noted the importance of developing an Outcomes Framework and accompanying Performance Dashboard that can illustrate progress against the improvements reported in the Invited Services Review

Further to the development of the RCPsych Invited Services Review response plan and associated improvements, a Health Board task and finish group was commissioned in October 2024 to identify a set of outcomes and associated performance indicators that could be adopted to provide a demonstrative proxy measure of the positive impact resulting from the progress on the response plan. The objective being to develop a RCPsych Business Intelligence (BI) Performance Dashboard that could be presented and also for transferring into any bespoke reports that may be required within the overall governance framework. This commissioned work has been developmental and dynamic in its development. This draft can be shared with colleagues and the EAG Chair for final consideration. Next steps in maturing the Framework and Dashboard needs to be a staged approach, but at pace and will require a more refined group to complete the Framework and Dashboard.

7.SUMMARY

This report seeks to draw out the Special Advisor's reflections of the Expert Advisory Group work programme and where further attention is required to deliver the sustainable 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 the Health Board focuses on demonstrating improvement and learning from feedback.

The report also highlights continued progress that has taken place in the improvement actions that are arranged under the ten themes of the RCPsych Invited Service Review and the development of a Draft Outcomes Framework and Draft Performance Dashboard that will be important in developing a "business as usual" approach to understanding the impact of improvements.

8.NEXT STEPS

- Continue to progress the Improvement Actions in the RCPsych Invited Services review.
- Follow up on the reflections of the Special Advisor highlighted in this report.
- Socialise work on the Draft Outcomes Framework and Performance Dashboard and report on progress at the Health Board meeting in July 2025.

9.RECOMMENDATIONS

This report asks the Committee to;

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

10.APPENDICES

Appendix 1 – Update on Improvements by Theme since the last Quality Safety and Experience Report.

Appendix 2 – Summary of Progress Reported to the Health Board Action Delivery Group on 9 June 2025

APPENDIX 1 – Update on Improvements by Theme Since The Last Quality Safety and Experience Report

5.1.1. Theme One Outcome – Patient and User Centred Care

Improved older adult and dementia care through a skilled workforce, improved communication, engagement and partnership working both strategically and operationally with service user, families, carer and wider stakeholder and partners.

There are seven MH&LD actions and eight Health Board wide actions to deliver this outcome. In total, fourteen action owners have submitted evidence and are awaiting approval through various stages of the agreed governance route for approval and final sign off. One action remains in progress, albeit not to deadline which is aligned to reviewing the Local Authority (LA) working model in Community Mental Health Teams to ensure collaborative partnership working.

The MH&LD Consultant Nurse for Dementia is now in post. The successful candidate comes into post with 20 years' experience working in dementia care in acute settings, Mental Health and Community Services and has previously worked for University College London Hospitals as a Consultant Nurse for Older People. Her work has spanned clinical leadership, service redesign, education and quality improvement which has driven innovative advancements including the design of therapeutic spaces and the implementation of new service models. An in-depth induction plan has been developed to support her settling into the role including meeting with MH&LD and Health Board colleagues and visiting sites across the Division. A focus of the MH&LD Consultant Nurse for Dementia, in partnership with the BCUHB Consultant Nurse for Dementia, will be the continued delivery of the dementia related actions.

Several Dementia related actions have progressed, including increasing Dementia education and awareness through the newly commissioned "Finding the Light in Dementia" Training and Dementia Training Study Days. Across the Health Board over a thousand staff have had various Dementia related training, with innovative ways of providing the training including Dementia Bus Training and Train-the-Trainer implemented for a PORT tool national pilot (Person-Centred Observation Reflection Tool. Feedback has been collected, to enable an understanding of the impact of the training, and several attendees noted positive feedback.

Improving communication and engagement with patients remains a key focus in the MH&LD and wider Health Board. An iCAN Communication and Engagement Plan has been produced to help increase awareness of iCAN hubs/iCAN Services across North Wales. A series of workshops organised by the Health Board with Third Sector organisations, and Local Authorities has been held to work together to inform a strategy to strengthen Mental Health Services including commissioning and partnerships. An iCAN Dashboard has been developed providing an overview of current activity including partnership working outcomes. The Multi-agency workshops include complex problem-solving sessions organised to support the development of partnership working.

The use of CIVICA, the Health Board's patient, carer and service user feedback system, allows the Health Board to listen, learn and act on feedback to ensure that managers and Health Care Professionals are able to utilise feedback in real time to improve services in order to provide a

safer, more positive experience. The Health Board is collecting both quantitative and qualitative data to turn in to valuable insights.

The whole of the MH&LD Division has been successfully mapped to CIVICA, with real time feedback reported into the Divisional Patient, Carer and Experience (PCE) Group Meetings. To increase the feedback a "Roll Out" plan has been developed to raise awareness and provide the necessary resources and training to ensure reporting on both quantitate and qualitative data occurs improving visibility of feedback at service level, and ensuring feedback loops are closed with clear outcomes.

The data will allow the Health Board to identify any issues and to better understand a patient's journey through services, alongside understanding the views of families and carers. From July 2025, monthly CIVICA Reports will be sent to 92 service leads and Area Senior Leadership Teams, embedding accountability at the local and divisional level. This will allow each team to act on feedback to improve patient experience.

MH&LD Division and Llais Meetings continue to occur, with all the five local area triumvirates (Head of Operations, Head of Nursing and Clinical Director).. The Llais Annual Plan 2024/25 has been shared along with the details of the "Safe Space Events, and arrangements are being made for Llais volunteers to visit the Learning Disability and Substance Services too. A focus for the next scheduled meeting will be on housing.

Further to the series of events held last year across North Wales, the MH&LD Division is continuing to develop a "Service User and Carer Engagement Plan. The events were an opportunity to bring together professionals, carers and importantly those with lived and living experience of Mental Health and Learning Disability challenges and using our services. The events were facilitated by Co-production Lab Wales, with the support of Caniad and BCUHB Teams, and were attended by a total of 67 people. Participants gave positive feedback and expressed a strong desire to remain involved and a follow-up event has been undertaken to share emerging themes. A strategy is currently being drafted and will be ready consultation Q2 25/26 with further sessions planned to co-produce detailed delivery plans. Members of the Expert Advisory Group have asked to attend sessions where appropriate.

5.1.2 Theme Two Outcome – Legislation and Clinical Guidance

Improved processes in place for sharing and embedding wider learning from incidents and audit activity which informs training, clinical practice and appropriate action to reduce incidents and risks.

There are nine Health Board wide actions to deliver this outcome. In total, seven action owners have submitted evidence and are awaiting approval through various stages of the agreed governance route for approval and final sign off. Two actions remain in progress, albeit not to deadline.

The MH&LD Physical Health Strategy is currently out for consultation, with a closing date of 30th June, and will progress and be finalised through due governance process including the Clinical

Effectiveness & Policy Group, Divisional Quality & Service Delivery Group, Executive Patient Safety Group and the Executive Policy Oversight Group.

A Divisional Implementation Plan was developed to launch the plan aiming to build strong engagement across clinical and operational teams to support to aid successful implementation. As part of this, the Assistant Director of Nursing has written to the Senior Leadership Team to request nominations from each service area to join the Physical Health Steering Group. This is an important opportunity for nominated staff, particularly clinicians and managers to contribute to embedding the policy in practice and to gain a clearer understanding of the expectations outlined with it. In addition, a 7-minute briefing has been developed to provide a detailed overview of Physical Health Policy. To help staff incorporate physical health into their holistic care model and improve health promotion and advice provision to patients using Mental Health Services a Physical Health Hub has been created on BetsiNet.

Audits have been undertaken between 5th and 28th February 2025 in the 23 wards within the MH&LD Division to assess their compliance with the Prevention and Management of Adult Inpatient Falls Operational Policy (NU06) and completion and quality of the Falls and Bone Health Multifactorial Assessment (FBHMA). The FBHMA is a mandatory assessment tool and care plan for all adult inpatients.

The Audit Teams were tasked to select five random inpatient risk assessments FBHMA (including the Care Plan) for each ward. The outcome of this comprehensive audit was that the scores were broadly excellent or good across areas. Older Persons Mental Health Wards (OPMH) performed particularly well across the Division, OPMH is the area where falls are most likely to occur. Person-centred assessments and interventions were observed across the majority of samples with narratives linked to the status of the patients achieved in the majority of areas.

The audit has identified areas for improvement which will subsequently improve the quality of record-keeping and the documentary evidence upon which our patient care is based. It will ensure that all staff can readily care for patients who are high risk of falls confidently, with all the information required to enable them to mitigate and identify risks where able to do so. The audit report was disseminated to Divisional SLTs for comment on 3rd March, with a final report produced on 6th March, and which has been disseminated to the Divisional SLTs.

5.1.3 Theme Three Outcome – Governance

For our patients to receive seamless care co-ordination through a fit for purpose, fully adopted Electronic Patient Record System in addition to an effective MH&LD Governance Framework from Ward to Board.

There are 14 actions to deliver this outcome. In total, seven action owners have submitted evidence and are awaiting approval through various stages of the agreed governance route for approval and final sign off. Seven actions remains in progress, three of which are not to deadline.

In April 2024, the corporate complaints team began focussed work on improving patient experience. This has been progressed by reducing the backlog of complaints, embedding improvement initiatives to support improved patient experience alongside sustaining the

performance in complaints management by reducing open complaints, overdue complaints, quality and timeliness of complaints. The achievements between 1ST April, 2024 and 31st March, 2025 include –

- An 67.12% decrease in the total number of open complaints from 660 to 217
- An 88.45% decrease in the total overdue complaints from 407 to 47
- An increase in the number of complaints being resolved within 30 working days from 38.33% to 78.34%
- A 43.47% Increase the average number of complaints resolved per week from 46 to 66
- National comparison, we are now the best performing Health Board in Wales at resolving complaints within 30 days, having been the worst for over five years.

The Head of Patient and Carer Experience is the Vice Chair of the BCUHB Organisational Culture and Leadership Group and presentation was made at the Strategic Patient and Carer Experience Group (PCEG) to highlight the recent progress that the Health Board has made.

In addition, the Health Board are closing more complaints per week, addressing complaints quicker and have sustained a reduction in complaints remaining open and have become the best performing Health Board in Wales in relation to the management of complaints and concerns. The MH&LD Division has achieved the 75% compliance on 2nd September, 2024 and has maintained this level.

There was a relaunch of the Health Board's Patient Advice and Liaison Service (PALS) through online platforms, ensuring the public how to raise a concern of complaint. The goal is to help support people in community to use the appropriate service based on their needs whether that be early resolution for low level concerns through PALS or formal concerns through complaints. A newly developed internal website has been developed to make it easier for staff to raise concerns, and complaints and new external public facing web pages are now available to make it easier for people to locate how to make a complaint or raise a concern.

BCUHB's Digital, Data and Technology (DDaT) Service continue to support the Division and the Child and Adolescent Mental Health Service (CAMHS) to progress with the implementation of an Electronic Patient Record (EPR) System, this will be transformative for patients and staff. The Programme Board is well established with input from across specialities, services and input from the National Team. The Invitation to Tender (ITT) was sent out to the market via NWSSP Procurement Team on the 8th May 2025 and a full procurement timeline has also been published. The evaluation process is critical to BCUHB to purchase the right system. There is an evaluation plan with an evaluation briefing for all staff involved in the evaluation, developed working collaboratively with Cwm Taf and NWSSP.

The Mental Health Electronic Health Record (EHR) sits under the scope of the EHR Programme Board and an update is provided at each meeting. Carol Shillabeer is the Senior Responsible Owner (SRO) for the EHR Programme and Iain Wilkie is the SRO for the Mental Health EHR. The Mental Health Project Board has been recently reviewed with new membership to take the project through the next stage. A project briefing session was run for all new members to provide an

overview of the project and for them to gain and understanding of their roles and responsibilities. A Clinical Service Officer has recently been appointed who will be responsible for leading the change across the service with the change team. The service transformation has begun with workshops with Local Primary Mental Health Support Services (LPMHSS) and Children and Adolescent Mental Health Services (CAMHS).

5.1.4 Theme Four Outcome – Staffing

To have in place a fully appointed substantive divisional structure, with an effective and efficient recruitment and retention plan focusing on attraction strategies to enable the Division to have the right staff, with the right skills at the right time to meet the mental health needs of the population of North Wales currently and in the future.

There are seven MH&LD actions to deliver this outcome and one Health Board actions to deliver this outcome. In total, five action owners have submitted evidence and are awaiting approval through various stages of the agreed governance route for approval and final sign off. Three actions remains in progress, albeit not to deadline which are aligned to the recruitment of a MH&LD Director of Nursing (that is now out to advert), a Consultant Psychiatrist for the Hergest Unit and progressing the funding the Wellness, Work and Us Service.

The MH&LD Division continues to progress the recruitment and retention activities aligned to the MH&LD Recruitment and Retention (R&R) Plan, with quarterly reporting through due governance including any agreed area of focus as determined by the Divisional People and Culture Delivery Group.

The MH&LD Recruitment and Retention Group continue to progress a range of activity to actively promote retention and recruitment across the Division. There continues to be a downward trajectory of divisional vacancies from the last update of 12.9% (reported in February 2025), to 12.6% in May 2025. Nurse vacancies have reduced from 13.8% in April 2024 to 11.4% in April 2025 and Adult Community Support (ACS) nursing vacancies reduced from 12.5% in April 2024 to 9.3% in April 2025.

Recruitment efforts include virtual events, social media campaigns, attendance at job fairs and sharing recruitment posters at school career events. Progress has also been made with reduced reliance on agency, ceasing all HCA agency since April 2025 with a reduction in Nurse Agency use per month from April 2024 at 4082 hours to April 2025 at 3197 hours.

5.1.5 Theme Five Outcome – Management Structure

To have in place a fully appointed substantive management structure, with an effective and efficient recruitment and retention plan focusing on attraction strategies to enable the Division to have stable leadership to support meeting the mental health needs of the population of North Wales currently and in the future.

The Division has two improvement actions and the Health Board has one. One action owner has submitted evidence and this action is awaiting approval through various stages of the agreed governance route for approval and final sign off. Two actions are in progress and within deadline.

The MH&LD Division continues to make progress in reducing interim posts and transitioning them into substantive roles in alignment with the MH&LD Operating Model and the wider Operating Model review.

To date, ten interim staff have been recruited to substantive posts following various recruitment activity. The remaining vacancies are planned for the next 18 months, 5 per each 6 months.

5.1.6 Theme Six Outcome – Clinical Services Organisation

All patients will have access to multi-disciplinary support based on need to improve patient outcomes and patient experience.

The Division has one action in progress not to deadline, 6.5 - Ensure all Centre and East Memory Assessment units attain Memory Service National Accreditation Programme (MSNAP) accreditation. Action 6.6 - Progress the pilot scheme for in-reach workers in care homes, review and measure impact and outcomes and carry out options appraisal to expand to all care homes to enable consistency of service provision is due October 2025.

To measure compliance with BCUHB Mental Health and Learning Disabilities Ward Round Terms of Reference (TORS) and to determine current status and representation in ward rounds across all Adult Acute wards, a table top audit was conducted in December 2024. All wards demonstrated that there was a weekly schedule for when ward round occurs and that patients and ward staff were aware of when to expect a ward round. Ward round were found to take place according to the schedule in all samples and outcomes were found to be clear and achievable. Divisional standard TOR's for MDT ward rounds on Acute Wards were not in existence. Since the audit a standard document has been implemented across all areas to enable consistency and clear standards. Key points are;

- There is a lack of Psychology provision throughout all acute inpatient wards.as the inpatient units have experienced challenges recruiting an inpatient Psychologist. As a result, the posts are currently being reviewed by the Head of Psychology.
- The data showed family representation in ward rounds was low across all areas. All areas were to focus on improving engagement with families and to re-audit to measure improvements.

The newly appointed MHLD Consultant Nurse Dementia will add support to the monthly Consultant Nurse Dementia led network meetings. In addition, Orientation Days have been introduced for new role-holders, plus half day training on their role in educating/training supporting patients who are distressed. In addition to this a team building day with Arts in Health and Improvement Cymru are examples of increased education aligned to the Dementia actions included in the RCPsych Response Plan.

5.1.7 Theme Seven Outcome – Training and Development

To ensure a skilled and developing workforce through the completion of identified training and learning opportunities including a programme of regular Divisional Learning Events with external speakers to enable an increase in networking with other organisations both within Wales and nationally.

Four key actions are aligned to this outcome, three for MH&LD and one for the Health Board.

A Divisional Learning Event is currently being planned for September 2025, date to be confirmed, as a preferred date is being requested via 365 forms. The aim is to have two events per year. This will enable a wide variety of stakeholder engagement as well as themed topics that will support learning and improvement across the Division. The events will include key external speakers and include topical themes within the Health Board.

