Bundle Quality, Safety and Experience Committee 15 August 2024

1 PRELIMINARY MATTERS

1.1 13:00 - QS24.86 Welcome & Apologies
Chair
Apologies received from:
Chris Field, Independent Member
Pam Wenger, Director of Corporate Governance. (Associate Director of Governance to deputise)
Geoff Ryall-Harvey, Llais. (Bill Whitehead to deputise)

1.2 13:02 - QS24.87 Declarations of Interest
Chair

1.3 13:04 - QS24.88 Unconfirmed minutes of the meeting held on 6 June 2024
Chair
QS24.88.1 Unconfirmed Minutes of PUBLIC QSE Meeting 6.6.24 v0.1 approved by AW, CT & PW

1.4 13:06 - QS24.89 Matters Arising and Actions Log
Chair
QS24.89.1 QSE Action Log PUBLIC - updated 08.08.24

1.5 13:11 - QS24.90 Patient Story
Executive Director of Nursing and Midwifery
QS24.90.1 Patient Story - Trans Voice Service

2 SERVICE PRESENTATIONS

2.1 13:26 - QS24.91 Service Presentation from Women's Services
Director of Midwifery and Women's Services, Maternity
QS24.91.1 Service Presentation - Women's Services Deep Dive
QS24.91.2 Service Presentation - Women's Services Deep Dive

3 QUALITY CONTROL

3.1 13:46 - QS24.92 Integrated Quality Report
Executive Director of Nursing and Midwifery
QS24.92.1 Integrated Quality Report Aug 24
QS24.92.2 Integrated Quality Report Aug 24 - Appendix - PSOW PIR 5663
QS24.92.3 Integrated Quality Report Aug 24 - Appendix - PSOW PIR 1962

3.2 14:01 - QS24.93 Integrated Performance Report
Director of Performance
QS24.93.1 Integrated Performance Report Coversheet
QS24.93.2 Appendix 1 Integrated Performance Report 6.8.24
QS24.93.3 Appendix 2 Clinical Coding Escalation

3.3 14:16 - QS24.94 Infection Prevention and Control Annual Report
Executive Director of Nursing and Midwifery
QS24.94.1 IPC Annual Report 2023-24 Cover Paper
QS24.94.2 IPC Annual Report 2023-24

4 QUALITY IMPROVEMENT

4.1 14:31 - QS24.95 Challenged Services Report - Cancer and Oncology
Deputy Executive Medical Director
QS24.95.1 Board Committee Coversheet - Cancer Annual Report 2023-24

4.2 14:56 - COMFORT BREAK

4.3 15:01 - QS24.96 Challenged Services Report - Urology
Deputy Executive Medical Director
QS24.96.1 Urology Improvment Plan - August 2024 Final
QS24.96.2 Urology Appendix paper 1

5 QUALITY ASSURANCE

5.1 15:26 - QS24.97 Health Board Response to the Royal College of Psychiatrists Invited Review Services Report
Executive Director of Allied Health Professionals and Health Science
QS24.97.1 Health Board Response to the Royal College of Psychiatrists Invited Review Services Report
QS24.97.2 ToR - Executive Delivery Group for HB RPsych Action Delivery Group V0.5 7 Aug

QS24.97.3 Appendix 2 HB RCPsych Delivery Group Evidence Submission form draft V0 (1)

5.2 15:46 - QS24.98 Corporate Risk Register
Head of Risk Management

QS24.98.1 Corporate Risk Register August 24 NC v2
QS24.98.2 Corporate Risk Register report for PCC August 2024 v2

6 FOR INFORMATION

6.1 QS24.99 NHS Wales – Joint Commissioning Committee Quality Committee Chairs Report

QS24.99.1 NHS Wales JCC Quality Committee Chair's Report

6.2 QS24.100 Quality Delivery Chairs Assurance Report
Executive Director of Nursing and Midwifery

QS24.100.1 Quality Delivery Group Chair's Report

6.3 QS24.101 Summary of Business to be Reported from Private
Head of Corporate Affairs

QS24.101.1 QSE Private session items reported in public

6.4 QS24.102 Committee Cycle of Business and Committee Workplan
Head of Corporate Affairs

QS24.102.1 QSE CoB V0.01 (Draft on new template)
QS24.102.2 QSE Forward Plan Non Routine Bus Draft v0.1

6.5 QS24.103 Organ and Tissue Donation Committee Annual Report
Executive Director of Therapies

QS24.103.1 Organ & Tissue Donation Committee Annual Report 2023-24 Coversheet
QS24.103.2 Organ & Tissue Donation Committee Annual Report
QS24.103.3 Organ & Tissue Donation Committee Annual Report 2023-24 - Letter
QS24.103.4 Organ & Tissue Donation Committee Summary Annual Report

7 CLOSING BUSINESS

7.1 16:01 - QS24.104 Meeting Effectiveness
Chair

7.2 QS24.105 Date of the Next Meeting
Thursday, 24th October 2024

7.3 16:03 - QS24.106 Resolution to Exclude the Press and Public
Chair
"Those representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960."

Betsi Cadwaladr University Health Board (BCUHB)
DRAFT Minutes of the Quality, Safety and Experience Committee meeting held in public
on 6th June 2024 13:00 to 16:30 hrs
The Board Room, Carlton Court, St Asaph

Committee Members Present	
Name	**Title**
Caroline Turner	Independent Member/Chair of Quality, Safety and Experience Committee
Mike Larvin	Independent Member (from 13:40 hrs)
Urtha Felda	Independent Member
Chris Field	Independent Member (via Teams)
In Attendance	
Angela Wood	Executive Director of Nursing and Midwifery (Executive Lead)
Dr James Risley	Deputy Executive Medical Director (deputising for Executive Medical Director)
Pam Wenger	Director of Corporate Governance
Other Executive Directors as required by the Chair	
Dr Jane Moore	Acting Executive Director of Public Health
Other BCUHB Senior Managers as required by the Chair	
Nesta Collingridge	Head of Risk Management
Andrea Hughes	IHC Director Of Nursing (East) (Part of the meeting)
Matthew Joyes	Deputy Director of Quality
Phil Meakin	Associate Director of Governance
Philippa Peake-Jones	Head of Corporate Affairs
Carol Evanson	Deputising for Acting Director of Mental Health
Adrian Jones	Assistant Director Of Nursing, MHLD
Ed Williams	Director of Performance (Part of the meeting)
Fiona Lewis	Minute Taker
Observing	
Dyfed Edwards	Chair (Part of the meeting)

Agenda Item	**Action**
OPENING BUSINESS	
QS24/63 Welcome, introductions and apologies for absence **QS24/63.1** The Chair welcomed everyone present. Apologies were noted from Nick Lyons (James Risley to deputise), Gareth Evans, Jason Brannan, Iain Wilkie (Carol Evanson to deputise) and Geoff Ryall-Harvey (Llais).	

QS24/64 Declarations of Interest on current agenda **QS24/64.1** There were no declarations of interest made in respect of items on the agenda.	
QS24/65 Draft minutes of the previous meeting. **QS24/65.1** The draft minutes of meeting held on 18th April 2024 were **approved.**	
QS24/66 Matters Arising and Table of Actions **QS24/66.1** Following a detailed discussion, the updates provided within the action log were **agreed**.	
QS24/67 Patient Story **QS24/67.1** The Committee was provided with a story from a patient who suffered with an ankle injury. The key messages from the story were: • lengthy wait for any treatment • impact waiting for treatment was having on the patient's physical health and therefore their ability to work • poor communication whilst on the waiting list • not knowing who to speak to or go to for help whilst on the waiting list • lack of support to manage their condition whilst waiting to be seen **QS24/67.2** The Committee was advised that from April 2024, the Health Board: • had introduced the 3P's programme (Promote, Prevent and Prepare), introduced, following the Welsh Government's Promote, Prevent and Prepare Services Charter', to help empower people waiting for treatment and to optimise their health and well-being. • had implemented a single point of contact for people to access information and support following referral to specialist secondary care. • Gave patients on waiting lists access to free of charge Education Programmes for Patients (EPP Cymru) health and wellbeing courses. **QS24/67.3** The Committee noted that the emerging theme was that communication needed to be better with patients on waiting lists, May's figures highlighted this as 56% of all complaints related to waiting lists. It was felt that the new arrangements would lead to an improved service for patients and would in turn result in fewer complaints, but that more service level and comparative data was required as soon as it becomes available. **It was resolved that** the Committee: • **Noted** the Patient Story	

[Christopher Field, Independent Member, joined the meeting.]	
QS24/68 Quality Report **QS24/68.1** The Executive Director of Nursing and Midwifery presented the item, specifically the recent oxygen no-flow incident, indicating that the organisation was working very closely with south Wales to identify how their control of oxygen was working and that the Prevention of Future Deaths Regulation 28 Notice was received for BOC themselves, as opposed to the Health Board, due to the issues with cylinders they provided. Substantial work was taking place across the Health Board to support staff with labelling on all cylinders. It was noted that the increase in incidents was likely to be due to the improved awareness across the organisation, thus triggering more Datix reporting. The Deputy Quality Director was asked to review the claims in relation to the oxygen issues and circulate outside of the meeting **QS24/68.2** Patients' Falls remained one of the key themes around national reported incidences (NRIs) as with incidents in general across the Health Board. The Executive Director of Nursing and Midwifery reported that she had recently met with teams from the IHCs and Divisions, these meetings also included representation from both Pharmacy and Therapies. In these meetings the actions required following the Health and Safety Executive (HSE) Notice of Contravention and plans put in place around the quality of Patients' falls assessments, were discussed. The Falls Improvement Plan continued to be updated, noting that a response from the HSE had yet to be received following the Health Board's notifications to them identifying the changes being made. Once received, this will be shared with Members. Members requested that more national comparative data be included in future reports; they were advised that with regards to HAPU, a national framework dashboard had just been developed which will soon enable the provision of comparative data per 1000 bed days. **QS24/68.3** The Executive Director of Nursing and Midwifery confirmed that the Improvement Plan regarding Pressure Ulcers had been circulated and that work continued on Incident Management and reporting of Hospital Acquired Pressure Ulcers (HAPUs). Work was ongoing to create a joint process across incident management for inquests, NRIs and complaints; a draft of which will be presented to Board in July. Deputy Director of Quality to circulate, when available, the national report on HAPU that is currently being populated **QS24/68.4** Whilst IHCs and Divisions continued to focus on reducing the number of open and overdue NRIs, the data provided showed a reduction from the previous report in March. **QS24/68.5** The Executive Director of Nursing and Midwifery shared information around Patient Safety and Infection Prevention and Control (IPC), identifying where the organisation was moving forward, highlighting	**MJ** **MJ** **MJ**

the quality assurance work being undertaken to ensure reviews remain consistent, with learning being shared. It was noted that all reviews required by the Nosocomial Covid-19 Project were completed on time (by 31st March 2024); the learning and end of project review was ongoing. **QS24/68.6** Members asked how the organisation would be kept abreast of the progress regarding the Regulation 28 Notice served on BOC. The Deputy Director of Quality confirmed that BOC must respond to the Coroner within 56 days, as to their intended response. The Health Board will not be party to any correspondence however it intends to monitor any relevant notices, which will be placed on the public website run by the Judiciary and Tribunal Service. **QS24/68.7** The Acting Executive Director of Public Health confirmed that • Work had been completed concerning the Measles outbreak and that there were no further ongoing cases. She had received very positive feedback from both Public Health Wales and Welsh Government regarding the management of the case. • work was now complete on doing an IPC audit of almost all (216 out of 217) care homes. The initial evaluations showed a very positive response from care homes and the changes in procedures. • as a result of the Infected Blood Inquiry, procedures had been put in place to provide a helpline for concerned people, but had received a very low uptake. Pathways had also been put in place for those who had tested positive. The Task & Finish Group has been closed, with all actions complete. • The first year was complete regarding the Hepatitis B and Hepatitis C Elimination Welsh Health Circular and that the organisation was ahead of target and doing well in comparison with the rest of Wales. It was noted that BCUHB was the first Health Board in the UK to have collaborated with its prisons, to micro-eliminate both Hepatitis B and Hepatitis C, by going into the prison and carrying out a targeted exercise. **QS24/68.8** Members requested that: • for clarity it would be useful for a reference date be included on the data table. • the Ombudsman Letter be a separate item, and not included in the Quality Report at both QSE and Board. • historic/comparison data be included on the tables that are broken down by themes and re-align tables **QS24/68.9** The Deputy Executive Medical Director presented the Clinical Effectiveness section of the report, noting the progress made over recent months. However within the Mortality Review, he also noted that both the lack of staffing resources, coupled with the 2 days per week previously provided by the Mortality Associated Medical Director post which had been vacated 4-5 months previously, was likely to explain the rise in the both the	**AW / MJ** **AW / PPJ** **AW / MJ**

'Total Pending Cases Awaiting Mortality Review' and the 'Pending Number of Cases Under One Month Awaiting Mortality Clinician Review'. **QS24/68.10** A discussion took place around problems caused by the lack of staff resources; in particular the lack of an Audit Administrator to enter data for the National Heart Failure Audit in the West. The Deputy Executive Medical Director indicated that he had contacted the IHCs and sites, advising them that if they no longer have the resources to meet the demands of data collection, resulting in consultants having to input data themselves, taking them away from clinical duties, they must put this information into a Situation, Background, Assessment, Recommendation (SBAR), where it can be assessed to determine the appropriate course of action. **QS24/68.11** The Deputy Quality Director noted that the organisation: • was still awaiting the HIW Report, following its inspection of the Ysbyty Glan Clwyd Emergency Department. HIW had requested a number of Immediate Assurances, to which action plans had been provided to, and accepted by, HIW. • was still awaiting a decision from HIW as to whether they will be de-escalating Ysbyty Glan Clwyd Emergency Department from being a 'service requiring significant improvement'. • had received three 'Tracked Public Interest Reports' from the Ombudsman, all of which were at the draft stage and once finalised would be brought to the Committee. **It was resolved that** the Committee: • **received assurance** from the Quality Report *[Mike Larvin, Independent Member and Andrea Hughes, IHC Director of Nursing (East), joined the meeting.]*	**AW / MJ**
QS24/69 Clinical Service of Concern Report – Vascular **QS24/69.1** In the absence of The Executive Medical Director, The Deputy Executive Medical Director presented the report, which provided the Management response to the action plan resulting from the Royal College of Surgeons' Review. The Review had identified a significant number of issues resulting in a great deal of work taking place, driven by the Improvement Group. **QS24/69.2** Members were pleased to note the very important progress made. It was agreed that in future an Escalation Report be provided, rather than a detailed Action Plan. **QS24/69.3** A discussion took place around the likelihood that resources would be found, how this would impact targets and what was being done to ensure that the Vascular Team's transitions from being supported by a Transformation team to becoming responsible for itself would be successful.	**NL / JR**

QS24/69.4 A Member noted that there was an issue of Vascular referral to the wrong place and queried how often this was happening. To take outside the meeting and discuss. **QS24/69.5** Concern was raised regarding the messaging around timeframes and the shifting of deadlines. It was argued that the intention of the action plan and timescales were appropriate at the time of writing, however the Abdominal Aortic Aneurysm (AAA) issues were identified later; there was the potential that new timescales might be required. A Member felt that the wording in item P1.07 sent the wrong message – perhaps 'Lessons learned from the AAA work, which is equally acute, will be applied to this area' – needs to be reviewed outside of the meeting. **It was resolved that** the Committee: • **Noted** the Clinical Service of Concern Report	**NL / JR** **NL / JR**
QS24/70 Quality Delivery Group Chair's Report **QS24/70.1** The Executive Director of Nursing and Midwifery presented the report which identified a number of service pressures and concerns. **QS24/70.2** It was agreed that the Quality Delivery Group Chair's Report should be moved to after the Quality Report at forthcoming meetings. **It was resolved that** the Committee: • **Received assurance** from the Quality Report *[Ed Williams, Director of Performance, and Nesta Collingridge, Head of Risk Management, joined the meeting]*	**AW / PPJ**
QS24/71 IHC Regional Service Quality Deep Dive – East IHC **QS24/71.1** The IHC Director Of Nursing (East) presented the report which highlighted: • the reporting structure • their achievements. In particular noting the progress made at HMP Berwyn in the prevention of Tuberculosis, Hepatitis B and Hepatitis C. • an improvement in the Harms indicators from the end of the final quarter of last year to the first quarter of this year. Members were assured that there was an action plan in place to improve the HAPU outcome. • Actions taking place to continually improve • continuing areas of concern • a summary of risks, actions and mitigations, noting that there were risks associated with cancelled elective procedures and how difficult it was to quantify this. **QS24/71.2** Not noted in the report was the recent recruitment of 28 salaried General Practitioners, which along with the improvement in staff retention, contributed to an improvement in patient safety and care.	

QS24/71.3 Members were pleased to note the improvement in staff retention. They also asked if there could be a fairer, less misleading way of categorising Hospital Aquired Pressure Ulcers (HAPUs). Currently all ulcers presenting at home, in a care home, in a GP surgery or in hospitals are noted as being 'hospital acquired'. It was believed that the recent removal of the differentiation between 'community acquired' and 'hospital acquired' pressure ulcers had unfairly distorted the figures; this concern had been fed back to Welsh Government. **QS24/71.4** Members wished to note their concerns regarding the significant numbers of loss of insourcing for planned care patients, resulting in increasing waiting lists, whilst noting the complexities of the situation and mitigations applied. It was confirmed that Health Board's Executive Team were also concerned and that the Planned Care trajectories were under scrutiny on a daily basis by the teams and a resolution was being sought to reduce the backlogs. Members were assured that new structures were in place to streamline the ownership of risks at management level and if the need arose, there was the ability to escalate to Directorate and/or IHC level. **QS24/71.5** It was noted that staff morale was improving but that there was still much work to do, to improve the staff communications flow. Events such as the recent Leadership Event at Llangollen were felt to be hugely successful. Frustration remained within both the nursing and medical teams, due to the ongoing Planned Care situation, with many going above and beyond, however concern remained as to how long this could continue, evidenced by increased levels of sickness now taking place. **It was resolved that** the Committee: • **received assurance** from the Quality Delivery Group Chair's Report *[Andrea Hughes left the meeting]*	
QS24/72 Integrated Performance Report **QS24/72.1** The Director of Performance presented the report highlighting that in Q4 2024, the organisation's Smoking Cessation Service was second best in Wales at 6.5%, which would be good news for patients' health in the future. **QS24/72.2** A discussion took place concerning Clinical Coders and the reviewing of patients' notes. Welsh coders, unable to use electronic medical records were unable to work from home, whereas in England, where electronic medical records are available, coders are able to work from home which is more desirable for some, resulting in coding staff leaving Wales. It was agreed to schedule a visit for Members to view Electronic records. **It was resolved that** the Committee:	**AW/PPJ**

• **received assurance** from the Integrated Performance Report *[Ed Williams left the meeting]*	
QS24/73 Corporate Risk Register & Board Assurance Framework **QS24/73.1** The Head of Risk Management presented the report, noting that several actions were progressing. Four of the six overdue actions accountable to QSE related to falls; updates had been requested for those and escalated as needing to be progressed. These risks would in time become overall safety risks and therefore managed as operational risks. **QS24/73.2** The Director of Corporate Governance noted the significant amount of work carried out by the Risk team to improve processes. She noted that at the forthcoming Board Development meeting she would be discussing the risks with the Board, asking if they agreed with the classification of these risks as being top risks facing the organisation. If so, making sure the risks are mitigated accordingly. **QS24/73.3** The Executive Director of Nursing and Midwifery wished to thank the Risk Team for their support; she also wished to note that until outcomes are received from the HSE regarding the Falls risk and Patient Safety, part of the risk was the uncertainty and therefore inability to mitigate those risks to enable the organisation to monitor. It was noted that the safeguarding risk had reduced but would remain being something which required close monitoring. Despite the significant strides in the 'Failure to Embed Learning' area, the Executive Director of Nursing and Midwifery did not feel it appropriate to reduce the risk until there was further confirmatory evidence available. **It was resolved that** the Committee: • **Noted and received assurance** from the Corporate Risk Register and Board Assurance Framework.	
QS24/74 Date of Next Meeting 15th August 2024	
QS24/75 Resolution to Exclude the Press and Public	

QSE Committee PUBLIC Action Log

Open Actions						
Action No.	**Minute Ref.**	**Date**	**Agreed Action**	**Lead**	**Timescale**	**Status**
1	QS24/68.3	6.6.24	To circulate, when available, the national report on HAPU that is currently being populated	Angela Wood	July 2024	Open
2	QS24/68.8	6.6.24	To include a reference date on the data table	Angela Wood / Matt Joyes	July 2024	Suggest close. Actioned.
3	QS24/68.8	6.6.24	The Ombudsman Letter to be a separate item not included in the Quality Report at both QSE and Board	Angela Wood / Philippa Peake-Jones	August 2024	Suggest close Now on COB for both QSE and Board
4	QS24/68.8	6.6.24	Include historic/comparison data on the tables that are broken down by themes and re-align tables	Angela Wood / Matt Joyes	August 2024	Suggest close. Actioned.
5	QS24/69.2	6.6.24	Vascular Action plans via an escalation report/template to be received at QSE	Nick Lyons / James Risley	August 2024	Open
6	QS24/69.4	6.6.24	Take outside the meeting the issue of Vascular referral to the wrong place and how often this is happening	Nick Lyons / James Risley	August 2024	Open
7	QS24/69.5	6.6.24	Review the Progress update narrative on P1. 07 of the Vascular Action Plan	Nick Lyons / James Risley	August 2024	
8	QS24/70.2	6.6.24	Move the Quality Delivery Group Chair's Report to after the Quality	Angela Wood / Philippa	August 2024	Suggest close Amended on Agenda/COB

			Report at forthcoming meetings	Peake-Jones		
9	QS24/72.2	6.6.24	Schedule a visit to Electronic Records visits	Angela Wood / Philippa Peake-Jones	August 2024	Suggest Close Now on Forward Work Plan for QSE. Will be scheduled after summer given holiday period.

Closed Actions						
Action No.	**Minute Ref.**	**Date**	**Agreed Action**	**Lead**	**Timescale**	**Status**
1	QS24.15.1	20.02.24	Bring the HAPU Improvement Plan to the most appropriate QSE Committee	Angela Wood	June 2024	To be submitted to June QSE Meeting 6.6.24. Update provided and circulated to Members.
2	QS24.47.4	18.04.24	To update the Committee at August meeting to understand progress with regards to the Urology Review.	Nick Lyons	August 2024	This will be scheduled on the August QSE Agenda
3	QS24/68.2	6.6.24	To review the claims in relation to the oxygen issues and circulate outside of the meeting	Matt Joyes	June 2024	A search has been completed and there are no relevant claims.

Teitl adroddiad: ***Report title:***	**Patient Story: Robyn's Story - Trans Voice Service Patient Story** **Stori Claf: Stori Robyn – Stori'r Claf Gwasanaeth Llais Traws**			
Adrodd i: ***Report to:***	Quality, Safety and Experience Committee (QSE)			
Dyddiad y Cyfarfod: ***Date of Meeting:***	15th August 2024			
Crynodeb Gweithredol: ***Executive Summary:***	A patient or carer story is presented to QSE to bring the voice of the people we serve directly into the meeting. The digital story will be played at the meeting. A short summary is included in the attached paper.			
Argymhellion: ***Recommendations:***	QSE is asked to note this report.			
Arweinydd Gweithredol: ***Executive Lead:***	Angela Wood, Executive Director of Nursing and Midwifery			
Awdur yr Adroddiad: ***Report Author:***	Mandy Jones, Deputy Executive Director of Nursing Leon Marsh, Head of Patient Experience Rachel Wright, Patient and Carer Experience Lead Manager Hannah Hughes, Patient & Carer Experience Project Manager			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				
In line with best practice, a patient or carer story is presented to QSE 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?	N/A			

In accordance with WP68, has an SEIA identified as necessary been undertaken?	
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	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: Final Trans Voice Service Patient Story - WELSH Subtites.mov Final Trans Voice Service Patient Story - ENGLISH Subtitles.mov I am willing for my story to be shared with: [√] Level 1 – Any Health and Social Care Professionals within BCUHB [√] Level 2 – Researchers for Service Evaluation and improvement beyond BCUHB [√] Level 3 – Meetings and Conferences with anyone present including public and journalists [√] Level 4 – Anyone including Online, Internet, Social Media and CIVICA ***List of Appendices:*** Appendix A- Patient Story Summary	

Betsi Cadwaladr University Health Board

Robyn's Story – Trans Voice Service Patient Story
Stori Robyn – Stori'r Claf Gwasanaeth Llais Traws

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

Overview of Patient Story

The storyteller describes her journey, which starts with coming out to her GP in 2019. The storyteller describes a subsequent difficult 2 years wait to access the Welsh Gender Service and a boost in positivity since accessing the BCUHB Trans Voice Service.

The storyteller's main gender dysphoria was her voice, which was deep and low. She wanted to be lighter, higher pitched and 'more passable' in different situations.

The storyteller describes the content of the sessions as a huge helpful resource that she didn't know existed and making a 'real difference'.

Key Messages

- Patient gender dysphoria.
- Long and difficult wait to access the Welsh Gender Service.
- Improved positivity and confidence since engaging with the Trans Voice Service.
- The storyteller accessed the specialist Trans Voice Service in a number of ways.
- The shared experience' and 'fellowship' of the Video Group Clinic sessions resulted in a real confidence boost with 'everyone going through the same thing'.
- The content of the sessions is really helpful – a huge resource for patients.
- Sessions have given the storyteller confidence to go out socially, take part in situations day-to-day, to come out fully and to feel that it's ok to be trans.

Summary of Learning and Improvement

Transition is the process whereby people usually change from the gender expression associated with their assigned sex at birth, to another gender expression that better matches their gender identity. The UK Parliament Census in England and Wales (2021) recorded that 262,000 people (0.5%) said that their gender identity and sex registered at birth were different.

The Welsh Gender Service (WGS) was set up in 2017. This is a funded specialist treatment service in Cardiff. The provision of a Specialist GP, Speech and Language Therapist (SALT) Service and additional services across Wales has been approached separately by individual Health Boards across Wales, due to lack of funding. The three Integrated Health Communities (IHCs) across Betsi Cadwaladr University Health Board recognised a growing need for a dedicated post for Trans and Gender Diverse Voice and communication therapy

within SALT services. An opportunity became available to pool budgets from unfilled vacancies across the three SALT services, collaborating to reduce financial risk in establishing this new service. The Trans and Gender Diverse Voice Service is currently for adults only. The team have approached the Welsh Health Specialised Services Committee (WHSSC) for additional funding for dedicated posts to also secure the future of the service for children and young people.

A Specialist SALT to support the Trans and Gender Diverse Voice Service was employed by the Health Board in June 2023 and the team is currently marking the one-year milestone of the delivery of this service. The post is funded for 3 days per week delivering services across North Wales. Each IHC gets approximately a day per week, providing an efficient and equitable service.

Recognising the value of remote learning for this patient group, the Specialist SALT was not required to live locally and could provide the service for the whole Health Board area. Providing a virtual service has opened up the field for recruitment and this has resulted in the appointment of a specialised team member.

The team have created an innovative and entirely virtual Trans and Gender Diverse Voice Service. The team are currently refining their care-pathway based on evidence-based practice for this specific patient group as well as communication with stakeholders and the WGS. Referrals can be made by individuals, GP's or other Health Professionals and also the Welsh Gender Service. Patients are provided with an initial assessment / appointment with a Speech and Language Therapist to complete a virtual Case History Questionnaire (CHQ). They are also provided with video resources, patient information leaflets, a vocal hygiene webinar and complete 'Baseline Measurements' and 'Goal Setting'. Patients are placed on a therapy waiting list until spaces are made available. Therapy is offered remotely on a 1:1 basis, but patients can also opt in to an online generalisation group clinic. The number of appointments provided are based on individual need, but 4-6 sessions are standard. Virtual sessions are provided currently via Microsoft Teams, but the Attend Anywhere option is currently being explored in line with BCUHB best practice. For patients who have barriers accessing remote healthcare (illiteracy, digital poverty, neurodiversity, fear etc.), the team provide facilitated access. In these instances, patients are invited to attend a clinic and a member of the SALT team is present in the room to provide support with the technological aspects of the session.

Since the setup of the WGS, the number of referrals received has been rapidly increasing and the WGS provide the bulk of the referrals. Prior to 2019, referral rates were on average 1-6 per year. Since 2019 there has been an increase in referrals from 14 in 2019 / 2022 to 76 in 2022 / 2023. Referrals currently average at 2 per week, with a caseload of 54 patients accessing the service.

Outcome measures for this service so far are positive, reporting reduced waiting times and increased clinical time for patients. Patients have reported an improvement in vocal parameters, decreased dysphoria and functional impact of voice, increased happiness with voice and increased confidence reported by patients following both 1:1 and group sessions.

The use of Video Group Clinics (VGC's) within Speech and Language Therapy aligns with the Health Boards recognition that there is a need to modernise outpatient appointments. The All Wales 'Transforming the way we deliver outpatients in Wales - three-year strategy and action plan (2020-2023)' promotes that the use of virtual activity and group consultations will continue to increase and support transformation in the way outpatient care can be delivered to ensure sustainability as an alternative to the default 1:1 model.

VGC's are consultations led by a clinician, or a team of clinicians, with a group of patients at the same time using an online platform such as TEAMS or Attend Anywhere. The primary purpose of a Video Group Clinic is to conduct a consultation with more than one patient in a group setting. The clinician reviews the patient's condition, and the next step of the patient's pathway is agreed and actioned. Video group consultations and clinics can be delivered in a single session or as part of an extended programme of care and support.

VGC's can have many benefits for patients, including consistent quality and access to care across the Health Board, mitigation of mobility barriers and reduction in patient travel, promotion of community connection and peer group support with improved confidence, motivation and outcomes. Patients can also join a VGC from the comfort of their own home or other confidential area, which often feels more relaxed.

The Patient and Carer Experience Team will promote this story widely during June, which is Pride Month. Pride Month is an annual celebration of the many contributions made by the LGBTQ+ community to history, society and cultures worldwide. The Health Board is proud to support the LGBTQ+ Action Plan for Wales (2023), LGBTQ+ staff, colleagues, patients, carers, families, stakeholders and partners and is committed to making the Health Board the most LGBTQ+ friendly health provider in Europe.

The Patient and Carer Experience Team has also shared the story with colleagues within the BCUHB Equalities team. Equalities provide support across the Health Board in furthering the equality agenda and supporting teams to act in accordance with Public Sector Equality Duty and Socio-Economic Duty in line with the Strategic Equality Plan (2024-28), promoting equality, diversity and inclusion, both as a place to work and as a public service. Equalities support teams with advice and guidance relating to equality and human rights legislation, provide training workshops to promote inclusive decision making and support the completion of Equality Impact Assessments and Socio-economic Impact Assessments. Equalities also provide an active staff network called Celtic Pride for LGBTQ+ colleagues. The network is a place for LGBTQ+ staff to share their experiences in a safe social space, plan events and awareness campaigns throughout the year and identify and work with the Health Board to improve the experiences of LGBTQ+ staff, patients and the wider LGBTQ+ community in North Wales.

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

Teitl adroddiad: ***Report title:***	QSE Committee – Women's Services QSE Deep Dive Presentation			
Adrodd i: ***Report to:***	QSE Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 15 August 2024			
Crynodeb Gweithredol: ***Executive Summary:***	The Duty of Quality was introduced under the Health and Social Care (Quality & Engagement) (Wales) Act in 2020. The introduction of the Health and Care Quality Standards (2023) provides an opportunity to align the standards not only with the duty but with the wider quality management practice in health. The Women's Service has taken this opportunity to present its update to the Health Board's QSE Committee, reflecting the six domains in the quality standards (safe, timely, effective, efficient, equitable and person-centred) supported by the six quality enablers (leadership, workforce, culture, information, learning, improvement/ research and whole systems approach)			
Argymhellion: ***Recommendations:***	The Committee is asked to note the content of the report.			
Arweinydd Gweithredol: ***Executive Lead:***	Angela Wood, Executive Director of Nursing and Midwifery			
Awdur yr Adroddiad: ***Report Author:***	Women's Senior Leadership Team			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☒	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence*	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*

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

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***	
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	BCUHB's Three Year Plan 2024-27 Outcome 3 - Creating compassionate culture, leadership and engagement Outcome 4 – Improving quality, outcomes and experience Outcome 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 Act 2020
Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqlA been identified as necessary and undertaken?***	N/A
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary ben undertaken?***	N/A
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	BAF-SP18 and CRR-24-04 – Quality, Innovation and Improvements.
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)*	N/A
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Amherthnasol Not applicable
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** ***Implementation of recommendations***	
Rhestr o Atodiadau: Dim ***List of Appendices:*** *None*	

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Women's Services
QSE Deep Dive

July 2024

WHOLE SYSTEMS APPROACH

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

Women's Services Operating Governance Structure – Updated July 2024

Health Board Executive Team

Advisory Groups/Executive Delivery Groups

National Committees

Mental Health Act Capacity and Compliance Committee

Planning, Population Health and Partnerships Committee

Quality, Safety and Experience Committee

Audit Committee

Remuneration Committee

Performance & Finance Committee

People Committee

Charitable Funds Committee

BCU Operational Leadership Team

Women's Senior Leadership Team

Women's North Wales Service Board

Women's Transformation Group (SDG) (quarterly)

- Women's Population Health Group
- GIRFT/ Gynae Group

Women's Quality, Safety and Experience Group (SDG) (inc H&S) (monthly)

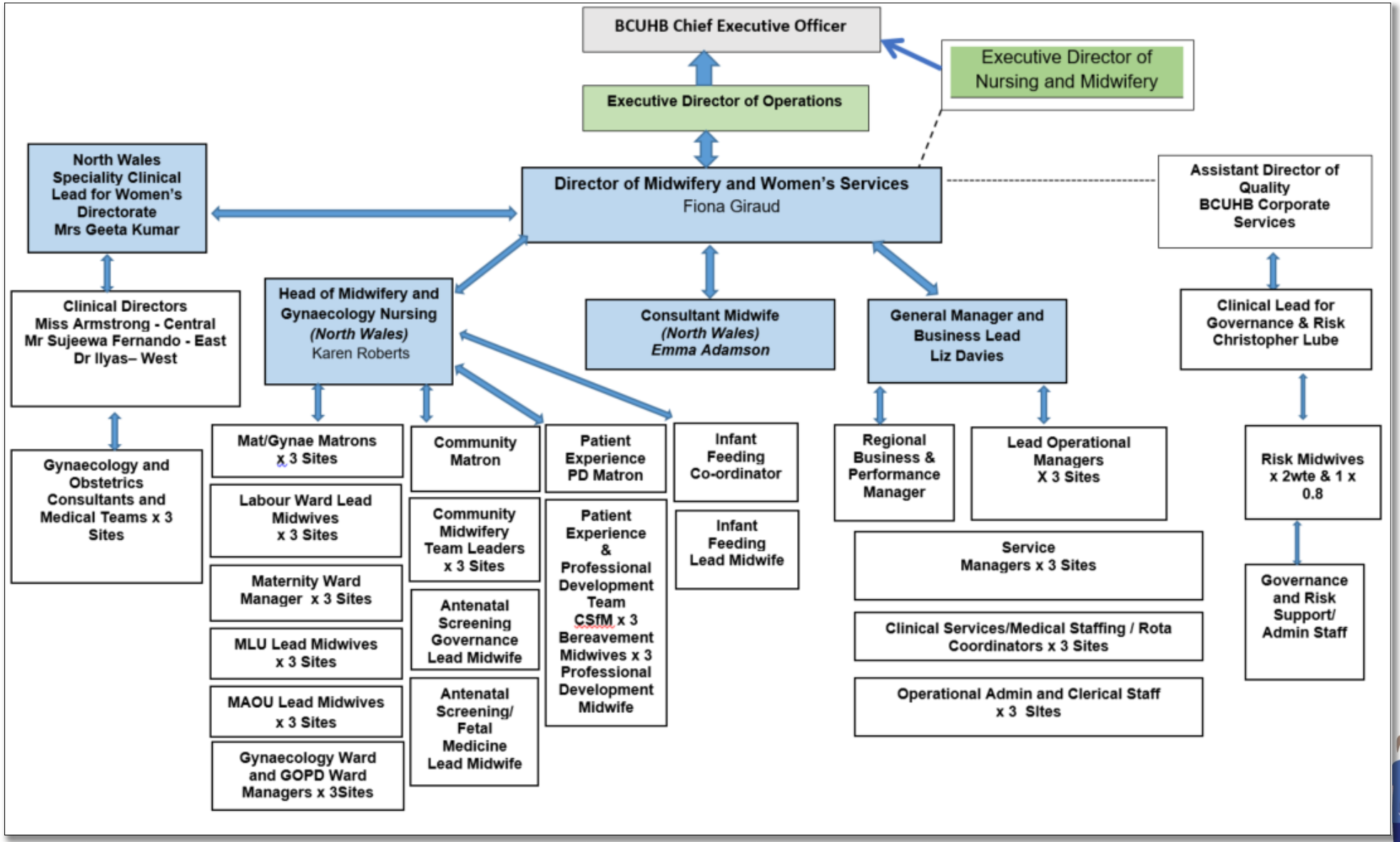
- Women's RMG
- Women's CEG
- Maternity and Gynae Voices Groups
- NW Antenatal Forum
- NW Intrapartum Forum
- NW Gynaecology Forum
- Bereavement Group
- Fetal Medicine

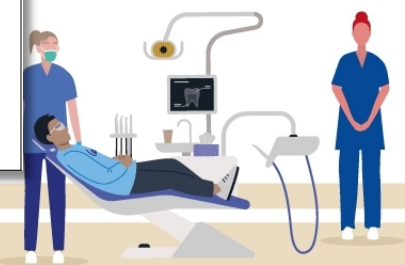
Women's Integrated Performance Group (SDG) (monthly)

- Planned & USC Recovery Group
- CSW Recovery Group
- Financial Recovery Group

Women's People and Culture Group (SDG) (monthly)

Leadership - Women's Services Management and Leadership Structure





Service Key Drivers

- A Healthier Wales: Long Term Plan for Health and Social Care (WG 2021)
- NHS Wales Planning Framework 2022-2025 (WG)
- The Health and Social Care (Quality & Engagement) (Wales) Act – 2020-updated 2023
- The NHS Quality and Safety Framework (2021)
- The Quality Statement for Women and Girl's Health (WG) – 2022
- Health and Care Quality Standards (WG) 2023
- The MatNeo Quality Statement (WG) – awaited
- The MatNeo Engagement Framework (WG) – awaited
- HEIW Perinatal Workforce 10 Year Plan – awaited
- Maternity and Gynaecology GIRFT Programme (2021)
- MatNeo Safety Support Programme (MatNeo SSP) - 2023

Learning, Improvement and Research

National Learning from Maternity Reviews

- HIW – 96.7% Compliant
  - 32 Recommendations
  - 28 Green/Completed
  - 3 Amber (Breastfeeding Strategic Action Plan, DMC, PRAMS)
  - 1 not applicable

- Cwm Taf - 97.1% Complaint
  - 70 Recommendations
  - 68 Green/Completed
  - 2 Amber (All Wales DMC, development of Emergency Gynae Service)

- Ockenden – 100% Complaint
  - 26 Recommendations
  - 24 Green/ Completed
  - 2 not applicable

- MapNeoSSP – Discovery Phase Recommendations (2023)
  - 124 Recommendations
  - 51 Green/ Completed
  - 37 Amber
  - 39 Red

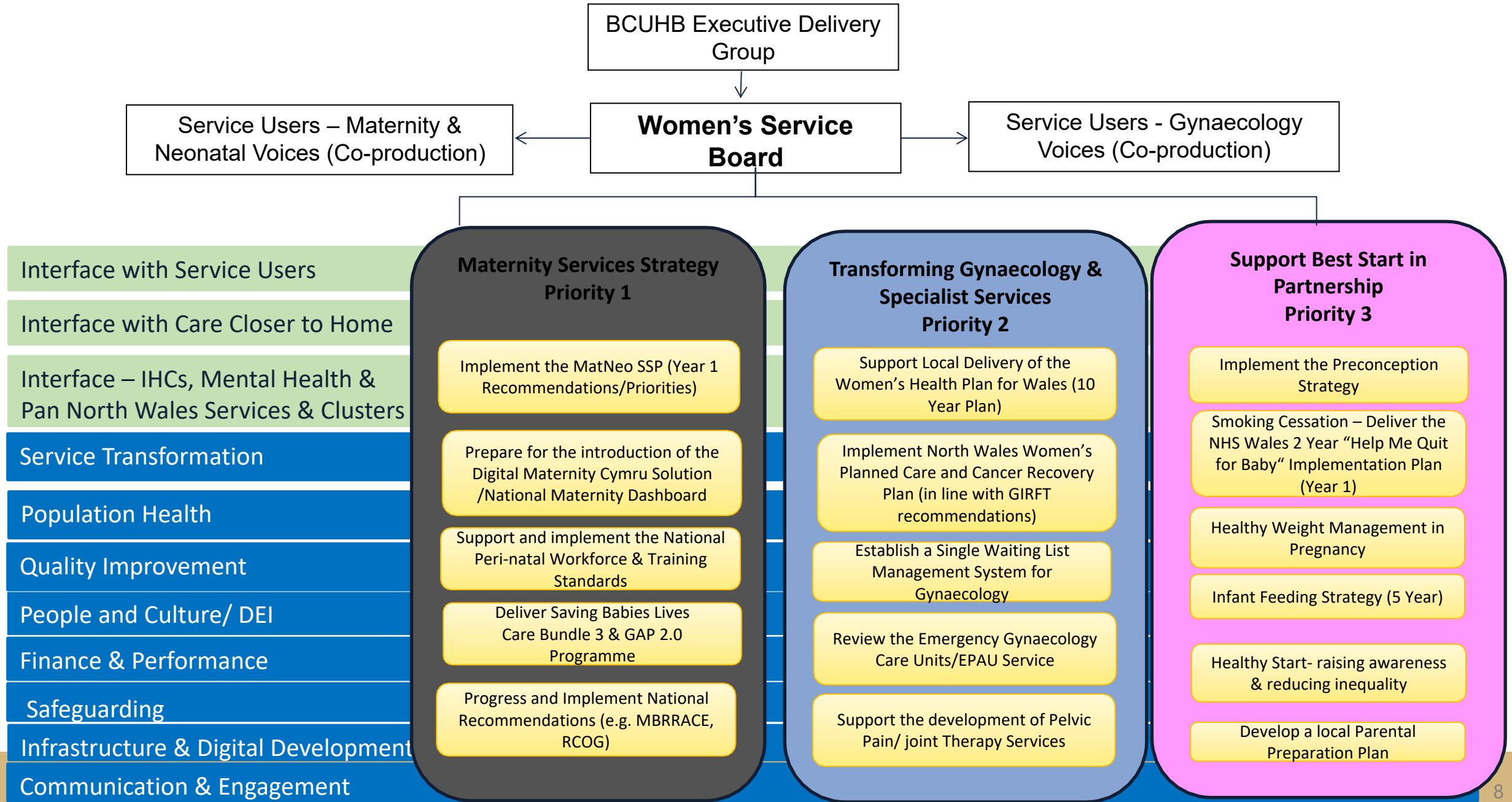
- MBRRACE Action Plans
- Review of Maternity and New-born safety Investigations- National Learning Report 2024 – Identified 4 Main Themes:
  - 18 Recommendations
  - 8 Green/Completed
  - 8 Amber
  - 2 Red – relate to Maternity Unit Standards and Telephone Triage (Q3)

- Local Quality Peer Reviews

Women's Annual Plan 2024/25 – Outcome 4 Improving quality, outcomes and experience

4K	Women's Services	Target Date	Current Position
4K.1	Supporting Local Delivery of the Women's Health Plan for Wales	Q4	The Women and Children's Network has been stablished in Q1 of 24/25 led by the NHS Executive. The Women's Plan is it's key objective. Potentially available in Q3/4.
4K.2	Implementation of the Maternity and Neonatal Safety Support Programme recommendations	Q4	MatNeo Champions continue to progress Phase 1 priorities. Local position against total 134 priorities has been submitted to the Network w/c 1/7/24. Currently awaiting national steer from the MatNeo Strategic Network in relation to the Phase 2 programme of works. MEWS - As part of the Maternity and Neonatal Safety Support Programme (MatNeo SSP) we have introduced Team of the Shift in one site with a view to spread and scale across three units of North Wales. This intervention is a safety huddle that occurs prior to clinical handover at 08:30 and 20:30 every day and designed to foster a culture of psychological safety, excellent teamworking and communication. Continuous data is collected on how often space is made for the team of the shift huddle to occur. This work lays the foundation of improving teamwork, communication and psychological safety which in turn promotes effective and timely escalation when there are concerns with the families in our care prior to the publication of a national Maternity Early Warning Score (MEWS) observation chart. This work is being led by an Expert Reference group of clinicians with representation from each health Board in Wales working with the Maternity and Neonatal Network (NHS Executive). NEWTT2 is updated guidance from BAPM on newborn observations and escalation. It describes at-risk groups and provides an updated Newborn Early Warning Track and Trigger (NEWTT2) chart aligning to current recommendations for newborn care and acknowledging feedback from healthcare professionals. The inclusion of parental concern supports highlighted concerns and recommendations made from recent maternity investigations. The chart acknowledges the importance of parental feedback in addition to the wider MDT. When to escalate and call for assistance using the NEWTT tool has been described previously and this update builds on this advice. The extended framework provides an escalation tool and a standard response and review tool for the multidisciplinary team to promote consistency between healthcare professionals and ensure that the team and family are involved in and fully informed of the actions required for a baby to receive safe and quality care. The response tool facilitates the documentation of the response taken and subsequent actions required NEWTT 2 has been published in multiple places and is being rolled out across the UK. An evaluation will be taking place by BAPM following implementation to evaluate it's effectiveness. We are going to be one of the evaluation sites to ensure all devolved nations are included.
4K.3	Progression and implementation of national recommendations including Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRACE)	Q4	The action plan has 241 individual actions (grouped under 225 recommendations) identified which have been in place since the plan was established. The Clinical Governance Lead, Women's Services continues to monitor and review all actions which are Amber to ensure the most up to date position is identified. Therefore, the status shows that there are no actions, which are red, 11 amber and 195 which are green; there are 19 actions, which are Grey as they fall under the responsibility of a National Body. A review will be completed to identify if there are any local actions that need to be taken whilst awaiting outcome form the national bodies.
4K.4	Preparing for the induction of Digital Maternity Cymru Solution	Q4	Latest version of the National business has been released to HB's to review, with HB expected to sign a declaration of interest by the 26th of July. WG has not yet to confirm funding proposal. BCU are reviewing financial and commercial implications and will respond accordingly. BCU continues to be engaged in the national standardisation activities.
4K.5	Implementing the North Wales Women's Planned Care and Cancer Recovery Plan in line with GIRFT recommendations	Q3	Cancer and Planned Care remain a priority to the Service. Mitigative actions are detailed on Slide 7.
4K.6	Supporting the implementation of the Preconception Strategy and population health work streams	Q4	Preconception Strategy was launched in 2023/24. Development of an implementation plan is delayed due to changes within the Public Health Team. Preconception will be a key priority within the Wales Women's Health Plan for Wales.
4K.7	Supporting Healthy Start by raising awareness and reducing inequality	Q3	Healthy Start is widely promoted with support from BCUHB Public Health Wales colleagues.
4K.8	Raising awareness of, and supporting the effects of, menopause on women's physical, emotional; mental and social well-being	Q3	WLI funding requested to support Menopause OPD appointments. National Menopause Training model launched – this has been shared widely with Clinical body and will support the care closer to home model. Virtual Sessions are also being progressed with Primary Care to reduce the number of referrals
4K.9	Reviewing the best configuration for endometriosis services in North Wales	Q4	Business Case to establish a North Wales Endometriosis Centre reviewed by the RIGA (Recurrent Investment Group Assurance) panel. Recurrent funding to progress with Endometriosis Business Case was not supported, £300k has been allocated from the Value Based Health Care Fund on a non-recurrent basis for 2024/25. Currently considering how to utilise this funding effectively and efficiently within this budget year – education, diagnostic clinics, progression of Nurse Led Pathways

WOMEN'S SERVICE ANNUAL PLAN (2024/25)



Quality Improvement & Development Initiatives

Pre-Conception Strategy 2023/24 – developed locally. Shared with Welsh Government and Women's Network. Local Implementation Plan to be progressed In Q3

Best Start Hub- Public facing information platform for Pregnant People and Families (Best Start Hub - Preconception, Pregnancy, Early Years and Family - Betsi Cadwaladr University Health Board (nhs.wales))

Migration to GROW 2.0/ SBLCB3 – focused on Diabetes in Pregnancy Pathway and Pre-term Pathway

Maternity Outpatient Assessment Unit (MOAU) Review

Parent Educational Work
Consultant Midwife working with Community Teams and Users to review and agree standardised content for sessions, to be completed by end of August.
Resource packs will be created for each team to ensure they can facilitate sessions effectively.
Two staff workshops are arranged for September in support of staff to facilitate revised sessions effectively.

MatNeo Safety Support Programme – Recognition and escalation of the deteriorating patient
Work focused on detecting and escalating the deteriorating Mother and Baby. Includes introduction of the 'Team of the Shift'.

PERIPrem Programme – focused on clinical optimisation and management of the Neonate

Induction of Labour (IOL)
The IOL improvement group, supported by the Transformation Service, are currently in the scoping phase and are mapping the IOL journey, across both community and acute settings. In addition service-user feedback is being collected. This aim of these initial activities is to identify any significant variance within the service and also to identify priority areas for improvement during the next phase of the improvement group.

Enhanced Recovery Ysbyty Glan Clwyd (YGC)
Officially launched from 14th January 2024. Registered Midwives have completed their Care of the Critically Ill Pregnant or Postpartum woman (CIPP) training and their shifts on Intensive Care Unit (ITU) and Acute Intervention Team (AIT).
Enhanced Maternity Care by Midwives focuses on providing a higher level of critical care to pregnant women with moderate health complications, aiming to prevent the need for intensive care unit (ICU) or high dependency unit (HDU) admissions. This approach is designed to manage and stabilise conditions that, if left unmonitored or untreated, could escalate to severe health issues requiring more intensive medical interventions.

ATAIN Project – Reducing Harm leading to avoidable admissions of full term babies into Neonatal Units
Focused on reducing mother and baby separation

Cancer and Planned Care
Roll out of the national Unscheduled Bleeding on HRT Pathway will commence at the beginning of August which will support USC performance. A meeting to review PMB Options appraisal is scheduled at the end of August. Both the Menopause and Urogynae Services are being reviewed to both support recovery and ensure an sustainable and equitable Service across North Wales.

Endometriosis Service
Whilst the full Business Case was not supported following RIGA2 £100k per quarter has been secured per quarter to progress the Service. Work is underway to identify activity inclusive of Diagnostic Clinics and implementation of Nurse Led Pathways.

SAFE, TIMELY, EFFECTIVE, EFFICIENT, EQUITABLE AND PERSON-CENTRED CARE

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Corporate Risk Register Entries

Single Cancer Pathway Performance Target (ID4966) Score 16

There is a risk Women's Services may continue to fail to comply with the Single Cancer Pathway Performance targets (10 days to first appointment and 62 days to commence treatment). This is caused by increasing demand, insufficient capacity, theatre availability and diagnostics. This could lead to an impact in diagnosis and treatment, increase in backlog, reputational damage, increased complaints and financial cost when addressing the backlog.

New Risk for Escalation to Corporate Risk Register:

Urgent Patients on backlog waiting lists (IDTBC) Score 16

There is a risk that urgent patients may be deteriorating due to the backlog in waiting lists. This is caused by increasing Cancer demand which is filling up core capacity.
This could lead to an impact in diagnosis and treatment, increase in backlog, reputational damage, increased complaints and financial cost when addressing the backlog.

Women's Services Top 5 Risks (In addition to the above):

Patient safety as a result of not achieving Ministerial Planned Care recovery Targets (ID3524) Score 12

- There is a risk of failing to treat/ see/ diagnose patients in a timely manner in line. This is caused by the backlog in patients due to the Covid-19 pandemic and insufficient capacity to meet demand. This may lead to a potential for increased patient harm and deterioration in their condition due to the delay.

Poor or unsafe care may be delivered by CoCH to women known to BCU due to limited assurance (ID4019) Score 12

- There is a risk that pregnant Women known to BCU who accessing commissioned care through the maternity services of Countess of Chester Hospital may not be receiving high quality patient-centred safe care and better outcomes.
- Business Case to decommission Services not supported by the Executive Team. 24/25 Contract currently being reviewed to revert to cost per case
- Updates sought in relation to progress made against CQC activity – action plans are awaited
- Issues highlighted for discussion at regular BCUHB/ COCH contracting meeting

Financial Balance (ID4631) Score 12

- There is a risk that the Service may not achieve financial balance in 24/25. This may be caused by very few 'transactional' savings opportunities to pursue in 2024/25, as many of these have already been maximised as far as possible
- Local Finance and Savings meeting in place and meeting regularly to review and pursue opportunities. Two transformational savings schemes submitted by the Service, but not supported by the Health Board, noting one of these schemes would have delivered the savings target in its entirety, on a recurrent basis, with minimal investment required/impact on BCU activity

Compliance of Women's Services Clinical staff compliant with Manual Handling training has fallen below an acceptable level (ID4748) Score 12

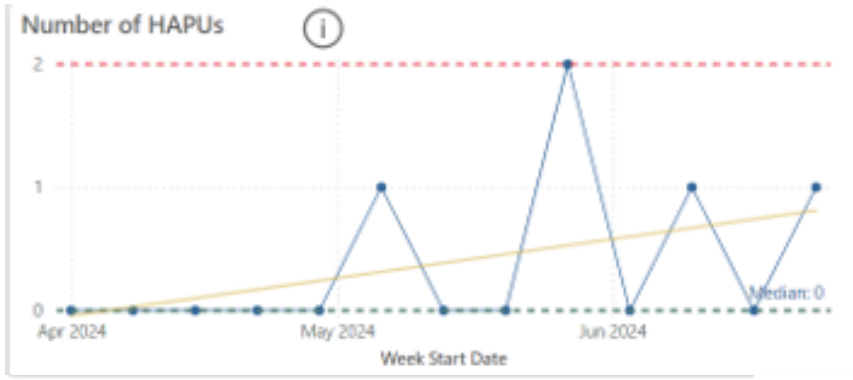
There is a risk that Womens Services and BCUHB may be in Breach of H&S Regulations (Manual Handling Operations Regulations 1992, as amended by the Health and Safety (Miscellaneous Amendments) Regulations 2002.)

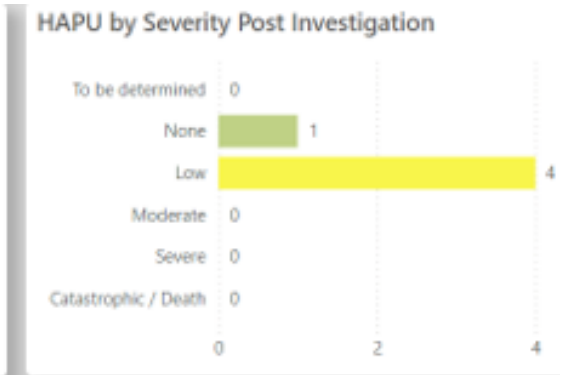
- All areas staffed to provide minimal staffing levels which also supports manual handling requirements
- Increased uptake in training
- Compliance at Level 1 is 83.6%
  Compliance at Level 2 is 51.39%

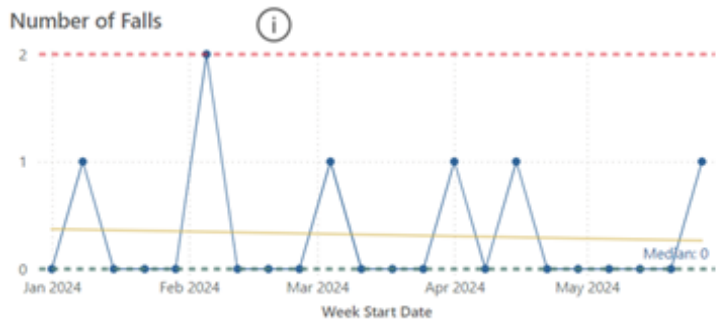
Water Ingress to Celyn Ward and Delivery Suite (YGC) (ID5056) Score 12

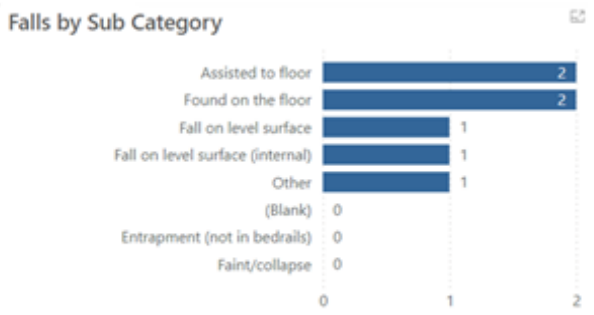
- There is a risk of flooding to Celyn Ward and the Delivery Suite. This is caused by water ingress from various parts of the roof and could impact on the Service's ability to deliver core services.
- Previous temporary repairs completed and gutters cleaned after nesting season to remove any nesting debris, which blocks guttering attributing to water ingress.
- Confirmed on 10/07/24 that Estates are currently working on the design solutions of the new roof, no works can start externally until September when the nesting birds have gone and works will be complete by March 2025.

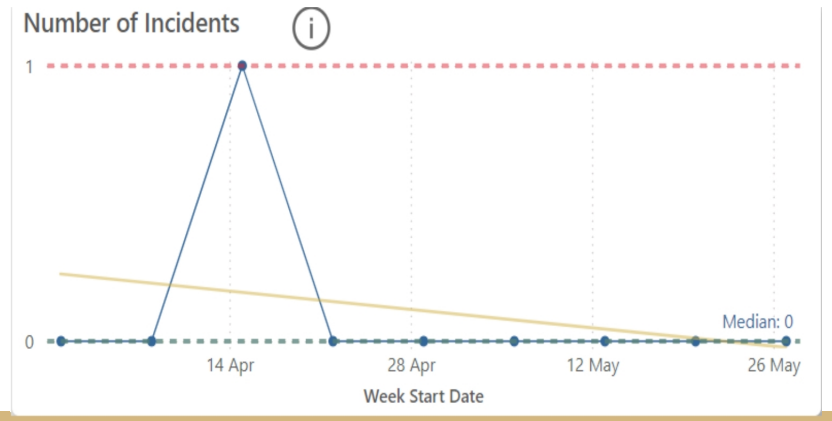
Harms Prevention











Medicine Management

1 – patient discharged without medication being prescribed

MatNeo Safety Support Programme – Recognition and escalation of the deteriorating patient

- Work focussed on detecting and escalating the deteriorating Mother and Baby
- Includes introduction of the 'Team of the Shift'

National Priority Actions

- Implement Birmingham Symptom Specific Obstetric Triage across all Health Board – Achieved
- Implement the All Wales standardised Maternity Early Warning Score toolkit across all Health Boards
- Implement a standard approach to the detection of the sick or deteriorating women in line with NICE guidance (NG133) – aligned to MEWS
- Scope out variation in clinical application of Sepsis Care Guideline – aligned to MEWS

Infection Prevention & Control (IPC)

Key Milestones and Priorities

- Funding approved for sinks in Ruabon and Brynteg to meet IPC standards
- Works planned for Pen-y-Groes to resolve IPC issues preventing use of a clinical room – predicted completion September.
- Focus on Hand Hygiene and BBE compliance in West clinical areas. Some improvement in Maternity, however reduced compliance for Gynaecology-topic board updated to reflect.

Areas of good practice / Issues to celebrate

- Clinical activity resumed in YPS for midwives following installation of sinks
- Capital approval for replacement of sinks labour ward East – knee operated taps.

C4C

West MICAD scores	Cleaning	Estates	Nursing	Overall
Ffrancon	98.3%	99.2%	97.52%	96.2%
Labour Ward	99.21%	99.06%	99.24%	98.4%
Llifon	98.3%	98.41%	99.61%	96.69%

Central MICAD scores	Cleaning	Estates	Nursing	Overall
19A	97.49%	96.11%	98.67%	93.32%
Labour Ward	98.7%	97.85%	98.32%	95.88%
Celyn	97.3%	94.51%	95.12%	89.61%

East MICAD scores	Cleaning	Estates	Nursing	Overall
Bromfield	100%	95.81%	100%	95.82%
Labour Ward	100%	97.28%	98.78%	96.59%
Lawson Tait	100%	98.56%	96.%	97.86%

IPC Training Compliance – Q1

Improve education and training in Infection Prevention and Decontamination				
e-learning	Target	Performance	Progress in last quarter	Actions for next quart
IP level 1	>85%	83.31%	83.54%	85%
IP level 2	>85%	86.43%	81.54%	85%
ANTT	>85%	79.37%	75.31%	85%

CSSI HARP Report (Q4 2023/24) – Key Findings

Consistent data collection, with data quality consistently at 100% for all of 2023.

The most recently published HARP report for Q4 2023 evidences a static rate of CSSI of 3.8% across BCU.

Our inpatient rates of CSSI remain extremely low at 0.3% and are associated with women who have systemic infection at the time of procedure.

Most commonly, our infections are defined as late community onset, more than 5 days following hospital discharge.

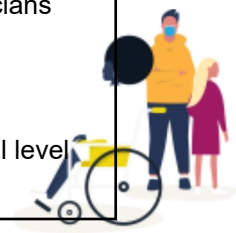
The themes identified through report analysis include the use of non-standard wound closure, the rate of infection associated with non-dissolvable sutures and staples is around 15%. Also poor swab technique with mixed culture and skin flora regularly seen in reports.

Overall SSI rate

	Betsi Cadwaladr UHB	
Valid forms received	2105	
Forms where inpatient and post-discharge SSI are completed, or there is a post-discharge SSI.		
Overall SSI rate	80	3.8%
= number of SSI / valid procedures x 100		
Hospital onset (inpatient)	7	0.3%
Community onset	9	0.4%
Late community onset	62	2.9%
Infection diagnosed 5 or more days after hospital discharge.		

Improvements for 2024

- A focus on reducing the use of non-standard wound closure methods by educating clinicians regarding their high infections rates.
- Education of swab takers to ensure standardisation in practice.
- Further improve reporting by decreasing over-reporting and identifying themes on a local level through the use of RCA



Maternity Quality Dashboard

CLINICAL PERFORMANCE INDICATORS	TARGET/ National	Jan-24	Feb-24	Mar-24	Apr 24	May 24		
C-section Rates (No National Target)	N/A	37.1%	36%	36.9%	37.1%	40.8%	↑	
Initial assessment within 10 weeks	85%	89.1%	80.4%	89.1%	84.9%	85.1%	↑	
Percentage of women who are smokers at 36-38 weeks	National Target 16%	14.6%	15.6%	18.2%	14.4%	15.1%	↑	
Proportion of women with a birth weight below 2.5kg (Low birth weight)	National Target 7%	8.1%	6.7%	6.6%	7.8%	9.1%	↑	
Women with existing MH condition	5.2%	3.5%	5.9%	5.7%	4.1%	4.8%	↑	
Women with existing MH condition who have a care plan in place	100%	43.8%	80.8%	52%	33.3%	52.4%	↑	
Induction of Labour Rates	National Target 36%	36.5%	39.5%	36.4%	37.1%	36.9%	↓	
3rd/ 4th Degree tear following Instrumental Delivery	3.5%	0%	0.26%	0.49%	1.02%	0.26%	↓	
		0	1	2	4	1	↓	
3rd/ 4th Degree tear following Normal Delivery	3.5%	0.35%	1.28%	1.96%	1.79%	0.52%	↓	
		1	5	8	7	2	↓	
PPH >= 1500 - 2499ml	National Target 2.9%	2.4%	2.2%	3.7%	2.4%	3.2%	↑	
		8	10	17	11	15	↑	
PPH >= 2500ml	National Target 0.5%	-	-	-	-	-	↓	
		2	3	1	5	1	↓	
Neonatal Deaths (Early)		3	1	0	0	1	↑	
Still births (>24 Weeks Gestation)		4	1	2	2	0	↓	

Morbidity & Mortality Rates

Mortality Data 2022,2023,2024 (inc. Still Births, Neonatal, Maternal & Gynaecology)						
	SB	**NND**	**Early NND**	**SB Per 1000 Birth (crude)**	**Maternal Deaths**	**Gyanecology Deaths**
2022 Jan to Dec	20	10	9	3.4	1 (Direct)	0
2023	13	3	5	2.25	1 (indirect)	1
2024 Jan to June	9	4	4	TBC end of year	1 (indirect)	0

Mothers and babies: Reducing Risk through Audits and Confidential Enquiries, United Kingdom (MBRRACE-UK) – 2022 – BCUHB

All deaths:
Our stabilised & adjusted stillbirth rate was 3.21 per 1,000 total births in 2022 compared to 3.21 in 2021. This is around the average for similar Trusts & Health Boards.

Our stabilised & adjusted neonatal mortality rate is 1.45 per 1000 livebirths compared to 0.94 per 1,000 live births in 2021. This is 5% higher than the average for similar Trusts & Health Boards.

Our stabilised & adjusted extended perinatal mortality rate is 4.74 per 1,000 total births. This is around the average for similar Trusts & Health Boards.
Data for 2023 is not yet available.

Perinatal deaths increased across the UK in 2021 for the first time in seven years.

A Thematic Review of Stillbirths in Betsi Cadwaladr University Health Board for 2023 has been completed. The recommendations have been included in the Women's Reducing Morbidity and Mortality Action Plan.

A Thematic Review of Neonatal Deaths for 2022/23 is awaited

BCUHB's Annual Stillbirth

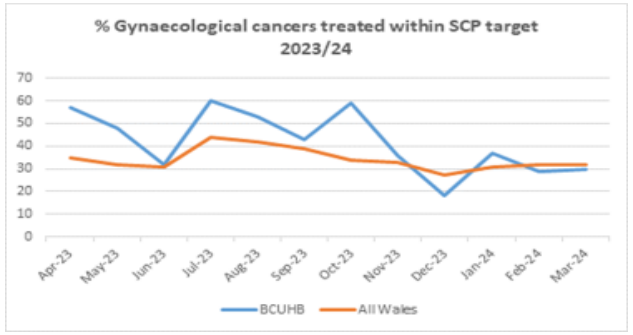
Year	England and Wales Stillbirth Rate (Office of National Statistics)	UK Stillbirth Rate (MBRRACE-UK)	Wales Stillbirth Rate (MBRRACE-UK)	BCUHB Total Births	BCUHB Number Of Stillbirths	BCUHB Stillbirth Rate (per 1000 total births)
2015	4.5	3.89	4.10	6727	21	3.12
2016	4.4	3.93	4.44	6650	26	3.90
2017	4.2	3.74	3.99	6594	13	1.97
2018	4.1	3.51	3.79	6602	22	3.3
2019	3.9	3.3	4.02	6322	28	4.4
2020	3.8	3.8	3.48	6085	21	3.45
2021	4.1	4.1	4.1	6082	17	2.79
2022	4.0	3.9	4.4	5870	20	3.4
2023	Not available at time of report	Not available at time of report	Not available at time of report	5775	13	2.25

Initiatives to reduce Morbidity and Mortality include:

- Introductions of the Saving Babies Lives Care Bundle 3
- Introduction of the GROW 2.0

Timely & Effective Care – Planned Care & Cancer

Cancer/ USC



As of May 2024 21% patients were booked within 62 days (National average 30%)

Short Term Action:	Medium Term Action:
• NHS England Commissioned activity • WLI funding secured • Transfer of Care – Pan North Wales model • 1WTE Gynae Oncology/ Consultant Vacancy out to advert, closing date 20/08/2024 • 1 WTE Gynae Cancer Unit Lead Vacancy out to advert, closing date 23/08/2024 • Locum cover being sought to support vacancy gaps • Bi-weekly Cancer Recovery meetings in place and drive local recovery plan • Best Practice meeting arranged 02/08/2024 with C&V following Ministerial Summit	• Capacity and Demand exercise • PMB Pathway review (Joint meeting with Radiology 30/08/24) • Implementation of unscheduled bleeding on HRT pathway (August 2024) • Business Case to increase establishment • Pathway Review and Development • Primary Care Education

Risks (ID 4966 – Score 16):

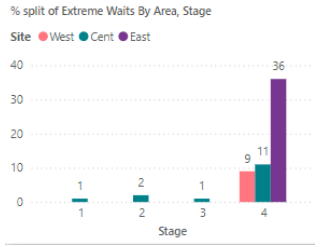
- National Recruitment position
- Removal of Pathway Tracker funding (RIGA 2 Decision) – Business Case submitted for Executive approval at Planned Care Board on 26/7/24
- PARR Equivalent rate agreement to support additionality (Stage 4)
- Patient availability (TOC)
- Theatre Availability

Planned Care

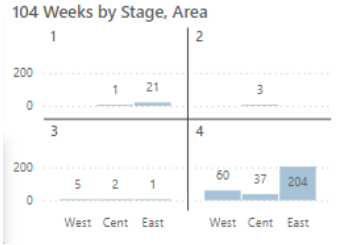
The current Gynaecology performance against the trajectory as submitted to Welsh Government and performance aligned to WG targets stand as:

Point of Delivery	Month Plan	Month Actual	Variance	YTD Plan	YTD Actual	Variance
Inpatients / Day-case	138	204	66	506	700	194
Outpatients	723	740	17	2757	2649	-108
Activity data up to and including (date)				21/07/24		

Extreme Waits 208 weeks and 156 weeks – All Waits at Stage 4 (15/07/24)



104 Weeks – all Stages (15/07/24)



Short Term Action:	Medium Term Action:
• Improved Theatre Utilisation • Menopause Super Clinics (subject to WLI funding) • Menopause Training (Appendix 3) • Menopause Virtual/ Primary Care Sessions • Transfer of Care Progressing to support Extreme Waiters • Review of Urogynae Services, next meeting 23/07/2024 • VBHC funding to support development of Endometriosis Service • Action plan in place to validate West FUWL	• Capacity and Demand exercise • Development of Business Case to secure ANPs to support Menopause Service • Referral Gateways • Pathway Review and Development

Risks (ID3524 – Score 12):

- Prioritisation/ Balance - Cancer Pressures
- Patient availability (TOC)
- Menopause Demand – WLIs to support Super Clinics – declined
- PARR Equivalent rate agreement to support additionality (Stage 4 Extreme Waiters)
- Theatre Availability

PERSON-CENTRED EXPERIENCE AND ENGAGEMENT

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

Patient Experience and Engagement

National Developments: Maternity and Neonatal Engagement Framework - awaited
Roll out of PREMS for Maternity and Neonatal Services - awaited

CIVICA

IHC/Specialist Service	Real-Time Feedback Survey - Number of returns from 1st March 2024 – 30th June 2024	Using a scale of 0-10, where 0 is very bad and 10 is excellent - overall experience rating
Womens Services	502	9.13

Women's Services received the highest number of Real-Time Feedback Survey returns from patients who received care and treatment at Ysbyty Glan Clwyd (216 returns).

- Overall satisfaction levels remain high with patients rating their experience as 9.14 out of 10 (10 being excellent), which is a 0.14% increase from Q3.
- 86.46% of patients always felt they got assistance when needed.
- 83.73% of patients stated they always felt listened to.
- 82.14% of patients always felt they were given all the information they needed.
- There was a significant number of positive qualitative feedback responses on CIVICA Praising staff within Maternity Service

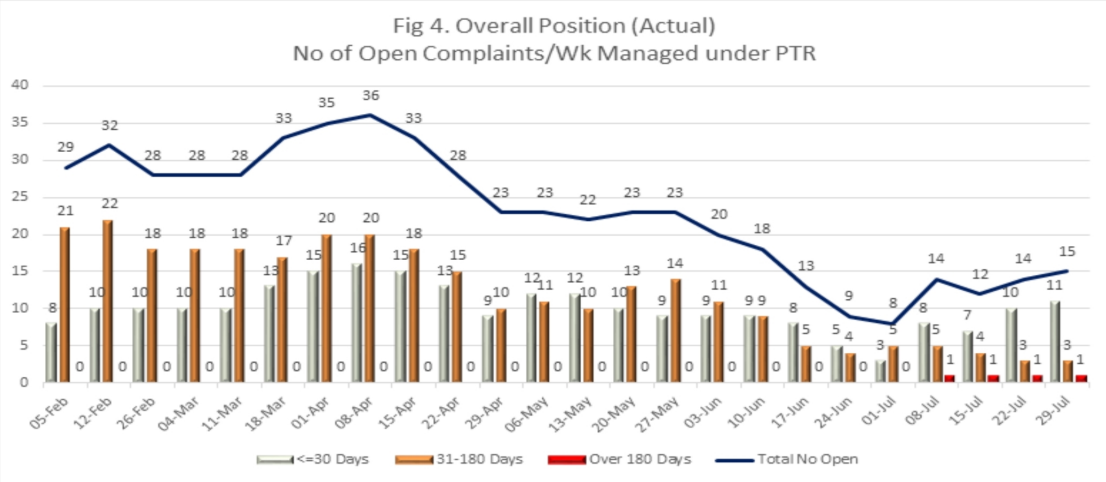
An improvement plan has been co-produced with Maternity Voices Partnership following feedback identified through the Birth Reflections Service, Real-time Feedback Surveys and formal concern themes raised. Informed consent, attitude and behaviours of staff and communication are areas identified in the plan requiring improvement.

Other Local User Experience Developments Include:

- 15 Steps in Maternity Services – Quality from the users perspective
- Birth Reflections Service
- User Focus Groups
- MatNeo Voices Group
- Gynae Voices Group
- Patient Experience feedback informs a local Action Plan
- Implementation of the National Cultural and Equality Competencies – includes vulnerable and ethnic minority populations

Patient Story - My Beautiful Home Birth

Complaints & Incidents



Current Status as of 29th July 2024

- Number of open complaints – Number of Complaints open less than 30 days – 10
- Number of Complaints open between 31 and 180 Days - 3
- Number of complaints open over 180 days – 1
- Number of Total Overdue complaints – 4

Themes and Trends:

Access (to Services)	3
Clinical treatment/Assessment	16
Communication issues (including Language)	4
Patient Care	3
Test and Investigation Results	1

Recovery

- Corporate Scrutiny Complaints meeting held weekly
- Local complaint performance meeting held twice weekly
- Recovery is a reduction of the overall number of complaints open and 75% as a percentage of the number of overall complaints being closed (before30 days)
- by the 14th October, 2024 – we are currently on trajectory to achieve 100% compliance based on the current closure and complaint received rates.

Incidents: During Q1 (24/25), 574 (increase of 29 incidents as compared to Q4) incidents were reported relating to maternity and obstetric services, this accounts for 84% of all incidents reported for the Women's Service for this period.

Current status of all open Incidents on Datix - 30/07/52024	
Stage	Total Open
Management review / Make it safe	173
Under investigation	85
Awaiting closure	67
Total	325

Serious Incidents: There has been 1 incident which is subject to a Serious Incident review. The case relates to a baby who had Meconium Aspiration at birth. The case is currently in the process of investigation.

Overall Themes:
Maternal: PPH >1500ml , <10 th centile , Unexpected admission / readmission
Neonatal: Unexpected Admission to NNU
Assessment, Investigation, Diagnosis
Improvement Plans reflecting the themes are being progressed.

NRIs
Seven cases open, six overdue :
82639 is the Never Event.
83767 and 82109 – AHCH cases, Women's Services now taking lead and review panel date being arranged as urgent to cover both cases.
88545 – Report being updated with panel comments. Plan for QSE 16/08/2024
90667 – Updates to report being made, plan for Serivce Board 23/08/2024, extension approved to 30/08/2024
91788 – Report updated, for QA plan QSE 16/08/2004
98440 – Panel being planned, NRI due 22/08/24

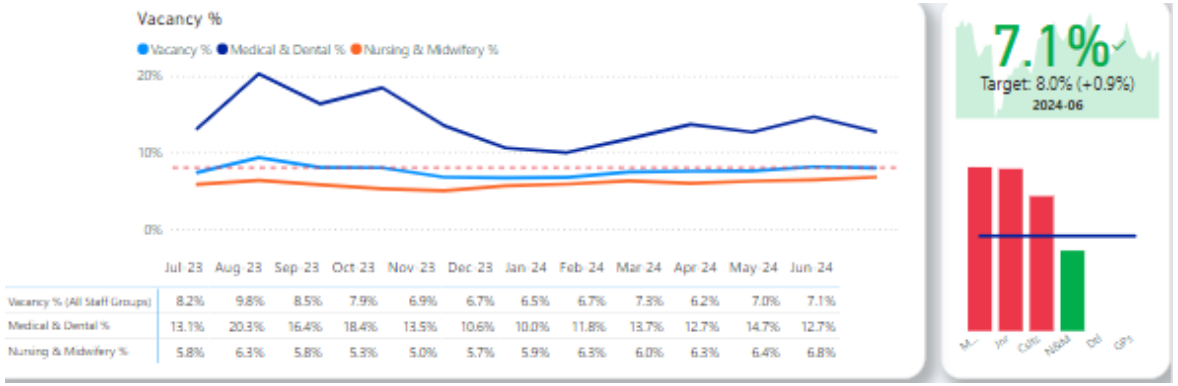
PST requested to close
78222 – Approved at Womens Board and 81460 – Approved at QSE

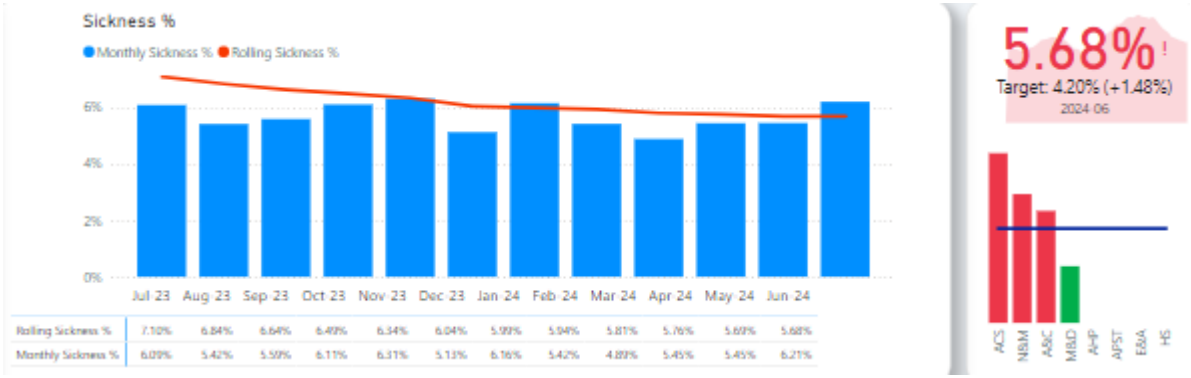
Inquests: There are five open inquest

Reg 28: 0

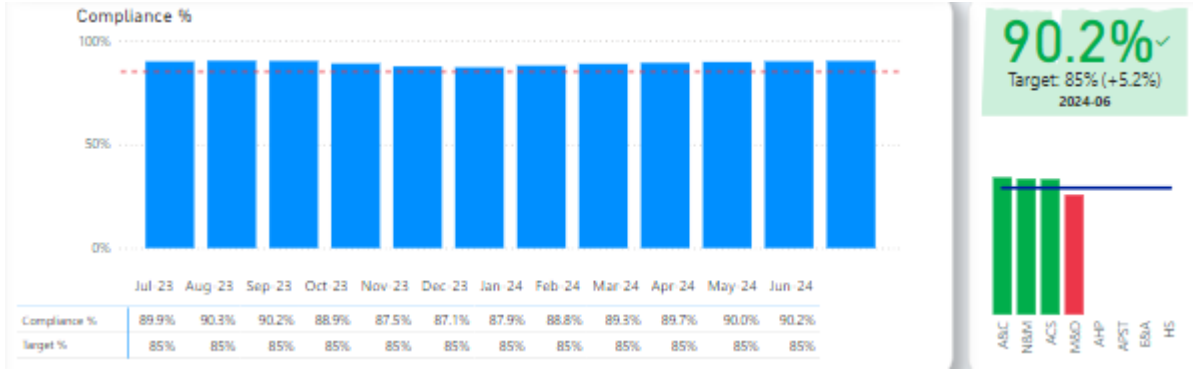
Workforce Governance – Our People and Organisational Development

- Birth Rate Plus – Compliant
- NSA – Compliant
- Medical Rota and Labour Ward Cover – Compliant

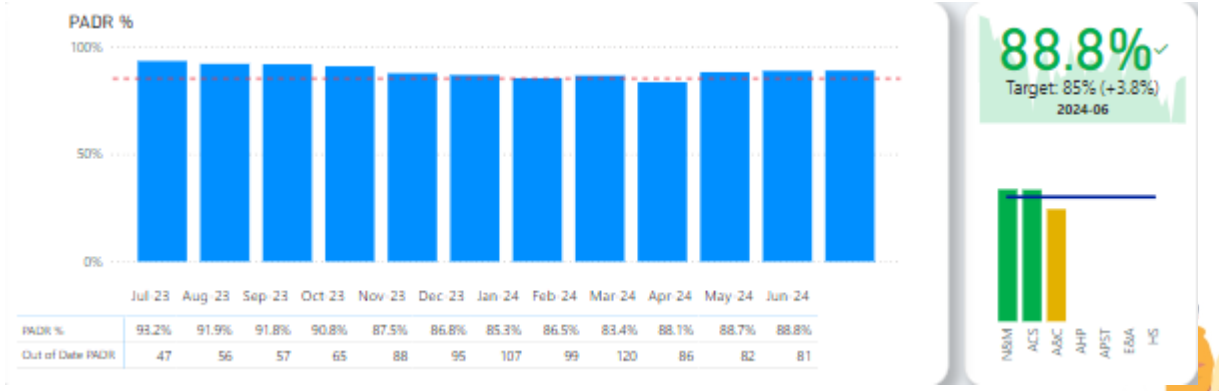




Training and Appraisal Compliance



- PROMPT Compliance
  - Midwifery 91.69%
  - Medical 80.63%



- Medical Appraisals - 95%

Staff Engagement

Women's People and Culture Work – includes:

- Staff Engagement Programme
- Diversity and Cultural Competency Programme
- Promotion of Compassionate Leadership
- Civility and Psychological Safety/ Speak Out Safely
- Standardisation of Induction for Leadership Roles
- Review of PADR process
- Walk in their Shoes Shadowing
- Professional Development Opportunities
- Commissioning, Recruitment and Retention Strategy

HOW WE LEARN AND IMPROVE

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

Women's Continuous Improvement Approach

- Ensure services are safe, reliable, accessible, equitable, effective and people-centred
- Avoid preventable harm
- Apply a Value-based approach to improve outcomes
- Maximise Learning and Sharing
- Use the learning to inform Planning, Development and Improvements

Teitl adroddiad: ***Report title:***	QSE Committee – Quality Report			
Adrodd i: ***Report to:***	QSE Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	August 2024			
Crynodeb Gweithredol: ***Executive Summary:***	This report provides the Committee with assurance, underpinned by analysis, on significant quality issues alongside longer-term data and information on the improvements underway			
Argymhellion: ***Recommendations:***	The Committee is asked to note this report			
Arweinydd Gweithredol: ***Executive Lead:***	• Angela Wood, Executive Director of Nursing and Midwifery • Dr Nick Lyons, Executive Medical Director • Teresa Owen, Executive Director of AHPs and Healthcare Science			
Awdur yr Adroddiad: ***Report Author:***	• **Patient Safety, Safeguarding and IPC Section:** Chris Lynes, Deputy Director of Nursing (Patient Safety), Tracey Radcliffe, Head of Patient Safety, Michelle Denwood, Director of Safeguarding, and 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 Section:** Dr James Risley, Deputy Medical Director (Clinical Effectiveness), and Joanne Shillingford, Head of Clinical Effectiveness • **Quality Assurance Section:** Matthew Joyes, Deputy Director of Quality and Erika Dennis, Quality Lead Manager • **Healthcare Law Section:** Matthew Joyes, Deputy Director of Quality and Debbie Kumwenda, Healthcare Law Lead Manager			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☐ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☒ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				
There is confidence in the data provided in the report however, the pace of learning and improvement remains a key focus of work. This is being addressed through a range of measures including the actions aligned to Special Measures and the Board Assurance Framework.				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Outcome 4 - Improved access, outcomes and experience for citizens			

	Outcome 5 - Recognition of BCU as a learning and self-improving organisation
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	The Duty of Quality is a statutory requirement under the Health and Social Care (Quality and Engagement) (Wales) Act 2020. The statutory duty of quality requires the decision-making processes by the Health Board take into account the improvement of health services and outcomes for the people of Wales – the duty also includes new Health and Care Quality Standards. Instances of harm to patients may indicate failures to comply with the NHS Wales standards or safety legislation.
Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqlA been identified as necessary and undertaken?***	N/A
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	N/A
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	BAF-SP18 and CRR-24-04 – Quality, Innovation and Improvement
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	N/A
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	N/A
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	N/A
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	BAF-SP18 and CRR-24-04 – Quality, Innovation and Improvement
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	N/A
Camau Nesaf: Gweithredu argymhellion ***Next Steps: Implementation of recommendations*** N/A	
Rhestr o Atodiadau: ***List of Appendices:*** QSE Committee Quality Report & 2 x Ombudsman Reports	

QSE Committee – Quality Report – August 2024

INTRODUCTION

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

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

The report is structured around three components of quality: Patient Safety, Patient and Carer Experience and Clinical Effectiveness, with a separate section covering Healthcare Law and Regulation. This reflects the organisational management arrangements for quality leadership in the Health Board.

PATIENT SAFETY

PATIENT SAFETY INCIDENTS

Oxygen 'no flow' incidents

An SBAR paper was presented to the BCUHB Medical Gases Group related to the 'no flow' oxygen incidents occurring in the Health Board involving BOC CD cylinders. The great majority of incidents arise because the Main Valve has not been opened (in addition to the Flow Selector). This problem has been recognised in national reports and alerts over several years (HSIB 2018, NHS Improvement 2018, Welsh Govt 2023)

The Health Board have agreed for the oxygen training to be mandatory and available on ESR. The first draft of content for the e learning slides has been completed and being designed for the platform including embedding the BOC you tube video for instructions for use of the CD cylinder, additional slides and an assessment. The package will also guide the staff to complete their competencies in practice. Confirmation of staff groups and position numbers that need to be attached to the training is also being completed. Timescales are officially 3 months to place on the platform however generally completed in 6 weeks. In the interim monthly face to face sessions are continuing, in house train the trainer and CD cylinder awareness on resuscitation training.

Labels have been developed that are attached to the handles of the cylinder that have been piloted across the Health Board that ask the user 'Am I on?' These have now being professionally printed with pictures of the 2 controls to prompt staff at the point of use. Consideration of how these are attached so they are not directly on the cylinder (BOC guidance) and avoiding the use of rubber bands is being explored.

BOC are now developing a ‘single control’ cylinder – ‘Vision’ valve which would address most risk issues related to no flow incidents. Prototype demonstration has taken place in July 2024 but these will not be available for approximately 12 months.

Patient Falls

The following falls were reported in May/June 2024:

	May 2024	Jun 2024	Total
None	75	74	149
Low	251	230	481
Moderate	38	47	85
Severe	3	2	5
Total	367	353	720

The third Health Board desktop review for the HSE improvement plan took place on 28th May 2024 with the aim to review progress and support against the actions within the overarching improvement plan which includes actions following HSE notice, Internal Audit review and KPI’s for the National Audit of Inpatient Falls.

Selected actions identified and also discussed in the strategic inpatient falls group:

- Sharing examples of good practice:
  Falls Champion for Gladstone ward Deeside Community Hospital shared their experiences and success with sustained quality of Falls and Bone Health Multifactorial Assessment (FBHMA) and the implementation of the I must detail on patients above bed boards.

- Agency induction:
  Health Board task and finish group commenced reviewing the induction checklist and process for Agency workers into the Health Board and onto our wards with an emphasis on Falls Prevention and accurate assessment. Reporting the Agency uptake of Health Board Falls Prevention E learning packages is an action within the overarching Health Board improvement plan.

- Training:
  There has been a dip in compliance for Falls Prevention E learning 1a and 1b training due to a number of staff requiring renewal (2 yearly renewal) but it is slowly improving month on month. Below is overall compliance for Falls E learning and Health Board moving and handling. All IHC’s and Divisions are aware of own compliance and areas of additional focus required.

Permanent / Fixed Term Temp	May-24	Jun-24
Falls 1A	80.11%	81.72%
Falls 1B	79.31%	80.79%
M&H level 1	87.94%	88.21%
M&H level 2	71.28%	71.61%
Bank / Locum / Honorary	May-24	Jun-24
Falls 1A	62.64%	63.30%
Falls 1B	62.16%	62.54%
M&H level 1	71.29%	71.44%
M&H level 2	61.47%	61.87%

IHC’s and Divisions have highlighted areas of good quality risk assessments and interventions however consistency of quality and detail within the risk assessments remains the challenge. Peer reviews with feedback on quality are continuing.

Pressure Ulcers

The following healthcare acquired pressure ulcers (HAPU) were reported in May/June 2024:

	May 2024	Jun 2024	Total
None	27	24	51
Low	399	435	834
Moderate	117	113	230
Severe	6	6	12
Catastrophic / Death	1	0	1
Total	550	578	1128

Recurrent themes of learning that have been identified from weekly HAPU review across all IHCs for avoidable incidents are incorrect grading of pressure ulcers and poor completion of Purpose T risk assessment. The WNCR dashboard allows ward managers and matrons to have regular oversight of compliance within each area enabling data to be reviewed in regards to compliance of initial assessment and ongoing update of Purpose t and skin and repositioning.

Tissue Viability Nurses (TVN) are continuing to offer face to face sessions each month and 'soundbites' of education are being developed for the Betsinet tissue viability page. Mandatory training on ESR is progressing with the workforce and organisational development team.

Central IHC have formed a subgroup with support from the Associate DON, and the Health Board medical photographer to develop a Standard Operating Procedure (SOP) for guidance in obtaining a medical photograph of pressure ulcers and wounds. Once completed the purchasing of cameras for areas will then be reviewed and progressed and shared across the Health Board.

Following dissemination of the traffic light system of reporting, and communication via Datix from the HAPU lead to notify of incident severity categories, improvements have been identified with the correct reporting of incident severity with pressure ulcers.

Medicines Management

Work is ongoing to review the current independent second practitioner check requirements for medicine administration. Once complete, recommendations will be presented to PSG for approval. This is part of the scoping exercise to review the publication of the Medicines Administration, Recording, Review, Storage and Disposal (MARRs) document and alignment to BCUHB medicine policy.

Following a theme of failure of second checking errors in West IHC, which is reflected across the HB, work is underway to launch a series of video training sessions that will be launched for all IHC's and services, to reinforce the key messages;

- Staff must have completed second checking competencies before undertaking a medicine check.
- The medicine check must be completely independent (training video to demonstrate and provide practical tips on how to check in a time efficient manner).
- Reinforcement of the patient safety consequences of not correctly second checking.

East IHC have identified learning and actions from medication incidents:

- HARMS prevention study days remain ongoing and are well attended, with discussion led by Medicines management nurse regarding incidents and the role all staff play in safe administration and medicine management.
- Individual support provided to staff by Medicines management nurses where themes are noted or a request for additional support from staff themselves or ward managers is requested.

- Medication safety training for the new starters and non UK registered nurses in pharmacy orientation and correct escalation process.
- Escalation of themes and issues BCUHB wide in presentation and sharing at Safe Medication Steering Group
- Ongoing BCUHB wide distribution of Stop and Think series for both prescribing and administration errors monthly
- Additional communications distributed relevant to changes implemented from learning from HARMs meetings

Incident Management

There are a high number of open incidents across BCUHB, some from 2022/2023. A workshop approach based on feedback and risk assessment has been approved by the Executive DON and supported by NHS Executive to address the backlog of incidents that require a management and closure plan to extract any new learning from incidents of patient pressure damage, patient falls and low/no harm incidents.

The workshops will be held with key manager/leads to review and identify new learning to inform local improvement plans and monitor red flag areas. Agreed process and narrative to close datix has been suggested.

The workshops are in support to the IHCs/Divisions for their improvement plans to address the open incidents and initial focus is for a review of the HAPU incidents which are the greatest number. The approach is to undertake a cluster/thematic review of the backlog, similar to the learning from nosocomial reviews which NHS Executive are supporting with the methodology.

Timely progression of incidents to ILP remains an issue. The Patient Safety Team provide weekly update to all IHC/Divisions to allow tracker for the outstanding cases required for ILP with positive response, most notably highlighting where support is required to progress the review with escalation for those currently overdue which may also be linked to an inquest and Nationally Reportable Incident (NRI)

The current ILP process has been adjusted from once weekly to daily review of incidents as they are submitted to allow a more timely response for those already delayed.

Nationally Reportable Incidents

From 01st May – 30th June 2024, 19 National Reportable Incidents (NRIs) occurred, and 34 notifications were submitted, including combined notification / outcome forms relating to incidents occurring in the months prior e.g. Health Care Acquired Pressure Ulcers or falls with harm which have been awaiting outcomes from harms meetings. The total number of NRI investigations that were open as at the end of June 2024 was 63, of which 32 were overdue closure with NHS Wales Executive. This is reduced considerably from May 2024 where there were 80 open.

72 NRI Outcome forms were sent during May and June (increase of 15 from previous months), of which 20 were for combined forms relating to HAPUs/ falls, and the remaining 49 were outcome forms for all other incident categories. 3 downgrades following further review where no harm was confirmed. Further detail and learning can be found in the confidential quality report.

Never Events

Two never events have been reported broken down as below, investigations are in progress.

Never Event reported	Total
Administration of medication by wrong route	1
Retained foreign object post procedure	1
Total	2

PATIENT SAFETY ALERTS

There are no outstanding All Wales patient safety alerts.

There is one alert not issued by the NHS Wales Executive and therefore compliance is not required for submission. However, the Health Board are still collating compliance as good practice and is now being managed by the Beds Management monthly meeting.

- MDA/2023/03 / NatPSA/ 2023/010/MHRA - Medical beds, trolleys, bed rails, bed grab handles and lateral turning devices: risk of death from entrapment or falls.

SAFEGUARDING

The Safeguarding and Public Protection Team provides oversight and Organisational assurance in relation to the Health Boards statutory duty under the Social Service and Wellbeing (Wales) Act 2014 and Wales Safeguarding Procedures 2019, the Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act (MCA) 2005. The activity includes key actions and activities to ensure that the Safeguarding and Public Protection agenda remains paramount to service delivery across BCUHB. Safeguarding reports throughout the Organisation in accordance with the Safeguarding Reporting Framework. This framework reinforces Organisational engagement, reporting and escalation by the Safeguarding Governance and Performance Group (SGPG), and key Forums and Committees.

Safeguarding Governance Update

A review of the Safeguarding, Governance and Performance Group [SGPG] membership remains underway to ensure Safeguarding Reporting and Governance is in-line with the Health Boards Organisational Framework. The last SGPG was cancelled at short notice due to the high number of apologies and this was reported into the Quality Delivery Group [QDG]. The next meeting is due to take place on the 30th July 2024.

A review is taking place of the Safeguarding Forums for the period 2023-2024 and consideration will be given to any actions in line with BCUHBs Governance structures.

The Safeguarding Governance and Performance Group ensures a BCUHB overview of Safeguarding Quality and Assurance, to ensure BCUHB is compliant with the Social Services and Well-being Wales Act 2014 and supporting legislation and guidance.

Datix Safeguarding Module Update

To introduce an All Wales NHS Safeguarding Report form, there is a proposal for all Health Boards across Wales to implement the use of the Datix Cymru Safeguarding Module from the 1st October 2024. The Safeguarding Network and Once for Wales team are supporting discussions with the Safeguarding Board and our Local Authority partners. An NHS Wales stakeholder Task and Finish Group has been put in place to navigate the proposed transition to the Datix Safeguarding Module which we, the Safeguarding and Public Protection Team are engaging in.

Adult and Child at Risk Reporting

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

June 2024 recorded 154 Adult at Risk Reports submitted across Health Board. There was a slight increase aligned to reports submitted from the East and Central, with the West experiencing a small decrease in reporting. A review of reporting is undertaken monthly, no additional concerns, themes or trends were noted with reporting in-line with legislative processes to maintain patient safety.

There we four hundred and fifteen (415) Child at Risk Reports submitted by the Health Board in June 24 which is slightly higher than the monthly average. The under 5 year old category saw the highest reporting rates which is a consistent trend and reflective of the national picture. The East IHC accounted for two hundred and eight (208) reports which equates to 50.1% of the reports, this is consistently the position.

Over the past twelve (12) months the Health Board have observed an increase in Child at Risk Reporting which includes Child at Risk concerns and those identified as having care & support needs. There are a number of factors contributing towards the increase of reporting which include local, national and international factors.

On a locality basis, there have been expansions to Flying Start catchment areas. These are identified by the Welsh Government and recognise areas of deprivation and need for children and families.

On a National basis there have been continued impacts associated to the cost of living crisis. This has contributed adversely to household incomes and Health Practitioners have been able to discuss and identify care and support needs with families.

Increasing socio-economic concerns for children and families continue to present a concern evidenced via referrals to foodbanks, early help support, and our Child at Risk Reporting.

On an International basis, the challenges associated to the Ukraine War continue to have an impact on children, adults and families. The Safeguarding and Public Protection Team continue to be a visible presence across the Health Board, completing training and offering advice and support to ensure the Health Board adheres to statutory legislation as well as local, regional, and national policies and procedures.

Violence Against Women, Domestic Abuse & Sexual Violence (VAWDASV) Update

There is an increasing number of child-on-parent abuse incidents being reported resulting in a challenging position that presents the victim/perpetrator debate in relation to the family setting. The Safeguarding Team attend the VAWDASV Board and MARAC Steering Group where these themes and trends are discussed. Actions to address these concerns are under negotiation with next steps to be considered and reported in Q3 and Q4.

The recently launched, 'North Wales without Violence: North Wales Serious Violence Response Strategy 2024' which is the first ever strategy of its kind, is a landmark document that marks a turning point in our collective efforts to create a safe and more just region. The Health Board are a key partner agency and have engaged in discussions and actions throughout the consultation and implementation stage. This work is ongoing with updates provided to Health Board services through the Safeguarding Performance and Governance Group.

Practice Reviews Update

In accordance with The Safeguarding Boards Wales (Functions and Procedures) Regulations (2015), Regional Safeguarding Children Boards (RSBs) have a statutory responsibility to undertake multi-agency Child Practice Reviews (CPRs) and Adult Practice Reviews (APRs) in circumstances of a significant incident where abuse or neglect of child or adult is known or suspected. The key purpose of practice review is to identify any steps that can be taken by RSB partners or other bodies, to achieve improvements in multi-agency protection and safeguarding practice.

There are currently twelve (12) North Wales Safeguarding Children's Board (NWSCB) commissioned CPRs in North Wales. Three (3) reviews are completed with ongoing Action Plans, two (2) reviews have not yet commenced and seven (7) Reviews are in progress.

Themes and risks of reviews vary across the region and include:

- Childhood Neglect
- Disguised compliance
- Professional Curiosity
- Impact of COVID19 upon family engagement and identification of concerns or understanding lived experiences
- Abusive head trauma
- Domestic Abuse
- Cannabis use

These themes are reflective of emerging themes in reviews across Wales. It is hoped that the implementation of the 12Cs, Collective Safeguarding Responsibility Model (2023) will promote a collaborative approach to develop a better understanding of repeating emerging themes.

The implementation of the 12Cs Model was a recommendation from the Risk, Response and Review: Multi-Agency Safeguarding. A Thematic Analysis of Child Practice Reviews in Wales 2023. There is currently one (1) active APR in North Wales. The North Wales Safeguarding Board published this APR on July the 25th 2024. The learning identified for the Health Board has/is being implemented and will be monitored and reviewed at Safeguarding Forums and the Safeguarding Governance and Performance Group, and then reported into the Quality Delivery Group. Actions from the APR recorded the need to ensure that the personal history of an individual who is known to services and is either currently or at risk of harm, abuse or neglect is made available to practitioners who are involved in their care and treatment (in-line with consent and GDPR policies). This will ensure that individuals do not need to repeat or revisit historical incidents in their lives and that information is added regularly to their personal history to support intervention from practitioners.

All North Wales Regional Safeguarding Board partners should implement the North Wales Self-Neglect Protocol and convene an initial meeting in line with the protocol. There is a further recommendation to support GP involvement in self-neglect and safeguarding meetings. Whilst the nature of all GP practice activity means that attendance at any multi-agency safeguarding meeting is difficult, there should be consideration as to how to ensure that information and advice from the GP is made available to the Safeguarding process.

There are currently Six (6) ongoing Domestic Homicide Reviews (DHRs) across North Wales. Four (4) DHRs are complete, three (3) reports remain with the Home Office awaiting approval. One (1) report has been returned as approved. Action plans to address identified learning are commenced prior to Home Office approval to avoid any delays.

A review of all action plans will be undertaken to identify further themes and trends. Monthly Quality Assurance Meetings chaired by the Head of Safeguarding Children are in place. This offers the opportunity for Panel Members, Reviewers and Chairs within the Safeguarding & Public Protection Team to have peer supervision of their CPR, APR and DHR engagement, whilst identifying challenges, risks, themes and trends. The Group also consider issues for immediate escalation to the Director of Safeguarding & Public Protection.

Single Unified Safeguarding Review (SUSR)

The Single Unified Safeguarding Review (SUSR) is a single review process incorporating all reviews in Wales. This ensures affected families can expect a swift and rigorous review process. The SUSR aims to reduce delay, improve the identification of themes, trends and inform national priorities and reduce duplication. The SUSR is due to be launched by Welsh Government in October 2024.

Thirlwall Inquiry Safeguarding Update

On the 30.08.2023 a public inquiry was commissioned to look into the events at the Countess of Chester Hospital, and the implications of those events. The Inquiry is divided into three parts:

Part A: Will explore the experience of parents of the babies named on the indictment.
Part B: Will consider the conduct of people working at the hospital and how a nurse was able to commit the crimes.
Part C: Will look at the wider NHS, examining relationships between various groups of professionals, the culture within hospital and how these affect the safety of newborns in neonatal units.

The Safeguarding and Public Protection Team are fully engaged in the Health Board response to the Inquiry and provide expert safeguarding and public protection advice and guidance.

New Child Practice Review

Following the conclusion of high profile criminal court case, the North Wales Safeguarding Childrens Board have commissioned a Child Practice Review (CPR) to explore learning and support future practices. This review commenced in July 2024. The Health Board will be represented by the Director of Safeguarding and Public protection.

Safeguarding People Living with Dementia

A key recommendation from the HASCAS and Ockenden Reports was the recruitment of a Specialist Dementia Care Safeguarding Lead for the Health Board. This was achieved in 2022. The role supports and evidences the need to work within the aims and objectives set out in the Welsh Dementia Strategy and The Hospital Charter. In addition to the specialist advice and support provided by the Safeguarding Dementia Specialist they engage in Dementia Care Mapping for the Health Board. This helps us to understand the experiences of care from the perspective for the people living with Dementia and to inform improvement in patient care to drive forward an individualized, person centered approach.

To date in 2024-25 more than 31% of Adult at Risk Reports submitted by the Health Board recorded that the individual had a diagnosis of Dementia. Work is ongoing across the Safeguarding Agenda and in collaboration with our Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) colleagues to strengthen Health Board staff understanding of the MCA as there are inherent links between Mental Capacity and Dementia care.

MCA and DoLS Update

The implementation of the Mental Capacity (Amendment) Act 2019 and the Liberty Protection Safeguards (LPS) was placed on hold by UK Government prior to the General Election in July 2024. However, it was announced within the Kings Speech (July 2024) that the priority for the Minister would be the reform of the Mental Health Act prior to any work in addressing the current DoLS process and the proposed/delayed implementation of the LPS.

Welsh Government (WG) continue to ensure additional funding is available to strengthen the current DoLS system and implement elements of the LPS. We follow WG directives by promoting MCA awareness and delivering MCA training whilst addressing the DoLS backlog (legal term for applications awaiting authorisation).

The MCA/DoLS National Workforce Group continues to focus on the MCA and DoLS enabling stakeholders to jointly consider issues of local concern that may have a wider or national relevance and provide a forum for joint working on national projects.

INFECTION PREVENTION AND CONTROL

The HABITS campaign continued with Asepsis and ANTT a continued focus. The focus for July will be around isolation.

When compared to other Health Boards, BCUHB are:

1st for MSSA & Klebsiella spp. bacteraemia (i.e. lowest infection rates)
2nd for Pseudomonas aeruginosa bacteraemia
3rd for C.difficile
5th for E. coli and MRSA bacteraemia

This is an improved position for MRSA since the previous month, with C.diff, E.coli, Klebsiella and MSSA remaining the same. We have fallen back slightly with Pseudomonas.

The ADoN IPC attended and presented at the All-Wales Cepheid user group to further understand the benefits of PCR for rapid testing and is developing an SOP to ensure this is used optimally for prompt detection, isolation and treatment.

The IPT continue to review their programme of work/ways of working to ensure compliance with the IP Code of Practice and enhanced visibility across the Health Board.

OTHER PATIENT SAFETY CONCERNS AND IMPROVEMENTS

Extravasation (the accidental leakage of any liquid from a vein into the surrounding tissues when administering solutions such as medication)

Following an incident that was reported about extravasation injuries to a patient it was evident following the MIS that there are significant gaps in the knowledge base and guidelines around extravasation at ward/unit level including recognition, management, high risk drugs and access to extravasation kits etc. Whilst this occurred in one site, the issues may not be unique to the area.

A BCUHB Task and Finish group has been set up to explore this issue and to facilitate improvements. The group will consist of vascular access specialists, pharmacy, medicines management, nursing and medical staff. Tesni Sullivan, Lead Vascular Access Nurse has agreed to lead this group and the first meeting took place on 5th July 2024.

Communication theme

The Women's division has identified that there is one theme which can be found in incidents, complaints and perinatal mortality reviews, that of Communication. This relates not only to communication with patients and family's but also between our own staff and other departments and organisations. Work has been commenced in relation to training staff in relation to civility by providing all Womens Services staff with specific training which has been developed by the Mat/Neo Lead midwife and the Clinical Supervisor of Midwives. The roll out of the training has been very successful which has led to the training being adopted by the Health Board for wider organisational role out.

GROW antenatal assessment

The reporting of incidents related to deliveries of baby below 10th centile is mandatory as part of the Saving Babies Lives initiative and part of the BCUHB Saving Babies Lives action plan. As part of

the ongoing development of fetal wellbeing monitoring, an updated version of the GROW antenatal assessment has been introduced called GROW 2.0. The update includes newer software for plotting, reviewing and visual alerts for staff concerns with a baby's growth. This is supported with a new app which staff can use to calculate a baby's growth rather than using graph plotted on paper and a set square to make the calculation.

Incident learning system

Members of BCUHB have been involved in the UK Health Security Agency working party, developing an incident learning system for clinical imaging, MRI and nuclear medicine. The system has now been published and BCUHB are to pilot the learning system as part of the All Wales roll out.

New Methotrexate chart now in use to improve safety

A new Methotrexate prescription chart is now in use across the Health Board, designed to promote good practice and improve medicines safety. This work came about following learning from methotrexate incidents.

Now, the new separate chart must be used when prescribing methotrexate, with an additional guideline to promote good practice and safety when using methotrexate which can be found on this page.

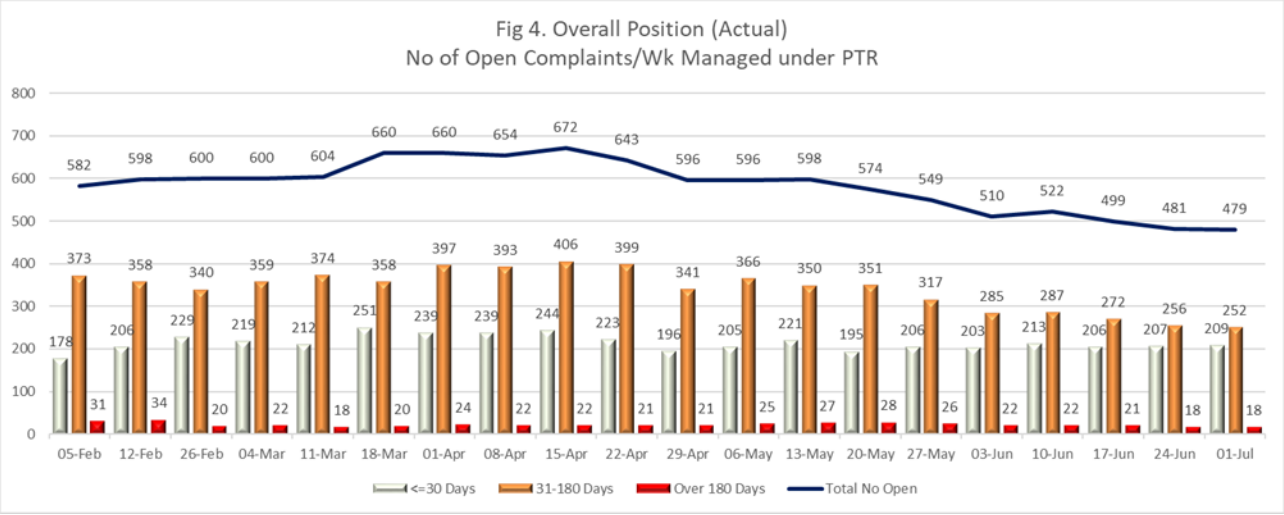
Methotrexate is a immunosuppressant used mainly for inflammatory conditions such as rheumatoid arthritis. It can be toxic if taken in excessive amounts, WEEKLY dosing minimises side effects while maintaining therapeutic level.

Adhering to the prescribed dosing schedule is crucial to minimise harm while optimising treatment.

