

Bundle BCU People and Culture Committee 11 June 2026

- 1 09:30 - PRELIMINARY MATTERS
 - 1.1 09:30 - PC26.52 Welcome and Apologies
Dyfed Jones, Chair
 - 1.2 09:31 - PC26.53 Declarations of Interest
Dyfed Jones, Chair
 - 1.3 09:32 - PC26.54 Unconfirmed Minutes of Meeting held on 09.04.26
Dyfed Jones, Chair
PC26.54 Minutes from P&C Committee 09.04.26 V0.2 (Public)
 - 1.4 09:35 - PC26.55 Matters Arising & Action Log
Dyfed Jones, Chair
PC26.55 Action Log P&C Committee - Public (Updated 04.06.26)
- 2 09:40 - STAFF STORY
 - 2.1 09:40 - PC26.56 Staff Story
Teresa Owen, Executive Director of Allied Health Professionals and Health Science
Focus on Welsh Language Champions Programme
Eleri Hughes-Jones to join the meeting for this item
PC26.56 Welsh Language Champions Programme Report (Staff Story)
- 3 09:50 - STRATEGIC PRIORITIES
 - 3.1 09:50 - PC26.57 Welsh Language Promotion Plan 2026-2027
Teresa Owen, Executive Director of Allied Health Professionals and Health Science
Eleri Hughes-Jones to join the meeting for this item
PC26.57 Welsh Language Promotion Plan 2026-2027
PC26.57.1 Welsh Language Promotion Plan 2026-2027
 - 3.2 10:05 - PC26.58 First Annual Report for Healthcare Sciences
Teresa Owen, Executive Director of Allied Health Professionals and Health Science
PC26.58 Healthcare Science First Annual Report. 11.06.26. TO.HH
PC26.58.1 Annual Review of the Health Science Professions 2025 Final
 - 3.3 10:15 - PC26.59 Sickness Actions Deep Dive Report
Georgina Roberts, Senior Associate Director, People Service
PC26.59 Sickness Actions Deep Dive Report May 2026 v3 FINAL
 - 3.4 10:30 - PC26.60 Staff Wellbeing Organisational Position Report
Debbie Eyitayo, Executive Director of People and Organisational Development
Sarah Blackshaw to join the meeting for this item
PC26.60 Staff Wellbeing Organisational Position Report
 - 3.5 10:45 - BREAK
 - 3.6 10:55 - PC26.61 Culture, Leadership and Engagement Improvement Plan
Debbie Eyitayo, Executive Director of People and Organisational Development
Nia Thomas to join the meeting for this item
PC26.61 Culture, Leadership & Engagement Improvement Plan FINAL

PC26.61.1a Appendix 1a CLE Improvement Plan (high level)
PC26.61.1b Appendix 1b CLE 2026-29 Plan on a Page
PC26.61.2 Appendix 2 Celebration Event Infographic 26
PC26.61.3 Final Internal Audit Report - Culture and Leadership Development

- 3.7 11:05 - PC26.62 People Operations Report
Georgina Roberts, Senior Associate Director, People Service
PC26.62 People Operations Report - Coversheet
PC26.62.1 People Operations Report Final - Reviewed GR
- 3.8 11:15 - PC26.63 Employee Experience and Engagement Report
Debbie Eyitayo, Executive Director of People and Organisational Development
PC26.63 Employee Experience and Engagement Report June 26 v1.1
- 3.9 11:25 - PC26.64 Foundations for the Future Programme
Carol Shillabeer, Chief Executive / Ffion Johnstone, Programme Director, Foundations for the Future
PC26.64 Foundations for the Future Report FINAL
PC26.64.1 FFTF Programme - Resource Management Plan 2026-27
- 4 11:40 - GOVERNANCE, RISK AND ASSURANCE
- 4.1 11:40 - PC26.65 Senior Doctor Job Planning
Clara Day, Executive Medical Director
Item to include:
Residents Doctors Contract Reform and Local Implementation
PC26.65 Senior Doctor Job Planning Final
PC26.65.1 Appendix A Job Planning table for update - May 2026
PC26.65.2 Appendix B Job Planning Compliance - Current Progress 12052026
PC26.65.3 Resident Doctors Contract Reform and Local Implementation
- 4.2 11:45 - PC26.66 Responsible Officer Designated Body Update Report 2025-26
Clara Day, Executive Medical Director
PC26.66 Responsible Officer Designated Body Update Report 2025-26
- 4.3 11:50 - PC26.67 Internal Audit Report: On Call Arrangements
Tehmeena Ajmal, Chief Operating Officer
PC26.67 Internal Audit Report - On-Call Arrangements v3
- 4.4 11:55 - PC26.68 Corporate Risk Register
Pam Wenger, Director of Corporate Governance
PC26.68 Corporate Risk Register V1.0 June 2026
- 4.5 12:00 - PC26.69 Corporate Governance Report
Pam Wenger, Director of Corporate Governance
PC26.69 Corporate Governance Report
PC26.69.1 Draft Cycle of Business for the P&C Committee 2026-27 V0.2
PC26.69.2 Workplan for P&C Committee (Live Version as at 04.06.26)
- 5 12:05 - CLOSING BUSINESS
- 5.1 12:05 - PC26.70 Agree Items for Referral to Board / Other Committees
Dyfed Jones, Chair

5.2 12:07 - PC26.71 Review of Meeting Effectiveness
Dyfed Jones, Chair

5.3 12:10 - PC26.72 Date of Next Meeting - 13.08.26

5.4 12:10 - PC26.73 Resolution to Exclude the Press and Public
"Those representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960."

Betsi Cadwaladr University Health Board (BCUHB)
UNCONFIRMED Minutes of the People & Culture Committee
held in Public on 9 April 2026
in the Boardroom, Carlton Court, St Asaph and via Teams

Committee Members Present	
Name	Title
Dyfed Jones	Independent Member (Chair of Committee)
Clare Budden	Independent Member
In Attendance	
Jason Brannan	Deputy Director of People
Clara Day	Executive Medical Director (part meeting)
Debbie Eyitayo	Executive Director of People and Organisational Development
Ffion Johnstone	Programme Director, Foundations for the Future (part meeting: via Teams)
Teresa Owen	Executive Director of Allied Health Professionals and Health Science
Katie Sargent	Head of Employee Engagement and Experience (part meeting)
Pam Wenger	Director of Corporate Governance
Committee Support	
Laura Jones	Corporate Governance Manager
Philippa Peake-Jones	Head of Corporate Governance

OPENING BUSINESS
PC26.28 Welcome and Apologies Apologies were noted for Billy Nichols, Paul Lambert and Dave Harries.
PC26.29 Declarations of Interest The Chair of the Committee declared an interest in item PC26.37 BCUHB Becoming a Foster Partner due to his membership on the Joint Committee for Foster Wales.
PC26.30 Unconfirmed Minutes of Meeting held on 12 February 2026 It was resolved that the Committee: • AGREED that the minutes of the People and Culture Committee meeting held on 12 February 2026 were a true and accurate record.
PC26.31 Matters Arising & Action Log The Committee reviewed the action log and agreed to close the actions that were proposed for closure noting the timescales for those actions which remained open.

STAFF STORY

PC26.32 Staff Story

The Committee received the staff story and Head of Employee Engagement and Experience highlighted:

- The story related to the support provided for staff across the Health Board to raise concerns and discuss issues in confidence with the Speaking Up Safely Guardians. The story also referred to the process for triage, signposting and seeking resolution.
- The results from the NHS Wales Staff Survey 2025 highlighted that staff do not feel confident speaking up noting that the organisation was reported as the lowest scoring Health Board in Wales in this area with a score of 63.9% against a Wales average of 65.6%.
- The story was anonymised due to concerns regarding identification as the narrative describes the experience of a member of staff who tried to suggest areas for improvement via their line management, the suggestions were not positively received and subsequently the individual contacted the Speaking Up Safely Service. It was noted that the experience had impacted the wellbeing of the staff member and contributed to time off work.
- Current engagement with the Speaking Up Safely platform was highlighted at around 2.5% of staff engagement and it was noted that colleagues may only register when they require the service rather than proactively using the system on a regular basis.
- Promotional activity is taking place to ensure staff are aware of the service and share the broader messages around staff feeling able to speak up if required.
- An Internal Audit Report focussed on Speaking Up Safely has recently been completed which provided limited assurance and noted that the outcome of the report will provide opportunities to strengthen compliance with Welsh Government expectations and embed arrangements more effectively.
- A significant proportion of themes raised in this area relate to management and leadership behaviours and therefore link directly to the wider culture and leadership work taking place. Plans are being developed to work closely with Wrexham University to strengthen leadership and management programmes.

In discussing the staff story, the Committee:

- Recognised that Speaking Up Safely should not be treated as a standalone initiative and needs to be embedded across all Health Board culture and leadership programmes noting the detrimental impact this can have on staff wellbeing.
- Discussed how to raise the profile of Speaking Up Safely at ground level, including the value of strong visible leadership behaviours and fostering conditions for teams to operate effectively. The work also needs to align with the activity of the Culture Change Leaders to ensure staff feel confident to raise issues in line with the Health Board values.
- Acknowledged that only 36% of staff completing the Staff Survey felt that the organisation would address their concerns and queried how the Committee could start to share anonymised examples of positive outcomes to build confidence and trust, for example highlighting issues that have been raised and emphasising how the organisation has acted in response.

- Suggested further work is required around training managers to have proactive discussions with staff and respond appropriately as well as providing staff touch points and a staff forum where people can raise concerns on behalf of other staff members. Staff also need to have the opportunity to speak with another manager if concerns relate to their direct line managers.
- Queried accessibility and inclusivity, including whether Welsh speaking support was available. It was confirmed that the team do have Welsh speakers and try to allocate staff to the most appropriate member of the team noting the need for a diverse team to enable open conversations.
- Noted that Trade Union representatives can provide intelligence to help target improvements in specific areas.
- Highlighted that staff may have concerns if the service sits within Human Resources as it may not be seen as independent and agreed this should be reviewed going forward.
- Referred to the relationship with Whistleblowing arrangements noting the need for clarity around reporting routes for those cases that report under the Whistleblowing Act and those that report through Speaking Up Safely.

It was resolved that the Committee:

- **NOTED** the themes raised.

STRATEGIC PRIORITIES

PC26.33 Staff Survey 2025

The Committee received the report and the Head of Employee Engagement and Experience and Executive Director of People and Organisational Development highlighted:

- The Staff Survey has been completed by 5,203 staff which equates to 24.9% of the organisation, representing a 45% increase from 2024.
- Additional data is yet to be received and there had also been delays in receiving the Welsh language comments however the team are currently working through the free-text comments received noting that the detailed thematic findings will follow once fully reviewed.
- Early positive themes include staff feeling supported by colleagues and line managers and are motivated to do the best for patients and their teams. Staff have pride in working for the Health Service and are happy to come into work and do more than is required.
- Early negative themes include inconsistency around access to flexible working, poor work / life balance and issues relating to wellbeing, stress, workload and staffing levels. Colleagues also feel that financial constraints are having an impact on patient care and there is a perceived disconnect between senior leadership and staff on the ground.
- Work is taking place to understand why staff did not participate in the Staff Survey, with key themes indicating that a lack of action in response to staff feedback may be a major factor. Going forward there is a need to share some tangible results with local managers to encourage future engagement.
- Local results have been shared with individual People and Culture forums and meetings to allow results to be shared and local discussions to take place.

- This information will form part of the Director of People and Organisational Development Report being submitted to the Board in May 2026 and wider communication across the organisation will follow.

In discussing the report, the Committee:

- Questioned how the organisation can increase staff confidence that completing the survey leads to action emphasising the need for a clear “you said, we did” narrative to ensure staff are aware of the improvements being implemented as a result of the feedback provided and ahead of completing the 2026 Staff Survey.
- Suggested targets should be set against internal baselines rather than Welsh averages and shared positive feedback on the data highlighting incremental changes.
- Queried what the objective is going forward, it was confirmed that the Culture, Leadership and Engagement Plan will address some areas and objectives relating to the data and further information will inform the detail being reported to the Board in May 2026.
- Discussed the need to build trust in staff to complete the survey in future, promote the resources available as well as the ability to complete the survey in Welsh and follow up the delays in receiving Welsh responses. There is also a need to focus on key actions around triangulating survey findings with other intelligence and targeting support to areas where required.
- Queried whether technology could be used more effectively to support analysis and accessibility of local data. It was confirmed that support and training for use of the Insights app is being provided to enable managers to review local information and the data analysis team are able to provide support where required.
- Noted that corporate and local action plans have been developed in certain areas following the last Staff Survey and may have achieved some areas of improvement therefore suggested this progress is highlighted to staff.
- Referred to the pace and expectations of culture change noting the organisational change activity that is underway and the improvements being made in gaining an understanding of the data on an annual basis within the broader context.

It was resolved that the Committee:

- **NOTED** and **DISCUSSED** the quantitative results of the NHS Wales Staff Survey 2025.
- **SUPPORTED** the planned next steps.

PC26.34 People Operations Report

The Committee received the report and the Executive Director of People and Organisational Development highlighted:

- Sickness absence is a currently priority area in line with the ongoing deep dive work which has a focus on attendance and utilising flexibility within the All Wales Policy to support staff to remain in work.
- There is also a continued focus on staff health and wellbeing, including consideration of how occupational health and wellbeing resources can be redistributed to strengthen both psychological and mental health support.

- The Integrated Leadership Development Framework has now been included in the report reflecting previous Committee feedback.

It was resolved that the Committee:

- **NOTED** the current position provided.

PC26.35 Three Year Culture, Leadership and Engagement Improvement Plan

The Committee received the report and the Deputy Director of People and Executive Director of People and Organisational Development highlighted:

- The team are building levels of accountability and ownership for this work and the Three Year Action Plan had been reviewed to ensure strategic alignment to the Integrated Medium Term Plan.
- Work is taking place with Executive Directors to ensure their programmes of work and actions relevant to culture, leadership and engagement are clear, specific, owned and measurable. These operational actions will sit behind the high level plan held by the People and Organisational Development Team. It is expected that progress against these actions is collated and overseen through corporate processes aligned to the Integrated Medium Term Plan reporting. Progress against reports will be presented to People and Culture Committee for assurance, clearly identifying any potential risks against delivery.
- A Culture Change Leaders event is due to take place in April 2026 with Executive Director and Independent Member involvement, supported by Michael West which will be an important event in the Culture Change Community.

In discussing the report, the Committee:

- Emphasised the importance of Executive Directors and Leaders shaping and demonstrating commitment to the organisational culture to ensure the plan translates into practical actions that leaders understand and deliver on a daily basis.
- Noted that when the progress report is received by the Committee in June 2026, there will be a need to agree the frequency of reporting to allow progress to be monitored against the high level plan to provide assurance to the Committee.
- Agreed that the plan will provide assurance that the Executive Directors are committed to the plan and embodying the culture of the organisation.

Action:

- **PC26.35.1** Bring a People and Culture progress update back to the June 2026 meeting for assurance.

It was resolved that the Committee:

- **NOTED** the progress made since the last meeting, including the executive review and OD-facilitated work.
- **ENDORSED** the proposed timeline for final approval and submission.
- **SUPPORTED** continued investment in the Culture Change Leaders network.
- will **RECEIVE** the revised People and Culture Plan at the June 2026 meeting for assurance.



PC26.36 Foundations for the Future Programme

The Committee received the report and the Programme Director, Foundations for the Future highlighted:

- The programme is based around the five pillars that have been developed and is not solely focused on the structures element noting that the discovery phase of the programme has now been completed.
- In relation to the Strategy workstream, the Board have now approved the Integrated Workforce Planning Framework along with the Strategic Intentions and work continues on the Clinical Services Plan.
- In relation to the People workstream, an Integrated Leadership Development Framework has been established, resources are available on BetsiNet and the competency and skills framework is being streamlined.
- In relation to the Culture workstream, progress continues around culture and values, the Culture Change Leaders work in developing and the revised PADR training and succession planning elements are being piloted.
- In relation to the Structures workstream, early socialisation and engagement has taken place and some of the methodology has been refined based on the feedback received. Formal consultation is expected towards the end of April 2026 and the team continue to work through the Operating Model, Operating Framework and Operational Governance.
- The key risks of the programme include communication and engagement challenges, ensuring staff wellbeing support is in place for staff as required and robust programme governance and decision-making are appropriate.

In discussing the report, the Committee:

- Noted that this is a fundamental cornerstone for the organisation and queried whether sufficient resource is in place to maintain pace and deliver the expected timelines questioning whether there are any barriers that can be addressed to achieve this. It was confirmed that this area of work is being prioritised to ensure the fundamental elements of the team are in place. The importance of the programme was highlighted noting that partner organisations such as Wrexham University are being contacted to explore what support can be provided to ensure the timelines are met.
- Referred to the capacity constraints affecting programme teams and Executive Directors noting the need for clarity in terms of requirements and where additional resource may be required.
- Highlighted a risk in relation to pressure on the Organisational Development team who may be supporting organisational change whilst also being individually affected by the changes taking place.
- Agreed that the issues raised and discussed are escalated to the Chief Executive including pace, timelines, resource and expertise concerns suggesting a paper comes back to the next meeting of the Committee focussed on resources, delivery confidence and next steps.

Action:

- **PC26.36.1** Escalate the issues raised around pace, timelines and resource with the Chief Executive and suggest a paper in presented to the next meeting in June 26 focussed on resources, delivery confidence and next steps.

It was resolved that the Committee:

- **NOTED** overall February–March 2026 progress and delivery across all workstreams.
- **NOTED** structures dependencies and rationale for re-phasing into 2026/27.
- **SUPPORTED** the revised structures timeline and associated communication and engagement approach.

PC26.37 BCUHB Becoming a Foster Partner

The Committee received the report and the Executive Director of People and Organisational Development highlighted:

- The Committee are requested to endorse the proposal for the Health Board to become a Foster Wales Partner (Level 2) and support the intention to seek Health Board approval in May 2026.
- The proposal suggests that the Health Board make a formal commitment to the Foster Wales friendly employer accreditation.
- As the Health Board is a major employer and anchor institution, the organisation are well placed to support staff who are foster carers as well as fostering capacity across North Wales.
- A wide range of organisational policies already align to this approach and allow work to continue to develop as a foster friendly employer.

In discussing the report, the Committee:

- Endorsed the proposal and the need to provide support for staff who are foster carers noting that as the biggest employer in the region, this commitment was welcomed.
- Queried what is required to reach the Foster Friendly Employer status in addition to the Foster Wales Partner and could this be approved at the same time. It was suggested that the Foster Wales Partner proposal is approved initially before the organisation go forward with the Foster Friendly Employer requirements.
- Suggested that the staff story for the next Board meeting in May 2026 could focus on foster carers and supporting local vulnerable children to bring the proposal to life.

It was resolved that the Committee:

- **ENDORSED** the proposal for Betsi Cadwaladr University Health Board to become a Maethu Cymru / Foster Wales Partner (Level 2) and support the intention to seek formal Board approval for this commitment at the May 2026 Board meeting, aligning with Foster Care Fortnight.
- **NOTED** that becoming a Maethu Cymru / Foster Wales Partner reflects the Health Board's role as an Anchor Institution, supporting the wellbeing of children and young people and contributing to regional fostering capacity across North Wales.
- **NOTED** that BCUHB already has a strong foundation through its adoption of All-Wales People Services policies, which provide flexibility and support for employees with caring responsibilities, including foster carers.

- **SUPPORTED** further work in 2026/27, led by People and Organisational Development, to explore the requirements and implications of achieving Foster Friendly Employer (Level 1) status, including review of relevant policies, supporting guidance, and organisational practice.
- **AGREED** that a further update and any associated recommendations relating to Foster Friendly Employer (Level 1) status are brought back to the People and Culture Committee for consideration and agreement in due course.

GOVERNANCE, RISK AND ASSURANCE

PC26.38 Consultant Job Planning

The Committee received the report and the Executive Medical Director highlighted

- This has been discussed by the Executive Committee where it was emphasised that consultant job planning is a key mechanism to ensure effective use of senior medical workforce capacity and therefore requires effective utilisation and clear expectations.
- A job planning protocol has been agreed with representative bodies including the Joint Local Negotiating Committee and the British Medical Association noting that collaboration to reach an agreed position has been a positive step forward.
- A key issue within the job planning guidelines relates to part sessional activity above 10 sessions. For example, if 10.7 sessions are completed, pay is only received for 10 sessions. Local approaches vary with some Health Boards paying for 0.25 and 0.5 sessions.
- A draft National policy is currently being developed which is expected to include 0.25 increments and the Joint Local Negotiating Committee have signed an agreed job planning protocol which includes this increment.
- The Executive Committee endorsed the need for a job planning protocol agreed with the Joint Local Negotiating Committee and the British Medical Association. It was also agreed that a small group would be established to work through the financial implications and modelling options such as waiting list initiatives to support this area of work.

In discussing the report, the Committee:

- Emphasised the need to progress and deliver sustainable improvements with support from representative bodies as this is important for staff and clarity in this area is required.
- Noted that Internal Audit have previously identified this as an issue and focus is required on achieving and embedding a solution. The Director of Corporate Governance agreed to inform the Chair of Audit Committee of the discussions that have taken place at the Committee.

Action:

- **PC26.38.1** Director of Corporate Governance to inform the Chair of the Audit Committee on the discussions that have taken place around Consultant Job Planning at the Committee.

It was resolved that the Committee:

- **NOTED** the update provided.

PC26.39 Corporate Governance Report

The Committee received the report and the Director of Corporate Governance highlighted that the Board effectiveness survey has been circulated to Board members and once this has been finalised, the Committee effectiveness survey will be circulated to members and return to the Committee with the Terms of Reference and the Cycle of Business.

It was resolved that the Committee:

- **NOTED** the summary of business considered in private session to be reported in public and the forward workplan.

CLOSING BUSINESS

PC26.40 Agree Items for Referral to Board / Other Committees

It was agreed that the Staff Survey 2025 and the endorsement to become a Foster Wales Partner would be highlighted in the Chair's Assurance Report. It was also noted that going forward the reports will be published on the Health Board website within 10 days.

PC26.41 Review of Meeting Effectiveness

It was agreed that there has been progress in relation to the discussions being held by the Committee and the items being presented.

PC26.42 Date of next meeting

Thursday 11 June 2026, 9.30am

PC26.43 Resolution to Exclude the Press and Public

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



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People & Culture Committee Action Log (Public)

Updated 04.06.26

Open Actions						
Action No.	Minute Ref.	Date	Agreed Action	Lead	Timescale	Status
ACTIONS PROPOSED FOR CLOSURE						
1	PC26.38.1	09.04.26	Consultant Job Planning Director of Corporate Governance to inform the Chair of the Audit Committee on the discussions that have taken place around Consultant Job Planning at the Committee.	Pam Wenger	June 26	Action proposed for closure 01.06.26 Discussions have taken place.
2	PC26.36.1	09.04.26	Foundations for the Future Programme Escalate the issues raised around pace, timelines and resource with the Chief Executive and suggest a paper is presented to the next meeting in June 2026 focussed on resources, delivery confidence and next steps.	Carol Shillabeer Ffion Johnstone	June 26	Action proposed for closure 01.06.26 A report has been prepared and included on the agenda for the June 2026 P&C Committee. A resource management plan has been developed and the timeline has been updated.
3	PC26.35.1	09.04.26	Three Year Culture, Leadership and Engagement Improvement Plan Bring a People and Culture progress update back to the June 2026 meeting for assurance.	Debbie Eyitayo Jason Brannan	June 26	Action proposed for closure 01.06.26 A report on the Culture, Leadership and Engagement Improvement Plan has been included on the agenda for the June 2026 P&C Committee.
4	PC26.14	12.02.26	Consultant Job Planning The People and Culture Committee to	Clara Day	June 26	Action proposed for closure 09.04.26 It was agreed at the April



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			continue to monitor progress against Consultant Job Planning to be provided for assurance rather than noting in future.			meeting that progress in relation to Consultant Job Planning would continue to be monitored by the Committee at this time and this has been included on the agenda for the June 2026 P&C Committee. 24.03.26 Consultant Job Planning is included on the agenda for the P&C Committee in April 2026.
5	PC25.130.1	04.12.25	Sickness Actions Deep Dive An update on the Sickness Absence Deep Dive Action Plan to be presented to the Committee in six months time to highlight the progress made and the implementation achieved.	Jason Brannan Georgina Roberts	June 26	Action proposed for closure 01.06.26 The Sickness Absence Deep Dive Action Plan has been included on the agenda for the June 2026 P&C Committee. 03.02.26 The Sickness Absence Deep Dive Action Plan has been included on the Committee forward workplan for the meeting in June 2026.
6	PC25.132.1	04.12.25	Education and Training Discovery Report Deputy Director of People to discuss with the Director of Corporate Governance the Education and Training reporting arrangements to the Committee once the framework has been developed and also confirm the metrics that will be required to be measured.	Jason Brannan Pam Wenger	June 26	Action proposed for closure 04.06.26 The Education and Training Discovery Report is included on the draft P&C Committee 2026/27 Cycle of Business. 04.02.26 A workshop was held at the end of January 2026 in Ysbyty Glan Clwyd with professional leads, facilitated by Jason Brannan. A paper will be developed with potential options for submission the



						Executive Committee in March 2026. The majority of professions were represented at the workshop. The Cycle of business will be now updated to align with the recently Board approved IMTP.
7	PC25.134.1	04.12.25	On-Call Arrangements: Progress Report The outcome of the follow-up Internal Audit Review relating to on-call arrangements to be presented back to the Committee once completed and reported to the Audit Committee.	Tehmeena Ajmal	June 26	Action proposed for closure 01.06.26 The internal audit report focused on on-call arrangements has been finalised and the outcome has been reported to the Audit Committee. The report has been included on the agenda for the June 2026 P&C Committee. 24.03.26 The report has now been issued as final and is scheduled for presentation to the Audit Committee on 21 April 2026. 05.02.26 The draft report has been issued and is scheduled for Executive clearance by 2 March 2026. The report is then due to be presented to the Audit Committee in April 2026 and then onward to the P&C Committee.
Closed Actions (as agreed at meeting on 09.04.26)						
Action No.	Minute Ref.	Date	Agreed Action	Lead	Timescale	Status
1	PC26.08.1	12.02.26	Three Year Culture, Leadership and Engagement Improvement Plan Bring the Three Year Culture,	Georgina Roberts	April 26	24.03.26 This has been included on the agenda for the meeting being held in April 2026.



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			Leadership and Engagement Improvement Plan back to a future meeting of the Committee once further work has been completed to review and reprioritise the actions.			
2	PC25.133.1	04.12.25	Consultant Job Planning Consultant Job Planning to be included as a standing item for the People and Culture Committee to monitor progress on a regular basis until improvements are made in this area.	Clara Day Karen Mottart	April 26	12.02.26 It was agreed at the meeting in February 2026 that the Committee would continue to monitor progress against Consultant Job Planning. 04.02.26 Consultant Job Planning is included on the agenda for the meeting being held in February 2026 where the Committee will confirm whether this requires further monitoring.
3	PC26.11	12.02.26	Strategic Equality Plan 2024-2028 Referred an action to the Quality, Safety and Experience Committee to review the breakdown of complaints by Ethnicity.	Philippa Peake-Jones	June 26	02.04.26 The request has been made and will be included in the Quality Report to QSE if possible.
4	PC26.09	12.02.26	Strategic Workforce Planning Framework Discuss at the Chair's Assurance Group whether 'for noting' items could be shared outside of Committee meetings going forward.	Philippa Peake-Jones	June 26	02.04.26 This was discussed at the Chair's Assurance Group, this will be taken forward as work commences on the trial of a "Consent Agenda"

People and Culture Committee

WELSH LANGUAGE CHAMPIONS PROGRAMME

Dyddiad y Cyfarfod Date of Meeting	11 June 2026
Statws Cyhoeddi Publication Status	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad Report Author name and title	Eleri Hughes-Jones, Head of Welsh Language Services Manon Celyn Roberts, Welsh Language Officer
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol Lead Executive Team Member name and title	Teresa Owen Executive Director of Allied Health Professions and Health Science
Pwrpas yr Adroddiad Report Purpose	For Approval

Crynodeb Gweithredol **Executive Summary**

The Welsh Language Champions Programme within the Health Board has been developed to strengthen the organisation's commitment to delivering bilingual healthcare services in line with the Welsh Language Standards under the Welsh Language (Wales) Measure 2011.

The programme recognises and formalises the contributions of staff who are already actively promoting the Welsh language in their daily roles.

Welsh Language Champions play a vital role in fostering a workplace culture where Welsh is visible, valued, and routinely used. They support colleagues, promote good practice, and help ensure compliance with statutory requirements, contributing directly to improved patient experience and person-centred care.

A key example highlighted is Maureen Roberts, a Site Administrator across community hospitals in Conwy and Denbighshire. Through proactive leadership, she has improved bilingual signage, raised staff awareness of Welsh language requirements, and encouraged colleagues to deliver services bilingually. Her



efforts have led to measurable improvements in the availability and quality of Welsh-medium services across multiple sites.

The programme aligns with Welsh Government's 'More than just words' Five-year plan 2022 – 2027, including the principle of the 'Active Offer', which requires healthcare providers to offer services in Welsh without patients needing to request them. It also aligns with internal intent as part of the Health Board's Integrated Medium-Term Plan 2026-2029, where Welsh language and culture has been identified as a central driver in delivering safe, person-centred care.

The Welsh Language Champions Programme will strengthen the Health Board's ability to meet statutory obligations and enhance patient dignity and experience by embedding bilingualism into everyday practice. Continued acknowledgment of endeavours and achievements will increase awareness, support, and recognition which will be essential to sustain and expand these improvements across the organisation.

The Welsh Language Champions Programme also contributes to the wider work of promoting the Welsh language and culture within the organisation.

A video will be made of each Champion sharing their stories and experiences, and the first video presented today is of Mauren Roberts.

Trawsgrifiad o'r fideo Transcript of the video

*"My name is Maureen Roberts.
I'm site administrator for Ruthin, Denbigh and Rhyl Hospitals.
My role is to line manage staff within these Hospitals.
As a Welsh Language Champion, I ensure that all posters and notices within public areas are compliant with the Welsh Language and have been translated into Welsh.
If any information is in English only, I will send for translation or I will show staff where to access the Welsh translation portal.
When I complete local inductions with new staff, I always reinforce how new staff should answer the phone bilingually and also how they should meet and greet patients and visitors."*

Ymgysylltu (mewnol/allanol) yr ymgwymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp)
Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)

Pwyllgor / Grŵp / Unigolion Committee / Group / Individuals	Dyddiad Date	Canlyniad, Tystiolaeth a Data Outcome, Evidence and Data
Executive Committee	3/6/26	Approved

Welsh Language Champions Programme

1. SITUATION

The Welsh Language Standards within the Health Board came into force under the Welsh Language (Wales) Measure 2011, and ensure that Welsh is treated no less favourably than English in the delivery of healthcare services. Under these legal duties, patients have the right to receive care and information in Welsh, helping to support dignity, safety, and a better overall experience.

The Health Board meets these standards by providing bilingual services, promoting the 'Active Offer' principle aligned to the Welsh Government's 'More than just words' Five-year plan, and supporting staff to use and develop their language skills. The Standards help embed Welsh into everyday healthcare across North Wales, ensuring services are accessible and culturally-appropriate.

However, ensuring consistent delivery of Welsh-language services across a large organisation can be challenging due to variations in staff awareness, confidence, and resources. The Welsh Language Champions Programme has been introduced to strengthen compliance, support staff, and embed bilingual practice more consistently across services.

2. BACKGROUND

The Welsh language is a fundamental part of culture, identity, and service delivery across North Wales. Within the Health Board, ensuring compliance with the Welsh Language Standards is a core responsibility shared by all members of staff, regardless of role or department. These Standards are in place to ensure that patients, service users, and colleagues are able to use the Welsh language naturally and confidently when accessing healthcare services.

Welsh Language Champions play a key role in supporting this commitment. They promote the active use of Welsh in the workplace, encourage good practice, and help raise awareness of the importance of bilingual service provision. Importantly, these responsibilities are not separate from the day-to-day work of staff. They align closely with the expectation that all staff contribute towards meeting the Welsh Language Standards in their roles.

The Champion role is undertaken as part of existing duties, reflecting a commitment to the Welsh language and culture, as well as a willingness to support colleagues and services in embedding bilingualism more consistently. Crucially, many individuals identified as Welsh Language Champions are already demonstrating these behaviours in practice by promoting the Welsh language, supporting others, and contributing positively to a culture where the language is visible and valued. Designating these individuals as Welsh Language Champions is about formally recognising and acknowledging the work they are doing. It highlights their

dedication, celebrates their contribution, and helps create a supportive network of staff who can lead by example and inspire others.

The 'Welsh Language Champions' is a well-known term across Wales with many organisations across Wales already proactively executing this programme. It is acknowledged by the Welsh Language Commissioner as part of her successful practices initiatives. By recognising and supporting Welsh Language Champions, the Health Board strengthens its ability to meet statutory requirements, enhance patient experience, and foster a workplace culture where the Welsh language can thrive.

3. SPECIFIC MATTERS FOR CONSIDERATION

The Welsh Language Champions Programme delivers a range of strategic and operational benefits, particularly in strengthening compliance with the Welsh Language Standards. By embedding the 'Active Offer' more effectively, the programme supports staff to provide Welsh language services proactively.

In addition, the programme offers clear benefits to workforce development and organisational culture. It enhances staff awareness, confidence, and capability to use Welsh in the workplace, contributing to a more skilled and engaged bilingual workforce. The recognition and support of Welsh Language Champions also foster a positive culture where the Welsh language is visible, valued, and integrated into everyday practice. This cultural shift supports long-term sustainability in delivering bilingual healthcare services.

From a patient perspective, the advantages are significant. The programme contributes directly to improved patient experience, dignity, and safety by enabling individuals to receive care in their preferred language. It supports equitable access to healthcare services, ensuring Welsh speakers are not disadvantaged, and aligns with wider strategic priorities around quality, equality, and person-centred care. Overall, these benefits demonstrate that the programme not only supports compliance but also enhances service quality and outcomes across the organisation.

4. KEY RISKS / MATTERS FOR ESCALATION

The programme provides a structured and practical mechanism to ensure more consistent delivery of bilingual services across all sites, reducing variation in practice and mitigating risks associated with non-compliance, including potential regulatory or reputational consequences.

5. RECOMMENDATIONS

- For members of the People and Culture Committee to **SUPPORT** the implementation and roll-out of the Welsh Language Champions Programme to embed bilingual practice from within the organisation.

ASESIAD / ASSESSMENT

Cysylltiad â'r Bwriadau Strategol Link to Strategic Intentions	3. Improve Access, Outcomes and Experience
	The programme supports strategic priorities by improving equitable access to services, enhancing quality and safety of care through better communication, and strengthening patient experience by enabling individuals to receive care in their preferred language. It also contributes to a positive organisational culture where staff feel supported to deliver person-centred, bilingual services.
Yr Egwyddorion Dylunio Design Principles	People First Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd Corporate Risks and Board Assurance Framework	N/A

ASESIADAU O EFFAITH / IMPACT ASSESSMENTS

Equality Act 2010 Public Sector Equality Duty: Has BCUHB provided evidence of 'Due Regard' to compliance with the three parts of the Public Sector Equality Duty (General Duty): https://www.gov.wales/public-sector-equality-duty-htmlPublicSectorEqualityDuty[HTML] GOV.WALES	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	N/A
Equality Act 2010 - Socio-economic Duty Has BCUHB provided evidence of 'Due Regard' to compliance of ther Socio-economic Duty when making strategic decisions?	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	N/A

<i>Have you completed an Integrated Equality Impact Assessment WP8a?</i> WP8a Template	Canlyniad/Outcome: Do/Yes:	Naddo/No: ☒
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale: Canlyniad/Outcome:	N/A
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Human Rights Act <i>Have Human Right based concerns been addressed within WP8a</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	N/A
Compliance to the Welsh Language requirements? <i>Have you undertaken an Impact Assessment</i>	Do/Yes: ☐	Naddo/No: ☒
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	N/A
Compliance to giving 'Due Regard' to the principles of the Armed Forces Covenant <i>Have the principles of the Armed Forces Covenant been addressed within WP8a</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	N/A
Ansawdd <i>A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?</i> Quality <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	N/A
	Galluogwyr Ansawdd Enablers of Quality Culture and Valuing People Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant	A Healthier Wales	

<u>Wellbeing of Future Generations Act – Wellbeing Goals</u>	Supports better communication between staff and patients, leading to safer, more effective care and improved health outcomes. A More Equal Wales Ensures Welsh speakers can access services in their preferred language, reducing inequality and promoting fair access to healthcare. A Wales of Cohesive Communities Strengthens community connections by valuing and promoting the Welsh language within local healthcare settings. A Wales of Vibrant Culture and Thriving Welsh Language Actively promotes and normalises the use of Welsh in everyday healthcare, supporting its growth and sustainability. A Prosperous Wales Develops a skilled and confident bilingual workforce, supporting sustainable public services.	
Effaith Amgylcheddol / Cynaliadwyedd (5Rs) Environmental /Sustainability Impact (5Rs)	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below: No - Not Applicable	
Asesiad o Effaith ar Ddiogelu Data <i>A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?</i> Data Protection Impact Assessment <i>Have you undertaken a Data Protection Impact Assessment Screening?</i>	Do/Yes: ☐ Canlyniad/Outcome: Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Naddo/No: ☒ N/A
Asesiad o Effaith ar Atal Twyll	Do/Yes: ☐ Canlyniad/Outcome:	Naddo/No: ☒

<i>A ydych chi wedi ystyried yr effeithiau ar atal twyll?</i> Counter Fraud Impact <i>Have you considered the counter fraud impacts</i>	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	N/A
Cyfreithiol Legal	Yes (Include further detail below) The Health Board has a legal duty to comply with the Welsh Language (Wales) Measure 2011 and the associated Welsh Language Standards. These standards require the organisation to ensure that the Welsh language is not treated less favourably than English and that services can be delivered in Welsh. This includes: • Providing bilingual services, communications, and signage • Enabling patients to use Welsh without having to request it (Active Offer) • Supporting staff to deliver services in Welsh • Meeting the requirements set out in the organisation's compliance notice issued by the Welsh Language Commissioner	
Enw Da Reputational	Yes (Include further detail below) Failure to meet these obligations may result in regulatory action and reputational risk, making compliance a statutory requirement for the Health Board.	
Effaith ar Adnoddau <i>(Pobl / Ariannol)</i> Resource Impact <i>(People / Financial)</i>	Yes (Include further detail below) Positive impact on workforce development by enhancing skills, engagement, and cultural awareness	

People and Culture Committee

WELSH LANGUAGE PROMOTION PLAN 2026-2027

Dyddiad y Cyfarfod Date of Meeting	11 June 2026
Statws Cyhoeddi Publication Status	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad Report Author name and title	Eleri Hughes-Jones, Head of Welsh Language Services Manon Celyn Roberts, Welsh Language Officer
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol Lead Executive Team Member name and title	Teresa Owen Executive Director of Allied Health Professions and Health Science
Pwrpas yr Adroddiad Report Purpose	For Approval

Crynodeb Gweithredol Executive Summary

This Welsh Language Promotion Plan 2026–2027 sets out a structured, year-round programme to strengthen the Health Board’s Welsh language culture, capability, and confidence. Rooted in statutory duties under the Welsh Language (Wales) Measure 2011 and aligned with the Welsh Government’s ‘More than just words’ Framework, the plan positions the Welsh language as a core component of person-centred care, cultural identity, and organisational excellence. It also addresses the Welsh Language and Culture priorities with the Health Board’s Integrated Medium-Term Plan 2026-2029.

The plan aims to build a sustainable model of operational support that normalises the Active Offer and embeds Welsh language use into everyday practice. It adopts a phased, cultural-change approach across four quarters:

- **Quarter 1** establishes foundations through a baseline staff awareness survey and the launch of the Welsh Language Champions Programme, creating early cultural leadership and insight into organisational readiness.

- **Quarter 2** focuses on building confidence and peer support through internal campaigns, patient stories, and shared learning within the Champions network.
- **Quarter 3** strengthens visibility and normalisation through Welsh Language Week, practical tools for teams, and the sharing of good-practice case studies.
- **Quarter 4** celebrates cultural identity, assesses cultural maturity through a bilingual mystery shopper exercise, and consolidates learning via Champion reports and an annual impact report.

The plan highlights several key considerations for successful cultural embedding: visible leadership, consistent reinforcement of expectations, workforce confidence, and the integration of Welsh language behaviours into routine processes such as induction, supervision, and team meetings.

Risks include variable engagement, inconsistent adoption across divisions, low staff confidence, and the potential for cultural initiatives to lose momentum if not sustained.

The Welsh Language Promotion Plan will be monitored through quarterly progress dashboards, cultural insight, and operational performance measures to ensure sustained cultural change. Quarterly reporting will track delivery of planned activities, staff engagement, and emerging barriers, while cultural indicators—such as staff surveys, Champion feedback, and case studies—will assess shifts in confidence, attitudes, and everyday behaviours. Operational monitoring will focus on practical measures including ESR updates, training uptake, and visibility of bilingual materials, alongside Active Offer assurance through mystery shopper exercises and service-user feedback. Leadership visibility will also be reviewed to ensure bilingual behaviours are modelled consistently. An annual impact report will consolidate findings, highlight progress, and identify priorities for the following year, providing clear organisational accountability.

Ymgysylltu (mewnol/allanol) yr ymgwymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp)
Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)

Pwyllgor / Grŵp / Unigolion Committee / Group / Individuals	Dyddiad Date	Canlyniad, Tystiolaeth a Data Outcome, Evidence and Data
N/A		

Acronymau / Rhestr Termiau
Acronyms / Glossary of Terms

N/A

Welsh Language Promotion Plan 2026-2027

1. SITUATION

The Health Board operates within a statutory, cultural, and societal context in which the Welsh language is not only a legal requirement but a fundamental expression of national identity. The Welsh Language (Wales) Measure 2011 establishes Welsh as an official language, placing a duty on public bodies to ensure that it is treated no less favourably than English. However, the significance of the Welsh language extends beyond compliance. Welsh is deeply intertwined with the culture, lived experience, and sense of belonging of communities across Wales. For many service users—particularly older people, those receiving care, and individuals in vulnerable circumstances—Welsh is the language of emotion, comfort, and trust.

The Welsh Government's 'More Than Just Words' Framework recognises this cultural dimension, emphasising that the 'Active Offer' is not simply a linguistic obligation but a commitment to culturally sensitive, person-centred care. The attached plan reflects this understanding by positioning Welsh language promotion as both a cultural and operational priority, aiming to embed the language into the identity, behaviours, and everyday practice. Its objective—to "increase awareness and understanding by building a model of operational support to promote the use of Welsh language incorporating the 'Active Offer' principle"—demonstrates a clear alignment with national expectations and a recognition that cultural change is essential for sustainable improvement.

2. BACKGROUND

The plan outlines a comprehensive programme of work designed to strengthen Welsh-language provision and embed the language into the organisation's culture. It does so through a structured, year-round sequence of activities, each of which contributes to cultural embedding in a different way.

Quarter 1 – Establishing Cultural Awareness and Foundations

Quarter 1 focuses on understanding the organisation's current cultural landscape through a baseline survey of staff awareness. This survey is described as providing "a baseline of current position with regards to awareness and understanding," enabling the organisation to identify cultural strengths and areas requiring development. This diagnostic stage is crucial for cultural embedding because it reveals how staff currently perceive the Welsh language, how confident they feel using it, and what cultural barriers may exist.

In parallel, the launch of the Welsh Language Champions Programme begins to establish local cultural leadership. Champions are introduced as individuals recognised for their commitment to promoting Welsh internally. Their early visibility helps signal that Welsh language is a shared cultural responsibility, not a niche or specialist function. This early-stage cultural signalling is essential for setting expectations and shaping organisational norms.

Quarter 2 – Building Cultural Confidence and Peer Support

Quarter 2 activities focus on strengthening cultural confidence and creating peer-supported learning environments. The internal “Cymraeg yn Gyntaf” campaign uses patient stories to highlight the emotional and cultural impact of hearing Welsh in care settings. These stories act as cultural anchors, helping staff understand that language is not transactional but relational—deeply connected to dignity, identity, and trust.

Peer learning sessions within the Champions network further embed cultural expectations by creating safe spaces for staff to share experiences, discuss challenges, and celebrate progress. This peer-driven model reinforces the idea that cultural change is collective and that Welsh language use is a normal, everyday behaviour rather than an exceptional one.

Quarter 3 – Normalising Welsh Language Through Visibility and Shared Practice

Quarter 3 activities are designed to normalise Welsh language use by increasing its visibility and embedding it into everyday organisational life. Welsh Language Week, supported by an information stall and a promotional video, is positioned not merely as a celebratory event but as a cultural intervention that strengthens identity and encourages staff to see Welsh as part of the organisation’s shared culture.

Simultaneously, the development of the Champions Support Toolkit and low-intensity team interventions—such as encouraging ESR updates and identifying local barriers—help embed Welsh language expectations into routine processes. These activities reinforce cultural norms by making Welsh language considerations part of everyday operational conversations.

The sharing of case studies showcasing good practice also contributes to cultural embedding by highlighting real examples of teams who have successfully integrated Welsh into their work. These stories help normalise bilingual practice and demonstrate that cultural change is achievable and valued.

Quarter 4 – Celebrating Cultural Identity and Assessing Cultural Maturity

Quarter 4 focuses on cultural celebration, reflection, and assessment. St David’s Day activities are used to celebrate staff, promote Welsh language lessons, and strengthen cultural identity. The plan notes that these activities contribute to “stronger cultural identity and belonging,” reinforcing the idea that Welsh language is a source of pride and collective ownership.

The bilingual mystery shopper exercise provides an opportunity to assess how deeply Welsh-language expectations have been embedded into everyday practice. By evaluating the visibility of Welsh and the consistency of the Active Offer, the organisation gains insight into its cultural maturity and identifies areas requiring further development.

The collection of Champion reports and the publication of an annual impact report further reinforce cultural embedding by recognising achievements, celebrating progress, and demonstrating organisational commitment to bilingualism.

This cultural promotion roadmap outlines the organisation's journey toward becoming a culturally bilingual institution where the Welsh language is visible, valued, and naturally integrated into everyday practice.

Monitoring Framework

Monitoring of the Welsh Language Promotion Plan will be delivered through a structured combination of quarterly reporting, cultural insight, and operational performance measures. Quarterly dashboards will track progress against planned activities, levels of staff engagement, and any emerging barriers or themes.

Alongside this, cultural indicators—such as staff awareness surveys, feedback from Welsh Language Champions, and narrative case studies—will provide a deeper understanding of how attitudes, confidence, and behaviours are shifting across the organisation.

Operational monitoring will focus on practical measures that demonstrate normalisation of Welsh language use, including ESR updates, uptake of training, visibility of bilingual materials, and participation in team-level interventions. Delivery of the Active Offer will be assessed through bilingual mystery shopper exercises, spot checks, and service-user feedback, ensuring that real-world experience aligns with organisational expectations.

Leadership visibility will also be monitored, recognising its central role in cultural change. Evidence of leaders modelling bilingual behaviours, supporting initiatives, and embedding Welsh language expectations into routine processes will form part of the assurance picture. An annual impact report will consolidate findings, highlight progress, and identify priorities for the following year, ensuring sustained focus and organisational accountability.

3. SPECIFIC MATTERS FOR CONSIDERATION

Several important considerations arise from the plan, particularly in relation to cultural change and the embedding of Welsh language as a core organisational value.

Cultural Embedding and Behavioural Change

The plan recognises that cultural change requires more than awareness-raising; it requires consistent reinforcement, visible leadership, and opportunities for staff to engage meaningfully with the language. Cultural embedding will depend on the organisation's ability to integrate Welsh-language expectations into everyday processes such as induction, supervision, team meetings, and performance discussions.

Normalising Welsh Language Use

The plan's emphasis on visual identifiers, internal campaigns, and cultural celebrations reflects an understanding that normalisation is a cultural process. Staff must feel that using Welsh is not exceptional but expected and valued.

Leadership and Organisational Tone

Cultural change is most effective when leaders model the behaviours they expect from others. Leadership endorsement of the Champions Programme and cultural initiatives will be essential for building momentum.

Workforce Confidence and Identity

The plan highlights the importance of increasing staff confidence in using Welsh. Confidence is both a skill and a cultural factor; staff must feel safe, supported, and encouraged to use Welsh, even if they are learners.

Sustaining Cultural Change

Cultural change is long-term and requires sustained effort. The plan's year-round programme of activities provides a strong foundation, but the organisation must ensure that these activities are not perceived as isolated events.

By following this roadmap, the organisation moves toward a future where:

- Welsh language is a natural, confident part of everyday interactions.
- Staff feel proud of their bilingual identity and understand the cultural significance of language.
- Leaders model bilingual behaviours and set clear expectations.
- The Active Offer is consistently delivered across all services.
- Cultural change is sustained through continuous learning, recognition, and improvement.

This roadmap positions the Welsh language not merely as a compliance requirement but as a defining element of organisational culture, identity, and excellence in person-centred care.

4. KEY RISKS / MATTERS FOR ESCALATION

Cultural Resistance or Low Engagement

If staff perceive Welsh-language initiatives as optional or peripheral, cultural change may be limited.

Insufficient Workforce Confidence

A lack of confidence among staff—particularly learners—may inhibit the use of Welsh in practice.

Inconsistent Cultural Adoption Across Divisions

Cultural change may progress unevenly across the organisation.

Leadership Visibility

If leaders do not model Welsh-language behaviours, staff may not perceive the language as a genuine organisational priority.

Sustainability of Cultural Initiatives

If activities are not sustained or integrated into core processes, initial momentum may diminish.

This plan aims to mitigate these concerns and will be reviewed on uptake on a quarterly basis.

5. RECOMMENDATIONS

- For members of the People and Culture Committee to **SUPPORT** the implementation and roll-out of the Welsh Language Promotion Plan to increase awareness and normalise the language within the organisation's daily activities.

ASESIAD / ASSESSMENT	
Cysylltiad â'r Bwriadau Strategol Link to Strategic Intentions	3. Improve Access, Outcomes and Experience The plan supports strategic priorities by improving equitable access to services, enhancing quality and safety of care through better communication, and strengthening patient experience by enabling individuals to receive care in their preferred language. It also contributes to a positive organisational culture where staff feel supported to deliver person-centred, bilingual services.
Yr Egwyddorion Dylunio Design Principles	People First Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd Corporate Risks and Board Assurance Framework	N/A

ASESIADAU O EFFAITH / IMPACT ASSESSMENTS		
Equality Act 2010 Public Sector Equality Duty: Has BCUHB provided evidence of 'Due Regard' to compliance with the three parts of the Public Sector Equality Duty (General Duty): https://www.gov.wales/public-sector-equality-duty-html Public Sector Equality Duty [HTML] GOV.WALES	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	N/A
Equality Act 2010 - Socio-economic Duty <i>Has BCUHB provided evidence of 'Due Regard' to compliance of ther Socio-economic Duty when making strategic decisions?</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	N/A
	Canlyniad/Outcome: Do/Yes:	Naddo/No: ☒

<i>Have you completed an Integrated Equality Impact Assessment WP8a?</i> WP8a Template	Os naddo, dylech gynnwys y rheswm: If no, please include rationale: Canlyniad/Outcome:	N/A
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Human Rights Act <i>Have Human Right based concerns been addressed within WP8a</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	N/A
Compliance to the Welsh Language requirements? <i>Have you undertaken an Impact Assessment</i>	Do/Yes: ☒	Naddo/No: ☐
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Compliance to giving 'Due Regard' to the principles of the Armed Forces Covenant <i>Have the principles of the Armed Forces Covenant been addressed within WP8a</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	N/A
Ansawdd <i>A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?</i> Quality <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	N/A
	Galluogwyr Ansawdd Enablers of Quality Culture and Valuing People Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	

<u>Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant Wellbeing of Future Generations Act – Wellbeing Goals</u>	A Healthier Wales Supports better communication between staff and patients, leading to safer, more effective care and improved health outcomes. A More Equal Wales Ensures Welsh speakers can access services in their preferred language, reducing inequality and promoting fair access to healthcare. A Wales of Cohesive Communities Strengthens community connections by valuing and promoting the Welsh language within local healthcare settings. A Wales of Vibrant Culture and Thriving Welsh Language Actively promotes and normalises the use of Welsh in everyday healthcare, supporting its growth and sustainability. A Prosperous Wales Develops a skilled and confident bilingual workforce, supporting sustainable public services.			
Effaith Amgylcheddol / Cynaliadwyedd (5Rs) Environmental /Sustainability Impact (5Rs)	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below: No - Not Applicable <table border="1" data-bbox="635 1350 1437 1534"> <tr> <td data-bbox="635 1350 1072 1534"> Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list: </td><td data-bbox="1072 1350 1437 1534"></td></tr> </table>		Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:	
Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:				
Asesiad o Effaith ar Ddiogelu Data <i>A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?</i> Data Protection Impact Assessment <i>Have you undertaken a Data Protection Impact Assessment Screening?</i>	Do/Yes: ☐ Canlyniad/Outcome: Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Naddo/No: ☒ N/A		
Asesiad o Effaith ar Atal Twyll	Do/Yes: ☐ Canlyniad/Outcome:	Naddo/No: ☒		

<i>A ydych chi wedi ystyried yr effeithiau ar atal twyll?</i> Counter Fraud Impact <i>Have you considered the counter fraud impacts</i>	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	N/A
Cyfreithiol Legal	Yes (Include further detail below) The Health Board has a legal duty to comply with the Welsh Language (Wales) Measure 2011 and the associated Welsh Language Standards. These standards require the organisation to ensure that the Welsh language is not treated less favourably than English and that services can be delivered in Welsh. This includes: • Providing bilingual services, communications, and signage • Enabling patients to use Welsh without having to request it (Active Offer) • Supporting staff to deliver services in Welsh • Meeting the requirements set out in the organisation's compliance notice issued by the Welsh Language Commissioner	
Enw Da Reputational	Yes (Include further detail below) Failure to meet these obligations may result in regulatory action and reputational risk, making compliance a statutory requirement for the Health Board.	
Effaith ar Adnoddau <i>(Pobl / Ariannol)</i> Resource Impact <i>(People / Financial)</i>	Yes (Include further detail below) Positive impact on workforce development by enhancing skills, engagement, and cultural awareness	

DEFNYDDIWCH EICH
CYMRAEG



USE YOUR
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Welsh Language Promotion Plan 2026-2027



Welsh Language Services

Promotion Plan 2026-2027

Objective: Increase awareness and understanding by building a model of operational support to promote the use of Welsh language, incorporating the “Active Offer” principle <i>(aligned to the Integrated Medium-Term Plan – Welsh Language and Culture Objectives)</i>						
Ref.	Output	Activities / Key Performance Indicators				Lead
		Quarter 1	Quarter 2	Quarter 3	Quarter 4	
1.1	Promote the use of Welsh language within the organisation to ensure the co-design of culturally sensitive activities.	Action: Conduct a baseline survey of current Welsh language awareness across the organisation Organisational Outcome: Clear outline of current awareness and understanding within the organisation. Benefit: Provide baseline of current position with regards to awareness and understanding.	Action: Conduct an internal campaign to encourage staff to use Welsh first / ‘Cymraeg yn Gyntaf’ – use a patient story to highlight the positive impact hearing even a few words of Welsh can have on patients and their families. Organisational Outcome: Increased visibility of Welsh language.	Action: Hold our annual ‘Welsh Language Week’ with information stall to target staff and a promotional video to raise awareness of the language internally. Organisational Outcome: Improved staff engagement with learning. Benefit: Enhanced staff morale and wider cultural ownership.	Action: Celebrate St David’s Day with an internal campaign celebrating our staff and promoting Welsh language lessons that are available to staff. Organisational Outcome: Stronger cultural identity and belonging. Benefit: Evidence base for future planning of activities and events to inspire pride and ownership.	Head of Services (HoS) / Welsh Language Officers (WLOs)

			Benefit: Increased understanding of the impact that Welsh language has on service delivery.			
1.2	Scale successful initiatives across divisions through the launch the 'Welsh Language Champions Programme'.	Actions: Launch of the programme to introduce an individual recognised for their practices in promoting the Welsh language internally. Launch of a new Welsh champion every quarter at Welsh Language Strategic forum. Organisational Outcomes: Sustainable network of Welsh	Action: Peer learning sessions within the Champion network to facilitate an opportunity where champions can collaborate and share examples of best practice Organisational Outcomes: Consistent local implementation. Benefit: Increased staff confidence in	Actions: Create a Champions Support Toolkit to assess their local areas. Begin low-intensity team interventions: e.g. Encourage ESR language skills updates Identify local barriers and escalate to the Welsh Language Service (e.g., signage gaps, materials needed).	Actions: Collect Champion reports and identify themes for organisational improvement. Recognise and celebrate achievements. Publish a short annual impact report showing how Champion activity supports MTJW actions. Organisational Outcomes:	WLOs

		language advocates. Benefit: Reduced pressure on central services.	their ability to promote the Welsh language.	Promote the Active Offer through service level internal campaigns, newsletters, notice boards. Organisational Outcomes: Increased accuracy of ESR data. Clear organisational intelligence. Benefit: Improved visibility of Welsh language and streamline central service workloads.	Stronger culture of recognition. Benefits: Demonstrable progress against MTJW. Decrease reliance on core Welsh language Team service.	
1.3	Collaborate with primary care providers to promote and increase the use of the Welsh language	Actions: Conduct a baseline survey of the expectations and current provision from the perspective of patients and the public and evaluate the results. Carry out a baseline survey of services offered by GP practices in Anglesey and conduct a baseline survey on the current use of Welsh Language within the practices		Action: Work with the two identified GP Practices to launch a Welsh Language Primary Care Tool-kit.	Action: Roll out the Primary Care Tool-kit Organisational Outcomes: Strengthened partnership working.	WLOs

		Finalise the Welsh Language Section on the Primary Care Academy website Organisational Outcomes: Clear understanding of Welsh language needs in primary care. Increased availability of resources. Benefits: Better patient experience. Increased compliance in contracted services.	Organisational Outcomes: Improved consistency of provision. Benefit: Reduced risk of complaints.	Benefit: Enhanced reputation of BCUHB.	
1.4	Establish a sustainable model of operational support that normalises the Welsh language as a core component of service delivery.	Actions: Audit current use of Iaith Gwaith materials and address gaps in uptake. Internal campaign to reinforce the initiative with additional visual markers (e.g. Teams status) to identify Welsh speakers/learners. Organisational Outcomes: Enhancing the visibility of Welsh-speaking staff through the consistent use of Iaith Gwaith visual identifiers (e.g. badges and lanyards)	Action: Share case study in the form of a video showcasing good practice across teams on a higher level. Organisational Outcomes: Increased organisation-wide consistency and standardisation in delivering the Active Offer, through shared learning that	Action: Conduct a bilingual mystery shopper exercise to assess the consistent delivery of the Active Offer and the visibility of Welsh language provision across services. Organisational Outcomes: Assurance that the Active Offer is being delivered consistently, with Welsh language	WLOs

		Expanding the Iaith Gwaith initiative to ensure that staff who can fully or partially provide services in Welsh are easily recognised. Benefit: Reinforce a culture of belonging and promote Welsh as a natural, everyday language within all services.	embeds good practice and normalises Welsh language use across teams and services. Benefit: Strengthened organisational culture and staff engagement	services visible, proactive, and embedded across all service areas. Benefit: Strengthened quality, compliance, and continuous improvement that drives cultural change.	
Cross-Cutting Organisational Benefits: • Strengthened leadership capacity. • Improved patient safety and experience. • Workforce development and retention. • Compliance and risk reduction. • Cultural transformation.					
Evaluation & Success Measures: • Increase in staff confidence. • Increase in ESR accuracy. • Number of Champions active. • Toolkit adoption in primary care. • Increase in Active Offer compliance. • Reduction in complaints. • Positive patient feedback.					