- To support networking through partnership working the Division has numerous well established meetings and see networking as a key mechanism for driving meaningful change and a forum for individuals to come together, share ideas and raise awareness of challenges. The team collaborate and co-operate with organisations at national and local level to improve outcomes and in partnership with their patients and communities. Examples of these are:
- Royal College of Psychiatry Networks: Participation in national peer reviews and forums (e.g. Forensic and Perinatal Quality Networks) to share learning and best practice.
- Multi-agency Meetings: Regular engagement with North Wales Police, Local Authorities, and Third Sector partners through forums such as the 135/136 Strategic Monitoring Group, Missing Patient Meetings, and Joint Commissioning Meetings.
- All-Wales Networks: Involvement in national groups such as the All-Wales Rehab and Perinatal Networks, fostering cross-Health Board collaboration.
- Local Partnership Forums: Monthly GP Cluster Groups, Wellbeing Hub planning meetings, and Local Authority liaison meetings to address local service needs and integration.
- Internal Networking Platforms: Healthcare Support Worker forums and Clinical Audit drop-in clinics provide staff with opportunities to share experiences and drive service improvement.
- Strategic Projects: Engagement in initiatives like the Caledfryn Project Board and Pan Cluster Planning Group to co-design future service models with partners.

5.1.8 Theme Eight Outcome – Leadership and Staff Engagement

To ensure our MH&LD staff receive a clear and consistent level of information appropriate to their needs, underpinned by a communication and engagement strategy and action plan. This will support a culture of openness and honesty with the ability to challenge safely.

There are seven actions across the Health Board to support delivery of this outcome.. Six actions are awaiting formal approval following evidence submissions and the remaining one is in progress albeit not within the deadline for delivery. These are outlined below, including HEIW training, Cultural Change Leaders, MAPP, Staff Survey and Divisional SLT walkabout.

To support and develop our leaders in the Division, four of our Senior Leadership Team (SLT) and colleagues across have commenced the HEIW Mentorship Training, with four mentees also receiving mentorship from participants of the scheme across Wales. In addition, nine SLT members have undertaken the induction to become Cultural Change Leaders with improved access to coaching for existing and new leaders. A Managing Attendance and Performance

Prompt (MAPP) Tool has been developed by the "Wellness, Work and Us" Project group and is available to support new and existing managers.

The Division has undertaken a thematic analysis of the 2024 NHS Staff Survey responses, and compared the results with the 2023 NHS Staff Survey. There has been an slight increase with the number of responses and a infographic developed to share the key themes with all staff across the Division. One outcome of the results of the Staff survey is the commencement of Staff Voice workshops to give staff the opportunity to discuss some of the themes from the staff survey with the initial three sessions around the themes of Morale , Retention and Recognition & Contribution.

The focus of MH&LD Communication and Engagement Plan implementation is to ensure plans and priorities are informed by what matters to stakeholders. The intention is that this will help build deeper connections leading to greater customer satisfaction by engaging with them meaningfully at various touchpoints. The plan will ensure that engagement efforts are aligned and consistent across the Division. By strategically planning how to engage with citizens the Health Board will be able to create more meaningful interactions leading to increased participation. The plan will bring structure, clarity and strategy to engagement efforts helping maximising relationships and achieving desired outcomes.

In support of the plan, senior leadership connectedness to the wards and services will enhance and be strengthened by ensuring there is clear visibility, communication and engagement by the Senior Leadership Team (SLT) from Ward to Board. This is underway with the 2025/26 SLT walkabout schedule developed. In their walkabouts two members of the SLT attend a variety of services and sites. During each walkabout there is either a drop in session for patients, family members, staff or carers to meet with the SLT or an "Ask DSLT" staff session with feedback developed, with a QR code, for anyone in attendance to provide feedback.

5.1.9 Theme Nine Outcome – Resources

For our inpatients to be able to access multi-disciplinary support to improving their health which includes psychological therapies.

There are five improvement actions across the whole Health Board to support the delivery of this outcome.

The response to the RCPsych Invited Services review highlights that the Therapy Services gap analysis is underway. The Health Board supports the vital contribution Therapy Services can make to achieve the aspirations of the refreshed Health Board Clinical Services plan: to supporting the delivery of integrated mental and Physical Health Services and which meet the needs of our population.

Meetings have been held between the IHC AHP Directors and MH&LD Divisional Directors, to consider future plans for collaborative working and developing multi- professional workforce plans.

5.1.10 Theme Ten Outcome – Physical Environment

A MH&LD Capital and Estates Strategy which will ensure that we have short, medium and long term plans so estates and all patient environments remain fits for purpose currently and in the future.

There are eight Health Board wide actions to deliver this outcome. In total, seven action owners have submitted evidence and are awaiting approval through various stages of the agreed governance route for approval and final sign off. One action remains in progress, albeit not to deadline which is aligned to progressing necessary Divisional Capital Estates works as part of the annual plan to ensure all works are captured.

The Divisional Estates and Capital Group is focussed on the ward environment and remedial actions that are required to improve the facilities and make it safe. Minutes and action plans associated with the meeting provide assurance that works are undertaken and reported back to the group upon completion. The MH&LD Divisional Combined Ligature Reduction and Risk Management Group received updated reports on ward environment anti-ligature assessments to ensure compliance with current operational procedures. These meetings have resulted in a pro-active approach to safety in the ward environment and an opportunity to look at where small changes can result in significant benefits in delivering better care.

As part of the Targeted Estates Funding the Health Board submitted a 2 year anti-ligature programme to Welsh Government to seek funding to support a ward environmental improvement programme aligned with anti-ligature. The funding programme was approved by Welsh Government on 21st March 2025 and progress will be reported at the Divisional Estates and Capital Group Meeting. The investment in upgrading anti-ligature doors and windows within MH&LD will result in a safer ward environment. A focus of the Division, with the support from corporate and estates colleagues is to develop an overarching strategy for improvement in both anti-ligature projects and ongoing maintenance of anti-ligature and load bearing equipment that is reported to a Ligature Board.

Annual Tripartite Ligature assessments (Clinical, Estates and Health & Safety) continue to progress across the Division in all inpatient areas, Emergency Department Psychiatric Departments and in CAMHS, with compliance reported into the MH&LD Ligature and Risk Meeting and also the Divisional Estates and Capital meeting. In addition, there has been an end of year ligature capital report that shows those schemes within the agreed capital allocation reported into Capital Investment Group. Compliance in the Annual Tripartite Ligature Assessment for April 2025 was 86%, noting two area additional areas where the audit had been completed but awaited documentation.

The monthly Ligature Environmental Risk Assessment training events continue. Over 500 staff currently trained in ligature awareness including domestic and estates staff. This training is promoted via the Health and Safety BetsiNet and monthly reports to the IHCs. In addition, the Ligature Rescue Procedure managed by Resuscitation Services is included in their training package. Rescue equipment (ResQ Hook and Timesco Scissors) is issued and replaced by

Resuscitation Services. An All-Wales project is in process of converting training slides to an ESR package with support from the Corporate Health And Safety Advisor.

APPENDIX 2- RCPsych Invited Services Review Summary Update

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 14 February 2025

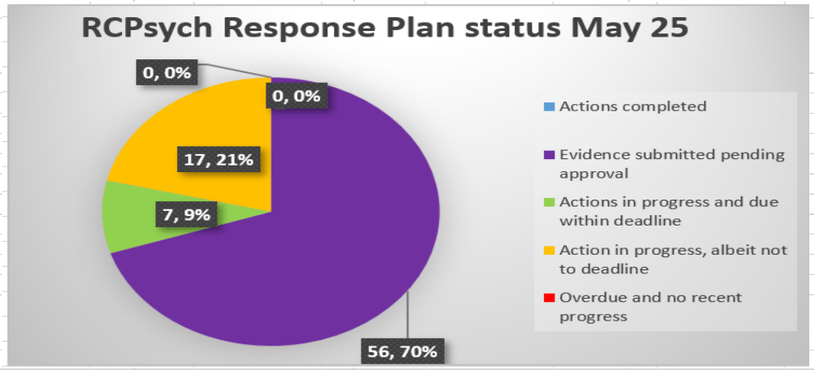
GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Date	**12/05/2025**	**Period**	**Month 10/ May 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 - 56 actions pending approval, 7 actions in progress and due within deadline, and 17 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	14	0	1	0
Theme 2	0	7	0	2	0
Theme 3	0	7	4	3	0
Theme 4	0	5	0	3	0
Theme 5	0	1	0	2	0
Theme 6	0	5	0	2	0
Theme 7	0	3	0	1	0
Theme 8	0	6	0	1	0
Theme 9	0	1	3	1	0
Theme 10	0	7	0	1	0
Total	0	56	7	17	0
Change from previous month	No Change	Increased by 2 from previous month	No change from previous month	Decreased by 2 from previous month	No change



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

ACTION RECOVERY & MITIGATION

Themes		
1.Patient and user centred care		Evidence submitted to close 14 actions
2.Legislation and clinical guidelines		Evidence submitted to close 7 actions
3.Governance		Evidence submitted to close 7 actions
4.Staffing		Evidence submitted to close 5 actions
5.Management structure		Evidence submitted to close 1 actions
6.Clinical services organisation		Evidence submitted to close 5 actions
7.Training and development		Evidence submitted to close 3 action
8.Leadership and Staff Engagement		Evidence submitted to close 6 actions
9.Resources		Evidence submitted to close 1 action
10.Physical Environment		Evidence submitted to close 7 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	Complete
9. Report into Health Board meeting 6 monthly 30/1/25	30/01/25	Complete
9. Report into Health Board meeting 6 monthly 30/7/25	31/12/25	
10. Completion of all actions	31/01/26	In progress
11. Evaluation, summary report and post action review.	31/01/26	
12. Future developments/next Steps		

PROGRESS SINCE LAST MONTH

5 Evidence submissions were reviewed at PIDG meeting held in May 25 and 2 Health Board actions were reporting to RAG meeting in May.
3 actions endorsed for approval at PIDG, one of which were due for completion 31/3/25 - 17 Actions remain in progress not to deadline.
1 action - 3.6 - request approval at HBADG to close action as aligned to Health Board progressing development of learning repository and process.

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

- 1.2 - Achieve Finding the light in Dementia Care training compliance across the MH&LD Division to 85% for Tiers 1 (Informed/Foundation), Tier 2 (Skilled/Intermediate) and Tier 3 (Influencers/Advanced).
- 2.4 - Complete consultation and approval of Physical health Strategy in preparedness for implementation.
- 5.1 - Continue to progress recruitment of interim posts to substantive posts aligned to the MH&LD Operating Model and in line with the wider Operating Model review, aiming to reduce interim posts by 25% by 31/3/25

NEXT MONTHS ACTIVITIES

1. Progress completion of 17 actions in progress, albeit not to deadline
2. Progress submission of evidence of action completion to Expert Advisory Group meetings.
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 Performance Dashboard and the Outcomes Framework to measure the impact of outcomes, outputs and benefits to patients, workforce and service

CHALLENGES, RISKS & ESCALATIONS

Updated Risks and Issues Log to be reviewed and considered at each HBADG meeting.

LESSONS LEARNED AND IMPACT THIS MONTH

- 15 Non-Reg MHLD staff to have attained Tiers 1 to 3 dementia training between April 2024-Dec 2024. Leading to increased awareness of Dementia to enable staff to support patients and carers across the Division.

- A MH&LD Physical Health Strategy has been developed, went out for consultation during 2024 and has progressed through due governance process. A Divisional Implementation Plan to launch the plan aiming build strong engagement across clinical and operational teams is progressing, including a 7-minutes briefing to aid staff awareness. In addition, a Physical Health Hub has been developed on Betsinet to provide staff with an easily accessible resource to support health promotion and advice provision for patients using mental health and learning disability services.

- Following a focused recruitment campaign there has been a 45% reduction in the number of interim posts across the Division. This equates to ten posts that are not recruited to on a permanent basis which provides stability for both the staff, leadership and service.

Teitl adroddiad: ***Report title:***	Corporate Risk Register Report (May 2025)
Adrodd i: ***Report to:***	Quality, Safety and Experience Committee (QSE)
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 03 July 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. Seven 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' • **CRR24-23** – 'Vascular Services' • **CRR24-27**– 'Neurodevelopmental Waiting Lists'. • **CRR24-28** – 'Pharmacy Technical Services'. (Newly Escalated Risk) Risks have been reviewed and updated by the relevant service: Increase to the current risk score for the following risk • **CRR24-23** 'Vascular Services' – Following deep dive into the risk during the April 2025 Risk Scrutiny Group, proposal to increase the current risk score from 16 (Impact = 4 x Likelihood = 4) to a current score of 20 (Impact = 4 x Likelihood = 5) resulting in the risk score above the tolerance set in the risk appetite due to the lack of medical staff within the Vascular Service. Reduced Target risk score for the following risk: • **CRR24-24** 'Renal Services' – Following a deep dive into the risk during the April 2025 Risk Scrutiny Group, proposal to decrease the target risk score from 12 (Impact = 4 x Likelihood = 3) to a score of 8 (Impact = 4 x Likelihood = 2) and reduce the risk tolerance level for the risk in relation to patient safety. No proposed reductions in current risk scores. Appendix 1 provides the Corporate Risk Register dashboard. Appendix 2 provides the full corporate risk register as of May 2025. Appendix 3 provides the newly escalated risks onto the Corporate Risk Register.
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*	The effective and efficient mitigation and management of risks has the potential to			

Financial implications as a result of implementing the recommendations	leverage a positive financial dividend for the Health Board through better integration of risk management into business planning, decision-making and in shaping how care is delivered to our patients thus leading to enhanced quality, less waste and no claims.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	Failure to capture, assess and mitigate risks can impact adversely on the workforce.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	Individual Executive Sign off of CRR reports, 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 Committee as per normal reporting cycle. 2. Submission of Corporate Risks to Board.	
Rhestr o Atodiadau: ***List of Appendices:*** Appendix 1 – Corporate Risk Dashboard (May 2025) – Quality, Safety and Experience Committee (QSE) Appendix 2 – Corporate Risk Register Report (May 2025) - Quality, Safety and Experience Committee (QSE) Appendix 3 – Newly escalated risks – 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 15 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
- CRR24-27 – Neurodevelopmental Waiting List
- CRR24-28 – Pharmacy Technical Services (Newly Escalated Risk)

2.0 Key Highlights

The group is asked to **consider and note** updates to the Corporate Risk register entries, with the full details of the risks included within Appendix 2 – Full Corporate Risk Register:

Increase to the current risk score for the following risk:

- **CRR24-23** 'Vascular Services' – Following deep dive into the risk during the April 2025 Risk Scrutiny Group, proposal to increase the current risk score from 16 (Impact = 4 x Likelihood = 4) to a current score of 20 (Impact = 4 x Likelihood = 5) resulting in the risk score above the tolerance set in the risk appetite due to the lack of medical staff within the Vascular Service.

Reduced Target risk score for the following risk:

- **CRR24-24** 'Renal Services' – Following a deep dive into the risk during the April 2025 Risk Scrutiny Group, proposal to decrease the target risk score from 12 (Impact = 4 x Likelihood = 3) to a score of 8 (Impact = 4 x Likelihood = 2) and reduce the risk tolerance level for the risk in relation to patient safety.

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

April 2025 Risk Scrutiny Group:

- **CRR24-21** – Ophthalmology Service
- **CRR24-23** – Vascular Services
- **CRR24-24** – Renal Services

May 2025 Risk Scrutiny Group:

- **CRR24-25 – '**Dermatology and Plastic Surgery Services'.

Further planned deep dives into the following Corporate Risks are scheduled to be undertaken during the August 2025 Risk Scrutiny Group:

- **CRR24-22 –** 'Orthodontics'
- **CRR24-26 –** 'Urology Services'

2.1 Changes in Score

- **CRR24-24** 'Renal Services' – Following a deep dive into the risk during the April 2025 Risk Scrutiny Group, proposal to decrease the target risk score from 12 (Impact = 4 x Likelihood = 3) to a score of 8 (Impact = 4 x Likelihood = 2) and reduce the risk tolerance level for the risk in relation to patient safety.

2.2 New Risks

The risk(s) added to the Corporate Risk Register since the last update are (full details within Appendix 3):

Risk Ref	New Risks	Lead Exec Director	Current Risk Score (and IxL)
CRR24-28	Pharmacy Technical Services	Chief Operating Officer	**20 (4x5)**

2.3 Overdue/Delayed Actions

The corporate risk register report was produced during May 2025 for review and approval by the Executive Team. At the time of producing two actions were 'delayed' due to unforeseen absence and time constraint/work priorities.

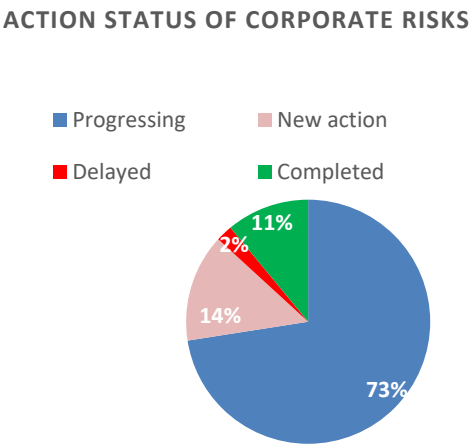
As per the normal cycle of reporting, the next updates are being sought for current updates on all of these actions. The status of these actions of will be included in the next update/iteration of the risk register.