PATIENT EXPERIENCE

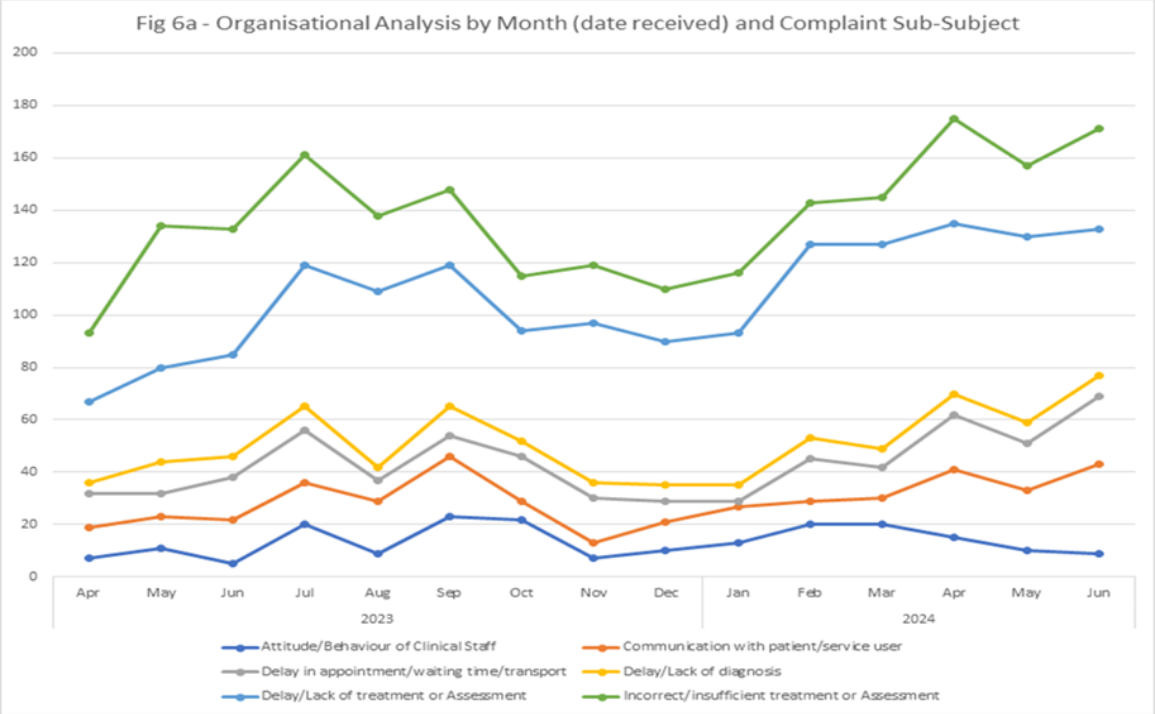
COMPLAINTS

During 1st April 2024 to 30th June 2024, the Health Board **received** 757 complaints, 620 of those were managed under Putting Things Right, an additional 106 were resolved as Early Resolutions and 31 complaints re-opened (re-opened concerns refer to complaints which have been re-opened due to additional questions raised or dissatisfaction with the initial response).



The majority of the complaints related to Secondary Care Services, with a significant rise in complaints relating to

- Incorrect / Insufficient Treatment or assessment
- Delay Lack of treatment / assessment
- Delay / Lack of diagnosis
- Delay in appointment/ Waiting Time / transportation



Thematic Analysis

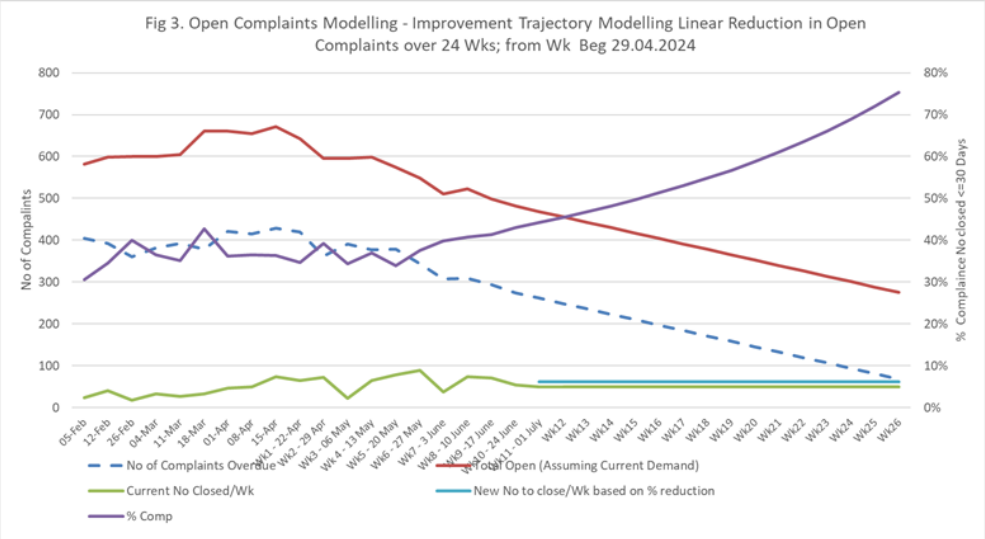
Communication with Patient/Service User and Attitude and behaviours of clinical staff have remained consistent with small statistical variances in range. The assumption that that lack of communication regarding planned care appointments may have contributed to this rise, as those specific complaints were aligned to subject codes delays / lack of treatment or assessment.

Count of ID	Column Labels						
Row Labels	Attitude/Behaviour of Clinical Staff	Communication with patient/service user	Delay in appointment/waiting time/transport	Delay/Lack of diagnosis	Delay/Lack of treatment or Assessment	Incorrect/insufficient treatment or Assessment	Grand Total
Apr	15	26	21	8	65	40	175
May	10	23	18	8	71	27	157
Jun	9	34	26	8	56	38	171

Complaints Performance

There were 270 overdue complaints in total at the end of June 2024.

The complaints performance improvement Trajectory (Linear Model) to support the achievement of the performance target for complaints closures by the 14th of October 24 for compliance of 75% of complaints responded to within less than 30 working days is on track.



All IHC and Specialist Services are on Track to be compliant with the 75% target of overdue complaints with exception of the Central IHC who will be **61.34%** compliant by the 14th Oct, 2024 with their current closure rate. A wrap around support is being put in place to support and increased focus will be applied to recover the position.

Complaints Received / Closed

1st April 2024 – 30th June 2024

The number of complaints received in comparison to the number of complaints closed is negatively impacting the overall total open complaints position. Although we are closing more complaints than we are receiving, there is a continual up trend of complaints received, resulting in a lower drop of overall complaints

Wk Beg	01-Apr	08-Apr	15-Apr	22-Apr	29-Apr	06-May	13-May	20-May	27-May	03-Jun	10-Jun	17-Jun	24-Jun
No Overdue	421	415	428	420	362	391	377	379	343	307	309	293	274
No Closed	46	49	74	64	72	22	64	78	89	38	73	70	70
No Received	44	54	56	41	51	46	46	44	40	55	61	44	54

To meet the current complaints performance improvement trajectory, a separate thematic analysis has been completed, and submitted to the Executive Team and operational leads, to inform improvement initiatives over the next 3 months.

There is a statistical correlation between complaints rising, during the period where additional scrutiny in addressing the backlog has taken place. A significant number of grade 1 and 2 complaints are going over the 30-day threshold, suggesting there is not enough resources to provide timely responses, or that there needs to be a reallocating of existing resources to see improvements in this area.

Our Emergency Department and Outpatient departments within the three hospital sites are the main source of complaints, and where their needs to be additional focus across the IHC's.

The closure rate within 30 working days has improved from 39.5% to 44.22%, this is evident following the increased scrutiny by the Directors of the IHC to promote early resolution and closure to complaints.

Improvement Initiatives

Business Intelligence - The IRIS Dashboard has enabled complaints performance data to support the complaints trajectories for the IHC and support services since the 1st of June 2024.

Improvement Collaborative - Ongoing work continues in relation to the Complaints Improvement Collaborative which commenced in June 2024 focussing on Tests of Change to support the improvements in the overall complaints position.

Scrutiny Meetings - Each Integrated Health Community (IHC) has adopted weekly Putting Thing Right Meetings to manage the progress of complaints received.

The Deputy Executive Director of Nursing continues to lead weekly improvement meetings with the services, targeting support to facilitate resolution of complaints.

Integrated Complaints / Mortality / Incidents policy - An integrated approach to the BCUHB management of complaints / mortality and incidents, including standing operating procedures, joint policies and standardised templates, which should improve both efficiency and accuracy is being undertaken.

Grade 1 and 2 complaints - Increasing the ownership of IHC's to close Grade 1 and 2 complaints once they have reached conclusion, reducing the administrative burden of corporate QA and Approval. This will ensure timelier responses for the public to their concerns.

Consent - Consent will be reduced to 10 working days (two weeks) from the date the complaint was received to align to other health boards across Wales.

Planned Care – The 3P's - The patient experience team are working closely with the development of the 3P's approach, which will prioritise, diagnosis and treatment, increase health service capacity and provide better information and support to patients, including setting appropriate expectations and improving communication.

Future Priorities

Pro-active engagement with the 3 P's team to ensure a consistent approach to the experience of patients awaiting planned care treatment to support an improved experience and a reduction in the Planned Care Complaints.

- Further enhance the IRIS Dashboard to support a qualitative model for data for the IHC's and Specialist Services.
- To undertake quarterly triangulation of quality data identifying themes and trends
- Implementation of an agreed training plan for the Corporate and Operational teams in relation to Complaints Management and PALs
- Implementation of the Telephony System to support an improved single point of contact for the public to raise concerns/enquiries.
- Commence a formal campaign to promote how to raise concerns
- Complete the review of the Complaints Policy once the Integrated Complaints/Incident and Mortality Review Framework has been approved by the Board.

Complaints Compliance

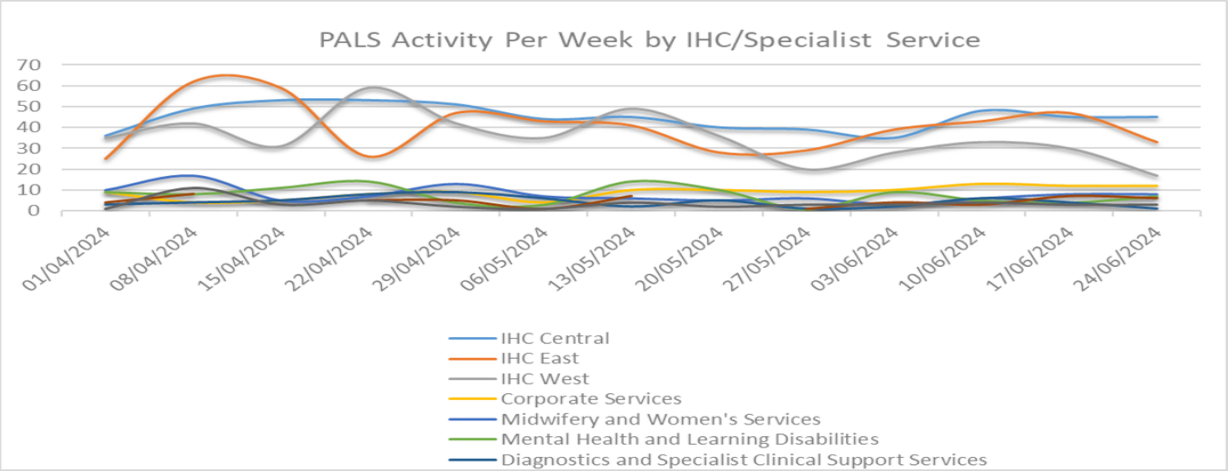
External Review - Welsh Risk Pool Assessment undertaken on the 13th June 2024 to consider compliance of BCUHB in relation to the regulatory and Putting Things Right (PTR) procedural requirements. A final report will be issued to the BCUHB.

Internal Review – Internal audit for 2024 includes a review of Complaints Management.

PATIENT FEEDBACK

From 1st April 2024 – 30th June 2024, PALS supported the resolution of 1685 enquiries, 271 compliments were received in writing and 88 suggestions were also received. Key themes identified from PALS enquiries include:

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



PALS continue to work with Integrated Health Communities and Specialist Services to identify and support areas where there is an increase in the number of PALS enquiries/dissatisfaction, with the aim to encourage local resolution of concerns or enquiries. Examples of support provided to services by PALS include; proactive work to provide resolution to Insourcing and Orthodontics enquiries, and support to Managed GP practices who receive a high number of PALS enquiries.

CIVICA Results and Rollout

From 1st April 2024 to 30th June 2024 the Patient and Carer Experience Team received 13,266 All Wales Real Time Feedback survey responses via the Civica feedback system. 81.03% of respondents were satisfied with their overall experience of accessing Health Board services.

Key findings from the real-time patient survey feedback include:

- 81.17% of respondents were always given all of the information needed
- 84.28% of respondents always felt listened to
- 81.04% of respondents felt that staff always took the time to understand what mattered to them as a person and took this into account when planning and delivering their care.

There has been a slight increase in responses from the All-Wales Emergency Department national patient feedback survey than previous quarters. In this reporting period, 92 All Wales Emergency Department (ED) survey responses were received via Civica All Wales Feedback System.

Below are key findings from the All-Wales Emergency Department Real-time Feedback Survey:

- 78.57% of respondents felt from the time they needed to use this service they waited much too long
- 26.80% of respondents always felt listened to
- 23.71% of respondents always got assistance when needed
- 33.33% of respondents always felt things were explained in a way that they could understand.

Using a scale of 0 – 10, where 0 is very bad and 10 is excellent, how would you rate your overall experience?

In June 2024, overall satisfaction remains low with respondents rating their overall experience as 4.65 out of 10 being excellent (data source Beacon Dashboard, NHS Wales Executive, 11/7/2024).

To help improve Emergency Department Survey response rates, the Patient and Carer Experience Team are working with Heads of Nursing and Emergency Quadrant staff.

Below are examples of work being undertaken to improve feedback responses:

- In Wrexham Maelor Emergency Department, improvement work is being undertaken to improve the number of feedback survey responses, this includes the delivery of a series of staff training and awareness sessions led by PALS.

- Ysbyty Gwynedd Emergency Department, have taken an ‘always on’ approach to feedback to ensure there are always opportunities for patients/relatives to provide feedback through a variety of ways (paper, QR codes on backs of chairs, feedback kiosk, posters up and the promotion of these methods through Red Cross Volunteers).

- At the end of April 2024, Ysbyty Glan Clwyd had a Health Inspectorate Wales unannounced inspection in the Emergency Department. The inspection highlighted good practice around the presence and ongoing work of the PALS team in the department and reflected the improvement in the real time patient feedback surveys seen in Quarter 4. Based on previous visits and reflective patient experience in the ED noting a significant improvement.

PALS are working with IHCs and Specialist Services to ensure all wards, services and departments are mapped to Civica All Wales Feedback System. The Mental Health Learning Disability (MHLD) Service have undertaken a significant piece of work to ensure all of their wards/service points are mapped to Civica.

PALS are working with MHLD Services to facilitate ‘Feedback Friday’ sessions with patients across the West area, by visiting wards, and liaising with patients and carers. PALS have been visiting Hergest Unit and Cemlyn Ward at Cefni Hospital. The information shared by PALS allows staff to identify learning and improvements which is reported back to Mental Health Patient and Carer Experience Group. There is current consideration for this approach to be replicated across North Wales.

OTHER PATIENT EXPERIENCE CONCERNS AND IMPROVEMENTS

Small Business Research Initiative (SBRI) Patient Communication Project

The SBRI pilot has now ended. The benefits realisation of the project is currently being analysed and will be submitted to SBRI Board on 24th July 2024. An independent evaluation is due to talk place this summer to capture staff feedback.

Initial findings suggest there has been no direct impact on the reduction of calls received to the wards due to the sample size involved in the pilot. However initial feedback has shown that relatives have benefited from receiving daily updates. Relatives have felt reassured and included in decisions around patient care. A positive theme emerging included how the digital systems supported relatives who lived outside of the local area/aboard and relatives in full time employment who struggle to visit/ring in daily.

Throughout the pilot there were opportunities for relatives and staff to share feedback regarding their experience. Initially relatives reported that they felt “very frustrated” and not involved in their loved ones care due to the difficulties they had experienced ringing the ward for updates and not being able to get through.

Feedback from end of project survey highlighted the benefits the digital solution offered including:

- ‘It stopped me having to ring in the morning to find out how my mum was. I was happy to receive the message before I visited in the evening. It meant I had to ask less questions to staff as I know from the message mum had a wash, mum had been sitting in a chair.’

PALS have delivered a series of Patient and Carer Experience awareness sessions to student nurses affiliated with Wrexham and Bangor Universities, Internationally Educated Nurses and District Nurses at Wrexham University.

The Patient and Carer Experience Lead facilitated a session in partnership with the Centre of Sign Sight and Sound (COS) and the deaf community in North Wales to understand how the Health Board can best meet the needs of the deaf and BSL using community. The session invited feedback around experiences of being an inpatient, outpatient and accessing both urgent and primary care.

Feedback shared at the session included:

- ‘I was an inpatient for 2 weeks and I was not offered a BSL Interpreter. I did not understand what was happening with my care’.
- ‘We received a letter from hospital to ask us to phone the hospital to arrange an appointment. This is not good for deaf people who can’t communicate on the phone’.
- ‘Deaf person went to ED and receptionist had no awareness of how to ask for a BSL interpreter’.

Examples of improvements identified include; the introduction of Sign Live, staff awareness training sessions and capturing a shared experience patient story from the deaf community.

All IHCs and Specialist Services have established local Patient & Carer Experience Group that report into the corporate Patient & Carer Experience Group. IHC/Specialist Services, Patient & Carer Experience Groups celebrate good practice and report on critical issues in relation to patient & carer experience.

On the 22nd July 2024, the Patient and Carer Experience Department will be implementing a new single point of contact telephony system for the PALS and Complaints Team. The new telephony system will improve call handling and call waiting experiences for customers and will enable the department to monitor quality control. The telephone line will also have a survey at the end, allowing callers to provide feedback on their call experience.

Chaplain and Spiritual Care Service

The Chaplain and Spiritual Care Service continue to work with Dementia Support and Occupational Health teams across North Wales. On Glaslyn Ward at Ysbyty Gwynedd the Chaplain and Spiritual Care Service introduced a bay watch initiative where Chaplains will visit the ward on Tuesday's to chat with staff, patients and families and offer music sessions.

Chaplain and Spiritual Care training sessions have been delivered to staff at North Wales Adolescent Service, and in partnership with the Continuing Health Care Team at care homes with Health Board funded beds (Yned Merion, Dolgellau & Leonard Cheshire Home, and Colwyn Bay) to establish closer working relationships with staff and patients.

CLINICAL EFFECTIVENESS

CLINICAL AUDIT

To give an overview of clinical audit activity carried out across Betsi Cadwaladr University Health Board, quarterly reports have been submitted from April 2023 to March 2024 to both the Strategic Clinical Effectiveness Group (SCEG) and Quality Delivery Group (QDG). These quarterly reports are then incorporated within a Clinical Audit Annual Report, which identifies recommendations for areas of focus for the following year.

The Clinical Audit Team within the Clinical Effectiveness Department is primarily concerned with facilitating the development of SMART action plans for improvement in response to the recommendations from the National Clinical Audit published clinical audit reports. The Department focusses on the projects identified in the National Clinical Audit and Outcome Review Plan (NCAORP), which are classed as Tier 1 Audits, and the Betsi Cadwaladr University Health Board (BCUHB) list of prioritised audits are Tier 2. The effect of ongoing system pressures is still felt within the organisation and clinical teams have identified a resulting shortage of time to participate and respond to audit findings. However, there are several points to celebrate in this report.

The BCUHB Clinical Audit Policy was reviewed and updated in July 2023 for the Clinical Audit Team to promote, maintain and support a culture of best practice in the management and delivery of Clinical Audit within the Health Board. The policy clarifies the roles and responsibilities of all staff engaged in Clinical Audit activities.

Processes within the team, such as the Service Assessment of Compliance proforma, were introduced in November 2022, and continues to track quality assurance, capturing details from National Audit findings, recommendations, and local continuous quality improvement, whilst also identifying levels of assurance and any clinical risk.

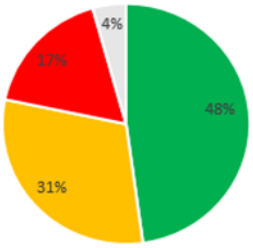
The form was further developed during 2023/2024 to better understand the process of validation of data submitted to the National Clinical Audits. The Clinical Effectiveness Department continues to be able to extract more detail from specialities on action outcomes following an audit, and what evidence can be provided for sharing learning with others.

During 2023/2024 BCUHB has engaged with the 27 out of 38 NCAORP projects which are relevant to the organisation. Where non-participation is identified, they are escalated via the Assurance Report to local Clinical Effectiveness Groups (CEG) to discuss and resolve locally. If escalation is needed for support, the process is to report to Strategic CEG and the Quality, Safety and Experience

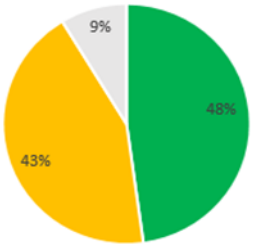
(QSE) committee. Monitoring continues of the Tier 1 and Tier 2 audit plans and the completion of SMART actions in response to findings within specified timescales.

When a National Audit report includes Health Board specific data, we benchmark BCU against both National outcomes and against BCU data in previous reports. During 2023/2024, there were a total of 23 National audit publications and the comparison for these as shown below:

Comparison with National Benchmark



Comparison with Last BCUHB Report



Key	*Comparison with National Benchmark:*	*Comparison with Last BCUHB Report:*
R	Where BCUHB reported performance is at or above the benchmark in fewer than 50% of KPIs	Where the previously reported BCUHB performance has deteriorated in more than 50% of Key performance indicators (KPIs) according to the latest National audit report
A	Where BCUHB reported performance is at or above the benchmark in 50% to 74% of KPIs.	Where the previously reported BCUHB performance has been maintained or improved in 50% to 74% of KPIs in the latest reporting period.
G	Where BCUHB reported performance is at or above the benchmark in 75% or more of KPIs.	Where BCUHB has maintained or improved in 75% or more of KPIs since the previous reporting period
	Unable to compare due to nature of data/reporting	Data not comparable with previous reported data

Assurance responses were requested for a total of 23 National Clinical Audit publications during 2023/2024, of which 19 (83%) were fully completed with a further 4 (17%) received in draft.

The Audit Management and Tracking database (AMaT) was rolled out during the last year and continues to progress, with Tier 1 actions being monitored through AMaT, as well as support for a small number of Tier 2 audits and the roll out of NICE guidance compliance monitoring across BCUHB. Through this, we are engaging clinical and corporate stakeholders to deliver increased visibility of audit activity and have strengthened real-time reporting. We continue building relationships with colleagues in other Welsh Health Boards through an AMaT forum group and the All-Wales Clinical Audit and Effectiveness Network Group.

OTHER CLINICAL EFFECTIVENESS CONCERNS AND IMPROVEMENTS

Within each Clinical Annual Report, we will review what has worked well and what requires improvement over the following audit year. Below is a list of recommendations submitted in this year's report, that we consider important for us as a team to focus on and prioritise.

Recommendations and Key Priorities for Clinical Effectiveness Department:

1. The Clinical Effectiveness Policy was approved in 2023, with the aim of supporting a culture of best practice in the management and delivery of patient care whilst clarifying the roles and responsibilities of all staff engaged in clinical audit activities. The Clinical Effectiveness Department needs to continue to promote the policy to ensure understanding of the rational for clinical audit and provide a framework for such activity including standards, guidance, and procedures. This will reinforce the role within the quality framework in delivering quality improvement and quality control.

2. Continue to monitor the implementation plan for Tier 1 to ensure that completion of set actions in line with specified timelines are achieved. These actions will be escalated to local Clinical Effectiveness Groups if dates are not met, to discuss and resolve locally.

3. Following the re-design of the Service Assessment of Compliance Form by the Clinical Effectiveness Department, there has been an improved ability in being able to extract more detail from specialities on what has happened following the completion of an audit, gain assurance that data is appropriately validated, and what evidence can be provided for sharing learning to others and how this is being communicated across BCUHB. Participation has also improved, with the team regularly monitoring processes to make improvements as and when necessary, and focus is now required to embed this change.

4. The Clinical Effectiveness Department continues the ongoing development of the clinical audit exception report escalation (as noted above) for presentation at Clinical Effectiveness Group meetings, as required, providing timely information to address delivery risks and to maximise the positive impact of audit on quality and safety. Regular monthly updates are provided to the Integrated Health Community (IHCs) and Divisions and updates are uploaded onto the Clinical Effectiveness webpage, which is constantly developing.

5. Continued development of risk identification with clinicians to better understand what the implications of partial or non-compliance with an audit are, and how compliance can reduce this risk.

6. Promotion of clinical audit through training via links on the BetsiNet webpage. There have previously been “Learn at Lunch” sessions with the Clinical Audit Support Centre (CASC), and we will continue to share these as and when they are available. The Clinical Effectiveness BetsiNet webpage will be promoted via BCUHB bulletins and in meetings, with the link noted on agendas and on departmental emails. Feedback is invited on a regular basis to help improve the contents of the webpage and to include up-to-date information and regular updates on Tier 1, 2 and 3 audits to share learning and support target dates being met with clear and contemporaneous information.

7. The Clinical Effectiveness team will be developing presentations on clinical audit to share on the BetsiNet webpage and offer drop-in sessions that can be arranged for areas on request, offering support and guidance as needed.

8. The Audit Management and Tracking database (AMaT) was further developed last year and we are now embedding the process to include monitoring of Tier 1 audits. The database is also being used for several agreed Tier 2 audits to help areas engage with the benefits of information sharing, with reports that specialities can access.

9. Over the last year the Clinical Effectiveness Department has been more involved in Local Clinical Effectiveness meetings, to build closer partnership and working relationships with Clinical Audit Leads and Secondary Care Medical Directors. This will continue as it has supported their knowledge and understanding of national and local audit activities and enabled them to provide guidance and support, as needed.

10. Building relationships with colleagues in other Welsh Health Boards has proved to be beneficial and will continue through the regular AMaT forum group and general networking groups.

11. Commitment to working towards 100% participation in the full programme of National Clinical Audits and Clinical Outcome Reviews and agreed Tier 2 audits.

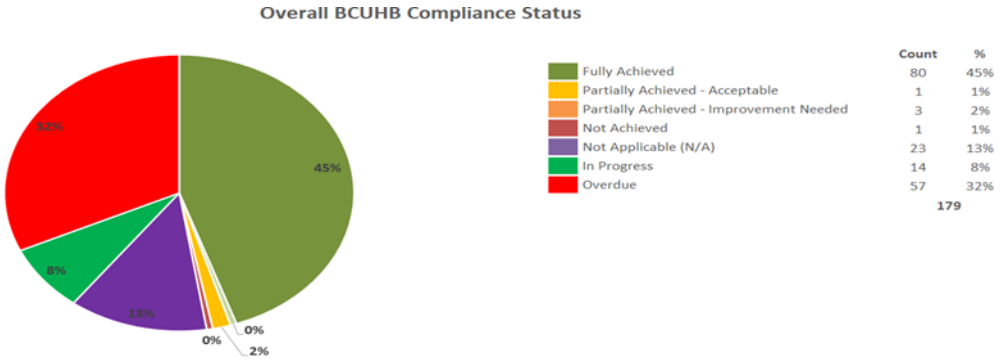
12. Outcome Reviews (ORPs) reporting and escalation to follow the same process as other Tier 1s, as detailed above, and for the same reasons in terms of quality improvement, risk management and learning and undertake thematic review of the lessons learned from National projects.

NICE GUIDELINES

NICE guidance compliance continues to move in the right direction with support from most Specialties. Escalations through the Local CEGs (Clinical Effectiveness Group) has improved levels of assurance. Any overdue responses following this are escalated via SCEG (Strategic Clinical Effectiveness Group). East are doing particularly well with their guidelines being reviewed in a timely manner.

Meetings are taking place with Primary Care and other specialties to look at how compliance can be improved.

AMaT is now being used and can more readily identify risks and barriers.



IHCs

Status of compliance responses requested - IHC West

Period from: 05 January 2024 to: 30 June 2024	N value	Percentage	Current position - as of 30 June 2024		
Fully Achieved	up from 43 to 85	up 9.6%	85	36%	Fully Achieved
Partially Achieved - Acceptable	up from 1 to 3	up 0.7%	3	1%	Partially Achieved - Acceptable
Partially Achieved - Improvement Needed	up from 8 to 36	up 10.5%	36	15%	Partially Achieved - Improvement Needed
Not Achieved	up from 1 to 2	up 0.2%	2	1%	Not Achieved
Not Applicable (N/A)	up from 13 to 24	up 2.2%	24	10%	Not Applicable (N/A)
In Progress	down from 32 to 14	down 14.0%	14	6%	In Progress
Overdue	up from 62 to 69	down 9.1%	69	30%	Overdue
Total	up from 160 to 233		233		

Status of compliance responses requested - IHC Central

Period from: 05 January 2024 to: 30 June 2024	N value	Percentage	Current position - as of 30 June 2024		
Fully Achieved	up from 45 to 89	up 10.0%	89	37%	Fully Achieved
Partially Achieved - Acceptable	up from 3 to 7	up 1.1%	7	3%	Partially Achieved - Acceptable
Partially Achieved - Improvement Needed	up from 2 to 9	up 2.6%	9	4%	Partially Achieved - Improvement Needed
Not Achieved	up from 1 to 2	up 0.2%	2	1%	Not Achieved
Not Applicable (N/A)	up from 15 to 29	up 3.0%	29	12%	Not Applicable (N/A)
In Progress	down from 32 to 12	down 14.4%	12	5%	In Progress
Overdue	up from 67 to 91	down 2.5%	91	38%	Overdue
Total	up from 165 to 239		239		

Status of compliance responses requested - IHC East

Period from: 05 January 2024 to: 30 June 2024	N value	Percentage	Current position - as of 30 June 2024		
Fully Achieved	up from 51 to 114	up 17.1%	114	49%	Fully Achieved
Partially Achieved - Acceptable	up from 11 to 30	up 6.0%	30	13%	Partially Achieved - Acceptable
Partially Achieved - Improvement Needed	up from 8 to 20	up 3.6%	20	9%	Partially Achieved - Improvement Needed
Not Achieved	no change	down 0.6%	3	1%	Not Achieved
Not Applicable (N/A)	up from 15 to 35	up 5.6%	35	15%	Not Applicable (N/A)
In Progress	down from 30 to 14	down 12.7%	14	6%	In Progress
Overdue	down from 42 to 17	down 19.0%	17	7%	Overdue
Total	up from 160 to 233		233		

MORTALITY REVIEW

- From 9th September 2024, it will be statutory for **all** deaths to be independently reviewed across the country by either a Medical Examiner (ME) or a Coroner; this now includes all BCUHB Primary Care, Secondary Care and Private Care Home deaths. There is an expected increase of workload to follow with these additional reviews being sent to the HB for consideration of review, which will impact the Corporate Mortality Team, IHC's, Mortuary Teams and Record Scanning Teams. The new death certification process will also be coming into force; changes within the process are being triangulated among services such as MES, Coroners, and the Health Board (HB).

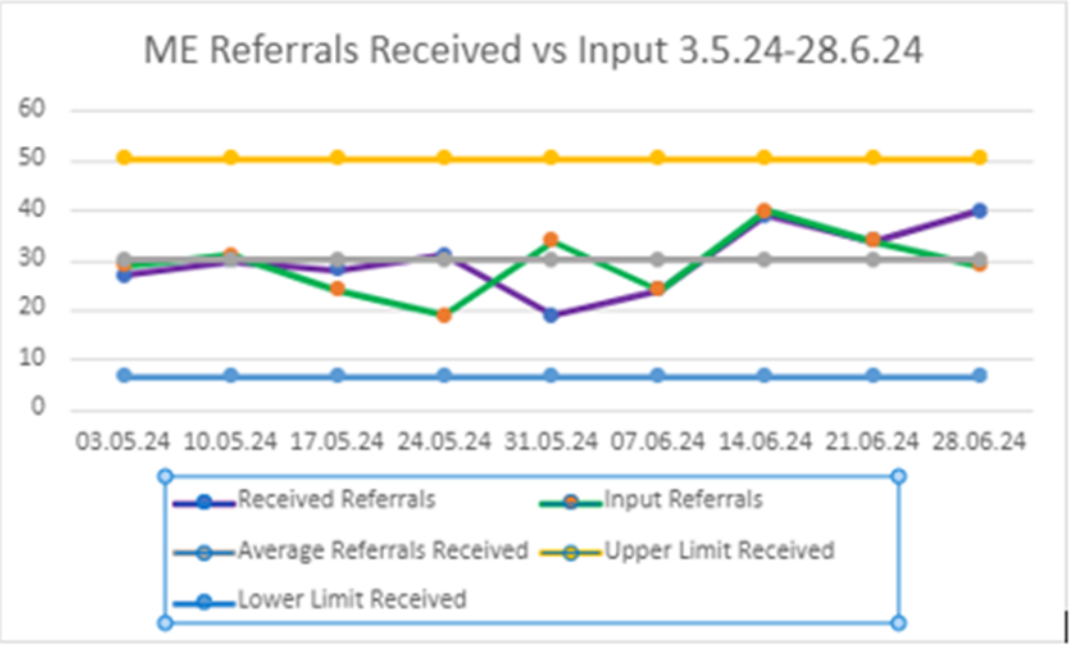
- There is currently a review of the Putting Things Right (PTR) process within BCU, where Mortality will also be aligned to PTR, as directed by the All-Wales Mortality Framework. This project is being managed by the Quality Directorate.

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

- Continuing to attend All Wales level meetings to support the development and improvements of the Mortality Datix module making it more fit for purpose.

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

- The All-Wales DNACPR (Do Not Attempt Cardiopulmonary Resuscitation) Action Plan will be integrated with the BCU action plan and redistributed.



	Input/output			Inputting Backlog				Datix Status										
Date	Total received per week*	Total input per week	Output Differential	Total w/e Backlog inc compliments	Backlog of cases requiring inputting within 1 month from date received by MES	Backlog of cases requiring inputting within 2 months from date received by MES	Backlog of cases requiring inputting within 3 months from date received by MES	Total New cases (awaiting mortality admin s&s)	New Under 1 month DOD (awaiting mortality admin s&s)	New Within 2 months DOD (awaiting mortality admin s&s)	New Within 3 months & over DOD (awaiting mortality admin s&s)	Total Pending Cases awaiting Mortality Clinician Review S&S	Pending Cases Under 1 month awaiting Mortality Clinician Review	Pending Cases Within 2 months awaiting Mortality Clinician Review	Pending Cases Within 3 months awaiting Mortality Clinician Review	Pending scrutiny panel (with IHC's, for IHC's to RAG rate)	Under investigation / action required (with IHC's, for IHC's to RAG rate)	Process completed
03.05.24	27	29	2	3	3	0	0	208	77	107	24	217	18	24	175	557	249	2146
10.05.24	30	31	1	2	2	0	0	166	68	97	1	229	14	24	191	567	231	2210
17.05.24	28	24	-4	6	6	0	0	120	71	49	0	239	7	39	193	564	242	2263
24.05.24	31	19	-12	18	18	0	0	67	67	0	0	271	8	65	198	577	244	2289
31.05.24	19	34	15	3	3	0	0	75	66	9	0	253	8	54	191	587	245	2315
07.06.24	24	24	0	3	3	0	0	54	54	0	0	257	20	54	183	601	226	2364
14.06.24	39	40	1	2	2	0	0	40	36	2	2	260	34	46	180	630	226	2387
21.06.24	34	34	0	2	2	0	0	59	59	0	0	246	22	46	178	639	222	2406
28.06.24	40	29	-11	11	11	0	0	45	43	1	1	265	33	45	187	640	225	2425

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

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

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

QUALITY ASSURANCE

The Health Board's Regulatory Assurance Group provides central oversight and coordination of quality related regulatory matters to strengthen the approach to quality governance. The group, and the work of the Quality Assurance Team, has focused over the last year on significantly on improving process and evidence.

HEALTHCARE INSPECTORATE WALES

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

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

Healthcare Inspectorate Wales Activity May to June 2024

Published Reports (0)

Concerns / Requests for Assurance (8)

Case 1: IHC Central, Mental Health and Learning Disabilities

The Health Board received a letter of concern from HIW regarding a patient who was under the care of the Community Mental Health Team in Nant Y Glyn. The complainant stated that the patient had been unsafely discharged from the service.

Case 2: IHC West, Cardiology

The Health Board received a letter of concern from HIW in relation to a doctor's request for assurances pertaining to clinical practice of other medical staff members in Ysbyty Gwynedd.

Case 3: IHC East, Wrexham Maelor Emergency Department

The Health Board received a letter of concern from HIW in relation to the care of a patient in the Wrexham Maelor Emergency Department. The family of the patient reported that they had sustained head injuries from a fall. The Care Home Manager stated that the patient was not appropriately investigated.

Case 4: IHC East, Wrexham Maelor Emergency Department

The Health Board received a letter of concern from HIW in relation to a patient who sustained a longer than normal wait in Maelor Emergency Department with suspected heart failure. The patient spent 53 hours on an ambulance trolley, following admission.

Case 5: IHC West, Coronary Care Unit

The Health Board received a letter of concern pertaining to unsafe staffing levels in the Coronary Care Unit in Ysbyty Gwynedd

Case 6: IHC Central, Mental Health and Learning Disabilities

The Health Board received a letter of concern with regards to a patient who had endured a long surgical wait in ENT. This significant wait had caused mental health problems.

Case 7: IHC Central, Medicine

The Health Board received a letter of concern with regards to a mental health patient who was admitted to Ward 5, YGC. The concerns were around the patient’s care and access to internet.

Case 8: IHC East, Wrexham Maelor Emergency Department

The Health Board received an enquiry from HIW regarding an elderly patient, who was admitted with a broken neck. The patient endured an 18 hour wait, prior to medical treatment. The patient was offered inadequate pain relief by way of co-codamol. The Health Board responded to this as a formal concern.

All of the above have been responded to by the Health Board. No further requests have been received from HIW.

Healthcare Inspectorate Wales – Progress with Improvement Plans May to June

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

Service / Area	Date	Responsible Lead	Position overview
Local Review of Discharge Arrangements for Adult Patients from Inpatient Mental Health Services (Action Plan)	Mar 2023	Iain Wilkie, Interim Director, MHLD	**15**% ⇧
Nant Y Glyn Community Health (Improvement Plan)	Jan 2024	Iain Wilkie, Interim Director, MHLD	**22%** ⇧
Emergency Department, Ysbyty Gwynedd (Improvement Plan)	Aug 2023	Ffion Johnstone, Integrated Health Community Director, West	**6%** ⇨
Emergency Department, Ysbyty Glan Clwyd (Immediate Improvement Plan)	Apr 2024	Libby Ryan-Davies	**32%** ⇧

The main improvement plan for the Emergency Department, Ysbyty Glan Clwyd was received by the Health Board from HIW on 10 July 2024 and is due for submission back to HIW on 24 July 2024. Progress will then be reported monthly to the Regulatory Assurance Group chaired by the Deputy Director of Quality Governance.

CARE INSPECTORATE WALES

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

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

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

Quality of Care Review visits

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

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

develop. No immediate issues were raised by the teams or by the Health Boards Responsible Individual (Deputy Director of Quality Governance).

Amendment to CIW Registration

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

The request has been made in line with the considerations outlined in the Regulation and Inspection of Social Care (Wales) Act 2016. The Health Boards Responsible Individual will inform CIW and clarify the next steps.

Annual Return

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

QUALITY PEER REVIEWS

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

The review involves an internal process of self-assessment and mock inspections against core criteria which has been developed based on the approach of Healthcare Inspectorate Wales (HIW).

The process remains under development and was put in place with the need to help the Health Board to assess its progress against the recommendations issued by HIW following inspections they undertook of the Emergency Department at Glan Clwyd back in 2022 whereby the service was subsequently escalated to a Service Requiring Significant Improvement (SRSI).

Further reviews have taken place as follows:

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

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

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

HEALTH AND SAFETY EXECUTIVE / LOCAL AUTHORITY

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

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

PUBLIC SERVICES OMBUDSMAN FOR WALES

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

Public Interest Reports (PIRs)

The Health Board currently has 3 draft public interest reports:

1. **Public Interest Report ID1962: IHC East (Medicine)**: The Health Board received the draft public interest report on 29 April 2024 and has commented on the proposed conclusions and recommendations. The report was published on 10 July 2024, and a copy of the final report can be found here. The Health Board are proceeding with progressing actions to meet the recommendations made by the Ombudsman and reporting to the Regulatory Assurance Group (RAG). The Action Plan can be found in the appendix of the Private Quality Report. The wider issues contained within the report will form part of a wider Health Board action plan. The Executive Director of Nursing and Midwifery has requested the formation of a task group to develop this and take forward to ensure the wider work required, compliments the local service action plan.

2. **Public Interest Report ID5663, IHC East (Urology):** The Health Board received the draft public interest report on 06 March 2024 and has commented on the proposed conclusions and recommendations. The report was published on 18 July 2024, and a copy of the final report can be found here. The Health Board are proceeding with progressing actions to meet the recommendations made by the Ombudsman and reporting to the Regulatory Assurance Group (RAG). The Action Plan can be found in the appendix of the Private Quality Report.

3. **Public Interest Report ID753, IHC East (Gastroenterology):** The Health Board has received the draft report and has accepted the draft report. There will be a delay in the Ombudsman issuing the final report which is sadly due to a recent bereavement within the family.

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. The Health Board AVT is currently -4 (i.e. submissions are on average 4 days ahead of a deadline).

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

ORGANISATIONAL LEARNING

Quality Learning Portal – *ShareWise*

The Health Board is developing a centralised learning repository. This ambitious, exciting project will enhance our organisational memory using evolving technology to support our move towards becoming a learning organisation. The learning repository is a crucial deliverable for Outcome 5 of the Special Measures Programme, which aims to make us a learning and self-improving organisation. It is also the first such innovative system.

"ShareWise" will be a centralised repository where learning is captured, stored, analysed and shared. This will ensure that the right information is available to the right people at the right time, creating a culture of continuous learning, improvement and innovation.

> *Example:*
>
> *The pharmacy supplied rifampicin liquid bottles to the CT department instead of contrast media. The Gastrograffin bottles were sent out to patients prior to attending for a CT scan. Both were packed down into small brown medicine bottles with the same packaging.*
>
> *The error was not realised until a patient phoned the department to say the bottle did not state Gastrograffin.*
>
> *The learning here was around putting medicines with similar packaging on different shelves to minimise picking errors.*
>
> *This learning is specific to pharmacy and is not appropriate to share BCU-wide. A notification would be sent to pharmacy staff alerting them to a piece of learning relevant to them with a link to access the learning material.*

The Health Board will be able to track how many people have accessed the material, which is a significant step forward in providing assurance.

The potential for this system, particularly with the use of Artificial Intelligence, is significant.

Not only can staff feed into the system the learning from when things go wrong, but they can feed into the repository the learning from when things go well, from a range of sources. This mvoes the organisation forward into the modern thinking around safety called *Safety II* which is seen reflected in other high reliability organisations.

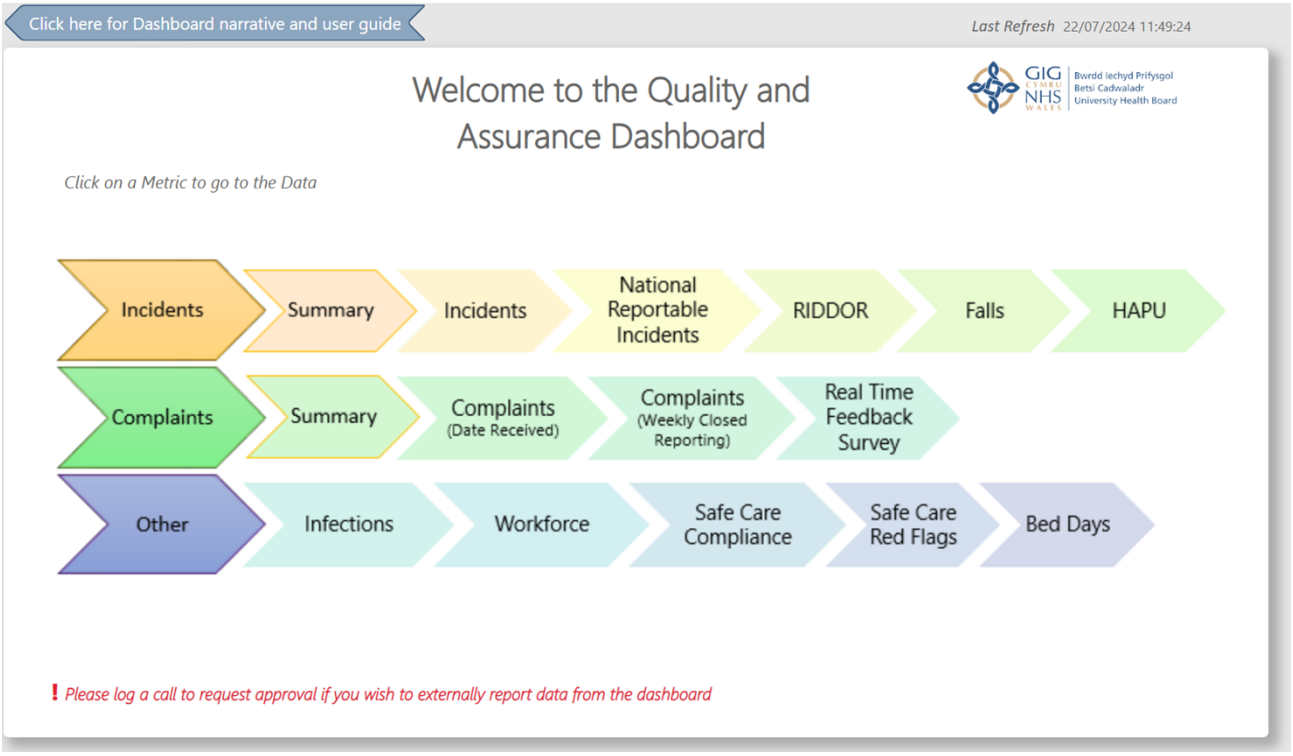
The ShareWise app to capture learning has been completed with a pilot group for the first round of testing. The aim for the full system to be ready to pilot/test by the end September and will be formally launched via the OLF (Organisational Learning Forum) with support from our internal communications team.

Quality Informatics Portal - *Quality Dashboard*

The new Quality Informatics Portal/Quality Dashboard was launched in June 2024 on the Health Board “IRIS” business intelligence system.

This suite of dashboards will provide a single, organisation-wide resource for accessing quality information. The data is ward/team to Board and pulls on data from Datix, Civica, ICNet, SafeCare, eRoster and ESR.

Early usage of the portal will support data validation of feeds from the different systems and will inform future development.



Learning from Excellence - *Great-ix*

It's now a year since the Health Board launched Greatix, showcasing the wealth of innovation, improvement, kindness and empathy our workforce has in abundance.

Any member of staff is welcome to submit a GREAT-ix to capture excellent things that happen within the Health Board and to support the sharing of learning.

An example of Great-ix reports include:

Joanne Owen

Community Nurse, Learning Disability Services

Jo has been thanked by a Local Authority manager following her excellent work supporting a service user who is now very settled in their placement. The local authority service staff have thanked Joanne for responding so quickly when the incident took place and attended a duty visit.

Jo introduced them to the mindfulness app and provided some tools and resources. The service user and the other two residents are now practising mindfulness techniques daily and it has become an established practice in the home. She also introduced her to the DBT group she now attends and is getting a lot out of it. Joanne has been supporting and motivating the service user to progress with psychiatric support and her medication has since been reviewed.

Jo has also been mentoring the staff to see things from a different perspective.

She always goes over and above to ensure the best quality service is provided, this is a beautiful example of the work she does on a daily basis. She is a valued role model to our newer members of these team we are very lucky to have her in the team.

HEALTHCARE LAW

HIS MAJESTY'S CORONER

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

Regulation 28 – Prevention of Future Death Reports

During May and June 2024, the Health Board has received one Regulation 28 Prevention of Future Death Report. A summary of the issues raised by the Coroner are listed as follows:

1. **IHC Central, Emergency Department at Glan Clwyd Hospital** – issues raised relate to notification of abnormal results. In this instance, abnormal blood results were telephoned through to the emergency department as required by the current system within an hour of the blood being taken to highlight the abnormal results. The results were available on the system; but they were not initially documented by the emergency department following the telephone call. They were not actioned, nor were they noted until many hours later until a clinician actively considered the electronic emergency department medical records. The Coroner is concerned there is no electronic or IT method or system by which the laboratory can send the results to the emergency department quickly and efficiently with an alert to indicate abnormal results. Instead, the system relies on person-to-person discussions and for this to then be escalated, as necessary.

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

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

Escalation of investigation reports by the Coroner.

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

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

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

LITIGATION (WELSH RISK POOL)

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

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.

Where claims are justified we aim for early settlement to provide support for those affected and to reduce costs. All claims are managed to ensure a fair and equitable settlement. However, where unjustified claims are made, these are robustly defended, and are taken to trial if necessary. No trials took place during the period of May/June 2024.

During the two months on May and June 2024, 39 new claims were opened. This consisted of 33 clinical negligence claims and 6 personal injury claims.

At the end of June 2024, there were 432 confirmed clinical negligence claims, 436 potential clinical negligence claims and 100 personal injury claims opened within the Health Board.

Learning from Events Reports (LFERs)

The Health Board has a number of overdue Learning from Events Reports (LFERs) which are due to be submitted to the Welsh Risk Pool (WRP). At the time of writing, this number was 38 (all bar two are out with services for providing evidence of learning). There is a risk of financial penalty for delayed forms. As with other areas of overdue documents (such as incidents and complaints which both remain unacceptably high) support is being provided to divisions to facilitate completion and regularly reporting and escalation is in place.

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The investigation of a complaint against Betsi Cadwaladr University Health Board

A report by the
Public Services Ombudsman for Wales
Case: 202207270

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Introduction

This report is issued under s.23 of the Public Services Ombudsman (Wales) Act 2019.

In accordance with the provisions of the Act, the report has been anonymised so that, as far as possible, any details which might cause individuals to be identified have been amended or omitted. The report therefore refers to the complainant as Mrs B.

Summary

Mrs B complained about her husband, Mr B's, care and treatment by Betsi Cadwaladr University Health Board ("the Health Board"). Mr B went to the Emergency Department ("the ED") at Wrexham Maelor Hospital in April 2022 with urinary retention. My investigation considered whether his symptoms should have led to an urgent suspected cancer referral. My investigation also considered whether the Health Board's management of Mr B's care, between April 2022 and February 2023, was clinically appropriate and in line with the suspected cancer pathway. I considered if the Health Board's communication with Mr and Mrs B, including sharing information about investigations and treatment plans, during this time was appropriate. I also considered if the likely waiting time for a biopsy in August 2022 was reasonable. Finally, my investigation considered the Health Board's complaint handling of this case.

My investigation found that Mr B was treated appropriately when he attended the ED in April 2022 and this complaint was not upheld. I found that, whilst there were elements of Mr B's care that were clinically appropriate, Mr B was denied potentially curative surgery. The decision not to offer surgery was based on the view his cancer had spread. However, there was uncertainty about whether this was the case and I concluded that he should have been offered surgery.

Mr B's treatment fell significantly outside the suspected cancer pathway target time of 62 days from suspicion of cancer to treatment. Mr B had a biopsy done privately due to an unacceptable delay in the Health Board being able to undertake this procedure. Mr B should have had the opportunity to discuss his complex investigation results and treatment plan with a senior clinician. These complaints were upheld. Finally, I found failings in the initial complaint handling of this case.

I recommended that the Health Board should:

a) Apologise to Mr and Mrs B for the failings identified.

b) Make a financial redress payment of £6,850 to Mr and Mrs B, which includes reimbursement of costs for a private test and consultation, £1,000 for the injustice caused by denying Mr B potentially curative surgery and £250 for the time and trouble caused to Mrs B for the complaint handling failings identified.

c) Share my report with relevant clinicians to reflect on my findings.

d) Review its complaint handling of this case to identify any lessons to be learned.

e) Summarise actions taken and progress made against the remedial actions and recommendations, following internal and external reviews, including those by:

- the Health Board's Urology Steering Group
- the Getting it Right First Time Team (GIRFT)
- the Royal College of Surgeons
- task and finish groups set up following review of the prostate cancer pathway.

The Health Board accepted my investigation findings and recommendations.

The Complaint

1. Mrs B complained about her husband, Mr B's, care and treatment by Betsi Cadwaladr University Health Board ("the Health Board"). The investigation considered whether:

a) The urological symptoms displayed at Mr B's attendance at Wrexham Maelor Hospital ("the First Hospital") Emergency Department ("ED") on 19 April 2022 should have led to an urgent suspected cancer referral.

b) The Health Board's management of Mr B's care between April 2022 and February 2023 was clinically appropriate and in line with the suspected cancer pathway.

c) The likely waiting time for a biopsy, in August 2022, was reasonable.

d) The Health Board communicated appropriately with Mr and Mrs B between April 2022 and February 2023, including sharing information about investigations undertaken and Mr B's treatment plan.

e) The Health Board managed Mrs B's complaint, submitted in November 2022, in line with Putting Things Right (the NHS complaints process), in particular in communicating with Mrs B.

Investigation

2. My investigator obtained comments and copies of relevant documents from the Health Board and considered these in conjunction with the evidence provided by Mrs B. They also obtained professional advice from one of my professional advisers, a Consultant Urologist, Mr David Almond ("the Adviser"). The Adviser was asked to consider whether, without the benefit of hindsight, the care or treatment had been appropriate in the situation complained about. I determine whether the standard of care was appropriate by making reference to relevant national standards or regulatory, professional or statutory guidance which applied

at the time of the events complained about. I have not included every detail investigated in this report, but I am satisfied that nothing of significance has been overlooked.

3. Both Mrs B and the Health Board were given the opportunity to see and comment on a draft of this report before the final version was issued.

Relevant legislation

4. The National Institute for Health and Care Excellence 'Prostate cancer: diagnosis and management' guideline [NG131] (published 9 May 2019, updated 15 December 2021) ("the NICE Guideline").

5. European Association of Urology Guidelines on Prostate Cancer, 2022 ("the EAU Guidelines"). The EAU develops best practice clinical guidelines for urologists.

6. Welsh Government 'Guidance for Managing Patients on the Suspected Cancer Pathway' (version 4, June 2022) ("the SCP"). This includes:

- The waiting time for patients on the SCP starts at the point at which cancer is suspected (the point of suspicion) and ends at the start of first definitive treatment. The performance target is that at least 75% of patients start their first definitive treatment within 62 days of the point of suspicion.

- Occasionally a patient is initially seen under the NHS but chooses to seek diagnosis privately and then returns to the NHS for treatment. The NHS must then communicate with the patient that their pathway will be closed from the date the patient informs they wish to seek diagnosis privately and a new pathway opened when they then inform the health board they are ready to restart their NHS pathway.

7. The Welsh Government's 'Putting Things Right: Guidance on dealing with concerns about the NHS' (version 3, November 2013) ("the PTR Guidance") was produced to provide guidance on how to effectively handle concerns according to the requirements set out in

the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011. The PTR Guidance states that when a concern is received, the date must be carefully noted, and all concerns must be acknowledged within 2 working days of receipt. When investigating concerns, bodies must ensure that the person who raised a concern is kept updated in a timely manner about the investigation.

8. The Public Services Ombudsman for Wales "Principles of Good Administration" (January 2022) outlines what bodies should do to deliver good administration and customer service. Principle 2 – being customer focused – incudes dealing with people helpfully, promptly and sensitively and ensuring people can access services easily. Principle 5 – putting things right – includes providing an appropriate range of remedies and the remedy offered should seek to put the complainant back in the position they would have been in had nothing gone wrong.

The clinical background events

9. Mr B attended the First Hospital ED on 19 April **2022** as he was unable to empty his bladder. He was noted as struggling to pass urine from 18:00 the previous day, with pain in his lower abdomen radiating towards his back. He had a similar episode 2 weeks previously. Mr B was catheterised (a procedure to insert a tube to drain urine from the bladder). An examination identified an enlarged prostate. The provisional diagnosis was urinary retention due to obstruction. Mr B was advised to make an appointment with his GP in relation to the possible prostate enlargement. It was noted a referral would be made to the urology department and to the trial without catheter ("TWOC") clinic.

10. On 16 June Mr B's GP referred him to the First Hospital's urology department due to an episode of acute urinary retention and a prostate-specific antigen ("PSA" – this is not a specific test for cancer but a marker of cancer risk; the higher the PSA level, the more likely it is that the patient has prostate cancer) level of 16. The referral was marked 'urgent suspected cancer'.

11. Mr B was seen by a consultant urological surgeon ("the First Consultant") on 12 July; a rectal examination noted an enlarged prostate. A plan was made that included a repeat PSA test (which reported an increased level of 18.3) and a multiparametric magnetic resonance imaging scan ("mpMRI" – a type of scan that produces a detailed picture of the prostate gland) to look for signs of cancer. Finasteride (medication used to treat an enlarged prostate) was also prescribed.

12. An mpMRI on 5 August concluded that there were appearances of a right sided prostatic tumour (prostate cancer) with an overall Likert score of 5 (the Likert scale is used to score the likelihood of clinically significant cancer, a score of 5 means that it is very likely you have prostate cancer that needs treatment). The disease was noted to be confined within the prostate, with a provisional radiological staging of T2a N0 MX.[1] Mr B was given the results of the PSA and mpMRI during a telephone consultation on 22 August and he was booked for an urgent prostate biopsy (a procedure where a sample of tissue from the prostate is taken to look for cancer cells).

13. On 28 September Mr B underwent a biopsy on a private basis under the care of a consultant urological surgeon ("the Second Consultant").

14. Mr B attended a private clinic appointment on 20 October for the results of his biopsy. The results showed Gleason[2] scores of 7 in 2 different areas of the prostate. The scores indicated cancer likely to grow at a moderate rate in 1 part of the prostate, with slower growth in the second area. Mr B was referred for a bone scan as an NHS patient. If the test results were clear, radical treatment options were to be considered. The Second Consultant asked a urology nurse specialist ("the Specialist Nurse") to see Mr B at the First Hospital with the results and for counselling. Mr B's interest for radical prostatectomy (surgery to remove the prostate) as a private patient was noted.

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[1] The TNM system is a way of staging prostate cancer. It stands for Tumour, Node, Metastasis. T describes the size of the tumour. T2a means the cancer is completely inside the prostate gland. N describes if the cancer has spread to the lymph nodes. N0 means that the nearby lymph nodes do not contain cancer cells. M describes whether the cancer has spread (metastasised) to a different part of the body. MX means that metastasis cannot be evaluated.

[2] The Gleason score is a system used to grade prostate cancer using samples from a biopsy of the prostate. It helps predict prognosis. The higher the score, the more aggressive the cancer.

15. Mr B's bone scan on 28 October showed no evidence of metastatic bone disease (when cancer cells spread from the original cancer site to bone).

16. Mr B was seen by the Specialist Nurse on 4 November. On 7 November he was referred to a hospital outside of the Health Board area ("the Second Hospital") to consider robot assisted surgery to remove the prostate. The Health Board has a contract with an English Hospital Trust responsible for the Second Hospital for it to provide prostatectomies. This was put in place to support the delivery of prostate surgery and treatment for other urological cancers to address capacity concerns relating to the Health Board's ability to deliver cancer targets for urology.

17. The outcome of the Second Hospital urology multi-disciplinary team ("MDT") meeting on 16 December was for Mr B to undergo an urgent scan ("PSMA PET scan" – a test used to detect if and where prostate cancer has spread). It emailed the Health Board requesting this and asked the Specialist Nurse to update Mr B.

18. Mr B's PMSA PET scan on 22 December concluded that his disease was in the prostate gland, predominantly on the right side, with suspicion of skeletal metastases (where cancer has spread to the bone) in the upper spine and in a rib.

19. The First Consultant requested a magnetic resonance imaging scan ("MRI scan" – the use of strong magnetic fields and radio waves to produce detailed images of inside of the body) of Mr B's spine on 11 January **2023**. This was undertaken on 15 January. The MRI report concluded that a small lesion noted "must be regarded as suspicious for metastasis".

20. On 20 January an internal email raised concerns about communication with Mr B and requested clarification as to which consultant he was under the care of. Mr B had been seen in the NHS by the First Consultant and as a private patient by the Second Consultant.

21. The Second Hospital urology MDT on 27 January reviewed the MRI findings. It decided that Mr B was not suitable for surgery to remove the prostate in view of the spinal metastasis, and he was noted for oncology treatment by the Health Board.

22. Mr B was seen as a private patient at another hospital ("the Private Hospital") by a consultant urologist ("the Third Consultant") on 29 January for a second opinion. They noted that robotic surgery would be a reasonable way forward. While the PSMA PET or MRI scan might determine the final treatment decision, the Third Consultant said if there was any doubt, they should give him the benefit from this and proceed to radical curative treatment.

23. Mr B was seen by the Specialist Nurse on 1 February. She noted that the minutes of the Second Hospital urology MDT stated that Mr B was deemed unsuitable for surgical input. She discussed alternative treatment options with Mr B (hormones and chemotherapy). Mr B requested an oncology referral on an urgent basis. Mr B was prescribed bicalutamide (a hormonal therapy drug used to treat prostate cancer) for 4 weeks with a plan to administer Decapeptyl (another hormonal therapy drug) in 2 weeks.

24. On 9 February a urology pelvic MDT at the Private Hospital determined Mr B was for "all treatment options" with the intention to pursue curative treatment. It noted the areas within the spine and rib (as noted on the PSMA PET scan) but said that these appearances on the MRI were unclear and not completely convincing of metastases. Mr B's cancer was staged as T3a N0 M0 meaning the extent of the cancer had increased, but it had not spread to the nearby lymph nodes or elsewhere in the body.

25. Following a complaint from Mrs B to the Health Board, a radiological second opinion was obtained on 14 February. It agreed that the MRI of 15 January showed a lesion highly suspicious for spread of the cancer which corresponded to the findings of the PSMA PET on 22 December 2022.

26. Mr B was seen by the Specialist Nurse on 20 February. It was noted they had a lengthy discussion and Mr B indicated he wished to pursue oncological treatment as opposed to surgery. Decapeptyl was administered with a plan for this to be continued by his GP at 6-monthly intervals, lifelong.

27. The First Hospital urology MDT on 22 February confirmed metastatic disease of the prostate. The Private Hospital recommendation for all radical treatment options and agreement to perform prostatectomy was noted, along with Mr B's wish for oncological treatment. The plan was for hormone therapy, with referral to oncology locally for chemotherapy and radiotherapy.

28. Mr B spoke with a consultant at the Second Hospital on 17 March. They said that communication was "not up to scratch" and agreed that his complex problem should have been discussed with a consultant, not solely with the clinical nurse specialist team. Mr B was advised that the scans suggested oligometastatic disease (where the cancer has spread to only a few sites beyond the prostate).

29. Mr B was seen in the oncology clinic on 31 March and started chemotherapy.

The complaint handling background events

30. In October **2022** Mrs B raised concerns about the delays in Mr B's treatment with Healthcare Inspectorate Wales ("HIW" – the independent inspectorate and regulator of all healthcare in Wales). On 25 October, HIW's Director of Clinical Advice and Quality Assurance emailed the Health Board. They highlighted general concerns and questioned the management of patients with suspected cancer, seeking assurance in relation to Mr B's treatment, given the delays already encountered.

31. On 17 November Mrs B emailed the Surgical Site Specialty Manager, General Surgery ("the Site Specialty Manager") noting her concerns about the delays encountered in her husband's treatment. On 2 December Mrs B emailed the Health Board's concerns team stating that she had not received a response to her 17 November email and raising a formal complaint.

32. On 8 December Mrs B emailed the concerns team again and said that the lack of communication from the Health Board was "deplorable". She further indicated her wish to make a formal complaint regarding delayed

treatment, having to pay for a private biopsy due to the length of wait for one by the Health Board, and lack of communication from cancer services from 17 November.

33. On 12 December the concerns team were notified that Mrs B had called about the lack of response to her formal complaint.

34. On 13 December HIW emailed the Health Board, noting that HIW contacted the Health Board in October and November, and Mrs B contacted the Health Board making a formal complaint in November. Despite this communication, Mrs B had informed them that she had received no response or communication from the Health Board about her complaint. On the same day, the Health Board acknowledged Mrs B's complaint.

35. Between January and March **2023**, there was evidence of communication between the Health Board and Mr and Mrs B about Mr B's treatment, including with the Site Specialty Manager and the Specialist Nurse. The Health Board responded to Mrs B's complaint on 19 April 2023; it apologised for the delay in completing the investigation.

Mrs B's evidence

36. Mrs B said that the Health Board failed to refer Mr B to a urologist following his presentation at the First Hospital ED on 19 April 2022 with red flag urinary symptoms, including a very large prostate. She said this should have been done as a matter of urgency.

37. Mrs B said that they were informed in August 2022, when Mr B required a biopsy, that there was a delay of 3-4 months. They therefore arranged a private biopsy. Mrs B said there were also significant delays in the contracted-out service to the Second Hospital for curative surgery; this required further scans. As a result of these delays, harm was caused because what was initially deemed curative was subsequently not considered suitable for surgery. She said there was a significant delay, of nearly 12 months, from Mr B's presentation to treatment.

38. Mrs B also highlighted that no clinical history was taken of any bony injuries, including to the suspicious areas of Mr B's ribs/spine. This could have meant that he had received chemotherapy, and denied possible curative surgery, which may not have been appropriate.

39. Mrs B said that she and Mr B were not informed that Mr B's cancer had been regraded. She said they found out by accessing Mr B's medical records and were only informed by a clinician prior to commencing radiotherapy, at which point the clinician confirmed the cancer was incurable.

40. Mrs B said the complaint handling of her concern was inadequate. She said that formal complaints in November and December 2022, along with other requests for explanations and treatment plans, were not responded to. The Health Board's investigation response failed to address why they had been denied access to a senior consultant to explain scan results, despite numerous requests. Mrs B referenced the Second Hospital's consultant's comments, in March 2023, that a senior consultant should have discussed the complexities of Mr B's case with them.

41. Mrs B described the psychological distress of knowing that something curable at the time was now incurable. She said that, in addition to the financial cost of arranging private consultations and biopsy, this had caused significant anxiety, impacted all their future plans and reduced her husband's life expectancy. She felt they had been robbed.

42. In commenting on the draft report, Mrs B said that when Mr B attended the First Hospital ED on 19 April 2022, the referral to the urology department was not sent and Mr B's GP had to do this. Mrs B said that Mr B only expressed a wish for oncological treatment, on 22 February 2023, as the Specialist Nurse was unclear as to whether Mr B would receive ongoing monitoring from the Health Board if he chose to have surgery privately. She said his choices were made from fear due to lack of information and a desire not to delay treatment further, rather than being fully informed as, despite requests, no consultation meeting was offered. She said scans were inconclusive about metastases and, following chemotherapy, his computerised tomography scan ("CT scan" – the use of X-rays and a computer to create an image of inside of the body) did not

show any scarring to the bony lesions, which the radiologist said they would have expected to see. Mrs B said there remained a lack of clarity about which consultant Mr B was under.

The Health Board's evidence

43. In responding to Mrs B's complaint, the Health Board said that Mr B experienced significant delays following his GP referral in June 2022, which amounted to a breach of duty of care. It did not identify any qualifying liability as, despite the delay, it considered the care and treatment provided to Mr B was appropriate based upon his clinical presentation and no harm had been caused. The Second Consultant (who, although he saw Mr B on a private basis, is also a consultant at the Health Board), advised that whilst the initial delays experienced were extremely regrettable, in his professional opinion no harm had been caused to Mr B as a result.

44. The Health Board said that based on the SCP, Mr B's treatment should have taken place by 17 August 2022; he was seen on 12 July 2022 (day 26) and the outcome of the review was for an mpMRI, repeat PSA and renal function test. These were done and an appointment to review the investigation results took place on 22 August 2022 (day 67). It said the timeframe between initial consultation and review was to ensure that all the investigations were completed and reported upon. It said that Mr B then required a prostate biopsy on an urgent basis. As Mr and Mrs B had been advised that the waiting time for this was 3-4 months, they then arranged for the procedure privately.

45. In responding to this investigation, the Health Board further said that the initial date of suspicion of cancer was 16 June 2022, and this was recorded as day 0 for the purposes of the SCP. The SCP was reset with a new date of suspicion on 28 October 2022 when Mr B returned to the NHS after his private biopsy. This reset was in line with the SCP in relation to patients returning from the private sector. The Health Board said that the date of Mr B's first definitive treatment was 1 February 2023 when hormones were commenced. Mr B's pathway was reported to Welsh Government as a breach of the 62-day target in February 2023. The reason for the breach of the 62-day target was given as a delay in discussion at the First Hospital

urology MDT because histology from the private laboratory was not available. It said the pathway was complex due to the request for additional scans by the Second Hospital urology MDT (PSMA PET and MRI spine). In addition, there was the original delay for a biopsy.

46. The Health Board said that prostate cancer is slow-growing, and Mr B's bony metastases were likely to have been present before the urinary symptoms appeared, although difficult to detect on standard bone scans.

47. The Health Board explained that in September 2022 the waiting time for a biopsy was 2-4 months depending on patient availability and the patient being medically fit. It said there had been a 3-4 month wait for prostate biopsies in the summer of 2022 and that currently its waiting times were 3-4 weeks due to running weekly sessions.

48. The Health Board said that, after Mr B's private biopsy and his referral back into the care of the NHS, his case was then managed according to the SCP, including a bone scan to determine if the cancer had spread. It said Mr B was referred for consideration of curative surgery to the Second Hospital, which reviewed the histology and judged the cancer to be a higher grade than previously thought (Gleason grade 9). The Second Hospital urology MDT therefore requested more detailed and specific imaging.

49. The Health Board said PSMA PET scans are being used more widely in the staging process for high grade prostate cancer because they can detect metastatic disease earlier than traditional bone scans. If metastases are already present, surgery is not in the patient's best interests.

50. The Health Board said that all 'breach' reasons were collated and reviewed at a monthly Health Board Urology Steering Group and the following remedial actions had been noted:

a) A nurse led biopsy list started in April 2023 to increase capacity and reduce delays.

b) Enquires were being made for prostatectomy capacity closer to North Wales.

c) A new administrative process had been established centrally to ensure quicker access to biopsy specimens and reports relating to patients who have a biopsy in the private sector, to reduce delay to subsequent MDT discussion.

d) It had appointed 3 SCP validators; their role is to assist in streamlining the SCP.

e) A straight to test mpMRI pathway is to be piloted with subsequent roll out across the Health Board – it anticipates this will vastly improve the pathway for patients and reduce the number of breaches.

51. The Health Board said it had invited external reviews of the urology service from GIRFT (Get it Right First Time – a programme to improve the treatment and care of patients through in-depth reviews of services) and the Royal College of Surgeons. The resulting recommendations were being included in a Urology Improvement Plan. It had also set up 5 task and finish groups following review of the prostate cancer pathway, with a focus on reducing waiting time to diagnosis.

52. On commenting on the draft report, the Health Board said there were some very significant points of learning that it has and will continue to translate into service improvements to ensure patients receive better and safer care across the Health Board.

53. The Health Board also provided further comments explaining its reasoning for not offering Mr B surgery. It said that the decision making around treatment options for prostate cancer was based on TNM staging (see paragraph 12), taking into account findings from radiological and histopathological (examining changes in tissue samples) investigations. It provided comments from a Consultant Radiologist who said that the PSMA PET scan was performed at the request of the Second Hospital on 22 December 2022. He said it showed disease in the prostate gland and possible signs of bone metastases in a rib and spine. He said an MRI on 15 January 2023 showed a lesion on the spine, which further supported a diagnosis of bone metastasis. He commented that the EUA guidelines include discussion that a PSMA PET scan is better at detecting some

metastatic disease compared to conventional imaging. A Professor of Urology from the Second Hospital also said that a PSMA PET scan is routinely used to stage patients with high grade prostate cancer and as a means to detect metastatic disease. He reiterated that if metastasis was detected then surgery would not be curative.

54. The Health Board was therefore of the view that Mr B had metastatic incurable disease and radical surgery was not in Mr B's best interests. However, following further discussion with my investigator, the Health Board agreed to accept my findings and recommendations in full.

Professional Advice

55. The Adviser said that a rectal examination was carried out at Mr B's ED attendance on 19 April 2022, noting that Mr B was "positive for enlarged prostate". He said this suggested that urinary retention was caused by a benign prostate enlargement rather than prostate cancer. The Adviser explained that prostate cancer would have felt abnormally hard and nodular. The Adviser said that PSA testing for early, clinically undetectable, prostate cancer in April would have risked a false positive result because there had been an episode of urinary retention requiring catheterisation. The advice given to Mr B to have his prostate checked for early prostate cancer by his GP was an appropriate course of action.

56. The Adviser considered the management of Mr B's urological care between April 2022 and February 2023. He said that, following the GP referral with a raised PSA level of 16, the investigations carried out by the Health Board were consistent with the NICE Guideline. Mr B underwent an mpMRI, the first line investigation for people with suspected prostate cancer and a biopsy was advised.

57. The Adviser said that a 2–4-month wait for this "important cancer investigation" was considerably beyond the SCP target cancer treatment time. He said that all new suspected cancers should be regarded as high grade until proven otherwise and biopsied urgently within SCP timescales. The Adviser noted that Mr B would also have had his SCP clock reset due to making the decision to have the biopsy done privately.

58. When Mr B returned to the care of the NHS following the private biopsy, the Adviser said a bone scan (which subsequently showed no evidence of skeletal metastatic disease) was requested, in line with the NICE Guideline.

59. The Adviser noted that, following referral to the Second Hospital, emails suggested that Mr B's Gleason score should be upgraded from Gleason 7 to 9, but this was not documented in the Second Hospital urology MDT outcome forms.

60. The Adviser said the Second Hospital urology MDT asked the First Hospital to carry out a PSMA PET scan. He said this scanning was not mentioned as a pre-treatment staging investigation in the NICE Guideline but was discussed in the EAU Guidelines. The Adviser said that, on the basis of the PSMA PET scan and MRI scan reports, the Second Hospital urology MDT advised that surgery to remove the prostate was inappropriate because Mr B's prostate cancer had spread to the bone. The Adviser noted the First Hospital MDT on 22 February which documented the Private Hospital opinion on 9 February for all radical treatment (that is, surgical treatment), but that Mr B elected for oncology treatment. He said it appeared Mr B made this decision following a discussion with the Specialist Nurse and the background to this decision was that the Second Hospital urology MDT considered radical treatment inappropriate. The advice of the Private Hospital was disregarded.

61. The Adviser said the PSMA PET scan and MRI reports described a suspicious abnormality, not a confirmed bony metastasis. However, he said that Mr B was considered unsuitable for radical treatment by the First Hospital urology MDT because of the abnormality detected on the PSMA PET scan. He said that Mr B was therefore denied potentially curative treatment and instead was offered palliative chemoradiotherapy and hormone therapy.

62. The Adviser noted the Private Hospital had suggested that the presence of significant metastatic disease had not been proven by the PSMA PET and MRI scans. He said the only marker of disease activity for

Mr B was his PSA. This fell during the period of time between referral and treatment, which suggested that his prostate cancer had not progressed or metastasised.

63. The Adviser said that, following the GP referral with suspected prostate cancer on 16 June, treatment should have commenced on 17 August to satisfy the SCP 62-day target. However, the Adviser noted that, on this date, Mr B was yet to be reviewed with his MRI report. As previously noted, the SCP clock would have stopped when Mr B elected to have his prostate biopsy carried out privately and re-set when he was re-referred to the NHS urology clinic on 14 October with a confirmed diagnosis of prostate cancer. On 15 December, 62 days later, the Adviser noted that Mr B continued to wait for treatment for his prostate cancer to begin.

64. In the Adviser's view, there was a "huge delay" in the commencement of Mr B's treatment which was eventually started 230 days after the GP referral. In terms of the impact on Mr B, the Adviser noted that Mr B's PSA fell from 16 to 12.6 between 15 June 2022 and 1 February 2023, suggesting the disease had not progressed. That said, he noted that Mr B was started on finasteride in August 2022, which is known to halve the PSA level. In addition, he said it was possible that finasteride was having a direct suppressive effect on the disease and was not simply influencing PSA level.

65. The Adviser considered the communication with Mr and Mrs B about Mr B's investigations and treatment plans. He said that there was conflicting opinion about the correct management of Mr B's prostate cancer, with the Second Hospital urology MDT advising against surgery and the Private Hospital advising radical, curative treatment. Mr B was subsequently counselled by the Specialist Nurse at the First Hospital who followed the advice of the First Hospital urology MDT which had decided to follow the recommendation of the Second Hospital urology MDT. The Adviser already identified that, contrary to EAU guidelines, the decision whether to cure or palliate Mr B's disease was based on the result of a PSMA PET scan, a test which the EAU suggest should not be considered during clinical decision making. The Adviser agreed with Mr B that a senior consultant with a special interest in urological pelvic cancer should have

discussed the complexities of the case with him. He said the clinical relevance of the findings by the Second Hospital and Private Hospital MDTs required review and explanation by an experienced expert.

66. The Adviser noted the Health Board's comment, in response to this investigation, that prostate cancer is slow-growing, and the bony metastases were likely to have been present before the urinary symptoms appeared, although difficult to detect on the standard bone scan. He said that this was a speculative statement without supportive evidence. He said the clinical significance and history of oligometastatic disease detected with PSMA PET and MRI scanning was uncertain. Scanning at regular intervals would have revealed the rate of growth, if any, and would have helped to determine whether the abnormal focus was cancerous or non-cancerous. He said it was impossible to know when this abnormality first appeared.

67. The Adviser considered the Health Board's comments in response to the draft report. The Adviser confirmed this did not change his advice. He reiterated that the clinical outcome for patients with PSMA PET detected disease was uncertain. He said EAU guidelines were clear that aggressive treatment options, including the possibility of radical prostatectomy, should not have automatically been denied to Mr B.

Analysis and conclusions

a) Should the urological symptoms displayed at Mr B's attendance at the First Hospital's ED on 19 April 2022 have led to an urgent suspected cancer referral?

68. Taking into account the advice I have received, I am satisfied that, based on Mr B's presentation, advice to see his GP to check his prostate was the appropriate course of action. An urgent suspected cancer referral which was not indicated at this juncture. I **do not uphold** this complaint.

b) Was the Health Board's management of Mr B's care between April 2022 and February 2023 clinically appropriate and in line with the SCP.

69. There were elements of Mr B's management that were clinically appropriate, namely the request for mpMRI scan and biopsy, following the urgent suspected cancer referral by his GP, and request for a bone scan following Mr B's biopsy results. These investigations were the appropriate ones to request at these stages of Mr B's care, and in line with the NICE Guideline recommendations.

70. While the request for PSMA PET scan is not mentioned as a pre-treatment staging investigation in the NICE Guideline, the EAU Guidelines discuss the use of such scans. However, I note the advice I have received that the EAU Guidelines indicate the need for caution when making decisions about treatment based on the results of PSMA PET scanning. The EAU Guidelines suggest this test should not be considered during clinical decision-making. Nevertheless, the First Hospital urology MDT followed the recommendation of the Second Hospital urology MDT, that Mr B was not for radical treatment based on the PSMA PET and MRI scan reports.

71. I accept the advice that the decision whether to cure or palliate Mr B's disease based on the results of the PSMA PET scan was contrary to EAU Guidelines. I have considered the Health Board's comments on the draft report, that there was evidence that Mr B's cancer had spread, and it was not in his best interests to offer surgery. I have also considered the additional comments I received from the Adviser. This is a finely balanced decision that rests on whether there was evidence that Mr B's cancer had spread. On the balance of probabilities I am of the view that it was not proven Mr B's cancer had spread, there was only a suspicion. The Adviser also said these reports described a suspicious abnormality not a confirmed bony metastasis. On the basis that this was not proven, Mr B should have been offered surgery and he was therefore denied potentially curative treatment. This is a service failure.

72. This failure is compounded by the view of the Private Hospital MDT that the presence of significant metastatic disease had not been proven by the PSMA PET and MRI scans and that Mr B should have been offered

radical curative treatment options. This view was available to the First Hospital urology MDT when it made its decision against surgery. It is also noteworthy, notwithstanding the advice about the impact of finasteride (paragraph 64), that Mr B's PSA fell during the time between referral and treatment. I am guided by the advice that this suggested it was possible Mr B's prostate cancer had not progressed or metastasised during this time. This is potentially an injustice to Mr B as this decision may have impacted on the course of his treatment, depending on whether he would have chosen radical surgery if offered. That said, I must emphasise that we cannot say with any certainty, if Mr B had been offered radical surgery, and he had opted for it, whether the outcome would have been any different.

73. In relation to the SCP, as Mr B elected to have his biopsy privately, the SCP was closed at this point, with a new pathway opened when he returned to the NHS for his care. This approach was in line with the SCP; a Wales wide guidance published by Welsh Government. Even taking this into account, the Health Board breached the 62-day target initially, following the GP referral (resulting in Mr B's decision to seek a biopsy privately) and again following Mr B's return to the NHS (Mr B did not start definitive treatment until day 96). The Health Board has already accepted significant delays following the GP referral and a breach of the 62-day target. This breach was a service failure and an injustice to Mr B whose first definitive treatment was delayed as a result. I **uphold** this complaint.

c) Was the likely waiting time for the biopsy, in August 2022, appropriate.

74. If Mr B had not elected to have his biopsy privately, taking into account the waiting times for biopsies in August 2022, a further 3 to 4 months wait for this procedure would have added up to122 days to the 67 days he had already waited at the point the decision was made to request an urgent biopsy. I have taken into account the advice that all new suspected cancers should be regarded as high grade until proven otherwise and biopsied urgently and within SCP timescales. Given the importance of this investigation for Mr B's management and decision-making, this wait, significantly in excess of the SCP, was a service failure.

75. To uphold a complaint, I must be satisfied that a service failure has caused harm or injustice. Mr B was in a position where he had been told that he likely had prostate cancer, but that he had to wait 3 to 4 months for further investigations. He was left with a stark choice of choosing to wait for an NHS biopsy, not knowing the impact this would have on his prognosis or treatment or paying for this to be completed privately. This was an injustice to him. I **uphold** this complaint.

76. A key aspect of my work is remedying injustice and hardship. The underlying principle to remedy is to ensure that a public body restores the complainant to the position they would have been in if the maladministration or poor service had not occurred, when this is possible, as detailed in the Principles of Good Administration. The Health Board has previously agreed to reimburse the costs of private investigations or treatment, where appropriate, including in the case of my predecessor's previous public interest report (reference 201905373) relating to a delay in providing treatment for prostate cancer. I consider reimbursement of the cost of Mr B's private consultations and biopsy will restore him to the position he would have been in had this service failure not occurred.

d) Did the Health Board communicate appropriately with Mr and Mrs B, between April 2022 and February 2023, including sharing information about the investigations undertaken, and Mr B's treatment plan.

77. Mr B was seen by the First Consultant following the GP referral on 12 July 2022 and the Second Consultant, on a private basis, on 20 October, when he was referred back to the NHS for investigations. After this time, Mr B was seen by the Specialist Nurse with no further direct consultant input by Health Board clinicians. The Specialist Nurse met Mr B 3 times during this period, on 4 November 2022 and 1 and 20 February 2023. While she clearly shared information with Mr B about his investigation results, the outcome of the various MDTs and about his recommended treatment, I am concerned, given the complexities of Mr B's case that there was no further direct consultant input to discuss the outcomes of the investigations and the treatment plan with him.

78. The second opinion Mr B sought on a private basis conflicted with advice from the Second Hospital urology MDT (in terms of curative or palliative treatment) and his case was complex. Given these circumstances, it would have been appropriate for a consultant with the necessary speciality to have met Mr and Mrs B to discuss the investigation results and treatment options; this was the view of the Adviser which I accept. I also note that this view is supported by the opinion of the Second Hospital (see paragraph 28) and even the Health Board's own consultants questioned who the responsible consultant for Mr B's care was (see paragraph 20), given that Mr B had been seen both by the NHS and privately. Given the lack of consultant input, I am not satisfied that communication was appropriate. This is a service failure and an injustice to Mr and Mrs B, who were not provided with the level of input and information appropriate to the complexities of Mr B's case. I **uphold** this complaint.

e) Was the Health Board management of Mrs B's complaint, submitted in November 2022, in line with the PTR guidance, in particular about communication with Mrs B.

79. I am concerned that the initial management of Mrs B's complaint was not in accordance with the PTR guidance. Despite raising concerns on 17 November 2022, Mrs B did not receive an acknowledgement of her complaint for 13 working days. As the Health Board had not confirmed it was investigating her concerns, she had to follow this up on a number of occasions. She also involved HIW who contacted the Health Board several times before Mrs B's complaint was acknowledged.

80. This lack of formal acknowledgement and recognition of Mrs B's complaint was maladministration and meant that communication with her about her concerns was not timely. This was an injustice to Mrs B, as it took additional effort and the involvement of HIW before the Health Board acknowledged her complaint. The evidence shows that communication with Mr and Mrs B about their concerns and about Mr B's treatment improved after this date and until the Health Board issued its complaint response. I **uphold** this complaint to the extent that the initial management of Mrs B's complaint was contrary to the PTR Guidance and the Principles of Good Administration, which in turn meant that communication

was not of an acceptable standard initially. My recent thematic report, "Groundhog Day 2: An opportunity for cultural change in complaint handling?" June 2023 also highlighted the importance of timeliness and good communication so that complainants do not lose trust and confidence in the complaints process.

Additional comments

81. I highlighted concerns about the Health Board's delivery of treatment/investigations for prostate cancer previously in 2 public interest reports (references 201905373 and 202002273). While I have noted the ongoing actions outlined by the Health Board (see paragraph 50), it is concerning that the urology service provision, in particular in relation to prostate cancer, continues to be a problem for the Health Board. My predecessor received assurance from the Health Board that it was "grasping the nettle". However, the similarity of the concerns in this complaint raises questions about whether the Health Board's actions have been effective in improving the service.

82. It is of real concern to me that I have identified more failings in the provision of prostate cancer care, and that I have identified detriment to another patient. The Health Board has told my office of actions it has taken and is taking to achieve improvements. I have asked the Health Board for information and evidence of these in my recommendations which follow at the end of this report. I urge the Health Board to fully commit to change and improvement so people do not have cause to approach my office again with similar concerns.

83. In the last public interest report about the Health Board's prostate cancer management (202002273), I noted that HIW had identified several serious concerns following its Urological Cancer Peer Review of the Health Board in February 2014. In light of the concerns identified in this report, I will be sharing the report and its findings with HIW for it to take into consideration when planning its future work in this area.

Recommendations

84. I **recommend** that, within **1 month** of the date this report the Health Board should:

a) Provide Mr and Mrs B with a fulsome written apology for the failings identified in this report.

b) Make a financial redress payment of £6,850 to Mr and Mrs B, which includes reimbursement of £5,350 in private costs for the biopsy, reimbursement of £250 for the private consultation regarding surgery, £1,000 for the injustice caused by denying Mr B potentially curative surgery resulting in him requiring life-long treatment for incurable cancer, and £250 for the time and trouble caused to Mrs B for the complaint handling failings identified.

c) Share this report with relevant clinicians to reflect on my findings.

d) Review its complaint handling of this case to identify any lessons to be learned.

85. I recommend that, within **2 months** of the date of this report the Health Board should:

e) Summarise actions taken and the impact of the progress against the remedial action identified by its Urology Steering Group including:

- The reduction in delays following the introduction of a nurse-led biopsy list.
- Exploring options for prostatectomy capacity closer to North Wales.
- A new process to ensure quicker access to biopsy reports for those undertaken in the private sector.
- Three suspected cancer pathway validators assisting to streamline the pathway.

- A straight to mpMRI pathway to be piloted.

f) Summarise the actions taken, and impact of these actions, in addressing the recommendations made following external reviews of the urology service by GIRFT and the Royal College of Surgeons.

g) Summarise the actions taken, and impact of these actions, by the task and finish groups set up following review of the prostate cancer pathway, with a focus on reducing waiting times to diagnosis.

86. I am pleased to note that in commenting on the draft of this report the Health Board has agreed to implement these recommendations.

Michelle Morris

4 July 2024

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The investigation of a complaint against Betsi Cadwaladr University Health Board

A report by the
Public Services Ombudsman for Wales
Case: 202300527

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Introduction

This report is issued under s.23 of the Public Services Ombudsman (Wales) Act 2019.

In accordance with the provisions of the Act, the report has been anonymised so that, as far as possible, any details which might cause individuals to be identified have been amended or omitted. The report therefore refers to the complainant as Ms D. Relevant staff involved are referred to by their posts/designations.

Summary

Ms D complained about the care and treatment her sister, Ms A, received from Wrexham Maelor Hospital ("the Hospital") in July 2022. Ms A had several medical conditions, including epilepsy (a condition which causes seizures), cerebral palsy (a condition that affects movement and co-ordination) and learning disabilities. She lived in a nursing home, had limited communication, and required 24 hour care and support.

The Ombudsman found that the Health Board's management of Ms A's personal care needs, her nutrition and hydration, and communication with her fell below an adequate standard. On the occasions that the Learning Disability ("LD") team and Ms A's family were not present to assist, the nursing care on the ward fell short of acceptable standards, especially at weekends and overnight. No additional staff were brought in to support care delivery. There was no person-centred nursing care plan setting out the care objectives and adjustments that were needed to provide Ms A with effective care. This meant that staff did not fully understand her needs.

The Ombudsman also found that there were multiple occasions when Ms A's pain was identified by her family and the LD team, but it was unclear whether nursing staff were consistently able to identify pain, as the assessment tool used was not adapted for Ms A's particular needs. This failure meant that Ms A suffered unnecessarily.

The Ombudsman found that there was a poor standard of record keeping in relation to Ms A's seizures. This was dangerous and represented a poor level of care. It was unclear whether nursing staff recognised Ms A's seizures themselves, and had her family not been present, it is likely that many of her seizures would have gone unnoticed. Administration of medication was also found to be inadequate. Poor compliance with anti-seizure medication may have contributed to the increase in Ms A's seizure activity.

The Ombudsman made a number of recommendations, which the Health Board accepted. These included:

- An apology to Ms D, on behalf of Ms A for the failings identified, and for Ms D having to pursue her complaint.

- A review of care planning practices on the ward to ensure care plans are embedded into basic care.

- A review of a sample of person-centred care plans to ensure they include any adjustments to meet a patient's individual needs.

- Implementation of a regular ward audit of nursing documentation, to include care plans and seizure charts.

- A review of the approach to pain assessment for people with learning disabilities to ensure adjustments and appropriate tools are used.

- Providing training to ward staff in respect of mental capacity and best interest decision making.

- Engagement with the social services departments of all local authorities within the Health Board area to implement a joint care pathway to ensure safe staffing levels when vulnerable people with additional needs are admitted from care/nursing homes.

- Providing confirmation that its Patient Safety and Experience Committee will monitor compliance with ongoing actions to satisfy the Ombudsman's recommendations.

The Complaint

1. The investigation considered Ms D's complaint about the care and treatment her sister, Ms A, received from Wrexham Maelor Hospital ("the Hospital"), between 30 June and 12 July 2022. The investigation focused on whether Betsi Cadwaladr University Health Board ("the Health Board"):

a) Failed to fully support Ms A, including with her personal care, nutrition and hydration, and in its communication with her.

b) Failed to monitor and manage Ms A's pain, including medication administration.

c) Failed to monitor and manage Ms A's epilepsy, including medication administration.

Investigation

2. My investigator obtained comments and copies of relevant documents from the Health Board and considered those in conjunction with the evidence provided by Ms D. They also obtained evidence from one of my Professional Advisers, Ms Gwen Moulster, a Learning Disability Nurse ("the Adviser").

3. The Adviser was asked to consider whether, without the benefit of hindsight, the care or treatment had been appropriate in the situation complained about. I determine whether the standard of care was appropriate by referring to relevant national standards or regulatory, professional or statutory guidance which applied at the time of the events complained about.

4. I have not included every detail investigated in this report but I am satisfied that nothing of significance has been overlooked.

Relevant legislation, guidance and policies

5. British Journal of Nursing (BJN): “Assessing the patient’s needs and planning effective care” (2021).

6. Science Direct: “Perceived trigger factors of seizures in persons with epilepsy” (Balamurugan et al. 2013).

7. Epilepsy Foundation: “Seizure Triggers” (2023).

8. Equality Act 2010.

9. Mental Capacity Act 2005.

10. Kings College London: “Learning from Lives and Deaths - people with a learning disability and autistic people” (LeDeR) (2022).

11. Mencap: “Treat me well: Reasonable adjustments for people with a learning disability in hospital” (2018).

12. Nursing and Midwifery Council (NMC) “The Code - Professional standards of practice and behaviour for nurses, midwives and nursing associates” (2015).

13. NHS Professionals: “Record keeping guidelines” (2021).

14. NHS Wales: “Health and Care Quality Standards” (2023).

15. NHS Wales Shared Services Partnership: “Person Centred Care” (2023).

16. Welsh Government: “The Duty of Quality Statutory Guidance and Health and Care Quality Standards” (2023).

17. Public Health Wales: “Learning Disability Health Improvement Programme” (2023).

18. Public Health Wales: “Learning Disabilities Care Bundle” (2022).

19. Royal College of Nursing: “Impact of staffing levels on safe and effective patient care” (2023).

20. The NHS Wales Duty of Candour was introduced in Wales on 1 April 2023. The overriding principle (set out in accompanying Welsh Government Guidance) is that “being open with service users and their representatives when things go wrong in their care is the right thing to do”. This is in addition to any professional duty of candour a healthcare professional will be subject to under their own professional practice regimes, and specifically applies when a healthcare provider is responding to complaints about a service.

21. The Equality Act 2010 requires healthcare providers to provide reasonable adjustments for disabled people to ensure they are not disadvantaged when accessing healthcare. While it is not the function of the Ombudsman to make definitive findings about whether a public body may have breached the Equality Act 2010, I will identify where equality matters are engaged and comment on a public body’s regard for them.

The background events

22. Ms A had a history of epilepsy (a condition which causes seizures), non-insulin dependent diabetes (a condition which causes a person’s blood sugar to be too high), Autism Spectrum Disorder (a diverse group of conditions related to development of the brain), cerebral palsy (a condition that affects movement and co-ordination) and learning disabilities.

23. Ms A lived in a nursing home and required 24 hour care and support.

24. On 26 June **2022** a carer from the nursing home accompanied Ms A to the Emergency Department (“ED”) at the Hospital due to concerns about increased frequency of seizures, a history of leg swelling and a 1 day inability to weight bear.

25. Ms A was diagnosed with a probable lower respiratory tract infection and was commenced on a course of antibiotics. An X-ray revealed a fracture of the right ankle, and a conservative management plan was commenced for the injury.

26. On 27 June Ms A was assessed by a specialist nurse from the Learning Disability ("LD") team. A risk assessment was completed that day which included information from Ms A's care provider and her family regarding her history and support requirements.

27. Ms A was admitted to the Hospital for treatment of her chest infection, initially to the Acute Medical Unit and on 30 June to a ward. She was seen regularly by members of the LD team and also received regular support from family members. During her admission there were frequent references to Ms A being in pain as identified by LD team staff or family members which led to pain management measures being implemented. It was also noted that on occasion Ms A was pain-free.

28. Ms A's seizures required frequent monitoring using a seizure diary, although there were often gaps in its completion and sometimes the entries were incomplete. It was evident that at times there was an increased frequency of Ms A having seizures and on occasion the increasing frequency of seizures were escalated to the medical team.

29. There is evidence of contact between Ms A's family and members of the LD, Medical and Ward nursing teams. It was agreed early on that the LD team would continue to support Ms A and contact would be made with the community social services team to explore additional support. There is no evidence that any additional support was provided.

30. The neurology team reviewed Ms A and made some suggestions to provide appropriate pain control and about how to improve Ms A's compliance with taking medication (she was sometimes seen to spit out medication). Poor compliance with medication was a recurrent challenge for staff throughout Ms A's admission and on one occasion a hypoglycaemic (low blood sugar levels) episode appears to have been associated with Ms A's refusal to take medication.

31. The respiratory team also reviewed Ms A and concluded that some of the symptoms she exhibited were as a result of poor compliance with medication. Some changes were suggested to the manner in which medication was administered, such as the use of intravenous administration for the more important medications.

32. Ms A's family pointed to instances whereby Ms A was not given appropriate support such as being left in a soiled bedding and being unsupported at mealtimes and with personal care (except when family members or members of the LD team were present). It has been confirmed by the Health Board that the family was told that this was because of low staffing levels.

33. Ms A was discharged back to the nursing home on 12 July.

Ms D's evidence

34. Ms D said that there were several occasions where staff explained things to Ms A in a way she could not understand, and they struggled to understand her needs. As an example, Ms A was left with a call bell available on occasions, so staff clearly did not appreciate she would not be able to use it, or to seek/ask for assistance.

35. Ms D said that there were also occasions when family would visit in the morning to find cold breakfast on the table. As a result, they ensured that wherever possible, a family member was available at mealtimes to assist Ms A. Ms D said that family had to provide hot/cold drinks to Ms A, and that the completion of her fluid charts was inconsistent and food records were completed intermittently, with significant gaps.

36. Ms D said there were gaps in the consistency and frequency of Ms A's enhanced risk assessments. Whilst the assessment said Ms A should be cared for in an area of high visibility, at times she was not, and doors were closed and staff did not enter. Ms D said the level of supervision of Ms A was not appropriate.

37. Ms D said that despite the family telling staff about Ms A's pain indicators/signs, such as grimacing, teeth grinding, irritability, and even yelling out, they had to repeatedly ask whether she could have pain relief, and then often had to wait for her to be given it. Ms D said that an adapted pain assessment tool was not in place for Ms A.

38. Ms D said that a nurse struggled to understand why Ms A was saying no to pain medication, when she was in obvious pain. Family had to explain that due to her learning disabilities, Ms A had no understanding of her medication, or that it was linked to her pain or pain relief. If not present, the family worried whether Ms A would be allowed to decline medication, despite her lacking capacity to give consent.

39. Ms D said that for significant parts of the day, there were no staff present in the bay or in the cubicle and that another patient had to press the buzzer to alert nurses regarding Ms A's seizures on one occasion. Ms D said there was not sufficient monitoring of Ms A's seizure activity, with a heavy reliance on family, and there was no monitoring of seizure activity at night, due to insufficient staffing levels.

40. Ms D said that staffing levels were poor throughout Ms A's admission. She added that family regularly had to assist Ms A with toileting and washing and with changing her bed sheets. Ms D reported that on one occasion, Ms A was left lying in her own diarrhoea for approximately 2 hours and that this was unacceptable in terms of her privacy, dignity, and infection control, in addition to the obvious distress caused to Ms A.

41. Ms D said that the Health Board's complaint response did not address the family's concerns. Despite the complaint investigation highlighting several gaps in the documentation regarding Ms A's care and treatment, and there being no apparent discussions with the staff who were responsible for her care on the ward, the investigation concluded there were no obvious lapses in the care provided to Ms A.

42. Ms D said they were very concerned to see this conclusion as they had serious concerns about the level of care provided. Whilst the Health Board identified learning actions, the family did not believe these addressed the serious concerns raised about the care and treatment that Ms A experienced or ensured that another patient would not experience the same problems.

The Health Board's evidence

43. The Health Board said there was evidence in Ms A's clinical records that showed that efforts were made to ensure her nutrition and hydration needs were met. It said there were some gaps within the food charts, however, there was supplementary evidence in written documentation from both the ward staff and the LD team that meals were offered, and that Ms A was supported with her meals. Upon review, the Health Board acknowledged that the results of these efforts were variable due to a number of factors including Ms A's willingness to eat. Staff had to balance the risk of encouraging her to eat against any potential undue distress, therefore this was a delicate balancing act.

44. The Health Board said that in relation to personal care, there was mainly good evidence of 3-4 hourly personal care, with intentional rounding (the structured process whereby nurses in hospitals carry out regular checks, usually hourly, with patients) and supportive written documentation, which indicated a good standard of personal care. There were occasional gaps within the documentation, which the Health Board acknowledged in its investigation report.

45. The Health Board said there was also good evidence that Ms A's pain was assessed, monitored and analgesia was administered. The Health Board said the routes that Ms A's medication was administered were altered according to her clinical condition and to meet her needs. Consideration was given to ensure the medication prescribed was able to be administered as effectively as possible, and that Ms A's medication administration was also supported by the LD team on numerous occasions.

46. The Health Board said that the medical management plan was for Ms A to have her seizure activity recorded; the use of a seizure diary was recommended. It said there was evidence that this was commenced, though the documentation tool was not consistently completed or in full. There was, however, a clear narrative regarding Ms A's seizure activity throughout her notes indicating that this was both monitored, and that the management plan was amended accordingly. There was evidence that monitoring and communicating Ms A's seizure activity was a clinical priority and that family members were also encouraged to communicate/escalate any identified seizure activity.

47. The Health Board said that Enhanced Care Risk Assessments ("ECRA") were undertaken and reviewed although there were gaps in the frequency of these being completed/reviewed. It said there was evidence that the level of supervision was appropriately increased as a response to increased seizure activity.

Professional Advice

Personal care, hydration and communication

48. The Adviser considered the appropriateness of the care provided to Ms A from 30 June to 12 July, in respect of her personal care, nutrition and hydration and communication.

49. The Adviser said that from the notes, some nursing staff on the ward did not appear to recognise Ms A's communication needs or her level of understanding, despite family giving advice on the best ways to support her.

50. The Adviser was of the view that there appeared to have been an over-reliance on the family to support and care for Ms A, including with aspects of personal care when insufficient nursing staff were available.

51. The Adviser noted evidence that intentional rounding (a structured process whereby nurses carry out regular checks) was carried out for the most part every 3-4 hours. However, reliance on the family demonstrated that this frequency during the day was inadequate.

52. The Adviser said that the information from the family suggested that the level of care was inadequate, especially at mealtimes and medication times when neither the family nor the LD team were able to be present. The Adviser said that an appropriate standard of care would have been to consider Ms A's additional individual needs at key times (such as mealtimes and medication times) and in this respect, a satisfactory standard of care was not achieved.

53. The Adviser said there were serious staff shortages and was of the view that this had impacted on the standard of care at times, and that on occasion, Ms A did not receive timely dignified personal care. The Adviser noted there was no record of additional staff being sought to assist in Ms A's care at times of extreme staff shortage. The Adviser added that the ward team was over reliant on the LD team. While their input was good, it was not available outside office hours or at weekends, when staffing levels seemed to have been at their lowest.

54. The Adviser explained that the LD team was a small specialist resource, and its availability would have been dependent on the needs of other patients with learning disabilities in hospital at the time. The team should not therefore have been included in the ward staffing resource level.

55. The Adviser said that at times Ms A required additional support that was not available. The Adviser confirmed that this could have been organised by the Health Board by following up with social services and funding the additional support hours needed.

56. The Adviser said that despite serious staff shortages, it was important to maintain minimum standards, which included good clinical observation and record-keeping.

57. The Adviser said there was no evidence of a care plan for Ms A to ensure person-centred care and effective communication with her. She said that whilst the lack of a care plan would be an issue for the effective care of any patient, for more vulnerable individuals who have communication problems, this could result in poor, sometimes catastrophic, outcomes.

58. The Adviser noted that the documentation included a blank example of the Learning Disability Care bundle. She explained that if followed, a clear person-centred approach to care would be in place and recorded, enabling all staff to access relevant information on Ms A's needs. The Health Board was unable to provide a completed care bundle for Ms A which could only lead to an assumption that it was not completed, and no care plans were in place for her.

59. The Adviser said that the lack of clear person-centred care and communication plans - describing the health goals and methods to support effective communication, nutrition and hydration - could have negatively impacted on staff understanding Ms A's needs. The Adviser added that there were no records to suggest person-centred information was routinely used as a basis for care. In fact, some of the records suggested staff did not know the best ways to approach, support and provide clinical interventions to Ms A despite advisory notes from the LD team detailing effective methods to meet her needs. The Adviser said that there was little evidence in the notes provided of ward staff building positive relationships with Ms A, or of getting to know her through a person-centred approach.

60. The Adviser noted frequent occasions where Ms A was given a call bell to call for help if she needed it, despite both the family and LD team highlighting her lack of understanding in relation to this. This demonstrated a lack of awareness of her level of understanding and ability.

61. The Adviser said that as Ms A was mostly left unsupported at night and at times during the day, it is unlikely she could have solicited help when she needed it, and it would have been good practice to ensure more regular checking and closer observation, especially as Ms A had epilepsy. This should have been highlighted in her care plans.

62. The Adviser explained that the Mental Capacity Act 2005 included an expectation that health staff should have assessed capacity and where there was doubt about mental capacity, they should have initiated

a best interest approach. However, it was not clear if the nurses assessed Ms A's mental capacity, especially in relation to eating, drinking, and taking medication.

63. The Adviser highlighted that there were no records of a best interest discussion until a meeting on 8 July which focused on safeguarding concerns and safe discharge. She said that fortunately, the family and the LD team were able to give advice on adjustments in relation to administration of medication, eating and drinking. However, it was clear that on occasion, a refusal to eat or take medication was assumed to be a decision made with capacity, when it may not have been. The Adviser was of the view that a lack of knowledge and understanding about mental capacity and best interest decision making may have had an impact on Ms A's health and wellbeing whilst in hospital.

64. Overall, the Adviser considered that the quality of care at times fell below the standards identified by the Welsh Government.

Pain Management

65. The Adviser considered the appropriateness of the care provided to Ms A in respect of the monitoring and management of pain.

66. The Adviser said it was clear there were multiple occasions when pain was identified by the family and the LD team. However, it was unclear whether the ward nursing staff were consistently able to identify pain, as the tool used was not adapted to support better assessment.

67. The Adviser said that using the All Wales Pain Assessment tool enables a standardised approach but for people who have communication difficulties, using this numerical self-report can be meaningless, making the tool inadequate. In this case there was a need for adjustments to meet Ms A's needs, to ensure a person-centred pain assessment process and effective pain management. The Adviser said that identification of pain was very patchy and dependant on whether someone who knew Ms A well was present.

68. The Adviser said that whilst there was a record that the Pain Team responded to a referral on 1 July when Ms A reacted adversely to the pain medication prescribed, there was no record that the Pain Team responded to the referral made to it on 30 June.

Epilepsy Management

69. The Adviser considered the appropriateness of the care provided in respect of the monitoring and management of Ms A's epilepsy. The Adviser said that there appeared to have been multiple seizure events that were noted by the family, but there was little evidence that nursing staff observed or recognised seizures. Poor record keeping made it impossible to know if the reported seizure activity was accurate, so it was possible that further seizure activity occurred, but was not observed or reported. The Adviser said there was limited evidence of a person-centred seizure baseline having been established to enable nursing staff to recognise specific signs of seizure for Ms A.

70. The Adviser said that despite repeated requests from the medical team for a seizure diary to be maintained, records kept were incomplete. She said that a lack of seizure recording was dangerous and could result in a catastrophic outcome, so this was a serious issue that suggested the need for further training and learning.

71. The Adviser said that in Ms A's case it was difficult to correlate seizure activity with failure to administer timely anti-epileptic medication because of the poor seizure records. However, there was evidence that not taking prescribed anticonvulsant medication was a recognised seizure trigger. It was therefore safe to assume that poor compliance with medication may have been a contributory factor to the increase in observed seizure activity.

72. The Adviser noted that in the LD nurse assessment, there was mention of the frequency of seizures prior to admission and an awareness that non-compliance with medication was an issue. It was also documented that medication needed to be administered covertly however, the family reported repeated occasions when medication was

found in Ms A's bed or on the bedside table. The Adviser said that it was of concern that medication was left on the bedside table of someone with severe learning disabilities.

73. The Adviser said that the evidence of non-compliance indicates that administration of medication was at times inadequate and that an entry on the medicine chart may not have been a safe record that Ms A had swallowed the medication. With Ms A's history and the need for adjustments to support Ms A to take medication, this was concerning.

74. The Adviser said the medical notes demonstrated that the medical team was monitoring the frequency of seizures, the LD team notes also report seizure activity; however, the ward nursing notes were limited. Even on occasions when other notes identified that Ms A had experienced seizures, any nursing actions taken at the time, or any follow up observations were rarely recorded in the nursing notes. In most instances it was unclear if the ward nurses observed or recognised seizures themselves. This possible lack of awareness may also have impacted on other aspects of Ms A's care. For example, if she was post-ictal (the stage after a seizure, prior to recovery), she might have been confused, or have refused personal care, food, hydration, or medication.

75. The Adviser commented that it appeared that if family members had not been present, many of the seizures would not have been noticed and that on at least one occasion, Ms A's brother recorded the seizures on the seizure chart.

76. The Adviser noted that Ms A was seen by the neurology team on 30 June and no changes to her anti-convulsant medication were recommended. She said there was no evidence in the notes that an epilepsy nurse had seen Ms A in response to the referral on 8 July.

77. The Adviser said that the lack of staff knowledge about Ms A's capacity to make an informed decision, and their understanding of the need to make person-centred adjustments could also be contributory factors to increased seizure activity. She added that there was evidence to suggest missed medication, dehydration, missed meals and stress, which are common seizure triggers.

78. The Adviser noted little reference to clinical nurse leadership at ward level and said that although nurse leadership was evident in the LD team, there was little mention of senior nurse involvement in planning, decision making, reviewing, monitoring or supervising care on the ward. There was no indication that the ward manager or senior nursing staff on the ward were engaged in the Health Board's investigation.

79. The Adviser said that the Health Board's recommendation to introduce Learning Disability champion roles was good practice and that these roles would aid an increase in awareness and understanding amongst their colleagues. In addition, champions could help build targeted communication and care adjustment resources within the ward or department. However, there were no action points related to nurse leadership on the ward, safe staffing and the role of families, or the importance of care planning and good record keeping. The Adviser added that it was important that all nurses recognised their responsibilities to ensure they have the necessary knowledge and skills to provide effective care.

Analysis and conclusions

80. In reaching my conclusions, I must consider whether there were failings on the part of the Health Board and if so, whether those failings caused an injustice to Ms A or her family. In doing so, I have considered whether the actions of the Health Board met appropriate standards rather than best possible practice. I have had regard to the advice I have received, which I accept. However, the conclusions reached are my own.

81. The Equality Act requires healthcare providers to make reasonable adjustments for disabled people to ensure they are not disadvantaged when accessing healthcare, and this applies to both systems and in relation to individualised care. Healthcare providers need to anticipate and support the holistic needs of disabled people and make reasonable adjustments to make sure they are not disadvantaged, and to reduce the health inequalities that they experience. The evidence in this case suggests this did not occur.

82. I have concluded that Ms A's learning disabilities meant she received a poor standard of care that did not take account of her needs as an individual. I set out below several specific areas of failing which together demonstrate a lack of understanding of the approach needed to provide care to meet Ms A's needs as an individual.

a) Whether there was a failure to fully support Ms A, in respect of her personal care, nutrition and hydration and communication with her.