People and Culture Committee

FIRST ANNUAL REPORT FOR HEALTHCARE SCIENCES

Dyddiad y Cyfarfod Date of Meeting	11 June 2026
Statws Cyhoeddi Publication Status	Open/ Public
Enw a theitl Awdur(on) yr Adroddiad Report Author name and title	Helen Hughes Professional Service Manager Radiography/Assistant Director Allied Health Professions & Health Science
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol Lead Executive Team Member name and title	Teresa Owen Executive Director of Allied Health Professionals and Healthcare Science

Pwrpas yr Adroddiad Report Purpose	For Noting
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Crynodeb Gweithredol Executive Summary

This paper is the first Annual report for Healthcare Sciences. It is written to inform committee members of the work of the clinical scientific professions that work across BCU. The report describes which professions make up the healthcare scientists and demonstrates their contribution to modern healthcare. It covers some key achievements and challenges over 25/26 for this group of clinical professionals. The Healthcare sciences have a strong underpinning of quality management systems. The report highlights some of the accreditation, regulation and quality management that underpins the healthcare scientist work.

Ymgysylltu (mewnol/allanol) yr ymgwymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp)
Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)

Pwyllgor / Grŵp / Unigolion Committee / Group / Individuals	Dyddiad Date	Canlyniad, Tystiolaeth a Data Outcome, Evidence and Data
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Acronymau / Rhestr Termiau
Acronyms / Glossary of Terms

BETSI CADWALADR UNIVERSITY HEALTH BOARD (BCUHB) - FIRST ANNUAL REPORT FOR HEALTHCARE SCIENTISTS (2026-27)

1. Y SEFYLLFA/THE SITUATION

This is the first annual report for Healthcare Scientists and is written in order to highlight the work and significant impact this group of clinical health care professions has in supporting patients across the whole healthcare system at BCUHB.

2. Y CEFNDIR/ THE BACKGROUND

There are over 30 professions divided into six families. These professions contribute to over 95% of patient pathways. Over 8million tests and patient contacts were conducted by health care scientists in 2025. In addition, clinical engineering look after 56,000 medical devices in North Wales.

3. MATERION PENODOL I'W HYSTYRIED/ SPECIFIC MATTERS FOR CONSIDERATION

3.1. To note the number of different professions that make up the healthcare scientists within BCU and their contribution to modern healthcare science.

4. RISGIAU ALLWEDDOL - MATERION I'W HUWCHGYFEIRIO/KEY RISKS - MATTERS FOR ESCALATION

The challenges for healthcare scientists are noted in the report.

5. ARGYMHELLION/RECOMMENDATIONS

5.1. The People and Culture Committee is asked to:

5.1.1. **RECEIVE** and **DISCUSS** the report and contents.

5.1.2. **FEEDBACK** on the report format so as to inform future iterations.

ASESIAD / ASSESSMENT

Link to Strategic Intentions	3. Improve Access, Outcomes and Experience
Yr Egwyddorion Dylunio Design Principles	Consistency with Organisational Values
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd Corporate Risks and Board Assurance Framework	

ASESIADAU O EFFAITH / IMPACT ASSESSMENTS

Equality Act 2010 Public Sector Equality Duty: Has BCUHB provided evidence of 'Due Regard' to compliance with the three parts of the Public Sector Equality Duty (General Duty): https://www.gov.wales/public-sector-equality-duty.html Public Sector Equality Duty [HTML] GOV.WALES	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	This is an annual report and thus not applicable
Equality Act 2010 - Socio-economic Duty <i>Has BCUHB provided evidence of 'Due Regard' to compliance of ther Socio-economic Duty when making strategic decisions?</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	This is an annual report, and thus not applicable
<i>Have you completed an Integrated Equality Impact Assessment WP8a?</i> WP8a Template	Canlyniad/Outcome:	Naddo/No:
	Do/Yes:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale: Canlynaid/Outcome:	This is an annual report, and thus not applicable

	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Human Rights Act <i>Have Human Right based concerns been addressed within WP8a</i>	Do/Yes: ☐	Naddo/No: ☐
	Canlyniad/Outcome:	
Compliance to the Welsh Language requirements? <i>Have you undertaken an Impact Assessment</i>	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Naddo/No: ☐
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Compliance to giving 'Due Regard' to the principles of the Armed Forces Covenant <i>Have the principles of the Armed Forces Covenant been addressed within WP8a</i>	Do/Yes: ☐	Naddo/No: ☐
	Canlyniad/Outcome:	N/A
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
<u>Ansawdd</u> <i>A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?</i> <u>Quality</u> <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Galluogwyr Ansawdd Enablers of Quality Choose an item. Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
<u>Deddf Llesiant</u> <u>Cenedlaethau'r Dyfodol -</u> <u>Nodau Llesiant</u>	Choose an item.	

Wellbeing of Future Generations Act – Wellbeing Goals		
Effaith Amgylcheddol / Cynaliadwyedd (5Rs) Environmental /Sustainability Impact (5Rs)	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below: No - Not Applicable	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:	
Asesiad o Effaith ar Ddiogelu Data <i>A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?</i> Data Protection Impact Assessment <i>Have you undertaken a Data Protection Impact Assessment Screening?</i>	Do/Yes: ☐ Canlyniad/Outcome:	Naddo/No: ☒ This is an annual report, and thus not applicable
Asesiad o Effaith ar Atal Twyll <i>A ydych chi wedi ystyried yr effeithiau ar atal twyll?</i> Counter Fraud Impact <i>Have you considered the counter fraud impacts</i>	Do/Yes: ☐ Canlyniad/Outcome:	Naddo/No: ☒ This is an annual report, and thus not applicable
Cyfreithiol Legal	Yes (Include further detail below) Compliance with Ionising Radiation regulations will need to update the co-operation of employers documentation to cover the reporting for the placental reporting. No specific legal implications for the MRI	
Enw Da Reputational	Choose an item.	
Effaith ar Adnoddau (Pobl / Ariannol) Resource Impact (People / Financial)	There is no direct impact on resources as a result of the activity outlined in this report.	

Health Science Professions

Annual Report 2025/2026



FOREWORD

I am pleased to present the 2025–2026 Annual Report for Healthcare Science Professions across Betsi Cadwaladr University Health Board (BCUHB).

This report highlights the significant contribution Healthcare Science (HCS) professionals make to patient care, service delivery, and innovation across North Wales, alongside the challenges and opportunities facing this diverse workforce.

Teresa Owen

Executive Director of Allied Health Professionals and Health Science

1. Introduction

This is the first annual report that focuses on the Health Care Science Professions that work within BCUHB and the wider health economy. The aim of the report is to strengthen the visibility and understanding of the of this varied group of health care professions and raise the understanding of the diversity of services provided in supporting the whole health economy. Healthcare scientists play an integral part in the functioning and flow of the whole healthcare system.

Most Health Care Scientists are part of the Diagnostic Specialist Clinical Support Services. However a number are also found in the Integrated Care Communities IHCs e.g. Operating department assistances in theatres, Radiotherapy radiographers in cancer services, respiratory and cardiac physiologist.

Healthcare Science Professions play an essential role in delivering high quality care to the patients of North Wales professionally they sit within the portfolio of Teresa Owen the Executive Director of Allied Health Professions (AHPs) and Healthcare Science. There are over 30 different professions, contributing to approximately 95% of all patient pathways, grouped into six families this helps simplify understanding, however it is important the professions retain their individual identity -and protected titles are full recognised.

- 1.1. **Physiology** -Audiology, Cardiac physiology, Respiratory & sleep physiology, Neurophysiology, Perfusion Science, Vascular Science, Vision Science, Gastrointestinal Physiology & Urology
- 1.2. **Pathology** – Blood Sciences & Transplantation, Cellular Sciences, Reproductive Sciences, Infection Sciences, Decontamination Science, Public Health & Environmental Science, Anatomical Pathology Technology, Phlebotomy Genomics – including Human Genomics, Pathogen Genomics & Genetic Counselling
- 1.3. **Physical Sciences** – Clinical Engineering, Medical Physics, Medical Illustration, Reconstructive Science, Pharmaceutical Science
- 1.4. **Clinical Computational Sciences** – Bioinformatics (Human & Pathogen), Clinical Informatics, Clinical Scientific Computing
- 1.5. **Radiography** – Diagnostic Radiography, Therapeutic Radiography
- 1.6. **Operating Department Practitioners (ODP)**

(NB. Radiographers and ODPs are classed as AHPs in the other UK nations)

Healthcare scientists will be registered with the HCPC, Academy of Health Sciences or for some smaller groups with voluntary registers

Healthcare Science Facts for 2025

BCU has 793 Healthcare Scientists



Pathology processed over 7.5 million tests in blood science and over 80,000 specimens



Audiology had 122,616 Patient contacts



Radiology Imaged 500,000 patients



Medical physics look after 56,000 medical devices

2. Registration

Many Healthcare Scientists have protected titles and have statutory registration with the Health and Care Professional Council (HCPC). Others hold voluntary registration through the Academy of Health Sciences, IPEM (Institute of Physics and Engineering in Medicine) or other similar bodies depending upon the profession. A small number hold no registration as it is not currently mandated

Work is underway to identify and understand the registration status of all Healthcare Scientists within BCU.

3. NHS Wales Healthcare Science Framework

In June 2025 HEIW launched a career framework for both Healthcare science professionals and health board managers. The aim of the frame work is to map out the development pathway from non-registered to consultant practitioner. This will support the wider transformation agenda, new ways of working and clearer career development opportunities. The frame work can be accessed from the link below:

heiw.nhs.wales/files/hcs-framework-eng-pdf/

Healthcare scientists training follows different pathways depending upon the profession. Radiographers and ODPs follow a three year undergraduate degree course prior to being able to register. Other health science professions follow a training programme (NHS Scientific Training Programme STP) which is a degree programme funded by HEIW. The STP programme is paid to work in the service whilst gaining their degree. BCU have a number of STP trainees across the specialities and have trained the first Vascular Scientist in Wales via the programme and are currently training a Clinical Computational Scientist.

4. Healthcare Science Network

The national Healthcare Science Network is already well established, and BCUHB led the way in Wales by being the first Health Board to develop a local Health Science Network, helping to embed the approach early and support consistent development across the organisation. The network is chaired by Mr John Day Consultant Clinical Scientist and Clinical Director Audiology. The network has two sub groups:-

5. Quality and Transformation led by Bernadette Astbury Head of Quality & Governance Pathology

- 5.1. Bernadette has recently taken over as lead for this work stream. The group have initially set a workplan in 2025/26 which will be updated for 2026/27
- 5.2. Conducting a Baseline Review of current Clinical Audit, Benchmarking, and Continuous Quality Improvement (QI) Leadership Skills and Capacity
- 5.3. Job Role Analysis in the Quality Management System (QMS) / Training Needs Analysis (TNA) within QMS
- 5.4. Assessing Digital Transformation Challenges in HCS Accreditation
- 5.5. To Enhance HCS Representation and Share Best Practices

6. Research and Innovation led by Dr Jenna Allsup Research Radiographer

The BCUHB R&I Subgroup is working to strengthen research capacity, capability and collaboration across the Healthcare Science workforce in BCUHB. It reports to the local Network and updates/informs the All-Wales National Healthcare Science Research Interest Group early work has focused on a gap analysis between the research expectations set out in Advanced and Consultant Healthcare Science (HCS) job descriptions and the degree of job planning and protected time currently in place, highlighting an opportunity to bring greater clarity and consistency locally. Alongside this, the subgroup has begun developing improved access to research resources and education (Capability workstream) and exploring a collaboration database to better connect HCS researchers across North Wales (Collaboration workstream). Over the coming year, we aim to build on this foundation by enhancing local job planning structures, and improving visibility of R&I opportunities.

A Betsinet page has been set up to facilitate communication
https://nhswales365.sharepoint.com/sites/BCU_Intranet_HCS

7. Quality Management, Accreditation and Regulation

Healthcare Science professionals have a strong background in the use of Quality Management Systems (QMS) and accreditation and are supporting the BCU QMS development

- 7.1. **ISO 9001** - Medical Physics are currently certified to this QMS. It provides a structured quality management framework that helps a Medical Physics team deliver safe, consistent, and reliable services. By standardising processes such as equipment commissioning, quality assurance, calibration, and incident management, it reduces variation and risk while improving traceability and documentation. The emphasis on continual improvement, audit, and staff competence supports regulatory compliance and strengthens patient safety, while clearer roles and data-driven decision-making enhance efficiency and team confidence in both clinical and support activities.
- 7.2. **ISO15189** – Pathology successfully completed a significant 11 day accreditation visit in 2025 with only a very small number of minor non-conformities
- 7.3. **Quality Standards in Imaging (QSI)** – Radiology have commenced the formal move to gaining endorsement by joining the QSI hub and have completed the self-assessment with a plan to achieve “working towards” award in September 2026.
- 7.4. **Audiology** – Tier 1 Welsh Government mandated external clinical audits against service quality standards. Such national collaborative audits are part of the new Welsh Government Quality Strategy for Audiology (2026).

[nhs.wales/sa/audiology/audiology-docs/quality-strategy-and-framework-for-delivery/](https://nhs.uk/wales/sa/audiology/audiology-docs/quality-strategy-and-framework-for-delivery/)

- 7.5. **IQIPS (Improving Quality in Physiological Services)**– Respiratory Physiologists have commenced work on developing a Quality management System using the principles set out in the IQIPS standard.

During 2025 and 2026 Healthcare scientists have participated in various regulatory inspections

Regulations	Regulator/enforcement body	Sites inspected	Health Scientists involved
Environmental permitting Regulations	Natural Resources Wales	Nuclear Medicine Radiopharmacy all sites	Radiographers Medical Physicists
Ionising (Medical Exposure) Regulations IR(ME)R	HIW accompanied by UKHSA	Focused on Gamma Camera radiology Ysbyty Glan Clwyd	Radiographers Medical Physicists
Counter Terrorism	North Wales Police	All sites	Radiographers Medical Physicists

8. Medical Device Regulations

Clinical engineering are working collaboratively with services on compliance with respect to the post market surveillance required in the regulations. The health board has made good progress with teams introducing the required quality management systems (QMS). There is however, more work to do to fully implement the QMS in some services that make medical devices. The regulations ensure that medical devices either procured or custom made in the health board are appropriately regulated and used safely and effectively in all clinical settings.

9. Challenges

9.1. Fragility of specialist expertise in small teams

Pathology/ Radiology and many HCS areas continue to experience high clinical demand, causing:

Reduced time for supervision, quality improvement and innovation

Increased burnout and reduced space for strategic projects

Difficulty releasing staff for courses or research activities

Operational firefighting limits progression towards strategic aims including digital optimisation, service modernisation and research engagement.

9.2. Kingdon Review

The report looked at paediatric Audiology service in England. The findings of this report has relevance to Wales and across the HCS disciplines, particularly those smaller patient facing disciplines with a low profile.

<https://www.gov.uk/government/publications/kingdon-review-of-childrens-hearing-services-final-report>

A sample of report recommendations for Audiology and relevant to other HCS services across the UK:

9.2.1. Professional registration should be a requirement

9.2.2. Network models of delivery are encouraged, inc observation of practice elsewhere

9.2.3. Organisations should implement improved governance arrangements for Audiology and other HCS services

9.2.4. National Key Performance Indicators KPIs should be agreed, monitored and published within a quality management systems

9.2.5. Every organisation should appoint an lead healthcare scientist – responsible for reviewing KPIs across healthcare science disciplines

9.2.6. Need for fit for purpose undergraduate and postgrad training pathways and support for CPD

9.2.7. The importance of scientific leadership and professional development of healthcare scientists

9.2.8. Improvements to workforce culture and morale

9.2.9. Improved escalation of quality and safety concerns inc through to ministers

10. Successes and Achievements over 2025/26

10.1. National Healthcare Science conference

BCU supported HEIW in running the annual Healthcare Science Conference in Llandudno. This was the first time the conference had been held in North Wales. The conference was well attended and was seen as a great success both by delegates and HEIW.

The conference introduced the new Chief Scientific Officer Vicky Heath who addressed the conference.

Following the conference Vicky made a visit to BCU where she meet members of the Health Science Professions from across BCU where we discussed some of the challenges and also positive contributions affecting the Health Care Science Professions. Vicky provides leadership at a national level.

10.2. Audiology

The North Wales Medical Physics teams encompassing EBME, Clinical Engineering, and Non-Ionising Radiation are responsible for the end-to-end lifecycle management of approximately 50,000 medical devices. This includes specification, procurement, commissioning, maintenance, performance assurance, risk management, and decommissioning, ensuring that all equipment remains safe, effective, and fit for clinical use throughout its operational life.

10.3. Radiology

BCU was the first major health board to go live the Radiology Information System(RISP) in September. This involved connecting over 200 systems and changing all workflows in one weekend whilst keeping all imaging services operational in particular urgent and emergency services.

BCU radiology piloted the implementation of the incident learning taxonomy for radiation and MRI incidents and then supporting the other health boards to implement. This has led to Wales being the first country to full adopt the learning system which will complement the system that has been in place for radiotherapy for a number of years.

10.4. Pathology

Pathology are currently rolling out a new pathology digital system - LIMs Tranche 1 & 2 have been successfully completed. Tranches 3,4 & 5 are currently being worked through. This is a significant piece of work with a very tight time scale and significant implementation challenges

10.5. Healthcare awards

Outstanding Leadership – Healthcare Science (sponsored by Welsh Government): . John Day, Clinical Director of Audiology in Betsi Cadwaladr UHB was also Highly Commended.

New Ways of Working – Healthcare Science: Suzanne Tyson, Principal Audiologist, Jane Wild, Head of Adult Audiology & Consultant Clinical Scientist, and the Adult Audiology Team of Betsi Cadwaladr UHB awarded for their “*North Wales Mobile Audiology Service.*”

BCU Rising Stars Milly Trigg first vascular Scientific Training Programme (STP) to train in Wales

11. Priorities for 2026/2027

Building on the work undertaken by both the Office of the Executive Director of AHP's and Health Science and the BCU Health Science Network over 2025/26, working together we will raise the understanding of how Health Science professions can contribute to improving patient care and experience by:

- Improve visibility and understanding of HCS across the organisation
- Strengthen leadership and coordination of HCS activity
- Support research and innovation capability proportionate to service capacity
- Improve data and understanding of the HCS workforce

People and Culture Committee

SICKNESS ACTIONS DEEP DIVE 6/12 REPORT

Dyddiad y Cyfarfod Date of Meeting	11 June 2026
Statws Cyhoeddi Publication Status	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad Report Author name and title	David Maslen-Jones, Associate Director People Services
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol Lead Executive Team Member name and title	Debbie Eyitayo- Executive Director of People & OD
Pwrpas yr Adroddiad Report Purpose	For Noting

Crynodeb Gweithredol Executive Summary

The purpose of this paper is to update the committee on the progress following the sickness absence deep dive carried out in the summer of 2025 across the Health Board. A detailed review was presented to People and Culture Committee in December 2025, which identified progress against plans to reduce absence.

Betsi Cadwaladr University Health Board has maintained the lowest sickness absence rates among large NHS Wales organisations over the past year. However, overall absence remains above 6%, exceeding the national target of 4.4%. In response, the People Services Directorate conducted a comprehensive sickness absence deep dive in July 2025. This strategic plan outlines targeted actions to improve policy consistency, strengthen early intervention, and support cultural change, aligned with the Health Board's values of compassion, openness, and respect.

With a clear focus on achieving a reduction in sickness absence in line with the Cabinet Secretary's priorities for the NHS. These actions aim to strengthen support for staff, improve operational resilience, and ensure alignment with national expectations for workforce health and well-being.

This report summarises the agreed actions and progress against each action.



Ymgysylltu (mewnol/allanol) yr ymgwymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp)
Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)

Pwyllgor / Grŵp / Unigolion Committee / Group / Individuals	Dyddiad Date	Canlyniad, Tystiolaeth a Data Outcome, Evidence and Data
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N/A		
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Acronymau / Rhestr Termiau
Acronyms / Glossary of Terms

N/A	
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The actions established and agreed upon to reduce absence and support staff are:

1. **Policy Compliance** Ensure the sickness absence policy is applied correctly, particularly regarding triggers and return-to-work meetings led by line managers.
2. **Ownership and Accountability** Confirm that sickness absence is owned and managed by line managers, with professional support from People Services.
3. **Policy Deviations** Any deviation from policy must be recorded and reviewed by a member of the People Services team.
4. **Hotspot Identification** Establish clear processes to identify sickness absence hotspots and agree targeted interventions to reduce absence.
5. **Occupational Health Referrals** Ensure prompt referrals to Occupational Health by line managers.
6. **Staff Experience** Improve the experience of staff on long-term sickness absence through proactive support and engagement.



Accountability for implementation

Area	Accountable	Supporting
Sickness reduction in areas	COO Area Director of Operations Directors	AD of People/ People Services
Correct application of policy	Line managers	AD of People & Heads
ESR central record for sickness absence	Associate Director of People (Workforce Optimisation)	AD of People & Heads
Review of exceptions	Heads of People	AD of People/ People Services
Hotspot selection and support	COO and Deputy Exec Director of People	AD of People/ People Services
Reconciliation of records	Line managers	Heads of People
Policy training	Heads of People	AD of People/ People Services

Updates against Actions Identified in the sickness absence deep dive:

SECTION ONE – Driving Cultural Change via Policy:

*Our core values of **compassion, openness and respect** must be how we undertake any of the actions noted in this report. These actions need to connect to the culture change programme.*

1.1: Return to Work Meetings:

- Ensure that a minimum of 85% of all staff have a return-to-work meeting recorded on ESR by March 2026.
- Ensure that staff are provided with access to the interactive Health and Wellbeing Resource Toolkit during the return-to-work meeting.
- Provide training and guidance to managers on conducting effective return to work meetings, including how to identify support needs and make appropriate referrals. This includes how to use trigger reports and persistent absence work patterns.
- Bi- weekly updates to COO and Directors of staff with no RTW on ESR with statistical performance.

Progress to Date:

- As of April 26, the percentage of return-to-work meetings recorded was 38.1% compared to 32% in April 2025. This is an increase of 6% year on year. Local People Teams continue to raise the importance of undertaking and recording return to work discussions at their monthly manager surgeries.
- Whilst training and guidance is being produced on conducting effective return to work discussions as a standalone session, it has not been fully implemented as yet. Currently People Services teams regularly hold Managing Attendance at Work training sessions in their areas. The teams are working to integrate the training and guidance support on managing attendance at work prompts, occupational health referrals and return to work discussions into these discussions.
- The Wellbeing toolkit will form part of the new PADR process being introduced shortly.

1.2: Policy Prompts:

- Line managers must confirm that staff meeting prompts are placed on the appropriate stage of the policy. Prompt/trigger reports will be provided via ESR to Directorates and teams.
- Where deviation from the policy is proposed, managers must consult with People Services in advance.
- A centralised record will be maintained to document actions taken and to record valid justifications for any non-enactment of a prompt. The central ESR team will support the development of a recording system and electronic form to note any policy deviation by the line manager.



- People Services will audit prompt/trigger report management quarterly to ensure compliance and identify areas for improvement.

Progress to Date:

Information regarding prompts/triggers is shared with managers on a monthly basis. At present we are still in the process of developing the centralised records to be able to identify centrally the numbers of staff on the various stages of the policy and where managers have used their discretion.

People Services teams working alongside line managers have focussed on the management of sickness absence, with a particular focus on staff approaching 28 days absence as well as cases with specific complexities i.e., work-related stress or particular chronic conditions. Case conferences with occupational health are held in complex and challenging cases. Local oversight is undertaken through the IHC's People and Culture groups.

1.3: Early Intervention Systems:

- Line managers must engage with People Services on day seven of an employee's absence.
- People Services will provide guidance on policy application and Occupational Health referrals.
- A written entry will be made in the central absence management record.
- Develop a standardised checklist for managers to use during early intervention discussions.

Progress to Date:

As part of the overall Managing Attendance at Work action plan, the ongoing education of managers is critical, work has begun to record this on ESR however the people services teams are prioritising hot spots at present and as agreed.

The provision of guidance to managers on policy application and OH referral is effectively "business as usual" and covered in 1.2 above, policy prompts.

Divisional People Service teams have commenced use of the early intervention checklist template at App A, for early intervention discussions. Feedback on the use of the template is to be discussed at the Healthy Workforce Group on 20th July 2026.

1.4: Long Term Absence

- All staff on long-term sickness will be case managed by People Services on a monthly basis, with exception reports discussed during 1:1 meeting with the Deputy Executive Director of People.

- All staff on long-term sickness will be provided with a Betsi Net login to facilitate access to information and maintain connection with the organisation.
- Ensure that all long-term absence cases include a documented Occupational Health plan and review schedule.

Progress to Date:

People Services teams monitor long term sickness using the Power BI workforce absence dashboard, BI and become directly involved in cases of more than 3 months duration or those where there are specific complexities i.e., work-related stress or particular chronic conditions. The team focus on adjusted duties and what the employee could do if they returned to work to support their return to work or in cases where they are in work to help them remain well in work. Referrals through to occupational health are encouraged for fitness to work opinions and to focus on what needs to be in place for staff to return. Case conferences with occupational health are held in complex and challenging cases.

SECTION TWO – Targeted Hotspot Focus:

Given the limited central capacity, People Services will undertake quarterly hotspot interventions in the five areas with the highest sickness absence rates, as identified via the Healthy Workforce Dashboard.

2.1: Hotspot Sickness Team

To determine the approach for the area identified in the hotspot a team will be developed. The team will comprise of the following:

- Director of Operations for the IHC/ Division/ or deputy director for corporate areas (Chair of the team)
- Associate Director of People for the area
- Head of Culture Change or Deputy
- Area occupational health nurse
- Head of Occupational Health or Deputy

Progress to Date:

- Hotspot areas have been identified across the Health Board and focussed work is now taking place across these areas as well as business as usual support for all other areas.
- Due to operational pressures across some areas not all hotspot team meetings have started. Work has commenced in the East IHC, with meetings across all areas expected to be in place by early quarter 2. In the interim all People Teams have ensured that ongoing awareness of the hot spot areas and associated work is being profiled through local People and Culture Groups and Senior Leadership Team meetings across IHCs and Divisions.

2.2: Reporting and Escalation:

- Establish a quarterly review panel to assess hotspot interventions and outcomes.
- Develop a dashboard to track compliance with sickness absence policy across all directorates.
- Provide regular updates to the Board on progress against sickness absence targets.

Progress to Date:

Work is ongoing to ensure the quarterly review panel is put in place. Working with the COO and Divisional Directors it is anticipated that the absence management groups in each division will report into the central group.

A central dashboard has been created and specific information from the dashboard is shared with individual managers as part of the ongoing engagement work carried out by the People Service teams.

Regular updates are provided to People and Culture Committee via the People Operations Report and to Board via the Integrated Performance Report.

SECTION THREE – Communications Linked to Culture:

The Health Board's culture change programme aspires to cultivate a compassionate and high-performing organisation. Communications relating to the interventions outlined above will prioritise the theme of supporting staff. Messaging must be consistent, empathetic, and aligned with organisational values.

- Review and revise all sickness-related correspondence templates to reflect a supportive tone.
- Provide communication training to managers on delivering sensitive messages.
- Align sickness absence messaging with broader wellbeing and inclusion campaigns.
- Monitor staff feedback on policy communications through surveys and engagement forums.

Progress to Date:

All letters and correspondence are currently under review and being amended to ensure that they are in line with the requirements of the Managing Attendance at Work policy and that the language within them is consistent with the values of the organisation and demonstrates a compassionate approach to sickness absence.

Work on how to communicate effectively with individuals, especially where challenging conversations are required is being supported through the Health Board's, Conversations with Care training. This training is provided for all managers and is actively encouraged by the People Teams when in their operational areas.

The training has also been shared through the People Managers Forum. Currently Ripple training is being rolled out across the Health Board to highlight the impact of positive behaviours.

The staff surveys have been reported on and engagement forums have and continue to take place involving health and wellbeing. As a result of staff survey feedback, the Health Board has:

- Held wellbeing workshops and roadshows,
- provided coaching,
- promoted the revised flexible working policy and guidance,
- expanded our wellbeing champion network and
- publicised the Living Well, Working Well handbook, which is shared with colleagues who are absent from work.

The wellbeing programme is currently reviewing the support offered in relation to menopause cafes, health roadshows and improved emotional wellbeing support.

SECTION FOUR –Basic Measures of success

Progress to Date:

Return to Work Compliance Rates

Org L4	Apr-25	Apr-26	Difference from previous year
Health Community Centre (HCCX) L4	26.7%	30.0%	3.3%
Health Community East (HCEX) L4	31.4%	44.8%	13.4%
Health Community West (HCWX) L4	23.5%	34.1%	10.6%
Integrated Clinical Delivery - Primary Care (ICDP) L4	61.5%	60.0%	-1.5%
Integrated Clinical Delivery - Regional Care (ICDR) L4	49.6%	39.7%	-9.9%
Mental Health & LDS (MX00) L4	43.6%	38.7%	-4.9%
Midwifery and Womens Services (WXXX) L4	13.6%	20.0%	6.4%
Corporate Services	52.4%	60.4%	8.0%
Total	32.0%	38.1%	6.1%

The link below provides access to the latest absence dashboard

[Summary - Workforce Absence Dashboard - Power BI](#)

SUMMARY

In summary, steps have taken place to improve the quality of workforce information provided to managers, together with an improved offer of support from both OD and Health and Wellbeing Services.

The key next step required is to ensure that the divisional absence groups are fully formed involving the key stakeholders in each division. This will be used to focus on the hot spot areas and to bring managers from those areas to meet with the Divisional Ops Directors, People Services, Occupational Health, Organisational Development and Health and Wellbeing service to identify what support is required to develop targeted interventions which can then be measured for impact.

ASESIAD / ASSESSMENT

Cysylltiad â'r Bwriadau Strategol Link to Strategic Intentions	1. Focus on Health and Wellbeing
	Developing Strategy and Long-Lasting Change Creating Compassionate Culture, Leadership and Experience Improving Quality, Outcomes and Experience
Yr Egwyddorion Dylunio Design Principles	Consistency with Organisational Values
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd Corporate Risks and Board Assurance Framework	CRR24-01 - 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. BAF24-01 - Not Fully Building an Effective and Accountable Organisation

ASESIADAU O EFFAITH / IMPACT ASSESSMENTS

Equality Act 2010 Public Sector Equality Duty: Has BCUHB provided evidence of 'Due Regard' to compliance with the three parts of the Public Sector Equality Duty (General Duty): https://www.gov.wales/public-sector-equality-duty-htmlPublic Sector Equality Duty [HTML] GOV.WALES	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	This report is purely administrative in nature and submitted for information only at this stage. The associated public sector duties are not engaged (there are no associated impacts on any of the protected groups at this stage).
Equality Act 2010 - Socio-economic Duty Has BCUHB provided evidence of 'Due Regard' to compliance of ther Socio-	Do/Yes: ☒	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	This report is purely administrative in nature and submitted for information only at this

<i>economic Duty when making strategic decisions?</i>		stage. The associated public sector duties are not engaged (there are no associated impacts on any of the protected groups at this stage).
<i>Have you completed an Integrated Equality Impact Assessment WP8a?</i> WP8a Template	Canlyniad/Outcome: Do/Yes:	Naddo/No: : ☒
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale: Canlyniad/Outcome:	This report is purely administrative in nature and submitted for information only at this stage. The associated public sector duties are not engaged (there are no associated impacts on any of the protected groups at this stage).
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Human Rights Act <i>Have Human Right based concerns been addressed within WP8a</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
Compliance to the Welsh Language requirements? <i>Have you undertaken an Impact Assessment</i>	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Naddo/No: ☒
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	This report is purely administrative in nature and submitted for information only at this stage. The associated public sector duties are not engaged.
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Compliance to giving 'Due Regard' to the principles of	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	

the Armed Forces Covenant <i>Have the principles of the Armed Forces Covenant been addressed within WP8a</i>	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
<u>Ansawdd</u> <i>A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?</i> <u>Quality</u> <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Galluogwyr Ansawdd Enablers of Quality Choose an item. Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	This report is purely administrative in nature and submitted for information only at this stage. The associated public sector duties are not engaged (there are no associated impacts on any of the protected groups). Domains of Quality All Apply
<u>Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant Wellbeing of Future Generations Act – Wellbeing Goals</u>	Not Applicable	
Effaith Amgylcheddol / Cynaliadwyedd (5Rs) Environmental /Sustainability Impact (5Rs)	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below: Choose an item.	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:	This report is purely administrative in nature and submitted for information only at this stage. The associated public sector duties are not engaged (there are no associated impacts on any of the protected groups).
Asesiad o Effaith ar Ddiogelu Data <i>A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?</i>	Do/Yes: ☐	Naddo/No: ☐
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm:	No: ☒ This report is purely administrative in nature

Data Protection Impact Assessment <i>Have you undertaken a Data Protection Impact Assessment Screening?</i>	If no, please include rationale:	and submitted for information only at this stage. The associated public sector duties are not engaged (there are no associated impacts on any of the protected groups).
Asesiad o Effaith ar Atal Twyll <i>A ydych chi wedi ystyried yr effeithiau ar atal twyll?</i> Counter Fraud Impact <i>Have you considered the counter fraud impacts</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	This report is purely administrative in nature and submitted for information only at this stage. The associated public sector duties are not engaged (there are no associated impacts on any of the protected groups).
Cyfreithiol Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw Da Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith ar Adnoddau <i>(Pobl / Ariannol)</i> Resource Impact <i>(People / Financial)</i>	There is no direct impact on resources as a result of the activity outlined in this report.	

Appendix A: ABSENCE PROMPTS – WP 11 Managing Attendance at Work Policy

ABSENCE PROMPTS – WP 11 Managing Attendance at Work Policy

Prompts

- three episodes of sickness absence of any length in any **rolling 6-month period**
- two or more absences totalling 10 calendar days or more in a **rolling 12-month period**
- recognisable patterns of absence, including any in previous years, which cause concern but may not meet other review prompts.

Rolling Year

If an episode of sickness occurs the manager should review the twelve-month period preceding the first day of that specific absence.

The review period is the previous 12 months from the first day of the most recent sickness.

Rolling period

The definition of the rolling period is the 6-month or 12-month period counted back from the first day of the episode of sickness being looked at.

With any sickness absence, we should look back 6 or 12 months from the start date of the most recent sickness.

These review prompts include any episodes of short- or long-term sickness absence which occur within the rolling period – including all episodes that have been used for previous prompts if they fall within the rolling period.

Following a period of sickness absence a return to work meeting will take place within 72 hours of the employee's return (unless the employee is on a none working day or annual leave) with the manager and the employee. If the manager is not available to complete the return to work, it must be delegated to another appropriate member of staff. During this meeting, the reviews prompts will be considered and if met, **when previous absences are taken into account**, further management support may be required at the manager's *discretion. Managers may want to consider a number of factors e.g. the employee's previous sickness record, the nature of the absence, long term health conditions etc.

Setting levels of improvement- Review Period

It is important that the employee understands the level of improvement required and this must be explained at the meeting.

The definition of the review period is **12 months running forward from the last date of the most recent episode of sickness that occurred before the sickness review meeting**. It is the time period within which if a further review prompt is met (which can be established by looking at the rolling period) may lead to escalation through the stages of the policy.

The review period may be paused if an employee is absent from work for a period in excess of 28 days, to cover the period where sickness absence cannot be monitored. The review prompts set out in Section 3 are used to measure

improvement. Thus, where no review prompt is met during the review period this will be regarded as an appropriate level of improvement. However, where a review prompt is met this will be regarded as an unacceptable level of improvement and a further meeting may be held. The manager should arrange for review meetings to be undertaken every three months at each of the stages

Please find an example table below:

FIRST DAY OF ABSENCE	No OF DAYS	REASON	PROMT MET?	OUTCOME
01/02/2022	9	Viral infection	No	N/A
10/11/2022	2	Pulled muscle	Yes - two or more absences totalling 10 calendar days or more in a rolling 12-month period	Informal
20/05/2023	7	Bad back	No	N/A
15/08/2023	3	Headache	Yes - two or more absences totalling 10 calendar days or more in a rolling 12-month period	1 st formal
10/11/2023	5	Tonsilitis	Yes - three episodes of sickness absence of any length in any rolling 6-month period + two or more absences totalling 10 calendar days or more in a rolling 12-month period	2 nd formal
24/12/2024	1	Toothache	No	N/A
02/01/2025	5	Flu	No	N/A
21/02/2025	2	Fatigue	Yes - three episodes of sickness absence of any length in any rolling 6-month period	Informal
29/07/2025	20	Sprained ankle	Yes - two or more absences totalling 10 calendar days or more in a rolling 12-month period	1 st Formal

People and Culture Committee

STAFF WELLBEING ORGANISATIONAL POSITION REPORT

Dyddiad y Cyfarfod Date of Meeting	11 June 2026
Statws Cyhoeddi Publication Status	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad Report Author(s) name and title	Dr Sarah Blackshaw, Strategic Lead for Staff Wellbeing (Consultant Clinical Psychologist)
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol Lead Executive Team Member name and title	Debbie Eyitayo, Executive Director of Workforce and Organisational Development
Pwrpas yr Adroddiad Report Purpose	For Approval

Crynodeb Gweithredol **Executive Summary**

This paper provides a report for assurance and information on the current delivery and future direction of Staff Wellbeing Support Services (SWSS). It seeks Committee support of the approach to strengthen governance, oversight and resourcing.

Key findings/highlights

SWSS operates a multi-level model focusing on prevention and compassion, with the majority of need met through universal and targeted supports (e.g. Wellbeing Champions, coaching, resilience training, Schwartz Rounds). Specialist provision through the Staff Wellbeing Psychology Service (SWPS) has been stabilised and enhanced, including the introduction of a new trauma-focused pathway, which was previously unavailable in-house. Demand evidence and staff feedback indicate high perceived value and effectiveness of all wellbeing interventions across the Health Board. The appointment of a substantive Strategic Lead has enabled a shift from wellbeing as a standalone offer towards greater system working and preventative focus, which is aligned to IMTP objectives.

Risks and implications

We have a solid base, but the nature of current challenges requires a more targeted, integrated, and organisationally focused approach. Fragmented oversight and inconsistent resourcing creates a risk of avoidable employee harm, increased sickness absence, burnout and difficulties in retaining staff. Additionally, insufficient system-level wellbeing data limits both the Strategic Lead's and POD services' ability to triangulate impact against workforce metrics (e.g. sickness absence, staff retention, or employee relations activity). Finally, lack of appropriate physical space and central funding for key interventions risks undermining staff confidence in organisational commitment to wellbeing, with potential reputational and cultural impact.

Actions taken or underway

Re-establishment and repositioning of the Strategic Lead role alongside Occupational Health and Wellbeing has already started to strengthen integration and pathways, as has the appointment of an Executive Director for Workforce. For the future, expansion of SWPS provision to include time-limited therapy and trauma-focused interventions, improving services for staff where previously there have been referrals out to local providers with lengthy waits. We are also focusing on increasing systemic interventions, including reflective practice, consultation with managers and teams, and partnership working with People Services, Organisational Development and Trade Union colleagues. To provide high-quality data, there has been work on development of a staff wellbeing evaluation framework to improve consistency of reporting and support future Committee assurance.

Recommendations/ask of the Committee

The Committee is asked to:

- **NOTE** that an approach focused on targeted support, strengthened leadership capability, trauma-informed approaches, and improved integration and co-ordination is required.
- **NOTE** the Staff Wellbeing Support Services plans to go forwards in this manner, noting any concerns with this approach.

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)

This paper was requested by the Chairman of the Board; it is a specific paper with no previous receipt/consideration.

Acronymau / Rhestr Termau

Acronyms / Glossary of Terms

Staff Wellbeing Support Services	SWSS
Staff Wellbeing Psychology Service	SWPS
Trauma Risk Management	TRiM

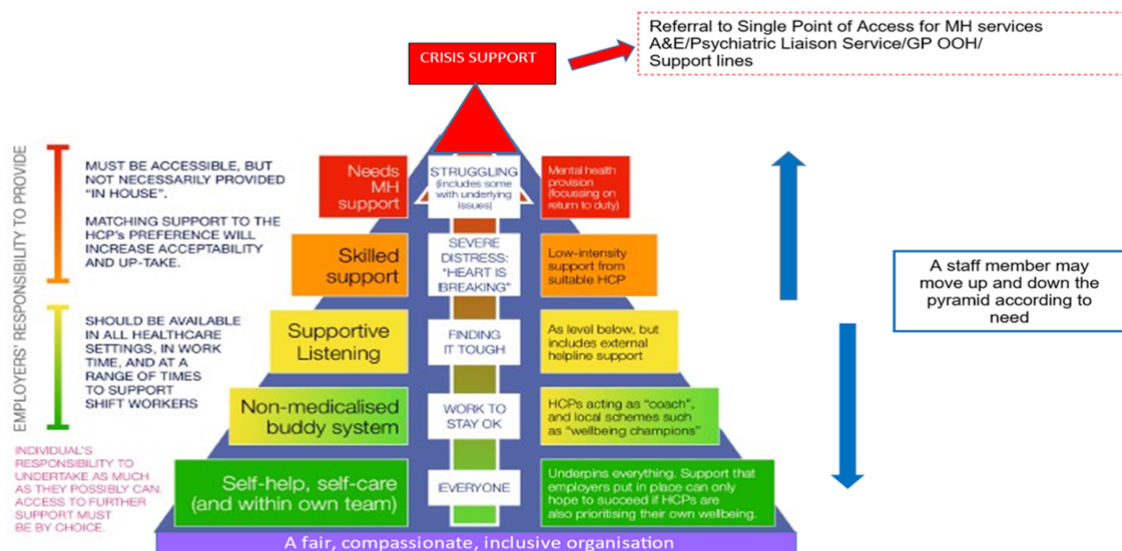
STAFF WELLBEING ORGANISATIONAL POSITION UPDATE

1. SITUATION

The organisation is seeing sustained demand relating to staff wellbeing, particularly in areas experiencing high workload, team dysfunction, and exposure to distressing events. While a range of wellbeing support is in place, current demand increasingly reflects systemic and relational challenges rather than individual wellbeing needs. This paper provides an overview of the current offer, identifies gaps, and sets out priorities for strengthening our approach as a Health Board.

2. BACKGROUND

Following approval of a business case to secure initial 12month funding, the Staff Wellbeing Support Service (SWSS) was established during 2021/22 to provide five interconnected levels of support to meet the differing needs of staff. Since the establishment of SWSS, changes to the model and structure have encompassed additional support structures for staff, with SWSS becoming an umbrella term for a number of different services, all providing support to staff along a number of lines (emotional, psychological, physical, financial, etc).



SWSS was conceived as a multi-layered support model with the majority of staff requiring low-level intervention and support.

- Levels one and two comprise of support for staff to self-care and to remain psychologically well at work. These levels include our wellbeing champion programme, emotional resilience training from the Self-Care Team, support from the Occupational Health and Wellbeing team, Schwartz Rounds, and emotional wellbeing check-ins and signposting from the emotional wellbeing assistant within the Staff Wellbeing Psychology Service.
- Level three comprises of Occupational Health counselling support as well as signposting to external counselling providers such as Canopi and Parabl, and if appropriate, use of SilverCloud (online cognitive behavioural therapy).
- Level four support comprises of targeted support provided by a Practitioner Psychologist within the Staff Wellbeing Psychology Service, for staff experiencing distress with a degree of complexity that may not be appropriately managed at a lower level of the model. This includes trauma-focused interventions, which are a new offer from the service.
- Level five support is not offered in-house; this is crisis support, and is offered through a pathway agreed with the Mental Health and Learning Disability Division for staff who may be experiencing an acute crisis, suicidal ideation, or be at risk of self-harm.

During 2022/23, the establishment and development of SWSS was led by the Strategic Lead for Staff Wellbeing who also chairs the multi-professional Staff Wellbeing Programme Delivery Group, which oversees and monitors the development of the SWSS. This post was vacant between September 2023 and August 2025.

The commencement of the new Strategic Lead in August 2025 was also complemented by the move from this role sitting underneath the Deputy Director of People to the Assistant Director for Occupational Health and Wellbeing. This move has fostered closer working relationships with Occupational Health and has allowed for clearer pathways and processes to support staff in relation to the individual therapeutic offer for staff (counselling and psychological support).

Whilst the above make up the core offer of universal and targeted support, there are other colleagues working in areas adjacent to staff wellbeing. These would include the Chaplaincy Service; Organisational Development colleagues, with the Culture Change programme and the Specialist Organisational Development team working on complex team dynamics; the Coaching Network, established within Organisational Development; and the Equalities Team, providing support to staff via our Staff Networks. Colleagues from within SWSS work closely with the above teams, and there are opportunities to develop shared pathways moving forwards.

For a more detailed overview of wellbeing support within the Health Board, as well as assessment of its impact, please see **Appendix 1**.

Staff wellbeing is a core enabler of safe, compassionate and effective patient care. Meaningful improvement in staff wellbeing is only achieved through the active

mobilisation of staff working in the wellbeing space, all working in partnership with colleagues across the organisation.

With the realisation of the Strategic Lead post, we are closer to achieving the shift required from staff wellbeing being perceived as a discrete function to one of shared organisational responsibility. This work so far has focused on strengthening clarity of purpose in relation to SWSS and how these services function together, including data collection and organisation, as well as starting to create the conditions for staff wellbeing to be embedded into all areas of the organisation rather than delivered as a standalone offer. This has included close working with People Services colleagues on topics such as avoidable employee harm and management of death in service, consultation relating to Foundations for the Future, and working with Organisational Development to embed wellbeing into our culture change work.

Key to this has been establishing a shared vision for staff wellbeing rooted in compassion, preventative action and inclusion. The Staff Wellbeing Programme Delivery Group, which contains representatives from all of the above services as well as Trade Union partners, has been utilised for this purpose. Services have been brought together around the Health Board's Integrated Medium-Term Plan and, whilst each wellbeing service has its own ways of working towards this, there is limited overlap and movement between services should be seamless, ensuring that wellbeing interventions respond to both staff experience and operational pressures.

Going forwards, a strong emphasis will be placed on empowerment and capability building. Teams across the Health Board will be supported to take ownership of their wellbeing and utilise data from their own staff members to consider bespoke wellbeing interventions, supported by SWSS. This will shift the focus from "wellbeing support" as an intervention to wellbeing as an ongoing conversation within teams. We cannot continue to solely offer support to individuals who happen to seek out our support; we must work differently to offer support to all staff across the Health Board as required.

Effective staff wellbeing is sustained by resourced wellbeing support with a clear mandate, trusted relationships between service providers, and a shared commitment to compassion and prevention, rather than by individual silo working. Continued investment in staff wellbeing will remain essential to strengthening staff experience, resilience and retention, and to delivering high-quality, safe services for our patients.

Areas to focus on in the next year include:

- Strengthening links across SWSS in order to allow for shared reporting. At present this is challenging due to the Strategic Lead not having oversight of all wellbeing work within the Health Board. Some parts of the wellbeing offer do not sit within Workforce (for example, Wellness, Work and Us reports directly to the Mental Health and Learning Disability Directorate). This means that there is no single central reporting structure for Staff Wellbeing services. With

closer alignment and strengthened links, the risk of duplicating services is reduced. Making staff wellbeing a formal agenda item for People and Culture may help with shared reporting. The introduction of the People and Culture Delivery group will ensure a focus on operational delivery.

- Strengthening pathways and relationships across both SWSS and services adjacent to SWSS to ensure that work is not duplicated but that staff are referred appropriately to the correct support for their needs.
- Triangulating workforce data alongside SWSS data to try to understand the impacts on areas such as staff sickness levels (especially anxiety, stress and depression), staff retention (using data from exit interviews), staff survey results, and employee relations cases.
- Fully establishing a functioning psychology service, which will reduce pressure on Occupational Health Counselling (who are currently seeing more distressed, complex staff members than is within their remit) and will offer trauma-focused support to staff. Ultimately, to embed trauma-informed principles across the Health Board, with the support of Traumatic Stress Wales.

Specific opportunities to improve staff wellbeing:

Whilst the resource available to staff meets much of the core need, there are other discrete interventions that could be offered to improve wellbeing. At the request of the Chairman, these are detailed below. These are considerations only at this stage, and would need to be taken to the Executive Team for approval should the opportunity to offer these resources progress. These are:

- Staff being given a certain number of hours a year to dedicate to their wellbeing. This has been offered in other NHS Trusts (e.g., Salford Royal Hospital, where staff have four hours a year that they can use on wellbeing-related activities). This would show staff that the organisation has their wellbeing in mind, and also allow staff to attend many of the wellbeing offers available to them without concerns about making this time back. The extra day a year offered within Wales for annual leave does not specifically address wellbeing concerns, as staff may not use this time for their wellbeing. Concerns related to staff being unable to access support in work time will be escalated to the Delivery Group for consideration.
- Bereavement and grief makes up a significant proportion of referrals to staff counselling and psychology. Bereavement groups for staff, potentially supported by staff wellbeing or the Chaplaincy service, would provide an increased level of supportive care at a time of increased stress. Again, this is an option only at this stage – increased staffing within the psychology service will help to support with this.
- Some staff will never get in touch with our services but may be motivated to self-support. An opt-in text message option of small wellbeing practices sent over a two-to-six-week period and focused around key themes for staff (sleep, decompression after shift, worry, compassion) may provide greater reach. This is an option that we are looking at trialling within Occupational Health.

- Collaborative group work between areas – we are currently trialling an Acceptance and Commitment Therapy group between SWPS and OH counselling for staff on the counselling waiting list, with the hope that this will reduce demand on individual counselling. We plan to trial further group working options in the future, once the Staff Wellbeing Psychology Service is adequately staffed.
- Wellbeing areas in every acute & Community site for timeout and wellbeing information, periodically manned by wellbeing staff.
- Mandatory departmental annual wellbeing action plans for teams to deliver aligned to standardised delivery plans to support local accountability, PADRs, staff support and development, ill health prevention management and support BCUHB values & behaviours.
- Structured return-to-role support after investigations/disciplinarys – in line with the new All-Wales Disciplinary Policy, creation of a standard post-process reintegration offer would reduce repeat conflict and sickness absence post-process.

3. SPECIFIC MATTERS FOR CONSIDERATION

It is not within the scope of this report to collate all data in relation to staff sickness, burnout/morale, presenteeism, retention, and employee relation concerns. Much of this data has already been presented to this Committee in relation to the Staff Survey and work across the Health Board. Suffice it to say, staff sickness is higher than we would like as an organisation, and the Staff Survey notes that morale, engagement, and compassion are below NHS Wales benchmarking. A key concern is that the majority of the current wellbeing provision is designed primarily for individual wellbeing, whereas demand increasingly relates to team dynamics, leadership, and workload pressures. Whilst burnout and sickness absence are individual indicators of distress, intervention focused solely on individual wellbeing will not adequately manage or support with these difficulties.

Uptake of wellbeing interventions varies, particularly in teams experiencing the highest levels of strain. Staff are not always able to access support due to staffing rotas and not being released to attend appointments, or increased workloads putting pressure on staff to work longer hours. SWSS makes it clear on the Intranet that we expect staff to be able to attend wellbeing interventions in the same way that they are able to attend medical appointments; going forwards, any refusals will be escalated to the People and Culture Delivery Group.

Requests for wellbeing input are often linked to underlying relational or management issues, or trauma-related difficulties, which are not fully addressed by current wellbeing interventions. The re-establishment of the Staff Wellbeing Psychology Service, utilising all available funding within the budget to recruit two Principal Psychologists and an additional Highly Specialised Psychologist, will allow for us to

offer trauma therapy. BCUHB currently has no established mediation offer; talks are ongoing with Organisational Development to develop this offer.

People Services, Organisational Development, Occupational Health and Staff Wellbeing offers are not always integrated, leading to duplication or gaps in support. There has been work done in this area and the establishment of POD meetings in Central, West and PAN areas of the organisation have led to better intelligence sharing and more cohesive support offers; work remains to be done in this space. The introduction of the new People and Culture Delivery group will support bring pieces of work across POD together.

There is a lack of organisational oversight for wellbeing services as a whole. Individual services have their own reporting structures and governance, and this can make it challenging for the organisation to be appropriately sighted on staff wellbeing as a whole. The establishment of the People and Culture Delivery Group provides a significant update on the oversight of SWSS, with the Staff Wellbeing Programme Delivery Group able to report directly to this Group for escalation.

There are specific gaps in resource across wellbeing services on a practical level. These are:

- The Staff Wellbeing Psychology Service has no adequate room space in which to see staff. The Chairman's Office is available on Fridays in Ysbyty Gwynedd, and there is some space in the old Trust HQ building at Wrexham Maelor, but otherwise psychologists are unable to offer face-to-face support to staff or go onto site for meetings, as they have no space to return to afterwards. This has been raised with Estates and escalated within Workforce, but resolution has not been possible.
- Wellness, Work and Us has been unable to secure recurrent funding. This has led at times to being funded on a bimonthly basis. Funding is now secured until early 2027; however, there is ongoing uncertainty in relation to funding past this point. A lack of clarity around this has caused stress and uncertainty for the staff within this service, and a reduction in this service itself would cause a shift in demand to other parts of the system, which would likely be unsustainable without additional funding. The funding of this resource ultimately sits with the Mental Health and Learning Disability Directorate.
- Schwartz Rounds, whilst being the only dedicated reflective space for all staff across the organisation, are not centrally funded or afforded organisation-wide support. The funding has been found within Occupational Health for 2026/2027, but this cannot continue as there is no dedicated funding for Schwartz Rounds within Occupational Health. We are at risk of losing this vital resource.