2.4 Risks above Health Board 24/25 appetite

Seven 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	Chief Operating Officer	**20**	**Quality <16**
CRR24-13	Timely Diagnostics	Chief Operating Officer	**20**	**Quality <16**
CRR24-19	Community Care Provision	Chief Operating Officer	**20**	**Quality <16**
CRR24-21	Ophthalmology Service	Chief Operating Officer	**20**	**Quality <16**
CRR24-23	Vascular Services	Chief Operating Officer	**20**	**Quality <16**
CRR24-27	Neurodevelopment Waiting List	Chief Operating Officer	**20**	**Quality <16**
CRR24-28	Pharmacy Technical Services	Chief Operating Officer	**20**	**Quality <16**

2.5 Action Plan status of Corporate Risks



Out of the 15 (including 1 newly escalated risk) corporate risks, 91 actions have been developed to mitigate the risks. 10 actions have been completed, 66 actions are progressing, with 13 new actions identified. 2 actions are currently delayed and to be reviewed during next iteration for future update.

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 (May 2025) – 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	CRR 24-02	Patient Safety	4 x 4 = 16 ⟷	12	Quality / Open <16	Quality, Safety and Experience Committee	Opened Dec 23. Risk revised to become broader patient safety risk, 5 actions identified, 2 completed, and 3 new actions
EDoN	CRR 24-04	Failure to Embed Learning	5 x 3 = 15 ⟷	5	Quality / Open <16	Quality, Safety and Experience Committee	Opened Dec 23, 3 actions identified, 1 completed, 1 progressing with 1 action delayed. Reduction in current risk score from 20 to 15 – September 2024.
COO	CRR 24-09	Primary Care	4 x 5 = 20 ⟷	12	Quality / Open <16	Quality, Safety and Experience Committee	Opened Feb 24, 6 actions identified, 5 progressing, with 3 revised due dates and 1 new action identified. 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	CRR 24-13	Timely Diagnostics	5 x 4 = 20 ⟷	5	Quality / Open <16	Quality, Safety and Experience Committee	Opened Feb 24, 7 actions identified, 6 progressing, with 2 revised dates, and 1 new action **Risk Score above tolerance set in risk appetite.**
EDoTH	CRR 24-14	Harm from the Medical Devices/ Equipment	4 x 4 = 16 ⟷	8	Quality / Open <16	Quality, Safety and Experience Committee	Opened Feb 24, 4 actions identified, all 4 progressing with revised due dates.
COO	CRR 24-19	Community Care Provision	4 x 5 = 20 ⟷	12	Quality / Open <16	Quality, Safety and Experience Committee	Risk reviewed Jan 2025, 10 actions identified, 5 actions completed, with 1 action progressing and 4 new actions identified. **Risk Score above tolerance set in risk appetite.**

EMD	CRR 24-20	Oncology Services	3 x 5 = 15 ⟷	9	Quality Open <16	Quality, Safety and Experience Committee	Risk approved Nov 24, 4 actions in total, 4 progressing.
COO	CRR 24-21	Ophthalmology Services	4 x 5 = 20 ⟷	9	Quality Open <16	Quality, Safety and Experience Committee	Risk approved Nov 24, 5 actions in total, 5 progressing. **Risk Score above tolerance set in risk appetite.**
COO	CRR 24-22	Orthodontic Services	4 x 4 = 16 ⟷	4	Quality Open <16	Quality, Safety and Experience Committee	Risk approved Nov 24, 4 actions in total, 3 progressing with 1 new action
COO	CRR 24-23	Vascular Services	5 x 4 = 20 ↑	12	Quality Open <16	Quality, Safety and Experience Committee	Risk approved Nov 24, 11 actions in total, 9 progressing with 2 new actions **Risk Score above tolerance set in risk appetite.**
COO	CRR 24-24	Renal Services	4 x 4 = 16 ⟷	12	Quality Open <16	Quality, Safety and Experience Committee	Risk approved Nov 24, 4 actions in total, 3 progressing with revised dates
EMD	CRR 23-25	Dermatology & Plastic Surgery Services	3 x 5 = 15 ⟷	9	Quality Open <16	Quality, Safety and Experience Committee	Risk approved Nov 24, 6 actions in total, 5 progressing, 1 new action
EMD	CRR 24-26	Urology Services	4 x 4 = 16 ⟷	6	Quality Open <16	Quality, Safety and Experience Committee	Risk approved Nov 24, 4 actions in total, 1 completed actions, 2 progressing and 1 action delayed.
COO	CRR 24-27	Neurodevelopmental Waiting List	5 x 4 = 20 ⟷	15	Quality Open <16	Quality, Safety and Experience Committee	Risk approved March 2025, 14 actions identified, 13 progressing with 1 revised date **Risk Score above tolerance set in risk appetite.** **Target score of 15 not in line with appetite**.

COO	CRR 24-28	Pharmacy Technical Services	4 x 5 = 20 ⟷	8	Quality Open <16	Quality, Safety and Experience Committee	New risk approved May '25. 4 actions identified, 1 completed. **Risk Score above tolerance set in risk appetite.**

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 Therapies and Allied Health Professions	EDoTH
Executive Director of Transformation and Strategic Planning	EDTSP
Chief Operating Officer	COO

Appendix 2 – Corporate Risk Register Report (May 2025) – Quality, Safety and Experience Committee

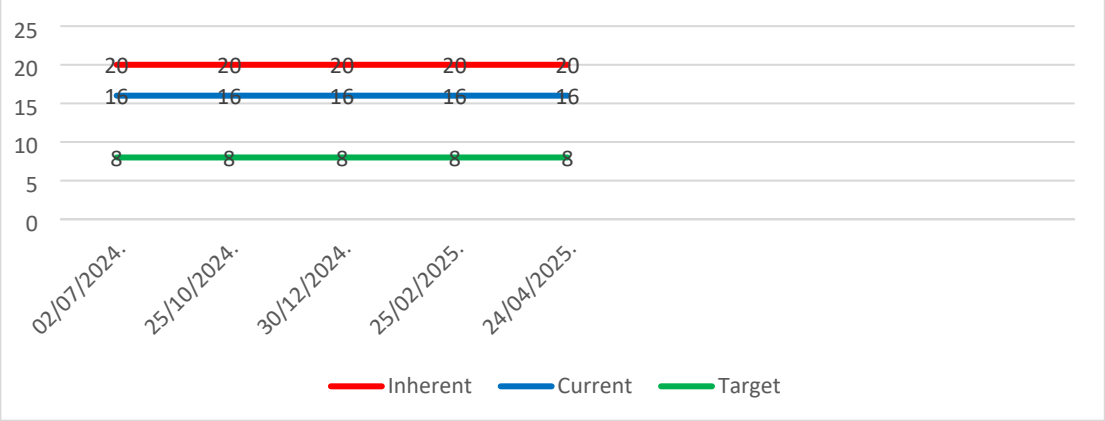
CRR 24-02	**Risk Title:** Patient Safety		**Date Opened:** 02/07/2024
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** 01/05/2025
Date Last Reviewed: 24/04/2025	**Director Lead:** Executive Director of Nursing and Midwifery	**Link to BAF**:	**Target Risk Date**: 30/09/2025
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.			

Mitigations/Controls in place	Additional Controls required
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, Improving Nutrition and Catering Standards , Safer 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 ,HAPUs Nutrition and Medicines safety 7. Incident management process including rapid reviews, focused reviews and learning panels. 8. All Staff induction, training and competency	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. Continued work on the 6 goals and Urgent and Emergency Care pathways to reduce the risk of patient safety Incidents. d. Continued work on the planned care delays and backlog harms reviews associated with long delays. e. Continued work with People services to ensue robust assurance measures are in place for our temporary workforce to ensure they have the skills and competencies required to maintain patient safety.

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. 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
Strategy for Increasing compliance with patient safety related mandatory training Positive Increase noted in both falls part a and b and manual handling and will be ongoing as 02 has just come on line as mandatory training. Action complete and will be ongoing as training will need updating and new starters will need to complete .	31/03/2025	Complete
Planned Care Programme board in place to monitor progress and improvements to reduce patient risk of harm	30/09/2025	New Action
Urgent & Emergency Care (UEC) & 6 Goal Programme Board in place to monitor and implement improvements in patient safety and reduce harm.	30/09/2025	New Action
Temporary Staffing assurance and improvement group in place let by the assistant director of people service	30/09/2025	New Action
Deliver all the actions from the Internal Audit of falls Combined HSE and Internal Audit action plan in place. Evidence compiled for action plan and submitted and reviewed at bi monthly to Falls Steering Group.	31/03/2025	Complete

Action closure as all actions completed and Internal Audit are revisiting the initial audit in Q1, any further identified actions will be included on the risk following review.



	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.

To support the planned target score improvement have been noted in the reduction of all open incidents , NRI and overdue NRI .Falls and HAPU as our highest number of incidents are on a reducing trajectory .
No Reg 28 or Never events have been reported in 2025.
Reduction in RIDDOR reportable incidents noted..

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:** 01/05/2025
Date Last Reviewed: 24/04/2025	**Director Lead:** Executive Director of Nursing and Midwifery	**Link to BAF**:	**Target Risk Date:** 30/09/2025

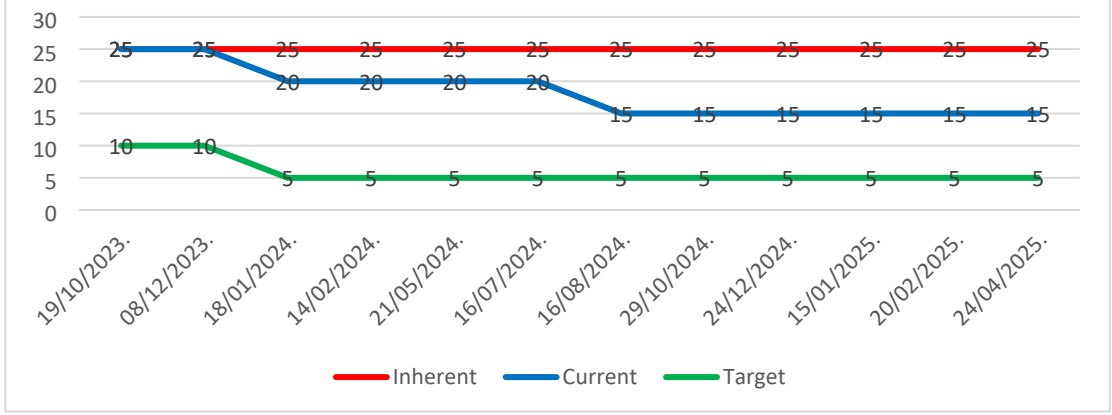
There is a risk that the Health Board could fail to meet requirements for **timely review and learning** from mortality cases, claims, inspections, incidents and complaints. This could be caused by insufficient resources, lack of unified processes, outdated IT systems, duplication of effort, and overreliance 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. Organisational Learning Forum (OLF) Betsinet shared learning page 13. Exec Oversight Group**:** This group provides strategic direction and high-level oversight for risk management, ensuring alignment with	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. Ongoing embedding and training 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.

organisational goals and adequate resource allocation. It also monitors and adjusts risk mitigation strategies. 14. Inquest Review Group**:** Focused on cases with significant adverse outcomes, this group conducts thorough investigations to recommend changes in policies and practices, ensuring accountability and transparency. 15. 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. 16. 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 May 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, 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, which has been finalised. The second app is due to be tested in early May with plans to be finalised end of May 25, with the final part of the Solution due to be complete early in mid to late june 25. 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.	01/06/2025 – delayed due to DDAT priorities	Delayed (Date Revised from 30/03/2025)
Implementation of the new/approved QMS assessment 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	Completed
Delivery of overdue LFER recovery plans by each IHC/Division to eliminate the overdue position	31/06/2025	Progressing

	Impact	Likelihood	Score
Inherent Risk Rating	5	5	25



Current Risk Rating	5	3	15
Target Risk Score	5	1	5
Risk Appetite	Quality		<16

Position & Intended Outcome for 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.

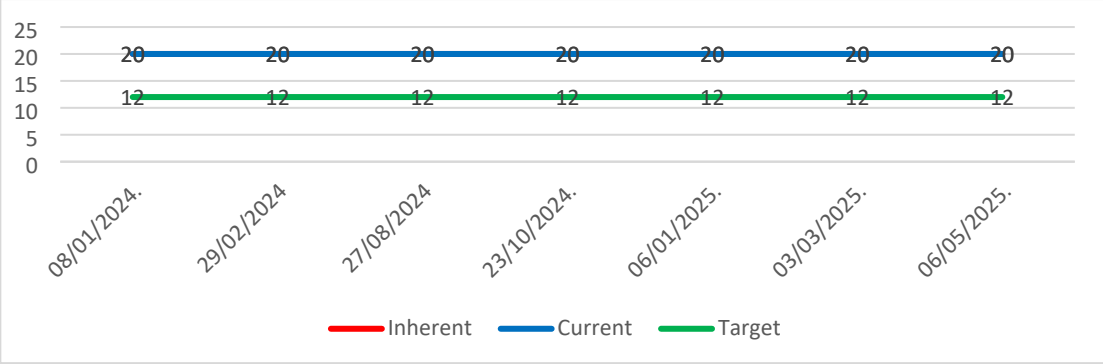
CRR 24-09	**Risk Title:** Primary Care		**Date Opened:** 08/02/2024
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** 01/05/2025
Date Last Reviewed: 06/05/2025	**Director Lead:** Chief Operating Officer	**Link to BAF**: N/A	**Target Risk Date:** 31/03/2026

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 governance framework, with 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	30/06/2025	Progressing

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.		
Implementation of recommendations from the National Strategic Programme for Primary Care. Workshop planned to review the recommendations and programme of work for 24/25 in April	30/06/2025	Progressing (revised date from 30/06/2024)
Primary Care Academy to utilise SPPC monies to further progress multi-professional working Work ongoing to develop local health board response to the national strategy and year 1 priorities as set out by HEIW/SPPC.	30/06/2025	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	30/06/2025	Progressing (revised date from 31/12/2024)
Deep dive / diagnostic into general dental and community dental services Report is with Executives for consideration	30/06/2025	Progressing
Ongoing review of current risk actions to be updated as per annual plan once finalised.	30/06/2025	New action



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

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

Position & Intended Outcome for 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.

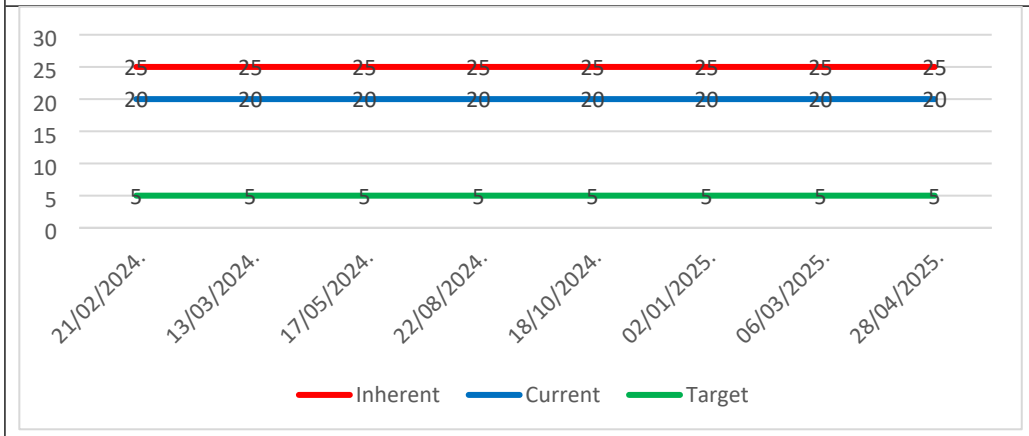
CRR 24-13	**Risk Title:** Timely Diagnostics		**Date Opened:** 21/02/2024
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** 01/05/2025
Date Last Reviewed: 28/04/2025	**Director Lead:** Chief Operating Officer	**Link to BAF**:	**Target Risk Date:** 31/12/2025

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 7. Diagnostic services have well embedded QMS (Quality Management System) systems for accreditation and regulation. Supporting the BCU QMS development with knowledge and learning 8. Endoscopy insourcing 9. OBC for PETCT/Nuclear Medicine consolidation approved by board and submitted to WG	a. Replacement of Radiology Informatics System (RISP) – implementation underway go live delayed till July 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 - Revision drafted and almost ready for wider consultation e. PHW Collaborative Executive group. f. Diagnostic Strategy for BCU needs to be developed g. Work commenced on new radiology staffing model for the identification of significant restructuring of the service with succession planning, career development, staff wellbeing etc.