83. I accept the advice I have received that the standard of care in relation to Ms A's personal care, nutrition and hydration and communication fell below an adequate standard.

84. There were several shortcomings in the approach to Ms A's care:

- Without the involvement of the LD team and Ms A's family, the nursing care on the ward sometimes fell short of acceptable standards, especially at weekends and overnight when staff shortages were more pronounced. Further, no additional staff were brought in to support care delivery.

- There was no person-centred nursing care plan setting out the care objectives and adjustments that were needed to provide Ms A with effective care. The lack of a clear person-centred care and communication plan, describing Ms A's health goals and ways to support effective communication, nutrition and hydration meant that staff did not fully understand her needs. There is little evidence that ward staff recognise Ms A's individual needs. On occasion, Ms A did not receive timely dignified personal care.

- Whilst an initial nursing assessment was completed by the LD specialist team, the Learning Disability Care bundle was not completed and no care plans were in place.

- There is a strong indication that many of the nursing staff did not have a good understanding about mental capacity, adjustments for Ms A's disabilities, or adapted communication. This lack of

understanding led to issues with their ability to provide consistent safe and effective administration of medication, to ensure good nutrition and hydration, and may have impacted on pain experience and seizure frequency.

- There is little evidence that senior nursing staff were involved with planning, decision making, reviewing, monitoring or supervising the care provided on the ward.

85. Taking into account the above, I **uphold** this complaint as I am satisfied that these shortcomings represent a serious service failure. The standard of care Ms A received fell short of the required standard.

b) Whether there was a failure to monitor and manage Ms A's pain.

86. The advice I have received is very clear that that there were multiple occasions when Ms A's pain was identified by the family and the LD team. It is unclear whether the ward nursing staff were consistently able to identify pain as the tool used was not adapted for Ms A's particular needs.

87. The identification of whether Ms A was in pain depended on whether someone who knew her well was present at the time. In order to make sure pain management was effective, Ms A's individual needs should have been considered. There was a failure to do so.

88. I am satisfied that the failings identified amount to service failure. It is clear from the notes that Ms A was at times in pain, which was not only distressing for her, but for her family as well. I consider that Ms A would likely have been very frightened when alone in hospital without family present, and experiencing periods of pain. This failure meant that Ms A suffered unnecessarily and, on this basis, I **uphold** this complaint.

c) Whether there was a failure to monitor and manage Ms A's epilepsy.

89. I am concerned to note a lack of record keeping or seizure diary in relation to Ms A's seizures. Even on occasions when other notes identified she had experienced seizures, any nursing actions taken at the

time, or any follow up observations were rarely recorded in the nurses' notes. The lack of seizure recording is dangerous and represents a poor level of care.

90. There appear to have been multiple seizure events that were noted by the family, but there is little evidence that nursing staff observed or recognised seizures. Poor record keeping makes it impossible to tell if the reported seizure activity was accurate. It is possible further seizure activity occurred but was not observed or reported. In most instances it is unclear if the ward nurses observed or recognised seizures themselves and that if the family had not been there, it is likely that many of Ms A's seizures would not have been noticed.

91. There is limited evidence of a person-centred seizure baseline having been established to enable nursing staff to recognise specific signs of seizure for Ms A.

92. It is also concerning that effective administration of medication was at times inadequate, with medication being left on the bedside table or found in Ms A's bed.

93. I accept the advice I have received that not taking prescribed anticonvulsant medication is a recognised seizure trigger and that poor compliance with medication may have been a contributory factor to the increase in Ms A's observed seizure activity. For this reason, I **uphold** this complaint.

94. In addition to the distress caused to Ms A, it has also been a source of frustration to Ms D in having to pursue her complaint with me because the Health Board's own investigation lacked both rigour and candour. My investigation has revealed significant failings on the part of the Health Board but I consider that the Health Board failed to objectively review the complaint and consider Ms A's additional needs prior to issuing its complaint response.

95. Finally, therefore, I must invite the Health Board to review its complaint handling and approach to responses to service users. Whilst not in force at the time of the response here, it was well known that the

NHS Wales Duty of Candour would be implemented. The response to Ms D here fell well short of what this duty promotes and is intended to achieve (see paragraph 20). The Health Board needs to ensure that in future it responds openly and honestly to complaints, and that clinicians involved in formulating/feeding into the response also reflect on both the duty, and their own professional standards obligations when doing so.

Recommendations

96. I am pleased to note that the Health Board has already taken the following action in response to the concerns raised by Ms D:

- Sharing of its investigation report across the medical directorate and LD team to ensure learning.

- Delivery of training to staff in respect of LD awareness and epilepsy awareness and monitoring.

- Introduction of a Learning Disability champion on each medical ward to ensure best practice is adopted within their local area.

- Auditing of patient nursing assessments on the ward to identify themes such as gaps with content/consistency and to identify barriers with the completion of assessments.

- LD team liaison with Ms A's family to assist with the completion of a LD passport.

97. In addition to the action already taken, I **recommend** that the Health Board, within **1 month** of the date of the final report:

a) Provides Ms D, on behalf of Ms A, with a fulsome apology for the failings identified in this report. The apology should also make reference to the significant time and trouble she has been put to in pursuing this complaint in order to gain answers to her concerns.

98. I **recommend** that the Health Board, within **3 months** of the date of the final report should:

b) Review care planning practices on the ward to ensure care plans are embedded into basic care.

c) Review a sample of person-centred care plans to ensure they include any adjustments to meet a patient's needs that need to be made.

d) Implement a regular ward audit of nursing documentation, to include care plans and seizure charts.

e) Review the approach to pain assessment for people with learning disabilities to ensure adjustments and appropriate tools are used.

f) Provide confirmation that its Patient Safety and Experience Committee will monitor compliance with ongoing actions to satisfy these recommendations.

99. I **recommend** that the Health Board, within **6 months** of the date of the final report should:

g) Provide training to ward staff in respect of mental capacity and best interest decision making.

h) Engage with the social services departments of all local authorities within the Health Board area to implement a joint care pathway with social care to ensure safe staffing levels when vulnerable people with additional needs are admitted from care/nursing homes.

100. I am pleased to note that in commenting on the draft of this report the Health Board has agreed to implement these recommendations.

MM· Morris.

Michelle Morris 26 June 2024
Ombwdsmon Gwasanaethau Cyhoeddus/Public Services Ombudsman

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Teitl adroddiad: ***Report title:***	Our Integrated Performance Report – Month 3, 2024/25
Adrodd i: ***Report to:***	Quality, Safety & Experience Committee
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 15 August 2024
Crynodeb Gweithredol: ***Executive Summary:***	This Report relates to the Month 3, 2024/25. The structure of our IPR is based upon the Quadruple Aims as per the Welsh Government's 'A Healthier Wales' paper and the NHS Wales Performance Framework 2024-25. It identifies where metrics fall within the Special Measures Framework for BCUHB. Where appropriate, we have linked performance metrics to items on the Corporate risk Register (CRR). Performance is RAG rated against the targets set within the NHS Wales Performance Framework 2024-25, or as set by Welsh Government in the Special Measures Framework for BCUHB. However, where appropriate, BCUHB's internal improvement trajectories as submitted and agreed by Welsh Government have also been included. Key areas of escalation are identified within the 'Our Escalated Performance Measures' section at the beginning of the report. (We will strengthen this section as the report matures, 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 structure, components and contents of the report and confirm agreement to continue with this format, propose any actions arising from the report, or identify any additional assurance work or actions it would recommend Executive colleagues to undertake.
Arweinydd Gweithredol: ***Executive Lead:***	Russell Caldicott, Acting Executive Director of Finance and Performance
Awdur yr Adroddiad:	Ed Williams, Director of Performance

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

In accordance with WP68, has an SEIA identified as necessary been undertaken?	
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	There remians a number of risks to the delivery of care across the healthcare system due to the legacy impact the COVID-19 Pandemic had upon planned care delivery between 2020 and 2022.
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	The delivery of the performance indicators within our IPR will directly/ indirectly impact upon the financial recovery plan of the Health Board.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	The delivery of the performance indicators within our IPR will directly/ indirectly impact on our current and future workforce.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	The full report has been reviewed by the Director of Performance, and the Executive Director of Finance & Performance.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	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 Performance Report will undergo continuous development through the remainder of 2024-25 and utilise the Performance Directorate's 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 3)**

Report Author: **Director of Performance**

1. Introduction

The Performance Directorate continues to develop the Integrated 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 Performance Report' includes a section summarising the areas requiring escalation for Committee members, divided into the following four quadrants;

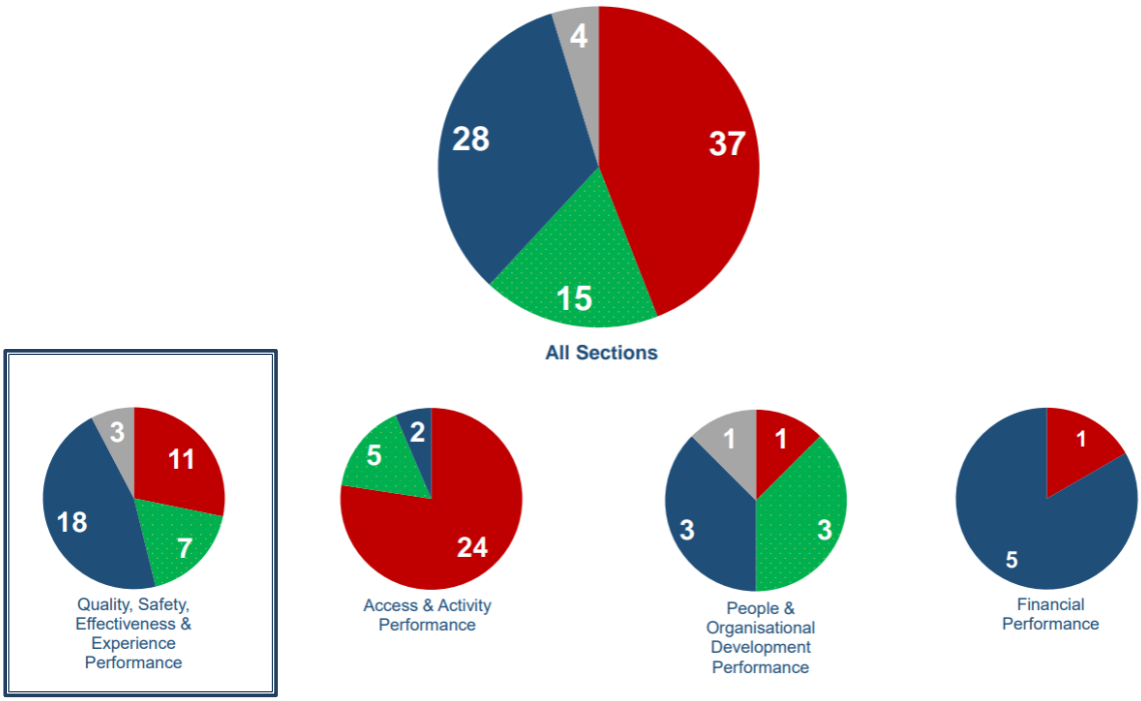
- Quality (Safety, Effectiveness & Experience) Performance
- Access & Activity Performance
- People & Organisational Development Performance
- Financial Performance

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.

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

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

2. Overall Summary



3.1 Quality (Safety, Effectiveness & Experience) Performance

The key areas highlighted centre upon:-

Overdue investigations remain a challenge. A total of 484 complaints remain open, with 264 of those overdue as of the week of the 5th August 2024. Of the number of overall complaints made, the sub category of Delay / Lack of treatment has risen significantly due to complaints about the situation with insourcing.

298 of the total open complaints 484 - 62% relate to these top four themes

- Delay/lack of treatment
- Delay/lack of diagnosis
- Delay on appointment/waiting times
- Incorrect/insufficient treatment

A revised trajectory model has been put in place to meet the target trajectory of 75%.

The new model shows

- **We must** increase the complaints closure rate to a minimum of 64 complaints per week (Current Average 49)
- **We must** close at least 277 complaints per calendar month
- Complaints being received must **remain consistent and not increase** (Current average 51),

Clinical coding compliance has and will continue to see a significant reduction as it is a result of the loss of staff. Latest data shows continuation of trend across IHC's with East being less effected by staff turnover during last 12 months. 6 whole time equivalent (WTE) trainee coders started during July 2024 and some have been transferred from West to East to redress the balance of trainee staff to qualified staff ratio. A recovery plan is to be presented to the Executive team which outline plans to invest in departmental underspend into agency staffing and collaboration with WOD to address recruitment and retention issues.

Integrated Performance Report

Reporting period to the 30th June 2024 (where data is available)

Presented to the

Quality, Safety & Experience Committee

on the 15th August 2024

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Produced on behalf of the Health Board by the
Performance Directorate and Partners

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GIG CYMRU NHS WALES
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Produced on behalf of the Health Board by the Performance Directorate and Partners

A summary of escalated performance measures

Quality, Safety, Effectiveness & Experience Performance

Access & Activity Performance

Reported via the Performance, Finance & Information Governance Committee

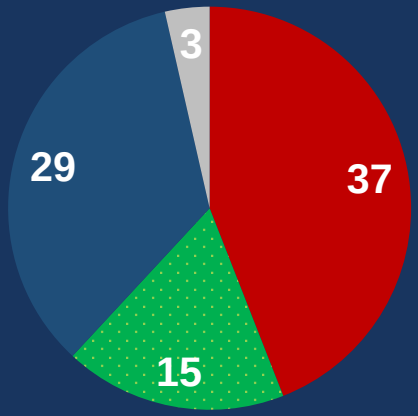
People & Organisational Development Performance

Reported via the Performance, Finance & Information Governance Committee

Financial Performance

Reported via the Performance, Finance & Information Governance Committee

The Integrated Performance Report



GIG CYMRU NHS WALES
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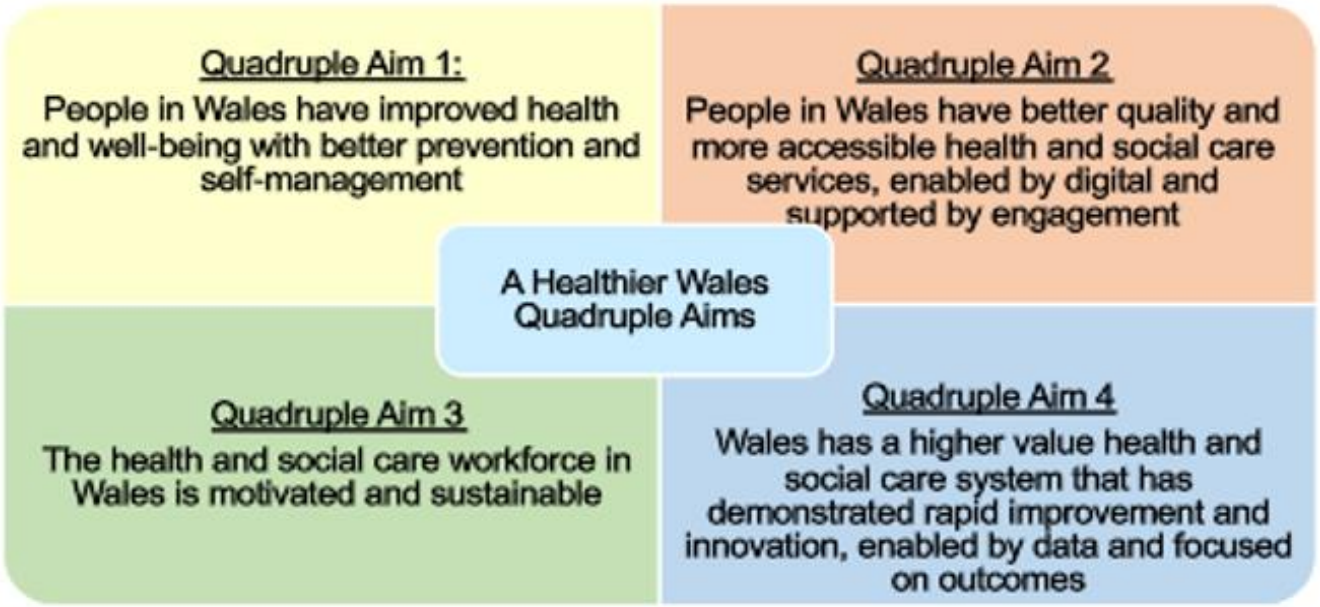
NHS Wales Performance Framework 2023-24

The performance measures in the NHS Wales Performance Framework for 2024-2025 reflect the National Programme areas as outlined in the NHS Wales Planning Framework 2024-2027.

The 2024/25 revision now consists of 54 quantitative measures and twelve policy assurance statements where assurance is sought either quarterly or bi-annually.



The Integrated Performance Report

Quality, Safety, Effectiveness & Experience Performance

Access & Activity Performance

People & Organisational Development Performance

Financial Performance

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.

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.

About this report: Rating System

Performance is monitored against our Annual Plan but is rated against the Welsh Government targets contained in the Performance Framework.

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

Exception

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

Criteria of an exception

Any metric failing against an NHS Performance Framework, operational, or local target / trajectory

Where statistical process chart (SPC) methodology flags consistent negative variance and no assurance.

Any reportable commissioned metric where the performance is not meeting the National target

Escalation

When a performance matter (exception) does not meet target and hits criteria for a higher level for resolution, decision-making, or further action.

Criteria for escalation

Any measure that fails a health submitted trajectory as part of the Ministerial Priorities.

Performance recovery failing its Remedial Action Plan (local plan to improve or maintain performance)

Any significant failure of a quality standard e.g. never event or failing accountability conditions.

About this report: Charts

This report contains some statistical process charts (SPCs); please see below for legends.
If you would like any support / advice regarding interpretation of these charts, please contact the team, who will be happy to discuss.

Variance

Common cause variation present: there is no significant change or pattern

Special cause variation present: changes or patterns appear to show improvement

Special cause variation present: concerning changes or patterns present that require investigation / action.

Special cause variation present: a upwards or downwards change or pattern is evident, which is neither positive or negative in nature.

Assurance (*based on data presented in the SPC only)

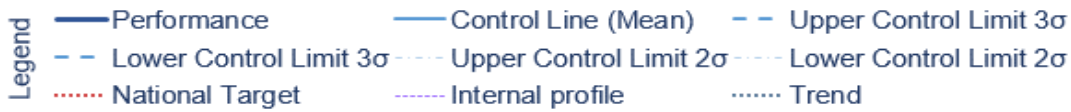
No assurance: we would expect to sometimes achieve, and sometimes miss the target

Positive assurance: we would consistently expect to achieve the target

No assurance: we would consistently expect to miss the target

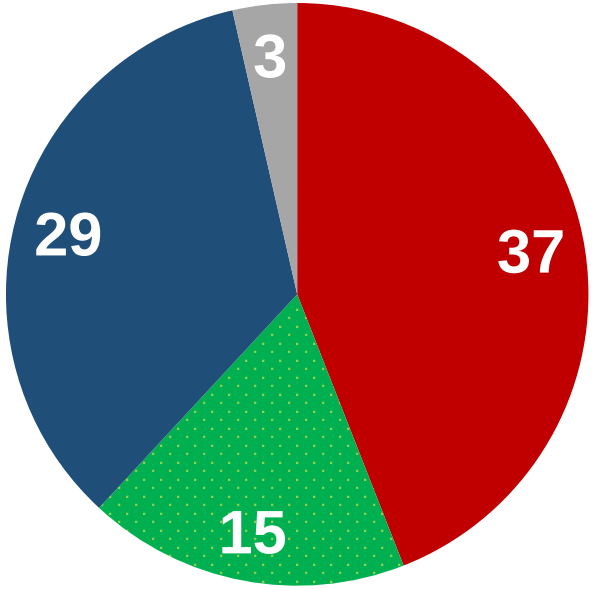
There is no profile or target, or insufficient data, thus assurance can not be ascertained

Orange icons indicate negative occurance
Blue icons indicate a positive occurance
Grey icons indicate no significant data occurance

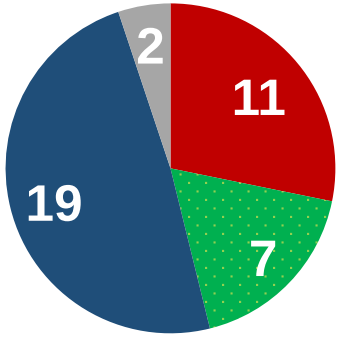


The column charts that feature within this report use the following legend:

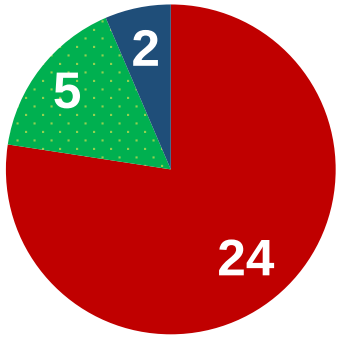
Summary of Performance



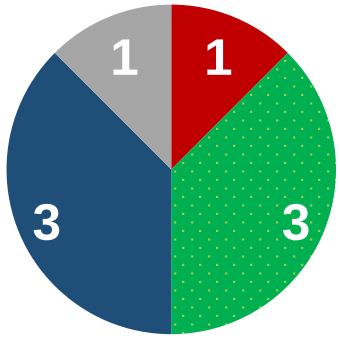
All Sections



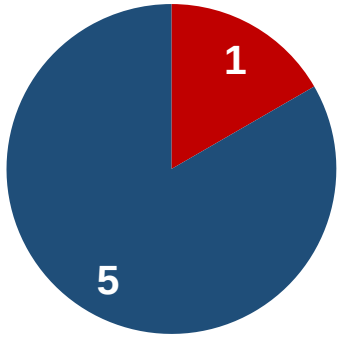
Quality, Safety, Effectiveness & Experience Performance



Access & Activity Performance



People & Organisational Development Performance

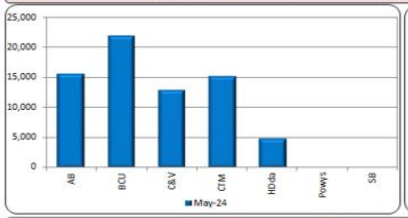


Financial Performance

NHS Wales Performance Dashboard - part 1

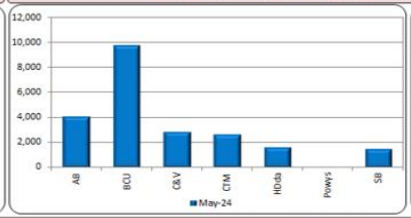
PERFORMANCE DASHBOARD

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



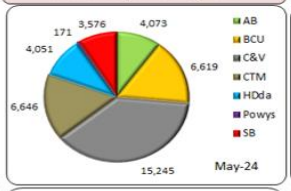
- In May-24, Powys and SB achieved the target of zero for the number of patients waiting over 52 weeks for a new outpatient appointment.
- At an all Wales level, the number of over 52 week new outpatient waits has increased in May-24, when compared to the previous month, by 5,188 to 70,299, an 8.0% increase.
- AB, BCU, C&V, CTM and HDda all saw an increase in May-24 compared to the previous month.
- Powys and SB had no over 52 week new outpatient waits in May-24, BCU had the highest number of waits at 21,898 (31.1% of the total).

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



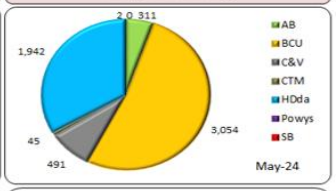
- In May-24, no HB achieved the target of zero for the number of patients waiting over 104 weeks for referral to treatment.
- At an all Wales level, the number of over 104 week referral to treatment waits has increased in May-24, when compared to the previous month, by 1,165 to 22,455, a 5.5% increase.
- Only SB saw a reduction in May-24 when compared to the previous month.
- Powys had the lowest number of over 104 week referral to treatment waits in May-24 at 1, BCU had the highest number of waits at 9,708 (43.2% of the total).

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



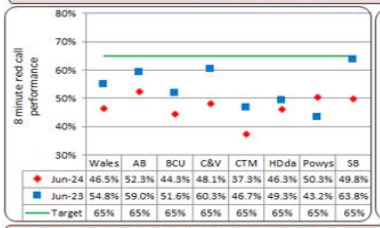
- In May-24, no HB achieved the target of zero for the number of patients waiting over 8 weeks for a specified diagnostic.
- At an all Wales level, the number of over 8 week waits for specific diagnostics has increased in May-24, when compared to the previous month, by 283 to 40,381, a 0.7% increase.
- HDda and SB saw a reduction in May-24 when compared to the previous month.
- Powys had the lowest number of over 8 week waits for specific diagnostics in May-24 at 171, C&V had the highest at 15,245 (37.8% of the total).

Number of patients waiting more than 14 weeks for a specified therapy



- In May-24 only SB achieved the target of zero for the number of patients waiting over 14 weeks for a specified therapy.
- At an all Wales level, the number of over 14 week waits for specific therapies increased in May-24, when compared to the previous month, by 577 to 5,845, an 11.0% increase.
- CTM and Powys saw a reduction in May-24 when compared to the previous month - SB remained the same.
- SB had no over 14 week waits for specific therapies in May-24, BCU had the highest at 3,054 (52.2% of the total).

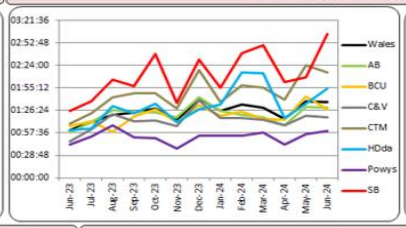
% of emergency responses to red calls arriving within 8 minutes



	Wales	AB	BCU	C&V	CTM	HDda	Powys	SB
Jun-24	46.5%	52.3%	44.3%	48.1%	37.3%	46.3%	50.3%	49.8%
Jun-23	54.8%	59.0%	51.6%	60.3%	46.7%	49.3%	43.2%	63.8%
Target	65%	65%	65%	65%	65%	65%	65%	65%

- In Jun-24, data shows no HB achieved the 65% target for the % of emergency responses to red calls within 8 min.
- At an all Wales level, the % of emergency responses to red calls within 8 minutes has improved in May-24, when compared to the previous month, by 0.7 percentage points to 46.5%.
- Over the last 12 months all HBs have seen a deterioration trend in performance. AB, BCU, Powys and SB all saw an improvement in performance when compared to the previous month.
- AB were the best performing HB in May-24 with performance at 52.3%, CTM were the lowest with performance at 37.3%.

Median emergency response time to amber calls



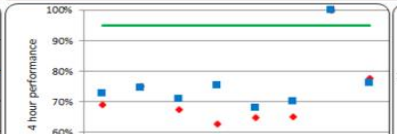
- In Jun-24, no HB achieved the 12 month reduction trend target for median emergency response time to amber calls.
- At an all Wales level, the median amber response time was quicker in Jun-24, when compared to the previous month, by 51 secs to 1 hr, 37 mins and 12 secs.
- Over the last 12 months all HBs have seen a deterioration trend in performance.
- AB, BCU, C&V and CTM all saw an improvement in performance in Jun-24 when compared to the previous month.
- Powys was the best performing HB in Jun-24 with a median response time of 1 hr and 37 secs, SB had the longest median response time of 3 hrs, 3 mins and 55 secs.

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

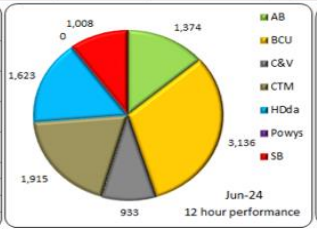
- In May-24, CTM ,HDda and SB achieved the target of a 12 month improvement trend towards a target of 80% by 31 March 2026 for the % of patients starting first definitive cancer treatment within 62 days from point of suspicion.
- At an all Wales level, the % of patients starting first definitive cancer treatment within 62 days from point of suspicion has improved in May-24, when compared to the previous month, by 1.6 percentage points to 55.4%.
- BCU, CTM, HDda and SB all saw an improvement in performance in May-24 when compared to the previous month.
- C&V was the best performing HB in May-24 was C&V with performance at 62.1%, AB had the lowest performance at 49.2%.

	AB	BCU	C&V	CTM	HDda	SB
May-23	61.9%	61.1%	64.4%	49.0%	42.9%	50.6%
May-24	49.2%	57.0%	62.1%	56.5%	52.5%	57.0%
Target	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%

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



	Wales	AB	BCU	C&V	CTM	HDda	Powys	SB
Jun-24	69%	75%	67%	63%	65%	65%	100%	78%
Jun-23	72%	74%	71%	75%	68%	70%	100%	76%
Target	95%	95%	95%	95%	95%	95%	95%	95%

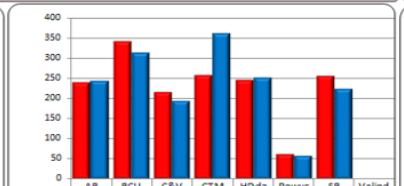


- In Jun-24 AB, Powys and SB achieved the target of an improvement compared to the same month in the previous year, towards the target of 95%, for the % of patients who spent less than 4 hours in ED.
- At an all Wales level, the % patients who spent less than 4 hours in ED has deteriorated in Jun-24, when compared to the previous month, by 0.9 percentage points to 68.9%.
- Only HDda saw an improvement in performance in Jun-24 when compared to the previous month.
- SB was the best performing HB in Jun-24 (exc. Powys) at 77.5%, C&V had the lowest performance at 62.6%.
- In Jun-24 AB, Powys and SB achieved the target of a reduction compared to the same month in the previous year, towards the target of zero for the number of patients who spent more than 12 hours in ED.
- At an all Wales level, the number of patients who spent more than 12 hours in ED has reduced in Jun-24, when compared to the previous month, by 525 to 9,989.
- AB, CTM, HDda and SB all saw an improvement in performance in Jun-24 when compared to the previous month.
- C&V had the lowest number of patients who spent more than 12 hours in A&E (exc. Powys) at 933, BCU had the highest at 3,136 (31.4% of the total).

NHS Wales Performance Dashboard - part 2

Number of Pathways of Care delayed discharges

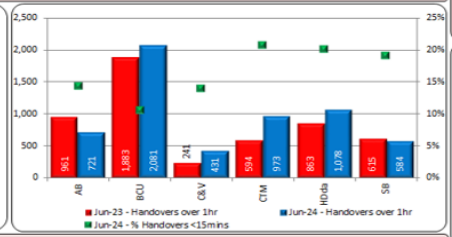
- In Jun-24, AB, Powys and Velindre all achieved the 12 month reduction trend target for the number of pathways of care delayed discharges.
- At all Wales level, the number of pathways of care delayed discharges has increased in Jun-24, when compared to the previous month, by 26 to 1,652, a 1.6% increase.
- All HBs, except BCU, saw a deterioration in performance in Jun-24 when compared to the previous month.
- Powys had the lowest number of pathways of care delayed discharges in Jun-24 at 59, CTM had the highest at 362. Velindre had no pathways of care delayed discharges.



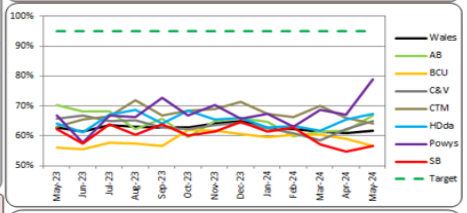
	AB	BCU	C&V	CTM	HDda	Powys	SB	Velind
Jun-23	241	343	216	258	247	63	256	1
Jun-24	244	315	194	362	253	59	225	0

Number of ambulance patient handovers over 1 hour and % of ambulance patient handovers within 15 minutes

- In Jun-24, no HB achieved the zero target for handovers over 1 hour.
- At all Wales level, the number of over 1 hour handovers has decreased in Jun-24, when compared to the previous month, by 380 to 5,858, a 6.1% decrease.
- Over the last 12 months, AB, C&V and SB saw an improvement trend in performance.
- C&V had the lowest number of over 1 hour handovers in Jun-24 at 431, BCU had the highest at 2,081 (35.5% of the total).
- In Jun-24, no HB achieved the improvement compared to the same month in the previous year, towards the target of 100% for the % of handovers within 15 mins.
- At all Wales level, the % of handovers within 15 mins has remained the same in Jun-24, when compared to the previous month.
- Over the last 12 months all HBs have seen a deterioration trend in performance.
- CTM had the best performance in Jun-24 at 20.7%, BCU had the lowest at 10.6%.



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



- In May-24, BCU and Powys achieved the target of a 12 month improvement trend towards the target of 95% for the % of ophthalmology R1 appointments attended which were within their clinical target date or within 25% beyond their clinical target date.
- At all Wales level, the % of ophthalmology R1 appointments attended which were within their clinical target date or within 25% beyond their clinical target date has improved in May-24, when compared to the previous month, by 0.7 percentage points to 61.7%.
- In May-24, all HBs, except BCU and CTM, saw an improvement in performance compared to the previous month.
- Over the last 12 months, BCU and Powys saw an improvement trend in performance.
- Powys had the best performance in May-24 at 78.8%, BCU had the lowest at 56.5%.

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

May-24

LMPHSS assessments within 28 days

	Wales	AB	BCU	C&V	CTM	HDda	Powys	SB
<18 years	81%	86%	77%	92%	98%	96%	98%	41%
>=18 years	66%	41%	81%	19%	93%	97%	54%	99%
Target	80%	80%	80%	80%	80%	80%	80%	80%

May-24

Therapeutic interventions started within 28 days

	Wales	AB	BCU	C&V	CTM	HDda	Powys	SB
<18 years	59%	0%	24%	14%	76%	95%	86%	98%
>=18 years	79%	16%	86%	100%	94%	95%	95%	100%
Target	80%	80%	80%	80%	80%	80%	80%	80%

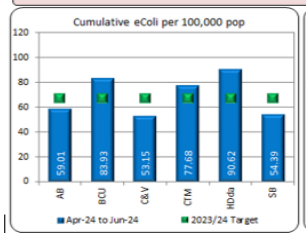
<18 years

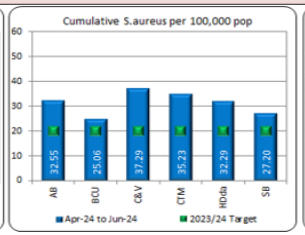
- In May-24, AB, C&V, CTM, HDda and Powys achieved the 80% target for % of LMPHSS assessments undertaken within 28 days of a referral. The best performing HB was Powys at 98.1%, SB had the lowest performance at 41.4%. Over the last 12 months, BCU, CTM and HDda saw an improvement trend in performance.
- In May-24, HDda, Powys and SB achieved the 80% target for % of therapeutic interventions started within 28 days of an LPMHSS assessment. The best performing HB was SB at 98.3%, AB had the lowest performance at 0.0%. Over the last 12 months, all HBs, except BCU, saw an improvement trend in performance.

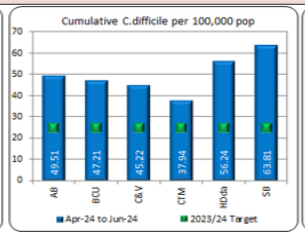
>=18 years

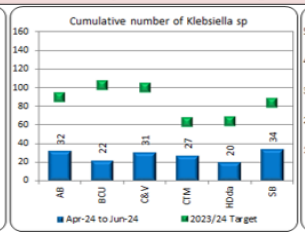
- In May-24, BCU, CTM, HDda and SB achieved the 80% target for % of LMPHSS assessments undertaken within 28 days of a referral. The best performing HB was SB at 98.8%, C&V had the lowest performance at 19.1%. Over the last 12 months, all HBs, except BCU and C&V, saw an improvement trend in performance.
- In May-24, all HBs, except AB, achieved the 80% target for % of therapeutic interventions started within 28 days of an LPMHSS assessment. The best performing HBs were C&V and SB at 100%, AB had the lowest performance at 15.6%. Over the last 12 months, BCU, CTM, Powys and SB saw an improvement trend in performance.

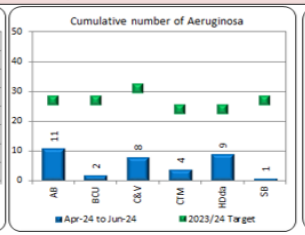
Health Care Acquired Infections - HCAIs (provisional data)





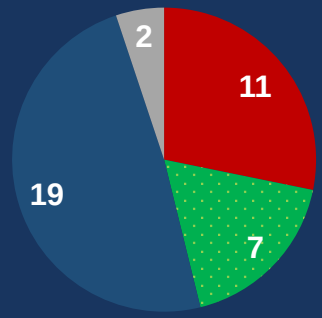






- For eColi, AB, C&V and SB are currently achieving the 2023/24 cumulative target. In the Apr-24 to Jun-24 period, HDda had the highest rate of eColi at 90.62 per 100,000 population compared to C&V who had the lowest rate at 53.15 per 100,000 population.
- For S.aureus, none of the HBs are currently achieving the 2023/24 cumulative target. In the Apr-24 to Jun-24 period, C&V had the highest rate of S.aureus at 37.29 per 100,000 population compared to BCU who had the lowest rate at 25.06 per 100,000 population.
- For C.difficile, none of the HBs are currently achieving the 2023/24 cumulative target. In the Apr-24 to Jun-24 period, SB had the highest rate of C.difficile at 63.81 per 100,000 population compared to CTM who had the lowest rate at 37.94 per 100,000 population.
- For Klebsiella, all HBs are currently achieving the 2023/24 cumulative target. In the Apr-24 to Jun-24 period, SB had the highest number of cases of Klebsiella at 34 compared to HDda who had the lowest number at 20.
- For Aeruginosa, all HBs are currently achieving the 2023/24 cumulative target. In the Apr-24 to Jun-24 period, AB had the highest number of cases of Aeruginosa at 11 compared to SB who had the lowest number at 1.

Note: Target is for achievement for Mar-24 (awaiting confirmation of the 24/25 targets).



Section 1

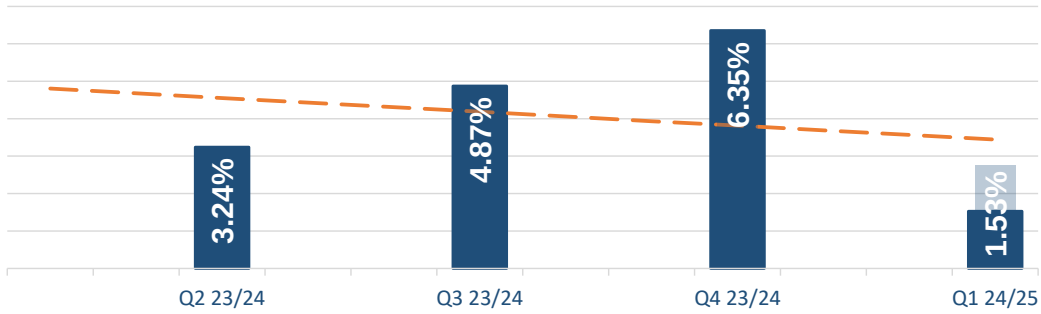
Quality, Safety, Effectiveness and Experience Performance

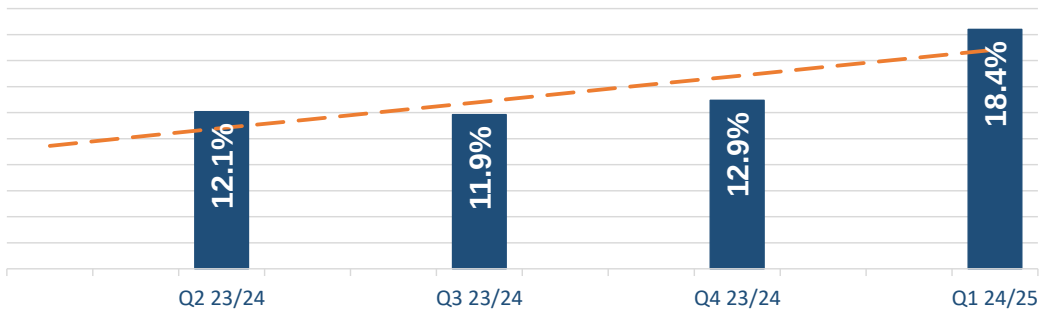
GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Betsi Cadwalar
University Health Board

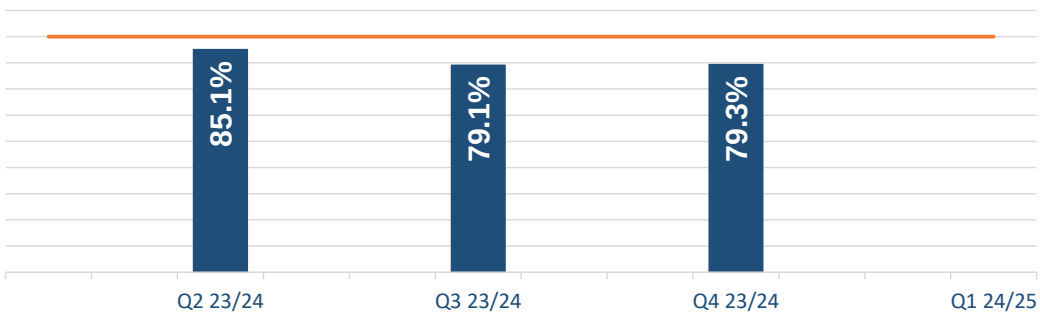
Produced on behalf of the Health Board by the Performance Directorate and Partners

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	1.53%	2nd of 7 (at Mar 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	18.4%	
-	QSE	Percentage of girls receiving the Human Papillomavirus (HPV) vaccination by the age of 15	90%	TBC	79.3%	5th of 7 (at Mar 24)

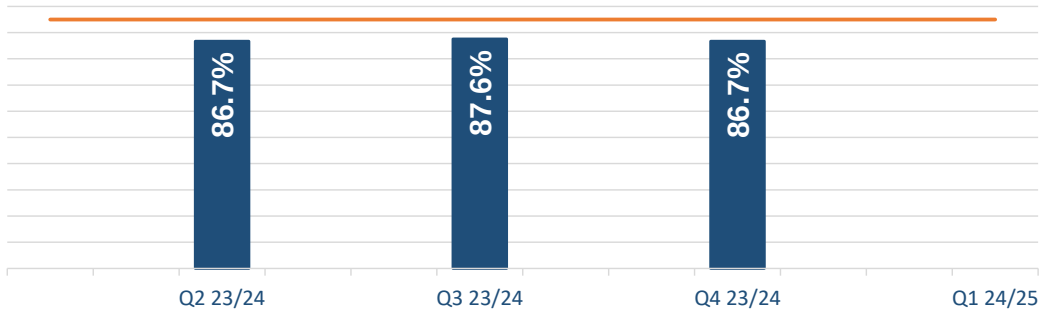


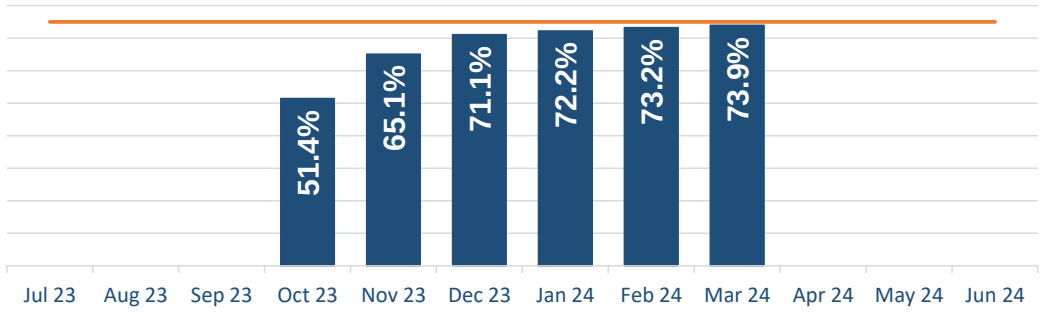


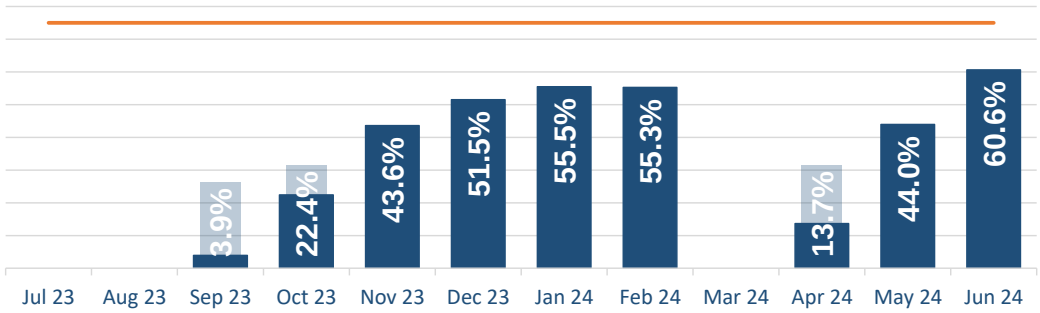


Quality: Performance

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	86.7%	2nd of 7 (at Mar 24)
-	QSE	Percentage uptake of the influenza vaccination amongst adults aged 65 years and over	75%	TBC	73.9%	2nd of 7 (at Mar 24)
-	QSE	Percentage uptake of the COVID-19 vaccination for those eligible Spring Booster 2023: Aged 75 years & over; residents in care home for older adults and; immunosuppressed aged 5 years & over Autumn Booster 2023: Age range to be confirmed	75%	TBC	60.6%	4th of 7 (at Jun 24)

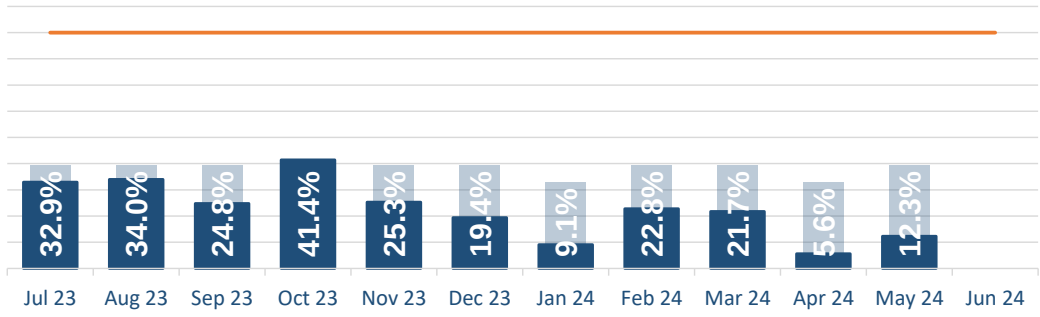


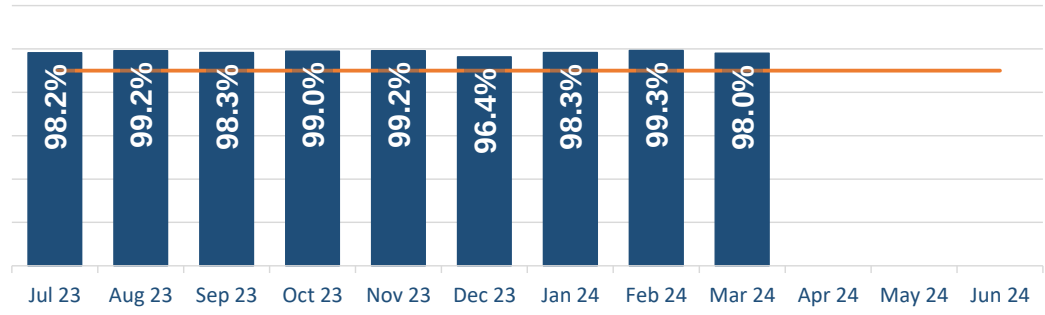


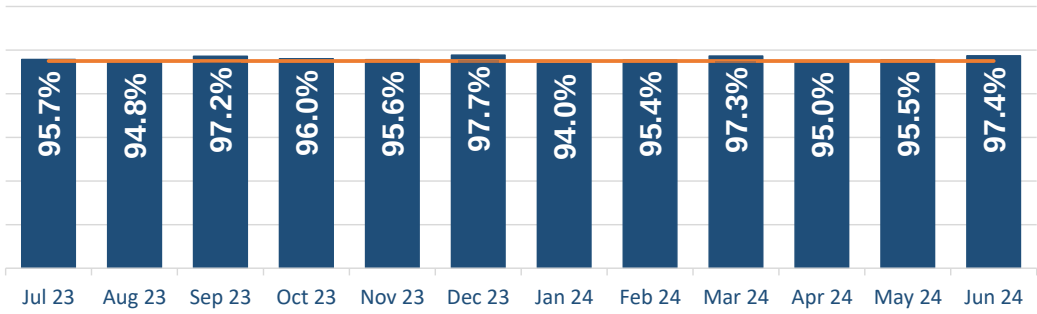


Quality: Performance

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	12.3%	4th of 7 (at Apr 24)
-	QSE	Percentage of well babies entering the new-born hearing screening programme who complete screening within 4 weeks	90%	TBC	98.0%	5th of 7 (at Apr 24)
-	QSE	Percentage of eligible newborn babies who have a conclusive bloodspot screening result by day 17 of life	95%	TBC	97.4%	6th of 7 (at May 24)

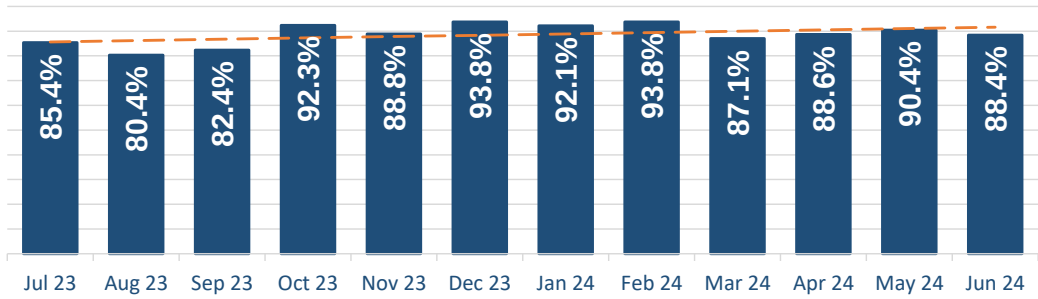


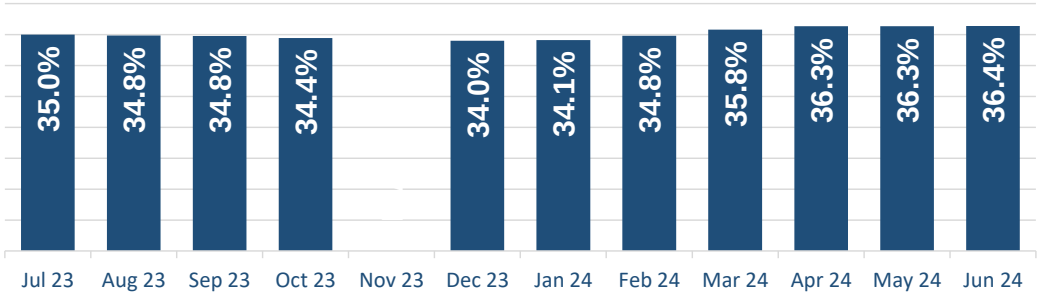


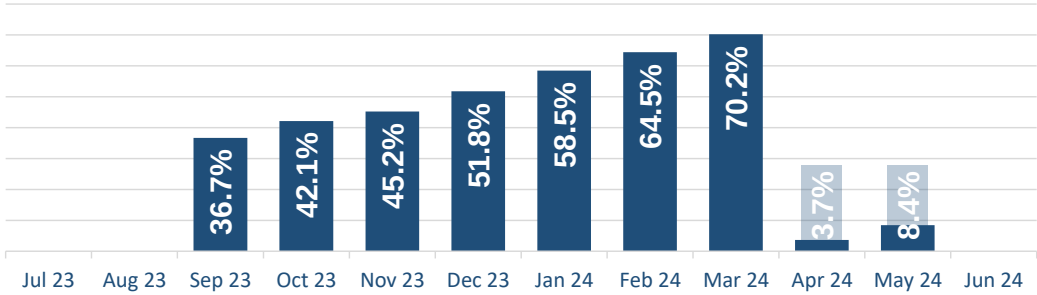


Quality: Performance

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	88.4%	2nd of 7 (at Mar 24)
-	QSE	Percentage of patients (aged 12 years and over) with diabetes who received all eight NICE recommended care processes	Equival-ent month increase (2024/25 to 2023/24) to 100%	TBC	36.4%	7th of 7 (at Jun 24)
-	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	8.4%	7th of 7 (at May 24)

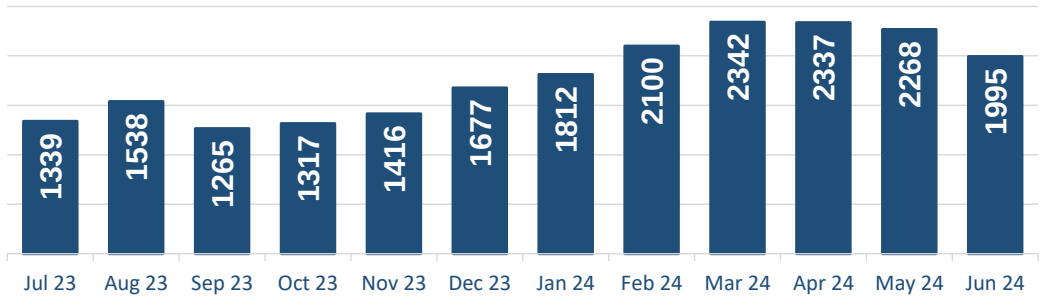


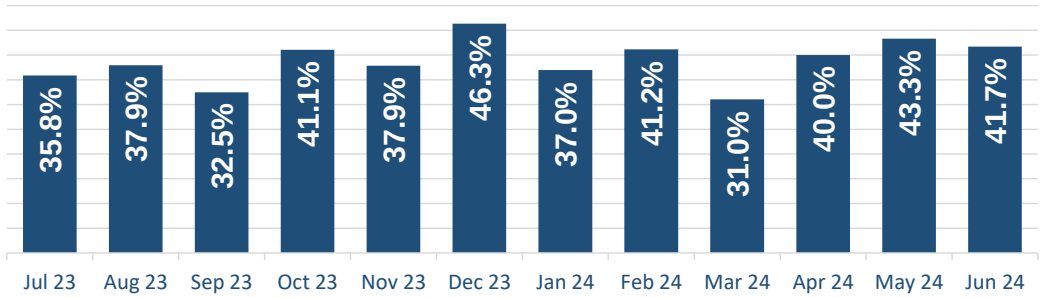


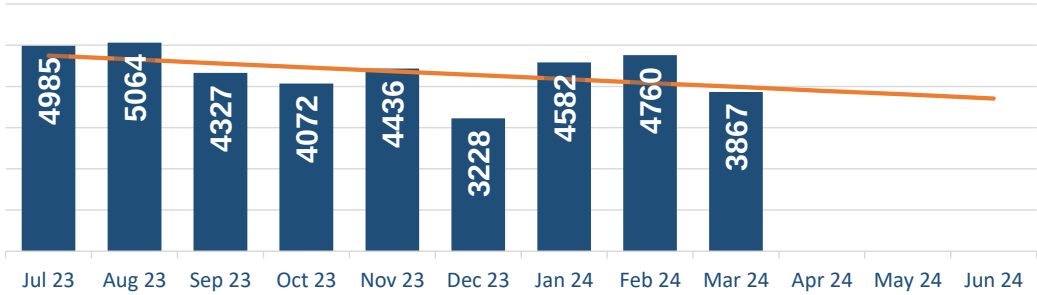


Quality: Performance

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 (2024/25 to 2023/24)	TBC	1995	1st of 7 (at Apr 24)
-	QSE	Percentage of confirmed COVID-19 cases within hospital which had a definite hospital onset of COVID-19	Equival-ent month reduct-ion (2024/25 to 2023/24)	TBC	41.7%	4th of 6 (at Jun 24)
-	QSE	Number of service user feedback experience responses completed and recorded on CIVICA	Increas-ing trend	TBC	3867	2nd of 10 (at Mar 24)

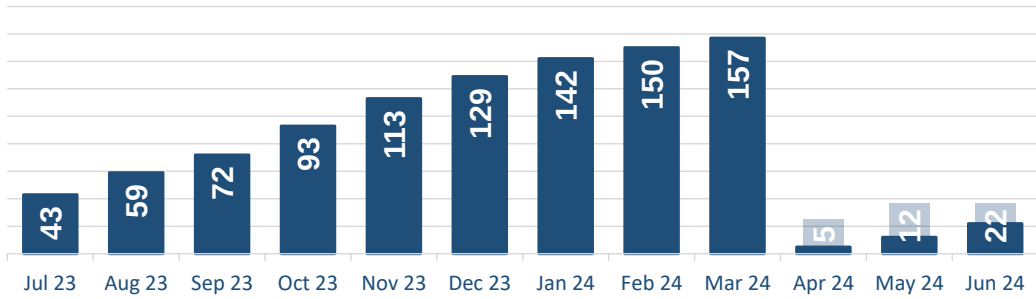


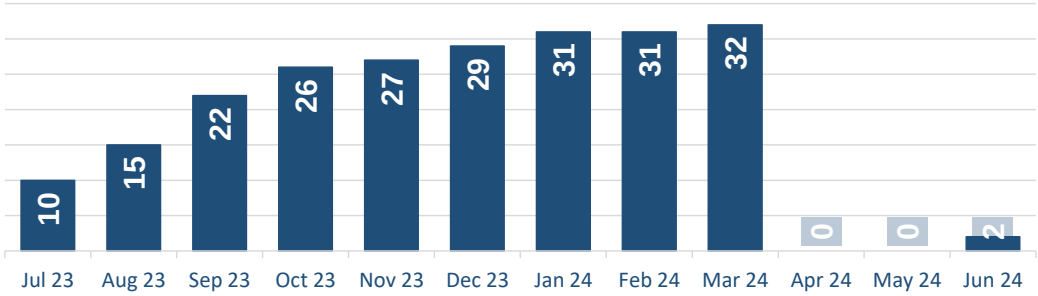


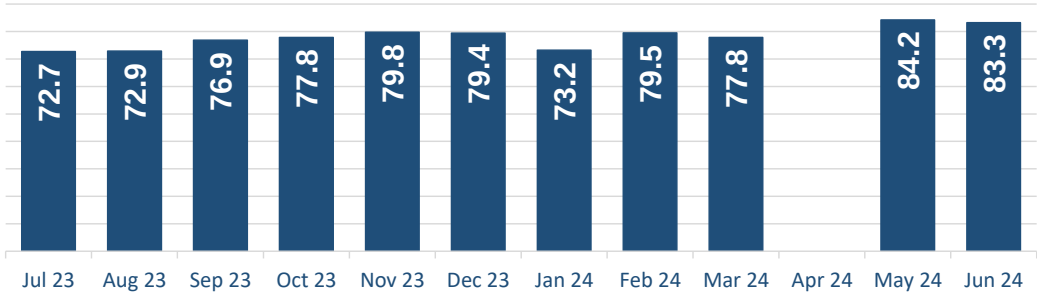


Quality: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
CRR: 24-04	QSE	The cumulative number of laboratory confirmed Klebsiella in reporting month	Not available	TBC	22	2nd of 6 (at Jun 24)
CRR: 24-04	QSE	The cumulative number of laboratory confirmed Pseudomonas Aeruginosa in reporting month	Not available	TBC	2	2nd of 6 (at Jun 24)
CRR: 24-04	QSE	The cumulative rate of laboratory confirmed E.coli bacteraemias cases per 100,000 population	Not available	TBC	83.3	5th of 6 (at Jun 24)

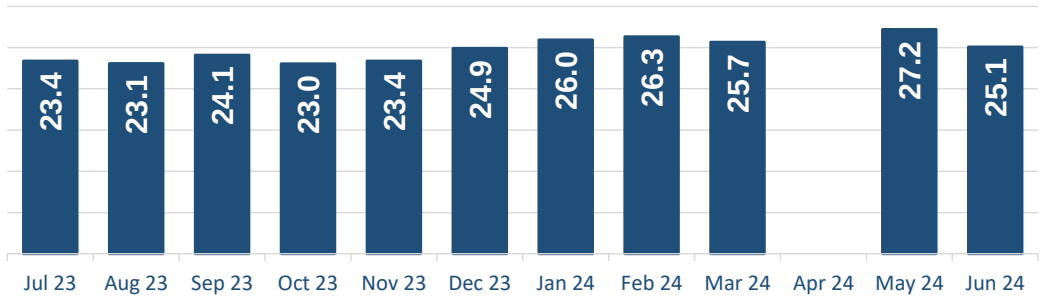


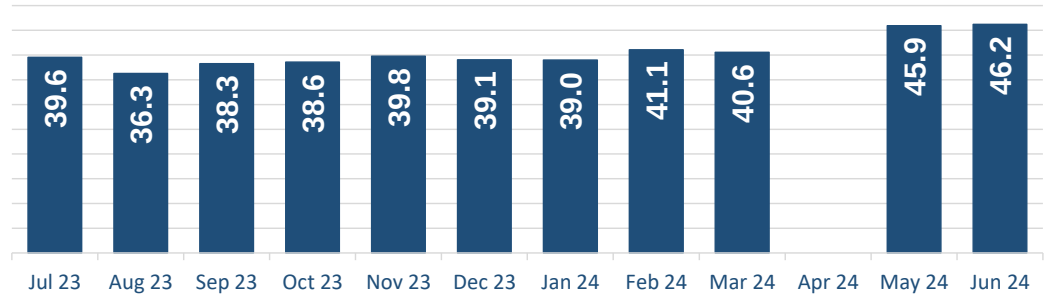


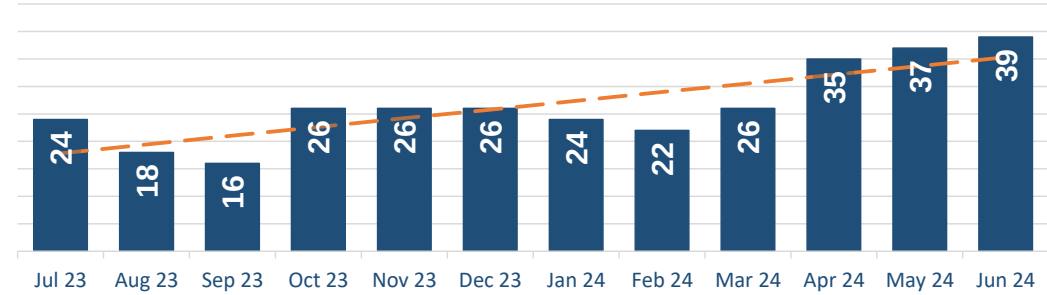


Quality: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
CRR: 24-04	QSE	The cumulative rate of laboratory confirmed S. Aureus Bacteraemia (MRSA and MSSA) cases per 100,000 of the population	Not available	TBC	25.1	1st of 6 (at Jun 24)
CRR: 24-04	QSE	The cumulative rate of laboratory confirmed C.difficile cases per 100,000 of the population	Not available	TBC	46.2	3rd of 6 (at Jun 24)
CRR: 24-04	QSE	Number of National reportable incidents that remain open 90 days or more	Decreasing trend	TBC	39	6th of 10 (at Jun 24)

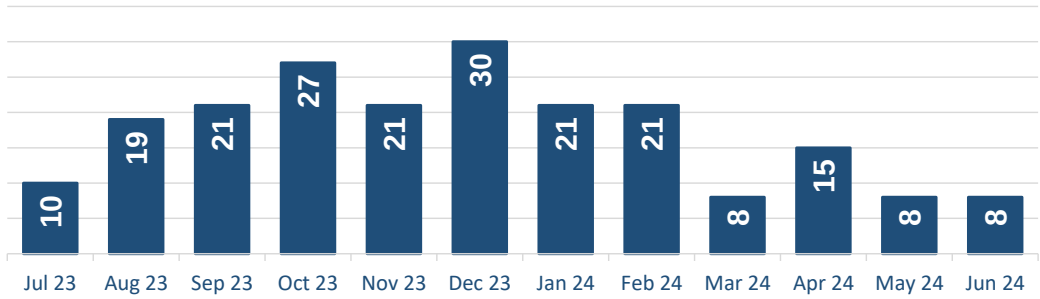


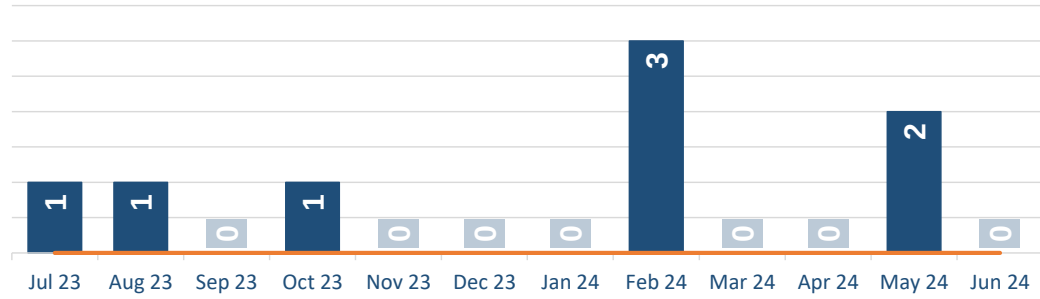


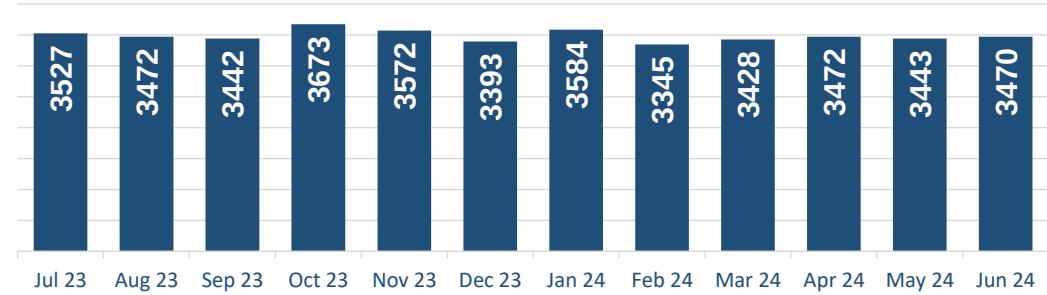


Quality: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	QSE	Number of new National reportable incidents (NRIs)	N/A	TBC	8	
-	QSE	Number of new never events	0	TBC	0	
-	QSE	Number of new patient safety incidents	N/A	TBC	3470	

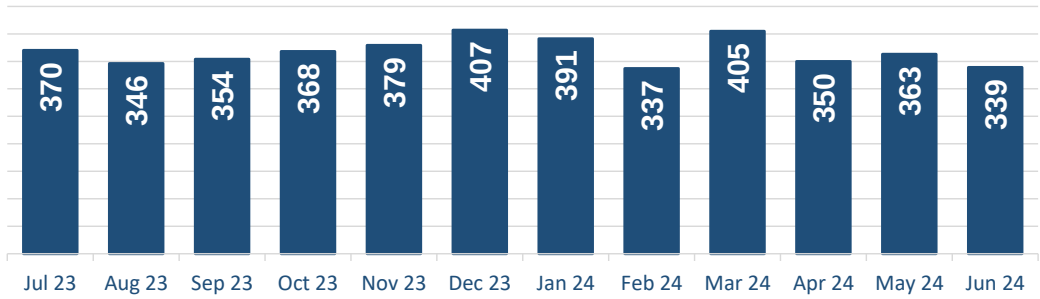


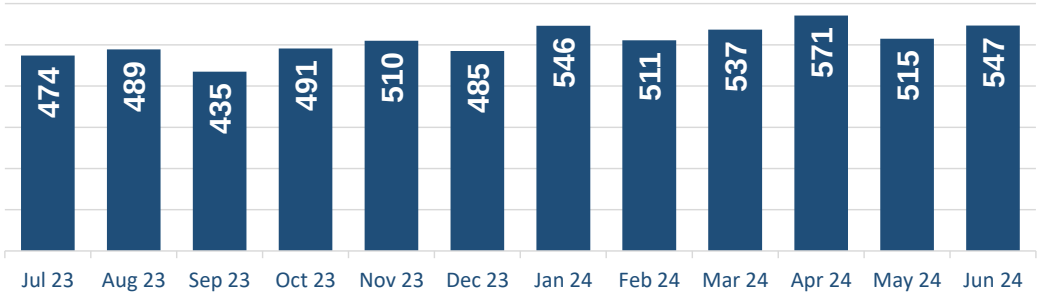


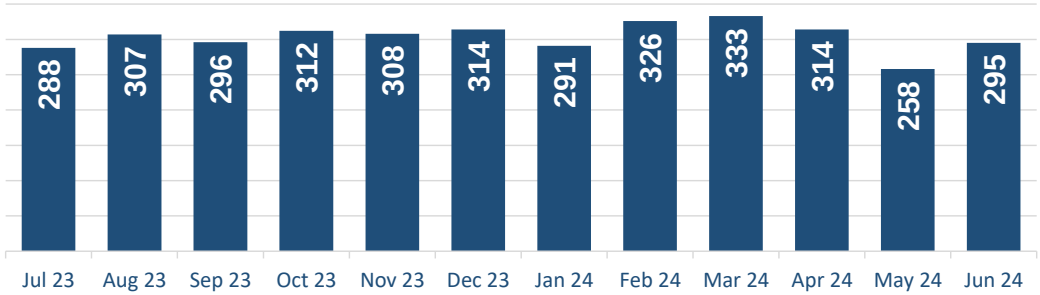


Quality: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	QSE	Number of new reported falls	N/A	TBC	339	
-	QSE	Number of new reported hospital acquired pressure ulcers (HAPU) (excluding new to caseload)	N/A	TBC	547	
-	QSE	Number of new reported medication incidents	N/A	TBC	295	

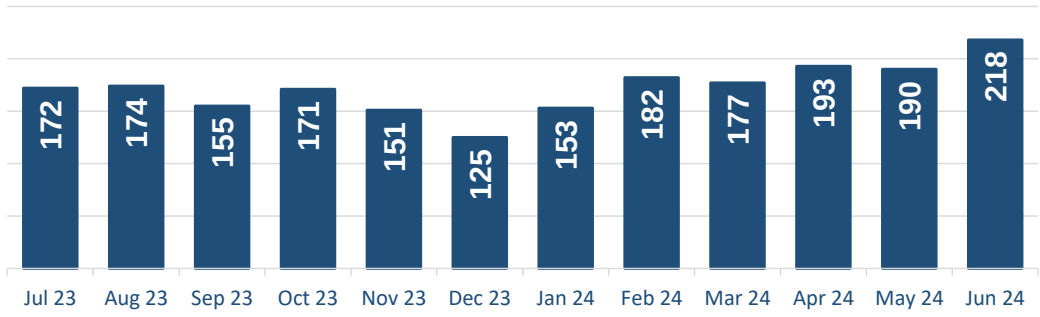


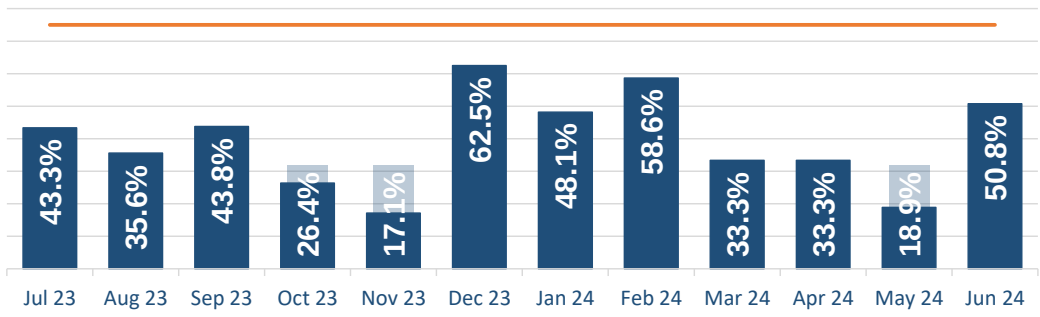


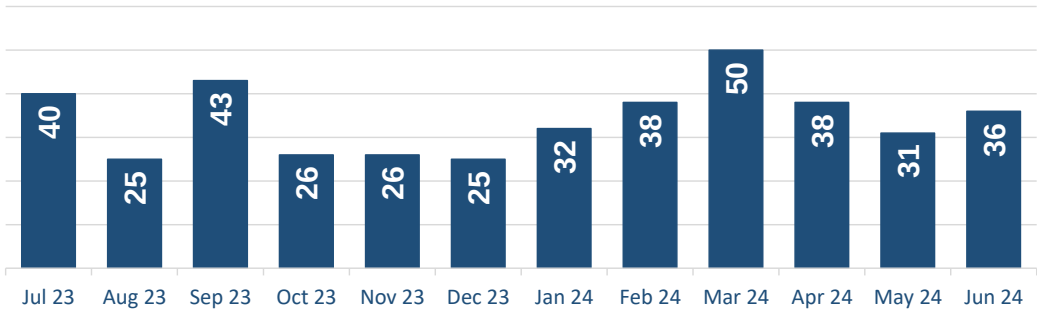


Quality: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	QSE	Number of new 'Putting Things Right' (PTR) complaints	N/A	TBC	218	
-	QSE	Of the complaints closed, the percentage that were closed within 30 days	75.0%	TBC	50.8%	
-	QSE	Number of new early resolutions	N/A	TBC	36	

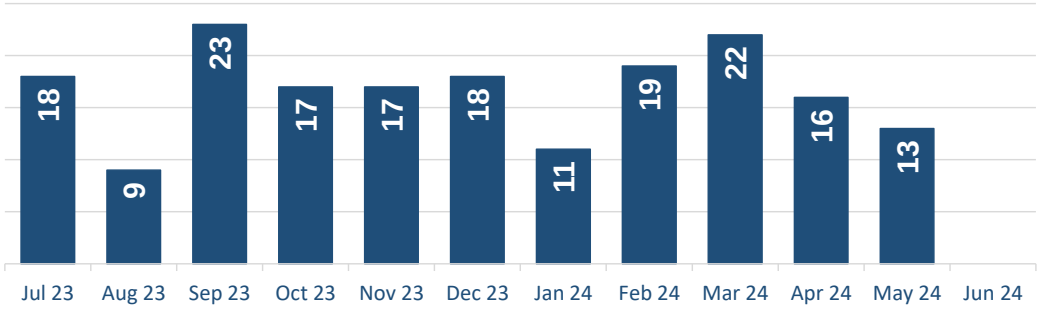






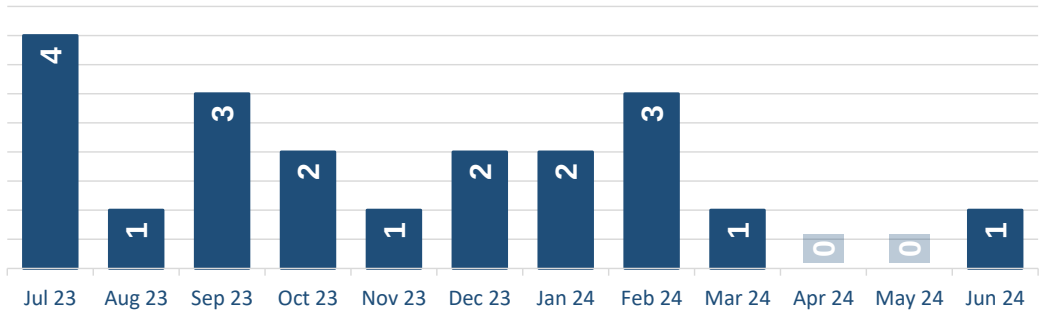
Quality: Performance

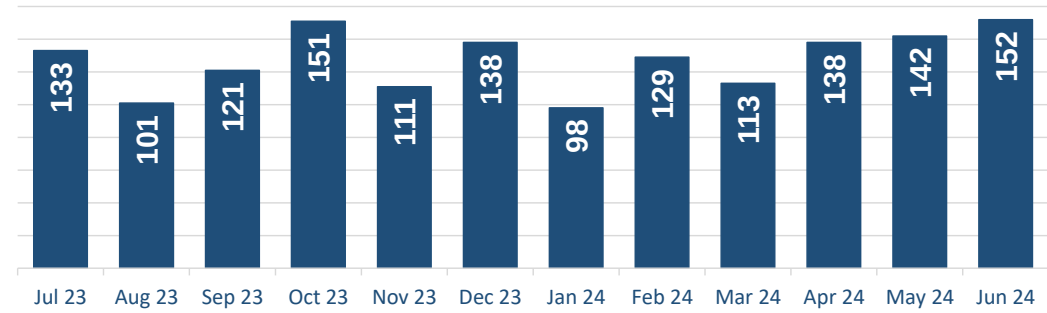
Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	QSE	Number of new PALS (Patient Advice and Liason Service) contacts	N/A	TBC	8303	
-	QSE	Number of new Ombudsman contacts	N/A	TBC	13	
-	QSE	Percentage of survey responses rating care as good or very good	N/A	TBC	93.5%	



Quality: Performance

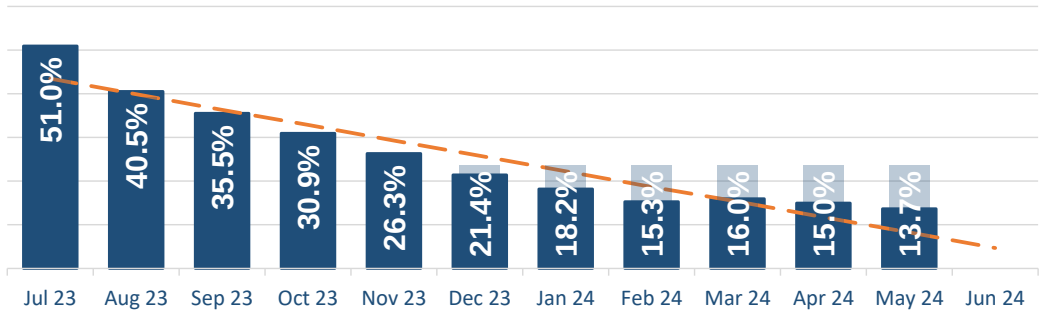
Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	QSE	Number of regulation 28 notices	N/A	TBC	1	
-	QSE	Number of overdue 'Learning from Event Reports' (LFERs)	N/A	TBC	37	
-	QSE	Number of Great-ix submissions	N/A	TBC	152	

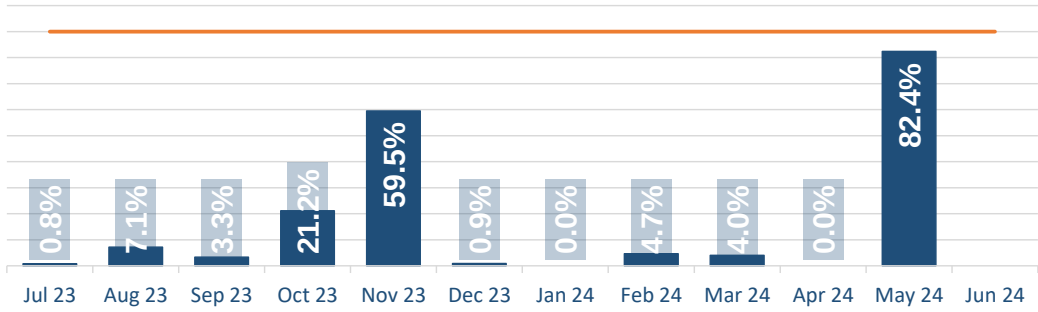


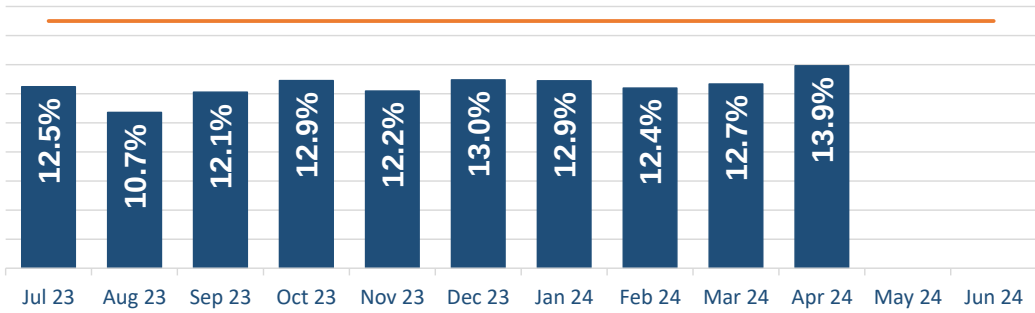


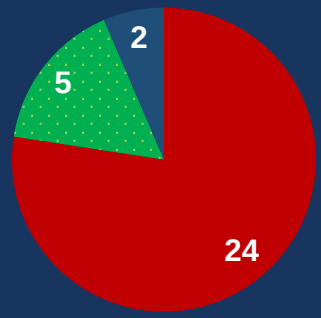
Quality: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	QSE	Percentage of episodes clinically coded within one reporting month post episode discharge end date	Increas-ing trend (to 95%)	TBC	13.7%	8st of 8 (at Apr 24)
-	QSE	Percentage of all classifications' coding errors corrected by the next monthly reporting submission following identification	90%	TBC	82.4%	6th of 8 (at May 24)
-	QSE	Percentage of calls ended following WAST telephone assessment (Hear and Treat)	>17%	TBC	13.9%	5th of 7 (at Apr 24)









Section 2

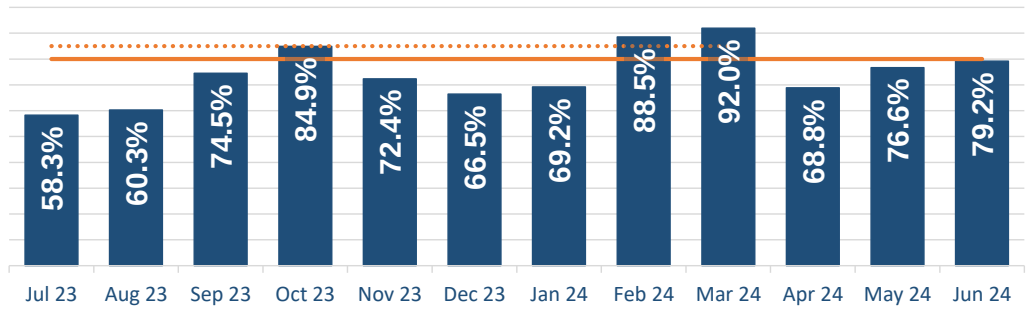
Access & Activity Performance

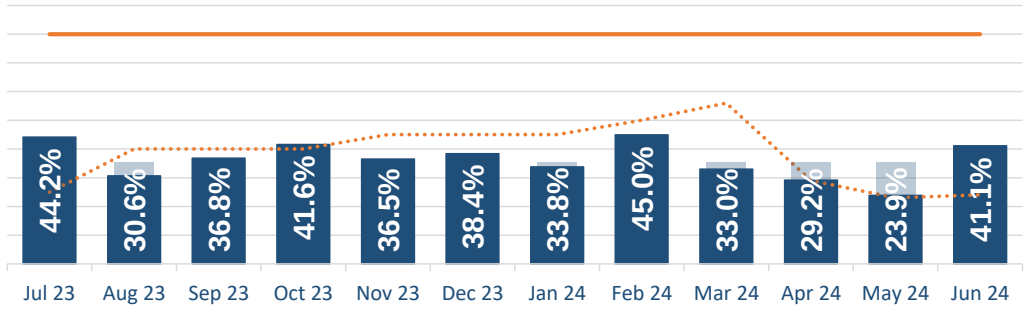
GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Betsi Cadwalar
University Health Board

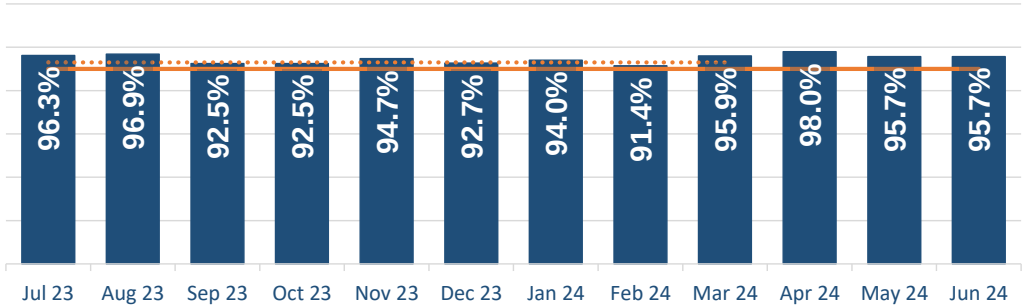
Produced on behalf of the Health Board by the Performance Directorate and Partners

Access and Activity: Performance

Ref	Cmt	Measure	WG Target	Internal Target	BCU Position	Wales Rank
SM: DM16	PFIG	Percentage of Local Primary Mental Health Support Service (LPMHSS) assessments undertaken within (up to and including) 28 days of the date of receipt of referral (for those aged under 18 years)	80.0%	TBC	79.2%	6th of 7 (at May 24)
SM: DM15	PFIG	Percentage of theraputic interventions started within (up to and including) 28 days following an assessment by LPMHSS (for those aged under 18 years)	80.0%	24.0%	41.1%	5th of 7 (at May 24)
SM: DM16	QSE	Percentage of health board residents in receipt of secondary mental health services who have a valid care and treatment plan (for those age under 18 years)	90%	TBC	95.7%	2nd of 7 (at May 24)

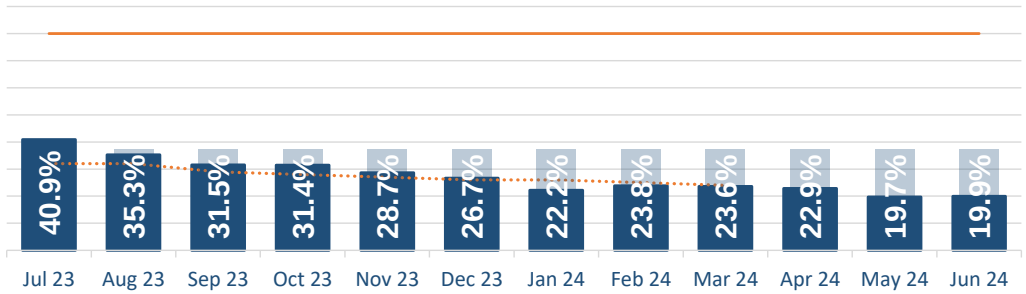


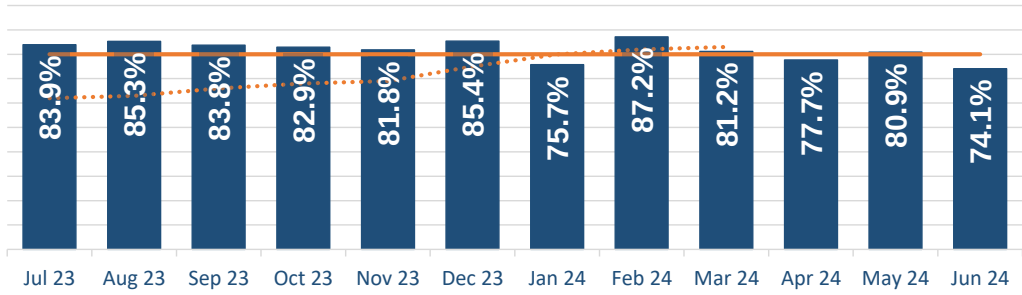


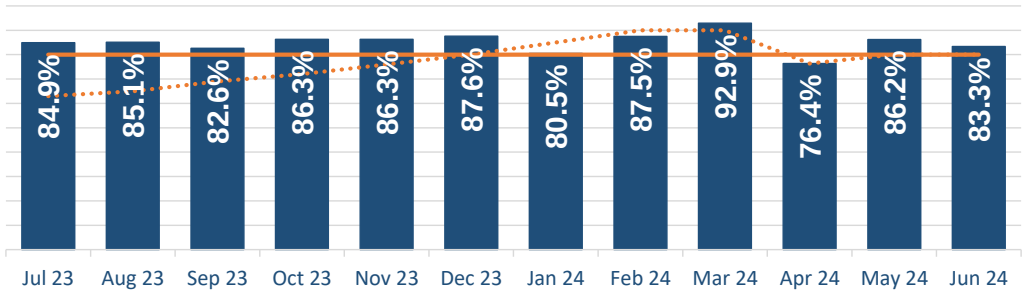


Access and Activity: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
CRR: 24-11	PFIG	Percentage of children and young people waiting less than 26 weeks to start an ADHD or ASD neurodevelopment assessment	80%	TBC	19.9%	6th of 7 (at May 24)
SM: DM11	PFIG	Percentage of Local Primary Mental Health Support Service (LPMHSS) assessments undertaken within (up to and including) 28 days of the date of receipt of referral (for those aged 18 years and over)	80%	TBC	74.1%	4th of 7 (at May 24)
SM: DM12	PFIG	Percentage of theraputic interventions started within (up to and including) 28 days following an assessment by LPMHSS (for those aged 18 years and over)	80%	80.0%	83.3%	6th of 7 (at May 24)

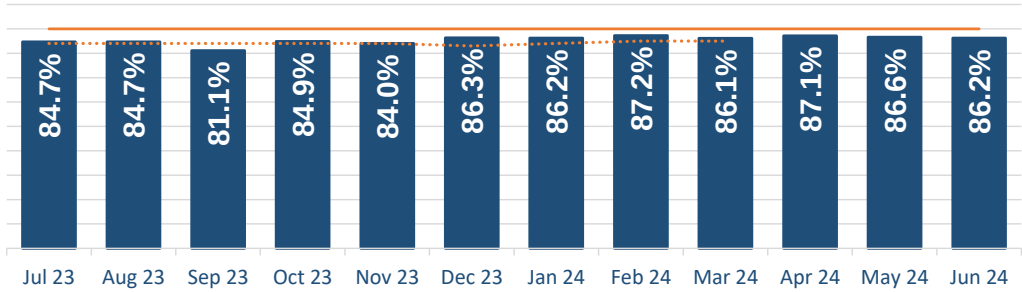


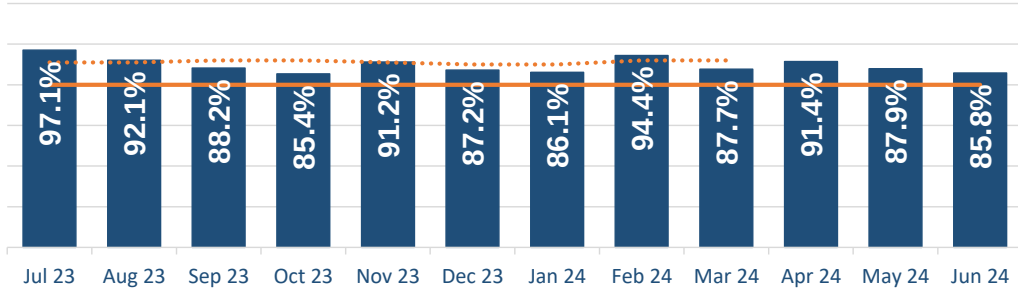


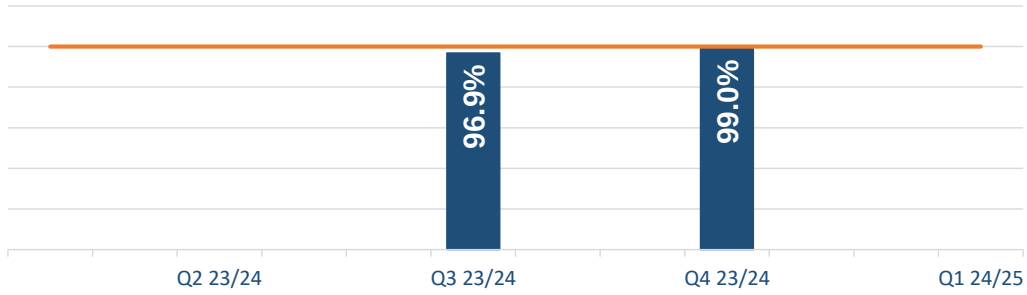


Access and Activity: Performance

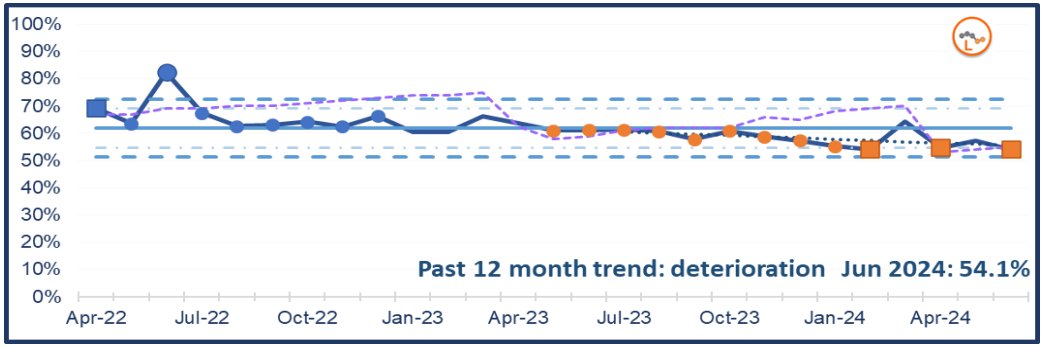
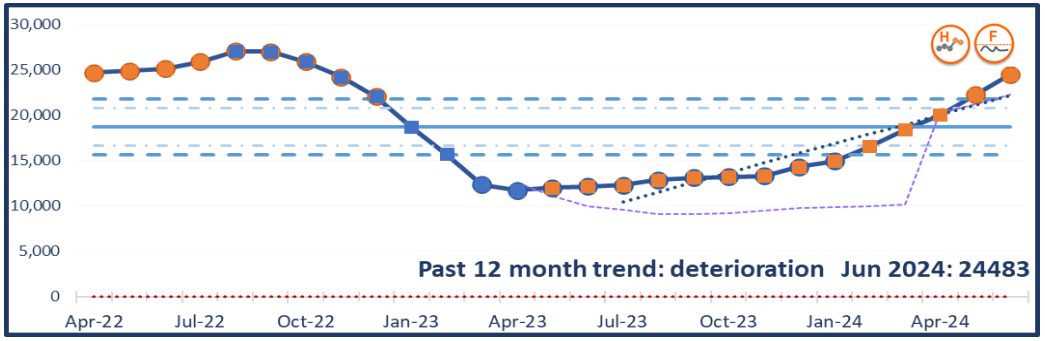
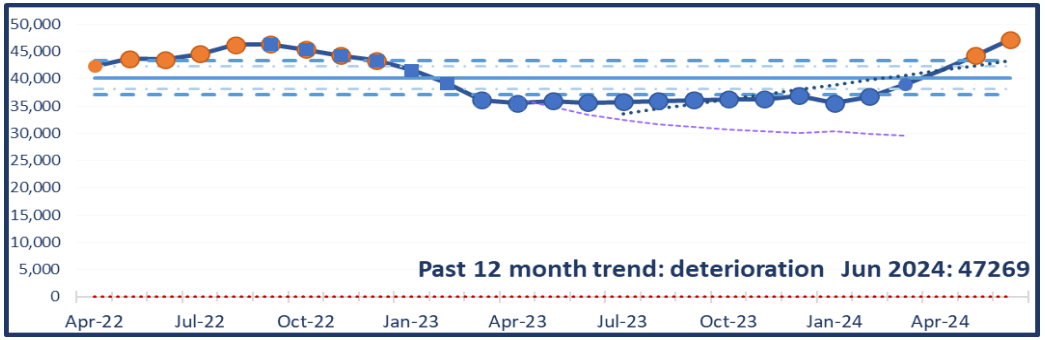
Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
SM: DM13	QSE	Percentage of health board residents in receipt of secondary mental health services who have a valid care and treatment plan (for those age 18 years and over)	90%	TBC	86.2%	5th of 7 (at May 24)
-	PFIG	Percentage of patients waiting less than 26 weeks to start a psychological therapy in specialist Adult Mental Health BCU Level	80%	TBC	85.8%	1st of 7 (at May 24)
-	PFIG	Percentage of GP practices that have achieved all standards set out in the National Access Standards for In-hours	100%	TBC	98.96%	6th of 7 (at Mar 23)





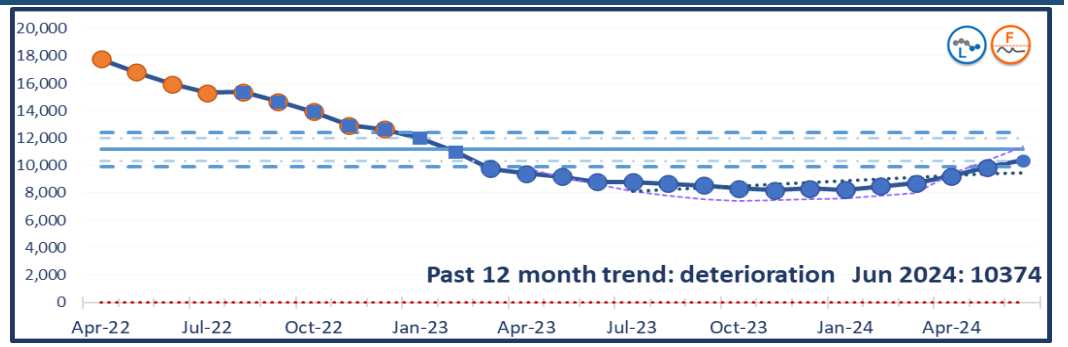


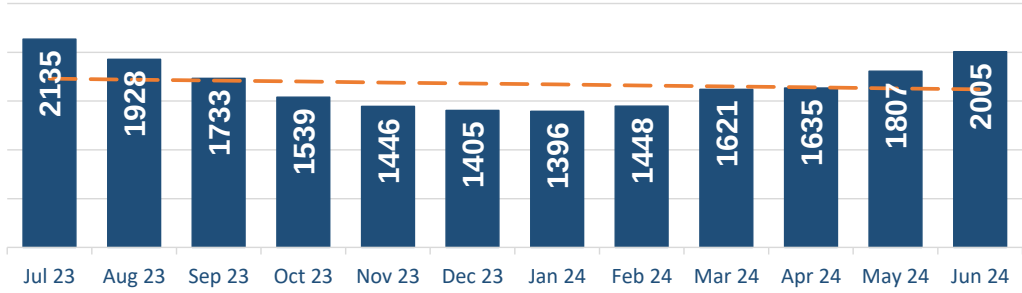
Access and Activity: Performance

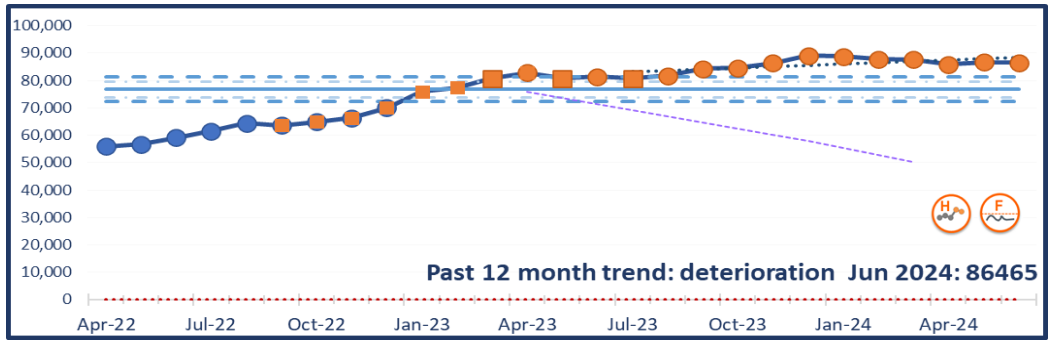
Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank	
CRR: 24-11 SM: DM01	PFIG	Percentage of patients starting first definitive cancer treatment within 62 days from point of suspicion (regardless of the referral route)	Increas-ing trend (to 80%)	55.0%	54.1%	2nd of 6 (at May 24)	
CRR: 24-11	PFIG	Number of patients waiting over 52 weeks for a new outpatient appointment	0	22293	24483	7th of 7 (at May 24)	
CRR: 24-11 SM: DM02	PFIG	Number of patients waiting more than 52 weeks for referral to treatment	Decreas-ing trend (to 0 by Jun 25)	TBC	47269	7th of 7 (at May 24)	

Access and Activity: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
CRR: 24-11 SM: DM03	PFIG	Number of patients waiting more than 104 weeks for referral to treatment	0	11390	10374	7th of 7 (at May 24)
CRR: 24-11	PFIG	Over 156 weeks all stages	N/A	TBC	2005	N/A
CRR: 24-11	PFIG	Number of patients waiting for a follow up outpatient appointment who are delayed by over 100%	Decreas-ing trend (to 0)	TBC	86465	7th of 7 (at Jun 24)

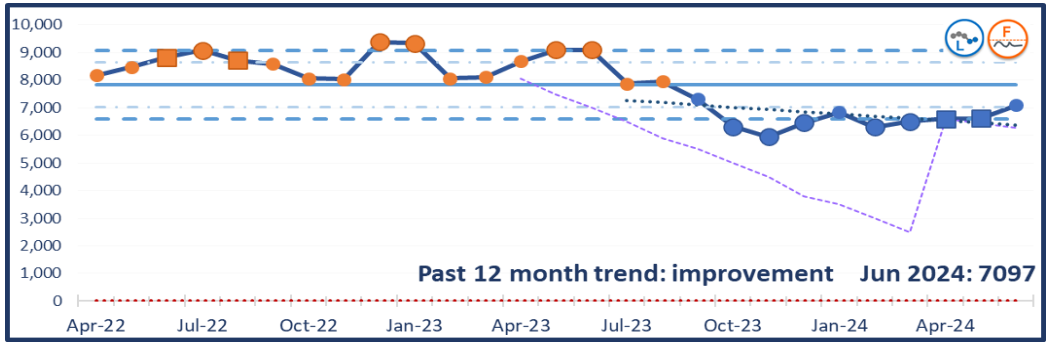


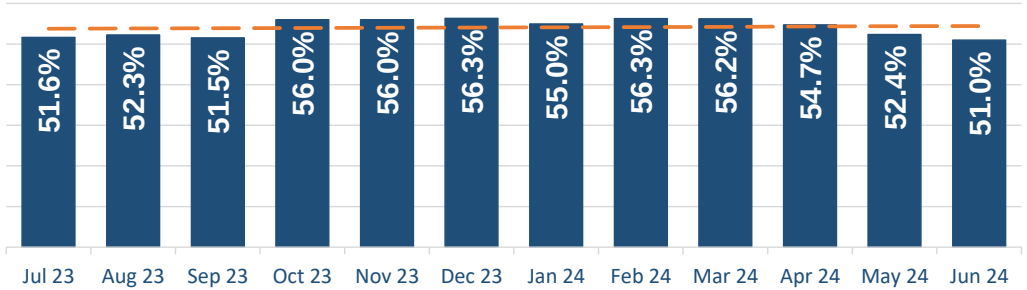


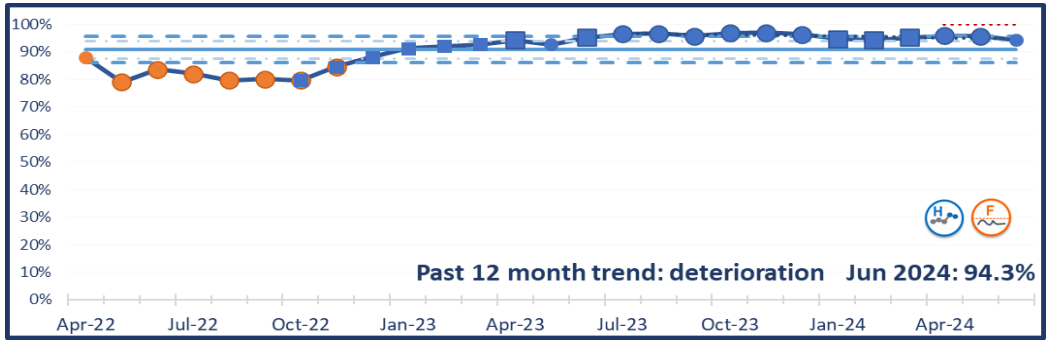


Access and Activity: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
CRR: 24-13 SM: DM04	PFIG	Number of pathways waiting 8 weeks for specific diagnostic	0	6288	7097	5th of 7 (at May 24)
CRR: 24-11 24-12	PFIG	Percentage of ophthalmology R1 appointments attended which were within their clinical target date or within 25% beyond their clinical target date	Increas-ing trend (to 95%)	TBC	51.0%	7th of 7 (at May 24)
CRR: 24-11	PFIG	Percentage of children (aged under 18 years) waiting 14 weeks or less for a specified Allied Health Professional (Includes: Art therapy; podiatry; dietetics; occupational therapy, physiotherapy and; speech and language therapy)	100.0%	TBC	94.3%	4th of 7 (at May 24)

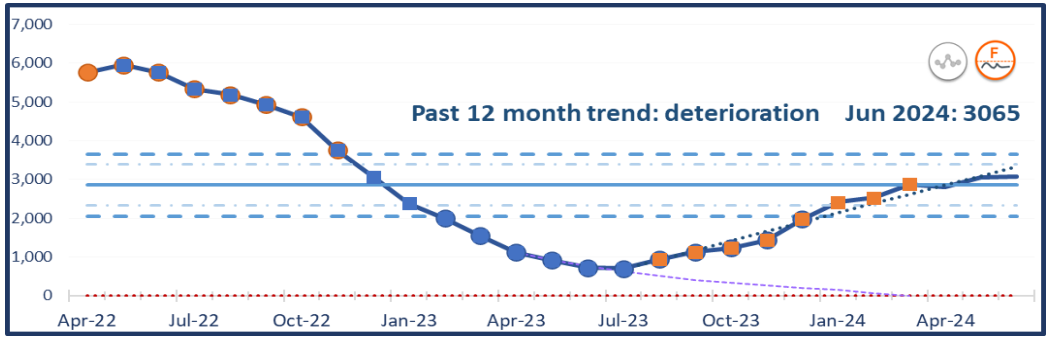


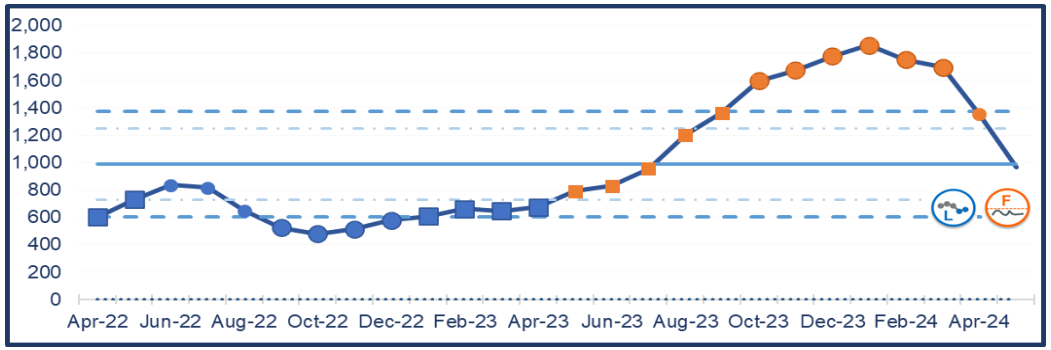


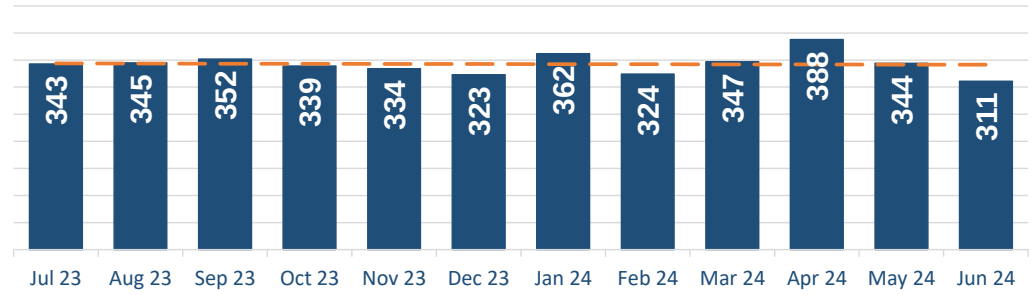


Access and Activity: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
CRR: 24-11 SM: DM05	PFIG	Number of patients (all ages) waiting more than 14 weeks for a specified therapy (excluding audiology)	0	TBC	3065	7th of 7 (at May 24)
-	PFIG	Number of patients (all ages) waiting more than 14 weeks for audiology	0	TBC	544	
-	PFIG	Number of Pathways of Care Delayed discharges	Decreas-ing trend	TBC	311	7th of 8 (at Jun 24)

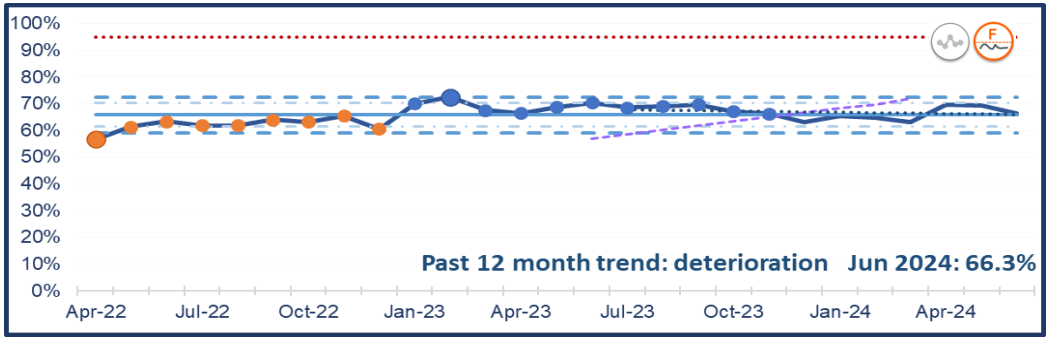


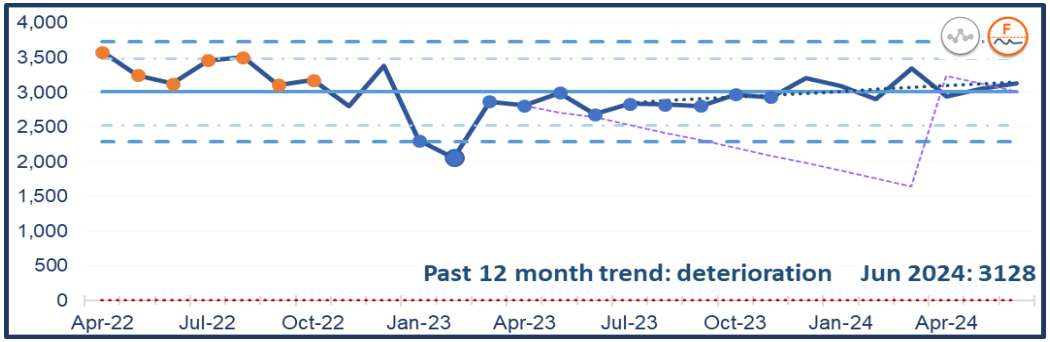


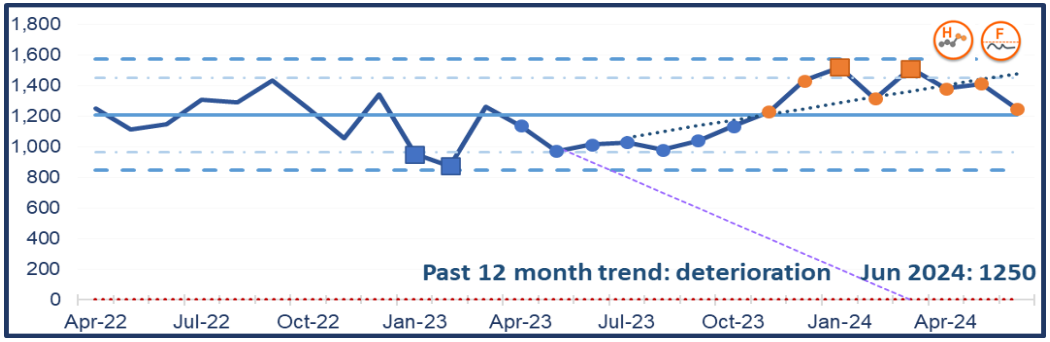


Access and Activity: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
CRR: 24-10	PFIG	Percentage of patients who spend less than 4 hours in all major and minor emergency care (i.e. A&E) facilities from arrival until admission, transfer or discharge	Equival-ent month increase (2024/25 to 2023/24) to 95%	TBC	66.3%	4th of 7 (at Jun 24)
CRR: 24-10 SM: DM08	PFIG	Number of patients who spend 12 hours or more in all hospital major and minor emergency care facilities from arrival until admission, transfer or discharge	Equival-ent month reduct-ion (2024/25 to 2023/24) to 0	3009	3128	7th of 7 (at Jun 24)
-	N/A	Number of patients who spend 24 hours or more in all hospital major and minor emergency care facilities from arrival until admission, transfer, or discharge	N/A	TBC	1250	