4. KEY RISKS/MATTERS FOR ESCALATION

Workforce Risks:

- Without adequate and accurately targeted wellbeing resource, staff will continue to report difficulties with morale, sickness absence will stay the same or increase, and staff retention will become increasingly difficult. Whilst there are a number of strategic interventions aiming to support with these areas, they are not as aligned as they could be. The development of the People and Culture Delivery Group is a key mitigation here.
- Without adequate physical and financial backing, it is a challenge to retain staff in wellbeing services. The SWPS has been unable to see new clients this year due to a lack of staffing; the lack of physical space to meet and see clients was a specific reason given at exit interview by previous staff as to why they left. Mitigation here is limited due to being unable to secure physical space in spite of discussions with Estates and Workforce colleagues.

Operational Risks:

- Should reporting lines remain unclear, there is a risk that the organisation remains incorrectly sighted on staff wellbeing. The Staff Wellbeing Programme Delivery Group brings together all staff working in the wellbeing space, but with no specific organisational oversight there is limited opportunity to advance a shared narrative of staff wellbeing with specific aims and objectives. Again, the new People and Culture Delivery Group, alignment of the SWPS with Occupational Health, and recruitment of the Strategic Lead and the Executive Director of Workforce are all mitigations for this.
- The lack of attention paid to physical resources for wellbeing services, and financial resources for key initiatives such as Schwartz Rounds and Wellness, Work and Us, risks wellbeing being seen as an “optional extra” rather than a core part of our organisational plan. Mitigation here is limited, as above.

Reputational Risks:

- Staff continue to report bullying, harassment and employee relations difficulties in individual therapy sessions and within Occupational Health. Staff often report a sense of not feeling heard by the organisation, which is a key reputational risk in terms of staff feeling that BCUHB is a good place to work (this can be measured on the staff survey). Increased psychological resource and access to mediation (which is in discussion with Organisational Development) will support to reduce the strain on staff.
- The lack of physical and financial resource dedicated to some areas of the wellbeing offer can lead to staff taking the view that wellbeing is not valued by the organisation. Mitigation is limited due to inability to find physical space.

Strategic Risks:

- Whilst individual staff wellbeing interventions are necessary and clearly valued by staff given their feedback, continued interest solely in demand and experience data risks wellbeing services being unable to expand more broadly into use of psychological skills and experience in a more consultative way. Specifically, if the sole focus of reports is how many people we have seen, we will miss the opportunity to work collaboratively across the organisation to improve wellbeing, culture and staff experience in ways that are more challenging to measure but higher-impact.

5. RECOMMENDATIONS

The Committee is asked to **NOTE** that the following approach is recommended, and that Staff Wellbeing and Support Services, with the support of the Strategic Lead and within the Staff Wellbeing Programme Delivery Group Meeting, plan to go forwards in this manner:

- Rebalance the wellbeing approach by shifting emphasis from universal wellbeing initiatives towards targeted support for teams and services experiencing the highest levels of strain.
- Strengthen management and leadership capability by developing a more co-ordinated offer in conjunction with Organisational Development and People Services colleagues to support managers in addressing team dynamics, psychological safety, and workload-related pressures.
- Develop a structured response to stress and trauma by establishing a clear, consistent approach to supporting teams following critical incidents, investigations or sustained organisational pressure.
- Improve integration across functions and enhance co-ordination between People Services, Occupational Health, Organisational Development and all SWSS to ensure a coherent and timely response to staff needs.
- Improve insight and evaluation by strengthening data collection and impact evaluation to better understand what is effective and where to prioritise investment of time and resource.

ASSESSMENT	
Cysylltiad â'r Bwriadau Strategol Link to Strategic Intentions	Choose an item.
	Developing Strategy and Long-Lasting Change Creating Compassionate Culture, Leadership and Experience Improving Quality, Outcomes and Experience
Design Principles	People First Consistency with Organisational Values
Corporate Risks and Board Assurance Framework	CRR24-01 - 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. BAF24-01 - Not Fully Building an Effective and Accountable Organisation
<u>Wellbeing of Future Generations Act – Wellbeing Goals</u>	Not Applicable

IMPACT ASSESSMENTS		
Equality Act 2010 Public Sector Equality Duty: Has BCUHB provided evidence of 'Due Regard' to compliance with the three parts of the Public Sector Equality Duty (General Duty): Public Sector Equality Duty [HTML] GOV.WALES	Yes: ☐	No: ☒
	Outcome:	
	If no, please include rationale:	This report is purely administrative in nature and submitted for information only at this stage. The associated public sector duties are not engaged (there are no associated impacts on any of the protected groups at this stage).
Equality Act 2010 - Socio-economic Duty <i>Has BCUHB provided evidence of 'Due Regard' to compliance of ther Socio-economic Duty when making strategic decisions?</i>	Yes: ☐	No: ☒
	Outcome:	
	If no, please include rationale:	This report is purely administrative in nature and submitted for information only at this stage. The associated public sector duties are not engaged (there are no associated impacts on any of the protected groups at this stage).
<i>Have you completed an Integrated Equality Impact Assessment WP8a?</i> WP8a Template	Canlyniad/Outcome: Do/Yes:	Naddo/No:
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale: Canlynaid/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	This report is purely administrative in nature and submitted for information only at this stage. The associated public sector duties are not engaged (there are no associated impacts on any

		of the protected groups at this stage).
Human Rights Act <i>Have Human Right based concerns been addressed within WP8a</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
Compliance to the Welsh Language requirements? <i>Have you undertaken an Impact Assessment</i>	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Naddo/No: ☒
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	This report is purely administrative in nature and submitted for information only at this stage. The associated public sector duties are not engaged.
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Compliance to giving 'Due Regard' to the principles of the Armed Forces Covenant <i>Have the principles of the Armed Forces Covenant been addressed within WP8a</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	This report is purely administrative in nature and submitted for information only at this stage. The associated public sector duties are not engaged (there are no associated impacts on any of the protected groups).
<u>Quality</u> <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Enablers of Quality All Apply	Domains of Quality All Apply
<u>Wellbeing of Future Generations Act – Wellbeing Goals</u>	Not Applicable	
	No - Not Applicable	



Environmental /Sustainability Impact (5Rs)		
	If no, please include rationale:	This report is purely administrative in nature and submitted for information only at this stage. The associated public sector duties are not engaged (there are no associated impacts on any of the protected groups).
Data Protection Impact Assessment <i>Have you undertaken a Data Protection Impact Assessment Screening?</i>	Yes: ☐	No: ☒
	Outcome:	
	If no, please include rationale:	This report is purely administrative in nature and submitted for information only at this stage. The associated public sector duties are not engaged (there are no associated impacts on any of the protected groups).
Counter Fraud Impact Assessment <i>Have you considered the counter fraud impacts</i>	Yes: ☐	No: ☒
	Outcome:	
	If no, please include rationale:	This report is purely administrative in nature and submitted for information only at this stage. The associated public sector duties are not engaged (there are no associated impacts on any of the protected groups).
Legal	There are no specific legal implications related to the activity outlined in this report.	
Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Resource Impact (People / Financial)	There is no direct impact on resources as a result of the activity outlined in this report.	

Appendix 1: An overview of wellbeing offers within the Health Board and data on impact:

There are a number of options for staff accessing support within the Health Board. The main areas of support are listed below:

- Health and Wellbeing Champion Programme
- Emotional Resilience Training
- Occupational Health and Wellbeing
- Occupational Health Counselling
- Staff Wellbeing Psychology Service
- Schwartz Rounds
- Trauma Risk Management (TRiM)
- Wellness, Work and Us

This does not include functions that work indirectly on staff wellbeing, such as Organisational Development, Chaplaincy Services, and Equalities.

The Health and Wellbeing Champion Programme

A Health and Wellbeing Champion is a member of the workforce who supports the wellbeing of staff within the organisation. They champion the organisations' wellbeing offer by raising awareness of wellbeing support information and activities available across BCUHB.

We currently have 257 employees signed up as Health and Wellbeing Champions. The programme is supported by the Health and Wellbeing Co-ordinator within Occupational Health.

Emotional Resilience Training

The Self-Care Team offer Emotional Resilience Training to BCUHB staff – this is a group session designed to improve resilience and manage stress. The Self-Care Team also offer groups for physical health conditions such as chronic pain and heart disease, which staff can access to support them with physical health difficulties.

Occupational Health and Wellbeing

Occupational Health and Wellbeing is a service which provides advice and support for staff and managers about workplace matters. They offer an advice helpline regarding work or personal issues staffed by a team of Support Advisors, workplace health consultations, information about health and wellbeing (alcohol use, smoking cessation, physical activity support, etc.), advice regarding debt, caring responsibilities, and men's/women's health, and health and wellbeing workshops, training and roadshows.

Occupational Health Counselling

Occupational Health has a small team of counsellors who provide:

- Time-limited counselling support (four to six sessions) for a range of difficulties, focused on brief intervention techniques
- Information and support following critical incidents (in conjunction with TRiM)
- Group and individual stress risk assessments

Staff Wellbeing Psychology Service

The SWPS is a provider of tier 4 support for staff who are struggling psychologically in work. This service, when fully functional, will offer three main individual options:

- One-off consultation and signposting with either a Practitioner Psychologist or an Emotional Wellbeing Assistant depending on the level of need.
- Up to eight sessions of psychological input for common workplace concerns.
- Up to twelve sessions of trauma-focused therapeutic support for traumatic stress reactions related to work (for example, the death of a patient). Trauma-focused support has not been offered in-house to BCUHB staff previously.

The SWPS operates on a preventative model; therefore, individual psychological input should be the smallest part of our offer. Work has started to focus on systemic factors rather than individual input, examples of which would be:

- Work to support the new All-Wales Disciplinary Policy and consider ways of mitigating employee harm.
- Reflective practice sessions offered to support staff in key areas who come into contact routinely with organisational distress and have limited space to consider its impact on themselves.
- Providing input to POD meetings across West, Central and PAN areas, which are also attended by Occupational Health, Organisational Development and People Services Colleagues, to consider specific areas of difficulty within the organisation and how we can best support.

Schwartz Rounds

Schwartz Rounds have been operating in BCUHB since August 2022. They are an evidenced based model, endorsed by Michael West, of scaffolding more compassionate and inclusive cultures via mechanisms of flattening professional hierarchies and improving communication and connections between colleagues. Recent developments have moved the contract for Schwartz Rounds from the Point of Care Foundation in the UK back to the Schwartz Center in Boston, USA. The contract for the 2026/2027 Rounds has been generously paid for by the Occupational Health budget; there is no yearly budget for the Rounds across the organisation.

Trauma Risk Management (TRiM)

Organised by the Safeguarding Team, Trauma Risk Management (TRiM) is a recognised method of assessing risk after traumatic exposure whilst at work. The process of TRiM does not replace current management welfare checks, debriefs or management support but provides an additional level of assistance. Staff can be referred 72hrs post-incident, and TRiM Practitioners will offer assessment, advice and signposting to appropriate resources.

Wellness, Work and Us

Wellness, Work and Us is a bespoke offer for staff working in the MHLD Directorate, consisting of staff who are able to offer emotional support, counselling, coaching, and informal facilitated resolution approaches to manage workplace relationships. Based in the Resource Centre in Bryn-y-Neuadd, there is space for staff to drop in as well as a small gym and access to yoga mats and DVDs, guided meditation CDs, and a “chill out” room.

This service also offers a focus on managing the root causes of stress and modifying stressors in the work environment by looking at divisional and team culture, support with induction into the MHLD Directorate and retention, and supporting leaders to reflect on their leadership over time.

Organisational impact

There are challenges with assessing the full organisational impact of staff wellbeing initiatives. The Strategic Lead for Staff Wellbeing does not have operational oversight of any service aside from the SWPS, and data outside of Occupational Health can be challenging to ascertain. This is an area for concern, and a key target for the Staff Wellbeing Programme Development Group in 2026/2027.

With the support of our Business Support Manager, an evaluation framework for Staff Wellbeing is being created which includes:

- Monitoring demand and waiting times for each element of our SWSS
- Collecting anonymised demographic data about staff who access SWSS, including equality monitoring information
- A core service evaluation feedback form to be given to every member of staff who receives a series of appointments from OH Counselling, Psychology or Wellness, Work and Us.
- Where appropriate, the use of bespoke measures to assess changes in the emotional health of an individual who has accessed a staff wellbeing intervention. This may include specific measures for trauma (e.g., the IES-R) or anxiety/low mood (e.g., the CORE-10).



Staff Wellbeing Psychology Service:

The Staff Wellbeing Psychology Service initially offered one-off consultation appointments to staff, with no follow-up. In the year 2023/24, less than half the staff who used the service had their needs met within one appointment. With the appointment of a new Strategic Lead for Staff Wellbeing, this offer has changed to include therapy options – including a new trauma pathway.

Between October 2025 and April 2026, with 1.0WTE psychology input (the Strategic Lead role) and 0.8WTE Emotional Wellbeing Assistant, the service was able to offer:

- 44 individual psychology sessions (maximum of three per staff member) for staff struggling with a range of concerns. Most commonly, staff were contacting the service due to relationship difficulties in work (grievances, managerial conflict, anxiety in relation to colleagues).
- 13 one-off consultations with staff in relation to signposting and emotional containment. These sessions are varied in their scope, but often relate to challenges outside of work where the pathway for support is unclear, or interpersonal/relational challenges within work.
- 20 reflective practice sessions attended by 57 staff, to offer space to consider challenges at work and how to manage these as a team. These have been offered to People Services colleagues in West and PAN areas, Professional Nurse Advocates, and our Speak up Safely Guardians.
- 13 emotional wellbeing calls to staff experiencing mild-moderate distress.

100% of staff said that they would recommend the SWPS to a colleague. Qualitative comments include:

“I felt like it was a safe space where I could express how I was feeling and someone was there to listen. The session made me look at myself and how I handle tough conversations.”

“I was really struggling before my session with (the psychologist) but even though it was just three sessions, it has given me an insight into the how beneficial psychologists are and the positive impact the profession has on individuals struggling.”

Occupational Health:

There have been 4166 Management referrals to Occupational Health in the last 12 months, and 1597 self-referrals to the service. Of those, 599 Staff received direct counselling support.

Of those 599 staff, 98 of them accessed counselling due to work arrangements or changes, 27 accessed support due to bullying and harassment, and 161 accessed support due to anxiety.

Qualitative data includes:

“The counselling sessions alongside the wellness sessions have really given me the ability to take a step back and look at the situation that is causing me stress and anxiety, also giving me skills to manage that stress ,occupational health has been outstanding with me and I wouldn’t have had the strength to turn myself around and return to work without them , thank you to the whole of the wellness team.”

The Occupational Health and Wellbeing Team offer a variety of events including wellbeing workshops, menopause awareness, and sessions on neurodiversity. They have been in contact with over 1200 people in the last year at these events, signposting staff and supporting them. The Support Advisors in Occupational Health have also taken 3388 calls and signposted staff to appropriate support.

Our Wellbeing Champions have attended:

- 4 x Induction session – 74 attendances
- 6 x Champion network sessions – 45 attendances
- 4 x ICAN suicide awareness sessions – 81 attendances

A specific area of work is around menopause. For this area the team have delivered:

- 45 awareness sessions – 701 attendances
- 3 x menopause live roadshows – 391 attendances
- 10 x virtual menopause café sessions – 141 attendances

Qualitative feedback notes:

‘The overall impact on my wellbeing was truly remarkable. It was incredibly valuable to talk things through with other NHS colleagues.’

‘To be in a space with others feeling the same, helped me find relief from the mental strain I feel.’

Schwartz Rounds:

Following each Schwartz Round the Storytellers and audience members are asked to complete feedback. Evaluation indicates:

- 96% of audience members planned to attend the Rounds again
- 99% advised that they would recommend Schwartz Rounds to colleagues
- 96% reported of respondents reported that the Rounds will help them work better with colleagues
- 84% gained insights that will help them meet the need of their patients
- 96% agreed that the discussions were well facilitated

Qualitative feedback from audience members and Storytellers is below:



Lovely to see everyone come together and it is very humbling to see and hear that we all experience challenges of some sort - just in different roles.

What I expected to get from being a panellist and what I actually got were quite different and much more positive than I expected. Within a few hours it has already led to a number of useful conversations around the topic.

Wellness, Work and Us:

In Q1-Q4 of 2025, there were 657 total contacts across Wellness, Work and Us.

- Counselling consisted of 64% of all activity (420 contacts)
- Emotional support was 20% of service output
- Coaching was 16% of service output

The main themes for staff input were anxiety/stress, work-related pressure, confidence/career challenges (for which staff specifically accessed coaching) and low mood/depression.

Qualitative data includes:

Prior to receiving support, I felt extremely vulnerable and very low in confidence in the workplace. (The coach) made me feel valued and appreciated for the 20 years I have worked for the organisation. Due to the support I was given and advice I was able to return to the workplace with confidence and find a role where I can contribute and feel valued.

I think that I have been supported in a gentle but compassionate way to figure out what I needed to do for myself and how to help myself. This in turn has meant a massive improvement in my wellbeing.

People and Culture Committee

CULTURE, LEADERSHIP & ENGAGEMENT IMPROVEMENT PLAN

Date of Meeting	11 June 2026
Publication Status	Open/ Public
	Not Applicable
Report Author name and title	Nia Thomas, Head of Culture Development
Lead Executive Team Member name and title	Debbie Eyitayo Executive Director of People and Organisational Development

Report Purpose	For Noting
	The Committee is asked to: • NOTE the progress outlined in this report and TAKE ASSURANCE on the direction of travel and governance arrangements supporting delivery of the Improvement Plan. • SUPPORT continued investment in the Culture Change Leaders network.

Executive Summary

This paper provides an update on the development and early implementation of the Three-Year Culture, Leadership and Engagement Improvement Plan, which has been informed by the Discovery Phase of the Culture and Leadership Programme and key organisational intelligence, including the NHS Wales Staff Survey 2024 and *Foundations for the Future* engagement.

The plan is focused on embedding sustainable cultural change, improving staff experience, and strengthening leadership capability, with the ultimate aim of enhancing patient outcomes. Since the last update, positive progress has been made, including early delivery against key actions, strengthened Executive oversight, and increasing organisational engagement. Further targeted support is being developed for fragile services through the introduction of a Cultural Health

Assessment Tool, alongside external learning from partner organisations such as WAST and delivery of actions arising from a recent internal audit of the Culture Programme.

Notably, the Culture Change Leaders (CCL) network continues to expand, with significant interest in Cohort 3 and growing capacity across the organisation to lead cultural improvement locally. Early implementation activity, alongside the development of accessible formats of the plan, demonstrates strong organisational commitment and momentum.

The Committee is asked to note progress to date and support continued investment in key enablers, particularly the Culture Change Leaders Network.

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)

Committee / Group / Individuals	Date	Outcome, Evidence and Data
Executive Committee	01.04.25	Discussion and feedback

Acronyms / Glossary of Terms

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THREE YEAR CULTURE, LEADERSHIP & ENGAGEMENT IMPROVEMENT PLAN

1. SITUATION

The Synthesis Report presented to the Board in November 2025 summarised the findings from the Discovery Phase of the Culture and Leadership Programme. Drawing upon multiple sources of feedback—including the NHS Wales Staff Survey 2024, the *Foundations for the Future* engagement exercise, and staff wellbeing data—the report identified key themes, challenges, and opportunities. These findings have informed the development of a three-year improvement plan aimed at embedding sustainable cultural change, enhancing staff experience, and ultimately improving patient outcomes.

Recognising the strategic importance of this work, the Executive Team requested a more detailed review of action ownership, alignment with organisational priorities, and clarity of intended outcomes. This paper provides an update on progress to date against the Improvement Plan.

2. SPECIFIC MATTERS FOR CONSIDERATION

A simplified, high-level version of the Improvement Plan has been developed to improve accessibility and usability across the organisation (**Appendices 1a and 1b**).

2.1. Ongoing Executive Engagement

In addition to formal review sessions, ongoing engagement with Executive colleagues continues to support delivery against agreed milestones. These discussions are ensuring alignment with strategic priorities and with ongoing workstreams under *Foundations for the Future*, enabling timely resolution of issues and reinforcing Executive ownership and oversight as the programme progresses.

It is also noted that several elements of the Improvement Plan are already underway, with delivery activity commenced in advance of formal plan finalisation. This reflects strong early momentum and a clear organisational commitment to the programme.

This includes oversight of actions arising from the recent internal audit of the Culture Plan, ensuring that recommendations are embedded within delivery plans and contribute to strengthened governance and assurance arrangements.

2.2 Management of the Improvement Plan via the Programmes, Projects and Plans Power App Portal

Work is progressing to incorporate the Improvement Plan within the Programmes, Projects and Plans Power App Portal. This includes mapping areas of overlap with existing programmes to minimise duplication and ensure streamlined reporting.

Once this work is complete, the Committee will receive high-level assurance in relation to delivery of the Improvement Plan, including oversight of progress, identification of associated risks, and early escalation of any issues or barriers that may impact the achievement of agreed objectives.

2.3 Progress to date

A number of elements of the Improvement Plan have already commenced, in some cases delivered through aligned or existing workstreams. These include:

- **Values-based appraisal system** – currently in development and reported through Foundations for the Future People Workstream, with pilot testing underway ahead of wider rollout.
- **Consistent cultural framework** – development of a shared approach to behaviours and expectations across the Health Board.
- **Values-based induction and transition programme** – our values and behaviours are contained within the current Induction but this needs to be strengthened. A T&F group will be established to look at the transition into new roles element for phased implementation.
- **Governance review to enable timely decision-making, reducing duplication and administrative burden** – review of governance processes via the Foundations for the Future programme.
- **Organisational metrics** – development of measures to evidence impact on staff engagement and culture.
- **Staff recognition programme** – Revision and plans to implement new initiatives under the staff recognition programme including revisions to the Long Services recognition scheme and introduction of staff recognition boards.
- **Leadership roles redesign** – work is underway through Foundations for the Future structures workstream to clarify expectations, behaviours and accountabilities aligned to compassionate leadership principles.

- **Review of organisational structures** which is being progressed through Foundations for the Future structures workstream.

Additional targeted and strategic developments include:

- **Culture Health Assessment Tool** – introduction of the diagnostic tool to support targeted improvement activity within identified fragile services, including Ysbyty Glan Clwyd Emergency Department. This will enable a more granular understanding of team culture and support locally owned action planning to improve staff experience and patient care.
- **External learning and benchmarking** – engagement with external partners to inform our approach, such as the Director of Culture at the Welsh Ambulance Services NHS Trust (WAST). This will support shared learning and adoption of best practice from organisations further advanced in their culture change journey.
- **Internal audit actions** – progress is being made against management actions arising from the recent Culture Plan audit, with oversight arrangements in development to ensure delivery and strengthen governance, measurement and assurance

2.4 Culture Change Leaders Network Update

Interest in the Culture Change Leaders (CCL) programme continues to grow, with 96 colleagues currently registered for Cohort 3 (closing date: 29 May 2026). Targeted recruitment activity has focused on areas identified as requiring additional support through the 2025 NHS Wales Staff Survey.

Upon completion of Cohort 3 recruitment, the CCL network is expected to reach approximately 260 members across BCUHB, significantly strengthening organisational capacity to support cultural improvement at a local level. Further work will take place to consider how the CCLs can be engaged as a conduit between services and engagement with members of the executive team and board for insight and feedback.

The Culture Change Leaders Celebration Event, held on 29 April 2026, was highly successful, with 93 colleagues in attendance. Initial feedback and evaluation data are provided at **Appendix 2**, and a video montage of the event is currently in production and will be shared widely across the organisation. A compendium of case studies have been compiled and can be seen here [Culture Change Leaders Case Studies April 2026 - ENG](#)

The continued expansion of the CCL network, alongside delivery already underway in key areas of the Improvement Plan, demonstrates tangible progress in embedding cultural change across the organisation.

RECOMMENDATIONS

The Committee is asked to:

1. **Note** the progress made since the previous meeting.
2. **Support** continued investment in the Culture Change Leaders network.

ASSESSMENT	
Link to Strategic Priorities	    
	3. Creating compassionate culture, leadership and engagement
	If more than one applies, please list below:
Design Principles	People First If more than one applies, please list below: Inclusive design Wise spending Simplify, standardise and adopt best practices Consistency with organisational values
Corporate Risks and Board Assurance Framework	CRR24-01 - 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 CRR24-16 - 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.
Wellbeing of Future Generations Act – Wellbeing Goals	A Prosperous Wales
	If more than one applies, please list below:

IMPACT ASSESSMENTS		
Equality	Yes: ☐	No: ☒
Have you undertaken an Equality Impact Assessment	Outcome:	

Screening (which includes the requirements of the Welsh Language Standards)	If no, please include rationale:	Each individual objective will require a EQIA once plan is approved
Socio-Economic Impact Assessment Have you undertaken a Socio-Economic Impact Assessment	Yes: ☐	No: ☒
	Outcome:	
	If no, please include rationale:	Each individual objective will require a SEIA once plan is approved
<u>Quality</u> Have you undertaken a Quality Impact Assessment Screening?	Enablers of Quality Culture and Valuing People	Domains of Quality All Apply
	If more than one applies, please list below:	If more than one applies, please list below:
<u>Wellbeing of Future Generations Act – Wellbeing Goals</u>	A Prosperous Wales	

Environmental /Sustainability Impact (5Rs)	If more than one applies, please list below:	
	No - Not Applicable	
	If more than one applies, please list:	
Armed Forces Covenant Due Regard Duty Have you considered the Armed Forces Covenant Due Regard Duty?	Yes: ☐	No: ☒
	Outcome:	
	If no, please include rationale:	
Data Protection Impact Assessment <i>Have you undertaken a Data Protection Impact Assessment Screening?</i>	Yes: ☐	No: ☒
	Outcome:	
	If no, please include rationale:	
Counter Fraud Impact Assessment <i>Have you considered the counter fraud impacts</i>	Yes: ☐	No: ☒
	Outcome:	
	If no, please include rationale:	
Legal	There are no specific legal implications related to the activity outlined in this report.	
Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Resource Impact (People / Financial)	There is no direct impact on resources as a result of the activity outlined in this report.	

Culture, Leadership & Engagement Improvement Plan (2026–2029)

This plan is about creating a compassionate, values-led organisation where people feel safe, supported and empowered to do their best work, with strong leadership, clear goals and a culture of learning and improvement.



What we're aiming for:

A kind, inclusive organisation where people feel safe to speak up, understand our values, and see how their work makes a difference.

Key actions (simplified):

- Create and clearly communicate a shared organisational vision.
- Build psychological safety so staff feel confident to speak up.
- Recruit, induct and appraise staff based on our values and behaviours.
- Embed shared values consistently across teams and leaders.

What success looks like:

- Staff feel listened to, supported and aligned to the organisation's values.
- Higher staff engagement and survey participation.
- Fewer grievances and early staff turnover.



What we're aiming for:

Clear goals, less bureaucracy, and faster decisions made closer to patients and teams.

Key actions (simplified):

- Streamline governance and reduce unnecessary processes.
- Clarify decision-making authority so teams feel empowered.
- Improve workforce planning and recruitment efficiency.
- Introduce fair, inclusive recruitment and clearer leadership roles.
- Strengthen feedback, recognition and performance conversations.

What success looks like:

- Staff feel trusted and able to make decisions.
- Improved role clarity and leadership effectiveness.
- Better retention, fewer interim roles, and quicker hiring.

**What we're aiming for:**

A learning organisation that develops people, shares ideas and encourages innovation.

Key actions (simplified):

- Introduce structured talent reviews and succession planning.
- Improve access to clear development and progression pathways.
- Promote reflective practice, collaboration and shared learning.
- Support innovation through ideas, pilots and leadership training.

What success looks like:

- More internal progression and ready future leaders.
- Stronger teamwork and cross-organisation collaboration.
- Staff feel able to contribute ideas and improvements.

**What we're aiming for:**

A compassionate organisation where staff feel valued, supported and included.

Key actions (simplified):

- Improve leadership visibility and accessibility.
- Introduce consistent leadership and management development.
- Strengthen staff wellbeing and trauma-informed support.
- Build compassionate leadership skills and inclusive behaviours.
- Create safe ways for all voices to be heard.

What success looks like:

- Improved wellbeing, reduced stress and better staff morale.
- Leaders role-model compassion and inclusion.
- Staff feel respected, heard and supported.

**What we're aiming for:**

Well-led teams with clear roles, strong communication and shared accountability.

Key actions (simplified):

- Review organisational structure to improve clarity and efficiency.
- Improve how information flows from Board to teams.
- Strengthen team leadership capability and training.
- Introduce team-based development and appraisal approaches.

What success looks like:

- Better communication and understanding of decisions.
- Stronger team relationships and performance.
- Improved wellbeing, reduced absence and better outcomes for patients.

Culture, Leadership & Engagement Improvement Plan

2026 - 2029



Vision and Values

What we're aiming for:

A kind, inclusive organisation where people feel safe to speak up, understand our values, and see how their work makes a difference.

Key actions:

- Create and clearly communicate a shared organisational vision.
- Build psychological safety so staff feel confident to speak up.
- Recruit, induct and appraise staff based on our values and behaviours.
- Embed shared values consistently across teams and leaders.

What success looks like:

- Staff feel listened to, supported and aligned to the organisation's values.
- Higher staff engagement and survey participation.
- Fewer grievances and early staff turnover.

Goals and Performance

What we're aiming for:

Clear goals, less bureaucracy, and faster decisions made closer to patients and teams.

Key actions:

- Streamline governance and reduce unnecessary processes.
- Clarify decision-making authority so teams feel empowered.
- Improve workforce planning and recruitment efficiency.
- Introduce fair, inclusive recruitment and clearer leadership roles.
- Strengthen feedback, recognition and performance conversations.

What success looks like:

- Staff feel trusted and able to make decisions.
- Improved role clarity and leadership effectiveness.
- Better retention, fewer interim roles, and quicker hiring.

Support and Compassion

What we're aiming for:

A compassionate organisation where staff feel valued, supported and included.

Key actions:

- Improve leadership visibility and accessibility.
- Introduce consistent leadership and management development.
- Strengthen staff wellbeing and trauma-informed support.
- Build compassionate leadership skills and inclusive behaviours.
- Create safe ways for all voices to be heard.

What success looks like:

- Improved wellbeing, reduced stress and better staff morale.
- Leaders role-model compassion and inclusion.
- Staff feel respected, heard and supported.

Learning and Innovation

What we're aiming for:

A learning organisation that develops people, shares ideas and encourages innovation.

Key actions:

- Introduce structured talent reviews and succession planning.
- Improve access to clear development and progression pathways.
- Promote reflective practice, collaboration and shared learning.
- Support innovation through ideas, pilots and leadership training.

What success looks like:

- More internal progression and ready future leaders.
- Stronger teamwork and cross-organisation collaboration.
- Staff feel able to contribute ideas and improvements.

Team Work

What we're aiming for:

Well-led teams with clear roles, strong communication and shared accountability.

Key actions:

- Review organisational structure to improve clarity and efficiency.
- Improve how information flows from Board to teams.
- Strengthen team leadership capability and training.
- Introduce team-based development and appraisal approaches.

What success looks like:

- Better communication and understanding of decisions.
- Stronger team relationships and performance.
- Improved wellbeing, reduced absence and better outcomes for patients.

465 total CPD hours across all attendees

12%

20%

27%

32%

"Confident that we have started the ripple effect in changing the landscape for the future of BCUHB and it's workforce"



Beth yw un peth rydych chi'n ei gymryd oddi wrth digwyddiad heddiw?

Culture and Leadership Development – delivery of priorities

Internal Audit Report

2025/26

Betsi Cadwaladr University Health Board



Reasonable Assurance

Contents

Executive Summary	1
Findings & Agreed Action Plan	2
Appendix A	6

Review Reference
Fieldwork
Executive Sign Off
Audit Committee
Executive Lead

Audit Team

BCU-2526-24

December 2025 – January 2026

30 March 2026

April 2026

Debbie Eyitayo, Executive Director of People Services & OD

Dave Harries, Head of Internal Audit

Nicola Jones, Deputy Head of Internal Audit

Patrick Williams, Principal Auditor

Executive Summary

Purpose

To review the delivery and progress of actions outlined in Health Board Plans (Three Year Plan 2024 -2027 and IMTP 2025 – 28) to create a compassionate leadership culture across the Health Board. We have considered the delivery of 2024/25 priorities and how these are embedded, and how current priorities are progressing.

Overview

We have concluded reasonable assurance on this area. The matters requiring management attention include:

- Although structured plans are in place and updates are provided regularly, the evidence submitted to the Programme Management Office (PMO) portal remains incomplete in relation to the delivery priorities set out in the 2025–2028 Integrated Medium-Term Plan (IMTP).
- People and Organisational Development’s (POD) operations reports submitted to the People and Culture Committee include sections on Leadership and Development as well as Culture and Engagement, however there is no indication that comprehensive progress updates on the Culture, Leadership, and Engagement plans are being provided to the Committee.

Full details of matters arising are detailed within the Findings & Agreed Action Plan.

Scope & Assurance Summary

Objectives	The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.	Related Findings	Assurance
1	There are implementation plans in place to support delivery of the priorities outlined in the Health Board IMTP objective 3 (3A Culture Development and 3B Leadership Development). These plans include clear actions, timescales, owners, success priorities / benefits, and are monitored, with appropriate escalation if required.	-	Substantial
2	There is evidence to support deliverables that have been achieved, and these are continuing / embedded.	1	Reasonable
3	The Health Board and relevant Committees are provided with sufficient information to be assured on the progress of delivery.	2	Limited

Management Actions

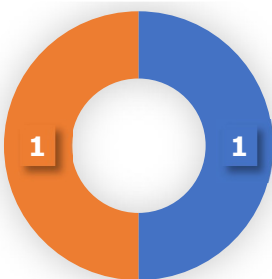


High Priority



Medium Priority

Themes



- Governance
- Planning, Delivery & Deadline Management

Risk Types

Quality or Safety Issues

Findings & Agreed Action Plan

Objective 1: There are implementation plans in place to support delivery of the priorities outlined in the Health Board IMTP objective 3 (3A Culture Development and 3B Leadership Development). These plans include clear actions, timescales, owners, success priorities / benefits, and are monitored, with appropriate escalation if required.	Substantial
---	--------------------

Overview / Summary of Observations

Implementation plans for 2024-25 and 2025-26 are in place that align with the delivery priorities and strategic direction outlined in the Health Board’s Integrated Medium-Term Plan (IMTP) 2025–2028. Each plan sets out specific actions supported by defined tasks, timelines, designated responsible owners, and requirements for regular progress updates to maintain effective oversight.

A review of the progress updates submitted for the IMTP period shows that, for 2024-25, all planned objectives have been reported as achieved. Furthermore, the updates for 2025-26 demonstrate that the majority of objectives are either fully completed or progressing in line with expected timeframes.

Additional evidence supporting the delivery priorities within the IMTP includes:

- The high-level BCUHB Culture, Leadership and Engagement Plans
- The Values & Behaviours Framework – Deployment Plan

A synthesis report providing an update on the Culture and Leadership Programme was presented to the Health Board on 27 November 2025. This included a Three-Year Culture, Leadership & Engagement suggested Improvement Plan (2026–2029) which was formally approved by the Board. The plan is scheduled for presentation to the People and Culture Committee on 12 February 2026 for approval.

Objective 2: There is evidence to support deliverables that have been achieved, and these are continuing / embedded.	Reasonable
---	-------------------

Overview / Summary of Observations

Information relating to the plans, along with progress against the IMTP 2025–28, is submitted by responsible officers to the Programme Management Office (PMO) through a dedicated reporting portal. This process is intended to provide assurance that all relevant updates and supporting evidence are being captured and monitored.

As part of our review, we sought confirmation from the PMO that all required progress information had been received. The evidence from the PMO included their assessment on whether the information provided supported closure of the actions.

Although evidence was available for several areas, we could not confirm that the PMO had obtained the full set of information relating to progress against the Strategic Objectives within the IMTP 2025–28. As a result, assurance regarding the completeness of reporting for these specific actions is reduced. We note, however, that Workforce & Organisational Development did subsequently provide the outstanding information needed to demonstrate progress against the priorities for the year.

It was noted that the culture change programme needed to be commenced in a flexible way to meet special measures requirements, so elements of the programme had commenced prior to final board sign off in November 2025. The culture change programme is based on the Kings Fund/

NHS England programme which is an evidence-based model. Elements of this programme, namely values and behaviours needed to commence before completion of discovery, or the health board would have been deemed not to meet special measures priorities. People Services have confirmed that all of the interventions so far on culture are key elements of the programme including the synthesis report, culture change leaders and new management training and development.

The evidence reviewed confirms that planned activities were carried out according to the agreed milestones. For 2025/26, all delivery priorities scheduled up to Quarter 3 in the IMTP 2025–2028 have been completed to the level expected at this stage in the reporting period.

Key Findings		Risk & Impact	Agreed Management Action
1	Submission of evidence to support delivery of actions Although structured plans and reporting mechanisms exist, incomplete evidence submitted to the PMO for certain actions reduces assurance that all priorities under Objective 3 (A,B) are being delivered. We would expect management to agree evidence required for submission with the PMO.	Gaps in reporting delays or issues affecting delivery may remain unaddressed, increasing the likelihood that IMTP milestones and objectives are not met.	Agreed Action: The Culture and Leadership Programme approved by the Board in November 2025 is designed both to address the organisation’s Special Measures requirements and to deliver on the nine strategic objectives for culture and leadership that were originally committed to at Board in October 2023. All programme actions will now be monitored through a dedicated portal, where evidence of delivery will be uploaded quarterly or at the point of completion for each intervention. The Year One implementation plan contains detailed actions, clearly identifying intended outputs and outcomes to support robust tracking and assurance. The establishment of the new People and OD Delivery group in Q1 26/27 will strengthen operational governance and provide oversight of programme delivery and relevant actions Alongside this, the Welsh Government has set two ministerial workforce priorities: 1) reducing sickness absence- the health board has a target of 5.6% by the end of 2026/27 (Q4 rolling) and 2) reduction in agency utilisation. The Culture and Leadership Programme will act as a key enabler to support progress in both areas by strengthening organisational climate, leadership capability, and staff experience, contributing to improved attendance and reduced reliance on temporary staffing.

		Expected Evidence of Implementation: Workforce KPI Data Objective delivery plans Objective review documentation New systems, toolkits Attendance of key meetings Correlation with staff survey data
	Medium Priority	Officer: Head of Culture Development, Deputy Executive Director of People and OD Target Implementation Date: Q1(30 June 2026) for process Q4 (31 March 2027) for annual evidence collection
Theme: Planning, Delivery & Deadline Management	Control Design	

Objective 3: The Health Board and relevant Committees are provided with sufficient information to be assured on the progress of delivery.

Limited

Overview / Summary of Observations

The People and Culture Committee receive the People and Organisational Development (POD) Operations report that includes sections on Leadership and Development and Culture and Engagement. However, there is no evidence that detailed updates on the Culture, Leadership, and Engagement plans are being presented to the Committee.

This limits the Committee's ability to gain assurance that key initiatives and actions agreed in the IMTP are progressing as intended and are completed within agreed timelines. While progress updates have been provided to other forums, such as the Organisational Development Steering Group and the Local Partnership Forum, similar updates have not been consistently shared with the People and Culture Committee.

To strengthen governance and oversight, information regarding the Integrated Leadership Development Framework (ILDF) project plan and Culture, Leadership & Engagement initiatives should be presented regularly to the Committee. This will ensure that plans remain on track and that the Committee can effectively monitor progress and hold management accountable for delivery within agreed timelines.

Key Findings		Risk & Impact	Agreed Management Action
2	Assurance to Committee Although the People's Operations reports submitted to the People and Culture Committee include sections on Leadership and Development as well as Culture and Engagement, there is	Committee may lack assurance that key cultural and leadership	Agreed Action: Quarterly reporting of the culture and leadership programme and access into leadership interventions to be implemented, linked to the action plan.

no indication that comprehensive progress updates on the Culture, Leadership, and Engagement plans are being provided to the Committee.	initiatives are progressing as intended.	Reporting on Integrated Leadership Development Framework to commence in March 2026, as part of the people operations pack, which is presented to People and Culture Committee. The establishment of the new People and Organisation Delivery group in Q1 26/27 will strengthen operational governance and provide oversight of programme delivery and relevant actions
Theme: Governance	High Priority Control Design	Expected Evidence of Implementation: Quarterly review of action plan outputs and outcomes. Compliance reporting for leadership and management development to be built in as part of the people operations report. Officer: Deputy Executive Director of People and OD Target Implementation Date: 31 March 2026 for compliance report. 30 June 2026 for Q1 review.

Appendix A

Assurance Opinion

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

Prioritisation of Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
Medium	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership](#)

Disclaimer

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit Committee.

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Betsi Cadwaladr University Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

The report is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given with regard to the advice and information contained.

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

Public Sector Internal Audit Standards

Audit work undertaken by NHS Wales Audit and Assurance Services conforms with the International Standards for the Professional Practice of Internal Auditing and associated Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.



People and Culture Committee

People Operations Report

Dyddiad y Cyfarfod Date of Meeting	11 June 2026
Statws Cyhoeddi Publication Status	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad Report Author name and title	Nick Graham, Associate Director of Workforce Optimisation
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol Lead Executive Team Member name and title	Debbie Eyitayo, Executive Director of People Services and OD

Pwrpas yr Adroddiad Report Purpose	For Noting
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Crynodeb Gweithredol **Executive Summary**

The purpose of this report is to outline the current workforce operational position as of end of April 2026. To note, this report includes reference to the Shared Services Partnership Report (Timelines of Shortlisting Process) to link with an action transfer from PFIG.

Ymgysylltu (mewnol/allanol) yr ymgwymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp) **Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)**

Pwyllgor / Grŵp / Unigolion Committee / Group / Individuals	Dyddiad Date	Canlyniad, Tystiolaeth a Data Outcome, Evidence and Data

Acronymau / Rhestr Termiau **Acronyms / Glossary of Terms**

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ASESIAD / ASSESSMENT

Cyswllt â'r Blaenoriaethau Strategol Link to Strategic Intentions	4.Create a Modern, People Centred Healthcare System
Yr Egwyddorion Dylunio Design Principles	People First
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd Corporate Risks and Board Assurance Framework	All risks associated with the subject and scope of this paper are already highlighted and managed through the current risk management structures within the organisation.

ASESIADAU O EFFAITH / IMPACT ASSESSMENTS

Equality Act 2010 Public Sector Equality Duty: Has BCUHB provided evidence of 'Due Regard' to compliance with the three parts of the Public Sector Equality Duty (General Duty): https://www.gov.wales/public-sector-equality-duty.html Public Sector Equality Duty [HTML] GOV.WALES	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	N/A
Equality Act 2010 - Socio-economic Duty <i>Has BCUHB provided evidence of 'Due Regard' to compliance of ther Socio-economic Duty when making strategic decisions?</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	N/A
<i>Have you completed an Integrated Equality Impact Assessment WP8a?</i> WP8a Template	Canlyniad/Outcome: Do/Yes:	Naddo/No: ☒
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	N/A

	Canlynaid/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	It does not apply at this stage as no formal actions have been agreed as a result of this this report.
Human Rights Act <i>Have Human Right based concerns been addressed within WP8a</i>	Do/Yes: ☐	Naddo/No: ☐
	Canlyniad/Outcome:	N/A
Compliance to the Welsh Language requirements? <i>Have you undertaken an Impact Assessment</i>	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Naddo/No: ☒
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	N/A
Compliance to giving 'Due Regard' to the principles of the Armed Forces Covenant <i>Have the principles of the Armed Forces Covenant been addressed within WP8a</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
<u>Ansawdd</u> <i>A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?</i> <u>Quality</u> <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Galluogwyr Ansawdd Enablers of Quality Choose an item. Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	It does not apply at this stage as no formal actions have been agreed as a result of this this report.

<u>Deddf Llesiant</u> <u>Cenedlaethau'r Dyfodol -</u> <u>Nodau Llesiant</u> <u>Wellbeing of Future</u> <u>Generations Act –</u> <u>Wellbeing Goals</u>	Not Applicable	
Effaith Amgylcheddol / Cynaliadwyedd (5Rs) Environmental /Sustainability Impact (5Rs)	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
	No - Not Applicable	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:	
Asesiad o Effaith ar Ddiogelu Data <i>A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?</i> Data Protection Impact Assessment <i>Have you undertaken a Data Protection Impact Assessment Screening?</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	It does not apply at this stage as no formal actions have been agreed as a result of this this report.
Asesiad o Effaith ar Atal Twyll <i>A ydych chi wedi ystyried yr effeithiau ar atal twyll?</i> Counter Fraud Impact <i>Have you considered the counter fraud impacts</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	It does not apply at this stage as no formal actions have been agreed as a result of this this report.
Cyfreithiol Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw Da Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith ar Adnoddau <i>(Pobl / Ariannol)</i> Resource Impact <i>(People / Financial)</i>	There is no direct impact on resources as a result of the activity outlined in this report.	

People Operations Report

May 2026

Debbie Eyitayo

Executive Director of People Services & Organisational Development



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board



Executive Summary

- The vacancy rate currently stands at 8.9%, with no change against the position during the same period last year. Clinical staff groups including Registered Nursing, AHPs, and Add Professional Scientific and Technical are seeing positive reductions in vacancy FTE, however, increases in some staff groups, particularly those impacted by Enhanced Establishment Control, are causing the vacancy rate to remain fairly static. Recruitment challenges, process delays, and hard-to-fill roles continue to impact the organisation's ability to reduce vacancies, however, progress is being made through strengthened recruitment planning, improved filtering of applications, and focused support for priority areas.
- Turnover stands at 7% and continues its downward trend. Registered Nursing staff group reporting the lowest turnover rate at 4.8%, whilst Estates and Ancillary see the highest rates of 11.4%. BCUHB has a Staff Retention Lead in post, a role commissioned as part of the non-pay elements of the 2022-4 collective agreement; a line of work at this time seeks to review processes surrounding Exit Interviews, to improve the volume and quality of the information captured.
- The organisation-wide Sickness Reduction work is underway with hotspots areas identified for targeted intervention to support staff in attending work and to achieve a measurable decrease in our absence levels. IHC Action plans have been developed and monitoring of these areas is ongoing through provision of update reports and regular meetings. These actions aim to strengthen support for staff, improve operational resilience, and ensure alignment with national expectations for workforce health and well-being with progress reported via People & Culture Committee.
- BCU continues to perform strongly across most recruitment metrics, meeting or exceeding NHS Wales performance in five of eight measures, though delays remain in shortlisting and reference checking. While overall time to recruit is within target at 64.2 days, high application volumes, increased use of AI-generated submissions, and operational pressures on clinical managers are contributing to bottlenecks. Targeted actions include — strengthened escalation processes, improved planning, and targeted support — these are underway to reduce delays and improve the quality and efficiency of recruitment activity.
- PADR compliance currently stands at 80.8%, a 1.1% improvement on the same period in the previous year. The revised PADR process is currently under development. This will bring more of a focus on staff wellbeing and performance and align PADR to the new BCUHB values and behaviours framework. This process will also provide the opportunity to highlight talent across the organisation as we focus on Talent Management and Succession Planning.
- Level 1 mandatory training compliance remains above the target of 85% at 90.8%. There is a focus on compliance for bank staff, medics and targeted intervention in departments that are failing to achieve the 85% target.

People

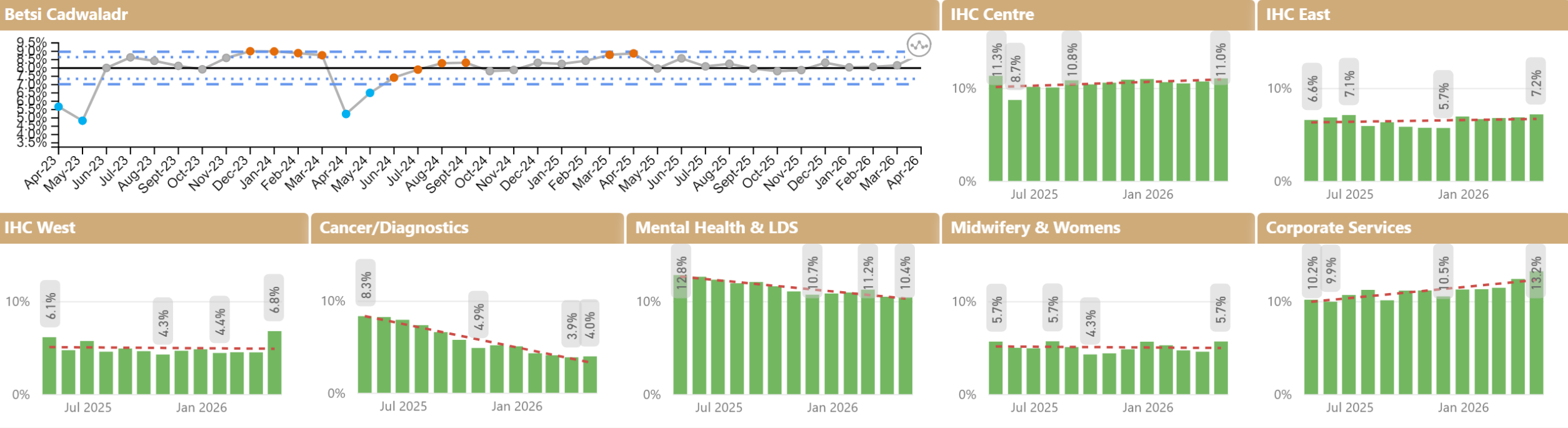


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Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Vacancy % by IHC

BCU Data as at April 26



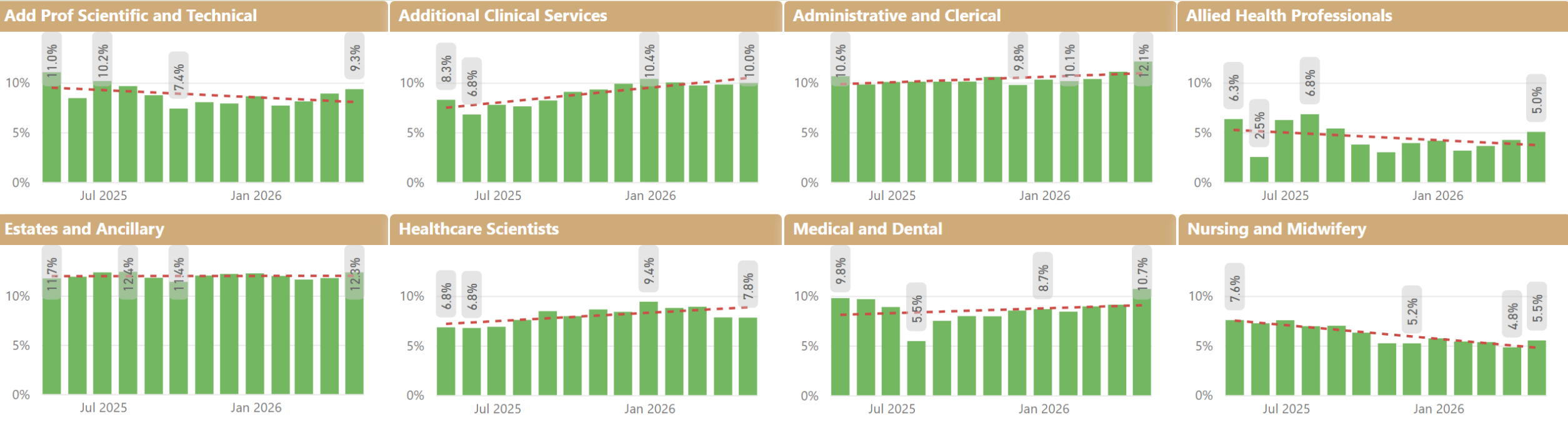
Analysis: The overall BCU vacancy rate for April 2026 stands at 8.9%, with no change on the same period in the previous year. Corporate Services has the highest vacancy rate at 13.2%, an increase of 3% from the previous year. Whilst IHC Centre has the highest number of vacancies at 550.1 FTE with a vacancy rate of 11%, followed by IHC East with 345.9 FTE vacancies, equating to a vacancy rate of 7.2%. There is a downward trend in the vacancy rate for Cancer/Diagnostics over the last year, with a reduction in vacancies of 61.0 FTEs bringing the vacancy rate down from 8.3% to 4.0%, which is the lowest rate seen. Midwifery & Womens has the next lowest vacancy rate at 5.7%.

Challenges: The enhanced establishment control process is having a consequential effect on the efficiency of resourcing to some staff groups causing an increase in the vacancy FTE in some IHCs such as Corporate Services where the workforce is predominantly Admin & Clerical staff. High volumes of applications of low overall quality continues to present a challenge and cause delays to the recruitment process, particularly for HCA roles. Other delays in the recruitment process are contributing to posts remaining vacant for longer periods such as pre-employment checks, timely recruitment from notice date and update of shortlisting and interview outcomes. Hard to fill vacancies require multiple re-advertisements owing to low interest or lack of appointable candidates and Ward Clerk roles are problematic where Welsh language skills are essential.

Progress: Where there are large numbers of ECRs within the system, the People Services Teams continue to support with moving them through to completion as efficiently as possible. There is a focus on planning for external recruitment including the scheduling of shortlisting ahead of adverts. Services are encouraged to advertise vacancies internally where appropriate to reduce volumes and to utilise filtering questions to improve the quality of applications at shortlisting. The recruitment and retention working group is currently developing guidance and communications to support managers to plan and prioritise recruitment activity in order to reduce delays throughout the process.

Vacancy % by Staff Group

BCU Data as at April 26



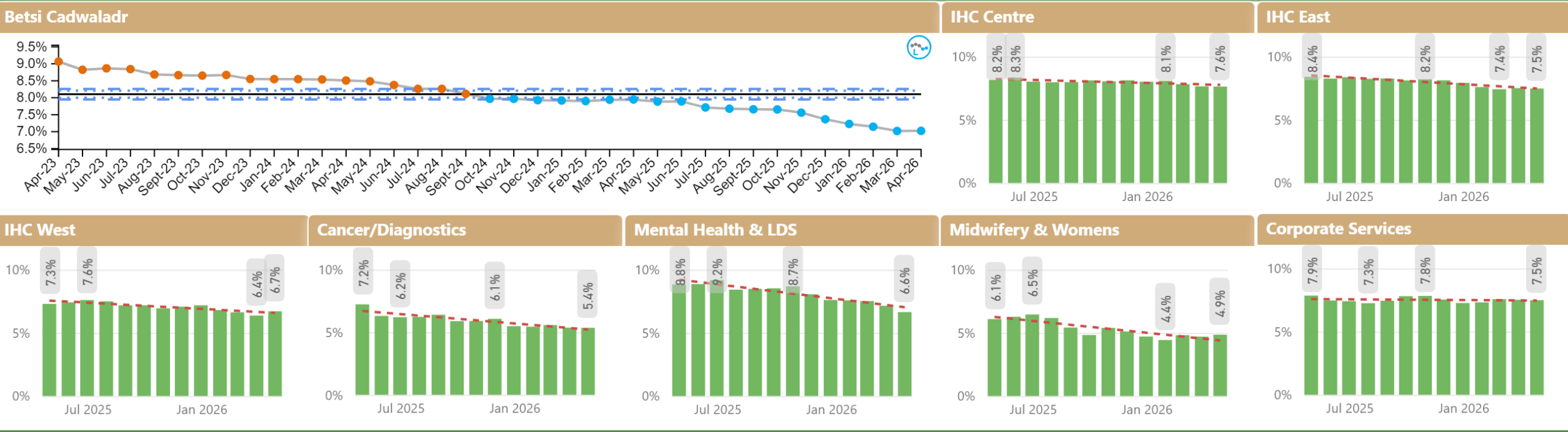
Analysis: Vacancy rates have remained consistently high within the Estates & Ancillary and Admin & Clerical staff groups which stand at 12.3% and 12.1% respectively. Whilst Additional Clinical Services have seen the largest increase in rate of 1.7% from April 25, equating to 75.3 FTEs to show a vacancy rate of 10.0% in April 2026. Nursing and Midwifery have seen a 2.1% reduction in vacancy rate when compared to the same period in the previous year, which is the largest of all the staff groups. Allied Health professionals and have the lowest rate at 5.0%. The Medical and Dental vacancy rate is 10.7%, equating to 200.5 FTEs.