10. Establish Diagnostics PTL group(s) from April 2025 to monitor performance across all diagnostic areas including all physiological measurement services	h. Complete demand and capacity reviews across diagnostic services to identify improvement plans i. Progression the development of the medical illustration service to support the teledermoscopy service j. Complete estates reviews for all diagnostic services, with prioritisation and progression of identified improvement projects k. Progression of Regional Diagnostics Hub project within the Planned Care Programme l. Progression of diagnostic business cases e.g. Endoscopy, Nuclear Medicine / PET-CT and Digital Cellular Pathology business cases m. Identify capacity for work focused on transformational change including opportunities for AI

Actions	Due Date	Progression Analysis
Replacement of Radiology Informatics System (RISP) – implementation with anticipated go live date of the 19/05/2025. Delayed till July 2025	01/07/2025	Progressing (revised date from 14/04/2025)
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
National Digital Cellular Pathology Business justification case for scrutiny / approval at Board and relevant committees	31/07/2025	New action
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	Overdue



	Impact	Likelihood	Score
Inherent Risk Rating	5	5	25
Current Risk Rating	5	4	20
Target Risk Score	5	1	5
Risk Appetite	Quality		<16

Position & Intended Outcome for 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:** 01/05/2025
Date Last Reviewed: 28/04/2025	**Director Lead:** Executive Director of Allied Health Professions & Health Science	**Link to BAF**: BAF 24-07	**Target Risk Date:** 31/03/2026

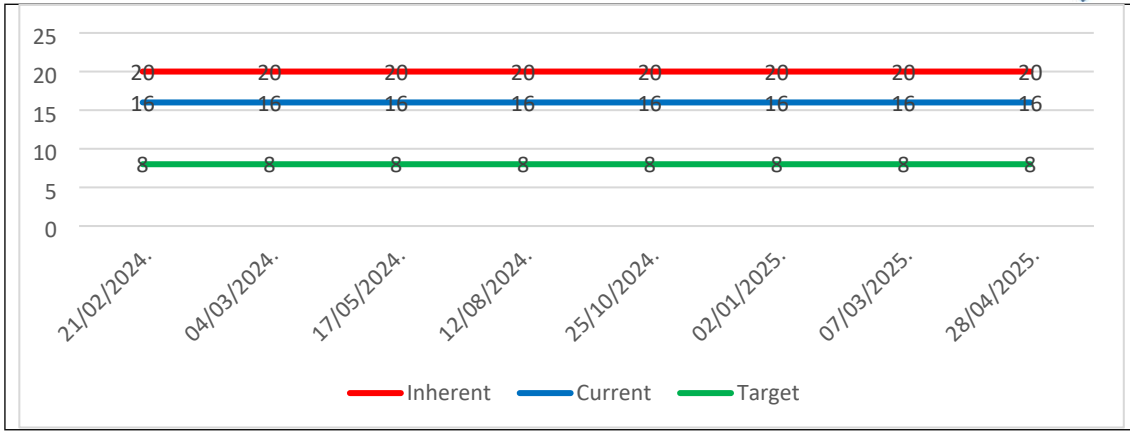
There is a risk of harm and infection from aging, **unsuitable** or unreliable **medical equipment** and devices. This could be caused by equipment breakdowns, **lack of replacement funding**, ineffective cleaning and **decontamination**, insufficient **staff training**, improper use and poor traceability. 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 Electric Biomedical Engineer Department (EBMD) 6. EBMD 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 to be taken forward as part of the 26/27 submission for capital bids. 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 Executive Director AHPS and Health Science 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 developed following review of current preparedness f. Review of the local medical devices groups governance and membership

9. External links with National Imaging and Pathology Diagnostic Programmes are documented and appropriately reported through correct channels to ensure transparency and potential benchmarking. 10. Working group assessing compliance with the Medical Devices Regulations and confirm governance arrangements for medical devices 11. Head of Clinical engineering appointed to oversee medical devices work 12. SES announced £30K for 25/26 for replacement of imaging equipment and also BCU Linac. The current round of the National Imaging Capital Equipment programme peer review took place in April BCU fully participating in this process 13. Start date of Head of Clinical Engineering agreed	

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)
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)
Long term management plans with equipment, regulation and compliance and discussions around improving governance	30/06/2025	Progressing
Audit of Medical Devices readiness of services to be completed	30/06/2025	Progressing

	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16



Target Risk Score	4	2	8
Risk Appetite	Open		<16

Position & Intended Outcome for 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. Intended outcome to ensure compliance and any gaps in medical device regulation supported by robust process for medical equipment capital replacement.

CRR 24-19	**Risk Title: Community Care Provision**		**Date Opened:** 01/05/2024
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** 01/05/2025
Date Last Reviewed: 15/04/2024	**Director Lead:** Chief Operating Officer	**Link to BAF**:	**Target Risk Date:** 31/03/2026

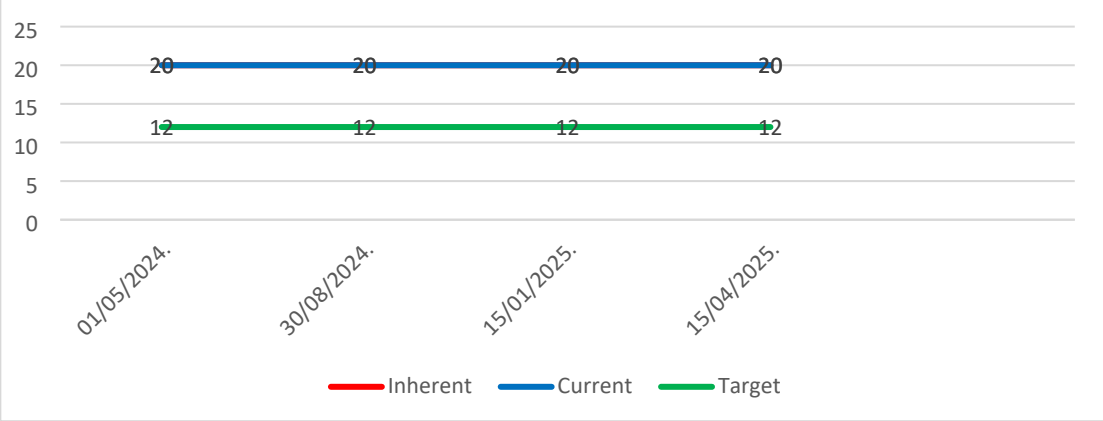
There is a risk that the Health Board may not be able to provide safe, effective and timely care to patients in the community, and the Health Board not fully meeting its obligation to commission and provide accessible and high-quality community care, D2RA, Care Home support services and continuing health care (CHC) services. This may be caused by insufficient provision of care in the community, the fragility of independent providers (domiciliary care and care homes), delays of joint assessments, staffing shortages and gaps in service provision out of hours.
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.
There is a risk that we cannot meet current and future requirements set out by the Care Action Committee and requirements within the Ministerial Priorities and enabling actions.

Mitigations/Controls in place	Additional Controls required
6. Daily patient flow meetings including focus on long-stay patients and partnership with Local Authorities 7. 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. 8. Community Resources Team model bringing together agencies and professionals supporting locality populations. 9. North Wales care homes single action plan overseen by Regional Commissioning Board and Regional Partnership Board. 10. Care home Quality Assurance Framework and tools in place 11. Established Continuing Healthcare (CHC funding) teams and processes including escalation where delays occur 12. Agreed joint escalation processes with Local Authorities for care homes of concern 13. 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.	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) community for teams. Connecting Care Implementation for community services. f. Financial systems that support transformative systems in line with Primary Care Model for Wales outcome 13. g. Improved joint planning with local Mental Health services.

	h. Improved planning for access to diagnostics in the community setting i. Community Care and CHC services audits of sustainability matrix ongoing periodically – Programmes to be put in place to undertake the audits j. Equity of resource to support community care and CHC transformation, innovation, management and governance. k. Improved discharge planning and support in line with All Wales good practice guidance, this is being taken forward by UEC workstream 4 l. Implementation of Pathways of Care Regional Action Plan m. Develop surge plans jointly with Local Authorities for winter pressures – did not happen to be progressed again. n. Complete pre-placement agreements with all providers and implement strengthened contract monitoring (Still Draft and currently being reviewed by Legal prior to engagement with providers) o. Undertake 'block purchasing' expressions of interest for specialist care e.g. OPMH

Actions		**Due Date**	**Progression Analysis**
1.	Primary Care Board established.	30/05/2024	Completed
2.	Community Care and CHC strategic plan to be drafted to inform the Health Board strategic plans, including block purchasing of specialist OPMH beds	30/09/2025	Progressing
3.	Escalation process in place for community hospitals, community nursing and Continuing Healthcare.	31/12/2024	Complete
4.	Programme management to be implemented to monitor and drive strategic priorities. Raised through 25/26 Ministerial Template process that programme management approach is required but not in place, a request has been made through the planning process for identified Executive Leadership and Programme Management Resource.	31/05/2025	New action
5.	Community Care and Continuing Healthcare services audits of sustainability matrix ongoing periodically – Audit programme already in place, this is now available to view on IRIS dashboard	31/03/2025	Complete
6.	Equity of resource to support community care and Continuing Healthcare transformation, innovation, management and governance. Value and Sustainability CHC Group established and will finalise priorities for 25/26. Complex, VFM & High Risk CHC panel established. Terms of Reference drafted – will meet fortnightly – focus will be on Packages of Care / Placements > 200k / annum	31/05/2025	New action
7.	Establish a health board group to agree a strategy, vision and aligned 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.	30/06/2025	New action

8.	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. 97 providers have now been successful and contracts will be issued on 11/3/25	25/04/2025	Completed
9.	Review of community services model and development of business case to address gaps in capacity. Linked to action 4.	31/03/2026	New action
10.	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	Complete



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	5	20
Target Risk Score	4	3	12
Risk Appetite	Quality		–<16

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.

The Ministerial Priorities referred to - Building Community Capacity.

CRR 24-20	**Risk Title:** Oncology Services		**Date Opened:** November 2024
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** 01/05/2025
Date Last Reviewed: 06/05/2025	**Director Lead:** Executive Medical Director	**Link to BAF**:	**Target Risk Date:** 31/03/2026

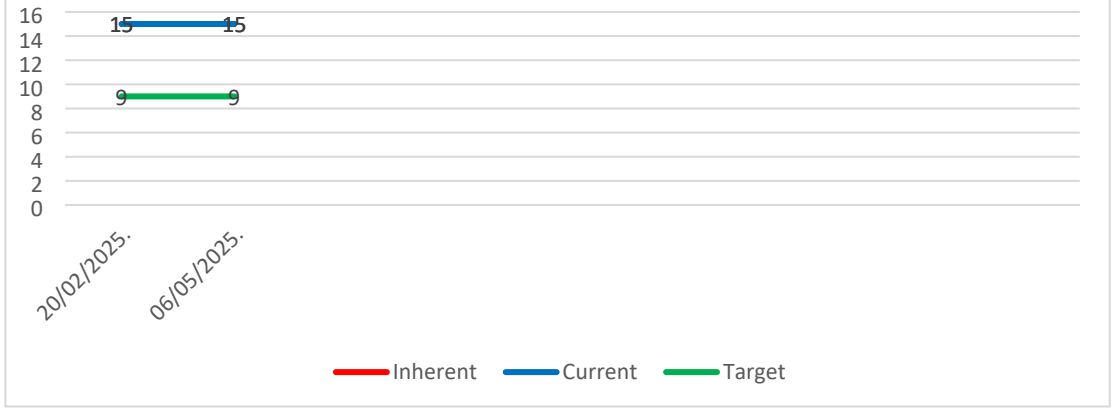
There is a risk that patients may not experience a safe, effective and timely Oncology service provided by the Health Board. This may be caused by reduced substantive medical workforce, demands for oncological care, increasing numbers of NICE approved treatments for cancer, and patients remaining within the service due to ongoing/long term oncological treatment. 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 (this would also release funding as VAT is exempt). 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**
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. Professor-level post agreed with medical school, job description awaiting approval from Royal College – position confirmed	30/08/2025	Progressing (revised date from 30/01/2025)
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. JSCC meeting arranged awaiting approval at Executive Leadership Team meeting	30/06/2025	Progressing (revised date from 30/04/2025
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 Initial conversations have happened with Clatterbridge but needs further executive to executive conversations – date to complete needs to be extended	30/08/2025	Progressing revised date from 30/04/2025)
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. Specific Oncology training for managing the waiting list has been undertaken; data quality issues regarding BANO has been resolved as backlog has been agreed to be removed by the 'robot'; plan to improve more data issues has been established for 25/26	31/03/2026	Progressing (revised date from 31/03/2025)

		Impact	Likelihood	Score



Inherent Risk Rating	3	5	15
Current Risk Rating	3	5	15
Target Risk Score	3	3	9
Risk Appetite	Quality		<16

Position & Intended Outcome for 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)
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.

Extreme risk within gynae, breast and upper GI remain as a result of unavailability of suitable locums and lack of capacity within current staffing. The highest risk is with the availability of a consultant to cover the medical oncology element of care to patients with a gynae cancer in East.

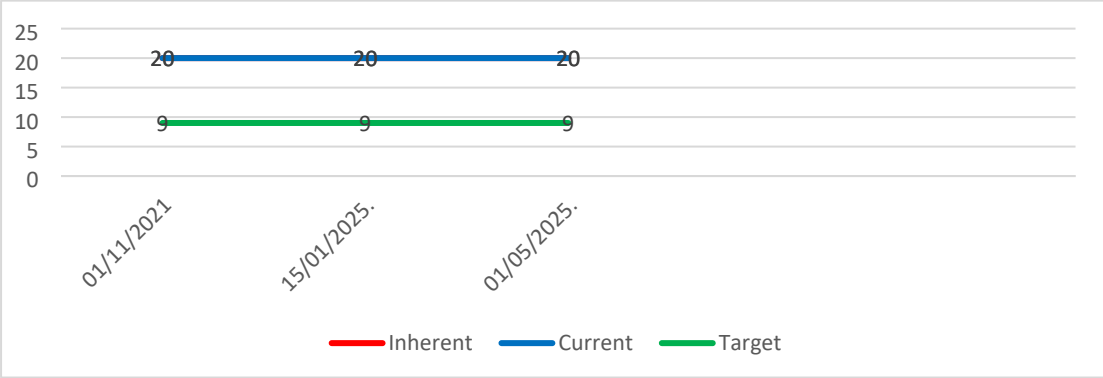
CRR 24-21	**Risk Title:** Ophthalmology Services		**Date Opened:** November 2024
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** 01/05/2025
Date Last Reviewed: 01/05/2025	**Director Lead:** Chief Operating Officer	**Link to BAF**: BAF24-07	**Target Risk Date:** 31/12/2025

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. Train and Treat embedded and successfully expanded to two site delivery (Deeside Glaucoma and Holywell Hospital Independent Prescribing: meeting delivery targets. 2. Outsourcing solution for cataract procedures in place. 3. Development of High flow lists for cataracts in place with West	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
b. Develop a Speciality Plan i for agreement through governance process. Workforce review component has commenced, to inform service redesign. Funding clarification for delivery being explored with Clinical Lead Operations. New date to be determined with COO.	31/07/2025	Progressing (revised date from 28/02/2025)
c. Delivery of High flow lists for cataracts embedded in West: with two lists with 8 patients consistently delivered/month. Delivery of 6 patients/list consistently achieved in East: with a working group supporting delivery of HVLC (7 per list) sessions. Central have a firm plan in place to deliver 4 lists / month, with 7 patients/list: to commence June 2025. Pathway currently being reviewed against All Wales pathway to inform short medium and long term improvement plan, initial draft delivered May 25: to be reviewed by Service Teams in Pan BCU Cataract Network by close of July 2025 .	31/07/2025	Progressing
a.To Appoint a Health Board Pan BCU Clinical Lead. The Office of Medical Director is progressing recruitment. (progression/funding clarification being explored with Clinical Lead Operations)	30/06/2025	Progressing (revised date

		from 31/12/204)
d. Develop a work programme for delivery of Speciality plan service design New date to be determined with COO. Operational workforce review key enabler commenced April 2025	31/08/2025	Progressing (revised date from 28/02/2025)
Reinstate Eye Care Performance resources ato prior funding levels reduced through RIGAII financial prioritisation. Funding clarification being explored with Clinical Lead Operations and Finance	01/07/2025	Progressing



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	5	20
Target Risk Score	3	3	9
Risk Appetite	Quality		<16

Position & Intended Outcome for 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+

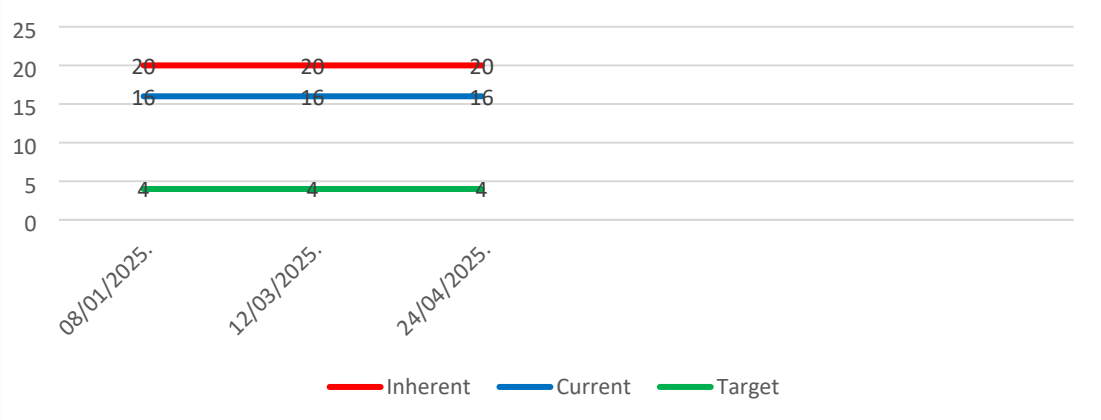
CRR 24-22	**Risk Title:** Orthodontics Services		**Date Opened:** November 2024
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** 01/05/2025
Date Last Reviewed: 24/04/2025	**Executive Lead:** Chief Operating Officer	**Link to BAF**:	**Target Risk Date:** 31/03/2026