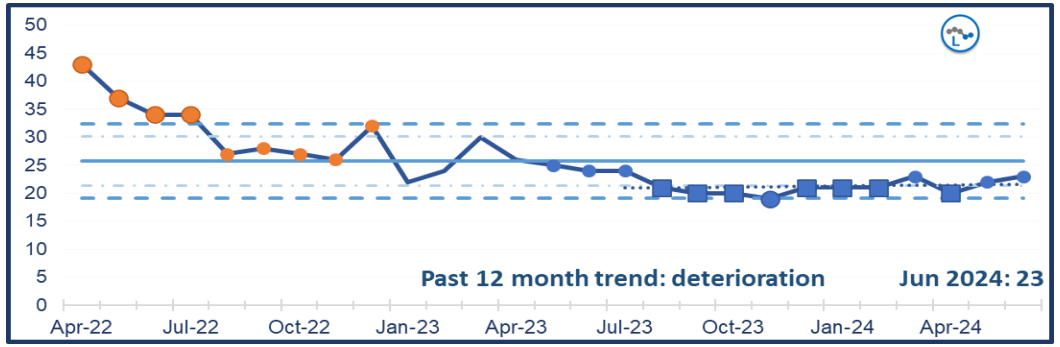


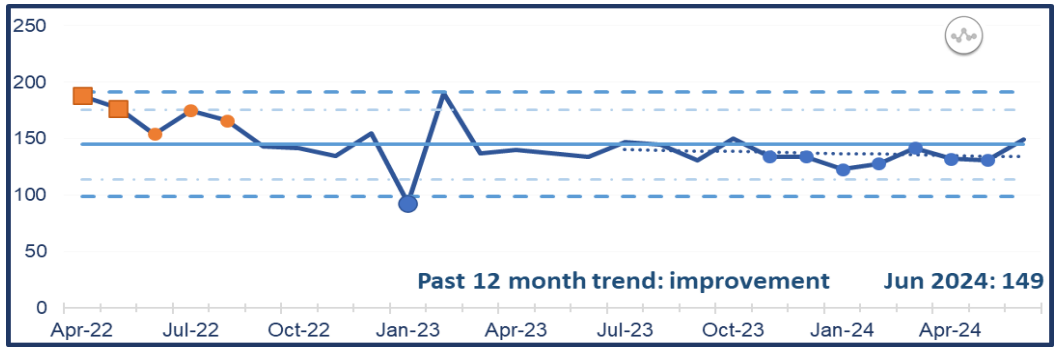


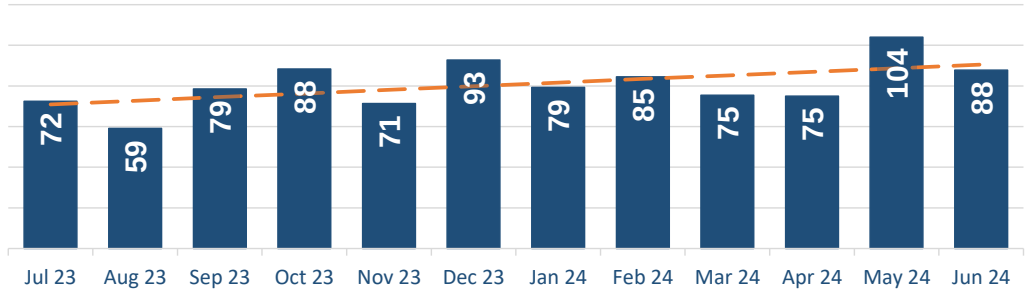


Access and Activity: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
CRR: 24-10	PFIG	Median time from arrival at an emergency department to triage by a clinician	15 minutes or less	TBC	23.0	4th of 6 (at Jun 24)
CRR: 24-10 SM: DM07	PFIG	Median time from arrival at an emergency department to assessment by a clinical decision maker	60 minutes or less	TBC	149.0	5th of 6 (at Jun 24)
CRR: 24-10	PFIG	Median emergency response time to amber calls	Decreas-ing trend	TBC	87.8	3rd of 7 (at Jun 24)

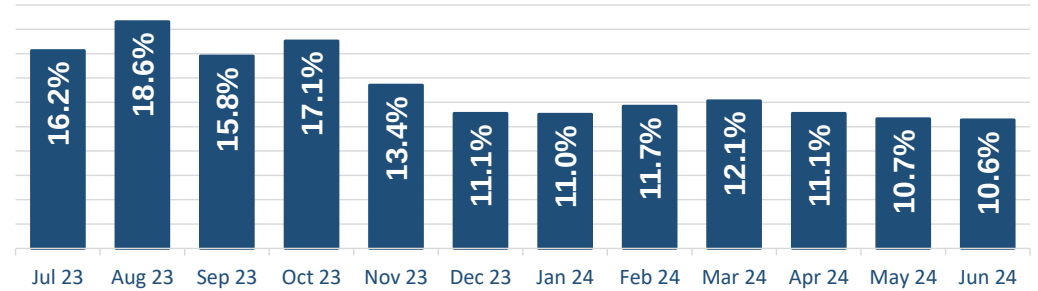


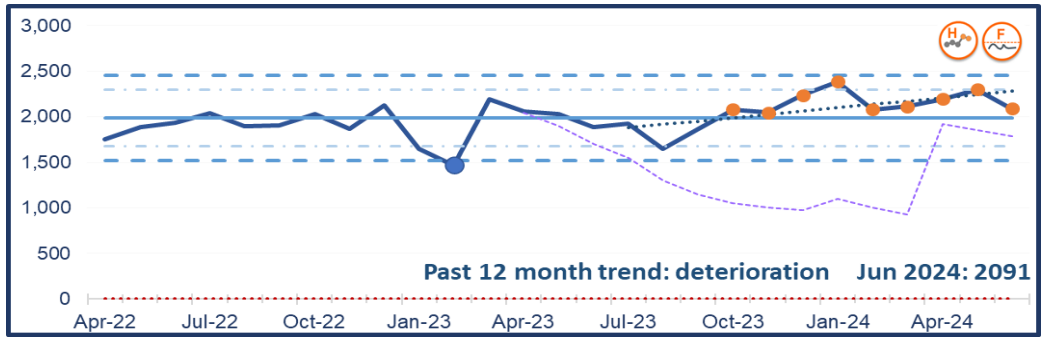


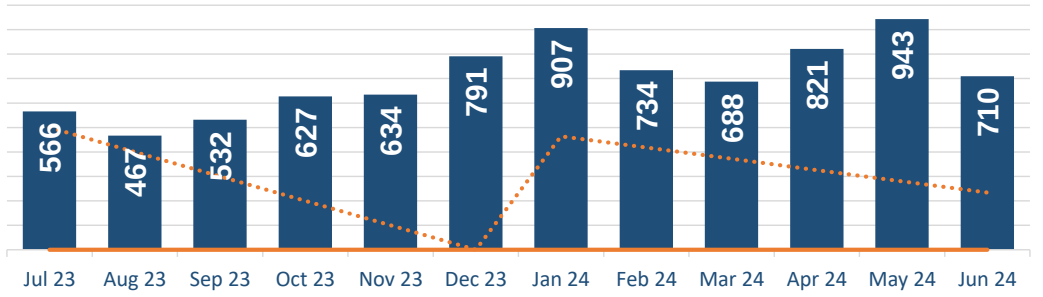


Access and Activity: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	PFIG	Percentage of ambulance handovers within 15 minutes	Equival-ent month increase (2024/25 to 2023/24) to 100%	TBC	10.6%	
CRR: 24-10 SM: DM06	PFIG	Number of ambulance patient handovers over 1 hour	0	1788	2091	6th of 6 (at Jun 24)
CRR: 24-10	PFIG	Number of ambulance patient handovers over 4 hour	0	234	710	

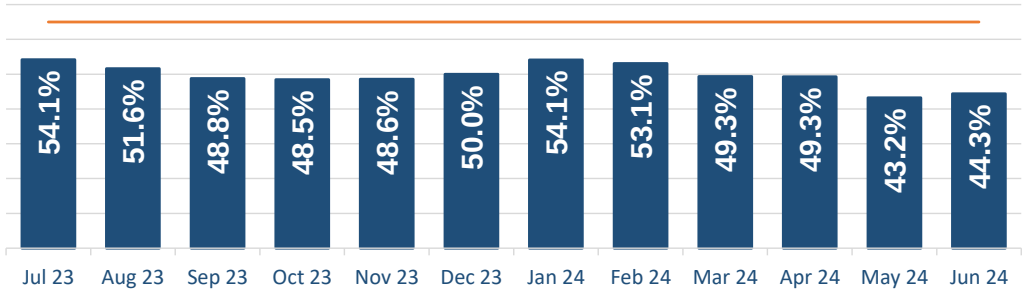


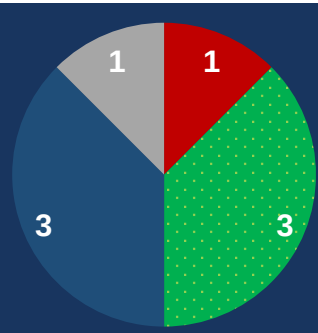




Access and Activity: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
CRR: 24-10	PFIG	Percentage of emergency responses to red calls arriving within (up to and including) 8 minutes	65.0%	TBC	44.3%	6th of 7 (at Jun 24)





Section 3

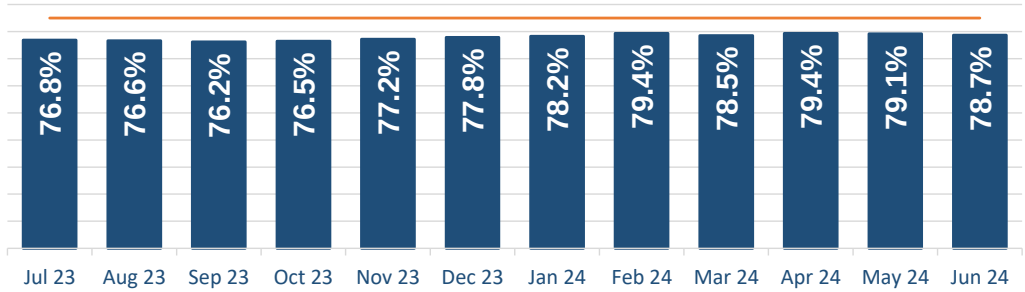
People & Organisational Development Performance

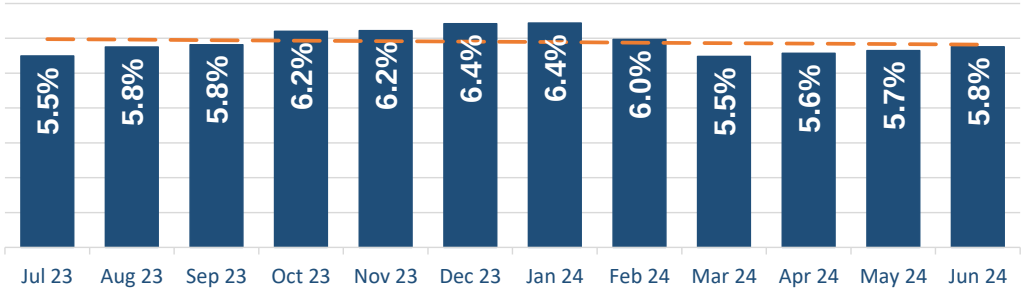
GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

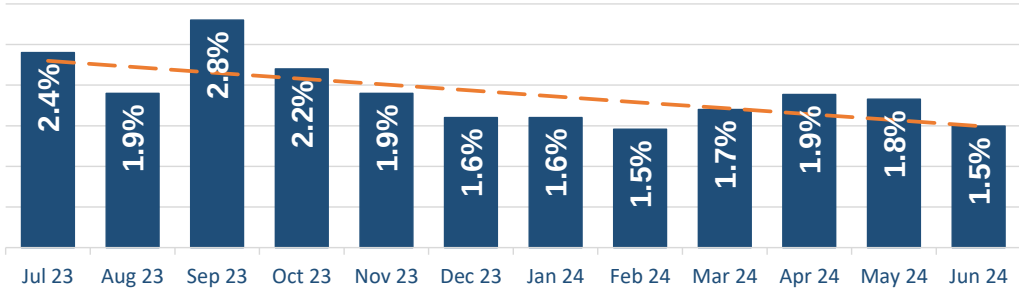
Produced on behalf of the Health Board by the Performance Directorate and Partners

People: Performance

Ref	Cmt	Measure	WG Target	Internal Target	BCU Position	Wales Rank*
-	PFIG	Percentage of headcount by organisation who have had a Personal Appraisal and Development Review (PADR)/medical appraisal in the previous 12months(excluding doctors and dentists in training)	85%	TBC	78.7%	4th of 13 (at Apr 24)
-	PFIG	Percentage of sickness absence rate of staff	Decreas-ing trend	TBC	5.8%	7th of 13 (at Apr 24)
-	PFIG	Turnover rate for nurse and midwifery registered staff leaving NHS Wales	Decreas-ing trend against 2019/20	TBC	1.5%	2nd of 11 (at Mar 24)



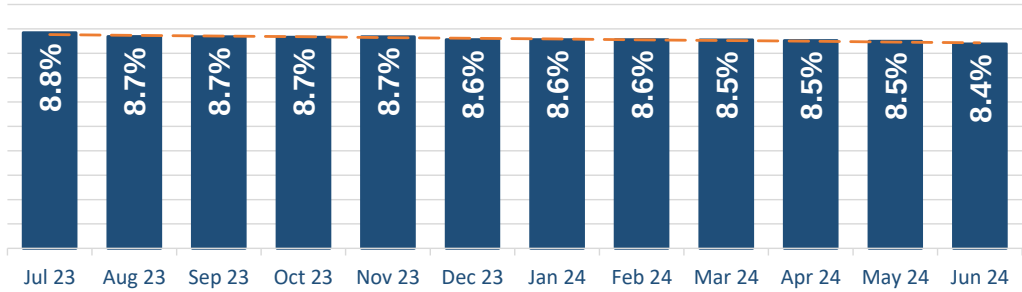


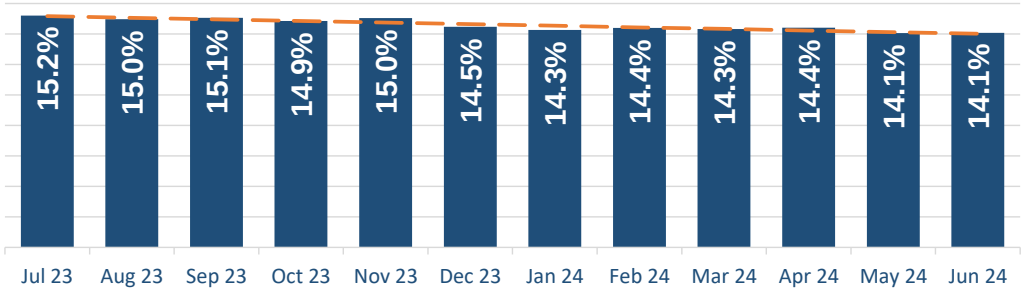


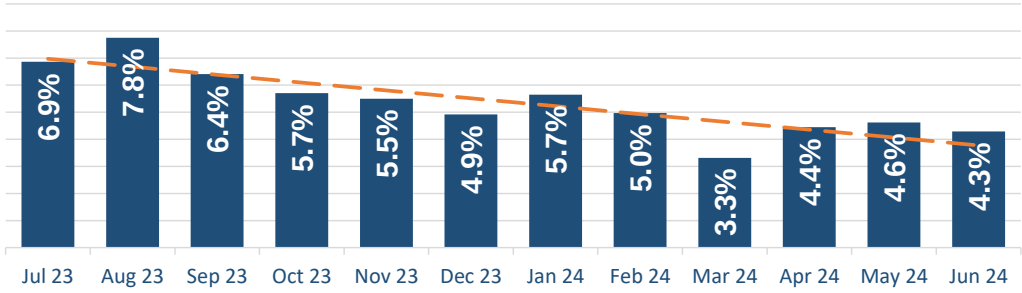
*Rank is based on National HEIW data, where as position data uses BCU methodology

People: Performance

Ref	Cmt	Measure	WG Target	Internal Target	BCU Position	Wales Rank*
-	PFIG	12 month rolling turnover rate (External)	N/A	TBC	8.39%	N/A
-	PFIG	Staff turnover rate for those who had less than 1 year service	N/A	TBC	14.08%	
CRR: 24-05	PFIG	Agency spend as a percentage of total pay bill	Decreas-ing trend	TBC	4.3%	10th of 12 (at Apr 24)



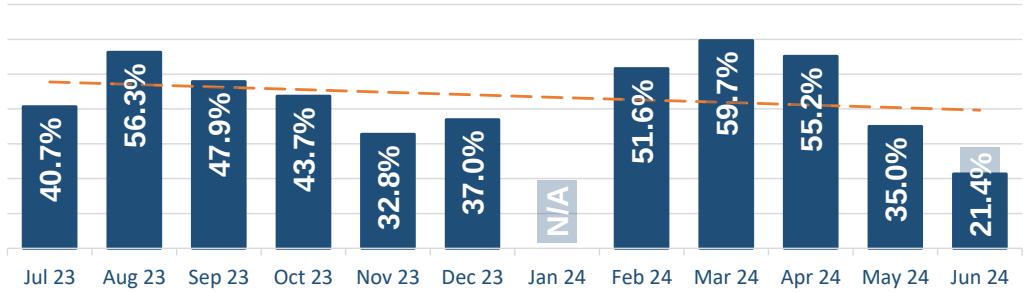


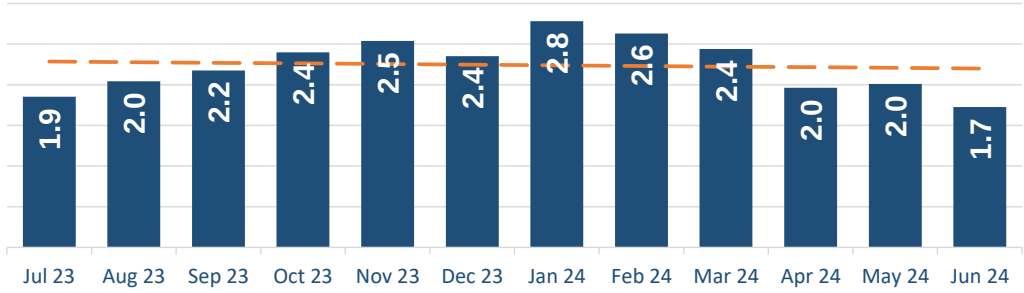


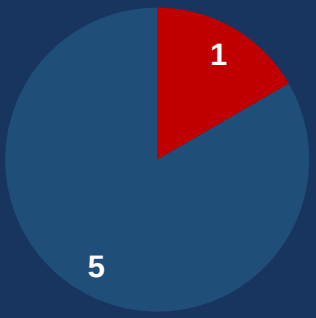
*Rank is based on National HEIW data, where as position data uses BCU methodology

People: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	PFIG	Roster compliance	N/A	TBC	21.4%	
-	PFIG	Open disciplinary cases per 1000 staff	N/A	TBC	1.7	







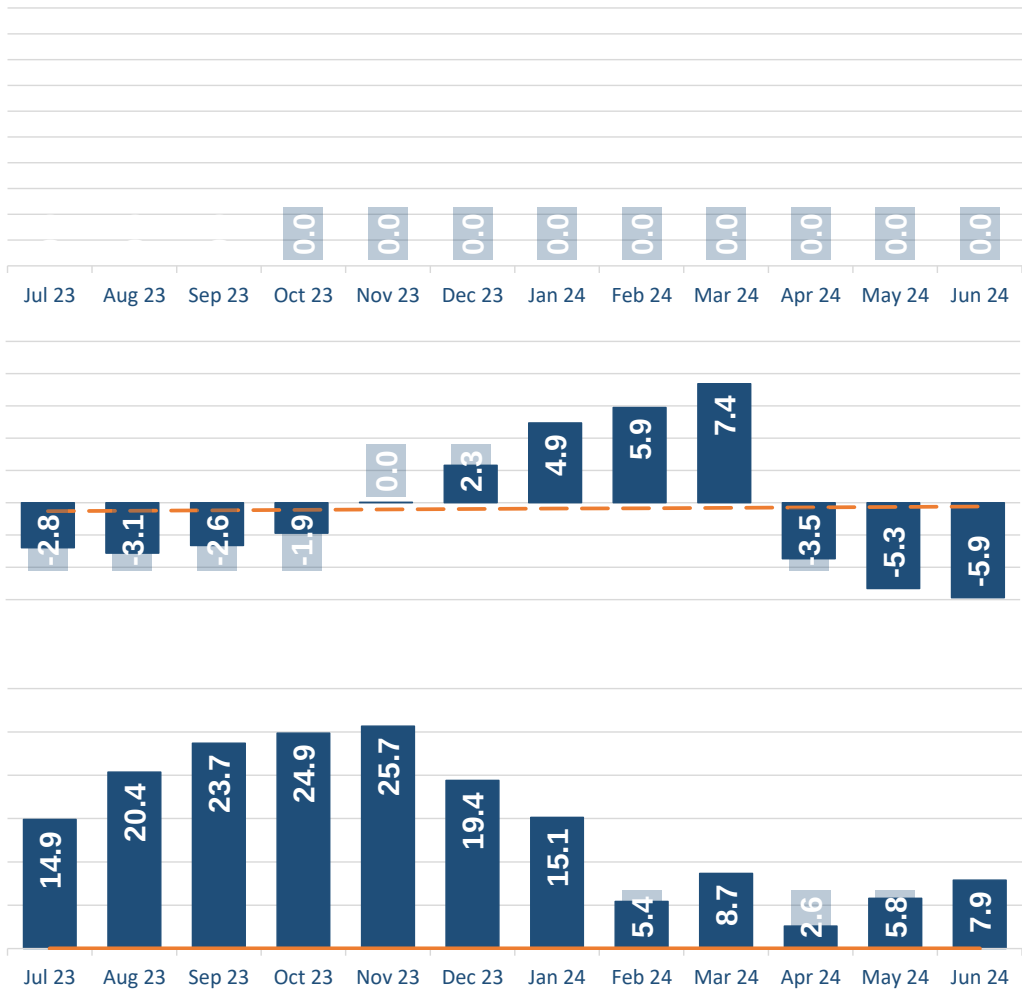
Section 4

Financial Performance

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

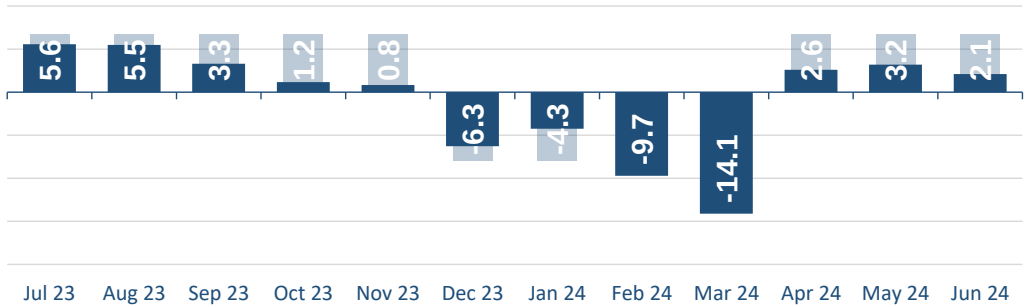
Finance: Performance

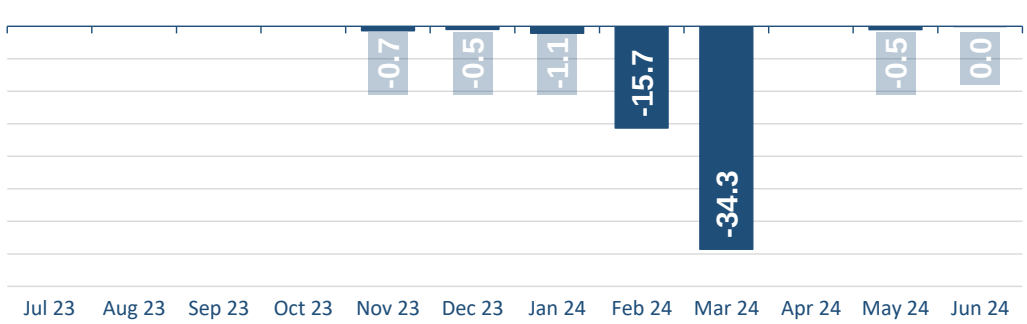
Ref	Cmt	Measure	WG Target	Internal Target	BCU Position	Wales Rank
CRR: 24-05	PFIG	Forecast outturn (£million)	N/A	TBC	0.0	
CRR: 24-05	PFIG	Year to date savings delivery against target (£million)	N/A	TBC	-5.9	
CRR: 24-05	PFIG	Year to date deficit against plan (£million)	N/A	TBC	7.9	



Finance: Performance

Ref	Cmt	Measure	WG Target	Internal Target	BCU Position	Wales Rank
CRR: 24-05	PFIG	In month variance to plan (£million)	N/A	TBC	2.1	
CRR: 24-05	PFIG	Forecast savings delivery against target (£million)	N/A	TBC	-21.5	
CRR: 24-05	PFIG	In year capital expenditure against plan (£million)	N/A	TBC	0.0	





Finance: Performance

BCU Wide and Divisional Positions (Red = overspend against plan)	April £m	May £m	June £m	YTD £m
West IHC	(1.8)	(1.8)	(1.2)	(4.7)
Central IHC	(2.9)	(2.9)	(2.9)	(8.6)
East IHC	(3.3)	(2.7)	(2.6)	(8.6)
Womens	(0.1)	(0.1)	(0.1)	(0.3)
MH & LD	(1.6)	(1.7)	(1.6)	(5.0)
Commissioning Contracts	(1.7)	(1.9)	1.0	(2.7)
ICD Primary Care	0.2	0.6	0.3	1.0
ICD Regional Services	(1.3)	(0.2)	(1.0)	(2.5)
Support Functions & Other Budgets	9.8	7.6	6.2	23.5
BCU Wide	**(2.6)**	**(3.2)**	**(2.1)**	**(7.9)**

Service Performance against Target	Annual			Year to Date		
	Target	Delivery	Delivery v Target (+ve = adverse)	Target	Delivery	Delivery v Target (+ve = adverse)
West Integrated Health Community	8.7	4.7	4.0	2.2	1.3	0.9
Central Integrated Health Community	10.9	4.4	6.6	2.7	1.5	1.2
East Integrated Health Community	11.2	5.8	5.4	2.8	1.5	1.3
MHLD	4.2	7.7	-3.4	1.1	0.5	0.5
Womens Services	1.4	0.1	1.3	0.3	0.0	0.3
Diagnostic and Specialist Clinical Support	2.1	0.7	1.4	0.5	0.2	0.3
Cancer Services	1.6	1.3	0.3	0.4	0.3	0.1
Dental North Wales	0.0	0.0	0.0	0.0	0.0	0.0
Community Dental Sevices	0.2	0.0	0.2	0.0	0.0	0.0
Other Primary Care	0.0	0.0	0.0	0.0	0.0	0.0
Corporate & Support Services	3.7	2.0	1.7	0.9	0.8	0.1
Reserves	4.0		4.0	1.0		1.0
Saving Total	**48.0**	**26.5**	**21.5**	**12.0**	**6.1**	**5.9**

Finance: Performance

B - Agency / Locum (premium) Expenditure - Analysed by Type of Staff		1	2	3	4	5	6	7	8	9	10	11	12		
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total YTD	Forecast year-end position
REF	*TYPE*	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
1	Administrative, Clerical & Board Members	49	47	43	43	31	31	31	31	31	31	31	31	**49**	**430**
2	Medical & Dental	1,489	1,490	1,504	1,504	1,495	1,495	1,495	1,494	1,480	1,480	1,480	1,480	**1,489**	**17,886**
3	Nursing & Midwifery Registered	1,912	1,901	1,901	1,901	1,901	1,901	1,901	1,901	1,901	1,901	1,901	1,901	**1,912**	**22,823**
4	Prof Scientific & Technical	10	10	10	10	10	10	10	10	10	10	10	10	**10**	**120**
5	Additional Clinical Services	19	20	20	20	20	20	20	20	20	20	20	20	**19**	**239**
6	Allied Health Professionals	467	491	500	500	500	500	500	481	481	481	481	481	**467**	**5,863**
7	Healthcare Scientists	25	25	25	25	25	25	25	25	25	25	25	25	**25**	**300**
8	Estates & Ancillary	-1	1	1	1	1	1	1	1	1	1	1	1	**-1**	**10**
9	Students	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**0**
10	TOTAL AGENCY/LOCUM (PREMIUM) EXPENDITURE	3,970	3,985	4,004	4,004	3,983	3,983	3,983	3,963	3,949	3,949	3,949	3,949	3,970	47,671
11	Agency/Locum (premium) % of pay	4.45%	4.42%	4.44%	4.44%	4.41%	4.39%	4.40%	4.38%	4.36%	4.35%	4.36%	4.36%	4.45%	4.39%

The Agency forecast are being reviewed.

Additional Information

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

Produced on behalf of the Health Board by the Performance Directorate and Partners

Introduction to the Integrated Performance Report (IPR)

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

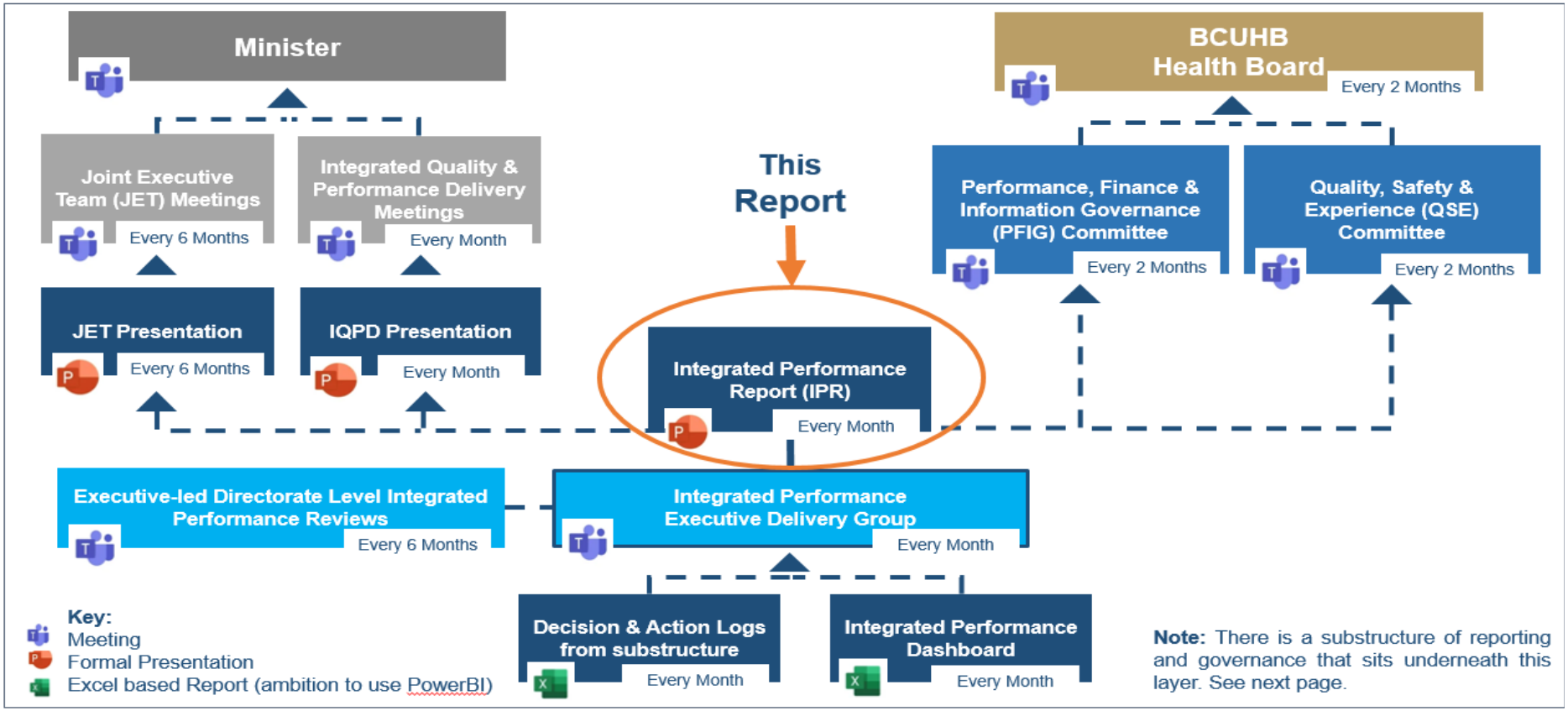
The Integrated Performance Framework (IPF)
The Integrated Performance Framework (IPF) for 2023-2027 was ratified by the Health Board on 28th September 2023. The Framework lays the foundations for an integrated approach to performance monitoring, intelligence, management, assurance and improvement. An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

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

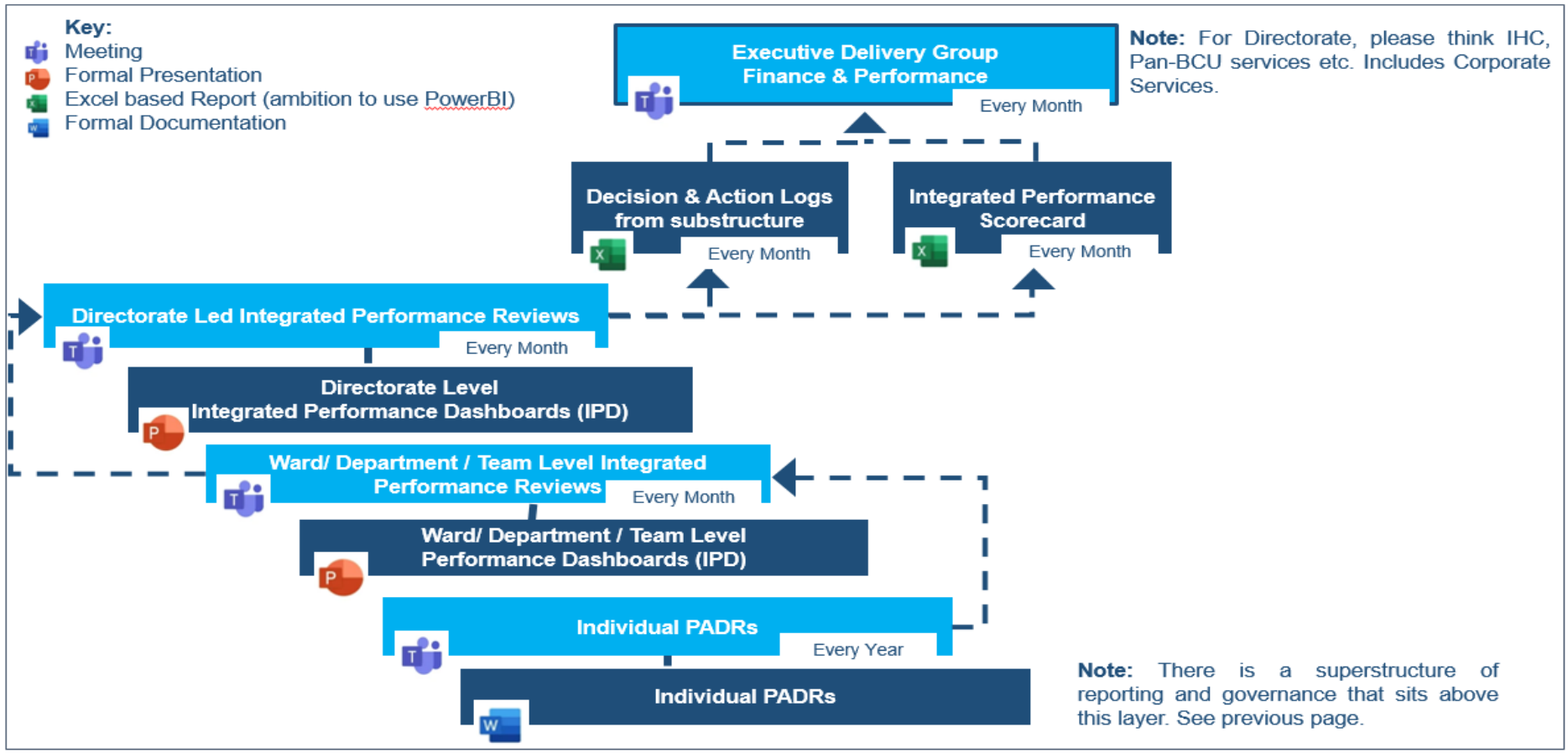
Where does the IPR feature within the Performance Governance Structure?
The Health Board's business rules are designed to highlight potential challenge and provide clear assurance for the Board and Public stakeholders. The IPR as a function of the IPF contains information on all metrics, including those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

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



The IPR and Governance Substructure



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 the Joint Executive Team (JET).
Integrated Performance Scorecards	Summary scorecards for the Integrated Performance Executive Delivery Group *et al.*
Integrated Performance Dashboards	Operational level performance dashboards with drill through capabilities. For the end of month submitted position. There is an ambition for production in PowerBI (produced by Digital, Data & Technology (DDAT) in partnership with the Performance Directorate.
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 and 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.

The Integrated Performance Report
Betsi Cadwaladr University Health Board

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

Our website: www.bcu.wales.nhs.uk

StatsWales: https://statswales.gov.wales/Catelogue/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

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

Produced on behalf of the Health Board by the Performance Directorate and Partners

Abbreviations

Please see below a list of abbreviations commonly found within the report:

A&E	Accident and Emergency
AB	Aneurin Bevan Health Board
ADHD	Attention Deficit Hyperactivity Disorder
ASD	Autistic Spectrum Disorder
BCU/BCUHB	Betsi Cadwaladr University Health Board
C&V	Cardiff and Vale University Health Board
Cmt	committee
CRR	Corporate Risk Register Reference
CTM	Cwm Taf Morgannwg University Health Board
ENT	Ear, Nose, and Throat
GDS	General Dental Services
GP	General Practitioner
HDda	Hywel Dda University Health Board
HEIW	Health Education and Improvement Wales
IHC	Integrated Health Community
LPMHSS	Local Primary Mental Health Support Services
MH&LD	Mental Health and Learning Disabilities
MMR	Measles, Mumps and Rubella
NHS	National Health Service
NR	non-recurrent
PADR	Performance Appraisal and Development Review
PFIG	Performance, Finance, and Information Governance Committee
QSE	Quality, Safety, and Experience Committee
R	recurrent
SB	Swansea Bay University Health Board
SM	Special Measures
WAST	Welsh Ambulance Services NHS Trust
WG	Welsh Government
YTD	year to date

Partners

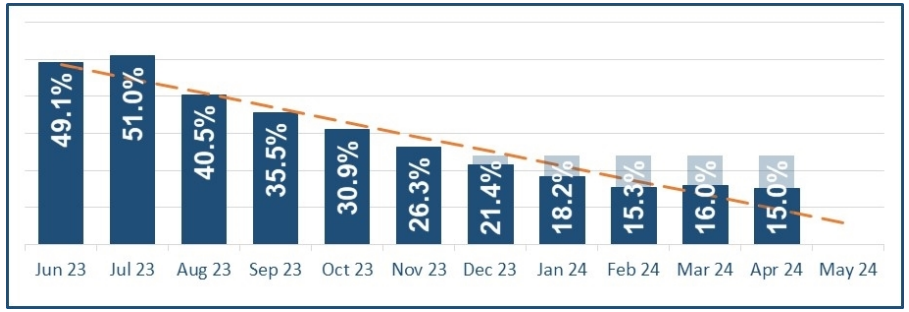
This report has been produced on behalf of the Health Board by the Performance Directorate in partnership with:
- Integrated Health Communities (West, Centre & East)
- Digital, Data & Technology Directorate (DDAT)
- People & Organisational Development Directorate (POD)
- Adult Mental Health & Learning Disabilities Directorate (AMH&LD)
- Children & Young Adolescent Mental Health Services Directorate (CAMHS)
- Women's Services Directorate (WS)
- Public Health
- Finance Directorate
- Office of the Medical Director (OMD)
- Quality & Patient Experience Directorate (Q&PE)
- Equal Opportunities Team
- Risk Management Department
- Corporate Communications Team

...and the following as Senior Responsible Officers for the measures within their respective Executive Portfolios.
- Executive Director of Operations
- Executive Director of Finance
- Executive Director for Public HealthExecutive Director for People & Organisational Development
- Executive Director of Therapies and Health Sciences
- Executive Director of Strategic Planning & Transformation
- Executive Director of Nursing & Midwifery
- Executive Medical Director

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

Clinical Coding Escalation – Highlight Report

Percentage of Episodes Clinically Coded within one reporting month post episode discharge data



Apr 24 IHC data = West = 4.0%, Central = 18.5% and East 25.3%

Theme: Current Status

- *Latest data shows continuation of trend across IHC's with East being less effected by staff turnover during last 12 months*
- *We are moving some trainee posts from West to East to redress the balance of trainee staff to qualified ratio*
- *The recruitment and retention issues affecting coding completeness in BCU is also effecting other Welsh Health Boards. Coding Completeness levels have reduced across Wales but approaches to work prioritisation vary.*

Theme: Impact

- *Recovery plan being developed to work to lower than lower than target level of coding completeness for latter part of 2023/24 and early 2024/25 to avoid further delays to clinical coding. Reduce timescale to achieve Welsh Target by 6 months to 01/01/2025. Investment in agency would further reduce timescale.*
- *Recruitment to Coding Assurance lead role completed, with start date of 19th of August Agreed*
- *Vacancies update – 6 WTE trainee coders started during July 2024*

Theme: Recovery

- *Recovery plan to be presented to Executive team*
- *Invest departmental underspend into agency staffing.*
- *Working with WOD to address recruitment and retention issues*
- *Coding Assurance Lead role will support development of new trainees as they progress*
- *Working with WAPS operation steering group to improve availability of electronic records to enable some remote working opportunities – starting with theatre operation sheets*

Risks and Mitigations

- Loss of further experienced and trained staff, delay in recruitment through Establishment Control process
- Persuing Recruitment & Retention premium to retain coding staff, Increase digital sources of coding to offer remote working for staff out of area

Presenter: Dylan Roberts

Teitl adroddiad: ***Report title:***	Annual IPC Report 2023-24			
Adrodd i: ***Report to:***	QSE Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	15th August 2024			
Crynodeb Gweithredol: ***Executive Summary:***	This annual report relates to the period April 2023 to March 2024 and seeks to provide the Board with assurance that the organisation is meeting its statutory requirements in relation to the management of infection prevention and control in accordance with the Code of Practice for the Prevention and Control of Healthcare Associated Infections, 2014 (the 'Code'). A requirement of the Code is that the Board receives an annual Infection Prevention and Control (IPC) Report consisting of an overview and progress on the infection prevention and control arrangements together with other activities and initiatives. Prevention and control of infection is a high priority for Betsi Cadwaladr University Health Board (BCUHB), with a commitment to preventing all healthcare associated infections (HCAI) by adopting a zero tolerance approach to all avoidable infections.			
Argymhellion: ***Recommendations:***	The Committee is asked to note this report.			
Arweinydd Gweithredol: ***Executive Lead:***	Angela Wood, Executive Director of Nursing and Midwifery			
Awdur yr Adroddiad: ***Report Author:***	Andrea Ledgerton, IPC Team			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☐ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☒ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/ tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				
There is confidence in the data provided in the report however, the pace of learning and improvement remains an area of concern and is a key focus of work. This is being addressed through a range of measures including the actions aligned to Special Measures and the Board Assurance Framework.				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Outcome 4 - Improved access, outcomes and experience for citizens Outcome 5 - Recognition of BCU as a learning and self-improving organisation			

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

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

Infection Prevention and Control Annual Report 2023-24

Infection Prevention and Control Annual Report 2023-24

V 1.5

Table of Contents

Executive Summary

This annual report relates to the period April 2023 to March 2024 and seeks to provide the Board with assurance that the organisation is meeting its statutory requirements in relation to the management of infection prevention and control in accordance with the Code of Practice for the Prevention and Control of Healthcare Associated Infections, 2014 (the 'Code'). A requirement of the Code is that the Board receives an annual Infection Prevention and Control (IPC) Report consisting of an overview and progress on the infection prevention and control arrangements together with other activities and initiatives.

Prevention and control of infection is a high priority for Betsi Cadwaladr University Health Board (BCUHB), with a commitment to preventing all healthcare associated infections (HCAI) by adopting a zero tolerance approach to all avoidable infections.

1.1 Key Achievements and Challenges

Key Achievements 2023/24

- BCUHB had the lowest rate for Methicillin Resistant *Staphylococcus aureus* (MRSA) bloodstream infection (BSI) compared to other Health Boards in Wales. There were 8 cases in 2023/24 compared to 17 the previous year.
- BCUHB 'age standardised' infection rates for the 6 key reportable organisms were below the All Wales average except *E.coli.* Rates were also lower than the previous year for *Clostridioides difficile* (*C.difficile)*, MRSA and Pseudomonas aeruginosa (*P. aeruginosa)* BSI.
- For the latest period of data ending December 2023, all three acute sites in BCUHB achieved the Welsh Health Circular (WHC) prescribing goal to increase or maintain the proportion of antibiotic usage within the WHO Access category to ≥55% of total antibiotic consumption.
- A successful IP Conference was held in October for over 100 delegates.
- The Infection Prevention Team (IPT) have now trained over 550 Infection Prevention (IP) Champions, an increase from 390 in 2022/23.
- The IPT completed and reported on a significant number of regular and ad hoc audits of practice and of the environment in 2023/24. Several of the audit tools were also strengthened to ensure they were in line with the latest national standards.
- A number of successful IP campaigns and awareness events took place this year including participation in World Hand Hygiene Day, International Infection Prevention Week in October 2023 focussing on 'Celebrating the Fundamentals of IP' and the launch of our own 'HABITS' campaign to promote the basic principles of IP and to encourage staff to 'get into the HABIT' of practicing these principles at all times.
- IPC Resource Packs for care homes have been developed in partnership with Public Health Wales to ensure that the care homes have up to date guidance.
- The Authorising Engineer for water in NHS Wales Shared Services Partnership, Specialist Estates Services Team completed their annual review/audit of operational procedures and compliance and reported a compliance rating of Green which maintains the standards set out during the previous year.
- BCUHB's principle recycling and general waste contractor has sent zero waste to landfill in the last twelve months.
- The Health Board's 'de-clutter' campaigns continue to be a great success, encouraging wards and departments to clear clutter and unused items, improving tidiness and easing the cleaning of their areas and supporting our efforts to maintain a safe, clean environment.
- The Operational Estates Department received £300,000 discretionary capital funding within 2022/2023 to improve the hospital environment. A number of areas were improved which included upgrading kitchens and bathrooms and installing new floors and doors. In addition £250k was aligned for improvement of infrastructure and environment within Abergele Hospital.

- During 2023-24 there has been a transition in the software auditing tool used by the Health Board to capture and report on the National Standards of Cleaning from Credits 4 Cleaning (C4C) to 'MICAD'. This should be complete by June 2024.
- In 2023/24, all food outlets scored a 5 star rating in their food safety assessment by the Food Standards Agency.
- A new electronic Track & Traceability system was installed in all three Sterile Service Departments (SSD's) across BCUHB in 2023.
- The plan at Wrexham Maelor Hospital (WMH) to undertake decontamination processes for gastro/endoscopy in a refurbished area in the modular theatres is progressing well with four new Endoscopy Washer Disinfectors (EWD's) installed and a plan to open June 2024.

Key Challenges

- Antimicrobial resistance: In May 2023, it was reported that WMH had the highest rates in Welsh hospitals of resistance to key antimicrobials used in the empiric treatment of *Escherichia coli (E. coli)* blood stream infection.
- Norovirus: During 2023/24, there were 615 laboratory confirmed cases of Norovirus compared to 451 in 2022/23 (an increase of 36%), with more cases being seen all year round, as well as the normal winter peak. There were 37 outbreaks in hospitals across BCUHB creating additional pressure on siderooms and patient flow.
- *Bordetella pertussis (B. pertussis)*: In 2023/24, between the 1st September 2023 and 9th April 2024, BCUHB reported 41 cases of *B. pertussis* compared to just 1 the previous year.
- Blood culture contamination rate: in 2023/24, 3.6% (399/10983) of all blood cultures taken were classed as contaminants: 3.1% at Ysbyty Gwynedd (YG), 4.5% at Ysbyty Glan Clwyd (YGC) and 3.3% for WMH. The national average is 2-3%.
- An internal audit report for water policy provided only 'limited' assurance. The Water Safety Group (WSG) have developed a number of actions to improve compliance including a new BCUHB Water Safety Training Programme for non-estates staff, which is currently being mobilised across the Health Board.
- There have been challenges with the use of hypochlorous acid misting for high level disinfection and it has been out of use since September 2023. Work is ongoing to try to resolve the remaining issues.
- Significant funding will be required in the near future to relocate the endoscopy decontamination unit at YGC.
- BCUHB is the only Health Board in Wales still not adhering to Welsh Health Technical Memorandum (WHTM) 01-06 in relation to the decontamination of choledochoscopes. Up to date quotes have been obtained for Integrated Health Communities (IHCs) to progress business cases.

2.0 Infection Prevention and Control Governance and Delivery Frameworks

The Strategic Infection Prevention Group (SIPG) is authorised by the Quality, Safety and Experience Committee and the Board to support safety throughout BCUHB by monitoring, directing and ensuring assurance of effective Infection Prevention (IP) arrangements throughout the Health Board; and the assurance of compliance with external standards for healthcare providers. It met every month in 2023/24 but the meeting in May was shortened due to the industrial action taking place that week. Additional meetings also took place in February and March to review meeting templates and format and discuss the gram negative blood stream infection (BSI) issue in more detail.

SIPG reports through the Group Chair, the Executive Director of Nursing and Midwifery, to the Executive Quality Delivery Group, Quality Safety and Experience Committee and onwards to the Executive Board. See Appendix A.

Local Infection Prevention Groups (LIPGs) function within each community (Central, East, and West) and are accountable to SIPG.

Groups reporting in to the Infection Prevention Sub Group include:

- The Decontamination Group
- The Antimicrobial Stewardship Group
- The Corporate-Led Healthcare Associated Infection (HCAI) Review Group
- The Water Safety Group
- The Ventilation Safety Group
- The Beds and Mattresses Group
- The Environmental Steering Group
- The Strategic Immunisation Group

The Infection Prevention and Control Team

The Executive Director of Nursing is the appointment lead with Board responsibility for IP. The main operational team is led by the Director of Nursing for Infection Prevention and Decontamination.

Within the IPT there are 2.0WTE Decontamination staff who are specifically designated for the provision of decontamination advice across BCUHB; namely the Decontamination Advisor supported by the Decontamination Sister.

A Consultant Antimicrobial Pharmacist reports to the Director of Infection Prevention and Decontamination but this post is currently vacant following internal promotion in January 2024. 6.3WTE Antimicrobial Pharmacists are assigned to support the antimicrobial stewardship programme reporting officially through the Pharmacy Team, although some of these posts have also been vacant this year due to secondment and inability to recruit.

The IP Nursing Team is further supported by a part time Information Technology Analyst who sits within the Informatics Team and a Healthcare Associated Infection (HCAI) Epidemiologist employed by Public Health Wales (PHW), however, this resource is limited.

The IP Nurses provide routine service during week days 8:30-17:00 and an on call service at weekends and bank holidays from 09:00-17:00, with the on call Public Health Wales Microbiologists providing cover outside of these hours.

Due to some ongoing long-term sickness and inability to recruit to senior posts, a risk assessment scoring 12 is still in place (see Appendix B).

Public Health Wales Consultant Microbiologists

The microbiologists working within BCUHB are employed by PHW of which just 1.5 WTE were directly employed in 2023/24; with the others working as agency or bank employees due to longstanding difficulties in recruitment. Physician Associates and Senior Biomedical Scientists support the work programme. Recruitment to current vacancies within the team continues but with limited success and work is ongoing towards developing a microbiologist trainee programme in North Wales to attract others. There is a risk assessment relating to the low numbers of Consultant Microbiologists supporting BCUHB currently scoring 6 (see Appendix B).

Infection Prevention and Control Policies and Guidance

A comprehensive suite of pan-BCUHB infection prevention written control documents, e.g. policies, protocols, standard operating procedures (SOPs) and guidelines are available on the Health Board's intranet site. Infection prevention written control documents reflect relevant current legislation, Welsh and UK guidance, Welsh Health Circulars (WHCs), published professional guidance and best practice.

Excellent progress has been made in the review of draft or out of date policies, protocols and standard operating procedures and there are currently no existing infection prevention written

control documents that exceed their review dates. Furthermore, a number of new protocols and standard operating procedures have been developed according to Health Board need.

New policies and protocols in 2023/24 included:

- Protocol for the Identification and Management of Group A Streptococcus
- Standard Operating Procedure for the Decontamination of Flexible Nasendoscopes including Double Sink Manual Cleaning and the "Tristel 3-stage Wipe" System.
- BCUHB Standard Operating Procedure for the use of the 'MiniPro' Protein Detection System for Endoscopes only
- Protocol for Blood Culture Sampling
- Protocol: Which clean do I mean?

New policies and protocols planned for 2024/25 include:

- An overall Strategic Infection Prevention Policy (awaiting publication of the new Code of Practice)
- Tuberculosis protocol
- Glycopeptide-resistant Enterococci
- HCAI surveillance and national reporting
- Diphtheria protocol
- Fluid balance measurement protocol

3.0 Compliance with Welsh Health Circular 2023/031: AMR & HCAI IMPROVEMENT

GOALS FOR 2023-24, published August 2023

Many of these improvement goals remained unchanged from the previous year. The aim is to combat antimicrobial resistance through lowering the burden of infections, improving treatments and optimising our use of antimicrobials in humans.

Goal number	Goal	BCUHB Compliance
1	To achieve a minimum 25% reduction in antimicrobial usage in the community from the 2013/14 baseline.	For 2022/23, BCUHB did not achieve the 2.5% year-on-year reduction required to meet the minimum 25% reduction rate by 2023/24. The rate achieved at the end of 2022/23 represented a 20.4% reduction in total antimicrobial volume by the HB against the baseline. It is uncertain if BCUHB will meet the 25% reduction rate for primary care, with one year of the target remaining. A final report from PHW for financial year 2023/24 remains outstanding.
2	Prescribers should document the indication and appropriate clinical diagnosis codes for all antimicrobial prescriptions	
3	Primary care clusters should ensure urgent dental cases should be seen by dental services rather than General Medical Services.	
4	Increase to or maintain the proportion of antibiotic usage within the WHO Access category to ≥55% of total antibiotic consumption (as WHO Defined Daily Doses).	For the latest period of data ending December 2023, all three acute sites in BCUHB achieved this prescribing goal. (YG: 57.5%, YGC: 59.8%, WM: 59.3%)
5	All health boards and NHS trusts will support the implementation of antimicrobial stewardship interventions	Ongoing, driven by the Antimicrobial Stewardship Group.

A summary of performance for BCUHB with Improvement Goals 6-9 is provided in the table below. The columns display the target number/ rate for BCUHB, then BCUHB's performance in 2022/23 and in 2023/24 for comparison, and the All Wales performance (average) in blue. The final column shows the 'age standardised rates' for 2023/24; this data is produced just once per year by PHW. In BCUHB all rates reduce when this is calculated because of its high elderly population compared to other Health Boards. When data is 'age standardised', all BCUHBs infection rates were below the average for Wales in 2023/24 except for *E. coli.*

Improvement Goal	Target	BCUHB performance 2022/23 (crude rate)	BCUHB performance 2023/24 (crude rate)	All Wales performance 2023/24 (i.e. average)	BCUHB 'age standardised' infection rates 2023/24
6. E.coli: Reduce the annual incidence of *E. coli* BSI to below 67 cases per 100,000.	n~471 Rate: 67	n~511 Rate: 72.6	n~548 ↑ Rate: 79.6	Rate: 72.6	Rate: 73.8
7. Klebsiella species: Reduce the annual incidence of by 10% against 2017-18 figures (n~115).	n~103	n~144 Rate: 20.4	n~156 ↑ Rate: 22.7	Rate: 23.5	Rate: 21.02
P. aeruginosa: Reduce the annual incidence by 10% against 2017-18 figures (n~31).	n~27	n~38 Rate: 5.4	n~32 ↓ Rate: 4.6	Rate: 4.6	Rate: 4.26
8. C.difficile: Reduce the annual incidence to 25 cases per 100,000 or below.	n~175 Rate: 25	n~301 Rate: 42.8	n~287 ↓ Rate: 41.7	Rate: 38.9	Rate: 38.59
9. S. aureus: Reduce the annual incidence of Staphylococcus aureus BSI to 20 cases per 100,000 or below.	Rate: 20	n~185 Rate: 26.3	n~180 ↓ Rate: 26.1	Rate: 27.4	Rate: 23.71
MRSA: Zero tolerance of MRSA BSI	n~0	n~17 Rate: 2.42	n~8 ↓ Rate: 1.16	Rate: 1.82	Rate: 1.11

4.0 Mandatory Reporting of Health Care Associated Infections

4.1 The Six Key Performance Indicators

In 2023/24, BCUHB's reported cases were again over trajectory for all mandatory organisms, however, even using using crude data infection rates were lower than the All Wales average for Methicillin Resistant *Staphylococcus aureus* (MRSA) and Methicillin Sensitive *Staphylococcus aureus* (MSSA) BSI, and lower than the previous year for *Clostridiodes difficile (C. difficile)*, MRSA and *Pseudomonas aeruginosa* (*P. aeruginosa)* BSI.

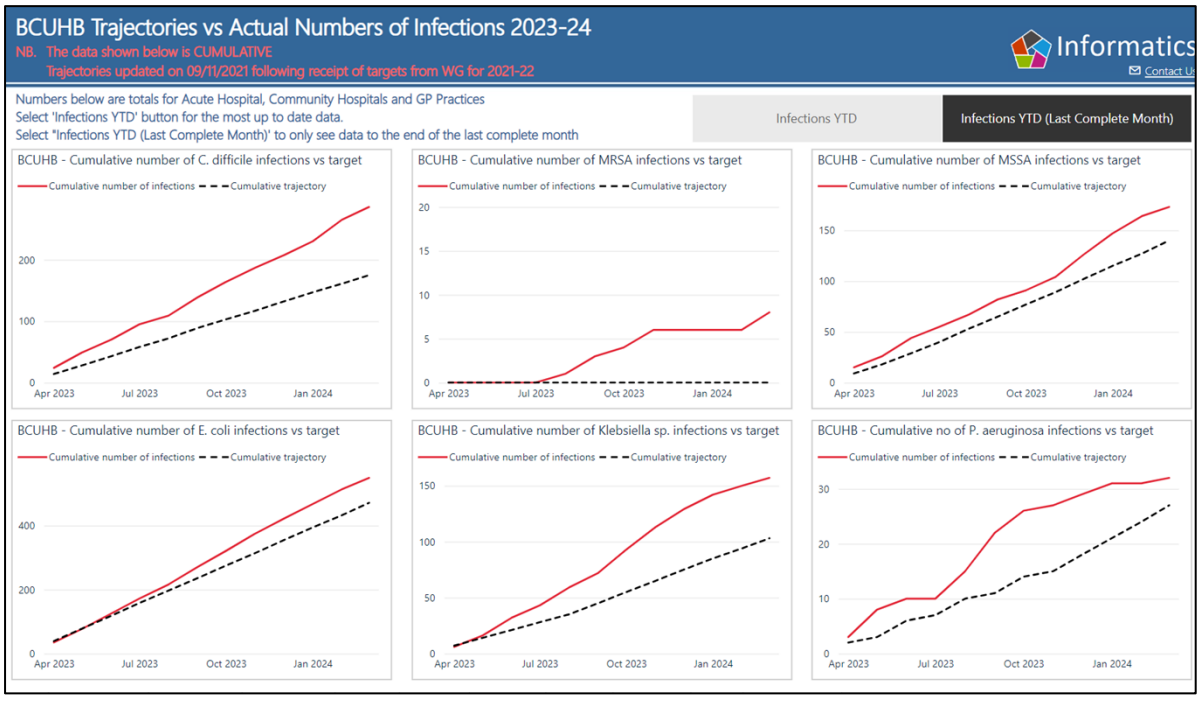
The table below illustrates the crude rate per 100,000 population for the 6 key Health Boards in Wales:

Table 1. Current FY rate per 100,000 population of specimens by HB, Apr - Mar 24

Additional filters for Table 1.
Select month or FY: Current FY
Select organism group: All organisms
< than same period last FY
= same period last FY
> than same period last FY

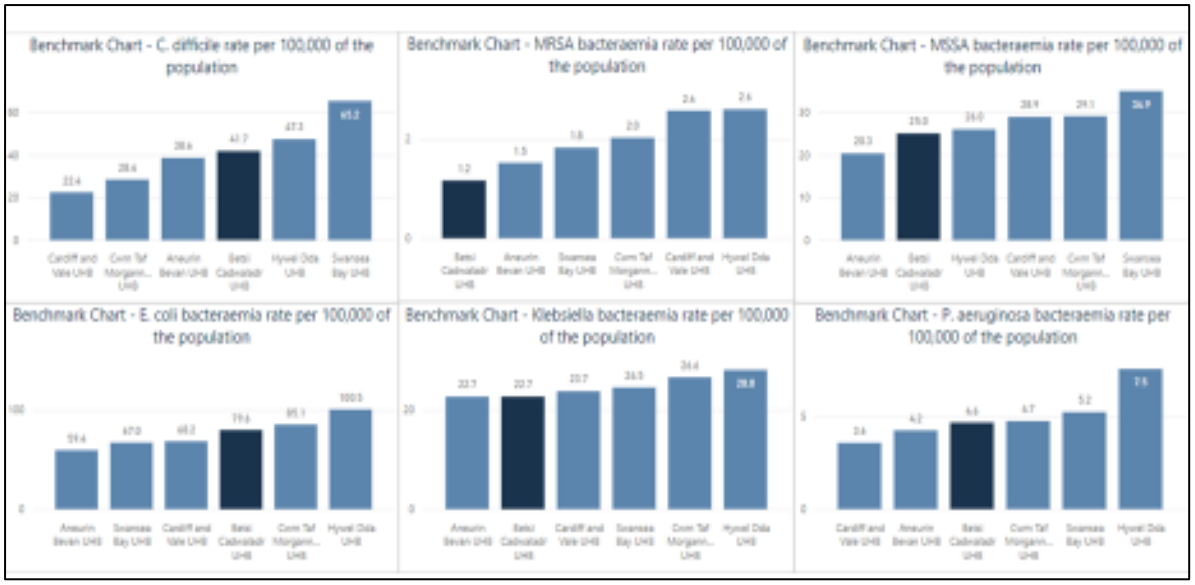
	C. difficile	MRSA bacteraemia	MSSA bacteraemia	E. coli bacteraemia	Klebsiella sp bacteraemia	P. aeruginosa bacteraemia
Aneurin Bevan UHB	38.55	1.52	20.29	59.35	22.66	4.23
Betsi Cadwaladr UHB	41.7	1.16	24.99	79.63	22.67	4.65
Cardiff and Vale UHB	22.35	2.57	28.88	68.24	23.74	3.56
Cwm Taf Morgannwg UHB	28.38	2.03	29.05	85.13	26.57	4.73
Hywel Dda UHB	47.26	2.6	25.97	100.49	28.05	7.53
Powys THB	18.67	0	0.75	1.49	0	0
Swansea Bay UHB	65.2	1.83	34.95	67.02	24.51	5.22
Velindre NHST						
Wales	38.89	1.82	25.61	72.61	23.5	4.63

The graphs below illustrates BCUHB trajectories versus actual numbers of infections in 2023/24:



Using 'crude' data, BCUHB's performance at the end of 2023/24 in comparison with the 6 other main Welsh Health Boards was ranked:
1st for MRSA,
2nd for MSSA and *Klebsiella species (Klebsiella spp.)*,
3rd for *P. aeruginosa* and
4th for *C. difficile* and *E. coli*.

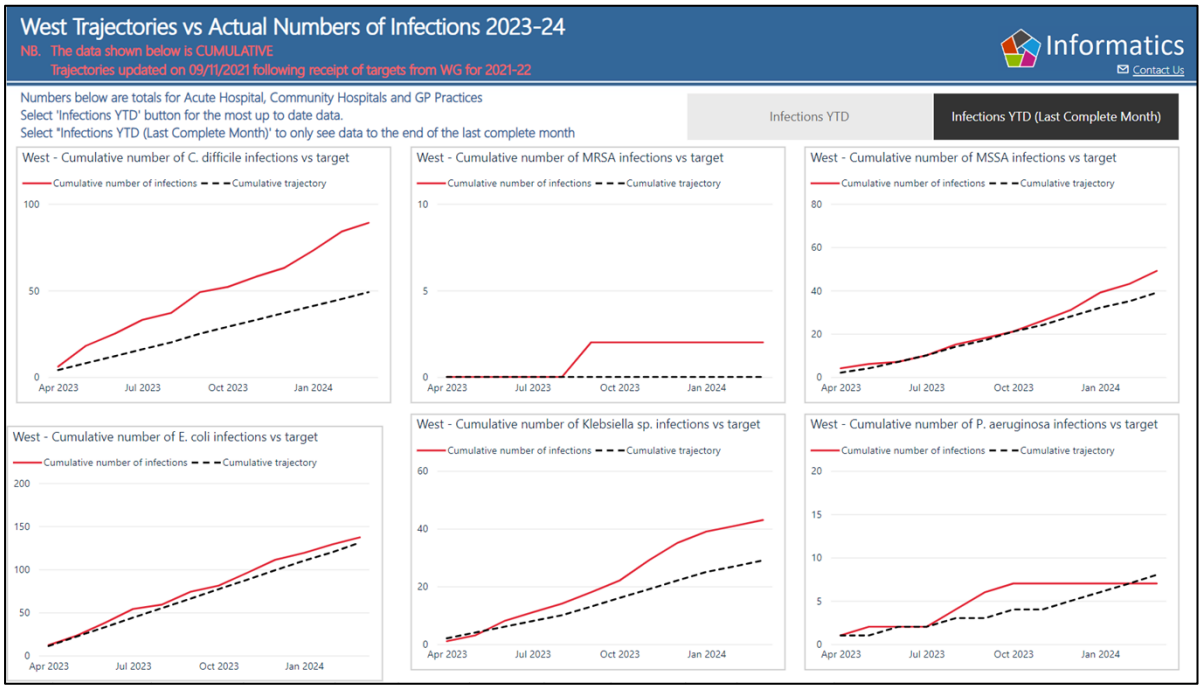
In comparison with the other Health Boards, BCUHB's position this year has improved in relation to MRSA (BCUHB was actually 4th in 2023/23) and *Klebsiella spp.* (BCUHB was 3rd in 2022/23) and is unchanged for the other 4 organisms.



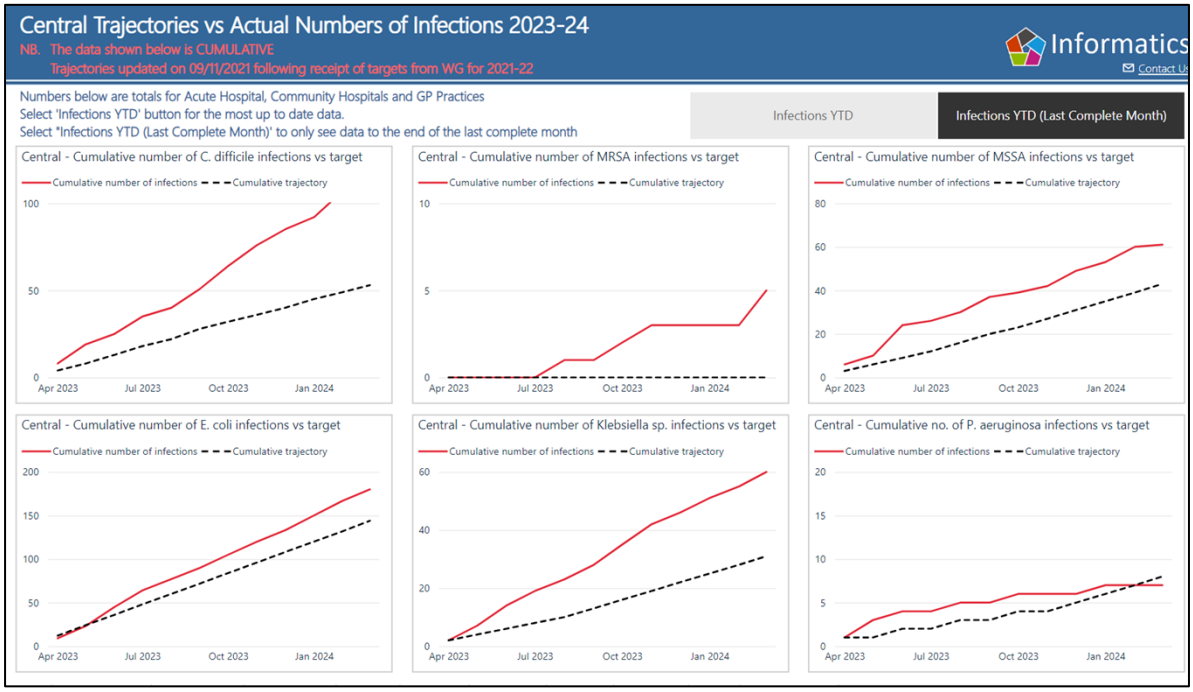
However, using 'age standardised' data, BCUHBs performance at the end of 2023/24 in comparison with other Welsh Health Boards was ranked:
1st for MRSA and *Klebsiella spp.*
2nd for *P. aeruginosa,*
3rd for MSSA, C.difficile and E.coli.

Compliance with trajectories in each of the three healthcare communities is illustrated below.

Data for West



Data for Centre



Data for East

4.2 Post Infection Reviews

All NHS organisations are required to complete a Post Infection Review (PIR) for key healthcare associated infections. Within BCUHB the target is to convene a multi-disciplinary team meeting within 72 hours of the reported result to undertake an initial review of the case and determine if it was unavoidable or avoidable.

Action plan development addresses any required recommendations to prevent reoccurrence and enhance clinical practice and learning is shared across the organisation.

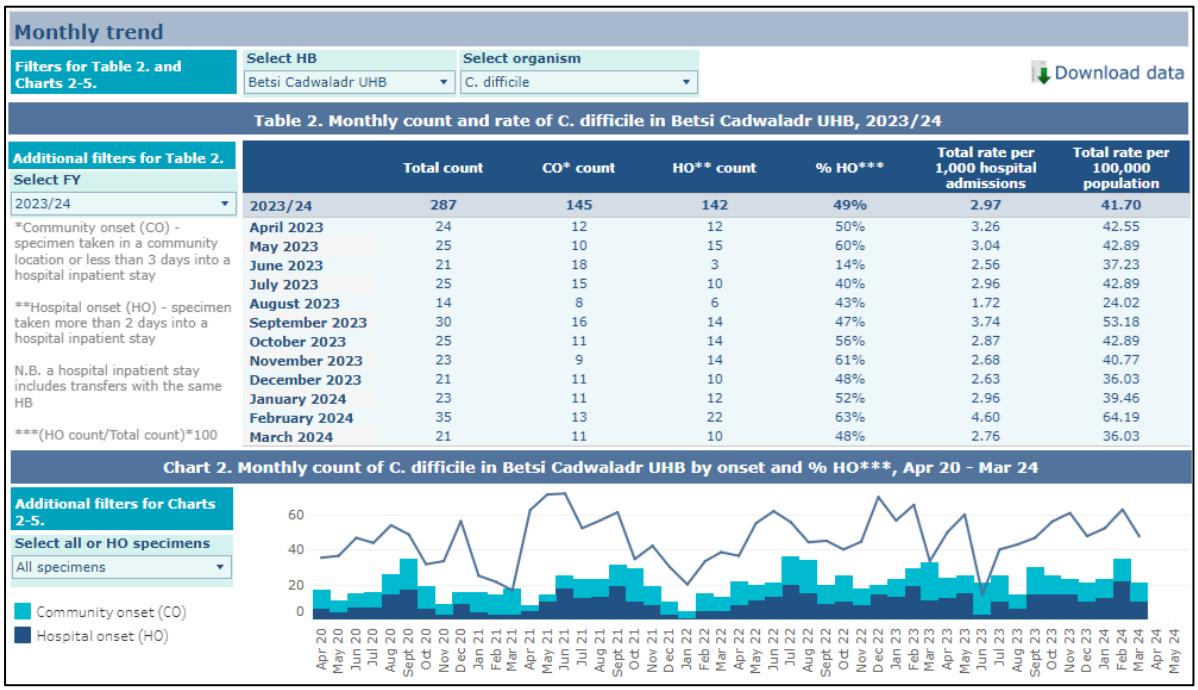
The Datix system is utilised by Ward Managers to upload the completed PIR document.

Each of the three IHCs selects two cases to present to the monthly Corporate HCAI Review meetings for wider learning across the organisation.

The IP team carry out 'Deep dives on each of the key mandatory infections to help identify trends and key learning to take forward. This is also presented for discussion at SIPG meetings.

4.3 Clostridiodes difficile Infection

In 2023/24, BCUHB reported 287 cases (rate of 41.7) compared to 301 (rate of 42) in 2022/23. The overall rate for Wales also increased from 37 to 38.9.



Monthly trend

Filters for Table 2. and Charts 2-5.

Select HB: Betsi Cadwaladr UHB

Select organism: C. difficile

Download data

Table 2. Monthly count and rate of C. difficile in Betsi Cadwaladr UHB, 2023/24

Additional filters for Table 2.

Select FY: 2023/24

*Community onset (CO) - specimen taken in a community location or less than 3 days into a hospital inpatient stay

**Hospital onset (HO) - specimen taken more than 2 days into a hospital inpatient stay

N.B. a hospital inpatient stay includes transfers with the same HB

***(HO count/Total count)*100

	Total count	CO* count	HO** count	% HO***	Total rate per 1,000 hospital admissions	Total rate per 100,000 population
2023/24	287	145	142	49%	2.97	41.70
April 2023	24	12	12	50%	3.26	42.55
May 2023	25	10	15	60%	3.04	42.89
June 2023	21	18	3	14%	2.56	37.23
July 2023	25	15	10	40%	2.96	42.89
August 2023	14	8	6	43%	1.72	24.02
September 2023	30	16	14	47%	3.74	53.18
October 2023	25	11	14	56%	2.87	42.89
November 2023	23	9	14	61%	2.68	40.77
December 2023	21	11	10	48%	2.63	36.03
January 2024	23	11	12	52%	2.96	39.46
February 2024	35	13	22	63%	4.60	64.19
March 2024	21	11	10	48%	2.76	36.03

Chart 2. Monthly count of C. difficile in Betsi Cadwaladr UHB by onset and % HO***, Apr 20 - Mar 24

Additional filters for Charts 2-5.

Select all or HO specimens: All specimens

Community onset (CO)

Hospital onset (HO)

For *C.difficile*, deep dives were fully completed for 96% of cases.

- 67% had had a hospital stay in the last 12 months.
- 72% had received antibiotics in the last 3 months.
- 65% of patients were on Protein Pump Prohibitors (PPIs) and 11% had been on laxatives.
- 56% of cases were female.
- Just over half (54%) started with symptoms in the community.
- 13% of cases were a relapse or reoccurrence whereby faecal transplant should be considered. Each IHC now has a named lead for carrying out faecal transplants so they are not just relying on the service in West. In 2024, the IPT are looking to establish a nurse-led service to make this service more accessible and reduce waiting times.

In 2023/24 there were 8 outbreaks associated with *C.difficile*. One was a level 2 outbreak in Central involving 34 patients running from May – August 2023; 21 cases were genomically linked.

There were also 11 areas with Periods of increased incidence (PIIs) where additional precautions and monitoring were introduced. In June 2023, the Medical Director wrote to all clinical leads to ask them to provide strong visible leadership and a clean environment to help reduce *C.difficile* numbers.

4.4 Staphylococcus aureus Blood Stream Infections

In 2023/24, BCUHB reported 180 cases (rate of 26.1), a slight decrease from 2022/23 when there were 185 cases (rate of 26.3).

The overall rate for Wales increased during this period from 26.3 to 27.5.

Monthly trend

Filters for Table 2. and Charts 2-5.

Select HB: Betsi Cadwaladr UHB

Select organism: S. aureus bacteraemia

Download data

Table 2. Monthly count and rate of S. aureus bacteraemia in Betsi Cadwaladr UHB, 2023/24

Additional filters for Table 2.

Select FY: 2023/24

*Community onset (CO) - specimen taken in a community location or less than 3 days into a hospital inpatient stay

**Hospital onset (HO) - specimen taken more than 2 days into a hospital inpatient stay

N.B. a hospital inpatient stay includes transfers with the same HB

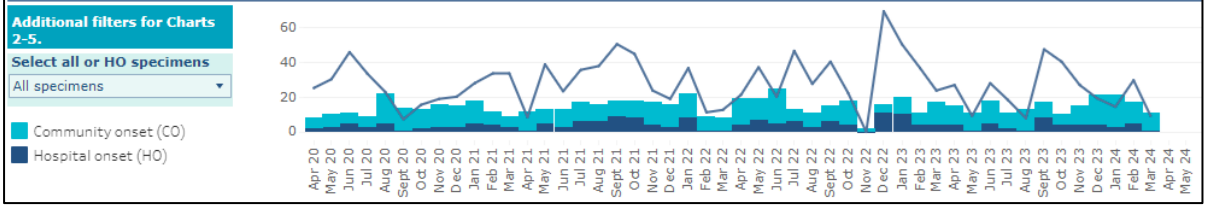
***(HO count/Total count)*100

	Total count	CO* count	HO** count	% HO***	Total rate per 1,000 hospital admissions	Total rate per 100,000 population
2023/24	180	138	42	23%	1.86	26.16
April 2023	15	11	4	27%	2.04	26.59
May 2023	11	10	1	9%	1.34	18.87
June 2023	18	13	5	28%	2.19	31.91
July 2023	11	9	2	18%	1.30	18.87
August 2023	13	12	1	8%	1.60	22.30
September 2023	17	9	8	47%	2.12	30.14
October 2023	10	6	4	40%	1.15	17.16
November 2023	15	11	4	27%	1.75	26.59
December 2023	21	17	4	19%	2.63	36.03
January 2024	21	18	3	14%	2.70	36.03
February 2024	17	12	5	29%	2.23	31.18
March 2024	11	10	1	9%	1.45	18.87

Chart 2. Monthly count of S. aureus bacteraemia in Betsi Cadwaladr UHB by onset and % HO***, Apr 20 - Mar 24

Additional filters for Charts 2-5.

Select all or HO specimens: All specimens



Methicillin Resistant *Staphylococcus Aureus*

BCUHB reported 8 cases in 2023/24 compared to 17 in 2022/23. The rate was 1.16 which was below the All Wales rate of 1.82. There were no outbreaks recorded.

Of the 8 cases, 5 were community onset, 3 were hospital onset.

Deep dives were completed for 7 of the 8 cases, 5 males and 2 females.

- 1 patient was from a nursing home and 1 of no fixed abode, the others from a private address.
- 5 had been in hospital in the last 12 months.
- 5 had a healthcare intervention in the last 7 days.
- 5 patients had a medical device (e.g. urinary catheter, vascular cannula) inserted in the last 3 months.
- 4 had had a wound in the last 6 months.
- 4 of the 7 patients had community onset infection, 3 had hospital onset but 6 of the 7 were healthcare related.
- In only 1 case was there full compliance with the blood culture pack documentation.
- 4 had MRSA from another specimen site before this BSI.
- 6 of the 7 were classed as avoidable, 1 unavoidable.
- The source of the infection was urinary tract for 3, skin and soft tissue for 2, device related for 1 and unknown for 1.

Methicillin Sensitive *Staphylococcus Aureus* Blood Stream Infections

There was little change in 2023/24 compared to 2022/23; BCUHB reported 172 cases in 2023/24 compared to 171 in 2022/23.

The rate was 24.9 which was lower than All Wales rate of 25.6.

Of the 172 cases, 133 were community onset, 39 (23%) were hospital onset.

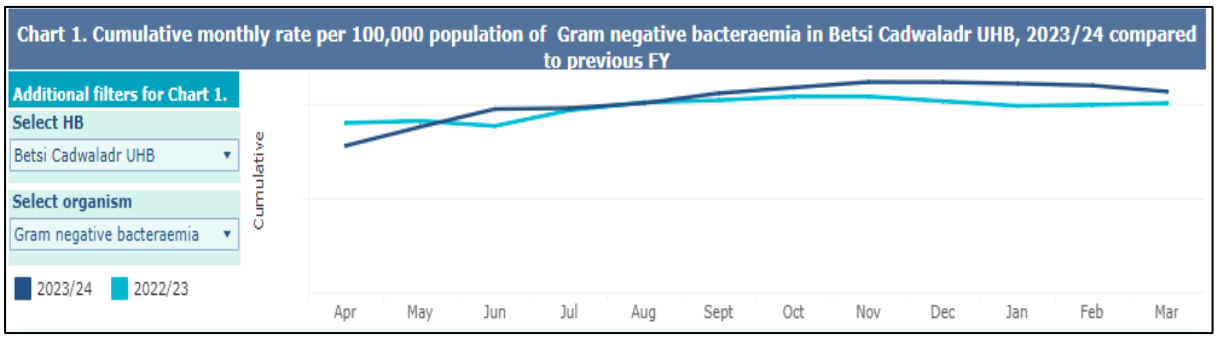
From the deep dive data completed on 170 cases:

- 41% had a hospital stay in the last 12 months.
- 31% had a healthcare intervention in the last 7 days.
- 31% had a medical device in the last 3 months.
- 32% had a wound in the last 6 months.
- Only 29% had full compliance with the blood culture pack documentation.
- 79% had community onset, 19% hospital onset (2% not answered).

- 56% had MSSA from another specimen site before this BSI
- 14% were classed as avoidable, 84% unavoidable (2% undetermined).
- The top three sources of the BSI was skin and soft tissue (36%) followed by unknown (16%) and then urinary tract (13%).
- 79% were healthcare associated.

4.5 Gram negative blood stream infections (GNBSIs)

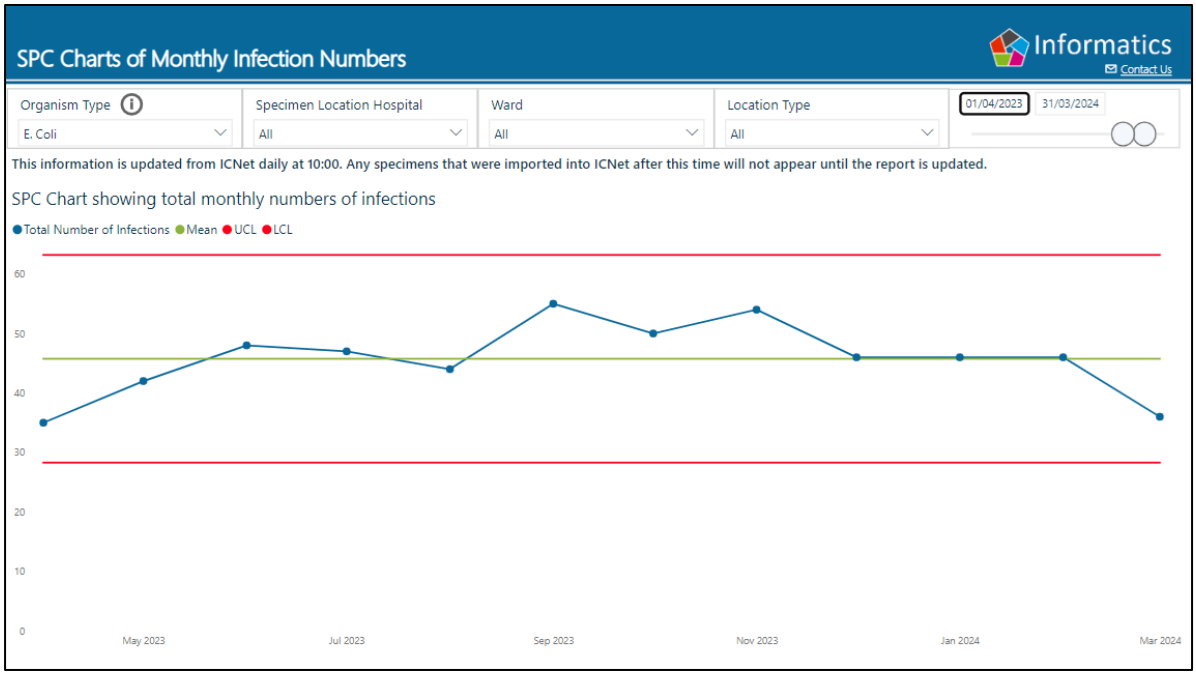
Gram negative bacteria are the leading cause of healthcare associated BSI. *E.coli* (most common), *Klebsiella spp.* and *P. aeruginosa* account for approx. 72% of all GNBSIs.
In 2023/24 the rate of gram negative BSIs was 106.9 per 100,000 population which was 6% higher than the previous year.



There was an increase in *E.coli* and *Klebsiella spp.* infections but a decrease for *P. aeruginosa.*

Escherichia coli Blood Stream Infections

In 2023/24 the *E. coli* BSI rate increased from 72.6 to 79.6 per 100,000 population, which was higher than the All Wales rate of 72.6.
The chart below illustrates the total number of cases per month for the last 12 months. Higher numbers of cases were seen towards the end of 2023 but there has been a number of initiatives introduced recently focusing on reducing catheter associated urinary tract infections (CAUTI) and it is thought this is starting to make a difference to the *E. coli* infection rate.



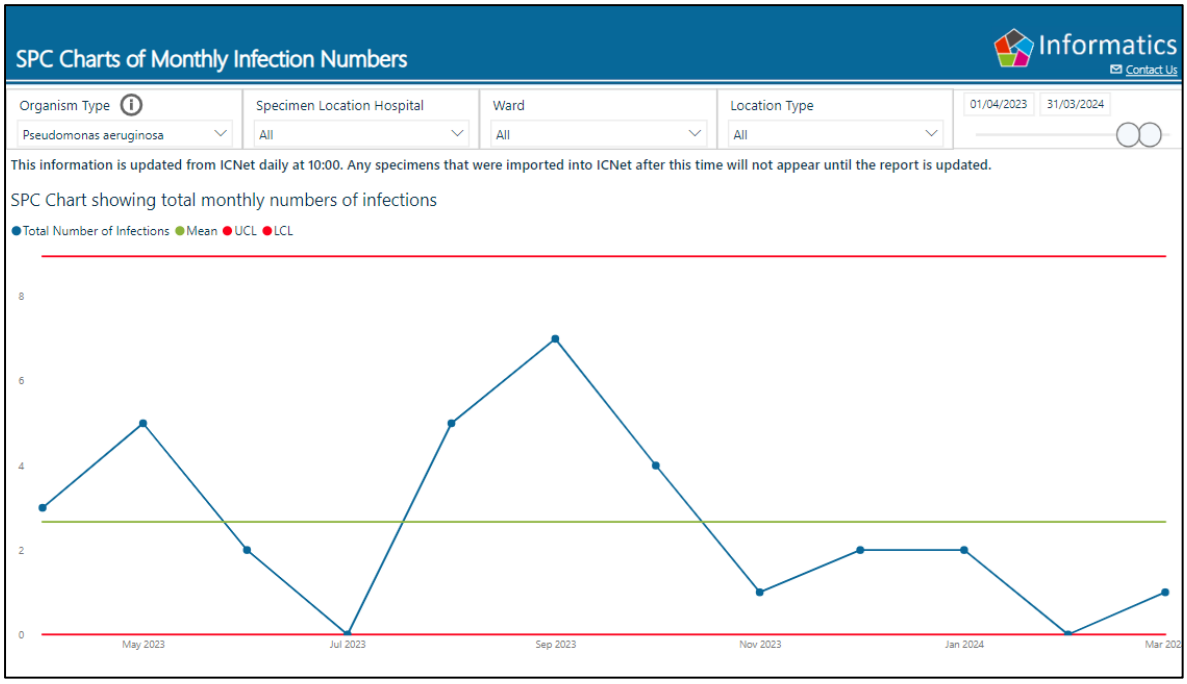
531 cases had deep dives completed on them:

- 13% were from nursing or residential homes.
- 52% female, 48% male.
- 46% had a hospital stay in the last 12 months.
- 33% had had a healthcare intervention in the last 7 days.
- 34% had a medical device in the last 3 months.
- 13% had a wound in the previous 6 months.
- 22% had full compliance with the blood culture pack documentation.
- 77% had community onset, 20% hospital (3% not answered).
- 54% had E.coli from another specimen site before this BSI.
- 21% had antibiotic resistance reported.
- 10% were classed as avoidable, 87% unavoidable, 3% undetermined.
- The top three sources of the BSI was urinary tract (63%) followed by hepatobiliary (13%) and unknown (5%).
- 15% were classed as healthcare associated, 81% not, 4% undetermined.

***Pseudomonas aeruginosa* (*P. aeruginosa*) Blood Stream Infections**

In 2023/24 the *P. aeruginosa* BSI rate fell from 5.4 to 4.6 per 100,000 population, which was the same as the All Wales rate.

The chart below illustrates the total number of cases per month for the last year. Again, as with *E. coli*, case numbers of *P. aeruginosa* have been lower in the last few months.



Deep dives were completed on 27 infections:

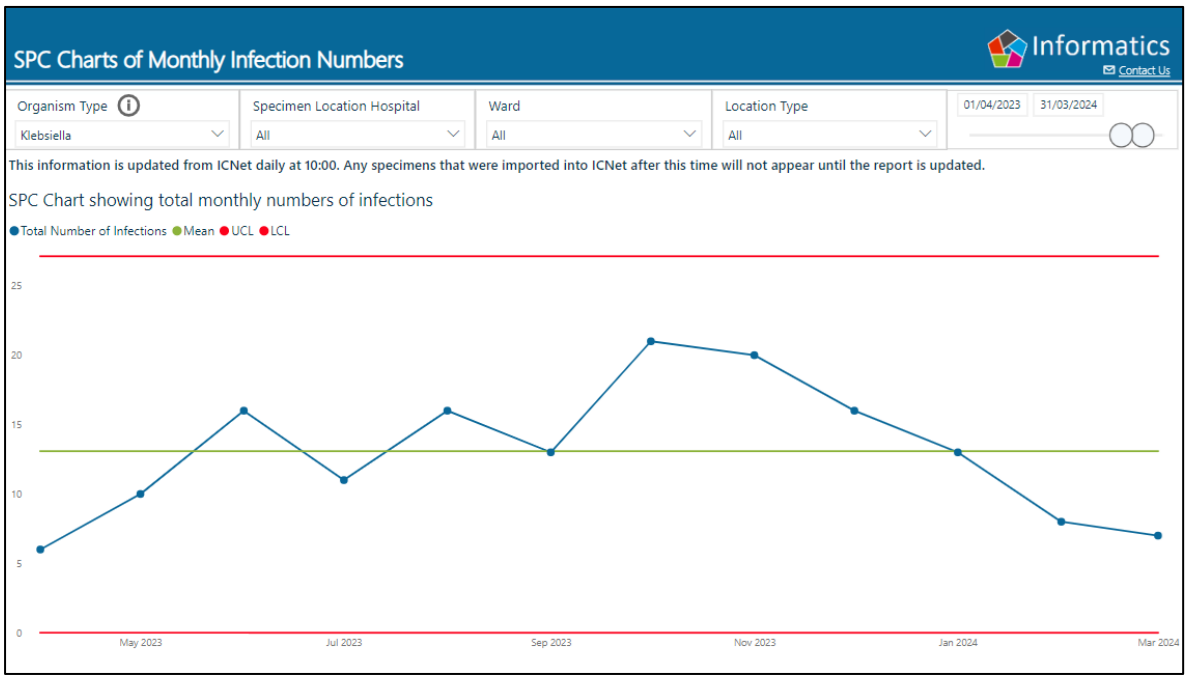
- 14% were from nursing or residential homes.
- 30% female, 70% male.
- 44% had a hospital stay in the last 12 months.
- 37% had had a healthcare intervention in the last 7 days.
- 44% had a medical device in the last 3 months.
- 33% had a wound in the previous 6 months.
- 41% had full compliance with the blood culture pack documentation.
- 74% had community onset, 26% hospital onset.
- 52% had *P. aeruginosa* from another specimen site before this BSI.

- 11% had antibiotic resistance reported.
- 19% were classed as avoidable, 81% unavoidable.
- The top three sources of the BSI was urinary tract (41%) followed by unknown origin (22%) and then skin and soft tissue (15%).
- 19% were classed as healthcare associated.

Klebsiella species Blood Stream Infections

In 2023/24 the *Klebsiella spp.* BSI rate increased from 20.4 to 22.7 per 100,000 population but was lower than the All Wales average 23.5.

The chart below illustrates the total number of cases per month for the last year. As with the other gram negatives, case numbers have reduced in the last few months.



Deep dives were completed on 150 infections:

- 13% were from nursing or residential homes.
- 45% female, 55% male.
- 58% had a hospital stay in the last 12 months.
- 39% had had a healthcare intervention in the last 7 days.
- 49% had a medical device in the last 3 months.
- 17% had a wound in the previous 6 months.
- 27% had full compliance with the blood culture pack documentation.
- 77% had community onset, 21% hospital (1% not answered).
- 39% had *Klebsiella* spp. from another specimen site before this BSI.
- 20% had antibiotic resistance reported.
- 19% were classed as avoidable, 79% unavoidable, 3% undetermined.
- The top three sources of the BSI was urinary tract (48%) followed by hepatobiliary (16%) and device related (6%).
- 19% were classed as healthcare associated, 77% not, 4% undetermined.

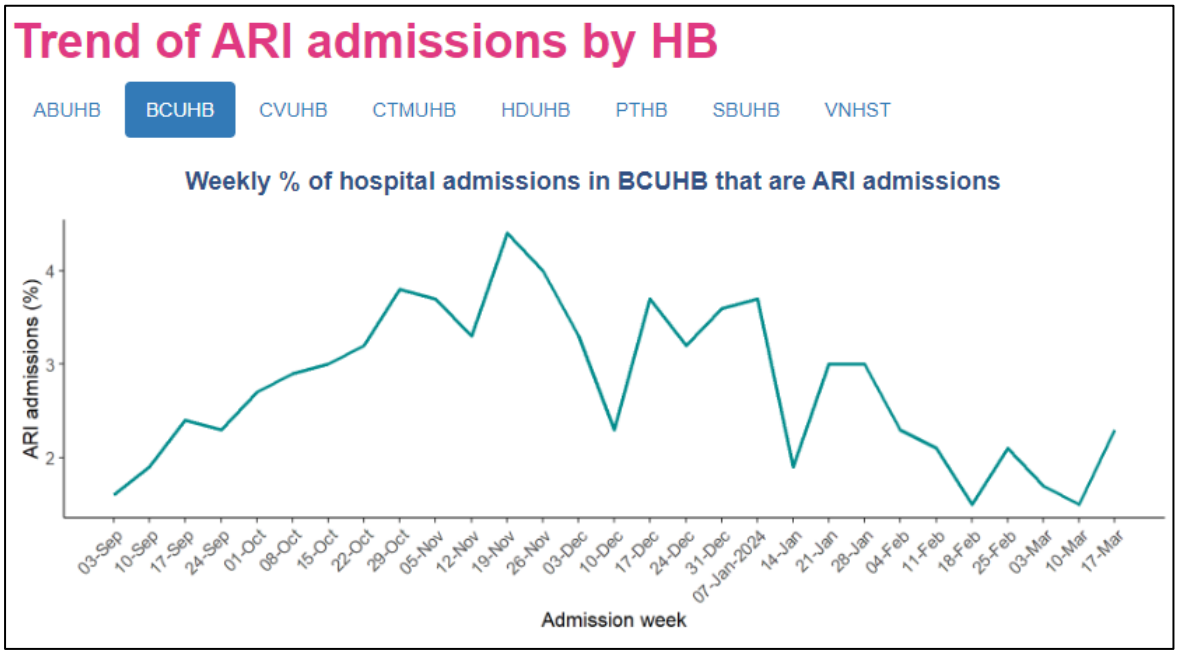
Further work planned to reduce gram negative BSIs includes:

- The Urinary Catheterisation Protocol to be reviewed and updated.
- Each IHC now has a Task and Finish Group to work through an action plan to address the measures required to prevent CAUTI and Urinary Tract Infection (UTI) enforcing best practise.

- IHCs to determine who has completed the urinary catheterisation e-learning and promote completion by staff who insert and manage urinary catheters.
- The full CAUTI audit will be repeated in July 2024.

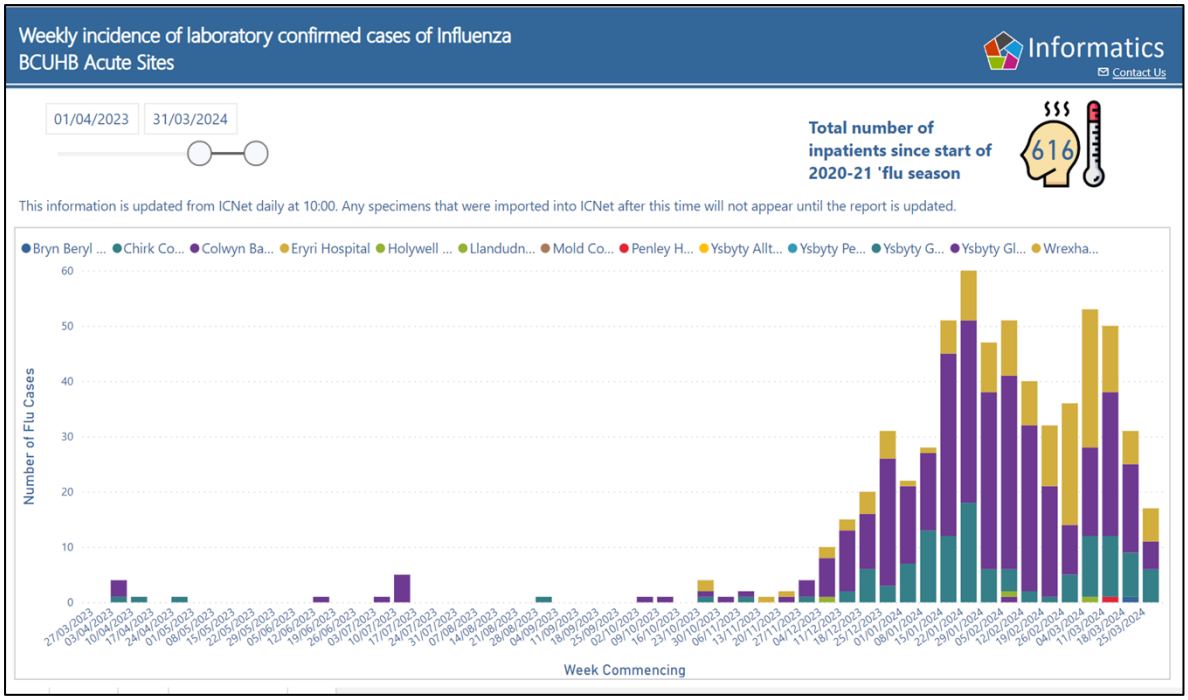
5.0 Other Significant Infections

5.1 Acute respiratory Infections (ARI)
As usual numbers peaked in the winter as illustrated below.

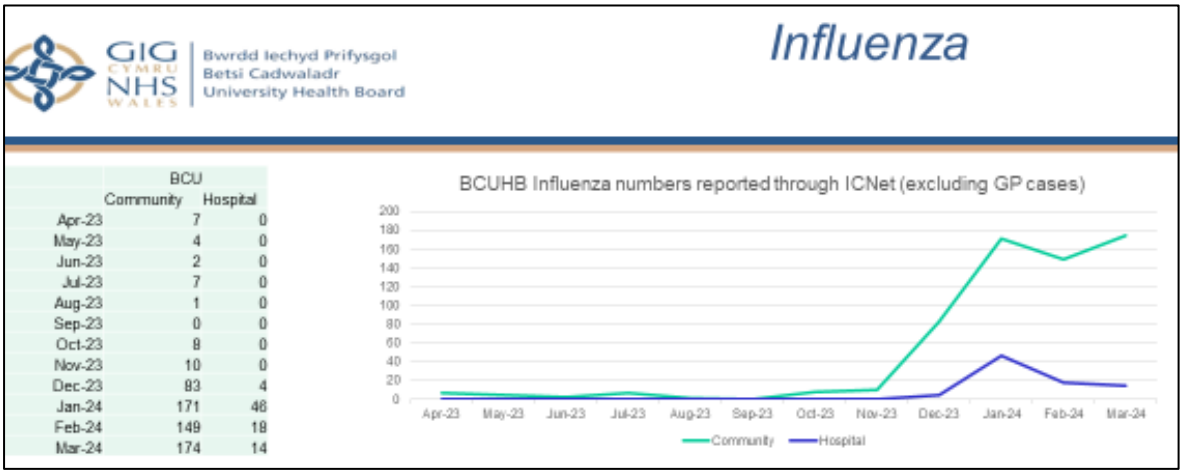


In October 2023, information on COVID-19 was revised with a new focus being on all acute respiratory infections, not just COVID, in the run up to winter. Over 2,600 views were recorded in Betsinet on this page in just 2 weeks.

Influenza
During the 2023/24 influenza season, there were 616 laboratory confirmed cases of influenza across BCHUB in inpatients, compared to 1,432 cases the previous year.
There was a gradual increase from early December with a peak towards the end of January.
Cases rose again mid-March before falling again in April.
There were 16 outbreaks recorded across BCUHB.
The majority were community onset.



Approximately 11% of influenza cases were hospital onset, compared to 9% in 2022/23 i.e. from samples collected 48 hours after admission.



	BCU	
	Community	Hospital
Apr-23	7	0
May-23	4	0
Jun-23	2	0
Jul-23	7	0
Aug-23	1	0
Sep-23	0	0
Oct-23	8	0
Nov-23	10	0
Dec-23	83	4
Jan-24	171	46
Feb-24	149	18
Mar-24	174	14

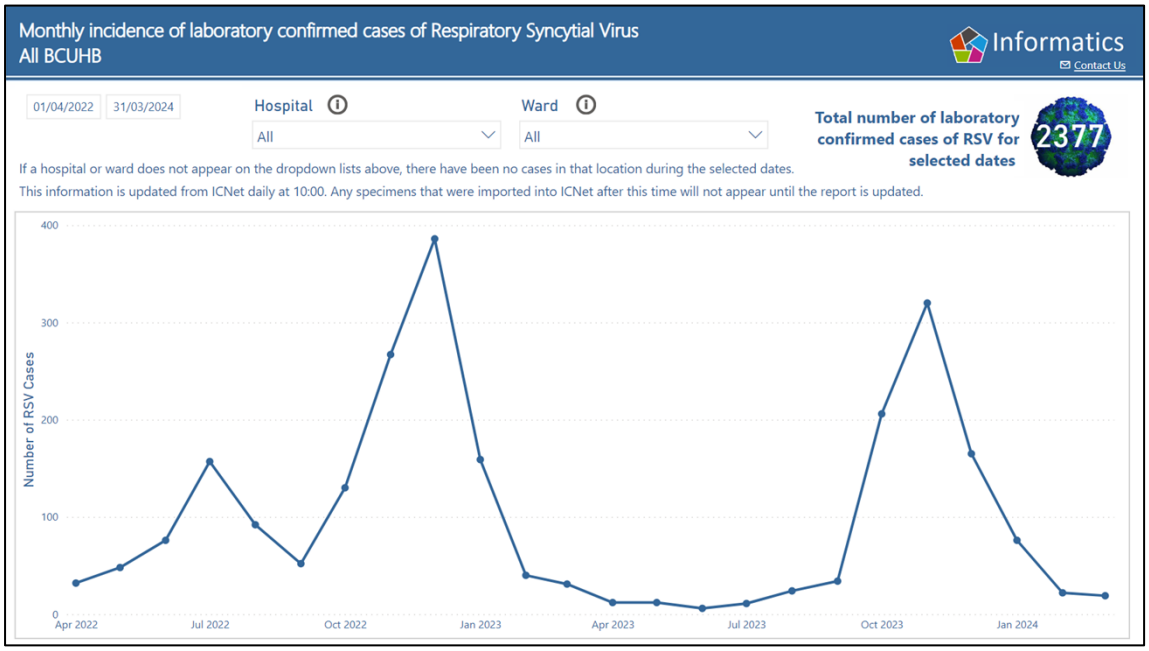
Hospital onset cases were lower in Central, despite the higher numbers in the community. A lower hospital onset rate here is probably related to the better inpatient and isolation facilities in the Central acute site compared to West and East.

Location	Hospital Onset	Community Onset
Central	30 (8%)	333
East	22 (11.7%)	165
West	30 (20%)	118

Respiratory Syncytial Virus

There were 907 laboratory confirmed cases of Respiratory Syncytial Virus (RSV) in BCUHB during 2023/24 with a peak in November, compared to 1,470 in 2022/23 where the peak was in December. There were no RSV outbreaks identified.

The graph below shows the numbers per month for the last 2 years for comparison.



***Bordetella pertussis* (*B. pertussis*)**

In 2022/23, there was only one reported case of *B. pertussis* (commonly known as Whooping Cough) in BCUHB. In 2023/24, between the 1st September 2023 and 9th April 2024, BCUHB reported 41 cases of *B. pertussis* (11 in Central, 10 in East and 20 in West).

Of these, 19 were reported through the hospital (8 in Central, 4 in East and 7 in West) and 22 were reported via the GP (3 in Central, 6 in East and 13 in West).

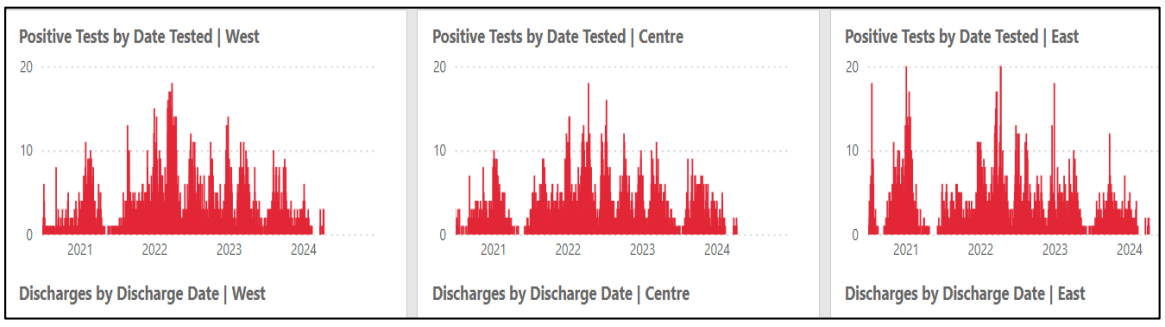
Of the 19 cases identified in hospital, 17 were isolated promptly, either within the Emergency or Children's Departments with no staff or patient contacts reported. Of the two cases not isolated, neither had presented with symptoms typical of *B. pertussis* but resulted in a total of 5 staff contacts.

Further learning identified the need for:

- Further communication and infection prevention training around the correct Personal Protective Equipment (PPE) to be used when caring for patients suspected or confirmed to have B. *pertussis.*
- A review of the process and support available for prescribing and processing prophylaxis out of hours.
- A review of the process and support available for prescribing and processing prophylaxis for non BCUHB staff (student nurses).

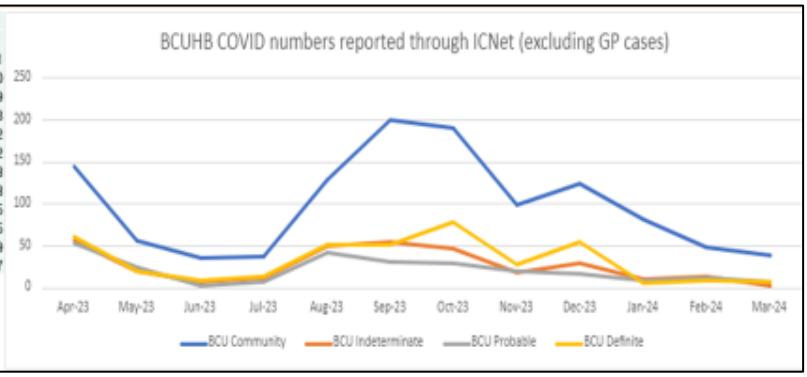
COVID-19

Numbers and severity of COVID-19 cases reduced in 2023/24. Positive tests by area are illustrated below.