Challenges: Increases in the vacancy rate for Admin & Clerical and Estates and Facilities staff groups are likely the result of their inclusion in the Enhanced Establishment Control process. M&D have a challenge with regards to the budget establishment and some areas continue to employ a number of locum doctors and have high agency costs. Medical and dental staff group currently have 216.4 Fixed Term contract FTEs and many are overseas doctors with CoS and Visa requirements. As we approach August, there are concerns around the level of Deanery gaps, which are not yet known, and the ability to fill these without a prompt process for LAS. Nursing and Midwifery staff has a low vacancy rate at 5.5% which presents a challenge for identifying suitable posts for the next cohort of graduates.

Progress: Good progress has been made in transitioning SAS grade Drs to the 2021 contract where requested. Teams are engaging with the student streamlining exec paper to understand actions associated with this and to support the North Wales University newly qualified nurses gaining employment in BCUHB.

Turnover % by IHC

BCU Data as at April 26



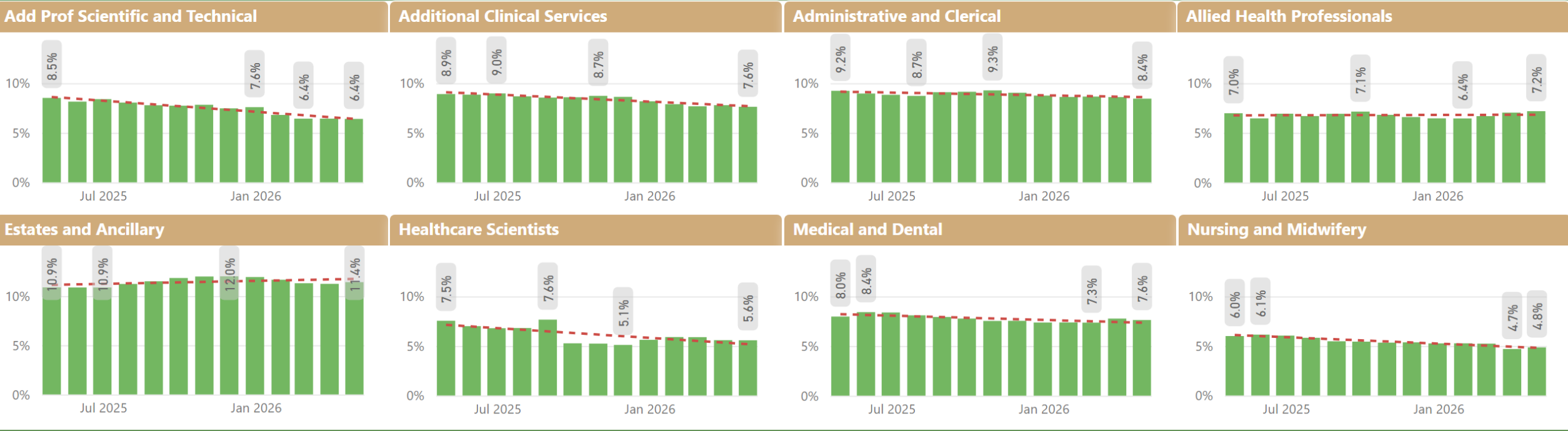
Analysis: The overall BCU turnover rate continues to reduce following the trend over the last 3 years and currently stands at 7%. All IHCs are showing an improvement on the position from the same period within the previous year. IHC Centre has the highest rate at 7.6% with both IHC East and Corporate Services showing a rate of 7.5%. Over the last 12 months IHC Centre has had the greatest number of leavers at 347.5 FTEs, followed by IHC East at 331.4 FTEs. Mental Health & LDS has seen the greatest improvement in turnover over the previous 12 months, falling by 2.2% to a rate of 6.6% as at April 2026.

Challenges: Whilst positive progress is evident at IHC level, there are still services and departments with higher turnover such as Facilities and HMP Berwyn in East IHC. Exit interview completion remains low at 23.2% in April 2026 (ESR Data only), limiting the organisation’s ability to gain meaningful insight into why staff are leaving. This low level of compliance continues to restrict the value of the data collected and hampers efforts to identify and address underlying retention issues.

Progress: The People Services teams are working identify hotspot areas of high turnover and are reviewing leavers data and exit interview results to better understand the factors driving the decisions to leave BCUHB.

Turnover % by Staff Group

BCU Data as at April 26



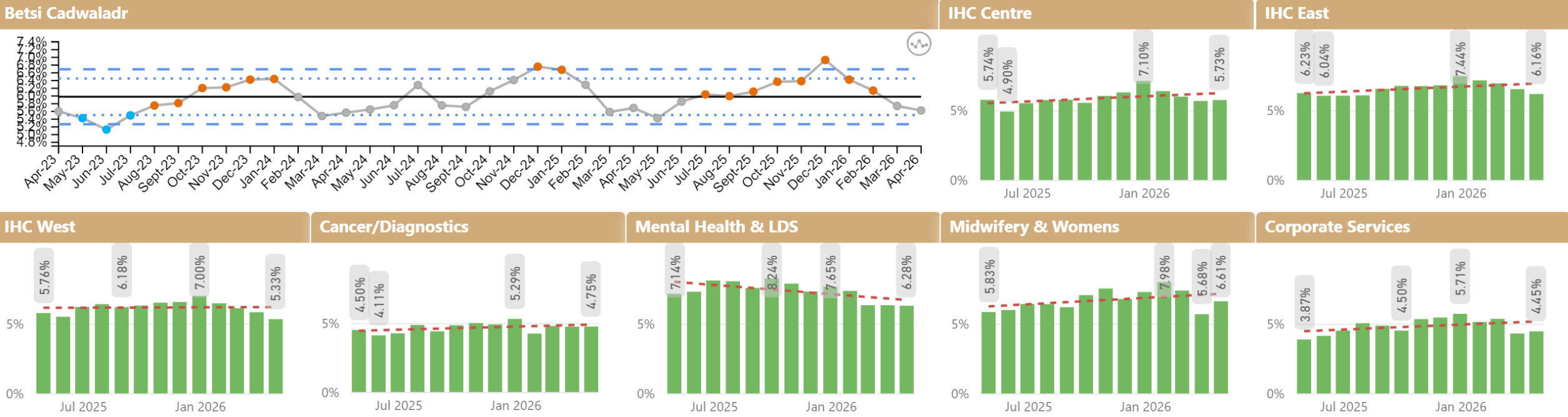
Analysis: Estates and Ancillary staff group is reporting a deteriorating position with regards to turnover increasing by 0.5% over the last 12 months to 11.4%, equating to 151.2 FTE leavers. Rates amongst this staff group are particularly high within East and West IHCs (14.5% and 12.6% respectively). All other staff groups are showing a positive, or static, trend with the overall turnover rate decreasing over the period. Add Prof Scientific and Technical have seen the biggest improvement in turnover across the last 12 months, reducing from 8.5% in April 2025 to 6.4% in April 2026. Nursing and Midwifery staff group continues to show improvement in the turnover rate and remains the best performing staff group at 4.8% turnover.

Challenges: Estates and Ancillary staff group remains the most challenging staff group in regards to turnover.

Progress: Positive progress is evident across several staff groups including Nursing and Midwifery, Add Prof Scientific and Technical and Healthcare Scientists.

Monthly Sickness % by IHC

BCU Data as at April 26



The charts above report the monthly sickness rate for BCU.

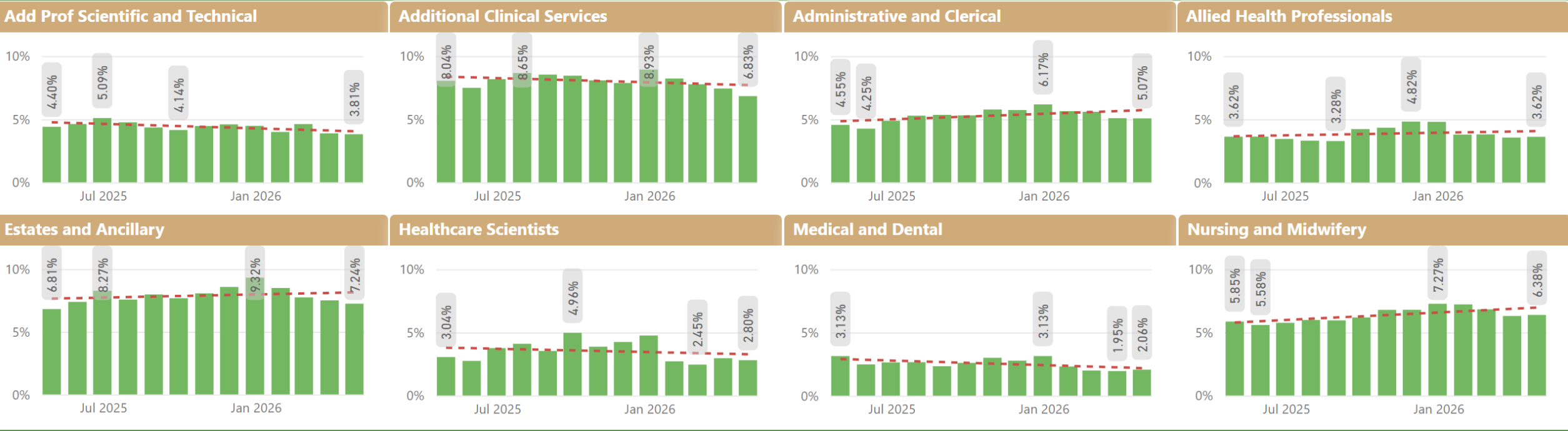
Analysis: The BCU monthly sickness absence rate currently stands at 5.63% and shows no special cause for concern. The rolling sickness absence rate currently sits at 6.09%, a slight increase on the rate of 6.06% reported in April 2025. Midwifery & Womens shows the highest monthly rate at 6.61%, an increase of 0.77% on the rate reported at the same point in the previous year. Mental Health & LDS has seen the biggest improvements in rates when compared to April 2025, a drop of 0.86% means the monthly rate now stands at 6.28%. Stress related absence continues to be the most prolific reason for absence, accounting for 1.76% of absence during April 2026. The East IHC is higher than BCUHB average however. Absence levels are continuing their downward trend. A key focus is absence for HCSW, currently at 9.45% monthly which is outlier versus other areas which has rates anywhere between 5-7%. The East has also established a monthly health workforce group to review process against baseline for each directorate in scope.

Challenges: Absence continues to be present a challenge across the organisation, particularly absence related to Stress, Anxiety and Depression. Recording of Return to Work Interviews are low with just 38% of absences closed in April 2026 having had a RTW interview recorded in a workforce system.

Progress: Targeted support is being given to sickness hotspot areas identified via the Health Workforce Group. Meetings have now taken place with the relevant SLT and targeted action plans agreed. Regular review meetings have been arranged to monitor performance and ensure continued focus. Teams continue to monitor and escalate to managers where staff have breached a trigger and there is also a push to improve recording of return to work interviews; work is currently underway to developed a process to record instances whereby a managers chooses not to proceed with the policy where a trigger has been breached and there is also a review of processes through which RTW information is captured.

Sickness % by Staff Group

BCU Data as at April 26



The charts above report the monthly sickness rate for BCU.

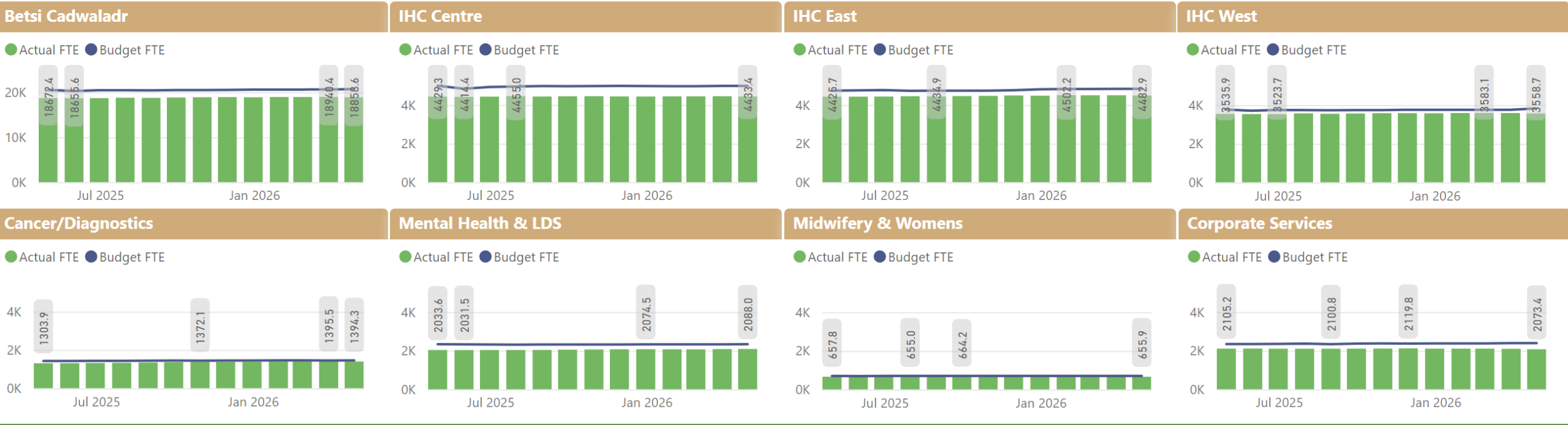
Analysis: Estates and Ancillary currently records the highest monthly sickness rate at 7.24%, an increase of 0.43% from the position in April 2025. Additional Clinical Services has the second highest sickness rate at 6.83% in February, however, this is 1.21% lower than the rate reported for same period last year. Nursing and Midwifery sickness rate was also high during the latest month at 6.38%, this figure has been trending upwards over the period. Monthly sickness absence within Add Prof Scientific and Technical, Allied Health professionals, Healthcare Scientists and Medical and Dental all stand below 5%.

Challenges: Sickness rates are increasing across Nursing & Midwifery and Estates and Ancillary staff groups and remain high amongst Additional Clinical Services staff, and there are concerns that absence may be inaccurately reported as sickness where special leave or flexible working adjustments may be more appropriate.

Progress: There is ongoing delivery of Managing Attendance at Work training, with the new format is receiving positive reviews and feedback. Work is also underway around the validation of sickness reasons to determine whether support is required from an alternative policy such as special leave or flexible working. Departmental reviews of cases including those which have recently closed are underway to explore lessons learnt. Wellness Plans are recommended as soon reasonably practical for all Stress, Anxiety or Depression absences and Teams are supporting managers to ensure action plans are in place for all long term sickness cases. Teams are working with culture change leaders and OD to ensure the promotion of self-compassion.

Budget v Actual FTE by IHC

BCU Data as at April 26



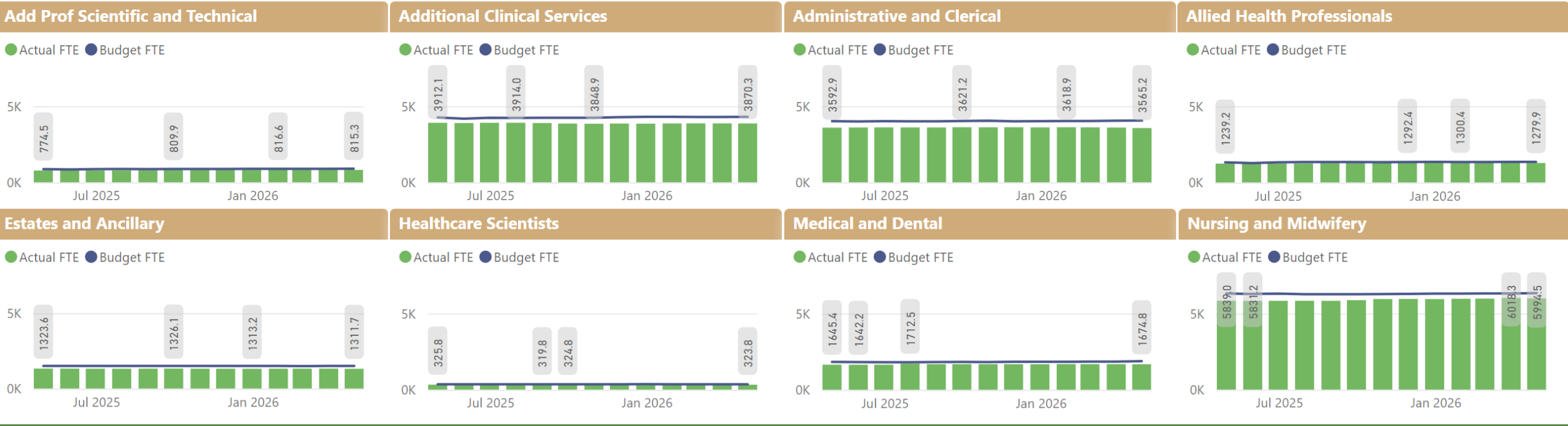
Analysis: In April 2026, budgets were 201 FTEs higher than April 2025 whilst actuals have increased by 186.2 FTEs, causing vacancies to fall by 14.8 FTEs. IHC East saw the greatest increase in budget, rising by 92.4 FTEs, whilst the actual also increased by 57.2 FTEs, this caused vacancies to rise by 35.2 FTEs. Corporate Services have seen the biggest increase in vacancy FTE of 77.7 FTE, within this IHC budgets have increased by 45.9 FTEs and actuals have decreased by 31.8 FTEs. The largest increase in actuals from April 2025 can be seen in Cancer/Diagnostics which have an additional 90.3 FTEs whilst budgets increased by 29.3 FTEs.

Challenges: There has been little change in the number of Fixed Term Contracts over the last 12 months.

Progress: People Services teams are working with managers to ensure they are looking at alternative ways to resource the work when appropriate. Medium Term it is the intention to strengthen the workforce planning process/activities at the directorate level. Teams are supporting managers to meet the challenge of enhanced ECR controls balanced with ensuring patient services are well supported and safe. This includes increased support on planning for vacancies at the ECR Stage and looking to support increased activity on workforce planning across the IHC, focussing on key activity areas. There is a continued focus on the reduction of using FTCs unless necessary.

Budget v Actual FTE by Staff Group

BCU Data as at April 26



Analysis: Nursing and Midwifery have seen the largest increase in actuals when compared to the same period in the previous year of 155.5 FTEs with budgets increasing by only 27.9 FTEs this has caused vacancies to decline by 127.6 FTEs. Additional Clinical Services have seen their actuals decline by 41.8 FTEs when compared to April 2025, budgets have also grown by 33.4 FTEs meaning that vacancies have grown by 75.3 FTEs. Medical and Dental have seen the largest increase in budget from the previous year of 51.7 FTEs with actuals also increasing by 29.4 FTEs.

Challenges: The nurse student streamlining is presenting a challenge owing to the low number of nursing and midwifery vacancies. The upcoming nursing cohort will be recruited to 30 hour per week (0.8 FTE) contracts and the midwives to 22.5 hour contracts (0.6 FTE). The HCSW appeals process is also presenting challenges with the current budget establishment position. Medical job planning and cost is also a challenge, for example, extra PAs above 12 as well as on call allowances may not be consistent in Allocate.

Progress: The Medical and Dental Establishment Dashboard is currently being rolled out to IHC management teams to support with the review and reconciliation of Job Planning sessions against ESR paid sessions. The dashboard has been rolled to leads in West Area initially and will be rolled out across the organisation over coming weeks.

Highlighted Areas

Org L6	Actual FTE	Vacancy %	Monthly Sickness %	PADR %	Mandatory Training %	Turnover %
Facilities Covid - West (RX54) L6						
2025-07	21.4	7.1%	5.29%	92.0%	96.0%	4.2%
2025-10	20.4	11.2%	15.11%	79.2%	91.7%	4.3%
2026-01	19.9	13.6%	6.30%	60.9%	94.1%	7.1%
2026-04	18.4	20.0%	11.95%	63.6%	91.3%	10.8%
Facilities Domestics - West (RX56) L6						
2025-07	150.7	13.3%	4.41%	94.5%	95.6%	13.1%
2025-10	150.3	13.6%	8.89%	88.6%	93.7%	13.3%
2026-01	147.2	15.4%	9.00%	67.3%	92.8%	12.1%
2026-04	149.3	14.3%	7.46%	58.9%	90.4%	11.0%
COVID 19 Vaccination (AX75) L6						
2025-07	126.8	15.9%	10.73%	63.6%	95.3%	10.2%
2025-10	126.5	16.0%	10.38%	59.9%	97.0%	11.0%
2026-01	126.0	15.7%	8.64%	58.7%	94.9%	12.2%
2026-04	126.8	15.2%	10.10%	72.0%	95.0%	13.0%
HMP Berwyn (AX57) L6						
2025-07	116.9	30.0%	8.36%	95.0%	92.4%	10.5%
2025-10	122.5	26.6%	6.21%	91.5%	93.5%	11.4%
2026-01	128.0	21.6%	6.30%	93.7%	93.5%	11.8%
2026-04	124.6	24.6%	7.88%	92.1%	90.4%	13.3%

Analysis:

Facilities Covid – West has seen the most deteriorations within the previous 4 quarters. However, the main concerns seen within the metrics would be an increasing monthly sickness rate which currently stands at 11.95%, a vacancy rate standing at 20% and a PADR rate that has fallen to 63.6%.

Facilities Domestics - West have seen deteriorations in the vacancy, monthly sickness rates and PADR rates during the previous years quarters. Mandatory training remains over the target despite recent reductions of the rate.

Covid 19 Vaccination shows cause for concern in turnover with this deteriorating each quarter. Vacancy rates and monthly sickness are high within this service.

HMP Berwyn has seen all metrics deteriorate within the latest quarter. Whilst PADR and Mandatory training rates are above target other metrics show a poor performance with the vacancy rate standing at 24.6% and turnover rates climbing each quarter.

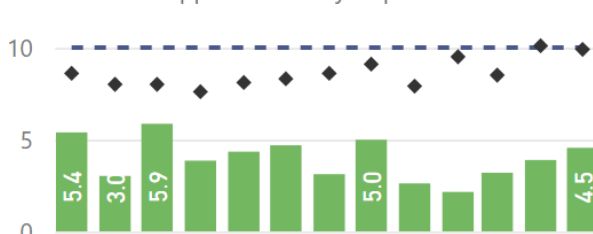
Progress: Deteriorating performance within Facilities Teams in West has been escalated via accountability meetings as well as via monthly Facilities leadership team to identify intervention and support to specific highlighted areas.

The table above shows the top 4 deteriorating areas, in order, for 5 key metrics. Each quarter that returns a poorer performance when compared to the previous is given a value. The Org L6s above have the most deteriorations within the previous 4 quarters. Where there is a tie between departments, this is sorted by those with the highest Actual FTE.

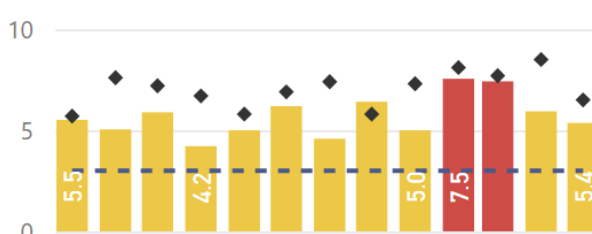
T0a - Notice Date to authorisation start date



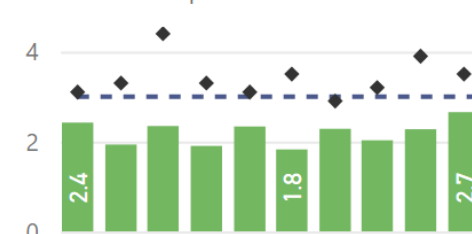
T1a - Time to approve vacancy request



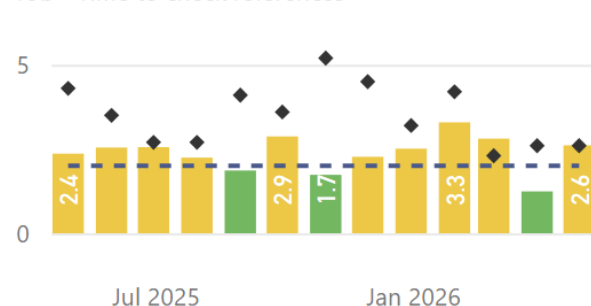
T4 - Time to shortlist



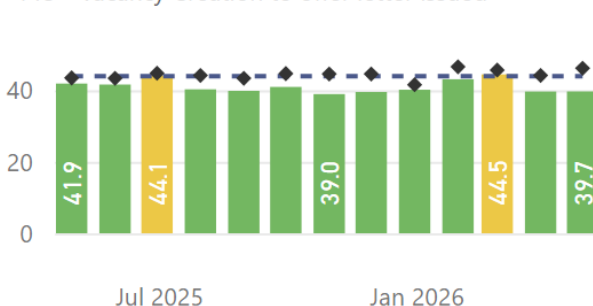
T5b - Time to update interview outcomes



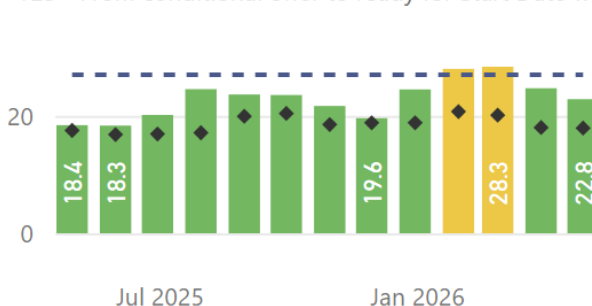
T9b - Time to check references



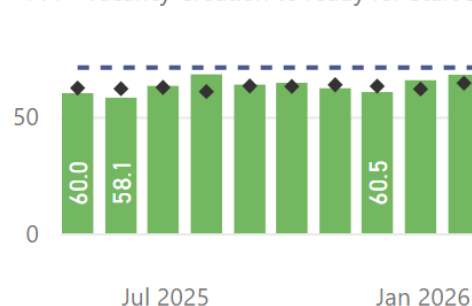
T13 - Vacancy Creation to offer letter issued



T23 - From conditional offer to ready for Start Date wit...



T14 - Vacancy Creation to ready for Start D



The KPI metrics included above are all specific metrics that are the responsibility of the Health Board and are within our gift to effect.

Analysis: BCU is performing better than, or equal with NHS Wales against 5 out of the 8 recruitment metrics and is compliant across 5 of the 7 measures with a defined target. Time to shortlist currently is 5.5 days over target. However, this is still performing better than the NHS Wales average and has reduced 2.1 days from the highest point in January 2026. Time to check references has exceeded the target by 0.1 days per month. Whilst from conditional offer to ready for start date is now under the target, it is still on average 4.9 days longer than the NHS Wales average. Time to recruit (from vacancy creation to ready for start date) is currently 44.5 days, which is under the target at 64.2 days.

Challenges: High volumes of applications of low overall quality continues to present a challenge and cause delays to the recruitment process, as does the increasing use of AI by applicants. Patient and clinical managers to be in the shift numbers which impacts on timely recruitment activity and update of shortlisting and interview outcomes. Other delays in the recruitment process are contributing to vacancies being vacant for longer periods such as pre-employment checks and where hard to fill vacancies require multiple re-advertisements owing to low interest or lack of appointable candidates.

Progress: Ongoing actions that teams are undertaking to ensure compliance with the 3 day time to shortlist KPI include; contacting managers where shortlisting time is outside of timescale to establish reasons for delay, weekly review of Trac recruitment reports/Trac dashboard to escalate imminent breaches to recruiting managers, planning activity in advance to ensure adequate time is allocated for recruitment, emphasising/promoting the importance of time to hire timescales at recruitment training events and developing an escalation process to the People Business Partners so they are aware of support needed in these areas.

Additional actions to be taken going forward include discussions with NWSSP regarding roles and responsibilities to remove duplication of actions, allowing time to be spent on other activities to support recruitment and to also explore whether they are able to support long listing of high volume posts. Consideration will be given to the use of person specification application forms which may reduce AI application volume and the requirement to demonstrate how the person specification is met. Review the filtering questions available for managers to use to help long list applications.

Time to Shortlist

Target Times	Responsibility	Trac Recruitment Health Check Average Times in Working Days (Excludes Covid Trac Teams)	Apr-26
5	Manager	Notice Date to authorisation start date	79.9
Variable (target to be agreed)	Manager	Authorisation Start Date to Leaving Date (previous post holder)	10.5
10	Org	Time to approve vacancy request	4.6
2	NWSSP	Time to advertise	1.5
Variable but target 10	Manager	Duration of advertising	8.6
2	NWSSP	Time to move to shortlisting	1.0
3	Manager	Time to Shortlist	5.4

Performance Update
Performance has improved from January 2026 where it was taking 7.5 days to shortlist to 5.4 in May 2026. The Resourcing teams met collectively to review the time to hire reports, specifically time to shortlist which increased

in January 2026. The ongoing actions the teams will take to support and encourage managers to shortlist in line with the required 3 day target are as follows:

- Contact managers where shortlisting time is outside of timescale to establish and issues or reasons
- Review the weekly Trac recruitment reports/Trac dashboard for actions which may be about to breach the timescales and contact managers immediately
- Encourage managers to factor in to the recruitment process time to shortlist
- Emphasise the importance of time to hire timescales at recruitment training events
- Build in escalation to the People Business Partners so they are aware of support needed in their areas

The teams also identified challenges that managers faced which included:

- High volumes of applicants, sometimes in the hundreds to shortlist
- AI completed application forms
- Patient activity may require clinical managers to be in the shift numbers

Additional actions to be taken:

Discussion to take place with NWSSP regarding roles and responsibilities to ensure that there is not duplication of actions, allowing time to be spent on other activities to support the process. To also discuss whether they are able to support long listing of high-volume posts. Consideration of using person specification application forms which may reduce AI application forms due to the requirement to demonstrate how the person specification is met. Review the filtering questions available for managers to use to help long list applications.

Leadership and Development



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

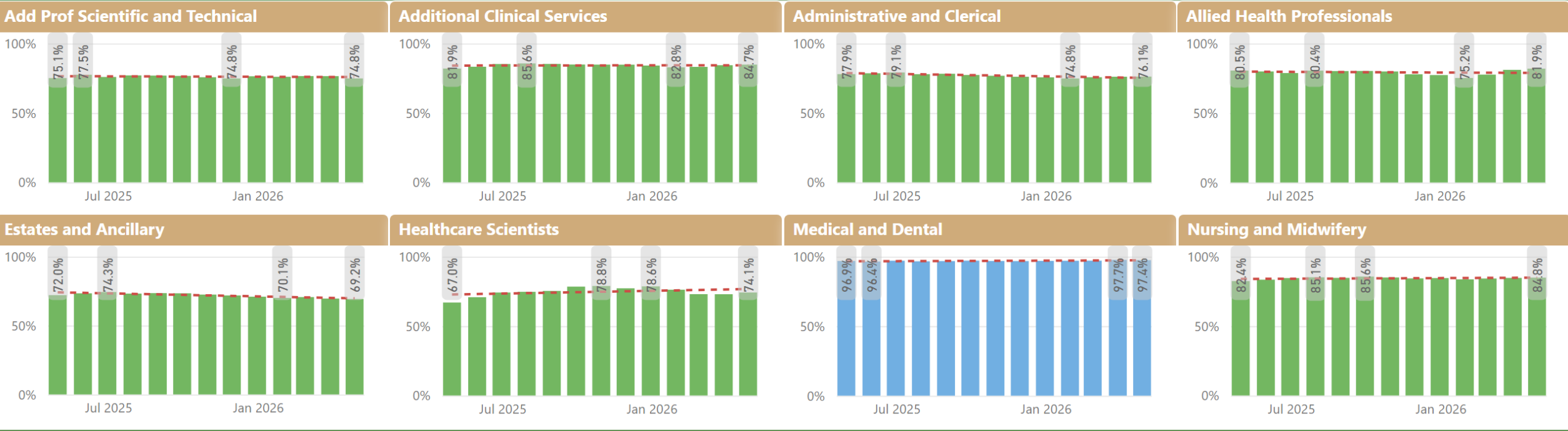
Analysis: Overall BCU PADR compliance currently stands at 80.8%, which is a 1.1% improvement since the same period last year. The best performing areas are Mental Health & LDS and Women’s and Midwifery, exceeding the target of 85% at 89.4% and 89.6% respectively. East IHC is just 0.5% below the 85% target whilst both IHC Centre and IHC West are both a little over 5% away from the target. Compliance is lowest in Cancer/ Diagnostics at 65.8%.

Challenges: Overall, the organisation fails to meet the 85% target for PADR compliance, however, following a period of deterioration through the latter half of 2025, the rate is slowly improving. PADR performance in Cancer & Diagnostics remains a challenge with low compliance rates impacted by both operational factors, including higher levels of sickness, and new IT systems

Progress: People Services teams continue to promote the appraisal process and encourage managers to invest time and planning to undertake effective and meaningful PADRs. Within IHC West Accountability meetings there has been a specific intervention in the facilities area to improve compliance which has shown signs of success within facilities Catering, with additional support and intervention provided via People and Culture. Within Cancer services the focus is currently on Admin & Clerical as a priority area for improvement. Within Corporate teams, hotspot areas have been identified for targeted support and for teams above the 85% target, actions plans remain under discussion to ensure all PADRs are completed.

PADR/MARS % by Staff Group

BCU Data as at April 26



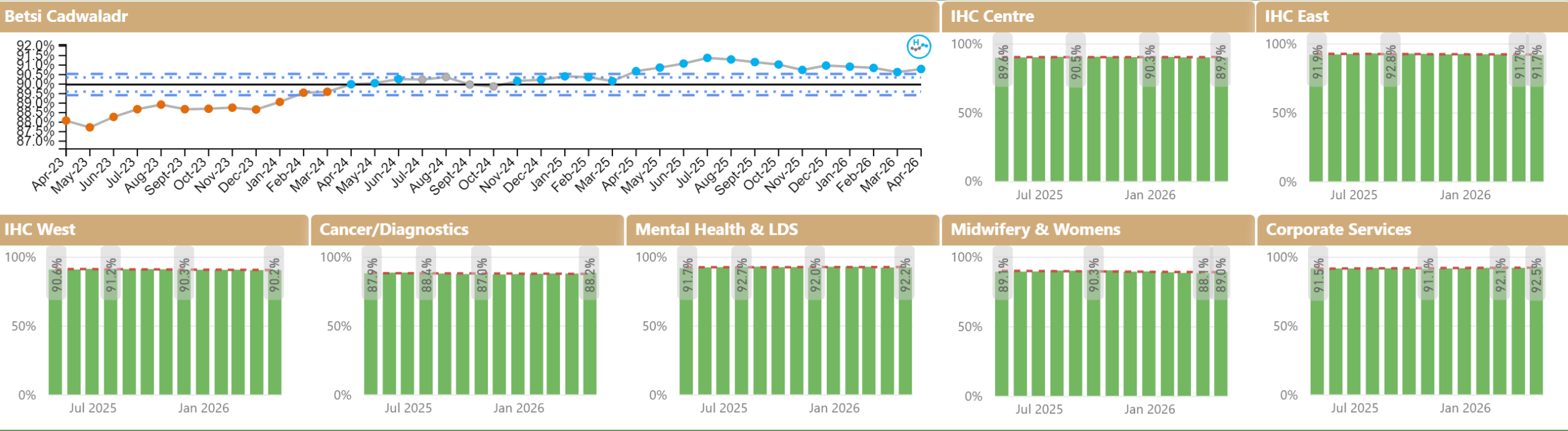
Analysis: At present, all staff groups are failing to meet the 85% PADR compliance target, however, Medical Appraisal Rate (MARS) currently stands at 97.4%. Additional Clinical Services and Nursing and Midwifery staff groups have previously achieved the 85% target but currently sit below at 84.7% and 84.8% respectively. Healthcare Scientists have seen the greatest improvement in PADR compliance over the last 12 months, increasing by 7.1% to 74.1%. Estates and Ancillary and Add Prof Scientific and Technical staff Groups have the lowest PADR compliance rates at 69.2% and 74.8% respectively.

Challenges: PADR compliance lowest within Estates and Ancillary and is showing a deteriorating position.

Progress: People Services teams are actively identifying out of date and "never had" PADRs, and contacting the managers, as employees have the right to have a PADR and to have this recorded on ESR. Areas of concern are discussed in meetings involving Senior Managers via SLT and People and Culture groups. Teams are working with managers within the hotspot areas to ensure action plans are produced and monitored to complete PADR's as soon as possible. Compliance continues to be discussed with Managers on a monthly basis in order to ensure an ongoing plan is in place to ensure completion of PADRs. Targeted interventions within Facilities West has shown positive results, particularly within catering.

Mandatory Training % by IHC

BCU Data as at April 26



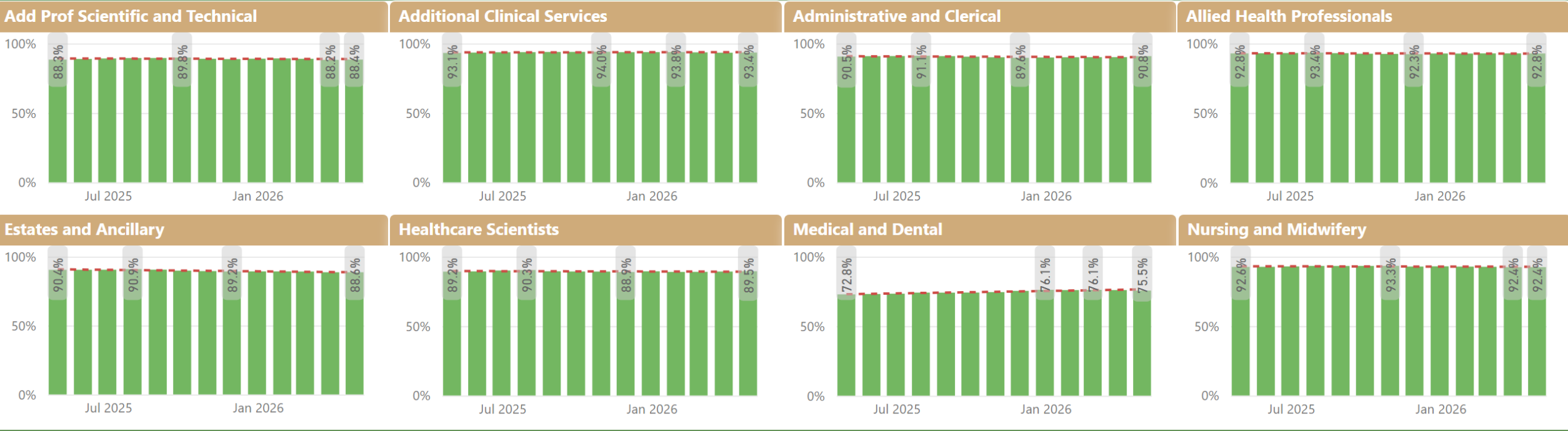
Analysis: BCU training compliance currently stands at 90.8% for Level 1 training and has been consistently above the 85% target across the last 12 months for all IHCs. Mental Health and Corporate Services have the best compliance rates, 92.2% and 92.5% respectively. There are pockets of non compliance against level 1 competencies in some areas; Midwifery and Womens are below the 85% target for 3 competencies and IHC Centre, Cancer/Diagnostics and Midwifery & Womens are all below the target for Information Governance. Overall, Level 2 compliance also exceeds the 85% target at 87.8%. However, overall compliance Infection Prevention level 2 and Moving and Handling Level 2 fall below the 85% target at 82.3% and 82% respectively.

Challenges: Whilst level 1 mandatory training compliance remains high overall, there are pockets of non compliance within services and departments across the organisation.

Progress: Monthly PADR rate reports are produced within the division and circulated to the SLTs. In addition, low performing areas are discussed in monthly People Services meetings with the SLTs. Work continues to identify and support hotspot areas to improve their compliance rate through the development of action plans to support sustained improvement. Managers are encouraged to have plans in place to support individuals returning to work following absence to ensure mandatory training is a priority.

Mandatory Training % by Staff Group

BCU Data as at April 26



Analysis: All staff groups have high compliance rates, exceeding the target throughout the last year with the exception of Medical and Dental. Despite improvement of 2.7% over the last year, Medical and Dental level 1 compliance rate falls 9.5% below the 85% target, with failure to meet the target against all level 1 mandatory competencies with the lowest levels of compliance for Medical and Dental staff being seen within Infection Prevention and Control and Information Governance at 66.5% and 70% respectively.

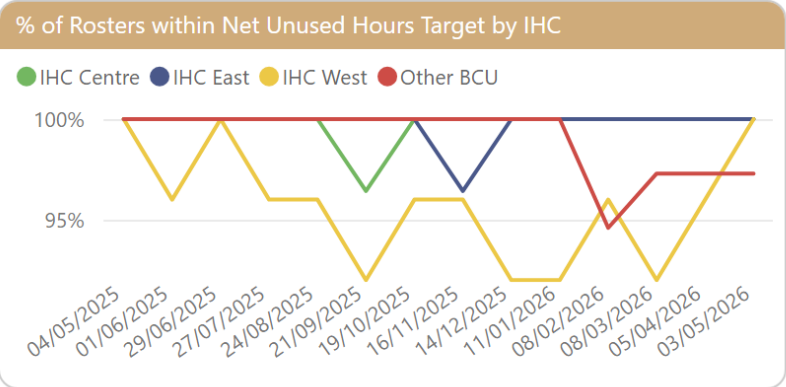
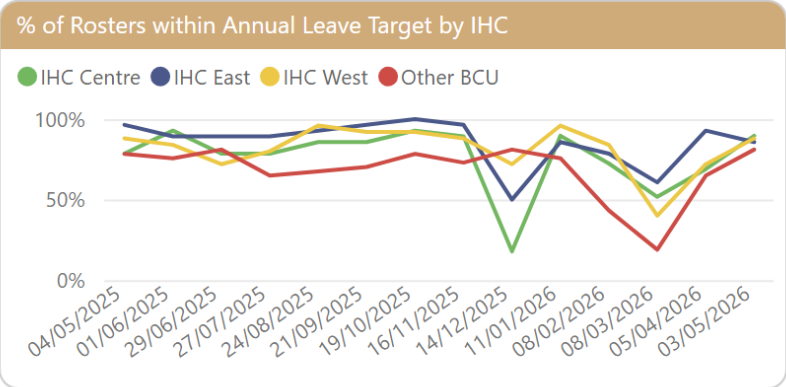
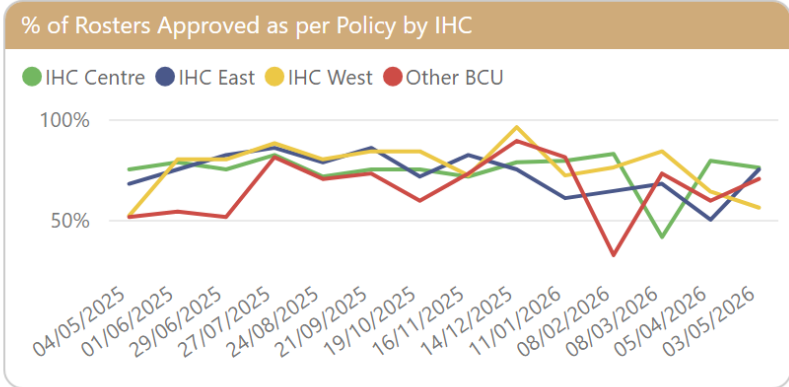
Challenges: Medical and Dental staff group remain below benchmark. There are also pockets of non compliance within some staff groups across IHCs and departments.

Progress: There is a focus on Medical staff to complete mandatory training and within the Community areas now, requests for medical study leave are balanced as to whether the mandatory training is also completed.

Summary

	04/05/2025	01/06/2025	29/06/2025	27/07/2025	24/08/2025	21/09/2025	19/10/2025	16/11/2025	14/12/2025	11/01/2026	08/02/2026	08/03/2026	05/04/2026	03/05/2026
Approved in Policy %	61%	70%	70%	84%	75%	79%	71%	75%	85%	74%	61%	66%	63%	70%
Annual Leave %	85%	85%	81%	77%	84%	85%	90%	86%	57%	86%	67%	41%	74%	86%
Net Unused Hours %	100%	99%	100%	99%	99%	97%	99%	98%	98%	98%	97%	97%	98%	99%

IHC Summary



As per Lord Carter’s recommendations and the [Nursing & Midwifery E-Rostering Guidance 2019](#) it is recognised that a firmer grip of rostering will reduce the dependency on bank and agency staff whilst also improving the predictability and consistency of staff deployment even where recruitment is still a challenge. Whilst BCUHB report and monitor on seven rostering KPI’s, for the purpose of this report, there will be three main areas of focus which are within the ward managers scope to control, Roster Approvals, Annual Leave & Net Unused Hours. The graphs are reflective of all 24/7 ward rosters across BCU and detail the percentage of rosters within each IHC that were approved in line with BCU policy, that were within the target annual leave allocation of between 11% - 16%, and that were below the target net unused hour’s range of less than 10% of total staff contracted time used.

Analysis : The percentage of Rosters approved currently stands at 70% and is 9% higher than it was during the same period in the previous year. The percentage of Rosters within the Annual Leave target is a figure that will fluctuate depending on the time of year. For instance lower levels of compliance in February to March is possibly linked to the utilisation of annual leave prior to the new financial year. The percentage of net unused hours within target shows a positive picture with 99% of rosters compliant and has remained consistently high through the previous year.

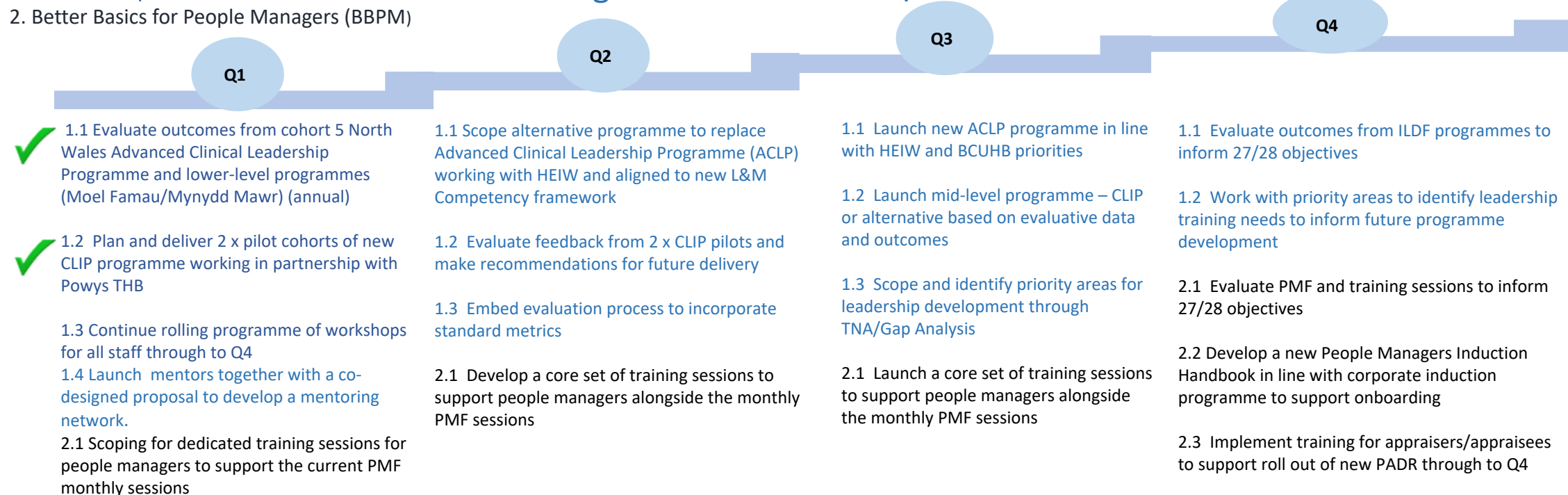
Challenges: There is strong compliance in governance and approval processes, but partial compliance in workforce planning and roster quality, with key risks around vacancy fill, post-approval changes, and temporary staffing reliance.

Progress: The teams continues to support nursing colleagues to work toward improving roster quality and meeting KPIs through attending Roster Review meetings and flagging where there are opportunities for improvement. Roster reviews continue to take place where the focus is on ensuring all shifts are fully allocated and contracted hours are appropriately assigned, reasons for additional duties and annual leave records are accurate, and maintained within the 11%–16% KPI range.

Integrated Leadership Development Framework (ILDF)

1. ILDF Development
2. Better Basics for People Managers (BBPM)

High Level Priorities 26/27



ILDF Workshops	2025 - 2026			2026 - 2027
	Q2	Q3	Q4	Q1
The Coaching Approach	2	3	3	2
Conversations with Care	4	5	5	3
Compassionate Leadership	5	7	7	8

ILDF Programme / Sessions	2025 - 2026			2026 - 2027
	Q2	Q3	Q4	Q1
Moel Famau: Learning to Lead and Manage	2	4	4	2
Mynydd Mawr: Fundamentals of Leadership and Management	2	3	3	3
Cadair Idris: Clinical Leadership Immersive Programme	X	X	X	2
Glyder Fawr: Advanced Clinical Leadership Programme	1 programme run over 12 months			X

Coaching Supervision & CPD	2025 - 2026			2026 - 2027
	Q2	Q3	Q4	Q1
CPD Workshops	X	X	1	1
Supervision	X	X	1	1

Training Sessions	2025 - 2026			2026 - 2027
	Q2	Q3	Q4	Q1
People Manager	X	6	6	X
PADR	X	X	24	X

People Managers Forum	Topic	Guest
April	Speaking up Safely Staff Stories	Tracey Eccles
May	Disciplinary Policy Update	People & OD Team
June	Governance	Pam Wenger

Culture and Engagement



GIG
CYMRU
NHS
WALES

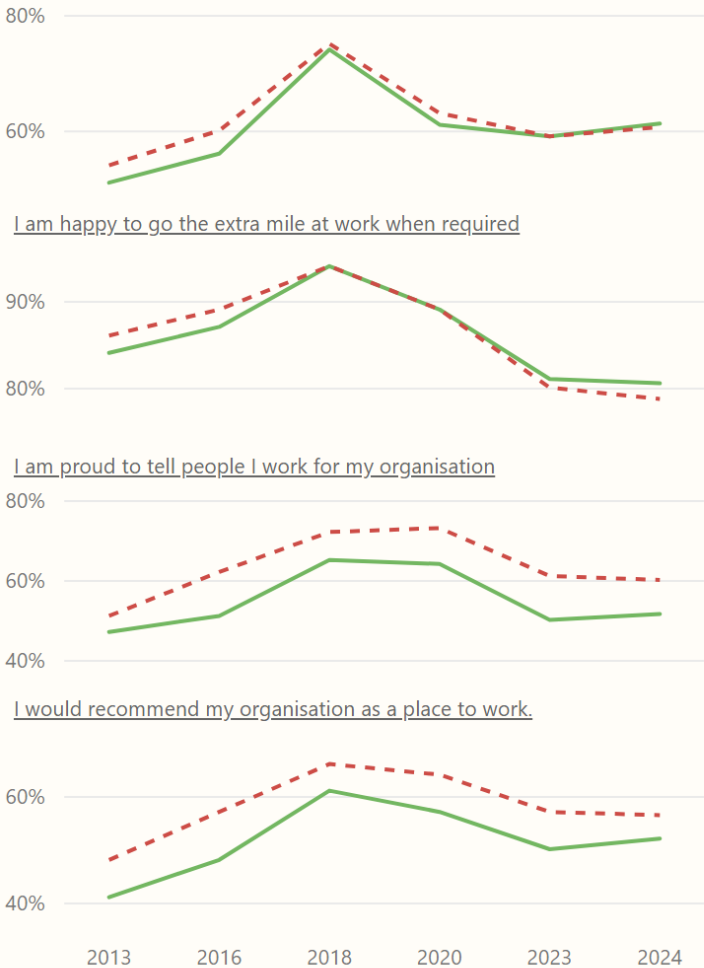
Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Staff Survey BCU Staff Engagement Results

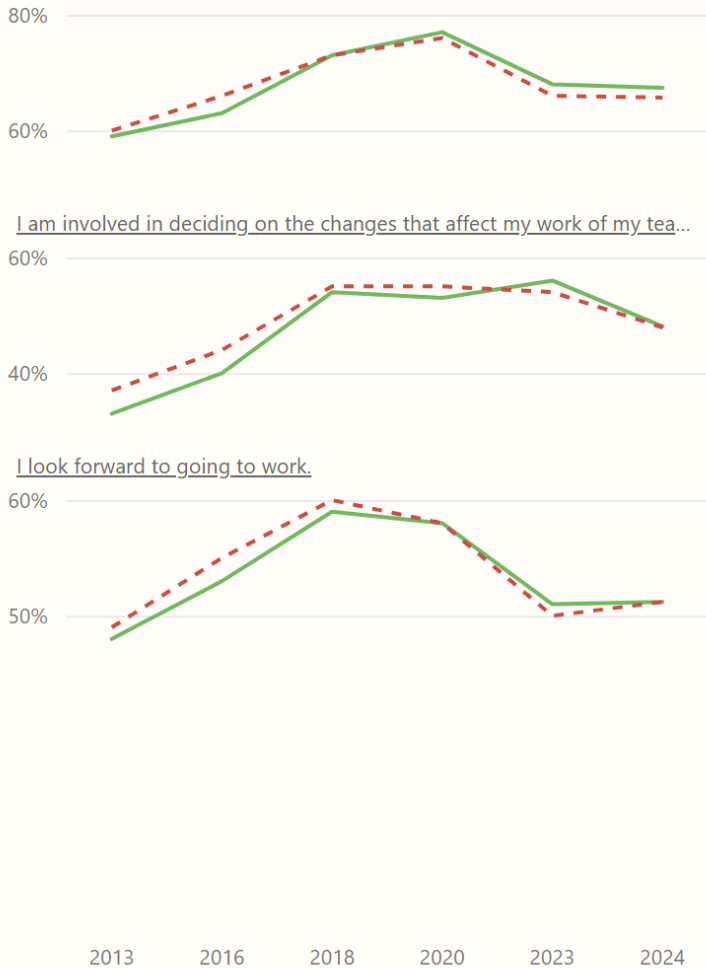
Staff Survey

Org ● BCUHB ● NHS Wales

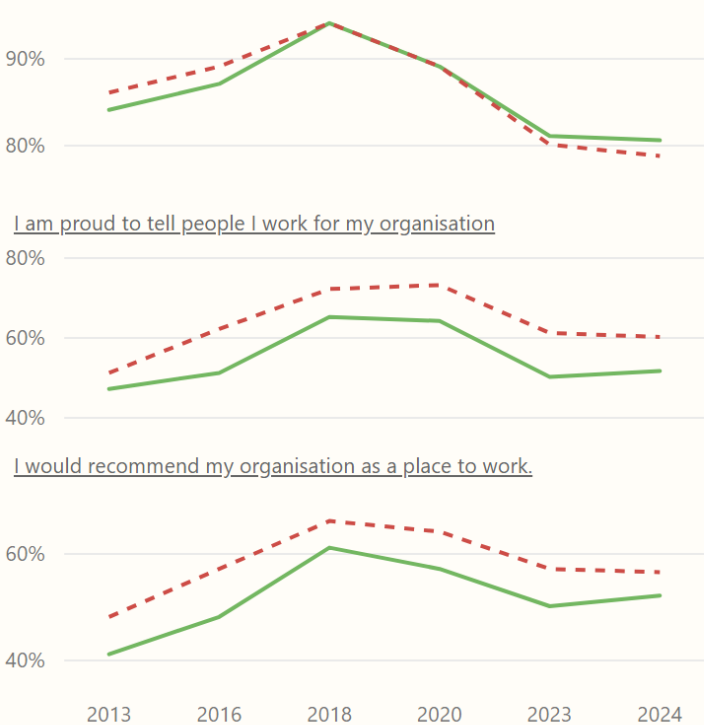
I am able to make improvements in my area of work.



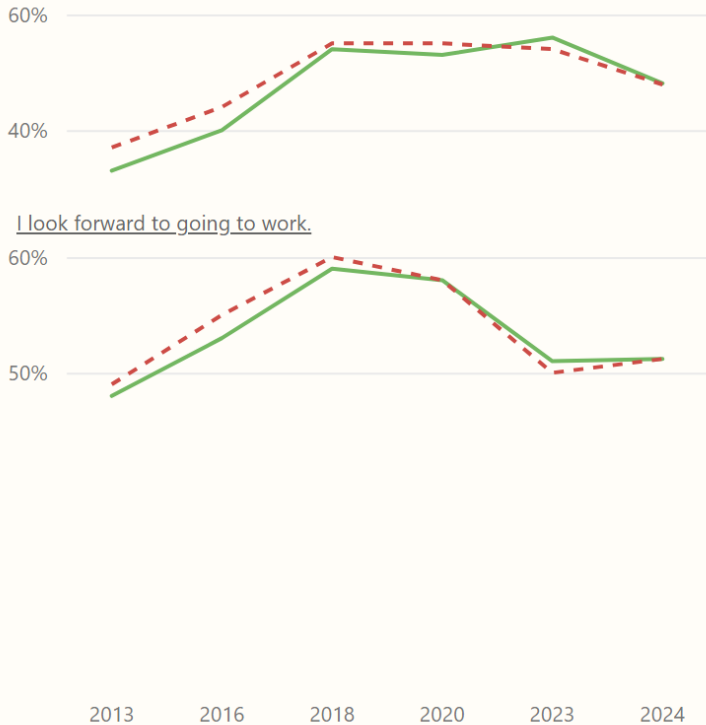
I am enthusiastic about my job.