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
Attempted but unsuccessful recruitment of Agency & NHS Locums – further attempt in progress 2025	31/09/2025	Progressing

Restorative Consultant re-advertisement	31/12/2025	Progressing
SBAR submission recommendation 2024: Continued procurement exercise to determine full treatment plan capacity with external providers-funding noted as available	31/12/2025	Progressing
GiRFT Recommendations following completion of the review. Report to be formally signed off by Health Board and to then implement the recommendations for service improvement.	31/03/2026	New action



	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

Position & Intended Outcome for 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:** 01/05/2025
Date Last Reviewed: 06/05/2025	**Director Lead:** Chief Operating Officer	**Link to BAF**:	**Target Risk Date:** 31/03/2026

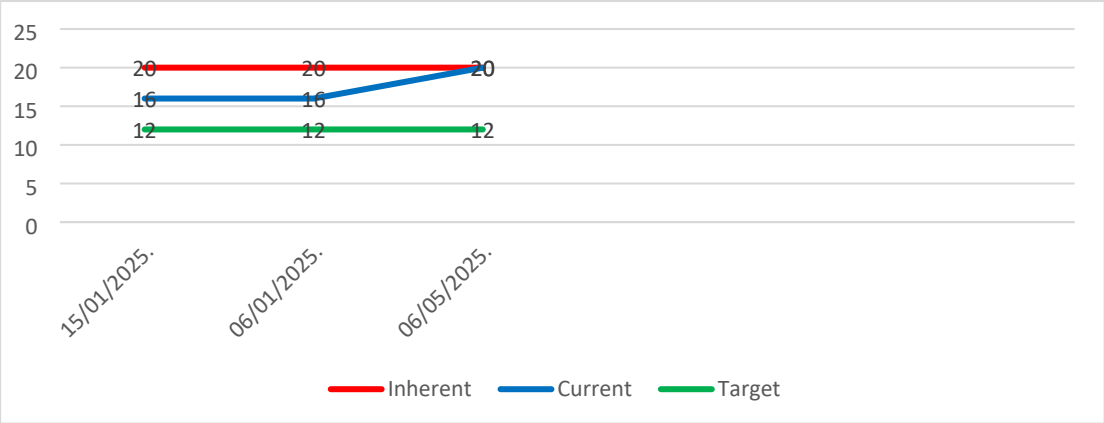
There is a risk that individuals may expeirence preventable harm and a poor experience whilst receiving care from the North Wales Vascular Service.This may be caused by current and projected future staffing challenges,a lack of capacity across the network a lack of clarity with regards secondary care and/ or end-to-end, vascular pathways, as well as the recent decision taken by HEIW to suspend FY1 trainees into the service from August 2025 This could lead to increased morbidity and mortality, poor quality of care, reduced quality of life, psychologcial distress, difficulties recruiting and retaining staff, difficulties in maintaining staffing levels, 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 9. Weekly Multi-Disciplinary Team meeting to allocate patients onto the waiting list and ensuring consultants are aware of patients that need	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

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 11. Ops teams seeking to recruit additional agency staff to cover absent FY1 posts from August 12. Close working with current FY1s to ensure positive experience during their time with the service 13. Introduction of a pan-BCU vascular theatre utilisation group	h. Development of Quality dashboard, to support improved use of service and outcome data i. Development of improvement plan to support return of FY1s into the service j. Introduction of a series of actions aimed at improving the culture and behaviour across the service

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	31/09/2025	Progressing (revised date from 31/03/2025)
Work with East IHC Medical Director to establish Local Vascular Delivery Group	31/07/2025	Progressing (revised date from 31/03/2025)
Review AAA surveillance protocol / pathway to ensure timely monitoring of persons with an AAA not identified by Welsh Abdominal Aortic Aneurism screening programme.	31/07/2025	Progressing (revised date from 31/03/2025)
Strengthen information, advice and support provided to people turned down for AAA repair, and ensure 'register' of persons turn down is maintained	30/07/2025	Progressing (revised date from 30/05/2025)
Implement quarterly quality audit tool to enable network to proactively identified areas for improvement	31/07/2025	Progressing (revised date from 31/03/2025)
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	31/03/2026	Progressing
Build pan-BCU and local quality dashboard to support improved use of service and outcome data	30/03/2026	Progressing
Development of improvement plan to support return of FY1s into the service	30/03/2026	New action
Introduction of a series of actions to support improvements in culture and behaviour within the service	30/06.2026	New action



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

Position & Intended Outcome for 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:** 01/05/2025
Date Last Reviewed: 06/05/2025	**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 (WLI) request to facilitate additional theatre lists, in order to reduce current backlog Continue to undertake additional lists and WLIs to help reduce backlog	30/08/2025	Progressing (revised date from 30/12/2024
Undertake Workforce review across entire Service to ensure equity across the Region	30/08/2025	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
Work with new Locum consultants to ensure cover for any vacant theatre lists and clinic sessions	30/05/2025	Progressing

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

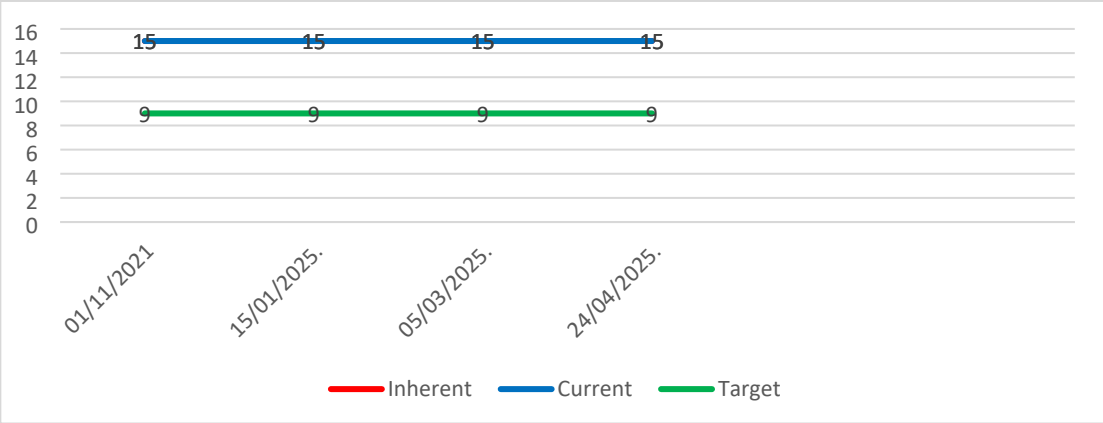
CRR 24-25	**Risk Title:** Dermatology and Plastic Surgery Services		**Date Opened:** November 2024
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** 01/05/2025
Date Last Reviewed: 24/04/2025	**Director Lead:** Executive Medical Director	**Link to BAF**: BAF24-07	**Target Risk Date:** 30/07/2025

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) 6. Appointment of Specialty Managerial Lead to take forward service redesign. 7. Increased treatment capacity through the insourcing contract and appointment of further locum commenced in East.	a. Support for the Clinical Leads in Dermatology as part of a single Dermatology Service for North Wales b. Funding for Minor Operating Procedure capacity to support expansion of Teledermoscopy. c. Expanded GP with Special Interest Model for referrals to Secondary Care. d. Service Level Agreement between Partner Organisations. e. Additional dressings clinics to address current variation across North Wales.

Actions	Due Date	Progression Analysis
Dermatology - Maintain support for the Clinical Leads in Dermatology as part of a single Dermatology Service for North Wales. Monitoring BAU.	30/06/2025	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	30/06/2025	Progressing
Plastic Surgery - Implement additional dressings clinic to address current variation across North Wales	01/07/2025	Progressing
Specialty Managerial Lead to lead on redesign of Service Away afternoon scheduled for June 2025 to begin discussions on redesign	01/07/2025	New action



	Impact	Likelihood	Score
Inherent Risk Rating	3	5	15
Current Risk Rating	3	5	15
Target Risk Score	3	3	9
Risk Appetite	Quality		<16

Position & Intended Outcome for 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.

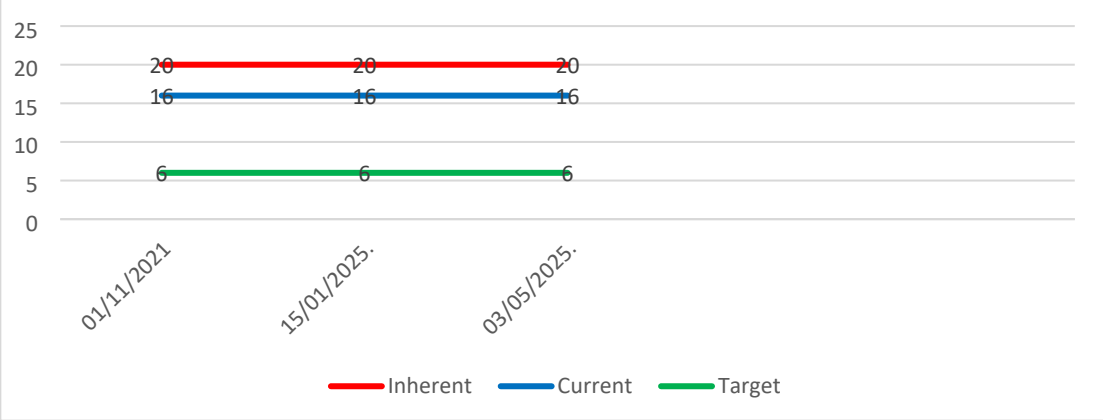
CRR 24-26	**Risk Title:** Urology Services		**Date Opened:** November 2024
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** 20/02/2025
Date Last Reviewed: 05/03/2025	**Director Lead:** Executive Medical Director	**Link to BAF**: BAF24-07	**Target Risk Date:** 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 network 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. (*Delayed due to SRO and Network manager unplanned absence).*	01/04/2025	Delayed

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



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

Position & Intended Outcome for 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

CRR 24-27	**Risk Title:** Neurodevelopment Waiting List		**Date Opened:** 02/05/2024
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** 01/05/2025
Date Last Reviewed: 01/05/2025	**Executive Lead:** Chief Operating Officer	**Link to BAF**:	**Target Risk Date:**02/05/2027

There is a risk that the Health Board may not meet the target set by the Welsh Government (WG) for Neurodevelopment (ND) services which requires that 80% of assessments commence within 26 weeks of the date of referral. Currently Children and young people referred into the service now will not be seen (not assessed) before their 18th birthday. This could be caused by an increase in demand on the service without the support and funding to increase capacity within the team. This may lead to children and young people not being assessed in a timely manner.

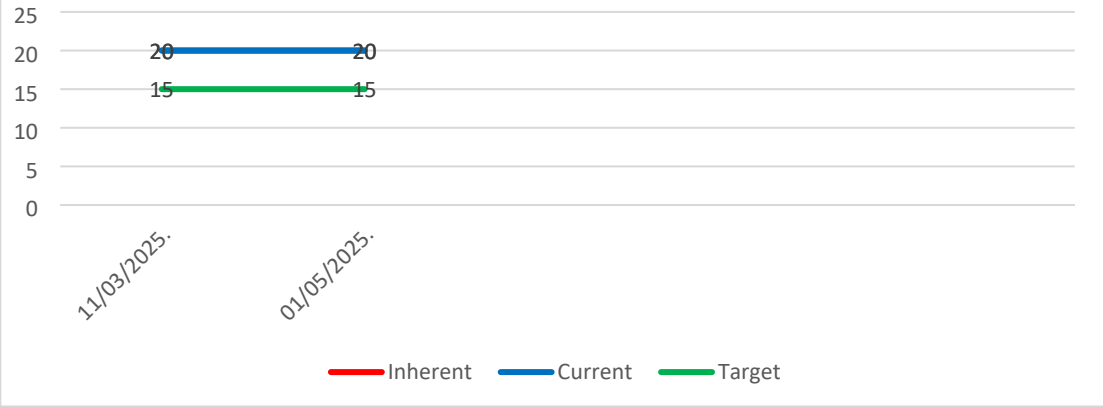
Mitigations/Controls in place	Additional Controls required
1. BCUHB transformation programme commenced, and a full programme of work has been developed to support the move to a needs led service. 2. Welsh Government have issued short term funding to support longest waiters on the list, the service are looking to staff overtime, Agency staff and waiting list validation.	1. Programme Manager essential for delivery of revised service model – only approved until end June 25. 2. Support from external stakeholders (Schools, Local Authority and Third sector) for a new service model to implement significant change. 3. The National work programme needs to be implemented at pace with the recognised changes required in BCUHB. 4. Profile of Needs Training has commenced with Conwy and Denbighshire Local Authorities to support Children on the waiting list and will be rolled out to all local authorities as their capacity allows. 5. Recurrent funding is required to allow the team to recruit to substantive posts and funding often given with short notice/time limited with specific aim, such constraints become difficult to navigate. 6. Approval of a Business case to support additional staffing structures, and support the improvement programme. 7. Greater engagement with external stakeholders such as schools and upskilling staff. 8. An agreed current plan to address the backlog waiting list, excessive backlog would require £20m* investment based on current model (e.g. if outsourced). 9. A consistent Executive Director to lead on ND challenges

	10. The Regional Partnership Board workshop in March 2025 will produce short, mid and long term actions with regards to providing support, information and advice for those both on the waiting list and those at early identification. This will include support from Third Sector, Local Authority and Education colleagues. 11. Agree a transfer policy for Children and young people approaching 18 - to Adult Mental Health Services/Integrated Autism Service . 12. Development of a new prudent assessment to standardise the process and align to best practice. The prudent assessment process will allow all assessment processes to be streamlined and aligned across the Region and reduce inequity. 13. The ND services across the Region have an approximate workforce of 70 staff including Clinical and Non-clinical which is in adequate to support the demand on the service. However, additional staffing would not be supported by the current Health Board Estate. 14. A single digital information system in place to support the sharing of information across teams eg ND teams, CAMHS, Therapies, Education, Social care 15. The Health Board compliance against the Welsh Government 26 week target currently stands at 11% against the target of 80 %

Actions	**Due Date**	**Progression Analysis**
The Regional Partnership Board have agreed to prioritise ND services for 2025-2026 as part of their work plan. The ND programme team are working with the Regional Partnership Board and wider stakeholders eg schools, Local authorities and Third Sector to agree a cohesive way of working to support Children and Young People on the waiting list	**31/03/2026**	Progressing

Work with one Local Authority to train staff to undertake profiling for children on the waiting list. This will provide support for Children, young people and their families whilst waiting for assessment. This will be a pilot project with Ynys Mon and further roll out with other local authorities as they have capacity to support the process. The aim would be for all local authorities to be trained in profiling by March 2026.	30/06/2025 (pilot) March 2026	Progressing
Agreement and production of a new draft service model with key partners to promote a whole system approach embedded within a social model of disability that focuses on changing attitudes, environments and systems in collaboration with all stakeholders..	30/04/2026	Progressing
Commence implementation of a new service model to support CYP with early support and intervention. This should reduce referral numbers	31/03/2028	Progressing
Development of agreed Transfer policies between Child and Adult Services to provide support and timely assessment for those moving into adulthood.	31/03/2026	Progressing
Maintain close working relationships with the National Programme of work and the Regional Partnership Board to ensure a consistent approach to whole system approach.	31/03/2026	Progressing
Ensure recommendations from the National event in Lampeter are reviewed and implemented as necessary following their release from Welsh Government. Actions will be measured and reviewed	31/12/2025	Progressing
Submission of Business case to support key roles including the programme and operational staffing (Clinical Lead). Approval will be required by the Health Board	30/07/2025	Progressing
Validation of current waiting list (waiters over 3 years) to ensure all patients wish to remain on the list. Currently 600 patients on the long waiters list.	30/06/2025	Progressing
Identification of an Executive Lead for the service to support the programme of work	31/05/2025	Progressing
Implement new prudent assessment process to decrease the length of the process and provide a more streamlined process for CYP and their families. Revised assessment processes are currently being identified by our Clinical Leads	31/07/2025	Progressing
Stratification of the waiting list to identify those at greater risk and agree their prioritisation. It is envisaged that this work will support those most in need and allow a more timely assessment.	30/09/2025	Progressing
Approval of waiting list options paper by ND Strategic Improvement and Development Group. Prudent assessment (streamlined processes aligned to NICE guidance) options will be measured during the monthly performance meeting.	30/05/2025	Progressing
Funding is being used from Welsh Government to support pilot projects, with the aim to develop new ways of working, increase capacity/support for Children and Young People on the waiting lists. All projects are currently undergoing evaluation via the Regional Partnership Board and findings are expected by the end of April for approval to continue funding in 2025/2026	30/06/2025	Progressing (revised date from 30/04/2025)

	Impact	Likelihood	Score
Inherent Risk Rating	5	4	20
Current Risk Rating	5	4	20



Target Risk Score	5	3	15
Risk Appetite	Quality		<16

Rationale for Corporate Risk

Waiting list time approaching 20 years for new referrals based on current capacity, with an average monthly capacity gap of approximately 200 assessments. A key ministerial priority for 2025/26 is to deliver an improvement in the target compliance rate to 15% by Q4, for which additional investment will be required. The pressures on the ND waiting list are national with no Health Board in Wales meeting the WG 26-week target, BCUHB are currently the second worse performer against the target.