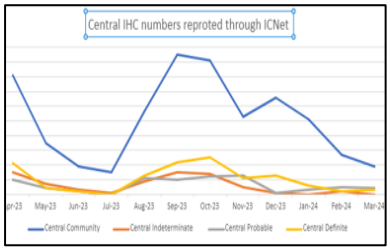


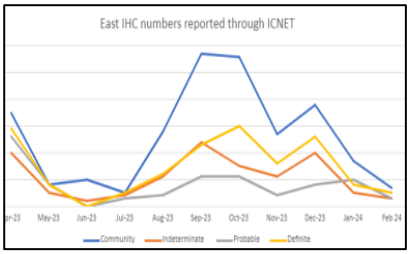
There was a peak in BCUHB in the autumn but numbers tailed off afterwards.

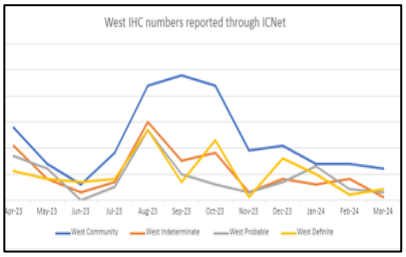
	BCU			
	Community	Indeterminate	Probable	Definite
Apr-23	144	56	53	61
May-23	57	20	24	20
Jun-23	35	8	2	9
Jul-23	38	12	8	13
Aug-23	129	50	42	52
Sep-23	200	54	31	52
Oct-23	191	47	29	78
Nov-23	99	19	20	28
Dec-23	125	29	16	55
Jan-24	82	11	9	5
Feb-24	48	13	12	9
Mar-24	39	3	7	7



Central had more than double the number of community acquired cases of COVID-19 than West and East (609 compared to 282 and 206 respectively), but less hospital onset cases (269 compared to 359 and 372) as illustrated below. Again, this is probably due to the better inpatient facilities and a greater number of siderooms in Central.







BCUHB COVID Ward study internal report

Public Health Wales and BCUHB collaborated on a project examining ward level factors associated with large nosocomial COVID outbreaks. The work compared, using a case control study design, hospital wards that experienced large outbreaks to wards that experienced small outbreaks. The starting hypothesis was that large outbreaks may have been due to differences in the 'on the ground' conditions on these wards. If identified, these factors may then be the focus of mitigations to reduce the impact of future outbreaks of respiratory infections. This approach differed to the more commonly reported epidemiological investigation exploring what predicts any one individual acquiring COVID. It concluded that large outbreaks were associated with high numbers of transfers into a ward in the preceding fortnight. Recommendations made included:

- Asking clinicians and bed managers to ensure they record the rationale for transfer, and who makes the decision.
- Ensuring important information on prior patient risk is not lost on patient handover when a transfer occurs.
- Review and revise existing policies relevant to patient transfer.
- Improve the ability to robustly track bed, bay and ward contacts in real time.

The full study was published in the Journal of Hospital Infection in March 2024.

Oxygen requirements in inpatients with respiratory infections

Since December 2023, a report summarising the findings of oxygen bundle data collection has been produced and disseminated via SIPG. This report summarises data collected by the IPT across BCUHB, as part of ongoing work to understand the extent of oxygen requirement in patients who test positive for three respiratory pathogens: influenza, COVID-19, and RSV.

The report has given insight into patterns of disease severity and disease burden across the health board. It includes an epidemiological summary of cases of the three respiratory pathogens over time, covering a six week period. It also considers the characteristics of

oxygen requirement in terms of total proportion requiring oxygen and the proportion of patients requiring oxygen at first presentation. The findings are split by adult and paediatric patient groups in order to account for differences in risk profiles between these two groups.
A key finding of the report since reporting began, is an understanding of baseline levels of oxygen requirement, with around 25% of adult respiratory bundle patients requiring oxygen at some point. There was also evidence of changes in the proportion of patients affected by each pathogen, with a shift in the primary causative agent to fit bundle criteria from COVID-19 to influenza in early March 2024.
Ongoing surveillance will continue where there is a moderate burden of disease from any of the three pathogens. The burden of disease will be considered in order to inform ongoing understanding of disease severity and monitor any changes in this profile. Changes in these trends may reflect national or local changes in transmission and microbiological characteristics, and so by investigating these changes we will be able to inform local response where needed.

Nosocomial COVID-19 Project (NNCP)
The project came to a close on 31st March 2024, with disbandment of the project team. The original caseload of 3539 cases were reviewed including 671 deaths.

- All investigations have been uploaded to Datix and closed.
- A learning report was finalised by the team's Business Analyst and submitted to the National Programme Team
- An end of Programme SBAR and checklist was completed and sent to The National Programme Team.

There were 4 cases referred to Legal and Risk to determine the extent of any qualifying liability. All 4 cases are aligned to an outbreak on a ward which was closed to admissions mid July 2020 following a cluster of cases of COVID-19. A contributory factor to the outbreak was due to wandering patients making social distancing difficult and potentially resulting in environmental contamination. Unfortunately, it has not proved possible to determine the index case for this outbreak.
An improvement programme based on the learning from the reviews will be carried forward via the Patient Safety Team.

5.2 Clinically Significant Antimicrobial Resistant Organisms (CSARO)
Clinically Significant Organisms that are Antimicrobial Resistant Organisms-also termed Multidrug Resistant Organisms (MDRO), are defined as organisms that have become resistant to one or more antimicrobials from three or more antimicrobial categories or classes and also other micro/macro-organisms that have developed multi-drug and chemical resistance. CSARO's have the ability to cause harm, increase morbidity and mortality and the more resistant the organism, the fewer options there are available for treatment. Hence surveillance of and their prevention and control in any healthcare setting is key to reducing harm and preventing avoidable HCAIs, increased incidents and outbreaks.

Standards for the Identification, Management and Treatment of CSARO were published by PHW in August 2023 along with 'Guidance on the Management of CSAROs'. Health boards have been requested to ensure they have robust processes and systems in place to identify, manage and treat these pathogens.
The IPT at BCUHB carried out a gap analysis to identify areas of non-compliance which was presented to SIPG in March 2024. A SBAR was requested to identify the highest risk areas and priority areas for action for escalation to the Quality Delivery Group. There are 3 main areas rated red that require additional resource for BCUHB to fully comply with the CSARO standards. These are:

1. Additional side rooms (preferably ensuite) are required in YG and WMH.
2. Additional facilities staff are required to meet all of the requests for enhanced cleaning and high level disinfection (HLD) related to patients, incidents and outbreaks

associated with CSARO. Decant facilities need to be identified and ring-fenced in each acute site, to enable HLD to occur.

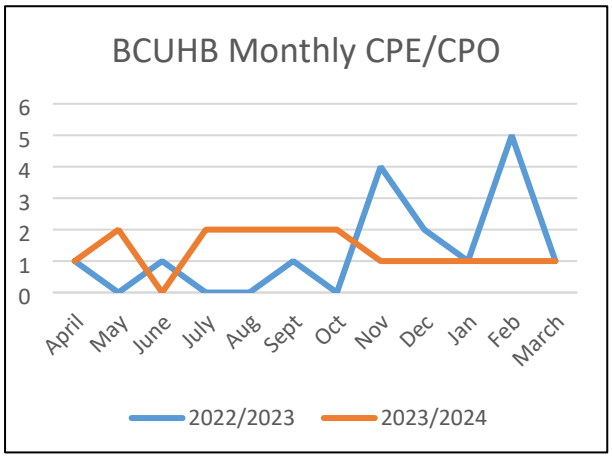
3. Increased medical support for the Antimicrobial Stewardship Group (ASG) and the Antibiotic Resistance Group along with further education and training for staff in antimicrobial stewardship.

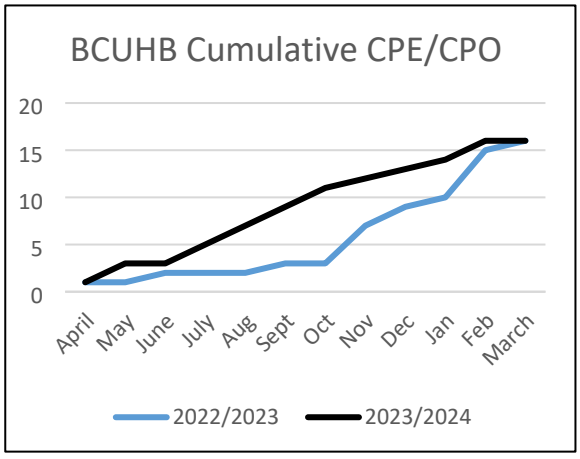
CPE/CPO

CPE/CPO stands for Carbapenemase Producing Enterobacterales / Carbapenemase Producing Organism. This group of bacteria are very resistant to antibiotics, including carbapenems). CPE (include *E. coli* and *Klebsiella*) are regarded as the biggest threat as the resistance genes can transmit vertically and horizontally, thereby rapidly spreading between different strains of bacteria.

In 2022-2023 and 2023-2024 there was an equal number of cases of CPE/CPO; 16 in total, but there were no outbreaks. There were more clinical samples from urine samples and this year type CPE/CPO OXA 48 was the most virulent strain seen, the most transmissible and the strain that has caused significant outbreaks in other organisations.

East had an increase in cases this year and more than the two other sites; much of this is related to increased screening activity. With the most common source the urinary tract, a focus on the practices associated with urinary catheters and preventing CAUTI will assist in reducing these infections. A number of patients from across the border have been found to be positive, having been screened for CPE as they have been transferred from Chester to Wrexham Maelor Hospital (WMH). Central had a larger number of cases last year, but reduced this year. West had a small outbreak last year in Critical Care but no cases were identified this year.





Due to the high risks associated, a new procedure for screening for CPE has been established for patients admitted to critical care, renal patients admitted to renal inpatient wards and renal dialysis patients.

Multi-drug resistant *E. coli*

In the most recent report (2018) covering England, Wales and Northern Ireland, the rates of *E.coli* BSI have increased year-on-year since 2009. The rate in Wales is higher than in England, probably due to a more comprehensive data collection method. However, in May 2023, it was reported that WMH had the highest rates in Welsh hospitals of resistance to key antimicrobials used in the empiric treatment of *E.coli* BSI as outlined in the table below:

Resistance rates to antimicrobials, Wales and WMH 01 January – 31 December 2022

Antimicrobial	Resistance rates	
	All-Wales	Wrexham Maelor
Co-amoxiclav	47.7	62
Gentamicin	10.1	24.8
Piperacillin-tazobactam	13.9	28.2
3rd Generation cephalosporins	11.9	24.8
Fluoroquinolones	18.1	35
Co-trimoxazole	30.9	46.1

Investigations have been carried out between PHW and BCUHB. In September 2023 a collaborative working group concluded that this is a problem specifically in WMH and that the transmission is occurring within the hospital. As a result of this a number of actions are being undertaken to:

1. Strengthen IP measures to reduce spread of these anti-microbial resistant organisms between patients and hospitals.
2. Enhanced antibiotic stewardship to reduce selection for these clones, including a review of past resistance profiles where there are new *E. coli* BSIs.
3. Further investigation and monitoring of cases to better understand spread and evaluate control measures.

Actions completed to date include:

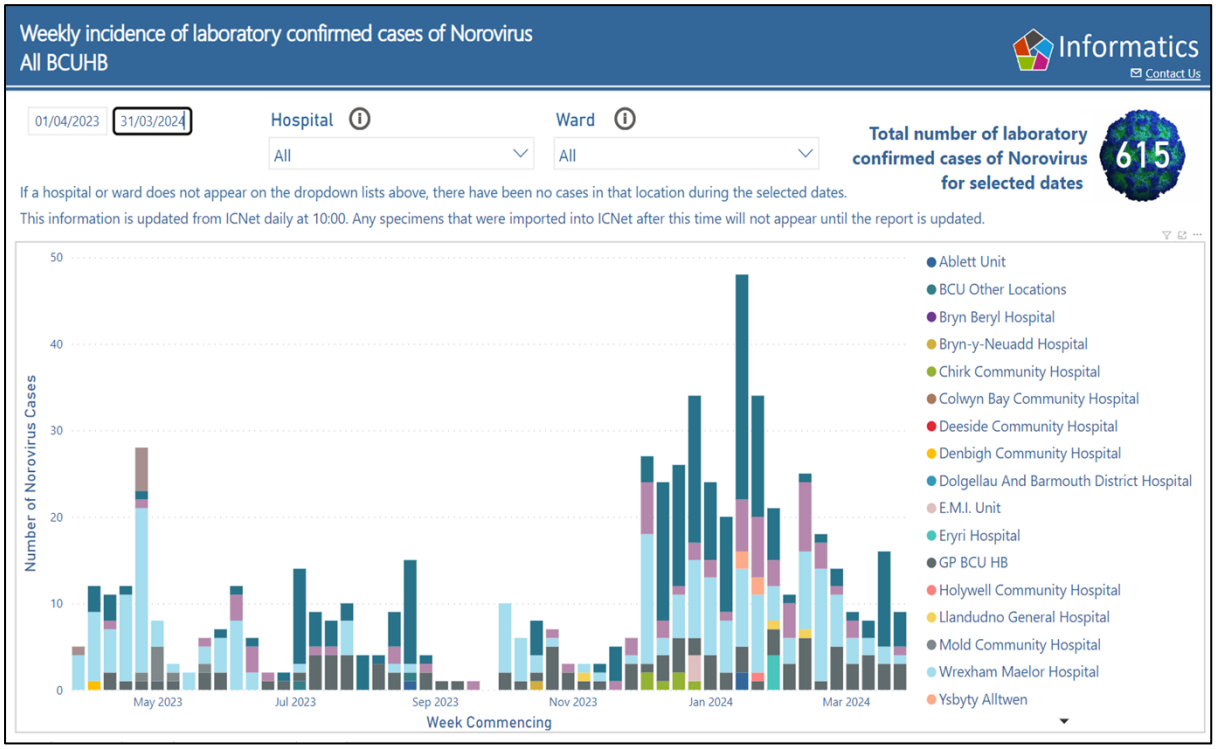
- A detailed SBAR and action plan was drawn up in October 2023 and a specific multi-disciplinary working group established by the local healthcare community leadership team within WMH to drive forward the IPC measures required. Additional resource will be required for several of these improvements. Progress is being reported through SIPG.
- Launch of a new back-to-basics campaign in October 2023 at our IP Conference titled 'HABITS', to refocus attention and compliance on IP across all sites.
- Amended isolation protocols so that inpatients with a multidrug resistant (MDR) strain are prioritised for isolation in side rooms.
- Completion of a full PIR following every new infection to determine if it was unavoidable or avoidable. This includes a 12 month 'look back' to help identify the source of the infection. Action plan development addresses any required recommendations to prevent reoccurrence and enhance clinical practice and learning is shared across the organisation. Key information from each case is also collated on to a separate database enabling it to be interrogated to identify key themes and areas for focus.
- Audits of urinary catheter care and vascular cannula have taken place to identify the specific areas requiring improvement and each area has established a CAUTI group for driving forward the recommendations locally.
- Empirical antimicrobial guidelines (as described in Microguide®) have been amended so that Amikacin STAT is given for all septic patients attending WMH. However, BCUHB is unable to give further doses safely at present due to the lack of on onsite level testing; a risk assessment is in place and options to provide this are being explored.
- BCUHB has established an in-house dashboard to enable us to monitor, review and implement actions in areas with high prescribing or where they differ from guidance. This dashboard shows WMH prescribing of antibiotics lower than the other acute sites in BCUHB, with the exception of co-amoxiclav which has reduced to similar levels as Ysbyty Gwynedd (YG) and Ysbyty Glan Clwyd (YGC). We will seek to improve our

local scrutiny of resistance patterns and establish a system for robust and timely monitoring of trends led by the office of the medical director.

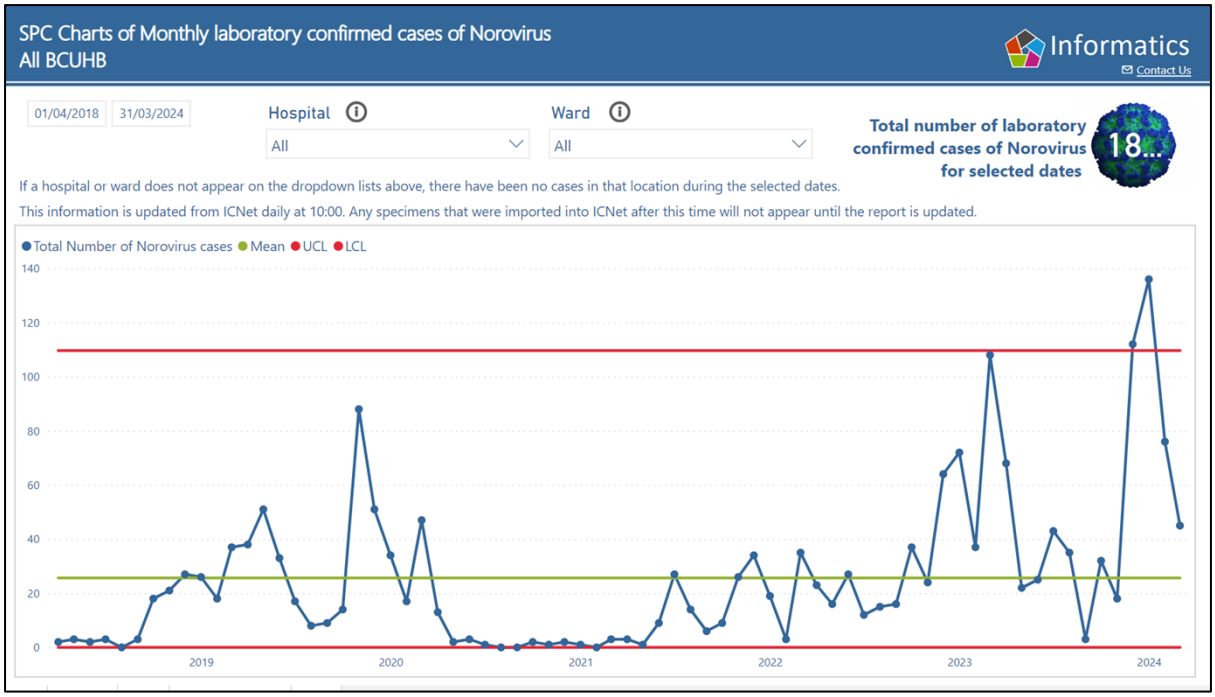
- Antimicrobial Stewardship (AMS) team has implemented a programme utilising both national and local tools including the Antibiotic Review Kit (ARK) chart and TARGET toolkits. The health board also participates in the yearly Point Prevalence Surveys and the Start Smart then Focus (SSTF) audits. Both these Welsh audits are Tier 2 audits in BCUHB.
- Further work is in progress with PHW and BUCHB staff to identify genome clusters and draw up timeline data for patient journeys. This should help BCUHB to identify if there are specific 'hot-spot locations' within WMH where transmission is likely to have occurred. BCUHB can then target IPC efforts in these areas.
- An extra-ordinary SIPG meeting was held on 5th March 2024 to review progress with GNBSIs and explore additional potential solutions required in more detail. One of the key outcomes of the meeting was to draw up a SBAR to highlight the key issues to the Executive team and ask for additional support for IP measures.

5.3 Norovirus

During 2023/24, there were 615 laboratory confirmed cases of Norovirus compared to 451 in 2022/23, with more cases being seen all year round, as well as the normal winter peak.
There were 37 outbreaks in hospitals across BCUHB creating additional pressure on siderooms and patient flow. In December in WMH, visiting was restricted for a short period to help bring the outbreaks under control.



Numbers in 2023/24 were higher than they have been since 2018. The graph below shows cases from 1/4/2018 – 31/3/2024:



Of the 434 Norovirus cases seen in hospital, 283 (65%) were hospital onset i.e. from samples collected 48 hours after admission.

Location	Hospital Onset	Community onset	Total
Central	20 (30%)	44	67
East	140 (70%)	60	200
West	123 (72%)	47	170
Total	283 (65%)	151	434

Numbers were lower in Central, which is probably related to the better isolation facilities in the acute site compared to West and East.

5.4 Blood Culture Data

In 2023/24, 21,213 blood culture samples were taken.

- 13% (2803) were positive.
- 46% (9,913) were taken in the Emergency departments; 4140 in WM ED, 3463 in YGC ED and 2310 in YG ED.
- *E.coli* was the most common blood stream infection accounting for 631 (22.5%) of the 2803 positive samples. 289 were from WM, 192 from Central and 150 from YG.

Blood culture contamination rate: a contaminant is defined as a microorganism that is supposed to be introduced into the culture during either specimen collection or processing and that may not be pathogenic for the patient. Organisms classed as contaminants in blood cultures include *Staphylococci*, aerobic spare-bearing bacilli (ASB), *Corynebacterium* spp., and *Micrococcus* spp. Most of these organisms are present on the skin as normal commensal flora.

Contamination due to skin flora especially in a single culture, makes interpretation difficult and may result in excessive and sometimes unnecessary use of antibiotics, with the risk of

promoting bacterial resistance, increased morbidity and mortality, extended hospital stays, and increased costs.
Factors associated with blood culture contamination include poor technique and procedure used to collect blood, lack of dedicated phlebotomists and improper skin antisepsis.
The acceptable blood contamination rate benchmark is <3%.
In BCUHB in the last 6 months of the year (Oct 23 – Mar 24), 3.6% (400/10916) of all blood cultures taken were classed as contaminants: 3.5% at YG, 4.7% at YGC and 2.9% for WM.
A blood culture training presentation and assessment tools have been devised and further training is being offered across BCUHB as part of the Practice Development Programme delivered by the Corporate Education Team.

5.5 Hepatitis B and C Elimination Plan
In July 23, BCUHB submitted its Hepatitis B and C Elimination Joint Recovery Plan to Welsh Government (WG) in response to WHC/2023/001 for hepatitis B and C elimination. The BCUHB plan was assessed as being "strong" by WG due to its clear governance arrangements, the fact that it had been developed in partnership; it addressed the specified actions from WHC, and had evidenced current and future planned investment. The BCUHB Hepatitis B and C Elimination Steering Group overseeing and monitoring delivery of the plan feeds into the SIPG.
Areas of positive progress include HMP Berwyn, achieving and sustaining micro-elimination of hepatitis C ahead of the WG target of March 2023 and there has been a significant increase (129%) in Blood Borne Virus (BBV) community testing in BCUHB this year compared to 2022/2023, through the High Intensity Test and Treat initiatives (HITTs) and outreach testing projects.
Areas where further work is required have been identified and are being actioned. BCUHB reported progress to WG on the hepatitis B and C elimination plan at the end of March 2024 and submitted a plan for 2024/2025 at the end of May 2024.

5.6 Nosocomial infections in patients experiencing delayed discharge
Collaborative work between PHW and BCUHB auditing harms, observed amongst in-patients in Ysbyty Gwynedd (in 2022) experiencing delayed hospital discharge reported a concerning number of infections following a decision that the patient was medically fit for discharge. The data on harms clearly showed a considerable burden of bacterial and viral infections, and of clinical cases of hospital acquired pneumonia (HAP) experienced by the cohort of delayed discharge patients.
The observed incidence of HAP (0.37 per 100 bed days of delayed discharge) was of particular concern, for every 300 days of delayed discharge experienced by the hospital one new HAP might be expected. 300 days of delayed discharge were reached within a few days under conditions observed in the audit. HAP was associated with high mortality within the hospital spell. HAP remains poorly monitored due to the relatively low number of patients in whom a causative organism is observed.
Delayed discharge following clinical optimisation is a major challenge for the health board; this audit demonstrated that in addition to subsequent pressures on hospital flow hospital acquired infections in this cohort are also significant.

6.0 Caesarean section Surgical Site Infection (CSSI) Surveillance
Data has been collected consistently; 100% for all of 2023. The most recently published Health Care Associated Infection, Antimicrobial Resistance and Prescribing Programme (HARP) report for Q4 2023 evidences a static rate of CSSI of 3.8% across BCUHB.
Our inpatient rates of CSSI remain extremely low at 0.3% and are associated with women who have systemic infection at the time of procedure. Most commonly, infections are defined as late community onset; more than 5 days following hospital discharge.
The themes identified through report analysis include the use of non-standard wound closure, the rate of infection associated with non-dissolvable sutures and staples is around 15%. Also poor swab technique with mixed culture and skin flora regularly seen in reports.

Reporting of swab results that do not meet the criteria is also an issue affecting overall results.

Overall SSI rate

	Betsi Cadwaladr UHB	
Valid forms received	2105	
Forms where inpatient and post-discharge SSI are completed, or there is a post-discharge SSI.		
Overall SSI rate	80	3.8%
= number of SSI / valid procedures x 100		
Hospital onset (inpatient)	7	0.3%
Community onset	9	0.4%
Late community onset	62	2.9%
Infection diagnosed 5 or more days after hospital discharge.		

In 2024 there will be:

- A focus on reducing the use of non-standard wound closure methods by educating clinicians regarding their infections rates.
- Education of swab takers to ensure standardisation in practice.
- Further improve reporting by decreasing over-reporting and identifying themes on a local level through the use of root cause analysis.

7.0 Vaccination Programmes delivered in BCUHB 2023-2024
COVID-19 Vaccination

The COVID-19 vaccination programme in North Wales launched a Spring Booster Vaccination Campaign from 1st April 2023 – 30th June 2023. Following the Spring Booster campaign, the programme launched a further Autumn Vaccination Booster Campaign, 11th September 2023 – 31st March 2024.

In conjunction, other vaccination programmes that were being offered alongside the Spring Booster vaccine included:

- The Infant vaccination programme, which commenced during the Spring Booster campaign for those who were identified in a high-risk category between the ages of 6 months to 4 years old.

The offer of the initial two dose universal primary course of vaccine, that was offered from December 2020 to all the population aged over 5, ceased on 30th June 2023. The Joint Committee on Vaccination and Immunisation (JCVI) recommended that the high level of population immunity enabled the changes.

The programme continued to be delivered simultaneously via vaccination centres, and 'Hub and Spoke' models, GP Primary Care providers and community settings. BCUHB teams focused on the most vulnerable, delivery to care homes, the identified cohort for each campaign, citizens within HMP Berwyn and those who identified as house-bound. Regular reviews of the hard to reach and low uptake areas were undertaken, in an ongoing effort to 'leave no person behind' and tackle potential inequalities.

The aim was to protect the most vulnerable in our communities, including residents in care homes for older adults, people aged 75 and over and those aged five years and over who are immunosuppressed.

The exceptional Health Board uptake rates for 2023-2024, as illustrated in the table below could not have been possible without the support and assistance of key stakeholders including:

- Conwy, Gwynedd and Flintshire Local Authorities
- Glyndwr University whose facility at Catrin Finch has been the base for our Wrexham Vaccination Centre and continues to do so.
- North Wales General Practitioners and Community Pharmacies.
- Various services within BCU such as School Nursing and District/Community Nurses.

Covid-19 Vaccination Position from April 1st 2023 – March 31st 2024

Cumulative Total Vaccinations	Spring Booster 2023	Autumn Booster 2023	Immunosuppressed 0.1, 0.2 & 0.3	Spring Booster April 24 – Present
249,689	73,156	175,777	25,777	27,056

Data Correct as of 09.05.24, 08:55

During the Spring Booster programme 2023, the programme utilized Comirnaty BA4/5 & Sanofi-VidPrevtyn-Beta for Adults and Comirnaty 3 for 6 months to 4-year old's & Comirnaty 10 for 5 – 11-year-olds. Novavax was available to order in the event of any allergies.

The Spring Campaign 2023 was a huge success surpassing the national target of 75% with more than 73,000 vaccinations being delivered (the national average was 81.7%), and more than two million in total since the programme started in December 2020.
The Covid-19 Spring Booster Programme finished with more than 85% of those eligible people living and working in North Wales having been vaccinated.

The Autumn Booster Programme 2023 adhered by WG direction, following an increase in hospital admissions as a result of identifying a new variant (BA.2.86). As instructed by Vaccine Planning Wales, plans were changed from prioritizing health and social care staff to Care Home residents and the most vulnerable citizens. This was consistent with JCVI's advice that "the principle of timeliness should take priority over the choice of vaccine". Following this, programme planning was adapted and planned appointments already booked onto the system (Office 365) were honored.

The Autumn Booster programme 2023 commenced by utilizing Comirnaty BA.4/5, which was available from 04/09/2023. Planning assumptions stated that BBX monovalent vaccines were to be utilized from October 2023. The license for the Pfizer XBB was due on 14/09/2023 for the delivery on 02/10/2023; and the Moderna XBB on 21/09/2023 for the delivery on 16/10/2023.
The Pfizer XBB monovalent vaccine was initially utilized for the three higher risk priority groups (75+ years, Care home resident, Immunosuppressed 6 months and over).
Sanofi VidPrevtyn Beta was the recommended vaccine choice for those who were clinically advised to receive a non-mRNA vaccine. Moreover, there was a hard stop for the use of Comirnaty BA4/5 on 30/09/23 and therefore the vaccine was changed to Comirnaty XBB.

Other vaccination programmes that were being offered throughout the Autumn Booster vaccine programme included:

- The Infant vaccination programme; this commenced during the Autumn Booster campaign for those who were identified in a high-risk category between the ages of 6 months to 4 years old; They were offered Comirnaty 3 XBB.
- The children's vaccination programme for those aged 5-17 years; those who were identified in a high-risk category between 5-11 years were offered Comirnaty 10 XBB and those aged 12-17 offered Comirnaty XBB.

The programme was also successful and finished with more than 74.5% of those eligible citizens living and working in North Wales being vaccinated. This surpassed the national Welsh average uptake of 70% (not including staff) and BCUHB ended as the highest volume health board in Wales
As of 31/03/2024, 176,413 total doses were administered for eligible citizens excluding opt outs and Health & Social care staff, which was a 74.5% uptake. Moreover, a total of 2,260,939 of vaccinations were administered and 2,227,656 were given by BCU.
The COVID-19 Spring Booster Programme 2024 commenced on 01.04.2024 and will end on

30.06.2024 with limited flexibility into July for those who are unable to receive a booster within the main programme, due to illness.
Following JCVI advice, the vaccine is being offered to; adults aged 75 years and over and residents in a care home for older adults and individuals aged 6 months and over who are immunosuppressed.
The programme is utilising the Pfizer-BioNTech mRNA (Comirnaty) Omicron XBB.1.5 vaccine for all eligible cohorts with the exception of Moderna mRNA (Spikevax) XBB.1.5 vaccine for aged 5 years to 11 years of age.

- As of 09.05.24 at 09:25 **28,607** Spring 2024 Booster Vaccinations administered.
- We currently have **55,389** bookings in the system.
- We have a **10%** DNA rate across the programme.
- As of 09.05.24 at 08:25 **2,281,133** total vaccinations have been administered and **2,255,801** given by BCU.

LIVE Spring 2024 Covid-19 Vaccines Administered as of 03.05.2024								
Areas	Care Homes		Housebounds		Over 75'S		Immuno 6months+	
East	1296	72%	764	37%	9383	26%	1182	14%
Centre	1414	85	1286	77	4474	14	0	0%
West	915	76%	429	35.40%	4171	24.30%	0	0%

There are 16,813 Care Homes in Wales and 4,500 are within BCUHB. Therefore, it is anticipated that first passes will take slightly longer to complete, due to having 26.7% of the Care Homes in Wales to vaccinate.

Wider BCUHB Immunisation Framework Planning
BCUHB are now strategically planning following the publication of the National Immunisation Framework (NIF), which marks a move into the implementation phase of vaccination transformation, with a process of transition to the new arrangements expected during 2024. The framework provides an aim with regards to equity of access to all immunisations offered through BCUHB by introducing a one programme approach and following the below principles;

- Provision for identifying groups with low vaccination uptake.
- Provision for determining barriers to uptake.
- Partnership working and meaningful engagement with community champions, trusted voices and third sector organisations.
- Co-production of tailored interventions.
- Evaluation of actions and interventions.

Implementation will be overseen by the NHS Executive, with WG moving into an oversight role while retaining the lead on key workstreams that enable transformation. WG ambition is to establish a National Immunisation Framework for Wales to deliver world-leading outcomes in vaccine preventable disease.

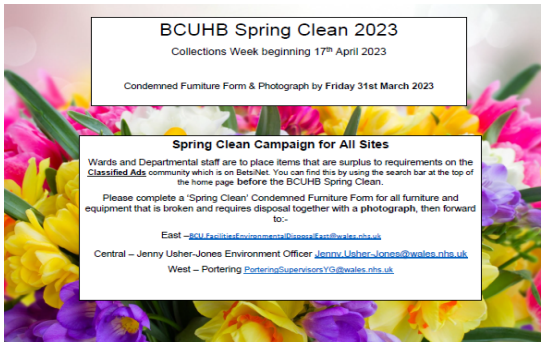
8.0 Education and Training in Infection Prevention and Control

8.1 Infection Prevention Campaigns and Awareness Events

Spring Clean May 2023
The importance of cleanliness within our wards and departments was highlighted through fun initiatives, exploring the use of Adenosine Triphosphate (ATP) cleaning monitoring technology and promoting the new 'Which Clean do I Mean?' document. Ward and department staff were asked to instigate a spring clean in their areas and informed how to get rid of surplus and / or

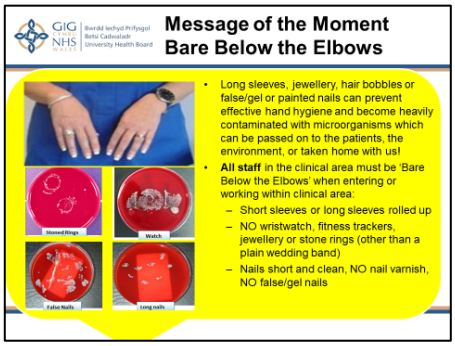
broken equipment. For Central there were 31 requests for items to be collected from different departments and sites. Some had many items collected, some only a few but was well received. In West an Environmental Cleanliness Group was established.

Ward 2 at Central site won the 'How Clean is your Ward' competition.



World Hand Hygiene Day in May 2023

Each year the World Health Organisation (WHO) Save Lives: Clean Your Hands campaign aims to maintain a global profile on the importance of hand hygiene in health care and to 'bring people together' in support of hand hygiene improvement globally. The IPT organised exhibition stands, circulated promotional posters and used the Ultra Violet (UV) lightbox to identify areas on hands that staff commonly miss.



Message of the Moment in July 2023

This campaign followed on from Hand Hygiene day and focussed on promoting 'Bare Below the Elbows' with staff in clinical areas.

Preventing CAUTI (Catheter Associated Urinary Tract Infection) in September 2023

In September as part of 'CAUTI prevention month' the IPT promoted ways to 'Crush CAUTIs' to keep patients safe and free from urinary tract infections associated with urinary catheters. Information was provided on criteria for insertion, how to secure urinary catheters, when they

should be removed and when urinary catheter passports should be issued. A SBAR paper was approved at SIPG with recommendations including a request for each IHC to form a Task & Finish Group to develop an action plan to address the measures required. Since then, each of the 3 IHCs have held education events to raise awareness and established groups; West have also established CAUTI Champions to promote the key messages in their areas.

International Infection Prevention Week in October 2023

This focussed on 'Celebrating the Fundamentals of Infection Prevention' and BCUHBs IP conference held that month followed the same theme.

Around 100 delegates took part in the conference sharing success stories and innovative approaches to infection prevention at Faenol Fawr next to YGC. The agenda included presentations from staff from across North Wales who had made valuable contributions to IP, as well as information stands from IPC suppliers and a drop-in flu jab clinic. The event was kindly funded from the exhibitors and Awyr Las charity.

Initiatives to promote the key messages included a Thank you Card, Break the Chain of Infection posters, 10 Ways to Protect Yourself and Others and the Dos and Don'ts of Glove Use. In Central and East IP hosted exhibition stands with information, games, competitions and freebies. IP staff also visited wards educating staff on key IP topics. In West there was a 'Gloves Off' campaign and training session for therapy staff on appropriate use of PPE.

International Sharps Injury Prevention Awareness Month was the focus for December

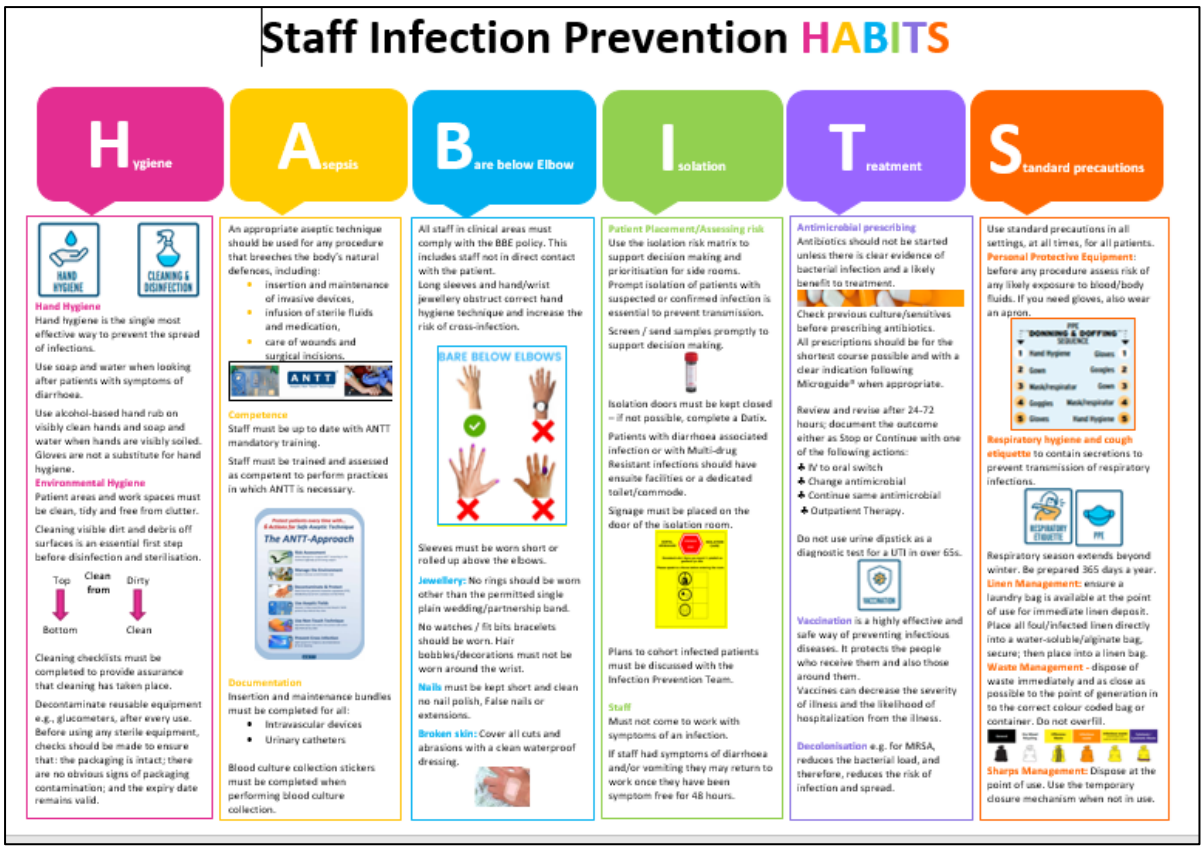
During December results of the Sharps Bin Audit recently undertaken at the acute hospitals and a number of community sites was shared, highlighting the need for improvements regarding the 'Temporary Closure' and signing and dating bins accurately. Data on sharps injuries is now reported to SIPG on a monthly basis and key issues and/or trends acted upon.

HABITS 2024

In February 2024, the IPT officially launched the Staff Infection Prevention HABITS campaign. This is an ongoing campaign to promote the basic principles of IP and to encourage staff to 'get into the HABIT' of practicing these principles at all times.

The campaign commenced with the introduction of the overarching HABITS poster to be displayed within the entrances to all clinical wards and departments with information also uploaded onto Betsinet IP pages. Throughout the month, the IPT visited all areas to promote the HABITS concept. The campaign continues with a different focus each month on a different letter from the mnemonic HABITS:

- March – H - Hand Hygiene and Bare Below Elbows
- April – H - Hygiene Environmental
- May – Asepsis
- June – Isolation
- July - Treatment
- August – Standard Precautions



As we approach September 2024, the IPT will develop the campaign further to include a patient/public facing approach.

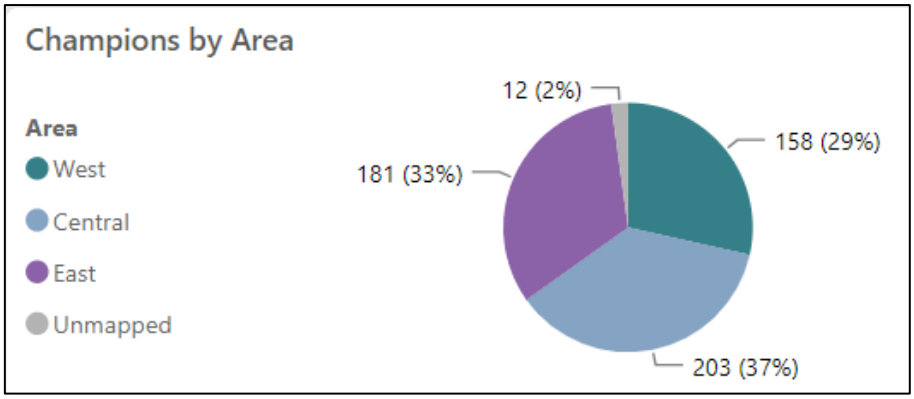
8.2 Compliance with Mandatory Infection Prevention Training

Level	Competency Name	Compliance % 2022/23	Compliance % 2023/24
Level 1	Infection Prevention and Control - Level 1 - 3 Yearly	83.39%	84.12%
Level 2	Infection Prevention and Control - Level 2 - Annual	78.25%	76.64%
ANTT	Aseptic Non-Touch Technique - 3 Yearly	86.25%	83.75%
Average		**82.58%**	**81.5%**

Donning and doffing of PPE is included as part of the IP mandatory training and not reported separately.
Training levels amongst medical staff remains low despite being highlighted at various forums.

8.3 Infection Prevention Champions

The ITP have now trained over 550 IP Champions, an increase from 390 in 2022/23.



Fortnightly drop-in sessions continue to be held on Teams with IPT members enabling them to ask questions and seek further support.

8.4 Ad hoc Infection Prevention Training Sessions

In 2023/24 the local IPTs delivered a range of teaching sessions between them including:
On an ad hoc basis, teaching sessions for clinical staff in small groups and at meetings e.g. for ward managers on:

- Back to Basics in IP and aspects of the HABITS campaign
- Use of Prontosan
- Norovirus
- MRSA
- *C. difficile*
- Commode cleaning sessions with Housekeepers
- Hand hygiene
- Multi-drug resistant *E.coli*,
- Use of Isolation Matrix
- CAUTI
- Water flushing protocol
- Intravenous access insertion and maintenance

Also learning from PIRs delivered at meetings/forums and GP training sessions.
General IP sessions to Practice Development Nurses, student nurses on induction, Biomedical students in year 2, Medical students in year 3 and at Harm Free Care days in East.
ANTT Train the trainer sessions in acute and community settings including dental, paediatrics, Practice Development Nurses and at intravenous education days.
Presentations at Grand Rounds on *C.difficile* in West.
C.difficile 'Summits' in all 3 acute sites.
Sessions on cleaning dynamic mattresses in each acute site supported by the company reps.
Training in Emergency Departments (ED) and admission wards for High Consequence Infectious Diseases (HCIDs).

8.5 Infection Prevention Massive Open Online Course (MOOC)

This provides enhanced IP knowledge, understanding and application, and is aimed at registered practitioners and senior level staff in supervisory roles who are responsible for ensuring compliance with good IP practice e.g. ward and departmental clinical managers. The online programme is run by Bangor University over eight weeks.

After a gap due to staffing issues at Bangor University this programme restarted in October 2023 and staff have been encouraged to attend. We are unable to get an accurate list of attendees from BCU but all junior IP Nurses are given time to complete this programme.

9 Education and Support in Social Care/Care Homes

The North Wales response to preventing, containing and managing the spread of infectious diseases in care homes and other closed care settings continues to be, multi-agency and multi-disciplinary. The care home Multi-Agency Oversight Group (MAOG) was established and continues to meet on a weekly basis. We promote a proactive approach to IPC management by providing education, training and support for our care homes and working in partnership with the BCU Health Protection team and the IPT

Key Achievements:

- The Quality Development Team have developed the Clinical Quality Support Tools (CQSTs) for IP control and management for all care homes across North Wales.
- Operational implementation has been transferred over to the BCUHB Health Protection team who are carrying out proactive visits and offering support to residential care homes across North Wales.
- IPC Resource packs for care homes have been developed in partnership with Public Health Wales to ensure that the care homes have up to date guidance and evidenced based practice.
- The COVID-19 vaccination programme is ongoing and delivered by our BCUHB COVID Vaccination teams. They continue to offer an in house service for both staff and residents within the health and social care sector. Accessing vaccinations for staff and residents in care homes was much improved with good uptake and minimal delays experienced. This is currently continuing for our spring and autumn booster campaigns for social care.
- The flu campaign programme for 2024 is in progress and the quality development team are working closely with the community pharmacy teams and currently remain the highest in wales for administration of flu vaccinations across Wales.

Table 11b. Numbers of social care sector staff (Domiciliary and Carers in a care home) and unpaid (voluntary or informal) carers immunised by community pharmacies in Wales, by Health Board, data as at 29 January 2024.

Health Board	Social Care Staff		
	Domiciliary Carers	Carers in a Care Home	Unpaid Carers
Aneurin Bevan UHB	186	309	938
Betsi Cadwaladr UHB	333	1,144	1,699
Cardiff and Vale UHB	115	328	999
Cwm Taf Morgannwg UHB	276	178	933
Hywel Dda UHB	91	182	882
Powys Teaching HB	82	90	204
Swansea Bay UHB	136	228	969
Wales	**1,219**	**2,459**	**6,624**

Data Source: Choose Pharmacy

- We are currently planning our 2024-2025 flu campaign to build on improving Flu Vaccination uptake in our care homes across North Wales. Flu Campaign Webinars for All Nursing and Residential Care Homes and Domiciliary Care For 2023 were held following lessons learnt and promoted the importance of having the Flu and COVID vaccines and ultimately increase the Flu vaccine uptake within the care homes.

- IP webinars are held for all care homes across North Wales on an annual basis working alongside PHW and the health board's IPT.
- The Quality Development team also promoted the flu campaign by holding three educational webinars for care home managers and clinical leads in August and September.
- The quality development team will continue to plan and to promote the eLearning Flu/COVID-19 1 module. We will also send the NICE guidance with the specific recommendation for health and social care staff (Quality statement 4: Vaccinating health and social care staff | Flu vaccination: increasing uptake | Quality standards | NICE) for information.
- The Quality Development team have developed a monthly Provider briefing for care homes across north wales, where we have a dedicated section for IP as well as evidenced based practice, this was greatly enhanced when information from local and national guidance changed.
- Scabies information has been provided to ensure care home staff were aware of scabies outbreaks and information on who to contact.
- The Quality Development Team has supported the development of IP champions in care homes across North Wales to act as ambassadors of good practice. This is being led by our BCUHB Health Protection team.
- IP training for care homes across North wales has been re-focused following a scoping exercise to ensure we have equitable training. Further work is required with our partners e.g. nursing homes to support them with IP education programmes to implement the safe clean care campaign in care homes.
- The BCUHB Quality Development Team have also worked in partnership with PHW to promote IPC webinars which have been held over 2023/2024 as well as promoting the eLearning links on their website. This is shared with our local authority members of staff as part of our quality assurance framework training and education group which is held monthly.

Planned activity for 24/25

- Re-Launch of the catheter passport to help improve urinary catheter care for care homes.
- ANTT training which is being supported by the practice development nurses, they request care homes complete the eLearning element on the all wales eLearning platform https://learning.nhs.wales/. We are working on a 'train the trainer' approach for completing competencies within the care home.
- Further work is required with our partners to support them with IP education programmes to implement the Safe Clean Care campaign in care homes.
- Working alongside National group to support care homes with Peer to Peer vaccinations for Nursing homes across North Wales, support with IP/Cold Chain will need to be considered.

10 Infection Prevention and Control Team Audits

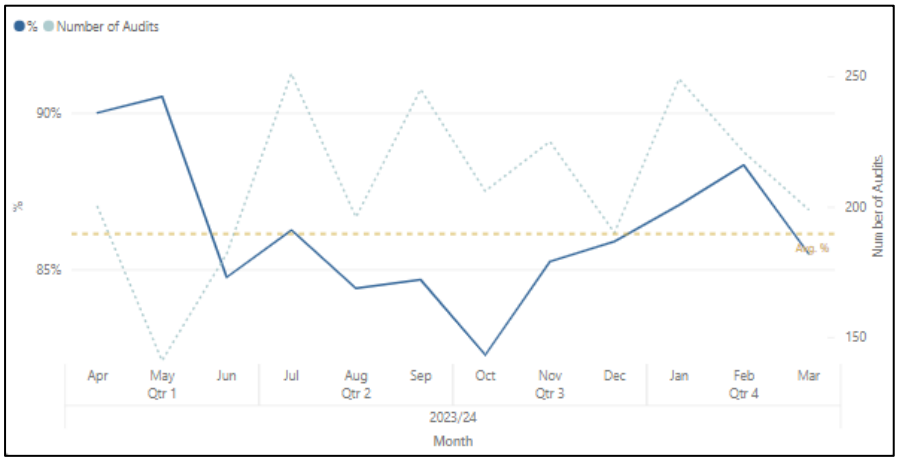
The IPT completed and reported on a significant number of regular and ad hoc audits of practice and the environment in 2023/24. Several of them were also strengthened to ensure they were in line with national standards.

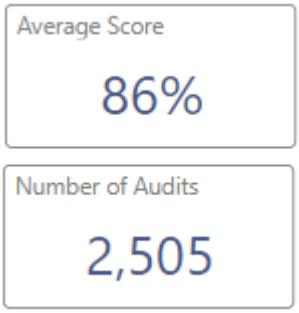
10.1 Regular Audit Programme

The IPT have delivered a regular proactive audit programme throughout 2023/2024 auditing staff hand hygiene monthly, commode cleanliness (and practices associated with cleaning of a commode) every other month and mattress and pressure relieving cushion audits quarterly.

All audit data is submitted into the IRIS system by the IPT, with ward level staff and senior managers able to access the system to extrapolate their own results/reports.

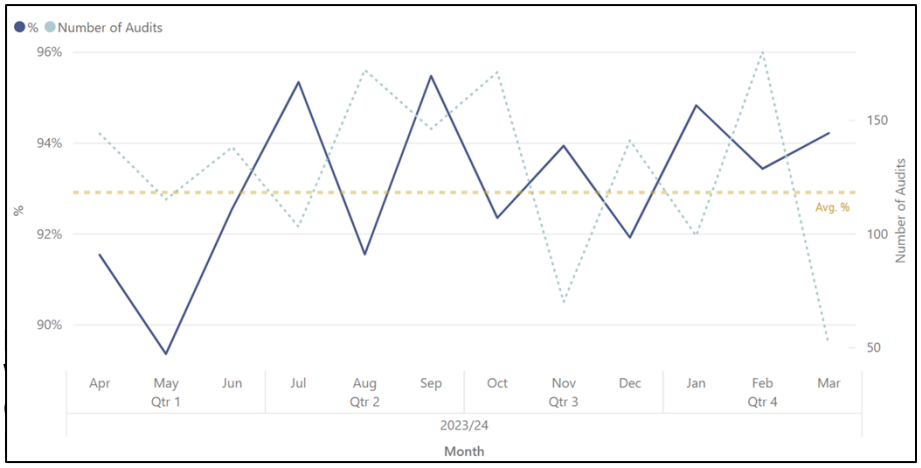
Staff Hand Hygiene

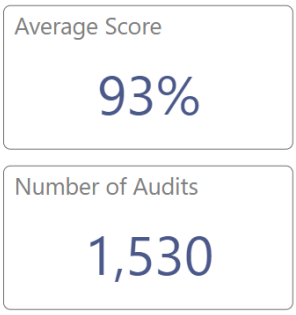




- 52% of staff were observed to perform hand hygiene when the opportinuty arose (i.e. in line with the WHO 5 Moments for Hand Hygiene)
- 89% were observed to decontaminate all areas of their hands in line with the six step process.
- 99% of staf had a wound or broken skin covered with a waterproof dressing if required.
- 88% of staff used the most appropriate product for hand hygiene.
- 80% of staff were observed to be ‘bare below the elbow’.

Commodes





Observe 3 Staff:

Question	Total no. Staff	Yes	No
Are Staff wearing a clean apron and gloves for the decontamination procedure?	440	429 (97.5%)	11
Are commodes and bedpan holders decontaminated in area away from clean equipment?	849	843 (99.3%)	6
Is hand hygiene completed before and after decontamination of commode or bedpan holder?	466	453 (97.2%)	13

Do staff demonstrate the correct decontamination procedure in line with BCUHB standard?	516	492 (95.3%)	24

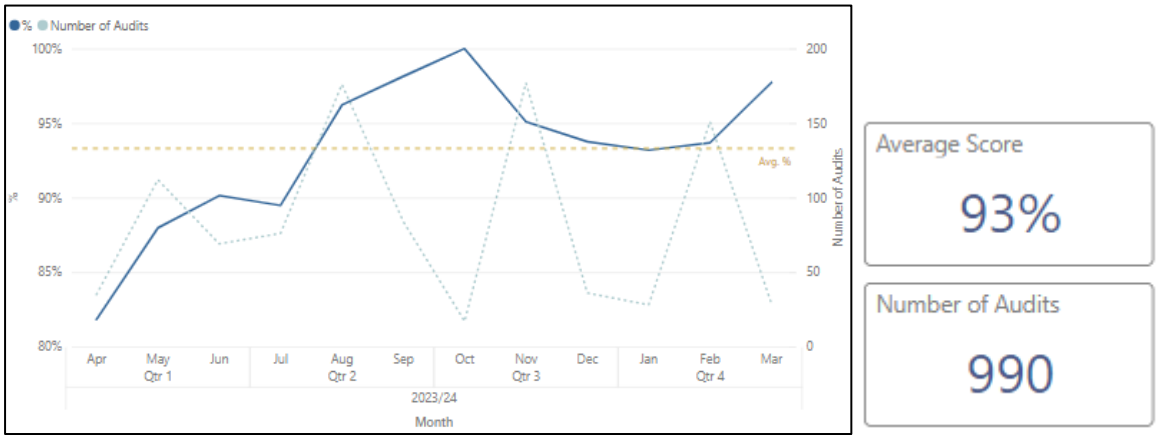
Observation of Area:

Question	Total no. Staff	Yes	No
Is there access to disinfectant wipes or Actichlor plus, warm water, and correct waste disposal (orange bags)?	1,494	1,486 (99.5%)	8

Observe all Commodes:

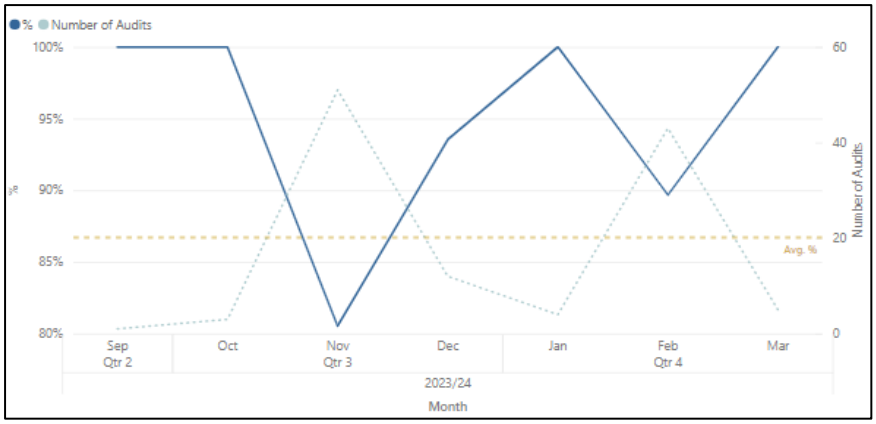
Question	Total no. Staff	Yes	No
Are commodes are in a good state of repair (free from rust/scratches)?	2,545	2,519 (98.9%)	26
Are stored commodes labelled as clean with indicator tape labelled correctly?	2,555	2,227 (87.2%)	328
Are stored commodes visibly clean?	2,552	2,351 (92.1%)	201

Mattress Audit



- 27 mattresses were observed to have a breach in integrity to the outer cover.
- 61 mattresses were observed to have staining on the outer cover that could not be removed with cleaning.
- 7 mattresses with removable covers were observed to have a compromised fastening e.g., broken zip.
- 95 mattresses were observed to have signs of staining, ingress of fluid or malodour inside.
- 4 mattresses with non-removal mattress covers e.g., no zip, failed the water penetration test.

Pressure Relieving Cushions



- 8 cushion covers were observed to have a breach in integrity to the outer cover.

Full Ward/Departmental Audits
Each year, the IPT are required to perform a full ward/departmental audit in all inpatient areas and high-risk departments to include emergency department, theatres, endoscopy, radiology, renal dialysis and outpatient oncology services.

The audit pays particular attention to the environment and compliance scores are as follows:

- 90% - 100% is green with a full audit scheduled for the following year
- 79% - 89% is amber with a repeat audit scheduled in 6 months
- ≤78% is red requiring a repeat audit within one month

East	**Number of areas**	**No. of audits completed**	**Green**	**Amber**	**Red**	**No. reaudited (Red and Amber)**	**No. improved to green**
Inpatient	37	36 (97%)	16 (44%)	14 (39%)	6 (17%)	15 out of 20	9
High Risk	14	12 (86%)	4 (33%)	4 (33%)	4 (33%)	4 out of 8	0
Outpatient (inc HMP)	22	16 (73%)	4 (25%)	7 (44%)	5 (31%)	8 out of 12	3
Central	**Number of areas**	**No. of audits**	**Green**	**Amber**	**Red**	**No. reaudited (Red and Amber)**	**Improved to green**
Inpatient	43	43 (100%)	27 (63%)	8 (19%)	8 (18%)	16 out of 16	3
High Risk	12	12 (100%)	7 (58%)	2 (17%)	3 (25%)	3 out of 5	3
Outpatient	19	19 (100%)	11 (14%)	6 (32%)	2 (10%)	6 out of 8	2
West	**Number of areas**	**No. of audits**	**Green**	**Amber**	**Red**	**No. reaudited (Red and Amber)**	**Improved to green**

Inpatient	42	42 (100%)	2 (5%)	14 (33%)	26 (62%)	27 out of 40	2
High Risk	9	9 (100%)	1 (11%)	3 (33%)	5 (56%)	5 out of 8	2
Outpatient	7	4 (57%)	0 (0%)	1 (14%)	3 (43%	2 out of 4	1

10.2 Ad-hoc Audit Programme

The table below shows a summary of the ad hoc audits completed this year.

Audit	Date	Key findings
CAUTI (	April 2023 and Jan 2024	- 15.3% of patients had a urinary catheter - 10% of them had a CAUTI - E. coli BSIs increased from April to January - Improvement seen in catheterisation being clinically indicated and in being reviewed daily - To repeat the audit in July 2024.
Patient hand hygiene audit	August 2023	- Compliance was higher in Central than East and West
Peripheral vascular devices audit	August 2023	- 33% of patients had one or more vascular devices. - There was poor compliance with standards, especially in the West.
Compliance with MRSA screening	Sept 2023	- Compliance was poor, particularly in the West.
Bristol Stool chart audit	Sept 2023	- Compliance was better in East and Central than West. - Some areas are still using paper versions of the charts as opposed to the Welsh Nursing Care Record
Audit of sharps bins and macerators in sluices	Sept 2023	- sharps bins: improvement required regarding use of the temporary closure and with signing and dating. - macerators: the vast majority were in working order although there were many obsolete/tired machines.
Fluid balance audit	Dec 2023	- Intake was generally documented appropriately - Improvement required in the documentation of IV fluids. - Fluid output particularly in relation to urine was not always documented accurately/appropriately making it difficult to calculate overall fluid balance. - Fluid balance charts were often difficult to read and interpret due to illegible hand writing.
Flushing of little-used water outlets	January 2024	- 73% (95/130) of infrequently used outlets observed were compliant with the SOP.
Personal protective equipment audit	March 2024	- A total of 84 areas and 179 observations made across BCU with an overall compliance of 69%. - PPE was deemed necessary in 97% (174/179) of cases. - PPE was worn in 95% of cases (166/174). - PPE was appropriate in 84% of cases and inappropriate in 16%, being underused in 85% and overused in 15%. - PPE was removed following completion of a task on 170 occasion (95%), however on 9 occasions (5%),

		staff continued to wear PPE after a task had been completed.

11 Estates

11.1 Water

BCUHB uses in excess of 490,000m³ (figure based on consumption 2023-2024) of water during the course of a normal year, which is provided for by Local Water Authorities' (Welsh Water and Harfen Dyfrdwy). The water system and functions on site range from the provision of potable water supplies, tank fed water supplies and specialist 'treated' water supplies providing for process plant and medical equipment.

The management arrangements for Water Safety Systems within BCUHB are contained within ES02 Policy for the management of Safe Water Systems which is published on BetsiNet. Guidance on the management arrangements is contained within Welsh Health Technical Memorandum (WHTM 04-01) and HSG274.

During 2023-2024 the Water Safety Group (WSG) developed a number of key documents to support the safe use of water systems at department level, the below documentation were finally approved and inserted on BetsiNet.

- Standard Operating Procedure (SOP) for Management of Little Used Outlets
- Standard Operating Procedure (SOP) for Management of Pseudomonas (Operational Estates)

NHS Wales Shared Services, Special Estates Services Authorising Engineer (Water) Annual Report

The Authorising Engineer is appointed by the Deputy Duty Holder (Director of Capital and Estates) and is a named representative of the NWSSP Specialist Estates Services Team. They conduct an annual review/audit of operational procedures and compliance and submit a report to the WSG. The report for 2023-2024 reported a compliance rating of Green, which maintains the standards set out during the previous year.

2022	2023
Performance of Water safety Compliance Contractor has improved. **WSG meetings held regularly and good attendance from members.** **2 Site Audits completed.** **5 RP/ DRP Assessments completed** 	**Performance of Water safety Compliance Contractor has been maintained.** **WSG meetings held regularly and good attendance from members.** **1 Site Audit completed.** **2 DRP Assessments completed.** 
Green	**Green**

Water Safety – Internal Audit Report

The review considered whether there were robust processes and controls in place within the Health Board to ensure compliance with the Policy for the Management of Safe Water Systems (ES02) and Welsh Health Technical Memorandum 04-01 - Safe water in healthcare premises.
Following the review, limited assurance was reported to the Health Board with matters requiring management attention listed below:

- There is poor attendance / clinical representation at Local and pan-Health Board WSG Meetings.
- Ward areas and departments do not provide assurance that flushing of little used outlets is completed in line with policy.
- There is a lack of training provision in respect of water hygiene / microbiological control and competency assessment for staff whose responsibilities directly impact water safety.
- It is not clear whether risk assessments adequately assess the risk of Pseudomonas or whether the assessment is solely of Legionella. There is no formal process to ensure risk assessments are reviewed within specified timescales.
- There is a lack of assurance from water providers regarding testing and quality of contingency plans.

The WSG have developed a number of actions that align with the Agree Management Actions to improve compliance which are reported to the Health Board Internal Audit Committee to provide assurance around progress.
A key document that was developed following the internal audit review was the development of a BCUHB Water Safety Training Programme for non-estates staff, the content of the programme has been approved by both the WSG and SIPG and is currently being mobilised across the Health Board.

11.2 Ventilation
BCUHB acknowledges its responsibilities under the Health and Safety at Work Act 1974 and supporting legislation relevant to this discipline, (including The Control of Substances Hazardous to Health (COSHH) Regulations 2000 and subsequent approved codes of practice such as L8 and published guidance documentation such as Health Technical Memorandum (HTM) 03-01 Specialised Ventilation Systems for Healthcare Premises and HTM 04-01, The Control of Legionella), to ensure that it meets the criteria and standards for Ventilation Systems within its control.
The Policy for the Management of Ventilation Systems ES05 was developed to ensure compliance with existing legislation, helping ensure that good practice standards are applied to all ventilation systems in use within the organisation. The policy is published on BetsiNet.

During 2023-24, the Ventilation Safety Group has supported redevelopment projects and reviewed information on verification of critical ventilation systems and this includes a review of isolation rooms within the Health Board and agree a principle of negative pressure.

NHS Wales Shared Services, Special Estates Services – Authorising Engineer (Ventilation) Annual Report
The Authorising Engineer, Ventilation is appointed by the Deputy Duty Holder (Director of Estates and Facilities) and is a named representative of the NWSSP, Specialist Estates Services team. The Health Board has yet to formally appoint the new Authorising Engineer (Ventilation) and have not receive an annual report for 2023.

11.3 Waste Management
BCUHB has now reverted back to pre-Covid times, the reintroduction of clear bags for general/recyclable waste for correct segregation of waste has reduced the number of clinical waste bags, however there is still recyclable/general waste in clinical waste bags.
The wearing of masks has ceased and there is no requirement to have clinical waste bins at entrances and exits.

BCUHB's principle recycling and general waste contractor has sent zero waste to landfill in the last twelve months.
The Health Board's 'de-clutter' campaigns continue to be a great success, encouraging wards and departments to clear clutter and unused items, improving tidiness and easing the cleaning of their areas and supporting our efforts to maintain a safe, clean environment.
WMH implemented a reusable sharps bin trial for three months within theatres, maternity unit and two wards. 563 containers were reused, which produced 1.45 tonnes of sharps waste at a cost of £5,415.46. The trial was very successful with positive outcomes from staff.

Legislation
Environmental Legislation – The Separate Collection of Waste Materials for Recycling: A Code of Practice for Wales came into force as of the 6th April 2024 and is now law.
Waste legislation in Wales has changed and the following changes apply:-
All BCUHB sites are required to segregate their food waste.

1. All NON-hospital sites are required to segregate plastic and cans together, paper and card together, food waste, general waste and glass.
2. All hospital sites from 6th April 2026 are required to segregate plastic and can together, paper and card together, food waste, general waste and glass.

All BCUHB sites are recycling food waste except YGC who will start recycling food waste from mid-June, and YG where internal areas need to segregate their food waste.

East Area
All non-hospital sites are recycling plastic and can, paper and card, food waste, glass and general waste.
Community Hospitals and WMH are segregating food waste.
Recycling waste streams will be introduced at community hospitals later this year followed by WMH.

Central Area
All non-hospital sites are recycling plastic and can, paper and card, food waste, glass and general waste.
All hospitals are recycling food waste, YGC Catering are recycling patient food waste, the remainder of the site will introduce food waste recycling mid-June.
Ruthin & Denbigh Hospitals are recycling plastic and can, paper and card, food waste, glass and general waste internally waiting for contractor to supply bins.
The remaining hospital sites will have recycling in place by December 2024, followed by YGC once a business case has been approved.

West Area
All non-hospital sites and hospital sites are recycling plastic and can, paper and card, food waste, glass and general waste. Except for Bryn Y Neuadd and YG. Bryn Y Neuadd is recycling food waste only. YG has food waste recycling from catering areas and seven external buildings.

Pre Acceptance Waste Audit (PAWA)
East Area: All areas compliant, any PAWA's due will be completed in the next few months.
Central Area: All sites are compliant, any PAWA's due will be completed at the relevant due date.
West Area: Due to the time constraints with the implementation of the new WG legislation all West Hospital site pre acceptance waste audits will be undertaken during June, July and Aug 2024.

11.4 Environmental Improvement Works
The Operational Estates Department within BCUHB received £300,000 discretionary capital funding within 2022/2023 to improve the hospital environment. The projects were presented

to each LIPG for approval. Four different work streams were developed based on geographical responsibility within Operational Estates (East, Central and West) and MHLD. In addition £250k was aligned for improvement of infrastructure and environment within Abergele Hospital.

Abergele Hospital Projects

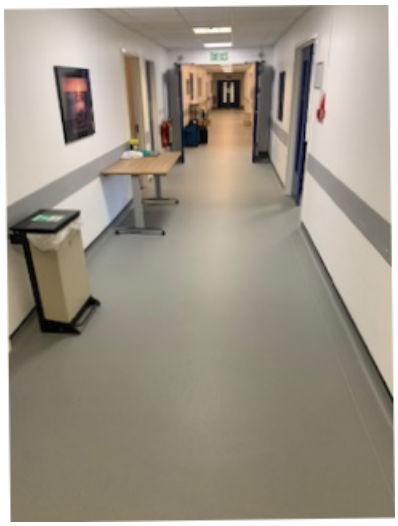
Project	Capital File Number	Capital Code	Budget	Status
Abergele Hospital - Main Intake Substation - Switchgear Upgrade	2H36	CCP00153	£5,000	Completed
Abergele Hospital- Ward 6 steam plant room services upgrade	2P3D	CCP00194	£140,000	Commenced
Abergele Hospital - Orthopaedics theatre changing room building defects upgrade	2X4G	CCP00199	£19,000	Completed
Abergele Hospital- Porters entrance building defects Upgrades	2X4H	CCP00200	£16,000	Completed
Abergele Hospital Ward 3 building fabric upgrade	2P3B	CCP00192	£ 13,000	Completed
Abergele Hospital Ward 4 building fabric upgrade	2P39	CCP00190	£6,000	Completed
Abergele Hospital Ward 6 building fabric upgrade	2P3D	CCP00194	£26,000	Completed
Abergele Hospital Ward 8 building fabric upgrade	2P3C	CCP00193	£10,000	Completed

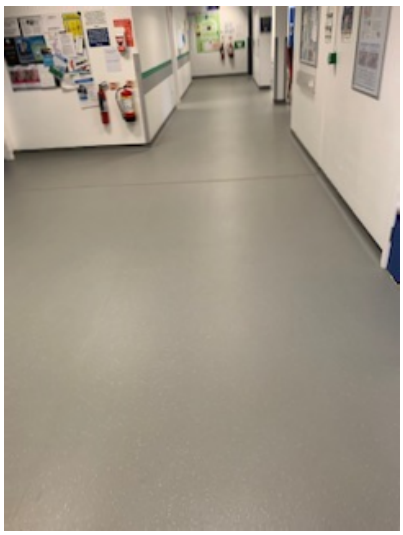
Safe Clean Care

Pan	**Safe Clean Care - West**	
	YG Ophthalmology Unit	Completed
	YG Ophthalmology Eye Clinic	Completed
	Eryri IPS and Kitchens	Completed
	YPS Kitchen and Flooring	Completed
	Original Approved Budget	**£ 92,500**
Pan	**Safe Clean Care - Central**	
	YGC - AMU Flooring	Completed
	Colwyn Bay Hospital - Replace Radiator Covers	Completed
	Llandudno Hospital Flooring	Completed
	Original Approved Budget	**£ 92,500**
Pan	**Safe Clean Care - East**	
Cunliffe Ward	Shower Room	Completed
Bursham Ward	Assisted Bathroom	Completed
Emergency Dept	Flooring and wall protection	Completed
Main OPD	Flooring Upgrade	Completed

	Original Approved Budget	**£ 92,500**
Pan	**Safe Clean Care - MHLD**	
	Projects to be approved by end of June	
	Central Ablett Unit	Completed
	East - Heddfan	Completed
	West - Hergest	Completed
	Original Approved Budget	**£ 20,000**

Examples of some of the improvements are illustrated below.
New flooring:

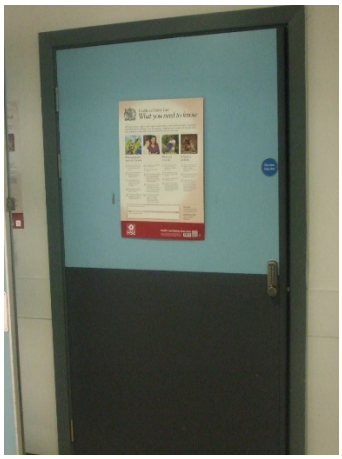




New kitchens, bathrooms and sinks:



New doors and wall protection:


11.5 Risk Register

A number of IP related risks are part of the Operational Estates Risk Register; they are reviewed regularly. Specific elements included are ventilation and control of contractors.

ID	Ref	If Pan BCU 'Yes' who is the Host Region?	Specialty	Unit	Handler	Title	Risk Rating (Initial)	Risk Rating (current)	Risk Rating (Target)	Risk Type
4618	Op E QSAM		Estates Operational - Environmental	Ysbyty Abergele Hospital	Hughes, Mr Arwel	Abergele Hospital - Environmental Infrastructure and Patient Safety Risk	12	12	6	Tier 2 - (Current Score 9-12)
3030	CRR20-02	Other (Pan BCU Corporate Offices e.g. Finance, Estates, MIH&LDS, etc.)	Estates Operational - Engineering		Taylor, Mr Rod	Contractor Management and Control	20	15	8	Tier 1 - Corporate Risk (Current
2446	Ventilation Safety Group	Other (Pan BCU Corporate Offices e.g. Finance, Estates, MIH&LDS, etc.)	Estates Operational - Engineering	Wrexham Maelor Hospital Acute	Hughes, Mr Arwel	Critical Ventilation - Estates Operational - Engineering	15	12	6	Tier 2 - (Current Score 9-12)
2194			Estates Operational - Building	Ysbyty Abergele Hospital	Hughes, Mr Arwel	current vulnerability of the Abergele estate	16	12	6	Tier 2 - (Current Score 9-12)
1673	Op E QSAM	Other (Pan BCU Corporate Offices e.g. Finance, Estates, MIH&LDS, etc.)	Estates Operational - Environmental		Taylor, Mr Rod	Divisional Health and Safety Management Arrangements	16	12	6	Tier 2 - (Current Score 9-12)
2434	CRR23-35		Estates Operational - Engineering	Wrexham Maelor Hospital Acute	Taylor, Mr Rod	Electrical and Mechanical Infrastructure on the Wrexham Maelor Site	20	16	6	Tier 1 - Corporate Risk (Current Score 15-25)
2451	Electrical Safety Group		Estates Operational - Engineering		Hughes, Mr Arwel	Electrical Infrastructure Community Hospitals - Estates Operational Engineering	12	9	6	Tier 2 - (Current Score 9-12)
3022	Electrical Safety Group	Other (Pan BCU Corporate Offices e.g. Finance, Estates, MIH&LDS, etc.)	Estates Operational - Engineering		Hughes, Mr Arwel	Electrocution at Work	20	10	6	Tier 2 - (Current Score 9-12)
1664	OP E QSAM	Other (Pan BCU Corporate Offices e.g. Finance, Estates, MIH&LDS, etc.)	Estates Operational - Building		Taylor, Mr Rod	Estates and Facilities Backlog Maintenance / Infrastructure Modernisation	16	12	9	Tier 2 - (Current Score 9-12)
4255	Op E QSAM		Estates Operational - Building	Bryn y Neuadd Hospital	Taylor, Mr Rod	Facilities Department - Structural Risk	20	12	5	Tier 2 - (Current Score 9-12)
4356	Decommissioning GP		Estates Operational - Building	Field Hospital	Welham, Dale	Field Hospital - Security Incursions to Vacant Site	12	1	1	Tier 2 - (Current Score 9-12)
3618	Decommissioning Group		Estates Operational - Building		Welham, Dale	Field Hospital Decommissioning - Timeline	20	1	1	Tier 2 - (Current Score 9-12)
4283	Op E QSAM	Other (Pan BCU Corporate Offices e.g. Finance, Estates, MIH&LDS, etc.)	Estates Operational - Engineering		Taylor, Mr Rod	Health & Safety and Statutory Compliance Resources Business Case	16	12	6	Tier 2 - (Current Score 9-12)
1666	Op E QSAM	Other (Pan BCU Corporate Offices e.g. Finance, Estates, MIH&LDS, etc.)	Estates Operational - Environmental		Hughes, Mr Arwel	Infection Prevention and Control	16	9	6	Tier 2 - (Current Score 9-12)
3023	CRR20-03	Other (Pan BCU Corporate Offices e.g. Finance, Estates, MIH&LDS, etc.)	Estates Operational - Environmental		Taylor, Mr Rod	Legionella Management and Control.	20	16	8	Tier 1 - Corporate Risk (Current Score 15-25)
4275	Ventilation Safety Group	Other (Pan BCU Corporate Offices e.g. Finance, Estates, MIH&LDS, etc.)	Estates Operational - Engineering		Taylor, Mr Rod	Non-Critical Ventilation	12	12	6	Tier 2 - (Current Score 9-12)
1318	IP Estates Priorities		Estates Operational - Environmental		Hughes, Mr Arwel	Risk of infection due to delays in Infection Prevention Urgent Estates Work Priorities	16	6	6	Tier 2 - (Current Score 9-12)
1667			Estates Operational - Engineering		Taylor, Mr Rod	Staff Resources and Capability	16	12	8	Tier 2 - (Current Score 9-12)

12 Facilities

Changes to Operational Facilities Structures

2023/24 saw Operational Facilities settling in to the new Stronger Together Structure where Operational Facilities had been separated from Operational Estates to be realigned under the three Integrated Health Communities (East, Centre and West).

Following the retirement of the Head of Operational Facilities in early 2023, the Facilities Oversight Team were realigned several times to the line management of the Director of Operations, then the Chief of Staff and latterly back to the Head of Operational Estates pending the appointment of a Director of Environment. During this period of corporate flux, the Operational Facilities Oversight Team have remained focussed on supporting the portfolio of operational issues that need to be maintained to provide service support to the Health board.

12.1 Management Arrangements

Operational Facilities provide Domestic Services across the HB, they provide a quality service and strive to improve the cleaning agenda wherever possible. The Domestic Services Departments work closely with the Integrated Health Communities, by daily representation at the hospital huddle meetings and are in regular contact with the IPT.

12.2 Environmental Cleaning Services

The cleanliness of the healthcare environment is important for the prevention of the spread of infection and patient safety and well-being. Furthermore, the cleanliness of an environment can contribute to the overall quality of a patient's experience. All Health Board staff have a responsibility for the cleaning and maintenance of their workplace and have a role to play in providing continuous improvement in environmental cleanliness. The National Standards of Cleaning, Wales (2009) sets out the cleanliness requirements for all Health Boards in Wales.

As part of the response to COVID-19, an addition to the present National Standards of Cleaning (Wales) was issued in late 2020 under the title COVID-19 Addendum, Key Standards for Environmental Cleanliness; this relates to all staff who undertake cleaning within a healthcare facility. During December 2021 this was superseded by the All Wales Key Standards for Environmental Cleanliness.

12.3 Refresh of National Standards for Cleaning

An All Wales Task and Finish Group was set up in early 2023 to review and update the National Standards for Cleaning in NHS Wales (2009) document. This work is led by the HCAI Delivery Board on behalf of WG. BCUHB have two representatives on the group: Assistant Director of Nursing Infection Prevention and Head of Facilities for IHC East. The refreshed document is currently in final draft format and will be presented to WG and NWSSP in May 2024. It is anticipated that the document will be launched in autumn 2024, followed by a period of consultation and implementation.

The refreshed document will comprise 10 separate standards, in similar format to the All Wales Covid 19 Addendum Key Standards for Environmental Cleanliness (published September 2020) and the National Standards for Cleaning in Wales – ADDENDUM - Key Standards for Environmental Cleanliness (published in December 2021).

As in the 2009 document, the refreshed version is expected to include the requirement for Health Boards to have a nominated Independent member of the Board with responsibility for cleanliness and to have an agreed Cleaning Responsibility Framework. It is anticipated that the recommended cleaning frequencies outlined in the revised document will be in line with the 2021 National Standards (for example, a ward would require 2 standard cleans a day - morning and evening, plus an afternoon touch point clean), which is higher than the recommended frequencies in the 2009 document.

12.4 Reduced Covid addendum funding

In August 2021 the Health Board authorised the creation of 96 WTE Band 2, and 3 WTE Band 3 permanent posts within Domestic Services. These posts were split equally between the three Areas (East, West, and Central) to meet the increased cleaning frequencies specified in the All Wales Covid Addendum Key Standards for Environmental Cleanliness (published September 2020).

During May 2023, it became apparent that the funding allocations into the Domestic Services budgets for Covid addendum for 2023/2024 had been reduced and was not sufficient to fund the 96 WTE authorised posts. Action has been taken to reduce Domestic Services posts in an attempt to meet the available funding and this has resulted in reduced cleaning frequencies and difficulties in achieving enhanced cleaning requests.

The National standards for cleaning in Wales – Key Standards for Environmental Cleanliness (replacing the All Wales Covid Addendum Key Standards) was launched in December 2021 and the cleaning frequencies contained in this document are expected to be replicated in the refresh of the National Standards for Cleaning which is due to be launched in Autumn 2024.

Domestic Services have undertaken a piece of work to identify the additional funding which is required to bring the services in line with the frequencies in the December 2021 Wales - Key Standards for Environmental Cleanliness and the shortfalls are as follows:

Area	Estimate additional funding required	Less current Covid Addendum funding	Funding shortfall
West	£1,262,260	£ 818,111	£444,149
Central	£2,625,597	£ 793,895	£1,831,702
East	£1,256,765	£ 815,541	£443,224
TOTAL	**£5,144,622**	**£2,427,547**	**£2,719,075**

Further information was provided in a SBAR, presented to the Organisational Leadership Team in December 2023. Recommendations included:

- Highlight the situation at each LIPG and escalate to SIPG.
- IHC need to agree with the IPT whether to continue to reduce cleaning frequencies or increase budget.
- As all three IHC's will potentially be affected in the same manner and it's anticipated that the Health Board will each wish to apply the same standards. Consideration should be given to establishing a task and finish group including Facilities/Domestic Services and the IPT to review current frequencies, staffing levels, receive guidance on cleaning frequencies and undertake a gap analysis.
- Further pieces of work need to be undertaken by Domestic Services to identify the cleaning frequencies that can be achieved within the current financial allocation and review times of work of Domestic Assistants appointed under Covid addendum funding and identify how the allocated hours affects the department's ability to fulfil cleaning frequency requirements.

Meanwhile, until further clarity is received, where resources are limited, Domestic services discuss prioritisation with IP colleagues.

12.5 All Wales Facilities Framework Qualification

Facilities have recently started to work with local colleges to offer the above Level 2 qualification to members of our Domestic Services teams. At the time of writing we can confirm that four Domestic Assistants have signed up to commence their assessments.

12.6 Enhanced cleaning processes

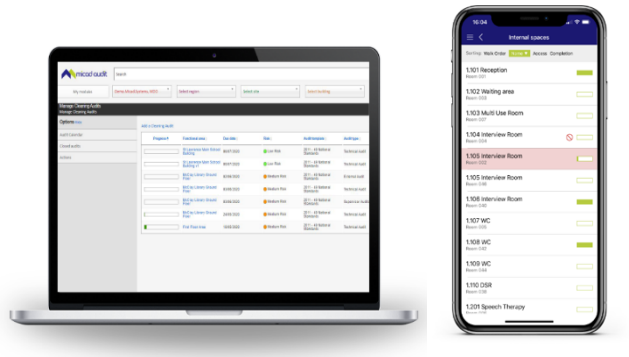
Since the last report, as part of the Domestic Services high-level disinfection process, the use of hypochlorous acid misting (HPA) has been embedded in to the equipment fleet for the Deep Cleaning Teams. There have been challenges in regard to implementation of this technology, which has been out of use since September 2023, however the benefits have been tangible

and all parties are invested in resolving any remaining issues. The future balance of Deep Cleaning equipment is currently under review in LIPGs with a report due to go to SIPG in the summer of 2024.

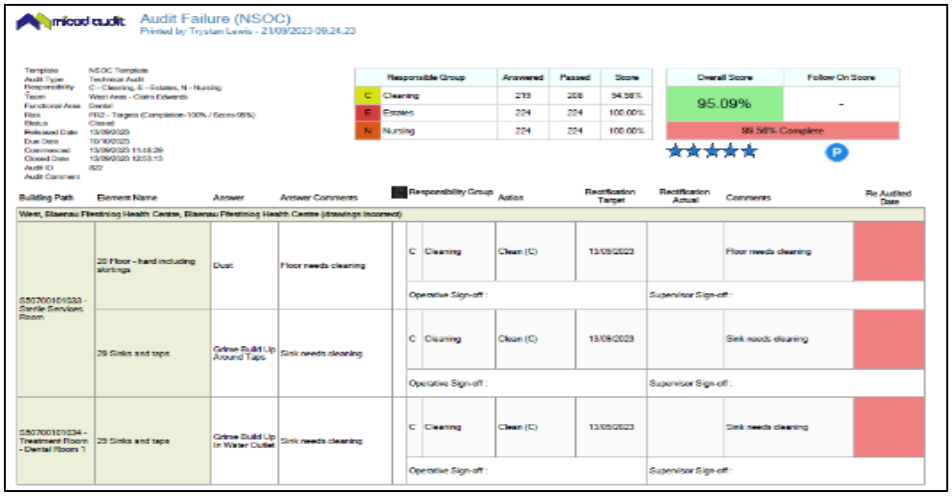
12.7 Monitoring against National Standards of Cleaning (NSoC) in Wales

The National Standards for Cleaning, Wales (2009) stipulate that continuous monitoring of environmental cleanliness is undertaken.

During 2023-24 there has been a transition in the auditing tool used by the Health Board to capture and report on NSoC – previously we used a software tool called Credits 4 Cleaning (C4C) which had ceased to be supported by the supplier; it was necessary therefore to switch. After a market review 'MICAD Audit' was chosen as the preferred solution. This transition has required a significant amount of work to data cleanse and rebuild audit schedules as the data in C4C has become out of date. All West Area wards were live on Micad Audit by November 2023, with a scheduled completion date for all three Areas by 30th June 2024. This transition to a new system has allowed the re-mapping of services, so that the reports more accurately reflect the current layouts. It has also been an opportunity to review the auditing frequencies for each area relevant to the activity being undertaken within the spaces, and in accordance with national guidelines.



The Domestic Supervisors facilitate the audit process with support from Nursing and Estates colleagues. Senior Nursing Leads, Operational Estates Managers and Domestic Services Managers are provided with reports following each audit for their respective responsibility elements. The reports inform the basis for an improvement plan required by each manager. Where the result falls below the target score, a follow-up audit may be undertaken to check that failures have been rectified within agreed timescales. A follow-up score is then provided, giving assurance of improvement.



The frequency of audits is guided by the risk category of the area as defined in NSoC. Very high risk functional areas are audited weekly – these include operating theatres, ICUs, SCBUs,

EDs, and other departments where invasive procedures are performed or where immuno-compromised patients are receiving care. High-risk functional areas are audited monthly – these include general wards (acute, non-acute and mental health), sterile supplies, public thoroughfares and public toilets.

Monthly Compliance Reports are provided to Heads of Facilities and IP leads to give assurance that areas are audited in line with agreed frequencies. Audit scores are also provided. A summary of these reports is reviewed at the Area LIPGs.

micad audit **12 Month Review (NSOC)**

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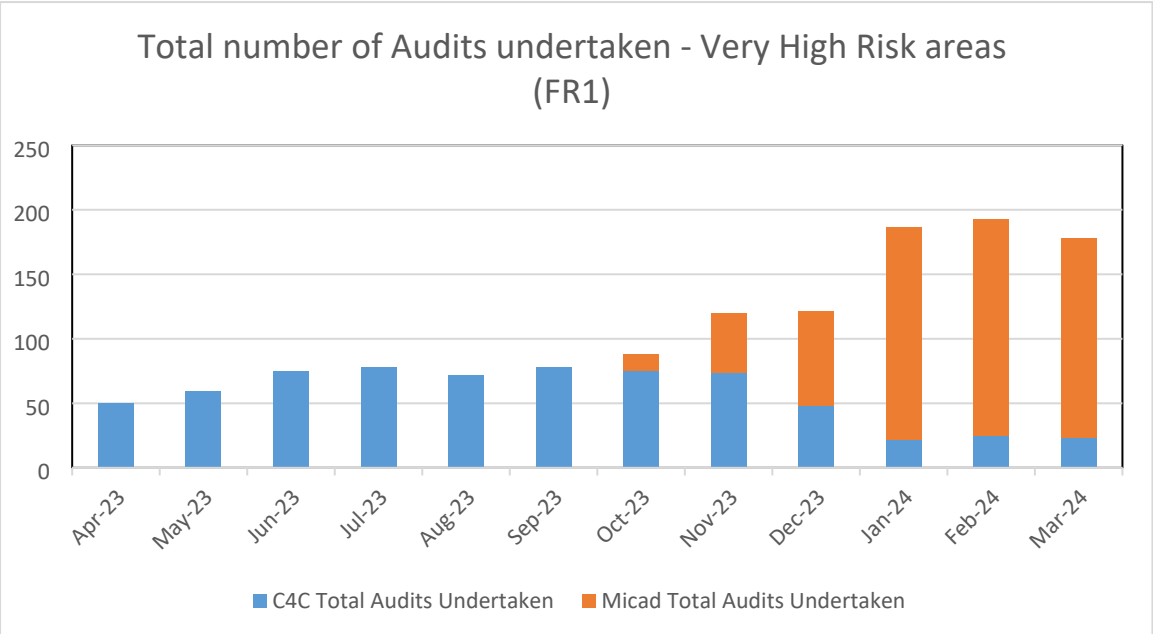
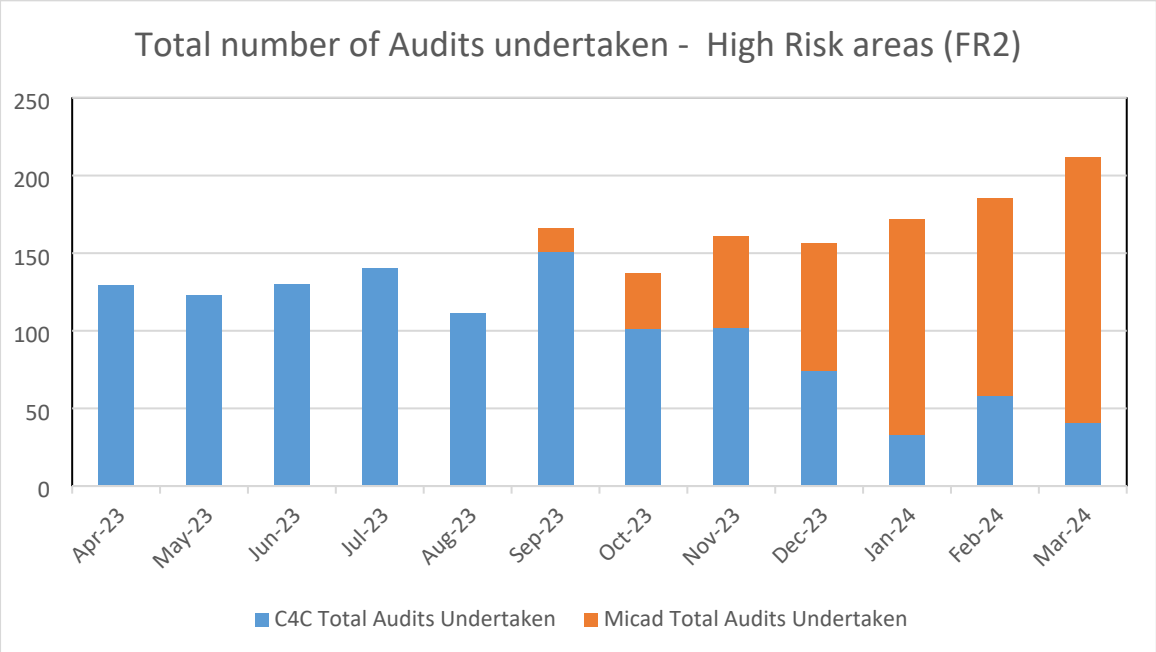
Audit types	All Audit Types
Responsibility groups	All Responsibility Groups
Teams	All Audit Teams
Directorates	All Directorates
Functional areas	All Functional Areas
Risks	All Audit Risks
Room element templates	All Internal Space Templates
Element types	All Element Types
Selected date range	01/05/2023 to 18/04/2024

Functional Area	Audit Closed	Month No. 6 Oct 23	7 Nov 23	8 Dec 23	9 Jan 24	10 Feb 24	11 Mar 24	12 Apr 24	Target %	Ave (%)
Dewi Ward/Ffrancon Ward/Prysor Ward/ Hebog Ward 009		**96.23**	**96.18**	**93.39**	**94.04**	**95.52**	**95.18**	**96.06**	**93.83**	**95.01**
Dewi Resus - Ysbyty Gwynedd				88.46	80.77	94.87	90.67	96.30	95.00	91.98
Dewi Ward - Ysbyty Gwynedd		94.55	94.93	95.92	94.28	96.02	96.02	96.37	95.00	95.44
Ffrancon Ward - Ysbyty Gwynedd				-	98.36		96.88		95.00	96.26
Hebog Ward - Ysbyty Gwynedd		97.08	96.44	97.14	97.27	97.18	97.46	98.06	98.00	97.28
Prysor Ward - Ysbyty Gwynedd		-	96.89	96.90	95.47	96.89	95.66		95.00	96.36
Sleep Clinic - Ysbyty Gwynedd		-		81.48	85.19	88.89	92.59	89.29	85.00	87.49
Heulwen/GUM/Paediatric/SCBU/Labour /Maternity/OAU		**94.98**	**96.60**	**95.29**	**95.94**	**95.80**	**96.10**	**96.79**	**94.00**	**96.04**
GUM Clinic - Ysbyty Gwynedd					96.27		95.71	96.77	85.00	96.25
Heulwen Paediatric Clinic - Ysbyty			96.63	94.90	96.12	92.91	92.42	96.05	95.00	94.84
Labour Theatre					94.17	94.91	94.59	-	98.00	94.70
Labour Ward - Ysbyty Gwynedd		-		95.57	95.85	96.02	97.02	96.32	98.00	96.09
Maternity Outpatient Assessment				96.73	96.13	98.08	98.10	99.37	98.00	97.68
Midwife-led Unit - Ysbyty				95.41	99.01	97.64	97.69	98.38	95.00	97.63
SCBU - Ysbyty Gwynedd		94.98	96.58	94.80	96.20	96.04	96.62	96.25	98.00	96.02
Ty Enfys - Ysbyty Gwynedd							98.64	98.37	85.00	98.50

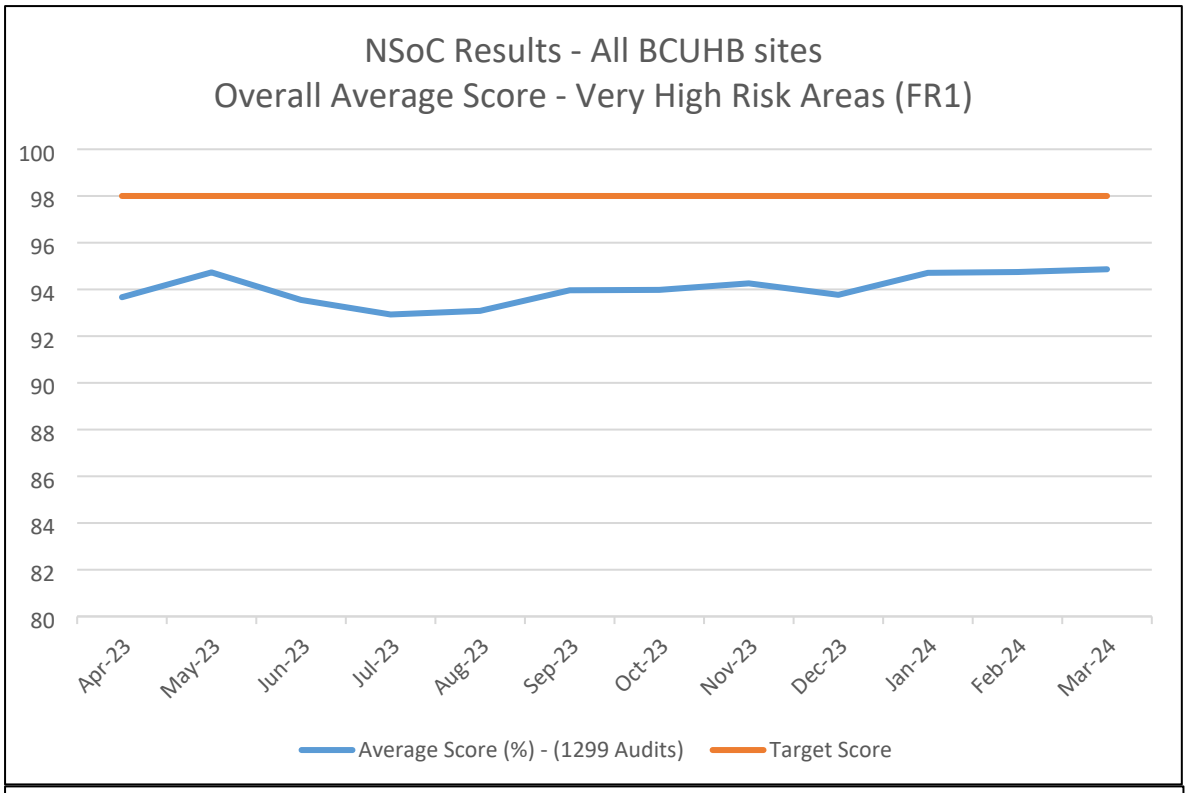
12.8 Progression and Improvement

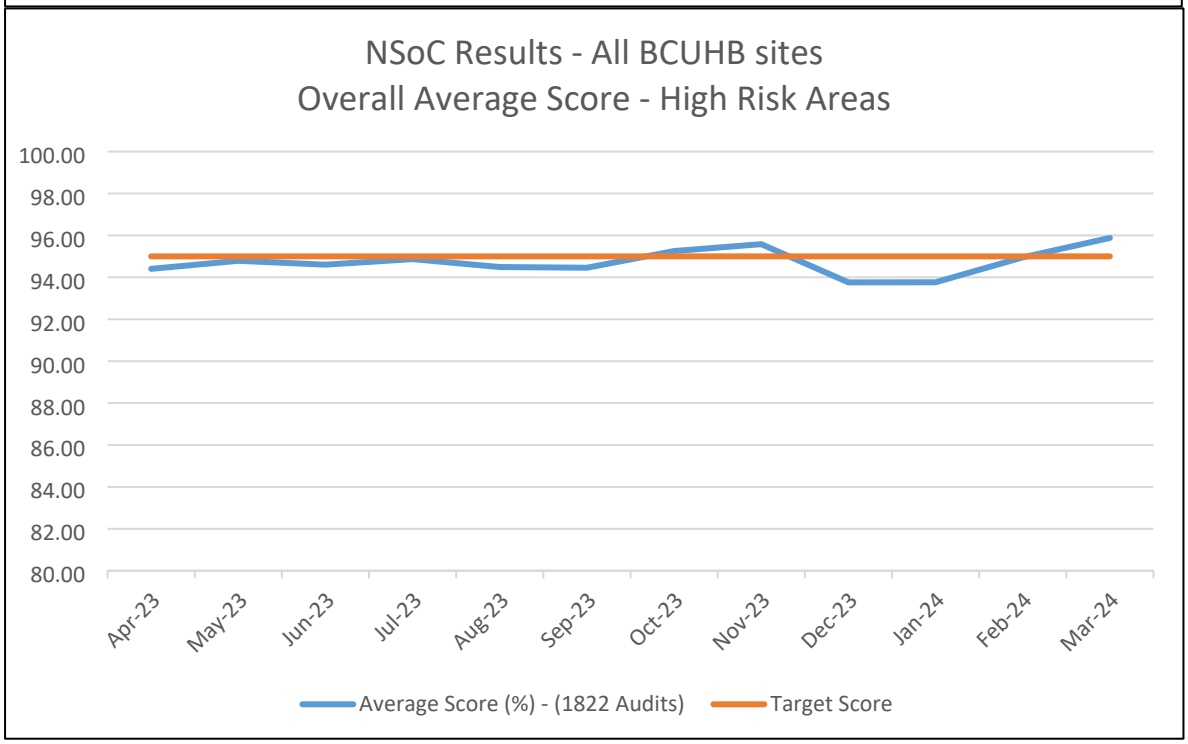
The Very High and High Risk area graphs below portray the progression of switching from C4C to MICAD Audit, as well as highlighting that the number of cleaning audits has improved dramatically. This is due to the audit schedules now being accurate and updated to match our modern clinical footprint which in turn gives confidence to our Auditing Supervisors that a system of rigour is in place and that an improvement methodology is once again possible.





The two graphs below show that our MICAD Audit reports confirm that our cleaning processes across the Health board meet or are very near the mandated required standards for Very High Risk (FR1) and High Risk Areas (FR2). Where reported standards in Very High Risk Areas (FR1) are slightly lower than the ideal, this is thought to be due to further asset/element rectification work that is required to the new software tool and is also likely affected by the reduced staffing situation that we find ourselves in.





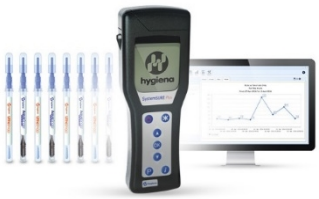
12.9 Current Establishment Gapped Posts

In addition to the issues described above relating to the posts required to meet NSoC compliance, at the time of writing there is a real world staffing deficit in Domestic Services as follows:

IHC West - 22.16 WTE shortfall
IHC East - 20.93 WTE shortfall
IHC Centre -19.71 WTE shortfall

12.10 Forensic Cleanliness Auditing

Both ATP Testing units and Ci-Fi Torches are held within the Health Board and can be used by IPC colleagues as required in response to outbreaks.
Partnership working is ongoing with Staffordshire University under a Memorandum of Understanding with their Centre for Crime, Justice and Security. Research continues into best use of a forensics torch to support cleanliness auditing within Healthcare settings.



12.11 NWSSP Linen Services

The North Wales Laundry is located on the YGC site and run as part of the All Wales Laundry Service (NWSSP). The Laundry provides linen services for all Health Board sites and Wales Ambulance NHS Trust sites in North Wales. The service is used by all clinical wards and departments within the Health Board. The Laundry produces over six million individual pieces of linen per year.
The below table details the breakdown of linen items processed in 2023/24:

Site	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	
Central IHC													Total
Abergele Hospital	6,111	5,692	3,902	5,318	6,174	4,813	7,449	4,504	5,297	4,038	5,132	3,368	61,798
Breast Test Wales Llandudno				107	125	125	90	159	100	103	131	90	1,030
Bryn Hesketh Unit	703	850	1,181	1,419	2,099	2,096	1,898	2,088	1,639	2,199	1,327	1,458	18,957
Colwyn Bay Hospital	3,887	4,363	5,438	4,035	4,504	4,093	4,253	4,616	2,947	5,770	5,547	2,757	52,210
Denbigh Hospital Ward	3,397	2,615	3,579	2,954	2,928	3,536	2,493	2,810	3,220	2,732	2,511	2,710	35,485
Glan Clwyd Ablett Unit	2,795	2,937	3,266	2,957	2,758	2,940	2,680	2,871	3,556	3,134	3,100	3,166	36,160
Glan Clwyd Hospital	108,456	125,347	111,153	124,654	126,030	117,340	117,767	120,888	117,592	128,409	115,938	107,903	1,421,477
Glan Clwyd Mortuary	580	280	819	537	545	580	495	598	645	535	560	650	6,824
Glan Clwyd Residences	1,236	1,693	2,040	1,343	1,241	1,460	1,347	1,481	1,491	1,145	1,025	1,173	16,675
Hafod Unit Rhyl	18		18		18		20						74
Llandudno Hospital	11,549	14,476	12,420	12,804	12,422	12,255	12,916	12,569	12,907	12,612	10,499	9,154	146,583
NWAS	273	393	204	314	469	243	311	250	280	240	195	176	3,348
Royal Alex Hospital	168	275	400	160	140	220	120	155	230	32	120	129	2,149
Ruthin Hospital	2,581	3,132	3,687	2,789	2,676	4,527	2,662	2,963	3,590	3,029	3,056	2,896	37,588
Tan Y Castell	529	821	762	685	701	974	697	759	953	732	684	793	9,090
YGC Ty Nerys Unit	275	230	220	355	210	301	225	280	175	160	190	180	2,801
East IHC													
Chirk Hospital	2,512	2,299	2,644	2,038	2,550	2,226	2,051	3,023	2,387	2,868	2,981	1,857	29,436
Coed Celyn Hospital	125	190	116	83	104	254	298	64	145	120	104	132	1,735
Croes Newydd Wrexham	2,165	2,227	1,759	2,251	2,419	2,091	2,514	2,285	2,262	1,944	2,251	1,899	26,067
Deeside Hospital	5,452	5,340	6,252	4,980	5,682	4,614	4,465	6,018	5,543	5,634	6,111	3,702	63,793
Heddfan Unit Wrexham	2,805	2,956	2,271	2,361	2,809	2,923	1,982	2,186	2,615	2,531	1,933	2,410	29,782
Holywell Hospital	4,588	4,544	5,862	3,979	5,452	4,853	4,705	6,134	5,110	5,096	6,330	4,055	60,708
Mold Hospital	4,519	4,347	5,410	4,703	4,621	5,719	5,116	4,784	5,509	4,406	4,406	4,910	58,450
Penley Hospital	487	546	816	743	715	565	445	536	442	473	625	426	6,819
Wrexham Maelor Hospital	76,704	95,507	78,468	85,137	91,552	80,018	85,915	88,465	84,020	90,728	82,707	77,159	1,016,380
Wrexham Renal Unit	1,540	2,225	1,495	920	1,915	1,145	1,675	1,515	1,385	1,574	1,360	915	17,664
Wrexham Residences	640	750	970	978	270	325	273	260	272	260	40	180	5,218
Wrexham Surgical Unit	7,304	8,561	8,978	8,903	9,317	8,410	9,281	10,397	8,316	8,721	8,944	8,184	105,316
Wrexham Top Floor Unit	23,647	23,399	24,696	21,695	23,875	22,166	25,660	24,435	21,708	24,097	21,543	21,291	278,212
West IHC													
Alltwen Hospital	2,698	3,041	2,611	2,583	3,040	2,133	2,280	3,508	2,723	3,558	2,610	2,390	33,175
Bangor Hospital	98,576	112,936	103,312	112,529	117,432	104,686	110,351	109,811	104,645	115,181	103,675	97,676	1,290,810
Bangor Renal	615	700	595	984	1,040	1,530	1,025	1,370	1,378	1,530	1,325	870	12,962
Bangor Residences	843	1,320	1,877	1,080	762	345	563	906	1,613	1,445	770	940	12,464
Bryn Beryl Hospital	2,211	2,726	2,093	2,201	2,539	2,126	2,052	2,616	1,885	2,463	2,061	1,815	26,788
Bryn Y Neuadd Hospital	1,250	2,102	2,380	2,230	1,984	2,521	3,253	2,627	2,492	2,981	1,970	1,603	27,393
Cefni Hospital	1,886	1,967	1,564	1,643	1,605	1,564	2,296	2,045	1,833	1,744	1,561	1,015	20,723
Dolgellau Hospital	2,201	3,146	2,375	3,003	3,755	2,605	2,122	3,114	2,342	3,226	2,419	1,986	32,294
Eryri Hospital	3,554	4,074	3,990	3,914	5,375	4,649	4,229	5,170	4,120	5,357	4,447	4,185	53,064
Penrhos Stanley Hospital	4,032	4,884	3,499	3,220	4,730	3,719	4,998	3,441	4,282	4,904	4,074	3,106	48,889
Tywyn Hospital	1,085	100	80	80	100	60							1,505
Grand Total across all sites	393,997	452,991	413,202	432,669	456,683	416,750	432,972	441,701	421,649	455,711	414,262	379,309	5,111,896

The following additional items have also been processed in 2023/24 as part of the NWSSP Laundry cleaning:

- Pan BCUHB - 1,085, 909 Microfibre Mops & Cloths
- Pan BCUHB – 508,974 Vileda or String Mops
- Pan BCUHB – 1,455 Dynamic Mattresses

12.12 Food Safety

The Health Board introduced a BCUHB Primary Authority Scheme (PAS) agreement between Wrexham County Council (WCC) and the Health Board in 2016 originally on a three year agreement which was retendered in 2020 for a further three years with WCC. Following a multi-quote in May 2024, WCC will continue with the PAS agreement until 2025 and then a retender will take place. Prior to the PAS being in place, food safety was monitored by the six different Local Authority, Environmental Health Teams across North Wales. This did not allow standardisation for BCUHB in relation to food safety policy and process. BCUHB Facilities Management Services have developed over the last three years in partnership with their Primary Authority Scheme provider, a robust food safety system which merged 21 food safety policies and associated documentation into one.

The objectives which formed the agreement of activity to be undertaken in partnership between the primary authority and the Health Board are:

- To provide expert advice with the updating of the BCUHB Catering Strategy in relation to the Food Safety Act and associated regulations and guidelines. The PAS advises on the strategic direction for both Acute and Community Hospitals which may require different methods of food delivery dependant on the type of patient. The advice will also include satellite ward/department and retail catering.
- To support the maintenance of the BCUHB Food Safety Management System to cover both primary and satellite catering facilities to achieve the performance indicator set by the organisation to have all catering outlets at a Food Safety Score of level 5.
- To provide expert advice on Food Standards and new/changes in food safety legislation and regulations e.g. Allergens, labelling.
- The training of Nursing, Catering and Non Clinical staff on the BCUHB Food Safety Management System and Food Hygiene to a level which matches their job description and employment personal specification in relation to food service.
- To provide expert advice with the prioritising of catering equipment and kitchen infrastructure to support the writing of business justification cases for the modernisation and replacement of equipment and premises in line with the BCUHB catering strategy. The business justification cases will form the case of need for requesting capital funding.
- To conduct a programme of audits and associated compliance checks on Health Board catering premises to support continuous improvement in relation to the BCUHB Food Safety Management System.
- Undertake other activities which sit within the scope of the primary authority scheme agreement requested by the Health Board.

Food Safety Scores at time of writing are given below:

Location	Rating	Date	Status
Anglesey & Gwynedd (West IHC)			
Ysbyty Gwynedd	5	27/03/24	→
Ysbyty Bryn Beryl	5	12/03/24	↑
Ysbyty Dolgellau	5	07/09/23	→
Ysbyty Tywyn	5	11/10/23	→
Ysbyty Alltwen	5	30/11/22	↑
Ysbyty Cefni	5	12/05/23	→
Eryri Hospital	5	20/02/24	↑
Penrhos Stanley Hospital	5	19/09/23	→
Bryn y Neuadd	5	21/04/23	→
Conwy & Denbighshire (Centre IHC)			
Ysbyty Glan Clwyd	5	06/01/23	→
Child Adolescent Unit Catering, Abergele Hospital	5	07/02/23	→
Denbigh Infirmary	5	13/01/23	→
Llandudno Hospital	5	09/02/23	→
Colwyn Bay Hospital	5	08/03/24	→
Ruthin Hospital	5	08/02/23	→
Wrexham & Flintshire (East IHC)			
Wrexham Maelor	5	20/03/23	↑
Deeside Community Hospital	5	12/03/24	→
Mold Community Hospital	5	23/02/24	→
Chirk Community Hospital	5	03/05/23	→
Holywell Community Hospital	5	02/08/23	→
Penley Hospital	5	19/04/24	→

Key	
No Change	→
Increase	↑
Decrease	↓

NB – All Health Board food hygiene ratings are available on the BCUHB intranet or via the Food Standards Agency website.