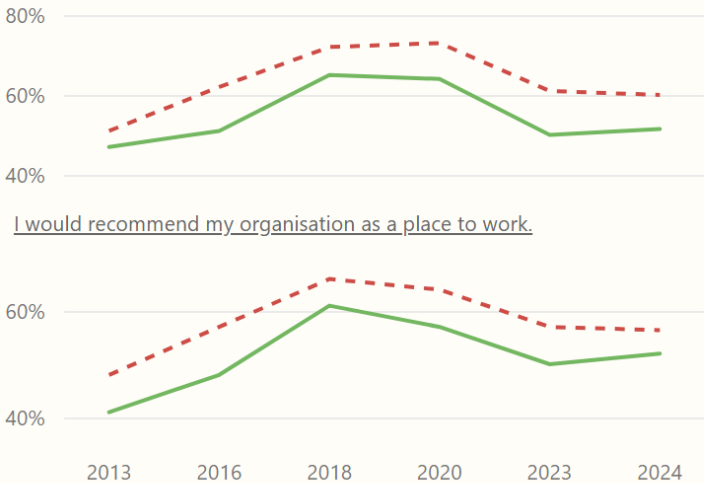
I am happy to go the extra mile at work when required



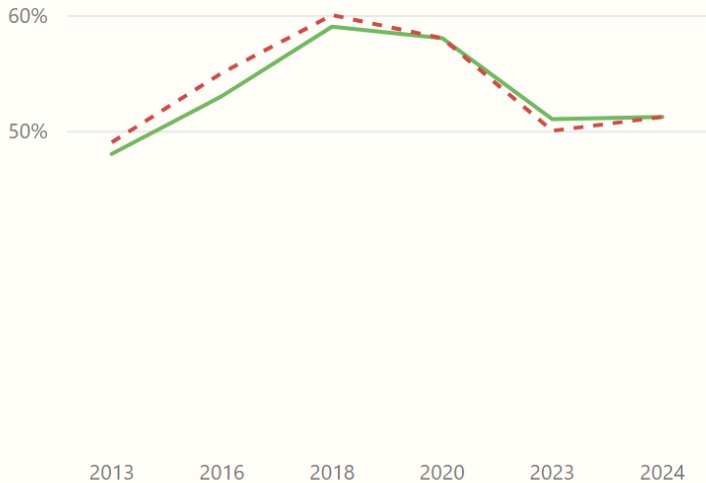
I am involved in deciding on the changes that affect my work of my tea...



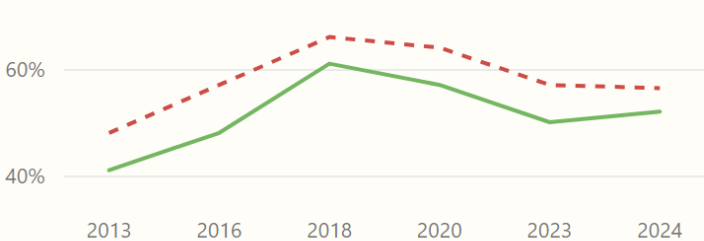
I am proud to tell people I work for my organisation



I look forward to going to work.



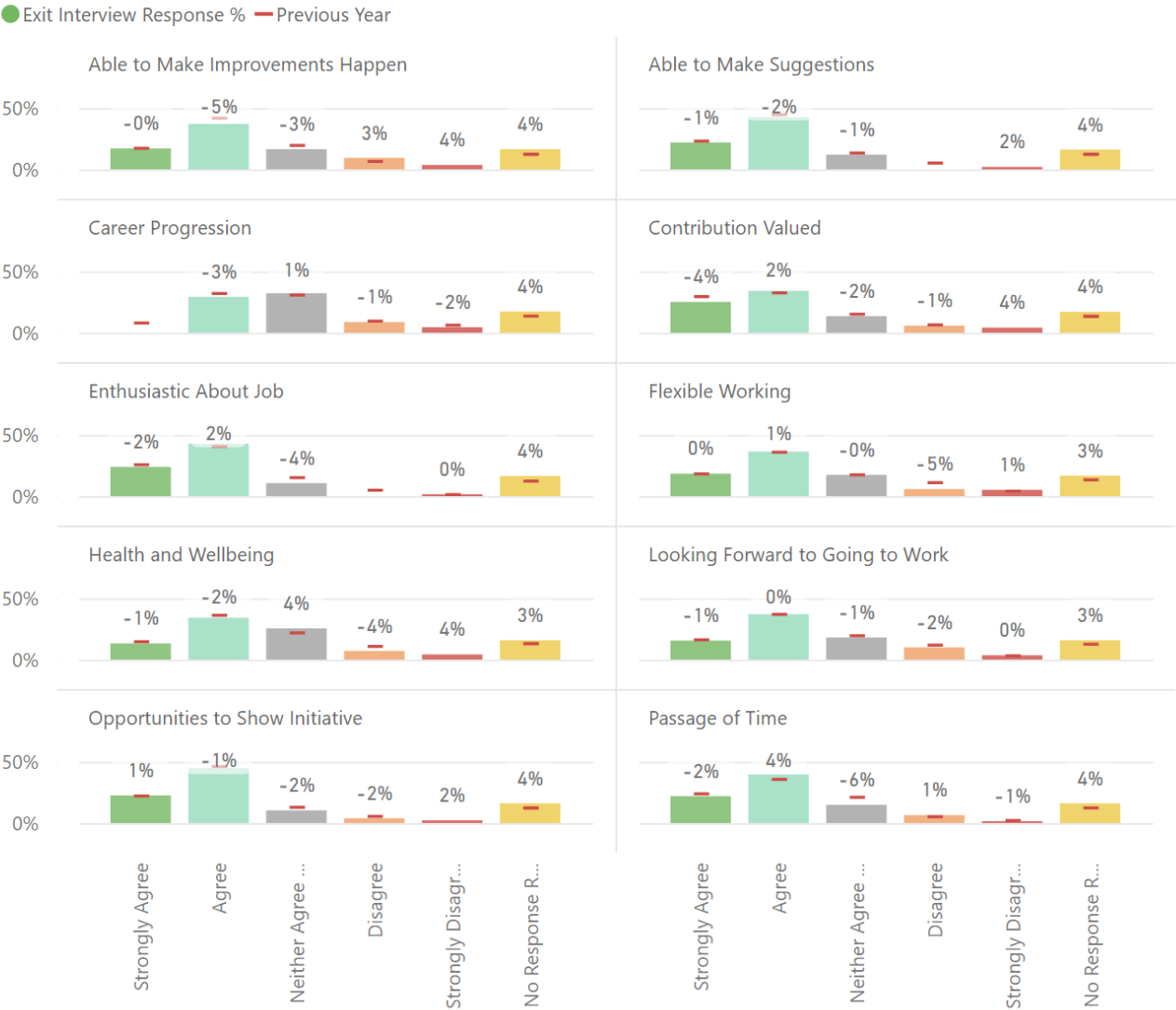
I would recommend my organisation as a place to work.



The charts to the left show the BCU response positivity score to the Staff Survey Staff Engagement question over the last 11 years.

Analysis : Across the 7 Staff Engagement questions, there has been fall in the levels of positive responses to these questions since 2018. However, the 2024 results show an increase in staff who are proud to tell people they work for the organisation and that they would recommend it as a place to work.

12 Month External Leavers - Data Labels Show Comparison v Previous Year



Exit Questionnaire Questions

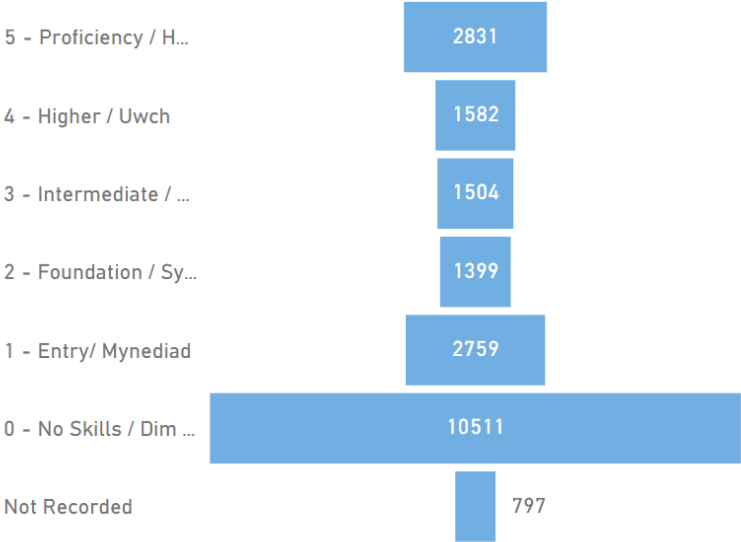
- There have been frequent opportunities for me to show initiative in my role
- I have been able to make suggestions to improve the work of my team / department
- I have been able to make improvements happen in my area of work
- I often/always looked forward to going to work
- I was often/always enthusiastic about my job
- Time often/always passed quickly when I was working
- Does your organisation take positive action on health and well-being?
- Does your organisation act fairly with regard to career progression / promotion
- Does your organisation provide opportunities for flexible working patterns?
- I felt my contribution was valued by my manager/team/organisation
- What is your reason for leaving?
- Is there anything that would have made you stay in your current role or organisation?

Analysis : Exit Interviews responses are generally more positive than negative. However, in April 2026 there was a 5% decrease in positive responses to being able to make improvements happen when compared to the previous year. Most questions saw a decrease in positive responses with only passage of time and flexible working showing a slight improvement on the previous year.

Welsh Language Skills

BCU Data as at April 26

Org L4	Not Recorded	0 - No Skills / Dim Sgiliau	1 - Entry/ Mynediad	2 - Foundation / Sylfaen	3 - Intermediate / Canolradd	4 - Higher / Uwch	5 - Proficiency / Hyfedredd	Total
Health Community Centre (HCCX) L4	239	2758	767	357	361	198	372	5052
Health Community East (HCEX) L4	163	3679	611	183	193	124	189	5142
Health Community West (HCWX) L4	151	793	398	307	422	730	1285	4086
Integrated Clinical Delivery - Primary Care (ICDP) L4	11	94	28	7	19	13	38	210
Integrated Clinical Delivery - Regional Care (ICDR) L4	88	741	209	103	102	102	216	1561
Mental Health & LDS (MX00) L4	47	1052	325	176	189	171	295	2255
Midwifery and Womens Services (WXXX) L4	31	390	80	61	41	58	127	788
Corporate Services	67	1004	341	205	177	186	309	2289
Total	797	10511	2759	1399	1504	1582	2831	21383

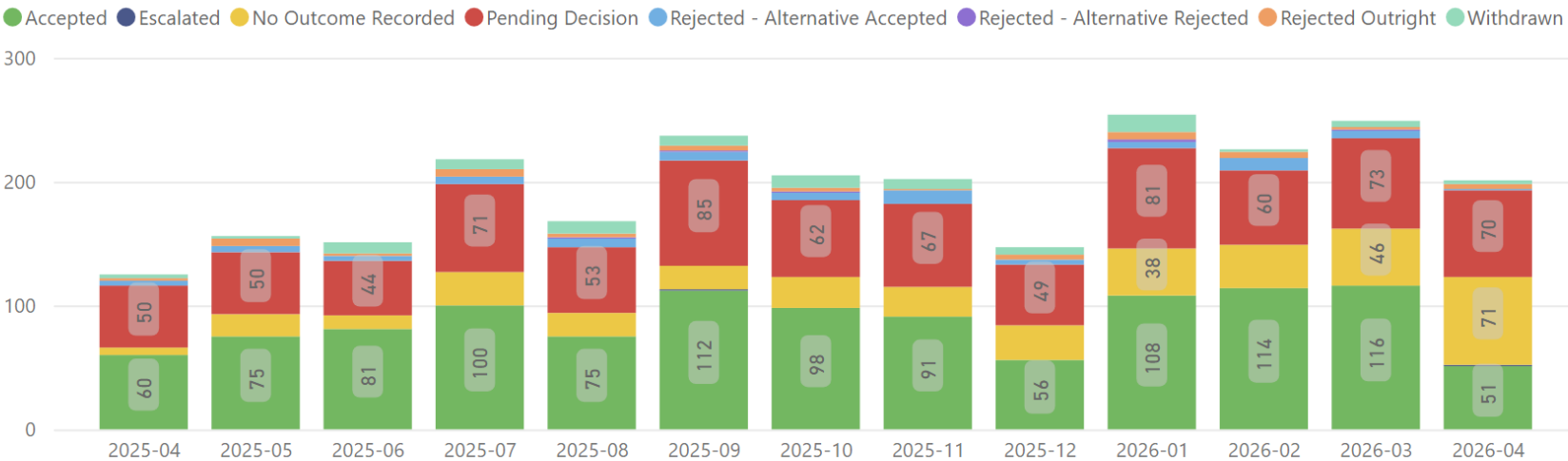


Analysis : The number of employees without Welsh Language Skills recorded in ESR continues to improve, reducing from 813 in February 2026 to 797 in April 2026. 3.7% of the workforce currently do not have Welsh Language skills recorded in the system. 10511 employees (49% of the workforce) do not hold any level of Welsh Language skills. 49.3% of staff within IHC West have Welsh language skills defined as ‘higher’ or ‘proficient’ compared with just 6.1% of the IHC East workforce with the overall workforce being 20.6%.

Flexible Working Requests

BCU Data as at April 26

ESR Flexible Working Requests by Date Submitted



Flexible Working data is sourced from ESR, however, it is not mandatory that requests are made via ESR and requests may be submitted via paper form which is then held in the personal file, and as such data presented is incomplete. Increases in Flexible Working requests evidenced in this data over the last 3 years may be the result of increased use of ESR rather than an increase in flexible working applications. Requests are reported by the date the request was submitted. There are a large number of requests submitted more than 6 months ago which are ‘pending decision’ suggesting that data held in ESR is incomplete.

Analysis: Through May 2025 to April 2026 there were 2414 flexible working requests submitted, 1077 were accepted, 765 are pending decision, 2 have been escalated, 361 have no outcome recorded, 85 were withdrawn, and 46 were rejected outright.

IHC Centre has the greatest number of flexible working requests recorded in ESR with 651 in the previous 12 months with 44% having currently been accepted. Primary Care has the greatest number of successful accepted requests over the last 12 months followed by MHL D with 47% of requests accepted. Whilst only 37% of requests were accepted within Midwifery & Womens.

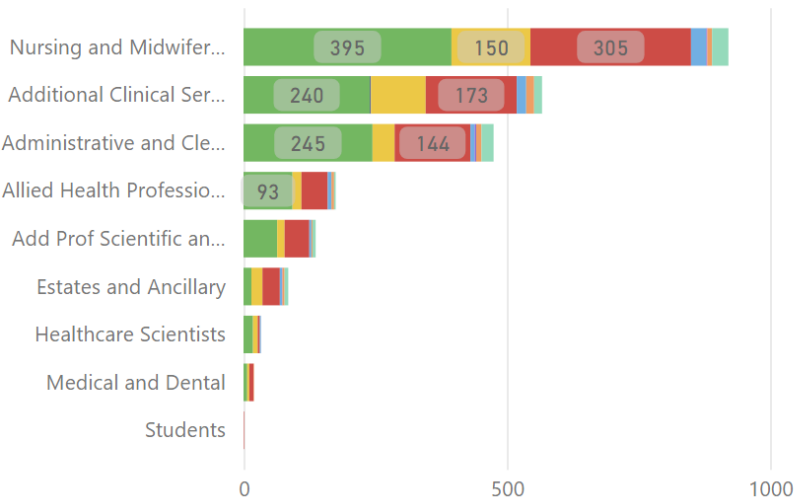
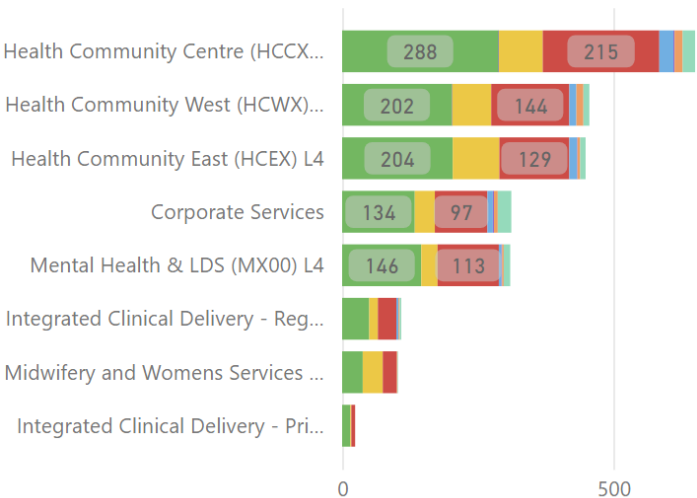
Nursing and Midwifery staff group has made the greatest number of flexible working requests over the past 12 months, however, a significant proportion are ‘pending decision’.

Challenges : The quality of the data within ESR remains a challenge as evidenced by the number of older cases within the status of ‘pending decision’.

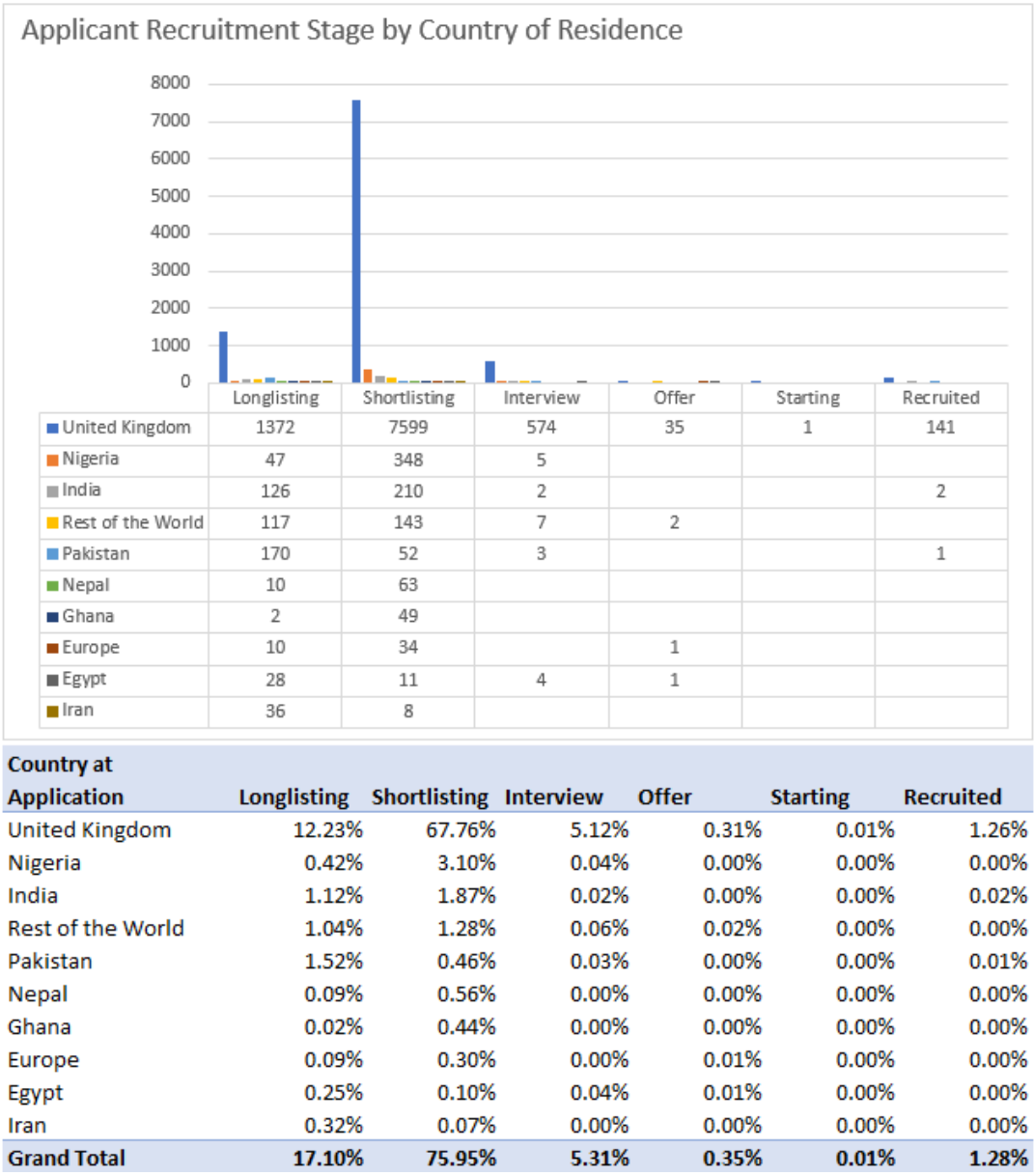
Progress: Work continues to promote flexible working within departments where they have been a greater number of rejections when compared to acceptations.

ESR Flexible Working Requests by IHC Submitted May 2025 to Apr 2026

ESR Flexible Working Requests by Staff Group May 2025 to Apr 2026



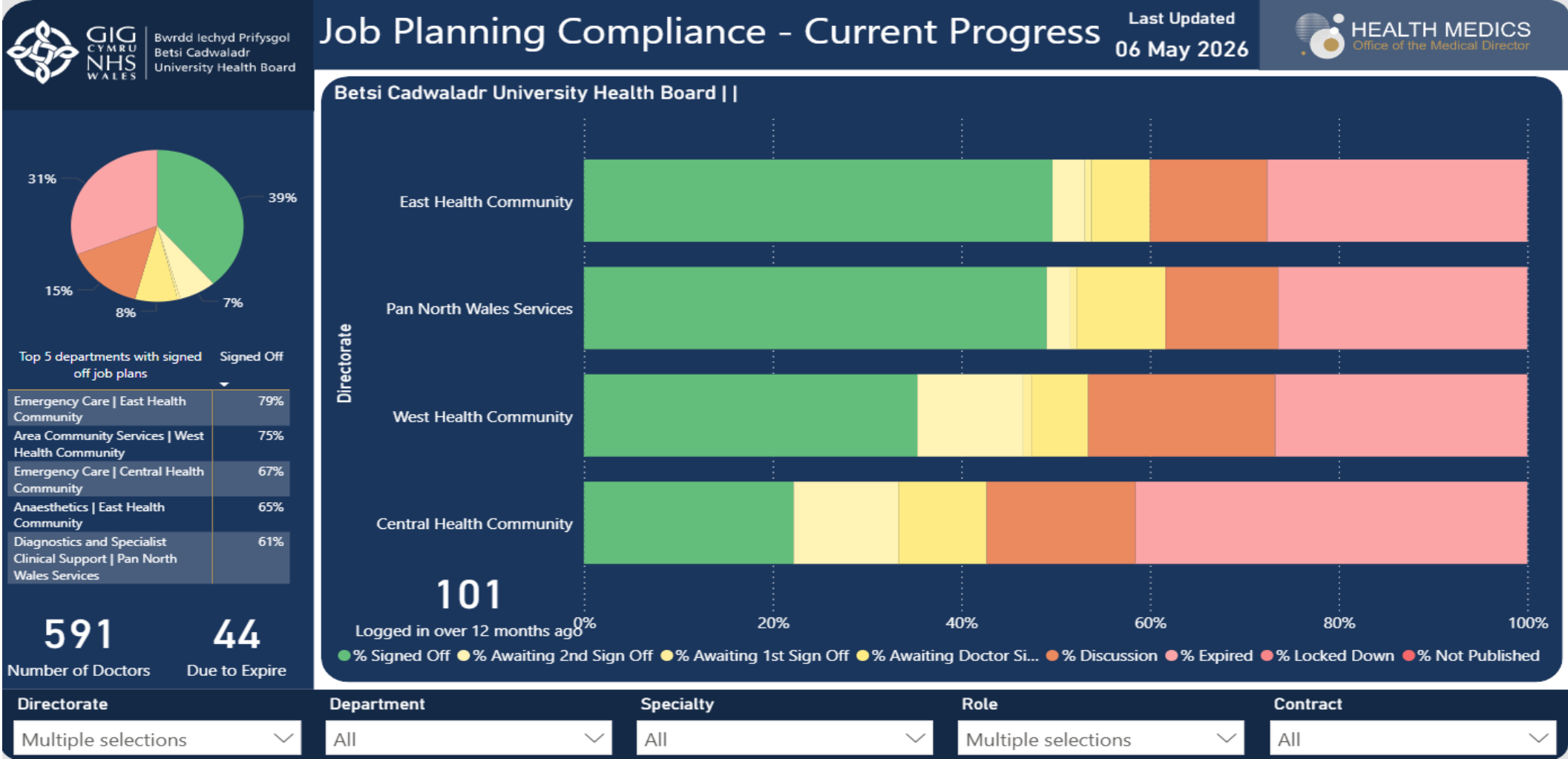
Overseas Recruitment



The Overseas Recruitment data is sourced from TRAC. The data provides a count of external applicants, and the stage in the vacancy process that they reached, for vacancies that were moved to outcome. Data collection for applicant country of residence at application date commenced at this time.

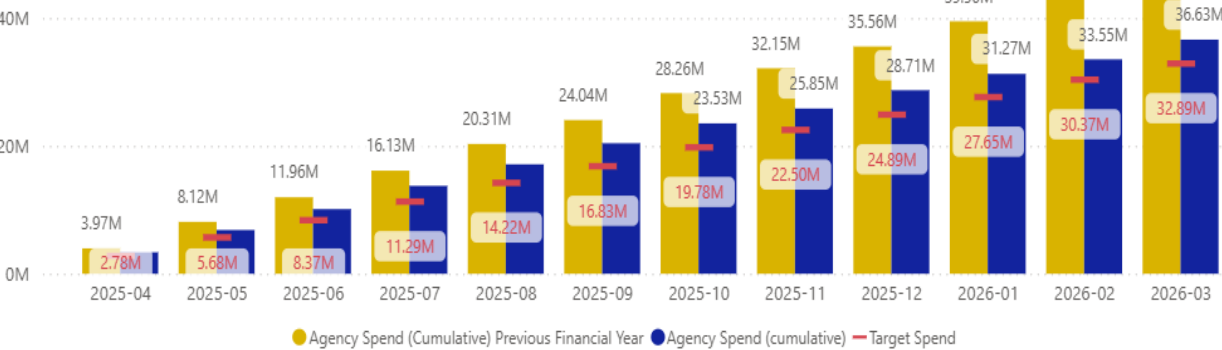
For the 209 vacancies that were moved to outcome during April 2026, there were 11214 external applications. 13% of these applicants were based outside of the UK. For vacancies moved to outcome during February 2026, 25% of applicants were based outside of the UK, pointing to a decrease in applications from outside of the UK when comparing February to April 2026. Of the 144 external applicants that were recruited, 141 of whom were UK based at the point of making the application.

Consultant Job Planning



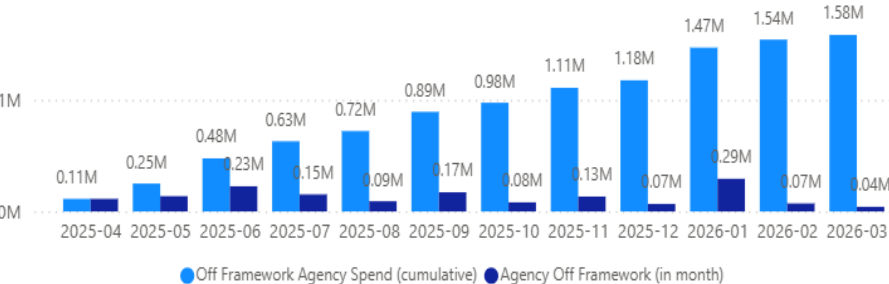
Enabling Actions

Deliver a further continued and sustained reduction in agency expenditure, with a target 30% reduction in 2025/26 from 2024/25 outturn, and ensuring no off-contract expenditure.



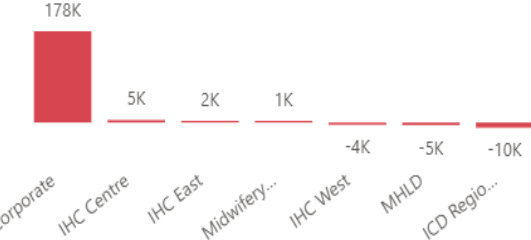
Month	Target Agency Spend	Agency Spend (cumulative)	Agency Reduction year on year (cumulative)	Agency Spend (in month)
2025-06	8,374,978	10,106,266	-16%	3,263,265
2025-07	11,290,702	13,751,013	-15%	3,644,746
2025-08	14,217,476	17,122,497	-16%	3,371,484
2025-09	16,831,022	20,417,854	-15%	3,295,357
2025-10	19,780,266	23,529,341	-17%	3,111,487
2025-11	22,502,257	25,851,508	-20%	2,322,167
2025-12	24,890,793	28,711,499	-19%	2,859,991
2026-01	27,649,103	31,269,402	-21%	2,557,903
2026-02	30,365,265	33,547,303	-23%	2,277,902
2026-03	32,887,371	36,629,164	-22%	3,081,861

Off Framework Agency Spend



Month	On Framework (cumulative)	Off Framework (cumulative)	Unknown Framework (cumulative)	On Framework (in month)	Off Framework (in month)	Unknown Framework (in month)
2025-09	19,627,381	893,544	-103,071	3,473,417	172,322	-350,382
2025-10	22,186,217	975,444	367,680	2,558,836	81,900	470,751
2025-11	24,465,129	1,109,224	277,155	2,278,912	133,780	-90,526
2025-12	26,925,173	1,176,800	609,526	2,460,044	67,576	332,371
2026-01	29,131,994	1,469,937	667,471	2,206,821	293,137	57,945
2026-02	31,206,259	1,541,791	799,254	2,074,265	71,854	131,783
2026-03	33,779,776	1,583,333	1,266,055	2,573,517	41,542	466,802

Zero Agency Spend within A&C, E&A & ACS from Sep 25



Ensure a reduction in agency spend on Healthcare Support Worker, Admin & Clerical, and Estates & Ancillary staff to zero by 30th September 2025.

Staff Groups		2025-04	2025-05	2025-06	2025-07	2025-08	2025-09	2025-10	2025-11	2025-12	2026-01	2026-02	2026-03
Additional Clinical Services (Nursing)	Agency Spend (cumulative)			-97	-97	-97	-97	-97	220	220	220	220	220
	Agency Spend (in month)			-97		0			318				
Estates & Ancillary	Agency Spend (cumulative)		-338	-3,789	-245	-245	-245	236	20,880	20,879	22,020	6,911	6,598
	Agency Spend (in month)		-338	-3,451	3,544		0	482	20,643	-1	1,141	-15,110	-313
Administrative & Clerical	Agency Spend (cumulative)	105,192	180,857	227,313	342,153	332,910	405,106	396,420	395,290	464,723	476,832	461,108	563,942
	Agency Spend (in month)	105,192	75,665	46,456	114,840	-9,243	72,196	-8,686	-1,130	69,433	12,109	-15,725	102,834

Analysis : For the previous financial year to the end of March 2026, there has been a 22% reduction in agency spend compared to the 2024/25 financial year.

Nursing and Midwifery have achieved a 56% reduction in agency spend whilst Medical has seen a 11% increase in spend, largely attributable to Consultants where spend is up 40% on the previous year.

Agency spend has increased on the previous year within Healthcare Science and Add Prof Scientific and technical staff Groups whilst AHPs have seen a 12% reduction.

There continues to be some off framework agency spend, a significant proportion of which relates to medical staff within Gastro in Centre.

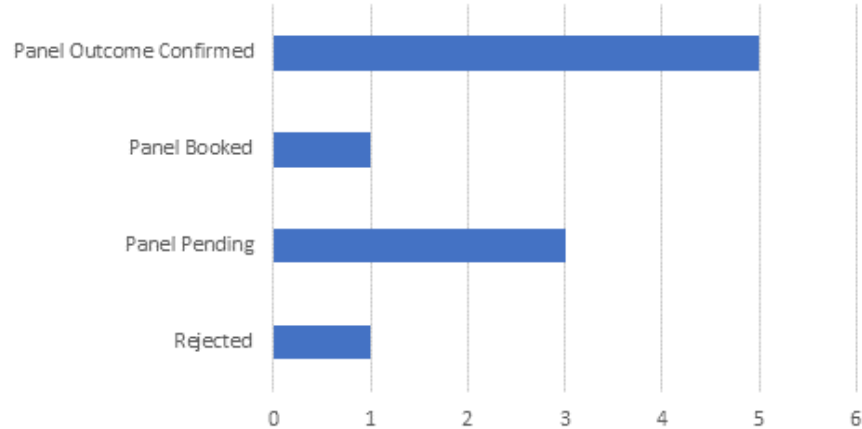
There continues to be some agency spend in A&C beyond September 2025, however, this is linked to Planned Care funding.

SAS Regrades

Panel Outcomes



Application Summary



Average time taken is 54 working days (KPI is 40)

● Performance is off target

Challenges

Coordinating availability for the three required panel members remains the main challenge. A proposal to revise the panel arrangement process has been submitted to POD SLT for consideration.

Progress

New national guidance designed to ensure consistent interpretation of the policy is now also included in the pack for the panel as well as a recently developed guide to the role of each panel member.

Average time taken has improved from 90 to 54 working days, a reduction of 36 days, demonstrating clear progress toward the 40 day KPI. This improvement is expected to continue as new applications received in 2026 are being processed within target timescales.

People and Culture Committee

EMPLOYEE EXPERIENCE AND ENGAGEMENT REPORT REWARD AND RECOGNITION

Dyddiad y Cyfarfod Date of Meeting	11 June 2026
Statws Cyhoeddi Publication Status	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad Report Author name and title	Katie Sargent Head of Employee Experience and Engagement
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol Lead Executive Team Member name and title	Debbie Eyitayo Executive Director of People and Organisational Development

Pwrpas yr Adroddiad Report Purpose	For Noting
	The Board is asked to: SUPPORT the approach outlined and progress described in the report as part of the wider Culture, Engagement and Leadership improvement work.

Crynodeb Gweithredol **Executive Summary**

This report updates the Committee and sets out recent progress on the *effective recognition* element of our Staff Experience Strategic Intent, which was approved by the Board in March 2026.

This is a key strategic aspiration for improving how valued by and connected to our organisation employees feel. Numerous insights gathered by the Health Board indicate that work is required to improve metrics relating to morale and staff engagement, as highlighted by our 2025 NHS Wales Staff Survey findings and in feedback relating to how staff feel the organisation recognises and rewards colleagues' efforts.

This work is closely connected to the Culture and Leadership Programme.

The main updates in this report relate to:

1. our refreshed organisational approach to recognising long-serving staff following Executive Committee approval of a Task and Finish Group report. This staff group are particularly valuable as they have shown commitment, dedication and have amassed considerable skills and experience during their years of service;
2. annual Staff Achievement Awards;
3. introduction of staff celebration and recognition display boards across the organisation.

Ymgysylltu (mewnol/allanol) yr ymgwymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp)
Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)

Pwyllgor / Grŵp / Unigolion Committee / Group / Individuals	Dyddiad Date	Canlyniad, Tystiolaeth a Data Outcome, Evidence and Data
People and Culture Committee	4.12.25	Discussion and agreement to convene a Task and Finish Group to examine possibilities for a refreshed approach to recognising long-serving colleagues
Executive Committee	20.5.26	The Committee supported the approach set out in the Task and Finish Group report

**Acronymau / Rhestr Termiau
Acronyms / Glossary of Terms**

N/A	
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1 SITUATION

1.1 A key part of our developing strategic approach to improving the experience and engagement of our employees is effective, consistent recognition. We aspire to regularly and publicly acknowledge and celebrate employee efforts and achievements to cultivate a culture of appreciation.

1.2 Our Values and Behaviours Framework details how we will provide *a good place to work, learn and succeed* and *we say thank you and well done*.

1.3 We have a number of mechanisms in place to deliver this aspiration which include:

- annual Long Service Awards;
- annual Staff Achievement Awards which celebrate staff excellence;
- monthly Seren Betsi Awards which shine a light on colleagues who live our values of compassion, openness and respect;
- Greatix, which is a platform to recognise colleagues' great practice, behaviour and effort. This currently attracts some 200 individual nominations per month;
- the Executive Director of Nursing and Midwifery (EDoN) awards; and
- Welsh Language awards.

1.4 Despite this, findings from the 2025 NHS Wales Staff Survey suggest that there is more to do to improve how valued by the organisation staff feel. Although 72 per cent of survey respondents agree that their immediate line manager values their work, only 44 per cent agree that their work is valued by the organisation. This represents a decline of 2.66 percentage points since 2024 and is 3.6 percentage points below the NHS Wales Health Board average.

Therefore work is underway to further strengthen our offer.

1.5 This report updates the Committee on the progress made in this area over recent months and plans for further improvement over the next year.

Deliverables related to employee reward and recognition are captured and monitored in the overarching Culture, Leadership and Engagement Improvement Plan 2026-2029.

2 BACKGROUND

2.1 Long Service Award ceremonies celebrating colleagues who have worked in the NHS for over 25 years have been established in BCUHB for a number of years. The format of the events has differed from year to year, but has been consistent for the

years 2022, 2023 and 2024, following the pausing of ceremonies during the COVID-19 pandemic.

Following the 2025 Long Service Awards celebrations in October, a need for change in our approach was identified due to a number of factors, notably:

- feedback from staff;
- the inequity of the established process - 75 per cent of eligible employees do not receive any recognition because they do not apply (due to being unaware of the process or unable to submit the required paperwork due to time constraints);
- the absence of designated funding to support the delivery of a sustainable Long Service recognition programme; and
- declining sentiment scores relating to staff morale in the NHS Wales Staff Survey 2025.

2.2 The above presented justification for the re-evaluation of our Long Service offer to staff. Following discussion at the December 2025 People and Culture Committee, it was agreed that a Task and Finish Group be established to carry out an assessment of a future approach to recognising our long serving employees and to make recommendations to the Executive Committee.

2.3 After gathering feedback from over 1,000 staff through surveys and during one-to-one and group conversations, the Task and Finish Group was convened, bringing together subject matter experts including Trade Union partners.

2.4 The Group worked through key issues to reach consensus regarding an organisational approach to recognising long serving NHS colleagues that is equitable, meaningful and sustainable.

2.5 Proposals were considered by the Executive Committee on 20th May 2026 and were supported. It was agreed that costs would be met via charitable funding.

3 SPECIFIC MATTERS FOR CONSIDERATION

3.1 New approach to long service recognition

Whilst the Task and Finish Group acknowledged the financial constraints the Health Board is operating under, they agreed that investment in recognition for long serving employees should continue. It was agreed that it will bring benefits including improved morale, engagement and motivation which in turn will lead to improved experience and outcomes for patients.

3.2 Key elements

The Group agreed the following principles for recognising long service in Betsi Cadwaladr University Health Board as of 2026:

- the introduction of an automated system based on ESR data identifying eligible staff, where employees are contacted proactively, thus ending the requirement to self-nominate (which results in 75 per cent of eligible staff not being recognised);
- recognising aggregated time in the NHS, not solely BCUHB, ceasing the requirement for at least five years' service of the 25 to be completed at BCUHB. It is understood that this approach may mean that some recipients of the award have already received recognition of their long service in other NHS organisations. It should also be noted that ESR may not hold robust data on previous NHS service for all staff;
- the inclusion of all contracted, validated NHS employment. This does not include bank staff; and
- retaining the 25 years' service milestone and introducing 40 years as an additional milestone for recognition. This will be reviewed after three years.

3.3 It was also agreed that ad-hoc requests for recognition for service milestones other than 25 and 40 years cannot be supported corporately, as could incur additional costs outside of the milestones recommended by the Group and agreed by the Committee. To support the recognition of other career milestones the Culture Team have developed a toolkit to support managers to organise local celebrations.

3.4 The approximate number of employees expected to reach the proposed milestones of 25 and 40 years are as follows:

Years of service	2026	2027	2028
25	450	452	508
40	89	88	127
Total	539	540	635

Figure 1: Forecasted numbers of employees reaching proposed career milestones by year

Please note that further work is required to refine these estimated numbers due to incomplete historic data and changes in staff turnover. Although this approximate number of staff would be eligible for recognition under the proposed principles set

out in section 3.2, not all colleagues are expected to engage with the process and some may decline the offer of the proposed tokens of appreciation/attendance at the celebration events.

Therefore it is important to be mindful that actual costs would likely be less than those indicated in Figure 2 below.

3.5 Tokens of appreciation

The Group also examined what recognition could look like and what could be offered to staff who qualify for recognition in line with the above principles.

3.6 Due to the current challenging financial position, the Group felt it is important that proposals for our future approach are realistic in terms of 1. capacity to deliver and 2. sustainability of funding streams.

3.7 A token of appreciation was the element of recognition deemed most important by staff. A high number of staff (approx. 500) indicated that they thought pin badges were an appropriate token of recognition and appreciation compared with other options provided.

3.8 Smaller numbers of staff stated other options including monetary vouchers (approx. 120) and additional annual leave. These options were not deemed as viable by the Group due to funding constraints, administrative burden and inequity.

3.9 Career citations were deemed the least important element of the Long Service reward package by staff and some fed back that they felt the reading of the citations at the celebration events (which were edited in 2025 in the interests of being concise) took too long.

3.10 The Group proposed that citations do not remain a feature of the long service recognition package going forward.

3.11 Celebration venues

The Executive Committee accepted the Group's recommendation to continue to hold these events at external venues so that staff feel effort has been made to provide them with a special, memorable experience.

They also supported the recommendation that staff are permitted to attend these events in work time i.e. are not required to take annual leave, flexi-time or time off in lieu.

3.12 Costings and funding

3.13 Given the varying costs associated with different aspects of what the Group determined as appropriate ways of celebrating the long service of BCUHB staff, three proposals were presented to the Executive Committee – a basic option, a better option, and a best option. These ranged from a minimal offer which is largely

administrative to continuing to hold celebration events. The Committee supported the preference of the Group, which was the best option.

This, along with costings, is set out below.

- Pin badge and framed certificate;
- Letter of thanks from the Chief Executive (emailed to recipients); and
- Afternoon tea celebration events for staff members who have served 25 and 40 years plus a guest.

Approx. cost for 25 and 40 year staff (inc VAT)	2026 539 staff	2027 540 staff	2028 635 staff
Pin badges and framed certificates	£4, 409.02	£3, 617.20	£5, 194.30
Afternoon tea at hotel/restaurant (£25pp) for 25 and 40 years service for staff member and guest	£26, 950	£27,000	£31, 750

Figure 2: Approximate maximum costings of proposed recognition offer elements in Option 3

3.14 Retrospective recognition

The Committee agreed that 2026/27 would be an ‘amnesty year’ where colleagues who have missed out on the current 25 year recognition milestone under the existing process are captured. During 2027/8, we would then focus solely on colleagues reaching 25 and 40 years service during that calendar year.

In the interests of equity, the Committee agreed that these colleagues would receive the new Long Service offer, rather than what was provided in previous years. This will generate additional costs, depending on the number of colleagues who come forward.

3.15 Retiring staff

We also intend to begin sending letters from the Chief Executive to colleagues who are due to retire to thank them for their service.

3.16 Annual BCUHB Staff Achievement Awards

A record 534 separate nominations for 223 teams and 312 individuals were submitted during March and April, providing us with an array of case studies and examples of staff achieving excellence across the organisation, in all manner of roles and disciplines. Each year, the number of nominations received has increased as does the standard of entries.

3.17 These stories provide us with shining examples and rich insight into innovation, good practice and team working that are shared to inspire others and promote learning.

3.18 Each award category criteria includes the requirement to evidence the demonstration of our organisational values. This year, the new category of Unsung Hero attracted 79 nominations – the third most popular category behind the hotly contested Extra Mile Award and Team of the Year categories.

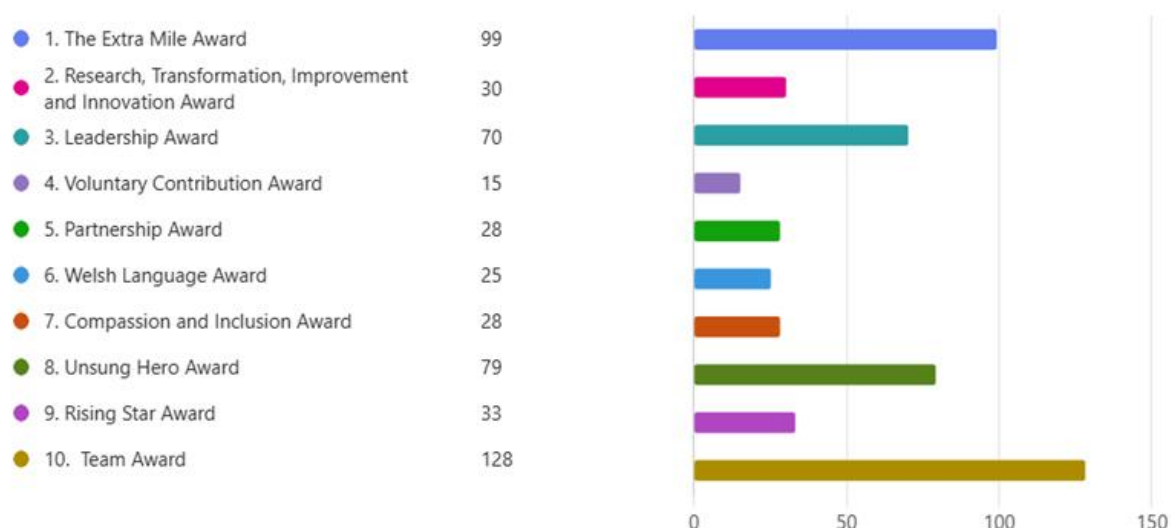


Figure 3: number of nominations received for the 2026 Staff Achievement Awards by award category

3.19 Following a shortlisting process, the six best nominations in each category will be judged by a panel of staff from across the Health Board, including members of the Board. The top three in each category will be announced as finalists in July.

The awards ceremony will be held at Venue Cymru on Friday 25th September and around 500 guests will include category finalists and their teams, Board members, event sponsors and partners.

3.20 Every member of staff or team who receives a nomination will be written to by the Chief Executive, congratulating their efforts and enclosing a copy of their nomination and a special email signature to show their achievement.

3.21 Finalists and winners will receive *BCUHB Achievement Awards finalist* and *BCUHB Achievement Awards winner* email signatures which demonstrates the organisational pride in their achievements both internally and externally.

3.22 Last year, 87.5 per cent of the cost of the event was generated by the Employee Experience and Engagement Team through sponsorship, ticket sales revenue and a grant from NHS Charities Together. Our ambition is to cover the majority of the costs of the 2026 event in the same way.

3.23 Each of the three finalists in the ten award categories will be featured in a short film, narrated by their nominator, to showcase why they were nominated and what they mean to their colleagues and patients.

3.24 To extend the reach of the celebration of colleagues on the night, a highlights video of the event will be produced and shared on BetsiNet so that it is widely accessible. This provides an opportunity for colleagues to congratulate finalists on their achievement, helping to grow a culture of peer recognition.

3.25 Staff recognition and celebration boards

3.26 In order to help deliver demonstrable evidence that BCUHB recognises, promotes and values the efforts of our staff, and bolster efforts to improve morale and pride in colleagues' efforts at work, we will be introducing staff celebration display boards in 21 of our hospital locations initially.

3.27 These will be populated with short, bilingual case studies of BCUHB staff from a wide range of disciplines and grades, to publicly recognise and celebrate their excellent work and accomplishments.

3.28 The Employee Engagement and Experience Team have selected the initial tranche of 144 staff and teams who will be featured on the boards. They reflect a broad range of job roles and achievements, incorporating:

- national recognition e.g. NHS Wales Award winners/finalists, Royal College Award recipients;
- Health Board recognition e.g. Staff Achievement Award winners, Seren Betsi recipients, GREAT-ix nominees, Welsh Language Award winners;
- patient feedback; and
- personal achievements.

3.29 The narrative used will be positive, engaging and of course bilingual. Each member of staff/team featured will be required to provide permission and approve the text for accuracy.

3.30 Our intention is that by showcasing a wide range of staff and different types of achievements, this will in turn encourage colleagues to utilise the 'call to action' on the posters' QR codes to submit their own examples of colleagues deserving of recognition.

3.31 This will be achieved using the existing well-established GREAT-ix system and will fuel our Staff Experience Strategic Intent of giving staff a voice and supporting consistent recognition, helping to foster a culture of peer appreciation and praise.

3.32 The boards also present an opportunity to enable patients and service users to use an additional QR code to feed back to our Patient and Carer Experience Team. We are working closely with them to facilitate this in order to maximise patient feedback routes. There was discussion amongst the Executive Team to work towards the introduction of digital displays across sites and, in the longer term, this will be explored with Digital, Data and Technology colleagues.

3.33 The initiative has been developed in a way believed to be sustainable and affordable, with quarterly updates ensuring fresh staff achievements are celebrated.

3.34 Our preparatory engagement work on this endeavour with scores of colleagues across the organisation has signalled a strong support for public recognition of this kind.

3.35 A charitable funding application to cover the establishment costs of this work has been approved and the Executive Committee expressed support for this at their meeting on 20th May.

3.36 Staff wellbeing

3.37 As part of our commitment to deliver an improved staff benefits package, a new development to update the Committee on relates to becoming an Active Workplace. We have teamed up with parkrun to showcase how staff can take part – by walking, jogging, running, volunteering or even just spectating and supporting.

3.38 parkrun is a free, timed and volunteer-led 5k event, which takes place in venues across North Wales every Saturday at 9am. There's no time limit, and everyone can go at their own pace with no pressure.

3.39 We plan to promote a different parkrun each month amongst our colleagues, and share what BCUHB parkrunners and walkers love about taking part. On May 30, we will be focusing on Y Promenâd parkrun in Rhos on Sea, Conwy as the first of our new monthly feature events.

This has already sparked considerable enthusiasm amongst staff who are both seasoned parkrunners and the parkrun curious.

3.40 We are also working with our local authority leisure and physical activity providers to co-ordinate sharing opportunities available locally to staff to participate in exercise and wellbeing activities. This includes promotion of preferential rates and offers which have been negotiated with local gyms and leisure facilities.

4 KEY RISKS / MATTERS FOR ESCALATION

If we are to fulfil our ambition to improve our culture, leadership and engagement, demonstrating that we appreciate our employees as our most valuable asset is crucial. An engaged workforce who feel valued is critical to providing consistent, high quality services.

There is a risk of disengagement and low morale if employees do not feel that they are appreciated by the organisation. Some may choose to seek employment elsewhere.

5 RECOMMENDATIONS

The Committee is asked to:

- **SUPPORT** the progress outlined in the report as part of the wider Culture, Engagement and Leadership improvement work.

The organisation has made significant progress in strengthening its staff reward and recognition approach. The next step is to ensure these efforts are aligned, coordinated and embedded consistently.

Committee support will provide the clarity and authority needed to accelerate this work and ensure staff engagement remains central during a period of substantial organisational change.

ASESIAD / ASSESSMENT	
Cysylltiad â'r Bwriadau Strategol Link to Strategic Intentions	1. Focus on Health and Wellbeing
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Yr Egwyddorion Dylunio Design Principles	People First Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd Corporate Risks and Board Assurance Framework	CRR24-01 - 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
Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant Wellbeing of Future Generations Act – Wellbeing Goals	A Healthier Wales
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:

ASESIADAU O EFFAITH / IMPACT ASSESSMENTS		
Cydraddoldeb <i>A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o'r Effaith ar Gydraddoldeb (sy'n cynnwys gofynion Safonau'r Gymraeg)</i> Equality <i>Have you undertaken an Equality Impact Assessment Screening (which includes the requirements of the Welsh Language Standards)</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Asesiad o'r Effaith Economaidd-gymdeithasol	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	

<i>A ydych chi wedi cynnal Asesiad o'r Effaith Economaidd-Gymdeithasol?</i> Socio-Economic Impact Assessment <i>Have you undertaken a Socio-Economic Impact Assessment</i>	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
<u>Ansawdd</u> <i>A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?</i> <u>Quality</u> <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Galluogwyr Ansawdd Enablers of Quality Culture and Valuing People	Meysydd Ansawdd Domains of Quality Efficient
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
<u>Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant</u> <u>Wellbeing of Future Generations Act – Wellbeing Goals</u>	A Healthier Wales	

Effaith Amgylcheddol / Cynaliadwyedd (5Rs) Environmental /Sustainability Impact (5Rs)	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
	No - Not Applicable	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:	
Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog <i>A ydych chi wedi ystyried Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog:</i> Armed Forces Covenant Due Regard Duty	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	

Have you considered the Armed Forces Covenant Due Regard Duty?		
Asesiad o Effaith ar Ddiogelu Data <i>A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?</i>	Do/Yes: ☐	Naddo/No: ☒
Data Protection Impact Assessment <i>Have you undertaken a Data Protection Impact Assessment Screening?</i>	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Asesiad o Effaith ar Atal Twyll <i>A ydych chi wedi ystyried yr effeithiau ar atal twyll?</i>	Do/Yes: ☐	Naddo/No: ☒
Counter Fraud Impact Assessment <i>Have you considered the counter fraud impacts</i>	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Cyfreithiol Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw Da Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith ar Adnoddau <i>(Pobl / Ariannol)</i> Resource Impact <i>(People / Financial)</i>	There is no direct impact on resources as a result of the activity outlined in this report.	

People and Culture Committee

FOUNDATIONS FOR THE FUTURE

Dyddiad y Cyfarfod Date of Meeting	11 June 2026
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Enw a theitl Awdur(on) yr Adroddiad Report Author name and title	Ffion Johnstone Programme Director Foundations for the Future
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol Lead Executive Team Member name and title	Debbie Eyitayo Executive Director of People Services & Organisational Development
Pwrpas yr Adroddiad Report Purpose	For Noting

Crynodeb Gweithredol Executive Summary

The Foundations for the Future (FFTF) programme continues to make good progress. Key developments include refinement of organisational structures ahead of consultation, completion of the strategy diagnostic phase, expansion of culture interventions, and mobilisation of workforce and leadership frameworks.

While progress remains positive, delivery is increasingly constrained by capacity and resource pressures, alongside dependencies on the finalisation of organisational structures. The programme is now entering a critical phase, with readiness for consultation and implementation requiring a more coordinated and sustainable resourcing approach.

The Committee is asked to note progress and support consideration of resourcing requirements to ensure effective consultation and maintain programme momentum.

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Pwyllgor / Grŵp / Unigolion Committee / Group / Individuals	Dyddiad Date	Canlyniad, Tystiolaeth a Data Outcome, Evidence and Data
Not applicable for this report		

Acronymau / Rhestr Termiau Acronyms / Glossary of Terms	
ADP	Annual Delivery Plan
BAF	Board Assurance Framework
CCL	Culture Change Leader
CLIP	Clinical Leadership Improvement Programme
CRR	Corporate Risk Register
CSP	Clinical Services Plan
DMF	Decision-Making Framework
FFTF	Foundations for the Future
IHC	Integrated Health Community
ILDF	Integrated Leadership Development Framework
IMTP	Integrated Medium-Term Plan
IPF	Integrated Performance Framework
OD	Organisational Development
P&CC	People & Culture Committee
PFIG	Planning & Finance Investment Group
PPHP	Planning, Population Health & Partnerships Committee
QMS	Quality Management System
QSE	Quality, Safety & Experience Committee
SoRD	Scheme of Reservation & Delegation
SWPF	Strategic Workforce Planning Framework
WG	Welsh Government

FOUNDATIONS FOR THE FUTURE

1. Y SEFYLLFA SITUATION

1.1 This section provides an overview of progress across the FFTF programme. All workstreams have continued to advance. Overall progress remains positive; however, delivery continues to be influenced by interdependencies, particularly alignment with structures, and by capacity constraints. The next period will focus on preparing for consultation ensuring coordinated delivery across workstreams.