There was a significant increase in demand during the Covid pandemic with accepted referrals rising by 130% from 20/21 to 22/23 , and a further increase of 43% in accepted referrals from 22/23 to 23/24. – Year to date in 24/25 accepted referrals are 10% lower partially due to demand management initiatives implemented

The ND waiting list is forecast to be over 7,000 by the end of March 25.

Whilst the target date for this risk is identified as 2027, it must be noted that delivery of a supported and sustainable service will not be achievable within this timescale due to current capacity, funding and support required from external partner organisations. The above actions have been identified to support the mitigation of the current risk.

Appendix 3 – Newly escalated risks – Quality, Safety and Experience Committee (QSE)

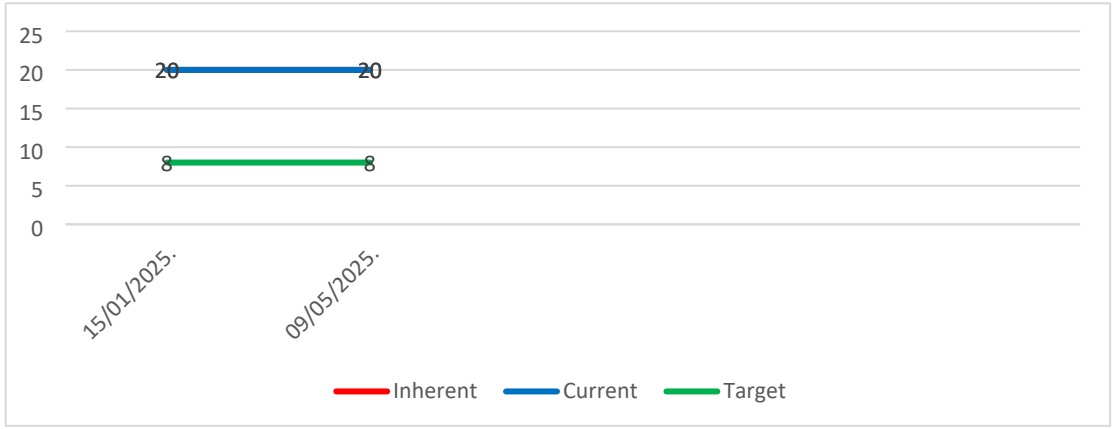
CRR 24-28	**Risk Title: Pharmacy Technical Services**		**Date Opened:** 15/01/2025
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** New Risk
Date Last Reviewed: 09/05/2025	**Executive Lead:** Chief Operating Officer	**Link to BAF**:	**Target Risk Date:** 01/01/2026

There is a risk that Pharmacy Technical Services for the delivery and the preparation of high risk injectable medicines including chemotherapy, radiotherapy, total parenteral nutrition for adults and babies at BCUHB will fail to maintain operational capacity and regulatory compliance.
This could be caused by increasing demand for aseptic products, with each unit currently operating above capacity, exacerbated by pandemic recovery demands, workforce shortages, and escalating regulatory requirements.
This could lead to significant patient safety risks, delays in treatment, regulatory intervention or Service restrictions and unit closures.

Mitigations/Controls in place	Additional Controls required
1. Capacity monitoring through a validated model assessing daily workload against workforce and facility resources. 2. Existing quality management systems, including validation and documentation control. 3. Monitoring of incidents, errors, near misses and complaints through the departmental quality management system and Datix 4. Monitoring and oversight of key performance indicators and escalating concerns through senior leadership teams. 5. Reallocation of resources to prioritise high-risk areas such as Systemic Anti-Cancer Treatments (SACT), radiopharmaceuticals, and ready-injectable medicines. 6. External validated monitoring arrangement. Medicines and Healthcare products Regulatory Agency (MHRA) inspection for the MHRA licensed unit at Wrexham Maelor Hospital and National Quality Assurance audits for all three units. 7. Limited outsourcing of products scoped and implemented to reduced demand.	a. Further workforce controls required. Current workforce levels are below requirements, with all units operating above the recommended 70-80% capacity. Appropriate workforce levels will be put in place to meet demand from a production and regulatory perspective once funding has been approved. b. Appropriate investment in quality assurance and regulatory compliance roles to ensure gaps in regulatory compliance are closed to further control the risk. This will reduce the risk of regulatory intervention or closure of units. c. Increasing the range of outsourced products and ensure there is a robust process and infrastructure in place to manage them efficiently. d. Delays in recruitment causing a gap in control. Delays due to protracted processes and lack of training for specialised roles. The significance of vacancies in relation to capacity, service failure and regulatory compliance will be escalated appropriately to ensure the recruitment process is as efficient as possible and the vacancies will be prioritised. e. Current contingency plans are inadequate (Business Continuity) to address immediate regulatory non-conformances and meet increasing demand which leads to failure to deliver services. The contingency plans will be reviewed to ensure they are fit for purpose.

Actions	Due Date	Progression Analysis
C: Outsourcing: Scale up existing outsourcing of selected injectable medicines to reduce capacity stress. This includes procurement of individual patient doses of injectable systemic anti-cancer treatment and batch produced special licensed aseptic products and over-labelled/pre-packaged medicines. Develop KPIs and workload statistics to demonstrate the increase, maximise efficiency, economy of scale and monitor performance and report into Pharmacy IHC senior management meetings.	August 2025	Progressing

A & D: Workforce Expansion: Recruit and onboard additional staff through a phased plan over three years, targeting critical gaps in production, quality assurance, and regulatory roles. Timeline: Initiate recruitment in Q1 2025/26; Completion date October 2025	Oct 2025	Progressing
E: Governance Improvements: Review and update contingency (business continuity plans) for technical services across BCU to ensure they are fit for purpose. This will be included together with capacity, key equipment status, service demand and risk of service failure in technical services Quality meetings as standard agenda items on a monthly basis. Monthly KPI reports for the service and any issues concerning risk to service delivery will be escalated through the Directors of Pharmacy. Any immediate risks will be escalated appropriately. Timeline: Immediate changes to Quality meeting agenda and include in monthly reviews starting June 2025.	June 2025	progressing
B: Regulatory Compliance Investment: Strengthen quality management systems and address gaps identified during audits and escalate if any concerns with achieving compliance	May 2025	Complete



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

Rationale for Corporate Risk

BCUHB) three pharmacy aseptic units based at each district general hospital have been operating above capacity, exacerbated by pandemic recovery demands. This has created a high-risk environment for regulatory compliance and patient safety. Year-on-year activity increases by 10%. Re-prioritisation of resources has led to reduced services for adult/children's wards and batch manufacturing lines. Output constrained by staffing and resource limitations. Products produced facilitate maintaining hospital patient flow via quicker discharge in high turnover areas (note circa 100% increase in activity over Winter 2023/24).

Agenda Item
6.2.1

Joint Commissioning Committee

Quality Safety and Outcomes Sub-Committee Highlight Report

Dyddiad y Cyfarfod / Date of Meeting	20/05/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Maxine Evans, Interim Corporate Governance Officer
Cyflwynydd yr Adroddiad / Report Presenter	Mandy Rayani, Lay Member
Noddwr yr Adroddiad / Report Sponsor	Carole Bell, Director of Nursing and Quality

Pwrpas yr Adroddiad / Report Purpose	For Noting Choose an item.

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
N/A		Choose an item.

1. SITUATION/BACKGROUND

This report had been prepared to provide a summary of the key issues considered by the Joint Commissioning Committee Quality, Safety and Outcomes sub-committee at its meeting on 31 March 2025.

Key highlights from the meeting are reported in Section 3.

2. PURPOSE

The Purpose and Role of the Joint Committee and the sub-committees are set out in Paragraphs 2.18 and 2.20 of the JCC Standing Orders.

The Quality and Safety Outcomes Committee Terms of Reference can be found here.

3. HIGHLIGHT REPORT

RAG Rating	Highlight
Alert / Escalate	• Members commented on the importance of developing a video tour for the Mother and Baby Unit and agreed to highlight this in the Chairs report, and to provide feedback to the HB that provides this service.
Advise	• Members were advised that further work was being undertaken on the Quality Newsletter to align it with the JCC communications strategy. This was close to being completed and will be referred to as a Quality Bulletin. • Members received an update on the escalation status of the Paediatric Critical Care Unit (PCCU) and the Neonatal Intensive Care Unit (NICCU) at the Children's Hospital for Wales. The following points were noted: ○ Improvements in the governance structure including key appointments and regular meetings to ensure clearer oversight and accountability. ○ Introduction of a dashboard to accurately capture activity and cot availability. ○ Key improvements demonstrated in neonatal mortality and national benchmarking in areas such as retinopathy, prematurity screening and infection rates. ○ Positive feedback from patient and families highlighting the improvements in care and the importance of ongoing work to maintain these improvements. ○ Clear expectations and requirements for de-escalation improved understanding of what was being asked and once established the service was able to provide the necessary information and assurance. • Members received the Welsh Kidney Network (WKN) report which provided a briefing on the current Quality and Patient Safety issues within the WKN commissioned services. The following points were noted: ○ Oxa 48 e-coli infection identified on a kidney ward and the challenges related to this outbreak. Although this primarily affects kidney patients, it may become a broader infection control concern. It was noted that the environment had been a contributing factor. An

RAG Rating	Highlight
	infection prevention and control meeting is arranged to discuss and agree a consistent approach across Wales. o The WKN meetings with the three providers of BCUHB, CVUHB and SBUHB and how the wider JCC will be made aware and kept informed of this issue. This would be highlighted in the QSO Chairs report to the JCC. o The diversity of dialysis providers and whether this poses any challenges in terms of applying a uniform approach to protocols and standards. It was confirmed that the renal community work very closely, sharing clinical input and that infection prevention and control issues are driven by the clinical teams within the renal centres. • The Director of Commissioning for Specialised Services provided updates on various specialist services including: o The continued challenges in engagement with Salford Royal Hospital obesity services. This will continue to be escalated. Meanwhile, additional capacity has been secured in South Wales. o Improvements in plastic surgery waiting times, the data for March 2025 was still pending, but the target of 104 weeks is likely to be achieved. There was insufficient capacity to make any significant in-roads into achieving 52 weeks targets. o Prostate-Specific Membrane Antigen (PSMA) due to the ongoing production challenges with Positron Emission Tomography Imaging Centre (PETIC) in CVUHB. A clinical update was provided advising that undertaking clinical revalidation with all the PMSA PET requests has been agreed with a view to shared decision making, noting that these scans were not mandated according to NICE guidance, therefore, the suggested triage involves categorising patients into high, intermediate, and lower risk groups. This positive progress was welcomed. o South Wales Specialist Auditory Implant Device Service and the continued lack of progress. This will form part of a broader conversation however there was an action plan in place and the requirements were more visible. • A report for the Commissioning for Ambulance and 111 services was received. The quality and safety dashboard, which includes high-level reports on quality domains was highlighted. In addition: o The establishment of a new clinically led 'National Ambulance Patient Handover Improvement Implementation Group.' The work of this group will be

RAG Rating	Highlight
	a key enabler in supporting the JCC in reducing its emergency ambulance services associated risks around utilisation of capacity. ○ The new ambulance performance framework and introduction of new categories was noted which included a purple category for incidents of cardiac and respiratory arrest. ○ High rate of 111 call abandonments and whether the service can cope with demand. The JCC has yet to assess whether it provides sufficient or effective call handling and clinical capacity as a formal strategic demand and capacity review of the 111 system has not yet been conducted. A detailed analysis of the GDPR breaches within the Ambulance and 111 report was requested to understand the causes. ○ A deep dive on Ambulance services, including a patient story, was scheduled for June 2025 where several issues can be addressed. • The Director for Mental Health and Vulnerable Groups report was presented. The following points were highlighted: ○ Improvements in High Secure services through the introduction of positive interaction program (PIP) at Ashworth, reducing long-term segregation numbers, noting that Broadmoor and Rampton were implementing similar strategies. ○ Environmental issues at Caswell Medium Secure Unit and Ty Llewellyn, including lack of seclusion facilities. SBUHB has appointed an independent assessor to undertake an independent review of their mental health services. The JCC needs to stay cited on the work of this review to help with informing strategic commissioning decisions. ○ Inpatient numbers have risen within eating disorder services. Noting ongoing discussions to enhance gatekeeping processes. ○ Plans for two newly commissioned perinatal beds for North Wales patients located in Chester, by October 2025.
Assure	• Members heard a story from a patient's specific experience of the Tonna Mother and Baby Unit stating the challenges she faced as a mother with physical health disabilities. It was noted that the Unit worked hard to address the environment and accessibility issues and the staff's willingness to listen and adapt. To minimise anxiety for patients, the Unit is now planning to produce booklets with

RAG Rating	Highlight
	photographs of the unit and to introduce phone calls between staff and patients prior to admission to discuss and prepare for their stay. A video tour was also planned, however due to resources this has not been possible. The Chair thanked her for her sharing her personal story and wished her well for the future. • Members received the risk register as at 31 January 2025, highlighting the risks relating to the Quality Safety and Outcomes assigned for monitoring and scrutiny purposes. The following areas were highlighted: o Cardiac Device Services, the Chair inquired whether this risk was specific to North Wales or if it represented a broader issue concerning engagement within the service. It was clarified that the service was safe, and the engagement issues relate to the provider. The risk was likely to be resolved by the next meeting. o Paediatric Intensive Care Beds and Neonatal Infection Control which had been covered in the earlier presentation. Whilst these remain on the Risk Register as risks scoring 20, these should also be updated by the time of the next meeting. It was noted however there appeared to be some underlying issues that could be related to the environment. The infections rates appeared to be higher than national averages despite good compliance with infection control measures. o Neurosurgery Sustainability, noting that this risk had been de-escalated from 16 to 8. It was queried if this was premature as the funding had been allocated but the overall sustainability of the service was dependent on successful recruitment. The matter around when a risk is mitigated from a commissioner perspective and becomes a provider risk/issue was discussed. It was suggested that this topic could be addressed in a JCC strategy session since the JCC still needed to conclude their discussions around risk appetite. o C&VUHB Neurosciences Staffing issues/level was queried as the description around the risk being addressed by the rehabilitation strategy was due for consideration by the JCC in Quarter three 2024/2025 but this has now passed. It was agreed to review this outside of the meeting and provide an update at the next meeting.
Inform	• The forward plan of business for the next twelve months was presented noting that it was a work in progress and would be used to support Agenda planning for future meetings.

RAG Rating	Highlight
	• A report outlining recent incidents and concerns reported to the JCC from provider and commissioned services covering the period January 2025 – February 2025 was received. • An update on the Regulator Report (Healthcare Inspectorate Wales (HIW) / Care Quality Commission (CQC) regulatory activity was provided noting the ongoing collaboration with HIW to improve reporting and assurance processes.
Appendices	None

4. ASSESSMENT

Objectives / Strategy	
Dolen i Amcan (au) Strategol CBC Link to JCC Strategic Objectives(s)	Improve Equity and Population Health Ensure Quality
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A More Equal Wales
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Whole-systems Perspective If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality**	Person Centred If more than one applies please list below: Equitable

(*Duty of Quality Statutory Guidance (gov.wales)*)	
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: N/A
Cydraddoldeb *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /* **Equality** *Have you undertaken an Equality Impact Assessment Screening?*	Yes: ☒	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE	If no, please include rationale below: N/A
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Joint Committee as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

5. RECOMMENDATIONS

The Joint Committee is asked to:

- **Note** the highlights outlined in Section 3 of this report.