Food Safety Training
Our commitment to ensure that all our Catering staff receive the highest quality Food Safety training through the Primary Authority, which means that our trained capability often exceeds Food Safety Legislation which helps our Catering Teams to provide the best levels of Food Safety.

Ward Kitchens
The responsibility for the management of Ward kitchens sits with Nursing Leadership. Regular ward kitchen audits are carried out by ward staff with support from the Health Boards Catering

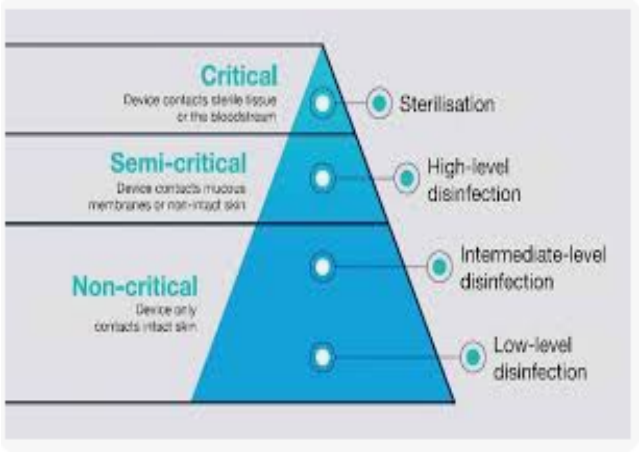
Departments who continue to undertake ad-hoc audits to ensure compliance in line with the Food Safety Act.
The IPT have taken a number of interventions to ensure compliance, which has supported best practice and improvement in the management of ward fridges. Recent Environmental Health Officer, Food Safety enforcement visits have recognised this in the corrective action reports following the visits.

12.13 Facilities Risk Management
Of the Risks currently on the Facilities Risk Register those with an IP aspect are as follows:

Risk 4695 – NWSSP Laundry – This risk is being managed by way of BCUHB executive partnering with NWSSP via the NWSSP Committee and by the Facilities Oversight team facilitating reviews of operational solutions along with a medium term review of the Service Level Agreement and Memorandum of Temporary Occupation. Updates will be reported in the SIPG.
Risk 4463 – Central IHC – Domestic Services 7 day service pressure – This risk is being managed by the Central Area IHC with unfunded service support demands being reported via the LIPIG.
Risk 4465 – West IHC - Domestic Services – Recruitment - This risk is being managed by the West Area IHC with service support shortfalls being reported via the LIPIG.
Risk 4456 – East IHC - Domestic Services – Enhanced Cleaning Requests - This risk is being managed by the East Area IHC with unfunded service support demands being reported via the LIPIG.
Risk 4466 – West IHC – Domestic Services 7 day service pressure - This risk is being managed by the West Area IHC with unfunded service support demands being reported via the LIPIG.

13 Decontamination of Re-usable Medical Devices
Decontamination involves pre-cleaning; leak testing (where applicable), cleaning, disinfection, removal of residue chemical, inspection and assembly, sterilisation, transport and storage of reusable medical devices. The Spaulding classification identifies the level of decontamination of medical devices required and is used to identify the appropriate process, this may include a combination of manual and automated processes. For the decontamination processes to be effective, all decontamination staff/technicians must be trained and be competent to undertake each stage of the decontamination process and the processing equipment must meet national WHTM standards which will include controls and monitoring of the processes.

Spaulding Classification:



A medical device can be any instrument, apparatus, implement, machine, appliance, implant, reagent for in-vitro use, software, materials or other similar or related articles intended by the manufacturer to be used alone or in combination for a medical purpose" (WHO 2023). They are used in healthcare for the diagnosis, prevention, monitoring and treatment of illness or disability. Therefore, the majority of patients treated within BCUHB will be in contact with a re-usable medical device that has undertaken a decontaminated process unless, the medical device utilised is by way of a "Single-Use" device (used once for one patient and discarded). Dependent on the procedure, the decontamination process will range from relatively low-level disinfection to extremely high-risk devices, such as surgical instruments, which need sterilisation.

Reusable Medical devices used on more than one patient have the potential to transmit infection between patients. This can occur if any of the decontamination processes undertaken between patients is not completed. Decontamination processes undertaken by untrained staff or, who are not competent with the decontamination processes, could lead to contamination residue remaining on the device after the decontamination process.

International Organization for Standardisation (ISOs), National guidance (WHTM's) manufacturer's instructions for use (IFU's) adherence is necessary to ensure patient safety.

13.1 The Decontamination Team

BCUHB IPT provide professional advice to clinical and estates teams to ensure patient and staff safety by way of the Decontamination Team, employing one Decontamination Advisor and one Decontamination Sister.

The decontamination of re-usable medical devices and the assurance needed to comply with the above is ever increasing. The assurance needed for BCUHB to demonstrate compliance in relation to the decontamination is vast and difficult to achieve with only two members of staff, so since the part time, temporary Agency Consultant Decontamination Lead left in May 2023, work has had to be prioritised and less specialised queries referred to the IPT. There is also no overall Operational Decontamination Lead for Decontamination. The request by the IPT for such a role was turned down by the Executive team in in July 2023 and responsibility is devolved to the individual IHCs to manage. However, as outlined in the Strategic Review of the Decontamination of Medical Devices undertaken by NHS Wales Shared Services Partnership – Specialist Estates Services (NWSSP-SES) in August 2022, there is a need for collaboration on a Health Board wide management strategy, as currently each Decontamination Unit operates to different standards and systems.

The Decontamination Advisor is to visit two other HBs to understand how they work, a plan is being drawn up to train Decontamination Champions in key areas and the audit programme is being revised based on a RAG rating for decontamination areas. The situation will be reviewed later in 2024 when a new Chief Operating Officer is employed. Meanwhile, each decontamination department has been asked to ensure they have fully documented risk assessments and Business Continuity Plans in place.

13.2 Audit

The Decontamination Team provide necessary assurance of compliance in relation to the decontamination of re-usable medical devices by way of six monthly decontamination audits with the addition this year of a "bed-side" clean audit for assurance of pre-full decontamination processes.

Identification of several infrastructure/resource challenges were highlighted including out of date/aged automatic washer disinfectors, autoclaves and environments, including air-handling units which pose a significant risk if they fail, as they are either at end of life or obsolete and will require significant capital and will interrupt service continuity. These significant issues are on the risk register. In addition, annual manufacturers certificated update training had lapsed in some services following COVID but action is now being undertaken to rectify this.

13.3 Sterile Services Departments (SSD)

SSD services continue to be provided from each of the 3 acute sites who are all registered with the Medicines and Healthcare Products Regulatory Agency (MHRA); this a WG requirement.

All three SSD engineering services i.e. sterilisers and disinfectors are near or, at the end of life and will require replacement over the next 5-10 years with WMH SSD unit being the priority. Concerns were also escalated by SSD at YGC in September 2023 in relation to machine testing and estates works not being done, also steam and quality failures going on for some time which could result in a major non-conformance on next inspection. Meetings with Estates were held to prioritise the backlog.

A new electronic Track & Tractability was installed in all three SSD sites across BCUHB in 2023.

The first joint BCUHB SSD Decontamination and IPC Environmental Audit has taken place at Wrexham SSD. YGC and YG are to follow.

WMH and YG SSD have recently installed chiller machines to reduce the high temperatures being experienced.

13.4 Scopes and Probes

Endoscopy

BCUHB has committed to enter the national agreement, in development for the All-Wales systems within sterile services. This agreement is to be implemented across all three endoscopy areas in the near future.

East/WMH: In September 2023 there was an issue with failed water samples in East endoscopy and theatres affecting 5 out of 8 bowls that had to be investigated. A risk assessment was completed. A small number of procedures had to be cancelled at the time. The source of contaminant was found to be in the laboratory and the service resumed within a few days. Processes in the lab have been amended to prevent reoccurrence and the SOP has been revised.

The plan at WMH to undertake decontamination processes for gastro/endoscopy in a refurbished area in the modular theatres is progressing well with four new Endoscopy Washer Disinfectors (EWD's) installed and a plan to open June 2024. It is hoped that decontamination of scopes for both Ear, Nose and Throat (ENT and urology can also be undertaken in this new facility moving forwards if there is capacity.

West/YG: There was a shortage of chemicals for washer disinfectors in YG in August 2023; this affected endoscopy sites across Wales. However, YG held sufficient stocks and did not have to cancel any clinics.

The Institute for Healthcare Engineering and Estate Management (IHEEM) Decontamination Annual report from NWSSP in January 2024 scored Amber and the team are making good progress working through the recommendations; a new capital bid is required for the fifth EWD.

A risk assessment is to be implemented in relation to the use of reusable buttons as these should be single use as outlined in national guidance.

Central/YGC: In December 2023, PHW, NWSSP and Bowel Screening services raised concern about the ongoing lack of plan/progress to upgrade and provide compliant decontamination facilities in endoscopy. Although previous requests had been submitted for Discretionary Capital Funding they had not been prioritised and taken forward. The latest report following IHEEM) Decontamination Audit undertaken during September 2023 scored Red/Amber, highlighting the significant concerns raised with the current decontamination infrastructure (especially as the increasing demands for diagnostic services is expanding), and requested that urgent consideration was given to move decontamination to a purpose designed facility or modular-facility that presents a segregated environment compliant to relevant standards. The report was shared with NHS Wales Health Collaborative and Bowel Screening teams.

A letter was subsequently issued by Bowel Screening to the IHC leads to seek assurance that the risk to patients was being effectively managed and addressed. Following an options appraisal it has been agreed to relocate the decontamination unit into an identified space within the current laundry footprint and transfer management to SSD. This is currently awaiting approval for funding. Meanwhile YGC continue to demonstrate risk identification and reduction in decontamination processes with regular feedback to Bowel Screening Wales (BSW).

Choledochoscopes
BCUHB is the only Health Board in Wales still not adhering to WHTM01-06 in relation to the decontamination of choledochoscopes. These scopes are used in East and Central and are only disinfected, not sterilised. Risk assessments score low as there is no evidence of infection.
The issue was highlighted to Quality Delivery Group again in January 2024. In England it is estimated that more sites are sterilising than not (70/30 split) and the ones that are not sterilising have it on the risk register and it is in the capital plan to purchase sterilisers. Up to date quotes were obtained for IHCs to progress business cases. The Decontamination Team have also requested that out of hours training assurance is strengthened in relation to these scopes.

ENT Scopes
Non-lumened Nasendoscopes used by the ENT service should be decontaminated using automated methods as per WHTM 01-06; WMH have carried out a risk assessment (approved by the local Clinical Effectiveness Group and decided to use the manual method of 'Tristel 3 Stage Wipe' system without the recommended double sink 'pre-wash and rinse' as recommended by the Decontamination team.
YGC do undertake the double-sink method and utilise single-use nasendoscopes whenever possible. The endoscopy option appraisal for YGC has included all services who utilise flexible endoscopes including nasendoscopes and would address all current risks.
WMH and YG ENT service provision of nasendoscopes during clinics has increased significantly and further scopes will be required to keep pace with demand.
In YG, the endoscopy service are awaiting a 5th EWD to enable them to decontaminate ENT scopes within their facility. Meanwhile ENT Outpatients Department (OPD) have reverted back to the Tristel 3 stage wipe system to manage their extra demand but this is not an approved decontamination method for an acute setting.
ENT Decontamination Incident: the Decontamination pathway was compromised during February 2024 in a clinic at YGC. A patient received a Nasendoscope procedure using a contaminated scope. Datix completed and incident review undertaken to understand why the decontamination protocol failed. Lessons learned were documented and presented at SIPG, Quality Operational Delivery Group and the Clinical governance meeting.

Urology scopes
Following a recent decontamination audit undertaken at the Urology department at YGC, the drying cabinet along with the EWD were found to have significant rust and damage to the inner aspect of the machinery. Recommendations by the decontamination team to condemn all three machines and draw up a risk assessment with a 6 week time-line to rectify this was implemented. Two new EWDs have been approved via Capital, however there is currently a £30k shortfall due to inflated prices; alternative options are being reviewed.
At WMH, theatre decontamination will remain on the first floor to accommodate urology and theatres endoscopes until it is established if there will be enough capacity at the new modular unit.

Ultrasound probes
In May 2023, following an IP incident where a trans-vaginal probe was not fully decontaminated (cleaned but not disinfected) between patients and staff were unsure what to do. The Decontamination team requested that all procedures relating to decontamination

should be reviewed to minimise the risk of this happening in their areas and include in the SOP what to do in the event of a decontamination failure.
The decontamination of ultrasound probes has been resolved with the introduction of new wipes to mitigate the risk of damage to current probes and the SOP is being updated.
Six monthly decontamination audits are taking place where assurance for training, compliance and adherence to policies and procedures are assessed.

Trans-oesophageal echocardiogram (TOE) probes
A SBAR was completed for the TOE decontamination processes at BCUHB which remain uncompliant with WHTM 01-06. The recommendation is to purchase an ultra-violet cabinet +/- a low temperature steriliser to address the issue. Progress is to be assessed in June 2024.

13.5 Carpal tunnel procedures
These are now undertaken in refurbished outpatient areas in WMH and Llandudno hospital following advice from the Decontamination Team.

13.6 Ophthalmology
Following a MHRA alert regarding the Ophthalmology "Phaco" hand pieces, advice from the IHEEM Decontamination Technical platform (DTP) has changed the way these are managed post-surgery. The Decontamination Team has confirmed that there is no issue across BCUHB, however YG need to purchase an initial flushing device.
Ophthalmology in Abergele are challenging BCUHB decontamination guidance recommended for laser lenses. A risk assessment has been requested and advice from Health and Safety is being sought.
None of the three Ophthalmology Units across BCUHB have a dedicated decontamination room/area to undertake decontamination processes, however WMH and YG have adopted decontamination recommendations to mitigate the risks.

13.7 Community Dental Services
Following on from a decontamination review of all 26 Community Dental Service (CDS) clinics in BCUHB by the Decontamination Team, a rolling programme of improvement work is being implemented in line with WHTM 01-05. This included a total refurbishment of the dental surgery situated within the current Health Centre at Penygroes and a new build at Bryn Beryl Hospital, Pwllheli. Ruabon and Saltney CDS will not re-open following COVID due to significant monies needed for up-grade. Patients have been redirected to other CDS's. The six mobile dental units have been condemned due to unsuitability and non-conformance.

13.9 Mattresses and Beds
Sleep Angel Mattresses: these mattresses did not have an outer cover with a zip enabling inspection so were classed as an infection risk. They have now been removed from all acute beds in BCUHB and the risk assessment closed in January 2024.

Hill Rom beds: a risk of cross-infection related to the Hill Rom 900 beds was identified in September 2023 due to the inside of the split side-rail interface cover on the side panels becoming contaminated with body fluids, but staff cant access it to clean it out. This could lead to increased rates of infection as this area could harbour infective micro-organisms such as *C. difficile* spores which could potentially find their way out to the environment to infect another patient. The manufacturers were contacted but did not feel there was a significant risk. The MHRA were also informed. A risk assessment was added to Datix with a score of 9, an embargo on the purchase of new beds was issued and a new bed specification written (with support from Electro Bio-Medical Engineering (EBME), Fire Safety officers, Health and Safety and Tissue Viability) to help avoid issues like this in future, that can be used when new patient beds are required.

Air mattresses: A survey of air mattress was conducted early in 2024. It identified that there is overuse of air mattresses and some staff are not following the SOP. A risk assessment has been drawn up scoring 12. Results of the survey have been fed back to the newly formed Bed and Mattress group and discussed with Facilities and the laundry manager. The SOP/Policy is being reviewed to include detailed advice in relation to mattress specification, procurement, loaning and decontamination products and processes. Decontamination training for ward staff has also been undertaken across BCUHB in conjunction with Direct Health Group Medical.

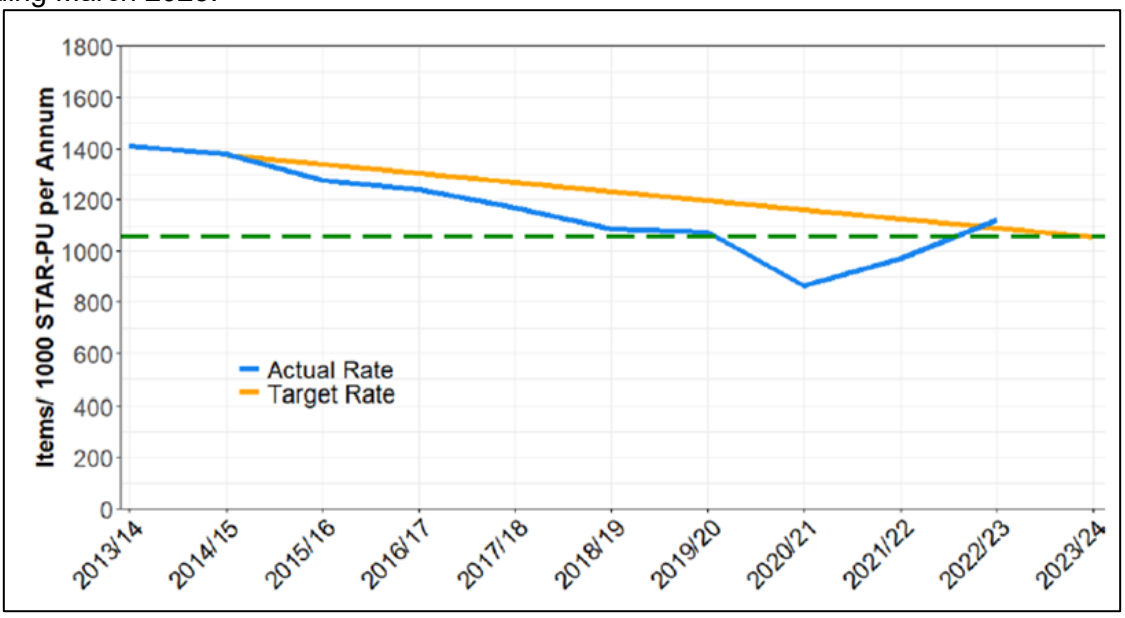
13.8 The Decontamination Group

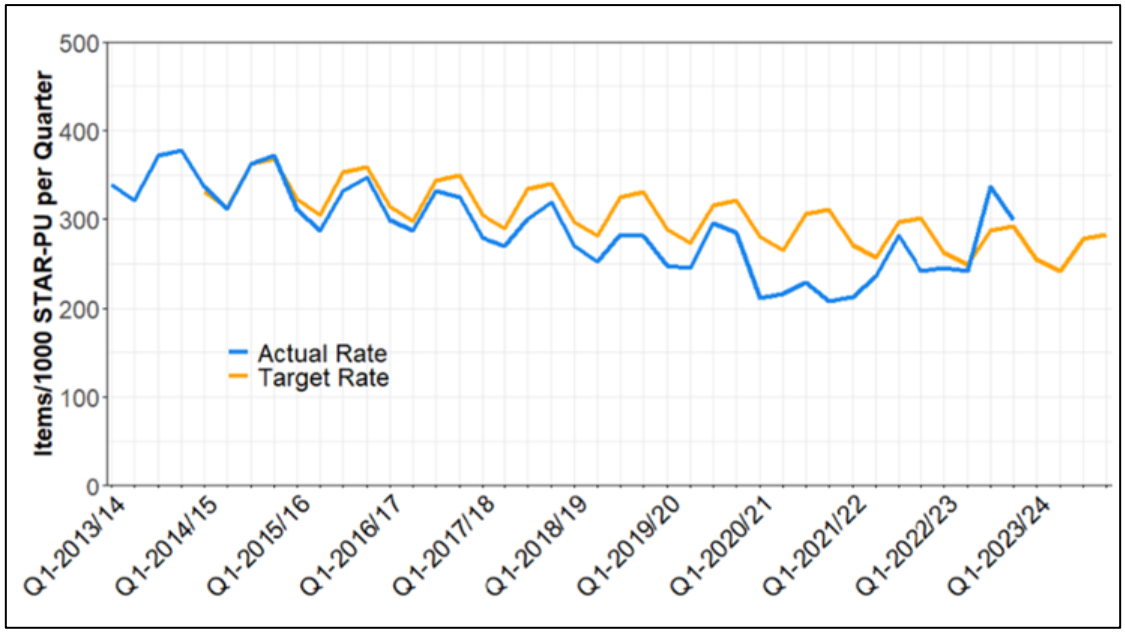
The terms of reference, format and presentation slides for the Decontamination Group Meeting have been revised with key areas now submitting a report at alternate meetings, but can raise issues for escalation at every meeting.
BCUHB have also re-instated Estates Officers responsible for Decontamination meetings on a quarterly basis with positive feedback.

14 Antimicrobial Resistance and Prescribing Programme

14.1 Primary Care Antimicrobial Prescribing

For financial year 2022/23, BCUHB did not achieve the 2.5% year-on-year reduction required to meet the minimum 25% reduction rate by 2023/24 (TARGET - Items/1000 STAR-PU). The 2013/14 baseline rate for BCUHB was 1,408.4 items/1000 STAR-PU, and the rate achieved at the end of the 2022/23 financial year was 1120.5 items/1000 STAR-PU: This represented a 20.4% reduction in total antimicrobial volume by the HB against the baseline.
Currently, it is uncertain if BCUHB will meet the 25% reduction rate for primary care, with one year of the target remaining. A final report from PHW for financial year 2023/24 remains outstanding.
The figure below highlights BCUHB's annual & quarterly trajectory position for the period ending March 2023.





Information & data for BCUHB to support WHC prescribing improvement goals 2023/24 for primary care period ending 31st March 2023, PHW.

14.2 Secondary Care Antimicrobial Prescribing

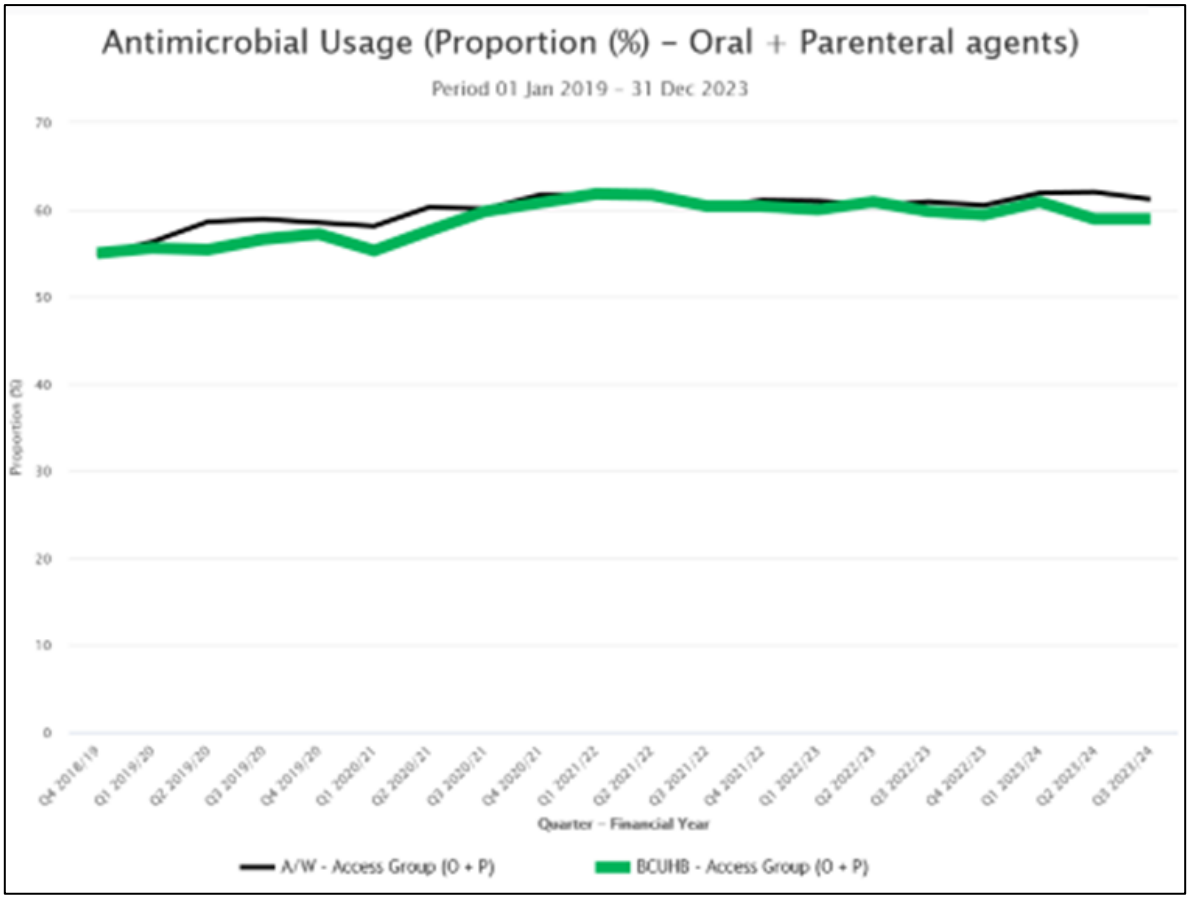
Ongoing issues surrounding the new pharmacy stock control system 'WellSky' prevented PHW from regularly reporting updates on surveillance data of antibacterial usage across Wales.

The WHO categorises antibiotics into three broad groups [AWaRe: Access, Watch and Reserve] based on their spectrum, anticipated risk of resistance development, risk of toxicity, and risk of causing healthcare-associated infections.

For Wales, BCUHB has an ongoing target to increase or maintain the proportion of antibiotic usage within the WHO Access category to ≥55% of total antibiotic consumption.

For the latest period ending December 2023, all three acute sites in BCUHB achieved the WHC 2023/24 Secondary Care Antimicrobial prescribing goal. (YG: 57.5%, YGC: 59.8%, WM: 59.3%)

The figure below highlights BCUHB's position in achieving the ≥55% WHO Access category improvement goal (Overall: 58.9%)



Information & data for BCUHB to support WHC prescribing improvement goals 2023/24 for secondary care period ending 31st December 2023, Llygad dashboard. PHW.

14.3 Antimicrobial Stewardship in Primary care

Primary care AMS staffing provision has improved throughout 2023/24 with the appointment of a new primary care antimicrobial pharmacist in BCUHB IHC East and the return of an antimicrobial pharmacist in BCUHB IHC West following a period of maternity leave.

Despite not achieving the 2.5% year-on-year reduction required to meet the minimum 25% reduction rate by 2023/24, it is thought the increase in prescribing rates was driven by quarter 3 of 2022/23 where an increase in cases of scarlet fever, invasive group-A streptococcal and respiratory tract infections were reported. This caused significant public concern and resulted in a negative impact in prescribing behaviour.

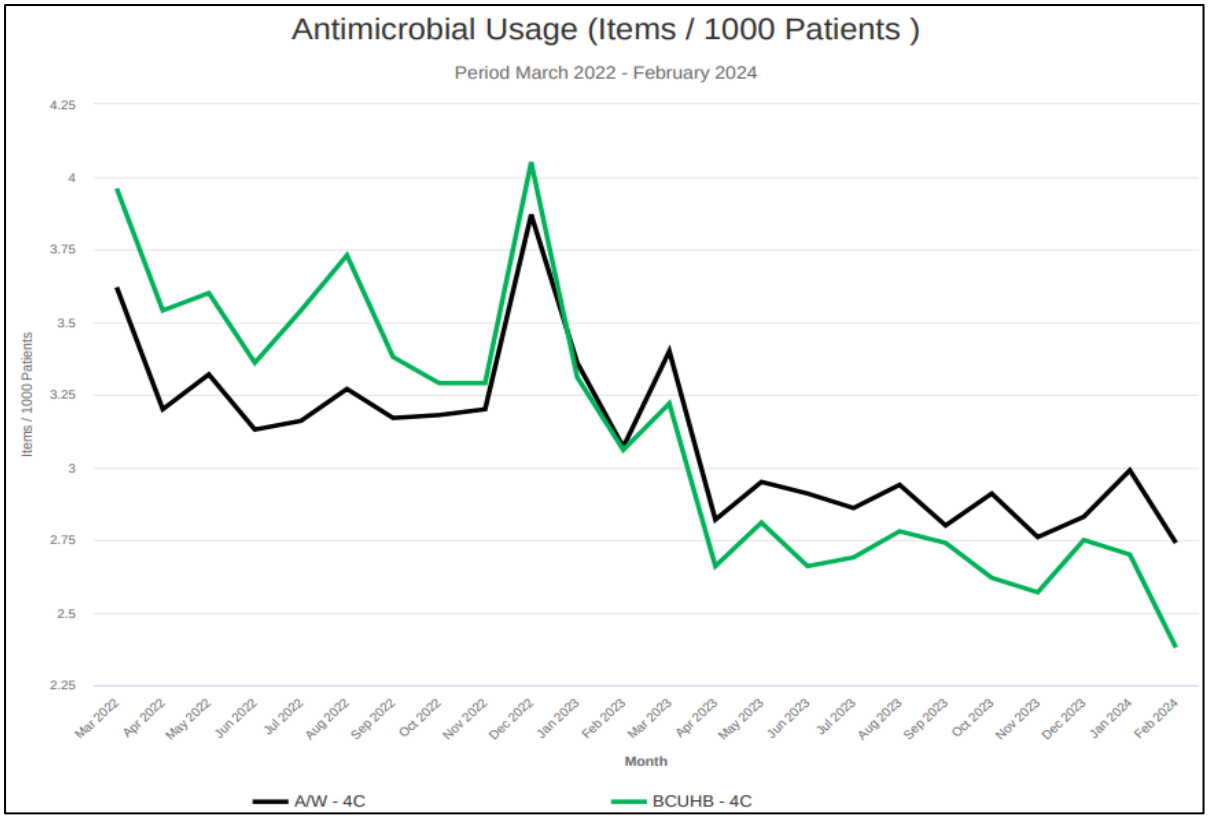
With the difficulties reported above, the AMS team have continuously monitored primary care prescribing & resistance rates closely and have worked with colleagues to help decrease prescribing and to ensure ongoing patient safety.

For 2024/2025, antimicrobial prescribing targets were once again included in the Local Enhanced Clinical Effectiveness Service (LECES) with the aim to incentivise prudent prescribing, maximise cost effectiveness and promote best practice in relation to antimicrobial prescribing.

Targets included within the LECES include:

- Reduce Total antibacterial items per 1000 STAR PU (or remain in the lowest prescribing quartile).
- > 90% trimethoprim prescribing in those age 65 or over with confirmed microbiology sensitivities
- > 90% quinolone prescribing in accordance with MicroGuide (which reflect the recently updated MHRA warning).

A clinical educational event regarding "cellulitis and lymphoedema" is also incorporated into the LECES. A reduction in 4C prescribing has been removed in view of the excellent reduction in prescribing rates (see graph below). (4C antimicrobials refer collectively to four broad-spectrum antibiotics, or groups of antibiotics: co-amoxiclav, cephalosporins, fluoroquinolones and clindamycin.) The quinolone audit was included as an alternative, to support adherence to the new MHRA warning. The *C. difficile* incentive with regards to post-infection engagement has also been removed.



The AMS primary care team also worked closely in collaboration with the All-Wales Lymphoedema network to help support the reduction in antibiotic use for patients presenting with cellulitis.

14.4 Antimicrobial Stewardship in Secondary Care

The continued lack of PHW surveillance reporting on secondary care antibacterial usage has made it difficult to determine and monitor whether local antimicrobial stewardship activities are having an impact.

Despite the above, compliance with the SSTF audit has improved on all sites following a review in the data collection methodology. Quality data on antimicrobial prescription compliance is now provided and feedback on a quarterly basis. Colleagues from the AMS and IPTs now support the data collection process and results are shared with ward managers and clinical teams to inform areas for improvement.

The audit covers five key areas of antimicrobial prescribing governance;

- The infection is recorded as either Possible or Probable as per ARK principles.
- An indication for the antimicrobial is documented on the drug chart.
- The antimicrobial prescribed is in accordance to health board guidelines, cultures and sensitivities or following advice from a consultant microbiologist.
- A senior review is carried out within 72 hours.

- A review/stop date is clearly documented on the drug chart.

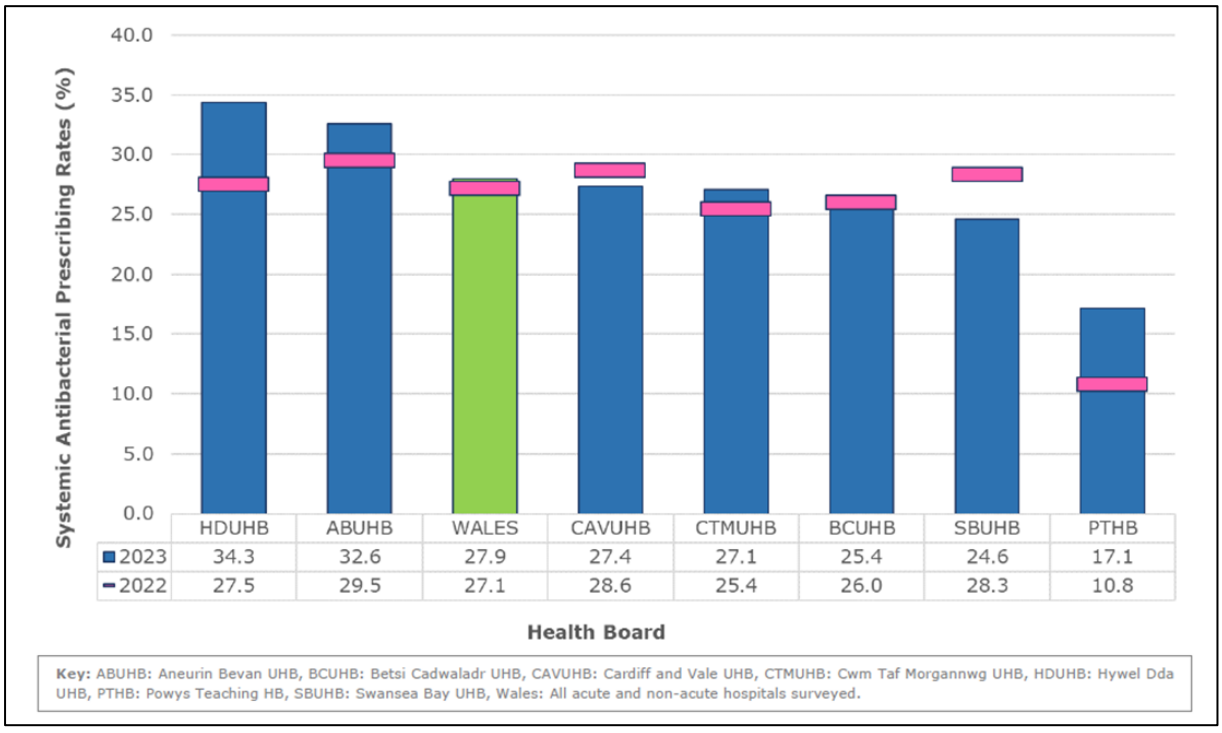
Antimicrobial stewardship multidisciplinary team ward rounds are conducted regularly on each acute site. The rounds consist of antimicrobial pharmacists, physician associates and consultant microbiologists who review patients on broad spectrum antibiotics. During the ward rounds, interventions are made, and the nature of the intervention is recorded.

The AMS team continue to support antimicrobial stewardship education & training programmes throughout BCUHB and higher education institutions. For BCUHB, regular teaching sessions are provided to junior doctors, nurses and pharmacists on prudent antibiotic prescribing. Work has been established on trying to standardise antimicrobial stewardship education & training provided by the AMS team.

Over the next 12 months, the AMS team will look at delivering a campaign to improve intravenous to oral switching of antibiotics. Timely intravenous to oral switching of antibiotics has potential significant benefits and early analysis has demonstrated possible financial benefits with regards to drug expenditure and reduction in nurse time.

The annual Point Prevalence Survey of Antimicrobial Prescribing in 2023 continued to highlight improvements for BCUHB, with the antimicrobial prescribing rates below the Welsh average at 27.4% and the systemic antibacterial prescribing rates also below the Welsh average at 25.4%. This demonstrated a continued decrease for BCUHB in prescribing rates in comparison to 2022 results.

The figure below demonstrates comparison of systemic antibacterial prescribing rates for each Health Board in 2022 and 2023.



Antimicrobial Resistance & Prescribing Programme Point Prevalence Survey of Antimicrobial Prescribing in Hospitals in Wales 2023, Public Health Wales, Version 1 Issued: 19/03/2024.

14.5 Antimicrobial Prescribing Guidelines

BCUHB Antimicrobial Guidelines for specific body systems are in place. These are based on national evidence-based guidelines and local antimicrobial resistance patterns with adaptation

by the antimicrobial stewardship group. Several guidelines have been reviewed, updated and published during 2023/24. Guidelines are made available via Microguide® on a smartphone device or via BetsiNet and continue to be popular with prescribers, facilitating easy access of antimicrobial guidelines at the point of prescribing.

14.6 Antibiotic Resistance and Monitoring

There is continued concern regarding levels of Gram-negative bacteria resistance across BCUHB with clear variation between hospitals. *E.coli* resistance in blood cultures and urinary samples remains a concern with resistance rates greater than the all-wales average for most broad-spectrum antibiotics tested.

The availability of the PHW Llygad platform has supported the review of antimicrobial resistance data at a local level, however there remains issues with access. There is a recommendation for a resistance working group to be established to anticipate arising issues. Overall, there is a need for greater emphasis of antimicrobial stewardship from all individuals to tackle this threat.

The lack of certain antibiotic therapeutic blood level monitoring being available in BCUHB continues to be a major issue and therefore limits guideline change and safe use of certain antibiotics in BCUHB.

14.7 World Antibiotic Awareness (WAAW) week 18-24 November 2023

The theme for this year's WAAW campaign was to '*Prevent antimicrobial resistance together*' which focused on how everyone, not just healthcare professionals have a role to play in preventing the spread of antimicrobial resistance.

Activities across the health board focused on encouraging SSTF principles, ARK and encouraging prompt IV to Oral switching of antimicrobials.

In all three acute sites in BCUHB, trainee pharmacists supported a service evaluation survey on inpatient antibiotic awareness in addition to organising promotional stands to share key public messages, antimicrobial prescribing and resistance resources. Each hospital also organised & participated in multi-disciplinary IV to oral and Outpatient Parenteral Antimicrobial Therapy (OPAT) ward rounds and there was a greater emphasis in reporting antimicrobial related interventions via the All-Wales intervention database platform.

Within primary care, the antibiotic checklist for community pharmacies was again used to help engage patients in discussions regarding their antibiotics and a virtual learning event tackling acute respiratory tract infections was provided by Health Education and Improvement Wales (HEIW) for all primary and community care prescribers. Empirical dental antimicrobial prescribing guidelines were also published and presented at the HEIW North Wales Symposium following an extensive programme of work with dental teams across BCUHB.

14.8 AMR International Work

The Commonwealth Partnerships for Antimicrobial Stewardship 2.0 (CwPAMS) started following the grant of £96,000 being awarded over 2 years 2023-2025. The hub and spoke model is being used , with Kamuzu Central Hospital in Lilongwe being a hub for 3 district hospitals , Mchinji, Dedza and Ntcheu, as well as the other tertiary hospitals in Malawi in Mzuzu, Zomba and Queen Elizabeth hospital in Blantyre. The aim is to train over 600 healthcare professionals again using the train the trainer model.

The first year has been very successful. All 7 hospitals now have trained AMS committees and have done the following:

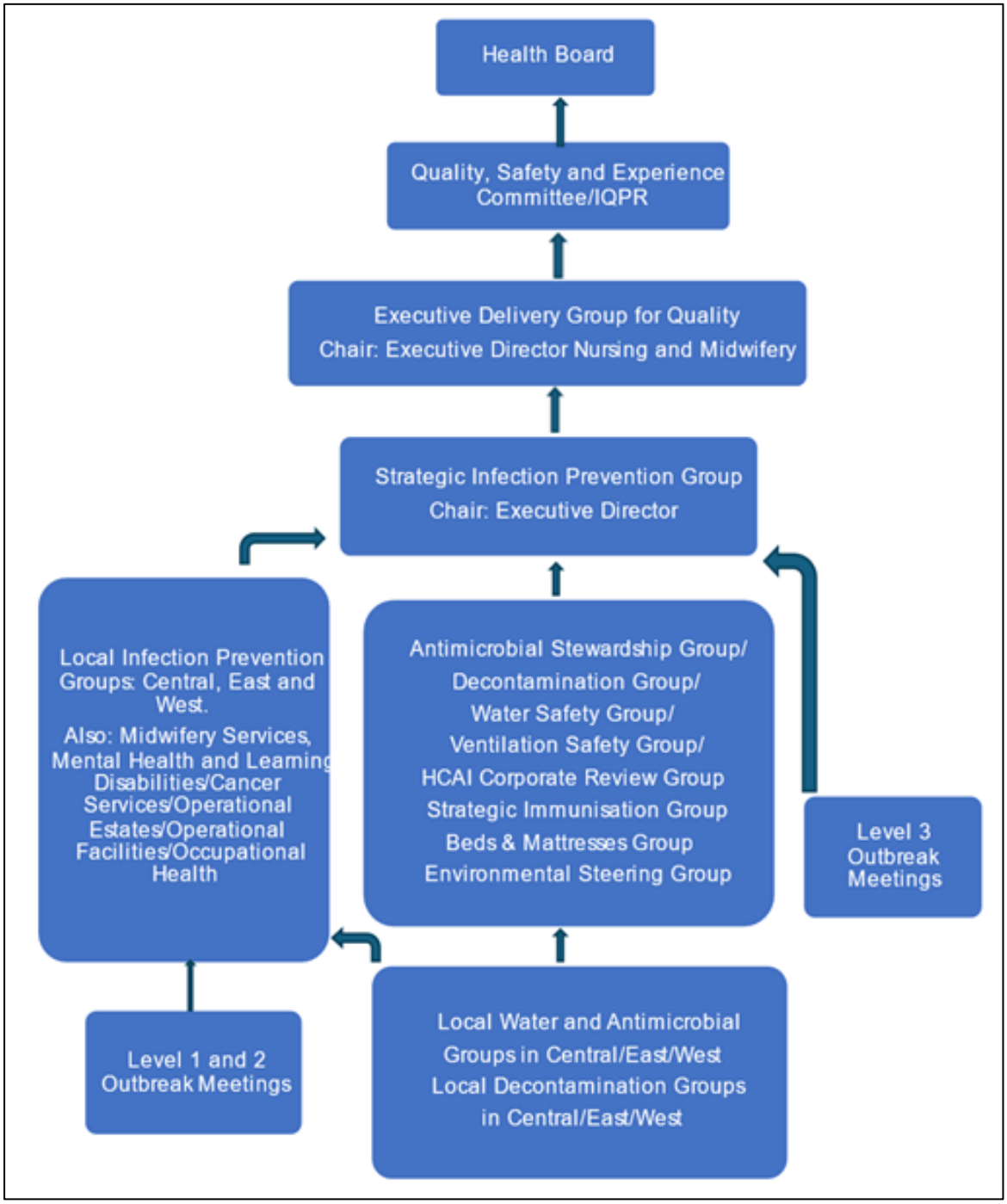
- Completed a Global Point Prevalence Survey (Global-PPS) of antimicrobial usage in the hospitals, identifying areas where antimicrobial stewardship could be improved: for example, reduced usage or oral administration.
- Developed and supported implementation of a toolkit to guide these improvements, including tools for ongoing audit.
- Engaged with national pharmacy groups and lead, including within the Ministry of Health in Malawi, to ensure the partnership's work aligns to national plans and is embedded as standard practice.

This work will continue in the final year. The Wales team also visited Malawi and the Mawali team are due to visit in 2024 to Wales.

The CwPAMS 1.5 project has also now been published in Antibiotics journal.

15.0 Appendices

Appendix A
Strategic Infection Prevention Group Governance and Reporting Arrangements



Appendix B
The Infection prevention and decontamination Corporate Risk Register as at 04/04/2024 is below:

ID	Title	Date Opened	Current Score	Last Reviewed
4978	Air mattress infection risk	12/10/2023	12	02/04/24
4971	Decontamination issues related to the side panels of the Hill Rom 900 beds	02/10/2023	9	02/04/24
4241	Inability to deliver timely Infection Prevention & Control services due to limited capacity (Following a review with the new Head of Risk this risk assessment was downgraded to tier 2 in July 2023 as the nurse staffing situation had improved slightly and there was a lack of evidence for the high score).	10/12/2021	12	02/04/24
5007	Metis hydra disinfection machines are not in use due to electrical concerns	31/10/2023	12	02/04/24
4325	Potential that medical devices are not decontaminated effectively so patients may be harmed. (Following a review with the new Head of Risk this risk assessment was downgraded to tier 2 in July 2023 as mitigations and controls had been strengthened and there was not sufficient evidence to keep the high score.)	21/02/2022	12	02/04/24
1319	Reduction in Public Health Wales Consultant Microbiologists (Following review in January 2024 his risk score was reduced from a 9 to a 6 as a number of other supportive roles have been employed to spread the work out and support the consultants including specialist grade doctors, Physician Associates and Clinical fellows.)	02/01/2014	6	02/04/24

OUR VISION

Zero healthcare associated infections (HCAIs)

Strategic Infection Prevention Group – Plan on a Page 2024-25

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

PRIORITIES FOR 2024-25

Lower the burden of infection	Reduce IP risk from medical devices	Optimise antimicrobial use	Improve education & training in IP	Lower the environmental burden

A COLLABORATIVE APPROACH TO DELIVERING OUR PRIORITIES: ZERO AVOIDABLE HCAIs

Staff engagement & ownership across all staff groups. Standard precautions for all. Patient & outbreak reviews (PIRs). Audit & surveillance programmes. Vaccination campaigns. Policies & protocols. Data & epidemiology. Optimised use of sidercoms. Local SMART action plans to reduce HCAIs. Effective outbreak control meetings.	Risk management. Datix for incidents. Improvement plans and work plans. Capital investment. Policies and protocols. Audit and surveillance. Education and training. Sharps management. Management of beds and mattresses. IPSG subgroups e.g. Decontamination	Engagement with all healthcare professionals. Prudent prescribing. Antibiotic resistance data. Audit and surveillance. Policies and protocols. Antimicrobial ward rounds. Education and training including primary care. Multi-disciplinary PIRs. Antimicrobial pharmacists.	IP in every job description. All Staff qualified in IP for their role. IP improvement initiatives. Sharing lessons learnt & good practice. IP Champions and MOOC Programmes. IP mandatory training. Patient/carer/visitor education. Policies and protocols. Up to date Betsinet with all IP info.	Environmental/Hicad audits. Cleaning checklists and protocols. Proactive/reactive HLD programmes. Ventilation maximised. Safe Water, incl water sampling & little-used sinks/outlets. Improvements to the estate. ATP testing. Risk management. IP Environmental audits. National Cleaning Standards. Food safety. Cleaning Responsibilities Framework.

DELIVERABLES / SUCCESS LOOKS LIKE

1. Approved local IP Improvement Plan to achieve Welsh Government Improvement Goals/trajectories, learning identified from PIRs and current IP Priorities - regular review, trends & progress to be demonstrated.
2. Audit programme including hand hygiene, PPE, Mattresses, Pillows, Commodes, Water flushing, CAUTI, MRSA and CPE screening, completion of Blood culture, catheter and cannula care bundles, Bristol stool chart, cleaning schedules etc.
3. Capital programme in place and being achieved to drive improvements on identified priorities.
4. Comprehensive risk register related to Infection Prevention and Decontamination with an appropriate/effective governance approval and review structure.

In lower ¼ for 'surgical site infection' rates. >85% compliance with audits & audit scores. **PIRs**: 85% PIRs completed within 10 days. A multi-disciplinary team, including Drs present at all PIRs & HCAI Executive reviews where 2 are presented each month. Prompt investigation of all other key HCAIs e.g. CPE with summary report to SIPG. Audit programmes – highlight compliance, action being taken to improve and progress. Faecal transplant programme at each site. Outbreak closure slides completed for all outbreaks and submitted to LIPGs. All wards complete daily sidercom reviews. Improved compliance with screening e.g. MRSA and CPE. Evidence that patients with MRSA are decolonised promptly & appropriately as per SOP. Improved vaccination rates.	Improved compliance with audits. CAUTI rates reduced. Gram negative blood stream infection rate reducing (E.coli target <87 per 100,000). Blood culture & vascular bundles completed. Evidence ANTT documented in all cases. Blood culture contamination rates <3%. Zero tolerance to MRSA bacteraemias. All patients with long-term catheter have a passport. MSSA bacteraemia rate reducing (target <20 cases per 100,000). Sharps injuries reduced. **Decontamination**: Capital investment / Continuous improvement programme for decontamination facilities. No decontamination incidents. Reduction in sharps incidents. Proactive management of Datix incidents.	Achieve Antimicrobial Workplan goals – quarterly reporting to SIPG. Reduce antibiotic resistance rates. Microguide is kept up to date. SSIF audits completed. Implement mandatory AMR training and for compliance to be >85%. Improved compliance with audit programmes and improved scoring. Specimens sent as requested and results followed up and acted upon. Complete yearly Point Prevalence Study. Improve primary/secondary care information exchange. No vacant positions in Antimicrobial Pharmacy team. Well attended, regular ASGs. Promotes/encourages use stewardship.	ESR training compliance rates >85%. IP Champion on every shift. Programme for Clinical supervisors to attend IP MOOC. Improved compliance with fit testing. Patients informed and aware of how they can contribute to IP/self-care. ANTT assessors in every ward/dept. Monitored programme of improvement initiatives based on infection rates/key themes from PIRs. Processes for sharing lessons learnt with audit data to show learning has been achieved and sustained. All IP and Decontamination related policies and protocols up to date. Junior doctors training sessions. Process to cascade information/new protocols etc to clinical staff.	Facilities cleaning audit scores and trends. Enhanced cleaning completed as requested by IP. Audit schedule increased during outbreaks. Proactive and re-active HLD programme in place and achieved. Improved water and ventilation scores. Improved compliance with audits & tests. 5 star food ratings achieved across BCU. Patients with diarrhoea isolated within 2 hours. Respiratory patients isolated within 6 hours. Ward fridge audits completed daily. Full IP clinical/environmental audit scores >85%. ATP swab scores <50. Bristol Stool Chart completed at least daily for all patients. Monthly mattress checks completed in full. De-clutter campaigns. Cleaning schedules completed in full.

Appendix D: IP Team Audit Programme for 2024/25

Proactive Infection Prevention Annual Audit Programme 2024/25

The programme below must be followed as a matter of routine to:
- Provide quality assurance around IPC practices to LIPGs and SIPG
- Support your Post Infection Reviews
- Allow you to identify concerns around practices and support implementation of improvement plans

Feedback must be provided in real time to Departmental Manager/Ward Sister/Nurse in Charge and followed up with an email toinclude Senior Nurses/Managers

Audit	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
Hand Hygiene	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Patient Hand Hygiene	✓						✓					
PPE						✓						✓
Commode	✓		✓		✓		✓		✓		✓	
Mattress		✓			✓			✓			✓	
Cushion		✓			✓			✓			✓	
CAUTI				✓						✓		
PVC counts/bundles and VIPs/ANTT/Blood cultures		✓						✓				
Fans	✓				✓							
Water Flushing				✓						✓		
Isolation	✓						✓					
Cleaning Checklists		✓						✓				
Bristol Stool Chart			✓						✓			
MRSA Screening and decolonisation			✓						✓			
CPE Screening						✓						✓
Full IPC ward/departmental	All inpatient areas (including assesssment areas) and high risk clinical areas (e.g. theatres, endoscopy, radiology should receive a full IPT audit during the year 2023/2022. All other areas (e.g outpatients/clinics should have an IP observational audit within the year. Audits of care homes and managed practices should be performed when IPC support is required due to IPC concerns ≤ 78% reaudit within 1 month (actions only), 79% - 89% reaudit within 6 months (actions only), 90% - 100% full reaudit in 12 months											

Infection Prevention Rapid Reviews

These should be completed reactively when there is an issue of concern in a particular area

Feedback must be provided in real time to Departmental Manager/Ward Sister/Nurse in Charge and followed up with an email toinclude Senior Nurses/Managers

	COVID checklist	Hand Hygiene	Patient HH	PPE	Commode	Mattress	Cushion	Catheter counts/ passport	PVC counts/bundles	Screening	Water Safety	CPE checklist	ATP
COVID outbreak	✓	✓	✓	✓									
Flu outbreak		✓	✓	✓									
Norovirus outbreak		✓	✓	✓	✓	✓	✓						
PII diarrheoa		✓	✓	✓	✓	✓	✓						✓
C.diff		✓	✓	✓	✓	✓	✓						✓
CPE		✓	✓	✓	✓	✓	✓	✓		✓		✓	✓
MRSA isolate (inc BSI)		✓		✓		✓	✓	✓	✓	✓			
HA MSSA BSI		✓		✓				✓	✓				
HA Klebsiella (BSI)		✓		✓				✓	✓				
HA Ecoli (BSI)		✓		✓				✓	✓				
Ps. Aeruginosa (Augmented care)		✓	✓	✓				✓	✓		✓		
Other for discussion with site lead													

Appendix E: IP Team Workplan

The Workplan for 2024/25 is based around the headings in the new (not yet published) Code of Practice.

Standard 1: Appropriate organisational structures and management systems for IPC are in place:
Review SIPG and LIPG TOR and Agenda format
Redesign PIR tool for Bloodstream Infections
Prompt/timely learning shared from PIRs as per agreed timescales
Develop deep dive for CPE/CPO
Ensure Deep dives are completed for each reporting month with no gaps in data identified
Support Local IPTs to utilise deep dive data to improve outcomes through LIPGs, directorates
Further optimise the use of ICNet across all site IPTs
Monitor blood culture contamination rates and report via Strategic IP group every 6 months
Regular/Annual to the Executive/Board as requested
Senior team to meet every 6-8weeks with Microbiology team
Agree priorities and meet at least monthly with IP Doctor
Devise a post infection review tool for CPE/CPO
Undertake a Post Infection Review on all CPE/CPE isolates believed to be hospital acquired
Improve the reporting mechanism for CPE/CPO to LIPGs and SIPG
Undertake a Post Infection Review on all MRSA isolates believed to be hospital acquired
Perform a spot check audit of infection alerts on WPAS/WCP
Roll out proactive and reactive audit programme
Strengthen audit proformas for all of the above
Develop a robust feedback/reporting process
Deliver audit feedback as per reporting process
Develop audit proformas for speciality/OPD areas
Work with informatics to further develop audit tools and reporting formats within IRIS
Revisit and complete IP acuity matrix in preparation for winter
Undertake trials of new products/technology to ensure effectiveness, efficiency and cost effectiveness e.g., Spectrum sanitiser trial
Ensure IPT representation on every Pan BCU and local Water Safety Group
Ensure IPT representation on every Ventilation Group
Develop SOP for actions following a Cepheid result to standardise processes across all 3 sites
Engage with procurement to ensure that IPT are informed in a timely manner of any issues that may impact on IPC
Corporate IP risks are identified, discussed at SIPG and recorded on Datix
Standard 2: All care equipment including medical devices* is decontaminated effectively and safe at the point of use.
Deliver a robust decontamination audit programme prioritising high risk areas using a combination of self-audit and IP decontamination team to identify level of compliance.
Engage with procurement to ensure that there is a robust system in place to ensure all reusable medical devices that are purchased have compatible manufacturers decontamination instructions
Work with clinical teams and procurement to develop standardisation of medical devices to provide a cost effective and patient safe device.
Manage the BCUHB Decontamination Group and escalate concerns to the SIPG.
Review the decontamination strategy and seek Executive approval
Identify and support the operational decontamination executive lead in raising the profile of decontamination services as a profession and its essential contribution to patient safety.
Organise and develop Decontamination Champion training days

Standard 3: The physical environment is maintained and cleaned to a standard that facilitates effective IPC and minimises the risk of infection.
Support the IHCs with their option appraisals to secure decant facilities for HLD and PPM
Work with IHCs to develop a priority list for deep cleaning using Hypochlorous acid for each site based on CDI risk and monitor at LIPGs
Work with Facilities to ensure alternative technology/product available should METIS fail to operate
Promote Environmental Hygiene through the ongoing HABITS campaign
Build upon/enhance Which clean do I Mean? to include additional appendices e.g., bed space cleaning checklist
Ensure IP attendance at every Laundry Group meeting
Revise SOP for ATP and to include facilities responsibilities if funding agreed
Support the launch and promote the revised National Cleaning Standards once published
Ensure cleaning audit data and compliance with requested enhanced cleans and the HLD programme is reviewed and challenged at LIPGs
Continue to provide IP leadership and support to the research study through Staffordshire University
Explore the introduction of Handheld Hydra machines for East and Central
Standard 4: Suitable, timely and accurate information on infections is available and communicated to staff, service users and their visitors, and those responsible for providing care to others.
Improve and standardise the use of Cepheid across all sites
Develop a repository of information leaflets for patients and carers
Make sure CPE card being given to all relevant patients
Develop patient card for all clinically significant organisms
Standard 5: All staff employed to provide care in all settings are fully engaged in preventing and controlling infection.
Maintain and further develop the HABITS campaign
Keep IP intranet pages up to date
Promote any national/international campaigns
Continue Message of the Moment
Summary outbreak slides produced for all outbreaks and circulated widely
Review ANTT gap analysis
Each IPT to ensure trained IPN in each team are competent at a minimum of Level 2 ANTT Trainers (APs are not able to train staff but can assist with the delivery of the training)
Arrange and deliver annual refresher training to current level 2 ANTT trained staff for Central, East and West. Initial plan to set up 2 sessions for each area (One acute One area)
Promote ANTT through the ongoing HABITS campaign during May focus on Asepsis
A repository of remaining microteaching sessions to be developed and uploaded onto Betsinet
Each site to establish a delivery programme of planned microteaching sessions and keep records that can be collated
Review and revise the IPC champions training session to add and ensure a focus on ‘what’s new’
IPC Champions – Maintain monthly training sessions and fortnightly drop-in sessions
Extend champions role to include Estates and Facilities
Introduce a monthly Infection Prevention Award sharing good practice observed
Explore feasibility of increasing IPT time slot for Doctor’s induction/training
IPT to arrange to present quarterly at Grand rounds
Consider novel ways of promoting IPC through social media platforms
Develop an induction booklet for wards and departments for new clinical staff/Agency
Standard 6: Suitable and sufficient isolation facilities are provided to support effective IPC.
Support IHCs to develop option appraisals to increase side room capacity
Bi annual isolation audit and timely feedback as per proactive audit planner
Promote isolation and side room risk matrix through HABITs campaign with isolation focus

Work with LIPGs to ensure staff working in IPC, A&E, admissions units, and allocated wards are trained in the management of a patient with a suspected/known High Consequence Infectious Disease.
Promote the importance of the live bed tracking tool for IP purposes.
Standard 7: Evidence based IPC policies are in place; are accessible and reviewed regularly
Maintain a programme to ensure policies and procedures are reviewed and re-launched in a timely manner
Launch all new policies
When documents are reviewed and amended, communicate/promote change to relevant staff groups e.g. the approach in relation to decolonising of wounds
Through the HABITS campaign promote the Standard precautions protocol
Ensure all IPC related documents are available on Betsinet
Support directorates in the developing of any relevant SOPs
Review and revise the Standard Precautions protocol to ensure it also includes all aspects of transmission based precautions
Standard 8: Organisational systems and processes are in place that protect staff from the risk of exposure to infections that can be transmitted in the workplace.
All team members are encouraged to be fully vaccinated as recommended by Occupational Health, unless contra-indicated
Arrange for Sharps company to repeat Sharps audit and then share results at LIPGs and SIPG
Work in partnership with OH to ensure IP are aware of areas/devices that are associated with a high needlestick/inoculation incident rate and promote learning
Actively support vaccination campaigns – Measles, COVID, Flu
Standard 9: All staff are trained, educated and competent in IPC and decontamination as appropriate for their role.
Arrange a full IPT team away day
Local teams to have half day away day
Review format and structure of IPT meetings
Devise a programme of educational sessions for the IPT
Team 1:1s to take place using template designed post away day 2022
All PADRs completed annually and recorded on ESR
All sickness management according to policy
Mandatory training compliance >85%
Work shadowing and cross site working supported
Team members who attend conferences / webinars etc. provide feedback at the next IPT meeting
All junior staff to attend MOOC programme
Review study activity of team to ensure a fair and equitable approach to study leave and funding
Standard 10: There is an organisation wide antimicrobial stewardship programme in place.
Participate in the quarterly Start Smart and Focus Audits
Provide IP representation at the Antimicrobial Stewardship Steering Group
Through the HABITS campaign further promote stewardship during TREATMENT month in August
Standard 11: The organisation's strategy to deliver a net zero health service is compatible with maintaining the prevention and control of infection.
Provide IP representation at Pan BCU Green Group
Provide IP representation at local Green Groups
Representation as required form decontamination advisors on Green Groups
Support Green Groups with relevant campaigns and Trials
Provide the green group with IP recommendations for glove use – to support the implementation of the gloves off campaign

Teitl adroddiad: ***Report title:***	Cancer Annual Report 2023/24			
Adrodd i: ***Report to:***	QSE Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 15 August 2024			
Crynodeb Gweithredol: ***Executive Summary:***	This paper updates the Committee on progress in delivering the objectives set out in the Health Board's 2023/24 annual plan in relation to cancer services and outlines the key objectives for 2024/25.			
Argymhellion: ***Recommendations:***	The Board is asked to note this report			
Arweinydd Gweithredol: ***Executive Lead:***	Dr Nick Lyons, Executive Medical Director			
Awdur yr Adroddiad: ***Report Author:***	Caroline Williams, Acting Network Manager for Cancer			
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):***	Cancer is a Ministerial Priority for NHS Wales			
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	As above			

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
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
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 SPF 5 There is a risk of failing to achieve the aims and actions outlined in the cancer strategic priority plan such as maintain access standards, further develop and implement the Cancer Roadmap for North Wales and implement immediate targeted actions to improve access in diagnostics and key specialities
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)*	As above
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Not applicable
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** ***Implementation of recommendations*** The Committee are asked to note the contents of this report	
Rhestr o Atodiadau:	

Dim

List of Appendices:
None

BCUHB Cancer Annual Report 2023/24

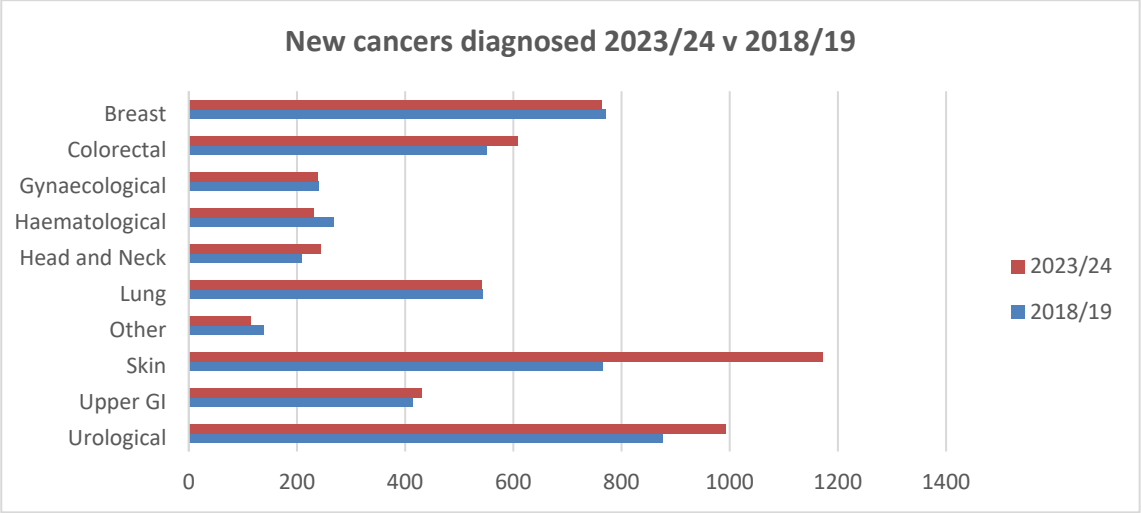
1. Introduction

This paper updates the Health Board on progress in delivering the objectives set out in the Health Board's 2023/24 annual plan in relation to cancer services and outlines the key objectives for 2024/25.

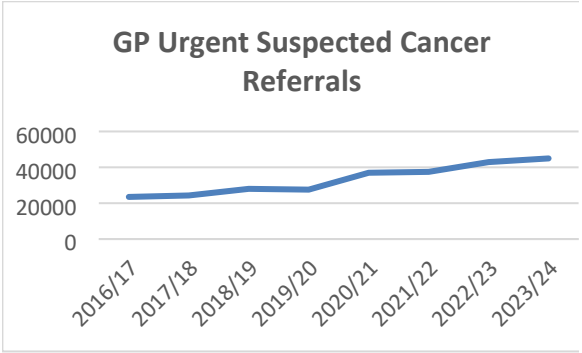
2. Context – Cancer Services Activity and Performance

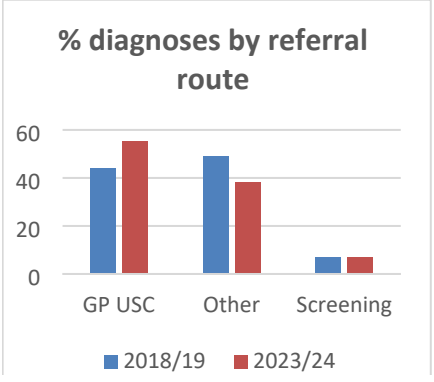
In 2023/24 BCUHB diagnosed 5,335 patients with a new cancer. This represents a 12% increase from pre-COVID levels, although it should be noted that approximately half of this increase is due to a change in the way skin cancers are reported with all cancers now included in reporting rather than just the first case.

The tumour sites with the largest increases in reported cancer diagnoses are skin (partly due to the change in reporting highlighted above), urology, colorectal and head and neck:



Referrals of suspected cancer patients from primary care continue to increase year on year; as a result more patients are being diagnosed via this route (see charts below). This is positive as early diagnosis is key to improving outcomes but it has placed significant pressure on outpatient and diagnostic services. The percentage of patients diagnosed via national screening programmes has returned to pre-COVID levels with the percentage diagnosed through other routes (routine referral or emergency admission) falling:





3. 2023/24 objectives

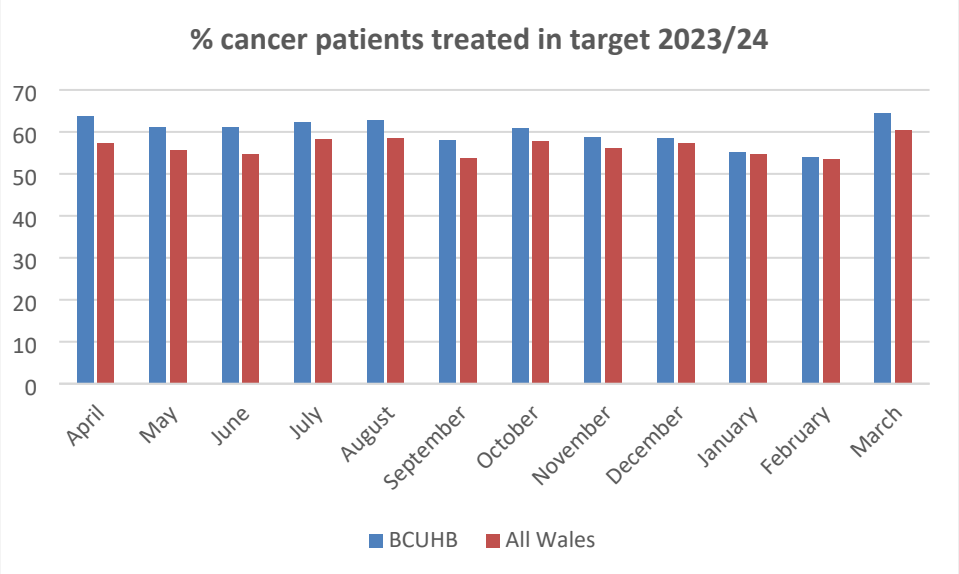
In the BCUHB Annual Plan for 2023/24 the Health Board committed to the following improvement aims in relation to cancer services:

- Aim to achieve 70% of cancer referrals starting their first definitive treatment within 62 days by the end of the year by maximising use of resources in line with capacity and demand modelling and aiming for first appointment within 10 days of referral
- Redesign of pathways that enable a 'straight to test' approach; to include finalising four local cancer pathways this year (prostate, colorectal, breast and gynaecology) and commencing a new prostate pathway to facilitate straight to test and pre-booking of biopsies
- Refresh and finalise the cancer plan and commence action to implement
- Ensure a sustainable oncology service by continuing to work towards filling all Consultant Clinical Oncologist vacancies by the end of the year, recognising the challenge presented by the national shortage of cancer doctors, supporting the development and use of new NICE approved cancer treatment regimens and developing a capital estates plan for the Shooting Star Unit, which will provide additional capacity for treatments and outpatient clinics

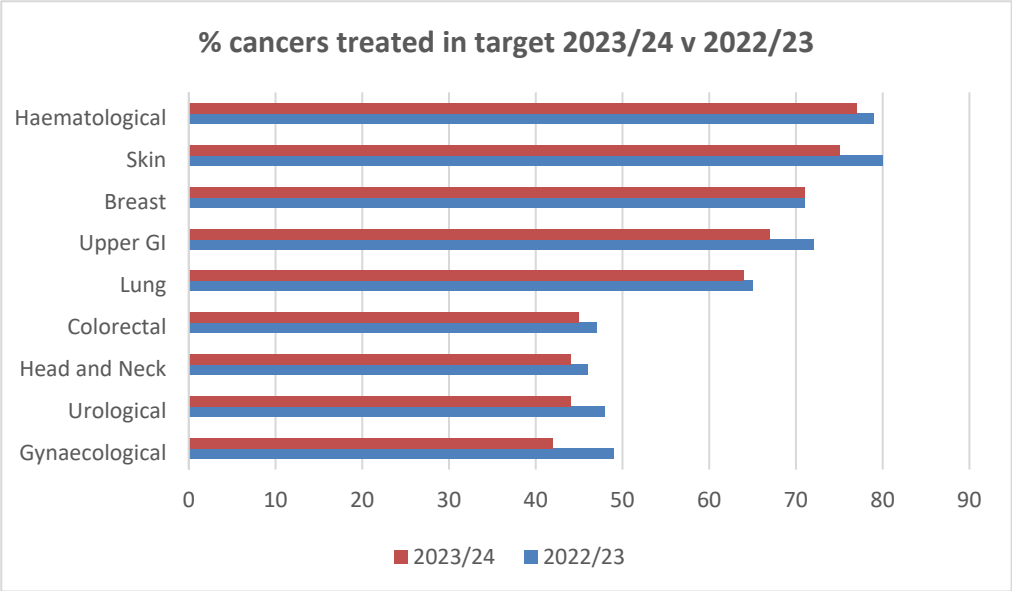
4. Delivery of 2023/24 objectives

4.1 Compliance with national waiting times target

BCUHB treated 61% of these new cancer patients within 62 days of suspicion of cancer ie within the national suspected cancer pathway waiting times target. Whilst this is below the 70% target, BCUHB continues to perform consistently above the all Wales average:



There are challenges for all tumour sites, with the most challenged being colorectal, urology, head and neck and gynaecology. Skin performance in particular deteriorated during 2023/24 due to the current pressures within the dermatology service. This has contributed significantly to the overall reduction in Health Board performance given that skin is the largest single tumour site:



The most significant issues leading to delays on cancer pathways are:

- Increase in referrals
- Diagnostic capacity, in particular within endoscopy, dermatology, urology and gynaecology
- Treatment capacity, in particular within dermatology, urology and colorectal surgery and oncology
- Increasingly complex clinical pathways

4.2 Redesign of cancer pathways

Cancer teams have worked closely with the Health Board's Transformation and Improvement team, together with national partners in the NHS Executive to review and improve cancer pathways. Four pathways have been reviewed – prostate, colorectal, gynaecology and breast with the following improvements made or underway:

- Introduction of nurse led triage and straight to test prostate cancer pathway, reducing time to diagnosis by 2 weeks
- Pilot of nurse led triage on the colorectal cancer pathway with a business case now being prepared for roll out across the Health Board to increase straight to test rates
- Options appraisal developed for roll out of post-menopausal bleeding one stop clinics across the Health Board, to be taken forward further in 2024/25
- New breast pain pathway in development

4.3 Developing a cancer plan

The Health Board's Cancer Partnership Board, comprising key stakeholders from primary care, secondary care and the third sector, has developed a Roadmap for Cancer Services in North Wales 2024-29. This was presented to the Health Board's Executive Team in early 2024 and will contribute towards the development of the Health Board's overarching review of its clinical strategy over the coming year. The vision within the roadmap, which will form the basis of all cancer development work over the next 5 years is as follows:

- To reduce cancer incidence, mortality and morbidity in north Wales so that people experience a better quality and length of life
- To commission and provide excellent person centred care in the right place at the right time, taking a whole system approach that focuses on improving outcomes and user experience and, where possible, brings care closer to home

- To empower our staff to transform and innovate and deliver continuous improvement
- To work in partnership with all stakeholders, including service users, other public sector organisations, third sector organisations and the wider community, to maximise value from the resources we have available to improve cancer outcomes in north Wales

4.4 Oncology services

The Health Board has been successful in recruiting two new substantive Consultant Clinical Oncologists during 2023/24 but unfortunately further medical vacancies remain unfilled in line with the national picture of a shortage of consultant oncologists. The service therefore continues to be heavily reliant on locum and agency medics.

Demand for oncological treatment is increasing by approximately 6-8% every year as more treatments become available, placing further pressure on the service. During 2023-24 five NICE Technology Appraisals were ratified for use in north Wales, supported by additional infrastructure resources to support this service.

The oncology service is currently developing a business case to ensure a sustainable service both in the short and longer term. This includes a focus on workforce including supporting overseas recruitment of middle grade doctors with the aim to train them to become Clinical Oncologists in the future.

Service expansion will also be necessary, both in terms of workforce and estates. Some minor improvements have been made to the chemotherapy units, including the Shooting Star Unit in Wrexham during 2023/24 and the Oncology Leadership Team are working with the East Integrated Health Community to explore other options to improve this facility.

5. Priorities for 2024/25

Within its 3 year plan the Health Board has committed to the following priorities for cancer services:

- Maintain access standards for treatment within 62 days by the end of 2025
- Implement the clinically led ‘Roadmap for Cancer Services in North Wales 2024-29’ and in so doing contribute to the overall shaping of the Health Board’s 10 year strategy
- Eliminate the current backlog of suspected cancer dermatology referrals and implement the use of teledermoscopy
- Within urology, build on the success of the straight to test pathway to revise the overall model of urology cancer care and related pathways
- Within colorectal, build on the success of the nurse led triage pilot and continue the improvements in endoscopy waiting times; ensure workforce is more closely aligned to support future demand
- Progress within implementation of post menopausal bleeding clinics on each site
- Further develop the sustainable services plan for oncology with a particular focus on workforce

The above priorities will provide the focus for work within cancer services during 2024/25.

6. Recommendation

The Committee are asked to note the contents of this report

Report title:	Urology Improvement Plan – Update August 2024			
Report to:	Quality, Safety and Experience Committee			
Date of Meeting:	Thursday, 15 August 2024			
Executive Summary:	This paper is to update the QSE committee on progress of the Urology Improvement Plan, as agreed at the previous QSE meeting in June 2024.			
Recommendations:	The Committee is asked to note the updates within this paper following discussions at the Committee meeting in June 2024.			
Executive Lead:	Dr Nick Lyons – Executive Medical Director			
Report Author:	Dr James Risley – Deputy Executive Medical Director Dino Tedaldi – Urology Network Manager			
Purpose of report:	I'w Nodi *For Noting* ☒	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
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:***				
Link to Strategic Objective(s):	Strategic Priority 4 – Urgent and Emergency Care			
Regulatory and legal implications:	Welsh Government Quality Standards 2023			
In accordance with WP7 has an EqIA been identified as necessary and undertaken?	N/A			
In accordance with WP68, has an SEIA identified as necessary been undertaken?	N/A			
Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)	ID5050 – Network Urology Risks			

Financial implications as a result of implementing the recommendations	N/A Updated Paper
Workforce implications as a result of implementing the recommendations	N/A Update paper
Feedback, response, and follow up summary following consultation	This is a follow up paper in response to further details requested from the paper shared in April 2024
Links to BAF risks: *(or links to the Corporate Risk Register)*	In relation to sustainability of clinical services
Reason for submission of report to confidential board (where relevant)	Not applicable

Next Steps:

Implementation of recommendations, aligned to the approach and prioritisation of themes through the Urology Improvement Plan, monitored by the Urology Improvement Group.

List of Appendices:

Appendix 1 - Suspected Prostate Cancer Pathway - Straight to mpMRI Test Evaluation Report 2023

Suspected Pr

QUALITY SAFETY & EXPEIRENCE COMMITTEE MEETING IN PUBLIC
Thursday 15th August 2024
Urology Improvement Plan

Following submission of the UIP (Urology Improvement Plan) update to QSE in June 2024, there was a request to provide updates for actions within the UIP for the QSE meeting in August 2024. As advised in the previous paper, the priority themes, as agreed through the Executive Team meeting on the 28th February 2024, are Unscheduled Care and Governance and Risk.

Unscheduled Care

As all the actions under the unscheduled care theme are interdependent, a single workbook and timeline for the whole theme has been developed.

Reference to GIRFT Recommendations G3 + G11; RCS Recommendations 5 + 19

Out of Hours and on-call milestones completed to date:

- Identify scope of the programme - 21/11/2023
- Unscheduled Care and Governance/Risk themes prioritised within the Urology Improvement Plan with paper to ET - 07/02/24
- Development of a options appraisal, subsequently shared at the Urology Review Group - 21/03/2024
- Development of feasibility study aligned to the options appraisal - 25/04/2024
- Discussion with Consultants and Operational teams to agree on the feasibility matrix, scoring and preferred option - 25/04/2024
- Agree mitigation model to support operational challenges – update shared with the Executive Team 25/04/2024
- Paper to the Executive team to share the options appraisal, feasibility, preferred option – Paper submitted for Executive Team information in August 2024 (exact date TBD)

Next step:

- Review feedback following Executive team discussion
- Demand and Capacity modelling for Planned Care and Urgent and Emergency Care to be undertaken based on the two feasible options from the appraisal.
- This will inform the workforce requirements, which will subsequently then be able to allow a preferred recommendation for the on-call model to be submitted to the Executives.
- Next steps will then depend on whether a three-site model or two-site model is required, and whether service reconfiguration will be required.

Governance and Risk

Below are the actions from the Improvement Plan, under the Governance and Risk theme with updates against each action.

BCUHB to set up a Task and Finish Group to develop an action plan to implement the GIRFT recommendations and allocate responsibilities to relevant people to share the workload Ref: G1	Complete	01/10/2023	Support from GIRFT and T&F set up, this Improvement plan will now work under the Urology review group and be monitored by the Urology Improvement group

BCUHB should establish a formal stone MDT Ref: G18	Complete	01/10/2023	MDT in situ but not regularly attended by all three sites, audit of ongoing attendance with escalation to UIG and IHC MD's
Review and action of 8 cases highlighted from the casenote review Ref: RCS2	In Progress	01/07/2024 Adjusted timeline 01/10/2024	First review undertaken, quality assurance process in place. Second review delayed due to industrial action and Clinical Governance sessions which have supported the on-call options appraisal development
Investigate case A51 and consider duty of candour in respect of misdiagnosis of the patient. Ref: RCS3	In Progress	01/07/2024 Adjusted timeline 01/10/2024	First, review undertaken, quality assurance process in place. Second review delayed due to industrial action and Clinical Governance sessions, which have supported the on-call options appraisal development.
Effective performance management of all clinicians, particularly with regard to MDT involvement, is required to ensure accountability and transparency. Ref: RCS 7d	Complete	01/07/2024	1:1 meetings with each consultant and the Executive Medical Director have taken place, to remind them of their professional responsibilities. All are engaged with the requirements of the Improvement Plan
Management of diagnostic results and patient follow-up. Clinical and Operational teams are to ensure that they have processes in place to review and action results, and that processes are in place to prevent patients being lost to follow-up Ref: AIP1	In Progress	01/10/2024	Centre - Fully reviewed, agreed and implemented new processes. West - Discussions have taken place with the team following the lessons learnt from YGC, agreed to adopt and follow the YGC process to be implemented by 20th July 2024. East – Currently awaiting feedback from process review and an agreed date for implementation

The health board should review the consent-taking practices within the urology surgical services to ensure that copies of consent forms are given to patients (and/or their parents/guardians/carers). Ref: RCS 7h	In Progress	01/10/2024	West - 5th July 24, All patients are offered copy of consent forms in clinic and on day of surgery if they have not been consented sooner is currently in place. Centre - 12th July 24, All patients are offered copy of consent forms in clinic and on day of surgery if they have not been consented sooner is currently in place. East - Awaiting confirmation Network Audit dates to be agreed
The Health Board should ensure that all GP correspondence is copied to patients (or written to patients and copied to GPs) after consultations. The health board should ensure there are systems in place in which letters are written and sent out to patients and their GP's after each clinic visit in a timely manner. Ref: RCS 7i	In Progress	01/10/2024	West - 5th July, not all patients receive a copy of the outpatients consultation letter but have agreed that from W/C 15th July all patients will receive a copy of the clinical letter. Centre - 12th July, Correspondence is sent to patient's GPs after each hospital attendance but this correspondence is not routinely copied to patients but have agreed that from 5th August all patients will receive a copy of the clinical letter East - Correspondence is sent to patients GP'S after each hospital attendance but is not routinely copied to the patient. Awaiting confirmation of a date for all letters to be sent to the patient.
Health board, at every level, must focus on resolving the issues that have been highlighted by the review team in this report and ensure that they have accessible and committed operational and strategic management in place , dedicated to fulfilling the recommendations made by the team and able to influence transformational change.	Complete		The improvement plan is central to the discussion at the Urology Improvement group and review group. Agreed operational and clinical leads are in place for each action to ensure that transformational change is influences to achieve the agreed outcomes.

Ref: RCS 1			
It is recommended that strong links and channels of communication between primary care and patient groups need to be enhanced. Ref: RCS 7g	Not Started		No Update

Planned care

The Planned Care theme was not identified as a priority theme but through internal projects and external funding opportunities a number of the actions have progressed as outlined below. A project evaulation report has been completed for the Straight to Test (STT) which provides details on the approach and benefits from the programme.

BCUHB to improve the pre-investigation of patients attending the departments, especially those on suspected cancer pathways. A priority area would be those patients needing mpMRI of the prostate. Ref: G8	Complete	01/01/2024	STT implemented across all three sites, East and West Nurse triage, Centre Consultant triage but supporting the development of a newly employed nurse. Update: Funding for key tracker posts, 1 WTE each site, funded by planned care budget until March 2027
All departments in BCUHB should implement TULA services. It is low cost and offers an outpatient treatment to what are often elderly and co-morbid patients as well as a rapid release of theatre capacity. Ref: G6	In Progress	01/10/2024	13/02: East - Service implemented 19/06: West - Planned start date July 2024 Centre – To identify source of funding to purchase equipment

Suspected Prostate Cancer Pathway

Straight to mpMRI Test Evaluation Report 2023

V1.2

Content

Abbreviations

CNS: clinical nurse specialist
mpMRI: multiparametric MRI
OPA: outpatient appointment
PoS: Point of suspicion ("Date referral is sent from primary care to the health board" [Wales Cancer Network, 2018])
STT: straight to test
WMH: Wrexham Maelor Hospital
YGH: Ysbyty Gwynedd Hospital

1. Introduction

Betsi Cadwaladr University Health Board's Transformation & Improvement and Cancer Services team have undergone a project in collaboration with Urology, to improve our current prostate cancer pathway. The aim of the prostate cancer pathway redesign work is to standardise and streamline processes across the health board, to reduce clinical variation and align practice with nationally agreed pathway recommendations and targets to ensure our patients/service users are receiving the best possible care and outcomes that we can provide.

One of the areas which was prioritised, was the implementation of a nurse led triage to allow patients to go straight for an mpMRI test (STT) when a suspected cancer referral is made to secondary care. The aim of this improvement is to reduce the number of outpatient appointments that patients require and to establish a quicker diagnosis. Furthermore, it is expected that the reduction in the need for outpatient appointments will release clinical capacity for other activities, such as performing biopsies.

To support the change to the prostate cancer pathway, the health board employed three prostate cancer pathway coordinators, whom are funded by the Wales Cancer Network until the end of March 2024. The coordinators' roles and responsibilities in supporting the pathway include providing patients with information, coordinating radiology appointments and escalating delays (summarised in the embedded flowchart below).

STT Pathway-Straight to mpMRI (with admi

2. Overview

The intention of this report is to review the impact of the STT pathway for suspected prostate cancer. Data used for this report has been collected from spreadsheets used by the pathway coordinators, cancer tracking SharePoint and Welsh Clinical Portal. The data is presented for each site separately and in combination. Due to staffing circumstance, the nurse led STT pathway is only established in Wrexham Maelor Hospital (WMH) and Ysbyty Gwynedd Hospital (YGH), therefore, the data is only presented for both sites. Patients included for this report are all suspected prostate cancer referrals from General Medical Practitioner (Primary Care) received from July – October 2023. For patients referred by General Medical Practitioner, the point of suspicion (PoS) is the 'date referral is sent from primary care to the health board' [Wales Cancer Network, 2018].

This report aims to answer a number of key questions:

1. How many patients were suitable and not suitable for STT?
2. What are the reasons for not being suitable for STT?
3. What's the average waiting time between PoS and first contact?

4. What's the average waiting time between PoS and mpMRI scan?
5. What's the average waiting time from mpMRI scan to mpMRI report?
6. What's the average waiting time from PoS to biopsy?
7. What's the average waiting time from PoS to treatment?
8. What impact has the STT pathway had on patient experience?

Data to answer questions 1 – 7 will be presented as whole sample sizes, normality test results, mean ± standard deviation, median (interquartile range), minimum value, and maximum value. For each section of the report, key findings will be reported using mean values for normally distributed data and median values for non-normally distributed data.

3. Straight to test suitability

This section looks at the number of patients who were triaged by the clinical nurse specialist (CNS) to assess and determined suitability for STT. All referrals were vetted by the urologists in the first instance.

3.1. *Site: Wrexham Maelor Hospital*

3.1.1. Total GP Suspected Prostate Cancer Referral:

- 132

3.1.2. Sent to STT Triage:

- 54 *(Not Sent to STT Triage: 78)*

3.1.3. Of those sent to STT:

- Suitable: 42 / Not Suitable: 12

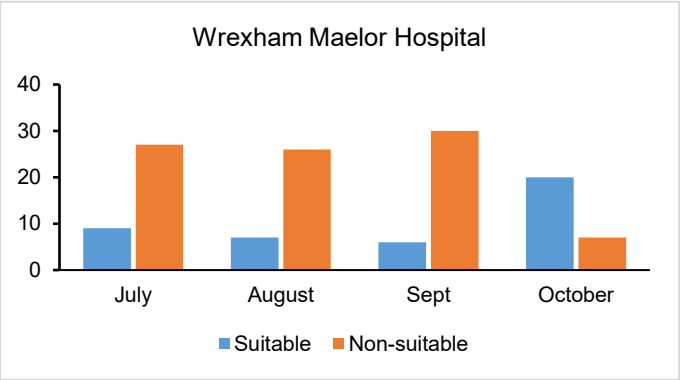


Figure 1. Monthly suitability figures for WMH.

	WMH			
	July	August	Sept	October
Suitable	9	7	6	20
Non-suitable	27	26	30	7

Table 1. Monthly suitability figures for WMH.

3.2. *Site: Ysbyty Gwynedd Hospital*

3.2.1. Total GP Suspected Prostate Cancer Referrals:

- 217

3.2.2. Sent to STT Triage:

- 183 *(Not Sent to STT Triage: 34)*

3.2.3. Of those sent to S2T:

- Suitable: 49 / Not Suitable: 134

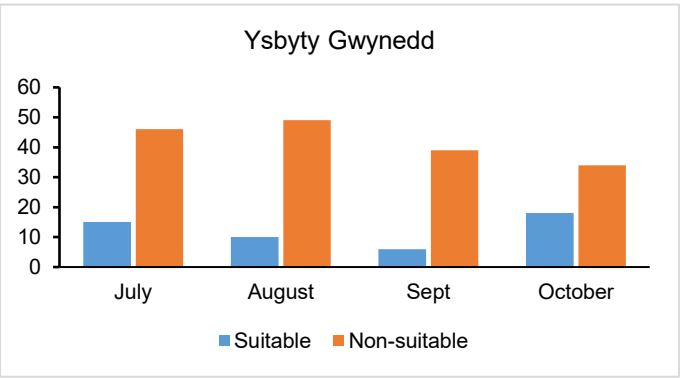


Figure 2. Monthly suitability figures for YGH.

	YG			
	July	August	Sept	October
Suitable	15	10	6	18
Non-suitable	46	49	39	34

Table 2. Monthly suitability figures for YGH.

3.3. *Sites: Both*

3.3.1. Total GP Suspected Prostate Cancer Referral:

- 349

3.3.2. Sent to STT Triage:

- 237 *(Not Sent to STT Triage: 112)*

3.3.3. Of those sent to STT:

- Suitable: 91 / Not Suitable: 146

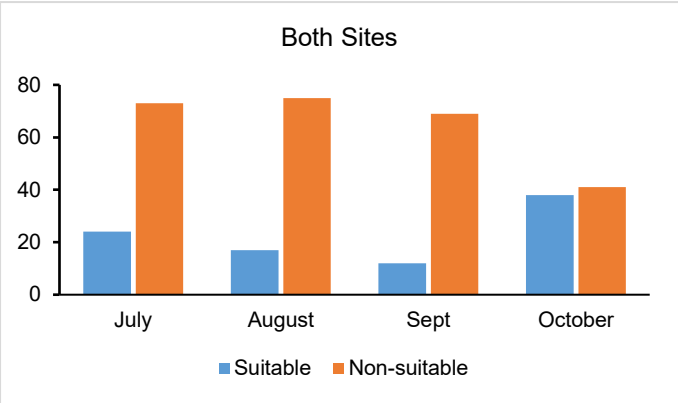


Figure 3. Monthly suitability figures for WMH & YGH.

	Total			
	July	August	Sept	October
Suitable	24	17	12	38
Non-suitable	73	75	69	41

Table 3. Monthly suitability figures for WMH & YGH.

3.4. *Key Findings*

- 237 patients were reviewed by STT nurse triage across WMH and YGC, however 146 (62%) were not suitable for STT. The main reasons for this were:

Reason	Number
Age	32
Not required (diagnosed, treated or follow-up)	29
Awaiting other tests (including eGFR, ultrasound or PSA)	13
Health reasons	10
Co-morbidities (inc. urological complexities)	10
High PSA	8
Other	8
Does not meet inclusion criteria	7
Unable to contact patient	5
Investigations elsewhere	3

Table 4. Ten main reasons why patients were not suitable for STT across WMH and YGH.

- The number of patients triaged by the CNS at YGH are much greater than WMH, this is due to the fact that the coordinator actively picks-up all suspected prostate cancer referrals from the tray, whereas in WMH, the urologists use a proforma to preselect eligible patients for triage when vetting.
- A significant increase in the number of suitable patients was observed in October at WHM. This can possibly be explained by the fact that a small internal audit was done in September, and the proforma was introduced to prompt urologists to send eligible patient for STT triage.

4. Time from point of suspicion to first contact

This section looks at the difference in waiting time from PoS to first contact between STT and non-STT patients. First contact for STT patient is the point whereby the patient was triaged by the CNS via telephone. For non-STT patients, first contact is the first outpatient appointment (OPA). The data presented is only for WMH (*data not available for YGH*).

4.1. *Site: Wrexham Maelor Hospital*

4.1.1. Total time from PoS to First contact (STT + non-STT):

- **Sample size:** 132
- **Normality Test:** Not normally distributed *(p<0.05)*
- **Mean + SD:** 18 ± 13 days
- **Median (IQR):** 18 (22) days
- **Minimum:** 0 days
- **Maximum:** 64 days

4.1.2. STT Average time from PoS to First Contact:

- **Sample size:** 54
- **Normality Test:** Not normally distributed *(p<0.05)*
- **Mean + SD:** 7 ± 5 days
- **Median (IQR):** 6 (4) days
- **Minimum:** 0 days
- **Maximum:** 21 days

4.1.3. Non-STT Average time from PoS to First Contact:

- **Sample size:** 78
- **Normality Test:** Normally distributed *(p=0.05)*
- **Mean + SD:** 27 ± 10 days
- **Median (IQR):** 25 (14) days
- **Minimum:** 9 days
- **Maximum:** 64 days

4.1.4. Differences:

- **Mean Difference:** 20 Days (in favour of STT)
- **Median Difference:** 19 Days (in favour of STT)

4.2. Key Findings

- At WMH, patients who were suitable for the STT pathway were contacted via telephone 19 days sooner than patients who were not suitable and required an OPA.
- Some STT patients were contacted the same day as PoS.

5. Time from point of suspicion to mpMRI

This section looks at the difference in waiting time from PoS to mpMRI scan between STT and non-STT patients. The mpMRI is ordinarily the first diagnostic scan performed. The data is presented separately for both sites, and in combination.

5.1. *Site:* Wrexham Maelor Hospital

5.1.1. Total time from PoS to mpMRI (STT + non-STT):

- **Sample size:** 115
- **Normality Test:** Not normally distributed *(p<0.05)*
- **Mean + SD:** 42 ± 16 days
- **Median (IQR):** 40 (25) days
- **Minimum:** 14 days
- **Maximum:** 111 days

5.1.2. STT Average time from PoS to mpMRI:

- **Sample size:** 40
- **Normality Test:** Normally distributed *(p=0.06)*
- **Mean + SD:** 27 ± 4 days
- **Median (IQR):** 26 (7) days
- **Minimum:** 19 days
- **Maximum:** 34 days

5.1.3. Non-STT Average time from PoS to mpMRI:

- **Sample size:** 75
- **Normality Test:** Not normally distributed *(p<0.05)*
- **Mean + SD:** 50 ± 14 days
- **Median (IQR):** 47 (18) days
- **Minimum:** 14 days
- **Maximum:** 111 days

5.1.4. Differences:

- **Mean Difference:** 23 Days (in favour of STT)
- **Median Difference:** 21 Days (in favour of STT)

5.2. *Site:* Ysbyty Gwynedd Hospital

5.2.1. Total time from PoS to mpMRI (STT + non-STT):

- **Sample size:** 90
- **Normality Test:** Not normally distributed *(p<0.05)*
- **Mean + SD:** 36 ± 18 days
- **Median (IQR):** 33 (16) days
- **Minimum:** 17 days
- **Maximum:** 134 days

5.2.2. STT Average time from PoS to mpMRI:

- **Sample size:** 45
- **Normality Test:** Not normally distributed *(p<0.05)*
- **Mean + SD:** 31 ± 13 days
- **Median (IQR):** 26 (12) days
- **Minimum:** 17 days

- **Maximum:** 82 days

5.2.3. Non-STT Average time from PoS to mpMRI:

- **Sample size:** 45
- **Normality Test:** Not normally distributed *(p<0.05)*
- **Mean + SD:** 41 ± 20 days
- **Median (IQR):** 36 (10) days
- **Minimum:** 20 days
- **Maximum:** 134 days

5.2.4. Differences:

- **Mean Difference:** 10 Days (in favour of STT)
- **Median Difference:** 10 Days (in favour of STT)

5.3. *Sites:* Both

5.3.1. Total time from PoS to mpMRI (STT + non-STT):

- **Sample size:** 205
- **Normality Test:** Not normally distributed *(p<0.05)*
- **Mean + SD:** 39 ± 17 days
- **Median (IQR):** 35 (20) days
- **Minimum:** 14 days
- **Maximum:** 134 days

5.3.2. STT Average time from PoS to mpMRI:

- **Sample size:** 85
- **Normality Test:** Not normally distributed *(p<0.05)*
- **Mean + SD:** 29 ± 10 days
- **Median (IQR):** 26 (8) days
- **Minimum:** 17 days
- **Maximum:** 82 days

5.3.3. Non-STT Average time from PoS to mpMRI:

- **Sample size:** 120
- **Normality Test:** Not normally distributed *(p<0.05)*
- **Mean + SD:** 47 ± 17 days
- **Median (IQR):** 43 (21) days
- **Minimum:** 14 days
- **Maximum:** 134 days

5.3.4. Differences:

- **Mean Difference:** 18 Days (in favour of STT)
- **Median Difference:** 17 Days (in favour of STT)

5.4. *Key Findings*

- At WMH, patients who were suitable for the STT pathway received their mpMRI scans 21 days sooner than those on the non-STT pathway.
- At YGH, patients who were suitable for the STT pathway received their mpMRI scans 10 days sooner than those on the non-STT pathway.
- When combining the data of both sites, patients who were suitable for the STT pathway received their mpMRI scans 17 days sooner than those on the non-STT pathway.

6. Time from mpMRI scan to mpMRI report

This section looks at the difference in waiting time from mpMRI scan appointments to mpMRI reports between STT and non-STT patients. The data is presented separately for both sites, and in combination.

6.1. *Site:* *Wrexham Maelor Hospital*

6.1.1. Total time from mpMRI to mpMRI report (STT + non-STT):

- **Sample size:** 97
- **Normality Test:** Not normally distributed *(p<0.05)*
- **Mean + SD:** 6 ± 5 days
- **Median (IQR):** 5 (5) days
- **Minimum:** 0 days
- **Maximum:** 21 days

6.1.2. STT Average time from mpMRI to mpMRI report:

- **Sample size:** 29
- **Normality Test:** Not normally distributed *(p<0.05)*
- **Mean + SD:** 6 ± 4 days
- **Median (IQR):** 6 (5) days
- **Minimum:** 1 days
- **Maximum:** 19 days

6.1.3. Non-STT Average time from mpMRI to mpMRI report:

- **Sample size:** 68
- **Normality Test:** Not normally distributed *(p<0.05)*
- **Mean + SD:** 6 ± 5 days
- **Median (IQR):** 5 (5) days
- **Minimum:** 0 days
- **Maximum:** 21 days

6.1.4. Differences:

- **Mean Difference:** 0 Days
- **Median Difference:** 1 Days (in favour of non-STT)

6.2. *Site:* *Ysbyty Gwynedd Hospital*

6.2.1. Total time from mpMRI to mpMRI report (STT + non-STT):

- **Sample size:** 81
- **Normality Test:** Not normally distributed *(p<0.05)*
- **Mean + SD:** 4 ± 3 days
- **Median (IQR):** 4 (2) days
- **Minimum:** 0 days
- **Maximum:** 23 days

6.2.2. STT Average time from mpMRI to mpMRI report:

- **Sample size:** 36
- **Normality Test:** Not normally distributed *(p<0.05)*
- **Mean + SD:** 4 ± 2 days

- **Median (IQR):** 4 (2) days
- **Minimum:** 0 days
- **Maximum:** 12 days

6.2.3. Non-STT Average time from mpMRI to mpMRI report:

- **Sample size:** 45
- **Normality Test:** Not normally distributed *(p<0.05)*
- **Mean + SD:** 5 ± 4 days
- **Median (IQR):** 4 (3) days
- **Minimum:** 1 days
- **Maximum:** 23 days

6.2.4. Differences:

- **Mean Difference:** 1 Days (in favour of STT)
- **Median Difference:** 0 Days

6.3. *Sites:* *Both*

6.3.1. Total time from mpMRI to mpMRI report (STT + non-STT):

- **Sample size:** 178
- **Normality Test:** Not normally distributed *(p<0.05)*
- **Mean + SD:** 5 ± 4 days
- **Median (IQR):** 4 (3) days
- **Minimum:** 0 days
- **Maximum:** 23 days

6.3.2. STT Average time from mpMRI to mpMRI report:

- **Sample size:** 65
- **Normality Test:** Not normally distributed *(p<0.05)*
- **Mean + SD:** 5 ± 3 days
- **Median (IQR):** 4 (3) days
- **Minimum:** 0 days
- **Maximum:** 19 days

6.3.3. Non-STT Average time from mpMRI to mpMRI report:

- **Sample size:** 113
- **Normality Test:** Not normally distributed *(p<0.05)*
- **Mean + SD:** 6 ± 5 days
- **Median (IQR):** 4 (23) days
- **Minimum:** 0 days
- **Maximum:** 23 days

6.3.4. Differences:

- **Mean Difference:** 1 Days (in favour of STT)
- **Median Difference:** 0 Days

6.4. *Key Findings*

- There is no significant difference in the time from mpMRI scan appointments to mpMRI reports between STT and non-STT at WMH and/or YGH.

7. Time from point of suspicion to biopsy

This section looks at the difference in waiting time from PoS to biopsy procedure. Delays to biopsy appointments are frequently observed in the pathway due to numerous reason, including resources and clinician's availability. The data is presented separately for both sites, and in combination.

7.1. *Site: Wrexham Maelor Hospital*

7.1.1. Total time from PoS to Biopsy (STT + non-STT):

- **Sample size:** 36
- **Normality Test:** Not normally distributed *(p<0.05)*
- **Mean + SD:** 87 ± 25 days
- **Median (IQR):** 78 (43) days
- **Minimum:** 46 days
- **Maximum:** 134 days

7.1.2. STT Average time from PoS to Biopsy:

- **Sample size:** 12
- **Normality Test:** Normally distributed *(p=0.16)*
- **Mean + SD:** 68 ± 16 days
- **Median (IQR):** 67 (21) days
- **Minimum:** 49 days
- **Maximum:** 110 days

7.1.3. Non-STT Average time from PoS to Biopsy:

- **Sample size:** 24
- **Normality Test:** Normally distributed *(p=0.24)*
- **Mean + SD:** 96 ± 24 days
- **Median (IQR):** 104 (38) days
- **Minimum:** 46 days
- **Maximum:** 134 days

7.1.4. Differences:

- **Mean Difference:** 28 Days (in favour of STT)
- **Median Difference:** 37 Days (in favour of STT)

7.2. *Site: Ysbyty Gwynedd Hospital*

7.2.1. Total time from PoS to Biopsy (STT + non-STT):

- **Sample size:** 40
- **Normality Test:** Normally distributed *(p=0.30)*
- **Mean + SD:** 53 ± 24 days
- **Median (IQR):** 55 (34) days
- **Minimum:** 10 days
- **Maximum:** 132 days

7.2.2 STT Average time from PoS to Biopsy:

- **Sample size:** 14
- **Normality Test:** Normally distributed *(p=0.12)*
- **Mean + SD:** 76 ± 26 days

- **Median (IQR):** 72 (36) days
- **Minimum:** 47 days
- **Maximum:** 138 days

7.2.3. Non-STT Average time from PoS to Biopsy:

- **Sample size:** 26
- **Normality Test:** Normally distributed *(p=0.06)*
- **Mean + SD:** 63 ± 21 days
- **Median (IQR):** 60 (22) days
- **Minimum:** 31 days
- **Maximum:** 132 days

7.2.4. Differences:

- **Mean Difference:** 13 Days (in favour of Non-STT)
- **Median Difference:** 12 Days (in favour of Non-STT)

7.3. *Sites: Both*

7.3.1 Total time from PoS to Biopsy (STT + non-STT):

- **Sample size:** 76
- **Normality Test:** Normally distributed *(p=0.06)*
- **Mean + SD:** 69 ± 30 days
- **Median (IQR):** 65 (33) days
- **Minimum:** 10 days
- **Maximum:** 134 days

7.3.2. STT Average time from PoS to Biopsy:

- **Sample size:** 26
- **Normality Test:** Not normally distributed *(p<0.05)*
- **Mean + SD:** 72 ± 22 days
- **Median (IQR):** 70 (25) days
- **Minimum:** 47 days
- **Maximum:** 138 days

7.3.3. Non-STT Average time from PoS to Biopsy:

- **Sample size:** 50
- **Normality Test:** Not normally distributed *(p<0.05)*
- **Mean + SD:** 79 ± 28 days
- **Median (IQR):** 74 (45) days
- **Minimum:** 31 days
- **Maximum:** 134 days

7.3.4. Differences:

- **Mean Difference:** 7 Days (in favour of STT)
- **Median Difference:** 4 Days (in favour of STT)

7.4. *Key Findings*

- At WMH, patients who were suitable for the STT pathway received their biopsy 28 days sooner than those on the non-STT pathway.
- At YGH, patients who were not suitable for the STT pathway received their biopsy 13 days sooner than those on the STT pathway.

- When combining the data of both sites, patients who were suitable for the STT pathway received their biopsy 4 days sooner than those on the non-STT pathway.
- It seems like YGH have greater delays to biopsy, and therefore lose some of the time saved from STT. Proposed reasons for this include; not enough slots, limited number of urologists performing biopsies, reliance on weekend sessions and capacity within the unit.

8. Time from point of suspicion to treatment

This section looks at the difference in waiting time from PoS to treatment. The data presented is only for WMH (data not available for YGH).

8.1. *Site:* *Wrexham Maelor Hospital*

8.1.1. Total time from PoS to treatment (STT + non-STT):

- **Sample size:** 58
- **Normality Test:** Not normally distributed *(p<0.05)*
- **Mean + SD:** 57 ± 29 days
- **Median (IQR):** 51 (35) days
- **Minimum:** 15 days
- **Maximum:** 132 days

8.1.2. STT Average time from PoS to treatment:

- **Sample size:** 12
- **Normality Test:** Not normally distributed *(p<0.05)*
- **Mean + SD:** 46 ± 27 days
- **Median (IQR):** 31 (39) days
- **Minimum:** 23 days
- **Maximum:** 108 days

8.1.3. Non-STT Average time from PoS to treatment:

- **Sample size:** 46
- **Normality Test:** Not normally distributed *(p<0.05)*
- **Mean + SD:** 60 ± 29 days
- **Median (IQR):** 51 (32) days
- **Minimum:** 15 days
- **Maximum:** 132 days

8.1.4. Differences:

- **Mean Difference:** 14 Days (in favour of STT)
- **Median Difference:** 20 Days (in favour of STT)

8.2. *Key Findings*

- At WMH, patients who were suitable for the STT pathway received their treatment 20 days sooner than those on the non-STT pathway.

9. Summary of key findings

Here's a summary of all the key findings that have been studied in this report:

- 237 patients were reviewed by STT nurse triage across WMH and YG, however 146 (62%) were not suitable for STT.
- At WMH, patients who were suitable for the STT pathway were contacted via telephone 19 days sooner than patients who were not suitable and required an OPA.
- Some STT patients were contacted the same day as PoS.
- At WMH, patients who were suitable for the STT pathway received their mpMRI scans 21 days sooner than those on the non-STT pathway.
- At YGH, patients who were suitable for the STT pathway received their mpMRI scans 10 days sooner than those on the non-STT pathway.
- When combining the data of both sites, patients who were suitable for the STT pathway received their mpMRI scans 17 days sooner than those on the non-STT pathway.
- No significant difference was observed in the time from mpMRI scan appointment to mpMRI report between STT and non-STT at WMH or YGH.
- At WMH, patients who were suitable for the STT pathway received their biopsy 28 days sooner than those on the non-STT pathway.
- At YGH, patients who were not suitable for the STT pathway received their biopsy 13 days sooner than those on the STT pathway.
- When combining the data of both sites, patients who were suitable for the STT pathway received their biopsy 4 days sooner than those on the non-STT pathway.
- It seems like YGH have greater delays to biopsy, and therefore lose some of the time saved from STT. Suggested reasons for this include; not enough slots, limited number of urologists performing biopsies, reliance on weekend sessions and capacity within the unit.
- At WMH, patients who were suitable for the STT pathway received their treatment 20 days sooner than those on the non-STT pathway.

10. Patient feedback

As the STT process change in the suspected prostate cancer pathway is having a direct impact on the patient, it is valuable to capture the voice of the patient. Therefore, in collaboration with YGH's Urology Department and the health board's Patient Advice and Liaison team, a patient survey was produced and completed.

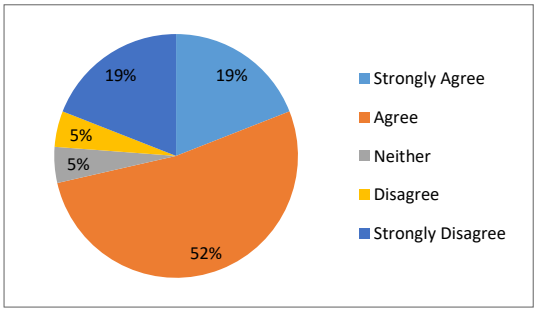
In total, an attempt was made by a Patient Advice and Liaison Support Officer to contact 28 suitable patients. Out of 28, the officer was able to speak to 22 patient, with 21 able to answer all the survey question, whilst 1 patient was occupied and only provided a brief comment;

"*The overall speed that I was seen and treated was fantastic.*"

Here are the results of the responses and comments given to the 12 questions which were asked to the 21 patients.

Question 1

The information I was given by my GP prior to receiving the telephone consultation explained why I would receive a telephone consultation.

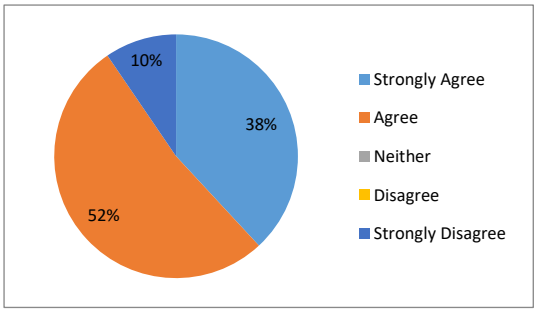


Additional Comment(s):

- *"I felt that there was a step missing. I felt that I should have been informed of the Mri scan and why I needed a biopsy."*

Question 2

The Clinical Nurse Specialist introduced themselves to me on the telephone and told me the reasons why I had been referred.