1.2 **Structures Workstream:** Progress during this period has focused on the continued development and refinement of proposed organisational structures, incorporating stakeholder engagement and strengthening alignment with programme objectives. Additional time has been utilised to enable more comprehensive design and engagement, supporting development of a more robust proposal for Board consideration. Following earlier delays to original milestones, revised timelines have been established to support a more structured transition into consultation.

Activity has focused on:

- Completion of detailed design work and refinement of proposed structures
- Incorporation of pre-consultation and early socialisation feedback
- Alignment of Executive and Corporate functions

The workstream is progressing towards key milestones, including:

- Finalisation of proposed structures and supporting documentation (May–June 2026)
- Preparation for and mobilisation of formal consultation activity including development of engagement materials, communications, and addressing identified resource requirements (June 2026)

These timelines reflect the need to balance pace with meaningful engagement, ensuring proposals are sufficiently developed ahead of consultation. Progression into consultation represents a critical milestone, with delivery dependent on sufficient senior capacity to enable effective engagement and implementation. Supporting elements, including the Clinical Leadership Model, have continued to progress in parallel and will evolve alongside the proposed structures.

1.3 **Strategy Workstream:** Continued to progress development of the 10-year organisational strategy and Clinical Services Plan (CSP). During this period, work has focused on completing the diagnostic phase and preparing outputs to inform strategy design. Mobilisation activity for the CSP has also progressed, including planning for large-scale clinical engagement. While progress has been impacted by competing organisational priorities and

capacity constraints, the workstream is now transitioning into the design phase. The next period will focus on developing strategic options, progressing CSP Phase 2, and establishing this as a key transformation programme aligned with organisational priorities.

- 1.4 **Culture Workstream:** Made strong progress, with a clear shift from engagement and awareness into delivery and embedding activity. Expansion of the Culture Change Leader (CCL) network and rollout of interventions such as the 'Ripple Effect' programme have supported increasing organisational engagement and participation. A key challenge remains the availability of staff to be released to undertake CCL roles, which continues to limit scaling of activity. The next period will focus on expanding culture interventions, strengthening evaluation of impact, and targeting support to priority areas across the organisation.
- 1.5 **People Workstream:** Made significant progress, with key frameworks for workforce planning, leadership development and organisational capability now largely complete and moving into delivery. The Strategic Workforce Planning Framework has been approved and is being embedded across the organisation, supported by associated tools and resources. Leadership development programmes are fully mobilised and ready for delivery, while the Talent Management programme has completed its pilot phase and is progressing into evaluation and refinement. Resource constraints across Organisation Development (OD) and Talent Management remain a key issue, which may impact the pace of implementation and scaling. The next phase will focus on delivering leadership programmes, embedding workforce planning approaches, and scaling capability development across the organisation.
- 1.6 **Processes Workstream:** Continues to progress core enabling frameworks. The Quality Management System (QMS) is now transitioning from development into business-as-usual operation, with activity focused on strengthening system ownership, enhancing supporting tools and increasing engagement across services. The Operational Governance Framework has also advanced, with design principles endorsed and work progressing into co-design with services. Delivery remains constrained by the absence of dedicated long-term resource and funding to support QMS sustainability, alongside dependency on organisational restructure for full rollout. The next reporting period will focus on embedding QMS practices, progressing governance framework development, and preparing for organisational rollout aligned with structural changes.
- 1.7 **Cross-Cutting:** The Cross-Cutting workstream has progressed development of the Organisational Approach to Change, moving from concept into a structured design phase. Stakeholder engagement has been initiated, and a draft implementation plan has been developed and refined through collaboration with key partners. The Operating Model has been developed in

draft form, though further progress remains dependent on Programme leadership feedback and alignment with structural developments. The next period will focus on establishing governance arrangements, strengthening stakeholder engagement, and embedding a consistent, organisation-wide approach to change to support programme delivery.

- 1.8 Overall, the programme continues to make good progress, with increasing movement into delivery across several workstreams. However, successful transition into the next phase will depend on effective management of capacity constraints, readiness for consultation, and continued engagement across the organisation.

2 **Y CEFNDIR BACKGROUND**

- 2.1 The FFTF Programme was established to design and implement a coherent and sustainable operating model for BCUHB. The programme integrates Strategy, Culture, People, Structure and Process components into a single phased transformation approach, providing clarity on organisational arrangements, leadership expectations, governance pathways, workforce capability and the tools required for delivering high-quality care.
- 2.2 Throughout 2025/26, the programme has focused on design, including the organisational structure, clinical leadership arrangements, workforce principles, governance requirements and the operational frameworks that support the new model. Extensive discovery activity, internal and external engagement and national expectations have shaped this work.
- 2.3 The programme remains primarily in the Design and preparation phase, with several products progressing toward readiness for implementation. While some products within the Culture, People, and Process workstreams are continuing to mature, the overall operating model cannot move into delivery until the organisational structure is finalised in Quarter 2 of 2026/27 post consultation phase. Socialisation feedback from February 2026 has informed the next stage of the structure refinement, and this work will determine the sequencing and readiness of related products before any formal transition to delivery can begin.

3 **MATERION PENODOL I'W HYSTYRIED SPECIFIC MATTERS FOR CONSIDERATION**

- 3.1 As the programme transitions from design and development into implementation and delivery, there is a need to consider the resourcing required to support this next phase.
- 3.2 Across all workstreams, there is a consistent theme of limited capacity and reliance on existing teams to deliver programme activity alongside core operational responsibilities. While this has enabled progress to date, the

scale and pace of delivery required in the next phase, particularly in relation to consultation, implementation, and organisational rollout, will require a more coordinated and sustainable resourcing approach.

- 3.3 A key area of concern relates to the resourcing required to support the forthcoming consultation and implementation phases, where a high-level programme risk has been identified regarding insufficient capacity to adequately prepare for and deliver effective engagement. In addition, there is a requirement to ensure alignment of the People and Culture workstreams in supporting the delivery of the proposed organisational structures. Failure to address these risks may adversely impact both the quality of the consultation and implementation process and the overall programme timelines.
- 3.4 In addition, several workstreams have highlighted ongoing constraints, including:
- Limited OD and Talent Management capacity to support delivery and embed new workforce and leadership frameworks
 - Challenges in releasing staff to support Culture Change activity, impacting the ability to scale interventions
 - Absence of dedicated resource to support sustainable implementation of key enabling processes, including the QMS
- 3.5 Taken together, these constraints indicate that the programme is now entering a phase where delivery demand exceeds current resourcing models.
- 3.6 The Committee is therefore asked to consider the approach to resourcing for the next phase of the programme, including:
- The requirement for dedicated capacity to support consultation, engagement and implementation activity
 - Opportunities to align and prioritise existing organisational resources to support programme delivery
 - The potential need for additional or temporary resource to ensure safe and effective transition into implementation
 - How best to support release of staff to participate in programme activity, particularly in relation to culture and capability interventions
- 3.7 Addressing these considerations will be critical to ensuring that the programme can maintain momentum, deliver its intended benefits, and support the organisation effectively through the next phase of transformation.

- 3.8 The programme is dependent on a wide range of organisational resources spanning multiple functions/directorates and workstreams. **Appendix 1: FFTF Programme - Resource Management Plan 2026/27** sets out the required roles, time commitments, cost profile, and alignment of resources to support successful delivery.

4 **RISGIAU ALLWEDDOL / MATERION I'W HUWCHGYFEIRIO KEY RISKS / MATTERS FOR ESCALATION**

- 4.1 The programme continues to operate within a moderate risk environment, with several consistent themes identified.
- 4.2 Capacity and resource constraints remain a key challenge across multiple workstreams, including Culture, People, and Processes workstreams, with limited dedicated resource impacting delivery pace and sustainability.
- 4.3 A high-level risk has emerged in relation to consultation readiness, with insufficient capacity identified to support preparation and delivery of the consultation phase, which may impact timelines and quality of engagement.
- 4.4 The programme also remains dependent on structural sequencing, with delays or changes to organisational structures impacting multiple downstream workstreams, including workforce deployment, governance and organisational development activity.
- 4.5 Ongoing risks relating to engagement and communication continue, including potential impacts on staff morale, stakeholder trust, and participation during transition.
- 4.6 There is also a recognised risk that focus on structural change may outweigh wider transformation activity, including culture, processes and capability development, which may limit overall organisational impact if not actively managed.

5 **ARGYMHELLION RECOMMENDATIONS**

- 5.1 Gofynnir i'r Pwyllgor/Cyfarfod/Grŵp:
The Committee is asked to:
- **NOTE** overall progress and delivery across all workstreams.
 - **NOTE** the Foundations for the Future Programme - Resource Management Plan 2026/27
 - **SUPPORT** the prioritisation of resources to support the FFTF Programme in 2026/27

Appendices:

Appendix 1: Foundations for the Future Programme - Resource Management Plan 2026/27

ASESIAD / ASSESSMENT	
Cyswllt â'r Blaenoriaethau Strategol Link to Strategic Priorities	4.Create a Modern, People Centred Healthcare System
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below: - Improve Access, Outcomes and Experience
Yr Egwyddorion Dylunio Design Principles	People First Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below: - Inclusive Design - Simplify, Standardise, and Adopt Best Practices - Consistency with Organisational Values
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd Corporate Risks and Board Assurance Framework	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) Several key risks have been identified at this stage, linked directly to the Corporate Risk Register and Board Assurance Framework. These include the potential for ineffective communication of the case for change, the risk of undue focus on the structures redesign at the expense of wider cultural and process improvements, financial pressures emerging through consultation, possible impacts on operational service delivery during transition, and the need to ensure robust tracking of outcomes and benefits. Mitigations are in place through the Engagement and Communication Plan, Programme Board oversight across all workstreams, refreshed financial assessment, focused executive support for high-risk operational areas, and the development of a comprehensive benefits measurement framework.

ASESIADAU O EFFAITH / IMPACT ASSESSMENTS

Equality Act 2010 Public Sector Equality Duty: Has BCUHB provided evidence of 'Due Regard' to compliance with the three parts of the Public Sector Equality Duty (General Duty): https://www.gov.wales/public-sector-equality-duty-htmlPublicSectorEqualityDuty[HTML] GOV.WALES	Do/Yes: ☒	Naddo/No: ☐
	Canlyniad/Outcome: Integrated Equality Assessment has been completed	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Equality Act 2010 - Socio- economic Duty <i>Has BCUHB provided evidence of 'Due Regard' to compliance of their Socio- economic Duty when making strategic decisions?</i>	Do/Yes: ☒	Naddo/No: ☐
	Canlyniad/Outcome: Integrated Equality Assessment has been completed	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
<i>Have you completed an Integrated Equality Impact Assessment WP8a?</i> WP8a Template	Do/Yes: ☒	Naddo/No: ☐
	Canlyniad/Outcome: Integrated Equality Assessment has been completed	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Human Rights Act <i>Have Human Right based concerns been addressed within WP8a</i>	Do/Yes: ☒	Naddo/No: ☐
	Canlyniad/Outcome: Integrated Equality Assessment has been completed	
	Os naddo, dylech gynnwys y rheswm:	

	If no, please include rationale:	
Compliance to the Welsh Language requirements? <i>Have you undertaken an Impact Assessment</i>	Do/Yes: ☒	Naddo/No: ☐
	Canlyniad/Outcome:	
	Integrated Equality Assessment has been completed	
Compliance to giving 'Due Regard' to the principles of the Armed Forces Covenant <i>Have the principles of the Armed Forces Covenant been addressed within WP8a</i>	Do/Yes: ☒	Naddo/No: ☐
	Canlyniad/Outcome:	
	Integrated Equality Assessment in draft for amendments and sign-off	
Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Os naddo, dylech gynnwys y rheswm:	
	If no, please include rationale:	
Ansawdd <i>A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?</i> Quality <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Do/Yes: ☒	Naddo/No: ☐
	Canlyniad/Outcome:	
	All Apply	
Galluogwyr Ansawdd Enablers of Quality All Apply	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod:	
	If more than one applies, please list below:	
Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant	A Healthier Wales	

Wellbeing of Future Generations Act – Wellbeing Goals		
Effaith Amgylcheddol / Cynaliadwyedd (5Rs) Environmental /Sustainability Impact (5Rs)	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below: No - Not Applicable	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:	
Asesiad o Effaith ar Ddiogelu Data <i>A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?</i> Data Protection Impact Assessment <i>Have you undertaken a Data Protection Impact Assessment Screening?</i>	Do/Yes: ☐ Canlyniad/Outcome:	Naddo/No: ☒ Not required
Asesiad o Effaith ar Atal Twyll <i>A ydych chi wedi ystyried yr effeithiau ar atal twyll?</i> Counter Fraud Impact <i>Have you considered the counter fraud impacts</i>	Do/Yes: ☐ Canlyniad/Outcome:	Naddo/No: ☒ Not required
Cyfreithiol Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw Da Reputational	Yes (Include further detail below) Leading effective change is key. A focus on engagement and consultation is key.	
Effaith ar Adnoddau (Pobl / Ariannol) Resource Impact (People / Financial)	Yes (Include further detail below) There looks to be a reduction in costs, however this remains subject to engagement and consultation process and refinement following that.	



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Foundations for the Future

Programme Resource Management Plan 2026/27



Additional / New Cost to BCUHB - specifically required due to FFTF - 2026/27

Team / Workstream	Role (PO = Production Owner)	Band	WTE	Duration 2026/27 (months)	Cost 2026/27 (£000')	Person in Role	Notes / Risk / Gap
Programme Team	Senior Programme Manager	8c	0.2	2	5	Steph O'Donnell	Bank
Structures Workstream (Consultation & Implementation)	HR JD/Role Redesign Support	8d	0.5	8	47	Lesley Hall	Bank
	Prep for interview/career conversations	8b	0.5	8	34	Collette King	Bank
				TOTAL	£86		

Existing Absorbed Cost – protected or reprioritised time- 2026/27

Team / Workstream	Role (PO = Production Owner)	Duration 2026/27 (months)	Person in Role	Notes / Risk / Gap
Programme Team	Senior Responsible Officer	12	Carol Shillabeer	Prioritised within workload to support programme
	Programme Director	12	Ffion Johnstone	Part of Programme Role
	Programme Manager	12	Charlotte Love	Prioritised within workload to support programme Not yet agreed from July 2026 onwards
	Administrative Support	12	Lucy Francis	Prioritised within workload to support programme

NB: Duration is based on financial year and estimated that the programme will run until Feb 2027.

NB: Based on the seniority and expected level of experience of these posts, it is assumed that all will be appointed at the top point of the incremental scale.

Existing Absorbed Cost – protected or reprioritised time- 2026/27

Team / Workstream	Role (PO = Production Owner)	Duration 2026/27 (months)	Person in Role	Notes / Risk / Gap
Structures Workstream (Consultation & Implementation)	Executive lead – Structures	12	Teresa Owen	Prioritised within workload to support programme
	Subject Matter Expert – Structures	12	Georgina Roberts Ffion Johnstone	Prioritised within workload to support programme Part of Programme Role
	PO - Job Families, Skills lists & RACI	12	Kay Hannigan John Martin	Prioritised within workload to support programme
	PO - Established Clinical Leadership Models	4	Teresa Owen	Prioritised within workload to support programme
	PO - Function/Job Directory	8	Charlotte Love Lucy Francis	Prioritised within workload to support programme
	Pres-Consultation prep	4	Ffion Johnstone Georgina Roberts Kay Hannigan John Martin Gill Cooper	Prioritised within workload to support programme
	Consultation	1.5	Ffion Johnstone /Georgina Roberts John Martin Michelle Hughes Devonport Andrea Orme /Max Wright	Prioritised within workload to support programme
	Post Consultation	1.5	Ffion Johnstone / Georgina Roberts Kay Hannigan / John Martin Gill Cooper	Prioritised within workload to support programme
	Implementation	4	OD Planning Finance Governance	Prioritised within workload to support programme

Existing Absorbed Cost – protected or reprioritised time- 2026/27

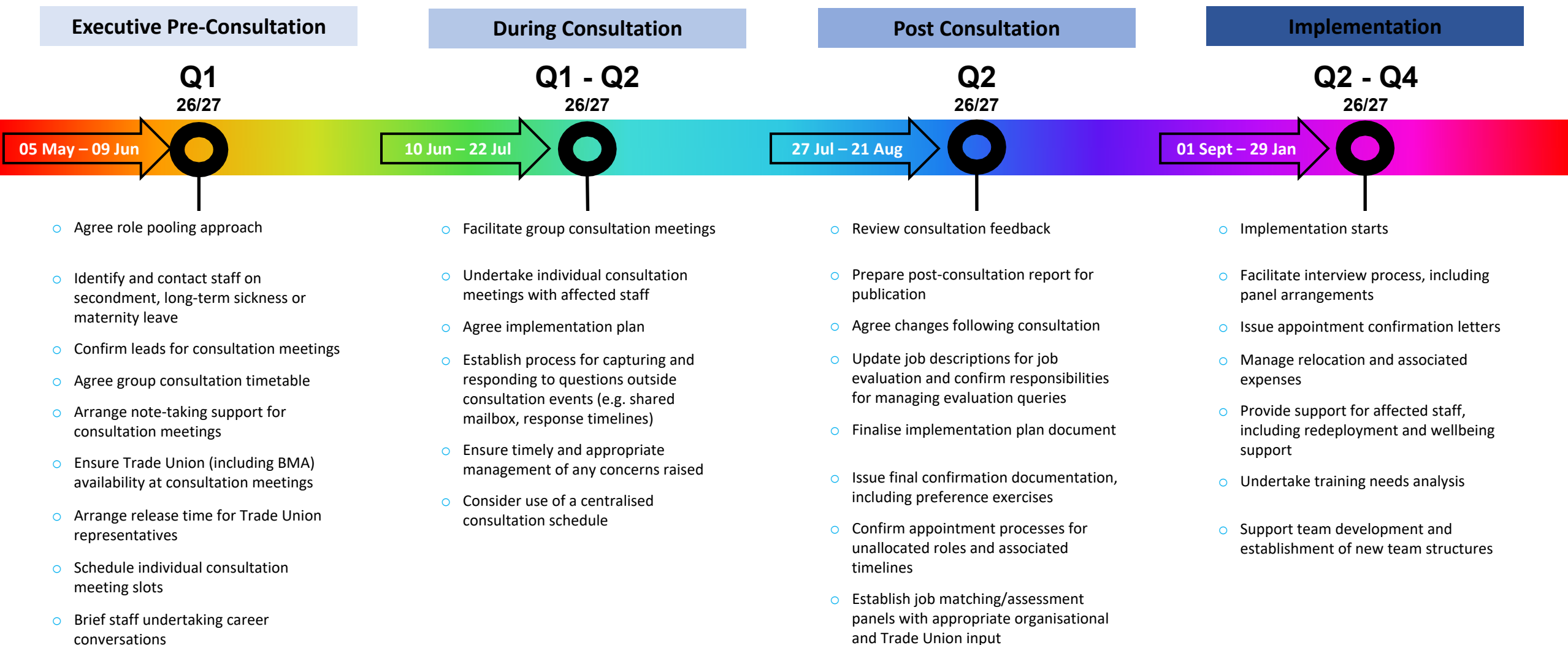
Team / Workstream	Role (PO = Production Owner)	Duration 2026/27 (months)	Person in Role	Notes / Risk / Gap
People Workstream	Executive lead – People	12	Angela Wood	Prioritised within workload to support programme
	Subject Matter Expert – People	12	Rebecca Testa	Prioritised within workload to support programme
	PO - Integrated Leadership Development Framework (ILDF)	10	Joy Lloyd	Prioritised within workload to support programme
	PO - Talent Management and Succession planning	12	Gillian Cooper	Prioritised within workload to support programme
	PO - Collated Knowledge & Skills Required (Skills/Competency Assessment)	6	OD Planning Finance Governance	Prioritised within workload to support programme
	PO - Resource Toolkit to support skills and capability development for staff	10	Rebecca Testa	Prioritised within workload to support programme
	PO - Workforce Planning & Redesign (Proposed Organisational Approach)	10	Lou Foulkes	Prioritised within workload to support programme
	Further development of existing and new products is being assessed, to support the Implementation period of the Structures/Operating Model	TBA	TBA	TBA
Culture	Executive lead – Culture	12	Debbie Eyitayo	Part of BAU
	Subject Matter Expert – Culture	12	Jason Brannen	Part of BAU
	PO – Culture Change Programme	12	Nia Thomas	Part of BAU
	PO - Values & Behaviours Framework	12	Nia Thomas	Part of BAU
	PO – Teamworking Journey	12	Gareth Evans	Prioritised within workload to support programme

Existing Absorbed Cost – protected or reprioritised time- 2026/27				
Team / Workstream	Role (PO = Production Owner)	Duration 2026/27 (months)	Person in Role	Notes / Risk / Gap
Processes Workstream	Executive lead – Processes	12	Pam Wenger Russ Caldicott	Prioritised within workload to support programme Prioritised within workload to support programme
	Subject Matter Expert – Processes	TBA	TBA	TBA
	Subject Matter Expert - Finance	TBA	TBA	Consider a Finance Rep as a Subject Matter Expert to cover Financial Systems Governance
	PO – Governance Pathways & Reporting	6	Pam Wenger	Prioritised within workload to support programme
	PO – Operational Governance	6	Phil Meakin	Prioritised within workload to support programme
	PO – Quality Management System	6	Angela Wood	Prioritised within workload to support programme PO will need to be reallocated in August 2026
	PO – ECR Review	TBA	TBA	PO needs to be allocated and product scoped
	PO – Business Cases Review	TBA	TBA	PO needs to be allocated and product scoped
Strategy Workstream	Executive lead – Strategy	TBA	Paolo Tardivel	Part of BAU Dependency on agreeing completion of CSP-Phase 2
	Subject Matter Expert – Strategy	TBA	Kamala Williams	Part of BAU Dependency on agreeing completion of CSP-Phase 2
	Chief Finance Manager – Strategy & Planning	TBA	Rebecca Hughes	To consider inclusion of Chief Finance Manager to ensure financial resources are aligned
	PO – Clinical Service Plan – Phase 2	TBA	Kamala Williams	Part of BAU Dependency on agreeing completion of CSP-Phase 2
	PO – 10 Year Strategy	3	Kamala Williams	Part of BAU
	PO – IMPT/ADP	3	Emma Lea	Part of BAU

Existing Absorbed Cost – protected or reprioritised time- 2026/27

Team / Workstream	Role (PO = Production Owner)	Duration 2026/27 (months)	Person in Role	Notes / Risk / Gap
Cross-Cutting	Executive lead – Cross-Cutting	10	Ffion Johnstone	Part of Programme Role
	PO – Organisational Change	10	Geraint Parry Julie Ward-Jones	Prioritised within workload to support programme
	PO – Operating Model/Framework	10	Programme Team	Prioritised within workload to support programme
Enablers / Support	Finance Support for Programme	12	Nigel McCann	Prioritised within workload to support programme
	Engagement & Communications Lead	12	Andy Rogers / Rachel Starkey	Prioritised within workload to support programme
	TU time for consultation TU time for job comparison panels	4	Jan Tomlinson - Unison Vivienne Nelson – Unison Michelle Parsonage – Unite Toni Wood – RCM Cathrine Jones – RCN Stephen Kelly - BMA	Prioritised within workload to support programme
	Reallocation of budgets and hierarchy	6	CFO's x 7	Prioritised within workload to support programme
	Establishment (ESR) updated to reflect new budgets & hierarchy	6	Clair Tipton & team (tbc)	Prioritised within workload to support programme

Structures - Executive Pre, During & Post Consultation Plan



NB: For reference noting the duration of the Consultation & Implementation, conditional on timescales as of 02nd June 2026.

People and Culture Committee

SENIOR DOCTOR JOB PLANNING

Dyddiad y Cyfarfod Date of Meeting	11 June 2026
Statws Cyhoeddi Publication Status	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad Report Author name and title	Dr Clara Day Executive Medical Director Dr Karen Mottart IHC Medical Director West; Chair Medical Workforce Group
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol Lead Executive Team Member name and title	Dr Clara Day Executive Medical Director Debbie Eyitayo Executive Director of People Services and Organisational Development
Pwrpas yr Adroddiad Report Purpose	For Noting

Crynodeb Gweithredol **Executive Summary**

This paper is to update People and Culture Committee in the progress around senior doctor job planning. Appendix A gives an update against internal audit recommendations.

Senior medical job planning compliance remains significantly below the Welsh Government Target of 90% (Appendix B) across all divisions and departments despite positive engagement from senior medical and operational staff and the Joint Local Negotiating Committee (JLNC), and constructive support from the BMA.

There continue to be delays in sign-off of the Job Planning Protocol (JPP) which has been co-developed through Medical Workforce Group with endorsement by the JLNC and the BMA. The tension remains related to the approval of payment of part sessions above the standard contract of 10 sessions. Four other HB already include part session payment within their JPP.

While there will be financial implications from paying part sessions, robust job planning would adequately off set the cost by ensure that job plan activity is evidenced and closely aligned to BCU, service and agreed personal objectives. No part payments will be paid retrospectively.

The benefit of having the collaborative support of the JLNC and BMA cannot be overvalued

This has been discussed at Executive Committee on 08/04/26 and after financial modelling and operational discussion will be discussed again on 17/06/26.

Ymgysylltu (mewnol/allanol) yr ymgwymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp)
Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)

Pwyllgor / Grŵp / Unigolion Committee / Group / Individuals	Dyddiad Date	Canlyniad, Tystiolaeth a Data Outcome, Evidence and Data
Audit Committee	21.10.2025	Verbal Update
Medical Workforce Group	21.01.2026	For Discussion
People & Culture	12.02.2026	For Discussion
Executive Committee	08.04.2026	For Discussion

Appendices

Appendix A	Job Planning Audit recommendations update May 2026
Appendix B	Job Planning current progress report May 2026

ASESIAD / ASSESSMENT	
Cysylltiad â'r Bwriadau Strategol Link to Strategic Intentions	4.Create a Modern, People Centred Healthcare System
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Yr Egwyddorion Dylunio Design Principles	Wise Spending Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below: People First
	CRR25-01 Timely patient access to safe and effective care BAF24-07 Not Delivering Timely Access to Care Resulting In Potential Clinical Harm, Poor Delivery of Performance Targets and Reputational Risk
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd Corporate Risks and Board Assurance Framework	A Healthier Wales
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
<u>Deddf Llesiant</u> <u>Cenedlaethau'r Dyfodol -</u> <u>Nodau Llesiant</u> <u>Wellbeing of Future</u> <u>Generations Act – Wellbeing</u> <u>Goals</u>	

ASESIADAU O EFFAITH / IMPACT ASSESSMENTS		
Cydraddoldeb <i>A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o'r Effaith ar Gydraddoldeb (sy'n cynnwys gofynion Safonau'r Gymraeg)</i> Equality <i>Have you undertaken an Equality Impact Assessment Screening (which includes the requirements of the Welsh Language Standards)</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Asesiad o'r Effaith Economaidd-gymdeithasol <i>A ydych chi wedi cynnal Asesiad o'r Effaith Economaidd-Gymdeithasol?</i> Socio-Economic Impact Assessment	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	

<i>Have you undertaken a Socio-Economic Impact Assessment</i>		
<u>Ansawdd</u> <i>A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?</i> <u>Quality</u> <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Galluogwyr Ansawdd Enablers of Quality Culture and Valuing People	Meysydd Ansawdd Domains of Quality All Apply
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
<u>Deddf Llesiant</u> <u>Cenedlaethau'r Dyfodol - Nodau Llesiant</u> <u>Wellbeing of Future Generations Act – Wellbeing Goals</u>	A Healthier Wales	

Effaith Amgylcheddol / Cynaliadwyedd (5Rs) Environmental /Sustainability Impact (5Rs)	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
	No - Not Applicable	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:	
Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog <i>A ydych chi wedi ystyried Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog:</i> Armed Forces Covenant Due Regard Duty <i>Have you considered the Armed Forces Covenant Due Regard Duty?</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Asesiad o Effaith ar Ddiogelu Data	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	

<i>A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?</i> Data Protection Impact Assessment <i>Have you undertaken a Data Protection Impact Assessment Screening?</i>	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Asesiad o Effaith ar Atal Twyll <i>A ydych chi wedi ystyried yr effeithiau ar atal twyll?</i> Counter Fraud Impact Assessment <i>Have you considered the counter fraud impacts</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Cyfreithiol Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw Da Reputational	Yes (Include further detail below)	
	Effective working relationships with the JLNC and BMA are vital. Without these it will be very difficult to progress through discussions and actions that need to be taken to improve workforce productivity.	
Effaith ar Adnoddau <i>(Pobl / Ariannol)</i> Resource Impact <i>(People / Financial)</i>	Yes (Include further detail below)	
	This is extremely difficult to judge. We don't currently have a complete picture of all the money spent on senior doctor pay as comes from several different, currently unconnected pots. We know we have a huge reliance on waiting list initiatives and will continue to do so until we reach a sustainable status quo of demand and capacity, at a productivity which is acceptable. This work needs to be done in concert with job planning. Discussions around resourcing of a medical workforce function to bring all this work together are also vital.	

Ref	Key Finding	Original Responsibility & Timescale	Priority Rating	Appropriate Progress, Adequate Evidence & Actions address issues highlighted.
Objective 1: There is relevant and up to date procedures in place that are available to staff and align to the All-Wales guidance.				
1.	Health Board Policy The Health Board has no Policy or Procedure detailing the expectations of both management and Consultant in discussing and agreeing the Job Plan in line with the nationally agreed Consultant Contract. Based on our review, it has not had a comprehensive Policy in place for thirteen years, per the original review undertaken by the former Wales Audit Office in 2011. Limited training is provided to all individuals involved in the job plan process.	Interim Medical Director 31 May 2025	High	Current status – Not implemented Finding The Health Board does not have an agreed Policy/Standard Operating Procedure in place to support management, and consultants fulfil expected compliance with the nationally agreed Consultant Contract. This remains a significant gap in internal control. We are advised that the Health Board has not progressed with its own draft policy/procedure as it waited for nationally developed best practice guidance which has not materialised. With no policy or standard operating procedure in place, we recognise the decision not to develop a Health Board wide training needs analysis. We have seen evidence where the Job Planning Specialist undertakes ad-hoc training and note this as good practice. Revised Action, Responsibility and Timescale – May 2026 The final draft of the BCU job planning procedure (JPP) which has been co-authored with LNC and BMA, as been scrutinised at both medical workforce group and JLNC in January 2026. It contains the proposal that payment for sessions above 10 should be paid to nearest 0.25 sessions. This is in line with 3 Health Boards in Wales with a 4th paying at 0.5 session It is also anticipated that this will form part of the updated All Wales job planning policy due in August 2026. There are concern regards the financial impact of such a proposal but it is difficult to predict the cost exactly. A paper is to be discussed at Executive Committee on 08/04/26 At the LNC meeting 28 April 2026 is was agreed the protocol can be approved out of meeting and still with the executives to support. The programme to train operational staff to be confident and competent to use Allocate is progressing at pace, with the training team providing targeted team training as need identified. Compliance is tracked locally by Medical Directors / Clinical Directors and Directorate General Managers (or equivalent). Rates will be monitored via local People and Culture and local workforce groups. At Health Board level compliance will be reported via Medical Workforce Group, highlighting any departments of concern. Job planning compliance as at 12th May 2026 was at 36%.

Ref	Key Finding	Original Responsibility & Timescale	Priority Rating	Appropriate Progress, Adequate Evidence & Actions address issues highlighted.
3.	EJob Plan First and second sign-off Through a review of first and second sign off details in the EJob plan system, and verification with the seven clinical directorates / divisions, there were several issues noted with the accuracy of the information on the system. This includes gaps in second approvers, officers no longer in post, and inconsistency with operational management included as either first or second sign off. There was also test data included in the live system.	Interim Medical Director 30 April 2025	High	Current status – Not implemented Finding There has been no formal review of first and second sign-off within the EJob Plan system. We were advised that Women’s Services have undertaken a review of their sign-off details but have not corroborated this. Our review of the information has again identified test and generic details in the system that compromises data quality. Only the training module should be used for test data to preserve the integrity of the live system. Revised Action, Responsibility and Timescale - May 2026 Continued scrutiny of sign off process, optimising both appropriate operational and clinical line management review and sign off. For those staff who have a job plan that spans more than one service the facility of 3rd sign off has been put in place We have not yet found a method to implement the previously approved ‘distant’ sign off process within Allocate. Health Medics team continue discussions. If allocate are unable to provide the Health Board will need to find a ‘work around’ which would be in place within 4 months i.e. April 2026 A Standard Operating Procedure (SOP) for Job Planning Meetings – Administrative Processes and Sign-Off has been developed, outlining the required process as well as the roles and responsibilities associated with planning and undertaking a job plan meeting. The draft SOP is currently awaiting initial approval from the V&S Job Planning Group, after which it will be submitted to the Medical Workforce Group for final ratification.

ive 2: Job plans accurately reflect both the individual and organisation activity requirements and are completed in a timely manner.

Ref	Key Finding	Original Responsibility & Timescale	Priority Rating	Appropriate Progress, Adequate Evidence & Actions address issues highlighted.
5.	Job Plan annual review Through our review meetings, we were advised that undertaking the job plan within one month of the incremental date is not something that is actively followed as the system does not capture the data. The Health Board is not compliant with its responsibility for ensuring annual job plan reviews are undertaken every twelve months and ensuring adequate narrative is completed around additional SPA sessions and place of work.	Interim Medical Director and Deputy Director of People 30 April 2025	High	Current status – Not implemented Finding Our review of Health Board data as of 1 September 2025 showed overall compliance of 42% (Image 1 above) where job plans have been agreed and signed off. We have been advised that review dates have not been amended to reflect the individual’s incremental date. It remains unclear how the Health Board will meet the 90% target of in-date job plans by 30 September 2025, set by Welsh Government. Revised Action, Responsibility and Timescale - May 2026 The proposed trajectory for compliance of 50% end Q3, 75% end Q4, >90% by end Q1 was signed off at Medical Workforce Group 15 October 2025. The trajectory of 75% at the end of Q4, was not be met, primarily due to the delay with approving the JPP. This has led to a delay with awareness and education for our senior leaders and doctors involved, and lack of clarity around some of our local agreements e.g. maximum sessions, anticipated evidence. A trajectory for compliance of >90% is the target for end of Q1. Monitoring via Power BI in place and allows for drill down by team (but not to individual staff level) and is circulated monthly by OMD. Monitoring of compliance would be as above, via local processes and at HB level at Medical Workforce Group and People and Culture Committee
6.	Directorate/Specialty objectives are explicit There is a generic statement within the Service Outcomes section of job plans <i>“To ensure service and job plan aligned to deliver CPG and wider BCU Strategic direction”, (sic)</i>. The Service Outcomes section overall was either incomplete or noted <i>“During job plan discussions need to review this”</i>. From our review, we are unclear how management are approving job plans without expected service objectives.	Interim Medical Director 30 April 2025	High	Current status – Not implemented Finding We reviewed a sample of one job plan from the three Integrated Health Communities and the four pan North Wales clinical directorates. We found four (57%) were in-date and current, however none had any directorate or specialty service objectives recorded. Revised Action, Responsibility and Timescale - May 2026 There has been a gradual adoption of recording Health Board and directorate / speciality priorities, although this has not been formally audited. It is anticipated that compliance with recording and discussing priorities will improve at the point of roll out of the JPP. The JPP outlines importance of service demand / capacity discussion <i>prior</i> to an individual job plan timetabling meeting. Individuals PDP from appraisals will inform service and personal priorities and objective for the coming year. The need for service priorities to be clearly articulated and aligned within individual job plans will be a core expectation for the training program and roadshows. Compliance with this element will need to be monitored via a quality assurance process which is beyond current capability of PowerBI monitoring. A sustainable automated solution will be in place within 6 months if DDaT colleagues have the capacity to prioritise this work. <u>However, with the current focus on ePMA roll out there has been limited capacity to plan the next step</u>

Ref	Key Finding	Original Responsibility & Timescale	Priority Rating	Appropriate Progress, Adequate Evidence & Actions address issues highlighted.
	We note different approaches taken in agreeing team objectives where colleagues collectively agree on the service requirements and then meet individually as part of the job plan approach to agree individual objectives. These should be SMART and recorded in the system.			It is anticipated that implementation of any operational structure following Foundations for the Future review may impact on a need to review service priorities and alignments
Objective 3: Job plans include outcomes that are linked to the Health Board's organisational objectives, and the level of achievement is subject to appropriate assessment.				
7.	Evidencing achievement of the Board objectives Whilst there were strategic goals detailed in the Board Outcomes section of the job plan, they did not reflect the current strategic objectives, and there were no measurable outcomes agreed from which it could be evidenced as being worked to/achieved.	Interim Medical Director 30 April 2025	High	Current status – Implemented Finding The review of the seven job plans confirmed that all had the current Health Board objectives recorded. In addition, we found that three included Ministerial Priorities, with two also recoding the Values and Behaviours Framework.
Objective 4: Completed job plans reconcile to system records and session payments are correct.				
8.	Regular review of payments to agreed job plan commitments We identified six (27%) of the twenty-two job plans with a variance between the sessions paid and that recorded on the job plan.	Deputy Director of People 30 April 2025	High	Current status – Not implemented Finding The Medical Dental and Elements pay report has not been developed for use across the Health Board. We have been advised a dashboard has been produced in conjunction with the Office of the Medical Director (OMD), Surgical IHC West, Finance and People Services. We are advised a meeting was held on 19 August 2025 with a further meeting scheduled for 25 September 2025 but have not corroborated this or requested sight of the draft dashboard. Revised Action, Responsibility and Timescale - May 2026

Ref	Key Finding	Original Responsibility & Timescale	Priority Rating	Appropriate Progress, Adequate Evidence & Actions address issues highlighted.
	We also found a variance in Intensity Band payments and are unclear whether these payments are subject to annual review or simply roll-over. The payment of only whole sessions could adversely impact the Health Board to deliver against its waiting lists as this does not always reflect the agreed job plan.			The dashboard linking Allocate to ESR is now live. The SOP has been approved via Medical Workforce Group in January 2026, and identification of discrepancies is enabling focused discussions with the medical staff involved
Objective 5: The completion rates of job plans are monitored and reported to an appropriate forum, with further escalation if there is low compliance.				
10.	Medical and Dental Job Plan reporting There is inadequate reporting of medical and dental job plan performance, across the Health Board from operational management to the Executive and associated scrutiny meetings up to Committee for assurance.	Deputy Director of People 30 April 2025	High	Current status – Partially implemented Finding The OMD Job Planning team send out a monthly <i>Job Planning Compliance</i> email that includes a link for the job planning dashboard to a pre-determined circulation. We are unclear whether this circulation captures all relevant leads with responsibility/accountability for job plan compliance. We contacted the seven clinical service Directors to obtain details of their People and Culture meeting or to confirm where job plan performance and assurance was discussed. We received a reply for Centre, East and West IHCs and Women’s Services but received no reply from Mental Health and Learning Disabilities, North Wales Managed Clinical Services or Cancer Services. We noted limited assurance reporting at a local level within IHC West on job planning. The West IHC Medical Director (Chair of the MWG) provided evidence of follow-up compliance with job plan completion to West operational leads. Women’s Services hold monthly Centre, East and West Accountability Meetings where we noted job planning as an agenda item. We also noted a standing agenda item on the Clinical Directors bi-monthly meeting. Through our review of operational People and Culture meetings provided to us, we were unable to find any reference in the People Operations Report or any specific reporting on consultant job plan performance. Revised Action, Responsibility and Timescale - May 2026

Ref	Key Finding	Original Responsibility & Timescale	Priority Rating	Appropriate Progress, Adequate Evidence & Actions address issues highlighted.
				Monthly compliance figures are circulated to operational teams and the divisional and IHC medical leaders. It is tracked at Medical Workforce Group at Health Board Level, which has membership drawn from all IHCs and divisions. Further work is required to evidence that compliance and local plans are discussed at IHC and divisional meetings. It has not been formally audited by MWG Real time data is accessible via Allocate. How to access forms part of the Allocate 'how to' training.
11.	Medical Workforce Group & People & Culture Executive Delivery Group (EDG) The Medical Workforce Group (MWG) has responsibility in its Terms of Reference that it <i>"....will receive regular reports (on job plans) as per its Cycle of Business"</i> but we have been unable to verify they have actually received any reports for assurance recently. Of the ten MWG meetings scheduled to take place this calendar year, only three have taken place (April, June and September 2024). The MWG provides assurance to the People & Culture EDG although we have been advised this meeting has similarly not been taking place, exposing an operational gap in control and assurance across the Health Board.	Deputy Director of People 30 April 2025	High	Current status – Not implemented Finding There is no evident reporting on consultant job plan performance to the Health Board's People and Culture Committee through the People Operations Report. We note a verbal update was provided to the Committee by the Interim Executive Medical Director at the 14 August 2025 meeting (Agenda Item PC25/82). The People & Culture Executive Delivery Group is still yet to be re-established. Consequently, assurance reporting from the Medical Workforce Group is not subject to any scrutiny or assurance to the Executive Committee and/or the Health Board People & Culture Committee. The Medical Workforce Group (MWG) is meeting regularly although we note its Terms of Reference require review as there has been a change in Chair that has not been reflected. A review of minutes has identified regular discussion on job plan performance. Of the minutes viewed, we noted the June 2025 meeting recorded <i>"action...to recirculate the Power BI link to ensure all members could access and monitor their compliance data."</i> We note in July and August 2025 meetings a focus on the Welsh Government set target of 90% completed job plans by 30 September 2025 with the draft August 2025 minutes noting <i>"Current compliance was reported to be significantly below this target, prompting concern and a renewed focus on improvement."</i> Revised Action, Responsibility and Timescale - May 2026 Medical Workforce Group continues to meet monthly. While it receives reports from the 4 Value and Sustainability workforce groups, it does not yet formally receive appropriate reports from locality / divisional groups. This is being addressed for April's medical workforce group

Job Planning Compliance - Current Progress

[View in Power BI](#) ↗

Last data refresh:
12/05/2026 14:01:42 UTC

Downloaded at:
12/05/2026 16:18:53 UTC



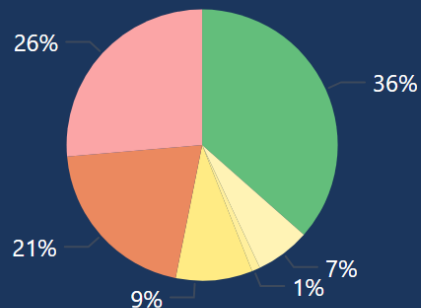


GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Job Planning Compliance - Current Progress

Last Updated
12 May 2026



Top 5 departments with signed off job plans

Signed Off

Emergency Care East Health Community	88%
Anaesthetics East Health Community	69%
Area Community Services Central Health Community	67%
Area Community Services West Health Community	67%
Diagnostics and Specialist Clinical Support Pan North Wales Services	63%

907

53

Number of Doctors

Due to Expire

11

Directorate

East Health Community

Pan North Wales Services

West Health Community

Central Health Community

GP Practices

186

Logged in over 12 months ago

● % Signed Off ● % Awaiting 2nd Sign Off ● % Awaiting 1st Sign Off ● % Awaiting Doctor Sign Off ● % Discussion ● % Expired ● % Locked Down ● % Not Published

Directorate

Department

Specialty

Role

Contract

All

All

All

All

All



People and Culture Committee

RESIDENT DOCTORS CONTRACT REFORM AND LOCAL IMPLEMENTATION

Date of Meeting	11 June 2026
Publication Status	Open/ Public
	Not Applicable
Report Author(s) name and title	Ellen Strudwick, Medical Workforce Policy, Practice and Compliance Specialist
Lead Executive Team Member name and title	Clara Day, Executive Medical Director

Report Purpose	For Noting
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Executive Summary

This report provides assurance to the People and Culture Committee on the current position regarding implementation of the nationally mandated 2026 Resident Doctors Contract, with a specific focus on workforce impact, organisational readiness, and key risks.

Overall readiness remains **Red**, reflecting continued national dependencies, including delayed Terms and Conditions and the absence of a fully configured rostering system, which constrain full implementation. However, local delivery activity is progressing in line with current guidance, with rota reviews completed across all specialties, providing improved visibility of workforce capacity and service resilience.

From a People and Culture perspective, the Committee is asked to take assurance that the key workforce risks are understood and actively managed. These include workforce sustainability, staff experience and engagement, and the impact of ongoing uncertainty on morale and retention. While no formal concerns have been raised by staff side, there remains a recognised risk that confidence and perceived equity may be affected as implementation progresses.

The organisation has established governance and oversight arrangements to support delivery, with continued focus on workforce modelling, risk mitigation, and staff engagement to ensure a safe and consistent transition.

The Committee is asked to take assurance on the current position, note the associated workforce risks, and support continued focus on staff engagement and safe implementation.

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)

Committee / Group / Individuals	Date	Outcome, Evidence and Data
Medical Workforce Group	Ongoing	Monthly updates provided by the Local Implementation Group
Local Implementation Group	Ongoing	Bi-weekly meetings to monitor progress, track actions and escalate risks as required.
Joint Local Negotiating Committee	28 th April 2026	Initial briefing provided to staff side representatives.
Speciality Rota Review Meetings	21 st April to 1 st May 2026	Meetings with individual specialities within each IHC to review rotas, identify compliance options, and assess risks and workforce implications.
Senior Medical Leadership Group	Ongoing	
People & Organisational Development - Associate Directors, Senior Leadership and wider team meetings	Ongoing	Updates provided by the Local Implementation Group
Executive Committee	03.06.2026	To be share with P&C Committee

Acronyms / Glossary of Terms

Resident Doctors	Doctors in postgraduate training previously referred to as junior doctors
Locally Employed Doctors (LEDs)	Doctors employed directly by the Health Board outside national training programmes.
Joint Local Negotiating Committee (JLNC)	The formal local forum for negotiation and consultation between the Health Board and medical staff representatives.
British Medical Association (BMA)	The recognised trade union and professional body representing doctors
RLDatix Health Roster	The national medical rostering system used to design rotas, manage working hours, and support contractual monitoring.



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Guardian of Safe and Flexible Working (GOSFW)	A statutory role responsible for overseeing compliance with safe working hours and contractual safeguards for Resident Doctors.
Pay protection	Contractual arrangements intended to prevent reduction in earnings during transition to new pay structures.

RESIDENT DOCTORS CONTRACT REFORM AND LOCAL IMPLEMENTATION

1. SITUATION

- 1.1 The Health Board is required to implement the 2026 Resident Doctors Contract, a nationally mandated reform with significant workforce, operational and financial implications. Overall readiness remains **Red**, with delivery constrained by national dependencies, workforce capacity pressures, and system readiness limitations.

2. BACKGROUND

- 2.1 The revised contract introduces substantial changes to pay structures, working patterns, and governance arrangements, with implementation commencing from August 2026. Preparatory work has progressed, including completion of rota reviews across all specialties, alongside the establishment of a structured governance framework to support delivery.
- 2.2 However, progress continues to be constrained by the delayed publication of national Terms and Conditions and the absence of a fully configured national rostering system. These remain critical dependencies for finalising implementation.

3. SPECIFIC MATTERS FOR CONSIDERATION AND NOTING

The Executive Committee has considered the emerging position in relation to implementation of the Resident Doctors Contract, with particular focus on operational delivery, workforce capacity, financial implications, and organisational risk. The Committee noted the current Red readiness status and the extent to which national dependencies continue to constrain progress, including the impact on workforce modelling and service delivery planning.

The Committee recognised the scale of workforce challenges identified through rota review, particularly in high-risk specialties, and the likely requirement for service prioritisation and continued reliance on temporary staffing where gaps cannot be filled. It emphasised the need for a balanced approach that ensures safe clinical cover for August 2026 while acknowledging that full compliance will require a phased implementation beyond this point.

In doing so, the Executive Committee endorsed continued development of detailed workforce and financial modelling, strengthened oversight of risks, and alignment of implementation plans with organisational priorities and available resources. It also reinforced the importance of clear communication and engagement with staff to support safe and consistent delivery.

The People and Culture Committee is asked to note the outcome of this consideration.

In terms of specific progress:

3.1 Implementation progress and workforce insight

Rota review activity has now been completed across all specialties, providing improved visibility of workforce capacity, compliance, and service resilience. Initial findings indicate:

- 43% of rotas likely compliant with minimal adjustment
- 43% require moderate redesign
- 15% present significant compliance challenges requiring additional workforce or service change

Detailed analysis highlights that compliance is often achievable on paper but not operationally deliverable, once factors such as leave, educational time, and flexible working are accounted for. This reduces effective workforce capacity and increases reliance on temporary staffing.

3.2 Service and workforce sustainability

Early modelling demonstrates that a number of services are operating with limited resilience, including:

- Rotas working close to contractual limits
- Limited flexibility to absorb vacancies or absence
- Workforce gaps in key specialties (notably Emergency Medicine and Medicine)

In these areas, compliance is likely to require additional workforce which may not be achievable within existing labour market constraints, leading to potential service prioritisation and reduced planned care.

3.3 National constraints

Implementation continues to be impacted by:

- Delayed national Terms and Conditions
- Absence of a fully configured national rostering system
- Ongoing uncertainty affecting workforce and financial planning

These constraints limit the organisation's ability to finalise rota design, workforce modelling, and full contractual implementation.



3.4 People and Culture considerations

From a workforce perspective, the programme presents key considerations relating to:

- Staff understanding and engagement
- Perceived equity across specialties
- Workforce wellbeing and sustainability

No formal concerns have been raised by staff side; however, there is a recognised risk that ongoing uncertainty may impact confidence

4. KEY RISKS / MATTERS FOR ESCALATION

From a People and Culture perspective, the principal risks are:

- **Workforce experience and engagement risk:** Ongoing uncertainty may impact staff confidence, understanding, and engagement
- **Workforce sustainability risk:** Identified rota gaps and limited resilience may impact wellbeing, safe working, and retention
- **Operational/service risk:** Workforce constraints may lead to reduced planned care, increased reliance on temporary staffing, and pressure on patient flow
- **Digital/system dependency risk:** Lack of a fully operational national rostering system limits implementation and monitoring capability
- **Financial uncertainty risk:** Unclear workforce and pay implications present affordability and planning risks

If not mitigated, there is potential for workforce dissatisfaction, service disruption, increased costs, and reputational impact.

5. RECOMMENDATIONS

The Committee is asked to:

- **NOTE** the current position and progress to date
- **NOTE** the continued Red readiness status and national dependencies
- **NOTE** the workforce risks, sustainability challenges, and service implications identified
- **SUPPORT** continued focus on staff engagement, communication, and equitable implementation
- **SUPPORT** ongoing oversight of workforce modelling, risk mitigation, and phased implementation planning
- **RECEIVE** further updates as national detail is confirmed and implementation progresses

ASSESSMENT	
Link to Strategic Intentions	1. Focus on Health and Wellbeing
	<i>If more than one applies, please list below:</i>
Design Principles	People First
	<i>If more than one applies, please list below:</i>
Corporate Risks and Board Assurance Framework	Implementation of the Resident Doctors Contract aligns with existing Corporate Risk Register and BAF themes, particularly workforce sustainability, service delivery, financial control, and organisational capacity.
Wellbeing of Future Generations Act – Wellbeing Goals	A More Equal Wales
	<i>If more than one applies, please list below:</i>



IMPACT ASSESSMENTS		
Equality <i>Have you undertaken an Equality Impact Assessment Screening (which includes the requirements of the Welsh Language Standards)</i>	Yes: ☐	No: ☒
	Outcome:	n/a
	If no, please include rationale:	This report is purely administrative in nature and submitted for information only. The associated public sector duties are not engaged (there are no associated impacts on any of the protected groups)
Socio-Economic Impact Assessment <i>Have you undertaken a Socio-Economic Impact Assessment</i>	Yes: ☐	No: ☒
	Outcome:	n/a
	If no, please include rationale:	This report is purely administrative in nature and submitted for information only. The associated public sector duties are not engaged (there are no associated impacts on any of the protected groups)
<u>Quality</u> <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Enablers of Quality All Apply	This report is purely administrative in nature and submitted for information only. The associated public sector duties are not engaged (there are no associated impacts on any of the protected groups)
<u>Wellbeing of Future Generations Act – Wellbeing Goals</u>	A More Equal Wales	
	<i>If more than one applies, please list below:</i>	
Environmental /Sustainability Impact (5Rs)	No - Not Applicable	
	If more than one applies, please list:	
Armed Forces Covenant Due Regard Duty	Yes: ☐	No: ☒
	Outcome:	N/A

Have you considered the Armed Forces Covenant Due Regard Duty?	If no, please include rationale:	<i>For example, "This report is purely administrative in nature and submitted for information only. The associated public sector duties are not engaged (there are no associated impacts on any of the protected groups)."</i>
Data Protection Impact Assessment <i>Have you undertaken a Data Protection Impact Assessment Screening?</i>	Yes: ☐	No: ☒
	Outcome:	N/A
	If no, please include rationale:	<i>This report is purely administrative in nature and submitted for information only. The associated public sector duties are not engaged (there are no associated impacts on any of the protected groups)</i>
Counter Fraud Impact Assessment <i>Have you considered the counter fraud impacts</i>	Yes: ☐	No: ☒
	Outcome:	N/A
	If no, please include rationale:	<i>This report is purely administrative in nature and submitted for information only. The associated public sector duties are not engaged (there are no associated impacts on any of the protected groups)</i>
Legal	Yes (Include further detail below)	
	There is a risk of contractual breach if rotas do not meet required standards for working hours, rest, and monitoring, particularly in the context of incomplete national Terms and Conditions and reliance on interim processes. Robust governance and oversight are therefore required to ensure consistent and compliant application of the contract as implementation progresses	
Reputational	Yes (Include further detail below)	

	Continued national uncertainty, combined with visible workforce pressures and potential impact on service delivery, may affect stakeholder confidence, including staff, patients, partners, and Welsh Government.
Resource Impact (People / Financial)	Yes (Include further detail below)
	Rota review findings indicate that additional workforce capacity will be required in a number of specialties to achieve compliance, with reliance on bank and agency staffing likely to increase where recruitment is not achievable. This will place sustained pressure on pay budgets and reduce financial flexibility. In addition, delivery of the programme requires dedicated organisational capacity across workforce, operational, finance, and digital teams, creating further pressure alongside competing priorities.



People and Culture Committee

RESPONSIBLE OFFICER DESIGNATED BODY UPDATE REPORT 2025 - 2026

Dyddiad y Cyfarfod Date of Meeting	11 June 2026
Statws Cyhoeddi Publication Status	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad Report Author name and title	Mrs Val Morris Revalidation Manager Dr Evan Moore Associate Medical Director and Deputy Responsible Officer
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol Lead Executive Team Member name and title	Dr Clara Day Responsible Officer and Executive Medical Director
Pwrpas yr Adroddiad Report Purpose	For Noting

Crynodeb Gweithredol **Executive Summary**

This paper provides a summary of the Responsible Officer (RO) function (the Designated Body (DB)), which is held by the Executive Medical Director. This function ensures upholding of professional standards for all doctors and dentists employed by the Health Board, including those in primary care.

The RO function oversees annual appraisal and revalidation for doctors within the Health Board and this paper includes the annual report summarising this activity.

- Overall compliance is good with deferral rate and no late submissions being the best in Wales.
- All levels of assurance are at green except having lay person on revalidation committee.

In addition, this paper provides the following:

- Summary of the constraints identified within Medical Appraisals
- Summary of proposed changes to overview of professional standards to implement the All Wales Fair Concerns Management Best Practice. This is a joint work programme between General Medical Council and the All Wales Medical Directors.



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Ymgysylltu (mewnol/allanol) yr ymgwymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp)

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)

Pwyllgor / Grŵp / Unigolion Committee / Group / Individuals	Dyddiad Date	Canlyniad, Tystiolaeth a Data Outcome, Evidence and Data
Executive Committee	03.06.2026	Noted to go to P&C Committee.

**Acronymau / Rhestr Termiau
Acronyms / Glossary of Terms**

RO	Responsible Officer
DB	Designated Body
GMC	General Medical Council



RESPONSIBLE OFFICER DESIGNATED BODY UPDATE REPORT 2025 - 2026

1. Y SEFYLLFA SITUATION

- 1.1 This paper provides assurance-level information and performance data on medical and dental appraisal and revalidation, including compliance with established protocols and statutory requirements. The annual report requires approval
- 1.2 It also provides an update on other important areas within the Responsible Officer function for information.