Cyfarfod a dyddiad: **Meeting and date:**	Quality, Safety & 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:

1st May 2025

- Confidential Quality Report

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
27.03.25	Action from Board	Board	**Learning & Embedding Change**	It was suggested that learning and embedding change is reviewed in more detail by the QSE Committee (This was discussed as part of the Integrated Performance Report discussion)	Executive Director of Nursing & Midwifery **(Angela Wood)**	Pam Wenger Caroline Turner Angela Wood	TBC	
30.04.25	Sree Andole/ Jo Shillingford	Sree Andole	**Clinical Audit Improvement Plan**	To be discussed at QSE, once approved by Execs.	**Jo Shillingford**	Sree Andole	July 2025	
30.01.25	Board Meeting 30.01.25	Chair	**25/09.01 Citizens Engagement Report**	Patient Experience to be discussed at a QSE Committee Development Session.	Head of Corporate Affairs **(Philippa Peake-Jones)**	Pam Wenger	March 2025 Development Session	
30.01.25	Board Meeting 30.01.25	Chair	**25/09.03 Citizens Engagement Report**	A briefing on the new legislation due to be issued, to be discussed at a future QSE Committee.	Head of Corporate Affairs **(Philippa Peake-Jones)**	Pam Wenger	May 2025	
30.01.25	Board Meeting 30.01.25	Chair	**25/15.1 Improving Quality Report**	QSE Committee to review patient feedback data and discuss how this can be addressed to provide longer term solutions to improve performance.	Head of Corporate Affairs **(Philippa Peake-Jones)**	Pam Wenger	May 2025	
20.2.25	QSE Meeting 20.2.25	Chair	**QS25/07.1** Integrated Quality Report	The Committee to review the Clinical Audit as a substantive item.	Interim Executive Medical Director **(Sree Andole)**	Interim Executive Medical Director **(Sree Andole)**	March 2025 Development Session	
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	Add Llais Experience paper to CoB annually, in February.	Head of Corporate Affairs **(Philippa Peake-Jones)**	Director of Governance **(Pam Wenger)**	May 2025	**10.03.25** Added item onto COB.
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	**Dec 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 / Executive Director of Nursing & Midwifery	Monitoring of Patient safety & experience	Arrange for QSE Committee workplan to include monitoring of patient safety and experience across EDs reporting	Director of Corporate Governance (**Pam Wenger**) / Exec. Dir. of Nursing & Midwifery (**Angela Wood**)	Director of Corporate Governance **(Pam Wenger)**	February 2025	

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	**Feb 2025** Added to 20.02.25 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 a Development session.	Executive Director of Nursing & Midwifery	Executive Director of Nursing & Midwifery	~~March 2025~~ March 2026	**17.3.25** Leon Marsh confirmed that guidance still in draft, with no further updates. Current schedule being embedded is Dec 25.
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 July 2025 September/November	**17.3.25** Added to May 25 agenda. Lois asked for it to be removed and split into 2 separate items – 1st part in July (Pharmacy &

								Medicine Mngt in either Sept/Nov 25). **18.6.25** Controlled Drug Accountable Officer report on July's Private Agenda.

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MONTHLY REPORT: REGIONAL ACTIVITIES >NORTH WALES<

Reporting period: (May, 2025)

CONTENTS

HEADLINES

No. engagement activities	No. visits	No. consultations	No. service changes	No. representations	No. open advocacy cases	No. people engaged with
22	0	0	2	9	284	185

NETWORKS

Partners engaged with this month:

Partner name	New partner (Y/N)	Existing partner (Y/N
Betsi Cadwaladr University Health Board	N	Y
Carers Outreach	N	Y
Caniad	N	Y
Mind the Gap	N	Y
Rape and Sexual Abuse Support Centre (RASASC)	N	Y
Tenovus	N	Y
Royal British Legion	N	Y
Ministry of Defence	N	Y
One Voice Wales	N	Y
HIW	N	Y
Conwy County Borough Council (CCBC)	N	Y
North Wales Regional Partnership Board (NWRPB)	N	Y

REGIONAL ACTIVITIES

>NORTH WALES< ENGAGEMENT ACTIVITIES

(Engagement activities include hosting events or workshops, attending partner events/networks, meetings, profile raising activities, information sharing and promotion of Llais.

NOTE: new sections below for entering Visits and Representing Llais at formal meetings)

No. relating to health	7
No. relating to social care	0
No. relating to both health and social care	15
Total No. engagement activities	22

Activity	**Type** (H/SC/ Both)	**Strategic priority aligned with**	**Host** (Llais/ external/joint)	**No. people engaged with**	**No. partners engaged with**	**Outcomes** (what happened as a result of the engagement activity? Any follow up actions?)
Meeting with Mabon ap Gwynfor AS	Both		Joint	1	1	• Receiving monthly reports, these are welcomed • Discussed Dyfi ward at Tywyn hospital and the forthcoming public engagement consultation and the role that Llais will play – agreed to share the recent statement made at the Petitions Committee • Discussed the proposed change to stroke services at Hywel Dda and how this might impact patient from South Meirionnydd • Key issues being raised by patients, GP appointments, poor access to NHS dentists,

Activity	**Type** (H/SC/ Both)	**Strategic priority aligned with**	**Host** (Llais/ external/joint)	**No. people engaged with**	**No. partners engaged with**	**Outcomes** (what happened as a result of the engagement activity? Any follow up actions?)
						waiting time and car parking at DGHs. Car parking is being raised more and more with people unable to find parking spaces when attending outpatient appointments, some have received fines. • Discussed Kinmel Bay public forum – agreed to share report • Discussed the forthcoming structural changes at BCUHB – Mabon not yet sighted on this. Informed him that BCUHB intend to brief MSs
Tywyn Inpatient Ward - update	H		Joint			It is understood that a report is to go to the public Board meeting to be held in May 2025. The Welsh Government Petitions Committee had discussed this issue for the seventh time just recently. Things need to progress as the ward has now been closed for 2 years. There are concerns locally around end-of-life care, if loved ones are in Dolgellau, the road conditions and public transport links are not ideal. Enhanced services are now being provided and in the main these are welcomed. Need to evidence how these are being provided to the wider community as well as how end of life care can be provided locally. The date of the public engagement and consultation is awaited.

Activity	**Type** (H/SC/ Both)	**Strategic priority aligned with**	**Host** (Llais/ external/joint)	**No. people engaged with**	**No. partners engaged with**	**Outcomes** (what happened as a result of the engagement activity? Any follow up actions?)
Penley Hospital Temporary Closure Update	H		Joint			Llais was advised of the closure after the event and is still unsure why it was closed. It is understood that it was closed as a result of patient safety, but this has not been confirmed. Options for the premises are being considered; it is believed that there is no covenant on the current premises, there was on the former. The criteria for admission have changed in that there is no longer a requirement for a Polish connection. Llais has received no concerns from the public about the closure of the facility; Plaid Cymru have raised some concerns. It was acknowledged that no service change protocol had been prepared. KW, BCUHB, to discuss with East IHC. Llais need to know what services were provided at the facility, the number of patients affected, where these patients are going instead and what is being to mitigate the closure of the facility. BCUHB have provided answers to Llais questions and will share the Urgent Change Protocol Document once finalised.
Sunday pharmacy Penrhyndeudraeth	H		External	3	1	Information received from Volunteer regarding Sunday opening of Pharmacy at Penrhyndeudraeth. Should be advertised

Activity	**Type** (H/SC/ Both)	**Strategic priority aligned with**	**Host** (Llais/ external/joint)	**No. people engaged with**	**No. partners engaged with**	**Outcomes** (what happened as a result of the engagement activity? Any follow up actions?)
						better by BCUHB. This should be raised through the West Cluster Groups
Llangefni Volunteering Network	Both			18	8	Awaiting Report
Meeting with BCUHB Equality and Inclusion Manager to discuss LGBTQ + work at nursing homes.	Both		Joint	1	1	Discussion around Llais article in Care Home Newsletter and how to introduce Llais to Care Homes. Care Home Webinar Pride Events in North Wales
Carers Outreach Llangefni	Both		External	4	1	Llais presentation. Discussion on ND assessments, maternity services and cardiology. Themes: - Not enough support offered to people / parents whilst waiting for an assessment. - Not enough support from CAMHS. - Difference in what you receive in Wales compared to England, such as support courses, educational courses, workshops, ALN hours. - Not enough support for maternity staff. Offered to attend the group again in future for further discussion.
North Wales Recovery College	Both		External	15	15	In 2022 HIW and Social Care Wales launched their strategic plan, which included setting up a Recovery College. They are currently writing a business case,

Activity	**Type** (H/SC/ Both)	**Strategic priority aligned with**	**Host** (Llais/ external/joint)	**No. people engaged with**	**No. partners engaged with**	**Outcomes** (what happened as a result of the engagement activity? Any follow up actions?)
						which will be submitted to Welsh Government later this year. The purpose of these sessions is to work in partnership with stakeholders and people with lived experience. The Business Case will be submitted to the BCUHB Board in August after analysing the feedback from these sessions; an engagement report will then be produced and an options appraisal. The Business Case will be submitted to Welsh Government in October.
Tenovus and Llais introductions	Both		Joint	1	1	Explained the role of Llais in complaints and gave information about the structure of Llais
Meeting with Royal British Legion and Ministry of Defence	Both		Joint	4	2	Discussion on arrangements for Llais to sign the Armed Forces Covenant. The ceremony will form part of the pre-Board event in Wrexham in July. Information shared with Board secretary
Llais Local Nifty 60's	Both		External	44	0	Awaiting feedback forms - will form part of Llais Local Ynys Môn Report
Penley Hospital Temporary Closure Update	H		External	1	1	Correspondence with Plaid Cymru regarding the Penley Hospital temporary closure.
Llais Local Toddler Group	Both		External	20	0	Part of Llais Local Ynys Môn - main themes of conversation: GP service NHS Dentists

Activity	**Type** (H/SC/ Both)	**Strategic priority aligned with**	**Host** (Llais/ external/joint)	**No. people engaged with**	**No. partners engaged with**	**Outcomes** (what happened as a result of the engagement activity? Any follow up actions?)
						Ysbyty Gwynedd Social Care services
Llais Local Warm Space & Hwb Dillad	Both		External	22	0	Awaiting feedback forms - will form part of Llais Local Ynys Môn Report
BCUHB Patient Champion Meeting	H		External	12	1	Presented to BCUHB PALS and Engagement staff on the role and function of Llais
Meeting with Volunteer to discuss Engagement guidance	Both		Llais	5		Discussion on guidance for Volunteers when engaging with public on behalf of Llais and how to capture Equality data.
Meeting with Mark Isherwood MS	Both		Llais	1	1	• Discussions around the work being undertaken by Llais NW • Discussions around volunteers and not helping out with engagement work meaning this is being picked up by staff. • Wider discussions around recruiting volunteers; MI to promote volunteering with Llais via his social media • Discussions around recent experiences of Wrexham Maelor A&E; incorrect information being displayed on the screens around wait time for triage and time to see a doctor. The screens have subsequently turned off. Very chaotic department. • GRH to write to MI about: outsourcing cataracts; orthopaedic unit at Llandudno;

Activity	**Type** (H/SC/ Both)	**Strategic priority aligned with**	**Host** (Llais/ external/joint)	**No. people engaged with**	**No. partners engaged with**	**Outcomes** (what happened as a result of the engagement activity? Any follow up actions?)
						Ablett Unit replacement and issues around contracting and commissioning. MI to raise this at the Public Accounts Committee
Correspondence with BCUHB Engagement Officer - Black, Asian and Minority Ethnic Communities	H		Llais	1	1	Set up a meeting to discuss the work undertaken with ethnic minority communities. Meeting arranged for 9/6
Meeting with Darren Millar MS	Both					Discussed the progress of Llais, the Military Covenant, an individual client and waiting times and primary care access
One Voice Wales Presentation	Both		External	1	1	Email to One Voice Wales offering to do another round of meetings/presentations to the various town councils in North Wales discussing Llais work
Llais Local Lunch Club and Carers Trust Dementia	Both		External	25	1	Part of Llais Local Ynys Môn - main themes of conversation: GP service NHS Dentists Ysbyty Gwynedd Dementia friendly venues
BCUHB Specialist Palliative Care joint working	H		Joint	1	1	Request from BCUHB Specialist Palliative Care Team for meeting to discuss joint working with Llais. Date to be confirmed

>NORTH WALES< VISITS

(Visits to health or social care premises)

No. relating to health	0
No. relating to social care	0
No. relating to both health and social care	0
Total No. Visits	0

What we heard:

- *When sharing what you've heard, wherever possible state how many people expressed the opinion by using (x -) e.g. there were concerns about access to dentistry (x 6)*
- *Try and keep points concise where possible.*
- *Please state if event was hosted by us, a partner or jointly hosted.*
- *Copy and paste the tables below based on the number of activities where people shared information with us.*

Group/event/activity name	***Carers' Outreach Llangefni (parents of neurodiverse children)***
Working well	• In England, charities offer support courses for people whilst they wait for an assessment, they also offer workshops on sensory needs and give parents the tools to deal with their child's diagnosis. • Once diagnosed you can get access to ADHD medication.
Needs improvement	• My 15 year old has now finally been accepted for assessment, but my other child hasn't been accepted – if we pay privately, my other child will be accepted. • The support I received from CAMHS was that they gave me a piece of paper with a list of books that we as parents should read. That's all I was given. • Before we moved here to live from England, my son received 30 ALN hours, but in Wales they reduced it to 20 hours. After an assessment, they upped it to 27 hours, but it's still less than he used to receive, and is less than what he needs.

	• There's not enough support for maternity staff at hospitals or in the delivery suites. A lot of maternity staff leave due to PTSD or lack of support.

Group/event/activity name	***Bodorgan Toddler Group***
Working well	• Gwalchmai GP surgery service is excellent. • Staff at the SCBU at Ysbyty Gwynedd are wonderful. • At Coed y Glyn GP surgery, you phone in the morning and the doctor calls you back to discuss the problem, some sort of triage. That works brilliantly. It's a shame it doesn't happen everywhere • Husband had cancer treatment at YG and YGC. They offered him some kind of rapid radiotherapy at YGC, so you have more of the treatment over f fewer weeks, which was great for us as it saved us having to travel there more than needed. The staff at both YG and YGC were wonderful. • Paediatric staff at Ysbyty Gwynedd and Alder Hey are wonderful. • Dwyran GP surgery – can always get an appointment on the day.
Needs improvement	• Dental – only private providers available locally. It's a shame the school dental service no longer visits schools. • Experiences of End-of-life care at Ysbyty Gwynedd hasn't been great. • Social Care – don't know who to contact if help is needed. • Ysbyty Gwynedd maternity – went in a bit too soon after starting having contractions, the midwife sent me straight home and I was made to feel a bit of a nuisance. • At the Holyhead dentist, which is NHS, you can no longer get regular check-ups, they only offer emergency appointments now. • Staff shortages at Ysbyty Gwynedd over the weekends.

Group/event/activity name	***Lunch Club & Carers Trust Dementia Group - Llangefni***
Working well	• The care received at A+E was excellent. • Ambulance service are amazing.
Needs improvement	• Struggle to find a dentist, and the emergency dentist is only available on Sunday, can't access that service due to no car.

	• Would like getting a GP appointment easier, can't get an appointment the same day now. • Registered with NHS dentist but have not been called in for a check-up for over two years. • Toilets at venues need to have a Steady, so that people can change their pads. This is especially important at venues that hold Dementia Groups.

>NORTH WALES< CONSULTATIONS

(Responses made to external consultations on regional matters)

No. relating to health	0
No. relating to social care	0
Total No. consultations	0

>REGION NAME< SERVICE CHANGES

(This should include Llais' involvement in service changes - including service reorganisation, reconfiguration, service redesign, service variation, service improvement, or service expansion)

Name of body	Type (H/SC)	Level (Up to 4, 8 or 12 weeks)	Involvement (Active / Monitoring)	Service change overview	Status/Outcomes
BCUHB	H		Active	Penley Hospital temporary closure update	Llais was advised of the closure after the event and is still unsure why it was closed. It is understood that it was closed as a result of patient safety, but this has not been confirmed. Options for the premises are being considered; it is believed that there is no covenant on the current premises, there was on the former. The criteria for admission have

Name of body	Type (H/SC)	Level (Up to 4, 8 or 12 weeks)	Involvement (Active / Monitoring)	Service change overview	Status/Outcomes
					changed in that there is no longer a requirement for a Polish connection. Llais has received no concerns from the public about the closure of the facility; Plaid Cymru have raised some concerns. It was acknowledged that no service change protocol had been prepared. KW, BCUHB, to discuss with East IHC. Llais need to know what services were provided at the facility, the number of patients affected, where these patients are going instead and what is being to mitigate the closure of the facility.
Public Health Wales	H		Monitoring	Change of base for diabetic retinopathy clinic; this is a service improvement as the current location is impeded by the size of the rooms that are available to the service. The new location is on the same business park as the current base and is served by the same bus. There is also more parking at the new clinic location. Patients are aware of the new location of the clinic, and none have raised any concerns. The	No service protocol needed; this has been advised as for information only. A detailed EQIA has been prepared and received.

Name of body	Type (H/SC)	Level (Up to 4, 8 or 12 weeks)	Involvement (Active / Monitoring)	Service change overview	Status/Outcomes
				new location is better for both patients and staff.	

>NORTH WALES< - REPRESENTATIONS

(Representations made 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. The overall purpose of these representations is to support the process of co-development of health and social care services by amplifying and reinforcing the voice of the citizen.

Representations should be put forward in a format which has some degree of permanency about it and lends itself to being recorded and tracked through the relevant regional team, local authority and NHS body systems e.g. emails, reports, communicated verbally in a formal meeting where minutes are taken.)

No. relating to health	8
No. relating to social care	1
Total No. representations	9

Name of body	New/ ongoing	Type (H/SC)	Source (engagement, advocacy, partner working)	Method (email, letter, minuted in meeting)	Concern (brief overview, inc. CRM No.)	Status/Outcomes
BCUHB	New	H	Partner Working	Email	**RER-250506-1975** Concerns raised about an elderly patient living with dementia and ill with cancer, unsure	Email from BCUHB to confirm that person is being cared for.