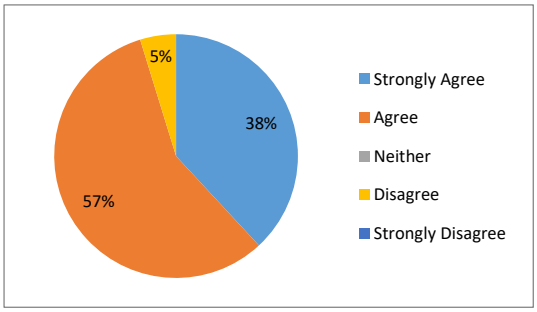


Additional Comment(s):

- *"The Urology Department have been very good."*

Question 3

All the information I was given was clear and my plan of care and investigation were discussed and agreed with me.

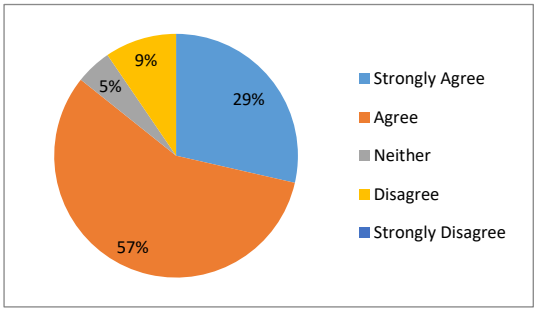


Additional Comment(s):

- *"There was some contradictory information in the pre-op leaflets - two different copies."*

Question 4

I felt involved in the decision about my investigations and care.

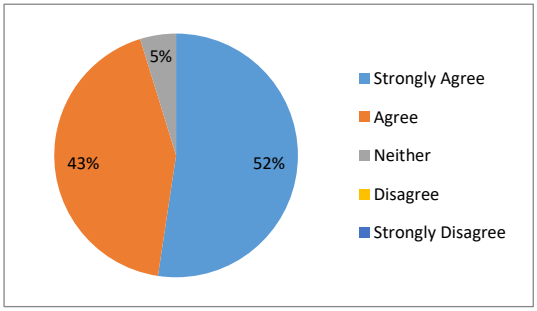


Additional Comment(s):

- *"At no point did anyone ask for my PSA levels to be monitored, I have had them monitored myself".*
 - Patient has been discharged from the service. Thinks men of a certain age should have regular PSA checks.

Question 5

I found the Clinical Nurse Specialist informative and supportive.

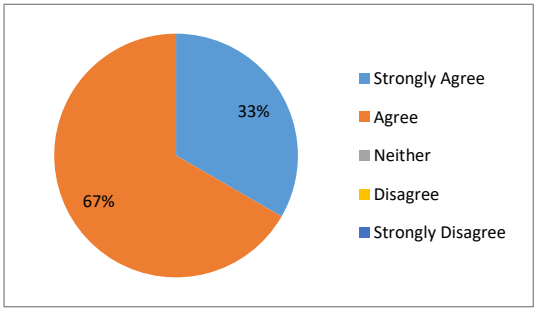


Additional Comment(s):

- *"The Specialist Nurse was superb! She explained everything to me and my friend. Discussing all the treatment options. I felt that all the time scales were hit in a timely manner. The Specialist Nurses are very good very good at what they do, I feel that I am in very capable hands and filled with confident and reassuring."*

Question 6

I was given enough time to ask any questions during the telephone consultation.

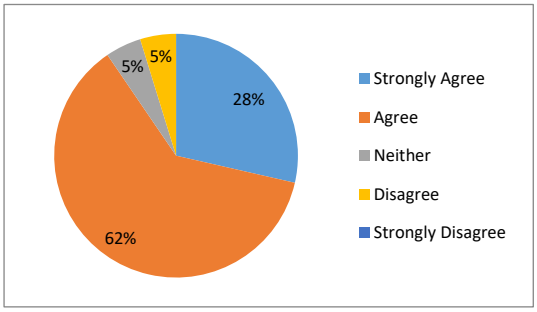


Additional Comment(s):

- *"Very efficient. The clinical services are excellent."*

Question 7

Arrangements for investigations were discussed with me.

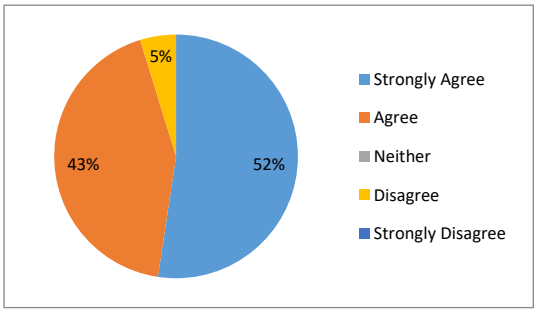


Additional Comment(s):

- *"Very pleased with the way that everything went, it went really quickly."*

Question 8

I received a letter explaining that the telephone consultation had taken place and what the next steps would be along with a leaflet regarding the MRI.

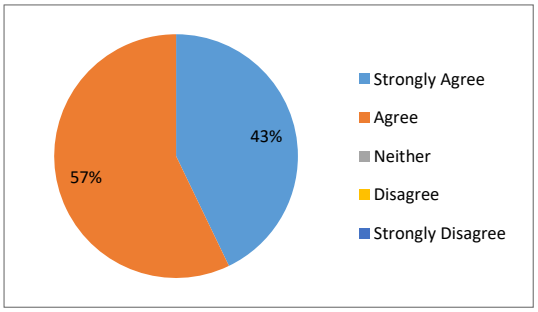


Additional Comment(s):

- *"The Specialist Nurses were first class. So was the surgeon. I felt that I was in excellent hands."*

Question 9

I felt the support was available if required.

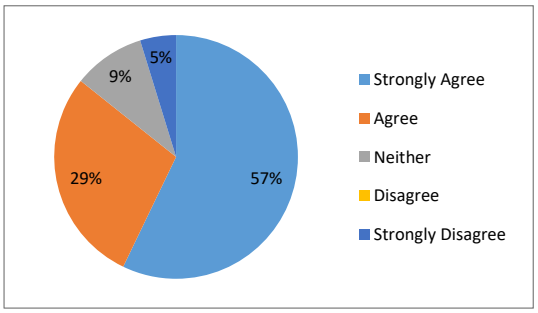


Additional Comment(s):

- *"They are doing a wonderful job."*

Question 10

I received a copy of the patient information leaflet about undergoing a prostate biopsy and what this procedure involves, prior to me having a biopsy.

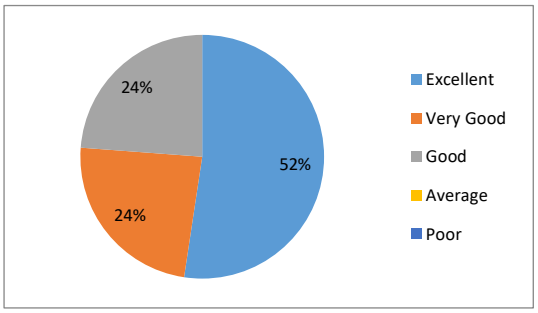


Additional Comment(s):

- *"There seemed to be a bit of a mix with reason for referral. I felt it was not entirely joined up and felt that the final outcome could have been come to a lot quicker."*

Question 11

How would you rate your patient experience?

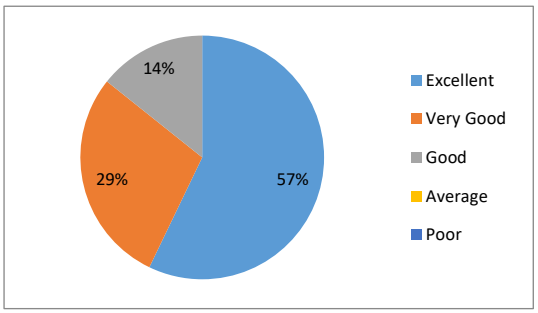


Additional Comment(s):

- *"The Specialist Nurse was exceptional."*

Question 12

My overall satisfaction with the service



No Additional Comment(s)

11. Potential next steps

Straight to test requires coordination to ensure that all the necessary processes take place in the correct order, thus the role of the pathway coordinator is central to its success. This role is also adaptable and can be utilised to make further improvements. For example, it would be possible to seek additional training for the pathway coordinators to take some additional responsibilities from the CNS, allowing more patients to be triaged in a timely manner. Furthermore, additional improvements to the pathway are currently being explored, such as developing a one-stop clinic for all diagnostic tests. The role of the pathway coordinator would certainly support this initiative.

12. Conclusion

The combination of performance data and patient feedback data demonstrates that the STT pathway for suspected prostate cancer has a significant positive effect on pathway waiting times, which has a direct impact on patient outcomes. Moreover, patients report that they are still satisfied with the care that's provided. A small limitation to this report is the sample sizes used from a number of the analyses. Due to insufficient data, the sample sizes are different between groups and sites, therefore this should be taken into consideration when interpreting these findings.

13. Cost

The ongoing cost for the health board to sustain these improvements will be the staff-pay costs for three Band 4 prostate cancer pathway coordinators. As of December 2023, the current top-end annual cost for a full-time Band 4 (including on-costs) is £34,647.00. Therefore, the maximum possible investment required for 2024/25 to secure all three positions is £103,941.00.

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, 15 August 2024
Crynodeb Gweithredol: ***Executive Summary:***	The purpose of this report is to clarify the governance approach and arrangements for providing oversight on the progress and trajectory against the recommendations of the Royal College of Psychiatrists Invited Review Services Report (RCPsych Report). The RCPsych undertook a review of how the Health Board implemented the findings from four previous reports and the extent to which these have been maintained and integrated into "business as usual "practices. The Board, at its meeting on 25 July 2024, received and considered the Health Board response to Royal College of Psychiatrists Invited Review Service Report. The full report can be found on the BCU website. It included a high level description of proposed governance arrangements to oversee the response plan delivery. The Board reiterated the apology to those people who were let down and expressed the continued commitment to use their experience to drive forward actions that lead to improvements for patients, carers, families and staff. It is vitally important that governance arrangements are such that they can demonstrate transparency and accountability to the citizens of North Wales, including the families of current and previous Service users. The Board considered and endorsed the outline approach and governance arrangements. This included the establishment of a governance framework that enables transparent and accountable progress. This included: 1. Establishment of an Expert Advisory Group that would be a Sub-Committee of QSE Committee, independently Chaired with family and user representatives, and Llais included as group members. Initial membership to be agreed in advance of the QSE Committee in August 2024. 2. Establishment of a Health Board RCPsych Action Delivery Group (an internal management group) that reports into the Executive Team. The Draft Terms of Reference will be received and considered at the Executive Team Meeting. 3. Regular monitoring and oversight of response plan progress/delivery via the Quality Safety and Experience Committee.

<table>
<tr><td></td><td colspan="4">4. Terms of Reference to be collaboratively developed and agreed for all groups, supported by the Directorate of Corporate Governance.
5. A procedure for providing progressive and sustained evidence of actions is required.
6. That the governance approach should be approved at the next QSE Committee (15 August 2024)

The Board has now agreed that oversight of the response to the RCPsych Report will be through the Quality Safety and Experience (QSE) Committee with six-monthly progress reports. provided to the Board.</td></tr>
<tr><td>Argymhellion:

Recommendations:</td><td colspan="4">The Committee is asked to:

• Consider and Endorse the proposed governance arrangements to oversee/monitor the response plan in order to assure the Board that progress and trajectory address the recommendations within the RCPsych Report.
• Agree to establish the Expert Advisory Group as a sub committee of the Quality Safety and Experience Committee which will have the responsibility for the oversight of the action plan.
• Note the Draft Terms of Reference for the Health Board RCPsych Action Delivery Group that will be received and considered at Executive Team Meeting.</td></tr>
<tr><td>Arweinydd Gweithredol:

Executive Lead:</td><td colspan="4">Teresa Owen, Executive Director of Allied Health Professionals and Health Science</td></tr>
<tr><td>Awdur yr Adroddiad:

Report Authors:</td><td colspan="4">Carole Evanson, Interim Director of Nursing/Interim Director of Operations, MH&LD
Iain Wilkie, Director MH&LD
Adrianne Jones, MH&LD Operational Business Lead
Phil Meakin, Associate Director of Governance</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>
</table>

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***	
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	1. Building an Effective Organisation 2. Compassionate Culture, leadership and engagement 4. Improving quality, outcomes and experience 5. Effective environment for learning
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	None
Yn unol â WP7, a oedd 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)***	Strategic Priority P18 Quality, Innovation and Improvement
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	This paper has been prepared following the recommendations agreed at the Health Board,

Feedback, response, and follow up summary following consultation	25 July 2024, to report to QSE Committee on the 15 August 2024.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	CRR 24-04 Failure to Embed Learning
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Not applicable

Camau Nesaf:
Gweithredu argymhellion
Next Steps:

- To commence the implementation of the governance framework
- Confirm the appointment of the Independent Chair of the Expert Advisory Group and progress Terms of Reference for the Expert Advisory Group
- To provide regular reports on progress at QSE Committee
- To report every six months on progress to the Board

List of Appendices:

Appendix 1 – Draft Terms of Reference for Health Board RCPsych Action Delivery Group
Appendix 2 - Draft Evidence Submission form for use by the Delivery Group

1. Introduction

The purpose of this report is to clarify the governance approach and arrangements for providing oversight on the progress and trajectory against the recommendations of the Royal College of Psychiatrists Invited Review Services Report (Psych Report). This includes the approach to providing updates on progress to the Quality Safety and Experience (QSE) Committee.

This report has been produced one week after the Board Meeting on 25 July 2024, where members of the Board including QSE Committee members received an update on a summary of progress being made in a number of the specific themed areas highlighted by the Royal College Review. Therefore this report focuses on the governance arrangements to provide ongoing oversight to QSE Committee on how it will receive assurance on the extent of progress against the specific themed areas. This report asks the Quality Safety and Experience Committee to;

- **Consider** and **Endorse** the proposed governance arrangements to oversee/monitor the response plan in order to assure the Board that progress and trajectory address the recommendations within the RCPsych Report.
- **Agree** to establish the Expert Advisory Group as a sub committee of the Quality Safety and Experience Committee which will have the responsibility for the oversight of the action plan.
- **Note** the Draft Terms of Reference for the Health Board RCPsych Action Delivery Group that will be received and considered at Executive Team Meeting.

2. Background

The Health Board received the Royal College of Psychiatry (RCPsych) Stocktake of Reviews 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 main goal of the Health Board is to have focussed support to the MH&LD and the wider Health Board Leadership Team to progress the improvements recommended in the report.

The Royal College of Psychiatry (RCPsych) Stocktake Review summarised their findings under ten themes. From the ten themes the Health Board has aligned them in to a joint RCPsych Response Plan. Each of the ten themes has specific actions aligned to MH&LD and Corporate Health Board colleagues to progress. Each theme has a clear outcome and aim to ensure there are tangible and measured improvements across the Division that improve patient care and experience.

It was considered fundamental that people who had experienced poor care in the past were able to influence the way in which the Health Board considers the RCPsych Response Plan, the potential actions and next steps for improvement. These

discussions were enabled by Llais who have been involved over many years in work regarding the concerns raised, in its role as the former Community Health Council.

During these discussions, there were a number of comments and views from the families. There was disappointment that not all families with experience had been involved in informing the review, but the meeting to consider the way forward was welcomed. Actions from this meeting have been agreed and have subsequently informed the response plan.

2.1 Summary from the Board Meeting on 25 July 2024

On the 25 July 2024 the Board received a report that contained:

1. A core report detailing the key Health Board building blocks/foundations which will support the overall improvement to support safe and reliable care, and gained valuable feedback from the families to shape the next steps.
2. A high level description of proposed governance arrangements to oversee the response plan delivery.
3. A description of some of the positive progress being made in a number of specific themed areas highlighted by the Royal College Review

In addition, the Board also agreed that a governance framework will be established that enables transparent and accountable progress with full assurance provided to all involved. The following is being progressed:

1. Establishment of an Expert Advisory Group, independently chaired with family and user representatives, and Llais included as group members. Initial membership to be agreed in advance of the QSE Committee in August 2024.
2. Establishment of a Health Board RCPsych Action Delivery Group (an internal group) that reports into the Executive Team.
3. Regular monitoring and oversight of response plan progress/delivery via the Quality Safety and Experience Committee.
4. Terms of Reference to be collaboratively developed and agreed for all groups, supported by the Directorate of Corporate Governance.
5. A procedure for providing progressive and sustained evidence of actions is required.

In relation to the improvement trajectory the RCPsych Response Plan details 80 actions, 41 of which are already being progressed. The target for all actions to be completed is end of financial year 25/26.

3. Governance Arrangements to Oversee/Monitor the Response Plan

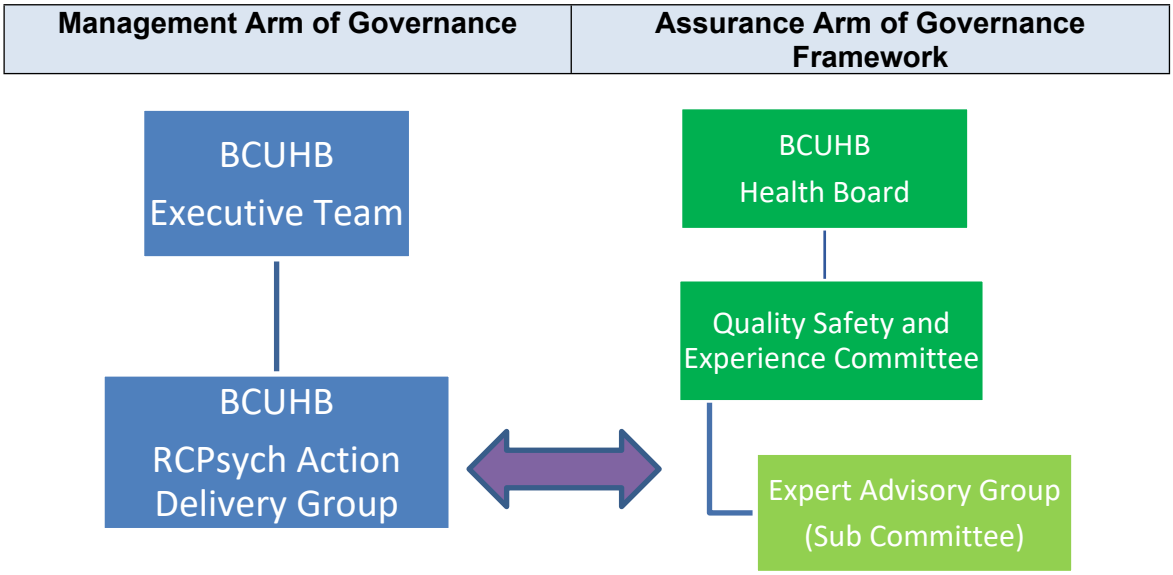
Figure 1 below summarises a proposed governance framework to reflect what has been agreed at the Board on 25 July 2024. Governance arrangements are summarised below. It reflects the development of an Expert Advisory Group and Health

Board RCPSych Action Delivery Group (an internal management group that reports into Executive Team).

In order for the Response Plan to progress there are a number of detailed actions which are required to close off the outstanding recommendations.

The work is system-wide - with HB system-wide actions and specific Mental Health and Learning Disability (MH&LD) actions. The delivery actions have been aligned to the ten themes as outlined by the Royal College of Psychiatry. Support has been provided by the Transformation team to ensure actions are described appropriately for scrutiny and sign off in due course.

Figure 1 Governance Framework Summary



3.1 Establishment of an Expert Advisory Group

The Board has agreed to establish an Expert Advisory Group that will be a Sub-Committee of the QSE Committee. The Group will be independently Chaired by a Special Adviser to the Board with family and user representatives, and Llais included as group members. The appointment is being progressed.

The Chair of the Expert Advisory Group will co-produce Terms of Reference for the Group and once developed these will be brought back to the next QSE Committee for formal approval and adoption. This is scheduled for the 24 October 2024.

Subject to the above point there are a number of outline principles that are proposed for the new Chair to consider.

- The Expert Advisory Group will be a Sub Committee of the QSE Committee.

- Purpose of the Group is to provide independent advice directly to QSE Committee relating to the Health Board's progress against the RCPsych Review Response.
- The Group will receive and review Chairs Assurance Reports from the Health Board RCPsych Action Delivery Group and check, challenge and quality assure evidence submitted by the Delivery Group prior to it being reported via a Chairs Assurance Report to the QSE Committee.
- Independent Chair of the Group (The precise nature of the role is to be determined with the individual and the Chair/Vice Chair of the Health Board).
- Membership to contain both current and previous family and user representatives
- Membership to contain Llais representatives.
- Standing Invitees to include the Executive Director responsible for MH&LD and the Director for MH&LD.
- Standing invite to a Senior Nurse that can provide expertise on Learning and Development.
- That the new Chair give consideration to a role for a Clinical advisor that can provide peer support and challenge.
- That the group should meet a minimum of bi-monthly (every two months).

3.2 Establishment of a Health Board RCPsych Action Delivery Group (an internal management group) that reports into the Executive Team.

The Board acknowledges the need to take a system wide approach, and the need to take key strategic actions to improve services as well. Clearly, much of the work to progress the actions contained within the response plan will be progressed by the MH&LD Services and Leadership Team.

In light of this it is proposed that a Health Board RCPsych Action Delivery Group is established that reports into the Executive Team. A Draft Terms of Reference for this Delivery Group is contained in Appendix 1. The Committee is only asked to note the Terms of Reference as evidence of progress. The Executive Team will formally receive and consider the Terms of Reference as it is an internal management group.

3.3 Regular monitoring and oversight of response plan progress/delivery via the Quality Safety and Experience Committee.

The Board agreed that the QSE Committee would receive a report at every meeting from the Expert Advisory Group which would highlight progress against an agreed response plan. This will be introduced once the group is established, and is reflected in the Governance framework in Table 1 above. The first such report is scheduled for the 24 October 2024.

The reports produced would need to highlight evidence' to demonstrate the satisfactory completion of recommendations, using the Expert Advisory Group to support evaluation of this.

Under the ten themes, reports to future QSE Committees (via the Expert Advisory Group) should include a focus on progress made with evidence produced. A proposed approach is in Table 1 below. Appendix 2 illustrates the evidence submission form that has now been developed to collate evidence. The format has been supported by the BCUHB Transformation Team.

Table 1: The ten themes

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

It is important to note that the system-wide actions across the Health Board now need to be brought into a consolidated Programme Plan that captures progress against the eight key system-wide actions and reported consistently at the newly established Health Board RCPsych Action Delivery Group. Related to this, the consolidated Programme Plan will be updated to reflect the importance of multi-disciplinary working with Psychology and Therapies in particular. This will be clarified in the next report to QSE Committee.

3.4 Terms of Reference to be collaboratively developed and agreed for all groups, supported by the Directorate of Corporate Governance

As outlined above the Terms of Reference for the Expert Advisory Group will be developed when the Independent Chair is appointed and their development supported by the Directorate of Corporate Governance.

Likewise, Terms of Reference for the Health Board RCPsych Action Delivery Group will be received and considered at Executive Team during August 2024 and will be in place before the next QSE Committee meeting.

The Committee are asked to note the draft Terms of Reference in Appendix 1. The Executive Team will receive, consider the Terms of Reference for this management group.

3.5 A procedure for providing progressive and sustained evidence of actions is required

To further, support this programme an agreed procedure has been developed for providing progressive and sustained evidence of actions. Monthly Chairs Assurance Reports will be provided from the Health Board RCPsych Action Delivery Group to both the Expert Advisory Group and QSE Committee. This will enable robust oversight to check; challenge and quality assure evidence submitted by each of the delivery groups and ensure that the evidence threshold has been obtained to meet the expectations of all involved.

A repository for the evidence has now been established with access provided to corporate colleagues to enable critical oversight of the progress. A copy of the form used is attached in Appendix 2. It is an important development as it illustrates that the Health Board will take an evidence based approach to this work.

4. Next Steps

- To commence the implementation of the governance framework.
- Confirm the appointment of the Independent Chair of the Expert Advisory Group
- To report every two months on progress at QSE Committee
- To report every six months on progress to the Board

5. Recommendations

This report asks the Quality Safety and Experience Committee to;

- **Consider** and **Endorse** the proposed governance arrangements to oversee/monitor the response plan in order to assure the Board that progress and trajectory address the recommendations within the RCPsych Report.
- **Agree** to establish the Expert Advisory Group as a sub committee of the Quality Safety and Experience Committee which will have the responsibility for the oversight of the action plan.
- **Note** the Draft Terms of Reference for the Health Board RCPsych Action Delivery Group that will be received and considered at Executive Team Meeting.

Health Board Royal College of Psychiatrists Invited Review Action Delivery Group. (Health Board RCPsych Action Delivery Group)

Terms of Reference

1.0 INTRODUCTION

1.1 The Chief Executive Officer as Accountable Officer can establish groups and associated governance arrangements, including in this case a time limited Delivery Group which is a Management Group reporting to the Executive Team. The detailed terms of reference and operating arrangements in respect of these meetings are set out below in these Terms of Reference document.

1.2 The Delivery Group has a direct line of accountability to the Executive Team with its reports being received at the Executive Team Meeting, and Executive Delivery Groups (EDGs) as required.

1.3 In May 2023, as part of Special Measures, the Welsh Government commissioned the Royal College of Psychiatry (RCPsych) to review the extent to which recommendations from previous Mental Health reports have been implemented and the extent to which these have maintained and consistently integrated into “business as usual” practices.

2.0 PURPOSE

2.1. The purpose of this Delivery Group is to ensure the Health Board can deliver transparent and accountable progress against the ten themes identified in the Royal College of Psychiatrists (RCPsych) Invited Services Review. This includes overseeing progress against the delivery of recommendations that derive from the Mental Health and Learning Difficulties (MH&LD) Services and the wider Health Board, This reflects that the responses to the Review need to take a system-wide approach and the need to take key strategic actions to improve services. This includes identifying areas of concern and risk as well as best practice, and ensuring the continuous progress against the Review. Specifically the group will:

- Establish this RCPsych Invited Review Action Delivery Group (on a time limited basis) to develop a ToR and core framework for delivery of the actions, evidence of progress and assurance reporting to the Executive Team.

- To ensure the updates and evidence submitted by the action leads meet the required level of assurance to mark the action as complete and adhering to an agree evidence submission process that includes an approved Evidence Data Collection form.
- To bring together key representatives across the Health Board with the appropriate authority and ability to effect change to provide assurance on behalf of the group, and to provide assurance to the Executive Team.
- To receive and respond to the recommendations of the Royal College of Psychiatrists Invited Services Report May – December 2023.
- To develop an action plan that delivers against the recommendations from the RCPsych Invited Review Services Report. To ensure that changes and actions to meet these recommendations are equitable, sustainable and embedded in every day practice across the whole Health Board through the implementation of a programme of audit activity.
- To oversee the development of an evidence bank to store actions and accomplishments for each of the recommendations across the ten themes with access to Corporate colleagues and the Expert Advisory Group to provide oversight and further assurance.
- To identify inter-dependencies and commonalities with other pieces of work and agree joint reporting and action as necessary i.e. HSE Notice of Contravention, Special Measures/Annual Delivery Plan and the MH&LD Improvement Plan.
- Establish arrangements to ensure robust assurance that recommendations are being implemented.

Additionally, this group will:

- Promote improvement skills and knowledge that can be enacted at every level, from the top tiers through to front line staff.
- Recognise the importance of creating a workplace culture that is conducive to improvement.
- Ensure that all staff have the time, space, permission, encouragement and skills to collaborate on planning and delivering improvement.
- Seek subject matter expert guidance and support from within BCUHB, and externally if required.

3.0 DELEGATED POWERS

3.1 The Health Board RCPsych Action Delivery Group is established by the Chief Executive and Executive Team to:

- Oversee the implementation of the recommendations and actions arising the RCPsych Invited Services Review maintaining the trust of patients and public throughout its delivery against these recommendations;
- The Group at key points during delivery of required actions may recommend stopping, starting or extending work on key matters with approval from the Executive Team and in consultation with the Expert Advisory Group;

- The Group has authority from the Executive Team to investigate and act upon any activity within its Terms of Reference with particular reference to the recommendations cited within the RCPsych Invited Services Review, and the ongoing Improvement and development agenda;
- Seek evidence based assurance from clinical and corporate services in relation to the delivery against the recommendations of the RCPsych Invited Services Review;
- Seek evidenced based assurance that there is compliance with all appropriate legislation and regulatory requirements related to delivery against the recommendations of the RCPsych Invited Services Review;
- Provide executive direction to clinical and corporate services in relation to delivery against the recommendations of the RCPsych Invited Services Review;
- Support the effective operational management of the Health Board, enabling issues related to delivery against the recommendations of the RCPsych Invited Services Review to be anticipated, discussed and actions agreed;
- Enable and support the appropriate integration, connection and liaison between individual services, between clinical and corporate functions and between strategic and operational matters;
- Support individual executive directors to deliver their delegated responsibilities by providing a forum for briefing, exchange of information, mutual support, resolution of issues and achievement of agreement;
- Act as the forum in which executive directors and senior managers can formally raise concerns and issues for discussion relating to the response to the recommendations of the review;

4.0 AUTHORITY

4.1. The Delivery Group is in effect an extension of the Executive Team, and derives its authority from and is therefore accountable to the Executive Team.

4.2. The Delivery Group has responsibility for co-ordinating and providing the Health Board with evidence based assurance regarding the Health Board response to the RCPsych Invited Services Review.

4.3. The Delivery Group will engage with employees, committees or groups as set up by the Board or by the Accountable Officer to assist in expediting its role.

4.4. The Delivery Group may obtain outside legal or other independent professional advice via the Directorate of Corporate Governance if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements;

4.5. The Delivery Group will, where appropriate, recommend courses of action to the Executive Team within the remit of the Group's 'business.

4.6 Make management decisions on issues within the remit of the Delivery Group, in-line with the Board's Scheme of Delegation.

5.0 SUB-GROUPS

5.1 The Delivery Group may, subject to the approval of the Chair of the Group, establish groups to carry out on its behalf specific aspects of its's business. These sub groups may in turn establish permanent or task limited sub-groups to support their own work, with the approval of the Chair of the strategic group. Any groups established outside of this scheme of approval will be considered invalid.

5.2 The Executive Director of Allied Health Professionals and Health Science will maintain the single directory of all sub-group meetings and provide direction on good governance arrangements with the support of the Directorate of Corporate Governance.

6.0 MEMBERSHIP

6.1 The core members of the Delivery Group (Health Board RCPsych)

Executive Director of Allied Health Professionals- Chair
Executive Director of Nursing – Vice Chair
Medical Director(s) for MH&LD
Deputy Director of Quality
Director of Operations MH&LD
Director of MH&LD
Director of Nursing for MH&LD
Chief Digital and Information Officer
Director of Environment
Associate Director of Governance
MH&LD Operational and Business Lead
Non-Core Members
Directorate Committee Support
Director of Transformation and Improvement
Associate Director of Health, Safety and Security
Deputy Director of People

6.2 Other directors/officers will attend as required by the Chair of the Delivery Group, as well any others from within or outside the organisation whom the Chair of the Delivery Group considers should attend, taking into account the matters under consideration at each meeting.

6.3 The membership of the Group shall be determined by the Chair of the Delivery Group taking account of the balance of skills and expertise necessary to deliver the Delivery Group remit and subject to any specific directions made by the Executive Team.

6.4 Subject to approval by the Chair of the Delivery Group, nominated deputies are permitted and will have the full voting rights and accountability of the member for whom they are deputising.

6.5 The Directorate of Allied Health Professionals shall act and provide secretariat for the meeting.

7.0 MEETINGS (Including Attendance)

7.1 At least one third of core members must be present to ensure the quorum of the Delivery Group, one of whom must be the Chair or Vice-Chair (which means the presence of at least one executive director).

7.2 Where members are unable to attend a meeting, a nominated deputy should be asked to attend, at the discretion of the meeting Chair. The Chair will initiate action in the event that a members fails to attend, or sends a representative to three consecutive meetings.

7.3 Decisions shall be made by consensus. However, this does not affect any area of executive authority given in the Scheme of Reservation and Delegation and such authority always takes precedence.

7.4 Where the Delivery Group is unable to make a decision, the meeting Chair may refer the matter to the Executive Team.

7.5 Where there is a matter for concern derived from an Executive Team decision, the meeting Chair will escalate to the Executive Team.

7.6 There may, occasionally, be circumstances where decisions, which would normally be made by the Delivery Group, need to be taken between scheduled meetings. In these circumstances, the Chair of the Delivery Group, supported by the secretariat, may deal with the matter on behalf of the group. The secretariat must ensure that any such action is formally recorded and reported to the next meeting for consideration and ratification. Chair's Action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

7.7 The Directorate of Allied Health Professionals, as secretariat, will develop and maintain a Cycle of Business for the Delivery Group which shall be approved by the Chair of the Group. The Directorate will also ensure standard templates are used throughout the Delivery Group and its supporting structure and will take action to ensure the good governance and effectiveness of the supporting structure including the cross-referral and escalation of issues between meetings.

7.8 This is a time limited Group. The Group will be scheduled to meet 12 times a year (monthly) with a minimum of ten meetings at appropriate times in the reporting cycle. The Chair is able to schedule additional meetings if in their opinion that is required.

8.0 RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES

8.1 The Delivery Group is a time limited Management Group and it will provide a Chair's Report that will be shared with the Executive Team and other fora as required and agreed by the Chair of the Group..

8.2 The Delivery Group will engage with other Executive Delivery Groups to ensure the connection and consideration of programmes of work.

8.3 Delivery Group members are directly accountable to the Chair (an Executive Director) for delivering the functions set out in the Terms of Reference.

8.4 The Delivery Group shall embed the Health Board's values, standards, priorities and requirements across all aspects of its work.

9.0 REPORTING AND ASSURANCE ARRANGEMENTS

9.1 The Delivery Group shall:

- Report on progress against the Invited Services Report to Executive Team on a monthly basis.
- Provide a Chair's Report that will be shared with other fora (as agreed by the Chair of this Group)to support common understanding of delivery against the recommendations of the Invited Services Review.
- Bring to the Executive Team specific attention to any significant matters under consideration by the Delivery Group;
- Ensure that the BCUHB Portfolio Assurance system is updated in a timely manner
- Ensure appropriate escalation arrangements are in place to alert the Chair of the Executive Team any urgent or critical matters that may affect the operation and/or reputation of the Health Board.

9.2 The Executive Team may also require the Chair of the Delivery Group to update on its activities at public meetings, e.g., Annual General Meeting, or to community partners and other stakeholders, where this is considered appropriate;

9.3 Members are expected to communicate any development, decisions and or recommendations arising from the work delivered that may affect their area of responsibility;

9.4 The Directorate of Corporate Governance, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of Delivery Group performance and operation.

10.0 REVIEW ARRANGEMENTS

10.1 These terms of reference and operating arrangements shall be reviewed after 6 months by the Delivery Group and any changes recommended to the Executive Team for approval. This Group is established on a time limited basis and the end point of the Group will be reviewed and considered by the Chair as and when required.

10.2 The minutes, RAID Log and associated action plans of the meeting and issues of significance shall be formally reported to the Delivery Group.

Version 0.2

Drafted: 5 August 2024

Approved by the Delivery Group:

Approved by the Executive Team:

Health Board Royal College of Psychiatry (RCPsych) Action Delivery Group

EVIDENCE COLLECTION FORM

(Action Lead to complete the form for each piece of evidence submitted)

LINKS TO KEY DOCUMENTS: RCPsych RESPONSE PLAN

Theme number (i.e. 1 to 10)	
Theme REFERENCE NUMBER and agreed action (i.e. 1.1)	.
ACTION LEAD NAME	
TITLE OF EVIDENCE DOCUMENT/S (please embed document)	
Date submitted	
ACTION UPDATE (i.e. how the evidence meets the action and can demonstrate an improvement in outcomes)	
ANY RISKS IDENTIFIED	
BARRIERS TO PROGRESS	
FEEDBACK FROM HEALTH BOARD RCPSYCH REVIEW DELIVERY GROUP	

Please email completed form to XXX

Thank you for your support with submitting evidence to progress the Royal College of Psychiatry Response Plan

For office use only:

Reviewed, checked and agreed by xxx on xxxx

Reviewed by **Health Board Royal College of Psychiatry Review** Delivery Group and added to Master RCPsych Response Plan on xxx

Teitl adroddiad: ***Report title:***	Corporate Risk Register Report
Adrodd i: ***Report to:***	Quality Safety and Experience (QSE) Committee
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 15 August 2024
Crynodeb Gweithredol: ***Executive Summary:***	The purpose of this standing agenda item is to provide an update position of the Corporate Risk Register to which QSE has oversight. The Committee is asked to note and discuss the following risks which are above the risk appetite of the Health Board; • CRR24-02 'Patient Falls' • CRR24-04 'Failure to Embed Learning' • CRR24-09 'Primary Care' De-escalated Risks • CRR24-03 'Safeguarding' Appendix 1 Risk Dashboard Appendix 2 Detailed Risk Reports of seven risks
Argymhellion: ***Recommendations:***	The Committee is asked to **receive assurance** for the seven corporate risks to which the Committee has overall accountability.
Arweinydd Gweithredol: ***Executive Lead:***	Pam Wenger, Director of Corporate Governance
Awdur yr Adroddiad: ***Report Author:***	Nesta Collingridge Head of Risk Management

Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☒	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒

Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: N/A ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this: N/A***	
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Links to the BAF detailed in respective CRR reports
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	It is essential that the Health Board has robust arrangements in place to assess, capture and mitigate risks, as failure to do so could have legal implications for the Health Board.
Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqlA been identified as necessary and undertaken?***	Not applicable for this report
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary ben undertaken?***	Not applicable for this report
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	Links to the BAF detailed in respective CRR reports
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	The effective and efficient mitigation and management of risks has the potential to leverage a positive financial dividend for the Health Board through better integration of risk management into business planning, decision-making and in shaping how care is delivered to our patients thus leading to enhanced quality, less waste and no claims.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	Failure to capture, assess and mitigate risks can impact adversely on our workforce.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	Individual Executive sign off of CRR reports, Review at Risk Scrutiny Group 09/07/2024.

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:*** • Patient Safety/ Community Care/ Six Separate Areas of Clinical Concern Corporate Risks all to be further developed and to be reviewed at Risk Scrutiny Group	
Rhestr o Atodiadau: ***List of Appendices:*** Appendix 1 – Quality, Safety and Experience Committee Risk Dashboard Appendix 2 – Corporate Risk Register Report: **1.** Patient Safety-Falls **2.** Safeguarding **3.** Failure to Embed Learning **4.** Community Care and Primary Provision **5.** Areas of Clinical Concern **6.** Timely Diagnostics **7.** Harm from Medical Devices/Equipment	

Corporate Risk Register Report

1) Introduction and Background

What Is a Corporate Risk?

A corporate risk register is a repository used by services and corporate functions to record significant risks that could impact the strategic objectives and operations of the Health Board. The register provides a comprehensive overview of the key risks facing the organisation. It is a pivotal tool to help proactively strengthen risk oversight and management.

1.1 There are 7 Corporate Risks for Quality, Safety and Experience Committee oversight and assurance. The full details of these risks are highlighted in Appendix 2 and include

evidence of controls in place, assurances on those controls, additional controls required and actions with due dates.

- CRR24-02 - Patient Safety-Falls
- CRR24-03 - Safeguarding
- CRR24-04 - Failure to Embed Learning
- CRR24-09 - Community Care and Primary Provision
- CRR24-12 - Areas of Clinical Concern
- CRR24-13 - Timely Diagnostics
- CRR24-14 - Harm from Medical Devices/Equipment

1) Key Highlights

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

To note, the Audit Committee (18 July 2024) approved changes to the Risk Management Framework following discussion at the Risk Management Board Developmental session around the cycle of reporting corporate risks to committee, in that the committees will receive all corporate risks on a quarterly basis but risks which are above the tolerance set within the risk appetite of the Health Board at every committee. This paper presents all risks and highlights those above tolerance.

The Committee is asked to discuss the risks which are above tolerance of the risk appetite of the Health Board:

- CRR24-02 'Patient Safety – Falls' (risk score 20, **above tolerance 15-19**) – The committee is asked to note previous discussions at committee, that this risk will be de-escalated and draft Patient Safety risks (avoidable patient deterioration and healthcare acquired pressure ulcers) has been developed to provide a more strategic narrative on patient safety risks to the Executive Team and Committees. The Patient safety risk will be reviewed at the next Risk Scrutiny Group (13 Aug 24) and subsequently reported in the following committee paper.
- CRR24-04 'Failure to Embed Learning' (risk score 20, **above tolerance 15-19**).
- CRR24-09 'Primary Care' (risk score 20, **above tolerance 15-19**)

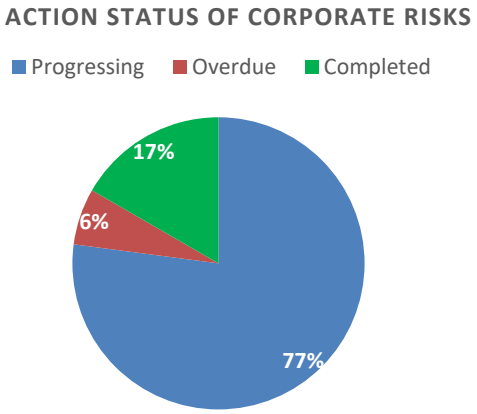
The committee is asked to note the following development;

- CRR24-12 'Areas of Clinical Concern' - the risk is currently being split into 6 separate risks that will focus on specific services:
    - Urology services
    - Oncology services
    - Ophthalmology
    - Vascular services
    - Orthodontics
    - Dermatology & Plastics

The committee is asked to note the following de-escalated risks;

- CRR24-03 'Safeguarding' (Score 12 below tolerance) – Following presentation at the Risk Scrutiny Group in July 2024, the risk will be de-escalated from the Corporate Risk Register, to be managed at Tier 1 operational level, with the same score, and can be monitored through the Quality report to the Committee.

The committee is asked to receive assurance of the 7 corporate risks, noting 48 actions have been developed to mitigate the risks. 8 actions have been completed since the last report, 37 actions are progressing and on track but 3 actions are overdue. Of the 3 overdue actions, one overdue action is related to lack of progress from all Wales group (CRR24-02-Falls), and 2 actions have been escalated to Chair of Medical Devices committee (CRR24-14 Harm from Medical Devices and Equipment).



Although several actions have progressed and some completed, no risk scores have reduced.

Next steps

1. Review of the Patient Safety Corporate risk at Risk Scrutiny Group and Executive Team approval.
2. Development of 'Community Care' as a standalone Corporate risk.
3. Further development of the 'Areas of Clinical Concern' risk.
4. De-escalation of CRR24-03 'Safeguarding' to be managed at Tier 1 operational level.

Appendix 1 - Corporate Risk Register Dashboard

Lead	Ref	Risk Title	Current Score (Impact x Likelihood)	Risk Target Score	Appetite Main Risk Type / Appetite Level	Lead Board Committee	Risk Management Commentary
EDoN	CRR24-02	Patient Safety-Falls	4 x 5 = 20 ⟷	12	Quality / Open 15-19	Quality, Safety and Experience Committee	Opened Dec 23. 7 actions identified, 2 completed, 3 revised date, **1 overdue**, 1 new action. Risk to be downgraded to be managed as an operational risk and broader patient safety risk to be presented back for approval. **Risk above appetite tolerance**
EDoN	CRR24-03	Safeguarding	4 x 3 = 12 ⟷	8	Regulatory / Seek 20-25	Quality, Safety and Experience Committee	Opened Dec 23. 8 actions identified, 1 completed, 7 progressing, highlighted, some, action deadlines have all been extended to Sept 2024. Scored reduced 18/04/24 from 16 to 12. Risk Scrutiny Group recommended de-escalating the risk from the corporate risk register.
EDoN	CRR24-04	Failure to Embed Learning	5 x 4 = 20 ⟷	5	Quality / Open 15-19	Quality, Safety and Experience Committee	Opened Dec 23, 10 actions identified, 2 completed (rolled into QMS action), 8 progressing. March 2024 **highlighted action deadlines have all been extended** to end of July-Sept 2024. The current risk score remains at 20. Some actions delayed due to reliance on NHS Executive National team. **Risk above appetite tolerance**
EDoO	CRR24-09	Primary Care	4 x 5 = 20 ⟷	12	Quality / Open 15-19	Quality, Safety and Experience Committee	Opened Feb 24, 6 actions identified, 3 completed, 3 progressing. The **inherent and current risk scores are both 20**, indicating the controls are not yet reducing the risk. This risk has been revised and now only reflects primary care and not community. A separate community risk is being drafted. **Risk above appetite tolerance**

EDoO	CRR24-12	Areas of Clinical Concern (encompasses ophthalmology and dermatology)	5 x 3 = 15 ⟷	12	Quality Open 15-19	Quality, Safety and Experience Committee	Opened Feb 24, 6 actions identified, 0 completed, 6 progressing. Further work will be done to separate this risk to the key areas of clinical concern.
EDoTH	CRR24-13	Timely Diagnostics	5 x 4 = 20 ⟷	5	Reputational Seek 20-25	Quality, Safety and Experience Committee	Opened Feb 24, 5 actions identified, 0 completed, 5 progressing.
EDoTH	CRR24-14	Harm from the Medical Devices/Equipment	4 x 4 = 16 ⟷	8	Quality Open 15-19	Quality, Safety and Experience Committee	Opened Feb 24, 6 actions identified, 0 completed, 4 progressing, **2 overdue**. Overdue actions escalated to Chair of Medical Devices committee but need to be addressed.

Key:

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

Appendix 2 – Corporate Risk Register Report as of July 2024

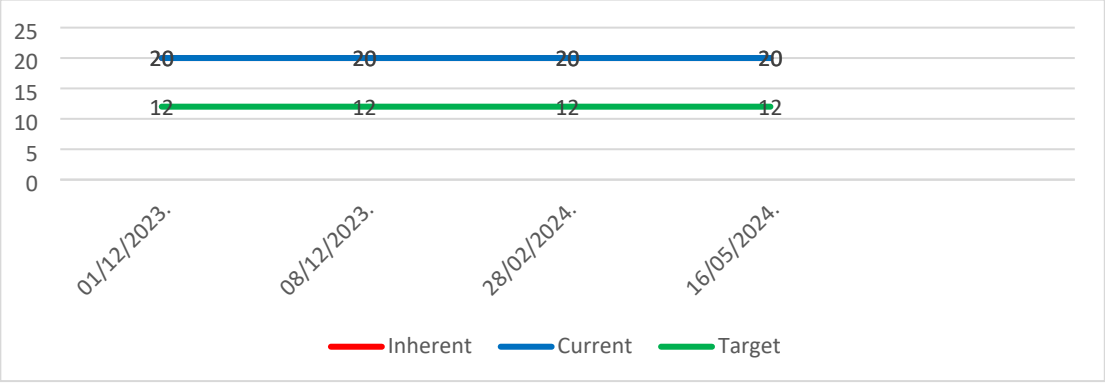
CRR 24-02	**Risk Title:** Patient Safety - Falls		**Date Opened:** 01/12/2023
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** 06/06/2024
Date Last Reviewed: 16/05/2024	**Director Lead:** Executive Director of Nursing and Midwifery	**Link to BAF**: N/A	**Target Risk Date:** 30/10/2024

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

Mitigations/Controls in place	Additional Controls required
1. Mandatory E learning modules (1a and 1b) for Falls Prevention launched and monitoring in place for completion via the Strategic Inpatient Falls Group. Health Board compliance currently 1a 93.83%, 1b 94.55%. 2. Manual Handling training data cascaded monthly to respective IHC's/Division Director of Operations to include compliance, Did Not Attend rates and available capacity for upcoming 2 months. 3. Welsh Nursing Care Record (WNCR) has been implemented which has an electronic version of the Falls and Bone Health Multifactorial Assessment (FBHMA) that is identified on the dashboard if not completed and monitored for compliance by the Ward Manager. 4. How to /good practice guide developed and implemented to support with completion and quality of FBHMA across all Adult Inpatient wards: 5. Peer review process in place for 3 months to improve quality of the FBHMA across adult inpatient wards. 6. Falls review groups in place across the Health Board with exception reporting, updating of improvements to Strategic Inpatient Falls Group.	1. Falls prevention and management policy to be ratified and relaunched - has been updated to include a clear step by step approach to completion of the Falls and Bone Health Multifactorial Assessment (FBHMA) and post falls management and currently under review with Patient Safety Group. 2. Assurance and training of agency workers. 3. Improved compliance with manual handling training. 4. Sustained improvement in the quality of completion of FBHMA.

Actions	Due Date	Progression Analysis
New updated and revised Falls Prevention and Management Policy NU06 reviewed in BCUHB Patient Safety Group to be ratified and re-launched. Policy approved at Patient Safety Group, disseminated and uploaded to Betsinet	30/12/2023	Completed

Audit of Ward Managers induction for agency/temporary staff to ensure falls training has been completed. A review of the checklist is underway to make it more user friendly and compliance is being reported in the strategic falls group a question on compliance is being added to the ward accreditation audit	30/08/2024	Progressing (revied date from April 2024)
Capacity within the Manual Handling training team to be optimised with focused recruitment drive for Band 6 posts (x3) supported by workforce The Workforce Directorate are exploring options for another supplier to address this risk – propose to change the review date as further work to address this.	30/09/2024 (30/04/2024)	Progressing (revised date from April 2024)
Manual Handling corporate team to progress contract arrangements for external training facilities to support capacity The Workforce Directorate are exploring options for another supplier to address this risk – propose to change the review date as further work to address this.	30/09/2024 (30/04/2024)	Progressing (revised date from April 2024)
Outcome of peer review pilot to be evaluated Peer reviews discussed at strategic falls group and quality of risk assessments have shown some improvement. Review of quality of risk assessments need to form part of business as usual and this is part of the ward metrics. The patient safety team are conducting spot checks of the Risk Assessments on the acute wards. Some areas are also conducting spot checks via the Weekly Harms Meetings and chairs of the groups know 'what good looks like'. Plans to embed as part of Board Round process to be discussed with Senior Nurses – New action created	30/04/2024	Completed
Future enhancement to the Welsh Nursing Care Record on an all-Wales basis. still no progress from All Wales group	31/05/2024	Overdue (Revised date from April)
Embed sample review of Falls Risk Assessment at Board Rounds	31/07/2024	New action



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

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

Rationale for Corporate Risk

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

CRR 24-03	**Risk Title: Safeguarding**		**Date Opened:** 07/12/2023
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** 06/06/2024
Date Last Reviewed: 20/05/2024	**Director Lead:** Executive Director of Nursing and Midwifery	**Link to BAF**: N/A	**Target Risk Date:** 31/03/2025

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

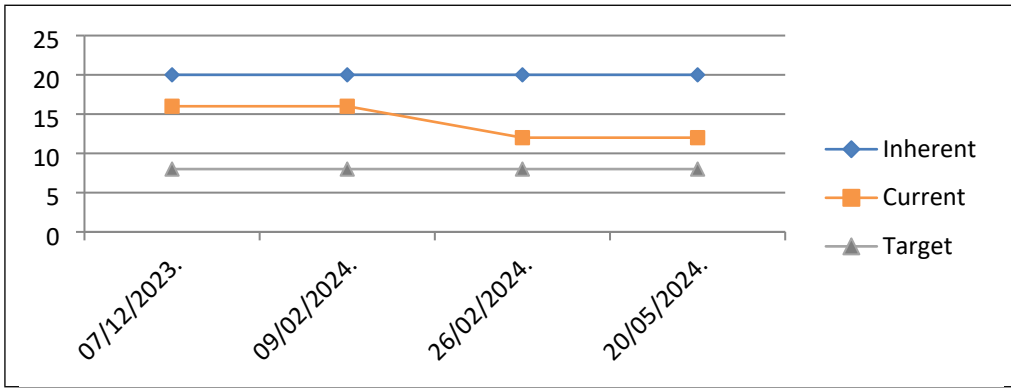
Mitigations/Controls in place	Additional Controls required
1. Standardised formal reporting and escalation of activity, mandatory compliance and exception reports are presented in line with Health Board Governance and Reporting Frameworks. 2. Audit findings and data are monitored and escalated. Risk Management has been embedded into the processes of the reporting framework. 3. BCUHB mandatory safeguarding training is in place for all staff. 4. Welsh Government interim monies has supported temporary the implementation of additional Mental Capacity Act (MCA) training, the completion of Deprivation for Liberty (DoLS) applications, and strengthened the implementation of Court of Protection DoL for 16/17-year-olds. 5. BCUHB local work programmes are in place and aligned to the National Strategies which are regularly reported to Welsh Government. 6. Safeguarding support the Sexual Abuse Referral Centre (SARC) implementation, compliance and accreditation but the accountability remains with the Central Integrated Health Community (IHC). 7. Fully engaged and supporting the Single Unified Safeguarding Review led by Welsh Government and the Home Office/Central Government for the re-write of Safeguarding and Homicide Reviews.	1. New legislation and statutory guidance driven by case law, UK and Welsh Government impacts upon the organisation and the date of implementation is not within BCUHB control. 2. The increase in safeguarding activity with enhanced complexity has resulted in the delay of the implementation of strategic and operational interventions. 3. Local Authorities frequently develop independent local guidance which requires duplication of implementation across BCUHB. This is time consuming and can result in reduced compliance. 4. The rise in the number of DoLS assessments has resulted in a backlog. Current post holders work additional hours, weekends and evenings. There are local and national staffing challenges with regard to the recruitment of Safeguarding, MCA and DoLS specialist staff. This is recognised by Public Heath Wales and WG. We support flexible working arrangements within the team to ensure staff retention. Reduced leadership team capacity due to absences. A risk assessment and an amendment to the service delivery structure is in place to mobilise staff where required. 5. There is a lack of governance and reporting of Court of Protection activity relating to a Community setting. Immediate safeguards are in place and work is taking place to develop a standard procedures.

Actions	**Due Date**	**Progression Analysis**
Review of the safeguarding team and structure A review of the safeguarding team structure has started, a report will be submitted in March 2024 This date has been amended to reflect an achievable and realistic date given the interdependencies that are required to deliver it	30/09/2024	Date Revised from March 2024

National development and implementation of Single Unified Safeguarding Review SUSR training has been approved by WG. BCUHB attending February 2024	31/03/2025	Progressing
Implementation and monitoring of the 'Workforce Safeguarding Responsibilities SoP, Approved at SGPG being shared at QDG during February2024.	31/03/2024	Completed
North Wales Sexual Assault Referral Centre (SARC) to meet the National Service ISO Specifications, discussions ongoing. This date has been amended to reflect an achievable and realistic date given the interdependencies that are required to deliver it	30/09/2024	Date Revised from March 2024
Development of a DoLS/CoP DoL Standard Operating Protocol (SoP)	31/07/2024	Date Revised from March 2024
CNO is undertaking a safeguarding audit of provision which will provide a benchmark for consideration This date has been amended to reflect an achievable and realistic date given the interdependencies that are required to deliver it	30/09/2024	Date Revised from March 2024
Whilst awaiting the All Wales Data Module conduct a review of the current data capture processes that inform current service demand and future projections which will identify potential gaps and manual data collection practices The timescale for this will be reviewed next month once the action dependencies (team resource) are understood	31/07/2024	Date Revised from March 2024
Risks associated with the DoLS & MCA May 2024 Audit	31/03/2025	Progressing

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

Rationale for Corporate Risk



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

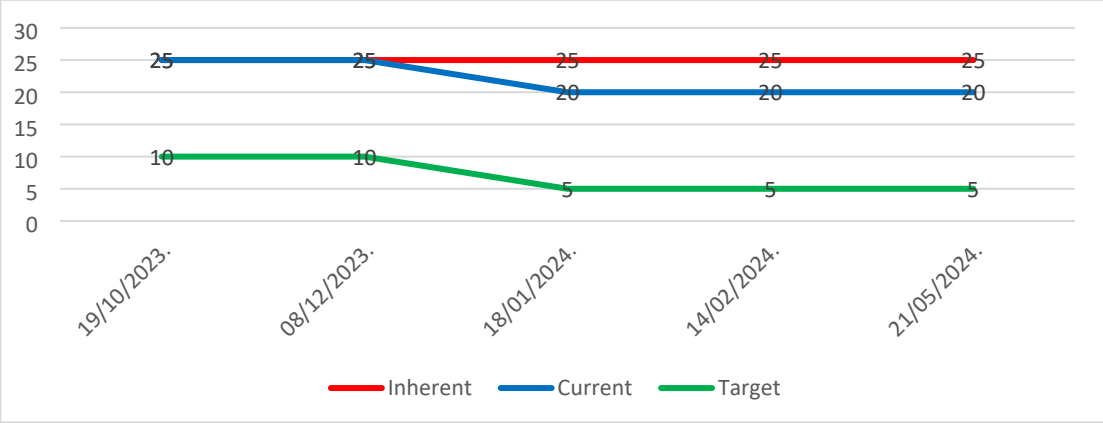
CRR 24-04	**Risk Title:** Failure to Embed Learning		**Date Opened:** 19/10/2023
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** 06/06/24
Date Last Reviewed: 21/05/2024	**Director Lead:** Executive Director of Nursing and Midwifery	**Link to BAF**: SP18 - Quality, Innovation and Improvement	**Target Risk Date:** 30/09/2024

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. Putting Things Right and clinical review processes and monitoring 2. Risk management processes 3. Audit programmes & monitoring arrangements 4. Patient and carer feedback and involvement processes 5. Senior sign-off process for National Reportable Incidents (NRIs) and Complaints 6. Clinical policies, procedures, guidelines, pathways, supporting documentation & IT systems 7. Clinical staff recruitment, induction, mandatory and professional training, registration & re-validation 8. Defined nurse staffing levels for all wards & departments as per Nurse Staffing Act 9. Ward accreditation schemes and ward manager/matron checks/audits. 10. Tracking of regulatory action plans 11. Internal Reviews against External National Reports 12. Getting it Right First Time (GIRFT), localised deep dives, reports and action plans 13. HIW, Ombudsman, Coroner NHS Wales Exec and WG engagement Meetings	1. Development of a Quality Management System (QMS) setting out an integrated approach to Quality Planning, Control, Assurance and Improvement 2. Clarity on quality leadership, structures and accountabilities 3. Review of the quality governance framework of meetings and reporting 4. Development of a quality learning framework, aligned to the overall learning organisation programme 5. Review of Putting Things Right and clinical review processes and monitoring 6. Resolution of outstanding overdue positions for incidents, complaints, claims, mortality reviews and inquests

Actions	Due Date	Progression Analysis
The Quality Governance Framework will be reviewed and refreshed and will include greater clarity on the roles, responsibilities and authorities of all groups including the reporting expectations, process and templates. This will include mapping meetings into an overall cycle and introducing standard templates and a single document repository This work is being taken forward with the support of the NHS Wales Executive as part of the Quality Governance Intervention, who are currently observing to inform their recommendations, therefore the work will take slightly longer and a revised date of 30 June 24. A QSE Committee workshop is being held on 29/05/2024.	30/06/2024 due dates to end of July 30/07/24	Date Revised from March 2024
Best practice guidance will be issued to IHCs and Regional Divisions to support effective local quality governance arrangements This work is being taken forward with the support of the NHS Wales Executive	30/06/2024 due dates to end of July 30/07/24	Date Revised from March 2024
A Quality Dashboard will be developed underpinned by a series of specialist dashboards (i.e. falls, complains, etc). These dashboards will create a single version of the truth using agreed metrics directly connected to the quality systems for real time data Work is progressing on the Dashboard and a test version is live however technical issues remain in extracting and presenting data – these are being resolved and the Dashboard will be soft launched on 01 June 2024.	31/05/2024 due dates to end of July 30/07/24	Date Revised from April 2024
A central and digital library of learning will be established which will be launched alongside a revised approach to the collation, analysis and dissemination of learning. The system prototype is in place and will be tested with MHLD during Q1 with a view to refinement based on the feedback and roll-out over the summer.	30/09/2024	Date Revised from April 2024
The approach to quality assurance will be reviewed and refreshed and a new regulatory procedure and quality assurance procedure will be developed This work is being taken forward with the support of the NHS Wales Executive as part of the Quality Governance Intervention, who are currently observing to inform their recommendations, therefore the work will take slightly longer and a revised date of 30 June This action is being discontinued with the work rolled into the QMS (see below).	30/06/2024	Completed (action rolled into QMS action)
The new Quality Strategy will be developed through a co-design process A refreshed approach to planning arising from Special Measures - a separate Quality Strategy will not be produced and quality will be part of the overall organisational strategy underpinned by a QMS, see below. A quality section for the ongoing planning process has been written and submitted – May 2024 – Revised date from 03/24 to 05/24 due to external dependencies. This action is being discontinued with the work rolled into the QMS (see below).	31/05/2024	Completed (action rolled into QMS action)
A Quality Management System will be developed in line with the Duty of Quality, which will describe how Quality Planning, Quality Control, Quality Assurance and Quality Improvement will work together as a collective quality system Update - The initial draft of a QMS is due at Board in May 2024. Therefore, the deadline will be extended. A QMS working group is in place, the first meeting was 13 December 2023. There was a workshop at the Executive Team on 24/01/24, at the Senior Leadership Team on 30/01/24, and at the Board on 29/02/24.The Quality Team visited ELFT (an Outstanding rated English Trust) on 26/02/24.The Quality Team are part of the all-Wales working group. Research has been undertaken into work in Wales and Scotland. Support is being provided by Improvement Cymru and the NHS Wales Executive National Quality Team. We plan two further meetings of the working group, and a wider engagement workshop in April May 2024 – Revised date from 03/24 to 05/24 due to external dependencies	31/05/2024 due dates to end of July 30/07/24	Date Revised from March 2024
The Terms of Reference and Cycle of Business for the Organisational Learning Forum is being refreshed and revised to build on and strengthen the work of the group.	30/06/2024 due dates to end of July 30/07/24	New action
A project has been commissioned to develop a new, integrated approach to Investigating and Learning from Incidents, Complaints and Mortality Reviews – this new policy is due at Board for approval in July 2024	31/07/2024	New action

A Learning from Investigations Project has been commissioned to review all open cases due at inquest and to ensure the investigations and evidence of learning is robust. Phase 1 of this project is due for completion by the end of June 2024. The learning from this work will inform the new Investigating and Learning from Incidents, Complaints and Mortality Reviews Policy and process.	30/06/2024	New action



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

Rationale for Corporate Risk

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

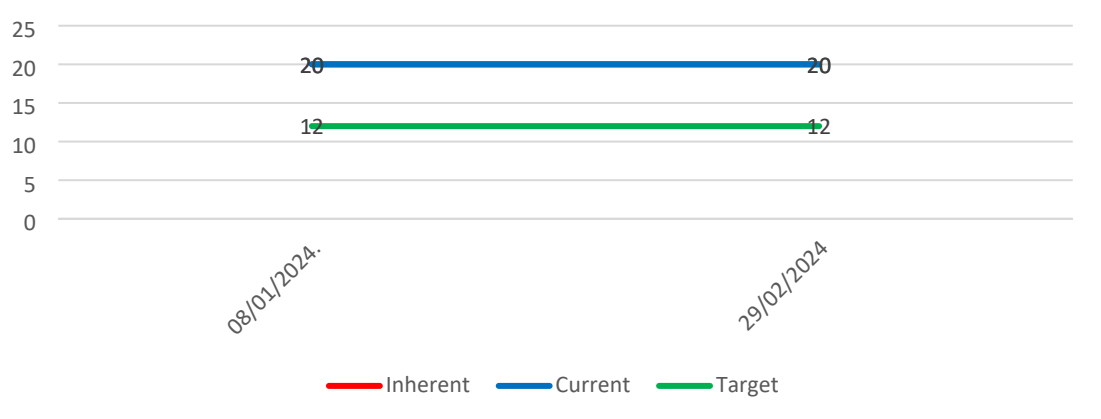
CRR 24-09	**Risk Title: Primary Care**		**Date Opened:** 08/02/2024
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** 06/06/2024
Date Last Reviewed: 11/06/2024	**Director Lead:** Executive Director Transformation And Strategic Planning	**Link to BAF**: N/A	**Target Risk Date:** 31/03/2025

There is a risk of the Health Board not fully meeting its legal obligation to provide accessible and high-quality primary care. This may be due the sustainability of primary care professions, patient access, timely diagnosis, and appropriate healthcare utilisation. This may result in a demoralised primary care workforce, increased strain on emergency services, prolonged hospital stays, preventable admissions, lapses in care, regulatory non-compliance, and declining population health indicators. Consequently, there is a cascading effect on patient flow, service performance, care quality, collaborative partnerships, cost-effectiveness, and the viability of primary care and community care models. The ultimate consequence is a rise in mortality rates, treatment delays, and extended hospitalisations, exacerbating patients' health conditions.

Mitigations/Controls in place	Additional Controls required
1. Escalation and sustainability report to address risks associated with workforce and workload pressures allows for early identification and management. 2. Risk management training completed Q3 2023 for all primary care leaders for better identification and management. 3. Programme management implemented to monitor and drive strategic priorities. 4. Primary Care Quality and Delivery Group established Q3 23/24 5. Primary Care Board has now been established with the first meeting held May 2024, monthly meetings planned moving forwards. Sub group reporting into the Primary Care Board. 6. Primary Care contractor services audits of sustainability matrix ongoing periodically – Programmes in place to undertake the audits 7. Greater Health Board oversight of Primary Care issues and risks via PPHP Committee with first report to committee during April 2024 with further reporting in June 2024.	1. Strategy and resources to support introduction of new roles, ways of working and models of service delivery. 2. Equity of resource to support primary care transformation, management and governance.

Actions	**Due Date**	**Progression Analysis**
Primary Care Board established Primary Care Board has now been established with the first meeting held May 2024, monthly meetings planned moving forwards. Sub group reporting into the Primary Care Board.	30/05/2024	Completed

Primary Care strategic plan National Primary Care model being reviewed with HB input which will inform the Betsi Strategic plan.	31/03/2025	Progressing
Escalation and sustainability implementation Primary Care contractor services audits of sustainability matrix ongoing periodically – Programmes in place to undertake the audits which were included in the annual delivery plan.	30/06/2024	Completed
Health Board Managed Practices – recommendations for improved governance report Managed practices governance and assurance sub group reporting into Primary Care Board	31/01/2024	Completed
Focused on implementation of recommendations from the National Strategic Programme for Primary Care. July workshop planned to review the recommendations and programme of work for 24/25	31/03/2025	Progressing (revised date from 30/06/2024)
Primary Care academy to utilise SPPC monies to further progress multi-professional working with a review of cluster monies spend to allow introduction of new roles, ways of working and models of service delivery.	31/12/2024	New action



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

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

Rationale for Corporate Risk

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

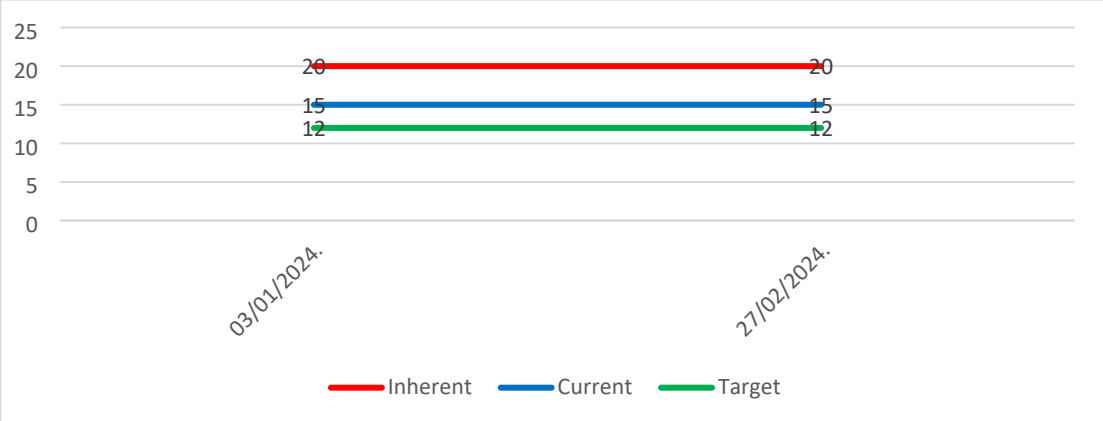
CRR 24-12	**Risk Title:** Clinical Areas of Concern		**Date Opened:** 15/12/2023
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review: New**
Date Last Reviewed: 29/05/2024	**Director Lead:** Executive Medical Director/ Executive Director of Operations	**Link to BAF**: N/A	**Target Risk Date:** 01/03/2025

There is a risk of service failure leading to patient harm across a number of fragile clinical specialties. This could be caused by staffing shortages, clinical leadership gaps, lack of productivity, demand backlog, increasing patterns of demand and estates and equipment deficits. The impact may be delayed diagnosis and treatment of significant conditions. This impacts patient safety, healthcare access and public health outcomes.

Mitigations/Controls in place	Additional Controls required
1. Strategic Improvement Groups for the fragile clinical specialities. 2. Progress review groups for ophthalmology, dermatology and urology to develop and review progress of improvement plans. 3. Improvement plans for fragile specialities for specialities with clinical leadership. 4. Prioritising/triaging cases in specialities with backlog.	1. Implement plans for integrated electronic patient records 2. Dermatology, ophthalmology, urology continue to have clinical leadership gaps 3. Address lack of consistent medical cover in some specialities. 4. SLA for services provided by non-BCUHB organisations 5. Development of clinical model/pathways for fragile specialities with limited leadership incorporating relevant GIRFT and College recommendations 6. Clinical validation of waiting lists.

Actions	Due Date	Progression Analysis
Engagement with National Procurement Processes (i.e. eye record system) and National Programmes (i.e. Robotics) Ongoing engagement with Welsh Government is taking place and is satisfactory.	01/07/2024	Progressing
Ongoing recruitment for substantive medical leadership roles. Now recruited into an Ophthalmic Clinical lead role (May 2024). Start date to be confirmed. In addition the team has now had authorisation to appoint a Clinical Lead for Dermatology	01/01/2025	Progressing
Recruitment efforts including substantive, locum and agency staff. Work continues on a cycle of recruitment. Locum dermatological cover in Ysbyty Gwynedd from June 2024 has been confirmed in May 2024.	01/01/2025	Progressing
SLAs to be signed off through governance structures Work has now commenced on the process to implement a Dermatology Outsourcing SLA with national lead input. In relation to governance. Updates and any approvals will be sought through the Executive Team. (for SLA approval)	01/08/2024	Progressing
Clinical pathway events Engagement during May 2024 with NHS Wales Executive on the development of the Community Clinical Pathway system. This will be received at Executive Team for consideration.	30/07/2024	Progressing

Non-clinical and clinical validation exercises Andrew Oxberry from BCUHB has commenced work on this and this will be able to reported at the next update to this risk.	30/07/2024	Progressing



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

Rationale for Corporate Risk

The impact of the inherent risk has not been altered by current actions, although its likelihood has been reduced by the identification of the clinical issues and improved governance around the services.

- Ophthalmology R1 seen within 25% over their clinical due date - NHS Wales Performance Framework 2024-25 Target improve to 95%
- Cancer 62 Days - NHS Wales Performance Framework 2024-25 Target improvement trajectory to 80% by 31.03.2026

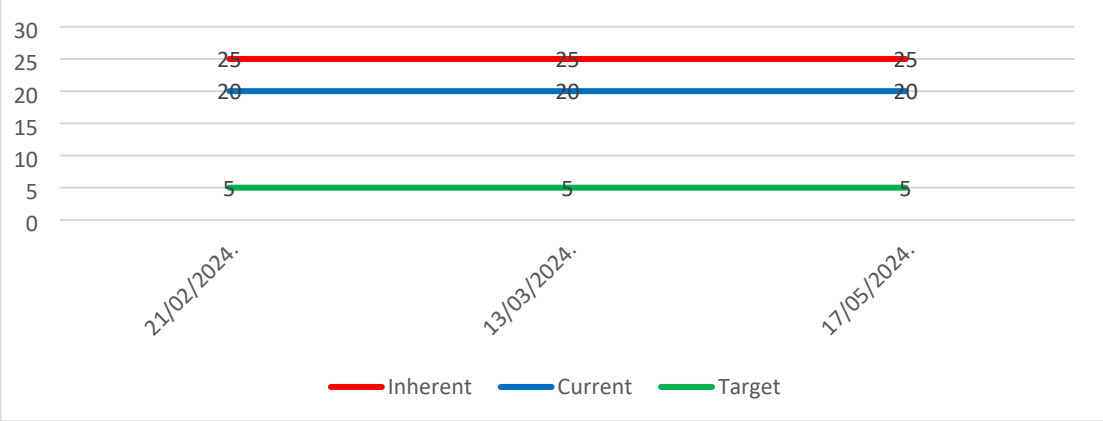
CRR 24-13	**Risk Title:** Timely Diagnostics		**Date Opened:** 21/02/2024
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** 06/06/2024
Date Last Reviewed: 17/05/2024	**Director Lead:** Executive Director of Therapies & Healthcare Sciences	**Link to BAF**: N/A	**Target Risk Date:** 31/12/2025

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

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

Actions	Due Date	Progression Analysis
Replacement of Radiology Informatics System (RISP) – implementation with anticipated go live date of the 14/04/2024.	14/04/2025	Progressing
Replacement of LINC (national pathology IT system) - Contract signed with current supplier plans to implement by September 2025 being progressed nationally	30/09/2025	Progressing

Procedure MD23 (Mitigation of the risk of failure to act on diagnostic results) to be updated	31/12/2025	Progressing
Radiology workforce revised model to be developed by June 2025	30/06/2025	Progressing
Diagnostic Strategy to be developed by diagnostic group	30/09/2024	Progressing



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

Rationale for Corporate Risk

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

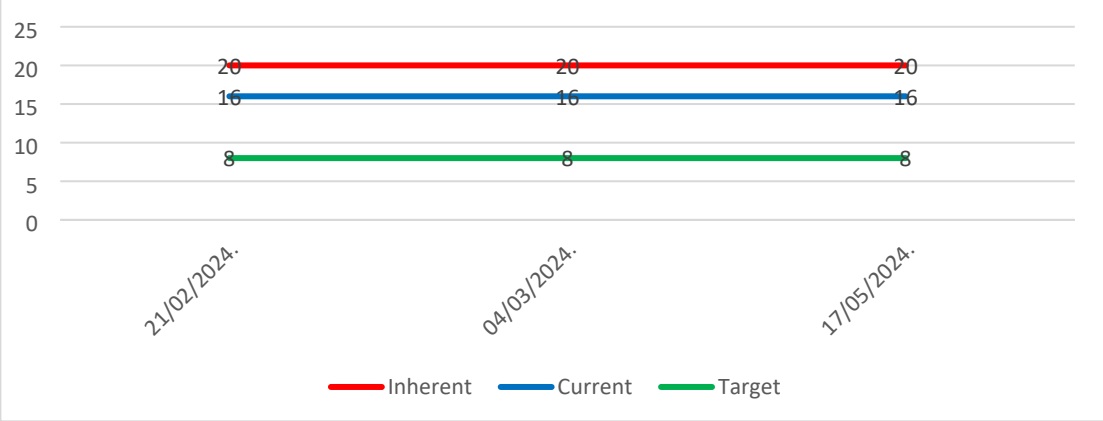
CRR 24-14	**Risk Title:** Harm from the Medical Devices/Equipment		**Date Opened:** 21/02/2024
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** 06/06/2024
Date Last Reviewed: 17/05/2024	**Director Lead:** Executive Director of Therapies & Healthcare Sciences	**Link to BAF**: N/A	**Target Risk Date:** 31/09/2024

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 Oversight Group leads on the capital investment and replacement plan. 2. Annual capital planning process reflects known priorities taking account of key pieces of equipment due for replacement with a risk assessment that support the overall outcome. 3. Scrutiny and assessment of the capital programme at Capital Programme Management Team (CPMT) and Capital Investment Group (CIG). 4. Welsh Government Capital review meeting to escalate and discuss potential risks and requirements for key medical equipment e.g. Linac. 5. An effective medical devices management system is utilised through EBME. 6. EBME uses the management system to monitor the condition and performance of medical devices including device failures and issues; utilisation, performance, maintenance; repair and calibration history. 7. Audits on majority of affected equipment in line with regulatory compliance completed.	1. Internal risk assessment and priorities are flagged in the context of fully depreciated equipment (£34.659m) to understand priorities and potential risks. 2. External links with National Endoscopy and Diagnostic Programmes are documented and appropriately reported through correct channels to ensure transparency and potential benchmarking. 3. Lack of comprehensive governance structure around ensuring equipment **all** is safe and in line with regulations. 4. Lack of training around equipment and good governance of safety of equipment has been lacking and documented as a risk since 2016. 5. Robust risk assessments of how often certain equipment breaks down, the scale of difficulty sourcing spare parts to be considered for included in requests for capital replacement. 6. The number of bids not approved now reaching over millions in capital and resources required. Backlog of equipment beyond end of life, some 10 years+

Actions	Due Date	Progression Analysis
CPMT and CIG to review annual planning process to ensure risk scoring to inform prioritisation	31/03/2024	Overdue
Review of internal and external group membership and communication to ensure all opportunities and risks are reported and escalated as appropriate.	31/02/2024	Overdue
Medical physics have been tasked with testing all ultrasound equipment to ensure its safety and will consider compliance	31/09/2024	Progressing

Review medical devices capital replacement to ensure all services have a medical devises replacement programme in place	31/09/2024	Progressing
Medical Devices strategy review	31/9/2024	Progressing
Recruitment to medical devices team	31/09/2024	Progressing



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	2	8
Risk Appetite	Quality		3 - Open

Rationale for Corporate Risk

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

Teitl adroddiad: ***Report title:***	Corporate Risk Register Report			
Adrodd i: ***Report to:***	People & Culture Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 08 August 2024			
Crynodeb Gweithredol: ***Executive Summary:***	The purpose of this paper is to provide an update of the corporate risk register (CRR). • All risks reported to People and Culture Committee currently sit within the tolerance set within the risk appetite of the Health Board. • No overdue actions to note. A total of 22 actions remain open and progressing for all 3 risks with 4 completed actions. No reduction in current risk scoring during this iteration of the risks.			
Argymhellion: ***Recommendations:***	The Committee is asked to **take assurance** on corporate risks attached in the report.			
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: N/A	
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Further work will be undertaken to align corporate risks to Board Assurance Risks and subsequent strategic objectives.
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	It is essential that the Board has robust arrangements in place to assess, capture and mitigate risks, as failure to do so could have legal implications for the Health Board.
Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqlA been identified as necessary and undertaken?***	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)***	Corporate Risk Report.
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	The effective and efficient mitigation and management of risks has the potential to leverage a positive financial dividend for the Health Board through better integration of risk management into business planning, decision-making and in shaping how care is delivered to our patients thus leading to enhanced quality, less waste and no claims.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	Failure to capture, assess and mitigate risks can impact adversely on the workforce.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	Approved by Executives responsible for the individual corporate risk and quality assurance by Corporate Risk Management Team.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)	Further work will be completed to develop links to the Board Assurance Framework.

Links to BAF risks: *(or links to the Corporate Risk Register)*	
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Not applicable for this report
Camau Nesaf: ***Next Steps:*** Further scrutiny of all corporate risks by Executive Team as per normal reporting cycle.	
Rhestr o Atodiadau: ***List of Appendices:*** Appendix 1 – People & Culture Committee Corporate Risks Dashboard Appendix 2 – People & Culture Committee Corporate Risk Register	

Corporate Risk Register Report

1) Introduction and Background

What Is a Corporate Risk?

A corporate risk register is a repository used by services and corporate functions to record significant risks that could impact the strategic objectives and operations of the Health Board. The register provides a comprehensive overview of the key risks facing the organisation. It is a pivotal tool to help proactively strengthen risk oversight and management.

1.1 There are 3 Corporate Risks for People and Culture Committee oversight and assurance. The full details of these risks are highlighted in Appendix 2 and include evidence of controls in place, assurances on those controls, additional controls required and actions with due dates.

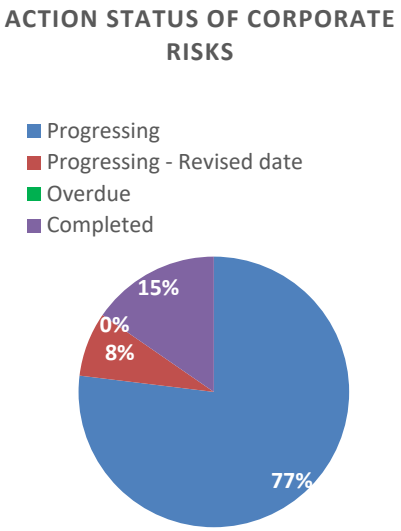
- CRR24-01 - People, Culture and Wellbeing
- CRR24-15 - Health and Safety
- CRR24-16 - Leadership/Special Measures

1) Key Highlights

Corporate Risks Dashboard highlights the current score, target score in relation to the risk appetite.

To note, the Audit Committee (18 July 2024) approved changes to the Risk Management Framework following discussion at the Risk Management Board Developmental session around the cycle of reporting corporate risks to committee, in that the committees will receive all corporate risks on a quarterly basis but risks which are above the tolerance set within the risk appetite of the Health Board at every committee. This paper presents all risks to which People and Culture Committee has oversight, currently all risks are within the tolerance set within the risk appetite.

Out of the 3 corporate risks, 26 actions have been developed to mitigate the risks. 4 actions have been completed, 22 actions are progressing and on track with 2 of those actions progressing with revised due dates allocated onto the actions.



Although several actions have progressed and some completed, no risk scores have reduced.

Next steps

1. Continued scrutiny of the actions, controls and progress of all corporate risks by Executive Team.

Appendix 1 - People & Culture Committee Corporate Risks Dashboard

Lead	Ref	Risk Title	Current Score (Likelihood x Impact)	Risk Target Score	Appetite Main Risk Type / Appetite Level	Lead Board Committee	Risk Management Commentary
EDoW	CRR24-01	People, Culture and Wellbeing	4 x 4 = 16 ⟷	8	Quality / Open 15-19	People & Culture Committee	Opened Dec 23. 6 actions identified, 1 completed, 5 progressing, **with 2 revised due dates**.
EDoW	CRR24-15	Health and Safety	4 x 4 = 16 ⟷	8	Regulatory / Seek 20-25	People & Culture Committee	Opened Feb 24, 14 actions identified, 0 completed, 14 progressing. Work has been completed by the lead to strengthen the action plan and also reflect the recent Internal Audit report recommendations however there remain to be some quality assurance comments sent to the service lead around controls, gaps in controls and dates of **all actions being Dec 24**.
EDoW	CRR24-16	Leadership/Special Measures	4 x 4 = 16 ⟷	8	Reputational / Seek 20-25	People & Culture Committee	Opened Dec 23. 7 actions identified, 4 completed, and 3 progressing.

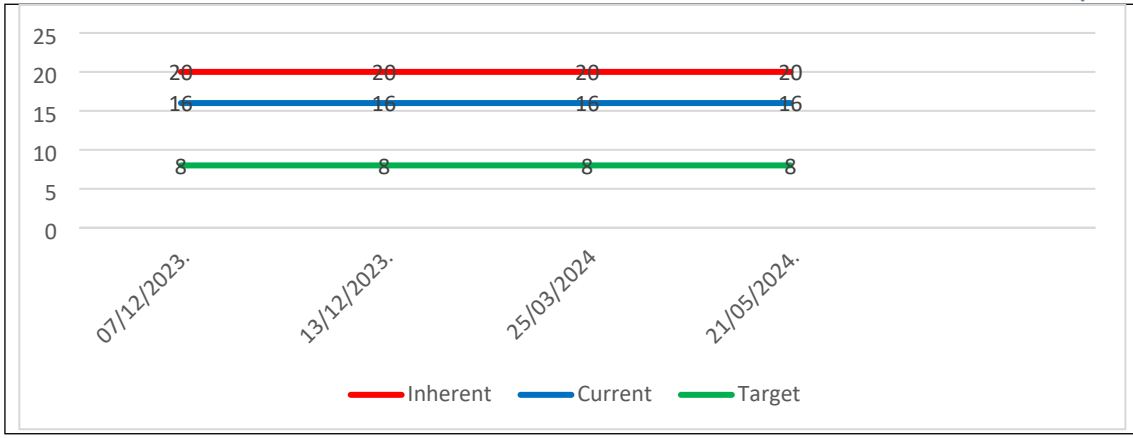
Appendix 2 – People & Culture Committee Corporate Risk Register

CRR 24-01	**Risk Title:** People, Culture and Wellbeing		**Date Opened:** 07/12/2023
	Assuring Committee: People & Culture Committee		**Date Last Committee Review:** 13/06/2024
Date Last Reviewed: 12/06/2024	**Director Lead:** Deputy Director of Workforce	**Link to BAF**: SP12	**Target Risk Date:** 31/03/2025
There is a risk that BCU do not have a **highly skilled**, engaged and **motivated** workforce which could impact on safe delivery of care. This could be caused by **staffing shortfalls**, organisational reputation and staff not feeling psychologically safe which could lead to burnout. This could lead to the inability to attract and retain high quality and skilled people.			

Mitigations/Controls in place	Additional Controls required
1. People Committee oversee delivery of the People Services agenda 2. Local IHC & Pan Services People & Culture Committees in place 3. The Strategic Recruitment team in place to oversee efficient and effective professional recruitment for all senior leadership and medical & dental consultant appointments across the Health Board 4. Local IHC Resourcing Teams are in place across all IHC/Pan Services to drive forward recruitment and staffing priorities. 5. The Recruiting well and Joining Well programmes in place 6. Organisational Retention lead in post for BCU linked with national retention work through HEIW 7. Dedicated Nurse Retention Lead in place to deliver the Nurse Retention Implementation Plan for the organisation 8. New All Wales Flexible working policy has been ratified and is in place 9. Staff feedback conjunction with the NHS Wales Staff Survey in place. Development of Pulse surveys to ensure staff have a voice across the organisation 10. Speak out Safely MDT in place 11. Work in Confidence platform for staff to safely raise concerns. 12. Workstreams associated with this risk which links into the Special Measures Framework are monitored via the governance of the Framework and reported to Executive Team and Board 13. An Agreed scope to the operating model review is underway 14. A range of employee engagement tools have been agreed at the OD steering group in March 2024 15. The Culture Change Plan, which incorporated the results from the Staff Survey, was agreed at People & Culture Committee in March 2024 16. Staff facing version of the Learning Organisation Framework developed for use in work-based learning contexts	1. The programme of work through the Education and Learning Committee to be finalised 2. Increased measures on employee engagement 3. Development of a programme of work to ensure line manager's full involvement in employee engagement 4. Feedback from the HEIW Nurse retention tool.

Actions	Due Date	Progression Analysis
REF Gaps in controls; A. Education and Learning Committee is being established as a control measure	31.07.24	Progressing
REF Gaps in controls; B. NHS Staff Survey action plan to be developed and implemented across 24/25. The corporate action plan has been developed, the next steps is to take it forward at IHC level. This work is scheduled to be completed by end of June	30.06.24	Progressing
REF Gaps in controls; C. Findings from the wider review of the 2022 Operating Model restructure presented via an appropriate Executive governance process and next steps agreed. A full report of the findings is due to be submitted by Ararna by the end of May. The Findings will determine what the next steps will be, therefore they cannot be agreed until the full report has been received. The findings will inform the PID for the Operating Model which is one of BCUHB's 3 major transformation programmes of work.	30/06/24	Revised Date 2 weeks (Progressing)
Clinical engagement: Progress demonstrated in the part of the OD plan relating to clinical engagement field work conducted in previous cycles. Recommendations made were reviewed by the Organisational Development Steering Group on 5.2.24. As agreed there, further work is being undertaken to understand the barriers to engagement of clinicians, which will inform proposals for the development of a broader corporate engagement offer. A draft OD Plan was presented to the Steering Group on 4.3.24 for feedback before being finalised.	29/02/2024	Complete
REF Gaps in controls; B. Revisit the values of the organisation: Views on the existing values and suggestions for modifications presented to Exec Team prior to scheduling for review at Board. Previously collected staff feedback on the existing values to be analysed and proposals of methods of co-production with the staff including comms and engagement plans to be submitted via an appropriate Executive governance process. Culture World Café to take place at Leadership Conference 04.06.24. The revised date for the culture world café is scheduled for 4th June, the feedback will be collated and available by the end of June 2024	30/06/2024	Revised Date from April (Progressing)
REF Gaps in controls; D. The Recruiting Well, Joining Well, Leaving Well Programme is being developed to ensure we recruit, support and retain a skilled motivated workforce. The programme for Recruiting Well, Joining Well, Leaving Well will now be incorporated into the **Staff Journey** programme of work. An illustrative map is currently being developed showing all areas within People Services and OD that employees typically encounter, from Hire to Retire'. Work in being undertaken to identify gaps in each of the services with regards to policies and procedures. This will enable the Staff journey programme plan, which will include timescales, to be drafted.	30/06/2024	Progressing

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



Rationale for Corporate Risk

This is a corporate risk due to the current position across the Health Board with high turnover rates across certain key staff groups. Staff engagement score at 72%, comparable with all Wales average of 73%.

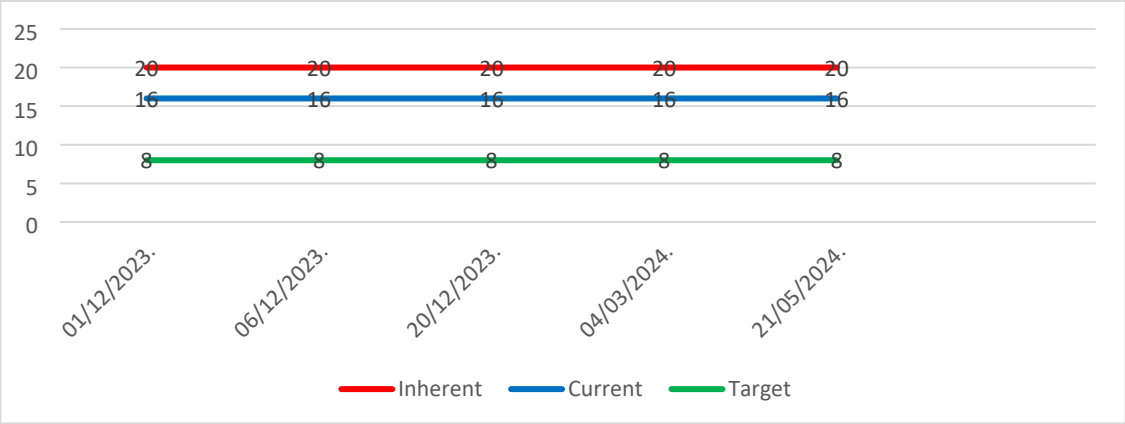
CRR24-15	**Risk Title:** Health and Safety		**Date Opened:** 01/12/2023
	Assuring Committee: People & Culture Committee		**Date Last Committee Review:** 13/06/2024
Date Last Reviewed: 11/06/2024	**Director Lead:** Deputy Director of People	**Link to BAF**: N/A	**Target Risk Date:** 31/12/2024

There is a risk of avoidable harm to patients and staff. This is may be caused by a failure of the Health Board to provide safe systems of delivery and work in accordance with the Health and Safety at Work Act 1974 and associated legislation due to the lack of Health and Safety Leadership. The impact is patient and staff harm, financial implications, and reputational impact to the Health Board.

Mitigations/Controls in place	Additional Controls required
1. Health and Safety short courses for managers and staff, and mandatory e-learning are in place, with regular monitoring reported to Strategic H&S group. Further training commenced January 2024 with the NEBOSH General Certificate and NEBOSH Award. 2. Policies and subgroups have been established including asbestos, water safety, fire electrical safety etc. to monitor and report into the Strategic Occupational Health & Safety Group. 3. Competence in training in service areas has been reviewed. Plan in place through business case (subject to approval) to establish robust Safety Competence and leadership training programme. 4. There is a three-year Occupational Health, Safety and Security strategy in place that supports the Strategic Objectives of BCUHB. 5. Gap Analysis has been repeated to establish areas of non-compliance and to inform a new 3 year strategy 6. Falls are closely monitored by H&S advisors to review under RIDDOR reporting requirements 1. The H&S team have additional controls around learning from near misses and mistakes, participating in Falls investigation meetings and learning panels 2. Professional training and qualifications provided by H&S team to ensure a whole system approach around Health & Safety learning and development	1. HS01 to be updated when the Executive portfolios have been finalised. This will go out of date in December 2023 and a six month extension has been requested. 2. There have been a number of HSE interventions and internal reviews that have highlighted significant gaps in the OHS system. 3. Manual handling training compliance is currently at 68%. The team have moved back to the BCUHB sites as the two year contracts for external training venues have ended. The effects of these moves is not fully known yet. 4. The HSE have identified gaps in safe systems of work and risk assessment in connection with the sudden death of a patient within mental health resulting in. prosecution. 5. A Further intervention has been made by HSE in respect of the deaths of 3 patients following patient falls, a prosecution is expected 6. Lack of formal arrangements in place to protect premises and people in relation to CCTV, violence and aggression, Security Contract issues (personnel), lone working, lock down systems, access control and training that provides assurance that Security is effectively managed

Actions	Due Date	Progression Analysis
A clear strategy and framework. The HS01 Policy, and supporting procedures and documents on BetsiNet require a review to ensure staff are provided with up-to-date requirements and guidance relating to Health & Safety.	31/12/2024	Progressing
NEBOSH training courses to go forward for the General Certificate and the Award.	31/12/2024	Progressing
Business case for security provision approval process underway.	31/12/2024	Progressing
H&S not noted as a deliverable on the Annual Plan for priorities and Strategic Objectives are due to be reviewed.	31/12/2024	Progressing
Executive level responsibility for Occupational Health and Safety should be considered, to ensure Health and Safety is a key focus within the Health Board.	31/12/2024	Progressing
Management ensure regular monitoring, reporting, communication, escalation and de-escalation of Health & Safety issues through the appropriate governance structure, in line with the HS01 policy and terms of reference for relevant meetings (Strategic Occupational Health and Safety Group, Quality Safety and Experience Committee and Risk Management Group).	31/12/2024	Progressing
The Strategic Health and Safety Operational Group to confirm the reporting required to the group by services and ensure this is communicated to all relevant areas. Instances of non-reporting should be communicated to the services and escalated appropriately, via the Executive or QSE.	31/12/2024	Progressing
The Health Board Executive Lead for Health and Safety ensures Policy reference 5.1.3 Training for Health Board Executive Directors and Independent Members is adhered to: “the Health Board will provide suitable and sufficient training and instruction to Members of the Board in respect of H&S Management. This will also include responsibilities under section 37 of the Health and Safety at Work etc. Act 1974 and the Corporate Manslaughter and Corporate Homicide Act 2007”.	31/12/2024	Progressing
Health Board Policy 5.3.4 is reviewed to ensure that all Corporate Health & Safety recommendations are agreed, assigned to owners, allocated appropriate dates and are subject to follow-up.	31/12/2024	Progressing
The gap analysis is reviewed and management identify what further work needs undertaking to ensure areas of risk / focus remain relevant. This should be considered alongside the strategy to inform Health and Safety activity across the Health Board.	31/12/2024	Progressing
Estates to standardise action plans resulting from Health and Safety reviews and ensure regular review and update of actions to monitor progress.	31/12/2024	Progressing
A process to monitor and review department self-assessments should be put in place to ensure departments are adhering to the Health and Safety Policy. This should also include escalation where self-assessments are not completed, reviewing self-assessments for potential risks / issues and identifying areas of similarities / opportunities across departments.	31/12/2024	Progressing
An up-to-date list of Health and Safety leads / champions be developed to ensure there are contacts in place for all departments who are required to undertake self-assessments.	31/12/2024	Progressing
New role of Director of Environment to be recruited to reporting to CEO, which will review Estate business cases. Director of People Services being recruited to.	01/09/2024	Progressing

	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20



Current Risk Rating	4	4	16
Target Risk Score	4	2	8
Risk Appetite	People		4 - Seek

Rationale for Corporate Risk

There is an inherent risk that the failure of Health & Safety management systems could lead to RIDDOR Reportable. Specified Injuries to Workers. Patient mismanagement, long-term effects. Death or significant irreversible harm which will result in prosecution by the Health and Safety Executive consequently leading to loss of reputation and financial penalties. The risk is extenuated by Non-compliance with national standards with significant risk to patients/public. An unacceptable level or quality of treatment/service. Gross failure of patient safety leading. Inquests and Coroners reports. Low staffing level that reduces the service quality. Low staff morale. Poor staff attendance for mandatory/key professional training. Uncertain delivery of key objective/ service due to lack/loss of staff within the Health and Safety team. Structural changes will be implemented in summer 2024, with Health and Safety moving from Workforce Directorate to a new role of Director of Environment, reporting directly to CEO.

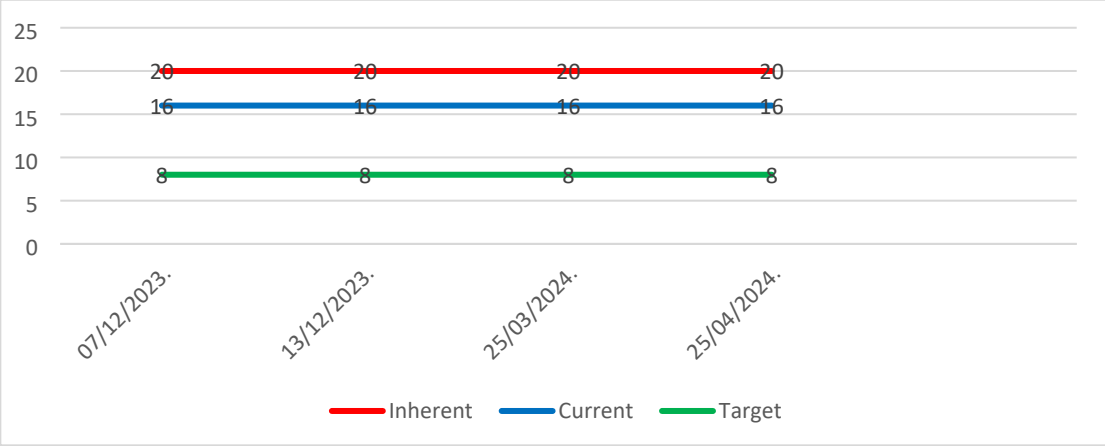
CRR 24-16	**Risk Title:** Leadership/Special Measures		**Date Opened:** 07/12/2023
	Assuring Committee: People & Culture Committee		**Date Last Committee Review:** 13/06/2024
Date Last Reviewed: 12/06/2024	**Director Lead:** Deputy Director of Workforce	**Link to BAF**: SP17	**Target Risk Date:** 30/09/2024

There is a risk of traditional models of leadership which do not define the expectations, values and behaviours of our leaders to transform the organisation. We recognise a compassionate leadership approach supports the delivery of safe and reliable care. This could be caused by inadequate governance arrangement and lack of integrated leadership development pathways across the Health Board. This could have an impact on the sustainability of staffing and subsequently patient care and safety and service delivery.

Mitigations/Controls in place	Additional Controls required
1. Board Workshop with Professor Michael West on compassionate leadership 2. Suite of leadership conferences, networking and masterclasses on compassionate, inclusive leadership and engagement. 3. Work associated with this risk which links into the Special Measures Framework now monitored via the governance of the Framework and reported to Executive Team and Board. 4. Full Board now in place and all committees now chaired and attended by full complement of Independent Members 5. The new Integrated Leadership Development Framework (ILDF) has been ratified and is live on BetsiNet, this includes the 'Approach to Leadership' which was approved by the OD Steering Group in March 2024 6. The OD Steering Group now in place since February 2024	1. Integrated Leadership Development Framework has been signed off by OD Culture group and will be tabled at P&C Steering group mid-June. 2. New compassionate approach to leadership and how to adopt it, aligned with the work on values and behaviours 3. Formal Culture Change Plan and accompanying Comms and Engagement plan 4. A Behaviours Framework, will be derived from the culture change workstream 5. Fully resourced Culture Change programme and realignment of resources within the OD function

Actions	Due Date	Progression Analysis
Integrated Leadership Development Framework socialised across the organisation for feedback. Work has taken place on further co-design and to socialise the draft Integrated Leadership Development Framework (ILDF) across the organisation. This has involved members of the OD team attending meetings already in place to share the proposed framework, inviting staff to feed back on the design and logo as well as the content of the framework. MS Teams virtual sessions (including evening and weekend sessions) have also been hosted inviting staff from across the organisation to attend and share their feedback and comments. Based on the feedback, amendments have been made, a recent copy of the draft ILDF can be found on BetsiNet.	31/01/2024	Complete
Integrated Leadership Development Framework implementation plan presented to Executive Team. The ILDF is currently being updated following feedback from March's OD Steering group where it was presented. The revised ILDF will go to May's OD Steering group for agreement. The ILDF has been tabled and approved by the OD Steering group in May 2024	29/02/2024	Complete

Exploration of approach to leadership: Draft proposal of the approach and how to adopt it presented via an appropriate Executive governance process. The Approach to Leadership is integral to the culture development work, the approach was agreed at the ODSG in March	29/02/2024	Complete
REF Gaps in controls; A & B. Draft Integrated Leadership Development Framework in place (forms part of special measures monitoring) With OD resources in place, the ILFD training is expected to be live in September 2024	30/09/2024	Progressing
REF Gaps in controls; C & D. Draft OD plan in development (forms part of special measures monitoring) and has been initially approved by the culture steering group. The next steps is to ratify the plan with the senior team and People & Culture Steering Group	31/08/2024	Progressing
REF Gaps in controls; C& E. Examine the current pervasive culture: Final results from NHS Wales Staff Survey shared with all relevant managers and thematic analysis fed into Culture Change Plan The culture world café in June will deep dive into key themes of the current culture with 800 staff members expected to attend. The results will be analysed and available by end of August 2024	31/08/2024	Progressing



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	2	8
Risk Appetite	Regulatory		3 - Open

Rationale for Corporate Risk

Structures currently being embedded to ensure IHCs, Divisions and Services have clear accountable delivery plans so new ways of leading are embedded locally. Organisational expectations being defined.

Joint Commissioning Committee
16 July 2024
Agenda Item: 4.1.5

Reporting Committee	**Quality Patient Safety Committee (QPSC)**
Chaired by	**Susan Elsmore**
Lead Executive Director	**Director of Nursing & Quality**
Date of Meeting	**24 June 2024**

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

1. CARDIAC PATIENT SOTRY

Members received an informative patient story about a gentleman who had suffered a sudden cardiac arrest. Members noted the challenges that the patient faced at the outset and how a range of JCC services and the public saved his life. The patient and his family praised the care that they had received throughout this traumatic event. The patient story highlighted the positive impact that the EMRTS service and the cardiac services had made to the patient's quality of life.

2. WELSH KIDNEY NETWORK REPORT

Members received a report outlining the current Quality and Patient Safety issues within the services that are commissioned by the Welsh Kidney Network (WKN) across Wales and a summary of the highest scoring risks was provided.

3. COMMISSIONING TEAM AND NETWORK UPDATES

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

3.1 Cancer & Blood

Members received an update of the quality issues for services relating to the Cancer and Blood Commissioning Team Portfolio.

- **South Wales Plastic Surgery**
  Members noted that this service provided by SBUHB remained at Level 2 of the Escalation process and was the only NWJCC commissioned service where patients were waiting over 104 weeks. The JCC made a choice around not accelerating improvements but within the ICP for 2024/2025 it was agreed to continue with this steady improvements towards the target. However, following approval of the ICP, WG published targets to achieve

104 weeks by March 2025. These were further revised in a letter received from the Deputy General/CEO NHS Wales on 7 May 2024 outlining revised Ministerial targets of no patients waiting over 104 weeks by the end of December 2024. This will require a decision to be made by the NWJCC in July 2024 and the NWJCC is undertaking further work currently with SBUHB to understand the demand, activity and efficiency assumptions in this delivery plan and trajectory, and engaging with Health Boards on the approach to the balance between the financial position and performance.

- **Plastic Surgery Outreach at BCUHB**
  This service was currently within the Welsh Government escalation/ special measures framework for BCUHB as the quality issues concern the operational responsibility of BCUHB for the provision of clinic administration and facilities under a Service Level Agreement between the Health Board and MWL. WG have acknowledged that there was evidence of improvement. Since the last meeting the harms review had been completed and it was presented to BCUHB QPSC Committee in June 2024. The report provides assurance that no evidence of patient harm was found. Despite this being a retrospective review, these issues have been mitigated as the level of service support, administration, quality reporting process, activity and waiting times reporting and ongoing monitoring arrangements have been strengthened. In addition, they have also funded waiting list initiatives to address the backlog and there were fewer patients on the waiting list compared to when the review was started.

3.2 Cardiac

Members received an update of the quality issues for services relating to the Cardiac Commissioning Team Portfolio.

- Although the two service providers in South Wales following a Getting it Right First Time (GIRFT) review have been in escalation for some time, they have been on a de-escalation trajectory for most of that time and both services have engaged well with the escalation process. Swansea Bay Cardiac Surgery Service was de-escalated from Level 2 to 0 of the Escalation Framework in May 2024 and was now out of escalation completely. The Cardiff and Vale Cardiac Surgery Service has been de-escalated to Escalation Level 1 pending receipt of an audit report.
- An update was provided on the exercise into any unreported cases of Mycobacterium Chimera. This bacteria is associated with water heater cooling systems used in cardiac surgery. They undertook an extensive piece of work in terms of a look back and this work has concluded with no new cases having been reported within the last 8 years. This extensive work seems to be working as there had been no recent reported cases.

3.3 Neurosciences

Members received an update of the quality issues for services relating to the neurosciences Team Portfolio.

- NWJCC had reallocated funding to address the Neurosurgery risk and agreed additional money within the ICP for 2024-2025.

- There were two service related risks which were being managed in line with the engagement for service change guidance issued by Welsh Government and the NWJCC were keeping in close contact with Llais.

3.4 Women & Children

Members received an update on the quality issues for services relating to the Women & Children Commissioning Team Portfolio. The risks largely mirror the services in escalation, and it was acknowledged that the volume of risks and escalation issues within the portfolio are concerning and make this a complex and challenging area.

Paediatric Surgery

Members noted the positive progress and good evidence of operational improvement underpinning a reduction in the waiting times and the waiting list in line with the accelerated target over and above the ministerial measures of 52 weeks that the JC agreed last year. The HB was not able to achieve the target by the end of March 2024 due to the industrial action but assurance has been received that the target will be achieved by the end of June 2024. Based on this assurance, the Commissioning Team agreed to de-escalate the service to Level 0 and the service has returned back to normal performance monitoring arrangements. The letter confirming the de-escalation was sent to the provider last week. The JCC ambition for this year was to maintain that 52 week wait.

Wales Fertility Institute

Members noted the positive progress with the Fertility service issues. Due to regulatory issues following an inspection by the HFEA the service was placed in escalation Level 4 with regular reporting through the NWJCC via the Performance Report. A positive inspection report from the HFEA had recently been received and reported through the escalation meeting. There had been good progress in the appointment of a Person responsible (PR) with the intention to appoint more than one person to perform the PR role to ensure sustainability going forward. Following confirmation of the above progress, the Commissioning Team agreed to de-escalate the service to Level 3 and remove the service from the critical escalation Level 4.

Neonatal Care (NICU) and Paediatric Intensive Care (PICU)

Members noted that there was less assurance in relation to Paediatric Intensive Care (PICU) and Neonatal Care and as commissioners it was noted that the same level of progress had not been made within these service areas. A decision was taken to reset the process at executive level and move towards a more outcomes and objectives based escalation. Whilst most of the services have been on a de-escalation trajectory, progress within these two service areas was complicated

due to some underlying themes such as the scarcity of specialist workforce. The NWJCC understood the complexities and this was the reason for the reset approach to try and achieve a better outcome for the population of South Wales.

Members discussed the new approach and questioned how these services would be measured going forward. Members were assured that the NWJCC would be using national benchmarks and metrics and monitoring those together with the Health Board and addressing access to those really highly specialised services to ensure that we are assured on the quality management systems and workforce availability within these two areas.

3.5 Mental Health

Members received an update of the quality issues for services relating to the Mental Health and Vulnerable Groups for the former WHSSC Commissioning Team Portfolio.

Members noted that there had been little change to the commissioning risks since the last report. Funding to address the Neuropsychiatry sustainability risks was approved and was included in the ICP for 2024/2025 with the aim to bring the business case seeking funding release to the Management Group meeting in July 2024.

Members noted the comprehensive summary regarding Gender Development Service (GIDS) for Children and Young People, the Cass review, the new legislation around prescribing puberty supressing hormones and the progress that has been made on Phase one and Phase two of the NHS England transformation programme.

Members were made aware of some issues in relation to a specialist eating disorder provider.

3.6 Intestinal Failure (IF) – Home Parenteral Nutrition

Members received an update on the quality issues for services relating to the Intestinal Failure Commissioning Team Portfolio. Members noted that the Independent Provider Framework Agreement with the independent sector for the provision of home care and parenteral nutrition products ended on 30th June 2024. A procurement process was undertaken by the NHS Wales Shared Services Partnership (NWSSP) to renew the Framework agreement. The three open risks were linked to this issue and will be de-escalated following the renewal of this Framework agreement.

4.0 OTHER REPORTS RECEIVED

Members received reports on the following:

4.1 Services in Escalation Summary

Members noted the content of the report and the Paediatric services in escalation Level 3 were discussed in detail above under the Women and Children's Report.

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

4.2 Quality and Safety Report (Former EASC)

Members received a report providing an update on quality and safety matters for the Emergency Ambulance Services Committee (EASC) commissioned services. Members noted that this report was usually considered under the EASC Management Group before being presented to the EASC Joint Committee.

A range of the measures were presented and discussed. Members provided useful feedback on what information they would find useful for future reports.

4.3 Mental Health and Vulnerable Groups Commissioning Management Team Report

Members received a report providing an update on issues for services relating to the MHVG Commissioning Management Team. Due to the transition of work from the former Quality Assurance Improvement Service into the new NWJCC, the service portfolio reported was focused on the 'National Collaborative Framework for the provision of services for Adult Mental Health Learning Disability / Child and Adolescent Mental Health Hospitals', with a view to presenting a fully integrated MHVG report for the next QPSC meeting.

Members provided useful feedback on what information they would find useful for future reports.

4.4 Care Quality Commission (CQC)/ Health Inspectorate Wales (HIW) Summary Update

A briefing on Healthcare Inspectorate Wales (HIW) and Care Quality Commission (CQC) reports published during the period February 2024 to May 2024 was presented to the committee.

4.5 Incident and Concerns Report

Members received a report outlining the incidents and concerns reported to WHSSC and the actions taken for assurance.

4.6 Policy Group Report

Members received an update on activity and output from the NWJCC Policy Group during the period 1 January 2024 – 31 March 2024 together with an updated overview of all NWJCC policies and service specifications including those published during the current financial year, together with the rationale for their development.