2 Y CEFNDIR BACKGROUND

- 2.1 The annual report provides assurance on the effectiveness and compliance of appraisal and revalidation protocols for both primary and secondary care doctors who are included on BCUHB's designated body list. This needs approval by the Executive Committee as below.
- The Executive Committee are asked to assure Welsh Government that BCUHB are compliant with the Medical Profession (RO) regulations 2010 (as amended in 2013)
 - That the Executive Committee is satisfied with the level of assurance of these systems and processes, both now and throughout the year, and the way in which they support and inform revalidation.
 - That the Executive Committee is satisfied with the organisation's progress in terms of revalidation, and that there is a clear plan in place to guide further quality improvements
- 2.2 Other information is included within this report relating to the Designated Body.

3 MATERION PENODOL I'W HYSTYRIED SPECIFIC MATTERS FOR CONSIDERATION

- 3.1 The annual report provides a summary of the activity of the Designated Body for the year 2025-2026.
- 3.2 As of 31/03/2026 1862 doctors had a prescribed connection to BCUHB Designated Body. This includes:
- | | |
|--|-----|
| • GP | 612 |
| • Consultants | 547 |
| • Staff grade, associate specialists, specialist doctors | 244 |
| • Temporary or short-term post holders | 407 |
| • Others included purely management | 2 |
- 3.3 Overall compliance is good with revalidation deferral rate and number of late submissions being the best in Wales.



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3.4 The outstanding action is the appointment of a lay person onto revalidation committee. This is usually held by an Independent Member and will be progressed in discussion with the Director of Governance and the Chair.

4 During the appraisal process, doctors are asked to **identify constraints to best practice at both a personal level and within their workplace.** This is completed by a very large number of BCUHB doctors and is therefore one of the most complete mechanisms of receiving feedback from the medical group. It includes both primary and secondary care doctors. Doctors in training are not included in this process; their feedback is collected via the annual GMC survey and then feedback to the health board

4.1 For BCUHB the following is a summary of constraints identified. These are similar to those raised nationally.

4.2 Summary of constraints identified:

- Secondary care = constrained by internal capacity (staff, beds, infrastructure)
- Primary care = constrained by spillover demand from secondary care

4.3 Workforce vs Demand Pressure

Secondary Care

- Staff-related issues: 712 (largest category)
- Includes shortages across medical, nursing, and admin staff
- Workforce gaps directly limit service capacity

Primary Care

- Workforce issues present but secondary:
- Doctor-related issues: 283
- Staff-related issues: 258
- Dominated instead by rising demand and workload

Key difference:

- Secondary care = capacity constrained by workforce
- Primary care = overwhelmed by demand (partly due to secondary care delays)

4.4 Service Pressure and Patient Flow

Primary Care

- Chronic secondary care constraints eg long waiting lists: 1637
- Acute secondary care constraints eg emergency care / inadequate discharge: 823
- Interface issues eg workload transferred to primary care: 446

Secondary Care

- Waiting lists: 475
- Chronic issues including inadequate numbers of speciality beds, poor access to social services: 452
- Acute issues: 300

Key difference:

- Secondary care experiences service pressure internally



- Primary care experiences the downstream consequences of those pressures

4.5 Infrastructure and IT

Secondary Care

- IT issues: 334 (major category)
- Accommodation and bed pressures also prominent

Primary Care

- IT issues are less prominent
- Infrastructure concerns more about:
 - Premises (172)
 - Practice capacity

Key difference:

- Secondary care = technology and hospital infrastructure constraints
- Primary care = physical capacity and estate limitations

4.6 Nature of Workload

Secondary Care: Workload pressure linked to:

- Staffing shortages
- Job planning (SPA time, overcommitment)

Primary Care: Workload driven by:

- Patient demand growth
- Shifted work from secondary care

4.6.1 Increasing complexity in community

Key difference:

- Secondary care workload = resource-constrained delivery
- Primary care workload = expanding scope and volume of demand

4.7 Personal Constraints

Present in both but not dominant:

Secondary care:

- Life changes (388), job issues (449)

Primary care:

- Life changes (233), time pressures (175)

Conclusion:

Personal constraints are similar and relatively minor compared to system pressures.

4.8 In summary

Secondary care constraints:

- Workforce shortages



- Bed shortages
- Waiting lists and delays

System effect:

- Slower access to treatment
- Bottlenecks in patient flow

Impact on primary care:

- Increased workload
- More follow-up and holding of patients
- Pressure to manage risk in the community

5 **Adoption of All Wales best practice framework for managing concerns about doctors in a fair, consistent, and compassionate way**

- 5.1 The GMC and All Wales Medical Directors have worked together to design a standardised framework to improve how concerns about practice are handled to ensure that doctors are supported, patients are protected, and organisations can be assured of fair processes.
- 5.2 The core approach includes:
- Managing of concerns early and locally where possible
 - Using proportionate escalation only when risks remain
 - Avoiding unnecessary formal or disciplinary processes
- 5.3 These principles have always been at the core of management of professional standards with BCUHB which currently supports local leaders to handle concerns overseen via a Doctors in Difficulties group. This does however sometimes lead to differences of approach by local management.
- 5.4 Standardisation will be overseen by introduction of a number of PAGs (Professional Advisory Groups) to provide advice and consistency at a local level and a ROAG (Responsible Officer Advisory Group) which supports escalation decisions. The Responsible Officer (RO) will make all final decisions

Professional Advisory Group (PAG):

- Provides early advice and support to managers dealing with concerns
- Helps identify options for resolution, focusing on informal, compassionate approaches
- Ensures consistency, fairness, and consideration of bias
- Advises whether escalation is needed to ROAG
- Currently these will remain at IHC level for secondary care with divisional groups as required for Diagnostics, Mental Health and Women's services. A PAG will be established for Primary Care outside of IHC structure recognising the differences in oversight. Following adoption of any proposed changes with Foundations for the Future, PAGs will be changed as required.
- Attendance will include Deputy RO with local medical and workforce colleagues.

5.5 Responsible Officer Advisory Group (ROAG):

- Review concerns that require escalation or formal consideration
- Provides independent advice to the Responsible Officer (RO) from a diverse group of medical and workforce leaders
- Ensures appropriate risk, proportionality, and fairness have been considered



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- Recommends whether formal investigation or further action is needed
- Chaired by Responsible Officer with attendance to include Executive Director of Workforce, Deputy RO and representation from all PAGs. Lay membership will be sought.

5.6 This framework is to be introduced from June 2026 within BCUHB to ensure concerns about doctors are handled early, fairly, consistently, and compassionately, with clear escalation and oversight.

6 **RISGIAU ALLWEDDOL / MATERION I'W HUWCHGYFEIRIO** **KEY RISKS / MATTERS FOR ESCALATION**

6.1 Lay representation is very helpful to add diversity to decision making when considering the function of the Designated Body.

- This is required for the Revalidation Committee; this is usually an Independent Member
- This would be helpful for the responsible officer advisory group; suitable attendees can be health board employees without a professional workforce or medical background

7 **ARGYMHELLION** **RECOMMENDATIONS**

7.1 Gofynnir i'r Pwyllgor/
The Committee is asked to:

- **COMMENT** on the identified constraints.
- **SUPPORT** the introduction of the All-Wales best practice framework for managing concerns.
- **AGREE** to approve the Annual Revalidation Progress Report for 2025-2026.



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ASESIAD / ASSESSMENT	
Cysylltiad â'r Bwriadau Strategol Link to Strategic Intentions	1. Focus on Health and Wellbeing
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Yr Egwyddorion Dylunio Design Principles	Consistency with Organisational Values Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd Corporate Risks and Board Assurance Framework	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)
<u>Deddf Llesiant</u> <u>Cenedlaethau'r Dyfodol -</u> <u>Nodau Llesiant</u> <u>Wellbeing of Future</u> <u>Generations Act – Wellbeing</u> <u>Goals</u>	Not Applicable
	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:

ASESIADAU O EFFAITH / IMPACT ASSESSMENTS		
Cydraddoldeb <i>A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o'r Effaith ar Gydraddoldeb (sy'n cynnwys gofynion Safonau'r Gymraeg)</i> Equality <i>Have you undertaken an Equality Impact Assessment Screening (which includes the requirements of the Welsh Language Standards)</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Asesiad o'r Effaith Economaidd-gymdeithasol <i>A ydych chi wedi cynnal Asesiad o'r Effaith Economaidd-Gymdeithasol?</i> Socio-Economic Impact Assessment <i>Have you undertaken a Socio-Economic Impact Assessment</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
<u>Ansawdd</u> <i>A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?</i> Quality	Galluogwyr Ansawdd Enablers of Quality All Apply	Meysydd Ansawdd Domains of Quality All Apply



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Have you undertaken a Quality Impact Assessment Screening?	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
<u>Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant</u> <u>Wellbeing of Future Generations Act – Wellbeing Goals</u>	A Healthier Wales	

Effaith Amgylcheddol / Cynaliadwyedd (5Rs) Environmental /Sustainability Impact (5Rs)	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
	No - Not Applicable	
Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog A ydych chi wedi ystyried Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog: Armed Forces Covenant Due Regard Duty Have you considered the Armed Forces Covenant Due Regard Duty?	Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:	
	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
Asesiad o Effaith ar Ddiogelu Data A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data? Data Protection Impact Assessment Have you undertaken a Data Protection Impact Assessment Screening?	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
Asesiad o Effaith ar Atal Twyll A ydych chi wedi ystyried yr effeithiau ar atal twyll? Counter Fraud Impact Assessment	Os naddo, dylech gynnwys y rheswm:	
	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	



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<i>Have you considered the counter fraud impacts</i>	If no, please include rationale:	
Cyfreithiol Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw Da Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith ar Adnoddau (Pobl / Ariannol) Resource Impact (People / Financial)	There is no direct impact on resources as a result of the activity outlined in this report.	

REVALIDATION PROGRESS REPORT (RPR) 2025-26

Please be aware that completion of all parts of this report is required.

1.1 Name of Designated Body (DB)	Betsi Cadwaladr UHB
Name of Responsible Officer (RO)	Dr Clara Day
Type of organisation	NHS
Name of person completing this report	Mrs Val Morris
Job title of person completing this report	Revalidation Manager

Part 1 - Appraisal Figures

Appraisal Completion Figures	Number of prescribed connections	Number of doctors exempt from appraisal due to extenuating circumstances	Number of completed appraisals (summary agreed)
General Practitioners	612	48	524
Consultants (including honorary contract holders)	547	22	503
Staff grade, associate specialist, specialty doctor (including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere)	299	44	240
Doctors with practising privileges (for independent healthcare providers only); all doctors with practising privileges who have a prescribed connection should be included in this section, irrespective of their grade)	N/A	N/A	N/A
Temporary or short-term contract holders			

(including trust doctors, locums for service, clinical research fellows, trainees not on national training schemes, doctors with fixed-term employment contracts)	402	134	268
Other (including some management/leadership roles, research, civil service, other employed or contracted doctors, doctors in wholly independent practice, etc.)	2	0	2
Trainee doctor on national postgraduate training scheme (for Deaneries only)	N/A	N/A	N/A

In this section you are required to provide your appraisal completion figures for the period 1st April 2025-31st March 2026. **Only doctors with whom the DB has a prescribed connection should be included in this section. Each doctor should be included in only one category.**

Part 2 – Quality Assurance of Processes

In this section you are required to self-rate your level of assurance against each statement or question. Please select a rating from the drop-down list on the right-hand side of the table and provide evidence in the free text box to support your rating or details on your future development plans.

2.1 Revalidation processes - what level of assurance does the DB have?

2.1.1 there are sufficient support structures in place to support the RO and revalidation team

Level of Assurance (RAG):

GREEN

Evidence for rating assessment / future plans

Dr Clara Day, Executive Medical Director and Responsible Officer (RO), took up post in September 2026.

Dr Evan Moore, Associate Medical Director and Deputy Responsible Officer (DRO), retains delegated responsibility for the Revalidation and Appraisal Portfolio. Acute Site Medical Directors, Primary Care Medical Directors (PCMD), pan BCUHB Mental Health & Learning Disability Medical Director (MH&LD MD), and Women's services Medical Director and Integrated Health Community Medical Directors (IHC MD) support governance processes and the sign-off of revalidation templates prior to revalidation meetings. All colleagues above attend the relevant the following meetings

- Doctors in Difficulty & GMC Fitness to Practice Meetings
- Primary Care Concerns Meetings

These arrangements are currently chaired by the Deputy Responsible Officer (DRO), with attendance from both the Revalidation Manager (RM) and Deputy Revalidation Manager (DRM). Please note these meetings are currently in the process of being restructured to Performance Advisory Groups (PAGs), and Responsible Officer Advisory Group (ROAG).

Revalidation Team Structure

- Three Revalidation Officers (0.8 WTE each) based across the three acute sites
- Deputy Revalidation Manager (0.8 WTE)
- Revalidation Manager (1.0 WTE)

Appraiser Leads

Two Appraiser Leads are currently in post.

Appraiser Lead cover for Ysbyty Gwynedd has been provided through a combination of support from the two other Appraiser Leads at Ysbyty Glan Clwyd and Wrexham Maelor Hospital. A prospective new Appraiser Lead for Ysbyty Gwynedd has been identified and is awaiting funding allocation.

2.1.2 revalidation recommendation decisions are made timely and in line with GMC RO regulations

Level of Assurance (RAG):

GREEN

Evidence for rating assessment / future plans

At 31.3.2026 BCUHB had 1862 doctors attached to their designated body list.

As per GMC explorer tool (please see below;

Designated body	Submitted	% Revalidated	% Deferred	% Non engagement	% Submitted late	Revalidated	Deferred	Non engagement	Submitted late
Betsi Cadwaladr University Health Board	310	98.39%	1.61%			305	5		
Cardiff and Vale University Local Health Board	201	75.62%	24.38%		0.50%	152	49		1
Aneurin Bevan University Health Board	140	87.86%	12.14%		1.43%	123	17		2
Swansea Bay University Health Board	135	82.96%	17.04%		0.74%	112	23		1
Cwm Taf Morgannwg University Health Board	126	63.49%	34.92%	1.59%	0.79%	80	44	2	1
Hywel Dda University Health Board	100	86.00%	14.00%		1.00%	86	14		1
Powys Teaching Local Health Board	11	90.91%	9.09%		9.09%	10	1		1

This year being the 1st in the revalidation cycle is a particularly busy year recommending 310 doctors, 305 positively and having 5 deferrals. We were the only HB in Wales not to submit any late recommendations.

Positive revalidation recommendations are decided by the Deputy Responsible Officer (DRO) at a monthly Revalidation Meeting.

In advance of the meeting, revalidation templates are reviewed and formally signed off by the appropriate senior clinical leaders, including:

- Acute Site Medical Directors
- Mental Health Medical Director
- Women's Services Medical Director
- Integrated Health Community Medical Directors
- Primary Care Medical Directors

The Responsible Officer (RO) is sighted on all cases on a monthly basis prior to recommendations being confirmed, providing senior oversight and assurance.

Where required by timescales or individual circumstances, there is flexibility by the Deputy Responsible Officer to discuss recommendations outside of the scheduled meeting, ensuring timely and proportionate decision-making while maintaining governance integrity.

2.1.3 revalidation deferral decisions are made and managed appropriately

Level of Assurance (RAG):

GREEN

Evidence for rating assessment / future plans

As stated above, the option to discuss revalidation recommendations outside of the scheduled Revalidation Meeting is readily available with both the Deputy Responsible Officer (DRO) and the Responsible Officer (RO) should the need arise, ensuring flexibility and timely decision-making.

Where a deferral is being considered, exceptional circumstances are reviewed in advance and discussed with both the doctor concerned and the appropriate Medical Director, ensuring transparency, proportionality, and adherence to due process.

Katie Laugharne, GMC Employee Liaison Officer, is available to provide specialist support and advice where required, particularly in relation to GMC processes or complex cases.

2.1.4 there are processes in place for reviewing Whole Practice Appraisal (WPA) in the context of appraisal and revalidation

Level of Assurance (RAG):

GREEN

Evidence for rating assessment / future plans

Spire Healthcare and Betsi Cadwaladr University Health Board (BCUHB) continue to maintain well-established and effective communication arrangements. Spire Healthcare provides BCUHB with appropriate and timely documentation for doctors employed by Spire in relation to any concerns, incidents, or significant events, supporting robust information-sharing and assurance for revalidation purposes.

Links have also been established with Bangor University to enable the implementation of a joint appraisal process for doctors undertaking dual clinical and academic roles. To date this continues to have no requests for joint appraisal with universities. In secondary care academic staff submit a university

appraisal for inclusion within their BCUHB appraisal portfolio. However, should such a request be received, appropriate arrangements are in place to support this.

Whole Practice Appraisal (WPA) Awareness and Training

Training and guidance on Whole Practice Appraisal (WPA) are promoted regularly through monthly appraiser workshops, during which Revalidation Support Unit (RSU) guidance, accessed via the Revalidation Wales website, is highlighted and distributed.

In addition, when doctors receive initial training on Medical Appraisal Revalidation System (MARS) by the Revalidation Officers, Whole Practice Appraisal requirements are explicitly discussed. This ensures doctors are aware of WPA expectations, whether applicable at the outset of their appraisal career or at a later stage.

2.1.5 the RO role can be covered in the event of unplanned absence

Level of Assurance (RAG):

GREEN

Evidence for rating assessment / future plans

RO and Deputy RO are able to cover role. No development needs required.

2.1.6 revalidation processes are reviewed for effectiveness and quality, and key issues arising from reviews and quality improvement activity are progressed

Level of Assurance (RAG):

GREEN

Evidence for rating assessment / future plans

A robust three-tier checking and assurance process is in place for each revalidation recommendation to ensure completeness, consistency, and compliance with GMC Responsible Officer requirements.

Tier 1 – Revalidation Team Quality Assurance

The Revalidation Manager (RM) or Deputy Revalidation Manager (DRM) undertakes a comprehensive review of all appraisals within the relevant revalidation cycle to ensure that all required supporting evidence has been appropriately submitted and considered. Where queries are identified—most commonly relating to Quality Improvement Activity (QIA)—these are clearly highlighted and escalated to the relevant Medical Director for clarification as part of this stage of the process.

Tier 2 – Medical Director Review and Sign-Off

Following Tier 1 checks, the completed revalidation templates (excluding final governance sign-off) are shared with the appropriate senior clinical leaders for review. These include:

- Acute Site Medical Directors (ASMDs)
- Mental Health & Learning Disability Medical Director (pan-BCUHB)
- Women's Services Medical Director (pan-BCUHB)
- Primary Care Medical Directors (PCMDs)

All relevant Medical Directors have access to the Medical Appraisal Revalidation System (MARS) to support their review. Medical Directors undertake checks informed by Clinical Director input and local clinical governance arrangements. Where satisfied, the revalidation template is signed off. Any queries arising at this stage are responded to by the Revalidation Team, with Deputy Responsible Officer (DRO) input as required.

Tier 3 – Deputy Responsible Officer Review and Recommendation

A consolidated Revalidation List, together with the relevant signed revalidation templates, is then submitted to the Deputy Responsible Officer (DRO) in the week preceding the scheduled Revalidation Meeting. This enables advance review of:

- Recommendations to be confirmed at the meeting
- Any cases requiring discussion

- Any additional matters arising

Following the Revalidation Meeting, the finalised revalidation list and recommendations are formally submitted to the Responsible Officer (RO). These are signed by the DRO and shared immediately post-meeting, providing timely assurance and accountability.

2.1.7 all revalidation processes consider equality, diversity and inclusivity issues and are fair and non-discriminatory	Level of Assurance (RAG):	GREEN
Evidence for rating assessment / future plans		
Ceri Harris, Head of Equality and Human Rights, outlined Betsi Cadwaladr University Health Board's (BCUHB) ongoing commitment to improving the experiences of service users, colleagues and the wider population of North Wales. This commitment is grounded in respect for people's identities, rights and lived experiences and is informed by an intersectional approach that recognises how barriers can arise through the interaction of multiple protected characteristics, socio-economic disadvantage and wider structural inequalities. This approach is embedded across our Strategic Equality Plan (SEP) 2024–2028 and underpins our work to advance fairness, inclusion and human rights in line with Welsh Government priorities. Through delivery of our Strategic Equality Objectives and Action Plan, BCUHB continues to implement Welsh Government–mandated equality action plans, supporting national outcomes set out in <i>Anti-racist Wales</i>, the <i>LGBTQ+ Action Plan</i>, the <i>Women's Plan for Wales</i> and the <i>Disabled People's Rights Plan</i>. Progress against these commitments is routinely reviewed through the Equality and Human Rights Strategic Forum, which provides senior leadership oversight and includes representation from third-sector partners, supporting effective challenge, accountability and co-production. Over the past year, we have actively supported implementation of the <i>Women's Plan for Wales</i>, contributing to actions that promote gender equality, safety, health equity and fair work. We also welcomed the publication of the <i>Welsh Government Disabled People's Rights Plan</i>, aligning our work with its social model of disability and rights-based approach, and supported the revision and expansion of the <i>Accessible Communication and Information Standards</i> to improve access, autonomy and patient experience. Collectively, this activity contributes to SEP objectives relating to equitable access, inclusive service design and the reduction of health and workforce inequalities. During 2024–2025, we further strengthened our approach to evidence-based improvement through enhanced analysis of data from our equality reporting dashboard and NHS Staff Survey intelligence. This enables improved monitoring of workforce experience and outcomes across all protected characteristics and supports delivery of SEP objectives relating to fair treatment, workforce equality and transparency. BCUHB has established a Health Board–focused		

Workforce Race Equality Standard (WRES) Task and Finish Group and continues to chair an All-Wales group, learning from and sharing best practice informed by the first two Welsh WRES reports. This learning will directly inform the development of the new Workforce Equality Standard, with a stronger focus on intersectionality as we move into Year 3 of our Strategic Equality Plan.

The Health Board's pay gap reporting has also expanded to include gender, race and disability, with the publication of our first Disability Pay Gap Report this year. This work supports SEP objectives and Welsh Government fair work ambitions by enabling the identification of pay inequalities and informing actions to improve progression, development and opportunity. In parallel, our People Services teams continue to enhance the quality and accessibility of reporting and analysis on disciplinary, grievance and harassment processes within ESR systems, strengthening our ability to identify and address disproportionate outcomes.

BCUHB continues to promote Speak Up Safely, staff wellbeing services and staff networks as key enablers of psychological safety and inclusion. During the year, we expanded our staff network offer through the establishment of a Neurodivergent Staff Network, alongside the development of tailored resources to promote understanding, reasonable adjustments and inclusive practice. This contributes to SEP objectives relating to inclusive workplaces and aligns with the principles of the Disabled People's Rights Plan.

We are also proud of our coproduced work with Public Health colleagues addressing homelessness, ensuring equality, human rights and lived experience are central to planning and delivery. This work supports both SEP objectives and wider Welsh Government commitments to tackling inequality, poverty and social exclusion.

Building on increased visibility during 2025, the Equality and Human Rights Team has continued to engage with communities through participation in cultural events and celebrations, alongside leading internal activity. This includes coproduction with community stakeholders to deliver two equality-focused Health Fairs—one addressing LGBTQ+ health needs and the other exploring ethnic minority experiences of accessing healthcare services. The content and focus of these events were shaped directly by people with lived experience, ensuring relevance and authenticity. Feedback from participants was overwhelmingly positive, with attendees reporting that they felt both seen and heard. Further information on these activities and progress against SEP objectives is available within the Equality Annual Report. [BCUHB StrategicEqualityAnnualReport 24-25 V0.3 Final.docx](#)

From the above initiatives which are happening throughout BCUHB doctors are treated equitably, and respectfully whether substantive consultant or FY1 LAS bank doctor. All have access to the same training and 'open door' policy from the revalidation team members.

2.1.8 the DB takes into consideration public and patient views regarding revalidation processes

Level of Assurance (RAG):

AMBER

Evidence for rating assessment / future plans

There is currently lay representation on the Board of BCUHB, which oversees the revalidation process. The Executive Medical Director has approached the Chair of the Health Board, to request a lay representative on the revalidation decision making committee.

Lay representation is currently in place at BCUHB Board level, providing independent oversight of the organisation's revalidation arrangements.

To further strengthen transparency and public assurance within revalidation decision-making, the previous Executive Medical Director has approached the Chair of the Health Board to request the inclusion of a lay representative on the Revalidation Decision-Making Committee. This proposal reflects a commitment to enhanced governance, independence, and alignment with best practice in assurance processes.

2.1.9 the DB engages with national activity relating to revalidation (e.g., Wales Revalidation Appraisal Group (WRAG) and RO meetings, quality assurance events)

Level of Assurance (RAG):

GREEN

Evidence for rating assessment / future plans.

The Deputy Responsible Officer (DRO), Revalidation Manager (RM), and Deputy Revalidation Manager (DRM) maintain regular attendance at national and regional forums, including WRAG, RQA, and RAC events, ensuring continued alignment with best practice, policy developments, and system-wide learning. The Revalidation Managers and Appraiser Leads facilitate annually at the Quality Assurance event, contributing to training, discussion of assurance standards, and dissemination of national guidance.

In addition, the DRO attends the Responsible Officer (RO) Network Group WROG, supporting peer engagement and statutory RO assurance.

Appraiser Leads attend national Appraiser Lead meetings, alongside the Revalidation Manager and Deputy Revalidation Manager, contributing to shared learning, standardisation, and continuous improvement of appraisal practice across Wales.

The Revalidation Manager has volunteered to participate in the working group for the new Single Platform software, supporting the development and implementation of the CODI platform. The Revalidation Team currently utilises a range of software systems that will migrate into CODI, and engagement in the working group provides early insight, influence, and operational readiness for transition.

The Revalidation Manager has also agreed to be on a working group to re-design the RSU's scoring sheets for the RQA event, and what the revalidation team also utilise when undertaking local quality assurance.

2.1.10 thresholds applied for revalidation recommendations are in line with those of other DBs

Level of Assurance (RAG):

GREEN

Evidence for rating assessment / future plans.

The Deputy Responsible Officer (DRO) attends Responsible Officer (RO) networking events, supporting shared learning, peer support, and alignment with national Responsible Officer expectations.

The Revalidation Manager (RM) and Deputy Revalidation Manager (DRM) attend Wales Revalidation Advisory Group (WRAG) meetings, ensuring awareness of national developments and consistency with GMC and All-Wales policies and processes, which are embedded within local revalidation arrangements.

Attendance at Primary Care Appraisal Quality (AQ) meetings, with representation from the Revalidation Support Unit (RSU), supports continuity and consistency of appraisal and revalidation processes across Wales. As part of service development, actions arising from these meetings are now managed directly by the Revalidation Team, rather than the Primary Care Health Board Team, providing clearer accountability and streamlined follow-up.

Appraiser Lead meetings are attended by the Revalidation Manager, Deputy Revalidation Manager, and Appraiser Leads, when clinical duties allow. This ensures effective communication, shared oversight, and coordinated leadership across appraisal and revalidation activity.

The Swansea Bay Revalidation Team has re-established the Revalidation Manager and Support Team Group, with strong support from the BCUHB Revalidation Manager. This forum provides a structured opportunity for collaborative discussion and shared learning across organisations, including consideration of protocols, forthcoming national and local events, the implementation of the CODI Single Platform, staff wellbeing, and operational challenges experienced by teams.

Within BCUHB, an Appraisal and Revalidation Support Officer attend this group on a rotational basis, supporting equitable access and fair representation across the team. This approach also contributes to succession planning, enabling increased understanding of regional revalidation arrangements and fostering resilience within the Revalidation Team. Various discussions are then raised in the next WRAG meeting.

Please outline any areas identified for development relating to **2.1 Revalidation Processes**

BCUHB continues to operate robust and well-embedded revalidation processes, underpinned by strong governance arrangements and adhering to national guidance.

The Health Board actively seeks to adopt and embed best practice shared through engagement with other Health Boards. This collaborative approach was specifically encouraged by the Revalidation Support Unit (RSU) during the most recent Quality Assurance visit, and BCUHB remains fully engaged in contributing to continuous improvement across Wales.

2.2: Underpinning systems: appraisal – what level of assurance does the DB have?

2.2.1 there is sufficient support for doctors to enable them to be appraised? Including number of available Appraisers, information about appraisal, support with MARS, access to relevant data etc.	Level of Assurance (RAG):	GREEN
Evidence for rating assessment / future plans		
Revalidation Officers are based across the three acute hospital sites, providing both face-to-face and virtual training and support. They also offer flexibility by delivering training in satellite hospitals throughout BCUHB, ensuring equitable access for doctors working across the organisation. Revalidation Officers provide ongoing individual support, and doctors are actively encouraged to engage with them throughout their appraisal and revalidation cycle.		

A face-to-face experience has shown that this format encourages reflection and dialogue, often raising additional questions that enhance understanding and appraisal quality.

All doctors are issued with supporting information in the month prior to the commencement of their Appraisal Quality (AQ) process. This includes:

- Postgraduate education attendance
- A named contact for CHKS data
- A reminder to declare any directives issued

Revalidation templates also include confirmation of whether job plans are current and up to date, supporting assurance around scope of practice.

Doctors whose revalidation date falls within 18 months of joining BCUHB receive a welcome letter from the Deputy Responsible Officer (DRO) outlining the requirements for a successful revalidation recommendation, and to forward any previous appraisal summaries from their previous designated bodies. To the Appraisal and Revalidation Management.

On commencement of employment with BCUHB, **all doctors**—including locums, permanent staff, FY1 LAS doctors, and consultants—are contacted consistently and advised to:

- Register on the Medical Appraisal Revalidation System (MARS)
- Attend an introductory appraisal and MARS training session

Refresher training is actively promoted for doctors who require additional support, are returning to appraisal, or have experienced changes in role, practice, or MARS functionality.

Face-to-face introduction to Revalidation Officers enables doctors to establish a named, ongoing point of contact, fostering continuity, trust, and long-term engagement with appraisal and revalidation throughout their career at BCUHB.

Appraiser Workforce and Capacity

Appraisers are encouraged to incorporate appraisal discussion into job-planning meetings, supporting alignment between workload, scope of practice, and appraisal expectations.

BCUHB currently has sufficient appraiser capacity, although some appraisers undertake significantly more than the mandatory minimum of five appraisals per year, particularly Appraiser Leads and more experienced appraisers.

The option of virtual appraisal supports efficiency and sustainability, reducing travel time and car-parking pressures across BCUHB's large geographical footprint.

BCUHB had at 31.3.26;

- 127 secondary care appraisers (at 31.3.25)
- 1,120 secondary care appraisals completed annually (this includes secondary care maxillo facial dentists and Physicians Assistants) ¹

This equates to an average of approximately nine (8.81) appraisals per appraiser, with Appraiser Leads and experienced appraisers consistently undertaking activity above the minimum required levels.

Recruitment of new appraisers remains ongoing throughout the year and is supported through:

- Internal newsletters
- Engagement by Appraiser Leads
- Direct approach by Revalidation Officers to suitable candidates

However, a targeted recruitment drive was undertaken towards the end of 2025, with all departments asked to review and confirm that they had sufficient appraiser capacity in relation to their non-training grade medical workforce.

As a result of this initiative and ongoing recruitment, 31 appraisers were recruited during 2025–2026. At the time of reporting:

- 12 appraisers are fully trained and active
- 13 appraisers are currently completing Revalidation Support Unit (RSU) training modules
- 4 candidates have subsequently withdrawn due to service pressures or lack of funding for the role

¹ Number of appraisals taken from BCUHB database which shows all appraisals undertaken between 1.4.25 – 31.3.26 (including those not currently on DB list, and those who have left BCUHB)

- 2 further candidates are scheduled to commence training in the near future

To ensure equity of appraisals for appraisers – a database has been set up by the Appraisal and Revalidation Officers which shows how many appraisals each appraiser has undertaken – this is updated bi-weekly to direct appraisees to appraisers who are not meeting their minimum of 5 appraisals a year.

To ensure equity, sustainability, and appropriate distribution of appraisal workload, the Appraisal and Revalidation Officers have developed and maintain a central appraisal activity database. This records the number of appraisals completed by each appraiser and is updated on a bi-weekly basis.

The database is actively used to:

- Monitor compliance with the minimum requirement of five appraisals per appraiser per year
- Support fair allocation of appraisees
- Direct doctors requiring an appraiser towards those who are currently below their annual appraisal activity threshold

This approach provides additional assurance regarding workload balance, appraiser engagement, and effective use of available capacity.

The annual Appraiser Survey Results confirmed that appraisers are supported with the appraisal and revalidation processes. 60 responses were received. (7 Primary Care, 53 secondary care)

What topics would you like to see in the future Appraiser training and resources? – you said we did.

You said	We did
• How to add value	• Through local QA days – feedback given on a one-to-one basis to appraisers who struggle with this. Also discussed in monthly appraiser workshop
• Managing deficit appraisees	• Covered in 2025 appraiser workshop

• Updates on appraisal process	• Through quarterly newsletter and also appraiser workshops updated on monthly basis.
• Appraisal in difficult situations/ consultant who is not engaging	• Covered in 2025 monthly appraiser workshop
• Case studies	• Covered in 2025 & 2026 monthly appraiser workshop
• Quality Improvement activity and what is acceptable? Examples that are not audits •	• Covered in monthly appraiser workshop in 2025 – advised in 2026 workshop of new QIA guidance which will be forthcoming shortly.
• How to work with doctors who have had GMC transactions, ill health and directives	• Covered in monthly appraiser workshop in 2026
• Newsletters and updates	• Quarterly newsletter issued, along with noticeboards having same information.
• The current format is good and useful	• Feedback gratefully received
• Bringing face to face training back	• The monthly appraiser workshop is face to face and has been since 2022, it is held on a rolling basis on the 3 acute sites – appraisers can attend any site.

2.2.2 there is a robust induction process for doctors including appraisal and revalidation guidance for the organisation

Level of Assurance (RAG):

GREEN

Evidence for rating assessment / future plans

The Revalidation Managers' access to the Electronic Staff Record (ESR) enables the timely identification of new starters, leavers, and changes in role or post. A weekly download of workforce data is undertaken to maintain an accurate and current doctors who should be on BCUHB's designated body list.

From this, exception and breach reports are generated and shared with Appraisal and Revalidation Officers, enabling proactive engagement with doctors who are approaching the end of their Appraisal Quarter (AQ) or who are overdue.

Access to TRAC, Medical Register, Medical Performers list (MPL) is used daily to establish where the doctor is employed.

At the point of initial registration on MARS, doctors are required to attend a structured MARS training session delivered by the Appraisal and Revalidation Officers via Microsoft Teams or face- to -face. These sessions are also routinely promoted to doctors requiring a refresher, support following changes in practice, or assistance with updated system functionality. An open-door policy is adopted by all of the Appraisal and Revalidation Team.

Early and visible identification of the Appraisal and Revalidation Team to newly appointed doctors—through face-to-face contact wherever possible—ensures that each doctor is linked to a named Appraisal and Revalidation Officer who will provide continuity of support throughout their appraisal and revalidation cycle. Ongoing face-to-face and virtual engagement is actively encouraged, with the team placing strong emphasis on relationship-building, accessibility, and sustained professional rapport.

Where a doctor's revalidation date falls within 12–18 months of their commencement with BCUHB, a welcome letter is issued by the Deputy Responsible Officer (DRO). This initiates early engagement by the Revalidation Manager and Deputy Revalidation Manager to request and review appraisal information **from** previous employing Health Boards, where applicable. This approach ensures continuity, supports early identification of outstanding requirements, and enables the provision of timely, tailored advice to facilitate a successful revalidation recommendation.

Transfers of Information (TOI) are monitored on a weekly basis, with follow-up reminders issued as required to ensure completeness and accuracy of appraisal and revalidation records.

2.2.3 all doctors requiring appraisal are appraised when they should be

Level of Assurance (RAG):

GREEN

Evidence for rating assessment / future plans

A weekly database is produced to monitor breaches which is issued to Revalidation Officers every Friday. This database identifies:

- Doctors who are overdue for appraisal or revalidation action
- Doctors awaiting submission of their appraisal summary
- Doctors with no appraisal meeting date scheduled for the current quarter

The database is updated weekly, with clear notes recorded to reflect actions undertaken and progress made.

To ensure a consistent and transparent approach to managing non-compliance, formal escalation columns have been incorporated into the database. These define agreed thresholds for escalation to:

1. Appraisal and Revalidation Managers
2. Clinical Lead
3. Medical Director
4. Deputy Responsible Officer (DRO) and, where necessary, the Responsible Officer (RO)

This framework provides clarity and equity in decision-making across all specialties and sites.

Revalidation Officers, based on each acute hospital site, provide ongoing advice and support to all doctors. They proactively contact new starters to:

- Advise registration on MARS
- Offer appraisal and MARS training, delivered virtually via Microsoft Teams or face-to-face, as requested.

For Primary Care, the Appraisal Quality (AQ) GP Meeting identifies GPs who are on maternity leave, have extenuating circumstances, or are non-compliant with appraisal requirements. The Primary Care Medical Directors (PCMD), HEIW Appraisal Officer, and Revalidation Manager work collaboratively, sharing appropriate information regarding:

- Adjustments to AQ dates
- Long-term sickness absence
- Maternity leave
- Doctors temporarily working abroad

HB1 matters are discussed both within the scheduled quarterly meetings and, where required by timing or risk, outside of formal meetings to ensure timely oversight.

The Revalidation Team works closely with the HEIW Appraisal Officer to maintain accuracy and alignment across the Medical Performers List (MPL), Designated Body listings, and MARS records. In addition, a regular audit is undertaken to identify any doctors not recorded across all relevant systems, enabling prompt reconciliation and assurance of data completeness.

2.2.4 reasons for non-completion are documented, and non-engagement is managed appropriately	Level of Assurance (RAG):	GREEN
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Evidence for rating assessment / future plans

Detailed timelines, correspondence, and documented offers of support are recorded within the breaches report and are updated weekly to reflect actions taken and progress made.

Where non-engagement persists, the formal escalation pathway is followed through the Appraisal and Revalidation Managers, Clinical Director, Medical Director, and Deputy Responsible Officer (DRO). As part of this process, assurance is sought and recorded that no exceptional circumstances (including sickness or significant personal issues) have been declared by the doctor.

Where appropriate, formal correspondence is issued by the DRO, requiring the doctor to engage with the appraisal and revalidation process by a specified deadline. Doctors are also explicitly offered the opportunity to declare any exceptional circumstances directly to the DRO.

If a doctor fails to engage by the agreed deadline, a further discussion takes place between the DRO and the Revalidation Manager, and the Employer Liaison Adviser (ELA) is notified regarding the potential submission of a Revocation of Licence (REV6) recommendation to the GMC.

Where engagement subsequently commences, the Revalidation Managers review submitted evidence and provide an update to the DRO and RO. The GMC is informed accordingly, ensuring that regulatory records accurately reflect the doctor's engagement status and progress.

2.2.5 Appraisers are fit for purpose, appropriately trained and up to date	Level of Assurance (RAG):	GREEN
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Evidence for rating assessment / future plans

An annual audit is undertaken to review and cleanse the appraiser pool, ensuring that appraisers remain active, appropriately trained, and compliant with appraisal requirements.

Ongoing checks are conducted throughout the year to confirm that all appraisers are completing the minimum requirement of five appraisals per annum. Where variation is identified, Appraisal and Revalidation Officers actively direct appraisees to appraisers who are below the minimum threshold, supporting equity of workload and sustained appraiser engagement.

Mandatory annual attendance at either a local or national appraiser training event is encouraged and formally recorded. Appraiser workshops and training opportunities are promoted quarterly via internal newsletters and targeted email communications to maximise awareness and uptake.

Appraiser Quality Assurance (QA) days were introduced in October 2022 and are held on a quarterly basis.

Prior to face-to-face QA meetings, the Revalidation Team completes an initial review of the selected appraisers. Appraisers are randomly selected via MARS, and three appraisals per appraiser are formally assessed using the AQA Scoring Template.

In addition, Appraiser Leads provide structured qualitative feedback to appraisers using the standard feedback template. During the current year:

- 40 appraisers have been quality assured, totalling 120 appraisals
- Feedback is given by the Appraisal and Revalidation Manager and Deputy Manager

Feedback includes:

- Review of the appraiser's biographical profile on MARS
- Confirmation of up-to-date annual CPD compliance
- And all elements on RSU scoresheet

Where appraisers do not meet expected standards, targeted one-to-one development and support is provided by the Revalidation Manager and Deputy. Subsequent appraisal summaries are monitored to assess improvement, with outcomes recorded and fed back to the appraiser to support sustained quality improvement.

During the reporting period 1 April 2025 to 31 March 2026, a total of 12 local appraiser workshops were delivered:

- Four workshops per acute site
- Delivered on different days of the week
- Offered at varied times (morning and afternoon) to improve accessibility

Workshops were delivered face-to-face, and appraisers were able to attend at any site most convenient to them, irrespective of base location.

2.2.6 Appraisers are supported and managed in their role, and are performing the role appropriately

Level of Assurance (RAG):

GREEN

Evidence for rating assessment / future plans

All Appraisers and Appraiser Leads have formal job descriptions in place and are actively encouraged to discuss their appraisal role as part of the job planning process, supporting clarity of expectation and appropriate recognition of appraisal activity.

The programme of local appraiser workshops continues (as outlined previously), providing regular opportunities for development, peer discussion, and updates on appraisal and revalidation requirements. The Appraisal and Revalidation Team and Appraiser Leads remain available to provide additional support and advice where required.

Strong and collaborative working relationships continue to be developed with the Primary Care Unit, General Practice Medical Directors, and GP Appraiser Co-ordinators, based on mutual support and shared oversight across appraisal and revalidation processes.

Quality Assurance (QA) days are held on a quarterly basis, with structured feedback provided to appraisers following review. To support consistency and clarity, standardised appraisal checklists have been developed and issued to both appraisers and appraisees through workshop sessions, reinforcing expectations and supporting appraisal quality.

2.2.7 appraisal outputs (summary and PDP) meet agreed standards	Level of Assurance (RAG):	GREEN
Evidence for rating assessment / future plans		
Revalidation Support Unit (RSU) Quality Assurance (QA) events are used to reinforce national expectations and required standards for appraisal practice. Structured feedback is provided to appraisers following these events, including recognition of high-quality appraisals and targeted feedback where appraisals score less well. Themes and trends identified through local Quality Assurance Days are routinely analysed and used to inform continuous improvement. Learning from these reviews is incorporated into appraiser workshop content, ensuring that emerging best practice is shared consistently. Areas of focus have included: • Effective use of action points • Completion and quality of appraiser biographical profiles (biopics) • Clear and SMART Personal Development Plan (PDP) entries • Structured presentation, including numbering of achievements within appraisal summaries Appraiser Workshop Programme 2025 The January 2025 – December 2025 Appraiser Workshop Programme addressed a comprehensive range of topics to support appraiser competence, consistency, and confidence. Content included: • National and local updates • Key policy and guidance documents • How BCUHB is performing in appraisal and revalidation • New MARS updates • CPD and scenario		

- Quality Improvement Activity and scenarios
- Significant Events and scenario
- Difficult situations – scenarios
- Projects undertaken by Appraisal and Revalidation team – 360 project QA project
- Identify new appraisers

This structured and responsive approach ensures that appraisal practice continues to align with national standards, local governance expectations, and evolving regulatory requirements, while providing appraisers with clear guidance, feedback, and ongoing professional support.

Appraiser Workshop Programme 2026

- Supportive message from RO and Deputy RO
- National and local updates, QIA guidance, WPA guidance, post appraisal survey, Revalidation in Wales Website reviewed, CODI
- RSU Appraisal QA Event – what to work on
- How BCUHB is performing in appraisal and revalidation
- Physician Associates update
- Declarations
 - Scope of work
 - Whole Practice Appraisal – scenario
 - Constraints – scenario
 - Directives and suggestions - scenario
 - Health Declaration – scenario
 - Safeguarding
 - Mandatory Training
 - Training Roles and declarations
 - PDP – tips
 - Identify new appraisers

2.2.8 appraisal and its outputs are having a positive impact on individuals and on the organisation	Level of Assurance (RAG):	GREEN
Evidence for rating assessment / future plans		

A strong focus on doctor wellbeing, both during the appraisal process and in the lead-up to appraisal, is embedded within local appraisal and revalidation arrangements. Wellbeing considerations are routinely addressed through appraiser workshops and form part of the discussions undertaken when Appraisal and Revalidation Officers meet with doctors.

Extenuating circumstances are recognised and sensitively considered throughout the appraisal and revalidation process. Where a doctor wishes, these matters may be discussed within the appraisal itself and/or directly with the Appraisal and Revalidation Team, particularly in cases where an appraisal has not been undertaken within the relevant Appraisal Quarter (AQ).

The Appraisal and Revalidation Team and Appraisers provide a safe, confidential, and neutral environment in which doctors are able to discuss wellbeing concerns, both personally and professionally. This supportive approach encourages openness and early engagement, helping to mitigate the impact of difficulties on appraisal and revalidation outcomes.

A directory of wellbeing signposting resources is regularly reviewed and updated and is issued at the conclusion of each appraiser workshop to ensure that both appraisers and doctors are aware of available support services.

The ongoing development of trusting professional relationships between doctors and the Appraisal and Revalidation Team is recognised as fundamental to effective revalidation support. Early engagement, visibility, and continuity of open door contact, and swift responses enable the establishment of trusted connections that support wellbeing and professional development.

Refresher training, alongside structured training for newly appointed doctors, is offered on an ongoing basis by the Revalidation Team. This supports improved understanding of appraisal requirements, promotes reflective practice, and assists doctors in planning and managing their career development effectively within a supportive and well-governed appraisal framework.

Please outline any areas identified for development relating to **2.2 Underpinning systems: appraisal**

Feedback and updates are routinely provided to Appraiser Leads through scheduled meetings at appropriate intervals, ensuring shared situational awareness, consistency of approach, and responsive leadership.

Quality Assurance (QA) Days are undertaken on a quarterly basis, 120 appraisals are reviewed across 30 appraisers have been QA'd this year. Appraisals are formally scored using the agreed QA framework. Individualised one-to-one feedback is provided directly to each appraiser, incorporating input and reflective feedback from the Appraiser Lead, to support continuous improvement and consistency in appraisal quality.

The Appraiser Workshop Programme for 2026–2027 has been reviewed, redesigned, and updated to reflect national guidance, local QA findings, feedback from the Appraiser Survey, and evolving appraisal and revalidation requirements.

ORBIT Project: Revalidation Officers contact all doctors at year three of their revalidation cycle to encourage early completion of ORBIT 360 feedback. This is then monitored and followed up when the Revalidation Manager and Deputy Revalidation Manager begin formal revalidation preparation 18–24 months prior to the revalidation date.

Biopic Project: A programme is in place to ensure that all appraisers maintain a current biographical profile (biopic) on MARS. Annual email prompts are issued to appraisers who do not have a biopic or require updates. Biopic requirements are also reinforced during appraiser workshops, and at initial training the appraiser is encouraged to input their biopic.

Quarterly newsletters are issued to both appraisers and appraisees, providing updates, guidance, learning from QA activity, and signposting to support resources.

Training and workshop activity for Physician Associates (PAs) has been developed and delivered, including work to identify and support PA appraisers, ensuring parity of support and governance across professional groups. All PAs due until end of June 2026 have been added to MARS and are matched with an appraiser (medical doctor). Their AQ has fallen in line with their PADR to try to reduce the PAs work.

The Revalidation Managers have undertaken 3 presentation for SAS LED doctors on the invitation of the SAS Tutor for BCUHB, it was undertaken on each of the 3 acute sites and was a development day, advising of useful tips, and progression to consultant grade. Several appraisers were recruited from these days.

2.3: Underpinning systems: governance. What level of assurance does the DB have:

2.3.1 That appropriate checks, including regarding their appraisal status and any outstanding concerns, are carried out prior to establishing a connection with a doctor?

Level of Assurance (RAG):

GREEN

Evidence for rating assessment / future plans		
Transfer of Information (TOI) requests are issued to the doctor's previous Health Board (HB) upon commencement of employment at BCUHB. Where responses are outstanding, reminders are issued on a monthly basis to ensure timely completion. Escalation is made should any concerns be raised by the previous HB. All TOIs issued by BCUHB are reviewed and confirmed by the appropriate Medical Director for the relevant specialty and area. Confirmation is recorded on a central database, and further reminders are generated as required to maintain oversight and completion. Completed TOIs are sent to the new HB. Doctors are required to declare any outstanding concerns at both the application and interview stages. This ensures transparency and early identification of any issues that may impact employment or revalidation. The central mailbox MedicalAppraisals@wales.nhs.uk receives all correspondence from the General Medical Council (GMC). This mailbox is monitored several times daily by both the Revalidation Manager and Deputy Revalidation Manager. This process ensures that additions to and removals from the designated body list are accurate and actioned promptly. Investigations are undertaken where required to confirm that a doctor has commenced employment with BCUHB and is not working as an agency doctor. The Revalidation Manager, Deputy Revalidation Manager, and MEDACs staff have developed a strong and effective working relationship. MEDACs proactively prioritise revalidation-related queries, supporting timely updates and prompt removal of doctors who are not actively working within BCUHB. The Revalidation Team Managers have direct access to ESR, TRAC, the All-Wales Medical Performers List (MPL), and CODI. This access enables independent verification of employment status and significantly reduces administrative delays. As a result, man-hours are saved, dependency on external email responses is reduced, and the BCUHB designated body list is kept up to date and accurate.		
2.3.2 That the DBs GMC Connect list is up to date (in terms of both joiners and leavers), and cross-checked against your staff records and / or the MPL?	Level of Assurance (RAG):	GREEN
Evidence for rating assessment / future plans		
An Access database is used by the Revalidation Managers to triangulate data from multiple sources to ensure accuracy and completeness of doctor records. These sources include GMC Connect, MARS, MARS GP, ESR, ESR Starters listings, ESR Leavers listings, and the ESR Movement List. In		

addition, the Revalidation Team Managers have access to the Medical Performers List (MPL), TRAC, and CODI, enabling robust cross-checking of employment and practice status.

Regular audits are undertaken to establish and maintain accurate links between GP MARS, the All-Wales Medical Performers List (MPL), and BCUHB's Designated Body. These audits provide assurance that doctors are correctly aligned to the appropriate designated body and are practising within Wales.

As part of an annual exercise, the Revalidation Manager contacts over 150 GPs were contacted in the 2024- 2025 cleanse to request their most recent appraisal summary. These GPs are recorded on BCUHB's MPL but are not currently aligned to BCUHB as their designated body. The 2025 -2026 has been delayed by NWSSP (usually issued in December 2025 – has still not as yet been issued).

All appraisal summaries received are reviewed and either approved or not approved by the Primary Care Medical Directors for East, West, and Central.

This structured exercise strengthens collaborative working between the Revalidation Team Managers and NWSSP, enhances the accuracy of designated body records, and ensures appropriate governance of GP revalidation arrangements across Wales.

2.3.3 That where concerns arise about doctors with whom you have a prescribed connection, these are managed and inform the revalidation recommendation appropriately?

Level of Assurance (RAG):

GREEN

Evidence for rating assessment / future plans

Any concerns identified in relation to doctors connected to BCUHB's Designated Body list are appropriately escalated to the Deputy Responsible Officer (DRO) and the Responsible Officer (RO) in line with established governance arrangements.

The DRO chairs the Doctors in Difficulty **and** GMC Fitness to Practise/ PAG meetings for both primary and secondary care doctors. These meetings provide a formal forum for the review, management, and oversight of professional concerns and regulatory matters. ROAG meetings once set up will be between RO & DRO.

The Revalidation Manager and Deputy Revalidation Manager attend all meetings, managing the administration, ensuring continuity between revalidation processes and wider clinical governance arrangements. This enables timely information sharing, appropriate escalation, and alignment of decisions relating to doctor appraisal, revalidation, and fitness to practise.

Strong and effective working relationships exist between the Revalidation Team Managers, Clinical Governance teams, Workforce, and the NHS Resolution representative. These close links enhance the robustness of the support and oversight network, ensuring that concerns are managed consistently, appropriately, and in accordance with national and local policy.

2.3.4 That should concerns arise during the appraisal process, these will be shared and managed appropriately?	Level of Assurance (RAG):	GREEN
Evidence for rating assessment / future plans		
Appraiser Leads meet regularly with the Revalidation Team Managers, providing an established forum for discussion, support, and early identification of any emerging concerns arising through appraisal processes. Where a concern requires escalation, it is referred to the appropriate Medical Director in accordance with agreed escalation pathways. The Deputy Responsible Officer (DRO) is available to provide additional oversight and support as required. The Revalidation Team Managers play an active role in supporting Appraiser Leads throughout this process and vice versa, facilitate the timely and appropriate escalation of concerns. This ensures consistency, clarity of process, and alignment with wider revalidation and clinical governance frameworks.		
2.3.5 That should concerns arise about a doctor who works for the DB but does not have a prescribed connection with the DB, or no longer has a prescribed connection with the DB, this information is shared appropriately between organisations?	Level of Assurance (RAG):	GREEN
Evidence for rating assessment / future plans		

Where a doctor who has an ongoing, previous investigation or concerns transfers to a new Health Board, the Responsible Officer (RO) of the receiving organisation is formally informed by the RO or Deputy Responsible Officer (DRO) and/or the appropriate Medical Director for the relevant specialty and site.

This notification is undertaken via the Transfer of Information (TOI) form, ensuring that all relevant information is shared in line with GMC requirements. Where necessary and appropriate, this process is supported by a follow-up telephone discussion to ensure clarity, continuity, and effective handover of any pertinent information.

2.3.6 That governance information is consistently available relating to all doctors, including for example those who work within the DB for a short period of time?

Level of Assurance (RAG):

GREEN

Evidence for rating assessment / future plans

All relevant systems are interrogated on a weekly basis to triangulate data and ensure that full, accurate, and up-to-date information is maintained. Systems reviewed include GMC Connect, ESR, ESR Starters listings, ESR Leavers listings, ESR Movement reports, and MARS for both medical and GP doctors.

Ongoing collaboration with MEDACS, who employ on behalf of BCUHB, continues to support the accuracy of workforce and designated body data. This collaborative approach ensures timely resolution of discrepancies and effective information sharing.

The Access database enables information requests from a variety of internal and external sources to be extrapolated quickly and efficiently, while ensuring compliance with GDPR and information governance requirements. This approach provides assurance that data is handled appropriately, proportionately, and securely at all times.

2.3.7 That governance data is shared appropriately with those making revalidation recommendations – including for example information about complaints and incidents, and feedback from patients?

Level of Assurance (RAG):

GREEN

Evidence for rating assessment / future plans

All Medical Directors and Deputy Medical Directors who are required to sign off revalidation templates have RO access to MARS. MARS includes relevant information to support revalidation decisions, such as QIAs, Significant Events (SEAs), 360° feedback, and complaints data.

Any requests for information are managed on an individual, case-by-case basis, ensuring that access is proportionate and appropriate. GDPR and information governance requirements are adhered to at all times, with safeguards in place to ensure confidentiality, data minimisation, and lawful processing.

2.3.8 That the DB encourages lay involvement in quality assurance processes to provide independent scrutiny and challenge?

Level of Assurance (RAG):

AMBER

Evidence for rating assessment / future plans

Lay members (Independent Board Members) are represented at Health Board level, supporting transparency, accountability, and robust governance arrangements.

The previous Executive Medical Director has been working collaboratively with the Chair of the Health Board to secure lay member representation on the Revalidation Review Committee. Progress has been temporarily delayed due to changes in Health Board Responsible Officer and Independent Members; however, the organisation remains fully committed to achieving lay representation within this forum to further strengthen assurance and independent challenge within revalidation governance.

2.3.9 That the organisation's Board is appropriately engaged in / informed about governance and revalidation processes?

Level of Assurance (RAG):

GREEN

Evidence for rating assessment / future plans

Appraisal compliance is reported on a monthly basis through the Integrated Quality Performance Report, which is formally presented to the Board. This provides regular executive and non-executive oversight of appraisal and revalidation performance.

A Monthly Accountability Report is also produced for each Acute Site and is received by the Secondary Care Medical Directors, Integrated Health Medical Directors, Mental Health Director, and Women's Services Medical Director ensuring local leadership oversight and accountability.

The Responsible Officer sits on the Health Board in their role as Executive Medical Director, providing direct assurance at Board level and ensuring that appraisal and revalidation are embedded within the organisation's executive governance structures.

In addition, the Revalidation Manager attends and presents updates to the Office of the Medical Director Executive Oversight Group, ensuring regular scrutiny, escalation where required, and alignment between operational revalidation processes and senior medical leadership.