Name of body	New/ ongoing	Type (H/SC)	Source (engagement, advocacy, partner working)	Method (email, letter, minuted in meeting)	Concern (brief overview, inc. CRM No.)	Status/Outcomes
					what care packages are being provided by NHS and social care.	
BCUHB	New	H	Volunteer	Email	**RER-250513-1989** Concerns raised regarding Traffic Management at Ysbyty Gwynedd during scheduled roadworks on roads surrounding hospital.	Email received from Chair of BCUHB with assurance that YG team are involved with the Highways officers to minimise impact to patients and staff.
BCUHB	New	H	Partner Working	Email	**RER-250603-2073** Email to CEO BCUHB re. Llais Maternity Services Report requesting corporate response to the report and what learning BCUHB will take from the report	Letter received from CEO BCUHB in response to Llais Maternity Report. BCUHB shared its findings of a local review and gap analysis of the health board's position, with identified actions, in relation to the report LLAIS Report has been cascaded widely across the Health Board to ensure that the

Name of body	New/ ongoing	Type (H/SC)	Source (engagement, advocacy, partner working)	Method (email, letter, minuted in meeting)	Concern (brief overview, inc. CRM No.)	Status/Outcomes
						learning is shared and informs service improvements for Women and their Families. The report will also be formally presented at the Health Board's Quality and Safety Committee in July 2025.
HIW	Ongoing	H	Engagement	Email	**RER-250325-1852** ND Assessment waiting times - correspondence with HIW regarding waiting times figures for BCUHB. Email to Carers Outreach contact asking if HIW statement that there is no one waiting for more than 4 years for assessment in NW is what their experience is. Email to BCUHB asking for an update on their waiting list.	Awaiting response from BCUHB and Carers Outreach

Name of body	New/ ongoing	Type (H/SC)	Source (engagement, advocacy, partner working)	Method (email, letter, minuted in meeting)	Concern (brief overview, inc. CRM No.)	Status/Outcomes
BCUHB	New	H	Advocacy	Email	**RER-250528-2049** Experiences received of A+E department at Wrexham Maelor. Number of concerns raised. Shared with BCUHB	Response received from Senior Management Team - this will be investigated, and support will be offered by the East IHC Senior Nurses
BCUHB	New	H	Engagement	Email	**RER-250603-2070** Legs Matter - email to BCUHB asking for response to questionnaire.	Awaiting response
Llais	New	H	Engagement	Email	**RER-250603-2070** Legs Matter Questionnaire - email to Llais Director of Engagement and Insights to ask all Llais regions to request this information from their Health Boards.	Awaiting response
Conwy Council	New	SC	Engagement	Email	**RER-250603-2071** Concerns from parent with low vision regarding treatment from Conwy Council Social Services	Awaiting response

Name of body	New/ ongoing	Type (H/SC)	Source (engagement, advocacy, partner working)	Method (email, letter, minuted in meeting)	Concern (brief overview, inc. CRM No.)	Status/Outcomes
					in respect of child. X feels there was a bias against parents with low vision and would like to know how the Council now operate in relation to parents with low vision and what learning was taken from their experience.	
BCUHB	New	H	Engagement	Email	**E-250509-1817** Email from BCUHB Director of Partnerships, Engagement and Communication stating that Llais NW monthly reports are now taken to their Executive Committee. Response received to one of the enquiries logged in the report regarding patient language preference.	It is possible to log which language a patient prefers in the WPAS system

>NORTH WALES< - REPRESENTING LLAIS

(Representing Llais at formal meetings and working groups)

No. relating to health	8
No. relating to social care	0
No. relating to both health and social care	1
Total No. Representing Llais activities	9

Name of committee, meeting or working group	Frequency of attendance	Type (H/SC)	Contribution (voting, observing)	Status/Outcomes
BCUHB QSE Committee	Bi-Monthly	H	Contributing	Regular meeting – agenda and minutes available on the BCUHB website. RD highlighted key local issues in our monthly report
Patient and Carer Experience Group	Monthly	H	Contributing	This is a monthly meeting and draws together PCE leads from across the Health Board. Key items on the agenda included: Patient story - My Diabetic Journey CAMHS Patient Experience Update Patient Experience Review Centre IHC update report Llais feedback NHS Wales people's experience framework All Wales PTR Guidance Procedures / Sops for Approval - re-opening complaint SOP
Royal College of Psychiatry Review EAG Adults Mental Health	Fortnightly	H	Contributing	Received a presentation on dementia care from the Consultant Dementia

Name of committee, meeting or working group	Frequency of attendance	Type (H/SC)	Contribution (voting, observing)	Status/Outcomes
				nurse. Supported MHLD service users and cares to engage with BCUHB
HIW Summit	6 Monthly	H	Contributing	Outlined key local issues. Full information is provided in the submission on the Llais proforma
Conwy East Cluster Meeting	Quarterly	H	Contributing	Awaiting Report from Volunteer
Tywyn Hospital Steering Group		H	Contributing	Provide advice on effective and meaningful engagement and advised to include the HDD service changes in the process
BCUHB Board Meeting	Monthly	H	Observing	Observed the meeting and engaged with Board members. BCUHB thanked Llais NW for sharing monthly reports. Recommendations for both the inpatient ward at Tywyn Hospital and Penley Community Hospital were presented.
Royal College of Psychiatry Review EAG Adults Mental Health	Fortnightly	H	Contributing	Llais supported and facilitated service users to tell of their experiences
Regional Partnership Board	Monthly	Both		Agenda and notes available online. Key issues were; CRPB Priorities RPB Endorses the Children's RPB Priorities and approach taken. It also acknowledged that partner participation will be essential as the agenda develops. Consensus view as to the priorities and

Name of committee, meeting or working group	Frequency of attendance	Type (H/SC)	Contribution (voting, observing)	Status/Outcomes
				direction for 2025/26. Further consideration as to the how required, with the development of the ND workstream being an example of good collaborative practise. RPB agreed to receive an annual update on the Combined Organisational Response to the Audit Wales - Flow from Hospital Report

>NORTH WALES< - COMPLAINTS ADVOCACY

Total no. new cases opened this month	71
Total no. cases closed this month	56
Total no. open advocacy cases	284

EMERGENT THEMES

(Please briefly highlight the key themes that are emerging from complaints advocacy cases this month)

- Treatment / Care
- Waiting times for appointments
- Attitude of Staff
- Communication

- Lack of follow up from GPs
- Not enough support from CMHT
- Social care process
- Care given at Care Home.

The following themes were identified:

East IHC

- Magnesium IV was administered by student nurse at the same time as another nurse was cleaning the PICC line. Patient needed ECG, saline treatment and then follow-up ECG.
- Unhappy that nerve damage was caused to elbow and wrist when nurse tried to insert cannula. Patient unable to undergo colonoscopy procedure due to distress caused.
- Patient waiting 10 years for an Ortho appt and 2.5 yrs for urology appt. Patient attended for a urology appointment, which was cancelled due to priority patient needing to be seen. Patient chased up appointment and was told that they did send an alternative appointment, but this was not received. Because patient didn't attend, patient has been discharged to GP care and will now go to the back of a queue. Patient is a veteran.

Central IHC

- Seeking Redress from BCUHB for poor treatment of broken ankle that needed additional surgery in Broadgreen, Liverpool in March 2025.
- ED waiting times and doctor called patient a hypochondriac.
- Pt had their leg amputated and should have been put on a special air mattress. Pt was not turned or moved for 2 weeks and developed grade 4 pressure sore.
- Following a hip replacement pt has suffered with pain in their legs and nerve damage to the spine and would like to know what happened during surgery.

West IHC

- Patient attended hospital multiple times with abdominal pain. Symptoms were dismissed and it was suggested at one point that it may be psychological. Patient was eventually diagnosed with severe faecal impaction which has had lasting consequences.

- Patient suffered fractured pelvis was admitted by WAST to ED and given morphine-based analgesia, after which patient was difficult to rouse and transferred to Resus. Family unhappy about 3 doses of Naloxone administered by ED staff.
- Complaint already made about care of elderly patient in hospital before they died. Client has been offered LR meeting with Medical Director and would like advocacy support.
- Pt had to have their coil removed and it was sent off for testing. Results came back confirming an infection. Pt was not given any information of the side effects.

Cross Border

- Complaint regarding poor standard of care of elderly patient in Countess of Chester hospital, who was on end-of-life care.
- Countess of Chester ED failed to listen to severe allergies. Info not shared with ward about patient's medical condition so suffered further attacks. Diagnosed with Mast Cell Activation Syndrome (MCAS), this causes the anaphylaxis.

Other BCUHB

- Stroke patient wants to complain that their physiotherapy sessions were ended abruptly, and patient doesn't feel sufficient support was given.
- AtHR patient has requested his Audiology medical record in June 2024 so he can pursue an MOD hearing loss claim (veteran). Patient still hasn't received their records. Patient has approached ICO.
- Case with PSOW but wants advocacy support to process BCUHB response when it is sent. Wants help navigating between PSOW and BCUHB as patient believes outstanding issues have been overlooked.

Primary Care

<u>General Medical Services</u>

- Patient was referred to Llais by OT for help to make a complaint. GP prescribed Mounjaro, then changed their mind and decided patient would need to be referred to Weight Management instead. Patient feels they are not being listened to.
- Pt has been prescribed medication since 2010 which has poisoned their brain and caused their legs and arms not to work properly. GP failed to carry out regular medication reviews and follow ups.
- Patient wants to complain about advice given by GP practice and the lack of follow-up when the recommended medication didn’t resolve their symptoms.
- Patient was using translation service during GP appointment and the call kept being cut off. Patient believes that the receptionist was responsible.

- Patient is unhappy GP has restricted prescription for pain relief medicines. Struggles with pain every day. Also wants referral to explore family history of narrow arteries for stents but feels GP is not listening. Has been under CMHT.
- Complaint about lack of support from GP practice for end-of-life patient.
- Pt reports difficulties with GP practice organising a cholesterol test - has been trying for the last 6 weeks to get one.
- Patient unable to access a GP appointment pt is unable to queue outside the surgery or call at 8am due to their physical health needs and employment commitments.
- Patient was informed during an appointment recently that comments made by a previous GP were "nasty" and has issues with the prescribing of Amitriptyline. Patient will request records and wants to complain about both aspects.
- GP wouldn't prescribe medication until pt had an x-ray on their lungs. Pt is still waiting for the x-ray appointment and is having difficulty breathing. Receptionist was rude after pt asked for a complaint form. Pt will be registering at another GP practice.

Mental Health

- ASD/Disabled person contacted NHS 111 MH service as she in distress. Patient was told to get a job and throw away items hoarded. Parent feels strongly that this is inappropriate.
- Pt was referred to CAMHS by school. Assessment took place in Winter 2025 and child was diagnosed with ASD, OCD and autism. A month later the child received a letter advising they had discharged the child from the service with no intervention.
- Patient is eligible for Section 117 aftercare and wants to complain about lack of support from Community Mental Health Team.
- Pt has requested to change to another psychiatrist. Pt received a telephone call to say their care-coordinator is off sick. Pt has been left with no help and support.
- Wants Mental Health diagnosis from CMHT. Patient wants support for FLR letter/PSOW.
- MH Practitioner in Nant Y Glyn was rude and unprofessional when pt who has been on waiting list since Autumn 2024 asked for status update on the pre-arranged call. Told "someone else deals with lists".
- Called NHS Helpline 111 option 2, having MH crisis. Patient ASD, under Plas Gororau but does not have regular support. NHS transferred to the CALL (Welsh Mental Health helpline service) but they were told they are not a chatline and became frustrated that the NHS service had re-directed his call twice.

Social Services

- Domiciliary care package (commissioned by WCBC) means patient pays a contribution towards their care costs of £100p/w. The panel had considered application and concluded they could not claim that patient had Disability Related Expenses. Complaint is about process.
- Life-long friends visiting patient throughout the day all separately reported their concerns to Care Home staff that pt looked unwell, speech was incoherent. Concerns dismissed as 'patient has a cold'. WAST called later that evening and confirmed patient had suffered a stroke. Patient now in YG and has lost the ability to speak. Care was part funded by LA.
- Formal concern submitted to Denbighshire Social Services (child) by parent. Child has been placed in foster care after family requested crisis support. Unhappy with foster placements and new Social Worker.
- Following a social care review the client has had their hours for care and support reduced due to finances and would like help to make a formal complaint.

Enquiries

- Pt would like information about making a complaint.
- A friend with long term hip, lower back and thigh pain is currently receiving significant help from an osteopath. They resorted to this costly private health help following less than effective NHS investigations and treatment: hip X-ray & physio session. The osteopath in just three sessions has helped significantly and they have far less pain and much improved movement both walking and back movement. All this at significant cost because osteopath treatment is not provided by the NHS. Have Llais ever considered encouraging the NHS to offer osteopath treatment, and if not why not? Osteopaths seem to be offering effective treatment for a wide range of skeletal/muscular issues where the NHS struggles to provide effective treatment.
- Doctor from Walton Centre called, trying to get hold of endocrinology dept at BCUHB.
- Patient was verbally abused by a member of staff whilst an inpatient in hospital.
- Unhappy with diagnosis from neurologist 19 years ago. Had counselling for PTSD from 2022 - 2024 and told needs closure on this matter. Outside of PTR, signposted to GP to request reassessment.
- Advice required for an individual who is very upset and annoyed that their alcoholism condition was incorrectly noted on their medical records, they have been sober since 2010. They are seeking for support for what the individual should do next or contact.
- Caller wanted to know if Llais could support with a Continuing Health Care appeal.
- Caller thought they had received a call from Llais.
- Caller had received a consent form to access records from the Complaints Team and didn't know how to send it back they had no envelope or stamp and is housebound.

- Caller has been on Ophthalmology list for 2 years for cataract surgery. Called PALS in November 2024 and was told the operation would be that month. Spoke to secretary who said March, then PALS again today, who said May. Patient just wants an idea of how long they will be waiting so they can decide whether or not to have it done privately. Wanted to know if there was anyone else, they could contact.
- Pt arrived at their therapy appointment and was informed that a CPN may no longer be assigned to them, and no explanation was given.
- Caller has submitted a complaint to BCU in February 25 but has not received a formal acknowledgment letter, only being informed that the complaint is under review.
- Caller wanted information on behalf of a relative about complaints process in England, and the difference between a 'Concern' and a 'Complaint'.
- Patient requires dental work (crown and bridge). Dentist says it cannot be done on the NHS and patient must have it done privately, despite NHS website stating that this treatment is covered under NHS Band 3 treatment. Patient has an appointment this afternoon and wanted information on how to argue this with the dentist.
- Caller was having issues with Dental Access Portal. It would only allow them to accept a place for themself, despite receiving offer emails for the rest of the family too. The dental practice who accepted pt said they are hearing about other patients having the same issue.
- Caller wanted help with a CHC appeal.
- Patient has damaged vertebrae from a hospital admission in 2021. Patient awaits surgery to repair the issue, but surgeon can't proceed without a current cardiology report, and there have been delays in obtaining this.
- Caller wanted general advocacy for support at appointments etc.
- Cancer patient waited 6 months for follow up appointment when they should have been seen every 6 weeks.
- Caller's parent is 95, suffering with dementia and living in a care home. Caller is having issues with a sibling and professionals are delaying risk assessment as agreed at meeting. Caller feels it is impacting patient's wellbeing as they are unable to take patient out.
- Patient paid privately for ankle fusion surgery three years ago. Pt’s having to undergo further NHS surgery in 3 weeks as original procedure was unsuccessful. They want compensation and refund for poor private treatment. Signposted to AvMA.
- Client wants advocacy support for raising a complaint about their bin.
- Walton hospital needed help finding scan images for a patient. Signposted with contact details of the BCUHB Access to Records team.
- Having issues with GP and would like help to move surgeries.
- Looking to appeal a recent Full DST for their mother (CHC funding appeal).

- Wants to complain about attitude of LA staff in FCC bin department.
- Please help, I've been in a horrendous battle with the hospital after they butchered & nearly killed me. The same surgeon is refusing me treatment and bullying me into going to a hospital I've repeatedly explained I can't afford to get too and I'm Neurodiverse so mentally can't get too.
- Would it be possible to arrange a quick call with someone who could give my Partner and I some advice before we submit a formal complaint to Betsi Cadwaladr.
- Caller left unrecognised telephone number so unable to contact about GP's in Llandudno.
- Pt has contacted a solicitor and waiting to see if they will take on the case. Pt wants to make a claim against misdiagnosis from incident Jan 2024.
- Please give advice how I can be compensated for treatment since 2015 to 2023, and to get copy of medical records.
- I'm trying to get hold of somebody in or around Wrexham in North Wales about a medicine supply issue. The medicine in concern is Febuxostat which is proving difficult to get hold of in the Wrexham area.

IMPACT

Activity (what did you do?)	Outcome (what was the result?)	Impact (what's the difference it made?)
Patient suffered a fall in February 2023 and suffered damage to her arm. She was seen in the Emergency Department. The 2nd doctor they saw on that day said they needed surgery that day but they were discharged with no operation. They are now having a lot of trouble with their arm and following an MRI scan it shows that they need an operation which should have been done whilst they were a patient.	Case submitted to PSOW – complaint upheld 2025.06.02e PSOW Summary - 202400375.pdf	Client happy that their concerns have been listened to and upheld, and to receive a small payment in recognition of her pain and emotional distress