5. ITEMS FOR INFORMATION

Members received a number of documents for information only:

- Chair's Report and Escalation Summary to Joint Committee April 2024;
- Welsh Health Circular: NHS Wales National Clinical Audit and Outcome review plan: Annual Rolling Programme from 2024/2025; and
- QPSC Distribution List.

6. ANY OTHER BUSINESS

Members provided useful feedback on the quality newsletter.

Key risks and issues/matters of concern and any mitigating actions

Key risks are highlighted in the narrative above and summarised below;

- The general concerns with paediatric services in CVUHB.
- Ensuring future reports are aligned to the new duty of quality.
- Ensuring concerns report contain some trends and themes as well as capturing patient experience/stories.

Summary of services in Escalation

- Attached (***Appendix 1***)

Matters requiring Committee level consideration and/or approval

None

Matters referred to other Committees

As above.

Confirmed minutes for the meeting are available upon request

Date of Next Scheduled Meeting	2 September 2024

Teitl adroddiad: ***Report title:***	Quality Delivery Group – Chair's Report			
Adrodd i: ***Report to:***	QSE Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	15th August 2024			
Crynodeb Gweithredol: ***Executive Summary:***	This report provides the Committee with the Chair's Report from the Executive Quality Delivery Group (QDG). The QDG is the clinical executive led quality group in the Health Board through which all other quality-related groups report.			
Argymhellion: ***Recommendations:***	The Committee is asked to note this report			
Arweinydd Gweithredol: ***Executive Lead:***	Angela Wood, Executive Director of Nursing and Midwifery Dr Nick Lyons, Executive Medical Director Teresa Owen, Executive Director of AHPs and Healthcare Science			
Awdur yr Adroddiad: ***Report Author:***	Angela Wood, Executive Director of Nursing and Midwifery (Chair) Matthew Joyes, Deputy Director of Quality			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☐ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☒ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				
There is confidence in the data provided in the report however, the strength of learning and improvement remains an area of concern and is a key focus of work. This is being addressed through a range of measures including the actions aligned to the Board Assurance Framework.				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Outcome 4 - Improved access, outcomes and experience for citizens Outcome 5 - Recognition of BCU as a learning and self-improving organisation			
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	The Duty of Quality is a statutory requirement under the Health and Social Care (Quality and Engagement) (Wales) Act 2020.			

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

Chair's Report

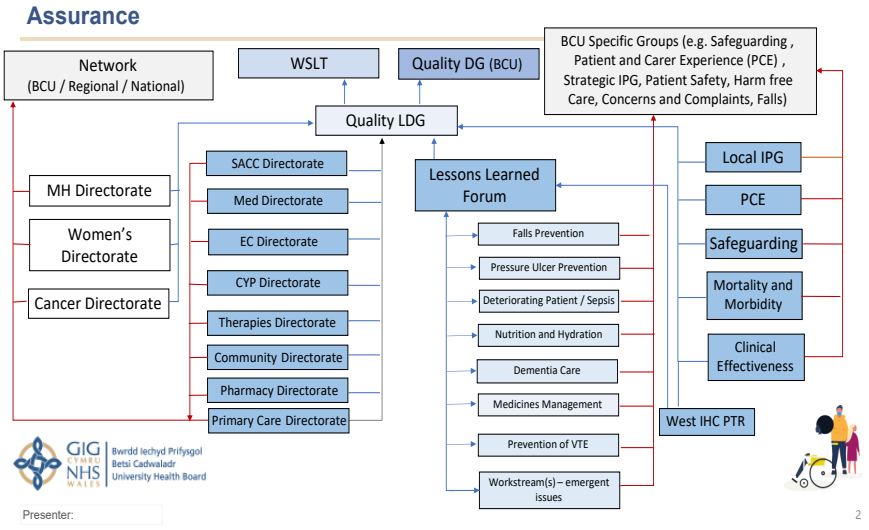
Report to:	Quality, Safety and Experience Committee
Report from:	Executive Quality Delivery Group
Report date:	July 2024
Presented by:	Angela Wood, Executive Director of Nursing & Midwifery

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

Issues for escalation – requiring action/decision	None.
Issues for escalation – for information	• A number of service pressures and concerns are noted in the reports from IHCs detailed below. • The Executive Director of Nursing and Midwifery will now chair the group permanently, rather than rotate, to ensure consistency.
Summary of business conducted – for assurance	Quality highlight and escalation reports were received from IHC/Divisions. • **Central IHC** advised they identified concerns with birthing floor mattresses in the Central Maternity Led Unit. Mattress have several parts and is difficult to check for ingress, increasing bodily fluid exposures risk to other patients. This has been escalated locally and to the Decontamination Team to review, as there may be issues on other sites, as the same mattresses are used. Complaint performance continues to be a slightly improved picture but continues to be of concern due to the number of open and overdue complaints • **East IHC** advised demand for children's neurodevelopment (ND) service far outweighs capacity and as such they are unable to deliver a timely service to patients. The waiting list in East stands at (end May 24): 2426, with 2055 waiting over the 26-week target. In 24/25 there has been a 57% increase in the waiting list from March 23 – March 24; with an 81% increase in those waiting over 26 weeks. The increase in waiting list predicts that across BCUHB there will be 8000 children waiting at end March 2025. This is on the Risk Register as a Tier 1 risk. The impact of this waiting may be affecting primary care and CAMHS / ED as families struggle to cope. The IHC also reported Haematology workforce challenges (one Locum covering with CNS). The key themes

and trends in relation to formal concerns relate to communication, delays in accessing planned and unplanned care and clinical treatment and outcome.

- **West IHC** advised all directorates have been requested to review risks that have not be updated within the required timeframe. The Local Quality Delivery group governance structure has been reviewed (see below). A Lessons Learned forum will be developed, which will steer to progress of improvement groups and emergent workstreams.



The volume of open incidents is being closely monitored. Additional support has been put in place by the Associate Director of Nursing to progress closer of incidents the Emergency Care directorate; old incidents will be closed in accordance with the agreed processes via Patient Safety Group and Executive Director of Nursing direction. It is expected that the number of open incidents will reduce with this additional support and the management of the incidents will be improved to enable the identification of learning to inform improvements in care delivery promptly. The Peer Review of Consent to Examination and Treatment audit cycle now closed. The IHC are awaiting confirmation from Clinical Effectiveness Team around next audit cycle. Overview of HB responses show poor compliance around evidence of use of EIDO leaflets. IHC specific review to follow once we are able to drill down into the detail.

- **MHLD Division** reported the Division has been working to reduce the number of inpatient ligature incidents, this is being tracked and monitored through Divisional PTR on a weekly basis. All ligature incidents are reviewed appropriately and considered according to the level of risk and harm. In relation to Valproate Safety update, the initiation checklist will need to be adopted by the wider system as they is national concern that women in child bearing are continuing to be prescribed these medications.

- **Women's and Midwifery** Division advised there remains a significant risk to delivering the North Wales Gynae Cancer Service in line with the Welsh Government Single Cancer Pathway. In terms of mitigating the

	risk and improving performance we have undertaken a number of actions. In January 2024 the Service secured approval from the Executive Team to commission additional activity NHS England in relation to Hysterectomy (Open +/- Laparoscopic) for Gynaecology USC/ Cancer and Vulval Surgery for Gynaecology Cancer. Following approval, the Service has worked closely with the Contracting Team and contact has been made with all Cancer Alliances in the North West. At present none are in a position to support any additional activity. There is an ongoing risk of flooding to Celyn Ward and the Delivery Suite. This is caused by water ingress from various parts of the roof and could impact on the Service's ability to deliver core services. Welsh Government has been working with the Maternity and Neonatal Strategic Network to develop a Quality Statement for Maternity and Neonatal care. The quality statement will establish a strategic policy direction by setting clear, high-level, national expectations for maternity and neonatal services. A draft quality statement has been developed structured according to the 12 Health and Care Quality Standards based on insights gained from recent reviews and reports, as well as broader Welsh Government policies and strategies. The Draft Statement is currently out for comments at Health Board Organisational level with a 30/6/24 submission date. • **Cancer Division** highlighted the Clinical Haematology Consultant workforce has been depleted by 2 long term sickness and 1 long term sickness at Speciality Grade. Patients with diagnosed acute leukaemia will be sent to The Christie Hospital Manchester. Please note that patients from the Wrexham area already go to Christie for treatment. Cancer Services are experiencing extreme and unprecedented pressure on the Systemic Anti-Cancer Treatment (SACT) service. There has been a surge of new patient referrals with a simultaneous increase in SACT deferrals. This is on the background of a service already at capacity. Cancer Services staff are working hard to find solutions, both immediate and medium term, and there are work streams currently underway to take this forward. • **Diagnostics and Clinical Support** did not submit a report. • **Dental Division** advised an equipment review of dental chairs and patient lifting equipment continued across the service to support timely servicing and maintenance to ensure equipment is safe and operational at all times. A Nitrous Oxide audit programme being drafted across the service. Single use badges have been procured for initial testing programme. Two nitrous oxide monitoring machines have recently been returned from a servicing and calibration programme in the USA, and are now ready for use. CDS is undergoing significant organisational and transformational changes. An Improvement Plan has been developed and an Operational Management Group established to support the workstreams identified. • **The Infection Prevention and Control Group** reported in comparison with other Welsh Health Boards, in May 2024 BCUHB were 1st for MSSA, Klebsiella and Pseudomonas, 3rd for C. diff, 5th for E. coli and 6th for MRSA. Having not yet received trajectories for 2024/25, the six

	mandatory organisms were presented against last year's trajectory placing us above trajectory for all reportable organisms, except Klebsiella and Pseudomonas. Other infections: COVID-19 number of cases on the increase. Norovirus cases increased in May resulting in a number of ward/bay closures. Influenza not resulting in outbreaks with a small number of isolated cases. A deep dive into gram negative bloodstream infections was presented with data now including invasive devices and wounds. West remain unable to provide a decant solution to allow the implementation of full ward high level disinfection. The HABITS campaign continues to be promoted and supported across BCUHB and isolation is to be the focus during July. Occupational Health and well-being reported 35 needlestick/bodily fluid incidents in May compared with 20 the previous month. The originally calculated additional 33 Domestic Services roles to meet the COVID addendum (in each IHC) which had been confirmed as recurrently funded are under resourced against the currently calculated establishment, with the shortfall leading to inability to fulfil IPC requests for enhanced cleaning. • The **Regulatory Assurance Group** advised the CIW Annual Return had been submitted. • The **Patient Safety Group** reported timely progression of incidents to ILP remains an issue. The Patient Safety Team provide weekly update to all IHC/Divisions to allow tracker for the outstanding cases required for ILP with positive response, most notably highlighting where support is required to progress the review with escalation for those currently overdue which may also be linked to an inquest and Nationally Reportable Incident (NRI). Work is ongoing to review the current independent second practitioner check requirements for medicine administration. Once complete, recommendations will be presented to PSG for approval. There are no outstanding All Wales patient safety alerts. • The **Dementia Delivery Group** reported a need identified to refresh ToRs/membership of the group to align with a strengthened approach to IHC involvement in the dementia improvement work. Dementia Hospital Charter sub-groups being proposed in East, West, Central that would formally provide Chair's reports to DDT. • The **Patient and Carer Experience Group** reported In 2021 Welsh Government published a Code of Practice for Autism Services, on how all services being inclusive and accessible. The Equality & Human Rights Team are currently developing a series of guides which inform people on what to expect when they come to hospital (noises, environment etc.). Work is being undertaken to improve Emergency Department Feedback survey responses, QR codes have been placed on backs of chairs in the Emergency Department, to encourage patients to give feedback whilst they are waiting. An update was provided on the new NHS Wales patient and carer experience framework called 'People's Experience Framework'. The new framework will include a self-assessment audit for completion by Health Boards. Maternity and Neonatal are developing their own People's Experience Framework,

	this is a separate piece of work to the framework currently being developed. • The **Clinical Effectiveness Group** reported the May Strategic Clinical Effectiveness Group meeting was stood down due to an inability to find a Chair; all papers had been sent to the Group to review and these were attached for information to the meeting held in June, with the Group asked to note if anything specific required escalation. • The group approved MM41 Policy for the Covert Administration of Medication.

Cyfarfod a dyddiad: **Meeting and date:**	Quality, Safety & Experience 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:

6 June 2024

- Learning from Investigations Update

- Quality Report
- Insourcing Update
- Update on Urology Service Reconfiguration

Quality Safety and Experience – Annual Cycle of Committee Business

(1st April 2025 to the 31st March 2025)

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

The role of the Committee is set out in the Health Board's standing orders and the Terms of Reference, both of which are available here:

The **Quality Safety and Experience Committee** meets bi-monthly

Committee Chair: • Caroline Turner **Committee Vice Chair**	**Members** Mike Lavin Urtha Felda Williams Nichols	**In Attendance** • Angela Wood (Executive Director of Nursing and Midwifery) – Exec Lead • Nick Lyons (Executive Medical Director) • Gareth Evans (Acting Executive Director of Therapies and Health Science • Jane Moore (Acting Executive Director of Public Health	**Preliminary matters to be included on agenda:** Welcome & Apologies Declarations of Interest Unconfirmed minutes of meeting held on xxxx Matters Arising & Action Log

	MAY (JUNE)	JULY (AUG 15) Q1	SEPTEMBER Q2	NOVEMBER Q3	JANUARY Q4	MARCH Q4
PRELIMINARY MATTERS						
PATIENT STORY						
Patient Story						
SERVICE PRESENTATIONS – 30 mins						
IHC East						
Womens, Maternity and Gynaecology						
Children's						
IHC West						
Pharmaceutical Services						
Mental Health						
IHC Central	2025					
QUALITY PLANNING						
Clinical Services Plan *Executive Medical Director*		.				
Nursing Staffing (March & September)						
QUALITY CONTROL						
Integrated Quality Report • Patient Safety • Patient Experience • Clinical Effectiveness (Audit work) • Safeguarding • IPC • Regulatory • Legal *Executive Director of Nursing and Midwifery*						
Integrated Performance Report *Director of Performance*						
QUALITY IMPROVEMENT						
Quality Management System *Executive Medical Director*						
Challenged Services *Relevant Executive Director*	• Vascular	• Cancer • Oncology	• Dermatology (Plastics)	• Urgent and Emergency Care	• Ophthalmology	• Orthodontics

Note 1

	MAY (JUNE)	JULY (AUG 15) Q1	SEPTEMBER Q2	NOVEMBER Q3	JANUARY Q4	MARCH Q4
	• Stroke (2025)					
QUALITY ASSURANCE						
Update on the Royal College of Psychology Action Plan *Lead for Mental Health*						
ROUTINE REPORTING						
Corporate Risk Register						
Board Assurance Framework						
Internal Audit Reports (as and when required)						
ANNUAL REPORTING						
Committee Annual Report to Board						
Annual Quality Report • Duty of Candour • Putting Things Right (PTR)	Draft	Final				
Ombudsman Annual Letter						
Organ Donation						
Infection Prevention Control (IPC)						
Safeguarding		Possibly Sept				
Medicine Management (Controlled Drugs)						
Research and Development	2025					
FOR INFORMATION						
Any Clinical Policy (to be identified)						
NHS Wales – Joint Commissioning Committee Quality Committee Chairs Report						
Quality Delivery Chairs Assurance Report						
Summary of Business to be Reported from Private						
Committee Workplan						
Cycle of Business						
CLOSING BUSINESS						
Meeting Effectiveness						
Date of the Next Meeting						
Resolution to Exclude the Press and Public						

Note 1

	MAY (JUNE)	JULY (AUG 15) Q1	SEPTEMBER Q2	NOVEMBER Q3	JANUARY Q4	MARCH Q4
PRIVATE AGENDA						
Confidential Quality Report						

Note 1

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
11.06.24	QSE Agenda Setting	Chair	Primary Care	Update on the work that is ongoing	Ffion Johnstone	Angela Wood	September 2024	

Teitl adroddiad: ***Report title:***	Annual Organ and Tissue Donation Report
Adrodd i: ***Report to:***	Quality, Safety and Experience Committee
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 15 August 2024
Crynodeb Gweithredol: ***Executive Summary:***	This annual report highlights the ongoing relationship between BCUHB with NHS Blood and Transplant encompassing Organ and Tissue Donation and Transplantation during 2023-2024. The paper highlights the successful work undertaken by the BCUHB Organ and Tissue Donation Committee to ensure that Organ/Tissue donation remains an integral part of end-of-life care planning within Critical Care and the Emergency Departments. During 2023/24, from 15 consented donors, the Health Board facilitated 13 actual solid organ donors resulting in 32 patients receiving a life-saving or life-changing transplant. Additionally, 20 corneas were received by NHSBT Eye Banks from the Health Board. In Wales, 44% of the population have registered an NHSBT Organ Donor Register (ODR) opt in decision. This compares to 42% of the population. It has been demonstrated that UK consent rates are conclusively higher when a Specialist Nurse Organ donation (SNOD) is present for the organ donation conversation with family. In this period a SNOD was present for 100% of the time. The BCUHB SNOD team work hard to ensure that all end-of-life care conversations involving the option of Organ and Tissue donation are done in a supportive and respectful manner. Our collective focus is to uphold the decisions made by the potential donor whilst respecting the wishes of grieving families.
Argymhellion: ***Recommendations:***	The Committee is asked to note for information the report contents and in particular in respect to quality of care in organ donation in 2023-24, when compared with national data, the Health Board: • Is in line with the national average for the referral of potential organ donors • Is exceptional for Specialist Nurse presence when approaching families to discuss organ donation • Referred 146 patients to NHSBT's Organ Donation Services Team; 87 met the referral criteria and were included in the UK Potential Donor Audit. There were a further 6 audited patients that were not referred. • Ensured a Specialist Nurse was present for 18 organ donation discussions with families of eligible donors. There were no occasions when a Specialist Nurse was absent for the donation discussion.

Arweinydd Gweithredol: ***Executive Lead:***	Executive Director AHPs and Health Science			
Awdur yr Adroddiad: ***Report Author:***	NHS Blood and Transplant			
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 primary strategic link is to the unscheduled care progarmme and to critical care improvement, with some key considerations: Organ donation work is unscheduled therefore meets the criteria for emergency treatment. To have achieved the successes of this period is a credit to the workforce within BCUHB. The effort has placed an enormous workload on under pressure units. Theatre space in particular can be problematic due to the anticipated pressure on lists. Bed pressures within ITU have represented a challenge at times and will continue to do so. Adherance to the DBI Pathway and NDT Protocols within BCUHB continue to be exemplarly, despite the prolonged ITU stay that this generates. This gold standard of practice invariably has a positive result on Organ Donation and good end of life care. Organ Donation remains a critical area of practice UK Wide with donor numbers increasing yearly along with transplant lists. Each donor has the potential for 9 life-saving transplants so the need for emergency			

	care/treatemnt will continually feature within Critical Care Practice.
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	Organ and Tissue Donation is bound to the Human Tissue Authority. In Wales we are required to seek compliance within the boundaries of the Wales Human Tissue Authority Act 2013. Of significance is the approach and consent conversation; application of Deemed Consent has a rigid legal framework that the Specialist Nurse Organ Donation (SNOD) are trained to apply, thus pre-approaching potential donor families should now be constrained to historic practice.
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***	none
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	As a team from NHSBT covering the North West of England and North Wales the workforce is mainly English speaking. However, we have 2 Welsh Speakers in the team who are available to facilitate conversations in Welsh if needed. Our promotional work is always bilingual and we have a great working relationship with the BCUHB Communication Team
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	Prior scrutiny: BCUHB Organ and Tissue Donation Committee

Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	BAF Risk of the provision of poor standards of care to the patients and population of North Wales, falling below the expected standards of quality and safety, resulting in a deterioration of care and harm to patients and service users
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:

Next Steps:
Continued efforts to support and improve Organ and Tissue Donation and Transplantation services in North Wales through:

The Health Board continuing to support the Organ and Tissue Donation Committee and Clinical Lead for Organ Donation in promoting best practice as they seek to minimise missed donation opportunities through the work of the Organ and Tissue Donation committee.

The Health Board ensuring activity and quality data within North Wales is discussed at the Organ and Tissue Donation Committee with support from the Organ Donation Committee Chair

Recognising and celebrating the success the Health Board has in facilitating donation or transplantation and promotes opt-in registration on the NHSBT Organ Donor Register Organ via a series of ongoing events, activities and memorial services each year.

Rhestr o Atodiadau:
Dim

List of Appendices:
None

Detailed Report

Actual and Potential Deceased Organ Donation

1 April 2023 - 31 March 2024

Betsi Cadwaladr University Health Board

Table of Contents

Further Information

- Appendix A.1 contains definitions of terms and abbreviations used throughout this report and summarises the main changes made to the PDA over time.
- The latest Organ Donation and Transplantation Activity Report is available at https://www.organdonation.nhs.uk/supporting-my-decision/statistics-about-organ-donation/transplant-activity-report/
- The latest PDA Annual Report and our Power BI reports with up to date Health Board metrics are available at https://www.odt.nhs.uk/statistics-and-reports/potential-donor-audit-report/.
- Please refer any queries or requests for further information to your local Specialist Nurse - Organ Donation (SNOD)

Source

NHS Blood and Transplant: UK Transplant Registry (UKTR), Potential Donor Audit (PDA) and Referral Record.
Issued May 2024 based on data meeting PDA criteria reported at 8 May 2024.

1. Donor Outcomes

A summary of the number of donors, patients transplanted, average number of organs donated per donor and organs donated.

Data in this section is obtained from the UK Transplant Registry

Between 1 April 2023 and 31 March 2024, Betsi Cadwaladr University Health Board had 13 deceased solid organ donors, resulting in 32 patients receiving a transplant. Additional information is shown in Tables 1.1 and 1.2, along with comparison data for 2022/23. Figure 1.1 shows the number of donors and patients transplanted for the previous ten periods for comparison.

Table 1.1 Donors, patients transplanted and organs per donor, 1 April 2023 - 31 March 2024 (1 April 2022 - 31 March 2023 for comparison)

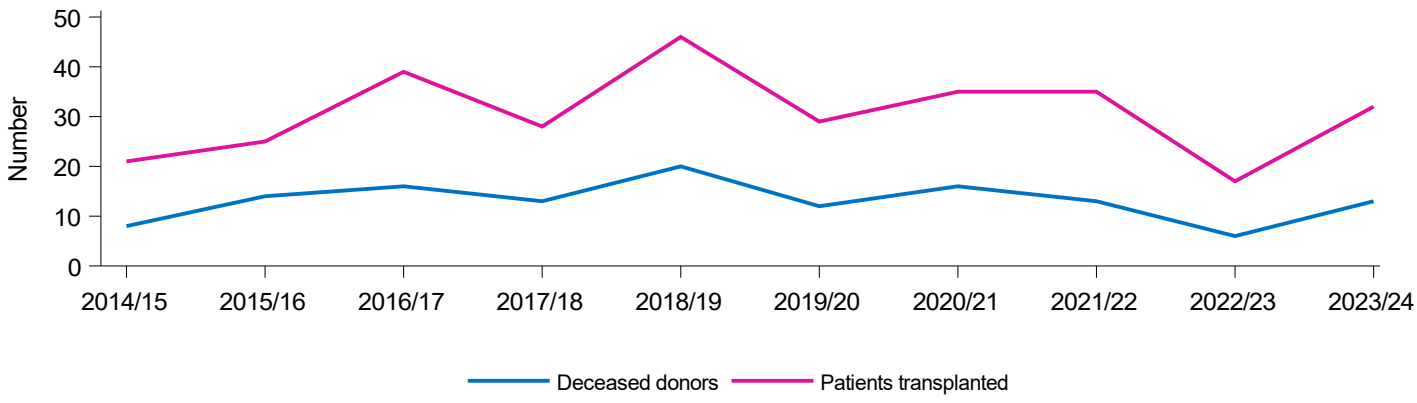
Donor type	Number of donors		Number of patients transplanted		Average number of organs donated per donor: Health Board		UK	
DBD	9	(5)	24	(15)	3.6	(3.4)	3.6	(3.4)
DCD	4	(1)	8	(2)	2.3	(2.0)	2.9	(2.8)
DBD and DCD	13	(6)	32	(17)	3.2	(3.2)	3.2	(3.2)

In addition to the 13 proceeding donors there were 2 additional consented donors that did not proceed, all where DCD donation was being facilitated.

Table 1.2 Organs transplanted by type, 1 April 2023 - 31 March 2024 (1 April 2022 - 31 March 2023 for comparison)

Donor type	Number of organs transplanted by type: Kidney		Pancreas		Liver		Heart		Lung		Small bowel	
DBD	16	(10)	2	(1)	5	(4)	2	(2)	2	(0)	0	(0)
DCD	7	(2)	0	(0)	1	(0)	0	(0)	0	(0)	0	(0)
DBD and DCD	23	(12)	2	(1)	6	(4)	2	(2)	2	(0)	0	(0)

Figure 1.1 Number of donors and patients transplanted, 1 April 2014 - 31 March 2024



2. Key Rates in Potential for Organ Donation

A summary of the key rates on the potential for organ donation

Data in this section is obtained from the National Potential Donor Audit (PDA)

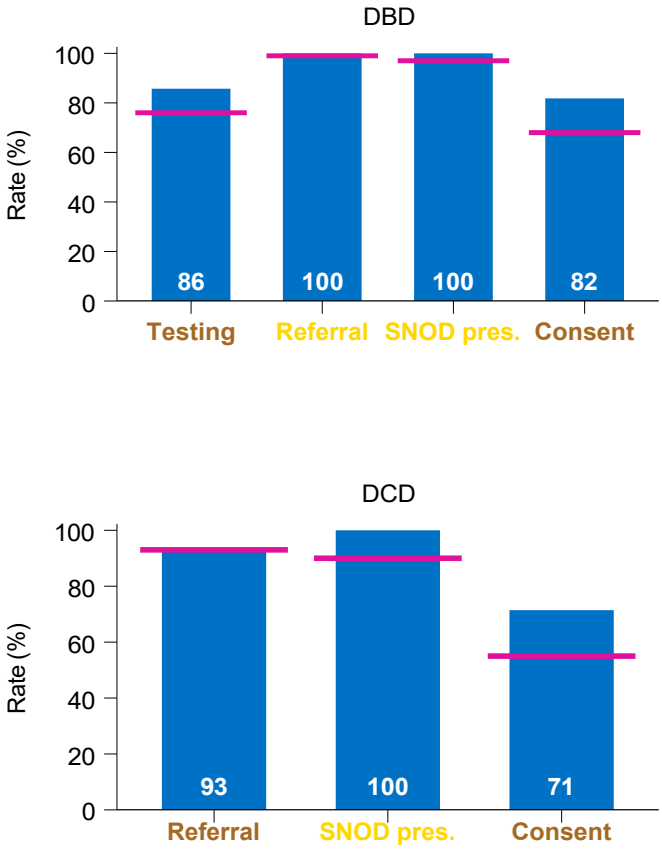
This section presents specific percentage measures of potential donation activity for Betsi Cadwaladr University Health Board.

Performance in your Health Board has been compared with UK performance in both Figure 2.1 and Table 2.1 using funnel plot boundaries and the Gold, Silver, Bronze, Amber, and Red (GoSBAR) colour scheme. When compared with UK performance, gold represents exceptional, silver represents good, bronze represents average, amber represents below average, and red represents poor performance. See Appendix A.3 for funnel plot ranges used.

It is acknowledged that the PDA does not capture all activity. There may be some patients referred in 2023/24 who are not included in this section onwards because they were either over 80 years of age or did not die in a unit participating in the PDA.

Note that caution should be applied when interpreting percentages based on small numbers.

Figure 2.1 Key rates on the potential for organ donation including UK comparison, 1 April 2023 - 31 March 2024



H. Board — UK

Gold | Silver | Bronze | Amber | Red

Figure 2.2 Trends in key rates on the potential for organ donation, 1 April 2019 - 31 March 2024

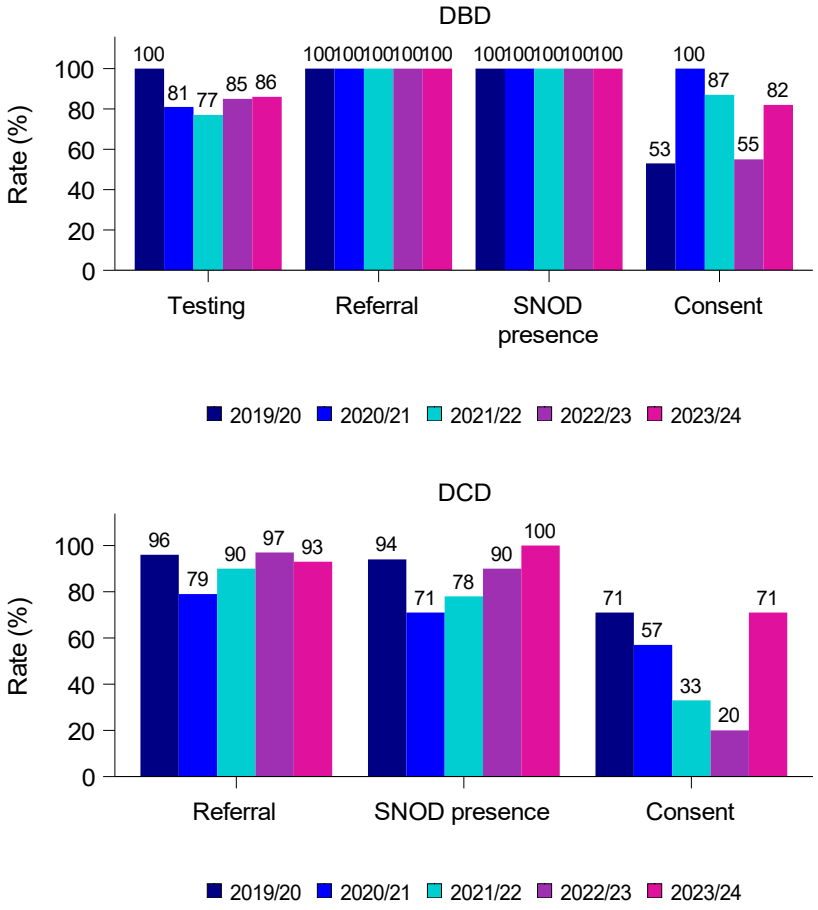


Table 2.1 Key numbers, rates and comparison with national rates, 1 April 2023 - 31 March 2024

	DBD		DCD		Deceased donors	
	H. Board	UK	H. Board	UK	H. Board	UK
Patients meeting organ donation referral criteria[1]	14	2029	82	5331	93	6911
Referred to Organ Donation Service	14	2017	76	4949	87	6522
Referral rate %	G *100%*	*99%*	B *93%*	*93%*	B *94%*	*94%*
Neurological death tested	12	1534				
Testing rate %	B *86%*	*76%*				
Eligible donors[2]	11	1426	65	3635	76	5061
Family approached	11	1259	7	1849	18	3108
Family approached and SNOD present	11	1215	7	1672	18	2887
% of approaches where SNOD present	G *100%*	*97%*	G *100%*	*90%*	G *100%*	*93%*
Consent ascertained	9	858	5	1023	14	1881
Consent rate %	B *82%*	*68%*	B *71%*	*55%*	B *78%*	*61%*
- Expressed opt in	4	533	2	637	6	1170
- Expressed opt in %	*80%*	*95%*	*67%*	*85%*	*75%*	*89%*
- Deemed Consent	4	246	2	323	6	569
- Deemed Consent %	*100%*	*58%*	*100%*	*47%*	*100%*	*51%*
- Other*	1	78	1	63	2	141
- Other %*	*100%*	*52%*	*100%*	*34%*	*100%*	*42%*
Actual donors (PDA data)	9	788	4	710	13	1499
% of consented donors that became actual donors	*100%*	*92%*	*80%*	*69%*	*93%*	*80%*

[1] DBD - A patient with suspected neurological death
DCD - A patient in whom imminent death is anticipated, ie a patient receiving assisted ventilation, a clinical decision to withdraw treatment has been made and death is anticipated within 4 hours

[2] DBD - Death confirmed by neurological tests and no absolute contraindications to solid organ donation
DCD - Imminent death anticipated and treatment withdrawn with no absolute contraindications to solid organ donation

* Includes patients where nation specific deemed criteria are not met and the patient has not expressed a donation decision in accordance with relevant legislation

Note that a patient that meets both the referral criteria for DBD and DCD organ donation is featured in both the DBD and DCD data but will only be counted once in the deceased donors total

Gold Silver Bronze Amber Red

3. Best quality of care in organ donation

Key stages in best quality of care in organ donation

Data in this section is obtained from the National Potential Donor Audit (PDA)

This section provides information on the quality of care in your Health Board at the key stages of organ donation. The ambition is that your Health Board misses no opportunity to make a transplant happen and that opportunities are maximised at every stage.

3.1 Neurological death testing

Goal: neurological death tests are performed wherever possible.

Figure 3.1 Number of patients with suspected neurological death, 1 April 2019 - 31 March 2024

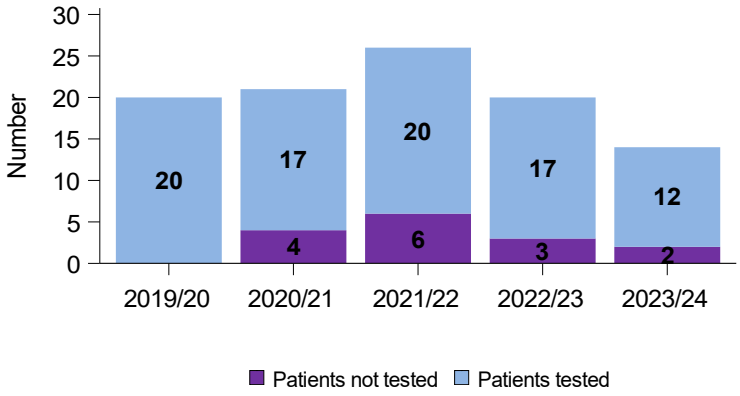


Table 3.1 Reasons given for neurological death tests not being performed, 1 April 2023 - 31 March 2024

	Health Board	UK
Biochemical/endocrine abnormality	-	32
Clinical reason/Clinician's decision	-	72
Continuing effects of sedatives	-	15
Family declined donation	-	40
Family pressure not to test	1	55
Hypothermia	-	1
Inability to test all reflexes	-	20
Medical contraindication to donation	-	5
Other	-	58
Patient had previously expressed a wish not to donate	-	4
Patient haemodynamically unstable	1	151
Pressure of ICU beds	-	1
SN-OD advised that donor not suitable	-	13
Treatment withdrawn	-	20
Unknown	-	8
Total	**2**	**495**

If 'other', please contact your local SNOD or CLOD for more information, if required.

3.2 Referral to Organ Donation Service

Goal: Every patient who meets the referral criteria should be identified and referred to the Organ Donation Service, as per NICE CG135[1] and NHS Blood and Transplant (NHSBT) Best Practice Guidance on timely identification and referral of potential organ donors[2].

Aim: There should be no purple on the following charts.

Note that patients who met the referral criteria for both DBD and DCD donation will appear in both bar charts and both columns of the reasons table.

Figure 3.2 Number of patients meeting referral criteria, 1 April 2019 - 31 March 2024

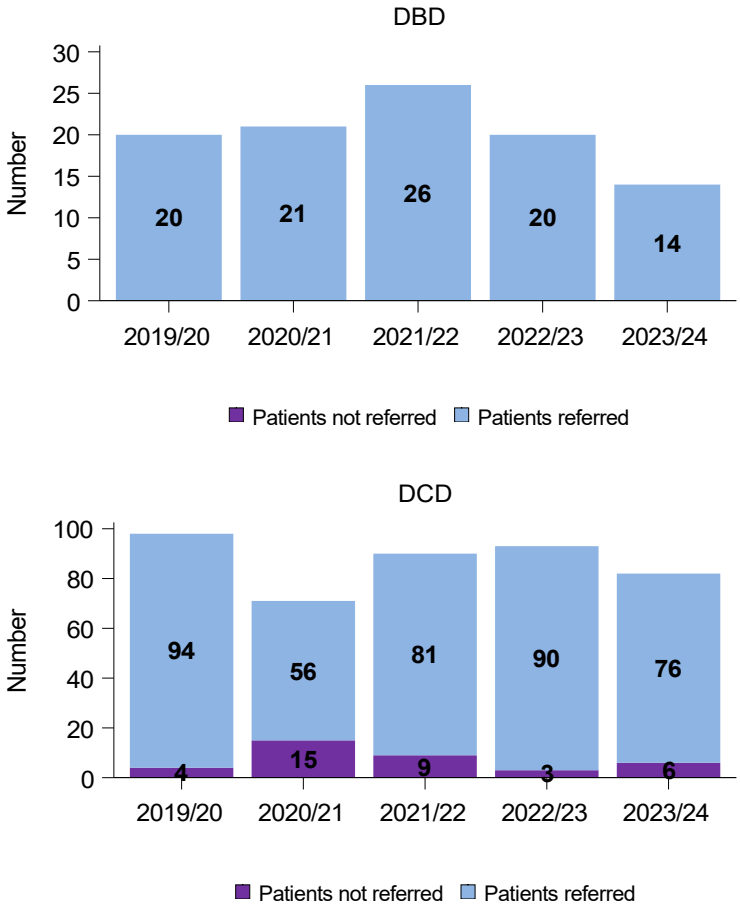


Table 3.2 Reasons given why patient not referred to SNOD, 1 April 2023 - 31 March 2024

	DBD		DCD	
	Health Board	UK	Health Board	UK
Clinician assessed that patient was unlikely to become asystolic within 4 hours	-	-	-	4
Coroner / Procurator Fiscal reason	-	1	-	-
Family declined donation following decision to remove treatment	-	-	-	9
Family declined donation prior to neurological testing	-	-	-	1
Medical contraindications	-	-	-	42
Not identified as potential donor/organ donation not considered	-	8	4	260
Other	-	1	1	9
Patient had previously expressed a wish not to donate	-	-	-	2

If 'other', please contact your local SNOD or CLOD for more information, if required.

Table 3.2 Reasons given why patient not referred to SNOD, 1 April 2023 - 31 March 2024

	DBD		DCD	
	Health Board	UK	Health Board	UK
Pressure on ICU beds	-	-	-	5
Reluctance to approach family	-	-	-	2
Thought to be medically unsuitable	-	-	1	42
Uncontrolled death pre referral trigger	-	2	-	6
Total	**-**	**12**	**6**	**382**

If 'other', please contact your local SNOD or CLOD for more information, if required.

3.3 Contraindications

In 2023/24 there were 18 potential donors in your Health Board with an ACI reported, 3 DBD and 18 DCD donors. Please note, the number of potential DBD and DCD donors with an ACI reported may not equal the total stated as a patient can meet potential donor criteria for both DBD and DCD donation.

3.4 SNOD presence

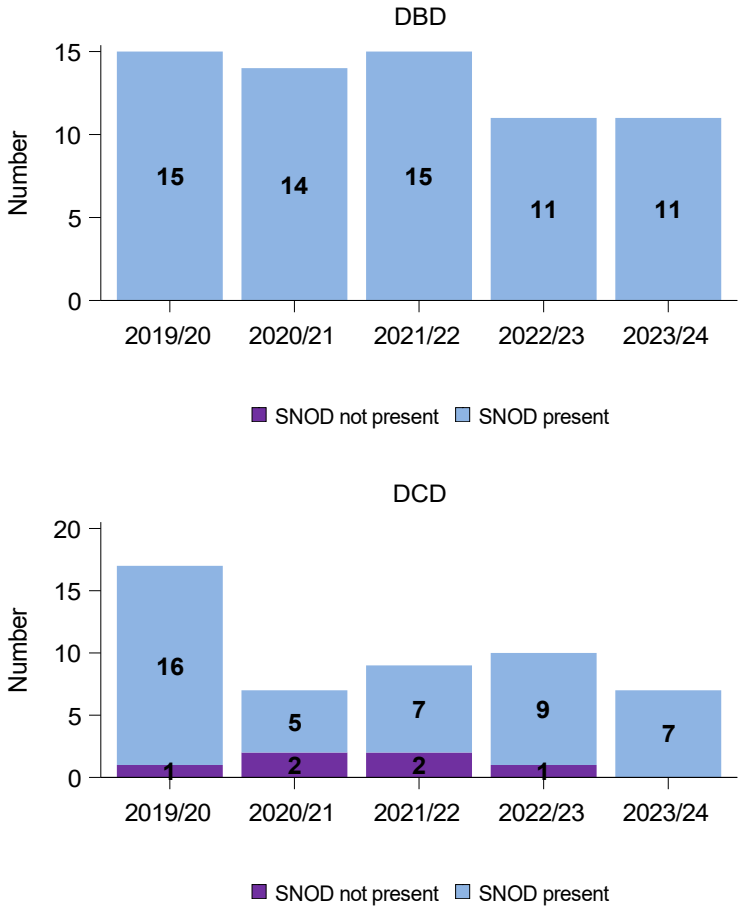
Goal: A SNOD should be present during the formal family approach as per NICE CG135[1] and NHS Blood and Transplant (NHSBT) Best Practice Guidance.[3]

Aim: There should be no purple on the following charts.

In the UK, in 2023/24, when a SNOD was not present for the approach to the family to discuss organ donation, DBD and DCD consent/authorisation rates were 23% and 14%, respectively, compared with DBD and DCD consent/authorisation rates of 70% and 60%, respectively, when a SNOD was present.

Every approach to those close to the patient should be planned with the multidisciplinary team (MDT), should involve the SNOD and should be clearly planned taking into account the known decision of the patient. The NHS Organ Donor Register (ODR) should be checked in all cases of potential donation and this information must be discussed with the family as it represents the eligible donor's legal consent to donation.

Figure 3.3 Number of families approached by SNOD presence, 1 April 2019 - 31 March 2024



[1] NICE, 2011.
NICE Clinical Guidelines - CG135
[accessed 8 May 2024]

[2] NHS Blood and Transplant, 2012.
Timely Identification and Referral of Potential Organ Donors - A Strategy for Implementation of Best Practice
[accessed 8 May 2024]

[3] NHS Blood and Transplant, 2013.
Approaching the Families of Potential Organ Donors – Best Practice Guidance
[accessed 8 May 2024]

3.5 Consent

In 2023/24 the DBD consent rate in your Health Board was 82%, less than 10 families of eligible DCD donors were approached therefore this consent rate is not presented.

Figure 3.4 Number of families approached, 1 April 2019 - 31 March 2024

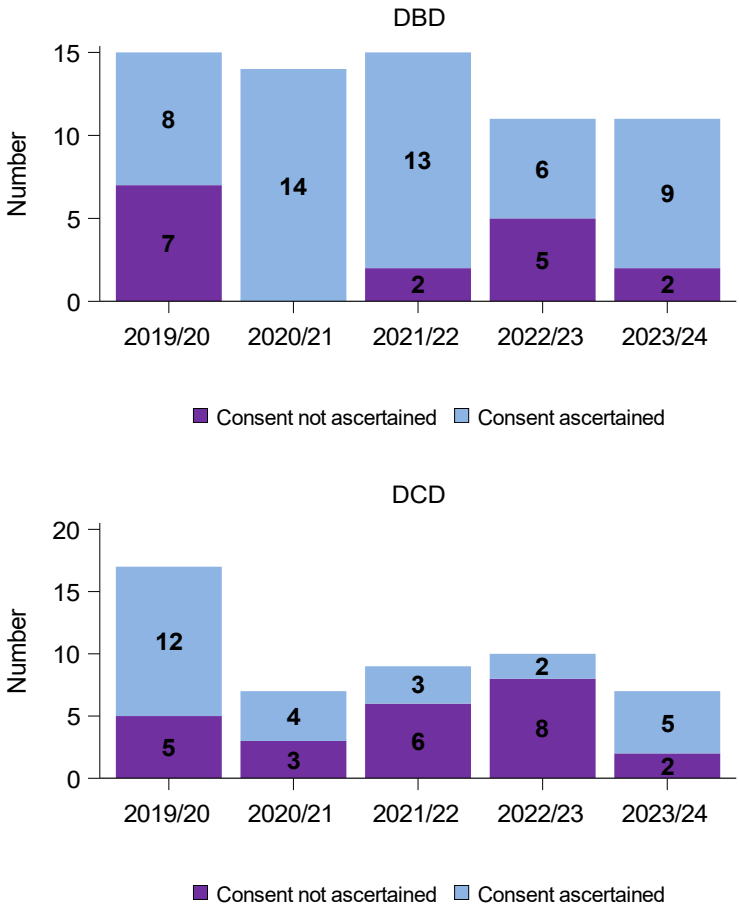


Table 3.3 Reasons given why consent was not ascertained, 1 April 2023 - 31 March 2024

	DBD		DCD	
	Health Board	UK	Health Board	UK
Family believe patient's treatment may have been limited to facilitate organ donation	-	-	-	1
Family concerned other people may disapprove/be offended	-	3	-	4
Family concerned that organs may not be transplantable	-	2	-	8
Family did not believe in donation	-	5	-	9
Family did not want surgery to the body	-	42	-	57
Family divided over the decision	-	12	-	20
Family felt it was against their religious/cultural beliefs	-	49	-	28
Family felt patient had suffered enough	-	24	1	78
Family felt that the body should be buried whole (unrelated to religious/cultural reasons)	-	13	-	17
Family felt the length of time for the donation process was too long	-	30	-	167

If 'other', please contact your local SNOD or CLOD for more information, if required.

Table 3.3 Reasons given why consent was not ascertained, 1 April 2023 - 31 March 2024

	DBD		DCD	
	Health Board	UK	Health Board	UK
Family had difficulty understanding/accepting neurological testing	-	3	-	-
Family wanted to stay with the patient after death	-	5	-	17
Family were not sure whether the patient would have agreed to donation	-	49	-	113
Other	1	24	-	57
Patient had previously expressed a wish not to donate	-	94	1	167
Patient had registered a decision to Opt Out	1	21	-	43
Strong refusal - probing not appropriate	-	25	-	39
Total	**2**	**401**	**2**	**825**

If 'other', please contact your local SNOD or CLOD for more information, if required.

3.6 Solid organ donation

Goal: NHSBT is committed to supporting transplant units to ensure as many organs as possible are safely transplanted.

Table 3.4 Reasons why solid organ donation did not occur, 1 April 2023 - 31 March 2024

	DBD		DCD	
	Health Board	UK	Health Board	UK
Clinical - Absolute contraindication to organ donation	-	3	-	5
Clinical - Considered high risk donor	-	4	-	8
Clinical - DCD clinical exclusion	-	-	-	2
Clinical - No transplantable organ	-	7	-	12
Clinical - Organs deemed medically unsuitable by recipient centres	-	17	-	58
Clinical - Organs deemed medically unsuitable on surgical inspection	-	9	-	6
Clinical - Other	-	3	-	7
Clinical - PTA post WLST	-	-	1	164
Clinical - Patient actively dying	-	4	-	7
Clinical - Patient asystolic	-	3	-	1
Clinical - Patient's general medical condition	-	1	-	6
Clinical - Positive virology	-	2	-	-
Clinical - Predicted PTA therefore not attended	-	-	-	1
Consent / Auth - Coroner/Procurator fiscal refusal	-	10	-	8
Consent / Auth - Family placed conditions on donation	-	-	-	1
Consent / Auth - NOK declined organ donation	-	1	-	-
Consent / Auth - NOK withdraw consent / authorisation	-	6	-	22
Consent / Auth - Other	-	-	-	1
Logistical - Other	-	-	-	1
Logistical - Retrieval team not available	-	-	-	1
Logistical - Unit unable to maintain patient	-	-	-	1
Total	**-**	**70**	**1**	**312**

If 'other', please contact your local SNOD or CLOD for more information, if required.

4. Comparative Data

A comparison of performance in your Trust/Board with national data

Data in this section is obtained from the National Potential Donor Audit (PDA)

This section compares the quality of care in the key areas of organ donation in your Health Board with the UK rate using funnel plots. The UK rate is shown as a green dashed line and the funnel shape is formed by the 95% and 99.8% confidence limits around the UK rate. The confidence limits reflect the level of precision of the UK rate relative to the number of observations. Performance in your Health Board is indicated by a black cross. The Gold, Silver, Bronze, Amber, and Red colour scheme is used to indicate whether performance in your Health Board, when compared to UK performance, is exceptional (gold), good (silver), average (bronze), below average (amber) or poor (red).

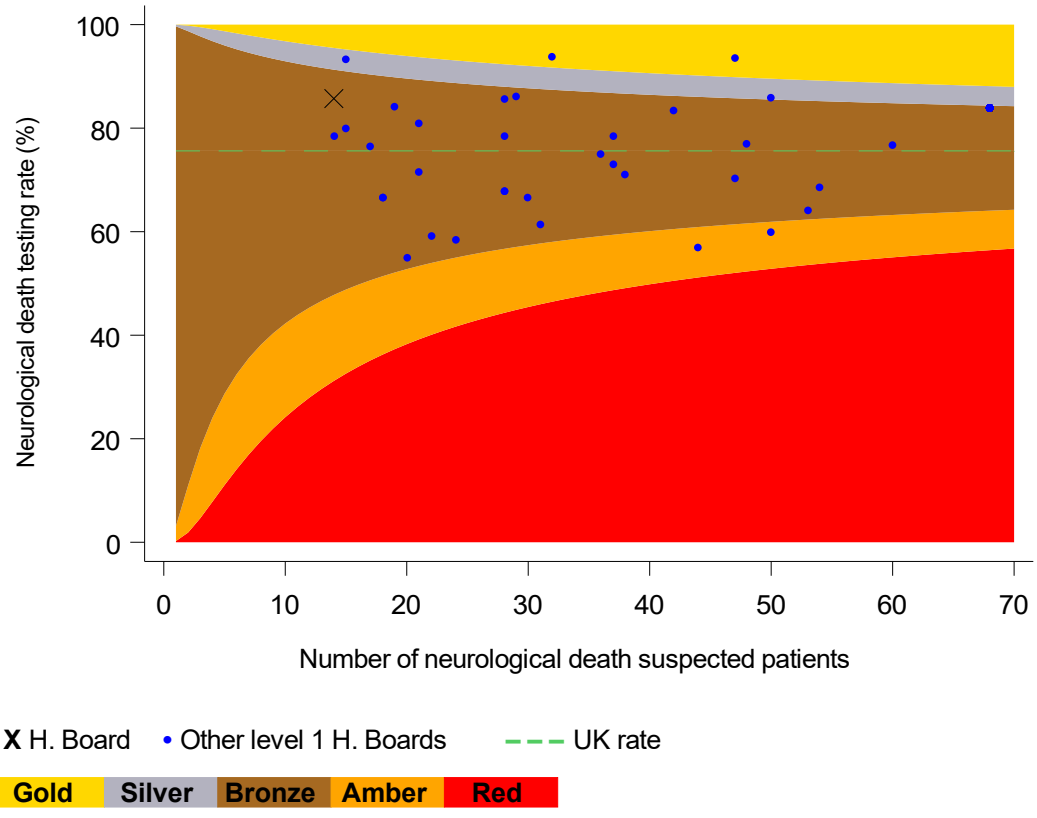
It is important to note that the differences in patient mix have not been accounted for in these plots. Further to these, separate funnel plots for DBD and DCD rates are presented in Section 7.

Note that caution should be applied when interpreting percentages calculated with numbers less than 10.

4.1 Neurological death testing

Goal: neurological death tests are performed wherever possible.

Figure 4.1 Funnel plot of neurological death testing rate, 1 April 2023 - 31 March 2024

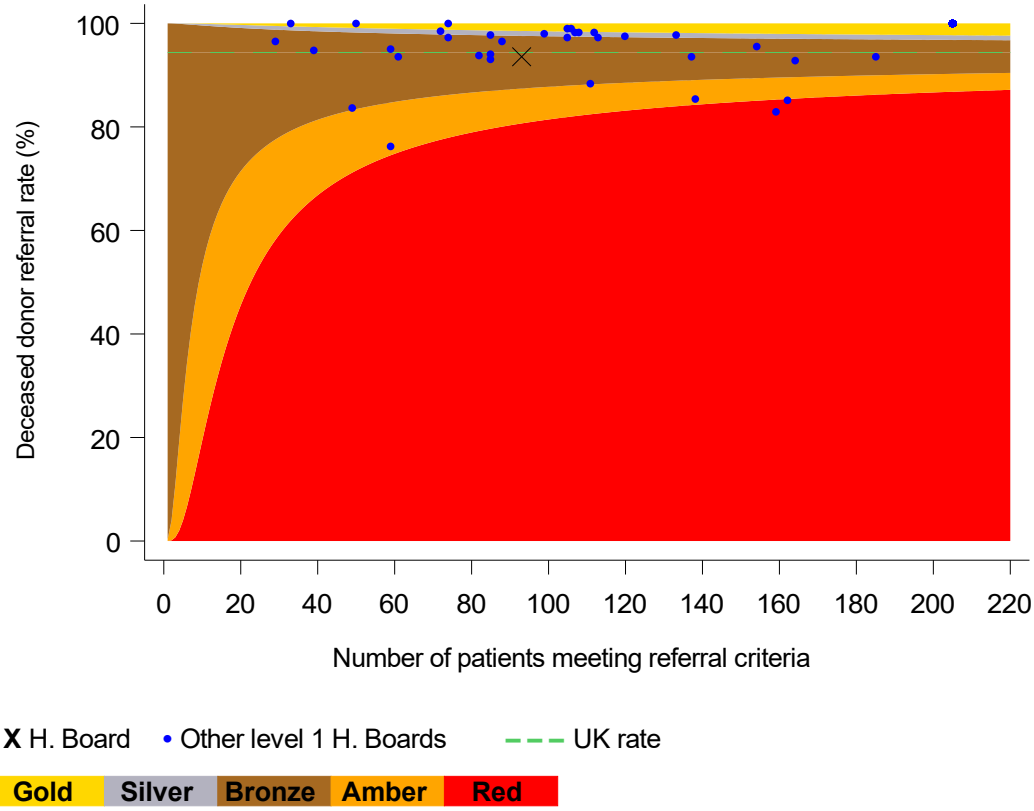


When compared with UK performance the neurological death testing rate in Betsi Cadwaladr University Health Board was average (bronze).

4.2 Referral to Organ Donation Service

Goal: Every patient who meets the referral criteria should be identified and referred to NHSBT's Organ Donation Service, as per NICE CG135[1] and NHS Blood and Transplant (NHSBT) Best Practice Guidance on timely identification and referral of potential organ donors[2].

Figure 4.2 Funnel plot of deceased donor referral rate, 1 April 2023 - 31 March 2024

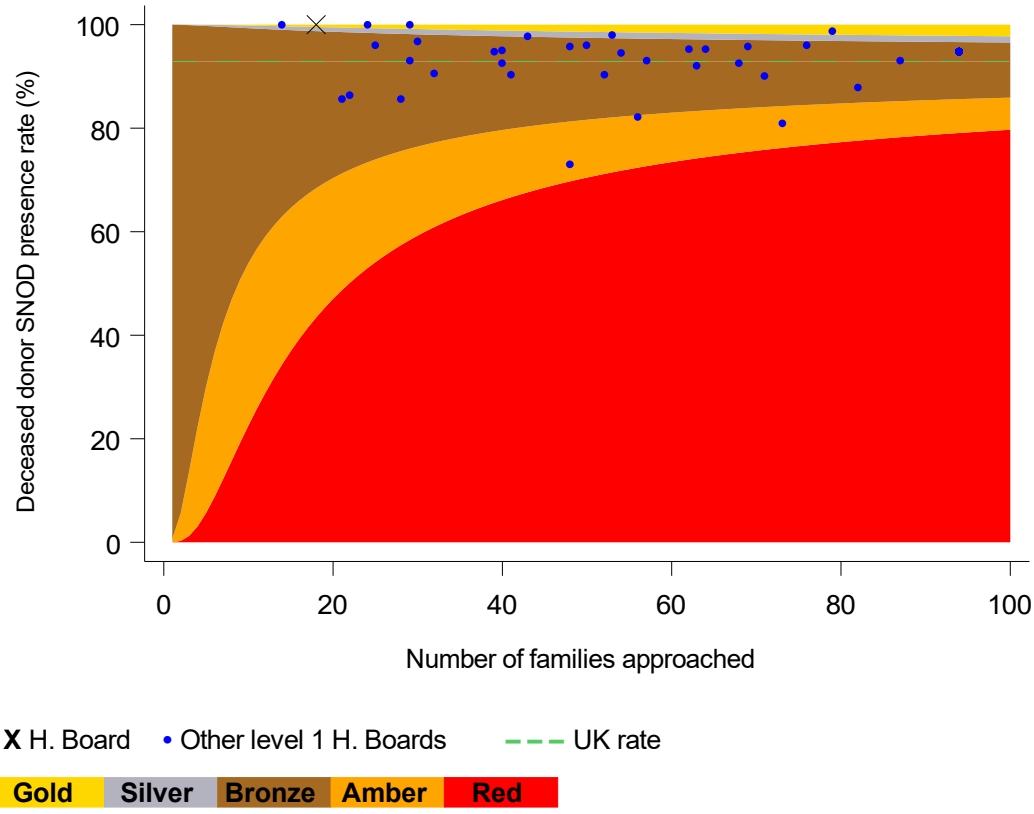


When compared with UK performance Betsi Cadwaladr University Health Board was average (bronze) for referral of potential organ donors to NHS Blood and Transplant's Organ Donation Service.

4.3 SNOD presence

Goal: A SNOD should be present during the formal family approach as per NICE CG135[1] and NHS Blood and Transplant (NHSBT) Best Practice Guidance.[3]

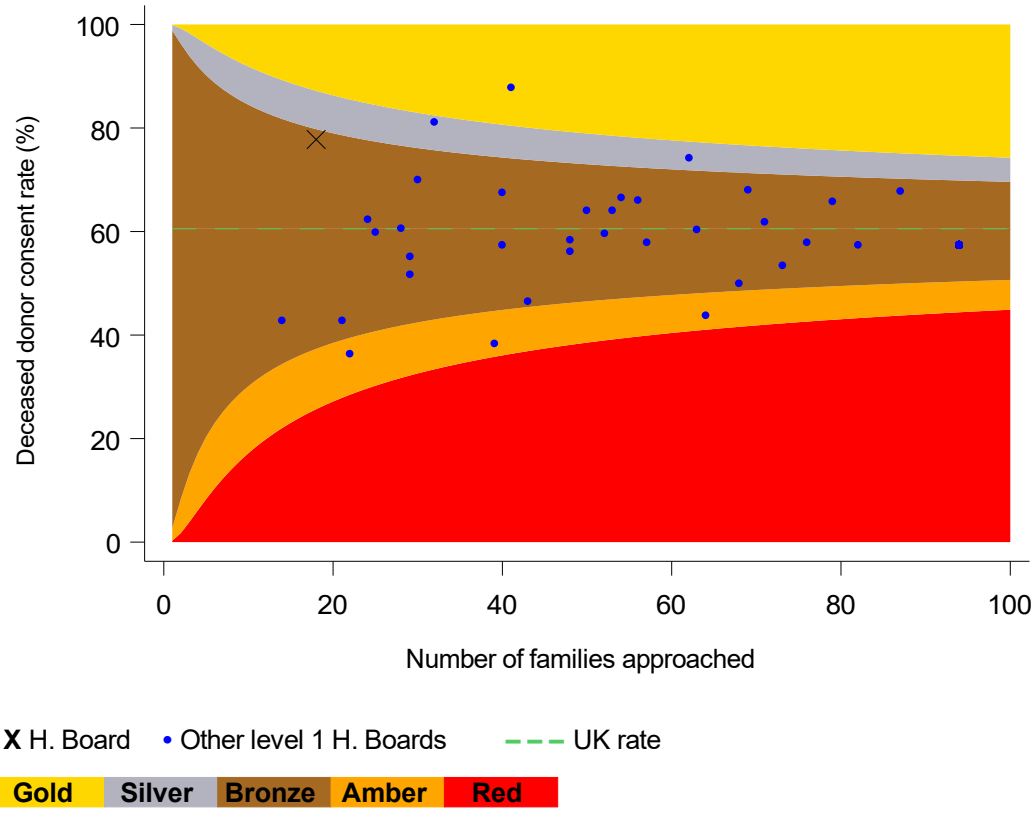
Figure 4.3 Funnel plot of SNOD presence rate, 1 April 2023 - 31 March 2024



When compared with UK performance Betsi Cadwaladr University Health Board was exceptional (gold) for Specialist Nurse presence when approaching families to discuss organ donation.

4.4 Consent

Figure 4.4 Funnel plot of consent rate, 1 April 2023 - 31 March 2024



When compared with UK performance the consent rate in Betsi Cadwaladr University Health Board was average (bronze).

5. PDA data by hospital and unit

A summary of key numbers and rates from the PDA by hospital and unit where patient died

Data in this section is obtained from the National Potential Donor Audit (PDA)

Tables 5.1 and 5.2 show the key numbers and rates for patients who met the DBD and/or DCD referral criteria, respectively. Percentages have been excluded where numbers are less than 10.

Table 5.1 Patients who met the DBD referral criteria - key numbers and rates, 1 April 2023 - 31 March 2024

Unit where patient died	Patients where neurological death was suspected	Patients tested	Neurological death testing rate (%)	Patients referred	DBD referral rate (%)	Patients confirmed dead by neurological testing	Eligible DBD donors	Eligible DBD donors whose family were approached	Approaches where SNOD present	SNOD presence rate (%)	Consent ascertained	Consent rate (%)	Actual DBD and DCD donors from eligible DBD donors
Bangor, Ysbyty Gwynedd District General Hospital													
A & E	0	0	-	0	-	0	0	0	0	-	0	-	0
General ICU/HDU	5	4	-	5	-	3	3	3	3	-	3	-	3
Bodelwyddan, Glan Clwyd District General Hospital													
A & E	0	0	-	0	-	0	0	0	0	-	0	-	0
General ICU/HDU	5	4	-	5	-	4	4	4	4	-	2	-	2
Wrexham, Maelor General Hospital													
A & E	0	0	-	0	-	0	0	0	0	-	0	-	0
General ICU/HDU	4	4	-	4	-	4	4	4	4	-	4	-	4

Table 5.2 Patients who met the DCD referral criteria - key numbers and rates, 1 April 2023 - 31 March 2024

Unit where patient died	Patients for whom imminent death was anticipated	Patients referred	DCD referral rate (%)	Patients for whom treatment was withdrawn	Eligible DCD donors	Eligible DCD donors whose family were approached	Approaches where SNOD present	SNOD presence rate (%)	Consent ascertained	Consent rate (%)	Actual DCD donors from eligible DCD donors
Bangor, Ysbyty Gwynedd District General Hospital											
A & E	0	0	-	0	0	0	0	-	0	-	0
General ICU/HDU	21	20	95	20	12	3	3	-	2	-	2
Bodelwyddan, Glan Clwyd District General Hospital											
A & E	3	1	-	3	2	0	0	-	0	-	0
General ICU/HDU	27	25	93	27	25	1	1	-	0	-	0
Wrexham, Maelor General Hospital											
A & E	0	0	-	0	0	0	0	-	0	-	0
General ICU/HDU	31	30	97	31	26	3	3	-	3	-	2

Tables 5.1 and 5.2 show the unit where the patient died. However, it is acknowledged that there are some occasions where a patient is referred in an Emergency Department but moves to a critical care unit. In total for Betsi Cadwaladr University Health Board in 2023/24 there were 0 such patients. For more information regarding the Emergency Department please see Section 6.

6. Emergency Department data

A summary of key numbers for Emergency Departments

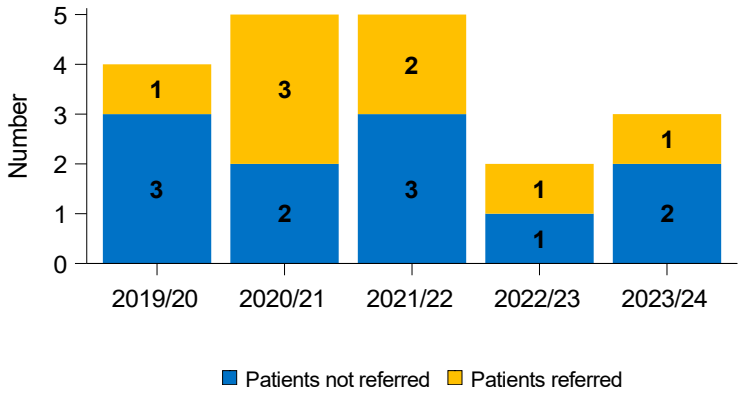
Data in this section is obtained from the National Potential Donor Audit (PDA)

Most patients who go on to become organ donors start their journey in the emergency department (ED). Deceased donation is important, not just for those people waiting on the transplant list, but also because many people in the UK have expressed a decision in life to become organ donors after their death. The overarching principle of the NHSBT Organ donation and Emergency Department strategy [4] is that best quality of care in organ donation should be followed irrespective of the location of the patient within the hospital at the time of death.

6.1 Referral to Organ Donation Service

Goal: No one dies in your ED meeting referral criteria and is not referred to NHSBT's Organ Donation Service.
Aim: There should be no blue on the following chart.

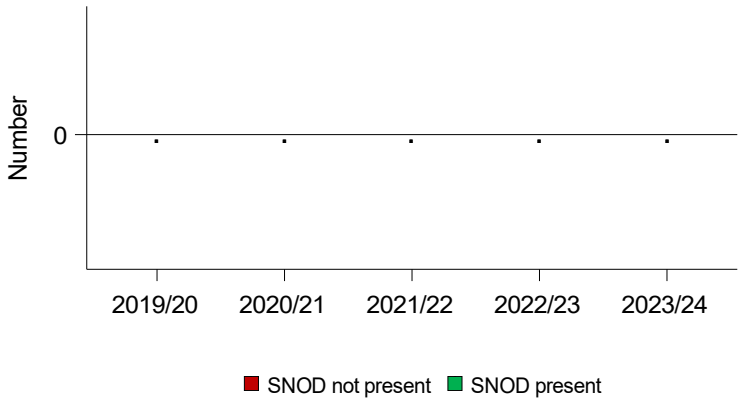
Figure 6.1 Number of patients meeting referral criteria that died in the ED, 1 April 2019 - 31 March 2024



6.2 Organ donation discussions

Goal: No family is approached in ED regarding organ donation without a SNOD present.
Aim: There should be no red on the following chart.

Figure 6.2 Number of families approached in ED by SNOD presence, 1 April 2019 - 31 March 2024



[4] NHS Blood and Transplant, 2016.
Organ Donation and the Emergency Department
[accessed 8 May 2024]

7. Additional data and figures

Regional donor, transplant, and transplant list numbers

Data in this section is obtained from the UK Transplant Registry

7.1 Supplementary Regional data

Table 7.1 Regional donors, transplants, waiting list, and NHS Organ Donor Register (ODR) data

	Wales*	UK
1 April 2023 - 31 March 2024		
Deceased donors	57	1,510
Transplants from deceased donors	154	3,723
Deaths on the transplant list	15	418
As at 31 March 2024		
Active transplant list	271	7,484
Number of NHS ODR opt-in registrations (% registered)**	1,376,148 (44%)	28,161,705 (42%)
Number of NHS ODR opt-out registrations (% registered)**	189,059 (6%)	2,577,667 (4%)

*Regions are defined using the NHS region definitions
** % registered based on population of 3.11 million, based on ONS 2021 census data

Key numbers and rates on the potential for organ donation

Data in this section is obtained from the National Potential Donor Audit (PDA)

7.2 Trust/Board Level Benchmarking

Betsi Cadwaladr University Health Board has been categorised as a level 1 Health Board. Levels were reallocated in July 2018 using the average number of donors in 2016/17 and 2017/18, Table 7.2 shows the criteria used and how many Trusts/Boards belong to each level.

Table 7.2 Trust/Board level categories

		Number of Trusts Boards in each level
Level 1	12 or more (≥ 12) proceeding donors per year	36
Level 2	6 or more but less than 12 (≥ 6 to <12) proceeding donors per year	51
Level 3	More than 3 but less than 6 (>3 to <6) proceeding donors per year	31
Level 4	3 or less (≤ 3) proceeding donors per year	39

Tables 7.3 and 7.4 show the national DBD and DCD key numbers and rates for the UK by Trust/Board level, to aid in comparison with equivalent Trusts/Boards. Note that percentages have been excluded where numbers are less than 10.

Table 7.3 National DBD key numbers and rate by Trust/Board level, 1 April 2023 - 31 March 2024

	Patients where neurological death was suspected	Patients tested	Neurological death testing rate (%)	Patients referred	DBD referral rate (%)	Patients confirmed dead by neurological testing	Eligible DBD donors	Eligible DBD donors whose family were approached	Approaches where SNOD present	SNOD presence rate (%)	Consent ascertained	Consent rate (%)	Actual DBD and DCD donors from eligible DBD donors
Your Trust	14	12	86	14	100	11	11	11	11	100	9	82	9
Level 1	1183	881	74	1174	99	858	814	715	682	95	483	68	451
Level 2	539	414	77	538	100	402	388	344	339	99	242	70	220
Level 3	169	138	82	167	99	138	130	119	116	97	81	68	72
Level 4	138	101	73	138	100	98	94	81	78	96	52	64	45

Table 7.4 National DCD key numbers and rate by Trust/Board level, 1 April 2023 - 31 March 2024

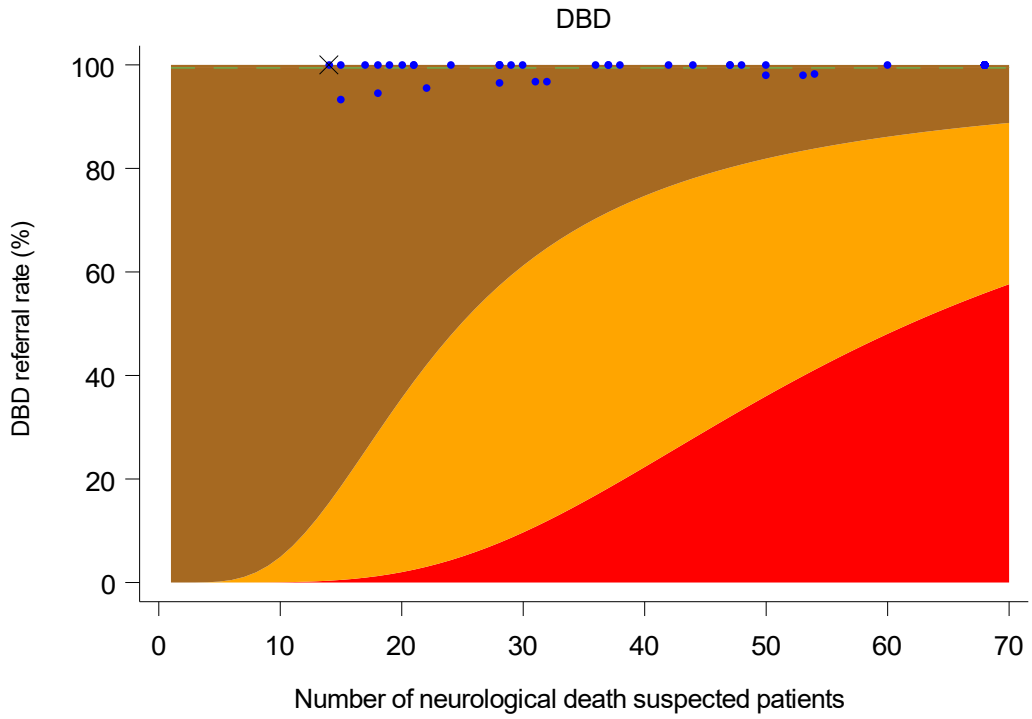
	Patients for whom imminent death was anticipated	Patients referred	DCD referral rate (%)	Patients for whom treatment was withdrawn	Eligible DCD donors	Eligible DCD donors whose family were approached	Approaches where SNOD present	SNOD presence rate (%)	Consent ascertained	Consent rate (%)	Actual DCD donors from eligible DCD donors
Your Trust	82	76	93	81	65	7	7	-	5	-	4
Level 1	2735	2533	93	2669	1932	1066	965	91	590	55	430
Level 2	1532	1426	93	1494	1039	499	454	91	285	57	187
Level 3	583	547	94	559	353	167	154	92	93	56	54
Level 4	481	443	92	464	311	117	99	85	55	47	39

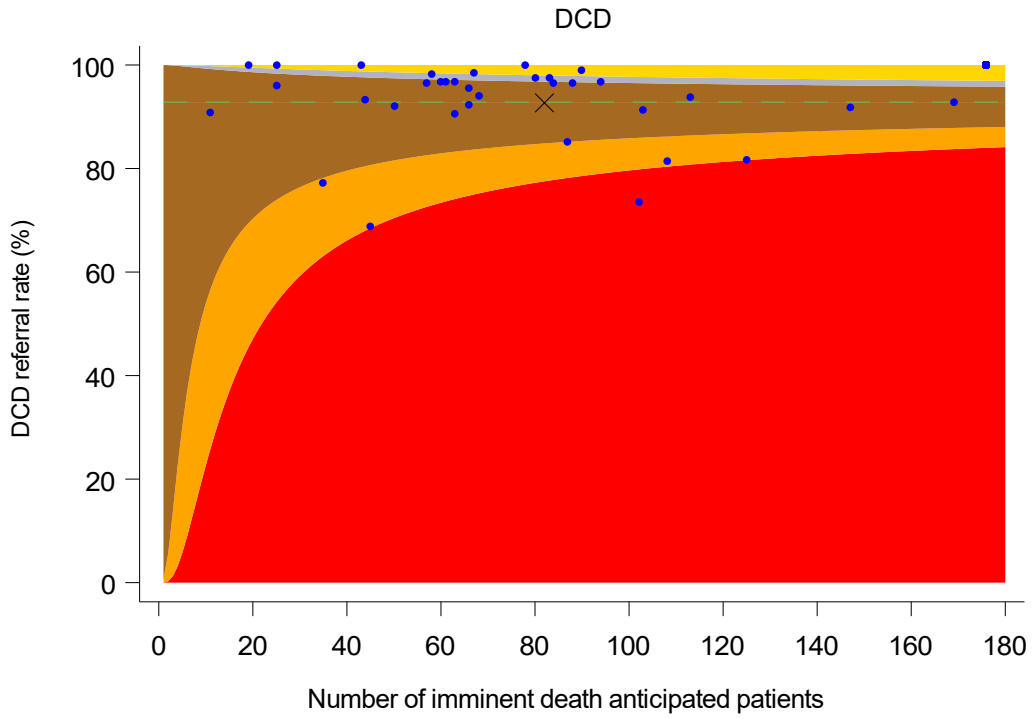
7.3 Comparative data for DBD and DCD deceased donors

Funnel plots are presented in Section 4 showing performance in your Health Board against the UK rate for deceased organ donation. The following funnel plots present data for DBD and DCD donors separately.

Note that caution should be applied when interpreting percentages calculated with numbers less than 10.

Figure 7.1 Funnel plots of referral rates, 1 April 2023 - 31 March 2024



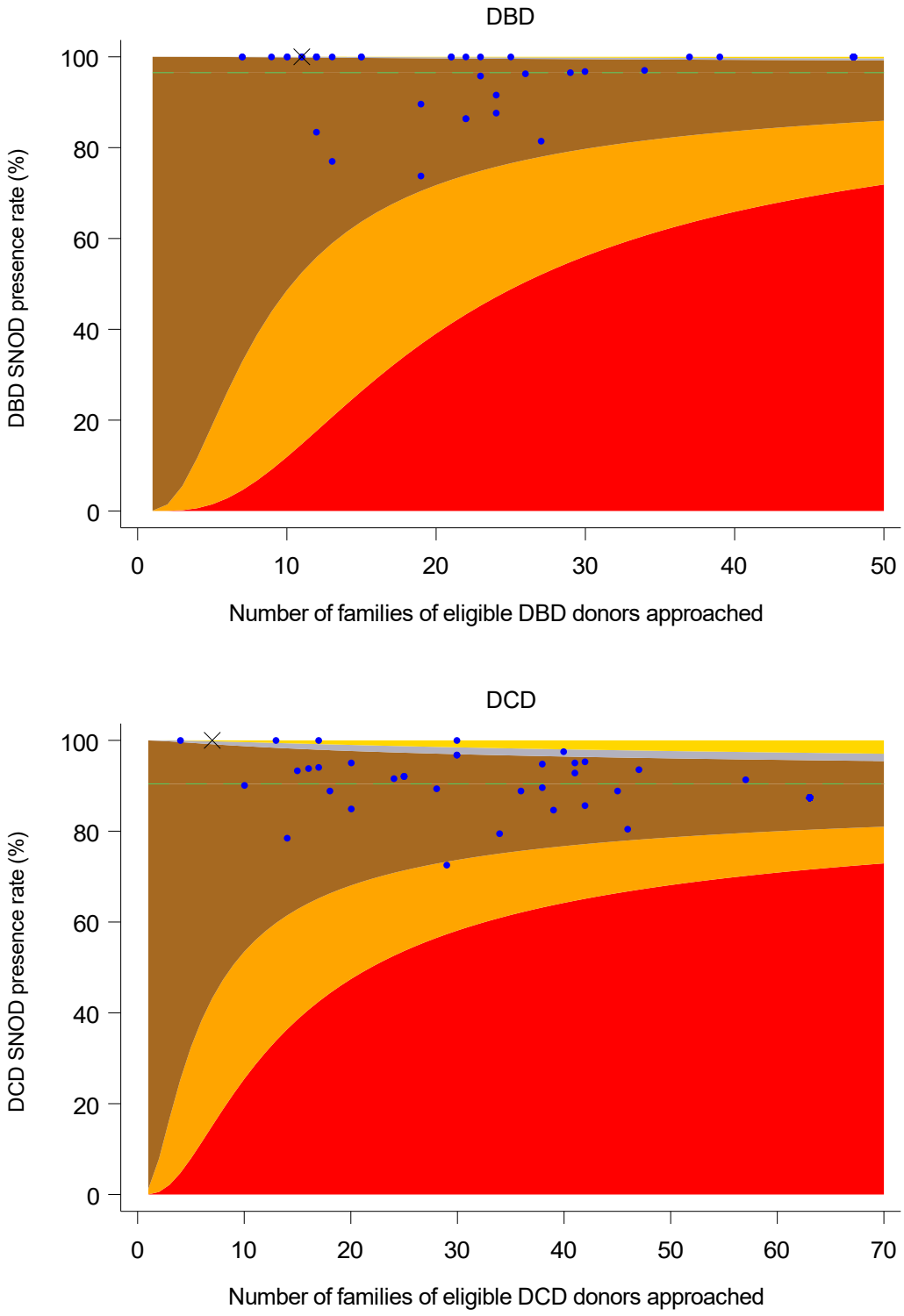


X H. Board • Other level 1 H. Boards – – – UK rate

Gold | **Silver** | **Bronze** | **Amber** | **Red**

When compared with UK performance Betsi Cadwaladr University Health Board was exceptional (gold) for referral of potential DBD organ donors and average (bronze) for referral of potential DCD organ donors to NHS Blood and Transplant's Organ Donation Service.

Figure 7.2 Funnel plots of SNOD presence rates, 1 April 2023 - 31 March 2024

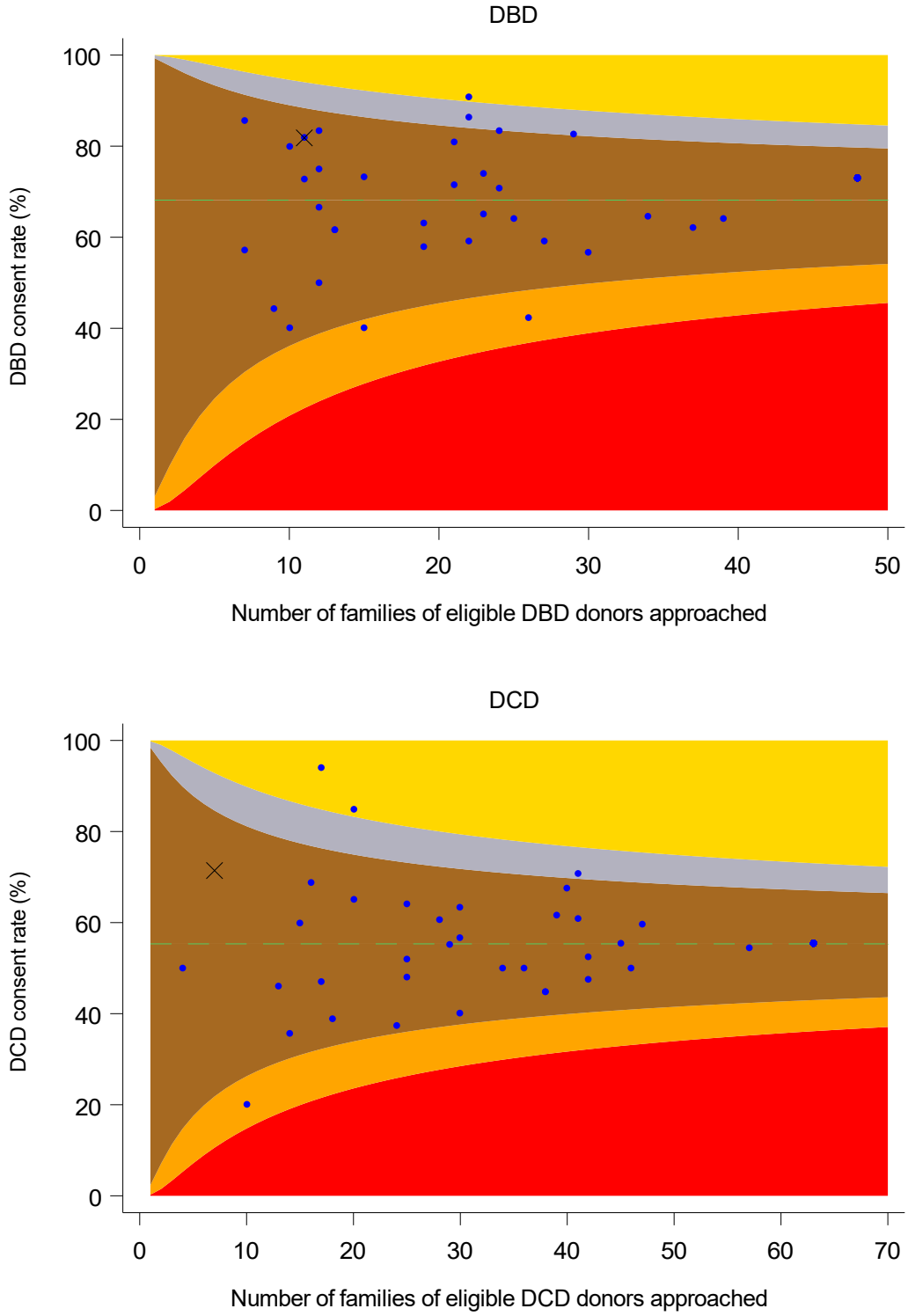


X H. Board • Other level 1 H. Boards – – – UK rate

Gold	Silver	Bronze	Amber	Red

When compared with UK performance Betsi Cadwaladr University Health Board was exceptional (gold) and exceptional (gold) for Specialist Nurse presence in approaches to families of eligible DBD and DCD donors, respectively.

Figure 7.3 Funnel plots of consent rates, 1 April 2023 - 31 March 2024



When compared with UK performance the consent rate in Betsi Cadwaladr University Health Board was average (bronze) and average (bronze) for DBD and DCD donors, respectively.

Appendices

Appendix A.1 Definitions

Potential Donor Audit Definitions

Potential Donor Audit inclusion criteria	1 October 2009 – 31 March 2010 All deaths in critical care in patients aged 75 and under, excluding cardiothoracic intensive care units 1 April 2010 – 31 March 2013 All deaths in critical and emergency care in patients aged 75 and under, excluding cardiothoracic intensive care units 1 April 2013 onwards All deaths in critical and emergency care in patients aged 80 and under (prior to 81st birthday)

Donors after brain death (DBD) definitions

Suspected Neurological Death	A patient who meets all of the following criteria: invasive ventilation, Glasgow Coma Scale 3 not explained by sedation, no respiratory effort, fixed pupils, no cough or gag reflex. Excluding those not tested due to reasons 'cardiac arrest despite resuscitation', 'brainstem reflexes returned', 'neonates – below 37 weeks corrected gestational age'. Previously referred to as brain death
Neurological death tested	Neurological death tests performed to confirm and diagnose death
DBD referral criteria	A patient with suspected neurological death
Specialist Nurse Organ Donation or Organ Donation Services Team Member (SNOD)	A member of Organ Donation Services Team including: Team Manager, Specialist Nurse Organ Donation, Specialist Requester, Donor Family Care Nurse
Referred to Specialist Nurse – Organ Donation	A patient with suspected neurological death referred to a SNOD. A referral is the provision of information to determine organ donation suitability. NICE CG135 (England) : Triggers for clinicians to refer a potential donor are a plan to withdraw life sustaining treatment or a plan to perform neurological death tests
Potential DBD donor	A patient with suspected neurological death
Absolute contraindications	Absolute medical contraindications identified in assessment which clinically preclude organ donation as per NHSBT criteria (POL188) Absolute medical contraindications to donation are listed here: https://nhsbtdbe.blob.core.windows.net/umbraco-assets-corp/17160/clinical-contraindications-to-approaching-families-for-possible-organ-donation-pol188.pdf
Eligible DBD donor	A patient confirmed dead by neurological death tests, with no absolute medical contraindications to solid organ donation
Donation decision conversation	Family of eligible DBD asked to make or support patient's organ donation decision - This includes clarifying an opt out decision
Consent/Authorisation ascertained	Family supported opt in decision, deemed consent/authorisation, or where applicable the family or nominated/appointed representative gave consent/authorisation for organ donation
Actual donors: DBD	Patients who became actual DBD donors following confirmation of neurological death, as reported through the PDA (80 years and below). At least one organ donated for the purpose of transplantation (includes organs retrieved for transplant however used for research)
Actual donors: DCD	Patients who became actual DCD donors following confirmation of neurological death, as reported through the PDA (80 years and below). At least one organ donated for the purpose of transplantation (includes organs retrieved for transplant however used for research)
Neurological death testing rate	Percentage of patients for whom neurological death was suspected who were tested

Referral rate	Percentage of patients for whom neurological death was suspected who were referred to the SNOD
Donation decision conversation rate	Percentage of eligible DBD families or nominated/appointed representatives who were asked to make or support an organ donation decision - This includes clarifying an opt out decision
Consent/Authorisation rate	Percentage of donation decision conversations where consent/authorisation was ascertained
SNOD presence rate	Percentage of donation decision conversations where a SNOD was present (includes telephone and video call conversations)
Consent/Authorisation rate where SNOD was present	Percentage of donation decision conversations where a SNOD was present and consent/authorisation for organ donation was ascertained (as above)

Donors after circulatory death (DCD) definitions

Imminent death anticipated	A patient, not confirmed dead using neurological criteria, receiving invasive ventilation, in whom a clinical decision to withdraw treatment has been made and a controlled death is anticipated within a time frame to allow donation to occur (as determined at time of assessment)
DCD referral criteria	A patient for whom imminent (controlled) death is anticipated following withdrawal of life sustaining treatment (as defined above)
Specialist Nurse Organ Donation or Organ Donation Services Team Member (SNOD)	A member of Organ Donation Services Team including: Team Manager, Specialist Nurse Organ Donation, Specialist Requester, Donor Family Care Nurse
Referred to SNOD	A patient for whom imminent death is anticipated who was referred to a SNOD. A referral is the provision of information to determine organ donation suitability NICE CG135 (England) : Triggers for clinicians to refer a potential donor are a plan to withdraw life sustaining treatment or a plan to perform neurological death tests
Potential DCD donor	A patient who had treatment withdrawn and imminent death was anticipated within a time frame to allow donation to occur.
Absolute contraindications	Absolute medical contraindications identified in assessment which clinically preclude organ donation as per NHSBT criteria (POL188). Absolute medical contraindications to donation are listed here: https://nhsbtdbe.blob.core.windows.net/umbraco-assets-corp/17160/clinical-contraindications-to-approaching-families-for-possible-organ-donation-pol188.pdf
Eligible DCD donor to be assessed	A patient who had treatment withdrawn and imminent (controlled) death was anticipated, with no absolute medical contraindications to solid organ donation.
DCD exclusion criteria	DCD specific criteria determine a patient's suitability to donation when there are no absolute medical contraindications (see absolute contraindications documentation above)
DCD screening process	Process by which an organ may be screened with a local and national transplant centre to determine suitability of organs for transplantation
Medically suitable eligible DCD donor	An eligible DCD donor to be assessed considered to be medically suitable for donation (i.e. no DCD exclusions and not deemed unsuitable by the screening process)
Donation decision conversation	Family of medically suitable eligible DCD donor who were asked to make or support patient's organ donation decision - This includes clarifying an opt out decision.
Consent/Authorisation ascertained	Family supported opt in decision, deemed consent/authorisation, or where applicable the family or nominated/appointed representative gave consent/authorisation for organ donation
Actual DCD	DCD patients who became actual DCD as reported through the PDA (80 years and below). At least one organ donated for the purpose of transplantation (includes organs retrieved for transplant however used for research)
Referral rate	Percentage of patients for whom imminent (controlled) death was anticipated who were referred to the SNOD

Donation decision conversation rate	Percentage of medically suitable eligible DCD families or nominated/appointed representatives who were asked to make or support an organ donation decision - This includes clarifying an opt out decision
Consent/Authorisation rate	Percentage of donation decision conversations where consent/authorisation was ascertained.
SNOD presence rate	Percentage of donation decision conversations where a SNOD was present (includes telephone and video call conversations).
Consent/Authorisation rate where SNOD was present	Percentage of donation decision conversations where a SNOD was present and consent/authorisation for organ donation was ascertained (as above).

Deemed Consent/Authorisation

Deemed consent applies if a person who died in Wales, Jersey or England has not expressed an organ donation decision either to opt in or opt out or nominate/appoint a representative, is aged 18 or over, has lived in the country in which they died for longer than 12 months and is ordinarily resident there, and had the capacity to understand the notion of deemed consent for a significant period before their death.

Deemed authorisation applies if a person who died in Scotland has not expressed, in writing, an organ donation decision either to opt in or opt out, is aged 16 or over, has lived in Scotland for longer than 12 months and is ordinarily resident there, and had the capacity to understand the notion of deemed authorisation for a significant period before their death. Note that, in Scotland, a patient who has verbally expressed an opt in decision is included as a deemed authorisation, whereas a patient who has verbally expressed an opt out decision is not included.

Consent/Authorisation groups

Expressed opt in	Patient had expressed an opt in decision. Opt in decisions can be expressed in writing or via the ODR in all nations and verbal opt in decisions are also included in Wales, England and Jersey. Verbally expressed opt in decisions are not included in Scotland
Deemed consent/authorisation	Patient meets deemed criteria specific to each nation as described above. In Scotland, this includes patients who have verbally expressed a decision to opt in
Expressed opt out	Patient had expressed an opt out decision. Opt out decisions can be expressed verbally, in writing or via the ODR in all nations
Other	Patient has expressed no decision or deemed criteria are not met. Paediatric patients are included in this group

UK Transplant Registry (UKTR) definitions

Donor type	Type of donor: Donation after brain death (DBD) or donation after circulatory death (DCD)
Number of actual donors	Total number of donors reported to the UKTR
Number of patients transplanted	Total number of patients transplanted from these donors
Organs per donor	Number of organs donated divided by the number of donors.
Number of organs transplanted	Total number of organs transplanted by organ type

Appendix A.2 Data Description

This report provides a summary of data relating to potential and actual organ donors as recorded by NHS Blood and Transplant via the Potential Donor Audit (PDA), the accompanying Referral Record, and the UK Transplant Registry (UKTR) for the specified Trust, Board, Organ Donation Services Team, or nation.

This report is provided for information and to facilitate case based discussion about organ donation by the Organ Donation Committee at your Trust/Board.

As part of the PDA, patients over 80 years of age and those who did not die on a critical care unit or emergency department are not audited nationally and are therefore excluded from the majority of this report. Data from neonatal intensive care units (ICU) have also been excluded from this report. In addition, some information may be outstanding due to late reporting and difficulties obtaining patient notes. Donations not captured by the PDA will still be included in the data supplied from the accompanying Referral Record or from the UKTR, as appropriate.

Percentages have not been calculated for level 3 or 4 Trust/Boards and where stated when numbers are less than 10.

Appendix A.3 Table and Figure Description

1 Donor outcomes	
Table 1.1	The number of actual donors, the resulting number of patients transplanted and the average number of organs donated per donor have been obtained from the UK Transplant Registry (UKTR) for your Trust/Board. Results have been displayed separately for donors after brain death (DBD) and donors after circulatory death (DCD).
Table 1.2	The number of organs transplanted by type from donors at your Trust/Board has been obtained from the UKTR. Further information can be obtained from your local Specialist Nurse – Organ Donation (SNOD), specifically regarding organs that were not transplanted. Results have been displayed separately for DBD and DCD.
Figure 1.1	The number of actual donors and the resulting number of patients transplanted obtained from the UKTR for your Trust/Board for the past 10 equivalent time periods are presented on a line chart.

2 Key rates in potential for organ donation	
Figure 2.1	Key percentage measures of DBD and DCD potential donation activity for your Trust/Board are presented in a bar chart, using data from the Potential Donor Audit (PDA). The comparative UK rate, for the same time period, is illustrated by the pink line. The key rates labels are coloured using the gold, silver, bronze, amber, and red (GoSBAR) colour scheme to show the performance of your Trust/Board, relative to the UK rate, as reflected in the funnel plots (see description for Figure 4.1 below.
Figure 2.2	Trends in the key percentage measures of DBD and DCD potential donation activity for your Trust/Board are presented for the past five equivalent time periods, using data from the PDA.
Table 2.1	A summary of DBD, DCD and deceased donor data and key numbers have been obtained from the PDA. A UK comparison is also provided. Note that caution should be applied when interpreting percentages based on small numbers. Appendix A.1 gives a fuller explanation of terms used. The key rates are highlighted using the gold, silver, bronze, amber, and red (GoSBAR) colour scheme to show the performance of your Trust/Board, relative to the UK rate, as reflected in the funnel plots (see description for Figure 4.1 below).

3 Best quality of care in organ donation	
Figure 3.1	A stacked bar chart displays the number of patients with suspected neurological death who were tested and the number who were not tested in your Trust/Board for the past five equivalent time periods.
Table 3.1	The reasons given for neurological death tests not being performed in your Trust/Board, have been obtained from the PDA, if applicable. A UK comparison is also provided.
Figure 3.2	Stacked bar charts display the number of DBD and DCD patients meeting referral criteria who were referred to the Organ Donation Service and the number who were not referred in your Trust/Board for the past five equivalent time periods.
Table 3.2	The reasons given for not referring patients to the Organ Donation Service in your Trust/Board, have been obtained from the PDA, if applicable. A UK comparison is also provided.
Table 3.3	The primary absolute medical contraindications to solid organ donation for DBD and DCD patients have been obtained from the PDA, if applicable. A UK comparison is also provided.
Figure 3.3	Stacked bar charts display the number of families of DBD and DCD patients approached where a SNOD was present and the number approached where a SNOD was not present in your Trust/Board for the past five equivalent time periods.
Figure 3.4	Stacked bar charts display the number of families of DBD and DCD patients approached where consent/authorisation for organ donation was ascertained and the number approached where consent/authorisation was not ascertained in your Trust/Board for the past five equivalent time periods.

Table 3.4	The reasons why consent/authorisation was not ascertained for solid organ donation in your Trust/Board, have been obtained from the PDA, if applicable. A UK comparison is also provided.
Table 3.5	The reasons why solid organ donation did not occur in your Trust/Board, have been obtained from the PDA, if applicable. A UK comparison is also provided.

4 Comparative data

Figure 4.1	A funnel plot of the neurological death testing rate is displayed using data obtained from the PDA. Each Trust/Board, of the same level, is represented on the plot as a blue dot, although one dot may represent more than one Trust/Board. The UK rate is shown on the plot as a green horizontal dashed line, together with 95% and 99.8% confidence limits for this rate. These limits form a 'funnel', which is shaded using the gold, silver, bronze, amber, and red (GoSBAR) colour scheme. Graphs obtained in this way are known as funnel plots. If a Trust/Board lies within the 95% limits, shaded bronze, then that Trust/Board has a rate that is statistically consistent with the UK rate (average performance). If a Trust/Board lies outside the 95% confidence limits, shaded silver (good performance) or amber (below average performance), this serves as an alert that the Trust/Board may have a rate that is significantly different from the UK rate. When a Trust/Board lies above the upper 99.8% limit, shaded gold, this indicates a rate that is significantly higher than the UK rate (exceptional performance), while a Trust/Board that lies below the lower limit, shaded red, has a rate that is significantly lower than the UK rate (poor performance). It is important to note that differences in patient mix have not been accounted for in these plots. Your Trust/Board is shown on the plot as the large black cross. If there is no large black cross on the plot, your Trust/Board did not report any patients of the type presented. The funnel plots can also be used to identify the maximum rates currently being achieved by Trusts/Boards with similar donor potential.
Figure 4.2	A funnel plot of the deceased donor referral rate is displayed using data obtained from the PDA. See description for Figure 4.1 above.
Figure 4.3	A funnel plot of the deceased donor SNOD presence rate is displayed using data obtained from the PDA. See description for Figure 4.1 above.
Figure 4.4	A funnel plot of the deceased donor consent/authorisation rate is displayed using data obtained from the PDA. See description for Figure 4.1 above.

5 PDA data by hospital and unit

Table 5.1	DBD key numbers and rates by unit where the patient died have been obtained from the PDA. Percentages have been excluded where numbers are less than 10.
Table 5.2	DCD key numbers and rates by unit where the patient died have been obtained from the PDA. Percentages have been excluded where numbers are less than 10.

6 Emergency department data

Figure 6.1	Stacked bar charts display the number of patients that died in the emergency department (ED) who met the referral criteria and were referred to the Organ Donation Service and the number who were not referred in your Trust/Board for the past five equivalent time periods.
Figure 6.2	Stacked bar charts display the number of families of patients in ED approached where a SNOD was present and the number approached where a SNOD was not present in your Trust/Board for the past five equivalent time periods.

7 Additional data and figures

Table 7.1	A summary of deceased donor, transplant, transplant list and ODR opt-in registration data for your region have been obtained from the UKTR. A UK comparison is also provided.
Table 7.2	Trust/board level categories and the relevant expected number of proceeding donors per year are provided for information.
Table 7.3	National DBD key numbers and rates for level 1, 2, 3 and 4 Trusts/Boards are displayed alongside your local data to aid comparison with equivalent Trusts/Boards. Percentages have been excluded where numbers are less than 10.
Table 7.4	National DCD key numbers and rates for level 1, 2, 3 and 4 Trusts/Boards are displayed alongside your local data to aid comparison with equivalent Trusts/Boards. Percentages have been excluded where numbers are less than 10.
Figure 7.1	A funnel plot of the DBD and DCD referral rates are displayed using data obtained from the PDA. See description for Figure 4.1 above.
Figure 7.2	A funnel plot of the DBD and DCD SNOD presence rates are displayed using data obtained from the PDA. See description for Figure 4.1 above.
Figure 7.3	A funnel plot of the DBD and DCD consent/authorisation rates are displayed using data obtained from the PDA. See description for Figure 4.1 above.

NHS
Blood and Transplant
www.nhsbt.nhs.uk

May 2024

Dear Ms Shillabeer and Dr Lyons,

The number of donors and transplants in the UK have continued to improve and we are returning to pre-pandemic levels. Please accept our recognition and thanks for the effort of your staff.

This letter explains how your Health Board contributed to the UKs deceased donation programme.

Organ and tissue donation and transplantation activity - 2023/24

From 15 consented donors, Betsi Cadwaladr University Health Board facilitated 13 actual solid organ donors resulting in 32 patients receiving a transplant during the time period. Additionally, 20 corneas were received by NHSBT Eye Banks from your Health Board.

Quality of care in organ donation - 2023/24

When compared with national data, during the time period your Health Board was:

- In line with the national average for the referral of potential organ donors
- Exceptional for Specialist Nurse presence when approaching families to discuss organ donation

- Your Health Board referred 146 patients to NHSBT's Organ Donation Services Team; 87 met the referral criteria and were included in the UK Potential Donor Audit. There were a further 6 audited patients that were not referred.
- A Specialist Nurse was present for 18 organ donation discussions with families of eligible donors. There were no occasions when a Specialist Nurse was absent for the donation discussion.
- In Wales, 44% of the population have registered an NHSBT Organ Donor Register (ODR) opt in decision. This compares to 42% of the population nationally.

Up to date Health Board metrics are always available via our Power BI reports found here:
https://www.odt.nhs.uk/statistics-and-reports/potential-donor-audit-report/.

What we would like you to do

- Ensure your Health Board supports your Organ Donation Committee and Clinical Lead for Organ Donation in promoting best practice as they seek to minimise missed donation opportunities.
- Discuss activity and quality data at the Board with support from your Organ Donation Committee Chair.
- Recognise any successes your Health Board has had in facilitating donation or transplantation, especially during the ongoing NHS pressures.
- An opt-in registration on the NHSBT Organ Donor Register results in the highest rates of consent, please support your Organ Donation Committee in their efforts to promote the NHSBT Organ Donor Register where possible.

Deemed Consent Legislation - Wales

Wales introduced deemed consent in December 2015. In Wales, between 1 December 2015 – 31 March 2024, there were 220 occasions when consent was deemed from 346 occasions where deemed consent applied.

Why it matters

In 2023/24, 154 people benefited from a solid organ transplant in Wales. However sadly, 15 people died on the transplant waiting list during this time.

Thank you once again for your vital ongoing support for donation and transplantation.

Yours sincerely,

Anthony Clarkson
Director of Organ and Tissue Donation and Transplantation
NHS Blood and Transplant

Business Disability Forum
Building disability-smart organisations

Positive About Disabled People

Actual and Potential Deceased Organ Donation 1 April 2023 - 31 March 2024

NHS Blood and Transplant

Betsi Cadwaladr University Health Board

Organ Donation and Transplantation 2030: Meeting the Need

In 2023/24, from 15 consented donors the Health Board facilitated 13 actual solid organ donors resulting in 32 patients receiving a life-saving or life-changing transplant. Data obtained from the UK Transplant Registry.

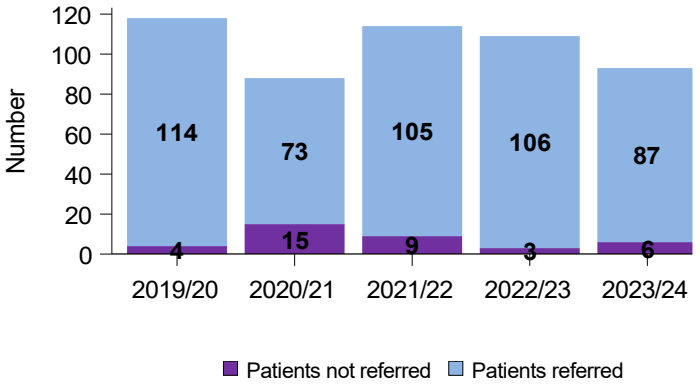
In addition to the 13 proceeding donors there were 2 consented donors that did not proceed.

Best quality of care in organ donation

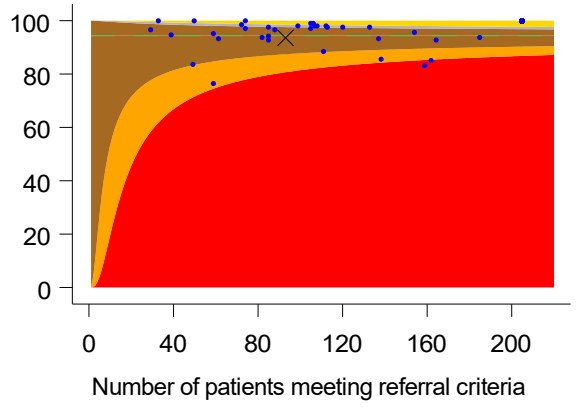
Referral of potential deceased organ donors

Goal: Every patient who meets the referral criteria should be identified and referred to NHS Blood and Transplant's Organ Donation Service

Aim: There should be no purple on the chart



Aim: The Health Board (marked with a cross) should fall within Bronze, Silver, or Gold



X H. Board • Other level 1 H. Boards – – – UK rate

Gold | Silver | Bronze | Amber | Red

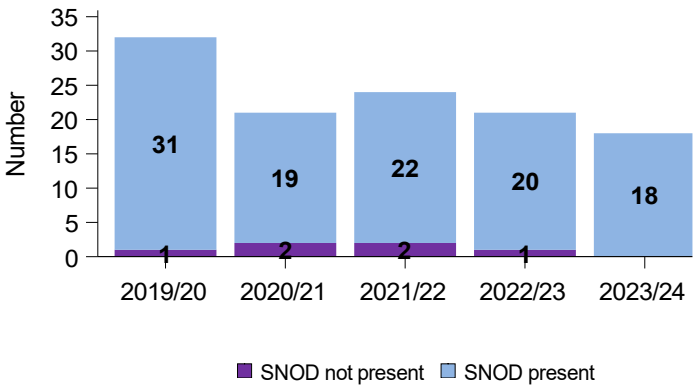
The Health Board referred 87 potential organ donors during 2023/24. There were 6 occasions where potential organ donors were not referred.

When compared with UK performance, the Health Board was average (bronze) for referral of potential organ donors to NHS Blood and Transplant.

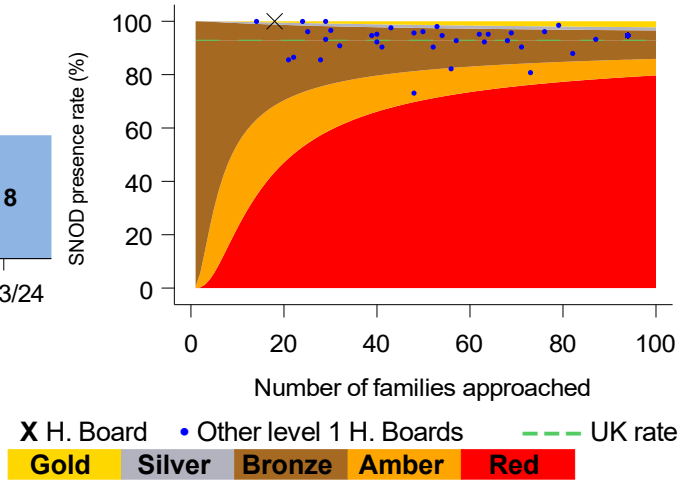
Presence of Specialist Nurse for Organ Donation

Goal: A Specialist Nurse for Organ Donation (SNOD) should be present during every organ donation discussion with families

Aim: There should be no purple on the chart



Aim: The Health Board (marked with a cross) should fall within Bronze, Silver, or Gold



A SNOD was present for 18 organ donation discussions with families during 2023/24. There were no occasions where a SNOD was not present.

When compared with UK performance, the Health Board was exceptional (gold) for SNOD presence when approaching families to discuss organ donation.

Why it matters

- If suitable patients are not referred, the patient's decision to be an organ donor is not honoured or the family does not get the chance to support organ donation.
- The consent rate in the UK is much higher when a SNOD is present.
- The number of patients receiving a life-saving or life-changing solid organ transplant in the UK is increasing but patients are still dying while waiting.

Regional donors, transplants, waiting list, and NHS Organ Donor Register (ODR) data

	Wales*	UK
1 April 2023 - 31 March 2024		
Deceased donors	57	1,510
Transplants from deceased donors	154	3,723
Deaths on the transplant list	15	418
As at 31 March 2024		
Active transplant list	271	7,484

*Regions are defined using the NHS region definitions
* % registered based on population of 3.11 million, based on ONS 2021 census data

Regional donors, transplants, waiting list, and NHS Organ Donor Register (ODR) data

	Wales*	UK
Number of NHS ODR opt-in registrations (% registered)**	1,376,148 (44%)	28,161,705 (42%)
Number of NHS ODR opt-out registrations (% registered)**	189,059 (6%)	2,577,667 (4%)

*Regions are defined using the NHS region definitions
* % registered based on population of 3.11 million, based on ONS 2021 census data

Further information

Further information on potential donors after brain death (DBD) and potential donors after circulatory death (DCD) at the Health Board are shown below, including a UK comparison. Data obtained from the Potential Donor Audit (PDA).

Key numbers, rates and comparison with UK data, 1 April 2023 - 31 March 2024

	DBD		DCD		Deceased donors	
	H. Board	UK	H. Board	UK	H. Board	UK
Patients meeting organ donation referral criteria[1]	14	2029	82	5331	93	6911
Referred to Organ Donation Service	14	2017	76	4949	87	6522
Referral rate %	G *100%*	*99%*	B *93%*	*93%*	B *94%*	*94%*
Neurological death tested	12	1534				
Testing rate %	B *86%*	*76%*				
Eligible donors[2]	11	1426	65	3635	76	5061
Family approached	11	1259	7	1849	18	3108
Family approached and SNOD present	11	1215	7	1672	18	2887
% of approaches where SNOD present	G *100%*	*97%*	G *100%*	*90%*	G *100%*	*93%*
Consent ascertained	9	858	5	1023	14	1881
Consent rate %	B *82%*	*68%*	B *71%*	*55%*	B *78%*	*61%*
- Expressed opt in	4	533	2	637	6	1170
- Expressed opt in %	*80%*	*95%*	*67%*	*85%*	*75%*	*89%*
- Deemed Consent	4	246	2	323	6	569
- Deemed Consent %	*100%*	*58%*	*100%*	*47%*	*100%*	*51%*
- Other*	1	78	1	63	2	141
- Other %*	*100%*	*52%*	*100%*	*34%*	*100%*	*42%*
Actual donors (PDA data)	9	788	4	710	13	1499
% of consented donors that became actual donors	*100%*	*92%*	*80%*	*69%*	*93%*	*80%*

[1] DBD - A patient with suspected neurological death
DCD - A patient in whom imminent death is anticipated, ie a patient receiving assisted ventilation, a clinical decision to withdraw treatment has been made and death is anticipated within 4 hours

[2] DBD - Death confirmed by neurological tests and no absolute contraindications to solid organ donation
DCD - Imminent death anticipated and treatment withdrawn with no absolute contraindications to solid organ donation

* Includes patients where nation specific deemed criteria are not met and the patient has not expressed a donation decision in accordance with relevant legislation

Note that a patient that meets both the referral criteria for DBD and DCD organ donation is featured in both the DBD and DCD data but will only be counted once in the deceased donors total

Gold | Silver | Bronze | Amber | Red

For further information, including definitions, see the latest Potential Donor Audit report and up to date metrics via our Power BI reports at:
https://www.odt.nhs.uk/statistics-and-reports/potential-donor-audit-report/.