2.3.10 That doctors' constraints identified at appraisal are reported to the Board for consideration i.e., to be included in risk register if appropriate?	Level of Assurance (RAG):	GREEN
Evidence for rating assessment / future		
HEIW provides an annual Constraints Report, which is circulated to the Responsible Officer (RO), Deputy Responsible Officer (DRO), Revalidation Managers, and Appraiser Leads. Constraints are also visible to Medical Directors when completing the revalidation recommendation template, ensuring transparency and oversight. Newly appointed doctors are advised that, while an appraiser may not always be able to resolve issues raised within the constraints, they may be able to support the doctor by signposting them to appropriate routes or sources of support. The Appraiser Workshop includes discussion of the <i>Dealing with Discrimination</i> Fact Sheet, which is actively promoted. This has encouraged open discussion which is important as there was an increase in discrimination-related constraints reported within BCUHB this year. Other constraints identified are broadly consistent with national themes.		
2.3.11 That governance processes are having a positive impact, and informing revalidation appropriately?	Level of Assurance (RAG):	GREEN

Evidence for rating assessment / future

Health Education and Improvement Wales (HEIW) provide an annual constraints report, which is circulated to the Responsible Officer (RO), Deputy Responsible Officer (DRO), Revalidation Managers, and Appraiser Leads. This ensures shared awareness of national themes and any constraints relevant to appraisal and revalidation processes.

The constraints are also visible within MARS and are reviewed by Medical Directors (MDs) when completing revalidation templates, ensuring that relevant information is considered as part of the revalidation decision-making process.

New doctors are advised that, while an appraiser may not always be able to directly resolve issues identified within the constraints, they are well placed **to** support reflective discussion and signpost doctors to appropriate support pathways or escalation routes, where required.

The most recent HEIW report highlighted a notable negative variance for BCUHB, that discrimination or harassment-related constraints has increased, from 2 to 13 for harassment, and 11 – 13 for discrimination. BCUHB continues to take a proactive and preventative approach. The Dealing with Discrimination Fact Sheet is routinely included within appraiser training workshops, and open discussion is encouraged to support awareness, challenge, and early identification of concerns. Speaking Up Safely is proactively providing a safe, confidential online platform to raise concerns when other options have been tried and a concern remains unresolved.

Please outline any areas identified for development relating to **2.3 Underpinning systems: Governance**

- Appraiser Lead and Appraiser Job Descriptions have been reviewed and updated and are currently awaiting formal ratification.
- The organisation will continue to deliver local Quality Assurance (QA) Days, supporting consistency, peer learning, and continuous improvement in appraisal quality.
- The Revalidation Team will re-train and provide ongoing support to revalidation team staff and doctors in relation to CODI.
- Good practice identified through QA Days will be anonymised and shared through newsletters, workshops, and nationally in the Revalidation Managers Meetings, enabling wider learning and dissemination of effective appraisal and revalidation approaches across the organisation.

Part 3 – Progress against Revalidation Quality Assurance Review action plan

In this section you should provide progress details on your action plan from your last revalidation quality assurance review.

Part 3 - progress against Revalidation Quality Assurance Review action plan		
DB action pan and comments/progress		Date of Visit: 5.6.2025
Action	Most recent progress/status	
Share Best Practices with other Health Boards The Revalidation Managers continue to share any best practices or local pathways with other Health Boards.	- BCUHB has shared best practices through WRAG (deferrals being 12 months) - BCUHB has shared best practices with Swansea HB and Cwm Taff specifically on processes	
Lay Person on Revalidation Committee	Lay Person; The Health Board is fully committed to implementing this recommendation, and actions to appoint lay members will progress. Interim arrangements ensure that lay representation and scrutiny continue through existing Health Board and Committee structures, including external Quality Assurance visits and Board-level oversight.	

Part 4 – Internal Quality Assurance and Other Projects

Please provide details of any internal quality assurance exercise, quality improvement or revalidation or appraisal project the DB have undertaken

- **Orbit 360 Project**

The ongoing Orbit 360 programme ensures that doctors are contacted between years 2–3 of their revalidation cycle, with guidance recommending completion of 360° feedback during the year 3 appraisal, supporting timely and meaningful revalidation evidence decreasing deferrals.

- **Appraiser Quality Assurance (QA) Days**

Appraiser QA Days continue, with three appraisals reviewed per appraiser. Detailed feedback is provided by Appraisal and Revalidation Team, with additional face-to-face feedback from Revalidation Managers, With additional feedback from Appraiser Leads, supporting continuous improvement and consistency in appraisal quality.

- **Appraiser Workshops**

Appraiser Workshops will continue to be delivered regularly to ensure annual CPD, maintain appraisal standards, and ensure appraiser knowledge remains current and aligned with national guidance.

- **Audit of GP Appraisees and Designated Body Alignment**

Audits continue for GP appraisees on the BCUHB Medical Performers List (MPL) but not aligned to BCUHB as their Designated Body (DB). Appraisals are checked and the designated body status updated where appropriate to ensure accuracy and governance compliance.

- **Weekly Breaches Monitoring**

A weekly interrogation of the breaches list is undertaken, triangulating data from ESR, GMC Connect, CODI and MARS, for both primary and secondary care doctors, to ensure prompt identification and management of any issues.

- **Training Material Updates – Good Medical Practice (GMP)**

Appraisal and revalidation training materials are being updated to reflect the new Good Medical Practice (GMP) domains, ensuring relevance and consistency for both appraisees and appraisers.

- **UPSW training**

UPSW training was attended by all of the Appraisal and Revalidation Team to give insight into dealing with wellness appraisals and the process for doctors.

- **Intranet Website**

Training has been attended by all the Appraisal and Revalidation Team members to enable the team to update and manage the intranet website, posting quarterly newsletters, guides, and policies and helpful tips.

Part 5 – Board Statement of Compliance

On behalf of the DB (Chief executive or chairman, or executive if no board exists) I can confirm that:

The organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013)

- ☐ Agree
☐ Disagree

We are satisfied with the level of assurance we have about these systems and processes, both now and throughout the year, and the way in which they support and inform revalidation

- ☐ Agree
☐ Disagree

We are satisfied with the organisation's progress in terms of revalidation, and that there is a clear plan in place to guide further quality improvements

- ☐ Agree
☐ Disagree

Or: we have concerns about any of the above, as described below:

Part 6 - Submission Declaration

Completed report authorised by Responsible Officer

By completing this RPR, I declare that all the requested information has been provided and the Responsible Officer or Responsible Person has agreed and authorised submission to the Revalidation Support Unit.

☐ Agree

People and Culture Committee

INTERNAL AUDIT REPORT: ON CALL ARRANGEMENTS

Dyddiad y Cyfarfod Date of Meeting	11 June 2026
Statws Cyhoeddi Publication Status	Open/ Public
	Not Applicable
Report Author name and title Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol Lead Executive Team Member name and title	Tehmeena Ajmal Chief Operating Officer
Pwrpas yr Adroddiad Report Purpose	For Noting

Crynodeb Gweithredol **Executive Summary**

This paper is to inform the Committee of the outcome of the Internal Audit review of on-call arrangements across the Health Board, undertaken between October 2025 and January 2026.

Ymgysylltu (mewnol/allanol) yr ymgwymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp) **Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)**

Pwyllgor / Grŵp / Unigolion Committee / Group / Individuals	Dyddiad Date	Canlyniad, Tystiolaeth a Data Outcome, Evidence and Data
Audit Committee	21/04/2026	Noted

Acronymau / Rhestr Termiau **Acronyms / Glossary of Terms**

EPRR	Emergency Preparedness, Resilience and Response
FFTF	Foundations for the Future
CCA	Civil Contingencies Act
SOC	Silver on-Call
WOD	Workforce & Organisational Development
CCAG	Civil Contingencies Advisory Group
IHC	Integrated Health Community
ESR	Electronic Staff Record

INTERNAL AUDIT REPORT: ON CALL ARRANGEMENTS

1. Y SEFYLLFA / SITUATION

- 1.1 The Health Board received the above audit report in February 2026, linked to a review of on-call arrangements for Bronze, Silver, Gold and System Lead rotas and assurance of whether on-call rotas across the Health Board include the appropriate mix and seniority of staff, and whether arrangements are fair and sustainable.
- 1.2 The internal audit review found limited assurance that on-call arrangements are operating effectively, with key weaknesses including the absence of a finalised policy, inconsistent management of compensatory rest, and uneven access to training and support, which also affects compliance with the Civil Contingencies Act. Although issues remain, staff reported improvements in recent years, and the draft policy and strengthened training represent positive progress.
- 1.3 There were four assurance objectives:
- 1.3.1 Review the on-call arrangements across the Health Board, and consider whether rotas include the relevant mix/seniority of staff, are fair, and sustainable – **limited assurance**.
 - 1.3.2 Review whether staff are taking, or are able to take, compensatory rest periods following on-call duty, and how these are recorded/monitored – **limited assurance**.
 - 1.3.3 Confirm that on-call payment arrangements are applied fairly across the Health Board – **reasonable assurance**.
 - 1.3.4 Confirm that appropriate training, guidance, and support are available for staff – **limited assurance**.

2 Y CEFNDIR / BACKGROUND

- 2.1 An earlier internal audit review was undertaken in 2022 of on-call arrangements against which some improvements were noted with strengthened support and the development of a draft on-call policy in response to the management actions identified. Further work is ongoing to finalise and embed this policy.
- 2.2 Agreed management actions have subsequently been agreed and submitted in response to the findings, with updates provided as follows:
- 2.2.1 On-call rota composition, fairness and sustainability
- Under the Civil Contingencies Act (CCA) 2004 the Health Board is required to have appropriate on-call rotas in place to support major incident / business continuity response. Changes to the organisational structure

following FFtF will need to be taken into account in the future operating model to ensure that the on-call model is fit for purpose.

Work is ongoing through WOD / FFtF to facilitate all Job Descriptions at 8a and above to be within the requirements to participate in the appropriate management on call rota (Bronze/Silver/Gold). Whilst no timescale is currently available this action is expected to bring additional resource onto all of the on-call management rotas which should reduce the frequency of on-calls and improve resilience

13 senior managers at 8C and above, in corporate roles, were contacted and asked to volunteer to participate in the Silver on-call rota (with training, education and support provided). 3 colleagues agreed. 2 have commenced and 1 is undergoing further training and support. The rest declined and were supported by their Executive Director.

As at April 2026, there are 23 staff participating in the SOC rota (this will reduce in June following x 2 retirements). This continues to put additional pressure on SOC's to pick up additional duties – ongoing concerns have been raised by SoC colleagues in terms of the frequency and intensity of the current SOC rota. There remains an ongoing risk that the rota is unsustainable unless actions (pre FFtF) are implemented at pace. Whilst a respect and resolution was upheld, actions have not yielded any improvement in rota numbers nor any improvement in on-call expectations and intensity.

Support from Executive Directors and IHC Directors to engage senior managers in corporate roles and IHC roles that currently do not participate in the current SOC rota would support an urgent and necessary improvement in cover.

The draft on-call policy will require alignment to the FFtF structure. Consideration of future ways of working and on call expectations will need to be agreed as part of the new future operating model.

2.2.2 Compensatory Rest Arrangements

The Executive Director of Nursing issued a communication cascade in December 2024, to all managers on the Bronze and Silver on-call rotas to remind them of the need to ensure that they factor into their diaries compensatory rest after an on-call as well as the need for compliance with the Working Time Regulations was also included in the communication.

This is now also included within the draft on-call policy, as well as EPRR on-call training and reiterated to staff via operational masterclass training sessions.

2.2.3 Training, guidance and support for on-call staff

Conversations are to be held with workforce team to make the training mandated and live on Electronic Staff Record (ESR).

25 EPRR on-call training sessions have been offered internally with 79.4% (154) staff undertaken this training which is an improving trend.

Monthly on-call learning sessions remain well attended with positive discussions and support.

Two operational masterclasses have been delivered with good attendance. Operational Advice and guidance for on-call has been developed and is held on the on-call information channel on Microsoft teams.

Training compliance reports are taken to CCAG quarterly. Monthly compliance training reports are shared with Directors to support attendance.

To date 6 Gold on-call have attended All Wales Gold training; 4 Gold are booked to attend All Wales Gold in 2026. 18 are on the GoC rota, leaving 8 left to attend All Wales Gold Training. 4 Gold on-call have not attended EPRR / on call internal training or All Wales Gold.

3 **MATERION PENODOL I'W HYSTYRIED / SPECIFIC MATTERS FOR CONSIDERATION**

3.1 An update was presented to Audit Committee in April which noted the **limited assurance** outcome.

3.2 The Committee also noted the ongoing pressures on gold and silver on-call rotas; inconsistencies in job descriptions and contractual expectations and training gaps, particularly for executive directors undertaking gold on-call roles. In response to this an update was provided to confirm the identified actions underway for the review of job descriptions through "Foundations for the Future"; expanded training and support for on-call roles and improved learning and feedback following incidents.

3.3 It was agreed that Audit Committee will receive further assurance updates at 6 and 12 months on progress in strengthening on-call arrangements.

4 **RISGIAU ALLWEDDOL / MATERION I'W HUWCHGYFEIRIO KEY RISKS / MATTERS FOR ESCALATION**

4.1 There remains an ongoing risk that the rota is unsustainable unless actions (pre FFfF) are implemented at pace.

5 ARGYMHELLION / RECOMMENDATIONS

5.1 Gofynnir i'r Pwyllgor / The Committee is asked to:

5.1.1 **NOTE** the outcome of the internal audit review (limited assurance) and the position against agreed management actions.

ASESIAD / ASSESSMENT

Cysylltiad â'r Bwriadau Strategol	1. Focus on Health and Wellbeing
Link to Strategic Intentions	
Yr Egwyddorion Dylunio Design Principles	Consistency with Organisational Values
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd Corporate Risks and Board Assurance Framework	CRR25-01 Timely Access to safe delivery of care

ASESIADAU O EFFAITH / IMPACT ASSESSMENTS

Equality Act 2010 Public Sector Equality Duty: Has BCUHB provided evidence of 'Due Regard' to compliance with the three parts of the Public Sector Equality Duty (General Duty): https://www.gov.wales/public-sector-equality-duty.html Public Sector Equality Duty [HTML] GOV.WALES	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Equality Act 2010 - Socio-economic Duty <i>Has BCUHB provided evidence of 'Due Regard' to compliance of ther Socio-economic Duty when making strategic decisions?</i>	Do/Yes: ☒	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
<i>Have you completed an Integrated Equality Impact Assessment WP8a?</i> WP8a Template	Canlyniad/Outcome: Do/Yes:	Naddo/No:
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
	Canlyniad/Outcome: Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	

Human Rights Act <i>Have Human Right based concerns been addressed within WP8a</i>	Do/Yes: ☐	Naddo/No: ☐
	Canlyniad/Outcome:	
Compliance to the Welsh Language requirements? <i>Have you undertaken an Impact Assessment</i>	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Naddo/No: ☐
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Compliance to giving 'Due Regard' to the principles of the Armed Forces Covenant <i>Have the principles of the Armed Forces Covenant been addressed within WP8a</i>	Do/Yes: ☐	Naddo/No: ☐
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
<u>Ansawdd</u> <i>A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?</i> <u>Quality</u> <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Do/Yes: ☐	Naddo/No: ☐
	Canlyniad/Outcome:	
	Galluogwyr Ansawdd Enablers of Quality Culture and Valuing People Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
<u>Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant Wellbeing of Future Generations Act – Wellbeing Goals</u>	Not Applicable	
Effaith Amgylcheddol / Cynaliadwyedd (5Rs) Environmental /Sustainability Impact (5Rs)	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below: No - Not Applicable	

	Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:	
Asesiad o Effaith ar Ddiogelu Data <i>A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?</i> Data Protection Impact Assessment <i>Have you undertaken a Data Protection Impact Assessment Screening?</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Asesiad o Effaith ar Atal Twyll <i>A ydych chi wedi ystyried yr effeithiau ar atal twyll?</i> Counter Fraud Impact <i>Have you considered the counter fraud impacts</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	
Cyfreithiol Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw Da Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith ar Adnoddau <i>(Pobl / Ariannol)</i> Resource Impact <i>(People / Financial)</i>	Yes (Include further detail below)	
	There is a requirement to consider the Organisational duties under the Health and Safety At Work Act etc 1974 and the Working Time Regulations 1998	

People and Culture Committee

CORPORATE RISK REGISTER

Dyddiad y Cyfarfod Date of Meeting	11 June 2026
Statws Cyhoeddi Publication Status	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad Report Author name and title	Jody Evans, Assistant Head of Risk Management Anthony Hughes, Risk Assurance Manager
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol Lead Executive Team Member name and title	Pam Wenger, Director of Corporate Governance
Pwrpas yr Adroddiad Report Purpose	For Assurance

Crynodeb Gweithredol **Executive Summary**

Two corporate risks within the Committee's remit (CRR25-02: Future Demand & Sustainable Workforce and CRR25-07: Leadership and Operating Model) have been transferred to the revised Corporate Risk Register format, improving clarity of risk articulation and the alignment between controls, gaps and mitigating actions.

Both risks remain rated 16, which is above the Health Board's risk appetite (Quality <15) and therefore represent a current and material exposure. No reduction in risk score is proposed at this stage.

There is evidence of progress in delivery, with 18 of 20 mitigating actions currently in progress, however two actions have not commenced and are dependent on completion of the Demand and Capacity review, which is a critical enabler. This dependency limits the extent to which risk exposure can be reduced at this time.

Executive-level deep dive reviews have been undertaken and provide additional scrutiny of the adequacy of controls and planned actions. These have identified the need for further refinement to ensure that risk descriptions, control effectiveness, and action plans fully reflect the current operational position.

The Committee should note that:

- Risk exposure remains above tolerance, with no immediate trajectory to within appetite
- Delivery of key actions is contingent on system-wide planning work, particularly Demand and Capacity
- Organisational capacity and competing priorities may impact the pace of delivery

A full refresh of both risks is in progress to strengthen the accuracy of the risk position and the credibility of mitigating actions. Updated risks will be presented in the next reporting cycle.

Ymgysylltu (mewnol/allanol) yr ymgwymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp)
Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)

Pwyllgor / Grŵp / Unigolion Committee / Group / Individuals	Dyddiad Date	Canlyniad, Tystiolaeth a Data Outcome, Evidence and Data
Informal EC Deep Dive	27/05/2026	Deep Dives held: • CRR25-02: Future Demand & Sustainable Workforce • CRR25-07: Leadership and Operating Model
Executive Committee (EC)	20/05/2026	Full CRR presented to the Executive Committee.
Risk Scrutiny Group (RSG)	12/05/2026	Following review by the Risk Scrutiny Group (RSG) on the 12th May 2026, minor further amendments to the template were agreed, alongside the need to present action details in a more succinct and consistent manner in future iterations of the cycle.

Acronymau / Rhestr Termiau
Acronyms / Glossary of Terms

CRR	Corporate Risk Register
RSG	Risk Scrutiny Group
BAF	Board Assurance Framework

CORPORATE RISK REGISTER

1. Y SEFYLLFA SITUATION

This report provides an update on the Corporate Risks falling within the remit of the People and Culture Committee.

Two Corporate Risks sit within the Committee's oversight:

- CRR25-02: Future Demand & Sustainable Workforce
- CRR25-07: Leadership and Operating Model

2. Y CEFNDIR BACKGROUND

The Committee is asked to scrutinise and endorse two Corporate Risks within its remit prior to submission to the Board:

Both risks have been mapped over to the newly approved Corporate Risk Register template. This provides improved clarity and consistency in the articulation of risk position, and strengthens the alignment between identified control gaps, mitigating actions and intended outcomes.

Both risks currently have a score of 16, which remains above the Health Board's risk appetite (Quality <15). Action plans are in place to mitigate risk exposure, with the majority of actions progressing as planned. A small number of actions are dependent on completion of key enabling work, most notably the Demand and Capacity review.

Targeted Executive-level deep-dive sessions have been undertaken for both risks to further strengthen assurance. Discussions are ongoing with the Executive Director of People Services & Organisational Development to review both risks, ensuring they accurately reflect the current position and associated mitigation plans. **A full refresh** will be undertaken and reported in the next iteration of the Corporate Risk Register.

The Committee is invited to review the risks in their current form and provide feedback to support further refinement ahead of Board consideration.

3. MATERION PENODOL I'W HYSTYRIED SPECIFIC MATTERS FOR CONSIDERATION

Overdue/Delayed Actions

Two actions identified under Corporate Risk 25-02, '*Future Demand and Sustainable Workforce*', have not yet commenced. Progress is dependent on completion of a preceding action: a full demand and capacity review to identify the true gaps within the workforce model. Both actions will be initiated following completion of this review.

Risks above Health Board 24/25 appetite

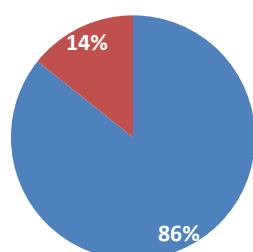
Both risks reported to the Committee are outside the tolerance levels set within the risk appetite.

Risk Ref	Risks	Lead Exec Director	Current Risk Score	Risk Tolerance Range in Appetite Score
CRR25-02	Future Demand & Sustainable Workforce	Executive Director of Workforce	16	Quality <15
CRR25-07	Leadership and Operating Model	Executive Director of Workforce	16	Quality <15

Action Plan status of Corporate Risks

ACTION STATUS OF CORPORATE RISKS

■ Progressing ■ Not Started



Out of the 2 corporate risks, 20 actions have been developed to mitigate the risks, with 18 open actions progressing and on track.

4. **RISGIAU ALLWEDDOL / MATERION I'W HUWCHGYFEIRIO KEY RISKS / MATTERS FOR ESCALATION**

- Both risks remain outside risk appetite, indicating continued exposure.
- Delivery of key actions is dependent on system-wide planning activity (Demand & Capacity)
- Organisational capacity and competing priorities (e.g. FFtF programme) may impact pace of delivery in some areas.

No change in risk score is proposed at this stage, pending full refresh of the risks.

5. **ARGYMHELLION RECOMMENDATIONS**

The Committee is asked to:

- **REVIEW** the corporate risks set out in the Appendix, including consideration of the current risk position, existing controls, and identified gaps.
- **ENDORSE** the risks for submission to the Board, noting that both risks remain above the Health Board's risk appetite and therefore represent a continued exposure.
- **SUPPORT** the planned refresh of the risks, in line with advice from the Executive Director of People Services & Organisational Development, to ensure they accurately reflect the current position and mitigation plans.

ASESIAD / ASSESSMENT	
Cysylltiad â'r Bwriadau Strategol	3. Improve Access, Outcomes and Experience
Link to Strategic Intentions	If more than one applies, please list below:
Yr Egwyddorion Dylunio Design Principles	People First
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd Corporate Risks and Board Assurance Framework	Corporate Risk Register and Board Assurance Framework - Betsi Cadwaladr University Health Board

ASESIADAU O EFFAITH / IMPACT ASSESSMENTS		
Equality Act 2010 Public Sector Equality Duty: Has BCUHB provided evidence of 'Due Regard' to compliance with the three parts of the Public Sector Equality Duty (General Duty): https://www.gov.wales/public-sector-equality-duty.html Public Sector Equality Duty [HTML] GOV.WALES	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	<i>This report is purely administrative in nature.</i>
Equality Act 2010 - Socio-economic Duty <i>Has BCUHB provided evidence of 'Due Regard' to compliance of ther Socio-economic Duty when making strategic decisions?</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	<i>This report is purely administrative in nature.</i>
<i>Have you completed an Integrated Equality Impact Assessment WP8a?</i> WP8a Template	Canlyniad/Outcome:	Naddo/ <u>No</u> :
	Do/Yes:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale: Canlynaid/Outcome:	<i>This report is purely administrative in nature.</i>

	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	N/A
Human Rights Act <i>Have Human Right based concerns been addressed within WP8a</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	N/A
Compliance to the Welsh Language requirements? <i>Have you undertaken an Impact Assessment</i>	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Naddo/No: ☒
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	N/A
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	<i>This report is purely administrative in nature.</i>
Compliance to giving 'Due Regard' to the principles of the Armed Forces Covenant <i>Have the principles of the Armed Forces Covenant been addressed within WP8a</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	N/A
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	<i>This report is purely administrative in nature.</i>
<u>Ansawdd</u> <i>A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?</i> <u>Quality</u> <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	N/A
	Galluogwyr Ansawdd Enablers of Quality All Apply Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
<u>Deddf Llesiant</u> <u>Cenedlaethau'r Dyfodol - Nodau Llesiant</u>	A Healthier Wales	

Wellbeing of Future Generations Act – Wellbeing Goals		
Effaith Amgylcheddol / Cynaliadwyedd (5Rs) Environmental /Sustainability Impact (5Rs)	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below: Yes - Refine	
	Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:	
Asesiad o Effaith ar Ddiogelu Data	Do/Yes: ☐	Naddo/No: ☒
<i>A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data?</i>	Canlyniad/Outcome:	N/A
Data Protection Impact Assessment	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	<i>This report is purely administrative in nature.</i>
<i>Have you undertaken a Data Protection Impact Assessment Screening?</i>		
Asesiad o Effaith ar Atal Twyll	Do/Yes: ☐	Naddo/No: ☒
<i>A ydych chi wedi ystyried yr effeithiau ar atal twyll?</i>	Canlyniad/Outcome:	N/A
Counter Fraud Impact	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	<i>This report is purely administrative in nature.</i>
<i>Have you considered the counter fraud impacts</i>		
Cyfreithiol Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw Da Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith ar Adnoddau (Pobl / Ariannol) Resource Impact (People / Financial)	Yes (Include further detail below) As per detail relating to resources within risk and actions.	

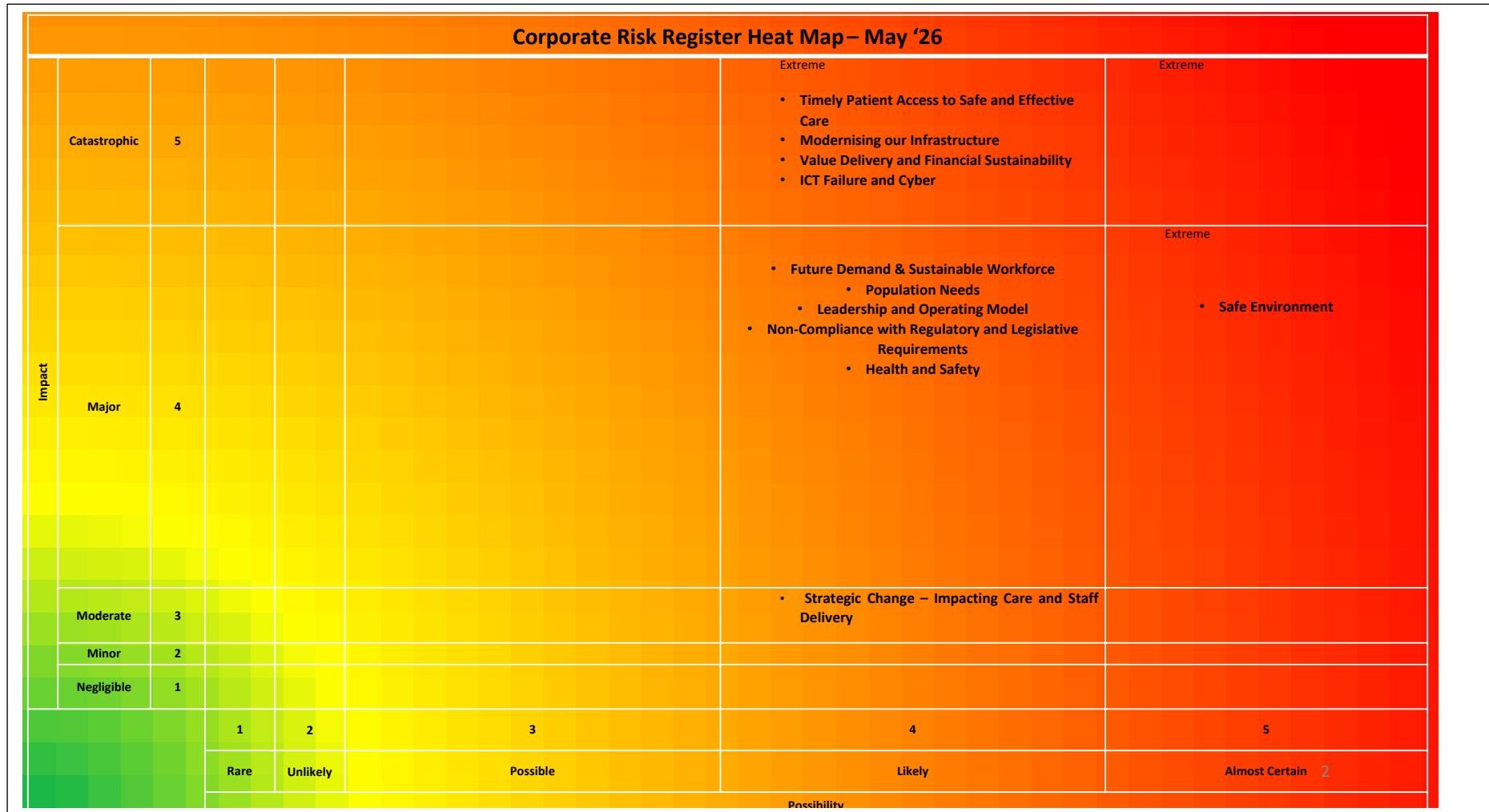
Appendix 1 - Corporate Risk Register Dashboard - People & Culture Committee (P&C)

Lead	Ref	Risk Title	Current Score (Impact x Likelihood)	Risk Target Score	Appetite Main Risk Type Appetite Level	Lead Board Committee	Action Progression			Risk Management Commentary
							Total	Completed	Delayed or Overdue	
EDoW	CRR25-02	Future Demand & Sustainable Workforce	4x4 16	8	Quality (<15)	People & Culture Committee	11	0	2	Risk transferred and reviewed to updated template.
					Above Tolerance					Executive Committee Deep Dive Review undertaken on 27/05/2026
EDoW	CRR25-07	Leadership and Operating Model	4x4 16	8	Quality (<15)	People & Culture Committee	9	0	0	Risk transferred and reviewed to updated template.
					Above Tolerance					Executive Committee Deep Dive Review undertaken on 27/05/2026

Key:

Executive	
Executive Director of Workforce	EDoW

Appendix 2 – Corporate Risk Register Heatmap



Appendix 3 - Corporate Risk Register P&C Committee – May 2026

CRR REF: 25-02		
Risk Title: Future Demand & Sustainable Workforce		
Director Lead: Executive Director of People and Organisational Development		Date Opened: 21/08/2025
Assuring Committee: People & Culture Committee		Date Last Committee Review: 12/02/2026
Date Last Reviewed: 30/04/2026	Link to BAF: BAF26-04	Target Risk Date: 31/03/2027
Risk Detail: There is a risk that the Health Board does not have an effective, coherent workforce plan and workforce supply, that is based upon an incorrect funded establishment. This may be caused by the organisation not undertaking effective of demand and capacity planning, which may be compounded by high sickness rates and recruitment challenges. This may lead to staff burnout, reduced morale and retention and an inability to consistently deliver safe, high-quality care. This will likely place additional strain on services and impacting patient outcomes.		
Mitigations/Controls in place		
1. A new workforce planning framework has been agreed 2. A Healthy Workforce group is in place overseeing a comprehensive range of actions to improve sickness rates and employee wellbeing 3. The Foundations for the Future (FFTF) Board is in place to oversee the development of the future workforce model 4. The Board has approved the three-year culture change programme		

5. A Value & Sustainability programme is in place, overseeing a range of initiatives to improve productivity and financial efficiencies
6. A recently introduce Medical & Dental policy advisory service is in place
7. Work around retention initiatives has seen a reduction in avoidable turnover

Gaps in Controls	Action	Action Owner	Due Date	Progression Analysis
G1 Implement a system-wide Workforce Planning service with reportable workforce plans across key services	Adoption of the workforce planning framework, based on the results of the demand and capacity review in conjunction with the clinical services plan	Chief Operating Officer, Executive Medical Director and Executive Director of Transformation and Improvement	31/03/2027	Will commence fully once D&C has been completed
Gaps in Controls	Action	Action Owner	Due Date	Progression Analysis
G2 Demand and Capacity (D&C) forecasting	Full demand and capacity review that will identify true gaps in the workforce model	Finance and Performance	31/03/2027	Progressing
G3 An establishment review is required following D&C review	Undertake establishment reviews based on the outputs of the Demand & Capacity review	Finance and Performance	31/03/2027	Will commence fully once D&C has been completed

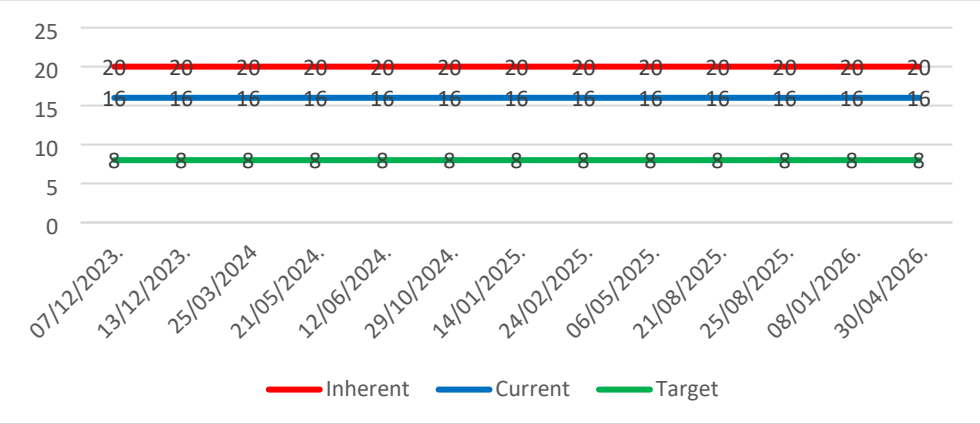


G4 An agreed operating model for the Health Board through the FFTF programme	Consultation and Implementation of the new operating model leadership structure. The first phase is Band 8c +	Senior Associate Director of People & Organisational Development (OD)	31/03/2027	Progressing
G5 Clinical Service plan that outlines workforce requirements	Engagement sessions are being held in May 26, a draft outline plan has been shared.	Executive Medical Director	01/04/2027	Progressing
Gaps in Controls	Action	Action Owner	Due Date	Progression Analysis
G6 M&D leadership and engagement is not fully effective	Strengthen the governance arrangements for the Medical Workforce Group, to report into the new Executive Delivery Group for People & OD.	Senior Associate Director of People & OD	30/09/2026	Progressing
	To scope and put forward proposals for a wider Medical Staffing function in the People Service directorate.	Senior Associate Director of People & OD	31/03/2027	Progressing
G7 M&D Job Planning policy	To approve and publish the new Job Planning procedure and meet the target of achieving 90% of M&D Job Plans being in place.	Executive Medical Director	31/03/2027	Progressing



G8 More effective workforce pipelines in fragile services	Within the overarching OD plan, Values Based Recruitment (VBR), values based induction and transition are being introduced as part of the new Health Board values implementation	Exec Director People & Organisational Development (POD)	31/03/2027	Progressing
Gaps in Controls	Action	Action Owner	Due Date	Progression Analysis
G9 Absence and sickness management to deliver on ministerial targets and enabling actions	Targeted management of sickness absence. A Healthy Workforce group is in place and is overseeing the action plan to target reducing sickness absence rates, in line with the Welsh Government requirements by March 2026. A range of actions are being worked on through this group, which are expected to be delivered by the end of 2026/27.	Deputy Director, People & Organisational Development	31/03/2027	Progressing
	A sickness deep dive paper was tabled at December 2025 People & Culture Committee which incorporates a series of initiatives that will help reduce sickness absence rates. The planned delivery for these is March 2027	Deputy Director, People & Organisational Development	31/03/2027	Progressing



			Impact	Likelihood	Score
		Inherent Risk Rating	4	5	20
		Current Risk Rating	4	4	16
		Target Risk Score	4	2	8
		Risk Appetite	Quality <15		Not in Toleranc e
Position & Intended Outcome for Risk					
KPIs to that inform our risk in this area as at February 2026;					
Overall Vacancy rate of 8.1%; Target 8%. M&D, Add Clin Services, Healthcare Sciences, E&F and A&C above target					
Turnover stands at 7.1% and continues its downward trend from 7.9% this time last year.					
Sickness rates currently 6.08%; Target 4.2%					
Time to Hire currently 77 days; target 71 days					

CRR REF: 25-07		
Risk Title: Leadership and Operating Model		
Director Lead: Executive Director of People and Organisational Development		Date Opened: 21/08/2025
Assuring Committee: People & Culture Committee		Date Last Committee Review: 12/02/2026
Date Last Reviewed: 30/04/2026	Link to BAF: 25-04	Target Risk Date: 31/03/2027
Risk Detail: There is a risk that the Health Board does not deliver high quality patient care aligned to operational plans, or not meeting HB targets or adhering to legislative requirements. This may be caused by not building and maintaining an effective culture and leadership environment, or developing the necessary skills and knowledge of our leaders. This may lead to poor organisational culture and behaviours which in turn will lead to low staff morale, poor patient care and inefficient services for the population of North Wales.		
Mitigations/Controls in place		
1. Speak Out Safely Multi Disciplinary Team (MDT) and Work in Confidence platform for staff to raise concerns 2. Organisational Culture Change Plan and Behaviours Framework approved by Board and is being deployed 3. Integrated Leadership Development Framework (ILDF) in place 4. Improved nurse retention results over the last 2 years		



5. Clear top-down commitment to reinforce leadership culture that prioritises staff wellbeing, inclusion, and psychological safety (Pledge signed)
6. Increased uptake on the 2025/26 staff survey
7. 60% of senior staff trained in leadership through conferences and masterclasses
8. New all Wales Flexible Working policy in place – monitored at the People and Culture Committee
9. Organisational Development (OD) plans are in place in 2026/27 to support recruiting well and joining well, for example Values Based Recruitment and Corporate induction

Gaps in Controls/Additional Controls required	Action	Action Owner	Due Date	Progression Analysis
G1 - Leadership development pathways not fully integrated	Further embed ILDF and measure effectiveness HEIW will release a Management Competency Framework due to be launched April 2026. This will be used to inform the mid-level management ILDF leadership courses / resources design. There has been a delay in HEIW launch of Management Competency Framework Mid level pilot to commence in May 26 this has been delayed due to financial restrictions on training. Evaluation of programmes	Head of Organisational Development Workforce & Organisational Development	30/09/2026	Progressing

	completed for Q1 & Q2 with Q3 & Q4 due May 26. People Managers forum evaluation underway for first 12 month roll out			
Gaps in Controls	Action	Action Owner	Due Date	Progression Analysis
G2 Outdated PADR process and system in place	A new values and behaviours based PADR system will be deployed in 2026. It is expected this programme will show results within the first year following the launch	Head of Organisational Development, People & OD	30/09/2027	Progressing
G3 Leadership taking on board and acting on staff survey results	Assess and agree the actions based on the 2025 staff survey results. The preliminary results are in. The next phase is for each service to confirm the localised actions in place to address the necessary actions in their areas	Head of Employee Engagement and Experience - Corporate Office	31/12/2026	Progressing
	A paper detailing the key findings from the NHS Wales Staff Survey 2025 and suggested next steps in response to feedback (including areas of focussed action) will go to the Board in May 2026. Directors received the results for their areas of responsibility in early March to inform discussions and action and teams across the organisation have access to HEIW'S survey dashboard to review	Head of Employee Engagement and Experience – Corporate Office	30/06/2026	Progressing



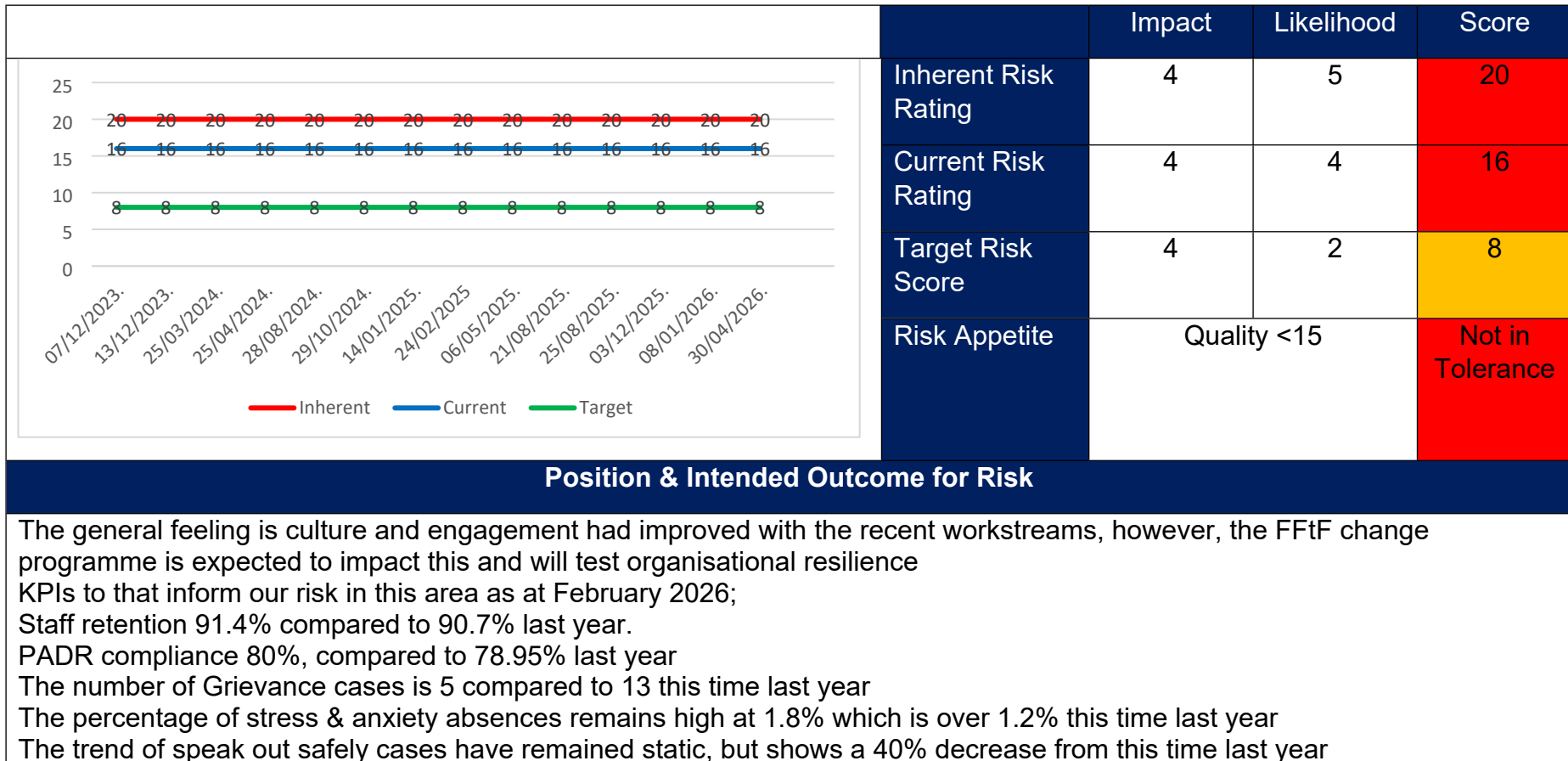
	performance and identify improvement opportunities. Briefings have also been held through established forums including local People and Culture Committees.			
G4 Capacity in delivering planned programmes of work alongside FFtF without any additional resource in OD, this may impact on the timelines for delivery	Review and prioritise workload in the OD function in 2026/27 to accommodate FFtF	Deputy Director, People & OD	30/09/2026	Progressing



Gaps in Controls	Action	Action Owner	Due Date	Progression Analysis
G5 Fully implemented culture change programme that will demonstrate improved KPIs	Implement Employee Engagement Plan with suite of indicators The actions underway listed below are part of the 2025-26 plan for culture and engagement. The 2025 staff survey result will be used to assess the impact these actions have had. It is expected the result will be available in early 2026. • Embedded new engagement listening approach including staff stories being shared at People and Culture Committee, Local Partnership Forum and more widely to support organisational understanding and learning. • Refreshed reward and recognition activity to introduce monthly recognition awards 'Seren Betsi' with Executive involvement, improved annual staff achievement awards event. A new approach to recognise 25 & 40 years service will be ratified in the April 2026 P&CC	Head of Employee Engagement and Experience - Corporate Office	31/12/2026	Progressing



	Staff survey champions will be trained to support local monitoring and reporting			
	Deliver Culture Change Plan with Comms and Engagement rollout. P&CC received an update on the plan in February 2026 and it was agreed a revised plan would be submitted back to P&CC in June 2026	Head of Organisational Development, Workforce & Organisational Development	30/06/2026	Progressing
	Quarterly Culture, Leadership & Engagement Plans finalised and monitored P&CC received an update on the plan in February 2026 and it was agreed a revised plan would be submitted back to P&CC in June 2026.	Head of Organisational Development, Workforce & Organisational Development	30/06/2026	Progressing
G6 Regular culture performance reporting at IHC/Directorate level	Introduce culture reporting at IHC level. A new dashboard to be deployed in Q1 26/27 to track Y1 performance against corporate and divisional target.	Deputy Director, People & OD	30/09/26	Progressing



People and Culture Committee

CORPORATE GOVERNANCE REPORT

Dyddiad y Cyfarfod Date of Meeting	11 June 2026
Statws Cyhoeddi Publication Status	Open/ Public
	Not Applicable
Enw a theitl Awdur(on) yr Adroddiad Report Author name and title	Philippa Peake-Jones, Head of Corporate Governance
Enw a theitl Aelod Arweiniol o'r Tîm Gweithredol Lead Executive Team Member name and title	Pam Wenger, Director of Corporate Governance

Pwrpas yr Adroddiad Report Purpose	For Noting
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Crynodeb Gweithredol Executive Summary
Members are asked to: NOTE the matters considered in Private at the 09 April 2026 meeting NOTE the draft Cycle of Business for comment prior to approval NOTE The Committee forward workplan

Ymgysylltu (mewnol/allanol) yr ymgwymerwyd ag ef hyd yma (gan gynnwys derbyn/ ystyried yn y Pwyllgor/Grŵp) Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Pwyllgor / Grŵp / Unigolion Committee / Group / Individuals	Dyddiad Date	Canlyniad, Tystiolaeth a Data Outcome, Evidence and Data
Not applicable for this report		

Acronymau / Rhestr Termiau Acronyms / Glossary of Terms
N/A

CORPORATE GOVERNANCE REPORT

1. Y SEFYLLFA SITUATION

- 1 The Health Board is required to act according to its Standing Orders. This report contains information to allow the Health Board to conform to this.
- 2 It is essential that the Board has robust arrangements in place for Corporate Governance and failure to do so could have legal implications for the Health Board.

3 Y CEFNDIR BACKGROUND

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

4 MATERION PENODOL I'W HYSTYRIED SPECIFIC MATTERS FOR CONSIDERATION

4.1 Summary of Business Considered in Private

- 4.1.1 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.
- 4.1.2 The below items were considered in private at the meeting held on 09 April 2026:

Agenda Item	Subject (including narrative)	Committee Resolution	Rationale for item in Private
PC26.48	High Risk Employment Issues and Employee Relations (Senior Managers) Quarterly Professional Standards Report	It was resolved that the Committee: NOTED the content of the report.	Business Sensitive
PC26.48	AAC Panel Consultant Appointments	it was resolved that the Committee: AGREED the consultant appointment made on	Identifiable Information



Agenda Item	Subject (including narrative)	Committee Resolution	Rationale for item in Private
		behalf of the Health Board during the period of the report. • NOTED the AAC Panels which were stood down, or did not make appointments, during the reporting period. • NOTED the forthcoming AAC panels which will be reported at the next meeting of the Committee.	
PC26.50	Pay Award 2025/26 Regular Verbal Update from Local Partnership Forum	it was resolved that the Committee: • NOTED the update concerning the 2025/26 pay award.	Identifiable Information

4.2 Committee Cycle of Business

The Committee Cycle of Business is an annual, structured plan that sets out all the regular items a committee is expected to consider over the year to ensure it fulfils its governance responsibilities. Each year the Committee reviews the plan, it is attached here in draft as Appendix 1.

4.3 Committee Forward Work Plan

4.3.1 The Forward Work Plan sets out the Committee's priorities and scheduled business outside of the normal Cycle of Business, helping ensure a structured, timely, and transparent approach to decision-making and oversight. It collates suggested referral items from other Committees and the Board.

5 RISGIAU ALLWEDDOL / MATERION I'W HUWCHGYFEIRIO KEY RISKS / MATTERS FOR ESCALATION

5.1 There are no matters for escalation.

6 ARGYMHELLION RECOMMENDATIONS

6.1 Gofynnir i'r Pwyllgor:
The Committee is asked to:

- **NOTE** the matters considered in Private at the 09 April 2026 meeting.
- **NOTE** the draft Cycle of Business for comment prior to approval.
- **NOTE** The Committee forward workplan.

ASESIAD / ASSESSMENT	
Cysylltiad â'r Bwriadau Strategol Link to Strategic Intentions	4.Create a Modern, People Centred Healthcare System Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Yr Egwyddorion Dylunio Design Principles	Simplify, Standardise, and Adopt Best Practices Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
Fframwaith Risgiau Corfforaethol a Sicrwydd y Bwrdd Corporate Risks and Board Assurance Framework	BAF24-01 Building an Effective and Accountable Organisation CRR-16 – Leadership/Special Measures

ASESIADAU O EFFAITH / IMPACT ASSESSMENTS		
Cydraddoldeb <i>A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o'r Effaith ar Gydraddoldeb (sy'n cynnwys gofynion Safonau'r Gymraeg)</i> Equality <i>Have you undertaken an Equality Impact Assessment Screening (which includes the requirements of the Welsh Language Standards)</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not necessary for this report
Asesiad o'r Effaith Economaidd-gymdeithasol <i>A ydych chi wedi cynnal Asesiad o'r Effaith Economaidd-Gymdeithasol?</i> Socio-Economic Impact Assessment <i>Have you undertaken a Socio-Economic Impact Assessment</i>	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not necessary for this report
<u>Ansawdd</u> <i>A ydych chi wedi ymgymryd â phrawf Sgrinio o'r Asesiad o'r Effaith ar Ansawdd?</i> <u>Quality</u>	Galluogwyr Ansawdd Enablers of Quality All Apply	Meysydd Ansawdd Domains of Quality All Apply

Have you undertaken a Quality Impact Assessment Screening?	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:
<u>Deddf Llesiant Cenedlaethau'r Dyfodol - Nodau Llesiant Wellbeing of Future Generations Act – Wellbeing Goals</u>	Not Applicable	

Effaith Amgylcheddol / Cynaliadwyedd (5Rs) Environmental /Sustainability Impact (5Rs)	Os oes mwy nag un yn berthnasol, rhestrwch hynny isod: If more than one applies, please list below:	
	No - Not Applicable	
Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog A ydych chi wedi ystyried Dyletswydd Sylw Dyladwy Cyfamod y Lluoedd Arfog: Armed Forces Covenant Due Regard Duty Have you considered the Armed Forces Covenant Due Regard Duty?	Os oes mwy nag un yn berthnasol, rhestrwch hynny: If more than one applies, please list:	
	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not necessary for this report
Asesiad o Effaith ar Ddiogelu Data A ydych chi wedi cynnal prawf Sgrinio o'r Asesiad o Effaith ar Ddiogelu Data? Data Protection Impact Assessment Have you undertaken a Data Protection Impact Assessment Screening?	Do/Yes: ☐	Naddo/No: ☒
	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not necessary for this report
	Do/Yes: ☐	Naddo/No: ☒

Asesiad o Effaith ar Atal Twyll <i>A ydych chi wedi ystyried yr effeithiau ar atal twyll?</i> Counter Fraud Impact Assessment <i>Have you considered the counter fraud impacts</i>	Canlyniad/Outcome:	
	Os naddo, dylech gynnwys y rheswm: If no, please include rationale:	Not necessary for this report
Cyfreithiol Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw Da Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith ar Adnoddau <i>(Pobl / Ariannol)</i> Resource Impact <i>(People / Financial)</i>	There is no direct impact on resources as a result of the activity outlined in this report.	



DRAFT

Betsi Cadwaladr University Health Board

People and Culture Committee

Cycle of Business
(1 April 2026 – 31 March 2027)

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

The Committee Cycle of Business cover the period 1 April 2026 to 31 March 2027.

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

The role of the People and Culture Committee is set out in the Terms of Reference which is available here: [Insert here]

Committee Chair Dyfed Jones	Independent Members Paul Lambert Clare Budden	Executive Members Debbie Eytayo (Executive Director of People and Organisational Development) Teresa Owen (Executive Director of Allied Health Professionals & Health Sciences) Carol Shillabeer (Chief Executive)	In Attendance Jason Brannan (Deputy Director of People Services) Stuart Keen (Director of Environment & Estates) Pam Wenger (Director Corporate Governance)
Committee Vice Chair William Nichols			

PEOPLE AND CULTURE CYCLE OF BUSINESS 2026-27

Item of Business	Executive Lead	Reporting period	Q1			Q2			Q3			Q4			2027-28	
			April 2026	May 2026	June 2026	July 2026	Aug 2026	Sep 2026	Oct 2026	Nov 2026	Dec 2026	Jan 2027	Feb 2027	Mar 2027	April 2027	May 2027
PRELIMINARY MATTERS																
Minutes of the Previous Meeting	Director of Corporate Governance	All Regular Meetings	R		R		R		R		R		R		R	
Matters Arising and Action Log	Director of Corporate Governance	All Regular Meetings	R		R		R		R		R		R		R	
Staff Story	Executive Director of People & Organisational Development	All Regular Meetings	R		R		R		R		R		R		R	
STRATEGIC ITEMS (Aligned to Strategic Priority 4 - Create a Modern, People-Centred Healthcare System)																
People Operations Report (Highlight report to each meeting for assurance) - Job Planning - Health Education & Improvement Wales (HEIW)	Executive Director of People & Organisational Development	All Regular Meetings	R		R		R		R		R		R		R	
Strategic Workforce Planning Framework	Executive Director of People & Organisational Development	Annually	R												R	
Education and Training Discovery Report	Executive Director of People Services	Annually									R					
Education and Training Plan Education Commissioning	Executive Director of People & Organisational Development	Annually											R			
Consultant Job Planning Report	Executive Medical Director	Bi-Annually	R		R		R		R		R		R		R	
Culture and Leadership Programme - Compassionate Leadership - Values & Behaviours - Fair Work element of the Well-being objectives	Executive Director of People & Organisational Development	Quarterly	R				R				R				R	
Employee Engagement and Experience Report (Including Staff Survey and Staff Engagement Plan)	Executive Director of People & Organisational Development	Quarterly (For onwards submission to Board)			R				R				R			
Strategic Equality Plan 2024-2028	Executive Director of People & Organisational Development	Bi-Annually					R						R			

[illegible]

People & Culture Committee – Non-Routine Committee Business Workplan

(1 April 2026 – 31 March 2027)

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
31.07.25 18.11.24	Action from July 25 Board 25/129.1 Action from Nov 24 Board 24/204	Health Board	Recruitment & Development of Young People	25/129.1: People and Culture Committee to discuss opportunities to support young people into the workplace and report back to the Board. 24/204: Arrange for P&C Committee forward workplan to include Recruitment and Development of local young people in North Wales to meet the future needs of different service areas across BCUHB.	Katie Sargent	Georgina Roberts	April 26 October 26	GR and DJ agreed to move this forward as this needs to align with the FFTF Programme and also needs to report back to the Board.
31.12.25	Request from Teresa Owen via email	Teresa Owen	End of Year Report on Health Sciences Activity	To increase the visibility of Health Sciences. Report to go to the Committee and consider including as an annual item for the Committee CoB (discuss at meeting)	Helen Hughes	Teresa Owen	June 26	Included on June 26 agenda
04.12.25	Action PC25.130.1 from December P&C Committee	P&C Committee	Sickness Absence Deep Dive Action Plan	Sickness Actions Deep Dive: An update on the Sickness Absence Deep Dive Action Plan to be presented to the Committee in six months time to highlight the progress made and the implementation achieved.	Jason Brannan Georgina Roberts	Debbie Eyitayo	June 26	Included on June 26 agenda
29.03.26	Request via email from Dyfed Edwards 01.04.26	Chair, Dyfed Edwards	Staff Wellbeing	Request from Dyfed: Given the current context where many staff are under huge pressure, I think it would be good to capture the current programme of activities and how we can offer further support to staff. I feel that this would be appreciated by staff at the current time.	Debbie Eyitayo	Debbie Eyitayo	June 26	Included on June 26 agenda
09.04.26	Action PC26.35 from the April P&C Committee	P&C Committee	People and Culture Plan	The revised People and Culture Plan to be shared at the June 2026 meeting for assurance.	Jason Brannan	Debbie Eyitayo	June 26	Included on June 26 agenda